



# Treating Patients with Depression Using Coordinated Medication Management

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May 5, 2016



# Treating Patients with Depression? Going it Alone?

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May 5, 2016

# Good Morning!

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## Learning objectives:

- 1) Improve the accuracy of diagnosing depression
- 2) Optimize the use of depression screening tools
- 3) Identify four medical mimics of depression
- 4) Understand the value of and access to the Psychotropic Drug Intervention Program (PDIP) & Antidepressant Medication Management (AMM)

....so you're not alone when treating complex patients....

A close-up photograph of a person's hands holding a piece of white paper that has been torn at the top and bottom edges. The word "Depression" is written in the center of the paper in a black, cursive-style font. The background is a blurred, out-of-focus image of a person's face, suggesting a personal or intimate context. The lighting is soft, and the overall tone is somber.

Depression

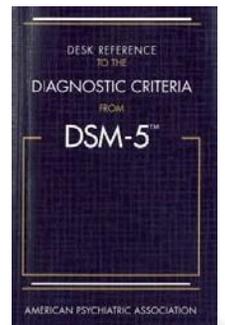




# Depressive Disorders

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- Major Depressive Disorder
- Disruptive Mood Dysregulation Disorder
- Persistent Depressive Disorder (Dysthymia)
- Premenstrual Dysphoric Disorder
- Substance/Medication-Induced Depressive Disorder
- Depressive Disorder Due to Another Medical Condition
- Unspecified Depressive Disorder











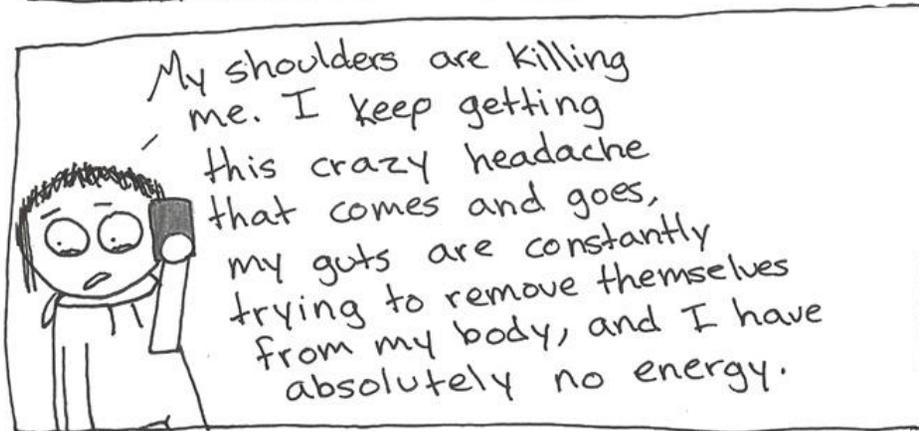


# Psychosomatic Disorders

<ul style="list-style-type: none"><li>■ Somatoform and Pain Disorders</li></ul>	<ul style="list-style-type: none"><li>■ Subjective experience of many physical symptoms, with no organic causes</li></ul>
<ul style="list-style-type: none"><li>■ Psychosomatic Disorders</li></ul>	<ul style="list-style-type: none"><li>■ Actual physical illness present and psychological factors seem to be contributing to the illness</li></ul>
<ul style="list-style-type: none"><li>■ Malingering</li></ul>	<ul style="list-style-type: none"><li>■ Deliberate faking of physical symptoms to avoid an unpleasant situation, such as military duty</li></ul>
<ul style="list-style-type: none"><li>■ Factitious Disorder</li></ul>	<ul style="list-style-type: none"><li>■ Deliberate faking of physical illness to gain medical attention</li></ul>

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***How much is depression playing a role?***







# Why is Identification of Depression Difficult?

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- General reluctance of patients to seek care for mental health problems complicates the diagnosis of mental illness.
- 40% of patients with MDD do not want or perceive the need for treatment.
- Patients consistently underreport emotional issues to their physicians.
- One study found that only 20% to 30% of patients with emotional/psychological issues reported these to their primary care physicians.

