Home & Community-Based Services (HCBS)
LEARNING OBJECTIVES

- Overview of health homes and the relationship between health homes and managed care organizations (MCO)

- Explain the importance of the Health and Community-Based Services (HCBS) Model

- Define the HCBS services for the Health and Recovery Plan (HARP)

- Describe the levels of care (LOC) and medical necessity criteria (MNC)

- Identify the reference tools needed for documentation and critical incident reporting
What is a health home?

- A health home is a care management service model whereby all of an individual’s caregivers communicate with one another so that all of a patient’s needs are addressed in a comprehensive manner.

- This is done primarily through a “care manager” who oversees and provides access to all of the services an individual needs to ensure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital.

- Health records are shared (either electronically or paper) among providers so that services are not duplicated or neglected.

- The health home services are provided through a network of organizations, providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual “health home.”
Required to provide the following six core services:

1. Comprehensive care management
2. Care coordination and health promotion
3. Comprehensive transitional care
4. Enrollee and family support
5. Referral to community and social supports
6. Use of health information technology to link services

Our health plan will coordinate care with each health home’s contact to collaborate and avoid duplication of services.
The role of the health home care manager is to:

- Facilitate communication with providers.
- Assist members in selecting providers from the HARP network.
- Develop a plan of care (POC) and submit the completed document to the member’s HARP or HIV special needs plans (SNP) for authorization.
- Facilitate the referrals for the members to the providers of each HCBS. The managed care HARP or HIV SNP is responsible for ensuring members have access to the services identified in the POC.
<table>
<thead>
<tr>
<th>Health Home or Entity</th>
<th>Contact</th>
<th>Counties Served</th>
<th>Billing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic Charities of Broome County</td>
<td>Julie Smith</td>
<td>Broome</td>
<td>232 Main St., Binghamton, NY 13827</td>
</tr>
<tr>
<td>Central New York Health Home Network, Inc.</td>
<td>Laura Eannace</td>
<td>Herkimer, Oneida</td>
<td>1020 Mary St., Utica, NY 13501</td>
</tr>
<tr>
<td>Greater Rochester Health Home Network, LLC (GRHHN)</td>
<td>Deborah Peartree</td>
<td>Monroe</td>
<td>29 Leland Rd Rochester, NY 14617</td>
</tr>
<tr>
<td>HHUNY- Huther Doyle</td>
<td>Sharon Bauer</td>
<td>Livingston, Monroe, Ontario, Orleans,</td>
<td>c/o NYCCP, 1099 Jay St. Bldg. J, Rochester,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seneca, Wayne, Yates.</td>
<td>NY, 14611</td>
</tr>
<tr>
<td>United Health Services Hospitals</td>
<td>Anne DePugh</td>
<td>Broome</td>
<td>81-99 Mitchell Ave. Phelps Hall, 1st floor</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Binghamton, NY 13903</td>
</tr>
<tr>
<td>Mary Imogene Bassett Hospital dba Bassett Medical Center</td>
<td>John Migliore, III</td>
<td>Chenango, Delaware, Otsego, Schoharie</td>
<td>320 N. Prospect St. Herkimer, NY 13350</td>
</tr>
</tbody>
</table>
Managed Care Organizations (MCO):

- Participate in health homes care management team.
- Offer training to providers to enhance best practices.
- Care managers help with outreach to the eligible members.
- Review and authorize necessary services to ensure that members get the services they need.
- Coordinate care between providers:
  - Provide a list of contracted behavioral health, physical health providers and credentialing requirements.
- Participate in comprehensive transitional care activities when discharged or transferred between settings.
- Collaborate at least quarterly with health homes for re-evaluation of the member’s needs and revisions to POC.
MCO, HEALTH HOMES & HARP MEMBERS

- MCO will identify (on monthly basis) HARP members who are not engaged in health homes and may benefit from services.

- MCO care managers will outreach, educate and assist members in selecting a health home for care coordination in their area.

- If a HARP member declines health home services:
  - MCO care managers will conduct outreach to provide member support.
  - MCO contracts with HCBS providers to conduct New York State Community Mental Health assessment within 90 days to develop or revise plan of care.
  - MCO will provide support for the implementation of the member’s POC in accordance with MMC contract requirements for HCBS and HARP services.
    - This includes ensuring that members have access to services included in the POC, periodic updating of the POC, and arranging for community mental health re-assessment at least once annually.
WHAT IS HCBS?

- Designed to help adults (21 and over) in the HARP program with serious mental illness (SMI/SPMI) and/or substance use disorder remain and recover in the community.

- The goal is to reduce preventable admissions to hospitals, nursing homes, or other institutions by ensuring that members are engaging in a multitude of services offered.

- MCO management of HCBS benefits are effective October 1, 2016, for HARP-eligible members.
When a member is referred for enhanced HCBS services, the New York State Community Health Assessment (CMHA) is used to determine eligibility.

Based on scoring, the member is deemed eligible for either Tier 1 or Tier 2 services:

- **Tier 1 Services**: peer support services, education support services or individualized employment support services.

