STATE MEDICAID AND CHIP IMPROVING BEHAVIORAL HEALTH FOLLOW UP CARE DRIVER DIAGRAM AND CHANGE IDEAS

A driver diagram shows the processes or systems that affect the aim of your quality improvement (QI) project and determine what you need to do to improve outcomes. Use the state Medicaid and CHIP improving behavioral health follow up care driver diagram on the next page to help plan your state behavioral health care-related quality improvement project. You may also want to develop your own driver diagram and related change ideas. Here are some suggestions to begin:

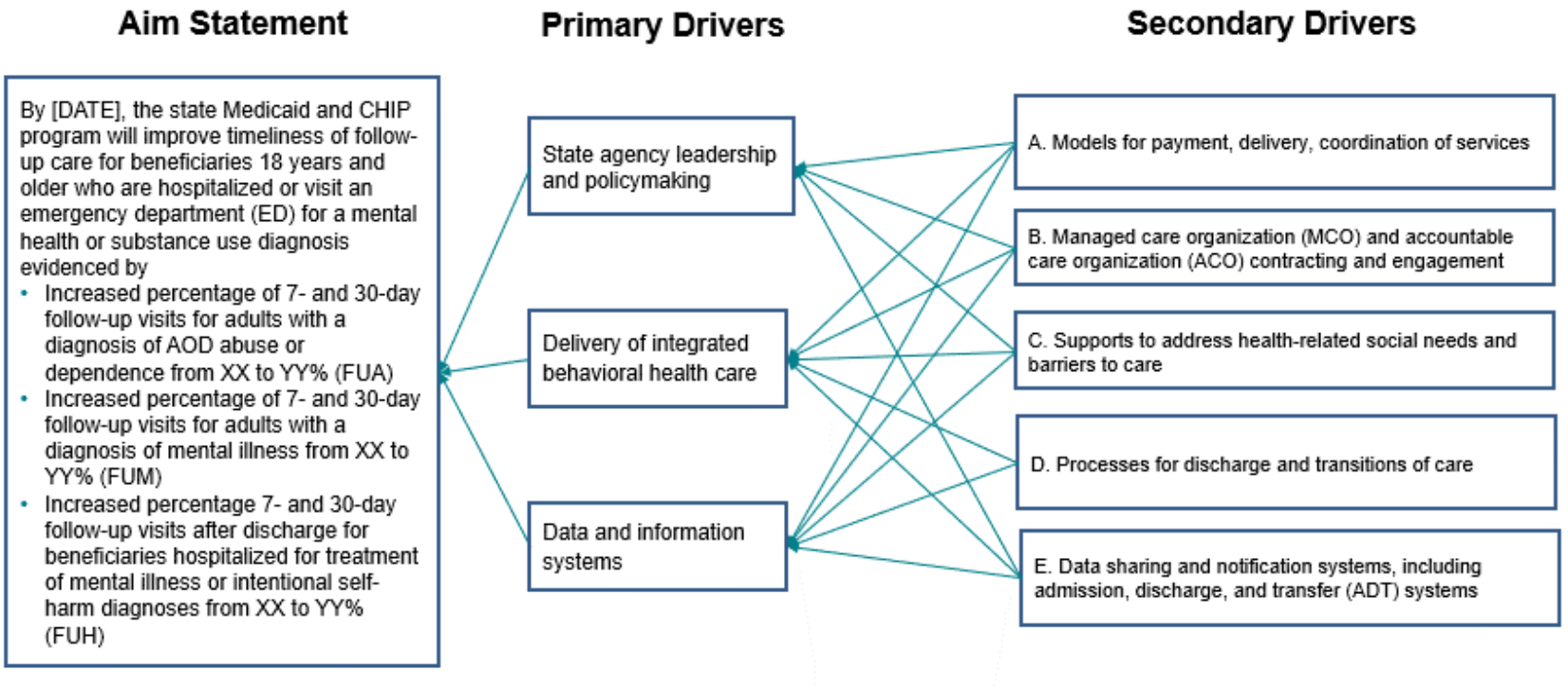
- Develop an aim statement. A good aim statement is specific, measurable, and answers the questions, "For whom, how much, and by when?" It should be brief, easy to understand, and should not include background or side issues. An example aim statement is given on the driver diagram on the next page.

