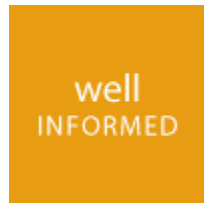




# THE CBH PROVIDER CONNECTION

*Quarterly publication produced by CIGNA Behavioral Health's  
Professional Relations Department to keep you . . .*



## 4th Quarter 2005 Volume XVI

***In This Edition:***

***EAP Corner***

<u><i>Lessons Learned in the 2005 Hurricane Season</i></u> .....	1- 3
<u><i>Regional Recruitment</i></u> .....	3

***Professional Relations Corner***

<u><i>2005 CIGNA Behavioral Health Practitioner Conferences</i></u> .....	3- 4
<u><i>Website Enhancements</i></u> .....	4

***Quality Management Corner***

<u><i>Attention-Deficit/Hyperactivity Disorder Preventive Health Program</i></u>	
<u><i>Results</i></u> .....	5- 6
<u><i>Cultural Competence</i></u> .....	6- 7
<u><i>Practice Guidelines</i></u> .....	7- 8

<u><i>Claims/Customer Service Corner</i></u> .....	8- 9
--	------

***Clinical Corner***

<u><i>Metabolic Dysregulation and Atypical Antipsychotic Medications</i></u> .....	9-10
--	------



## EAP CORNER

### LESSONS LEARNED IN THE 2005 HURRICANE SEASON

With yet another traumatic hurricane season finally at an end, we at CIGNA Behavioral Health (CBH) would like to share with you some of the lessons we learned from our experiences. Some of these lessons pertain to businesses with operations in the hurricane zone. Some apply to our own operations, in terms of the services we offer our customers. All are relevant to providers who do EAP consulting.

Perhaps the most important lesson from, especially, Hurricane Katrina is the need for business continuity planning well before a disaster. A large percentage of businesses don't survive the first year after a major disaster, largely because they aren't ready with a recovery plan they can put into place quickly. Business continuity planning (or disaster response planning) can stack the odds in their favor.

Business continuity planning should start with a vulnerability analysis that looks at both the likelihood and impact of various events, including hurricanes, floods, tornadoes, earthquakes, fires, terrorism, and blackouts. Where the likelihood is significant and the impact would be large, plans should be developed. Planning should cover the following issues at a minimum:

1. Employee and plant safety and security

2. Business operations—i.e., meeting contractual obligations and customer needs as well as possible
3. Who's in charge of what—i.e., a designated team with specific roles based on skills and current duties
4. Policies around employee leave and continued pay for those who can't do their jobs due to the disaster
5. Methods of communication and delivery of paychecks for employees who may be dislocated and "offline"

The following websites provide comprehensive business continuity planning suggestions:

<http://www.fema.gov/library/bizindex.shtm>

<http://www.osha.gov/SLTC/etools/evacuation/index.html>

<http://www.ready.gov/business/index.html>

<http://www.cdc.gov/niosh/topics/prepared/>

[http://www.redcross.org/services/disaster/0,1082,0\\_606\\_,00.html](http://www.redcross.org/services/disaster/0,1082,0_606_,00.html)

<http://www.vaemergency.com/business/>

Secondly, as a result of Katrina, CBH has continued to refine and gain experience with a critical incident response modality that we began to use



after 9/11; that is, telephonic town hall meetings (the International Critical Incident Stress Foundation calls similar *onsite* meetings for large audiences “crisis management briefings”).

The challenge after a major disaster is how to quickly reach large numbers of impacted individuals who are geographically dispersed and unable to gather at a central location for more traditional critical incident response services. The telephonic town hall meeting accomplishes this very efficiently, and from the feedback we get, effectively as well.

