Network Notes

News and updates for clinicians contracted with U.S. Behavioral Health Plan, California Summer 2006

Notifying Patients of Firearms Prohibition

By Michael Bailey, M.D.,
Associate Medical Director

California statutes prevent firearm access by someone who is involuntarily admitted to a psychiatric facility. Welfare and Institutions Code (WIC) Section 8103(f)(2) requires a facility to report to the State of California Department of Justice instances in which an individual has been admitted to the facility on an involuntary hold. Individuals identified by this type of report are prohibited from owning, possessing, receiving, controlling, or purchasing any firearm for a period of five years from the admission date to a facility. This law applies to all persons taken into custody as a danger to themselves or others under the provision of WIC Section 5150. In these cases, all firearms within the household must be removed or secured to prevent access. Firearms can be turned over to local law enforcement authorities if other arrangements to secure them cannot be made.

While facilities are required to notify the individual of the firearms prohibition, this notification is sometimes issued only in a written form given to the patient upon admission. In addition to this initial notification, it should be reviewed during the course of treatment and emphasized as part of the discharge planning process with the enrollee and his or her family as appropriate. The patient and family should be made aware that the patient cannot possess, control, receive, own or purchase a firearm. Since making a firearm available to an individual prohibited from having access is a felony, family members need to be educated about this legal requirement.

California law (WIC Sections 8100-8108) also prevents firearm ownership or access for those individuals who:

- Communicate a serious threat of physical violence against a reasonably identifiable victim or victims
- Have been adjudicated as not guilty by reason of insanity of a crime
- Have been adjudicated to be a mentally disordered sex offender
- Have been found mentally incompetent to stand trial
- Have been placed under a conservatorship by a court because of grave disability as a result of a mental disorder or impairment by chronic alcoholism

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Any person subject to these provisions may appeal such a prohibition by requesting a hearing by the Superior Court to provide relief from the firearms prohibition. A signed request may be made to the Superior Court during the five-year prohibition period. The form to request the hearing may be provided by the facility at discharge. Following discharge, a hearing may be requested by contacting the State of California Department of Justice at (916) 227-3664. A form will be sent to the individual to complete and then mail to the State of California Superior Court in the county of residence.

USBHPC encourages all facilities and clinicians to remain vigilant in educating and informing enrollees and their families about firearms regulations.

Preventing Readmission: The Special Role of Outpatient Clinicians for Newly Discharged Patients

USBHPC initiated several interventions to improve seven-day ambulatory follow-up after a psychiatric hospitalization, which is a Health Plan Employer Data and Information Set (HEDIS) measurement established by the National Committee of Quality Assurance (NCQA), a body that accredits health plans. Unfortunately, only 45.6% of USBHPC enrollees discharged from a facility in 2005 kept a follow-up appointment with a psychiatrist or therapist within the seven-day timeframe, which is below the NCQA's national mean score of 55%. While our performance on this measure has improved over time, progress has been slow and incremental.

Why is this measure important for patients?

Keeping an appointment shortly after a hospital confinement is crucial in decreasing the chance of the patient needing readmission. This metric is an important HEDIS standard for patients to evaluate and compare NCQA accredited health plans.

What is USBHPC doing to improve HEDIS scores?

USBHPC care advocates work diligently during a patient's hospitalization in support of the hospital's efforts to secure an appropriate appointment for the patient as part of their comprehensive discharge plan.

USBHPC has also implemented the Inpatient Follow-Up Program to assist enrollees. As part of this program, a USBHPC Discharge Specialist contacts the patient immediately after discharge to confirm that the patient has a scheduled appointment, help address any barriers to keeping the appointment, and to assist with other discharge instructions. The Discharge Specialist then confirms the patient's attendance at the appointment with the clinician.

To support compliance with the ongoing treatment plan, we continue to monitor the enrollee for up to six months after discharge, depending on the severity of the enrollee's condition.

In our annual visits with high-volume facilities, staffs from USBHPC and the facility review the facility's performance on seven-day follow-up and other measures. We then collaborate with the facility to develop plans for improving patient care as measured by HEDIS.

