HEDIS Toolkit

A Guide for Providers in the New Directions Network

Contents

Introduction

This is the New Directions Behavioral Health (New Directions®) Healthcare Effectiveness Data and Information Set (HEDIS®) Provider Toolkit. HEDIS was developed by the National Committee for Quality Assurance (NCQA®). HEDIS is a set of performance measures used in the healthcare industry, is part of NCQA accreditation, and is an essential activity for New Directions to ensure members receive the highest quality care from providers. The purpose of this toolkit is to offer better understanding of the 2022 Measurement Year HEDIS behavioral health performance measures and to provide guidance to healthcare providers on how they can help improve the quality of care and performance on the HEDIS measures.

Improving health through positive change: that is our company mission and what each of our employees live by every day. Members receive care that is coordinated, focused on whole-person health and customized to fit the unique needs of the individual.

Our goal is to help you help others. Providers are at the heart of health care delivery, serving members when they are most vulnerable, suffering from mental illness or impacted by trauma. A better quality of life for our members starts with you.

About New Directions

For over 25 years, New Directions has been helping people live healthier lives by focusing on the behavioral health of those we serve.

We are committed to serving members, customers, and providers with 24/7/365 support, reducing cost through active preventative solutions and delivering innovation through our unique clinical service infrastructure and technology-enabled solutions.

New Directions delivers best-in-class services to over 16 million people nationwide. New Directions' tremendous growth has been realized by creating a strategy and corporate culture focused on high-quality service, which has resulted in one of the fastest growing companies in the managed behavioral health industry. New Directions offers behavioral health treatment management, integrated care management services, employee assistance program, student well-being program, and analytics to improve the delivery of care

New Directions is headquartered in Overland Park, KS. New Directions Behavioral Health is accredited by both URAC and NCQA

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

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of follow-up visits or services for members with a principal diagnosis of substance use disorder (SUD).

Substance Use Disorders are a significant contributor to morbidity and mortality. Although clinical guidelines recommend follow-up care after "high-intensity" treatment to reduce negative health outcomes, few individuals receive any treatment or follow-up care.[1]

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

Assesses the percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder.

Two rates are reported:

The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge.

The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.

Measure does not apply to members in hospice. Measure does not apply to members directly transferred to an acute inpatient or residential behavioral health care setting with a principal mental health diagnosis. Does not apply to members with a principal diagnosis of mental health.

Note: Follow-up visits may not occur on the same date of inpatient or residential treatment discharge or detoxification visit.

Any of the following qualifies as a follow-up visit (with a principal diagnosis of substance use disorder):

- Inpatient/Residential
- Observation
- Partial hospitalization
- Intensive outpatient
- Outpatient
- Community mental health center
- Telehealth
- Telephone
- On-line assessment (E-visit or virtual check-in)
- Pharmacotherapy dispensing event. Methadone and Buprenorphine administered via

transdermal patch or buccal film are not included in the medication lists for this measure. (Only applies to members with an Alcohol or Opioid abuse or dependence diagnosis)

Note:

- Follow-up does not include detoxification.

You Can Help

- Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location and time of the appointment.
- Make sure that the member has follow-up appointment scheduled; preferably within 7 days but no later than 30 days of the inpatient discharge.
- If the member is an adolescent, engage parents/guardian or significant others in the treatment plan. Advise them about the importance of treatment and attending appointments.
- Aftercare appointment(s) should be with a healthcare provider and preferably with a licensed behavioral therapist and/or a psychiatrist.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Providers should maintain appointment availability for members with recent SUD diagnosis.
- Emphasize the importance of consistency and adherence to the medication regimen.
- Advise the member and significant others of side effects of medications, and what to do if side effects are severe and can potentially result in lack of adherence to the treatment plan and medication regimen.
- Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
- Care should be coordinated between providers and begin when the SUD diagnosis is made. Encourage communication between the behavioral health providers and Primary Care physician (PCP).
- Transitions in care should be coordinated between providers. Ensure that the care transition plans are shared with the PCP.
- Instruct on crisis intervention options.
- Provide timely submission of claims with correct service coding and principal diagnosis.

New Directions is Here to Help

For providers calling New Directions -
If you need to refer a member or receive guidance on appropriate services, please call:

- New Directions Behavioral Health at (888) 611-6285
- Florida providers call (866) 730-5006

For providers directing members to call New Directions -

- Behavioral healthcare coordination and referrals 24 hours a day, call toll-free (800) 528-5763.
- Reach a substance use disorder clinician, call our member Hotline at (877) 326-2458.

or

New Directions' Substance Use Disorder Resource Center:
https://www.ndbh.com/Resources/SubstanceUseCenter

References:

1. NCQA: https://blog.ncqa.org/hedis-2020-public-comment-opens-now/

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

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of follow-up care for children prescribed ADHD medication.

Attention-deficit/hyperactivity disorder (ADHD) is one of the most common mental disorders affecting children. The main features include hyperactivity, impulsiveness and an inability to sustain attention or concentration.[1,2] When managed appropriately, medication for ADHD can control symptoms of hyperactivity, impulsiveness and inability to sustain concentration. To ensure that medication is prescribed and managed correctly, it is important that children be monitored by a pediatrician with prescribing authority.

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

Assesses children 6–12 years of age newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.

Newly prescribed ADHD medication means a period of 120 days (4 months) prior to the new prescription when the member had no ADHD medications dispensed for either new or refill prescriptions.

Two rates are reported:

Initiation Phase - Members 6–12 years of age with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.

Continuation and Maintenance (C&M) Phase - Members 6–12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

A practitioner with prescribing authority includes nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.

Measure does not apply to members with a diagnosis of narcolepsy or in hospice.

Initiation Phase Treatment
Any of the following treatment qualifies for the initial follow-up visit with a practitioner with prescribing authority:

- Observation
- Partial hospitalization
- Intensive outpatient

- Outpatient
- Behavioral health outpatient
- Health and behavior assessment or intervention
- Community mental health center
- Telehealth
- Telephone

Note:

- Initiation Phase visit cannot be on the same day when the new ADHD medications were prescribed.

Continuation and Maintenance Phase Treatment
The member must fill a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the new ADHD medications were prescribed.

Any of the following qualifies for the two follow-up visits on different dates of service with any practitioner, from 31 to 300 days (9 months) after the new ADHD medications were prescribed:

- Observation
- Partial hospitalization
- Intensive outpatient
- Outpatient
- Behavioral health outpatient
- Health and behavior assessment or intervention
- Community mental health center
- Telehealth
- Telephone
- On-line assessment (E-visit or virtual check-in) – can be used for no more than one of the two visits

Note:

- The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 91 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].) Gaps can include either washout period gaps to change medication, weekend drug holidays, or treatment gaps to refill the same medication. Regardless of the number of gaps, the total gap days may be no more than 91.

