Healthy Louisiana
Performance Improvement Project (PIP)

Health Plan: Louisiana Healthcare Connections

PIP Title: Behavioral Health Transitions in Care

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

Submission Dates:

	Report Year 2022
Version 1	03/01/2022
Version 2	04/04/2022
Version 3	12/09/2022
Version 4	12/30/2022

MCO Contact Information

1. Principal MCO Contact Person

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

First and last name:	Lesley Istre, BSN RN CPHQ CCM
Title:	Manager, Quality Improvement
Phone number:	(225) 319-3446
Email:	Lesley.M.Istre@LouisianaHealthConnect.com

2. Additional Contact(s)

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

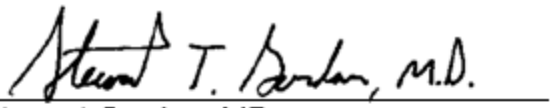
First and last name:	Yolanda Wilson, MSN, RN, CPHQ
Title:	SVP Quality Improvement
Phone number:	(225) 319-3550
Email:	Yolanda.Wilson@LouisianaHealthConnect.com

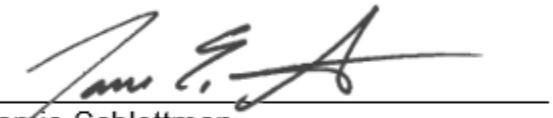
3. External Collaborators (if applicable): N/A

Attestation

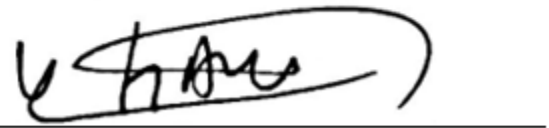
Plan Name: Louisiana Healthcare Connections
Title of Project: Behavioral Health Transitions of Care

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

Medical Director signature: 
First and last name: Stewart Gordon, MD
Date: 12/9/2022 Chief Medical Officer

CEO signature: 
First and last name: Jamie Schlottman
Date: 12/9/2022 Chief Executive Officer

Quality Director signature: 
First and last name: Yolanda Wilson
Date: 12/9/2022 Sr. Vice President, Quality Improvement

IS Director signature: 
First and last name: Michel Hanet
Date: 12/9/2022 Director, Reporting & Business Analytics

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	04/25/2022	☐ Methodology ☐ Barrier Analysis ☐ Intervention ☒ ITM	ITM 3a: updated numerator/denominator descriptors to reflect the targeted subpopulation (edited in error with the 4/4/2022 proposal submission)
Change 2	08/01/2022	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☒ ITM	Addition of intervention and ITM to track and monitor provider notification of member ED visits
Change 3		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ ITM	
Change 4		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ ITM	

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/Rationale/Objectives

Project Topic: Behavioral Health Transitions in Care

Rationale: Mental illness affects people across the spectrum, regardless of age, sex, race, or socioeconomic status, impacting approximately 17-20% of adolescents and adults in the United States. The 2019 National Survey on Drug Use and Health reported that about 1% of the U.S. population received inpatient treatment and nearly 14% received outpatient services (SAMHSA, 2021). By 2021, the National Committee for Quality Assurance (NCQA) reported that despite the nearly 2 million Americans receiving inpatient behavioral services, follow-up care after hospitalization is not consistently delivered even though it is known to reduce readmissions and associated costs (NCQA, 2021). The behavioral health spectrum encompasses mental illness as well as substance use (co-occurring at times), with similar opportunities to improve access to care and support optimal patient outcomes. As we aim for improved quality and utilization of health services, effective management of care transitions is essential to reduce preventable readmissions and emergency room visits for mental health and substance abuse populations and promote member engagement with available behavioral health services for optimal condition management. Interventions for this project are tailored to improve member access to care through member education, awareness, and linkage to treatment, with a parallel focus on increasing provider knowledge, educational offerings, linkage to resources, and provider network access.

Objectives: 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**:

- enhance hospital-to-MCO workflow for notification of hospital and emergency department admissions, discharges and transfers, record sharing
- enhanced MCO case/care management to ensure aftercare planning for members prior to discharge from hospital or emergency department
- member linkage 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
- identification and interventions to address needs of sub-populations by stratifying data to identify specialized needs
- initiation of 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)

Methodology

Eligible population and description of performance indicators: All eligible Healthy Louisiana enrollees included in the HEDIS® Follow-up After Hospitalization for Mental Illness (FUH), Follow-up After Emergency Department Visit for Mental Illness (FUM), Follow-up After Emergency Department Visit for Substance Use.

Sampling Method: No sampling used.

Baseline and Re-measurement Periods: Baseline period: 1/1/2021-12/31/2021; Interim Measurement Periods: 1/1/2022-12/31/2022; Final Measurement Period: 1/1/2023-12/31/2023.

Data Collection Procedures: Performance indicator data for these measures are collected administratively, electronically, using extraction software. The parameters for extraction come directly from the Healthcare Effectiveness Data and Information Set (HEDIS®) measures identified while intervention measure tracking data are collected through administrative claims data using Centene's enterprise vendor Inovalon's Quality Spectrum Insight (QSI-XL) database, Centene's Enterprise Data Warehouse, and other programs such as Microstrategy, TruCare, and Sharepoint through LHCC's Data Analytics department and Case Management reporting.

Interventions

Interventions developed to address member needs and barriers to outreach and linkage to care include:

- MCO care management and quality teams providing outreach (telephonic, face-to-face, electronic) to all members following inpatient hospitalization or emergency department visit to provide education, support provider engagement post-discharge, assist with linkage to providers when needed, and address SDoH that may impact member access to follow-up care
- Targeted outreach and specialized interventions to address the needs of the substance use disorder sub-populations identified through stratification and identification of specialized needs
- Initiation of printed and electronic (text/email) communication to facilitate broader follow-up with members with an appropriate mental health provider (per NCQA Appendix 3)

Interventions developed to address the identified provider needs and barriers include:

- provider outreach and education to promote and expand hospital-to-MCO workflow for notification of hospital and emergency department admissions, discharges and transfers, record sharing
- provider outreach and education/resources supporting follow-up processes and care delivery to members discharging from inpatient hospital and emergency department settings for mental health or substance use disorders
- expanded provider education topics via provider training platform to support improved follow-up care strategies, and HEDIS follow-up measures in particular, in a web-based 'on-demand' format

Results

Annual HEDIS rates will not be finalized until June 2023 for the Reporting Year 2022. Available performance indicator data through 12/9/2022, found in the *Results* section beginning on page 31, indicate limited growth YTD with only the FUA HEDIS rate increasing from the previous measure year baseline.

Follow-up After Hospitalization for Mental Illness (FUH) within 7 days is 17.05 percent, 4.23 percentage points below baseline; within 30 days is 35.24, 5.49 percentage points below baseline.

Follow-up After Emergency Department Visit for Mental Illness (FUM) within 7 days is 20.52 percent, 0.54 percentage points below baseline; within 30 days is 34.02 percent, 2.01 percentage points below baseline.

Follow-up After Emergency Department Visit for Substance Use (FUA) within 7 days is 8.63 percent, 0.47 percentage points above baseline; within 30 days is 12.53 percent, 0.42 percentage points above baseline.

Conclusion and Next Steps

Ongoing analysis of performance indicators, as well as interventions and outcomes, provided valuable insight into member and provider-centric challenges and opportunities for continued improvement in 2023. Despite focused intervention on member engagement for follow-up following discharge from inpatient and emergent care settings, limited improvement in rates were noted. Processes to support member engagement with follow-up care and provider delivery of follow-up care remain prominent in goals for the upcoming project measurement year. Residual impacts from the COVID-19 pandemic continued to influence and disrupt member and provider-facing initiatives as well as provider operations. Interventions in the next reporting year will seek to utilize more live, in-person engagement and innovative electronic communication methods to support engagement and education opportunities.

Project Topic

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

Describe Project Topic and Rationale for Topic Selection

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

The pursuit of optimal quality care and health outcomes is a rare constant in the midst of the current dynamic healthcare environment, even more so with the impact of the ongoing pandemic. As a significant focus under the Triple Aim targeting population health and cost control, reducing avoidable hospital readmissions, and promoting care delivery in the appropriate levels of care is a priority for behavioral health populations as well as physical health. As we aim for improved quality and utilization of health services, effective management of care transitions is essential to reduce preventable readmissions and emergency room visits for mental health and substance abuse populations and promote member engagement with available behavioral health services for optimal condition management.

Mental illness affects people across the spectrum, regardless of age, sex, race, or socioeconomic status, impacting approximately 17-20 percent of adolescents and adults in the United States. The 2019 National Survey on Drug Use and Health reported that about 1 percent of the U.S. population received inpatient treatment and nearly 14 percent received outpatient services (SAMHSA, 2021). In 2021, the National Committee for Quality Assurance (NCQA) reported that despite the nearly 2 million Americans receiving inpatient behavioral services, follow-up care after hospitalization is not consistently delivered even though it is known to reduce readmissions and associated costs (NCQA, 2021). NCQA supports that follow-up care for people with mental illness is linked to lower rates of Emergency Department visits, improved outcomes, and increased compliance with follow-up recommendations (2021). The behavioral health spectrum encompasses mental illness as well as substance use (co-occurring at times), with similar opportunities to improve access to care and support optimal patient outcomes. Additional disparities are noted in specific mental health subpopulations. For example, non-adherence with follow-up following a hospitalization for patients diagnosed with schizophrenia is nearly 60 percent whereas patients diagnosed with alcohol abuse are 15 percent less likely to attend follow-up visits in the outpatient setting (Borg, et al, 2018; Vega, et al, 2021). Focused initiatives to improve care transitions in the behavioral health population are necessary to address these challenges.

