CDPHP Launches Opioid Initiative

By Tara M. Thomas, RPh, MBA, BCPS
Medicaid Pharmacy Program Manager, Lead for State Programs

Over the past two decades, sales of prescription opioids in the U.S. nearly quadrupled.

This has led to an increase in abuse and diversion of these prescribed medications. According to the CDC, deaths from prescribed opioids have quadrupled over this same time frame. Heroin-related deaths are surging as well, highlighting the devastating connection between prescription opioids and illicit drugs. Research has shown that 75 percent of heroin users started with prescription opioids. This epidemic is tearing apart families and communities, including here in the Capital Region.

Opioid medications provide relief for many responsible, compliant patients who benefit from their powerful, pain-reducing effects. To combat the opioid and heroin epidemic, stakeholders across the health care industry are challenged with balancing access to opioid medications and preventing misuse and abuse. CDPHP leadership and subject matter experts are working to understand the intricacies of this epidemic, map out a strategic approach, and develop a multi-prong strategy to support the Capital Region, our members, and the physician community.

As a non-profit, physician-governed health plan, CDPHP is in a unique position to make an impact on the overutilization of opioids through a partnership with our providers. Our Opioid Initiative consists of four core elements: promoting judicious prescribing practices; promoting improved outcomes for members; identifying overuse, misuse, and fraud; and building community coalitions. It will also incorporate recommendations from recently updated CDC and U.S. Department of Veterans Affairs guidelines, as well as initiatives proven to be effective by other health plans. These will guide formulary and policy changes that will go into effect January 1, 2018.

Elements of the CDPHP Opioid Initiative will be rolled out over the next year.

The goals are as follows:

- Provide affordable, accessible, and appropriate pain care
- Prevent those newly prescribed opioids from becoming chronic, opioid-dependent patients
- Support efforts to discontinue or taper patients off high-dose opioids
- Educate providers, members, and employees of CDPHP on appropriately treating chronic pain
- Reduce diversion of prescription medications
- Support members who need treatment for substance use disorders
The effectiveness of collaborative initiatives to improve the appropriate diagnosing, treatment, and referring of members with depression is measured with the HEDIS Antidepressant Medication Management (AMM) metric. This metric measures the percentage of adult members with a new diagnosis of major depression, who were treated with antidepressants, and who remained on them for treatment.

CDPHP interventions in 2014-2015 included informational mailings tailored to members and providers; on-site visits by the Enhanced Primary Care (EPC) team to high-volume primary care providers to educate on depression, which included distributing tools to assist with treating and referring members with depression; informational articles about depression in provider newsletters; and including HEDIS measures in EPC payment models.

After a review of provider-focused interventions, member non-persistence was identified as an additional driver of the results for 2014-2015. According to interviews with area providers, patients chose to stop taking a medication after starting it, without being advised by their doctor. Most patients who stop taking the medication do so within the first six months of starting.

These efforts were general in nature and not as focused on improving adherence. Planned actions for member experience were as follows:

- A provider letter was mailed monthly to all EPC providers who had a member on the AMM gap list. It explained that patients beginning antidepressant medications should be closely monitored to assess side effects, clinical condition, safety, and their response to pharmacotherapy, as well as prevent clinical worsening, relapse, and medication nonadherence. The American Psychiatric Association guideline, which recommends assessing patients at least six times during the first three months of initiating an antidepressant drug, was also included. In addition, a list of specific members who fell within the AMM metric and were attributed to that provider was enclosed.

- Pay-for-performance strategies were used to improve outcomes for patients with depression.

- Increased BH case management and physician engagement support were offered to offices that had members on the AMM HEDIS gap list, along with the Recognizing the Signs and Symptoms of Depression flyer and PHQ-9 with instructions.

Additional analysis continues. CDPHP will monitor results over time and compare them year over year to our goals.

