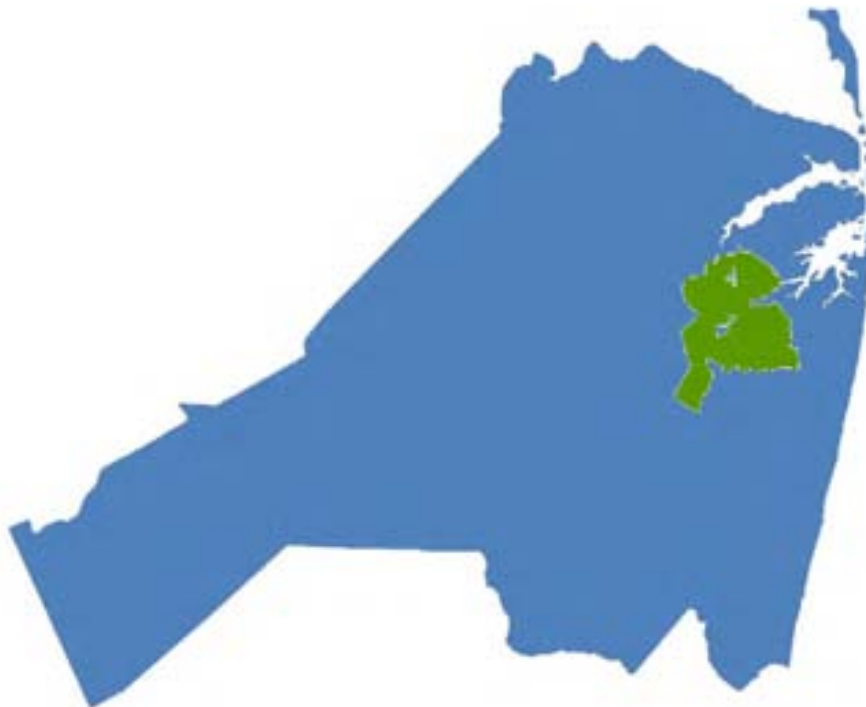


Enhancing Coordination of Behavioral Health Services after Superstorm Sandy: Planning for Future Disasters

Updated Data Profile: Eatontown and Shrewsbury Community Medicare Fee-for-Service Beneficiaries

Demographics, Behavioral Health Conditions, and Utilization of Health Services (Medicare Fee-for-Service Beneficiaries)

May 13, 2014



This Page Left Intentionally Blank

TABLE OF CONTENTS

Preface	1
Introduction.....	2
HQSI Project Team.....	7
Acknowledgements.....	8
Executive Summary	9
Demographics.....	11
• Total Medicare FFS Beneficiaries	11
• Percent of Medicare FFS Beneficiaries in the General Population in 2012	11
• Percent of Medicare FFS Beneficiary Population by Female.....	11
• Percent of Medicare FFS Beneficiary Population by Race	12
• Percent of Medicare FFS Beneficiary Population by Age.....	12
• Median Household Income	12
Behavioral Health Conditions	13
• Prevalence and Incidence.....	13
– Summary	13
– Depression or Proxy Disorders	16
– Depression.....	22
– Anxiety Disorders	23
– Adjustment Disorders	24
– Post-Traumatic Stress Disorder.....	25
– Alcohol or Substance Abuse	26
– Substance Abuse Alone	27
– Suicide and Intentional Self-Inflicted Injury.....	28
• Risk Factors for Depression or Proxy Disorders.....	29
– Summary	29
– Any of the Top Five Risk Factors for Depression or Proxy Disorders	30
– Alzheimer's Disease and Related Disorders or Senile Dementia.....	33
– Sleep Disturbance.....	33
– Substance or Alcohol Abuse or Tobacco Use	33
– Hip/Pelvic Fractures	34
– Amputations	34
Utilization	35
• Utilization of Outpatient Behavioral Health Services	35
– Assessments	35
› Summary	35
› Depression Screening	35

TABLE OF CONTENTS

› Neuropsychological Tests	40
› Psychiatric Diagnostic Procedures	42
– Therapies	44
› Summary	44
› Individual Psychotherapy	45
› Family Psychotherapy	47
› Group Psychotherapy	48
• Inpatient Health Services	49
– Summary	49
– Psychiatric Hospital Admissions	50
– Acute Care Hospitals	51
› Admissions	51
› Observation Stays	52
› Emergency Department Visits	53
– Within 30 Days of Acute Care Hospital Discharge	54
› Summary	54
› 30-Day Hospital Readmissions	55
› Observation Stays Within 30 Days of Discharge	56
› Emergency Department Visits Within 30 Days of Discharge	57
– Other Settings	58
› Summary	58
› Home Health Agency Services	59
› Skilled Nursing Facility Services	60
› Hospice Services	61
› Medical Rehabilitation Services	62
• Listing of Major Health Providers	63
• Eatontown and Shrewsbury Community Providers	64
• Appendix A: Behavioral Health Conditions	65
• Appendix B: Risk Factors for Depression or Proxy Disorders	68
• Appendix C: Utilization of Outpatient Mental Health Services	72
• Appendix D: Utilization of Services – Inpatient and Other Settings	74
• Appendix E: Time Frames and Formulae	76
• Appendix F: References	77
• Appendix G: Provider Summary Tables and Provider Listings	78
Index of Figures	81

On October 29, 2012, Superstorm Sandy hit the Eastern Seaboard, impacting more than a dozen states. New Jersey, which took the brunt of the storm along its densely populated coastline, was devastated. Thousands of residents were displaced, their homes and communities damaged or destroyed.

Lessons learned from prior natural disasters showed that victims of storms like Superstorm Sandy are often at an elevated risk for acute or behavioral health issues such as post-traumatic stress disorder (PTSD), depression, and substance abuse.^{1,2} While disaster-related issues subside over time, evidence shows that victims can experience a prolonged period of elevated risk, especially those with pre-existing mental health issues.³ Older adults and disabled residents with mental health conditions are at increased risk of deteriorating health, depression, increased isolation, and breakdown in the continuum of health care. Additionally, past natural disasters also show that access to informational resources on disaster-related mental health disorders, outcomes, and service utilization are important factors to consider.^{4,5}

This updated community profile – one of 10 being created for selected communities in the Federal Emergency Management Agency (FEMA)-declared disaster counties in New Jersey – explores potential county and community level health status and health determinants of post-disaster spikes in behavioral health issues and treatments. This update includes more comprehensive post-Sandy data than the initial profile, which was published in February 2014. A final update is planned for summer 2014, when additional data is available.

Enhancing Coordination of Behavioral Health Services after Superstorm Sandy: Planning for Future Disasters is a Special Innovation Project funded by the Centers for Medicare & Medicaid Services (CMS). As part of this project, Healthcare Quality Strategies, Inc. (HQSI), the CMS quality improvement organization (QIO) for New Jersey, studied data on prevalence and incidence of selected behavioral health conditions, the utilization of health services, and demographic information from the Medicare claims database for Medicare Fee-for-Service (FFS) beneficiaries residing in the 10 New Jersey FEMA-declared disaster counties after Superstorm Sandy. From its analysis, HQSI created data profiles for each of these FEMA-designated counties, as well as a subset of 10 selected communities.

This is the updated profile for the Eatontown and Shrewsbury community in Monmouth County. The Eatontown and Shrewsbury community was selected because it had high rates of Medicare FFS beneficiaries both with and at risk for depression or proxy disorders prior to Superstorm Sandy (January 1, 2011 – September 30, 2012).

This profile is based on Medicare FFS claims data and provides a glimpse into the prevalence and incidence of selected 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 community before and after Superstorm Sandy. Since patients with behavioral health conditions may receive other health services because of medical problems caused by their behavioral health conditions or they may avoid utilizing behavioral health services, this report also looks at the utilization of non-behavioral health services.

The county and community profiles are being shared with state and local governments and agencies, health care providers, community-based organizations, and the research community to support a community-based approach to enhance the coordination of behavioral health services after a natural disaster, and to increase utilization of the Medicare depression screening benefit which became a covered service in October 2011. This benefit is important for victims of major disasters like Superstorm Sandy who are often at an elevated risk for behavioral health issues and can experience a prolonged period of elevated risk after a disaster. Older adults and disabled residents with behavioral health conditions in particular are at increased risk of deteriorating health, depression, increased isolation, and breakdown in the continuum of health care. They are also less likely to report symptoms, which a depression screening can capture.

WHAT'S NEW IN THIS UPDATE

This updated profile includes an additional six months of post-Sandy data. It focuses on a 12-month pre-Sandy time period as opposed to 21 months used in the initial profile and includes pre and post-Sandy analyses comparing the rates from the year before and during/after the storm. In this profile, we reference October 2011 to September 2012 as the year before Superstorm Sandy and October 2012 to September 2013 as the year after Superstorm Sandy.

This profile now includes:

- Annual trend charts for the selected behavioral health conditions to allow the comparison of changes in prevalence over time (pages 15 and 30)

- A summary of the prevalence of depression or proxy disorders rate by demographic characteristics (race, gender, and age) to allow the comparison of rates across different demographic groups (pages 16-17)
- State maps highlighting the 10 FEMA-declared disaster counties before and after Superstorm Sandy and county-specific maps reflecting changes in prevalence of depression or proxy disorder (pages 20 and 21), top five risk factors for depression (pages 31 and 32), and depression screening rates (pages 38 and 39)
- Summary tables that highlight changes in the community and its county before and after Superstorm Sandy on annual prevalence of selected behavioral health conditions (page 13), utilization of outpatient behavioral health services for assessment (page 35) and therapies (page 44), utilization of inpatient services (pages 49 and 54), and utilization of services in other settings (page 58)

HOW TO USE THIS PROFILE

This profile includes an analysis of the eight behavioral health conditions which, based on literature review and feedback from the subject matter experts consulted for this project, were found to increase after natural disasters.

This profile is divided into the following sections, each of which is preceded by a user-friendly overview:

- Demographics (page 11)
- Prevalence and incidence of behavioral health conditions (page 13)
- Risk factors for depression or proxy disorders (page 29)
- Utilization of outpatient behavioral health services – assessments (page 35)
- Utilization of outpatient behavioral health services – therapies (page 44)
- Utilization of inpatient health services (page 49)
- Utilization of inpatient health services within 30 days of acute care hospital discharge (page 54)
- Other settings (page 58)
- Listing of major health providers (page 63)

Here are some additional tips for using this profile:

- Use the Executive Summary (pages 9-10) for a quick overview of this profile's key points, as well as the snapshot table that summarizes the prevalence of the selected behavioral health conditions and utilization of behavioral health services before and after Superstorm Sandy
- Use the Behavioral Health Conditions section (pages 13-34) for in-depth analyses and graphical comparison on the prevalence and incidence of eight behavioral health conditions before and after Superstorm Sandy
- Use the New Jersey and county maps to identify areas with higher rates of Medicare FFS beneficiaries at risk for depression and proxy disorders (pages 31-32); and areas with low utilization of the depression screening benefit (pages 38-39)

METHODOLOGY

Each community profile compares one community's statistics to the aggregate of its county. Primary data sources include Medicare 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 socioeconomic status. Based on the ICD-9-CM (International Classification of Disease, Ninth Revision, Clinical Modification), CPT (Current Procedural Terminology), 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 contain documentation, technical notes, codes, algorithms, data sources, and references.

Medicare Part A and Part B claims provide information on the utilization of mental health outpatient services for assessment (e.g., depression screening, diagnostic psychological tests) and treatment (e.g., individual psychotherapy). Medicare Part A claims were also used to analyze utilization of health services in or by acute care hospitals, skilled nursing facilities, medical rehabilitation facilities, home health agencies, hospice, and inpatient psychiatric facilities.

Furthermore, Medicare Part A and Part B claims were used to aggregate data on behavioral health providers including: provider location, overall provider type, provider type by services, and major provider listing. Geographical mapping of health providers was also done using ArcGIS Online Explorer.

To identify beneficiaries with an elevated risk of depression or proxy disorders after the storm, HQSI conducted a literature review on risk factors for depression or proxy disorders (see Appendix B). Previous studies identified psychosocial and biological factors, increased age, history of cancer, Parkinson's disease, Alzheimer's disease, changes in mental function, and medication side effects as risk factors for developing depression. Based on findings from the literature review and factors available through Medicare claims, logistic regression analysis was conducted with Medicare claims and the top five risk factors – Alzheimer's disease and related disorders or senile dementia, hip/pelvic fractures, amputations, substance or alcohol abuse or tobacco use, and sleep disturbance – were used to identify beneficiaries with high risk for developing depression or proxy disorders.

MEASUREMENT TIME FRAMES

This profile includes data from January 1, 2011 through September 30, 2013. Results are presented using different charts and measurement time frames as follows:

- Annual bar charts show the annual rates in the year before (October 1, 2011 to September 30, 2012) and during/after (October 1, 2012 to September 30, 2013) Superstorm Sandy. Statistics on demographics, prevalence of behavioral health conditions, and utilization of health services are presented for this 12-month period. These statistics allow for comparison between the community and its county
- Annual trend charts with rolling quarters for the behavioral health conditions and utilization statistics are included to adjust for seasonal variation and to examine possible changes in the year before and during/after Superstorm Sandy. The time period includes eight data points from January 1, 2011 to September 30, 2013
- Annual percent change (relative change) bar charts show relative increase or decrease in rates from the year before and during/after Superstorm Sandy. These statistics allow for comparison between the community and its county and to analyze the potential impact of Superstorm Sandy
- Quarterly new incidence charts for eight behavioral health conditions include seven quarters of data from January 1, 2012 to September 30, 2013. This allows for the identification of new cases in a given quarter when compared to the prior year
- Quarterly line charts show the trend in the utilization of depression screening for seven quarters from January 1, 2012 to September 30, 2013

DATA CONSIDERATIONS

Currently, there are three quarters of post-storm data available. This is the first of two planned profile updates. Claims data processing lag (at least six months) coupled with the one-year project time frame, reduces the optimal time frame for more accurate estimation of post-Sandy effects.

Identification of beneficiaries with behavioral health conditions is based on diagnoses being reported in Medicare FFS claims and could result in underestimation. There is no accurate way to identify when certain health conditions began and ended when claims data is used.

According to the subject matter experts consulted for this project, unlike other conditions, behavioral health issues are often underdiagnosed in our society and the stigma associated with behavioral health conditions may prevent people from seeking care in mental health facilities. The subject matter experts also indicated that estimating the prevalence of depression using claims data can be particularly difficult as depression is often undiagnosed or not documented. Depression can be present with symptoms of anxiety and adjustment disorders. Based on this feedback, a combination measure named “depression or proxy disorders” was created to estimate prevalence and incidence of depression. If a patient has at least one of the three conditions reported in Medicare claims, he/she will be flagged as having depression or proxy disorders.

This community profile can be used to compare the prevalence and incidence rates of eight selected behavioral health conditions based on the ICD-9-CM codes through the analysis of Medicare claims. This profile may 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.

HQSI will produce a final update in summer 2014 that will include additional data for the post-Superstorm Sandy time period.

Martin P. Margolies
Chief Executive Officer

Mary Jane Brubaker, MCIS
Chief Operating Officer

Diane Babuin, MS, CPHQ
Director, Quality Improvement and Communications

Ya-ping Su, PhD
Director, Research and Analysis

Suzanne Dalton, RN, BS, EdM
Project Manager

Andrew Miller, MD, MPH
Medical Director

Mona Abdalla, BA
Administrative Associate

Christine Aisenberg, BA
Proofreader

Kathy Brown, BS
InDesign Specialist

Zhengyu Bu, MS
Health Services Research Analyst

Sue Chen, MS
Statistician

Wei-Yi Chung, MS
Database Administrator

Barbara Coleman
Administrative Associate

Dawn Cullen, BA
Communications Specialist

Diane Fairchild-Maretzky
Proofreader

Karen Hale, MEd
Community Liaison

Kim Karnell, BS
Information Specialist

Janet Knoth, BS, RN, CHPN, CPHQ
Quality Improvement Specialist

Judy Miller, MS, RN
Quality Improvement Specialist

Olubukunola Oyedele, MPH
Community Liaison

Rita Pascale
Administrative Associate

Barbara Perzyna, BS
Visual Communications Specialist

Ziphora Sam, MPH
Epidemiologist

Marianne Sagarese, BSN, RN
Quality Improvement Specialist

Nicole Skyer-Brandwene, MS, RPh, BCPS
Quality Improvement Specialist

Ashley Strain, BA
Communications Specialist

ACKNOWLEDGEMENTS

Special thanks to the subject matter experts who assisted with the project by providing feedback and guidance to the HQSI project team.

Carol Benevy, MSW

New Jersey Hope and Healing Project
Barnabas Health Institute for Prevention

Mary Ditri, MA, CHCC

New Jersey Hospital Association

Adrienne Fessler-Belli, MSW, LCSW

New Jersey Department of Human Services
Disaster & Terrorism Branch

Mark Firth, MA, MSW

New Jersey Department of Human Services
Division of Mental Health and Addiction Services

Mary Goepfert, MPA, APR, CPM

New Jersey Group for Access and Integration Needs in Emergencies and Disasters

Sheldon Green

New Jersey Primary Care Association

Connie Greene, MA, CAS, CSW, CPS

Barnabas Health Institute for Prevention

Bob Kley

Mental Health Association in New Jersey, Inc.

Lynn Kovitch, MEd

New Jersey Department of Human Services
Division of Mental Health and Addiction Services

Karen McCoy, RN, BSN

Home Care Association of New Jersey

Elyse Perweiler, MPP, RN

NJ Institute for Successful Aging

Lynn Stefanowicz, MA, LCSW

Meridian Behavioral Health

Megan Sullivan, LPC, LCADC, DRCC

New Jersey Department of Human Services
Disaster & Terrorism Branch

Pete Summers

The New Jersey Association of County and City Health Officials (NJACCHO)

KEY OBSERVATIONS

The following observations show the Eatontown and Shrewsbury community's percent change and rates after Superstorm Sandy among Medicare FFS beneficiaries.

1. The Eatontown and Shrewsbury community had a relative increase in depression or proxy disorders (3.14%), anxiety disorders (1.83%), alcohol or substance abuse (9.69%), and PTSD (23.09%) after Superstorm Sandy.
2. The highest rates of depression or proxy disorders in the Eatontown and Shrewsbury community were among Hispanics (359.27 per 1,000 Medicare FFS beneficiaries), females (262.43 per 1,000 beneficiaries) and those below 65 years (369.79 per 1,000 beneficiaries), after Superstorm Sandy.
3. After Superstorm Sandy, the Eatontown and Shrewsbury community had a relative decrease in the prevalence rate of any of the top five risk factors of depression or proxy disorders (1.43%).
4. Use of depression screening in the Eatontown and Shrewsbury community increased from 1.29 per 1,000 Medicare FFS beneficiaries to 5.93 per 1,000 beneficiaries.
5. The Eatontown and Shrewsbury community had a relative decrease in the utilization of neuropsychological tests (6.75%) and individual psychotherapy (7.20%).
6. After Superstorm Sandy, the Eatontown and Shrewsbury community had higher rates of acute care hospital admissions (323.45 per 1,000 Medicare FFS beneficiaries), emergency department visits (273.15 per 1,000 beneficiaries), and observation stays (11.09 per 1,000 beneficiaries) than Monmouth County.
7. The Eatontown and Shrewsbury community had a relative increase in the utilization of skilled nursing facilities (1.36%) and hospice services (2.48%) after Superstorm Sandy.

EXECUTIVE SUMMARY

The *Snapshot of the Eatontown and Shrewsbury Community* (Figure 1) summarizes the prevalence of the behavioral health conditions as well as risk factors for depression or proxy disorders analyzed for this profile. This *Snapshot* also lists the most frequently performed behavioral health assessments and therapies in the Eatontown and Shrewsbury community compared to the average of Monmouth County. The non-behavioral health utilization measures that were calculated for this profile are not included in the *Snapshot*.

Figure 1. Snapshot of Eatontown and Shrewsbury

Behavioral Health Disorders	Prevalence per 1,000 Medicare FFS Beneficiaries			
	Eatontown and Shrewsbury			Monmouth County
	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change	% Change
Depression or Proxy Disorders	216.30	223.09	3.14	-0.34
• Depression alone	137.74	135.40	-1.70	-1.74
• Anxiety Disorders alone	116.76	118.90	1.83	3.16
• Adjustment Disorders alone	50.00	50.29	0.58	-4.50
Alcohol or Substance Abuse	41.38	45.39	9.69	11.60
• Substance Abuse alone	20.69	20.89	0.97	1.86
PTSD	5.24	6.45	23.09	7.42
Suicide and Intentional Self-Inflicted Injury	7.07	5.67	-19.80	-2.85
Any of the Top Five Risk Factors* for Depression or Proxy Disorders ⁶	137.22	135.26	-1.43	-0.14
• Alzheimer’s Disease and related disorders or Senile Dementia	38.23	38.03	-0.52	-8.79
• Sleep Disturbance	27.23	25.18	-7.53	-0.49
• Substance or Alcohol Abuse or Tobacco Use	81.18	82.23	1.29	4.26
• Hip/Pelvic Fractures	6.55	6.16	-5.95	-1.74
• Amputations	0.79	1.34	69.62	6.67
Behavioral Health Services	Utilization per 1,000 Medicare FFS Beneficiaries			
	Eatontown and Shrewsbury			Monmouth County
	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change	% Change
Assessments				
• Depression Screening**	1.29	5.93	359.69	131.42
• Psychiatric Diagnostic Procedures	73.82	75.83	2.72	-11.01
• Neuropsychological Testing	14.66	13.67	-6.75	0.96
Therapy				
• Individual Psychotherapy	63.09	58.55	-7.20	-2.11
• Family Psychotherapy	3.14	2.06	-34.39	-14.61
• Group Psychotherapy	1.83	2.06	12.57	-12.38
Psychiatric Hospital Admissions	14.93	8.51	-43.00	-8.47

*The top five risk factors were identified based on findings from a literature review (Appendix B) and factors available through Medicare claims. Logistic regression analysis was conducted with Medicare claims.

**Depression Screening comparison time frames are different (October 1, 2012 – September 30, 2013 vs. January 1, 2012 – December 31, 2012) due to availability of depression screening data starting in January 2012.

Medicare FFS Demographics

Eatontown and Shrewsbury

At A Glance

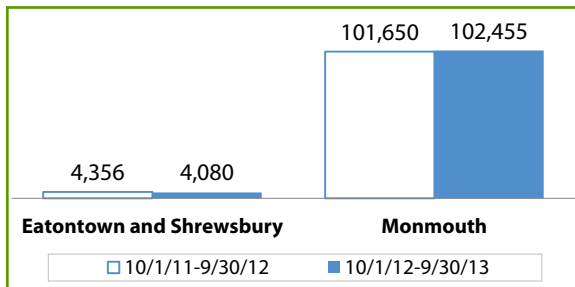
(October 1, 2012 – September 30, 2013)

Total Medicare FFS Population	4,080
Females	2,330 (57.11%)
Males	1,750 (42.89%)
White	3,329 (81.59%)
Black	505 (12.38%)
Asian	78 (1.91%)
Hispanic	46 (1.13%)
Other	122 (2.99%)
Average Age	71.85
ZIP Codes	07724, 07702

Source: Medicare Claims Database



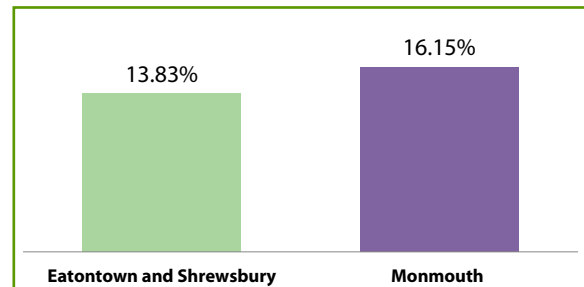
FIGURE 2. TOTAL MEDICARE FFS BENEFICIARIES*



* Total beneficiaries who were under Medicare FFS coverage for at least one month during the time frame.

The total Medicare FFS population of the Eatontown and Shrewsbury community prior to Superstorm Sandy was 4,356. After the storm, this number decreased to 4,080.

FIGURE 3. PERCENT OF MEDICARE FFS BENEFICIARIES IN THE GENERAL POPULATION IN 2012*



* Source: Medicare Claims Database, U.S. Census Bureau, American Community Survey (ACS), 2012 <http://www.census.gov/>.

Medicare FFS beneficiaries made up 13.83% of the Eatontown and Shrewsbury community in calendar year 2012.

FIGURE 4. PERCENT OF MEDICARE FFS BENEFICIARY POPULATION BY FEMALE

	10/1/11 – 9/30/12	10/1/12 – 9/30/13	Absolute Change*
Eatontown and Shrewsbury	57.07	57.11	0.04
Monmouth County	56.24	56.04	-0.20

* Due to rounding, the absolute change may not be the same as the difference subtracted from the two time frames shown.

Prior to the storm, females made up 57.07% of the entire Medicare FFS population residing in the Eatontown and Shrewsbury community and males made up 42.93%. After the storm, the female beneficiary population increased to 57.11% and males decreased to 42.89%.

FIGURE 5. PERCENT OF MEDICARE FFS BENEFICIARY POPULATION BY RACE

Race	Eatontown and Shrewsbury			Monmouth		
	10/1/11 – 9/30/12	10/1/12 – 9/30/13	Absolute Change*	10/1/11 – 9/30/12	10/1/12 – 9/30/13	Absolute Change*
White	81.38	81.59	0.21	87.88	87.57	-0.31
Black	12.58	12.38	-0.20	7.00	6.77	-0.23
Hispanic	1.06	1.13	0.07	0.81	0.75	-0.05
Asian	2.09	1.91	-0.18	1.56	1.45	-0.11
Other	2.89	2.99	0.10	2.75	3.45	0.70

* Due to rounding, the absolute change may not be the same as the difference subtracted from the two time frames shown.

Both before and after Superstorm Sandy, the majority of Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community were White followed by Black, Asian, and Hispanic.

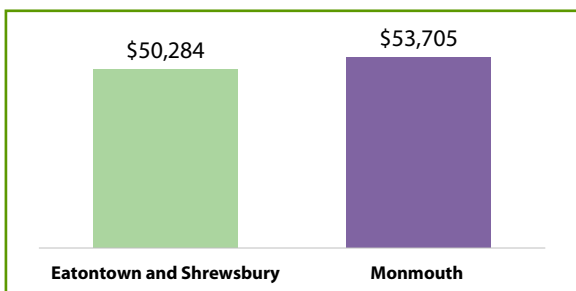
FIGURE 6. PERCENT OF MEDICARE FFS BENEFICIARY POPULATION BY AGE

Age	Eatontown and Shrewsbury			Monmouth		
	10/1/11 – 9/30/12	10/1/12 – 9/30/13	Absolute Change*	10/1/11 – 9/30/12	10/1/12 – 9/30/13	Absolute Change*
<65	21.03	15.05	-5.98	19.83	18.31	-1.52
65 – 74	40.66	45.10	4.44	42.27	44.52	2.26
75 – 84	24.93	25.61	0.68	24.98	24.36	-0.62
85 and Above	13.38	14.24	0.86	12.92	12.81	-0.11
Average Age	71.23	71.85	0.62	71.42	71.41	-0.01

* Due to rounding, the absolute change may not be the same as the difference subtracted from the two time frames shown.

Prior to Superstorm Sandy, the largest age group of Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community was between ages 65 and 74 years old, followed by beneficiaries between 75 and 84 years old. After the storm, the largest age group was still between 65 and 74 years old, and the second largest group was still beneficiaries between 75 and 84 years old. The average age of beneficiaries residing in this community increased from 71.23 years old prior to the storm to 71.85 years old after the storm.

FIGURE 7. 2012 MEDIAN HOUSEHOLD INCOME (65 YEARS AND ABOVE)



According to U.S. Census Data from 2012, residents aged 65 and older residing in the Eatontown and Shrewsbury community had a median household income of \$50,284. This was lower than the average income among seniors residing in all of Monmouth County.

Source: U.S. Census Bureau, American Community Survey (ACS), 2012 <http://www.census.gov/>.

PREVALENCE AND INCIDENCE

Using Medicare FFS claims data, eight behavioral health conditions were analyzed: depression or proxy disorders, depression, adjustment disorder, anxiety disorder, post-traumatic stress disorder (PTSD), alcohol or substance abuse, substance abuse alone, and suicide and intentional self-inflicted injury. These conditions were chosen based on literature review and feedback from subject matter experts.

Claims data can underestimate the real prevalence and incidence of depression in the population and individuals with depression could be diagnosed as having anxiety or adjustment disorders, as noted by the subject matter experts consulted for this project. Therefore, HQSI created a combination measure for depression (depression or proxy disorders) which includes beneficiaries who were reported for either depression, anxiety, or adjustment disorders.

