State of New Hampshire
Department of Health and Human Services

New Hampshire Annual Quality Meeting

September 29, 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgements

Health Services Advisory Group, Inc., confirms that no one organizing the New Hampshire Quality Meeting activities had a conflict of interest with **AmeriHealth Caritas New Hampshire** (**ACNH**), **New Hampshire Healthy Families** (**NHHF**), or **Well Sense Health Plan** (**WS**) health plans.

1. Introduction

On September 29, 2021, The New Hampshire Department of Health and Human Services (DHHS) held an annual quality meeting virtually with representatives from the State and a variety of stakeholders. Health Services Advisory Group, Inc. (HSAG), the external quality review organization for New Hampshire, assisted DHHS by organizing and coordinating the virtual meeting.

The purpose of the meeting was to discuss issues impacting the following Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] rate for New Hampshire Medicaid Members: *Follow-Up Appointments After Emergency Department Visits for Alcohol and Substance Abuse/Misuse (FUA)*. A total of 78 people attended the four-hour virtual meeting from the following organizations:

- DHHS: 27
- Managed care organizations (MCOs): 20
- Provider groups and community organizations: 15
- Hospitals: 7
- Speaker, facilitator, patient representatives, and support personnel: 9

The main objectives of the meeting included:

- Reaching consensus concerning the barriers to follow-up appointments that are affecting New Hampshire's HEDIS rate
- Brainstorming potential DHHS and MCO support to assist in addressing the barriers that impact New Hampshire's HEDIS rate

The meeting agenda included a short introduction from DHHS, a speaker who shared her experiences as a former substance use disorder (SUD) patient, an explanation of the FUA HEDIS measure, a review of New Hampshire Medicaid Care Management (MCM) Program SUD policies, an address from the keynote speaker, and facilitated brainstorming sessions to identify barriers to care and interventions to mitigate barriers. The meeting agenda is included in Appendix A.

This report will include information generated during the meeting through presentations and brainstorming sessions with the attendees. The ideas should not be assumed to be *statistically* representative of the organizations attending. They can be used, however, to identify salient issues relevant to the population, provide contextual information for the larger assessment process, and identify avenues for further research.

In this report, the word *member* is used generically to denote Medicaid beneficiaries, MCO members, patients, and clients.

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

2. Performance Measure

The HEDIS measure, *Follow-Up Appointments After Emergency Department Visits for Alcohol and Substance Abuse/Misuse*, is defined by the National Committee for Quality Assurance (NCQA). To ensure that MCOs use the same information when compiling this rate for Medicaid members, NCQA provides the following specifications for the rate's denominator:

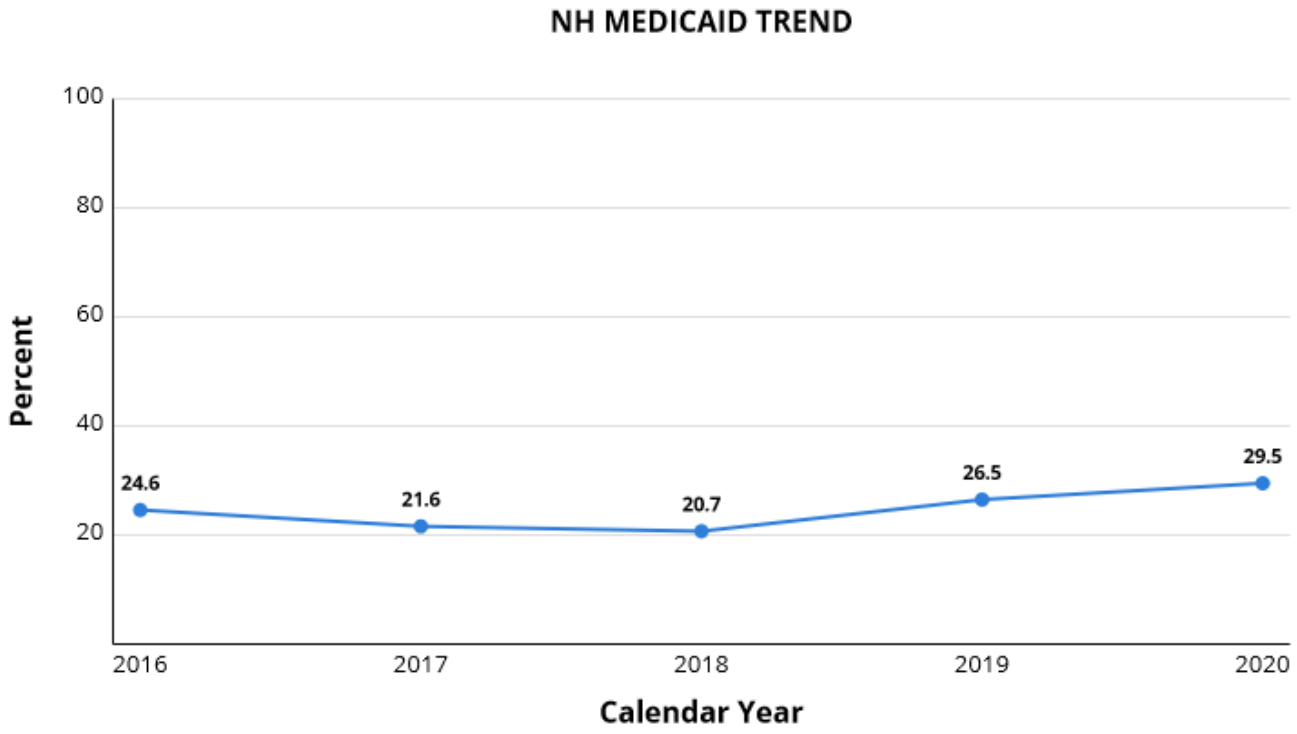
The member must have a primary diagnosis of alcohol and other drug (AOD) abuse or dependence

- Alcohol and other drugs include:
  - Opioids
  - Alcohol
  - Other drugs (stimulants, hallucinogens, inhalants, cocaine)
- The denominator includes visits, not people (e.g., one person could have multiple visits in the denominator)
- Members must be enrolled in the health plan for at least 31 days after the emergency department (ED) visit
- Members are excluded if transferred to an inpatient setting for any diagnosis (residential treatment is not excluded in most cases)

The numerator includes members who were seen in the ED for a primary diagnosis of AOD and received a follow-up visit at any practitioner's office (e.g., primary care, SUD provider, or mental health center) within seven days. Visits include but are not limited to counseling, screening and assessment, office visits for medication assisted treatment (MAT), and office-administered medication for MAT (e.g., methadone).

New Hampshire has tracked member results of the HEDIS measure, *Follow-Up Appointments After Emergency Department Visits for Alcohol and Substance Abuse/Misuse*, over time beginning with calendar year (CY) 2016, and the results are shown in the figure below:

Figure 2-1—*Follow-Up Appointments After Emergency Department Visits for Alcohol and Substance Abuse/Misuse* from CY 2016–2020 for New Hampshire Medicaid



Currently, the numerator does not count pharmacotherapy prescriptions filled for alcohol/opioid use disorder medications or MAT medications, and the denominator does not count drug overdoses coded as a secondary diagnosis. New NCQA specifications for calculating the measure for CY 2022, however, will address those limitations.

Limitations to the measure also include no control for appropriateness of the follow-up treatment and limiting the measure to the initiation of treatment versus continuation of treatment. Currently, no rates are available showing breakouts for race and ethnicity, although those rates will be available in the future.

This measure is becoming recognized and endorsed on the national stage by the Centers for Medicare & Medicaid Services (CMS) and the National Quality Forum.