Interventions for this project are tailored to improve member access to care through member education, awareness, and linkage to treatment, with a parallel focus on increasing provider knowledge, educational offerings, linkage to resources, and provider network access. While the Follow Up After Hospitalization (FUH) member population represents the largest volume, the population is relatively small in comparison to Louisiana Healthcare Connections (LHCC) overall membership. LHCC provides health and wellness outreach and support services to a larger group of members identified within the Special Health Care Needs (SHCN) population. SHCN groups overlap members with mental health and substance use disorders, including members with intravenous drug use; pregnant women with substance use or co-occurring disorders; individuals with substance use disorders who have dependent children; persons living with HIV/AIDS who need mental health or substance use treatment; and chronic health conditions like Hepatitis C Virus and other chronic liver disease.

- **Describe high-volume or high-risk conditions addressed:**
  The performance improvement project will address the high-risk conditions of behavioral health disorders in pediatric and adult members. Additional overlapping disparate populations identified through analysis of the FUH population, including members which substance use disorders and members residing in Region 1 were targeted, and member and provider feedback is expected to provide deeper insight into related barriers and opportunities for next steps.

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

  The American Psychological Association (APA) provides professional practice, evidence-based guidelines for psychological practice in health care (2021). In addition to these, and available research support, clinical practice guidelines for screening and treatment of members living with or at risk for substance use disorders are supported through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Society of Addiction Medicine (ASAM). These entities provide updated evidence-based practices to inform and support healthcare providers in improving outcomes for members. As such, provider education efforts are focused on linkage to education and resources from these sources.

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

  Though annual HEDIS health plan measures for the Reporting Year 2021 were not finalized until June 2022, administrative data through January 2022 was included in Table 2 (beginning on page 10). Analysis of these HEDIS rates highlighted an opportunity for Louisiana Healthcare Connections to improve FUH, FUM, and FUA HEDIS measures by at least 3 percentage points from the 2021 rates through the interventions and initiatives identified through this project. A deeper analysis of these rates historically since 2018 further supports the increased focus on FUA and FUM populations, in particular, as these rates have declined over the last 3 years.

  In further analysis of the data provided in Table 2 earlier this year:
  - FUH total 7-day and 30-day measures for MY2021 YTD were 21.28 percent and 40.73 percent respectively, and less than the corresponding Quality Compass 25th percentiles, 30.86 and 51.90;
  - FUM total 7-day and 30-day measures for MY2021 YTD were 21.06 percent and 36.03 percent respectively, and less than the corresponding Quality Compass 25th percentiles, 30.22 and 45.45; and
  - FUA total 7-day and 30-day measures for MY2021 YTD were 8.16 percent and 12.11 percent respectively in comparison to the corresponding Quality Compass 25th percentiles, 7.10 and 10.75.

  Additionally, analysis of under-represented populations in the FUH measure with the highest volume denominator provides insight into overlapping populations that could benefit from targeted outreach to promote adherence with follow-up appointments following emergency department visits or hospitalizations for designated behavioral health and/or substance use disorders. Initially, groups that may benefit from focused intervention include members with substance use disorders and members residing in the Greater New Orleans area (Region 1). As outreach efforts are initiated and aggregation/analysis of member and provider feedback provides deeper insight into related barriers, the focus on targeted populations will be narrowed.

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

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

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

Aims, Objectives and Goals

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

- 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.

- 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.

- 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.
- 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: 1/1/2021–12/31/2021	Interim Rate Measurement Period: 1/1/2022–12/9/2022[2]	Final Rate Measurement Period: 1/1/2023–12/31/2023	Target Rate[3]	Rationale for Target Rate[4]
Indicator #1a. Follow-Up After Hospitalization for Mental Illness (FUH) – Total, 7 days	N: 1,735 D: 8,154 R: 21.28%	N: 1,424 D: 8,351 R: 17.05%	N: D: R:	R: 24.28%	3 percentage point increase from CY2021 to CY2022 NCQA Quality Compass rates
Indicator #1b. Follow-Up After Hospitalization for Mental Illness (FUH) – Total, 30 days	N: 3,321 D: 8,154 R: 40.73%	N: 2,943 D: 8,351 R: 35.24%	N: D: R:	R: 43.73%	3 percentage point increase from CY2021 to CY2022 NCQA Quality Compass rates

[1] Baseline rate: the MCO-specific rate that reflects the year prior to when PIP interventions are initiated.
[2] Final 2022 data will not be available for reporting until 2023; Q4 data represent the results of outcomes collected to date.
[3] 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.
[4] 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).

Indicators	Baseline Rate[1] Measurement Period: 1/1/2021–12/31/2021	Interim Rate Measurement Period: 1/1/2022–12/9/2022[2]	Final Rate Measurement Period: 1/1/2023–12/31/2023	Target Rate[3]	Rationale for Target Rate[4]
Indicator #2a. Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Total, 7 days	N: 377 D: 1,790 R: 21.06%	N: 269 D: 1,311 R: 20.52%	N: D: R:	R: 24.06%	3 percentage point increase from CY2021 to CY2022 NCQA Quality Compass rates
Indicator #2b. Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Total, 30 days	N: 645 D: 1,790 R: 36.03%	N: 446 D: 1,311 R: 34.02%	N: D: R:	R: 39.03%	3 percentage point increase from CY2021 to CY2022 NCQA Quality Compass rates
Indicator #3a. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 7 days	N: 184 D: 2,254 R: 8.16%	N: 166 D: 1,923 R: 8.63%	N: D: R:	R: 11.16%	3 percentage point increase from CY2021 to CY2022 NCQA Quality Compass rates
Indicator #3b. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 30 days	N: 273 D: 2,254 R: 12.11%	N: 241 D: 1,923 R: 12.53%	N: D: R:	R: 15.11%	3 percentage point increase from CY2021 to CY2022 NCQA Quality Compass rates

Methodology

To be completed upon Proposal submission.

Performance Indicators

Table 3: Performance Indicators

Indicator[5]	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 practitioner within 7 days after discharge.	Administrative/ Claims/ Encounter data	Medicaid enrolled LA residents 6 years and older with an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year.	Medicaid enrolled Louisiana residents in hospice care	A follow-up visit with a mental health practitioner within 7 days after discharge. Do not include visits that occur on the date of discharge.	Number of members in the eligible population less number of excluded members.

[5] 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.

Indicator[5]	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 practitioner within 30 days after discharge.	Administrative/ Claims/ Encounter data	Medicaid enrolled LA residents 6 years and older with an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year.	Medicaid enrolled Louisiana residents in hospice care	A follow-up visit with a mental health practitioner within 30 days after discharge. Do not include visits that occur on the date of discharge.	Number of members in the eligible population less number of excluded members.
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.	Administrative/ Claims/ Encounter data	Medicaid enrolled LA residents 6 years and older as of the date of the ED visit with an ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year.	Medicaid enrolled Louisiana residents in hospice care	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. Include visits that occur on the date of the ED visit.	Number of members in the eligible population less number of excluded members.

Indicator[5]	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #2b. Follow-Up After Emergency Department Visit for Mental Illness (FUM)- Total, 30 days	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the ED visit.	Administrative/ Claims/ Encounter data	Medicaid enrolled LA residents 6 years and older as of the date of the ED visit with an ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year.	Medicaid enrolled Louisiana residents in hospice care	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. Include visits that occur on the date of the ED visit.	Number of members in the eligible population less number of excluded members.
Indicator #3a. Follow-Up After Emergency Department Visit for 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 Opioid or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit.	Administrative/ Claims/ Encounter data	Medicaid enrolled LA residents 13 years and older as of the date of the ED visit with an ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year.	Medicaid enrolled Louisiana residents in hospice care	A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit.	Number of members in the eligible population less number of excluded members.

Indicator[5]	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #3b. Follow-Up After Emergency Department Visit for 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 Opioid or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit.	Administrative/ Claims/ Encounter data	Medicaid enrolled LA residents 13 years and older as of the date of the ED visit with an ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year.	Medicaid enrolled Louisiana residents in hospice care	A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit.	Number of members in the eligible population less number of excluded members

Data Collection and Analysis Procedures

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

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:**
  No sampling utilized; PIP interventions target the entire eligible population.

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:**
  Performance indicator and intervention tracking measure data will be collected through administrative claims/encounter data using the Centene-level corporate Quality Spectrum Insight (QSI-XL) database. We will also utilize data from Centene's Enterprise Data Warehouse, and additional data collection and/or abstraction programs such as SQL Server Management Studio, Teradata, Microstrategy, Interpreta, ImpactPro, and clinical and other document software applications like TruCare and Sharepoint. In addition to the administrative claims and encounter data that will provide insight into the effectiveness of interventions on the targeted groups, staff will use the aforementioned department appropriate applications to document feedback collected from members and providers through direct telephonic, face-to-face, and/or other electronic outreach so that it can be extrapolated and reviewed by the project team in order to guide intervention changes using the PDSA model for performance improvement. While most data elements will be collected monthly for consistency in process and workflows, some PIP data may be aggregated and reported on a quarterly basis. Those who collect the data include Data Analysts, Quality Improvement, Case Management, and/or Provider Network team members who track and trend their department's data.

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:**
  Data is validated by Quality Improvement Abstractors as well as HEDIS and Data Analytics staff. All Quality Improvement Abstractors are provided training and must pass subsequent testing. Abstractors are also audited on a quarterly basis. For data reliability, treatment rates are compared to number of claims in our data warehouse for the same time-period, hence a correlation ratio is derived to check data consistency. Data validation is conducted using various methods, including consultation with medical director, case management, provider network, and quality teams. Additional validation methods include enrollment checks to ensure timely treatment continuity of this population. In addition to above methods, statistical methods (experimental design) are used to compare the number of related claims received and unique number of Medicaid members.

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:**
  Data will be analyzed by data analysts, quality improvement abstractors, case management, and provider network staff who track and trend their department's data. ITM data is collected through departmental reporting and analyzed on a quarterly basis, or more often as needed. Data used for ITMs includes claims data, case management enrollment data, and overall membership data. Data is compared to previous year's data when available, denominators and numerators will be checked for inclusion of all eligible populations and any discrepancies are investigated. Data is compared to all sources and histories available in an effort to produce the most valid data possible. As mentioned above, data will be collected on a quarterly basis and analyzed for increasing or decreasing trends. Any stagnating or decreasing trends identified will result in a root-cause analysis and interventions will be modified as needed based on the information gathered.

