Optum

Co-Occurring Mood and Endocrine Disorders

Whole Health Engagement (WHE) Education

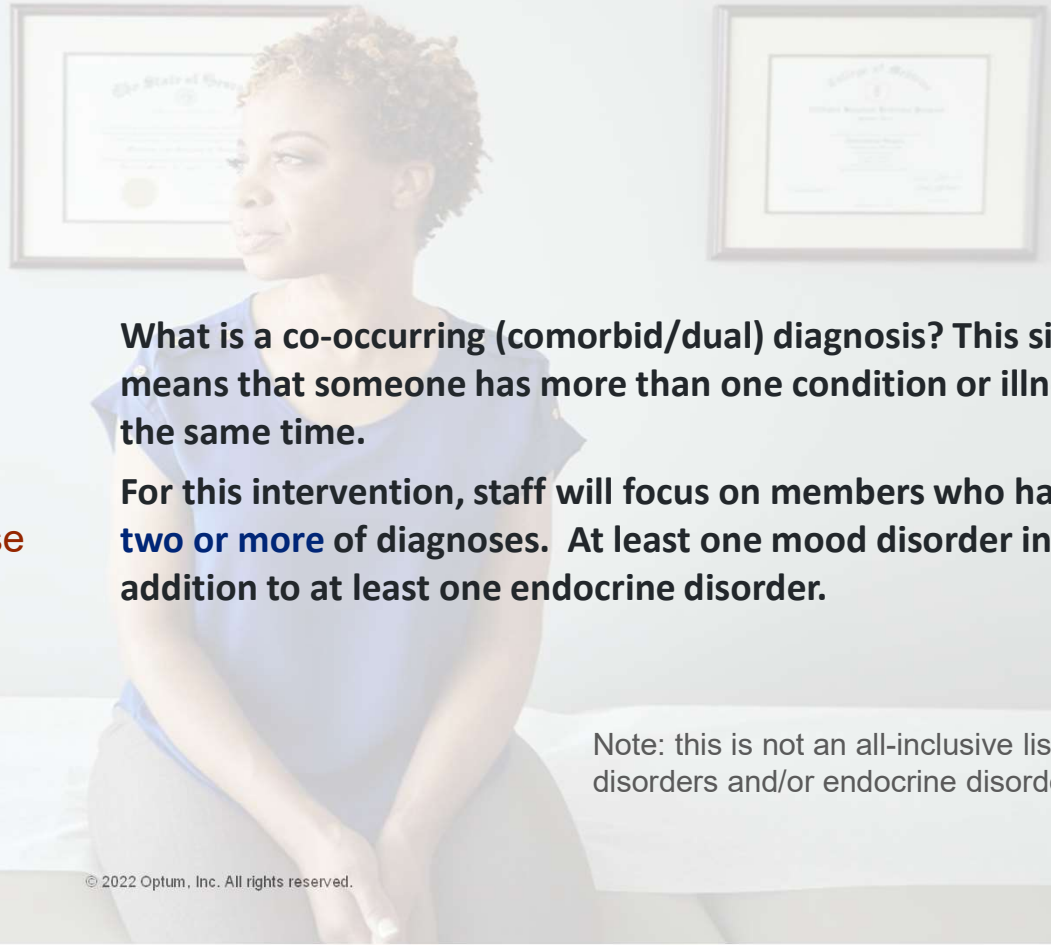
CEA Medical Directors Team

March 2024

Co-Occurring Mood and Endocrine Disorders

1. Mood disorders
   - Depression
   - Bipolar disorder

2. Endocrine Disorders
   - Diabetes
   - Thyroid disease
   - Cushing and Adison's Disease
   - Post partum depression
   - Low Vitamin D



What is a co-occurring (comorbid/dual) diagnosis? This simply means that someone has more than one condition or illness at the same time.

For this intervention, staff will focus on members who have two or more of diagnoses. At least one mood disorder in addition to at least one endocrine disorder.

Note: this is not an all-inclusive list of mood disorders and/or endocrine disorders.

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Why Mood and Endocrine Disorders?

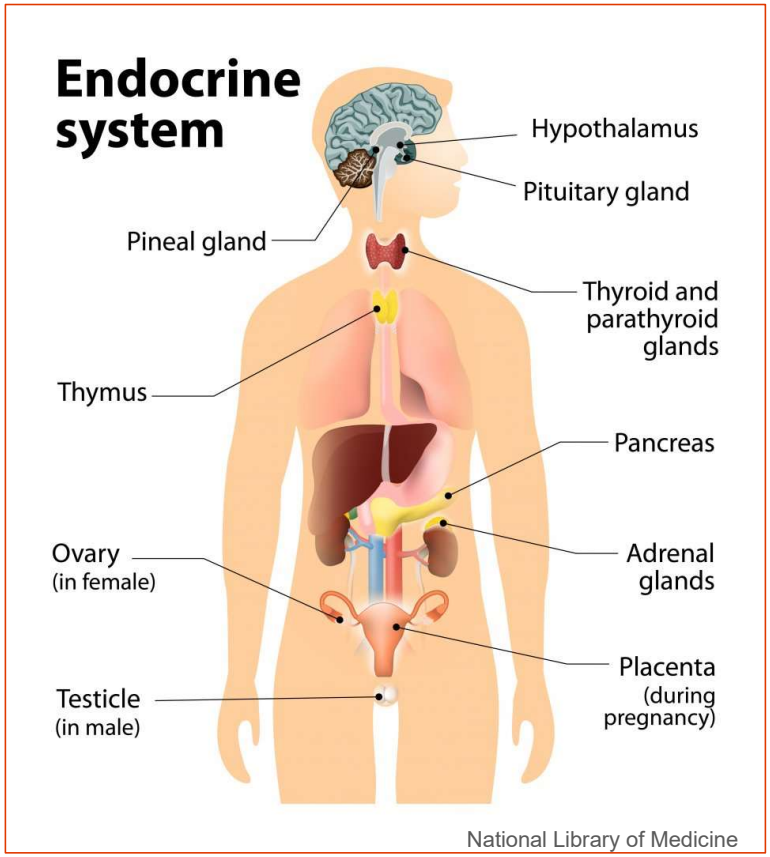
Hormones act as chemical messengers that are released into the blood stream to act on an organ in another part of the body.

Hormones control or regulate many biological processes including:

- Blood sugar control (insulin) and metabolism
- Differentiation, growth, and function of reproductive organs (testosterone and estradiol)
- Reproduction
- Body growth and energy production (growth hormone and thyroid hormone)
- **Mood,** bonding, aggression

About 5-32% of people in the US have an endocrine disorder. Of these, up to 25% have both a mood and an endocrine disorder. (>minoritized pop.)

Stabilizing both conditions is necessary for health, well-being and reducing ER visits and hospitalizations.



