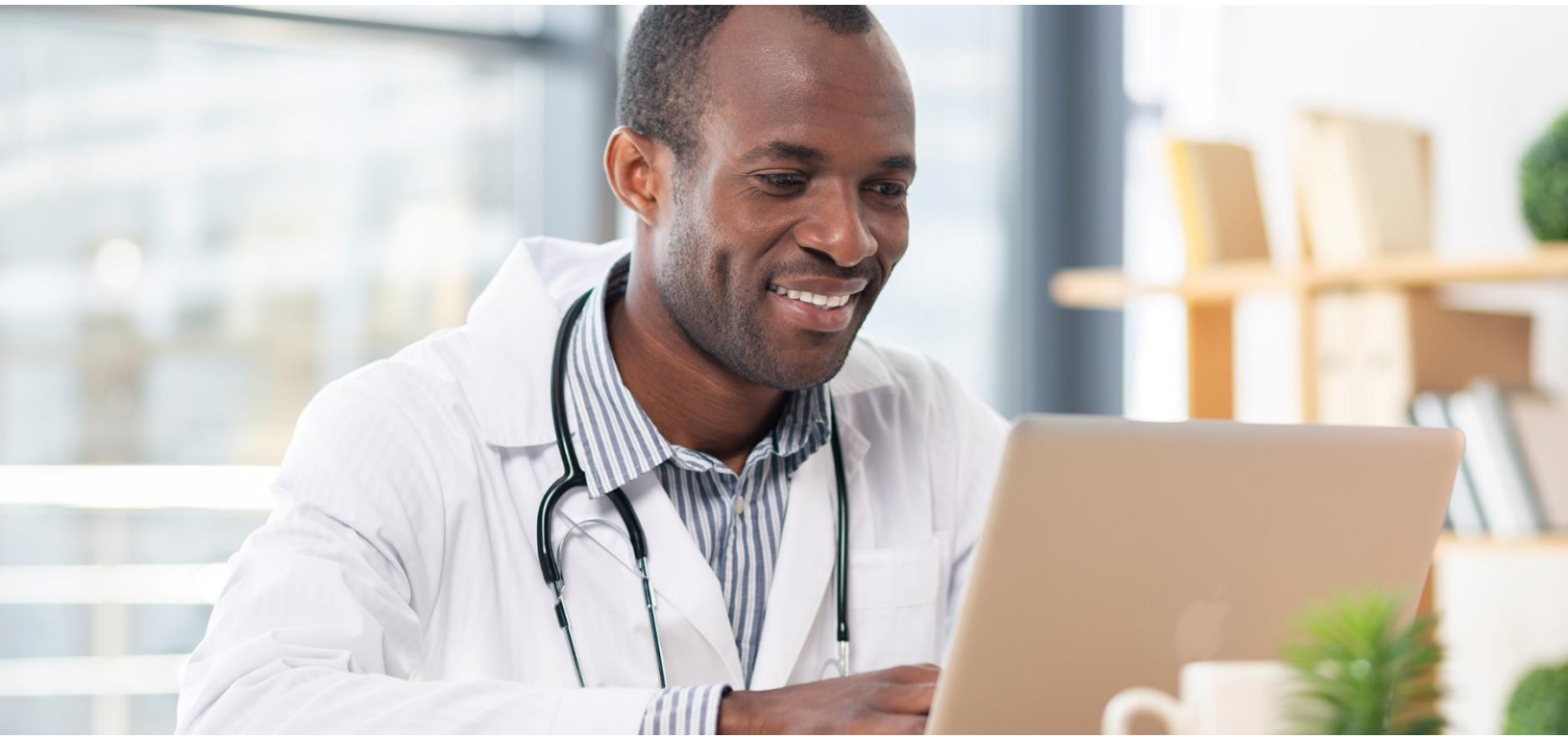
Today we are Carelon Behavioral Health. We are working on updating all documents, but some historic references to Beacon may remain.

Our name may be new, but our commitment to you remains the same.



Beacon/Well Sense

Provider Resource Guide

Beacon Health Strategies is a Beacon Health Options company.

Table of Contents

Welcome to the Beacon/Well Sense Provider Resource Guide

This is the Beacon/Well Sense Provider Resource Guide. The purpose of this guide is to offer a better understanding of the resources and supports available to our provider network in caring for our membership. Well Sense and Beacon have partnered since 2013 to ensure that comprehensive services, inclusive of behavioral health services, are provided to Well Sense members and that those services are founded on specific member needs and health outcome expectations. Each member is unique and brings his/her distinct cultural expectations, experiences, values, strengths, and vulnerabilities to the treatment setting. Similarly, our physical health and behavioral health providers are diverse. Our objective is to support our providers by recognizing and building upon strengths, as well as offer education and supports for identified areas of need. This resource guide has several different components, some of which may or may not apply to your practice. It is intended to be a reference guide that provides resources to address some priority items outlined in the Medicaid Care Management (MCM) contract.

The information found in this Provider Resource Guide can also be found on the Beacon and Well Sense websites. If you have any questions, please don't hesitate to contact Beacon or Well Sense at the numbers below:

- Beacon: 855-834-5655
- Well Sense Health Plan: 877-957-1300

Disclaimer: This is a resource guide for the Beacon/Well Sense provider network and is not intended to provide specific medical advice for individual patients. We encourage providers to review this information and apply as clinically appropriate to each individual patient.

Beacon Primary Care Physician (PCP) Toolkit

The Case for Addressing Behavioral Health Issues in a Primary Care Setting

Primary care settings for behavioral health services enhance access. When mental health and substance use disorder treatment is integrated into primary care, people can access services closer to their homes. This, in turn, allows patients to stay in the community and maintain daily activities:

- Delivering mental health services in primary care settings reduces stigma and discrimination.
- Treating common mental disorders in primary care settings is cost-effective.
- The majority of people with mental disorders treated in collaborative primary care have good outcomes, particularly when linked to a network of services at a specialty care level and in the community.

Let us help you when behavioral health care is needed for your patients
Primary care settings are increasingly the first line of identification for behavioral health (BH) issues, especially for depression. As your patients' primary medical practitioner, you already know the large number of patients who present with both physical and behavioral health disorders. Beacon supports PCPs as the locus of treatment for a wide variety of BH diagnoses. To that end, we offer you a toolkit to help you with identification of BH conditions, as well as next steps in treatment of BH conditions. We are committed to leading the integration of medical and BH services with goal of improved patient outcomes.

The Beacon PCP Toolkit can be found online:

https://providertoolkit.beaconhealthoptions.com/

The PCP toolkit contains general guidelines for diagnosis and treatment of the most common mental health disorders. It also provides evidence-based screening tools for depression, anxiety, alcohol and substance use, and other common mental health diagnosis. It is recommended that regular screenings of mental health and substance use disorder occur in primary care and other health care settings, to allow for earlier identification, which translates into earlier care.

In the Appendix, a PCP Toolkit Webinar presentation has been included to provide additional training as to how to use the PCP Toolkit. In addition, there is a recorded webinar on Beacon's website that can be found here: PCP Toolkit Webinar - Recording

Integrated Care

Beacon and Well Sense are committed to leading the integration of medical and behavioral health services, to ensure that our members receive a seamless continuum of care that addresses the whole health needs of the member. Integrated care is an effective approach in caring for members with the most complex health care needs.

The Substance Abuse and Mental Health Services Administration (SAMHSA) promotes integrated care and provides a framework consisting of "Six Levels of Collaboration/Integration," which helps both primary and behavioral health care providers assess where they are on the integration continuum. The six-level framework can be used to help providers plan for how they can move up the continuum of integration. Beacon and Well Sense are here to support providers through integration efforts.

In the appendix, there is additional detail describing SAMHSA's "Six Levels of Collaborations/Integration (Core Descriptions)." Please review for further details on the different levels of integration.

In addition to SAMHSA's six-level framework of integration, Beacon has created an Integrated Practice Assessment Tool (IPAT), which is a quick tool that scores providers on the level of collaboration or integration based on the six levels outlined by SAMHSA. Providers can find the IPAT on Beacon's website: Beacon's Integrated Care Toolkit

In efforts to support the state of NH moving toward an integrated health system, Beacon and Well Sense have developed some general guidance to be used by the provider network to identify when a member may need to be referred to a PCP or may need a referral to a behavioral health provider. This guidance is not meant to be all-inclusive, but rather includes the most common symptoms seen for either a behavioral health referral or referral to a PCP.

