HEDIS® Overview

The National Committee for Quality Assurance (NCQA®) has developed measures of healthcare that are quantifiable, comparable and meaningful. They are called the Healthcare Effectiveness Data and Information Set (HEDIS®) measures. NCQA reports that, “HEDIS is one of health care's most widely used performance improvement tools. 191 million people are enrolled in plans that report HEDIS results" to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 90 measures across six domains of care.

Stemming from the measures set forth by HEDIS, CMS deployed its 5-Star Plan rating system that effectively rates a health plan’s Medicare Advantage programs. Ratings emphasize patient care and satisfaction, using national clinical and service-quality measures (HEDIS), health outcomes and patient feedback. Though the behavioral health HEDIS measures are not yet a part of the CMS rating system, they may be in the future.

- We work in collaboration with our health plan customers to design activities to improve our health plans’ HEDIS rates. We can only do this in coordination with your efforts to provide good clinical care of our patients.
- Improvement in HEDIS measures demonstrates that patients are experiencing better clinical outcomes.

How is HEDIS Relevant to My Practice?

HEDIS offers a clear standardized measure of clinical outcome that is used throughout the entire healthcare industry. As such, it allows us to identify the impact of clinical interventions across a population of health plan members.

What is Your Role in HEDIS?

You and your office staff can help facilitate the HEDIS process improvement by:

- Understanding and adhering to the best practice recommendations for each of the HEDIS measures
- Providing the appropriate care within the designated timeframes
- Documenting all care in the patient’s medical record
- Accurately coding all claims

Behavioral Health HEDIS Measures

Measure Name	Description	Tips for Success
Measures related to common behavioral health disorders		
Antidepressant Medication Management (AMM)	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: • *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).	**This measure focuses on medication compliance. Use screening tools to aid in diagnosing and treatment.** Screening: • Screening tools (e.g., PHQ-9) may provide objective assessment and better identify who would or would not benefit from medication. • Screening tools are available at Providerexpress.com. Go to Clinical Resources - Clinical Tools and Quality Initiatives. After New Prescription: • Encourage patients to actively engage in discussion about starting medication and agree with the treatment plan. • Inform patients that it may take up to 12 weeks for full effectiveness of medication and discuss side effects and the importance of medication adherence. • Encourage patients to make an appointment, in person or using telemental health/virtual visits with you if they have any questions or are considering stopping a medication.

Measure Name	Description	Tips for Success
Measures related to common behavioral health disorders		
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	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: • *Initiation Phase*: A follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. • *Continuation and Maintenance (C&M) Phase:* Children that remained on the ADHD medication and have at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	**This measure focuses on follow-up care after patients are prescribed an ADHD medication. Use screening tools to aid in diagnosing.** <u>Screening:</u> • Use screening/assessment tools (e.g., Vanderbilt Scales) to assist diagnosing ADHD. • Screening tools are available at Providerexpress.com. Go to Clinical Resources - Clinical Tools and Quality Initiatives. <u>After New Prescription:</u> • Schedule a return appointment with prescriber within 30 days of initial ADHD prescription start date. • Continue to monitor patient s with two more visits in the next 9 months. • Appointments may be in person or using telemental health/virtual visits.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: • *Initiation of AOD Treatment.* Treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • *Engagement of AOD Treatment.* Patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 34 days of the initiation visit.	**This measure focuses on follow-up treatment when diagnosing a patient with substance use disorder. Use screening tools to aid in diagnosing.** • Schedule a follow-up appointment prior to patient leaving the office, hospital or Emergency Department to occur within 14 days and then two more visits within the next 34 days. • Appointments may be in person or using telemental health/virtual visits. • Reach out to patients if they do not attend their appointments • Although community supports such as AA and NA are beneficial, they do not take the place of professional treatment. • Encourage newly diagnosed individuals to accept treatment by assisting them in identifying their own motivation for change. • Obtain release of information (ROI) to involve the patient's family and support system as well as other providers.

Measure Name	Description	Tips for Success
Measures related to follow up after receiving higher levels of care		
Follow-Up After Hospitalization for Mental Illness (FUH)	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: • Follow-up within 7 days of discharge. • Follow-up within 30 days of discharge.	**This measure focuses on follow-up treatment, which must be with a behavioral health practitioner.** • When one of your patients is discharged from an inpatient mental health stay, please make every effort to schedule their follow-up appointment within 7 days. • If a situation arises where a patient is unable to be seen within 7 days, ensure they have an appointment within 30 days of discharge. • Contact patients prior to their appointments to explain the importance of timely follow-up. • Virtual visits are an effective way to provide care within 7 days after discharge. • Reach out to patients to reschedule missed follow-up appointments.
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	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: • Follow-up for substance use disorder within the 7 days after the visit or discharge. • Follow-up for substance use disorder within the 30 days after the visit or discharge.	**This measure focuses on follow-up treatment with a PCP or a behavioral health practitioner.** • When one of your patients is discharged from an inpatient mental health stay, please make every effort to schedule their follow-up appointment within 7 days. • If a situation arises where a patient is unable to be seen within 7 days, ensure they have an appointment within 30 days of discharge. • Contact patients prior to their appointments to explain the importance of timely follow-up. • Virtual visits are an effective way to provide care within 7 days after discharge. • Reach out to patients to reschedule missed follow-up appointments.