National Library of Medicine

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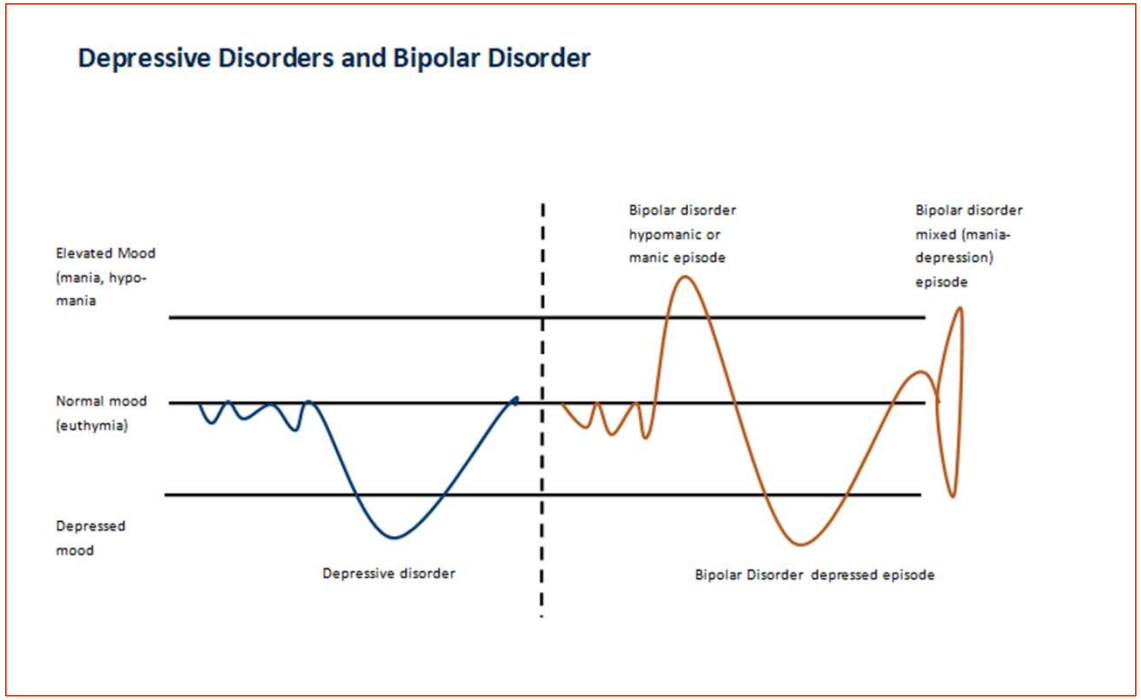
Mood Disorders Overview *********

- **Mood disorders** are a category of mental illnesses in which a person's mood is outside of the "normal mood" state. (NIMH 2023)
- In the US, 1 in 5 people (21%) will have a mood disorder in their lifetime. (Harvard 2017)
- Mood disorders are caused by a combination of genetics, life experiences, and/or the use of substances, medications, and/or the presence of medical conditions.

Key Takeaway

- Many people have mood disorders
- There are multiple causes that lead to difficulty in leading healthy and happy lives



National Institute of Mental Health (NIMH) 2023: Any Mood Disorders https://www.nimh.nih.gov/health/statistics/any-mood-disorder

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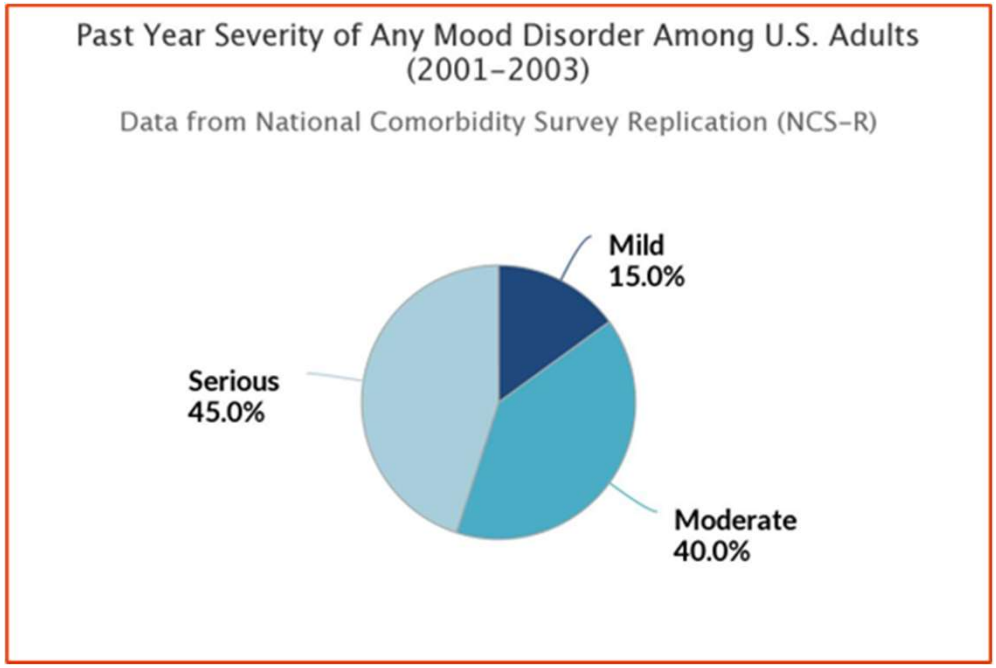
Mood Disorders Overview

- **Common mood disorders include:**
  - Major Depressive Disorder
  - Persistent Depressive Disorder (Dysthymia)
  - Bipolar Disorder-
- **Assessing Depression:**
  - PHQ-2 (screening), PHQ-9
- **Assessing Bipolar Disorder:**
  - Rapid Mood Screener (RMS)
  - Mood Disorders Questionnaire (MDQ)

Key Takeaway

- Major Depression and Bipolar are the two most common mood disorders
- Anyone can do an initial assessment to determine if follow-up is needed using the tools listed



National Institute of Mental Health (NIMH) 2023: Any Mood Disorders
https://www.nimh.nih.gov/health/statistics/any-mood-disorder

Mood and Endocrine Disorders

Endocrine Disorders	Effect on Mood
Diabetes	Depressed Mood
Hyperthyroidism (high thyroid)	Elevated Mood
Hypothyroidism (low thyroid)	Depressed Mood
Cushing's Disease (high cortisol)	Elevated Mood
Addison's Disease (low cortisol)	Depressed Mood
PMDD (low estrogen)	Depressed Mood
Postpartum Depression (low estrogens, progesterone + other risk factors	Depressed Mood
Menopause (low estrogen)	Depressed Mood
Andropause (low testosterone)	Depressed Mood
Low Vitamin D	Mixed Mood

