FRAMEWORKS
in Health and Quality

Value of Collaborative Care in Major Depressive Disorder

Quality Improvement Project:

Measurement and Intervention Development

This resource is provided for informational purposes only and is not intended as reimbursement or legal advice. You should seek independent, qualified professional advice to ensure that your organization is in compliance with the complex legal and regulatory requirements governing health care services, and that treatment decisions are made consistent with the applicable standards of care.

©2016 Otsuka Pharmaceutical Development & Commercialization, Inc. All Rights Reserved.

June 2016 MRC2.UNB.X.00032

Table of Contents

Affordable Care Act and the Changing Landscape for Mental Health 3-4

Performance Measures 4-5

Appendix A—Measurement Logic 5-9

References 10-11

Affordable Care Act and the Changing Landscape for Mental Health

Major Depressive Disorder: Rationale for Care Management

Major depressive disorder (MDD) will affect approximately 16.2% of Americans during their lifetime, with women more likely than men to have depression during their lifetime.[1,2]

MDD is characterized by the presence of persistent depressive symptoms, including depressed mood and loss of interest or pleasure, as well as significant weight gain or loss, sleep disturbances, fatigue, feelings of worthlessness, difficulty concentrating, and/or suicidal thoughts.[3] Complicating treatment for MDD is the interrelationship between MDD and comorbid medical conditions, which may result in poorer outcomes and higher costs.[4,5]

> MDD is about 3 times more common among patients with diabetes than among the population at large, which may lead to adverse health outcomes (eg, poorly controlled blood glucose) and an increased risk of complications.[6]

Comorbid medical conditions that are strongly linked with MDD include[4,7]:

- Diabetes
- Cardiovascular disease (heart disease, stroke, hypertension)
- Cancer
- Substance use (tobacco, alcohol)
- HIV/AIDS
- Hepatitis C
- Asthma

The direct health care costs incurred by patients with MDD was approximately $99 billion (2012 U.S. dollars).[8] As the severity of MDD symptoms increases, resource utilization and costs also increase.[9]

Studies have shown that patients with treatment-resistant MDD had higher resource utilization, particularly in inpatient and outpatient settings, compared with patients with chronic MDD.[10] Better management of MDD with attention to severity levels may help to improve care and management of health care-related costs associated with higher resource utilization.[9]

Management of patients with MDD and comorbid medical conditions relies on accurate diagnosis and treatment management through collaborative care of the patient's overall physical and mental health. Recognizing the interrelationship between MDD and comorbid medical conditions may help improve outcomes for comorbid medical conditions, while also improving functional status, enhancing quality of life, and decreasing health care utilization.[11]

Impact of the Affordable Care Act

The Affordable Care Act (ACA) was passed with the goal of reforming the American health care system to provide high-quality health care to a larger portion of the United States (U.S.) population. The ACA outlines a variety of provisions aimed at changing health care through the improvement of quality and efficiency of health care, as well as the prevention of chronic disease and overall improvement of public health.[12] Population health initiatives, including integration of physical and behavioral health care services for those with serious mental illness, are specifically called out in the ACA's focus on improved quality of care and population health initiatives.[13-15] The ACA also brought the development of the Health Insurance Marketplace in 2014, offering millions of Americans access to an expanded choice of payers via the Health Insurance Exchanges, as well as expanded coverage for millions on Medicaid.[12]

Performance Measures

Quality in health care, availability of preventive services, and reductions in the total cost of care through improved management of overall health are the primary goals of the ACA.[12,16] Particularly, the ACA requires health plans to cover 10 categories of services as Essential Health Benefits, with an expansion of mental health and substance use disorder benefits and parity protections for 62 million Americans, offering preventive services like depression screening for adults.[17] Payers may experience challenges in managing this new membership while maintaining or improving quality of care.