- **Tier 2 Services**: all of Tier 1, psychosocial rehabilitation, community psychiatric support and treatment, habilitation, family support and training.
HCBS COMPONENTS

- Person-centered
- Evidence-based
- HCBS
- Recovery Oriented
- Integrated
GOALS OF HCBS

- Ensure that patients with chronic conditions have access to appropriate services by providing coordinated, comprehensive medical and behavioral health care.

- Improve health outcomes.

- Reduce preventable hospitalizations and emergency room visits.

- Promote use of health information technology.

- Avoid duplicated care and promote evidenced-based determination standards for service delivery.
### CORE PRINCIPLES FOR HCBS

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
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<tbody>
<tr>
<td>Person-centered</td>
<td>Care should be self-directed (wherever possible) and emphasize shared decision-making and minimize stigma.</td>
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<tr>
<td>Recovery-oriented</td>
<td>System should include a broad range of services that support recovery (living, vocational and social skills).</td>
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<tr>
<td>Integrated</td>
<td>Providers should attend to both physical and behavioral health needs and actively communicate with care coordinators and other providers to ensure that health and wellness goals are met.</td>
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<tr>
<td>Data-driven</td>
<td>Providers and MCOs should use data to define outcomes, monitor performance and promote health and wellbeing.</td>
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<td></td>
<td>MCO should use service data to identify high-risk/high-need members in need of focused care management.</td>
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## CORE PRINCIPLES FOR HCBS

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<tr>
<td>Evidence-based</td>
<td>Services should use evidence-based practices where appropriate and provide or enable continuing education activities to promote uptake of these practices.</td>
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<tr>
<td>Trauma-informed</td>
<td>Providers should understand the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be more supportive and avoid re-traumatization.</td>
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<tr>
<td>Peer-supported</td>
<td>Peers will play an integral role in the delivery of services and the promotion of recovery principles.</td>
</tr>
<tr>
<td>Culturally competent</td>
<td>Services should contain a wide range of expertise in treating and assisting people with SMI and SUD in a manner responsive to cultural diversity.</td>
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GUIDELINES FOR PROVIDERS

All providers must meet NYS requirements to provide HCBS. Some requirements include:

- Complete a state HCBS designated survey and process for designated HCBS provider.
- Maintain updated license for practice.
- Complete provider background checks.
- Provide sufficient resources and staffing for members.
- Deliver services in a timely manner according to the HARP and HCBS provider guidelines on the New York State Office of Mental Health (NYS OMH) website.
HCBS SERVICES

- Psychosocial rehabilitation (PSR)
- Community psychiatric support and treatment (CPST)
- Habilitation services
- Short-term crisis respite
- Intensive crisis respite
- Non-medical transportation
- Family support and training

- Pre-vocational services
- Education support services
- Transitional employment services
- Intensive supported employment services (ISE)
- Ongoing supported employment services
- Empowerment services (peer support)
MEMBER ENGAGEMENT

Health Home Care Manager (HHCM) will conduct a brief eligibility assessment, and if eligible, begin a person-centered discussion to address the individual’s needs and decide what HCBS services they are interested in receiving.

HHCM develops and submits Proposed POC to MCO.

Upon contact from HHCM, MCO will call HCBS suggested providers to confirm referral readiness.

MCO approves Level of Service Determination, along with authorization for three visits with the HCBS provider within 14 days.

HCBS providers submit requests to MCO for continued services after the three visits.
MEMBER ENGAGEMENT

- HHCM refers member to HCBS provider who contacts MCO for prior authorization

- MCO monitors for completion of full assessment within 90 days, and confirms that the POC is updated and implemented

- HHCM updates and shares final POC with MCO and member

- Ongoing monitoring of POC by HHCM through work with member and coordination with providers ongoing
Federal Adult BH HCBS POC Documentation Requirements:

- Person-centered
- Working document:
  - Includes all attempts, referrals and progress: past and present
- Includes all providers responsible for care
- Reflects services that will help the member be successful
- Addresses strengths, barriers and individualized needs of the member
Federal Adult BH HCBS Person-Centered Planning Process

Requirements/Characteristics:

- Member-centered and driven
- Includes supports and providers the member chooses
- Culturally competent
- Includes conflict resolution strategies
- Documents all offered services
WHAT DOES THIS MEAN FOR YOU?

- We recognize that multiple co-morbidities will be common among our members.

- The goal of HARP and HCBS is to collaborate with the:
  - Member
  - Interdisciplinary team
  - MCO

- In order to improve member health and wellness, partnership and collaboration are essential.
Critical incident reports should be sent to our health plan to report when a member has been hurt or harmed in an adverse incident while in a providers care.

Reports should be mailed to:

Excellus BlueCross BlueShield
Provider Advocate Unit
PO Box 4717
Syracuse, NY 13221
Phone: 1-800-920-8889
QUESTIONS
Integrated Health Care
LEARNING OBJECTIVES

- List types of health care providers involved in integrated health
- Define various models of care
- Assess efforts towards integration
- Identify benefits of integration
- Identify various types of symptoms
Physical health (PH), behavioral health (BH) and SUD

Physical disease/illness

Mental disorder/BH issue

Substance use, withdrawal, intoxication
WHAT IS HEALTH?

Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. This is no health without mental health.

-The Word Health Organization
What is the importance of all providers being aware of physical health, mental health, substance use, and psychosocial issues?