Depression	
Mania-hypomania	
Bipolar and depression	

Key Takeaway

- Thyroid disorders can cause mood changes or worsen mood disorders

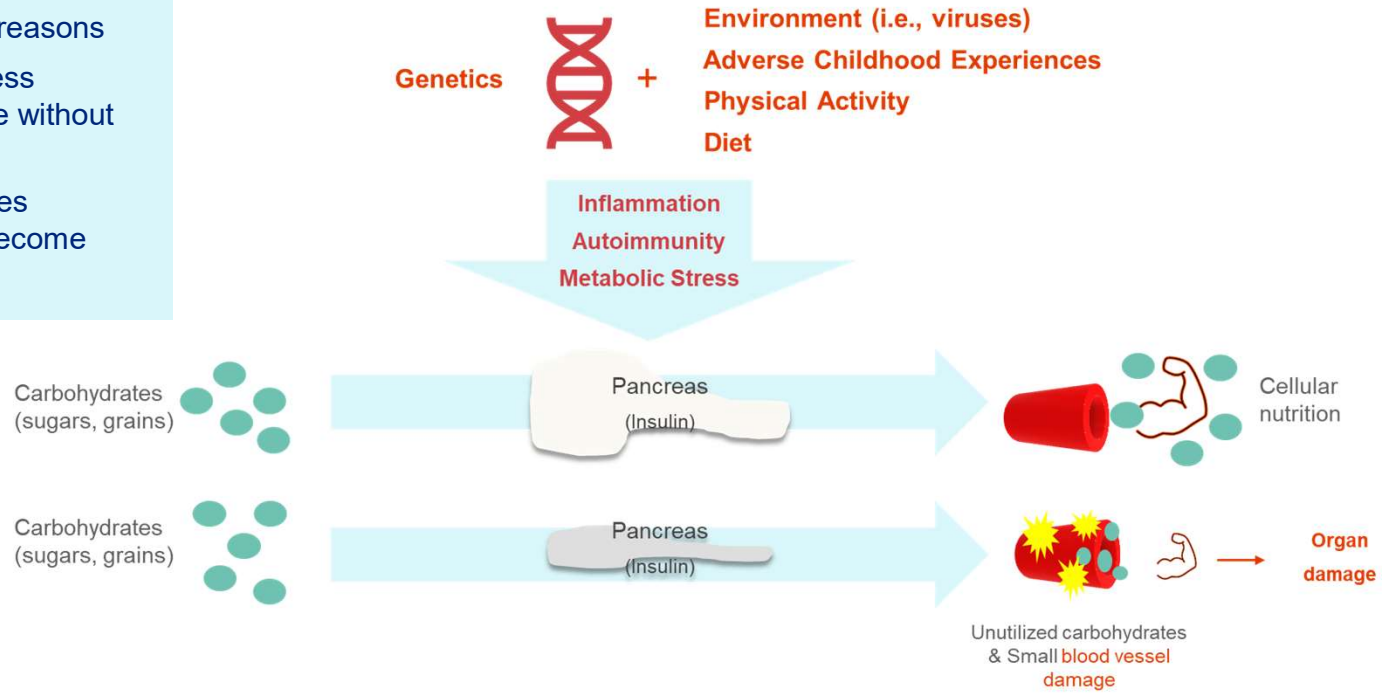
Salvador, J. et al., (2019). Endocrine Disorders and Psychiatric Manifestations. In: Portincasa, P., Frühbeck, G., Nathoe, H.M. (eds) Endocrinology and Systemic Diseases. Endocrinology. Springer, Cham.

Diabetes

Diabetes Mechanism Overview

Key Takeaway

- People develop diabetes for multiple reasons
- Individuals with diabetes do not process carbohydrates the same way as those without diabetes.
- Being diagnosed with diabetes requires monitoring of carbohydrates, which become sugar and can damage the organs



Diabetes Overview

8th leading cause of death in the US

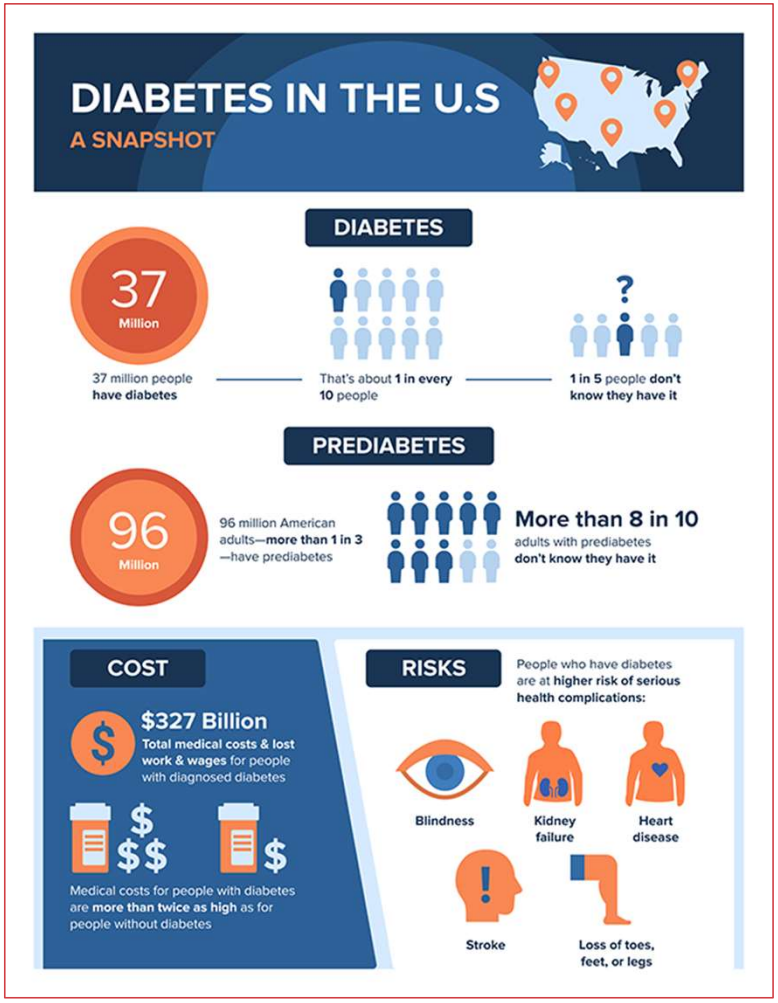
No.1 cause of kidney failure, limb amputations and adult blindness

Types of Diabetes:

- **Type 1:** 5-10% of persons diagnosed with diabetes
  - Cause: Autoimmune
- **Type 2:** 90% of persons diagnosed with diabetes
  - Cause: Genetics and lifestyle
- **Gestational:** During pregnancy
- **Pre-diabetes:** 1/3 adults

Screening and monitoring:

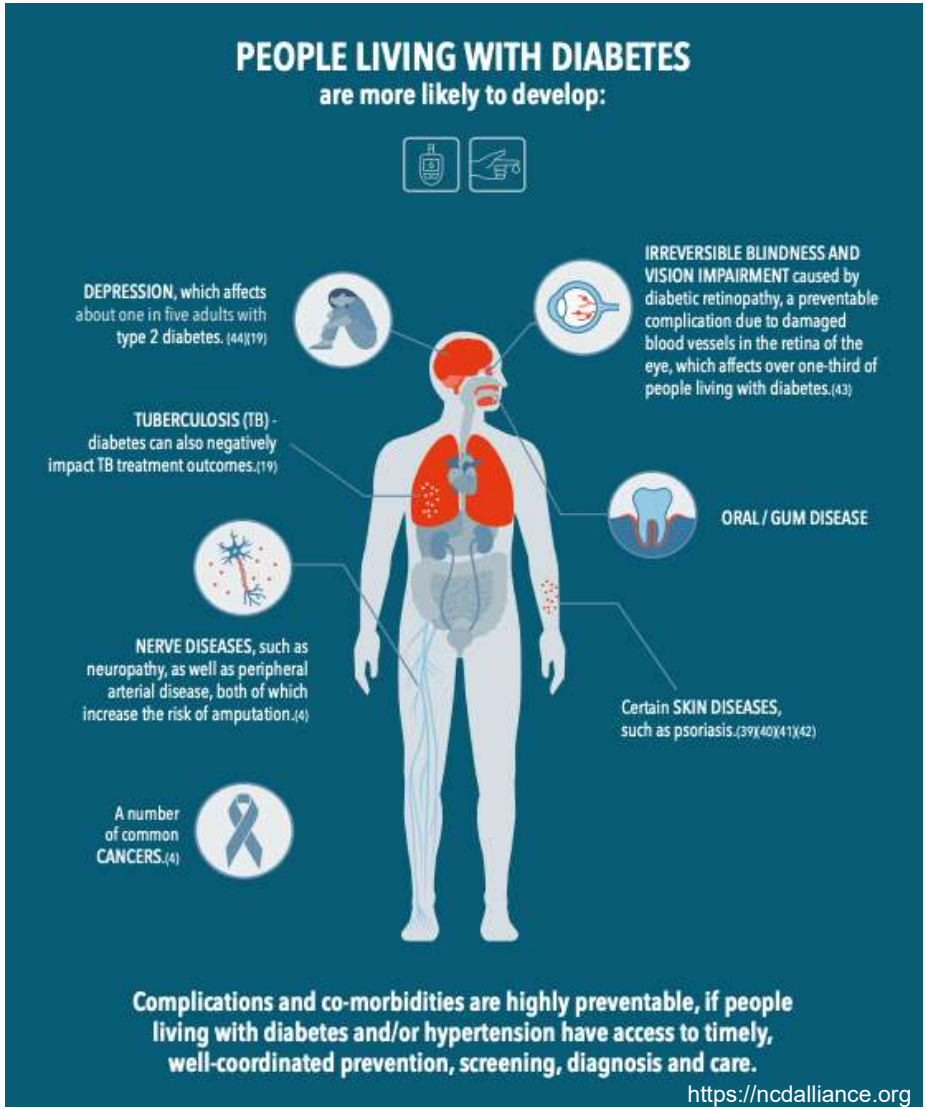
- Fasting blood sugar (FBS)
- Hemoglobin A_1C (HgA_1C) – ***Key to ensuring health of kidneys and other organs***



