

THE PROVIDER LINE

Vol 4-2011

Community Care Awarded Behavioral Health Organization Contract in New York's Hudson River Region

Community Care has been awarded a contract to promote the holistic treatment of individuals with mental health and substance abuse disorders in the Hudson River Region of New York state. Earlier this month, the New York State Office of Mental Health (OMH) and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) jointly awarded Community Care a contract to provide utilization management and care coordination services as the Behavioral Health Organization (BHO) for the 16-county Hudson River Region.

Community Care is in the process of developing the Hudson River Region BHO program with OMH and OASAS in advance of its full implementation on January 1, 2012.

Plans are underway to open a regional office in Yonkers, NY, in November 2011 and a satellite office in Albany, NY, by the end of the year.



SAVE THE DATE for Community Care's spring 2012 conference!

Creating Health Homes: Embracing Recovery will be held on March 8, 2012 at the Omni William Penn Hotel in Pittsburgh.

In an effort to improve the delivery of health services, "health home" models are being evaluated and implemented in PA and other states. The models promote the integration of behavioral and physical health services. In behavioral health settings, health home models incorporate physical health and wellness goals into recovery plans

Presenters will address ways to improve services for consumers, particularly those with serious behavioral illness. Keynote and workshop topics will include:

- Tools for consumers and providers that support tobacco cessation, weight management, and the management of physical health conditions.
- Strategies to engage primary care settings in improved coordination.
- The training of case managers and peer specialists to serve as health navigators.

Mark your 2012 calendar and watch for more details!

Discharge and Crisis Planning

Discharge and crisis planning are key to a consumer's recovery.

Discharge Planning. Providers are expected to begin actively coordinating resources for discharge upon admission and discharge plans should reflect the goals of the treatment plan. Community Care expects that members be linked with a service provider within 7 days of discharge and providers notify Community Care within 48 hours of a discharge.

2

Effective discharge planning ensures that members stay engaged in treatment post-discharge and that they are linked with aftercare.

Crisis Planning. Crisis planning is an important part of a member's treatment. Crisis plans should be individualized for each member and comprehensive. Plans should contain information related to each member's individual coping skills and resources to contact in the event of an emergency, as well as natural and professional supports.

* Family-Based providers must submit the member's initial crisis plan and treatment plan to the assigned Care Manager prior to the member's first continued stay review; otherwise, the Care Manager is required to issue a Provider Performance Issue report.

New Terminology: Provider Performance Issue (PPI)

In an effort to clarify and streamline processes for communicating with providers, the term "Provider Benchmarking Incident," or "PBI", is being replaced with the term "Provider Performance Issue" or "PPI".

The new term more accurately reflects Community Care's view of the nature of PPIs and how we deem these issues related to performance that can be addressed via effective Quality Improvement Plan implementation to ensure our members receive a high level of quality care. Community Care hopes that the new terminology will eliminate any confusion among providers related to our Annual Provider Benchmarking process.

More information about PPIs is available on our website, www.ccbh.com. You can view and/or download Community Care's Provider Performance Standards, a list of the Provider Performance Issues that we monitor, expectations related to provider performance, and other topics by clicking on Provider Resources, HealthChoices Resources, and Informational Articles.

**Please call
Community Care's
toll-free Provider Line
at 1-888-251-2224
to report all
adverse events.**

Information online at www.ccbh.com

The Community Care website, www.ccbh.com, has important information for you. You can view and/or download information about the following topics by clicking on Provider Resources, HealthChoices Resources, and Informational Articles.

