

Select Health Quality Provider Program

FOLLOW UP AFTER ACUTE MENTAL HEALTH CARE 2026 Quality Measure Reference Guide



What's Inside

Measure Descriptions	2
• Follow Up After ED Visit for Mental Illness (FUM).....	2
• Follow Up After ED Visit for Substance Use (FUA).....	3
• Follow Up After Hospital Visit for Mental Illness (FUH).....	4
Allowable Corrections	5
Frequently Asked Questions.....	6
Working Your Open Gaps List.....	8
Best Practices.....	10

Related Quick Links

- [Mental Health Measures Quick Guide](#)
- [Report Hub Instructions: Basic User](#)
- [Formatting a Gaps List in Excel](#)
- [Demographic Allowable Corrections](#)



This measure is included in the Mental Health Quality Provider Program.

Measure Description: Follow Up After ED Visit for Mental Illness (FUM)

<p>Description</p>	<p>The percentage of ED visits for members ages 6 and older with a principal diagnosis of mental illness or intentional self-harm, who received a follow-up visit for mental illness within:</p> <ul style="list-style-type: none"> • 7 days of the ED visit (8 total days) • 30 days of the ED visit (31 total days) <p>NOTE: Each of the measures listed above is evaluated and scored separately.</p>
<p>Denominator</p>	<p>Members ages 6 and older who had an ED visit with a principal diagnosis of mental illness or intentional self-harm and any diagnosis of a mental health disorder in the measurement year.</p> <p>The denominator for this measure is 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, and do not include more than one visit per 31-day period.*</p>
<p>Numerator</p>	<p>Members in the denominator who have had the following:**</p> <ul style="list-style-type: none"> • 7-Day Follow-Up: A follow-up visit with any practitioner within 7 days after the ED visit (8 total days), including visits that occur on the date of the ED visit. • 30-Day Follow-Up: A follow-up visit with any practitioner within 30 days after the ED visit (31 total days), including visits that occur on the date of the ED visit.
<p>Intake and Measurement Periods</p>	<p>January 1 through December 31 of the measurement year for both the:</p> <ul style="list-style-type: none"> • Intake Period (the time period when a new member can be identified for inclusion in the denominator) • Measurement Period (the time period wherein data is evaluated for compliance to measure)
<p>Exclusions</p>	<p>ED visits that:</p> <ul style="list-style-type: none"> • Result in an inpatient stay • Are followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 20 days after the ED visit (31 total days), regardless of principal diagnosis for the admission

* If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

NOTE: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

** Any of the following options meet criteria for a follow-up visit: outpatient visit, intensive outpatient encounter or partial hospitalization, community mental health center visit, electroconvulsive therapy, telehealth visit, observation visit, telephone visit, e-visit or virtual check-in, psychiatric residential treatment, or peer-support services for a mental health diagnosis.

Measure Description: Follow Up After ED Visit for Substance Use (FUA)

<p>Description</p>	<p>The percentage of emergency department (ED) visits among members ages 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. Two rates are reported:</p> <ol style="list-style-type: none"> 1. The percentage of ED visits for which the member received follow up within 30 days of the ED visit (31 total days) 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days)
<p>Denominator</p>	<p>Members ages 13 and older at the time of the ED visit, with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose.</p> <p>The denominator for this measure is 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 and do not include more than one visit per 31-day period.*</p>
<p>Numerator</p>	<p>Members in the denominator who have had the following:**</p> <ul style="list-style-type: none"> • 7-Day Follow-Up: A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit. • 30-Day Follow-Up: A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.
<p>Intake and Measurement Periods</p>	<p>January 1 through December 31 of the measurement year for both the:</p> <ul style="list-style-type: none"> • Intake Period (the time period when a new member can be identified for inclusion in the denominator) • Measurement Period (the time period wherein data is evaluated for compliance to measure)
<p>Exclusions</p>	<p>ED visits followed by residential treatment on the date of the ED visit or within the 30 days after the ED visit.</p> <p>Members who use hospice services or benefit any time during the measurement year.</p> <p>Members who die any time during the measurement year.</p>

* If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

NOTE: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

** Any of the following meet criteria for a follow-up visit: outpatient visit with a mental health provider, intensive outpatient encounter or partial hospitalization, non-residential substance abuse treatment facility, community mental health center visit, peer support, an opioid treatment service that bills monthly or weekly, a substance use disorder service, a pharmacotherapy dispensing event, electroconvulsive therapy, telehealth visit, observation visit, telephone visit, and e-visit or virtual check-in.

