

The 2018 HEDIS Behavioral Health Measures and Beacon's Network Providers

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Agenda



Agenda

Topic

- Introductions
- Learning Objectives
- What is NCQA and HEDIS
- HEDIS Measure Description
- Provider Intervention Best Practices
- Post Test

Appendices

- Measure Rationale
- References

Learning Objectives

- Understand the importance of the HEDIS Behavioral Health Measures as best practice
- By understanding the HEDIS Behavioral Health Measure modify practice to support patient adherence
- Learn interventions that could be applied in practice to supporting and improving patient adherence

NCQA and HEDIS



What is NCQA and HEDIS?

NCQA = National Committee for Quality Assurance

- A private, not-for-profit organization
- Dedicated to improving health care quality; and
- Active in quality oversight and improvement initiatives at all levels of the health care system.

HEDIS = Healthcare Effectiveness Data Information Set (HEDIS).

- Widely used set of performance measures in the managed care industry, developed and maintained by NCQA.
- Purpose is to allow consumers to compare health plan performance to other plans and to national or regional benchmarks.

HEDIS Domains

HEDIS contains 80+ measures across 6 domains of care

1. **Effectiveness of Care**
2. **Access/Availability**
3. Utilization and Relative Resource Use
4. Experience of Care **n/a**
5. Health Plan Descriptive Information
6. **Measures Collected Using Electronic Clinical Data Systems**

There are 15 Measures Beacon monitors divided into the 3 of the 6 domains of care

Aftercare Measures Description



Follow-up After Hospitalization for Mental Illness (FUH)

MEASURE DESCRIPTION

For all patients (6 years and older) discharged from a mental health/psychiatric hospital who are not transferred to another inpatient setting.

Best practice is that the individual has an outpatient visit, an intensive outpatient encounter or a partial hospital visit with a mental health practitioner.

Two rates are reported:

1. Follow-up visit within 7 days of discharge.
2. Follow-up visit within 30 days of discharge.

Follow-up After Emergency Department Visit for Mental Illness (FUM)

MEASURE DESCRIPTION

The percentage of emergency department (ED) visits for patients 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:

1. Follow-up visit to occur within 7 days of ED discharge.
2. Follow-up visit within 30 days of ED discharge.

Follow-up After Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence (FUA)

MEASURE DESCRIPTION

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

Two rates are reported:

1. Follow-up visit to occur within 7 days of ED discharge.
2. Follow-up visit within 30 days of ED discharge.

Alcohol and Other Drug Use Treatment Measures Description



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

MEASURE DESCRIPTION

For all patients with a new diagnosis of a Substance Use Disorder (SUD), best practice for initial treatment requires that the patient **Initiate** and **Engage** in treatment:

- The percentage of patients who **initiate** treatment with an inpatient Alcohol or other drugs (AOD) admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of diagnosis
- The percentage of patients who initiated treatment and **engaged** with two or more additional AOD services or MAT within 34 days of the initiation visit

Antidepressant Medication Management Measures Description



Antidepressant Medication Management (AMM)

MEASURE DESCRIPTION

For patients with a new diagnosis of depression prescribed antidepressant medication, this measure looks at the length of time the patient remains on this medication.

There are 2 treatment phases:

1. Acute Phase the initial period of time the patient must stay on medication for the majority of symptoms to elicit a response is 12 weeks; and
2. Continuation Phase the period of time the patient must remain on medication in order to maintain the response is for at least 6 months.

Follow-up Care for Children Prescribed ADHD Medication Measures Description



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

MEASURE DESCRIPTION

- For children (6-12) newly prescribed ADHD medication (Initiation Phase) best practice requires a follow up visit with a prescriber within 30 days of receiving the medication.
- For ongoing treatment with an ADHD medication, best practice requires:
 - At least 2 additional follow up visits with a prescriber in the preceding 9 months; AND
 - The child remain on the medication for at least 7 months.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia Measures Description



Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

MEASURE DESCRIPTION

For adult patients diagnosed with schizophrenia and prescribed antipsychotics best practice requires that the individual consistently remain on the medication at least 80% of the time to prevent exacerbation of symptoms.

