WellCare of New York

Behavioral Health Orientation Training

Last Update: 9-10-15
Training Overview
Overview

In this training we will be covering the following:

- The mission of the WellCare of New York Mainstream program
- The “Integrated Model of Care” of Medical, Behavioral and Pharmacy services
- The “Care Management Model” for managing member care and outcomes
- Care Coordination member engagement strategies
- New York Behavioral Health Populations and Programs
- Utilization protocols and criteria
- New York specific managed care rules
- New York providers and crisis resources
- WellCare’s Quality Improvement program
- Additional training materials and information
WellCare of NY Program Overview
Objectives

In this section we will be covering the following:

- The mission of the WellCare of New York mainstream program
- New York state’s transition to managed care
- Mainstream and HARP Plan overviews and differences
- New York coverage areas
- Eligible populations
- Mainstream plan implementation
NYS Vision, Mission, System Goals

WellCare of New York incorporates the following transformational goals as a Qualified Mainstream Plan (QMP):

• Improved health outcomes and reduced health care costs through the use of managed care strategies and technologies
• Transformation of the BH system from an inpatient focused system to a recovery focused outpatient system of care.
• Improved access to a more comprehensive array of community-based services that are grounded in recovery principles including:
  - Person centered care management;
  - Patient/consumer choice;
  - Member and family member involvement at all system levels; and
  - Full community inclusion.
• Integration of physical and behavioral health services and care coordination
• Effective innovation through the use of evidence-based practices
• Improved cross system collaboration with State and local resources
• Delivery of culturally competent services
• Assurance of adequate and comprehensive networks with timely access to appropriate services.
• Continuity of care during the transition from fee-for-service (FFS) to managed care
As a Mainstream Plan, WellCare incorporates the MCO Operating Principles, including the following:

- Earlier identification and intervention through screening for common conditions such as anxiety, depression, and alcohol misuse.

- Integrated, person-centered treatment within a strengths-based framework that is culturally relevant; incorporates natural supports; and promotes hope, empowerment, mutual respect, and full community inclusion.

- Use of integrated care models such as the Collaborative Care model for treating BH conditions in primary care.

- An inclusive culturally competent provider network that contains a wide range of providers with expertise in treating and managing SMI and SUD consumers.

- Efficient and timely service delivery, care coordination, and care management with minimal duplication across providers and between providers and the Plan.
NY State Behavioral Health Transition to Managed Care

Background:

- NYS is transitioning certain behavioral health (mental health and substance abuse) services from FFS to managed care.
- This transition impacts WellCare of New York’s current adult, Medicaid membership, also known as NMD.
- The transition results from the partnership between:
  - State Department of Health (SDOH)
  - Office of Mental Health (OMH)
  - NYC Dept. of Health and Mental Hygiene (NYC DOHMH)
  - Office of Alcoholism and Substance Abuse Services (OASAS)
# Mainstream and HARP Plan Overview

## Mainstream Medicaid Managed Care Plan (MMC)

**Who:**
- All Medicaid Managed Care-eligible adults (21+) who require BH services.
- Enrolled members whose BH benefit was covered under FFS Medicaid through SSI will begin receiving these benefits through the MCO.

**What:** Carve-in of BH benefits, which are currently provided through Medicaid FFS.

**Where:** New York City Area (Bronx, Kings, Queens, New York)

**When:**
- NYC Area: October 1, 2015 implementation of BH services for enrolled members.
- Rest of State: July 1, 2016 implementation of BH services for enrolled members.

## Health and Recovery Plan (HARP)

**Who:**
- All Medicaid-enrolled adults (21+) who require BH services, and have select Serious Mental Illness (SMI) and Substance Use Disorder (SUD) diagnoses. Subject to additional target and risk criteria.

**What:** Carve-in of BH benefits, which are currently provided through Medicaid FFS, and addition of HCBS Services.

**Where:** New York City Area (Bronx, Kings, Queens, New York)

**When:**
- NYC Area: October 1, 2015 implementation of non-HCBS BH services for enrolled members.
- NYC Area: October-January 2016 phase in of HARP enrollment.
- Rest of State: July 1, 2016 phase in of HARP enrollment.

WellCare of New York is considered a Mainstream Plan, NOT a HARP, and will be only offering the Mainstream BH Service Array plus Peer Supports.
Coverage Area of the Mainstream Plan

WellCare serves approximately 109,000 Medicaid members across the state.

New York Medicaid Presence:

- Serves approximately 98,000 TANF members.
- Serves approximately 5,000 SSI members.
- Serves approximately 3,000 members enrolled in New York’s Child Health Plus program.
- Serves approximately 3,000 Dual-eligible members.
- Effective 10-1-15, carve in of expanded BH Benefits under QMP impacts adult members in
  - Bronx
  - Kings
  - Queens
  - New York (Manhattan)

Data is per the last reported quarter, ending March 31, 2015
Updated: May 2015
Eligible Populations*

**QMP Members Today:**
- Age 21 or older at time of enrollment
- Full Medicaid
- Reside in one of the downstate NY Counties

**HARP Eligible Members**
- Adult Medicaid beneficiaries 21 and over who are eligible for mainstream MCOs are eligible for enrollment in the HARP if they meet:
  - HARP target criteria and risk factors, OR
  - If identified as having serious functional deficits as determined by:
    - Case Review of member’s usage history
    - Completion of HARP eligibility screen

As a QMP, WellCare is expected to refer HARP eligible members to the enrollment broker, Maximus (see HARP Enrollment on next slide).

*Members in nursing homes for long term care will not be eligible for enrollment in HARP. Dual Eligibles are not an included population at this time.*
HARP Enrollment

Ability to opt out of HARP or choose different Plan:

• Members identified for passive enrollment will be contacted by the NYS Enrollment Broker (Maximus).

• Members will be given 30 days to opt out or choose to enroll in another HARP.

• Once enrolled in a HARP, members will be given 90 days to choose another HARP or return to WellCare’s QMP before they are locked into the HARP for 9 additional months (after which they are free to change Plans at any time).

• Those members who are initially identified as HARP eligible who are enrolled in the WellCare’s QMP will NOT be passively enrolled.

• They will be notified of their HARP eligibility and referred to the NYS Enrollment Broker (Maximus) to help them decide which Plan is right for them.

• This process is supported by WellCare staff, who can connect members to their assigned Health Homes and/or Maximus.
HARP Target Criteria:

Targeting criteria are defined as follows:

• Age 21 or older at time of enrollment
• SMI/SUD diagnoses
• Eligible to be enrolled in Mainstream MCOs
• Not participating in an Office for People with Developmental Disabilities (OPWDD) program
HARP Risk Factors:

For members who meet the targeting criteria, the HARP Risk Factor criteria include any of the following:

- Members who have Supplemental Security Income (SSI) and who received an "organized" MH service in the year prior to enrollment.
- Non-SSI individuals with three or more months of Assertive Community Treatment (ACT) or Targeted Case Management (TCM), Personalized Recovery Oriented Services (PROS) or prepaid mental health plan (PMHP) services in the year prior to enrollment.
- SSI and non-SSI individuals with more than 30 days of psychiatric inpatient services in the three years prior to enrollment.
- SSI and non-SSI individuals with 3 or more psychiatric inpatient admissions in the three years prior to enrollment.
- SSI and non-SSI individuals with a current or expired Assisted Outpatient Treatment (AOT) order in the five years prior to enrollment.
Implementing the Mainstream Plan

- WellCare was approved as a Mainstream Plan in July, 2015, and began offering the expanded benefits to qualified WellCare Medicaid members on October 1st.