- Our Quality Improvement Program including goals, processes and outcomes related to care and service.
- Our efforts to measure the accessibility of care and service for our members, such as how long it takes to get an appointment, and actions taken to improve accessibility.
- The clinical practice guidelines and processes utilized to measure adherence to the guidelines.
- Our expectations for exchange of information with PCPs and within the behavioral health continuum to facilitate continuity and coordination of care.
- Our Medical Necessity Criteria, including how to obtain or view a copy.
- The toll-free number to contact staff regarding utilization management issues or if you have a utilization management question.
- The availability of, and process for, contacting an appropriate peer advisor to discuss utilization management decisions.
- A description of the availability of an independent external appeals process for utilization management decisions made by Community Care.
- Our policy prohibiting financial incentives for utilization management decision-makers.
- Our members' rights and responsibilities.
- Our confidentiality policies including what a "routine consent" is and how it allows us to use information about enrollees; their right to approve release of personal health information not covered by "routine consent"; how enrollees may request restriction on the use or disclosure of personal health information, amendments to personal health information, access to personal health information or an accounting of disclosures of personal health information; our commitment to protect the enrollee's privacy in all settings and our policy on sharing personal health information with employers.
- Information about our preventive behavioral health programs including how successful these programs have been.

For our treatment record policies regarding confidentiality of treatment records, documentation standards, systems for organization of treatment records, standards for availability of treatment records at the practice site and performance goals, please see your Provider Manual, which can also be found at www.ccbh.com.

For a description of the process to review information submitted to support your credentialing application, correct erroneous information and upon request to be informed of the status of your credentialing and recredentialing application, please see your Provider Manual, which can also be found at www.ccbh.com.

If you have questions about accessing our website or would like more information or paper copies of any of the above items, please call 1-888-251-2224.

Pharmacy News

Concurrent use of Benzodiazepines while in Methadone Treatment

Many individuals in methadone treatment have had some experience with benzodiazepine use. Benzodiazepines are primarily indicated for anxiety or sleep disorders. While they are effective and widely prescribed, they can become addictive when used chronically. Benzodiazepines are rarely the preferred or sole drug of abuse. An estimated 80 percent of benzodiazepine abuse is part of polydrug abuse, most commonly with opioids.¹ Unfortunately, there is limited controlled data about the continued use of benzodiazepines to help with the treatment of opioid withdrawal. Some psychiatrists maintain that the abuse potential of sedative-hypnotics and anxiolytics is too great to be used with these patients and that these medications may also precipitate craving for opioids and relapse. Others feel that for carefully selected patients and with appropriate monitoring, the use of benzodiazepines over a relatively brief period (i.e., 1–2 weeks) may be helpful in ameliorating the often debilitating insomnia that can accompany opioid withdrawal.²

Results from a survey among patients enrolled in a Baltimore city Methadone treatment program showed that 47% of the respondents had a history of benzodiazepine use and that half of the benzodiazepine users (54%) started using benzodiazepines after entering the methadone program.³ Analysis of data in Allegheny County methadone programs indicates that 43% of members had used benzodiazepines during a 90 day period. Concurrent use of high-dose benzodiazepines can result in subjective drug effects of euphoria or drug “high” that may be

sought by some patients. However, it can also produce impaired performance and memory, and hence may contribute to problems such as high-risk injecting practices, aggression, and criminality.⁴ The other major concern regarding benzodiazepine use in patients receiving methadone is the increased risk of death. While there are no specific guidelines on when or if it is appropriate to prescribe benzodiazepines to those in methadone treatment, it is clear that if prescribed, it should be done so with caution and re-evaluated frequently.

1 Gold MS, Miller NS, Stennie K, Populla-Vardi C. Epidemiology of benzodiazepine use and dependence. *Psychiatr Annals*. 1995; 25:146–8.

2 American Psychiatric Association: Practice Guideline for the Treatment of Patients With Substance Use Disorders, Second Edition, in American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders 2004.

3 Chen et al. Benzodiazepine Use and Misuse Among Patients in a Methadone Program. *BMC Psychiatry*. 2011; 11:90.

4 Lintzeris N, Nielsen S. Benzodiazepines, Methadone and Buprenorphine: Interactions and Clinical Management. *The American Journal on Addictions*. 2009; 19:59–72.

New Drug Warnings

Serious Allergic Reactions Have Been Reported with Saphris® Use

The U. S. Food and Drug Administration (FDA) has issued a Safety Announcement warning that life-threatening allergic reactions have been reported with the use of the antipsychotic drug Saphris® (asenapine maleate), even with the first dose. A search of the FDA’s Adverse Event Reporting Systems database identified 52 cases of type 1 hypersensitivity reactions with Saphris® use.