Cardiovascular and Diabetes Monitoring and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Measures Description



Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD)

MEASURE DESCRIPTIONS

The percentage of patients 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year (SSD).

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Cardiovascular and Diabetes Monitoring for People with Schizophrenia (SMD, and SMC)

MEASURE DESCRIPTIONS

1. The percentage of patients 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test (screening test for cardiac disease) and an HbA1c test (screening test for diabetes) during the measurement year. (SMD).

2. The percentage of patients 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test (monitoring test for patients with cardiovascular disease) during the measurement year (SMC).

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Metabolic Monitoring for Children and Adolescents on Antipsychotics

Measures Description



Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

MEASURE DESCRIPTION

For child and adolescent patients (1-17) prescribed antipsychotic medication on an ongoing basis, best practice requires testing to measure glucose levels (Blood Glucose or HbA1C) and cholesterol levels to monitor for development of metabolic syndrome.

The metabolic monitoring occur once during the measurement year.

Use of Multiple Concurrent Antipsychotics in Children and Adolescents Measures Description



Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)

MEASURE DESCRIPTION

Identifies children and adolescents who are on two or more concurrent antipsychotic medications.

Multiple concurrent use of antipsychotic medications is not a best practice nor approved by the FDA.

While there are specific situations where a child or adolescent requires concurrent medications, the risk / benefit of the treatment regime must be carefully considered and monitoring in place to prevent adverse outcomes.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics Measures Description



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

MEASURE DESCRIPTION

For children and adolescents with a new prescription for an antipsychotic, best practice requires that the child receive psychosocial care as part of first line treatment.

First line treatment is associated with improved outcomes and adherence.

Depression Monitoring Utilizing Electronic Data Measures Description



Utilization of the PHQ-9 to Monitor Depression for Adolescents and Adults (DMS)

MEASURE DESCRIPTION

For patients diagnosed with depression treated in outpatient settings the PHQ-9 or PHQ-A (adolescent tool) must be administered by the outpatient treater at least once during a 4 month treatment period.

Depression Screening and Follow-Up for Adolescents and Adults (DSF)

MEASURE DESCRIPTION

The percentage of patients 12 years of age and older who were screened for clinical depression using a standardized tool and, if screened positive, who received follow-up care.

- Depression Screening. The percentage of patients who were screened for clinical depression using a standardized tool.
- Follow-Up on Positive Screen. The percentage of patients who screened positive for depression and received follow-up care within 30 days.

Depression Remission or Response for Adolescents and Adults (DRR)

MEASURE DESCRIPTION

The percentage of patients 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 5 to 7 months of the elevated score. Four rates are reported:

1. ECDS Coverage. The percentage of patients 12 and older with a diagnosis of major depression or dysthymia, for whom a health plan can receive any electronic clinical quality data.
2. Follow-Up PHQ-9. The percentage of patients who have a follow-up PHQ-9 score documented within the five to seven months after the initial elevated PHQ-9 score.
3. Depression Remission. The percentage of patients who achieved remission within five to seven months after the initial elevated PHQ-9 score. (Most recent score <5)
4. Depression Response. The percentage of patients who showed response within five to seven months after the initial elevated PHQ-9 score. (Most recent score 50% or more less than previous)

Provider Interventions Best Practice



Provider Interventions

- Coordination with the patient's PCP or BH provider on medication adherence. For example:
 - The prescriber of an ADHD medication is the pediatrician and the outpatient therapist discovers that the child is not taking the medication
- During routine assessment when it is determined that the patient meets criteria for one or more measures. For example:
 - The patient has schizophrenia and diabetes and meets HEDIS measure criteria for annual HbA1C and LDL-C screening
- Health education with patients, parents and/or other caregivers on importance adherence to HEDIS best practice. For example:
 - Provide health education for parents whose child is being treated with ADHD or antipsychotic medication

Provider Interventions

- Train clinical staff on what the BH measures are and their importance in improved health outcomes. For example:
 - The therapist diagnoses a patient with a substance abuse diagnosis and includes in the treatment plan referral to a substance use service
- Health coaching of patients who meet criteria for measures on importance of adherence. For example:
 - The patient is started on an antidepressant by their PCP and the therapist provides health coaching on the importance of staying on the medication from a response to remittance
 - The therapist encourages healthy life style, routine exercise to avoid metabolic problems such as weight gain

