

THE PROVIDER LINE

Vol 1-2012

**Register for Community Care's
annual spring conference!**

**CREATING HEALTH HOMES:
EMBRACING RECOVERY
THURSDAY, MARCH 8, 2012
OMNI WILLIAM PENN HOTEL
PITTSBURGH, PA**

Intended for consumers, families, psychologists, psychiatrists, nurses, and other behavioral health stakeholders, this conference will focus on wellness. Presenters will describe the Health Home model and how it addresses the need for integrated care and promotes wellness.

Keynote speaker Peggy Swarbrick, PhD, Director, Institute for Wellness and Recovery Initiatives, Collaborative Support Programs of New Jersey, will present ways to develop a workforce and service system grounded in wellness. Personal life challenges resulted in Dr. Swarbrick's desire to work in the behavioral health field. She has made significant contributions to the service delivery system in regards to peer-delivered service models and community-based health and wellness programs. Dr. Swarbrick will also provide an overview of the SAMSHA Wellness Campaign. Additional workshops on a number of current wellness-related topics will be offered.

To see the conference brochure and/or register, visit www.ccbh.com.

Buprenorphine Best Practices

"Best Practices in the Use of Buprenorphine," – an initiative that identifies guidelines for providers and payers to enhance the use of buprenorphine and address quality concerns related to its use – has been released by Community Care. Developed by the Institute for Research, Education, and Training in Addictions (IRETA) with support and assistance from Community Care, "Best Practices in the Use of Buprenorphine" is available on the Community Care website at <http://www.ccbh.com/buprenorphine>.

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In addition, Community Care has completed an analysis of patterns of medication-assisted treatment of opioid dependence. An article describing this analysis will appear in a forthcoming issue of "Drug and Alcohol Dependence," one of the leading substance-abuse, peer-reviewed journals.

Buprenorphine is a narcotic analgesic used to provide medication-assisted treatment for opiate addiction by community-based providers who work outside of methadone programs. Buprenorphine is marketed under the brand name Subutex® and buprenorphine/naloxone is marketed under the brand name Suboxone®.

Community Care is committed to continued work with its members, providers, and other stakeholders to improve the value of this novel treatment for opiate addiction.



Treating Alcohol Dependence with Naltrexone

Alcohol use disorders, including abuse and dependence, affect about 15 to 20 million Americans at any given time.¹ Treatments for alcohol dependence range from brief interventions (counseling and education) to drug therapies.¹ Several medications have been approved by the U.S. Food and Drug Administration for the treatment of alcohol use disorders.

Summaries of research findings have highlighted the following beneficial effects of medication-assisted treatment for alcohol use disorders: lengthened periods of abstinence, prevents a lapse from becoming a full-blown relapse, allows brains cells to readapt to a normal nonalcoholic state, relieves symptoms of protracted withdrawal, supports the effects of psychosocial treatment and sustains the gains of interventions.²

Despite this evidence relatively few patients receive pharmacotherapy.³ An analysis conducted by Community Care shows that naltrexone utilization by our members is low. We identified 6,010 members who had at least one service claim with an alcohol use disorder diagnosis during the time period of January 1, 2011 to June 30, 2011. Of these members, only 95 (1.6%) received a prescription for naltrexone or Vivitrol® during the same time period. Also, of the members with an alcohol-related disorder diagnosis, 16 had a prescription filled for Antabuse and 60 had a prescription filled for Campral during the analysis period.

Naltrexone is a pure opioid antagonist approved by the FDA for the management of alcohol dependence and opioid dependence. Sometimes known under its brand names ReVia®, Depade® and Vivitrol®, naltrexone is an effective medication for some patients with alcohol dependence. In a

systematic review of 11 double-blind placebo-controlled trials, researchers found that naltrexone reduces short-term relapse rates in patients with alcohol dependence when combined with psychosocial treatments. Short-term outcomes in favor of naltrexone included fewer patients relapsing to alcohol dependence, fewer patients returning to drinking, reduced cravings for alcohol, and fewer drinking days.⁴

Naltrexone competitively displaces opioid medications from their binding sites, precipitating withdrawal. Patients have to be fully withdrawn from all opioids before considering therapy with naltrexone.²

Common side effects include nausea and vomiting (10%) but these tend to be transient. It can also cause anxiety, nervousness, insomnia, headache, joint or muscle pain, and tiredness. A 25 mg starting dose has been suggested to minimize these side effects.