The drug label for Saphris® has been revised to include information about this risk and to inform healthcare professionals that Saphris® should not

be used in patients with a known hypersensitivity to the drug. Healthcare professionals should counsel patients on how to recognize the signs and symptoms of a serious allergic reaction.

For the complete MedWatch Safety Summary along with information for healthcare professionals, please refer to the FDA website: <http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm270600.htm>.

Heart Warning Added to Seroquel® Label

AstraZeneca has added a new warning to the label of Seroquel® (quetiapine). The new label cautions against the use of Seroquel® in combination with other drugs known to prolong the QTc interval including Class 1A antiarrhythmics (e.g., quinidine, procainamide) or Class III antiarrhythmics (e.g., amiodarone, sotalol), antipsychotic medications such as ziprasidone and chlorpromazine, antibiotics (e.g., gatifloxacin, moxifloxacin), or any other class of medications known to prolong the QTc interval (e.g., pentamidine, levomethadyl acetate, methadone).

The previous labeling had warned of the risk of heart arrhythmia with Seroquel® use but did not include other drugs that could interact with the antipsychotic. For the complete MedWatch Safety Summary along with information for healthcare professionals, refer to the FDA website: <http://www.fda.gov/Safety/MedWatch/SafetyInformation/ucm267700.htm>.

High Dose Celexa® Warning

The U.S. Food and Drug Administration (FDA) has lowered the maximum recommended dose of the antidepressant Celexa® (citalopram) to 40 mg/day.

The decrease in the maximum recommended dose was based upon post-marketing surveillance reports and a prospective trial linking doses of 60 mg per day to unacceptable QT interval prolongations and Torsade de Pointes and the fact that studies showed no benefit in the treatment of depression at doses higher than 40 mg per day.

Patients with underlying heart conditions and those predisposed to low levels of potassium and magnesium are at risk of developing prolongation of the QT interval. It is recommended that patients with the above conditions have regular electrocardiography if prescribed Celexa® and that potassium and magnesium levels are within normal range before Celexa® is given.

For the complete MedWatch Safety Summary along with information for healthcare professionals, refer to the FDA website: <http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm269481.htm>.

New Products

Kapvay®

Kapvay® (clonidine hydrochloride, extended-release) was approved by the FDA in September of 2010. Kapvay® is indicated for the treatment of attention deficit hyperactivity disorder as monotherapy or as adjunctive therapy to stimulant medication in children and adolescents ages 6-17 years. The efficacy of Kapvay® is based on the results of two clinical trials in children and adolescents. Maintenance efficacy has not been systematically evaluated, and patients who are continued on longer-term treatment require periodic reassessment. Dosing should be initiated

with one 0.1 mg tablet at bedtime, and the daily dosage should be adjusted in increments of 0.1 mg/day at weekly intervals until the desired response is achieved.

Doses should be taken twice a day, with either an equal or higher split dosage being given at bedtime. Tablets should not be crushed, chewed, or broken before swallowing. Do not substitute for other clonidine products on a mg-per-mg basis. When discontinuing, taper the dose in decrements of no more than 0.1 mg every 3 to 7 days.

The most common side effects of Kapvay® include sleepiness, tiredness, and upper respiratory tract infection (symptoms may include cough, runny nose, and sneezing) irritability, sore throat, trouble sleeping (insomnia), nightmares, change in mood, constipation, stuffy nose, increased body temperature, dry mouth, and ear pain.

Viibryd®

The new selective serotonin reuptake inhibitor, Viibryd® (vilazodone), was approved in January 2011 by the FDA to treat major depressive disorder in adults. The mechanism of action is not fully understood but is thought to be related to the enhancement of serotonergic activity in the CNS through selective inhibition of serotonin reuptake.

The recommended dose for Viibryd® is 40 mg once daily. Viibryd® should be titrated to the 40 mg dose, starting with an initial dose of 10 mg once daily for 7 days, followed by 20 mg once daily for an additional 7 days, and then increased to 40 mg once daily. It should be taken with food. Administration without food can result in inadequate drug concentrations and may diminish effectiveness. When discontinuing treatment, reduce the dose gradually.

