QI 9: Clinical Practice Guidelines

Element A: ABH adopts evidence-based clinical practice guidelines for at least three behavioral conditions, with at least one guideline addressing children and adolescents, by:

1. Establishing the clinical basis for each guideline.
2. Updating each guideline at least every two years.

Element B: ABH annually measures performance against at least two important aspects of each of the three clinical practice guidelines.

Purpose

Report date March 1, 2024

The ABH Data Manager provided 2023 data to tables for each measure. The formal review of the Clinical Practice Guidelines and this report will occur March 7, 2024 during the Quality Subcommittee meeting to analyze results. The ABH Director of Quality Management and Improvement will then update this report to reflect the analyses determined by the Quality Subcommittee. Final review and determination by the Quality Management Committee will occur in June 2024, see minutes.

The clinical practice guidelines (CPGs) provide guidance for physicians and clinicians who prescribe psychotherapeutic medications for the treatment of behavioral health conditions. (American Psychiatric Association: https://www.psychiatry.org and www.aacap.org .) The guidelines indicate that following the initiation of a psychotherapeutic medication, members need follow up appointments to assess for therapeutic improvement and to determine the need for medication continuation or adjustments in medication. Access Behavioral Health (ABH) reviews the CPGs at least every two (2) years to ensure the most recently published guidelines are included.

In 2017, ABH created clinical practice guideline (CPG) studies to measure the adherence in meeting the treatment guidelines for newly diagnosed behavioral health conditions. In 2022, ABH QI-UM Subcommittee reviewed the existing CPG studies to determine if national guidelines had been updated. During the Committee discussion, it was determined that the 2019 update by the American Psychiatric Association was just a draft, later finalized in 2020. This revised CPG was accepted and adopted by ABH and linked to the ABH website (www.abhfl.org). The guidelines for ADHD were revised most recently in 2007 by the American Academy of Child & Adolescent Psychiatry and are currently available through the ABH website. Disruptive Mood Dysregulation Disorder is considered a newer diagnosis as it was first described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published in 2013. There are no current published clinical practice guidelines, therefore, the expert opinion of the ABH Medical Director was used in making treatment recommendations.

The QI-UM Subcommittee determined there will again be three (3) clinical practice guidelines for 2020 – 2023. The first study, Clinical Issue 1, follows the percentage of children aged 6-12 newly diagnosed with ADHD who had at least one follow-up visit with a mental health practitioner 30 days after initial diagnosis. Two additional follow-up visits must be attended within 150 days after the initiation phase, with a 180 days total in the study. The committee also determined that it was appropriate to add H2019HR to the outpatient follow up codes in accordance to the clinical practice guidelines for ADHD. The QI-UM Subcommittee discussed replacing the existing (2017) CPG addressing Depression and determined it would be more meaningful to identify another guideline addressing children. Therefore, Clinical Issue 2 was updated to reflect Disruptive Mood Dysregulation Disorder (20%) being diagnosed in children between the ages of 13 and 17, in addition to ADHD. The study design will mirror that of Clinical Issue 1. Clinical Issue 3 was updated to include Schizoaffective Disorder, the methodology did not change. Clinical Issue 3 determined the percentage of adults newly diagnosed with schizophrenia or schizoaffective disorder who had at least one follow-up visit with a prescribing practitioner within 30 days and the percentage of members who had at least two additional follow-up visits within 150 days after the initiation phase (180 days total in the study).

Methodology

ABH uses claims data to identify newly diagnosed members and follow-up visits for each study. "Newly diagnosed" members are defined as having the appropriate ICD 10 code for their diagnosis linked with an H2000HO (psychological evaluation by a non-psychiatrist) or H2000HP (psychological evaluation by a psychiatrist) visit, with or without a telehealth modifier. Follow-up visits are T1015 (medication management), with or without a telehealth modifier. As recommended by the clinical practice guidelines used for the study, members in the ADHD and DMDD CPG studies can also have a H2019HR (individual/family therapy) follow-up visit, with or without a telehealth modifier. The members had to be continuously enrolled during the aspect periods, which is July 1 of the prior year to June 30 of the measurement year. The clinical practice guidelines are reviewed every two years, as needed. ABH also discusses methodological changes, if necessary.

