

**MICHIGAN HEALTH  
ENDOWMENT FUND**

Michigan Public Health Institute  
2436 Woodlake Circle  
Okemos, MI 48864

**Racial/Ethnic and  
Geographic Disparities  
in Behavioral  
Healthcare in Michigan  
Medicaid**

*Final Report and  
Recommendations*

**Center for  
Social Enterprise**

March 2021



**HMA**

# CENTER FOR SOCIAL ENTERPRISE

The Center for Social Enterprise (CSE) is driven by creating a social purpose in all our work by addressing social issues and creating positive community change. Our work focuses on applying commercial strategies in the fields of public health and human services with the goal of helping our clients fulfill their mission by delivering high value services. Through our content expertise, we seek innovative solutions to inform policy-making, program development and the advancement of health initiatives.



## PROJECT MANAGEMENT

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Our team keeps projects moving ahead on schedule and on budget, and makes clear, concise communication on all issues a priority.



## POLICY ANALYSIS

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CSE efficiently conducts research, performs insightful analysis, and writes actionable reports on the intersections of public policy and public health.



## FACILITATION

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Our staff is comprised of trained facilitators that specialize in small, medium, and large group facilitations, and can easily navigate multi-sector groups which often have competing interests.



## STAKEHOLDER ENGAGEMENT

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Team members develop engagement frameworks that highlight local knowledge, promote full participation, and lead to optimal results.



## CONTENT EXPERTISE

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The Center includes subject matter experts with years of experience in public health, Medicaid, health information technology, and public policy.



## TECHNOLOGY

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Our personnel effectively deliver training to frontlines public health and service delivery staff on web-based applications that promote health.



## EVALUATION

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Staff develop sound evaluation plans with culturally responsive methodologies.

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# EXECUTIVE SUMMARY

## BACKGROUND:

The Michigan Public Health Institute was asked by the Michigan Health Endowment Fund to support the development of a community-based initiative to address racial/ethnic disparities in behavioral healthcare. MPHI took a data-driven approach to development of baseline disparities data, thereby ensuring principles of performance assessment and health equity were foundational elements. The goal of this work is to provide Health Fund program leadership with a valid data set to incorporate into their decision-making process, and to support ongoing efforts with reliable performance measurement in selected areas. The Center for Social Enterprise (CSE) at MPHI led this work and contracted with Health Management Associates (HMA).

“Many pilots, demonstrations, and grant projects focus on making the system perform better for everyone—that is not unreasonable. But in a state where the quality of behavioral healthcare in the Medicaid program is better than half the country, overall quality is not enough, because when the data are disaggregated, there is no equity.”

## METHODOLOGY:

Medicaid claims and encounter data were pulled from the Data Warehouse for calendar years 2018, 2019, and 2020 (to the extent available considering claims lag). Data were aggregated at the county and Prepaid Inpatient Health Plan (PIHP) region level. Numerators and denominators for individual measures were generated for each racial/ethnic category, which is self-reported at the time of application to the Medicaid program. Rates were established for each racial/ethnic group in specified counties and PIHP regions, for all three reporting years. County wide and statewide performance rates for each measure were also calculated and graphed alongside disaggregated race/ethnicity data, to establish overall quality of care in the county, in addition to disparity.

## HIGHLIGHT OF FINDINGS:

Disparities in quality of care exist in all counties and PIHP regions, for most measures.

For the Follow-up after Emergency Department (ED) visit for alcohol and other drug abuse dependence measure (FUA), a consistent, large disparity stems across counties and time periods. **ALL COUNTIES** have a double-digit gap between Black and White patients in **ALL YEARS**. Quality of care in all counties is worsening overall, with rates decreasing over time. Follow up after Hospitalization (FUH) and ED visit for mental illness (FUM) have the smallest disparities by race/ethnicity, with some counties exhibiting better quality for Black patients. The Initiation and Engagement of alcohol and other drug abuse or dependence treatment (IET) measure shows consistent disparities across counties, with some counties showing greater variance in disparity over time. *Rates for White patients consistently exceeded the Statewide rates across measures and counties.*

# EXECUTIVE SUMMARY

## RECOMMENDATIONS:

As a result of the analysis, it is recommended that the initiative be based *on county-level data*, not PIHP region. While some counties and PIHP regions are the same (Macomb, Oakland, Wayne), most PIHP regions cover many counties. Though this is a benefit for the purposes of data analysis (larger population=higher numbers for the numerator and denominator counts), this level of analysis is not ideal for a community-based intervention.

The rubric for scoring proposals and ultimately, decision on awardees should ensure that the level of intervention is appropriate for the point in the system at which the disparity exists. The FUA, FUM, and FUH measures are indicators of access to care in the community after an event at the hospital (ED visit or inpatient stay), so an intervention aimed at reducing the disparity in those measures would include an aspect of discharge planning with a nurse, social worker, or community health worker/navigator.

As this project is specific to reducing racial/ethnic disparities to achieve equity, a 'rising tides raises all boats' ideology is not appropriate. This is not simply a performance improvement project aimed at raising the county or statewide average for these measures. Overall quality of care should be maintained, but the emphasis ought to be on ensuring that patients of color receive appropriate and timely service.

A separate approach should be considered for rural areas. Fundamental population differences in urban vs. rural areas limit the use of traditional statistical analyses. For rural areas, MPHI recommends starting with an altered approach that includes these quantitative data but also incorporates other strategies such as utilizing qualitative data methods (surveys, interview, or focus groups), asset mapping, SWOT analysis, and social vulnerability index.

## Additional Recommendations

- Incorporate significant expertise in system wide performance assessment in behavioral health into the RFP planning and evaluation process.
- Ongoing analysis of these same measures and methodology for all communities, with particular emphasis on communities funded through this initiative.
- Additional asset mapping to determine the extent to which county/regional resources may impact potential success of the initiative.
- Expansion of the measure set to other aspects of the system of care.

## BACKGROUND

The Michigan Public Health Institute (MPHI) was contracted by the Michigan Health Endowment Fund to support the development of a community-based initiative to address racial/ethnic disparities in behavioral healthcare. The Center for Social Enterprise (CSE) at MPHI took a data-driven approach to development, thereby ensuring principles of performance assessment and health equity were foundational elements of the Health Fund's unique and admirable philanthropic endeavor. Both MPHI and the Health Fund sought to establish a framework for future racial disparity/health equity efforts, starting with essential knowledge about equity and quality. MPHI engaged Health Management Associates (HMA) as a subcontractor.

