Meeting the Challenges of New Behavioral Health Management Quality Standards

• Introduction: Building Accountability in Behavioral Health Care
• HEDIS 1999 Overview
• HEDIS 1999: A First Step Toward Improving Management of Depression
• The Role of Pharmacy in Supporting Behavioral Health Care Quality Improvement Initiatives
• Meeting the HEDIS 1999 Challenge: Issues and Opportunities for Managed Care
• Conclusion
Meeting the Challenges of New Behavioral Health Management Quality Standards

EDITORS

Robert Browne, MD, FACP       Lawrence W. Osborn, MD, MPH
Meeting the Challenges of New Behavioral Health Management Quality Standards

This supplement is based on the continuing medical and pharmacy education program, *Meeting the Challenges of New Behavioral Health Management Quality Standards*, held on September 18, 1998, in Philadelphia, PA, at the University of the Sciences in Philadelphia. The material presented herein is intended to be a thorough, objective, balanced presentation of the new Health Plan Employer Data and Information Set (HEDIS®) behavioral health management measures and standards and how health plans can prepare for reporting.

This supplement to the *Journal of Clinical Outcomes Management®* (JCOM®) is supported by an educational grant from Eli Lilly and Company and was prepared by Bimark Healthcare Communications. The content of this supplement was reviewed by a member of the JCOM Editorial Board and approved by the Program Editors. The views and opinions expressed in this supplement are those of the authors and do not necessarily reflect the views of the JCOM Editorial Board or Turner White Communications, Inc., publisher of JCOM.
Meeting the Challenges of New Behavioral Health Management Quality Standards

Introduction: Building Accountability in Behavioral Health Care .............................................. S5
Robert Browne, MD, FACP

HEDIS 1999 Overview ................................................................. S8
Cary Sennett, MD, PhD

HEDIS 1999: A First Step Toward Improving Management of Depression ................................ S12
Lawrence W. Osborn, MD, MPH

The Role of Pharmacy in Supporting Behavioral Health Care Quality Improvement Initiatives .................. S17
Michael J. Sax, PharmD, and Bernice Friesen, PharmD

Meeting the HEDIS 1999 Challenge: Issues and Opportunities for Managed Care .......................... S23
Patricia Harwood, PharmD, Fredric Michael Shecter, DO, and Victor G. Villagra, MD

Conclusion ................................................................................. S27
Philip P. Gerbino, PharmD
Editors

Robert Browne, MD, FACP
Senior Health Outcomes Research Consultant
Eli Lilly and Company
Indianapolis, IN

Lawrence W. Osborn, MD, MPH
Medical Director for Behavioral Health
Aetna US Healthcare
Blue Bell, PA

Contributors

Bernice Friesen, PharmD
Clinical Pharmacist
United Behavioral Health
San Francisco, CA

Cary Sennett, MD, PhD
Executive Vice President
National Committee for Quality Assurance
Washington, DC

Philip P. Gerbino, PharmD
President
University of the Sciences in Philadelphia
Philadelphia, PA

Fredric Michael Shecter, DO
Assistant Medical Director
United Behavioral Health
Philadelphia, PA

Patricia Harwood, PharmD
Former Vice President, Pharmacy and Special Programs
NYLCare
Coppell, TX

Victor G. Villagra, MD
Vice President, Medical Care Management
CIGNA HealthCare
Hartford, CT

Michael J. Sax, PharmD
Managed Pharmacy Consultant
The Pharmacy Group LLC
Glastonbury, CT
Introduction: Building Accountability in Behavioral Health Care

Robert Browne, MD, FACP

Rising Consumer Demand for Value in Health Care

In today’s competitive health care market, the battle to win customer confidence is increasingly aggressive. For years, this pitched battle has been waged predominantly around price competition. Unfortunately, price competition, with its focus on unit costs and controlling line-item expenses, is not necessarily a stimulus for quality improvement. Nevertheless, as health plans continue to focus primarily on the cost of care, payers have begun to demand greater value for their health care dollars: health care that is both affordable and of high quality.

Today’s employers wield considerable influence on competition in the health care market and are becoming a driving force in reform. Payers facing price increases from insurers must examine health care issues more broadly than before—issues that affect employee productivity as well as the financial bottom line. An employer’s role is no longer limited to paying health care premiums. Today’s employers hold health plans accountable for both price control and quality measures. In fact, some employers have developed specific objectives for employee health benefits, including:

• To keep employees healthy and on the job
• To restore to optimal levels of health status and work performance those employees who suffer from specific health-related conditions
• To reduce employees’ risk of developing disease or incurring injury
• To achieve high levels of employee satisfaction with plan services

As employers assume a more active role in managing employee health plans and in defining health care value, many are devising strategies for selecting health care providers that offer optimal services and produce documented results at reasonable cost [1]. Employers are supplying information to their employees and inviting them to participate in critical health benefit decision making regarding choice of health plan. Furthermore, if employees complain about an existing health plan, corporate benefits managers listen and subsequently seek plans that offer enhanced value.

Although formerly satisfied with low premiums and fixed costs, many companies today are likely to contract with plans that meet employees’ quality criteria. Some business leaders have even formed health care purchasing coalitions, which establish quality benchmarks that plans must meet to win contracts. These trends indicate a move from price competition to value competition in the health care market.

Quest for Health Plan Performance Information

In this value-conscious environment, consumers are seeking useful, readily understandable information about how health plans, hospitals, and physicians in their area measure up to quality standards and compare with one another. “Report cards” have evolved as one type of instrument for collecting and communicating comparative information about the performance of health care providers and plans. These reports generally contain measures (eg, enrollee satisfaction rates), indices (eg, percentage of participating primary care physicians who are board certified), and ratings that use a scale of normative values (eg, “superior” or “below average”) [1].

A recent 18-month study conducted by KPMG Peat Marwick LLP and Northwestern University revealed that 70% of American consumers have sought information about the benefits provided by their health plans [2]. This level of engagement demonstrates the consumer’s desire to be involved in establishing expectations for health plan performance. Newsweek also reports dramatic evidence of consumer thirst for health plan information. In 1998, for the third consecutive year, Newsweek published its rankings of the top health maintenance organizations (HMOs). In 1996, the first year during which Newsweek published its HMO rankings, sales of reprints of the article were greater than for any other reprint in the magazine’s history.

Sources of health care information are growing exponentially to meet increasing demands of patients and purchasers. Professional provider associations, health systems, and pharmaceutical companies offer extensive disease-specific and treatment information through toll-free phone

Robert Browne, MD, FACP, Senior Health Outcomes Research Consultant, Eli Lilly and Company, Indianapolis, IN.
numbers and interactive web sites. Daily television reports and print media coverage of health care issues—political, economic, and clinical—continue to increase demands for accountability on the part of health care providers and plans. Media reports that reveal substandard care at an area hospital or that paint a negative picture of a health plan not only raise consumer awareness but also feed consumer suspicions and apprehensions about the quality of care they receive. Consumers are insisting that health plans live up to their self-proclaimed commitment to quality and related self-promotional assertions.

The Role of NCQA and HEDIS

Clearly, consumers want information to help them choose a health plan that offers the price and quality combination of highest value to them. Plans are being asked to demonstrate how they compare with their competitors on issues that matter most to consumers (ie, access, service, and clinical outcomes) and to document the quality of their providers. The complexity of medical care and the myriad variables that affect outcomes, however, make the prospect of gathering and interpreting health care data enormously challenging.

In an attempt to create a standardized, widely accepted method for evaluating health plans, the National Committee for Quality Assurance (NCQA) developed the Health Plan Employer Data and Information Set (HEDIS®), a set of performance measures that serves as a report card on health plans and a tool to enable plans to distinguish themselves. HEDIS is regularly updated; the most recent version, HEDIS 1999, was released in November 1998. Although HEDIS currently is not required for NCQA accreditation, many employers rely on HEDIS data when choosing their health plans and share the data with employees so they can make informed choices. In the future, conformity with HEDIS measures will be strongly weighted in the NCQA accreditation process.

HEDIS 1999: New Measures for Improving Behavioral Health Care

HEDIS revisions implemented in 1999 include modifications to the requirements for how plans gather and report their data, changes in the HEDIS Member Satisfaction Survey, and “retirement” of provider availability measures, which are no longer considered relevant. In addition, three measures in the Effectiveness of Care domain have been added: Cholesterol Management After Acute Cardiovascular Events, Comprehensive Diabetes Care, and Antidepressant Medication Management. Also included in HEDIS 1999 are specific behavioral health testing set measures that address substance abuse counseling for adolescents, medication management and psychotherapy for schizophrenic patients, and appropriate use of psychotherapeutic medications.

In general, behavioral health issues (ie, costs, quality, assessment) are a major priority for NCQA, due to the high prevalence of behavioral health problems and the difficulty in measuring outcomes in behavioral health care services. In 1999, as a response to increased demands from health care purchasers, NCQA began to apply the standards it uses to accredit managed behavioral health care organizations to the behavioral health activities within managed care organizations (MCOs). In doing so, NCQA affirms what employers and consumers clearly recognize—that many of the leading health challenges facing the United States are related to behavioral health issues. Physical illness may affect a person’s emotional health, and vice versa [3]. Further, according to a study recently completed by the Harvard School of Public Health and the World Health Organization, 5 of the 10 leading causes of worldwide disability, evaluated according to the number of years a person has lived with a disability, were conditions related to mental illness: unipolar depression, alcohol abuse, bipolar disorder, schizophrenia, and obsessive-compulsive disorder [4]. Together, these psychiatric conditions accounted for 28% of the total number of years of life lost to disability, 1.4% of all deaths, and 1.1% of years of life lost. Unipolar depression alone was responsible for 1 in every 10 years of life lived with a disability. Projections forecast that by the year 2020, incidence of disability and death due to psychiatric illnesses will increase significantly, from 10.5% to 15% of the total global disease burden [4]. Thus, managing patients’ total health—physical and mental—makes both clinical and economic sense.

Meeting the Challenge to Improve Behavioral Health Care

In a value-competitive environment, only the best MCOs can expect to grow in both enrollment and profitability. Increasingly, the ways in which behavioral health services are provided will affect how purchasers, providers, and patients perceive value. MCOs that do not provide as high a value will have a strong incentive to do better. Consumers, by making informed choices about value-based health care, will be the ultimate beneficiaries.

The HEDIS 1999 behavioral health care measures present managed care professionals with a unique opportunity to integrate the services they provide and to demonstrate their value to purchasers and consumers of health care. However, to succeed in this endeavor, managed care medical and pharmacy directors need to understand the new HEDIS behavioral health measures and prepare themselves to report on them. In response to this need, Jefferson Medical College and the University of the Sciences in Philadelphia, with support from Eli Lilly and Company, presented a live, continuing medical and pharmacy education program, which took place on September 18, 1998, in
Philadelphia. The program presentations and ensuing discussion among faculty participants provide the basis for the articles in this supplement. The contributors to the supplement include experts in behavioral health care, HEDIS measures, and managed care medicine and pharmacy.

This publication includes an overview of the evolution of HEDIS measures, including a review of HEDIS 1999 and the new behavioral health measures. The supplement also includes discussions on the economic and workplace issues related to depression management, the role of pharmacy in supporting quality improvement initiatives, the challenges faced in meeting patient needs in behavioral health and in bridging the gap between primary care and behavioral health, and the opportunities for managed care medical and pharmacy directors and providers to support their organizations’ efforts in meeting the new HEDIS behavioral health standards. It is our hope that these subjects will provide a useful framework for improving the quality of behavioral health care in health plans.

References

NCQA’s Role in Evaluation of Health Plans

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to assessing and reporting on the quality of managed health care plans. Driven by employers’ need to obtain value from their health plans, NCQA’s mission is to provide information that allows purchasers and consumers of managed health care to differentiate among plans based on quality, thereby allowing more informed health care purchasing decisions. It is NCQA’s hope that, in such an environment, health plans will compete based on quality and value, rather than on price and provider network alone. NCQA’s efforts focus on accreditation and performance measurement, with the ultimate goal of improving health care by making available information that can guide choice and decision making.

Accreditation

In 1991, NCQA began its accreditation process as a means of providing employers and consumers with a simple method for assessing the quality of managed care organizations (MCOs). Since that time, NCQA has expanded the range of organizations it accredits or certifies to include managed behavioral health care organizations as well as physician organizations. To earn NCQA accreditation, an MCO must demonstrate that it is capable of delivering care that meets the needs of the population it serves and that it is deploying that capability effectively. Each month more than 15,000 purchasers and consumers of health care either call the NCQA’s toll-free Accreditation Status Line to learn the accreditation status of area health plans, download the Accreditation Status List from the NCQA web site (http://www.ncqa.org), or search the list online. NCQA also provides Accreditation Summary Reports—brief, user-friendly descriptions of how well plans have performed on their NCQA accreditation surveys—on its website. These reports are available for all plans that have undergone a full review since July 1, 1995. Figure 1 and Figure 2 show portions of the Accreditation Summary Report for BlueCross BlueShield of Massachusetts, Inc.

Performance Measurement

NCQA also manages the development of the Health Plan Employer Data and Information Set (HEDIS®), a standardized set of performance measures that enable employers and consumers to compare the performance of one managed care plan against that of others. HEDIS was created as a complement to the accreditation process. Currently, about 90% of health plans report at least some HEDIS data [1]. Table 1 shows the type of information addressed in HEDIS reports.

As health care costs continue to rise and employers face escalating rates, increasing numbers of purchasers and consumers—concerned that the value of health care has not risen proportionately—have turned to HEDIS to help them make more educated choices and to measure value. As Table 2 illustrates, a wide range of news media have demonstrated their confidence in HEDIS by developing health plan report cards based on HEDIS data.

Evolution of HEDIS

To appreciate the current status of HEDIS, it is useful to examine its evolution. HEDIS is the result of a cooperative effort by representatives of a variety of health plans and employers to develop standardized performance measures for health plans. In 1991, a draft document, HEDIS 1.0, was completed and distributed to several health care organizations and business coalitions for their review. Several areas for improvement or revision were identified, and NCQA was asked to revise and refine the draft [2]. The result of that effort, HEDIS 2.0, was published in November 1993 and became the preferred performance measurement system for managed care plans. HEDIS data were used to inform employer clients and to report improvements in quality, emerging as an objective standard for assessing how successfully health care plans treat certain acute and chronic illnesses.

In response to strong public interest in HEDIS, NCQA developed Medicaid HEDIS, a version that included special parameters relevant to populations served by Medicaid [3]. In 1995, NCQA released HEDIS 2.5, a technical update of HEDIS 2.0. Medicaid HEDIS and HEDIS 2.5 were brought together with the 1996 launch of HEDIS 3.0, which included over 100 performance measures appropriate for

Cary Sennett, MD, PhD, Executive Vice President, National Committee for Quality Assurance, Washington, DC.
the evaluation of both private and public (Medicaid and Medicare) plans. NCQA’s pioneering health care quality measurement mechanism has led to increased sponsorship of HEDIS data collection and development. For example, the Health Care Financing Administration and the Agency for Health Care Policy and Research have funded NCQA to do research and to develop additional measures particularly relevant to geriatric and pediatric members [4].

**HEDIS 1999 Overview**

The latest revision of HEDIS, HEDIS 1999, was released in November 1998 and is currently being implemented. Even more sophisticated than its predecessors, HEDIS 1999 includes numerous changes and additions. The most significant amendments are described below [5]:

- Plans may choose whether or not to submit data that combines their health maintenance organization and point-of-service (POS) populations and may disregard overlap between provider networks and the percentage of out-of-network services utilized by POS members.
- Three new performance measures have been implemented in the area of Effectiveness of Care: Cholesterol Management After Acute Cardiovascular Events, Antidepressant Medication Management, and Comprehensive Diabetes Care.
- The Member Satisfaction Survey and the Consumer Assessment of Health Plan Study (CAHPS) questionnaire have been consolidated as, and superseded by, the CAHPS 2.0H Survey. Survey procedures and instruments have also been amended. The CAHPS 2.0H Survey is intended for Medicaid and commercial populations; a separate survey is given to adult and pediatric populations outside these parameters.
- Whether a health care plan serves the private or public sector, HEDIS 1999 allows purchasers to use the same performance measurement system to evaluate plans. Today, most health plan report cards reflect HEDIS data (Table 2).
- The public reporting of HEDIS data requires some mechanism to assure its accuracy. In response, NCQA has developed standardized auditing procedures (the HEDIS Compliance Audit™) and an auditor certification program. In addition, certain HEDIS measures—specifically those related to clinical

