Healthy Louisiana
Performance Improvement Project (PIP)

Health Plan: Healthy Blue

PIP Title: Behavioral Health Transitions in Care

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

Submission Dates:

	Report Year 2022
Version 1	March 3, 2022
Version 2	December 30, 2022

MCO Contact Information

1. Principal MCO Contact Person

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

Kolletta Davis
Clinical Quality Program Manager
225-236-7034
kolletta.davis@elevancehealth.com

2. Additional Contact(s)

[Person(s) responsible in the event that the principal contact person is unavailable]

Jennifer Nethers, MS, MBA
Director of Clinical Quality
513-582-1756
jennifer.nethers@elevanhealth.com

3. External Collaborators (if applicable):

Attestation

Plan Name: Healthy Blue
Title of Project: 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: Cheryll Bowers-Stephens, MD
First and last name: Cheryll Bowers-Stephens, MD
Date: December 30, 2022

CEO signature: Christy Valentine, MD
First and last name: Christy Valentine, MD
Date: December 30, 2022

Quality Director signature: Jennifer Nethers
First and last name: Jennifer Nethers
Date: December 30, 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	2/2022	☐ Methodology ☐ Barrier Analysis ☐ Intervention ☒ ITM	Delay in deploying text campaign for FUA and FUM text
Change 2		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ ITM	
Change 3		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ ITM	
Change 4		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ ITM	

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Abstract

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

Project Topic/Rational: Healthy Blue initiated the Behavioral Health (BH) Transitions in Care Performance Improvement Plan (PIP) at the start of 2022. HEDIS 2021 rates for Healthy Louisiana MCOs show opportunities for improvement, which is the rationale supporting this project. Baseline data was taken in 2021 and is as follows:

- **Indicator #1a**. Follow-Up After Hospitalization for Mental Illness (FUH) – Total, 7 days: **17.09%**
- **Indicator #1b**. Follow-Up After Hospitalization for Mental Illness (FUH) – Total, 30 days: **36.07%**
- **Indicator #2a.** Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Total, 7 days: **20.84%**
- **Indicator #2b**. Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Total, 30 days: **35.31%**
- **Indicator #3a**. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 7 days: **9.24%**
- **Indicator #3b**. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 30 days: **14.40%**

Objectives: Enhance hospital-to-MCO workflow for notification of hospital and emergency department admissions, discharges, and transfers. Link members to aftercare with BH providers prior to discharge from hospital or emergency department. Lastly, 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.

Methodology and interventions: Once the objectives were devised, Healthy Blue then identified members based off claims data and automated hospital IP or ED notifications. Healthy Blue's Case Management department dedicated strategic focus to increase our seven and thirty-day follow-up after admissions to emergency departments for alcohol and other drug abuse or dependence and hospitalization for mental illness. The most effective intervention for HBL included targeted member outreach post hospital discharge for Mental Illness to schedule follow-up provider visits for members not enrolled in Case Management (CM).

Results and major conclusions of the project: The plan mostly experienced percentage increases among Provider Indicators (PI) when comparing 2021 baseline numbers to 2022 year to date numbers. HBL was able to identify the greatest increase with PI1a, *Follow-up after hospitalization for mental illness (FUH) – Total 7 days.* Baseline for this indicator was 17.09% in 2021 and currently the percentage is 19.35%. Healthy Blue also showed notable impact with ITM 2aii, as the plan sustained at above 35% with this measure. The plan identified areas of opportunities for 2023, specifically among ITMS. We have especially noted it is better for members to be discharged with a plan in place including but not limited to, follow-up appointments and transportation to and from those scheduled appointments.

Next Steps: This PIP will continue next year. Healthy Blue will continue to build on initiatives that were successful this year and refocus in areas of improvement.

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:**

  Addressing follow-up after hospitalization for Mental Illness, emergency department visits for Mental Illness, and emergency department visits for alcohol and other drug abuse among our health plan members is a priority and a key strategy for Healthy Blue as we continue to improve health outcomes. Timely follow-up care reduces the rate of avoidable readmissions and fewer repeat ED visits. In addition, high ED usage may indicate lack of access to care and/or lack of continuity of care, which is important for Healthy Blue to address for its members.

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

  Healthy Blue has a high disproportionate index for members with substance use and/or with housing insecurity. These members are potentially high risk for hospitalizations and are in need of case management or close follow-up post ED or hospital discharge. These two subpopulations will be areas of focus for Healthy Blue this year with specific targeted interventions to address the disparity in follow-up care.

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

  Research shows timely follow-up care can be an effective action against reducing avoidable readmissions (Croake, S). This can also impact ED and hospital readmissions for worsening conditions. Additional research shows that timely follow-up can be linked to suicide prevention for those with mental illnesses (Brown, GK). These are important points to communicate to our providers as we educate them on the need for timely follow-up care post hospital and ED visit.

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

  Healthy Blue's current rates suggest that there are areas of improvement in FUH and FUM, as the 2021 data shows that the rate was below the QC 25th percentile. FUA was the only measure to perform above the QC 25th percentile. The monthly MCO collaborative meetings

will be a helpful forum to learn best practices from other organizations and how we can best apply those learnings to the benefit of our members.