- **Describe how plan will interpret improvement relative to goal:**
  Data is compared to previous year's data as available as well as established current year trending and benchmarks/targets; denominators and numerators will be checked for inclusion of all eligible populations and any identified discrepancies are investigated. Data is compared to all sources and histories available in an effort to produce the most valid data possible. Improvement will be monitored via internal benchmarking against established baseline thresholds and subsequent goals established beyond baselines assessed; in accordance with targets proposed for the purposes of this PIP continuation, this will be improvement from baseline to the next highest Quality compass percentile (or by 3 percentage points).

- **Describe how plan will monitor ITMs for ongoing QI:**
  ITMs will be monitored quarterly to evaluate positive improvement, plateaus, or identify adverse trends for prompt investigation, analysis and/or action to modify interventions if indicated.

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	7,985	100%	3,190	100%	
Age					
6–17 years	2,148	26.90%	1,254	39.31%	0.6843
18–64 years	5,790	72.51%	1,924	60.31%	1.2022
65+ years	47	0.59%	12	0.38%	1.5647
Race					
American Indian or Alaska Native	64	0.80%	22	0.69%	1.1622
Asian	267	3.34%	90	2.82%	1.1852
Black or African American	3,446	43.16%	1,320	41.38%	1.0429
Native Hawaiian or Pacific Islander	33	0.41%	13	0.41%	1.0140
White	3,941	49.36%	1,640	51.41%	0.9600
Other	0	0	0	0	0.0000
Unknown	234	2.93%	105	3.29%	0.8903
Ethnicity					
Hispanic	180	2.25%	73	2.29%	0.9851
Non-Hispanic	7729	96.79%	3,078	96.49%	1.0032
Unknown	76	0.95%	39	1.22%	0.7785
Substance Use Disorder	5,369	67.24%	1,770	55.49%	1.2118
Enrollment category: Foster Care	224	2.81%	115	3.61%	0.7782
Enrollment category: Disabled	1,739	21.78%	826	25.89%	0.8411
Housing Insecurity/Homeless[1]	424	5.31%	71	2.23%	2.3857
LA MCO Region of Residence					
Region 1: Greater New Orleans	1,047	13.11%	385	12.07%	1.0864
Region 2: Capital Area	805	10.08%	333	10.44%	0.9658
Region 3: South Central LA	454	5.69%	221	6.93%	0.8207
Region 4: Acadiana	1,415	17.72%	540	16.93%	1.0468
Region 5: Southwest LA	985	12.34%	405	12.70%	0.9716
Region 6: Central LA	810	10.14%	302	9.47%	1.0715
Region 7: Northwest LA	867	10.86%	405	12.70%	0.8552
Region 8: Northeast LA	650	8.14%	238	7.46%	1.0911
Region 9: Northshore Area	952	11.92%	361	11.32%	1.0535

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	5731	100.00%	3257	100.00%	
UNIVERSITY HEALTH SHREVEPORT LLC	887	15.477%	532	16.33%	0.9475
OCHSNER FOUNDATION HOSPITAL	517	9.021%	320	9.82%	0.9182
CHILDRENS HOSPITAL	503	8.777%	345	10.59%	0.8286
OUR LADY OF THE LAKE RMC	487	8.498%	202	6.20%	1.3701
UNIVERSITY HOSPITAL AND CLINIC INC	419	7.311%	209	6.42%	1.1393
UNIVERSITY MEDICAL CENTER	342	5.968%	150	4.61%	1.2958
MMO REHABILITATION & WELLNESS CENTER	287	5.008%	287	8.81%	0.5683
EAST BATON ROUGE MEDICAL CENTER LLC	263	4.589%	155	4.76%	0.9643
CHRISTUS ST. FRANCES CABRI HOSPITAL	189	3.298%	74	2.27%	1.4515
BRENTWOOD HOSPITAL	184	3.211%	164	5.04%	0.6376
BRFHH MONROE LLC	180	3.141%	83	2.55%	1.2325
SOUTHWEST LOUISIANA HOSPITAL ASSOCIATION	155	2.705%	64	1.96%	1.3764
OUR LADY OF THE ANGELS HOSPITAL	122	2.129%	50	1.54%	1.3867
SOUTHERN REGIONAL MEDICAL CORPORATION	121	2.111%	73	2.24%	0.9420
RAPIDES REGIONAL MEDICAL	108	1.884%	39	1.20%	1.5738
COMPASS BEHAVIORAL CENTER	102	1.780%	79	2.43%	0.7338
LALLIE KEMP MEDICAL CTR	84	1.466%	40	1.23%	1.1935
TOURO INFIRMARY	79	1.378%	44	1.35%	1.0204
WEST JEFFERSON MEDICAL CENTER	73	1.274%	40	1.23%	1.0372
NORTH OAKS MED CTR	71	1.239%	15	0.46%	2.6900
ST JAMES BEHAVIORAL HOSPITAL	64	1.117%	22	0.68%	1.6533
UNIVERSITY HEALTHCARE SYSTEM LC	53	0.925%	22	0.68%	1.3691
OCHSNER LSU HEALTH SHREVEPORT	44	0.768%	34	1.04%	0.7355
ST. TAMMANY PARISH HOSPITAL	40	0.698%	22	0.68%	1.0333
ST HELENA PARISH HOSPITAL	38	0.663%	38	1.17%	0.5683
SLIDELL MEMORIAL HOSPITAL	33	0.576%	14	0.43%	1.3396
OCHSNER MEDICAL CENTER	33	0.576%	21	0.64%	0.8931

SHRINERS HOSPITALS FOR CHILDREN INC	33	0.576%	22	0.68%	0.8525
NACHITOCHES PARISH HOSPITAL SERVICE DIST	30	0.523%	17	0.52%	1.0029
SAVOY MEDICAL CENTER	30	0.523%	15	0.46%	1.1366
CROSSROADS REGIONAL HOSPITAL LLC	28	0.489%	4	0.12%	3.9782
WOMAN'S HOSPITAL	27	0.471%	10	0.31%	1.5344
EAST JEFFERSON GENERAL HOSPITAL	26	0.454%	5	0.15%	2.9552
GREENBRIER HOSPITAL LLC	25	0.436%	18	0.55%	0.7893
OCHSNER MC KENNER	18	0.314%	9	0.28%	1.1366

Barrier Analysis, Interventions, and Monitoring

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

Barrier: Limited BH provider participation in ADT feeds/applications (See *Discussion*, p. 36) **Method of barrier identification:** Multidisciplinary work group established – direct feedback from BH Medical Director(s); direct hospital/provider feedback from 1:1 dialogue; analysis of related data sources		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4** ***(10/1/2022-12/9/2022)[6]***	**Q1**	**Q2**	**Q3**	**Q4**
Notification Intervention #1 to address barrier: Enhance hospital-to-MCO workflow for notification of hospital admissions, discharges, and transfers **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #1a: (non-cumulative)** **Numerator**: # hospital inpatient admissions for which MCO received any admission notification **Denominator**: FUH denominator (note: count # discharges)	N: 2232 D: 2320 R: 96.21%	N: 2295 D: 2344 R: 97.91%	N: 2433 D: 2490 R: 97.71%	N: 1234 D: 1281 R: 96.33%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: Enhance hospital-to-MCO workflow for notification of hospital admissions, discharges, and transfers **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #1b: (non-cumulative)** **Numerator**: # hospital inpatient admissions for which MCO CM received any admission notification **Denominator**: FUH denominator (note: count # discharges)	N: 2009 D: 2320 R: 86.59%	N: 2113 D: 2344 R: 90.15%	N: 2363 D: 2490 R: 94.90%	N: 1189 D: 1281 R: 92.82%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

[6] Q4 data represent the results of outcomes collected to date.

Notification Intervention #1 to address barrier: Enhance hospital-to-MCO workflow for notification of hospital admissions, discharges, and transfers **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #1c: (non-cumulative)** **Numerator**: # hospital inpatient admissions for which MCO received ADT/Health Information Exchange admission notification **Denominator**: FUH denominator (note: count # discharges)	N: 0 D: 2320 R: 0.00%	N: 4 D: 2344 R: 0.17%	N: 5 D: 2490 R: 0.20%	N: 1 D: 1281 R: 0.08%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: Enhance hospital-to-MCO workflow for notification of hospital admissions, discharges, and transfers **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #1d: (non-cumulative)** **Numerator**: # hospital inpatient admissions for which MCO CM received ADT/Health Information Exchange admission notification **Denominator**: FUH denominator (note: count # discharges)	N: 0 D: 2320 R: 0.00%	N: 3 D: 2344 R: 0.13%	N: 4 D: 2490 R: 0.16%	N: 1 D: 1281 R: 0.08%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier: Limited BH provider participation in ADT feeds/applications (See *Discussion, p. 36*) **Method of barrier identification:** Multidisciplinary work group established - direct feedback from BH Medical Director(s); direct hospital/provider feedback from 1:1 dialogue; analysis of related data sources		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4** ***(10/1/2022-12/9/2022)***[7]	**Q1**	**Q2**	**Q3**	**Q4**
Notification Intervention #1 to address barrier: Enhance hospital-to-MCO workflow for notification of emergency department admissions, discharges, and transfers **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #1e: (non-cumulative)** **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: 761 D: 916 R: 83.08%	N: 714 D: 980 R: 72.86%	N: 735 D: 1073 R: 68.50%	N: 298 D: 514 R: 57.98%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

[7] Q4 data represent the results of outcomes collected to date.

