Improving timely follow-up care after a behavioral health (BH)-related emergency department (ED) visit

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Learning Objectives

Describe the importance of timely follow-up care for individuals that have had an emergency department (ED) visit for mental illness or substance use diagnoses.

Identify different ways follow-up care can be administered to support the individual's treatment plan.

Administer the appropriate standardized screening tools to screen for mental health conditions and substance use disorders.

The emergency department (ED) is a frequent source of care for individuals with mental and substance use disorders.[1]

20.4 million individuals (approximately 7.4% of the population)

The number of individuals that reported having an substance use disorder (SUD) within the past year in 2019 [2]

1 in 8

The number of ED visits involving mental and substance use disorders compared to total visits to the ED [3]

ED care shifts during the pandemic

Overdoses exhibited great increases in weekly counts between 2019 and 2020. Drug and opioid overdose ED visits did not decrease compared to other ED visits[4]

1. Croake S, Brown JD, Miller D, Darter N, Patel MM, Liu J, Scholle SH. Follow-Up Care After Emergency Department Visits for Mental and Substance Use Disorders Among Medicaid Beneficiaries. Psychiatr Serv. 2017 Jun 1;68(6):566-572. doi: 10.1176/appi.ps.201500529. Epub 2017 Jan 17. PMID: 28093060.
2. Substance Abuse and Mental Health Services Administration (SAMHSA). 2020. Key Substance Use and Mental Health Indicators in the United States. https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf
3. Weiss, A., M. Barrett, K. Heslin, C. Stocks. 2016.Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006–2013. HCUP Statistical Brief #216. Agency for Healthcare Research and Quality. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-VisitTrends.pdf
4. Holland KM, Jones C, Vivolo-Kantor AM, et al. Trends in US Emergency Department Visits for Mental Health, Overdose, and Violence Outcomes Before and During the COVID-19 Pandemic. *JAMA Psychiatry.* 2021;78(4):372–379. doi:10.1001/jamapsychiatry.2020.4402

Importance of timely follow-up care after an ED visit

Clinical Risks	Improved Treatment Outcomes
• Patients with psychiatric disorders are more likely to have multiple ED visits than patients without psychiatric disorders.[2] • They're also more likely to experience worsened conditions.[3]	• Having one or more MSUD –related primary care visit was associated with lower odds of any ED visit • Use of one or more outpatient psychiatrist visits was associated with lower ED use among individuals treated for serious mental conditions or substance use disorders.[1] • Helps individuals adjust back to work and school • Increases the chances of medication/treatment adherence

1. Lavergne, M.R., Loyal, J.P., Shirmaleki, M. et al. The relationship between outpatient service use and emergency department visits among people treated for mental and substance use disorders: analysis of population-based administrative data in British Columbia, Canada. BMC Health Serv Res 22, 477 (2022). https://doi.org/10.1186/s12913-022-07759-z
2. Okafor M, Wrenn G, Ede V, Wilson N, Custer W, Risby E, Claeys M, Shelp FE, Atallah H, Mattox G, Satcher D. Improving Quality of Emergency Care Through Integration of Mental Health. Community Ment Health J. 2016 Apr;52(3):332-42. doi: 10.1007/s10597-015-9978-x. Epub 2015 Dec 28. PMID: 26711094.
3. Croake S, Brown JD, Miller D, Darter N, Patel MM, Liu J, Scholle SH. Follow-Up Care After Emergency Department Visits for Mental and Substance Use Disorders Among Medicaid Beneficiaries. Psychiatr Serv. 2017 Jun 1;68(6):566-572. doi: 10.1176/appi.ps.201500529. Epub 2017 Jan 17. PMID: 28093060.

Two key metrics that monitor timely follow-up care after an emergency department (ED) visit for behavioral health

FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS (FUM)

The percentage of emergency department (ED) visits for members **6 years of age and older with a principal diagnosis of mental illness or intentional self-harm**, who had a follow-up visit for mental illness within 7 days of the ED visit (8 total days) or within 30 days of the ED visit (31 total days).

FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR SUBSTANCE USE (FUA)

The percentage of emergency department (ED) visits among members **age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose**, for which there was follow-up within 7 days of the ED visit (8 total days) or within 30 days of the ED visit (31 total days).

These measures focus on ensuring **care coordination** for members who are discharged from the ED following high-risk substance use events, since those individuals may be particularly vulnerable to losing contact with the health care system. The intent is to support the transition back home and help providers detect early reactions or medication problems, providing continuing care.