# Why is Identification of Depression Difficult?

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- Many patients somaticize their psychological issues.
- One in three patients who go to the emergency department with acute chest pain is suffering from either panic disorder or depression.
- 80% of patients with depression initially present with physical symptoms such as pain, fatigue, or worsening symptoms of a chronic medical illness.
- Although this type of presentation creates a challenge for primary care physicians, these patients are not likely to seek care through the mental health system.

# Why is Identification of Depression Difficult?

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- Mental health issues are frequently unrecognized and, even when diagnosed, are often not treated adequately.
- Recognition and treatment of mental illness are significant issues for primary care physicians, especially since they provide the majority of mental health care.
- In a recent national survey of mental health care, 18% sought treatment during a 12 month period, with 52% occurring in the general medical (all primary care) sector.

# Prevalence of Psychiatric Disorders in Low-Income Primary Care Patients

Psychiatric Disorder	Low-Income	General Primary Care Population
$\geq 1$ Psychiatric Disorder	51%	28%
Mood Disorder	33%	16%
Anxiety Disorder	36%	11%
Alcohol Abuse	17%	7%
Eating Disorder	10%	7%

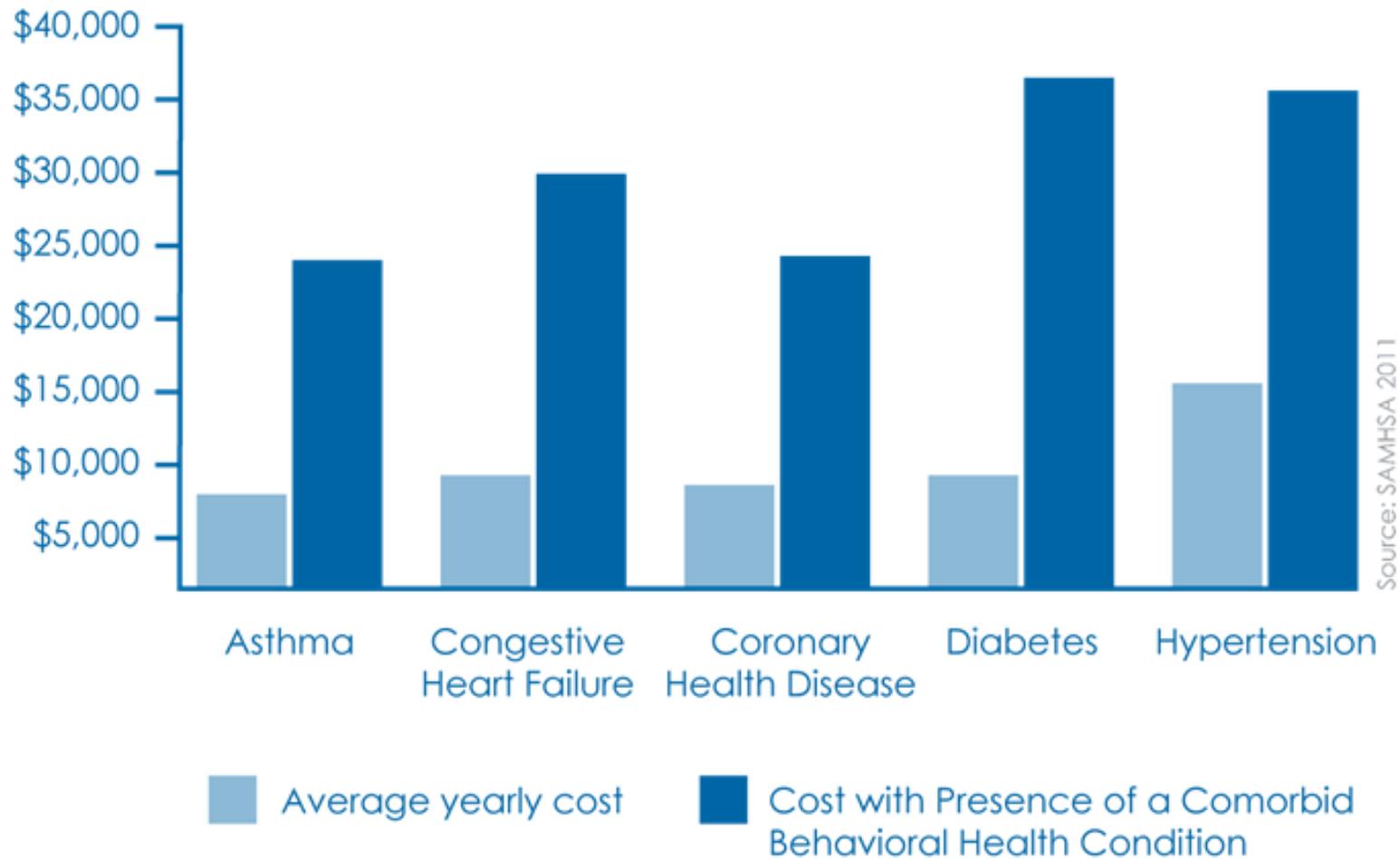
- Only 35% of low-income patients with a psychiatric diagnosis saw their PCP in the last 3 months
- 90% of patients preferred integrated care

