DEPARTMENTAL

POLICY & PROCEDURE

☒ **Medicaid** ☒ **Child Health Plus** ☒ **Exclusive Provider Organization** ☒ **Preferred Provider Organization** ☒ **Commercial HMO** ☒ **Essential Plan**		**TITLE OF POLICY** **CHEMICAL DEPENDENCE/SUBSTANCE ABUSE AND MENTAL HEALTH CASE MANAGEMENT PROGRAM**	
Policy ID	**CS/MM 7.3.0**	**Policy Status**	**Final**
Department	**Medical Management**	**Unit/Area**	
Effective Date	**5/1/15**	**Next Review Date**	**4/30/16**
Process/Procedure	Description of the Substance Abuse and Mental Health Case Management programs		

I. Policy Statement

All CRHP members will be screened, identified, assessed and supported as soon as possible. The CRHP CM will lead coordination of the interdisciplinary care team, ensuring that each member's chemical dependence/substance abuse/mental health and physical health services are coordinated and meet the individual needs of the member. CRHP's SAMH care management programs will comply with NYDOH requirements, Section 365-k of the Social Services Law, 2012 NCQA Standards for Complex Case Management (QI7 / SNP1), URAC Standards for Case Management (v4.1), 2012 HEDIS Technical Specifications, Preventive Services Task Force (USPSTF) recommendations, and Centers for the Disease Control and Prevention (CDC) guide lines.

II. PURPOSE

The purpose of this policy is to describe the Crystal Run Health Plans (CRHP) Chemical Dependence/Substance Abuse and Mental Health (SAMH) Case Management programs.

III. Definitions

Chemical Dependence Services: means examination, diagnosis, level of care determination, treatment, rehabilitation, or habilitation of persons suffering from chemical abuse or dependence, and includes the provision of alcohol and/or substance abuse services.

OASAS: means the New York State Office of Alcoholism and Substance Abuse Services.

IV. PROCEDURE

General Information:

CRHP Members may self-refer for: one mental health visit and one substance abuse visit per year for evaluation.

- Members are educated regarding this:
  - In the member handbook
  - During the new member welcome call
  - Through periodic member education initiatives, such as newsletters, telephone hold messages, member portal banners
- Providers are educated regarding this:
  - In the Provider manual
  - During the provider orientation
  - Through periodic provider education initiatives, such as newsletters, telephone hold messages, provider portal banners
- After the evaluation is completed, the provider is required to contact CRHP:
  - prior authorization may be required for continuation of services
  - to coordinate case management activities and other community resources available to the member

Member identification:

Members who need SAMH treatment and case management can be identified to CRHP CM staff through:

- provider referrals
- self-reporting by the member (call to Member Services, or inquiry to the Medical Management (MM) staff)
- encounter/claims data
- clinical record review

All newly enrolled or those members re-enrolled within 60 days will receive a new member packet that contains a health screening form. The form contains questions pertaining to chemical dependency/substance abuse/behavioral health. If the member does nto return the form, the questions are asked during the new member welcome call by Member Services Department staff.

If the member indicates that s/he may me experiencing any problems related to behavioral health, a Case Manager (CM) will conduct a Health Risk Assessment (HRA) utilizing a standardized tool to identify members with a current SAMH condition, past history, or factors that would indicate risk:

  - contains questions specific to lifestyle, past history, and general well-being which are aimed at identifying members who have actual or potential need for substance abuse and/or mental health services
  - screens for co-morbidities and other factors impacting self-management
- Members who provide HRA responses which trigger prompts for further investigation will initiate further assessment questions which:
  - identify or further explore with the member any potential risk factors and barriers to care
  - identify knowledge deficits regarding SAMH care and the member's benefits

- provide necessary member education and address the member's unmet needs
- verify that the member has identified his/her PCP, or if not, will assist he member to choose a CRHP PCP and set-up a visit
    - Members who present to the CRHP CM with urgent, emergent, or suspicious sequelae will be immediately referred to a SA or BH provider (as appropriate), or directed to seek Emergency Room care.

The CRHP Medical Management (MM) Department also regularly monitors claims and encounter data to identify members who may have SAMH challenges.

