Health Plan Performance Improvement Project (PIP)

Health Plan: UnitedHealthcare LA (UnitedHealthcare Community Plan of Louisiana)

PIP Title: Behavioral Health Transitions in Care (BH TOC)

PIP Implementation Period: January 1, 2022– December 31, 2023

Submission Dates:

	Report Year 2023
Version 1	03/01/2023
Version 2	

MCO Contact Information

1. Principal MCO Contact Person

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

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

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3. External Collaborators (if applicable):

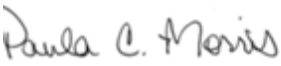
Attestation

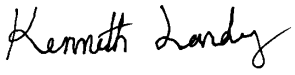
Plan Name: UnitedHealthcare
Title of Project: Behavioral Health Transitions in Care

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

Medical Director signature: 
First and last name: Julie Morial, MD
Date: 2/28/2023

CEO signature: 
First and last name: Karl Lirette
Date: 2/28/2023

Quality Director signature: 
First and last name: Paula Morris
Date: 2/28/2023

IS Director signature (if applicable): 
First and last name: Kenneth Landry
Date: 2/28/2023

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		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ ITM	
Change 2		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ ITM	
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

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

Describe Project Topic and Rationale for Topic Selection

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

  "In 2019, nearly one in five adults aged 18 and older in the U.S. had a diagnosed mental health disorder.[1] Despite this, individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization and the overall cost of outpatient care. In 2016, 20.1 million Americans over 12 years of age (about 7.5% of the population) were classified as having a substance use disorder involving AOD.[1] High ED use for individuals with AOD may signal a lack of access to care or issues with continuity of care.[2] Timely follow-up care for individuals with AOD who were seen in the ED is associated with a reduction in substance use, future ED use, hospital admissions and bed days.[3,4,5] Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function and increased compliance with follow-up instructions.[3,4,5]" (NCQA, 2022)

  The Behavioral Health Transitions of Care PIP specifically targets the findings in the research sited above by requiring focus on ensuring that members are receiving an appropriate continuum of care to improve overall treatment outcomes. This PIP will examine the root causes for current level member and provider engagement and participation in the transition of care process and implement interventions to address those targeted root causes. The overall aim is to enhance the treatment transition process for our members, improve follow-up treatment compliance, and in turn improve follow-up treatment adherence rates.

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

  This PIP will focus on follow-up after hospitalization for mental illness, follow-up after emergency department visit for mental illness, and follow-up after emergency department visits for alcohol and other drug abuse or dependence. Preliminary review of the data suggests focused interventions should be targeted toward members with housing insecurity and our adult population (18-64 as well as 65+) in addition to broader interventions targeted at the general population. Further data analysis will be completed, and appropriate interventions added as the PIP progresses.

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

  "Medicaid beneficiaries with mental health and substance use disorders (SUDs) often have complex conditions that require a comprehensive array of physical, behavioral health, and other supportive services. Unfortunately, many of these beneficiaries fail to receive the necessary services and supports. For example, recent research has found that only 5 percent of Medicaid beneficiaries with schizophrenia or bipolar disorder maintain a continuous supply of guideline-concordant medications and receive medication monitoring, preventive physical health care, and outpatient mental health care during a year. Individuals with serious mental illnesses (SMIs) have high rates of emergency department (ED) use and inpatient hospitalizations, and have been found to be one of the costliest groups of Medicaid beneficiaries" (Kehn, et.al, 2015)

  "Comparative analyses of patient characteristics revealed that black, non-Hispanic or non-Latino, female, single, not employed, Medicaid, self-pay, or smoker patients had a higher chance of missed appointments. The average annual income is lower, and the average prior missed appointment rate is higher in patients who no showed in their last appointment. Patients without a cell phone, email, or patient portal had a higher chance of a missed appointment. The comparative analysis of the provider characteristics showed that

patients scheduled with behavioral health or OB-GYN providers or not scheduled with their primary care providers have higher missed appointment rates compared with other appointment types. lower income and unemployment were associated with more missed medical appointments that would likely impair the health and/or health outcomes of patients. Studies found that socioeconomic characteristics have negative impact on health outcomes. The study found that behavioral health patients were more likely to miss their next appointments than any other type of patients. Differences in adherence with appointments here could either be related to different systems for scheduling and reminding patients of appointments between medical and behavioral health systems, or related to intrinsic differences in practices, attitudes, or adherence among behavioral health patients " (Mohammadi et al., 2018)

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

  Table 1b summarizes the plan performance for the baseline year, in comparison with NCQA Quality Compass benchmarks.

  - For the FUH 7-day measure, our rate was 23.68, which was below the 2021 NCQA quality compass 25th percentile of 30.86.
  - For the FUH 30-day measure, our rate was 44.26, which was below the 2021 NCQA quality compass 25th percentile of 51.90.
  - For the FUM 7-day measure, our rate was 23.62, which was below the 2021 NCQA quality compass 25th percentile of 30.22.
  - For the FUM 30-day measure, our rate was 38.37, which was below the 2021 NCQA quality compass 25th percentile of 45.45.
  - For the FUA 7-day measure, our rate was 7.28, which was slightly above the 2021 NCQA quality compass 25th percentile of 7.10.
  - For the FUA 30-day measure, our rate was 11.14, which was slightly above the 2021 NCQA quality compass 25th percentile of 10.75.

