Hennepin Health

Minneapolis Grain Exchange Building
400 South Fourth Street, Suite 201
Minneapolis, Minnesota 55415

Reduction of Racial Disparities in the Management of Depression Performance Improvement Project

2015-2017 PIP Reduction of Racial Disparities in the Management of Depression

Description

The Department of Human Services (DHS) Prepaid Medical Assistance Program (PMAP)/ MinnesotaCare (MNCare) and Special Needs Basic Care (SNBC) contracts require Managed Care Organizations (MCOs) to conduct performance improvement projects (PIPs) designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. Projects must meet the DHS and Centers for Medicare and Medicaid Services (CMS) requirements. The 2015-2017 Reduction of Racial Disparities in the Management of Depression PIP goals are to increase the use of antidepressant medication treatment by Hennepin Health members diagnosed with depression and to reduce disparities among critical racial groups for antidepressant medication adherence.

Mental illness may be stigmatizing and understood differently by racial and ethnic minority groups, including: African Americans, American Indians and Hispanics. Increasing awareness of depression and the benefits of treatment could help reduce stigma and improve the treatment engagement in these communities.

Process and Documentation

Collaborative Provider Interventions

Hennepin Health collaborated with the Minnesota Health Plans of BluePlus, HealthPartners, Medica and UCare (known as the "Collaborative") in order to achieve consistency across health care systems for members diagnosed with depression. Medica exited the Collaborative at the end of 2016 as its PMAP/MNCare contract with DHS ended. The collaborative group is able to leverage many intervention strategies that would otherwise be challenging to implement as a single health plan. Through new interventions, Hennepin Health can support members in improving their treatment of depression with increased medication adherence.

The Collaborative partnered to develop resources that included: a provider toolkit, webinars, conference presentations, newsletter articles, community outreach and engagement, as well as partnerships to promote a Family Health Fair. The Collaborative updated resources developed during the first year of the project and continued to offer webinars for providers who work with culturally diverse patients experiencing depression. All resources used for this three-year project are described below. The resources address best practices for depression care, with an emphasis on the importance of delivering such care in a culturally appropriate way.

The Collaborative developed a project website housed on the Stratis Health website that provides tools, resources, webinars, etc. Throughout the three-year duration of the project, there were over 4,000 unique visits to the website to access these resources.

Member Interventions

The member intervention consisted of telephonic outreach by care coordinators and Hennepin Health staff to members newly diagnosed with depression. The outreach calls addressed specific treatment barriers, such as concerns about addiction, and taught strategies for managing side effects. Distribution of educational materials took place in conjunction with telephonic outreach.

Analysis

Telephonic outreach to members was not as effective as anticipated. Hennepin Health considered alternatives such as notifying providers of members who were not compliant in refilling their medication. This was not pursued since medical practitioners from within Hennepin Health partner organizations stated this would not be effective for several reasons: 1) the member may not actually be a patient of the provider, 2) mail to providers gets intercepted by administrative staff and may not get to the provider, 3) if the provider gets the letter, they may not be at their computer to review the member record, 4) follow-up time may not be reimbursable for the provider, and 5) using claims data to determine eligible members does not account for discontinued medications and the member may show as non-compliant for refilling prescriptions. Referencing the electronic records would be more useful. Texting members was discussed, however, at this time, this option was not available.

Members cited various reasons as to why they did not get their medication filled which included: difficulties getting to the pharmacy, members feel better so do not feel they need their medication and members have other issues to deal with such as lack of housing, family issues and/or alcohol use/abuse before addressing their medication compliance. Members in the project make lifestyle choices related to their medication and often do not want phone calls to discuss these choices. Hennepin Health did not substantially impact the desired outcomes through these member interventions.

For both the PMAP/MNCare and SNBC populations in this project, Hennepin Health continued to see the following barriers to reaching members: the phone was disconnected, members did not consistently have a phone or was no longer at that number, the inability to leave a voice mail message or the member phone did not accept incoming calls. Once reached, a high volume of members requested not to receive further calls. However, these members continued to appear on subsequent data reports. In addition, members often stated they did not have problems taking their medication, although records showed their prescriptions had not been filled timely. A challenge when contacting members to discuss antidepressant adherence was that the data reports did not always list the member’s current medication.