The most frequent adverse reactions reported by patients taking Viibryd® in clinical trials included diarrhea, nausea, vomiting, and insomnia. Viibryd® is available in 10 mg 20 mg and 40 mg tablets. The use of Monoamine Oxidase Inhibitors is contraindicated with Viibryd®. The drug is available in 10 mg 20 mg and 40 mg tablets.

Latuda®

The new atypical antipsychotic, Latuda® (lurasidone) received FDA approval for the treatment of schizophrenia in October of 2010. Efficacy was established in four 6-week controlled studies of adult patients with schizophrenia. The effectiveness of Latuda® for more than 6 weeks has not been established in controlled studies.

The recommended starting dose is 40 mg/day taken with food (at least 350 calories) with no initial dose titration required. The maximum recommended dose is 80 mg/day.

The most common adverse reactions reported by those in clinical trials were drowsiness, feelings of restlessness and the urge to move (akathisia), nausea, movement abnormalities such as tremors, slow movement, or muscle stiffness (Parkinsonism), and agitation. Angioedema has been observed with Latuda® and it is contraindicated with strong CYP3A4 inhibitors and inducers.

Results from a pooled analysis of short-term study data showed that patients treated with Latuda® experienced, on an overall basis, low rates of weight gain and metabolic changes.

Visit www.ccbh.com.

Provider satisfaction

It is important for providers to know if members are satisfied with the care and services they are receiving. Community Care contracts with The Myers Group to conduct an annual Member Satisfaction Survey using a modified version of the Experience of Care and Health Outcomes (ECHO) Survey. The survey includes questions focused on services unique to HealthChoices such as BHRS. The 2011 survey, based on care received in 2010, showed that member satisfaction was high in several areas.

In general, members and families responded that providers:

- Listened carefully and explained things in a way that they could understand
- Made them feel safe and informed them about their rights
- Explained the benefits of taking medications
- Allowed them to be involved as much as they wanted in their treatment
- Were helpful in the Interagency Team Meetings and that in general the BSCs were helpful to their children

Areas that were identified as having lower scores and are being viewed as opportunities for improvement include:

- Urgent Access: when members/families needed treatment or counseling right away how long did they have to wait between trying to get care and actually seeing someone?
- Were they given the chance to make treatment decisions?

Interventions to improve satisfaction in these areas include:

- Implementation of Mobile and Walk-In Crisis throughout the HealthChoices contracts
- Promoting the crisis services that are available

as well as presenting information regarding the member Access Standards

- Addition of a Child/Adolescent Psychiatrist as well as other outpatient providers to the network
- Ongoing discussion with providers of the importance of referring members to other providers or back to Community Care if they are unable to accommodate the member within our access standards
- Ongoing work with the Common Ground recovery efforts and the opening of a new decision support center, as well as the implementation of a Personal Medicine and Power Statement Booster pack
- Continuum of Care provider trainings
- Ongoing work of The Recovery Learning Collaborative

Community Care thanks providers for their efforts to increase our members' satisfaction. If you have any thoughts, ideas, or comments please call your Provider Representative. The Community Care toll-free Provider Line is 1-888-251-2224.

7

Access standards

Community Care providers are contractually obligated to provide access to appointments for members that meet HealthChoices program requirements. Community Care members are entitled to:

- Immediate emergency services in life-threatening situations.
- Non-life-threatening emergency services within one hour.
- Services for urgent needs within 24 hours.
- Routine behavioral health services within seven calendar days.

Notify your Provider Representative if you are unable to meet these standards.

Opening the Door

~ Written by Sue Killmeyer and edited by Patty Schake, Helping Families Raise Healthy Children

The door opens and a young mother named Rhianna invites Ann, an early intervention service coordinator with the Helping Families Raise Healthy Children project, into her home. Her pediatrician referred her to the project after noting symptoms of depression since the birth of her twins, Brianna and Elana, four months ago.

