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## Communication and coordination of patient care

You can help improve patient outcomes by communicating and coordinating care with all treating providers. Take time to share the right information at the right time using teamwork, health information technology and care management approaches. The Institute of Medicine has identified care coordination as a key strategy to potentially improve the effectiveness, safety and efficiency of the American health care system.

Mental health and substance abuse issues rarely occur in isolation. These conditions are often present with medical illnesses. Assessing for potential coexisting medical conditions is critical to quality patient care. Talk to your patients about the importance of care coordination during your first visit. Ask them to grant consent for you to communicate with their primary care physician (PCP).

We can help you get follow-up medical care services. Just call the Member Services number on the member’s card. Or you can refer the member to log in to their secure member website at [www.aetna.com](http://www.aetna.com). This resource has:

- Referral options
- Education for members about medical conditions
  - Members can type “Healthwise® Knowledgebase” or “Emmi” into the Ask Ann search bar.
- An option to talk to or email a nurse

**Continued on page 2**
Survey results show room for improvement
Our recent 2016 provider experience survey results show opportunities for improvement in care coordination still exist with our behavioral health providers. We found that our providers ask their patients for permission to communicate with their PCPs about 60 percent of the time. When permission is granted, actual communication with the PCP happens about 73 percent of the time.

We ask for feedback from our members, too. Our 2016 member survey results show that:

- Forty-seven percent of our members said their behavioral health providers asked them for permission to share information with their PCPs.
- When asked, our members reported granting permission 94 percent of the time and were 95 percent satisfied with the sharing of information.

We also audit our behavioral health practitioners every year. A recent audit of treatment records show that:

- Only 43 percent documented a request to communicate with a PCP.
- Of those providers who documented a request, 80 percent followed through with communicating with the PCP.

These results show that behavioral health providers actually communicate with their patients’ PCPs only about 34 to 44 percent of the time. These survey results identify an opportunity to improve member clinical outcomes.

Communication benefits everyone
Increased communication and coordination between behavioral health and medical care is an important part of quality care. Our recent physician practice satisfaction survey shows that the vast majority of PCPs prefer communication to be:

- Via fax (66 percent)
- Electronic (35 percent)*

PCPs say they'd like to get copies of their patients’ progress notes (50 percent), diagnosis (31 percent) and lab results (19 percent).

PCPs are often unaware when their patients are getting behavioral health treatment. Communication can improve overall member care, enhance patient outcomes and help develop a professional relationship that may provide a network of referral sources. Check out the Agency for Healthcare Research and Quality (AHRQ) for more resources.

We encourage our behavioral health care practitioners to share patient information and promote complete patient care. Check out our online resources supporting enhanced communication:

Behavioral Health/Medical Provider Communication Form
Behavioral health sample forms
Practitioner communication — make the connection provider flyer

*The shift to electronic communication is trending sharply upward.
Quality Management (QM) program

Quality improvement strategy
Our strategy is to approach quality measurement and improvement from a comprehensive member-centric focus. We try to weave this into everything we do. We design our clinical programs and initiatives to enhance the quality of care for our members. We also design them to better inform members by relying on clinical data and industry-accepted, evidence-based guidelines.

We’re committed to transparency. We provide credible clinical information and tools to members and participating practitioners so they can make informed decisions.

QM program goals
- To promote the principles and spirit of Continuous Quality Improvement (CQI)
- To operate the QM program in compliance with and responsive to applicable requirements of plan sponsors, federal and state regulators and appropriate accrediting bodies
- To address racial and ethnic disparities in health care that could negatively impact quality health care
- To institute company-wide initiatives to improve the safety of members and our communities and to foster communications about the programs
- To implement a standardized and comprehensive QM program that addresses and is responsive to the health needs of our population including but not limited to serving members with complex health needs across the continuum of care
- To increase the knowledge/skill base of staff and to facilitate communication, collaboration and integration among key functional areas relative to implementing a sound and effective QM program
- To measure and monitor previously identified issues, evaluate the QM program and improve performance in key aspects of quality and safety of clinical care, including behavioral health and quality of service for members, customers and participating practitioners/providers
- To maintain effective, efficient and comprehensive practitioner/provider selection and retention processes through credentialing and recredentialing activities
- To ensure collaboration with behavioral health care networks to improve continuity and coordination of care between behavioral health specialists and primary care practitioners
- To encourage the development and use of new or existing services and activities that support state public health goals, and to incorporate public health goals from the state medical assistance QM program, where applicable

QM process
We use CQI techniques and tools to improve the quality and safety of clinical care and service delivered to members. This includes systematic and periodic follow-up on the effect of interventions. These enable correction of problems identified through internal surveillance, analysis of complaints or other mechanisms. We implement quality improvement through a cross-functional team approach, as evidenced by multidisciplinary committees. We use quality reports to monitor, communicate and compare key indicators.

