Dear Client Primary Care Physician:

Annually, Psychcare distributes a Primary Care Physician Manual to Client and requests that Client distribute the manual to their Primary Care Physicians. Psychcare would like your comments to improve the manual in the future. Once you have had an opportunity to review the content of the manual, please take a few moments to complete the survey and return it by mail or fax to:

Psychcare  
Attn: Quality Management Department  
10200 Sunset Drive  
Miami, FL 33173  
FAX 305.396.2197

1. Did the authorization and referral procedures contained in the Primary Care Physician Manual for Behavioral Health Services provide sufficient information to assist you and your office staff in coordinating treatment with your patients’ behavioral health practitioner(s)?

☐ Yes  ☐ No

2. Have you accessed the Psychcare website for educational and clinical resources?

☐ Yes  ☐ No

3. Have you reviewed and/or distributed the educational information contained in our Preventive Health Programs to your patients when indicated?

☐ Yes  ☐ No

What additional information would you like to see in the manual?

Thank you for assisting us in our efforts to continually improve the quality of care and services to members.
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BACKGROUND

Psychcare, LLC (“Psychcare”) is a comprehensive behavioral health care organization with headquarters in Miami, Florida. We began in 1988 as a local Employee Assistance Program.

Psychcare is licensed by the State of Florida as a Third Party Administrator. Our commitment to quality is evident by our URAC Accreditation since 1998, and NCQA Accreditation since 1999.

Our philosophy is to promote quality and safety of clinical care, and quality of service rendered by our practitioner and provider networks.

We are a comprehensive managed behavioral healthcare organization that specializes in the management of mental health and chemical dependency benefits for HMOs, PPOs, and large employer groups.

Psychcare is structurally organized as a network model delivery system. Our practitioners include such disciplines as psychiatrists, doctorate level licensed psychologists, and master’s level licensed clinicians. We contract with providers such as day treatment programs, inpatient treatment programs, and residential programs.

PSYCHCARE WEBSITE

Our website address is www.psychcare.com. The following information is contained on the provider section of our website, and updated at a minimum annually. You can access the materials on the website with the password "PsychcareProviders_FYEO".

CLINICAL QUALITY AND SERVICE ACTIVITIES:

- Health Literacy, Cultural, Ethnic, Racial and the Linguistic Needs of our Member Populations
- Member Safety Activities
- Member educational information about specific behavioral health disorders
- Website links to national and local community resources
- Florida Network Advance Directives
- Parenting A Child with ADHD Brochure
- Maternal Addiction Flyer
- Medication Adherence Flyer
- Healthy Minds Educational Materials Website Link
- Clinical Practice Guidelines
- Neuropsychological Testing Criteria
- Antidepressant Medication Management Initiatives
- Atypical Antipsychotic Medication Management Initiatives
- Childhood ADHD Initiatives
- Childhood ADHD Medication Management Webinar
- Substance Abuse Screening Tools and Member Educational Information
- Recommended Depression Rating Scales

CONTINUITY AND COORDINATION OF CARE ACTIVITIES:

- Continuity and coordination of care activities among behavioral healthcare specialists and between behavioral healthcare specialists PCPs
- Members with Complex Health Needs
- Encompass Program
- Florida Medicaid Coordinated Treatment of MH/Detox Guidelines
- Ambulatory Follow-up Brochure
- High Risk Criteria to enhance communication between practitioners and providers
- PsychCare Network Communication Forms to Improve the Exchange of Information among Behavioral Health Specialists and Between Medical and Behavioral Health Specialists
- The Annual Primary Care Physician Manual for Behavioral Health Services and Manual Satisfaction Survey
- 7 and 30 day ambulatory follow-up after an inpatient hospitalization processes
- PharmAssist© Program

**UTILIZATION MANAGEMENT:**
- Applied Behavioral Analysis Criteria
- PsychCare Mental Health Level of Care Clinical Criteria
- PsychCare Substance Abuse Level of Care Clinical Criteria
- Florida Medicaid Level of Care Guidelines
- Neuropsychological Testing Criteria
- Emergency, Urgent and Routine Access to Care Standards
- Ensuring appropriate utilization management
- Emergency services and Network Provider post-service review processes

**PREVENTIVE HEALTH PROGRAMS, MEMBER EDUCATIONAL MATERIALS, AND CLINICAL RESOURCES:**
- Prevention Program Outcomes Survey
- Substance Abuse Prevention Program
- Alzheimer’s Disease Preventive Health Program
- Eating Disorders Prevention Program
- Stress Management Program
- Tobacco Cessation Preventive Health Program
- Adolescent Suicide Prevention Program
- Childhood ADHD Preventive Health Program
- Domestic Violence Prevention Program
- Postpartum Depression Prevention Program

**PSYCHCARE CUSTOMER SERVICE**

We pride ourselves on our excellent customer service. We provide annual training on customer service techniques for our clinical staff.

PsychCare appreciates comments about our services, and encourages our members to let us know what we can improve upon. If you have a patient who is dissatisfied with the care and/or services they received from a PsychCare network practitioner or provider, or are dissatisfied with our processes, we would like to hear about it.

You can refer your patient to call 800.221.5487, and let the staff member know that they would like to file a member complaint, or they can write to us at:

PsychCare  
Mail Stop QI  
10200 Sunset Drive  
Miami, FL 33173  
FAX (800) 370-1116
Our clients contractually delegate member complaints or grievances to us. If we are not delegated member complaints or grievances, we will direct your patients to the appropriate source to file a complaint or grievance.

**PRIVACY PRACTICES**


As noted in the Office of Civil Rights Privacy Brief, Summary of HIPAA Privacy Rule, adherence to privacy practices assures that individuals' behavioral health information is properly protected while allowing the flow of information needed to provide and promote high quality care, and protects our members' health and well-being.

Psychcare does not disclose PHI, except as the Privacy Rule permits or requires; and when the member, who is the subject of the information, or member's legal representative when the member is a minor or deemed incompetent, authorizes the release of PHI in writing.

Psychcare does not provide direct treatment. We are a network model, therefore, all continuity and coordination of care communications between the PCP and the network behavioral healthcare practitioner are conducted directly among practitioners after the appropriate consent for the release of information to the specific practitioner is signed and dated by the member, or the member's legal representative.

Upon our practitioners' receipt of the executed patient consent, we encourage our network practitioners to communicate with their patients' PCPs using the communication forms located in this manual, in conjunction with our high risk communication criteria, described in the continuity and coordination of care section of this manual.