- Add primary drivers. Primary drivers are the high-level processes, structures, or norms in the system that must change in order to achieve your aim. While all the primary drivers are necessary to achieve your aim, begin your QI project by just focusing on one or two primary drivers and then expand your activities over time to address the other drivers.

- Add secondary drivers. Secondary drivers expand an understanding of the primary drivers and are action oriented, addressing the places, steps in a process, time-bound moments, or norms where changes are made to bring about improvement. Secondary drivers will help lead you to testable change ideas.

- Develop change ideas. Change ideas describe the specific, testable actions that can be taken to impact the secondary driver, the related primary driver, and achieve your aim. Change ideas should be evidence- or experience-based. The change ideas on the following tables were gathered from research, case studies, expert opinions, and other resources. Where available, the resources have been referenced. Short descriptions accompany Medicaid-specific experiences. Where no reference has been provided, the change idea comes from subject matter experts consulted to develop this driver diagram.

Example State Medicaid and CHIP Program Improving Behavioral Health Follow Up Care Driver Diagram



The driver diagram has the following relationships:

- Aim Statement: By [DATE], the state Medicaid and CHIP program will improve timeliness of follow up care for beneficiaries 18 years and older who are hospitalized or visit an emergency department (ED) for a mental health or substance use diagnosis evidenced by:
  - Increase percentage of 7- and 30-day follow-up visits for adults with a diagnosis of alcohol or drug (AOD) abuse or dependence from XX to YY% (FUA)
  - Increase percentage of 7- and 30-day follow-up visits for adults with a diagnosis of mental illness from XX to YY% (FUM)

- Increase percentage 7- and 30-day follow-up visits after discharge for beneficiaries hospitalized for treatment of mental illness or intentional self-harm diagnoses from XX to YY% (FUH)

- The aim statement is affected by three primary drivers. Each driver is affected by several secondary drivers.
  - Primary driver 1: State Agency Leadership and Policymaking. This driver is affected by four secondary drivers:
    - Models for payment, delivery, and coordination of behavioral health care
    - Managed care organization (MCO) and accountable care organization (ACO) contracting and engagement
    - Supports to address health-related social needs and barriers to care
    - Data sharing and notification systems, including admission, discharge, and transfer (ADT) systems

  - Primary driver 2: Delivery of Integrated Behavioral Health Care. This driver is affected by five secondary drivers:
    - Models for payment, delivery, and coordination of behavioral health care
    - Managed care organization (MCO) and accountable care organization (ACO) contracting and engagement
    - Supports to address health-related social needs and barriers to care
    - Processes for discharge and transitions of care
    - Data sharing and notification systems, including admission, discharge, and transfer (ADT) systems

  - Primary driver 3: Data and Information Systems. This driver is affected by five secondary drivers:
    - Models for payment, delivery, and coordination of behavioral health care
    - Managed care organization (MCO) and accountable care organization (ACO) contracting and engagement
    - Supports to address health-related social needs and barriers to care
    - Processes for discharge and transitions of care
    - Data sharing and notification systems, including admission, discharge, and transfer (ADT) systems

State Medicaid and CHIP Improving Behavioral Health Follow-Up Care Change Ideas

Secondary Driver

A. Models for Behavioral Health Care Delivery, Coordination, and Payment. Health care models include variations in the types of providers that deliver health services, the coordination of health services across locations, and how health services are paid.

