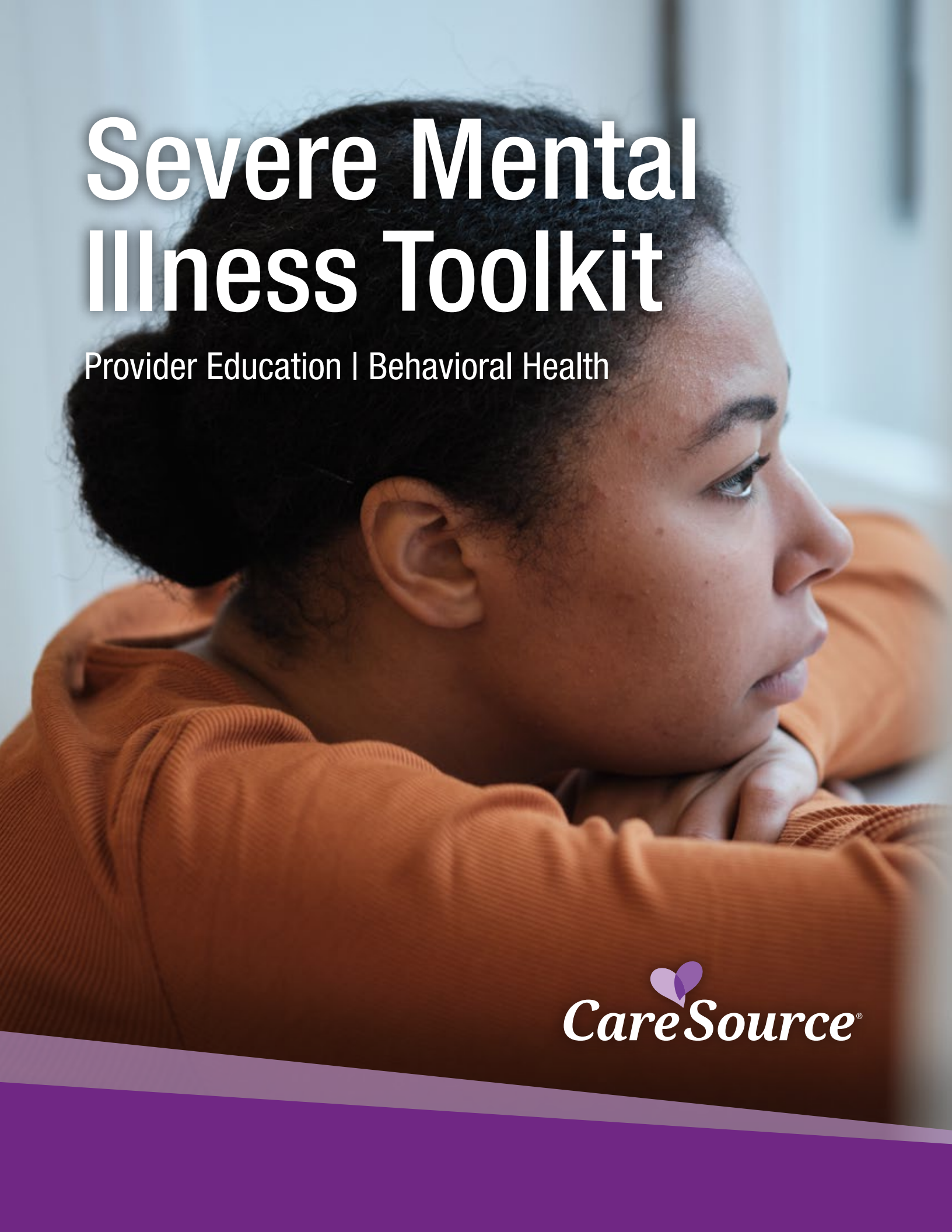


Severe Mental Illness Toolkit

Provider Education | Behavioral Health

CareSource®

Contents

Introduction

Mental illnesses are disorders that affect a person's thinking, mood, and/or behavior – they range from mild to severe. According to the National Institute on Mental Health, nearly one in five adults live with a mental illness.

A mental illness that interferes with a person's life and ability to function is called a serious mental illness (SMI). With the right treatment, people with SMI can live productive and enjoyable lives (SAMHSA, June 2002).

There are several types of serious mental illness diagnoses and here are some common ones:

- **Bipolar disorder** causes intense shifts in mood, energy, and activity levels. People have manic episodes in which they feel extremely happy or euphoric, and energized. Usually, they also have depressive episodes in which they feel deeply sad and have low energy.
- **Major depressive disorder (MDD)** is one of the most common mental health disorders. Symptoms vary from person to person, but may include sadness, hopelessness, anxiety, irritability, worthlessness, and fatigue. These symptoms interfere with a person's ability to work, sleep, eat, and enjoy their life.
- **Schizophrenia** is a chronic and severe mental health disorder that causes people to interpret reality abnormally. People experience hallucinations, delusions, extremely disordered thinking, and a reduced ability to function in their daily life.

Whether a patient is newly diagnosed with a SMI or has been living with a SMI diagnosis for a long time, providing them with additional resources and tools will be beneficial. We have created a SMI toolkit to serve as a resource to help members with a SMI diagnosis to become or remain stable.

Provider Resources

Behavioral health services focus on whole-body, whole-person health. This means ensuring your patients are not only physically healthy, but also mentally and emotionally healthy.

Screening Tools

Screening is an important part of coordinating care. We provide downloadable screening tools such as the PHQ-9 Questionnaire, Hypomania/Mania Symptom Checklist, Adult Anxiety and Related Disorders Questionnaire, Mood Disorder Questionnaire, and the CAGE-AID Questionnaire.

Depression Screening

The PHQ-9 can be used to assess for depression.

- A component of the longer Patient Health Questionnaire, PHQ-9, is a multi-purpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression.
- The tool is a diagnostic measure for Major Depression as well as for recognizing subthreshold depressive disorders.
- The tool can be administered repeatedly, reflecting improvement or worsening of depression in response to treatment.
- View the PHQ-9 Depression Questionnaire **online**.

Patient Health Questionnaire-9 (PHQ-9)
Assessment Over the last 2 weeks, how often have you been bothered by any of the following problems?
1. Little interest or pleasure in doing things.
0. Not at all 1. Several days 2. More than half the day 3. Nearly every day
2. Feeling down, depressed, or hopeless
0. Not at all 1. Several days 2. More than half the days 3. Nearly everyday
3. Please try to remember a period when you were in a "high" state (while not using drugs or alcohol). In such a state:
0. Not at all 1. Several days 2. More than half the days 3. Nearly everyday
4. Feeling tired or having little energy.
0. Not at all 1. Several days 2. More than half the days 3. Nearly everyday

5. Poor appetite or overeating.

0. Not at all
1. Several days
2. More than half the day
3. Nearly every day

6. Feeling bad about yourself – or that you're a failure or have let your family down.

0. Not at all
1. Several days
2. More than half the days
3. Nearly everyday

7. Trouble concentrating on things, such as reading the newspaper or watching television.

0. Not at all
1. Several days
2. More than half the days
3. Nearly everyday

8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.

