

THE CBH PROVIDER CONNECTION

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EFFECTIVE JULY 1, 2003 CIGNA BEHAVIORAL HEALTH INTRODUCES CARE ADVOCACY PROGRAM

A new and innovative approach to improving the ease of access and administrative tasks, Care Advocacy will apply technology and logic to speed up the access and referral process.

- No pre-authorizations for routine care
- No OTR submissions
- Easy access to eligibility & referral information for EAP and MH/SA services

With Care Advocacy, we will be able to identify complex cases via claims data, allowing us to apply our clinical algorithms regardless of the diagnosis. This will also enable us to touch cases and provide “Condition-Specific Care Management,” making the experience for the provider and participant less restrictive and more consultative. CIGNA Behavioral Health contracts with a qualified network of behavioral health professionals. The result of the Care Advocacy Program will be to allow CBH to focus its services on complex cases to promote improved utilization of benefits and quality of care outcomes.

Advantages to the member include:

- Initial registration for routine outpatient care is no longer required
- Greater ease of access to contracted providers via our Online Access & Referral
- Increased access to educational materials
- Access to a new “Personal Advocate” who can assist in finding community services, understanding benefit designs, and navigating the sometimes complex world of healthcare information

Additional advantages to you, the provider, include:

- Increased access to licensed Care Management staff for consultative purposes
- Access to educational material specific to the needs of your patients

Sound Interesting?

Look for additional information on CBH on our website at www.CIGNABehavioral.com.

NEW WEB CLAIMS PROCEDURE

As many of you probably already know, you no longer need to send in requests for prior authorization for most outpatient services! While that is good news, you may have noticed that you have been unable to find your new clients in the Web Claims search.

For the first claim you file for a new client you will need to choose the Enter Blank Claim option, and fill in the claim with the required information (required boxes are highlighted in bold green print).

To access a blank claim form, perform a search for your client. When you reach the page that states "No results found matching your criteria", you will find a BLANK claim form option.

After the first claim is processed in our system, you will be able to locate your client using the standard search function.

EAP CORNER

GAMBLING ADDICTION SPECIALISTS NEEDED

CBH is recruiting Gambling Addiction Specialists in the following areas:

- Las Vegas, NV
- Reno, NV
- Stateline, NV
- Laughlin, NV
- Atlantic City, NJ
- Elizabeth, IN
- Robinsonville, MS
- Gulfport, MS
- Biloxi, MS
- New Orleans, LA
- Elizabeth, LA

If you have an understanding of the assessment and treatment of gambling addiction and are located near the above-listed areas, please send email only to Dana.Kiel@CIGNABehavioral.com.

SUBSTANCE ABUSE PROFESSIONALS, CRITICAL INCIDENT DEBRIEFING PROVIDERS AND SEMINAR PRESENTERS NEEDED

CBH EAP is continuing recruitment efforts for the EAP subspecialties: Substance Abuse Professionals, Critical Incident Debriefing Providers and presenters for corporate seminars.

Substance Abuse Professional Recruitment: (per DOT)

To support our customers who need to stay in compliance with Federal Department of Transportation protocols we maintain a SAP network.

SAP Criteria

- Clinical experience in the diagnosis and treatment of alcohol and controlled substance-related disorders
- Knowledge about the SAP function, as it relates to employer interests in safety-sensitive duties
- Knowledge of the DOT regulations applicable to the employers/industries for whom he/she evaluates employees
- Knowledge of the DOT/SAP guidelines and any changes in these materials
- License in social work, psychology, medicine, certified employee assistance professional, drug and alcohol counselor as per the NAADAC

NOTE: Providers who are currently functioning as SAPs have until December 31, 2003, to complete the qualification training and exam. The exam can be taken online at www.eapa-association.org, and a training resource is <http://www.blairconsultants.com/>.

If you are interested in becoming a SAP provider for CBH, please send email only to Robbie.Hamill@CIGNABehavioral.com.

Critical Incident Debriefing Recruitment: **Criteria for Critical Incident Providers**

- CBH contracted provider with state license
- Knowledge of trauma issues and crisis theory
- Completed training at a Critical Incident training program that meets state board CEU requirements
- Or experience in providing CISDs and provision of a reference
- Willingness to clear schedule to provide services with little notice
- Willingness to supply CBH a pager or cell phone number
- Knowledge of the Mitchell Model
- Previous experience on-site at a corporation a plus

If you meet the above criteria and are interested in providing CISD services, please send email only to Dana.Kiel@CIGNABehavioral.com. If possible, please include resume and references.

