



Provider Report™

Congratulations on A Job Well Done!

The Member Satisfaction Survey results are in, and members have rated the services they received highly. CBH/IMHS asks members to tell us how they feel about you and your staff, if it was easy to get needed services, and if they have to wait a long time to get in to see you. For each question, a minimum of 86 percent of members rated you as meeting their needs. This is an improvement over last year's performance. CBH/IMHS also asked members if they had difficulty finding a provider with whom they could communicate in their preferred language. Most said yes, but we have room to improve in this area. When you are asked to update your profile this year, please pay particular attention to the languages you or your staff can speak so that we can direct members to you as needed.

Are We Doing Better?

In the last year, CBH/IMHS has been working to improve our performance in areas of importance to you. We invite you to take our Provider Satisfaction Survey and let us know how we are doing. Access the survey by visiting our website and clicking the link for the survey. Our network managers have also been given the provider satisfaction survey, if you prefer filling it out and mailing it back to us. Either way you choose to tell us, the important thing is to let us know if the changes we made have had a positive impact on you.



Dear Cenpatico Provider:

Welcome to the Spring Edition of *Provider Report*. At Cenpatico Behavioral Health (CBH), we are interested in your feedback! An article in this edition highlights how you can access our Provider Satisfaction Survey. We really want to know how you feel and how we can improve. Conversely, the results of the Member Satisfaction Survey are in and 86 percent of our members rated you as meeting the members' needs.

In this issue, CBH Medical Director Mark Konyecsni, M.D., continues his educational efforts by reporting on the early identification of PTSD in children. This is near and dear to our hearts as we roll out the Texas Foster Care product in April. Another important announcement is that the 2008 CBH Medical Necessity Criteria are available on our website. If you would like a copy mailed to you, please e-mail me at thamlin@centene.com. These criteria have added descriptions of our most frequently requested levels of care.

Other offerings in this edition are articles about appointment availability requirements, cultural competency and our quality program. This will be a year in which we audit actual medical records to assess the level of adherence to clinical practice guidelines. Please note the names and contact information of our senior management team members.

Please contact me at any time to make suggestions for future newsletters.

Sincerely,
Thomas A. Hamlin, M.D.
Vice President, Medical Affairs
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2 Early Identification
Of PTSD in Children

3 Resources to Develop
Cultural Competency

4 Fitting in Urgent
Patient Appointments

Watch for Early Signs of PTSD

Children exposed to trauma may or may not display symptoms of acute distress or manifest signs of longer-term post-traumatic stress disorder (PTSD), depending on their age. Symptoms of anxiety in children may present themselves in a variety of ways that appear like physical illness, including poor sleep, irritability/fussiness, frequent physical health complaints (headaches, stomach upset, etc.), poor concentration, loss of appetite, loss of energy and poor sleep. More severe signs of anxiety and exposure to trauma are impulsive anger outbursts, physical aggression and self-injurious behavior. The following information is presented to aid providers in early identification of this problem.

Assessing a child who may have been exposed to trauma is not easy, because it can create strong emotional reactions in the assessor. For this reason, it is important to follow a structured format. Key elements of assessing a child or adolescent for PTSD include:

1) Interview the parent, primary caregiver or caseworker to obtain the details of the trauma exposure (age at the time of trauma, chronicity), any other preceding or co-existing stressors, and major life disruptions or changes.

2) Assess the parent or caregiver's own reaction, understanding and impact of the trauma to the child to determine what support these individuals can offer for the child.

3) Interview the child to assess the presence of the DSM-IV symptoms of PTSD (re-experiencing, avoidant/numbing and increased arousal) and the occurrence of the symptoms in relation to the trauma. Additionally, it is important to obtain a description of the event, and understand what role the child played in the events and the impact of the event in the child's own words and point of view.

4) Evaluation for the presence of co-morbid disorders: ADHD, depression, self-abusive behavior, anxiety, panic attacks, substance abuse and conduct disorder.

5) After obtaining the appropriate releases, collateral information about the child's previous level of functioning and changes in level of functioning can be collected from other family members, caregivers or teachers.

6) Assess the need for additional evaluation/testing, such as cognitive testing, psychological evaluation or specialized medical evaluation.

To meet DSM-IV criteria for PTSD, the child's response to the trauma must include symptoms of re-experiencing, avoidance and increased arousal. The DSM stipulates that a child must exhibit one symptom of re-experiencing, three symptoms of avoidance/numbing, and two symptoms of increased arousal; however, one should focus on the intensity of the symptoms and the amount of dysfunction they cause. Re-experiencing symptoms can include repeti-

tive nightmares or dreams about the event, intrusive memories or distress when exposed to cues or triggers of the event. Younger children may play aggressively and demonstrate traumatic themes. Older children can experience the more classic "flashback," feeling as if the trauma was recurring. Avoidance of trauma stimuli can be manifested by avoiding thoughts, feelings, talking about the trauma, or anything that is a reminder of the trauma, or a complete denial of the event. Feelings of being "different" or misunderstood and a reluctance to participate in age-appropriate activities are common. Sleep difficulties; irritability or angry outbursts; difficulty concentrating; hyper-vigilance; and exaggerated startle responses are all signs of increased arousal.

Treatment of childhood PTSD should be individualized and based on the clinical presentation, acuity of symptoms and presence of co-morbid conditions. Different levels of care and treatment may be required for a single child at different stages of his or her disorder or in response to acuity of symptoms. No two children will be treated the same. The treatment for PTSD is multimodal and can include a combination of the following therapies:

1) Education of the child, parents, teachers and/or significant others regarding the symptoms, clinical course, treatment options and prognosis of childhood PTSD.