Notification Intervention #1 to address barrier: Enhance hospital-to-MCO workflow for notification of emergency department admissions, discharges, and transfers **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #1f: (non-cumulative)** **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: 761 D: 916 R: 83.08%	N: 714 D: 980 R: 72.86%	N: 735 D: 1073 R: 68.50%	N: 298 D: 514 R: 57.98%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: Enhance hospital-to-MCO workflow for notification of emergency department admissions, discharges, and transfers **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #1g: (non-cumulative)** **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: 761 D: 916 R: 83.08%	N: 714 D: 980 R: 72.86%	N: 735 D: 1073 R: 68.50%	N: 298 D: 514 R: 57.98%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: Enhance hospital-to-MCO workflow for notification of emergency department admissions, discharges, and transfers **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #1h: (non-cumulative)** **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: 761 D: 916 R: 83.08%	N: 714 D: 980 R: 72.86%	N: 735 D: 1073 R: 68.50%	N: 298 D: 514 R: 57.98%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Barrier: BH diagnoses/concurrent social determinants of health (SDOH) challenges may limit member engagement in follow-up care; successful outreach/collection of follow-up visit information (See *Discussion, pp. 36-38*) **Method of barrier identification:** Multidisciplinary workgroup established – direct feedback from member-facing staff; direct hospital/provider feedback from 1:1 dialogue; analysis of follow-up compliance rates; literature review		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4** ***(10/1/2022-12/9/2022)***[8]	**Q1**	**Q2**	**Q3**	**Q4**
Linkage Intervention #2 to address barrier: Linkage to aftercare with BH providers prior to discharge from hospital **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #2ai-1: (non-cumulative)** **Numerator:** # MH hospital discharges with a qualifying follow-up provider visit SCHEDULED within 30 days of discharge **Denominator:** # MH hospital discharges in FUH denominator for members who are enrolled (agreed to participate) in case management	N: 23 D: 61 R: 37.70%	N: 28 D: 71 R: 39.44%	N: 74 D: 195 R: 37.95%	N: 20 D: 87 R: 22.99%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2 to address barrier: Linkage to aftercare with BH providers prior to discharge from hospital **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #2ai-2: (non-cumulative)** **Numerator:** # MH hospital discharges with a qualifying follow-up provider visit ATTENDED[9] within 30 days of discharge **Denominator:** # MH hospital discharges in FUH denominator for members who are enrolled (agreed to participate) in case management	N: 36 D: 61 R: 59.02%	N: 20 D: 71 R: 28.17%	N: 47 D: 195 R: 24.10%	N: 18 D: 87 R: 20.69%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

[8] Q4 data represent the results of outcomes collected to date.
[9] The *visit attended* ITMs were updated for Q1 and Q2 for the Q2 submission in accordance with the new guidance provided in the updated quarterly report template. Because the numerator for these measures is dependent on the timing of claims submissions, the higher rates reflected in Q1 are expected.

Linkage Intervention #2 to address barrier: Linkage to aftercare with BH providers prior to discharge from hospital **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #2aii-1: (non-cumulative)** **Numerator:** # MH hospital discharges with a qualifying follow-up provider visit SCHEDULED within 30 days of discharge **Denominator:** # MH hospital discharges in FUH denominator for members who are not enrolled in case management	N: 166 D: 2259 R: 7.35%	N: 174 D: 2273 R: 7.66%	N: 144 D: 2295 R: 6.27%	N: 106 D: 1194 R: 8.88%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2 to address barrier: Linkage to aftercare with BH providers prior to discharge from hospital **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #2aii-2: (non-cumulative)** **Numerator:** # MH hospital discharges with a qualifying follow-up provider visit ATTENDED[10] within 30 days of discharge **Denominator:** # MH hospital discharges in FUH denominator for members who are not enrolled in case management	N: 913 D: 2259 R: 40.42%	N: 535 D: 2273 R: 23.54%	N: 390 D: 2295 R: 16.99%	N: 178 D: 1194 R: 14.91%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2 to address barrier: Linkage to aftercare with BH providers prior to discharge from hospital **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #2bi-1: (non-cumulative)** **Numerator**: # SUD + MH ED discharges with a qualifying follow-up provider visit SCHEDULED 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: 1 D: 15 R: 6.67%	N: 0 D: 22 R: 0.00%	N: 0 D: 63 R: 0.00%	N: 5 D: 26 R: 19.23%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

[10] The *visit attended* ITMs were updated for Q1 and Q2 for the Q2 submission in accordance with the new guidance provided in the updated quarterly report template. Because the numerator for these measures is dependent on the timing of claims submissions, the higher rates reflected in Q1 are expected.

Linkage Intervention #2 to address barrier: Linkage to aftercare with BH providers prior to discharge from hospital **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #2bi-2: (non-cumulative)** **Numerator**: # SUD + MH ED discharges with a qualifying follow-up provider visit ATTENDED[11] 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: 6 D: 15 R: 40.00%	N: 4 D: 22 R: 18.18%	N: 16 D: 63 R: 25.40%	N: 3 D: 26 R: 11.54%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2 to address barrier: Linkage to aftercare with BH providers prior to discharge from hospital **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #2bii-1: (non-cumulative)** **Numerator**: # SUD + MH ED discharges with a qualifying follow-up provider visit SCHEDULED 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: 4 D: 901 R: 0.44%	N: 2 D: 958 R: 0.21%	N: 0 D: 1010 R: 0.00%	N: 58 D: 488 R: 11.89%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2 to address barrier: Linkage to aftercare with BH providers prior to discharge from hospital **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #2bii-2: (non-cumulative)** **Numerator**: # SUD + MH ED discharges with a qualifying follow-up provider visit ATTENDED[12] within 30 days of ED discharge **Denominator**: # SUD + MH ED discharges in FUM + FUA denominator for members who are not engaged in case management	N: 196 D: 901 R: 21.75%	N: 141 D: 958 R: 14.72%	N: 138 D: 1010 R: 13.66%	N: 54 D: 488 R: 11.07%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2 for warm hand-off to address barrier:	**ITM #2c: (non-cumulative)** **Numerator:** # members with a warm hand-off (e.g., additional SUD level of care codes	Delayed due to Omicron	Began in Q3	N: 7 D: 19	N: 10 D: 31 R: 32.26%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

[11] The *visit attended* ITMs were updated for Q1 and Q2 for the Q2 submission in accordance with the new guidance provided in the updated quarterly report template. Because the numerator for these measures is dependent on the timing of claims submissions, the higher rates reflected in Q1 are expected.
[12] The *visit attended* ITMs were updated for Q1 and Q2 for the Q2 submission in accordance with the new guidance provided in the updated quarterly report template. Because the numerator for these measures is dependent on the timing of claims submissions, the higher rates reflected in Q1 are expected.

Linkage to aftercare with BH providers prior to discharge from hospital **Planned Start Date:** 8/1/2022 **(May be delayed due to Omicron)** **Actual Start Date**: 9/1/2022	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 at participating hospital providers in Regions 1 and 2 (note: Count # members, not visits. If you are testing this intervention with a high performing, high volume hospital, you may use that smaller denominator)			R: 36.84%[13]					
Barrier: The nature and timing of follow up visit metrics may limit MCO ability to provide timely D/C support prior to discharge (See *Discussion, pp. 37-38*) **Method of barrier identification:** Multidisciplinary workgroup established – direct feedback from member-facing staff; analysis of internal workflows and existing processes with local facilities; analysis of provider feedback		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4** ***(10/1/2022-12/9/2022)[14]***	**Q1**	**Q2**	**Q3**	**Q4**
Provider to Provider Communication Intervention #2 to address barrier: Share critical member information with aftercare BH providers within 3 days following member's discharge from the hospital or emergency department through provider-friendly, automated processes **Planned Start Date:** 5/1/2022 **Actual Start Date**: 4/1/2022	**ITM #2d: (non-cumulative)** **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)	Began in Q2	N: 171 D: 2344 R: 7.30%	N: 422 D: 2490 R: 16.95%	N: 154 D: 1281 R: 12.02%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

[13] Partial quarter data. This initiative began in September; therefore, data is limited to the claims submitted at the time of Q3 reporting and the inherent delays associated with the timing of claim submissions.
[14] Q4 data represent the results of outcomes collected to date.

Provider to Provider Communication Intervention #2 to address barrier: Share critical member information with aftercare BH providers within 3 days following member's discharge from the hospital or emergency department through provider-friendly, automated processes **Planned Start Date:** 5/1/2022 **Actual Start Date**: 4/1/2022	**ITM #2e: (non-cumulative)** **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 denominator[15] (note: you are counting the sum of # members, not visits)	Began in Q2	N: 0 D: 350 R: 0.00%	N: 5 D: 398 R: 1.26%	N: 3 D: 258 R: 1.16%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Provider notification Intervention #2 to address barrier: Share critical member information with aftercare BH providers within 3 days following member's discharge from the hospital or emergency department through provider-friendly, automated processes **Planned Start Date:** 8/1/2022 **Actual Start Date**: 8/1/2022	**ITM #2f: (non-cumulative)** **Numerator**: # PCP/MH provider notifications re: recent member ED visit completed **Denominator**: # of provider notification attempts re: recent member ED visit[16]	*Began in Q3*	*Began in Q3*	N: 152 D: 384 R: 39.58%[17]	N:193 D: 524 R: 36.83%				
Barrier: Members with Substance Use Disorders are less engaged in follow-up care increasing risk for readmission (See *Discussion, p. 38*) **Method of barrier identification:** Analysis of Disproportionate Under-Representation; multidisciplinary workgroup established – direct feedback from member-facing staff; direct hospital/provider feedback from 1:1 dialogue; literature review		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4** ***(10/1/2022-12/9/2022)[18]***	**Q1**	**Q2**	**Q3**	**Q4**

[15] Denominator updated pursuant to guidance provided in September LDH Collaborative PIP meeting; FUA population excluded retroactively.
[16] Denominator does not correlate directly to FUM/FUA HEDIS populations as data is identified through ADT feeds as notifications are received.
[17] Partial quarter data; initiative began in August.
[18] Q4 data represent the results of outcomes collected to date.

