



PROFESSIONAL RELATIONS CORNER



CIGNA Behavioral Health

IMPROVING THE TIMELINES OF VISITS FOLLOWING HOSPITALIZATION

The period immediately following discharge from inpatient psychiatric hospitalization can be a difficult time for members. These members need timely access to outpatient care to maintain stability and continue treatment. Failure to engage members in outpatient services during this time may greatly increase the probability of relapse and readmission. As a result, CIGNA Behavioral Health (CBH) has been striving to improve the rate of members being seen within the 7 days following their discharge inpatient care to ensure their successful transition to outpatient care.

The National Committee on Quality Assurance (NCQA) states, "Appropriate follow up care helps reduce the risk of repeat hospitalization for some people, and identifies those in need of further hospitalization before they reach a crisis point." This is supported by the literature and exemplified in the study done by Nelson, Maruish and Axler, (n = 3,113 patients), where a member's risk for re-hospitalization was doubled without at least one outpatient appointment following the index hospital discharge.

To gauge performance, CBH use measures that have become widely utilized and closely followed in the industry from the Health Plan Employer Data and Information Set (HEDIS).* The HEDIS Ambulatory Follow-Up specifications outline expectations for timely follow-up after a hospitalization:

- The percentage of members seen for outpatient mental health follow-up within 7 days after discharge from hospitalization for mental illness.
- The percentage of members seen for outpatient mental health follow-up within 30 days after discharge from hospitalization for mental illness

NCQA also uses the HEDIS 7-day and 30-day Ambulatory Follow-Up rates to measure this clinical initiative across the industry. The HEDIS 2005 90th percentile target rates for 7-day and 30-day follow-up are 70.2% and 86.2% respectively. CBH continues to strive to achieve these HEDIS Ambulatory follow-up goals. However, we need our practitioners and facility partners to help us succeed, and most importantly in providing our members the best quality of care and quality of life.

In an effort to strengthen the bridge between inpatient and outpatient care, CBH is working closely with facilities in order to drive improvements in follow up. Some of these initiatives are:

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- Making sure the member has an appropriate discharge plan in place, and that an appointment is being scheduled with an outpatient practitioner within 7 days of discharge.
- CBH dedicated staff working with the facility in terms of securing the discharge plan and making outreach to outpatient practitioners to schedule the member's aftercare appointment.
- CBH clinical staff seeking to have a meaningful conversation with the member while still inpatient in order to talk about their discharge plan, the importance of being engaged in their outpatient care and finding out any barriers they may have to attending an outpatient appointment, therefore to help reduce any no shows or possible readmissions.

CBH is committed to working with you to help our members achieve these levels of follow-up, post-hospitalization. We encourage you to help members engage in the needed outpatient treatment following inpatient care by:

- Scheduling appointments for those members being discharged from acute inpatient care within 7 days of their discharge date.
- Placing outreach calls to the members who do not attend appointments following hospitalization and encouraging them to attend appropriate outpatient care.
- Notifying CBH if the member does not keep the scheduled follow-up appointment. This way, CBH can attempt to contact the member and assist in rescheduling that aftercare appointment and can also talk to the member further about the importance of being engaged in their outpatient care.
- If you have any questions related to this article, please contact your local Provider Relations Representative.

Nelson Ed.D., Maruish Ph.D., and Axler M.D. *Effects of Discharge planning and Compliance With Outpatient Appointments on Readmissions Rates*. Psychiatric Services July 2000: Vol 51 No. 7

QUALITY MANAGEMENT CORNER

URAC HEALTH UTILIZATION MANAGEMENT ACCREDITATION

On October 31, 2006, the Utilization Review Accreditation Commission (URAC) granted Health Utilization Management re-accreditation to Cigna Behavioral Health (CBH). URAC is a Washington, DC based organization that establishes quality standards for the health care industry.

The URAC Health Utilization Management standards establish consistency in Utilization Management process. The standards assure that appropriately trained clinical staff conduct and oversee the Utilization Review process, that a reasonable and timely appeals process is in place, and that medical necessity decisions are based upon valid criteria. URAC's Health Utilization Management standards provide assurance to members, practitioners and providers, purchasers, regulators, and employers that the practices of the organization performing these services are fair and equitable for all parties.



