NCQA and HEDIS

Why Do I Need to Know About This?
NCQA

- NCQA, the National Committee for Quality Assurance, is a private, not-for-profit organization dedicated to improving health care quality.
- NCQA develops quality standards and performance measures for a broad range of health care entities.
NCQA accredits carriers by putting them through a comprehensive review of more than 60 standards.

Carriers are submitted to a triennial onsite review.

Carriers must also report annually on their performance.

NCQA develops statistics tracking the quality of care delivered by the nation’s health plans.
- NCQA claims these numbers have improved in the last five years.
- NCQA claims these improvements in quality care translate into lives saved, illnesses avoided and costs reduced.
The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service.

HEDIS consists of 75 measures across 8 domains of care, 4 of which are directly related to behavioral healthcare.

Designed and maintained by NCQA, HEDIS makes it possible to compare the performance of health plans.
Psychcare has been NCQA accredited since 2000.

Though Psychcare does not participate directly in the collection of HEDIS data, we assist our Health Plans in adhering to the measures that specifically relate to behavioral health services.
HEDIS Measures Relating to Behavioral Healthcare

Maintaining Clinical Gains Through Effective Discharge and Treatment Follow-up

- **Rationale:** Effective discharge planning is key to ensuring the ongoing health and well-being of a patient following acute care.

- Timely follow-up after hospitalization promotes continuity of care and supports a patient’s return to baseline functioning.

- The guidelines state:
  - Follow-up should occur with a behavioral health clinician within seven days of discharge.
  - Follow-up should occur with a behavioral health clinician within 30 days of discharge.
Psychcare case managers work closely with hospital discharge planners to ensure that a timely post discharge appointment has been scheduled with a practitioner.

This is sometimes challenging when an individual does not have a previous relationship with a behavioral health practitioner prior to their hospital admission.

Your help in ensuring timely and adequate follow-up for patients discharged from inpatient care is vital to facilitating therapeutic gains and successful outcomes.
Antidepressant Medication Management: Improving Treatment Compliance

- **Rationale:** Depression is the most common behavioral health condition affecting adults and it is one of the most treatable conditions.

- A key to successful treatment is compliance with medication and treatment recommendations.

- **HEDIS** has established two measures to monitor medication compliance for newly diagnosed patients with Major Depression, who are prescribed antidepressant medication. Compliance is monitored in the following ways:
  - The percentage of members with newly diagnosed Major Depression who stay on their meds at least 84 days (acute phase)
  - The percentage of members who stay in treatment for at least six months (continuation phase)
Antidepressant Medication Management: Improving Treatment Compliance - continued

- As a practitioner, you may receive notification that a member newly diagnosed with MDD, missed a refill on their medications.
- Please use these letters as a reminder to communicate with your patient as to why they did not refill their medications.
- Ideally a follow-up visit will be scheduled prior to the refill date, so that a patient can discuss any concerns they might have with regard to the medications.

- Ways to improve compliance with antidepressant medication:
  - Education regarding the medication, including time to response, and potential side effects.
  - Information regarding the expected length of treatment and outcomes.
Effective Treatment of ADHD

- **Rationale:** Attention Deficit-Hyperactivity Disorder is one of the most commonly diagnosed childhood behavioral health disorders.

- Symptoms are usually noticed first in preschool or early elementary school years.

- The effects of this disorder frequently persist into adolescence and adulthood and are frequently associated with comorbid conditions.

- Treatment works best with a team approach when behavioral health clinicians, teachers, parents, doctors and other healthcare professionals collaborate on care.

- It is important to monitor the child’s progress and visits with a behavioral health clinician are recommended at least monthly until optimal results are achieved.
Effective Treatment of ADHD - continued

- NCQA rates performance on the following HEDIS for children with newly diagnosed ADHD between 6-12 years of age:
  - The percentage with a new prescription dispensed for ADHD medication that had one follow-up visit with a MD within 30 days of the initiation of treatment (initiation phase)
  - The percentage with a prescription dispensed for ADHD medication that remained on the medication for at least 210 days and had at least two additional follow-up visits with a practitioner within nine months after the Initiation phase ends
Practitioners may help to improve treatment compliance by scheduling return appointments within 30 days of prescribing the medication.

Discussing with parents the expectations of medications and treatment as well as stressing the importance of compliance.

As a practitioner, you may receive notification that a member newly diagnosed with ADHD, missed a refill on their medications.

- Please use this as a reminder to contact your patient or schedule a follow-up visit.

The letters are not intended to dictate clinical practice, and should be used in conjunction with your clinical expertise.
The Use of High Risk Medication in the Elderly

- Rationale: Polypharmacy and the use of high risk medications in the elderly is a growing health concern.