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	34.99	34.92	36.89	37.41	38.37	45.45	53.54	64.59	74.39

Indicator	Aetna	ACLA	Healthy Blue	LHCC	UHC	QC 25th	QC 50th	QC 75th	QC 90th
Department Visit for Mental Illness (FUM) – Total, 30 days									
Indicator #3a. Follow-Up After Emergency Department Visit for Alcohol & Other Drug Abuse or Dependence (FUA) – Total, 7 days	9.01	8.05	7.91	7.1	7.28	7.1	13.36	17.66	22.98
Indicator #3b. Follow-Up After Emergency Department Visit for Alcohol & Other Drug Abuse or Dependence (FUA) – Total, 30 days	16.38	14.03	12.9	11.24	11.14	10.75	21.31	26.22	32.60

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

Aims, Objectives and Goals

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

1. Enhance hospital-to-MCO workflow for notification of hospital and emergency department admissions, discharges and transfers:
    a. Develop or enhance real-time/near-real-time admit, discharge, transfer (ADT) data exchange for behavioral health-related emergency department visits and hospital stays.
    b. Streamline and improve processes for obtaining and documenting member's consent to share information with aftercare providers.
    c. Ensure hospitals and emergency departments have user-friendly, accessible provider directories, which indicate BH providers with availability for urgent aftercare appointments.
    d. Perform medication reconciliation to ensure medication is on approved formulary and member has access to medication.
    e. Provide enhanced MCO case/care management to ensure aftercare planning for members prior to discharge from hospital or emergency department.
        i. Identify and address social determinants of health, which may serve as a barrier to aftercare.
        ii. Ensure member has a discharge plan, which includes current medication list, appointment with aftercare provider(s) at a time/location convenient to member/based on member preferences, and interventions to address barriers to care (e.g., transportation, language etc.).
        iii. Ensure member understands discharge plan using teach-back methods to address health literacy.
        iv. Educate members on purpose and importance of aftercare appointments, and how to reschedule appointments if the scheduled time does not work.
        v. Provide follow-up to member within 72 hours following discharge from hospital or emergency department to identify and address any unmet needs.
        vi. Provide ongoing MCO case management to members with special health care needs.
            1. Evaluate the effectiveness of the MCO case management program considering member feedback and engagement level, and develop and implement interventions to improve case management processes based on member feedback.

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

privacy requirements at 45 CFR Parts 160 and 164, 42 CFR Part 2, and other applicable state and federal laws.

3. Identify and address needs of sub-populations by stratifying data by member race/ethnicity, member region of residence, gender, high-utilizers, SMI diagnosis, co-occurring disorders, age, and if available LGBTQ.
4. Initiate a broader intervention to facilitate follow-up with members with an appropriate mental health provider (per NCQA Appendix 3) e.g., text messaging, letter to member and member's PCP with list of follow-up providers in member's location).

Table 2: Goals

Indicators	Baseline Rate[1] Measurement Period: 1/1/21–12/31/21	Interim Rate Measurement Period: 1/1/22–12/31/22	Final Rate Measurement Period: 1/1/23–12/31/23	Target Rate[2]	Rationale for Target Rate[3]
Indicator #1a. Follow-Up After Hospitalization for Mental Illness (FUH) – Total, 7 days	N: 1717 D: 7706 R: 22.28%	N: 1530 D: 7365 R: 20.77%	N: D: R:	R: 25.28%	At least 3 percentage point increase per year for all Performance Indicators
Indicator #1b. Follow-Up After Hospitalization for Mental Illness (FUH) – Total, 30 days	N: 3218 D: 7706 R: 41.76%	N: 2799 D: 7365 R: 38.00%	N: D: R:	R: 44.76%	
Indicator #2a. Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Total, 7 days	N: 391 D: 1733 R: 22.56%	N: 263 D: 1175 R: 22.38%	N: D: R:	R: 25.56%	
Indicator #2b. Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Total, 30 days	N: 603 D: 1733 R: 34.80%	N: 415 D: 1175 R: 35.32%	N: D: R:	R: 38.32%	
Indicator #3a. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 7 days	N: 176 D: 2349 R: 7.49%	N: 470 D: 2852 R: 16.48%	N: D: R:	R: 19.48%	

Indicators	Baseline Rate[1] Measurement Period: 1/1/21–12/31/21	Interim Rate Measurement Period: 1/1/22–12/31/22	Final Rate Measurement Period: 1/1/23–12/31/23	Target Rate[2]	Rationale for Target Rate[3]
Indicator #3b. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – Total, 30 days	N: 308 D: 2349 R: 13.11%	N: 741 D: 2852 R: 25.98%	N: D: R:	R: 28.98%	

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

Methodology

To be completed upon Proposal submission.

Performance Indicators

Table 3: Performance Indicators

Indicator[1]	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #1a Follow-Up After Hospitalization for Mental Illness (FUH)-Total, 7 days	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider, for which there was a follow-up within 7 days after discharge.	Administrative claims data	Members 6 years or older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow up visit with a mental health provider. Members must have continuous enrollment through 30 days after discharge and no gaps in enrollment.	Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period regardless of principal diagnosis for the readmission. Exclude nonacute inpatient stays. Members in hospice or using hospice services anytime during the measurement year.	A follow-up visit with a mental health provider within 7 days after discharge, not including visits that occur on the date of discharge	The eligible population minus exclusions.

Indicator[1]	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #1b Follow-Up After Hospitalization for Mental Illness (FUH)-Total, 30 days	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider, for which there was a follow-up within 30 days after discharge.	Administrative claims data	Members 6 years or older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Members must have continuous enrollment through 30 days after discharge and no gaps in enrollment.	Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. Exclude nonacute inpatient stays. Members in hospice or using hospice services anytime during the measurement year.	A follow-up visit with a mental health provider within 30 days after discharge, not including visits that occur on the date of discharge.	The eligible population minus exclusions

Indicator[1]	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #2a. Follow-Up At 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, for which there was a follow-up within 7 days of the ED visit (8 total days).	Administrative claims data	Members 6 years or older with an ED visit with principal diagnosis of mental illness or intentional self-harm, for which there was a follow-up. Members must have continuous enrollment through 30 days after the ED visit (31 total days) and no gaps in enrollment.	Exclude ED visits that result in an inpatient stay and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. Members in hospice or using hospice services anytime during the measurement year.	A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days), including visits that occur on the date of the ED visit.	The eligible population minus exclusions

