QUALITY BULLETIN

MOLINA HEALTHCARE

August 2026

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Behavioral Health: Improving Timely Follow-Up After Emergency Department Visits for Substance Use Disorder and Mental Illness

Timely follow-up after an Emergency Department (ED) visit for Substance Use Disorder (SUD) FUA (Follow-Up After Emergency Department Visit for Substance Use) or Mental Illness FUM (Follow-Up After Emergency Department Visit for Mental Illness) is critical to promoting ongoing treatment engagement, reducing avoidable readmissions and improving long-term health outcomes. Research consistently demonstrates that the period immediately following an ED visit is a high-risk transition point when patients are most vulnerable to disengaging from care. Establishing rapid connections to outpatient behavioral health (BH) services can significantly improve continuity of care and support recovery.

Strategies to Improve Timely Follow-Up:

Schedule Follow-Up Before Discharge**:** Whenever possible, schedule outpatient BH appointments before the patients leaves the ED. Providing the patients with a confirmed appointment date, time and location reduces the likelihood of missed follow-up opportunities and increases treatment adherence.

Utilize Warm Handoffs**:** Direct communication between ED staff and BH providers can improve transitions of care. Warm handoffs allow providers to share critical information, address immediate concerns and facilitate rapid access to treatment and recovery services.

Address Transportation and Social Barriers**:** Transportation challenges, housing instability, limited phone access and other social determinants of health can prevent patients from attending follow-up appointments. Screening for these barriers during the ED encounter and connecting patients to available community resources can improve follow-through with treatment plans.

Leverage Telehealth and Virtual Care Options**:** Telehealth services provide an effective opportunity to reduce access barriers, particularly for patients in rural or underserved communities. Virtual appointments can often be scheduled quickly and may improve attendance for follow-up BH services.

Strengthen Provider Collaboration**:** Behavioral health providers, hospitals, primary care providers and care management teams all play an important role in supporting successful transitions. Sharing information, coordinating care plans and maintaining communication across the continuum of care can improve engagement and reduce treatment gaps.

Focus on Patient Engagement**:** Providing education about the importance of follow-up care, utilizing motivational interviewing techniques and engaging family or support systems, when appropriate, can encourage patients to remain connected to treatment following an ED visit.

Collaborative Focus in Northwest and Central Ohio**:** The Managed Care Organization (MCO) BH Collaborative continues to work closely with providers in Northwest and Central Ohio to identify local challenges and implement targeted improvement strategies that can ultimately be spread statewide. Through provider partnerships, data review, best-practice sharing and coordinated outreach efforts, the collaborative aims to improve timely follow-up rates for patients receiving care for SUD and mental health conditions.

By working together to strengthen transitions of care, address barriers to treatment and promote rapid engagement with BH services, providers can help improve outcomes for patients and support ongoing quality improvement efforts across Ohio's BH system.

Key Takeaways for Providers**:**

- Schedule follow-up appointments before ED discharge whenever possible.
- Utilize warm handoffs to connect patients with ongoing BH services.
- Address transportation, access and social barriers early.
- Consider telehealth options to improve appointment availability and attendance.
- Collaborate with health plans and community partners to support care transitions.

Chronic Conditions: Diabetes Care – Closing Gaps and Improving Outcomes

Why It Matters**:** Diabetes remains one of the leading causes of cardiovascular disease, kidney disease, vision loss and premature mortality. Regular monitoring and evidence-based management can significantly reduce complications and improve long-term health outcomes. Focusing on key Healthcare Effectiveness Data and Information Set (HEDIS®) measures helps ensure patients receive recommended screenings and interventions while supporting quality performance.

Blood Pressure Control for Patients with Diabetes (BPD):

Measure Overview**:** Assesses the percentage of patients 18-75 years of age with diabetes whose most recent blood pressure (BP) reading during the measurement year is controlled (<140/90 mmHg).

Screening Frequency:

- BP should be assessed at every office visit.
- The most recent BP during the measurement year is used for HEDIS compliance.

Best Practices:

- Use proper BP measurement technique.
- Recheck elevated readings at the end of the visit.
- Document the lowest systolic and lowest diastolic values from repeat readings.
- Encourage home BP monitoring.
- Address medication adherence barriers.
- Consider ACE (angiotensin-converting enzyme) inhibitors or ARBs (angiotensin II receptor blocker) when clinically appropriate.
- Reinforce lifestyle modifications including sodium reduction, physical activity, weight management and tobacco cessation.

CPT II Codes:

- Systolic BP → 3074F, 3075F, 3077F
- Diastolic BP → 3078F, 3080F

Eye Exam for Patients with Diabetes (EED):

Measure Overview**:** Assesses the percentage of patients 18-75 years of age with diabetes who receive a retinal eye exam for diabetic retinopathy.

