

ARTICLE 1

Screening for Adolescent Depression

Colorado has one of the highest rates of teen depression and teen suicide in the country. Mental health screening is recommended by the American Academy of Pediatrics, the American Academy of Family Physicians, the National Association of Pediatric Nurse Practitioners, the U.S. Preventive Services Task Force and the Institute of Medicine on all of our teenage patients each year. It is a required component of routine care for new plans under the 2010 health reform legislation.

The Patient Health Questionnaire Modified for Teens (PHQ-9 Modified) is a well-accepted questionnaire, used by many providers and health plans across the country. It can be used with patients between the ages of 12 and 18 and takes less than five minutes for them to complete. The PHQ-9 Modified can be administered and scored by a nurse, medical technician, physician assistant, physician or other office staff. Teens are more likely to truthfully answer questions about depression on a questionnaire than when asked the same question by a provider.

The PHQ-9 Modified was developed by the Division of Child and Adolescent Psychiatry at Columbia and is available for free. You can download the questionnaire and a guide for implementation in your practice at [teenscreen.org](http://www.teenscreen.org). There is a guide for implementing depression screening in your practice (<http://www.teenscreen.org/library/implementation-materials-fact-sheets#PC>). It also has a **guide for when to refer and how to get reimbursed** (<http://www.teenscreen.org/library/implementation-materials-fact-sheets#PC>). There are training tools for office staff also at (<http://www.teenscreen.org/library/implementation-materials-fact-sheets#PC>)

Cherry Creek Pediatrics (private practice) and Community Health Services (a school-linked clinic in Commerce City) have been using this tool at each adolescent well child visit and recommend it. **Also, they are billing a 96110 and receiving reimbursement from Medicaid.** This screening tool is being used by John Genrich at Cherry Creek Pediatrics. If you have questions, contact him at johnhgenrich@comcast.net

Where to refer a teen at risk for suicide

Of course, what we all worry about is identifying a teen who is at risk for suicide, then not being able to find a mental health provider to see the teen. For teens covered by Medicaid or CHP+, figure out the county the teen's Medicaid or CHP+ card was issued in and go to the CCHAP on-line manual or "quick link" to determine who to call to make the referral.

Uninsured or Under-insured Teens at Risk for Suicide

When a teen at risk for suicide has no insurance or has inadequate mental health coverage, contact Second Wind Fund (SWF). The mission of Second Wind Fund of Metro Denver is to decrease the incidence of teen suicide by removing financial and social barriers to treatment for at-risk youth. Learn more by visiting <http://www.swfmd.org/aboutfund.html> or calling 303- 988-2645

After you make the referral, SWF will:

1. After ensuring that the student is a suicide risk, lacks financial means to pay for therapy, and is not on Medicaid, SWF assigns the student a referral number. If the student is on Medicaid, he or she is first referred to the county mental health association.
2. The counselor initiates a referral with parental permission. After given a SWF referral number, the school counselor writes the referral number on a program referral form, signs the form, and gives it to the student and/or parents.
3. The referred student is given the referral form and a list of private therapists who have agreed to see SWF clients.
4. All therapists in the SWF program are private therapists who are licensed, maintain malpractice insurance, have experience with teens at-risk for suicide, and have agreed to see SWF clients at a drastically reduced hourly rate.
5. SWF will pay for a student to visit a program therapist up to 20 times. (Eight visits are automatically approved at the time of the initial referral. More visits require additional information.)

To contact someone in your area to make a referral of a teen at risk of suicide:

SWF Metro Denver (Adams, Arapahoe, Broomfield, Denver, Jefferson, Park Counties) – call 303-988-2645

SWF Four Corners Colorado -- Lillian Ramey --
Lillian@riversagecounseling.com (covers La Plata and Montezuma Counties)

SWF Boulder County -- Faye Peterson and Kathy Valentine –
fayepeterson@comcast.net and vastone2@hotmail.com (covers Boulder County)
720.212.7527

SWF Uncompahgre Plateau -- Kimberly Hamilton –
Kimberly.hamilton@westernalum.org (covers Montrose, Ouray,
and San Miguel Counties)