- WellCare expects to transition its existing members who are non HARP eligible into the Mainstream plan with expanded BH program services over the next several months.

- Behavioral health is fully integrated with the medical health plan

- The Mainstream plan features an expanded behavioral health network and new benefits.
Summary

You should now be able to identify:

• The mission of the WellCare of New York mainstream program
• New York state’s transition to managed care
• Mainstream and HARP Plan overviews and differences
• New York coverage areas
• Eligible populations
• Mainstream plan implementation
The Integration Model
Objectives

In this section we will be covering the following:

• The principles of managing integrated care
• The “Four Quadrant Strategy”
• The framework for integration
WellCare’s integration goal is to develop targeted Integrated Care Programs between Medical, Behavioral Health and Pharmacy to identify members who have or are at high risk for developing co-morbid, chronic disease states and ensuring that these members receive quality medical and behavioral health care from an interdisciplinary team in an appropriate setting, resulting in an improved outcome for the member.
Integration Model of Care and Framework

• To offer an integrated model of care for our members, we have adopted the four quadrant clinical integration concept.

• This concept helps to identify members that can be served in a PCP setting vs a specialty mental health setting (i.e.: Community Mental Health Center, CMHC).

• This model allows us to organize the delivery of our care management for our members.

• When we apply this concept, it offers us a context for how we care for our members with behavioral, physical health and co-occurring conditions.
Integration and the Four Quadrant Strategy

- My Medications
- My Behavioral Health Needs
- My Support System
- Specialty Behavioral Care
- Primary Care
- My Physical Health Needs
- My Health Plan

“Hi, remember I am in the center of care!”
# Integration Conceptual Framework

## The Four Quadrant Strategy

<table>
<thead>
<tr>
<th>Quadrant II</th>
<th>Quadrant IV</th>
</tr>
</thead>
</table>
| **Patients with high behavioral health and low physical health needs.**  
**Served in Primary care and specialty mental health.**  
(Example: Patients with Bipolar and chronic pain)  
Note: when mental Health needs are stable, often mental health care can be transitioned back to primary care  
- Managed by BH CM Tele or Field  
(Primary Behavioral CM) |
| **Patients with high behavioral health and high physical health needs.**  
**Served in primary care and specialty mental health settings.**  
(Example: patients with Schizophrenia and metabolic syndrome or hepatitis C)  
- Managed by Medical CM with BH CM collaboration  
(Primary Medical CM / Secondary BH) |

<table>
<thead>
<tr>
<th>Quadrant I</th>
<th>Quadrant III</th>
</tr>
</thead>
</table>
| **Patients with low behavioral health and low physical needs.**  
**Served in primary care setting**  
(Example: patients with moderate alcohol abuse and fibromyalgia)  
- No Medical CM or BH CM needed  
(Primary Wellness) |
| **Patients with low behavioral health and high physical needs.**  
**Served in Primary Care setting.**  
(Example: patients with moderate depression and uncontrolled diabetes)  
- Managed by Medical CM No BH CM involvement  
(Primary Medical CM) |


Summary

You should now be able to identify:

• The principles of managing integrated care
• The “Four Quadrant Strategy”
• The framework for integration
Care Management Model
Objectives

In this section we will be covering the following:

- The “Care Management Model” for managing member care and outcomes
- How WellCare manages complex members
- The “Complex Behavioral Assessment”
- The “Care Plan”
The Care Management Model

- Assessment
- Planning
- Advocacy
- Facilitation
- Monitoring
Care Management

- The Plan offers comprehensive care management services to facilitate member assessment, planning and advocacy to improve health outcomes.

- WellCare’s Care Management teams are led by Registered Nurses and Licensed Mental Health Professionals to include all relevant participants to meet the member’s needs and develop an appropriate Person-Centered Service Plan. The team will coordinate with behavioral health, community based and facility based providers and peer advocates.

- Care Managers will work with our internal and external partners to identify community, facility based, and behavioral health resources to provide the most appropriate services for our members.

- **Key elements of Care Management include:**
  - A comprehensive assessment and evaluation to gauge the member’s support systems and resources and to align them with appropriate wellness and clinical supports.
  - Development of an individualized Plan of Care (POC).
  - Development of specialized WRAP, Crisis/Safety Plans
  - Care coordination with Health Homes including comprehensive care management of the member.
  - Application of recovery principles, including a person-centered approach, inclusive of member choice, community inclusion and family involvement.
Managing Complex Members

As a Qualified Mainstream Plan, WellCare manages complex and high-cost, co occurring BH and medical conditions of our membership. We do so by including the following elements:

- Identification processes, including claims based analyses and predictive modeling, to identify high risk members;
- Stratification of cases according to risk, severity, co morbidity, and level of need for targeted outreach;
- Outreach, engagement, and intervention strategies based on stratification (in partnership with health homes);
- Care coordination or linkage to Health Home care coordination as appropriate;
- Appropriate referral and use of community supports;
- Provider collaboration;
- Individualized, person-centered care plans; and
- Engagement monitoring, outcome monitoring and reporting at the individual, program and Health Home level.

The plan monitors clinical staff compliance with these elements.
You should now be able to identify:

- The “Care Management Model” for managing member care and outcomes
- How WellCare manages complex members
- The “Complex Behavioral Assessment”
- The “Care Plan”
Care Coordination and Engagement Strategies
Objectives

In this section we will be covering the following:

• The technique of “Motivational Interviewing”
• Care Management roles and responsibilities
• Setting member expectations
• An overview of the key Care Coordination Process concepts
• Linkage to New York health homes
• Community support
• Screening and referral guidelines
Motivational Interviewing is typically used to address barriers to change, including:

- Ambivalence
- Feeling pressured to make a change
- Healthcare providers or others who may employ a ‘fix it’ approach
- Reluctance to accept responsibility for their actions & outcomes

The focus is on creating a positive environment for the member by:

- Focusing on what the member does right
- Acknowledging positive thoughts and feelings toward change
- Keeping the member moving forward in the change process
- Using effective communication skills

Motivated members are engaged in the change process and use effective, two way communication and are more likely to act on disease management education and information.
## Plan Behavioral Health Care Management