https://www.cdc.gov/diabetes/basics/diabetes.html#:~:text=More%20than%2037%20million%20US%20adults%20have%20diabetes%2C,adults%20diagnosed%20with%20diabetes%20has%20more%20than%20doubled.

Complications of Diabetes

- Depression
- Tuberculosis
- Nerve Disease
- Cancer
- Blindness/Vision Impairment
- Oral/Gum Disease
- Skin Diseases
- Poor Circulation
- Neuropathy (lack of feeling/tingling)
- High Blood Pressure
- Obesity



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How Do You Help a Member with Diabetes?

Category	Items	Staff Actions
Providers (Some members may have one or more provider)	• Primary Care • Endocrinologist • Podiatrist • Ophthalmologist • Nutritionist • Nephrologist	• Coordinate appointments as needed
Home Equipment	• Blood Sugar Meter • Lancets • Testing Strips	• Inquire if member has necessary equipment to monitor Diabetes
Medication	• Oral Medications • Insulin • Insulin Pump	• Ask questions about treatment methods • Verify there are no challenges with obtaining medications
Skin Care	• Mild Shampoo • Antibiotic Cream (Dr approved) • Moisturizing soap • Skin Moisturizer	• Ask if member has items needed to maintain good skin care
Foot Care	• Toenail scissors • Emery Board • Mirror • Seamless Socks	• Ask if member talks to providers about foot care • Ask if member has items needed to maintain good foot care
Dental Care	• Fluoride Toothpaste • Dental Floss • Antiseptic mouthwash	• Ask if member has had dental appointment • Ask if member has items needed for good oral hygiene
Emergency Preparedness	• Medications • Provider Contact Information • Flashlight / Batteries • List of current medication dosages and times taken • Copy of Insurance Card	• Assist member with preparing for a possible emergency

Bipolar Disorders (Bipolar Spectrum Conditions)

Bipolar disorder is a mood disorder characterized by recurrent ***episodes*** (days-weeks) of intense fluctuations in the person's mood.

About 0.6-2.4% of the population suffer from a bipolar disorder in their lifetime.

Onset: Usually diagnosed in their 20's-30's. Both genders are affected equally, but women have more mixed and depressive states, comorbid eating and alcohol use disorders then men.

Manic Episodes: Distinctive period of abnormally elevated, expansive or irritable mood, decrease need for sleep, impulsivity, agitation and hyper focused on an activity. Mania may present with psychosis. **Hypomanic episodes** are episodes less intense than manic episodes but with the same symptoms.

Depressive Episodes: Persistent sadness or a lack of emotions, and/or a lack of interest or pleasurable activities, changes in sleep, appetite, energy, hopelessness, helplessness, guilt, sometimes suicidality. May present with psychosis.

Mixed episodes manic and depressive symptoms present at the same time.

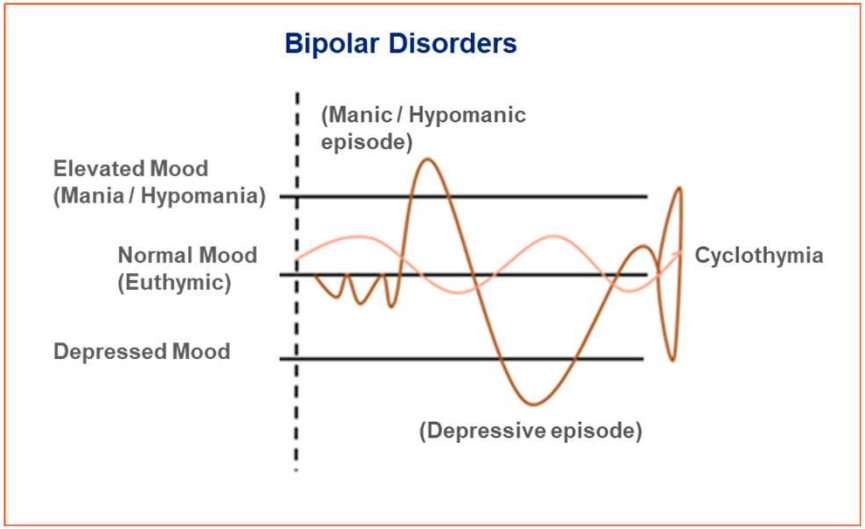
Bipolar I: Mania-depression; **Bipolar II** Hypomania-depression.

Cyclothymia: hypomania and mild depression fluctuating over a period of years.

Medication, substance, or medical condition-induced manic-depressive episodes.

These symptoms affect one's ability to function, and care for one-self. The most common bipolar state is depression.

Screening and monitoring: Rapid Mood Screener



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Key Takeaway

- Bipolar Disorders are episodic fluctuations in mood
- Persons with bipolar who are depressed and returning to normal mood state are at higher risk for suicide

Bipolar Disorder & Impact on Endocrine Disorders

Bipolar Disorders (Bipolar Spectrum Conditions) Cont.

At Risk Populations:

- **Genetic:** Those with relatives with mood disorders or schizoaffective disorders.
- **Experiences:** Adverse Childhood Experiences (ACE's), recent life events, substance use disorders.
- **Medications & Drugs:** steroids, stimulants, marijuana.
- **Medical:** Hyperthyroidism, Cushing's Disease (high cortisol), TBI, postpartum psychosis.

Patients with BPD have…

- Poor Quality of Life, loos productivity and high medical-BH spent.
- They die 9-17 years younger (cardiovascular, suicide, accidents)
- Cardiovascular disease, respiratory dis., thyroid dis., DM Type 2, obesity, and hepatitis.
- Comorbid SUD's 30-70% (incl. nicotine).
- Suicide attempts 20x in BPD adults and 50X in BPD adolescents.
- **Suicide risk:** previous suicidal acts, depression, mixed–agitated-depressed moods, rapid mood-shifts, impulsivity, and co-occurring substance abuse.