# Six Major Causes of Death in the U.S and Increased Relative Risk in the SPMI Population

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- Cardiovascular Disease: 3.4x
- Lung Cancer: 3x
- Stroke (in age < 50): 2x
- Respiratory Disease: 5x
- Diabetes: 3.4x
- Infectious Diseases: 3.4x

# Health Care Costs



# Depression Overview

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- Depression accounts for more than \$43 billion in medical care costs.
- The U.S. Preventive Services Task Force recommends **screening** in adolescents and adults in clinical practices that have systems in place to ensure accurate diagnosis, effective treatment, and follow-up.
- It does not recommend ***for or against*** screening for depression in children 7 to 11 years of age or screening for suicide risk in the general population.

***\*NHP/Beacon have programs to support patient adherence to treatment***

# PRIME-MD

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- The Primary Care Evaluation of Mental Disorders (PRIME-MD)
- Instrument developed and validated in the early 1990s to efficiently diagnose five of the most common types of mental disorders presenting in medical populations: depression, anxiety, somatoform, alcohol, and eating disorders

# PRIME-MD

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- Patients first completed a one-page, 27-item screener.
  - For any disorder(s) a patient screens positive, a clinician asked additional questions using a structured interview guide.
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- This 2-stage process took an average of 5-6 minutes of clinician time in patients without a mental disorder diagnosis and 11-12 minutes in patients with a diagnosis.
  - A barrier to using this tool was the competing demands in busy clinical practice settings.

# Screening Tools: PHQ-2 & PHQ-9

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- The Patient Health Questionnaire (PHQ)-2 and PHQ-9 were then developed and are commonly used and validated screening tools.
- If the PHQ-2 is positive for depression, the PHQ-9 should be administered.
- These tools are available in the public domain.

# PHQ-2 Questions

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- First 2 items of PHQ-9.
  - Ultra-brief depression screener.
  - Two items scored 0 to 3, for a total score between 0-6
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- Over the last 2 weeks, how often have you been bothered by any of the following problems?
    1. Little interest or pleasure in doing things 0 1 2 3
    2. Feeling down, depressed, or hopeless 0 1 2 3

# PHQ-9 Questions

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1. Little interest or pleasure in doing things 0 1 2 3
2. Feeling down, depressed, or hopeless 0 1 2 3
3. Trouble falling or staying asleep, or sleeping too much 0 1 2 3
4. Feeling tired or having little energy 0 1 2 3
5. Poor appetite or overeating 0 1 2 3

# PHQ-9 Questions

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6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down 0 1 2 3
7. Trouble concentrating on things, such as reading the newspaper or watching television 0 1 2 3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual 0 1 2 3
9. Thoughts that you would be better off dead or of hurting yourself in some way 0 1 2 3

# If Positive Screening Result

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- Further evaluation is needed to:
  - Confirm that the patient's symptoms meet the Diagnostic and Statistical Manual of Mental Disorders' (DSM) criteria for diagnosis
  - Develop a treatment plan
  - Initiate treatment
  - Engage services aimed at improving treatment adherence and outcome
    - PDIP
    - AMM