### Roles and Responsibilities

<table>
<thead>
<tr>
<th>BH Care Management</th>
<th>BH Utilization Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Complex BH Assessment</td>
<td>Authorization decisions for the full continuum of MH/SA services for adults, covered by the Mainstream Plan</td>
</tr>
<tr>
<td>Active care coordination, transition and discharge planning</td>
<td>Active care coordination, transition and discharge planning</td>
</tr>
<tr>
<td>Identify and develop BH Programs, Goals, Interventions and Measures (PGIMs) for the member-centered care plan</td>
<td>Review claims and clinicals to monitor for quality of care being provided to WellCare members</td>
</tr>
<tr>
<td>Manage Member’s Complex BH Needs</td>
<td>Case shaping with BH medical director supervision</td>
</tr>
</tbody>
</table>
Plan BH Care Management Expectations

<table>
<thead>
<tr>
<th>Where Do I Engage A Member?</th>
<th>Facility Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless Shelter</td>
<td>CMHC</td>
</tr>
<tr>
<td></td>
<td>Hospital</td>
</tr>
<tr>
<td></td>
<td>OMH Clinic</td>
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<tr>
<td></td>
<td>OASAS Clinic</td>
</tr>
<tr>
<td></td>
<td>PRTF</td>
</tr>
<tr>
<td>Respite Program(i.e. NYC Parachute)</td>
<td>Home Visit</td>
</tr>
<tr>
<td>Work/School</td>
<td>Community</td>
</tr>
<tr>
<td></td>
<td>Church/Synagogue/ Temple</td>
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<td></td>
<td>Support Group</td>
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<td></td>
<td>Library</td>
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<tr>
<td></td>
<td>Park</td>
</tr>
<tr>
<td></td>
<td>YMCA</td>
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<tr>
<td>Health Home</td>
<td>Emergency Room</td>
</tr>
</tbody>
</table>

To truly be transformational, care management must take an expanded and non-traditional approach to the member.
Plan BH Care Management Expectations

To truly be transformational, care management must take an expanded and non-traditional approach to the member, utilizing motivational interviewing as a common thread.

<table>
<thead>
<tr>
<th>How Do I Engage A Member?</th>
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</thead>
<tbody>
<tr>
<td><strong>Attend Treatment Team Meetings</strong>*</td>
</tr>
<tr>
<td>• Psychiatric Inpatient Hospital</td>
</tr>
<tr>
<td>• Medical Inpatient Hospital</td>
</tr>
<tr>
<td>• Residential Rehab</td>
</tr>
<tr>
<td>• Detox</td>
</tr>
<tr>
<td>• Respite Program</td>
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</table>

*visiting members while in treatment setting.

<table>
<thead>
<tr>
<th>Joint Visit with</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ACT Team</td>
</tr>
<tr>
<td>• Peer Specialist</td>
</tr>
<tr>
<td>• Health Home Coordinator or Case Manager</td>
</tr>
<tr>
<td>• PCP</td>
</tr>
<tr>
<td>• Psychiatrist/Therapist</td>
</tr>
<tr>
<td>• Guardian or Advocate</td>
</tr>
<tr>
<td>• Court Ordered Care (AOT), Probation Officer</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Meet Member - Day of Discharge Transitional LOC</th>
</tr>
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<tbody>
<tr>
<td>• SUD IP Detox to Rehab</td>
</tr>
<tr>
<td>• IP to Partial Hospitalization</td>
</tr>
<tr>
<td>• OP to Peer Program (ParachuteNYC)</td>
</tr>
<tr>
<td>• PROS to Standard OP</td>
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<table>
<thead>
<tr>
<th>Home Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Scheduled</td>
</tr>
<tr>
<td>• Unannounced</td>
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</tbody>
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<tr>
<th>Ancillary Supports, Meeting with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Member’s Family</td>
</tr>
<tr>
<td>• Pastor, Rabbi, Priest</td>
</tr>
<tr>
<td>• AA/NA Sponsor</td>
</tr>
<tr>
<td>• Other relational supports</td>
</tr>
<tr>
<td>• WellCare’s Community Navigator/Health Connector Program/Community Assistance Line</td>
</tr>
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<table>
<thead>
<tr>
<th>Non-Traditional Approaches:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting in settings that are important or comfortable to the member</td>
</tr>
<tr>
<td>• Shooting Hoops</td>
</tr>
<tr>
<td>• Playing chess or cards in a park</td>
</tr>
<tr>
<td>• Riding the Subway</td>
</tr>
<tr>
<td>• Yoga/Arts/Pottery/Music/Writing...self-expression</td>
</tr>
</tbody>
</table>
Coordination and Linkage with NY Health Homes

WellCare of New York works as an integrated team with Health Homes. Care management activities require focus on members with SMI, SUD, co-occurring physical health, co-occurring MH and/or SUD disorders and I/DD when appropriate.

Health Homes are 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 (HIT) to Link Services

The WellCare Utilization Manager and Care Manager work together to identify members who may need additional services, based on identified triggers, including the following:

<table>
<thead>
<tr>
<th>Frequent use of crisis/ED</th>
<th>Repeat admissions</th>
<th>Crisis prevention plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lacking effectiveness of treatment</td>
<td>Lack of treatment engagement</td>
<td>Correctional system involvement</td>
</tr>
<tr>
<td>Lacking evidenced based practices (EBP)</td>
<td>Lacking Clinical appropriateness of care</td>
<td>AOT Orders</td>
</tr>
</tbody>
</table>
WellCare has contracts and experience working with 18 NY certified Health Homes throughout NYS, including:

<table>
<thead>
<tr>
<th>Bronx Lebanon Hospital Center</th>
<th>Community Care Management Partners (CCMP)</th>
<th>Community Health Care Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinated Behavioral Care</td>
<td>Heritage Health and Housing Home Network</td>
<td>Institute For Community Living</td>
</tr>
<tr>
<td>Continuum Health Home Network</td>
<td>Bronx Accountable Healthcare Network Health Home (BAHN)</td>
<td>Hudson River HealthCare Inc.</td>
</tr>
</tbody>
</table>
Care Coordination, Case Management & Community Supports

- The Mainstream Plan will leverage a robust system of resources, including a variety of Case Management Services.
- **Care Coordination**: Services include case management, geriatric gatekeeper and mental health/physical health programs, home and community-based coordination, homeless placement, and transition services.
- **Case Management**: Promotes optimal health and wellness for adults diagnosed with severe mental illness and children and youth diagnosed with severe emotional disorders. Programs are organized around goals to improve access to services, promote member independence, self-sufficiency and achieve community integration.

