Healthy Louisiana
Performance Improvement Project (PIP)

Health Plan: AmeriHealth Caritas Louisiana

PIP Title: Behavioral Health Transitions in Care

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

Submission Dates:

	Report Year 2022
Version 1	12/09/2022
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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3. External Collaborators (if applicable):

Attestation

Plan Name: AmeriHealth Caritas Louisiana
Title of Project: Behavioral Health Transitions of Care

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

Medical Director signature: Rodney Wise, MD
First and last name: Rodney Wise, MD
Date:12/28/2022

CEO signature: 
First and last name: Kyle Viator
Date:12/28/2022

Quality Director signature: Rhonda Baird
First and last name: Rhonda Baird
Date:12/28/2022

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
Change 1	6/3/2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☒ ITM	Template updated to enhance consistency of reporting and to clarify specifications (IPRO).
Change 2	10/31/2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☒ ITM	ITM 2e was revised to exclude FUA due to 42 CFR part 2 concerns (IPRO).
Change 3	1/1/2022	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☒ ITM	ITM #3a: Outreach members with SDOH (Housing Insecurity/Homelessness) to assist with locating community resources ITM #3b: Outreach members in the FUH population to assist with care coordination such as appointment scheduling, transportation, housing, etc
Change 4	1/1/2022	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☒ ITM	ITM #5: Enhanced care coordination services for member that choose to opt out of Case Management

Abstract

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

Provide a high-level summary of the PIP, including the project topic and rationale (include baseline and benchmark data), objectives, description of the methodology and interventions, results and major conclusions of the project, and next steps.

Project Topic and Rationale

The Behavioral Health Transitions of Care Performance Improvement Project (PIP) was implemented to improve hospital inpatient and emergency room visit follow-up care for mental illness or intentional self-harm and alcohol or other drug abuse disorders (AOD). AmeriHealth Caritas Louisiana (ACLA) developed a multi-disciplinary workgroup to develop, design, test, implement, and refine interventions to address the objectives listed below:

1. Enhance admissions, transfers, discharges (ADT) notifications
2. Link members to aftercare with BH providers prior to discharge
3. Identify and address needs of sub-populations
4. Other interventions informed by the MCO's barrier analysis such as member/provider outreach and care coordination

Timely follow-up care following an inpatient discharge or emergency room visit is associated with a reduction in substance abuse, future ED use, hospital admissions and bed days (Kunz, French and Bazargan-Hejazi, 2004). It is important to identify barriers to follow-up care such as shortage of access to care or lack of continuity of care; and to help decrease the incidence of relapse or death and increase treatment and care management engagement among this population.

Objectives, Methodology, and Interventions

The overall objective was to design and implement innovative initiatives and strategies to improve rates for the 3 PIP HEDIS measures (FUH, FUM, FUA). The Performance Indicator methodology used to determine the baseline, quarterly, and final rates was based on the HEDIS MY 2022 Volume 2 Technical Specifications. Provider education included: advantages of participating in health information exchange such as ADT to increase continuity of care, registration/utilization of Provider Portal including the member clinical summary, BH Provider member attributions and incentives.

Member education and outreach was enhanced to target high risk subpopulations, this included: provider directory utilization, the teach back method, case management participation, and care coordination including appointment scheduling/appointment reminders/transportation/housing benefits for those that opted out of case management.

Results and Major Conclusions of the Project

Refer to Table 2 (page 12). When comparing the baseline rates to interim final rates (claims through October 2022), Indicators 1a, 1b, and 2b show a year over year decrease. Conversely, the interim final rates for Indicators 2a, 3a, and 3b have increased from 2021 to 2022. Target rates established in the PIP proposal (at least 3 percentage point increase from 2021 to 2022) were only met for Indicators 3a and 3b; the rates for follow-up after ED visit for AOD have nearly doubled from baseline to interim final rates. This success was in part due to the significant specification change implemented by NCQA for MY2022 to include pharmacotherapy events as numerator compliant. While the target rate for Indicator 2a (FUM- 7 days) was not met, the Plan notes that the interim final rate is higher that the baseline line rate for 2021.

Next Steps

Although the Plan did not meet target goals for FUH or FUM, meaningful interventions were implemented and enhanced throughout the year. The Plan acknowledges barriers such as BH provider shortages, transient populations, and dual diagnoses continue to directly impact outreach, interventions and utilization of services. ACLA anticipates that more members will choose to opt in to case management in 2023 as Case Managers and Community Navigators will have an opportunity to increase face to face interactions.

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:**

In 2021, AmeriHealth Caritas Louisiana had a total of 3,865 inpatient discharges and 798 ED discharges for members 6 years of age and older with a diagnosis of selected mental illness or intentional self-harm. A total of 1,143 ED visits were captured amongst members aged 13 years and older with a principal diagnosis of substance use disorder (SUD).

The Behavioral Health Transitions in Care PIP addresses the need for continued follow-up treatment after an ED or inpatient hospitalization discharge when a member is diagnosed with a mental illness or substance use disorder. The PIP highlights the Plan's follow-up rates which fall dramatically below the NCQA Quality Compass 50th percentile and offers innovative initiatives to engage improvement opportunities relative to the population.

The number of drug-overdose deaths in Louisiana rose more rapidly than any other state in the U.S. during the 12 months that ended July 2021, a period that included the first months of the coronavirus pandemic, according to preliminary data from the Centers for Disease Control (CDC). About 1,720 Louisianans died from overdoses during that period, which saw what the CDC estimates to be a record 86,000 overdose deaths. Louisiana's total is 53% more than the number that died during the same period the year before, a spike twice as steep as the national average (Adelson and DeRobertis, 2021).

Treatment and ongoing engagement can help decrease ED utilization and inpatient hospitalizations. High ED usage for members with SUD may indicate a shortage of access to care or lack of continuity of care. Timely follow-up care for members seen in the ED with AOD is associated with a reduction in substance use, future ED use, hospital admissions and bed days (Kunz, French and Bazargan-Hejazi, 2004).

As many as 40% of those with serious mental illness (SMI) do not attend any outpatient visits in the 30 days following discharge (NLM, 2017). In Louisiana, 715,000 adults have a mental health condition. More than half of people with a mental health condition in the U.S. did not receive any treatment in the last year. Of the 194,000 adults in LA who did not receive needed mental health care, 41.8% did not because of cost. 3,398,990 people in Louisiana live in a community that does not have enough mental health professionals (NAMI 2021).

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

The following categories were identified as either high-volume or high-risk:

1. FUH population posed the highest volume with 3,865 member discharges in 2021. Of these 3,865 discharges:
    a. 17.52% of members had a 7-day follow-up visit and 35.78% completed a 30-day follow-up visit after an inpatient discharge.
    b. 29% of members were identified as having 3 or more visits to the ER with 3% being enrolled in CM.

2. Within the FUM population, the Plan identified 798 member discharges with a mental illness diagnosis as high risk. Of these 798 discharges:
    a. 21.55% of members had a 7-day follow-up and 36.47% completed a 30-day follow-up visit following an ED discharge.
    b. 49% members were identified as having 3 or more visits to the ER with 3% being enrolled in CM.
    c. 67% of members were identified with a severe mental illness with 3% being enrolled in CM.

3. FUA population has been identified as high risk consisting of 1,043 member discharges. Of these 1,043 discharges:
    a. 9.45% of members had a 7-day follow-up visit and 14.26% completed a 30-day follow-up visit following an ED discharge.
    b. The plan identified 44% of members with three or more ED visits in 2021. Within this high ED utilization population, only 3% were engaged in case management.
    c. 97% of members reported at least 1 SDOH with 3% being enrolled in CM. Additionally, follow-up care for members seen in the ED specifically for SUD is associated with a reduction in substance use and can reduce future ED use, inpatient admissions.