- The use of multiple medications or those that fall into the high risk category, can present substantial risk of increased morbidity and mortality in this population.

- This HEDIS measure identifies patients 65 years of age or older at the end of the report period who received at least one (filled twice) or two different drugs to be avoided in the elderly.

- The HEDIS list of drugs to be avoided in the elderly is consistent with the revised Beers criteria with the exception of scopolamine and atropine.
As a practitioner, you may receive notification that one of your patients is receiving a high risk medication.

Please heed these letters as information which may affect the well being of your patient. Consider alternatives if appropriate.

The letters are not meant to dictate clinical practice, but are meant to serve as a guideline. Clinical expertise should dictate the care of your patients.
# Medications to Avoid in the Elderly*

<table>
<thead>
<tr>
<th>Description</th>
<th>Medications To Avoid</th>
<th>Adverse Side Effects/Concerns</th>
<th>Safer Alternatives¹ ²</th>
</tr>
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</table>
| Alpha agonists, central | *guanabenz*  
*guanfacine* | *methyldopa*  
*reserpine* *(doses greater than 0.1mg/day)* | High risk of central nervous system (CNS) effects; may cause bradycardia and orthostatic hypotension; not recommended for routine treatment of hypertension. |
| Analgesics | *indomethacin*  
*ketorolac* | | |
| Anti-anxiety | *aspirin-meprobamate*  
*meprobamate* | Addictive and sedating anxiolytic | Anxiety: selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), buspirone |
| Antidepressant, tricyclic | *amitriptyline*  
*clomipramine*  
*doxepin* *(doses greater than 6mg/day)*  
*imipramine*  
*trimipramine* | Highly anticholinergic effects; may cause orthostatic hypotension | Depression/Anxiety/OC D: Secondary Amine TCA’s *(nortriptyline, desipramine)*, SSRIs, SNRIs  
Neuropathic pain: gabapentin |
| Anti-emetics | *scopolamine*  
*trimethobenzamide*  
*promethazine* | Extrapyramidal adverse effects | ondansetron, dolasetron *(Anzemet)* |
| Antihistamines (includes single entity or as part of a combination product) | *brompheniramine*  
*carbinoxamine*  
*chlorpheniramine*  
*clemastine*  
*cyproheptadine*  
*dexbrompheniramine*  
*dexchlorpheniramine*  
*diphenhydramine* *(oral)*  
*doxylamine*  
*hydroxyzine*  
*hydroxyzine pamoate*  
*promethazine*  
*triprodilide* | Highly anti-cholinergic effects and sedation, weakness, blood pressure changes, dry mouth, urinary retention; clearance reduced in advanced age.  
Tolerance develops when used as hypnotic. | Pruritus/urticaria: fexofenadine, levocetirizine, fluticasone,  
Nausea/vomiting: ondansetron  
Allergic rhinitis: levocetirizine, fexofenadine, azelastine, |
**Medications to Avoid in the Elderly**

