



Provider Report™

Dear Cenpatico Provider:

Welcome to the winter edition of *Provider Report*. At Cenpatico Behavioral Health (CBH), we have inaugurated a People, Commitment and Results employee communications initiative. This initiative emphasizes that CBH employees have a collective mission to provide better health outcomes for our members. With this newsletter we hope to promote our initiative by continuing to provide useful information for the behavioral health providers.

In this issue, CBH Medical Director, Mark Konyecsni, M.D., has written an article that summarizes identifying substance abuse issues for those members dealing with schizophrenia. He has several key references that fall within our adopted clinical practice guideline for schizophrenia. Claudia Sumrall, LCSW, Clinical Director, contributed the article describing the CBH Case Management Program.

Please be aware that the 2008 Cenpatico Behavioral Health Medical Necessity Guidelines will be posted on our website at cenpatico.com in late December. We review these annually per industry standards. Please e-mail any questions you may have once they are posted.

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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Medical Record Review Coming in 2008

In 2008 our quality department will begin reviewing a sample of records for both adherence to our Medical Record Guidelines and adherence to the American Psychiatric Association guidelines for Schizophrenia and Depression. Our medical record guidelines are consistent with good medical record keeping practices and include putting the name on each page in the record; legible writing; presenting problems; and medication documentation and assessment of imminent risk of harm. The guidelines are in your Provider Manual for reference.

The APA guidelines for Schizophrenia and Depression remain the accepted standard of care for these disorders. They include formulation of a treatment plan; educating the patient and family; and managing the symptoms with medication as applicable, then monitoring the patient for break-through symptoms. CBH has developed a tool for use in the auditing process. It will be shared with you if your records are selected for review. We plan to have our Network Managers and Provider Relations representatives come to your office at a time convenient to you to make copies of the records. They will send them to CBH for review. Once audited, you will receive feedback on your records as well as on the overall performance of all those reviewed during this process.

If you have questions about this process, please feel free to ask your Network Manager, or you can contact the QI Department by calling (512) 406-7200.

FAX NUMBER UPDATE Effective September 15, we have a new toll-free number for your OTR fax submissions. **Fax to: 1-866-694-3649.**

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3 Consider Dual Diagnosis For Schizophrenia

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CBH Uses a Systematic Approach To Quality Care

Case Management Program and the Ohio Outcomes Scales measure outcomes.

Centenico Behavioral Health (CBH) employs a case management/care coordination program, overseen by the Utilization Management Department, to assist in providing higher quality service to the members of Centene's health plans. The purpose of Case Management/Care Coordination is to reduce recidivism, improve treatment compliance and facilitate positive treatment outcomes through the proactive identification of members with complex or chronic behavioral health conditions that require coordination of services and periodic monitoring in order to achieve desirable outcomes. The emphasis of this program is on prevention of high utilization, enabling continuity of care and coordination of local mental and physical health services.

The Case for Integration

CBH is integrated into Centene's health plans and works cohesively with the medical management staff of these plans to provide primary and secondary support for the members enrolled in the health plan. Part of this support includes identification of behavioral health diagnoses and any subsequent acute care admissions or negative care patterns, recognizing psychiatric/medical co-morbidities and providing community support with many psychosocial triggers and problems. CBH staff have the ability to engage a gambit of members, including

those with significant physical and mental disabilities, as well as those with cultural or communication barriers that may make treatment within their local communities difficult. Integration with medical staff allows CBH to provide a supportive or consultative role to members whose mental health diagnosis may be secondary to a medical diagnosis, but may interfere with the full therapeutic benefit of any treatment or service they currently receive.

Measuring Quality and Quantity

To measure the efficacy of case management services, CBH uses the Ohio Mental Health Consumer Outcomes System. The benefit of using these Scales is that both quantitative and qualitative outcomes can be measured from the interpretation of this tool. The outcomes system requires the case manager or care coordinator to administer a specific and focused questionnaire, and scores the result using a universal scoring instrument. Using specific statistical equations, the results measure the member's current quality of life and levels of symptom distress (in adults) and problem severity, functioning, hopefulness and satisfaction (in children). The ultimate goal is to demonstrate numerical, traceable improvement in the quality of life and a decrease in the symptom activity for members diagnosed with severe mental health problems.

Five different Outcomes Scales

exist. The Adult Consumer Scales are administered to mental health consumers over the age of 18, and are used as a self-report of the consumer's mental health status. A series of Youth Scales are administered to the child consumer (under 18 years of age), the child's parent(s) and/or caregiver(s), and the child's community worker. The Worker Scale can be completed with any community-based worker currently engaged in the child's treatment. These three scales are scored individually, and can be analyzed separately or collectively to represent a full compliment of improvements in the child's behavioral or mental status.

The goal of CBH's Case Management/Care Coordination program is to improve the quality of life and enhance the quality of care for Centene's members and the community they engage with. Using tools such as the Ohio Mental Health Outcomes System allows CBH to show continuous improvement in the mental health of Centene's members. Through avenues such as consumer and provider outreach, community referral and advocacy, and fully integrated member engagement, the CBH Case Management teams continue to achieve high levels of quality service to the member's of Centene's health plans while showing marked improvements in the outcomes of treatment for the consumers they engage on a daily basis.