- A periodic report capturing all SAMH related billing and diagnostic codes is reviewed.
    - Any member appearing on that list who has not been identified by the HRA or self reporting processes will be immediately contacted by a CRHP Case Manager to be assessed and connected to appropriate care and services.
    - Any member appearing on that list may also trigger re-assessment and re-stratification (as described below).

In addition, In-Network Providers are educated and required contractually to notify CRHP Case Management of all identified members with SAMH requirements who would benefit from enhanced care coordination. When a member is identified, the CRHP Case Manager (CRHP CM) will contact the member and initiate the assessment and screening process, as described above.

Member Stratification:

During the initial contact with the member, the CRHP CM will assess the member for the below exemplary list which impacts a member's ability to manage his/her health:

- Barriers: To meeting goals or complying with the Individual Care Plan
- Behavioral /Lifestyle: Weight gain, tobacco, alcohol and recreational drug usage; physical activity; nutrition
- Benefits / Coordination of benefits: Benefits availability and level of understanding
- Cognitive Status: Educational level; understanding of health / SAMH conditions
- Communication: Language, visual or hearing limitations, preferences or needs
- Cultural / Religious: Complementary and alternative medicine utilized; any religious or cultural needs, preferences or limitations that may impact the plan of care
- Functional level: Activities of Daily Living (ADL's), Instrumental ADL's (IADL's); DME usage / needs
- Health Status / Clinical History: Pre-existing conditions, conditions that impact the develop of the member's care plan

- Internal Care Management Process/Data gathering: Member contact information; HIPAA considerations; consent for engagement / participation; marital status; living arrangements
- Life Planning: Healthcare power of attorney, advance directives, living will
- Preventive Health / Key Metrics: Preventative screenings, immunizations
- Psychosocial / Mental health: Coping status; depression / stress; family and social support
- Resources & Support: Caregiver resources / level of involvement, external resources utilized
- Safety: Health and personal well being issues; safety concerns
- Treatment: Medications, screenings, diagnostic procedures, home/ outpatient procedures, and equipment and the member's level of adherence to those recommendations
- Utilization: Inpatient and ED utilization, surgical history, hospitalizations and outpatient treatment, care provider(s) utilization
- Desire/ability to self direct care (subject to eligibility category)

The presence of impacting factors, prior history, identified knowledge deficits or claims/encounter data will stratify the members into one of 3 categories:

Risk Stratification-example components/categories:

Risk Category	Definitions/Examples
Non-Complex Care (Low Risk)	• no pregnancy • resides in the community with no cognitive/social/physical deficits • stable living situation • no ER/urgent care visit or hospitalization in last year • high social, cognitive, and physical functioning; • controlled or no chronic diseases, no co-morbidities • multiple chronic conditions but sees PCP regularly • employed/providing community service (HCBS programs) • no safety/security issues • adequate support of family, friends, community, religious
Level 1 Targeted Care (Potential Risk)	• pregnancy • one or multiple chronic conditions but have identified care gaps through missed appointment tracking or HEDIS reports • polypharmacy • one or more ER or Urgent care visits for urgent/emergent or non-urgent conditions • has been homeless in last year

Risk Category	Definitions/Examples
	• hospitalized in last year for chronic diagnosis related illness • has >1 chronic disease DM, Asthma, COPD, A-fib, CHF, HIV, Cancer, chronic BH/cognitive disorder • presence of substance abuse/use with/without behavioral health diagnosis • history of inpatient or outpatient substance abuse rehabilitation care (in recovery or relapsed) • unstable support system • unable to read, communicate verbally, communicate in English
Level 2 Complex Care (High Risk)	• + ER/urgent care/hospitalization • <1 chronic dx, uncontrolled and/or non-adherent • Unstable living situation or institutional based (i.e. Homeless, SNF/LTC) • Pregnant and: o <18yo or other high risk factors (i.e. previous high-risk pregnancy, substance abuse, homeless, etc.) • 3+ deficit of IADL –or- =>1 late loss ADLs (feeding, bathing, dressing, transfer, etc.) • No support • Dually diagnosed (active substance abuse and mental health disorders, i.e. Depression, bipolar, schizophrenia, PTSD etc.) • Developmental delay • HIV/AIDS • Domestic violence • Special Health Care Needs or LTSS/MLTC (eligibility category) • Requires intensive coordination of services