Change Activity	Case Studies, Evidence, & Resources
A1. Implement payment and delivery models that promote coordinated care	Maryland Medicaid's behavioral health home improved follow-up care after hospitalization for persons with serious mental illness (SMI). Massachusetts Medicaid implemented a accountable care organization (ACO) primary care sub-capitation program, which includes flexible funding to help providers coordinate care and integrate behavioral health services. **Resource:** • Community Interventions to Promote Mental Health and Social Equity
A2. Increase payment for behavioral health services	Oregon Medicaid directed coordinated care organizations to increase payment rates to behavioral health providers. Providers who receive 50% or more of their revenue from Medicaid received a 30% rate increase while providers who receive less than 50% of their revenue from Medicaid received a 15% rate increase. **Resource** • A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs
A3. Implement bundled payment models that incentivize improved outcomes	Oklahoma Medicaid implemented a bundled payment model that incentivizes behavioral health providers to offer services to special populations including patients with SMI. Providers are eligible for enhanced payments if discharged patients are not hospitalized and do not return to the ED within a month of discharge.
A4. Provide enhanced care coordination for populations with higher needs	Massachusetts Medicaid (MassHealth) implemented the Community Partners program, which provides care coordination and management to improve the experience and continuity of care for patients with SMI, substance use disorders (SUDs), and long-term services and supports needs. Under the CalAIM initiative, California Medicaid will implement the Enhanced Care Management (ECM) program. The ECM program offers intensive health service coordination where a lead care manager spearheads care coordination for physical, behavioral, and other health-related needs.

Secondary Driver **A. Models for Behavioral Health Care Delivery, Coordination, and Payment.** Health care models include variations in the types of providers that deliver health services, the coordination of health services across locations, and how health services are paid.	
Change Activity	**Case Studies, Evidence, & Resources**
A5. Provide training and payment for peer support specialists, community health workers, and others with lived experience in behavioral health	California Medicaid utilizes an 1115 waiver to partner with community organizations and pay community health workers (CHWs) to engage patients and ensure support and access to resources. Services include patient advocacy, care coordination, social support, and culturally competent health education. Oregon Medicaid credentials and pays traditional health workers (THWs), working in a community or clinic under the direction of a licensed health provider. These THWs include birth doulas, community health workers, personal support specialists, peer support specialists, and peer wellness specialists who help coordinate care for behavioral health patients. **Resources**: • Recovery Support for Medicaid Beneficiaries with a Substance Use Disorder
A6. Leverage crisis support services to provide follow-up care in community settings	Connecticut Medicaid pays for emergency mobile psychiatric services to provide children and their families with crisis stabilization, including follow-up care and coordination, in their homes, schools, and communities. Additional information on crisis **Resources**: • A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth Recovery

Secondary Driver **B. Managed Care Organization (MCO) and Accountable Care Organization (ACO) Contracting and Engagement.** Providers and MCOs are accountable to Medicaid and CHIP agencies. Contracts can be used to outline Medicaid and CHIP program requirements.	
Change Idea	**Case Studies, Evidence, and Resources**
B1. Require MCOs to participate in performance improvement plans (PIPs) to increase follow-up care appointment scheduling and attendance	Hawaii's AlohaCare Medicaid managed health plan provided education to members on the importance of attending follow-up visits and gave incentives to patients who attended those visits. They paired this with outreach efforts through multiple communication mediums including a digital platform, email, phone, text, and web portal and successfully increased follow-up appointment attendance. Illinois Medicaid's Meridian managed care plan directed their transitions of care teams to track follow-up calls made within 72 hours of discharge and streamline outreach attempts to ensure patients receive timely outreach and attend their follow-up appointments within 30 days. Arkansas' Medicaid Empower Health Plan initiated an employee satisfaction PIP to improve care coordination for patients receiving follow-up care. They improved care coordination training manuals, engaged in case reconciliation to alleviate caseloads, implemented self-care supports, and created tools and resources for care coordinators to share with patients.
B2. Require MCOs to participate in data-sharing systems	Michigan Medicaid requires its MCOs to create incentives for providers using health information technology (HIT) and health information exchange (HIE) services to improve care management and coordination. Florida Medicaid requires its MCO to enroll and participate in Florida's Medicaid Electronic Health Record Incentive Program which provides incentive payments for providers' participation in the HIT and HIE notification network.
B3. Implement contracting models that integrate behavioral and primary health care	Minnesota Medicaid's Integrated Health Partnership (IHP) program, an ACO model, is designed to improve the efforts of MCOs and the state's fee-for-service model by coordinating behavioral health and physical health services.
B4. Outline expectations for MCOs to communicate and collaborate with providers	Minnesota Medicaid released a guidance document that outlines expectations for communication between MCOs and behavioral health home providers for events such as patient hospitalizations or emergency department visits.