Health disparities are a particular type of health difference that are closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, or other characteristics historically linked to discrimination or exclusion. Health equity is the principle underlying the commitment to reduce and eliminate those disparities. Equity means the resources and opportunities needed to pursue optimal potential is available to them regardless of their race, gender, religion, sexual orientation, ability status, income level, or other category of power and privilege.

Quality of care is the extent to which health care services provided improve the desired health outcome. It means that clinical practice guidelines for safe, effective, timely, efficient, equitable care are being followed. An example of a clinical practice guideline is this: people with Diabetes Mellitus (DM) should have their blood glucose checked regularly. To measure the quality of care for following this protocol, we would measure the number of people with DM who received the blood glucose test (the numerator) and divide by the number of people with DM (the denominator) in the population. If 85 people with DM received their blood glucose check out of 100 total people with DM at a clinic, the rate for this quality measure is 85%.

If we were to disaggregate these data by race/ethnicity, a different story of quality emerges. For example, let's assume that out of the 100 people at the clinic with DM who needed a blood glucose check, 60 of them were White and 40 of them were Black. We can then repeat the quality measure performance calculation for each racial group. If 55 White people and 30 Black people with DM got their appropriate blood glucose check, that would represent a performance rate of 92% (55/60) for White people and 75% (30/40) for Black people. The overall performance rate for the full population is still 85%, but without disaggregating the data by race, a key indicator of quality is missed—equity.

***Without equity, there is no quality.***

This project seeks to explore data-driven ways to address racial disparities in quality of care by highlighting key geographic instances of inequity in strategic measures of behavioral health quality of care.

# METHODOLOGY

## MEASURES:

MPHI developed a methodology to analyze the geographically defined racial disparities in key behavioral health quality of care measures. Four (4) measures were selected for this analysis and approved by the Behavioral Health team at the Health Fund. These measures are nationally standardized, with defined specifications applied across each measurement year and in each geographic area. Measure specifications are included as an appendix to this report.

The following measures were used:

- 1) Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse Dependence within 30 days (FUA-30). This measure is defined as the percentage of emergency department visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD with 30 days of the ED visit,
- 2) Follow-up after Emergency Department Visit for Mental Illness within 30 days (FUM-30). This measure is defined as the percentage of emergency department visits for members 18 years and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness withing 30 days of the ED visit,
- 3) Follow-up after Hospitalization for Mental Illness within 30 days (FUH-30). This measure is defined as the percentage of discharges for members 18 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days after discharge.
- 4) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment within 34 days (IET-34). This measure is defined as the percentage of adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.

## DATA SOURCE AND ANALYTICS:

Claims and encounter data from the Michigan Data Warehouse were used to calculate nationally standardized measurement specifications for behavioral health quality of care indicators. Measures were then stratified by race/ethnicity and county to determine local instances of racial inequity in the provision of clinically necessary healthcare. The Michigan Department of Health and Human Services (MDHHS) was consulted throughout the analysis. Race and ethnicity are self-reported at the time of application for Medicaid. The data are complete for approximately 80-85% of all Medicaid beneficiaries. The Data Warehouse vendor, Optum, employs the Symmetry measures engine, which adheres to the measure specifications included in the appendix. A full set of accompanying diagnosis and procedure codes used in the specifications is forthcoming.

Each measure was trended over 3 reporting periods: calendar year (CY) 2018, 2019, and half of CY 2020 (January 1 to June 30, 2020). When the full set of CY2020 data are available, results will be updated.

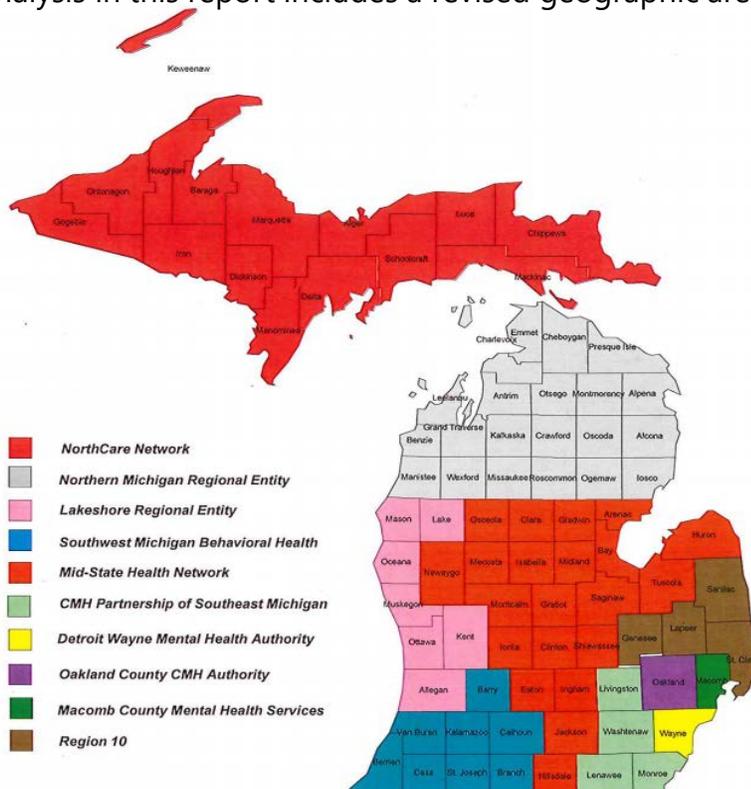
# METHODOLOGY

## GEOGRAPHIC ANALYSIS: Counties and PIHP regions

The geographic analysis focused on reviewing these measures by race/ethnicity at the County level. Detailed analysis of all 83 counties in Michigan was not feasible, nor would it have yielded discernable differences in the experience of people of color when compared to the most populated counties in Michigan. Therefore, MPHI chose nine (9) large counties to review the performance rates of the four quality measures by race/ethnicity.

- Genesee
- Ingham
- Kalamazoo
- Kent
- Macomb
- Oakland
- Saginaw
- Washtenaw
- Wayne

Public mental health services are paid for and monitored/managed by ten (10) prepaid inpatient health plans (PIHPs) covering between 1 and 21 counties each, ultimately providing coverage for all 83 counties in the state. MPHI analyzed quality of care by race/ethnicity for the remaining parts of the state not included in the county-level analysis by calculating performance rates by PIHP region. Regions that include one of the individual counties above were modified to exclude that county. For example, the Lakeshore Regional Entity covers seven counties, including Kent. Kent county was measured separate from the rest of LRE. The analysis in this report includes a revised geographic area for LRE that does NOT include Kent.