Indicator[1]	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #2b. Follow-Up At 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, for which there was a follow-up within 30 days of the ED visit (31 total days).	Administrative claims data	Members 6 years or older with an ED visit with principal diagnosis of mental illness or intentional self-harm, for which there was a follow-up. Members must have continuous enrollment through 30 days after the ED visit (31 total days) and no gaps in enrollment.	Exclude ED visits that result in an inpatient stay and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. Members in hospice or using hospice services anytime during the measurement year.	A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days), including visits that occur on the date of the ED visit.	The eligible population minus exclusions

Indicator[1]	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #3a. Follow-Up A Emergency Department for Alcohol a Other Drug Abuse or Dependenc e (FUA) – Total, 7 days	The percentage of emergency department (ED) visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 7 days of the ED visit (8 total days)	Administr ative claims data	Members 13 years or older with an ED visit with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Members must have continuous enrollment through 30 days after the ED visit and no gaps in enrollment.	Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. Members in hospice or using hospice services anytime during the measurement year.	A follow-up visit or a pharmacother apy dispensing event within 7 days after the ED visit (8 total days), including visits and pharmacother apy events that occur on the date of the ED visit	The eligible population minus exclusions
Indicator #3b. Follow-Up A Emergency Department for Alcohol a Other Drug Abuse or Dependenc e (FUA) – Total, 30 days	The percentage of emergency department (ED) visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 30 days of the ED visit (31 total days)	Administr ative claims data	Members 13 years or older with an ED visit with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Members must have continuous enrollment through 30 days after the ED visit and no gaps in enrollment.	Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. Members in hospice or using hospice services anytime during the measurement year.	A follow-up visit or a pharmacother apy dispensing event within 30 days after the ED visit (31 total days), including visits and pharmacother apy events that occur on the date of the ED visit.	The eligible population minus exclusions

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

Data Collection and Analysis Procedures

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

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 was used for the study.

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:**

Data for this study is collected administratively only, electronically, using extraction software. The parameters for extraction come directly from the Healthcare Effectiveness Data and Information Set (HEDIS®) measure for Follow-Up after Hospitalization for Mental Illness (FUH), Follow-Up After Emergency Department Visit for Mental Illness (FUM), and Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA). These data extracts are already in place in order to track and trend all HEDIS® measures throughout the year.

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:**

The data collection process is audited by specific NCQA certified auditors. The auditors perform a review of UHC's transaction systems and data analysis procedures, examine computer programs to confirm adherence to NCQA specifications, interview key process representatives, examine select transactions including claims, and benchmark the performance rates for each measure against normative data.

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:**

Methods to analyze data include a review of baseline results, as well as comparison with the results of the collaborating MCOs, as aggregated for the project. HEDIS® rates were also compared to the national Quality Compass® benchmarks. The indicator results will be calculated according to the study indicator specifications and then compared to the goals and benchmarks for each indicator.

- **Describe how plan will interpret improvement relative to goal:**

Improvement will be interpreted in terms of the extent to which the target rates are met for each sub-measure, as indicated in the results table.

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

Methods used to analyze the ITM data will include a review of all intervention tracking measures and drill down on any stagnating measures with the multi-disciplinary team to determine how interventions may need to be adjusted to increase efficacy

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.

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

Final Measurement Period:
Start date: 1/1/2023
End date: 12/31/23

Submission of 2023 PIP Proposal is due 3/1/2023.

Submission of 1st quarterly status report for intervention period 1/1/23–3/31/23 is due on 4/29/2023.
Submission of 2nd quarterly status report for intervention period 4/1/23–6/30/23 is due on 7/29/2023.
Submission of 3rd quarterly status report for intervention period 7/1/23–9/30/23 is due on 10/31/2023.

Submission of BH TOC Draft Final Report with CY 2023 data is due: 12/9/23

Submission of BH TOC Final Final Report with CY 2023 data is due:12/30/2023

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 in the FUH 30 Day Numerator	% of MCO TOTAL Numerator	% of MCO TOTAL Denominator ÷ % of MCO TOTAL Numerator
MCO TOTAL		100%		100%	
Age					
6–17 years	1660	20.51%	1009	30.37%	67.53%
18–64 years	6328	78.20%	2280	68.63%	113.94%
65+ years	104	1.29%	33	0.99%	130.30%
Race					
American Indian or Alaska Native	58	0.72%	25	0.75%	96.00%
Asian	37	0.46%	12	0.36%	127.78%
Black or African American	3079	38.05%	1211	36.45%	104.39%
Native Hawaiian or Pacific Islander	1	0.01%	0	0	0%
White	4151	51.30%	1795	54.03%	94.95%
Other	1	0.01%	0	0	0%
Unknown	765	9.45%	279	8.40%	112.50%
Ethnicity					
Hispanic	2	0.02%	1	0.03%	66.67%
Non-Hispanic	7325	90.52%	3042	91.57%	98.85%
Unknown	765	9.45%	279	8.40%	112.50%
Substance Use Disorder	5057	62.49%	1717	51.69%	120.89%
Enrollment category: Foster Care	10	0.12%	7	0.21%	57.14%
Enrollment category: Disabled	1539	19.02%	742	22.34%	85.14%
Housing Insecurity/Homeless[1]	1176	14.53%	316	9.51%	152.79%
LA MCO Region of Residence					
Region 1: Greater New Orleans	1309	16.18%	484	14.57%	111.05%
Region 2: Capital Area	1487	18.38%	642	19.33%	95.08%
Region 3: South Central LA	689	8.51%	353	10.63%	80.06%
Region 4: Acadiana	1436	17.75%	583	17.55%	101.14%
Region 5: Southwest LA	429	5.30%	162	4.88%	108.61%
Region 6: Central LA	587	7.25%	256	7.71%	94.03%
Region 7: Northwest LA	842	10.41%	377	11.35%	91.72%
Region 8: Northeast LA	558	6.90%	213	6.41%	107.64%
Region 9: Northshore Area	639	7.90%	226	6.80%	116.18%
Out of State	116	1.43%	26	0.78%	183.33%