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Guidelines for Referral to a Mental Health Provider

General signs your patient could benefit from a referral to a mental health provider:

- **Decreased attention to medical care:** Not making the effort to take medications regularly; ambivalence about what might happen if they don't follow medical recommendations
- **Decline in functioning:** Spending too much time in bed; isolating from others; not going to school or work regularly; not showering and getting dressed regularly
- **Neurovegetative symptoms:** Increase or decrease in appetite, sleep, or energy without an apparent medical cause
- **Cognitive complaints:** Difficulty concentrating on a book or a movie; difficulty keeping up with mail and bills; getting lost in familiar areas
- **Self-injurious behavior:** Apparently self-inflicted cuts, or other evidence of intentional self-harm

Symptoms suggestive of particular diagnoses:

- **Anxiety:** Worrying more about things than you would expect; worry is interfering with daily activities and/or sleep
- **Depression:** More severe or persistent sadness than you would expect; feeling guilty or worthless; feeling hopeless, thinking there is no way things will get better; nothing seems to cheer them up, even temporarily
- **Psychosis:** Irrational thoughts, such as people are following them or coming into their home; hearing or seeing things that are not real
- **OCD:** Intrusive thoughts that make someone think something bad will happen if they don't do something in a certain way; intolerable discomfort if things aren't arranged in a particular way; spending many hours each day on behaviors to counteract these beliefs or bad feelings; wishing they didn't need to spend so much time on these behaviors
- **Eating disorder:** Misperception of their body size; excessive focus on their weight; weight loss that is otherwise unexplained; electrolyte imbalances; teeth damaged by acid from repeated vomiting; cuts from teeth on finger used to induce vomiting
- **Post-Traumatic Stress Disorder (PTSD):** History of trauma that threatened or caused significant harm to themselves or someone close to them; nightmares about trauma; flashbacks, as if the trauma were happening again; avoiding things or places that remind them of the trauma; easily startled
- **Substance use disorder:** Worsening of tremors that could indicate withdrawal from substances; seizures; requesting early refills of controlled substances; family expresses concern about excessive alcohol intake, or suspects drug use

Emergencies

Individuals with these symptoms should not be left alone and require an emergency assessment by someone with mental health expertise:

- Thoughts of ending their life
- Voices telling them to hurt themselves or others
- Severe impairment in functioning, to the point that they are unable to take basic care of themselves

GUIDELINES ON REFERRING BEHAVIORAL HEALTH PATIENTS FOR MEDICAL ASSESSMENT AND MANAGEMENT

Many physical symptoms require general medical attention. These symptoms can be seen more commonly in individuals with mental illness, or individuals on psychotropic medication:

- Confusion
- Severe nausea vomiting/diarrhea
- Muscle stiffness
- High fever
- Worsening of tremor
- Seizure
- Rash
- Weight gain, low energy
- Anxiety, weight loss
- Frequent urination
- Difficulty walking
- Dizziness or lightheadedness
- Sexual dysfunction
- Difficulty swallowing
- Excessive sweating
- Falls

ROUTINE PREVENTATIVE CARE

Individuals with behavioral health conditions are at increased risk for **diabetes or heart disease,** so regular visits with their primary care provider are extremely important.

EMERGENCIES

The following medical presentations, particularly in the context of behavioral health conditions and psychiatric medications, require emergency medical attention:

- **No food or fluid intake** for more than one day
- **Seizures**
- **Self-injurious behavior** – ingestion of non-food objects; deep self-inflicted cuts; severe head-banging
- **Loss of consciousness** on standing
- **Serotonin syndrome** – Seizure, confusion, irregular heartbeat, muscle twitching, tremor, nausea/vomiting/diarrhea
- **Dystonic reaction** – Severe prolonged muscle spasm affecting tongue, neck, eyes, larynx, or other body part
- **Neuroleptic malignant syndrome** – High fever, confusion, muscle rigidity, tachycardia, tachypnea, unstable blood pressure

Community-Based Resources

Community mental health centers (CMHCs) are located in 10 regions of New Hampshire, providing full state coverage. Services provided by the CMHCs include: 24-hour Emergency Services, Assessment and Evaluation, Individual and Group Therapy, Case Management, Community-Based Rehabilitation Services, Psychiatric Services, and Community Disaster Mental Health Support.

Community Mental Health Centers:

Region 1: Northern Human Services
Conway, NH 603-447-3347

Region 2: West Central Behavioral Health
Lebanon, NH 603-448-0126

Region 3: Lakes Region Mental Health Center
Laconia, NH 603-524-1100

Region 4: Riverbend Community Mental Health, Inc.
Concord, NH 603-226-7505

Region 5: Monadnock Family Services
Keene, NH 603-357-4400

Region 6: Greater Nashua Mental Health at Community Council
Nashua, NH 603-889-6147

Region 7: Mental Health Center of Greater Manchester
Manchester, NH 603-668-4111

Region 8: Seacoast Mental Health Center
Portsmouth, NH 603-431-6703

Region 9: Community Partners of Strafford County
Dover, NH 603-516-9300

Region 10: Center for Life Management
Derry, NH 603-434-1577

For additional information of the CMHCs and which cities and towns they serve, please view the map of CMHCs.

The Doorways are located in nine regions of New Hampshire and provide single-points entry for people seeking help for substance use disorders, whether they require treatment, support, or resources for prevention and awareness. In addition to the Doorways, members have 24/7 access to services by dialing 2-1-1, which helps connect members with the appropriate supports and resources.

The Doorways:

The Doorway at Androscoggin Valley Hospital
Berlin, NH

The Doorway at Concord Hospital
Concord, NH

The Doorway Operated by Wentworth-Douglass Hospital
Dover, NH

The Doorway at Cheshire Medical Center
Keene, NH

The Doorway at Lakes Region General Hospital
Laconia, NH

The Doorway at Dartmouth-Hitchcock Medical Center
Lebanon, NH

The Doorway at Littleton Regional Healthcare
Littleton, NH

The Doorway at Catholic Medical Center (coming soon)
Manchester, NH

The Doorway at Southern NH Medical Center (coming soon)
Nashua, NH

Members are encouraged to call 2-1-1 to be connected with a Doorway.

Peer support and peer recovery support

Peer support and peer recovery support specialists are people who have lived experience with either mental health or substance use disorders and who have been successful in the recovery process and want to support their peers towards healing and recovery. Peer support specialists are those with lived mental health experiences and recovery, while peer recovery support specialists are those with lived substance use disorder experiences and recovery. These two services are described in more detail on the next pages.

Peer Support

What is Peer Support?

Peer support is a service provided by people who have lived experience with behavioral health diagnoses to guide and support their peers toward healing and recovery. Peer support recovery specialists are trained to work with individuals in an intentional, mutually supportive, non-judgmental environment.

Where Do Peer Support Specialists Work?

Across New Hampshire, peer support specialists work as part of Assertive Community Treatment (ACT) teams, in substance use disorder recovery facilities, at New Hampshire Hospital, and at the Behavioral Health Crisis Treatment Center in Concord. There are independent peer support agencies in each region of the state who offer peer support groups, education, respite, and operate warm lines.

What Do Peer Support Specialists Do?

- Direct support with recovery skills
- Community education
- Act as an advocate
- Create a personal recovery plan in partnership
- Provide education about illness management

Turn over for a list of New Hampshire Peer Support agencies.

New Hampshire Peer Support Agencies

Region	Agency Address	Phone Number
North Country	**The Alternative Life Center** 6 Main Street PO Box 241 Conway, NH 03818-0241	Tel: (603) 447-1765 Warmline: (866) 447-1765 (5 - 9 p.m., 7 days per week) Crisis Respite: (603) 447-1765
	Littleton Peer Support TBD	Tel: (603) 447-1765 Warmline: (866) 447-1765 (5 - 9 p.m., 7 days per week) Crisis Respite: (603) 447-1765
	The Haven 27 Lombard Street Colebrook, NH 03576	Telephone: (603) 237-4353 Warmline: (866) 447-1765 (5 - 9 p.m., 7 days per week) Crisis Respite: 603 447-1765
	Serenity Steps 567 Main Street Berlin, NH 03896	Tel: (603) 752-8111 Warmline: (866) 447-1765 (5 - 9 p.m., 7 days per week) Crisis Respite: 603 447-1765
Upper Valley and River Valley	**Stepping Stone** 108 Pleasant Street Claremont, NH 03743	Tel: (603) 543-1388 Warmline: (888) 582-0920 (4 - 9 p.m., 7 days per week) Warmline Claremont Area: (603) 543-1388 (same times as above) Crisis Respite: (888) 582-0920 or (603) 543-0920
	Next Step 109 Bank Street Lebanon, NH 03766	Tel: (603) 448-6941 Warmline: (888) 582-0920 (4 - 9 p.m., 7 days per week) Crisis Respite: (888) 582-0920 or (603) 543-1388
Lakes Region Area	**Lakes Region Consumer Advisory Board "CornerBridge"** 328 Union Avenue PO Box 304 Laconia, NH 03247-0304	Tel: (603) 528-7742 Warmline: (800) 306-4334 (5 - 10 p.m., 7 days per week)
	Plymouth Area Pemi Valley Outreach Plymouth, NH 03264	Tel: (603) 412-7050 Warmline: (800) 306-4334 (5 - 10 p.m., 7 days per week)
Central Region	**Lakes Region Consumer Advisory Board "Concord Peer Support Site"** 55 School Street Concord, NH 03301	Office: (603) 224-0083 Tel: (603) 224-0894 (1st floor) Warmline: (800) 306-4334 (5 - 10 p.m., 7 days per week)
Monadnock Region	**Monadnock Area Peer Support Agency** 64 Beaver Street PO Box 258 Keene NH 03431	Office: (603) 352-5093 Toll-Free: (866) 352-5093 Warmline: (866) 352-5093 (5 - 10 p.m., 7 day per week) Crisis Respite: (603) 352-5093 or (866) 352-5093
Southern NH Area	**HEARTS Peer Support Center of Greater Nashua Region 6** 5 Pine Street Extension, Suite 1-G PO Box 1564 Nashua, NH 03061-1564	Tel: (603) 882-8400 Warmline: (800) 306-4334 (5 - 10 p.m., 7 days per week) Crisis Respite: (603) 864-8769
Hillsborough County Area	**On The Road To Wellness - Manchester** 377 South Willow Street, Suite B2-4 Manchester, NH 03103	Tel: (603) 623-4523 Warmline: (800) 306-4334 (5 - 10 p.m., 7 days per week)
Seacoast Area	**Connections Peer Support Center** 544 Islington Street Portsmouth, NH 03801	Tel: (603) 427-6966 Warmline: (800) 809-6262 (5 - 10 p.m., 7 days per week)
Strafford County Area	**Tri-City Consumers' Action Co-operative** 55 Summer Street Rochester, NH 03867-1929	Tel: (603) 948-1043 Warmline: (800) 809-6262 (5 - 10 p.m., 7 days per week)
Southeastern Area	**On The Road To Wellness - Derry** 45 South Main Street Derry, NH 03038	Tel: (603) 552-3177 Warmline: (800) 809-6262 (5 - 10 p.m., 7 days per week

Peer Recovery Support

What is peer recovery support?