- Lakeshore Regional Entity (except Kent)
- Southwest Michigan Behavioral Health (except Kalamazoo)
- Mid-State Health Network (except Ingham and Saginaw)
- CMH Partnership of Southeast Michigan (except Washtenaw)
- Region 10 (except Genesee)
- Northcare Network
- Northern Michigan Regional Entity

# METHODOLOGY CONT.

## Data Source and Analytics continued:

Racial comparisons used the White rate as the reference rate when defining a racial inequity. Racial groups were suppressed from the racial comparison analysis when the numerator was less than 5 or the denominator was less than 30. These data were included, however, in the overall county and State rates despite being excluded in the individual racial comparison analysis.

In addition to reviewing racial inequities by geographies (both County and PIHP region), the CSE compiled a set of national benchmarks for performance on the selected measures and compared the overall State performance rates for each selected measure to national benchmarks. While the primary purpose of the analysis is to direct local efforts in addressing racial inequities occurring in their existing public mental health system, the comparisons to national benchmarks illustrate both the opportunity the State has in achieving high standards of excellence by attaining equity in quality of care and also the tendency for racial inequities to be disguised behind overall State performance rates that compare favorably to national benchmarks when performance rates are not disaggregated by race/ethnicity.

## Logic of the Analytic Visualization:

Data presented in the results slides grows progressively denser. The following pages give examples of each step.

**Step 1:** The analysis begins by presenting the performance rates for each measure stratified by racial/ethnic in each county. These multi-color line graphs include the  $n$  (denominator) for each racial group, compare each racial group over time, and compare these racial group rates to the overall county and State rates for the measure over time. Each graph will highlight specifically the percentage point difference between the Black and White performance rates, or the Black/White gap as the report refers to it, for each measure. The African American/Black population is the largest racial group outside of the White reference population, which allows for consistent measurement over time. This report will use Genesee County as an example.

**Step 2:** Summaries of the Black/White gap for each measure for each county are displayed next, in the green bar graphs. These graphs will demonstrate the specific inequity when comparing the African American/Black performance rates for each measure to the White reference population for each county. The demonstration will highlight differences in racial inequity by measure within the same county.

**Step 3:** The Black/White gaps for each county for each measure are then compared to one another in the final set of multi-color line graphs, showing differences in inequity by measure across counties, as well as commonalities in disparities across counties for specific measures. The analysis then show these same comparisons in Black/White gap for each measure across PIHP regions. The intent is to illustrate how these racial/ethnic disparities show up in the rest of the State (outside of the 9 counties at the center of the analysis).

The full set of graphs for all counties and PIHP regions are included under separate cover, *Individual County and PIHP Region Graphs*.

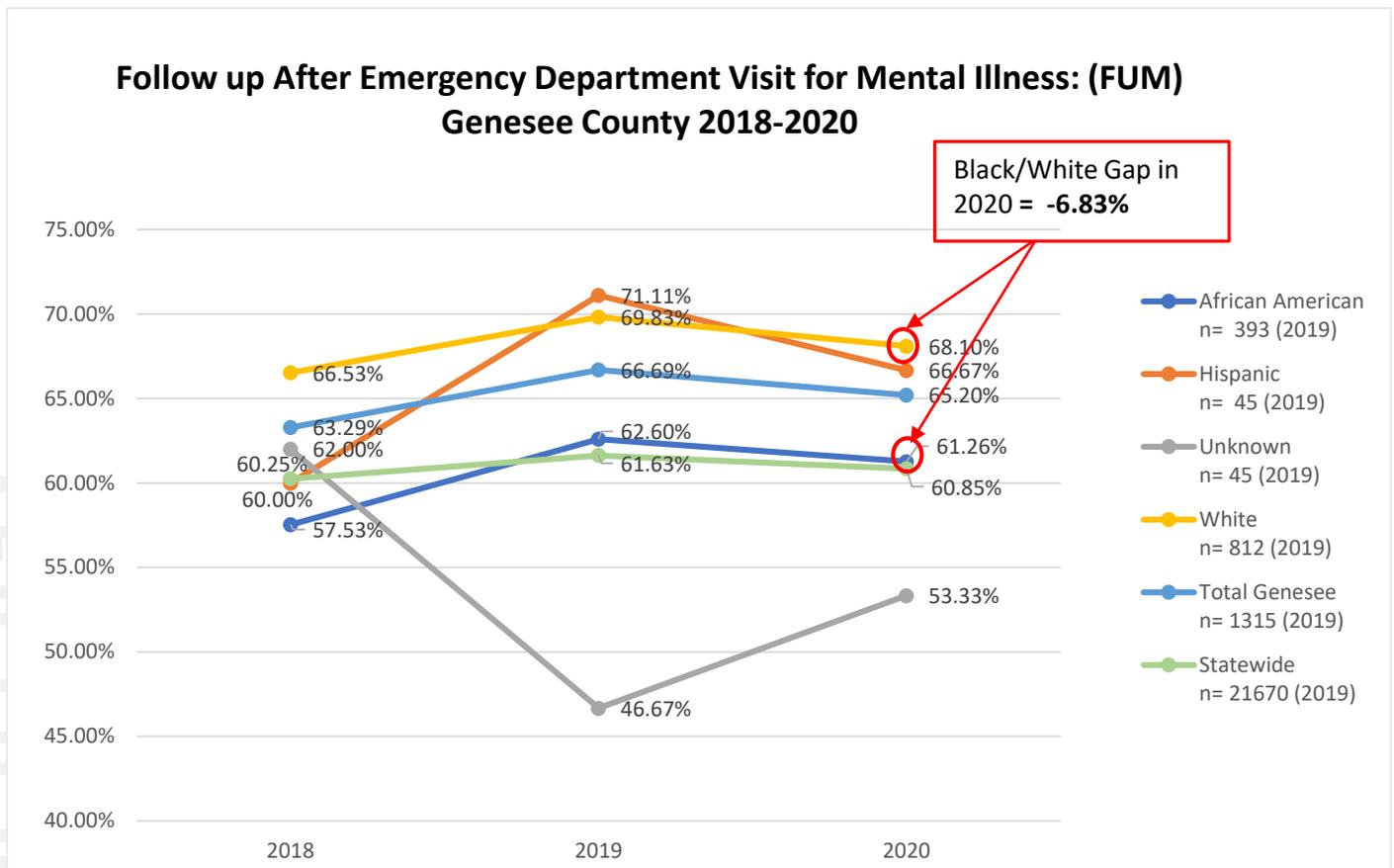
# METHODOLOGY CONT.

## Logic of the Analytic Visualization:

Data presented in the results slides grows progressively denser.

