Adult BH Quality Improvement Collaborative Session #2: 12/18/25

Disclosure: There are no relevant financial relationships, sponsorships, or other disclosures from anyone in control of content associated with this activity. This program is designed to provide educational information and does not involve the promotion of any specific product or service.

Arizona State University

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Targeted Investment Team

ASU TIPQIC

- William Riley, PhD
- George Runger, PhD
- Matthew Martin, PhD
- Kailey Love, MBA, MS
- Taylor Vaughan, MPH
- El-Ham Ismail
- Samantha Basch, MS
- Francisca Dibarrart, PhD
- Min Jang, PhD

AHCCCS Targeted Investment

- Julie Ambur
- Christina Quast
- Jane Otenyo

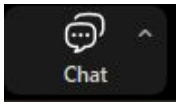
Agenda

Time	Topic	Presenter
12:00 PM to 12:03 PM	Opening	Matthew Martin, PhD
12:03 PM to 12:15 PM	Measure Overview & Network Performance	Kailey Love, MBA, MS Matthew Martin, PhD
12:15 PM to 12:35 PM	Measure Details: Definition, Coding, Targets, Attribution	George Runger, PhD Taylor Vaughan, MPH
12:35 PM to 12:45 PM	Common Barriers & Best Practices	Matthew Martin, PhD
12:45 PM to 12:57 PM	Discussion	Matthew Martin, PhD
12:57 PM to 1:00 PM	Closing	Kailey Love, MBA, MS

Learning Objectives

1. Describe strategies to facilitate population health management improvement.
2. Critically analyze the application of improvement methods and techniques to improve HEDIS quality metrics.
3. Evaluate strategies to identify and address upstream drivers of health for high risk populations
4. Explore process improvement strategies for population health management

Guidelines

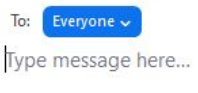


Do not enter your name or organization in the Chat. Zoom will automatically record your attendance. Please only use the chat for questions and comments.

At least one representative from each TI organization must have registered and attend the QIC session using that registration link for the required QIC sessions.

Participants will automatically be muted and videos off as they join.

When interested in participating in the discussion, please raise your hand and unmute yourself.



Please drop your questions into the Chat. If we do not have time to address your question, we will compile all questions into a FAQ document and distribute post-event.

Disclosure

This is a CME activity

Acknowledgment: This CME event is not supported by any commercial entity.

Disclosure: There are no relevant financial relationships, sponsorships, or other disclosures from anyone in control of content associated with this activity. This program is designed to provide educational information and does not involve the promotion of any specific product or service.

Credit Statement: Arizona State University designates this live activity for a maximum of 1-credit from the following:

- ***AMA PRA Category 1 Credit™ – CME – 1 credit hour per session***
- ***Nursing Continuing Professional Development – NCPD – 1 credit hour per session***
- ***Psychology – CEP – 1 credit hour per session***
- ***Social Work – ACE – 1 credit hour per session***
- ***Interprofessional Continuing Education – IPCE – 1 credit hour per session***

**Providers should only claim credit commensurate with the extent of their participation in the activity.*

Measure Overview & Network Performance

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Table 1 Targeted Investments (TI) 2.0 Year 4 Milestones and Incentive Percentages			
MILESTONES	**ADULT BH**		
	INCENTIVE % OF ANNUAL PAYMENT		
M1. Performance Measures	**50**		
	SAA	FUH7	FUM7
	10	20	20
M2. Screening and Referral Systems for Nonmedical Drivers of Health	**25**		
M3. Closed Loop Referral System (CLRS)	**15**		
M4. Quality Improvement Collaboratives (QICs)	**10**		

Adult BH QIC Curriculum Overview

Adult BH AOC Measures	TI Year 4: 10/1/2025 - 9/30/2026											
	O	N	D	J	F	M	A	M	J	J	A	S
SAA	QIC						QIC					
FUH7			QIC						QIC			
FUM7					QIC						QIC	
Optional Resources	Ongoing Performance Improvement Project (PIP)											
	Ongoing Technical Assistance & Consultation											

- **QIC's** in October, December, and February are **required**
  - Each QIC will focus on the a HEDIS measure as indicated in the above table
- ***QIC's*** in April, June, and August are ***optional***
  - The focus of these sessions may shift based on performance and other priorities

