

# ACLA BEHAVIORAL HEALTH MEASURE INITIATIVES

Effects of Pre-Established Care  
on 30-day Follow Up



# OVERVIEW

- Behavioral Health Measure
- Background
- Population Overview
- Findings
- Current Initiatives
- Recommendations

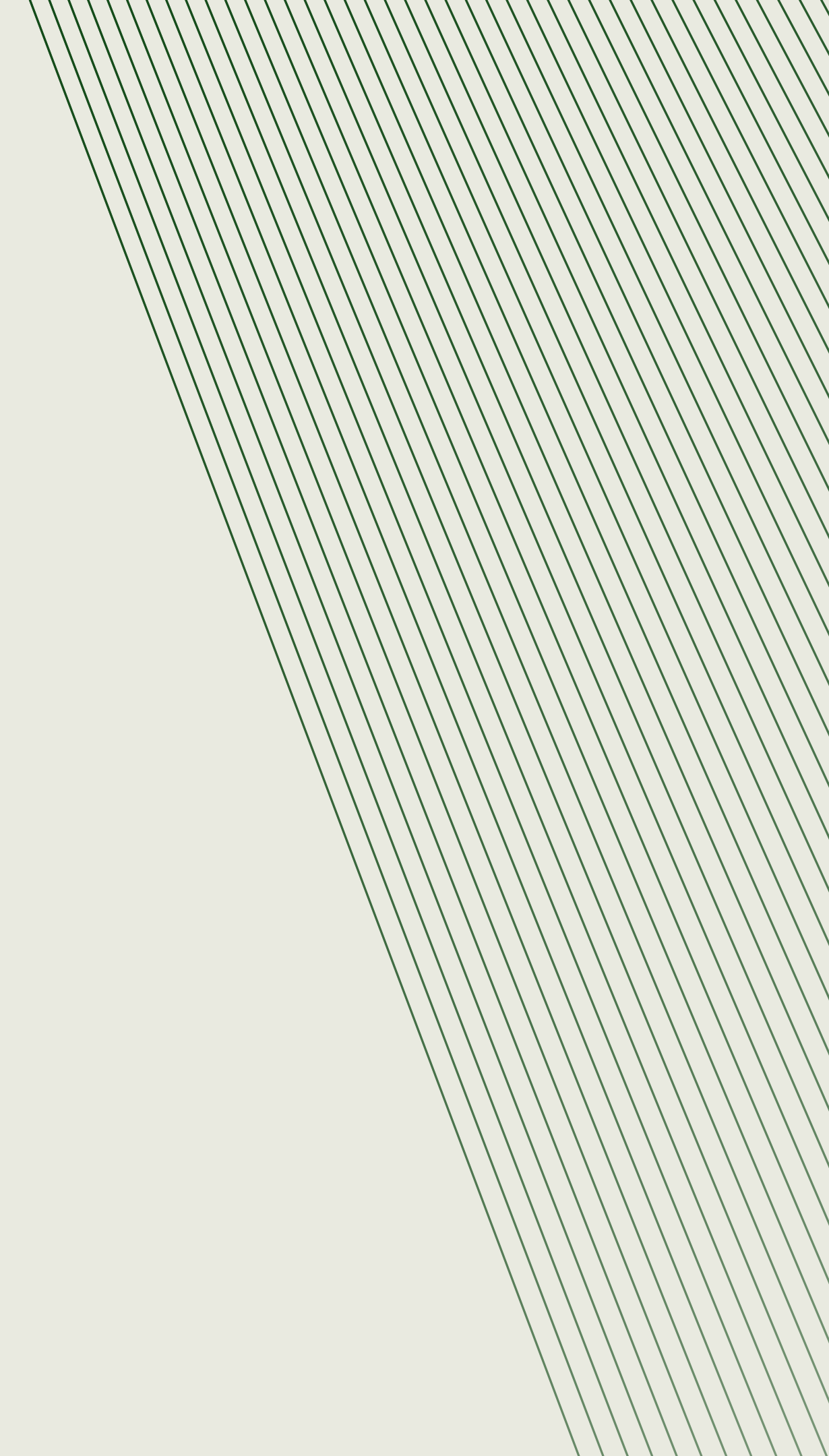
# ACLA MEASURE

Identifier	Healthy Louisiana Incentive Measure	Target for Measurement Year 2024
FUH \$\$	<b>Follow-Up After Hospitalization for Mental Illness - follow-up within 30 days after discharge</b>	57.69 NCQA Quality Compass 2023 (MY22) Medicaid National 50th percentile (All LOBs [Excluding PPOs and EPOs]; Average) for the year prior to the measurement year