The behavioral health data from January 1, 2011 to September 30, 2013 for these different measures were calculated to quantify disease occurrence:

1. The annual prevalence bar chart compares rates in two annual time frames
2. New incidence in a quarter for the specified disease that was not present in the prior 12 months (Q1 2012 – Q3 2013)
3. The yearly prevalence of the condition with quarterly rolling trends to account for seasonal variation

Refer to Appendix A for measurement calculation and Appendix E for quarterly time frames and formulae.

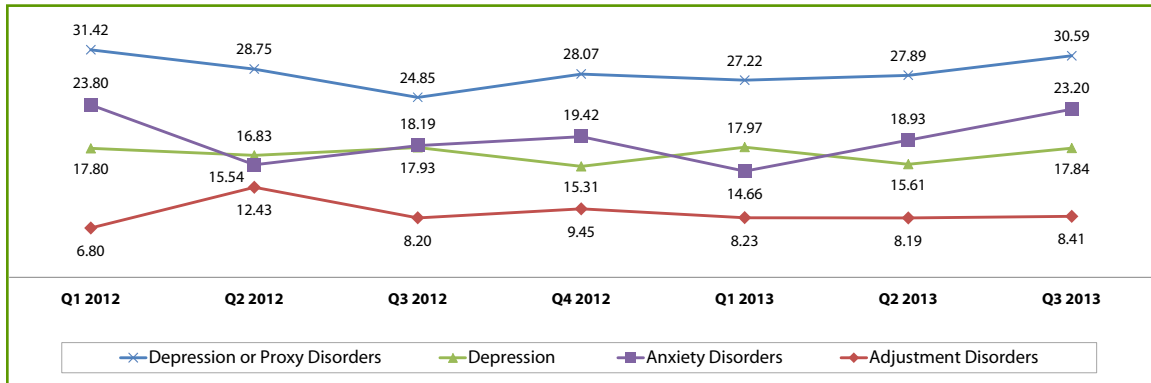
Summary

Figure 8. Percent Change of Prevalence of Selected Behavioral Health Conditions per 1,000 Medicare FFS Beneficiaries						
	Eatontown and Shrewsbury			Monmouth		
	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change
Depression or Proxy Disorders	216.30	223.09	3.14	206.69	205.98	-0.34
• Depression	137.74	135.40	-1.70	132.99	130.67	-1.74
• Anxiety	116.76	118.90	1.83	114.24	117.85	3.16
• Adjustment	50.00	50.29	0.58	39.09	37.33	-4.50
Alcohol or Substance Abuse	41.38	45.39	9.69	34.22	38.19	11.60
• Substance abuse alone	20.69	20.89	0.97	17.18	17.50	1.86
PTSD	5.24	6.45	23.09	5.12	5.50	7.42
Suicide and intentional self-inflicted injuries	7.07	5.67	-19.80	5.27	5.12	-2.85

The Eatontown and Shrewsbury community experienced a larger decrease in suicide and intentional self-inflicted injuries than Monmouth County. It also experienced a larger increase in PTSD than Monmouth County.

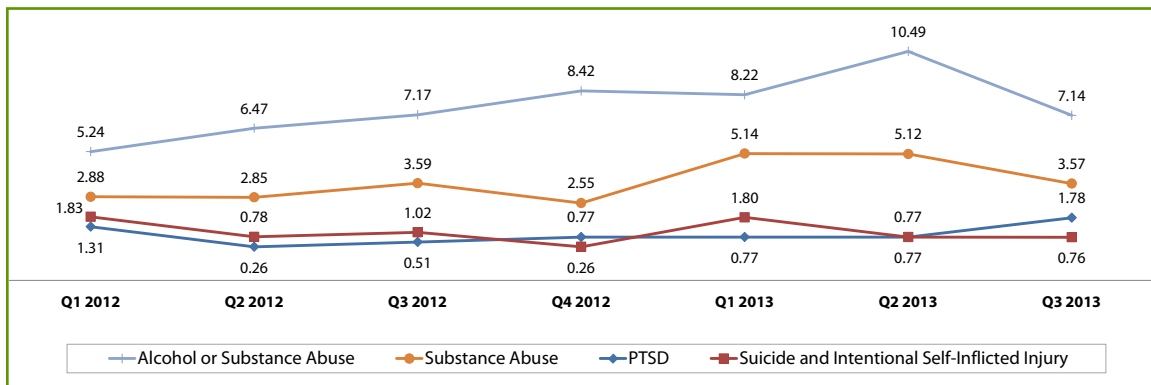
BEHAVIORAL HEALTH CONDITIONS

FIGURE 9. QUARTERLY NEW INCIDENCE TREND OF SELECTED BEHAVIORAL HEALTH CONDITIONS: DEPRESSION OR PROXY DISORDERS* PER 1,000 MEDICARE FFS BENEFICIARIES



* Quarterly new incidence of conditions that were not diagnosed in the prior year.

FIGURE 10. QUARTERLY NEW INCIDENCE TREND OF OTHER SELECTED BEHAVIORAL HEALTH CONDITIONS* PER 1,000 MEDICARE FFS BENEFICIARIES



* Quarterly new incidence of conditions that were not diagnosed in the prior year.

The charts above reflect quarterly trending in new incidence of the eight selected behavioral health conditions among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

FIGURE 11. ANNUAL PREVALENCE TREND OF SELECTED BEHAVIORAL HEALTH CONDITIONS: DEPRESSION OR PROXY DISORDERS PER 1,000 MEDICARE FFS BENEFICIARIES

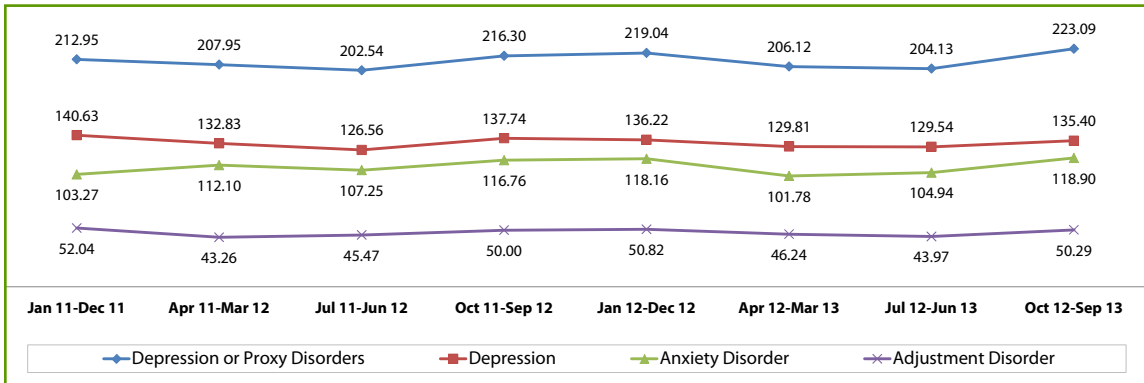
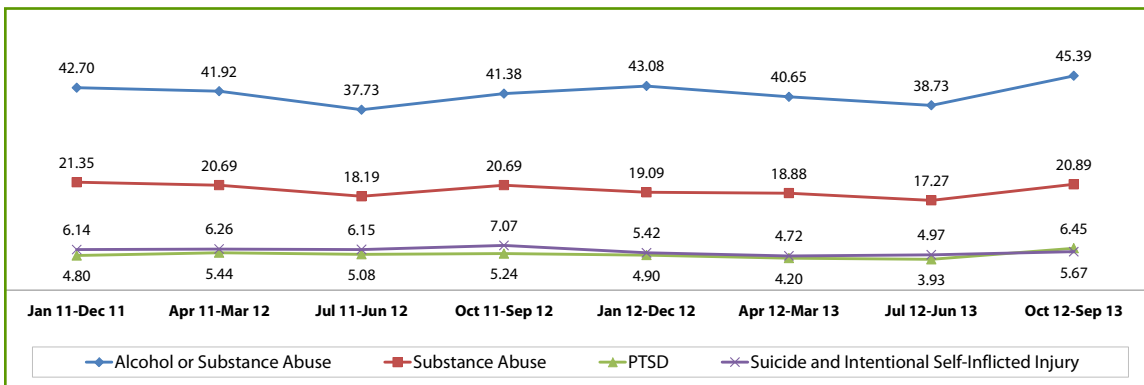


FIGURE 12. ANNUAL PREVALENCE TREND OF OTHER SELECTED BEHAVIORAL HEALTH CONDITIONS PER 1,000 MEDICARE FFS BENEFICIARIES



The charts above reflect annual trending in the prevalence of the eight selected behavioral health conditions among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

Depression or Proxy Disorders

Figure 13. Demographics of Depression or Proxy Disorders among Medicare FFS Beneficiaries

	10/1/11 – 9/30/12		10/1/12 – 9/30/13	
	Number of Beneficiaries	Percent (%)	Number of Beneficiaries	Percent (%)
Race				
• White	705	85.35	742	85.78
• Black	93	11.26	84	9.71
• Hispanic	13	1.57	16	1.85
• Asian	8	0.97	9	1.04
• Other	7	0.85	14	1.62
Gender				
• Males	243	29.42	287	33.18
• Females	583	70.58	578	66.82
Age				
• Below 65	181	21.91	189	21.85
• 65-74	238	28.81	253	29.25
• 75-84	212	25.67	207	23.93
• 85 and Above	195	23.61	216	24.97
Total	826	100.00	865	100.00

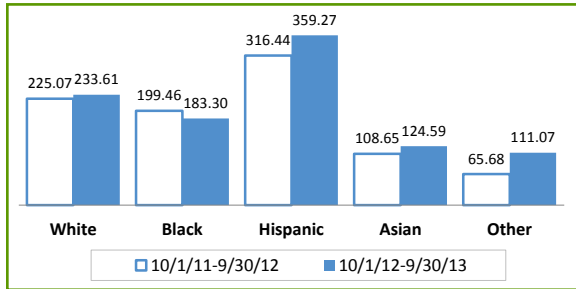
This table displays the number and percentage of Medicare FFS beneficiaries of each race, gender, and age diagnosed with depression or proxy disorders before and after Superstorm Sandy. There were 826 beneficiaries residing in the Eatontown and Shrewsbury community diagnosed with depression or proxy disorders before the storm. This increased to 865 beneficiaries after the storm.

Figure 14. Depression or Proxy Disorders Rate per 1,000 Medicare FFS Beneficiaries by Demographic Group						
	10/1/11 – 9/30/12			10/1/12 – 9/30/13		
	Numerator	Denominator*	Rate per 1,000 Beneficiaries	Numerator	Denominator*	Rate per 1,000 Beneficiaries
Race						
• White	705	3,132	225.07	742	3,176	233.61
• Black	93	466	199.46	84	458	183.30
• Hispanic	13	41	316.44	16	45	359.27
• Asian	8	74	108.65	9	72	124.59
• Other	7	106	65.68	14	126	111.07
Gender						
• Males	243	1,631	148.97	287	1,675	171.36
• Females	583	2,188	266.36	578	2,202	262.43
Age						
• Below 65	181	503	359.55	189	511	369.79
• 65-74	238	1,685	141.25	253	1,761	143.70
• 75-84	212	1,031	205.69	207	994	208.24
• 85 and Above	195	600	325.22	216	612	353.21
Total	826	3,819	216.30	865	3,877	223.09

* Total eligible beneficiaries (denominator) computed after adjusting for total enrolled FFS days divided by the total measurement days in the time frame

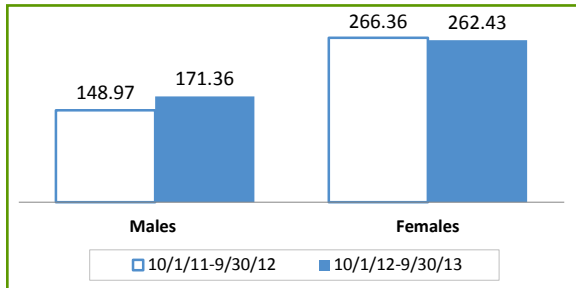
This table displays the rate of Medicare FFS beneficiaries per 1,000 diagnosed with depression or proxy disorders by race, gender, and age both before and after Superstorm Sandy by different demographic groups. The numerator is the number of beneficiaries with a claim for depression or proxy disorders; the denominator is the total number of beneficiaries residing in the community for each group.

FIGURE 15. DEPRESSION OR PROXY DISORDERS RATE BY RACE PER 1,000 MEDICARE FFS BENEFICIARIES



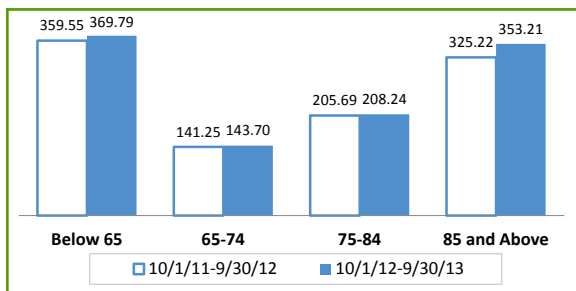
Hispanic Medicare FFS beneficiaries have the highest rate of depression or proxy disorders followed by White and Black beneficiaries. In the 12 months prior to Superstorm Sandy, 316.44 per 1,000 Hispanic beneficiaries were diagnosed with depression or proxy disorders. After the storm, this rate increased to 359.27 per 1,000 beneficiaries.

FIGURE 16. DEPRESSION OR PROXY DISORDERS RATE BY GENDER PER 1,000 MEDICARE FFS BENEFICIARIES



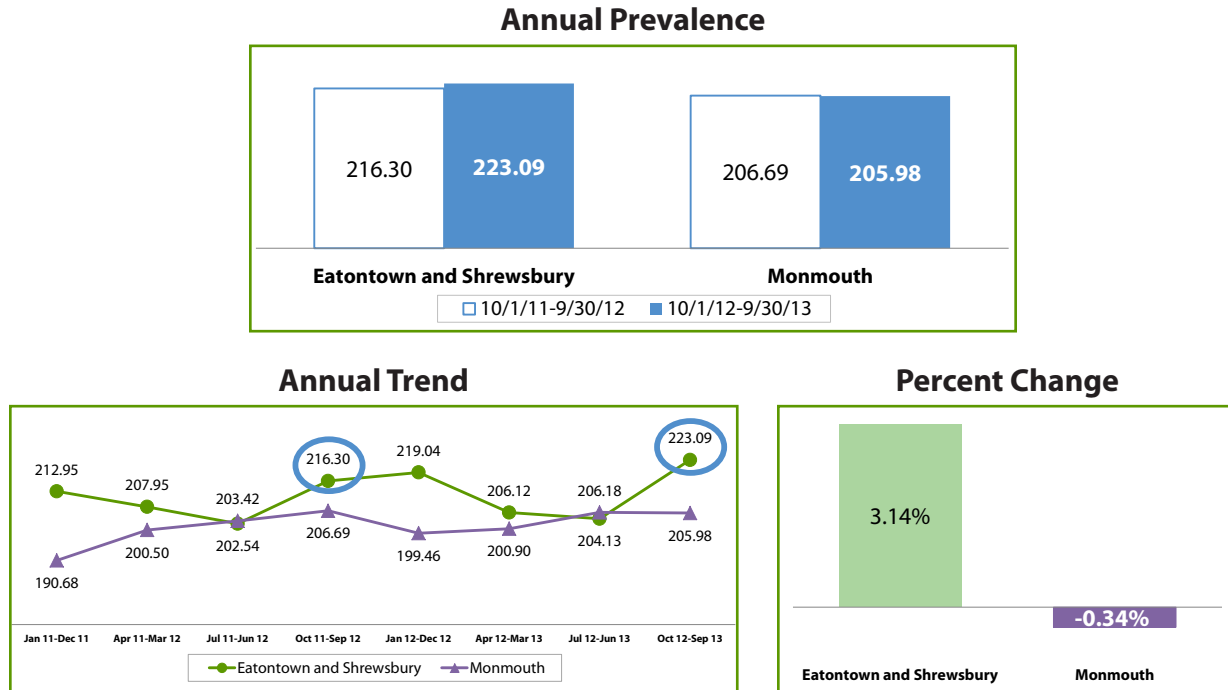
Female Medicare FFS beneficiaries have a higher rate of depression or proxy disorders than male beneficiaries. In the 12 months prior to Superstorm Sandy, 266.36 per 1,000 female beneficiaries were diagnosed with depression or proxy disorders. After the storm, this rate decreased to 262.43 per 1,000 beneficiaries.

FIGURE 17. DEPRESSION OR PROXY DISORDERS RATE BY AGE GROUP PER 1,000 MEDICARE FFS BENEFICIARIES



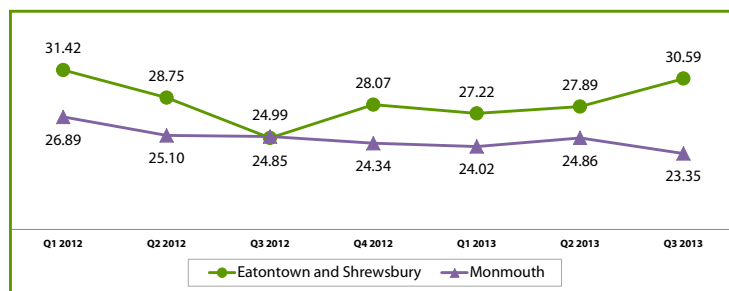
Medicare FFS beneficiaries below the age of 65 have the highest rate of depression or proxy disorders, followed by beneficiaries ages 85 and above. In the 12 months prior to Superstorm Sandy, 359.55 per 1,000 beneficiaries below the age of 65 were diagnosed with depression or proxy disorders. After the storm, this rate increased to 369.79 per 1,000 beneficiaries.

FIGURE 18. DEPRESSION OR PROXY DISORDERS PER 1,000 MEDICARE FFS BENEFICIARIES



The prevalence rate of depression or proxy disorders among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community in the 12 months prior to Superstorm Sandy was 216.30 per 1,000 beneficiaries. After the storm, this rate increased to 223.09 per 1,000 beneficiaries, reflecting a 3.14% relative increase.

FIGURE 19. QUARTERLY NEW INCIDENCE OF DEPRESSION OR PROXY DISORDERS* PER 1,000 MEDICARE FFS BENEFICIARIES



This chart reflects trending of quarterly new incidence of depression or proxy disorders among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

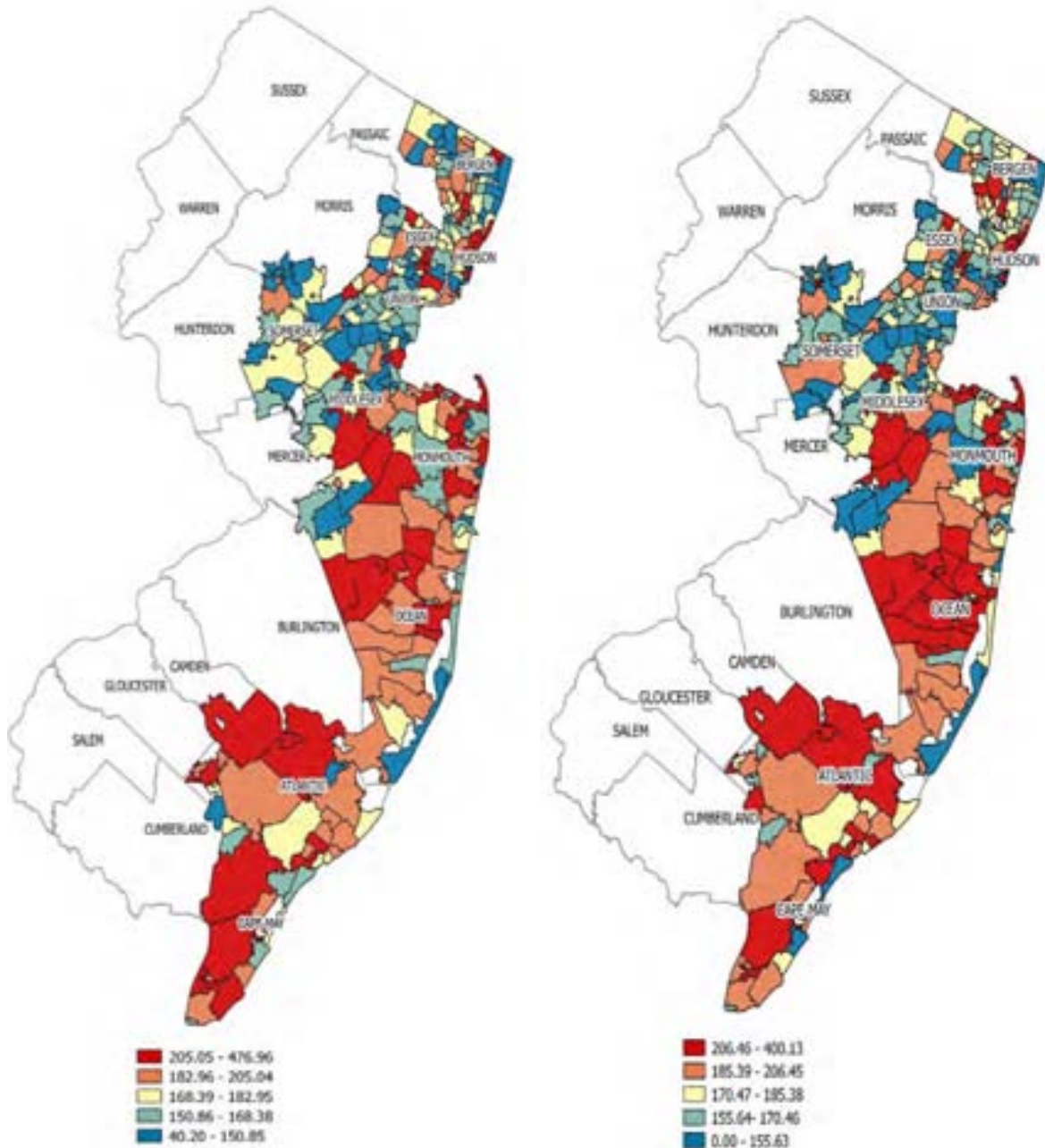
* Quarterly new incidences of conditions that were non-existent (not reported) in the last 12 months.

BEHAVIORAL HEALTH CONDITIONS

FIGURE 20. PREVALENCE OF DEPRESSION OR PROXY DISORDERS* PER 1,000 MEDICARE FFS BENEFICIARIES IN 10 COUNTIES

October 1, 2011 – September 30, 2012

October 1, 2012 – September 30, 2013



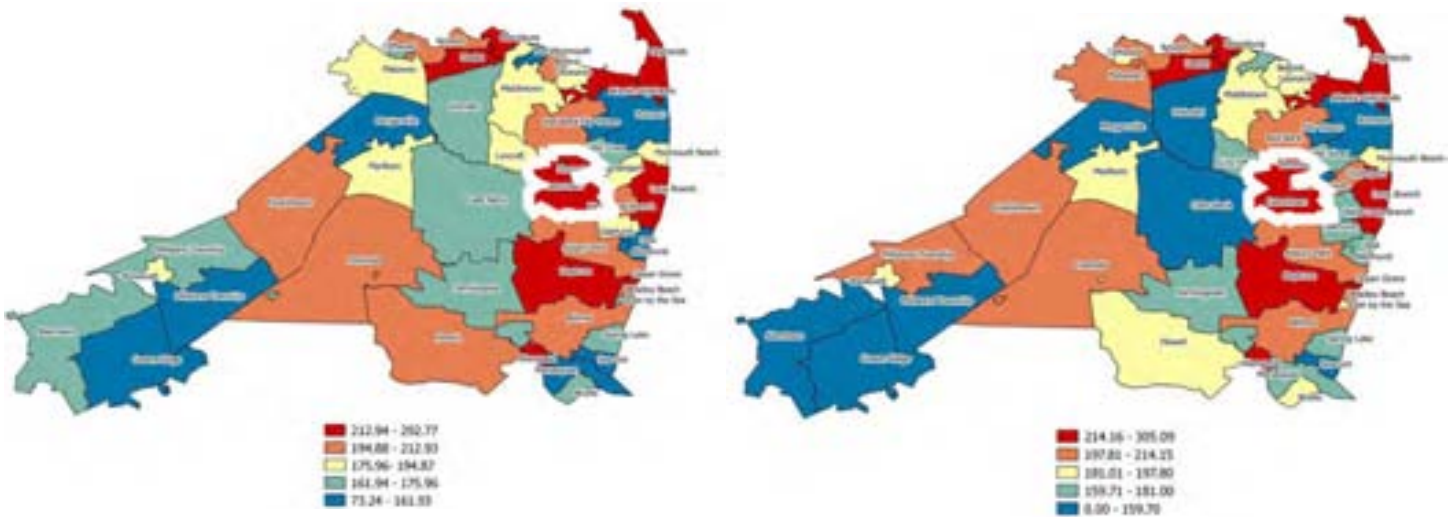
The color-coded map of New Jersey depicts prevalence of depression or proxy disorders from high (red) to low (blue) in the 10 FEMA-declared disaster counties before and after Superstorm Sandy.

* Mapped using ZIP codes of the 10 counties.

**FIGURE 21. MONMOUTH COUNTY PREVALENCE OF DEPRESSION OR PROXY DISORDERS*
PER 1,000 MEDICARE FFS BENEFICIARIES**

October 1, 2011 – September 30, 2012

October 1, 2012 – September 30, 2013

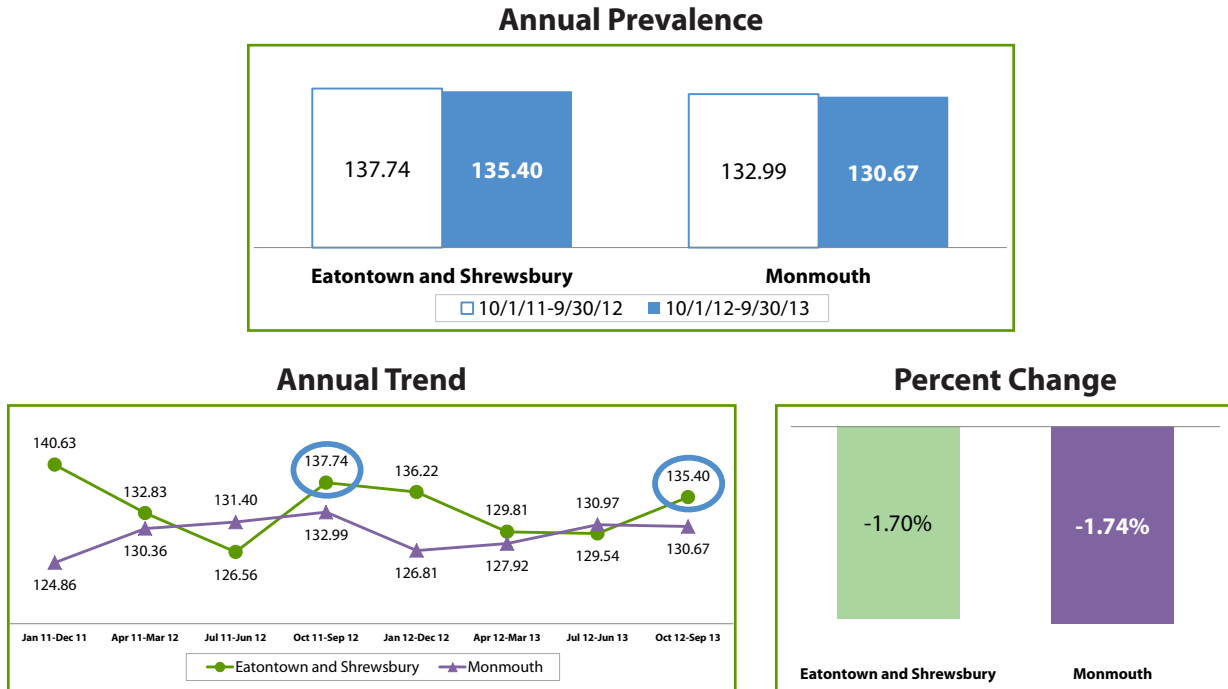


The color-coded map of Monmouth County depicts regional variation of prevalence of depression or proxy disorders from high (red) to low (blue) before and after Superstorm Sandy.

* Mapped using ZIP codes; may not display all the city names located within the ZIP code.