4. To identify additional susceptible subpopulations, the plan evaluated FUH discharges stratified by age, race, ethnicity, SUD, foster care, disabilities, housing insecurities, and regions. Out of 3,865 discharges:
    a. 24% of members were identified with a substance use disorder.
    b. 25% of members were identified as being disabled.
    c. 15% of members were identified as homeless or a housing insecurity. Of those 3,865 members, the top 3 regions with health disparities were found in region 1 (New Orleans area), region 5 (Southwest area), and region 9 (Northshore area).

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

In 2016, 20.1 million Americans over 12 years of age (about 7.5% of the population), were classified as having a substance use disorder; less than 20% receive treatment (SAMHSA, 2017). MAT and other treatment, including behavioral therapy and counseling has shown to reduce morbidity and mortality rates in connection with SUD, improve social outcomes, and reduce health care spending (NIDA, 2018). MAT is also a standard of care that can provide stabilization and improve birth outcomes (ACOG, ASAM, 2012). Half of all chronic mental illness begins by age 14; three-quarters by age 24.

Despite effective treatment, there are long delays – sometimes decades – between the first appearance of symptoms and when people get help (Kessler – Archives of General Psychiatry (2005). According to a study conducted by the AJPH, people with SUD or SMI that frequented the ER stated it was due to poor access to care, quality of care, affordability, and housing (APHJ, 2015). Louisiana's drug-poisoning death rate showed a statistically significant increase of 14.7% from 2015 to 2016 (CDC, 2017). Prescription and illicit opioids are the prime drivers of drug overdose deaths in the U.S. (CDC, 2017). The opioid-related overdose death rate in Louisiana has more than doubled over the past five years, from 3.7 per 100,000 persons in 2012 to 7.7 in 2016 (NIH, 2018). Prior to 2012, the prime driver of opioid-related overdose deaths was prescription opioids. Since 2012, the number of heroin-related deaths trended sharply upward to exceed that of prescription opioid-related deaths in 2016 (149 vs. 124, respectively; NIH, 2018). The overdose crisis has been interpreted as "an epidemic of poor access to care" (Wakeman and Barnett, 2018), with close to 80% of Americans with opioid use disorder lacking treatment (Saloner and Karthikeyan, 2015).

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

ACLA is aiming towards improvement for FUH, FUM, and FUA measures. In 2021, the Plan scored below the 25th Quality Compass benchmark for both 7 and 30-day follow-up visits following an inpatient or ED discharge for mental illness.

ACLA will continue to strive for rate improvement in 2022, as rates were significantly lower than the 25th QC benchmark for FUH and FUM. The Plan will strive to achieve the QC 50th percentile for all three measures. Using Table 1b, the rates below indicate opportunities for improvement for both indicators. Rates were calculated prior to MY end date of December 1, 2021.

ACLA is meeting the 25th QC benchmark for 7- and 30-day follow-up visits following an ED visit for SUD. Follow-up care for members seen in the ED specifically for SUD is associated with a reduction in substance use and can reduce future ED use and inpatient admissions.

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 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:

5. 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.

6. 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.

7. 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.
8. 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

Indicators	Baseline Rate[1] Measurement Period: 1/1/21–12/31/21	Interim Rate Measurement Period: 1/1/22–10/31/22	Final Rate Measurement Period: 1/1/23–12/31/23	Target Rate[2]	Rationale for Target Rate[3]
Indicator #1a. Follow-Up After Hospitalization for Mental Illness (FUH) – Total, 7 days	N: 677 D: 3,865 R: 17.52%	N: 606 D: 3,603 R: 16.82%	N: D: R:	R: 20.52%	At least 3 percentage point increase from CY 2021 to CY 2022
Indicator #1b. Follow-Up After Hospitalization for Mental Illness (FUH) – Total, 30 days	N: 1,383 D: 3,865 R: 35.78%	N: 1,155 D: 3,603 R: 32.06%	N: D: R:	R: 38.78%	At least 3 percentage point increase from CY 2021 to CY 2022
Indicator #2a. Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Total, 7 days	N: 172 D: 798 R: 21.55%	N: 156 D: 685 R: 22.77%	N: D: R:	R: 24.55%	At least 3 percentage point increase from CY 2021 to CY 2022
Indicator #2b. Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Total, 30 days	N: 291 D: 798 R: 36.47%	N: 228 D: 685 R: 33.28%	N: D: R:	R: 39.47%	At least 3 percentage point increase from CY 2021 to CY 2022
Indicator #3a. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 7 days	N: 108 D: 1,143 R: 9.45%	N: 221 D: 1,289 R: 17.15%	N: D: R:	R: 12.45%	At least 3 percentage point increase from CY 2021 to CY 2022
Indicator #3b. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 30 days	N: 163 D:1,143 R: 14.26%	N: 364 D: 1,289 R: 28.24%	N: D: R:	R: 17.26%	At least 3 percentage point increase from CY 2021 to CY 2022

[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).

Methodology

To be completed upon Proposal submission.

Performance Indicators

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.	HEDIS MY 2022, Volume 2 Technical Specifications Data Source: Claims/encounter data	Ages 6 years and older as of the date of discharge with an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim on or between January 1 and December 1 of the measurement year.	Exclude non-acute inpatient stays. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a non-acute inpatient care setting within the 30-day follow-up period. Members in hospice or using hospice services anytime during the measurement year.	A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.	The eligible population. The denominator for this measure is based on discharges, not on members.

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.	HEDIS MY 2022, Volume 2 Technical Specifications Data Source: Claims/encounter data	Ages 6 years and older as of the date of discharge with an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim on or between January 1 and December 1 of the measurement year.	Exclude non-acute inpatient stays. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a non-acute inpatient care setting within the 30-day follow-up period. Members in hospice or using hospice services anytime during the measurement year.	A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.	The eligible population. The denominator for this measure is based on discharges, not on members.

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.	HEDIS MY 2022, Volume 2 Technical Specifications Data Source: Claims/encounter data	Ages 6 years and older as of the date of ED visit with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year.	Exclude ED visits that result in an inpatient stay and ED visits followed by admission to an acute or non-acute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. Exclude members in hospice or using hospice services anytime during the measurement year.	A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.	The eligible population. The denominator for this measure is based on discharges, not on members.
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.	HEDIS MY 2022, Volume 2 Technical Specifications Data Source: Claims/encounter data	Ages 6 years and older as of the date of ED visit with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year.	Exclude ED visits that result in an inpatient stay and ED visits followed by admission to an acute or non-acute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. Exclude members in hospice or using hospice services anytime during the measurement year.	A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.	The eligible population. The denominator for this measure is based on discharges, not on members.

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 substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up.	HEDIS MY 2022, Volume 2 Technical Specifications Data Source: Claims/encounter data	Ages 13 years and older as of the date of ED visit with a principal diagnosis of SUD or any diagnosis of drug overdose on or between January 1 and December 1 of the measurement year.	Exclude 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 the principal diagnosis for the admission. Exclude members in hospice or using hospice services anytime during the measurement year.	A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.	The eligible population. The denominator for this measure is based on discharges, not on members.
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 substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up.	HEDIS MY 2022, Volume 2 Technical Specifications Data Source: Claims/encounter data	Ages 13 years and older as of the date of ED visit with a principal diagnosis of SUD or any diagnosis of drug overdose on or between January 1 and December 1 of the measurement year.	Exclude 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 the principal diagnosis for the admission. Exclude members in hospice or using hospice services anytime during the measurement year.	A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.	The eligible population. The denominator for this measure is based on discharges, not on members.

