



Provider *Insider*

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Who We Are and What We Do

The CDPHP Behavioral Health Access Center ensures that members and providers have a safe and reliable resource where questions related to mental health and substance use treatment can be quickly answered. The Access Center also assists members with receiving timely access to appropriate, affordable, and quality behavioral health care services. Clinical staff is available 24 hours a day, seven days a week, and can:

- ▶ Provide referrals for mental health and/or substance use treatment to members and providers, including specialty areas (eating disorders, trauma, chronic pain, bereavement, LGBT, etc.)
- ▶ Assess and verify eligibility, as well as confirm whether a member is enrolled in HARP and whether they are linked with a case manager
- ▶ Ensure members have a complete understanding of their behavioral health benefit information (copay, coinsurance, deductible, limits, etc.)
- ▶ Complete quality reviews for outpatient behavioral health services, including psychological, neuropsychological, and autism spectrum testing; outpatient therapy; personalized recovery oriented services (PROS); assertive community treatment (ACT); and home and community based services (HCBS)
- ▶ Provide a brief phone assessment to determine the most appropriate level of care

- ▶ Educate members and providers on treatment options available within the member’s benefit package
- ▶ Connect members with an in-house licensed behavioral health case manager should additional and/or ongoing support be beneficial
- ▶ Manage and coordinate appropriate care for members in crisis, including offering next-day appointments
- ▶ Provide information on behavioral health resources available in the community (National Alliance on Mental Illness, support groups, NA/AA, legal aid, etc.)
- ▶ Coordinate care between inpatient and outpatient levels of treatment

Call the CDPHP Behavioral Health Access Center toll free at 1-888-320-9584 between 8 a.m. and 6 p.m., Monday through Friday.



Community Transition Program

As an added benefit for members, CDPHP network providers will at times provide in-home outpatient follow-up care after discharge from a psychiatric unit in a hospital. This service entails reviewing the discharge plan and medication plan, as well as early support for recovery. After the in-home appointment, the Community Transition Program case manager will offer a follow-up call to ensure that members are attending outpatient treatment.

Because communication is important, hospitals share discharge plans with CDPHP behavioral health and outpatient providers. The Community Transition Program case manager also reviews the chart with a CDPHP behavioral health case manager.

For more information about the Community Transition Program, call the Behavioral Health Access Center at 1-888-320-9584 between 6 a.m. and 8 p.m. on weekdays.

Clinical Network Provider Training

Federal and state regulations require that Medicaid managed care plans monitor and ensure the quality of services offered by contracted network providers. Plans must provide 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 providers, primary care physicians, and health homes to receive training that is in line with this requirement:

- ▶ Article 31/32 clinic providers can register for training available through the Center for Practice Innovations by visiting www.practiceinnovation.org.
- ▶ The University of Pittsburgh Medical Center is also hosting training sessions for [all](http://www.cdphp.com/providers/programs/behavioral-health) providers. Visit www.cdphp.com/providers/programs/behavioral-health for more details.

Success Story: Behavioral Health HARP Case Management Helps Member Overcome Barriers

The member is a male who immigrated to the United States when he was in his 20s. He lives alone in his own apartment and has no identified social or familial supports. Some of his diagnoses include schizoaffective disorder, anxiety disorder, and several medical conditions, including type 2 diabetes. English is the member's second language, and he faces challenges understanding and being understood.

The HARP case manager reached out to the member to discuss changes in his benefits and assess his needs. At their initial meeting, the member was not very receptive to the home visit. The meeting went well, however. The case manager's approach was effective and she was able to successfully engage the member. A week later, the member initiated another meeting where the case manager helped him identify goals that included returning to work. While he had been involved in assisted outpatient treatment (AOT) for several years, the member noted that he had been resistant to many of the treatment suggestions and support.

In the past three months and over several meetings, the case manager has assisted the member with applying for and enrolling in school. She has also helped the member effectively advocate for himself. They continue to meet periodically, and she has remained involved in coordinating services with the AOT case manager.

