



PROVIDER

Newsletter

NEW DIETARY GUIDELINES

HELP YOUR PATIENTS MAKE HEALTHIER FOOD CHOICES AND CONFRONT THE OBESITY EPIDEMIC

More than one-third of children and more than two-thirds of adults in the United States are overweight or obese. In response, the seventh edition of *Dietary Guidelines for Americans* places a stronger emphasis on reducing calorie consumption and increasing physical activity.

The guidelines focus on balancing calories with physical activity, and encouraging Americans to consume healthy foods like vegetables, fruits, whole grains, fat-free and low-fat dairy products, and seafood. The guidelines also encourage Americans to consume less sodium, fewer saturated and *trans* fats, less sugar, and fewer refined grains.

The next generation Food Pyramid, which includes tips you can discuss with your patients, helps people translate the *Dietary Guidelines* into their everyday lives:

- Enjoy your food, but eat less.
- Avoid oversized portions.
- Make half your plate fruits and vegetables.
- Switch to fat-free or low-fat (1%) milk.
- Compare sodium in foods like soup, bread and frozen meals — and choose the foods with lower numbers.
- Drink water instead of sugary drinks.

The 2010 *Dietary Guidelines* are available at www.dietaryguidelines.gov.

For more information on dietary guidelines, visit www.health.gov/dietaryguidelines and www.healthfinder.gov/prevention.

Source:

United States Department of Agriculture. Press Release. USDA and HHS Announce New Dietary Guidelines to Help Americans Make Healthier Food Choices and Confront Obesity Epidemic. USDA Office of Communications. Available at: <http://www.cnpp.usda.gov/Publications/DietaryGuidelines/2010/PolicyDoc/PressRelease.pdf>

PROVIDER UPDATE

Since our last newsletter was published, the following correspondence was sent to providers via fax, mail, e-mail or was posted on the secure section of the WellCare website:

- April HEDIS® “Measure of the Month:” Appropriate Medications for Patients with Asthma, Pharmacotherapy Management of COPD Exacerbations, Use of Spirometry Testing (e-mail)
- April HEDIS® “Measure of the Month:” Colorectal Cancer Screening (Medicare)
- New York Medicaid Provider Manual Update Notice
- March HEDIS® “Measure of the Month:” Cardiovascular Conditions and Diabetes (e-mail)
- New York 2011 Issue I Provider Newsletter
- February HEDIS® “Measures of the Month:” Surveying Members’ Satisfaction (e-mail)
- 2011 Model of Care Self-Study Program (Medicare)
- Vascular Surgery CPT Code Change
- January HEDIS® “Measures of the Month:” Appropriate Use of Antibiotics (e-mail)

You can find copies of some of these correspondences when you log in to the secure area of www.wellcare.com (via the sign-in on the right that says “Member / Provider Secure Sign-In”). Then click on the *Provider* tab and you will see *Messages from WellCare* located on the right-hand side. Remember to check the messages regularly to receive new and updated information.

Q2 2011 PROVIDER FORMULARY UPDATE

GENERIC NEWS

The generic drugs listed below are now available:

BRAND NAME	GENERIC NAME	THERAPEUTIC CLASS
Accolate® 10mg, 20mg tablets	Zafirlukast 10mg, 20mg tablets	Antileukotrienes
Aricept® 5mg, 10mg tablets	Donepezil HCl 5mg, 10mg tablets	Cholinesterase Inhibitors
Aricept® ODT 5mg, 10mg tablets	Donepezil HCl 5mg, 10mg orally disintegrating tablets	Cholinesterase Inhibitors
Armour® Thyroid 30mg, 60mg, 90mg tablets	NP Thyroid 30mg, 60mg, 90mg tablets	Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)
Dovonex® 0.005% topical ointment†	Calcipotriene 0.005% topical ointment	Dermatological Agents
Lotrel® 5mg-40mg, 10mg-40mg capsules†	Amlodipine Besylate/Benazapril HCl 5mg-40mg, 10mg-40mg capsules	Renin-Angiotensin-Aldosterone System Inhibitors
Mirapex® 0.75mg tablet†	Pramipexole Dihydrochloride 0.75mg tablet	Antiparkinson Agents

†Not covered on the 2011 Medicare Formulary

The following additions have been made to the WellCare Medicare Formulary:

