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 2021 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.

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 alcohol or other drug (AOD) abuse or dependence.

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 2021 HEDIS® Guidelines

HEDIS Description

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 AOD abuse or dependence):

- Inpatient/Residential
- Outpatient office-based care
- Intensive outpatient
- Partial hospitalization
- Community mental health center
- Telehealth
- Telephone
- Observation
- On-line assessment (E-visit or virtual check-in)

- Pharmacotherapy dispensing event.
  - Buprenorphine administered via transdermal patch or buccal film are not included because they are FDA-approved for the treatment of pain, not for opioid use disorder.
  - Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. A pharmacy claim for methadone would be more indicative of treatment for pain than for an opioid use disorder; therefore, is not included on medication lists.
  - Only applies to members with an Alcohol or Opioid abuse or dependence diagnosis.

Note: Check with member's health plan for specific coverage for these levels of care.

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/family/support system 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 physician.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Employ urine drug screen and or breathalyzer to assess for continued use and other illicit substance use.
- The member and/or family member should be made aware of FDA-approved Medication Assisted Treatments (MAT) available. Document informed consent including the risks and benefits of MAT treatment as well as the risks of no MAT 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 AOD diagnosis.
- Emphasize the importance of consistency and adherence to the medication regimen.
- Educate the member and the parents/guardians/family/support system and/or significant others about side effects of medications and what to do if side effects appear. Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule, etc.
- Care should be coordinated between providers and begin when the AOD diagnosis is

made. Encourage communication between the behavioral health providers and 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, including specific contact information, specific facilities, etc.
- Provide timely submission of claims.

New Directions is Here to Help

If you need to refer a patient or receive guidance on appropriate services, please call:

Alabama: 855-339-8558	Kansas: 800-952-5906	Michigan: 800-762-2382
Arkansas: 816-523-3592	Kansas City Mindful: 800-528-5763	Michigan GM: 877-240-0705
Florida: 866-730-5006	Louisiana: 877-207-3059	Michigan URMBT: 877-228-3912

Reach a substance use disorder clinician by calling our member hotline at (877) 326-2458.

Visit New Directions' Substance Use Disorder Center for more resources and information.

References:

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

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 (occurrence in 5% of 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 physician with prescribing authority.

Meeting the Measure: Measurement Year 2021 HEDIS® Guidelines

HEDIS Description

The percentage of children 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. Two rates are reported.

Two rates are reported:

Initiation Phase - The percentage of 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 during the 30-day Initiation Phase

Continuation and Maintenance (C&M) Phase - The percentage of 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.

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.

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 members in hospice.

Initiation Phase Treatment

Any of the following treatment qualifies for the initial follow-up visit with a practitioner with

prescribing authority:

- Outpatient office-based care
- Behavioral health outpatient office-based care
- Health and behavior assessment or intervention
- Community mental health center
- Intensive outpatient
- Partial hospitalization
- Telehealth
- Telephone
- Observation

Note:

- Initiation Phase visit cannot be on the same day the new ADHD medications were prescribed.
- Check with member's health plan for specific coverage for these levels of care.

Continuation and Maintenance Phase Treatment

The member must fill a sufficient number of prescriptions to provide continuous treatment for at least 210 days 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:

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

Note:

- Check with member's health plan for specific coverage for these levels of care.
- The definition of "continuous medication treatment" allows gaps in medication treatment, up to a total of 90 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 90.

You Can Help

Before scheduling an appointment, verify with the member that it is a good fit considering transportation, location and time of the appointment.

