

Health Plan Performance Improvement Project (PIP)

CoventryCares of Kentucky

Major Depression: Antidepressant
Medication Management and
Compliance
PIP Part IV: Final Report - 92

Submission to:
Commonwealth of Kentucky
Department of Medicaid Service

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MCO and Project Identifiers

1. **Name of MCO:** CoventryCares of Kentucky

2. **Select the Report Submission:**
 - PIP Part I: Project Proposal Date submitted: November 16, 2012
 - PIP Part II: Baseline Report: Date submitted: September 1, 2013
 - PIP Part III: Interim Report : Date submitted: September 1, 2014
 - PIP Part IV: Final Report: Date submitted: September 1, 2015

3. **Contract Year:** 2012/2013/2014

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5. **Title of Project:** Major Depression: Antidepressant Medication Management and Compliance

6. **External Collaborators** (if any): NA

7. **For Final Reports Only:** If Applicable, Report All Changes from Initial Proposal Submission: NA

8. Attestation:

The undersigned approve this PIP Project Proposal and assure their involvement in the PIP throughout the course of the project.

Steven Goldberg MD
Medical Director

Therese Hughes PhD, RN
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IA Director (when applicable)

Michael Hest
CEO

DMS Proposal Approval Date 12/21/2012 per email

DMS Signature Stephanie Pataken Nurse Consultant Inspector
(JANUARY 3, 2013)

Regarding PIP for MAJOR Depression: antidepressant medication Management and Compliance.

Abstract

1. Project Topic / Rationale / Aims

Depression is a condition in which a person feels discouraged, sad, hopeless, unmotivated, or disinterested in life in general. But when such feelings last for more than two weeks and when the feelings interfere with daily activities such as taking care of family, spending time with friends, or going to work or school, it's likely a major depressive episode. Major Depression is a mental illness that can be costly, debilitating to sufferers and could adversely affect the course and outcome of common chronic conditions. An Estimated 1 in 10 U.S. adults report depression (2). According to the National Center for Health Statistics (3), Kentucky (KY) ranks as one of the worst in the nation for prevalence and seriousness of depression (49th out of 50).

HEDIS® measure included a 2% point increase from the baseline to interim year one. This was met, surpassed, and revised to exceed the 90th percentile in both phases (which began in the 25th and 50th percentiles) for the 2nd interim year. The second Aim was to meet the overall plan MPR goal of .80 when our baseline was .68. Both Aims and goals were met by CoventryCares.

2. Methodology

CoventryCares believes that HEDIS measures and systems provide the best data and reports available to us. To measure success, CoventryCares defines our PIPs on topics that include HEDIS measures, when available. The AMM HEDIS® measure includes two sub-measures that CoventryCares will focus on. The first sub-measure is the Acute Phase and looks at member compliance within the first 12 weeks of receiving a prescription for antidepressant medications. The second sub-measure is the Effective Continuation phase focused on 6 months adherence to their prescriptions. Outreach was focused on members that were non-compliant in the Effective Continuation Phases.

In addition to our HEDIS® measure, we will analyze the medication possession ratio (MPR) which calculates member compliance. The MPR is defined as the number of days that the medication was dispensed divided by the number of days the medication was actually prescribed. This report is pulled quarterly and is based on a 12 month rolling period.

3. Interventions

The main interventions were targeted at members that were non-compliant in the effective continuation phase to assist in providing educational materials, linguistic and cultural assistance as well as transportation help. CoventryCares also provided

reminders in October of both interim years to members that were still showing as non-compliant in the Effective Continuation phase. Provider outreach was also completed for the top 650 prescribing physicians, which accounted for only 20% of the physicians but 68.50% of the members that were prescribed antidepressants. CoventryCares and MHNet prepared tracking systems for member outreach with MHNet providing additional materials to members. Other interventions included multiple member newsletters as well as website updates for both members and providers.

4. Results

Between the baseline year of 2012 and final year of the PIP in 2014, there were substantial increases in both the antidepressant medication management (AMM) HEDIS® measure population (10x the amount) and compliance rates. CoventryCares efforts produced such a large improvement during 2013 that the goal was raised from a 2% increase over the 2012 baseline rates to a goal of surpassing the 90th Percentile NCQA Benchmark. Baseline benchmarks for the AMM acute phase results were in the NCQA 50th percentile and the effective continuation phase was rated even lower being in the 25th NCQA percentile. CoventryCares is happy to report that we achieved the 90th Percentile NCQA Benchmark for both measures in 2014. The large increase in the effective continuation phase is especially encouraging as it shows that our member population is staying compliant in their medications for a longer period of time. The Medication Possession Ratio (MPR) 12 month plan rate also saw a large increase and surpassed our goals. The large increase of new members in January 2014 saw a negative effect of the 12 month MPR rate, as the 1st quarter rate was just .75. With all of the new membership involved, we feel that a .90 in 2014 showed excellent progress within our membership.

5. Conclusions

CoventryCares believes that the great increases in our rates (25th and 50th percentiles to both being in the 90th percentile) are direct results of the resources made available to our membership through our website postings, newsletters and educational packets as well as our continuous outreach and dedicated follow up efforts made by quality management (QM) and MHNet. Our goal was to provide the same level of attention to all members regardless of demographic classification and the size of the AMM measure allowed us to do so. CoventryCares is very proud of our progress and the assistance provided to increase the compliance and behavioral health of our membership throughout the life of this PIP. As our systems and processes are in place and have proven successful, CoventryCares will continue our efforts on this topic as a focus study.

Project Topic

1. Project Topic

Changes/Updates to Project Topic in Final Report

- None

Depression is a condition in which a person feels discouraged, sad, hopeless, unmotivated, or disinterested in life in general. But when such feelings last for more than two weeks and when the feelings interfere with daily activities such as taking care of family, spending time with friends, or going to work or school, it's likely a major depressive episode. Major Depression is a mental illness that can be costly, debilitating to sufferers and might adversely affect the course and outcome of common chronic conditions. Major depression also can result in increased work absenteeism, short-term disability, and decreased productivity. Episodes of major depression effects individuals, families, workplaces and communities. In the U.S., an estimated 14.8 million Americans experience major depression in a given year. Major depression can also adversely affect the course and outcome of other chronic conditions such as asthma, arthritis, cancer, cardiovascular disease, diabetes and obesity (1).

An Estimated 1 in 10 U.S. adults report depression (2). According to a the National Center for Health Statistics (3), Kentucky (KY) ranks as one of the worse in the nation for prevalence and seriousness of depression (49th out of 50). In addition, KY ranks high (34th out of 50) in suicide rates. Major depression can appear as anger and discouragement, rather than feelings of sadness leading to violent behavior and suicide (4). Major depression is a common and treatable disease and antidepressants are usually an effective treatment for adults (4, 5, and 6). Children and adolescents have more risk factors associated with anti-depressant therapy (4, 5), so for the purpose of this PIP we will focus on the adult population, members 18 years of age and older.