Measure Description: Follow Up After Hospital Visit for Mental Illness (FUH)

<p>Description</p>	<p>The percentage of discharges for members ages 6 years and older who:</p> <ul style="list-style-type: none"> • Were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses within 7 days after discharge; and • Received a follow-up visit by any care provider (if there is an accompanying principle diagnosis of mental health on the claim) within 30 days after discharge* <p>NOTE: Each of the measures listed above is evaluated and scored separately.</p>
<p>Denominator</p>	<p>Members ages 6 and older with an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim.</p> <p>The denominator for this measure is based on discharges, not on members. If members had more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.</p>
<p>Numerator</p>	<p>Members in the denominator who have had the following:*</p> <ul style="list-style-type: none"> • 7-Day Follow-Up: A follow-up visit by any care provider within 7 days after discharge, if there is an accompanying principle diagnosis of mental health on the claim. Do not include visits that occur on the date of discharge. • 30-Day Follow-Up: A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.
<p>Intake and Measurement Periods</p>	<p>January 1 through December 31 of the measurement year for both the:</p> <ul style="list-style-type: none"> • Intake Period (the time period when a new member can be identified for inclusion in the denominator) • Measurement Period (the time period wherein data is evaluated for compliance to measure)
<p>Exclusions</p>	<ul style="list-style-type: none"> • Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. • If the readmission/direct transfer to the acute inpatient care setting was for: <ul style="list-style-type: none"> — A principal diagnosis of mental health disorder or intentional self-harm, count only the last discharge. — Any other principal diagnosis, exclude both the original and the readmission/direct transfer discharge. • Discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 20-day follow-up period, regardless of principal diagnosis for the readmission.

* Any of the following options meet criteria for a follow-up visit: outpatient visit, intensive outpatient encounter or partial hospitalization, community mental health center visit, electroconvulsive therapy, telehealth visit, observation visit, telephone visit, e-visit or virtual check-in, psychiatric residential treatment, or peer-support services for a mental health diagnosis.

Allowable Corrections

There are no measure-specific allowable corrections for this measure.

[Access guidance for general corrections to demographics.](#)

Frequently Asked Questions

Q: Why does this measure matter?

A: More than half of adults with mental illness in the U.S. do not receive the mental health treatment they need.¹ One in five adults are diagnosed with a mental disorder, and half of those with chronic mental illness experience the illness by the age of 14.² Visits to an emergency department (ED) and/or inpatient psychiatric treatment facility are often necessary for individuals to receive the help that they need.

Research shows that an important piece of achieving positive patient outcomes is adequate follow-up care with a trained professional after discharge from the ED or hospitalization.³ The Healthcare Effectiveness Data and Information Set (HEDIS) recommends follow-up visits **within 7 days** and again **within 30 days** from facility discharge.

This approach to follow up can help patients return to baseline functioning by discussing ordered treatment, medications, and needed adjustments for improved patient outcomes.⁴

Follow-up appointments are linked to:³

- Improved mental function
- Decreased repeat ED visits and inpatient readmission
- Increased compliance with discharge instructions

Q: What is Select Health doing to help?

A: Select Health offers one of the broadest mental health networks in Utah, improving access and enabling members to receive in-person and virtual services. Additionally, we provide:

- An up-to-date registry of patients included in these measures with their compliance status (via the Quality Provider Program)
- **Care Management services** for additional member support with understanding and managing their health conditions, helping to navigate their care, and connecting them with community resources

Q: How can clinics promote medication adherence?*

A: Best practices for promoting mental health medication adherence include these steps:

- Set a weekly reminder on your calendar to pull medication adherence lists so that you can contact those needing a refill.