At the currently recommended dose of 50 mg daily, hepatic toxicity is very unlikely but naltrexone has the capacity to cause hepatocellular injury when given in excessive doses especially for an extended period of time. It is recommended that liver function tests be performed before starting treatment and at regular intervals. More frequent testing should be done if baseline liver function test results are high, there is a history of hepatic disease, a potential hepatotoxic medication is also prescribed, or the patient is taking doses higher than 50 mg/day.²

Injectable naltrexone (Vivitrol®) came on to the market to help increase adherence by allowing once monthly dosing. However, there is a high expense issue and side effects are about equal to

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the oral formulation. The oral version also has a generic formulation which is available on most formularies. Most physical health plans require a pre-authorization for the injectable version of naltrexone with verification that a trial of oral naltrexone has been ineffective.

Individuals who have been diagnosed as alcohol dependent, are medically stable, and are not currently (or recently) using opioids (e.g., heroin, controlled pain medication) are suitable candidates for naltrexone therapy. Other considerations before starting therapy include:

- Patients should be willing to be in a supportive relationship with a health care provider or support group to enhance treatment compliance and work toward a common goal of sobriety.
- A patient's interest and willingness are important factors if treatment is to be successful.
- The final decision to use naltrexone should be based on a risk-benefit analysis.

For complete naltrexone prescribing information please go to <http://www.drugs.com/pro/naltrexone.html?printable=1>. Full prescribing information for Vivitrol® can be found at http://www.vivitrol.com/pdf_docs/prescribing_info.pdf. Information on clinical guidelines for the use of prescription medication in the treatment of alcohol use disorders can be found at <http://www.kap.samhsa.gov/products/manuals/tips/pdf/TIP49.pdf>.

- 1 Anton R. Naltrexone for the management of alcohol dependence. *N Engl J Med.* 2008;359:715-721.
- 2 Center for Substance Abuse Treatment. Incorporating alcohol pharmacotherapies into medical practice. Treatment Improvement Protocol (TIP) 49. HHS Pub No. (SMA) 09-4380. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.
- 3 Starosta A, Leeman R, Volpicelli J. The BRENDA model: integrating psychosocial treatment and pharmacotherapy for the treatment of alcohol use disorders. *J Psychiatr Pract.* 2006;12(2):80-89.
- 4 Williams S. Medications for treating alcohol dependence. *American Family Physician.* 2005;72(9):1775-1780.

New Standards for Health Indicators

Provider Alert #7, distributed 10/12/11 and updated in December 2011, contains information regarding new standards. Community Care deems it important for mental health and drug and alcohol facility based, partial hospital, and outpatient providers and other services that include physician services, such as CTT, to check the weight and height to calculate BMI with each new adult, child, and adolescent assessment. Providers are expected to identify whether the BMI places the adult, child, or adolescent at a normal weight or not.

A guideline outlining the frequency of continued monitoring of BMI is provided for adults and children who are prescribed antipsychotics or other medications that pose risk of weight gain or increased metabolic abnormalities. A guideline addressing the frequency of monitoring for adults and children who are not prescribed such medications is also provided.

Community Care expects providers to establish a policy/procedure to monitor these indicators and will measure how well providers meet the standards as part of our quality monitoring and service authorization processes. Mental health and drug and alcohol providers who do not fall into the above categories are expected to request height and weight at least annually and are encouraged to educate members and guardians about the importance of medication monitoring.

Community Care is available for assistance. Training opportunities and other resources are posted on our website, www.ccbh.com. Provider Alert #7 and the subsequent update are also on our website, under Provider Resources, Provider Manual and Alerts.

2011 Provider Benchmarking Results

For nearly a decade, Community Care has published annual Provider Benchmarking reports for service providers. In June 2011, 641 reports were mailed to 225 distinct providers. Community Care publishes Provider Benchmarking reports in an effort to share information with providers and to encourage continuous quality improvement throughout the provider network.

The 2011 reports included over 40 different indicators for six levels of care, specifically, Inpatient Mental Health (IMH), Short-Term and Long-Term Non-Hospital Rehabilitation (NHR, or 3B and 3C), Blended Case Management/Service Coordination (BCM), Residential Treatment Facilities (RTF), and Behavioral Health Rehabilitation Services (BHRS).

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The reports included the following indicators:

- Inpatient Mental Health
 - o 30-day psychiatric readmission rate.
 - o 7- and 30-day rates of follow-up post discharge.
 - o Average number of days to aftercare post discharge.
- Short-Term (3B) and Long-Term (3C) Non-Hospital Rehabilitation
 - o 7- and 30-day rates of follow-up post discharge.
 - o Average number of days to aftercare post discharge.
 - o Average length of stay.
- Blended Case Management/Service Coordination (Indicators for this level of care were published separately for adult and child/adolescent services.)
 - o Rate of contact during member inpatient stay.
 - o 7- and 14-day rates for linkage of members to aftercare post inpatient discharge.