ADULT BH

Performance Measure	Measure Description	TI AOC Performance *	All AHCCCS Performance *	2023 CMS AZ Average[1]	2023 HEDIS National Average[2]
✷ = Proposed 2026 ACOM306 Measure; ✲ = MAC 2024 Scorecard Measure; ✾ = 2025 CMS Core Set Measure; ✱ = 2024 UDS Quality of Care Measure; + = 2024 SAMHSA CCBHC Quality Measure; ✪ = NCQA HEDIS Stratified Measure; ❋ = MAC QRS Measure					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) ✷ ✾ +	Percentage of adult beneficiaries with schizophrenia who were dispensed and remained on antipsychotic medication for at least 80% of their treatment period	67.3%	50.6%	55.1%	61.1%
Follow-Up After Hospitalization for Mental Illness within 7 Days (FUH7) ✱ ❋ + ✪ ✸	**Percentage of adult beneficiaries with a follow-up visit seven days after hospitalization for mental illness**	**77.6%**	**53.7%**	**57.1%**	**38.5%**
Follow-Up After Emergency Department Visit for Mental Illness within 7 Day (FUM7) ✷ ✲ ✾ + ✪	Percentage of adult beneficiaries with a follow-up visit seven days after an ED visit for mental illness	74.2%	45.3%	44.9%	39.6%

*Report period ending June 30, 2025

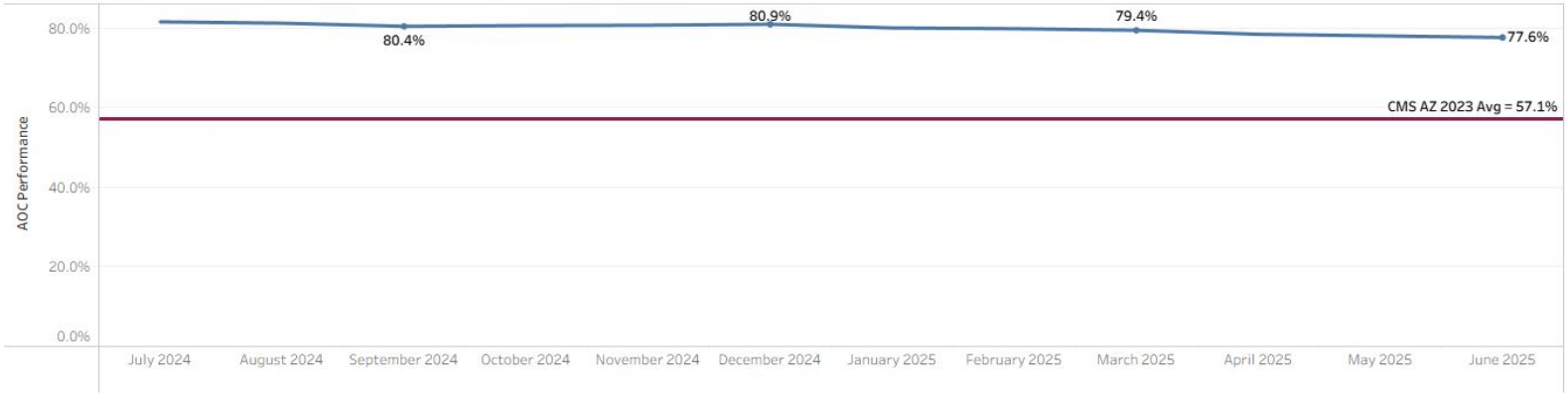
1. https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/main?focusStates=%5B%22AZ%22%5D
2. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/

Note: The HEDIS national average refers to performance under 'Medicaid HMO.' Performance data highlighted in blue (IET, FUH, FUM, FUI, FUA) do not have age-stratified values, so the reported figures represent aggregate performance across all ages.