3. MCO Contract Policy Review

During the meeting, participants voted on three DHHS policies using on-screen polls, and participants had 45 seconds to select answers to questions related to those policies. The policies and polling questions pertained to requirements in DHHS' MCM contract with the MCOs, and the questions concerned the performance measure *Follow-Up Appointments After Emergency Department Visits for Alcohol and Substance Abuse/Misuse*. The sections below list the DHHS contract requirements, the number of participants responding to questions about the three policies, the DHHS MCO contract requirements, the polling questions, and the polling results for each question.

Prior to the meeting, the MCOs and DHHS identified the people who would be voting for their organization when responding to the polling questions to ensure that the voting represented the organizations attending the meeting and not the number of participants from those organizations who attended the meeting.

Policy #1 Questions

DHHS Contract 5.4.1: DHHS shall institute a withhold arrangement through which an actuarially sound percentage of the MCO's risk adjusted capitation payment will be recouped from the MCO and distributed among the MCOs participating in the MCM program on the basis of meeting targets specified in the DHHS Withhold and Incentive Program Policy.

The table below indicates the number of participants from each type of organization represented at the meeting who responded to questions concerning Policy #1.

Table 3-1—Type of Organizations and Number of Participants Responding to Policy #1

Organization	# of Participants
Providers (i.e., hospital, primary care, behavioral health, SUD treatment provider)	15
DHHS	3
Other (e.g., members, provider association advocate, community organization)	4
MCOs	2
Total	**24**

Policy #1: *The Department withholds a portion of the MCOs' payments. MCOs can earn these payments back by achieving minimum performance targets for the performance measure discussed in the meeting.*

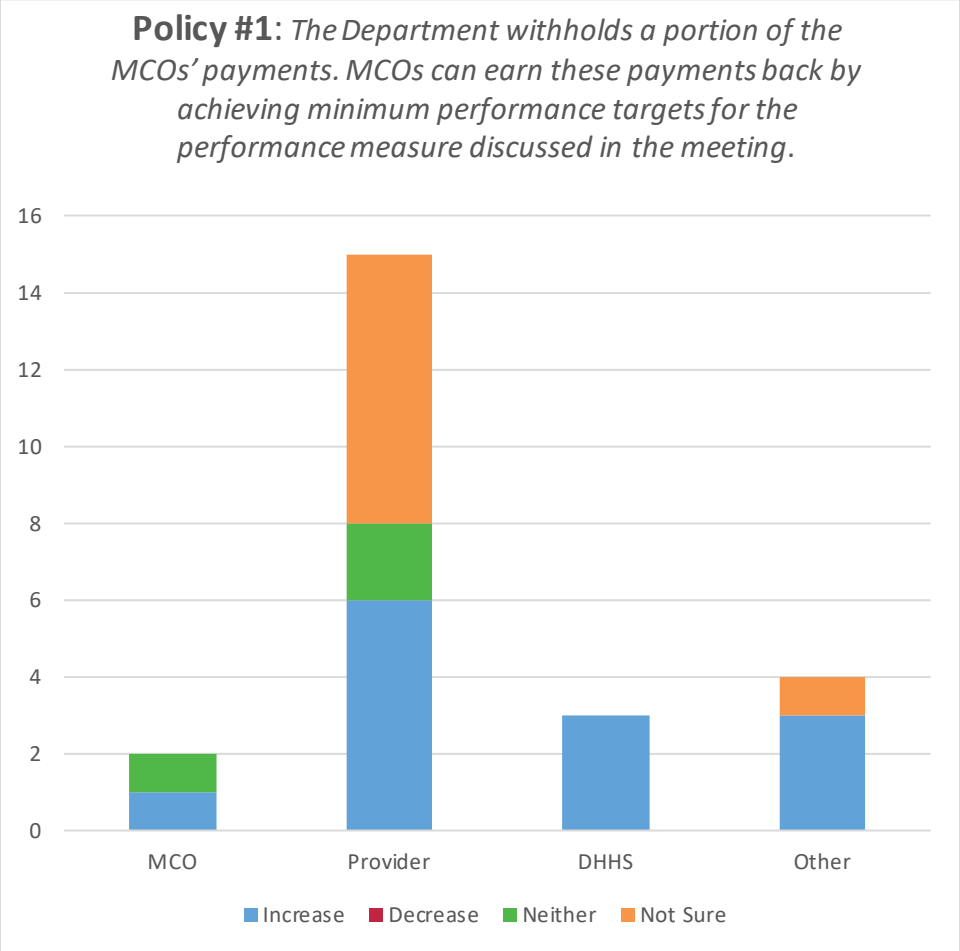
Policy #1—Question 1. Based on your expertise, how will the policy impact the performance rate?

Participant representatives from each organization could select one of four answers.

a. The policy will increase rates
b. The policy will decrease rates
c. The policy will neither increase nor decrease rates
d. I am not sure

Figure 3-1 displays the responses to Policy #1—Question 1.

Figure 3-1—Policy #1—Question 1: How Will the Policy Impact the Performance Rate?



A total of 54.2 percent of the respondents (number of responses [n]=13) indicated that the performance rate would increase. A total of 33.3 percent (n=8) were not sure if the rate would increase or decrease, 12.5 percent (n=3) did not think the rate would be impacted by the policy, and none thought the rate would decrease.

After indicating if Policy #1 would increase the rates, decrease the rates, neither increase nor decrease the rates, or the participant was not sure if the rates would increase or decrease, participants were asked if they previously were aware of the policy.

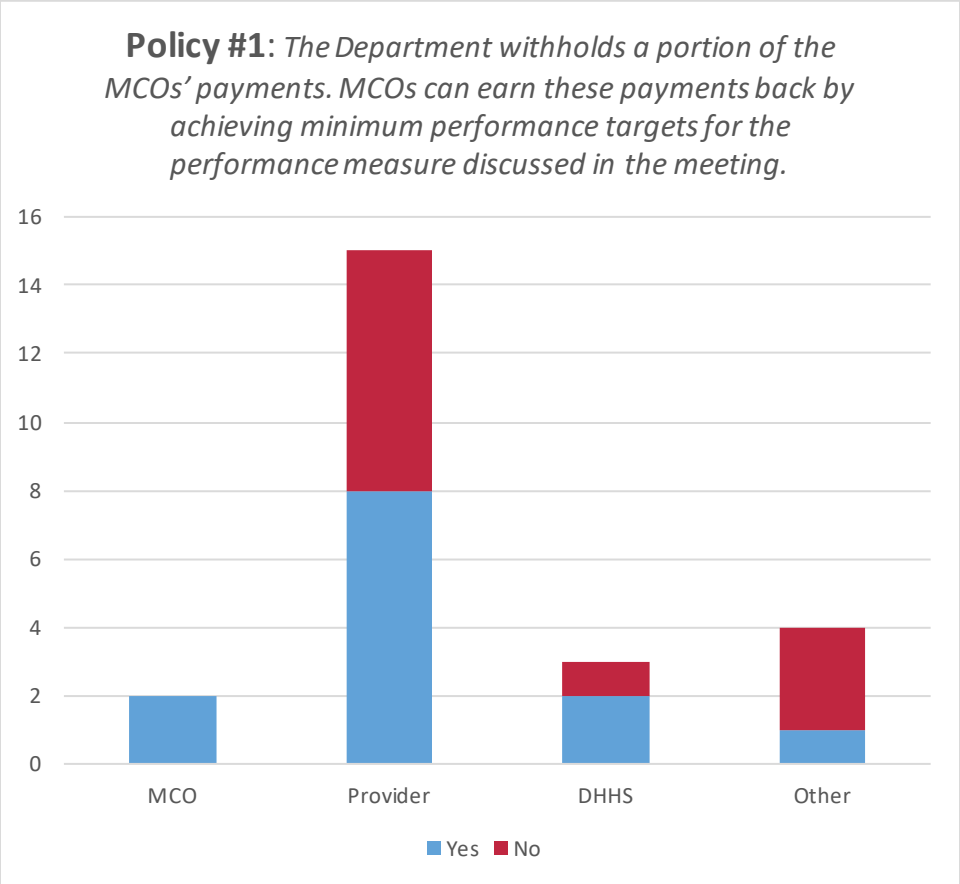
Policy #1—Question 2. Were you aware of this policy?

