



## On "Health Care Consumerism"



**Keith Dixon, PhD,**  
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Care Allies/CBH

The cost of delivering effective, high-quality health care in America has been rising steadily for nearly a decade a serious concern for the industry and for our country. Today, we spend 16 percent of our Gross Domestic Product on health care, about a third more than any other developed nation on earth. Left unchecked, that percentage is projected to rise to 20 percent of GDP by 2014. Yet, despite the high level of spending, the quality of care is inconsistent and access to care is uneven.

Health care consumerism – fully engaging consumers in the process of improving their own health and well-being represents a *bona fide* solution to the cost-quality conundrum. At CIGNA, we view consumerism not as a product or service, but as a way to fundamentally impact health care delivery – a vehicle for addressing consumer health care needs in a highly personal way, across the entire health continuum, from wellness to chronic illness.

We can realize the full value of health care consumerism by giving consumers meaningful choices. That means providing the tools, resources and incentives they need to meet their personal health goals, make smart health care decisions, and generally enhance their quality of life, cost-effectively.

One such resource is the consumer-directed health plan – or CDHP – a viable and innovative approach to health benefits that can control costs and improve quality. The data confirms this assertion. In an independent study of 40,000 CIGNA CDHP members, we found that medical costs for our CDHP enrollees were 16% lower than for those with traditional plans. At the same time, our CDHP members were more inclined to make positive changes in their behaviors; they were more likely to use preventive care services and maintain medication regimens to treat chronic conditions.

The point is, health care consumerism *works*. It offers us a proven way to reduce health care costs and improve the quality of care in America. All of us – consumers, employers, health care providers and health plans – have a critical part to play in achieving that goal.

You'll be hearing a lot more from CIGNA in the coming weeks and months about how we can work together to engage consumers more effectively, and ultimately, improve the health and well-being and security of the people who depend on us.

For now, I want to thank you for your participation in our network and for the services you provide to CIGNA Behavioral Health patients.

# Provider Connection

CIGNA BEHAVIORAL HEALTH

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# A Commitment to Quality

In 2006, five Regional Operating Units of CIGNA Behavioral Health (CBH) managed behavioral health benefits for a monthly national average of 9,761,471 members in all 50 states and in the Virgin Islands and Puerto Rico. Benefit management included services through health plans, Preferred Provider Organizations, Employer Products, Medicare, Employee Assistance Programs, and Disability Programs.

2006 Membership Distribution				
California	Texas	Maryland	Florida	National Care Center
9%	10%	15%	16%	50%

Quarterly in committees, our Quality Management Program reviews key performance measures against established goals and standards to identify and address opportunities for improvement and to assure that each individual safely receives quality clinical care and service. Key performance dimensions evaluated include, but are not limited to:

- ✓ Appointment and Telephone Access
- ✓ Quality and Coordination of Care
- ✓ Clinical and Service Outcomes
- ✓ Complaint and Appeal Analysis
- ✓ Population Demographics, and Member and Practitioner Satisfaction
- ✓ Authorization and Claims Payment Turnaround Time
- ✓ Network Availability and Adequacy

Annually in written Quality Improvement and Utilization Management program evaluations, CBH evaluates the successes and challenges to improved care and service for members.

## Results for 2006

### Appointment Access:

Industry standards suggest that following a request for service:

- 80% of Routine appointments should be offered within 10 days,
- 90% of Urgent appointments within 48 hours, and
- 100% of Emergency appointments within 6 hours.

For CBH, Routine appointment access performance is assessed in annual satisfaction surveys of members based upon their experience when receiving care. Urgent and Emergent appointment access is measured using timeframes recorded in CBH's Information System during care management activity.