ADDITIONS	
Bromday™ 0.09% ophthalmic solution (QL: 2.5mL/31 days)	Lumigan® 0.01% ophthalmic solution (QL: 5mL/31 days)
Calcitriol 1mcg/mL solution (PA)	Jalyn™ 0.5mg/0.4mg capsule
Carisoprodol 250mg tablet (QL: 124 tablets/31 days)	Latuda® 40mg, 80mg tablets (PA)
Cimetidine HCl 300mg/5mL solution	Pantoprazole Sodium 20mg, 40mg delayed-release tablets
Doxepin HCl 150mg capsule	Renvela® 800mg tablet, 0.8g and 2.4g packets
Dulera® 100mcg/5mcg, 200mcg/5mcg inhalation solution	

PA = Prior Authorization QL = Quantity Limit

The Utilization Management criteria have changed for the following medications as noted below for the WellCare Medicare Formulary:

DRUG NAME	CHANGE
Byetta® 5mcg, 10mcg injection	PA removed
Eliphos™ 667mg tablet	PA removed

PA = Prior Authorization

PLANNED MARKET DRUG WITHDRAWALS

COMPANY NAME	DRUG NAME	DATE OF REMOVAL	ADDITIONAL INFORMATION
Abbott Laboratories	Meridia® (sibutramine hydrochloride monohydrate) Capsules	October 12, 2010	Abbott has voluntarily withdrawn Meridia® Capsules from the U.S. market at the request of the U.S. Food and Drug Administration (FDA). The FDA's decision is based primarily on the results of the SCOUT (Sibutramine Cardiovascular Outcomes Trial) study, an approximately 10,000-patient, six-year study requested by European regulatory authorities as a post-marketing commitment to evaluate cardiovascular safety in high-risk patients. The majority of these patients had underlying cardiovascular disease and were not eligible to receive sibutramine under the current labeling. While Abbott believes sibutramine has a positive risk/benefit profile in the approved patient population, the company will comply with the FDA's request.
Xanodyne Pharmaceuticals	Darvon® (propoxyphene HCl) Darvon-N® (propoxyphene napsylate) and Darvocet-N® (propoxyphene napsylate/acetaminophen)	November 19, 2010	Xanodyne Pharmaceuticals, Inc., which makes Darvon® and Darvocet®, the brand version of the prescription pain medication propoxyphene, has agreed to withdraw the medication from the U.S. market at the request of the FDA. The FDA has also informed the generic manufacturers of propoxyphene-containing products of Xanodyne's decision and requested that they voluntarily remove their products as well. The FDA sought market withdrawal of propoxyphene after receiving new clinical data showing that the drug puts patients at risk of potentially serious or even fatal heart rhythm abnormalities. As a result of these data, combined with other information, including new epidemiological data, the agency concluded that the risks of the medication outweigh the benefits. The FDA is advising health care professionals to stop prescribing propoxyphene to their patients, and patients who are currently taking the drug should contact their health care professional as soon as possible to discuss switching to another pain management therapy.

Please visit www.wellcare.com to view the complete formulary and pharmacy updates.

HELPING PATIENTS WITH RHEUMATOID ARTHRITIS (RA)

According to a U.S. government survey on arthritis statistics, one out of every four adults in America will have arthritis by 2030. There are over 50 million people who suffer from arthritis and, according to the Centers for Disease Control and Prevention, people with rheumatoid arthritis die up to 10 years earlier than those who do not have this disease.

Together, we can help your patients become more educated about the disease process, maximize current treatment methods and avoid common mistakes associated with their RA. Consider the following strategies:

Prescriptions: Emphasize the importance of taking a disease-modifying anti-rheumatic drug (DMARD) or a biologic early on, since these classes of drugs address the root cause of the immune system malfunction, often at the cellular level. The American College of Rheumatology (ACR) recommends that all RA patients be given a DMARD, regardless of how active or severe their RA is. Studies show that starting powerful drugs earlier may be more effective in reducing or preventing joint damage.

Medication Regimen: Patients may stop taking their medications or skip doses as they feel better. Therefore, it is critical to help them understand that failing to take their medication may cause pain or the arthritis to get worse. Patient education in this area is a key to a successful treatment outcome.