Participant representatives from each organization could select one of two answers.

a. Yes
b. No

Figure 3-2 shows the responses to Policy #1—Question 2.

Figure 3-2—Policy #1—Question 2: Were You Aware of This Policy?



A total of 54.2 percent (n=13) were aware of Policy #1 before the meeting, and 45.8 percent (n=11) were not aware of Policy #1 before the meeting.

Policy #2 Questions

DHHS Contract 4.11.6.18.6: The MCO shall make at least three (3) attempts to contact members within three (3) business days of discharge from the ED to review the discharge plan, support the member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the member may have.

The table below indicates the number of participants from each type of organization represented at the meeting who responded to questions concerning Policy #2.

Table 3-2—Type of Organizations and Number of Participants Responding to Policy #2

Organization	# of Participants
Providers (i.e., hospital, primary care, behavioral health, SUD treatment provider)	15
DHHS	3
Other (e.g., members, provider association advocate, community organization)	4
MCOs	3
Total	**25**

Policy #2: *The Department requires the MCOs to make at least three (3) attempts to contact members within three (3) days after a discharge from the emergency department for an overdose or substance use disorder.*

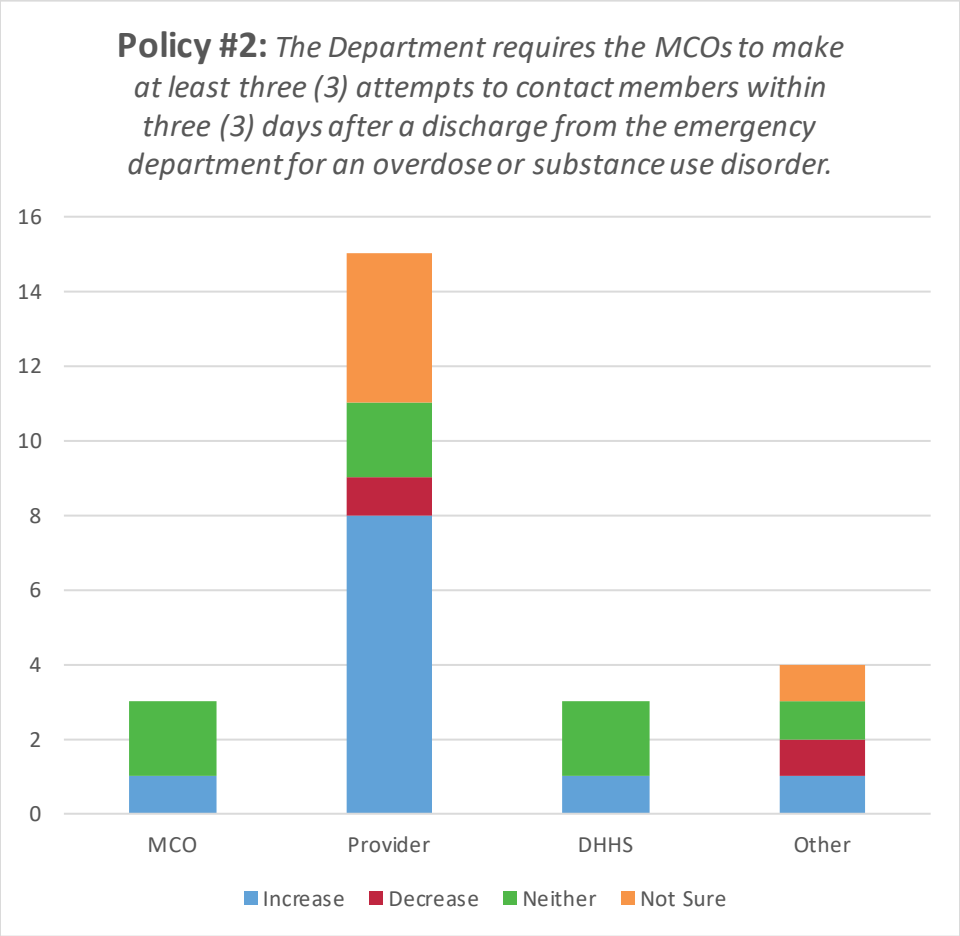
Policy #2—Question 1 asked participants the following question: Based on your expertise, how will the policy impact the performance rate?

Participant representatives from each organization could select one of four answers.

a. The policy will increase rates
b. The policy will decrease rates
c. The policy will neither increase nor decrease rates
d. I am not sure

Figure 3-3 displays the responses to Policy #2—Question 1.

Figure 3-3—Policy #2—Question 1: How Will the Policy Impact the Performance Rate?



A total of 44.0 percent of the respondents (n=11) indicated that the performance rate would increase. A total of 28.0 percent (n=7) did not think the rate would be impacted by the policy, 20.0 percent (n=5) were not sure if the rate would increase or decrease, and 8.0 percent (n=2) thought the rate would decrease.

After indicating if the policy would increase the rates, decrease the rates, neither increase nor decrease the rates, or the participant was not sure if the rates would increase or decrease, participants were asked if they previously were aware of the policy.

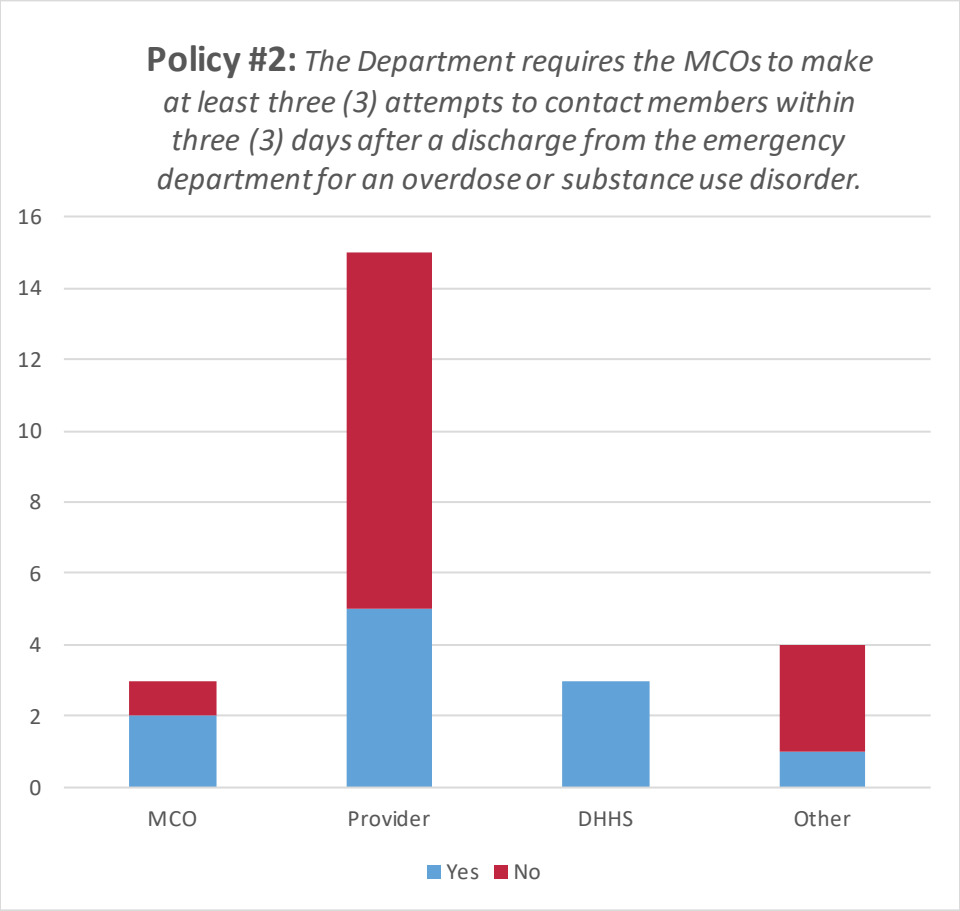
Policy #2—Question 2. Were you aware of this policy?