To encourage excellence, CBH strives to meet or exceed national industry performance averages that are published by the National Committee for Quality Assurance (NCQA). Our appointment access performance in 2006 was as follows:

- a. CBH's national score was 82% for Routine appointment access. All sites except the National Care Center (NCC) exceeded the 80% goal, though no Operating Unit scored a desired target of 85%.
- b. Every Operating Unit, and CBH nationally, exceeded the 90% performance goal for Urgent appointment access.
- c. The NCC, and the Glendale and Chesapeake Operating Units met the 100% goal for Emergent appointment access. While Tampa, and Dallas did not meet goal, their scores were 99.6% and 96.3% respectively. All Operating Units saw year-to-year improvement.

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To drive continuing improvements in 2007, CBH will encourage practitioners to voluntarily disclose appointment availability, practice specialties, and cultural, linguistic, or diversity information for CBH's Online Practitioner and Provider Directory and our internal database. Convenient access is provided through our web site, where members are encouraged to call CBH for assistance if they experience delays in getting appointments through our online directory. When cultural sensitivities and availability are known, access is made easier for members. Additionally, where appropriate, practitioners in CBH's Crisis and Intermediate Care networks are available to assure timely and effective urgent care. CBH has a 'Fast Certification' process to expedite inpatient admissions where Level of Care criteria are clearly met. Ongoing analysis of network performance will drive expansion of the network, as needed.

#### Telephone Access:

CBH's established national goals for a 30 second average speed of answer and a less than 5% abandonment rate are measured monthly and are identical for our separate Intake and Crisis lines, and for all product lines. In 2006, only the National Care Center and our After Hours services did not meet the established goal for Average Speed of Answer. All Operating Units and After-Hours services met the goal for Abandonment Rate.

In the later half of 2006, telephonic access performance declined temporarily as utilization management national operations were consolidated, the Tampa Operating Unit was closed and a single national team for Intake/Care Advocacy was created. To improve efficiency, additional staff were hired and trained. As a result, dedicated teams now handle provider and member calls separately.



#### Ambulatory Follow-up after Inpatient Discharge for Mental Illness:

Goals of 68% and 85% were not achieved at any Operating Unit. CBH worked to improve hospital discharge planning, to engage member appointments within 7 days following discharge, with intensive care management for high-risk cases. Improvements for appointments within 7 days of inpatient discharge were seen at the Tampa and Chesapeake Operating Units, while 30-day improvement was seen only in Chesapeake. Nationally, CBH success rate was 55% for appointments within 7-days, and 74.1% for appointments within 30-days of an inpatient discharge. A Six Sigma study found that Intensive Care Management has been highly effective to improve medication compliance, decrease medical and behavioral admission rates and the use of emergency room services.

#### Complaints and Appeals:

Nationally in 2006, the five most common categories of complaint were: Accessibility of Service, Attitude of Practitioner/Staff, Claim Status, Practitioner Balance Billing, and uneducated Practitioner/Staff. Complaints are tracked and trended continuously by CBH. Feedback is used to improve care and service whenever opportunities are identified. In 2006, 98% of all complaints were resolved within 30 days of receipt, and 87% of these were resolved with 1 day of receipt.

CBH strives to ensure that when medical necessity denials occur, they are appropriate. Annual analysis of appeal data includes examination of rates for medical necessity denials as a percentage of admissions, and for medical necessity appeals as a percentage of admissions. CBH works with network practitioners to reduce denials and appeals by creating a clinical partnership where requests for authorization share a common goal for appropriate, effective care.

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Compliance With Guidelines for Depression:

To monitor the effectiveness of psychopharmacological depression management, rates for practitioner contact, and for acute and continuation treatment are evaluated annually. The accepted benchmarks are the national 90th percentile performance scores published in NCOA's Quality Compass. Although CBH did not achieve these 90<sup>th</sup> percentile goals in 2006, all Operating Units achieved year-to-year improvements in the Acute treatment measure, and only Dallas Operating Unit did not see improvement on the Continuation phase measure.