Tailored & Targeted Intervention #3 to address barrier: MCO-specified ITM to monitor tailored and targeted intervention informed by Analysis of Disproportionate Under-Representation **Planned Start Date:** 3/1/2022 **Actual Start Date**: 3/1/2022	**ITM #3a: (non-cumulative)** **Numerator:** # of members in FUH-SUD subpopulation with referral to Quartet for assistance with linkage to BH Provider **Denominator:** # members in the FUH–SUD overlapping subpopulation	N: 0 D: 24 R: 0.00%	N: 1 D: 41 R: 2.44%	*Discontinued Q2*[19]					
Tailored & Targeted Intervention #3 to address barrier: MCO-specified ITM to monitor tailored and targeted intervention informed by Analysis of Disproportionate Under-Representation **Planned Start Date:** 7/1/2022 **Actual Start Date**: 9/1/2022	**ITM #3b: (non-cumulative)** **Numerator:** # of members in FUH-SUD subpopulation with referral to a designated provider for follow up care **Denominator:** # members in the FUH–SUD overlapping subpopulation in Regions 1 and 2 (Note: # of members in FUH population having a SUD dx within the previous 6 months (excluding caffeine and nicotine diagnoses) in Regions 1 and 2)	*Began in Q3*	*Began in Q3*	N: 1 D: 27 R: 3.70%[20]	N: 96 D: 161 R: 59.63%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier: Members not engaged in Case Management services require broader alternative outreach methods to receive follow-up care resources (See *Discussion, p. 37*) **Method of barrier identification**: Multidisciplinary workgroup established – direct feedback from member-facing staff; direct hospital/provider feedback from 1:1 dialogue		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4** ***(10/1/2022-12/9/2022)***[21]	**Q1**	**Q2**	**Q3**	**Q4**

[19] ITM outcomes related to Quartet referral intervention indicated limited provider linkage following discharge; new measure developed to track referral to designated provider offering physician and clinical support in the home setting (*See ITM 3b*).
[20] Partial quarter data; initiative began in September. Data is limited to the claims submitted at the time of Q3 reporting and the inherent delays associated with the timing of claim submissions.
[21] Q4 data represent the results of outcomes collected to date.

Broader Intervention to deliver follow-up resources #4 to address barrier: Provision of follow-up care resources through direct mailer following TOC event **Planned Start Date:** 4/1/2022 **Actual Start Date**: 4/1/2022	**ITM #4: (non-cumulative)** **Numerator:** # of members provided letter with follow-up resources **Denominator:** # members with an unsuccessful outreach following BH MH hospitalization and/or ED treat-and-release visit discharge	Began in Q2	N: 1602 D: 2187 R: 73.25%	N: 1781 D: 2532 R: 70.34%	N: 860 D: 1488 R: 57.80%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier: Hospitals may not be familiar with available online resources for referral and linkage to providers across the many payors/health plans (See *Discussion, p. 37*) **Method of barrier identification:** Direct hospital/provider feedback from 1:1 dialogue		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4** ***(10/1/2022-12/9/2022)***[22]	**Q1**	**Q2**	**Q3**	**Q4**
Intervention to deliver education and resources to hospitals #5 to address barrier: Provision of resources for referral and linkage to hospital providers **Planned Start Date:** 4/1/2022 **Actual Start Date**: 4/1/2022	**ITM #5: (non-cumulative)** **Numerator:** # of ED/BH IP providers provided education and resources[23] **Denominator:** # of ED/BH IP providers targeted	Began in Q2	N: 33 D: 35 R: 94.29%	N: 35 D: 35 R: 100.00%	N: 32 D: 35 R: 91.43%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

[22] Q4 data represent the results of outcomes collected to date.

[23] Provider education/resources includes HEDIS tip sheets; hospital and provider best practices; linkage to Find a Provider and Find a Specialist tools; In-Network MAT Provider list; reports and records available in portal; HEDIS Quick Reference Guide; and ASAM, SAMHSA, and LHCC training platforms).

Results

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

Table 5: Results

Indicator	Baseline Measure Period 1/1/21–12/31/21	Final Measure Period 1/1/22–12/9/22[24]	Target Rate[25]
Indicator #1a. Follow-Up After Hospitalization for Mental Illness (FUH)- Total, 7 days	N: 1,735 D: 8,154 R: 21.28%	N: 1,424 D: 8,351 R: 17.05%	3 percentage point increase from CY2021 to CY2022 Rate: 24.28%
Indicator #1b. Follow-Up After Hospitalization for Mental Illness (FUH)- Total, 30 days	N: 3,321 D: 8,154 R: 40.73%	N: 2,943 D: 8,351 R: 35.24%	3 percentage point increase from CY2021 to CY2022 Rate: 43.73%
Indicator #2a. Follow-Up After Emergency Department Visit for Mental Illness (FUM)- Total, 7 days	N: 377 D: 1,790 R: 21.06%	N: 269 D: 1,311 R: 20.52%	3 percentage point increase from CY2021 to CY2022 Rate: 24.06%
Indicator #2b. Follow-Up After Emergency Department Visit for Mental Illness (FUM)- Total, 30 days	N: 645 D: 1,790 R: 36.03%	N: 446 D: 1,311 R: 34.02%	3 percentage point increase from CY2021 to CY2022 Rate: 39.03%
Indicator #3a. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 7 days	N: 184 D: 2,254 R: 8.16%	N: 166 D: 1,923 R: 8.63%	3 percentage point increase from CY2021 to CY2022 Rate: 11.16%
Indicator #3b. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 30 days	N: 273 D: 2,254 R: 12.11%	N: 241 D: 1,923 R: 12.53%	3 percentage point increase from CY2021 to CY2022 Rate: 15.11%

[24] Final 2022 data will not be available for reporting until 2023; data represent the results of outcomes collected to date.
[25] 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.

<u>OPTIONAL</u>: 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.

  Annual performance data is pending year-end aggregation and review, thus annual rates will not be finalized until June 2023 for the Reporting Year 2022.

  - **Follow-up After Hospitalization for Mental Illness (FUH)**
    Follow-up after hospitalization for Mental Illness for the 7-day and 30-day subgroups decreased from the MY2021 baseline in the MY2022 interim rates. Follow-up after hospitalization for the 7-day subgroup showed less decrease than the 30-day subgroup.

    The Follow-up after hospitalization for Mental Illness 7-day rate is 17.05 percent, a 4.23 percentage point decrease from baseline, 0.95 percentage point decrease YTD from Q1, and below the 5th percentile (2022 National Quality Compass).

    The Follow-up after hospitalization for Mental Illness 30-day rate is 35.24 percent, a 5.49 percentage point decrease from baseline, 4.05 percentage point increase YTD from Q1, and below the 5th percentile (2022 National Quality Compass).

  - **Follow-up After Emergency Department Visit for Mental Illness (FUM)**

    Follow-up After Emergency Department Visit for Mental Illness for the 7-day and 30-day subgroups decreased from the MY2021 baseline in the MY2022 interim rates. Follow-up after hospitalization for the 7-day subgroup showed less decrease than the 30-day subgroup.

    The Follow-up After Emergency Department Visit for Mental Illness 7-day rate is 20.52 percent, a 0.54 percentage point decrease from baseline, 1.03 percentage point increase YTD from Q1, and below the 10th percentile (2022 National Quality Compass).

    The Follow-up After Emergency Department Visit for Mental Illness 30-day rate is 34.02 percent, a 2.01 percentage point decrease from baseline, 4.65 percentage point increase YTD from Q1, and below the 10th percentile (2022 National Quality Compass).

  - **Follow-up After Emergency Department Visit for Substance Use (FUA)**

    Follow-up After Emergency Department Visit for Substance Use for the 7-day and 30-day subgroups increased from the MY2021 baseline in the MY2022 interim rates. Follow-up after hospitalization for the 7-day subgroup showed greater increase than the 30-day subgroup.

    The Follow-up After Emergency Department Visit for Substance Use 7-day rate is 8.63 percent, a 0.47 percentage point increase from baseline, 0.21 percentage point increase YTD from Q1, and above the 25th percentile (2022 National Quality Compass).

    The Follow-up After Emergency Department Visit for Substance Use 30-day rate is 12.53 percent, a 0.42 percentage point increase from baseline, 1.67 percentage point increase YTD from Q1, and above the 25th percentile (2022 National Quality Compass).

As indicated in Table 5, FUA rates show improvement from the baseline rates established, while FUH and FUM rates did not increase as initially projected; target rates for the annual performance indicators were not met. When compared to Quality Compass National benchmarks, the FUA rates for the current year were at the 25th percentile, while FUH and FUM rates were lower.

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

  Project interventions were designed to improve performance indicator rates by enhancing hospital-to-MCO admission notification processes and information sharing, assisting members with access to follow-up care after hospitalization or emergency department visit, targeting identified disparate sub-populations, and facilitating broader interventions to address the needs of members when direct outreach is unsuccessful.

  Data collected through ITMs monitoring MCO receipt of admission notifications from inpatient hospitals (*ITM 1a-1d*) indicate successful workflow processes are in place to support member follow-up after receiving care in this setting, primarily through the prior authorization process. *ITM 1a*, reflective of MCO admission notification via all methods, maintained a rate of 96 percent or greater throughout 2022. Through monitoring of *ITM 1b*, CM admission notification via all methods, an initial Q1 rate of 87 percent prompted a deeper dive into internal processes resulting in improved CM notification rates of 93 percent or greater throughout the last half of 2022. Lower ITM rates related to inpatient hospital notification through ADT or HIE applications (*ITM 1c, 1d*) identified opportunities for improved identification and delineation of physical health and behavioral health hospitalizations and remain a focus for improvement by our Data Analytics teams in 2023.

  Admission notification following emergency department visits for mental health or substance use were tracked and monitored through *ITM 1e-1h*. These ITM rates indicate more streamlined hospital notification processes through ADT or HIE applications; however, since emergency department visits do not require prior authorization, rates are dependent on ADT/HIE data feeds or claims submissions (and the inherent delays associated with claims data). ITM denominator populations were updated mid-year, thus ITM outcomes in Q1 and Q2 were higher as a result of additional claim submissions received at the time the data was updated, while the Q3 and Q4 rates reflected an average of 63 percent of emergency department admission notifications were received by the MCO and/or MCO care manager within 30 days.