0. Not at all
1. Several days
2. More than half the days
3. Nearly everyday

9. Thoughts that you would be better off dead or hurting yourself in some way.

0. Not at all
1. Several days
2. More than half the days
3. Nearly everyday

Mania Screening

The Hypomania/Mania Symptom Checklist (HCL-32) is a tool for researchers to screen patients presenting with a depressive episode for hypomanic symptoms that may indicate a diagnosis of bipolar disorder.

- View the Hypomania/Mania Symptom Checklist **online**.

Hypomania/Mania Symptom Checklist (HCL-32)
Background The HCL-32 is a screening tool for researchers trying to find people with bipolar disorder. This is one of the better "complete but simple" lists of manic-side symptoms. It's a good "fine-tooth comb" when people want to inventory all possible hypomanic symptoms, usually in the context of asking, "do I really have bipolar disorder?"
Assessment At different times in their life everyone experiences changes or swings in energy, activity, and mood ("highs and lows", or "ups and downs"). The aim of this questionnaire is to assess the characteristics of the "high" periods.
1. First of all, how are you feeling today compared to your usual state?
a. Much worse than usual b. Worse than usual c. A little worse than usual d. Neither better nor worse than usual e. Better than usual f. A little better than usual g. Much better than usual
2. Compared to other people, my level of activity energy and mood (Not how you feel today, but how you are on average):
a. Is always rather stable and even b. Is generally higher c. Is generally lower d. Repeatedly shows periods of ups and downs
3. Please try to remember a period when you were in a "high" state (while not using drugs or alcohol). In such a state:
a. I need less sleep
b. I feel more energetic and more active
c. I am more self-confident
d. I enjoy my work more
e. I am more sociable (make more phone calls, go out more)

f. I want to travel and/or do travel more
g. I tend to drive faster or take more risks when driving
h. I spend more money/too much money
i. I take more risks in my daily life (in my work and/or other activities)
j. I am physically more active (sport, etc.)
k. I plan more activities or projects
l. I have more ideas and am more creative
m. I am less shy or inhibited
n. I wear more colorful and more extravagant clothes/makeup
o. I want to meet or actually do meet more people
p. I am more interested in sex, and/or have increased sexual desire
q. I am more flirtatious and/or am more sexually active
r. I talk more
s. I think faster
t. I make more jokes or puns when I am talking
u. I am more easily distracted
v. I engage in lots of new things
w. My thoughts jump from topic to topic
x. I do things more quickly and/or more easily
y. I am more impatient and/or get more irritable more easily
z. I can be exhausting or irritating for others
aa. I get into more quarrels
bb. My mood is higher, more optimistic
cc. I drink more coffee
dd. I smoke more cigarettes
ee. I drink more alcohol
ff. I take more drugs (sedatives, anti-anxiety pills, stimulants)
Additional Notes In the official version of this tool, there are additional questions about how these “highs” affect your life (positively or negatively); other people’s reactions to them; how long they last; whether you’ve had one recently; and how much of the last year has been spent in such a state.

Anxiety Screening

The Screening Tool for Adult Anxiety Related Disorders (SCAARED) has shown excellent psychometrics supporting its use to screen adults for anxiety disorders, longitudinal studies following youth into adulthood and studies comparing child and adult populations.

- The screening assessment has four factors: somatic/panic/agoraphobia, generalized anxiety, separation anxiety, and social anxiety that are useful to screen for the respective anxiety disorders.
- View the Screening Tool for Adult Anxiety Related Disorders (SCAARED) **online**.

Screening Tool for Adult Anxiety Related Disorders (SCAARED)
Background This assessment has a list of sentences that describe how people feel. Read each phrase and decide on your response for each question. Check the box that corresponds to the response that seems to describe you now or within the past three months.
Assessment
1. When I feel nervous, it is hard for me to breathe.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
2. I get headaches when I am at school, at work, or in public places.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
3. I don't like to be with people I don't know well.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
4. I get nervous if I sleep away from home.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
5. I worry about people liking me.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true

6. When I get anxious, I feel like passing out.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
7. I am nervous.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
18. It is hard for me to stop worrying.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
9. People tell me that I look nervous.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
10. I feel nervous with people I don't know well.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
11. I get stomachaches at school, at work, or in public places.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
12. When I get anxious, I feel like I'm going crazy.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
13. I worry about sleeping alone.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true

14. I worry about being as good as other people.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
15. When I get anxious, I feel like things are not real.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
16. I have nightmares about something bad happening to my family.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
17. I worry about going in to work or school, or to public places.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
18. When I get anxious, my heart beats fast.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
19. I get shaky.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
20. I have nightmares about something bad happening to me.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
21. I worry about things working out for me.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true

22. When I get anxious. I sweat a lot.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
23. I am a worrier.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
24. When I worry a lot, I have trouble sleeping.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
25. I get really frightened for no reason at all.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
26. I am afraid to be alone in the house.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
27. It is hard for me to talk with people I don't know well.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
28. When I get anxious, I feel like I'm choking.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
29. People tell me that I worry too much.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true

30. I don't like to be away from my family.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
31. When I worry a lot, I feel restless.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
32. I am afraid of having anxiety (or panic) attacks.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
33. I worry that something bad might happen to my family.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
34. I feel shy with people I don't know well.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
35. I worry about what is going to happen in the future.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
36. When I get anxious, I feel like throwing up.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
37. I worry about how well I do things.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true

38. I am afraid to go outside or crowded places by myself.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
39. I worry about things that have already happened.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
40. When I get anxious, I feel dizzy.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
41. I feel nervous when I am with other people and I have to do something while they watch for me (for example: speak, play a sport).
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
42. I feel nervous when I go to parties, dances, or any place where there will be people that I don't know well.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
43. I am shy.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true
44. When I worry a lot, I feel irritable.
0. Not true or hardly ever true 1. Somewhat true or sometimes true 2. Very true or often true

Mood Disorder Screening

CareSource recommends the use of the Mood Disorder Questionnaire (MDQ) to assess bipolar disorder.