[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?

- Yes, the entire eligible population is being targeted by PIP interventions.

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:** N/A

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 (on-line, phone, mail, face-to-face), the number of surveys distributed and completed, and the follow-up attempts to increase response rate.

- **Describe data collection:**

  - AmeriHealth Caritas Louisiana's Enterprise Analytics (Informatics) Department collects data from claims/encounter files of all eligible members. Data sources may include claims/encounter data (administrative data). Administrative data will be collected as needed, monthly, quarterly, and annually.

  - For Intervention Tracking Measures (ITM), data will be collected monthly utilizing claims/encounter data, clinical documentation software, and departmental tracking tools. In addition, ACLA will conduct manual telephonic outreach to obtain direct member feedback on barriers. Focused provider outreach by multidisciplinary teams will be used to obtain feedback on drivers and barriers to members' access to care and continuity of care.

Validity and Reliability

Describe efforts used to ensure performance indicator and intervention tracking measure (ITM) 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:**

  - Administrative data is collected by the Enterprise Analytics (Informatics) Department. The process for verifying ITM data validity and reliability will be conducted by quality associates within each department. Through the PDSA cycle, analysis will be conducted to determine process improvements, strengths and opportunities.

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 subpopulations 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 ITMs for ongoing quality improvement (QI; 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:**
  - Analysis will address the comparability of baseline and re-measurement data, including factors that impact validity. Results will present numerical data that is accurate, clear, and easily understood. Interpretation will involve looking at all possible explanations for results and factors that may have affected them. Historical circumstances will be considered. Visual displays of data will facilitate analysis and communicate results.

- **Describe how plan will interpret improvement relative to goal:**
  - Data analysis will guide how well interventions are influencing performance indicator rates and outcomes. This data will be assessed against established goals and will drive decisions on effectiveness of change.

- **Describe how plan will monitor ITMs for ongoing QI:**

  - ITMs will be validated and monitored weekly and monthly as appropriate through trending, PDSA cycles, run charts, and other QI tools to analyze impact and effectiveness. The process for verifying ITM data validity and reliability will be conducted by quality associates with each department.

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	3,865	100%	1,383	100%	
Age					
6–17 years	658	17.02%	374	27.04%	62.95%
18–64 years	3,205	82.92%	1,008	72.89%	113.77%
65+ years	2	0.05%	1	0.07%	71.57%
Race					
American Indian or Alaska Native	25	0.65%	10	0.72%	89.46%
Asian	19	0.49%	6	0.43%	113.31%
Black or African American	1,682	43.52%	615	44.47%	97.86%
Native Hawaiian or Pacific Islander	5	0.13%	2	0.14%	89.46%
White	1,864	48.23%	669	48.37%	99.70%
Other	3	0.08%	2	0.14%	53.67%
Unknown	267	6.91%	79	5.71%	120.94%
Ethnicity					
Hispanic	74	1.91%	33	2.39%	80.24%
Non-Hispanic	1,956	50.61%	776	56.11%	90.19%
Unknown	1,835	47.48%	574	41.50%	114.39%
Substance Use Disorder	923	23.88%	218	15.76%	151.50%
Enrollment category: Foster Care	4	0.10%	4	0.29%	35.78%
Enrollment category: Disabled	980	25.36%	384	27.77%	91.32%
Housing Insecurity/Homeless[1]	586	15.16%	148	10.70%	141.68%
LA MCO Region of Residence					
Region 1: Greater New Orleans	658	17.02%	203	14.68%	115.99%
Region 2: Capital Area	518	13.40%	199	14.39%	93.14%
Region 3: South Central LA	469	12.13%	181	13.09%	92.72%
Region 4: Acadiana	405	10.48%	148	10.70%	97.92%
Region 5: Southwest LA	227	5.87%	76	5.50%	106.88%
Region 6: Central LA	385	9.96%	146	10.56%	94.36%
Region 7: Northwest LA	478	12.37%	188	13.59%	90.98%
Region 8: Northeast LA	300	7.76%	101	7.30%	106.29%
Region 9: Northshore Area	425	11.00%	141	10.20%	107.86%

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 Denominator ÷ % of MCO TOTAL Numerator
MCO TOTAL	3865	100%	1383	100%	
LONGLEAF HOSPITAL	369	9.55%	109	7.88%	**121.14%**
BRENTWOOD HOSPITAL	363	9.39%	166	12.00%	**78.25%**
RIVER PLACE BEHAVIORAL HEALTH	152	3.93%	56	4.05%	**97.12%**
UNIVERSITY MEDICAL CENTER NEW ORLEANS	149	3.83%	52	3.76%	**101.84%**
VERMILION BEHAVIORAL HEAL	148	3.83%	70	5.06%	**75.65%**
COVINGTON BEHAVIORAL HEALTH	139	3.60%	40	2.89%	**124.34%**
OUR LADY OF THE LAKE REGIONAL MEDICAL CENTER	118	3.05%	61	4.41%	**69.22%**
SEASIDE HEALTH SYSTEM LLC	110	2.85%	28	2.02%	**140.57%**
CHILDRENS HOSPITAL	99	2.56%	46	3.33%	**77.01%**
CYPRESS GROVE BEHAVIORAL HEALTH LLC	95	2.46%	62	4.48%	**54.83%**
OCEANS BEHAVIORAL HOSPITAL OF GREATER NEW ORLEANS	95	2.46%	35	2.53%	**97.12%**
RIVER OAKS HOSPITAL	92	2.38%	40	2.89%	**82.30%**
LAKE PINES HOSPITAL LLC	83	2.15%	26	1.88%	**114.23%**
ST JAMES BEHAVIORAL HEALTH HOSPITAL - GONZALES	82	2.12%	21	1.52%	**139.72%**
SEASIDE BEHAVIORAL CENTER LLC NEW ORLEANS	81	2.10%	21	1.52%	**138.02%**
BEACON BEHAVIORAL HOSPITAL-NEW ORLEANS	72	1.86%	14	1.01%	**184.03%**
LOUISIANA BEHAVIORAL HEALTH	68	1.76%	19	1.37%	**128.06%**
LAFAYETTE BEHAVIORAL HEALTH UNIT	65	1.68%	10	0.72%	**232.59%**
LAKE CHARLES MEMORIAL HOSPITAL DPP UNIT	62	1.60%	23	1.66%	**96.46%**
BEACON BEHAVIORAL HOSPITAL - LUTCHER	62	1.60%	21	1.52%	**105.64%**
WILLIS KNIGHTON BEHAVIORAL MEDICINE UNIT	61	1.58%	26	1.88%	**83.95%**

REGIONS BEHAVIORAL HOSPITAL	59	1.53%	20	1.45%	**105.56%**
OCEANS BEHAVIORAL HOSPITAL OF KENTWOOD	57	1.47%	19	1.37%	**107.35%**
BATON ROUGE GENERAL MEDICAL CENTER	56	1.45%	21	1.52%	**95.42%**
APOLLO BEHAVIORAL HEALTH HOSPITAL LLC - BATON ROUG	55	1.42%	21	1.52%	**93.72%**
BEACON BEHAVIORAL HOSPITAL-CENTRAL	55	1.42%	13	0.94%	**151.39%**
NORTHLAKE BEHAVIORAL HEALTH SYSTEM	52	1.35%	26	1.88%	**71.57%**
ALLEN PARISH HOSPITAL	47	1.22%	10	0.72%	**168.18%**
OCEANS BEHAVIORAL HOSPITAL OF LAFAYETTE LLC	45	1.16%	16	1.16%	**100.64%**
COMMUNITY CARE LLC	45	1.16%	12	0.87%	**134.18%**
CHRISTUS HEALTH ST PATRICK HOSPITAL	42	1.09%	11	0.80%	**136.62%**
OCHSNER ST ANNE GENERAL HOSPITAL	38	0.98%	25	1.81%	**54.39%**
OCHSNER ST MARY	38	0.98%	24	1.74%	**56.66%**
JENNINGS SENIOR CARE HOSPITAL - JENNINGS	37	0.96%	10	0.72%	**132.40%**
PHYSICIANS BEHAVIORAL HOSPITAL LLC	34	0.88%	6	0.43%	**202.77%**

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.