Mental disorders are common, disabling, and associated with high health care costs and substantial losses in productivity, yet only about 25 percent of patients with these disorders receive effective care.
ONE BODY, ONE BRAIN, ONE SYSTEM

Behavioral health providers & SUD specialists treat emotional, behavioral health, and SUD issues

+ 

Physical health providers treat physical health issues

= 

BH/ SUD + PH = Integrated healthcare (Whole Person Approach)
Systematic integration facilitates communication and coordination of:

- PH care
- BH care
- SUD treatment

Integrated care promotes a cohesive service delivery system & better continuity of care.
BENEFITS OF INTEGRATED CARE

- Increases provider knowledge, expertise and capacity.
- Promotes understanding across the entire care continuum.
- Provides comprehensive and better coordinated care.
- Identifies BH concerns early.
- Facilitates communication, collaboration and treatment between providers.
- Allows PH providers to use the expertise of trained BH specialists.
- Improves patient education and satisfaction.
WHEN CARE IS NOT INTEGRATED

- One in four Americans experience a mental illness or SUD each year:
  - The majority of those individuals have a comorbid PH condition
- Compared to the general population, these individuals have:
  - Poorer medical outcomes
  - Higher rates of use
  - Die much earlier
- Mental illness is often not addressed in PH settings
NEW YORK STATE INITIATIVES

- SAMHSA’s Primary and Behavioral Health Care Integration (PBHCI) Grants program
- NYS OMH Medicaid Incentives for Health Monitoring and Health Physicals
- New York State’s Medicaid Health Homes
Upon discharge from inpatient facilities (emergency, psychiatric, substance use), we encourage you to:

- Talk to the member about risks during the discharge period and address potential barriers to maintaining initial recovery from symptoms.
- Provide additional mental health evaluations for targeted referrals.
- Conduct evaluations to consider the support of family and friends.
- Schedule follow-up appointments within five business days.
- Offer family/friends coaching and support resources about continuity in care.
- Ensure that the member understands how and when to administer medications.
During outpatient engagement, we encourage you to:

- Proactively follow-up after any inpatient admissions (therapist/care manager calling within 48 hours).
- Reach out to maintain communication with the member’s PCP, therapist and community supports (interdisciplinary care team).
- Use motivational interviewing to better understand the member’s personal goals in treatment planning.
- Coordinate care with comprehensive case management.
- Provide members with phone reminders of appointments.
- Provide a “crisis card” with emergency numbers/safety measures.
Some symptoms:

- Any subjective evidence of disease
- Anxiety, low back pain and fatigue are all symptoms
Which of the following are considered PH symptoms, BH symptoms or SUD symptoms?

- Heart palpitations
- Headaches
- Excessive fatigue
POSSIBLE ANSWERS

- **Heart palpitations can be associated with:**
  - Generalized anxiety disorder (BH)
  - Hyperthyroidism (PH)
  - Nicotine use disorder (SUD)

- **Headaches can be associated with:**
  - Anxiety disorders (BH)
  - Dehydration (PH)
  - Alcohol withdrawal (SUD)

- **Excessive fatigue can be associated with:**
  - Depressive disorders (BH)
  - Low iron (PH)
  - Substance withdrawal (SUD)
Patient comment:

“Around the time my bipolar condition was identified, I was diagnosed with kidney disease. Between the two disorders, it was a pretty upsetting time ... My doctors, dialysis clinic staff and mental health case manager are well connected. They take a team approach, to my care and they each check on the status of my health...

Today, I have control over my health - it doesn’t have control of me. The coordinated care allows me to feel like I can go out and be a part of the community.”
Questions
PHYSICAL HEALTH 101
COMMON HEALTH CONCERNS & IMPACT ON BEHAVIORAL HEALTH (BH)
LEARNING OBJECTIVES

Identify interactions between mental illness and the following physical illnesses:

- Hypertension
- Diabetes mellitus
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)
- Human immunodeficiency virus (HIV)
- Sickle cell anemia
HYPERTENSION (HTN)

- a.k.a. - “Arterial hypertension”
- #1 risk factor for mortality worldwide and leads to:
  - Heart failure/myocardial infarction (MI)
  - Stroke
  - Chronic kidney disease
  - Aortic aneurysms
  - Peripheral artery disease
  - Decreased life expectancy (even a moderate elevation of blood pressure)

- Risk factors:
  - Smoking
  - Drinking/drug use
  - Overeating
  - Sedentary lifestyle
  - High sodium diet
  - High stress
- Sleep disorders
- Anxiety disorders
- Anger
- Depressed mood
- Alcohol consumption
DIABETES MELLITUS

- Group of metabolic diseases in which a person has high blood sugar

- Classic symptoms:
  - Polyuria
  - Polyphagia
  - Polydipsia

- Uncontrolled diabetes is the leading cause of kidney failure, non-traumatic lower limb amputation and new cases of blindness among adults over age 20
DIABETES MELLITUS

- **Type 1:**
  - Autoimmune disease resulting in the destruction of the beta cells in the pancreas which causes an insulin deficiency
  - Usually diagnosed before age 30, but can occur at any age
  - 5-10 percent of those with diabetes have Type 1