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 &	16.38	14.03	12.9	11.24	11.14	10.75	21.31	26.22	32.60

Indicator	Aetna	ACLA	Healthy Blue	LHCC	UHC	QC 25th	QC 50th	QC 75th	QC 90th
Other Drug Abuse or Dependence (FUA) – Total, 30 days									

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 * *keep in mind that final rates are only capturing data through 10/31/22*

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: 1074 D: 6282 R: 17.09%	N:1183 D: 6113 R: 19.35%	N: D: R:	R: 20.09%	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: 2266 D: 6282 R: 36.07%	N: 2285 D: 6113 R: 36.40%	N: D: R:	R: 39.07%	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: 278 D: 1334 R: 20.84%	N: 197 D: 1070 R: 18.41%	N: D: R:	R: 23.84%	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: 471 D: 1334 R: 35.31%	N: 325 D: 1070 R: 30.37%	N: D: R:	R: 38.31%	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: 172 D: 1861 R: 9.24%	N: 149 D: 1597 R: 9.33%	N: D: R:	R: 12.24%	At least 3 percentage point increase from CY 2021 to CY 2022 for all Performance Indicators
Indicator #3b. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 30 days	N: 268 D: 1861 R: 14.40%	N: 234 D: 1597 R: 14.65%	N: D: R:	R: 17.40%	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).

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 within 7 days after discharge	HEDIS Administrative NCQA 2021 Measures and Guidelines	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	Members in Hospice; 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 nonacute inpatient care setting within the 7-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting	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.	Eligible Population

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 Administrative NCQA 2021 Measures and Guidelines	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	Members in Hospice; 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 nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting	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.	Eligible Population

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	HEDIS Administrative NCQA 2021 Measures and Guidelines	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	Members in Hospice; 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 principal diagnosis for the admission	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.	Eligible Population
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	HEDIS Administrative NCQA 2021 Measures and Guidelines	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	Members in Hospice; 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 principal diagnosis for the admission	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 (8 total days). Include visits that occur on the date of the ED visit.	Eligible Population

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 7 days of the ED visit	HEDIS Administrative NCQA 2021 Measures and Guidelines	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	Members in Hospice; 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 principal diagnosis for the admission	A follow-up visit 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.	Eligible Population
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 30 days of the ED visit	HEDIS Administrative NCQA 2021 Measures and Guidelines	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	Members in Hospice; 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 principal diagnosis for the admission	A follow-up visit 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.	Eligible Population

[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, interventions 1a through 2e denominators cover the span of eligible populations that pertain to FUH, FUA and FUM. In addition, the text campaign will cycle through all 3-measure denominator sets to include reminders for all eligible members.

Sampling Procedures

- **Describe sampling methodology:** N/A

Data Collection

Describe data collection: HEDIS Data will be provided by validated corporate data specific to Healthy Blue Louisiana. Data collection for Pharmacy Intervention strategy will be provided by Healthy Blue Louisiana Administrative data collection through Plan Pharmacy Data. Data collection for CM and UM initiatives will be collected through respective departments and claims data. Member feedback will be obtained through Behavioral Health provider audits, where documentation submitted will indicate member barriers that providers discussed with their patients (ie. Financial concerns, transportation). Provider feedback will be collected during quarterly meetings with facilities, including top volume hospitals noted in the Disproportionate Analysis. For facilities that have higher disproportionate index values (>1), we will explore barriers that impede their performance. Conversely, for facilities with lower disproportionate values (<1), we will discuss what helps them to improve follow-up care in a timely manner for their patients. From our routine collection of provider and member feedback, Healthy Blue will create or adjust ITMs to meet the needs of our providers and members.

Validity and Reliability

- **Describe validity and reliability:** All HEDIS data submitted by Healthy Blue is produced by Invovalon which is an NCQA certified vendor. Additionally, Healthy Blue uses an over-read process for all Hybrid measure data. Prior to any data being finalized, Healthy Blue also sends all data to a third-party auditor for review. Any additional administrative claims data information not HEDIS related is validated by ensuring that data pulled is for members who had a prior diagnosis via the claims system. Data collection is done in conjunction with the specifications set forth by the measures. The HEDIS manager performs an audit of data pulled and addresses any gaps in missing data by conducting a deep dive of data collection method.

Data Analysis

Describe data analysis procedures: Once the HEDIS data is obtained, it is analyzed and compared to the goals set forth for each performance measure. Additionally, the data is trended and compared to prior results for identification of opportunities of improvement. The data is stratified by region and member demographics to identify opportunities for targeted interventions to address specific performance measures. Additional administrative claims data, not HEDIS related, is validated by ensuring that data pulled is for those members who had a prior diagnosis via the claims system.

Describe how plan will interpret improvement relative to goal: Goals will be developed based upon the initial data set for members with substance use disorders. Data is continuously monitored, at minimum, on a quarterly basis to determine if metrics are on target or at risk to meeting goals. Data is benchmarked using similar studies and compared to previous results each quarter. Additionally, data deep dives may be required to determine a subset of population trends as related to regional prevalence, member disparities and/or access to care barriers.