Similarities and differences between FUM and FUA

	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Follow-Up After Emergency Department Visit for Substance Use (FUA)
Compliant (numerator)	• Visit with a **principal diagnosis of a mental health disorder** w/in 7 or 30 days after the ED visit (8 or 31 total days). • Visit with a **with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder** within 7 or 30 days after the ED visit (8 or 31 total days).	• **Visit or a pharmacotherapy dispensing event** within 7 or 30 days after the ED visit (8 or 31 total days). • Visits and pharmacotherapy events that occur on the date of the ED visit are compliant.
Eligible population (denominator)	• Active members age 6 and older • Had an ED visit with a **principal diagnosis of mental illness or intentional self-harm** • The ED visit was on or between January 1 and December 1 of the calendar year	• Active members age 13 and older • Had an ED visit with a **principal diagnosis of SUD or <u>any</u> diagnosis of drug overdose** • The ED visit was on or between January 1 and December 1 of the calendar year
	The denominator for these measures are based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year. Do not include more than one visit per 31-day period.	
Addt'l settings for follow-up visits	Telehealth visits, telephone visits, and e-visits or virtual check-ins	
Providers that can support follow-up	**Follow-up visits can be done with any practitioner**, including behavioral health and physical health providers. It depends on what is clinically and culturally appropriate for the individual.	

Additional information about multiple visits in 31-day period & exclusions

Multiple visits in a 31-day period

- If a member has more than 1 ED visit in a 31-day period, include only the first eligible ED visit
- Identify visits in chronological order, including only 1 per 31 day period.
- For example, if a member had an ED visit on January 1, include the visit on January 1. Do not include ED visits on or between January 2-January 31.
- If applicable, include the next ED visit that occurs on or after February 1.
- Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

Exclusions

- Exclude ED visits that result in an inpatient stay
- Exclude ED visits that are followed by an admission to an acute or nonacute inpatient care setting on the day of the ED visit or within 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission
- Admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Supporting Mental Health Follow Up Care (FUM)

Approved Follow-Up Visits for ED visits for Mental Illness (FUM)

Member can be seen by any Practitioner (Physical Health or Behavioral Health) but the claim must include a principal diagnosis for intentional self harm or any mental health disorder

- **Telehealth, Telephone, or Virtual visit**
- **Outpatient Visit**
- **An Observation visit**
- **Intensive outpatient encounter or Partial hospitalization**
- **Community Mental Health Center visit**
- **Electroconvulsive therapy**

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Additional Strategies to Impact ED visits for Mental Illness (FUM)

Engage the patient and guardian in their treatment:

- Discuss discharge, medications, side effects, crisis plan
- Use teach back methods
- Encourage questions
- Assess social, mental and physical health
- Refer to case management
- Ask for signed release of information forms

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Additional Strategies to Impact ED visits for Mental Illness (FUM)

- Offer telehealth and phone visits.
- Proactively outreach your patients.
- Code mental health related diagnoses and visits correctly on claims.
- Partner with the health plan and other providers to secure appointments.
- Work with PCP offices to offer Psychiatric Collaborative Care Management when applicable

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Follow-up for ED visits for Mental Illness (FUM) Telehealth, telephone, and e-visits requirements to support timely follow-up care

Measure	Telehealth	Telephone	E-Visits
Mental Illness	• Visit setting unspecified CPT Code • Telehealth Point of Service (POS) • Principal Diagnosis of a mental health disorder (DSM V)	• Telephone visit CPT code • Principal Diagnosis of a mental health disorder (DSM V)	• E-visit or virtual check-in CPT code • Principal Diagnosis of a mental health disorder (DSM V)
Intentional self-harm	• Visit setting unspecified CPT Code • Telehealth Point of Service (POS) • Principal Diagnosis code of intentional self-harm (DSM V) • With ANY diagnosis of a mental health disorder (DSM V)	• Telephone visit CPT code • Principal Diagnosis code of intentional self-harm (DSM V) • With ANY diagnosis of a mental health disorder (DSM V)	• E-visit or virtual check-in CPT code • Principal Diagnosis code of intentional self-harm (DSM V) • With ANY diagnosis of a mental health disorder (DSM V)

Supporting Substance Use Treatment Follow Up Care (FUA)

The Importance of Substance Use Disorder Treatment

- Stop or reduce harmful substance misuse
- Improve patients' overall health
- Increases overall quality of an individual's life
- Positive economic impact

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(Substance Abuse and Mental Health Service Administration, 2016)

Approved Follow-Up Visits for ED visits for Substance Use Treatment

The visit(s) must include a diagnosis of SUD, substance use, or drug overdose. OR occur with a mental health provider.