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 in the FUH 30 Day Numerator	% of MCO TOTAL Numerator	% of MCO TOTAL Denominator ÷ % of MCO TOTAL Numerator
MCO TOTAL		100%		100%	
BRENTWOOD	829	12.14%	437	15.36%	79.04%
LONGLEAF	465	6.81%	173	6.08%	112.01%
ACADIA VERMILION	424	6.21%	223	7.84%	79.21%
CHILDRENS	323	4.73%	188	6.61%	71.56%
RIVER PLACE BEHAVIORAL HEALTH	309	4.52%	126	4.43%	102.03%
RIVER OAKS	292	4.27%	109	3.83%	111.49%
COVINGTON BEHAVIORAL HEALTH	291	4.26%	93	3.27%	130.28%
CYPRESS GROVE BEHAVIORAL HEALTH	283	4.14%	171	6.01%	68.89%
OUR LADY OF THE LAKE REG MED CTR	262	3.84%	140	4.92%	78.05%
SEASIDE HEALTH SYSTEM	204	2.99%	69	2.43%	123.05%
ST JAMES BEHAVIORAL HEALTH	202	2.96%	75	2.64%	112.12%
LAKE PINES	201	2.94%	57	2.00%	147.00%
OCEANS BEHAVIORAL HSP OF GREATER NO LLC	190	2.78%	51	1.79%	155.31%
INTERIM LSU	186	2.72%	88	3.09%	88.03%
SEASIDE BEHAVIORAL CENTER LLC	152	2.23%	53	1.86%	119.89%
LOUISIANA BEHAVIORAL HEALTH LLC	148	2.17%	43	1.51%	143.71%
REGIONS BEHAVIORAL HOSPITAL	145	2.12%	47	1.65%	128.48%
ALLEN PARISH HOSPITAL	144	2.11%	54	1.90%	111.05%
BATON ROUGE GENERAL MEDICAL CTR INC	131	1.92%	54	1.90%	101.05%
NESS HEALTHCARE NFP	127	1.86%	75	2.64%	70.45%
APOLLO BEHAVIORAL HEALTH	125	1.83%	46	1.62%	112.96%
COMMUNITY CARE	116	1.70%	31	1.09%	155.96%
BEACON BEHAVIORAL HOSP NEW ORLEANS INC	115	1.68%	42	1.48%	113.51%
WILLIS KNIGHTON MEDICAL CENTER INC	112	1.64%	48	1.69%	97.04%
LAKE CHARLES MEMORIAL	111	1.62%	47	1.65%	98.18%
BEACON BEHAVIORAL	109	1.60%	38	1.34%	119.40%
OCEANS BEHAVIORAL HOSPITAL KENTWOOD LLC	107	1.57%	33	1.16%	135.34%
BEACON BEHAVIORAL HOSPITAL CENTRAL	104	1.52%	39	1.37%	110.95%

LAFAYETTE GENERAL MEDICAL CTR	99	1.45%	22	0.77%	188.31%
COMPASS BEHAVIORAL CTR OF ALEXANDRIA INC	92	1.35%	30	1.05%	128.57%
OPELOUSAS GENERAL	79	1.16%	30	1.05%	110.48%
OCHSNER ST ANNE GENERAL	73	1.07%	37	1.30%	82.31%
BATON ROUGE BEHAVIORAL	73	1.07%	12	0.42%	254.76%
SERENITY SPRINGS SPECIALTY	70	1.02%	22	0.77%	132.47%
GLENWOOD REGIONAL MEDICAL CTR	69	1.01%	15	0.53%	190.57%
CHRISTUS OCHSNER ST PATRICK	69	1.01%	27	0.95%	106.32%

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: Delays in notification of hospital admissions, discharges, and transfers between hospital and MCO hinder ability to begin discharge planning prior to discharge **Method of barrier identification:** LDH guidance and multi-disciplinary MCO staff discussion		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Notification Intervention #1 to address barrier: **Planned Start Date:** 01/01/2022 **Actual Start Date**: 01/01/2022	**ITM #1a :** **Numerator**: # hospital inpatient admissions for which MCO received any admission notification **Denominator**: FUH denominator (note: count # discharges)	N: 1867 D: 1867 R: 100%	N: 2113 D: 2113 R: 100%	N: 1275 D: 1275 R: 100%	N: 645 D: 645 R: 100%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: **Planned Start Date:** 01/01/2022 **Actual Start Date**: 01/01/2022	**ITM #1b :** **Numerator**: # hospital inpatient admissions for which MCO CM received any admission notification **Denominator**: FUH denominator (note: count # discharges)	N: 1867 D: 1867 R: 100%	N: 2113 D: 2113 R: 100%	N: 1275 D: 1275 R: 100%	N: 645 D: 645 R: 100%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: **Planned Start Date:** 01/01/2022 **Actual Start Date**:	**ITM #1c:** **Numerator**: # hospital inpatient admissions for which MCO received ADT/Health Information Exchange admission notification	N: 86 D: 1867 R: 4.61%	N: 99 D: 2113 R: 4.69%	N: 131 D: 1275 R: 10.27%	N: 115 D: 645 R: 17.83%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