Clinical Practice Spotlight

Screen for substance abuse during treatment of schizophrenia.

Recent studies of Medicaid populations in five states show that individuals with co-morbid substance abuse and a severe Axis I disorder (Schizophrenia, Bipolar disorder) are a significant factor in increasing ER visits, and have reduced community stability compared to individuals with either a diagnosis of Schizophrenia or Bipolar alone or individuals with substance abuse¹. The symptomatology of Schizophrenia can be exacerbated by substance use, and substances can negatively affect the efficacy of antipsychotic medication². This article will summarize and address the issue of co-morbid substance abuse within the framework of the clinical practice guidelines for the treatment of Schizophrenia published by the American Psychiatric Association (APA)³.

How Dual Diagnosis Treatment Works

The APA describes two phases of treatment for Schizophrenia: the acute phase, and the stabilization/maintenance phase. Selecting substance abuse interventions appropriate to the individual's treatment stage is based on symptom status and phase of treatment and form the basis

of integrated dual diagnosis treatment (IDDT)⁴. In the acute phase of treatment, engagement and persuasion are important elements of IDDT and include outreach, assistance with personal needs, crisis intervention and assessment of the individual's mental illness and substance abuse disorders. This information, coupled with education on the effects of co-morbid mental illness and substance abuse and the need for change, can assist the affected individual in understanding and accepting the need for psychiatric treatment for stabilization and ongoing treatment. As the psychotic symptoms are brought under control, support services, structured activities, self-monitoring, cognitive therapy, social skills training, substance abuse recovery programs and contingency planning will help solidify the patient's progress and emphasize the negative interrelationship between substance use and symptom severity in Schizophrenia.

Relapse prevention in an important factor in the treatment of Schizophrenia, and ongoing treatment of the co-morbid substance abuse should be part of any treatment plan to address potential rea-

sons for medication noncompliance as well as increased side effects.

Because substances can produce or exacerbate psychiatric symptoms, screening for substance abuse should occur at both the initial and ongoing contact with a patient. Data indicates that a coordinated approach to the treatment of co-morbid substance abuse and severe mental illness such as Schizophrenia can be beneficial if it matches the individual's need and readiness for treatment.

References:

- (1) Clark, RE et al, *Psychiatr Serv*, Jul 58(7):942-8.
- (2) Green, AI et al (2007). *J Subst Abuse Treat Jun 14*.
- (3) *The APA guidelines for the treatment of Schizophrenia were published in 2004, and are available online at psych.org either in a full text or quick-reference PDF version.*
- (4) Brunette, MF et al (2006) *J Clin Psychiatry 67 Supplement 7; 10-17*.

Have You Noticed Us?

Something you or your staff may have noticed in the past couple of months is the friendly presence of your local network manager or provider relations representative.

As part of our goal to improve relationships with our provider network, our network management team has set out to visit all participating providers by the end of the year. We understand that you have to work with many different systems, and we want you to know that you have someone who can help answer questions about our system and avoid frustration. We appreciate your partnership in providing care for our membership. This is an excellent opportunity for you to provide us with feedback. We are always interested in hearing about what is working well and how we can improve.

Perinatal Depression: An Opportunity for Connections

Perinatal depression is a phenomenon that impacts many of our members. Poverty is a risk factor that increases the chance of becoming depressed while pregnant or in the postpartum period. Although members may be treated with antidepressants, therapy is a reasonable option and is often the member's treatment of choice. When treating a member for perinatal depression, you have the opportunity to integrate care with the member's obstetrician. Perinatal depression can be a contributing factor to premature birth and, in the postpartum period, can lead to poor bonding between mother and baby. Where do you start? When a pregnant member begins therapy, ask if you can contact her obstetrician and explain the issues that can result from depression. We all have a role to play in treating the pregnant member. Integrating these key roles serves the member and the new baby well.

The Power of Prevention

You can impact prevention.

Underuse of preventive health services is costing lives. A new report from the Partnership for Prevention estimates that if utilization rates of just five relatively low-cost preventive services were increased from current rates to 90 percent, more than 100,000 lives could be saved each year in the United States (see chart below).

Of the 12 preventive services included in the report, seven are used by half or fewer of the people who should be using them.

Use of preventive services is highest among Non-Hispanic whites and lowest among Hispanic Americans for 10 preventive services, including smoking-cessation assistance, colorectal cancer screening and pneumonia vaccination. Asian Americans rank the lowest in use of aspirin for prevention of heart disease and in screenings for breast, cervical and colorectal cancer. Increasing use of screenings for colorectal and breast cancer for people age 50 and older would save the most lives among African-Americans because of their higher mortality rates for those conditions.

PREVENTIVE SERVICE	CURRENT UTILIZATION RATE	LIVES SAVED ANNUALLY AT 90 PERCENT UTILIZATION
Daily aspirin taken by adults to prevent heart disease	Less than 50%	45,000
Smokers advised by healthcare professional to quit and offered assistance	28%	42,000
Up-to-date colorectal cancer screenings for people age 50 and older	Less than 50%	14,000
Annual flu shot for people age 50 and older	37 %	12,000
Breast cancer screening within past two years for women age 40 and older	67%	3,700

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