- **Type 2:**
  - Defects in insulin resistance, increased release of stored sugar from the liver, insulin deficiency
  - Highly correlated with excess weight
  - May or may not have symptoms at diagnosis and often for undetected for years

- **Gestational:**
  - Glucose intolerance first recognized during pregnancy
  - Resolves after delivery
DIABETES & BEHAVIORAL HEALTH

- Anxiety - phobias of needles/injections
- Stress
- Denial of the illness
- Depression - less likely to seek treatment
- Schizophrenia - non-adherence rates up to 50 percent
- Delirium - could present as hypoactive or hyperactive delirium
- Tobacco abuse
- Alcohol abuse
Association of psychotic disorders and diabetes is well established

Diabetes with schizophrenia have higher mortality rates than individuals with diabetes alone

Co-occurrence:

- Impaired quality of life
- Poor treatment adherence
- Poor glycemic control
- Increased ED visits and hospitalizations
- Increased cost
Studies suggest a link between cognitive deficit and diabetes:

- Compared to those without diabetes, research shows that those with the disease have a 1.2 - 1.5-fold greater rate of decline in cognitive function and are at greater risk.

- Up to 45 percent of the cases of mental disorder/severe psychological distress are UNDETECTED among patients treated for diabetes.
ASTHMA

- Prevalence of asthma has increased significantly since the 1970s
- Chronic, reversible, inflammatory disease:
  - Bronchoconstriction
  - Bronchial inflammation
  - Increased secretion production
  - Airway inflammation
- Triggers:
  - Environmental
  - Hygiene
  - Genetic
  - Medical conditions - atopy
ASTHMA

- Risk factors:
  - Genetic predisposition
  - Airway hyperresponsiveness
  - Environmental risk factors:
    - Urban versus rural
    - Proximity to major highways, airports

- Symptoms:
  - Chest tightness (small children may complain of stomach pain)
  - Audible wheezing
  - Coughing and dyspnea (may be worse at night/early morning)
  - Use of accessory muscles
  - Anxiety, air hunger
  - Difficulty talking or moving
  - Progressive fatigue
ASTHMA

- Significant link between asthma and mental disorders:
  - Depression: odds ratio 1.6 in patients with asthma
  - Anxiety: odds ratio 1.5 in patients
  - Alcohol abuse: odds ratio 1.7 in patients
- Emotional difficulties
- Few youth with asthma, comorbid anxiety and depression receive guideline-level mental health treatment
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

- Obstructive lung disease that is preventable; however, irreversible.

- Characterized by a continued shortness in breath due to a gradual decline in lung function.

- Inflammatory response of the lung to noxious particles or gas.

- Comorbidities contribute to the overall severity of the disease.

- Made up of:
  - Chronic bronchitis
  - Emphysema
COPD

- **Dyspnea**: Hallmark symptom of COPD, may be described as effort to breathe, heaviness in the chest, air hunger or gasping

- **Cough**: Usually the first symptom to occur, may be nonproductive

- **Sputum production**: Small amounts of tenacious sputum after coughing is common

- **Wheezing and chest tightness**: Characteristic of late stages of COPD

- **Weight loss**: A common symptom of COPD

- **Cough syncope**:
  - Rib fracture secondary to coughing
  - Ankle swelling secondary to right heart failure
COPD & BEHAVIORAL HEALTH

- Depression:
  - Weight loss
  - Sleeping disorders
  - Eating disorders
  - Depletion of energy

- Anxiety

- Psychiatric illness

- Support
CORONARY ARTERY DISEASE

- Also known as “Atherosclerotic Heart Disease”
  - Most common type of heart disease (causes heart attacks)
  - Leading cause of death worldwide

- Occurs when arteries that supply blood to the heart muscle (coronary arteries) become hardened and narrowed due to the buildup of plaque on the inner walls or lining of the arteries (atherosclerosis).

- Blood flow to the heart is reduced as plaque narrows these arteries. This decreases the oxygen supply to the heart muscle.

- Risk factors: hypercholesterolemia, smoking, hypertension, diabetes, family history, diet, stress, lack of physical activity, HTN
CORONARY ARTERY DISEASE

- **Signs & Symptoms:**
  - Pain or pressure in the chest
  - Discomfort spreading to the back, jaw, throat or arm
  - Nausea
  - Lightheadedness
  - Diaphoresis
  - Weakness or fatigue
  - Anxiety
  - Shortness of breath
  - Rapid or irregular heartbeats

- **Women’s symptoms:**
  - Symptoms can differ from those experienced by men and can include:
    - Vague-unexplained fatigue, GI complaints, headache, neck/back discomfort, weakness, dizziness, flu like symptoms, anxiety, breathlessness, jaw pain
- Depression:
  - Major, minor and dysphoric patients
  - As poor a prognosis as left ventricular dysfunction
- Type A behavior patterns
- Stress
- Emotional distress
- Social dysfunction
- Schizophrenia
- Bipolar disorder
HUMAN IMMUNODEFICIENCY VIRUS (HIV)

- HIV:
  - Leads to AIDS (acquired immune deficiency syndrome)
  - Disease that compromises the body's immune system
  - Spreads through transfer of blood, semen, vaginal fluid, pre-ejaculate or breast milk