01/01/2022	**Denominator**: FUH denominator (note: count # discharges)								
Notification Intervention #1 to address barrier: **Planned Start Date:** 01/01/2022 **Actual Start Date**: 01/01/2022	**ITM #1d :** **Numerator**: # hospital inpatient admissions for which MCO CM received ADT/Health Information Exchange admission notification **Denominator**: FUH denominator (note: count # discharges)	N: 86 D: 1867 R: 4.61%	N: 99 D: 2113 R: 4.69%	N: 131 D: 1275 R: 10.27%	N: 115 D: 645 R: 17.83%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier: Delays in notification of emergency department admissions, discharges, and transfers between emergency department and MCO hinder ability to begin discharge planning prior to discharge **Method of barrier identification:** LDH guidance and multi-disciplinary MCO staff discussion		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Notification Intervention #1 to address barrier: **Planned Start Date:** 01/01/2022 **Actual Start Date**: 01/01/2022	**ITM #1e:** **Numerator**: # BH ED encounters for which MCO received any ED admission or discharge notification **Denominator**: Sum of FUM + FUA denominators (note: count # ED visits)	N: 80 D: 1084 R: 7.38%	N: 72 D: 1156 R: 6.23%	N: 67 D: 763 R: 8.75%	N: 79 D: 378 R: 20.90%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: **Planned Start Date:** 01/01/2023 **Actual Start Date**: 01/17/2023	**ITM #1f:** **Numerator**: # BH ED encounters for which MCO CM received any ED admission or discharge notification **Denominator**: Sum of FUM + FUA denominators (note: count # ED visits)	N: 0 D: 1084 R: 0%	N: 0 D: 1156 R: 0%	N: 0 D: 763 R: 0%	N: 0 D: 378 R: 0%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Notification Intervention #1 to address barrier: 01/01/2022 **Planned Start Date:** **Actual Start Date**: 01/01/2022	**ITM #1g:** **Numerator:** # BH ED encounters for which MCO received ADT/Health Information Exchange ED admission or discharge notification **Denominator:** Sum of FUM + FUA denominators (note: count # ED visits)	N: 80 D: 1084 R: 7.38%	N: 72 D: 1156 R: 6.23%	N: 67 D: 763 R: 8.78%	N: 79 D: 378 R: 20.90%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Notification Intervention #1 to address barrier: **Planned Start Date:** 01/01/2023 **Actual Start Date**: 01/17/2023	**ITM #1h:** **Numerator**# BH ED encounters for which MCO CM received ADT/Health Information Exchange ED admission or discharge notification **Denominator:** Sum of FUM + FUA denominators (note: count # ED visits)	N: 0 D: 1084 R: 0%	N: 0 D: 1156 R: 0%	N: 0 D: 763 R: 0%	N: 0 D: 378 R: 0%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 3: Members could be difficult to engage in follow-up treatment **Method of barrier identification:** LDH guidance, direct feedback from providers, and multi-disciplinary MCO staff discussion		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Linkage Intervention #2 to address barrier: **Planned Start Date:** 01/01/2022 **Actual Start Date**: 01/01/2022	**ITM #2a-1:** **Numerator:** # MH HOSPITAL DISCHARGES with a qualifying follow-up provider VISIT ATTENDED within 30 days of discharge **Denominator:** # MH HOSPITAL DISCHARGES in FUH denominator FOR MEMBERS who are enrolled	N: 128 D: 281 R: 45.55%	N: 130 D: 275 R: 47.27%	N: 61 D: 163 R: 37.42%	N: 25 D: 110 R: 22.73%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

	(agreed to participate) in case management								
Linkage Intervention #2 to address barrier: **Planned Start Date:** 01/01/2022 **Actual Start Date**: 01/01/2022	**ITM #2a-2:** **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: 195 D: 281 R: 69.40%	N: 205 D: 275 R: 74.55%	N: 98 D: 163 R: 60.12%	N: 32 D: 110 R: 29.10%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2 to address barrier: **Planned Start Date:** 01/01/2022 **Actual Start Date**: 01/01/2022	**ITM #2a-3:** **Numerator:** # MH HOSPITAL DISCHARGES with a qualifying follow-up provider VISIT ATTENDED within 30 days of discharge **Denominator:** # MH HOSPITAL DISCHARGES in FUH denominator FOR MEMBERS who are not enrolled in case management	N: 610 D: 1586 R: 38.46%	N: 656 D: 1838 R: 35.69%	N: 296 D: 1112 R: 26.62%	N: 89 D: 534 R: 16.67%:	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Linkage Intervention #2 to address barrier: **Planned Start Date:** 01/01/2022 **Actual Start Date**: 01/01/2022	**ITM #2a-4:** **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: 1122 D: 1586 R: 70.74%	N: 1289 D: 1838 R: 70.13%	N: 683 D: 1112 R: 61.42%	N: 177 D: 535 R: 33.08%				
Linkage Intervention #2 to address barrier: **Planned Start Date:** 01/01/2022 **Actual Start Date**: 01/01/2022	**ITM #2b-1:** **Numerator**: # SUD + MH ED DISCHARGES with a qualifying follow-up provider VISIT ATTENDED within 30 days of SUD + MH ED discharge **Denominator**: # SUD + MH DISCHARGES in FUM + FUA denominator FOR MEMBERS who are enrolled (agreed to participate) in case management	N: 15 D: 32 R: 46.88%	N: 13 D: 32 R: 40.63%	N: 5 D: 23 R: 21.74%	N: 5 D: 25 R: 20%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2 to address barrier: **Planned Start Date:** **Actual Start Date**:	**ITM #2b-2 (NEW):** **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/A *ITM added Q1 2023	N/A *ITM added Q1 2023	N/A *ITM added Q1 2023	N/A *ITM added Q1 2023				

Linkage Intervention #2 to address barrier: **Planned Start Date:** 01/01/2022 **Actual Start Date**: 01/01/2022	**ITM #2b-3:** **Numerator**: # SUD + MH ED DISCHARGES with a qualifying follow-up provider VISIT ATTENDED within 30 days of ED discharge **Denominator**: # SUD + MH ED DISCHARGES in FUM + FUA denominator FOR MEMBERS who are not enrolled in case management	N: 304 D: 1052 R: 28.90%	N: 305 D: 1124 R: 27.14%	N: 184 D: 740 R: 24.86%	N: 64 D: 535 R: 11.96%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Linkage Intervention #2 to address barrier: **Planned Start Date:** **Actual Start Date**:	**ITM #2b-4 (NEW):** **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/A *ITM added Q1 2023	N/A *ITM added Q1 2023	N/A *ITM added Q1 2023	N/A *ITM added Q1 2023				
Linkage Intervention #2 for warm hand-off to address barrier: **Planned Start Date:** **Actual Start Date**:	**ITM #2c:** **Numerator:** # members with a warm hand-off (e.g., additional SUD level of care codes provided by Ford to get credit for appropriate follow-ups not included by NCQA; examples of warm handoffs include peer services in EDs, buprenorphine induction in EDs with handoff to outpatient provider, having clinicians from SUD providers with multiple levels of care evaluate patients in EDs for best placement, including	N: 128 D: 715 R: 17.90%	N: 133 D: 807 R: 16.48%	N: 89 D: 480 R: 18.54%	N: 38 D: 239 R: 15.90%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