SAMH Case Management:

When a member has been screened and stratified by risk level, the CRHP CM will offer the member support and assistance to address any identified or potential circumstances that impact the member's ability to self manage his/her conditions, including, but not limited to:

- obtaining an appointment/verifying the member is under the care of the member's PCP
- educating the member ,including but not limited to:
  - clinical/physical related topics
  - member benefits
  - maintenance of confidentiality
  - other supportive services available in the community
  - reading or audio/visual educational materials

Level 2 and some Level 1 members: will be enrolled in a SAMH Case Management program, designed to target the needs of members who have risk factors, and/or Substance Abuse/Mental Health/Dual diagnoses. In addition to above description, enhanced care management includes, but is not limited to:

- collaboration with members of the interdisciplinary care team and the member to develop a plan of care
  - care plans will be made available securely electronically to the team, including real-time UM and CM notes, and claims history
- focused care coordination with the member's PCP, personal supports, community supports and services providers, and all other entities involved in the member's care
- arranging transportation to/from clinically related services
- assuring that homebound or homeless members are provided proactive and consistent visits by behavioral health practitioners
- connecting the member to covered and non-covered supportive social services within the community
- monitoring the member's compliance/assuring kept appointments
- picking up medications and monitoring for side-effects
- arranging for additional (covered and/or non-covered) health care services, such as: home health care, nutritional counseling, HIV screening, etc.
- reviewing claims and encounter data to assure compliance with medication regimens, outpatient therapies, etc.
- assures interpreter services are utilized when needed

The CRHP CM also leads the interdisciplinary care team's efforts to support the member enrolled in the SAMH Case Management programs, which entails coordination and communication among all providers.

Post-discharge Case Management

Members who are discharged from an inpatient or intensive outpatient substance abuse or mental health or dual diagnosis stay will be intensively supported by the CRHP CM by:

- ensuring follow-up appointments with behavioral health Providers are available and arranged prior to member discharge (as possible)
- informing members/responsible parties about follow-up appointments with behavioral health Providers at time of discharge
- educating the Member that although they may feel better after discharge, they must keep all follow-up appointments and take medications as prescribed
- prior to discharge, coordinating with the Provider and the member to develop an appropriate support system that will assist in ensuring the member complies with follow-up appointments

Routine CM Activities

- The CRHP CM monitors, tracks and reports any potential or served access or quality concerns and participates in the Quality Management process.
- Monitors hospital admission, admission diagnoses, and pending discharges reports.

Continuity of Care:

New members who have established a relationship with a non-contracted provider will be permitted to continue care with that provider through for a period of 60 calendar days, if the non-contracted provider agrees to comply with the CRHP quality, reporting, and billing requirements.

After 60 days, the member will be required to transfer his/her care to a CRHP contracted provider, unless the member or provider demonstrates that his/her needs cannot be met within the CRHP contracted network.

Member Education-Chemical Dependency, Substance Abuse and Mental Health COnditions

The following items list the methodologies used to notify members and providers of available educational information:

- Member mailings
- CRHP website, in both Member and Provider portals
- Provider manual
- On-site provider visits from CRHP's Provider Relations Department
- Provider/Member bulletins
- Special Mailings
- Telephonic Outreach
- Displayed education materials at community events

Materials intended for member education will be developed in an age and culturally sensitive manner, and will address specific risk factors.

- For members who tested HIV negative, materials will be provided about preventing exposure to the virus
- For pregnant members who are HIV Positive, materials will include use of antiretrovirus drugs to prevent transmission of the voirus to the fetus
- For members who tested positive, the materials will focus on the need to maintain AIDS free, by keeping appointments, complying with medication regimens, etc.; and about the availability of HIV counseling, testing, referral and partner notification (CTRPN) services.
- Pregnant members will be educated to get an HIV test, regardless of risk factors.

The Provider Relations, with input from Case Management and Member Services Staff, will maintain an updated list of community resources to assist the member. Provider Relations and/or The Director of UM/QM will post the list on the CRHP Intranet, and website, and will verify that it is current at least quarterly. The list of community resources will be provided to each member at entrance into Case Management, and as indicated, and by any member of the CRHP staff.