2. Rationale for Topic Selection

Changes/Updates to Rationale in Final Report

- Updated NCQA 90th Percentile rates
- Removed note regarding the percentage of members that are “compliant” in having a $\geq .80$ MPR as this was confusing and not relevant to the overall rate or rationale
- Moved more detailed description of MPR to the “Performance Indicators” section.

In 2009, 49.6% of Medicaid members, 18 years of age and older, who were diagnosed with a new episode of major depression, were treated with antidepressant medication for a specified time period. This was in comparison to 62.9% of individuals 18 years of age and older who were covered under commercial HMO health plans being treated with antidepressant medicine (7). Studies have shown that improved mental health equates to improved physical health. The use of proper antidepressant therapy for new episodes of Major Depression is proven to decrease the length and severity of the episode; therefore, impacting physical health less dramatically (1, 2, 7).

Studies show that depression affects White Non-Hispanic females more than males, the prevalence of major depression increases with age, from 2.8 percent among persons aged 18-24 years, to 4.6 among persons 45-64 years, but declined after age 65 to 1.6 percent. Women were significantly more likely than men to report major depression (4.0% versus 2.7%), as were persons without health insurance coverage compared with those with coverage (5.9% versus 2.9%). African Americans' (4.0%), Hispanics (4.0%), and non-Hispanic persons of other races (4.3%) were significantly more likely to report major depression than non-Hispanic whites (3.1%). Persons with less than a high school diploma (6.7%) and high school graduates (4.0%) were more likely to report major depression than those with at least some college (2.5%). (1, 7)

The article *Racial/Ethnic Differences in Rates of Depression Among Preretirement Adults*, (8) reports major depression and factors associated with depression were more frequent among members of minority groups than among Non-Hispanic Whites. Elevated depression rates among minority individuals are largely associated with greater health burdens and lack of health insurance, factors amenable to public policy intervention. African Americans and Hispanics exhibited elevated rates of major depression relative to Non-Hispanic Whites. Major depression was most prevalent among Hispanics (10.8%), followed by African Americans (8.9%) and Non-Hispanic Whites (7.8%).

CoventryCares of KY membership seems to follow this same pattern except that many more Non-Hispanic Whites report depression than African Americans. Currently, CoventryCares of KY shows current members with behavioral health claims of all diagnosis at approximately 150,000 members. Members diagnosed and being treated for major depression equal approximately 6,000. Of these, 74 percent are female, 86 percent are Non-Hispanic White and 88 percent are over 18 years of age. There are approximately 18,000 members treated with antidepressant medication. This suggests these members are being treated for depression other than major depression, or off-label uses.

The State of Health Care Quality 2010 HEDIS® Measures of Care (9) report indicates that depression affects approximately 14.8 million Americans, and if untreated, can lead to other physical/mental health conditions. Evidence-based

guidelines, including those of the American Psychiatric Association, recommend use of antidepressant medication and behavioral therapies (at the primary care level) to treat depression. The report also includes the following facts about antidepressant management:

- For the past 50 years, antidepressant medication has proven to be effective—especially for patients with more severe symptoms.
- Among patients who initiate antidepressant treatment, one in three discontinues treatment within one month, before the effect of medication can be assessed, and nearly one in two discontinues treatment within three months.
- Medication maintenance helps ensure that evaluation and improvement continue. More than 50 percent of patients discontinue antidepressant medications during the maintenance phase (i.e. after one month but before six months). Premature discontinuation of treatment is associated with higher rates of depression relapse and major depressive episodes.
- Follow-up visits to assess patient understanding and compliance with medication are critical components of a successful care plan. The purpose of the follow-up visits is to adjust medication dosage, monitor side-effects and identify suicidal ideation or worsening of suicidal thoughts. Additionally, follow-up visits help to assess patient understanding and compliance with the prescribed care plan.

The Case for Improvement

- Depression, emotional disorders and anxiety rank among the top five most costly diseases. The average cost per case is \$1,646.
- One study by Kaiser (7) showed that patients who discontinue antidepressant treatment within six months accumulate \$432 in higher medical costs per year than adherent patients. Major depression accounts for 48 percent of lost productive work time, translating to over \$30 billion lost per year.

CoventryCares of KY's major focus for this PIP is that our members are being diagnosed and effectively treated for major depression and to become an active and productive member in their community. As stated initially, depression is a behavioral health illness that is costly and debilitating to sufferers and may adversely affect the course and outcome of common chronic conditions such as asthma, arthritis, cancer, cardiovascular disease, diabetes and obesity.

Depression results in increased work absenteeism, short-term disability, and decreased productivity. It not only affects individuals, it affects families, workplaces and communities. The medical literature reports that major depression can be treated effectively with anti-depressant medication. Best practice guidelines are in place (1, 2, 8).

For the purpose of this PIP, we will focus on Major Depression for adults and compliance with anti-depressant medication treatment and management as prescribed by their primary care provider. The 2014 NCQA Quality Compass 90th Percentile national benchmark and threshold for members being treated with anti-depressant medication is 59.22 percent for members in the acute phase (treated for at least 12 weeks), and 44.08 percent for members in the continuous phase (treated for at least 6 months).

The Medication Possession Ratio (MPR) is a numerical indication of medication compliance as a decimal value. It is derived by dividing the number of days a medication was dispensed by the number of days the medication was prescribed. In order to be considered compliant the members MPR must be 0.80 at minimum. The 2012 MPR baseline for CoventryCares eligible members over eighteen (18) years of age is 0.68.

3. Aim Statement

Changes/Updates to AIM Statement in Final Report

- Cleaned up AIM Statements/updated goals

1. Initial AIM Goal: Will provider and member education regarding major depression increase compliance with antidepressant medication by 2% over the base-line measurement as defined by HEDIS® data for the acute and effective continuation phases?

Updated AIM Goal after 1st Interim Year when the initial goal of a 2% increase was surpassed: Will provider and member education regarding major depression increase compliance with antidepressant medication by 2% over the interim year 1 measurement as well as surpass the Quality Compass NCQA 90th Percentile Benchmark as defined by HEDIS® rates for the acute and effective continuation phases?

2. Will provider and member education lead to a compliant medication possession ratio (MPR) of 0.8 or greater?

Methodology

1. Performance Indicators

Changes/Updates to Performance Indicators in Final Report

- Updated the MPR definition in an effort to show that this method of measurement is standardized and clear. To also assist in consistency, any MPR reference will be solely based on the previous 12 months MPR as this is what the baseline of .68 was calculated from. Any references regarding percentages of “compliant” members being above .80 have been removed from this report.

This PIP will focus on the antidepressant medication management (AMM) HEDIS® measure. Within this measure, there are two sub-measures identified.