	residential SUD) from the ED to a qualifying SUD provider **Denominator:** # members in FUA denominator (note: Count # members, not visits. If you are testing this intervention with a high performing, high volume hospital, you may use that smaller denominator)								
Barrier: Lack of timely communication between treating providers regarding discharge planning post discharge from hospitals and emergency departments can cause gaps in treatment continuum **Method of barrier identification:** LDH guidance, direct feedback from providers, and multi-disciplinary MCO staff discussion		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Provider to Provider Communication Intervention #2 to address barrier: **Planned Start Date:** 01/01/2022 **Actual Start Date**: 01/01/2022	**ITM #2d:** **Numerator**: # members whose qualifying follow-up provider was sent enhanced D/C Plan (with at least medication lists) prior to F/U appointment **Denominator**: # members in the FUH denominator (note: you are counting # members, not visits)	N: 1298 D: 1818 R: 71.40%	N: 1452 D: 2046 R: 71.97%	N: 778 D: 1265 R: 61.50%	N: 209 D: 645 R: 32.40%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Provider to Provider Communication Intervention #2 to address barrier: **Planned Start Date:** TBD **Actual Start Date**:	**ITM #2e:** **Numerator**: # members whose qualifying follow-up provider was sent enhanced D/C Plan (with at least medication lists) prior to F/U appointment **Denominator**: Sum of # members in FUM denominators (note: you are counting the sum of # members, not visits)	N: 0 D: 347 R: 0%	N: 0 D: 320 R: 0%	N: 0 D: 278 R: 0%	N: 0 D: 139 R: 0%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Implementation of Shared Saving Programs with targeted inpatient facilities and Outpatient groups **Planned Start Date:** 01/01/2022 **Actual Start Date**: 01/01/2022	**ITM #3:** **Numerator**: # members with a billed qualifying follow-up provider appointment within 30 days of discharge from an Inpatient facility that has a current Value Based Contract **Denominator**: # members who have mental health discharge from an Inpatient facility that has a current Value Based Contract. Facilities (Beacon Behavioral Hospital, Seaside Behavioral Center)	N: 34 D: 141 R: 24.11%	N: 43 D: 168 R: 25.60%	N: 24 D: 106 R: 22.64%	N: 6 D: 52 R: 11.54%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Implementation of Shared Saving Programs with targeted inpatient facilities and Outpatient groups **Planned Start Date:** 04/01/2022 **Actual Start Date**: 04/01/2022	**ITM #4:** **Numerator:** # of kept 30 day follow up appointments **Denominator:** # of members who had a qualifying discharge for FUH or FUM attributed to group eligible for Behavioral Health Provider Incentive Program	N/A *Program was not implemented until 4/1/2022							

Provider	FUH	Provider	FUH	Provider	FUH	FUM
AAHSD	67%	AAHSD	67%	AAHSD	67%	100%
CAHSD	75%	CAHSD	100%	CAHSD	13%	100%
CLHSD	86%	CLHSD	N/A	CLHSD	0%	N/A
FPHSA	79%	FPHSA	N/A	FPHSA	33%	N/A
JC	N/A	JC	N/A	JC	N/A	N/A
JPHSA	100%	JPHSA	N/A	JPHSA	N/A	N/A
MHSD	60%	MHSD	100%	MHSD	0%	0%
NLHSA	75%	NLHSA	100%	NLHSA	N/A	0%
PTI	100%	PTI	N/A	PTI	N/A	N/A
SCLHS	85%	SCLHSD	80%	SCLHSD	50%	100%
UH	N/A	UH	N/A	UH	N/A	N/A

Barrier: Susceptible subpopulations pose unique challenges to engagement and treatment compliance Method of barrier identification: LDH guidance, direct feedback providers, member feedback via case management		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Provide field-based support to members that are engaged in the High Needs Engagement and Support Program, which engages members prior to	**ITM 5:** **Numerator**: # members successfully enrolled and outreached as part of field-based High Needs Engagement and Support Program	N: 4 D: 15 R: 26.67%	N: 8 D: 18 R: 44.45%	N: 12 D: 18 R: 66.67%	N: 0 D: 1 R: 0%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

discharge from facility-based treatment and throughout their transition to the community in coordination with the Focused Care Advocacy Program **Planned Start Date:** 02/01/2022 **Actual Start Date**: 02/01/2022	**Denominator**: # members eligible for participation in the Focused Care Advocacy Program								
Provide a member incentive to members who successfully kept a follow-up appointment with a qualifying provider after discharge from a targeted mental health inpatient facility **Planned Start Date:** 01/01/2023 **Actual Start Date:** 01/01/2023	**ITM #6:** **Numerator:** # members with a qualifying follow-up appointment attended within 7 days of discharge from a targeted inpatient mental health facility **Denominator:** # members discharged from a targeted inpatient mental health facility	N/A	N/A	N/A	N/A				
Provider education, including information on MAT, SBIRT, the engagement of members with SUD diagnoses, and appropriate level of care referral. **Planned Start Date:** 01/01/2022 **Actual Start Date**: 03/01/2022	**ITM #7:** **Numerator:** # of in-network providers educated **Denominator:** The total number of providers in-network	N: 27 D: 5628 R: 0.48%	N: 74 D: 5714 R: 1.30%	N: 40 D: 4016 R: 1.00%	N: 34 D: 4016 R: 0.85%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Contract with provider Eleanor Health, which would allow for proactive outreach and assistance in securing follow-up appointments and other case management needs for members. Eleanor Health has expanded its footprint in the state, with physical locations currently in Baton Rouge, Metaire and Shreveport **Planned Start Date:** 02/01/2022 **Actual Start Date**: 02/14/2022	**ITM #8a:** **Numerator**: # members successfully reached via mail as part of proactive outreach by Eleanor Health **Denominator**: # members attributed to Eleanor Health	N: 4400 D: 4477 R: 98.28%	N: 2492 D: 4508 R: 55.28%	N: 2518 D: 5211 R: 48.32%	N: 783 D: 5736 R: 13.65%				
Contract with provider Eleanor Health, which would allow for proactive outreach and assistance in securing follow-up appointments and other case management needs for members. Eleanor Health has expanded its footprint in the state, with physical locations currently in Baton Rouge, Metaire and Shreveport	**ITM #8b:** **Numerator**: # members successfully reached via phone as part of proactive outreach by Eleanor Health **Denominator**: # members attributed to Eleanor Health	N: 850 D: 4477 R: 18.99%	N: 2489 D: 4508 R: 55.21%	N: 2536 D: 5211 R: 48.67%	N: 178 D: 5736 R: 3.10%				