Note: All reported ITMs below are non-cumulative.

Barrier 1: Identification of BH inpatient discharge notifications • Hospital participation in Health Information Exchange • Providers report difficulty identifying patients in need of follow-up care • Plan needs to identify BH inpatient discharges timely to encourage follow-up care within recommended timeframe **Method of barrier identification:** Admission, Discharge, Transfer (ADT) Report and BH IP Report		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4** *October Only	**Q1**	**Q2**	**Q3**	**Q4**
Notification Intervention #1a to address barrier: Utilization of the IP BH Episode report to identify IP admits from the FUH population **Planned Start Date:** January 2022 **Actual Start Date**: January 2022	**ITM #1a:** **Numerator**: # hospital inpatient admissions for which MCO received any admission notification **Denominator**: FUH denominator (note: count # discharges)	N: 808 D: 999 R: 80.88%	N: 855 D: 1,029 R: 83.09%	N: 760 D: 1,051 R: 72.31%	N: 234 D: 291 R: 80.41%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1b to address barrier: Utilization of the IP BH Episode report to determine CM notification of IP admits from the FUH population **Planned Start Date:** January 2022 **Actual Start Date**: January 2022	**ITM #1b:** **Numerator**: # hospital inpatient admissions for which MCO CM received any admission notification **Denominator**: FUH denominator (note: count # discharges)	N: 808 D: 999 R: 80.88%	N: 855 D: 1,029 R: 83.09%	N: 760 D: 1,051 R: 72.31%	N: 234 D: 291 R: 80.41%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Notification Intervention #1c to address barrier: Utilization of ADT notification report of IP admits from FUH population **Planned Start Date:** January 2022 **Actual Start Date**: January 2022	**ITM #1c:** **Numerator**: # hospital inpatient admissions for which MCO received ADT/Health Information Exchange admission notification **Denominator**: FUH denominator (note: count # discharges)	N: 3 D: 999 R: 0.30%	N: 7 D: 1,029 R: 0.68%	N: 1 D: 1,051 R: 0.10%	N: 1 D: 291 R: 0.34%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1d to address barrier: Utilization of ADT notification report to determine CM notification of IP admits from FUH population **Planned Start Date:** January 2022 **Actual Start Date**: January 2022	**ITM #1d:** **Numerator**: # hospital inpatient admissions for which MCO CM received ADT/Health Information Exchange admission notification **Denominator**: FUH denominator (note: count # discharges)	N: 0 D: 999 R: 0.00%	N: 0 D: 1,029 R: 0.00%	N: 0 D: 1,051 R: 0.00%	N: 0 D: 291 R: 0.00%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 2: Identification of BH/SUD ED admission/discharge notifications • Hospital participation in Health Information Exchange • Providers report difficulty identifying patients in need of follow-up care • Plan needs to identify BH/SUD admissions/discharges timely to encourage follow-up care within recommended timeframe **Method of barrier identification:** Admission, Discharge, Transfer (ADT) Report		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4** *October Only	**Q1**	**Q2**	**Q3**	**Q4**
Notification Intervention #1e to address barrier: Utilization of ADT notification report of ED admits or discharges from FUM and FUA populations **Planned Start Date:** January 2022 **Actual Start Date**: January 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)	N: 195 D: 427 R: 45.67%	N: 156 D: 445 R: 35.06%	N: 262 D: 600 R: 43.67%	N: 74 D: 154 R: 48.05%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Notification Intervention #1f to address barrier: Utilization of ADT notification report to determine CM notification of ED admits or discharges from FUM and FUA populations **Planned Start Date:** January 2022 **Actual Start Date**: January 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)	N: 98 D: 427 R: 22.95%	N: 86 D: 445 R: 19.33%	N: 117 D: 600 R: 19.50%	N: 39 D: 154 R: 25.32%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1g to address barrier: Utilization of ADT notification report of ED admits or discharges from FUM and FUA populations **Planned Start Date:** January 2022 **Actual Start Date**: January 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)	N: 195 D: 427 R: 45.67%	N: 156 D: 445 R: 35.06%	N: 262 D: 600 R: 43.67%	N: 74 D: 154 R: 48.05%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1h to address barrier: Utilization of ADT notification report to determine CM notification of ED admits or discharges from FUM and FUA populations **Planned Start Date:** January 2022 **Actual Start Date**: January 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)	N: 98 D: 427 R: 22.95%	N: 86 D: 445 R: 19.33%	N: 117 D: 600 R: 19.50%	N: 39 D: 154 R: 25.32%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 3: Member access to care, resistance to treatment, MH Professional Shortages, and availability/knowledge of community resources **Method of barrier identification: Member feedback via CM or Rapid Response Team outreach**		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4** *October Only	**Q1**	**Q2**	**Q3**	**Q4**
Linkage Intervention #2ai to address barrier: Attempted telephonic contact and documentation of follow-up appointments scheduled and	**ITM #2ai:** **Numerator:** # MH HOSPITAL DISCHARGES with a qualifying follow-up	N: 19 D: 44 R: 43.18%	N: 13 D: 38 R: 34.21%	N: 17 D: 43 R: 39.53%	N: 2 D: 18 R: 11.11%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

care coordination for members discharged from an inpatient facility when enrolled in CM **Planned Start Date:** January 2022 **Actual Start Date**: January 2022	provider VISIT ATTENDED within 30 days of discharge **Denominator:** # MH HOSPITAL DISCHARGES in FUH denominator FOR MEMBERS who are enrolled (agreed to participate) in case management								
Note: CM is a NCQA defined process, members engaged/enrolled in CM have completed an assessment and have an established Plan of Care.									
Linkage Intervention #2aii to address barrier: Attempted telephonic contact and documentation of follow-up appointments scheduled and care coordination for members discharged from an inpatient facility not enrolled in CM **Planned Start Date:** January 2022 **Actual Start Date**: January 2022	**ITM #2aii:** **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: 244 D: 955 R: 25.55%	N: 252 D: 991 R: 25.43%	N: 234 D: 1,008 R: 23.21%	N: 34 D: 273 R: 12.45%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2bi to address barrier: Attempted telephonic contact and documentation of follow-up appointments scheduled and care coordination for members discharged from an ED with a mental illness or an SUD diagnosis when enrolled in CM **Planned Start Date:** January 2022 **Actual Start Date**: January 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: 8 D: 14 R: 57.14%	N: 2 D: 11 R: 18.18%	N: 4 D: 11 R: 36.36%	N: 1 D: 2 R: 50.00%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Linkage Intervention #2bii to address barrier: Attempted telephonic contact and documentation of follow-up appointments scheduled and care coordination for members discharged from an ED with a mental illness or an SUD diagnosis not enrolled in CM **Planned Start Date:** January 2022 **Actual Start Date**: January 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: 72 D: 413 R: 17.43%	N: 87 D: 434 R: 20.05%	N: 134 D: 589 R: 22.75%	N: 31 D: 152 R: 20.39%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2c for warm hand-off to address barrier: Provide peer services in ED for discharge planning including care coordination **Planned Start Date:** October 2022 **(May be delayed due to Omicron)** **Actual Start Date**:	**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 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)	N: D: R: N/A	N: D: R: N/A	N: D: R: N/A	N: D: R: N/A	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Note: ITM 2c is in progress with a planned implementation in Q12023. This ITM was delayed due to Omicron.									
Barrier 4: Limited care coordination between hospital and BH providers/PCPs for timely follow-up care **Method of barrier identification: Member feedback via CM outreach and appointment scheduling with providers**		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4** *October Only	**Q1**	**Q2**	**Q3**	**Q4**