- Telehealth, Telephone, or Virtual visit
- Outpatient Visit
- An Observation visit
- Intensive outpatient encounter or Partial hospitalization
- Non-Residential SUD facility
- Peer Support
- Community Mental Health Center visit
- Opioid Treatment
- Substance Use service or behavioral health screening
- Medication Assisted Treatment for Alcohol or Opioid

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Additional strategies to support follow-Up visits for ED visits for substance use disorders

Express empathy and engage the patient and guardian;

- Encourage questions
- Assess willingness to change
- Validate concerns
- Educate on relapse prevention and treatment options
- Ask for signed release of information forms

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Additional strategies to support follow-Up Visits for ED visits for substance use disorders

Encourage Providers and staff to:	Offer telehealth and phone visits.
	Schedule the first visit within 7 days.
	Code substance related diagnoses and visits correctly on claims.
	Partner with the health plan and assess for peer support and care management referrals.
	Coordinate care between physical and mental health providers.

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Additional ways to administer timely follow-up care after an ED visit for substance use disorders

Screening, brief intervention, and referral to treatment (SBIRT)

- Categorized as “Substance Use Disorder Services” or “Behavioral Health Screening/Assessment”

Pharmacotherapy dispensing events

- Alcohol Use or Opioid Use Disorder Treatment Medications
- Medication Assisted Treatment

Peer Support Services

- Peer support services procedure codes paired with any diagnosis of substance use or drug overdose

Telehealth, telephone, and e-visits requirements to support timely follow-up care for ED visits for substance use disorders

Measure	Telehealth	Telephone	E-Visits
FUA – Non behavioral health provider	• Visit setting unspecified CPT Code • Telehealth Point of Service (POS) • Any diagnosis of SUD, substance use, or drug overdose	• Telephone visit CPT code • Any diagnosis of SUD, substance use, or drug overdose	• E-visit or virtual check-in CPT code • Any diagnosis of SUD, substance use, or drug overdose
FUA – Behavioral health provider	• Visit setting unspecified CPT Code • Telehealth Point of Service (POS)	• Telephone visit CPT code	• E-visit or virtual check-in CPT code

Recommended actions to support timely follow-up care after an ED visit for mental illness and/or substance use

Leverage remote options	Care Coordination	Documentation
• Telehealth • Telephone • E-visits/virtual check-ins • Medical and behavioral health providers can provide these services to support compliance	• Consider prompt referral to a behavioral health provider or to case management • Obtain and document proper permissions and consents share necessary with a behavioral health provider	• If providing follow-up care, ensure to document the principal diagnosis of mental illness (FUM), or the principal diagnosis of intentional self –harm AND any diagnosis of mental illness (FUM)

MHN administers behavioral health benefits (mental health and substance use) for the CA Market

All LOBs	Commercial, Marketplace, Medicare	Medi-Cal
• Immediate crisis support is available, 24/7, at 800-322-9707 • For nonurgent treatment, members can call MHN customer service directly for referrals • No prior authorization is required for initial assessment or for outpatient behavioral health services	• Includes inpatient and outpatient treatment for mental health and substance use treatment • Includes members diagnosed with severe mental illness for medically necessary treatment • To reach MHN customer service, members call the phone number on the back of their ID card	• Includes individual and group mental health evaluation and treatment (psychotherapy) • Includes Psychological and neuropsychological testing when clinically indicated to evaluate a mental health condition; • Includes Psychiatric consultation for medication management; • Includes Applied behavioral analysis (ABA). • To reach customer service, members call the plan customer service and use the phone tree to reach MHN • **MHN coordinates referrals to county mental health plans for severe and persistent mental illness and substance use (also known as chemical dependency)**

MHN Numbers & Resources

MHN Customer Service	MHN Crisis Line	Online Provider Directory	Language Assistance
• The customer service number may differ by line of business (for Medi-Cal, it is the medical plan's customer service) • The number can be found on the back of the member's ID card • **If the ID card is not available, call (888) 327-0010, press 1 (for member services), then press 3 (for benefits and referrals)**	• **(800) 322-9707** • This phone number provides MHN support 24/7 • This line is not for medical emergencies. If there is a medical emergency, dial 9-1-1. • For emergencies, can also call the National Suicide Prevention hotline 9-8-8.	• Visit https: https://www.mhn.com/find-a-provider.html • Check the applicable Health Net Plan (or Check CHW) • There are 3 search options: "Search by Telehealth," "Search by Distance," or "Search by Provider Attributes and location"	• (888) 426-0023 • If you need an interpreter or for any other language assistance needs

Additional Telehealth Providers in the MHN Network*

Line of Business	California Telemedicine Assoc (Babylon)	Telehealth docs	Telemed2u	Inpathy	HealthLink Now	Bright Heart Health, Inc.	Bright Heart Health Med Grp	Octave Behavioral Health	Daybreak Health PC	AbleTo
Commercial and Marketplace	✓	✓	✓	✓	✓	✓		✓	✓	✓
Medicare		✓	✓				✓			✓
Cal MediConnect		✓								
HN Medi-Cal	✓	✓	✓	✓	✓		✓		✓	
CHW Medi-Cal	✓	✓	✓	✓	✓		✓		✓	
Age Group served	18 years +	10 years +; Will review case by case basis down to and age of 6	6 years +	5 years + for Med Management and Therapy in CA	6 years +	18 years +	18 years +	18 years +	12 - 19 years	18 years +

*This a living list of providers that could change as new information and new policies become available/are enacted. Contact MHN Customer Service via phone, or check their online provider directory for more information.