Clinical practice guidelines can be found on the ABH website: https://abhfl.org/information-providers/treatment-guidelines/

Clinical Issue 1: ADHD (F90 ICD Codes)

Aspect 1 (Initiation Phase): Percentage of children ages 6 to 12 newly diagnosed with ADHD who had one follow-up visit with a mental health practitioner within 30 days of diagnosis.

Aspect 2 (Continuation Phase): The percentage of members who passed Aspect 1, and who had at least two follow up visits within 150 days with a mental health practitioner after the initiation phase ended (180 days total in the measure).

	2019	2020	2021	2022	2023
	Aspect 1 (Initiation Phase)				
Goal	43.41%	43.41%	44.52%	39.82%	44.21%
Rate	39%	42%	41%	37.0%	46%
	Aspect 2 (Continuation Phase)				
Goal	55.90%	55.90%	54.73%	54.73%	54.40%
Rate	46%	53%	52%	52%	50%

* Goals are based on the 50th percentile as defined by NCQA.

Qualitative Analysis

April 2023 analysis for 2022:

The benchmark for the ADD CPG is the 50th percentile as defined by the National Committee for Quality Assurance (NCQA). The compliance rate for the initiation phase has decreased year over year since 2020. Providers attribute this to members receiving care from PCPs for ADHD. ABH does not receive claims when services are rendered by PCPs/pediatricians and the compliance rate for this measure is determined via claims submission. Those members who do receive services from behavioral health providers for ADHD consistently follow up with providers as evidenced by consistent year over year rates for compliance with the continuation phase.

Quarterly Quality meetings with Behavioral Health Homes continued in 2022. During these meetings, Clinical Practice guidelines were discussed and barriers and interventions were obtained from the providers.

Analysis for 2023

Completed June 18, 2024

The ABH Data Department presented quantitative information to the Quality Subcommittee in March 2024 regarding the diagnoses most often given to adolescent members. The findings revealed that for children aged 13-18, that 24.73% of services fell into the diagnostic category of Child and Adolescent Non-Psychotic Disorders. ADHD is included in this diagnostic category and in 2023 accounted for 85.39% of the diagnoses given within the category (the remainder were Oppositional Defiant Disorder and Conduct Disorder). This led to the continuation of this as a Clinical Practice Guideline.

The benchmark for the ADD CPG is the 50th percentile as defined by NCQA. The benchmark fluctuated year over year with an increase from 2022 at 39.82% to 2023 at 44.21% for the initiation phase. ABH exceeded the 50th percentile in 2023 with a compliance rate for the initiation phase of 46%.

The compliance rate for the continuation phase was maintained at 52% for 2021 and 2022 with a decrease to 50% in 2023. Providers attribute this to members receiving ongoing care from PCPs/pediatricians following the initial diagnosis by a behavioral health provider for ADHD. ABH does not receive claims when services are rendered by PCPs/pediatricians and the compliance rate for this measure is determined via claims submission.

Clinical Issue 2: Disruptive Mood Dysregulation Disorder (ICD Codes F34.81)

Aspect 1: The percentage of members aged 13-17 newly diagnosed with Disruptive Mood Dysregulation Disorder who had at least one follow-up visit with a mental health practitioner within 30 days of diagnosis.

Aspect 2: The percentage of members who passed Aspect 1, and who had at least two additional follow-up visits with a mental health practitioner within 150 days after the initiation phase ended (180 total in the measure).

	2019	2020	2021	2022	2023
Aspect 1	38%	36%	43%	38%	28%
Aspect 2	46%	42%	52%	46%	40%

Qualitative Analysis

April 2023 analysis for 2022:

Quarterly Quality meetings with Behavioral Health Homes continued in 2022 and included discussion of barriers for this CPG. During these meetings, Clinical Practice guidelines were discussed and barriers and interventions were obtained from the providers. Feedback from providers reflects that targeted interventions for those diagnosed with Disruptive Mood Dysregulation Disorder (DMDD) are challenging. Providers indicate that they see this diagnosis most often for those individuals who have been

discharged from a behavioral health hospitalization. The member then engages in outpatient services and the diagnosis is often updated by the outpatient psychiatrist or prescriber.