---

**Table 1. Information Contained in HEDIS Reports**

<table>
<thead>
<tr>
<th>Information Contained in HEDIS Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness of plan care</td>
</tr>
<tr>
<td>Access/availability of care</td>
</tr>
<tr>
<td>Satisfaction with experience of care</td>
</tr>
<tr>
<td>Health plan stability</td>
</tr>
<tr>
<td>Use of health plan services</td>
</tr>
<tr>
<td>Cost of care</td>
</tr>
<tr>
<td>Informed health care choices</td>
</tr>
<tr>
<td>Health plan descriptive information</td>
</tr>
</tbody>
</table>

---

**Figure 1.** BlueCross BlueShield of Massachusetts, Inc., score for the Physician Qualifications and Evaluation component of the NCQA accreditation evaluation. This component counts as 20% of the overall accreditation decision. (Information reproduced with permission from BlueCross BlueShield of Massachusetts, Inc. Available at: http://www.ncqa.org/accred/asrlist.htm)

<table>
<thead>
<tr>
<th>In Physician Qualifications and Evaluation for physicians in the network, NCQA evaluates:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• How fully the plan investigates each physician’s qualifications and practice history before allowing the physician into the network</td>
</tr>
<tr>
<td>• How the plan assesses the physicians in its network on an ongoing basis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The plan achieved the following score:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non</td>
</tr>
<tr>
<td>Average</td>
</tr>
<tr>
<td>This Plan</td>
</tr>
</tbody>
</table>

**Figure 2.** BlueCross BlueShield of Massachusetts, Inc., score for Members’ Rights and Responsibilities component of the NCQA accreditation evaluation. This component counts as 10% of the overall accreditation decision. (Information reproduced with permission from BlueCross BlueShield of Massachusetts, Inc. Available at: http://www.ncqa.org/accred/asrlist.htm)

<table>
<thead>
<tr>
<th>In Members’ Rights and Responsibilities, NCQA evaluates:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• How clearly the plan informs members about how to obtain care and use services</td>
</tr>
<tr>
<td>• How well the plan responds to members’ complaints and concerns</td>
</tr>
<tr>
<td>• What actions the plan takes to measure and improve members’ satisfaction</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The plan achieved the following score:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non</td>
</tr>
<tr>
<td>Average</td>
</tr>
<tr>
<td>This Plan</td>
</tr>
</tbody>
</table>
quality and patient satisfaction—are being integrated in NCQA’s Accreditation ‘99 program [6]. In particular, HEDIS results will be worth 25% of the overall accreditation score for a given plan; the other 75% will be based on the plan’s level of compliance with NCQA standards [7]. This results-driven program promises to provide a more complete, robust, and consumer-friendly picture of the health plan. In short, HEDIS is bringing accountability to managed care, not only for cost and network issues but for quality of care as well [1].

The New Behavioral Health Care Measures
The Antidepressant Medication Management measure in HEDIS 1999 evaluates how effectively health plans are managing patients with moderate to severe depression who are on antidepressant medication. Inclusion of this new measure in HEDIS 1999 sends a signal to health plans to focus on this key area. Specifically, the behavioral health measure looks at the reporting set measures listed in Table 3. Additional behavioral health measures still being tested for possible inclusion in a subsequent version of HEDIS include substance abuse counseling for adolescents, availability of medication management and psychotherapy for patients with schizophrenia, and appropriate use of psychotherapeutic medications [5].

Conclusion
The purpose of HEDIS data is to help consumers and health care purchasers assess the relative quality of plans in language that can be easily understood. As NCQA works to provide detailed, easy-to-understand information, health care organizations need to build better information systems to capture and manage the data. These data will help NCQA’s efforts to inform the public. They will also greatly enable health plan efforts to improve care.

While familiarity with NCQA accreditation for all employers increased from 29% to 35% between 1996 and 1997, more than half of the nation’s employers remain unfamiliar with NCQA accreditation [8]. In some cases, even employers who use accreditation and HEDIS, albeit indirectly through their benefits consultants, may be unfamiliar with their content and origin. Gaining acceptance among employers is not the only challenge facing HEDIS. Encouraging health plans to participate in Quality Compass—a database developed by

### Table 2. Health Plan Report Cards

<table>
<thead>
<tr>
<th>Source of Report Card</th>
<th>Date Published</th>
<th>Data Sources</th>
<th>Health Plans Sampled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Reports</td>
<td>Aug 1996</td>
<td>Survey of magazine readers HEDIS data collected in 1994</td>
<td>HMOs and PPOs identified from sample of 30,000 readers</td>
</tr>
<tr>
<td>Newsweek</td>
<td>Jun 1996</td>
<td>1996 Newsweek/foundation of accountability survey State insurance departments Center for the Study of Services Fortune 500 companies HEDIS</td>
<td>75 large HMOs</td>
</tr>
<tr>
<td>U.S. News and World Report</td>
<td>Oct 1998*</td>
<td>HEDIS data from NCQA Quality Compass</td>
<td>270 HMOs in 42 states and Washington, DC</td>
</tr>
<tr>
<td>NCQA Quality Compass</td>
<td>Sep 1998*</td>
<td>Plan-reported HEDIS 2.5 data</td>
<td>300 plans that voluntarily submitted HEDIS data</td>
</tr>
<tr>
<td>GTE Corporation</td>
<td>1996</td>
<td>Plan-reported HEDIS 2.5 data 1994 Employee Health Care Value Survey†</td>
<td>140 plans that GTE contracts with for retiree health benefits</td>
</tr>
<tr>
<td>Consumer’s Checkbook</td>
<td>1996</td>
<td>1995 survey of enrollees in plans of the FEHBP</td>
<td>Plans participating in FEHBP with 300 or more enrollees</td>
</tr>
<tr>
<td>California Cooperative HEDIS</td>
<td>1996</td>
<td>HEDIS 2.5 data collected and validated by third party</td>
<td>25 California HMOs</td>
</tr>
</tbody>
</table>

HMOs = health maintenance organizations; PPOs = preferred provider organizations; HEDIS = Health Plan Employer Data and Information Set; NCQA = National Committee for Quality Assurance; FEHBP = Federal Employees Health Benefits Program. (Adapted with permission from Scanlon DP, Chernew M, Shefflers, Fendrick AM. Health plan report cards: exploring differences in plan ratings. Jt Comm J Qual Improv 1998;24:5-20.)

†Enrollment information from GTE Corporation (Stamford, CT).
NCQA, which includes 71 HEDIS measures such as physician turnover rates, disenrollment rates, and patient satisfaction with care—is a challenge as well [9]. Fewer health plans (292) were willing to release performance data to the public in 1998 via Quality Compass than in the previous year (330) [9].

It is important to note that NCQA-accredited plans did outperform nonaccredited plans on all clinical and satisfaction measures. For example, 76.9% of patients in fully accredited plans received appropriate β-blocker therapy after myocardial infarction, compared to 65.4% in nonaccredited plans [9]. The KPMG survey also revealed that costs for fully accredited plans are actually 4% lower than for nonaccredited plans [8], a significant finding showing that employers do not need to sacrifice price for quality.

References

Table 3. HEDIS 1999 Antidepressant Medication Management Measures

| Percentage of members who had at least three outpatient follow-up visits during 12-week Acute Phase Treatment |
| Percentage of members initiated on antidepressants who received continuous treatment during Acute Phase Treatment |
| Percentage of members who completed continuous treatment for 180 days |


Available at: http://www.aacc.org/crn/profiles/97profiles/09/was099702.html.
Depression in the Workplace

The prevalence of behavioral health problems in the workplace has begun to receive significant attention from both employers and managed care organizations (MCOs). As employers calculate the costs of behavioral health-related employee absenteeism and morbidity with the productivity and efficiency of their organizations, they are becoming increasingly aware that the mental health of employees affects the bottom line. A recent study on the economic burden of depression in the United States found that work days lost to depression alone account for approximately $16 billion annually in lost revenue and health care costs [1]. Depressed individuals were absent from work at 1.5 times the average rate, with a 20% reduction in productivity [2]. For many companies, the single leading cause of short-term disability claims is depression [3]. Estimates of resultant indirect cost savings if depression were adequately treated are as high as $4 billion annually [4].

Currently, workplace programs are addressing factors that may contribute to depression and thus prevent employees from performing at optimal levels [2]. A growing number of employers are developing wellness programs and health strategies that focus on fitness, early disease detection, and initiatives through which employees learn to use their health system wisely. Employee assistance programs and work-family programs provide disease intervention and preventive services that help employees manage life stressors. These programs often furnish educational materials, brief counseling, and access to extensive databases of community resources [2]. For example, Digital Equipment Corporation takes a continuum of care approach, designing programs that develop employees’ cognitive skills and coping mechanisms to deal effectively with common life events (eg, marriage, birth of a child, divorce, care for elder dependents, serious illness). In addition, Digital seeks to establish partnerships with its health care providers to deliver health promotion and disease prevention services in the workplace. Digital’s efforts are a sharp contrast to most workplace systems, which are usually organized to treat illness, rather than to preventively manage health risks and promote wellness in a population [2].