  Member-focused outreach (telephonic or face-to-face) within 72 hours following discharge from inpatient hospitalization or emergency department visits for mental health or substance use is ongoing and incorporates assessment of needs (i.e., SDoH); identification of barriers to care (i.e., transportation, language services); verification of a discharge plan, including medication reconciliation and scheduling of follow-up; and education about the importance of and how to schedule follow-up appointments using the teach-back method. Measures tracking outreach to members discharged from inpatient hospitalization provided that approximately 35 percent of members engaged in ongoing care management services reported a follow-up visit *scheduled* within 30 days (*ITM 2ai-1*) in comparison to an average 8 percent of those not engaged in care management (*ITM 2aii-1*). Measures tracking follow-up visit *attendance* indicate broader compliance rates ranging from 21 to 59 percent for members engaged in care management (*ITM 2ai-2*) and 15 to 40 percent for members not engaged in care management (*ITM 2aii-2*) as these outcomes are dependent on timing of claim submissions. When project ITM denominators were updated mid-year by the project administrator to focus on HEDIS subpopulations specifically, the results of claim-dependent measures were higher in earlier quarters due to the additional time between visit and claim submission. Outcomes for these measures were impacted by the successful outreach and collection of follow-up visit information from the member. As a result, outreach staff contacted treating providers and pharmacies, and reviewed claims and

authorization documentation, for updated member contact information and utilized the broader intervention (*ITM 4*) mailing correspondence to support successful outreach and follow-up appointment scheduling assistance.

Outreach results for visits *scheduled* following emergency department visits ranged from 0 to 19 percent for members engaged in care management (*ITM 2bi-1*) and 0 to 12 percent for members not engaged in care management services (*ITM 2bii-1*). Improvements in these measure outcomes were noted following expansion of data collection fields in the 3rd quarter which allowed for broader extrapolation of outcomes through the electronic health record, though still impacted by member outreach for collection of follow-up visit information. Similar to inpatient follow-up, measures tracking follow-up visit *attendance* indicate broader compliance rates ranging from 12 to 40 percent for members engaged in care management (*ITM 2bi-2*) and 11 to 22 percent in members not engaged in care management *(ITM 2bii-2*) which is also attributed to claim submission timing and the mid-year updates to the measure denominators. Barriers to telephonic outreach were also noted following emergency department visits, and the strategies used to address post-discharge hospital follow-up were also employed for these emergency department follow-up measures.

To provide a broader intervention to facilitate follow-up for members when telephonic outreach was unsuccessful, follow-up letters were sent to members to support follow-up and provide resource assistance (*ITM 4*). Measure outcomes provided that an average of 67 percent of members were sent mailers, with quarterly ranges from 58 to 73 percent. As part of the review and analysis of the measure outcomes, it was noted that outcomes could be limited based on the timing of the hospital discharge or emergency department visit in relation to the completed (and unsuccessful) outreach. In Q4, an additional intervention was initiated to prompt members to attend follow-up visits via a member texting and email platform earlier in the outreach process. These additional electronic outreach efforts include messaging for accessing case management services and resource assistance to support follow-up appointment scheduling. Data aggregation for this initiative will be included in 2023 reporting.

In order to streamline and improve provider access to member treatment needs following discharge and ensure hospitals are aware of available user-friendly, accessible provider directories available to support follow-up appointment scheduling and access, Provider Network teams initiated outreach (telephonic or live) to higher volume hospitals associated with the FUH population (Table 4b). Through this outreach (*ITM 5*), the feedback collected highlighted recurring themes that helped to identify barriers as well as best practices associated with member follow-up after inpatient hospitalizations and emergency department visits. The feedback obtained through this outreach provided the framework for a provider support tool which was distributed to providers (electronically or printed) through provider education visits over the course of 2022. This tool highlights the processes and practices associated with better member outcomes including a high-level overview of the FUH, FUM, and FUA HEDIS measures, provider location resources on the LHCC website, utilization of telehealth, dedicated office staff for appointment scheduling, and access to member treatment records (assessments, discharge plans, care plans, medication lists/reconciliation, visit records) included in the Secure Provider Portal. The electronic resource also provides quick-links to resources including our In-Network MAT Provider list, Find a Provider/Specialist tools, Behavioral Health clinical training platform, HEDIS Quick Reference Guide, as well as external evidence based guidelines and training resources provided by the American Society of Addiction Medicine (ASAM) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Facility visits continued quarter-over-quarter during 2022, engaging these higher volume facilities in a continuous feedback loop that allowed for sharing of new ideas and effective initiatives as they were identified. In Q1, 29 percent of the top 35 hospitals were engaged initially, increasing to 94 percent in Q2, 100 percent in Q3, and 91 percent YTD representing partial data for Q4. Review of current MY2022 compliance rates associated with these higher volume hospitals indicated improved disproportionate indexes in 16 of the 35 hospitals outreached throughout the year.

ITMs tracking provider access to enhanced discharge plan sharing prior to follow-up appointments indicated 7 percent of providers had access to the plan in the FUH population (*ITM 2d*) and no providers in the FUM population (*ITM 2e*). These initial results prompted root-cause analysis and identification of opportunities to improve data collection points within the electronic medical record. Once updated, the FUH rate increased to 17 percent (*ITM 2d*) and the FUM rate increased to 1.3 percent (*ITM 2e*) in Q3. As part of the analysis, it was also noted that data collection is dependent on information collected from external sources such as members and hospitals. Outreach staff are contacting treating providers and pharmacies, as well as reviewing claims and authorization documentation for updated member contact information to support successful outreach. Next steps will include exploration of alternative data collection and sharing opportunities.

To facilitate broader provider insight into member follow-up needs, specifically around member emergency department visits, a Behavioral Health Quality Improvement Coordinator was dedicated to completing provider courtesy notification calls beginning in Q3 (*ITM 2f*). This intervention utilizes timely reporting of member emergency department visits to initiate calls to assigned PCPs to validate member-provider relationships, provide notification of the recent hospital visit, and provide education and resources, as needed, to support provider follow-up appointment scheduling, education regarding HEDIS guidelines, access to in-network provider listings, and assistance with coordination of care needs. When an existing relationship with a mental health provider is identified through claims or authorization records, additional notification is provided so that emergent needs can also be addressed in mental health visits. Initial results indicating completion of provider outreach and notification through telephonic outreach for Q3 was 40 percent. Partial Q4 data were slightly lower at 37 percent, attributed to provider office and staff observance of the Thanksgiving holiday in November, as well as staffing challenges due to reported flu and upper respiratory illnesses prevalent locally. Outreach results and common feedback themes (i.e., member engagement with PCP, poor appointment attendance, and provider-reported challenges with member contact) were discussed within the project workgroup and lessons learned were incorporated into provider and member messaging to support project outcomes.

Review of the Analysis of Disproportionate Under-Representation of the FUH-30 Day subpopulation stratified members by multiple defining characteristics, thus allowing for targeted interventions of smaller groups of members. Members with substance use disorders and members residing in Region 1 were identified earlier in the year and interventions were designed around impacting these smaller groups. Initial workgroup discussions also identified member access to in-network providers for follow-up as a barrier, hence an intervention was designed to refer members in the FUH population with co-occurring substance use disorders to Quartet services for assistance with linkage to a behavioral health provider following discharge when needed (*ITM 3a*). Tracking over Quarters 1 and 2 resulted in only 1 member interaction prompting referral to Quartet services. A review of member feedback indicated that members in this subgroup reported existing provider relationships and previously scheduled follow-up appointments during successful post-discharge outreach. As a result of its very limited impact, this intervention was discontinued.

Warm hand-off strategies were delayed early in 2022 due to the hospital and provider service utilization focusing on care-delivery associated with Omicron variant of the COVID-19 outbreak. In Q3, following retirement of the Quartet referral intervention discussed above, the first warm hand-off interventions designed to target members in the FUH-SUD population prior to discharge from the inpatient and emergency department settings were initiated. A local provider partnership yielded an opportunity to provide member follow-up for this FUH-SUD subpopulation using a model providing home visits and multi-disciplined care after inpatient discharge for members in Regions 1 and 2 (*ITM 3b*). The earliest preliminary results indicated a 4 percent success rate that improved to 60 percent in current Q4 results. In consideration of the previously

identified disparate group of members with substance use disorders and member and provider feedback indicating challenges with motivation and transportation at the time of scheduled follow-up visits, an additional intervention targeting members with emergency department visits for substance use treatment needs was initiated to improve follow-up rates for members with high utilization and/or high risk for substance use disorders *(ITM 2c*). By utilizing ADT/HIE services, and in agreement with multiple high-volume hospitals in Regions 1 and 2, this provider began engaging members prior to discharge from the emergency department to provide provided follow-up services utilizing a multi-disciplined, home-based care model. Since the initiative began in Q3, successful member outreach and follow-up outcomes for this intervention have ranged monthly from 32 to 37 percent. Next steps include expanding to additional regions to continue this strategy with a broader group.

- **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.

  Monthly monitoring and analysis of admission notifications supported strong internal processes for identification and outreach (telephonic, mail, face-to-face) of members discharged from inpatient hospitalizations and emergency department visits. This analysis also highlighted opportunities to increase visibility of discharges from behavioral health inpatient hospitals through ADT/HIE platforms and system limitations that impacted identification and discernment between physical health and behavioral health admissions. Provider network teams incorporated messaging to encourage increased participation in ADT or health information exchanges, highlighting the importance of early notification to support care coordination and follow-up after discharge. Data analytics teams continue to focus on system improvements that will support improved identification of primary inpatient diagnoses.