Depression: Watch for depression in RA patients, since this chronic condition can negatively affect their psychosocial well-being. Some people with RA benefit from antidepressants in concert with help from a mental health professional.

As you deem beneficial, advise patients to utilize their mental health benefits by calling the number on the back of their Plan member ID card. In addition, encourage them to attend local support groups such as those offered by The Arthritis Foundation or local hospitals.

Exercise: It is recommended that RA patients take short rest breaks throughout the day, especially when the disease is active or exacerbated. This can help reduce joint inflammation, pain and fatigue. However, it is prudent to advise RA patients that too much resting will increase stiffness and decrease joint mobility. Teach gentle range-of-motion exercises and encourage exercising in the water during flare-ups. When patients are feeling better, promote increased activity and resistance exercise to build muscle strength.

Referrals: Refer RA patients to follow up with a rheumatologist for ongoing monitoring, labs and medical treatment. Advise them to find a local rheumatologist through the Plan's website at www.wellcare.com or by calling Customer Service.

WellCare also has specialized Disease Management nurses who speak to members with RA via telephone to provide education in conjunction with educational mailings. To refer a member to Disease Management, please call **1-866-635-7045**. This program is at no charge to the member.

Sources: Arthritis Foundation, The American College of Rheumatology (ACR), <http://www.arthritis.org/facts.php>

The Centers for Disease Control (CDC), <http://www.cdc.gov/arthritis/media/quickstats.htm>

WELLCARE'S MAIL-ORDER PHARMACY SERVICE

AN EASY WAY FOR YOUR PATIENTS TO SAVE

With WellCare's new mail-order pharmacy service, your patients can now have the medications they take every month mailed directly to their home. It's easy, convenient (no more waiting in lines at the retail pharmacy) and accurate. They will also save money! By using WellCare's mail-order service, they will receive a three-month supply of medication for only two and a half monthly co-pays.

Simply call **1-866-892-9006**, Monday–Friday, from 8 a.m. to 6:30 p.m. Eastern, to get your patients started. Or fax their maintenance medication prescriptions to **1-866-892-8194**. Remember to prescribe the maximum days' supply (93 days) plus refills for up to one year.

Because the pharmacy team at WellCare's mail-order service has a deep understanding of the insurance process, they will work with your office to obtain all necessary information, allowing your patients to receive their medications promptly.

APPEALING AN ADVERSE DETERMINATION

When an adverse determination has been rendered, a provider may request an appeal of the decision within the time frame specified on the provider evidence of payment (EOP)/provider remittance advice.

The request must be submitted to the following address:

WellCare Health Plans, Inc.
P.O. Box 31368
Tampa, FL 33631-3368

The request should include information as to why the denial should be reversed. Pertinent documentation that supports the service provided should be included with the appeal request.

Once the case is received, the file will be reviewed by someone who was not previously involved in the initial determination. The Plan will conduct a review of the request that does not give deference to the denial decision. The Plan will also fully investigate the content of the appeal, including all aspects of clinical care involved.

A decision will be rendered to the provider within **30 calendar days**. Information regarding additional appeal rights, if applicable, will also be included in the appeal outcome letter.

Upon request, a copy of the clinical rationale used in making the appeal decision will be provided.

WHAT IS HEDIS®?

HEDIS® (Healthcare Effectiveness Data and Information Set) consists of a set of performance measures utilized by more than 90 percent of American health plans that compare how well a plan performs in these areas:

- Quality of care
- Access to care
- Member satisfaction with the health plan and doctors

WHY HEDIS® IS IMPORTANT

HEDIS® ensures health plans are offering quality preventive care and service to members. It also allows for a true comparison of the performance of health plans by consumers and employers.

VALUE OF HEDIS® TO YOU, OUR PROVIDERS

HEDIS® can help you save time while also potentially reducing health care costs. By proactively managing patients' care, you are able to effectively monitor their health, prevent further complications and identify issues that may arise with their care. HEDIS® can also help you:

- Identify noncompliant members to ensure they receive preventive screenings
- Understand how you compare with other WellCare providers as well as with the national average

VALUE OF HEDIS® TO YOUR PATIENTS, OUR MEMBERS

HEDIS® ensures that members will receive optimal preventive and quality care. It gives members the ability to review and compare plans' scores, helping them to make informed health care choices. In the upcoming months, as part of our planned HEDIS® initiatives, we will be making outreach phone calls and/or mailing periodicity letters to members and/or parents or guardians of targeted members. These calls and letters will inform and educate them about the importance of preventive health screenings. We will encourage the scheduling of appointments for breast cancer and cervical cancer screening, child and adolescent well visits, childhood immunizations, lead screening, glaucoma screening, postpartum visits and other preventive screenings.