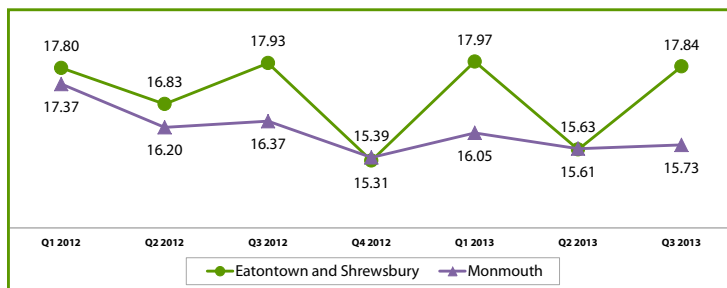
Depression

FIGURE 22. DEPRESSION PER 1,000 MEDICARE FFS BENEFICIARIES



The prevalence rate of depression among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community in the 12 months prior to Superstorm Sandy was 137.74 per 1,000 beneficiaries. After the storm, this rate decreased to 135.40 per 1,000 beneficiaries, reflecting a 1.70% relative decrease.

FIGURE 23. QUARTERLY NEW INCIDENCE OF DEPRESSION* PER 1,000 MEDICARE FFS BENEFICIARIES

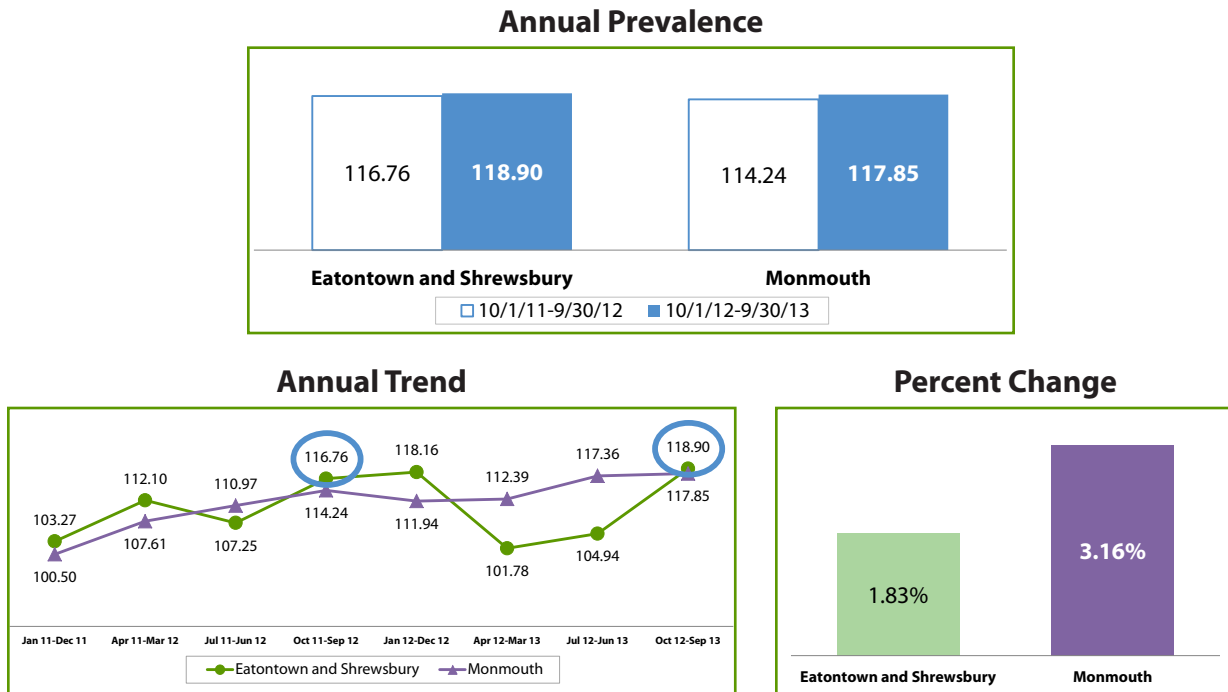


This chart reflects trending of quarterly new incidence of depression among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

* Quarterly new incidences of conditions that were non-existent (not reported) in the last 12 months.

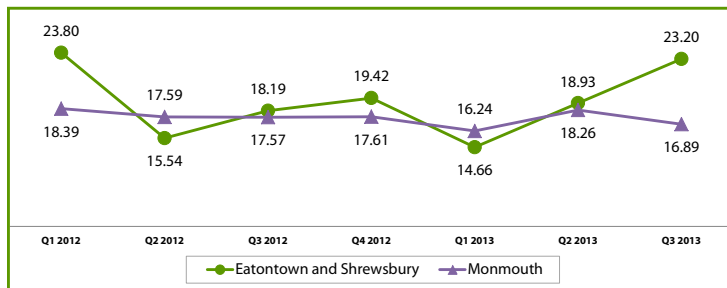
Anxiety Disorders

FIGURE 24. ANXIETY DISORDERS PER 1,000 MEDICARE FFS BENEFICIARIES



The prevalence rate of anxiety disorders among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community in the 12 months prior to Superstorm Sandy was 116.76 per 1,000 beneficiaries. After the storm, this rate increased to 118.90 per 1,000 beneficiaries, reflecting a 1.83% relative increase.

FIGURE 25. QUARTERLY NEW INCIDENCE OF ANXIETY DISORDERS* PER 1,000 MEDICARE FFS BENEFICIARIES

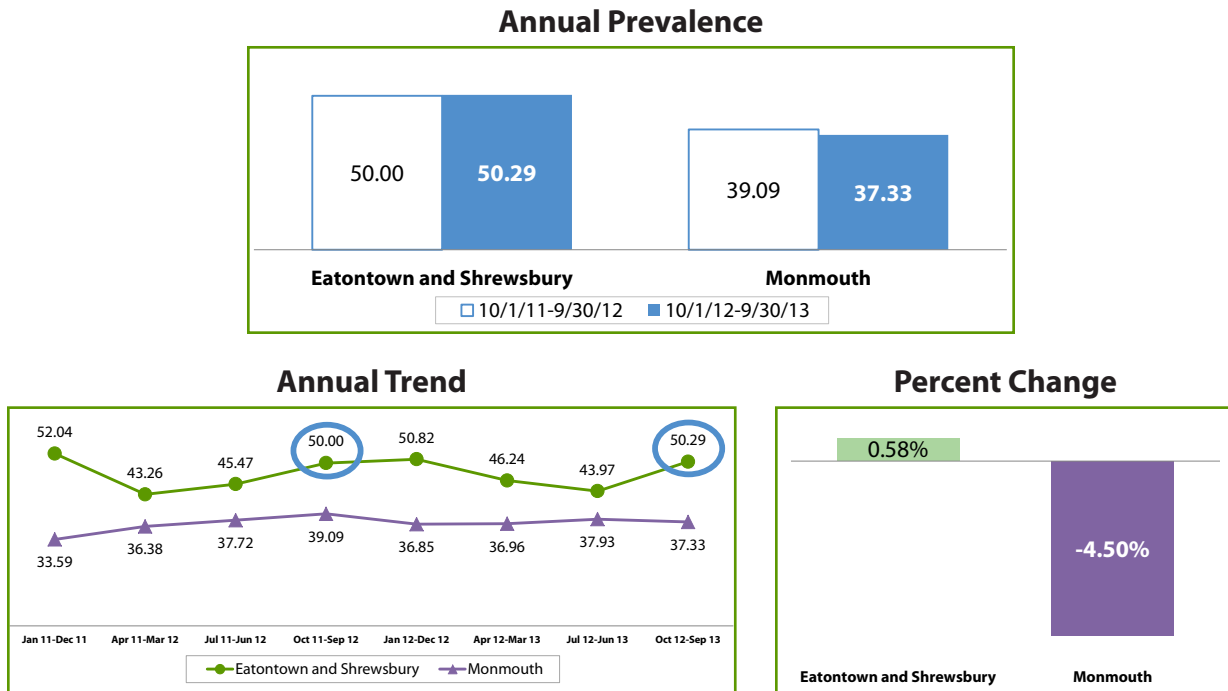


This chart reflects trending of quarterly new incidence of anxiety disorders among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

* Quarterly new incidences of conditions that were non-existent (not reported) in the last 12 months.

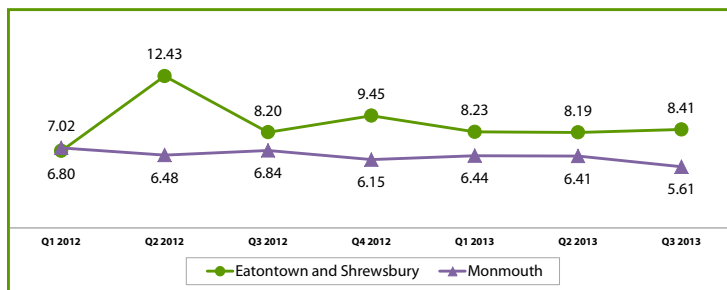
Adjustment Disorders

FIGURE 26. ADJUSTMENT DISORDERS PER 1,000 MEDICARE FFS BENEFICIARIES



The prevalence rate of adjustment disorders among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community in the 12 months prior to Superstorm Sandy was 50.00 per 1,000 beneficiaries. After the storm, this rate increased to 50.29 per 1,000 beneficiaries, reflecting a 0.58% relative increase.

FIGURE 27. QUARTERLY NEW INCIDENCE OF ADJUSTMENT DISORDERS* PER 1,000 MEDICARE FFS BENEFICIARIES

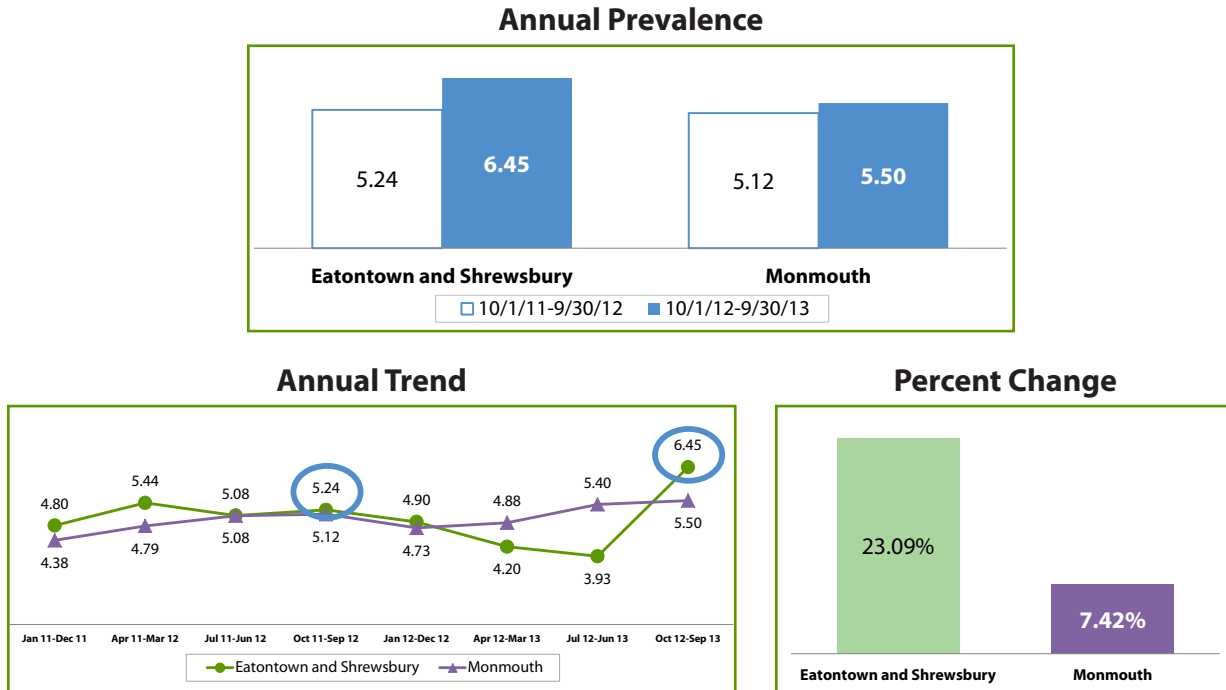


This chart reflects trending of quarterly new incidence of adjustment disorders among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

* Quarterly new incidences of conditions that were non-existent (not reported) in the last 12 months.

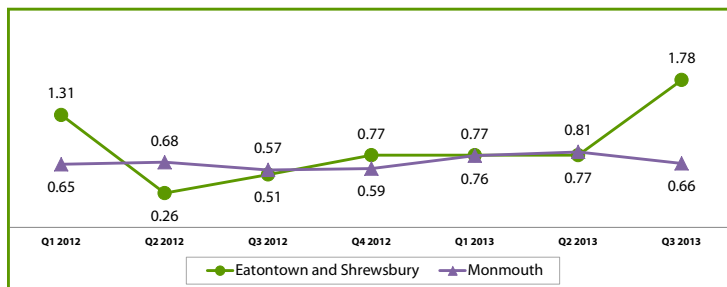
Post-Traumatic Stress Disorder (PTSD)

FIGURE 28. PTSD PER 1,000 MEDICARE FFS BENEFICIARIES



The prevalence rate of PTSD among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community in the 12 months prior to Superstorm Sandy was 5.24 per 1,000 beneficiaries. After the storm, this rate increased to 6.45 per 1,000 beneficiaries, reflecting a 23.09% relative increase.

FIGURE 29. QUARTERLY NEW INCIDENCE OF PTSD* PER 1,000 MEDICARE FFS BENEFICIARIES

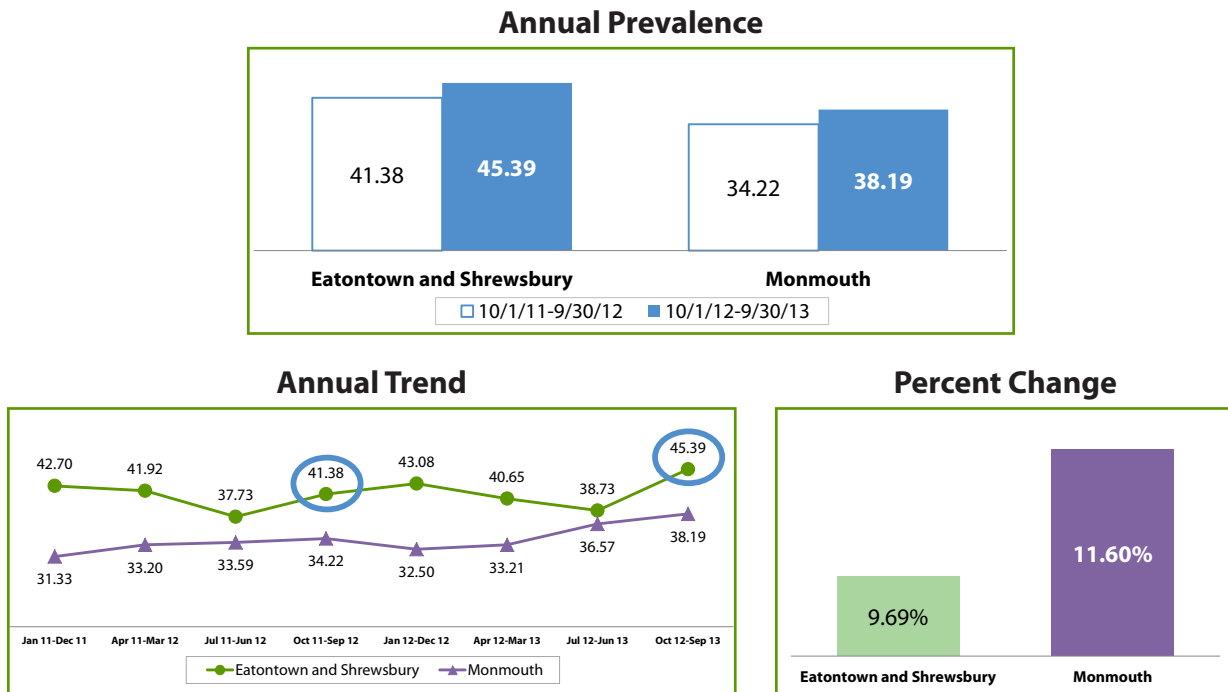


This chart reflects trending of quarterly new incidence of PTSD among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

* Quarterly new incidences of conditions that were non-existent (not reported) in the last 12 months.

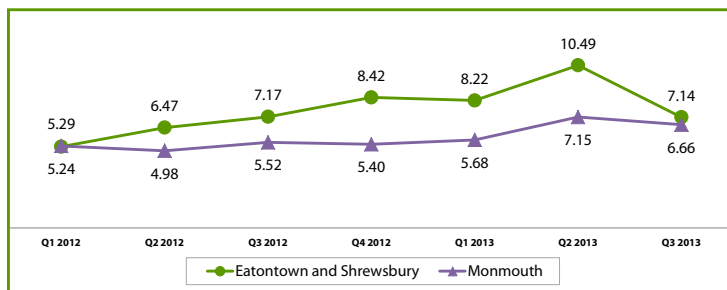
Alcohol or Substance Abuse

FIGURE 30. ALCOHOL OR SUBSTANCE ABUSE PER 1,000 MEDICARE FFS BENEFICIARIES



The prevalence rate of alcohol or substance abuse among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community in the 12 months prior to Superstorm Sandy was 41.38 per 1,000 beneficiaries. After the storm, this rate increased to 45.39 per 1,000 beneficiaries, reflecting a 9.69% relative increase.

FIGURE 31. QUARTERLY NEW INCIDENCE OF ALCOHOL OR SUBSTANCE ABUSE* PER 1,000 MEDICARE FFS BENEFICIARIES

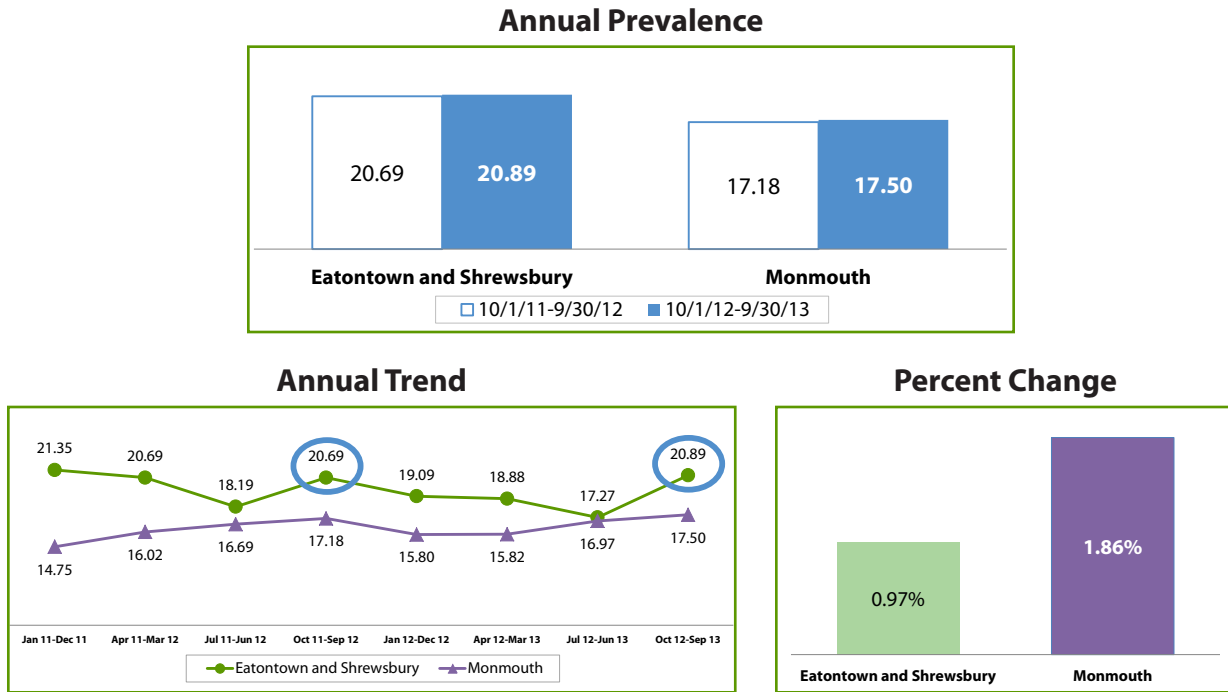


This chart reflects trending of quarterly new incidence of alcohol or substance abuse among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

* Quarterly new incidences of conditions that were non-existent (not reported) in the last 12 months.

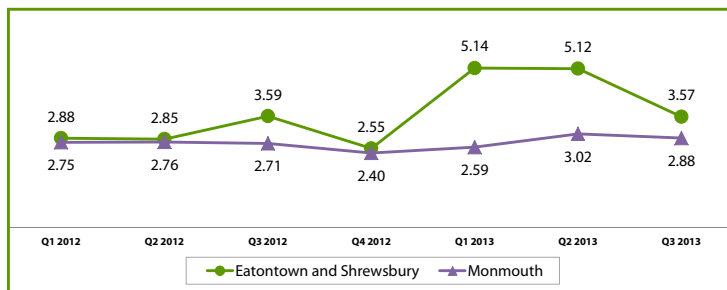
Substance Abuse Alone

FIGURE 32. SUBSTANCE ABUSE ALONE PER 1,000 MEDICARE FFS BENEFICIARIES



The prevalence rate of substance abuse alone among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community in the 12 months prior to Superstorm Sandy was 20.69 per 1,000 beneficiaries. After the storm, this rate increased to 20.89 per 1,000 beneficiaries, reflecting a 0.97% relative increase.

FIGURE 33. QUARTERLY NEW INCIDENCE OF SUBSTANCE ABUSE ALONE* PER 1,000 MEDICARE FFS BENEFICIARIES

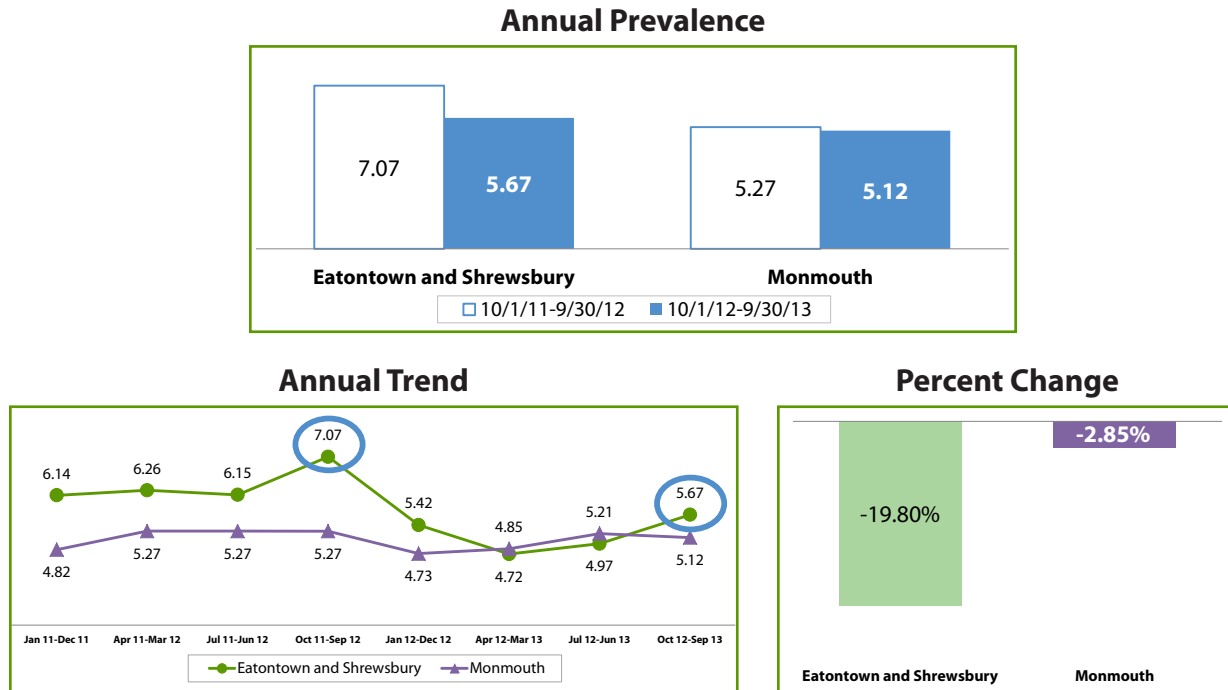


This chart reflects trending of quarterly new incidence of substance abuse alone among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

* Quarterly new incidences of conditions that were non-existent (not reported) in the last 12 months.

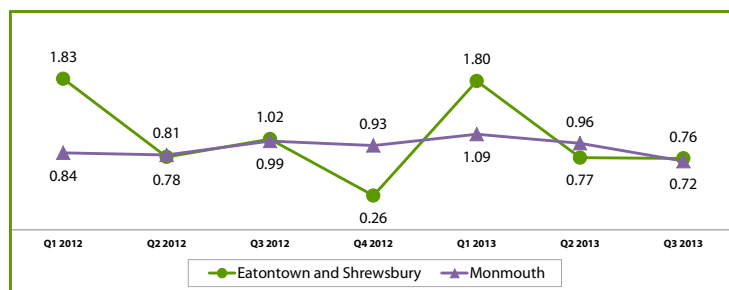
Suicide and Intentional Self-Inflicted Injury

FIGURE 34. SUICIDE AND INTENTIONAL SELF-INFLICTED INJURY PER 1,000 MEDICARE FFS BENEFICIARIES



The prevalence rate of suicide and intentional self-inflicted injuries among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community in the 12 months prior to Superstorm Sandy was 7.07 per 1,000 beneficiaries. After the storm, this rate decreased to 5.67 per 1,000 beneficiaries, reflecting a 19.80% relative decrease.

FIGURE 35. QUARTERLY NEW INCIDENCE OF SUICIDE AND INTENTIONAL SELF-INFLICTED INJURY* PER 1,000 MEDICARE FFS BENEFICIARIES



This chart reflects trending of quarterly new incidence of suicide and intentional self-inflicted injuries among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

* Quarterly new incidences of conditions that were non-existent (not reported) in the last 12 months.

RISK FACTORS FOR DEPRESSION OR PROXY DISORDERS

To identify beneficiaries at risk of developing depression or proxy disorders, HQSI conducted a literature review on the potential risk factors for depression or proxy disorders. Previous studies suggested that psychosocial factors, biological factors, deteriorating physical functioning, and medication side effects could increase the risk of depression or proxy disorders.

Based on the literature review and data analysis using factors available through Medicare claims data, the top five risk factors for depression or proxy disorders were identified as: Alzheimer’s disease and related disorders or senile dementia, sleep disturbance, alcohol or substance abuse or tobacco use, hip/pelvic fractures, and amputations (see Appendix B).

For Medicare FFS beneficiaries residing in the community who were diagnosed with these risk factor conditions prior to being diagnosed with depression or proxy disorders, these conditions may have contributed to the risk of developing depression or proxy disorders. The following figures show the prevalence rates for these five conditions in the 12 months before and after Superstorm Sandy.

Summary

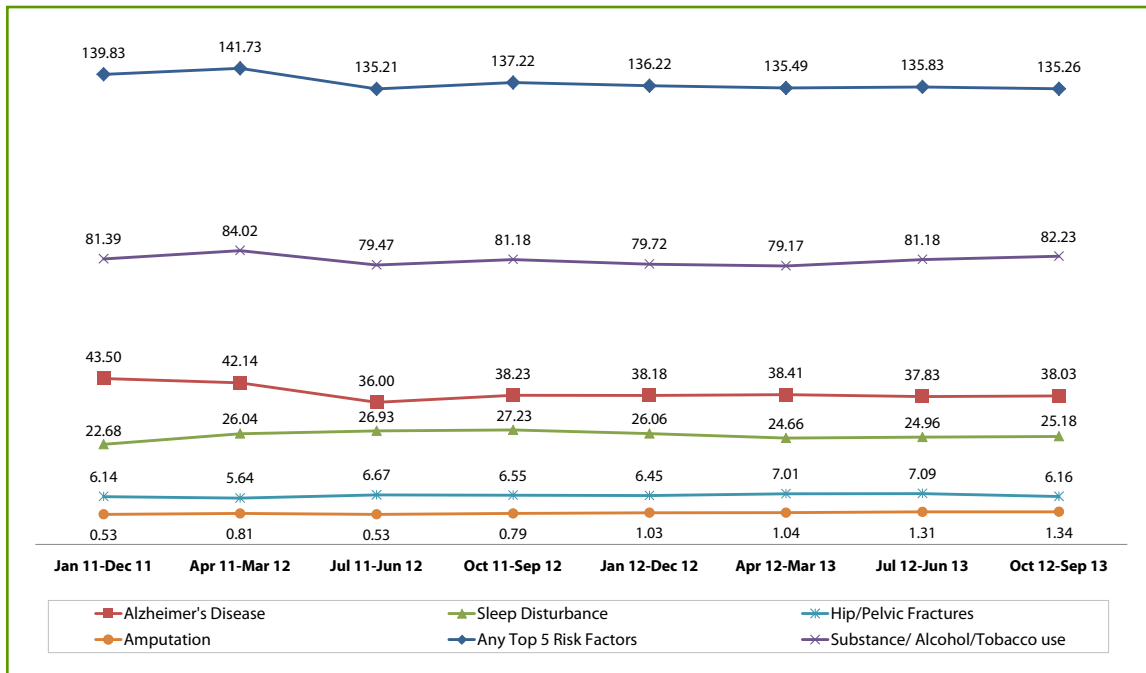
Figure 36. Percent Change of Prevalence of the Top Five Risk Factors of Depression or Proxy Disorders per 1,000 Medicare FFS Beneficiaries

	Eatontown and Shrewsbury			Monmouth		
	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change
Any of the Top Five Risk Factors for Depression or Proxy Disorders	137.22	135.26	-1.43	133.53	133.34	-0.14
• Alzheimer’s Disease and related disorders or Senile Dementia	38.23	38.03	-0.52	35.85	32.70	-8.79
• Sleep Disturbance	27.23	25.18	-7.53	24.36	24.24	-0.49
• Substance or Alcohol Abuse or Tobacco Use	81.18	82.23	1.29	79.12	82.49	4.26
• Hip/Pelvic Fractures	6.55	6.16	-5.95	7.47	7.34	-1.74
• Amputations	0.79	1.34	69.62	0.75	0.80	6.67

The Eatontown and Shrewsbury community experienced a larger increase in amputations than Monmouth County. It also experienced a larger decrease in any of the top five risk factors for depression or proxy disorders, as well as in sleep disturbance, and hip/pelvic fractures, than Monmouth County.