# Facts About Depression

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- Eight percent of persons aged >12 years report current depression.<sup>1</sup>
- Females have higher rates of depression than males in every age group.
- 6% Males and 10% females
- Two-thirds of all psychiatric medications are prescribed in primary care settings.<sup>2</sup>
- Approximately 50% of patients in BH programs and 50% of primary care patients prematurely discontinue antidepressant therapy (i.e., are non adherent when assessed at six months after the initiation of treatment).<sup>3</sup>

# Treatment without Diagnosis: What's Going On?

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- 75% of antidepressants prescribed by non-psychiatrists are done so in the absence of a psychiatric diagnosis<sup>1</sup>
- Possible Reasons:
  - ✓ Depression is expressed in a wide variety of ways
  - ✓ Stigma of mental illness
  - ✓ Lack of psychiatric resources for consultation or support
  - ✓ Unfamiliar with diagnostic codes/specifiers

# Major Depressive Disorder (MDD)

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**Symptoms: 5 or more of the following (with at least one symptom being either #1 or #2)**

1. *Depressed mood most of the day, nearly every day (children & adolescents may be irritable)*
2. *Markedly diminished interest or pleasure in all, or almost all, activities*
3. Significant weight loss or weight gain >5% in a month; or decrease in appetite (in children, need to consider failure to make expected weight gain)
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation (often observed by others)

# Major Depressive Disorder

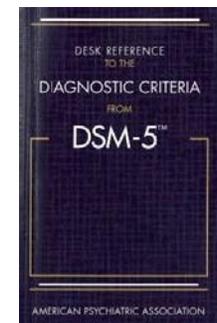
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6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive/inappropriate guilt
8. Diminished ability to think or concentrate, or indecisiveness
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or suicide attempt or a specific plan for committing suicide

# Major Depressive Disorder

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- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The episode is not attributable to the physiological effects of a substance or to another medical condition.



# Medications with Depressive Side Effects

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- Cardiovascular Medications (Beta-blockers, calcium channel blockers, amiodarone, digitalis)
- Steroids
- Sedative-hypnotics
- Alcohol
- Stimulants

# Medications with Depressive Side Effects

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- Chemotherapy agents
- Interferon
- Barbiturates and Anticonvulsants
- Statins
- Estrogens

# Medical Mimics of Depression

Mimicking Condition	Symptoms	Differentiators
Anemia	Fatigue Apathy	Hemoglobin Hematocrit, B12/Folate
Hyperthyroidism/ Hypothyroidism	Apathy Depression	Thyroid function tests
Neoplasm	Depression Mood Changes	Medical history CT scan, MRI Ultrasound
Chronic illnesses <ul style="list-style-type: none"> <li>• TB</li> <li>• HIV</li> <li>• Arthritis</li> </ul>	Loss of Appetite Apathy	Medical history Laboratory findings
CNS disease <ul style="list-style-type: none"> <li>• Parkinson's</li> <li>• Dementia</li> </ul>	Depressed Mood Loss of Appetite Apathy	Medical history Neurologic exam Screening cognitive test CT, MRI

# After Your Assessment.....

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- So you've screening for depression, and
- Determined that the patient's presentation meets the criteria for a depressive disorder, and
- The PHQ-9 score is 15 or greater.
- Now what?

# PHQ-9 Scores and Proposed Interventions

PHQ-9 Score	Symptoms	Intervention(s)
0-4	None/Minimal	No Intervention
5-9	Mild	Watchful Waiting Repeat PHQ-9 at Follow-Up
10-14	Moderate	Treatment Plan Consider Counseling Follow-Up and/or Pharmacotherapy
15-19	Moderately Severe	Active Treatment with Pharmacotherapy and/or Psychotherapy
20-27	Severe	Immediate Initiation of Pharmacotherapy and, if Severe Impairment or Poor Response to Therapy, Expedited Referral to a MH Specialist for Collaborative Management

# Treatment Options for Depression

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- Antidepressant Medications
  - TCAs, SSRIs, SNRIs, Trazodone, Bupropion, Mirtazapine and MAOIs
- ECT
- Psychotherapy
- Combination

