MY2023 HEDIS®
Provider Guide & Toolkit

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Welcome to 2023 HEDIS® Tips

This is the Carelon Healthcare Effectiveness Data and Information Set (HEDIS®) Provider Guide and Toolkit. Developed by the National Committee for Quality Assurance (NCQA), HEDIS® is a set of performance measures used in the managed care industry, is part of NCQA accreditation, and is an essential activity for Carelon to ensure members are getting the best care possible. The purpose of this toolkit is to offer better understanding of the HEDIS® applications and guidelines.

Carelon's mission is to help people live their lives to the fullest potential which includes ensuring our members receive the highest quality care from providers. This toolkit is intended to be a reference guide that covers the 2020 HEDIS ® behavioral health measures as they apply to Medicaid, Medicare, and Commercial lines of business.

About Carelon:

Carelon is a leader in changing the way people live with behavioral health conditions serving over 40 million people across all 50 states. Carelon offers superior clinical mental health and substance use disorder management, a comprehensive employee assistance program, work/life support, specialty programs for autism and depression, and insightful analytics to improve the delivery of care.

Carelon is headquartered in Boston, MA with more than 70 locations across the U.S. Carelon has 4,700 employees nationally, over 260 clients, including employers, Fortune 500 companies, health plans, and state and local governments serving commercial, FEP, Medicare, Medicaid, and Exchange populations, programs serving Medicaid recipients and other public sector populations in 25 states and the District of Columbia, and services for 5.4 million military personnel and their family members.

Carelon is accredited by both URAC and NCQA.

A better quality of life for patients starts with you, the providers at the core of their health care delivery.

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Provider Tip Sheet

What is HEDIS®?

HEDIS® (Healthcare Effectiveness Data Information Set) is a widely used set of performance measures in the managed care industry, developed and maintained by NCQA. HEDIS® measures drive improvement efforts surrounding best practices.

What is the HEDIS® ADD measure looking at?

The rate of members aged 6 – 12 on ADHD medication who had at least 3 follow up care visits within 10 months (one within 30 days) of the first ADHD medication being dispensed.

There are two best-practices being evaluated:

- *Initiation Phase*: Members receiving a follow up visit with a prescribing provider within 30 days of receiving their medication.
- *Continuation & Maintenance Phase*: Members who continue taking ADHD medication during the nine months after the initiation phase and receiving two additional follow up visits within those nine months.

Why is the HEDIS® ADD measure important?

According to a national 2016 parent survey, the estimated number of children (2-17 years of age) ever diagnosed with ADHD is 6.1 million (9.4%). Altogether, 77% were receiving treatment. Of these children:[1]

- About 30% were treated with medication alone
- About 15% were treated with behavioral therapy alone
- About 32% were treated with combination therapy (medication and behavioral therapy); and
- About 23% of children with ADHD were receiving neither medication treatment nor behavioral therapy

Who is included in the measure?

All members aged 6 – 12 that are dispensed an ADHD medication so long as they have not received ADHD medication in the 120 days prior.

Members can be in the Initiation Phase without being in the Continuation & Maintenance Phase. Members must meet a 7-month ADHD medication requirement to be in the Continuation & Maintenance Phase.

Which Members are excluded?

- Members with acute inpatient encounters for mental, behavioral, or neurodevelopmental disorders within 300 days after the medication dispense date
- Members with narcolepsy
- Members in hospice or using hospice services

When does a Member 'pass' the measure?

- *Initiation*: When they attend an OP visit with a practitioner who has prescribing authority within 30 days of the prescription being dispensed. A visit *on* the prescription dispense date does not qualify for initiation.
- *Continuation & Maintenance*: When they are compliant in the initiation phase AND attend at least two follow-up visits on different dates with any practitioner from days 31 – 300 from the prescription being dispensed.

What can providers do to help improve HEDIS® ADD rates?

Monitor dosage of meds after 30 days to make adjustments if needed.

Remind patients of their follow up appointments.

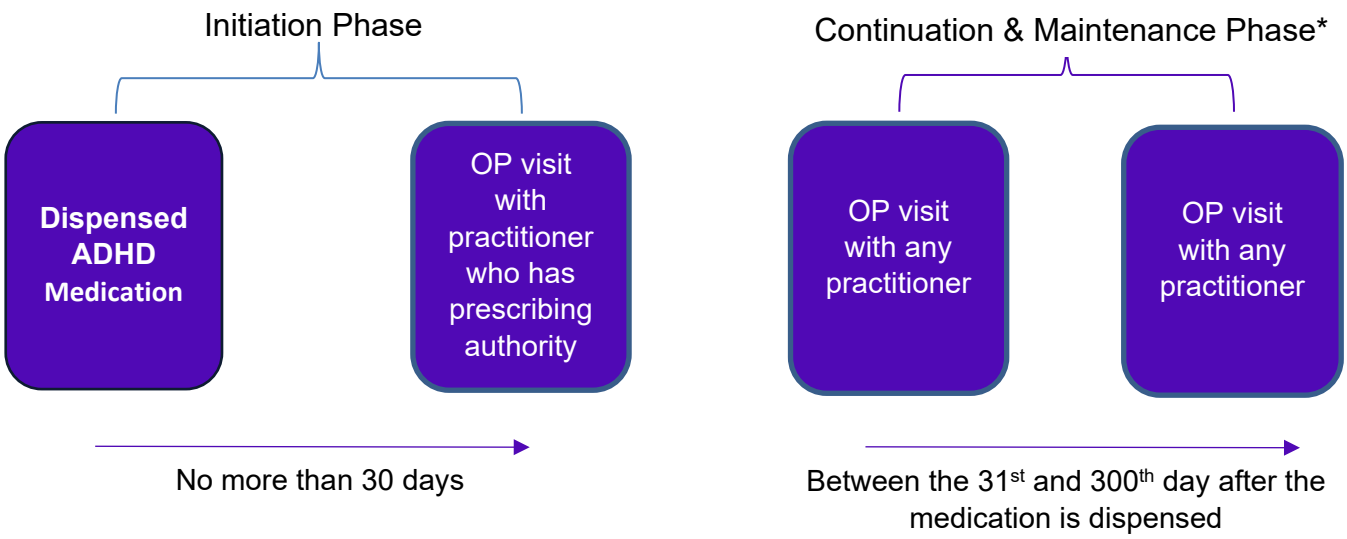
Explain to parents the medication options and side effects to come to a joint agreement on a treatment plan.