**Case Management Programs (Targeted Case Management):**

- **Adult Home Supportive**: Provided to Adult Home residents who work as a team with Peer Specialists as part of an integrated approach.
- **Blended (BCM)**: BCM facilitates a team approach to case management services by combining the caseloads of multiple Intensive Case Managers (ICMs) and/or Supportive Case Managers.
- **Intensive: (ICM)**: Leads the coordination of resources for individuals eligible for mental health services with a case manager/client ratio of 1:12.
- **Supportive: (SCM)**: Leads the coordination of resources for individuals eligible for mental health services with a case manager/client ratio of 1:20 or 1:30.
Behavioral Health Care Management Screening and Referral Guidelines

**CAGE /CAGE AID** Drug and alcohol use screening tool (for ages 16 years old and older)
*Refer to BH for a score of 2 or more*

**CRAFFT** Alcohol screening tool intended to screen for simultaneous high risk alcohol/other drug use disorders (ages 12 to 21)
A score of less than 2 indicates no problem and no action suggested at this time Member is managed by medical CM
*A score of 2 or > indicates potential of significant problem and assessment is required Refer member to BH CM*

**PHQ 9** Depression screening tool (for adolescents 13-17; adults 18-64; geriatric 65+)
Less than 14 Member is managed by medical
15-19 Member is managed medically, with BH consultation as needed
*20 and Above Refer member to Behavioral Health Care Management*

**Behavioral Health Referral Guidelines**
- Follow up on Psych IP & residential discharges/Ensuring members have access to follow up care within the NCQA guidelines.
- Follow up on crisis calls
- Co manage with CCM medical on Quadrant 4 members. BH to provide BH specific goals/interventions for medical care plan
- Serve as a SME resource to medical to help them manage Quadrant 1-3 member needs

**Behavioral Health Care Management Triggers**
Rapid Readmit (24, 48, 72 hours) • 7/30/90 Readmission • FUH treatment barriers that could prevent member from receiving follow up care after IP, Detox, Residential discharge • Member/provider request • Crisis Call Follow ups
- Pharmacy due to psychotropic utilization • Co management with CCM for Quadrant 4 members
Other Community Supports and Programs:

- Geriatric Demo Physical Health  Mental Health Integration:
  - Co-located MH Specialists within Primary Care Settings
  - Improved Collaboration between separate providers
- Health Home Care Management
- Home and Community Based Services Waiver
- Homeless Placement Services
- Transition Management Services (discharge planning)
- Mobile Mental Health Teams
- Home-Based Family Treatment
- On-site Rehabilitation
- Psychosocial Club
- Community Outreach
Summary

You should now be able to identify:

• The technique of “Motivational Interviewing”
• Care Management roles and responsibilities
• Setting member expectations
• An overview of the key Care Coordination Process concepts
• Linkage to New York health homes
• Community support
• Screening and referral guidelines
Behavioral Health Populations and Programs
Objectives

In this section we will be covering the following:

• Behavioral Health market specific populations and programs
• Behavioral Health Providers and their credentials
BH Populations and Programs

The following slides describe BH terms, market-specific programs, and the populations we serve:

<table>
<thead>
<tr>
<th>BH Populations</th>
<th>Details</th>
</tr>
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<tbody>
<tr>
<td>SMI (Adults)</td>
<td>Serious Mental Illness</td>
</tr>
<tr>
<td>SED (Children)</td>
<td>Serious Emotional Disability</td>
</tr>
<tr>
<td>SUD</td>
<td>Substance Use Disorder</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Co-occurring</td>
<td>Simultaneous MH &amp; SUD or SUD &amp; MH</td>
</tr>
<tr>
<td>Co-morbid</td>
<td>Simultaneous diseases or conditions occurring at the same time</td>
</tr>
<tr>
<td></td>
<td>• Migraines &amp; Bipolar • Bipolar &amp; Anxiety • Rheumatic Arthritis &amp; Depression</td>
</tr>
<tr>
<td>Medicare / Medicaid</td>
<td>SSI • ABD • TANF</td>
</tr>
<tr>
<td></td>
<td>Supplemental Security Income • Aged, Blind, Disabled • Temporary Assistance for Needy Families</td>
</tr>
</tbody>
</table>
## BH Populations and Programs

<table>
<thead>
<tr>
<th>BH Populations</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-Occurring BH and Medical Disorders and Diagnoses</td>
<td>-Depression + Diabetes + Asthma&lt;br&gt;-Bi-Polar Disorder + Migraines</td>
</tr>
<tr>
<td>Co-Occurring MH and SUDs</td>
<td>-Anxiety + Alcohol Misuse&lt;br&gt;-Schizophrenia + Alcohol + Opiates</td>
</tr>
<tr>
<td>Co-Occurring BH and I/DD</td>
<td>Anxiety + Prescribed Drug and Alcohol Misuse + Down Syndrome</td>
</tr>
<tr>
<td>Transition-Aged Youth (TAY)</td>
<td>Individuals under age 23 transitioning into the adult system from any OMH, OASAS or OCFS licensed, certified, or funded children’s program (Additional training available on WellCare U and on WellCare.com)</td>
</tr>
<tr>
<td>Assisted Outpatient Treatment (AOT)</td>
<td>Court-ordered participation in outpatient services for certain people with serious mental illness who, in view of their treatment history and present circumstances, are unlikely to survive safely in the community without supervision. (Additional training available on WellCare U, and WellCare.com)</td>
</tr>
<tr>
<td>First Episode Psychosis (FEP)</td>
<td>Members who have displayed psychotic symptoms suggestive of recently-emerged schizophrenia. FEP generally occurs in individuals age 16-35. (Additional training available on WellCare U, and WellCare.com)</td>
</tr>
<tr>
<td>I/DD in need of BH Services</td>
<td>Pervasive Developmental Disorder + Schizoaffective Disorder</td>
</tr>
<tr>
<td>Older Adults</td>
<td>Member typically 65+ and has a MH/SA condition.</td>
</tr>
</tbody>
</table>
Additional BH Populations and Programs

SMI Criminal Justice Involvement / AOT

Members who have an SMI diagnosis may have additional, special needs and challenges. This may include a history of criminal justice system involvement, and/or court ordered treatment.

SMI Functionally Limiting SUDs

Members may also have functionally limiting substance use disorders (SUDs):

- A member who has a schizophrenia diagnosis, and is a cannabis and alcohol user.
- A member who has a diagnosis of severe psychoses, and has an opioid addiction.
Summary

You should now be able to identify:

- Behavioral Health market specific populations and programs
- Behavioral Health Providers and their credentials
Utilization Protocols and Criteria
Objectives

In this section we will be covering the following:

- InterQual criteria
- LOCUS and CALOCUS criteria
- LOCADTR criteria
- OMH Clinical Standards of Care
- OASAS Clinical Guidelines
- Various templates used for authorizing BH utilization services based on real member scenarios
Applying UM Protocols and Criteria

WellCare UM Managers will be provided additional training on how to apply medical necessity criteria (Interqual, LOCADTR, LOCUS, Clinical Coverage Guidelines).

**InterQual:**
Medical necessity criteria used for level of care determinations for mental health (OMH) clinic and hospital mental health inpatient services.

**Level of Care Utilization System (LOCUS):**
A methodology for quantifying the assessment of service needs in order to reliably place a client into the service continuum. Used for community-based level of care determinations.

**Level of Care for Alcohol and Drug Treatment Referral (LOCADTR):**
NYS level of care placement tool which guides placement, continued stay and transfer/discharge of patients within the New York State system of OASAS certified programs. The use of LOCADTR is required within New York State for all Medicaid substance use disorder member placements.

All substance use disorder (SUD) services require the use of the LOCADTR tool for making prior authorization and continuing care decisions.