Being Culturally Competent

Numerous resources are available to help you and your staff.

2) Individual therapy (trauma-focused therapies, desensitization, supportive/insight oriented).

3) Cognitive behavioral therapy.

4) Behavioral therapy to address inappropriate behaviors that can follow abuse (sexually inappropriate behaviors, self-injurious, aggressive and other behavioral difficulties).

5) Family therapy to treat the impact of the trauma on the family, parenting training and behavioral modification.

6) Group therapy.

7) Psychopharmacology therapy.

In some cases, the use of antidepressant medication, mood stabilizers and additional medication may be useful to treat ADHD, impulsive aggression or self-abusive behavior.

It is important to remember that a child need not be directly exposed to physical or sexual abuse to have symptoms of PTSD. The trauma need only be “extreme” from the child’s point of view and produce intense feelings of helplessness, horror and intense fear. Very young children may witness an event capable of causing death or injury without experiencing many problems; however, threats of injury to a parent, caregiver or close relative can be a significant trauma. Additionally, it is important to understand the chronological and developmental age of the child at the time of the trauma.

A complete text of these guidelines can be downloaded at aacap.org/galleries/PracticeParameters/PTSD.pdf.

There is a lot of talk about cultural competency, with some states requiring their providers to take courses or continuing education classes in cultural competence. Cenpatico is responsible for ensuring that its behavioral health network providers are aware of the cultural diversity of the membership served and are competent in respectfully and effectively interacting with individuals who have varying racial, ethnic and linguistic differences. Cultural competence is a mindset that sees other cultures, languages and patterns of behavior and adapts care to them. The Department of Health and Human Services Office of Minority Health (OMH) offers insight into this topic. A Physician’s Practical Guide to Culturally Competent Care is a CME course that is available at no charge to you. Go to: cccm.thinkculturalhealth.org to get more information on this course as well as other general information on care that may be impacted by culture. Another resource is the National Association of Social Workers (NASW). NASW has an excellent website, www.naswdc.org/ce/default.asp, which provides information regarding NASW-approved cultural competency courses.

You can find the link for publications about mood disorders, a consumer’s guide

to mental health, and alcohol and drug use by using cccm.thinkculturalhealth.org. The OMH offers pamphlets that are targeted to consumers. Your office may benefit by having literature that is culturally competent in the waiting room.

On the website there are also publications in various languages free of charge on topics such as Real Men—Real Depression—It Takes Courage to Ask for Help. Help your patients access online resources for consumer health information in numerous languages, from Albanian to Vietnamese:

- National Network of Libraries of Medicine—Consumer Health Information in Many Languages Resources: nnlm.gov/outreach/consumer/multi.html
- The Stanford Health Library—Multilingual Health Information: healthlibrary.stanford.edu/resources/foreign/_intro.html
- 24 Languages Project—Consumer Health Brochures in Multiple Languages: library.med.utah.edu/24languages
- Health Information Translations—Quality Translations in Multiple Languages: healthinfotranslations.com/index.php
- Ethnomed—Patient Education Resources All Languages: ethnomed.org/ethnomed/patient_ed

Quality Program Summary Available A summary of the Cenpatico Quality Improvement Program for 2008 is now available. Each year Cenpatico develops a quality program that is focused on topics we want to specifically work on throughout the year. This year we are again focused on improving provider satisfaction, as well as several clinical initiatives. We will be checking practices that treat members with schizophrenia and depression to determine if we have best practices we can share with all of you. CBH and IMHS are also involved in the education of primary care providers. CBH/IMHS wants the member’s physical health doctor to understand the diagnosis and treatment of ADHD, management of perinatal depression and, especially for our foster care children, the signs and symptoms of Post Traumatic Stress Disorder. We invite you to request a copy of our quality program for your review through your network manager or directly through our quality department by calling (512) 406-7225.

Best Practices: Appointment Availability

Successful strategies for accommodating those last-minute, urgent patient appointments.

Many of us struggle to meet the appointment availability standards set forth in our contracts. One thing that has worked for some is the setting aside of a block of time each day to accommodate patients with urgent needs or those patients who have just been discharged from the hospital. One of our groups sets aside a 5 p.m. and 5:30 p.m. slot. Then, if no patients require those time slots, staff can go home early. Others apply the same concept but over the lunch hour,

setting aside time from 11:30 a.m. to 1 p.m. If the slot is not needed, you can always use the time to catch up on paperwork or to actually eat lunch! One more alternative to consider, though not as successful, is double-booking at select times of the day. Since you know that some patients will not keep their appointments, you can double-book at certain times. If your scheduler knows what times are available for double-booking, you shouldn't get too far behind if everyone shows up. No matter

what strategy you try, it is important that you find the time to accommodate those who need you the most. When a patient has a crisis and needs to be seen within a day, you risk losing him to the Emergency Department if you cannot see him. Just as important are patients who have been discharged from the hospital. They are especially fragile, and if you have seen them before they were hospitalized, they are likely to have a sense of comfort with you and want to see you again.

CBH/IMHS may test your appointment availability. When we call, we will ask if you can make room in your schedule for a newly discharged patient you have a history with and when you have room in your schedule for an urgent and a routine appointment. We will also ask for confirmation of your fax number and e-mail address.

We're Here to Help

We thought it would be good to let you know who our senior executives are and how to reach them. If you feel you are not getting the response you need, they can help.

- Sam Donaldson** CEOsdonaldson@centene.com
- Tom Hamlin M.D.** Vice President of Medical Affairsthamlin@centene.com
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Satisfaction Survey Available Online
 Please give us your opinion. Log on to our website at www.centenco.com and click the link for our satisfaction survey.



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