Discuss behavioral therapy, psychotherapy, family therapy, support groups, social skills training and/or parenting skills training in addition to medication therapy.

Promote continuity of care between primary care physicians, other providers and schools to ensure quality healthcare.

Use telehealth and telephone visits, where appropriate, when in-person services are not possible or telephone services are preferred.

ADD Measure At-a-Glance:



*Must remain on ADHD medication for at least 7 months of the 10-month measurement period to be included in the Continuation & Maintenance Phase; must be compliant with initiation phase in order to be compliant in Continuation & Maintenance Phase.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

[1] Centers for Disease Control and Prevention. Data and Statistics about ADHD. September 2021. https://www.cdc.gov/ncbddd/adhd/data.html Accessed 07/07/2022

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What is the HEDIS® AMM measure looking at?

The rate of members aged 18 and older with a diagnosis of major depression who were treated with an antidepressant and who remained on antidepressant medication.

There are two measures that assess medication adherence at different points in treatment:

- *Acute Phase*: Members who remained on their antidepressant for at least 84 days (12 weeks)
- *Continuation Phase*: Members who remained on their antidepressant for at least 180 days (6 months)

Why is the HEDIS® AMM measure important?

According to NCQA's "State of Health Care Quality 2013" report, approximately 50% of psychiatric patients and primary care patients prematurely discontinue antidepressant therapy (when assessed at six months after the initiation of treatment).

- Less than half of those impacted by depression receive treatment even though effective treatments are available.
- Appropriate dosing and continuation of medication therapy in both the short term and the long term treatment of depression decrease the recurrence of depressive symptoms.
- Increasing member compliance with prescribed medications, monitoring treatment effectiveness, and identifying and managing side effects are all best practices when managing care for members with depression.

Who is included in the measure?

- Members diagnosed with major depression in an inpatient, outpatient, partial hospitalization setting or telehealth visit who have not received an antidepressant medication within 105 days prior.
- Members aged 18+ covered under Commercial, Medicaid or Medicare LOB.

Which Members are excluded?

- Members using hospice services at any time during the year are excluded.

What are the diagnoses that include Members in the measure?

The following ICD-10 codes for major depression include members in the denominator (when paired with either an acute or non-acute inpatient stay or an outpatient visit):

F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.41, F33.9

When does the Member 'pass' the measure?

- Acute Phase: When they have remained on their antidepressant medication for at least 84 days (12 weeks)
- Continuation Phase: When they have remained on their antidepressant medication for at least 180 days (6 months)

What can providers do to help improve HEDIS® AMM rates?

Schedule a follow-up appointment no later than four weeks after starting a new prescription.

Remind patients about their appointments.

Assist members in setting up a follow-up appointment with a prescriber when patients are transitioning to another level of care.

Targeted outreach for members at risk of noncompliance via phone calls, medication prompts or case management.

Educate staff, patient, and family of the patient about the importance of adherence to prescription medications, side effects and benefits of antidepressant medication.

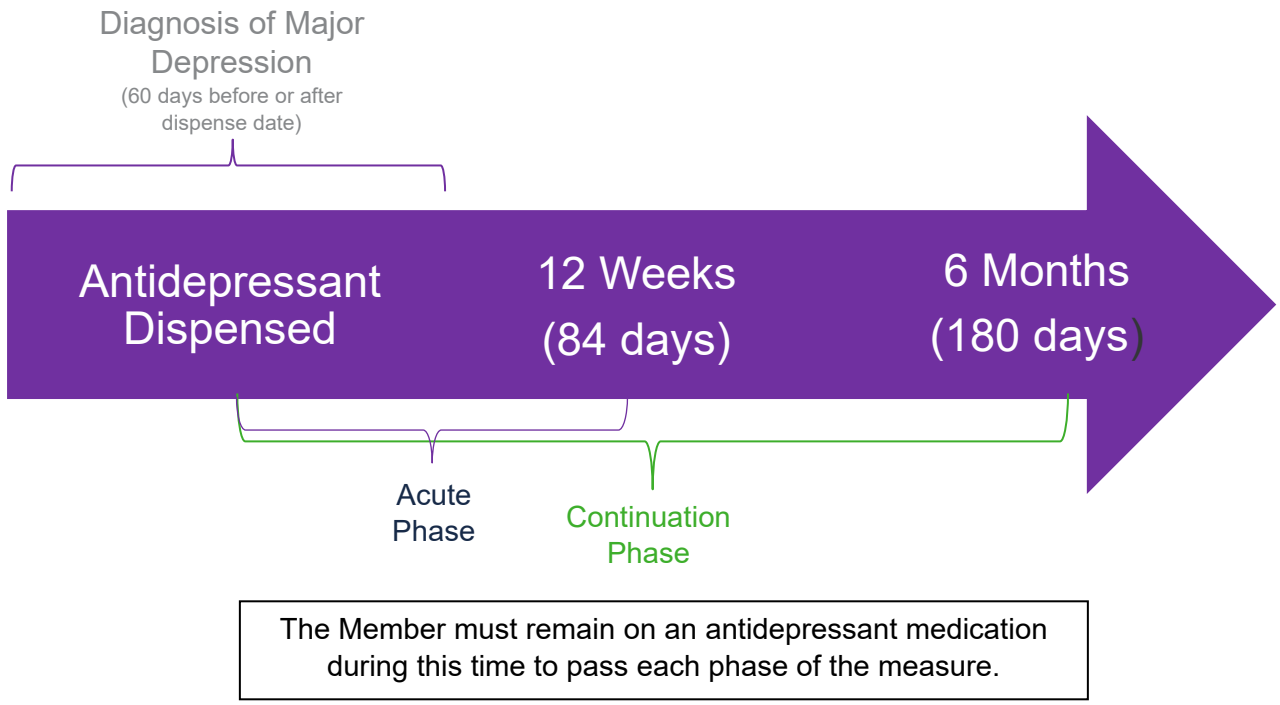
Involve the member and family in a collaborative discussion of treatment options, barriers to treatment, and promote member participation in decision-making.