Crisis Support is Available

CDPHP is pleased to connect members in need with community crisis services and resources. For children and adults experiencing a behavioral health emergency, including risk of harming themselves or others, CDPHP works collaboratively with the member and area crisis services to ensure that appropriate assistance and support are provided as quickly as possible. In addition to our after-hours crisis hotline, CDPHP has close working relationships with community mobile crisis teams and can advocate on behalf of members requiring support in the community or in their homes.

For members who do not need immediate community support, CDPHP can provide information on a range of additional crisis resources, including suicide hotlines, domestic violence offices, the NYS Parent Helpline, National Alliance on Mental Illness, and Homeless and Travelers Aid Society.

For questions about crisis-related services and resources, members should call our **Behavioral Health Access Center at 1-888-320-9584**.

OnTrackNY Program Supports Young Adults Dealing with Psychosis

Funded by the Office of Mental Health, the OnTrackNY initiative now has 14 coordinated specialty care programs for young people experiencing first episode psychosis (FEP) across New York state. The program at Parsons Child and Family Center serves Albany and all surrounding counties and is open for referrals.

OnTrackNY works with young adults who have experienced the onset of a primary psychotic disorder within the last two years achieve their goals for school, work, and social relationships. Teams serve up to 35 individuals, ages 16 to 30, and provide a range of treatment, including case management for social and community needs, supported employment and education, FEP-relevant psychotherapy, pharmacotherapy and primary care coordination, peer support, and family support and education. Care principles include shared decision-making, youth-friendly and welcoming environments, and flexible and accessible recovery-oriented services.

Research shows that the earlier individuals experiencing psychosis receive treatment, the better the outcomes. As a provider, you play a crucial role in connecting young adults with recently emerged psychotic disorders to specialized treatment as early as possible.

To make a referral, please call (518) 292-5452 or download the provider referral form at www.northernrivers.org/ontrackny/.

CDPHP Connects Members to Care

In 2017, CDPHP will focus outreach efforts on individuals with mental illness or substance use disorder who are discharged from the emergency department (ED). Two new HEDIS metrics will be monitored to address gaps in care for members who need extra support to keep them connected to their social supports, providers, and health plan:

- ▶ **Follow-Up After Emergency Department Visit for Mental Illness:** The percentage of emergency department visits for members 6 and older with a primary diagnosis of mental illness, who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization for mental illness.
- ▶ **Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence:** The percentage of ED visits for members 13 and older with a primary diagnosis of alcohol and other drug (AOD) dependence, who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization for AOD.

People who use the ED are in crisis, and this level of utilization may signal a lack of access to outpatient care. Outpatient visits with a clinician after discharge are recommended to ensure that a person's transition back home is supported. To decrease the likelihood of returning to the ED, CDPHP is developing initiatives so members have increased access to follow-up treatment in the outpatient setting. Preliminary discussions include:

- ▶ Working with area crisis centers to receive information related to ED use
- ▶ Exchanging Releases of Information forms signed by patients that coordinate care between medical and behavioral health providers and facilities
- ▶ Continuity and coordination of care meetings to better facilitate communication and connection to outpatient services

Group Therapy: Ready to Make a Comeback?

By Anne Carroll Fernandez, MD, MBA
CDPHP Medical Director, Behavioral Health

Despite its appearance in clinical practice guidelines as a first-line treatment, group therapy is notably underused by mental health professionals in the Capital District.

Practitioners first used group therapy to treat patients with tuberculosis in the early 1900s. It was effective for this large group of patients who were often indigent, ostracized, and could not easily access care. Later, overwhelmed by the psychiatric casualties of WWII, clinicians appreciated the efficiency of group therapy. The Veterans Administration and Department of Defense continue to employ group therapy, particularly for patients coping with addiction.

Economical concerns may have motivated the development of group therapy, but evidence shows that for many psychological disorders, it's as effective as individual therapy (*The American Psychiatric Publishing Textbook of Psychiatry, 5th Edition*, pg. 1330). Members of a group can experience an array of interpersonal relations, and with proper guidance, they can identify, explore, and alter maladaptive interpersonal behaviors.