CDPHP AFTER-HOURS CRISIS HOTLINE

As an additional, no-cost benefit to our members, CDPHP provides after-hours crisis services to supplement on-call behavioral health providers. The line affords members emotional support and crisis de-escalation, suicidal assessment, links to community resources, and follow-up services to ensure ongoing safety. The crisis line is available after-hours (6 p.m. to 8 a.m., as well as weekends and holidays). Members can reach the line via the CDPHP Behavioral Health Access Center at 1-888-320-9584 (a message prompts the member to select option 1).
Psychopharmacological Medications: Follow-Up Care for Children Prescribed ADHD Medications

Because of the over-diagnosis of ADHD, and the resulting over-prescribing of medications used to treat its symptoms, CDPHP began collaborative interventions with PCPs and behavioral health clinicians in 2014. The purpose was to educate providers on best practices to treat members on ADHD medications, encourage collaboration with multidisciplinary treatment teams, and ensure access to follow-up visits to appropriately monitor and manage the condition. Results of this study will be used to evaluate trends, provide education, and enhance access to care.

The appropriate use of psychotropics was measured by the collaborative efforts between medical and behavioral health providers to improve the HEDIS measure, Follow-Up Care for Children Prescribed ADHD Medication (ADD). This metric measures the percentage of children newly prescribed medication who had at least three follow-up visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.

The outreaches to the provider community, both to PCPs and behavioral health clinicians during 2015, demonstrated that more collaboration between members, providers, and CDPHP is necessary. To further develop interventions to increase performance success, CDPHP discussed and analyzed interim ADHD results with committees and hospitals. From these discussions, the following areas were identified for further action:

- An analysis of outcomes determined that member-only outreach did not address the larger volume of local PCPs and that the focus should remain centered on medical community outreach since it prescribes the vast majority of members with psychotropics. The coordination of care between PCPs and behavioral health clinicians may be increased by providing PCPs with education surrounding appropriate indications for prescribing and treating members with psychotropic medications.

To further educate PCPs on assessing mental health issues and appropriate indications for prescribing and treating members with psychotropics, an area psychiatrist conducted lunch-and-learn training sessions. The PCPs who attended were provided with a free psychiatric telephonic consultation line to assist them with evaluating symptoms and adhering to psychotropic prescription guidelines.

Further data collection, barrier analysis, and the effectiveness of the chosen opportunities for improvement will be documented in future reports.

CDSS Program Provides Extra Level of Support

CDPHP has partnered with Rehabilitation Support Services on its Capital District Stabilization & Support (CDSS) program to assist members who require hospital step-down or hospital diversion with connecting to a short-term stabilization residence.

Located in Albany, the CDSS program is available to adults 18 and older who need a permanent residence and are in a situational crisis requiring an added level of support. The program offers individual and group counseling from trained mental health professionals, peer counseling, 24/7 access to staff, medication supervision, connections to after-care and follow-up options, and coordination and consultation with treatment providers. Services provided through the CDSS program are paid for by the Office of Mental Health.

For assistance with making a referral to the CDSS program, please contact the CDPHP Behavioral Health Access Center at 1-888-320-9584 and ask to speak with a behavioral health case manager.
HARP Updates

Medicaid Behavioral Health Benefits

The New York State Office of Alcohol and Substance Abuse Services (OASAS), Office of Mental Health (OMH), and Department of Health (DOH) transitioned certain Medicaid fee-for-service behavioral health services to Medicaid managed care health plans, effective July 1, 2016, for Medicaid adult recipients 21 and older. New York seeks to create an environment where managed care plans, service providers, peers, families, and the government partner to help members prevent chronic health conditions and recover from serious mental illness and substance use disorders. The partnership is based on the following values:

**Person-Centered Care:** Care is self-directed whenever possible and includes shared decision-making approaches that empower people, provide choice, and minimize stigma. Services are designed to optimally treat illness and emphasize wellness and attention to the entire person.