To drive improvements in clinical practice, 44,416 medical and 5,232 psychiatric high-volume prescribers of antidepressants were mailed personal practice scores for compliance against guidelines, along with useful depression management tools that support clinical practice. In a fax-back survey to these practitioners, 76.5% of medical and 73.1% of psychiatric prescribers agreed that these steps would improve quality of care. Member education materials were also made available through CBH's web site and Care Advocacy Program. Additionally, screening for depression by medical and behavioral care management and in CIGNA HealthCare medical populations resulted in increased referrals to Preventive Health and Depression Disease Management Programs.

Engagement After Substance Abuse Detoxification:

CIGNA Behavioral Health measures initiation and engagement in treatment for Alcohol and Other Drug Dependency disorders using internal measures that mirror NCOA's HEDIS specifications. Due to a failure to include several key service procedure codes employed by CBH, the HEDIS specifications currently under-report our clinical activity. Goals were set at:

- 1) 58% for the percentage of adults diagnosed with alcohol or other drug dependence (AOD) who initiate treatment and at
- 2) 24% for the percentage of members who had two additional AOD treatments within 30 days after initiating treatment.

**CBH's internal scores for 2006 were as follows:**

Operating Unit	Tampa	Chesapeake	Dallas	Glendale	CBH Totals	Goals
Initiation	57.1%	56.0%	54.3%	51.9%	55.0%	58%
Engagement	17.8%	23.6%	20.1%	19.4%	20.5%	24%

Although no regional care center met the goals in this baseline measurement; drill down analysis of the data was performed and revealed that 67% of cases were diagnosed on the medical side but that those initially diagnosed on the medical side were less likely to initiate and engage in needed treatment than those initially diagnosed on the behavioral side. The highest percentage of members (25%) were first diagnosed with an AOD diagnosis during an emergency room visit; however, 90% of those failed to initiate treatment. The second highest percentage of members (23%) were first diagnosed with an AOD diagnosis during a medical office visit; however, 85% of those failed to initiate treatment.

To drive further improvements in 2007, CBH will intensively care manage these high risk cases, and will actively monitor initiation and engagement in treatment for those who, once identified, do not phone CBH to pursue and appointment.

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Member and Practitioner Satisfaction:

CBH administers the ECHO survey annually to measure member satisfaction. In 2006, scores for Access to Treatment exceeded NCOA national averages and demonstrated year-to-year improvement at three of five Operating Units. At all Operating Units, members reported fewer delays while awaiting treatment approvals and only Chesapeake Operating Unit did not exceed the NCOA national average in satisfaction for accessing care and information.

Practitioners are surveyed annually for overall satisfaction and for satisfaction with CBH processes for authorization, timeliness of response, and care management. In 2006 CBH was scored at statistically higher levels, when compared with 2005, for Overall Satisfaction and for Satisfaction with Timeliness of Response. Only the Dallas Operating Unit experienced increased satisfaction with the care management process, however beyond this, year-to-year Improvement was seen for all other scores in all Operating Units with only three exceptions. Tampa did not see an increase in overall satisfaction, and Tampa and Dallas did not see improvement in satisfaction with the authorization process.

Network Appropriateness and Adequacy:

Annual studies of geographical distribution, the match of the network composition with cultural and linguistic characteristics of those served, and the degree to which timely appointments are available, show that CBH's practitioner and provider network is able to meet the needs of those it serves. Target recruitment continues in 2007 for specific areas of need, including expansion of the crisis and intermediate care networks that respond to urgent care needs.

## Demographic/Geographic Updates

CBH would like to remind practitioners about the importance of keeping your address, telephone numbers, and email information up to date in our provider database. Incorrect phone numbers and outdated office addresses can have an impact on the referrals you receive, since members will be unable to contact you. An incorrect billing address can also create administrative difficulties that may lead to claim problems. Practitioners can submit demographic/geographic updates in several ways:

- On the web –You can access our Provider Information Update Form on the CBH website, under the Forms & Tools section. The form can also be accessed by clicking on the following link: <http://apps.cignabehavioral.com/web/basic/site/provider/customerService/providerInformationUpdateForm.jsp>
- By phone –You can also contact their local Provider Information Specialist and make the necessary updates telephonically.
- By email – You can forward any demographic updates and inquiries to [cforms@CIGNABehavioral.com](mailto:cforms@CIGNABehavioral.com).