Participant representatives from each organization could select one of two answers.

a. Yes
b. No

Figure 3-4 shows the responses to Policy #2—Question 2.

Figure 3-4—Policy #2—Question 2: Were You Aware of This Policy?



A total of 44.0 percent (n=11) were aware of Policy #2 before the meeting, and 56.0 percent (n=14) were not aware of Policy #2 before the meeting.

Policy #3 Questions

DHHS contract 4.10.9.9: The MCO shall ensure that admission, discharge, and transfer data from applicable hospitals be made available to primary care providers (PCPs), behavioral health providers, integrated delivery networks, local care management entities, and all other care management entities within twelve (12) hours of the admission, discharge, or transfer.

The table below indicates the number of participants from each type of organization represented at the meeting who responded to questions concerning Policy #3.

Table 3-3—Type of Organizations and Number of Participants Responding to Policy #3

Organization	# of Participants
Providers (i.e., hospital, primary care, behavioral health, SUD treatment provider)	14
DHHS	3
Other (e.g., members, provider association advocate, community organization)	3
MCOs	3
Total	**23**

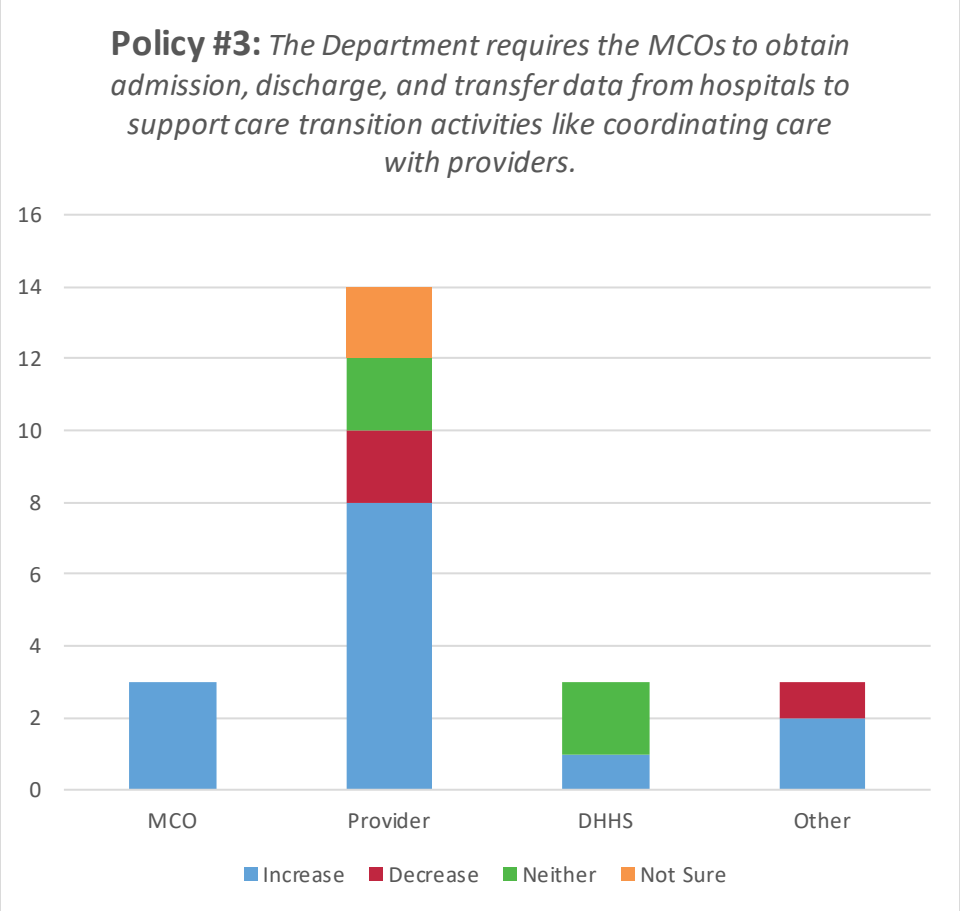
Policy #3—Question 1: *The Department requires the MCOs to obtain admission, discharge, and transfer data from hospitals to support care transition activities like coordinating care with providers.*

Policy #3—Question 1 asked participants the following question: Based on your expertise, how will the policy impact the performance rate?

Participant representatives from each organization could select one of four answers.

a. The policy will increase rates
b. The policy will decrease rates
c. The policy will neither increase nor decrease rates
d. I am not sure

Figure 3-5—Policy #3—Question 1: How Will the Policy Impact the Performance Rate?



A total of 60.9 percent of the respondents (n=14) indicated that the performance rate would increase. A total of 17.4 percent (n=4) did not think the rate would be impacted by the policy, 13.0 percent (n=3) thought the rate would decrease, and 8.7 percent (n=2) were not sure if the rate would increase or decrease.

After indicating if the policy would increase the rates, decrease the rates, neither increase nor decrease the rates, or the participant was not sure if the rates would increase or decrease, participants were asked if they previously were aware of the policy.

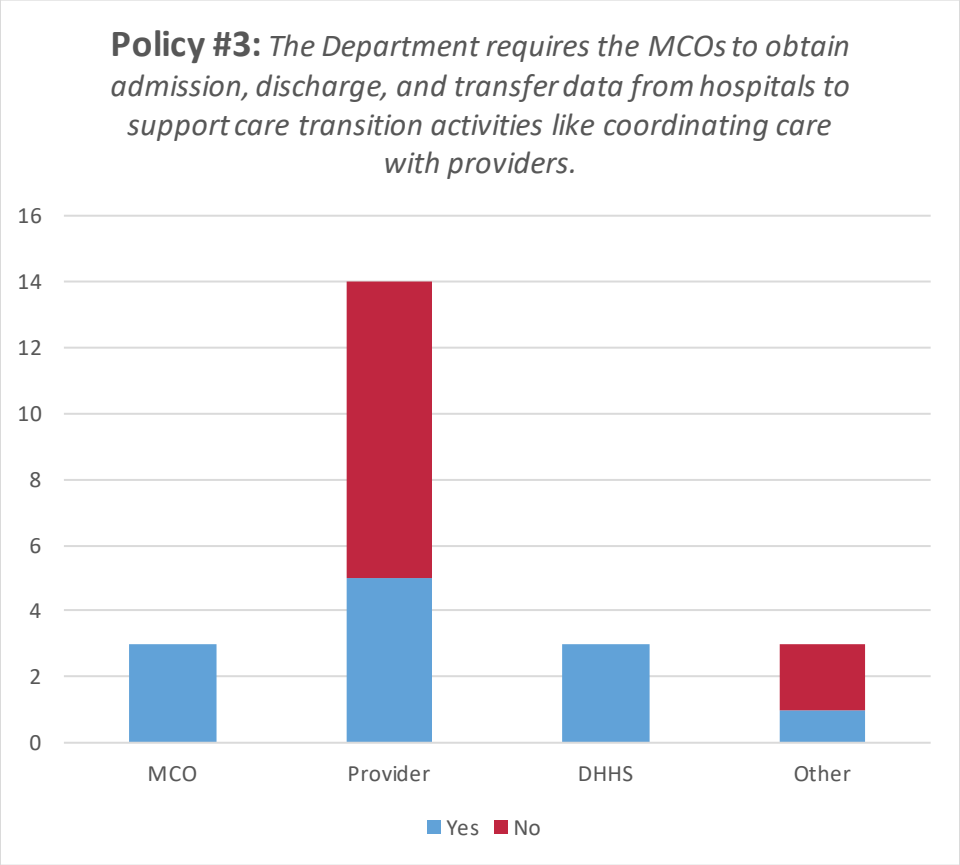
Policy #3—Question 2. Were you aware of this policy?