USBHPC has also worked with select facilities to provide "bridge" sessions at the facility site. These appointments may be used to review the patient's progress and the treatment plan if no outpatient clinician is available for an appointment within the established time frame. We have also set up special arrangements between outpatient clinicians and facilities to assure that the patient is seen within seven days.

What can outpatient clinicians do to help prevent readmissions?

A successful transition to outpatient care is crucial to the enrollee's improvement. Here are some ways you can help.

1. Observe the seven-day follow-up guideline: When one of your patients is admitted to an acute facility, remember the importance of quick

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follow-up and consider holding the earliest appointment open for the patient around the time of the expected discharge. If they already have a reserved time, hold that time for the patient.

2. Maintain the therapeutic relationship: If time allows, visit the patient in the hospital or speak with them by phone to reinforce your established and important relationship.

3. Notify of Referral Availability: Oftentimes, hospitalized individuals do not have current relationships with a psychiatrist or therapist. Consider contacting inpatient facilities in your area to let them know of your availability for immediate appointments post-discharge.

Regarding concerns that newly discharged patients may not show up for a scheduled appointment, you can call to remind these patients the day before to reduce the chances of a no-show. You can also try to schedule the appointment at a time that could be used for other tasks such as administrative duties, so the reserved time would not be wasted in the event that the patient does not keep the appointment.

In any case, please try to reschedule if a patient misses the original appointment. A newly discharged patient may have more complicated reasons for missing an appointment than patients in a less acute phase of treatment.

USBHPC also encourages discharged patients to call to confirm their appointment with you. This phone call can be an opportunity to be welcoming and establish rapport.

USBHPC appreciates the role of clinicians in transitioning newly discharged patients back to their daily lives. We welcome your feedback regarding how to improve the timeliness of post-discharge appointments to maintain and build upon therapeutic gains achieved and help prevent readmissions. Please contact Clinical Network Services at (800) 798-3053, ext 2058.

New Monitors Implemented for Access to Care

USBHPC established the following standards for appointment access to ensure that enrollees are able to secure treatment in a timely manner.

Non-Life-Threatening Emergency	A situation in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm to self or others.	100% of enrollees must be offered an appointment within 6 hours
Urgent	A situation in which immediate care is not needed for stabilization but, if not addressed in a timely way, could escalate to an emergency situation.	100% of enrollees must be offered an appointment within 48 hours
Routine	A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others	100% of enrollees must be offered an appointment within 10 business days.

In July 2005, USBHPC sent all network clinicians a letter outlining requirements for after-hours messaging and timely response to enrollees' phone calls. It was announced at that time that an annual survey will be performed to monitor compliance with these standards. The standards and results of the 2005 annual surveys are presented on the following page.

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	Standard	2005 Annual Survey Results
After-Hours Answering System and Messaging	Messaging must include instructions for obtaining emergency care	79% Met the standard 21% Did not include any instruction for obtaining emergency care
Clinician's Timely Response to Enrollee Messages	Clinicians shall respond to enrollee messages for routine issues within 24 hours.	44% Met the standard 51% Did not return calls within 24 hours. (48.9% did not respond at all)

The results of this survey reveal opportunities for improvement related to access to care. Many clinicians have incorporated clear instructions in their messaging system for patients in emergency or crisis situations. Clinicians who have not yet modified their messages are reminded to do so immediately. Lack of adequate messaging may result in a clinician being made unavailable for new referrals and, if not corrected, subsequent reevaluation of the clinician's participation status.

Responding to enrollee messages is also an issue according to these results. This finding aligns with complaints data which reveals that the highest volume of access related complaints received from enrollees is clinician non-response to enrollee phone calls.

Clinicians are expected to comply with the appointment availability and after-hours coverage standards. We appreciate your help in meeting these standards to ensure appropriate and timely access to care.

USBHPC Adopts Additional Best Practice Guidelines from APA and the AACAP

By Richard Jimenez, M.D., Regional Medical Director

USBHPC recently adopted Best Practice Guidelines for the clinical management of Acute Stress Disorder and Posttraumatic Stress Disorder, and for Child and Adolescent Substance Use Disorders as endorsed by the American Psychiatric Association (APA) and by the American Academy of Child and Adolescent Psychiatry (AACAP), respectively. These guidelines incorporate evidence-based rating systems, which rank the demonstrated validity of various therapeutic approaches. Both guidelines represent a synthesis of scientific knowledge and address the application of rational clinical practice.