You Can Help

- Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location, and time of the appointment.
- Make sure that the member has appointments:
  - One initiation visit with a practitioner with prescribing authority within 30 days of the date the new ADHD medications were prescribed.
  - Two follow-up visits on different dates of service with any practitioner, from 31 to 300 days (9 months) after the new ADHD medications were prescribed.
- Engage parents/guardian or significant others in the treatment plan. Advise them about the importance of treatment and attending appointments.
- Aftercare appointment(s) should be with a healthcare provider and preferably

with a licensed behavioral therapist and/or a psychiatrist.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Providers should maintain appointment availability for members with ADHD diagnosis.
- Closely monitor medication prescriptions and do not allow the total gap days to be more than 91 during the 300-day (10-month) period.
- Emphasize the importance of consistency and adherence to the medication regimen.
- Advise the member and significant others of side effects of medications, and what to do if side effects are severe and can potentially result in lack of adherence to the treatment plan and medication regimen.
- Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
- Care should be coordinated between providers and begin when the ADHD diagnosis is made. Encourage communication between the behavioral health providers and Primary Care Physician (PCP).
- Transitions in care should be coordinated between providers. Ensure that the care transition plans are shared with the PCP.
- Instruct on crisis intervention options.
- Provide timely submission of claims with correct service coding and diagnosis.

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If you need to refer a member or receive guidance on appropriate services, please call:
- New Directions Behavioral Health at (888) 611-6285
- Florida providers call (866) 730-5006

For providers directing members to call New Directions -
- Behavioral healthcare coordination and referrals 24 hours a day, call toll-free (800) 528-5763.

References:

1. N Visser, S.N., M.L. Danielson, R.H. Bitsko, J.R. Holbrook, M.D. Kogan, R.M. Ghandour, … & S.J. Blumberg. 2014. “Trends in the parent-report of health care provider-diagnosed and medicated attention-deficit/hyperactivity disorder: United States, 2003—2011.” Journal of the American Academy of Child & Adolescent Psychiatry, 53(1), 34–46.
2. The American Psychiatric Association. 2012. Children’s Mental Health. http://www.psychiatry.org/mental-health/people/children
3. NCQA: https://www.ncqa.org/hedis/measures/follow-up-care-for-children-prescribed-adhd-medication/

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Antidepressant Medication Management (AMM)

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of members with a diagnosis of major depression and treated with antidepressant medication remaining on antidepressant medication treatment.

Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide.[1] Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects.[2] Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide.

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications.

Two rates are reported:

Effective Acute Phase Treatment: Adult members who remained on an antidepressant medication for at least 84 days (12 weeks).

Effective Continuation Phase Treatment: Adult members who remained on an antidepressant medication for at least 180 days (6 months).

Newly treated with antidepressant medication means a period of 105 days prior to when the new antidepressant medication was prescribed when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.

Measure does not apply to members in hospice.

Effective Acute Phase Treatment
At least 84 days (12 weeks) of treatment with antidepressant medication, beginning on the date new antidepressant medication was prescribed through 114 days after the date new antidepressant medication was prescribed (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period.

Effective Continuation Phase Treatment
At least 180 days (6 months) of treatment with antidepressant medication (Antidepressant Medications List), beginning on the date new antidepressant medication was prescribed through 231 days after the date new antidepressant medication was prescribed (232 total days). This

allows gaps in medication treatment up to a total of 52 days during the 232-day period.

Note:

- Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

You Can Help

- Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location and time of the appointment.
- Make sure that the member has regular appointments with a practitioner with prescribing authority for at least 180 days (6 months) after newly prescribed antidepressant medication.
- Engage parents/guardian or significant others in the treatment plan. Advise them about the importance of treatment and attending appointments.
- Aftercare appointment(s) should be with a healthcare provider and preferably with a licensed behavioral therapist and/or a psychiatrist.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Providers should maintain appointment availability for members with major depression diagnosis.
- Closely monitor medication prescriptions and do not allow the total gap days to be more than:
  - 31 days during the Effective Acute Phase
  - 52 days during the Effective Continuation Phase
- Emphasize the importance of consistency and adherence to the medication regimen.
- Advise the member and significant others of side effects of medications, and what to do if side effects are severe and can potentially result in lack of adherence to the treatment plan and medication regimen.
- Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
- Care should be coordinated between providers and begin when the major depression diagnosis is made. Encourage communication between the behavioral health providers and Primary Care Physicians (PCP).
- Transitions in care should be coordinated between providers. Ensure that the care transition plans are shared with the PCP.
- Instruct on crisis intervention options.
- Provide timely submission of claims with correct service coding, medication name, and diagnosis.

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For providers directing members to call New Directions -

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References:

1. National Alliance on Mental Illness. 2013. “Major Depression Fact Sheet: What is Major Depression?”
2. Birnbaum, H.G., R.C. Kessler, D. Kelley, R. Ben-Hamadi, V.N. Joish, P.E. Greenberg. 2010. “Employer burden of mild, moderate, and severe major depressive disorder: Mental health services utilization and costs, and work performance.” Depression and Anxiety; 27(1) 78–89.
3. NCQA: Antidepressant Medication Management - NCQA

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Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of monitoring children and adolescents treated with antipsychotic medication to help avoid metabolic health complications such as weight gain and diabetes.

Antipsychotic medication prescribing in children and adolescents has increased rapidly in recent decades.[1,2] These medications can increase a child's risk for developing serious metabolic health complications[3,4] associated with poor cardiometabolic 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.

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

Assesses the percentage of children and adolescents 1–17 years of age with ongoing antipsychotic medication use who had metabolic testing during the calendar year.

Three rates are reported:

Children and adolescents on antipsychotics who received blood glucose testing.

Children and adolescents on antipsychotics who received cholesterol testing.

Children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

Ongoing antipsychotic medication use means two or more antipsychotic prescriptions of the same or different medications, on different dates of service during the calendar year

Measure does not apply to members in hospice.

Blood Glucose Testing
At least one test for blood glucose or HbA1c during the calendar year.

Cholesterol Testing
Members who received at least one test for LDL-C or cholesterol during the calendar year.

Note:

- It is enough to show that the tests were completed. It is not required to have the results or findings.