Image NAMI.org 2020

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Icick, R. at el., (2019). Tobacco smoking and other substance use disorders associated with recurrent suicide attempts in bipolar disorder. *Journal of affective disorders*, *256*, 348-357.

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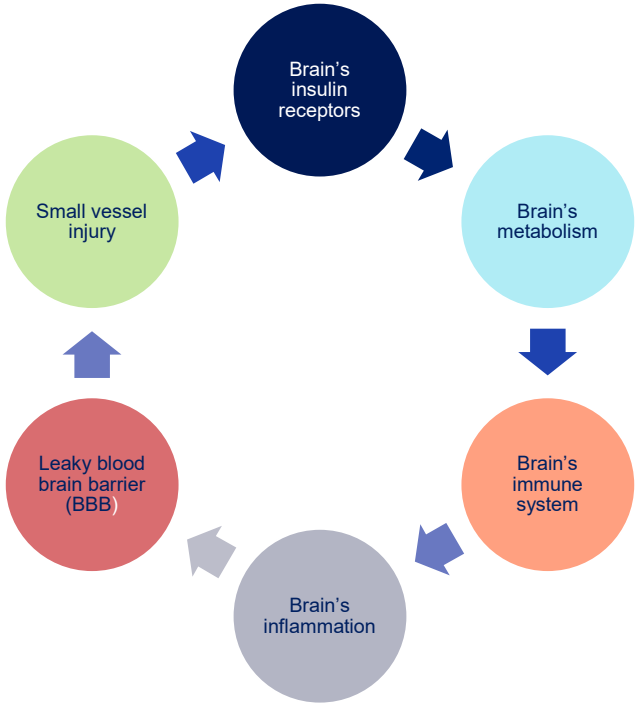
Bipolar disorder and Metabolic-Systemic Effects -Joint Mechanisms

DIABETES AND METABOLIC ANOMALIES

- Insulin resistance
- Small blood vessels injury
- Dysregulation of brain's metabolic processes
- Increase energy demand (mania)
- Appetite dysregulation
- Obesity
- Increased cardiovascular disease
- Increased risk of stoke
- Poor health behaviors
- Early complications: amputations, blindness, kidney failure



BIPOLAR DISORDERS

- Worsening of bipolar states & frequency *(neuroprogression)*
- Poorer response to treatment
- Alterations of circadian rhythms: sleep, appetite
- Worse neurocognitive impact
- Frequent re-hospitalization
- Heightened stress
- Impaired function & increased risk
- Decreased self care
- Decrease care for DM
- Impaired relationships

Sylvia, LG., et al., (2015). Medical burden in bipolar disorder: findings from the Clinical and Health Outcomes Initiative in Comparative Effectiveness for Bipolar Disorder study (Bipolar CHOICE). *Bipolar disorders*, *17*(2), 212-223.

Cuperfain, AB., et al (2020). Overlapping mechanisms linking insulin resistance with cognition and neuroprogression in bipolar disorder. Neuroscience & Biobehavioral Reviews, 111, 125-134.

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Diabetes and Bipolar Disorder

- One in ten members with Bipolar Disorder have Diabetes
- Bipolar Disorder increases Diabetes risk 2-3x.
- **Diabetes & Bipolar**
  - Greater likelihood for severe obesity
  - Poor self care:
    - Diet, physical activity
    - Glucose monitoring
    - Attending medical appointments
  - Earlier and more severe diabetic complications
  - Poor quality of life
  - Premature death
  - Increased health care costs
- **Monitoring**: Fasting Blood Sugar, Hb_1AC, lipids, BMI
  PHQ-9 (depression/suicidality)
- **Screening**: Suicidality, depression, SUD's, diabetic care

Sylvia, LG., et al., (2015). Medical burden in bipolar disorder: findings from the Clinical and Health Outcomes Initiative in Comparative Effectiveness for Bipolar Disorder study (Bipolar CHOICE). *Bipolar disorders*, *17*(2), 212-223.

Cuperfain, AB., et al (2020). Overlapping mechanisms linking insulin resistance with cognition and neuroprogression in bipolar disorder. Neuroscience & Biobehavioral Reviews, 111, 125-134.

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Depression & Impact on Endocrine Disorders

Depression

Depressive disorders are mood disorders that have common characteristics including persistent sadness or a lack of emotions, and/or a lack of interest or pleasure in previously rewarding or enjoyable activities. (WHO 2023)

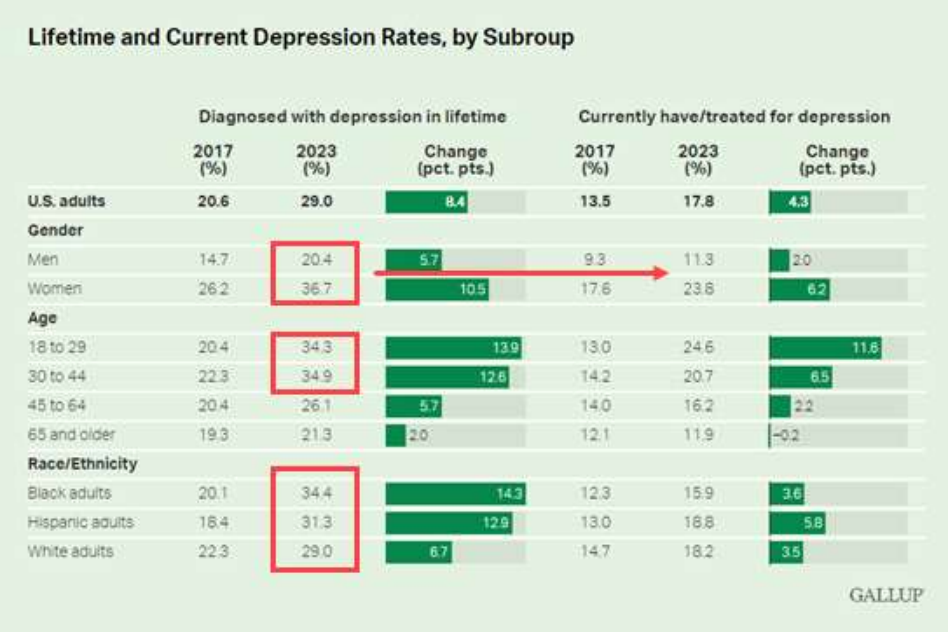
These symptoms affect a person's ability to fully function and care for one-self.

Depression includes a cluster of symptoms including:

- Mood: sad, irritable
- Cognitive: decreased attention, hopelessness, helplessness
- Impaired sleep and appetite (too little/too much)
- Low energy and low motivation
- Risk: Suicidal thoughts and acts
- Screening and monitoring: PHQ-2, PHQ-9

At Risk Populations:

- Those with Adverse Childhood Experiences (ACE's), chronic medical conditions, substance use disorders, anxiety disorders, & low socio-economic status,
- Immigrants, minorities, and women



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https://news.gallup.com/poll/505745/depression-rates-reach-new-highs.aspx

Post Partum Depression (PPD)

PPD is defined as moderate to severe depression within the first year after giving birth and often occurring within the first 3 months.

- PPD affects an estimated 13% to 19% of childbearing women.