A town-hall crisis-management meeting is similar to a critical incident stress defusing or debriefing with one important difference: there is no *reactions* phase where participants talk about their emotional reactions to the event. Town hall meetings are confined to cognitive processing. One obvious reason for this is that the facilitator is not present to assess, stabilize, and refer those who need it. And even when these meetings are held in person, the groups are typically too large for this phase. Instead, facilitators *describe* the kinds of reactions participants might experience or see in others. They then present strategies for taking care of oneself and for supporting others. Finally, they share resources for obtaining further assistance, and respond to questions.

We have also continued to hone a town hall format for managers. These telephonic meetings cover the above issues briefly and then focus on the human resource management aspects of the

disaster, such as communicating with employees and helping those most impacted by the disaster. Feedback from our customers indicates that these too are perceived as very helpful.

Another thing we have learned is that it is helpful for us to communicate with our critical incident response providers in advance of a hurricane or other major critical incident when we have the luxury of advance warning. We keep a list of available critical incident responders, which allows us to respond to needs more quickly than if we had to call providers at random. So, whenever you know a hurricane or other major critical incident is looming, and you are going to be available, please call Joy Fruetel, team leader, at 888-371-1125 to let us know.

A final lesson from Katrina is that downsizing often follows a major disaster as businesses are disrupted and much of their work simply disappears. Businesses need to include this eventuality in their continuity planning, and we need to be prepared to support them.

While we may never face another hurricane season as disruptive as 2005, it is certain that there will be other disasters. Because of lessons learned, let us hope that we will all be a little better prepared the next time.

And a final note: CBH received a “Certificate of Recognition” from the Governor of Minnesota (our home base) for our work helping victims of Katrina. The award reads: “This certificate is presented in recognition of your



patriotism and valuable contributions to Hurricane Katrina relief efforts. Your work and commitment in recognizing the need to assist others in times of crisis is truly remarkable.” We wish to acknowledge that we could not have achieved this without our providers who worked so diligently on our behalf. Thank you!

## REGIONAL RECRUITMENT

**New England** (CT, MA, ME, NH, RI, VT): needs EAP counselors, SAPs, and critical incident responders\* across the region, and experienced trainers\*\* throughout Connecticut, Massachusetts, New Hampshire and Maine. Inquire by email to Dan Fallon at [Daniel.Fallon@cignabehavioral.com](mailto:Daniel.Fallon@cignabehavioral.com).

**Northeast** (NY, NJ, PA): needs SAPs throughout the region and critical incident responders\* and trainers\*\* in the following counties of New York State: Jefferson, St. Lawrence, Franklin, and Lewis, and in the vicinity of Milton, Pennsylvania. Inquire by email to Dana Kiel at [Dana.Kiel@cignabehavioral.com](mailto:Dana.Kiel@cignabehavioral.com).

**Mid-Atlantic** (AR, DE, KY, MD, NC, SC, VA, WV): needs critical incident responders\* in Delaware, Maryland, North Carolina, Virginia, and Washington, D.C., and trainers\*\* in the Baltimore/Washington area. Inquire by email to Carlton Weinstein at [Carlton.Weinstein@cignabehavioral.com](mailto:Carlton.Weinstein@cignabehavioral.com).

**Southeast** (AL, FL, GA, LA, MS, TN, PR, USVI): needs SAPs across the region and critical incident responders\* and

trainers\*\* in Puerto Rico and the U.S. Virgin Islands. Inquire by email to Marsha Shewanown at [Marsha.Shewanown@cignabehavioral.com](mailto:Marsha.Shewanown@cignabehavioral.com).

**Midwest** (KS, IA, IL, IN, MI, MN, MO, ND, NE, OH, OK, SD, TX, WI): needs SAPs across the region, especially in northern Michigan and Minnesota. We also need critical incident responders in the Houston area. Inquire by email to Robbie Hamill at [Robbie.Hamill@cignabehavioral.com](mailto:Robbie.Hamill@cignabehavioral.com).

**West** (AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY): needs SAPs and critical incident responders\* across the region. Inquire by email to Bruce Steele at [Bruce.Steele@cignabehavioral.com](mailto:Bruce.Steele@cignabehavioral.com).