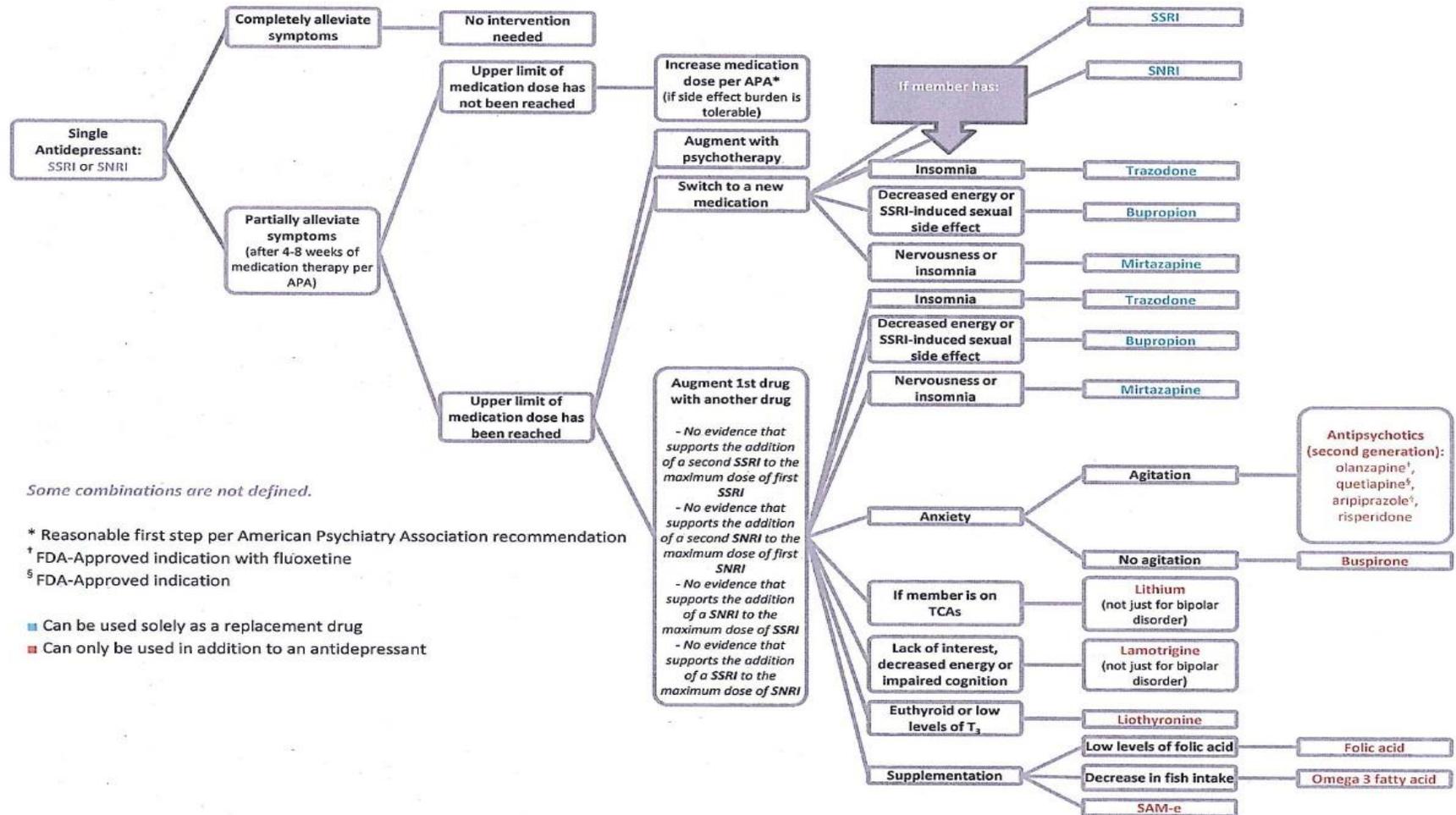
# Antidepressant Initiation and Titration

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- Patient Education:
  - Initial and treatment emergent side effects
  - Consider 'value' of side effect in medication choice
- Monitor closely
- Start low and go slow
- Allow adequate time for response
- Cross taper if medication change is required
- Discontinuation syndrome

# Augmentation Strategies for Major Depression

## Augmentation Strategies for Major Depression



Some combinations are not defined.