- Residential Treatment Facilities
 - o Median length of stay.
 - o 7-day rate of aftercare post-RTF discharge.
 - o Inpatient Mental Health admission rate (during the course of RTF treatment).
 - o Percentage of discharged members with length of stay greater than one year.
- Behavioral Health Rehabilitation Services
 - o Service provision rates for Behavioral Specialist Consultant, Mobile Therapy, and Therapeutic Staff Support services.
 - o Average length of stay, by service line and overall (this indicator was published for members without an autistic spectrum diagnosis, only).

The 2011 Benchmarking reports were based on claims submitted for services provided in calendar year 2010. Data for years 2009 and 2008 were included for comparison purposes. Reports were sent to high-volume providers, defined as 10 or more clients served (or distinct discharges for some indicators) for a given contract in 2010. Benchmarking findings were also shared with providers in 28 group meetings throughout the 35 counties served by Community Care in 2010. These meetings included 15 BHRS, 5 IMH, 4 RTF, 4 BCM, 2 NHR provider groups.

OMHSAS has established Gold Standards for several of these indicators: specifically, psychiatric readmission (10% or less) and rates of aftercare within 7 and 30 days post discharge from IMH and/or NHR (90%). Additionally, for some indicators Community Care has established target rates for all providers to meet.

Community Care adopted the OMHSAS Gold Standard of 10% psychiatric readmission or less as a goal. Community Care also established goals

Benchmarking (continued)

for the number of days between discharge for IMH/ NHR and first aftercare appointment of seven days or less. Any provider who did not meet a target goal for any of these four indicators was asked to engage in a quality improvement activity aimed at improving their rate.

This year, 55 providers were asked to develop quality improvement plans related to Benchmarking reports. Some providers were asked to engage in quality improvement activities related to more than one rate. In total, the 55 providers were asked to analyze 92 specific rates. Community Care had one-on-one discussions related to the Benchmarking reports with 11 providers. Each was asked to engage in quality improvement activities to improve their rates.

Community Care solicits feedback from providers regarding the factors which are influencing the Benchmarking rates. This information is solicited during group and individual provider meetings and at Provider Advisory Committee meetings.

Regarding the indicators for which Community Care has established goals (or for which OMHSAS has established a Gold Standard), providers have identified the following influencing factors, among others:

- Limited involvement of family members and other supportive people.
- Members do not have adequate transportation.
- Limited provider knowledge of available outpatient providers and referral process.
- Members have co-occurring drug and alcohol and mental health issues.
- Members choosing to not attend aftercare appointments or take medications as prescribed by their doctor.

Providers have developed many interventions to address these challenges, including:

- Educating staff about available outpatient resources, alternatives to inpatient admissions, and working with co-occurring mental health and drug and alcohol issues.
- Improving communication between the hospitals/rehabs and the outpatient providers.
- Beginning aftercare process with all team members including members' support system early on in the admission.
- Helping members obtain case management or service coordination services, as appropriate.
- Training staff on use of Motivational Interviewing and other relapse, prevention, and recovery programs.

Community Care welcomes provider input in the Benchmarking process. To share your ideas or comments regarding provider benchmarking, please send an e-mail to ccbh_benchmarking@ccbh.com.

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

Shaken Baby Syndrome ~ PA Department of Public Welfare (DPW)

Shaken Baby Syndrome (SBS) is the result of a traumatic brain injury. SBS happens when a baby is:

- Shaken.
- Dropped.
- Thrown.
- Caused head injury in some other way.

SBS is the leading cause of child abuse deaths in the United States. SBS is most commonly found in babies from 3 to 8 months of age. Babies up to 4 months of age are at the greatest risk for being shaken. SBS can occur in children up to five years of age.

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A baby's neck muscles cannot manage shaking or impact to the head. This can cause a baby's brain to swell, bruise and bleed. The result is SBS. Parents or caregivers may shake or strike a baby because they are frustrated or exhausted. They may not know how to deal with a crying baby.

They may not understand child development or how to comfort a baby. They may have learned the behavior from someone else.

SBS can affect children in many ways. Babies with SBS may be irritable or not able to eat much. Some may not stop crying. SBS can also cause learning delays, blindness, hearing problems or death. Other SBS symptoms may include:

- Sleep pattern changes.
- Difficulty in waking up.
- Seizures.
- Motor skill issues.
- Muscle spasms.
- Cerebral Palsy.

Parents or caregivers who feel at a loss for ways to cope with an upset baby can call a friend or relative to ask for help or just to talk.