What are your barriers to offering and promoting group therapy? Smaller practices may find it difficult to assemble a group drawn from their panels, while others may desire to establish a referral base to fill existing groups. As we develop new technologies to support registering people for programs, perhaps a central registration for groups may facilitate the use of group therapy in the Capital District. Let us know your thoughts on increasing the use of this important intervention by emailing BHInsider@cdphp.com. Please also let us know what types of groups you are providing. We will include you in the next newsletter.



Behavioral Health Member Satisfaction

The ECHO survey assesses and measures consumer/member satisfaction with their behavioral health treatment experience, services received from the plan, outcomes, and areas of opportunity for improvement, which could help plans increase the quality of care provided. Most of the core questions on the survey are only open to those who respond yes to whether they received treatment for a behavioral health issue. Because the survey is optional for managed care organizations, there are no national benchmarks. DSS Research has its own book of business benchmarks and these results were used for comparison where possible.

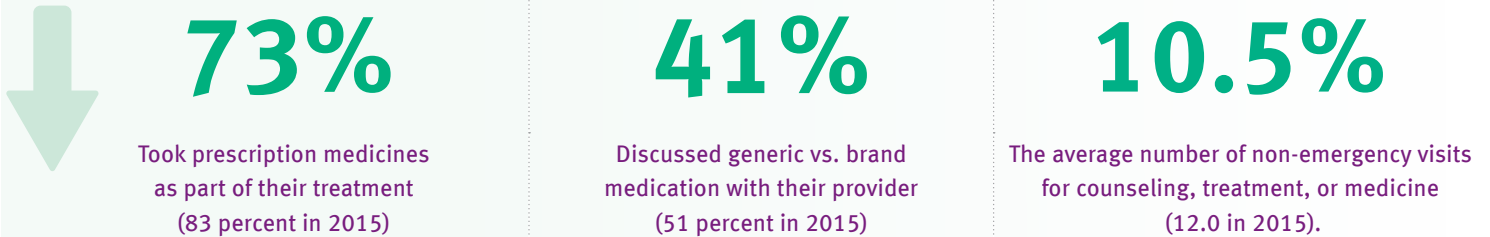
A random sample of 2,494 members was drawn, with 362 members completing the survey for a response rate of 14.8 percent. Specific objectives of the survey include:

- ▶ Member ratings of counseling and treatment overall
- ▶ Assessment of member perceptions related to receiving the counseling and treatment they needed
- ▶ Receiving the counseling and treatment when wanted
- ▶ How well clinicians communicate
- ▶ Informed about self-help or support groups
- ▶ Perceived improvement
- ▶ Experience with CDPHP behavioral health services
- ▶ How often members received services

Executive Summary

Certain items decreased significantly:

▶ A lower percentage of members:



Several items are significantly higher than the DSS average:

- ▶ Most ratings for clinicians' communication are higher (see table right)









▶ All measures regarding perceived improvement are higher:



- ▶ Also, higher percentages indicate that they always or usually were seen within 15 minutes of their appointment or as soon as they wanted when they needed help right away (see table right).
- ▶ A higher percentage of members were given as much information as they needed to manage their condition (see table right).

However, these items are significantly lower than the DSS average:

- ▶ Lower percentages of members were informed about self-help or support groups (see table below).
- ▶ The average number of ER or crisis center visits is lower (0.07 vs. 0.28 DSS).

	2015	2016	2016 DSS Avg.
Overall rating			
Rating of Counseling and Treatment (Q29) (% 8, 9, or 10)	80.00%	83.52%	77.66% 
Overall rating, composite and other selected attributes			
Rating of Counseling and Treatment (Q29) (% 9 or 10)	57.78%	62.17%	58.40%
How Well Clinicians Communicate Composite** (% Always or Usually)	96.52%	97.65%	
Clinicians listened carefully to you (Q12) (% Always or Usually)	96.20%	97.035	92.77% 
Clinicians explained things (Q13) (% Always or Usually)	96.84%	97.03%	92.80% 
Clinicians showed respect for what you had to say (Q14) (% Always or Usually)	96.52%	98.88%	94.54% 
Saw someone as soon as wanted (Q3) (% Always or Usually)	84.06%	83.17%	70.62% 
Seen within 15 minutes of appointment (Q11) (% Always or Usually)	89.87%	88.43%	81.16% 
Told about side effects of medications (Q19) (% Yes)	82.56%	81.68%	80.12%
Informed of self-help or support groups (Q20) (% Yes)	38.22%	33.33%	39.51% 
Given as much information as needed to manage condition (Q22) (% Yes)	86.58%	89.59%	83.39% 
Felt you could refuse a specific type of medicine or treatment (Q25) (% Yes)	84.97%	85.98%	83.81%

** This is not a standard DSS ECHO composite, as three of six standard items are omitted from the survey.

↑↓ Indicates a significant difference between the 2016 plan result and the 2015 plan result.