Peer recovery support workers are people who have been successful in their recovery and want to reach out to others struggling with addiction to offer guidance, compassion, and hope by sharing their own experience. Sharing lived experience and success can be a powerful motivator to remain on the path to recovery and lessen the chances of a relapse.

What do peer recovery support workers do?

Peer recovery support workers are a significant addition to recovery because they can work beyond the limits of a traditional clinical setting. A peer recovery support worker will have capabilities that make him/her ideal for his/her role to help others, such as lived experience, understanding, and compassion and can offer an example of hope. These natural attributes are also enhanced with additional training and can include:

- **Recovery-minded**: Peer recovery support workers are stable in their recovery and comfortable helping others reach their own recovery-based goals by offering hope, empathy, compassion, and sharing lived experience.
- **Trauma-informed**: Peer recovery support workers are trained on how to offer support in a way that helps peers feel empowered and gain control in their own environment.
- **Goal-centered**: Peer recovery support workers are always focused on advocating for peers as well as helping to encourage continued progress on the goals, hopes, achievements, and well-being of the peer. This helps keep the recovery process personalized to each individual and in turn helps drives the success of recovery.

Where can I find a peer recovery support worker?

Peer recovery support workers are located in community-based organizations. Please turn over for a list of organizations that offer peer recovery support workers as an ally for recovery.

Organizations Offering Peer Recovery Support Workers

Northern New Hampshire	
Berlin	Hope for New Hampshire Recovery 823 Main Street Berlin, NH 03570 P: (603) 752-9900 www.hopefornhrecovery.org/berlin
Colebrook	The Haven 27 Lombard Street Colebrook, NH 03576 P: (603)-237-4353 https://www.alccenters.org/colebrook-nh
Littleton	Littleton Peer Support Center 127 Saranac Street, Suite 100 Littleton, NH 03561 P: (603) 444-5344 https://www.alccenters.org/littleton-nh
Central New Hampshire	
Lebanon	Next Step 109 Bank Street Lebanon, NH 03766 P: (603) 448-6941 http://www.steppingstonenextstep.org/
Plymouth	Plymouth Area Pemi Valley Outreach Plymouth, NH 03264 P: (603) 412-7050 https://www.nhcornerbridge.info/pemi-valley-outreach.html
Laconia	Navigating Recovery of the Lakes Region 102 Court Street Laconia, NH 03246 P: (603) 524-5939 www.navigatingrecovery.org
Tilton	Greater Tilton Area Family Resource Center 5 Prospect Street Tilton, NH 03276 P: (603) 286-4255 www.gtafrc.com
Conway	Conway Peer Support Center 6 Main Street Conway, NH 03818 P: (603) 447-1765 https://www.alccenters.org/conway-nh
Ossipee	White Horse Recovery Services Center (The Shed) 70 Rt. 16B Center Ossipee, NH 03814 P: (603) 301-0041 www.whitehorseac.com
Claremont	Center for Recovery Resources 109 Pleasant Street, Suite 104 Claremont, NH 03743 P: (603) 287-7127 www.tlcfamilyrc.org/thecenter.html
Southern New Hampshire	
Concord	Concord Peer Support Site 55 School Street Concord, NH 03301 P: (603) 224-0083 https://www.nhcornerbridge.info
Manchester	HOPE for New Hampshire Recovery 293 Wilson Street Manchester, NH 03103 P: (603) 935-7524 www.hopefornhrecovery.org
Portsmouth	Safe Harbor Recovery Center 865 Islington Street Portsmouth, NH 03801 P: (603) 570-9444 https://granitepathwaysnh.org/safe-harbor-recovery-center
Hampton	SOS Recovery Community Organization 1 Lafayette Road, Unit 1 Hampton NH 03842 P: (603) 841-2350 https://straffordrecovery.org/our-locations/hampton/
Dover	SOS Recovery Community Center 4 Broadway Dover, NH 03820 P: (603) 841-2350 https://straffordrecovery.org/our-locations/dover/
Rochester	SOS Recovery Community Center 63 S. Main Street Rochester, NH 03867 P: (603) 841-2350 https://straffordrecovery.org/our-locations/rochester/
Nashua	Revive Recovery Center 263 Main Street Nashua, NH 03060 P: 1-888-317-8312 https://reviverecovery.org/
Keene	Keene Serenity Center 40 Carpenter Street PO Box 327 Keene, NH 03431 P: (603) 283-5015 www.keeneserenitycenter.org

Healthcare Effectiveness Data and Information Set (HEDIS®) Overview

Developed by the National Committee for Quality Assurance (NCQA), HEDIS[1] is a set of performance measures used in the managed care industry, is part of NCQA accreditation, and is an essential activity for Beacon to ensure members are getting the best care possible. Located in the Appendix, you will find a HEDIS Provider Guide and Toolkit, developed by Beacon. The purpose of this toolkit is to offer better understanding of the HEDIS applications and guidelines. Beacon and Well Sense encourage all providers to review the applicable HEDIS tip sheets as they may relate to your practice.

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

Appendix

1. *PCP Toolkit Webinar*
2. *SAMHSA Six Levels of Integration*
3. *2020 HEDIS Provider Guide and Toolkit*

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PCP Toolkit Webinar

July 11, 2019

Learning Objectives

1. How the PCP Toolkit was developed
2. How the PCP Toolkit is maintained
3. Which behavioral health conditions are included within the PCP Toolkit
4. What kind of content is available within the PCP toolkit
5. How to access and navigate within the PCP Toolkit

Agenda

1	Overview	2	Development
3	Features	4	Navigation
5	Question and Answer	6	Thank You

Chapter

01

Overview

“We help people live their lives to the fullest potential.”

Our Commitment

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Integration of Medical and Behavioral Health Services to Improve Outcomes

As the first line of defense for behavioral health (BH) issues, primary care physicians (PCPs) play a critical role in the proper identification and treatment of BH conditions.

As a collaborative health care partner, Beacon supports PCPs through information sharing and support so that they have the tools and resources needed to successfully treat these conditions.

Beacon's toolkit has been developed to support our ongoing collaborative initiatives with primary care practices.

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Recommendations

- Review the tools and resources in the PCP Toolkit to determine usage in individual practice.
- Explore additional recommendations provided by your applicable trade organization.

If treatment of a BH condition is outside of your scope of practice, we recommend a referral to a BH professional in the patient's health plan.

Chapter

02

Development

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Initial Development

Primary research targeting PCPs to determine:

- Who is presenting to their practice with BH conditions?
- What conditions are they seeing most frequently?
- How do they currently treat BH conditions?
- How do they refer patients for BH services?
- What additional resources would be helpful in treating their patients?

Secondary research of existing resources for BH conditions:

- Information gathered targeting up-to-date clinical guidelines, member-facing resources, and standard screening tools for BH conditions

Rigorous review of material included in the toolkit:

- Reviewed by consulting NP for relevance/usefulness to PCP practice
- VP of Medical Affairs reviewed for clinical appropriateness and accuracy

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Moving Forward

- Ongoing monitoring and maintenance to ensure relevance of clinical material by Scientific Review Committee

- Managed in house by Corporate Quality Department

Chapter

03

“We help people live their lives to the fullest potential.”

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Features

Behavioral Health Conditions Included

- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Alcohol/Substance Use Disorder
- Anxiety
- Depression
- Adolescent Depression
- Postpartum Depression
- Eating Disorders
- Obsessive-Compulsive Disorder (OCD)
- Post-Traumatic Stress Disorder (PTSD)
- Schizophrenia

Content Included

- Overview of each behavioral health condition
- Diagnostic references
- Prescribing references
- Member resources
- Screening Tools

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Chapter

04

“We help people live their lives to the fullest potential.”