CBH has been continuously accredited under URAC's Health Utilization Management standards since 1993. We are committed to quality utilization management processes, and we take pride in the achievement of being granted renewal of this important accreditation.



ONLINE ACCESS TO CIGNA HEALTHCARE COVERAGE POSITIONS

CIGNA Behavioral Health (CBH) regularly evaluates the appropriate use of new and existing behavioral health technologies, including new applications of established technologies. This may include drugs, devices, biologics, procedures, imaging and diagnostic interventions proposed for benefit coverage.

To ensure member access to safe and effective assessment and care, CBH, in partnership with CIGNA HealthCare's (CHC) Medical Technology Assessment Committee, meets approximately monthly to examine primary research reports and published scientific evidence, including information from appropriate government regulatory bodies, reviews done by other technology assessment agencies, and input from specialists and professionals who have expertise in the technology under review. Requests for the review of a proposed technology may be received from customers, network practitioners and providers, or from clinical review staff.

Because Committee decisions may result in benefit coverage changes, practitioners and providers may wish to learn more about current or new coverage recommendations. An alphabetical index of existing and updated coverage positions is maintained, and can be accessed on-line, through CHC's web site. Double-clicking the name of a Coverage Position opens it for viewing. In each Coverage Position information is generally available on the requested service, frequently used codes, common indications for use of the technology, general background information, common medical practices, medical and regulatory documentation, and references.

You can explore and review existing and new technology recommendations at the following destination:

http://www.cigna.com/health/provider/medical/procedural/coverage_positions/medical/index.html

PRACTICE GUIDELINES UPDATE

In August 2006, CIGNA Behavioral Health (CBH) adopted three recent revisions to the American Psychiatric Association (APA) Clinical Practice Guidelines. These include the updated APA guidelines for treating Eating Disorders, Substance Use Disorders, and for the Psychiatric Evaluation of Adults.

At least every two years, CBH formally adopts Practice Guidelines published from recognized sources. The intent is to help practitioners, providers, and members make decisions about appropriate, effective clinical care.

Semi-annual reviews of new scientific evidence or changes in national standards are also conducted. Revisions or updates to the guidelines may be made prior to the scheduled two-year review period, as a result. CBH selects only guidelines that are written and revised with appropriate peer review, are based on scientific evidence, professional standards and expert opinion, and are known to be effective in improving health outcomes.

Unless unique circumstances indicate otherwise, network practitioners and providers are encouraged to provide member care that is consistent with the best practice described in the clinical practice guidelines. For your convenience, a full index and links to the currently adopted guidelines can be found on CBH's web site at:

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

CLAIMS / CUSTOMER SERVICE CORNER

CLAIM SUBMISSION

Speed and accuracy of claim payment is affected by the presentation of claim information. Some tips to help you help us include:

- submit a typed claim form (improves readability),
- thoroughly completing the claim form (helps identify the correct member and provider)
- use the most up to date claim form.

An updated version of the HCFA 1500 form was initiated by the National Uniform Claim Committee (NUCC) in July 2006 – you can view and print out the new claim form, instructions for completing the new claim form, and information regarding implementation timelines at www.nucc.org.



Two changes to the form include your NPI (National Provider Identifier) number in box 17a. If you don't have an NPI, the form now asks for a two digit payer identification number (see website for these numbers) in box 17b. Additionally, when box 33a and b (billing provider) are different, Box 241 requires completion of similar information (see website for specifics)

The NPI or HIPAA National Provider Identifier number is the single source provider ID used in lieu of Tax ID numbers for electronic claims submission. For more information regarding NPI check out the web for additional information. Some useful sites include www.cms.gov or www.nppes.cms.hhs.gov/NPPES/Welcom.do.

CLINICAL CORNER

SUGGESTIONS ON MEDICATION ADHERENCE

In order to attempt to improve medication adherence one must first identify the risk factors as well as the barriers for non-adherence. Some examples of barriers include; denial of illness, laziness, forgetfulness, fear of side effects, actual side effects, multiple dosing regimes, the stigma of taking medications and the condition being treated, the cost of medications and co-pays and even the fear of lab work that might be required (for example in the case of lithium), etc. There are many risk factors of non-adherence from being elderly, severity of the condition, medication side effects, economic status, literacy, past inpatient admissions to the substance abuse disorders to name just a few. One should be aware of the different high risk factors that can affect medication adherence.