 Indicates a significant difference between the 2016 plan result and the 2016 DSS average.

Green symbols indicate a significantly higher score than the DSS average.

Red symbols indicate a significantly lower score than the DSS average.

Contemporary Composite of Experience with CDPHP Behavioral Health Services

When compared to 2015 internal scores, CDPHP 2016 member satisfaction has increased in all areas:

- ▶ Satisfaction with Customer Service increased from 78.1 percent to 81.4 percent.
- ▶ Satisfaction with the Coordination of Care Between Clinician and Primary Care Doctor increased from 75.3 percent to 82.6 percent.
- ▶ No Difficulty Getting a Provider Who Meets Special Needs increased from 90.9 percent to 94.9 percent.

CDPHP encourages its network providers to overcome barriers to collaboration and pursue a comprehensive approach to health care. Here are a few ideas for improvement:

- ▶ 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/providers as a writeable PDF that you can download, complete, and submit.
- ▶ Assess members for possible coexisting mental health, substance abuse, *and* medical conditions throughout the course of treatment and exchange information with the appropriate provider about any findings.
- ▶ At the time of the initial appointment or as soon as practical thereafter, discuss with the member the importance of coordinated care and seek consent to communicate with the PCP or behavioral health provider. If the member still refuses, document this in the chart.
- ▶ Maintain contact with not only PCPs, but also with other behavioral health providers, consultants, and health care institutions as appropriate.

Behavioral Health Practitioner Access Analysis

CDPHP monitors behavioral health practitioner appointment accessibility annually against its standards to determine whether members can receive timely appointments based on severity of illness and initiates actions as needed to improve. Appointment access is measured through a survey of practitioner offices.

- ▶ 16 BH prescriber office locations (5.1%) responded to this survey out of 312 office locations with prescribers represented
- ▶ 133 BH non-prescriber office locations (9.2%) responded to this survey out of 1,452 offices locations with non-prescribers represented

Access Measure	Standard and Performance Goal	Results	Goal Met? (Yes/No)
Prescriber behavioral health urgent appointments	80% of offices report a first available urgent appointment is open for a patient within 48 hours of patient request	79% of offices report a first available urgent appointment is open for a patient within 48 hours of patient request	No
Prescriber behavioral health new patient routine appointments	80% of offices report a third available routine appointment is open for a new patient within 10 business days of patient request	57% of offices report a third available routine appointment is open for a new patient within 10 business days of patient request	No
Prescriber behavioral health established patient routine follow-up appointments	80% of offices report a third available routine appointment is open for an established patient within 20 days of patient request	91% of offices report a third available routine appointment is open for an established patient within 20 business days of patient request	Yes
Non-prescriber behavioral health urgent appointments	80% of offices report a first available urgent appointment is open for a patient within 48 hours of patient request	79% of offices report a first available urgent appointment is open for a patient within 48 hours of patient request	No
Non-prescriber behavioral health new patient routine appointments	80% of offices report a third available routine appointment is open for a new patient within 10 business days of patient request	83% of offices report a third available routine appointment is open for a new patient within 10 business days of patient request	Yes
Non-prescriber behavioral health established patient routine follow-up appointments	80% of offices report a third available routine appointment is open for an established patient within 20 business days of patient request	99% of offices report a third available routine appointment is open for an established patient within 20 days of patient request	Yes
Complaints about behavioral health access	Rate of member complaints about behavioral health appointment access is 0	0%	Yes
Member appeals related to behavioral health access	Rate of member appeals about behavioral health access is 0	0%	Yes

INPATIENT SUBSTANCE USE DISORDER UTILIZATION MANAGEMENT UPDATES

- ▶ Affected members are entitled to medically necessary inpatient care without prior authorization or concurrent review for up to 14 days of any admission.
- ▶ Providers are required to submit Appendix A with the initial treatment plan and LOCADTR within 48 hours of admission.
- ▶ Plan and provider should engage in regular communication about cases even if concurrent review is not required to ensure collaboration on treatment and discharge needs.
- ▶ Medical necessity retrospective review is permitted and CDPHP may request medical records.