- Make sure 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- 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.
- Assess member for other comorbid behavioral health conditions.
- 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.
- If the member does not keep scheduled appointment, proactively reach out within 24 hours to schedule a new appointment.
- 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 90 during the 300-day (10-month) period.
- Emphasize the importance of consistency and adherence to the medication regimen and consider psychosocial evidence-based treatment., which includes Parent Training in Behavioral management and Behavioral Classroom interventions.[3]
- Educate the member and the parents/guardians/family/support system and/or significant others about side effects of medications and what to do if side effects appear. Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule etc.
- Advise member and /or significant others that there is often comorbidity of ADHD and other behavioral health conditions
- Care should be coordinated between providers and begin when the ADHD diagnosis is made. Encourage communication between the behavioral health providers and prescribing physician.
- Transitions in care should be coordinated between providers. Ensure that the care transition plans are shared with the PCP (Primary Care Physician).
- Instruct on crisis intervention options including specific contact information, specific facilities, etc.
- Provide timely submission of claims.

New Directions is Here to Help

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Florida: 866-730-5006	Louisiana: 877-207-3059	Michigan URMBT: 877-228-3912

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. CDC: https://www.cdc.gov/ncbddd/adhd/guidelines.html

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 2021 HEDIS® Guidelines

HEDIS Description

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.

Two rates are reported:

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

Effective Continuation Phase Treatment: The percentage of 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 transportation, location and time of the appointment.
- Make sure 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/family/support system and/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.
- Educate the member and the parents/guardians/family/support system and/or significant others about side effects of medications and what to do if side effects appear. Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule etc.
- Care should be coordinated between providers and begin when the major depression diagnosis is made. Encourage communication between the behavioral health providers and 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, including specific contact information, specific facilities, etc.
- Provide timely submission of claims.

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Florida: 866-730-5006	Louisiana: 877-207-3059	Michigan URMBT: 877-228-3912

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.

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 2021 HEDIS® Guidelines

HEDIS Description

The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Three rates are reported:

Blood Glucose Testing: The percentage of children and adolescents on antipsychotics who received blood glucose testing.
Cholesterol Testing: The percentage of children and adolescents on antipsychotics who received cholesterol testing.
The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

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

- EKG monitoring recommended for members on antipsychotics as all antipsychotics are associated with prolongation of QTc interval.
- Document blood glucose and cholesterol testing completion, lab results and any action that may be required.
- Monitor the members weight and blood pressure for significant changes.
- Monitor children on antipsychotic medications to help to avoid metabolic health complications. Monitor the glucose and cholesterol levels.
- Establish a baseline and episodically monitor glucose and cholesterol levels.
- Emphasize the importance of consistency and adherence to the medication regimen.
- Educate the member and the parents/guardians/family/support system and/or significant others about side effects of medications and what to do if side effects appear. Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects potential costs, clear written instructions for medication schedule 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/family/support system and/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 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, including specific contact information, specific facilities, etc.
- Provide timely submission of claims.

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Florida: 866-730-5006	Louisiana: 877-207-3059	Michigan URMBT: 877-228-3912

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.

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 2021 HEDIS® Guidelines

HEDIS Description

One rate is reported:

> The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of 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 listed below 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.

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:

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

Note: Check with member's health plan for specific coverage for these levels of care.

You Can Help

- If antipsychotics are prescribed, EKG monitoring recommended as all antipsychotics are associated with prolongation of QTc interval.
- Before prescribing an antipsychotic medication, assess the member's treatment and medication history.
- Determine member's diagnoses.
- Prescribe antipsychotic medication for 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/family/support system and/or significant others 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.
- Providers maintain appointment availability for members prescribed an antipsychotic medication.
- If antipsychotics are prescribed with psychosocial care, educate the member and the parents/guardians/family/support system and/or significant others about side effects of medications and what to do if side effects appear. Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule, etc.
- Instruct on crisis intervention options, including specific contact information, specific facilities, etc.
- 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.