You Can Help

- Document blood glucose and cholesterol testing completion, lab results and any action that may be required.
- Monitor children on antipsychotic medications to help to avoid metabolic health complications. Monitor the glucose and cholesterol levels.
- Establish a baseline and continuously monitor glucose and cholesterol levels.
- Emphasize the importance of consistency and adherence to the medication regimen.
- Advise the member and significant others of side effects of medications, and what to do if side effects are severe and can potentially result in lack of adherence to the treatment plan and medication regimen.
- Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
- Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location and time of the appointment.
- Make sure that the member has regular appointments with a practitioner with prescribing authority and preferably with a psychiatrist.
- Engage parents/guardian or significant others in the treatment plan. Advise them about the importance of treatment and attending appointments.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Providers should maintain appointment availability for members prescribed antipsychotic medication.
- Care should be coordinated between providers. Encourage communication between the behavioral health providers and Primary Care Physician (PCP).
- Transitions in care should be coordinated between providers. Ensure that the care transition plans are shared with the PCP.
- Instruct on crisis intervention options.
- Provide timely submission of claims with correct service coding, medication name, name of lab test and diagnosis.

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References:

1. Patten, S.B., W. Waheed, L. Bresee. 2012. “A review of pharmacoepidemiologic studies of antipsychotic use in children and adolescents.” *Canadian Journal of Psychiatry* 57:717–21.
2. Cooper, W.O., P.G. Arbogast, H. Ding, G.B. Hickson, D.C. Fuchs, and W.A. Ray. 2006. “Trends in prescribing of antipsychotic medications for US children.” *Ambulatory Pediatrics* 6(2):79–83.
3. 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*
4. 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.
5. 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.
6. NCQA: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/

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

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of utilizing psychosocial interventions for children and adolescents (1–17 years of age) before considering antipsychotic medications.

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.[1] Safer first-line psychosocial interventions may be underutilized. Children and adolescents may unnecessarily incur the risks associated with antipsychotic medications.

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

One rate is reported:

Children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had psychosocial care as first-line treatment.

Assesses whether children/adolescents (1–17 years of age as of December 31 of the measurement year) without an indication for antipsychotic medication use had psychosocial care as first-line treatment before being prescribed an antipsychotic medication.

A new prescription means the member had no antipsychotic medications dispensed for either new or refill prescriptions within a period of 120 days (4 months) prior to the date a new antipsychotic medication is being dispensed to the member.

Exclude members for whom first-line antipsychotic medications may be clinically appropriate: Schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder. Measure does not apply to members in hospice.

Psychosocial care qualifies if it started within 90 days prior to the date on which a new antipsychotic medication is started. Psychosocial care also qualifies if it started within 30 days after the date on which a new antipsychotic medication is started. Psychosocial Care includes behavioral health counseling and therapy in the following settings:

- Partial hospitalization
- Intensive outpatient
- Outpatient (Includes via Telehealth)
- Community mental health center

You Can Help

- Before prescribing an antipsychotic medication, assess the member's treatment and

medication history.
- Determine member's diagnoses.
- Prescribe antipsychotic medication for Food and Drug Administration (FDA) approved diagnoses.
- Before prescribing an antipsychotic medication for a diagnosis for which it is not indicated, utilize psychosocial care as first-line treatment.
- If psychosocial care cannot be utilized as first-line treatment before prescribing an antipsychotic medication for a diagnosis for which it is not indicated, start psychosocial care within 30 days.
- Involve the member's parent/guardian regarding medications and psychosocial care.
- Assist member with coordination of care to psychosocial care with appropriate referrals and scheduling.
- Talk frankly about the importance of psychosocial care to help the member engage in treatment.
- Make sure that the member has appointment scheduled within 30 days of prescribing an antipsychotic medication. Schedule psychosocial care within 20 days of prescribing an antipsychotic medication. If the appointment is missed, this will allow flexibility in rescheduling within 30 days.
- Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location, and time of the appointment.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Provide timely submission of claims with correct service coding and diagnoses.
- Providers maintain appointment availability for members prescribed an antipsychotic medication.
- Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
- Encourage communication between the behavioral health specialist and Primary Care Physician (PCP). Ensure that the member has a PCP and that care transition plans with the PCP are shared.

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Reference:

1. Olfson, M., C. Blanco, L. Liu, C. Moreno, G. Laje. 2006. "National Trends in the Outpatient Treatment of Children and Adolescents with Antipsychotic Drugs." Archives of General Psychiatry 63(6):679–85.
2. NCQA: https://www.ncqa.org/hedis/measures/use-of-first-line-psychosocial-care-for-children-and-adolescents-on-anti-psychotics/

Use of Opioids from Multiple Providers (UOP)

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of monitoring potentially high-risk opioid analgesic prescribing practices to identify members who may be at elevated risk for opioid overuse and misuse.

In 2016, opioid-related overdoses accounted for more than 42,000 deaths in the United States.[1] Of those, 40% involved prescription opioids.[1] One area of risk related to opioid use is receipt of opioid prescriptions from multiple prescribers and pharmacies. Studies show that individuals who receive opioids from four or more prescribers or pharmacies have a higher likelihood of opioid-related overdose death than those who receive opioids from one prescriber or one physician.[2] Evidence suggests that people who see multiple prescribers and use multiple pharmacies are at higher risk of overdose.[3]
This measure provides health plans with a tool to identify members who may be at high risk for opioid overuse and misuse.

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

Assesses potentially high-risk opioid analgesic prescribing practices: The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the calendar year from multiple providers.

Providers means prescribing providers and pharmacies.
Multiple providers means four or more.
Receiving prescription opioids means two or more opioid dispensing events on different dates of service that covered ≥15 total days during the calendar year.

Three rates are reported:

Multiple Prescribers: The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year.

Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year.

Multiple Prescribers and Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different prescribers *and* four or more different pharmacies during the measurement year.

Measure does not apply to members with cancer, sickle cell disease, or receiving palliative care (hospice).

This measure does not include the following opioid medications:

- Injectables.

- Opioid cough and cold products.
- Single-agent and combination buprenorphine products used as part of medication assisted treatment of opioid use disorder (buprenorphine sublingual tablets, buprenorphine subcutaneous implant and all buprenorphine/naloxone combination products).
- Ionsys® (fentanyl transdermal patch), because:
  - It is only for inpatient use.
  - It is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).
- Methadone for the treatment of opioid use disorder.

You Can Help

- When prescribing opioids:
  - Use the lowest dosage of opioids for the shortest length of time possible.
  - Track the daily dosage in Morphine Milligram Equivalents (MMEs) and the total number of days in the calendar year that the member is prescribed opioids. The average daily MMEs for all the days the prescription opioids covered should not be ≥90.
  - Establish and measure goals for pain and function.
  - Discuss risks with member of using multiple prescribers.
  - Discuss benefits and risks and availability of non-opioid therapies with the member
  - Evaluate benefits and harms with members within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation
  - Review the member's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the member is receiving opioid dosages or dangerous combinations that put them at high risk for overdose and to check status of member prescribing habits.
  - Emphasize the importance of consistency and adherence to the medication regimen.
  - Advise the member and significant others of side effects of medications, and what to do if side effects are severe and can potentially result in lack of adherence to the treatment plan and medication regimen.
  - Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
- Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location and time of the appointment.
- Make sure that the member has appointments.
- Engage significant others in the treatment plan. Advise them about the importance of treatment and attending appointments.
- Aftercare appointment(s) should be with a healthcare provider and preferably with a licensed behavioral therapist and/or a psychiatrist.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Providers should maintain appointment availability for members with opioid prescriptions.