The APA's "Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder" examines the use of exposure therapies and cognitive-behavioral and pharmacologic interventions. It outlines a comprehensive treatment approach from initial assessment through patient management considerations, including principles of treatment selection and specific treatment selection, evaluation and management of comorbid conditions, patient education, and improving patient adherence to treatment.

The AACAP's "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders" gives special consideration to the unique developmental context of adolescent experimentation, while also addressing the assessment of risk factors of the individual and "family unit". Routine screening for use of substances is indicated when adolescents experience dysfunction in one or more domains. Specific treatment modalities endorsed in the guidelines include family therapy and cognitive behavioral approaches, independently or in conjunction with motivational enhancement. Community reinforcement approaches are noted to be promising and self-support groups are endorsed as adjuncts to treatment management. Evaluation for comorbid psychiatric disorders is endorsed as a minimal standard. In addition, this guideline is unique for its listing of screening and evaluation instruments.

Links to these and other Best Practice Guidelines can are found at www.ubhonline.com. From the menu on the left side of the home page, go to "clinical resources"/"guidelines and policies", select "best practice guidelines", and click on the link to the particular guidelines you want to view. Or for additional information, contact Clinical Network Services at (800) 798-3053, ext. 2058.

Clinician Satisfaction Improves Over Prior Year

Every year USBHPC surveys network clinicians to assess satisfaction with USBHPC staff and processes. In 2005, 435 clinicians who had provided services to our enrollees in 2004 were surveyed.

Clinicians who responded conveyed an overall satisfaction rate of 84%, an improvement over the previous year's 81%. Intake, Care Management and Clinical Network Services scored 90% or higher in all categories surveyed. There was some decline in satisfaction with claims processing time and accuracy, while a new category regarding the quality of the response received from Customer Service staff scored an impressive 95% satisfaction level.

Of those responding, 24% submit claims through www.ubhonline.com, up from 17% in the 2003 survey. Satisfaction with submittals through ubhonline also showed improvement, from 81% in 2003 to 88% in 2004. We continue to make enhancements to ubhonline and encourage you to take advantage of the many features available on the site.

The survey responses offer great assistance in identifying valuable work practices and areas for improvement. Thank you to all the clinicians who participated in this survey.

Important Reminders

Information for Contracted Clinicians

California Code of Regulations § 1300.71(m) requires USBHPC to provide a minimum of 45 days prior written notice before implementing any revisions or updates to its procedures for filing claims and provider disputes, claims payment policies, and clinician fee schedules. USBHPC may utilize the clinician Web site, www.ubhonline.com to present such information to contracted clinicians.

Affirmative Incentive Statement

Care advocate decision-making is based only on the appropriateness of care as defined by the USBHPC Level of Care Guidelines, the USBHPC Psychological and Neuropsychological Testing Guidelines, and the existence of coverage for the requested service. USBHPC does not compensate employees, appeal reviewers or clinicians for denials of coverage or service. There are no financial incentives for utilization management decision makers to encourage denial of benefits.

The USBHPC Level of Care Guidelines and the USBHPC Psychological and Neuropsychological Testing Guidelines are available and can be downloaded from ubhonline®. From the menu on the left side of the home page, go to "clinical resources"/"guidelines and policies" and select "level of care guidelines". Or you may contact Clinical Network Services at (800) 798-3053, ext 2058.

Care Advocacy Process Offers Peer Review Discussion

USBHPC's care advocacy process offers every clinician the opportunity to discuss a potential adverse benefit determination based on medical necessity with an appropriate peer reviewer at USBHPC before a final determination is made. You may request a discussion with a peer reviewer at any time during the decision process or after the decision has been made.

Treatment Record Documentation Requirements

USBHPC expects all network clinicians and facilities to maintain high quality records related to behavioral health services they provide. These records must be maintained in a manner consistent with the standards of the community, as well as conform to applicable statutes and regulations.