Finally, we develop relationships with various professional entities and provider organizations that may provide feedback about structure and implementation of QM program activities. They may also collaborate on quality improvement projects.
QM program scope

The scope and content of the QM program are designed to continuously monitor, evaluate and improve the quality and safety of clinical care and service provided to members. Specifically, the QM program includes, but is not limited to:

- Review and evaluation of preventive and behavioral health services; ambulatory, inpatient, primary and specialty care; high-volume and high-risk services; and continuity and coordination of care
- Development of written policies and procedures reflecting current standards of clinical practice
- Development, implementation and monitoring of patient safety initiatives and preventive and clinical practice guidelines
- Monitoring of behavioral health case and condition management programs
- Achievement and maintenance of regulatory and accreditation compliance
- Evaluation of accessibility and availability of our network providers
- Establishment of standards for and auditing of behavioral health record documentation
- Monitoring for overutilization and underutilization of services (Medicare)
- Performance of credentialing and recredentialing activities
- Oversight of delegated activities
- Evaluation of member and practitioner experience
- Support for initiatives to address racial and ethnic disparities in health care
- Adherence to these guidelines in the development of provider performance programs: standardization and sound methodology; transparency; collaboration; and taking action on quality and cost, or quality only, but never cost data alone except in unique situations where there are not standardized measures of quality and/or there is insufficient data

Aetna Behavioral Health QM program outcomes

We evaluate our behavioral health QM program annually to monitor progress against goals. Significant achievements for 2015 included the following:

- Several behavioral health quality improvement activities showed improvement and progress from 2014 to 2015.
- We updated our utilization management (UM) clinical criteria (Applied Behavioral Analysis and Aetna’s Level of Care Assessment Tool or LOCAT).
- Member experience survey ratings improved for overall satisfaction (93 percent) and finding a therapist (88 percent).
- Provider experience survey ratings for overall satisfaction remained high (90 percent), and providers’ rating of the Aetna Behavioral Health Insights™ newsletter and of the Aetna Behavioral Health Quality Management Bulletin showed statistically significant improvements, at 2015 results of 89 percent and 88 percent, respectively.
- The Bridge Appointment Program contracted with an additional 10 hospitals. New billing practices helped to increase ambulatory follow-up rates by allowing facilities to bill for onsite, post-discharge meetings with follow-up providers.
- A new Opioid Overdose Risk Screening Program began on January 1, 2016. The program aims to reduce opioid overdose deaths by promoting naloxone as part of the member’s treatment plan.
- We expanded a successful behavioral health pilot program, which increased medication adherence to our MidAmerica Region medical utilization review team.
- Aetna Behavioral Health customer service teams met all telephone accessibility metrics in 2015.
- Our DocFind® directory underwent several improvements, including general appearance, improved navigability, a Spanish version and “Future View,” which allows viewers to view anticipated network participation prior to enrollment/re-enrollment.
- Mark Friedlander, chief medical officer for Aetna Behavioral Health, helped lead efforts to improve medication adherence via an AetNet medication adherence webpage.
The Complex Case Management (CCM) program achieved several firsts, including a new governing policy, a new staff audit and a new member survey, which showed a 90 percent rating for the CCM helping to manage members’ mental health.

Aetna Behavioral Health QM underwent a successful “mock audit” to help prepare for our 2016 National Committee for Quality Assurance (NCQA) managed behavioral health organization (MBHO) survey.

Audits of UM denials were conducted throughout 2015 and showed compliance of 95 – 100 percent to standards.

A study was published in the *American Journal of Managed Care*, which showed that the AbilTo program (a unique video/telephonic program) helped improve outcomes among cardiac populations.