Significant risk factors for PPD include high life stress, lack of social support, current or past abuse, prenatal depression, poor social support, and marital or partner dissatisfaction.

The 2 strongest risk factors were prenatal depression and current abuse/violence.

- PPD interferes with mother-child bonding, care, and could present with psychosis and thoughts of harming the baby.
- Health care providers can use the summary of risk factors for PPD to target prevention and screening strategies.

Recommended activities for pregnant and postpartum members

1. Link member with care during and after their pregnancy.
2. Connect the member to Healthy First Steps
3. Help schedule newborn well-child visits.
4. Look for risk factors: history of depression, SUD's, trauma, current abuse, domestic violence.
5. Quantify depression or anxiety using the PHQ-9 and/or GAD-7.
6. Discuss use of birth control immediately following birth to allow the member to control when they are ready to be pregnant again in the future.
7. Jointly develop a crisis plan including early warning signs and calling 988 during a BH crisis.
8. Assist the member in setting up childcare and/or opportunities for self-care and breaks from childcare.

US Department of Health and Hospitals, Office of Woman's Health. https://www.womenshealth.gov/mental-health/mental-health-conditions/postpartum-depression
Hutchens, B. F., & Kearney, J. (2020). Risk factors for postpartum depression: an umbrella review. Journal of midwifery & women's health, 65(1), 96-108.
Bromberger JT et al., Mood and menopause: findings from the Study of Women's Health Across the Nation (SWAN) over 10 years. Obstet Gynecol Clin North Am. 2011 Sep;38(3):609-25.

Diabetes and Depression

- Each increases the risk for the other… several times
- **Diabetes & Depression cause:**
  - Poor or worsening blood sugar control
  - Greater likelihood for severe obesity
  - Poor self care:
    - Diet, physical activity
    - Glucose monitoring
    - Attendance of medical appointments
  - Earlier and more severe diabetic complications
  - Poor quality of life
  - Premature death
  - Increased health care costs

Vanderlip, ER et al (2014). Depression among patients with diabetes attending a safety-net primary care clinic: relationship with disease control. Psychosomatics, 55(6), 548-554.

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Job Aids

Mood Disorder Management

Key Takeaway

To help you support members with mood disorders, we have created 2 job aids for your reference:

- Depression Management
  - Includes the PHQ-9
- Bipolar Disorder
  - Includes the Rapid Mood Screener

Depression Management

PHQ-9 Score	Provider Action	Patient Action	CHW Action
<5 Low	• Monitor for increase in symptoms	• Ensure adequate sleep, food, and exercise • Limit alcohol use	• No action required
5 - 9 Mild	• Provide education • Consider medication • Refer to BH therapy • Follow-up in 6-8 weeks • Rule out other conditions	• **Above +** • Schedule appointment with PCP and/or therapist • Keep appointments	• Assist with scheduling appointment with PCP or BH provider • Ensure transportation to appointments
10 - 19 Moderate	• Prescribe medication • Refer for BH therapy • Follow-up: 6 weeks	**All Items Above +** • Take medication as prescribed • Contact provider with questions or side effects • Keep appointments • Contact Care Navigator	**All Items Above +** • Refer to BHA for follow-up • Provide 988 info • Refer to MH support
20 - 27 Severe	• Prescribe medication • Evaluate for harm to self or others	• Same as above	**All Items Above +** • Call BHA/MD directly
• Suicidal thoughts (SI) • Homicidal thoughts (HI)	• Send to ER immediately	• Contact 911 • Call 988	• Contact 911

PHQ-9

Question: In the past 2 weeks, how often have you been bothered by the following items?	Never	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless?	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
4. Feeling tired or having little energy?	0	1	2	3
5. Poor appetite or overeating?	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
8. Moving or speaking so slowly that other people notice? Or the opposite—being so fidgety or restless that you are moving around a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself?	0	1	2	3
Total				

Bipolar Disorder Management

RMS Response	Provider Action	Patient Action	CHW Action
Yes to Question 1 or 2 only	• Monitor for increase in symptoms	• Ensure adequate sleep, food, and exercise • Limit alcohol use	• Review Depression Management & PHQ-9
Yes to any Question 3 - 6	• Provide education • Consider medication • Refer to BH therapy • Follow-up in 6-8 weeks • Rule out other conditions	• **Above +** • Schedule appointment with PCP and/or therapist • Keep appointments	• Assist with scheduling appt. with PCP or BH provider • Ensure transportation to appointments • Refer to MH support

Rapid Mood Screener (RMS)	Yes	No
1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?		
2. Did you have problems with depression before the age of 18?		
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?		
4. Have you ever had a period of at least 1 week (7 days) during which you were more talkative than normal with thoughts racing in your head?		
5. Have you ever had a period of at least 1 week (7 days) during which you felt **any** of the following? • Unusually happy, unusually outgoing or unusually busy/energetic?		
6. Have you ever had a period of at least 1 week (7 days) during which you needed much less sleep than usual (generally 2-4 hours and feel rested)?		

Language Line	Transportation Provider
To access the Language Line when speaking with a member who has a primary language that is different from your own, do the following:	To set up Non-Emergency Transportation for a member to any medical or behavioral appointment:
1. Dial: • Using Cell Phone: 844-888-4454 • Using Omni Choose: Language Interpretation Line 2. Enter your 9-digit Employee ID • (If less than 9-digits, include leading "0s") 3. Select the language needed for translation • If not known—the call will connect to a live person who can help 4. You will be connected to an interpreter 5. Be ready to provide the following: • Medicaid ID # • State of Residence • (If unable to determine, use the interpreter to obtain this information from the member)	Contact the provider at least 48 hours in advance and provide the following information: • Where you need to go (Address) • What tine you need to arrive • If wheelchair accessible vehicle is required **Florida**: • Modivcare MMA: 1-866-372-9891 **Louisiana**: • UnitedHealthcare: 1-866-726-1472

Endocrine Disorders Job Aid

Key Takeaway

Included in your job aids are additional information specific to:

- Diabetes Management
- Thyroid Management
- Home Medical Equipment (DME) required to support care for these (and other) conditions

Supplies / DME by Condition

Condition or Reason	Supplies / DME	Is Item Necessary for
Asthma	• Nebulizer & tubing	• Yes
Bathroom Safety	• Shower bench/chair • Shower rails • Toilet seat riser	• No • No • No
CHF	• Bathroom scale • Blood pressure monitor	• Yes • Yes
COPD	• Supplemental oxygen & tubing • Nebulizer & tubing	• Depends on stage of disease • Yes
Diabetes	• Glucometer, testing strips, & lancets	• Yes
Mobility	• Walker / Cane • Wheelchair (manual or electric) • Transfer bench • Electric scooter	• Depends on member level of mobility and need • Wheelchair/Scooter require additional evaluations

*All items should be ordered by PCP and generally require a prescription being sent to a local pharmacy or DME provider