**PSYCHCARE TRIAGE AND REFERRAL PROCESSES**

Our clinical philosophy is to provide the most appropriate member/practitioner match and the least restrictive treatment intervention for each member's needs across the life cycle. Our clinical orientation is a biopsychosocial approach with emphasis on wellness, early intervention, and integration of behavioral and medical healthcare. Excellent outcomes are maximized by good partnerships and a clinical consultation approach with all clinicians that deliver services to our members.

Psychcare makes decisions whether to approve or not approve payment for services based only on the appropriateness of the care or service, and what the member's benefit plan covers.
The Medical Director oversees all triage and referral decisions. The Medical Director is available 24 hours per day; 7 days per week, to consult on initial clinical review decisions, and conduct peer clinical review.

The Vice President of Clinical Operations supervises nonurgent pre-service processes, and initial clinical review processes. The Vice President of Clinical Operations is available 24 hours per day, 7 days per week, to consult with Case Managers regarding initial clinical review decisions.

**Emergency Referrals**

In the event a patient is experiencing a behavioral health emergency in your office, or contacts you in crisis, call the police. If your patient can be safely transported with support, route the member to the nearest emergency room. After ensuring that the patient is safe, call Psychcare 24 hours per day, 7 days a week at 800.221.5487 so that we can obtain the clinical information and begin managing the case.

If you call after hours or on the weekend, please inform the answering service that you have an emergency and the on-call case manager, a licensed clinician, will return your call within 30 minutes of the initial call. The on-call case manager arranges hospital admissions, crisis stabilization, and other required emergency services.

**Initial Referral Process**

Psychcare preauthorizes, and coordinates initial evaluations with our network psychiatrists and clinicians.

During the course of your patients’ medical treatment, you may determine that the patient could benefit from accessing their behavioral healthcare benefits when, for instance:

- the member requires an assessment of their current psychotropic medication(s), or an evaluation to determine the need for psychotropic medication
- the member is experiencing an acute crisis and needs to be evaluated by a psychiatrist
- the member is experiencing stressors that could possibly be reduced through psychotherapy

When callers request routine outpatient referrals, the calls are handled by our intake coordinators. The intake coordinator verifies the member’s eligibility and demographic information. They conduct a brief screening using an approved screening tool. During the screening, if, as indicated per the screening tool, the call requires clinical expertise, the intake coordinator transfers the call to a case manager. Once the intake coordinator completes the screening, the member is given the names of network practitioners who meet their geographic, language, and cultural preferences. The member selects the practitioner they wish to see and the intake coordinator authorizes the members’ outpatient visit.

If you would like refer a patient to Psychcare for mental health or substance abuse treatment, simply fax a referral to Psychcare to 800.370.1116, or call us to coordinate the referral at 800.221.5487 during business hours, Monday through Friday 8:30 AM to 5:30 PM EST. Please include all pertinent clinical information and member contact information.

**Continued Treatment**

All urgent care and continued treatment are reviewed by case managers. Case Managers are, at a minimum, Masters’ Level Licensed Clinicians, or Registered Nurses, with a minimum of 5 years experience post master and/or previous experience in providing direct patient care, crisis intervention and discharge planning. The case managers review the continued treatment at pre-determined intervals with the psychiatrist, clinician, hospital, or program. Ongoing authorization is based on, as applicable to the individual status of the member, Psychcare Mental Health Level of Care Clinical Criteria, Psychcare Substance Abuse Level of Care Criteria, or when indicated, the Florida Medicaid Level of Care Guidelines and the member’s benefit coverage.
In particular, cases, care may be required outside of the usual parameters set forth by the member’s benefit plan. In such cases, the Medical Director, and the Vice President of Clinical Operations may work with the case manager and the practitioner to develop an appropriate treatment care plan.

**Specialized Services Requirements**
The following services are authorized only when they are determined to be medically necessary, and inclusive in the member’s benefit coverage. The case manager consults with the Medical Director when the following services are requested and covered under the member’s benefit plan:

- psychological testing
- electroconvulsive therapy (ECT)

The following services are typically not covered under a typical benefit plan:

- marital counseling
- testing for educational placement
- neuropsychological testing

**CONTINUITY AND COORDINATION OF CARE**

The assessment, treatment, and follow-up of a member’s care are essential in the provision of continuous and appropriate healthcare services for members who access multiple practitioners for medical and/or behavioral purposes.

Our Clinical Standards Committee, consisting of network practitioners, identified high-risk communication criteria for circumstances in which continuity and coordination of care between the PCP and behavioral healthcare practitioner is efficacious in promoting optimal medical and behavioral health care:

- Members who are prescribed medications by their PCP and psychiatrist
- PCPs who prescribe psychotropic medications
- R/O thyroid disorders in members with symptoms of depression
- Members who have an underlying medical condition and are being prescribed psychotropic medication by their psychiatrist
- Failure to improve
- Sudden change(s) in mental status

Annually, Psychcare collects data about the following opportunities for collaboration between medical and behavioral care:

- Exchange of information
- Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care
- Appropriate uses of psychopharmacological medications
- Management of treatment access and follow-up for members with coexisting medical and behavioral disorders
- Primary or secondary preventive behavioral health program implementation

Psychcare collaborates with our client health plans to improve the coordination of behavioral health care and general medical care including:

- Collaboration between Psychcare and our clients’ medical delivery systems or PCPs
- Quantitative and qualitative analyses of data to identify improvement opportunities
- Identification and selection of at least one opportunity for improvement
Taking collaborative action to address at least one identified opportunity for improvement

We ask our network psychiatrists to complete the Network Psychiatrist Communication Form located at the end of the Continuity and Coordination of Care section; and we ask our network clinicians to complete the PCP/Network Clinician Communication Form. Both forms have a section that documents the members’ Consent for the Release of Confidential Information to their PCP.

**Management of Members with Complex Health Needs**

Psychcare ensures that appropriate resources are available to address treatment of complex conditions that reflect both mental health and physical health involvement. As part of our collaborative alliance with each of our clients the following conditions are addressed:

- Mental health disorders due to or involving a general medical condition, specifically ICD-9-CM Diagnoses 293.0 through 294.1, 294.9, 307.89, and 310.1; and

Our programs and guidelines include resources designed to assist network practitioners, providers and our clients’ Primary Care Physicians in the identification, management and treatment of:

- Members with severe and persistent mental illness;
- Children/adolescents with severe emotional disturbances; and
- Members with clinical depression.

The following Psychcare programs and guidelines address assessment, evaluation, referral and treatment of members with complex health needs.