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<td>Anti-infectives (Note: when cumulative days' supply greater than 90 days)</td>
<td>• nitrofurantoin</td>
<td>Potential for pulmonary toxicity; nitrofurantoin causes renal impairment. Avoid in persons with a CrCl &lt; 60mL/min due to inadequate drug concentration in the urine.</td>
<td>Dependent on the infection: sulfamethoxazole/trimethoprim, ciprofloxacin, cefalexin</td>
</tr>
<tr>
<td>Anti-parkinson agents</td>
<td>• benztropine (oral)</td>
<td>Not recommended for prevention of extrapyramidal symptoms with antipsychotics.</td>
<td>ropinirole (Requip) amantadine pramipexole (Mirapex)</td>
</tr>
<tr>
<td>Antipsychotic, typical</td>
<td>• mesoridazine</td>
<td>Highly anti-cholinergic; CNS and extrapyramidal effects; greater risk of QT interval prolongation</td>
<td>olanzapine (Zyprexa), quetiapine (Seroquel), risperidone (Risperdal), pimozide (Orap), trifluoperazine</td>
</tr>
<tr>
<td>Anti-thrombotic</td>
<td>• dipyridamole, oral short-acting only</td>
<td>Dipyridamole may cause orthostatic hypotension; more effective alternatives are available.</td>
<td>aspirin/dipyridamole extended-release capsules, low-dose aspirin</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>• amobarbital</td>
<td>High rate of physical dependence; patients develop tolerance which reduces sleep benefits; greater risk of overdose at low dosage.</td>
<td>Seizure: Seizure type dependent. Please note: Patients being switched off barbiturates should be tapered slowly over a prolonged period of time.</td>
</tr>
<tr>
<td>Calcium channel blockers</td>
<td>• nifedipine – short-acting only</td>
<td>Potential for hypotension; risk of causing myocardial ischemia.</td>
<td>Use long-acting formulation to avoid adverse effects: felodipine, nifedipine-long-acting (nifedipine ER)</td>
</tr>
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¹² These drugs have been recommended due to their potential for adverse effects or interactions in the elderly population.
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| Cardiovascular  | - digoxin *(doses greater than 0.125mg/day)*  
                 | - disopyramide                                                                         | **Digoxin:** in heart failure, higher doses have increased risk of toxicity with no additional benefits;  
                 |                                                                     | **Disopyramide:** potent negative inotrope that may induce heart failure in older adults;  
                 |                                                                     | anti-cholinergic effects                                      | **Heart failure:** digoxin 0.125mg, ACEI (lisinopril, quinapril, enalapril) or ARB (losartan) and/or a beta blocker (metoprolol XL, bisoprolol, carvedilol) instead of digoxin |
| Endocrine       | - megestrol                                                                           | Increases risk of thrombotic event and possibly death in older adults                      | Consider nutritional support and treatment of potential cause (e.g., depression in the elderly, certain medications); consider dronabinol for anorexia associated with weight loss in patients with AIDS or for nausea and vomiting in chemotherapy patients who failed to respond adequately to conventional treatments.  
                 |                                                                     | **OTC Benefit:** Almebex Plus                                                        |                       |
| Narcotics       | - acetaminophen-pentazocine  
                 | - belladonna-opium                                                                     | **Meperidine** may not be effective at commonly prescribed doses; side effects include confusion, falls, fractures, dependency and withdrawal.  
                 | - meperidine                                                                          | **Pentazocine** produces high CNS-adverse effects (e.g., confusion, hallucinations). |                       |
                 | - meperidine-promethazine                                                             |                                                                     |                       |
                 | - naloxone-pentazocine                                                                |                                                                     |                       |
                 | - pentazocine                                                                         |                                                                     |                       |
### Medications to Avoid in the Elderly*

#### Description
- Nonbenzodiazepine hypnotics

#### Medications To Avoid
- Lunesta (eszopiclone)
- Sonata (zaleplon)
- Ambien (zolpidem)
- chloral hydrate

#### Adverse Side Effects/Concerns
- **Chloral hydrate:** Tolerance develops within 10 days; risks outweigh benefits: delirium, risk of overdose (narrow therapeutic window)

#### Safer Alternatives
- Consider only short-term or intermittent use (less than 90 days per year).
- Discuss sleep hygiene and avoidance of caffeine, alcohol, nicotine and medications that cause insomnia.
- Evaluate for depression, a common cause of insomnia in the elderly. Secondary insomnia can be treated with trazodone 50 mg (may cause orthostatic hypotension) or doxepin (less than 6 mg per day).
- Over-the-counter option: melatonin, if appropriate; regarded as safe in recommended doses (up to 15 mg daily) for up to two years.

#### Oral estrogens and estriadiol transdermal patch
- conjugated estrogen
- conjugated estrogen-medroxyprogesterone
- estrified estrogen
- esterified estrogen-methyl-testosterone
- estropipate
- estradiol
- ethinyl estradiol/norethindo ne

#### Adverse Side Effects/Concerns
- Cardio-protective properties are absent; high carcinogenic effects (breast cancer and endometrial cancer)

#### Safer Alternatives
- Hot flashes: nondrug comfort therapy, SSRIs, venlafaxine
- Vaginal dryness: Premarin vaginal cream
- Bone density: calcium, vitamin D, alendronate, raloxifene, miacalcin
## Medications to Avoid in the Elderly* - continued

### Description | Medications To Avoid | Adverse Side Effects/Concerns | Safer Alternatives¹,²
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Oral hypoglycemics | • chlorpropamide  
• glyburide | Prolonged half-life causing prolonged hypoglycemia; also causes syndrome of inappropriate anti-diuretic hormone secretion | glimepiride, glipizide, glipizide/metformin

Skeletal muscle relaxants | • ASA/caffeine/orphenadrine  
• ASA/carisoprodol/codeine  
• aspirin-carisoprodol  
• carisoprodol  
• chlorzoxazone | Anti-cholinergic effects, sedation, weakness and increased risk of fractures.  
Poorly tolerated; effectiveness at doses tolerated by older adults is questionable. | baclofen, tizanidine

Thyroid | thyroid desiccated | Cardiac concerns | levothyroxine

Vasodilators, for dementia | • dipyridamole – short-acting only  
• ergot mesylate  
• isoxsuprine | Orthostatic hypotension | aspirin/dipyridamole extended-release capsules (Aggrenox), low-dose aspirin

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*List of Medications to Avoid obtained from the PQA June 2012 Technical Specifications Manual

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References:

