South Country Health Alliance
Anitdepressant Medication Management

Updated April 13, 2017
Supporting Antidepressant Medication Management

Overview

Depression and other behavioral health disorders are common, disabling, and associated with high health care costs. Yet only about 25 percent of patients with these disorders receive effective care (Unutzer, Harbin, Schoenbaum, and Druss 2013). Rates of depression have been estimated to be as high as 20 percent in the Medicaid population and 23 percent in the population eligible for both Medicare and Medicaid (Kasper, O'Malley, and Lyons 2010).

Individuals diagnosed with chronic illnesses have double the risk for major depression than people who don’t have any chronic illnesses (Plaff et al.; as cited in Antrobus 2011). Additional research points out that the presence of a depressive disorder often adversely affects the course and treatment of other chronic disease and is a particular concern among disabled individuals and older adults due to the prevalence of multiple chronic conditions in these groups of individuals (National Association of Chronic Disease Directors 2009).

The effectiveness of pharmacotherapies for the treatment of major depressive disorder is well documented in numerous research studies. However, approximately 50 percent of patients discontinue antidepressant medication prematurely (i.e., are non-adherent when assessed at six months after beginning treatment) for both patient-related and clinician-related reasons (Sandstone and Sandstone 2012).

Socioeconomic factors are significantly related to whether patients continue antidepressants beyond the acute phase of treatment. Hispanic patients and patients of lower socioeconomic status (low family income) and individuals with fewer than 12 years of education were cited as being at risk of early antidepressant discontinuation (Olfson et al. 2006). Therefore, ethnic and economic disparities appear to be important during the early critical phase of treatment (Harman et al. 2004; Alegria et al. 2002; as cited in Olfson et al. 2006). Researchers studying the means of improving engagement in the treatment of depression among underserved populations found collaborative care (including a focus on supportive outreach, patient education, and medication adherence) to be efficacious for improving patient engagement and clinical outcomes.
Project Goal

The goal of the Antidepressant Medication Management (AMM) project is to increase the number of members diagnosed with major depression and newly treated with an antidepressant medication who remain on an antidepressant medication for at least 180 days.

Depressive symptoms, especially in disabled individuals and the elderly, can be under-recognized and under-treated, often complicated by cognitive impairment, co-morbid illnesses, and adverse life events. South County members often have a higher level of chronic, co-morbid conditions that can be negatively impacted by inadequate antidepressant medication management. Recognizing the clinical significance of these issues, this project will strive to focus on the following strategies:

1. Adherence to antidepressant medications in conjunction with members’ understanding of the diagnosis and the intended outcomes of adherence with treatment protocols
2. Continuity of care coordination
3. Connectivity to preventive services and available resources
4. Effective communication across the continuum of care

Racial, ethnic-based disparities in the access to quality and timeliness of care were also monitored as a part of this study. Review of historical antidepressant medication management (AMM) baseline rates did not show evidence of any such disparities among South Country members. South Country continues to monitor for notable differences between white and non-white members to ensure disparities do not develop over time.

Target Populations

Project interventions target members (enrolled in the programs described below) with a diagnosis of major depression and prescribed an antidepressant.

- **Prepaid Medical Assistance Program (PMAP) and MinnesotaCare (MNCare):** Enrollees ages 18 to 64 who have Medicaid benefits administered by South Country.
- **SeniorCare Complete (MSHO):** Enrollees age 65 and over who have integrated Medicaid and Medicare benefits administered by South Country.
- **AbilityCare (SNBC):** Enrollees ages 18 to 64 who are eligible for Medicare and have integrated Medicaid and Medicare benefits administered by South Country.
- **Minnesota Senior Care Plus (MSC+):** Enrollees age 65 and over who have Medicaid benefits administered by South Country and may have Medicare benefits administered by another health plan.
- **SingleCare (SNBC):** Enrollees ages 18 to 64 who are not eligible for Medicare and have Medicaid benefits administered by South Country.
- **SharedCare (SNBC):** Enrollees ages 18 to 64 who have Medicaid benefits administered by South Country, but have Medicare and benefits administered by another health plan.
Performance Data

The outcome measure for this project is the HEDIS Antidepressant Medication Management (AMM) Effective Continuation Phase of Treatment measure. The goal rate was determined following the DHS Managed Care Financial Withhold methodology, with calculations based on a rate that is equal to or greater than ten percent of the difference between 80 percent (targeted benchmark rate) and the baseline rate. The annual goal will be re-calculated each measurement year, and the methodology will be applied over the course of the three measurement years, following HEDIS technical specifications.

The graph below shows the baseline and performance outcome rates for each of target populations. It is important to note that due to using the HEDIS measurement time frames for baseline and measurement year performance (May 1-April 30), rates will not reflect a full year of improvement project interventions until the third year for each of the projects.
Interventions

- **Member Outreach and Education**
  Supportive outreach telephone calls are conducted by South Country’s Member Services staff 21-27 days after a newly prescribed antidepressant prescription fill. Follow-up letters and educational materials (e.g., medication tip sheets, calendars with doctor appointment and prescription refill stickers) are provided to both contacted members and members that are unreachable during the designated call sessions.

  “Gap fill” outreach telephone calls are conducted by Member Services staff and supportive reminder letters are mailed to members who could not be reached by telephone and who are 4-10 days late in refilling their antidepressant medication prescription. Treatment gap notifications are provided to members experiencing second and third gaps in treatment.

  Congratulatory, positive affirmation letters and a 7-day pill organizer are mailed to members who meet the criteria for medication adherence during the *Acute Phase of Treatment* (84 days of continuous treatment). A *Finding the Balance Self-Care* booklet is mailed, along with a congratulatory letter to identified members who meet the criteria for antidepressant medication adherence at the completion of the *Effective Continuation Phase of Treatment* (180 days of continuous treatment). The booklet, developed by South Country, provides suggestions on dealing with stress when faced with physical and mental health conditions that may affect an individual’s sense of well-being.

- **Coordination of Care**
  Care coordination follow-up is given to eligible members assigned care coordinators and who self-report barriers to medication management during outreach calls conducted by South Country’s Member Services. Care coordinators are trained on the project annually and evidence-based care plans are developed for managing chronic conditions such as depression. This includes documentation of a management goal in the care plan when depression symptoms are identified in the health risk assessment.

- **Provider Outreach**
  News articles introducing and updates on the project are published in provider newsletters. Network pharmacy providers also received notification of the project along with a *Pharmacy Provider Toolkit* that includes strategies for increasing antidepressant medication adherence and sharing best practices.

  Collaboration with high volume pharmacies used by members demonstrating trends or patterns with AMM compliance for the purpose of identifying and sharing “best practices” that may contribute to compliance.

- **Cultural Competency**
  The cultural competency intervention was revised to focus on cultural sensitivity considerations for South Country’s Member Services staff and pharmacy providers. Member Services staff received training from South Country’s Chief Medical Officer on Major Depressive Disorder and on Sensitivity Awareness regarding stigma, labeling, attitudes, and beliefs often associated with diagnoses of mental illness. The *Pharmacy Provider Toolkit* mailed to network pharmacies included a section on cultural considerations when providing pharmaceutical care for individuals.
Lessons Learned and Next Steps for Continued Improvement

The HEDIS AMM rates include members who do not have more than one 45-day gap in enrollment and have a diagnosis of major depression. However, the specifications identifying members eligible for outreach and support strategies were specifically designed to allow a greater number of members being treated with antidepressant medication to be reached during the Acute Phase of treatment than who actually met the final AMM denominator. This has allowed South Country to integrate member and provider education and outreach strategies across a broader continuum of members, as well as both internal and external stakeholders, in hopes of improving continuity of care and strengthening AMM targeted outcomes.

In reviewing the PMAP/MNCare AMM data from HEDIS 2016, South Country experienced an increase in the percentage of Non-White members enrolled in PMAP/MNCare and eligible for this measure, from 6.6% (18/274) for HEDIS 2014 to 14.61% for HEDIS 2016, as well as a noticeable difference in the measure outcome between the two classifications of members. Further analysis of enrollment data shows a significant increase in the number of members who indicated “Unknown” for their race/ethnicity, from the baseline (N=4) to the first measurement period (N=42). These individuals are included in the “Non-White” category for this measure. Another significant increase was in the number of members identifying as “Black,” increasing from 9 eligible members in the baseline measure to 30 eligible members in measurement period one. This increase is consistent with growth in the racial diversity among South Country’s overall enrollment between 2014 and 2015, in which the proportion of non-white members went from 11% to nearly 21% (this includes members self-identifying as “Black” or “Unknown”).

South Country will continue to monitor potential factors influencing any compliancy discrepancies between white and non-white members, including a review of geographical areas, health care systems, and pharmacy provider use.

Call success rates for initial AMM member supportive outreach telephone calls range from 19.34%-23.93% with a mean of 20.62% (213/1033). Weekly call reports suggest that approximately 15% to 20% of our members have invalid telephone numbers on file (as obtained from enrollment data), and an increase was noted in the number of members with valid phone numbers for which incoming calls are not accepted. This suggests limitations for the amount of monthly minutes allocated and supports gap notifications to members who may not have refilled their prescriptions.

A random sampling (baseline) of members’ care plans having a depression management goal documented in their care plan was conducted during South Country’s county audit of the 2015 care plans for SeniorCare Complete, AbilityCare, SingleCare, and MSC+ members.

The baseline measurement rate for members with identified depression symptoms documented in the annual health risk assessment and who have a depression management goal in their care plans was 83.12% (128/154) with an overall goal expectation of 100% by the completion of Year 3 for the projects.

South Country reviewed member lists (pulled from pharmacy claims) to identify the potential for high volume pharmacies and determine patterns or trends among members eligible for the AMM denominator. There were no strong trends or patterns that emerged, however patterns and trends may not emerge until further into the project due too small numerators for each of the populations. South Country plans to analyze the results of the 2016 and 2017 HEDIS AMM measure to identify the potential for high volume pharmacies utilized by members eligible for the AMM project. Based on these findings, collaboration with pharmacies demonstrating trends or patterns with AMM compliance among members using their pharmacies is scheduled for implementation as a proposed provider outreach intervention during 2017.