One study assessed the impact of enhanced depression care using employer-based screening, outreach, and disease-management efforts. Results showed that compared to usual care, employed patients with MDD who were randomized to receive enhanced care had lower disease severity, significantly more hours worked, and higher job retention.[18]

Another study found that, of 326 employed patients with MDD in primary care, randomization to coordinated care led to a 6.1% gain in productivity and a 22.8% reduction in absenteeism over 2 years. These reductions resulted in an estimated total annual savings of $2,030 per person (2000 U.S. dollars).[19]

Understanding the Role of Quality Improvement Measures in Mental Health

Treatment for depression involves following patients over time and providing systematic follow-up care that may help ensure patients adhere to treatment plans.[20]

The following quality improvement measures are designed to help drive quality improvements in patient outcomes. Measures may best succeed when they are supported by all members of the health care system and used for continuous improvement.[21]

Performance Measures

Healthcare Effectiveness Data and Information Set (HEDIS®) Measures

Health care quality measures, including the Healthcare Effectiveness Data and Information Set (HEDIS) measures, help provide payers an opportunity to manage the quality of services rendered to patients with mental illness through appropriate medication management and screening for comorbid medical conditions.[22] Additionally, the Institute for Healthcare Improvement's Triple Aim initiative is one example of the importance of performance measures in achieving each of the 3 aims: population health, patient experience, and per-capita cost of care.[23]

Antidepressant Medication Management (AMM)[22]

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported, including acute phase treatment and continuation phase treatment.

Patients may be nonadherent for a variety of reasons.[24] Development of programs that improve adherence rates to antidepressant medications in patients with MDD may help improve patient outcomes.

Follow-up After Hospitalization for Mental Illness (FUH)[22]

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Both 7- and 30-day rates are reported.

Appendix A—Measurement Logic

Patients with MDD may require a broad range of possible therapeutic interventions.[7] It is, therefore, important for all members of the care team to work together. Use of this measure to assess current follow-up rates and procedures may identify areas for improvement leading to increased support and may hopefully lower readmission rates for recently hospitalized patients.

Mental Health Utilization (MPT)[22]

> The number and percentage of members receiving any mental health service during the measurement year. Rates for inpatient, intensive outpatient/partial hospital, and outpatient/ED are reported separately.

MDD severity has been associated with increased resource utilization and treatment adequacy. As a result, better management of mildly depressed patients may help mitigate the risk of more severe depression.[9]

National Quality Forum (NQF)-endorsed Measures

The National Quality Forum (NQF) endorses a portfolio of quality measures that support quality improvements in the management of patients with a variety of diseases and conditions, including MDD. NQF endorsements reflect rigorous scientific and evidence-based review, input from patients and their families, and the perspectives of people throughout the health care industry.[21,25]

Adult Major Depressive Disorder: Suicide Risk Assessment[25,]*

> Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

A careful and ongoing evaluation of suicide risk is necessary for all patients with MDD, including asking about suicidal thoughts and intent, co-occurring psychiatric conditions (psychosis, severe anxiety, substance use), or comorbid medical conditions that may increase suicide risk.[7]

These quality measures may offer payers and providers opportunities to help improve the delivery of care in the treatment of mental illness.[26]

Antidepressant Medication Management (AMM)[22]

This HEDIS measure determines the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported:

- *Effective Acute Phase Treatment*: The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks)
- *Effective Continuation Phase Treatment*: The percentage of members who remained on an antidepressant medication for at least 180 days (6 months)

Intake period: The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year

IPSD: Index prescription start date; the earliest prescription dispensing date for an antidepressant medication during the Intake period

Negative medication history: A period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication

*Physician performance measures and related data specifications have been developed by the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement (PCPI®).

Treatment days: The actual number of calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days' (3 months) supply dispensed on the 151st day will have 80 days counted in the 231-day interval.

Product lines: Commercial, Medicaid, Medicare (report each product line separately)

Ages: 18 years and older as of April 30 of the measurement year

Continuous enrollment: 105 days prior to the IPSD through 231 days after the IPSD

Allowable gap: One gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (ie, a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date: IPSD

Benefits: Medical and pharmacy

Event/diagnosis: Follow the steps below to identify the eligible population, which is used for both rates

Step 1: Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period.

