# Frequently Asked Questions

## 1. What is this project about?

*Healthcare Quality Strategies, Inc. (HQSI), with funding from the Centers for Medicare & Medicaid Services (CMS), studied data from the Medicare claims database to develop behavioral health data profiles for the 10 New Jersey counties FEMA designated as disasters after Superstorm Sandy and a subset of 10 communities. HQSI is sharing the profiles with state and local governments and agencies, healthcare providers, community-based organizations, and the research community, and posting them to the HQSI website (www.hqsi.org).*

*HQSI designed this project to help communities*

- *enhance their coordination of behavioral health services during and after a natural disaster; and*
- *increase utilization of the Medicare depression screening benefit, which can help mitigate deteriorating health*

## 2. How did you create these profiles? What data was used?

*Each county profile compares one county's statistics to the aggregate of the 10 counties and to the other nine counties. Each community profile compares that community's statistics to the data for its county.*

*Primary data sources include Medicare Fee-for-Service (FFS) Part A and Part B claims, the Medicare enrollment database and U.S. Census data. The Medicare enrollment database includes basic demographic statistics such as age, gender, and race while the U.S. Census data provides a proxy indicator (average household income) for socio-economic status. Based on the ICD-9 (International Classification of Disease, ninth revision), CPT-4 (Current Procedural Terminology, fourth edition) or HCPCS (Healthcare Common Procedure Coding System) codes in Medicare Part A and Part B claims, beneficiaries were identified for chronic conditions including diseases/conditions related to behavioral health, such as depression. Appendices A through F in the profiles contain documentation, technical notes, codes, algorithms, data sources, and references. For more information, view the data profiles.*

## 3. What's the purpose of these profiles?

*The profiles were designed to provide information about key behavioral health conditions and risk factors for depression, as well as the utilization of Medicare-covered behavioral health services among Medicare beneficiaries residing in the NJ counties FEMA declared as disaster areas after Superstorm Sandy. Evidence from prior natural disasters demonstrates that victims are often at an elevated risk for behavioral health issues and can experience a prolonged period of elevated risk after a disaster. Moreover, older adults and disabled residents with chronic behavioral health conditions in particular are at increased risk of deteriorating health, depression, increased isolation, and breakdown in the continuum of health care. The profile data will be used by the counties and communities to support a community-based approach to coordinated behavioral health services during and after a natural disaster, and to increase*

*utilization of the Medicare depression screening benefit, which can help mitigate deteriorating health.*

*The county profiles will help focus attention on communities that may be at risk. The profiles can help identify pockets of need, Medicare beneficiaries at higher risk for depression, and areas with high concentrations of Medicare beneficiaries with chronic behavioral health conditions.*

**4. How will the profiles help/benefit me?**

*The profiles provide county-specific demographics, behavioral health conditions, and utilization of health services. This data can support grant proposals and other funding opportunities designed to enhance behavioral health services in your area. The data can also identify where certain services are needed or help better use resources. In addition, identifying locations where there is a need to increase utilization of Medicare-covered depression screening can assist in allocating existing funds.*

**5. Can you explain the time periods used in the profile analyses?**

*The initial profiles include data from January 1, 2011 through March 31, 2013.*

- *The pre-Sandy time period was defined as January 1, 2011 through September 30, 2012*
- *October 1, 2012 through December 31, 2012 (Q4 2012) is defined as the quarter during which Superstorm Sandy occurred*
- *January 1 – March 31, 2013 is defined as the post-storm quarter (Q1 2013)*

*HQSI plans to produce updated profiles in spring 2014 that include an additional quarter of data for the post-Superstorm Sandy time period (April 1, 2013 – June 30, 2013).*

*The results are presented using three different measurement time frames as follows:*

- *Statistics on demographics, prevalence of behavioral health conditions, and utilization of health services are presented for this 21-month period. These statistics allowed for comparison across affected counties prior to Superstorm Sandy*
- *Annual prevalence with rolling quarters of behavioral health conditions and utilization statistics are included to adjust for seasonal variation and to examine possible changes pre- and post-Superstorm Sandy. The time period used for this analysis was January 1, 2011 through March 31, 2013. This time period includes six data time points*
- *Quarterly new incidence of the behavioral health conditions that includes five quarters of data from Q1 2012 (January 1, 2012 – March 31, 2012) through Q1 2013 (January 1, 2013 – March 31, 2013) allows the identification of new cases in a quarter when compared to the prior year*

**6. How can the profiles be used?**

*The profiles can be used to provide a baseline for the prevalence and incidence rates of the eight selected behavioral health conditions based on the ICD-9 codes through the Medicare claims database. Possibly, after further data collection and analytic development using post-Sandy data, they can also be used to prioritize and plan community and county preparation for the*

*care, tracking, and monitoring of Medicare beneficiary behavioral health status and health care utilization patterns.*

*The community/county profiles offer information/data that you never had before. Think about ways that you can use it to identify abundances and opportunities for improvement that you might not have been aware of before or suspected but now have data to support. For example, could you use this profile to support grants you are pursuing?*

**7. Why did you only analyze claims data for Medicare Fee-For-Service (FFS) beneficiaries?**

*As a quality improvement organization (QIO), HQSI only has access to claims for Medicare FFS beneficiaries. This does not include Medicare beneficiaries enrolled in Medicare Advantage (Managed Medicare) Plans. In New Jersey, 85% of Medicare beneficiaries are Medicare FFS users.*