FDA-Approved Pediatric Age Ranges and Indications for Atypical Antipsychotics3

	FDA Age								
Medication	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13-17**
aripiprazole									
asenapine									
olanzapine									
paliperidone									
quetiapine									
quetiapine XR									
risperidone									

Schizophrenia
Bipolar I disorder: manic or mixed
Bipolar I disorder: depressive episodes; adjunct therapy
Tourette's disorder
Autistic disorder with irritability

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Florida: 866-730-5006	Louisiana: 877-207-3059	Michigan URMBT: 877-228-3912

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/
3. Atypical Antipsychotic Medications: Use in Pediatric Patients October 2015. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Pharmacy-Education-Materials/Downloads/atyp-antipsych-pediatric-factsheet11-14.pdf. To see the electronic version of this fact sheet and the other products included in the "Atypical Antipsychotics" Toolkit, visit the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid- Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Pharmacy-Education-Materials/pharmacy-ed-materials.html on the CMS website.

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 2021 HEDIS® Guidelines

HEDIS Description

The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year who received opioids from multiple providers.

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.

Assesses potentially high-risk opioid analgesic prescribing practices.

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 system), 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

- 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.
- Consider employing UDS screens to assess other illicit substance use or other opiates.
- 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 patient
- Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation
- Review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations (e.g., benzodiazepines) 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.
- Educate the member and the parents/guardians/family/support system and/or significant others about side effects of medications and what to do if side effects appear. Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule, 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 parents/guardians/family/support system and/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 physician.
- 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 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 including specific contact information, specific facilities, etc.
- Provide timely submission of claims.

New Directions is Here to Help

If you need to refer a patient or receive guidance on appropriate services, please call:

Alabama: 855-339-8558	Kansas: 800-952-5906	Michigan: 800-762-2382
Arkansas: 816-523-3592	Kansas City Mindful: 800-528-5763	Michigan GM: 877-240-0705
Florida: 866-730-5006	Louisiana: 877-207-3059	Michigan URMBT: 877-228-3912

Reach a substance use disorder clinician by calling our member hotline at (877) 326-2458.

Visit New Directions' Substance Use Disorder Center for more resources and information.

References:

2. 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
3. Gwira Baumblatt, J.A., C. Wiedeman, J.R. Dunn, W. Schaffner, L.J. Paulozzi, T.F. Jones. 2014. High-Risk Use by Patients Prescribed Opioids for Pain and Its Role in Overdose Deaths. *JAMA Intern Med* 174(5):796–801.
4. Katz, N., L. Panas, M. Kim, A.D. Audet, A. Bilansky, J. Eadie, P. Kreiner, F.C. Paillard, C. Thomas, and G. Carrow. 2010. "Usefulness of Prescription Monitoring Programs for Surveillance—Analysis of Schedule II Opioid Prescription Data in Massachusetts, 1996–2006. *Pharmacoepidemiology and Drug Safety* 19:115–23.

NCQA: https://www.ncqa.org/hedis/measures/use-of-opioids-from-multiple-providers/

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 2021 HEDIS® Guidelines

HEDIS Description

One rate is reported:

> The percentage of 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 measurement 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
  - Outpatient office-based care
  - Intensive outpatient
  - Partial hospitalization
  - Community mental health center
  - Electroconvulsive therapy
  - Observation visit
  - Emergency Department visit
  - Telehealth
  - A telephone visit (Telephone Visits Value Set).
  - Online Assessment (e-visit or virtual check-in)

    Note: Check with member's health plan for specific coverage for these levels of care.

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

- EKG monitoring recommended for members on antipsychotics as all antipsychotics are associated with prolongation of QTc interval.
- Document all elements of diagnostic evaluation, 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 FDA approved diagnoses.
- 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, metabolic syndrome and cardiovascular disease and the importance of a healthy lifestyle.
- Establish a baseline and episodically monitor weight, blood pressure, blood glucose and cholesterol levels as documented in the treatment plan.
- Emphasize the importance of consistency and adherence to the medication regimen.
- Educate the member and the parents/guardians/family/support system and/or significant others about side effects of medications and what to do if side effects appear. Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule, 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 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 including specific contact information, specific facilities, etc.
- Provide timely submission of claims.