**The Encompass Program**

Each client health plan participates in the Encompass Program at their discretion. The Encompass Program enables caregivers, Psychcare and our client health plan case managers, and treating practitioners (i.e. Primary Care Physicians, specialists and/or community providers) to refer members for inclusion into the program. Outreach interventions are aimed at providing assistance and referrals for individuals who may benefit from behavioral health treatment to attain overall wellness.

The objectives of the Encompass Program include:

- Improving the health and wellness of participants
- Increasing the coordination of care and communication regarding medical and behavioral health treatment needs of members
- Reducing avoidable utilization and ensuring treatment at the least restrictive setting
- Increasing compliance with appropriate treatment to facilitate optimal functioning and promote wellness
- Promoting adherence to treatment recommendations that are most clinically effective and cost effective
- Increasing the number of members who receive care consistent with management treatment guidelines
- Providing data integrity, technical and staff support that will foster improved communication between Psychcare and the client health plan and across team member

Psychcare uses a team model approach to facilitate the effective coordination of care for all members who require integrated care between the medical and behavioral specialists to address complex comorbidities, co-
existing/co-occurring disorders, and/or a wide range of social problems that may impact the members’ ability to attain wellness.

The team is comprised of the Medical Director, Vice President of Clinical Operations, Case Managers, who are Licensed RN’s, Licensed Doctorate Level Clinicians or Masters’ Level Clinicians, and Care Coordinators. The team ensures that all avenues of care are addressed. Teams are designated to specific geographic areas and product lines throughout the individual client health plans’ service area to help facilitate relationship building with providers, practitioners, and community resources, and to promote effective coordination of care in the least restrictive setting.

**Intensive Case Management**

The Intensive Case Management Program was designed to improve treatment compliance and outcomes for at-risk members with a history of treatment noncompliance and/or co-morbid behavioral health and/or medical conditions.

Under the direction of the Psychcare Medical Director, the Intensive Case Management Program targets at-risk members with behavioral, substance abuse, and/or comorbid medical disorders, who are at high risk for multiple hospitalizations, identified with chronic treatment noncompliance, or have a history of state psychiatric hospitalizations. The population includes members with special health care needs who are dually-eligible for Medicare and Medicaid benefits; and members who consistently utilize emergency services in lieu of treatment.

The Case Manager facilitates care delivery among behavioral health practitioners and providers and between behavioral health practitioners and Primary Care Physicians, which contributes to the development of an effective community support system.

**Clinical Practice Guidelines**

Psychcare has adopted clinical practice guidelines from nationally recognized organizations in order to provide a concise version of treatment recommendations related to the top inpatient and outpatient mental health diagnoses. The diagnoses were based on our annual member demographic data analysis for each line of business.

Every two (2) years from the Clinical Standards Committee’s last review date, a review of each nationally recognized guideline is conducted to determine its continued applicability to the identified annual clinical activities based on the annual member demographic analysis by each line of business. The committee’s review of the guidelines is reported to the Quality Improvement Committee.

When the nationally recognized organization updates a clinical practice guideline before the next scheduled Clinical Standards Committee review of the guideline, the revised nationally recognized guideline will be reviewed and adopted by the committee and QIC within two (2) months of its publication by the nationally recognized organization.

The review criteria included:

- Current applicability based on the annual high risk/high volume demographic data;
- Consistency with Psychcare Clinical Criteria, and member education materials; and
- Current applicability for all behavioral healthcare disciplines.
Psychcare Preventive Health Programs
Psychcare designs preventive health programs to prevent or detect the incidence, emergence or worsening of behavioral health disorders for at-risk member populations.

PharmAssist Program©
The PharmAssist Program©, was developed by Psychcare to provide our clients with quality and cost-effective measures to evaluate psychotropic medications.

Our experience has shown that a majority of psychotropic medications are written by PCPs. The PharmAssist Program© is a Physician-to-Physician approach that addresses three factors:
- Education
- Consultation
- Referral

Education:
Psychcare provides PCP-focused workshops to address the complexities of prescribing psychotropic medication. The workshops address specific trends in managing psychiatric patients, and focus on the efficacy of treatment from a clinical and financial approach. We also provide individual education to PCPs who are unable to attend the workshops.

In coordination with our clients’ PBM, Psychcare analyzes psychotropic medication utilization and recommend targeted interventions either on an aggregate or individual basis to assist PCPs in improving their prescribing practices.

Consultation:
During business hours, we offer PCPs telephonic consultation with a Board Certified Psychiatrist to address any questions or concerns they may have related to their patients’ mental health status and appropriate use of psychotropic medications. Please call us 8:30 AM to 5:30 PM at 800.221.5487 to request a consultation.

Referral:
The PharmAssist Program© improves particular aspects of continuity and coordination of care, such as exchange of medical and clinical information; appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care; appropriate uses of psychotropic medications; and coordination of timely treatment access and follow-up for patients with coexisting medical and behavioral disorders.

Inpatient Psychiatric Consultations on a Medical Unit, Nursing Home, or Rehab Setting
Timely coordination and completion of inpatient psychiatric consultations provides integrated medical and behavioral healthcare services, and seamless continuity of care.

Inpatient psychiatric consultations are authorized only when members have an inpatient mental health benefit. It is recommended that if your patient does not have inpatient mental health benefits that the emergency room physician refer the patient to the community mental health system.

When your patients are admitted to acute care medical facilities, nursing homes or rehabilitative settings, a physicians’ order is required to proceed with the inpatient psychiatric consult. Please remember to contact Psychcare at (800) 221-5487 at our toll free number upon completion of the Physician’s order.
the referral request, the available clinical information regarding the medical necessity and clinical urgency of the consult will be requested.

Inpatient psychiatric consultations are conducted by a network psychiatrist, or if unavailable, a hospital affiliated staff psychiatrist; to coordinate timely access for appropriate treatment and follow-up for those members with coexisting medical and behavioral disorders.

Once the inpatient psychiatric consult is completed, and the outcome includes the psychiatrists’ recommendation for outpatient mental health or substance abuse treatment follow-up upon the patients’ discharge, please contact us at our toll free number and we will coordinate outpatient behavioral health services for the patient. If the patient has left the hospital and outpatient mental health or substance abuse treatment follow-up was recommended, please give the patient or the patients’ legal representative our toll free number to obtain services.