- Two types:
  - HIV-1:
    - More virulent
    - ELISA - screening
    - Western blot - confirmatory
  - HIV-2:
    - Lower infectivity

- Pathogenesis:
  - CD4+ T-cells (T-helper cells)
HIV

- Directly infects the brain:
  - Impairment to memory and thinking
- HIV-associated:
  - Cognitive motor disorder
  - Dementia complex
  - Delirium
  - Psychosis
- HIV drugs have BH side effects
- Compliance/adherence
HIV & BEHAVIORAL HEALTH

- Emotional distress:
  - Adverse life events
  - New diagnosis

- Depression:
  - Twice as common in people with HIV as in the general population
  - Suicide

- Anxiety:
  - Can accompany depression or be seen as a disorder by itself
HIV & BEHAVIORAL HEALTH

- Serious chronic mental illness:
  - Prevalence rates: 5-23 percent

- Substance abuse:
  - Very common
  - Increased levels of distress
  - Interferes with treatment adherence
  - Impaired thinking and memory
  - IV drug abuse
  - Alcohol abuse
SICKLE CELL ANEMIA

- Autosomal recessive
- Most common hemoglobinopathy
- Signs/symptoms: anemia/pain
- African American
- Crisis:
  - Vaso-occlusive - usually last five to seven days
  - Splenic sequestration
  - Aplastic
  - Hemolytic
Mental Health Disorders:
- Children and adolescents

Depression:
- Mixed results in children

Anxiety:
- Contributing causes:
  - Chronicity of illness
  - Unpredictability of crises
  - Chronic pain
  - Overwhelming nature of medical complications
Outpatient therapy:
  - Higher risk

Poor physical function more so than mental function:
  - Use of acute health care resources in adults

Sickle cell does not have as many psychological issues as the other previously discussed conditions
QUESTIONS
Behavioral Health 101

*Signs, Symptoms & Treatments*
LEARNING OBJECTIVES

Obtain a Greater Understanding of:

- Mental health diagnosis:
  - Depressive disorders
  - Bipolar and related disorders
  - Anxiety disorders
  - Obsessive compulsive disorder (OCD)
  - Post traumatic stress disorder (PTSD)
  - Psychosis
  - Substance use disorders
  - Suicidality and self-injury

- Learn about treatment options/recovery
When you hear the words...

“Behavioral Health?”
MENTAL ILLNESS DEFINED

According to the National Alliance on Mental Illness:

A mental illness is a medical condition that disrupts a person's thinking, feeling, and behavior. A person’s ability to relate to others and management of daily activities is affected.

www.nami.org
MENTAL ILLNESS FACTS

Mental illness:

- Is a diagnosable medical condition.
- Is NOT the result of a personal weakness, lack of character or poor upbringing.
- Does NOT discriminate.
- Is treatable through the combined application of physical and behavioral health interventions.
- People affected can benefit from professional and community expertise and support to learn to manage challenging situations.
WHO IS AFFECTED?

For American adults, approximately:

- 14.8 million people (6.7 percent) – live with depressive disorders
- 42 million people (18.1 percent) – live with anxiety disorders
- 6.1 million people (2.6 percent) – live with bipolar disorders
- 2.6 million people (1.1 percent) – live with schizophrenia spectrum disorders
- 9.2 million have co-occurring mental health and addiction disorders
- 46 percent of homeless, staying in shelters live with severe mental illness and/or substance use disorders
- 20 percent of state prisoners and 21 percent of local jail prisoners have “a recent history” of a mental health condition
SERIOUS MENTAL ILLNESS

- SMI/SPMI is an illness that results in significant dysfunction in one or more areas.

- What might occur if SMI is not treated?
  - Stigma and discrimination
  - Shame
  - Social isolation
  - Unemployment
  - Poverty
  - Criminalization
  - Homelessness
  - Premature death
DEPRESSION

Symptoms:

- Chronic sadness
- Changes in sleep
- Changes in appetite
- Loss of pleasure in activities once enjoyed
- Frequent tearfulness and crying spells
- Loss of energy and motivation
- Frequent thoughts of death or suicide
- Feelings of guilt or worthless
- Feelings of hopelessness or helplessness
- Difficulty concentrating
- Difficulty following routines
- Anger and irritability especially in children and adolescents
DEPRESSION DIAGNOSIS

- Major depressive disorder
- Persistent depressive disorder (dysthymia)
- Premenstrual dysphoric disorder
- Substance/medication induced depressive disorder
- Depressive disorder due to medical condition
- Unspecified depressive disorder (including seasonal patterns)
BIPOLAR & RELATED DISORDERS

- Bipolar and related disorders are characterized by varying degrees of episodic mania and depression, with some periods of full functioning between episodes.
- Duration of episodes can vary, but may last from several days to several months.
- Highlighted by unusual and dramatic shifts in mood, energy and the ability to think clearly.
- Symptoms include mood episodes that follow an irregular pattern:
  - High (manic)
  - Low (depressive mood or a major depressive episode)
  - Both are very intense emotional states
- Severity of symptoms can vary in intensity from one individual to another.
Anxiety disorders are characterized by constant feelings of anxiety, worry and fear:

- These feelings occur when faced with everyday situations.
- Interferes with a person’s ability to function.
- Is not normal stress related to an event.

