HEDIS Antidepressant Measures Biased by 2013 Revision

Most of the nation’s health plans and many provider groups use Healthcare Effectiveness Data and Information Set (HEDIS) measures to demonstrate the quality of the care they provide.1 Included among the HEDIS measures is the Antidepressant Medication Management (AMM) metric. The AMM metric is designed to assess the adequacy of patients’ prescription fill adherence during a 12-week acute phase and a 6-month continuation phase after a new diagnosis and treatment.2

For several years, our institution, the Massachusetts General Physicians Organization—a large (2,412 physicians) multispecialty medical group affiliated with a large urban academic quaternary care hospital—has invested in various efforts to improve the quality of depression care. Despite continuing efforts, our performance on the AMM metric has remained below average. We set out to better understand the drivers of our performance by reviewing the electronic medical records (EMR) of our patients who were not meeting the measure.

We identified 292 patients who had their primary care provided at our medical center and were not meeting one or both of the AMM metrics in 2013. A review of our EMR showed that 101 (34.5%) of these patients had received a diagnosis of depression and/or treatment with an antidepressant medicine in the year prior to the index episode.

The HEDIS AMM measure was designed to include only patients with new diagnosis and treatment of depression, in order to provide a reasonably homogenous cohort of patients, so the performance of providers treating this cohort could be compared. Patients with multiple episodes of depression by definition have “chronic depression” and may differ from the cohort of those with new, single episodes. For example, patients with chronic depression may be more likely to be nonadherent to antidepressants than newly diagnosed patients.3,4 A lower HEDIS score might therefore be expected for patients in this cohort. Our institution is a recognized center for excellence in psychiatric care and has made an effort to improve rates of depression recognition and treatment.5 Thus, we may have higher rates of depression recognition and treatment than other health care systems and may have a cohort enriched with patients with chronic depression. Failing to separate these patients from the standard cohort with new onset single episode depression may explain, at least in part, why our institutional rates on the HEDIS AMM are below average.

Previous critiques of the HEDIS AMM have addressed various limitations in the measure but have not addressed issues regarding prior treatment of depression.6,7 For example, while in 2013 the AMM criteria were revised to exclude patients with a negative diagnosis history, the requirement that patients have a 90-day negative medication history for antidepressants was retained.8 Our observations suggest that this approach may inadvertently produce a selection bias. This bias occurs because new patients are measured without regard to adherence, while inclusion of previously treated patients is related to their adherence history. Previously treated patients are excluded if adherent but included if their nonadherence results in a negative medication history.

Our findings suggest that further revisions in the exclusion criteria may be warranted and/or that the limitations of the measure be carefully considered when the results are displayed. Perhaps the measure should extend the search for evidence of prior antidepressant use beyond the current 90 days before the index episode or screen for evidence of a prior diagnosis of depression. Or, the measure might include all patients with any antidepressant use and/or depression diagnosis beyond the current 90-day cutoff. The limited observations provided here do not suggest how far back the cutoff should be extended; however, since we found evidence of prior treatment or diagnosis a year before the index episodes, studies that evaluate the question of extension of the “clean period” probably should look back a least a year to determine what the impact of including such patients on the measures sensitivity, specificity, and utility might be.

We hope that broader awareness of limitations in the HEDIS AMM metric will enable managed care professionals and providers to improve care for nonadherent patients, particularly where new and chronic episodes of depression may differentially benefit from different interventions. These findings suggest an opportunity to improve the AMM measures so that better measures can guide more effective improvement efforts and ultimately improve patient outcomes.

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