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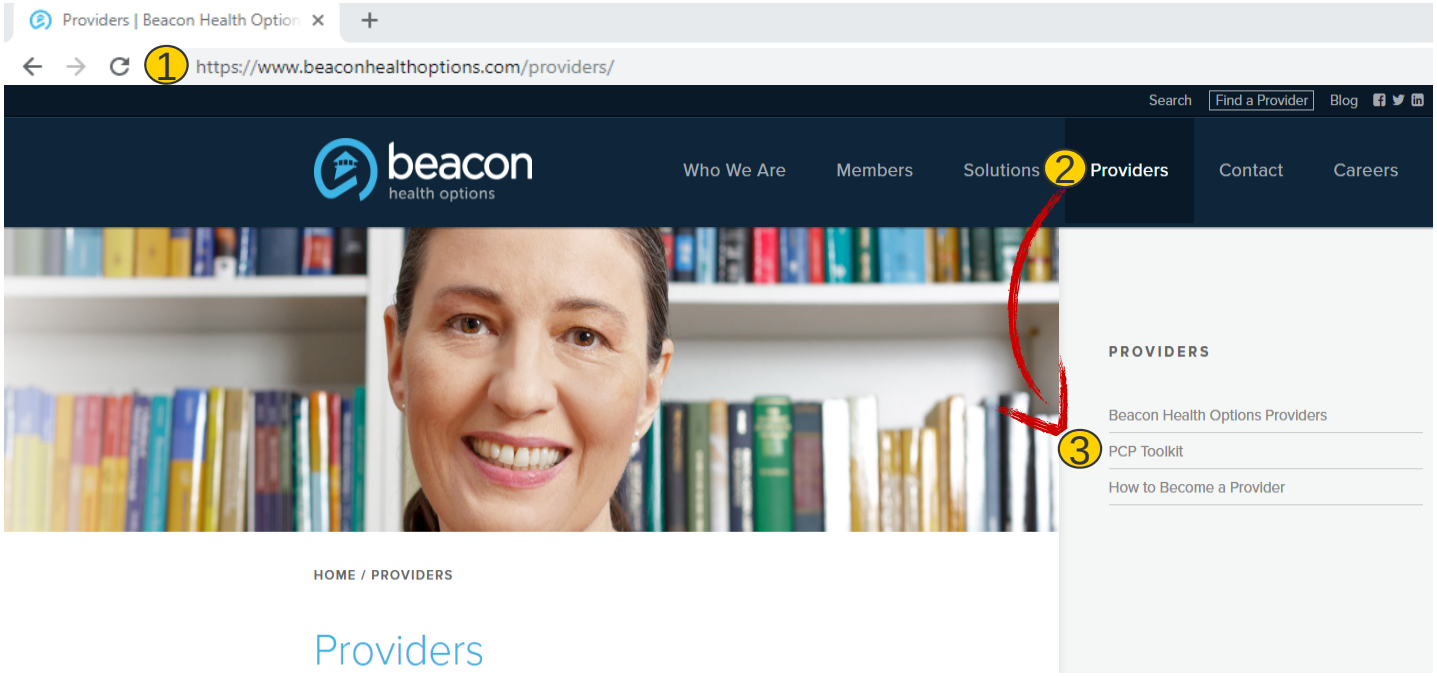
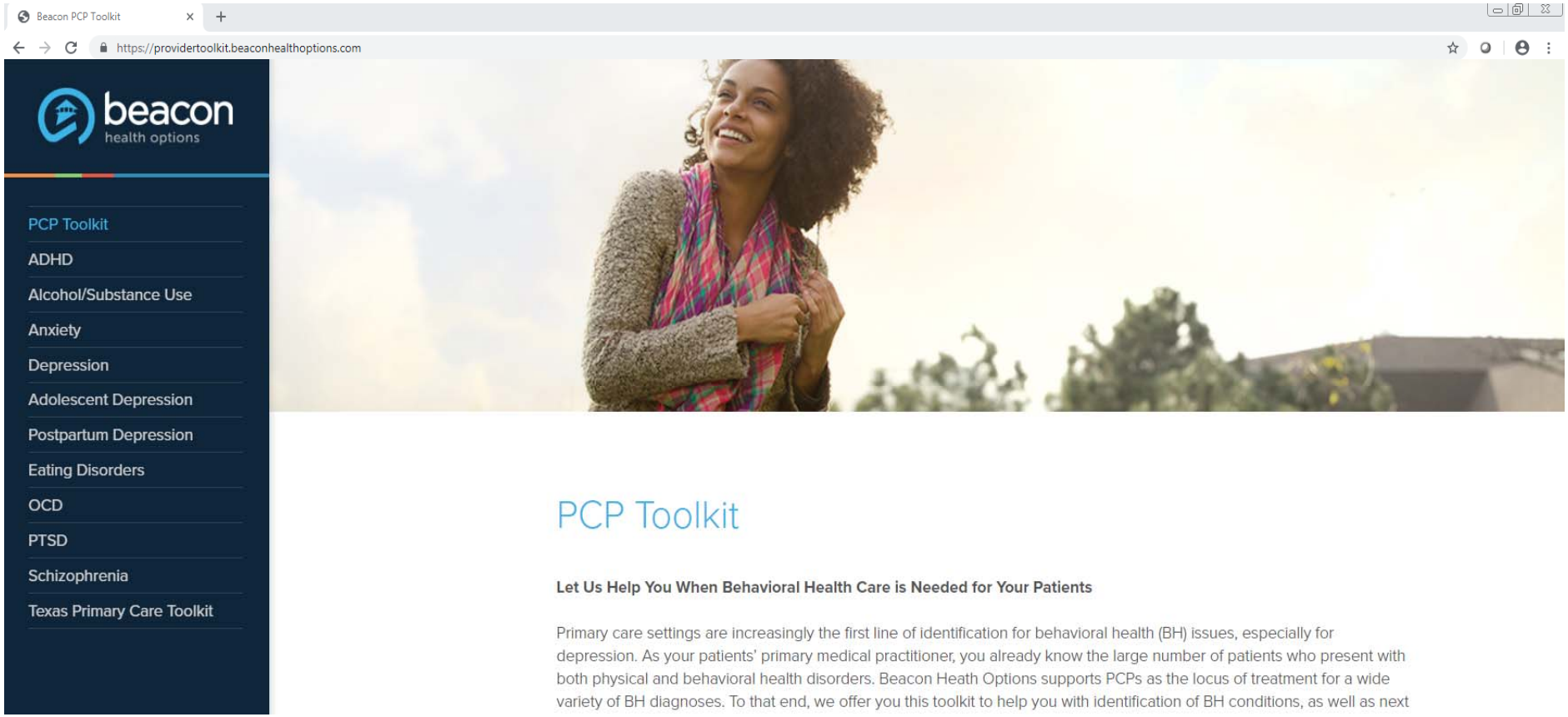
Navigation

Access

1. Go to **beaconhealthoptions.com**
2. Click on the **Providers** tab
3. Click on **PCP Toolkit**




Beacon PCP Toolkit
https://providertoolkit.beaconhealthoptions.com
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health options
PCP Toolkit
ADHD
Alcohol/Substance Use
Anxiety
Depression
Adolescent Depression
Postpartum Depression
Eating Disorders
OCD
PTSD
Schizophrenia
Texas Primary Care Toolkit
PCP Toolkit
Let Us Help You When Behavioral Health Care is Needed for Your Patients
Primary care settings are increasingly the first line of identification for behavioral health (BH) issues, especially for depression. As your patients' primary medical practitioner, you already know the large number of patients who present with both physical and behavioral health disorders. Beacon Heath Options supports PCPs as the locus of treatment for a wide variety of BH diagnoses. To that end, we offer you this toolkit to help you with identification of BH conditions, as well as next

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- PCP Toolkit
- ADHD
- Alcohol/Substance Use
- Anxiety
- Depression
- Adolescent Depression
- Postpartum Depression
- Eating Disorders
- OCD
- PTSD
- Schizophrenia
- Texas Primary Care Toolkit

ADHD

Attention-Deficit/Hyperactivity Disorder (ADHD) is one of the most common chronic childhood disorders and its prevalence is on the rise. Estimates based on a 2011 survey of parents indicate that approximately 11% of children ages 4 to 17 have been diagnosed with the disorder. Parents of children with current ADHD diagnoses, reported that 6.1% of their kids were taking medication to treat it. Children with ADHD may have difficulty controlling their behavior in school and social settings and often fail to achieve their full academic potential. Additionally, ADHD is frequently found with other psychiatric disorders.

The key to effective long-term management of the child with ADHD is continuity of care with clinicians experienced in the treatment of ADHD. The frequency and duration of follow-up sessions should be individualized for each family and child, depending on the severity of ADHD symptoms; the degree of co-morbidity of other psychiatric illness; the response to treatment; and the degree of impairment in home, school, work, or peer-related activities.

Guidelines for Diagnosis and Treatment

- American Academy of Pediatrics ADHD Guideline
- American Academy of Pediatrics Guideline Supplement
- ADHD Medication Treatment Algorithm

Member Materials

- ADHD: What Is It?
- Diagnosing ADHD in Children and Adults

Screening Tools

- Adult ADHD Assessment Tool
- Child ADHD Screening Tools:
  - ADHD Rating Scale: Home Version
  - NICHQ Vanderbilt Assessment Scales

Chapter

05

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Question and Answer

Thank You

Contact Us

With one call to Beacon, providers can:

- Get information on behavioral health benefits and services
- Locate behavioral health providers
- Get help making a routine appointment
- Make an urgent appointment
- Obtain crisis support

1-855-856-0582

www.beaconhealthoptions.com

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet non-formal team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Table 2A. Six Levels of Collaboration/Integration (Key Differentiators)

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Key Differentiator: Clinical Delivery					
▸▸ Screening and assessment done according to separate practice models ▸▸ Separate treatment plans ▸▸ Evidenced-based practices (EBP) implemented separately	▸▸ Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges ▸▸ Separate treatment plans shared based on established relationships between specific providers ▸▸ Separate responsibility for care/EBPs	▸▸ May agree on a specific screening or other criteria for more effective in-house referral ▸▸ Separate service plans with some shared information that informs them ▸▸ Some shared knowledge of each other's EBPs, especially for high utilizers	▸▸ Agree on specific screening, based on ability to respond to results ▸▸ Collaborative treatment planning for specific patients ▸▸ Some EBPs and some training shared, focused on interest or specific population needs	▸▸ Consistent set of agreed upon screenings across disciplines, which guide treatment interventions ▸▸ Collaborative treatment planning for all shared patients ▸▸ EBPs shared across system with some joint monitoring of health conditions for some patients	▸▸ Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place ▸▸ One treatment plan for all patients ▸▸ EBPs are team selected, trained and implemented across disciplines as standard practice
Key Differentiator: Patient Experience					
▸▸ Patient physical and behavioral health needs are treated as separate issues ▸▸ Patient must negotiate separate practices and sites on their own with varying degrees of success	▸▸ Patient health needs are treated separately, but records are shared, promoting better provider knowledge ▸▸ Patients may be referred, but a variety of barriers prevent many patients from accessing care	▸▸ Patient health needs are treated separately at the same location ▸▸ Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider	▸▸ Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers ▸▸ Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services	▸▸ Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others ▸▸ Care is responsive to identified patient needs by of a team of providers as needed, which feels like a one-stop shop	▸▸ All patient health needs are treated for all patients by a team, who function effectively together ▸▸ Patients experience a seamless response to all healthcare needs as they present, in a unified practice