Monitoring of records may occur during a scheduled site audit or through a record request. Site audits may occur for several reasons, including pre-credentialing visits of potential high-volume clinicians, routine random audits and audits concerning potential quality-of-care issues. The audits focus on the completeness and quality of documentation within treatment records, with a performance goal of 85%. Reviews that do not meet the performance goal require a plan of corrective action and/or a re-audit within six months.

Our requirements for Treatment Record Documentation are available in the USBHPC Clinician Manual, which can be found

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at www.ubhonline.com. From the menu on the left side of the home page, go to "clinical resources"/"guidelines and policies" and select "clinician manual" or "facility manual". You may also request a copy of the manual by contacting Clinical Network Services at (800) 798-3053, ext. 2058.

Identification and Authentication of Enrollees for Inpatient Facility

When an inpatient facility calls to obtain an enrollee's benefits or for utilization review purposes, USBHPC will identify and authenticate both the facility and the enrollee prior to releasing information. Facilities should be prepared to provide the following information about the enrollee to Customer Service or Utilization Review staff:

- Enrollee's name, including middle name or initial
- Either the enrollee's month and year of birth or the enrollee's address
- Enrollee's identification number
- The source of the insurance information (e.g., the Medi-Cal/Medicaid database, verbal information from the enrollee or a family member, the insurance ID card)

Through verification of this information, the enrollee's privacy is protected and the facility is given accurate information.

USBHPC Public Policy Committee

In accordance with California law, USBHPC leads a Public Policy Committee to provide a formal structure for the comments and participation of covered enrollees and employer and health plan representatives. This committee consists of at least three subscriber enrollees of USBHPC, one USBHPC-contracted clinician and one member of the USBHPC Board of Directors.

In addition to functioning as a focus group to evaluate care and service proposals and to define USBHPC's public policy in accordance with the state's Knox-Keene Act, the committee reviews and discusses:

- USBHPC's growth, management and fiscal updates
- Summary and trend reports on enrollee grievances and appeals, including information on the nature, volume and disposition of these actions
- Enrollee, clinician and facility satisfaction survey results and enrollee satisfaction activities
- Enrollee Rights and Responsibilities and other enrollee communications

The Public Policy Committee meets quarterly, and reports to the USBHPC Board of Directors.

Measuring Network Availability

In 2005, USBHPC measured our network availability throughout California in accordance with the following standards.

	Standard (within number of miles from enrollee)			
Provider Type	**Urban**	**Suburban**	**Rural**	**Performance Goal**
Physician	10 miles	20 miles	30 miles	95%
PhD/Master's Level	10 miles	20 miles	30 miles	95%
Child/Adolescent Clinician	10 miles	20 miles	30 miles	95%
Acute Inpatient Care	15 miles	30 miles	60 miles	90%
Intermediate Care/ Partial Hospitalization	15 miles	30 miles	60 miles	90%
Intensive Outpatient Care	15 miles	30 miles	60 miles	90%

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As in 2004, we met or exceeded our availability goals in all urban and suburban areas. There are challenges in rural areas of California where, in some instances, few clinicians and facilities are available for contracting. Changes in the distribution of our membership also have an impact on network availability.

We continue to aggressively recruit clinicians in those areas not meeting the standards. In addition, we are working to expand our relationships with key clinicians who may be able to assist us in identifying new clinicians in areas where availability is a challenge.

Enrollee Satisfaction Survey

USBHPC surveys its enrollees annually using the NCQA survey tool, the Experience of Care and Health Outcomes (ECHO). In 2005, general satisfaction improved for both the HMO and PPO products, especially with treatment received. Enrollees reported a great deal of satisfaction with the way clinicians listened to their concerns, demonstrated respect, and spent time with them. In 2006, USBHPC is working to improve lower scoring items such as enrollees' experience with coordination of care between their PCP and behavioral health clinician.

Educating Enrollees Can Set Clear Expectations

Care advocates find that many enrollees calling to seek mental health services have a limited understanding about medication management as compared with psychotherapy, sometimes leading to unrealistic expectations about their care. Enrollees may expect medication management visits to last as long as psychotherapy sessions, or may question why medication management sessions occur less frequently. Enrollees may also be unaware of the value of coordination of care between their psychiatrist, who is providing medication management, and their therapist. Many enrollees express confusion about the role of a psychiatrist, or the variations in the types of treatment a psychiatrist may offer. For example, some psychiatrists choose to do medication management or psychotherapy only, while others may provide both services.