New Directions is Here to Help

If you need to refer a patient or receive guidance on appropriate services, please call:

Alabama: 855-339-8558	Kansas: 800-952-5906	Michigan: 800-762-2382
Arkansas: 816-523-3592	Kansas City Mindful: 800-528-5763	Michigan GM: 877-240-0705
Florida: 866-730-5006	Louisiana: 877-207-3059	Michigan URMBT: 877-228-3912

Reference:

4. 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
5. NCQA: https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/

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 2021 HEDIS® Guidelines

HEDIS Description

One rate is reported:

> The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who 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 December 31 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
  - Outpatient office-based care
  - Behavioral health outpatient office-based care
  - Intensive outpatient
  - Partial hospitalization
  - Community mental health center
  - Electroconvulsive therapy
  - Observation bed visit
  - Emergency Department visit

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

Note: Check with member's health plan for specific coverage for these levels of care.

You Can Help

- EKG monitoring recommended for members on antipsychotics as all antipsychotics are associated with prolongation of QTc interval.
- Monitor the members weight and blood pressure for significant changes.
- Document medications and diagnoses.
- Before prescribing an antipsychotic medication, assess the member's treatment and medication history.
- Prescribe antipsychotic medication for FDA approved diagnoses.
- Educate member about the risks associated with antipsychotic medications, metabolic syndrome 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.
- Educate the member and the parents/guardians/family/support system and/or significant others about side effects of medications, including the risk of addiction and what to do if side effects appear. Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule, etc.
- Identify and address any barriers to medication adherence.
- Engage parent/guardian/family/support system and/or significant others in treatment planning.
- Assess the need for Case Management and refer if necessary.
- Care should be coordinated between providers. Encourage communication between the behavioral health providers and 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.
- Providers maintain appointment availability for members prescribed an antipsychotic medication.
- Instruct on crisis intervention options including specific contact information, specific facilities, etc.
- Provide timely submission of claims.

New Directions is Here to Help

If you need to refer a patient or receive guidance on appropriate services, please call:

Alabama: 855-339-8558	Kansas: 800-952-5906	Michigan: 800-762-2382
Arkansas: 816-523-3592	Kansas City Mindful: 800-528-5763	Michigan GM: 877-240-0705
Florida: 866-730-5006	Louisiana: 877-207-3059	Michigan URMBT: 877-228-3912

Reference:

6. American Psychiatric Association. Schizophrenia Fact Sheet. HTTPS://WWW.PSYCHIATRY.ORG/FILE%20LIBRARY/PSYCHIATRISTS/PRACTICE/DSM/APA_DSM-5-SCHIZOPHRENIA.PDF
7. 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.

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 2021 HEDIS® Guidelines

HEDIS Description

One rate is reported:

> The percentage of 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.

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.

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, including methadone, buprenorphine/naloxone and injectable naltrexone.
- 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.
- 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 parent/guardians/family/support system and/or significant others in the treatment plan. Advise them about the importance of treatment and attending appointments.
- Employ UDS screens and or breathalyzer as appropriate to assess for continued use or other substance use.
- Aftercare appointment(s) should be with a healthcare provider and preferably with a licensed behavioral therapist and/or a physician.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Educate the member and the parents/guardians/family/support system and/or significant others about side effects of medications and what to do if side effects appear. Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule, etc.
- 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 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 including specific contact information, specific facilities, etc.
- Provide timely submission of claims.

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If you need to refer a patient or receive guidance on appropriate services, please call:

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Florida: 866-730-5006	Louisiana: 877-207-3059	Michigan URMBT: 877-228-3912

Reach a substance use disorder clinician by calling our member hotline at (877) 326-2458.

Visit New Directions' Substance Use Disorder Center for more resources and information.

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 2021 HEDIS® Guidelines

HEDIS Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.

Two rates are reported:

The percentage of discharges for which the member received follow-up within 30 days after discharge.
The percentage of discharges for which the member received follow-up within 7 days after discharge.

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

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

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

Note: Check with member's health plan for specific coverage for these levels of care.