- Medically supervised outpatient withdrawal (OASAS services)
- Outpatient Clinic and Opioid Treatment Program (OTP) services (OASAS service)
- Inpatient Hospital Detoxification (OASAS service).
- Inpatient Medically Supervised Inpatient Detoxification (OASAS service).
- Inpatient Treatment (OASAS service)
- Rehabilitation Services for Residential SUD Treatment Supports (OASAS service).
OMH Clinical Standards of Care

WellCare has adopted the following standards into its plan guidance related to prior authorization, concurrent or retrospective review.

![Office of Mental Health](https://www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html)

<table>
<thead>
<tr>
<th>Standard of Care Focus</th>
<th>Exemplary (In addition to Adequate)</th>
<th>Adequate</th>
<th>Needs Improvement</th>
</tr>
</thead>
</table>
| 1.11 Requests for services are addressed appropriately and in a timely manner | 1. There is evidence that recipients have received same-day initial assessments following screening. or 2. The program provides a walk-in, same-day service which has designated staff scheduled on a regular basis. or 3. There is evidence of follow-up to assist individuals screened but referred elsewhere to connect with appropriate services. | 1. Requests for services are screened and flagged same business day and this process is overseen by supervisory staff. and 2. Calls, walk-ins or referrals for services are screened for risk by staff that has been appropriately trained and mechanisms are in place for alerting professional staff when risk is identified and 3. Recipients referred from inpatient, forensic, or emergency settings, or those at high risk receive initial assessment within 5 business days; priority access is given to recipients enrolled in AOT. and 4. A note is written upon decision to admit which includes reason for referral, primary clinical needs, services to meet those needs, and admission diagnosis. and 5. Interpreter services are made available as needed. and 6. There is documentation of the rationale for | 1. Criteria for screening and triaging requests for service are inappropriate or inconsistently applied, or certain required treatment modalities are not offered, or process is not reviewed by supervisory staff. or 2. Priority access is not given as required by regulations. or 3. Admission notes are not present or are incomplete. or 4. There is no rationale for non-admissions and no referrals provided. or 5. Individuals requesting services are not consistently offered intake appointments within a reasonable time frame.

WellCare has adopted the following standards into its plan guidance related to prior authorization, concurrent or retrospective review.
Summary

You should now be able to identify:

- InterQual criteria
- LOCUS and CALOCUS criteria
- LOCADTR criteria
- OMH Clinical Standards of Care and OASAS Clinical Guidelines
The following two slides list new BH services available for qualified mainstream plan members (including OASAS and OMH certified programs). Not all services require a prior authorization.

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assertive Community Treatment (ACT)</td>
</tr>
<tr>
<td>Continuing Day Treatment (CDT)</td>
</tr>
<tr>
<td>Day Treatment</td>
</tr>
<tr>
<td>Medically supervised outpatient withdrawal (MSOW OASAS services)</td>
</tr>
<tr>
<td>Clinic (OMH Licensed Clinic, OASAS Certified Clinic, OASAS Certified Opiate Treatment Clinic, and OASAS Certified Outpatient Rehabilitation)</td>
</tr>
<tr>
<td>Behavioral Health Crisis Intervention</td>
</tr>
<tr>
<td>Opioid Treatment Services Substance Abuse</td>
</tr>
<tr>
<td>Outpatient clinic services (OMH services)</td>
</tr>
<tr>
<td>Partial Hospitalization (PHP)</td>
</tr>
<tr>
<td>Empowerment Services Peer Supports</td>
</tr>
<tr>
<td>Personalized Recovery Oriented Services (PROS)</td>
</tr>
<tr>
<td>Intensive Psychiatric Residential Treatment Services (IPRT)</td>
</tr>
<tr>
<td>Comprehensive Psychiatric Emergency Program (CPEP)</td>
</tr>
</tbody>
</table>
BH Service Array

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Psychiatric Services</td>
</tr>
<tr>
<td>Medically Managed Inpatient Withdrawal</td>
</tr>
<tr>
<td>Stabilization Services in a Residential Setting</td>
</tr>
<tr>
<td>Rehabilitation Services in a Residential Setting</td>
</tr>
<tr>
<td>Reintegration in a Residential Setting</td>
</tr>
<tr>
<td>Medically Supervised Inpatient Withdrawal</td>
</tr>
<tr>
<td>Inpatient Treatment and Residential Rehabilitation for Youth</td>
</tr>
</tbody>
</table>
Contract / Rules and Regulations

- Our specific contract which includes the rules and regulations we must comply with will be made available as a supplement to this presentation.
- Links to NYS Code and State information regarding MCOs

Populations we Serve

- Healthy Choice – children and adults
- Family Health Plus – adults 19 to 64
- Advocate – members who have Medicaid and need long-term care services
- Six Medicare Advantage products, including a PDP
Summary

You should now be able to identify:

• BH service array for WellCare of New York’s Mainstream Plan
• New York specific managed care rules and resources
NY Behavioral Health Providers and Crisis Resources
In this section we will be covering the following:

- The New York Provider Network
- New York Crisis Providers and web site information
- Downstate crisis providers
- State-wide crisis resources
- The BH crisis vendor support – Health Integrated
- Appointment standards
- Community partnerships
The New York Provider Network

The WellCare of New York network includes many Community Providers (Article 28, 31 & 32), who perform MH and SUD Services:

<table>
<thead>
<tr>
<th>PSCH, Inc</th>
<th>Day Top Village</th>
<th>Service Program for Older People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steinway Children &amp; Family Services</td>
<td>Skills Unlimited, Inc.</td>
<td>Staten Island Mental Health Society</td>
</tr>
<tr>
<td>Association to Benefit Children</td>
<td>Sancia Healthcare</td>
<td>Jewish Association for Services of the Aged (JASA)</td>
</tr>
<tr>
<td>Westchester Jewish Community Services</td>
<td>FEGS Health &amp; Human Services</td>
<td>Jewish Board of Children &amp; Family Services</td>
</tr>
<tr>
<td>Maryhaven Center of Hope</td>
<td>Ackerman Institute for the Family</td>
<td>Inwood Community Services</td>
</tr>
<tr>
<td>The Bridge, Inc.</td>
<td>Upper Manhattan Mental Health Center</td>
<td>Puerto Rican Institute</td>
</tr>
</tbody>
</table>

Many of these providers also offer BH crisis intervention and peer supports.
New York BH Crisis Providers

The NY Office of Mental Health publishes a *New York Resource Directory*, which includes crisis response resources, and supporting materials. This comprehensive resource lists services by:

- Populations served
- Contact numbers
- Region
- County
- Program Name, Program Type

The resource guide can be filtered based upon your search needs. For example, column "1" filters on City. There are additional columns to the right and you can expand the column for full narrative.
New York BH Crisis Providers

Locate Mental Health Programs in New York State

The program directory allows you to:

- Search for mental health programs by county, program category or subcategory.
- View program details including program name, address and phone number.
- Click on any county on the map to view all of the programs in that county.