SWF Weld County – Keith and Shannon Wawrzyniak --
kpw@dynamicfamilydesign.com (covers Weld County)

SWF Eagle River Valley – Carrieann
Angrisani, page132@hotmail.com (covers Eagle County)

SWF El Paso and Teller Counties – Constance Gelvin, cvgelvin@aol.com (covers El
Paso and Teller Counties)

SWF Douglas County -- Lynn
Pender, secondwinddc@comcast.net (covers Douglas County) 303-895-0434

SWF Northeastern Colorado -- Maranda Miller and Jackie
Reynolds, maranda.miller@rural-solutions.org and [Jackie.reynolds@rural-
solutions.org](mailto:Jackie.reynolds@rural-solutions.org) (covers Sedgwick, Phillips, Yuma, Morgan, Lincoln, Washington, Logan,
and Kit Carson Counties)

ARTICLE 2

Modesty in Healthcare: A Cross-cultural Perspective

By Marcia Carteret, M. Ed.

Special thanks to Amy Sass, MD (Adolescent Medicine) and Erlinda DeLuna Elbaum of CCHAP for sharing their experiences, expertise, and ideas that informed the writing of this newsletter.

Studies have shown that obtaining accurate medical histories and diagnosing current symptoms can be adversely affected by a patients' concerns about modesty. Though these concerns are not exclusive to cross-cultural encounters, the most challenging situations do often arise because of differences in modesty mores between providers and their patients. Though initially our tendency is to think of modesty in fairly simple terms (i.e. covering the intimate body parts), cultural values around modesty can be far more complex. Therefore, expanding our assumptions about modesty is important to ensure successful cross-cultural interactions. This includes understanding the impact of acculturation and assimilation. To avoid stereotyping individual patients and family members, we may start by considering normative behaviors for *less acculturated* individuals first, but then we always expand our view and test our assumptions. We allow for a great diversity among human beings' values, beliefs, and behaviors.

Defining Modesty: *“Modesty is not just about covering up or wearing specific clothing. By definition, modesty is about respect. A provider who takes cultural modesty into account is someone who shows respect and caring in the highest degree.”*¹

Though we often associate modesty with the prescriptive doctrines of certain religions, modesty in many cultures often means showing *propriety in speech, dress, or behavior* and *lack of pretentiousness*. In many cultures, modesty demonstrates essential goodness in a person and is highly valued. Purity of thought and manners is as important as physical/sexual purity – and in fact the two are inextricably linked. In collectivist cultures where the family is the center of all loyalty, obligation and status, social approval is very important. Shame and honor are highly emphasized because a person's bad action dishonors their entire family, tribe, village, and so on. In a highly individualistic culture, this is lesser concern because a person's behavior reflects more on himself or herself.

In societies that place a high value on modesty, it is important for both sexes, but particularly emphasized for women. A woman's sexual purity and chastity honors her entire family. American women may view this as more discriminatory than protective. It is important not to assume that women in high-modesty cultures are forced to accept the restrictions placed on them by men. In fact, for many women in these cultures modesty is an attribute to be admired and attained. Women often impose modesty on themselves and other women as a way of keeping boundaries of privacy and respect.

In the majority of health care visits, a routine handling of modesty and privacy concerns suffices. However, sensitive interactions do arise for cultural and religious reasons. There are no hard and fast rules for handling these situations, but being prepared to ask culturally sensitive questions is important in reducing anxiety and stress for patients and

family members. Delicate situations require preparedness in the form of appropriate questions: After explaining what is usual in western medicine (drapes, closed doors and knocking before entering) asking **“Is there anything I should know about your privacy or modesty concerns before I conduct an examination?” Or, “In your culture, how would a doctor show respect for a female/male patient during the examination.”**