Describe how plan will monitor ITMs for ongoing QI: Healthy Blue will complete monthly PDSA and run charts for oversight of measuring interventions to impact overall goals. Additionally, barrier analysis and member/provider focus groups if needed, will be used to identify additional barriers with obtaining goals will be conducted as needed. These exercises will assist in the monitoring of interventions, developing new interventions or the realignment of existing interventions as needed.

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	5861	100%	2070	100%	1
Age					
6–17 years	1170	20.0%	613	29.6%	0.67
18–64 years	4664	79.6%	1452	70.1%	1.13
65+ years	27	0.5%	5	0.2%	1.91
Race					
American Indian or Alaska Native	44	0.8%	14	0.7%	0.71
Asian	19	0.3%	8	0.4%	0.84
Black or African American	264	4.5%	84	4.1%	1.11
Native Hawaiian or Pacific Islander	2312	39.45%	772	37.29%	1.06
White	2992	51.0%	1115	53.9%	0.95
Other	230	3.92%	77	3.72%	1.05
Unknown					
Ethnicity	0	0%	0	0%	0
Hispanic	5637	96.2%	1996	96.4%	1.00
Non-Hispanic	224	3.8%	74	3.6%	1.07
Unknown	343	5.9%	76	3.7%	1.59
Substance Use Disorder	253	4.3%	131	6.3%	0.68
Enrollment category: Foster Care	1300	22.2%	500	24.2%	0.92
Enrollment category: Disabled	1089	18.6%	272	13.1%	1.41
Housing Insecurity/Homeless[1]					
LA MCO Region of Residence					
Region 1: Greater New Orleans	969	16.4%	285	13.7%	1.20
Region 2: Capital Area	675	11.4%	253	12.2%	0.94
Region 3: South Central LA	434	7.4%	180	8.6%	0.85
Region 4: Acadiana	959	16.3%	326	15.7%	1.04
Region 5: Southwest LA	425	7.2%	149	7.2%	1.01
Region 6: Central LA	448	7.6%	188	9.0%	0.84
Region 7: Northwest LA	676	11.5%	244	11.7%	0.98
Region 8: Northeast LA	510	8.6%	171	8.2%	1.05
Region 9: Northshore Area	765	13.0%	274	13.2%	0.99

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	5896	100%	2081	100%	1
Brentwood Hospital	490	8%	230	11%	0.75
Longleaf Hospital	370	6%	118	6%	1.11
Vermilion Behavioral Health Systems	248	4%	105	5%	0.83
Covington Behavioral Health	209	4%	53	3%	1.39
River Place Behavioral Health	204	3%	80	4%	0.90
Childrens Hospital	163	3%	92	4%	0.63
Seaside Behavioral Ctr	157	3%	48	2%	1.15
River Oaks Hospital	147	2%	63	3%	0.82
University Medical Center Management Corporation	146	2%	41	2%	1.26
Cypress Grove Behavioral Health	145	2%	83	4%	0.62
St. James Behavioral Health Hospital	125	2%	40	2%	1.10
Lake Pines Hospital	120	2%	38	2%	1.11
Seaside Health System	116	2%	38	2%	1.08
Lake Charles Memorial Hospital	115	2%	42	2%	0.97
Oceans Behavioral Hospital of Greater New Orleans	115	2%	38	2%	1.07
Our Lady of the Lake Regional Medical Ctr	108	2%	58	3%	0.66
Louisiana Behavioral Health	97	2%	25	1%	1.37
Lafayette Behavioral Health Unit	93	2%	26	1%	1.26
Community Care Hospital	89	2%	20	1%	1.57
Oceans Behavioral Hospital of Kentwood	88	1%	30	1%	1.04
Regions Behavioral Hospital	83	1%	26	1%	1.13

Oceans Behavioral Hospital of Lafayette	80	1%	32	2%	0.88
Spring Lake Behavioral Health Bunkie	78	1%	25	1%	1.10
Beacon Behavioral Hospital New Orleans	77	1%	23	1%	1.18
Northlake Behavioral Health System	74	1%	39	2%	0.67
Beacon Behavioral Hospital	72	1%	25	1%	1.02
Willis Knighton Behavioral Medicine Unit	71	1%	17	1%	1.47
Apollo Behavioral Health Hospital	71	1%	23	1%	1.09
Christus St Patrick Hospital	62	1%	16	1%	1.37
IASIS Glenwood Regional Medical Ctr	62	1%	14	1%	1.56
The General	60	1%	28	1%	0.76
Allen Parish Hospital	52	1%	15	1%	1.22
St Charles Parish Hospital	46	1%	13	1%	1.25
Physicians Behavioral Hospital	45	1%	16	1%	0.99
Jennings Senior Care Hospital	44	1%	10	0%	1.55

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.
***ITMs are reported as non-cumulative measures**