Connect the member to health coaching programs, peer support and case management.

Communicate with other providers to ensure a whole health approach.

Use telehealth visits, where appropriate, when in-person services are not possible or telehealth services are preferred.

AMM Measure At-a-Glance



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What is the HEDIS® APM measure looking at?

The rate of members aged 1 – 17 taking two or more antipsychotics, who received metabolic testing.

Why is the HEDIS® APM measure important?

Antipsychotic medications can increase a child's risk for developing serious metabolic health complications[1, 2] associated with poor cardio-metabolic outcomes in adulthood.[3] Given these risks and the potential lifelong consequences, metabolic monitoring is important to ensure appropriate health management of children and adolescents on antipsychotic medications.

Who is included in the measure?

- Members with at least 2 dispensing dates of antipsychotic medications
- Members aged 1 – 17 covered under Commercial or Medicaid LOB

Which Members are excluded?

Members using hospice services at any time during the year.

When does the Member 'pass' the measure?

There must be at least one blood glucose lab test AND one LDL-C lab test during the calendar year.

What can providers do to help improve HEDIS® APM rates?

- Document patient's response to medication.
- Document lab results and any action that may be required.
- Use supplemental lab data to update medical records when applicable.
- Monitor the glucose and cholesterol levels of children and adolescents on antipsychotic medications.
- Monitor children on antipsychotic medications to help to avoid metabolic health complications such as weight gain and diabetes.
- Establish a baseline and continuously monitor metabolic indices to ensure appropriate management of side-effects of antipsychotic medication therapy.

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[1] Correll, C.U., P. Manu, V. Olshanskiy, B. Napolitano, J.M. Kane, and A.K. Malhotra. 2009. "Cardiometabolic risk of second-generation antipsychotic medications during first-time use in children and adolescents." *Journal of the American Medical Association*

[2] Andrade,S.E., J.C.Lo, D. Roblin, et al. December 2011. "Antipsychotic medication use among children and risk of diabetes mellitus." Pediatrics 128(6):1135-41

[3] Srinivasan,S.R., L. Myers, G.S. Berenson. January 2002. "Predictability of childhood adiposity and insulin for developing insulin resistance syndrome (syndrome X) in young adulthood: The Bogalusa Heart Study." *Diabetes* 51(1):204-9

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What is the HEDIS® APP measure looking at?

The percentage of children and adolescents aged 1 – 17 with a new prescription for an antipsychotic medication that had documentation of psychosocial care as their first-line treatment.

Why is the HEDIS® APP measure important?

Antipsychotic medications may be effective treatment for a narrowly defined set of psychiatric disorders in children and adolescents. However, they are often prescribed for nonpsychotic conditions for which psychosocial interventions are considered first line treatment. Safer first-line psychosocial interventions may be underutilized. Children and adolescents may unnecessarily incur the risks associated with antipsychotic medications.

Who is included in the measure?

- Members dispensed their first antipsychotic medication
- Members aged 1 – 17 covered under Commercial or Medicaid LOB

Which Members are excluded?

- Members with at least one inpatient encounter or 2 outpatient encounters with a diagnosis of schizophrenia, schizoaffective disorder, bipolar, other psychotic disorder, autism or other developmental disorder.
- Members using hospice services at any time during the year.

When does the Member 'pass' the measure?

When there is documentation of psychosocial care in the 121-day period from 90 days prior through 30 days after the medication is dispensed.

What can providers do to help improve HEDIS® APP rates?

- When prescribed, antipsychotic medications should be part of a comprehensive, multi-modal plan for coordinated treatment that includes psychosocial care
- Psychosocial care, which includes behavioral interventions, psychological therapies and skills training, among others, is the recommended first-line treatment option for children and adolescents diagnosed with nonpsychotic conditions such as attention-deficit disorder and disruptive behaviors
- Periodically review the ongoing need for continued therapy with antipsychotic medications
- Assess the need for Case Management and refer if necessary
- Ensure progress notes are complete and accurate

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What is the HEDIS® FUA measure looking at?

Individuals (thirteen years and older) who had an Emergency Department (ED) visit for a substance use disorder (SUD) diagnosis, or any diagnosis of drug overdose should have an outpatient appointment with a mental health provider as soon as possible after the ED visit. There are two submeasures for FUA – follow-up within *seven* days from the ED date and follow-up within *thirty* days from the ED date. A member who has an appointment within seven days of the ED visit is also compliant for the thirty-day FUA submeasure.

Why is the HEDIS® FUA measure important?

High ED use for individuals with SUD may signal a lack of access to care or issues with continuity of care.[1] Timely follow-up care for individuals with SUD who were seen in the ED is associated with a reduction in substance use, future ED use, hospitals admissions and bed days.[2,3,4]

Who is included in the measure?