**Psychcare has designated the following timeliness standards for the completion of a consult, except when otherwise specified by client:**

**Inpatient Psychiatric Consultations in Acute Care Facilities**
Inpatient psychiatric consultations in an acute care facility are completed within the clinical urgency, as determined by the attending physician, but not to exceed twenty-four hours from the time of the request.

**Medication Evaluations and Medication Management Follow-up Visits in Nursing Homes and/or Skilled Nursing Facilities**
- Medication evaluations in a nursing home and/or skilled nursing facility setting are completed within the clinical urgency, as determined by the attending physician, but not to exceed 72 hours from the request
- Medication management follow-up visits in a nursing home and/or skilled nursing facility setting are authorized within the clinical urgency, as determined by the psychiatrist, but not to exceed five (5) business days from the request

The completed consult must be in the medical record no more than 24 hours after completion of the consult by the psychiatrist. If this does not occur, the PCP should attempt to contact the psychiatrist who completed the consult. If the PCP is unsuccessful in reaching the psychiatrist, they may call Psychcare at 800.221.5487 during business hours, Monday through Friday. After hours or on the weekend please contact the on-call case manager at the above listed phone number.

Please visit our website, [www.psychcare.com](http://www.psychcare.com) to find out more about our continuity and coordination of care activities.
# NETWORK PSYCHIATRIST / PCP COMMUNICATION FORM

**Patient Name:** _______________

**Date of Birth:** _______________

**PCP Name:** _______________

**PCP Fax No.:** _______________

**Health Plan:** _______________

**ID No.:** _______________

## PSYCHIATRIST INFORMATION

**Psychiatrist Name:** _______________

**Psychiatrist Office No.:** _______________

**Evaluation Date:** _______________

## ASSESSMENT DATA

**DSM-IV-TR-DX**

<table>
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### MEDICATION PRESCRIBED

- | | | |
- | | | |

## PLAN OF ACTION

Patient will be seen for follow up in ___________ month(s)

- Once stable the patient will be followed up in: □ 3 months □ 6 months □ By PCP

- □ Patient will be referred for brief individual therapy

- □ No further treatment is needed at this time

## PARTICULAR CONCERNS

Patient will need the following labs monitored:

- □ Lithium Level
- □ Depakote Level
- □ Other Drug Level:
  - BUN/Creatinine
  - Thyroid for Lithium Treatment
  - Liver Panel for Depakote Treatment

Patient is on _______________, and at risk for metabolic syndrome.

The following should be monitored:

- □ Blood Glucose
- □ Cholesterol
- □ Triglycerides

The patient is on a benzodiazepine/stimulant and needs to be monitored for potential abuse/dependence.

## OTHER PERTINENT ISSUES


## PATIENT CONSENT

By signing below, I agree with and understand the above treatment plan, including the goals and the expected date of completion of this episode of care. I consent for my behavioral health practitioner, designated on this care plan, to release information to Primary Care Physician as designated below, until the period of time which I am no longer a Psychcare member, for the purpose of case management and quality improvement activities.

- □ I GIVE permission for the above information to be given to my Primary Care Physician.

- □ I DO NOT GIVE permission for the above information to be given to my Primary Care Physician.

**Patient Signature (Parent or Legal Guardian of a Minor Child):** _______________

**Date:** _______________

**PCP Name:** _______________
CLINICIAN / PCP COMMUNICATION FORM

NOTE: This is a recommended format for the purpose of continuity and coordination of care. The form should be sent only after the treating Psychcare network practitioner obtains the appropriate signed member consent for the release of information.

☐ The patient has signed a release of information and it is on file in the patient record.

PATIENT INFORMATION

Patient Name: ___________________________ PCP Name: ___________________________
Health Plan ID #: ___________________________ PCP Phone #: ___________________________
PCP Phone #: ___________________________ PCP Fax #: ___________________________
Practitioner Name: ___________________________ Practitioner Phone #: ___________________________
Practitioner Phone #: ___________________________ Practitioner Fax #: ___________________________

Please contact Psychcare at 800.221.5487 if you are unable to obtain phone and/or fax numbers.

DIAGNOSIS

Axis I: ___________________________________________
Axis II: ___________________________________________
Axis III: ___________________________________________
Date of Last Visit: ___________________________ Date of Anticipated Next Visit: ___________________________

SIGNIFICANT INFORMATION

The patient will/will not be referred for a psychiatric evaluation

Practitioner Signature ___________________________ Date ___________________________
**COVERAGE GUIDELINES**

Requested services are subject to the limitations and coverage exclusions of the member’s benefit plan. Psychcare authorizes services, coordinates all treatment, and pays claims directly to the provider of services.

**Services not authorized by Psychcare:**
- custodial services
- emergency and non-emergency transportation (unless included in the contract)
- emergency room services
- outpatient psychotropic medication
- diagnostic procedures, such as CAT scans, encephalograms or other radiology services
- laboratory services
- neurological testing or other neurological procedures, including tests designed to ascertain neurological development of infants
- charges for the treatment or diagnosis of medical conditions while the member is admitted under a primary psychiatric diagnosis

**PSYCHCARE PRACTITIONER / PROVIDER NETWORK**

Psychcare has a network model delivery system. Our practitioner network includes such disciplines as psychiatrists, licensed doctorate level clinical psychologists, and master’s level licensed clinicians. The provider network includes acute inpatient facilities, day treatment programs, partial hospitalization programs, and chemical dependency programs.

Psychcare carefully selects all practitioners/providers, balancing access and member choice concerns with quality, economic and geographic issues. Through a comprehensive credentialing and recredentialing process, Psychcare aims to identify highly competent and qualified practitioners/providers who share a goal of providing quality treatment.

Psychcare requires that all practitioners have:
- a license in a behavioral health discipline
- an advanced degree in their field
- at least 5 years of relevant clinical experience

All practitioners are approved by the Credentialing Committee. Credentialing criteria delineates minimum requirements for each discipline. An ability to work within a goal-oriented treatment model is essential.

Psychcare offers its network of practitioners/providers:
- collegial case management with minimal paperwork involved
- utilization review conducted by licensed, experienced clinicians
- shared concerns for treatment outcomes and quality
- reasonable levels of volume in exchange for discounted rates
- prompt claims processing and payment for authorized covered services

**PSYCHCARE CLINICAL ACTIVITIES**

As part of the annual Psychcare Quality Improvement Program, the following clinical studies have been implemented to improve the treatment for members with behavioral health disorders frequently seen among
Psychcare members.

Please visit our website, www.psychcare.com to find out about more about our clinical activities, including but not limited to, educational and clinical resources such as the Psychcare Clinical Management Guidelines, national and community resources, support groups and 12-step programs.