WHAT YOU CAN DO

- Encourage your patients to schedule their preventive screening exams.
- Remind your patients to follow up with ordered tests.
- Complete outreach calls to noncompliant members.

If you have questions about HEDIS®, or need more information, please contact your local Provider Relations representative.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).



SERVICE AUTHORIZATION REQUESTS

For some treatments and services, WellCare Health Plans Inc. requires a service authorization request, as listed in the Quick Reference Guides (QRG). The QRGs are updated on an annual basis, list all of the services that require prior authorization, as well as the appropriate steps to follow when requesting a service authorization, and can be found on the provider website.

WellCare has a review team of nurses and physicians that ensures members receive appropriate health care services, with a focus on meeting the clinical coverage guidelines and standards of practice.

Currently, reviews are conducted within the state-mandated time frames for Medicaid members and federally mandated time frames for Medicare members. However, with WellCare seeking NCQA accreditation, going forward we will conduct reviews using the more stringent review time frame, whether that is the state/federal requirement or the NCQA requirement. Any decision to deny a service authorization request, or to approve it for an amount that is less than asked for, is called an adverse organization determination. This determination will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a physician reviewer.

After we receive your request, we will review it under a standard or an expedited review process. Physicians who determine that a review under the standard time frame would jeopardize the member's life or health, or the member's ability to regain maximum function, can request an expedited review. Any physician request for an expedited review will be honored by WellCare. If a request for an expedited review is made by a member, we will look at the request and determine if it meets the standard above. If it does not, we will notify the member and handle the request within the standard time frame.

WellCare will provide you the decision through a fax or telephone notification. If we deny your request, the attending or treating physician has the right to discuss the denial with the physician who made the decision. When we notify you of the decision, we will provide instructions on how you would request a peer-to-peer review, so that you may present your reasons as to why you think we should overturn the denial decision. Physicians may contact WellCare during business hours and after hours by calling 1-800-278-5155 (Medicare) or 1-800-288-5441 (Medicaid) regarding utilization management issues or decisions.

EMPOWER PATIENTS TO MANAGE THEIR ASTHMA

As a provider, you can help your patients manage their asthma by continuously educating them in these areas, as outlined in the *Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma — Full Report, 2007*:

1. **Self-assessment and monitoring:** Encourage patients to keep a daily log of their peak flow volume upon waking and going to bed to detect subtle changes in their lung function. Spirometry testing is advised at least yearly.
2. **Patient education:** You play a crucial role in teaching a patient the skills he or she needs to self-monitor asthma and when to seek medical care. According to a recent report, only 34 percent reported receiving an asthma management plan with specific instructions on how to change the amount or type of medicine taken, when to call a doctor for advice and when to go to the emergency department.¹ Reinforce how to handle exacerbations using a written asthma action plan. The templates for asthma action plans may be accessed at: www.nhlbi.nih.gov/health/public/lung/asthma/asthma_actplan.pdf.
 - Refer WellCare members to our Disease Management program by calling 1-866-635-7045. This program provides telephonic education from an RN, at no cost to the member, to reinforce their understanding of asthma and adherence to their asthma action plan.
3. **Medications:** Help patients understand the importance of compliance with maintenance medications and the rationale for following the National Heart, Lung, and Blood Institute's Stepwise treatment guidelines. Consider referral to an asthma specialist for Step 3 and above or if difficulties persist in controlling asthma.²

National Heart, Lung, and Blood Institute's Stepwise treatment guidelines:

- **Step 1: Mild intermittent:** No daily medications needed. Rescue inhalers known as Short-acting Beta₂ Adrenergic Agonist Bronchodilators (SABA), i.e., albuterol.
- **Step 2: Mild persistent:** Low-dose inhaled corticosteroids. To be added for all persistent diseases, i.e., beclomethasone, mometasone. Alternative Tx: leukotriene modifier, i.e., montelukast.
- **Step 3: Moderate persistent:** Daily symptoms. Low- to medium-dose inhaled corticosteroids *and* Long-acting Beta₂ Adrenergic Agonist Bronchodilators (LABA), i.e., salmeterol or formoterol, to be added for asthmatics inadequately controlled on steroids. Per the FDA, LABAs are never to be used alone in the treatment of asthma.³
- **Step 4: Severe persistent:** High-dose inhaled corticosteroids *and* LABAs, *and* as needed, oral corticosteroids.