### STEP 1 Analysis Example:

Single Measure, Individual County, All Racial/Ethnic Populations (Genesee)



The full set of graphs for all counties and PIHP regions are included under separate cover, *County and PIHP Region and National Benchmark Graphs*.

# METHODOLOGY CONT.

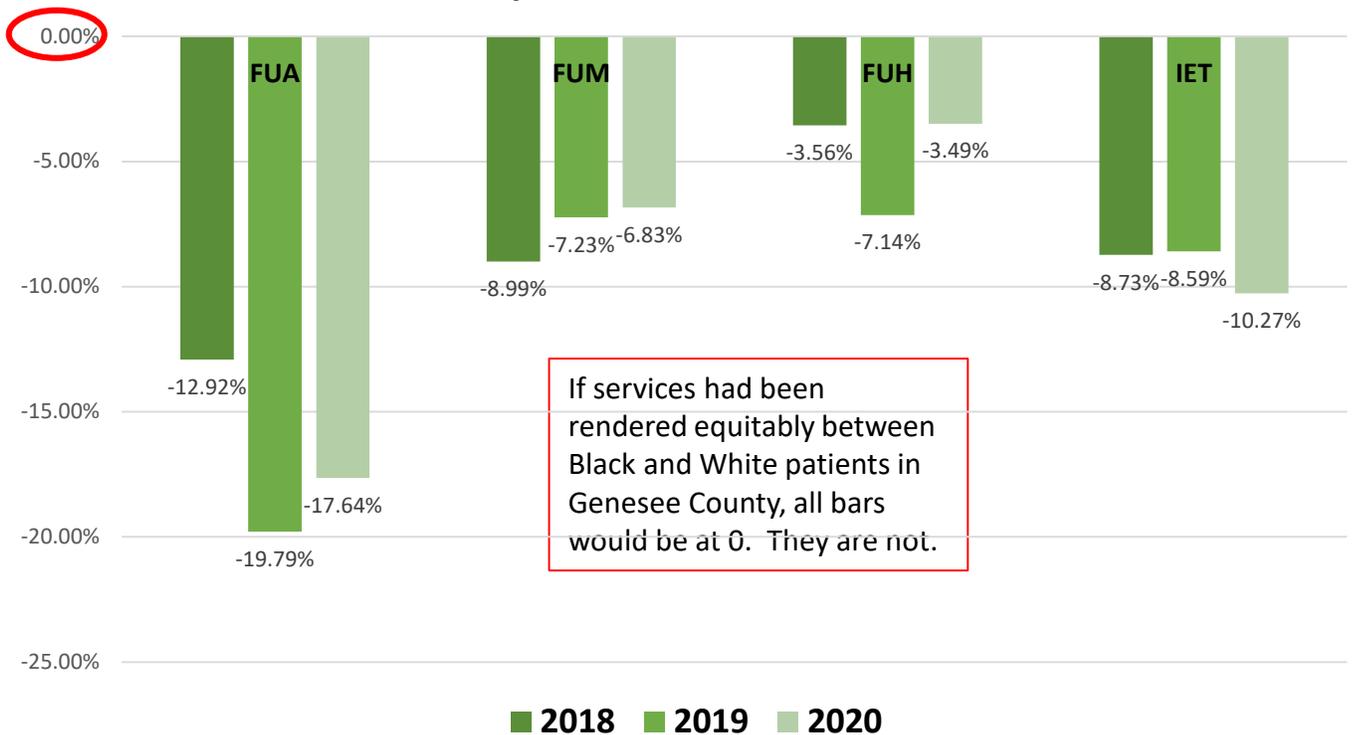
## Logic of the Analytic Visualization:

Data presented in the results slides grows progressively denser.

### STEP 2 Analysis EXAMPLE:

All Measures, Single County Black/White Gap  
(Genesee)

#### Genesee County Behavioral Health Services Black/White Gap: Key Measures for 2018-2020



The full set of graphs for all counties and PIHP regions are included under separate cover, *County and PIHP Region and National Benchmark Graphs*.

# METHODOLOGY CONT.

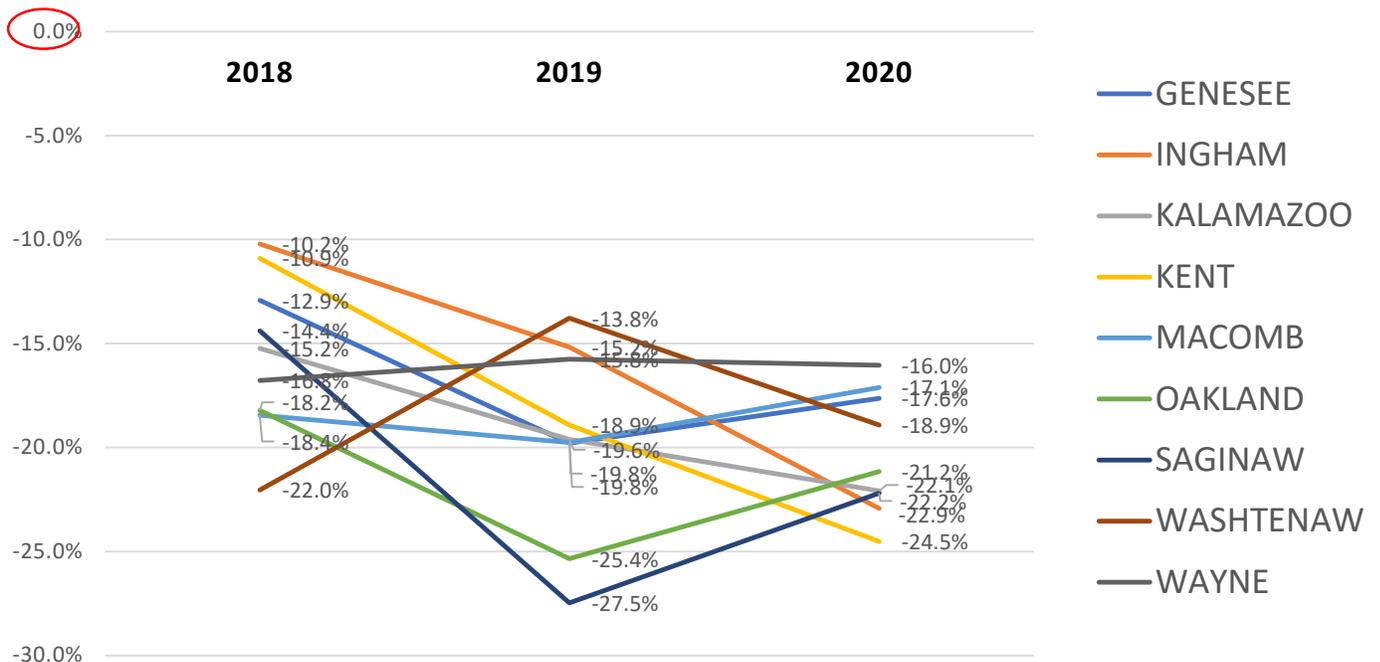
## Logic of the Analytic Visualization:

Data presented in the results slides grows progressively denser.