Provider to Provider Communication Intervention #2d to address barrier: High risk/high utilizer members are assigned a Behavioral Health Provider who can receive member clinical summaries through the Provider Portal **Planned Start Date:** April 2022 **Actual Start Date**: September 2022	**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)	N: D: R: N/A	N: D: R: N/A	N: 158 D: 304 R: 51.97%	N: 166 D: 291 R: 57.04%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Note: For ITM 2d, BH Attribution was implemented September 2022. Only discharges in September are included in the Q3 denominator.									
Provider to Provider Communication Intervention #2e to address barrier: All members are assigned a PCP who can receive member clinical summaries through the Provider Portal **Planned Start Date:** January 2022 **Actual Start Date**: January 2022	**ITM #2e:** **Numerator**: # members whose qualifying follow-up provider was sent enhanced D/C Plan (with at least medication lists) prior to F/U appointment **Denominator**: Sum of # members in FUM denominators (note: you are counting the sum of # members, not visits)	N: 198 D: 204 R: 97.06%	N: 204 D: 210 R: 97.14%	N: 218 D: 219 R: 99.54%	N: 62 D: 65 R: 95.38%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 5: Care Coordination opportunities • Transient population • Dual SUD diagnosis • Limited number of BH providers who can prescribe psychiatric medications/low appointment availability **Method of barrier identification: FUH Analysis of Disproportionate Under-Representation, Table 4b**		**2022** **Q1**	**Q2**	**Q3**	**Q4** *October Only	**2023** **Q1**	**Q2**	**Q3**	**Q4**
Tailored & Targeted Intervention #3a to address barrier: Outreach members with SDOH (Housing Insecurity/Homelessness) to	**ITM #3a:** **Numerator:** # members who engaged in care coordination	N: 1 D: 4 R: 25.00%	N: 1 D: 2 R: 50.00%	N: 0 D: 0 R: 0.00%	N: 0 D: 1 R: 0.00%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

assist with locating community resources **Planned Start Date:** January 2022 **Actual Start Date**: January 2022	**Denominator:** # members in the FUH den with a diagnosis of Homelessness or a Housing Insecurity in the relevant quarter *Denominator includes unduplicated count of unique members. Numerator includes Homelessness or a Housing Insecurity identified in clinical software, not claims.								
Note: Care Coordination is not enrolled in case management- these members are successfully contacted telephonically or in person and receive care coordination services including education, appointment services, transportation, PCP, housing, etc.)									
Tailored & Targeted Intervention #3b to address barrier: Outreach members in the FUH population to assist with care coordination such as appointment scheduling, transportation, housing, etc. **Planned Start Date:** January 2022 **Actual Start Date**: January 2022	**ITM #3b:** **Numerator:** # members who engaged in care coordination (not enrolled in case management) **Denominator:** # members in the FUH den with a dual SUD diagnosis	N: 56 D: 620 R: 9.03%	N: 115 D: 626 R: 18.37%	N: 109 D: 601 R: 18.14%	N: 8 D: 72 R: 11.11%:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Tailored & Targeted Intervention #4 to address barrier: Outreach and education to members recently discharged from the hospital for mental illness or self-harm **Planned Start Date:** October 2022 **Actual Start Date**:	**ITM #4:** **Numerator:** # MH HOSPITAL DISCHARGES with a qualifying follow-up provider VISIT ATTENDED within 30 days of discharge **Denominator:** # MH HOSPITAL DISCHARGES in FUH denominator who received a BH Text Message	N: D: R: N/A	N: D: R: N/A	N: D: R: N/A	N: D: R: N/A	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Note: ITM 4 is in progress with a planned implementation in Q1 2023.									
Tailored & Targeted Intervention #5 to address barrier: Enhanced care coordination services for member that	**ITM #5:** **Numerator:** # members who engaged in care coordination regarding member education, locating a BH provider, scheduling	N: 24 D: 32 R: 75.00%	N: 60 D: 68 R: 88.24%	N: 90 D: 96 R: 93.75%	N: 15 D: 16 R: 93.75%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

choose to opt out of Case Management **Planned Start Date:** January 2022 **Actual Start Date**: January 2022	F/U appointments, and community resource referrals **Denominator:** # FUH + FUM + FUA members who received a successful telephonic contact and opted out of CM enrollment								

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

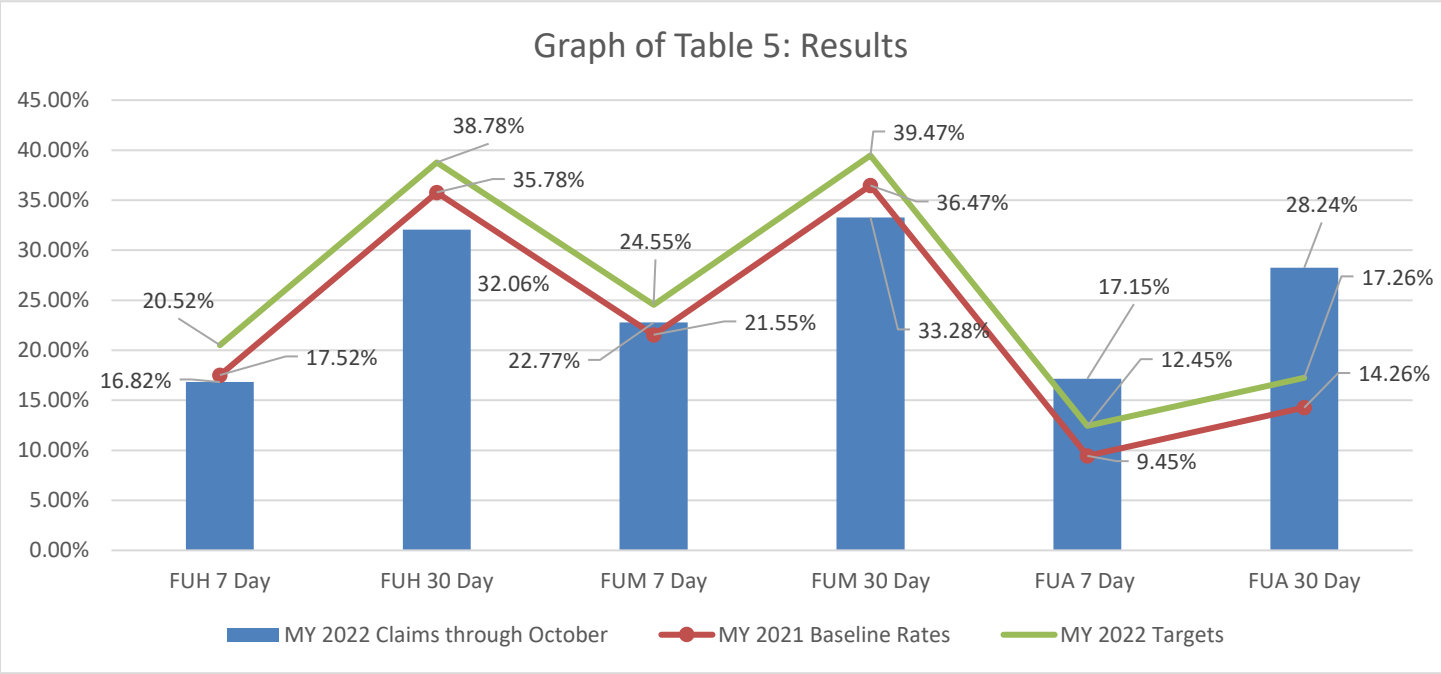
Indicator	Baseline Measure Period 1/1/21–12/31/21	Interim Final Measure Period 1/1/22–10/31/22	Target Rate[1]
Indicator #1a. Follow-Up After Hospitalization for Mental Illness (FUH)- Total, 7 days	N: 677 D: 3,865 R: 17.52%	N: 606 D: 3,603 R: 16.82%	Rate: 20.52%
Indicator #1b. Follow-Up After Hospitalization for Mental Illness (FUH)- Total, 30 days	N: 1,383 D: 3,865 R: 35.78%	N: 1,155 D: 3,603 R: 32.06%	Rate: 38.78%
Indicator #2a. Follow-Up After Emergency Department Visit for Mental Illness (FUM)- Total, 7 days	N: 172 D: 798 R: 21.55%	N: 156 D: 685 R: 22.77%	Rate: 24.55%
Indicator #2b. Follow-Up After Emergency Department Visit for Mental Illness (FUM)- Total, 30 days	N: 291 D: 798 R: 36.47%	N: 228 D: 685 R: 33.28%	Rate: 39.47%
Indicator #3a. Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence (FUA) – Total, 7 days	N: 108 D: 1,143 R: 9.45%	N: 221 D: 1,289 R: 17.15%	Rate: 12.45%
Indicator #3b. Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence (FUA) – Total, 30 days	N: 163 D: 1,143 R: 14.26%	N: 364 D: 1,289 R: 28.24%	Rate: 17.26%