- Care should be coordinated between providers. Encourage communication between the behavioral health providers and Primary Care Physician (PCP).
- Transitions in care should be coordinated between providers. Ensure that the care transition plans are shared with the PCP.
- Instruct on crisis intervention options.
- Provide timely submission of claims with correct medication name, dosage, frequency, and days covered.

New Directions is Here to Help

For providers calling New Directions -
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- New Directions Behavioral Health at (888) 611-6285
- Florida providers call (866) 730-5006

For providers directing members to call New Directions -

- Behavioral healthcare coordination and referrals 24 hours a day, call toll-free (800) 528-5763.
- Reach a substance use disorder clinician, call our member Hotline at (877) 326-2458.

or

New Directions' Substance Use Disorder Resource Center:
https://www.ndbh.com/Resources/SubstanceUseCenter

References:

1. S. Department of Health and Human Services (HHS). 2019. "What is the U.S. Opioid Epidemic?". Updated September 4, 2019. Retrieved from: https://www.hhs.gov/opioids/about-the-epidemic/index.html
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Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of diabetes screening for members who were prescribed an antipsychotic.

Diabetes is among the top 10 leading causes of death in the United States.[1] Because persons with serious mental illness who use antipsychotics are at increased risk of diabetes, screening and monitoring of this condition is important. Lack of appropriate care for diabetes for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing this physical health need is an important way to improve health, quality of life and economic outcomes downstream.

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

Assesses adults 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the calendar year.

One rate is reported:

Members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the calendar year.

Measure does not apply to members who are diabetic or in hospice.

Schizophrenia, schizoaffective disorder, or bipolar disorder can be identified from treatment in the following settings:

- At least 1 acute inpatient admission
- At least 2 treatment days or visits for:
  - Residential
  - Observation visit
  - Partial hospitalization
  - Intensive outpatient
  - Outpatient
  - Community mental health center
  - Electroconvulsive therapy
  - Emergency Department visit
  - Telehealth
  - A telephone visit (Telephone Visits Value Set).
  - Online Assessment (e-visit or virtual check-in)

Diabetes Screening
At least one test for blood glucose or HbA1c during the calendar year.

Note:

- It is enough to show that the test was completed. It is not required to have the results or findings.

You Can Help

- Document all elements of exam, including medications and diagnoses.
- Document blood glucose testing completion, lab results and any action that may be required.
- Before prescribing an antipsychotic medication, assess the member's treatment and medication history.
- Determine member's diagnoses.
- Prescribe antipsychotic medication for Food and Drug Administration (FDA) approved diagnoses.
- For members taking antipsychotic medication
  - Ensure members schedule appropriate lab screenings
  - Ensure member is aware of the risk of diabetes and have awareness of the symptoms of new onset diabetes while taking antipsychotic medication
  - Educate member about the risks associated with antipsychotic medications and cardiovascular disease and the importance of a healthy lifestyle.
  - Establish a baseline and continuously monitor glucose and cholesterol levels.
  - Emphasize the importance of consistency and adherence to the medication regimen.
  - Advise the member and significant others of side effects of medications, and what to do if side effects are severe and can potentially result in lack of adherence to the treatment plan and medication regimen.
  - Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
- Assess the need for Case Management and refer if necessary.
- Care should be coordinated between providers. Encourage communication between the behavioral health providers and Primary Care Physician (PCP).
- Assist member with coordination of care with appropriate referrals and scheduling.
- Talk frankly about the importance of treatment to help the member engage in treatment.
- Make sure that the members prescribed an antipsychotic medication have appointments scheduled.
- Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location, and time of the appointment.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Transitions in care should be coordinated between providers. Ensure that the care transition plans are shared with the PCP.
- Providers maintain appointment availability for members prescribed an antipsychotic medication.
- Instruct on crisis intervention options.
- Provide timely submission of claims with correct service coding, medication name, name of lab test and diagnosis.

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- Florida providers call (866) 730-5006

For providers directing members to call New Directions -

- Behavioral healthcare coordination and referrals 24 hours a day, call toll-free (800) 528-5763.

Reference:

1. Murphy, S.L., J.Q. Xu, J.D. Kochanek. March 1, 2013. “Deaths: final data for 2010.” Morbidity and Mortality Weekly Report (MMWR). 62(08);155 https://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf
2. NCQA: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/

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Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of members with schizophrenia adhering to their antipsychotic medications.

Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment and incoherent speech.[1] Medication nonadherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization.[2]

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

Assesses adults 18 years of age and older who have schizophrenia or schizoaffective disorder and were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

One rate is reported:

Adult members 18 years of age who have schizophrenia or schizoaffective disorder and were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period

Measure does not apply to members with a diagnosis of dementia or in hospice. Does not apply to Medicare members 66 years of age and older who either enrolled in an Institutional Special Needs Plan (I-SNP) or are long-term institution residents. Does not apply to members 66 to 80 years of age with both frailty and advanced illness.

Member must have at least two antipsychotic medication dispensing events.

The treatment period is the time between the members earliest prescription dispensing date for any antipsychotic medication through Dec. 31st of the same year.

Members can be identified from treatment in the following settings with a diagnosis of schizophrenia or schizoaffective disorder:

- At least 1 acute inpatient admission
- At least 2 treatment days or visits for:
  - Residential
  - Observation visit
  - Partial hospitalization
  - Intensive outpatient
  - Outpatient
  - Behavioral health outpatient
  - Community mental health center
  - Electroconvulsive therapy

  - Emergency Department visit
  - Telehealth
  - A telephone visit (Telephone Visits Value Set).
  - Online Assessment (e-visit or virtual check-in)

You Can Help

- Document medications and diagnoses.
- Before prescribing an antipsychotic medication, assess the member's treatment and medication history.
- Prescribe antipsychotic medication for Food and Drug Administration (FDA) approved diagnoses.
- For members taking antipsychotic medication
  - Educate member about the risks associated with antipsychotic medications and cardiovascular disease and the importance of a healthy lifestyle.
  - Emphasize the importance of consistency and adherence to the medication regimen.
  - Medication reminders: Possible reminder methods may include text messages, phone calls (live or automated), member placing notes around the house, and pillboxes that indicate the appropriate times to take medications.
  - Advise the member and significant others of side effects of medications, and what to do if side effects are severe and can potentially result in lack of adherence to the treatment plan and medication regimen.
  - Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
  - Identify and address any barriers to medication adherence.
- Assess the need for Case Management and refer if necessary.
- Care should be coordinated between providers. Encourage communication between the behavioral health providers and Primary Care Physician (PCP).
- Assist member with coordination of care with appropriate referrals and scheduling.
- Talk frankly about the importance of treatment to help the member engage in treatment.
- Make sure that the members prescribed an antipsychotic medication have appointments scheduled.
- Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location and time of the appointment.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Engage significant others in the treatment plan.
- Providers maintain appointment availability for members prescribed an antipsychotic medication.
- Instruct on crisis intervention options.
- Provide timely submission of claims with correct service coding, medication name, and diagnosis.