Table 2B. Six Levels of Collaboration/Integration (Key Differentiators, continued)

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Key Differentiator: Practice/Organization					
▸▸ No coordination or management of collaborative efforts ▸▸ Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow	▸▸ Some practice leadership in more systematic information sharing ▸▸ Some provider buy-into collaboration and value placed on having needed information	▸▸ Organization leaders supportive but often colocation is viewed as a project or program ▸▸ Provider buy-in to making referrals work and appreciation of onsite availability	▸▸ Organization leaders support integration through mutual problem-solving of some system barriers ▸▸ More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components	▸▸ Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced ▸▸ Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers	▸▸ Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development ▸▸ Integrated care and all components embraced by all providers and active involvement in practice change
Key Differentiator: Business Model					
▸▸ Separate funding ▸▸ No sharing of resources ▸▸ Separate billing practices	▸▸ Separate funding ▸▸ May share resources for single projects ▸▸ Separate billing practices	▸▸ Separate funding ▸▸ May share facility expenses ▸▸ Separate billing practices	▸▸ Separate funding, but may share grants ▸▸ May share office expenses, staffing costs, or infrastructure ▸▸ Separate billing due to system barriers	▸▸ Blended funding based on contracts, grants or agreements ▸▸ Variety of ways to structure the sharing of all expenses ▸▸ Billing function combined or agreed upon process	▸▸ Integrated funding, based on multiple sources of revenue ▸▸ Resources shared and allocated across whole practice ▸▸ Billing maximized for integrated model and single billing structure

Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Advantages					
▸▸ Each practice can make timely and autonomous decisions about care ▸▸ Readily understood as a practice model by patients and providers	▸▸ Maintains each practice's basic operating structure, so change is not a disruptive factor ▸▸ Provides some coordination and information-sharing that is helpful to both patients and providers	▸▸ Colocation allows for more direct interaction and communication among professionals to impact patient care ▸▸ Referrals more successful due to proximity ▸▸ Opportunity to develop closer professional relationships	▸▸ Removal of some system barriers, like separate records, allows closer collaboration to occur ▸▸ Both behavioral health and medical providers can become more well-informed about what each can provide ▸▸ Patients are viewed as shared which facilitates more complete treatment plans	▸▸ High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans ▸▸ Provider flexibility increases as system issues and barriers are resolved ▸▸ Both provider and patient satisfaction may increase	▸▸ Opportunity to truly treat whole person ▸▸ All or almost all system barriers resolved, allowing providers to practice as high functioning team ▸▸ All patient needs addressed as they occur ▸▸ Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue
Weaknesses					
▸▸ Services may overlap, be duplicated or even work against each other ▸▸ Important aspects of care may not be addressed or take a long time to be diagnosed	▸▸ Sharing of information may not be systematic enough to effect overall patient care ▸▸ No guarantee that information will change plan or strategy of each provider ▸▸ Referrals may fail due to barriers, leading to patient and provider frustration	▸▸ Proximity may not lead to greater collaboration, limiting value ▸▸ Effort is required to develop relationships ▸▸ Limited flexibility, if traditional roles are maintained	▸▸ System issues may limit collaboration ▸▸ Potential for tension and conflicting agendas among providers as practice boundaries loosen	▸▸ Practice changes may create lack of fit for some established providers ▸▸ Time is needed to collaborate at this high level and may affect practice productivity or cadence of care	▸▸ Sustainability issues may stress the practice ▸▸ Few models at this level with enough experience to support value ▸▸ Outcome expectations not yet established

2020 HEDIS®
Provider Guide and Toolkit

Table of Contents

Welcome to the Beacon 2020 HEDIS® Provider Guide and Toolkit

This is the Beacon Health Options (Beacon) Healthcare Effectiveness Data and Information Set (HEDIS®)[1] 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 Beacon 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.

Beacon'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 Beacon

Beacon is a leader in changing the way people live with behavioral health conditions, serving over 40 million people across all 50 states. Beacon 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.

Beacon is headquartered in Boston, MA, with more than 70 locations across the U.S. Beacon 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.

Beacon 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.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Measure Description

The rate of members age 6-12 on ADHD medication who had at least three 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:

1. *Initiation Phase*: members receiving a follow up visit within 30 days of receiving their medication
2. *Continuation and Maintenance Phase*: members who continue taking ADHD medication during the nine months after the initiation phase require two additional follow-up visits within those nine months

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance.

Why is the ADD measure important?
ADHD is the most common mental health disorder affecting children (5-7 percent worldwide)[1].

Both medication and/or behavioral therapy are recommended ADHD treatments, however[2]:

- 43 percent are treated with medication alone;
- 13 percent are treated with behavioral therapy alone;
- 31 percent are treated with combination therapy (medication and behavioral therapy); and
- 6.5 percent of children with ADHD are receiving neither medication treatment nor behavioral therapy.

Who is included in the measure?
All members aged 6 – 12 who are dispensed an ADHD medication as long as they have not received one in the 120 days prior. This applies to Commercial and Medicaid LOB only. Only encounters from the intake period of March 1, 2019 through Feb. 29, 2020 are included in the 2020 measurement year.

When does a member 'pass' the measure?

1. *Initiation*: When the member has had an OP visit with a practitioner who has prescribing authority within 30 days of the prescription being dispensed
2. *Continuation and Maintenance*: When the member is compliant in the initiation phase AND has had at least two follow-up visits on different dates with any practitioner from days 31 – 300 from the prescription being dispensed

Which members are excluded?

- Members with acute inpatient encounters for mental, behavioral, or neurodevelopmental disorders within 30 days after the medication dispense date
- Members with narcolepsy
- Members in hospice

What can providers do to improve ADD HEDIS scores?

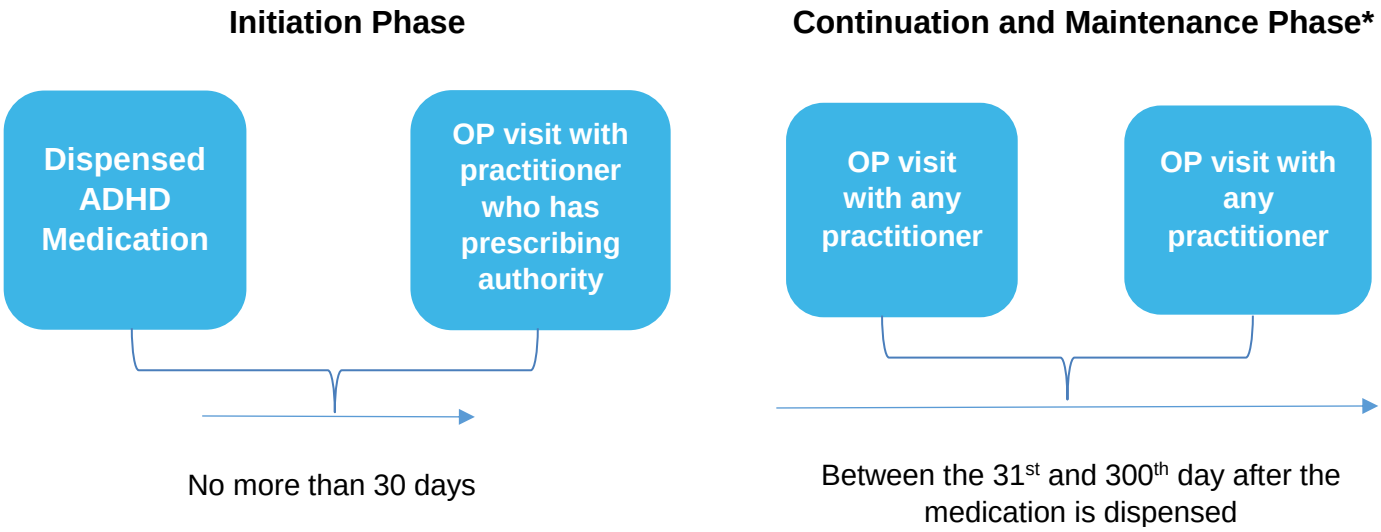
1. Monitor the dosage of medications after 30 days to make adjustments if needed.
2. Remind patients of their follow-up appointments.
3. Explain to parents the medication options and side effects to come to a joint agreement on a treatment plan.
4. Discuss behavioral therapy, psychotherapy, family therapy, support groups, social skills training, and/or parenting skills training in addition to medication therapy.
5. Promote continuity of care between primary care physicians, multiple providers, and schools to ensure quality health care.
6. Telehealth may be used for one visit in the maintenance phase to ensure compliance.

Which CPT codes should be present to be compliant with the measure?