And finally, be sure to follow up with your asthma patients seasonally or no less than every six months if stable. Discuss their concerns and adjust step-up or step-down treatment as necessary.

SOURCES

- 1) Centers for Disease Control & Prevention; National Center for Health Statistics, *National Health Statistics Reports, Number 32, January 12, 2011* pg.5; www.cdc.gov/nchs.
- 2) National Heart, Lung, and Blood Institute; *Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma — Full Report, 2007*; www.nhlbi.nih.gov/guidelines/asthma/index.htm.
- 3) U.S. Food and Drug Administration press release, "FDA Announces New Safety Controls for Long-Lasting Beta Agonists, Medications Used to Treat Asthma," Feb. 18, 2010; www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm200931.htm.

MEMBER RIGHTS AND RESPONSIBILITIES

New York law requires that health care providers or health care facilities recognize members rights while they are receiving medical care and that the member respect the health care provider's or facility's right to expect certain behavior on the part of patients. Members may request a copy of the full text of this law from their health care provider or health care facility. A summary of their rights and responsibilities is as follows:

THEIR RIGHTS

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services they need from WellCare.
- Get information about the Plan, its services, its Primary Care Providers (PCPs) and health care providers and member rights and responsibilities.
- Be told by their PCP what is wrong, what can be done for them, and what will likely be the result in language they understand.
- Get a second opinion about their care.
- Give their OK to any treatment or plan for their care after that plan has been fully explained.
- To talk openly about care they need for their health, regardless of cost or benefit coverage, as well as choices and risks involved. The information must be given in a way they can understand.
- Refuse care and be told what they may risk if they do.
- To decide with their PCP on the type of care they should receive.
- Get a copy of their medical record, and talk about it with their PCP, and to ask, if needed, that their medical record be amended or corrected.
- Be sure that their medical record is private and will not be shared with anyone except as required by law, contract or with their approval.
- Use the WellCare complaint system to settle any complaints, or they can complain to the New York State Department of Health or the local Department of Social Services any time they feel they were not treated fairly.
- To have a say in the Plan's member rights and responsibilities policy.
- Use the State Fair Hearing system.
- Appoint someone (relative, friend, lawyer, etc.) to speak for them if they are unable to speak for themselves about their care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

THEIR RESPONSIBILITIES

As a member of WellCare, they agree to:

- Work with their PCP to guard and improve their health.
- Give information that the Plan and PCPs need to provide care.
- Follow plans and instructions for care that they have agreed on with their health care provider.
- Find out how their health care system works.
- To follow plans and instructions for care that they have agreed on with their health care provider.
- To understand their health problems.
- Listen to their PCP's advice and ask questions when they are in doubt.
- Call or go back to their PCP if they do not get better, or ask for a second opinion.
- Treat health care staff with the respect they expect themselves.
- Call Customer Service if they have problems with any health care staff.
- Keep their appointments. If they must cancel, call as soon as they can.
- Use the emergency room only for real emergencies.
- Call their PCP when they need medical care, even if it is after hours.

REAP THE BENEFITS OF WELLCARE SPECIALTY PHARMACY

Helping your patients manage their long-term and/or rare conditions is never an easy task, especially considering the unique challenges each patient presents and the vast array of medications available to address those challenges. That's why it's important for you to partner with a pharmacy that will work with you and your patients to manage their health condition(s) and therapy.