Strategies to improve compliance should target the specific risk factors and barriers if they have been identified. For example a forgetful member might benefit from a pill-box that is visible and in a place where they would be reminded or even having a daily planner with scheduled medications, times and dosages.

Psycho-education is something you can do with the member and family. It can help to reduce the stigma that the member or family may have. It is important to ask the member and family about their views on medications and the condition. Discuss what the member should do if they experience side effects or how to deal with side effect should they develop such as weight gain. With some conditions members with supportive friends and families tend to adhere to treatment and medications better than those without supports.

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A member's knowledge and beliefs about medications can influence adherence. So inform and educate members about side effects and what to anticipate. It is important to empower a member in being part of the decision-making. Discuss different medication choices when available and ask what they might prefer. At the same time, give your recommendations as well as the evidenced-based facts to help them with decision-making. It is helpful to talk about ones availability and the plan of action should there be any concerns or problems. Once you are ready to prescribe medications, be ready to give simple directions and explanations on how and when to take medications as well as what to do if there are any problems. Remember to take into account one's cognitive level of functioning and other related factors that might require more simple directions. Be ready to give both verbal and written directions. Ask in a non-confrontational way what they see as barriers to treatment compliance



There is a greater chance of medication adherence post discharge when follow up appointments are reasonably close to the discharge date. At CBH we use the standard of getting an outpatient follow up within 7 days post discharge. It is a good idea to start discharge planning at admission including pre-discharge contact with existing providers.

Remember, two strong predictors of improved compliance include decreasing negative attitudes to medications and a strong therapeutic alliance.

EAP CORNER

PROVIDER RESOURCES FOR HELPING RETURNING MILITARY MEMBERS

Over the coming months (and probably years) we can expect many active duty military personnel, as well as Guard and Reserve members, to return from war zones to civilian life. Our nation spends large amounts of time and money preparing these individuals to go to war, but very little, by comparison, on preparing them to return to civilian life. Yet for many, the latter transition is the more difficult.

As a CIGNA Behavioral Health participating provider, you may be called upon to help some of these individuals in their transition back to civilian life, either directly or indirectly. We want to do our part by providing you with the best information and resources that we can. Following is, first, a high level overview of the dynamics involved in this transition, and the psychosocial tasks of reintegration as adapted from a presentation by Major John Morris of the Minnesota National Guard. Second, we provide some links where you can find additional information.

Transitions

The road to war can include making an adjustment from:

- Citizen to soldier (includes sailor, airman, marine)
- Safety to danger
- Comfort to discomfort
- Order to chaos
- Law to lawlessness
- Trust to mistrust

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When military members finish their tour of duty and return home they reverse this process, and may make the adjustment from:

- Soldier to citizen
- Danger to safety
- Discomfort to comfort
- Chaos to order
- Lawlessness to law
- Mistrust to trust

As much as they may look forward to the latter changes, those changes are not always easy, and many need help in the process.



Why should it be hard coming home?

Coming home most likely means coming back to good things. Life is most likely safer, easier, and more pleasant than in an active war zone. Why, then, isn't it easy? The answer has three parts:

- 1. Recovery from intense events:** Many have experienced the horrors of war: seeing people killed, handling body parts, having to kill. They may have had friends killed, for whom they have not been able to adequately grieve—there is little time for that in a war zone. Even those who weren't exposed to traumatic experiences may have lived with major ongoing stressors, such as cramped living quarters, no privacy, undesirable food, a harsh climate, and a foreign culture.

Long-term exposure to intense, stressful events can lead to social withdrawal, numbing of emotions, hyper-arousal, fear, anger, irritability, and re-experiencing of the upsetting events through nightmares and flashbacks. These things don't suddenly stop when the person returns to civilian life.

- 2. Continued use of "battlefield skills."** In a war zone, people learn a set of skills they need to survive. These skills are not necessarily helpful in civilian life, and are often self-defeating, but they may be hard to let go of because they have become habits. Battlefield skills can include:
 - Being on constant alert for danger
 - Not trusting people
 - Making quick decisions, on one's own
 - Expecting others to obey directives without question
 - ticking to a "mission" no matter what
 - Reacting quickly and asking questions later
 - Keeping one's emotions sealed off
- 3. Things have changed back home, too.** Children have grown, spouses have taken on new roles and responsibilities, and workplaces have changed. It takes time to re-establish relationships, talk through the changes, and adjust to them. The process is exacerbated by the preceding issues, and sometimes accompanied by conflict.