**Major Depressive Disorders Study**
According to the American Psychiatric Association Practice Guideline for Major Depressive Disorders in Adults “optimal treatment of major depression that is chronic or moderately severe generally requires some form of somatic intervention, in the form of medication or electroconvulsive therapy, coupled with psychotherapeutic management or psychotherapy”. Furthermore, “the combination of specific effective psychotherapy and medication may be a useful initial treatment of choice for patients with psychosocial issues, intrapsychic conflict, interpersonal problems, or a comorbid axis II disorder”. Poor adherence with treatments may also warrant combined treatment with pharmacotherapy and psychotherapeutic approaches that focus on treatment adherence”.

Psychcare Quality Improvement Committee and Clinical Standards Committee identified two quantifiable measures to improve the quality of care among our members 18 – 65 diagnosed with a Major Depressive Disorder.

**Bipolar Disorder Study**
The National Institute of Mental Health reported that in 2001 more than two million American adults, or approximately 1% of the population 18 and older, were diagnosed with bipolar disorder, typically emerging in late adolescence or early adulthood.

According to the American Psychiatric Association, Practice Guideline for the Treatment of Patients with Bipolar Disorder, initially, the psychiatrist should perform a diagnostic evaluation and assess the patient’s safety and level of functioning. At this time there is no cure for bipolar disorder; however treatment can significantly decrease associated morbidity and mortality. Additionally, Nationally recognized literature and the Psychcare Bipolar Disorder Clinical Management Guideline, the rate of alcohol abuse or dependence is evident in 46% of patients with bipolar disorder as compared to 13% for the general population; and the rate of drug abuse or dependence is evident in 41% of patients with bipolar disorder as compared to 6% for the general population; and comorbid substance abuse may be overlooked in patients with bipolar disorder, being one of the precipitants for mood episodes.

Psychcare Quality Improvement Committee and Clinical Standards Committee identified three quantifiable measures to improve the quality of care among our members 12 and older diagnosed with Bipolar Disorder; and those diagnosed with comorbid Bipolar Disorder and Substance Abuse.

**Childhood ADHD Study**
According to the National Institute of Mental Health, approximately 2 million children in the United States are ADHD, which means in a classroom of 25 – 30 children it is likely that at least one child will have ADHD.

The American Academy of Child and Adolescent Psychiatry noted that ADHD is one of the most common psychiatric disorders of childhood and adolescence.

The principle characteristics of ADHD are inattention, hyperactivity, and impulsivity. These symptoms appear early in a child’s life. Because many normal children may have these symptoms, but at a lower level, or the
symptoms may be caused by another disorder, it is important that the child receive a thorough examination and appropriate diagnosis by a well-qualified professional.

The study measures outcomes for our members 12 and younger diagnosed with Childhood ADHD.

**PSYHCARE PREVENTION PROGRAMS**

Each preventive health program includes information on the signs and symptoms of the disorder, how to get help, and lists of community resources.

The information for each prevention program, including educational brochures, 12-step programs, and links to community and national resources, can be viewed and downloaded on the Psychcare website, [www.psychcare.com](http://www.psychcare.com), or is available in hard copy upon request by calling (800) 221-5487. A Stakeholder Comment Form is included with each program to obtain your comments on the design and implementation of the program; and annually Psychcare requests that each of our clients distribute a Psychcare Prevention Program Survey to their PCPs to evaluate the effectiveness of each of the prevention programs. We encourage you to complete the survey located in the manual, to assist us in our continuing efforts to improve the quality of care to our members.

**Adolescent Suicide Prevention Program**

The Adolescent Suicide Prevention Program is a primary, secondary, and tertiary prevention program for our adolescent member population based on the following factors:

- The American Psychiatric Association reported that many teenagers who are depressed; overwhelmed by the uncertainties of adolescence which may lead them to begin “self-medicating” their pain by abusing drugs or alcohol; and/or express their rage and frustration by engaging in acts of violence; are too often troubled teens who opt to take their own lives.

- The American Association of Child and Adolescent Psychiatry reported that suicides among young people continue to be a serious problem. Each year in the U.S., thousands of teenagers commit suicide. Suicide is the third leading cause of death for 15-to-24-year-olds.

- According to the American Psychiatric Association:
  - Over half of all kids who suffer from depression will eventually attempt suicide at least once, and more than seven percent will die as a result.
  - Four times as many men commit suicide than women, but young women attempt suicide three times more frequently than young men.
  - Fifty-three percent of young people who commit suicide abuse substances.
  - Firearms are used in a little more than half of all youth suicides.

- In September 2007, the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR) cited that teen suicide had the largest annual single-year rise in 15 years.

- A report published in September 2007 by the National Center for Injury Prevention and Control noted that suicide affects all youth, but some groups are at higher risk than others. Boys are more likely than girls to die from suicide. Of the reported suicides in the 10 to 24 age group, 82% of the deaths were males and 18% were females. Girls, however, are more likely to report attempting suicide than boys. Cultural variations in suicide rates also exist, with Native American/Alaskan Native youth having the highest rates of suicide-related fatalities.

The Adolescent Suicide Prevention Program provides educational information to decrease, and minimize the potential for at risk teens to commit suicide. The materials included in the program are contained on the Psychcare website and available in hard copy upon request, they include the Teen Suicide Fact Sheet printed
in English and Spanish, the Adolescent Suicide Prevention Program Community Resource Guide, and links to community resources and support groups for suicidal and/or depressed teens and the parents of teens.

The program was designed based on feedback from our clients, network practitioners, network providers, and members. The educational materials used for the program were endorsed by community organizations including First Call for Help of Broward County and Switchboard of Miami. The educational information was adapted from the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the American Psychological Association.

**Alzheimer's Disease Preventive Health Program**

The Alzheimer's Disease Preventive Health Program was developed for our elderly adult member population based on the following factors:

- The National Institute on Aging reported that Scientists think that as many as 4.5 million Americans suffer from AD. The disease usually begins after age 60, and risk goes up with age. While younger people also may get AD, it is much less common. About 5 percent of men and women ages 65 to 74 have AD, and nearly half of those age 85 and older may have the disease. It is important to note, however, that AD is not a normal part of aging.
- Neuropsychology, which is published by the American Psychological Association reported that people can show early warning signs across several cognitive domains years before they are officially diagnosed, confirming that Alzheimer's causes general deterioration and tends to follow a stable preclinical stage with a sharp drop in function.
- Psychcare believes that screening and early detection of Alzheimer’s Disease improves the quality of life for our members, provides support to the members' caregiver(s), and reduces the risk of serious medical and psychological complications that are associated with the disease.