# BACKGROUND

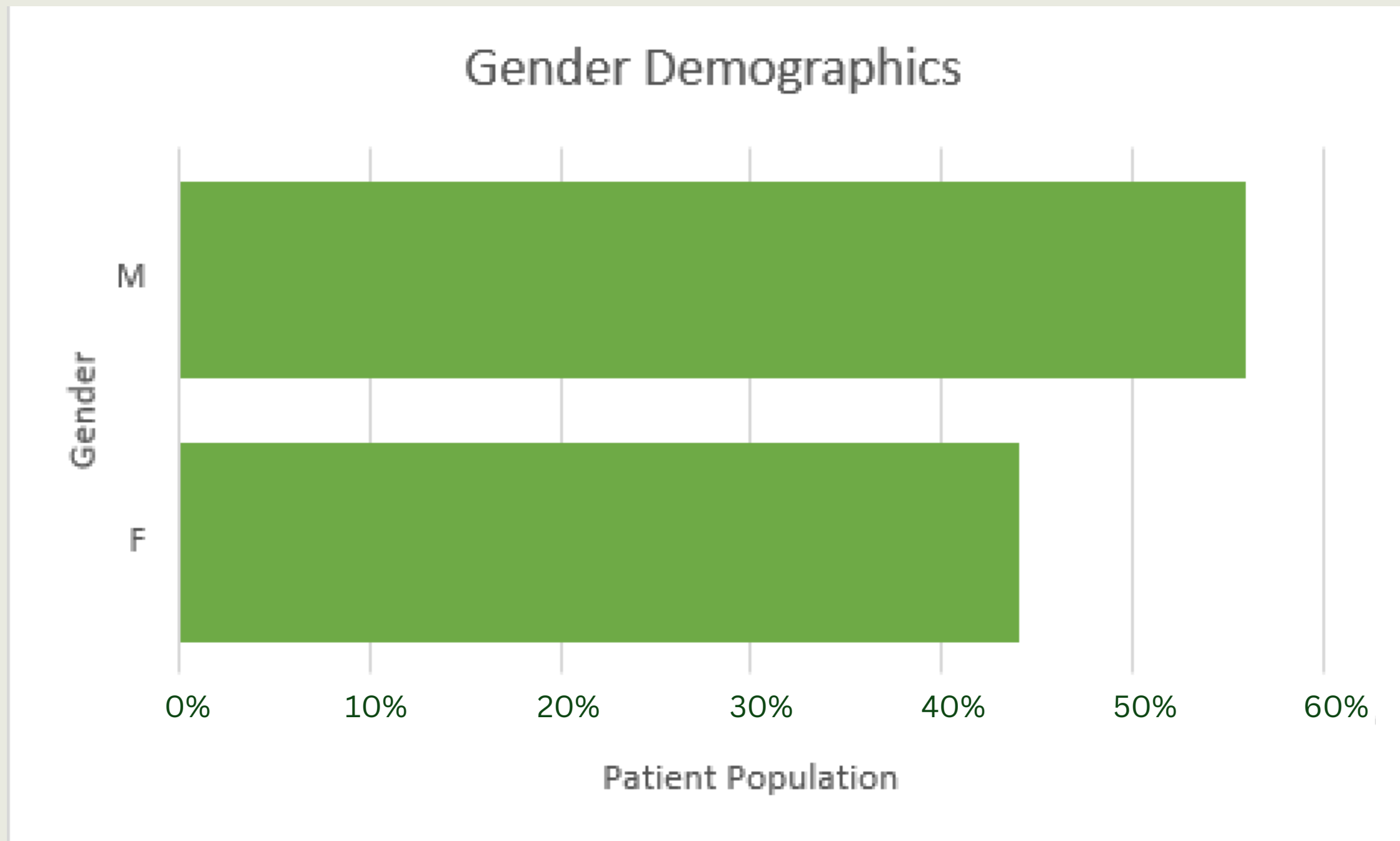
- Close follow-up appointments increase effectiveness of psychiatric care
  - Greater medication adherence
  - Greater utilization of outpatient resources
  - Lower readmission rates in the 180 days following hospitalization
- Known Predicting Factors
  - Prescription management
  - Clinical treatment in the month before admission
  - Case management services in the month before admission
- Struggles
  - Discharges against medical advice
  - Comorbid substance use disorder