**Recovery-Oriented:** The system includes a broad range of services that support recovery from mental illness and/or substance use disorders. These services support the acquisition of living, vocational, and social skills and are offered in settings that promote hope and encourage people to establish an individual path to recovery.

**Integrated:** All providers of care focus on physical and behavioral health needs and actively communicate with care coordinators and other providers to ensure health and wellness goals are met. Care coordination activities are the foundation for all care plans.

The adult transition includes two components: new benefits for some Medicaid members with moderate needs and the availability of a Medicaid product called the Health and Recovery Plan (HARP) for those needing more intensive services. HARP members who meet additional need-based criteria are eligible for an enhanced benefit package of Behavioral Health Home and Community Based Services (BH HCBS). Enhanced HCBS benefits include rehabilitation, habilitation, respite crisis intervention, educational support, employment support, family support, and training and peer support services. HARPs, in collaboration with regional health homes, provide enhanced care management to help coordinate all physical health, behavioral health, and non-Medicaid support needs.

All Medicaid members are eligible for individualized case management and the following services even if they are not in HARP:

- Alcohol and substance abuse services and mental health inpatient treatment programs
- Alcohol and substance abuse services and mental health clinic services
- Personalized recovery-oriented services (PROS)
- Intensive psychiatric rehabilitation treatment (IPRT)
- Continuing day treatment (CDT)
- Assertive community treatment (ACT)
- Comprehensive psychiatric emergency program (CPEP)
- Partial hospitalization
- Opioid treatment
- Outpatient chemical dependence rehabilitation
- Rehabilitation support for community residences
HARP Short-Term Crisis Respite

Short-term crisis respite is a benefit available to all HARP-enrolled members. The member must be experiencing a non-life-threatening crisis and be willing to stay voluntarily, be evaluated by a treating professional that includes undergoing a BH HCBS assessment (if not already completed), and be willing to authorize the release of medical records by relevant treating providers. The referrals may come from an emergency department, community-based providers, a treatment team, or as a step-down from an inpatient unit.

Certain limitations and exclusions apply:

- A stay greater than 72 hours requires prior authorization.
- Stays cannot be longer than one week per episode.
- Stays cannot exceed a maximum of 21 days per calendar year.
- Members cannot have a diagnosis of dementia, organic brain disorder, or TBI; acute medical conditions; be an imminent risk to self or others; or display symptoms of an active substance use disorder.
- Only members who have a permanent residence qualify.

Unity House and People, Inc. offer this service to HARP members. For more information, please contact the Behavioral Health Access Center at (518) 641-3600.

Are Your Patients Eligible for HARP but Not Enrolled?

Providers have reported that some Medicaid Select Plan members are HARP-eligible but are not enrolled in the CDPHP HARP plan. This is evident in eMedNY, with H1 denoting HARP-enrolled and H9 indicating HARP-eligible. Many of these members would benefit from the additional services and support available through the HARP plan, such as health home care management and the new Home and Community Based Services (HCBS). If your patients are interested in these benefits, and they are eligible but not enrolled, you can direct them to call New York State Medicaid Choice, the New York State Medicaid broker, at 1-800-505-5678 (TTY: 1-888-329-1541) to enroll. HARP enrollment and plan renewal are not available online at this time. As a provider, you can offer assistance with making this call, if needed. More information is available at www.nymedicaidchoice.com.
Anxiety and Addiction: The Clinical Distinctions between Klonopin and Xanax

By Paul D. Schefflein, MD
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Since the late 1950s, benzodiazepines have been a staple of psychiatric treatment for anxiety disorders. Beginning with Librium, benzodiazepines became a frequently reproduced drug, albeit under different brand names. Many times, a patient will enter an ER and present symptoms that mimic a heart attack, only to be prescribed Xanax and referred to a psychiatrist. It is now the psychiatrist’s duty to make a correct diagnosis and use his/her clinical understanding of the different benzodiazepine options to construct an effective treatment plan.