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.
- Engage members and parents/guardian/family/support system and/or significant others in the treatment plan. Advise them about the importance of treatment and attending appointments. This is critically important for a child or adolescent.
- 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.
- Emphasize the importance of consistency and adherence to the medication regimen.
- Educate the member and the parents/guardians/family/support system and/or significant others about side effects of medications and what to do if side effects appear. Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule, etc.
- Instruct on crisis intervention options, including specific contact information, specific facilities, etc.
- Transitions in care should be coordinated between providers. Ensure that the care transition plans are shared with the 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.

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.

New Directions is Here to Help

If you need to refer a patient or receive guidance on appropriate services, please call:

Alabama: 855-339-8558	Kansas: 800-952-5906	Michigan: 800-762-2382
Arkansas: 816-523-3592	Kansas City Mindful: 800-528-5763	Michigan GM: 877-240-0705
Florida: 866-730-5006	Louisiana: 877-207-3059	Michigan URMBT: 877-228-3912

References:

8. 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
9. 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
10. Centers for Disease Control and Prevention. 2010. “Health Data Interactive.” http://www.cdc.gov/nchs/hdi.htm

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 2021 HEDIS® Guidelines

HEDIS Description

One rate is reported:

> The proportion of 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.

Assesses potentially high-risk opioid analgesic prescribing practices.

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.

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 system) - 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

- 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.
- Employ UDS screens and/or breathalyzer to assess for use of other substances or illicit substance use.
- Engage parents/guardian/family/support system or significant others in the treatment plan when possible. Advise them about the importance of treatment and attending appointments.
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of non-opioid therapies with patient
- Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation
- Review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put them at high risk for overdose
- Emphasize the importance of consistency and adherence to the medication regimen.
- Educate the member and the parents/guardians/family/support system and/or significant others about side effects of medications, including the risk of addiction and what to do if side effects appear. Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule etc.
- 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 physician.
- 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 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, including specific contact information, specific facilities, etc.
- Provide timely submission of claims.

New Directions is Here to Help

If you need to refer a patient or receive guidance on appropriate services, please call:

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Reach a substance use disorder clinician by calling our member hotline at (877) 326-2458.

Visit New Directions' Substance Use Disorder Center for more resources and information.

References:

5. 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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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 2021 HEDIS® Guidelines

HEDIS Description

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.

Two rates are reported:

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

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

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

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 intentional self-harm):

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

Note: Check with member's health plan for specific coverage for these levels of care.

You Can Help

- ED assist member with coordination of care to follow-up visit with appropriate referrals and scheduling.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Engage the member and parent/guardian/family/support system and/or significant others regarding the follow-up plan after ED visit, if possible. This is critically important for a child or adolescent.
- Make sure that the member has appointment scheduled; preferably within 7 days but no later than 30 days of the 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.
- 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 principal diagnosis.
- Follow-up providers maintain appointment availability for members with recent ED visits.
- Instruct on crisis intervention options, including specific contact information, specific facilities, etc.
- Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule, etc.
- 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.

Tips

- Schedule follow-up visit within 5 days of ED visit to allow flexibility in rescheduling within 7 days of ED visit.
- If appointment doesn't occur within first 7 days, schedule within 30 days of ED visit.
- Involve the member's parent/guardian regarding the follow-up plan after ED visit, if applicable.

New Directions is Here to Help

If you need to refer a patient or receive guidance on appropriate services, please call:

Alabama: 855-339-8558	Kansas: 800-952-5906	Michigan: 800-762-2382
Arkansas: 816-523-3592	Kansas City Mindful: 800-528-5763	Michigan GM: 877-240-0705
Florida: 866-730-5006	Louisiana: 877-207-3059	Michigan URMBT: 877-228-3912

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Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (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 Alcohol and Other Drug Abuse or Dependence 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 (AOD).[1] High ED use for individuals with AOD may signal a lack of access to care or issues with continuity of care.[2] Timely follow-up care for individuals with AOD 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 2021 HEDIS® Guidelines

HEDIS Description

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD.