Coordination of Care

In today’s managed care environment, primary care physicians (PCPs) play a critical role in managing depression effectively, functioning as “quarterbacks” or “conductors” of patient care. Nearly 50% of individuals who seek treatment for mental health problems do so within the general medical sector [5]. Thus, primary care systems need to detect and treat the mental health problems of the patients they serve. Currently, more than 50% of patients who present with symptoms of depression in the primary care setting go undiagnosed [6]. Because mental health providers rely on PCPs to diagnose and treat common conditions such as depression, anxiety, and somatic complaints, appropriate referral of patients from PCPs is a critical component of a coordinated system of care. Therefore, efforts should be made to enhance the PCP’s informed involvement in recognition of the problem, its initial treatment, and specialty referral (eg, for complex psychological and psychiatric care). Simultaneously, the mental health care professional is encouraged to communicate with the PCP about the patient’s history and treatment in order to understand the problem and manage the condition effectively [7].

The costs associated with misdiagnoses and inadequate management are significant. For patients, the toll of depression may include mental anguish; poor physical, social, and occupational functioning; somatic symptoms (including pain); frustration with family; suicide; and other mortality risks. Indirect costs, including premature mortality and loss of productivity and wages, account for 55% of the expense of depression and often far exceed the direct cost of treating an episode of depression or other behavioral health problem [2]. The costs to the health care system—for increased medications, medical attention, morbidity, and mortality—are conservatively estimated at $43 billion annually (Figure 1) [4]. This figure does not reflect variable out-of-pocket expenses for patients and their families (eg, unwarranted or excessive diagnostic tests) or a generally reduced quality of life.

Lawrence W. Osborn, MD, MPH, Medical Director for Behavioral Health, Aetna US Healthcare, Blue Bell, PA.
The coordination of care between mental health providers and PCPs must be improved. Lack of communication among medical specialists treating the same patient is not uncommon. Sharing information in the mental health arena is especially complicated because of the sensitive nature of family relationships and confidentiality issues. The resulting fragmentation of care strongly contributes to misdiagnosed depression or untreated depressive episodes, which usually last between 6 and 24 months. Although the lifetime prevalence of depression is 24% in women and 15% in men, as few as 1 in 10 patients receives adequate treatment for depression [4]. Moreover, untreated depression may interfere with recovery from comorbid conditions, including cancer, diabetes, stroke, and myocardial infarction (MI) (Figure 2).

Recent studies indicate that depression may be an independent risk factor for the pathophysiologic progression of cardiovascular disease. In post-MI patients, undiagnosed depression leads to poor compliance with medical therapy and rehabilitation, resulting in increased medical comorbidity. Further, in coronary artery disease patients, depression predicts future cardiac events and may hasten mortality [8]. Collaboration of care among PCPs, cardiologists, and mental health providers presents a tremendous opportunity to maximize treatment and cost benefits.

**Improving the Outcomes of Depression Treatment**

**Merits of Combination Therapy**

A combination of psychopharmacology, psychotherapy counseling, and social support appears to lead to the best results in treatment of depression. Outcome measures for treating depression include an examination of the severity of a patient’s symptoms; measures of a patient’s quality of life, work absenteeism and productivity, and satisfaction with care; the direct costs of providing medical services; and the cost-effectiveness of the intervention(s) provided.

For example, in evaluating a young adult who suffers from a major depression and is being treated with an antidepressant, a provider must consider educational and social issues as well as family pressures that may profoundly affect treatment outcomes.

**Studies of New Interventions**

**Improving adherence to treatment regimens.** A recent study compared the effectiveness of a multifaceted intervention in patients with depression with that of the “usual care” by the PCP [9]. Patient adherence to medication regimens was monitored, and the frequency of patients’ visits with PCPs and psychiatrists was increased. Videotaped and written materials supplemented face-to-face patient education during these visits. In patients with major depression, the intervention group showed greater adherence to the proper dosage of medication for 90 days or more, compared with the control group (75.5% versus 50.0%) (Figure 3). Seventy-four percent of intervention patients showed a 50% or greater improvement on the Symptom Checklist–90 Depressive Symptom Scale, compared with 43.8% of controls. These results demonstrate that collaborative patient management by the PCP and a consulting

---

**Figure 1.** Economic costs of depression. (Adapted with permission from Greenberg PE, Stiglin LE, Finkelstein SN, Berndt ER. The economic burden of depression in 1990. J Clin Psychiatry 1993;54:405-18.)

physician psychotherapist provided psychotherapy. During approach, a psychiatrist provided pharmacotherapy and a non-
treatment [11]. In one case, a psychiatrist provided psychother-
depressed patients, illustrates the importance of integrated
$11,000 to $8200, with the advent of managed care.
tentially, average annual mental health expenditures per
admitted before the introduction of managed care. Add-
admitted in 1994 and 1995 were more disturbed than those
continuity of care, these results suggest that individuals
was reduced by 1000. Rather than indicating a decline in
al or state hospitals declined from 26% to 20% after the man-
amended care system was implemented, but the mean length of
stay (approximately 31 days per episode) did not change.

In assessing continuity of care, the study found that
although the incidence of admissions followed by rehospi-
talization increased slightly with managed care’s introduc-
tion, from 22.1% to 23.2%, the total number of readmissions
was reduced by 1000. Rather than indicating a decline in
continuity of care, these results suggest that individuals
admitted in 1994 and 1995 were more disturbed than those
admitted before the introduction of managed care. Add-
itionally, average annual mental health expenditures per
treated Medicaid beneficiary decreased by about 25%, indicating
that access was not curtailed. Inpatient admissions to gener-
al or state hospitals declined from 26% to 20% after the man-
aged care system was implemented, but the mean length of
stay (approximately 31 days per episode) did not change.

Results of the study indicate that more appropriate care for
depression—including appropriate use of medications to treat
depression, counseling, and avoidance of regular minor tranquil-
ilizer utilization—improves functional outcomes, such as
the ability to work at a job. Although this approach increases
the total cost of care, it also improves the value of care: each
dollar spent on care provides more benefits in terms of health
improvements. In contrast, although general medical
provider care under current treatment patterns may reduce
costs, it also worsens outcomes and does not increase the
value of health care spending. This study underscores the
value of making care for depression more cost-effective
through quality improvement. It also suggests that combined
methods of care could result in better outcomes and lower
treatment costs. To realize this potential, however, substantial
changes must be made in the approach to quality of care for
depression in general practice medicine [12].

To achieve this goal, some health organizations are pro-
moting more collaboration between PCPs and behavioral
health specialists. For instance, toll-free phone numbers have
been established so that network PCPs can easily reach
behavioral health specialists for consultation. Some service
systems are testing the practice of placing behavioral health
specialists in the same offices with PCPs. And carve-out
companies (ie, specialists in evaluating a patient’s need for
mental health services and in determining the level of ser-
vice to provide) have initiatives in place to instruct PCPs on
how to identify and refer patients with emotional problems.

**Pharmacologic Management of Depression**

**HEDIS 1999 Antidepressant Medication Measure**

The Health Plan Employer Data and Information Set
(HEDIS®) 1999 measures address behavioral health issues
more vigorously than did past measures, and the Antidepressant Medication Management measure identifies three facets of successful pharmacologic management of depression in adult patients. Table 1 summarizes the new Antidepressant Medication Management measure, and Table 2 lists the characteristics of a new episode of depression, as defined by the National Committee for Quality Assurance.

**Continuous Treatment**

The prevailing view concerning pharmacologic management of depression among clinicians is that patients should remain without interruption on medications that produce positive outcomes. In depression, much depends on the severity of the patient’s symptoms, but clinicians are increasingly moving away from drug holidays. Discontinuing a medication may create a problem if a relapse occurs, because the same medication may not work as well the second time around. For example, many physicians and pharmacists encourage their diabetic and hypertensive patients—even severe allergy sufferers—to comply with the drug treatment regimens that relieve their symptoms.