Initiation: 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99219, 99241-99245, 99341-99345, 99347, 99348-99350, 99381-33387, 99391-99397, 99401-99404, 99411-99412, 99483, and 99510

Continuation and Maintenance: Any of the above codes; additionally, one visit may be a telephone visit – represented by a Telehealth modifier – or telephone visit CPT: 98966 – 68, 99441 - 99443

ADD Measure At-a-Glance



*Must be compliant with initiation phase in order to be compliant in continuation phase

Antidepressant Medication Management (AMM)

What is the AMM measure looking at?
The rate of members age 18 and over 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:

1. *Acute Phase*: Members who remained on their antidepressant for at least 84 days (12 weeks)
2. *Continuation Phase*: Members who remained on their antidepressant for at least 180 days (six months)

Why is the AMM measure important?
According to NCQA's "State of Health Care Quality 2013" report, approximately 50 percent of psychiatric patient 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 client compliance with prescribed medications, monitoring treatment effectiveness, and identifying and managing side effects are all best practices when managing care for clients with depression.

Who is included in the measure?
Members diagnosed with major depression in an inpatient, outpatient, or partial hospitalization setting. Applies to members aged 18+; Commercial, Medicare, or Medicaid LOB are included. Only encounters from the intake period of May 1, 2019 – April 30, 2020 are included in the 2020 measurement year.

When does a member 'pass' the measure?

- *Acute Phase*: When he/she has remained on his/her antidepressant medication for at least 84 days (12 weeks)
- *Continuation Phase*: When he/she has remained on his/her antidepressant medication for at least 180 days (six months)

Which members are excluded?

Members in hospice are excluded.

What can providers do to improve AMM rates?

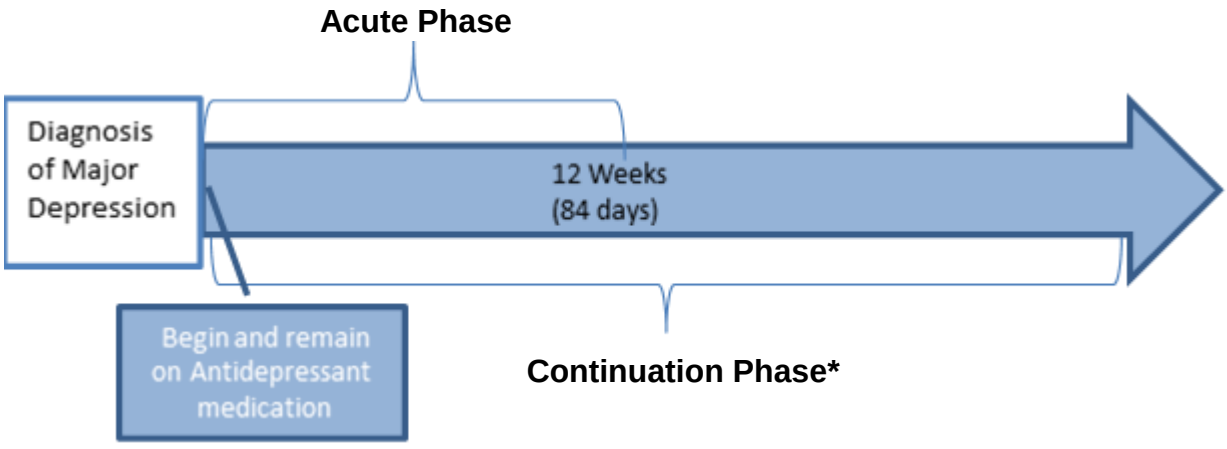
1. Schedule a follow-up appointment no later than four weeks after starting a new prescription.
2. Remind patients about their appointments.
3. Assist patients in setting up a follow-up appointment with a prescriber when they are transitioning to another level of care.
4. Targeted outreach for patients at risk of noncompliance via phone calls, medication prompts, or case management.
5. Educate staff about the importance of adherence to prescription medications, side effects, and benefits of antidepressant medication.
6. Involve the patient and family in a collaborative discussion of treatment options and promote patient participation in decision-making.
7. Connect the patient to health coaching programs, peer support, and case management.
8. Communicate with other providers to ensure a whole health approach.

What are some codes that include members in this 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, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.2, F33.3, F33.41

AMM Measure At-a-Glance



*The continuation phase is not measured until the acute phase is complete/compliant.

Metabolic Monitoring For Children and Adolescents on Antipsychotics (APM)

What is the APM measure looking at?
The rate of members age 1 – 17, taking two or more antipsychotics, who received metabolic testing

Why is the APM measure important?
Antipsychotic medications can increase a child's risk for developing serious metabolic health complications [3,4] associated with poor cardio-metabolic outcomes in adulthood [5]. Given these risks and the potential lifelong consequences, metabolic monitoring is important to ensure appropriate management of children and adolescents on antipsychotic medications.

Who is included in the measure?
Members aged 1 – 17 with at least two dispensing dates of antipsychotic medications. Commercial and Medicaid LOB are included.

When does a member 'pass' the measure?
There must be at least one documented Glucose lab test AND one LDL-C lab test.

Which members are excluded?
Members in hospice are excluded.

What can providers do to improve APM rates?

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

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

What is the APP measure looking at?
The percentage of children and adolescents age 1 – 17 with a new prescription for an antipsychotic medication who had documentation of psychosocial care as their first-line treatment

Why is the 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

Applies to members age 1 – 17; Commercial and Medicaid LOB are included

When does a 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

Which members are excluded?
Members with at least one inpatient encounter or two outpatient encounters with a diagnosis of schizophrenia, schizoaffective disorder, bipolar, other psychotic disorder, autism or other developmental disorder are excluded. Members in hospice are also excluded.

What can providers do to improve APP rates?
1. When prescribed, antipsychotic medications should be part of a comprehensive, multi-modal plan for coordinated treatment that includes psychosocial care.
2. 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.
3. Periodically review the ongoing need for continued therapy with antipsychotic medications.
4. Assess the need for case management and refer if necessary.
5. Ensure progress notes are complete and accurate.

Follow-Up After ED Visit for Alcohol/Drug Abuse or Dependence (FUA)

What is the FUA measure looking at?
The percentage of ED visits for members age 13+ with a principal diagnosis of alcohol or other drug abuse or dependence (AOD) with follow-up visit for AOD

Why is the FUA measure important?
High ED use for individuals with AOD may signal a lack of access to care or issues with continuity of care.[6] Timely follow-up care for individuals with AOD who were seen in the ED is associated with a reduction in substance use disorders, future ED use, hospitals admissions, and bed days.[7,8,9]

Who is included in the measure?
Members with an ED visit for a principal diagnosis of AOD

When does a member 'pass' the measure?
When there is a follow-up visit with any practitioner with a principal diagnosis of AOD within 7 (and 30) days after the ED visit. Applies to members age 13+; Commercial, Medicaid and Medicare LOB are included.

Please Note: Visits may occur on the same date of the ED visit.

What counts as a follow-up visit?
Any of the following with a principal diagnosis of AOD:
- An outpatient visit
- Telehealth
- Intensive outpatient visit
- Partial hospitalization
- An observation visit
- A telephone visit
- An online assessment

Which members are excluded?
Detox-only chemical dependency visits, ED visits followed by an inpatient admission within 30 days, and Members in hospice are excluded.

What can providers do to improve FUA rates?
1. Use appropriate documentation and correct coding.
2. Maintain appointment availability for patients with recent ED visits.
3. Explain the importance of follow-up to your patients.
4. Reach out to patients who do not keep initial appointments, and reschedule them as soon as possible.
5. Telehealth visits with the appropriate principle diagnosis will meet the follow-up criteria.
6. Provide timely submission of claims and encounter data.

What are the ED visit codes that need a follow-up visit?
These are some common ICD-10 codes for alcohol/drug abuse or dependence that need a follow up visit within 7 (or no longer than 30) days after the ED visit:

F10.10, F10.120, F10.121, F10.129, F10.19, F10.20, F10.220, F11.10, F11.120, F11.121, F11.20, F11.220, F11.23, F11.24, F13.19, F13.220, F14.10, F14.120, F15.10, F15.120, F16.10, F16.120, F18.19, F18.20, F18.220, F19.10, F19.120, F19.239, F19.24, F19.250

Follow-Up After Hospitalization for Mental Illness: 7- and 30-Day (FUH)

What is the FUH measure looking at?
Individuals (six years and older) who are hospitalized for a mental health diagnosis and then discharged to the community. The measure asses the percentage who receive an outpatient appointment with a mental health practitioner within seven days of discharge, but no later than 30 days from the discharge date.

Why is the FUH measure important?
Evidence suggests that individuals who receive follow-up care after a psychiatric hospitalization show a decline in re-admittance to an inpatient facility.[10,11] Additionally, the ability to provide consistent continuity of care can result in better mental health outcomes and supports 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. Applies to members age 6+; Commercial, Medicaid and Medicare LOB are included.

When does a member 'pass' the measure?
When there is 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
- 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 disorder assessments, screenings, treatment planning
- Residential services
- Rehabilitation services
- Community-based wrap-around and/or day treatment services

Which members are excluded?
Non-acute IP stays and Members in hospice are excluded.

What can providers do to improve FUH engagement rates?
Inpatient providers:

1. Discharge planning should begin as soon as the individual is admitted and should be ongoing and specific.
2. Schedule the patient's aftercare appointment prior to discharge.
3. Attempt to alleviate barriers to attending appointments prior to discharge (i.e., obtaining accurate, current contact information, coordinating with Beacon).
4. Ensure the member's discharge paperwork is sent to the outpatient provider and to Beacon within 24 hours.
5. Invite care coordinators to meet members so that aftercare planning can occur.