Analysis for 2023:

Completed June 18, 2024

On March 8, 2024 the Quality Subcommittee reviewed data supplied by Data Manager which reflects the top three diagnosis categories of Depression, Anxiety, and Child and Adolescent Non-Psychotic D/O which account for 75% of all services rendered in 2022 and 2023 based on claims data. The descriptive diagnoses for each category were also reviewed and discussed by the subcommittee. Disruptive Mood Dysregulation Disorder falls into the Depression category.

There is not a benchmark as identified by NCQA for this measure. The Quality Subcommittee monitors the compliance rates and continues to work with Behavioral Health Homes during quarterly quality meetings to ensure continuous quality improvement and compliance with this guideline. A decrease in performance was noted for both phases of this CPG in 2023 when compared to 2022.

The subcommittee discussed the increased focus of integration between primary care and behavioral health practitioners on site. One consideration for the decreased performance is the use of behavioral health providers within medical settings, thus the claims are processed through the medical side of the plan, not ABH. ABH does not have access to the data from the medical side of the plan.

Clinical Issue 3: Schizophrenia & Schizoaffective (F20 & F25 ICD Codes)

Aspect 1: The percentage of members aged 19-64 newly diagnosed with Schizophrenia or Schizoaffective disorder who had at least one follow-up visit with a practitioner with prescribing authority within 30 days.

Aspect 2: The percentage of members who passed Aspect 1, and who had at least two additional follow-up visits with a practitioner with prescribing authority within 150 days after the initiation phase ended (180 days total in the measure).

	2019	2020	2021	2022	2023
Aspect 1	51%	41%	61%	38%	26%
Aspect 2	44%	38%	44%	39%	43%

April 2023 analysis for 2022:

Quarterly Quality meetings with Behavioral Health Homes continued in 2022. During these meetings, Clinical Practice guidelines were discussed and barriers and interventions were obtained from the providers. Many providers expressed that there are alternative funding sources that support individuals with these diagnoses (CAT, FACT, MRT, EPIC, etc.). This data is not currently available to ABH from the Behavioral Health Homes. This was identified as an opportunity for improvement for 2023.

This CPG is similar to the HEDIS measure SAA: Adherence to antipsychotic medications for individuals with schizophrenia. CPG results reflect appointment adherence instead of the HEDIS SAA results which reflect medication adherence. ABH does not have access to pharmacy data. For SAA, the final rate for 2022 was 62.13% with benchmark at 61.39%. This suggests that those with these diagnoses are

medication compliant, despite not attending their follow up appointments and/or their follow up services are provided by alternate funding sources.

Analysis for 2023

Completed June 18, 2024

Aspect 1 of this clinical practice guideline reflects a decrease in performance from 2022 to 2023 of 12 percentage points. There is not a benchmark as identified by NCQA for this measure. The Quality Subcommittee monitors the compliance rates and continues to work with Behavioral Health Homes during quarterly quality meetings to ensure continuous quality improvement and compliance with this guideline. The primary identified barrier to this measure is the low denominator. The denominator accounts for only new diagnoses of schizophrenia and schizoaffective disorder. This population is small to begin with and the denominator decreases yearly as there are not many "new" instances.

	Aspect 1		Aspect 2	
Measurement Yr	Numerator	Denominator	Numerator	Denominator
2021	47	78	30	69
2022	20	53	18	46
2023	14	54	20	47

Aspect 2 of this clinical practice guideline reflects performance improvement of 4 percentage points. Inclusion of data from alternate funding sources provided by ABH's largest BHH had the desired effect of improving aspect 2 of this CPG.

This CPG is similar to the HEDIS measure SAA: Adherence to antipsychotic medications for individuals with schizophrenia. CPG results reflect appointment adherence instead of the HEDIS SAA results which reflect medication adherence. ABH does not have access to pharmacy data. For SAA, the projected final rate for 2023 as of May 2024 was 68%. This is an increase from 2022 and continues to exceed the benchmark as defined by NCQA for the 50th percentile. This indicates that members who have these diagnoses are compliant with their medications as prescribed.