Step 2: Required exclusion: Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient, or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD, and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population:

- An outpatient visit, intensive outpatient encounter, or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria:
  - AMM Stand Alone Visits Value Set with Major Depression Value Set
  - AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set
- An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set)
- An inpatient (acute or nonacute) encounter with any diagnosis of major depression (Major Depression Value Set)

For an inpatient (acute or nonacute) encounter, use the date of discharge. For a direct transfer, use the discharge date from the facility where the member was transferred.

Step 3: Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD

Step 4: Calculate continuous enrollment. Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD

Follow-up After Hospitalization for Mental Illness (FUH)[22]

This HEDIS measure determines the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the member received follow-up within 30 days of discharge
- The percentage of discharges for which the member received follow-up within 7 days of discharge

Product lines: Commercial, Medicaid, Medicare (report each product line separately)

Ages: 6 years and older as of the date of discharge

Continuous enrollment: Date of discharge through 30 days after discharge

Allowable gap: No gaps in enrollment

Anchor date: None

Benefits: Medical and mental health (inpatient and outpatient)

Event/diagnosis: Discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Use only facility claims to identify denominator events (including readmissions or direct transfers). Do not use professional claims.

***Acute facility readmission or direct transfer*:** If the discharge is followed by readmission or direct transfer to an acute facility for a principal diagnosis of mental health (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.

Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission.

Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set).

These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Mental Health Utilization (MPT)[22]

This HEDIS measure determines the percentage of members receiving the following mental health services during the measurement year:

- Any service
- Inpatient
- Intensive outpatient or partial hospitalization
- Outpatient or ED

Product lines: Report the following tables for each applicable product line:

- Table MPT-1a Total Medicaid
- Table MPT-1b Medicaid/Medicare Dual-Eligibles

- Table MPT-1c Medicaid—Disabled
- Table MPT-1d Medicaid—Other Low Income
- Table MPT-2 Commercial—by Product or Combined HMO/POS
- Table MPT-3 Medicare

Count members who received inpatient, intensive outpatient, partial hospitalization, outpatient, and ED mental health services in each column. Count members only once in each column, regardless of number of visits.

Count members in the Any Service column only if they had at least one inpatient, intensive outpatient, partial hospitalization, outpatient, or ED claim/encounter during the measurement year.

For members who had more than one encounter, count only the first visit in the measurement year and report the member in the respective age category as of the date of service or discharge.

Benefit: Mental health

Member months: For each product line and table, report all member months during the measurement year for members with the benefit. IDSS automatically produces member years data for the commercial and Medicare product lines. Refer to *Specific Instructions for Utilization Tables* for more information.

Because some organizations may offer different benefits for inpatient and outpatient mental health services, denominators in the columns of the member months table may vary. Include all members with any mental health benefit in the denominator in the *any* column.

Inpatient: Include inpatient care at either a hospital or a treatment facility with mental health as the principal diagnosis. Use an inpatient facility code in conjunction with a principal mental health diagnosis (Mental Health Diagnosis Value Set) to identify inpatient services. Include discharges associated with residential care and rehabilitation.

Intensive outpatient and partial hospitalization: Report intensive outpatient and partial hospitalization claims/encounters in conjunction with a principal mental health diagnosis. Any of the following code combinations meet the criteria:

- MPT Stand Alone IOP/PH Value Set ***with*** a principal mental health diagnosis (Mental Health Diagnosis Value Set)
- MPT IOP/PH Group 1 Value Set ***with*** POS 52 Value Set ***and*** a principal mental health diagnosis (Mental Health Diagnosis Value Set)
- MPT IOP/PH Group 1 Value Set ***with*** POS 53 Value Set ***and*** a principal mental health diagnosis (Mental Health Diagnosis Value Set), where the organization can confirm that the visit was in an intensive outpatient or partial hospitalization setting (POS 53 is not specific to setting)
- MPT IOP/PH Group 2 Value Set ***with*** POS 52 Value Set ***and*** a principal mental health diagnosis (Mental Health Diagnosis Value Set) billed by a mental health practitioner
- MPT IOP/PH Group 2 Value Set ***with*** POS 53 Value Set ***and*** a principal mental health diagnosis (Mental Health Diagnosis Value Set), where the organization can confirm that the visit was in an intensive outpatient or partial hospitalization setting (POS 53 is not specific to setting) and billed by a mental health practitioner

Count services provided by physicians and nonphysician practitioners.