- Members with an ED visit for a principal diagnosis of SUD or any diagnosis of drug overdose
- Members aged 13+ covered under Commercial, Medicaid or Medicare LOB

Which Members are excluded?

- Detox-only chemical dependency visits
- Members using hospice services at any time during the year
- ED visits followed by an inpatient admission with 30 days

When does the Member 'pass' the measure?

When they attend a follow-up visit with any practitioner or pharmacotherapy dispensing event within 7 (and 30) days after the ED visit

Please Note: Visits and pharmacotherapy events can occur on the same date of the ED visit.

What counts as a follow up visit?

Any of the following services done with a mental health provider or having an SUD diagnosis:

- An outpatient behavioral health or SUD service
- Telehealth/telephone visit
- Intensive outpatient therapy
- Partial hospitalization visit
- Opioid treatment service
- Non-residential substance abuse treatment service
- Community mental health center service
- Observation visit
- Online assessment
- Behavioral health or SUD assessment
- Pharmacotherapy dispensing event

What can providers do to help improve HEDIS® FUA rates?

- Use appropriate documentation and correct coding
- Maintain appointment availability for patient with recent ED visits
- Explain the importance of follow-up to your patients
- Reach out to patients who do not keep initial appointments and reschedule them as soon as possible
- Telehealth visits with the appropriate principle diagnosis will meet the follow-up criteria
- Provide timely submission of claims and encounter data

[1] New England Health Care Institute (NEHI). 2010. “A Matter of Urgency: Reducing Emergency Department Overuse, A NEHI Research Brief.” Available from URL: http://www.nehi.net/writable/publication_files/file/nehi_ed_overuse_issue_brief_032610finaledits.pdf

[2] Kunz, F.M., French, M.T., Bazargan-Hejazi, S. (2004). Cost-effectiveness analysis of a brief intervention delivered to problem drinkers presenting at an inner-city hospital emergency department. *Journal of Studies on Alcohol and Drugs,* 65, 363-370

[3] Mancuso, D., Nordlund, D.J., Felver, B. (2004). Reducing emergency room visits through chemical dependency treatment: focus on frequent emergency room visitors. Olympia, Wash: Washington State Department of Social and Health Services, Research and Data Analysis Division

[4] Parthasarathy, S., Weisner, C., Hu, T.W., Moor, C. (2001). Association of outpatient alcohol and drug treatment with health care utilization and cost: revisiting the offset hypothesis. *Journal of Studies on Alcohol and Drugs,*62 89-97

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What is the HEDIS® FUH measure looking at?

Individuals (six years and older) who are hospitalized for a mental health or intentional self-harm diagnosis and then discharged to the community should have an outpatient appointment with a mental health practitioner soon after discharge. There are two submeasures for FUH – follow-up within *seven* days from the discharge date and follow-up within *thirty* days from the discharge date. A member who attends an appointment within seven days of discharge is also compliant for the thirty-day FUH submeasure. Appointments on the day of discharge do not count toward compliance of the measure.

Why is the HEDIS® FUH measure important?

Evidence suggests that individuals who receive follow-up care after a psychiatric hospitalization are less likely to readmit to an inpatient facility.[1,2] The ability to provide continuity of care can result in better mental health outcomes and support a patient's return to baseline functioning in a less-restrictive level of care.

Who is included in the measure?

- Members hospitalized with a primary diagnosis of mental illness or intentional self-harm
- Members age 6+ covered under Commercial, Medicaid or Medicare LOB

Which Members are excluded?

- Non-acute inpatient stays are excluded
- Members using hospice services at any time during the year
- Members who have a non-behavioral health readmission within 30 days of the mental health inpatient discharge

When does the Member 'pass' the measure?

When they attend an aftercare appointment within 7 (or 30) days of the hospitalization

Please Note: Visits that occur on the same date of discharge are not reportable as part of the quality measure. Scheduling follow up appointments between the first and seventh day after hospital discharge ensures meaningful, effective engagement

What Aftercare Services Qualify?

- Medication Management with a Psychiatrist/ARNP/PA with a mental health license or certificate
- Individual Therapy in the home or office in accordance with program specifications
- Electroconvulsive Therapy (ECT)
- Intensive Outpatient Program (IOP) or Partial Hospitalization Program (PHP)
- Mental Health and/or Substance Use Assessments, Screenings, Treatment Planning
- Community-Based Wrap-Around and/or Day Treatment Services
- Telehealth Services with a Mental Health Provider
- Psychiatric Collaborative Care Management

What can providers do to help improve HEDIS® FUH rates?

Inpatient Providers:

- Discharge planning should begin as soon as the individual is admitted and should be ongoing and specific.
- Schedule the patient's aftercare appointment prior to discharge.
- Involve the member and family in all stages of discharge planning.

- Attempt to alleviate barriers to attending appointments prior to discharge (i.e., obtaining accurate, current contact information, coordinating with Carelon).
- Develop local referral sources of OP providers who are able to provide aftercare to patients within 7 days of discharge.
- Ensure the member's discharge paperwork is sent to the outpatient provider and to Carelon within 24 hours.
- Invite care coordinators to meet members so that aftercare planning can occur.

Outpatient Providers:

- Ensure flexibility when scheduling appointments for patients who are being discharged from acute care; the appointment should be scheduled within seven days of discharge.
- Reminder calls to members prior to appointment and after a missed appointment to reschedule.
- Review medications with patients to ensure they understand the purpose, appropriate frequency, and method of administration.
- Educate office staff on local resources to assist with barriers such as transportation needs.
- Establish communication pathways with inpatient discharge coordinators at local facilities.
- Submit claims in a timely manner.