Barrier : MCO is not notified timely of the admissions/last discharge (FUH) **Method of barrier identification: ADT feed, claims data**		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Notification Intervention #1 to address barrier: **Member hospital admission notification to MCO** **Planned Start Date: 03/01/22** **Actual Start Date: 03/01/22**	**ITM #1a :** **Numerator**: # hospital inpatient admissions for whom MCO received any admission notification **Denominator**: FUH denominator (note: count # discharges)	N: 478 D: 1675 R: 28.54%	N: 280 D: 1223 R: 22.89%	N: 1090 D: 1693 R: 64.38%	N:747 D:1328 R: 56.25%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: **Member hospital admission notification to Case Management** **Planned Start Date: 03/01/22** **Actual Start Date:03/01/22**	**ITM #1b :** **Numerator**: # hospital inpatient admissions for which MCO CM received any admission notification **Denominator**: FUH denominator (note: count # discharges)	N: 456 D: 1675 R: 27.22%	N: 270 D: 1223 R: 22.08%	N:1089 D:1693 R: 64.32%	N:747 D:1328 R: 56.25%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: ***Automation* of member hospital admission notification to MCO** **Planned Start Date: 03/01/22** **Actual Start Date: 03/01/22**	**ITM #1c:** **Numerator**: # hospital inpatient admissions for which MCO received ADT/Health Information Exchange admission notification **Denominator**: FUH denominator (note: count # discharges)	N: 105 D: 1675 R: 6.27%	N: 64 D: 1223 R: 5.23%	N: D: 1693 R:	N:213 D:1328 R: 16.03%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: ***Automation* of member hospital admission notification to Case Management**	**ITM #1d:** **Numerator**: # hospital inpatient admissions for which MCO CM received ADT/Health Information Exchange admission notification	N: 105 D: 1675 R: 6027%	N: 64 D: 1223 R: 5.23%	N: D: 1693 R	N: 213 D:1328 R: 16.03%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Planned Start Date: 03/01/22 **Actual Start Date**: **03/01/22**	**Denominator**: FUH denominator (note: count # discharges)								
Barrier : MCO is not notified timely of the admissions/last discharge (FUM, FUA) **Method of barrier identification: ADT feed, claims data**		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Notification Intervention #1 to address barrier: Member BH ED admission or discharge notification to MCO **Planned Start Date: 03/01/22** **Actual Start Date**: **03/01/22**	**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: 70 D: 656 R: 10.67%	N: 178 D: 689 R: 25.83%	N: 684 D: 755 R: 90.59%	N: 451 D: 484 R: 93.18%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: Member BH ED admission or discharge notification to Case Management **Planned Start Date: 03/01/22** **Actual Start Date**: **03/01/22**	**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:70 D: 656 R: 10.67%	N: 113 D: 689 R: 16.4%	N: 684 D: 755 R: 90.59%	N: 450 D: 484 R: 92.97%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: *Automated* member BH ED admission or discharge notification to MCO **Planned Start Date: 03/01/22** **Actual Start Date:03/01/22**	**ITM #1g:** **Numerator:** # members for whom MCO received ADT/Health Information Exchange ED admission or discharge notification **Denominator:** Sum of FUM + FUA denominators (note: count # ED visits)	N: 70 D: 656 R: 10.67%	N: 178 D: 689 R: 25.83%	N: 684 D: 755 R: 90.59%	N:451 D: 484 R: 93.18%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: *Automated* member BH ED admission or discharge notification to Case Management **Planned Start Date: 03/01/22** **Actual Start Date**: **03/01/22**	**ITM #1h:** **Numerator:** # members for whom MCO CM received ADT/Health Information Exchange ED admission or discharge notification **Denominator:** Sum of FUM + FUA denominators (note: count # ED visits)	N: 70 D: 656 R: 10.67%	N: 113 D: 689 R: 16.4%	N: 684 D: 755 R: 90.59%	N: 450 D: 484 R: 92.97%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Barrier : Timely appointment scheduled with provider		**2022**				**2023**			
Method of barrier identification: claims data, provider feedback		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Linkage Intervention #2 to address barrier: Targeted member outreach post hospital discharge for MH to schedule follow up provider appointment and are enrolled in CM **Planned Start Date: 03/01/22** **Actual Start Date: 03/01/22**	**ITM #2ai:** **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 enrolled (agreed to participate) in case management	N: 393 D: 1029 R: 38.19%	N: 208 D: 743 R: 27.99%	N: 454 D: 1100 R: 41.27%	N: 322 D: 825 R: 39.03%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2 to address barrier: Targeted member outreach post hospital discharge for MH to schedule follow up provider appointment not enrolled in CM **Planned Start Date: 03/01/22** **Actual Start Date: 03/01/22**	**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: 263 D: 646 R: 40.71%	N: 137 D: 480 R: 28.54%	N: 212 D: 593 R: 35.75%	N: 181 D: 503 R: 35.98%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2 to address barrier: Targeted member outreach post hospital discharge for BH to schedule follow up provider appointment and are enrolled in CM **Planned Start Date: 03/01/22** **Actual Start Date: 03/01/22**	**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: 4 D: 12 R: 33.33%	N: 4 D: 12 R: 33.33%	N: 2 D: 8 R: 25.00%	N: 10 D: 17 R: 58.82%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Linkage Intervention #2 to address barrier: Targeted member outreach post hospital discharge for BH to schedule follow up provider appointment not enrolled in CM **Planned Start Date: 03/01/22** **Actual Start Date: 03/01/22**	**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: 64 D: 277 R: 23.1%	N: 67 D: 303 R: 22.11%	N: 121 D: 331 R: 36.55%	N: 64 D: 216 R: 29.62%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2 for warm hand-off to address barrier: Targeted CM outreach post ED treat and release visit connecting to a qualifying SUD provider **Planned Start Date: 03/01/22** **Actual Start Date: 03/01/22**	**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 with a principal SUD diagnosis for an ED treat-and-release visit	May be delayed due to Omicron	N: 110 D: 767 R: 14.34%	N: 64 D: 477 R: 13.41%	N: 35 D: 300 R: 11.66%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier: Enhance provider to provider communication		**2022**				**2023**			
Method of barrier identification: provider feedback		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Provider to Provider Communication Intervention #2 to address barrier: Improve hand-off communication by sending enhanced discharge plans for MH hospital discharge prior to appointment **Planned Start Date: 03/01/22** **Actual Start Date: 03/01/22**	**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: 342 D: 1622 R: 21.09%	N: 234 D: 1208 R: 19.37%	N: N/A D: 1269 R: N/A	N: 43 D: 908 R: 4.75%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Provider to Provider Communication Intervention #2 to address barrier: Improve hand-off communication by sending enhanced discharge plans for BH hospital discharge prior to appointment **Planned Start Date: 03/01/22** **Actual Start Date:03/01/22**	**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 + FUA denominators (note: you are counting the sum of # members, not visits)	N: 0 D: 632 R: 0%	N: 0 D: 671 R: 0%	N:0 D: 646 R: 0%	N: 0 D: 405 R: 0%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier: targeted interventions for SUD and homeless populations		**2022**				**2023**			
Method of barrier identification: Disproportionate Analysis		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Tailored & Targeted Intervention #3 to address barrier: Partner with SUD providers in Region 1 **Planned Start Date: 2/2022** **Actual Start Date: TBD**	**ITM #3a:** **N:** # of providers outreached **D:** # of SUD providers in Region 1	Not Started	Not Started	Not Started	Not Started	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Tailored & Targeted Intervention #3 to address barrier: Events with homeless/housing insecurity organizations to obtain contact information **Planned Start Date: 2/2022** **Actual Start Date**: TBD	**ITM #3b:** **N:** # of events **D:** # of organizations outreached	Not Started	Not Started	Not Started	Not Started	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Tailored & Targeted Intervention #3 to address barrier: Text outreach campaign for FUH **Planned Start Date: 03/01/22** **Actual Start Date: 03/01/22**	**ITM #3c:** **N:** # of members enrolled for text campaigns **D:** # of members in FUH denominators	N: 287 D: 495 R: 57.98%	N:614 D: 1701 R: 36.09%	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Tailored & Targeted Intervention #3 to address barrier: Text outreach campaign for FUA **Planned Start Date: 03/01/22** **Actual Start Date: TBD**	**ITM #3d:** **N:** # of members enrolled for text campaigns **D:** # of members in FUA denominators	Not Started	Not Started	Not Started	Not Started	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Tailored & Targeted Intervention #3 to address barrier: Text outreach campaign for FUM **Planned Start Date: 03/01/22** **Actual Start Date: TBD**	**ITM #3e:** **N:** # of members enrolled for text campaigns **D:** # of members in FUM denominators	Not Started	Not Started	Not Started	Not Started	N: D: R:	N: D: R:	N: D: R:	N: D: R:

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 * *keep in mind that final rates are only capturing data through 10/31/22*

Indicator	Baseline Measure Period 1/1/21–12/31/21	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: 1074 D: 6282 R: 17.09%	N: 1183 D: 6113 R: 19.35%	At least 3 percentage points increase for each performance indicator. Rate: 20.09%
Indicator #1b. Follow-Up After Hospitalization for Mental Illness (FUH)- Total, 30 days	N: 2266 D: 6282 R: 36.07%	N: 2225 D: 6113 R: 36.40%	Rate: 39.07%
Indicator #2a. Follow-Up After Emergency Department Visit for Mental Illness (FUM)- Total, 7 days	N: 278 D: 1334 R: 20.84%	N: 197 D: 1070 R: 18.41%	Rate: 23.84%
Indicator #2b. Follow-Up After Emergency Department Visit for Mental Illness (FUM)- Total, 30 days	N: 471 D: 1334 R: 35.31%	N: 325 D: 1070 R: 30.37%	Rate: 38.31%
Indicator #3a. Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence (FUA) – Total, 7 days	N: 172 D: 1861 R: 9.24%	N: 149 D: 1597 R: 9.33%	Rate: 12.24%
Indicator #3b. Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence (FUA) – Total, 30 days	N: 268 D: 1861 R: 14.4%	N: 234 D: 1597 R: 14.65%	Rate: 17.4%

[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.