Effective Acute Phase Treatment:

Denominator: All CoventryCares members eighteen (18) years of age or greater during the measurement year who have met the continuous enrollment criteria that have been identified by the Anti-Depression Medication Management (AMM) HEDIS® Measure. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). The anchor date is December 31st of the measurement year.

Numerator: The number of members having met the inclusionary criteria for the denominator who have been identified as having undergone at least **84 days** (12 weeks) of continuous treatment with antidepressant medication (Table AMM-C) during the 114-day period following the IPSD (Index Prescription Start Date: The earliest prescription dispensing date for an antidepressant medication). The continuous treatment allows gaps in medication treatment up for a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. There may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

Exclusions: There are no exclusions.

Effective Continuation Phase Treatment:

Denominator: All CoventryCares members eighteen (18) years of age or greater during the measurement year who have met the continuous enrollment criteria that have been identified by the Anti-Depression Medication Management (AMM) HEDIS® Measure.

To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). The anchor date is December 31st of the measurement year.

Numerator: The number of members having met the inclusionary criteria for the denominator who have been identified as having undergone at least **180 days** (6 months) of continuous treatment with antidepressant medication (Table AMM-C) during the 231-day period following the IPSD . Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. There may be no more than 51 gap days. Count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days).

Exclusions: There are no exclusions

Table AMM-A: Codes to Identify Major Depression

Description	ICD-9-CM Diagnosis
Major depression	296.20-296.25, 296.30-296.35, 298.0, 311

Table AMM-C: Antidepressant Medications

Description	Prescription
Miscellaneous antidepressants	• Bupropion • Vilazodone
Monoamine oxidase inhibitors	• Isocarboxazid • Selegiline • Phenelzine • Tranylcypromine
Phenylpiperazine antidepressants	• Nefazodone • Trazodone
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide • Fluoxetine-olanzapine • Amitriptyline-perphenazine
SSNRI antidepressants	• Desvenlafaxine • Venlafaxine • Duloxetine
SSRI antidepressants	• Citalopram • Fluoxetine • Paroxetine • Escitalopram • Fluvoxamine • Sertraline
Tetracyclic antidepressants	• Maprotiline • Mirtazapine
Tricyclic antidepressants	• Amitriptyline • Desipramine • Nortriptyline • Amoxapine • Doxepin • Protriptyline • Clomipramine • Imipramine • Trimipramine

Medication Possession Ratio:

In addition to our HEDIS® measure, we will analyze the medication possession ratio (MPR) which calculates member compliance. The MPR is defined as the number of days that the medication was dispensed divided by the number of days the medication

was actually prescribed. The patient population is defined as eligible members over 18 years of age with a diagnosis of major depression currently on anti-depressant medication(s). Members considered compliant with their medications have a greater than 0.8 MPR. Due to claim lag and the amount of time it takes to process this report the MPR data is generated quarterly. The MPR is a standardized calculation based off of the most recent 12 month period. This report will be pulled and reviewed quarterly. To clarify, the 2nd quarter 2014 MPR would be based off of data from the previous 12 month period dating from July 2013 (the beginning of the 3rd quarter 2013) – June 2014 (the end of the 2nd quarter 2014). MPR rates considered “final” for a measurement year will be for the 12 month period of January-December of the given calendar year. The MPR calculation is a standardized measure and will be used for analysis and reporting purposes only.

2. Procedures

Changes/Updates to Procedures in Final Report

- Included note that due to unreliability of race/ethnicity data from our systems we were unable to provide additional breakdowns and focuses.

Data collection must ensure that data collected on PIPs are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Administrative data is loaded into the Catalyst HEDIS® software in accordance with HEDIS® specifications. For the PIP, administrative data collection will be utilized through a programmed pull from claims and encounters, per the HEDIS® specification. Full detailed demographic breakdowns and analysis is done annually when the final rates and measures are released as data is collected for a calendar year for this HEDIS® measure. No sampling data will be utilized. Our HEDIS® administrative data includes three months of claims run-out after year-end. Study indicators HEDIS® rates are calculated by the Quality Spectrum Insight (QSI) software, which was formerly Inovalon. Measurements will be made in the baseline period for each study indicator with each re-measurement period and reported at the 95% confidence level with a confidence interval of 5. CoventryCares of Kentucky will analyze the data using the NCQA Quality Compass benchmark percentiles. The aim of this project is to obtain year to year improvement. The Acute and Effective Continuation Phase compliance data is collected on a monthly basis and this data comes from QSI (Quality Spectrum Insight – formerly Inovalon) from the HEDIS® AMM (Anti-Depression Medication Management) Measure. Our analysis of the data will also include year over year evaluation. Race and ethnicity data capture our systems were unreliable and unusable for analysis. In 2014, the data received on the DMS HIPAA 834 file noted 77.28% of our population as “Other.” CoventryCares reached out to the DMS for a reason for this large discrepancy regarding race in the DMS HIPAA 834 file and an explanation was received indicating the method of collection for race on the Kentucky Health Benefit Exchange had changed and therefore impacted race data for all of Medicaid.

3. Member Confidentiality

Changes/Updates to Member Confidentiality in Final Report

- None

CoventryCares of Kentucky will utilize administrative data for the source of PIP data. The reported information will be in summary or an aggregate format to protect member health information. In the event protected health information is utilized that information would be de-identified. CoventryCares will consider the health information de-identified after removing the identifiers, as long as there is no knowledge that the information stripped of these identifiers could be used, alone or in combination with other information, to re-identify the member/individual.

Identifiers include the following:

- Names.
- All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip codes if the geographic unit formed by combining all the same three initial digits contain less than 20,000 people.
- If zip code area contains fewer than 20,000 people then change to 000.
- All elements of the dates (except year) for dates directly related to an individual, including birth date, admission date, and discharge date.
- Date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older.
- Telephone numbers.
- Fax numbers.
- Electronic mail addresses.
- Social security numbers.
- Medical record number.
- Health plan beneficiary numbers.
- Account numbers.
- Certificate/license numbers.
- Vehicle identifiers and serial numbers, including license plate numbers.
- Device identifiers and serial numbers.
- Web Universal Resource Locators (URLs).
- Internet Protocol (IP) address numbers.
- Biometrics identifiers, including finger and voice prints.
- Full face photographic images and any comparable images.
- Any other unique identifying number, characteristic, or code.