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[1] Smith et al. (2017). Psychiatric Inpatient Discharge Planning Practices and Attendance at Aftercare Appointments. Psychiatric Services, 68(1), 92-95. (doi:10.1176/appi.ps.201500552)

[2] Hengartner, Michael P., et al. (2015). Introduction of a psychosocial post-discharge intervention program aimed at reducing psychiatric re- hospitalization rates and at improving mental health and functioning. *Perspectives in Psychiatric Care*, 53(1): 10–15. (doi:10.1111/ppc.12131)

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What is the HEDIS® FUI measure looking at?

The percentage of acute inpatient hospitalizations, residential treatment, or detoxification visits for members aged 13+ seen for substance use who had a follow-up visit for substance use disorder.

Why is the HEDIS® FUI measure important?

Individuals receiving SUD care in high intensity settings are especially vulnerable to losing contact with the health care system after discharge. Failure to ensure timely follow-up can result in negative outcomes such as continued substance use, relapse, high utilization of intensive care services and mortality.

Who is included in the measure?

- Members with an inpatient stay with a principal diagnosis of substance abuse disorder
- Members aged 13+ covered under Commercial, Medicaid, or Medicare LOB

Which Members are excluded?

- Non-acute inpatient stays are excluded.
- Members using hospice services at any time during the year.

When does the Member 'pass' the measure?

When they attend a follow-up visit with any practitioner within 7 (or 30) days after the episode/discharge date

Please note: Visits may NOT occur on the same date of discharge

What counts as a follow up visit?

Any of the following services *having a substance use disorder diagnosis*:

- Acute or non-acute inpatient admission
- Outpatient behavioral health or SUD service
- Telehealth/telephone visit
- Intensive outpatient therapy
- Partial hospitalization visit
- Opioid treatment service
- Non-residential substance abuse treatment service
- Residential behavioral health treatment
- Community mental health center service
- Observation visit
- E-visit or virtual check-in
- Behavioral health or SUD assessment
- Pharmacotherapy dispensing event

Note: Follow-up does not include detoxification.

What can providers do to help improve HEDIS® FUI rates?

- Use appropriate documentation and correct coding.
- Maintain appointment availability for patient with recent hospital admissions.
- Explain the importance of follow-up to your patients.
- Coordinate assistance for members with competing social demands including childcare, transportation, and housing that otherwise prevent them from attending treatment appointments.
- Reach out to patients who do not keep initial appointments and reschedule them as soon as possible.
- Telehealth visits with the appropriate principle diagnosis will meet the follow-up criteria.
- Provide timely submission of claims and encounter data.

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What is the HEDIS® FUM measure looking at?

Individuals (six years and older) who had an Emergency Department (ED) visit with a mental illness or intentional self-harm primary diagnosis should have an outpatient appointment with a mental health disorder diagnosis as soon as possible after the ED visit. There are two submeasures for FUM – follow-up within *seven* days from the ED date and follow-up within *thirty* days from the ED date. A member who has an appointment within seven days of the ED visit is also compliant for the thirty-day FUM submeasure.

Why is the HEDIS® FUM measure important?

Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function and increased compliance with follow-up instructions.[1,2,3]

Who is included in the measure?

- Members with an ED visit with a principal diagnosis of mental illness or intentional self-harm
- Members aged 6+ covered under Commercial, Medicaid or Medicare LOB

Which Members are excluded?

- Members using hospice services at any time during the year
- ED visits followed by an inpatient admission with 30 days

When does the Member 'pass' the measure?

When they attend a follow up visit with any practitioner within 7 (or 30) days after the episode that has a principal diagnosis of mental health disorder

Please Note: Follow-up visits *can* occur on the same date as the ED visit.

What counts as a follow up visit?

Any of the following services having a *primary* diagnosis of mental health <u>or</u> having a primary diagnosis of intentional self-harm with *any* diagnosis of mental health:

- Outpatient behavioral health visit
- Telehealth/telephone visit
- Intensive outpatient therapy
- Partial hospitalization visit
- Community mental health center service
- Observation visit
- Online assessment
- Behavioral health assessment
- E-visit or virtual check-in
- Electroconvulsive therapy

What can providers do to help improve HEDIS® FUM rates?

- Use appropriate documentation and correct coding
- Maintain appointment availability for patient with recent ED visits
- Explain the importance of follow-up to your patients
- Reach out to patients who do not keep initial appointments and reschedule them as soon as possible
- Telehealth visits with the appropriate principle diagnosis will meet the follow-up criteria
- Provide timely submission of claims and encounter data

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[1] Bruffaerts, R.., Sabbe, M., Demyffanaere, K. (2005). Predicting Community Tenure in Patients with Recurrent Utilization of a Psychiatric Emergency Service. *General Hospital Psychiatry,* 27, 269-74

[2] Griswold, K.S., Zayas, L.E., Pastore, P.A., Smith, S.J., Wagner, C.M., Servoss, T.J. (2018) Primary Care After Psychiatric Crisis: A Qualitative Analysis. *Annals of Family Medicine,* 6(1), 38-43. Doi:10.1370/afm.760.

[3] Kyriacou, D.N., Handel, D., Stein, A.C., Nelson, R.R. (2005). Brief Report: "Factors Affecting Outpatient Follow-up Compliance of Emergency Department Patients. *Journal of General Internal Medicine,* 20(10), 938-942. Doi:10.1111/j.1525-1497.2005.0216_1.x

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What is the HEDIS® HDO measure looking at?

The percentage of members age 18+ who received prescription opioids at a high dosage (≥90 Morphine Milligram Equivalent (MME) dose) for ≥15 days.

Why is the HEDIS® HDO measure important?

HEDIS 2022 continues to measure high-risk opioid use and provides plans the opportunity to identify members at risk as a result of their chronic or high-dose opioid use. When used appropriately, prescription opioid analgesics provide pain relief to patients; however, misuse and overuse of opioids can lead to addiction, opioid use disorders and overdose deaths.

