

Clinical Practice Guidelines

UPMC Health Plan Behavioral Health Services utilizes Clinical Practice Guidelines to help providers and members make decisions about appropriate health care for specific clinical circumstances. These evidence-based guidelines are reviewed at least every two years, updated as appropriate and approved by the Quality and Care Management Committee. UPMC Health Plan Behavioral Health Services uses the American Psychiatric Association (APA) Guideline for Major Depressive Disorder (Second Edition) and the National Institute on Drug Abuse (NIDA) Principles of Drug Addiction Treatment: A Research-Based Guide for Substance Use Disorders. In addition to these to clinical practice guidelines, Community Care recently adopted the APA Practice Guideline for the Treatment of Patients with Schizophrenia (Second Edition – April 2004), as well as the APA's Treating Schizophrenia – A Quick Reference Guide.

UPMC Health Plan Behavioral Health Services measures compliance to the guidelines within the network through adherence measures. These measures include data for both the Commercial and Medicare populations.

The two adherence measures for depression are:

- Members in treatment for depression with more than one behavioral health clinician where there is evidence of communication between clinicians during the treatment episode.
- Members being treated for a new episode of major depressive disorder who have weekly visits during the first four weeks of treatment.

The first measure is based on 2007 record review data for inpatient and outpatient levels of care. For calendar year 2007, 88% of members in treatment with more than one behavioral health clinician had evidence of communication between clinicians during the treatment episode. The goal is 90%. Providers falling below expectation had to submit a Corrective Action Plan for improving communication with other behavioral health clinicians.

The second measure is based on calendar year 2006 claims data. In 2006, only 14.3% of members being treated for a new episode of Major Depressive Disorder had weekly visits during the first four weeks of treatment. The expectation is that members are seen at least weekly in the early phase of treatment. Our goal for the next re-measurement period is 25%. The Quality and Care Management Committee identified the following barriers to this measure:

- Members choose to not attend the expected number of sessions
- Members have scheduling conflicts
- Providers are not aware of the expectation of weekly visits

Interventions are in place to increase this rate and include:

- Distributing the Clinical Practice Guidelines to providers to make them fully aware of our criteria and standards in the Provider Newsletter.

- Publishing articles for providers with important information in relation to our indicators and standards for high quality care.
- Publicizing our web site with information for providers and members about guidelines and adherence measures.

The NIDA Guideline was adopted in April 2005. There are three adherence measures for Substance Use:

- Members with substance abuse disorders who receive an adequate length of treatment, defined as 90 days.
- Members that initiate follow up chemical dependency treatment after detoxification.
- Members in treatment for substance abuse who are assessed for the co-occurrence of a mental disorder and, if identified, receive integrated treatment for both conditions.

The first measure is based on calendar year 2006 claims data. In 2006, 27% of patients with substance use disorders received treatment for 90 days. Our goal for the next re-measurement period is 30%. The second measure is also based on calendar year 2006 claims data. In 2006, 52% of patients initiated follow up chemical dependency treatment after detoxification. Our goal for the next re-measurement period is 65%.

The Quality and Care Management Committee identified the following barriers to these measures:

- Member perception: some members consider detoxification to be a medical cure and not a behavioral health treatment. Thus, members do not seek follow-up appointments with a behavioral health care provider because they consider detoxification to be the first and final step necessary to cure their condition.
- UPMC Health Plan Behavioral Health Services only views a follow-up appointment as satisfying this indicator if the member schedules further treatments for chemical dependency. If the member schedules additional visits and seeks treatment for a mental health disorder, he or she is not included under this indicator.
- Members attend support groups such as Alcoholics Anonymous or Narcotics Anonymous, therefore no claim would show.

Interventions identified by the Quality and Care Management Committee include:

- Care Managers continue using problem solving techniques to get members enthusiastic and committed to treatment.
- Publishing articles about treatments for substance use disorders, detailing the Clinical Practice Guidelines and adherence measures for providers, and other valuable information for PCPs, Commercial members, and Medicare members.
- The Audit C screening tool for alcohol abuse is posted on both the provider and member websites at www.ccbh.com.

The third measure is broken down into two indicators and is based on 2007 record review data: Members in treatment for substance use disorders who are screened for a coexisting

mental disorder and members in treatment for substance use disorders who are identified as having a coexisting mental disorder and received integrated treatment for both conditions. The 2007 rates for these indicators were 100% and 96%, respectively. The goal for both of these indicators is 95%.

UPMC Health Plan Behavioral Health Services continues to encourage providers in our network to consider utilizing these guidelines when treating patients with Major Depressive Disorders and Substance Use Disorders.

In the 2006 Membership Analysis it was found that 4% of UPMC Health Plan Behavioral Health Services members currently receiving care are diagnosed with schizophrenia and an additional 3% are diagnosed with schizoaffective disorder. Schizophrenia diagnoses are evenly distributed between men and women, and for our Medicare members this diagnosis accounts for over 7% of the diagnoses documented for members under age 65 who are currently in treatment. Due to these findings, in the next coming year UPMC Health Plan Behavioral Health Services will incorporate the Schizophrenia guidelines from the APA into our Clinical Practice Guidelines. The APA guidelines are evidence-based and provide a wealth of information on all aspects of schizophrenia, from diagnosis to treatment. The guidelines review how to establish a diagnosis, they outline the phases of the disorder, they review different treatments, and they provide other critical information.

To obtain copies of the APA guideline for Major Depressive Disorder and Schizophrenia, contact the American Psychiatric Association, 1400 K Street NW, Washington, D.C. 20005. The guideline may also be obtained via the APA website at: http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm

To obtain copies of the NIDA substance use disorders guideline, contact the National Institute of Drug Abuse, National Institutes of Health, 6001 Executive Boulevard, Room 5213, Bethesda, MD 20892. The guideline may also be obtained via the NIDA website at: <http://www.nida.nih.gov/PODAT/PODATIndex.html>

For more information about our Clinical Practice Guidelines or adherence measures, please contact UPMC Health Plan Behavioral Health Services at 1-888-251-2224 and ask for a Quality representative.