Behavioral Health Partnership Oversight Council
Coordination of Care Subcommittee

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Meeting Summary: May 23, 2007
Co-Chairs: Sheila Amdur & Connie Catrone
Next meeting: June date TBA.

March meeting summary: accepted with provision that Health Net clarify the underlined:
How does the practitioner know a script has been rejected because of industry limitation on dosage or number of pills dispensed?

- Health Net applies the industry limitations as part of the PA process and the PBM follows up with the prescribing practitioner.

Health Net response: Physicians can be notified in two ways of a claim rejecting for quantity limitation.

1.) Point of service-rejection message comes up on the screen and the pharmacist can notify the physician
2.) Unresolved reject report is reviewed twice a week by HN. Unresolved rejects are pulled and the provider is notified of the rejection

Anthem will provide this information related to this question that will be included in the May 2007 summary. Received from Anthem:

Anthem applies limitations on dosage or the number of pills dispensed based on the FDA approved dosing for a particular medication. These are safety edits that help prevent overdose and unwanted side effects, and promote efficient use of medications. Once the pharmacist receives a message about a quantity limit, it is up to the pharmacist to contact the prescribing physician to verify the dose. The pharmacist can then contact the PBM for an override. If the pharmacist contacts the PBM instead of the prescribing physician, the PBM will then contact the physician as part of the PA process

Mercer Prescription update
Mercer and the MCOs have provided each other with appropriate data for the study:

- DSS expects draft report to MCOs and Subcommittee late July, with final report in October 2007.
- ***DSS will request Mercer provide the SC with list of MCO study questions and Mercer's answers.***

Other Pharmacy Issues
Sheldon Toubman stated that Anthem's new temporary drug supply policy change is not reflected in the pharmacy screen message when a client presents with a script that requires and does not have prior authorization. The DSS Dep. Commissioner had requested Anthem make the appropriate changes so the system reflects the policy change. Anthem stated they have responded to the DSS letter and are "estimating the level of effort" to make the changes.

Health Net stated their pharmacy screen reflects their policy change and the new processes are in place. ***DSS will send Anthem and Health Net pharmacy print screens to the SC.***

HUSKY MCO & CTBHP/ValueOptions (CTBHP/VO) Co-management of Complex Cases

Sandra Quinn, Director of UM, CTBHP/VO, provided examples of the CTBHP/MCO co-management process for complex HUSKY cases and 1st Quarter 07 intensive co-management of medical/BH issues. CTBHP/VO will provide the Subcommittee with quarterly reports on co-managed cases.

There were 109 cases referred by MCOs to CTBHP/VO for co-management. Of these Health Net made 45% (49) of the 109 referrals, CHNCT 36% (36), Anthem 17% (18) and Well Care 3% (3). Rose Ciarcia will review the low referral rate with WellCare. The MCO changed its base of operations from CT to the parent company Florida site early in 2007. The plan had assured the SC at an earlier meeting that this change will not impact the member or their services.

The MCOs and CTBHP/VO meet monthly to review co-management cases. Family peer specialists may work with the member/family as part of the VO clinical team. For example, peer specialist home visits with women with perinatal depression have been instrumental in connecting women to BH services. Crisis planning through EMPS may be implemented as appropriate for some cases.

The most frequent diagnoses in the co-management group include depression (34 cases) followed by alcohol abuse (10), substance abuse (9), anxiety disorder (6) and family supports.

Comments:

- Home care services for co-occurring diagnoses:
    - The home care agency determines what is needed – primary medical RN may manage psych. medication with medical problems or the agency may determine the patient needs both medical and psychiatric nursing services, depending on safety needs and quality of care issues.
    - Medical providers sensitive to patient BH needs do contact the MCO/CTBHP for medical/BH care management assistance. Family and/or providers may contact CTBHP/VO for difficult to access services such as in-home medical and developmental services.
    - MCOs identify frequent ED users and may engage CTBHP/VO care co-management.
    - Families with a special needs child cared for at home may require home-based behavioral health interventions for the child/family to prevent a crisis. CTBHP/VO can connect the family to an appropriate home-based BH provider.

PCP/BH Integration

Dr. Kant (CTBHP/VO) provided a ***DRAFT*** Educating Practices in the Community (EPIC) module for *Timely Connection of Children & Their Families to BH Services* developed by the BHP, CTBHP/VO primary care subcommittee, Child Health & Development Institute (CHDI). {*Click on icon below)*


EPIC Draft.ppt

A major barrier to integration of medical/BH care is availability of psychiatric services. Two initiatives within the BHP program seek to address this barrier:

- Enhanced Care Clinic (ECC) formal relationship with adult and child primary care will be part of the ECC criteria beginning January 2008.
- CTBHP/VO Pharmacy consultation line by a child & adolescent psychiatrist on general questions about medication options for specific disorder, dosage range, side effects.