When you refer your Medicare patients to WellCare Specialty Pharmacy, you enlist the expertise of a team skilled in the handling of medications for conditions that include anemia, ankylosing spondylitis, cancer, Crohn's disease, hemophilia, hepatitis, HIV, multiple sclerosis, organ transplant, psoriasis and others. However, patients aren't the only ones to reap countless benefits. With just one simple call, both you and your office staff can also benefit from a team that will:

- Help manage medication side effects and symptoms
- Order medication refills and supplies
- Work closely with your office to provide the right information to WellCare in order to obtain the medication promptly
- Provide educational materials
- Research alternative funding when needed
- Assist in teaching how to administer the medication
- Answer any questions regarding medication or condition
- In rare cases, quickly triage the order to another pharmacy while informing the patient and your office staff

For your patients to begin receiving the benefits of WellCare Specialty Pharmacy, just call in their specialty medication order to **1-866-458-9246**, Monday–Friday, 8 a.m. to 6:30 p.m. or fax the order to **1-866-458-9245**.

CLAIMS CORNER

WHAT'S THE DIFFERENCE BETWEEN AN APPEAL AND A CLAIM DISPUTE?

You should file an appeal if you disagree with an adverse organization determination. In most cases, these are related to authorization denials, claim denials or denials for reimbursement.

A contracted provider has the right to appeal authorization denials or claim denials related to lack of, or in excess of, authorization.

Appeals should be sent to:

WellCare Health Plans Inc.
P.O. Box 31368
Tampa, FL 33631

If you believe there has been an error in payment, or you believe a claim payment did not follow guidelines, you have the right to dispute the payment amount by submitting a claim dispute.

Claim disputes can include:

- A claim denial for timely filing
- Coding- or billing-related issues
- A dispute in the amount paid on a claim

Please be advised that the P.O. Box for claims disputes has changed since this article was last published in Issue II 2010. The updated P.O. Box is included below.

Claims disputes should be sent to:

WellCare Health Plans Inc.
P.O. Box 31370
Tampa, FL 33631-3370

Payment policy disputes (i.e., denials starting with IHXXX, MKXXX or PDXXX) should be sent to:

WellCare Health Plans Inc.
P.O. Box 31426
Tampa, FL 33631-3426

For more information about appeals or claim disputes, please refer to the telephone numbers on the *Quick Reference Guides*, available on the provider website at www.wellcare.com.

TAKE POSITIVE ACTION IN MANAGING MEDICATIONS

SIMPLE INTERVENTIONS PROMOTE PROPER DRUG USE, PATIENT SAFETY

WellCare encourages providers to make sure your patients are using the medications they need in the way they should be used. Some proactive steps you can take in this area can drive beneficial outcomes for patients.

Providers can almost instantaneously improve their patients' health care status by systematically re-assessing the indications for and dosages of all of the medications, (including herbal, over-the-counter and topical preparations) used by their patients. It's also the perfect time to uncover the use of illicit drugs and improper consumption of alcoholic beverages.

For patients on a daily medication regimen, the use of a pill carrier, or even two if a patient is on an AM-PM dosing schedule, will help with compliance. Encouraging the use of this user-friendly tool can keep your patients on track with what medications they need to take and when.

Do you ask your patients if they keep an up-to-date list of all their medications in their wallet or purse? Does the list also include their known allergies? If not, you may want to encourage them to do so. When a patient goes to an emergency room or sees a specialist, a list of his/her current medications can keep his/her care on track, highlighting the need to treat the complete patient and potentially avoiding harmful drug-drug interactions.

For Medicare patients discharged from an acute or non-acute facility, remember that the prescribing practitioner or clinical pharmacist should reconcile the discharged medications with the most recent medication list in the patient's medical record. This should be completed within 30 days of discharge. An outpatient visit isn't required, just documentation in the patient's medical record that the reconciliation was conducted.

Medical record documentation should include:

- Notation that medications prescribed upon discharge were reconciled with current medications by the appropriate practitioner, or
- Medications listed in the discharge summary present on the outpatient medical record and evidenced by reconciliation with current medications by the appropriate practitioner, or
- Notation that no medications were prescribed upon discharge.



DETECTING AND TREATING DEPRESSION IN ADULTS

- Primary care physicians can effectively detect and manage depression.
- Routinely screen for depression using a simple two-question tool (PHQ-2).
- Depression can be treated. Medication and psychotherapy, alone or in combination, may help most patients.

RECOGNIZING DEPRESSION

Most cases of depression in primary care are recognized through observation and active listening during an office visit. Physicians should always be alert to the possibility that a patient might have depression, especially patients with a prior personal or family history of mood disorders or chronic medical illness.