Provider Network-

CRHP requires all contracted providers to adhere to established standards, as a condition of participation. CRHP will include a full array of mental health and Chemical Dependence Services providers in the networks, in sufficient numbers to assure accessibility to all benefit services for both children and adults, using either individual, appropriately licensed practitioners or New York State Office of Mental Health

(OMH) and Office of Alcohol and Substance Abuse Services (OASAS) licensed programs and clinics, or both.

CRHP network providers include the following types of behavioral health providers:

- Individual Practitioners
- Psychiatrists
- Psychologists
- Psychiatric Nurse Practitioners
- Psychiatric Clinical Nurse Specialists
- Licensed Certified Social Workers
- OMH and OASAS Programs and Clinics, and providers of mental health and/or Chemical Dependence Services certified or licensed

The Provider Relations Department is responsible for educating contracted providers in the network, as well as for addressing any issues of non-compliance with those standards. The Provider Contracting staff and the CRHP Legal Department are accountable for assuring that contracts remain current and contain provisions that support the compliance with internal and external participation parameters.

Providers are educated about CRHP and externally (SDOH, NCQA, etc.) dictated requirements at:

- Initial contract orientation
- At annual update/contract renewals
- As needed, when non-compliance is identified
- As needed, when a change in clinical programs occurs.

All CRHP clinical guidelines, medical record and other documentation requirements, provider responsibilities in the interdisciplinary care team, are distributed to providers:

- Initial contract orientation
- At annual update/contract renewals
- As needed, when non-compliance is identified
- As needed, when a change in clinical programs occurs

Current clinical guidelines, member education tools and materials, documentation requirements, required forms, periodicity schedules, etc., are available to contracted providers via secure website portal access or in hard copy upon request.

Providers must comply with CRHP and SDOH access standards, which include but are not limited to:

- Timely access to appointments.
- Assisting or referring the member to specialist care, community resources, and other supports needed.
- Providing or arranging for the provision of 24 hour/7day week coverage and access to unscheduled/urgent/emergency visits on a 24 hour basis.
- Reminding members of appointments and assuring that follow-up appointments are made to address potential issues, such as abnormal test results, failure to keep specialist appointments, etc.
- Offering HIV testing to members between the age of 13 and 64, regardless of risk factors, and unless the member has tested HIV positive or has tested negative and had no interim risk factors. This includes educating members about availability of free anonymous testing.

Providers also must adhere to CRHP and SDOH documentation and reporting requirements, and maintain medical records and other patient information in a confidential manner, deploy the NYS Prenatal Care Risk Screening form (if indicated), and other data gathering requirements.

Provider Network- SAMH Specific

Provider Relations is also responsible for assuring that:

- CRHP contracts with HIV practitioners, focusing on key gaps in the network including cultural and language competence.
- Providers to make Treatment plans available securely and electronically to CRHP CMs
- High-volume providers permit imbedded CRHP CMs onsite
- SAMH contracted providers consistently participate in interdisciplinary care team functions
- HIV Specialist providers are available and are listed as such in the Provider Directory

V. Other Areas or Departments Affected

Quality Management, Provider Services, Member Services

VI. Auditing

Periodic audits will be performed by the following CRHP Departments: Quality Management and Medical Management

Failure to comply with this policy or related procedures may be subject to internal progressive disciplinary actions, up to and including employment termination, contract termination, or contract non-renewal.

VII. Attachments

N/A

VIII. References and Related Policies & Procedures (hyperlinks)

N/A

IX. Policy Approval

Jonathan Nasser, Chief Medical Officer **4/1/2015**

I. Policy Revision History

Originally Written By:	Michelle Reay, Vice President of Operations	**Implementation Date:** 4/1/2015	
Approved By:	Jonathan Nasser, Chief Medical Officer	**Date:**	4/1/2015
Revised By:		**Date:**	
Revision Description:			
Approved By:		**Date:**	
Revised By:		**Date:**	
Revision Description:			
Approved By:		**Date:**	
Revised By:		**Date:**	
Revision Description:			
Approved By:		**Date:**	
Revised By:		**Date:**	
Revision Description:			
Approved By:		**Date:**	
Revised By:		**Date:**	

Revision Description:			
Approved By:		**Date:**	
Revised By:		**Date:**	
Revision Description:			
Approved By:		**Date:**	