Who is included in the measure?

- Members with two or more opioid dispensing events (on different dates of service) and with at least 15 days covered by opioids
- Members aged 18+ covered under Commercial, Medicaid, or Medicare LOB

Which Members are excluded?

- Members having cancer or sickle cell disease.
- Members using palliative or hospice services at any time during the year.
- Additionally – Injectables, cough and cold products, fentanyl transdermal patches, and methadone are all excluded.

When does the Member 'pass' the measure?

If the member's average daily dose of morphine milligram equivalent [MME] is ≥90 for *fewer* than 15 days in a calendar year. Once the member's MME is ≥90 for at least 15 days, then the member is noncompliant for the measure.

What is an Average Daily Dose of Morphine Milligram Equivalent?

The Morphine Milligram Equivalent is the dose of oral morphine that is the analgesic equivalent of a given dose of another opioid analgesic.

A daily dose is calculated using the units per day, strength and the MME conversion factor (different for each drug).

A total sum of daily doses is calculated in order for an Average Daily Dose to finally be calculated representing all opioids dispensed to the member.

What can providers do to help improve HEDIS® HDO rates?

- Use the lowest dosage of opioids in the shortest length of time possible.
- Establish and measure goals for pain and function.
- Discuss benefits and risks and availability of non-opioid therapies with patient.
- Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.
- Review the patient's history of controlled substance prescriptions using state Prescription Drug Monitoring Program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put them at high risk for overdose.

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What is the HEDIS® IET measure looking at?

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. The measures being evaluated include:

- *Initiation of SUD Treatment*: The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days of the diagnosis.
- *Engagement of SUD Treatment*: The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Why is the HEDIS® IET measure important?

Early identification of substance use disorder issues can help your patients avoid future drug-related illnesses and deaths, improving quality of life.

Who is included in the measure?

- Members with a new substance use disorder episode
- Members aged 13+ covered under Commercial, Medicaid or Medicare LOB

Which Members are excluded?

- Members treated for SUD during the previous 194 days (i.e., 6.5 months)
- Members using hospice services at any time during the year

When does the Member 'pass' the measure?

- Initiation: SUD treatment within 14 days of the diagnosis episode

  If the episode is an inpatient encounter – this is considered treatment and the Member is compliant.
- Engagement: Compliant with the initiation treatment AND one of the following between the day after and 34 days after the initiation visit:
  - at least 2 inpatient, outpatient, or medication treatment visits (excluding methadone billed on a pharmacy claim)
  - a long-acting SUD medication administration event

What counts as a follow up visit?

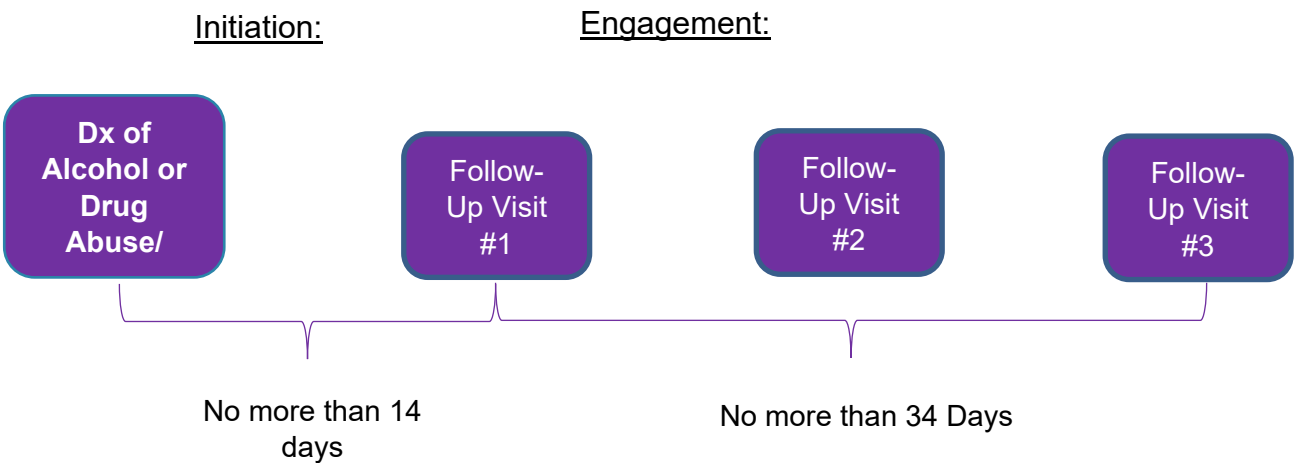
Any of the following services done with a mental health provider or having an SUD diagnosis:

- An outpatient behavioral health or SUD service
- Telehealth/telephone visit
- Intensive outpatient therapy
- Partial hospitalization visit
- Opioid treatment service
- Non-residential substance abuse treatment service
- Community mental health center service
- Observation visit
- Online assessment
- Behavioral health or SUD assessment
- Pharmacotherapy dispensing event

What can providers do to help improve HEDIS® IET rates?

- Use appropriate documentation and correct coding
- Explain the importance of follow-up to your patients
- Schedule an initial follow-up appointment within 14 days during the first service
- Reach out to patients who do not keep initial appointments and reschedule them as soon as possible
- Utilize telehealth and home based therapy where appropriate
- Provide timely submission of claims and encounter data

IET Measure At-a-Glance:



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Provider Tip Sheet

What is HEDIS®?

HEDIS® (Healthcare Effectiveness Data Information Set) is a widely used set of performance measures in the managed care industry, developed and maintained by NCQA. HEDIS® measures results and drives improvement efforts surrounding best practices.

What is the HEDIS® POD measure looking at?

The percentage of new Opioid Use Disorder (OUD) pharmacotherapy events for members with a diagnosis of OUD, age 16+, that have OUD pharmacotherapy for 180 days or more.