Modesty in Traditional Arab Culture: Strict cultural guidelines about modesty are very common in Arab cultures, especially among Muslims. The Islamic world view emphasizes the dependency of humans on God, and fear of God’s punishment tends to direct Arab Muslims to follow Islamic ethics. Modesty is stressed for both sexes, spiritually and physically. However, it is of greatest importance for Muslim women. Although there is considerable variation in the manner of dress and segregation of the sexes in different Arab countries, traditional custom dictates that women cover their hair, body, arms, and legs. This is a concern any time a woman might be seen by men who are not from her immediate family. Thus, special provisions should be made for female providers to examine Muslim women. Similarly, female nurses should be assigned, and a female nurse should always be present if a male doctor is treating a female Muslim patient. Some Muslim women may resist uncovering parts of the body not being examined. Opposite-sex medical interns, assistants and interpreters should be avoided. Sometimes a husband may ask to be present while his wife is being examined, and all efforts should be made to comply with his request. Muslim patients, both male and female, will appreciate privacy screens and consistency in closing examine room doors. They may be unsure about making direct requests for themselves about privacy measures, so being able to anticipate their needs will demonstrate real cultural awareness and sensitivity.

Finally, many Muslims believe it is forbidden to touch a member of the opposite sex outside their family and will resist shaking hands. However, others will shake hands (unless they have just performed cleansing rituals that precede prayer). The important thing to remember is to mirror the behavior you witness. If you offer your hand and the other person does not respond, do not take this as a personal insult. American women, especially, may feel rejected when an Arab male refuses her hand, especially if she is a doctor. She should not attach her culture’s meaning to this behavior. In general, healthcare professionals should avoid touching opposite-sex Muslim patients except when giving direct care. Such hesitation isn’t as necessary with a patient who is of the same sex.

The above discussion of modesty in Arab culture provides the normative values and behaviors of people who have recently immigrated and are not yet acculturated in the U.S. Many of the Arab American families in our community will not express these same concerns about modesty. It is important to ask questions of each individual patient/family to determine where they are along the assimilation continuum and how strictly they adhere to traditional customs and practices. The extremely modest Arab may be the exception in a provider’s experience, but it is important to be prepared to handle the exceptional case when it appears.

Asian Cultures and Modesty: In general, traditional Asian women place a high value on modesty and may be uncomfortable in health care interactions with male doctors. Even today, modesty is related to the relationship between genders specifically. Any overt display of affection in public between members of the opposite sex is unusual in parts of Asia, and even hand holding between men and women could be considered inappropriate unless they are married. This simple gesture of affection is more common between two women in China, for example, and does not in any way suggest a tendency towards homosexuality, which it might in American culture.

In China over 90% of obstetrical or gynecological providers are women which averts the problem of women's extreme modesty in health care interactions². In many Asian cultures, sexuality usually gets discussed within the context of marriage and child bearing only. Thus, sex is still a taboo subject in many parts of Asia. Parents and healthcare professionals may be reluctant to provide sexual information to young people in their families.

Traditionally, modesty and chastity are highly valued qualities in young Asian women who are taught to avoid premarital sex because it would tarnish their family honor. As Chinese and other Asians are exposed to western cultural values around modesty and sexuality, these attitudes change. Many highly acculturated Asian women have no objection to being examined by a male physician, are comfortable discussing their bodies, their sexuality, and reproductive health. The astute health care provider is aware of the spectrum of values, beliefs and attitudes and asks culturally sensitive questions of each patient to avoid stereotyping.

Modesty in Latino Cultures: As is the case in Arab and Asian cultures, acculturation is key to a person's attitudes and behaviors around modesty and privacy in Latino cultures. More traditional women who have recently immigrated from Mexico and countries in central and South America, for example, may be very modest, whereas the typical second or third generation Americans from the same countries will likely be much more relaxed in health care interactions. Religiosity can also be an important contributor to ideas about modesty; many Latinos are strict Catholics and may feel that modesty is an important part of being faithful to the church. Finally, among many Latinos the concept of modesty is closely connected to *respeto* and privacy. Latino cultures are collectivist with a strong sense of in-group belonging, interdependency and responsibility. Illness is often considered a very private family matter, and sharing private matters in front of strangers may be regarded as wrong. In more traditional Latino cultures, a doctor might be someone a family has established relationship with over many years. A doctor is thus a trusted member of the community who can be trusted with personal health matters. In American culture, patients expect a formal and detached relationship with health care professionals. We don't usually have close personal ties to our doctors and, for us, being open and less modest is easier with a professional we are unlikely to encounter outside the exam room.