The EPIC training program will be presented by CHDI to pediatricians and family practice practitioners. The training will include how the BHP program "works" and how CTBHP/VO can assist a family and medical provider in making connections to BH services.

- C***onnie Catrone suggested training the medical practitioner on the regional community collaborative: VO will look at this.***
- **Staff will follow up with DMHAS on status of BH Strategy Board appropriation to the agency for primary care training in mental health issues.**

Prior to development of the ECC/PC integration implementation, CHDI awarded grants to four PC sites that integrate BH services within the medical practice. These will serve as "case studies" of this model with data assessment over time *(see description of PCP site activities).*


BH & PC awards.doc

DSS has received a technical assistance (TA) grant - ABCD Screening - that includes perinatal depression screening. CHDI will be part of the DSS team that meets with other states on this grant.

DCF Prescribing Protocol

DCF is implementing changes on how providers obtain permission for psychiatric drug treatment for DCF committed children, where DCF is the "legal parent" of the child. Currently DCF approval involves several steps that can take days to complete for inpatient or outpatient medication. The plan includes

- 3 DCF medical regions staffed by a regional Medical director (full time psychiatrist) and part time pediatrician.
- DCF Centralized Medication Consent Unit (CMCU) that can accept and process requests for prescribed psychotropic medication consent/permission. The CMPU will be staffed by two APRNs, and will accept requests by toll free fax # or email. Telephone access will be available for questions, discussion, etc. The CMPU will interface with the Medical Region MD's to complete the medication permission process and communicate decisions to the prescribing provider and DCF Area Office.
- Off-hours will be directed to the DCF 'hot-line' and then to the on-call DCF MD.
- Starting in 2008, each medication request and outcome will be entered into the DCF LINK database as part of a new medication section for tracking meds/child and outcomes. The information will then be available for viewing by the SW and DCF staff.

Discussion:

- *How will this process interface with CTBHP/VO?* It was suggested and agreed that DCF, DSS and MCOs will work together on this to ensure smooth functioning of the DCF protocol.
- *Grey area: DCF involved but not committed child.* If the child's parent is not able/available to give consent to treatment, DCF would give consent.
- Medication management is a critical part of acute psychiatric inpatient discharge planning because outpatient prescriptions must adhere to MCO formularies: prior authorization is required for off-formulary and certain formulary drugs and may not be requested at time of script renewal.
    - CTBHP/VO performance target is assessing children's psychiatric hospital discharge delays, identify factors that contribute to delays and provide BHP with recommendations on discharge planning 'best practices' by the end of 2007.
    - Inpatient medication choice may, where ever possible, take into consider child's health plan & formulary as part of early discharge planning.

Logisticare Report on Coordination of BH Care

Logisticare, the only transportation broker in the U.S. that is accredited by the Utilization Review Accreditation Commission, provides transportation services in Medicaid managed care and fee-for-service. The company has researched the problem of 'no-show' rates, especially for BH services. By contract a transportation provider can arrive 15 minutes prior to scheduled pick up and is not required to wait more than 15 minutes after scheduled pick up time. The transportation provider does not get paid for no-show trips. The monthly percentage of no-show BH trips is 5-6% of almost 1000 BH trips. Some of the steps Logisticare has taken to address the BH no-show problem include:

- Appointing dedicated staff to work with BH facilities, and QA staff to work with MCOs.
- Collaborating with DSS to develop uniform service issue reporting process
- Extensive staff training at all levels on service issues and complaint management.
- Community outreach with partnership with BHP.
- ***Piloting a transportation appointment reminder project.***
- ***Consumer survey; results available late summer.***

Sheila Amdur commended Logisticare for their collaborative work for a unified Medicaid complaint management system and extensive efforts to reduce the "no-show" rates, in particular for BH services. The SC will forward to future reports, including the customer satisfaction survey results.

Rose Ciarcia will bring to BHP-DSS attention one transportation issue: Medicaid does not pay for a child's (age < 12 years) adult escort (aide, parent, guardian, etc) costs; the escort is required by CT Medicaid. The community or the provider (i.e. PHP, IOP, EDT) pays for the cost of the adult escort accompanying the child to services.

Sheila Amdur, Co-chair of the Subcommittee, announced she will no longer take a formal role in the SC or Council. Her efforts on behalf of adults/children have been very effective and her participation in the Council and Subcommittee will be missed. Ms. Amdur did indicate that she plans, however, to continue her advocacy on behalf of children and adults with serious mental health issues.

June meeting date TBD pending Mercer availability.