- The MDQ is a screening instrument for bipolar disorder that can easily be utilized in primary and other health care settings.
- It can correctly identify seven of ten patients with bipolar disorder, while nine of 10 patients without bipolar disorder would be correctly screened out.
- If the patient screens positive on the MDQ, the physician should proceed with a full clinical evaluation for bipolar disorder.
- View the Mood Disorder Questionnaire **online**

Mood Disorder Questionnaire (MDQ)

Background
The Mood Disorder Questionnaire (MDQ) was developed by a team of psychiatrists, researchers, and consumer advocates to address a critical need for timely and accurate diagnosis of bipolar disorder, which can be fatal if left untreated. The questionnaire takes about five minutes to complete, and can provide important insights into diagnosis and treatment. Clinical trials have indicated that the MDQ has a high rate of accuracy; it is able to identify seven out of 10 people who have bipolar disorder and screen nine out of ten people who do not.

A recent National Depressive and Manic-Depressive Association (DMDA) survey revealed that nearly 70% of people with bipolar disorder had received at least one misdiagnosis and many had waited more than 10 years from the onset of their symptoms before receiving a correct diagnosis. National DMDA hopes that the MDQ will shorten this delay and help more people to get the treatment they need, when they need it.

The MDQ screens for Bipolar Spectrum Disorder (which includes Bipolar I, II and NOS).

If the patient answers “Yes” to seven or more of the 13 items in question number 1, and “Yes” to question number 2, and “Moderate” or “Serious” to question number 3, you have a positive screen. All three of the criteria above should be met. A positive screen should be followed by a comprehensive medical evaluation for Bipolar Spectrum Disorder.

Assessment
Has there ever been a period of time when you were not your usual self and…

1. You felt so good or so hyper that other people thought you were not your normal self or you were so hyper you got in trouble?

a. Yes
b. No

2. You were so irritable that you shouted at people or started fights and arguments?

a. Yes
b. No

3. You felt much more self confident than usual?
a. Yes b. No
4. You got much less sleep than usual and found you didn't really miss it?
a. Yes b. No
5. You were much more talkative or spoke much faster than usual?
a. Yes b. No
6. Thoughts raced through your head or you couldn't slow your mind down?
a. Yes b. No
7. You were so easily distracted by things around you that you had trouble concentrating or staying on track?
a. Yes b. No
8. You had much more energy than usual?
a. Yes b. No
9. You were much more active or did many more things than usual?
a. Yes b. No
10. You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?
a. Yes b. No
11. You were much more interested in sex than usual?
a. Yes b. No

12. You did things that were unusual for you or that other people might have thought you were excessive, foolish or risky?
a. Yes b. No
13. Spending money got you or your family into trouble?
a. Yes b. No
If you checked Yes to more than one of the above, have several of these every happened during the same period of time?
a. Yes b. No
How much of a problem did any of these cause you – like being unable to work; having family, money, or legal troubles; getting into arguments or fights?
a. No problem b. Minor problem c. Moderate problem d. Serious problem
Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?
a. Yes b. No
Has a health professional every told you that you have manic-depressive illness or bipolar disorder?
a. Yes b. No

Trauma Screening

The Brief Trauma Questionnaire (BTQ) is a 10-item self report questionnaire designed to assess traumatic exposure according to DSM-IV but specifically including only life threat/serious injury because of the difficult of accurately assessing subjective response.

- View the Brief Trauma Questionnaire **online**

Brief Trauma Questionnaire (BTQ)

Background
The Brief Trauma Questionnaire (BTQ) is a brief self-report questionnaire that is derived from the Brief Trauma Interview. The BTQ was originally designed to assess traumatic exposure according to DSM-IV but specifically asked only about Criterion A.1 (life threat/serious injury) because of the difficulty of accurately assessing A,2 (subjective response) in a brief self-report format. Criterion A.2 has been eliminated from the PTSD diagnostic criteria in DSM-5, so the BTQ provides a complete assessment of Criterion A.

The questionnaire may be used to determine whether an individual has had an event that meets the A Criterion, or to determine the different types of Criterion A events an individual has experienced. In either case, exposure to an event should be scored as positive if a respondent says yes to either:

- Life threat or serious injury for events 1-3 and 5-7;
- Life threat for event 4;
- Serious injury for event 8, or;
- "Has this ever happened to you?" for events 9 and 10

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Circle "Yes" or "No" to report what has happened.

When answering "Yes" for an event, additional questions need answered listed on the right side to report: 1) Whether it was believed life was in danger or of being seriously injured; and 2) Whether serious injury occurred.

Answering "No" for an event warrants going to the next event.

Assessment

1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty?)

Has this ever happened to you?

a. Yes
b. No

If the event happened, did you think your life was in danger or you might be seriously injured?

a. Yes
b. No

If the event happened, were you seriously injured?

a. Yes
b. No

2. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill?

Has this ever happened to you?

a. Yes
b. No

If the event happened, did you think your life was in danger or you might be seriously injured?

a. Yes
b. No

If the event happened, were you seriously injured?

a. Yes
b. No

3. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?

Has this ever happened to you?

a. Yes
b. No

If the event happened, did you think your life was in danger or you might be seriously injured?

a. Yes
b. No

If the event happened, were you seriously injured?

a. Yes
b. No

4. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps, or other injuries?

a. Yes
b. No

5. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members, or strangers?

a. Yes
b. No

6. Has anyone ever made or pressured you into having some type of unwanted sexual contact?

Note: By sexual contact we mean any contact between someone else and your private parts or between you and someone else's private parts.

a. Yes
b. No

7. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?

a. Yes
b. No

8. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?

a. Yes
b. No

9. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed?

Note: Do not answer yes for any event you already reported in Questions 1-9.

a. Yes
b. No

Substance Use Disorder (SUD) Screening

CareSource recommends the use of the CAGE-AID (Cut Down, Annoyed, Guilty, Eye-Opener/Adopted to Include Drug Use) Screening Tool to assess for alcohol and other drug abuse and dependence.

- The CAGE-AID Screening Tool is used to test for alcohol and other drug abuse and dependence in adults.
- The tool is not diagnostic, but is indicative of the existence of an alcohol or other drug problem.
- View the CAGE-AID Audit Screening Tool **online**

CAGE-AID Screening Tool
Background The questions asked on the CAGE-AID Screening Tool are asked and scored to determine if substance abuse exists and needs to be addressed. The AID portion of the assessment was added on to include questions about drug use. The target population for CAGE-AID is both adults and adolescents and can be administered by patient interview or self-report. These tools are not used to diagnose diseases, but only to indicate whether a problem might exist. When evaluation drug use, include illegal drug use and the use of prescription drugs other than as prescribed. Item responses on the questions are scored 0 for “no” and 1 for “yes” answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant. The normal cutoff for the CAGE is two positive answers; however, the Consensus Panel recommends that the primary care clinicians lower the threshold to one positive answer to cast a wider net and identify more patients who may have substance abuse disorders. A number of other screening tools are available.
Assessment
1. Have you ever felt you ought to cut down on your drinking or drug use?
a. Yes b. No
2. Have people annoyed you by criticizing your drinking or drug use?
a. Yes b. No
3. Have you felt bad or guilt about your drinking or drug use?
a. Yes b. No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?
a. Yes b. No

Clinical Practice Guidelines

Clinical practice guidelines are designed to inform clinicians about best practices as they engage in shared decision-making to identify the right treatments for each patient. Providers can consider these guidelines together with their own expertise, keeping in mind a patient's culture, preferences, and values. We hope this will be a useful tool for providers to have in their toolbox, to be used as part of an evidence-based practice in psychology.