“Pardon the mess; I haven’t been able to pick up.” Rhianna clears a space on the sofa, littered with baby clothes, and invites Ann to sit. Ann notices that Rhianna looks tired and nervous. After talking a bit, Ann suggests they begin by filling out a simple depression screen. Rhianna reluctantly completes it, then anxiously hands it back. As Ann looks over the assessment, she notices that Rhianna is indeed at high risk for depression. “I feel ashamed about it,” Rhianna says quietly, her eyes filled with tears. “The thing is, I can’t talk about this to my family. For us, it’s just about staying strong and keeping problems between yourself and the Lord. But lately, I just want to leave the babies in the crib so I can sleep, even if they’re woke. I don’t know what to do, for real.”

Ann invites Rhianna to share what has been hard lately. As if a door has opened, she begins to share her worries about money, her children’s father who comes and goes, and the loss of freedom since having the babies. Suddenly, she stops and apologizes, “I’m sorry, nobody has ever asked me about what was going on with me like this. Just saying it out loud makes me feel a little lighter...” She jumps up suddenly. “Let me get the babies.”

Greeting the twins, Ann sees two very different babies. Brianna is alert, smiling, cooing, and active about soliciting attention. Rhianna smiles as she watches her. “She is one of the few people in my

life who can always make me smile.” Elana, sitting in an infant seat across the room, silently watches the shadows on the ceiling. Rhianna glances over and shakes her head, “She is always in her own world. She’ll even cry if I go to pick her up!” Ann invites Rhianna to sit on the floor and bring the babies down on the blanket. Moving through developmental assessment activities, Ann notices that Rhianna handles and speaks to Brianna more often. She notices too that Elana has a flat place on the back of her head and a head tilt. Ann wonders aloud, “What makes Elana smile?” Rhianna says, simply, “She smiles for angels”. Drawing closer to Ann, she speaks softly, “I pray to God every night that nothing is wrong with that child.”

Ann ponders the problem: Rhianna is experiencing symptoms of depression and reacting numbly to all but the most vigorous signals for interaction, something that active Brianna is able to do. Elana, the quieter baby, uses more subtle cues. She is being talked to and picked up less. Ann is concerned not only about Elana’s physical development, but also the essential “dance” of give-and-take interactions between mother and child that shape the earliest bonds of attachment. The downward spiral that can occur in families challenged by maternal depression and developmental delay seems to have already begun.

Ann shares the results of Elana’s assessment that reveal a slight delay. As Rhianna’s face clouds with fear, Ann reassures her that many twins are born with a tight neck muscle from their position in utero and experience reduced strength and mobility. She also shares with Rhianna that it can be painful for Elana to be lifted and turned if her neck is tight on one side. Ann explains that a physical therapist can come to the home and teach

Rhianna stretches that will help Elana. Rhianna nods and silently lets the tears fall that she has been holding until now.

Ann knows that the physical therapist who will work with the family has learned about the importance of early relationships, and is confident that the “dance” between mother and child will be supported. Similarly, as she talks with Rhianna about taking care of herself, Ann is able to share the names of trusted therapists she knows personally who can come into the home to help Rhianna with her depression and stress and also support family relationships.

Despite her fear about having an evaluation for her baby and therapy for herself, with Ann’s support, Rhianna decides to move forward; again opening the door to help for her child, herself, her family.

At a visit with Ann three months later, Rhianna reports that Elana blossomed after they began physical therapy sessions. She proudly tells Ann that Elana prefers it when Rhianna, not the therapist, does the stretches because she has the best touch and so the therapist coaches her on what to do. Ann can see the therapist’s coaching strategy has carved out a perfect place for mother and child to connect. Rhianna demonstrates tenderly how she moves Elana’s head and massages her neck. “You know, she is still a quiet baby, but she has her own way of telling me what she likes,” she says, smiling as she positions Elana carefully next to Brianna on the blanket nearby.

She also shares with Ann her experience of making a family tree with her behavioral health therapist, Maya, who she sees each week at home. “I realized that my mother, and even my grandmother, probably went through depression themselves. I can remember when others had to step in and do for them. Maya helped me find the people in my

life that might be there for me. I made myself reach out, and I was surprised! My aunt is watching the babies twice a week while I spend some time any old way. Maya helped me sign up at the Family Support Center and I’m going to start yoga next week. We’ll see how THAT goes!” Rhianna laughs as she walks Ann to the door. “Remember when I needed to sleep all day? I’m SO glad that’s past.” Ann is too, as she steps out into the sun and closes the door gently behind her.