Follow up after Hospitalization

- Direct outreach to patients to remind them of appointments- telephonic recorded reminders, text appointment information
- Outreach to patients who miss appointments and reschedule
- Submit claims
- Home Based Therapy
- Telehealth

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

- Include SUD treatment in discharge plan
- Direct outreach to patients to remind them of appointments to include MAT as appropriate
 - Telehealth
 - Home Based Therapy
- Outreach to patients who miss appointments and reschedule
- Use of Peer supports to engage patients and assist in recovery

Antidepressant Medication Management (AMM)

- Health coaching through education, assessment, and refill reminders for patients with new antidepressant prescription
- Depression Screening- use of standardized tools
- Suicide Risk Assessment- use of standardized tools
- Standardized tool assessment is part of the medical record
- Integrate outcomes/findings into the treatment and discharge plans

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

- .Targeted outreach to patients/parents newly prescribed to support adherence
- Educational materials and assistance accessing services as necessary (Achieve Solutions web site)
- Coordination with prescribing practitioner for ADHD medications
- Education for parents of minor children - importance of medication adherence, and encourage ongoing follow-up (who manages medications?)
- Promote coordination between care givers, parent/guardians, teachers, as well as other health care professionals (i.e. provide educational materials, direct contact, collaborative treatment planning etc.)

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

- Identify patients who have not filled their prescription and outreach to patients and/or care givers as appropriate
- Targeted outreach to patients prescribed antipsychotics or who have prescription refills that are past due
- Confirm with patients that they are taking their medication
- Inform the patients to let you know if they are experiencing adverse medication side-effects
- Utilize evidence-based practices for the treatment of schizophrenia, such as Cognitive-behavioral therapy (CBT)

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

- Provide education to parents and guardian
- Coordinate with pediatrician or psychiatrist to ensure metabolic testing is done
- Collaborate and educate non prescribing practitioners around best practices when prescribing antipsychotics to children- are there alternatives?
- Targeted outreach to families through health education, support and assistance accessing services as necessary
- Encourage blood glucose and cholesterol screening

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)

- Follow best practices when/if prescribing two or more antipsychotics medication
- Assess for untoward reactions
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- Educate patients/ parents/care givers on target symptoms for each medication

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

- Consider least restrictive and intensive interventions prior to prescribing antipsychotics for children and adolescents
- Promote first-line psychosocial care for children and adolescents
- Support parents of children with difficult behaviors (i.e. education, respite)

Depression Monitoring

- Achieve Solutions includes information on PHQ-9
- Importance of the use of a standardized measure to monitor depression response
- Provide education to patients on the importance of the PHQ-9 to monitor depression over time
- If do not prefer PHQ-9 then can use other standardized screening tools, e.g. HAM-D or Beck Depression

Beacon Support for Providers

- Distribute HEDIS Behavioral Health (BH) measure Toolkit to Beacon staff and providers both BH and medical
- Contact Beacon for referral to Case Management and Transitional Care Planning for patients eligible for one or more measures and at risk of non adherence
- Resources and tools are available to mental health and medical providers to educate patients including include screening and self-management tools
- Beacon will provide technical assistance and support to meet the measure
- Onsite Care Coordinators in specific regions to assist with discharge planning and educate patient/patient on importance of aftercare, and when applicable, educate patient's with comorbid SUD on importance of aftercare and engagement

Beacon Support for Providers

Train clinical staff on what the BH measures are and their importance in improved health outcomes

For example:

- The therapist diagnoses a patient with a substance abuse diagnosis and includes in the treatment plan referral to a substance use service
- Health coaching of patients who meet criteria for measures on importance of adherence
- The patient is started on an antidepressant by their PCP and the therapist provides health coaching on the importance of staying on the medication from a response to remittance

Appendices: Measure Rationale References



Follow-up After Hospitalization for Mental Illness (FUH)