4. Timeline

Changes/Updates to Timeline in Final Report

- Updated to match 2014 PIP template format

Baseline Measurement Period: January 1, 2012 – December 31, 2012

Baseline Measurement Report: September 1, 2013

Interim Period: January 1, 2013 – December 31, 2013

Interim Period Report: September 1, 2014

Final Measurement Period: January 1, 2014 – December 31, 2014

Final Measurement Report: September 1, 2015

Interventions/Changes for Improvement

1. Barrier Analyses

Changes/Updates to Barrier Analysis in Final Report

- Updated to match 2014 PIP template format
- Updated/improved barriers to be more in line for what they are meant to focus on
- Provider barrier based on that they “lack knowledge” was an incorrect statement on previous reports. This has been clarified to note that a barrier is that the provider may not take the time to provide knowledge to the patient

Category of Barrier	Target Group	Description of Barrier	Method of Identification
Lack of Knowledge/Compliance	Member	Members may have issues with knowledge/compliance due to: - Lack of education/understanding what they have been prescribed and the instructions that go with it - Linguistic/cultural barriers - Members may “feel fine” and do not feel the need to continue and do not understand the problems that discontinuing their medications may have	Member feedback Pharmacy Department MHNet QMAC/QMUM/Provider Forums HEDIS® Measures
Lack of Communication	Provider	The Medicaid population is typically an undereducated one and the patient may leave the office/pharmacy with out being fully aware of their instructions, health factors, importance of staying compliant with their medications, etc... Feedback from CAHPS reports and from MHNet show that many times members feel that the doctor does not take the	Member Feedback MHNet CAHPS Survey Reports

		time to fully educate the members on their treatments or leave without resources to assist them in gaining knowledge about their diagnosis	
Lack of Access, Transportation	Member	Member may have Access issues due to: - No transportation to the prescribing physicians office/pharmacy to pick up medications - Prescribing physician may not be close/convenient - Physician office hours may not coincide with member work hours	Member Feedback MHNNet
Lack of Tracking System	Health Plan	There is a need for a tracking system for the collaborative effort between MHNNet (CoventryCares behavioral health division) and Quality Management for this PIP. Needs include: - Members contacted by QM and MHNNet - Type of Outreach - Educational materials mailed - Members who requested information - MHNNet follow ups - Members who declined assistance	Interdepartmental Review

2. Interventions Planned and Implemented

Changes/Updates to Interventions in Final Report

- Updated to match 2014 PIP template format. Combined actions into one narrative vs breaking down what was completed in each year which proved to be redundant and confusing
- Removed introductory paragraph
- Updated/improved interventions to be more in line for what they are meant to focus on which is the implementation of the actions completed vs outreach

numbers, etc. Other data was moved to their appropriate sections. For example, the outreach number breakdowns have been moved to the Process Measures

- Combined 1st 2 Interventions as both are related to MHNet member outreach.
- The 5th intervention regarding MPR was removed. While the MPR data was used for reporting purposes only for members, the MPR report was used in order to identify the top 650 prescribing physicians for the provider outreach intervention.
- Combined interventions 7 and 8

Timeframe	Description of intervention	Target Group	Barriers addressed
1 ST Quarter 2013 and Ongoing	CoventryCares of Kentucky Case Management (CM) will complete an initial screening by the predictive modeling tool for new members enrolled in CM. CM will contact the member population deemed at risk by the CM predictive modeling tool for potential behavioral health issues by phone or letter in order to complete the full behavioral health assessment screening. If the member indicates that they are agreeable to MHNet outreach, CM will complete the continuity of care (COC) form as a referral. Forms of MHNet outreach include phone calls, member specific mailings, reminder letters, and educational materials regarding the importance of following their treatment plan. MHNet behavioral health specialists will base the type of outreach/educational materials per the member's specific needs. They will also stay in contact with these members, monitor their outcomes and provide further	Members	Lack of Knowledge/Compliance Lack of Access, Transportation

	<p>support as needed.</p> <p>Mid 2013, the medical and behavioral health grand rounds “high risk” members report was transitioned to MHNNet/CoventryCares of Kentucky Integrated Care Management (ICM). The ICM team is lead by the MHNNet Director of Clinical Health Services. These “high risk” members have more serious and immediate behavioral health concerns, such as risk of suicide, that fall outside the scope of the goal of this PIP which focuses on compliance. Data for these members will no longer be compiled for this PIP after 52 were identified in the first half of 2013.</p> <p>Beginning in the 3rd quarter 2013, the quality management (QM) department began collaboration on the non-compliant members in the antidepressant medication management (AMM) HEDIS® measure. MHNNet would further review these member’s claims and pharmaceutical history and follow up with them as needed. Methods of follow up as well as the educational materials used are as needed determined by the behavioral health specialist assigned including duties to assist in educating the member, scheduling doctor visits, transportation needed,</p>		
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	<p>etc.. MHNNet behavioral health specialists will stay in contact with these members in order to assist the members, monitor their outcomes, and provide further support as needed. Any follow up by phone or mail by MHNNet will be in addition to any outreach packets sent by QM.</p>		
<p>1st Quarter 2013 and Ongoing</p>	<p>The antidepressant medication management (AMM) HEDIS® measure is produced monthly by the Quality Spectrum Insight (QSI) system. Each month when this report is released, the quality management (QM) department will review the members who are shown as newly non-compliant in the AMM effective continuation phase and provide outreach to these members. All outreach materials will be per the state required reading level, provide information for transportation assistance and include phone numbers for multilingual assistance. It is CoventryCares goal to outreach to <u>all</u> members that are non-compliant in the AMM effective continuation phase and provide each of them the following packet:</p> <ul style="list-style-type: none"> ➤ Targeted member letter ➤ <i>Following your Treatment Plan</i> Health Sheet ➤ Krames On-Demand health sheet(s): <ul style="list-style-type: none"> - Depression Tips to Help Yourself 	<p>Members</p>	<p>Lack of Knowledge/Compliance</p>

	<ul style="list-style-type: none"> - Depression Affects Your Mind and Body - What Can Cause Depression? <p>Any members that are still showing as non-compliant in the AMM effective continuation phase in October in 2013 and 2014 received an additional follow up packet from QM, in addition to any follow up outreach done by MHNet, in an effort to provide a final bump to our HEDIS® member compliance rates.</p>		
2 nd Quarter 2013	<p>Internal referral process for tracking new members who were contacted, enrolled in CM and agreeable to MHNet outreach by completing the continuity of care (COC) referral form was developed</p> <p>Tracking systems for identifying members that were newly identified as non-compliant for the AMM effective continuation phase were developed. Shortly after, the referral process to MHNet was developed along with their tracking systems.</p>	Health Plan	Lack of Tracking System
2 nd and 3 rd Quarter 2013 and 3 rd Quarter 2014	<p>QMUM Provider forums – CoventryCares provided forums for providers to speak regarding the barriers that they and members are facing as well as discussions for interventions and solutions to these issues</p> <p>Quality Member Access Committee (QMAC) meetings</p>	Provider	<p>Lack of Communication</p> <p>Lack of Compliance</p>

	for April and June→ MHNNet speaker discussing major depression		
3 rd Quarter 2013	<p>The provider intervention for 2013 was completed in the 4th Quarter. A mailing was sent to all physicians that prescribed antidepressants to 10+ members per our 3rd quarter 12 month MPR data report. The prescribing physicians contacted were not just PCP's, as the AMM HEDIS® measure assesses members prescribed antidepressants by any prescriber. Initial plans for this intervention were to engage prescribing physicians with the lowest MPR. After review of the report, many of these physicians only had a few members that were prescribed antidepressants. CoventryCares believed that the outreach and educational materials would be most effective by reaching out to <u>all</u> prescribing physicians that had issued antidepressants to 10+ members which totaled 650 physicians. While these 650 physicians only made up about 20% of the physicians from the 3rd quarter 12 month MPR report, they prescribed to 68.50% of our members receiving antidepressant medications. The mailing included:</p> <ul style="list-style-type: none"> ➤ A targeted letter developed by the Director 	Provider	<p>Assisting in educational materials for member</p> <p>Lack of Knowledge</p> <p>Lack of Communication</p>