Figure 1. Follow-up after hospitalization for Mental Illness -7 day

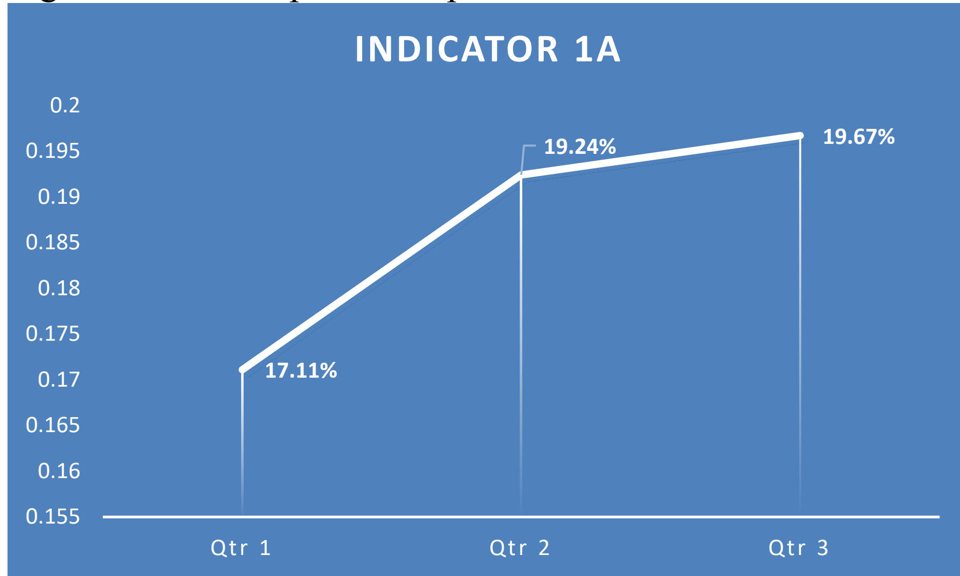


Figure 2. Follow-up after ED visit for Mental Illness – 7 day

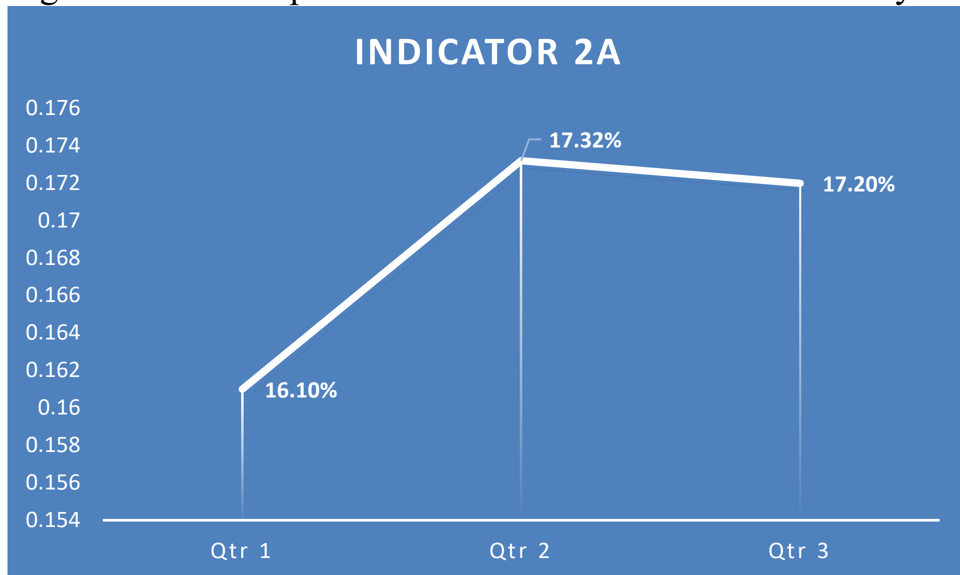
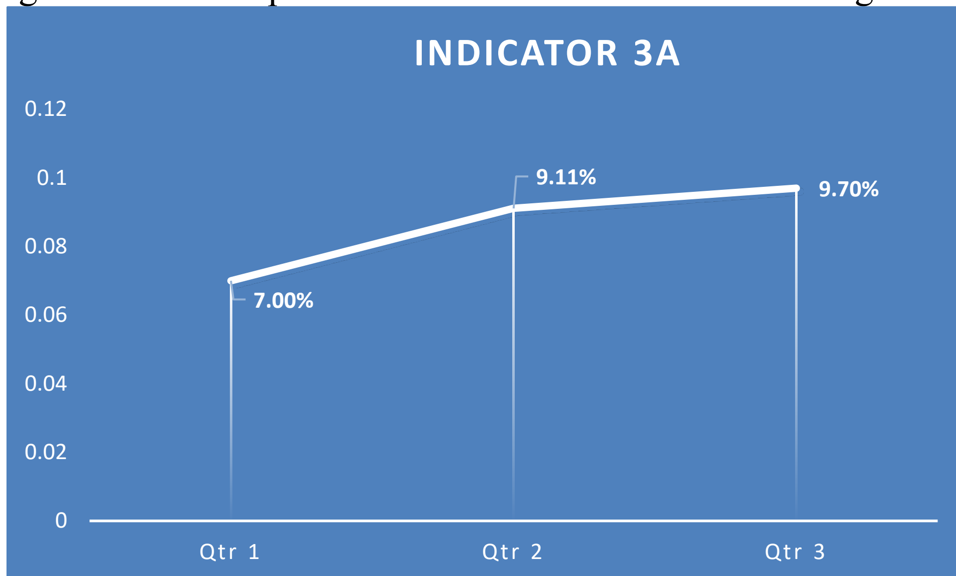