MEASURE RATIONALE

- Continuity of care between the inpatient and outpatient is a hallmark of a well-developed behavioral health care system.¹³
- The risk of suicide is higher during the period immediately following discharge from inpatient psychiatric care than at any other time.¹⁴
- A 2016 Joint Commission Alert Detecting and Treating Suicidal Ideation in All Settings cited the 2014 Roadmap for providers reporting the risk of suicide is more than three times as likely the first week after discharge from a psychiatric facility.¹⁵
- Outpatient follow-up care after inpatient admissions can provide the necessary continuity of care that people with acute and chronic mental health disorders require to maintain (and improve) their current functioning.²

Follow-up After Hospitalization for Mental Illness (FUH)

MEASURE RATIONALE

- Multiple studies have demonstrated an inverse correlation between a successful aftercare appointment within 7 days of discharge and the recidivism rate.^{1x,2}
- Allow practitioners to assess compliance with prescribed medication therapies.^{1x}
- Detect as early as possible changes in the patient's disease process that require additional intervention. ^{1x}
- Timely outpatient follow-up has been promoted as a key strategy to reduce hospital readmissions, though one-half of patients readmitted within 30 days of hospital discharge do not have follow-up before the readmission³

Follow-up After Hospitalization for Mental Illness (FUA & FUM)

MEASURE RATIONALE

The risk of suicide attempts and death is highest within the first 30 days after a person is discharged from an ED or inpatient psychiatric unit, yet:

- 70% of suicide attempt patients of all ages never attend their first outpatient appointment
- Access to clinical interventions and continuity of care after discharge is critical for preventing suicide¹⁶
- Individuals with behavioral health problems who do not receive follow-up care after psychiatric or substance abuse ED visits are much more likely to be readmitted to the ED¹⁷

Follow-up After Hospitalization for Mental Illness (FUA & FUM)

MEASURE RATIONALE

- Discharge from the ED is an important transition point because it is an opportunity to secure a connection or reconnection to appropriate follow up treatment in the outpatient setting.¹⁸
- State Medicaid programs have an opportunity to improve follow-up after ED visits for mental and substance use disorders, perhaps by focusing on groups of beneficiaries who are less likely to receive follow-up.¹⁹

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

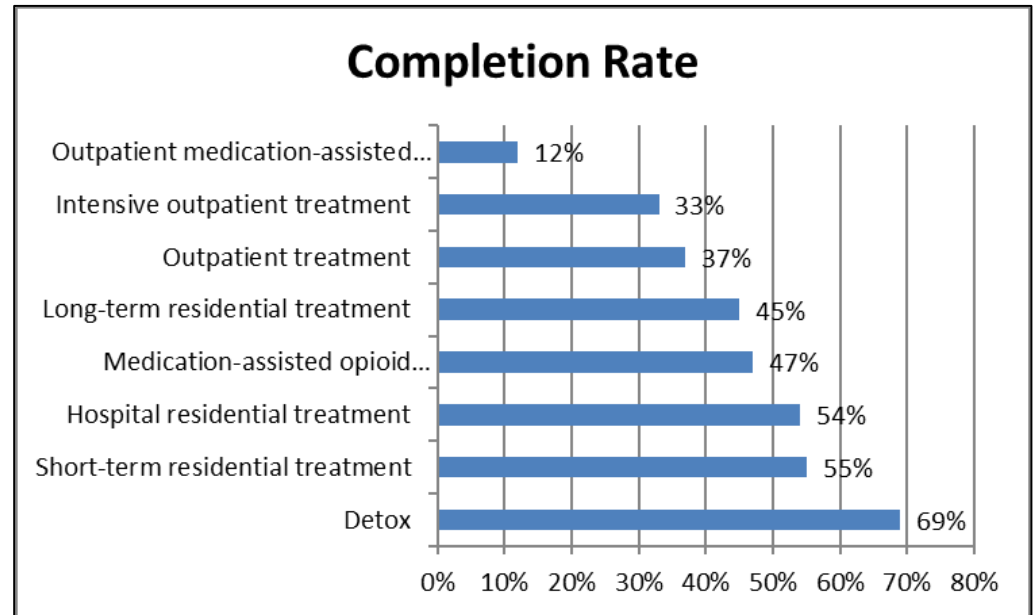
MEASURE RATIONALE

- In 2012, an estimated 23.1 million Americans (8.9 percent) needed treatment for a problem related to drugs or alcohol, but only about 2.5 million people (1 percent) received treatment.¹⁴
- Among Americans aged 12 or older, the use of illicit drugs has increased over the last decade from 8.3% of the population using illicit drugs in the past month in 2002 to 10.1% (27 million people) in 2015.³⁻¹
- The misuse of prescription drugs is second only to marijuana as the nation's most common drug problem after alcohol and tobacco, leading to troubling increases in opioid overdoses in the past decade.¹²
- The 2015 estimated 3.8 million people aged 12 or older who were current misusers of pain relievers represent 1.4% of the population aged 12 or older³⁻¹