## EAP Management Referrals: Procedures for Practitioners

The Management Referral process is a core component of CBH Employee Assistance Program (EAP). Managers and supervisors of our client companies refer employees whose job performance has declined. Examples of this include absenteeism, accidents, an EA Consultant, managers may refer the employees to EAP for evaluation. Below are guidelines for practitioners to follow when seeing these types of referrals.

### Meet with the Employee

- Complete a comprehensive assessment
- Formulate a plan to address the workplace performance issues and any areas that may be contributing to the problem. *Keep in mind that you have two 'clients' with an EAP Management Referral: the employee and the employer.*
- Inform the employee of your specific recommendations and let the employee know that those recommendations will be reported back to the employer. *No clinical or diagnostic information will be given to the employer.*
- If a referral is needed, provide the employee with the contact information for the referral resource. Obtain permission from the employee to communicate with the referral resource. *Follow up with the referral resource to verify initial compliance.*

### Contact the CBH EA Consultant with the initial update to include:

- EAP dates of service.
- Presenting problem.
- Diagnostic impressions.
- How are the workplace issues being addressed?
- Is the employee compliant with EAP process?
- Date of next EAP appointment.
- Recommendations or referral? Please provide a name and number for the referral source.
- Did the employee sign the CBH EAP Statement of Understanding?

### Update the EA Consultant regarding the employee's compliance

- Dates of subsequent EAP appointments.
- The employee's progress/compliance with the EAP process.
- If a referral was made, verification that the employee began attending the recommended treatment.
- Date that the EAP case was closed and any recommendations for continued treatment.

### Important Reminder to Practitioners

Do not communicate directly with the employer, suggest legal action against the employer, or complete any paperwork for the employee regarding return to work, disability, fitness for duty, etc.

### The EA Consultant obtains a signed release via the referring manager and provides the following information:

- Dates of EAP appointments attended or not attended.
- Date of next EAP appt.
- Any recommendations for services beyond the EAP. The information given to the employer is limited to the level of care, type of referral resource (inpatient, outpatient, etc.), and the name of the treating practitioner or facility.
- The employee's demonstrated compliance with the initial recommendations.

### EAP Claims Information

- Use CPT code 99404 for EAP claims.
- Claims can be submitted online at [www.cignabehavioral.com](http://www.cignabehavioral.com) or by mail to CBH at PO Box 46790 \* Eden Prairie, MN 55344-6270

## Psychosocial Treatment and Substance Use Disorders

Psychosocial interventions are the mainstay of treatment for substance use disorders. Although pharmacotherapies are important in some substance abuse disorders, psychosocial interventions are still often the primary method of treatment. In fact there are some substance use disorders such as cocaine and cannabis, where there are no pharmacological treatments with established efficacy for prevention or abstinence. In those substance use disorders like alcohol dependence where there are approved FDA pharmacotherapies, research seems to show that the utility of the pharmacotherapies for substance use disorders maybe limited unless they are delivered with adjunctive psychotherapy.

There are many types of psychosocial therapies that are used in the treatment of substance use disorders with some being more studied then others. The major therapies that have been studied are Cognitive Behavioral Therapy (CBT), Behavioral, psychodynamic and interpersonal therapy, and recovery-oriented therapies. Other therapies include MET (motivational enhancement therapy), group therapy, family therapies, brief therapies, self-help groups (also called mutual help groups), and 12-step-oriented approaches. Then there are the self-guided therapies, which are guided by written, programmed, or Internet based instructions. Hypnosis has been used in substance use disorders but mostly studied in smoking cessation where there is little scientific validation to support its effectiveness

No particular type of therapy has been found to be consistently superior when compared with other active psychotherapies. In fact even the comparatively brief psychotherapies appear to have durable effects among patients with substance use disorders. What is important to remember is that we do have different choices, which allows some flexibility in finding a treatment that best fits the member. Having different choices also allows room to consider changing to another type of psychosocial intervention when another treatment has not worked or is no longer suitable for the member. This can be done after a reassessment of the treatment plan. The APA guidelines mention that the member should be able to have input into the setting and choices of treatment.