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1. Andrews, C. 2006 Modesty and healthcare for women: understanding cultural sensitivities. *Community Oncology*. Vol. 3 No. 7 443-445

2. Mo, B. 1992 Modesty, Sexuality, and Breast Health in Chinese-American Women. *Cross-cultural Medicine – A Decade Later [Special Issue]* West J. Med Sept; 157:260-264

Additional Resources for this Article

1. Galanti, G. 2003 The Hispanic Family and Male-Female Relationships: An Overview. *Journal of Transcultural Nursing*, Vol. 14 No. 3 180-185
2. Lawrence P., Rozmus, C. 2001. Culturally Sensitive Care of the Muslim Patient. *Journal of Transcultural Nursing*, Vol. 12 No. 3 228-233
3. Hammad, A., Kysia, R., Rabah, R., Hassoun, R., Connelly, 1999 M Guide to Arab Culture: Health Care Delivery to the Arab American Community. *ACCESS Guide to Arab Cultur.* 1-32

ARTICLE 3

Practice Manager's Corner

The next Practice Manager's Meeting: Everything you need to know about obtaining **Federal Stimulus dollars to help fund meaningful use of an electronic medical record in your practice.** The head of Colorado's program will make a presentation and answer questions. The next Practice Manager's Meeting is Wednesday, July 21 at noon at Children's Hospital and it will also be available by webinar. Watch for details that will be sent by email to you

REMINDER: Billing Medicaid for 96110

Medicaid limits billing of screening code 96110 to ONE per patient per day. This code can be billed for developmental screening, ADHD screening, depression screening, etc.

New Medicaid Automatic Voice Response System (AVRS)

ACS will implement a new AVRS at the end of July 2010. The new system will still allow providers to retrieve client eligibility, claim status, and warrant information. The local number that is currently used, 303-534-3500, will be **disconnected** and all providers will be required to use the toll free number 1-800-237-0044. Providers will continue to be able to retrieve client eligibility through Faxback using the toll free number 1-800-493-0920.

Local Medicaid Provider Services Phone Number Will Be Discontinued

Beginning August 1, 2010, the local ACS Provider Services Call Center phone number currently used, 303-534-0146, will no longer be active. All providers will have to access the Call Center through the toll free number 1-800-237-0757.

Option for Submitting Medicaid Prior Authorization Requests (PARs) to the Colorado Foundation for Medical Care (CFMC)

CFMC is the authorizing agent contracted by the Department to process PARs for the following services for Medicaid fee-for-service (FFS) and Primary Care Physician Program (PCPP) clients:

- Durable Medical Equipment (DME) – limited to orthotics, prosthetics, power wheelchairs, power scooters, and miscellaneous DME
- Home Health – limited to EPSDT Extraordinary Home Health
- Medical/Surgical – as outlined in the monthly Provider Bulletins
- Out-of-state, non-emergent admissions and surgical services
- Physical Therapy (PT) and Occupational Therapy (OT)
- Diagnostic Imaging (effective August 1, 2009) – limited to non-emergent Computed Tomography (CT) Scans, Magnetic Resonance Imaging (MRIs), and all Positron Emission Tomography (PET) Scans
- Transportation – limited to non-emergent air ambulances, bariatric ground ambulances, commercial flights/trains, meals, and lodging

Beginning August 1, 2009, providers were given the option to submit PARs electronically through CFMC's Web Portal. Electronic submission allows the provider to view the PAR status through CFMC's Web Portal. Provider registration is required. Registration and submission instructions are available at <http://www.cfmc.org/copar/>. For additional assistance, please contact CFMC's PAR line at 1-800-333-2362 or 303-695-3300 ext. 3129.

Please note that faxing paper PARs to CFMC at 303-790-4643 remains an option.

New Medicaid Fee Schedule Effective July 1, 2010

<http://www.colorado.gov/hcpf> > Provider Services

Medicaid Provider Bulletins

Remember to review the monthly Provider Bulletins at:

<http://www.colorado.gov/hcpf> > Provider Services

ARTICLE 4

Provider Resource Helpline

Family Voices and CCHAP established a Provider Resource Helpline (PRH) to help you identify services and resources for chronically ill or special needs patients in your practice. The number to call is 1.877.731.6017. Our goal is to make your time with the patient and family more productive, focused and efficient.

