



Follow-up After Hospitalization HEDIS[®] Measure

Date:



Agenda

- 1 Overview of HEDIS Follow up After Hospitalization Measures
- 2 Behavioral Health Case Management Program
- 3 How to refer to a behavioral health provider
- 4 Facility Follow up After Mental Health Hospitalization Rates
- 5 Open Discussion – Facility Discharge Process and member challenges to aftercare planning

Follow-up after Hospitalization (FUH)

Measure:

FUH - The percent of discharges for members 6 years of age and older who were hospitalized for treatment of select mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider.

Two rates are reported: Percentage of discharges where the member received follow-up

1. within 7 days of their discharge
2. within 30 days of their discharge

Important Information

- Visits that occur on the date of discharge will not count towards compliance
- A successful 7-day appointment will also count towards the 30-day measure
- Telehealth with a behavioral health provider are acceptable to address the care opportunity

Tips & Best Practices

This measure focuses on follow-up treatment, which must be with a mental health provider.

- Schedule member with a mental health provider for a specific date and time to be seen within 7 days of discharge
- If a situation arises where a member is unable to be seen within 7 days, then they need to have an appointment within 30 days of discharge.

Even members receiving medication from their primary care provider still need post-discharge supportive therapy with a licensed mental health clinician such as a therapist or social worker

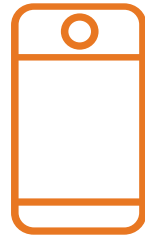
Follow-up after Hospitalization (FUH)

Which Providers and Services Qualify

FUH Measure	Qualifies	Does not Qualify
License types	<ul style="list-style-type: none"> • Licensed social workers • Licensed counselors • Licensed therapists • Psychiatrists • Psychologists • Psychiatric nurses 	<ul style="list-style-type: none"> • Primary care physicians • Drug and alcohol counselors • Non-licensed clinicians
Services	<ul style="list-style-type: none"> • Individual outpatient treatment for mental health • Group/family treatment for mental health • Intensive outpatient treatment for mental health • Partial hospitalization for mental health • Outpatient ECT • Home health services with a mental health provider 	<ul style="list-style-type: none"> • Appointments with a primary care physician (even if for medication management) • Appointments primarily for substance use disorder • School counseling • Pastoral counseling

Telehealth

NCQA allows telehealth (virtual visits) for the Follow up After Hospitalization Measure



Telehealth capabilities will continue to be an opportunity for behavioral health during the pandemic and beyond.

Partnerships in Care Management

Optum Health is the services arm of United Health Group, serving United Healthcare members.

We are seeking to improve patient health, access to care, and transitions back to the community

- Developing robust **onsite** relationships with facility care teams
- Collaborating with In-Network UHC providers and facilities interested in joining our network
- Lending the support of our clinicians to assist in discharge planning
- Providing community follow-up and support to reduce readmissions
- Assisting members to successfully engage in their treatment plans

Our team consists of licensed, professional clinicians (LSW, LCSW, LPC, LMFT, LCADC) and clinical support staff including Community Health Workers (CHW). Team members reside within the state of NJ and are well-versed in their knowledge of community resources to assist members in moving along their care continuum.

Every enrollee admitted with a SUD or MH diagnosis is assigned a care partner who will outreach the facility Social Workers to collaborate on care needs.



Case Management Services

Our telephonic and field visit outreach focus on

- Identification of high-risk members in need of care coordination support
- Providing comprehensive assessments to identify gaps in care and barriers to health
- Creating important linkages between members, providers, and community resources
- Ensuring post-discharge follow up appointments focusing on the 7-day, 30-day and 90-day HEDIS measures
- Facilitating medication management and access as needed
- Educating about complex medical, behavioral health, and healthcare information in easy-to-understand language
- Identifying potential barriers which may impact the member's ability to stabilize in the community
- Preventing unnecessary "rapid readmissions" that may result from gaps in care or other challenges
- Improving better member outcomes by addressing SDOH that can impact access to care



Collaboration Best Practices

Every member is assigned a BHA or CHW who WILL outreach the facility social worker/ discharge planner to collaborate on discharge planning, provide resources, and follow up on community referrals with our members.

For information or to determine who your Optum Care Partner is email:

NEBHCCA@uhc.com

Please provide member name and best contact for our team to outreach.





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