If you are interested in attending training on the Mitchell Model, one resource is www.icisf.org.

Presenter/Trainer Recruitment:

CBH is also looking for seasoned trainers to present Wellness Seminars and Supervisor Training on-site at our customers' offices. If you are interested in providing this type of service, please send email to Dana.Kiel@CIGNABehavioral.com. References will be requested.

KNOW YOUR REGIONAL EAP MANAGER (REM)

This is the third installment in a series designed to enhance the REM relationship with the provider community. The profile for this quarter is our REM from the Midwest Region, Robbie Hamill.

Can you please describe your educational background and EAP experience?

I am a Licensed Clinical Professional Counselor (LCPC) and a Certified Employee Assistance Professional (CEAP). I have a Master's Degree in Community Education and a Post-Graduate Certification in Marriage and Family Counseling from the University of St. Thomas in St. Paul, Minnesota. I started in EAP in 1982 after working with a Women's Program and Chemical Dependency Family Program in Minneapolis. In my current role I am responsible for EAP network development; supervision of Local EAP, program and administrative consulting for CBH's EAP customers, and helping implement, design and maintain quality EAP for corporate customers.

How long have you been with CBH?

I have been with CBH since April 1982. I have worked in both the Minnesota and Chicago offices and have had a variety of clinical and management positions, all relating to EAP.

Where is your office located and what states are included in your region?

I am located in the CIGNA Health Care office in downtown Chicago, Illinois. The Midwest Region includes: Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Iowa, Missouri, Kansas, Nebraska, North Dakota, South Dakota and Texas.

What is your philosophy about the value of EAP to our customers?

It is a fabulous benefit to serve our corporate customers. I believe that we have three customers: the corporation, management, and employees. EAP is the perfect tool to balance work and life so that employees can contribute to a productive workplace and take care of themselves and the ones they love.

Is there anything special you would like the providers to know about your customers?

I'd like our providers to understand the individual corporate culture each customer presents with the overall emphasis on service, service, service. Our customers understand that there are both clinical and non-clinical resources available to them through CBH, and our providers are empowered to work with customers for complete satisfaction.

Do you have any particular need for providers in your area?

Additional EAP providers with experience and/or training in Wellness Seminar Presentations, Critical Incident Response services, DOT Substance Abuse Services (SAP), and/or Executive Coaching/Consultation are always welcome. There is a current need for these provider specialties in the state of Texas.

What do you think about the strength of CBH's provider community and their value as a "face to the customer"?

Our Midwest providers are very SPECIAL. They are all talented clinicians, both open and willing to work with our customers. They have always been enterprising in their approach, providing clinical and non-clinical services without hesitation. Many have developed relationships with our corporate customers for quality service, which results in a more productive workplace.

If you are a provider in the Midwest Region and would like to contact Robbie about providing additional EAP services, please send email only to Robbie.Hamill@CIGNABehavioral.com.
Look for the REM from your area in upcoming newsletters!!

FROM OUR QUALITY MANAGEMENT DEPARTMENT

CBH'S LEVEL OF CARE GUIDELINES ANNOUNCING A NEW AND IMPROVED EDITION

CIGNA Behavioral Health uses objective guidelines for level of care and medical necessity decisions and has just released the updated 2003 edition. The Level of Care Guidelines are based on sound clinical evidence and are applied based on individual need and an assessment of the availability of services in the local delivery system.

We invite you to review the CBH Level of Care Guidelines (2003) on our website at www.CIGNABehavioral.com. CBH welcomes your input on the content and appropriateness of the guidelines. Through the website link, you can email your specific feedback and suggestions on the 2003 edition. We look forward to hearing from you.

PARTICIPANT SATISFACTION

Since 1993, CIGNA Behavioral Health has conducted a Participant Satisfaction Survey. The goal of the survey is to collect participant feedback that can be used to help improve care and service to our participants as well as to meet the needs of accreditation and document compliance with customer performance guarantees.

A contracted third-party vendor administers the Participant Satisfaction Survey. Participants are asked to rate their satisfaction on direct services received through the practitioner network as well as their satisfaction with CIGNA Behavioral Health's staff and services.