Two rates are reported:

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

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

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

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 Alcohol and Other Drug Abuse or Dependence):

- Outpatient office-based care
- Behavioral health outpatient office-based care
- Medication assisted treatment
- Intensive outpatient
- Partial hospitalization
- Community mental health center
- Telehealth
- Telephone

- On-line assessment (E-visit or virtual check-in)
- Observation

Note: Check with member's health plan for specific coverage for these levels of care.

You Can Help

- ED assist member with coordination of care to follow-up visit with appropriate referrals and scheduling.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Engage parents/guardian/family/support system and/or significant others in follow plan of care, if possible.
- Make sure that the member has appointment scheduled; preferably within 7 days but no later than 30 days of the 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.
- Identify and address any barriers to member keeping appointment.
- Provide reminder calls to confirm appointment.
- Instruct on crisis intervention options, including specific contact information, specific facilities, etc.
- Referrals to appropriate SUD treatment level of care, community resources (AA) and consider MAT (Medication Assisted Treatment).
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Provide timely submission of claims.
- 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.
- 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.

Tips

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

New Directions is Here to Help

If you need to refer a patient or receive guidance on appropriate services, please call:

Alabama: 855-339-8558	Kansas: 800-952-5906	Michigan: 800-762-2382
Arkansas: 816-523-3592	Kansas City Mindful: 800-528-5763	Michigan GM: 877-240-0705
Florida: 866-730-5006	Louisiana: 877-207-3059	Michigan URMBT: 877-228-3912

Reach a substance use disorder clinician by calling our member hotline at (877) 326-2458.

Visit New Directions' Substance Use Disorder Center for more resources and information.

References:

1. Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/
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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 identify 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.

Continued opioid use for noncancer pain is associated with increased risk of opioid use disorder, opioid-related overdose, hospitalization and opioid overdose-related mortality.

Meeting the Measure: Measurement Year 2021 HEDIS® Guidelines

HEDIS Description

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. Two rates are reported:

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:

The percentage of members with at least 15 days of prescription opioids in a 30-day
The percentage of members with at least 31 days of prescription opioids in a 62-day

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 system), 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

- Use the lowest dosage of opioids for the shortest length of time possible.
- Reference the CDC Guideline for Prescribing Opioids for Chronic Pain (see references).
- Track the total number of days in the calendar year that the member is prescribed opioids.
- Consider employing UDS screens to assess other illicit substance use or other opiates.
- 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 patient.
- Review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving other opioids from other prescribers or dangerous combinations that put them at high risk for overdose (e.g., benzodiazepines). and to check status of member medication usage habits.
- Emphasize the importance of consistency and adherence to the prescribed medication regimen.
- Educate the member and the parents/guardians/family/support system and/or significant others about side effects of medications, including the risk of addiction and what to do if side effects appear. Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule, 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 physician and potential psychosocial treatment should be with a licensed behavioral therapist.
- 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.
- Instruct on crisis intervention options, including specific contact information, specific facilities, etc.
- Care should be coordinated between providers. Encourage communication between the behavioral health providers and PCP (Primary Care Physician).
- Provide timely submission of claims.

New Directions is Here to Help

If you need to refer a patient or receive guidance on appropriate services, please call:

Alabama: 855-339-8558	Kansas: 800-952-5906	Michigan: 800-762-2382
Arkansas: 816-523-3592	Kansas City Mindful: 800-528-5763	Michigan GM: 877-240-0705
Florida: 866-730-5006	Louisiana: 877-207-3059	Michigan URMBT: 877-228-3912

Reach a substance use disorder clinician by calling our member hotline at (877) 326-2458.

Visit New Directions' Substance Use Disorder Center for more resources and information.

References:

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Initiation and Engagement of Alcohol and Other Drug or Dependence 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 principal diagnosis of alcohol or other drug (AOD) abuse or dependence.