Measure of Success

The outcome measure for this project is the HEDIS Antidepressant Medication Management (AMM) Effective Continuation Phase of Treatment measure. It is important to note that HEDIS rates did not reflect a full year of interventions until 2017, and a complete picture of the impact of the interventions will not be available until at least 2019. HEDIS rates for 2019 will reflect dates of service in 2018. Therefore, given the HEDIS measurement periods, the Hennepin Health

target to meet its improvement goal of reducing the disparity in antidepressant medication adherence between Blacks and Whites by 20 percent and between Native American and Whites by 20 percent is not reflected in the final data analysis.

Baseline Measurement

Table 7. HEDIS AMM Continuation Phase Measurement Periods		
HEDIS Reporting Year	**HEDIS Measurement Period**	**PIP Intervention Year**
2014	May 2012-April 2013	Baseline
2015	May 2013-April 2014	Pre-implementation
2016	May 2014-April 2015	Year 1 (first 4 months of implementation)
2017	May 2015-April 2016	Year 1-2
2018	May 2016-April 2017	Year 2-3
2019	May 2017-April 2018	Year 3

HEDIS Baseline Rates

The tables and graphs below show the yearly baseline rate for the PMAP/MNCare and SNBC populations respectively, and the rate disparity compared to the eligible White population.

For the PMAP/MNCare group, the rates remained relatively stable among the White population. However, the other populations fluctuated over time. For SNBC, all populations showed fluctuation.

For PMAP/MNCare, the average adherence rates from 2014-2017 were highest within the Asian population at 59.03 percent, followed by White at 45.18 percent. The Native American population had the lowest adherence rate, at 26.71 percent, and the Black population was at 32.54 percent. For the SNBC product, the White population had the highest adherence average rate of 35.73 percent, followed by Native Americans with 35.71 percent and the lowest was the Asian population at 29.17 percent. The Black population had an adherence rate of 30.82 percent.

The outcome of reducing the racial gap of depression medication adherence by 20 percent was not achieved. Due to the small numerators and denominators, any rate change had a large impact on the racial gap by creating an inflated negative or positive rate. As a result, the rates are unreliable.

Table 8. Hennepin Health PMAP/MNCare AMM Baseline Rates by Race for HEDIS 2014-2018					
Race	**HEDIS Rates by year**	**Numerator**	**Denominator**	**Rate**	**Racial Gap compared to White**
White	2014	33	71	46.47%	NA
White	2015	32	75	42.66%	NA
White	2016	84	177	47.46%	NA
White	2017	64	145	44.14%	NA
Black	2014	45	111	40.54%	-5.93%

Table 8. Hennepin Health PMAP/MNCare AMM Baseline Rates by Race for HEDIS 2014-2018					
Race	**HEDIS Rates by year**	**Numerator**	**Denominator**	**Rate**	**Racial Gap compared to White**
Black	2015	46	118	38.98%	-3.68%
Black	2016	39	146	26.71%	-20.75%
Black	2017	33	138	23.91%	-20.22%
Two or More Races	2014	--	--	--	--
Two or More Races	2015	--	--	--	--
Two or More Races	2016	2	10	20.00%	-27.46%
Two or More Races	2017	--	--	--	--
Asian	2014	5	12	41.66%	-4.81%
Asian	2015	3	3	100%	57.34%
Asian	2016	4	9	44.44%	-3.01%
Asian	2017	2	4	50.00%	5.86%
Native American	2014	14	39	35.89%	-10.58%
Native American	2015	4	23	17.39%	-25.27%
Native American	2016	6	24	25.00%	-22.46%
Native American	2017	6	21	28.57%	-15.56%
Hispanic	2014	0	7	0%	NA
Hispanic	2015	0	1	0%	NA
Hispanic	2016	1	1	100%	52.54%
Hispanic	2017	--	0	--	--
Unknown/Undeclared	2017	22	70	31.43%	-12.70%