* Applies to medication adherence for antidepressants, antipsychotic medications, and mood stabilizers is a crucial part of disease management.

Recommend that members:

- Consider 90- or 100-day prescription refills for maintenance medications.
- Contact Intermountain Home Delivery Pharmacy, which offers a 100-day supply for the cost of a 90-day supply for Select Health Medicare members.
- Encourage the use of auto-refill reminders from the member's pharmacy. The provider's office can also call the pharmacy and ask for the member to be put on an auto-refill reminder.
- Focus on education to address the member's personal need for the prescribed medication.
- Write prescriptions exactly how they are intended to be taken.
- Avoid pill splitting, when possible, as this may result in inaccurate dosing.
- Simplify the patient's drug regimen by reducing the number of pills taken a day, if possible.
- Use post-discharge visits to discuss medication continuation for chronic conditions and reinforce medication adherence.
- Encourage members to use their Select Health pharmacy benefit to pay for medications. Select Health pharmacy contracts allow a member to pay the lesser of either their copay or a partial cost of a drug.

Q: What are common barriers to mental health treatment and access?

A: Having access to mental health care is fundamental to helping individuals receive the necessary support to address their illnesses. Common barriers to mental health treatment and access are:¹

- Financial barriers to mental health treatment
- Lack of mental health care professionals and services
- Limited availability of mental health education and awareness
- Social stigma of mental health treatment and conditions
- Racial barriers to mental health care access and treatment

Frequently Asked Questions, Continued

Visit Type and Timing FAQs

Q: Will a follow-up visit on the day of discharge count towards the measure?

A: Yes, **IF** the patient was discharged from the ED. Follow-up visits on the day of discharge qualify to close the gap.

Q: How many ED visits can count towards the measure per member?

A: Only the first one. The denominator for this measure is based on ED visits, not on members. A second visit for a member cannot be counted until 31 days after the initial follow-up visit.

Q: If a patient is admitted from the ED, are both the ED and the inpatient visits eligible for payment?

A: No. The discharge from the hospital is the qualifying event when a patient is admitted as an inpatient from the ED.

Q: Do you count business days or calendar days to schedule a patient within the measure parameter?

A: Calendar days.

Q: Does a visit to a mental health (MH) “Access Center” qualify as a visit to an ED?

A: No. Currently, most MH access centers use billing codes that are similar to office visits, making it an office visit rather than an ED visit; however, this may change in the future.

Q: Do patients need to be seen for the 7-day follow-up visit and the 30-day follow-up visit to be eligible for payment?

A: No. Separate payments will be made for both the 7- and 30-day follow-up visits.

Q: What kind of visit counts towards the FUA measure gap closure?

A: A follow-up visit or a pharmacotherapy dispensing event within 7 and 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

References:

1. National Institute of Mental Health. *Statistics*. NIH Website. <https://www.nimh.nih.gov/health/statistics>. Accessed January 20, 2026.
2. National Alliance on Mental Illness. *Mental Health By the Numbers*. NAMI.org website. Updated April 2023. <https://www.nami.org/about-mental-illness/mental-health-by-the-numbers/>. Accessed January 20, 2026.
3. Eleos Health. *HEDIS Measures for Behavioral Health: What are They and Why Clinicians Should Care*. Eleos website/blog post. December 10, 2020. <https://eleos.health/blog-posts/hedis-measures-for-behavioral-health-what-are-they-and-why-clinicians-should-care/>. Accessed January 20, 2026.
4. Beacon Health Options. *MY2022 HEDIS® 7-day and 30-day Follow-up After Hospitalization for Mental Illness (FUH) Measure: Provider Tip Sheet*. Beacon Health Options. Updated July 2022. <https://s21151.pcdn.co/wp-content/uploads/HEDIS-FUH-Provider-Tip-Sheet.pdf>. Accessed January 20, 2026.