Types of anxiety disorders:

- Generalized anxiety disorder (GAD)
- Panic disorder
- Social anxiety disorder
Anxiety is a condition that ranges from mild to severe possible symptoms include:

- Overwhelming feeling of worry, dread or fear
- Difficulty sleeping
- Racing heart
- Difficulty concentrating
- Feeling on edge
- Muscle tension
- Worry that something bad is going to happen
- Fear of dying
- Irritability
- Easily fatigued
- Ritualistic behavior (counting, lock checking, hand washing)
- Obsessive thoughts
- Fear of being in social situations
POST TRAUMATIC STRESS DISORDER (PTSD)

- Development of specific symptoms after exposure to a traumatic event.

- Symptoms grouped in four clusters:
  - Intrusion
  - Avoidance
  - Cognitive alteration
  - Arousal

- Duration is longer than one month.
OBSESSIVE COMPULSIVE DISORDER (OCD)

- Presence of obsessions, compulsions or both

- Obsessions: Recurrent thoughts that cause disturbance
  Example: Preoccupation with dirt/germs, safety of loved ones

- Compulsions: Repetitive acts prompted by ‘rules’ to alleviate the distress
  Example: Excessive hand-washing to prevent contamination, locking and relocking doors, counting or repeating words silently
Psychosis:

- When a person has lost some contact with reality
- Can occur:
  - Episodically, as a part of other conditions (most common)
  - Chronic in illnesses, such as schizophrenia (less common)
  - In ranges (mild to severe)
  - With warning signs

Symptoms:

- Delusions
- Hallucinations
- Visual, audio, tactile, olfactory, etc.
- Disorganized thought and communication
- Disturbances in thinking, emotion, behavior and reality testing
Psychosis can cause changes in:

**Thinking & Perception**
- Concentration affected
- Sense of not feeling like themselves, or like the outside world is changing
- Odd ideas
- Changes in perceptual experiences - senses may change
- Reduction or increase in intensity of smell, sound, color

**Behavior**
- Sleep disturbances
- Isolation or withdrawal
- Affect becomes flat / blunted
- Change in appetite
- Decreased energy and motivation
- Decrease in ability to function in work/social roles

**Mood**
- Depression
- Irritability
- Anxiety
- Paranoia / suspicious nature
Schizophrenia spectrum and other psychotic disorders are defined by abnormalities in one or more of the following domains and negative symptoms:

- Delusions
- Hallucinations
- Disorganized thinking (speech)
- Catatonic/disorganized behavior
- Loss of drive
- Flattening of the affect
- Anhedonia
- Alogia
- Avolition
- Asociality
A substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating an individual continues using despite significant problems.

Diagnosis of a substance use disorder is based on groupings of criteria, including:

- Impaired control
- Social impairment
- Risky use
- Pharmacological criteria

The diagnosis can be applied to ten classes of substances identified in the DSM-V (i.e., alcohol use disorder, cannabis use disorder, opioid use disorder, etc.) with a continuum of specifiers to identify severity of use and impairment including mild, moderate or severe.
Warning signs:

- Increased use
- Increased tolerance
- Difficulty controlling use
- Symptoms of withdrawal
- Preoccupation with the substance
- Continued use even after identifying problem
• Patients with mood or anxiety disorders are more likely to develop a SUD.

• Not everyone wants abstinence as a goal, reducing the quantity of substances used can be a consideration (harm reduction).

• SUD can:
  • Co-occur with any mental illness
  • Be a result of self-medicating
  • Be a cycle of success and relapse

• Changing behavior is not easy.

• Willpower is not always enough to resolve the problem.
**SUICIDE: 2015 FACTS & FIGURES**

Suicide is a preventable public health problem and a leading cause of death in the United States. More investment in suicide prevention, education and research will prevent the untimely deaths of thousands of Americans each year.

### SUICIDE – BASIC FACTS

An American dies by suicide every 12.95 minutes\(^1\)

Americans attempt suicide an estimated 1 MILLION times annually\(^2\)

90% of those who die by suicide had a diagnosable psychiatric disorder at the time of their death\(^3\)

In 2012, firearms were the most common method of death by suicide, accounting for 50.9% of all suicide deaths, followed by suffocation (including hangings) at 24.8% and poisoning at 16.7%\(^4\)

For every woman who dies by suicide, four men die by suicide, but women are 3x more likely to attempt suicide\(^5\)

Over 40,000 Americans die by suicide every year\(^6\). Suicide is the 10th leading cause of death in the United States

- 2nd leading cause of death for ages 10-24
- 5th leading cause of death for ages 45-59
- The suicide rate among American Indian/Alaska Native adolescents and young adults ages 15-24 is 1.8 times the national average

Veterans comprise 22.2% of suicides\(^7\)

### SUICIDE – THE COST

$44 BILLION

The combined medical and work loss costs in the United States each year\(^8\)

More than 1.5 MILLION years of life are lost annually to suicide\(^9\)

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\(^1\) Data obtained from CDC’s Web Based Injury Statistics Query and Reporting System (WISQARS)