Why is the HEDIS® POD measure important?

Evidence suggests that pharmacotherapy can improve outcomes for individuals with OUD and that continuity of pharmacotherapy is critical to prevent relapse and overdose. Despite the evidence, pharmacotherapy is an underutilized treatment option for individuals with OUD and the NCQA seeks to address this gap by measuring episodes of pharmacotherapy and assessing adherence to treatment.

Who is included in the measure?

- Members with a new diagnosis of OUD that have an OUD dispensing or medication administration event
- Members aged 16+ covered under Commercial, Medicaid, or Medicare LOB

What are the Diagnosis Codes Used to Identify Included Members?

The following ICD-10 diagnosis codes for opioid use disorder require pharmacotherapy:

F11.10, F11.120, F11.121, F11.122, F11.129, F11.13, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29

Which Members are excluded?

- Members that have an acute or non-acute inpatient stay of 8 days or more within 6 months of the OUD dispensing or medication administration event.
- Members using hospice services at any time during the year.

When does the Member 'pass' the measure?

When OUD pharmacotherapy is received for 180 days or more without a gap in treatment of more than 8 day.

What can providers do to help improve HEDIS® POD rates?

- Consider Medication Assisted Treatment (MAT) for opioid abuse or dependence.
- Patients with OUD should be informed of the risks and benefits of pharmacotherapy, treatment without medication, and no treatment.
- Helping the patient manage stressors and identify triggers for a return to illicit opioid use.
- Provide empathic listening and nonjudgmental discussion of triggers that precede use or increased craving and how to manage them.
- Provide ongoing assessment to mark progress. Revise treatment goals via shared decision making to incorporate new insights.
- Engage and educate family members and friends who are reluctant to accept medication's role in treatment.
- Submit claims and encounter data in a timely manner.

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What is the HEDIS® SAA measure looking at?

The percentage of members 18+ diagnosed with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. The treatment period is the time between the members first antipsychotic medication fill date in the current year through Dec 31st of the current year.

Why is the HEDIS® SAA measure important?

As many as 60% of patients diagnosed with schizophrenia do not take medications as prescribed. When antipsychotics are not taken correctly, member outcomes can be severe, including hospitalization and interference with the recovery process.[1]
Adherence problems may make it difficult for a prescriber to assess the member's medication response. Prescribers may unnecessarily alter medication type or dosage in order to resolve what appears to be medication complications for a member who actually has an adherence problem.[2]

Who is included in the measure?

- Members with either one acute inpatient encounter or two outpatient encounters with a diagnosis of either schizophrenia or schizoaffective disorder with at least 2 antipsychotic medication dispensing events.
- Members aged 18+ covered under Commercial, Medicaid, or Medicare LOB.

Which Members are excluded?

- Members with dementia are excluded, as well as members over the age of 80 diagnosed with frailty.
- Members using hospice services at any time during the year.

When does the Member 'pass' the measure?

When their proportion of days covered for their antipsychotic medications is at least 80% of their treatment period.

What can providers do to help improve HEDIS® SAA rates?

Outreach directly to members who were recently prescribed antipsychotics or who have prescription refills that are past due:

- Follow up with members to confirm that they are taking their medications.
- Inform the members that they should talk to their providers if they are experiencing adverse medication side-effects.

Develop member-driven plans for medication reminders.

- Possible reminder modes include text messages, automated phone calls, alarms, signs in the member's home, and technology-equipped pillboxes that prompt members of the appropriate times to take medications.[1]

Provide evidence-based practices that are recommended for the treatment of schizophrenia, such as Cognitive-Behavioral Therapy (CBT), or refer members to providers who employ such practices.
Address risk factors and barriers associated with non-adherence, such as negative stigmas, homelessness, and substance use. Interventions focused on these risk factors may improve outcomes for members with the highest danger of non-adherence related relapse.
Discuss with the member the potential side effects of the medication.
Include a family member or caregiver in discussions regarding treatment when able.

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[1] Velligan, D. I. and Weiden, P. J. (2006, August). Interventions to Improve Adherence to Antipsychotic Medications. *Psychiatric Times, 23(9).* Retrieved from www.psychiatrictimes.com/articles/interventions-improve-adherence-antipsychotic-medications

[2] National Council for Behavioral Health. (February 21, 2018). *Improving Health Outcomes by Impacting Adherence to Medication* [PowerPoint slides]. Retrieved from https://www.nationalcouncildocs.net/wp-content/uploads/2018/03/Med-Adher-CCBHC-Feb-21-2018- Webinar-FINAL.pdf

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What is the HEDIS® SMC measure looking at?

The percentage of members aged 18 – 64 with schizophrenia or schizoaffective disorder AND cardiovascular disease, who had an LDL-C test during the calendar year.

Why is the HEDIS® SMC measure important?

Persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes; because of this, screening and monitoring of these conditions is important. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life and economic outcomes downstream.[1]

Who is included in the measure?

- Members with either 1 acute inpatient encounter or two outpatient encounters with a diagnosis of either schizophrenia or schizoaffective disorder during the current calendar year; AND have a cardiovascular disease diagnosis in the current or previous calendar year
- Medicaid members aged 18-64

Which Members are excluded?

- Members using hospice services at any time during the year.

When does the Member 'pass' the measure?

When they have a calculated or direct LDL.

What can providers do to help improve HEDIS® SMC rates?

- Order labs prior to patient appointments
- Ensure lipid levels, blood pressure and glucose are monitored at every appointment
- For patients that do not have regular contact with their PCP, coordinate medical management – including communication of lab results - with PCP
- Educate patient (and caregiver) about the risks associated with antipsychotic medications and cardiovascular disease and the importance of a healthy lifestyle.
- Assess the need for Case Management and refer if necessary

[1] NCQA Measures and Technical Resources Website: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/

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What is the HEDIS® SMD measure looking at?