### STEP 3 Analysis EXAMPLE:

All Counties, Single Measure Black/White Gap

**Follow up after ED Visit for Alcohol and Other Drug Abuse  
Dependence-30 Days (FUA)  
Black/White Gap 2018-2020**



The full set of graphs for all counties and PIHP regions are included under separate cover, *County and PIHP Region and National Benchmark Graphs*.

# RESULTS

## County-level

There were racial/ethnic disparities in quality of care in all counties in all years for most measures. There were differences in the extent of the disparity depending on the measure, county, and year. County-level rates for the White population are consistently higher than the statewide average. Despite considerable racial/ethnic and geographic disparities, Michigan statewide rates consistently exceed national benchmarks overall, demonstrating a high level of quality across the Medicaid program for all measures.

### **FUA**

Follow up after ED visit for alcohol and other drug abuse dependence (FUA) consistently demonstrates the widest gap between Black and White patients. This measure has the largest B/W gap in each county in every year, with a double-digit gap in all years in all years. For seven of the nine counties studied, the B/W gap got larger between 2018 and 2019. Full year results are not yet available for 2020. Washtenaw and Wayne counties were the only two that demonstrated a reduction in disparity between 2018 and 2019 for the FUA measure. Even with improvement, the B/W gap was 13.8 percentage points for Washtenaw county and 15.76 percentage points for Wayne county, on a measure in which the statewide average was 28.6%.

### **FUM and FUH**

The follow up after ED visit for mental illness (FUM) and follow up after hospitalization for mental illness (FUH) measures have the smallest disparities, with some counties exhibiting better quality of care for Black patients in some years. Saginaw county improved in FUH over time, while Ingham essentially remained flat. Kalamazoo was near equitable in FUM over time. These are the only two measures of the initial measure set that demonstrate equity or higher quality for Black patients. While Kalamazoo county demonstrates near equity for the FUM measure, and a very small disparity for the IET measure, it demonstrates a large disparity for the FUA measure, which gets progressively worse over the course of the measurement period. Oakland county demonstrates better quality of care for Black patients in 2018 for the FUH measure, with some loss of ground by 2020, with a 1.38 percentage point B/W gap. Conversely, the B/W gap in Oakland county for the FUA measure is one of the largest encountered in this project, at 25.3 percentage points in 2019. Similarly, while Saginaw demonstrates near equity in 2018, and better quality of care for Black patients in 2020 for the FUH measure, the Saginaw county B/W gap for the FUA measure is the largest in this data set, at 27.47 percentage points in 2019.

### **IET**

The initiation and engagement measure (IET34) shows consistent disparities across counties, with some counties showing greater variance in disparity over time. Ingham county started in the middle of the pack and improved to the smallest disparity over time at 2.55 percentage points. Kalamazoo county started with the smallest disparity and got worse over time, while Saginaw county remained essentially unchanged around 6-7 percentage points across the study period. The B/W gap in Oakland county was over 18 percentage points in 2018 and improved drastically in 2019 and 2020 to 8.6 percentage points.

# RESULTS

Revised PIHP Region is the PIHP region *minus* the most populous county.

## Revised PIHP Region

There were racial/ethnic disparities in quality of care in the majority of revised PIHP regions for most measures across time. In the case of some revised PIHP regions, small *n*'s may have contributed to large fluctuations across time exhibiting black/white gaps in care in both directions. While exhibiting slight increases/decreases in 2019, very few revised PIHP region gaps for any measure showed much change from 2018 to 2020 overall. For revised PIHP regions with relatively consistent gaps over time, racial/ethnic disparities in quality of care persisted for all years and all measures.

### FUA

Follow up after ED visit for alcohol and other drug abuse dependence (FUA) showed the consistently widest Black/White gaps for the largest proportion of revised PIHP regions. The disparity for FUA got worse over time for revised PIHP regions, whereas other measures showed some revised PIHP regions improving over time.

### FUH

The follow up after hospitalization for mental illness (FUH) measure showed some improvement over time for most revised PIHP regions, although some showed a worsening disparity similar to FUA. In some instances, the revised PIHP region (such as Lakeshore) improved year over year, while the excluded county (Kent) stayed constant over that same time period.

### FUM

Follow up after ED visit for mental illness (FUM) exhibited large Black/White gaps for some revised PIHP regions (second only to FUA), as well as increasing disparity over time. Disparities for some Revised PIHP regions (Southwest, Southeast, and Region 10) exceeded the gaps demonstrated by the excluded County for some years.

### IET

The initiation and engagement measure (IET) demonstrated consistent Black/White gaps over time for several revised PIHP regions, rarely approaching the large gaps shown in measures such as FUA and FUM. Both Southeast and Region 10 gaps got bigger over time, while their excluded counties (Washtenaw and Genesee, respectively) stayed relatively constant over time.

# RECOMMENDATIONS

RECOMMENDATIONS

## Level of Analysis

Rigorous statistical analysis is necessary for appropriate evaluation of interventions in a healthcare system. However, the nature of such analysis renders useless any dataset in which there are not sufficiently large numerators or denominators to establish rates in a given measurement period. For this reason, it is recommended that the Health Fund use county level data, not revised PIHP regional data. In removing the most populated counties from the PIHP regions, there are very few beneficiaries meeting the numerator and denominator criteria in those regions. The same logic applies to analysis of rural areas. There should be an additional effort, not centered on quantitative data, to define potential awardees in rural areas. Rural counties may also lack the infrastructure necessary to compete with urban counties

## Asset Mapping

It is also recommended that a systematic review of local contextual factors be conducted for each county including CBO infrastructure, faith organizations, and existing initiatives in place that can contribute to overall success. Medicaid demonstrations and pilots currently exist throughout the state that may impact or potentially impact the success of the Health Fund proposed initiative. Health Homes, Community Health Innovation Regions (CHIRs) Certified Community Behavioral Health Clinics (CCBHCs), and other community-based initiatives exist in many counties used in this analysis. Careful consideration of these assets should be made.