Figure 1. PMAP/MNCare AMM Measure Rate 2014-2018

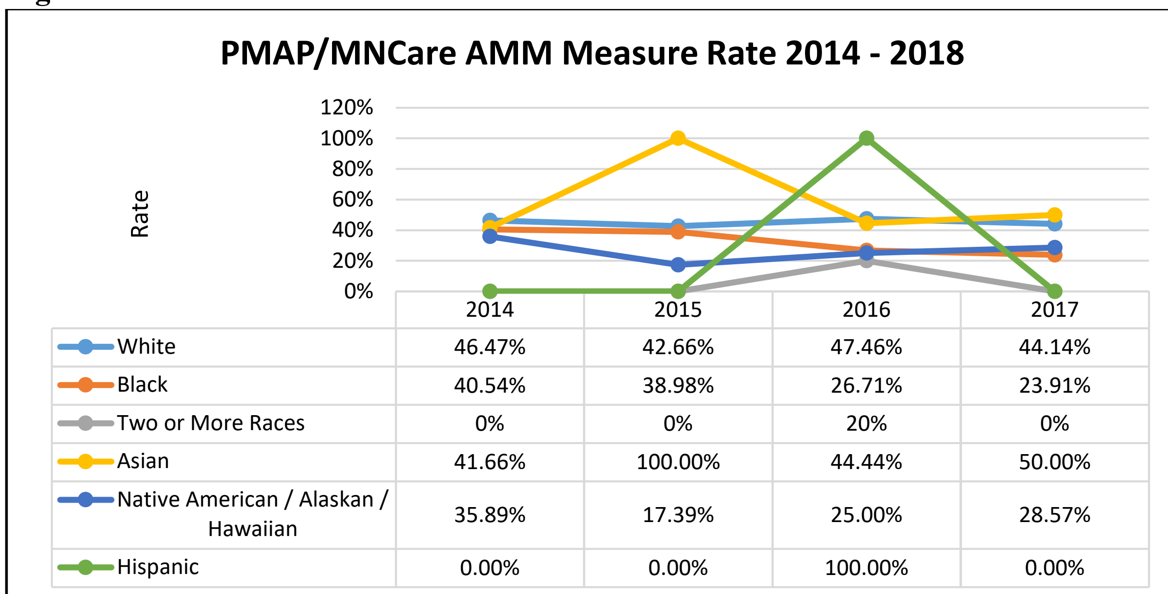


Figure 2. PMAP/MNCare Racial Gap Compared to White, 2014-2018

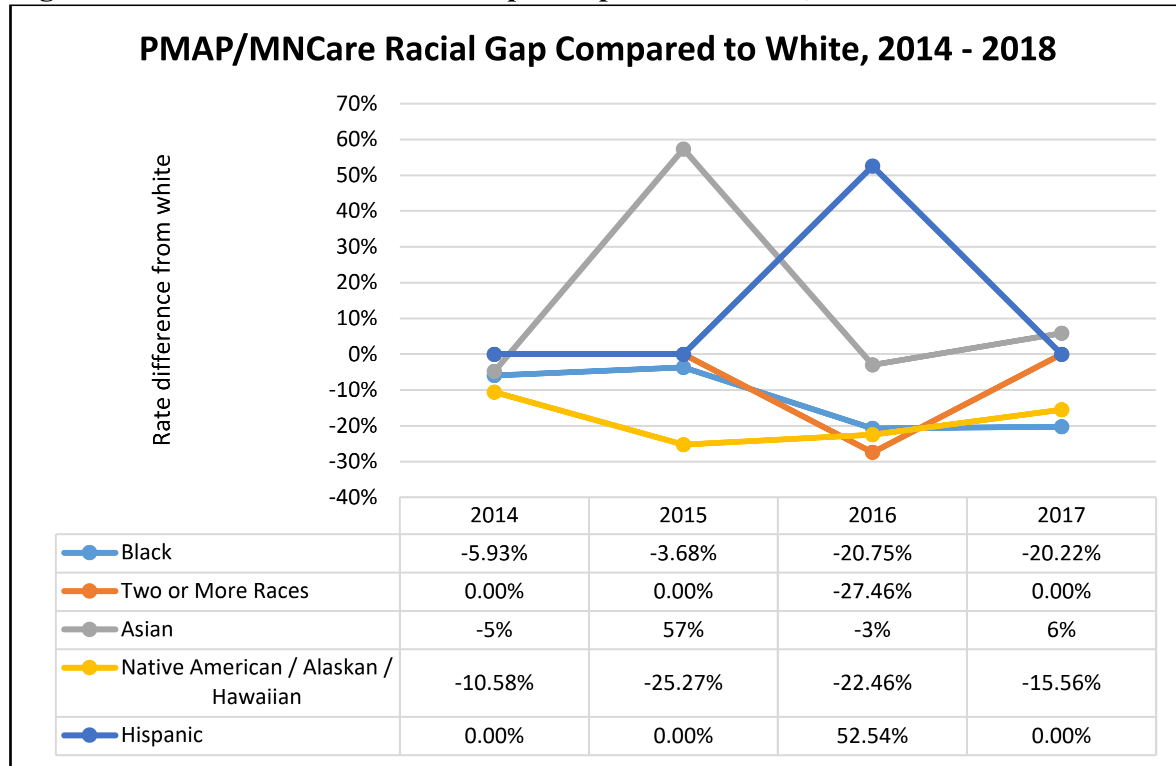


Table 9. Hennepin Health SNBC AMM Baseline Rates by Race for HEDIS 2014-2018					
Race	**HEDIS Rates by year**	**Numerator**	**Denominator**	**Rate**	**Racial Gap compared to White**
White	2014	13	37	35.13%	NA
White	2015	9	27	33.33%	NA
White	2016	9	30	30.00%	NA
White	2017	4	9	44.44%	NA
Black	2014	19	60	31.66%	-3.47%
Black	2015	28	83	33.73%	0.04%
Black	2016	27	110	24.55%	-5.45%
Black	2017	21	63	33.33%	-11.11%
Two or More	2014	1	1	100%	64.87%
Two or More	2015	2	4	50%	16.677%
Two or More	2016	0	0	0%	NA
Two or More	2017	--	--	--	--
Asian	2014	1	3	33.33%	-1.80%
Asian	2015	1	3	33.33%	0%
Asian	2016	0	6	0%	-30.00%
Asian	2017	1	2	50.00%	5.56%

Table 9. Hennepin Health SNBC AMM Baseline Rates by Race for HEDIS 2014-2018					
Race	**HEDIS Rates by year**	**Numerator**	**Denominator**	**Rate**	**Racial Gap compared to White**
Native American	2014	6	14	42.85%	7.72%
Native American	2015	1	2	50.00%	16.67%
Native American	2016	2	4	50.00%	20.00%
Native American	2017	0	4	0%	-44.44%
Hispanic	2014	1	2	50.00%	14.87%
Hispanic	2015	0	0	0%	-33.33%
Hispanic	2016	0	0	0%	NA
Hispanic	2017	--	--	--	--
Unknown/Undeclared	2017	0	1	0%	-44.44%