Although the umbrella affliction of “anxiety disorder” is the most common psychiatric problem, successful results do not nearly match the number of cases presented. Mistakes that occur in a physician’s treatment can be erased by following three basic principles, or the 3Ds: diagnosis, dosage, and duration of action. An effective treatment is contingent on following these criteria.

To correctly ascertain a diagnosis, a physician must first use a series of questions aimed at clarifying the extent of the anxiety disorder. First, a symptom gradation can be offered, ranging from mild (shortness of breath, chest pain, increased heart rate, dizziness) to more severe presentations (sweats, palpitations, fear of fear). Although this gradation can give a clearer picture of the severity of anxiety, it does not eliminate the possibility of traumatic event-induced anxiety. For this, a qualifying question is used to distinguish natural causes of anxiety from a prolonged disorder, giving the patient the options of “out of the blue” or “reaction to a specific event.” By the end of these inquiries, the physician should have a clear picture regarding the triggering factor, the severity, and the duration of the patient’s anxiety.

Without a full understanding of each unique presentation, a differential between treatment using Selective Serotonin Reuptake Inhibitors (SSRIs) in conjunction with benzodiazepines, or benzodiazepines alone, becomes unclear. Although the former has a tried history in psychiatric medicine, SSRI’s broad range of side effects make it a less desirable treatment for anxiety disorder than benzodiazepines alone. Additionally, the rapid nature of an anxiety disorder makes an SSRI-based treatment ineffectual, sometimes taking as long as a month for a patient’s body to acclimate to the drug. Thus, benzodiazepines alone are the preferred first treatment for an anxiety disorder, due to their limited side effects and quick onset.

Even after narrowing a diagnosis to a likely benzodiazepine-based treatment, a major discernment within this class of drugs is important. Xanax and Klonopin are the most widely used benzodiazepines—two drugs that, although mistakenly used interchangeably, have different onsets and durations. To compare these two options, look at the half-life of the medicines. Xanax has a half-life of six to 12 hours and Klonopin has a half-life of 12 to 48 hours. In practical terms, this means that a patient prescribed Xanax will have to re-dose in almost half the time a patient who is prescribed Klonopin will. The shorter half-life places patients prescribed Xanax at a much higher risk for addiction than Klonopin and creates more opportunities for Xanax users to increase their tolerance, leading to more profound, severe withdrawal symptoms (e.g., panic attacks). The cyclical nature of increasing dosage and withdrawal symptoms, or rebound anxiety, makes Klonopin a preferred option.

Despite the clear advantage of Klonopin’s half-life regarding addiction, the onset of each drug makes deciding between the two much less absolute. Klonopin usually takes an hour to fully circulate a patient’s system—a relatively short time in relation to the previously mentioned month-long SSRIs, but a potentially detrimentally slow time for a patient with sporadic and sudden panic attacks.
Contrastingly, Xanax can take effect as soon as 20 minutes after ingestion, providing a much-needed quick alternative to Klonopin. Thus, the onset difference between Klonopin and Xanax further separates these two treatment plans, with Xanax the preferred choice for patients with sporadic anxiety. If the patient presents with chronic anxiety that leads to attacks lasting a few hours and occurring at least three to four times a week, Klonopin is the preferred treatment, as its relatively long onset is balanced by its extensive half-life. Not differentiating between the various degrees of anxiety can lead to addiction, since a patient treated with Xanax for chronic anxiety will re-dose with twice the frequency that is necessary as with Klonopin, leading to a dependency that quickly develops and is difficult to reverse.

