ANNOUNCING A NEW INITIATIVE TO INCREASE THE COORDINATION OF BEHAVIORAL HEALTH AND MEDICAL CARE

February 2006

Dear UBH Network Clinician:

In February 2006, the United Behavioral Health (UBH) Chicago Care Management Center will be implementing a new initiative to increase the coordination of our enrollees' behavioral health services with their Primary Care Physicians (PCP) and/or other medical clinicians.

Each month, UBH Chicago will send a mailing to all enrollees that had an initial evaluation session with a UBH prescribing clinician. The mailing will consist of a cover letter explaining the importance of the coordination of behavioral health and medical services and a *UBH Confidential Exchange of Information Form* (attached). The letter asks the enrollee to fill in their PCP/medical clinician contact information and then to take the form to their next session with their UBH prescribing clinician. We ask that UBH prescribing clinicians, or their office staff, complete the rest of the form and then fax or mail it to the PCP or medical clinician.

Coordination of care between behavioral health clinicians and PCPs/ medical clinicians improves the quality of patient care by:

- Minimizing potential adverse medication interactions
- Providing more efficient and effective treatment
- Reducing risk of relapse for patients with substance abuse disorders
- Promoting early identification of non-compliance with treatment

For additional information on this intervention or for copies of the *UBH Confidential Exchange of Information Form*, please call 1-800-711-6089, extension 4730.

Thank you for continuing to provide high quality behavioral health services to UBH enrollees!

Quality Improvement Department
UBH Chicago Care Management Center

UNITED BEHAVIORAL HEALTH

CONFIDENTIAL EXCHANGE OF INFORMATION FORM

UBH requires contracted behavioral health practitioners and providers to coordinate treatment with other behavioral health practitioners and providers, primary care practitioners (PCPs), and other appropriate medical practitioners involved in a member's care. Please complete this form and send it to the appropriate care provider(s) treating the member.

PATIENT NAME: **DOB:**

A. Treating Behavioral Health Clinician/Facility Information:

Name: Phone:

Address:

B. PCP/Medical Clinician or Other Behavioral Health Clinician/Facility/ Information:

Name: Phone:

Address:

Fax:

C. Patient Clinical Information:

1. The patient is being treated for the following behavioral health problem(s):

☐ ADHD/ Behavior D/O ☐ Substance Abuse ☐ Psychotic Disorder ☐ Bipolar D/O
☐ Depressive D/O ☐ Anxiety D/O ☐ Eating Disorder ☐ Adjustment D/O
☐ Personality D/O ☐ OTHER: _____

2. The patient is taking the following prescribed psychotropic medication(s):

☐ Antidepressant-SSRI ☐ Antidepressant-Tricyclic ☐ Antidepressant-MAOI ☐ Antidepressant-Wellbutrin
☐ Lithium ☐ Antipsychotic-Atypical ☐ Antipsychotic-Typical ☐ Clozaril
☐ Stimulant ☐ Anxiolytic ☐ Anticonvulsant/Mood Stabilizer

☐ Other (Indicate medication name):

_____

3. Expected length of treatment: ☐ <3 months ☐ 3-6 months ☐ 6-12 months ☐ >1 year

4. Coordination of care issues/Other significant information impacting medical or behavioral health care:

_____

_____

DATE MAILED OR FAXED TO OTHER CLINICIAN/FACILITY: _____

(PLACE A COMPLETED COPY OF THIS FORM IN THE PATIENT'S MEDICAL RECORD)

I hereby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed above in Section A to release the information contained on this form to the practitioner/provider listed in section B above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last <u>one year</u> from the date signed. I understand that I may revoke my consent at any time.

_____

Patient Signature **Date**

_____

Behavioral Health Clinician/Facility Representative Signature **Date**

I do <u>not</u> want to have information shared with:

☐ my PCP/medical practitioner. ☐ my other behavioral health practitioner(s)/provider(s).
☐ I am not currently receiving services from a PCP/ other medical practitioner.
☐ I am not currently receiving services from any other behavioral health practitioner/provider.

For Patient Records Applicable Under Federal Law 42 CFR Part 2

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

THIS IS NOT A REQUEST FOR MEDICAL RECORDS