Table 2 breaks out the percent of offices offering urgent, first, second, and third available routine appointments for new and established patients. This data demonstrates that it is challenging for a patient to see their prescriber or non-prescriber within 48 hours for an urgent appointment. Also, it is much more challenging for a new patient to obtain a routine appointment with a prescriber within the standard than an established patient.

Table 2: Analysis of Routine Appointment Access by First, Second, and Third Available Appointment Date			
Practitioner type	Offices with first available routine appointment	Offices with second available routine appointment	Offices with third available routine appointment
BH prescriber urgent appointment	79%	n/a	n/a
BH prescriber new patients routine	79%	71%	57%
BH prescriber established patient follow-up appointment	100%	91%	91%
BH non-prescriber urgent	79%	n/a	n/a
BH non-prescriber new patient routine	95%	90%	83%
BH non-prescriber established patient follow-up appointment	99%	99%	99%

There are more behavioral health non-prescribers than prescribers, so offices that cannot offer an urgent appointment within the performance goal numbered 21 out of 1,452. For psychiatry, the number was three out of 312.

The data also identified offices that could not provide a routine appointment for a new patient within the performance goal at the time the measurement was completed. As expected, behavioral health prescribers are more likely to have appointment access issues than non-prescribers. Based on total number of survey respondents, six prescriber office locations did not have a first, second, or third available new patient appointment within the performance goal.

NEW FAX NUMBER

Clinical information pertaining to behavioral health services should now be faxed to (518) 641-3601.



FRAUD LOOKOUT

CDPHP is committed to preventing fraud, waste, and abuse. If you suspect any type of health care fraud involving CDPHP, please call our Fraud Hotline at 1-800-280-6885.

Attention-Deficit/Hyperactivity Disorder Medication Management

By A. George Pascual, MD, FAAP - CapitalCare Medical Group

Current estimates indicate that approximately 15 million children and adolescents have attention-deficit/hyperactivity disorder (ADHD). Clinical practice guidelines for the management of this disorder have been published within the past 10 years by the American Academy of Child and Adolescent Psychiatry^{1,2} and the American Academy of Pediatrics³.

Initiation of medication treatment

First-line options for initial treatment include stimulant and non-stimulant medications. Stimulant medications include amphetamine, amphetamine-dextroamphetamine, dexamfetamine, dextroamphetamine, lisdexamfetamine, methamphetamine, and methylphenidate. Non-stimulant medications include atomoxetine, clonidine, and guanfacine. These medications are available in immediate and sustained-release formulations as capsules, chewable tablets, oral dispersible tablets, suspensions, tablets, and transdermal patches. In general, sustained-release formulations are preferable, as they are only needed once daily and are more effective⁴. Discussing the advantages and disadvantages of these medications with the patient and/or patient's family will help guide treatment recommendations.

Initial follow-up visit

NCQA published HEDIS measures to assess the follow-up care for children and adolescents being treated with an ADHD medication. During the initiation phase of treatment, children 6 to 12 should be seen for at least one follow-up visit within the first 30 days. The primary purposes of this visit are to assess the efficacy, tolerability, and compliance of medication treatment. Meeting this measure can be facilitated in a few ways:

- ▶ Having the patient (or parent) schedule the initial follow-up visit at the time medication is prescribed

- ▶ Using a "contract" with the patient and/or parent that specifically outlines the expectations regarding the initial follow-up visit
- ▶ Having nursing staff contact the patient a couple of weeks before the scheduled follow-up visit to inquire about initial observations and/or concerns and to remind them of the appointment

Subsequent follow-up visits

The HEDIS measure for the continuation (maintenance) phase of medication treatment indicates that children 6 to 12 who have remained on a medication for at least 210 days have at least two follow-up visits in the nine months following the initiation of treatment. The efficacy, tolerability, and compliance are reassessed at these visits. Physical parameters such as weight, height, pulse rate, and blood pressure are also measured and recorded.