Figure 3. Follow-up after ED visit for alcohol or other drug abuse – 7 day



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:**
  The results for the Performance Indicators (PI) are as follows: (Data does not capture Q4 due to report timing)
  - Indicator #1a. Follow-Up After Hospitalization for Mental Illness (FUH) – Total, 7 days Increased from a baseline of 17.09% to 19.35% during Interim measurement period. Target rate of 20.09% was not met. However, plan is only .74% away from goal.
  - Indicator #1b. Follow-Up After Hospitalization for Mental Illness (FUH) – Total, 30 days Increased from a baseline measurement of 36.07% to 36.40% during Interim measurement period. Target rate of 39.07% was not met.
  - Indicator #2a. Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Total, 7 days unfortunately decreased from a baseline of 20.84% to 18.41% during Interim measurement period. The target goal was 23.84% for this indicator.
  - Indicator #2b. Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Total, 30 days decreased from a baseline measurement of 35.31% to 30.37% during Interim measurement period. Target rate of 38.31% was not met
  - Indicator #3a. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 7 days Increased from a baseline measurement of 9.24% to 9.33% during the Interim measurement period. Target rate of 12.24% was not met
  - Indicator #3b. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 30 days Increased from a baseline of 14.40% to 14.65% during the interim measurement period. Target rate of 17.40% was not met

The interpretation and analysis of the performance indicator rates for 2022 displayed a quarter over quarter improvement in most measures. Healthy Blue experienced an increased rate in most indicators from baseline to interim measurement with only being a few points away from the target rate with most measures.

- **Explain and interpret the results by reviewing the degree to which objectives and goals were achieved.**

Healthy Blue was able to achieve several objectives and goals due to specific interventions that supported the member by receiving an appointment with a provider before hospital discharge, as well as an increase with members ATTENDING provider visits more. Case Management especially focused on these interventions through committed outreach to members. Other ITMs which proved to indicate success included FUH members actively enrolled in text campaigns. This ITM successfully reminded members much earlier to ensure follow-up occurred as soon as possible.

- **What factors were associated with success or failure?**

Healthy Blue has a high disproportionate index for members with substance use and/or with housing insecurity. Understanding those factors, the plan strategically focused on supporting interventions by having collocated Healthy Blue representatives within hospitals to assist in discharge planning. This pilot was effectively implemented with Ready Responders in Region 1 - Orleans Parish.

PIP Highlights

Member Intervention – ITM 3c
Healthy Blue was able to identify ITM 3c, Text outreach for FUH as the most effective intervention for 2022. The plan maintained continued success month after month when reviewing member engagement followed by the enrollment of text campaigns.

Provider Intervention – ITM 2aii
The plan noted ITM 2aii, Targeted member outreach post hospital discharge for MH to schedule follow-up provider appointment not enrolled in CM as the most effective provider intervention. Healthy Blue was able to sustain at above 35% with follow-up appointments during 2022.

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).

NCQA for MY 2022 to include pharmacotherapy events as numerator compliant limits the internal validity of interpretation of improvement from MY 2021 for the FUA measure because pharmacotherapy events were not captured in MY 2021. The timing of this change did not present the opportunity for the plan to pivot and adjust to the new specs.

- **Were there any factors that may pose a threat to the internal validity the findings?**

Case Management receiving timely ADT feeds in order to complete outreach. The timing of reporting my pose as a threat due to factors of not reviewing the data in its entirety.

- **Were there any threats to the external validity the findings?**

External threat noted as receiving timely ED data collection related to FUA/FUM. ADT feed active but limited to only a few providers. The lack of Interoperability among the provider landscape within the state is a contributing factor to threats as well. This interrupts timely member follow-up.

- **Describe any data collection challenges.**

Claims lag from time to time prove to be a challenge. However, the plan continues to work closely with informatics to identify areas of improvement.

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
#1a Member hospital admission notification to MCO	Most providers lack interoperability therefore notifications may not be shared timely	Plan will continue to explore this concern for opportunities of improvement and partnership	Continue to engage providers and facilities developing relationships and improving systems
#1b Member hospital admission notification to Case Management	Most providers lack interoperability therefore notifications may not be shared timely	Plan will continue to explore this concern for opportunities of improvement and partnership	Continue to engage providers and facilities developing relationships and improving systems
#1b/#1c *Automation* of member hospital admission notification to MCO/CM	Most providers lack interoperability therefore notifications may not be shared timely	Plan will continue to explore this concern for opportunities of improvement and partnership	Continue to engage providers and facilities developing relationships and improving systems
#1e/1f Member BH ED admission or discharge notification to MCO/CM	Most providers lack interoperability therefore notifications may not be shared timely	Plan will continue to explore this concern for opportunities of improvement and partnership	Continue to engage providers and facilities developing relationships and improving systems
#2ai Targeted member outreach post hospital discharge for MH to schedule follow up provider appointment and are enrolled in CM	Targeted CM outreach and engagement to members who have frequent readmission with a MH diagnosis improves outcomes	Healthy Blue will continue engagement with members Enrolled in CM providing referrals if needed	Continue outreach and education with members
#2aii Targeted member outreach post hospital discharge for MH to schedule follow up provider appointment not enrolled in CM	Targeted CM outreach and engagement to members who have frequent readmission with a MH diagnosis improves outcomes	Healthy Blue will continue engagement with members Will continue to outreach members for opportunities to enroll in CM	Continue outreach and education with members

References

List any references that you cite.