*Prior authorization ALWAYS required for items more than $500

Diabetes Management

Blood Sugar	Provider Action	Patient Action	CHW Action
<60 Too Low	• Provide sugar & monitor • If in hospital, use IV dextrose	• Eat sugar (drink, fruit, or candy) • Review meds & dosage • Schedule urgent visit with PCP	• Provide sugar (drink, candy, or fruit) • Contact 911 for transport • Stay with member until EMS arrives
60 - 120 Normal	• Evaluate at next appointment	• Ensure adequate sleep, food, and exercise • Limit alcohol use	• Ensure appointment with PCP • Ensure transportation to appointments
121 - 250 Elevated	• Provide education • Review diet and medication • Obtain A1c • Follow-up: 6 weeks	All Items Above + • Schedule appointment with PCP and/or endocrinologist • Keep appointments	All Items Above + • Ask member if they understand how and when to take medication • If no, refer to BHA
251 - 350 Moderately High	All Items Above + • Review blood sugar • Follow-up: 1-2 weeks	All Items Above + • Take medication as prescribed • Contact provider with questions or side effects • Contact Care Navigator	All Items Above + • Refer to BHA for follow-up • Schedule follow-up within 3-7 days
351 - 450 Very High	• Prescribe Insulin • Provide hydration • Evaluate need for urgent care	• Same as above	All Items Above + • Call BHA/MD directly • Refer to Disease Management care team
450+ Dangerous	• Send to ER immediately	• Go to ER or Contact 911	• Contact 911 for transport

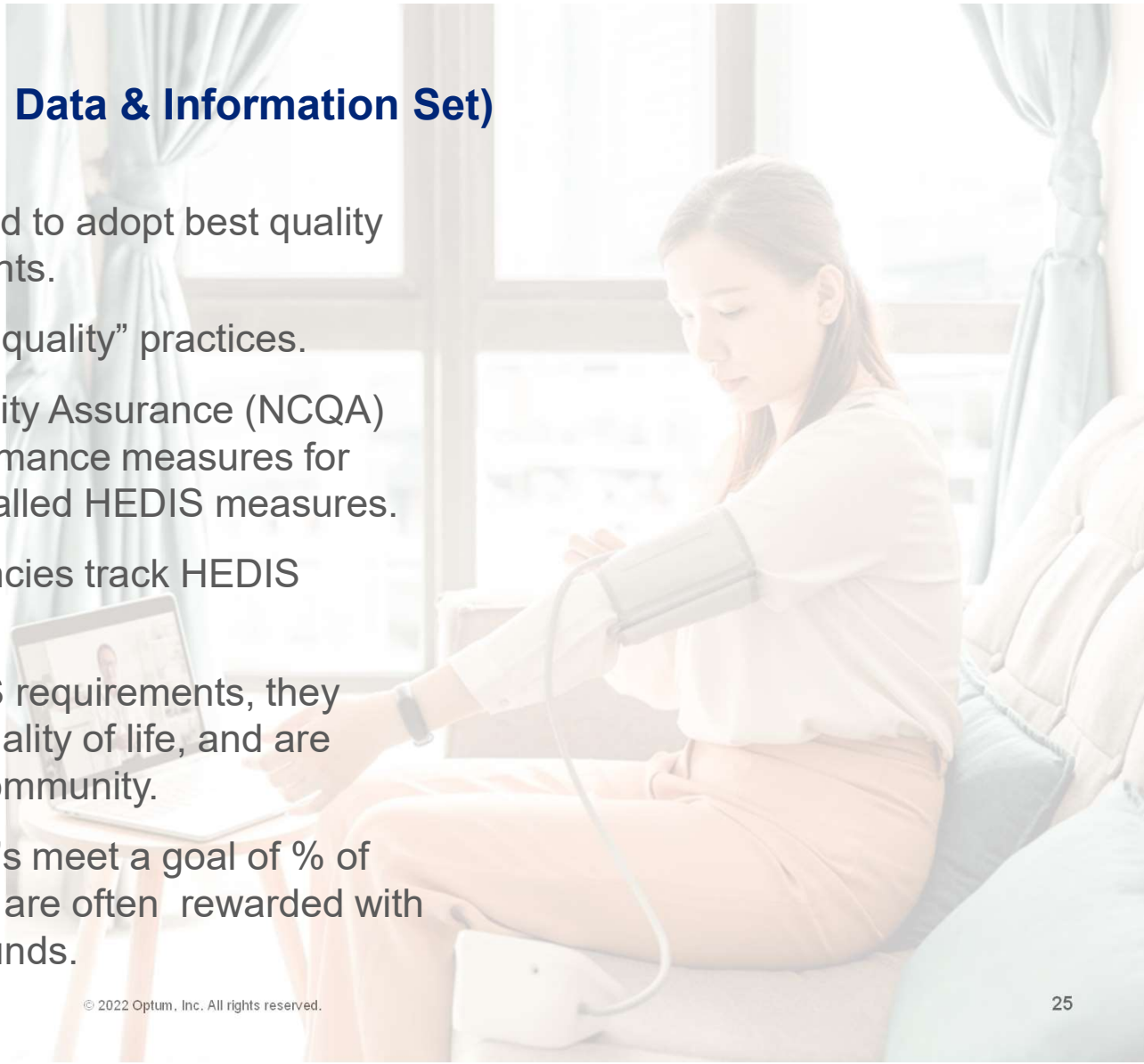
Thyroid Disorders Management

	Hypothyroidism (Slow Metabolism)	Hyperthyroidism (Fast Metabolism)
Symptoms	• Fatigue • Weight gain • Trouble handling cold temperatures • Joint/muscle pain • Dry skin or dry thinning hair • Slowed heart rate • Depression	• Weight loss despite an increased appetite • Racing heart rate • Being nervous, irritable, or have trouble sleeping • Too much energy / Not enough energy • Shaking hands, muscle weakness • Sweating or trouble handling heat • Swelling of the neck
*Provider Action	• Schedule routine follow-up • Prescribe Medications	• Order lab testing as needed to monitor thyroid level • Refer to Endocrinologist as needed
*Patient Action	• Take medication as prescribed • Monitor weight, mood, & energy	• Schedule routine follow-up with PCP and • Report any changes in weight, mood, or energy
*CHW Action	• Ensure member has PCP to monitor • Ensure transportation to appointments	• Discuss importance of taking meds as prescribed • Discuss any changes in in weight, mood, or energy that should be reviewed with PCP
*Contact PCP Immediately if:	• New masses or lumps on neck • Neck tenderness/swelling with increased heart rate, racing thoughts, or confusion • Sudden changes in weight, mood, or energy	• Changes in demeanor or personality • Any infection that causes rapid weight gain or loss • Sudden mania or depression • Significant change in eyes (bulging) • High Fever (104-106 degrees)

* All actions apply to both Hypothyroidism AND Hyperthyroidism

HEDIS

HEDIS (Healthcare Effectiveness Data & Information Set)



Healthcare providers are encouraged to adopt best quality practices when caring for their patients.

- Each specialty has a set of “best quality” practices.
- The National Committee for Quality Assurance (NCQA) puts together a set of best performance measures for different specialties. These are called HEDIS measures.

Health plans, state and federal agencies track HEDIS measures.

- When members complete HEDIS requirements, they typically do better, have better quality of life, and are healthier and live longer in the community.
- When Health Plans and provider’s meet a goal of % of HEDIS activities performed, they are often rewarded with higher reimbursements, and/or funds.