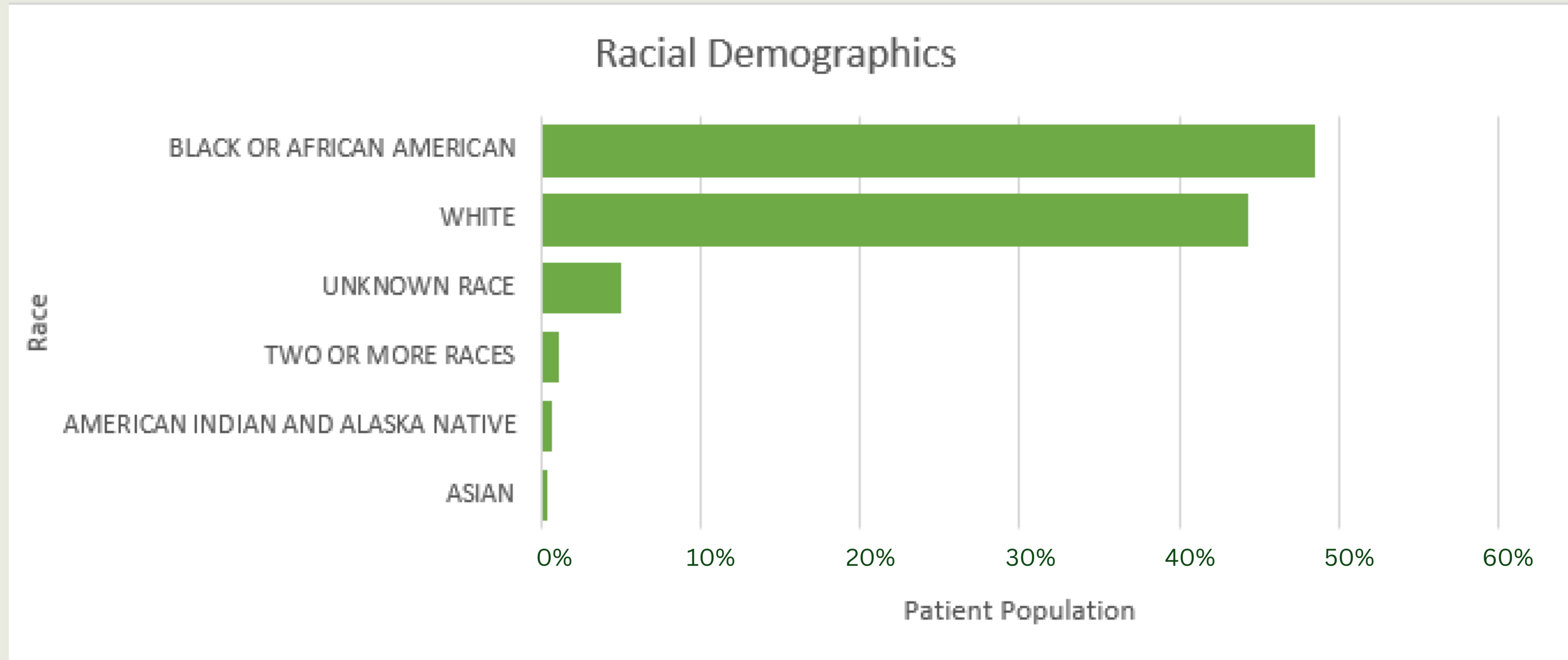
# RESEARCH FOCUS

- Total Population: Members 6+ years of age with a **diagnosis of selected mental illness or intentional self-harm in the calendar year**
- Compliant Population: % of discharges for members 6 years of age 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**
- History of **Primary Care Physician (PCP)** visit in the past calendar year
- History of **Behavioral Health (BH)** visit in the past calendar year
- Demographics
  - Rural/Urban
  - Gender
  - Race