Exclude services determined inpatient based on type of bill, place of service or location of service codes.

Outpatient and ED: Report outpatient and ED claims/encounters in conjunction with a principal mental health diagnosis. Any of the following code combinations meet the criteria:

- MPT Stand Alone Outpatient Group 1 Value Set ***with*** a principal mental health diagnosis (Mental Health Diagnosis Value Set)
- Observation Value Set ***with*** a principal mental health diagnosis (Mental Health Diagnosis Value Set) billed by a mental health practitioner
- ED Value Set ***with*** a principal mental health diagnosis (Mental Health Diagnosis Value Set) billed by a mental health practitioner
- MPT Outpatient/ED Value Set ***with*** MPT Outpatient/ED POS Value Set ***and*** a principal mental health diagnosis (Mental Health Diagnosis Value Set)
- MPT Outpatient/ED Value Set ***with*** POS 53 Value Set ***and*** a principal mental health diagnosis (Mental Health Diagnosis Value Set), where the organization can confirm that the visit was in an outpatient or ED setting (POS 53 is not specific to setting)
- MPT Stand Alone Outpatient Group 2 Value Set ***with*** a principal mental health diagnosis (Mental Health Diagnosis Value Set) billed by a mental health practitioner

Count services provided by physicians and nonphysicians.

Only include observation stays and ED visits that do not result in an inpatient stay.

Adult Major Depressive Disorder: Suicide Risk Assessment[25]

This NQF-endorsed measure determines the percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

Numerator statement: Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

Denominator statement: All patients aged 18 years and older with a new diagnosis or recurrent episode of MDD

Exclusions: None

Risk adjustment: No

This resource is provided for informational purposes only and does not guarantee that billing codes will be appropriate or that coverage and reimbursement will result. Providers should consult with their payers for all relevant coverage, coding, and reimbursement requirements. It is the sole responsibility of the provider to select proper codes and ensure the accuracy of all claims used in seeking reimbursement. This resource is not intended as legal advice or a substitute for a provider's independent professional judgment.

References

References:

1. Kessler RC, Berglund P, Demler O, et al. The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). *JAMA*. 2003;289(23):3095-3105.

2. National Institutes of Health, National Institute of Mental Health. What is depression? http://www.nimh.nih.gov/health/topics/depression/index.shtml. Accessed February 2, 2015.

3. American Psychiatric Association. Depressive disorders. In: *Diagnostic and Statistical Manual of Mental Disorders, 5th ed*. Washington, DC: APA;2013:155-188.

4. Chapman DP, Perry GS, Strine TW. The vital link between chronic disease and depressive disorders. *Prev Chronic Dis*. 2005;2(1):A14.

5. Katon WJ. Clinical and health services relationships between major depression, depressive symptoms, and general medical illness. *Biol Psychiatry*. 2003;54(3):216-226.

6. National Committee for Quality Assurance. Focus on depression: depression: overview, risk factors and comorbidities. http://www.qualityprofiles.org/leadership_series/depression/depression_overview.asp. Accessed February 2, 2015.

7. Gelenberg AJ, Freeman MP, Markowitz JC, et al, for the Work Group on Major Depressive Disorder, American Psychiatric Association. *Practice Guideline for the Treatment of Patients with Major Depressive Disorder. II. Formulation and Implementation of a Treatment Plan*. Arlington, VA: American Psychiatric Publishing, Inc.; 2004.