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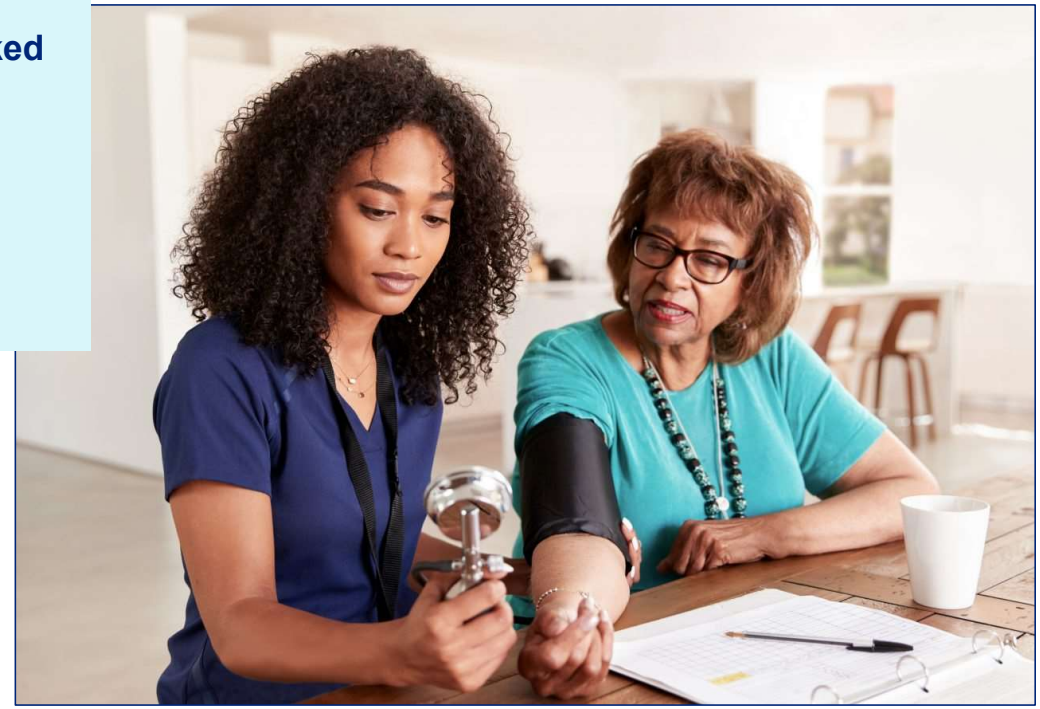
HEDIS

Key Takeaway

1. **Familiarize yourself with HEDIS measures tracked by WHE.**
2. **Identify and help resolve member's barriers completing activities related to HEDIS.**
3. **The following slides discuss the HEDIS Quality Measures tracked by WHE.**

https://www.uhcprovider.com/content/dam/provider/docs/public/reports/path/2023-PATH-Reference-Guide.pdf



Adult Access to Preventive/Ambulatory Health Services (AAP)

This measure assesses whether adult members had a preventive or ambulatory visit with their PCP.

Health care visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise. These visits also can help them identify or address acute issues or manage chronic conditions.

Description:

Percentage of members ages 20 and older who had an ambulatory or preventive care visit during the calendar year.

Recommended activities:

1. Inquire with the Health Plan or the provider if your member has had a preventive outpatient (ambulatory) visit with her/his PCP.
2. If not, assist the member in scheduling an annual exam with lab work.
3. Discuss with the member the importance of this visit and help remove barriers for testing including reminders, transportation and others.

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Antidepressant Medication Management (AMM-A)

Description:

Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications.

Two rates are reported:

- Acute Phase: Adults who remained on an antidepressant medication for at least 84 days (12 weeks).
- Continuation Phase: Adults who remained on an antidepressant medication for at least 180 days (6 months).

Recommended Activities:

1. If the member is taking antidepressant medications, ask about adherence:
   - How many days in the last week have you taken your medications for depression?
2. If the member is not taking their medication daily. Find out why…
   - Does the member have access to a provider?
   - Do they have a regular pharmacy to fill medication?
   - Do they know why they should take their medication daily?
   - Do they have difficulty remembering to take medications?
   - Do they experience side effects?
3. For any of these reasons, help figure out methods to solve or reach out to your BHA/ICT to identify support

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Diabetes Control (4 measures)

Blood Pressure Control (BPD):

- Percentage of members ages 18–75 with diabetes (Types 1 and 2) who have a blood pressure (BP) reading of <140/90 mmHg in the measurement year.

Eye Exam for Patients With Diabetes (EED)

- Percentage of members ages 18–75 with diabetes who had a retinal/dilated exam in the measurement year, negative retinal/dilated exam in the previous year, OR bilateral eye enucleation any time during their history.

Hemoglobin A1c Control for Patients With Diabetes (HBD)

- HbA1c test must be performed during the measurement year and documented.

Kidney Health Evaluation for Patients with Diabetes (KED)

- Percentage of members ages 18–85 with diabetes who had a kidney health evaluation in the measurement year.
- Both an eGFR and a uACR test are required on same or different dates of service.

Recommended Activities:

1. Inquire and support member's activities to control blood pressure: low sodium diet, physical activity, medication adherence, and obtain testing.
2. Encourage and help coordinate PCP, specialists, and ophthalmology visits, wound care, and DME for diabetic members:
   - Ensure member has home blood pressure monitor
   - Annual **physical exam with lab work** and evaluation for peripheral neuropathy by PCP.
   - Annual comprehensive foot examination.
   - Comprehensive foot examination and care at every visit for those with vascular and/or foot ulcers/amputations.
   - Annual eye exam
3. Remind provider's office to schedule missing visits or activities.
4. Assist with transportation and other needs.

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Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)

Background

Adults with serious mental illness commonly treated with antipsychotic drugs, have up to two-times-greater prevalence of type 2 diabetes, high cholesterol, high blood pressure, and obesity.

These conditions are major contributors to cardiovascular disease. Cardiovascular disease is the leading cause of death for individuals with SMI.

HEDIS SSD:

Percentage of members ages 18–64 with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Recommended Activities:

1. Determine if the member is currently and/or has previously taken antipsychotic medication.
2. Inquire with the Health Plan or the provider if your member with SMI has had laboratories to screen for diabetes (HbA1c) in the calendar year.
   - If not, assist the member in scheduling an HbA1c test.
3. Discuss with the member the importance of this test and help remove barriers for testing including reminders, transportation, fasting before the test, and other requirements from the provider.

Morrato EH et al., Metabolic Screening After the American Diabetes Association's Consensus Statement on Antipsychotic Drugs and Diabetes. *Diabetes Care* 1 June 2009; 32 (6): 1037–1042.

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Other important HEDIS Measures

Follow-Up After Hospitalization for Mental Illness (FUH)

- Members 6 years old and older who were hospitalized for mental illness or intentional self-harm and had a follow-up visit **with a mental health provider** within 7 and 30 days after discharge.
- **Visits can be telehealth with a LMHP.**

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

- Any member discharged from acute inpatient, residential treatment or detox with a principal diagnosis of substance use disorder, and had a follow up visit **for SUD** within 7 and 30 days after discharge.
- **Visits can be with PCP, SUD, or BH provider**

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

- Members 6 years and older who had an ED visit for mental illness or intentional self-harm, who then had a follow-up visit for mental illness within 7 and 30 days after discharge from the ED.
- **Visits can be with PCP or BH provider**

Recommended Activities:

1. Ensure the member has a scheduled appointment with the **correct provider type** within 7 days of discharge.
2. If not, assist the member in scheduling the visit.
3. Discuss the importance of attending the appointment and help remove barriers including reminders, transportation and others.
4. Jointly develop a Crisis Plan including the use of 988 for mental health emergencies

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https://ncdalliance.org