BEHAVIORAL HEALTH CONDITIONS

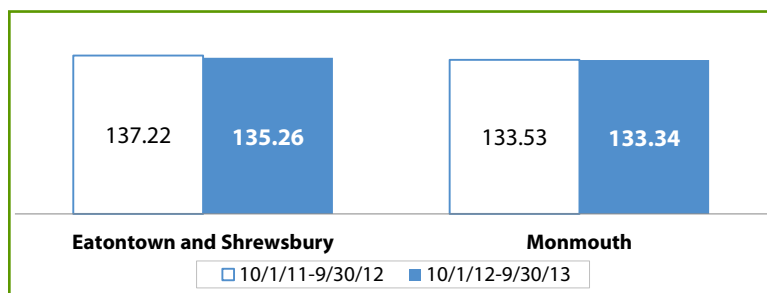
FIGURE 37. ANNUAL PREVALENCE TREND FOR RISK FACTORS OF DEPRESSION OR PROXY DISORDERS PER 1,000 MEDICARE FFS BENEFICIARIES



The chart above reflects annual trending in the prevalence of any of the top five risk factors for depression or proxy disorders among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

Any of the Top Five Risk Factors for Depression or Proxy Disorders

FIGURE 38. ANNUAL PREVALENCE OF ANY OF THE TOP FIVE RISK FACTORS FOR DEPRESSION OR PROXY DISORDERS PER 1,000 MEDICARE FFS BENEFICIARIES



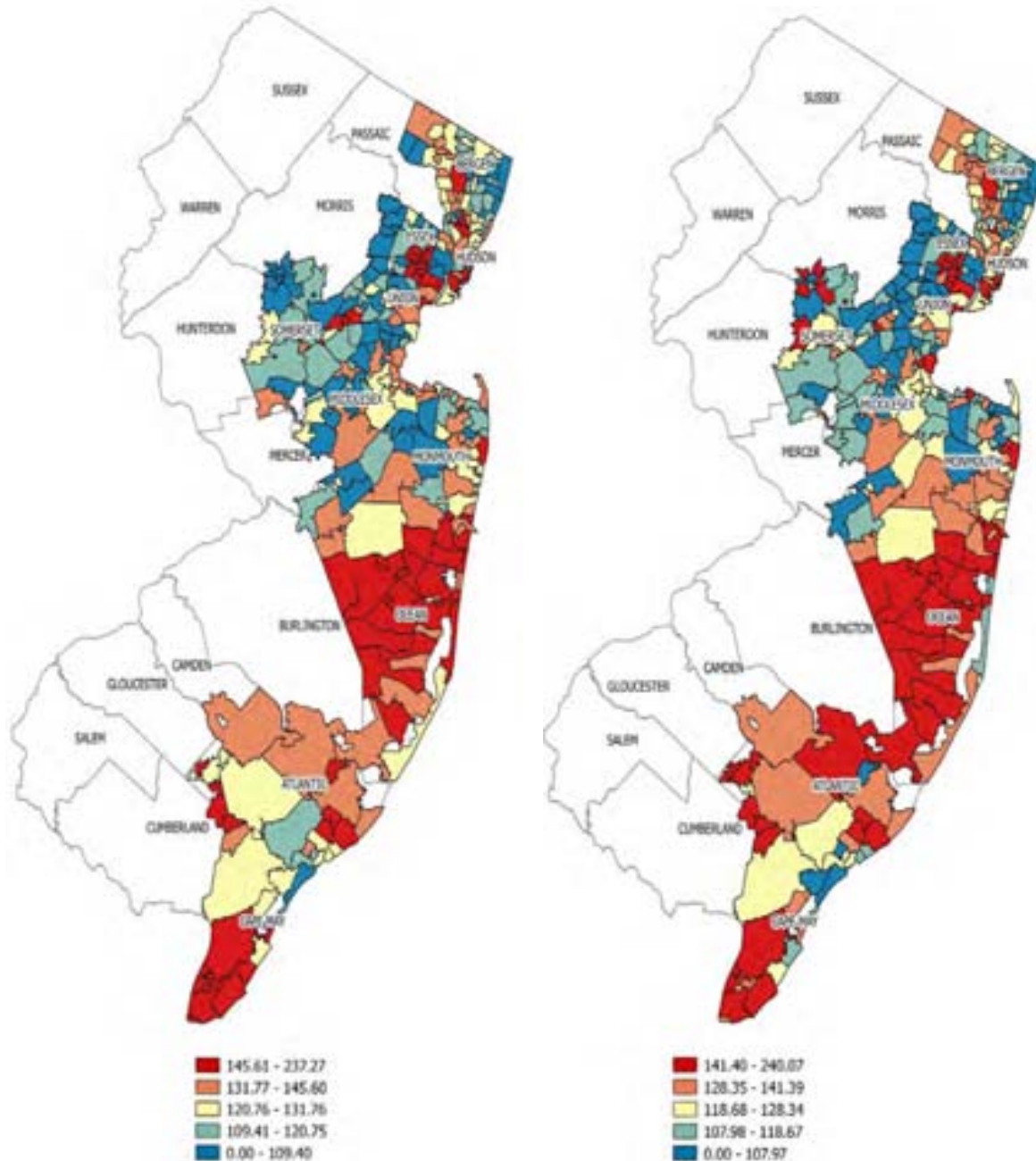
The prevalence rate of Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community with any of the top five risk factors for depression or proxy disorders in the 12 months prior to Superstorm Sandy was 137.22 per 1,000 beneficiaries. After the storm, the rate decreased to 135.26 per 1,000 beneficiaries.

BEHAVIORAL HEALTH CONDITIONS

FIGURE 39. PREVALENCE OF ANY OF THE TOP FIVE RISK FACTORS FOR DEPRESSION OR PROXY DISORDERS* PER 1,000 MEDICARE FFS BENEFICIARIES IN 10 COUNTIES

October 1, 2011 – September 30, 2012

October 1, 2012 – September 30, 2013



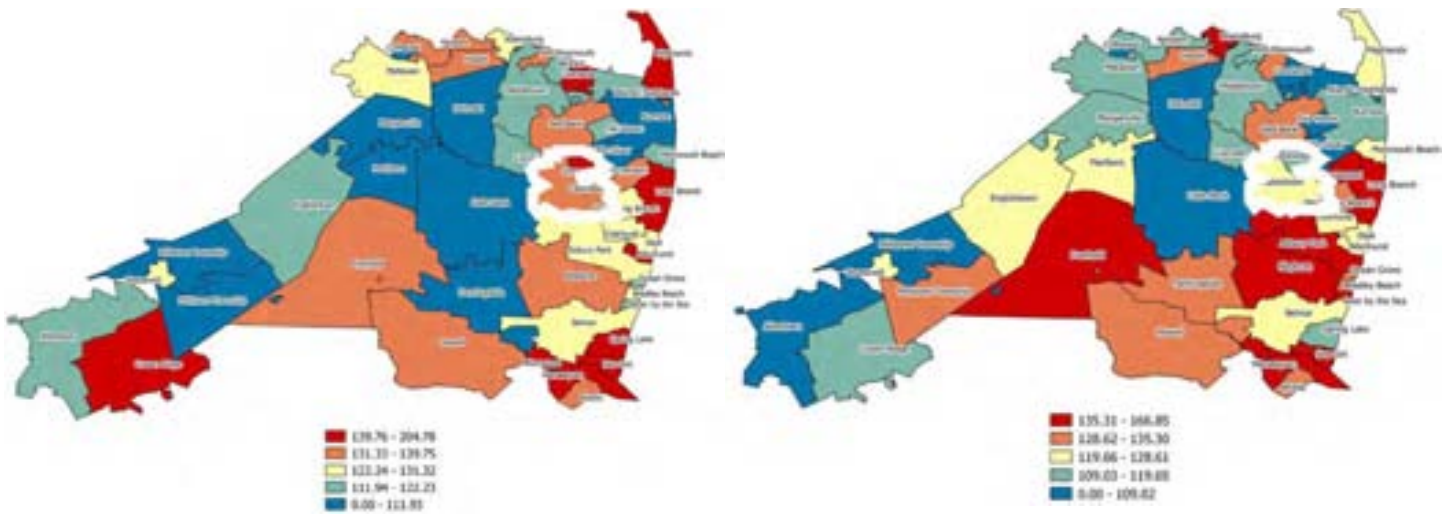
The color-coded map of New Jersey depicts prevalence of any of the top five risk factors from high (red) to low (blue) in the 10 FEMA-declared disaster counties before and after Superstorm Sandy.

* Mapped using ZIP codes of the 10 counties.

FIGURE 40. MONMOUTH COUNTY PREVALENCE OF ANY OF THE TOP FIVE RISK FACTORS FOR DEPRESSION OR PROXY DISORDERS* PER 1,000 MEDICARE FFS BENEFICIARIES

October 1, 2011 – September 30, 2012

October 1, 2012 – September 30, 2013

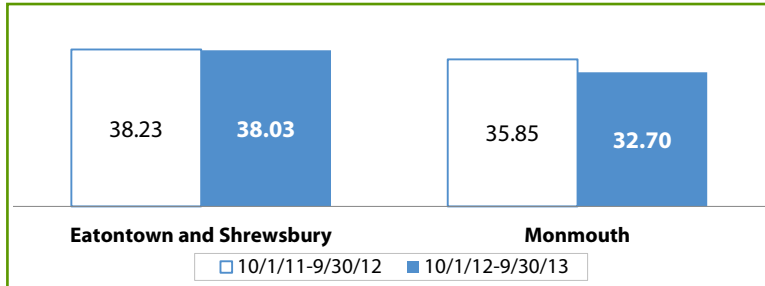


The color-coded map of Monmouth County depicts regional variation of prevalence of any of the top five risk factors from high (red) to low (blue) before and after Superstorm Sandy.

* Mapped using ZIP codes; may not display all the city names located within the ZIP code.

Alzheimer's Disease and Related Disorders or Senile Dementia

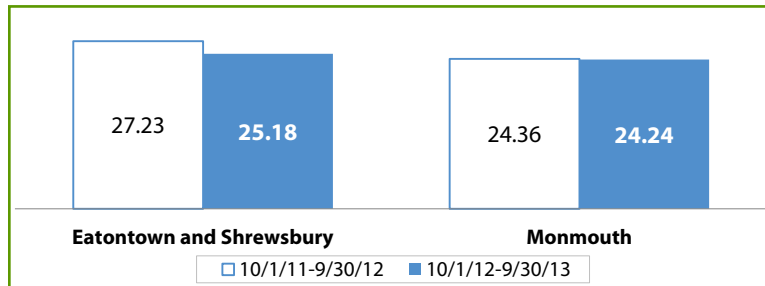
FIGURE 41. ANNUAL PREVALENCE OF ALZHEIMER'S DISEASE AND RELATED DISORDERS OR SENILE DEMENTIA PER 1,000 MEDICARE FFS BENEFICIARIES



The prevalence rate of Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community with Alzheimer's disease and related disorders or senile dementia in the 12 months prior to Superstorm Sandy was 38.23 per 1,000 beneficiaries. After the storm, the rate decreased to 38.03 per 1,000 beneficiaries.

Sleep Disturbance

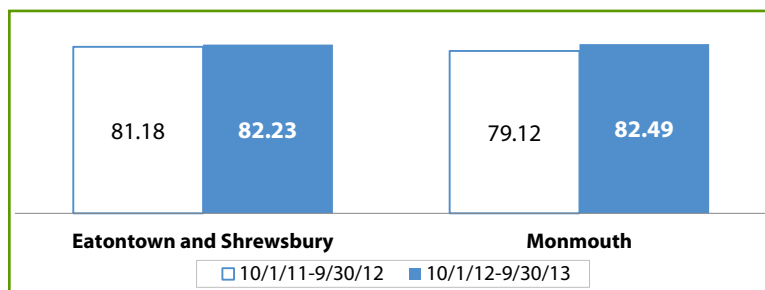
FIGURE 42. ANNUAL PREVALENCE OF SLEEP DISTURBANCE PER 1,000 MEDICARE FFS BENEFICIARIES



The prevalence rate of Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community with sleep disturbance in the 12 months prior to Superstorm Sandy was 27.23 per 1,000 beneficiaries. After the storm, the rate decreased to 25.18 per 1,000 beneficiaries.

Substance or Alcohol Abuse or Tobacco Use

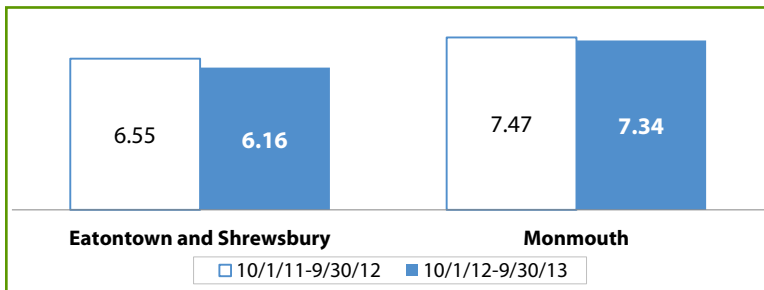
FIGURE 43. ANNUAL PREVALENCE OF SUBSTANCE OR ALCOHOL ABUSE OR TOBACCO USE PER 1,000 MEDICARE FFS BENEFICIARIES



The prevalence rate of Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community with substance or alcohol abuse or tobacco use in the 12 months prior to Superstorm Sandy was 81.18 per 1,000 beneficiaries. After the storm, the rate increased to 82.23 per 1,000 beneficiaries.

Hip/Pelvic Fractures

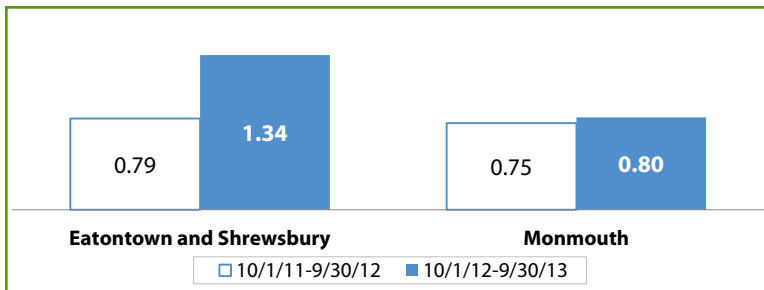
FIGURE 44. ANNUAL PREVALENCE OF HIP/PELVIC FRACTURES PER 1,000 MEDICARE FFS BENEFICIARIES



The prevalence rate of Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community with hip/pelvic fractures in the 12 months prior to Superstorm Sandy was 6.55 per 1,000 beneficiaries. After the storm, the rate decreased to 6.16 per 1,000 beneficiaries.

Amputations

FIGURE 45. ANNUAL PREVALENCE OF AMPUTATIONS PER 1,000 MEDICARE FFS BENEFICIARIES



The prevalence rate of Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community with amputations in the 12 months prior to Superstorm Sandy was 0.79 per 1,000 beneficiaries. After the storm, the rate increased to 1.34 per 1,000 beneficiaries.

UTILIZATION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES

Assessments*

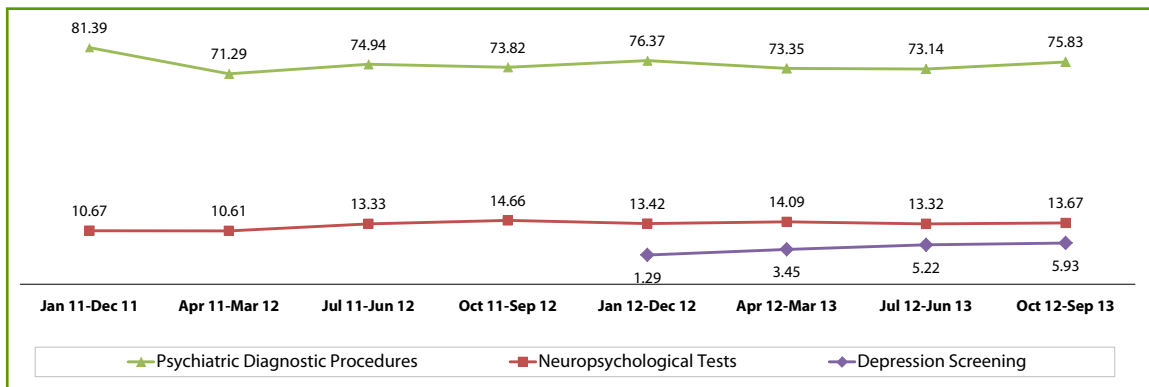
Summary

Figure 46. Percent Change of Behavioral Health Service Utilization – Assessments per 1,000 Medicare FFS Beneficiaries						
	Eatontown and Shrewsbury			Monmouth		
	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change
Annual Depression Screening**	1.29	5.93	359.69	4.71	10.90	131.42
Psychiatric Diagnostic Procedures	73.82	75.83	2.72	61.40	54.64	-11.01
Neuropsychological Tests	14.66	13.67	-6.75	10.46	10.56	0.96

** Depression screening comparison time frames are different (January 1, 2012 – December 31, 2012 vs. October 1, 2012 – September 30, 2013)

Annual depression screening in the Eatontown and Shrewsbury community has increased from 1.29 per 1,000 Medicare FFS beneficiaries to 5.93 per 1,000 beneficiaries. Psychiatric diagnostic procedures also increased.

FIGURE 47. ANNUAL UTILIZATION TREND OF BEHAVIORAL HEALTH ASSESSMENT SERVICES PER 1,000 MEDICARE FFS BENEFICIARIES



The chart above reflects annual trending in the utilization of behavioral health assessment services among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

Depression Screening

One of the long-term goals of this project is to increase the awareness and use of Medicare-covered depression screening among at-risk Medicare FFS beneficiaries residing in the 10 counties during Superstorm Sandy.

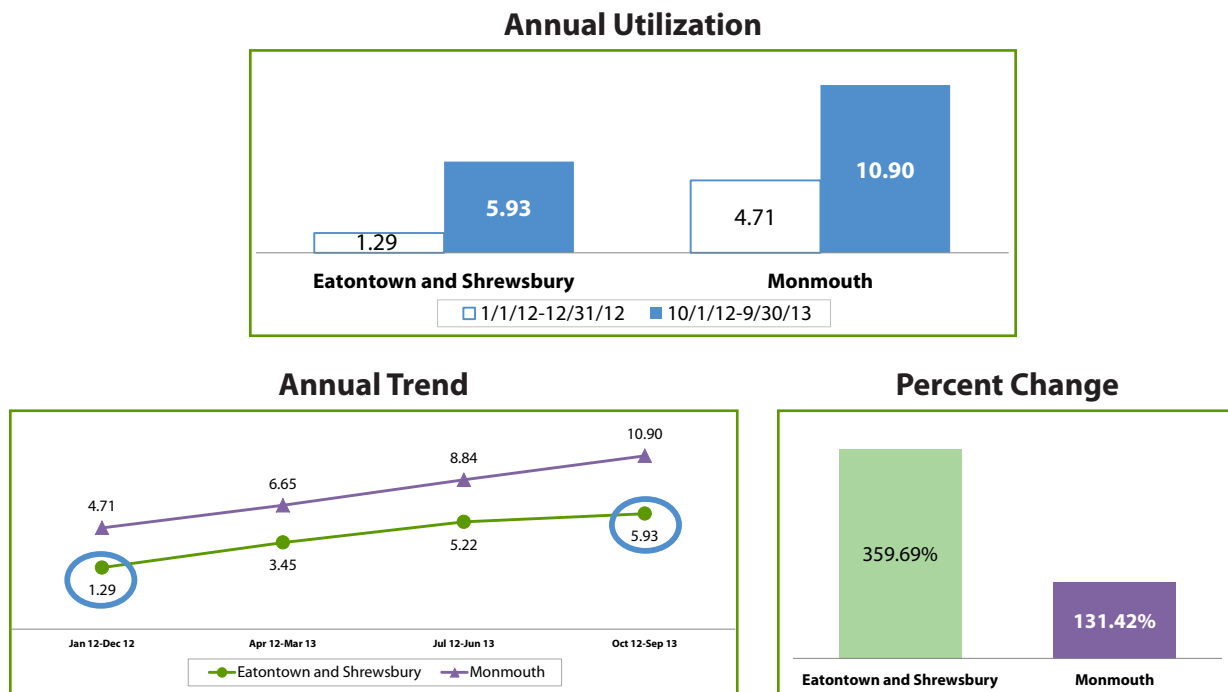
*The utilization rates for Diagnostic Psychological Tests and Health and Behavior Assessment/Intervention are not provided in this profile due to low rates.

UTILIZATION

Beginning October 2011, depression screening became a Medicare-covered service. According to the CMS Screening for Depression Booklet,⁷ Medicare Part B covers an annual screening for depression of 15 minutes in length for beneficiaries in primary care settings when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. The first quarter of data in this profile for depression screening starts on January 2012 since there were only 14 claims filed for depression screening in the last quarter of 2011 in all 10 counties.

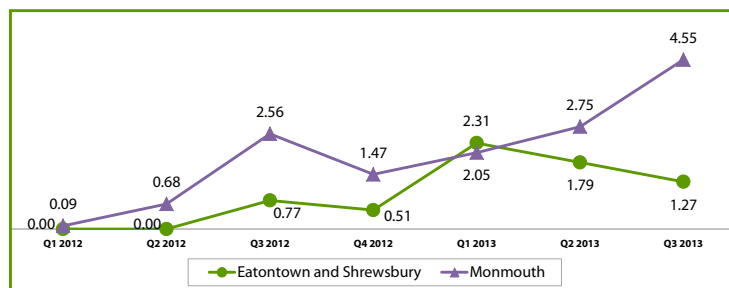
The depression screening utilization rates have been low in all 10 communities.

FIGURE 48. DEPRESSION SCREENING PER 1,000 MEDICARE FFS BENEFICIARIES



The rate of depression screening in the Eatontown and Shrewsbury community for calendar year 2012 was 1.29 per 1,000 Medicare FFS beneficiaries. After the storm, this rate increased to 5.93 per 1,000 beneficiaries, reflecting a 359.69% relative increase.

FIGURE 49. QUARTERLY DEPRESSION SCREENING* PER 1,000 MEDICARE FFS BENEFICIARIES



This chart reflects trending of quarterly utilization of depression screening among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

* Quarterly new incidences of conditions that were non-existent (not reported) in the last 12 months.

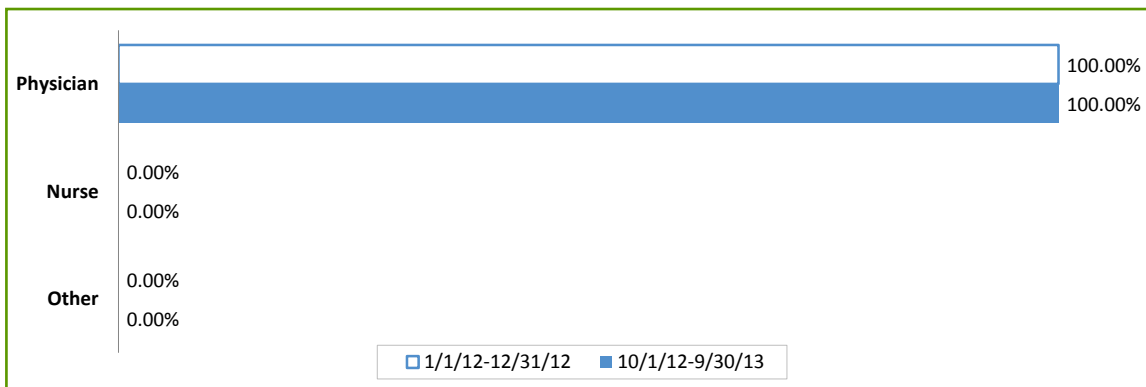
Figure 50. Provider Location for Depression Screening* Claims for Medicare FFS Beneficiaries Residing in Eatontown and Shrewsbury Community

Providers	1/1/12-12/31/12		10/1/12-9/30/13	
	Number of Claims N=5	Percent	Number of Claims N=23	Percent
Outside of New Jersey	0	0.0	1	4.3
New Jersey	5	100.0	22	95.7
• Monmouth County	4	80.0	18	78.3
– Eatontown and Shrewsbury Community	0	0.0	3	13.0
• Other Counties	1	20.0	4	17.4

* Depression screening is a one time benefit per year. Depression screening comparison time frames are different (January 1, 2012 – December 31, 2012 vs. October 1, 2012 – September 30, 2013)

After Superstorm Sandy, of the 23 claims filed for a depression screening for beneficiaries residing in the Eatontown and Shrewsbury community, 4.3% were filed outside of New Jersey and 95.7% were filed within New Jersey. Of those filed within New Jersey, 78.3% were filed within Monmouth County, and 13.0% were filed in the Eatontown and Shrewsbury community, and 17.4 % were filed in other counties.

FIGURE 51. DEPRESSION SCREENING* CLAIMS FOR MEDICARE FFS BENEFICIARIES



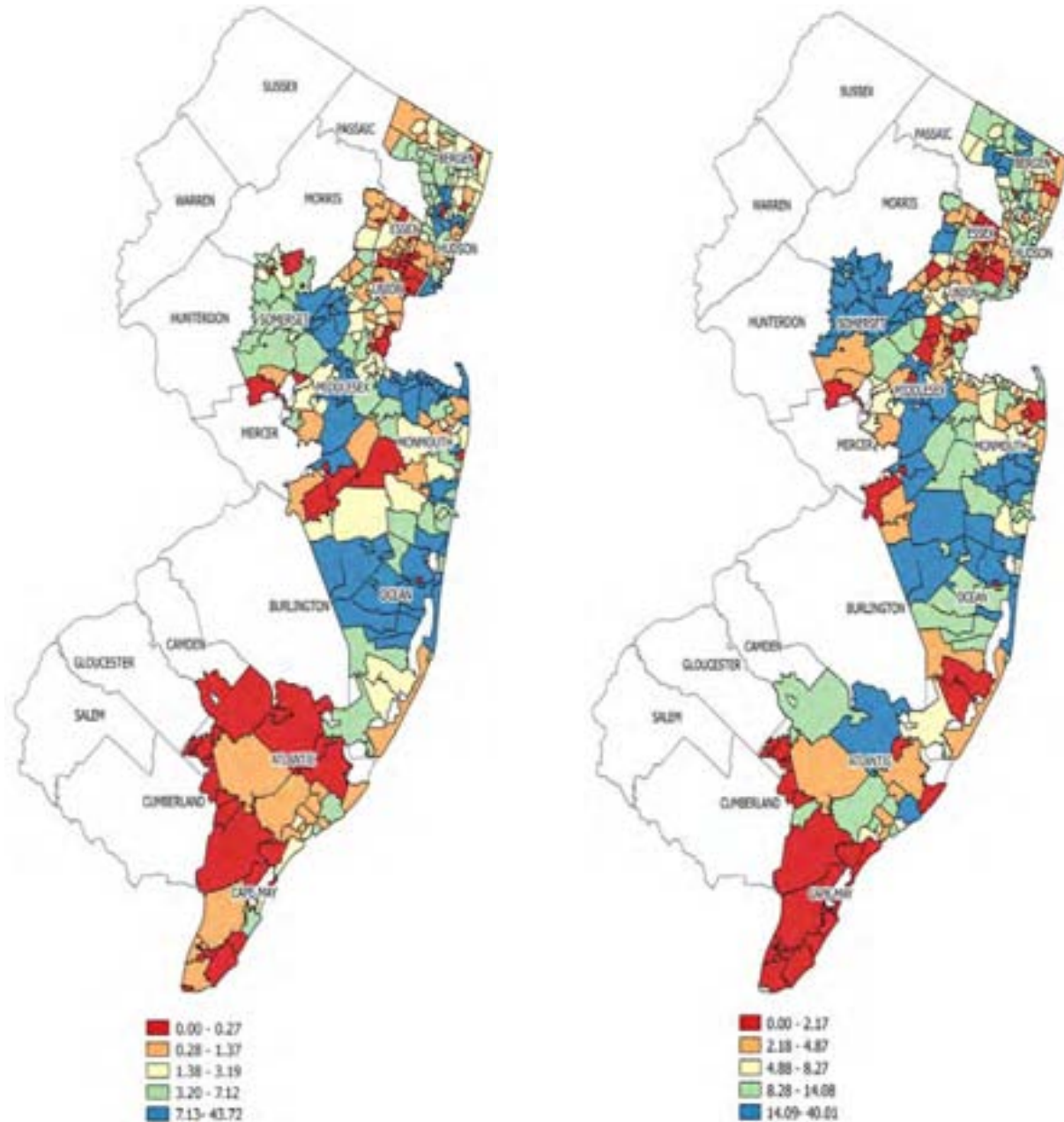
* Depression screening is a one time benefit per year

During calendar year 2012, 100.00% of depression screening claims recorded in the Eatontown and Shrewsbury community were filed by physicians. After the storm, all of the depression screening claims were also filed by physicians.