Treatment of Patients with Schizophrenia

- **American Psychiatric Association –** Summary Article on New Practice Guideline on Treatment of Patients with Schizophrenia
- **American Psychiatric Association –** Practice Guideline for the Treatment of Patients with Schizophrenia, Third Edition

Treatment of Patients with Bipolar Mood Disorder

- **National Library of Medicine –** Clinical Practice Guidelines for Management of Bipolar Disorder

Treatment of Patients with Major Depressive Disorder

- **American Psychiatric Association –** Clinical Practice Guideline for the Treatment of Patients with Major Depressive Disorder

Best Practices

The Department of Veterans Affairs is recognized as a top authority on behavioral services. They recommend the following principles to provide the most effective care:

- Mental health services should be recovery-oriented
- Mental health services should be provided in a therapeutically enriching environment
- Mental health services should be provided in a safe and secure environment
- Mental health services should be integrated and coordinated
- Mental health services should be provided in settings that respect and can accommodate a diverse range of populations and care needs

Linking your patient with resources within their community is beneficial in helping them to expand their support system, but also aid in their stabilization.

Medication Adherence Guidelines

Non-adherence to SMI treatment is associated with poor health outcomes, including psychiatric hospitalization, relapse, negative social outcomes (e.g., arrest, job loss), and increased risk of attempted suicide.

Patients who maintain the correct medication regimen more effectively managed their mental health symptoms and improve their emotional wellbeing. The willingness to take medication also indicated patients' confidence in the entire treatment process and the development of skills needed for living in recovery.

Anti-Depressant Medication Management (AMM) HEDIS Measure

This measure focused on members 18 years of age and older who were treated with antidepressant medication, and had a diagnosis of major depression and who remained on an antidepressant treatment. Two rates are reported for this measure:

- **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 (six months).

More information about how to improve your patients' adherence to anti-depressant medication can be found on our website.

Providers can access the CareSource medications and formulary tool for Healthy Indiana Plan (HIP) at the following links:

- HIP Basic and HIP State Plan Basic
- HIP Plus and HIP State Plan Plus
- Hoosier Healthwise Package A and C

Co-Occuring Disorders

Researchers have found that about half of individuals who experience a SUD during their lives will also experience a co-occurring mental disorder and vice versa. Co-occurring disorders can include anxiety disorders, depression, attention-deficit hyperactivity disorder (ADHD), bipolar disorder, personality disorder, and schizophrenia, which are some of the common diagnoses.

- Online SUD and Co-Occurring Disorders Flier

Community Resources

SMI Members diagnosed with a SMI would benefit from being linked with a behavioral health provider for additional support and resources. Behavioral health providers within the CareSource network can be located using our Find a Doc tool.

Community Mental Health Centers

Members can also be linked with a Community Mental Health Center (CMHC) that can provide more intensive services, including individual therapy, case management, skills training, peer recovery, and club house to facilitate social skills. A list of CMHCs can be found at the Indiana Council website.

Medically Frail Members

Members with a SMI diagnosis and who are receiving HIP benefits should be assessed for a medically frail designation in order to access enhanced benefits which could include Medicaid Rehabilitation Option, dental services, non-emergency transportation, and chiropractic services.

An individual is considered medically frail if he or she has one or more of the following:

- Disabling mental disorder
- Chronic substance abuse disorder
- Serious and complex medical condition
- Physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living, or
- Disability determination from the Social Security Administration

The form to refer members to be assessed for Medically Frail benefits can be found on our website.

Medicaid Rehabilitation Option (MRO) and 1915 (i) Adult Mental Health Habilitation (AMHH) Services State Plan Home and Community-Based Services
Medicaid Rehabilitation Option (MRO) services allow for individuals with a behavioral health diagnosis to access expanded services, such as case management. In order to access MRO services, an individual must be evaluated by their local CMHC. Further information regarding the benefits of accessing MRO services can be found on the Indiana Medicaid website.

Effective Nov. 1, 2014, Indiana implemented the 1915 (i) Adult Mental Health Habilitation (AMHH) services program. The AMHH services program was adopted by Indiana to provide community-based opportunities for the case of adults with serious mental illness who may most benefit from keeping or learning skills to maintain a healthy safe lifestyle in the community.

AMHH services are provided for individuals and their families, or groups of adult persons who are living in the community and who need help on a regular basis with serious mental illness or co-occurring mental illness and addiction disorders. This is accomplished by:

- Assessing the individual's needs and strengths

- Developing an Integrated Care Plan that outlines objectives of care, including how AMHH services assist in delivering appropriate home and community-based habilitation services to the individual
- Assisting the individual in reaching their habilitative goals

An eligible AMHH services recipient will be authorized to receive specific requested AMHH services as approved by the State Evaluation Team and on their care plan for one year (365 days) from the start date of the approval. The following are the AMHH services:

- Adult day services
- Home and Community Based Habilitation and Support Services
- Respite care
- Therapy and behavioral support services
- Addiction counseling
- Supported community engagement services
- Care coordination
- Medication training and support

AMHH services are intended for individuals who meet all of the following core target group criteria:

- Individual is enrolled in Medicaid
- Individual is 19 years of age or older
- Individual resides in a setting which meets federal requirements for home and community-based services
- Individual has an AMHH-eligible, DMHA-approved diagnosis, which may include the following (refer to eligible diagnoses link for a full listing of AMHH-eligible diagnosis codes):
    - Schizophrenic disorders (F20/F22/F25 in ICD-10/DSM-5; 295.xx in ICD-9/DSM-IV-TR)
    - Major depressive disorder (F33 in ICD-10/DSM-5; 296.xx in ICD-9/DSM-IV-TR)
    - Bipolar disorders (F31 in ICD-10/DSM-5; 296.xx in ICD-9/DSM-IV-TR)
    - Delusional disorder (F22 in ICD-10/DSM-5; 297.1 in ICD-9/DM-IV-TR)
    - Psychotic disorder NOS (F28/F29 in ICD-10/DSM-5; 298.9 in ICD-9/DSM IV-TR)
    - Obsessive-compulsive disorder (F42 in ICD-10/DSM-5; 300.3 in ICD-9/DSM-IV-TR)

For more information, please visit: Indiana FSSA Adult Mental Health Habilitation Services webpage.