Regardless of the type of treatment or setting used, one common finding is that retention in treatment improves outcomes. As in any other therapeutic relationship, the strength of the therapeutic alliance seems to be a significant predictor of psychotherapy outcome and treatment, leading to less substance use and better psychological functioning. Strong interpersonal skills on the part of the practitioner have also been shown to be a characteristic that is more likely to contribute to retention and reduced substance use.

It is suggested in the APA practice guidelines that, if relapse does occur, individuals should be praised for even limited success and encouraged to continue in or resume treatment. Practitioners can then help the member to analyze relapses as well as periods of sobriety from a functional and behavioral standpoint and use what is learned to adjust the treatment plan to fit the individual's present needs.

Additional resources, including participant and practitioner toolkits for use in treatment, can be found on CBH's website at: <http://apps.cignabehavioral.com/web/basicsite/provider/treatingBehavioralConditions/treatingBehavioralConditions.jsp>

The APA practice guidelines for substance use disorders can be found at <http://www.psych.org/>



# The Value of Intensive Care Management

It is common belief that certain clinical conditions require more intensive levels of care management. CBH philosophy of Care Advocacy argues that increased involvement should add value or improve care outcomes. Therefore, a one-year, Six Sigma quality improvement project was conducted to examine the impact of our Intensive Care Management program (ICM) on treatment and treatment adherence for members having complex behavioral conditions with medical co-morbidities.



The ICM program is the part of CBH's comprehensive Care Advocacy Program that focuses on members whose complex clinical behavioral conditions suggest high risk for hospital admission and readmission. Prior to instituting the ICM program, our examination of medical, behavioral and pharmacy data identified several diagnostic and demographic variables that may predict multiple readmissions. The CM program was developed to manage those variables through personal relationships with the member and with the care practitioner. The ICM empowers the member to take preventive action before their condition escalates to a higher risk.

The Six Sigma study compared results for a study group (n = 286) and a control group (n = 517) having similar behavioral and co-morbid conditions, and at least one psychiatric inpatient admission. The study was conducted after the ICM program was in place for one year. Three months pre-enrollment and three months post-enrollment data was examined for both groups. Interventions received by the study group included:

- Daily to weekly member contact with a care advocate who screened current symptoms and stressors, and who confirmed medical and behavioral appointment participation.
- Outreach to outpatient practitioners of care, at least twice monthly, to ensure compliance with, or discuss possible changes in, the treatment plan. Practitioner contact was also made whenever a higher level of care, increased symptoms, crisis, or medication side-effects were noted.
- Education and support, provided to members, family members, and practitioners of care.
- Assistance to coordinate behavioral and medical services.

Findings for the Six Sigma study included:

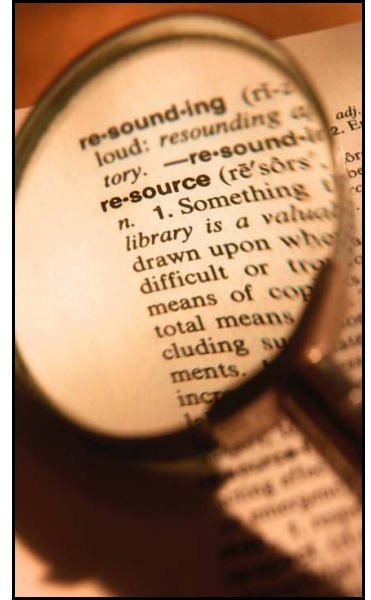
- An increase of 14.9% in medication compliance for the study group, compared to only a 2.9% increase for the control group. Medication compliance was defined as having a medication possession ratio of 80% or greater for the study period.
- Overall psychiatric admissions decreased by 53% for the study group, compared with an 11% increase in overall admissions for the control group.
- While medical admissions increased for both groups, the study group increased by only 6%, while the control group increased by 80%.
- Rates for readmission within seven days following an inpatient discharge was 14% for the study group versus 30% for the control group.
- Emergency room visits decreased 52% for the control group.