Below is an overview of the 2002 Participant Satisfaction Survey results:

- CBH's mean scores for process areas have either remained unchanged or declined somewhat when compared to the previous year's results.
- Satisfaction with Accessibility and Claims Processing sustained improvements seen in 2001.
- A decline in overall satisfaction was driven largely by a decline in satisfaction with provider-related areas such as Clinical Skills and Treatment Outcomes.
- CBH's strongest areas of satisfaction include:
 - Physical office environment of network practitioners and facilities
 - Accessibility (ease of arranging appointments)
 - Acceptability of services
- CBH's weakest areas of satisfaction include:
 - Availability and utilization management
 - Intake and referral process
 - Treatment outcomes

To improve satisfaction, CBH is redesigning our service delivery model to improve the ease of accessing care, to provide participants greater educational or self-help information, and to reduce the administrative burden of utilization review for routine care benefits. We also encourage practitioners to examine opportunities in clinical practice for improving the experience of care and satisfaction for consumers.

Results for the geographically located operating units generally mirrored these national trends. If you would like to get a more detailed view of the feedback from participants in your own geographic area please contact the Quality Service Manager for the Operating Unit you work with most often.

FOLLOW-UP AFTER HOSPITALIZATION

Participants being discharged from inpatient psychiatric or substance abuse care need timely access to outpatient care to maintain stability and continue treatment. In an effort to help strengthen the continuity from inpatient to outpatient care, CBH works with facilities and practitioners to help promote timely and appropriate discharge plans.

CBH monitors whether claims are received confirming that participants are seen for timely outpatient care following inpatient discharge. A recent audit of CBH cases not seen for outpatient care within seven days of discharge found:

- In 74% of the cases, a discharge plan had been established and in place prior to inpatient discharge.
- In 52% of the cases, participants were in outpatient treatment with a provider prior to inpatient admission but still failed to attend the scheduled outpatient follow-up.

- In 46% of the cases, we learned the participant missed the follow-up appointment. We learned this by calling the practitioner or the practitioner contacting us.
- In most cases, either CBH or the practitioner made outreach efforts to the participant to reschedule and encourage follow-up.

We encourage you to help participants engage in the needed outpatient treatment following inpatient care by:

- Scheduling timely follow-up appointments for those participants being discharged from acute inpatient care.
- Notifying CBH if the participant does not keep the scheduled follow-up appointment.
- Placing outreach calls to participants who do not attend appointments following hospitalization and encouraging them to attend appropriate outpatient care.

IMPROVING PARTICIPANT CARE AND SERVICE

The Quality Program for CIGNA Behavioral Health is designed to promote improved care and service to participants as well as improved service to providers. Clinical and service areas are examined to identify and address opportunities for improvements. The opportunities for improvement are often addressed through structured activities at local operating units.

Nationally in 2002, improvements were seen in the following areas:

- Communication with primary care physicians
- Access to appointments for routine care (within 10 business days)
- Urgent care (within 48 hours), non-life threatening emergent care (within 6 hours)
- Life threatening emergent care (immediately)
- Availability of facilities in both urban/suburban and rural areas
- Percentage of individuals with substance abuse diagnoses who were treated in Intensive Outpatient Programs or other structured group modality

The program functions through a defined committee structure, which meets at least quarterly to review results related to the quality of care, coordination of care, clinical outcomes, participant and provider satisfaction, appointment and telephone access, claims turnaround time and other key measures. At least annually each Operating Unit completes an evaluation of the local program's success in promoting improved quality of care and service. Many of you may be involved in one of the quality committees at CIGNA Behavioral Health or through involvement in one of our Practitioner Advisory Committees. We welcome practitioner input and involvement in our Quality Program and encourage you to contact us with your ideas and suggestions.

If you would like more information on the Quality Management Program and results in your area, you may contact the Quality Service Manager at the CIGNA Behavioral Health office that you work with most often.