Aetna Behavioral Health launched behavioral health televideo in Texas with accompanying measures to determine effectiveness.

We released the new “Assess Wellbeing” web-based tool to help members assess levels of depression and anxiety.

We released four new “It only takes a minute” videos in 2015, on various mental health topics.

We provided consultation on behavioral health/medical integration to several dozen Aetna accountable care organizations (ACOs). We also developed a behavioral health playbook tool for the ACOs.

The legacy MHNet/Coventry integration continues.

We developed and posted a new web-based tool for staff to help members dealing with autism spectrum disorder.

We initiated targeted mailings to various member and provider groups to improve care for members with issues such as medication adherence, attention-deficit/hyperactivity disorder, the side effects of antipsychotics and coordination of care.

Participating behavioral health care professionals contractually agree to support our behavioral health QM program, be familiar with our guidelines and standards and apply them in their clinical work. Specifically, behavioral health care professionals are expected to:

- Cooperate with our QM program
- Adhere to all Aetna policies and procedures, including those outlined in the *Aetna Behavioral Health Provider Manual*
- Communicate with the member’s PCP as warranted (after obtaining a signed release)
- Comply with treatment record standards, as outlined in our provider manual
- Respond promptly to inquiries by our behavioral health staff
- Cooperate with our complaint process
- Follow continuity-of-care and transition-of-care standards when the member’s benefits are exhausted, or if they leave the network
- Support onsite audits or requests for treatment records
- Complete and return annual provider satisfaction surveys when requested
- Submit claims with all requested information completed
- Adhere to patient safety principles
- Comply with state and federal laws, including confidentiality standards

Our health plan is rated by the NCQA on a regular basis. The NCQA is an independent, nonprofit group. Their goal is to improve health care quality. They created a set of measures called the Healthcare Effectiveness Data and Information Set (HEDIS). These measures are used to rate health plans and MBHOs. They rate quality of care, access to care and member satisfaction. More than 90 percent of America’s health plans use these measures, including Aetna.

We take our NCQA ratings seriously. They help us learn new ways to improve so we can meet your needs. See more information about our NCQA ratings.

You can get more information about our NCQA accreditations on the [NCQA website](https://www.ncqa.org).

If you have questions about our QM program, or to get a copy of the program description and outcomes summary, you can view the information online. Or just email our QM staff at qualityimprovement2@aetna.com. You can also call our Provider Service Center at 1-888-632-3862.
The shortage of behavioral health practitioners: a challenge to effective health care

Our sixth annual behavioral health summit this summer will focus on how the inadequate number of key providers impacts our members’ quality of and access to care. We want to identify what we can do to help address their needs. Our expert speakers will share engaging and relevant information on:

• Various treatment choices
• Technological advances as substitutes for trained professionals
• Who else can fill the gaps
• Our role in addressing our members’ needs

Look for our summit report in our upcoming fall Aetna Behavioral Health Insights newsletter. For information on last year’s summit, check out our 2015 Fall Aetna Behavioral Health Insights newsletter on page 7.

What you need to know about coverage determinations and UM

We use evidence-based clinical guidelines from nationally recognized authorities to make UM decisions. Aetna medical directors make all coverage denial decisions that involve clinical issues. Only licensed Aetna medical directors (for behavioral health, these are all board-certified psychiatrists), psychologists and pharmacists make denial decisions for reasons related to medical necessity. Licensed pharmacists and psychologists review coverage requests as permitted by state regulations and within their areas of expertise. Where state law mandates, utilization review coverage denials are made, as applicable, by a physician or pharmacist licensed to practice in that state.

Specifically, we review any request for coverage to determine if members are eligible for benefits, and if the service they request is a covered benefit under their plan. We also determine if the service delivered is consistent with established guidelines. The member, member’s representative or a provider acting on the member’s behalf may appeal this decision if we deny a coverage request. Members can do this through our complaint and appeal process.

Our UM staff helps members access services covered by their benefits plans. UM decision making is based only on appropriateness of care and service and existence of coverage. We don’t reward physicians, health care professionals or other individuals who conduct UM reviews for creating barriers to care or for issuing coverage denials. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Our medical directors and staff are available to speak with you on specific UM issues. If a treating health care professional does not agree with a decision regarding coverage or would like to discuss an individual member’s case, behavioral health UM and precertification staff is available 24 hours a day, 7 days a week. Just call the phone number on the member’s ID card. When the card only shows a Member Services number, we’ll direct you through a phone prompt to a Member Services representative.