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

MEASURE RATIONALE

- Treatment engagement is an intermediate step between initially accessing care (the first visit) and completing a full course of treatment.^{20, 21, 22}
- The 2012 treatment completion rate was 45% (SAMHSA TEDS (Treatment Episode Data Sets)) for all types of substance use treatment, highest 69% for those treated in Detox, and lowest for those treated in OP MAT.²³



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

MEASURE RATIONALE

- This measure is an important intermediate indicator, closely related to outcome. In fact, studies have tied frequency and intensity of engagement as important.^{21,22}
- Over the past 10 years, the prevalence of heroin and prescription opioid misuse has significantly increased, in large part because of the increased prescribing of opioid analgesics in the US.²⁴
- Four fold increase in opioid related deaths since 2000.²⁵
- AOD dependence is common across many age groups and a cause of morbidity, mortality and decreased productivity. There is strong evidence that treatment for AOD dependence can improve health, productivity and social outcomes, and can save millions of dollars on health care and related costs. [2016 State of HC Quality]

Antidepressant Medication Management (AMM)

MEASURE RATIONALE

- Major depression affects 6.7% of the U.S. adult population (approximately 14.8 million adults).²⁶
- Severity of major depression is significantly associated with poor work performance, costing up to \$2 billion monthly due to lost work productivity.²⁶
- Approximately 50% of psychiatric patients and 50% of primary care patients prematurely discontinue antidepressant therapy (i.e., are non adherent when assessed at six months after the initiation of treatment).²⁷
- Streamlined behavioral therapy delivered in a pediatrics practice offered much greater benefit to youth with anxiety and depression than a more standard referral to mental health care with follow-up²⁸

Antidepressant Medication Management (AMM)

MEASURE RATIONALE

Major depression is associated with:

- High rates of comorbidity with other psychiatric disorders and general medical illnesses;
 - Lower rates of adherence to medication regimens; and
 - Poorer outcomes for chronic physical illness. ²⁹
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- While 51.6% of cases reporting MDD received health care treatment for the illness, only 21.7% of all MDD cases received minimal guideline-level treatment. ²⁹
 - Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and suicide, the 11th leading cause of death in the U.S.²

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

MEASURE RATIONALE

- ADHD is the most common mental health disorder affecting children, 5%-7% worldwide.³⁰
- Children with ADHD cost approximately \$5,000 per student each year to the education system.³¹
- Increased risk for drug use disorders in adolescents with untreated ADHD.³²
- Effects of ADHD often persist into adolescence and adulthood with additional comorbid conditions.³³

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

MEASURE RATIONALE

- Less than 1 in 3 children with ADHD received both medication treatment and behavior therapy, the preferred treatment approach for children ages 6 and older (CDC 2016 Study)²².
- 9 out of 10 children with ADHD were treated with medication and/or behavioral therapy, both of which are recommended ADHD treatments. Of these children about:
 - 4 in 10 (43%) were treated with medication alone — the most common single ADHD treatment;
 - 1 in 10 (13%) received behavioral therapy alone, and
 - 3 in 10 (31%) were treated with combination therapy (medication and behavioral therapy).
 - 1 in 10 (6.5%) children with ADHD were receiving neither medication treatment nor behavioral therapy.
 - 1 in 10 (6.5%) were taking dietary supplements for ADHD, which are not currently recommended for the treatment of ADHD.³⁴