\(^2\) National Center for Health Statistics for the year 2009

\(^3\) Centers for Disease Control and Prevention. Suicide – Facts at a Glance

\(^4\) Department of Veterans Affairs 2012 Suicide Data Report

\(^5\) Centers for Disease Control and Prevention. Suicide – Facts at a Glance

\(^6\) American Foundation for Suicide Prevention

\(^7\) American Foundation for Suicide Prevention

\(^8\) American Foundation for Suicide Prevention

\(^9\) American Foundation for Suicide Prevention
Suicidality:

- The likelihood of an individual completing suicide
- Suicidal thinking and behavior
- Suicidal ideation ("SI"):
  - Thoughts about or an unusual preoccupation with death, dying or suicide
  - Range of intent varies greatly
  - Intent may be real or attempt at attention
  - Most people with SI do not go on to attempt suicide
  - BUT, a significant proportion DO, so all threats must be taken seriously
SUICIDAL IDEATION

Possible Symptoms:
- Hopelessness/helplessness
- Anhedonia
- Insomnia
- Depression
- Severe anxiety
- Angst
- Impaired concentration
- Psychomotor agitation
- Panic attack
- Severe remorse, guilt

Possible Red Flags:
- Unintentional weight loss
- Excessive fatigue
- Low self-esteem
- Presence of consistent mania
- Excessive talking
- Intent on previously dormant goals
- Acting recklessly/engaging in risky activity
- Racing thoughts
A combination of treatment modalities, medication management and supportive measures provide the best outcomes.

Some general interventions include:

- Psychiatric medication
- Individual and family therapy
- Diet and exercise
- Cognitive behavioral therapy (CBT)
- Brief solutions focused therapy
- Motivational interviewing
- Peer/support groups
- Psychosocial rehabilitation/focusing on skill building
Questions
Utilization Management & Authorizations
LEARNING OBJECTIVES

- Define utilization management (UM)
- Explain medical necessity criteria (MNC)
- Discuss authorizations and preauthorizations
- Recognize how this impacts you as the provider
The UM team consists of licensed BH clinicians whose education, training and experience are commensurate with the utilization management reviews they conduct.

The team follows UM policies and procedures that are systematically and consistently applied.

The UM review process ensures that treatment is:

- A Medicaid covered benefit
- Specific to the member’s condition and POC
- Meets medical necessity criteria
- Is effective, evidenced-based practice
- Provided at the least restrictive, most clinically appropriate LOC
MEDICAL NECESSITY CRITERIA (MNC)

- Highlights the member’s needs as the primary focus of care delivery
- Lowest/least restrictive LOC
- Information gathered from PCP, HHCM, HCBS provider or other providers pertinent to member’s care
- Ability to override based on needs of the member

Tools to determine medical necessity:

- LOCADTR* for SUD
- McKesson InterQual®* for BH

*LOCADTR and InterQual® criteria are reviewed annually.
SUBSTANCE USE MEDICAL NECESSITY CRITERIA

- LOCADTR- LOC for alcohol and drug treatment referral 3.0
  - www.oasas.ny.gov/treatment/health/locadtr/index.cfm

- Designed by NYS Office of Alcoholism and Substance Abuse Services (OASAS) and The National Center on Addiction and Substance Abuse at Columbia University

- Online assessments allow for standardized data collection to assess provider and system ability to determine member needs and support the connection between LOC determinations and client outcomes.

- LOC is determined by a variety of factors, including:
  - Assessment of the member’s need for crisis or detoxification services
  - Risk factors
  - Resources available to the member
McKesson InterQual® criteria is used for both adult and pediatric mental health guidelines

- InterQual is a nationally recognized instrument that provides a consistent, evidence-based platform for care decisions and promotes appropriate use of services and improved health outcomes. Criteria for HCBS were adopted from the New York State Department of Health (including the OMH and OASAS) HCBS provider manual.

- InterQual criteria sets are proprietary and cannot be distributed in full; however, a copy of the specific criteria relevant to any individual need for authorization is available upon request or visit:

  ExcellusBCBS.com/Provider > Patient Care > View Our Policies > InterQual Clinical Criteria
## BEHAVIORAL HEALTH MEDICAL NECESSITY CRITERIA

<table>
<thead>
<tr>
<th>LOC</th>
<th>Medical Necessity Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Psychiatric Hospitalization (IP)</td>
<td>BH InterQual</td>
</tr>
<tr>
<td>Intensive Psychiatric Residential Treatment (IPRT)</td>
<td>NYS Guidelines: OMH.NY.GOV</td>
</tr>
<tr>
<td>Partial Hospital Program (PHP)</td>
<td>BH InterQual</td>
</tr>
<tr>
<td>Outpatient Mental Health Services (BH OP)</td>
<td>BH InterQual</td>
</tr>
<tr>
<td>Community-Based Services (CBS)</td>
<td>NYS Guidelines: OMH.NY.GOV</td>
</tr>
<tr>
<td>Home and Community-Based Services (HCBS)</td>
<td>HCBS Manual BH: OMH.NY.GOV</td>
</tr>
</tbody>
</table>
GRIEVANCES & APPEALS

- We encourage members to voice both positive and negative comments regarding care and services they have received.