[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.

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.

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.

  - **Performance Indicator #1a (FUH, 7 days):** Displayed a decrease of 0.70 percentage points from 2021 baseline measurement period to the 2022 interim measurement period, (17.52% to 16.82%) as of claims data received through October 2022. The Plan is currently below the NCQA Quality Compass 5th percentile, which is a rate of 17.78%. The target goal of 20.52% was not achieved for the 2022 interim rate measurement period.

  - **Performance Indicator #1b (FUH, 30 days):** Displayed a decrease of 3.72 percentage points from 2021 baseline measurement period to the 2022 interim measurement period, (35.78% to 32.06%) as of claims data received through October 2022. The Plan is currently below the NCQA Quality Compass 5th percentile, which is a rate of 38.89%. The target goal of 38.78% was not achieved for the 2022 interim rate measurement period.

  - **Performance Indicator #2a (FUM, 7 days):** Displayed an increase of 1.22 percentage points from 2021 baseline measurement period to the 2022 interim measurement period, (21.55% to 22.77%) as of claims data received through October 2022. The Plan meets the NCQA Quality Compass 5th percentile, which is a rate of 20.34%. The target goal of 24.55% was not achieved for the 2022 interim rate measurement period.

  - **Performance Indicator #2b (FUM, 30 days):** Displayed a decrease of 3.19 percentage points from 2021 baseline measurement period to the 2022 interim measurement period, (36.47% to 33.28%) as of claims data received through October 2022. The Plan meets the NCQA Quality Compass 5th percentile, which is a rate of 33.05%. The target goal of 39.47% was not achieved for the 2022 interim rate measurement period.

  - **Performance Indicator #3a (FUA, 7 days):** Displayed an increase of 7.70 percentage points from 2021 baseline measurement period to the 2022 interim measurement period, (9.45% to 17.15%) as of claims data received through October 2022. The Plan meets the NCQA Quality Compass 50th percentile, which is a rate of 13.36%. The target goal of 12.45% was achieved for the 2022 interim rate measurement period.

  - **Performance Indicator #3b (FUA, 30 days):** Displayed an increase of 13.98 percentage points from 2021 baseline measurement period to the 2022 interim measurement period, (14.26% to 28.24%) as of claims data received through October 2022. The Plan meets the NCQA Quality Compass 75th percentile, which is a rate of 26.22%. The target goal of 17.26% was achieved for the 2022 interim rate measurement period.

- **Explain and interpret the results by reviewing the degree to which objectives and goals were achieved.** Use your ITM data to support your interpretations**.**
  - Although target goals were not met for FUH or FUM, meaningful interventions were developed and implemented throughout the PIP such as:
    - Regularly scheduled updates to the provider directory to increase utilization by members and hospitals.
    - Identification of members with social determinants of health needs (280 instances of members in the FUH den with a dual diagnosis of SUD utilizing care coordination services).
      - The Housing Standard Operating Procedure for referrals to the Housing manager was finalized.
      - Peer support specialists visited members prior to discharge to access SDOH needs.
      - Case Managers/Care Coordinators provided community resources and Medicaid benefits information to members.
    - Face-to-face outreach (Peer Support specialists) with members prior to BH Hospital Discharge.
    - FUH/FUA/FUM text message reminders to schedule and complete follow-up care within the recommended timeframe.

- Live Telephonic outreach by BH Case Managers and Care Connectors- appointment reminder calls, transportation coordination, SDOH referrals and resources, etc. (39% of members who are enrolled in Case Management completed their ED follow-up visit within the recommended timeframe)
- BH Provider Attribution- Like PCP Attributions, high risk BH members are attributed to the BH provider seen most. (Over 50% BH Providers with attributed FUH members were sent a D/C Plan medications lists in the Provider Portal).
- Provider education to BH and PCP providers including Provider Portal Utilization and Reports. (145 provider TINs received education and training in 2022).

PIP Highlights:

Our most effective member intervention was that FUH members with a dual SUD diagnosis received Care Coordination services, even though they were not engaged in Case Management Program. We had 288 members successfully outreached by our Rapid Response Outreach Team to offer Care Coordination services, such as assisting with appointment scheduling, locating BH provider, transportation, and housing.

Case Management successfully contacted 189 members in the FUA, FUH, and FUM population to offer engagement in Case Management Program. While these members opted out of Case Management, they were also offered Care Coordination services as defined above.

- Member feedback as to why they opt out of Case Management is that the initial assessment is time consuming, not comfortable sharing their personal information and not understanding the benefit of having a Case Manager.

Our most effective provider intervention was that in our FUH population, 324 members' qualifying follow-up provider were sent enhanced D/C Plan (with at least medication lists) prior to F/U appointment. For our FUM population, 682 members' qualifying follow-up provider was sent enhanced D/C Plan (with at least medication lists) prior to F/U appointment. We will continue to work with Louisiana Health Information Exchange to expand number of facilities who report into It so that this intervention can continue to improve.

- BH measures are reviewed in Quality Management Provider Trainings, either in-person or virtually, as well as direction on the Provider Portal and how to access the available BH reports. According to feedback from providers, they appreciate that ACLA offers the trainings and that the reports are accessible to them in the portal.

- **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.

  - **Factor 1: Limited ADT/Health Information Exchange for BH Hospitals.** ITMs 1c, 1d were extremely low throughout the interim period due to a lack of high-volume facilities reporting FUH admits/discharges. In September 2022, ACLA implemented the BH Attribution Report (ITM 2d). This is a monthly report that attributes high utilizer members to a BH provider for follow-up. The intent is to provide BH Hospital HIE data to the BH provider most seen by the member.

  - **Factor 2: Low enrollment in Case Management.** ITMs 2ai, 2bi showed stagnant low denominators throughout the interim period.