The program focuses on primary, secondary, and tertiary preventive health through education and support for members 65 and older and/or members who provide care to a loved one diagnosed with Alzheimer’s Disease. The program was designed based on feedback from our clients, network practitioners, community agencies, and members.

Program interventions include distribution of the Alzheimer's Disease Community Resource Guide; and selected website links from our website to the National Institute on Aging, the Alzheimer's Disease Education and Referral Center, and the Alzheimer's Association, which provide educational information to practitioners, members and their caregivers in both English and Spanish.

**Substance Abuse Prevention Program Description**

The Substance Abuse Prevention Program was developed as an adolescent, adult, and elderly adult focused prevention activity based on the following factors:

- Psychcare manages Commercial, Medicare, and Medicaid lines of business, which include members of all ages, cultural, and socioeconomic backgrounds.
- Based on clinical outcomes analyses of the Major Depression Disorders Study and the Bipolar Disorders Study, comorbid mental health and substance abuse are prevalent among our chronically ill member populations aged 12 and older; and opportunities to improve identification, and treatment were indicated.
- The 2006 National Survey on Drug Use and Health reported:
  - An estimated 8.3 percent of the American population aged 12 years old or older had used an illicit drug at least one month prior to the survey.
  - Slightly more than half of Americans aged 12 or older reported being current drinkers of alcohol in
the 2006 survey (50.9 percent). This translates to an estimated 125 million people, which is similar to the 2005 estimate of 126 million people (51.8 percent).

- Alcohol and illicit drug use affected both males and females 12 or older from all educational and socioeconomic backgrounds.
- Alcohol and illicit drug abuse affects individuals from all educational, cultural and socioeconomic backgrounds.

- The American Psychiatric Association Practice Guideline for the Treatment of Patients With Substance Use Disorders, 2nd Edition, noted:
  - Most adolescents with substance use disorders have co-occurring psychiatric diagnoses.
  - Early efforts at preventing and identifying substance use disorders in adolescents are crucial.
  - Abuse and dependence on prescribed medications in the elderly can lead to adverse outcomes, particularly in combination with alcohol use disorders. Cognitive impairments may increase.
  - Women may have greater rates of co-occurring mood or anxiety disorder or histories of physical or sexual abuse.
  - Women may have more adverse physical outcomes from smoking and from alcohol or opioid use disorders.
  - Men are more likely to use cigars, pipes, and smokeless tobacco, with associated increased rates of oral cancers.
  - Race, ethnicity, and culture can affect the likelihood of developing substance dependence and the metabolism of substances and medications used to treat substance use disorders.
  - Family and the influence of the social milieu can shape attitudes and psychosocial motivations about substance use and treatment, including socioeconomic and legal difficulties, domestic violence, child abuse or neglect, or psychiatric illness in other family members.

The Substance Abuse Prevention Program focuses on primary and secondary prevention by educating our audiences about substance abuse, and improving awareness of available community resources and 12-step programs. The program includes member educational brochures for alcohol and drugs, and the clinical resources for practitioners including screening tools for alcohol and substance abuse, and educational materials for screenings, referral, and treatment. All member and practitioner interventions can access on the Psychcare website and/or are available in hard copy upon request.

The program was designed based on feedback from our clients, network practitioners, network providers, and members. The educational information was adapted from national resources, such as the National Institute of Drug Abuse, and the National Council on Alcoholism and Drug Dependence; and a collaboration of the National Behavioral Consortium and Reckitt Benckiser Pharmaceuticals.

**Childhood ADHD Preventive Health Program Description**

The Childhood ADHD Preventive Health Program was developed for child and adolescent members based on the following factors:

- The member demographic data indicated that Attention Deficit and Disruptive Behavior Disorders were high volume diagnoses among our child and adolescent member populations.
- According to the National Institute of Health, Childhood ADHD is one of the most commonly diagnosed pediatric mental health disorders.
- According to the National Institute for Health Consensus Statement, Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder, ADHD is a commonly diagnosed behavioral disorder of childhood that represents a costly major public health problem, having long-term effects on academic performance, vocational success, and social-emotional development.
- NAMI reported that in general, boys with ADHD have been shown to outnumber girls with the disorder.
by a rate of about three to one.

- The Centers for Disease Control (2005) conducted the National Survey of Children’s Health during January 2003-2004, asking parents of over 100,000 children aged four to 17 years whether their child had ever been diagnosed with ADHD or received medication treatment (as opposed to currently being treated). The rate of lifetime childhood diagnosis of ADHD was 7.8%, while 4.3% (or only 55% of those with ADHD) had ever been treated with medication for the disorder.
- The American Academy of Child and Adolescent Psychiatry Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder noted that in any mental health assessment, the clinician should screen for ADHD by specifically asking questions regarding the major symptom domains of ADHD (inattention, impulsivity, and hyperactivity) and asking whether such symptoms cause impairment. These screening questions should be asked regardless of the nature of the chief complaint.

The Childhood ADHD Preventive Health Program promotes primary, secondary, and tertiary prevention through the provision of educational information and community resources that assist in improving the assessment, diagnosis, and treatment for children with ADHD. The materials included in the program are contained on the Psychcare website and available in hard copy upon request.

The program was designed based on comments from our clients, network practitioners, network providers, and parents of our members diagnosed with ADHD.

The educational resources were adapted from the American Academy of Child & Adolescent Psychiatry, The Nation’s Voice on Mental Illness (NAMI), CHADD, and the National Institute for Mental Health.

The program is available to parents concerned about assessment, diagnosis and treatment for their child, network childhood specialists, practitioners, providers, and our clients’ network pediatricians, who may obtain the educational, and community resource information for family members of their young patients.

Postpartum Depression Prevention Program Description

The Postpartum Depression Prevention Program is a secondary and tertiary prevention program for our adult female population.