\*Critical incident responders must have training in critical incident debriefing protocols.

\*\*Trainers deliver wellness seminars and management training.

## PROFESSIONAL RELATIONS CORNER

### 2005 CIGNA BEHAVIORAL HEALTH PRACTITIONER CONFERENCES

Due to the overwhelming success of our 2004 practitioner conferences, CBH expanded our conferences in 2005. We are proud of our provider community and wanted to take the opportunity to show our appreciation. This year we hosted nine one-day events—in Los Angeles, Boston, Dallas, Tampa,



Knoxville, Detroit, Denver, Chicago, and Phoenix. Over 800 providers from 25 states and the US Virgin Islands attended. Attendees included psychiatrists, nurse practitioners, psychologists, social workers, professional counselors, and substance abuse professionals.

CBH Medical Directors Douglas Nemecek, MD, and Craig Coenson, MD, presented "Evidence-Based Treatment of High-Risk Cases: Substance Abuse, Bipolar Disorder, and Dual Diagnosis," and Bart Bernstein, J.D., LMSW, a Dallas-based attorney and licensed social worker, presented "Professional Ethics for Clinicians." The topics were chosen based on attendees' program evaluations last year.

The overall goal of this series of one-day seminars was to provide each attendee with additional sources of knowledge and skills that would contribute to the care provided to CBH participants. By attending, providers gained a more thorough understanding of:

- "Back-pocket" skills for broader therapeutic options
- The risks and benefits of therapeutic choices
- Areas of professional vulnerability
- Typical ethical and malpractice complaints
- Avoiding involvement in the court system
- Steps to take when a complaint is received

We are currently in the process of planning our 2006 conferences. If you

were not able to attend in 2005 we hope you will next year. Topics promise to be informative and practical for all behavioral health disciplines, and are recommended for all levels of licensure and clinical practice. It is an opportunity to network with colleagues and fellow professionals and earn up to six CMEs/CEs. Continental breakfast and lunch are provided. Details about the 2006 conferences will be available in early spring.

### WEBSITE ENHANCEMENTS

CBH's website has several recent improvements for providers and participants, which should lead to better health outcomes for the latter.

Providers can direct participants to the "My Reminders" tool, which allows them to schedule email reminders for such things as prescription refills and therapy appointments. After logging in, the participant submits an email address, some information about the event, and indicates when the reminder should arrive. The Website automatically sends them an email reminder at the appropriate time. The goal of this tool is to help participants manage their path to wellness.

Providers can use the website to view level of care guidelines, submit claims, and check member eligibility. For more information, visit [www.cignabehavioral.com](http://www.cignabehavioral.com).



## QUALITY MANAGEMENT CORNER

### ATTENTION- DEFICIT/HYPERACTIVITY DISORDER PREVENTIVE HEALTH PROGRAM RESULTS

After two years of operation, CBH's Preventive Health Program for Attention-Deficit/Hyperactivity Disorder (ADHD) has plenty to celebrate. Since its inception in October 2003, rules for automated claims in our Care Advocacy Program (CAP) have identified 13,260 new cases of ADHD. We mailed educational information and tools to parents and guardians to improve their understanding of and ability to manage their children's condition, and to encourage coordination between multiple systems, including medical and behavioral care, education, and socialization. The intent of our program is to educate and empower caregivers, to reduce the impact of problems commonly associated with the disorder, and to encourage early detection of ADHD in siblings.

#### Program Utilization

In 2005, 5,620 information packets were distributed when automated claims review identified new ADHD cases. An additional 1,303 information packets were distributed by our Personal Care Advocates in response to telephone requests. Participants, behavioral health practitioners, and primary care physicians accessed program materials and other helpful information about ADHD through CBH's

website, where nearly 17,000 visits to our ADHD Web pages have been recorded over the life of the program.