Secondary Driver

C. Provide supports to address health-related social needs (HRSN) and barriers to care. HRSN, such as housing insecurity and lack of transportation, can make it hard for beneficiaries to attend behavioral health follow-up appointments.

Change Idea	Case Studies, Evidence, and Resources
C1. Address transportation barriers to care	Massachusetts hospitals participating in **Massachusetts' CHART Program** established patient assistance funds to assist patients with transportation to medical appointments. Approaches included offering taxi vouchers to patients and contracting with transportation services to provide patient transportation. As part of its Medicaid Non-Emergency Medical Transportation (NEMT) services, **Minnesota Medicaid** offers monthly public transportation passes to Medicaid beneficiaries who reside in areas that are well served by public transportation. **Resources**: • **Disruptive Innovation in Medicaid Non-Emergency Transportation** • **Ridesharing and Medicaid NEMT: An Advocacy Guide**
C2. Assist with post-hospitalization housing	Under **California Medicaid's CalAIM initiative**, managed care plans can provide short-term post-hospitalization housing to Medicaid beneficiaries exiting a hospital, behavioral health treatment facility or other facility who are homeless or at risk of homelessness. **Resource:** • **Homeless and Housed Inpatients with Schizophrenia: Disparities in Service Access upon Discharge from Hospital**
C3. Increase support services for individuals transitioning out of incarceration	Under **California Medicaid's CalAIM Justice Involved Initiative**, individuals with behavioral health conditions who are transitioning out of incarceration will be enrolled in Medicaid prior to release and can receive intensive care coordination, warm handoffs to health care providers, and connection to housing and nutrition supports. **Resources:** • **State Policies Connecting Justice-Involved Populations to Medicaid Coverage and Care** • **State Strategies for Establishing Connections to Health Care for Justice-Involved Populations: The Central Role of Medicaid**

Secondary Driver **C. Provide supports to address health-related social needs (HRSN) and barriers to care.** HRSN, such as housing insecurity and lack of transportation, can make it hard for beneficiaries to attend behavioral health follow-up appointments.	
Change Idea	**Case Studies, Evidence, and Resources**
C4. Expand availability of behavioral health follow up care (e.g., expanded hours, telemedicine)	Under its 1115 demonstration, **Kansas Medicaid** used telehealth to expand access to follow-up care after psychiatric hospitalization for Medicaid beneficiaries residing in frontier and rural areas **New Jersey Medicaid** is funding outpatient clinics to provide extended hours, including evenings and weekends for behavioral health services **Resource:** • **Telehealth Delivery of Behavioral Health Care in Medicaid: Findings from a Survey of State Medicaid Programs**
C5. Integrate technology-based interventions to provide appointment reminders and increase patient engagement	**Oklahoma Medicaid** provides beneficiaries and providers with access to mobile apps for individuals in SUD and mental health recovery. Beneficiaries may use the apps to receive appointment reminders, engage in virtual communities and message with peer recovery specialists. Providers use the apps to communicate with patients and track their progress. **Resources:** • **Text Messaging to Enhance Behavioral Health Treatment Engagement Among Justice-Involved Youth: Qualitative and User Testing Study** • **Access to and Preferences for Text Messaging for Medical and Insurance Reminders in a Safety Net Population**

Secondary Driver **D. Processes for discharge and transitions of care.** Timely transition between hospital emergency department (ED) visits and follow up care appointments is important for ensuring that behavioral health patients receive the care they need.	
Change Idea	**Case Studies, Evidence, and Resources**
D1. Ensure warm hand-offs on transitions of care	Pennsylvania Medicaid's Opioid Hospital Quality Improvement Program provided financial incentives to hospitals for implementing clinical pathways that ensure emergency department warm hand-offs for individuals initiating treatment for opioid use disorder. The program also provided financial compensation to hospitals that demonstrated improvements in opioid use disorder treatment using quality benchmarks. **Arizona Medicaid** leverages crisis preparation and recovery (CPR) rapid-response teams to provide same day follow-up care, connect patients to behavioral health services, and assist with navigating the behavioral health system. Under Washington Medicaid's 1115 demonstration, peer bridgers and certified peer counselors assist transitional age youth with care coordination and warm hand-offs for behavioral health discharges. **Resources:** • It Starts Before Discharge! Improving Follow-Up After Hospitalization for Mental Illness • Tackling The Mental Health Crisis in Emergency Departments: Look for Upstream Solutions
D2. Use a standardized script, to schedule or remind patients about follow-up appointments, and to identify and address barriers to care	Arizona Medicaid worked with Jewish Family and Children's Services to create an outreach script providing guidance for outreach staff to schedule follow-up appointments with patients and address barriers to care. **Resource:** • Post discharge Follow-Up Phone Call • Can what we learned about reducing no-shows in our clinic work for you?