It is important to educate patients early in treatment regarding your scope of practice and clinical approach. A review of each clinician's role will also foster patient understanding, as well as realistic expectations regarding how each clinician would be involved in the treatment.

Clinicians and Enrollees Pleased with Enhanced Outpatient Care Management

USBHPC's enhanced approach to outpatient care management was implemented in December, 2005. The enhancements eliminated the requirement to submit outpatient treatment plans and simplified the certification process for enrollees. The new process enables USBHPC to be more efficient and more focused on an outcomes-based approach to managing care. Claims data and patient information obtained through the Wellness Assessment (WA) are used to target cases in which care advocate outreach may be most useful to the enrollee and clinician in achieving a positive outcome.

Response to the enhanced outpatient process has been overwhelmingly positive. Clinicians report that they appreciate the elimination of written treatment plans for ongoing care. Clinicians contacted by care advocates about high-risk or other challenging cases have expressed appreciation for the support and assistance offered. Enrollees value the convenience of requesting certification once per year and being able to change clinicians without notifying USBHPC.

Important reminders about the enhanced process:

1. Do NOT submit Outpatient Treatment Progress Reports. Pre-certification for routine outpatient sessions is required. However, certification is valid for 12 months from the date of issue subject to the enrollee's continued coverage and benefit limits. In addition, the enrollee's condition must continue to meet medical necessity criteria for care, and services provided must be consistent with the enrollee's benefit.
2. Administer the WA to every new USBHPC enrollee during the first session.

The WA, along with claims data, is used to identify and support high-risk and other challenging cases. The WA screens for psychiatric symptoms, substance use conditions and functional impairments. There are two versions of the WA, one for adults and one for children/adolescents. Both are available in English and Spanish.

The Wellness Assessment process is simple:

1. A WA is given to each USBHPC enrollee by the clinician at the first appointment.

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2. The clinician reviews the responses with the enrollee, and uses the information in developing a treatment plan and tracking progress, as appropriate.

3. The clinician then mails or faxes the completed WA to USBHPC. The address and fax number are provided on the WA form.

4. Six months later, a follow-up WA is mailed to the enrollee along with a postage-paid return envelope.

USBHPC may periodically share summaries of these pre- and post-testing results with network clinicians. We may also aggregate information from the assessment to develop quality improvement programs addressing the needs of specific clinical populations.

Thank you for your support of the enhanced outpatient program. If you have any questions about the program, please visit www.ubhonline.com or call Clinical Network Services at (800) 798-3053, ext. 2058.

Dialectical Behavioral Therapy Clinicians Needed

Clinicians are needed who can provide dialectical behavioral therapy either individually or in a group setting. If you provide these services, please update your profile at ubhonline® or call us at (800) 798-3053, ext 2058.

Pharmacy Triggered PCP Communication Program

During the second half of 2005, USBHPC and Blue Shield of California (BSC) collaboratively piloted a program promoting communication between psychiatrists and Primary Care Physicians (PCPs). Based on the positive feedback received from PCPs and psychiatrists about the benefits of the program, it has now been introduced throughout California.

Close coordination of a patient's care between their psychiatrist and other physicians remains a major focus in healthcare quality. Communication between treating clinicians helps increase the overall quality of care provided to a patient by:

- Minimizing potential adverse medication interactions for patients prescribed psychotropic medication
- Allowing better management of treatment and follow-up for patients with co-existing behavioral health and medical disorders
- Reducing risk of relapse for patients with substance use disorders

PCPs report they are eager to communicate with psychiatrists and find shared information essential in managing their patients.