## Proposal Process

The Health Fund should ensure that its values are infused throughout the proposal and award process. Scoring rubric and criteria should include a requirement that applicant organizations are anchored in health equity, with diverse membership and, especially, leadership. The nature of systemic and institutional racism is power. When power is not shared by those who have been historically marginalized, disparities are inevitable.

It is recommended that the proposal evaluation process examine the extent to which the level of intervention is appropriate for the point in the system at which the disparity exists. The FUA, FUM, and FUH measures are indicators of access to care in the community after an event at the hospital (ED visit or inpatient stay), so an intervention aimed at reducing the disparity in those measures would include an aspect of discharge planning with a nurse, social worker, or community health worker/navigator. The IET measure is an access to care measure not based on a hospital event, so an appropriate intervention may not necessarily need to include anyone from the hospital.

It is further recommended that the Health Fund ensure a significant level of expertise is available to the proposal evaluation committee in the areas of system-wide performance assessment in behavioral health.

## RECOMMENDATIONS CONT'D

### **Focus on Disparities Reduction**

As this project is specific to reducing racial/ethnic disparities to achieve equity, a 'rising tides raises all boats' ideology is not appropriate. This is not simply a performance improvement project aimed at raising the county or statewide average for these measures. Overall quality of care should be maintained, but the emphasis ought to be on ensuring that patients of color receive appropriate and timely service. Many pilots, demonstrations, and grant projects focus on making the system perform better for everyone—that is not unreasonable. But in a state where the quality of behavioral healthcare in the Medicaid program is better than half the country, overall quality is not enough because when the data are disaggregated, there is no equity.

### **Ongoing Analysis and Expansion of Measure Set**

Ongoing analysis of these same measures and methodology should continue for all communities, with particular emphasis on communities funded through this initiative. Trends in quality, access, utilization, and outcomes are impacted by many more factors than individual projects alone. It will be important to continue tracking these measures in all nine counties to account for those environmental changes and establish 'control' counties against which to compare to grantees.

The measure set should be expanded to include measures that focus on other aspects of the system of care. As grantees begin their project planning, they may wish to target interventions that aren't readily measurable with the existing data set. Many more measures exist to define quality of care. It is recommended that the Health Fund begin exploring additional measures including those specific to children, opioids, and provider capacity to name a few.

# APPENDIX A: Measure Specifications

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These specifications are the property of the National Committee for Quality Assurance (NCQA) and cannot be published without their permission.

## Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

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### SUMMARY OF CHANGES TO HEDIS MY 2020 & MY2021

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- Added value sets to the numerators.

#### Description

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

#### Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	13 years and older as of the ED visit. Report two age stratifications and a total rate: <ul style="list-style-type: none"> <li>• 13–17 years.</li> <li>• 18 and older.</li> <li>• Total.</li> </ul> <p>The total is the sum of the age stratifications.</p>
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefit	Medical and chemical dependency.  Note: Members with detoxification-only chemical dependency benefits do not meet these criteria.
Event/diagnosis	An ED visit ( <u>ED Value Set</u> ) with a principal diagnosis of AOD abuse or dependence ( <u>AOD Abuse and Dependence Value Set</u> ) on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period, as described below.

**Multiple visits in a 31-day period** If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

**ED visits followed by inpatient admission** 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. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

## Administrative Specification

**Denominator** The eligible population.

### Numerators

**30-Day Follow-Up** A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

**7-Day Follow-Up** A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit:

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- ODU Weekly Non Drug Service Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- ODU Monthly Office Based Treatment Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- ODU Weekly Drug Treatment Service Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence ValueSet).
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence ValueSet).
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

#### Note

- Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (within 30 days after the ED visit or within 7 days after the ED visit).

#### Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUA-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

	Administrative
Measurement year	✓
Eligible population	For each age stratification and total
Numerator events by administrative data	Each of the 2 rates for each age stratification and total
Numerator events by supplemental data	Each of the 2 rates for each age stratification and total
Reported rate	Each of the 2 rates for each age stratification and total

## Rules for Allowable Adjustments of HEDIS

This section may not be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the Guidelines for the Rules of Allowable Adjustments of HEDIS for additional information.

Rules for Allowable Adjustments for Follow-Up After Emergency Department Visit for AOD Abuse or Dependence

NONCLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination date(s) may be changed (i.e., age 13 as of ED visit). Changing denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Event/Diagnosis	Yes, with limits	Only events and diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. Note: Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an emergency department visit with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow up visit for AOD).
Denominator Exclusions	Adjustments Allowed (Yes/No)	Notes
Exclusions	NA	There are no exclusions for this measures.
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
<ul style="list-style-type: none"> <li>● 30-Day Follow-Up</li> <li>● 7-Day Follow-Up</li> </ul>	No	Value sets and logic may not be changed.

## Follow-Up After Hospitalization for Mental Illness (FUH)

### SUMMARY OF CHANGES TO HEDIS MY 2020 & MY2021

- Replaced “mental health practitioner” with “mental health provider.”
- Removed the mental health provider requirement for follow-up visits for intensive outpatient encounters, partial hospitalizations, community mental health centers and electroconvulsive therapy settings.
- Added visits in a behavioral healthcare setting to the numerator.
- Added telephone visits to the numerator.
- Deleted the Mental Health Practitioner Value Set.
- Revised the instructions in the Notes for identifying mental health providers.

### Description

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. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

### Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of discharge. Report three age stratifications and total rate: <ul style="list-style-type: none"> <li>• 6–17 years.</li> <li>• 18–64 years.</li> <li>• 65 years and older.</li> <li>• Total.</li> </ul>
Continuous enrollment	The total is the sum of the age stratifications. Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefits	Medical and mental health (inpatient and outpatient).
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm ( <u>Mental Illness Value Set</u> ; <u>Intentional Self-Harm Value Set</u> ) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Acute  
readmission or  
direct transfer

Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge.

Nonacute  
readmission or  
direct transfer

Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

### Administrative Specification

Denominator      The eligible population.

Numerators

30-Day Follow-Up      A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.

7-Day Follow-Up      A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider.

- An outpatient visit (BH Outpatient Value Set) with a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) with (Community Mental Health Center POS Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
- A telehealth visit: (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider.
- An observation visit (Observation Value Set) with a mental health provider.
- Transitional care management services (Transitional Care Management Services Value Set), with a mental health provider.
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
- A telephone visit (Telephone Visits Value Set) with a mental health provider.

#### Note

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- Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).
- Refer to Appendix 3 for the definition of “mental health provider.” Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.