L.A. Care Health Plan
How to help members connect with Behavioral Health Services

- L.A. Care Health Plan offers Behavioral Health Services via telehealth by Beacon Health Options
  - (877)344-2858

Cultural considerations when utilizing remote follow-up care

Interpreter Services	• Avoid using family members or friends to foster open communication

Privacy & Confidentiality	• Ensure privacy:
	  • Determine locational privacy
	  • Ask if there is anyone off-camera or in hearing range
	  • Ask if they can respond during engagement
	• Clearly explain consent requirements- why and how to complete

Technology Fluency	• Be patient and adaptable • Avoid tech jargon • Provide demonstration prior to appointment, tech run
Health Literacy	• Use clear and plain language • Teach back- ask patient to repeat in own words what they need to know and do
Non-Verbal Communication	• Pay attention to your body language • Gestures, facial expressions, and eye-contact vary in meaning across cultures • Watch patients body language for comprehension or confusion
Rapport & Trust	• Illicit patient illness beliefs regarding disease and treatment • Avoid stigmatizing language • Create shared decision-making

Cultural considerations associated with ED utilization or follow-up care following the COVID-19 Pandemic

- Observed variations in patterns for MH care-seeking, both in ED visits within and across racial and ethnic groups.
- Literature encourages focus on proactive and preventive care for racial and ethnic groups more likely to experience new MH needs during the pandemic.
- Race and ethnicity are related to inequities in hospital care and mortality, and stigmatizing experiences and other factors that lead to mistrust.
- Primary prevention efforts are needed to maintain mental and physical health, sustain community resilience, and overcome additive stress owing to the COVID-19 pandemic.

1. Anderson KN, Radhakrishnan L, Lane RI, et al. Changes and Inequities in Adult Mental Health–Related Emergency Department Visits During the COVID-19 Pandemic in the US. *JAMA Psychiatry*. 2022;79(5):475–485. doi:10.1001/jamapsychiatry.2022.0164

Cultural factors that may influence seeking follow-up care

Stigma	• Fear of moral judgement • Shaming self and family • Patient and disease not separated • Lack of provider cultural consonance (in understanding disease and illness stigma) • Provider opinion and negative attitude
Healthcare/Provider Discrimination	• Substandard care • Colorblind view (diminishing racial inequalities and its impacts) • Lack of trust
Privacy & Confidentiality	• Fear impact on employment, housing, and access to services • Fear impact to legal status • Avoid documentation in medical record
Norms	• Sign of weakness • Private matter not shared or discussed publicly • Family is part of decision-making • Familial obligation roles in caring for family
Disease & Illness Etiology	• Beliefs about cause and treatment of disease • Shared decision-making • Respect patients approach to care
Social Determinants	• Competing priorities: housing, food, employment, childcare • Co-morbid physical and mental health conditions

Additional cultural considerations associated with ED utilization or follow-up care

ADULTS AND ED VISITS[1]

- The ED is more likely to serve as the entry point into the healthcare system for racial and ethnic minorities, compared to white populations in the US.
- At the ED, minority populations have been found to receive disparate treatment for many common symptoms (e.g., chest pain/coronary events; pain management, etc.).
- The largest disparity existed between black and white patients.

MINORS AND ED VISITS[2]

- Black and Hispanic children faced disparities in emergency care across multiple dimensions of emergency care when compared to non-Hispanic white children.
- These disparities were observed across multiple dimensions of the ED visits and care.
- For example, the receipt of general procedures was slightly lower in Black and Hispanic relative to white children, including blood tests, X-rays, and CT scans.

1. Zhang, X., Carabello, M., Hill, T., Bell, S. A., Stephenson, R., & Mahajan, P. (2020). Trends of racial/ethnic differences in emergency department care outcomes among adults in the United States from 2005 to 2016. *Frontiers in medicine*, 7, 300.
2. Zhang, X., Carabello, M., Hill, T., He, K., Friese, C. R., & Mahajan, P. (2019). Racial and ethnic disparities in emergency department care and health outcomes among children in the United States. *Frontiers in pediatrics*, 7, 525.

Sharing Information and Care Coordination Supports Follow-Up Care

When

- Forward feedback within a week from evaluating the patient
- When the patient is discharged, forward information the day of discharge
- Contact the specialist or procedure site to request a copy of the report if the report hasn't arrived within 30 days

How

- Direct phone calls are the best-case scenario for conveying information
- Utilize written forms/fax if providers cannot take phone calls
- If phone calls or fax are unavailable, send secure e-mails or US mail.