Screening Frequency:

- Annual diabetic retinal exam is recommended for most patients with diabetes.

Special HEDIS Compliance Opportunity:

- Patients with a retinal exam showing no evidence of diabetic retinopathy may remain compliant for up to two measurement years.

- A negative retinal exam performed by an eye care professional can satisfy the measure for the current year and the following year, reducing unnecessary repeat testing while maintaining HEDIS compliance. Documentation must clearly indicate the absence of diabetic retinopathy.

Best Practices:

- Refer newly diagnosed patients promptly for retinal screening.
- Utilize tele-retinal imaging programs when available.
- Obtain and retain consult reports from ophthalmologists and optometrists.
- Document whether retinopathy is present or absent.
- Establish referral tracking processes to ensure completed exams are received by the Primary Care Provider (PCP) office.

CPT II Codes:

- 2022F, 2023F, 2024F, 2025F, 2026F, 2033F, 3072F

Glycemic Status Assessment for Patients with Diabetes (GSD):

Measure Overview**:** Assesses glycemic control among patients 18-75 years of age with diabetes using HbA1c laboratory results. Current performance focuses on patients achieving HbA1c <9.0%.

Screening Frequency:

- HbA1c testing should be performed at least annually.
- Patients with uncontrolled diabetes often require testing every 3-6 months.

Best Practices:

- Order HbA1c testing proactively before follow-up visits.
- Review medication adherence at each encounter.
- Assess social determinants impacting diabetes management.
- Provide individualized nutrition counseling and diabetes education.
- Utilize care management and pharmacy outreach for high-risk patients.
- Intensify treatment when HbA1c is not at goal.

CPT II Codes:

- 3044F, 3046F, 3051F, 3052F

Kidney Health Evaluation for Patients with Diabetes (KED):

Measure Overview**:** Assesses the percentage of patients 18-85 years of age with diabetes who receive *BOTH*:

1. Estimated Glomerular Filtration Rate (eGFR) blood testing, and
2. Urine Albumin-Creatinine Ratio (uACR) testing during the measurement year. Both tests are required for compliance.

Screening Frequency:

- Annual kidney health evaluation is recommended for patients with diabetes.

Best Practices:

- Order eGFR and uACR together using diabetes standing-order protocols.
- Include kidney screening reminders within Electronic Health Record (EHR) diabetes registries.
- Review results promptly and initiative appropriate treatment when abnormalities are identified.
- Consider ACE inhibitor, ARB or other guideline-directed therapies when clinically appropriate.
- Educate patients regarding the importance of early kidney disease detection.

Provider Reminder: Don't Forget the Blood Test: Many providers are familiar with ordering the uACR, but KED (Kendrick Extrication Device) compliance requires both the urine test and the eGFR blood test. Missing either component leaves the care gap open. Because comprehensive kidney evaluation depends on both measures of kidney damage (uACR) and kidney function (eGFR), providers should consider ordering them together whenever diabetes monitoring labs are obtained.

Healthy Adults: Breast Cancer Screening – Close Care Gaps Before They Become Missed Opportunities

The Breast Cancer Screening (BCS-E) measure evaluates patients aged 40–74 who received a mammogram during the measurement timeframe. Breast cancer screening is an important preventive service that can help detect cancer early, when treatment may be more effective.

Many Molina Healthcare of Ohio, Inc. patients eligible for mammography remain unscreened even when they have frequent healthcare encounters. Screening performance often depends not only on access to care, but on whether each eligible encounter reliably identifies the gap, makes an appropriate recommendation and helps the patient take the next step toward completion. Encouraging patients to complete recommended screenings is one of several strategies providers can use to help close important care gaps.

Provider practices vary widely in staffing, workflows and available resources. The following strategies are practical and adaptable, so every practice can improve BCS-E performance in a way that fits its capacity. Providers can make a meaningful impact by consistently confirming screening status during eligible visits, clearly recommending mammography when due and documenting this shared plan. These workflows can be shared amongst many different patients of the clinic team; shared workflows, while not necessary, can strengthen follow-through.

Strategies to Improve BCS-E Rates:

1. Identify Eligible Patients Before the Visit:
   - Review schedules for patients ages 40–74 due for screening.
   - Use EHR alerts and care gap reports to identify eligible patients before appointments.
   - Include BCS-E status in pre-visit planning.
2. Use Standing Mammogram Orders:
   - Utilize standing mammogram orders for eligible patients.
   - Incorporate screening workflows into routine office processes to reduce missed opportunities.
3. Follow Up on Outstanding Orders:
   - A mammogram order does not close a care gap—a completed mammogram does.
   - Review open orders regularly and follow up with patients who have not completed screening.
   - Ensure mammography reports are received and documented.
4. Address Common Barriers:
   - Educate patients about the importance of early detection and encourage testing.
   - Discuss concerns or fears related to mammograms.
   - Inform patients that current testing methods are generally less uncomfortable and require less radiation than in the past.
5. Use Evidence-Based Outreach Strategies:
   - Provider and patient reminder systems have been shown to improve BCS-E rates.
   - Reducing scheduling and follow-up barriers can increase screening completion.