After a clear diagnosis is ascertained, the dosage becomes the most important issue for a physician. Because Xanax is a PRN (taken as needed), any daily dosage quickly culminates into addiction. Therefore, it is important to stress that Xanax must only be taken with the onset of a panic attack, rather than as a preventive measure. If a patient begins to take Xanax at scheduled times, his/her tolerance will escalate and the ensuing cycle of rebound anxiety and addiction will appear. On the other hand, Klonopin is much easier to dose, due to its prolonged half-life. Patients are instructed to begin a regime of .25 mg (usually breaking a .5 mg pill in two) in the morning and .25 mg at night. If the anxiety is still prevalent throughout the day, the patient can usually increase their dose to .5 mg in the morning (one pill) and .5 mg at night. By creating a schedule for the patient, possible addiction is curtailed, since the patient is not taking the drug whenever he/she feels necessary (as with Xanax).

As a general guide, it is recommended to outline a six to nine-month Klonopin treatment, slowly decreasing the patient’s dosage by .25 mg each week in the last few months. This will enable a gradual easing off of Klonopin usage (since Xanax is not recommended for an extended treatment, as previously stated), carefully avoiding the recurrence of panic attacks that comes with a sudden cessation of medication. It is clear that Klonopin and Xanax, although both used to treat anxiety disorders, differ greatly in their case-by-case use. With a thorough understanding of the clinical presentations that accompany different anxiety disorders, an effective treatment can be successfully implemented.
PROS Program Pros

By KiKi Garg, LMHC

The comprehensive Personalized Recovery Oriented Services (PROS) program (14 NYCRR Part 512) serves people with mental illness, often with a co-occurring disability such as substance use disorder.

The Office of Mental Health (OMH) defines PROS as a comprehensive recovery-oriented program for individuals with severe and persistent mental illness. Recovery involves the integration of treatment, support, and rehabilitation. Goals include improving functioning; reducing inpatient utilization, emergency services, and contact with the criminal justice system; increasing employment and education; and securing preferred housing.

The PROS program has roots in Boston University’s model of psychiatric rehabilitation. Using a person-centered approach, PROS offers individual and group counseling. Most programs have upwards of 50 different groups/classes per week, each focused on a specific topic that allows participants to choose classes that are medically necessary and meaningful to them. Examples include Cope without the Smoke, Professionalism in the Work Place, and Coping with Anxiety, among others. Also offered are non-billable activities that support a person’s goals, such as knitting, walking for better health, book clubs, etc. Classes and activities may be facilitated by licensed or unlicensed staff and peer counselors, depending on the subject matter.

Per OMH regulation, PROS is comprised of four components:

1. Community rehabilitation and support (CRS) services are designed to help people live independently in the community by assisting them with managing mental health symptoms, restoring skills, and establishing supports and resources. Examples of CRS services include individualized recovery planning, benefits and financial management, community living exploration, crisis intervention, and wellness self-management.

2. Intensive rehabilitation (IR) services are time-sensitive and often require specialized interventions. IR services include:
   a. Intensive relapse prevention - a service designed to prevent psychiatric or substance use relapse and/or the loss of a life role.
   b. Intensive rehabilitation goal acquisition – a set of intensive and targeted services to help individuals achieve a desired life role or goal, such as employment, housing, college enrollment, or improving overall health and wellness.
   c. Family psychoeducation – services to provide education, guidance, and support to enhance the family’s ability to assist with the recovery of a PROS participant.
   d. Integrated dual disorder treatment (IDDT) - services designed to simultaneously address mental health and substance abuse needs of individuals with co-occurring disorders.

3. Ongoing rehabilitation and support (ORS) is designed to assist individuals with maintaining integrated and competitive employment and is provided in the community.

4. Clinical treatment is optional and includes psychiatrist and registered nurse services. The focus is on improved physical health integrated with mental health recovery and rehabilitation.

Of the 87 licensed PROS programs in the state, 82 are comprehensive and include clinic treatment. PROS programs without the clinic component often focus more on employment and education.

Vocationally, PROS uses individualized placement and support (IPS), an evidence-based model aimed at helping individuals become employed. The only prerequisite is the desire to work. Examples of work activities include visiting work sites, informational interviews with employers, and learning time management and communication skills and activities that lead to employment, such as interview preparation, résumé writing, following job leads, applying online, and planning for transportation.