Behavioral and Primary Healthcare Coordination

The Behavioral and Primary Healthcare Coordination (BPHC) program offers a service that consists of the coordination of healthcare services to manage the mental health/addiction and physical healthcare needs of eligible recipients. This includes:

- Logistical support

- Advocacy that helps recipients gain access necessary to manage their physical and behavioral health conditions
- Support in adhering to health regimens
- Scheduling and keeping medical appointments
- Obtaining and maintaining a primary medical provider
- Facilitating communication across providers

In additions, BPHC includes: direct assistance in gaining access to services; coordination of care within and across systems; oversight of the entire case; linkage to appropriate services; needs based assessment of the eligible recipient to identify service needs; development of an individualized integrated care plan; referral and related activities to help the recipient obtain needed services; monitoring and follow-up; and evaluation

Target Criteria

To be clinically eligible for BPHC, an individual must meet the following target group criteria:

- Be 19 years of age or older
- Have been diagnosed with a BPHC-eligible primary mental health diagnosis

Needs-Based Criteria

Based on the behavioral health clinical evaluation, referral form, supporting documentation and FSSA/DMHA-approved behavioral health assessment tool results, the applicant must meet all of the following needs-based criteria

- Demonstrated needs related to management of his/her behavioral and physical health
- Demonstrated impairment in self-management of physical and behavioral health services
- A health need which requires assistance and support in coordinating behavioral and physical health treatment, and
- A recommendation for intensive community-based care based on the uniform FSSA/DHA-approved behavioral health assessment tool as indicated by a rating of three or higher

Other Criteria

To be eligible for a BPHC, an individual must reside in a setting which meets federal setting requirements for home and community-based services. Each setting must be assessed independently to determine if an applicant resides in a community-based setting.

Financial Eligibility Criteria

An individual can have countable income up to 300% above the federal poverty line (FPL). These income limits are updated annually when the federal government releases the new FPL standards. Annual updates can be accessed in the Federal Register located at www.federalregister.gov/ upon publication. They are typically published in late January and become effective for Indiana Medicaid eligibility determinations in March or April. There are certain income disregards that may be applied that may decrease countable income. For example, if there are children or other qualifying dependents in the individual's household, an individuals incomes may be higher; specifically, a $361 per qualifying individual deduction may be applied. There is no asset limit for the program. Determination of financial eligibility is conducted by the Division of Family Resources.

For more information on BPHC, please visit the FSSA Behavioral and Primary Healthcare Coordination web page.

Care Coordination

Care coordination has been identified as an important way to improve how the healthcare system works for patients, especially in terms of improved efficiency and safety. Most importantly, care coordination applied in a targeted way has the potential for improved outcomes for patients, providers, and payers.

CareSource understands that coordinated care is key to ensuring optimal outcomes for our members. We ensure that all of our providers have access to behavioral health resources and that behavioral health is integrated across all interventions.

Care coordination can impact how one interacts with the health care system. Coordination of care between behavioral health and primary care contributes to:

- Elimination of disjointed care
- Provision of referral clarity
- Liaison between primary care and specialist
- Prevention of information loss
- Patient satisfaction
- Reduced malpractice risk
- Reduced duplication of medications
- Reduced duplication of services
- Increased medication adherence
- Increased quality of life and patient outcomes
- Better communication between behavioral health and physical health providers for coordination of care issues involving lost records, ensuring that means of care is as efficient as possible

Many members with a SMI diagnosis often present with co-occurring medical and behavioral health conditions. That is why care coordination between primary care physicians and behavioral health providers is important.

- Behavioral Health and Primary Care Provider Coordination of Care Form
- HIPAA Consent Authorization Form

Tobacco Resources

Premature death among people with SMI, including schizophrenia, has been recognized for some time. It is also known that unhealthy lifestyle behaviors such as a poor diet, a lack of exercise, and smoking contribute to many of their physical problems. People with schizophrenia are much more likely to smoke than people with no mental illness.

Smoking rates are three to five times higher in individuals with mental illness or SUD, compared to the general population. Also, mental health providers who see more patients with SMI have the lowest rates of intervention. Patients with mental illness who smoke tobacco products have less access to tobacco dependence treatment across the health care spectrum. These are all reasons why it's important for providers to screen their patients for tobacco use. CareSource offers additional smoking cessation tools to assist members in quitting smoking.

- Tobacco Cessation Flier
- E-Cigvaping Brochure

Members can access our Smoking Cessation webpage on CareSource.com for more information and resources.

CareSource also offers provider training on member tobacco cessation on our Training and Events page at **CareSource.com**.

Indiana Tobacco Quitline

The Indiana Quit Now Program has free materials for providers to have at their location. Providers can select the materials they would like to have on hand for their staff to distribute to patients. All materials may also be downloaded at Quit Now Indiana. Other resources and materials can be downloaded:

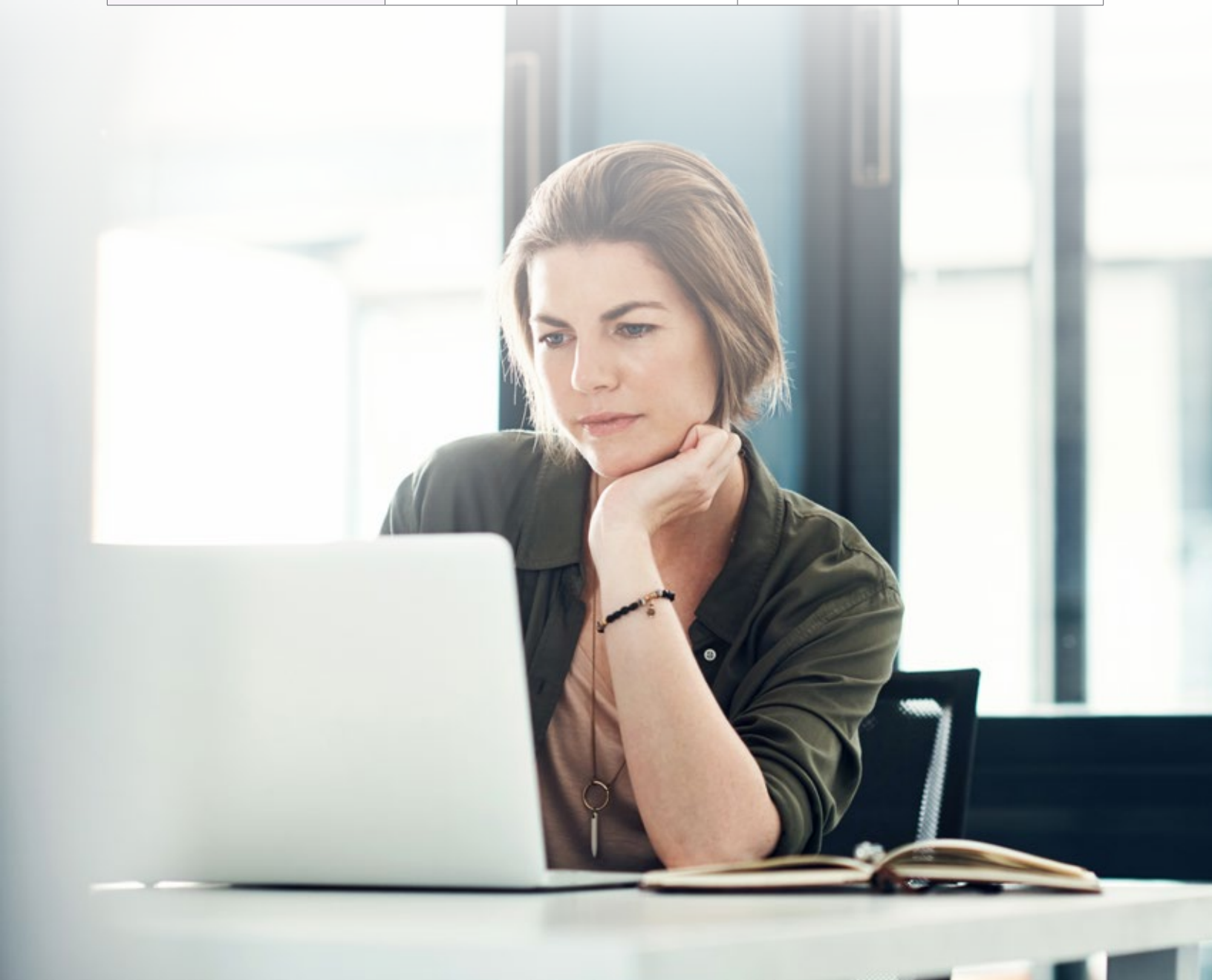
- Enroll as a Quit Now Preferred Provider
- Order Quit Now materials
- Quit Now online fax/referral form
- Text2Quit materials

Quality of Care

CareSource uses Health Effectiveness and Data Information Set (HEDIS) as one measure to determine the quality of care delivered to members. HEDIS is one of the most widely used means of health care measurement in the United States. HEDIS is developed and maintained by NCQA. The HEDIS tool is used by America's health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS benchmarks. HEDIS measures are based on evidence-based research and address significant health priorities in the United States.

Behavioral Health HEDIS Measures				
Measure	**Data Source**	**Denominator**	**Numerator**	**Included in HEDIS?**
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are using Antipsychotic Medications (SSD)	Claims	Members 18-64 years of age with schizophrenia or bipolar disorder and dispensed an antipsychotic medication	Members who had a glucose test or HbA1c test during the measurement year	Yes
Diabetes for Monitoring for People with Diabetes and Schizophrenia (SMD)	Claims	Members 18-64 years of age with schizophrenia and diabetes	Members who had an HbA1c test and a LDL-C during the measurement year	Yes
Cardiovascular Monitoring for People with Diabetes and Schizophrenia (SMC)	Claims	Members 19-64 years of age with schizophrenia and who were dispensed antipsychotic medications	Members who had a LDL-C test performed during the measurement year	Yes
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (APM)	Claims	Members 19-64 years of age with schizophrenia who were dispended antipsychotic medications	Members who achieved a proportion of days covered of at least 80% for their antipsychotic medications	Yes

Measure	Data Source	Denominator	Numerator	Included in HEDIS?
Adherence to Antidepressant Medication (AMM)	Claims	Members aged 18 and older who were treated with antidepressant medications, had a diagnosis of major depression, and remained on an antidepressant medication	Acute: Percentage of members who remained on an antidepressant medication for 12 weeks Continuation: Percentage of members who remained on an antidepressant medication for six months	Yes



Antidepressant Medication Management (AMM) Measure	
The Measure	• 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
The Rates	• **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 (six months)
Patient Education & Intervention	• Depression is common and impacts 15.8 million adults in the United States • Most antidepressants take one to six weeks to work before the patient will feel better • In many cases, sleep and appetite improve first whole improvement in mood, energy and negative thinking may take longer • The importance of staying on the antidepressant for a minimum of six months • Strategies for remembering to take the antidepressant on a daily basis • The connection between taking an antidepressant and signs and symptoms of improvement • Common side effects, how long they make last, and how to manage them • What to do if the patient has a crisis or has thoughts of self-harm • What to do if there are questions or concerns

Follow-Up After Hospitalization for Mental Illness (FUH) Measure	
The Measure	• This measure focuses on 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 with this measure: 1) The percentage of discharges for which the member received follow-up within 30 days after discharge 2) The percentage of discharges for which the member received follow-up within 7 days after discharge
The Rates	• 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 seven days after discharge
Patient Education & Intervention	• The literature indicates that during the first seven days post-discharge the member is at greater risk for rehospitalization and, within the first three weeks post-discharge, the risk of self-harm is high • Ensure that the follow-up appointment is made before the patient leaves the hospital and is scheduled within seven days of discharge; same-day outpatient visits count • Assist the patient with navigation of barriers, such as using their transportation benefit to get to their follow-up appointment • Review medications with patients to ensure they understand the purpose and appropriate frequency and method of administration • Ensure accurate discharge dates and document not just appointments scheduled, but appointments kept; visits must be with a mental health practitioner • Follow-up visits must be supported by a claim, encounter, or not from the mental health practitioner's medical chart • Since the window for timely follow-up is so brief, patients discharged to lower levels of care need to be documented accurately for the measure logic to be applied properly

Schizophrenia Management Background

Heart disease and diabetes are among the top 10 leading causes of death in the United States (NIMH, 2015). Because persons with serious mental illness who used antipsychotic are at an increased risk of cardiovascular disease and diabetes, screening and monitoring of these conditions is important. Lack of appropriate case for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life, and economic outcomes downstream.