Figure 3. SNBC AMM Measure Rate 2014-2018

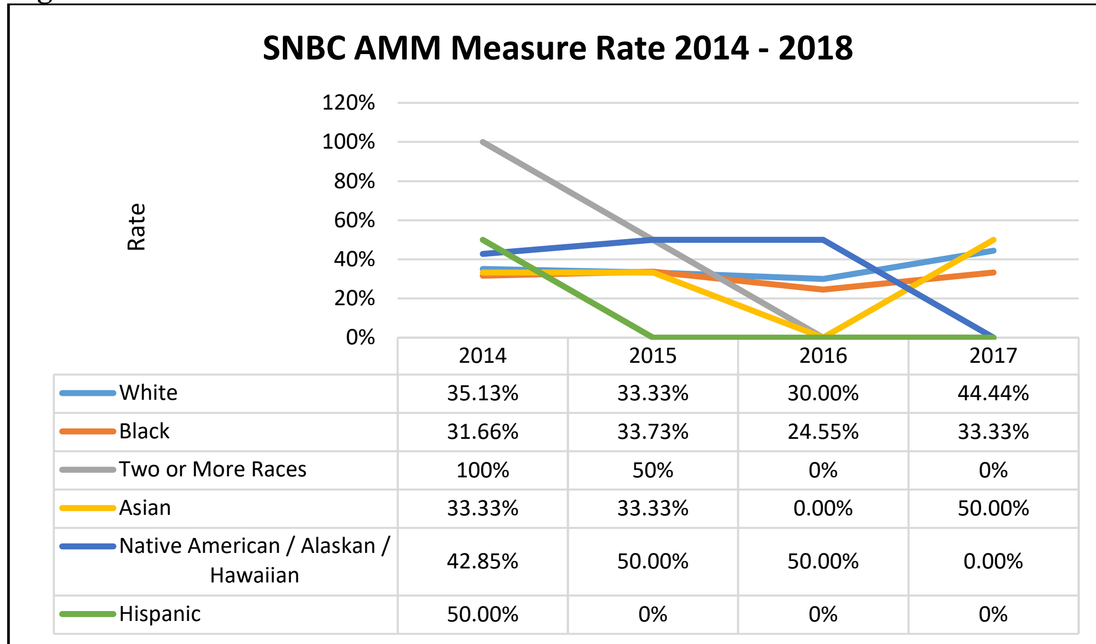
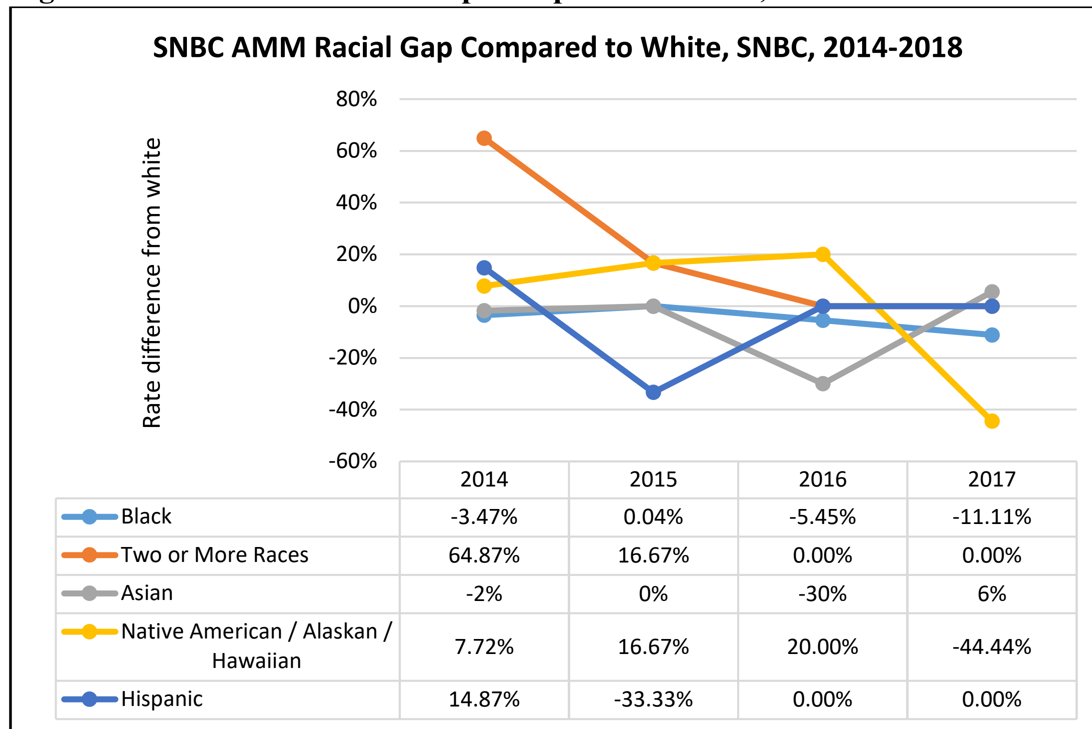