Participant representatives from each organization could select one of two answers.

a. Yes
b. No

Figure 3-6 shows the responses to Policy #3—Question 2.

Figure 3-6—Policy #3—Question 2: Were You Aware of This Policy?



A total of 52.2 percent (n=12) were aware of Policy #3 before the meeting, and 47.8 percent (n=11) were not aware of Policy #3 before the meeting.

4. Keynote Address

The keynote speaker, Sarah E. Wakeman, MD, provided information about the overdose crisis and displayed slides showing the alarming growth of drug overdose deaths in the United States since 2010 and during the coronavirus disease 2019 (COVID-19) pandemic. The data presented included success rates of patients treated with methadone and buprenorphine in reducing overdoses, and confirmed the importance of a strong relationship between the patient and a PCP in facilitating ongoing opioid use disorder treatment.

> *"I'm good with my doctor, you know. I could talk to her about anything that I'm going through. And she understands. She's not only my doctor, she's a friend. She's also a counselor as well, all in one. So I'm grateful."*

Dr. Wakeman emphasized that successful implementation of treatment in healthcare settings requires understanding and addressing the stigma patients encounter when accessing treatment. When patients with SUD were asked why they left the hospital prematurely, they gave the following reasons:

- *"Anytime that they hear that you [have addiction] they immediately shut down…it's like they just don't want anything to do with you."*
- *"They make you feel like a criminal because you have substance use issues."*
- *"[Not being allowed to leave the floor] feels just powerless. I don't have any control over anything anymore… Not having a break, not seeing the sun on my face, feeling like I'm in an institution… It makes it seem more like a prison than a helpful place."*

The keynote speech included two quotations from discharge summaries that were given to patients with SUD showing the different attitudes displayed toward the patients by the hospital staff members.

> *"You were hospitalized for shortness of breath. You were found to have new heart failure, and your heart was in an abnormal rhythm. You were also found to have narrowing of one of the arteries in your heart, so you had a stent placed in the artery via cardiac catherization. It was a pleasure taking care of you while you were here. Please do not hesitate to contact us with any questions or concerns. Best wishes for your good health and recovery."*

> *"You were seen in the emergency department today after you were found unresponsive in a bush. It appears this is likely due to your substance abuse. As you know, using illicit drugs can be extremely dangerous and even life-threatening." "Don't use drugs!"*

This powerful presentation set the stage for the ensuing discussions about barriers to care and the strategies to overcome the barriers.

5. Barrier Evaluation

The annual quality meeting included a brainstorming session for participants to define barriers that Medicaid members could encounter when attempting to access treatment within seven days after an ED visit for alcohol or substance abuse/misuse. The facilitator, Tanya Lord, PhD, led the participants through the activity using the MURAL application, which provided a visual, real-time collaboration of ideas. MURAL allowed participants to write ideas on "sticky notes" and post them to a community whiteboard. The facilitator then reviewed all the information provided by the participants and identified the three most frequently identified barriers.

The top barriers included three predominate themes:

1. Lack of community services
2. Member barriers
3. Communication

The next sections will provide additional information concerning the top three barriers.

Community Services

The participants generated 15 comments about community services, and those comments generated five categories of responses:

- Lack of mental health and community resources: Appointment availability hindered by facilities having extensive waitlists for treatment (e.g., first appointments and follow-up treatment); limited bed availability (n=8)
- Lack of personal handoff and coordination of care when continuing co-occurring treatment (i.e., mental health and SUD) (n=3)
- Lack of providers: Limited providers in the community; need additional PCPs who treat SUD; patients need quicker access to care (n=2)
- Lack of facilities offering 24-hour admissions (n=1)
- Need to address social determinates of health (SDoH) (e.g., affecting these members or available to these members) (n=1)

Member Barriers

The identification of member barriers generated the most diverse responses from the participants who generated 17 comments about member barriers. Those 17 comments, some containing multiple barriers, generated 13 categories of responses:

- Member attitude: Readiness to change or being unwilling to enter treatment (n=3)
- Inadequate housing or homelessness (n=2)
- Lack of response to outreach calls (n=1)
- Lack of up-to-date contact information to be able to communicate with the member (n=1)
- Perceived collaboration with law enforcement (n=1)
- Mental health and/or substance use interferes with his/her ability to follow through independently: Need more community-based support and case management (n=1)
- Children and parenting responsibilities (n=1)
- Lack of family and/or peer support (n=1)
- Lack of self-esteem, confidence, and motivation (n=1)
- Lack of access to telephone or transportation (n=1)
- Refusing care or discharged without a plan (n=2)
- Inability to understand SUD as a disease; (n=1)
- Providers creating a treatment plan without including the member; discharging a member without creating a treatment plan (n=1)

> Quote from a former patient:
>
> "I think, from a user's perspective, the biggest barrier is really not having access to a phone or transportation. To do any follow ups, I know, when I was out there using, if I had a phone, it was gone within like 24 hours because I lost it or someone stole it…so I think it makes it very difficult for the patients."

Communication

The participants generated 10 comments about communication, and those comments generated seven categories of responses:

- MCOs are not aware of the ED visit for SUD by the member or do not receive timely notification of the visit (3)
- Assist members by arranging warm handoffs to another provider instead of giving members a list of referrals (n=2)
- If members are treated with a lack of respect in the ED, they may not seek additional care (n=2)
- Data sent (e.g., admission, discharge transfer [ADT] information) from an emergency room admission pull in a large number of historical diagnoses due to the electronic medical records (n=1)

- MCO is unaware of the discharge plans from the ED and what supports were provided to the member (n=1)
- Better communication is needed among providers (n=1)
- Members' lack of access to a telephone to arrange follow-up appointments (n=1)

In addition to the top barriers, participants also noted barriers related to staffing (n=9), resources (n=8), stigma associated with alcohol or SUD (n=6), policy issues (n=4), lack of education (n=3), and transportation (n=3).

Appendix B includes detailed responses concerning the barriers identified by the participants.

Strategies to Address Barriers

After the brainstorming session identified the top three barriers, the facilitator initiated the final session of the meeting to identify strategies to overcome the barriers. Once again, the facilitator led the group through the activity using the MURAL application. The facilitator then reviewed all the information provided by the participants and identified the most frequently identified strategies to address the barriers.

The facilitator categorized the suggested strategies by the organization that could implement the strategies (e.g., DHHS, MCOs, and providers) as shown below. The top three strategies are listed for DHHS and MCO, and four provider strategies are listed due to the same number of respondents listing the last two strategies. The number of participant responses is shown for each suggested strategy.