The percentage of members aged 18 – 64 with schizophrenia or schizoaffective disorder AND diabetes who had both an LDL-C and an HbA1c test during the calendar year.

Why is the HEDIS® SMD measure important?

Persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes; because of this, screening and monitoring of these conditions is important. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life and economic outcomes downstream.[1]

Who is included in the measure?

- Members with either one acute inpatient encounter or two outpatient encounters with a diagnosis of either schizophrenia or schizoaffective disorder during the current calendar year; AND have a diabetes diagnosis during the current or previous calendar year.
- Medicaid members aged 18-64.

Which Members are excluded?

- Members using hospice services at any time during the year.

When does the Member 'pass' the measure?

When they have both an HbA1c test and LDL-C test performed.

What can providers do to help improve HEDIS® SMD rates?

- Document all elements of the exam, including response to medication and test results
- For patients that do not have regular contact with their PCP, coordinate medical management – including communication of lab results - with PCP
- Adjust therapy to improve HbA1c, LDL, and BP levels; follow-up with patients to monitor changes
- Give any patient caregiver instructions on the course of treatment, labs or future appointments
- Consider additional monitoring of associated factors (e.g. BMI, plasma glucose level, lipid profile)

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[1] NCQA Measures and Technical Resources Website: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/

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What is the HEDIS® SSD measure looking at?

The percentage of members aged 18 – 64 with schizophrenia or schizoaffective disorder OR bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the calendar year.

Why is the HEDIS® SSD measure important?

Persons with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes; because of this, screening and monitoring of these conditions is important. Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life and economic outcomes downstream.[1]

Who is included in the measure?

- Members with either one acute inpatient encounter or two outpatient encounters with a diagnosis of either schizophrenia, schizoaffective disorder, or bipolar disorder.
- Medicaid members aged 18-64.

Which Members are excluded?

- Members with a diagnosis of diabetes at any time during the current or previous calendar year.
- Members who had no antipsychotic medications dispensed during the current calendar year.
- Members using hospice services at any time during the current calendar year.

When does the Member 'pass' the measure?

When they have a glucose test or HbA1c test performed.

What can providers do to help improve HEDIS® SSD rates?

- Document all elements of exam, including medications, diagnosis, and results of HbA1c.
- Ensure patient schedules appropriate lab screenings.
- Ensure patient (and/or caregiver) is aware of the risk of diabetes and have awareness of the symptoms of new onset diabetes while taking antipsychotic medication.
- Educate patient (and caregiver) about the risks associated with antipsychotic medications and cardiovascular disease and the importance of a healthy lifestyle.
- Assess the need for Case Management and refer if necessary.

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[1] NCQA Measures and Technical Resources Website: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/

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What is the HEDIS® UOP measure looking at?

The measure assesses the opioid dispensing events of members 18 years and older during the calendar year, and calculates three rates associated with high risk of overdose/death:

- Members who use multiple providers (four or greater)
- Multiple pharmacies (four or greater)
- Both multiple providers (four or greater) *and* multiple pharmacies (four or greater)

Note: A lower rate indicates better performance for all three rates.

Why is the HEDIS® UOP measure important?

High dosage, multiple prescribers and pharmacies are all risk factors for dangerous overdose and death. These measures add health plans to the group of stakeholders currently addressing the opioid epidemic.

Who is included in the measure?

- Members with 2 or more opioid dispensing events (on different dates of service) and have at least 15 days covered by opioids
- Members aged 18+ covered under Commercial, Medicaid, or Medicare LOB

Which Members are excluded?

- Members using hospice services at any time during the year.
- Additionally, excluded medications include: Injectables, opioid cough and cold products, products used as part of medication-assisted treatment of opioid use disorder (buprenorphine), fentanyl patch and methadone.

When does the Member 'pass' the measure?

If they have 3 or fewer prescribers and 3 or fewer pharmacies from which they receive opioids.

What can providers do to help improve HEDIS® UOP rates?

- Have coordination of care conversations with other prescribers involved in care.
- Discuss the risks of using multiple prescribers with member.
- Involve Care Management to ensure coordination of care.
- Check State Prescription Drug Monitoring Program to check status of member prescribing habits.
- Understand community resources and educate staff on what is available.

Additional Resources

FOR ANY TOPIC:

A link to SAMHSA's (Substance Abuse and Mental Health Services Administration) resource center to search for any desired topic
https://www.samhsa.gov/ebp-resource-center

RELATED TO OPIOID USE DISORDERS

A one-page toolkit, with links to assist with dosing, tapering and education of opioids:
https://www.cdc.gov/opioids/healthcare-professionals/prescribing/opioid-use-disorder.html
Article by CDC with guidelines for prescribing opioids:
https://www.cdc.gov/opioids/healthcare-professionals/prescribing/guideline/at-a-glance.html

RELATED TO SCHIZOPHRENIA

An easy-to-read article including information on the link between schizophrenia and diabetes and integrating diabetes care into behavioral health treatment:
https://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780

An article outlining the importance of monitoring for diabetes in schizophrenia patient's:
https://www.hindawi.com/journals/ije/2015/969182/

RELATED TO ADOLESCENT AND MEDICATION MANAGEMENT

An article on Best Practices for prescribing Antipsychotic medications for children, including information on metabolic monitoring:
https://store.samhsa.gov/product/guidance-on-strategies-to-promote-best-practice-in-antipsychotic-prescribing-for-children/PEP19-ANTIPSYCHOTIC-BP

RELATED TO HEALTH EQUITY

A general overview regarding eliminating health disparities:
https://www.cms.gov/About-CMS/Agency-Information/OMH