What

- Evaluation, assessments, patient diagnosis, patient medications, lab, imaging and test results
- Share information to help the referring provider with diagnosis and treatment planning
- Keep in mind minimum necessary requirements and releases of information

Preventing ED visits through screening and early intervention

- For individuals with no prior outpatient encounters, earlier diagnosis and interventions offered in the outpatient setting may prevent future, avoidable ED visits or hospitalizations.[1]
- Based on a study of individuals with commercial insurance, individuals had encounters with the healthcare system with the same primary diagnosis as the index event one year before the hospital admission. [1]
- Among adolescents, Screening, Brief Intervention, and Referral to Treatment (SBIRT), has demonstrated clinically significant effects on the development of substance use disorders and healthcare utilization into young adulthood.[2]
- Please see the appendix for examples of behavioral health screening tools

1. Xi, W., Banerjee, S., Penfold, R. B., Simon, G. E., Alexopoulos, G. S., & Pathak, J. (2020). Healthcare utilization among patients with psychiatric hospitalization admitted through the emergency department (ED): A claims-based study. *General hospital psychiatry*, *67*, 92-99.
2. Sterling, S., Parthasarathy, S., Jones, A., Weisner, C., Metz, V., Hartman, L., ... & Kline-Simon, A. H. (2022). Young adult substance use and healthcare use associated with screening, brief intervention and referral to treatment in pediatric primary care. *Journal of Adolescent Health*, *71*(4), S15-S23.

Supporting linkages to behavioral health resources

- MHN, Health Net and CHW's behavioral health administrator utilizes Admit, Discharge, and Transfer (ADT) reports to identify individuals that have had a mental health or substance use disorder related ED visit.
  - MHN Case Managers attempt outreach over the course of 2-3 consecutive days from discharge to ensure their behavioral health needs are being met.
  - MHN Follow up Outreach team offers an array of supports including; Member Education, Referral to behavioral health providers Therapy/Psychiatry, Telemedicine, Provider Availability Check (PAC)s
  - Focus is on Commercial HMO/POS membership. Pending DHCS approval to expand to Medi-Cal members.

Your Role of the Provider in HEDIS®

Demonstrate commitment to quality care and improved patient outcomes

Know the BH HEDIS® measure requirements and provide appropriate care or referrals within the designated timeframes

Accurately code all claims and document clearly ALL services provided

Collaborate with the health plan for effective programs and interventions

Play an active role in coordinating care for our members

Slide courtesy of Centene's Population Health & Clinical Operations Behavioral Health Chapter

Additional Resources for Supporting Linkages to BH Resources

- https://www.samhsa.gov/programs
- https://providerlibrary.healthnetcalifornia.com/content/dam/centene/healthnet/pdfs/providerlibrary/Health-Equity-Cultural-and-Linguistic-Resources/Tips-to-Support-Patients-with-Childhood-Trauma-Comm-MCR-MCL.pdf
- https://www.heretohelp.bc.ca/infosheet/cross-cultural-mental-health-and-substance-use
- https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4849.pdf
- https://www.mentalhealthfirstaid.org/2019/07/four-ways-culture-impacts-mental-health/
- https://providerlibrary.healthnetcalifornia.com/medi-cal/health-equity--cultural-and-linguistic-resources-.html
- https://www.thetrevorproject.org/get-help/

Appendix

- Examples of behavioral health screening tools
- FUM/FUA recommended coding tips
- Approved Mental Health Providers per National Committee on Quality Assurance
- Upcoming available microlearnings on FUA and FUM

Standardized Behavioral Health Screenings and Tools

Condition	Screening Name	Special populations	Tips on Administering	Interpreting Results
Depression: http://www.phqscreeners.com/	Patient Health Questionnaire (PHQ-9)	Can be used for ages 12 and above	• Free to use • Scores can be entered into electronic health records • PHQ9 can be filled out two ways: directly by the patient (hard copy) or verbally by staff	Positive Score: Total Score ≥10
	Patient Health Questionnaire -2 (PHQ-2): **Patients who screen positive on PHQ-2 should be further evaluated with PHQ-9**	Can be used for ages 12 and above		Positive Score: Total Score ≥3
	Edinburgh Postnatal Depression Scale (EPDS) – 10 questions	For pregnant or post partum patients	• Most can complete this in five minutes • All 10 items should be completed • Parent/expecting parent should complete scale unless there are limited English or reading difficulties • Care clinical assessment recommended to confirm diagnosis	Total Score ≥10