The ICM program clearly demonstrates value. It is one of the thoughtful innovations and effective solutions that CBH offers to customers and members to improve care and outcomes.

## CBH Practitioner Education Resources

CBH believes in a well-informed provider community. To achieve this goal, CBH has implemented the following provider resources:

- eBrief – This monthly publication includes a short article or announcement, which is sent to practitioners who have a registered email address with CBH. Starting on February 2007, the eBrief has been archived in the Provider Resources section of the CBH website. To access the eBrief archive, please click on the following link: <http://apps.cignabehavioral.com/web/basicsite/provider/newsAndLearning/eBrief.jsp>
- CBH Provider Guide – This valuable resource includes important information on care management guidelines, claim submission process, quality management, appeal process, and much more. The Provider Guide can also be found in the Provider Resources section of the CBH website, or by clicking on the following link: <http://apps.cignabehavioral.com/web/basicsite/provider/newsAndLearning/providerguide.jsp>
- Practitioner Orientations – This 45-minute teleconference is designed to give providers a general overview of CBH policies and procedures, such as the Care Advocacy Program, EAP referrals, Crisis/Intermediate Care referrals, Meet & Greet services, Coordination of Benefits, and more. Practitioners interested in attending an orientation can contact their local Provider Education Specialist, or submit an email to [ProviderEducation@cignabehavioral.com](mailto:ProviderEducation@cignabehavioral.com).



## Provider Self-Introduction

CBH practitioners are now able to market themselves online to members and shape the types of referrals they receive in their practice. With our Provider Self Introduction (PSI) initiative, you are able to add to your profile a short introductory paragraph about yourself and your practice. In addition, you also have the option to upload a picture to your profile. You can submit your Self Introduction online through the Forms & Tools section found in the CBH website, or by simply clicking the following link: <http://apps.cignabehavioral.com/web/basicsite/provider/toolsAndSupport/onlineTools.jsp>

**Please note:** You will be asked to enter your login ID and password prior to submitting your self-introduction online.

The following are guidelines and hints for writing the self-introduction.

- Describe your office: Is it handicap accessible? Does it have a private entrance? Is it in your home or commercial area?
- Share your practice style, i.e. goal-oriented, psychoanalytic, family therapy-based, etc.
- Include any unique office hours, i.e. you work on Saturday mornings or keep late evening appointments.
- Give members an idea of what to expect when they come to see you.
- Avoid clinical and/or professional jargon.
- There is no need to list your office address and phone number in the body of your self-intro as this information is provided on the front page of your profile.

If you have any questions regarding Self-Introductions feel free to contact a Provider Education Specialist at [ProviderEducation@cignabehavioral.com](mailto:ProviderEducation@cignabehavioral.com).

## Facts About Claims

Does claims processing seem like a waiting game? CBH strives to exceed the turn around time it takes to process a claim. CBH exceeds standards by processing 98% of claims within 10 days of receipt, and 99.5% of claims within 15 days of receipt. Before sending in the claim a second time, Claim status can be verified by checking on our web site: [www.cignabehavioral.com](http://www.cignabehavioral.com) or calling CBH at 800.926.2273.