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

People with schizophrenia are at a greater risk of metabolic syndrome due to their serious mental illness (Cohn, et al., 2004). Diabetes screening is important for anyone with schizophrenia or bipolar disorder, and the added risk associated with antipsychotic medications contributes to the need to screen people with schizophrenia for diabetes. Diabetes screening for individuals with schizophrenia or bipolar disorder, or who are prescribed an antipsychotic, medication may lead to earlier identification and treatment of diabetes. This measure guides the effort in measuring the quality and effectiveness of the care provided. The measure focuses on promoting recommended diabetes screening for schizophrenia and bipolar patients prescribed antipsychotic medications.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Measure	
The Measure	• This measure focuses on 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.
The Rates	• Glucose test or an HbA1c test • Diabetes screening
Patient Education & Intervention	• Review diabetes services needed at each office visit • Order labs prior to patient appointments • If point of care HbA1c tests are completed in-office, it is helpful to bill for this; also ensure HbA1c results and date are documented in the chart • For LDLs, if the patient is not fasting, order a direct LDL to avoid a missed opportunity; some lab order forms have conditional orders - if fasting, LDL-C; if not fasting, direct LDL • The BH provider can order diabetic lab tests for patients who do not have regular contact with their PCP but who regularly see the BH provider; the BH provider can then coordinate medical management with the PCP • Adjust therapy to improve HbA1c, LDL, and BP levels; follow-up with patients to monitor changes • If patient has a caregiver, make sure they are given instruction on the course of treatment, labs or future appointment dates • Regular monitoring of body mass index, plasma glucose level, lipid profiles, and signs of prolactin elevation should be done at each appointment • Continue to educate patients about appropriate health screenings with some medication therapies • Patients can be referred for health management interventions and coaching by contacting health care services • Care coordination with the patient's behavioral health provider is a key component in the development of a comprehensive treatment plan

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) Measure	
The Measure	• This measure focuses on the percentage of members 18-64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and a HbA1c during the measurement year.
The Rates	• LDL-C test • HbAtc test
Patient Education & Intervention	• Review diabetes services needed at each office visit • Order labs prior to patient appointments • If point of care HbA1c tests are completed in-office, it is helpful to bill for this; also ensure HbA1c results and date are documented in the chart • For LDLs, if the patient is not fasting, order a direct LDL to avoid a missed opportunity; some lab order forms have conditional orders - if fasting, LDL-C; if not fasting, direct LDL • The BH provider can order diabetic lab tests for patients who do not have regular contact with their PCP but who regularly see the BH provider; the BH provider can then coordinate medical management with the PCP • Adjust therapy to improve HbA1c, LDL, and BP levels; follow-up with patients to monitor changes • If patient has a caregiver, make sure they are given instruction on the course of treatment, labs or future appointment dates • Regular monitoring of body mass index, plasma glucose level, lipid profiles and signs of prolactin elevation should be done at each appointment • Continue to educate patients about appropriate health screenings with some medication therapies • Patients can be referred for health management interventions and coaching by contacting health care services • Care coordination with the patient's behavioral health provider is a key component in the development of a comprehensive treatment plan

Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) Measure	
The Measure	• This measure focuses on 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.
The Rates	• LDL-C test
Patient Education & Intervention	• Patients with schizophrenia and cardiovascular disease require care coordination between the primary care physician (PCP) and BH provider; this care coordination is a key factor in the development of a comprehensive treatment plan • Order labs prior to patient appointments • The BH provider can order lab tests who do not have regular contact with their PCP but who regularly see the BH provider; the BH provider can then coordinate medical management with the PCP • Review cardiovascular services needed at each office and ensure lipid levels, blood pressure, and glucose are monitored at every appointment • Educate the patient and caregiver about the risks associated with antipsychotic medications and cardiovascular disease and the importance of a healthy lifestyle; this includes nutrition, exercise, and smoking cessation • For LDLs, if the patient is not fasting, order direct LDL to avoid a missed opportunity • Adjust therapy to improve HbAic, LDL, and BP levels; follow up with patients to monitor changes • Patients can be referred for care management through CareSource

Antipsychotic Medication Adherence (SSD) Measure	
The Measure	• This measure focuses on 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.
The Rates	• Routine labs to check for SSD, SMD, and SMC
Patient Education & Intervention	• Schedule appropriate follow-up with the patients to access if medication is taken as prescribed • Continue educating patients about the importance of adhering to their medication therapy and follow-up visits with their providers • Patients with at least six chronic medications and at least three qualifying diagnoses may be eligible for Medication Therapy Management (MTM) sessions • For additional information about MTM criteria and to request a referral, contact Provider Services at CareSource • Do not rely on the patient to follow through with scheduling subsequent appointments; routinely arrange the next appointment when the patient is in office • If the patient misses a scheduled appointment, office staff should contact the patient to: assess why the appointment was missed, reschedule the appointment and assess the possibility of a relapse • Patients can be referred for care management through CareSource