- Postpartum depression affects women of all socioeconomic status, ethnic backgrounds, and cultural identities who are either pregnant, postpartum twelve months or have had a history of postpartum depression.
- Based on the member demographic data, Mood Disorders were high volume diagnoses for Commercial, Medicare, and Medicaid members 18 – 65.
- According to the National Women’s Health Information Center, depression is one of the most common complications during and after pregnancy.
- The National Mental Health Association and the American Psychiatric Association have reported that postpartum depression affects one in ten new mothers within the first year after giving birth.
- If postpartum depression goes untreated, not only is the mother at risk, but the child is at high risk for developing emotional, behavioral and cognitive problems.
- Those more likely at risk for developing postpartum depression are women who have had:
  - Previous postpartum depression
  - Depression not related to pregnancy
  - Severe Premenstrual Syndrome (PMS)
  - A difficult marriage
  - Limited support from family members or friends
Stressful life events during the pregnancy or after the childbirth

The Postpartum Depression Preventive Health Program provides secondary and tertiary prevention through identification, education, and support for pregnant and postpartum members who may be at risk for depression. It also offers Obstetricians, Gynecologists, and Behavioral Health Specialists recommendations of best practices, based on scientific evidence.

Network practitioners and providers, along with our clients’ OB/GYN specialists assisted in the design and implementation of the program. The program was developed based on literature from nationally recognized organizations including the American Psychiatric Association, the National Mental Health Association, the Agency for Healthcare Research and Quality, and the National Women’s Health Information Center.

**Stress Management Program Description**

The Stress Management Program was developed as a community focused activity based on the following factors:

- Psychcare manages Commercial, Medicare, and Medicaid lines of business, which include members of all ages, cultural, and socioeconomic backgrounds.
- Based on an analysis of the member demographics, Adjustment Disorders were identified as one of the top four high volume diagnoses among members of all ages for all lines of business. The Clinical Standards Committee recommended that a primary, secondary, and tertiary Stress Prevention Program could potentially reduce the severity of the stressors and improve members’ coping skills.
- According to the National Mental Health Association, stress can cause physical, emotional, and behavioral disorders which can affect an individuals’ health, vitality, peace-of-mind, as well as personal and professional relationships.
- The American Academy of Child and Adolescent Psychiatry reported that teenagers, like adults, may experience stress everyday and can benefit from learning stress management skills. Most teens experience more stress when they perceive a situation as dangerous, difficult, or painful and they do not have the resources to cope.
- Nationally recognized resources support the following risk factors for stress:
  - Social and financial problems
  - Medical illness
  - Lack of social support
  - Family history

The Stress Management Program focuses on primary and secondary prevention by educating members about different types of stressors, the physical and emotional effects of stress, techniques for improving coping skills, and how to seek treatment for acute stress.

The program was designed and implemented based on feedback from our clients and their PCPs, network practitioners, and network providers. The educational information was adapted from national resources, such as the National Mental Health Association, The American Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the American Heart Association.

**Domestic Violence Prevention Program Description**

The Domestic Violence Prevention Program was developed as a community activity based on the following factors:

- Psychcare manages Commercial, Medicare, and Medicaid lines of business, which include members of all ages, cultural, and socioeconomic backgrounds who have the potential for experiencing some type
of domestic violence in their lifetime.

- In 2007 Psychcare conducted its annual Network Practitioner Outpatient Treatment Record Documentation Review Activity, which included evidence of domestic violence screening for members over the age of 18. The activity indicated that 27% of the treatment records reviewed contained domestic violence screening.

- The American Psychiatric Association reported:
  - Domestic violence occurs in every culture, country and age group.
  - It affects people from all socioeconomic, educational and religious backgrounds and takes place in same sex as well as heterosexual relationships.
  - Women with fewer resources or greater perceived vulnerability, girls and those experiencing physical or psychiatric disabilities or living below the poverty line, are at even greater risk for domestic violence and lifetime abuse.
  - Children are also affected by domestic violence, even if they do not witness it directly.

- The National Center on Elder Abuse noted that older women are likelier than younger women to experience violence for a longer time, to be in current violent relationships, and to have health and mental health problems.

- The Family Violence Prevention Fund cited that the prevalence and the health, social and economic costs of domestic violence require attention and effective action by the health care system.

The Domestic Violence Prevention Program promotes primary, secondary, and tertiary prevention to network practitioners/providers and our health plan clients’ PCPs, through the distribution of nationally recognized domestic violence screening tools from the Family Violence Prevention Fund for integration of domestic violence screening as part of the assessment process; along with giving both practitioners and members the educational information and community resources to assist in getting the domestic violence victim and/or abuser the help they need. The materials included in the program are contained on the Psychcare website and available in hard copy upon request by calling our toll free number, 800.221.5487.

The program includes educational materials from the Family Violence Prevention Fund and the American Psychiatric Association; national resources, and community resources in both Florida and Michigan.

**Eating Disorder Prevention Program Description**

The Eating Disorders Prevention Program was developed for children, adolescents and adults as a primary and secondary prevention program based on the following factors:

- The Office on Women’s Health reported that females and males from all ethnic and racial groups may suffer from an eating disorder and disordered eating; and it is evident that disturbed eating behaviors and attitudes occur across all cultures.

- The National Eating Disorders Association (NEDA) noted that our cultural obsession with slenderness as a physical, psychological, and moral issue contributes to an eating disorder.

- The Centers for Disease Control (CDC) reported in 2007 that more than one third of U.S. adults—more than 72 million people—and 16% of U.S. children are obese. Since 1980, obesity rates for adults have doubled and rates for children have tripled. Obesity rates among all groups in society—irrespective of age, sex, race, ethnicity, socioeconomic status, education level, or geographic region—have increased markedly.

- Research shows that more than 90 percent of those who have eating disorders are women between the ages of 12 and 25 (National Alliance for the Mentally Ill, 2003).

- Increasing numbers of older women and men have eating disorders. In addition, hundreds of thousands of boys are affected by these disorders (U.S. DHHS Office on Women’s Health, 2000).

- According to the National Institute of Mental Health (NIMH), eating disorders such as anorexia, bulimia
and binge-eating are real, treatable medical illnesses with complex underlying psychological and biological causes. They frequently co-exist with other psychiatric disorders such as depression, substance abuse, or anxiety disorders. People with eating disorders also can suffer from numerous other physical health complications, such as heart conditions or kidney failure, which can lead to death.

- Psychcare manages Commercial, Medicare, and Medicaid lines of business, which include members of all ages, cultural, and socioeconomic backgrounds.
- According to the NEDA the earlier an eating disorder is discovered and addressed, the better chance for recovery.

The Eating Disorders Prevention Program focuses on primary prevention, to improve awareness of the nature of different types of eating disorders and in turn promote healthy development through the distribution of educational information, and access to local and national resources; and secondary prevention to promote early identification of an eating disorder before it spirals out of control, through the distribution of educational information, access to local and national resources, and clinical resources.