One issue that practitioners often run into with a claim is having the claim be pended for Coordination Of Benefits (COB). CBH verifies COB information with the first claim submitted and then every 12 months unless change in status or plan is indicated. COB information needs to be obtained from the member on the plan. Practitioners can ask about other insurance at the first appointment. There is a COB form in the Provider Guide that the member can fill out and then can be submitted with the claim. As well, members can call CBH to update this information for faster claim processing—that number is 800.472.1680. Members are able to give this information through an automated phone system 24 hours a day. Refer the member to the number on their insurance card to ensure the benefit information obtained is the most current.

If there is other insurance coverage it is important to know which plan is primary. CBH can help the practitioner determine which plan is primary once the information is obtained from the member. If another insurance carrier is primary an Explanation Of Benefits (EOB) will need to be attached to the claim submitted to CBH in order to process. Obtaining the other insurance EOB is important as without this CBH is unable to ensure that the both the practitioner and member are paid at the highest level of payment available under the benefit plan.

## Preventive Health Program for Depression

At CBH's NCC, approximately 60% of all inpatient care and 50% of all outpatient care is for the treatment of depression. Changes in mood, motivation, and functioning associated with depression can be successfully treated in most cases. Untreated or inadequately treated major depression often requires inpatient care because of significant functional and cognitive disability and the risk of self-harm. Inpatient care may reduce symptoms or improve functioning, but resolution of clinical depression requires a period of ambulatory treatment with medication and psychotherapy. A failure to engage, or the premature cessation of, medication and outpatient psychotherapy increases the risks for recurrence.

Persons 19 – 44 years of age are the largest age group in the treatment population at the NCC. Recognizing that there is an 85 to 90 percent potential for improvement when individuals are properly treated with medication and psychotherapy, the NCC implemented this Preventive Health Program in 2004 and continues to work with those who Care Managers identify at the first inpatient admission for major depression (persons age 18 and over).

Interventions utilize mailings of information and tools specific to the diagnosis. These packets are mailed at a 30-day interval to those individuals identified. The first packet contains educational information and tools to support medication compliance and attendance at scheduled appointments. The second packet focuses on the continuation of treatment and depression relapse prevention. Members are also directed to additional diagnosis-specific resources on the CBH website. The information placed on the CBH website is available to the entire enrolled population and can also be useful to practitioners in their work with members diagnosed with major depression.

By providing information, tools, and resources, the program is a tertiary preventive health initiative having goals to:

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- Increase treatment compliance
- Limit functional and emotional deterioration
- Assist those in treatment for depression to understand their illness and to make good decisions about care. Provide information about staying well and reducing the risk of depression relapse.

The program also has a secondary preventive health focus with the goal to:

- Encourage early detection and treatment for those who experience depression.
- Provide access to an online self-assessment tool that may help to identify undiagnosed depression and the possible need for follow-up evaluation.

The 2006 review of this program demonstrates that case identification and communication is operating efficiently. The volume of members assisted, through the program interventions, is encouraging and affirms that the program is relevant for this high-risk population.

## Meet the EAP Service Coordinator Team

Every year CBH EAP delivers 1000s of wellness seminars and distributes EAP information during health fairs events at our EAP customer's sites. This is accomplished through our valuable network of specialty EAP practitioners. The Employer Service Coordinator (ESC) Team members interact with both the EAP customers and you, the specialty EAP practitioner, to ensure that all the details of the requested services are coordinated and delivered. Please take this opportunity to meet our team, which is located in Eden Prairie, Minnesota. Brief bios for each member are listed below.

**Sue W** - Wellness Education Manager, manages the Employer Service Coordinator team and the Education team. She graduated from the University of Minnesota-Twin Cities with a Bachelor of Arts degree in Psychology. She has been with CBH since February 1998 and began her career with CBH as a Personal Advocate. She has held a variety of positions within the organization and was a Personal Advocate Team Leader prior to managing the ESC team. Sue enjoys cooking, spending the weekends at her cabin, camping, being out in her boat, and trying her hardest to keep up with her two young sons.