**Next Steps**

The underrecognition and mistreatment of depression present an enormous opportunity for clinical and financial improvement. The HEDIS antidepressant measurement is a useful first step in gauging how well HMOs and MCOs capitalize on this opportunity. Currently, a variety of interventions are being tested in trials across the country. Only through the concentrated and unified efforts of health care and behavioral health professionals (ie, PCPs, mental health specialists, pharmacists, and employee assistance program administrators) will advances occur in the recognition and treatment of this illness. Correct identification of depression by the PCP provides a critical link in management of the disease. Missed opportunities to identify and treat the disease effectively need not be as rampant as they are.

**References**


---

**Table 1. HEDIS 1999 Antidepressant Medication Management**

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal Practitioner Contacts for Medication Management</td>
<td>Patients diagnosed with a new episode of depression, treated with medication, and who had three follow-up contacts with a primary care practitioner or mental health practitioner during the 12-week Acute Treatment Phase. At least one of the contacts must be with a prescribing practitioner (eg, licensed physician, physician assistant, or other practitioner with prescribing privileges).</td>
<td>Assesses the adequacy of clinical management of new treatment episodes for adults with major depressive disorder.</td>
</tr>
<tr>
<td>Effective Acute Phase Treatment</td>
<td>Patients treated with medication and who remained on a drug during the entire 12-week Acute Treatment Phase.</td>
<td>Assesses the percentage of adult members initiated on drug therapy who received a continuous trial of medication treatment during the Acute Treatment Phase.</td>
</tr>
<tr>
<td>Effective Continuation Phase Treatment</td>
<td>Patients who remained on medication to treat depression for at least 180 days (6 months).</td>
<td>Assesses the effectiveness of clinical management in achieving medication compliance and the likely effectiveness of the established dosage regimen by determining whether adult members completed a period of Continuation Phase Treatment adequate for defining a recovery according to the AHCPR guidelines.</td>
</tr>
</tbody>
</table>

AHCPR = Agency for Health Care Policy and Research.
Improving management of depression

The Role of Pharmacy in Supporting Behavioral Health Care Quality Improvement Initiatives

Michael J. Sax, PharmD, and Bernice Friesen, PharmD

Introduction

The 1999 Health Plan Employer Data and Information Set (HEDIS®) behavioral health management measures emphasize the identification of patients who are being treated for or in need of treatment for depression. The information in pharmacy databases provides pharmacists with a significant opportunity to enhance the care of depressed patients, improve medication compliance, identify problematic medication regimens, and enhance positive outcomes. Pharmacists can play a key collaborative role in educating people within their managed care organizations (MCOs) about the importance of pharmaceutical care. Through interaction with health care payers, managed care pharmacists gain intimate knowledge of the needs, desires, and concerns of pharmacy benefit managers.

An MCO’s contribution to the improvement of overall outcomes is a key element in its ability to maintain or expand its market share of pharmacy plan members [1]. Thus, managed care pharmacists can play a vital supporting role within their organizations. Pharmacists possess valuable technological, clinical, and management skills. Furthermore, they are in a position not only to implement the pharmaceutical care components of disease management programs effectively, but also to contribute to other areas of quality improvement, such as integrating pharmacy and other health care data; quantifying value, measuring results, and educating payers; and improving communication along the entire health care continuum [1].

Pharmacy Quality Indicators

The Academy of Managed Care Pharmacy’s Catalog of Pharmacy Quality Indicators [2] is the best place to start in developing methods for measuring pharmacy’s impact on and contribution to the health care delivery team. The catalog is designed to help document the value of pharmacists’ contributions to coordinated patient care and to identify areas of pharmaceutical care that require improvement.

The catalog is intended to be an aid to pharmacists and quality administrators within managed health care systems, external accrediting organizations, and health care purchasers who want to formally evaluate health care delivery. It identifies multiple operational areas within a managed health care system that present opportunities for developing quality measures (Table 1). These areas may include effectiveness of care, access to and/or availability of care, overall satisfaction with the experience of care, and cost of care. In the catalog, users find a detailed set of pharmacy benefit measurement areas that aim to assist MCOs in developing specific measures or benchmarks to address their unique situations. MCOs should examine these option areas and select the two or three that best address their organizations’ particular needs and structure. Although the guide is a template and does not purport to establish a standard of care in the managed care pharmacy industry, it can serve as a useful tool for identifying and establishing a professional role for the pharmacist as a member of an integrated health care team.

Integration of Data

Developing a pharmacy data information highway is a critical element in realizing these goals. An integrated medical information database would enable MCOs to integrate prescription data from various provider, corporate, and geographic locations quickly and accurately (Figure 1). Claims data are currently available but need to be supplemented with information from pharmacies, physicians, hospitals, and other points of patient care. Access to such data will enable MCOs to conduct financial and clinical reporting and retrospective drug utilization evaluations (DUEEs); to devise programs aimed at promoting more appropriate drug use and reducing related health care costs (eg, hospital admissions, doctor visits, laboratory tests); and to conduct pharmacoeconomic research, including outcomes measurement [1].

Within health care information systems, three integration trends are currently underway: software integration (including dispensing and drug reference material), network and data integration (which encompasses availability, computerization, and coding of data), and communication (among...
patients and care providers. Data integration is not, however, without its challenges. Costs, utilization, and outcomes measurement require an evaluation of the financial and clinical details of patient records. However, incomplete data sets plague the assessment process; only a limited number of managed care systems or insurers provide an integrated financial and clinical picture of medical, hospital, pharmacy, and ancillary services. This lack of data imposes significant constraints on the ability of database systems to assess the contributions of alternative therapeutic interventions toward efficient, effective health care delivery. Although MCOs that offer fully integrated health care are in the best position to capitalize on data integration, substantial financial and staffing resources are required to develop the software systems necessary to integrate information.

**Using DUE to Support the HEDIS Behavioral Health Management Measures**

Noncompliance with treatment regimens, misconceptions about the nature of depression, and outmoded prescribing habits often cause patients to remain undertreated or fail to complete a requisite course of care for depression. In addition, the stigma associated with a diagnosis of depression often keeps sufferers from seeking medical attention. Although physician understanding of depression has grown considerably in recent years, some primary care physicians still underestimate, ignore, or misdiagnose their patients’ expressions of emotional stress.

In addition, pharmaceutical treatment of depression also poses significant challenges. All medications for depression have side effects that may be troubling to a patient; identifying these adverse effects and making appropriate dose or therapy adjustments to alleviate them may help to encourage compliance and successful management. Further, the potential toxicity of certain agents may require subtherapeutic dosing, which also presents a challenge to developing effective therapy regimens. However, the pharmacy profession can identify and address all of these issues through the practice of pharmaceutical care and DUE.

DUE and drug utilization review (DUR) constitute essential steps for assuring and improving the quality of patient care and outcomes. DUEs may be performed retrospective to, concurrent with, or prospective to drug therapy. With retrospective DUE, pharmaceutical performance is assessed after the drug therapy regimen is complete. DUE that occurs during drug therapy and allows for active interventions is called concurrent DUE. Prospective DUE examines the drug therapy before the patient receives the first dose, allowing for active intervention before therapy initiation.

---

**Table 1. Characteristics of the Academy of Managed Care Pharmacy’s Catalog of Pharmacy Quality Indicators**

**Objectives**

- To guide individuals interested in setting up quality initiatives and/or performance measures within managed health care systems to help improve the effectiveness and efficiency of the medication use process and management of the pharmacy benefit.
- To provide information that will help managed health care systems develop the processes and procedures necessary to collect data to compare performance.
- To stimulate ideas and provide a guide for pharmacists within managed health care systems to evaluate and substantiate existing programs and processes that promote quality and to encourage development of new programs and processes.

**Catalog structure**

- **Domains** describe key services considered vital to a quality program.
- **Program Areas** identify a core set of broad operations within each domain that are conducive to measuring the delivery of services.
- **Indicators** suggest items to measure to determine the effectiveness of each program area.
- **Process Steps** identify programs necessary to have in place to measure the indicator of service delivery.

Adapted with permission from The Academy of Managed Care Pharmacy. Catalog of pharmacy quality indicators. Alexandria (VA): The Academy; 1997:2-3.
DUE of antidepressant therapy is a feasible and effective procedure by which pharmacists can implement the new HEDIS behavioral health management measures, which are in accordance with the practices defined in the Agency for Health Care Policy and Research’s guidelines for the treatment of depression [3]. Figure 2 provides an overview of the phases of treatment according to these guidelines.