Working Your Open Gaps List

STEP 1
<p>Create a current gaps-in-care list:</p> <ol style="list-style-type: none"> 1. Open your Gaps-in-Care-for-Download report: QPP Report Hub 2. Apply these filters: <ul style="list-style-type: none"> — Super clinic: Choose your clinic. — Measure: Click all mental health measures or the exact one you need from this list: <ul style="list-style-type: none"> • F/U After ED Visit for Mental Illness: 7 Day (FUM_7) • F/U After ED Visit for Mental Illness: 8-30 Day (SH_FUM_30) • F/U After Hosp. for Mental Illness: 7 Day (FUH_7) • F/U After Hosp. for Mental Illness: 8-30 Day (SH_FUH_30) • F/U After ED Visit for Substance Abuse: 7 Day (FUA_7) • F/U After ED Visit for Substance Abuse: 8-30 Day (SH_FUA_30) — Status: Unclick the "Compliant" box. This will filter for only the achievable members. 3. In the drop-down menu on the top right side of the page, change the view from "Member" to "Download." 4. Follow the instructions on the screen to export the data to Excel. <p>Refer to Report Hub Instructions: Basic User.</p>
STEP 2
<p>Format your Excel export. (Refer to Formatting a Gaps List in Excel.)</p>
STEP 3
<p>Review tips for working your gaps-in-care list (page 9).</p>

Measure Information

The objective behind these mental health measures is to encourage patients and providers to manage acute mental health episodes, in addition to decreasing risk for readmission. As a result, use the filtered gaps-in-care list to schedule appointments for achievable members.

For this measure:

- Members who had more than 1 hospital/emergency department (ED) discharge, which includes all discharges on or between January 1st and December 1st of the measurement year.
- This measure is based on discharges from hospital or ED, not on members.

NOTE: Examples used in this document are for instructional purposes only; the dates that appear are only representative of what a user might see.

Working Open Gaps List, Continued

Tips for Working your Gaps-in-Care List

1. There are NO allowable corrections. To receive payment, submit an appropriate billing code.

For telehealth codes, refer to the Select Health Coding and Reimbursement Policy #85: *Telehealth*, which was last revised on **July 1, 2022**, to address the evolving nature of telehealth during the coronavirus (COVID-19) pandemic. For more information, refer to [Select Health Preventive Care and Screening Guidelines](#), [Select Health Coding & Reimbursement policies](#), or contact your Select Health Provider Development Representative.

2. The denominator for this measure is based on mental health hospital and ED visits, not members; therefore:

- **FUH:** If a patient is readmitted to the hospital, they typically cannot attend their scheduled follow-up appointments because they may still be inpatient. For this reason, each new inpatient admission resets the cycle. The 30-day measurement window always begins again from the most recent discharge.

For example, if a patient was discharged from the hospital on July 4th and then was readmitted on July 10th., the July 10th visit would now fall into the denominator for the next 31 days unless a new hospital admittance takes place.

- **FUM:** The opposite is true for ED: The first visit and discharge from the ED is counted for the FUM or FUA denominator.

For example, a patient was discharged from the ED on July 4th with a principle diagnosis of mental health illness or intentional self-harm. This patient was then later seen in the ED on July 10th. **Only the first visit** (July 4th) would fall into the denominator for the next 31 days. A clinic would not be credited

for any readmittance that occurs before the 31 days, making August 5th the first day the patient could qualify to be included again in the FUM denominator.

- **FUA:** The same logic as for FUM applies for FUA, with principle diagnosis being substance use disorder (SUD), or any diagnosis of drug overdose.

3. Use the Hospital Census report (updated daily) to assist with scheduling timely appointments after member discharge from the ED or inpatient facility.

Best practice is to run this report 1–2 times a week, create a list of members to call, and schedule follow-up appointments within the 7- and 30-day time frame.