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

MEASURE RATIONALE

- Ensuring follow-up treatment for children prescribed ADHD medications following an initial prescription allows prescribing practitioners to focus on the appropriate medications, methods, and care needs of the patient within a reasonable time period to avoid complications and/or devise an appropriate plan for ongoing treatment and additional treatment interventions.³⁵
- Continuation and monitoring of children prescribed ADHD aims to protect and safeguard symptom relapse or provide for symptoms to remain within a manageable state for the patient and family to provide for a better quality of life in all aspects of school, social, and personal environments.³⁵

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

MEASURE RATIONALE

- Approximately 1% of adults in the United States have schizophrenia.²⁴
- 40% of hospital readmissions for patients with schizophrenia are attributed to nonadherence to antipsychotic medications.³⁶
- As many as 60% of patients with schizophrenia do not take medications as prescribed. When antipsychotics are not taken correctly, patient outcomes can be severe, including hospitalization and interference with the recovery process.³⁷

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

MEASURE RATIONALE

- Nearly half of people with schizophrenia take less than 70 percent of prescribed medication doses.³⁸
- People with schizophrenia who discontinue their medications are **twice** as likely to experience a relapse in symptoms than those who continue their prescribed doses.^{37, 39}
- The cost of care for people with schizophrenia and a history of prior relapse is **three times higher** than it is for people without a history of prior relapse.⁴⁰
- Poor medication adherence leads to increased emergency department utilization, more hospitalizations, and generally poorer health outcomes⁴¹

Cardiovascular and Diabetes Monitoring and Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD, SMD, and SMC)

MEASURE RATIONALE

- The lifespan of people with severe mental illness (SMI) is shorter compared to the general population. This excess mortality is mainly due to physical illness. ⁴²
- Many chronic physical disorders have been identified that are more prevalent in individuals with SMI (Diabetes and Cardiovascular disease). In addition to modifiable lifestyle factors and psychotropic medication side effects, poorer access to and quality of received health care remain addressable problems for patients with SMI.⁴²
- Greater individual and system level attention to these physical disorders that can worsen psychiatric stability, treatment adherence, and life expectancy as well as quality of life will improve outcomes of these generally disadvantaged populations worldwide.⁴²

Cardiovascular and Diabetes Monitoring and Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD, SMD, and SMC)

MEASURE RATIONALE

- In 2010, cardiovascular disease and diabetes were the leading causes of death in the United States with cardiovascular disease being the most frequently occurring cause of death in individuals with SMI.⁴³
- Individuals with diabetes and schizophrenia or bipolar disorder have 50% higher risk of death than diabetics without a mental illness.⁴⁴
- In terms of cost, the total cost of cardiovascular disease in 2010 was estimated to be \$315.4 billion ⁴⁵ and in 2007, diabetes was estimated to cost the U.S. economy \$174 billion. Of this, \$116 billion (67%) was attributed to medical care and \$58 billion (33%) to disability, work loss and premature death.⁴⁶
- Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder can lead to worsening health and death.⁴⁶

Cardiovascular and Diabetes Monitoring and Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD, SMD, and SMC)

MEASURE RATIONALE

- Individuals with serious mental illness who use antipsychotics are at increased risk of cardiovascular disease and diabetes, screening and monitoring of these conditions is important for prevention and early identification.⁴⁴
- In a Medicaid-receiving population, baseline glucose and lipid testing for patients treated with second generation antipsychotics was infrequent and showed little change following the diabetes warning and monitoring recommendations.⁴⁷

Cardiovascular and Diabetes Monitoring and Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD, SMD, and SMC)

MEASURE RATIONALE

- Addressing these physical health needs, lifestyle changes, and access to quality care for people with schizophrenia or bipolar disorder is an important way to improve health and economic outcomes downstream.
- Seriously mentally ill often face a double-edge sword. On the one hand, they are dealing with the significant impact of their illness, while on the other they frequently suffer from co-occurring (co-morbid) medical conditions that can be exacerbated by their treatment. These co-morbid medical conditions include Type 2 Diabetes, Obesity, Dyslipidemia, etc.⁴⁸