Medication refills

ADHD medications that are considered stimulants are classified as Schedule II controlled substances. Most prescribers are required to consult the New York State Prescription Monitoring Program (PMP) Registry when writing prescriptions for Schedule II medications. When a patient (or parent) calls between follow-up visits for a refill, the nurse or office staff member should include the Drug Utilization Report Reference Number obtained from the PMP Registry in the patient's medical record.



Changes in medication treatment

In some cases, a patient will either not respond to or not tolerate a specific medication. This may occur at any time during the course of treatment. Strategies to consider in these situations include:

- ▶ Changing the dosage of the medication (e.g., increasing the dosage of a medication that is tolerated without significant adverse effects)
- ▶ Changing the formulation of the medication (e.g., from an immediate to a sustained-release version)
- ▶ Changing the type of medication (e.g., from a stimulant to a non-stimulant medication)

Coexisting conditions

It is estimated that 50 to 60 percent of children and adolescents with ADHD also have at least one coexisting condition, and more than 10 percent have three or more. They may include:

- ▶ Disruptive behavior disorders (oppositional defiant disorder and conduct disorder)
- ▶ Anxiety disorders
- ▶ Mood disorders (including depression and bipolar disorder)
- ▶ Tic disorders
- ▶ Learning disabilities
- ▶ Autism spectrum disorders

Managing these various conditions may extend beyond the scope of primary care practice and may require consultation with developmental/behavioral, psychological, and/or psychiatric specialists.

¹ Practice Parameters for the Assessment and Treatment of Children and Adolescents with Attention Deficit/Hyperactivity Disorder, *Journal of the American Academy of Child and Adolescent Psychiatry*, 46:7, 894-921, 2007

² Practice parameter on the use of psychotropic medication in children and adolescents, *American Academy of Child & Adolescent Psychiatry*, September 2009

³ Diagnosis, Evaluation and Treatment of Attention Deficit/Hyperactivity Disorder in Children and Adolescents, American Academy of Pediatrics Subcommittee on Attention Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management *Pediatrics*, October 16, 2011

⁴ Extended-release medications for children and adolescents with attention deficit hyperactivity disorder, *Paediatrics and Child Health*, 14:9, 593-597, 2009

Behavioral Health Medical Necessity Criteria and Guidelines

CDPHP uses industry standard and internally developed, clinically based medical necessity criteria, including the 20th Edition Milliman Care Guidelines and NYS OASAS Level of Care for Alcohol and Drug Treatment Referral (LOCADTR). Internally developed criteria are determined based on industry standards.

CDPHP reviews guidelines developed by professional organizations and the federal government every two years and presents them to our behavioral health committee and quality management committee for approval. Practice guidelines help the health plan and providers assess whether or not a proposed treatment is medically necessary and direct clinicians toward a treatment that saves health care resources in a case where there is more than one equally effective option.

CDPHP posts guidelines online for common psychiatric illnesses and medication utilization at www.cdphp.com/providers/programs/behavioral-health. The following new guidelines are under consideration and will be voted upon by the Behavioral Health Utilization Management and HARP Utilization Management Committees in 2017:

Institute for Clinical Systems Improvement: Adult depression in primary care

U.S. Preventive Services Task Force screening for depression in adults: U.S. Preventive Services Task Force recommendation statement

AACAP: Practice parameter for the assessment and treatment of children and adolescents with obsessive-compulsive disorder

APA: Practice guideline for the treatment of patients with obsessive-compulsive disorder

AACAP: Practice parameter for the assessment and treatment of children and adolescents with tic disorders

CDC guideline for prescribing opioids for chronic pain — United States, 2016

Depression in children and young people: Identification and management in primary, community, and secondary care

VA/DoD: Clinical practice guideline for the management of major depressive disorder

STANDARD DOCUMENTATION UPDATES

The standard documentation for behavioral health requests has been revised. Please see Section 18 of the POAM for more information.