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- Florida providers call (866) 730-5006

For providers directing members to call New Directions -

- Behavioral healthcare coordination and referrals 24 hours a day, call toll-free (800) 528-5763.

Reference:

1. American Psychiatric Association. Schizophrenia Fact Sheet. HTTPS://WWW.PSYCHIATRY.ORG/FILE%20LIBRARY/PSYCHIATRISTS/PRACTICE/DSM/APA_DSM-5-SCHIZOPHRENIA.PDF
2. Busch, A.B., A.F. Lehman, H. Goldman, & R.G. Frank. 2009. "Changes over time and disparities in schizophrenia treatment quality." *Med Care* 47(2), 199–207.
3. NCQA: https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/

Pharmacotherapy for Opioid Use Disorder (POD)

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of pharmacotherapy for individuals with opioid use disorder (OUD).

Research suggests that the use of pharmacotherapy can improve outcomes for those with OUD and adherence to pharmacotherapy is critical to prevent relapse and overdose.[1,2,3] However, despite the evidence and recommendations of clinical practice guidelines, pharmacotherapy is an underutilized treatment option for individuals with OUD.

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

Assesses new OUD pharmacotherapy events with OUD pharmacotherapy for 180 or more days (treatment period) among members age 16 and older with a diagnosis of OUD.

New OUD pharmacotherapy event means the date of an OUD dispensing event or OUD medication administration event with a period of 31 days prior when the member was not already receiving OUD pharmacotherapy.

Treatment period of 180 days begins on the new OUD pharmacotherapy event date through 179 days without a gap in treatment of 8 or more consecutive days (Total of 180 days). Exclude any new OUD pharmacotherapy event where the member had an acute or nonacute inpatient stay of eight or more days during the 180-day treatment period.

One rate is reported:

New opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD.

Measure does not apply to members in hospice. This measure does not include Methadone for the treatment of opioid use disorder. Methadone for OUD administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.

You Can Help

- Consider Medication Assisted Treatment (MAT) for opioid abuse or dependence.
- Members with OUD should be informed of the risks and benefits of pharmacotherapy, treatment without medication, and no treatment.
- Closely monitor medication prescriptions and do not allow any gap in treatment of 8 or more consecutive days.
- Help the member 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.
- When prescribing opioids:
  - Use the lowest dosage of opioids for the shortest length of time possible.
  - Track the daily dosage in Morphine Milligram Equivalents (MMEs) and the total number of days in the calendar year that the member is prescribed opioids. The average daily MMEs for all the days the prescription opioids covered should not be ≥90.
  - Establish and measure goals for pain and function.
  - Discuss risks with member of using multiple prescribers.
  - Discuss benefits and risks and availability of non-opioid therapies with member.
  - Evaluate benefits and harms with members within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation
  - Review the member's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the member is receiving opioid dosages or dangerous combinations that put them at high risk for overdose and to check status of member prescribing habits.
  - Emphasize the importance of consistency and adherence to the medication regimen.
  - Advise the member and significant others of side effects of medications, and what to do if side effects are severe and can potentially result in lack of adherence to the treatment plan and medication regimen.
  - Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
- Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location and time of the appointment.
- Make sure that the member has appointments.
- Engage significant others in the treatment plan. Advise them about the importance of treatment and attending appointments.
- Aftercare appointment(s) should be with a healthcare provider and preferably with a licensed behavioral therapist and/or a psychiatrist.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Providers should maintain appointment availability for members with MAT for opioid abuse or dependence.
- Care should be coordinated between providers. Encourage communication between the behavioral health providers and Primary care Physicians (PCP).
- Transitions in care should be coordinated between providers. Ensure that the care transition plans are shared with the PCP.
- Instruct on crisis intervention options.
- Provide timely submission of claims with correct medication name, dosage, frequency, and days covered.

New Directions is Here to Help

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- Reach a substance use disorder clinician, call our member Hotline at (877) 326-2458.

or

New Directions' Substance Use Disorder Resource Center:
https://www.ndbh.com/Resources/SubstanceUseCenter

References:

1. National Institute on Drug Abuse. 2016. *Effective Treatments for Opioid Addiction.* https://www.drugabuse.gov/effective-treatments-opioid-addiction-0
2. Pew. 2016. *Medication-Assisted Treatment Improves Outcomes for Patient with Opioid Use Disorder.* https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder#1-background
3. Department of Health and Human Services. 2016. *Medicare Coverage of Substance Abuse Services.* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1604.pdf
4. NCQA: https://www.ncqa.org/wp-content/uploads/2019/02/20190208_07_POD.pdf

Follow-Up After Hospitalization for Mental Illness (FUH)

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of follow-up visits for members hospitalized with a principal diagnosis of mental illness.

Approximately one in four adults in the U.S. suffer from mental illness in a given year; nearly half will develop at least one mental illness in their lifetime.[1,2] There are over 2,000,000 hospitalizations each year for mental illness in the United States.[3] Patients hospitalized for mental health issues are vulnerable after discharge and follow-up care by trained mental health clinicians is critical for their health and well-being.

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

Assesses adults and children 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient treatment visit or a partial hospitalization with a mental health practitioner. The measure identifies the percentage of members who received follow-up within 7 days and 30 days of discharge.

Note: Follow-up visits may not occur on the same date of inpatient discharge.

Two rates are reported:

Discharges for which the member received follow-up within 30 days after discharge.

Discharges for which the member received follow-up within 7 days after discharge.

Measure does not apply to members admitted to inpatient or residential treatment within 30 days of the inpatient discharge. Does not apply to members in hospice. Does not apply to members with a principal diagnosis of substance use disorder.

Mental health provider means a provider who delivers mental health services:

- MD or doctor of osteopathy (DO)
- Licensed psychologist
- Certified clinical social worker
- Registered nurse (RN) - psychiatric nurse or mental health clinical nurse specialist
- Licensed or certified counselor or professional counselor
- Physician assistant who is certified to practice psychiatry
- Licensed or certified Community Mental Health Center (CMHC), or the comparable term (e.g. behavioral health organization, mental health agency, behavioral health agency) or a Certified Community Behavioral Health Clinic (CCBHC).