Community Services

DHHS

- Allow programs like residentials to use certified recovery support workers who could bill for the time they spend with members; work with members in the hospital prior to and until enrollment in treatment (n=5)
- Fund contingency management (i.e., interventions and motivational incentives) (n=3)
- Provide treatment for members who are incarcerated (n=3)

MCOs

- Pay for certified recovery support workers/community support to assist in getting members into treatment; outreach personnel working side-by-side with members to walk them through the process (n=15)
- Offer incentives to PCPs to provide MAT (n=7)
- Establish mobile and remote services to decrease institutional trauma (n=3)

Providers

- Assist members by arranging warm handoffs to another provider for a guaranteed contact (n=6)
- Develop resources in primary care for SUD (n=6)
- Include certified recovery support workers and community workers in program budgets (n=2)
- Develop feeder programs at primary schools for human services like the science, technology, engineering, and mathematics (STEM) programs (n=2)

All three groups made comments concerning the use of and payment for certified recovery support workers. Two groups mentioned developing additional resources for treatment in a primary care setting.

Member Barriers

DHHS

- Fund more respite services for individuals after hospitalization while waiting to get into treatment; remove housing and access barriers (n=5)
- Drug User Health Services: Create access to care that meets the current needs of members who use drugs to reduce drug-related death and disease (n=5)
- "Doorway" in every hospital or at other agencies (n=3)

MCOs

- Case management for all members (n=10)
- Contingency management: Rewarding patients for follow-up (n=6)
- Provide information to EDs about the MCOs' program to give phones to members (n=4)

Providers

- Train ED staff in motivational interviewing techniques to facilitate better client engagement (n=6)
- Use certified recovery support workers to get clients from the hospital to a facility (n=4)
- Create digital patient files that carry across organizations and shorten intake time (n=3)

Quote from a former patient:

"I do know at one point, when I used to be on a Medicaid health plan, I would get rewarded for showing up to my appointments and stuff…I remember it was like a great feeling when I would get a gift card or something like that sent to me when I would show up to my appointments, and so I feel like that would be an incentive for patients to follow up to their next appointment."

The member barriers defined by the three groups represent the most diverse answers to any of strategies suggested during the meeting.

Communication

DHHS

- Require hospitals to use ADT software to inform providers of an ED visit (n=14)
- Initiate a joint effort between all parties: Development of ED-to-treatment referral pathways like the models in other states (n=10)
- Examine reimbursement rates for provider types: Bill rate versus reimbursement rate (e.g., community mental health centers [CMHCs] versus federally qualified health centers [FQHCs] rate for counseling portion of MAT) (n=8)

MCOs

- Enhance reimbursement rates for all levels of care (e.g., H codes as well as T codes)[5-1] (n=6)
- Provide cell phone devices to patients before hospital discharge (n=5)
- Alert providers when a member first touches the ED (n=5)

Providers

- Designate staff members to coordinate discharge services (n=6)
- Create/buy and follow anti-stigma training for hospital-wide rollout (n=5)
- Establish ADT feeds to hospitals (n=5)

All three groups made comments about the need to ensure that hospitals have an automated system to alert providers when a member has an admission or discharge, or is transferred to the ED. Two groups mentioned enhancing reimbursement rates.

A complete list of the strategies to address the barriers is included in Appendix C.

[5-1] H and T codes are included in a collection of billing codes representing medical procedure, supplies, products, and services.

7. Conclusions

After the meeting, 34 participants completed evaluation forms. Five items required a *Strongly Agree*, *Agree*, *Disagree*, or *Strongly Disagree* response. From the 170 possible responses, all but two responses were *Strongly Agree* or *Agree*. The Evaluation Form is included as Appendix D.

Polling Questions

The participants responded to three polling questions during the meeting, and the answers varied for each question as shown in Table 7-1.

Table 7-1—Results From the Three Polling Questions

Questions and Responses	Number	Percentage
Polling Question Policy #1 (24 Respondents)		
The Department withholds a portion of the MCO's payments. MCOs can earn these payments back by achieving minimum performance targets for the performance measure discussed today.		
The policy will increase rates	13	54.2%
The policy will decrease rates	8	33.3%
The policy will neither increase nor decrease rates	3	12.5%
I am not sure	0	0.0%
Aware of Policy #1		
I was aware of the policy before the meeting	13	54.2%
I was not aware of the policy before the meeting	11	45.8%
Polling Question Policy #2 (25 Respondents)		
The Department requires the MCOs to make at least three (3) attempts to contact members within three (3) days after a discharge from the emergency department for an overdose or substance use disorder.		
The policy will increase rates	11	44.0%
The policy will decrease rates	2	8.0%
The policy will neither increase nor decrease rates	7	28.0%
I am not sure	5	20.0%
Aware of Policy #2		
I was aware of the policy before the meeting	11	44.0%
I was not aware of the policy before the meeting	14	56.0%

Questions and Responses	Number	Percentage
Polling Question Policy #3 (23 Respondents)		
The Department requires the MCOs to obtain admission, discharge, and transfer data from hospitals to support care transition activities like coordinating care with providers.		
The policy will increase rates	14	60.9%
The policy will decrease rates	3	13.0%
The policy will neither increase nor decrease rates	4	17.4%
I am not sure	2	8.7%
Aware of Policy #3		
I was aware of the policy before the meeting	12	52.2%
I was not aware of the policy before the meeting	11	47.8%

The answers for all three policies indicated that most participants believed the policies would increase the rates, and one-third or fewer of the participants thought the policies would decrease the rates. Those answers appear to support the continued implementation of the requirements found in the contract with the MCOs.

Barriers

The brainstorming sessions using the MURAL application produced barriers identified by the participants, and the three most frequently mentioned barriers are shown below:

1. Lack of community services
2. Member barriers
3. Communication

Lack of Community Services

The participants generated 15 comments about the lack of community services. The services mentioned included lack of appointment availability, limited bed capacity in the State, lack of providers, and the need for facilities offering 24-hour admissions. Suggestions also included addressing the community services providing SDoH and having personnel that could coordinate the care of co-occurring treatments.

Member Barriers

The participants generated 17 comments about member barriers, and those comments were very diverse. Inadequate housing and member attitude were at the top of the list of barriers for members. Additional barriers included lack of contact information for the member, the member not having a telephone or not responding to outreach calls, perceived collaboration with law enforcement, parenting responsibilities,

lack of family or peer support, the member's low self-esteem and lack of confidence or motivation, lack of transportation, lack of a discharge plan or creating a treatment plan without receiving member input, the member's inability to understand SUD as a disease, and mental health issues and/or substance use interfering with the member's ability to function independently.

Communication

The participants generated 10 comments about communication. Many of those comments concerned MCOs and practitioners receiving timely notification when a member was treated at an ED and receiving a copy of the discharge plans. Participants also thought better communication with the member and among providers could be achieved if there were warm handoffs between providers. Members' lack of having a telephone also hindered communication between the member and providers. Ensuring that ED personnel treat members with respect also may assist in improving member communication.

Strategies to Address Barriers

The facilitator categorized the suggested strategies by the organization that could implement the strategies (e.g., DHHS, MCOs, and providers), and the information below summarizes those responses.

COMMUNITY SERVICES

The strategies to address barriers identified for community services generated for DHHS included using certified recovery support workers to bill for time spent with members. Respondents indicated that these workers could spend time assisting members from the time the member was hospitalized until the beginning of treatment. Funding contingency management and providing treatment for members who are incarcerated were the final two suggested interventions.

MCOs could consider paying certified recovery support workers to work with members as they progress through treatment. Two additional strategies for MCOs included offering PCPs incentives to furnish MAT and establishing mobile and remote services to decrease institutional trauma.