Croake, S., Brown, JD, Miller, D., et al. Follow-up Care After Emergency Department Visits for Mental and Substance Use Disorders Among Medicaid Beneficiaries. Psychiatric Services. 2017; 68:566-572.

Brown, GK, Green, KL. 2014. A Review of Evidence-Based Follow-up Care for Suicide Prevention. American Journal of Preventive Medicine. 2014; 47(3S2):S209-S215.

New England Health Care Institute (NEHI). 2010. A Matter of Urgency: Reducing Emergency Department Overuse, A NEHI Research Brief. Retrieved from http://www.nehi.net/writable/publication_files/file/nehi_ed_overuse_issue_brief_032610finaledits.pdf

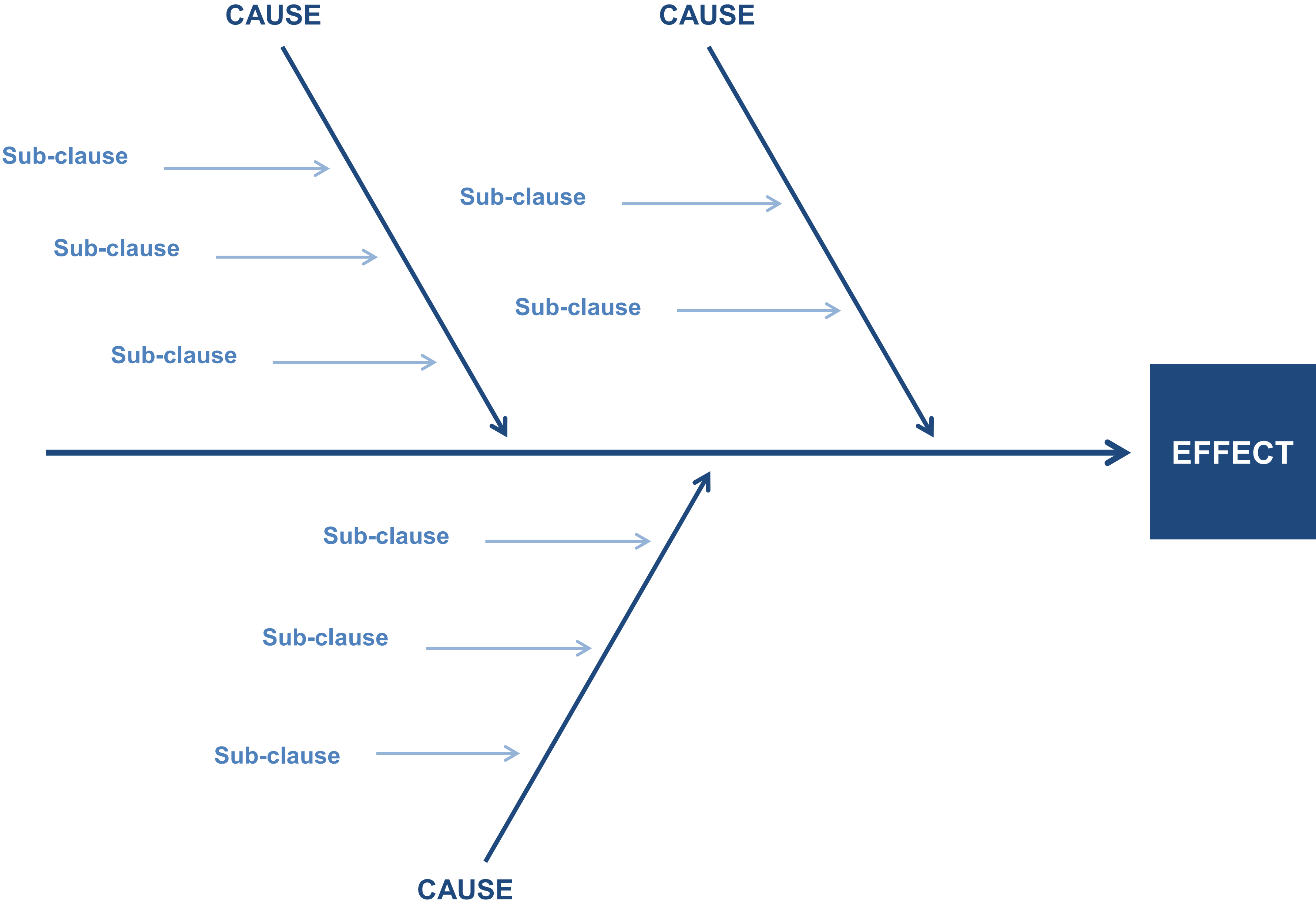
Glossary of PIP Terms

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		
Less Feasible to Address		

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 Patient education for increased health literacy including medical condition(s), medications, and importance of follow-up visits Ensuring members have a	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	

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
	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.	

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.		
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.	
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	

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.	•	•	•