Key Elements of the Program

On a quarterly basis, Blue Shield identifies patients who have received a new prescription or a change in an existing prescription from a psychiatrist. Based on that information the psychiatrist will receive:

- A cover letter with contact information for any questions about the information on the enclosed form(s)
- A pre-populated form including patient and PCP information
- A list of all medications currently prescribed by any physician (based on BSC pharmacy data)
- An envelope pre-addressed to the PCP

Information supplied on the form is generated from pharmacy claims data for Blue Shield HMO enrollees. The psychiatrist completes the form by providing up-to-date information and retains a copy for the patient's chart. The original form, along with the included list of all current medications, is then forwarded to the patient's PCP in the provided pre-addressed envelope.

The purpose of this program is to further enhance the ongoing dialogue between psychiatrists and other physicians. We look forward to working with you to improve communication in this vitally important area.

USBHPC QI Program

USBHPC's Quality Improvement (QI) Program includes QI monitors related to access and availability of clinicians, quality of care and services, patient safety, appropriate utilization of resources, and the USBHPC structure and processes to support them. Every year an in-depth evaluation of the QI Program is completed.

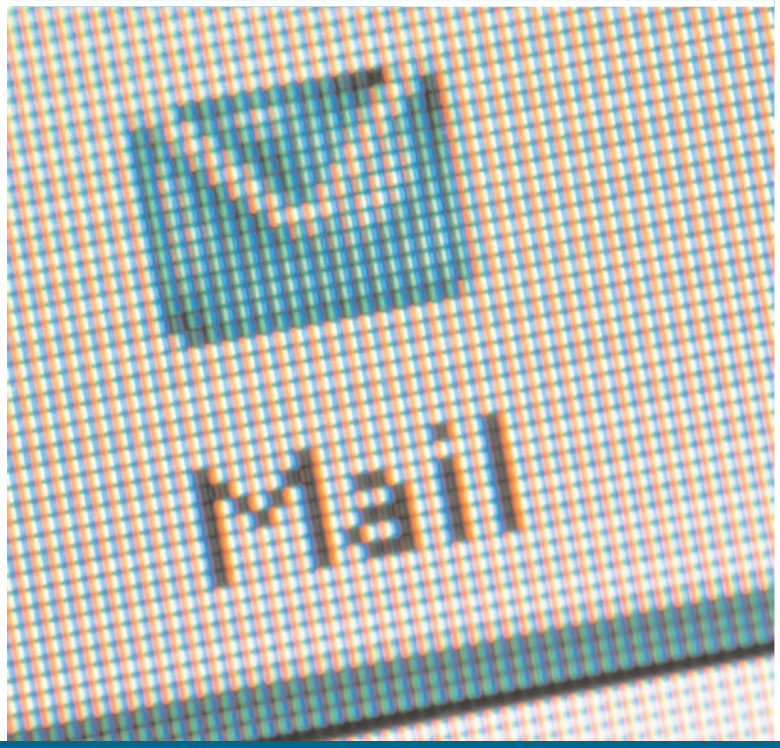
In 2005, USBHPC reported improvements to already excellent network availability and accessibility, continued excellence in the turnaround times for enrollee appeals and complaints, and for provider disputes. Continuous improvement was reported in other areas, including adverse benefit determination turnaround times and Intake and Customer Service call response times which frequently met or exceeded benchmark goals.

Although some improvement was noted in contracted network adherence to Best Practice Guidelines for ADHD and Depression, other metrics remain flat. Please see the article on Best Practice Guidelines elsewhere in this newsletter to learn more about obtaining these evidence-based standards related to patient care.

Continued effort is needed to improve with the seven- and 30-day follow-up appointment after hospitalization metric. The expectation is that every enrollee who is discharged from the hospital is seen within seven days at the ambulatory, partial hospitalization, or intensive outpatient level of care. Please see the article on "Preventing Readmission" on page 2 of this newsletter for additional information on this topic.

If you would like to know more about the USBHPC QI Program, please call Clinical Network Services at (800) 798-3053, ext 2058 and an Executive Summary will be sent to you.

Network Notes



News and updates for USBHPC-contracted clinicians

Summer 2006

Published by U.S. Behavioral Health Plan, California, Clinical Network Services, P.O. Box 880609, San Diego, CA 92167-0609

www.ubhonline.com

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For paper copies of any USBHPC documents, or for further information regarding the programs or procedures mentioned in this newsletter, please contact USBHPC at 1-800-798-3053, ext 2058.