LiveWell Program Offers Highly Effective Eating Disorder Treatment

For years, the Health Psychology Associates/LiveWell program has been widely regarded in the Capital District as the standard for outpatient eating disorder treatment for anorexia, bulimia, and binge eating. With a new location in Poughkeepsie, LiveWell also offers a comprehensive intensive outpatient program (IOP), as well as treatment options for those who need a strong adjunct to outpatient therapy to support their recovery.

In both the Albany and Poughkeepsie locations, IOP programming consists of multiple therapy techniques, such as individual and group mindful eating treatment sessions, cognitive behavior therapy, dialectical behavior therapy, and exposure/response prevention therapy. LiveWell also incorporates the family into the treatment plan to create a strong support network and employs registered dietitians to create personalized meal plans that allow for therapeutic yet achievable gains.

Furthermore, LiveWell works in collaboration with the Comprehensive Care Center for Eating Disorders of Northeastern New York at Albany Medical College. The center's mission is to serve those affected by eating disorders by providing expert treatment and a seamless continuum of care. In Albany, programming is available Monday through Saturday. Call (518) 218-1188. In Poughkeepsie, services are available Monday, Tuesday, Wednesday, and Saturday. Call (845) 372-4367 or visit www.hpallivewell.com for more details.

Four Winds Saratoga Programs Help Members Manage Conditions

For members who are acutely regressing, CDPHP encourages behavioral health practitioners to consider partial hospitalization and intensive outpatient programs to prevent further functional deterioration. These programs offer a safe, structured environment to develop coping skills to manage symptoms and everyday life stressors and are an effective alternative to inpatient hospitalization.

Four Winds Saratoga offers a short-term, medically supervised partial hospitalization program (PHP) and intensive outpatient program (IOP) for adults 18 and older. PHP participants attend the program five days a week from 9 a.m. to 4 p.m., while the IOP program has morning and afternoon sessions five days a week from 11:30 a.m. to 4 p.m.

PHP is an ideal choice for members who display acute symptoms of psychosis or depression, as well as disorganized or self-destructive behaviors. Both PHP and IOP can provide a brief, comprehensive reassessment of an individual's outpatient treatment, including possible changes in medication regimens. While in program, a multi-disciplinary treatment team uses individual, group, and family psychotherapy, individual case management, and medication education to tailor personalized treatment goals for each participant.

Four Winds Saratoga also offers an adolescent intensive outpatient program (AIOP) that entails medically supervised, structured group therapy for adolescents between the ages of 13 and 17. Participants attend the program three days a week from 4 to 7 p.m. AIOP can be an effective alternative to inpatient treatment for those exhibiting acute psychiatric symptoms and significant impairment in daily educational and social functioning.

For questions regarding a member's coverage for these programs and the prior authorization process, please contact the CDPHP Behavioral Health Access Center at 1-888-320-9584.

Opioid Legislation Updates

On January 1, the final components of the opioid addiction and substance use disorder (SUD) law went into effect. This applies to commercial members with contracts that are issued, renewed, modified, altered, or amended on and after January 1 and to Medicaid and Child Health Plus members. ASO, federal plans, and Medicare are not affected. The law covers the following:

- ▶ Initial opioid prescription for treatment of acute pain limited to a seven-day supply.
- ▶ Clinical review tool: CDPHP is required to use the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) tool for determining medical necessity.
- ▶ Large group contracts must provide coverage of FDA-approved medications for detoxification or maintenance treatment of substance use disorder.
- ▶ A five-day emergency supply of prescription drugs/medications to treat SUD must be provided without prior authorization where an emergency condition exists. This includes prescription drugs/medications associated with the management of opioid withdrawal and/or stabilization and opioid overdose reversal and applies to drugs covered by the plan.
- ▶ Medicaid managed care plans are prohibited from requiring prior authorization for an initial or renewal prescription for buprenorphine or injectable naltrexone for detoxification or maintenance treatment of opioid addiction. This does not apply to a non-preferred or non-formulary form of the drug.
- ▶ Inpatient SUD services: Plans are prohibited from requiring that admission to an OASAS-licensed facility participating with the insurer's plan receive prior authorization. It also prohibits plans from conducting concurrent utilization review for the first 14 days of the admission if the OASAS facility provides the plan with notice of admission and an initial treatment plan within 48 hours of the admission.