DEPRESSION MEDICATION MANAGEMENT

Depressive disorders are a major medical problem impacting 15-20 million Americans yearly, with 1 in 6 of us experiencing a depressive disorder at some point in our lives.¹ Despite a better understanding of the neurophysiology and natural history of depression, along with newer and better-tolerated antidepressants, rates of depression and suicide in the general population are increasing with the average age of onset of an initial episode decreasing.² It has become increasingly apparent that treating depression to remission (not just “better”) within the first 6 months of onset of symptoms decreases the risk of chronicity and treatment resistance.³ In spite of the improvement in the recognition and treatment of depression, it is still estimated that only 1 in 10 clinically depressed individuals receive appropriate treatment. That is, an adequate dose and duration of an antidepressant(s) and/or evidence based psychotherapy such as cognitive behavioral or interpersonal.⁴ Only about one-third of patients who are ultimately diagnosed with depression are treated to remission.⁵ Suboptimal treatment responses (better but not complete remission of symptoms and return to normal psychosocial functioning) and nonresponses are associated with continued risk of suicide, poor role functioning, and high rates of relapse and recurrence.⁶ Achieving remission is a dual goal, initially achieving it and then maintaining it.

There is good evidence suggesting poorly treated and recurrent, persistent depression results in neurodegenerative changes, primarily in the hippocampus and prefrontal cortex. These changes may be related to elevations of cortisol and a reduction in brain-derived neurotrophic factor (BDNF). Under stress, with persistent depression and reduced BDNF, brain cells atrophy and die at an accelerated rate.^{7,8}

All of the above information, as well as the myriad of clinical research findings that we are all familiar with, makes aggressive treatment of depression to full symptom and functional impairment resolution (remission) imperative. The goal of treatment includes accurately diagnosing depression, associated comorbid conditions, enhance patient compliance and treat to and maintain remission.

An adequate medication treatment trial includes an adequate dose of an antidepressant (i.e., at least a minimal effective dose and a maximally tolerated dose) for an adequate duration (i.e., at least 4-8 weeks during the acute phase of treatment and 6-9 months during the continuation

¹ Johnston DH. *Lessons for Living: Simple Solutions for Life's Problems*. Macon, GA: Dagali Press;2001:22.

² Montano CB and Montano M. A New Paradigm for Treating Depression in the Primary Care Setting. *Medscape* 2002; www.medscape.com

³ Keller M, et al. Time to recovery, chronicity, and levels of psychopathology in major depression. A 5-year prospective follow-up of 431 subjects. *Arch Gen Psychiatry* 1992; 49(10):809-816.

⁴ Montano CB. Recognition and treatment of depression in a primary care setting. *J Clin Psychiatry* 1994; 55(suppl):18-34.

⁵ Paykel ES, Ramona R, et al. Residual symptoms after partial remission: an important outcome in depression. *Psychol Med* 1995; 25:1171-1180.

⁶ Stahl SM. Why settle for silver when you can go for gold? Response vs. recovery as the goal of antidepressant therapy. *J Clin Psychiatry* 1999; 60:213-214.

⁷ Soares JC, Mann JJ. The anatomy of mood disorders – review of structural neuroimaging studies. *Biol Psychiatry* 1997; 41(1):86-106.

⁸ Sheline Y, et al. Hippocampal atrophy on recurrent major depression. *Proc Natl Acad Sci USA* 1996; 93:3908-3913.

phase).⁹ The HEDIS antidepressant measures require 3 follow-up visits in the initial 12 weeks, then 12 weeks of effective medication treatment in the acute phase, and 6 months of effective medication treatment in the continuation phase. To maximize compliance, however, it may be necessary to monitor a patient's response weekly or biweekly for at least the first 6-8 weeks of treatment.¹⁰

Studies have shown that up to 70% of patients treated with antidepressants are not compliant in some manner with taking their medication.^{11,12} While it is beyond the scope of this article to review the issues of treatment compliance/noncompliance, the following are some of the reasons for noncompliance: medication side effects, expense of treatment, decisions based on personal value judgment or religious or cultural beliefs about the advantages and disadvantages of the treatment, maladaptive personality traits or coping styles, and the presence of comorbid psychiatric/medical problems (i.e., substance/alcohol abuse).¹³ To facilitate compliance, the treating clinician must accomplish three objectives: develop an alliance with the patient, enable the patient's support system, and tailor the medication regimen to fit the convenience and lifestyle of the patient.¹³ Strong educational messages, both verbally and in writing since patients frequently forget up to 90% of what is said in any given interaction with their physician/clinician, is essential to develop and maintain compliance. Some important messages and ideas for enhancing and maintaining compliance taken from nationally recognized guidelines such as the APA's Depression Treatment guideline include: actively engage the patient in the treatment plan, ask about prior use of antidepressants, give patient written instructions and a number to call if questions or problems, keep dosing regimen as simple as possible, review of medication use and side effects at each visit, explain it may take 2-4 weeks before seeing any clinical response to the medication, have patient call if they are thinking about stopping medication, review other causes of noncompliance such as perceived lack of benefit from the treatment, financial/environmental obstacles, and motivational factors. (Michael Glasser, MD, Lead Associate Medical Director, CIGNA Behavioral Health of California, Inc.)

