Washington State Health Care Authority

Measure specifications: Follow-up After Hospitalization for Mental Illness (7 and 30 Days)

Metric information

Metric description: The percentage of discharges for eligible Medicaid beneficiaries 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 practitioner. Two submetrics are reported:

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

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	6 years and older at the time of the discharge.
Gender	N/A
Minimum Medicaid enrollment	Date of the discharge through 30 days after the discharge (31 total days). Enrollment must be continuous.

Allowable gap in Medicaid enrollment	No gaps in enrollment allowed.
Medicaid enrollment anchor date	Date of discharge.
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 (for both submetrics):

The denominator for this metric is based on discharges, not on Medicaid beneficiaries. If an eligible Medicaid beneficiary has more than one discharge, all discharges between January 1 and December 1 of the measurement year are identified.

Data elements required for denominator: An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) or intentional self-harm (Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:

- Identify all acute and non-acute inpatient stays (Inpatient Stay Value Set).
- Exclude non-acute inpatient stays (Non-acute Inpatient Stay Value Set).
- Identify the discharge date for the stay.

See HEDIS® for additional specifications and appropriate exclusions.

Required exclusions for denominator.

- Eligible population exclusions are listed in the eligible population table above.
- Metric specific exclusions:
    - Beneficiaries in hospice care.
    - Exclude discharges followed by readmission or direct transfer to a non-acute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. See HEDIS® for specific instructions.
    - Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period. See HEDIS® for specific instructions.

These discharges are excluded from the metric because re-hospitalization or direct transfer 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 with a mental health practitioner within 7 days after discharge. Do not include visits that occur on the date of discharge. See HEDIS® for specific instructions on identifying follow-up visits and mental illness diagnosis.

Data elements required for 30-day follow-up numerator: A follow-up visit with a mental health practitioner within 30 days after discharge. Do not include visits that occur on the date of discharge. See HEDIS® for specific instructions on identifying follow-up visits and mental illness diagnosis.

Required exclusions for numerator.

- None

Deviations from cited specifications for numerator.

- None

Version control

August 2019 update: Substantial changes have been made to this metric including expansion of the eligible population to include intentional self-harm, the inclusion of telehealth, and clarification of instructions for readmissions and direct transfers. See HEDIS® for specific instructions.

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 the process for identifying acute readmissions and/or direct transfer. See HEDIS® for specific instructions.