County

Bronx

Program Category/Subcategory

= Residential Treatment Facility

Go

http://bi.omh.ny.gov/bridges/index
New York BH Crisis Providers

Program Definitions

- Basic Search
- Full Directory
- Advanced Search
- Program Definitions
- Directory Help

Categories, Subcategories, and Program Types

Emergency
- Comprehensive Psychiatric Emergency Program
- Crisis
  - Crisis Intervention
  - Crisis Residence
  - Crisis/Respite Beds
  - FEMA Crisis Counseling Assistance and Training
  - Home-Based Crisis Intervention

http://bi.omh.ny.gov/bridges/definitions
Crisis and BH Providers Available in New York

- **Crisis/Respite Beds**: A non-licensed residential program, or dedicated beds in a licensed program, which provide consumers a homelike environment with room, board and supervision in cases where individuals must be removed temporarily from their usual residence. (Return to Index)

- **FEMA Crisis Counseling Assistance and Training**: A program to provide individual and/or group treatment procedures which are designed to alleviate the mental and emotional crises and their subsequent psychological and behavioral conditions resulting from major disaster or its aftermath. Funded through Federal Emergency Management Agency (FEMA). Agency administrative costs allocated to the operating costs of this program via the Ratio Value allocation methodology are redistributed to other OMH programs in the CFR. (Return to Index)

http://bi.omh.ny.gov/bridges/definitions#1600
# New York BH Crisis Providers-Downstate

<table>
<thead>
<tr>
<th>Program County</th>
<th>Agency</th>
<th>Populations Served</th>
<th>Address</th>
<th>Program Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronx</td>
<td>St. Barnabas Hospital</td>
<td>Adults</td>
<td>260 East 188th Street</td>
<td>(718) 960-3104</td>
</tr>
<tr>
<td>Kings</td>
<td>Community Healthcare Network Inc.</td>
<td>Adults</td>
<td>(718) 778-0198</td>
<td>94-98 Manhattan Ave</td>
</tr>
<tr>
<td>Kings</td>
<td>Institute For Community Living Inc.</td>
<td>Children, Adolescents, Adults</td>
<td>(718) 290-8100</td>
<td>1310 Rockaway Parkway</td>
</tr>
<tr>
<td>New York</td>
<td>Center for Hearing and Communication</td>
<td>Children, Adolescents, Adults</td>
<td>(917) 305-7800</td>
<td>50 Broadway, 6th Floor</td>
</tr>
<tr>
<td>New York</td>
<td>Lennox Hill Hospital-OP Clinic</td>
<td>Children, Adolescents, Adults</td>
<td>(212) 434-3365</td>
<td>210 E. 64th Street, 4th Floor</td>
</tr>
<tr>
<td>New York</td>
<td>Karen Horney Clinic Inc.</td>
<td>Children, Adolescents, Adults</td>
<td>(212) 838-4333</td>
<td>329 East 62nd Street</td>
</tr>
<tr>
<td>Queens</td>
<td>Catholic Charities Neighborhood Svcs</td>
<td>Children, Adolescents, Adults</td>
<td>(718) 779-1600</td>
<td>91-14 37th Avenue, 1st, 2nd Floors</td>
</tr>
<tr>
<td>Queens</td>
<td>Safe Space NYC Inc.</td>
<td>Children, Adolescents, Adults</td>
<td>(718) 206-3440</td>
<td>89-74 162nd Street, 5th Floor</td>
</tr>
<tr>
<td>Richmond</td>
<td>Richmond Medical Ctr.</td>
<td>Adults</td>
<td>(718) 876-1272</td>
<td>110 Henderson Avenue</td>
</tr>
<tr>
<td>Richmond</td>
<td>Staten Island Univ. Hospital</td>
<td>Adolescents, Adults</td>
<td>(718) 226-8910</td>
<td>450 Seaview Avenue</td>
</tr>
</tbody>
</table>
The NYC Department of Health and Mental Hygiene also offers citywide crisis resources for members. This includes the following:

- **Project HOPE**
  Free and confidential 24/7 mental health and substance abuse information, referral, and crisis hotline services for NY city residents.

- **LifeNet 1 800 LIFENET (1 800 543 3638)**
  Assists people who are experiencing a crisis. LIFENET has authorized linkages with the 23 mobile crisis teams and Emergency Medical Services (EMS). Services members in multiple languages.

- **Mobile Crisis Teams**
  Interdisciplinary team of mental health professionals who operate under voluntary agencies and hospitals. They respond to persons in the community and typically in their homes, and provide a wide range of services including assessment, crisis intervention, supportive counseling, referrals and linkage with appropriate community based services.

- **Parachute NYC**
  Provides alternatives to hospitalization for people experiencing emotional crises. Parachute NYC offers free, community based options that focus on overall wellness, recovery, and hope.

More information on these programs can be found at the following link:

Parachute NYC

- Parachute NYC offers free, community based options that focus on overall wellness, recovery, and hope and is largely driven by

- Parachute NYC offers **crisis respite centers** where people can stay overnight in a calm, open, and supportive environment:
  
  - **Manhattan**: 646 257 5665
  - **Brooklyn**: 347 505 0870
  - **Bronx**: 718 884 2900
  - **Queens**: 718 464 0375

- The Parachute **Support Line** (646 741 HOPE) is also available for those experiencing emotional distress.

- Parachute NYC services available in
  
  - **Bronx, Brooklyn, Manhattan, and Queens** to New Yorkers ages 18 to 65.
  - **Brooklyn** also has home based treatment services for ages 16 to 30.
  - **Staten Island** residents ages 18 to 65 can seek services in **Manhattan**

For more information available on Parachute NYC services and programs visit:

WellCare BH Crisis Vendor – Health Integrated

- WellCare subcontracts with Health Integrated for our 24 hour, 7 days-a-week BH crisis line, which is staffed with licensed BH crisis counselors.

- Calls to the BH Crisis Line are answered by specially trained non-clinicians within established time frames for call handling. If the call is a true crisis call, licensed BH clinicians immediately join the call to assess, support and manage the situation for the most timely and effective outcome for the member in need.