Planned Start Date: 02/01/2022 **Actual Start Date**: 02/14/2022									
Provide member outreach after emergency department discharge with either a mental health or substance use disorder diagnosis, as identified by ADT feeds, to help with securing a qualified follow-up appointment and provide additional resources. **Planned Start Date:** 01/01/2023 **Actual Start Date**: 01/17/2023	**ITM #9a:** **Numerator**: # members successfully outreached via phone as part of ED follow-up program **Denominator**: # unique ED discharges per month with a mental health or substance use disorder diagnosis primary, as determined by manual scrub of ADT data								
Provide member outreach after emergency department discharge with either a mental health or substance use disorder diagnosis, as identified by ADT feeds, to help with securing a qualified follow-up appointment and provide additional resources. **Planned Start Date:** 01/01/2023 **Actual Start Date**: 01/17/2023	**ITM #9b:** **Numerator**: # members successfully outreached via phone as part of ED follow-up program who attended a follow up appointment within 30 days of discharge **Denominator**: # members successfully outreached via phone as part of ED follow-up program								

Results

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

Table 5: Results

Indicator	Baseline Measure Period 1/1/21–12/31/21	Final Measure Period 1/1/22–12/31/22	Target Rate[1]
Indicator #1a. Follow-Up After Hospitalization for Mental Illness (FUH)- Total, 7 days	N: 1717 D: 7706 R: 22.28%	N: 1530 D: 7365 R: 20.77%	At least 3 percentage points increase for each performance indicator. Rate: 25.28%
Indicator #1b. Follow-Up After Hospitalization for Mental Illness (FUH)- Total, 30 days	N: 3218 D: 7706 R: 41.76%	N: 2799 D: 7365 R: 38.00%	R: 44.76%
Indicator #2a. Follow-Up After Emergency Department Visit for Mental Illness (FUM)- Total, 7 days	N: 391 D: 1733 R: 22.56%	N: 263 D: 1175 R: 22.38%	R: 25.56%
Indicator #2b. Follow-Up After Emergency Department Visit for Mental Illness (FUM)- Total, 30 days	N: 603 D: 1733 R: 34.80%	N: 415 D: 1175 R: 35.32%	R: 38.32%
Indicator #3a. Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence (FUA) – Total, 7 days	N: 176 D: 2349 R: 7.49%	N: 470 D: 2852 R: 16.48%	R: 19.48%
Indicator #3b. Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence (FUA) – Total, 30 days	N: 308 D: 2349 R: 13.11%	N: 741 D: 2852 R: 25.98%	R: 44.76%

[1] At least 3 percentage points increase for each performance indicator.
Upon subsequent evaluation of quarterly rates, consideration should be given to improving the target rate, if it has been met or exceeded at that time.

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

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

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

Discussion

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

Discussion of Results

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

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

- **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.

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.

- **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).

- **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.

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

References

List any references that you cite.

Kehn, Matthew, et al. “Improving the Coordination of Services for Adults with Mental Health and Substance Use Disorders: Profiles of Four State Medicaid Initiatives.” *ASPE*, 2015, https://aspe.hhs.gov/reports/improving-coordination-services-adults-mental-health-substance-use-disorders-profiles-four-state-0.

Mohammadi, Iman, et al. “Data Analytics and Modeling for Appointment No-Show in Community Health Centers.” *Journal of Primary Care & Community Health*, SAGE Publications, 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6243417/.

“HEDIS Measures and Technical Resources.” *NCQA*, 27 Jan. 2022, https://www.ncqa.org/hedis/measures/.