**Parents or caregivers
may also call the:
Crying Baby Hotline
at 1-866-243-2229 or
the Brain Injury Helpline
at 1-866-412-4755**

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



Clinical Practice Guidelines for Decision Making

Community Care uses clinical practice guidelines to help practitioners and members make decisions on appropriate care for specific clinical circumstances. These evidence-based guidelines are reviewed annually, updated as appropriate, and approved by Community Care's Quality and Care Management Committee. Community Care has adopted three clinical practice guidelines.

APA Guideline for the Treatment of Patients with Major Depressive Disorder (3rd Edition)

Major depressive disorder (MDD) is the top diagnosis for the Community Care membership; therefore Community Care has adopted the recently published 3rd Edition of the MDD guideline. This new edition contains several recommendations including the use of a clinician- and/or patient-administered rating scale for psychiatric symptoms to help with treatment strategies, using aerobic exercise or resistance training to improve mood symptoms, and that for the initial treatment of mild and moderate depression both psychotherapy and medications are useful.

This edition also contains new evidence-based guidelines related to clinical issues such as the use of antidepressant medications, depression-focused psychotherapies, and guidelines for somatic treatments such as electroconvulsive therapy.

APA Guideline for the Treatment of Patients with Schizophrenia (2nd Edition)

Schizophrenia is among the top ten diagnoses for the Community Care membership, therefore Community Care has adopted this guideline for the treatment of patients with schizophrenia.

NIDA Principles of Drug Addiction Treatment: A Research Based Guide (2nd Edition)

Because substance abuse disorders account for two of the ten most prevalent diagnoses within the membership, Community Care has adopted this NIDA guideline for the treatment of substance use disorders.

Community Care measures provider adherence to clinical practice guidelines through claims data and record reviews. Providers are notified of the results of these measurements through newsletter articles, letters, and web-based communications.

To obtain a copy of the APA Guidelines:

- Contact the American Psychological Association, 1400 K Street, NW Washington, DC 20005..
- Visit <http://www.psychiatryonline.com/pracGuide/pracGuideHome.aspx>.

To obtain copies of the NIDA Guidelines:

- Contact the National Institute of Drug Abuse, National Institute of Health, 6001 Executive Boulevard, Room 5213, Bethesda, MD 20892
- Visit <http://www.nida.nih.gov/PODAT/PODATIndex.html>.

If you have questions regarding the use of these guidelines, please call us at 1-888-251-2224 and ask to speak to a Quality representative.

A Healthy New Year

The New Year is a time when many people try to adopt healthy habits. Please talk with Community Care members about quitting smoking and eating healthier in the new year.

Smoking Cessation

One of the best things that people can do to improve their health is to quit smoking. There are many resources available that support the decision to quit.

A new website, www.DeterminedToQuit.com, provides a free quit companion, articles, and motivational guides for quitting and staying tobacco free. Information about support programs and resources in each county is provided. A link to this website is provided on Community Care's website, www.ccbh.com, under Topics of Interest/Smoking Cessation/Hotline on the home page.

Members can call the National Free Quit Line at 1-800-QUIT NOW, the Great Start Pregnant Smokers Quit Line at 1-866-667-8278, or their Community Care office for information about local programs.

Weight Management

Making small changes as a family related to diet and exercise can make a big difference with childhood obesity. There are fun things that the entire family can do this winter to get moving - like sled riding or building a snowman. Eating healthy meals and buying snacks that are low in sugar will help the entire family lose weight and keep it off. Getting and staying in shape helps kids to feel better about themselves.

Preventive Health Programs

Community Care maintains two Preventive Health programs: a Depression Program for adults (age 18 and over) and an Attention Deficit Hyperactivity Disorder (ADHD) program for parents/guardians of children (age 12 and under).

Available in Allegheny, York, Adams, Berks, Chester, North Central, Carbon, Monroe, Pike, and Erie counties, both programs are designed to help members and their families learn more about their illnesses and how to help themselves or their children. Adult members recently diagnosed with depression and the parents or guardians of child members recently diagnosed with ADHD are automatically sent a series of three free newsletters. The newsletters are also sent to any member who requests them.

Information specific to depression in older adults, such as symptoms, treatment, and recovery is also available. All of the Preventive Health materials are posted on Community Care's website, www.ccbh.com.

A survey of members showed that the newsletters are very helpful. Participants said that they felt less stressed and more informed after reading the Preventive Health materials.

Community Care encourages you to refer any member who you feel may benefit from the program. For more information and/or to obtain copies of the newsletters, call the Preventive Health phone line, toll-free 1-866-639-2943.