While performing a review of systems and taking a social history, be attentive to clues suggesting depression, especially in patients with chronic or severe physical illnesses.

Asking questions in an open-ended manner about a patient's level of functioning, energy, motivation, and any work or social difficulties can reveal depression while avoiding stigmatization.

Screen for depression by using a simple two-question tool, the Patient Health Questionnaire-2 (PHQ-2):

Over the past two weeks, have you been bothered by:

1. Little interest or pleasure in doing things?
2. Feeling down, depressed or hopeless?

A "yes" answer to either question requires further evaluation. If the patient's response to both questions is "no," the screen is likely negative.

DIAGNOSIS OF DEPRESSION

Further evaluation of depression can be facilitated by using the Patient Health Questionnaire (PHQ-9). This nine-item questionnaire is available at www.depression-primarycare.org/clinicians/toolkits/. It can be completed before or during an office visit, and can reliably assist in detecting and quantifying the severity of depression.

MANAGEMENT OF DEPRESSION BY PRIMARY CARE CLINICIANS

Once a diagnosis is made, effective management may include patient education, self-management support, treatment and ongoing monitoring.

Self-management goals include:

- Taking medications regularly.
- Spending time with people who are supportive.
- Engaging in regular physical activity.
- Making time for enjoyable or relaxing activities.

Depression may be treated with psychotherapy, pharmacotherapy or both. Either or both modalities can be used for patients presenting mild episodes of major depressive disorder (MDD). Patients with moderate to severe MDD should generally be prescribed antidepressant medication, and may also benefit from psychotherapy. Factors affecting choice of treatment include severity of symptoms, psychosocial stressors, comorbid conditions, patient preference and availability of resources. The PHQ-9 may be used to aid in selection of treatment, as well as assist in diagnosis.

Some patients are reluctant to see a specialist for psychotherapy, or may prefer not to take medication. Despite patient reluctance, it is critical that you remain engaged with these patients, approach them in a supportive manner and offer additional treatments or referrals as the opportunities arise. When psychosis, suicidal ideation or severe dysfunction is present, medication will be needed and hospitalization may be necessary.

Source: City Health Information: Detecting and Treating Depression in Adults. (2008) The New York City Department of Health and Mental Hygiene. 26(9), 59-66. Available at: <http://www.nyc.gov/html/doh/downloads/pdf/chi/chi26-9.pdf>.



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S*T*A*R*T CAN STOP THE CYCLE

ENCOURAGE PATIENTS TO QUIT SMOKING

Quitting smoking works best when the person is prepared. Help your patients start by communicating a new acronym, **START**, which stands for these five important steps:

S = **Set** a quit date.

T = **Tell** family, friends and coworkers that you plan to quit.

A = **Anticipate** and plan for the challenges you'll face while quitting.

R = **Remove** cigarettes and other tobacco products from your home, car and work.

T = **Talk** to your doctor about getting help to quit.

For more information, visit www.smokefree.gov.

Source: <http://www.smokefree.gov/qg-preparing-steps.aspx>, January 2011.



IMMUNIZATION SCHEDULE

Vaccines are among the 20th century’s most successful and cost-effective public health tools for preventing disease and death. Because of immunizations, diseases like polio that were once common are now only distant memories for most Americans. Today, there are few visible reminders of the suffering, injuries and deaths caused by diseases that are now prevented with vaccines.

Immunizations are for people of all ages. From newborns to older adults, timely immunizations are one of the most important ways for people to protect themselves and others from serious diseases.

The New York State Department of Health Immunization Program’s goal is to prevent vaccine-preventable diseases by making sure children receive the vaccines they need. The program ensures:

- All children have access to vaccines;
- Health care providers are aware of immunization standards of practice;
- The latest recommendations on new vaccines are available to providers; and
- Providers and the public have up-to-date answers to vaccine questions.

If you are inquiring about vaccinations received from a provider within the five boroughs/counties of New York City: Bronx (which is Bronx County), Brooklyn (Kings County), Manhattan (New York County), Queens (Queens County), and Staten Island (Richmond County), please call the New York City Department of Health and Mental Hygiene’s Immunization Hotline at 1-212-676-2323.