  The analysis of disproportionate under-representation completed at the onset of the PIP highlighted the top 35 hospitals providing inpatient treatment for members for mental illness. Provider network teams surveyed higher and lower scoring providers for insights into best practices and barriers related to scheduling follow-up after discharge. Based on common themes highlighted through analysis of this feedback, a resource was developed to improve awareness among providers of health plan resources available to locate in-network providers, use of telehealth services when appropriate, and the most effective office staffing and process models. Outreach to these top 35 facilities was ongoing, allowing provider network specialists to revisit lessons-learned and continue to identify any new ideas or themes deemed successful. Additionally, provider incentives offered to PCPs and MHPs for visits associated with the completion of follow-up care after an enrollee's discharge from an inpatient hospitalization for mental illness or an emergency room visit for mental illness or substance use disorder added context and support around discussions requiring changes to internal processes. Common continued feedback focused on themes related to provider staffing inconsistencies and turnover impacting their internal processes which prompted development of a resource (electronic, paper) that condensed HEDIS guidelines for the impacted measures (FUH, FUM, FUA), as well as best practices and tips collected and quick links to provider location tools and related education resources offered through ASAM and SAMHSA.

  Member feedback highlighted barriers related member's motivation to complete follow-up and unexpected issues with transportation when family member or friends were unable to provide previously planned transportation. Outreach through member-facing teams included encouraging engagement with care management staff to provide a supplemental and supportive service to assist with maintaining motivation to attend follow-up visits and support transportation planning and requests. However, completion of timely member contact to provide support and coordination of care following discharge remains an ongoing barrier to both member outcomes and data collection efforts allowing for deeper understanding of member

challenges to attending follow-up visits. Member outreach focused on direct and automated telephonic outreach and direct mail correspondence for much of 2022. Health plan staff utilized member treatment history to identify providers and pharmacies, as well as contact information contained in submitted records, to identify updated or alternate contact information to support outreach efforts. In order to supplement limited member outreach, a dedicated staff member was engaged to complete provider notifications as members discharged from emergency department visits. This outreach initiative not only gave providers a real-time insight into member utilization of emergency department services, but also allowed for barrier identification related to the member-provider relationship or lack thereof; member follow through with scheduled appointments; provider feedback related to their engagement with ADT/HIE platforms and utilization of provider portals to access current discharge information and treatment history, including medication lists and care plans. In Q4, a pilot initiative was launched to provide text and email messaging to members following discharge from emergency department visits to provide engagement with care management teams and resources, as needed, for completion of follow-up visits. Outcomes will be aggregated and analyzed for impact on successful outreach, as well as additional insight into barriers to member outreach.

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

  Internal validity related to collection of required data elements for member outreach initiatives impacted collection of follow-up appointment data and associated barriers. Updates to LHCC's internal documentation system improved data collection and visibility into ITM progression. System limitations impacted extrapolation of member feedback entered into free-text assessment and comment fields. Additionally, free text fields in existing documentation platforms are prone to variability in documentation across multiple clinicians. Provider utilization of ADT/HEI services continues to impact live-time notification of discharge information.

  In MY2022, NCQA implemented a change to the FUA technical specification to include pharmacotherapy events within numerator compliant limits. This update impacted the internal validity of interpretation of improvement year-over-year for the FUA measure as these pharmacotherapy events were not captured in MY 2021.

- **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).

  All data for the HEDIS performance indicators is collected administratively, hence accuracy and validity of performance data is dependent on provider coding and claim accuracy.

Performance indicator and intervention tracking measures that utilize administrative claims data are impacted the inherent delays associated with unique provider claim submission practices and timing of claim submissions.

- **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.

  All data for the HEDIS performance indicators are collected administratively, hence accuracy and validity of performance data is dependent on provider coding and claim accuracy. Intervention tracking measure data related to HEDIS populations and measure outcomes were also dependent on the accuracy, validity, and submission timing of administrative claims data. ITMs related to the collection and distribution of enhanced care plan information to providers performing follow-up care was impacted by the timing of successful member outreach to collect, assimilate, and distribute prior to the follow-up appointment. ITMs related to utilization of ADT/HIE applications, especially those of behavioral health inpatient hospitals were impacted identification and discernment between physical health and behavioral health admissions.

PIP Highlights

Effective member interventions include MCO receipt of admission notifications from inpatient hospitals (ITM 1a) indicating successful workflow processes to support member follow-up after receiving care in this setting, primarily through the prior authorization process. ITM 1a, reflective of MCO admission notification via all methods, maintained a rate of 96 percent or greater throughout 2022 and ITM 1b, CM admission notification via all methods, maintained a rate of 93 percent or greater throughout the last half of 2022. Admission notification following emergency department visits for mental health or substance (ITM 1e-1h) were also indicative of effective processes. These ITM rates indicate more streamlined hospital notification processes through ADT or HIE applications since emergency department visits do not require prior authorization, though rates are dependent on ADT/HIE data feeds or claims submissions (and the inherent delays associated with claims data). ITM rates for the last half of MY2022 reflected an average of 63 percent of emergency department admission notifications were received by the MCO and/or MCO care manager within 30 days. Another more impactful member intervention is the broader intervention to facilitate follow-up for members when telephonic outreach was unsuccessful. Follow-up letters were sent to members to support follow-up and provide resource assistance (ITM 4), and measure outcomes provided that an average of 67 percent of members were sent mailers, with quarterly ranges from 58 to 73 percent.

The provider intervention identified as having the most significant impact on efforts to meet the goals and objectives of this project are the provider education visits to the top 35 hospitals providing behavioral health inpatient services (identified through FUH analysis). Based on common themes highlighted through analysis of this feedback, a resource was developed to improve awareness among providers of health plan resources available to locate in-network providers, use of telehealth services when appropriate, and the most effective office staffing and process models. Outreach to these top 35 facilities was ongoing, allowing provider network specialists to revisit lessons-learned and continue to identify and share any new ideas or themes deemed successful. In Q1, 29 percent of the top 35 hospitals were engaged initially, increasing to 94 percent in Q2, 100 percent in Q3, and 91 percent YTD representing partial data for Q4.

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
Notification Intervention - Enhance hospital-to-MCO workflow for notification of hospital and emergency department admissions, discharges, and transfers	Review/analysis of ADT participation by hospitals providing behavioral and substance use disorder services reveal limited comfort with and management of electronically-shared behavioral health information. Variances in data entry at the point-of-care and other system limitations create challenges in stratifying primary admission diagnoses determination (i.e., PH vs BH).	Provider Network teams are including ADT participation in outreach and education efforts re: BH Transitions of Care. Provider Network teams continuing to include ADT participation in outreach/education to BH inpatient facilities to broaden access admission notifications. Corporate data team improving/ expanding ADT system identification related to primary admission diagnoses (i.e., PH vs BH).	ADT system improvements to support identification of primary admission diagnoses (i.e., PH vs BH). Continued outreach/ education by Provider Network teams to encourage ADT participation by BH inpatient facilities to expand the number of participating facilities and support more timely discharge planning/ coordination of care efforts.
Linkage Intervention - Linkage to aftercare with BH providers prior to discharge from hospital and emergency department	Co-occurring BH diagnoses and other SDoH, i.e., consistent access to telephone services, social support, impact member prioritization of follow-up care following hospitalization or ED visit.	Member-facing teams utilizing successful member contacts to provide education, improve access to needed resources, and assist in engagement with providers for follow-up visits. Increasing utilization of face-to-face visits during hospitalization to develop rapport, identify SDoH needs prior to discharge, and increase engagement in follow up care post discharge. Expanding data collection points within clinical documentation	Continued member outreach and assessment through multiple modalities (direct telephone, automated telephone, face-to-face) to provide education and engagement with providers for follow up visits after discharge. Aggregation and analysis of results from small study/pilot using of new platform for text/email member outreach campaigns for post discharge follow-up after emergency room visit for use in

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
		system assessment to support further data extrapolation providing additional insight into member outcomes and barriers. Established specialized teams to assist LHCC members with transition of care and/or ED discharge needs, including follow-up appointment scheduling prior to discharge from hospital or ED. Small study/piloted use of new platform for text/email member outreach campaigns for post discharge follow-up after emergency room visit.	development of additional next steps.
Linkage Intervention for warm hand-off - Increase warm hand-offs to BH providers to ensure member continuity of care	Hospital initiatives focusing on warm hand-off delayed as hospitals worked to reduce community spread of COVID-related infection within patient populations and provide safe treatment environments.	Interventions deferred and/or placed on hold in observance and prioritization of patient safety and hospital staffing needs related to community spread of COVID-19 virus and related protocols. Continued discussions with participating high volume facilities and follow-up providers until intervention for warm-off could be launched. Initiation of warm handoff to participating providers with in-person/in-home follow-up care provided following IP/ED visit for SUD in Regions 1 and 2.	Ongoing monitoring and analysis of warm hand-off intervention outcomes for determination of effectiveness, barrier analysis, and identification of next steps as needed. Next steps include expanding to additional regions to continue this strategy with a broader group.

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
Provider-to-Provider Communication Intervention - Share critical member information with aftercare BH providers within 3 days following member's discharge from the hospital or emergency department through provider-friendly, automated processes	The nature and timing of facility notification processes, discharge processes, timing of member discharges (evening, weekends), and timing of successful member outreach for collection, sharing, and distribution of member visit information impacts the MCO's ability to share D/C plans prior to discharge and/or follow-up visit.	Expanded menu of member encounter records available to provider through secure provider portal to include post-discharge assessments, medications, and care plans. Provider Network teams continuing outreach and education to BH inpatient facilities to include ADT/HIE participation, enhanced care planning documents included in the Secure Provider Portal, utilization of Find a Provider tools, including In-Network MAT provider list, best practices identified, and HEDIS guidance on FUH/FUM/FUA measures.	Review and analysis of existing intervention outcomes and barriers; workgroup development of additional interventions to distribute discharge records with BH providers.
Provider notification regarding member ED visit – Enhance provider insight into member follow-up needs through telephonic provider outreach	Provider feedback identified lack of provider resources to support processes that allowed for consistent monitoring of multiple health plan portals to identify member follow-up needs.	Added dedicated staff member to provide courtesy outreach to notify PCP and/or MH provider of a member's recent ED visit. Upon contacting the PCP/MH provider the relationship between the member and the provider is verified, notification of the recent ED visit is made, the follow-up visit is verified, and education provided re: access to discharge information/treatment history available on portal.	Ongoing provider notification outreach; utilization of intervention outcomes and provider feedback to aggregate barriers reported and explore and develop additional processes to support provider insight into member follow-up needs.