Any of the following qualifies as a follow-up visit (with a mental health provider):

- Observation
- Partial hospitalization
- Intensive outpatient
- Electroconvulsive therapy
- Outpatient
- Mental health outpatient
- Community mental health center
- Telehealth
- Telephone
- Transitional care management services
- A visit in a behavioral healthcare setting
- Psychiatric collaborative care management

You Can Help

- Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location and time of the appointment.
- Assist member with coordination of care to follow-up visit with appropriate referrals, scheduling and communication.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Make sure that the member has follow-up appointment scheduled; preferably within 7 days but no later than 30 days of the inpatient discharge.
- If the member is a child or adolescent, engage parents/guardian or significant others in the treatment plan. Advise them about the importance of treatment and attending appointments.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Follow-up providers maintain appointment availability for members with recent inpatient discharge.
- Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
- Emphasize the importance of consistency and adherence to the medication regimen.
- Advise the member and significant others of side effects of medications, and what to do if side effects are severe and can potentially result in lack of adherence to the treatment plan and medication regimen.
- Instruct on crisis intervention options.
- Transitions in care should be coordinated between providers. Ensure that the care transition plans are shared with the Primary Care Physician (PCP).
- Encourage communication between the behavioral health specialist and PCP. Ensure that the member has a PCP and that care transition plans with the PCP are shared.
- Provide timely submission of claims with correct service coding and principal diagnosis.

TIPS

- Schedule follow-up visit within 5 days of inpatient to allow flexibility in rescheduling within 7 days of inpatient discharge.
- If appointment doesn't occur within first 7 days, schedule within 30 days of inpatient discharge.

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For providers directing members to call New Directions -

- Behavioral healthcare coordination and referrals 24 hours a day, call toll-free (800) 528-5763.

References:

1. National Alliance on Mental Illness. 2011. "Mental Illness: What is Mental Illness: Mental Illness Facts." https://www.nami.org/Search?searchtext=about+mental+illness&searchmode=anyword
2. Centers for Disease Control and Prevention. Updated September 1, 2011. CDC Mental Illness Surveillance. "CDC Report: Mental Illness Surveillance Among Adults in the United States." https://www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm?s_cid=su6003a1_w
3. Centers for Disease Control and Prevention. 2010. "Health Data Interactive." http://www.cdc.gov/nchs/hdi.htm
4. NCQA: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/

Use of Opioids at High Dosage (HDO)

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of monitoring potentially high-risk opioid analgesic prescribing practices to identify members who may be at elevated risk for opioid overuse and misuse.

In 2016, opioid-related overdoses accounted for more than 42,000 deaths in the United States.[1] Of those, 40% involved prescription opioids.[1] Literature suggests there is a correlation between high dosages of prescription opioids and the risk of both fatal and nonfatal overdose.[2,3,4]
The Centers for Disease Control and Prevention Guideline on opioid prescribing for chronic, nonmalignant pain recommends the use of "additional precautions" when prescribing dosages ≥50 morphine equivalent dose (MED) and recommends providers avoid or "carefully justify" increasing dosages ≥90 mg MED.[5]
In 2019, the authors of the 2016 guidelines published commentary that cautioned providers, systems, payers and states from developing policies and practices that are "inconsistent with and go beyond" the guideline recommendations.[6] The commentary included cautions regarding strict enforcement of dosage and duration thresholds, as well as abrupt tapering of opioids.[6] The opioid dosage assessed in this measure is a reference point for health plans to identify members who may be at high risk for opioid overuse and misuse.

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

Assesses potentially high-risk opioid analgesic prescribing practices. The proportion of members who received prescription opioids at high dosages out of members 18 years and older receiving prescription opioids for ≥15 days during the calendar year.

Receiving prescription opioids means two or more opioid dispensing events on different dates of service that covered ≥15 total days during the calendar year.

High dosage means average daily milligram morphine equivalent [MME] for all the days the prescription opioids covered was ≥90.

One rate is reported:

> Members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year.

Measure does not apply to members with cancer, sickle cell disease, or receiving palliative care (hospice).

This measure does not include the following opioid medications:

- Injectables.
- Opioid cough and cold products.
- Ionsys® (fentanyl transdermal patch) - This is for inpatient use only and is available only

through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).
- Methadone for the treatment of opioid use disorder.

You Can Help

- When prescribing opioids:
  - Use the lowest dosage of opioids for the shortest length of time possible.
  - Track the daily dosage in MMEs and the total number of days in the calendar year that the member is prescribed opioids. The average daily MMEs for all the days the prescription opioids covered should not be ≥90.
  - Establish and measure goals for pain and function
  - Discuss benefits and risks and availability of non-opioid therapies with member
  - Evaluate benefits and harms with members within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation
  - Review the member's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the member is receiving opioid dosages or dangerous combinations that put them at high risk for overdose
  - Emphasize the importance of consistency and adherence to the medication regimen.
  - Advise the member and significant others of side effects of medications, and what to do if side effects are severe and can potentially result in lack of adherence to the treatment plan and medication regimen.
  - Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
- Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location and time of the appointment.
- Make sure that the member has appointments.
- If the member is an adolescent, engage parents/guardian or significant others in the treatment plan. Advise them about the importance of treatment and attending appointments.
- Aftercare appointment(s) should be with a healthcare provider and preferably with a licensed behavioral therapist and/or a psychiatrist.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Providers should maintain appointment availability for members with opioid prescriptions.
- Care should be coordinated between providers. Encourage communication between the behavioral health providers and Primary Care Physician (PCP).
- Transitions in care should be coordinated between providers. Ensure that the care transition plans are shared with the PCP.
- Instruct on crisis intervention options.
- Provide timely submission of claims with correct medication name, dosage, frequency, and days covered.

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References:

1. S. Department of Health and Human Services (HHS). 2019. "What is the U.S. Opioid Epidemic?" Updated September 4, 2019. Retrieved from: https://www.hhs.gov/opioids/about-the-epidemic/index.html
2. Dunn, K.M., K.W. Saunders, C.M. Rutter, C.J. Banta-Green, J.O. Merrill, M.D. Sullivan, M. Von Korff. 2010. "Overdose and Prescribed Opioids: Associations Among Chronic Non-Cancer Pain Patients." *Annals of Internal Medicine* 152(2), 85–92.
3. Gomes, T., M.M. Mamdani, I.A. Dhalla, J.M. Paterson, and D.N. Juurlink, 2011. Opioid dose and Drug-Related Mortality in Patients With Nonmalignant Pain. *Arch Intern Med* 171:686–91.
4. Paulozzi L.J., C. Jones, K. Mack, and R. Rudd. 2011. "Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008." *MMWR* 60(43):1487–92.
5. Dowell, D., T.M. Haegerich, and R. Chou. 2016. "CDC guideline for prescribing opioids for chronic pain—United States, 2016." *JAMA* 315(15), pp.1624–45.
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Follow-Up after Emergency Department Visit for Mental Illness (FUM)

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of follow-up visits for members with a principal diagnosis of mental illness after being seen in the Emergency Department (ED).