	<p>of Clinical Pharmacy</p> <ul style="list-style-type: none"> ➤ Following your Treatment Plan Brochure ➤ The following Krames On-Demand Health Sheets: <ul style="list-style-type: none"> - Treating Anxiety Disorders with Medication - Using Antidepressants - Treating Affective (Mood) Disorders - Taking Medicine Safely. <p>The Krames On-Demand Health Sheets were selected by the Director of Clinical Pharmacy as well.</p>		
3 rd Quarter 2013 and ongoing	<p>CoventryCares of Kentucky in collaboration with MHNet will continue to evaluate and expand upon the resources that are available to our members and providers. Website enhancements and newsletters focusing on depression posted throughout this PIP are as follows:</p> <p><u>Website Enhancements</u></p> <p>CoventryCares of Kentucky will utilize the member and provider website pages to them with educational information regarding the identification, diagnosis, current guidelines and the importance of proper compliance and management of major depression. Website enhancements made throughout the PIP include:</p> <ul style="list-style-type: none"> ➤ Behavioral Health link added to member website ➤ Member 2012 & 2013 newsletters posted to website ➤ A CoventryCares Provider 	Member Provider	Lack of Knowledge

	<p>Newsletter titled Provider Connection was initiated and mailed to providers, and posted on the CoventryCares provider web site. The newsletter contained an article about the Major Depression: Antidepressant Medication and Compliance PIP including a brief overview of the rationale for the topic selection, data, and the focus of the PIP</p> <ul style="list-style-type: none"> ➤ Best Practice guidelines were reviewed at the QMUM meeting, posted on the Provider web site and information sent to the provider via fax blast. Educational material for Depression and about this PIP disseminated to providers via the Provider Newsletter. ➤ The Behavioral Health Guidelines can be assessed for all ages on the CoventryCares provider web site. The Major Depressive Disorder Guideline was refreshed 3/2014. ➤ American Psychiatric Association (APA) Behavioral Health Guidelines for Depression posted to the CoventryCares of Kentucky (CoventryCares) Provider website <p><u>Newsletters</u></p> <ul style="list-style-type: none"> ➤ Summer member 		
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	<p>newsletter with article on depression mailed to members</p> <ul style="list-style-type: none"> ➤ Fall 2013 Member Newsletter article identifying the symptoms of depression and encouraging members to talk to their health care provider as soon as possible ➤ Spring 2014 Member Newsletter article providing information about the health of the body and mind and encouraging members to call a mental health staff member regarding medical or mental health problems. ➤ CoventryCares' provider newsletter titled Provider Connection was mailed to providers. The newsletter contained an article about the Major Depression: Antidepressant Medication and Compliance PIP including a brief overview of the rationale for the topic selection, data, and the focus of the PIP members 18 years of age and older 		
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3. Process Measures

Changes/Updates to Process Measures in Final Report

- This is a new addition as the Process Measures section was not a part of the template when the proposal was written in 2012. Per DMS/IPRO requests, CoventryCares has incorporated all points of the 2014 PIP template for clarity and standardization among all 8 of our PIPs

Intervention Name/Description	Related Process Measure
QM outreach to members	2013 Total – 1,742 2014 Total – 4,803 CoventryCares believes that the substantial AMM HEDIS rates improvements show the effectiveness of our interventions. Again, the reason that the total outreach is greater than the denominator for the AMM measure is due to the 2 nd round of outreach in October to members still showing as non-compliant
MHNet follow up/outreach to members	Please see the 2013 and 2014 tables below. CoventryCares and MHNet feel that our collaboration and interventions were effective based on the substantial AMM HEDIS rates improvements
CM COC referrals to MHNet	2013 Total – 110 2014 Total – 165
650 Providers Outreach	The average MPR for these 650 providers in the 3 rd quarter was .92 in the 3 rd quarter 2013. This improved to .94 in the 4 th quarter 2013 which brought up the plan level MPR to .93

2013 and 2014 MHNet Outreach for Major Depression Tables:

MHNet Coordination of Care Major Depressive Disorder Outreach														
Year		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2013	Number Outreached	n/a	n/a	9	10	36	25	112	123	128	177	127	158	905
	Number Contacted	n/a	n/a	4	3	7	6	112	123	128	177	127	158	845
	Want Depression Materials	n/a	n/a	4	3	7	6	1	3	0	1	0	0	25
	Declined Information	n/a	n/a	0	0	0	3	0	1	0	2	0	0	6
	Mailed depression info	n/a	n/a	6	9	28	23	112	123	128	177	127	158	891

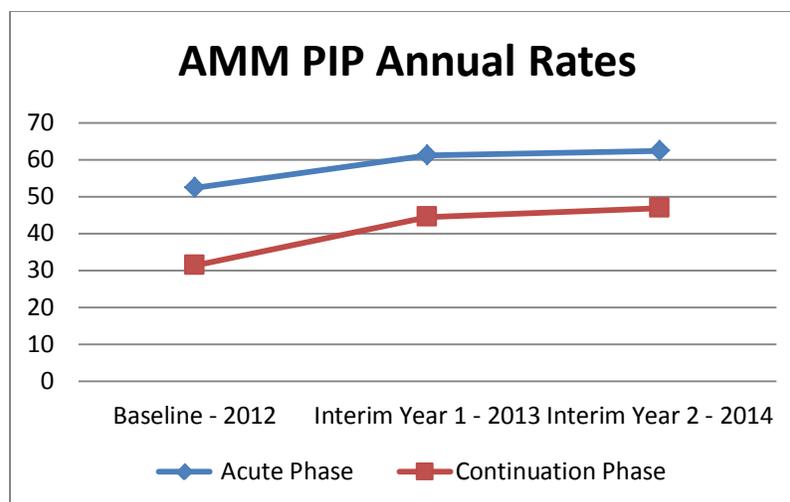
MHNNet Coordination of Care Major Depressive Disorder Outreach Letter and Brochure Information Count													
Year		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Se p	Oct	Nov	Dec
2014	Number Outreached from Medical Side	52	68	73	66	68	80	40	36	47	47	224	246
	Number Contacted from Medical Side	52	68	73	66	68	80	40	36	47	47	224	246
	Want Depression Materials from Medical Side	49	62	71	64	66	79	37	35	45	44	69	78
	Declined Information from Medical Side	3	6	2	2	2	1	3	1	2	3	155	168
	MHNNet Mailed Depression Info	49	62	130	155	66	80	40	36	47	47	283	301
	Mailed Depression Info from Medical Side	0	0	0	1,707	1,072	940	2,144	240	9	1,588	1,396	0
	Medical and MHNNet Follow-up Letters	231	297	201	1,862	1,138	1,020	2,184	754	56	1,635	1,679	301