The December 2015 edition of the Statewide Region Performance Packet suggests that PROS is effective. The following are key state-wide outcomes:

- According to data collected through the NYS OMH Child and Adult reporting system, hospitalization rates of PROS participants decreased after a six-month enrollment in PROS. Furthermore, Medicaid data confirms that this decreased rate is sustained through six months following the participant’s discharge from PROS.

- Similarly, the rate of utilization of psychiatric emergency care declined for PROS participants compared to the rates six months prior to their enrollment in PROS.

- Employment and education rates vary among providers, but the statewide average for both is approximately 15 percent.

In addition, data from OMH indicates a lower average utilization in PROS (60 percent of participants attend fewer than seven hours/week) compared to earlier program models such as continuing day treatment. The average length of stay in PROS is approximately 12½ months.

To learn more about PROS, visit www.omh.ny.gov/. 
Helpful Ways to Break Down Provider Silos

CDPHP is committed to improving the physical and mental health of our members by collaborating with providers engaged in their care and opening the lines of communication. Early intervention and timely coordination of care between primary care, behavioral health, and specialty providers will likely increase compliance and reduce unnecessary hospital admissions. Overcoming barriers to collaboration, particularly with regard to communication with behavioral health providers, will be key to lowering medical utilization, hospitalization rates, and medical costs.

Communication can be as simple as a phone call or documentation using progress notes, discharge summaries, or the CDPHP Exchange of Information form, which is available in the Forms section of www.cdphp.com as a writeable PDF that you can complete and send to the appropriate providers treating the member. This is particularly useful if your patient has recently been discharged from an inpatient mental health facility or chemical dependency clinic, as it’s important to ensure that they see a behavioral health provider within one week of discharge and at least once more within 30 days to make sure their transition back to their home or work environment is supported, and that growth made during the inpatient stay is not lost. It also helps providers notice early post-hospitalization reactions or medication issues.

If a member is unable to see their provider within one week of discharge, CDPHP can arrange for an in-home follow-up visit with a licensed clinician from the Community Transition Program, which works with participating network providers and hospitals. With the patient’s consent, this visit can be scheduled prior to leaving the hospital. The appointment can be made between 24 to 48 hours after discharge, but no later than five days post-discharge.

Given the shortage of psychiatry in our community, primary care physicians are often tasked with prescribing psychiatric medication. To support these providers, CDPHP has collaborated with Four Winds Hospital to offer training programs that include lectures on relevant psychiatric treatment. The collaboration also includes telephonic psychiatric consults for CDPHP Enhanced Primary Care participants.

If you need referrals for your patients concerning community mental health or chemical dependency treatment clinics, please call the CDPHP Behavioral Health Access Center at 1-888-320-9584 for guidance on medication management, pharmacy benefits, and help accessing providers and coordinating treatment.

Parsons Child and Family Center Offers No-Cost Mobile Intervention Service

Parsons Child and Family Center responds to children, adolescents, and families experiencing an emotional or behavioral crisis. The team serves families in Albany, Rensselaer, and Schenectady counties.

Depending on the severity of the symptoms, crisis interventions may be telephonic or take place wherever the child or adolescent is situated (e.g., school, home, and in the community). Services include consultations and information, crisis assessment, intervention and de-escalation, and facilitation of alternate levels of care.

Mobile crisis services are available 11 a.m. to 9:30 p.m. weekdays. Call the CDPHP Behavioral Health Access Center at 1-888-320-9584 (for after-hours support, select option 1).

Behavioral Health Transitions Program Expands to Columbia and Green Counties

In addition to offering mobile crisis services at no cost, CDPHP members returning to Columbia or Greene counties following a mental health hospital discharge will be offered phone and in-person support from the Mobile Crisis Assessment Team (MCAT) in their home, school, or community. They will visit the member on the scheduled date and time to provide assistance, ensure the member is able to follow through with their discharge plan, and review medication regimens.