Clinical criteria

We use the following criteria as guidelines in making coverage determinations, which are based on information about the specific member’s clinical condition:

• Aetna’s Clinical Policy Bulletins
• Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and the Medicare Benefit Policy Manual
• MCG™ guidelines
• American Society of Addiction Medicine (ASAM) Criteria — Treatment for Substance-Related, Addictive, and Co-Occurring Conditions; Third Edition Revised
  - You can find these standards online.
• Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers (28 TAC §§3.8001-3.8030) (formerly known as TCADA is used in place of ASAM for treatment in Texas)
• Applied Behavioral Analysis (ABA) Guidelines for the Treatment of Autism Spectrum Disorders
• Aetna’s Level of Care Assessment Tool (LOCAT) for mental health conditions

Where to learn more

If requested in writing or by phone, we provide participating practitioners with the criteria used to make a determinations. Just call 1-888-632-3862 for a paper copy or if you need a copy of the criteria upon which we base a specific determination. Our UM criteria are also available online.
Consult behavioral health Clinical Practice Guidelines as you care for patients

Aetna adopts evidence-based Clinical Practice Guidelines from nationally recognized sources. You can access them on our secure provider website. Once on the site, go to My Health Plans > Aetna Health Plan > Support Center > Clinical Resources. Or you can just click on the links below.

- **ADHD:**
  Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents  
  Adopted 3/2016

- **Helping Patients Who Drink Too Much**  
  Adopted 3/2016

- **Practice Guideline for the Treatment of Patients with Major Depressive Disorder**  
  Adopted 3/2016

For a hard copy of a specific Clinical Practice Guideline, call our Provider Service Center at **1-888-632-3862**.
Updates to screening programs

Opioid overdose risk screening
We’ve initiated a new screening program to help counter the deadly results of opioid overdose. Deaths due to opioid overdose have escalated dramatically as the use of opioids to fight pain has increased. Opioid dependence is a medical condition that can occur when pain medications are not taken as prescribed, and it can lead to more dangerous alternatives such as heroin when opioid prescriptions are reduced or stopped.

When a member screens positive for opioid dependence, our behavioral health clinicians discuss naloxone, an opioid overdose rescue medication, with the member or their provider. Naloxone immediately counters the effects of opioid overdose and allows the member to continue on the road to recovery. Because relapse is a common occurrence during the recovery effort, naloxone can, and does, save lives when available for use by the patient’s family or other supports.

If you’re a practitioner that treats patients with opioid dependence, please contact us at qualityimprovement2@aetna.com to submit your best practice on this issue. We’d like to hear from you. We may highlight your best practice in our upcoming newsletter.

Depression screening for pregnant and postpartum women
We collaborate with Aetna National Care Management to facilitate depression prevention and screening for pregnant women. This includes all members who qualify for postpartum calls during the postpartum period. The Beginning Right® maternity program helps members and providers ensure a healthy, term delivery. Depression screening is a key element of the program. We complete the depression screening as part of the pregnancy risk survey. We encourage women who screen positive for depression to access their behavioral health benefits. They may also be eligible for Aetna Behavioral Health Condition Management Case Management Services.

Program elements
• The clinical case management process focuses on members holistically, including behavioral health and condition assessment, care formulation, care planning and focused follow-ups.
• Beginning Right refers members with positive depression screens to Behavioral Health Condition Management if they have the benefit and meet the program criteria.
• Through the behavioral health medical integration initiative, a behavioral health specialist supports the Beginning Right team to enhance identification and effective engagement for members with behavioral health concerns.
• Beginning Right nurses reach out to members who have lost their babies to offer condolences and to offer behavioral health resources.

How to contact us
• Pregnant and postpartum members who have the Beginning Right benefit can participate.
• Members and providers call 1-800-CRADLE-1 (1-800-272-3531) to verify eligibility or register for the program.
- Members can complete enrollment with a representative at this number.
- Members can also enroll online through their member website.

Alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) program
Our SBIRT program is designed to support mental health professionals in screening patients for alcohol abuse, providing brief intervention and referring individuals to treatment. Overall, the program aims to improve both the quality of care for patients with substance abuse conditions, as well as outcomes for patients, families and communities.

Our goal is to help increase the adoption of alcohol screening, brief intervention and the referral to treatment process in mental health care. The program incorporates the evidence-based protocol established by the National Institute on Alcohol Abuse and Alcoholism. We reimburse you for screening and brief intervention. This program is open to Aetna participating mental health care professionals treating any patient who is 18 years of age or older and has Aetna medical benefits. Click here to get started.
Treatment record review criteria, results and best practices — coming soon

We completed our annual provider treatment record review in July 2016. We’ll share results of this annual audit, as well as review criteria and best practices, in our upcoming fall 2016 Aetna Behavioral Health Insights newsletter. To see last year’s results, read page 9 of our Aetna Behavioral Health Insights Fall 2015 issue.

A reminder for our outpatient providers

Nonurgent authorizations can take up to 14 days to finalize. Plan ahead and call promptly for any nonurgent service requiring precertification. Go to www.aetna.com for more information on services requiring precertification and for electronic precertification.

Transcranial magnetic stimulation (TMS) requires preauthorization effective November 1, 2016. For more information, go to www.aetna.com and Clinical Policy Bulletins. Search for “Transcranial Magnetic Stimulation and Cranial Electrical Stimulation,” CPB 0469. The CPB will include specific criteria for approval of TMS.

Just call our Provider Services Center at 1-800-624-0756 for health maintenance organization (HMO) plans and Medicare Advantage plans. For all other plans, call 1-888-MDAetna (1-888-632-3862). You can also reach us online.
Behavioral health care provider access to care standards

All of our members have the right to receive timely access to medically necessary behavioral health care services. Our network providers and practitioners are accountable for upholding the Aetna Behavioral Health member access-to-services standards. The standards* are:

<table>
<thead>
<tr>
<th>Service</th>
<th>Time frame</th>
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<tbody>
<tr>
<td>Non-life-threatening emergency needs</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Urgent needs</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Routine office visits</td>
<td>Within 10 working days</td>
</tr>
<tr>
<td>Follow-up routine mental health care</td>
<td>Within 4 weeks for behavioral health practitioners who prescribe medications; within 2 weeks for behavioral health practitioners who do not prescribe medications</td>
</tr>
<tr>
<td>Following hospital discharge for a behavioral health condition</td>
<td>Within 7 days</td>
</tr>
</tbody>
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After-hours care

Behavioral health care professionals must have a reliable 24-hour-a-day, 7-day-a-week answering service or machine with a beeper or paging system. This should include a message to the member that if they feel they have a serious medical condition, they should seek immediate attention by calling 911 or going to the nearest emergency room.

The acceptable answering options for members to receive when contacting you after hours includes reaching:

- The practitioner or a person with the ability to patch the call through to the practitioner (for example, answering service)
- An answering machine with instructions on how to contact the practitioner or their backup
- An answering machine that allows messages to be automatically forwarded to a phone (for example, practitioner’s cell phone or pager) so that the practitioner can retrieve and respond to those after-hours messages for life-threatening emergencies, as soon as possible

*Unless state requirements are more stringent.
**Member focus**

**Member experience results for provider accessibility**

Each year, Aetna Behavioral Health measures accessibility to provider offices by analyzing member experience survey results and access-related complaints. Our most recent member experience survey results showed:

<table>
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<th>Provider access measures</th>
<th>Prescribing practitioner</th>
<th>Non-prescribing practitioner</th>
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<tr>
<td>Member satisfaction with obtaining non-life-threatening</td>
<td>81 percent</td>
<td>83 percent</td>
</tr>
<tr>
<td>mental health emergency care within 6 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member satisfaction with obtaining care for an urgent</td>
<td>82 percent</td>
<td>82 percent</td>
</tr>
<tr>
<td>mental health need within 48 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member satisfaction with obtaining routine</td>
<td>88 percent</td>
<td>89 percent</td>
</tr>
<tr>
<td>mental health care within 10 business days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member satisfaction with getting follow-up routine</td>
<td>91 percent</td>
<td>N/A</td>
</tr>
<tr>
<td>mental health care within 4 weeks of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member satisfaction with getting follow-up routine</td>
<td>N/A</td>
<td>92 percent</td>
</tr>
<tr>
<td>mental health care within 2 weeks of request</td>
<td></td>
<td></td>
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Our target for these measures is 85 percent. We still have opportunity for improvement on two measures: 1) non-life-threatening emergent member access to care and 2) urgent member access to care. You can help improve patient access to care by providing no-fuss scheduling, offering choices in appointment times and coordinating care.