8. Greenberg PE, Fournier AA, Sisitsky T, Pike CT, Kessler RC. The economic burden of adults with major depressive disorder in the United States (2005 and 2010). J Clin Psychiatry. 2015;76(2):155-162.

9. Birnbaum HG, Kessler RC, Kelley D, Ben-Hamadi R, Joish VN, Greenberg PE. Employer burden of mild, moderate, and severe major depressive disorder: mental health services utilization and costs, and work performance. *Depress Anxiety*. 2010;27(1):78-89.

10. Olchanski N, McInnis Myers M, Halseth M, et al. The economic burden of treatment-resistant depression. *Clin Ther*. 2013;35(4):512-522.

11. Nierenberg AA. Current perspectives on the diagnosis and treatment of major depressive disorder. *Am J Manag Care*. 2001;7(suppl 11):S353-S366.

12. Protection P, Act AC. Public Law 111-148. *Title IV, x4207, USC HR*. 2010;3590:2010.

13. Davis K, Guterman S, Collins SR, Stremikis K, Rustgi S, Nuzum R. Starting on the path to a high performance health system: analysis of the payment and system reform provision in the Patient Protection and Affordable Care Act of 2010. http://www.commonwealthfund.org/publications/fund-reports/2010/sep/analysis-of-the-payment-and-system-reform-provisions. Published September 23, 2010. Accessed February 2, 2015.

14. Manderscheid R, Kathol R. Fostering sustainable, integrated medical and behavioral health services in medical settings. *Ann Intern Med.* 2014;160(1):61-65.

15. Mechanic D. Seizing opportunities under the Affordable Care Act for transforming the mental and behavioral health system. *Health Aff (Millwood).* 2012;31(2):376-382.

16. Democratic Policy & Communications Center. The Patient Protection and Affordable Care Act: detailed summary. http://www.dpc.senate.gov/healthreformbill/healthbill04.pdf. Accessed April 22, 2015.

References

17. U.S. Department of Health and Human Services. Health insurance and mental health services: Q: How will the Affordable Care Act help people with mental health issues? http://www.mentalhealth.gov/get-help/health-insurance. Accessed February 2, 2015.

18. Wang PS, Simon GE, Avorn J, et al. Telephone screening, outreach, and care management for depressed workers and impact on clinical and work productivity outcomes: a randomized controlled trial. *JAMA*. 2007;298(12):1401-1411.

19. Rost K, Smith JL, Dickinson M. The effect of improving primary care depression management on employee absenteeism and productivity: a randomized trial. *Med Care*. 2004;42(12):1202-1210.

20. Agency for Healthcare Research and Quality. Depression: percent of patients with a diagnosis of major depression or dysthymia who, as of their last visit, are taking an antidepressant. http://www.qualitymeasures.ahrq.gov/content.aspx?id=27612. Accessed February 2, 2015.

21. National Quality Forum. ABCs of measurement. http://www.qualityforum.org/Measuring_Performance/ABCs_of_Measurement.aspx. Accessed February 2, 2015.

22. National Committee for Quality Assurance. HEDIS 2015. Technical specifications for physician measurement. http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2015.aspx. Accessed February 2, 2015.

23. McCarthy D, Klein S. The triple aim journey: improving population health and patients' experience of care, while reducing costs. *Commonwealth Fund*. 2010;1421(48):1-12.

24. Wood B. Medication adherence: the real problem when treating chronic conditions. *US Pharm*. 2012;37(4):(compliance suppl):3-6.

25. National Quality Forum. Measuring performance. http://www.qualityforum.org/Measuring_Performance/Measuring_Performance.aspx. Accessed February 2, 2015.

26. Pincus HA, Spaeth-Rublee B, Watkins KE. Analysis & commentary: The case for measuring quality in mental health and substance abuse care. *Health Aff*. (Millwood) 2011;30(4):730-736.

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

©2016 Otsuka Pharmaceutical Development & Commercialization, Inc. All Rights Reserved.

June 2016 MRC2.UNB.X.00032