**FIGURE 52. DEPRESSION SCREENING*
PER 1,000 MEDICARE FFS BENEFICIARIES IN 10 COUNTIES**

January 1, 2012 – December 31, 2012

October 1, 2012 – September 30, 2013



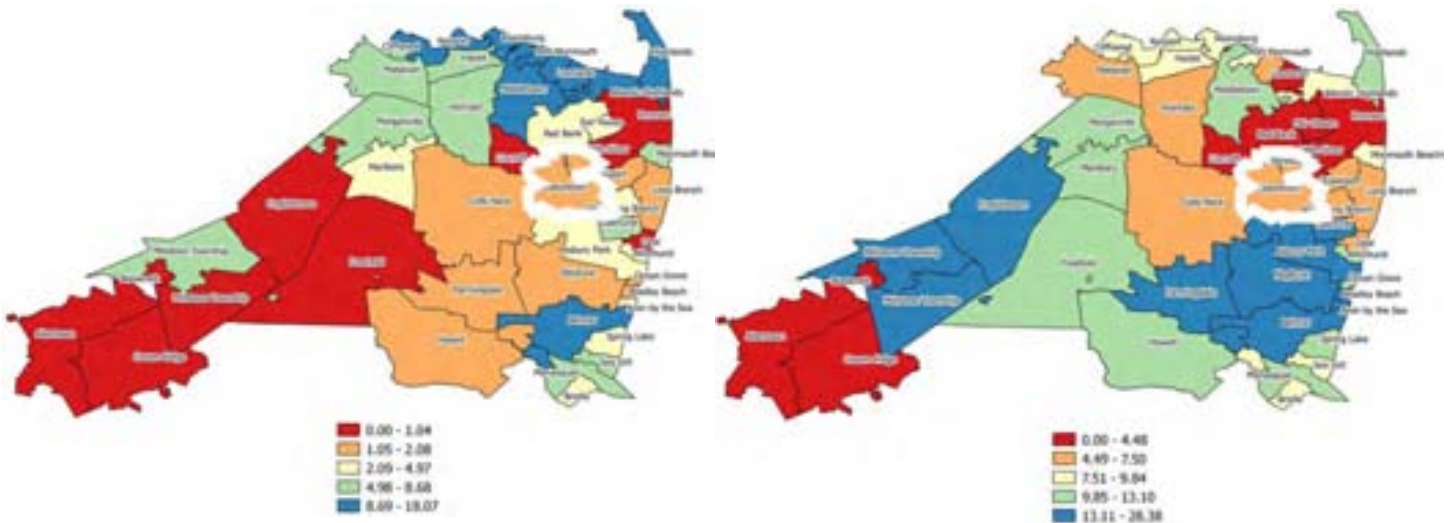
The color-coded map of New Jersey depicts the use of depression screening from low (red) to high (blue) in the 10 FEMA-declared disaster counties before and after Superstorm Sandy.

* Mapped using ZIP codes of the 10 counties.

**FIGURE 53. MONMOUTH COUNTY DEPRESSION SCREENING*
PER 1,000 MEDICARE FFS BENEFICIARIES**

January 1, 2012 – December 31, 2012

October 1, 2012 – September 30, 2013



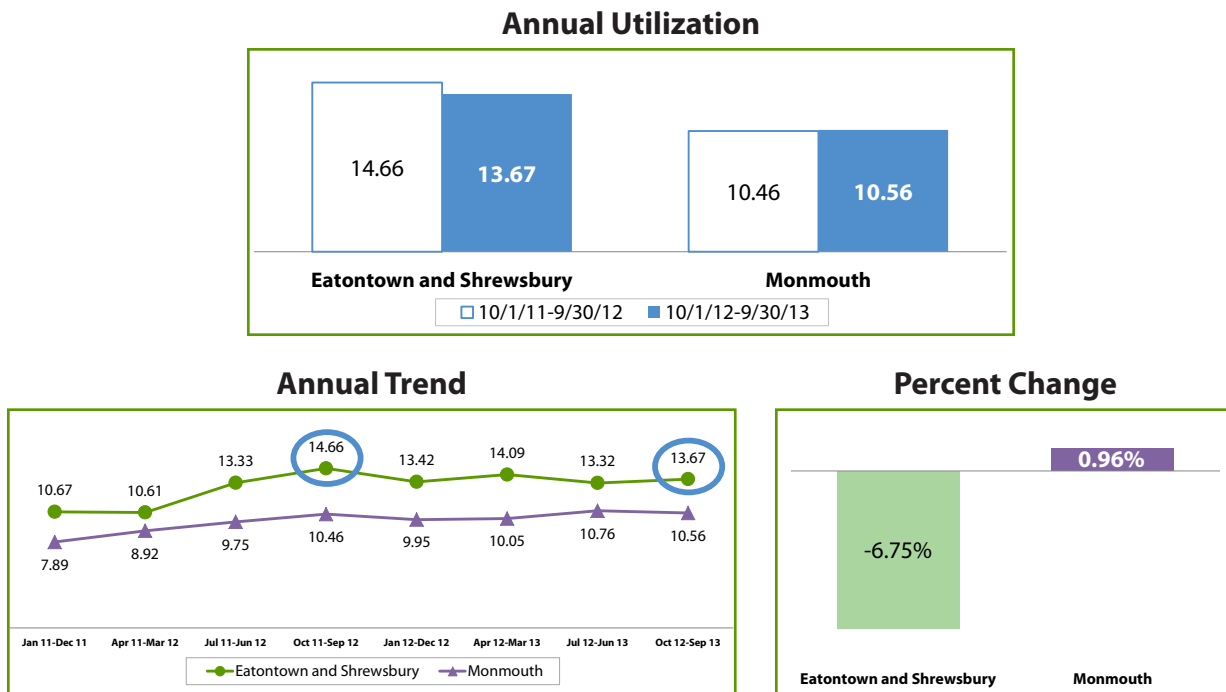
The color-coded map of Monmouth County depicts regional variation in the rates of the use of the depression screening benefit from low (red) to high (blue) before and after Superstorm Sandy.

* Mapped using ZIP codes; may not display all the city names located within the ZIP code.

Neuropsychological Tests

According to the CMS Mental Health Services Billing Guide, neuropsychological tests are evaluations designed to determine the functional consequences of known or suspected brain injury through testing of the neurocognitive domains responsible for language, perception, memory, learning, problem solving, and adaptation.⁸

FIGURE 54. NEUROPSYCHOLOGICAL TESTS PER 1,000 MEDICARE FFS BENEFICIARIES



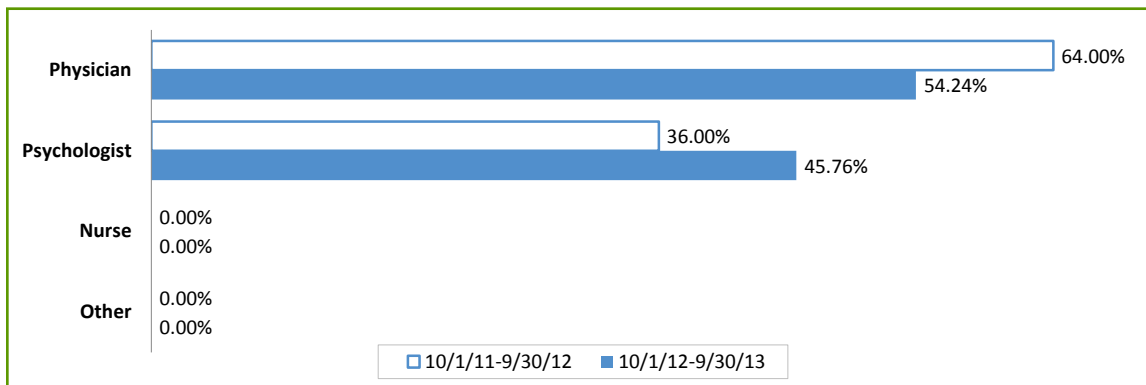
The rate of neuropsychological tests among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community in the 12 months prior to Superstorm Sandy was 14.66 per 1,000 beneficiaries. After the storm, this rate decreased to 13.67 per 1,000 beneficiaries, reflecting a 6.75% relative decrease.

Figure 55. Provider Location for Neuropsychological Tests Claims for Medicare FFS Beneficiaries Residing in Eatontown and Shrewsbury Community*				
Providers	10/1/11-9/30/12		10/1/12-9/30/13	
	Number of Claims N=75	Percent	Number of Claims N=59	Percent
Outside of New Jersey	1	1.3	3	5.1
New Jersey	74	98.7	56	94.9
• Monmouth County	47	62.7	35	59.3
– Eatontown and Shrewsbury Community	3	4.0	3	5.1
• Other Counties	27	36.0	21	35.6

* Number of claims, instead of unique beneficiaries were used in this analysis because a beneficiary can have multiple encounters for these procedures at different locations.

After Superstorm Sandy, of the 59 claims filed for neuropsychological tests for beneficiaries residing in the Eatontown and Shrewsbury community, 5.1% were filed outside of New Jersey and 94.9% were filed within New Jersey. Of those filed within New Jersey, 59.3% were filed within Monmouth County, 5.1% were filed within the Eatontown and Shrewsbury community, and 35.6% were filed in other counties.

FIGURE 56. NEUROPSYCHOLOGICAL TESTS CLAIMS FOR MEDICARE FFS BENEFICIARIES

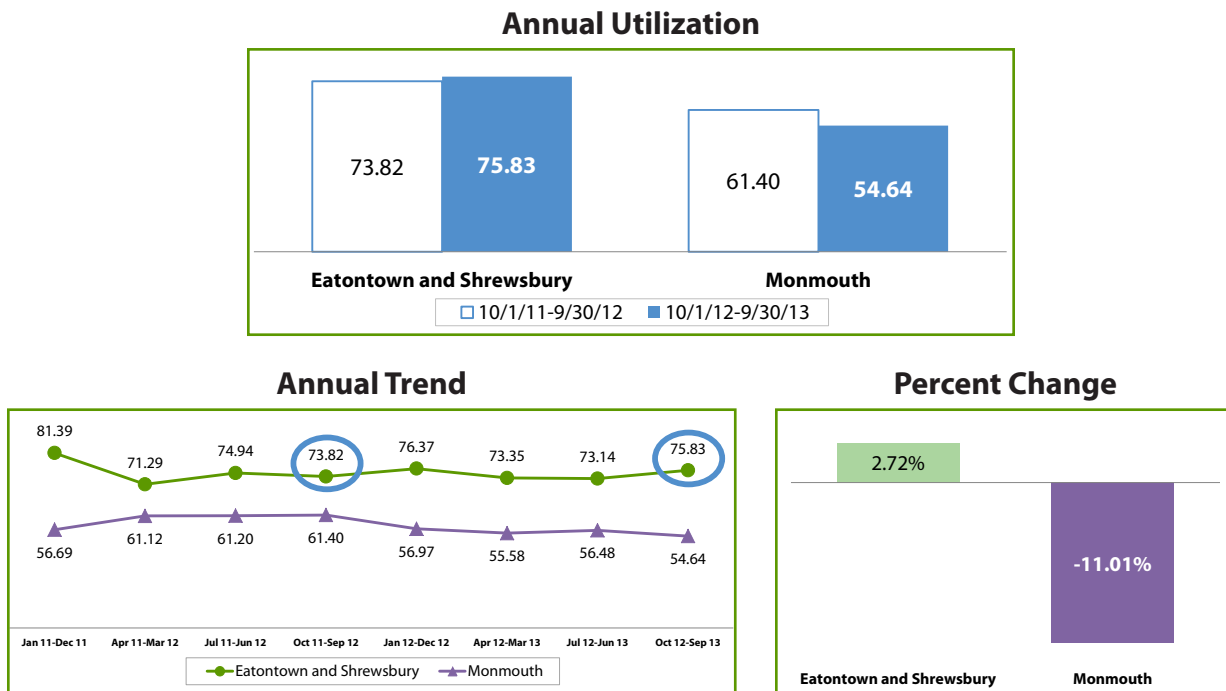


In the 12 months prior to Superstorm Sandy, 64.00% of neuropsychological tests claims were filed by physicians and 36.00% were filed by psychologists. After the storm, 54.24% of neuropsychological tests claims were filed by physicians and 45.76% were filed by psychologists.

Psychiatric Diagnostic Procedures

According to the CMS Mental Health Services Billing Guide, psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review of diagnostic studies.⁸

FIGURE 57. PSYCHIATRIC DIAGNOSTIC PROCEDURES PER 1,000 MEDICARE FFS BENEFICIARIES



The rate of psychiatric diagnostic procedures among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community in the 12 months prior to Superstorm Sandy was 73.82 per 1,000 beneficiaries. After the storm, this rate increased to 75.83 per 1,000 beneficiaries, reflecting a 2.72% relative increase.

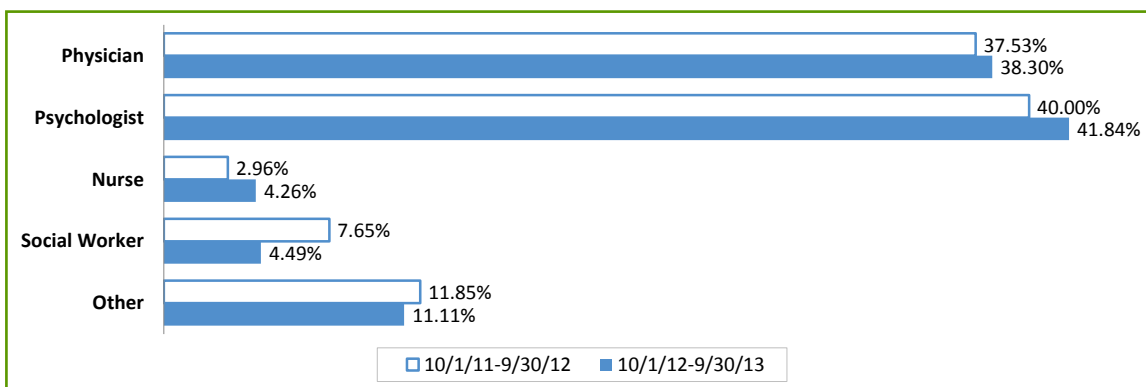
Figure 58. Provider Location for Psychiatric Diagnostic Procedures Claims for Medicare FFS Beneficiaries Residing in Eatontown and Shrewsbury Community*

Providers	10/1/11-9/30/12		10/1/12-9/30/13	
	Number of Claims N=405	Percent	Number of Claims N=423	Percent
Outside of New Jersey	12	3.0	6	1.4
New Jersey	393	97.0	417	98.6
• Monmouth County	296	73.1	306	72.3
– Eatontown and Shrewsbury Community	4	1.0	6	1.4
• Other Counties	97	24.0	111	26.2

* Number of claims, instead of unique beneficiaries were used in this analysis because a beneficiary can have multiple encounters for these procedures at different locations.

After Superstorm Sandy, of the 423 claims filed for psychiatric diagnostic procedures for beneficiaries residing in the Eatontown and Shrewsbury community, 1.4% were filed outside of New Jersey and 98.6% were filed within New Jersey. Of those filed within New Jersey, 72.3% were filed within Monmouth County, 1.4% were filed in the Eatontown and Shrewsbury community, and 26.2% were filed in other counties.

FIGURE 59. PSYCHIATRIC DIAGNOSTIC PROCEDURES CLAIMS FOR MEDICARE FFS BENEFICIARIES



In the 12 months prior to Superstorm Sandy, 40.00% of psychiatric diagnostic procedures claims were filed by psychologists, 37.53% were filed by physicians, 11.85% were filed by others, 7.65% were filed by social workers, and 2.96% were filed by nurses.

After the storm, 41.84% of psychiatric diagnostic procedures claims were filed by psychologists, 38.30% were filed by physicians, 11.11% were filed by others, 4.49% were filed by social workers, and 4.26% were filed by nurses.

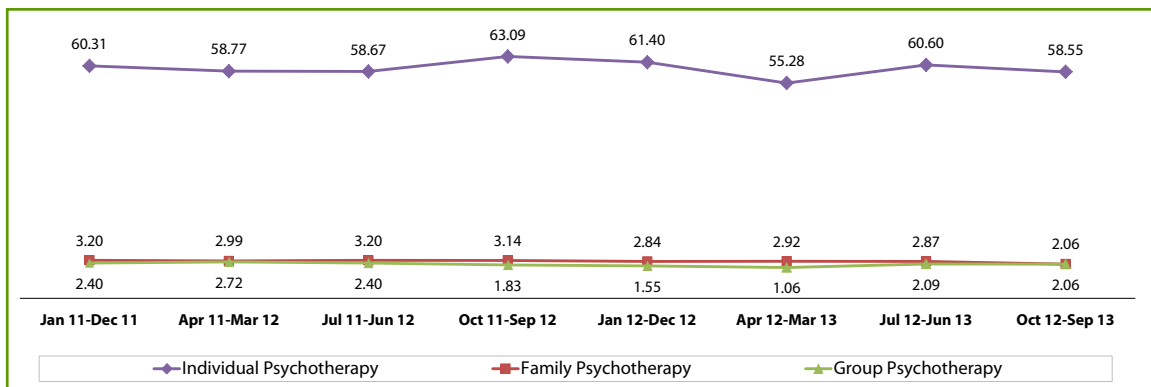
Therapies*

Summary

Figure 60. Percent Change of Behavioral Health Service Utilization – Therapies per 1,000 Medicare FFS Beneficiaries						
	Eatontown and Shrewsbury			Monmouth		
	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change
Individual Psychotherapy	63.09	58.55	-7.20	53.48	52.35	-2.11
Family Psychotherapy	3.14	2.06	-34.39	3.56	3.04	-14.61
Group Psychotherapy	1.83	2.06	12.57	3.23	2.83	-12.38

The Eatontown and Shrewsbury community experienced a larger decrease in the utilization of individual psychotherapy and family psychotherapy, than Monmouth County.

FIGURE 61. ANNUAL UTILIZATION TREND OF BEHAVIORAL HEALTH THERAPY SERVICES PER 1,000 MEDICARE FFS BENEFICIARIES



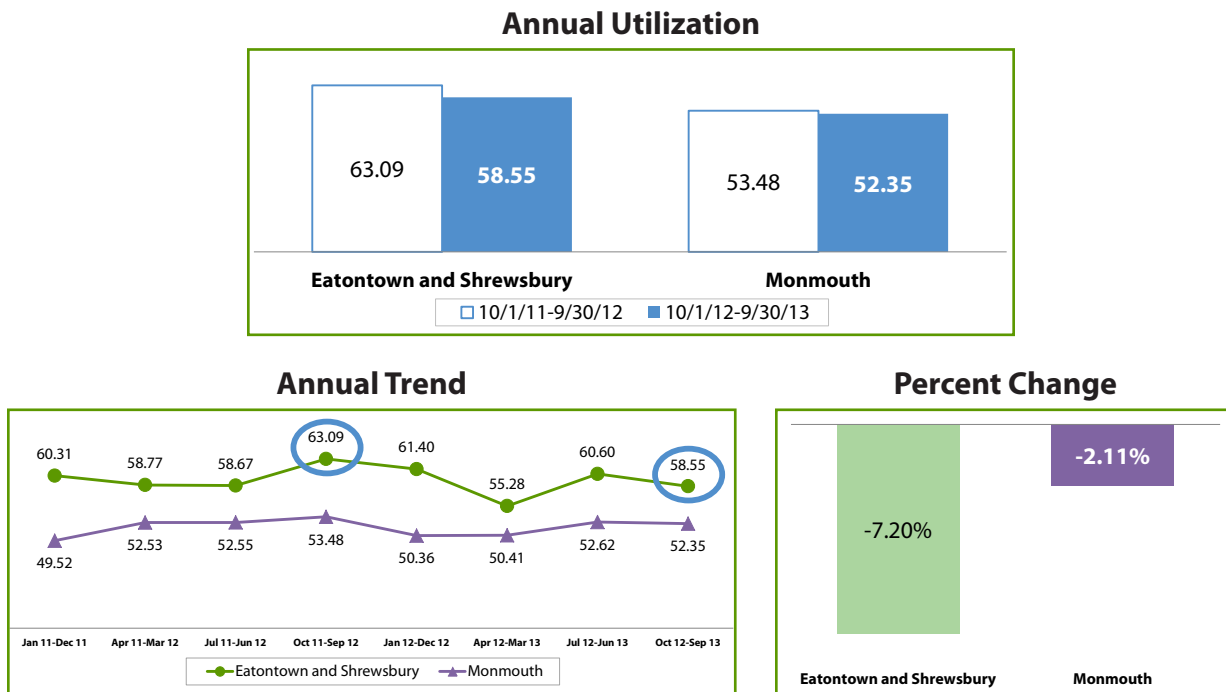
This chart reflects trending of annual utilization of behavioral health therapy services among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

*The utilization rates for Electroconvulsive Therapy and Biofeedback Therapy are not provided in this profile due to low rates.

Individual Psychotherapy

According to the CMS Mental Health Services Billing Guide, individual psychotherapy is the treatment of mental illness and behavioral disturbances where the physician or other qualified health professional attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This is done through the use of definitive therapeutic communication.⁸

FIGURE 62. INDIVIDUAL PSYCHOTHERAPY PER 1,000 MEDICARE FFS BENEFICIARIES



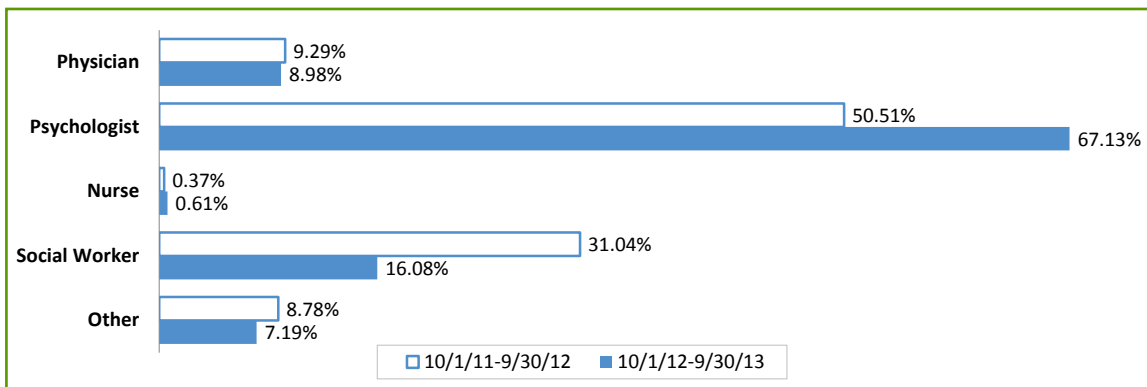
The rate of individual psychotherapy among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community in the 12 months prior to Superstorm Sandy was 63.09 per 1,000 beneficiaries. After the storm, this rate decreased to 58.55 per 1,000 beneficiaries, reflecting a 7.20% relative decrease.

Figure 63. Provider Location for Individual Psychotherapy Claims for Medicare FFS Beneficiaries Residing in Eatontown and Shrewsbury Community*				
Providers	10/1/11-9/30/12		10/1/12-9/30/13	
	Number of Claims N=2,152	Percent	Number of Claims N=2,282	Percent
Outside of New Jersey	84	3.9	59	2.6
New Jersey	2,068	96.1	2,223	97.4
• Monmouth County	1,012	47.0	957	41.9
– Eatontown and Shrewsbury Community	89	4.1	101	4.4
• Other Counties	1,056	49.1	1,266	55.5

* Number of claims, instead of unique beneficiaries were used in this analysis because a beneficiary can have multiple encounters for these procedures at different locations.

After Superstorm Sandy, of the 2,282 claims filed for individual psychotherapy for beneficiaries residing in the Eatontown and Shrewsbury community, 2.6% were filed outside of New Jersey and 97.4% were filed within New Jersey. Of those filed within New Jersey, 41.9% were filed within Monmouth County, 4.4% were filed in the Eatontown and Shrewsbury community, and 55.5% were filed in other counties.

FIGURE 64. INDIVIDUAL PSYCHOTHERAPY CLAIMS FOR MEDICARE FFS BENEFICIARIES



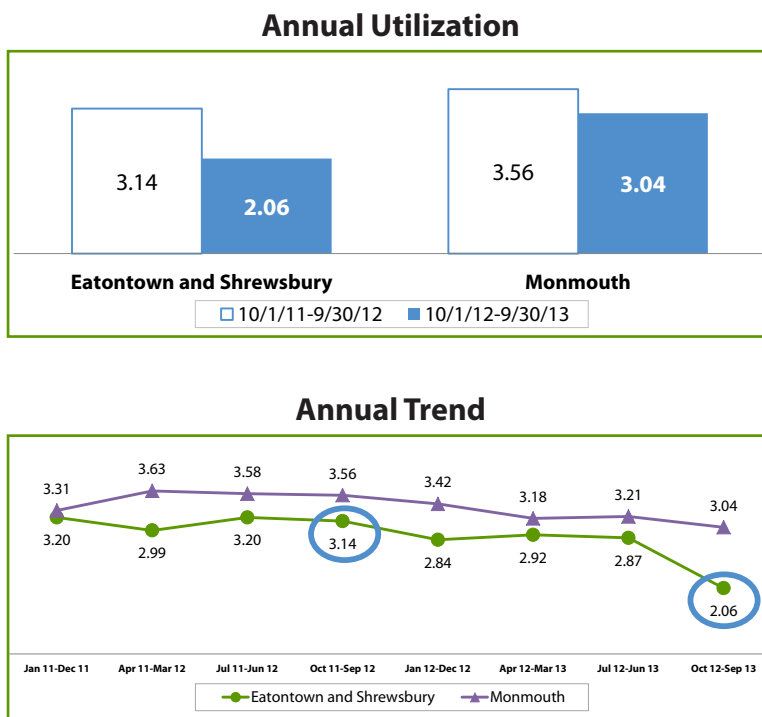
In the 12 months prior to Superstorm Sandy, 50.51% of individual psychotherapy claims were filed by psychologists, 31.04% were filed by social workers, 9.29% were filed by physicians, 8.78% were filed by others, and 0.37% were filed by nurses.

After the storm, 67.13% of individual psychotherapy claims were filed by psychologists, 16.08% were filed by social workers, 8.98% were filed by physicians, 7.19% were filed by others, and 0.61% were filed by nurses.