MCAT will assist with linking members to appropriate outpatient services to support the transition back home and into the community and connect them with a counselor or a CDPHP case manager.

For additional information, please call MCAT at (518) 943-5555 and ask about the CDPHP Behavioral Health Transitions Program.
Member Incentives Available for Completing Certain HEDIS Metrics

CDPHP Medicaid and Child Health Plus members may be offered financial incentives for completing certain health care goals. They are identified for outreach based on gaps in care or certain health conditions. Outreach strategies include phone calls, mailings, and collaborating with members’ providers.

Behavioral health goals approved by New York state include:

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<tr>
<th><strong>ADHD: Medication Follow-Up Visit</strong></th>
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<tr>
<td>Children 6 to 12 who are newly prescribed ADHD medication will complete a follow-up visit with a prescriber within 30 days of when the first ADHD medication was dispensed.</td>
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<tr>
<th><strong>Schizophrenia Adherance and Antipsychotics (SAA): 90-Day Supply of Antipsychotics</strong></th>
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<tr>
<td>(The member must fill at least a continuous 90-day supply for antipsychotic medications.)</td>
</tr>
<tr>
<td>▶ Aripiprazole, Asenapine, Brexpiprazoe, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurisadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone, Chlorpromazine, Fluphenazine, Perphenazine, Perphenazine-amitriptyline, Prochlorperazine, Thioridazine, Trifluoperazine, Fluoxetine-olanzapine, Thiothixene</td>
</tr>
<tr>
<td>▶ Long-Acting Injections (14-day supply): HCPCS: J2794 Risperidone</td>
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<tr>
<td>▶ Long-Acting Injections (28-day supply): HCPCS: J0401 Aripiprazole, J1631 Haloperidol decanoate, J2358 Olanzapine, J2426 Paliperidone Palmitate, J2680 Fluphenazine decanoate</td>
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| **Schizophrenia Monitoring Diabetes (SMD):** HbA1c and LDL |

| **Schizophrenia Monitoring Cardiovascular Disease (SMC):** LDL |

| **Schizophrenia Screening Diabetes (SSD):** HbA1c or Glucose |

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<th><strong>Follow-Up After Hospitalization for Mental Illness</strong></th>
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<tr>
<td>Members who were hospitalized for treatment of a mental illness diagnosis and who had a follow-up with a mental health practitioner within seven days of discharge</td>
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Upon confirmation that the office visit or lab work has been completed, a gift card will be issued to the member by the CDPHP behavioral health case manager. Generally, gift cards are mailed to the member after address confirmation; however, at times, embedded case managers will provide the gift card to the member at the Enhanced Primary Care (EPC) practice or community location.

We appreciate you assisting with coordinating care between our members and CDPHP.
Clinical Network Provider Trainings

Federal and state regulations require that Medicaid managed care plans monitor and ensure the quality of services offered by contracted network providers. Plans must offer training to network providers in clinical core competencies and evidence-based practices for behavioral health (BH) and substance use disorder (SUD) services.

CDPHP is offering two convenient ways for BH/SUD, primary care physicians, and health homes to receive training that is in line with this requirement. Trainings are hosted by the Center for Practice Innovations (CPI). Article 31/32 clinic providers are now invited to register by visiting www.practiveinnovation.org. CPI will send mailings to providers with more details.

The University of Pittsburgh Medical Center (UPMC) will also host trainings for all providers. Visit www.cdphp.com/providers/programs/behavioral-health for more information.
Alert Your PCP Colleagues:

**Physician Education and Consultation Appointments**

Given the shortage of psychiatry in our community, clinicians are often tasked with prescribing psychiatric medication. To support these providers, CDPHP has collaborated with Four Winds Hospital to offer training programs that include lectures on relevant psychiatric treatment. The collaboration also includes telephonic psychiatric consults for CDPHP providers. For more information about telephonic consult or training sessions, please call Four Winds at (518) 584-3600.