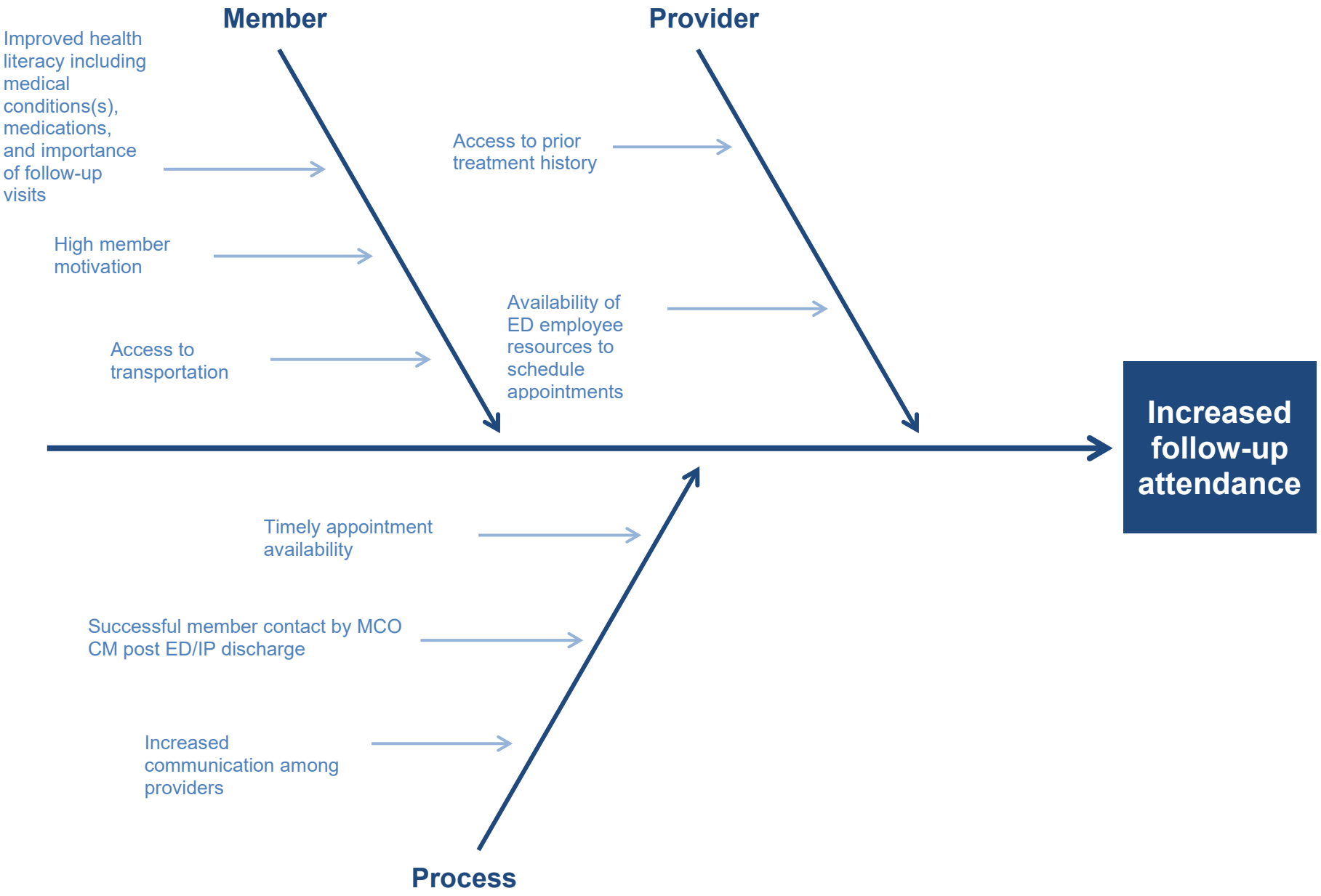
Glossary of PIP Terms

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	• Visibility to prior treatment history • Timely appointment availability • Successful member contact by MCO CM post ED/IP discharge	• Improved heath literacy including medical condition(s), medications, and importance of follow up visits • Access to transportation
Less Feasible to Address	• Increased communication among providers • High member motivation	• Availability of ED employee resources to schedule appointments

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

	Positives	**Negatives**
INTERNAL ***under your control***	***build on*** **STRENGTHS** ***Examples:*** • Historical data available to confirm prior interventions that lead to positive impacts • Established case management program • Developing vendor agreements and value-based contracts to aid in member engagement and gap closure	***minimize*** **WEAKNESSES** ***Examples:*** • COVID-19 related delays in Case Management team's ability to perform community-based member interactions • Increase case management staffing to meet referral needs
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** ***Examples:*** • Provider engagement with education • Member engagement with vendor support to increase appointment compliance • Provider engagement with vendor support to increase appointment scheduling and follow up	***protect from*** **THREATS** ***Examples:*** • Lack of provider participation • Difficulties engaging with ED facilities and staff • Claims lag in performance indicators to assess intervention effectiveness • Low member motivation for treatment

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	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	Geo mapping providers EDs/Hospitals using teach back methods for health literacy, d/c planning components and medication reconciliation Scheduling appointments prior to d/c (when possible for EDs); to include provider contact information for rescheduling as necessary Encouraging referrals to MH and SU providers who have urgent appointment availability Phone contact attempt with patient within 72 hours of d/c to identify and address any unmet needs Encouraging allowing practitioners to pull data from ADTs Asking patients if they are currently enrolled in	Provide field-based support to members that are engaged in the High Needs Engagement and Support Program, which engages members prior to discharge from facility-based treatment and throughout their transition to the community in coordination with the Focused Care Advocacy Program Provide a member incentive to members who successfully kept a follow-up appointment with a qualifying provider after discharge from a targeted mental health inpatient facility Implementation of Shared Saving Programs with targeted inpatient facilities and Outpatient groups Implementation of Behavioral Health Provider Incentive Programs with targeted Outpatient groups Provide proactive member outreach via vendor agreement with Eleanor Health, which provides a comprehensive array of SUD treatment and wrap-around services, in coordination with the Focused Care Advocacy Program.

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
	Warm handoffs to providers **<u>EDs/ Hospitals and MCOs</u>** Use of real-time or near real-time admit/discharge transfer (ADT) data exchange information sharing systems) **<u>MCOs</u>** Initiating CM contact with eligible patients prior to d/c from EDs or hospitals	plan's formulary. Encouraging more facilities to use automated ADT information systems Encouraging more provider-to-provider communications MCOs provide ongoing CM for members already enrolled in CM CM identifying and addressing SDOH needs as quickly as possible Enhanced outreach to members post d/c including CM, CHWs, Pt navigators, etc.	CM and contacting their case manager Follow-up BH appointment reminders Rescheduling missed appointments.	
Measure specific factors				
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.	Provider education, including information on MAT, SBIRT, ASAM, Motivational Interviewing, the engagement of members with SUD diagnoses, and appropriate level of care referral.

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
				Provide member outreach after emergency department discharge with either a mental health or substance use disorder diagnosis, as identified by ADT feeds, to help with securing a qualified follow-up appointment and provide additional resources.
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	Provider education, including information on MAT, SBIRT, ASAM, Motivational Interviewing, the engagement of members with SUD diagnoses, and appropriate level of care referral. Provide proactive member outreach via vendor agreement with Eleanor Health, which provides a comprehensive array of SUD treatment and wrap-around services, in coordination with the Focused Care Advocacy Program. Provide member outreach after emergency department discharge, as identified by ADT feeds, to help with securing a qualified follow-up appointment and provide additional resources.

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

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

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