Results

Quantitative Results and Demographics Tables

Quantifiable Measure 1: The AMM Acute Phase - percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). The baseline and interim year 1 NCQA 90th Percentiles were from the 2012 Quality Compass (QC) data and interim year 2 was from the 2014 QC data.

Time Period Measurement Covers	Baseline Project Indicator Measurement	Numerator	Denominator	Rate or Results	Industry Benchmark (90 th Percentile)	Goal
01/01/2012-12/31/2012	Baseline	180	344	52.33%	61.58%	N/A
01/01/2013-12/31/2013	Interim Year 1	840	1,374	61.14%	61.58%	2% Increase over Baseline
01/01/2014-12/31/2014	Interim Year 2	2,018	3,236	62.35%	59.22%	90 th percentile



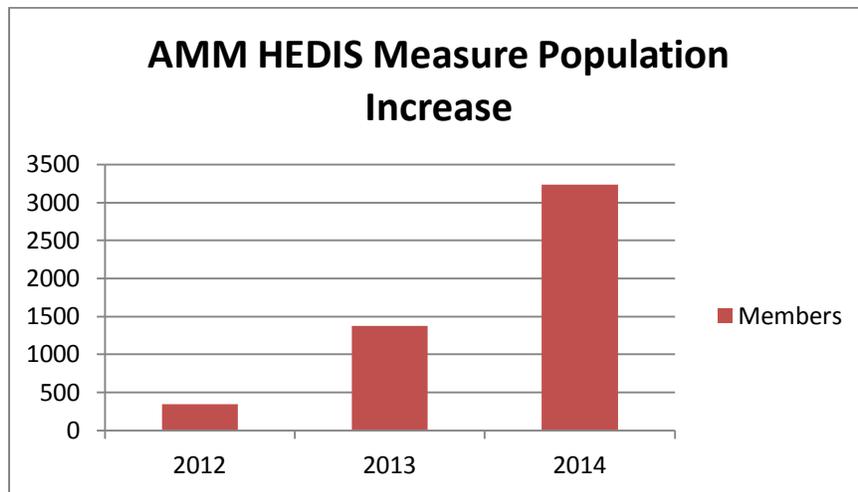
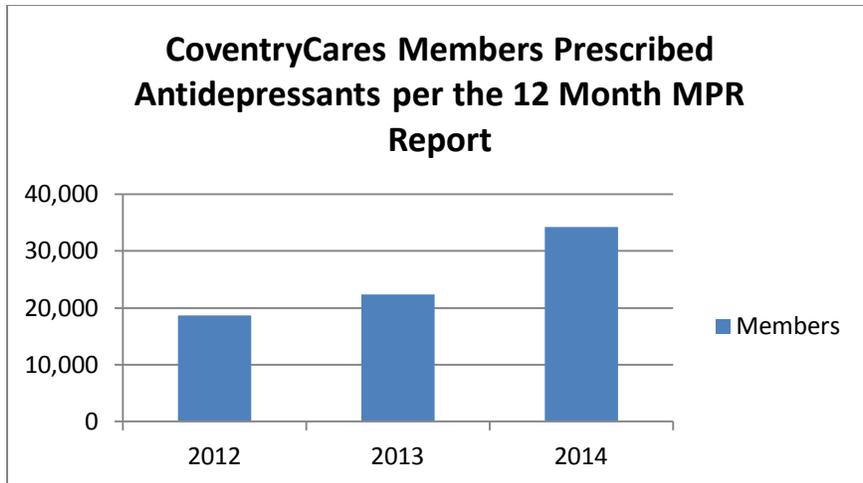
Quantifiable Measure 2: The AMM Effective Continuation Phase - percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months). The baseline and interim year 1 NCQA 90th Percentiles were from the 2012 Quality Compass (QC) data and interim year 2 was from the 2014 QC data.

Time Period Measurement Covers	Baseline Project Indicator Measurement	Numerator	Denominator	Rate or Results	Industry Benchmark (90 th Percentile)	Goal
01/01/2012-12/31/2012	<i>Baseline</i>	108	344	31.40%	42.94%	N/A
01/01/2013-12/31/2013	Interim Year 1	610	1,374	44.40%	42.94%	2% Increase over Baseline
01/01/2014-12/31/2014	Interim Year 2	1,514	3,236	46.78%	44.08%	90 th percentile

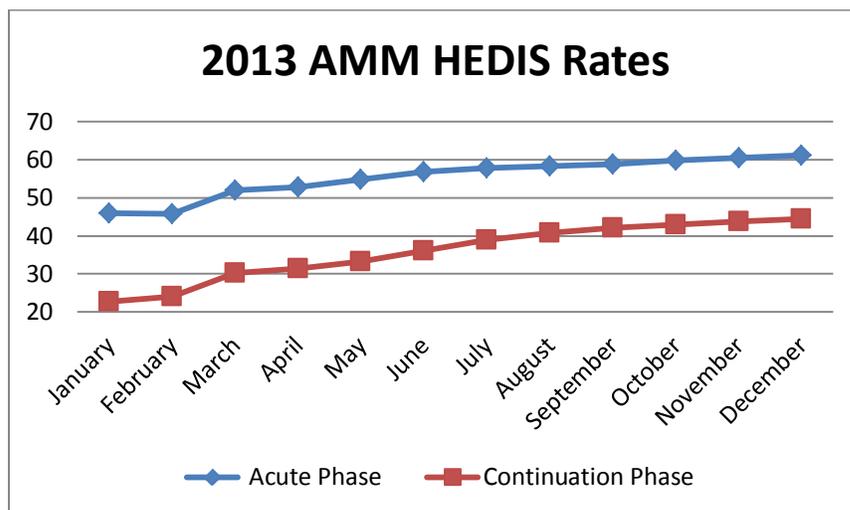
Mid year rates and denominators reported in the interim year 1 report noting a large increase in compliance and a large decrease in membership were incorrect. Our systems reported a new measure of AMMAM versus just the AMM report. The AMMAM reports on a different methodology and population than the AMM does with the extra AM accounting for “Adult Medicaid. This error was caught the next month and was corrected

Quantifiable Measure 3: The Medical Possession Ratio (MPR) is the number of days that the medication was dispensed divided by the number of days the medication was actually prescribed. As noted in the Performance Indicator section, CoventryCares will only focus on the plans overall 12 month MPR. The numerator was removed as the number of members with >= .80 is not relevant in the calculation of the plans overall 12 month MPR average. The denominator represents how many members were prescribed antidepressants that were included in the overall MPR rate for our calculation.