**Case Studies in Depression Management**

The following case studies illustrate how profiling data can be used to interpret variation of care and to conduct appropriate interventions that lead to quality improvement in the pharmacotherapeutic management of depression. These case studies illustrate the types of interventions that pharmacy professionals on both the corporate and provider levels can perform to support the HEDIS 1999 behavioral health management measures. Support of these measures can help dispel common misconceptions about the nature and treatment of depression. Each case study focuses on a different HEDIS performance measure.

**Case 1: Optimal Practitioner Contacts for Medication Management**

Jane Smith, a 55-year-old woman diagnosed with depression, fills a new prescription for a medication at her local pharmacy. Data captured by the pharmacy benefit management database at the time she fills the prescription are shown in Table 2.

This measure evaluates the percentage of adult patients diagnosed with a new episode of depression, treated with medication, and seen at least three times during the Acute Treatment Phase (84 days, or 12 weeks). The goal during this phase is to assess the adequacy of a health care plan’s clinical management of adults first presenting with major depressive episodes. Case 1 offers an example of a population-level, retrospective DUE designed to identify an inappropriately high number of refills, resulting in a medication supply of greater than 84 days.

According to the parameters of this measure, a newly diagnosed depressed patient on medication should be seen by a clinical practitioner at least three times within the Acute Treatment Phase. Patients following correctly prescribed drug regimens should be prompted by a depleted supply of medication to call their prescribing physician and, if requested, return for a follow-up visit. However, patients who are prescribed an amount of medication that extends beyond the Acute Treatment Phase may not feel the need to return to the prescriber for a follow-up evaluation. Possible interventions include a follow-up call or letter that reinforces the need for the patient to contact her physician.

**Case 2: Effective Acute Phase Treatment**

Mike Jones is a 38-year-old man who was diagnosed with depression and initiated on medication almost 4 months ago. His prescription history, captured by the pharmacy benefit management organization, is shown in Table 2.

This measure evaluates the percentage of adult patients diagnosed with a new episode of depression, treated with medication, and who remained on continuous therapy during the entire Acute Treatment Phase. Case 2 illustrates a population-level, retrospective DUE designed to identify incomplete refill histories, the presence of concomitant medications indicating that the medication is being prescribed for depression, and the presence of concomitant medications indicating that the medication is not being prescribed for depression.

This patient’s refill history indicates inappropriate filling; the intervals between prescription refills indicate that he is noncompliant with therapy. The reason for such noncompliance cannot be determined from these data, but the patient’s prescription refill history should provoke an
inquiry by the prescribing physician to identify the precipitating factors.

In response to data indicating ongoing noncompliance with treatment regimens, especially with medications for depression, some retail pharmacy chains have implemented intervention programs. In such programs, information from individual stores is downloaded to the chain’s computer system warehouse. There, the data are analyzed, and records indicating noncompliance are flagged. Some chains then send out a corporate correspondence to patients, reminding them of the benefit of staying on the medication, along with a reminder to refill the prescription at the prescribed interval. Other systems prompt the dispensing store to perform the intervention, creating concurrent DUE.

Case 3: Effective Continuation Phase Treatment

Mary Paul is a 69-year-old woman who has completed Acute Phase Treatment for depression. Treatment was initiated with one drug, but the patient experienced difficulty tolerating its adverse effects and, thus, was switched to a different medication for the duration of Acute Phase Treatment. Table 2 contains the data captured during the patient’s Acute Phase Treatment as well as her Continuation Phase Treatment.

This measure evaluates the percentage of adult patients who have been diagnosed with a new episode of depression, treated with medication, and remained on drug therapy for at least 180 days (6 months). The effectiveness of clinical management in achieving medication compliance and the adequacy of the dosage regimen can be evaluated by determining the percentage of adult patients who sufficiently complete Continuation Phase Treatment. Case 3 illustrates a population-level, retrospective DUE intended to identify inconsistent refills of medications to treat depression during a 6-month period.

The addition of another drug (ie, not one used to treat depression) during Continuation Phase Treatment may be indicative of ineffective antidepressant therapy or newly emergent side effects. Such data should prompt the pharmacy or health plan to initiate an intervention to investigate the cause.

Current Limitations and Future Opportunities

Although the technology needed to perform DUE is currently available to pharmacy professionals, the information in these databases has limitations. Complete medical information (eg, diagnoses and ICD-9 codes, laboratory and examination follow-up data, concurrent disease states) is not currently available to the pharmacist. Concurrent disease states often mandate an individualization of therapy that deviates from standard treatment protocols and practices. Laboratory and examination notes could be used to justify or question regimen changes. Therefore, this information is required for the pharmacist to effectively evaluate the appropriateness of a therapeutic regimen.

In the future, as the pharmacist becomes a more integral part of the health care team, merger of medical and pharmacy databases will allow pharmacists and other health care professionals to ensure that a patient’s care is maximally effective, continuous, and complete. (Preserving patient confidentiality by restricting database access to the appropriate individuals should continue to be a priority.) Once a completely integrated database is in place, established software
applications will be able to identify patients who could benefit from pharmaceutical intervention (ie, patients with diseases such as depression, patterns of hospitalization, or overuse or underuse of other health care services).

Other pharmaceutical care challenges in the managed health care environment include sparse, incomplete, and inconsistent data; a lack of identified opportunities to improve medication outcomes; and as-yet-unidentified patterns of drug use and outcomes. To meet these challenges and persuade health care providers that change can improve their practice patterns and patient outcomes, data must be captured and evaluated along with historical information.

**Pharmacy’s Role in Medical Review**

Overall, the medical review process involves three main activities: tracking patient outcomes in response to medications, identifying problematic medication regimens, and intervening with treating clinicians. Several key “triggers” help pharmacists avoid prescribing difficulties and ensure the best possible patient outcomes by preemptively identifying problematic medication regimens. These triggers, based on the results of the Medical Outcomes Study published by the RAND Corporation [4], are listed in Table 3. The outcome of an intervention can be documented in electronic chart notes, and as clinical pharmacists follow up on the intervention, they can indicate whether or not the problems have been resolved.

Clinical pharmacists can play a significant role in bringing about both improved patient care and enhanced health care outcomes. By utilizing a continuous high-quality medication review process, a clinical pharmacist at a managed behavioral health care organization can review patient cases to ensure that both network and nonnetwork physicians prescribe medication regimens that are consistent with the diagnosis, treatment goals, and documented symptoms of a specific condition.

Once a clinician or therapist sees a patient, written information should be submitted for review to ensure that the medication regimen matches symptomatology and diagnosis. If necessary, the pharmacist could then intervene by speaking with the clinician to obtain additional clinical information or clarification. Such communication would not only result in a more detailed clinical picture of the patient, but would also further promote internal collaboration in patient care. For cases in which psychotherapy is separate from medical management, this review process would promote active communication between a clinician and psychiatrist.

Medication review programs can be enhanced by incorporating additional problem indicators to identify patients who are not on medication but whose diagnosis or symptoms warrant consideration of pharmacotherapy. A managed care pharmacy program can allow access to more comprehensive and systematic data on all medications being prescribed, particularly prescriptions outside the mental health system. These data can further identify potential adverse interactions between psychotropic and nonpsychotropic medications, as well as enhance coordination of care between mental health clinicians and primary care physicians.

Other information systems programs integrate mental health case management, managed behavioral health care, and medication history information. By linking the prescribing patterns of primary care and specialist physicians and monitoring the use of psychotropic drugs, programs have increased patient satisfaction, improved medical outcomes, and decreased prescription drug and mental health costs for employers. Some systems also use intranet communications to import data from multiple provider sites, labs, pharmacies, and hospitals to one centrally located information system, thereby monitoring care across an entire population. These systems are flexible and able to communicate with any legacy system. Information feeds can be provided daily, weekly, or monthly and range from technical reporting functions to very high-touch contact. For example, a system might be able to identify potential medical crises as a result of documented medication noncompliance.