RECOMMENDED 2011 IMMUNIZATION SCHEDULE FOR PERSONS AGES 0 THROUGH 6 YEARS

Vaccine ▼	Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years
Hepatitis B ¹	HepB	HepB	HepB			HepB						
Rotavirus ²				RV	RV	RV ²						
Diphtheria, Tetanus, Pertussis ³				DTaP	DTaP	DTaP	<i>see footnote³</i>	DTaP				DTaP
Haemophilus influenzae type b ⁴				Hib	Hib	Hib ⁴	Hib					
Pneumococcal ⁵				PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus ⁶				IPV	IPV	IPV						IPV
Influenza ⁷						Influenza (Yearly)						
Measles, Mumps, Rubella ⁸							MMR		<i>see footnote⁸</i>			MMR
Varicella ⁹							Varicella		<i>see footnote⁹</i>			Varicella
Hepatitis A ¹⁰							HepA (2 doses)				HepA Series	
Meningococcal ¹¹											MCV4	

Range of recommended ages for all children

Range of recommended ages for certain high-risk groups

Sources:

New York State Department of Health. Immunization. Available at: <http://www.health.state.ny.us/prevention/immunization/>.

Department of Health and Human Services. Centers for Disease Control and Prevention. (2011) Recommended Immunization Schedule for Persons Aged 0 Through 6 Years. Available at: <http://www.cdc.gov/vaccines/recs/schedules/downloads/child/0-6yrs-schedule-pr.pdf>.

This schedule includes recommendations in effect as of December 21, 2010. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or by telephone, 1-800-822-7967. Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

¹ **Hepatitis B vaccine (HepB).** (Minimum age: birth)

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

Doses following the birth dose:

- The second dose should be administered at age 1 or 2 months. Monovalent HepB should be used for doses administered before age 6 weeks.
- Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
- Administration of 4 doses of HepB to infants is permissible when a combination vaccine containing HepB is administered after the birth dose.
- Infants who did not receive a birth dose should receive 3 doses of HepB on a schedule of 0, 1 and 6 months.
- The final (3rd or 4th) dose in the HepB series should be administered no earlier than age 24 weeks.

² **Rotavirus vaccine (RV).** (Minimum age: 6 weeks)

- Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
- The maximum age for the final dose in the series is 8 months 0 days
- If Rotarix is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

³ **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** (Minimum age: 6 weeks)

- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

⁴ **Haemophilus influenzae type b conjugate vaccine (Hib).** (Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- Hiberix should not be used for doses at ages 2, 4, or 6 months for the primary series but can be used as the final dose in children aged 12 months through 4 years.

⁵ **Pneumococcal vaccine.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])

- PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- A PCV series begun with 7-valent PCV (PCV7) should be completed with 13-valent PCV (PCV13).
- A single supplemental dose of PCV13 is recommended for all children aged 14 through 59 months who have received an age-appropriate series of PCV7.
- A single supplemental dose of PCV13 is recommended for all children aged 60 through 71 months with underlying medical conditions who have received an age-appropriate series of PCV7.

- The supplemental dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7. See *MMWR* 2010;59(No. RR-11).
- Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant.

⁶ **Inactivated poliovirus vaccine (IPV).** (Minimum age: 6 weeks)

- If 4 or more doses are administered prior to age 4 years an additional dose should be administered at age 4 through 6 years.
- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.

⁷ **Influenza vaccine (seasonal).** (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- For healthy children aged 2 years and older (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used, except LAIV should not be given to children aged 2 through 4 years who have had wheezing in the past 12 months.
- Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
- Children aged 6 months through 8 years who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010–2011 seasonal influenza vaccine. See *MMWR* 2010;59(No. RR-8):33–34.

⁸ **Measles, mumps, and rubella vaccine (MMR).** (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.

⁹ **Varicella vaccine.** (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

¹⁰ **Hepatitis A vaccine (HepA).** (Minimum age: 12 months)

- Administer 2 doses at least 6 months apart.
- HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

¹¹ **Meningococcal conjugate vaccine, quadrivalent (MCV4).** (Minimum age: 2 years)

- Administer 2 doses of MCV4 at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
- Persons with human immunodeficiency virus (HIV) infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
- Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
- Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years if the first dose was administered at age 2 through 6 years.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (www.aap.org) and the American Academy of Family Physicians (www.aafp.org).