**8. How did you choose the top five risk factors for depression or proxy disorders?**

*HQSI conducted a literature review on risk factors for depression (see profile Appendix B). Based on findings from the literature review and factors available through Medicare claims, logistic analysis was conducted with Medicare claims to identify factors associated with development of depression. The top five risk factors—Alzheimer's disease and related disorders (senile dementia), hip/pelvic fracture, amputations, alcohol or substance abuse or tobacco use, and sleep disturbance—were shown to be the top five risk factors and were subsequently used to identify beneficiaries with high risk for developing depression or proxy disorders.*

**9. Were the prevalence or incidence rates adjusted for age or gender?**

*These rates are crude rates and were not adjusted/standardized for age or gender. Therefore, in regions with different distribution of age groups or gender, we calculated their rates without adjusting for the differences.*

**10. What does "quarterly new incidence when compared to the prior one year" mean?**

*This shows the number of cases of the condition that newly occurred (for which a claim was submitted) in a quarter, when compared to the previous one year, during which the individual did not have a claim for that condition.*

**11. In the data profiles, some of the charts/figures use two decimal points and others use only one? Why?**

*We used two decimal points for data calculated per 1,000 beneficiaries and one decimal point for data shown in percentages.*

**12. Why are the relative change percentages in the bar charts different from the percentages found if you calculate the changes from the numbers on the graphs?**

*The relative change percentages were calculated prior to rounding the rates to two decimal points. Therefore, the relative change percentages in the charts would be slightly different from the calculated values.*

**13. In the depression screening charts, the sum of quarterly rates does not equal the rate for the calendar year 2012, why?**

*The denominator for the two time frames is different. The denominator is the number of eligible beneficiaries during a given time-frame. The number of total eligible beneficiaries varies for each given quarter. So, the average of eligible beneficiaries in all quarters in 2012 is not equal to the total eligible beneficiaries for the calendar year 2012, because the number of eligible beneficiaries in a county or community changes over time. Therefore, taking the sum of the quarterly rates would not equal the calendar year rate.*

**14. How did you select the 10 communities for this project?**

*We selected the 10 communities for this project based on the following criteria:*

*1. Communities within the 10 FEMA-declared disaster counties after Superstorm Sandy*
*2. Communities having high incidence of depression or proxy disorders (either depression or anxiety or adjustment disorders).*
*3. Communities with high concentration of at risk population for depression or proxy disorders.*
*4. Communities with low utilization of behavioral health services (depression screenings, psychiatric diagnostic procedures, and individual psychotherapy).*
*5. Communities that were also listed as the top communities for behavioral health encounters according to the Mental Health Association in New Jersey Hope and Healing data.*

**15. Why wasn't my community chosen; it meets your criteria.**

*Although many communities met the above five criteria, we could only select 10 communities due to funding limitations.*

**16. How did HQSI map the rates of behavioral health conditions?**

*HQSI mapped the depression or proxy disorders, risk and depression screening rates by ZIP codes using Microsoft MapPoint. HQSI categorized ZIP codes in a given county into five equal data categories (quintiles) based on their values. For example, if there are 10 ZIP codes in a given county, two ZIP codes are assigned to each of the five categories. So the two ZIP codes with the highest prevalence rates in the county were color coded dark red and the two ZIP codes with the lowest prevalence rates were color coded dark blue. This gave us the ability to view a color-coded county map and quickly see where the lowest and highest rates were.*

**17. The overall 10-county prevalence map does not match the county-specific prevalence map. Why?**

*The 10-county map and the county-specific maps were both created by grouping ZIP codes into five equal data categories (quintiles). The 10-county map looks at all ZIP codes in the 10 counties together and assigns red to ZIP codes with the highest prevalence rates in the entire 10 county area. The county-specific map looks only at ZIP codes within the county and assigns red to those ZIP codes with the highest prevalence rates in that county. Thus, the color assigned to a ZIP code in the 10-county map may be different than the color assigned to that ZIP code in the county-specific map, and these two maps should be analyzed separately.*

**18. Why isn't (name town/neighborhood) included in the map for the (name) community profile?**

*HQSI analyzed data for the selected communities based on ZIP codes. Since New Jersey ZIP codes sometimes encompass more than one town or township, and municipal maps do not always align with the ZIP codes upon which GIS mapping software is based, the depiction of the communities may be incomplete.*

**19. Why aren't all the providers in this community included in the provider listing?**

*The provider listings included only providers serving the majority of patients in the community based on patient care transition data. The goal was to identify major providers in the community. Therefore, we did not include all providers.*

**20. In the charts, the 10-county rate doesn't equate with computing the average rates of the counties listed. Why?**

*The 10-county rate is not equal to the average of the 10 counties. Rather, the rate is created based on all of the beneficiaries residing in the 10 counties. It's a beneficiary-level pooled rate, not a county average rate.*

**21. So what if we increase depression screening? There are no services, doctors, beds, etc. for these people to see in New Jersey.**

*Some of the behavioral health service gaps are being filled by behavioral health grants that are funding programs like New Jersey Hope and Healing and programs at the Federally Qualified Health Centers (FQHCs). Parts of the Affordable Care Act are also increasing the availability of behavioral health services for those that have insurance through expanded coverage.*

*This project is about educating and connecting stakeholders and providers so these resources will be utilized to their maximum potential. The data can also be used to draw attention to service gaps or areas in need.*

**22. Do you (HQSI) or CMS plan to do any follow up profiles or reports beyond this project (which ends July 2014)?**

*HQSI will update the County/Community data profiles in spring 2014. Currently, CMS funding for this SIP ends on July 31, 2014.*

**23. If the post-Sandy Medicare claims are still incomplete, why bother to create charts/review the statistics? What is it going to tell us that we don't already know?**

*The data profiles offer what is currently available and can assist the county/community in coordination of behavioral health services.*