The Provider Resource Helpline provides accurate, comprehensive and timely assistance to healthcare providers throughout the state of Colorado. Whether the family or child has commercial or public insurance, the PRH makes resource information and care coordination services available. The PRH considers physical, mental health, developmental disability, disability specific resources, health care coverage and oral health. The PRH offers referral and resource information regarding socio-economic, family education, public and private funding, Medicaid waiver, and family and community resources. For example, the Helpline can ensure that your patients gain access to case management, care coordination, education resources and advocacy groups, Medicaid waiver information, medical assistance grant funds and supports services for parents. Feel free to offer the Helpline to families directly and we will make sure we will get back to you to support the partnership between families and professionals. The number is 1.877.731.6017

ARTICLE 5

Apply Fluoride Varnish To the Teeth of Young Children ON Medicaid And Receive Generous Reimbursement

Cavity Free at Three is a statewide effort aimed at improving oral health in children and pregnant women. We are working with CCHAP to offer our program model to interested practices. Recent Medicaid and CHP+ guidelines allow primary caregivers to provide oral health counseling along with fluoride varnish application and receive reimbursement for these services. Medicaid will pay for two applications of fluoride varnish in the primary care office per year and two applications in the dentist's office. CHP+ has begun this month to pay for these services.

In order to participate, the medical provider as well as the staff members who will be involved in this care should complete online training through the Smiles for Life Curriculum. Simply visit <http://www.smilesforlife2.org>, and complete Module 2: Child Oral Health and Module 6: Fluoride Varnish. After the online process is completed, we can provide a site visit for a "hands on" demonstration and training, as well as follow up and support of our program.

We are in the process of coordinating training opportunities throughout the state of Colorado. As they are organized around the state, practices within the geographical area will be notified. This will allow for representatives from your group to attend trainings in your area. If you have questions about our program, please contact karen.savoie@ucdenver.edu or visit <http://cavityfreeatthree.org>. Thank you.

ARTICLE 6

For those children and their families in our practice with Autism...

Early diagnosis and treatment determines the best outcome for children with autism. A few options exist for your patients to gain access to early treatment.

An autism waiver exists in Colorado to provide Medicaid benefits in the home or community for children with a medical diagnosis of Autism who are most in need due to the severity of their disability. This waiver, specifically called the HCBS Children with Autism Waiver (CWA), exists to serve those children with autism that have intense behavioral needs placing them at risk of institutionalization. As this is a waiver, parental financial resources or income for eligibility is not considered. The waiver uses the child's income and resources, independent of the parent(s). Parents may access this waiver through the child's community centered board, the county-specific agency responsible for services for the developmental disabilities population. The autism waiver serves children under the age of six; however, there is a wait list. The waiver covers Applied Behavioral Analysis (ABA) therapy. ABA is the only method of treatment supported by the American Academy of Pediatrics for the treatment of autism, including the U. S. Surgeon General.

As of July 1, 2010, SB 244, or HIMAT - Health Insurance Mandated Autism Treatment - becomes in effect for the autism community in Colorado. While the law takes effect July 1, individual insurance policies and benefits become effective only on their renewal date of the policy. Therefore, if a patient has a policy that renews January 1, 2011, the new benefits under HIMAT would only take effect then, and not July 1, 2010. HIMAT mandates that insurance companies provide coverage for the assessment, diagnosis and treatment of Autism Spectrum Disorder (ASD), no longer classifying ASD as a mental illness or condition. The law defines what type of coverage is required for the treatment of ASD, including ABA therapy; therefore, insurance plans will be able to cover more therapies for Autism. The law allows for unlimited speech, physical and occupational therapy. As you consider this information, however, please remember that the HIMAT mandate is valid **only** for fully funded commercial insurance plans, originating in Colorado. Self-funded plans, known as ERISA plans, are not privy to the same rules outlined by the Colorado Division of Insurance - Department of Regulatory agency (DORA). Additionally, the public insurances of Medicaid (unless on the Autism waiver) and CHP+ will not cover ABA therapies.

For more resources or questions, please call Colette Christen at the Provider Resource Helpline at 877.731.6017 or 303-733-3000x105.