#### Feedback Received

A survey is sent to participants approximately 30 days following the ADHD informational mailing. Over the past two years, the overall survey response rate was 8.2%, with all CBH operating units represented (29% of survey respondents were serviced through Tampa, Florida; 28% through the National Care Center in Eden Prairie, Minnesota; 17% through the Chesapeake Operating Unit, in Maryland; 17% through Dallas, Texas; and 10% through Glendale, California).

The typical survey respondent is a Caucasian (84%) mother (82%), 35-44 years of age (52%), whose educational experience includes some college (41%), who is living in a two-child household (45%), where a child between the ages of 6-12 has been diagnosed with ADHD (92%). During the second year of the program, more representative feedback has become available through rising minority participation in the survey (17%).

There were slight improvements in several areas of the survey from 2004 to 2005. In 2005:

- 88.6% of participants felt the information was helpful (versus 86% in 2004)
- 86.5% felt the packet information was complete (versus 82% in 2004)



- 94.8% would recommend the program to other parents with an ADHD child (versus 94% in 2004)

In 2005, CBH added several new survey questions to determine how participants are using the provided materials. Responses reveal that 70.6% did use the tools they received. After exposure to the materials, 77% report a better understanding of ADHD, while 71.4% felt better able to manage their child. However, only 31.2% report using the tools in practitioner appointments, and only 31.6% report using them with schools, reflecting lower than expected systems integration. Further, a slight decline in participant assessment of practitioner skill (93.3% in 2005 versus 95% in 2004) was coupled with substantial declines in satisfaction with treatment progress (83.4% in 2005 versus 92% in 2004).

### Looking Forward

While CBH is pleased that the materials provided as a part of the ADHD Preventive Health Program improve caregiver understanding and child-management practices, program results suggest that there are opportunities for improvement. It may be possible to improve tools to better promote their use across treatment and educational systems. We will explore reasons for decreases in satisfaction with treatment progress and will look more closely at consistency of treatment with *Practice Guidelines*. We will review frequency of practitioner visits and medication prescription patterns. We will seek practitioner input and work toward higher levels of medical-

behavioral integration since primary care physicians often provide treatment for this population.

The ADHD Preventive Health Program materials and additional information about ADHD can be found in the "Provider Resources" section of our website at [www.cignabehavioral.com](http://www.cignabehavioral.com), or can be obtained by contacting the CBH operating unit with which you are customarily associated. Practitioner feedback and input is welcome.

### CULTURAL COMPETENCE

CBH is committed to equal access to high quality care for every individual. Sensitivity to diversity of culture and lifestyle improves quality of care. Annually, CBH assesses the cultural, linguistic, and other demographic characteristics of those we serve. We also assess these characteristics in our provider network to assure adequate diversity to meet customer needs.

In 2005, we increased our focus on the verification of practitioner skill-sets, and reminded practitioners to keep us up to date on their areas of clinical specialization. Through CBH's website, participants can search network resources online and select providers based on the culture, language, and lifestyle information those providers have chosen to provide. CBH monitors provider responsiveness to diversity, and responds to participants' complaints.

The need within health care to manage greater diversity in language, lifestyle, race, ethnicity, and culture has



increased sharply as the U.S. population and Americans' lifestyle choices have grown more diverse. The concept of "cultural competence" in health care systems recognizes the impact of culturally sensitive care on quality and cost. For example, improved communication between provider and patient may lead to better patient comprehension of providers' instructions, better adherence to treatment, reduction in treatment errors, better health outcomes, and a reduced need for emergency or inpatient levels of care.