- WellCare Customer Service Representatives (CSRs) are trained on the BH crisis process and are educated on BH conditions

- The BH Crisis Line is available to all New York members:

  1 855 582 6265
## Appointment Availability Standards

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Emergency</th>
<th>Urgent</th>
<th>Non Urgent</th>
<th>BH Specialist MH/SUD</th>
<th>Follow up to Emergency of Hospital Discharge</th>
<th>Follow up to Prison Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Outpatient Clinic/PROS Clinic</td>
<td>Within 24 hrs</td>
<td>Within 1 wk</td>
<td>n/a</td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>Within 24 hrs for AOT</td>
<td>n/a</td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROS</td>
<td>Timeframe to be determined</td>
<td>Within 2 wks</td>
<td>Within 5 days of request</td>
<td></td>
<td>Timeframe to be determined</td>
<td></td>
</tr>
<tr>
<td>Continuing Day Treatment</td>
<td></td>
<td>2-4 wks</td>
<td></td>
<td></td>
<td>Timeframe to be determined</td>
<td></td>
</tr>
<tr>
<td>IPRT</td>
<td></td>
<td>2-4 wks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td></td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Psychiatric Services</td>
<td>Upon presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPEP</td>
<td>Upon presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OASAS Outpatient Clinic</td>
<td>Within 24 hrs</td>
<td>Within 1 wk of request</td>
<td></td>
<td>Within 5 days of request</td>
<td>Timeframe to be determined</td>
<td></td>
</tr>
<tr>
<td>Detoxification</td>
<td>Upon presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUD Inpatient Rehab</td>
<td>Upon presentation</td>
<td>Within 24 hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioid Treatment Program</td>
<td>Within 24 hrs</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services for residential SUD treatment supports</td>
<td></td>
<td>2-4 wks</td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Community Partnerships

We will partner with the community and community providers, and work together to develop special programs and services (i.e., E.R. Diversion) as we will require the teams to work with the community providers and forge relationships with these agencies.

Providers:

- Community Mental Health Centers (Article 31)
- Federally Qualified Health Centers (Article 28)
- Substance Abuse Providers (Article 32)

Community Stakeholders:

- Mental Health Advocates  NAMI, MHA
- Peers, Mentors, and other advocates
- Members support recovery reach beyond traditional managed care
Behavioral Health is part of a robust system of care, with available resources and supports found in the community. These resources are utilized to augment collaborative care. Some examples of community supports and resources can be found at the following links:

**Guide to Community Based Resources**

**The Coalition of Behavioral Health Agencies, Inc.**
http://www.coalitionny.org/members/member_list.php

**New York Office of Mental Health Program Directory**
http://bi.omh.ny.gov/bridges/directory

**CPI Center for Practice Innovations**
Focused training in Evidence Based Practices (EBPs)
www.practiceinnovations.org

**MCTAC Managed Care Technical Advisory Committee**
www.MCTAC.org
You should now be able to identify:

- The New York Provider Network
- New York Crisis Providers and web site information
- Downstate crisis providers
- State-wide crisis resources
- The BH crisis vendor support – Health Integrated
- Appointment standards
- Community partnerships
Quality Improvement
Objectives

In this section we will be covering the following:

• New York specific program measures
• Access and quality standards
• Communication with our members and related tools
• Care Coordination member engagement strategies
Quality Improvement

The New York Quality Improvement Program includes the following measures:

- **Antidepressant Medication Management** - Acute phase: 84 days of continuous therapy. Continuation phase: 180 days of continuous therapy

- **Follow Up Care for Children Prescribed ADHD Medication** - One follow-up visit within 30 days of medication initiation. At least two more follow-up visits between 4 and 9 weeks if on the medication at least 210 days

- **Patients discharged from an inpatient mental health admission receive** - One follow-up encounter with a mental health provider within 7 and 30 days after discharge

- **Initiation and engagement of alcohol and other drug dependence treatment** - Patients diagnosed with alcohol and/or other drug dependence who initiate treatment within 14 days of diagnosis and who receive two additional services within 30 days of the initiation visit

- **Diabetes Screening** for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

- **Diabetes Monitoring** for People With Diabetes and Schizophrenia

- **Cardiovascular Monitoring** for People With Cardiovascular Disease and Schizophrenia

- **Adherence to Antipsychotic Medications** for Individuals with Schizophrenia
WellCare is committed to continually improving the quality of care and service that we provide to our members.

**Access**

**Provider Access (approximately):**
- 7,000 primary care providers.
- 27,000 specialists.
- 3,300 behavioral health and substance abuse providers.

**Facilities Access (approximately):**
- 200 hospitals.
- 2 community mental health centers.
- 120 federally qualified health centers.

**Geographic Access:**
- One primary care provider within 30 minutes for urban counties and 45 minutes for rural counties.
- One hospital within 30 minutes for urban counties and 45 minutes for rural counties.

**Quality**

**People:**
- Company-wide, WellCare has increased its quality improvement staff by 50%.
- Focused on preventive health, wellness, chronic diseases and care management.
- An enhanced care management model helps to more effectively serve the most medically complex members.
  - The model leverages both field-based and telephonic resources using state-specific, multi-disciplinary care teams.

**Process:**
- The National Committee for Quality Assurance (NCQA) awarded WellCare of New York’s Medicaid plan an accreditation status of Commendable and an Accredited designation for its Medicare Advantage plan in the state.

**Technology:**
- Company-wide, more than $60 million has been invested for information technology and integrated, electronic care management to support quality.
Communicating with New and Existing Members

*WellCare uses a variety of means to communicate with members about the new and existing behavioral health benefits including:*

<table>
<thead>
<tr>
<th>Direct Mailers</th>
<th>Member Welcome Calls</th>
<th>Frequently Asked Questions (FAQ)</th>
<th>Member Portal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Health Care Information</td>
<td>Member Newsletters-published quarterly</td>
<td>Member Handbook</td>
<td>Provider Directory</td>
</tr>
<tr>
<td>Member Rights and Responsibilities</td>
<td>Behavioral Health Benefits Array</td>
<td>Member Customer Service</td>
<td>Community Health Worker Contacts</td>
</tr>
</tbody>
</table>

- **WellCare websites**—WellCare regularly updates its member and provider websites with information and updates on programs and services.
Summary

You should now be able to identify:

- New York specific program measures
- Access and quality standards
- Communication with our members and related tools
- Care Coordination member engagement strategies
# Key BH Contacts

<table>
<thead>
<tr>
<th>Functional Area</th>
<th>Leads</th>
<th>Title</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>NY BH Clinical Operations</td>
<td>Ellen Grabowitz, MD</td>
<td>BH Medical Director</td>
<td>914-705-2542</td>
</tr>
<tr>
<td></td>
<td>Edward Elles</td>
<td>BH Clinical Director</td>
<td>917-229-1998</td>
</tr>
<tr>
<td></td>
<td>Carlene Zincke</td>
<td>Director-Field Service Coordination</td>
<td>917-229-2026</td>
</tr>
<tr>
<td>NY BH Quality</td>
<td>JoAnn Spangler</td>
<td>BH QI Project Manager</td>
<td>917-229-2942</td>
</tr>
<tr>
<td>NY Network Management</td>
<td>Milna Thomas</td>
<td>BH Sr. Network Manager</td>
<td>917-229-1984</td>
</tr>
<tr>
<td>Corporate BH Operations</td>
<td>Carole Matyas</td>
<td>Vice President, Behavioral Health</td>
<td>813-206-2625</td>
</tr>
<tr>
<td></td>
<td>Pat Glynn</td>
<td>Sr. Director, BH Product Operations</td>
<td>813-206-1528</td>
</tr>
<tr>
<td></td>
<td>Nicole Drelles</td>
<td>Program Manager, Behavioral Health</td>
<td>813-206-5652</td>
</tr>
<tr>
<td>BH Utilization Management</td>
<td>Kim Newton</td>
<td>Manager, BH UM Care Management</td>
<td>813-206-5429</td>
</tr>
<tr>
<td></td>
<td>MaryKate Owens</td>
<td>Supervisor, BH Multistate UM</td>
<td>813-206-7897</td>
</tr>
<tr>
<td>BH Customer Service</td>
<td>Orrin Blossom</td>
<td>Provider Customer Service</td>
<td>813-206-3701</td>
</tr>
<tr>
<td></td>
<td>Mark Leiker</td>
<td>Member Customer Service</td>
<td>813-206-3976</td>
</tr>
</tbody>
</table>
Objectives

In this section we will be covering the following:

- New York Cultural Competency and training resources
- Transition Age Youth and training resources
- First Episode Psychosis and training resources
- Assisted Outpatient Treatment and training resources
Cultural Competency

What is Cultural Competency?