Family Psychotherapy

According to the CMS Mental Health Services Billing Guide, family psychotherapy describes the treatment of the family unit when maladaptive behaviors of family members are exacerbating the beneficiary’s mental illness or interfering with treatment. It can also be used to assist the family in addressing the maladaptive behaviors of the patient and improve treatment compliance.⁸

FIGURE 65. FAMILY PSYCHOTHERAPY PER 1,000 MEDICARE FFS BENEFICIARIES



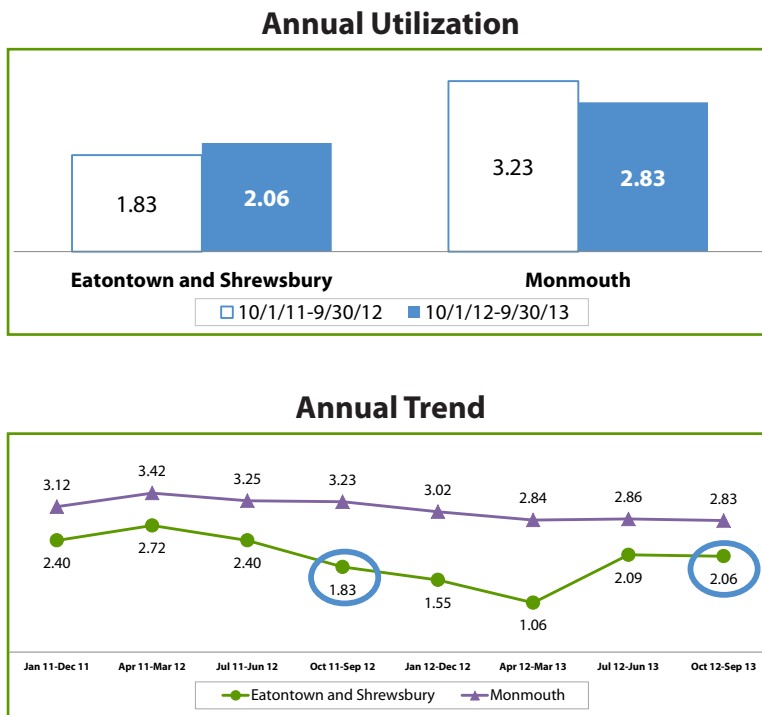
The rate of family psychotherapy among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community in the 12 months prior to Superstorm Sandy was 3.14 per 1,000 beneficiaries. After the storm, this rate decreased to 2.06 per 1,000 beneficiaries.

Due to these low numbers, no percent change data has been provided for this therapy.

Group Psychotherapy

According to the CMS Mental Health Services Billing Guide, group psychotherapy is a form of treatment where a selected group of patients are guided by a licensed psychotherapist for the purpose of helping to change maladaptive patterns which interfere with social functioning and are associated with a diagnosable psychiatric illness.⁸

FIGURE 66. GROUP PSYCHOTHERAPY PER 1,000 MEDICARE FFS BENEFICIARIES



The rate of group psychotherapy among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community in the 12 months prior to Superstorm Sandy was 1.83 per 1,000 beneficiaries. After the storm, this rate increased to 2.06 per 1,000 beneficiaries.

Due to these low numbers, no percent change data has been provided for this therapy.

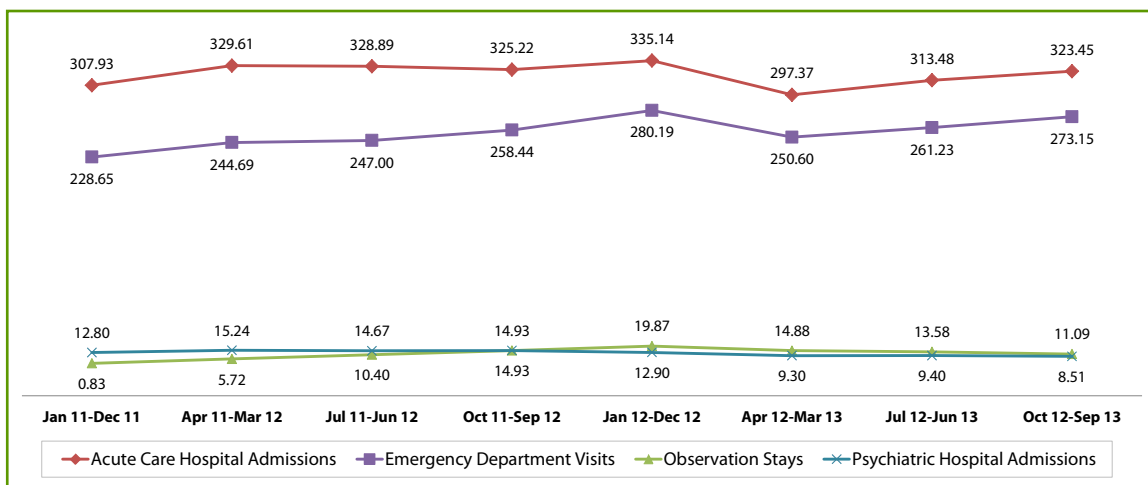
INPATIENT HEALTH SERVICES

Summary

Figure 67. Percent Change of Inpatient Health Service Utilization per 1,000 Medicare FFS Beneficiaries						
	Eatontown and Shrewsbury			Monmouth		
	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change
Psychiatric Admissions	14.93	8.51	-43.00	9.45	8.65	-8.47
Acute Care Hospital Admissions	325.22	323.45	-0.54	319.96	300.94	-5.94
Emergency Department Visits	258.44	273.15	5.69	249.46	240.31	-3.67
Observation Stays	14.93	11.09	-25.72	6.64	7.09	6.78

The Eatontown and Shrewsbury community experienced a larger decrease in psychiatric admissions than Monmouth County.

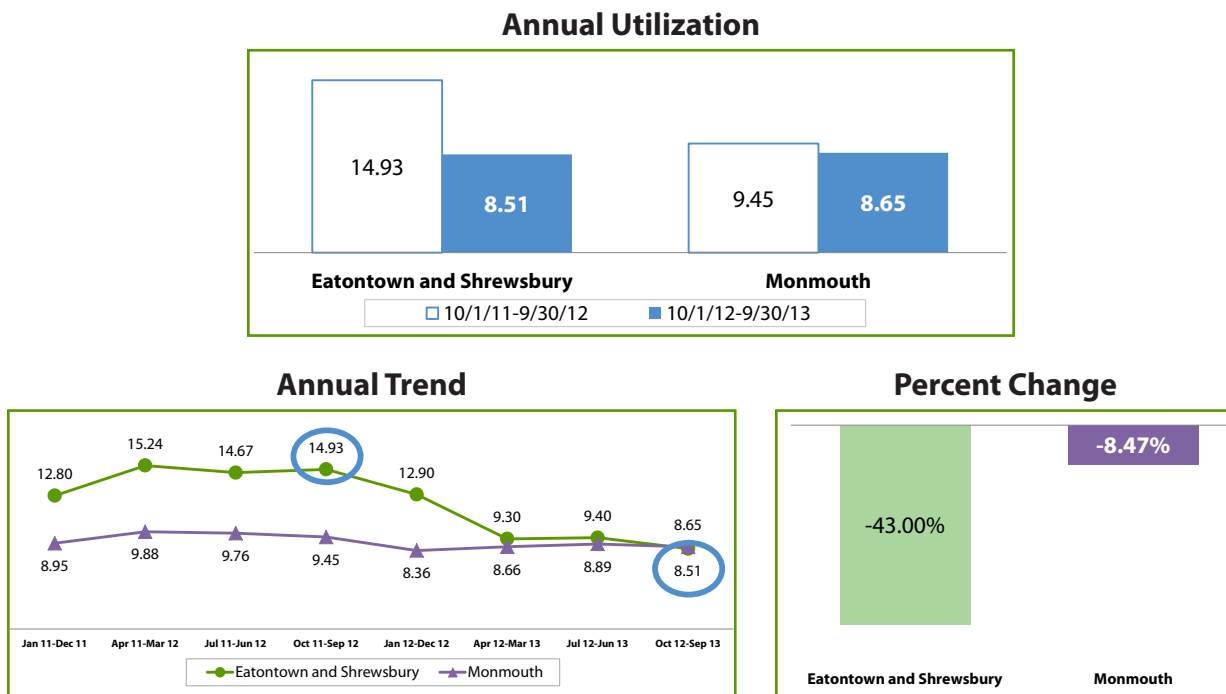
FIGURE 68. ANNUAL UTILIZATION TREND OF INPATIENT HEALTH SERVICES PER 1,000 MEDICARE FFS BENEFICIARIES



This chart reflects trending of annual utilization of inpatient health services among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

Psychiatric Hospital Admissions

FIGURE 69. PSYCHIATRIC HOSPITAL ADMISSIONS PER 1,000 MEDICARE FFS BENEFICIARIES



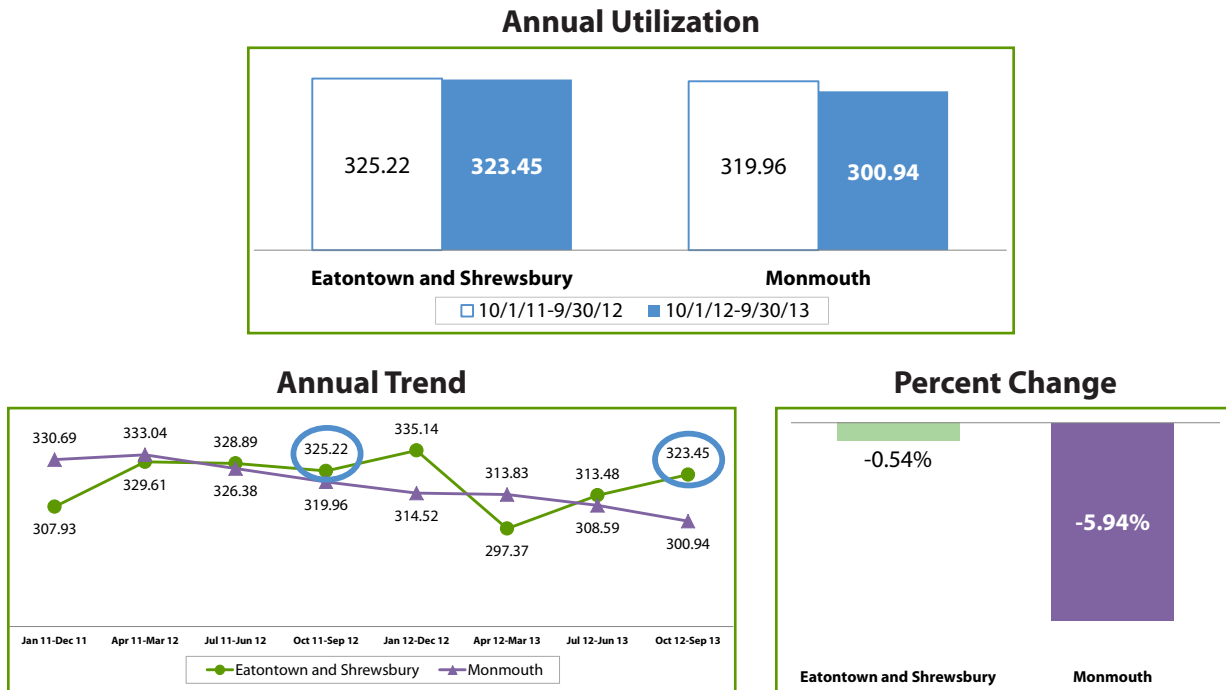
In the 12 months prior to Superstorm Sandy, standalone psychiatric hospitals or distinct part psychiatric units in acute care hospitals in the Eatontown and Shrewsbury community had an admissions rate of 14.93 per 1,000 Medicare FFS beneficiaries. After the storm, the rate decreased to 8.51 per 1,000 beneficiaries, reflecting a 43.00% relative decrease.

Acute Care Hospitals

Admissions

The following data shows all-cause utilization measures and includes all Medicare FFS beneficiaries, not just beneficiaries with behavioral health conditions.

FIGURE 70. ACUTE CARE HOSPITAL ADMISSIONS PER 1,000 MEDICARE FFS BENEFICIARIES

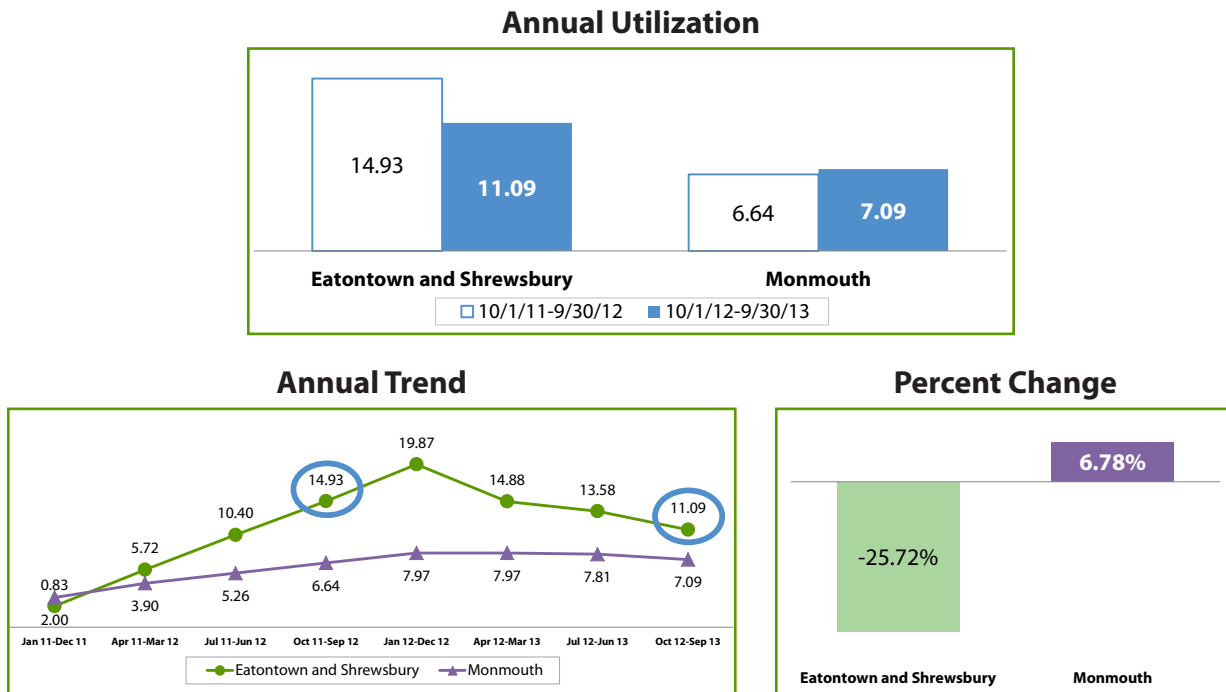


In the 12 months prior to Superstorm Sandy, acute care hospitals in the Eatontown and Shrewsbury community had an acute care admissions rate of 325.22 per 1,000 Medicare FFS beneficiaries. After the storm, the rate decreased to 323.45 per 1,000 beneficiaries, reflecting a 0.54% relative decrease.

Observation Stays

According to the U.S. Department of Health and Human Services, observation stays are short-term treatments and assessments provided to Medicare FFS beneficiaries as outpatients to determine whether they require further treatment as inpatients or can be discharged.

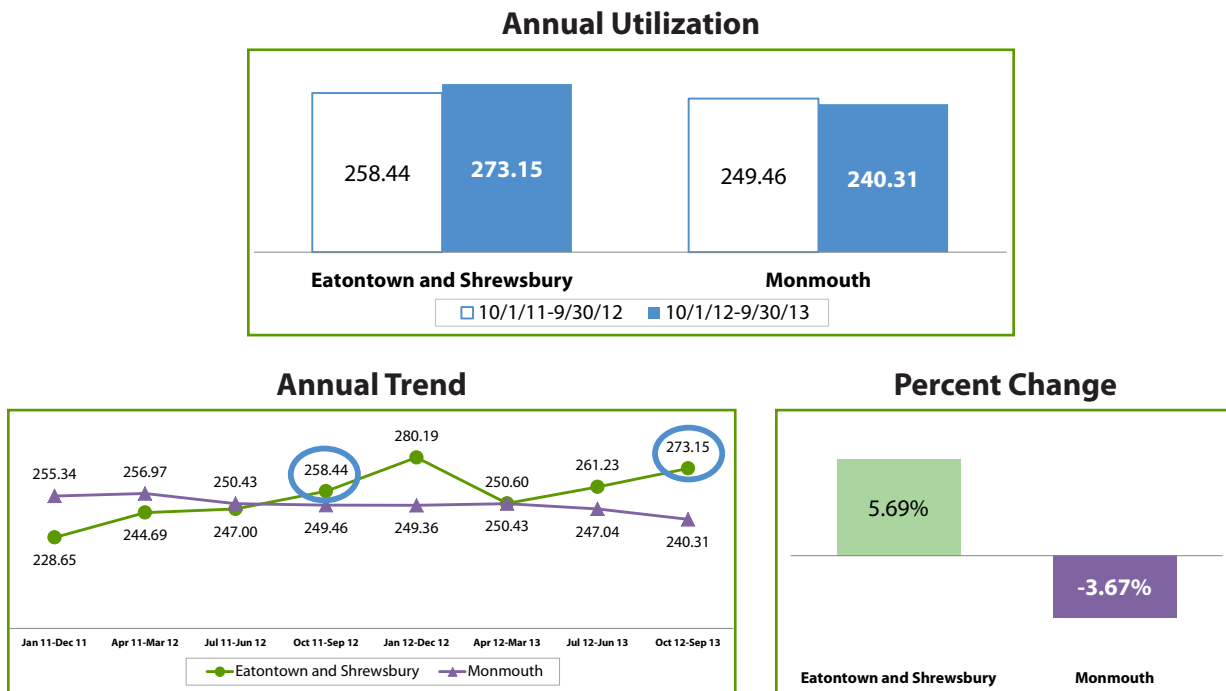
FIGURE 71. OBSERVATION STAYS PER 1,000 MEDICARE FFS BENEFICIARIES



In the 12 months prior to Superstorm Sandy, observation stays in acute care hospitals in the Eatontown and Shrewsbury community had a rate of 14.93 per 1,000 Medicare FFS beneficiaries. After the storm, the rate decreased to 11.09 per 1,000 beneficiaries, reflecting a 25.72% relative decrease.

Emergency Department Visits

FIGURE 72. EMERGENCY DEPARTMENT VISITS PER 1,000 MEDICARE FFS BENEFICIARIES



In the 12 months prior to Superstorm Sandy, emergency department visits in the Eatontown and Shrewsbury community had a rate of 258.44 per 1,000 Medicare FFS beneficiaries. After the storm, the rate increased to 273.15 per 1,000 beneficiaries, reflecting a 5.69% relative increase.

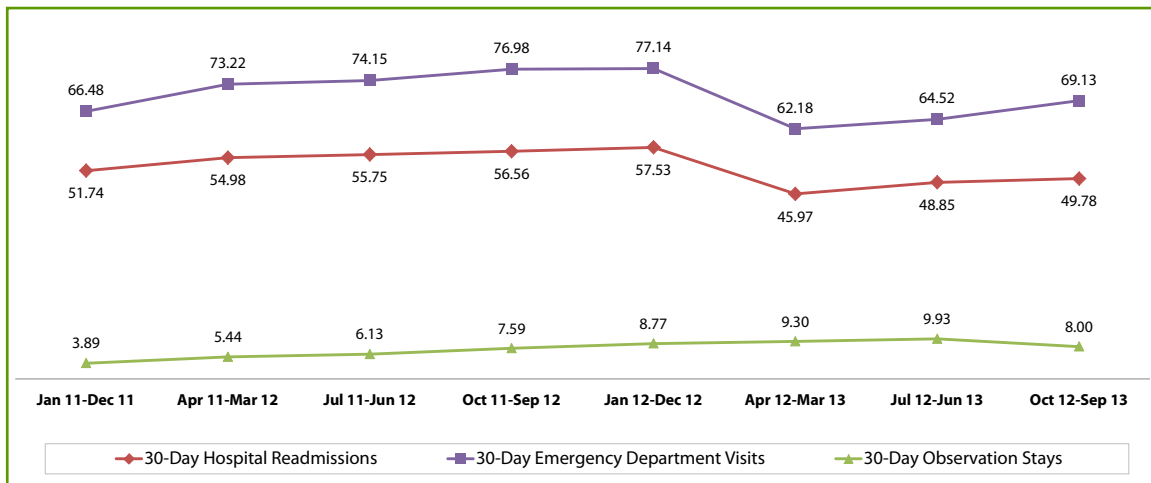
Within 30 Days of Acute Care Hospital Discharge

Summary

Figure 73. Percent Change of Inpatient Health Service Utilization Within 30 Days of Discharge per 1,000 Medicare FFS Beneficiaries						
	Eatontown and Shrewsbury			Monmouth		
	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change
30-Day Hospital Readmissions	56.56	49.78	-11.99	57.72	49.98	-13.41
Emergency Department Visits	76.98	69.13	-10.20	71.73	66.74	-6.96
Observation Stays	7.59	8.00	5.40	6.17	6.23	0.97

The Eatontown and Shrewsbury community experienced a larger decrease in emergency department visits than Monmouth County.

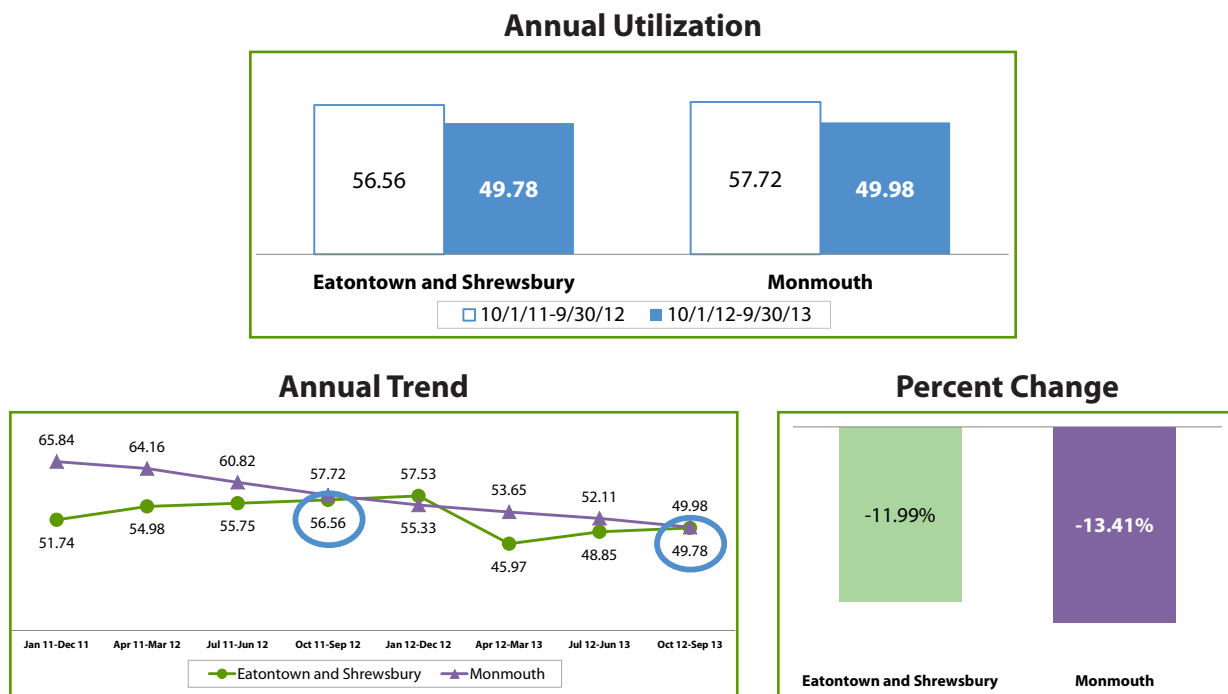
FIGURE 74. ANNUAL UTILIZATION TREND OF INPATIENT HEALTH SERVICES WITHIN 30 DAYS OF DISCHARGE PER 1,000 MEDICARE FFS BENEFICIARIES



This chart reflects trending of annual utilization of inpatient health services within 30 days of discharge among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

30-Day Hospital Readmissions

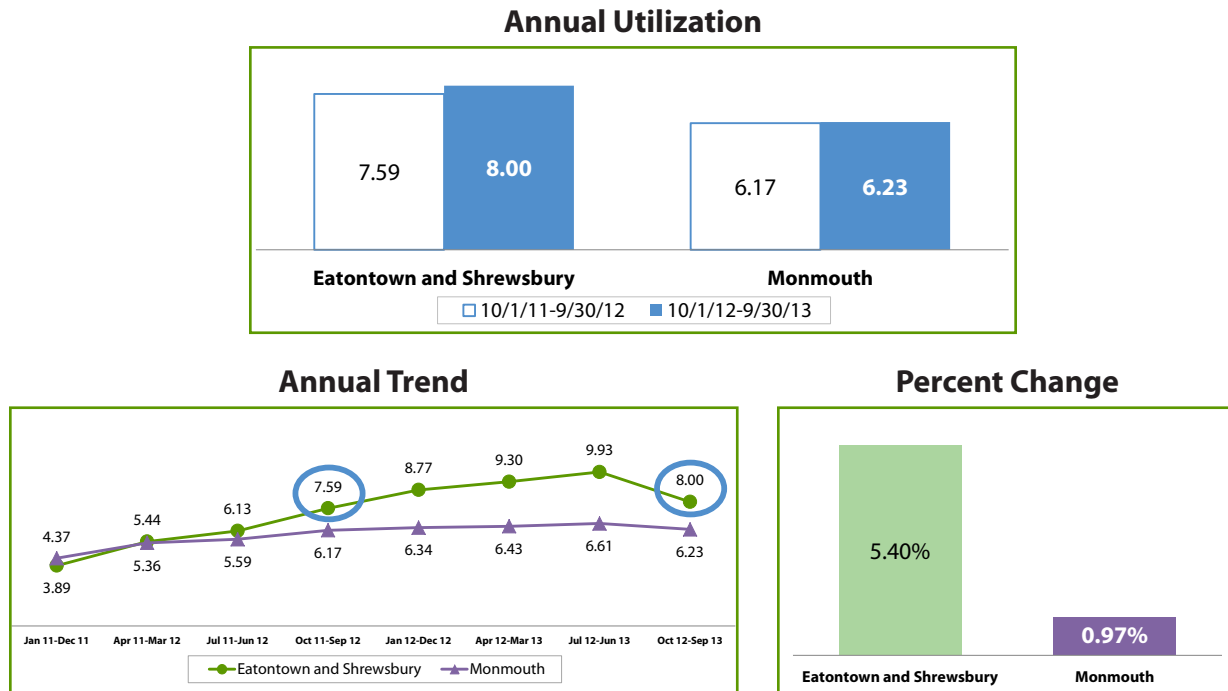
FIGURE 75. 30-DAY HOSPITAL READMISSIONS PER 1,000 MEDICARE FFS BENEFICIARIES



In the 12 months prior to Superstorm Sandy, acute care hospitals in the Eatontown and Shrewsbury community had a 30-day readmissions rate of 56.56 per 1,000 Medicare FFS beneficiaries. After the storm, the rate decreased to 49.78 per 1,000 beneficiaries, reflecting an 11.99% relative decrease.

Observation Stays Within 30 Days of Discharge

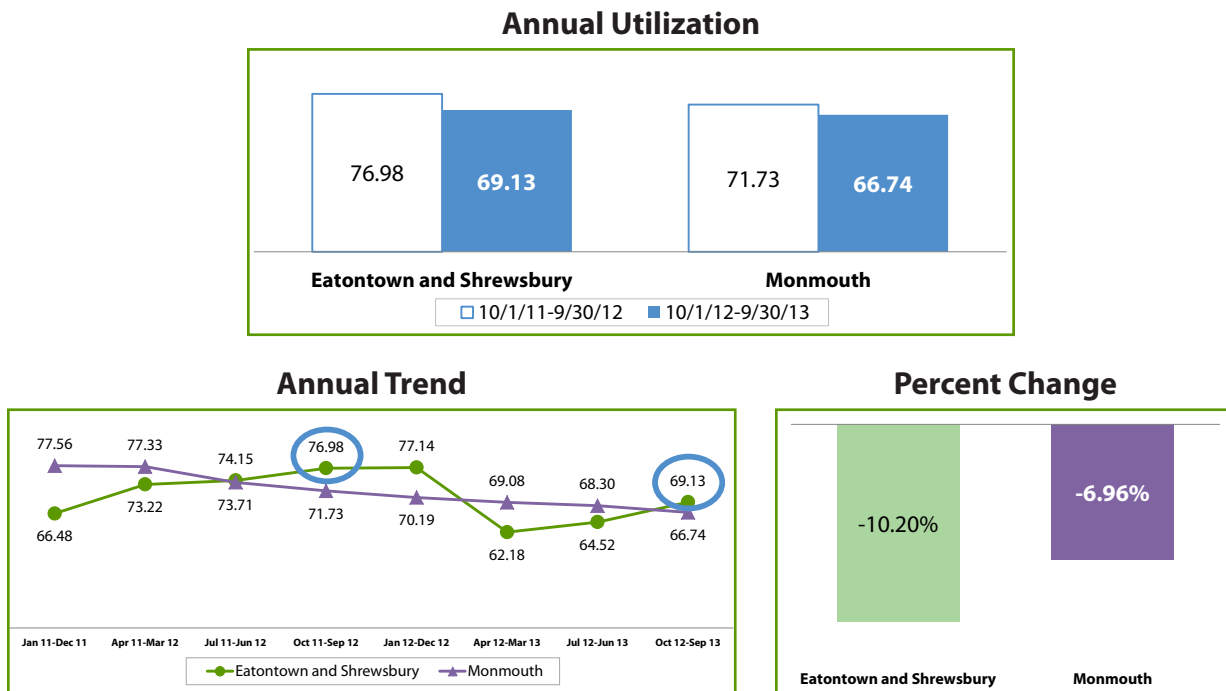
FIGURE 76. OBSERVATION STAYS WITHIN 30 DAYS OF DISCHARGE PER 1,000 MEDICARE FFS BENEFICIARIES



In the 12 months prior to Superstorm Sandy, the rate of observation stays within 30 days of discharge in the Eatontown and Shrewsbury community was 7.59 per 1,000 Medicare FFS beneficiaries. After the storm, the rate increased to 8.00 per 1,000 beneficiaries, reflecting a 5.40% relative increase.