  Efforts to increase enrollment for the FUH population:

  1. Population Health moving to a face-to-face model with new contract, attempts to find member based on the latest known address.
  2. Continue collaboration with provider facing departments to encourage providers to use the case management referral process to engage members in case management. Providers may have more accurate phone numbers or addresses for these members.
  3. Community Health Education team is in the process of visiting BH facilities to determine who is allowing visitors. ACLA staff will meet the member before discharge to discuss follow-up appointment importance, assist with scheduling and provide additional resources including case management.
  4. Conducting randomized member calls to non-compliant members in the previous quarter to determine barriers to care. Member feedback will be used to develop/enhance interventions if needed.

  Efforts to increase enrollment for the FUM/FUA populations:

  1. Enhanced ER Outreach. MCO receives a daily list of members with ED discharges in the top 1% who are not engaged in CM, these members are offered care coordination services including enrollment in case management.

2. To combat the large number of members who are UTC, the MCO outreaches providers for secondary phone numbers.
3. MCO Case Managers can implement 2-way texting if member consents (engaged or unengaged). This care coordination allows members to receive care coordination at their convenience.
4. Conducting a randomized member calls to non-compliant members in the previous quarter to determine barriers to care. Member feedback will be used to develop/enhance interventions if needed.
5. Utilize follow up calls if the member is unable to complete the assessment for CM enrollment during the initial call.

    - There was an effort to increase enrollment in case management, however, ACLA experienced a high unable to contact rate with this population. In addition, members reported that they did not have time to complete the lengthy assessments and didn't believe that that they needed help. ITMs 3b, 5 showed that even though these members were not enrolled in Case Management, they were offered or received Care Coordination Services.

- **<u>Factor 3:</u> BH Provider Shortage Areas.**
    - CM outreach for 7/30-day F/U visits to obtain member feedback and adjust/revise interventions as needed
    - Improve care coordination services (ITM #5) to assist member who opt out of CM with locating a BH provider, scheduling F/U appointments (telehealth or office visit), transportation, and community resource referrals
    - Identify and address SDOH (ITM #3a and #3b) using claims data to assist with continuity of care between the MCO and provider
    - Obtain member feedback on the effectiveness of the MCO case management program
    - Reminder outreach calls

- **<u>Factor 4:</u> Limited use of Z-Codes for SDOH.** ITM 3a showed an extremely low rate for the interim period.
    - Educational materials created to provide training to providers
    - Collaboration with Health Equity Director
    - Utilize widgets/keywords in the clinical documentation system
    - Peer support specialists visiting members prior to DC to offer care coordination services, referral to Housing program manager, if needed and member agrees.

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).

- **Were there any factors that may pose a threat to the internal validity the findings?**
  <u>Definition and examples</u>*: 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.*

    - Threats to the internal validity of the findings include care management/ case management process measure data accuracy due to the limitations of episodic documentation and data abstractions from the plan's integrated care management software. Care Coordination enrollment isn't accurately represented in the Care Management enrollment rates.
    - The specification change implemented by NCQA for MY 2022 to include pharmacotherapy events as numerator compliant" limits the internal validity of interpretation of improvement for the FUA measure due to lag in pharmacy claims.

- **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 member population, e.g., a sample that was not randomly selected from the eligible population or that includes too many/too few members from a certain subpopulation (e.g., under-representation from a certain region).

- The administrative measure accuracy that are specified using diagnosis or procedure codes are limited to the extent that providers and coders enter the correct codes.

- **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.

- The Plan faced data collection challenges for numerous ITMs with accurately tracking Case Management and Care Coordination interventions. Limitations relative to the episodic documentation and data abstraction from the plan's integrated care management software resulted in under-represented Case Management / Care Management member interactions.

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, 1b- Hospital Inpatient Admission Notifications (ITMs 1a, 1b)	Not all BH hospital admissions are reported in a timely manner		Review admission notifications to determine which facilities are not reporting admissions. Provide education.
ITM 1c, 1d- Hospital Inpatient Admissions Notifications (ADT Alerts)	Many free standing BH facilities do not participate in Health Information Exchange (ADT) alerts which drastically reduces the number of FUH notifications received		Hospital outreach to high-volume hospitals to educate and encourage HIE participation. Work with Louisiana Health Information Exchange to improve # facilities who report into it.
ITM 1e, 1f, 1g, 1h- ED Admission and Discharge Notifications	Not all ED admissions/discharges are reported in a timely manner If a member is not engaged in Case Management Program, the CM will not get admission/discharge notification		Review admission notifications to determine which facilities are not reporting admissions. Provide education to encourage HIE participation. Continue to outreach and offer Case Management Program to members in the FUM/FUA population
ITM 2ai, 2aii, 2bi, 2bii- MH Hospital Discharges in FUH Denominator and ED Discharges for the FUM/FUA Denominators	The assessment used to enroll members in case management is lengthy and takes more than an hour to complete. Members enrolled in case management have a higher rate of follow-up care than those that are not enrolled.	Review assessment content. Shorten the Case Management Enrollment assessment and the time it takes to complete. Increase Case Management Enrollment.	Reach out to other LOBs within the family of companies to determine if there are alternative methods for collecting information needed to complete the assessment (Example, member sent link via email/text/website link to complete on their time). Determine if there is an opportunity to implement a questionnaire for BH population that are opting out of CM.

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
ITM 2c- Warm Hand Offs	ACLA has attempted to gain access to high volume facilities such as FMOL, however, the facilities are concerned with patient privacy and hesitant to allow access.		Continue to work with high-volume facilities to gain access. Utilize hospital relationships developed by the Peer Support team.
ITM 2d, 2e- Enhanced Discharge Plan	While over 90% of providers have access and are registered in the Provider Portal, they may not all be utilizing the reports produced.		Multidisciplinary provider outreach to increase utilization of the portal and discharge plans (member clinical summaries)
ITM 3a- Care Coordination for Housing Needs	Difficult to identify members who need care coordination for housing because there is no standardized documentation process for care connectors and care managers.	Utilize widgets/keywords in the clinical documentation system	Work with Housing Program Manager to identify members that are referred. Develop a SOP for Housing Referrals and care coordination.
ITM 3b- Care Coordination for FUH/SUD dual diagnosis members not enrolled in CM	Roughly 18% of members who are not enrolled in CM have received some form of care coordination. This means that these members were successfully contacted telephonically and could have been enrolled in CM.	Review assessment content. Shorten the Case Management Enrollment assessment and the time it takes to complete.	Reach out to other LOBs within the family of companies to determine if there are alternative methods for collecting information needed to complete the assessment (Example, member sent link via email/text/website link to complete on their time). Train case managers on motivational interviewing techniques. Determine if there is an opportunity to implement a questionnaire for BH population that are opting out of CM. Refer members with housing insecurities to ACLA's Housing Program manager for assistance.
ITM 4- FUH text message reminder to schedule and attend follow-up visit			Implemented Q42022

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
ITM 5- Care Coordination for BH/AOD members not who opted out of CM.	More than 75% who choose to 'opt out' of case management enrollment received some form of care coordination. Unable to contact members make it difficult to engage members in care coordination / case management		Train case managers on motivational interviewing techniques. Determine if there is an opportunity to implement a questionnaire for BH population that are opting out of CM. Staff to continue to look for alternate member contact information by outreaching Providers/Pharmacies