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

MEASURE RATIONALE

- Antipsychotic medications offer the potential for effective treatment of psychiatric disorders in children; however, they can also increase a child's risk for developing serious health concerns, including metabolic health complications.⁴⁹
- In a 2010 study of young, privately insured youth, most children who were prescribed antipsychotic medication by a primary care provider had not received a mental health assessment, a psychiatrist visit, or any psychotherapy during the year in which the medications were prescribed.⁵⁰
- In a large study of Medicaid children (published in 2010), the number of newly treated with second-generation antipsychotics increased from 1,482 in 2001 to 3,110 in 2005. Of the new users of these agents during the study period, 41.3% had no diagnosis for which such treatment was supported by a published study.⁵¹

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

MEASURE RATIONALE

- Research suggests that metabolic problems in childhood and adolescence are associated with poor cardiometabolic (High Blood Pressure, Hypercholesterolemia, obesity) outcomes in adulthood.⁵⁸
- The long-term consequences of pediatric obesity and other metabolic disturbances include higher risk of heart disease in adulthood.⁵⁹
- The American Academy of Child and Adolescent Psychiatry (AACAP) guidelines recommend metabolic monitoring, including monitoring of glucose and cholesterol levels, for children and adolescents on antipsychotic medications.⁶⁰

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)

MEASURE RATIONALE

- Antipsychotic prescribing for children has increased rapidly in recent decades, driven by new prescriptions and by longer duration of use.^{61, 62}
- The frequency of prescribing antipsychotics among youth (from a 2006 study) increased almost fivefold from 1996 to 2002, from 8.6 per 1,000 children to 39.4 per 1,000.⁶³
- Although some evidence supports the efficacy of antipsychotics in youth for certain narrowly defined conditions, less is known about the safety and effectiveness of antipsychotic prescribing patterns in community use (e.g., combinations of medications, off-label prescribing, dosing outside of recommended ranges).⁶²

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)

MEASURE RATIONALE

- While there is no research on long-term effects of multiple concurrent antipsychotics on children's health, the increased side effect burden of certain antipsychotic medications for youth has implications for future physical health concerns including obesity and diabetes.⁶⁴
- Children and adolescents prescribed antipsychotics are more at risk for serious health concerns, including weight gain, extrapyramidal side effects, hyperprolactinemia and some metabolic effects.⁶⁴
- Often being prescribed for nonpsychotic conditions such as ADHD, antipsychotic medications are associated with a number of potential adverse events as described in the APC and APM measures.⁶²
- The American Academy of Child and Adolescent Psychiatry recommends that clinicians avoid the simultaneous use of multiple concurrent antipsychotic medications for children and adolescents.⁶⁰

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

MEASURE RATIONALE

- Guidelines recommend that psychosocial treatments be provided **prior** to initiating an antipsychotic.⁶⁰
- Treatment guidelines for management of aggression (and disruptive behavior disorders all endorse psychosocial interventions as **first-line** treatment.⁶⁰
- Increasing consensus exists that antipsychotic medication should be the treatment of **last resort**, after parenting skills training and other behavioral treatments have been tried and have failed.⁶⁵
- Early Pediatric Interventions Can Prevent Behavior Problems in Young Children⁶⁶

Utilization of the PHQ-9 to Monitor Depression for Adolescents and Adults (DMS)

MEASURE RATIONALE

- The use of standardized tools is essential for tracking depressive symptoms and monitoring patient response to treatment.⁶⁷
- Standardized instruments are useful in identifying meaningful change in clinical outcomes over time.⁶⁷
- Guidelines recommend that providers establish and maintain regular follow-up with patients diagnosed with depression and use a standardized tool to track symptoms⁶⁷.
- In a 2000 study, the mortality risk for suicide in depressed patients was more than 20-fold greater than in the general population.⁶⁸
- In terms of other chronic conditions, depression is associated with an increased risk of type 2 diabetes,^{69, 70} and has been identified as a risk factor for development of cardiovascular disease.⁷¹

Utilization of the PHQ-9 to Monitor Depression for Adolescents and Adults (DMS)

MEASURE RATIONALE

- In addition, depression adversely affects the course, complications and management of other chronic medical illnesses.⁷²
- Patients with depression are not always asked about depression symptoms when they present to primary care and so worsening symptoms can be missed.⁷³
- PHQ-9 has emerged as standard in the field in terms of depression identification and symptom monitoring.⁷³
- The PHQ-9 has been validated for measuring depression severity and treatment response.⁷³

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Thank you