Standardized Behavioral Health Screenings and Tools

Condition	Screening Name	Special populations	Tips on Administering	Interpreting Results
Anxiety http://www.phqscreeners.com/	Generalized Anxiety Disorder (GAD-7)	Rapid screening for the presence of a clinically significant anxiety disorder, including Panic Disorder, Social Anxiety & Posttraumatic Stress Disorder (PTSD), especially in outpatient settings.	• Can be administered by non-clinical or clinical staff but results must be interpreted by trained clinician • Can be filled out directly by patient or verbally by staff	Total Score ≥10
	Generalized Anxiety Disorder 2 –item (GAD-2)	GAD-2 also performs reasonably well as a screening tool for three other common anxiety disorders—Panic Disorder, Social Anxiety Disorder, and PTSD		Total Score ≥3

Standardized Behavioral Health Screenings and Tools

Condition	Screening Name	Special populations	Tips on Administering	Interpreting Results
Alcohol https://auditscreen.org/	Alcohol Use Disorders Identification Test (AUDIT) Screening Instrument https://pubs.niaaa.nih.gov/publications/audit.htm	• Primary care and emergency room patients, psychiatric patients • Employees in employee assistance programs and industrial settings • Individuals in jail, court, prison, or Armed forces	• Free with an interactive audit at https://auditscreen.org/about/faqs/ • Considered highly suitable for primary care and other healthcare settings	• Positive finding: Total Score ≥8 • Score of 8 to 14 suggests hazardous or harmful alcohol consumption • Score of 15+ indicates likelihood of alcohol dependence
	Alcohol Use Disorders Identification Test Consumption (AUDIT-C) Screening Instrument	• Validated for primary care settings	• Both AUDIT-C and Single-question screen can equally detect unhealthy alcohol use and current alcohol use disorders (American Family Physician) • Single- question can be on intake questionnaire or asked verbally • Patients who score positive on single-question should then receive full AUDIT to determine level of risk (Centers for Disease Control & Prevention)	Positive finding: Total Score ≥4 for men Total Score ≥3 for women
	Single-Question Screen: "How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?"	• Validated for primary care settings		Positive finding: Total Score ≥1
Other Substance use	Please refer to the National Institute on Drug Abuse for a "Screening and Assessment Tools Chart," available at https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools			

Patient Health Questionnaire 9 item and 2 item (PHQ9 and PHQ2)

Patient Health Questionnaire-2 (PHQ-2)

Instructions:
Please respond to each question.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Give answers as 0 to 3, using this scale:
0=Not at all; 1 =Several days; 2=More than half the days; 3=Nearly every day

1. **Little interest or pleasure in doing things**

☐ 0 ☐ 1 ☐ 2 ☐ 3

2. **Feeling down, depressed, or hopeless**

☐ 0 ☐ 1 ☐ 2 ☐ 3

Instructions

Clinic personnel will follow standard scoring to calculate score based on responses.

Total score: --

Patients who screen positive on PHQ-2, with a score ≥3 should be further evaluated with PHQ-9

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use ✓ to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Interpreting PHQ-9 Results and Treatment Response

PHQ9 SCORES AND ACTIONS

Table 4. PHQ-9 Scores and Proposed Treatment Actions *

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0—4	None-minimal	None
5—9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10—14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15—19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20—27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

* From Kroenke K, Spitzer RL, Psychiatric Annals 2002;32:509-521

PHQ9 SCORES AND TREATMENT RESPONSE

Initial Response after Four - Six weeks of an Adequate Dose of an Antidepressant		
PHQ-9 Score	**Treatment Response**	**Treatment Plan**
Drop of ≥ 5 points from baseline.	Adequate	No treatment change needed. Follow-up in four weeks.
Drop of 2-4 points from baseline.	Probably Inadequate	Often warrants an increase in antidepressant dose.
Drop of 1-point or no change or increase.	Inadequate	Increase dose; Augmentation; Switch; Informal or formal psychiatric consultation; Add psychological counseling.
Initial Response to Psychological Counseling after Three Sessions over Four - Six weeks		
PHQ-9 Score	**Treatment Response**	**Treatment Plan**
Drop of ≥ 5 points from baseline.	Adequate	No treatment change needed. Follow-up in four weeks.
Drop of 2-4 points from baseline.	Probably Inadequate	Possibly no treatment change needed. Share PHQ-9 with psychological counselor.
Drop of 1-point or no change or increase.	Inadequate	If depression-specific psychological counseling (CBT, PST, IPT*) discuss with therapist, consider adding antidepressant. For patients satisfied in other type of psychological counseling, consider starting antidepressant. For patients dissatisfied in other psychological counseling, review treatment options and preferences.