Emergency Department Visits Within 30 Days of Discharge

FIGURE 77. EMERGENCY DEPARTMENT VISITS WITHIN 30 DAYS OF DISCHARGE PER 1,000 MEDICARE FFS BENEFICIARIES



In the 12 months prior to Superstorm Sandy, the rate of emergency department visits within 30 days of discharge in the Eatontown and Shrewsbury community was 76.98 per 1,000 Medicare FFS beneficiaries. After the storm, the rate decreased to 69.13 per 1,000 beneficiaries, reflecting a 10.20% relative decrease.

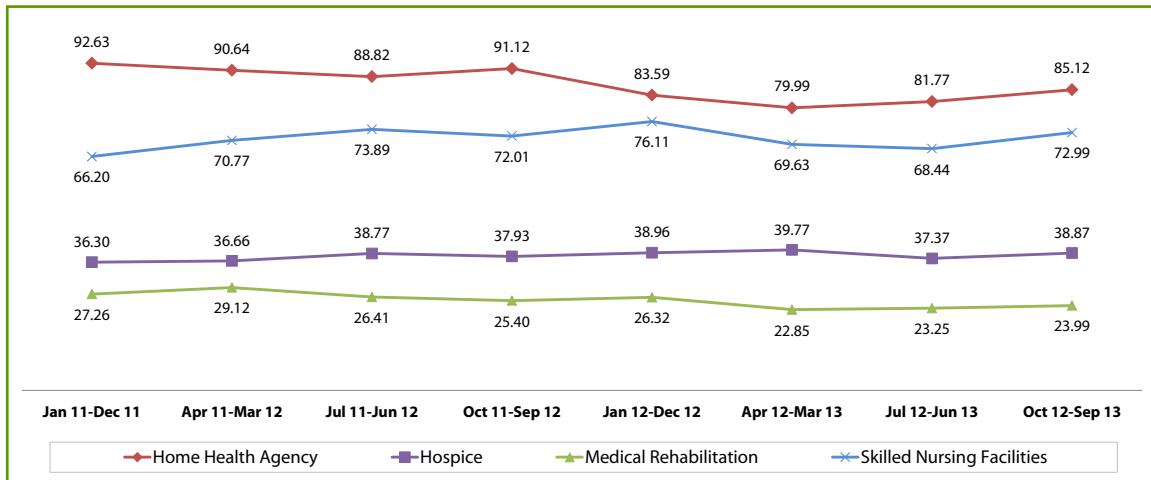
Other Settings

Summary

Figure 78. Percent Change of Other Health Services Utilization per 1,000 Medicare FFS Beneficiaries						
	Eatontown and Shrewsbury			Monmouth		
	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change	10/1/11 – 9/30/12	10/1/12 – 9/30/13	% Change
Home Health Agency	91.12	85.12	-6.58	95.92	91.98	-4.11
Skilled Nursing Facility	72.01	72.99	1.36	71.29	70.68	-0.86
Hospice	37.93	38.87	2.48	30.02	28.62	-4.66
Medical Rehabilitation	25.40	23.99	-5.55	16.02	15.77	-1.56

The Eatontown and Shrewsbury community experienced a larger decrease in home health agency services, as well as in medical rehabilitation services, than Monmouth County.

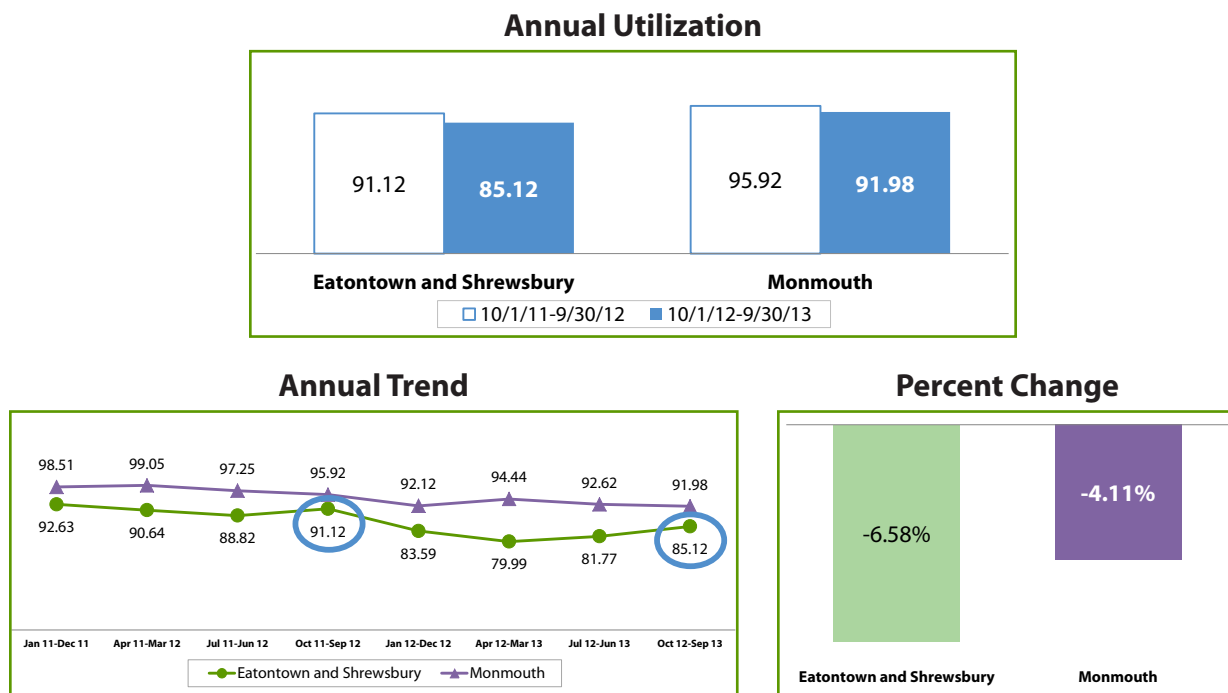
FIGURE 79. ANNUAL UTILIZATION TREND IN OTHER HEALTH SERVICES PER 1,000 MEDICARE FFS BENEFICIARIES



This chart reflects trending of annual utilization of other health services among Medicare FFS beneficiaries residing in the Eatontown and Shrewsbury community.

Home Health Agency Services

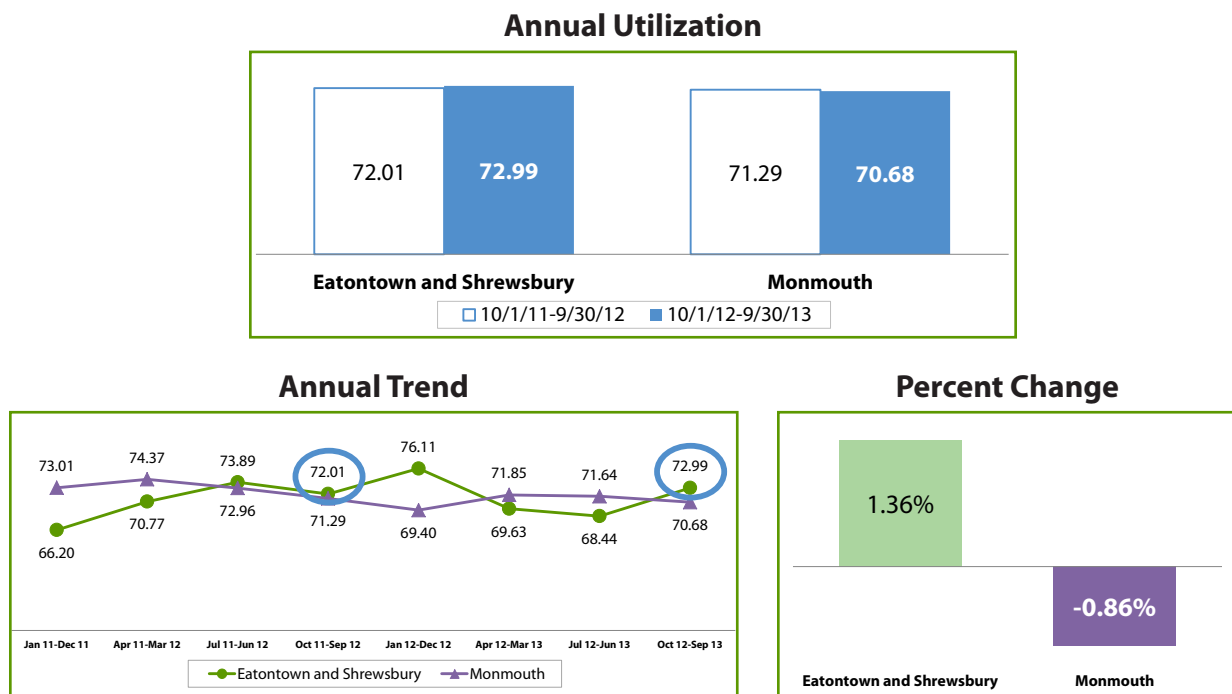
FIGURE 80. HOME HEALTH AGENCY SERVICES PER 1,000 MEDICARE FFS BENEFICIARIES



In the 12 months prior to Superstorm Sandy, the utilization rate of home health agency services in the Eatontown and Shrewsbury community was 91.12 per 1,000 Medicare FFS beneficiaries. After the storm, the rate decreased to 85.12 per 1,000 beneficiaries, reflecting a 6.58% relative decrease.

Skilled Nursing Facility Services

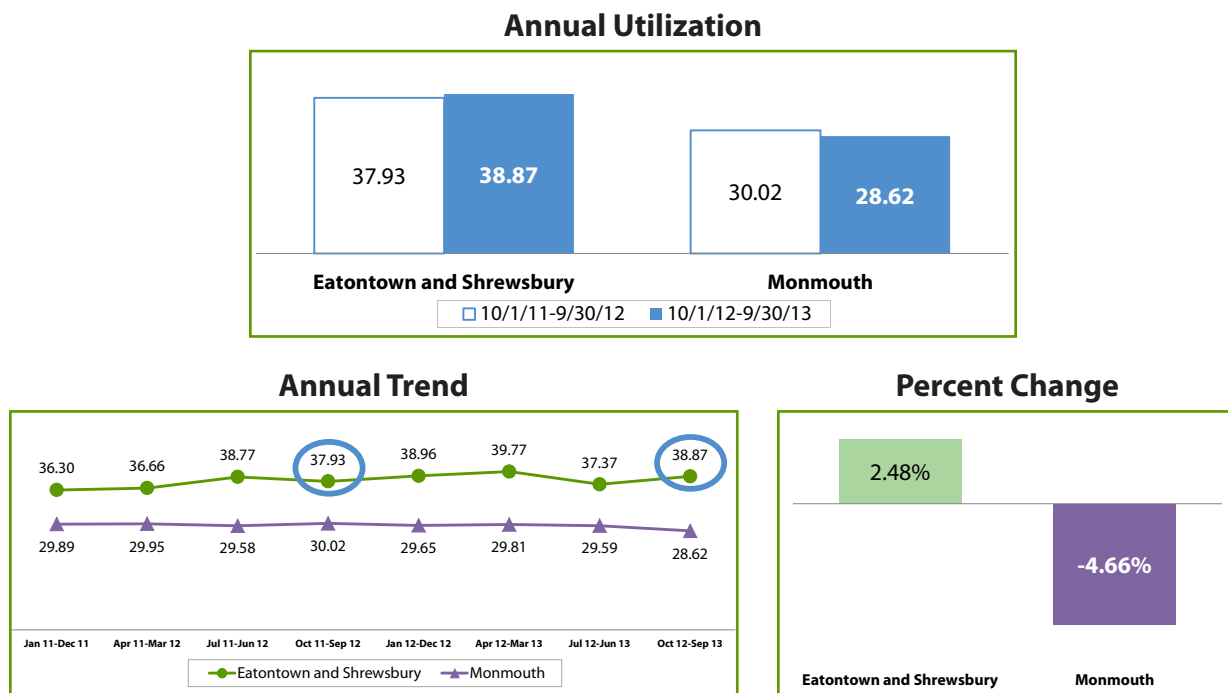
FIGURE 81. SKILLED NURSING FACILITY SERVICES PER 1,000 MEDICARE FFS BENEFICIARIES



In the 12 months prior to Superstorm Sandy, the utilization rate of skilled nursing facility services in the Eatontown and Shrewsbury community was 72.01 per 1,000 Medicare FFS beneficiaries. After the storm, the rate increased to 72.99 per 1,000 beneficiaries, reflecting a 1.36% relative increase.

Hospice Services

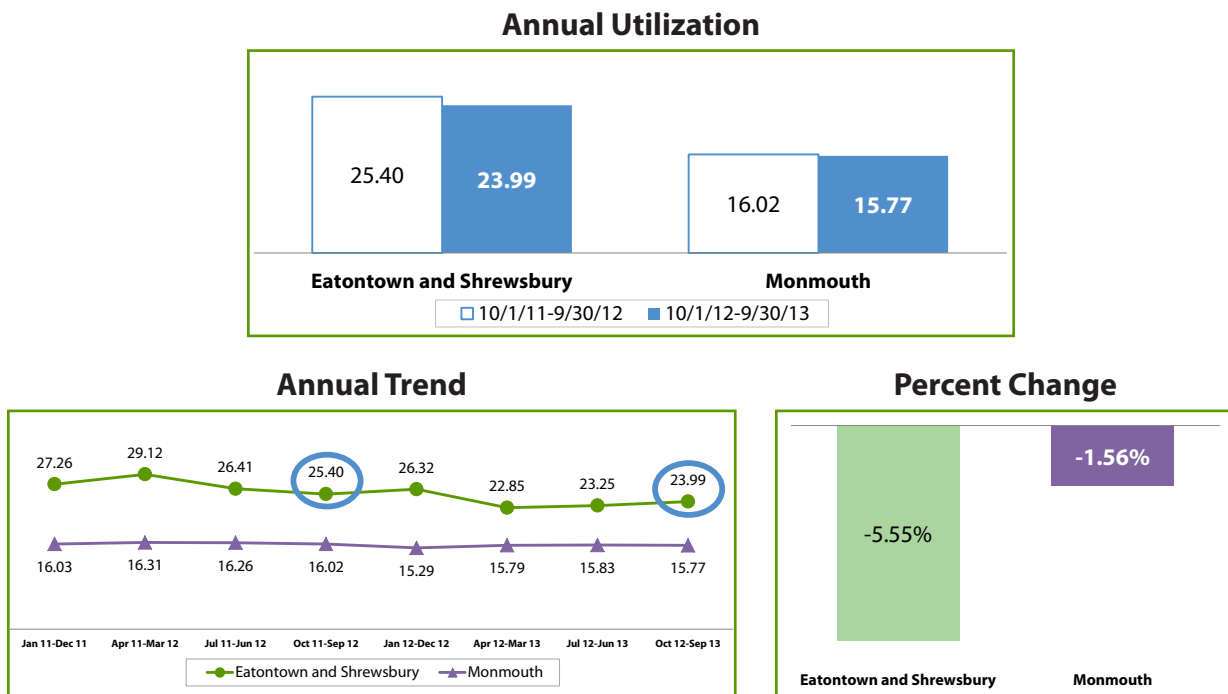
FIGURE 82. HOSPICE SERVICES PER 1,000 MEDICARE FFS BENEFICIARIES



In the 12 months prior to Superstorm Sandy, the utilization rate of hospice services in the Eatontown and Shrewsbury community was 37.93 per 1,000 Medicare FFS beneficiaries. After the storm, the rate increased to 38.87 per 1,000 beneficiaries, reflecting a 2.48% relative increase.

Medical Rehabilitation Services

FIGURE 83. MEDICAL REHABILITATION SERVICES PER 1,000 MEDICARE FFS BENEFICIARIES



In the 12 months prior to Superstorm Sandy, the utilization rate of medical rehabilitation services in the Eatontown and Shrewsbury community was 25.40 per 1,000 Medicare FFS beneficiaries. After the storm, the rate decreased to 23.99 per 1,000 beneficiaries, reflecting a 5.55% relative decrease.

LISTING OF MAJOR HEALTH PROVIDERS

The list below shows the major healthcare facilities that provided 90% of all health services to beneficiaries residing in the Eatontown and Shrewsbury community. These are providers in different care settings and are not restricted to behavioral health providers or services. The map on the following page depicts the location of these providers in relation to the community.

Acute Care Hospitals

CentraState Medical Center
Jersey Shore University Medical Center
Monmouth Medical Center
Riverview Medical Center

Psychiatric Facilities

CentraState Medical Center
Monmouth Medical Center

Medical Rehabilitation Centers

HealthSouth Rehabilitation Hospital of Tinton Falls
Riverview Medical Center

Skilled Nursing Facilities

Chapin Hill at Red Bank
Gateway Care Center
Jersey Shore Center
Meridian Nursing and Rehab at Shrewsbury

Hospice Facilities

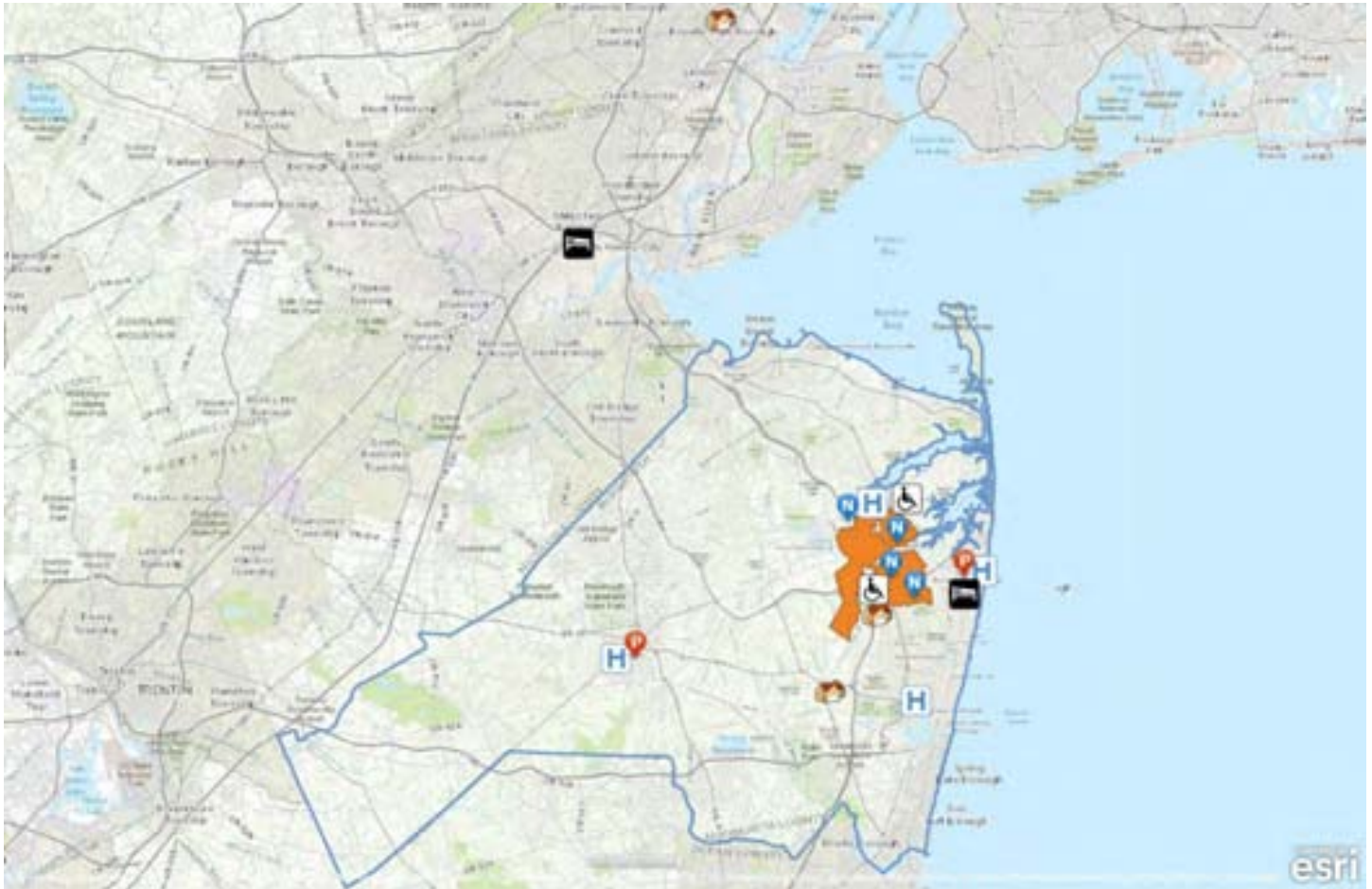
Barnabas Health Hospice and Palliative Care Center
Grace Healthcare Services, LLC

Home Health Agencies

Holy Redeemer Home Care - NJ, North
Meridian Home Care - Monmouth County
Visiting Nurse Association Health Group

EATONTOWN AND SHREWSBURY COMMUNITY PROVIDERS

The map below shows the major healthcare facilities that served the beneficiaries of the Eatontown and Shrewsbury community based on the Medicare Part A claims database. These are providers in all different care settings and are not restricted to behavioral health providers or services. There are four providers located in the community: three nursing homes and one medical rehabilitation center.



APPENDIX A: BEHAVIORAL HEALTH CONDITIONS

Documentation and Technical Notes

The following defines the study population, the time frames, and the exclusion and inclusion criteria:

Data Source

- New Jersey Medicare FFS Part A and Part B claims data and denominator file

Reference Time Period

- Annual prevalence of risk factors for depression or proxy disorders comparing October 1, 2011 – September 30, 2012 to October 1, 2012 – September 30, 2013
- Annual prevalence trend for risk factors for depression or proxy disorders consists of eight points of data with rolling quarters (starting January 2011 and ending September 2013)
- Quarterly new incidence trend charts of the selected behavioral health conditions contain data from January 1, 2012 to September 30, 2013 and allows for the identification of new cases in a given quarter when compared to the prior year

Mapping Tool

- QGIS Development Team, 2014, QGIS Geographic Information System. Open Source Geospatial Foundation Project. <http://qgis.osgeo.org>
- Source: ZIP code boundaries based on the 2013 U.S. Census Tiger Files

Denominator

- Denominator was the sum of all eligible Medicare FFS beneficiaries who were in the CMS denominator file during the measurement time frame
- Eligible beneficiaries were computed after adjusting for total enrolled FFS days divided by the total measurement days in the time frame
- Where Medicare FFS enrolled days > 0

Numerator

- Unique Medicare FFS beneficiaries with disease-specific inpatient or outpatient claims during the time frame
- CCW and AHRQ disease diagnosis code match (ICD-9-CM codes) Part A dgns_cd_1-25 and dgns_e_cd_1-3; Match Part B dgns_cd_1_12

Exclusions

- HMO coverage period
- Age <18 or >= 110
- Eligible Medicare FFS days/total measurement days = 0

Resources

More information on the classification codes, requirements, and processing of the behavioral health conditions highlighted in this profile can be located at the following links:

- Buccaneer, A General Dynamics Company. Chronic Condition Data Warehouse: Additions and Access – Task Order 10 New Clinical Conditions: Requirements and Processing [Internet]. [unknown]: Buccaneer, A General Dynamics Company. 2013 May 22 [cited 17 Sep 2013]. Available from: https://www.ccwdata.org/cs/groups/public/documents/document/clin_cond_algo_req_proc.pdf
- Healthcare Cost and Utilization Project (H-CUP). Clinical Classifications Software (CCS) for ICD-9-CM [Internet]. Rockville (MD): Agency for Healthcare Research and Quality; Nov 2013 [15 Sep 2013]. Available from: <http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp>

The following table shows the ICD-9-CM codes for the eight behavioral health conditions:

Behavioral Health Conditions	Numerator: Valid ICD-9-CM Codes
Depression or Proxy Disorders (Depression, Anxiety Disorders or Adjustment Disorders)	29384, 29620, 29621, 29622, 29623, 29624, 29625, 29626, 29630, 29631, 29632, 29633, 29634, 29635, 29636, 30000, 30001, 30002, 30009, 30010, 30020, 30021, 30022, 30023, 30029, 3003, 3004, 3005, 30089, 3009, 3080, 3081, 3082, 3083, 3084, 3089, 3090, 3091, 30922, 30923, 30924, 30928, 30929, 3093, 3094, 30981, 30982, 30983, 30989, 3099, 311, 3130, 3131, 31321, 31322, 3133, 31382, 31383, V790
Depression	29620, 29621, 29622, 29623, 29624, 29625, 29626, 29630, 29631, 29632, 29633, 29634, 29635, 29636, 3004, 311, V790
Anxiety Disorders	29384, 30000, 30001, 30002, 30009, 30010, 30020, 30021, 30022, 30023, 30029, 3003, , 3005, 30089, 3009, 3080, 3081, 3082, 3083, 3084, 3089, 3130, 3131, 31321, 31322, 3133, 31382, 31383
Adjustment Disorders	3090, 3091, 30922, 30923, 30924, 30928, 30929, 3093, 3094, 30981, 30982, 30983, 30989, 3099
Post-Traumatic Stress Disorder (PTSD)	30981
Alcohol or Substance Abuse	2920, 29211, 29212, 2922, 29281, 29282, 29283, 29284, 29285, 29289, 2929, 30400, 30401, 30402, 30403, 30410, 30411, 30412, 30413, 30420, 30421, 30422, 30423, 30430, 30431, 30432, 30433, 30440, 30441, 30442, 30443, 30450, 30451, 30452, 30453, 30460, 30461, 30462, 30463, 30470, 30471, 30472, 30473, 30480, 30481, 30482, 30483, 30490, 30491, 30492, 30493, 30520, 30521, 30522, 30523, 30530, 30531, 30532, 30533, 30540, 30541, 30542, 30543, 30550, 30551, 30552, 30553, 30560, 30561, 30562, 30563, 30570, 30571, 30572, 30573, 30580, 30581, 30582, 30583, 30590, 30591, 30592, 30593, 64830, 64831, 64832, 64833, 64834, 65550, 65551, 65553, 76072, 76073, 76075, 7795, 96500, 96501, 96502, 96509, V6542 Alcohol Abuse: 2910, 2911, 2912, 2913, 2914, 2915, 2918, 29181, 29182, 29189, 2919, 30300, 30301, 30302, 30303, 30390, 30391, 30392, 30393, 30500, 30501, 30502, 30503, 76071, 9800

Behavioral Health Conditions	Numerator: Valid ICD-9-CM Codes
Substance Abuse Alone	2920, 29211, 29212, 2922, 29281, 29282, 29283, 29284, 29285, 29289, 2929, 30400, 30401, 30402, 30403, 30410, 30411, 30412, 30413, 30420, 30421, 30422, 30423, 30430, 30431, 30432, 30433, 30440, 30441, 30442, 30443, 30450, 30451, 30452, 30453, 30460, 30461, 30462, 30463, 30470, 30471, 30472, 30473, 30480, 30481, 30482, 30483, 30490, 30491, 30492, 30493, 30520, 30521, 30522, 30523, 30530, 30531, 30532, 30533, 30540, 30541, 30542, 30543, 30550, 30551, 30552, 30553, 30560, 30561, 30562, 30563, 30570, 30571, 30572, 30573, 30580, 30581, 30582, 30583, 30590, 30591, 30592, 30593, 64830, 64831, 64832, 64833, 64834, 65550, 65551, 65553, 76072, 76073, 76075, 7795, 96500, 96501, 96502, 96509, V6542
Suicide and Intentional Self-Inflicted Injury	E9500, E9501, E9502, E9503, E9504, E9505, E9506, E9507, E9508, E9509, E9510, E9511, E9518, E9520, E9521, E9528, E9529, E9530, E9531, E9538, E9539, E954, E9550, E9551, E9552, E9553, E9554, E9555, E9556, E9557, E9559, E956, E9570, E9571, E9572, E9579, E9580, E9581, E9582, E9583, E9584, E9585, E9586, E9587, E9588, E9589, E959, V6284