- If a member has a concern that cannot be resolved immediately on the phone with Customer Care, we inform the member of his or her right to file an appeal or grievance.
AUTHORIZATIONS

- Utilization managers approve or extend the use of HCBS services
- Decision is based on MNC and POC
- Completion of the NYS CMH Eligibility Assessment is required

**Tier 1 Services:**
- Peer support services
- Education support services
- Individualized employment support services (IESS includes: pre-vocational, transitional employment, intensive supported employment and ongoing supported employment)

**Tier 2 Services:**
- All of Tier 1
- Psychosocial rehabilitation
- Community psychiatric support and treatment
- Habilitation
- Family support and training
AUTHORIZATIONS

ExcellusBCBS.com/ProviderReferralsAuths

- Click on **Preauthorization**
- This takes you to a new page where you click on the tab called **Request Preauthorization**
- Refer to the **Behavioral Health** area to obtain details on requesting Prior Authorization, including authorization forms.
ARRAY OF BENEFITS

<table>
<thead>
<tr>
<th>LOC</th>
<th>Description</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient MH</td>
<td>Assessment and/or symptom reduction or management through individual, family and/or group therapies</td>
<td>No</td>
</tr>
<tr>
<td>Psychiatric Inpatient Services</td>
<td>Hospital-based 24/7 program for assessment and treatment for members unable to adequately function in the community</td>
<td>Yes</td>
</tr>
<tr>
<td>Partial Hospitalization (PHP)</td>
<td>Stabilization or reduction of acute symptoms for a member who would otherwise need hospitalization</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### ARRAY OF BENEFITS

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<tr>
<th>LOC</th>
<th>Description</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personalized Recovery Oriented Services (PROS) Pre-Admission</td>
<td>For members living with SPMI. Pre-admission visits are prior to an admission</td>
<td>No</td>
</tr>
<tr>
<td>PROS Admission: Individualized Recovery Planning (IRP)</td>
<td>Admission begins following approval of service recommendations by MCO</td>
<td>Yes</td>
</tr>
<tr>
<td>PROS Active Rehabilitation</td>
<td>Active rehabilitation begins following approval of IRP by MCO</td>
<td>Yes</td>
</tr>
</tbody>
</table>
LOC

- SUD Outpatient Clinic
- Inpatient SUD Rehabilitation
- Medically Supervised Inpatient SUD Detoxification

Description

- Treatment delivered at different levels of intensity based on severity of problem presented
- OASAS-certified 24-hour, structured, short-term, intensive treatment services provided in a hospital or a free-standing facility.
- Provides treatment of moderate withdrawal symptoms and non-acute physical or psychiatric complications.

Prior Authorization

- No
- Yes
- Yes
## ARRAY OF BENEFITS

<table>
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<th>LOC</th>
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<tbody>
<tr>
<td><strong>Psychosocial Rehabilitation (PSR)</strong></td>
<td>Helps members improve skills to reach goals listed on their recovery plan</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Community Psychiatric Support &amp; Treatment (CPST)</strong></td>
<td>Treatment services at a location of the member’s choosing (i.e., members’ home) with a referral to a licensed treatment facility</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Habilitation Services</strong></td>
<td>Services providing skill building to support members in living independently in the community</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Non-Medical Transportation</strong></td>
<td>Transportation to non medical activities related to a goal on the member’s POC</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Questions
REFERENCES

- 2010 dietary guidelines at www.choosemyplate.gov


- American Academy of Allergy, Asthma, and Immunology; www.AAAAI.org


- American College of Cardiology, www.acc.org


- American Heart Association (AHA) website www.heart.org


- American Lung Association http://www.lung.org


- Best Masters in Counseling http://www.bestmastersincounseling.com/nutrition-mental-health/

- Burden of Asthma-2013; Wisconsin DHHS, Bureau of Environmental and Occupational Health

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- Centers for Disease Control and Prevention [http://www.cdc.gov](http://www.cdc.gov)
- Depression and HIV. [http://www.aidsinfonet.org/fact_sheets/view/558](http://www.aidsinfonet.org/fact_sheets/view/558)
- Gilchrist, D., M.D, Medical Director, Sunshine Health Plan. (2014) **Physical Health 101** [PowerPoint slides].
- HelpGuide.org - Trusted guide to mental, emotional & social health [http://www.helpguide.org/mental/depression](http://www.helpguide.org/mental/depression)
- HIV and Delerium. [https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/HIV-Psychiatry/FactSheet-Delirium-2012.pdf](https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/HIV-Psychiatry/FactSheet-Delirium-2012.pdf)
REFERENCES


- Mental Health First Aid: http://www.mentalhealthfirstaid.org/cs/program_overview/

- NAMI: National Alliance on Mental Illness http://www.nami.org


- NIH. http://www.nhlbi.nih.gov/health/health-topics/topics/sca/atrisk

- Nurtur Health Inc. (2012) *Asthma* [PowerPoint slides].


- Nurtur Health Inc. (2008) *Overview of HTN and CAD* [PowerPoint slides].
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- SAMSHA:  http://www.samhsa.gov
- Shoyinka, S., M.D, Medical Director for Behavioral Health, Sunflower State Health Plan, from PPT Medical Consequences of Drug Abuse
- Treating Chronic and Severe Mental Disorders. A Handbook of Empirically Supported Interventions by Stefan Hofmann and Martha C. Thompson
- Welcome to AIDS.gov https://www.aids.gov/