** CBT- Cognitive-Behavioral Therapy; PST- Problem Solving Treatment; IPT- Interpersonal Therapy*

Edinburgh Postnatal Depression Scale[1] (EPOS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy.
☐ Yes, all the time
☒ Yes. most of the time
☐ No, not very often
☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week.
Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   ☐ As much as I always could
   ☐ Not quite so much now
   ☐ Definitely not so much now
   ☐ Not at all

2. I have looked forward with enjoyment to things
   ☐ As much as I ever did
   ☐ Rather less than I used to
   ☐ Definitely less than I used to
   ☐ Hardly at all

*3 I have blamed myself unnecessarily when things went wrong
   ☐ Yes, most of the time
   ☐ Yes, some of the time
   ☐ Not very often
   ☐ No, never

4. I have been anxious or worried for no good reason
   ☐ No, not at all
   ☐ Hardly ever
   ☐ Yes, sometimes
   ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   ☐ Yes, quite a lot
   ☐ Yes, sometimes
   ☐ No, not much
   ☐ No, not at all

*6. Things have been getting on top of me
   ☐ Yes, most of the time I haven't been able to cope at all
   ☐ Yes, sometimes I haven't been coping as well as usual
   ☐ No, most of the time I have coped quite well
   ☐ No, I have been coping as well as ever

*7 I have been so unhappy mat I have had difficulty sleeping
   ☐ Yes, most of the time
   ☐ Yes, sometimes
   ☐ Not very often
   ☐ No, not at all

*8 I have felt sad or miserable
   ☐ Yes, most of the time
   ☐ Yes, quite often
   ☐ Not very often
   ☐ No, not at all

*9 I have been so unhappy that I have been crying
   ☐ Yes, most of the time
   ☐ Yes, quite often
   ☐ Only occasionally
   ☐ No, never

*10 The thought of harming myself has occurred to me
   ☐ Yes, quite often
   ☐ Sometimes
   ☐ Hardly ever
   ☐ Never

Administered / Reviewed by _____ Date_____

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPOS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression". The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EFDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center < www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0,1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

Generalized Anxiety Disorder (GAD-7)

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it Is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(***For office coding: Total Score T*** _____ = _____ + _____ + _____)

GUIDE FOR INTERPRETING GAD-7 TOTAL SCORES

Total Score	Anxiety Severity
0—4	NONE - MINIMAL
5—9	MILD
10—14	MODERATE
15—21	SEVERE

Note: Measures with more than one unanswered item should not be scored and entered into PEI OMA. If only one item is unanswered, calculate the arithmetic mean of the 6 scored items. Sum the 6 scored items and the mean to generate the GAD-7 total score.

Sources:
https://www.phqscreeners.com/select-screener
LA County GAD-7 Quick Guide:
http://file.lacounty.gov/SDSInter/dmh/1061861_GAD-7QuickGuide12282016.pdf

Alcohol Use Disorders Identification Test (AUDIT) Screening Instrument

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes. during the last year	
					Total	

Alcohol Use Disorders Identification Test-Concise (AUDIT-C)

General Instructions:

The Alcohol Use Disorders Identification Test-Concise (AUDIT-C) is a brief alcohol screening instrument. Please give a response for each question.

Segment: _ _
Visit Number: _ _

1. **How often do you have a drink containing alcohol?**
   - ☐ Never
   - ☐ Monthly or less
   - ☐ 2-4 times a month
   - ☐ 2-3 times a week
   - ☐ 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ 1 or 2
   - ☐ 3 or 4
   - ☐ 5 or 6
   - ☐ 7 to 9
   - ☐ 10 or more

3. **How often do you have six or more drinks on one occasion?**
   - ☐ Daily or almost daily
   - ☐ Weekly
   - ☐ Monthly
   - ☐ Less than monthly
   - ☐ Never

Follow-Up After ED Visit for Mental Illness — 30 Days

Coding

- **Visit Type WITH principal Mental Health (MH) Diagnosis or Intentional Self-Harm Diagnosis**
- **Visit Type WITH Place of Service (POS) WITH principal MH Diagnosis or Intentional Self-Harm**

CPT/HCPCS Codes

Visit Setting Unspecified:
- **CPT** 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

Observation Visit:
- **CPT** 99217, 99218, 99219, 99220

Telephone Visit:
- **CPT** 98966, 98967, 98968, 99441, 99442, 99443

Online Assessment:
- **CPT** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457
- **HCPCS** G0071, G2010, G2012, G2061, G2062, G2063

Places of Service (POS)
- **Outpatient POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
- **Community Mental Health Center:** 53

ICD codes

Mental Health Diagnosis

Intentional Self-Harm

Telehealth coding
- Telehealth used to add members to the numerator
- Synchronous: modifier “95” or “GT”
- POS service code “02” (Not applicable to FQHC’s, RHC’s, IHS)