**Data Elements for Reporting**

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUH-1/2/3: Data Elements for Follow-Up After Hospitalization  
for Mental Illness

	Administrative
Measurement year	✓
Eligible population	For each age stratification and total
Numerator events by administrative data	Each of the 2 rates for each age stratification and total
Numerator events by supplemental data	Each of the 2 rates for each age stratification and total
Reported rate	Each of the 2 rates for each age stratification and total

**Rules for Allowable Adjustments of HEDIS**

This section may not be used for reporting health plan HEDIS.

NCQA’s Rules for Allowable Adjustments of HEDIS describe how NCQA’s HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the Guidelines for the Rules of Allowable Adjustments of HEDIS for additional information.

Rules for Allowable Adjustments for Follow-Up After Hospitalization for Mental Illness

NONCLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, “age as of June 30”). Changing the denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Event/Diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify inpatient stays and diagnoses. Value sets and logic may not be changed.  Note: Organizations may assess at the member level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of members who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses who had a follow-up visit with a mental health practitioner).
Denominator Exclusions	Adjustments Allowed (Yes/No)	Notes
Optional Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
<ul style="list-style-type: none"> <li>● 30-Day Follow-Up</li> <li>● 7-Day Follow-Up</li> </ul>	No	Value sets and logic may not be changed.

## Follow-Up After Emergency Department Visit for Mental Illness (FUM)

### SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Added telephone visits, e-visits and virtual check-ins to the numerator.

#### Description

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. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

#### Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of the ED visit. Report three age stratifications and total rate: <ul style="list-style-type: none"> <li>• 6–17 years.</li> <li>• 18–64 years.</li> <li>• 65 years and older.</li> <li>• Total.</li> </ul> <p>The total is the sum of the age stratifications.</p>
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefit	Medical and mental health.
Event/diagnosis	An ED visit ( <u>ED Value Set</u> ) with a principal diagnosis of mental illness or intentional self-harm ( <u>Mental Illness Value Set</u> ; <u>Intentional Self-Harm Value Set</u> ) on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit. <p>The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.</p>

Multiple visits in a 31-day period	<p>If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.</p> <p>Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.</p>
ED visits followed by inpatient admission	<p>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 (31 total days), regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Identify the admission date for the stay.</li> </ol> <p>These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.</p>

### Administrative Specification

Denominator      The eligible population.

#### Numerators

30-Day Follow-Up      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). Include visits that occur on the date of the ED visit.

7-Day Follow-Up      A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

Note

- Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (within 30 days after the ED visit or within 7 days after the ED visit).

**Data Elements for Reporting**

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUM-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Mental Illness

	Administrative
Measurement year	✓
Eligible population	For each age stratification and total
Numerator events by administrative data	Each of the 2 rates for each age stratification and total
Numerator events by supplemental data	Each of the 2 rates for each age stratification and total
Reported rate	Each of the 2 rates for each age stratification and total

## Rules for Allowable Adjustments of HEDIS

This section may not be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the Guidelines for the Rules of Allowable Adjustments of HEDIS for additional information.

### Rules for Allowable Adjustments for Follow-Up After Emergency Department Visit for Mental Illness

NONCLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	Age determination dates may be changed (i.e., age 6 as of the date of the ED visit). Changing the denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Event/Diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed.  Note: Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an emergency department visit with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness).
Denominator Exclusions	Adjustments Allowed (Yes/No)	Notes
Optional Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
<ul style="list-style-type: none"> <li>• 30-Day Follow-Up</li> <li>• 7-Day Follow-Up</li> </ul>	No	Value sets and logic may not be changed.

## Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

### SUMMARY OF CHANGES TO HEDIS MY 2020 & MY2021

- Clarified the Episode Date when detoxification occurs during an acute inpatient stay.
- Updated the step 3 instructions for ED and observation visits that result in an inpatient stay, to make them consistent with instructions in the Definitions section.
- Added value sets for opioid treatment services that are billed weekly or monthly to the denominator and numerators.
- Updated the continuous enrollment period.

### Description

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following.

- **Initiation of AOD Treatment.** The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.
- **Engagement of AOD Treatment.** The percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.

### Definitions

Intake Period	January 1–November 14 of the measurement year. The Intake Period is used to capture new episodes of AOD abuse and dependence.
Index Episode	The earliest eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.  For ED or observation visits that result in an inpatient stay, the inpatient discharge is the Index Episode.
Date of service for services billed weekly or monthly	For an opioid treatment service that bills monthly or weekly ( <u>ODU Weekly Non Drug Service Value Set</u> ; <u>ODU Monthly Office Based Treatment Value Set</u> ; <u>ODU Weekly Drug Treatment Service Value Set</u> ), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the IESD, negative diagnosis history and numerator events).
IESD	Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.  For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, or ED visit (not resulting in an inpatient stay), the IESD is the date of service.  For an inpatient stay or for detoxification that occurred during an inpatient stay, the IESD is the date of discharge.  For detoxification (other than detoxification that occurred during an inpatient stay), the IESD is the date of service.

For ED or observation visits that result in an inpatient stay, the IESD is the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort).

For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).

#### Negative Diagnosis History

A period of 60 days (2 months) before the IESD when the member had no claims/encounters with a diagnosis of AOD abuse or dependence.

For an inpatient stay, use the admission date to determine the Negative Diagnosis History.

For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History.

For direct transfers, use the first admission to determine the Negative Diagnosis History.

#### Direct transfer

A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify admissions to and discharges from inpatient settings.

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission and discharge dates for the stay.

### Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.

**Product lines** Commercial, Medicaid, Medicare (report each product line separately).

**Age** 13 years and older as of December 31 of the measurement year. Report two age stratifications and a total rate:

- 13–17 years.
- 18+ years.
- Total.

The total is the sum of the age stratifications.