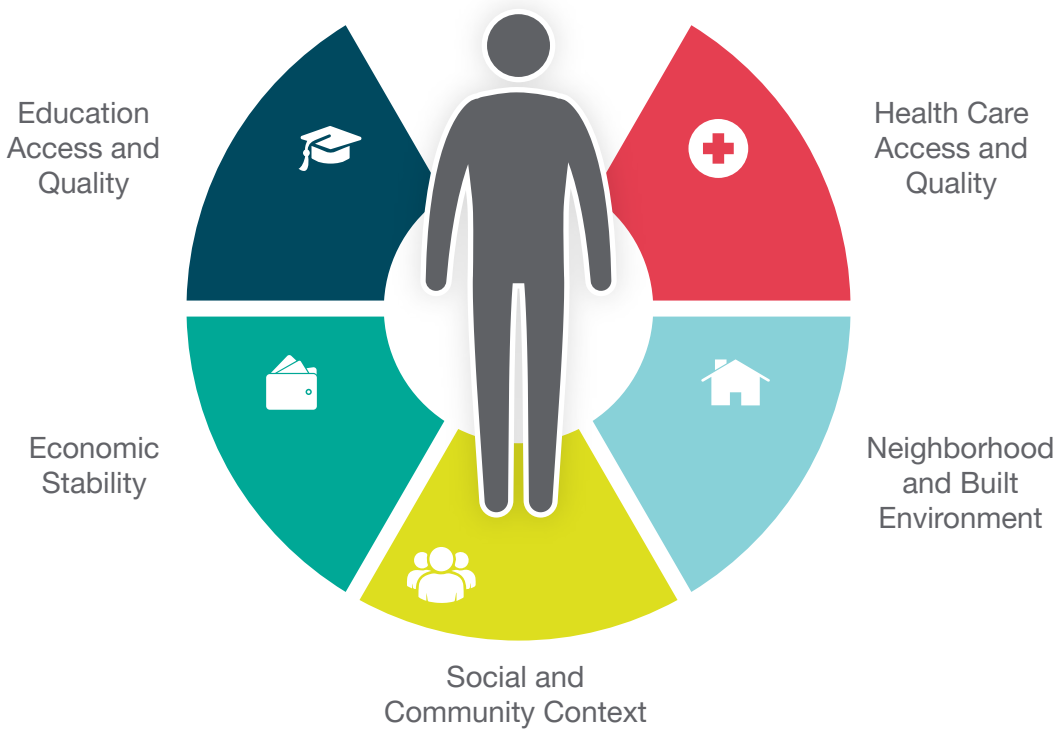
Health Disparities

Health disparities are the avoidable difference that result from cumulative social disadvantage, including health outcomes, health care access, coverage, and quality of care between group of people. Health disparities are often caused by systemic factors known as social determinants of health, which can include access to safe housing, healthy food, health services, transportation, public safety, media, and technology. Barriers to mental health and substance use treatment services can occur at three different levels: individual, organizational, and systemic. The barriers at the individual level are related to the individual's characteristics such as demographics, health beliefs and attitudes, personal enabling resources, perceived illness and personal health practices. The barriers at the organization level are related to provider and organization characteristics such as skills and attitudes. Barriers at the system level are related to the system characteristics in the organization of the health care system, including system-wide policies, cost of care, scope, and types of services offered (National Council for Mental Well Being).

Social Drivers of Health

A recent article and commentary in *JAMA Psychiatry* contains disturbing statistics about early death for people with serious mental illness (SMI). Mark Olfson's team followed a group of 1.1 million people with schizophrenia and found that, during the study period, they were more than 3.5 times more likely to die than the general population. These individuals are estimated to be losing 28.5 years of life, primarily because of natural causes. Eighty-five percent of the premature deaths were due to largely preventable conditions such as high blood pressure, high cholesterol, diabetes, and heart disease.

Premature death among people with SMI, including schizophrenia, has been recognized for some time. It is also known that unhealthy lifestyle behaviors such as poor diet, lack of exercise, and smoking contribute to many of their physical problems. People with schizophrenia are much more likely to smoke than people without mental illness (Jama Psychiatry).



Additional Resources

With the stresses of today's world, our mental health is as important as our physical health. For this reason, CareSource offers behavioral health as part of your patient's core benefits. This means that your patients can get counseling and substance use services from their CareSource health plan. CareSource offers additional support for your patients with a SMI diagnosis which can include the services described below.

Behavioral Health Benefits & Services

CareSource behavioral health benefits and services can be found on our website.

Integrated Care Management

A member can be linked with a social worker, nurse, or community health worker for ongoing support to help manage their medical and/or behavioral health conditions. Providers can refer members for care management through the Provider Portal at **CareSource.com** > Providers > Provider Portal LogIn or by calling Member Services at 1-844-607-2829.

Transition of Care

During or up to 30 days post-discharge from a behavioral health hospitalization, a member can be linked with a social worker or nurse to ensure they are connected to a behavioral health provider to receive the necessary follow-up care. Transition of care referrals can be made at 1-833-230-2032 ext. 1747462.

If you are not linked with a mental health provider, you can locate a provider using our Find-a-Doc tool.

myStrength™

There are benefits to having a member maintain a daily journal. Journaling can help to manage stress and anxiety through releasing emotions. It can be relaxing and therapeutic. myStrength is an online tool to help members live their best. Members will find help for stress, anxiety, chronic pain, and more. It's safe, secure, and personalized – just for members with their individual needs. Members can track their health and mood and enjoy activities that help them become inspired. Members can start at any time by registering on the website.

CareSource Rewards Program

Tell your patients how they can start earning rewards for medication adherence and completing health promoting behaviors. CareSource provides rewards to individuals who are ready to quit smoking. CareSource has an online health tool for our HIP and Hoosier Healthwise (HHW) members called MyHealth. They can access their account by creating or logging into their personal account at **CareSource.com** and begin redeeming their rewards.

Through the MyHealth app, HIP members can:

- Take a health needs screening (HNS) to see how they can improve their health and earn a $30 Walmart gift card.
- Learn more about the dangers of tobacco use and how they can stop using tobacco
- Get one-on-one coaching to stop using tobacco
- Can earn up to $200 in rewards for taking healthy steps to stop using tobacco products

Through the MyHealth app, HHW members can:

- Take a health needs screening (HNS) to see how they can improve their health and earn a $30 Walmart gift card.
- Learn more about the dangers of tobacco use and how they can stop using tobacco
- Get one-on-one coaching to stop using tobacco
- Can earn up to $20 in rewards for taking healthy steps to stop using tobacco products
- Those who have been diagnosed with a Major Depressive Disorder (MDD), had a behavioral health hospitalization, and attended their seven-day FUH appointment, are eligible to receive a $40 reward
- Those with specific chronic medical or behavioral health conditions who demonstrate medication adherence can be eligible to receive $15 per refill of a prescription up to four refills or $60 per calendar year
- Those with a SUD diagnosis and who attend IOP can receive up to $10 per session attended, up to $100 per calendar year

Rewards are claims-based and there is a maximum of $300 per member per year. Members can contact Member Services or access their online account to see which activities are eligible for rewards. Members can learn more about the rewards available and eligibility on our website.

CareSource Behavioral Health Toolkits

We provide tools and resources to help providers coordinate care across the physical and behavioral health continuum. Access the toolkits below for additional support in your practice:

- Suicide Prevention Toolkit
- ADHD Toolkit
- Depression Toolkit
- SUD Toolkit
- Tobacco Cessation Toolkit

Provider Community and Professional Support/Peer Support for Members

- American Psychiatric Association (APA)
- Treatment Advisory Center
- National Alliance of Mental Illness (NAMI)
- Mental Health America of Indiana (MHAI)
- Be Well Indiana
- Indiana Department of Mental Health Administration (DMHA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- 988 Crisis Hotline

References

American Psychiatric Association
What Are Bipolar Disorders? , What is Schizophrenia? , What is Depression?

Avalere
Medication Adherence Rates Low Among Patients with SMI

Department of Health and Human Services
Healthy People 2030: Social Determinants of Health

Erdman
Trends and Best Practices in Behavioral Health Environments

HealthStream
The Importance of Patient Care Coordination for Outcomes

JAMA Psychiatry
Premature Mortality Among Adults with Schizophrenia in the United States

National Alliance of Mental Illness
About Schizophrenia

National Council for Mental Well Being
Health Disparities & Social Determinants

National Institute of Mental Health
Substance Use and Co-Occurring Mental Disorders , Combatting Early Death in People with SMI

SAMHSA
Living Well with SMI

Treatment Advocacy Center

National Committee for Quality Assurace
https://www.ncqa.org/wp-content/uploads/HEDIS-MY-2024-Measure-Description.pdf

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