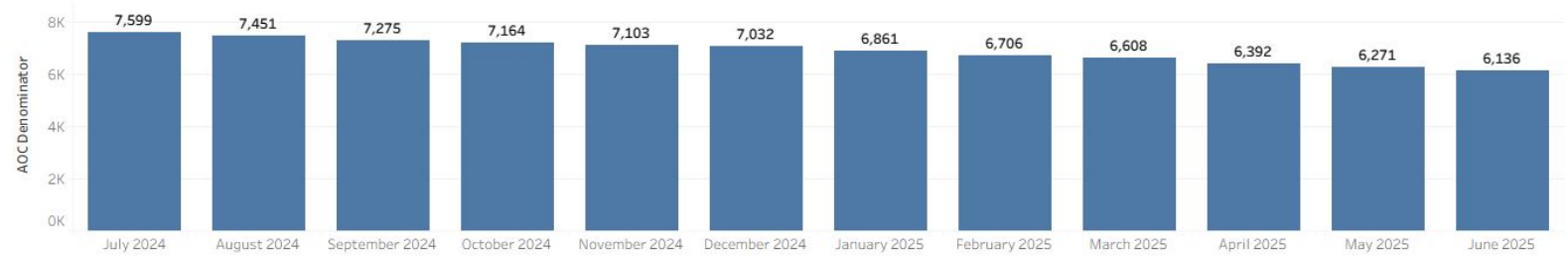
FUH7 Network Performance

Measure Performance (each month is a 12-month report period)

ADULT BH



Measure Denominator



Measure Details

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

Follow-up After Hospitalization within 7 Days

FUH7: The percentage of discharges for persons 18 years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service within 7 days after discharge.

Quality Alignment

ADULT BH									
Performance Measure	Measure Description	TI AOC Performance*	Quality Alignment						
			2026 ACOM 306 Measure	MAC 2024 Scorecard Measure	2025 CMS Core Set Measure	2024 UDS Quality of Care Measure	2024 SAMHSA CCBHC Quality Measure	NCQA HEDIS Stratified Measure	MAC QRS Measure
Follow-Up After Hospitalization for Mental Illness within 7 Days (FUH7)	Percentage of adult beneficiaries with a follow-up visit seven days after hospitalization for mental illness	**77.6%**		✻	❋		+	✪	❋

FUH7 Importance

1. Ensures Safe Transitions of Care

2. Improves Long-Term Mental Health Outcomes

3. Supports Family Engagement and Stability

4. Facilitates Coordination Across Systems

5. Addresses Equity and Access Challenges

6. Indicator of System Quality and Accountability

Why the 7-Day Window Matters

1. High-Risk Period Post-Discharge
2. Promotes Continuity of Care
3. Supports Family and Caregiver Engagement
4. Encourages Adherence to Treatment Plans
5. Prevents Deterioration and Readmission
6. Supports Population Health and Equity

FUH7

Your performance is reported as a percentage calculated as the = numerator/denominator

TI Area of Concentration	Measure	Denominator Definition	Numerator Definition
Adult BH	Follow-Up After Hospitalization for Mental Illness within 7 Days (FUH7)	Discharges for members 18 years and older who were hospitalized for treatment of selected mental illness or intentional self-harm in the reporting period.	Discharges in the denominator where the member had a qualifying follow-up visit within 7 days after discharge.

Note: For the FUH7 measure, the member must be continuously enrolled in medical benefits from the episode end date through 30 days after the episode end date with no breaks in enrollment.

What is the Reporting Period?

- A HEDIS® measure's reporting period is a continuous 12-month window.
- TIP Provider Dashboards show your organization's performance on the selected measure for 12 consecutive, overlapping report periods, where each report period is a 12-month period ending in the month and year shown on the X-axis.
- Your performance levels for 12 report periods are provided so you can track how your performance changes across time. TI incentive payments are based on your performance for the Federal Fiscal Years (October 1st September 30th).

Which Members Are in My Denominator?

To understand the members that you are accountable for and who are attributed to you (i.e., in your denominator) for this measure, you need to know the denominator definition (above), as well as the AHCCCS member population assessed, and the attribution method used.

Member Population Assessed

- Members enrolled in one of the six AHCCCS Complete Care (ACC) health plans
- Members with SMI enrolled in an ACC Regional Behavioral Health Agreement (RBHA) health plan are included

Member Population Exclusions

- ACC and ACC-RBHA members who utilized hospice services or died

Note: These measures are based on the number of hospitalizations, not the number of members. Members with multiple hospitalizations (with sufficient time between them) are counted multiple times in the denominator.

What Services Qualify for the Numerator?

Provider Types & Specialties

- Certain AHCCCS provider types and specialties qualify as mental health providers. With the exception of CoCM services, qualified follow-up services only count in the numerator if the “Service” provider (box 32a) is credentialed as a qualified mental health provider.

What Services Qualify for the Numerator?