Outpatient providers:

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

What are the discharge diagnosis codes that need a follow-up visit?
These are some common ICD-10 codes for mental illness that need a follow up visit within 7 (or no longer than 30) days after the inpatient visit:

F20.0, F20.1, F20.89, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F29, F30.10, F31.0, F31.10, F31.30, F31.89, F32.0, F34.9, F39, F42, F90.0, F90.1, F90.2, F91.1, F91.2, F91.3, F91.8, F93.0, F93.8, F94.8

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

What is the FUI measure looking at?
The percentage of acute inpatient episodes for members age 13+ seen for substance use disorders who had a follow-up visit for substance use disorders

Why is the 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. Applies to members aged 13+; Commercial, Medicaid and Medicare LOB are included.

When does a member 'pass' the measure?
When there is 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 qualifies as a follow up visit?
Any of the following, with a principal diagnosis of substance use disorder:

- An acute or non-acute inpatient admission
- Residential behavioral health stay
- An outpatient visit
- Telehealth
- Intensive outpatient visit or partial hospitalization
- Residential behavioral health treatment
- A telephone visit
- An online assessment
- A pharmacotherapy dispensing event

Which members are excluded?
Non-acute inpatient stays and members in hospice are excluded.

What can providers do to improve FUI rates?

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

What are the discharge codes that need a follow-up visit?
These are some common ICD-10 codes for substance use disorders that need a follow up visit within 7 (or no longer than 30) days after the inpatient or detox visit:

F10.10, F10.120, F10.121, F10.129, F10.19, F10.20, F10.220, F11.10, F11.121, F11.20, F11.220, F11.23, F11.24, F13.19, F13.220, F14.10, F14.120, F15.10, F15.120, F16.10, F16.120, F18.19, F18.20, F18.220, F19.10, F19.120, F19.239, F19.24, F19.250

Follow-Up After ED Visit for Mental Illness (FUM)

What is the FUM measure looking at?
The percentage of ED visits for members age 6+ with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness

Why is the 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. [12,13,14]

Who is included in the measure?
Members with an ED visit with a principal diagnosis of mental illness or intentional self-harm. Applies to members age 6+; Commercial, Medicaid and Medicare are included.

When does a member 'pass' the measure?
When there is a follow-up visit with any practitioner within 7 (or 30) days after the episode that has a principal diagnosis of mental health disorder or intentional self-harm

Please note: Visits may occur on the same date of the ED visit.

What qualifies as a follow-up visit?
Any of the following, with a principal diagnosis of a mental health disorder or intentional self-harm:

- An outpatient visit
- A behavioral health outpatient visit
- An intensive outpatient encounter or partial hospitalization
- A community mental health center visit
- Electroconvulsive therapy
- A Telehealth visit
- An observation visit

Which members are excluded?
ED visits followed by an inpatient stay or admission to acute or non-acute inpatient care within 30 days are excluded. Members on hospice are also excluded.

What can providers do to improve FUM rates?

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

What are the discharge codes that need a follow-up visit?
These are some common ICD-10 codes for mental illness that need a follow up visit within 7 (or no longer than 30) days after the ED visit:

F20.0, F20.1, F20.89, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F29, F30.10, F31.0, F31.10, F31.30, F31.89, F32.0, F34.9, F39, F42, F90.0, F90.1, F90.2, F91.1, F91.2, F91.3, F91.8, F93.0, F93.8, F94.8

Use of Opioids at High Dosage (HDO)

What is the HDO measure looking at?
The percentage of members age 18+ who received prescription opioids at a high dosage (≥90mg morphine milligram equivalent) for ≥15 days

Why is the HDO measure important?
HEDIS 2020 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. Applies to members age 18+; Commercial, Medicaid and Medicare LOB are each included.

When does a member 'pass' the measure?
If the member's average daily dose of morphine milligram equivalent is <90

What is an average daily dose of morphine milligram equivalent?
The Morphine Milligram Equivalent (MME) 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.

Which members are excluded?
Members with cancer and sickle cell disease and Members on hospice are excluded. Additionally, injectables, cough and cold products, fentanyl transdermal patches, and methadone are all excluded.

What can providers do to improve HDO rates?
1. Use the lowest dosage of opioids in the shortest length of time possible.
2. Establish and measure goals for pain and function.
3. Discuss benefits and risks and availability of non-opioid therapies with the patient.
4. Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.
5. 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 puts him/her at high risk for overdose.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

What is the IET measure looking at?
The percentage of adolescent and adult members with a new episode of alcohol and other drug (AOD) use or dependence who received the following:
- Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization, Telehealth. or medication-assisted treatment (MAT) within 14 days of the diagnosis
- Engagement of AOD Treatment: The percentage of members who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit

Why is the 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 episode of alcohol or drug abuse or dependence. Applies to members age 13+; Commercial, Medicaid and Medicare LOB are included. Only encounters from the intake period of Jan. 1, 2020 – Nov. 13, 2020 are included in the 2020 measurement year.

When does a member 'pass' the measure?
- Initiation: AOD 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 at least 2 visits within 34 days after the initiation visit
  - One may be a MAT event such as a medication dispensing event for the treatment of alcohol abuse, dependence, or opioid abuse or dependence.

Does a Telehealth visit count as a treatment visit?
Yes; the Telehealth service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via face-to-face interaction. Telehealth visits billed with the Telehealth modifier 95 or GT will meet the IET measure.

Which members are excluded?
Members already being treated for AOD and Members in hospice are excluded.

What can providers do to improve IET rates?

1. *Follow up*: When a substance use disorder concern is identified, it is very important to schedule appropriate follow-up treatment. For newly diagnosed patients in particular, it is recommended that you schedule an initial follow-up appointment within 14 days and two additional appointments within 34 days of that first visit. Utilize Telehealth and home-based therapy.
2. *Contact PCC/PCP*: It is recommended that you contact the member's PCC/PCP to alert him/her of the new AOD diagnosis. This will support coordinated care long-term and more effectively address the member's whole health.
3. *Assess barriers to treatment*: When possible, use motivational interviewing to assess the social, economic, and cultural barriers to the member's access and/or engagement in treatment. If barriers cannot be addressed through brief intervention, consider connecting to a collateral contact such as a community support provider (CSP), recovery coach, recovery support navigator, peer bridge support, or family.

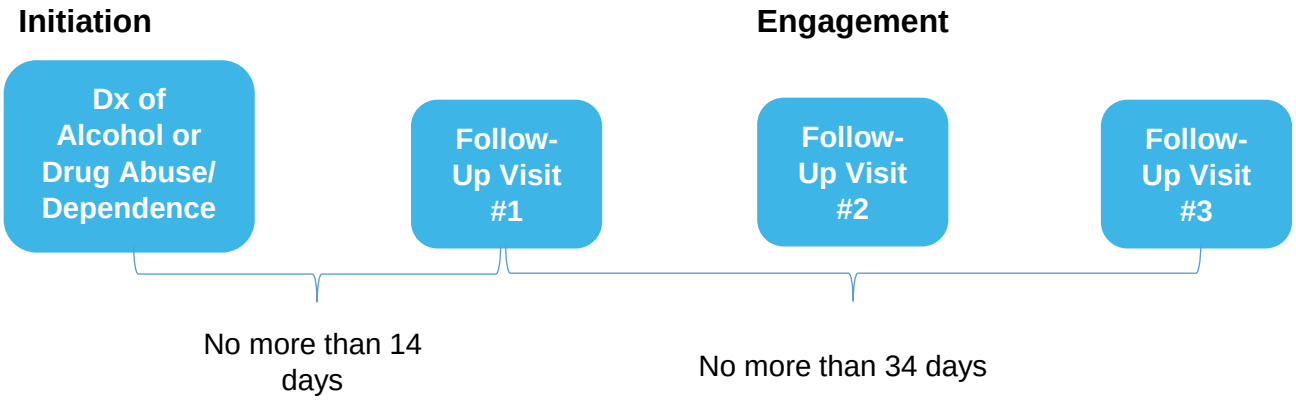
What codes represent members who need this follow-up?
When paired with an outpatient visit, Telehealth, intensive outpatient visit, partial hospitalization, detox visit, ED visit, observation visit, or an acute/non-acute inpatient stay, some ICD-10 codes for alcohol/drug dependence that require follow-up are:

F10.10, F10.120, F10.120, F10.14, F10.180, F10.19, F10.220, F10.232, F10.239, F10.24, F10.26, F10.288, F10.29

F11.10, F11.120, F11.121, F11.121, F11.129, F11.14, F11.150, F11.19, F11.20, F11.220, F11.23, F11.24, F11.288, F11.29

F12.10, F12.120, F12.121, F12.180, F12.20, F12.220, F13.10, F13.14, F13.20, F13.220, F14.10, F14.120, F14.121, F14.14, F14.222, F14.229, F15.10, F15.20, F16.10, F16.20, F18.10, F18.20, F19.10, F19.20

IET Measure At-a-Glance:



Pharmacotherapy for Opioid Use Disorder (POD)

What is the 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 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 Applies to members age 16+; commercial, Medicaid and Medicare LOB are included. Only encounters from the intake period of July, 1 2019 – June, 30, 2020 are included in the 2020 measurement period.

When does a member 'pass' the measure?
When OUD pharmacotherapy is received for 180 days or more without a gap in treatment of more than eight days

Which members are excluded?
Members who have an acute or non-acute inpatient stay of eight days or more and Members in hospice are excluded.