What does it take to successfully make the transition?

The following are four tasks that returning military members may need to accomplish in order to successfully make the transition back to civilian life:

- 1. Reconnect with family, friends, co-workers, and community.** War experiences often leave people feeling different and separated from others. The returning member must work to overcome this alienation and reconnect with people.
- 2. Move from simplicity to complexity.** Life may have been simpler in a war zone. Civilian life may be less dramatic, but issues more complex. The returning member may need to relearn how to consciously act, rather than react to people, places, and things.

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3. **Replace war with another, healthy, form of high.** War is an adventure, an adrenaline rush. Nothing in civilian life may come close to matching the intensity of war. Sometimes, the lack of similar intensity in every day life can create a void, which can in turn cause extreme boredom and even depression. Some seek to fill this void with dangerous replacement activities, such as reckless driving, compulsive gambling or drug and alcohol abuse. A better solution is to find “healthy highs,” such as exercise, learning new things, sports, hobbies, and the outdoors.
4. **Find meaning and purpose outside of combat.** This task may be the hardest of all because it is so broad and abstract. In a war zone, there may be a defined and underlying purpose for things and everything else is subordinate to that. That may be lost upon return to civilian life, and individuals must find different sources of meaning and purpose.

Questions for assessing returning military members

Following are some questions to ask as part of your assessment of individuals who have served in the military in a war zone.

General military service history:

- Tell me about your military experience.
- When and where do you/did you serve?
- What do you/did you do while in the service?
- How has military service affected you?

Probing for traumatic experiences:

If client answers *yes* to any of the following, ask “Can you tell me more about that?”

- Were you a prisoner of war?
- Did you see combat, enemy fire, or casualties?
- Were you wounded, injured or hospitalized?
- Did you ever become ill while you were in the service?



Assessing for potential PTSD (Posttraumatic Stress Disorder):

Have you had an experience so frightening, horrible, or upsetting that, in the past month, you..

- had nightmares about it or thought about it when you did not want to?
- tried hard not to think about it, or went out of your way to avoid situations that reminded you of it?
- were constantly on guard, watchful, or easily startled?
- felt numb or detached from people, activities, or your surroundings?

Further resources for clinicians

The following resources have been compiled to further help you assist servicemen and women and their families as they transition in and out of military service. Please copy and paste the web address onto your browser.

Iraq War Clinicians Guide: <http://www.ncptsd.va.gov/war/guide/index.html>

Guide for helping professionals who are assisting returning military members and their families.


Deployment Health Clinical Center: <http://www.pdhealth.mil/>

Contains post-deployment health information designed to assist clinicians in the delivery of post-deployment healthcare to military members.

US Department of Veterans Affairs – “The War in Iraq” <http://www.ncptsd.va.gov/topics/war.html>

Comprehensive resource for all aspects of readjustment to civilian life. Includes “Returning from the War Zone: A Guide for Military Personnel” and “Returning from the War Zone: A Guide for Families”

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Department of Veterans Affairs: Facts About Posttraumatic Stress Disorder (PTSD)

<http://www.ncptsd.va.gov/facts/index.html>

Information on PTSD, including general facts, associated problems, treatment for veterans, disasters and traumatic stress, specific audiences and topics, and further reading.

The Military OneSource Programs: Marine Corps: Call 800-869-0278 or go to www.mccsonesource.com; Army: Call 800-464-8107 or go to www.armyonesource.com; Navy: Call 800-540-4123 or go to www.navyonesource.com; and Air Force: Call 800-707-5784 or go to www.airforceonesource.com. Provides a full array of EAP and work/life services for military personnel and their families.

Deployment Link (Department of Defense resources):

http://deploymentlink.osd.mil/deploy/post_deploy/post_deploy_intro.shtml

Post-deployment articles and information for all branches of the military.

Readjustment Counseling Services: Call 800-827-1000 or go to www.va.gov/rcs and click “Find your nearest vet center.” This is a Veterans Administration outreach service and is available in all 50 states.