Time Period Measurement Covers	Baseline Project Indicator Measurement	Denominator	MPR Rate	Goal (Considered Compliant)
1/1/2012-12/31/2012	Baseline	18,650	.68	.8
1/1/2013-12/31/2013	Interim Year 1	22,363	.93	.8
1/1/2014-12/31/2014	Interim Year 2	34,223	.90	.8

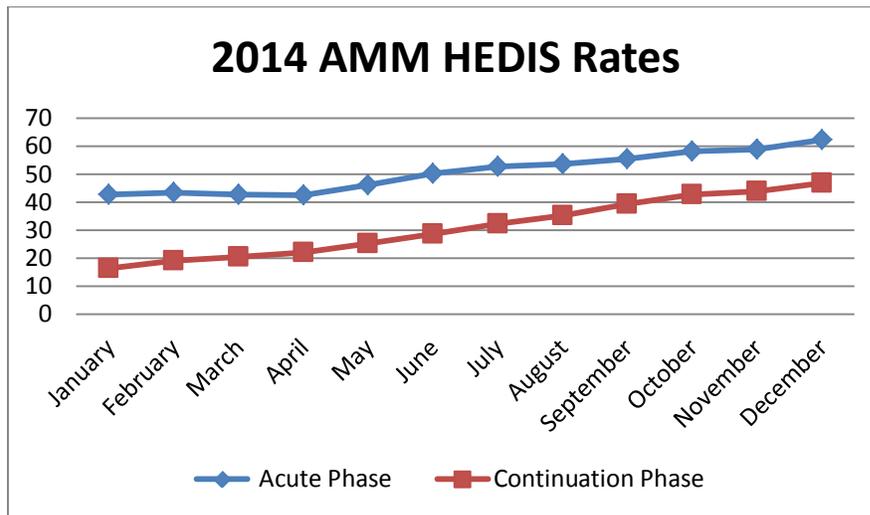


2013 Interim Year 1 AMM Monthly Rate Results



HEDIS® Monthly Rate	Acute Phase	Continuation Phase
January	45.95	22.8
February	45.83	24.07
March	51.99	30.23
April	52.77	31.39
May	54.7	33.33
June	56.78	36.01
July	57.74	38.91
August	58.36	40.84
September	58.86	42.09
October	59.78	42.92
November	60.38	43.7
December	61.14	44.4

2014 Interim Year 2 AMM Monthly Rate Results



HEDIS® Monthly Rate	Acute Phase	Continuation Phase
January	42.81	16.3
February	43.36	19.17
March	42.61	20.56
April	42.44	22.04
May	46.15	25.33
June	50.12	28.66

July	52.62	32.26
August	53.65	35.19
September	55.33	39.23
October	58.09	42.65
November	58.82	43.96
December	62.35	46.78

2014 Interim Year 2 AMM Demographics Results- Acute Phase

2014 Final AMM Acute Phase Age Breakdown				
Age	Denominator	Total %	Numerator/Compliant	Comp %
Age 18-30	1,003	31.05%	603	60.12%
Age 31-44	1,236	38.27%	801	64.81%
Age 45-64	978	30.28%	602	61.55%
Age 65+	13	0.40%	8	61.54%
Total	3,230	100%	2,014	62.35%

2014 Final AMM Acute Phase Gender Breakdown				
Gender	Denominator	Total %	Numerator/Compliant	Comp %
Male	723	22.38%	419	57.95%
Female	2,507	77.62%	1,595	63.62%
Total	3,230	100.00%	2,014	62.35%

2014 Final AMM Acute Phase Regional Breakdown				
Region	Denominator	Total %	Numerator/Compliant	Comp %
Region 1	221	6.84%	142	64.25%
Region 2	468	14.49%	308	65.81%
Region 3	177	5.48%	120	67.80%
Region 4	585	18.11%	356	60.85%
Region 5	615	19.04%	390	63.41%
Region 6	330	10.22%	220	66.67%
Region 7	185	5.73%	108	58.38%
Region 8	649	20.09%	370	57.01%
Total	3,230	100%	2,014	62.35%

CoventryCares 2014 Regional Breakdown		
Region	Population	%
Region 1	17,528	5.78%
Region 2	35,457	11.70%
Region 3	26,950	8.89%
Region 4	54,123	17.85%
Region 5	66,523	21.94%
Region 6	28,596	9.43%
Region 7	21,091	6.96%
Region 8	52,912	17.45%
Total	303,180	100%

2014 Interim Year 2 AMM Demographics Results- Effective Continuation Phase

2014 Final AMM Continuation Phase Age Breakdown				
Age	Denominator	Total %	Numerator/Compliant	Comp %
Age 18-30	1,003	31.05%	402	40.08%
Age 31-44	1,236	38.27%	614	49.68%
Age 45-64	978	30.28%	489	50.00%
Age 65+	13	0.40%	6	46.15%
Total	3,230	100%	1,511	46.78%

2014 Final AMM Continuation Phase Gender Breakdown				
Gender	Denominator	Total %	Numerator/Compliant	Comp %
Male	723	22.38%	316	43.71%
Female	2,507	77.62%	1,195	47.67%
Total	3,230	100.00%	1,511	46.78%

2014 Final AMM Continuation Phase Region Breakdown				
Region	Denominator	Total %	Numerator/Compliant	Comp %
Region 1	221	6.84%	103	46.61%
Region 2	468	14.49%	239	51.07%
Region 3	177	5.48%	92	51.98%
Region 4	585	18.11%	258	44.10%
Region 5	615	19.04%	289	46.99%
Region 6	330	10.22%	169	51.21%
Region 7	185	5.73%	80	43.24%
Region 8	649	20.09%	281	43.30%
Total	3,230	100%	1,511	46.78%

Discussion

1. Discussion of Results

Between the baseline year of 2012 and final year of the PIP in 2014, there were substantial increases in both the antidepressant medication management (AMM) HEDIS® measure population (10x the amount) and compliance rates. CoventryCares efforts produced such a large improvement during 2013 that the goal was raised from a 2% increase over the 2012 baseline rates to a goal of surpassing the 90th Percentile NCQA Benchmark. Baseline benchmarks for the AMM acute phase results were in the NCQA 50th percentile and the effective continuation phase was rated even lower being in the 25th NCQA percentile. CoventryCares is happy to report that we achieved the 90th Percentile NCQA Benchmark for both measures in 2014. The large increase in the effective continuation phase is especially encouraging as it shows that our member population is staying compliant in their medications for a longer period of time. The Medication Possession Ratio (MPR) 12 month plan rate also saw a large increase and surpassed our goals. The large increase of new members in January 2014 saw a negative effect of the 12 month MPR rate, as the 1st quarter rate was just .75. With all of the new membership involved, we feel that a .90 in 2014 showed excellent progress within our membership.