More information about the legislation changes is included in Section 18 of the Provider Office Administrative Manual (POAM), available at www.cdphp.com/providers.



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 (please inquire about which consultation request form to use). Call Four Winds directly at (518) 581-5015, ext. 3310.

Encourage Patients to Attend Follow-Up Visits to Prevent Readmissions

Care coordination and follow-up visits after hospitalization for mental illness and substance use disorder are important services that CDPHP is committed to providing for our members. NCQA/HEDIS research for the *Follow-Up After Hospitalization for Mental Illness (FUH)* measure shows that supportive services provided during this time will help ensure that gains made during hospitalization are not lost. This research also shows that attendance at follow-up visits helps health care providers detect early post-hospitalization reactions or medication problems.

Gaps in care coordination have been recognized at the national level as an impediment to the delivery of quality health care and in turn have led to recommendations for the development and adoption of quality measures specific to inpatient psychiatric facilities, as well as emergency departments. The final 2015 report by the U.S. Department of Health and Human Services found that quality measures linked to follow-up visits help improve overall patient outcomes by fostering partnerships among inpatient facilities, community mental health agencies, health plans, and providers needed to coordinate care.¹

According to the Agency for Healthcare Research and Quality (AHRQ), readmissions are a substantial problem affecting the seriously mentally ill, and up to 50 percent of patients with repeated psychiatric hospitalizations are readmitted within 12 months.² Readmissions may be an indication of poor initial care delivery by the inpatient team, insufficient support services needed to transition patients to outpatient settings, or inadequate outpatient services to allow the individual to remain in the community.

CDPHP is following readmissions for HARP members as a quality marker and as a measure of adequate care coordination. Our team seeks to effectively prevent psychiatric readmissions by creating alternatives to psychiatric hospitalizations, ensuring that patients have adequate lengths of stay to stabilize presenting problems, and facilitating discharge planning and adequate transitional services with care coordinators and case managers.



¹ U.S. Department of Health and Human Services; Assistant Secretary for Planning and Evaluation; Office of Disability, Aging and Long-Term Care Policy. Development of Quality Measures for Inpatient Psychiatric Facilities: Final Report. February 2015: pages 1-122.

² Agency for Healthcare Research and Quality. Effective Health Care Program. Evidence-based practice Center, Technical Brief Protocol, Project Title: Management Strategies to Reduce Psychiatric Readmissions; www.effectivehealthcare.ahrq.gov; September 2014

What is CCBH?

The Community Care Behavioral Health Organization (CCBH) partnered with CDPHP in July 2016 to provide behavioral health case management for HARP members. Case managers are regionally based and work with members in their homes, the hospital, outpatient programs, or other public locations. Their role is to engage with individuals, address any immediate concerns, and connect members to services and supports that will meet their goals and promote their success in the community, including enrolling in health homes for ongoing care coordination. Case managers also work with members to reduce unnecessary hospitalizations and support their follow-up with behavioral health and medical care.

Based in Pennsylvania, CCBH has provided services in New York since 2009 and has been directly involved in the state's transition to Medicaid managed care. To coordinate care with a CCBH case manager, please call the Behavioral Health Access Center at 1-888-320-9584.



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HARP Success Story

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Behavioral Health Access Standards

The CDPHP behavioral health staff is available 24 hours a day, seven days a week. Our network providers are required to ensure that members have access to care within the following standards*:

- ▶ Emergency – immediate access (may be referred to the ER)
- ▶ Care for non-life threatening emergency – within six hours (may be referred to the ER)
- ▶ Urgent appointment – within 48 hours
- ▶ Non-urgent initial appointments – within 10 business days
- ▶ Non-urgent routine appointments – within 20 business days
- ▶ Mental health or substance abuse ambulatory appointment – within seven days of request/discharge
- ▶ After-hours access - telephone response within one hour

**If you cannot comply with these standards, please notify our Access Center so we can direct our members to other providers. If you have suggestions for how CDPHP can assist with improving appointment access, please email BHInsider@cdphp.com.*

CDPHP® publishes *Provider Insider* two times a year.

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