Community Care operates the *Helping Families Raise Healthy Children* initiative in Allegheny County with a grant from the Robert Wood Johnson Foundation Local Funding Partnerships program and matching support from local funders including Highmark Foundation, UPMC Health Plan, The Fine Foundation, FISA Foundation, Jewish Healthcare Foundation, and The Pittsburgh Foundation. It is a quality improvement initiative that provides enhanced, coordinated services to families in Allegheny County who are facing the challenges of parental depression and early childhood developmental delays. The initiative recognizes that parental depression can affect early childhood development and that having a child who has a developmental delay can place a parent at risk for depression. *Helping Families Raise Healthy Children* identifies families experiencing these challenges and connects them to coordinated behavioral health and early intervention services that work together to help parents, children, and families.



Brain Injury and Domestic Abuse

~ From the Pennsylvania Department of Public Welfare (DPW)

About one third of all domestic abuse victims suffer injuries to the head, neck, and face. The abuse can cause traumatic brain injury (TBI).

Domestic abuse victims may suffer TBI from being:

- Hit on the head.
- Shaken.
- Pushed down stairs.
- Thrown.
- Shot in the head.
- Stabbed in the head.
- Slammed against a wall or floor.

10

A victim with TBI may not be able to make good choices. It may be hard to keep safe or find help. An abuser may use these problems to confuse and abuse a victim even more.

TBI may cause a person to become anxious or depressed. A person with TBI may have trouble holding a job. Paying attention or doing tasks may be hard.

TBI can affect how a person relates to his or her children and other family members. TBI can cause trouble with finding the right words, being patient or dealing with emotions.

Other problems that may result from TBI are reduced memory or thinking speed. A person with TBI may be confused or very sleepy. He or she may be less aware or less creative. Repeated hits to the head may cause worse damage to the brain or even death.

TBI is serious, but can be treated. A victim who may have TBI must see a doctor. If the person has a TBI, he or she can ask about ways to heal.

If you or someone close to you needs to learn more about TBI, please contact the Brain Injury Line at 1-866-412-4755, TTY 1-877-232-7640.

To speak with someone about abuse or locate a local domestic violence program: National Domestic Violence Hotline 1-800-799-7233 (SAFE) 1-800-787-3224 (TTY for the Deaf) For more information, visit: www.ndvh.org.



Know the Facts

Did you know that...

- People with serious behavioral illness die earlier than the general population.
- People without SMI who have risk factors common to SMI (e.g., smoking, poverty, homelessness, obesity) also die much earlier than the general population.
- 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary, and infectious diseases.
- About 3 out of 5 people with SMI who die prematurely, die from mostly preventable diseases.

Please share the information on this page about quitting smoking and diet and exercise with Community Care members.

Little things add up

Little things can make all the difference when trying to keep your family healthy and happy. Making changes, even small ones, can keep diet and exercise new and exciting!

Try taking the family to a local farm or farmer's market for fresh fruits and vegetables. Let the kids pick a new or unusual food from the produce section at the grocery store and learn to cook it as family – trying new foods increases our tastes and encourages our curiosity!

Take a family walk to the local park or play a game of tag. Remember, being active is important and play counts!

Determined to quit

Smoking is harmful for your health and the health of those around you. It is very important to stop smoking, especially if you are pregnant.

Quitting can be hard and you might need help. A new website, www.DeterminedToQuit.com, has ways to help you quit smoking and using tobacco. Information on the website can help you get on the path to healthier living and stay tobacco-free. The website shows contact information for local resources and support programs.

You can get to the Determined To Quit program information at www.ccbh.com. For help with quitting, talk to your doctor. You can also call Community Care or one of the numbers below.

**National
Free Quit Line
1-800-QUIT-NOW;
(1-800-784-8669)**

**Great Start Pregnant
Smokers Quit Line
1-866-667-8278**