Follow-Up After ED Visit for Mental Illness — 30 Days

Coding

- **Visit Type WITH principal Mental Health (MH) Diagnosis or Intentional Self-Harm Diagnosis**
- **Visit Type WITH Place of Service (POS) WITH principal MH Diagnosis or Intentional Self-Harm**

CPT/HCPCS Codes

BH Outpatient:

- **CPT** 98960,98961, 98962, 99078, 99201,99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99483, 99510
- **HCPCS** G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015

Places of Service (POS)

- **Outpatient POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
- **Community Mental Health Center:** 53

ICD codes

Mental Health Diagnosis

Intentional Self-Harm

Telehealth coding

- Telehealth used to add members to the numerator
- Synchronous: modifier “95” or “GT”
- POS service code “02” (Not applicable to FQHC’s, RHC’s, IHS)

Follow-Up After ED Visit for Substance Use — 30 Days

Coding

- **Visit Type** WITH **Substance Use (Alcohol or Other Drug) Diagnosis or Drug Overdose**
- **Visit Type** WITH **Place of Service (POS)** WITH **Substance Use (Alcohol or Other Drug) Diagnosis or Drug Overdose**

CPT/HCPCS Codes

Visit Setting Unspecified:
- **CPT** 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255

Observation Visit:
- **CPT** 99217, 99218, 99219, 99220

Telephone Visit:
- **CPT** 98966, 98967, 98968, 99441, 99442, 99443

Online Assessment:
- **CPT** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457
- **HCPCS** G0071, G2010, G2012, G2061, G2062, G2063

Places of Service (POS)
- **Outpatient POS:** 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
- **Partial Hospitalization POS:** 52
- **Non-residential substance abuse treatment facility:** 57, 58
- **Community Mental Health Center:** 53

ICD codes

Alcohol or Other Drug (AOD) Abuse and Dependence

Unintentional Drug Overdose

Telehealth coding
- Telehealth used to add members to the numerator
- Synchronous: modifier “95” or “GT”
- POS service code “02” (Not applicable to FQHC’s, RHC’s, IHS)

Follow-Up After ED Visit for Substance Use — 30 Days

CPT/HCPCS Codes

BH Outpatient:
- **CPT** 98960, 98961, 98962, 99078, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401,99402, 99403, 99404, 99411, 99412, 99483, 99510
- **HCPCS** G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, T1015

Peer Support Services
- **HCPCS** G0177, H0024, H0025, H0038, H0039, H0040, H0046, H2014, H2023, S9445, T1012, T1016

Opioid Treatment Service
- Weekly Non-Drug Service: **HCPCS** G2071, G2074, G2075, G2076, G2077, G2080
- Monthly Office Based Treatment: **HCPCS** G2086, G2087

Substance Use Disorder Services (can be used alone without a specific POS or diagnosis code)
- **CPT** 99408, 99409
- **HCPCS** G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H0050, H2035, H2036, T1006, T1012

Substance Use Services (can be used alone without a specific POS or diagnosis code)
- **HCPCS** H0006, H0028

Behavioral Health Screening or Assessment for SUD or mental health disorders (can be used alone without a specific POS or diagnosis code)
- **CPT** 99408, 99409
- **HCPCS** G0396, G0397, G0442, G2011, H0001, H0002, H0031, H0049

Pharmacotherapy Dispensing Event
- **AOD Medication HCPCS** H0020, H0033, J0570, J0571, J0572, J0573, J0574, J0575, J2315, Q9991, Q9992, S0109
- **Opioid Use Disorder Weekly Drug Treatment HCPCS** G2067, G2068, G2069, G2070, G0272, G0273

Approved Mental Health Providers per National Committee on Quality Assurance

- Licensed Clinical Social Worker
- Licensed Master of Social Work
- Registered Nurse (RN) with Psychiatric Specialty
- Licensed Marriage and Family Therapist
- Licensed Professional Counselor
- Psychiatric Nurse
- Psychiatrist
- Psychologist
- MD/DO Certified as a Psychiatrist
- Certified Physician Assistant in Psychiatry
- Certified Community Mental Health Center (CMHC)
- Certified Community Behavioral Health Clinic (CCBHC)

Slide courtesy of Centene's Population Health & Clinical Operations Behavioral Health Chapter

Upcoming available microlearnings on FUA and FUM in Q4 2022!

Strategies to Improve Follow-Up Care After a Hospital or Emergency Department Visit for Mental Illness

Optimizing the Impact of the FUH and FUM Behavioral Health HEDIS® Measures

Strategies to Improve Initiation and Engagement, Follow-Up After Emergency Department or High Intensity Care for Substance Use Disorders

Optimizing the Impact of the Behavioral Health IET, FUA, and FUI HEDIS® Measures

The provider library can be accessed at:

- Health Net: providerlibrary.healthnetcalifornia.com
- California Health and Wellness: https://www.cahealthwellness.com/providers.html