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]

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

Assesses ED visits for adults and children 6 years of age and older with a principal diagnosis of mental illness or with a principal diagnosis of intentional self-harm plus a secondary diagnosis of a mental health disorder and who received a follow-up visit for mental illness with any health care practitioner preferably within 7 days but no later than 30 days of the ED visit.

Note: Follow-up visits may occur on the same date of the ED visit.

Two rates are reported:

ED visits for which member received follow-up within 7 days of the ED visit (8 total days)

ED visits for which member received follow-up within 30 days of the ED visit (31 total days)

Measure does not apply to members admitted to inpatient or residential treatment within 30 days of the ED visit. Does not apply to members in hospice. Does not apply to members with a principal diagnosis of substance use disorder.

Any of the following qualifies as a follow-up visit (with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm plus a secondary diagnosis of a mental health disorder):

- Observation
- Partial hospitalization
- Intensive outpatient
- Electroconvulsive therapy
- Outpatient
- Mental health outpatient
- Community mental health center
- Telehealth
- Telephone
- On-line assessment (E-visit or virtual check-in)

You Can Help

- Emergency Department
  - Talk frankly about the importance of follow-up to help the member engage in treatment.
  - Assist member with coordination of care to follow-up visit with appropriate referrals and scheduling.
  - Make sure that the member has appointment scheduled; preferably within 7 days but no later than 30 days of the ED visit. Tip: Schedule follow-up visit within 5 days of ED visit to allow flexibility in rescheduling within 7 days of ED visit.
  - Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location and time of the appointment.
  - Involve the member's parent/guardian regarding the follow-up plan after ED visit, if applicable.
- Follow-up Provider
  - Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
  - Provide timely submission of claims with correct service coding and principal diagnosis.
  - Follow-up providers maintain appointment availability for members with recent ED visits.
  - Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
  - If appointment doesn't occur within first 7 days, schedule within 30 days of ED visit.
- Both Emergency Department and Follow-up Provider
  - Identify and address any barriers to member keeping appointment.
  - Provide reminder calls to confirm appointment.
  - Encourage communication between the behavioral health specialist and Primary Care Physician (PCP). Ensure that the member has a PCP and that care transition plans with the PCP are shared.

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- Florida providers call (866) 730-5006

For providers directing members to call New Directions -

- Behavioral healthcare coordination and referrals 24 hours a day, call toll-free (800) 528-5763.

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Follow-Up after Emergency Department Visit for Substance Use (FUA)

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of follow-up visits for members with a principal diagnosis of Substance Use Disorder (SUD) or any diagnosis of drug overdose after being seen in the Emergency Department (ED).

In 2016, 20.1 million Americans over 12 years of age (about 7.5% of the population) were classified as having a substance use disorder involving alcohol or other drugs.[1] High ED use for individuals with SUD may signal a lack of access to care or issues with continuity of care.[2] 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, hospital admissions and bed days.[3,4,5]

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

Assesses ED visits for members 13 years of age and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, who had a follow-up visit or a pharmacotherapy dispensing event for SUD, substance use, or drug overdose with any health care practitioner preferably within 7 days but no later than 30 days of the ED visit.

Note: Follow-up visits and pharmacotherapy dispensing events may occur on the same date of the ED visit.

Two rates are reported:

ED visits for which member received follow-up within 7 days of the ED visit (8 total days)

ED visits for which member received follow-up within 30 days of the ED visit (31 total days)

Measure does not apply to members admitted to inpatient or residential treatment within 30 days of the ED visit. Does not apply to members in hospice. Does not apply to members with a principal diagnosis of mental illness disorder or intentional self-harm.

Any of the following qualifies as a follow-up visit (with a principal diagnosis of SUD, substance use, or drug overdose):

- Observation
- Partial hospitalization
- Intensive outpatient
- Outpatient
- Behavioral health outpatient
- Medication assisted treatment
- Community mental health center
- Telehealth
- Telephone
- On-line assessment (E-visit or virtual check-in)

You Can Help

- Emergency Department
  - Talk frankly about the importance of follow-up to help the member engage in treatment.
  - Assist member with coordination of care to follow-up visit with appropriate referrals and scheduling.
  - Make sure that the member has appointment scheduled; preferably within 7 days but no later than 30 days of the ED visit. Tip: Schedule follow-up visit within 5 days of ED visit to allow flexibility in rescheduling within 7 days of ED visit.
  - Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location and time of the appointment.
  - Involve the member's parent/guardian regarding the follow-up plan after ED visit, if applicable.
- Follow-up Provider
  - Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
  - Provide timely submission of claims with correct service coding and principal diagnosis.
  - Follow-up providers maintain appointment availability for members with recent ED visits.
  - Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
  - If appointment doesn't occur within first 7 days, schedule within 30 days of ED visit.
- Both Emergency Department and Follow-up Provider
  - Identify and address any barriers to member keeping appointment.
  - Provide reminder calls to confirm appointment.
  - Encourage communication between the behavioral health specialist and Primary Care Physician (PCP). Ensure that the member has a PCP and that care transition plans with the PCP are shared.

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For providers directing members to call New Directions -

- Behavioral healthcare coordination and referrals 24 hours a day, call toll-free (800) 528-5763.
- Reach a substance use disorder clinician, call our member Hotline at (877) 326-2458.

or

New Directions' Substance Use Disorder Resource Center:
https://www.ndbh.com/Resources/SubstanceUseCenter

References:

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Risk of Continued Opioid Use (COU)

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of identifying members with a new episode of opioid use who are dispensed opioids for a period of time that puts them at an increased risk of continued use.

Literature suggests that long-term opioid use often begins with the treatment of acute pain, and a relationship exists between early prescribing patterns and long-term use of opioids.[1] Continued opioid use for noncancer pain is associated with increased risk of opioid use disorder, opioid-related overdose, hospitalization, and opioid overdose-related mortality.[2,3,4,5]
Studies find a consistent link between increasing days' supply of the first prescription with probability of continued opioid use, and the rate of opioid use at 1-year post-initial prescription increases substantially for patients with 31 or more days of opioid therapy.[1,6]
This measure is intended to identify a population that is at risk for opioid overuse and misuse who may benefit from additional monitoring, services, or support.

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

Assesses the percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use.

New episode of opioid use means a period of 180 days prior to a prescription dispensing date for an opioid medication when the member had no pharmacy claims for either new or refill prescriptions for an opioid medication.

Two rates are reported:

Members with at least 15 days of prescription opioids in a 30-day period.

Members with at least 31 days of prescription opioids in a 62-day period.