AOD diagnosis cohorts	<p>Report the following diagnosis cohorts for each age stratification and the total rate:</p> <ul style="list-style-type: none"> <li>• Alcohol abuse or dependence.</li> <li>• Opioid abuse or dependence.</li> <li>• Other drug abuse or dependence.</li> <li>• Total.</li> </ul>
Continuous enrollment	60 days (2 months) prior to the IESD through 47 days after the IESD (108 total days).
Allowable gap	None.
Anchor date	None.
Benefits	<p>Medical, pharmacy and chemical dependency (inpatient and outpatient).</p> <p>Note: Members with detoxification-only chemical dependency benefits do not meet these criteria.</p>
Event/diagnosis	<p>New episode of AOD abuse or dependence during the Intake Period.</p> <p>Follow the steps below to identify the eligible population, which is the denominator for both rates.</p>
Step 1	<p>Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following:</p> <ul style="list-style-type: none"> <li>• An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria: <ul style="list-style-type: none"> <li>– <u>IET Stand Alone Visits Value Set</u> with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.</li> <li>– <u>IET Visits Group 1 Value Set</u> with <u>IET POS Group 1 Value Set</u> and with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.</li> <li>– <u>IET Visits Group 2 Value Set</u> with <u>IET POS Group 2 Value Set</u> and with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.</li> <li>– <u>ODU Weekly Non Drug Service Value Set</u> with <u>Opioid Abuse and Dependence Value Set</u>.</li> <li>– <u>ODU Monthly Office Based Treatment Value Set</u> with <u>Opioid Abuse and Dependence Value Set</u>.</li> <li>– <u>ODU Weekly Drug Treatment Service Value Set</u> with <u>Opioid Abuse and Dependence Value Set</u>.</li> </ul> </li> <li>• A detoxification visit (<u>Detoxification Value Set</u>) with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.</li> <li>• An ED visit (<u>ED Value Set</u>) with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.</li> </ul>

- An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An acute or nonacute inpatient discharge with one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (ODU Weekly Non Drug Service Value Set; ODU Monthly Office Based Treatment Value Set; ODU Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set).

For members with more than one episode of AOD abuse or dependence, use the first episode.

For members whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD.

Step 2 Select the Index Episode and stratify based on age and AOD diagnosis cohort.

- If the member has a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), place the member in the alcohol cohort.
- If the member has a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set), place the member in the opioid cohort.
- If the member has a drug abuse or dependence that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the member in the other drug cohort.

If the member has multiple substance use diagnosis for the visit, report the member in all AOD diagnosis stratifications for which they meet criteria.

The total is not a sum of the diagnosis cohorts. Count members in the total denominator rate if they had at least one alcohol, opioid or other drug abuse or dependence diagnosis during the measurement period. Report member with multiple diagnoses during the Index Episode only once for the total rate for the denominator.

Step 3 Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.

For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.

For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History.

Step 4 Calculate continuous enrollment. Members must be continuously enrolled for 60 days (2 months) before the IESD through 47 days after the IESD (108 total days), with no gaps.

### Administrative Specification

Denominator The eligible population.

Numerator

Initiation of AOD Treatment Initiation of AOD treatment within 14 days of the IESD.

If the Index Episode was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant.

If the Index Episode was an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set), the opioid treatment service is considered initiation of treatment and the member is compliant.

If the Index Episode was not an inpatient discharge, the member must initiate treatment on the IESD or in the 13 days after the IESD (14 total days). Any of the following code combinations meet criteria for initiation:

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visit Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (ODU Weekly Non Drug Service Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (ODU Monthly Office Based Treatment Value Set).
- If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set; ODU Weekly Drug Treatment Service Value Set).

For all initiation events except medication treatment (AOD Medication Treatment Value Set; Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List), initiation on the same day as the IESD must be with different providers in order to count.

If a member is compliant for the Initiation numerator for any diagnosis cohort (alcohol, opioid, other drug) or for multiple cohorts, count the member only once in the Total Initiation numerator. The “Total” column is not the sum of the diagnosis columns.

Exclude the member from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

Engagement of  
AOD Treatment

Step 1 Identify all members compliant for the Initiation of AOD Treatment numerator.

For members who initiated treatment via an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 2 Identify members who had an opioid treatment service that bills monthly (OD Monthly Office Based Treatment Value Set) or who had a visit that included medication administration (OD Weekly Drug Treatment Service Value Set) beginning on the day after the initiation encounter through 34 days after the initiation event.

For these members, if the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), the member is numerator compliant for Engagement of AOD Treatment.

Step 3 Identify members whose initiation of AOD treatment was a medication treatment event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List; AOD Medication Treatment Value Set).

These members are numerator compliant if they have two or more engagement events, where only one can be an engagement medication treatment event, beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days).

Step 4 Identify the remaining members whose initiation of AOD treatment was not a medication treatment event (members not identified in step 3).

These members are numerator compliant if they meet either of the following:

- At least one engagement medication treatment event.
- At least two engagement visits.

Two engagement visits can be on the same date of service but they must be with different providers in order to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

Engagement visits Any of the following beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days) meet criteria for an engagement visit:

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.

- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visits Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (ODU Weekly Non Drug Service Value Set).

Engagement  
medication  
treatment events

Either of the following meets criteria for an engagement medication treatment event:

- If the IESD diagnosis was a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), one or more medication treatment dispensing events (Alcohol Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Alcohol Abuse and Dependence Treatment.
- If the IESD diagnosis was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment.

If the member is compliant for multiple cohorts, only count the member once for the Total Engagement numerator. The Total column is not the sum of the Diagnosis columns.

## Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

## Opioid Use Disorder Treatment Medications

Description	Prescription
Antagonist	• Naltrexone (oral and injectable)
Partial agonist	• Buprenorphine (sublingual tablet, injection, implant) • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

## Note

- Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some organizations may bill comparable to outpatient billing, with separate claims for each date of service; others may bill comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing is comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate.
- For members in the “other drug abuse or dependence” cohort, medication treatment does not meet numerator criteria for Initiation of AOD Treatment or Engagement of AOD Treatment.
- Methadone is not included in the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. A pharmacy claim for methadone would be more indicative of treatment for pain than treatment for an opioid use disorder; therefore they are not included in the medication lists. The AOD Medication Treatment Value Set includes some codes that identify methadone treatment because these codes are used on medical claims, not pharmacy claims.

## Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table IET-1/2/3: Data Elements for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

	Administrative
Measurement year	✓
Eligible population	For each age stratification, diagnosis stratification and total
Numerator events by administrative data	Each rate, for each age stratification, diagnosis stratification and total
Reported rate	Each rate, for each age stratification, diagnosis stratification and total

## Rules for Allowable Adjustments of HEDIS

This section may not be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the Guidelines for the Rules of Allowable Adjustments of HEDIS for additional information.

Rules for Allowable Adjustments for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

NONCLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed.
AOD diagnosis cohorts	Yes, with limits	Reporting each stratum or combined strata is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
CLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Event/Diagnosis	Yes, with limits	Only events that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists and value sets and logic may not be changed. Note: This measure uses new episodes of AOD abuse and dependence; modifying the Intake period can affect the Index Episode and other dates; however, the order and relationship of the events may not be changed.
Denominator Exclusions	Adjustments Allowed (Yes/No)	Notes
Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
<ul style="list-style-type: none"> <li>● Initiation of AOD Treatment</li> <li>● Engagement of AOD Treatment</li> </ul>	No	Medication lists, value sets and logic may not be changed.



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