Provider Checklist**:**

✓ Identify patients ages 40–74 due for screening.
✓ Utilize standing mammogram orders.
✓ Track and follow up on outstanding orders.
✓ Discuss the benefits of early detection.
✓ Address concerns and misconceptions about mammography.
✓ Inform eligible patients about the $75 reward opportunity.*
✓ Document applicable exclusions according to current HEDIS specifications.

*Reward eligibility and program requirements apply. Refer to current Molina patient incentive guidelines.

References:
1. U.S. Preventive Services Task Force. *Breast Cancer: Screening Recommendation Statement.* JAMA. 2024.
2. Community Preventive Services Task Force. *Cancer Screening: Multicomponent Interventions—Breast Cancer.*

Older Adults: Osteoporosis Screening – A Critical Preventive Service for Older Women

Osteoporosis remains a significant and often underdiagnosed health concern among older women. Characterized by decreased bone density and increased fracture risk, osteoporosis affects millions of women and can lead to serious consequences, including loss of independence, disability, reduced quality of life and increased mortality following hip fractures.

Clinical guidelines recommend osteoporosis screening with bone mineral density (BMD) testing for women aged 65 years and older, regardless of risk factors. Early identification of osteoporosis or low bone mass allows providers to implement evidence-based interventions that can significantly reduce the risk of fractures and associated complications.

As part of routine preventive care, providers should ensure eligible patients receive timely dual-energy X-ray absorptiometry (DXA) screening and appropriate follow-up based on results. To ensure eligible patients receive recommended preventive care, providers are encouraged to:

- Review osteoporosis screening status during annual wellness visits and preventive care encounters.
- Identify women age 65 years and older who have not had a documented DXA scan.
- Educate patients on osteoporosis risk factors and the benefits of early detection.
- Discuss lifestyle interventions, including adequate calcium and vitamin D intake, weight-bearing exercise, smoking cessation and fall prevention strategies.
- Coordinate timely follow-up and treatment for patients with osteopenia or osteoporosis.

Fracture prevention starts with early detection. By prioritizing osteoporosis screening, providers can help reduce avoidable fractures, improve patient outcomes and support healthy aging among older women.

Provider Action Item: Review your patient panel for women age 65 and older who may be due for osteoporosis screening and schedule appropriate testing during upcoming preventive care visits.

Women's Health: Improving Postpartum Care for Black Mothers

Postpartum care is a critical period for new mothers. Studies show that Black women continue to face unique and preventable challenges rooted in systemic racism, implicit bias and gaps in culturally responsive care. According to the Centers for Disease Control and Prevention (CDC), Black women are three times more likely to die from pregnancy-related complications than white women, with most of the maternal deaths being preventable.

Harvard T. H. Chan School of Public Health has highlighted key strategies to improve Black maternal health outcomes including:

- Diversify the Healthcare Workforce: A workforce that reflects the communities it serves strengthens trust, communication and quality of care. Diverse care teams promote cultural humility, shared learning and more equitable postpartum care experiences.
- Improve Cultural Competence and Empathy: Disparate maternal health outcomes are driven by systemic and structural factors—not biological differences. Ongoing training supports providers in recognizing implicit bias, validating patient concerns and delivering respectful, patient-centered postpartum care.
- Strengthen Postpartum Monitoring and Support: Postpartum care extends beyond the traditional six-week visit. Early and continuous follow-up improves identification of warning signs and reduces the risk of severe maternal outcomes.

Moving Forward: The postpartum period presents a critical opportunity to reduce maternal health disparities. By diversifying care teams, strengthening cultural competence and providing proactive, respectful postpartum support, providers can significantly improve outcomes for Black mothers and their families.

References: Centers for Disease Control and Prevention (CDC). Maternal Mortality Rates in the United States. https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm

Questions and Quick Links		
Provider Services: (855) 322-4079 Mon. – Fri. Medicaid 7 a.m. to 8 p.m., MyCare Ohio 8 a.m. to 8 p.m., Medicare and Marketplace 8 a.m. to 5 p.m.	Email: OHProviderRelations@MolinaHealthcare.com	Provider Website: Molina Healthcare.com/OhioProviders.