\* Reasonable first step per American Psychiatry Association recommendation

<sup>†</sup> FDA-Approved indication with fluoxetine

<sup>5</sup> FDA-Approved indication

■ Can be used solely as a replacement drug

■ Can only be used in addition to an antidepressant

"Augmentation Strategies for Depression." Harvard Health Publications, 1 Dec. 2010. Web. 30 May 2012. <http://harvardpartnersinternational.staywellsolutionsonline.com/HealthNewsLetters/69,M1210a>

PL Detail-Document, Antidepressant Combinations. Pharmacist's Letter/Prescriber's Letter. July 2011.

# Treat-to-Target

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- Concept used in designing therapeutic strategies, with treatment modalities oriented towards achieving a well-defined, clinically relevant end-target.
- Dynamic and responsive treatment plan that guides adjustments in the administration of an intervention and facilitates target achievement.
- PHQ-9 scores decrease by 50% (on average):
  - 4 weeks for research use
  - at 4-12 weeks for clinical use

# What Can Be Done to Improve Patient Adherence to Treatment?

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- Engage the patient collaboratively in the development of his/her treatment plan.
- Educate the patient on important issues that impact adherence, such as:
  - ✓ How long will it take for the medication to work?
  - ✓ How long should the patient expect to take the medication?
  - ✓ Why is it important to continue the medication?
  - ✓ What should the patient do if he/she has questions, possible side effects or concerns?

# Patients Also Benefit from:

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- Information about common side effects,
  - How long the side effects may last, and
  - How to manage those side effects.
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This information should be simple and specific.

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*....And here's the part where you have allies to support your patients' adherence efforts....*

# Enhancing Medication Adherence: PDIP

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- The Psychotropic Drug Intervention Program (PDIP)
  - a unique and comprehensive quality management program
  - identifies claims-based, medication-related problems through the use of analytics and clinical review.
- Goal: to improve patient health through better medication adherence for patients with depression and/or other psychiatric illness.
- The program engages both prescribers and patients to understand and resolve medication related issues.
- It is designed to be complementary to the traditional services offered by pharmacy benefit management.

# Benefits of PDIP

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- Monitoring medication adherence for members taking psychotropic medications requiring consistent, ongoing use
- Identifying poly-pharmacy of psychotropic medications
- Recognizing potential cases of uncoordinated care and prescribing by multiple clinicians treating the same member
- Checking for possible fraudulent or abusive prescriptive patterns
- Monitoring for outlier member cases when there are potential medication utilization safety concerns

# What You Can Expect of PDIP

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- Beacon's PDIP employs various interventions, singly and in combination, on a case-by-case basis.
  - If you are a prescriber, you may receive messages by phone, secure electronic mail, postal mail, and/or fax.
- Each message identifies a patient and contains a brief explanation of the circumstances.
  - For example, you will be notified if one of your patients has not filled the prescription for antidepressants or has prescriptions from multiple physicians for similar medications.
- PDIP notices also indicate whether your patient will be contacted and identifies resources such as Beacon's Decision Support Line for non-psychiatrist prescribers.

# Medication Monitoring

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- The American Psychiatric Association (APA) and the Agency for Healthcare Research and Quality (AHRQ) adopted evidenced based standards for the treatment of depression in adults.<sup>1</sup>
- The best outcomes for antidepressant treatment were 84 consecutive days on an antidepressant during the acute phase and
- 180 consecutive days on an antidepressant during the continuation phase of a depressive episode.<sup>2</sup>

<sup>1</sup> US Department of Health and Human Services Agency for Health Care: Policy and diagnosis and treatment. Rockville MD. AHRP publication 93:0552.

<sup>2</sup> Brook OH, van Hout H, Stalman W, et al: A pharmacy-based coaching program to improve adherence to antidepressant treatment among primary care patients. *Psychiatr Serv* 56: 407-409, 2005.