APPENDIX B: RISK FACTORS FOR DEPRESSION OR PROXY DISORDERS

Documentation and Technical Notes

The following defines the study population, the time frame, the exclusion and inclusion criteria, and the literature review references:

Data Source

- New Jersey Medicare FFS Part A and Part B claims data and denominator file

Reference Time Period

- Annual prevalence of risk factors for depression or proxy disorders comparing October 1, 2011 – September 30, 2012 to October 1, 2012 – September 30, 2013
- Annual prevalence trend for risk factors for depression or proxy disorders consists of eight points of data with rolling quarters (starting January 2011 and ending September 2013)

Mapping Tool

- QGIS Development Team, 2014, QGIS Geographic Information System. Open Source Geospatial Foundation Project. <http://qgis.osgeo.org>
- Source: ZIP code boundaries based on the 2013 U.S. Census Tiger Files

Denominator

- Denominator was the sum of all eligible Medicare FFS beneficiaries who were in the CMS denominator file during the measurement time frame
- Eligible beneficiaries were computed after adjusting for total enrolled FFS days divided by the total measurement days in the time frame
- Where Medicare FFS enrolled days > 0

Numerator

- Unique Medicare FFS beneficiaries with disease-specific inpatient or outpatient claims during the time frame
- CCW and AHRQ disease diagnosis code match (ICD-9-CM codes) Part A dgns_cd_1-25 and dgns_e_cd_1-3; Match Part B dgns_cd_1_12

Exclusions

- HMO coverage period
- Age <18 or >= 110
- Eligible Medicare FFS days/total measurement days = 0

Model

- Logistic Regression Models were used to determine the top five risk factors with the highest Odds Ratios (OR) ($p < 0.001$)

Resources

More information on the classification codes, requirements, and processing of the combination measure of depression or proxy disorders which includes beneficiaries reported for either depression, anxiety, or adjustment disorders can be located at the following links:

- Buccaneer, A General Dynamics Company. Chronic Condition Data Warehouse: Additions and Access – Task Order 10 New Clinical Conditions: Requirements and Processing [Internet]. [unknown]: Buccaneer, A General Dynamics Company. 2013 May 22 [cited 17 Sep 2013]. Available from: https://www.ccwdata.org/cs/groups/public/documents/document/clin_cond_algo_req_proc.pdf
- Healthcare Cost and Utilization Project (H-CUP). Clinical Classifications Software (CCS) for ICD-9-CM [Internet]. Rockville (MD): Agency for Healthcare Research and Quality; Nov 2013 [15 Sep 2013]. Available from: <http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp>

Literature Review References for Risk Factors for Depression or Proxy Disorders

National Alliance on Mental Illness. Information Helpline: Depression in Older Persons Fact Sheet [Internet]. Arlington (VA): National Alliance on Mental Illness; 2009 Oct [cited 2013 Sep 17]. Available from: <http://www.nami.org/Template.cfm?Section=Helpline1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=144039>

National Institute of Mental Health. Depression: Causes and Risk Factors [Internet]. Bethesda (MD): National Institute of Mental Health; 2013 Jul [cited 2013 Sep 17]. Available from: <http://nihseniorhealth.gov/depression/causesandriskfactors/01.html>

Centers for Disease Control and Prevention and National Association of Chronic Disease Directors. The State of Mental Health and Aging in America [Internet]. Atlanta (GA): National Association of Chronic Disease Directors, 2008 [cited 2013 Sep 19]. 11 p. Available from: http://www.cdc.gov/aging/pdf/mental_health.pdf

Jacques L, Jensen T, Schafer J, Caplan S, Schott L. Final Coverage Decision Memorandum for Screening for Depression in Adults [Internet]. Baltimore (MD): Centers for Medicare & Medicaid Services; 2011 Oct 14 [cited 2013 Sep 18]. 42 p. Available from: <http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=251>

Thakur M, Blazer DG. Depression in long-term care. *Journal of the American Medical Directors Association* [Internet]. 2008 Feb [cited 2013 Sep 19];9(2):82-87. Available from: <http://www.amda.com/tools/clinical/depression/DepressioninLongTermCare.pdf>

Sozeri-Varma G. Depression in the elderly: clinical features and risk factors. *Aging and Disease* [Internet]. 2012 Dec [cited 2013 Sep 18];3(6):465-471. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3522513/>

Qian J, Simoni-Wastila L, Rattinger GB, Lehmann S, Langenberg P, et al. Associations of depression diagnosis and antidepressant treatment with mortality among young and disabled Medicare beneficiaries with COPD. *General Hospital Psychiatry*. 2013 Jul 18 [cited 2013 Sep 22]; 35(6):612-618.

APPENDIX B

Shao W, Ahmad R, Khutoryansky N, Aagren M, Bouchard J. Evidence supporting an association between hypoglycemic events and depression. *Current Medical Research and Opinion*. 2013 Sep 23 [cited 2013 Sep 22]: 1-7.

Substance Abuse and Mental Health Services Administration. *The Treatment of Depression in Older Adults: Depression and Older Adults: Key Issues* [Internet]. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2011 [cited 2013 Sep 24]. HHS Pub. No. SMA-11-4631. 24 p. Available from: <http://store.samhsa.gov/shin/content/SMA11-4631CD-DVD/SMA11-4631CD-DVD-KeyIssues.pdf>

Himelhoch S, Weller WE, Wu AW, Anderson GF, Cooper LA. Chronic medical illness, depression, and use of acute medical services among Medicare beneficiaries. *Medical Care*. 2004 Jun [cited 2013 Sep 25];42(6):512-521.

Mohile SG, Fan L, Reeve E, Jean-Pierre P, Mustian K, et al. Association of cancer with geriatric syndromes in older Medicare beneficiaries. *Journal of Clinical Oncology: Official Journal of the American Society of Clinical Oncology* [Internet]. 2011 Apr 10 [cited 2013 Sep 25];29(11): 1458-1464. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3082984/>

Jayadevappa R, Malkowicz SB, Chhatre S, Johnson JC, Gallo JJ. The burden of depression in prostate cancer. *Psycho-oncology*. 2012 Dec [cited 2013 Sep 26];21(12):1338-1345.

Missouri Department of Mental Health. *CPS Facts: Depression and Older Adults* [Internet]. Jefferson City(MO): Missouri Department of Mental Health, [date unknown, cited 2013 Sep 26], 2 p. Available from: <http://dmh.mo.gov/docs/mentalillness/elderlydepress.pdf>

Oregon State University, Washington State University, University of Idaho. *Depression in Later Life: Recognition and Treatment* [Internet]. Corvallis(OR): Pacific Northwest Extension Publication; 2004 Jul [Published April 1990; revised July 2000; cited 2013 Sep 29]; 32 p. Available from: <http://ir.library.oregonstate.edu/xmlui/bitstream/handle/1957/20713/pnw347.pdf>

Cole MG, Dendukuri N. Risk factors for depression among elderly community subjects: a systematic review and meta-analysis. *American Journal of Psychiatry* [Internet]. 2003 Jun [cited 2013 Sep 29]; 160(6):1147-1156. Available from: <http://ajp.psychiatryonline.org/article.aspx?articleid=176272>

Kohn R, Levav I, Garcia ID, Machuca ME, Tamashiro R. Prevalence, risk factors and aging vulnerability for psychopathology following a natural disaster in a developing country. *International Journal of Geriatric Psychiatry*. 2005 Sep [cited 2013 Sep 29];20(9):835-841.

Pietrzak RH, Southwick SM, Tracy M, Galea S, Norris FH. Posttraumatic stress disorder, depression, and perceived needs for psychological care in older persons affected by Hurricane Ike. *Journal of Affective Disorders* [Internet]. 2012 Apr [cited 2013 Sep 30];138(1-2):96-103. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3306486/>

Oriol W. *Psychosocial Issues for Older Adults in Disasters* [Internet]. Washington (DC): Emergency Services and Disaster Relief Branch, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration; 1999 [cited 2013 Sep 30]; DHHS Publication No. ESDRB SMA 99-3323. 79 p. Available from: <http://store.samhsa.gov/shin/content/SMA99-3323/SMA99-3323.pdf>

O'Connor EA, Whitlock EP, Gaynes B, Beil TL. Screening for Depression in Adults and Older Adults in Primary Care: An Updated Systematic Review. [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2009 Dec [cited 2013 Sept 30]. 167 p. (Evidence Synthesis No. 75. AHRQ Publication No. 10-05143-EF-1). Available from: <http://www.ncbi.nlm.nih.gov/books/NBK36403/pdf/TOC.pdf>

Noyes K, Liu H, Lyness JM, Friedman B. Medicare beneficiaries with depression: comparing diagnoses in claims data with the results of screening. *Psychiatric Services* [Internet]. 2011 Oct [cited 2013 Sep 30];62(10):1159-1166. Available from: http://ps.psychiatryonline.org/data/Journals/PSS/4336/pss6210_1159.pdf

The following table shows the ICD-9-CM codes for the top five risk factors for depression or proxy disorders:

Top Five Risk Factors for Depression or Proxy Disorders*	Numerator: Valid ICD-9-CM Codes
Alzheimer's Disease and Related Disorders or Senile Dementia	3311, 33111, 33119, 3312, 3317, 2900, 29010, 29011, 29012, 29013, 29020, 29021, 2903, 29040, 29041, 29042, 29043, 2940, 2941, 29410, 29411, 2948, 797
Sleep Disturbance	04672, 29182, 29285, 30740, 30741, 30742, 30748, 30749, 32700, 32701, 32702, 32709, 78050, 78051, 78052, 78059
Substance or Alcohol Abuse or Tobacco Use	2910, 2911, 2912, 2913, 2914, 2915, 2918, 29181, 29182, 29189, 2919, 2920, 29211, 29212, 2922, 29281, 29282, 29283, 29284, 29285, 29289, 2929, 30300, 30301, 30302, 30303, 30390, 30391, 30392, 30393, 30400, 30401, 30402, 30403, 30410, 30411, 30412, 30413, 30420, 30421, 30422, 30423, 30430, 30431, 30432, 30433, 30440, 30441, 30442, 30443, 30450, 30451, 30452, 30453, 30460, 30461, 30462, 30463, 30470, 30471, 30472, 30473, 30480, 30481, 30482, 30483, 30490, 30491, 30492, 30493, 30500, 30501, 30502, 30503, 3051, 30510, 30511, 30512, 30513, 30520, 30521, 30522, 30523, 30530, 30531, 30532, 30533, 30540, 30541, 30542, 30543, 30550, 30551, 30552, 30553, 30560, 30561, 30562, 30563, 30570, 30571, 30572, 30573, 30580, 30581, 30582, 30583, 30590, 30591, 30592, 30593, 33392, 3575, 4255, 5353, 53530, 53531, 5710, 5711, 5712, 5713, 64830, 64831, 64832, 64833, 64834, 65550, 65551, 65553, 76071, 76072, 76073, 76075, 7795, 7903, 96500, 96501, 96502, 96509, 9800, V110, V111, V112, V113, V114, V118, V119, V154, V1541, V1542, V1549, V1582, V6285, V6542, V663, V701, V702, V7101, V7102, V7109, V790, V791, V792, V793, V798, V799
Hip/Pelvic Fractures	73314, 73315, 73396, 73397, 73398, 8080, 8081, 8082, 8083, 80841, 80842, 80843, 80849, 80851, 80852, 80853, 80859, 8088, 8089, 82000, 82001, 82002, 82003, 82009, 82010, 82011, 82012, 82013, 82019, 82020, 82021, 82022, 82030, 82031, 82032, 8208, 8209
Amputations	8870, 8871, 8872, 8873, 8874, 8875, 8876, 8877, 8960, 8961, 8962, 8963, 8970, 8971, 8972, 8973, 8974, 8975, 8976, 8977, 9059, 99760, 99761, 99762, 99769

* Other risk factors for depression or proxy disorders analyzed include Acute Myocardial Infarction (AMI), Stroke/Transient Ischemic Attack, Coronary Artery Bypass Graft Surgery (CABG), Parkinson's Disease, Chronic Obstructive Pulmonary Disease and Bronchiectasis (COPD), Diabetes, Chronic Kidney Disease, Rheumatoid Arthritis/Osteoarthritis (RA/OA), Macular Degeneration, Disability, History of Cancer, Heart Failure, and Acquired Hypothyroidism.

APPENDIX C: UTILIZATION OF OUTPATIENT MENTAL HEALTH SERVICES

Documentation and Technical Notes

The following defines the study population, the time frame, and the exclusion and inclusion criteria:

Data Source

- New Jersey Medicare FFS Part A and Part B claims data and denominator file

Reference Time Period

- Annual utilization comparing October 1, 2011 – September 30, 2012 to October 1, 2012 – September 30, 2013
- Annual utilization trend consists of eight points of data with rolling quarters (starting January 2011 and ending September 2013)
- Quarterly utilization trend charts for depression screening contains data from January 1, 2012 to September 30, 2013 and allows for the identification of new cases in a given quarter when compared to the prior year

Mapping Tool

- QGIS Development Team, 2014, QGIS Geographic Information System. Open Source Geospatial Foundation Project. <http://qgis.osgeo.org>
- Source: ZIP code boundaries based on the 2013 U.S. Census Tiger Files

Denominator

- Denominator was the sum of all eligible Medicare FFS beneficiaries who were in the CMS denominator file during the measurement time frame
- Eligible beneficiaries were computed after adjusting for total enrolled FFS days divided by the total measurement days in the time frame
- Where Medicare FFS enrolled days > 0

Numerator

Unique Medicare FFS beneficiaries with specific outpatient mental health service claims

Exclusions

- HMO coverage period
- Age <18 or >= 110
- Eligible Medicare FFS days/total measurement days =0

Resources

More information on the definitions and uses of the outpatient mental health services highlighted in this profile can be located at <http://www.medicarenhic.com/providers/pubs/REF-EDO-0012MentalHealthBillingGuide2013.pdf>.

The following table shows the CPT/HCPCS codes for the outpatient mental health services:

Mental Health Services	Numerator: CPT/HCPCS Codes
Assessments	
Depression Screening	G0444
Diagnostic Psychological Tests	96101, 96102, 96103, 96105, 96110, 96111
Health and Behavior Assessment/Intervention	96150, 96151, 96152, 96153, 96154, 96155
Neuropsychological Tests	96116, 96118, 96119, 96120
Psychiatric Diagnostic Procedures	90801, 90802, 90791, 90792
Therapies	
Individual Psychotherapy	90804, 90805, 90832, 90833, 90806, 90807, 90834, 90836, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90837, 90838, 90839, 90840
Family Psychotherapy	90846, 90847
Group Psychotherapy	90849, 90853, 90857
Electroconvulsive Therapy	90870
Biofeedback Therapy	90901, 90911

APPENDIX D: UTILIZATION OF SERVICES – INPATIENT AND OTHER SETTINGS

Documentation and Technical Notes

The following defines the study population, the time frame, and the exclusion and inclusion criteria:

Data Source

New Jersey Medicare FFS Part A claims data and denominator file

Reference Time Period

- Annual utilization comparing October 1, 2011 – September 30, 2012 to October 1, 2012 – September 30, 2013
- Annual utilization trend consists of eight points of data with rolling quarters (starting January 2011 and ending September 2013)

Denominator

- Denominator was the sum of all eligible Medicare FFS beneficiaries who were in the CMS denominator file during the measurement time frame
- Eligible beneficiaries were computed after adjusting for total enrolled FFS days divided by the total measurement days in the time frame
- Where Medicare FFS enrolled days > 0

Exclusions

- HMO coverage period
- Age <18 or >= 110
- Eligible Medicare FFS days/total measurement days =0

Utilization Measure

Refer to Appendix E.

Numerator

Utilization Measure Description	Numerator
Psychiatric Hospital Admissions	Number of eligible beneficiaries with at least one psychiatric hospital admission claim
Acute Care Hospital Admissions	Number of acute care hospital admissions
Observation Stays	Number of observation stays
Emergency Department Visits	Number of emergency department visits
30-Day Hospital Readmissions	Number of 30-day hospital readmissions
Observation Stays Within 30 Days of Hospital Discharge	Number of observation stays within 30 days of hospital discharge
Emergency Department Visits Within 30 Days of Hospital Discharge	Number of emergency department visits within 30 days of hospital discharge
Home Health Agency Services	Number of eligible beneficiaries with at least one home health agency claim
Skilled Nursing Facility Services	Number of eligible beneficiaries with at least one skilled nursing facility claim
Hospice Services	Number of eligible beneficiaries with at least one hospice claim
Medical Rehabilitation Services	Number of eligible beneficiaries with at least one medical rehabilitation claim

APPENDIX E: TIME FRAMES AND FORMULAE

Time Frames	
Quarters	Dates
Q1	January 1 to March 31
Q2	April 1 to June 30
Q3	July 1 to September 30
Q4	October 1 to December 31

Formulae

$$\text{Incidence} = \frac{\text{(Number of new cases in a time frame, not present in prior year)}}{\text{(Total eligible beneficiaries in the population during the time frame)}}$$

$$\text{Prevalence} = \frac{\text{(Number of cases in a time frame)}}{\text{(Total eligible beneficiaries in the population during the time frame)}}$$

$$\text{Utilization} = \frac{\text{(Number of beneficiaries or measures with specific service utilization)}}{\text{(Total eligible beneficiaries in the population during the time frame)}}$$

$$\text{Relative change} = \frac{\text{(Current rate - Former rate)}}{\text{(Former rate)}}$$

APPENDIX F: REFERENCES

1. Weiss MG, Saraceno B, Saxena S, van Ommeren M. Mental health in the aftermath of disasters: consensus and controversy. *The Journal of Nervous and Mental Disease*. 2003 Sep; 191(9):611-615.
2. Foa EB, Stein DJ, McFarlane AC. Symptomatology and psychopathology of mental health problems after disaster. *The Journal of Clinical Psychology* [Internet]. 2006;[cited 16 Sep 2013];67 Suppl 2:15-25.
3. Wang PS, Gruber MJ, Powers RE, Schoenbaum M, Speier AH, Wells KB, Kessler RC. Mental health service use among hurricane Katrina survivors in the eight months after the disaster. *Psychiatry Services* [Internet]. 2007 Nov [cited 16 Sep 2013]; 58(11):1403-1411. Available from: <http://ps.psychiatryonline.org/data/Journals/PSS/3824/07ps1403.pdf>
4. Voelker R. Post-katrina mental health needs prompt group to compile disaster medicine guide. *JAMA*. 2006 Jan [cited 2013 Sep 17]; 295(3):259-260.
5. Centers for Medicare & Medicaid Services. Medicare Claims Database, Parts A and B, January 1, 2011 – March 31, 2013. Baltimore (MD): CMS, Department of Health and Human Services. Accessed: September 15, 2013.
6. U.S. Department of Commerce: United States Census Bureau, American Fact Finder [Internet]. Washington (DC): U.S. Department of Commerce. Median Income in the Past 12 Months (in 2012 Inflation-Adjusted Dollars); 2012 [cited 15 Sep 2013]; [about 2 screens]. Available from: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_12_1YR_S1903&prodType=table
7. Centers for Medicare & Medicaid Services. Screening for Depression, February 2013. Available from: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN-MLNProducts/Downloads/Screening-for-Depression-Booklet-ICN907799.pdf>
8. Centers for Medicare & Medicaid Services. Mental Health Services Billing Guide, April 2013. Hingham (MA): NHIC, Corp. Apr 2013. 40 p.

APPENDIX G: PROVIDER SUMMARY TABLES AND PROVIDER LISTINGS

The following defines the data source and time period for the provider summary tables and listings:

Data Source

New Jersey Medicare Part A and Part B FFS claims data

Reference Time Period

Provider summary tables were based on Pre-Sandy time frame (Q1 2011-Q3 2012)

Mapping Tool

ArcGIS Explorer Online. ArcGIS® software by Esri. www.esri.com

Professional Type by Behavioral Health Services

The following defines the data source and time period for the provider summary tables and listings:

Data Source

New Jersey Medicare FFS Part B claims data

Reference Time Period

- Professional type of behavioral health service claims during October 1, 2011 – September 30, 2012 and October 1, 2012 – September 30, 2013

Professional Type Credentials – Including, but not limited to:

- Physicians: DO, MD
- Psychologists: PhD, PsyD, EdD
- Social Workers: MSW, LCSW
- Nurses: APN, RN, NP
- Others: Other

This Page Left Intentionally Blank

Executive Summary

Figure 1. Snapshot of Eatontown and Shrewsbury	10
--	----

Demographics

Figure 2. Total Medicare FFS Beneficiaries	11
Figure 3. Percent of Medicare FFS Beneficiaries in the General Population in 2012	11
Figure 4. Percent of Medicare FFS Beneficiary Population by Female	11
Figure 5. Percent of Medicare FFS Beneficiary Population by Race	12
Figure 6. Percent of Medicare FFS Beneficiary Population by Age	12
Figure 7. 2012 Median Household Income (65 years and above)	12

Prevalence and Incidence

Figure 8. Percent Change of Prevalence of Selected Behavioral Health Conditions	13
Figure 9. Quarterly New Incidence Trend of Selected Behavioral Health Conditions: Depression or Proxy Disorders	14
Figure 10. Quarterly New Incidence Trend of Other Selected Behavioral Health Conditions	14
Figure 11. Annual Prevalence Trend of Selected Behavioral Health Conditions: Depression or Proxy Disorders	15
Figure 12. Annual Prevalence Trend of Other Selected Behavioral Health Conditions	15
Figure 13. Demographics of Depression or Proxy Disorders	16
Figure 14. Depression or Proxy Disorders Rate by Demographic Group	17
Figure 15. Depression or Proxy Disorders Rate by Race	18
Figure 16. Depression or Proxy Disorders Rate by Gender	18
Figure 17. Depression or Proxy Disorders Rate by Age Group	18
Figure 18. Depression or Proxy Disorders (Annual Prevalence, Annual Trend, and Percent Change)	19
Figure 19. Quarterly New Incidence of Depression or Proxy Disorders	19
Figure 20. Prevalence of Depression or Proxy Disorders in 10 Counties	20
Figure 21. Monmouth County Prevalence of Depression or Proxy Disorders	21
Figure 22. Depression (Annual Prevalence, Annual Trend, and Percent Change)	22
Figure 23. Quarterly New Incidence of Depression	22
Figure 24. Anxiety Disorders (Annual Prevalence, Annual Trend, and Percent Change)	23
Figure 25. Quarterly New Incidence of Anxiety Disorders	23
Figure 26. Adjustment Disorders (Annual Prevalence, Annual Trend, and Percent Change)	24
Figure 27. Quarterly New Incidence of Adjustment Disorders	24
Figure 28. PTSD (Annual Prevalence, Annual Trend, and Percent Change)	25
Figure 29. Quarterly New Incidence of PTSD	25
Figure 30. Alcohol or Substance Abuse (Annual Prevalence, Annual Trend, and Percent Change)	26
Figure 31. Quarterly New Incidence of Alcohol or Substance Abuse	26
Figure 32. Substance Abuse Alone (Annual Prevalence, Annual Trend, and Percent Change)	27
Figure 33. Quarterly New Incidence of Substance Abuse Alone	27

INDEX OF FIGURES

Figure 34. Suicide and Intentional Self-Inflicted Injury (Annual Prevalence, Annual Trend, and Percent Change)	28
Figure 35. Quarterly New Incidence of Suicide and Intentional Self-Inflicted Injury	28
Risk Factors for Depression or Proxy Disorders	
Figure 36. Percent Change of Prevalence of the Top Five Risk Factors of Depression or Proxy Disorders	29
Figure 37. Annual Prevalence Trend for Risk Factors of Depression or Proxy Disorders	30
Figure 38. Annual Prevalence of Any of the Top Five Risk Factors for Depression or Proxy Disorders	30
Figure 39. Prevalence of Any of the Top Five Risk Factors for Depression or Proxy Disorders in 10 Counties	31
Figure 40. Monmouth County Prevalence of Any of the Top Five Risk Factors for Depression or Proxy Disorders	32
Figure 41. Annual Prevalence of Alzheimer’s Disease and Related Disorders or Senile Dementia	33
Figure 42. Annual Prevalence of Sleep Disturbance	33
Figure 43. Annual Prevalence of Substance or Alcohol Abuse or Tobacco Use	33
Figure 44. Annual Prevalence of Hip/Pelvic Fractures	34
Figure 45. Annual Prevalence of Amputations	34
Utilization of Outpatient Behavioral Health Services	
<i>Assessments</i>	
Figure 46. Percent Change of Behavioral Health Service Utilization – Assessments	35
Figure 47. Annual Utilization Trend of Behavioral Health Assessment Services	35
Figure 48. Depression Screening (Annual Utilization, Annual Trend, and Percent Change)	36
Figure 49. Quarterly Depression Screening	36
Figure 50. Provider Location for Depression Screening Claims for Medicare FFS Beneficiaries	37
Figure 51. Depression Screening Claims for Medicare FFS Beneficiaries	37
Figure 52. Depression Screening in 10 Counties	38
Figure 53. Monmouth County Depression Screening	39
Figure 54. Neuropsychological Tests (Annual Utilization, Annual Trend, and Percent Change)	40
Figure 55. Provider Location for Neuropsychological Tests Claims for Medicare FFS Beneficiaries	41
Figure 56. Neuropsychological Tests Claims for Medicare FFS Beneficiaries	41
Figure 57. Psychiatric Diagnostic Procedures (Annual Utilization, Annual Trend, and Percent Change)	42
Figure 58. Provider Location for Psychiatric Diagnostic Procedures Claims for Medicare FFS Beneficiaries	43
Figure 59. Psychiatric Diagnostic Procedures Claims for Medicare FFS Beneficiaries	43

Therapies

Figure 60. Percent Change of Behavioral Health Service Utilization – Therapies	44
Figure 61. Annual Utilization Trend of Behavioral Health Therapy Services	44
Figure 62. Individual Psychotherapy (Annual Utilization, Annual Trend, and Percent Change)	45
Figure 63. Provider Location for Individual Psychotherapy Claims for Medicare FFS Beneficiaries	46
Figure 64. Individual Psychotherapy Claims for Medicare FFS Beneficiaries	46
Figure 65. Family Psychotherapy (Annual Utilization and Annual Trend)	47
Figure 66. Group Psychotherapy (Annual Utilization and Annual Trend)	48

Inpatient Health Services

Figure 67. Percent Change of Inpatient Health Service Utilization	49
Figure 68. Annual Utilization Trend of Inpatient Health Services	49
Figure 69. Psychiatric Hospital Admissions (Annual Utilization, Annual Trend, and Percent Change)	50

Acute Care Hospitals

Figure 70. Acute Care Hospital Admissions (Annual Utilization, Annual Trend, and Percent Change)	51
Figure 71. Observation Stays (Annual Utilization, Annual Trend, and Percent Change)	52
Figure 72. Emergency Department Visits (Annual Utilization, Annual Trend, and Percent Change)	53

Within 30 Days of Acute Care Hospital Discharge

Figure 73. Percent Change of Inpatient Health Service Utilization Within 30 Days of Discharge	54
Figure 74. Annual Utilization Trend of Inpatient Health Services Within 30 Days of Discharge	54
Figure 75. 30-Day Hospital Readmissions (Annual Utilization, Annual Trend, and Percent Change)	55
Figure 76. Observation Stays Within 30 Days of Discharge (Annual Utilization, Annual Trend, and Percent Change)	56
Figure 77. Emergency Department Visits Within 30 Days of Discharge (Annual Utilization, Annual Trend, and Percent Change)	57

Other Settings

Figure 78. Percent Change of Other Health Services Utilization	58
Figure 79. Annual Utilization Trend in Other Health Services	58
Figure 80. Home Health Agency Services (Annual Utilization, Annual Trend, and Percent Change)	59
Figure 81. Skilled Nursing Facility Services (Annual Utilization, Annual Trend, and Percent Change)	60
Figure 82. Hospice Services (Annual Utilization, Annual Trend, and Percent Change)	61
Figure 83. Medical Rehabilitation Services (Annual Utilization, Annual Trend, and Percent Change)	62

This page left intentionally blank



557 Cranbury Road, Suite 21
East Brunswick, NJ 08816
T 732-238-5570 • F 732-238-7766
www.hqsi.org