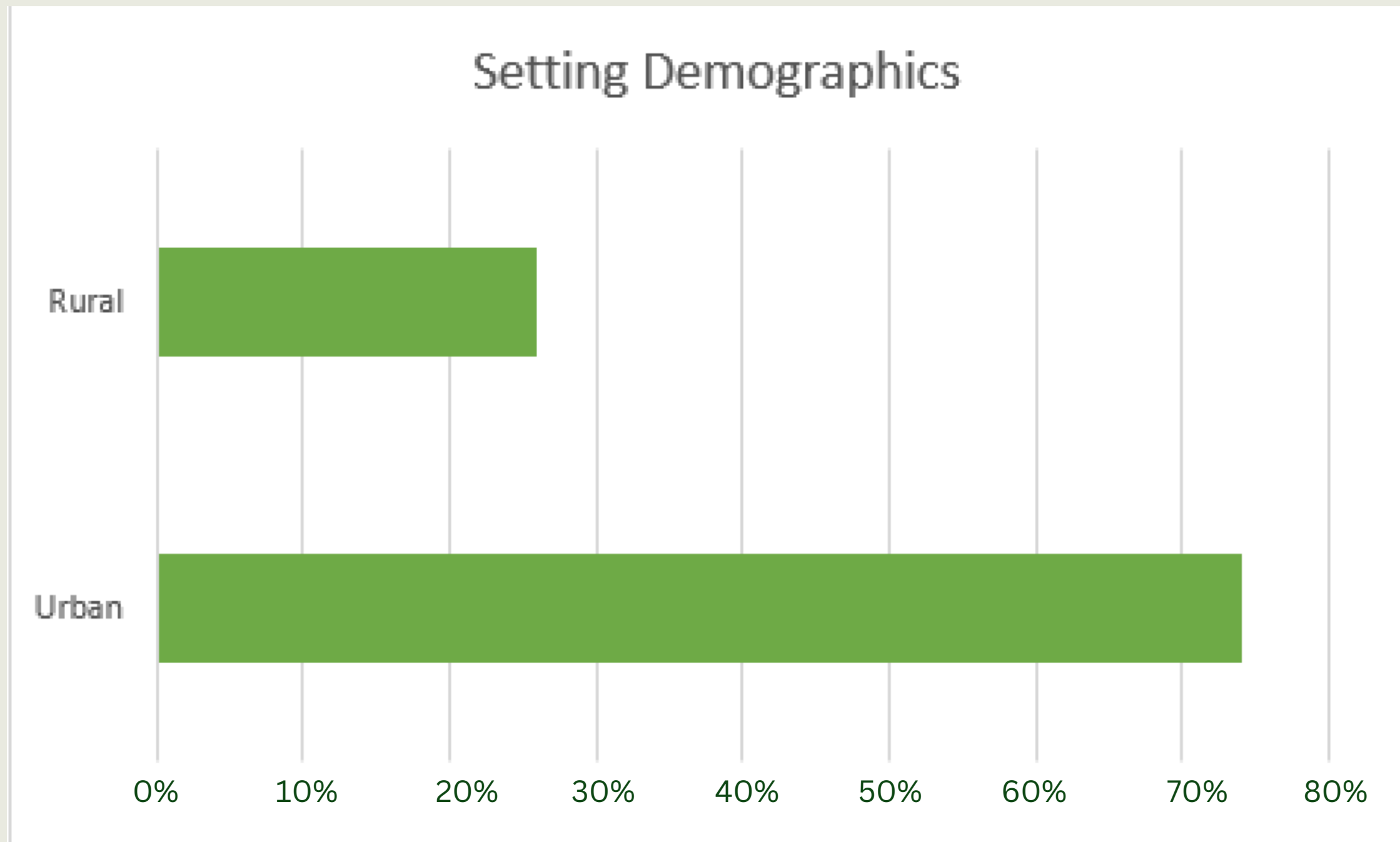
# DEMOGRAPHIC OVERVIEW



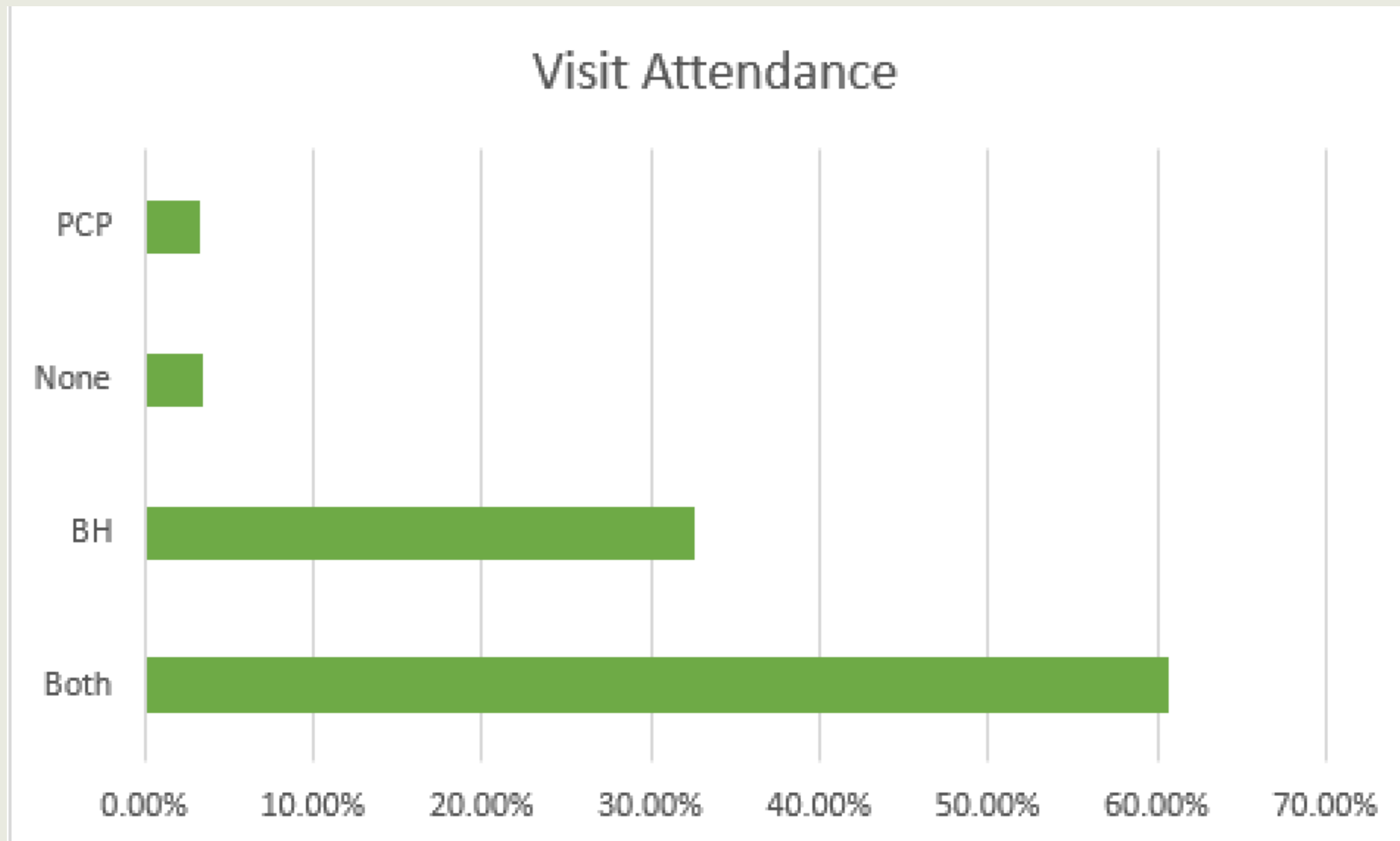
# DEMOGRAPHIC OVERVIEW



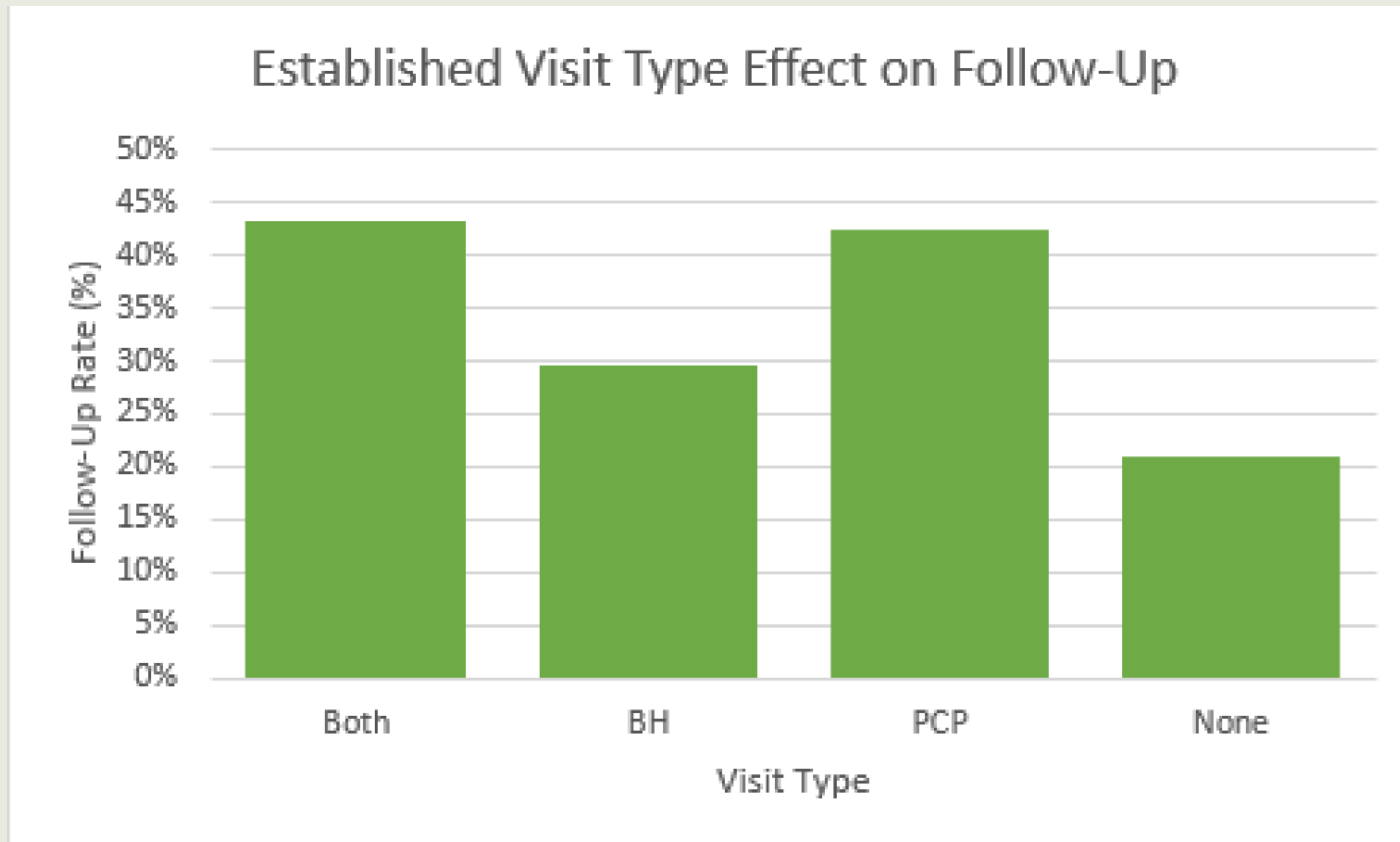
# DEMOGRAPHIC OVERVIEW



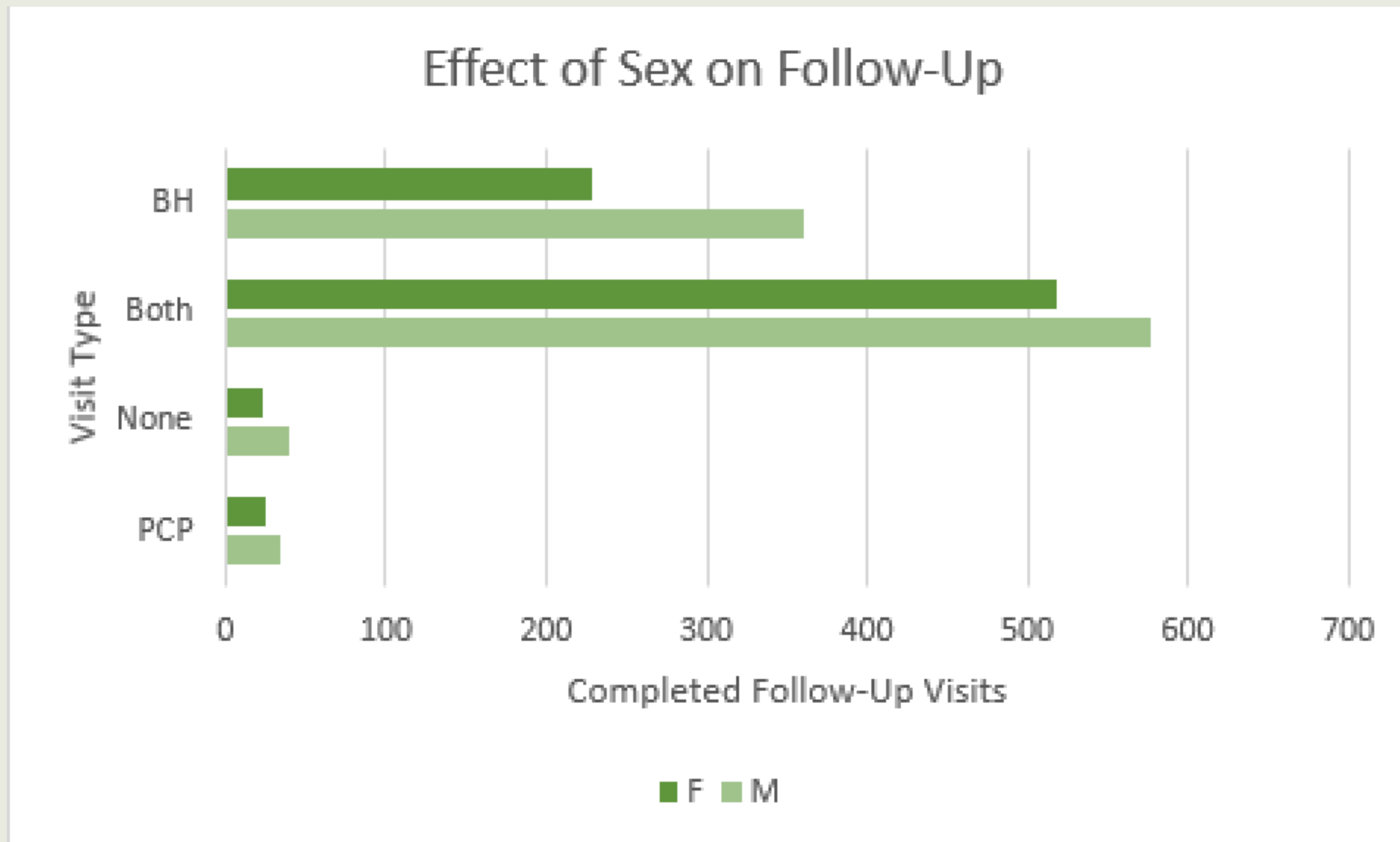
# ESTABLISHED CARE



# EFFECT ON FOLLOW-UP



# EFFECT ON FOLLOW-UP



# ACLA INTERVENTIONS

## FOCUS

## CURRENT STRATEGY

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Enhancing hospital to MCO workflow

- Enhancing real-time admit, discharge, and transfer data exchange
- Review FUH discharges to ensure scheduled follow-up appointment easily visible for member