**Marlin H** - has been employed at CBH since 1998. The first 4 years at CBH Marlin was a Personal Advocate and was an Employer Service Coordinator since 2002. Marlin currently coordinates wellness and management trainings for EAP customers in the Southeast U.S., Puerto Rico and the U.S. Virgin Islands. Marlin is married and has 2 children. Marlin is a graduate of the University of Minnesota-Twin Cities. His hobbies include - golfing, fishing, playing cards, and following his beloved University of Minnesota Golden Gophers football team. (Go Gophers Go.)

**Sara G** - has been an employee with CBH since June 2005. For her first year at CBH, she worked as a Personal Advocate performing client intake. Sara has been in her role as an Employer Service Coordinator since May 2006. She coordinates EAP wellness seminars and health fairs for the Northeast region. Sara grew up in Saint Paul, MN. She graduated from the University of Wisconsin-Madison with a B.S. degree in Psychology and a minor in Criminal Justice. In her free time, Sara enjoys traveling, watching movies, and spending time with family and friends.

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**Laura T** - has been with CBH since July of 2005. Initially, she began as Personal Advocate until her transition to Employer Service Coordinator in July of 2006 as the coordinator for the Western Region. Laura is a graduate of the University of Minnesota with a degree in Family Social Science. Some of her interests include cooking, being with family and friends, and enjoying a good laugh!

**Jessiy M** - coordinates for the Mid-Eastern Region, including Canada. She is originally from Silver Lake, Minnesota. She attended college at Saint Cloud State University where she received her Bachelor of Arts degree, with a Psychology Major and an English Minor. She currently is attending graduate school at the University of Minnesota Saint Mary's, where she is working towards her Master's degree in Counseling and Psychological Services. She started at CBH in February of 2006 in Advocate department. She is the newest addition to the Employer Service Coordinator team, as of March 2007. In her free time she loves to travel and has been to 5 different countries. She would love to have the opportunity to eventually travel the whole world.

**Sherrie B** - has been with CBH since March 2007 as a part-time Employer Service Coordinator. Before joining CBH she was a Retreat Director for Youth Frontiers where she, among other things, blew up balloons with her nose and hosted burping contests. Be sure to ask her about it. She attended the University of North Dakota on a volleyball scholarship and studied Psychology and Communications. Of all the daughters in the world, Sherrie and her husband, Rand, are blessed to have the best one — Francesca, 22 months. In her spare time, Sherrie enjoys making Frannie giggle by making up silly songs and performing interpretive dances for her.

## Quick Reminders

### Level of Care Guidelines

For medical necessity decisions, CBH uses objective guidelines founded in sound clinical evidence and applied based on individual need and an assessment of the availability of services in the delivery system. CBH's Level of Care Guidelines were updated and revised in 2006, with input from practitioners and providers.

The current CBH Level of Care Guidelines are available, free of charge, at <http://www.cignabehavioral.com>. From our home page, select 'are you a Provider?' then select 'Provider Resources'. From there, select 'Level of Care Guidelines'. If you are unable to access the Internet, you can contact your local Provider Education Specialist to request a copy.

### CBH Staff Availability:

Licensed behavioral health and substance abuse professionals, backed by physicians are available at CBH 24 hours daily, 365 days throughout the year to respond to emergencies, or to answer questions about and to perform utilization management. Whenever you phone CBH, you can now use dedicated provider call-routing options that connect you to a Provider Advocacy team established exclusively to assist with the clinical and non-clinical needs of our practitioners and providers. We can also be reached through our Web site at <http://www.cignabehavioral.com>. Whatever your needs, we are here when you need us.

## Tell us what you think!

If you have any comments, suggestions, or questions about the information on the Provider Connection Newsletter, please contact your local Provider Education Specialist. We would love to hear your feedback.

Email us at:

[ProviderEducation@CignaBehavioral.com](mailto:ProviderEducation@CignaBehavioral.com)



CIGNA Behavioral Health

## Winner



**2<sup>nd</sup> Consecutive Year!**

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