Providers could arrange for warm handoffs between providers (i.e., PCPs and SUD providers) to guarantee that members would contact the provider. Participants also suggested that providers could develop resources in the primary care setting for SUD to assist in overcoming barriers. Once again, reference was made to the use of certified recovery support workers in the recovery process. There was also a recommendation for providers to begin developing feeder programs in primary schools for careers in human services much like the STEM program.

MEMBER BARRIERS

Participants generated a suggestion for DHHS to remove housing and access barriers and provide respite funds for members after hospitalization and before treatment to reduce member barriers. The creation of Drug User Health Services also could reduce drug-related deaths and disease. A Doorway[7-1] in every hospital also could assist in overcoming member barriers.

Participants overwhelmingly supported MCOs providing case management for all members. They also supported MCOs using contingency management and informing ED providers about the MCOs' program to give phones to members.

Participants suggested that providers assist in training ED staff members in motivational interviewing techniques to facilitate better client engagement. Participants also mentioned that providers could use certified recovery support workers to assist members moving from the hospital to another facility. Digital patient files that were shared by providers and organizations also could shorten intake time.

[7-1] The "doorway" connects people to the supports and services and the level of care that's "right" for the patient, including screening and evaluation, treatment (including MAT), prevention (including naloxone), supports and services to assist in long-term recovery, and peer recovery support services. It is also a resource for people who are curious about, entering, or sustaining recovery from SUD.

COMMUNICATION

Participants suggested that DHHS staff members could encourage hospitals to use ADT software to ensure timely notification to providers when a member visits the ED. Participants also encouraged DHHS staff members to initiate the development of ED-to-treatment referral pathways as have been established in other states. Examining and comparing reimbursement rates for CMHCs and FQHCs for the counseling portion of MAT also would improve communication with the member.

Participants suggested that MCOs review and enhance reimbursement rates for all levels of care, especially the H and T codes.[7-2] Giving members cell phones prior to discharge and knowing when a member first enters the ED also would assist in improving communication.

Participants encouraged providers to designate staff to coordinate discharge services and implement anti-stigma training for hospital workers to improve communication with SUD members. They also agreed that communication would be improved by ensuring that hospitals used an ADT system to alert providers when members were admitted to the ED.

The number of participants attending the meeting, the number of participants who attended the MURAL training sessions prior to the meeting, the diversity of attendees, participation by past SUD patients, the information presented by the keynote speaker, the guidance provided by the facilitator, and the feedback generated during the meeting attest to the success of the virtual New Hampshire Annual Quality Meeting on September 29, 2021.

[7-2] H and T codes are included in a collection of billing codes representing medical procedure, supplies, products, and services.

DHHS Roundtable: Increasing Medicaid Member Follow-Up Appointments after Emergency Department Visits for Alcohol and Substance Abuse/Misuse

Agenda

Wednesday, September 29, 2021

Objectives

- Objective #1—Reach consensus on the barriers to follow-up appointments that are resulting in NH rates
- Objective #2—Brainstorm potential DHHS and MCO support for addressing the barriers that are impacting NH's rates

Time	Agenda Item	Speaker/Presenter
8:30 am	Welcome and Logistics	HSAG
8:35 am	Introduction – Outline of the Day	Dr. Jonathan Ballard *DHHS Chief Medical Officer*
8:40 am	Speaker – Lived Experience	Kylee M.
8:55 am	FUA Rates and Measure • Explain HEDIS Measure and Limitations • NH Medicaid FUA data • Selected Provider Screening Rates	Patrick McGowan *Bureau of Program Quality*
9:15 am	Review Existing NH SUD Medicaid MCM Policy	Jamie Powers *Bureau of Drug and Alcohol Services*
9:25 am	Polling on Existing NH SUD Medicaid MCM Policy	Patrick McGowan
9:30 am	Keynote Speaker • What research is showing concerning the importance of timely treatment	Dr. Sarah Wakeman
9:50 am	Facilitated Discussion on Brainstorming Barriers • Structured feedback from different groups versus opening-up the floor for anyone to talk • Potential Barriers – group voting	Tanya Lord, PhD

Time	Agenda Item	Speaker/Presenter
10:45 am	Break	
11:00 am	Facilitated Discussion on Brainstorming Solutions	Tanya Lord, PhD
11:50 am	Facilitator Discussion – Summary of Brainstorm Exercise • Potential Solutions: What can be done – group voting Next Steps	Tanya Lord, PhD
12:15 pm	Closing Remarks	Patrick McGowan

Appendix B. Barriers

Barriers Sorted by Themes[B-1]	
Community Services (15)	
1	Need to address SDoH
2	Lack of primary care providers who treat SUD
3	Lack of primary care providers who treat SUD[B-2]
4	Lack of mental health resources
5	Referred to a place with an extensive waitlist/back at square one!
6	Lack of personal handoff, continue enhanced co-occurring treatment and reduce siloing of "MH and/or SUD"
7	Lack of community services
8	Lack of 24-hour admissions
9	Soft referrals don't allow for outreach
10	Lack of communication between services
11	Appointment availability
12	Limited bed availability
13	Limited providers in the community, low barrier quick access, remove need for ID to get MAT treatment
14	Provider waitlists as a possible delay
15	Lack of available appts for follow-up care in timely manner

B-1 The facilitator prepared the *Table of Barriers Sorted by Themes* after reviewing the participant responses during the meeting.

B-2 Each line represents a response from one participant. Similar or the same response is noted on a separate line.

Barriers Sorted by Themes[B-1]	
Member Barriers (14)	
1	Members don't respond to outreach calls
2	Lack of up-to-date contact information to communicate with the patient/member
3	Perceived collaboration with law enforcement
4	Clients' mental health/substance use interferes with ability to follow through independently need more community-based supports/case management
5	Readiness to change
6	Patient unwilling to enter treatment
7	Inadequate housing or homelessness
8	Childcare and parenting responsibilities
9	Lack of family, peer support
10	Client barriers – lack of self-esteem, confidence, motivation
11	Patient has no access to phone or transportation
12	Discharged to homelessness
13	Didn't see my SUD as a disease; discharged with no plan/refusal of care
14	Providers make a plan without including the patient. Nothing with us without us
Communication (10)	
1	MCO's unaware of discharge plans from ED, and what supports if any were provided
2	MCO's aren't aware of ED visits
3	No centralized system notifying of patient ED admission. ADT feeds pull in ALL historical diagnoses which is a large number due to EMRs
4	If patients are treated poorly in ED by staff it may deter them from following up

Barriers Sorted by Themes[B-1]	
5	If patients are treated poorly in ED by staff it may deter them from following up[B-3]
6	Provider not notified timely of ED visit
7	Not adequate notification when someone has touched the ED
8	Better communication among providers
9	Warm handoffs vs. list of referrals/appointments
10	Give you a paper with follow up numbers and send you off/maybe patient doesn't have a phone
Staffing (9)	
1	Staffing issues amongst community providers
2	Engagement of ED staff
3	Available staff to coordinate
4	Out-of-network providers/no claims
5	EDs not having enough staffing to follow up causing burn out
6	Staffing shortages extreme
7	High burnout from existing providers – documentation overload coupled with few staff and high demand
8	Increased requirements for SUD documentation – including monthly treatment plans, etc.
9	ED staffing precluded ability to provide attention to follow up visits
Resources (8)	
1	Increased low barrier MAT treatment, enhanced co-occurring treatment protocols
2	No 24/7 walk in capability after the ED
3	Lack of support between ED visit and 7 day appt

[B-3] Ibid.