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Link members to aftercare prior to discharge

- Increase warm hand-offs to BH providers to ensure continuity of care
- Increase face-to-face visits while in-patient
- Broaden follow-up messaging and reminders
- Offer outpatient/telehealth bridge follow-up appointments

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Incentives for follow-up

- Implementing incentive measures for members who complete 30-day follow up with provider type
- Reward for members discharged from ED with complete 30-day follow up

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Interdisciplinary strength

- Enhanced MCO case/care management for aftercare planning
- BH CM staff who hold licensure as LMHPs to outreach to members in FUH population and conduct post-discharge follow-up assessments

# FUTURE RECOMMENDATIONS

## CARE GAP OPPORTUNITIES

## SUGGESTED STRATEGY

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### Appointment Availability

- Scheduling timely post-discharge appointments during discharge planning
- **Focusing on continuity of care within hospital system**

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### Facilitating Transition

- Collaborative discharge planning emphasized in patient billing
- Comprehensive patient education with a **focus on medication management**

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### Interdisciplinary Approach

- Incorporating care coordination and case management teams into established behavioral health appointments
- Involving **family in pre-established primary care visits**

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### PCP Screenings

- Increase **awareness of reimbursement for mental health screening** at primary care visits
- Utilize telemedicine or strategic **proximity of PCP and BH visit locations** at follow-up appointments

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