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
Tailored & Targeted Intervention: MCO-specified ITM to monitor tailored and targeted intervention informed by Analysis of Disproportionate Under-Representation: Substance Use Disorders	Initial Quartet referral process, fully integrated into member electronic health record, to improve member access to in-network providers for follow-up did not yield data supporting significant need to referral process. More significant barriers identified related to member motivation and transportation needs impacting member attendance to follow-up appointments.	Warm hand-off initiative expanded to target populations with overlapping substance use disorders following both inpatient and emergency department visits. Initiation of warm handoff to participating provider with in-person/in-home follow-up care provided following IP/ED visit for SUD in Regions 1 and 2 once measures taken to limit community spread of COVID-19 virus were lifted.	Ongoing monitoring and analysis of newly initiated warm hand-off intervention outcomes for determination of effectiveness, barrier analysis, and identification of next steps as needed.
Intervention to deliver follow-up resources - Provision of follow-up care resources through direct mailer following TOC event	Broader intervention was needed to support volume of unsuccessfully outreached members following discharge from IP/ED.	Member mailers offering assistance with linkage to follow-up care and resources to address additional barriers distributed following failed successful member outreach attempts.	Distribution of member follow-up via mailer continues; text/email outreach campaign to member populations following an ED visit recently initiated. Outcomes and barriers identified will be used to develop additional next steps.
Intervention to deliver education and resources to hospitals - Provision of resources for referral and linkage to hospital providers	Feedback from higher and lower performing hospitals in the Top 35 Hospitals (Table 4b) provided valuable insight into best practices supporting FUH outcomes.	Tips, best practices, quick links to helpful resources, utilization of portal resources, promotion of telehealth services, and education re: HEDIS measures and external education sites (i.e., ASAM and SAMHSA) were assimilated and distributed (electronically, print) through virtual and in-person provider education visits.	Expanded BH Provider education modules available on-demand in provider education portal to support excellence in HEDIS measure outcomes. Incorporation of measure(s) to track portal utilization for additional insight into effectiveness as a platform for distribution of additional materials.

References

List any references that you cite.

American Psychological Association. (2021). APA Guidelines on evidence-based psychological practice in health care.

Borg B, Douglas IS, Hull M, Keniston A, Moss M, Clark BJ. Alcohol misuse and outpatient follow-up after hospital discharge: a retrospective cohort study. Addict Sci Clin Pract. 2018 Dec 4;13(1):24. doi: 10.1186/s13722-018-0125-1

Chung DT, Ryan CJ, Hadzi-Pavlovic D, Singh SP, Stanton C, Large MM. Suicide Rates After Discharge From Psychiatric Facilities: A Systematic Review and Meta-analysis. JAMA Psychiatry. 2017 Jul 1;74(7):694-702. doi: 10.1001/jamapsychiatry.2017.1044

Griswold, K.S., Zayas, L.E., Pastore, P.A., Smith, S.J., Wagner, C.M., Servoss, T.J. (2018) Primary Care After Psychiatric Crisis: A Qualitative Analysis. Annals of Family Medicine, 6(1), 38-43. doi:10.1370/afm.760.

National Committee for Quality Assurance (NCQA. (2021). Follow-up after hospitalization for mental illness. Retrieved from https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/

Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (NSDUH). Retried from https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf

Vega D, Acosta FJ, Saavedra P. Nonadherence after hospital discharge in patients with schizophrenia or schizoaffective disorder: A six-month naturalistic follow-up study. Compr Psychiatry. 2021 Jul;108:152240. doi: 10.1016/j.comppsych.2021.152240

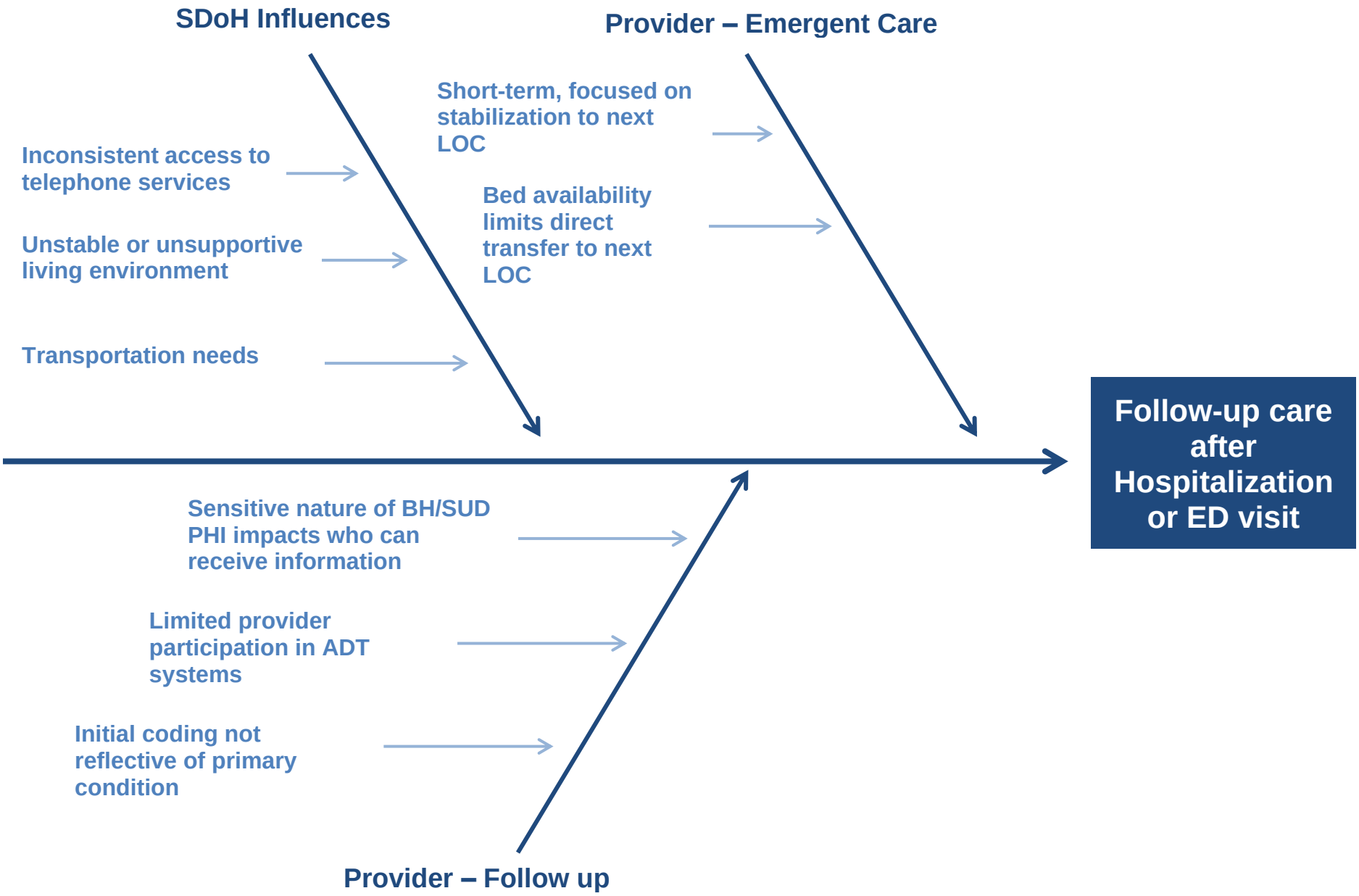
Glossary of PIP Terms

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 • Roadblock	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	• Utilize in-person outreach to provide support for hard-to-reach members • Address member SDoH needs to assist with supportive housing, telephone service access, etc. • Provide ongoing support through CM/CHSR, particularly with high utilizers • Provide easy to identify BH Provider Network listings to linkage to follow up care	• Include Community Based Organizations in the conversation to support member engagement
Less Feasible to Address	• Ability to impact individual processes of each hospital	• Encourage providers to utilize ADT systems for sharing member information

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

	Positives	**Negatives**
INTERNAL ***under your control***	***build on*** **STRENGTHS** • Easy-to-use Provider Network platform • Availability of ADT applications	***minimize*** **WEAKNESSES**
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES**	***protect from*** **THREATS** • Member willingness to engage in follow up services • Provider willingness to utilize ADT applications

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)**	**<u>EDs and Hospitals</u>** Staff having easy access to <u>and</u> 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 **<u>EDs/ Hospitals and MCOs</u>**	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	Targeted outreach to provide education including access/utilization of LHCC's Find A Provider tool and resources to support linkage to in-network telehealth and MAT providers to support follow-up care Targeted outreach to promote/support increased provider participation in ADT application for timely notification of admission/discharge encounters

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
	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	ADT information systems Encouraging more provider to provider communications MCOs provide ongoing CM for members already engaged 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.	address any unmet needs Encouraging allowing practitioners to pull data from ADTs Asking patients if they are currently engaged in CM and contacting their case manager Follow-up BH appointment reminders Rescheduling missed appointments.	
Measure specific factors				
AIM	Primary Drivers	Secondary Drivers	Change concepts	MCO-identified Enhanced Interventions to test Change Concepts

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.	Targeted outreach to provide education including access/utilization of LHCC's Find A Provider tool and resources to support linkage to in-network telehealth and MAT providers to support follow-up care Targeted outreach to provide education on ASAM and SAMHSA resources for SUD treatment. Identification of top utilizers for in-person engagement by TOC/CHSR staff for direct linkage to provider.
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	Targeted outreach to provide education including access/utilization of LHCC's Find A Provider tool and resources to support linkage to in-network telehealth and MAT providers to support follow-up care Targeted outreach to provide education on ASAM and SAMHSA resources for SUD treatment. Identification of top utilizers for in-person engagement by TOC/CHSR staff for direct linkage to provider.

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	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis	•	•	•
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	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis	•	•	•

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