# Medication Monitoring Rationale

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- The 180-day standard for antidepressants applies for MDD or for other clinical indications (also chronic/recurrent in nature)
- Such indications include the anxiety disorders (i.e., generalized anxiety, posttraumatic stress, obsessive compulsive, panic, social anxiety), somatoform disorders, anorexia nervosa and bulimia.<sup>1</sup>
- Non-adherence reduces antidepressant effectiveness.
- Providing patients with information about medication adherence, including what to expect from the medications and timeframes for therapeutic effect, has been shown to improve medication adherence.<sup>2</sup>

<sup>1</sup> Pomerantz JM, Finkelstein SH, Berndt ER, et al: Prescriber Intent, off-label usage and early discontinuation of antidepressants: a retrospective physician survey and data analysis. *J Clin Psychiatry* 65:3 395-404, 2004.

<sup>2</sup> Brook OH, van Hout H, Stalman W, et al: A pharmacy-based coaching program to improve adherence to antidepressant treatment among primary care patients. *Psychiatr Serv* 56: 407-409, 2005.

# Dosage Level Monitoring of Antidepressants

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- The goal is to improve both patient safety and clinical efficacy
  - ✓ by ensuring that patients who receive prescriptions for these antidepressants are prescribed dosages adequate to treat depression
  - ✓ without risking untoward side effects or toxicity.

# Dosage Level Monitoring of Antidepressants

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- Health care providers whose patients are receiving psychotropic medications with dosages outside the evidence-based clinical practice guideline recommendations:
  - ✓ can expect to receive emails, faxes, or letters notifying them that the currently prescribed dosages may be ineffectual
  - ✓ may also receive current clinical research on the optimal dosages for yielding the desired outcomes
- Patients are not contacted in these cases.

# Dosage Level Monitoring Rationale

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- The majority of depressed people are not treated with at least the minimally effective dose.<sup>1</sup>
- 1 in 5 depressed persons receives what evidence-based guidelines would consider minimally adequate treatment (64.3% of those treated in the MH sector, and 41.3% of those treated in the general medical setting).<sup>2</sup>
- A patient maintained for longer than a month on a sub-therapeutic dose is essentially untreated: this exposes the patient to side effects but makes it unlikely that he/she will receive any therapeutic benefit.

# AMM Member Outreach Program

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- A Quality Improvement program administered by the Psychotropic Drug Intervention Program (PDIP) at Beacon.
- Trained health coaches provide telephonic member outreach and therapy coaching services to enrolled members.
- Members benefit from participation by:
  - receiving increased support for appropriate adherence to a treatment plan, and
  - having the opportunity to ask questions and express concerns about a treatment plan

# The Antidepressant Medication Management Program is designed to increase adherence and improve HEDIS AMM measures

## Overview of the Program (available in English and Spanish)



### 1. DATA FROM PLAN

Weekly Medical & Prescription claims data received from plan



### 2. HEDIS AMM CRITERIA REVIEW

Algorithm identifies members who meet the AMM Measure and sends to IVR



### 3. INITIAL OUTREACH

Automated outreach call with option to speak to a live AMM specialist



### 4. ENGAGEMENT CALL

A specialist calls the member using script to promote participation in the program and engage the patient



### 5. MEMBER ENCOUNTER

Once the member opts in the program, the specialist will provide peer-level support, coaching and promotion



### 6. REFILL REMINDER

Member called before each anticipated refill



### 7. GAP ANALYSIS

Non-adherence GAP calculated daily



### 8. CONTINUED FOLLOW-UP

Monthly calls x 7-8 months

# AMM Member Outreach Enrollment

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- You may refer eligible members, who are at the **beginning** of medication therapy for depression, for enrollment to this complimentary program.
- Eligible members must:
  - Be at least 18 years of age and currently eligible as an NHP member
  - Have recently (within last 30 days) been prescribed an antidepressant which was filled at a pharmacy
  - Be starting a new course of prescription antidepressant treatment and thus have **NOT** filled a prescription for an antidepressant medication in the immediately preceding 90 days from when the new prescription was filled.