Secondary Driver

D. Processes for discharge and transitions of care. Timely transition between hospital emergency department (ED) visits and follow up care appointments is important for ensuring that behavioral health patients receive the care they need.

Change Idea	Case Studies, Evidence, and Resources
D3. Utilize home visits, Critical Time Intervention, and other "bridging" strategies after hospital discharge	In California Medicaid's Transitions of Care Program (part of the Whole Person Care – Los Angeles Pilot under California Medicaid's 1115 waiver demonstration), CHWs perform a home visit within 72 hours of discharge to schedule future appointments, arrange transportation, and assist with medications. New Hampshire Medicaid developed team-based critical time interventions at ten inpatient psychiatric facilities to connect patients to community-based services and provide ongoing support for the first nine months following discharge. **Resources:** • Care Management Intervention to Decrease Psychiatric and Substance Use Disorder Readmissions in Medicaid-Enrolled Adults | SpringerLink • Improving Care Coordination and Reducing ED Utilization Through Patient Navigation • Use of a Critical Time Intervention to Promote Continuity of Care After Psychiatric Inpatient Hospitalization
D4. Center patients in standardized discharge planning	Illinois Medicaid's CountyCare Health Plan leveraged care managers in completing discharge documents with individuals receiving inpatient psychiatric care. Using the Re-Engineered Discharge (RED) toolkit, care managers involve the patients in discharge planning. **Resources:** • Re-Engineered Discharge (RED) Toolkit | Agency for Healthcare Research and Quality • Strategy 4: IDEA Discharge Planning (Implementation Handbook)

Secondary Driver

E. Data sharing and notifications systems, including admission, discharge, and transfer (ADT) systems. Efficient knowledge transfer systems can help to ensure that all healthcare partners have the information they need to meet behavioral health needs.

Change Idea	Case Studies, Evidence, and Resources
E1. Leverage admission, discharge, and transfer (ADT) notifications to support timely outreach and care coordination	Through Minnesota Medicaid's Encounter Alert Service (EAS), healthcare providers and care managers receive ADT notifications for all patients on their panels. All healthcare and care coordination entities in the state can participate in EAS, with the state paying onboarding costs for Medicaid providers. Tennessee Medicaid developed a secure online care coordination tool that provides ADT notifications to physical and behavioral health providers, managed care organizations, and other state users. Oklahoma Medicaid requires Health Home providers to use a population management tool to track and monitor patient hospitalizations and ED visits.
E2. Increase interoperability to support data sharing across providers and systems	California Medicaid launched its Population Health Management Service in 2023. This technology service allows Medicaid managed care plans, providers, counties, Medicaid beneficiaries, and other authorized users to access and share medical and social service data, and supports risk stratification and care coordination. Montana Medicaid designated and funds a statewide health information exchange network to facilitate timely information sharing and support care coordination and behavioral health integration. North Carolina Medicaid's NCCARE360 platform supports closed-loop referrals between health care providers and social service organizations to facilitate connection to needed services. **Resource:** • State Strategies to Advance Health Data Interoperability
E3. Use data to identify beneficiaries at higher risk for targeted outreach and support	Oklahoma Medicaid maintains a "most in need" list of patients with certain risk factors and utilization history. Providers can access this list through a centralized data site and receive an incentive payment if patients are not readmitted within 30 days following a hospital or emergency department visit. **Resources:** • Equity in CalAIM: How to Identify the Patients Who Will Benefit Most • Identifying "Rising Risk" Populations: Early Lessons from the Complex Care Innovation Lab

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