Participation in a medication review process is not the only opportunity for pharmacists. Pharmacists should also participate in efforts to monitor medication dosage and ensure that appropriate regimens are followed for a sufficient duration before a patient’s prescription is changed. In addition, care managers in mental health settings may not have

<table>
<thead>
<tr>
<th>Table 3. Key Triggers That Enable Pharmacists to Identify Problematic Medication Regimens</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Connectivity</strong></td>
</tr>
<tr>
<td><strong>Low or high dose of medication</strong></td>
</tr>
<tr>
<td><strong>Medication interaction</strong></td>
</tr>
<tr>
<td><strong>Atypical use of medication</strong></td>
</tr>
<tr>
<td><strong>Lack of appropriate medication use</strong></td>
</tr>
</tbody>
</table>

Adapted with permission from Wells KB, Katon W, Rogers B, Camp P. Use of minor tranquilizers and antidepressant medications by depressed outpatients: results from the medical outcomes study. Am J Psychiatry 1994;151:694–700.
extensive knowledge of medication. In such situations, pharmacists may educate their health care partners and help them to obtain a better understanding of medications and their proper usage. Likewise, pharmacists can also play important roles in patient education, patient compliance, and therapeutic counseling. Patients should be informed both of the time required to produce an initial response to drug therapy and of the importance of continuing drug therapy after symptoms improve. Pharmacists can also impart this information to physicians, whose busy schedules do not always allow them to stay abreast of the latest medication studies. By disseminating important medication information to fellow health care providers, pharmacists may improve the outcomes of patient care.

**Putting It All Together**

Clearly, challenges still exist in coordinating and exchanging data, but pharmacists can assist by working closely with patients and providers and by providing drug profiles that identify potential drug-drug or drug-disease interactions. They can also implement provider interventions that will improve treatment programs and hasten a patient’s progress. Additionally, pharmacists can educate providers about prescribing patterns that optimize patient therapy while providing profiles on complicated and high-risk patients.

Although the information available in pharmacy databases will not provide all of the answers, it is an excellent point from which pharmacists can begin to support behavioral health management quality improvement initiatives consistent with the HEDIS 1999 measures. The HEDIS behavioral health care measures will create increased awareness of and demand for valuable, useful information. Providers will want to evaluate their own treatment methods and compare their programs with those of their colleagues. Health plans will want to enhance their measurable outcomes. Thus, health care professionals will seek solution strategies, and pharmacy can be part of the solution.

**References**

Meeting the HEDIS 1999 Challenge: Issues and Opportunities for Managed Care

Patricia Harwood, PharmD, Fredric Michael Shecter, DO, and Victor G. Villagra, MD

New behavioral health management quality standards present managed care organizations (MCOs) with challenges and opportunities alike. More exacting quality measures certainly raise performance expectations for MCOs. At the same time, the improved standards are part of a broader movement to redefine the behavioral health care model, and MCOs have the chance to be proactive, positive contributors to this process.

Consider the magnitude of the behavioral health management issue in the United States. Fifty percent of individuals who experience symptoms of depression are misdiagnosed or go undiagnosed. This failure to diagnose depression accurately comes at a steep price to society. Estimates of the potential indirect cost savings that would result if depression were adequately identified and treated run to $4 billion per year [1]. And although treatment is readily available and effective for most depressed patients, nearly half of all individuals who suffer from depression do not seek professional care. Patients with depression often underreport their symptoms, in part because of the stigma still associated with mental illness. Depression is a health issue whose impact is felt not only by the patient, but by the many individuals and institutions that are implicated, directly or indirectly, in the patient’s illness. For all those involved—patients, family members, health care and pharmaceutical providers, MCOs, and payers—the formation of a new model for delivering behavioral health care is a critical step toward improving care for patients with depression.

The following discussion draws from a roundtable held in conjunction with the Meeting the Challenges of New Behavioral Health Management Quality Standards program. Panelists who participated in this exchange, and whose views are represented here, include: Philip Gerbino, PharmD; Cary Sennett, MD, PhD; Bernice Friesen, PharmD; Patricia Harwood, PharmD; Jeffrey Lenow, MD, PhD; Naim Munir, MD; Lawrence Osborn, MD, MPH; Michael Sax, PharmD; Fredric Shecter, DO; Craig Stern, PharmD, MBA; and Victor Villagra, MD. The roundtable was an exchange of ideas and views on issues and opportunities for MCOs with respect to evolving behavioral health management quality standards. What follows is a series of questions extrapolated from this roundtable. The questions, which were formulated based on the substance of the actual question-and-answer session, aim to encapsulate the discussion by topic. Each question is followed by a narrative summary of panelists’ responses.

What are some of the key opportunities for improving care for patients with depression?

Society’s heightened awareness of the enormous costs of depression—personal, social, and economic—encourages an improved, proactive system of care for depression sufferers. Gauging these costs and confronting their impact are vital steps toward acknowledging the need for enhanced behavioral health management. The increased awareness of depression’s devastating toll has been accompanied by a positive shift in societal attitudes toward mental illness, which may in turn encourage those who are clinically depressed to seek treatment and follow a care regimen. Further good news is the dramatic increase in the number and variety of treatment options available for treating depression. Finally, beyond the clinical advances is an initiative within managed care to raise behavioral health management standards and thereby improve quality and strengthen accountability. A driving force behind this initiative are the new behavioral health care standards set forth by the National Committee for Quality Assurance (NCQA) and the Health Plan Employer Data and Information Set (HEDIS®) behavioral health measures, which seek to shift managed care’s focus from price competition to value competition. MCOs are also driven to offer quality care in a cost-effective manner as part of their underlying philosophy, thereby driving quality improvement initiatives.
• What would a new health care delivery model look like? Would behavioral health have an expanded role in this model?

Significant and quantifiable improvement in the delivery of behavioral health care requires the formation of a new health care model—one oriented to the principles and imperatives of managed care. The most immediate challenge to developing a new model is the existing division between primary care and behavioral health care. The strict time constraints under which primary care physicians (PCPs) practice—constraints dictated by competitive economic pressures—rarely allow physicians the opportunity to identify and accurately diagnose depression. In the standard 15-minute primary care visit, a PCP lacks the time to conduct a thorough behavioral health examination; depression’s symptoms can be too complex to gauge during this brief encounter. Moreover, while most health care professionals can and often do recognize depression resulting from a major personal loss or traumatic life event (e.g., the death of a loved one, a job loss, a severe financial setback), they may not detect a depression associated with coexisting medical conditions. Thus, to be successful, a new health care delivery model must break down the division between primary and behavioral health care in order to create a functionally integrated care model.

Behavioral health would have a greatly expanded role in a new delivery model that embraces the importance of behavioral health in overall human health. The establishment of improved NCQA behavioral health standards is evidence of the increased emphasis on behavioral health outcomes as a measure of overall health care value. The NCQA standards and HEDIS measures were promulgated to promote behavioral health activities and to coordinate behavioral health care and primary medical care.

• How can MCOs facilitate such change in behavioral health care delivery?

To create a new health care delivery model, MCOs must shift their emphasis from providing episodic acute care to offering population-based health management focused on prevention and early detection. Such a shift would be consistent with a commitment to the new results-driven NCQA accreditation and HEDIS outcomes standards, which demand greater accountability for the quality and range of mental health services provided. The aftercare that MCOs provide or enable is critical to avoiding relapse and maintaining adequate functioning. MCOs address a continuum of care and recognize that a patient may move back and forth along the continuum. Moreover, MCOs must embrace their role as communications brokers between medical and behavioral health providers. In the managed care setting, the MCO is the entity that can promote coordination of behavioral health care and primary medical care. An MCO can further promote a new health care model by ensuring that drug formularies are up-to-date, based on sound clinical evidence, and developed with the input of appropriate practitioners.

• What are the roles of the PCP and pharmacist in promoting a new health care model?

PCPs have a critical role in promoting a new behavioral health care delivery model. As managed care’s gatekeepers, PCPs see a tremendous volume of patients daily and must be able to make quick assessments while providing quality care. Although some PCPs may be comfortable managing a patient’s single episode of major depression, they also may encounter challenging situations involving the diagnosis or ongoing clinical management of depression. For other PCPs, an initial diagnosis of depression may present difficulties in determining an appropriate treatment course. Thus, PCPs need to have a heightened awareness of depression’s prevalence as well as a ready and reliable support system through which they can obtain an immediate consultation.

Pharmacists also have an important role in creating a new model for behavioral health care delivery. One of the main causes of recidivism in behavioral health care is medication noncompliance, which may result in compromised outcomes and productivity losses, among other negative consequences. Pharmacists, through their direct contact with patients, are well-situated to address this problem and to educate patients about the critical importance of adhering to their medication regimens. Further, because most behavioral health drugs are prescribed by PCPs, not by psychiatrists, pharmacologic management in the general medical sector has become an extremely important element in treatment plans. Pharmacists can work closely with PCPs to monitor any potential problems regarding drug interactions and to reinforce patient compliance, thereby promoting optimal health care outcomes.