What can providers do to improve POD rates?
1. Consider MAT for opioid abuse or dependence.
2. Patients with OUD should be informed of the risks and benefits of pharmacotherapy, treatment without medication, and no treatment.
3. Help the patient manage stressors and identify triggers for a return to illicit opioid use.
4. Provide empathic listening and nonjudgmental discussion of triggers that precede use or increased craving and how to manage them.
5. Provide ongoing assessment to mark progress. Revise treatment goals via shared decision making to incorporate new insights.
6. Engage and educate family members and friends who are reluctant to accept medication's role in

treatment.
7. Submit claims and encounter data in a timely manner.

What are the codes used to identify included members?
The following are some of the ICD-10s for opioid use disorder requiring pharmacotherapy:

F11.10, F11.120, F11.121, F11.129, F11.14, F11.150, F11.19, F11.20, F11.220, F11.23, F11.24, F11.288, F11.29

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

What is the 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 percent of their treatment period. The treatment period is the time between the member's first antipsychotic medication fill date in the current year through Dec. 31 of the current year.

Why is the SAA measure important?
As many as 60 percent 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[15]. Adherence problems may make it difficult for a prescriber to assess the member's medication response. Prescribers may unnecessarily alter medication type of dosage in order to resolve what appears to be medication complications for a member who actually has an adherence problem[16].

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. Applies to members age 18+; Commercial, Medicaid and Medicare are included.

When does a member 'pass' the measure?
When their proportion of days covered for their antipsychotic medications is at least 80 percent of their treatment period

Are there common patient-reported barriers to adherence with antipsychotic medications that providers should be aware of?
- Stigma
- Adverse drug reactions
- Side effects, such as weight gain, different from adverse reactions
- Homelessness
- Lack of social support
- Substance use

Which members are excluded?
Members with dementia are excluded, as well as members over age 80 diagnosed with frailty. Members who do not have at least two medication-dispensing events, and Members in hospice are also excluded.

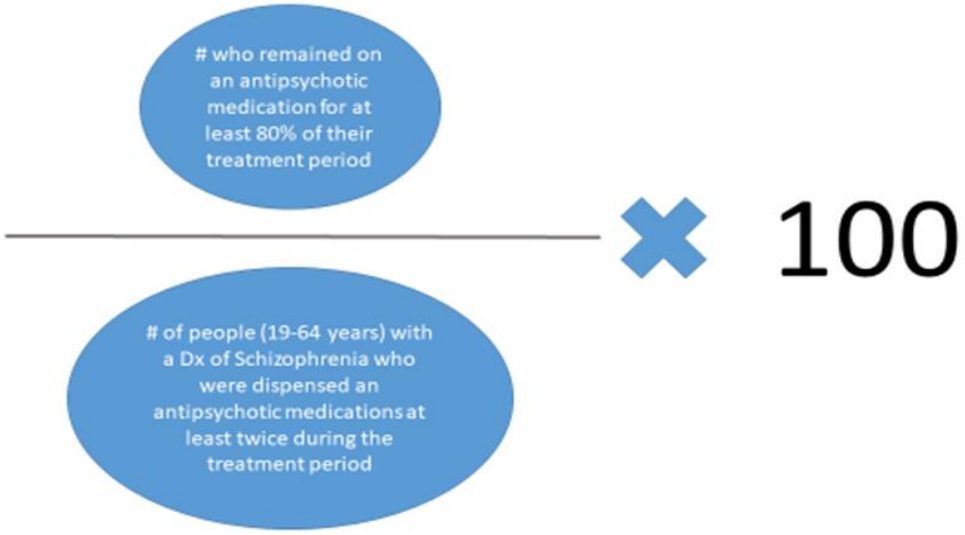
What can providers do to improve SAA rates?
1. **Outreach** directly to members who were recently prescribed antipsychotics or who have prescription

refills that are past due:
   a. Follow up with members to confirm that they are taking their medications.
   b. Inform the members that they should talk to their providers if they are experiencing adverse medication side effects.
2. **Develop** member-driven plans for medication reminders:
   a. 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. [17]
3. **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.
4. **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.
5. **Discuss** with the member the potential side effects of the medication.
6. **Include** a family member or caregiver in discussions regarding treatment when able.

Which codes identify the members that are being looked at in this measure?
Some common ICD-10 codes for schizophrenia, placing members in this measure (when coupled with either an IP stay or two OP encounters) are:

F20.0, F20.1, F20.89, F25.0, F25.1, F25.8

SAA Measure At-a-Glance:



Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)

What is the SMC measure looking at?
The percentage of members age 18 – 64 with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test

Why is the 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 one acute inpatient encounter or two outpatient encounters with a diagnosis of either schizophrenia or schizoaffective disorder and have cardiovascular disease are included. Applies to members age 18 – 64; Medicaid is the only included product line.

When does a member 'pass' the measure?
When he/she has a calculated or direct LDL

Which members are excluded?
Members in hospice are excluded.

What can providers do to improve SMC rates?
1. Order labs prior to patient appointments.
2. Ensure lipid levels, blood pressure, and glucose are monitored at every appointment.
3. For patients who do not have regular contact with their PCP, coordinate medical management – including communication of lab results - with the PCP.
4. Educate the patient (and caregiver) about the risks associated with antipsychotic medications and cardiovascular disease and the importance of a healthy lifestyle.
5. Assess the need for case management and refer if necessary.

Which codes include members in this measure?
Members with a combination of an inpatient encounter or two outpatient visits with an ICD code for schizophrenia, such as one of the following:

F20.0 F20.1, F20.89, F25.0, F25.1, F25.8

along with also having a cardiovascular code such as:

For having a PCI (CPT examples: 92920, 92924, 92928), CABG (ICD-10 examples: 021193, 0212083, 0213083, 021008C), or a diagnosis of IVD (ICD-10 examples: I20.0, I20.8, I20.9, I24.0, I24.8)

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

What is the SMD measure looking at?
The percentage of members age 19 – 64 with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C and an HbA1c test

Why is the 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 and also have cardiovascular disease are included. Applies to members age 18 – 64; Medicaid is the only included product line.

When does a member 'pass' the measure?
When he/she has both an AbA1c test and LDL-C test performed

Which members are excluded?
Members with a diagnosis of gestational diabetes or steroid-induced diabetes and Members on hospice are excluded.

What can providers do to improve SMD rates?

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

Which codes are including members in this measure?
Members with a combination of an inpatient encounter or two outpatient visits with an ICD code for schizophrenia, such as one of the following:

F20.0 F20.1, F20.89, F25.0, F25.1, F25.8

along with also having a diabetes ICD-10 code such as:

E10.10, E10.11, E10.21, E11.341, E11.349

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

What is the SSD measure looking at?
The percentage of members age 18 – 64 with schizophrenia or schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test

Why is the 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[18].

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 or bipolar disorder are included. Applies to members age 18 – 64; Medicaid is the only included product line.

When does a member 'pass' the measure?
When he/she has a glucose test or AbA1c test

Which members are excluded?
Members with diabetes and Members on hospice are excluded.

What can providers do to improve SSD rates?
1. Document all elements of the exam, including medications, diagnosis, and results of A1c.
2. Ensure patients schedule appropriate lab screenings.
3. Ensure the patient (and/or caregiver) is aware of the risk of diabetes and has awareness of the symptoms of new onset diabetes while taking antipsychotic medication.
4. Educate the patient (and caregiver) about the risks associated with antipsychotic medications and cardiovascular disease and the importance of a healthy lifestyle.
5. Assess the need for case management and refer if necessary.

Which codes are including members in this measure?
Members with a combination of an inpatient encounter or two outpatient visits with an ICD code for schizophrenia, such as one of the following:

F20.0 F20.1, F20.89, F25.0, F25.1, F25.8

or an ICD-10 code for Bipolar such as:

F30.10, F30.11, F30.3, F30.8, F31.0, F31.10, F31.2, F31.64, F31.71

along with also receiving an antipsychotic medication.

Use of Opioids from Multiple Providers (UOP)

What is the UOP measure looking at?
The measure assesses the opioid-dispensing events of members 18 years and older during the measurement year and calculates three rates associated with high risk of overdose/death:
- Members who use multiple prescribing providers (four or greater)
- Multiple pharmacies (four or greater)
- Both multiple prescribing providers (four or greater) and multiple pharmacies (four or greater)

**A lower rate indicates better performance for all three rates.*

Why is the 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 two or more opioid dispensing events (on different dates of service) and have at least 15 days covered by opioids are included. Applies to members 18+; Commercial, Medicaid, and Medicare LOB are all included.

When does a member 'pass' the measure?
If he/she has three or less prescribers and three or less pharmacies that he/she receives opioids from

Which members are excluded?
Members in hospice are excluded. Excluded medications include: injectables, cough and cold products, products used as part of medication-assisted treatment of opioid use disorder (buprenorphine), fentanyl patch, and methadone.

What can providers do to improve UOP rates?

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

Additional Resources

For any topic:
A link to the Substance Abuse and Mental Health Services Administration (SAMHSA) 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/drugoverdose/pdf/guidelines_factsheet-a.pdf

Article by CDC with guidelines for prescribing opioids:
https://www.cdc.gov/media/modules/dpk/2016/dpk-pod/rr6501e1er-ebook.pdf

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/system/files/sma13-4780.pdf

An article outlining the importance of monitoring for diabetes in schizophrenia patients:
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

Fact sheet on coordinated specialty care:
https://www.nimh.nih.gov/health/publications/raise-fact-sheet-coordinated-specialty-care/raise-fact-sheet-coordinated-specialty-care-om-16-4304_152927.pdf

Related to transitions of care/follow up:
A general overview regarding transitions of care to/from any setting:
https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf

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