To run the Hospital Census report:*

- Open your Gaps-in-Care-for-Download report: [QPP Report Hub](#).
- Choose “Hospital Census.”
- Apply the super clinic filter (choose your clinic), and click “Apply.”

SelectHealth Quality Provider Program Hospital Census and Emergency Department Visits										
Filters		Hospital Census								
Super Clinic	▼	Provider	EMPI	Member	Birth Date	Admit Date	Facility	Discharge Date	Admitting Dx	Scheduled
Clinic Specialty	▼	Null				7/10/2024	Mckay-Dee	Null	Accidental Drug Overdose	Rutoven, Mc, Daniel F
Quality Provider Behavioral Health Pr...	▼					7/10/2024	Mckay-Dee	Null	Crisis	Von Bose, Do, Charles J.
Clinic	▼					7/15/2024	Intermountain Medical Center	Null	Cad(A) Dilated Aorta	Caine, Md, William T.
Provider	▼					7/15/2024	Mckay-Dee	Null	Unk	Crofts, Md, Robert D.
Member Status	▼									
	<input checked="" type="checkbox"/> Inpatient									
Emergency Department Visits Previous 7 Days										
Provider	EMPI	Member	Birth Date	Admit Date	Facility	Acuity	Acuity Desc	Chief Complaint	Status	
				7/15/2024	Mckay-Dee Hospital Center	4	Semi-urgent	Leg Pain-Swelling	Discharged	
				7/12/2024	Logan Regional Hospital	2	Emergent	Altered Mental Status	Admitted	
				7/13/2024	Mckay-Dee Hospital Center	3	Urgent	Pain In Face	Discharged	
				7/15/2024	Mckay-Dee Hospital Center	2	Emergent	Behavioral Health Complaint	Discharged	
								Crisis Evaluation	Left without treatment	

* If your clinic is not listed, this may mean there are no patients with ED or inpatient visits. If this seems inaccurate, promptly share examples of expected members with your Quality Provider Representative.

Best Practices: Follow up After Acute Mental Health Care^{1,2}

Scheduling Visits

- Help schedule follow-up appointments with the patient and educate patients on their importance:
 - As soon as the patient has been identified as having visited the ED (emergency department) for mental illness/intentional self-harm or substance use
 - Prior to discharge if admitted
- Set up systems to generate reminders for “reschedule” notices that are mailed to patients if a follow-up visit is missed or canceled.
- Develop outreach systems or assign case managers to encourage recently released patient to keep follow-up appointments or reschedule missed appointments.
- Set flags, if available, in EHR (Electronic Health Record) or develop a tracking method for patients due or past due for follow-up after discharge visits and require staff to follow up with patients who miss or cancel their appointments.

Discharge Planning

- Begin discharge planning as soon as an individual is admitted and ensure it is ongoing and specific.
- Involve member and family in all discharge planning stages.

Staff Training

- Educate on the “Teach-Back Method” to ensure patients and caregivers review and understand discharge instructions and the next steps in their care for follow-up.
- Provide local resources to help with barriers such as transportation needs.
- Encourage patients to use clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.

Practice Processes

- Proactively evaluate practice processes for ways to close care gaps every time a patient is seen.
- Submit claims and encounter data promptly.
- Review medications with patients to ensure they understand the purpose, proper frequency, and method of administration.

References:

- ¹ Horizon Blue Cross Blue Shield of New Jersey. *HEDIS Resources*. horizonblue.com website. 2025. <https://www.horizonblue.com/providers/resources/patient-quality-outcome-resources/hedis-resources>. Accessed February 18, 2026.
- ² Blue Cross Blue Shield of Illinois. Encourage Follow-up Care after Hospital Visits for Mental Health. bsbsil.com website. February 6, 2026. <https://www.bcbsil.com/provider/education/education-reference/news/2026/2-6-2026-encourage-follow-up-care-after-hospital-visits-for-mental-health>. Accessed February 27, 2026.

Questions about the Quality Provider Program? Contact us at QualityProvider@selecthealth.org.