New York defines Cultural Competency as having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

• Given the growing diversity of New York’s population, cultural competency (CC) needs to be at the forefront of healthcare initiatives and activities.

• Culture has multiple dimensions, and applies to all people.

• Member care can suffer if service models are not culturally competent.

• CC activities are important to improve member engagement and retention, particularly in behavioral health care.

• Member CC activities can also help enhance the experience of the traditionally underserved racial and ethnic groups, such as through the use of bilingual clinicians, culturally adapted interventions.
Cultural Competency

Working towards cultural competence for providers

*Cultural Competence includes:*

- A set of skills to ensure appropriate, culturally sensitive health care
- An ability to interact effectively with people of different cultures and socioeconomic backgrounds
- Obtaining cultural information and then applying that knowledge (cultural awareness)
- Adapting to different cultural beliefs by listening and learning about the person’s beliefs about health and illness
- Recognizing the intersection of race, income, cultural beliefs, language proficiency, physical and cognitive disabilities, and/or sexual orientation should be considered and taken into account when providing patient centered care and respecting the individual’s wishes as they relate to how they identify themselves.
Cultural Competency

- Cultural competence is an ongoing process that also requires provider agility/balance between understanding general value systems without oversimplifying and also respecting unique individual needs.

- There is a continuum of competence, and that this definition must permeate at every level of service, including administrators, practitioners, and larger institutions for an agency or clinic to work towards “cultural competence.”

- Culture influences how people seek health care and how they behave toward providers
Cultural Competency

Variations in patients’ beliefs, values, preferences and behaviors impact

• Patient recognition of symptoms
• Patient thresholds for seeking care
• Ability to communicate symptoms to a provider
• Ability of the provider to understand the meaning of what is presented by the patient
• Ability of the patient to understand the prescribed management strategy
• Patient expectations of care
• Patient adherence to preventive measures and medications
• Patient’s perception of the value of prevention
### Cultural Competency

Some populations may require modifications in service delivery…

<table>
<thead>
<tr>
<th><strong>Target populations</strong></th>
<th><strong>Consideration</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Mental Illness and Substance Abuse Disorders</td>
<td>Clarity in language and non-judgmental approach. Referrals to Mental Health providers.</td>
</tr>
<tr>
<td>Intellectual disabilities</td>
<td>Assistance with understanding. Materials written at a basic level.</td>
</tr>
<tr>
<td>Homeless</td>
<td>Non-judgmental approach and assistance/referrals for basic needs.</td>
</tr>
<tr>
<td>Complex Medical Needs, ex. Chronic diseases, HIV/AIDS, ESRD</td>
<td>Break down information in smaller pieces and prioritize. Determine priorities and needs from the patient perspective.</td>
</tr>
<tr>
<td>Physical disabilities</td>
<td>Ensure instructions can be followed or arrange for accommodations. Physical office and examination rooms should be accessible.</td>
</tr>
<tr>
<td>TBI/Dementia/Alzheimer's</td>
<td>Assess understanding and accommodate.</td>
</tr>
<tr>
<td>Elderly</td>
<td>Allow for more time with the patient. Speak clearly and face the patient.</td>
</tr>
</tbody>
</table>
Cultural Competency

The module is available on WellCare.com.
Who are Transition Age Youth (TAY)?

TAY are members who are under age 23 and transitioning into the adult health care system from any OMH, OASAS or OCFS licensed, certified or funded children's program.

This also includes members transitioning from State Education 853 schools, which are operated by private agencies and provide day and/or residential programs for students with disabilities.

WellCare is required to work with NYS to ensure TAY members are provided continuity of care without service disruptions or changes in service providers.

TAY are identified as needing help with:

- Addressing Behavioral Health issues including FEP, and Alcohol and Substance Abuse
- Developing Communication Skills and independent living skills
- Relationships, sexual health and wellness
- Other critical life skills
Transition Age Youth (TAY)

This module is available on WellCare.com.
First Episode Psychosis (FEP)

What is First Episode Psychosis (FEP)?

Members with FEP are individuals who have displayed psychotic symptoms suggestive of recently emerged schizophrenia. FEP generally occurs in individuals age 16–35.

FEP includes:

- Members whose emergence of psychotic symptoms occurred within the previous 2 years,
- Members who remain in need of mental health services, and
- Members who have a diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, psychotic disorder NOS (DSM IV), or other specified/unspecified schizophrenia spectrum and other psychotic disorder (DSM 5).

- FEP excludes individuals whose psychotic symptoms are due primarily to a mood disorder or substance use.

- In New York FEP training is also available through the Centers for Practice Innovation or CPI and is called OnTrackNY.
First Episode Psychosis (FEP)

This module is available on WellCare.com.
Assisted Outpatient Treatment (AOT)

What is Assisted Outpatient Treatment (AOT)?
AOT is court-ordered participation in outpatient services for certain people with serious mental illness who, in view of their treatment history and present circumstances, are unlikely to survive safely in the community without supervision.

AOT is also known as “Kendra’s Law, named after Kendra Webdale, who was killed by a person with an untreated mental illness.

AOT law mandates that the state to provide services to those with the greatest need and requires those who meet certain criteria to comply with mental health services mandated through a civil court.

Eligibility criteria include:

- Age 18 or older
- Diagnosed with mental illness and are unlikely to live safely in the community with supervision
- History of treatment non compliance that resulted in a psychiatric hospitalization or incarceration at least 2x in past 36 months or have committed serious acts or threats of violence in the past 48 months.
- Once AOT is court ordered, members are engaged in comprehensive, community treatment and monitored extensively for treatment plan adherence.
Assisted Outpatient Treatment (AOT)

This module is available on WellCare.com
You should now be able to identify:

- The mission of the WellCare of New York Mainstream plan
- The “Integrated Model of Care” of Medical, Behavioral and Pharmacy services
- The “Care Management Model” for managing member care and outcomes
- Care Coordination member engagement strategies
- New York Behavioral Health Populations and Programs
- Utilization protocols and criteria
- New York specific managed care rules
- New York providers and crisis resources
- WellCare’s Quality Improvement program
- Additional information on specific programs, including Cultural Competency, TAY, FEP, and AOT
Thank You!