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

Meeting the Measure: Measurement Year 2021 HEDIS® Guidelines

HEDIS Description

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:

Two rates are reported:

> Initiation of AOD Treatment: The percentage of members who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of diagnosis.

> Engagement of AOD Treatment: The percentage of members who initiated treatment and who were engaged in on-going AOD treatment within 34 days of the initiation visit.

Assesses adults and adolescents 13 years of age and older with a new episode of AOD abuse or dependence (no diagnosis of AOD abuse or dependence or given an alcohol or opioid dependency treatment medication within the past 60 days), who initiate AOD treatment and members who initiate and stay engaged in AOD treatment.

Measure does not apply to members in hospice.

Initiation of AOD treatment

Any of the following qualifies for initiation of AOD treatment (with a principal diagnosis of Alcohol and Other Drug Abuse or Dependence):

- Inpatient/Residential
- Outpatient office-based care
- Behavioral health outpatient office-based care
- Medication assisted treatment (Only applies to members with an Alcohol or Opioid abuse or dependence diagnosis)
- Intensive outpatient
- Partial hospitalization

- Telehealth
- Telephone
- On-line assessment (E-visit or virtual check-in)
- Observation bed

Check with member's health plan for specific coverage for these levels of care.

Notes:

- If the new episode of AOD abuse or dependence 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 episode of AOD abuse or dependence was during an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant.
- If the new episode of AOD abuse or dependence was not during an inpatient discharge, the initiation visit must occur on the same date diagnosed with a new episode of AOD or in the 13 days after (14 total days).
- For all initiation events except medication treatment (AOD Medication Treatment; Alcohol Use Disorder Treatment Medications; Opioid Use Disorder Treatment Medications), initiation on the same day diagnosed with a new episode of AOD must be with different providers.

Engagement of AOD treatment

At least two engagement services are needed for engaged in ongoing AOD treatment with no more than one of the services being a medication treatment event.
Any of the following qualifies for engagement services (with a principal diagnosis of Alcohol and Other Drug Abuse or Dependence):

- Medication treatment event. Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. A pharmacy claim for methadone would be more indicative of treatment for pain than for an opioid use disorder; therefore, they are not included on medication lists. (Only applies to members with an Alcohol or Opioid abuse or dependence diagnosis)
- Treatment visits
  - Inpatient/Residential
  - Outpatient office-based care
  - Behavioral health outpatient office-based care
  - Intensive outpatient
  - Partial hospitalization
  - Telehealth
  - Telephone
  - On-line assessment (E-visit or virtual check-in)
  - Observation bed
  - Opioid Weekly Non-Drug Service with an Opioid abuse or dependence diagnosis

Check with member's health plan for specific coverage for these levels of care.

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 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 AOD abuse or dependence and other engagement visits within 34 days of the initiation visit.
- If the member is an adolescent, engage parents/guardian/family/support system and/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 physician.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- Employ UDS screens and or breathalyzer as appropriate to assess for continued use or other substance use.
- 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 AOD diagnosis.
- Emphasize the importance of consistency and adherence to the medication regimen.
- Educate the member and the parents/guardians/family/support system and/or significant others about side effects of medications and what to do if side effects appear. Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, clear written instructions for medication schedule, etc.
- 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 AOD diagnosis is made. Encourage communication between the behavioral health providers and 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 including specific contact information, specific facilities, etc.
- Provide timely submission of claims.

New Directions is Here to Help

If you need to refer a patient or receive guidance on appropriate services, please call:

Alabama: 855-339-8558	Kansas: 800-952-5906	Michigan: 800-762-2382
Arkansas: 816-523-3592	Kansas City Mindful: 800-528-5763	Michigan GM: 877-240-0705
Florida: 866-730-5006	Louisiana: 877-207-3059	Michigan URMBT: 877-228-3912

Reach a substance use disorder clinician by calling our member hotline at (877) 326-2458.

Visit New Directions' Substance Use Disorder Center for more resources and information.

References:

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