**Member Rights and Responsibilities available online**

You can find our commercial and Medicare Member Rights and Responsibilities statements at [www.aetna.com](http://www.aetna.com) in the “Individuals & Families” section under Rights & Resources. (The language may vary depending upon the state law applicable to each plan.) They’re also available in our Behavioral Health Provider Manual. Go to the Health Care Professionals > Education & Manuals section of our public website.

If you’d like a hard copy of this information and don’t have Internet access, call our Provider Service Center at 1-800-624-0756 for HMO-based and Medicare Advantage plans or 1-888-632-3862 for all other benefits plans.

**Nondiscrimination policy**

As a network behavioral health care provider, you should have a documented nondiscrimination policy. Federal and state laws prohibit discrimination against patients based on:

- Race, ethnicity, national origin or religion
- Age, gender or sexual orientation
- Genetic information
- Mental or physical disability
- Medical condition, medical history, evidence of insurability (including conditions arising out of acts of domestic violence)
- Source of payment

Under the federal Americans with Disabilities Act, you may also have to give physical access to your office and reasonable accommodations for patients and employees with disabilities. More information on access standards and the nondiscrimination policy is available in the Behavioral Health Provider Manual posted on [www.aetna.com](http://www.aetna.com).
Patient adherence to antidepressants

Depression in adults is treatable. When patients follow their medication program, treatment can be more effective. You can help increase adherence by educating patients at the start of treatment about:

- How antidepressants work
- Benefits of antidepressant treatment
- Expectations about symptom remission
- How long medications should be used
- Coping with medication side effects

Remind your patients to:

- Talk with you about any side effects.
- Tell you about their current medical conditions and the medications they’re taking, including over-the-counter drugs, herbs and supplements. This can help identify potential drug interactions.
- Schedule regular follow-up visits to see if the medication is working.
- Expect they may need to try a few different medications before finding which one works best.
- Keep taking their medication as prescribed for at least six months after they feel better.

How to monitor adherence

- The NCQA* has established two measures to monitor patients’ adherence to their medications. It’s important to monitor the percentage of your patients who stay on their antidepressant medication for at least three months and for at least six months.

*NCQA is a private, nonprofit organization dedicated to improving health care quality.
For more information or if you need to contact us

Online
www.aetna.com
Access our secure provider website on NaviNet® through our public website. Once there, select "Health Care Professionals," then "Log In/Register."
Already registered? Go to https://connect.navinet.net.

To access the Aetna Behavioral Health and employee assistance program page:
• Log in to our secure provider website
• Choose “Aetna Support Center” from the upper-left menu
• Select "Doing Business with Aetna" followed by "Aetna Benefit Products"

By phone
Aetna Behavioral Health
• For general questions about Aetna Behavioral Health, call 1-888-632-3862.
• For HMO-based and Medicare Advantage plans claims, benefits, eligibility, precertification, case management or demographic changes, call 1-800-624-0756.
• For all other plans claims, benefits, eligibility, precertification, case management or demographic changes, call 1-888-MDAETNA (1-888-632-3862).
• For questions about joining our Aetna Behavioral Health network, call 1-800-999-5698.

Aetna Behavioral Health — Quality
• Contact us at 1-800-624-0756 for HMO-based and Medicare Advantage plans.
• Call 1-888-632-3862 for all other plans if you:
  - Have questions about our UM criteria or you would like a copy
  - Need information about a coverage decision for one of your Aetna Behavioral Health patients
  - Want to speak with one of our clinical reviewers (24 hours a day, 7 days a week)
If you have questions or want more information on provider quality efforts, you can also email our Quality Management staff at qualityimprovement2@aetna.com.

Employee assistance program call center: 1-888-238-6232

By mail
Aetna Behavioral Health
1425 Union Meeting Road
PO Box 5
Blue Bell, PA 19422

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