Billing Codes

- TI 2.0 Year 4 use HEDIS® Measurement Year 2023 measure definitions.
- Due to licensing agreements, we are not able to publish a list of all qualifying services codes. However, we can direct you to resources containing the billing codes.
  - Please see these Arizona Health Plan Measure Guides. You do not have to be contracted with the plan to access these resources.
    - United Healthcare - HEDIS® MY 2023 Reference Guide
  - For more information on HEDIS measures or to get your own license, see the NCQA HEDIS® site.
  - Value sets and codes used in HEDIS 2024 (Measurement Year 2023) measure calculations are available at no cost. Download the 2023 Quality Rating System (QRS) HEDIS Value Set Directory from the NCQA store.
- Note: While the FUH, FUA, and FUM measures are similar, the numerator-qualifying criteria differ. Carefully review the linked measure guides for differences in qualifying billing codes.

FUH Accommodations

- In addition to the billing codes listed in the guides linked, the following accommodations have been made for TI performance measurement:
  - The measure's numerator-qualifying telehealth services will get credit if they follow AHCCCS's telehealth billing guidelines allowed on the date of service.
  - Psychiatric Collaborative Care Model (CoCM) services (i.e., codes 99492, 99493, and 99494) will count as a numerator-qualifying visit for all servicing provider types (licensed and non-licensed).
    - CoCM is an approach to behavioral health integration recognized by CMS. Please see TIPQIC.org for billing guidance to maximize CoCM services for FUH compliance and a list of TIP Providers who deliver CoCM services.

What Services Do Not Qualify for the Numerator?

- Day 0 (Zero) is the day of discharge and is not eligible to be included in the FUH, FUM, and FUA measures. This is a CMS and NCQA policy. AHCCCS seeks to align with the national standards to the greatest extent possible.
- Reach-in (i.e., non-billable) services do not qualify for the numerator. Any procedure code not listed in the previous section does not qualify.

Attribution

- Members are attributed to their prescribing provider. If multiple prescribing providers are identified, attribution considers the strongest relationship based on the frequency and recency of dispensation.
- If there is no prescribing provider, members are attributed to the behavioral health provider with whom they have the strongest relationship with prior to the event or secondarily, the provider with the numerator qualifying services after the event.
- Interested providers can work with the ASU TIPQIC team to examine member events eligible for each measure and attributed to their organization through a member list comparison (Data Harmonization).

Target Setting

- Two tiers were set for the FUH7 measure
  - AHCCCS emailed each provider organization with individual target setting information
- For your organization's specific target, please see your dashboard or the email received from the AHCCCS TI team.
- TI Adult BH providers need to exceed their target to achieve the incentives associated with this performance measure.

To log in to your dashboards, please visit data.tipqic.org.

If you would like to make any changes to your log-in or password, please email support@tipqic.org

Common Barriers & Best Practices

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

FUH7 Common Barriers

1. Care Coordination and Transition Challenges

- Limited discharge planning and communication
- No standardized warm handoff
- Data fragmentation
- Unclear accountability

2. Family and Patient-Level Barriers

- Parental stress and competing priorities
- Limited understanding of the 7-day requirement
- Stigma and fear
- Transportation or logistical challenges
- Youth reluctance

3. Access and Capacity Constraints

- Provider shortages
- Wait times for outpatient services
- Limited evening/weekend availability
- Insurance and coverage barriers

FUH7 Common Barriers

4. System and Data Limitations

- Incomplete or delayed notification of discharges
- Coding and documentation gaps
- Lack of real-time monitoring tools

5. Equity and Social Determinant Barriers

- Socioeconomic instability
- Language and cultural barriers
- Geographic disparities
- Digital divide

6. Pediatric-Specific System Barriers

- Fragmented care networks
- School reentry pressures
- Lack of child-specific transitional supports
- Inconsistent engagement of primary care

FUH7 Best Practices

1. Strengthen Care Transitions and Discharge Planning

- Schedule the follow-up before discharge
- Provide warm handoffs
- Develop standardized discharge workflows
- Ensure same-week appointment availability

2. Strengthen Coordination Between Inpatient and Outpatient Providers

- Create formal communication protocols
- Use shared care plans
- Designate transition coordinators
- Engage primary care providers

3. Engage Families and Youth Early and Often

- Educate families before discharge
- Use motivational interviewing
- Offer flexible appointment options
- Include caregivers in treatment planning

FUH7 Best Practices Cont.