Books of Interest: “*Down Range: To Iraq and Back*” by Bridgett Cantrell and Chuck Dean; and “*Courage After Fire*” by Keith Armstrong, Suzanne Best, and Paula Domenici. Access at www.namvetbook.com and www.amazon.com, respectively.

Article from the American Psychological Association:

<http://helping.apa.org/featuredtopics/feature.php?id=6>

Title “The Road to Resilience”; includes sections on what is resilience? 10 ways to build resilience; learning from your past; staying flexible; and places to look for help.

PARTNERING IN MANAGEMENT INTERVENTIONS

A Formal Management Referral is a performance-based referral where an EAP assessment is offered voluntarily as a way for an employee to address whatever personal issues may be impacting their work performance. A formal referral is contingent upon the employee’s written permission granted on the EAP Consent for Release of Confidential Information form which explains the limits of confidentiality. This provides the employee with assurance that only compliance updates—to include dates of service and any final clinical recommendation—are to be released to the manager.

Examples of a Formal Referral might be:

- When performance has, or will lead, to a corrective action or warning.
- When performance has declined over time.
- When an employee’s behavior is having a negative impact upon the work environment or impacting the productivity of other employees.
- When an employee is making offensive, abusive, or vulgar remarks to others.
- When drugs or alcohol are suspected in a drug-free workplace.
- When an employee threatens suicide, and is willing to get assistance.

The employee may or may not have disclosed any such information to their manager. Whenever a manager has received additional information regarding possible personal stressors and/or medical concerns, this background information can be quite helpful to the EAP provider and relayed as rationale for the referral.

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Continuation of Employment Referral (or Mandatory Referral)—

A Continuation of Employment or Mandatory Referral occurs when the manager declares that the employee's compliance with the referral, as well as any subsequent treatment recommendation, are a condition for the employee's continued employment.

Examples of a Continuation of Employment Referral might be:

- When a person has tested positive in a random or for-cause drug test.
- When a person is given a last chance to get some help, before they lose their job.
- When the manager wants continued employment to be contingent on compliance.

The employee may have been suspended from work and needing to meet return-to-work criteria per his/her employer's company policy and manager's discretion.

EA Consultant Responsibility—

Once the employee has confirmed a scheduled appointment, the Employee Assistance (EA) consultant will contact the provider identifying the case as a management referral and providing relevant information that lead to the referral by the employer. The EAP Provider should update the EA Consultant following each EAP session to confirm that the employee maintains compliance with attendance and to discuss any recommendations or referrals deemed to be clinically appropriate as based on the assessment.

Prompt reporting of any problems with attendance or follow through with any referrals or recommendations allows the manager to stay involved with the process, and to make sure the employee realizes the impact of non-compliance with the Management Referral process. The EA Consultant will inform you of any feedback provided by the manager and/or decisions made at the work site that may impact the employee's ability to complete this process.

It is the EA Consultant's role to communicate with the referring manager. The EA Consultant will update the referring manager with all information pertaining to compliance with attendance following each scheduled EAP session as well as compliance with any recommendations made based upon the EAP assessment. The EAP Provider should never communicate with the referring manager directly.



Provider Responsibility—

As a CBH network provider, you will meet with the employee to complete a comprehensive clinical assessment and formulate a plan to address the workplace performance issues and any other concerns that may be contributing to the problem. No clinical or diagnostic information will be given to the employer.

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CIGNA Behavioral Health

**The right help
at the right time!**

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Please confirm promptly any/all EAP sessions completed as well as next scheduled appointment dates, and report any scheduling changes, or failed appointments. Also please report any recommendations for further treatment, self-help groups, or community resources, as confirmed with the employee. Make sure the employee has all referral information including contact names, addresses, and phone numbers in writing. Releases should be obtained that allow you, as the referring provider, to contact any referral sources to coordinate intakes and verify that the employee has followed through with the recommendations made. Remind the employee that these recommendations will be reported back to the employer.

Keep in mind that you have two “clients” with an EAP Management Referral—the employee and the employer. Do not communicate directly with the employer, suggest legal action against the employer, or make referrals or complete any paperwork for the employee regarding return to work, disability, fitness for duty, or workers compensation.

Working Together. . .

Together we are able to facilitate a process that often results in a much more motivated and productive employee. One who is better able to manage the stressors of the workplace and to be successful in their continued employment!

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: www.ProviderEducation@cignabehavioral.com

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