The program was designed based on feedback from our clients, network practitioners, network providers, and members. The educational information was adapted from national resources, such as, but not limited to, NIMH and the American Academy of Child and Adolescent Psychiatry (AACAP).

**Tobacco Cessation Program Description**

The Tobacco Cessation Program was developed for adolescents and adults as a primary, secondary, and tertiary prevention program based on the following factors:

- Cigarette smoking damages multiple organ systems making it the single most preventable cause of disease, disability and death in the United States.
- An estimated 8.6 million smokers currently live with at least one smoking related illness.
- Cancer is the second leading cause of death and was among the first diseases to be causally related to smoking.
- Lung cancer is the leading cause of cancer death and cigarette smoking causes most cases.
- In 2003, an estimated 171,900 new cases of lung cancer occurred and approximately 157,200 people died from lung cancer.
- The 2004 Surgeon General’s report adds more evidence to previous conclusions that smoking causes cancers of the oral cavity, pharynx, larynx, esophagus, lung and bladder. It also identifies other cancers caused by smoking, including cancers of the stomach, cervix, kidney, pancreas and acute myeloid leukemia.
- For smoking-attributable caners, the risk generally increases with the number of cigarettes smoked and the number of years smoked and generally decreases after quitting completely.
- Coronary heart disease and stroke are the primary types of cardiovascular disease caused by smoking and are the first and third leading cause of death in the United States. More that 2,600 Americans die every day because of cardiovascular disease, about one death every thirty-three seconds.
- In 2001, chronic obstructive pulmonary disease (COPD) was the fourth leading cause of death in the United States, resulting in more than 118,000 deaths. More than 90% of these deaths were attributable to smoking.
- Secondhand smoke, also known as environmental tobacco smoke contains at least 250 chemicals known to be toxic, including more than 50 that cause cancer.
- Nonsmokers who are exposed to secondhand smoke at work, or at home increase their risk for heart disease by 25-30% and their lung cancer risk by 20-30%.
- Secondhand smoke exposure causes respiratory symptoms in children and slows their lung growth.
- Secondhand smoke causes sudden infant death syndrome, acute respiratory infections, ear problems,
and more frequent severe asthma attacks in children.

- Women who smoke are at increased risk for infertility. Research has also shown that smoking during pregnancy causes health problems for both mothers and babies, including premature birth, low birth weight, stillbirth and infant death.

Through the distribution of the educational information and clinical resources, along with access to local and national organizations, the Tobacco Cessation Program focuses on primary prevention to improve awareness of the medical and addictive risks involved in smoking; secondary prevention to promote tobacco cessation before medical complications occur; and tertiary prevention to promote further medical complications from occurring.

The program was designed based on feedback from our clients, network practitioners, network providers, and members. The educational information was adapted from national resources such as, but not limited to, the Centers for Disease Control and Prevention, and the National Cancer Institute.
2012 - 2013 PREVENTION PROGRAM SURVEY

Dear Network Practitioner /Provider, and Client Primary Care Physician/ Medical Specialist:

Psychcare conducts an annual assessment of our prevention programs to determine whether each program has effectively improved the quality of care to our members, or whether opportunities are indicated to improve a particular program. As part of this process we would like to hear from you.

Quarterly, we notified you of each prevention program in our Network Practitioner/Provider Website Notification, which provided you with information about each of our prevention programs found on our website, www.psychcare.com, or in hard copy upon request; and we requested that you review and distribute the programs with your Psychcare patients as indicated based on their clinical status.

Please take a few moments to respond to the survey below. We appreciate your collaboration in continually improving the quality of care to our members. Once you have completed the survey, please return it to:

Psychcare
Attention: Quality Management Department
10200 Sunset Drive
Miami, FL 33173
FAX: 305.397.2197, Attention QM Department

Respondent Information:

☐ Psychcare Network Practitioner    ☐ Psychcare Network Facility    ☐ Client PCP/Medical Specialist

Date of Completion: ___/___/___

Survey Questions:

1. Have you distributed any of the following prevention programs to your patients? (Please check all that apply)

☐ Adolescent Suicide Prevention Program
☐ Alzheimer’s Disease Prevention Program
☐ Childhood ADHD Preventive Health Program
☐ Domestic Violence Prevention Program
☐ Eating Disorders Prevention Program
☐ Postpartum Depression Prevention Program
☐ Stress Management Program
☐ Substance Abuse Prevention Program
☐ Tobacco Cessation Program

2. Which of the prevention programs did your patients find most helpful? (Please check all that apply)

☐ Adolescent Suicide Prevention Program
☐ Alzheimer’s Disease Prevention Program
☐ Childhood ADHD Preventive Health Program
☐ Domestic Violence Prevention Program
2012 - 2013 PREVENTION PROGRAM SURVEY

☐ Eating Disorders Prevention Program
☐ Postpartum Depression Prevention Program
☐ Stress Management Program
☐ Substance Abuse Prevention Program
☐ Tobacco Cessation Program

3. Which of the prevention programs did your patients find least helpful? (Please check all that apply)

☐ Adolescent Suicide Prevention Program
☐ Alzheimer’s Disease Prevention Program
☐ Childhood ADHD Preventive Health Program
☐ Domestic Violence Prevention Program
☐ Eating Disorders Prevention Program
☐ Postpartum Depression Prevention Program
☐ Stress Management Program
☐ Substance Abuse Prevention Program
☐ Tobacco Cessation Program

4. Which of the prevention programs would change and what would you change? (Please check all that apply and comment below.)

☐ Adolescent Suicide Prevention Program

☐ Alzheimer’s Disease Prevention Program

☐ Childhood ADHD Preventive Health Program

☐ Domestic Violence Prevention Program

☐ Eating Disorders Prevention Program
Postpartum Depression Prevention Program

Stress Management Program

Substance Abuse Prevention Program

Tobacco Cessation Program

Thank you for completing the survey.
Clinical practice guidelines help practitioners and members make decisions about appropriate behavioral healthcare for specific clinical circumstances.

Psychcare, a Beacon Organization, adopts clinical practice guidelines from nationally recognized organizations.

The Clinical Standards Committee uses the following review criteria to determine the adoption of the guideline and its applicability to Psychcare member populations:

- Current applicability based on the annual high risk/high volume demographic data;
- Consistency with Psychcare Clinical Criteria, and member education materials; and
- Current applicability for all behavioral healthcare disciplines.

The Psychcare website, www.psychcare.com provides information on how to access the nationally recognized guidelines on the nationally recognized organization’s website, and how to obtain a hard copy of the guideline(s) upon request.