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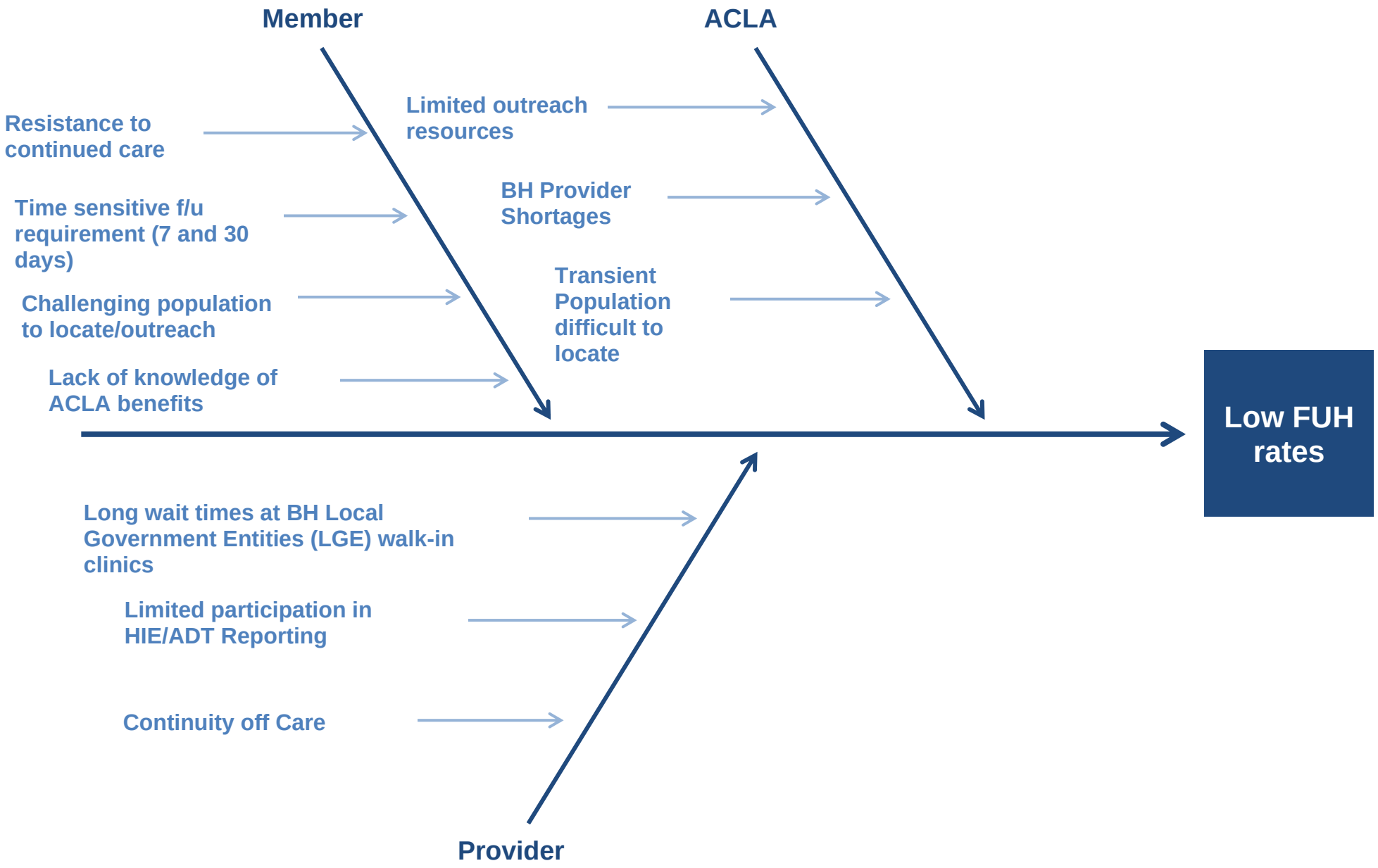
Glossary of PIP Terms

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	Provider virtual trainings for both BH and medical groups Provider awareness of ACLA portal capabilities Internal staff training on BH measures and PIP requirements Internal collaboration for developing/reporting ITMs Locating members when discharged from Inpatient or ED Streamline processes for accurate documentation and outreach Provider and member feedback BH provider ADT participation	Improve clinical software reporting Contracting more BH groups for Value-Based Program
Less Feasible to Address	Partnering with hospitals to coordinate care prior to ED discharge Valid member demographics/contact information Community Navigator/Peer Support outreach prior to inpatient discharge	Conducting home visits

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

	Positives	Negatives
INTERNAL ***under your control***	***build on*** **STRENGTHS** ***Examples:*** • Member telephonic outreach to all eligible members and enroll in care coordination • Contract with telehealth provider to conduct 7/30-day f/u visits • Provide reminder text messages with connection link to Rapid Response team • Address health disparities for FUM and FUA with development of member mailers • ADT ED notification report for FUA and FUM • Provider education	***minimize*** **WEAKNESSES** ***Examples:*** • Limited Plan resources • Inability to contact members • Clinical software limitations • Improve documentation and outreach processes
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** ***Examples:*** • Providers utilizing portal for awareness of ED alerts • Providers contacting members to schedule follow-up appointments • Hospitals utilizing provider directory and “Let Us Know” form for referring members to CM Dept. for outreach • Increasing workforce of prescribing Medicaid providers treating mental health/SUD	***protect from*** **THREATS** ***Examples:*** • ADT participation from BH facilities • ADT reporting mechanisms • Limited prescribers in rural areas

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 Patient education for increased health literacy including medical condition(s), medications, and importance of follow-up visits Ensuring members have a comprehensive d/c plan Warm handoffs to providers **EDs/ Hospitals and MCOs** Use of real-time or near real-time	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 Ensuring meds prescribed for use post d/c are included in plan's formulary. Encouraging more facilities to use automated	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 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	*FUM, FUA Change Concepts* Targeting regions with highest non-compliancy for telehealth provider F/U visits Monthly updates to provider directory Collaboration with Marketing to distribute the following via fax or email blast on a bi-annual basis: • BH Toolkit • ASAM's Updated National Practice Guideline for Treating Opioid Use Disorder • ASAM Motivational Training • SBIRT coding • ATLAS, the free, on-line SUD Treatment Located at https://www.treatmentatlas.org/ to all first line medical and behavioral health providers Provider Training – Goal of 75 virtual visits with top volume BH/PCP facilities. • HEDIS measure training • Provider portal usage training • ACLA provider BH resources – newsletters, alerts, interventions, TeleECHO clinic, teach back method Revision of outreach processes to include documentation of scheduled appointments in clinical software reporting system Creating activities for contact within 48 hours of discharge for members actively engaged in CM Outreach will be conducted within 72 hours of discharge from ADT or D/C summary notifications

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
	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	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 Enhanced outreach to members post d/c including CM, CHWs, Pt navigators, etc.	Rescheduling missed appointments.	Text messaging follow-up reminders with link to Rapid Response team Member Benefits Education through mailers and CM outreach: Locating and scheduling with a BH provider, transportation assistance, care coordination, Telehealth benefits Reminder calls for scheduled appointments by either inpatient facility or CM Dept. ***FUH change concepts*** Member attribution to BH provider in secure portal Encourage BH providers to participate in HIE-ADT (Health Information Exchange) clinical software system Initiate ADT alerts for BH providers in Q2 Contract agreement between ACLA and BH inpatient facilities requiring available appointment slots for urgent aftercare needs
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.	ED Partnership – Initiate care coordination services by utilizing “Let Us Know” referral form on ACLA website for electronic submission Coordinate F/U efforts by partnering with practicing physician affiliate of hospital

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
5. Improving FUA	ED staff SUD knowledge/skills Importance of rapport established with warm handoffs CM knowledge/skills	Better understanding of addictions; screening using motivational interviewing techniques; ASAM 6 Dimension risk evaluations in EDs when possible Provider access to patients prior to d/c	Facilitating getting more SUD qualified staff into EDs for evaluating Pts 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	ED Partnership – Initiate care coordination services by utilizing "Let Us Know" referral form on ACLA website for electronic submission Coordinate F/U efforts by partnering with practicing physician affiliate of hospital

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.	•	•	•