Questions about this program or requests for referral forms may be directed to 781-994-7572, or by email at [pdipamm@beaconhs.com](mailto:pdipamm@beaconhs.com)

# Early AMM Member Outreach Results

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What have we learned?

- Very few members report that depression has worsened at any point after their initial prescription start date (IPSD)
- The vast majority of members report improvement in depression within 90 days of treatment initiation
- The portion of members that reported no change or no improvement in their depression symptoms (CGI) drops over time from 75% at 30 days to less than 30% by 120 days.
- Member's adherence and program participation seems no different between those who reported side effects vs. those who did not
- Member's lack of understanding that antidepressant therapy takes weeks/months to be effective seems the most common reason why patients become non-adherent with antidepressants

# Additional Insights

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- Answering patient questions and letting them know what to expect is key for continued adherence
- Referral program promotes adherence, especially for those with a non-adherence history
- Member's lack of understanding that antidepressant therapy takes weeks or months to be effective seems the most common reason why patients become non-adherent with antidepressants
- Answering patient questions and letting them know what to expect is key for continued adherence
- Members' willingness to continue or interest in discontinuing participation in the AMM Member Outreach Program is not an indicator of future adherence. It is the education around their treatment and their having realistic expectations from it, good or bad, which promotes improved adherence.

# 2015 PDIP AMM Metrics

# AMM Program Participant Metrics

Status	Number
<b>Program Enrollees</b>	
Adherent and Participant	74
Adherent, Not Participant	0
Not Adherent, Participant	7
Not Adherent, Not Participant	0
<b>Program Graduates</b>	
Continuation Phase Completed	6
<b>Program Discontinuations</b>	
Eligibility Lost	4
Allowable Gap Days Exceeded	41
Withdrew from program	59

PDIP data: Aggregate data 3/17/2015-12/31/15

Adherent =MPR  $\geq$ 0.8; Participant= Member is actively engaging in program

# AMM Outreach Metrics

<b>Automated Outreach</b>	
Total Potential AMM Members	12,994
Total Reachable AMM Members	12,215
Unsuccessful Contact	10,316
Outreach in Progress	665
Successful Contact	1,234
<b>AMM Specialist Outreach</b>	
Transferred to AMM specialist	765
Enrolled in Program	191
Declined enrollment- received educational materials	34

PDIP data: Aggregate data 3/17/2015-12/31/15

# PROGRAM OUTCOMES

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- Outcomes to date have been impressive
- Quality metrics have improved markedly, including:
  - 29% positive change in the medication possession ratio
  - 74% positive change in sub-optimal dosing
  - 20% reduction in the incidence of non-evidence based polypharmacy, primarily resulting from the elimination of uncoordinated care

# PRESCRIBER DECISION SUPPORT LINE

## 800-414-2820

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Beacon provides daily psychiatrist coverage through its network of psychiatric specialists in order to support non-specialists in the application of psychopharmacological treatment.

- Beacon's website provides information regarding decision support availability to all active physicians, nurse practitioners, and physician assistants in the NHP provider network.
- Prescribers may find that the resources listed on Beacon's website provide helpful medical information about psychiatric conditions and medications.

# Contact Us

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- PDIP staff is available to answer questions about the program, direct callers to available resources, and assist with finding appointments for members.
- For clinical consultation about a specific case, please call Beacon's Decision Support line at **800-414-2820**.
- Since email is not secure, please do not use this method for clinical consultation or to provide any patient-identifying information.
  - Inclusion of even one piece of member information (member's initials, date of birth, or health plan identification number) is prohibited by HIPAA.

# Questions for You

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- What are your impressions of PDIP and the AMM programs? Do they seem useful?
- How many of you knew about the programs prior to this morning?
- What do anticipate to be barriers to accessing the AMM program?
- Do you anticipate using the AMM program?
- What would make it more likely that you would access the AMM program?

# Questions Continued

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NHP and Beacon are invested in providing education to NHP's primary care providers around behavioral health issues.

- What is the best way to provide this education? Webinars, in person trainings, other?
- How do we reach the most appropriate audience?
- What other ideas do you have around provider education?

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*Questions ?*

*Questions for PDIP/AMM:*

*800-414-2820*



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# Thank you

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