CBH encourages providers to expand their cultural knowledge and to adapt their practice to greater patient diversity. Following are some suggestions for how to do this:

1. Make a commitment to increase your sensitivity to cultural and lifestyle differences
2. Be aware of how physical office environments may represent languages and culture through pictures, magazines, media, and décor
3. Seek to provide services that are accessible to different cultures and lifestyles and that better meet the cultural-linguistic needs of individuals
4. Collect relevant cultural and lifestyle data when conducting histories and assessments
5. Be conscious of attitudinal differences and avoid stereotyping

6. Plan treatment in a culturally sensitive way that reinforces adherence
7. Understand cultural differences in verbal and nonverbal communication styles
8. Acknowledge the uniqueness of each participant's frame of reference, world view, and social structure
9. Explore kinship and social ties, and be sensitive to family roles in participant care
10. Evaluate your own world view and engage in skill training
11. Use the resources of multi-cultural treatment teams, where available.

Cultural competence is a developmental process that evolves over time; it may impact individual access and response to care. CBH encourages providers to help eliminate health care disparity and to provide high quality care through an understanding and validation of diversity.

### PRACTICE GUIDELINES

Annually, CBH reviews and adopts clinical practice guidelines relevant to the provision of acute and chronic behavioral health services to participants. Practice guidelines help practitioners and participants to make decisions about appropriate health care for specific clinical circumstances.



CBH only supports published guidelines from recognized sources, which are written and revised at least every two years with appropriate peer review. Further, the guidelines must be based on scientific evidence, professional standards, and expert opinion of what is effective in improving health outcomes.

In October 2005, CBH approved the following guidelines for use in 2006:

- The American Psychiatric Association's *Practice Guidelines* for acute and chronic behavioral health conditions. The full text documents are available on the American Psychiatric Association website at:

[http://www.psych.org/psych\\_pract/treatg/pg/prac\\_guide.cfm](http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm)

Specific APA guidelines adopted by CBH include:

- Acute Stress Disorder and Posttraumatic Stress Disorder
  - Alzheimer's Disease and Other Dementias of Late Life
  - Bipolar Disorder
  - Borderline Personality Disorder
  - Delirium
  - Eating Disorders
  - HIV/AIDS
  - Major Depressive Disorder
  - Panic Disorder
  - Psychiatric Evaluation of Adults
  - Schizophrenia
  - Suicidal Behaviors
- The American Academy of Pediatrics' *Practice Guidelines* for Attention-Deficit/Hyperactivity

Disorder, available in summarized format on the CBH website at:

<http://apps.cignabehavioral.com/web/basicsite/provider/treatingBehavioralConditions/treatingBehavioralConditions.jsp>

- The National Institute on Alcohol Abuse and Alcoholism's guidelines on alcohol abuse, entitled *Clinician's Guide: Helping Patients Who Drink Too Much*, available on the National Institute on Alcohol Abuse and Alcoholism website at:

<http://www.niaaa.nih.gov/Publications>

It can also be obtained on the CBH website at:

<http://apps.cignabehavioral.com/web/basicsite/provider/treatingBehavioralConditions/treatingBehavioralConditions.jsp>

<http://www.niaaa.nih.gov/Publications>

## CLAIMS/CUSTOMER SERVICE CORNER

Did you know that CBH returns approximately 450 claims per week to contracted providers? These claims are returned because the billing name or tax identification number (TIN) does not match the contracted-provider record CBH has on file. This results in additional administrative work and delayed claim processing. If you add a practice location or change your billing



address or TIN, please go to [www.cignabehavioral.com](http://www.cignabehavioral.com) and click on "Are you a Provider?". Click the "Forms and Tools" link and then the "Update Demographic Data" link, and update this important information.

By investing a few minutes up front, you can eliminate additional work and delay in paying your claims.

## CLINICAL CORNER

### METABOLIC DYSREGULATION AND ATYPICAL ANTIPSYCHOTIC MEDICATIONS

There is ample literature on the potential metabolic effects of atypical antipsychotic medications (for the purpose of this article, the terms atypical and second generation anti-psychotics are used interchangeably; they include clozapine, olanzapine, risperidone, quetiapine, ziprasidone and aripiprazole). Although the metabolic changes vary with the different medications, the FDA has instructed that the manufacturers of all atypical antipsychotics include a warning regarding the potential effects of these drugs on hyperglycemia and diabetes.

