Washington State Health Care Authority

Measure specifications: Follow-up After ED Visit for Substance Use (7 and 30 Days)

Metric information

Metric description: The percentage of emergency department (ED) visits for Medicaid beneficiaries, 13 years of age and older, with a principal diagnosis of substance use disorder (SUD), or any diagnosis or drug overdose, for which there was follow-up. Two rates are reported:

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

Metric specification version: HEDIS® Measurement Year 2022 Technical Specifications for Health Plans, NCQA.

Data collection method: Administrative only.

Data source: ProviderOne Medicaid claims/encounter and enrollment data.

Claim status: Include only final paid claims or accepted encounters in metric calculation.

Identification window: Measurement year.

Direction of quality improvement: Higher is better.

URL of specifications: NCQA HEDIS measures

DSRIP program summary

Metric utility: ACH Project P4P ■ ACH High Performance □ DSRIP statewide accountability □

ACH Project P4P – Metric results used for achievement value: Submetric results reported for: follow-up within 7 days of the ED visit and follow-up within 30 days of the ED visit. Each submetric contributes equal weight in the final AV calculation for the overall metric.

ACH Project P4P – improvement target methodology: improvement over self (1.9% improvement over reference baseline performance).

ACH regional attribution: Residence in the ACH region for 11 out of 12 months in the measurement year.

DSRIP metric details

Eligible population

Measure	Description
Age	13 years and older at the time of the emergency department visit.
Gender	N/A
Minimum Medicaid enrollment	Date of the emergency department visit through 30 days after the ED visit (31 total days). Enrollment must be continuous.

Allowable gap in Medicaid enrollment	No gaps in enrollment allowed.
Medicaid enrollment anchor date	Date of emergency department visit.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid and beneficiaries with primary insurance other than Medicaid.

Denominator (used for both submetrics):

The denominator for this metric is based on ED visits, not on Medicaid beneficiaries. If an eligible Medicaid beneficiary has more than one ED visit, all eligible ED visits between January 1 and December 1 of the measurement year are identified and more than one visit per 31-day period are not included.

If a Medicaid beneficiary has more than one ED visit in a 31-day period, only the first eligible ED visit is included. For example, if a Medicaid beneficiary has an ED visit on January 1, then the January 1 visit is included and ED visits that occur on or between January 2 and January 31 are not included. Then, if applicable, the next ED visit that occurs on or after February 1 is included. Visits are identified chronologically including only one per 31-day period.

Data elements required for denominator: An ED visit with a principal diagnosis of SUD or any diagnosis of drug overdose on or between January 1 and December 1 of the measurement year, where the eligible Medicaid beneficiary was 13 years or older on the date of the visit.

Required exclusions for denominator.

- Eligible population exclusions are listed in the eligible population table above.
- Metric specific exclusions:
  - Beneficiaries in hospice care.
  - ED visits followed by an admission to an acute or non-acute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. Admissions to an acute or non-acute inpatient care setting are identified by doing the following:
    - Identify all acute and non-acute inpatient stays (Inpatient Stay Value Set)
    - Identify the admission date for the stay.

An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. These events are excluded from the metric because admission to an acute or non-acute inpatient setting may prevent an outpatient follow-up visit from taking place.

Deviations from cited specifications for denominator.

- None.

Numerator (different for the two submetrics reported):

Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator.

Data elements required for 7-day follow-up numerator: A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date

of the ED visit. See HEDIS® for specific instructions on identifying follow-up visits and pharmacotherapy dispensing events.

Data elements required for 30-day follow-up numerator: A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit. See HEDIS® for specific instructions on identifying follow-up visits and pharmacotherapy dispensing events.

Required exclusions for numerator.

- None

Deviations from cited specifications for numerator.

- None

Version control

August 2020 update: Per HEDIS® General Guideline 43, unless specifically excluded, HEDIS® metrics include telehealth by default and do not require the use of a specific value set to identify relevant CPT and HCPCS place of service modifiers.

August 2023 update: Substantial changes have been made to this metric including revising terminology, adding ED visits with a diagnosis or unintentional and undetermined drug overdoses to the denominator, and revising and restructuring the logic for the numerator. See HEDIS® for specific instructions. The metric name has been updated.