⁹ American Psychiatric Association. *Practice Guideline for the Treatment of Patients with Major Depression*. 2nd Edition 2000.

¹⁰ Dalto CJ, et al. Do Clinician and Patient Adherence Predict Outcome in a Depression Disease Management Program? *JCOM* 2003; 10(2):79-85.

¹¹ Katon W, et al. Adequacy and duration of antidepressant treatment in primary care. *Med Care* 1992; 30:67-76.

¹² Lin EH, et al. The role of the primary care physician in patient adherence to antidepressant therapy. *Med Care* 1995; 33:67-74.

¹³ Kaplan and Sadock's *Comprehensive Textbook of Psychiatry* 2000. Section 27.1; Lippincott, Williams and Wilkins.

¹³ Kaplan and Sadock's *Comprehensive Textbook of Psychiatry* 2000. Section 27.1; Lippincott, Williams and Wilkins.



CIGNA Behavioral Health

DEPRESSION TOOLS & CONSUMER ORIENTED INFORMATION

CIGNA Behavioral Health would like to let you know about the following Web sites with tools and information related to depression management. These Web sites offer a variety of tools that may be helpful to physicians and health care practitioners treating members with depression. This list is not inclusive, and there are other valuable sources, as well. We hope you will find these sites helpful in providing quality clinical outcomes for your patients.

Tools to Support Depression Management

Harvard Medical School, Department of Psychiatry

<http://www.mhc.com/Algorithms/index.html>

At this site you can use computerized, evidence-based algorithms produced by the Psychopharmacology Algorithm Project.

The MacArthur Initiative on Depression in Primary Care at Dartmouth Medical School

<http://www.depression-primarycare.org>

Includes Clinician Resources such as the Depression Management Tool Kit[®].

U.S. Army MEDCOM Quality Management Office

<http://www.cs.amedd.army.mil/qmo/depress/depress.htm>

Includes guidelines and Provider Materials on depression from the Veterans Administration and the Department of Defense.

Texas Medication Algorithm Project

<http://www.mhmr.state.tx.us/CentralOffice/MedicalDirector/TIMA.html>

Contains a Physician Manual and treatment Algorithms on depression developed as part of the Texas Implementation of Medication Algorithms project.

University of Texas Health Science Center at San Antonio

<http://www2.uthscsa.dcci.com/legler/UHSFormulary/RefDocs/UHSPathways.html>

Includes algorithms, clinical pathways, medication information sheets and assessment tools.

Resources for Consumer Oriented Information

National Institute of Mental Illness

<http://www.nimh.nih.gov/publicat/index.cfm>

Offers brochures and information on depression and other behavioral disorders.

National Mental Health Association

<http://www.nmha.org/infoctr/factsheets/index.cfm>

Offers fact sheets on depression and other disorders.

The MacArthur Initiative on Depression in Primary Care at Dartmouth Medical School

<http://www.depression-primarycare.org>

Includes Clinician Resources such as the Depression Management Tool Kit[®] which includes patient education materials.

U.S. Army MEDCOM Quality Management Office

<http://www.cs.amedd.army.mil/qmo/depress/depress.htm>

Includes Patient Information from the Veterans Administration and the Department of Defense.

Texas Medication Algorithm Project

<http://www.mhmr.state.tx.us/CentralOffice/MedicalDirector/timaPtEd.html>

Contains Patient/Family Education Materials developed as part of the Texas Implementation of Medication Algorithms project.

Any reference in this material to other organizations or companies, including their Internet Web sites, is not an endorsement or warranty of services, information or products provided by those organizations or companies. Practitioners should conduct their own inquiry into the applicability and appropriateness of such services, information or products for their own clinical practices.