Measure does not apply to members with cancer, sickle cell disease, or receiving palliative care (hospice).

This measure does not include the following opioid medications:

- Injectables.
- Opioid cough and cold products.
- Single-agent and combination buprenorphine products used as part of medication assisted treatment of opioid use disorder (buprenorphine sublingual tablets, buprenorphine subcutaneous implant and all buprenorphine/naloxone combination products).
- Ionsys® (fentanyl transdermal patch), because:

  - It is only for inpatient use.
  - It is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).
- Methadone for the treatment of opioid use disorder.

You Can Help

- When prescribing opioids:
  - Use the lowest dosage of opioids for the shortest length of time possible.
  - Reference the CDC Guideline for Prescribing Opioids for Chronic Pain.
  - Track the total number of days in the calendar year that the member is prescribed opioids.
  - Establish and measure goals for pain and function.
  - Discuss risks with member of using multiple prescribers.
  - Discuss benefits and risks and availability of non-opioid therapies with the member
  - Review the member's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the member is receiving opioid dosages or dangerous combinations that put them at high risk for overdose and to check status of member prescribing habits.
  - Emphasize the importance of consistency and adherence to the medication regimen.
  - Advise the member and significant others of side effects of medications, and what to do if side effects are severe and can potentially result in lack of adherence to the treatment plan and medication regimen.
  - Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
- Establish follow-up appointments shortly after prescribing opioids and when adjustments are made to reassess the pain management plan.
- Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location and time of the appointment.
- Make sure that the member has appointments.
- Engage significant others in the treatment plan. Advise them about the importance of treatment and attending appointments.
- Appointment(s) should be with a healthcare provider and preferably with a licensed behavioral therapist and/or a psychiatrist.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Providers should maintain appointment availability for members with opioid prescriptions.
- Care should be coordinated between providers. Encourage communication between the behavioral health providers and Primary Care Physician (PCP).
- Provide timely submission of claims with correct medication name, dosage, frequency, and days covered.

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Initiation and Engagement of Substance Use Disorder Treatment (IET)

New Directions Behavioral Health® is committed to working with participating physicians to improve the quality of care for members. To evaluate performance on important care and service measures, we use the Healthcare Effectiveness Data and Information Set (HEDIS®) tool developed by the National Committee for Quality Assurance (NCQA®). This bulletin provides information about a HEDIS measure concerning the importance of follow-up visits for members with a diagnosis of substance use disorder (SUD).

Treatment, including medication-assisted treatment (MAT), in conjunction with counseling or other behavioral therapies, has been shown to reduce SUD-associated morbidity and mortality, improve health, productivity and social outcomes and reduce health care spending.[1,2,3]

Meeting the Measure: Measurement Year 2022 HEDIS® Guidelines

Assesses adults and adolescents 13 years of age and older with a new episode of SUD (no diagnosis of SUD or given an SUD treatment medication within the past 194 days), who initiate SUD treatment and members who initiate and stay engaged in SUD treatment.

Two rates are reported:

Initiation of SUD Treatment: Adolescents and adults who initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication-assisted treatment (MAT) within 14 days of diagnosis.

Engagement of SUD Treatment: Adolescents and adults who initiated treatment and who were engaged in on-going SUD treatment within 34 days of the initiation visit.

Measure does not apply to members in hospice.

Initiation of SUD treatment
Any of the following qualifies for initiation of SUD treatment (with a diagnosis of SUD):

- Inpatient/Residential
- Observation
- Partial hospitalization
- Intensive outpatient
- Outpatient
- Behavioral health outpatient
- Medication assisted treatment (Only applies to members with an Alcohol or Opioid abuse or dependence diagnosis)
- Telehealth
- Telephone
- On-line assessment (E-visit or virtual check-in)

Notes:

- If the new SUD episode was an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment), the opioid treatment service is considered initiation of treatment and the member is compliant.

- If the new SUD episode was initiated during an Emergency Department/observation visit it counts as initiation whether or not the member was admitted to inpatient treatment or discharged home.
- If the new SUD episode was initiated on a day that did not correspond to a discharge from inpatient, the initiation visit must occur within 14 days of when the member was diagnosed with a new SUD (14 total days including the day of diagnosis).

Engagement of SUD treatment
Any of the following qualifies for engagement of SUD treatment:

- SUD Episodes that had at least one weekly or monthly opioid treatment service with medication administration.
- SUD Episodes with long-acting SUD medication administration events. Any of the following meet criteria:
    - For alcohol use disorders, an alcohol use disorder medication treatment dispensing event or a medication administration event (Naltrexone Injection).
    - For opioid use disorder, an opioid use disorder medication treatment dispensing event or a medication administration event (Naltrexone Injection, Buprenorphine Injection, Buprenorphine Implant.
- At least two engagement services with no more than one of the services being a medication treatment event. Any of the following qualifies for engagement services (with a SUD diagnosis):
    - Medication treatment event. Methadone is not included in the medication lists for this measure. (Only applies to members with an Alcohol or Opioid abuse or dependence diagnosis)
    - Treatment visits
        - Inpatient/Residential
        - Observation
        - Partial hospitalization
        - Intensive outpatient
        - Outpatient
        - Behavioral health outpatient
        - Opioid Weekly Non-Drug Treatment Service
        - Telehealth
        - Telephone
        - On-line assessment (E-visit or virtual check-in)

Notes:

- Engagement visits must occur on the day after the initiation visit through 34 days after the initiation visit (34 total days)
- Two engagement visits can be on the same date of service, but they must be with different providers in order to count as two events.

You Can Help

- Before scheduling an appointment, verify with the member that it is a good fit considering things like transportation, location, and time of the appointment.
- Make sure that the member has appointments: one initiation visit within 14 days of the new episode of SUD abuse or dependence and other engagement visits within 34 days of the initiation visit.
- If the member is an adolescent, engage parents/guardian or significant others in the treatment plan, with appropriate consent of the adolescent. Advise them about the

importance of treatment and attending appointments.

- Aftercare appointment(s) should be with a healthcare provider and preferably with a licensed behavioral therapist and/or a psychiatrist/addictionologist.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Providers should maintain appointment availability for members with recent SUD diagnosis.
- Emphasize the importance of consistency and adherence to the medication regimen.
- Advise the member and significant others of side effects of medications, and what to do if side effects are severe and can potentially result in lack of adherence to the treatment plan and medication regimen.
- Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects etc.
- Care should be coordinated between providers and begin when the SUD diagnosis is made. Encourage communication between the behavioral health providers and Primary Care Physician (PCP).
- Transitions in care should be coordinated between providers. Ensure that the care transition plans are shared with the PCP.
- Instruct on crisis intervention options.
- Provide timely submission of claims with correct service coding and principal diagnosis.

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References:

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