• What strategies might be implemented to bridge the gap between behavioral health and primary care?
With PCPs assuming an integral role in the initial identification of depression symptoms in the managed care setting, it is crucial that the health care system forge links between primary care and behavioral health care providers. PCPs must take the initiative to reach out to patients, and to all relevant parties in the community, to improve access to mental health services [2]. MCOs can help by facilitating direct and timely communication between PCPs and mental health professionals early in the care cycle. Toward this end, some managed behavioral health organizations (MBHOs) have instituted toll-free hotlines, which enable PCPs to talk directly with a psychiatrist or other mental health specialist [2]. Furthermore, some managed care plans and physician groups are considering placing behavioral health specialists in the same clinical care setting as PCPs [2]. Given the reliance on PCPs to diagnose and treat common depressive conditions, as well as to refer patients for more complex psychological and psychiatric care, it serves the best interests of both behavioral health care and primary care to improve the PCP’s functional knowledge of at least three behavioral health–related factors: recognition of the problem, initial treatment, and criteria for special referral [2].

• How should patients be educated about the long-term effects of failing to treat a mental health problem properly?

The personal, familial, social, and economic costs of untreated or undertreated depression can be devastating. PCPs can and should make their patients aware that depression and other mental health problems can have a profound and long-term impact if they are not treated properly. Working with behavioral health specialists, PCPs can identify high-risk populations for intensive preventive care, reassure and treat the “worried well,” and steer chronically medically ill patients to appropriate mental health services [2]. Educating patients about the long-term effects of ineffective treatment is one part of the process. Another part involves raising patient awareness of the importance of self-management and behavior modification in preventing behavioral health problems. Here, PCPs can serve a purposeful role, counseling patients on such matters as stress management, conflict resolution, and the perils of substance abuse [2].

• Is there a role for others in patient education?

Responsibility for educating patients does not rest solely with PCPs. MCOs, employers, and patients themselves all have important roles to play. In order to target educational efforts toward specific audiences, MCOs and health care provider groups will need to use information databases to identify subpopulations and members who may be at risk for behavioral health problems. Targeting populations defined by formal risk assessment will become necessary for survival as delivery systems assume greater responsibility for both the physical and behavioral health status of the populations they serve. Strong educational efforts will ultimately help organizations to realize their clinical outcomes and competitive value goals [2].

• What can employers do to facilitate improved behavioral health outcomes?

An increasing number of employers are recognizing the tremendous amount of lost work time and productivity that result from employee mental health problems. These employers are developing wellness programs and health strategies that focus on physical fitness, early disease detection, and modification of unhealthy lifestyles. Such efforts include comprehensive behavioral health education components and initiatives aimed at empowering employees to achieve maximal benefit from their health care system. Educational components, including printed materials and periodic workplace seminars, encourage employees to actively monitor and manage their own physical and mental health [3].

• How might new partnerships affect the development of a functionally integrated behavioral health management model?

All stakeholders play vital roles in the development of new partnerships aimed at early detection, prevention, and treatment of behavioral health problems. The stigma still associated with mental illness leads many patients to want to go directly to a mental health professional without their PCP’s knowledge. MCOs, employers, and behavioral health professionals all recognize that requiring plan members to see their PCP first may impose a barrier to accessing mental health services. Many MCOs integrate the behavioral health offering but allow members to bypass the PCP and access the mental health provider directly. Nonetheless, a balance must be struck between a patient’s desire for direct access and the prerogative of caregivers in collaborating to deliver safe, efficient, and effective
treatment. Increased use of “carved-out” MBHOs by employers and health care providers presents a challenge to, and underscores the need for, collaborative effort [2].

- How might partnerships with carve-out companies impact the development of integrated behavioral health care delivery systems?

In any system striving toward functional integration, the allocation of economic risks and rewards varies widely. In the carved-out model, a behavioral health vendor is under contract with an employer that also contracts with other independent health care providers, purchasers, or vendors. Within this system, only the employer itself may promote integration, given that the behavioral health vendor has no organizational or economic relationship to the employer’s other vendors. Normally, this model introduces little or no incentive for physical and behavioral health care providers to work collaboratively. Some employers have opted for carve-out models in part due to the perception that MCOs have not been responsive enough to members’ behavioral health needs [2].

In the characteristic carve-out model, MCOs contract with behavioral health management organizations or brokers that arrange for services through direct contact from members seeking care. In this scenario, the PCP often is excluded altogether and thus serves no gatekeeping role for behavioral health services. Purely economic forces at work in carve-out models, especially when primary care and behavioral health care are separately capitated, may prompt PCPs to over-refer patients to behavioral health care providers. At the same time, it could encourage such providers to underserve their assigned populations [2].

References
Conclusion

Philip P. Gerbino, PharmD

The relentless challenge in health care is clear but certainly not simple: sustain and enhance quality in a cost-conscious environment. Employers are spending enormous resources on health care and, by increments, are discovering the influence they wield over health plans. With the aid of skilled benefit managers, coalitions, buying groups, and consultants, employers are becoming forward-thinking and ever more thoughtful and precise in their queries about quality. They are also beginning to canvass their employees on the subject of health care quality. Does this mean that consumerism is on the rise in health care? Perhaps. More likely, it reflects a growing interest among payers to understand health outcomes and to achieve patient satisfaction. Employees are now empowered to speak out and provide feedback so that employers can better assess how health benefit dollars are spent. Some employers have even taken innovative steps to educate employees so they may better understand quality of care and differentiate among health plans and providers on the basis of quality.

The provider community of physicians and pharmacists has also sought improved ways to express quality, primarily as a competitive strategy for individuals, groups, networks, independents, and chains. Provider preferences have centered on benchmarks and comparative statistics for physicians and the provision of pharmaceutical care (including counseling and compliance programs) for pharmacies. Consumers have requested consistent, prompt, and effective treatment and accessible care.

The formation of the National Committee for Quality Assurance (NCQA) and the subsequent development of the Health Plan Employer Data and Information Set (HEDIS®) are landmark events in the quality movement in managed care. HEDIS 1999 and the behavioral health care guidelines it contains represent a solid stimulus for quality improvement in the area of behavioral health care. A health plan's success or failure should be based on how well the plan delivers care in conformity with these standards. A plan's response to HEDIS measures of quality may vary broadly. One plan may revamp its internal investment engine; another may search for external consultation in the area of disease management. Because there are many ways to improve performance among different plans and providers, NCQA recognizes the need for flexibility in judging a plan's quality initiatives against HEDIS measures.

Ultimately, many opportunities exist to enhance care for patients with behavioral health problems, and all members of the health care team—health plans, providers, and patients—must work together to realize this improvement. Several general principles should guide initial efforts to improve the quality of managed behavioral health care, including the following:

- Engage consumers, family members, providers, and community leaders in discussions about the core values that are the heart of behavioral health care services. This discussion can evolve into an analysis of the goals the community wishes to achieve from its behavioral health care services.
- Continue the process with the same groups to develop potential plans of action. This discussion should identify the essential characteristics of behavioral health care service systems.
- Promote the development of systemic, clinical, and ethical guidelines for behavioral health care systems. If appropriate resources are available in the environment, use them; if not, seek consensus on how best to bring available information to bear on the issue of concern.
- Promote the use of consumer- and family-centered outcome measures and report cards.
- Use these results to improve behavioral health care systems.

The road ahead will be difficult, but embarking down that road is a necessary first step forward. The key to implementing procedures and systems to improve care for patients with depression is to continue moving forward in a way that is as comfortable as possible for providers but ultimately meets the needs of payers and consumers. Forward momentum also can be sustained by more effective and better-defined educational efforts to destigmatize depression, especially in the workplace. Partnerships among employers, health plans, the pharmaceutical industry, behavioral health agencies, and providers are ideal for this type of educational initiative. Among the points to highlight with the educational campaign is the value and effectiveness of providers using the most appropriate medications for...
CONCLUSION

treating depression. The advantages to using NCQA and HEDIS as the quality platforms in these educational programs are emerging. HEDIS permits a description of the ways in which improvement in the treatment of depression can be measured in a managed care setting. A quality position also places cost in a more appropriate context.

Despite advancements in the science and therapeutics of depression, significant challenges in the area of behavioral health care must be surmounted. The panel and content experts who participated in this narrative have identified opportunities for improving care, provided suggestions for MCOs, articulated the roles of primary care providers and pharmacists in the management of depression, and suggested ways to bridge the gaps between behavioral health and primary care. They also examined partnerships, integration, and patient education strategies and suggested ways in which employers might facilitate better behavioral health outcomes.

Copyright 1999 by Turner White Communications, Inc., Wayne, PA. All rights reserved.