Measure Name	Description	Tips for Success
Measures related to follow up after receiving higher levels of care		
Follow-up After Emergency Department Visit for Mental Illness (FUM)	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported: • Follow-up within 30 days of the ED visit. • Follow-up within 7 days of the ED visit.	**This measure focuses on follow-up treatment with a PCP or a behavioral health practitioner.** • If you are aware that one of your patients was in the Emergency Department, please make every effort to schedule their follow-up appointment within 7 days. • If a situation arises where a patient is unable to be seen within 7 days, ensure they have an appointment within 30 days of discharge. • Contact patients prior to their appointments to explain the importance of timely follow-up. • Virtual visits are an effective way to provide care within 7 days after discharge. • Reach out to patients to reschedule missed follow-up appointments.
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported: • Follow-up within 30 days of the ED visit. • Follow-up within 7 days of the ED visit.	**This measure focuses on follow-up treatment with a PCP or a behavioral health practitioner.** • If you are aware that one of your patients was in the Emergency Department, please make every effort to schedule their follow-up appointment within 7 days. • If a situation arises where a patient is unable to be seen within 7 days, ensure they have an appointment within 30 days of discharge. • Contact patients prior to their appointments to explain the importance of timely follow-up. • Virtual visits are an effective way to provide care within 7 days after discharge. • Reach out to patients to reschedule missed follow-up appointments.

Measure Name	Description	Tips for Success
Measures related to patients with Schizophrenia and/or those prescribed antipsychotics		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	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.	**This measure focuses on appropriate monitoring for members with schizophrenia or bipolar disorder.** • Encourage patients with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed antipsychotic medications to schedule an annual screening for diabetes (HbA1c or blood glucose) • Obtain release of information (ROI) to coordinate care with other providers involved in the member's treatment to promote consistency in the individual's care and more efficient and longer-lasting stabilization.
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	**This measure focuses on appropriate monitoring for members with schizophrenia or schizoaffective disorder and diabetes.** • Encourage patients with schizophrenia or schizoaffective disorder and diabetes to schedule an annual screening for diabetes (HbA1c and LDL-C) • Obtain release of information (ROI) to coordinate care with other providers involved in the member's treatment to promote consistency in the individual's care and more efficient and longer-lasting stabilization.
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.	**This measure focuses on appropriate monitoring for members with schizophrenia or schizoaffective disorder and cardiovascular disease.** • Encourage patients with schizophrenia or schizoaffective disorder and cardiovascular disease to schedule an annual LDL-C. • Obtain release of information (ROI) to coordinate care with other providers involved in the member's treatment to promote consistency in the individual's care and more efficient and longer-lasting stabilization.

Measure Name	Description	Tips for Success
Measures related to patients with Schizophrenia and/or those prescribed antipsychotics		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	The percentage of members 18 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.	**This measure focuses on medication compliance.** • Encourage patients to take medications as prescribed. • Discuss potential side effects with your patients. • Offer tips to patients such as: take medication at the same time each day, use a pill box, and enroll in a pharmacy automatic refill program.
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. (Glucose or HbA1C and LDL–C or other cholesterol test)	**This measure focuses on appropriate monitoring for children with prescribed antipsychotic medications.** • Encourage patients to schedule an annual glucose or HbA1C and LDL-C or other cholesterol test. • Assist caregivers in understanding the importance of annual screening.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	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.	**The measure focuses on children and adolescents who are prescribed antipsychotic medications and yet do not have a diagnosis of Bipolar Disorder, Schizophrenia or other Psychotic Disorders.** • Ensure children and adolescents receive psychosocial treatments prior to or in conjunction with prescribing antipsychotic medication for non-psychotic conditions such as attention deficit disorder and disruptive behaviors. • Ensure a psychosocial care appointment occurs at least 90 days prior to prescribing medication or within 30 days of starting an initial prescription for non-psychotic conditions such as attention deficit disorder and disruptive behaviors. • Psychosocial treatments (interventions) include structured counseling, case management, care-coordination, psychotherapy and relapse prevention.

Measure Name	Description	Tips for Success
Measures related to Opioid Use		
Pharmacotherapy for Opioid Use Disorder (POD)	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.	**This measure focuses on using MAT Treatment for opioid use disorder.** • Refer for Medication Assisted Treatment (MAT) for opioid use disorders when appropriate.