Figure 4. SNBC AMM Racial Gap Compared to White, 2014-2018



	2014	2015	2016	2017
Black	-3.47%	0.04%	-5.45%	-11.11%
Two or More Races	64.87%	16.67%	0.00%	0.00%
Asian	-2%	0%	-30%	6%
Native American / Alaskan / Hawaiian	7.72%	16.67%	20.00%	-44.44%
Hispanic	14.87%	-33.33%	0.00%	0.00%

Lessons Learned

One barrier encountered during this project was that a high percentage of members did not have a phone, or if reached by phone, preferred to have no phone calls from the health plan. The low rate of call success resulted in a small percentage of members where an impact on medication compliance might occur. Even with up to three attempts to reach each member, the percentage of members reached did not rise significantly as compared to only using one attempt to reach a member. In addition, very few members utilized or read the educational flyer sent to them.

The Hennepin Health - PMAP/MNCare population has high levels of alcohol and/or other drug use, mental illness, and stress due to a lack of basic needs such as housing and food. These factors may contribute to non-compliance with medication adherence. There is also a high rate of homelessness for this population. For Hennepin Health - PMAP/MNCare members, their primary focus is addressing these psychosocial/physical needs prior to addressing their medical needs. Developing a trusting relationship with health care providers/programs that are outside of their "trusted" support system can be difficult for individuals with mental illness. Additionally, this population typically does not have an adequate social support system available to them, often having lost contact and/or alienating their family or friends. These individuals generally seek medical care only when an acute medical illness arises. Once the acute medical illness is addressed, they generally do not seek ongoing primary and preventive care services. Many Hennepin Health-PMAP/MNCare members live in "survival mode," thinking only of their immediate needs. Lacking the ability to think long term is often a major barrier to members receiving primary/preventive health care services. This was reflected by the reasons given by members for both Hennepin Health - PMAP/MNCare and SNBC for not taking their

medications. Members in both products also experienced the following, which made it difficult to be compliant with taking their medications:

- No primary care provider or psychiatrist
- Felt they had a physical problem, such as inability to sleep and not a mental health problem
- Continued drinking alcohol so they stopped taking their medication
- Memory issues so forgot to take their medications
- Missed provider appointments so unable to get a timely refill
- On advice from their provider, halved the dosage of their medication
- Began taking on an as needed basis so did not get refills as frequently
- Dental concerns they wanted to deal with first
- Family issues they wanted to address first or were too stressed to take their medications
- Housing issues so couldn't focus on their mental health
- Did not feel they needed their medications

Another challenge for this study was that using pharmacy claims data to determine eligible members did not account for discontinued medications. Therefore, the medication may still show up on the data report suggesting the member was non-compliant in refilling prescriptions. In order to determine if medications are discontinued, staff utilized the Epic medical record. Hennepin Health received authorization from Hennepin County Medical Center, who owns the Epic records, to access medical record information via Epic for SNBC members beginning in 2017, thus limiting the ability in 2016 to verify if medications were current. During calls, SNBC members often stated they were no longer taking that medication. If staff had been able to verify the medications in Epic prior to making outreach calls for the entire length of the project, the data would have been more accurate. The PIP concluded on December 31, 2017 and the final report was submitted to DHS on August 30, 2018.

Recommendations and Next Steps

Hennepin Health will continue to look for opportunities to reduce racial disparity between the Black and the Native American populations and the White population for depression management. As potential psychosocial issues are identified, Hennepin Health will continue to work with its partner organizations to address these issues. This could allow members to change their focus from meeting psychosocial needs to addressing their medical well-being/medication compliance.

For sustainability, Hennepin Health will update its "Taking Antidepressants" flyer with the rebranded Hennepin Health logo and place on the Hennepin Health website. The Provider Toolkit will be updated annually and remain on the Stratis Health website as a reference guide until at least 2021. At that time, the Collaborative will evaluate its ongoing resource and its usage based on the number of times it has been accessed. Provider updates will be issued reminding providers of the Provider Toolkit, webinars, and resources including a link to the Stratis Health website to access these resources.

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