Barriers Sorted by Themes[B-1]	
4	ED not able or equipped to provide members with appropriate follow-up visits
5	One of the programs we have is an FQHC. Currently the state of New Hampshire reimburses fee for service (~$80 an encounter) for SUD services which includes MAT. The FQHC rate is around $190 an encounter. It's my understanding that has been in place since 2017/18.
6	Data
7	Members don't want/expect help from their insurer - they want it from a provider
8	Lack of outreach workers/funding for outreach workers to warm hand off to clients and follow them daily until they are completely engaged in services
Stigma (6)	
1	Lack of contact information for members to follow up. Very minimal response from members
2	Stigma at triage
3	Lack of apathy is instilled in staff when seeing a large volume or the same patients revisit the ED for the same medical issues such as SUD
4	Stigma, discrimination, avoidance of police
5	Feeling infantilized and feeling like an unreliable witness to my own health
6	Stigma trainings, revision of policies, increased training/x-waiver, policy modifications to reduce the need for waiver, improved policy/procedure to enhance flow of patients from ED setting to f/u location
Policy Issues (4)	
1	High burnout from existing providers – documentation overload coupled with few staff and high demand
2	Delay in communication regarding treatment needs and ED visits
3	Privacy laws create barriers
4	Peer recovery services don't count toward this measure (H0038)

Barriers Sorted by Themes[B-1]	
Lack of Education (3)	
1	Barriers in staff training
2	Lack of knowledge on the topic of addiction
3	There are no feeder programs for Human Services and counseling like there is for STEM
Transportation (3)	
1	Geographic barriers and lack of transportation
2	Lack of transportation
3	Lack of transportation[B-4]

[B-4] Ibid.

Appendix C. Strategies to Address Barriers

Strategies to Address Barriers[C-1]
Improve Communication
Strategies for DHHS to Consider
Require hospitals to be on an ADT software to inform of ED visits (14)[C-2]
Joint effort between all parties - development of ED to treatment referrals pathway like the models in other states (10)
Examine reimbursement rates for provider types - bill rate versus reimbursement rate (e.g., CMHC vs. FQHC rate for counseling portion of MAT) (8)
Strategies for MCOs to Consider
Enhance reimbursement rates for all levels of care (H codes as well as T codes) (6)
Provide cell phone device to patient before hospital d/c- Well Sense does offer this when able (5)
Alert providers when a member 1st touches ED (5)
Work with PCPs to ensure patients are engaged in care (3)
Strategies for Providers to Consider
Designated staff to coordinate discharge services (6)
Create/buy and follow an anti-stigma training for hospital wide rollout (5)
Establish ADT feeds to hospitals (5)
Utilize universal communication system such as CMT (4)
Develop workflows for all EDs to have the ability to do a warm handoff to a provider 24/7 (4)

C-1 The facilitator prepared the *Table of Barriers Sorted by Themes* after reviewing the participant responses during the meeting.

C-2 The number shown in parentheses is the number of participant responses mentioning that strategy.

Strategies to Address Barriers[C-1]
Create workflows for ED providers to access SUD specialist (e.g., on call) to assist with the hand off. This could be a licensed clinician or peer (2)
Shift power, control, and decision-making into the hands of the patient. Empowerment works better than behavior modification (1)
Stop pathologizing and infantilizing patients who use drugs. Embody a culture of dignity, respect, consent, and hospitality (1)
Cont. to advocate for Medicare to expand their provision of care for SUD and other disciplines such as LCMHC/MLADC (1)
Direct video link from ED to SUD provider (1)
Use ROIs to allow for outreach (1)
Community Services
Strategies for DHHS to Consider
Allow programs (like residentials) to utilize CRSW's and be able to bill for that time, prior to enrollment in treatment to begin working with individuals while at the hospital and continue to work with them until they are engaged in services needed (5)
Fund contingency management (3)
Treatment for people who have been incarcerated (3)
Enhance SUD reimbursement for FQHCs (2)
Reduced admin barriers to provide community-based services (2)
Ensure accuracy of member contact info on 834 file to health plans (2)
Transportation services specifically for members with SUD diagnosis (2)
Greater focus on licensing standards for treatment professionals to increase credentialing (1)
Avoid interactions with law enforcement. End law enforcement role in addressing health-related issues. Affirm drug use as a health issue, not a legal or criminal justice issue. (1)

Strategies to Address Barriers[C-1]
Strategies for MCOs to Consider
Pay for CRSW/community support to help get clients into treatment, outreach workers working side by side with the client to walk them through the process (15)
Incentivize PCP to provide MAT (7)
Think about institutional trauma. Mobile and remote services that meet people where they're at without leaving them there. (3)
Treatment for people who have been incarcerated (2)
Strategies for Providers to Consider
Warm handoffs. Make the phone call with the patient for guaranteed contact (6)
Develop resources in primary care for SUD (6)
Include CRSWs and community workers into their budgets (2)
Develop Feeder Programs at Primary school age for Human Services like STEM (2)
Treatment for people who have been incarcerated (1)
More, well-paid, peer navigators (1)
Member Barriers
Strategies for DHHS to Consider
Fund more respites for individuals to stay at after hospitalization while waiting to get into treatment, removing housing and access barriers (5)
Drug User Health Services. Create access to care that meets the current needs of people who use drugs to reduce drug-related death and disease (5)
Doorway in every hospital or at other agencies (3)
Create coordination amongst stakeholders (1)

Strategies to Address Barriers[C-1]
Strategies for MCOs to Consider
Case management for all beneficiaries (10)
Contingency management-rewarding patients for follow up (6)
Provide info to EDs about ability to get phones through MCO (4)
Medically adjacent peer as a patient navigator (3)
Strategies for Providers to Consider
Train ED staff in MI to facilitate better client engagement (6)
Utilize CRSWs to get clients from hospital to the facility (4)
Digital patient file that carries across orgs and shortens intakes (3)
Give phones/tables/data plan and transportation vouchers in the ED (1)
Give financial incentives for moving through the care cascade (1)
Provider can talk with patient about what they would like to see happen for a plan moving forward (1)
Staff Training (1)
Offer interim services (1)
Provide transportation from the ED to treatment or respite (1)
A strengths-based approach to the coproduction of a health and wellness plan built on affirmative consent and patient dignity (1)
Increase patient agency, autonomy, and decision-making (1)

DHHS Roundtable: Increasing Medicaid Member Follow-Up Appointments after Emergency Department Visits for Alcohol and Substance Abuse/Misuse

Evaluation Form
Wednesday, September 29, 2021

Please check the response that most accurately describes your evaluation of the following statements.

A. Objectives

The following objectives were met during the meeting:	Strongly Agree	Agree	Disagree	Strongly Disagree
1. Participant is able to name at least two barriers to follow-up appointments that are resulting in low New Hampshire rates that were identified today.				
2. Participant is able to list at least one potential DHHS or managed care organization (MCO) solution for addressing the barriers that are affecting NH's rates.				
3. Participant is able to identify at least two ways to increase the number of patients who have follow-up visits after an ED visit for alcohol and/or substance abuse/misuse treatment.				

B. Keynote Speaker

Sarah Wakeman, MD
Associate Professor, Harvard Medical School
Medical Director, Mass General Hospital Substance Use Disorder Initiative
Medical Director for Substance Use Disorder at Mass General Brigham

The following objectives were met during the meeting:	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The speaker was knowledgeable about the topic of the meeting, an effective speaker, and presented valuable information regarding the importance of follow-up appointments after ED visits for alcohol and substance abuse/misuse.				

C. Meeting Facilitator

Tanya Lord, PhD
Director, Patient and Family Engagement—Foundation for Healthy Communities
Director, Quality Improvement—Peer Support Community Partners

The following objectives were met during the meeting:	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The facilitator effectively and efficiently managed the discussions during the meeting.				

D. Please explain any *Disagree* or *Strongly Disagree* Responses.

E. Please share any other comments relevant to this conference.