The FDA and the American Diabetes Association's (ADA) Consensus Development Conference On Anti-psychotic Drugs And Obesity have issued recommendations for monitoring patients treated with atypical antipsychotic medications. The FDA recommendations have three categories:

1. Patients with preexisting diabetes—monitor regularly for worsening of glucose control
2. Patients with risk factors for diabetes—check fasting blood glucose at baseline, then periodically during treatment
3. All patients initiated on an atypical antipsychotic—monitor for symptoms of hyperglycemia (polydipsia, polyuria, polyphagia, and weakness) and check fasting blood-glucose in patients who develop symptoms of diabetes

The ADA consensus development guidelines are more extensive, with six categories to monitor, and recommended time frames on when to monitor each. The categories are 1) personal and family history, 2) weight (BMI), 3) waist circumference, 4) blood pressure, 5) fasting plasma glucose, and 6) fasting lipid profile. It is recommended that all six categories be checked at baseline, and then re-checked at various intervals.

We do not have all the answers, nor do we know the exact causes for these metabolic changes, but some studies suggest possible mechanisms of action. Indirect effects of weight gain and increased adiposity may be caused by medication. Although poorly understood, histamine and serotonin receptors are being looked at, among other things. Weight gain is not an uncommon indirect effect, which is often seen with some chronic illnesses (due in part to lack of motivation, apathy, decreased energy, poor



nutrition, etc.). One theory is that some of the atypicals may not only increase insulin resistance but also affect glucose metabolism and transport. There does seem to be a difference in the amount of risk that each of the medications has on diabetes, hyperglycemia, weight gain, and other metabolic changes.

In summary, there has been an increased focus on metabolic changes with atypical antipsychotic medications, including weight gain, lipid dysregulation, diabetes mellitus, and glucose metabolism, all of which can lead to increased risk of cardiovascular disease. The literature seems to show that early interventions and monitoring (of weight, lipids, blood glucose, etc.) are more effective than waiting until the patient has already gained weight or developed hyperglycemia, diabetes, or hyperlipidemia.

There are many measures a physician should consider, including nutrition

consults, nutrition education, discussions regarding exercise and increased physical activity, education about the symptoms of diabetes, changes in daily routines, and even changing medications. One should also be aware that weight gain in itself is a common reason for medication noncompliance and should be monitored closely. Remember that recommendations such as diets, nutritional consults, and exercise should be followed up to assure compliance and success.

In any event, the fact that there is the potential for such metabolic changes has led to some recommendations on how to monitor those who will be considered, or have already started, atypical antipsychotics. It also appears that other drugs may require monitoring until more data becomes available. In fact the FDA is looking at whether “typical” antipsychotic medications also need a warning about the potential risks of hyperglycemia and diabetes.

---

We want to hear from you. Do you have any feedback about “The CBH Provider Connection” newsletter? Do you have suggestions for article topics? Please email us at

<mailto:ProviderServiceDel@CIGNABehavioral.com>.

## Editorial Board

### Editorial Board Leader

Sherry Estrada, Professional Relations Manager

### Article Contributors

Josue Arguello, Provider Education Specialist, Glendale Regional Care Center

Sheila Cain, Professional Relations Manager, Dallas Regional Care Center

Robert Cirelli, Associate Medical Director, Chesapeake Regional Care Center

Dale Demarest-Bryan, Manager, EAP Services

Dana Kiel, Regional EAP Manager

Jan Miller, Senior Account Manager

Ken Richard, Quality Manager

Jeffrey Van Pelt, EAP Manager

Caroline Woitas, Claim Supervisor

### Design & Editing Contributors

Anita Ivarson, Project Manager

Elizabeth Jordan, Legal Resource Consultant

Jeffrey Van Pelt, EAP Manager