In terms of demographics changes throughout the timeline of the PIP, the greatest was the growth of the members in the AMM measure as well as in the MPR report. We believe that much of this is due to the growth of our membership, which grew 50% from 2012 to 2014. Females were the by far the largest portion of our membership in this PIP, ranging between 77 and 82 percent of our AMM measure population and between 70 and 74 percent of members prescribed antidepressants per the 12 month MPR report. Females make up around 54% of CoventryCares member population per the 2014 population analysis and while this is larger than our male population it does not explain the sizable discrepancy between genders. Feedback and analysis of the data suggests that postpartum depression plays a large role in the difference as well as males being more prone to “deal” with their behavioral health issues versus seeking help. Regions 4, 5 and 8 consistently had the highest number of members in the AMM measure population, but this is to be expected as they contain the highest CoventryCares membership. In comparison with the regional member population, regions 3 and 5 fared better in terms of percentage of AMM members versus the percentage of CoventryCares regional member percentage and 2 and 8 fared worse. The regions that consistently fared the worst throughout the PIP in terms of compliance rates were 4, 7 and 8. These regions were expected to have the lowest compliance rates as they face specific obstacles in terms of it being rural in nature and having high levels of poverty.

CoventryCares believes that the great increases in our rates (25th and 50th percentiles to both being in the 90th percentile) are direct results of the resources made available to our membership through our website postings, newsletters and educational packets as well as our continuous outreach and dedicated follow up efforts made by quality management (QM) and MHNet. Our goal was to provide the same level of attention to all members regardless of demographic classification and the size of the AMM measure allowed us to do so. CoventryCares is very proud of our progress and the assistance provided to increase the compliance and behavioral health of our membership throughout the life of this PIP. As our systems and processes are in place and have proven successful, CoventryCares will continue our efforts on this topic as a focus study.

2. Limitations

After two years of interventions and interactions with providers and members, CoventryCares believes that the biggest “limitation” in dealing with major depression is keeping the members medications compliant. The members have a choice as to whether or not they adhere to their prescription and behavioral health plans. To expand on that, we have found that members go non-compliant due to several reasons including:

- They “feel fine” and choose not to continue
- They do not like how the medications make them feel and choose to stop versus reviewing this with their doctor first
- They forget to refill their prescriptions
- They do not take their medications as prescribed

This PIP has stayed close to the original proposal in many ways and we have expanded on our initial interventions as well. That being said, two interventions were removed throughout the evolution of the PIP. The first was tracking the members that were identified as “high risk” upon discharge from the hospital. These members are being cared for by Integrated Care Management (ICM) and these members face far greater issues (such as immediate risk of suicide) than are the focus of this PIP. The second was removing the intervention based on using the 12 month MPR report for anything other than analysis and provider identification. This was due to several factors:

- This report was useful in tracking how our membership was staying compliant on all antidepressant medications, but our main focus was on the medications used in the AMM HEDIS measure.
- Due to this report pulling additional medications than the AMM measure, the numbers were too great to have an effect through direct intervention other than a provider intervention
- This report and the data involved was confusing, so any references to percentages of members that were compliant were removed

3. Member Participation

Member participation was limited outside of the interactions with MHNet, but the feedback that was received was included in the barriers as well as noted above in the limitations section.

4. Financial Impact

CoventryCares Final Cost Analysis based on Kaiser Study

The following calculation is based upon the savings represented by the increase in member compliance for the antidepressant medication management (AMM) effective continuation (EC) phase from our baseline rate vs our 2014 final rate. The AMM EC measure also measures based on a six month compliance period, which matches the Kaiser study showing that patients who discontinue antidepressant treatment within six months accumulate \$432 in higher medical costs per year than adherent patients. In order to provide an accurate estimate of the savings resulting in the increase of compliance shown by CoventryCares we will need to have equal denominators. This will be accomplished by calculating the baseline non-compliant (NC) percentage times the 2013 and 2014 measure populations:

2013 Cost Analysis

- AMM EC Baseline Rate Non-Compliant (NC) Percentage = 100% - 31.40% (the compliance rate) = 68.60%
- AMM EC NC Baseline NC Member Total = 68.60% x 1,374 = 943 NC Members
- 943 NC Members x \$432 = \$407,376

- AMM EC Final 2014 Non-Compliant (NC) Member Total = 534 NC Members
- 534 NC Members x \$432 = \$230,688

- Savings by increasing the AMM EC Rate from 31.40% to 44.40% = **\$176,688**

2014 Cost Analysis

- AMM EC Baseline Rate Non-Compliant (NC) Percentage = 100% - 31.40% (the compliance rate) = 68.60%
- AMM EC NC Baseline NC Member Total = 68.60% x 3,236 = 2,220 NC Members
- 2,220 NC Members x \$432 = \$959,040

- AMM EC Final 2014 Non-Compliant (NC) Member Total = 1,770 NC Members
- 1,722 NC Members x \$432 = \$743,904

- Savings by increasing the AMM EC Rate from 31.40% to 46.78% = **\$215,136**

Next Steps

1. Lessons Learned

CoventryCares has learned that through making resources available to members and following up with them that this will have a positive effect on member compliance. Due to the substantial progress that was made from baseline to interim year 2 by the systems we have in place and outreach efforts that we made CoventryCares will continue all efforts in transitioning this PIP to a focus study. Migration with Aetna will occur on 11/1/2015 which will bring new systems for us and new online resources for our membership that we believe will continue to have a great and positive impact on our membership's behavioral health.

2. Dissemination of Findings

Findings will be shared with the Department of Medicaid Services, IPRO and will be presented at the 3rd Quarter QMUM provider forum. This report will also be shared with Aetna corporate with a summary of what was successful, unsuccessful, what barriers were faced, etc. for other Aetna health plans across the country to access and learn from.

3. System-level Changes Made and/or Planned

CoventryCares will complete our migration with Aetna on 11/1/2015 and we believe that many positive changes due to this integration are on the way. We believe that these new systems will allow greater resources for us as well as our members and providers. An example of something that we can look forward to post migration will be an all new, more user friendly, more interactive, more thorough health risk assessment for our members that encourages healthy living. This tool will provide members access to many educational resources tailored for their lifestyle needs whether it involves a healthier diet, increased exercise or mental health needs.

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