4. Leverage Technology and Data Systems

- Automate discharge alerts
- Use population health dashboards
- Monitor outreach attempts
- Enable telehealth and hybrid models

5. Address Access and Equity Barriers

- Coordinate transportation supports
- Prioritize high-risk populations
- Offer culturally responsive care
- Use peer and family navigators

6. Build Community and Cross-System Partnerships

- Collaborate with schools and child-serving agencies
- Engage child welfare and juvenile justice partners
- Integrate with crisis response teams
- Work with managed care organizations

7. Use Continuous Quality Improvement (CQI) Methods

- Monitor FUH-7 data monthly
- Conduct root cause analyses
- Test small PDSA cycles
- Recognize and reward performance

FUH7 Non-Medical Drivers and Closed Loop Referral Systems

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

Non-Medical Drivers of Health (NMDOH) G/Z Codes

- Between May 2024 and June 2025, TI providers screened 28,328 unique patients for non-medical drivers of health, submitting 33,350 G codes via claims.
  - 81 TINs submitted at least one G code during this time period.
- The most commonly identified needs were employment, housing, and larger economic conditions. Over 4,500 NMDOH referrals were given to help patients meet these needs.
- Year 4 Milestone 2B: **ATTEST** to documenting NMDOH screening and referral results via consistent submission of claims using G procedure codes (G9919 and G9920), V4 modifier, and Z diagnosis codes as appropriate.

https://www.azahcccs.gov/PlansProviders/Downloads/TI/Milestone/Year4MilestoneRequirements.pdf

Advantages of Providers Screening for Non-Medical Drivers of Health for FUH7

Why Screening Matters for FUH-7

- Identifies social and logistical barriers to follow-up
- Surfaces post-discharge risks affecting appointment completion
- Clarifies communication challenges (phones, digital access)
- Supports tailored discharge planning and outreach
- Enhances safety planning by flagging environmental risks
- Strengthens transitions by addressing non-medical needs early
- Promotes equity by highlighting disproportionate social drivers

How This Improves FUH-7 Results

- Reduces missed appointments
- Increases successful 7-day follow-up
- Supports sustained outpatient engagement and lowers readmissions

Closed Loop Referral Systems for FUH7

What Closed-Loop Referrals Enable

- Track completion of community and social service referrals
- Ensure key supports (transportation, housing, food, peers) are resolved
- Alert care teams when referrals fail
- Improve collaboration across inpatient, outpatient, and community partners
- Reduce drop-off during the post-discharge period

How This Drives Better FUH-7 Outcomes

- Increases follow-up completion by stabilizing social needs
- Prevents care gaps through timely intervention
- Supports reliable coordination and reminders
- Strengthens warm handoffs and continuity of care

Provider Discussant

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

Provider Discussant & Respondent

- Provider Discusant
  - Diane Martin, Crisis Preparation and Recovery

- Provider Respondent
  - Kyle Lininger, Assurance Assertive Community Treatment

Provider Discussant Questions

- What is your current process for the WCV measure?
- What factors seem to impact the success of your process performance on the WCV measure?
- What QI methods or techniques have you used to improve your process (if any)?
- What is your plan to improve your performance on the WCV measure?
- What is your process for non-medical drivers in relation to the WCV?

Discussion

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

Discussion Questions

Understanding Barriers & Patient Experience

- What are the most common barriers our patients face in attending a follow-up appointment within 7 days of discharge?
- How do social needs (housing instability, transportation, financial stress, caregiver responsibilities) impact a patient's ability to complete timely follow-up?
- What challenges do patients experience during transitions of care that we might not be seeing from the clinic side?

Care Coordination & Workflow

- How effectively is our current discharge planning process identifying and scheduling follow-up appointments before the patient leaves the hospital?
- What types of warm handoffs or bridge supports (peer support, crisis teams, care navigators) have worked well for timely follow-ups?
- Where do we see breakdowns in communication between inpatient teams, outpatient providers, and community partners?

Patient Engagement & Outreach

- What strategies have been most successful in engaging patients who are ambivalent, anxious, or exhausted after hospitalization?
- How do we ensure that outreach is culturally responsive, trauma-informed, and aligned with patient preferences?
- What role could telehealth, virtual check-ins, or flexible visit types play in improving FUH7 performance?

Closing

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

Closing & Next Steps

- For those interested in CME, an evaluation survey will be distributed following this event and CME certificates will be distributed to those who complete this survey at the end of the month.
- Register for the February QIC session(s)

Questions?

AHCCCS Questions: targetedinvestments@azahcccs.gov
ASU TIPQIC General Inquiries: TIPQIC@asu.edu
Support Tickets: support@TIPQIC.org

Relevant Websites:

- AHCCCS TI: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/
- ASU TIPQIC: tipqic.org
- Dashboards: data.tipqic.org

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM