Depression Management in the Senior Population

2016 MSHO & MSC+ Health Plan Quality Improvement Project / Performance Improvement Project (QIP/PIP)

Presenters:
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Kayla Baufield, LSW & Cynthia Stevens, RN, Bluestone Physician Services
Lisa Benrud, PhD, Blue Cross and Blue Shield of Minnesota
This session is presented by a collaboration of Minnesota health plans working to improve depression management.
2016 QIP/PIP: Depression Management in the Senior Population

- **Goal:** Improve depression management, including medication adherence, among MSHO & MSC+ members
- **Timing:** Three year project (2016 – 2018)
- **Multiple Interventions:** Care Coordinator, Member, Provider
- **Outcome Measure:** HEDIS Antidepressant Medication Management Measure (medication adherence over 6 months)
- **QIP/PIP Collaborative:** Blue Plus, HealthPartners, Hennepin Health, Medica & UCare
Why Depression?

- One of the most common mental health conditions among older adults
- Often undiagnosed and undertreated
- Care coordinators can play an important role in identifying and addressing barriers to effective treatment
QIP/PIP Interventions

- **Care Coordinator:** Training & resources on identification and management of depression in seniors
  - Webinars/Presentations
  - Toolkit ([http://www.stratishealth.org/pip/antidepressant.html](http://www.stratishealth.org/pip/antidepressant.html))

- **Member:** Education & outreach

- **Provider:** Training & outreach
Today’s Session

A Pharmacist’s Perspective
- Common barriers to antidepressant medication adherence
- How pharmacists can help with the management of depression in seniors

Two Care Coordinators’ Perspectives
- A care coordinator’s role in working with seniors experiencing depression
- Identifying red flags, addressing depression in the care plan, working with interdisciplinary care teams
Antidepressant Use in the Elderly

Leann McDowell, PharmD
HealthPartners Pharmacy Resident
Background

- Risk of developing some physical illnesses is higher if depression remains untreated (e.g. CV disease, diabetes, stroke, Alzheimer’s disease)
- Patients with untreated depression are at a higher risk for worse outcomes (e.g. CV disease, hip fractures)
- Unclear whether treated depression will improve physical outcomes for comorbid diseases, but can improve quality of life
- Treatment can include medications, cognitive behavioral therapy (CBT), and/or electroconvulsive therapy (ECT)
Objectives

• Recognize medications that may cause depression or interact with antidepressants
• Identify three factors that may affect antidepressant adherence in elderly patients
• Describe the role of the MTM pharmacist in managing antidepressant medications for seniors
Antidepressants

**SSRI**
- Fluoxetine (Prozac)
- Sertraline (Zoloft)
- Paroxetine (Paxil, Brisdelle)
- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Fluvoxamine (Luvox)

**SNRI**
- Venlafaxine (Effexor)
- Desvenlafaxine (Pristiq)
- Duloxetine (Cymbalta)
- Milnacipran (Savella)
- Levomilnacipran (Fetzima)

**Serotonin modulators**
- Bupropion (Wellbutrin)
- Mirtazapine (Remeron)
- Vortioxetine (Brintellix; Trintellix)
- Trazodone (Oleptro)
- Vilazodone (Viibryd)
- Nefazodone (brand Serzone is not available in U.S.)

SSRI = selective serotonin reuptake inhibitors
SNRI = serotonin-norepinephrine reuptake inhibitors
# Antidepressants (slide 2)

**TCA = tricyclic and tetracyclic antidepressants**  
**MAOI = monoamine oxidase inhibitor**

<table>
<thead>
<tr>
<th>TCAs</th>
<th>MAOIs</th>
<th>OTC</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Amitriptyline</td>
<td>• Isocarboxazid (Marplan)</td>
<td>• St. John’s wort</td>
</tr>
<tr>
<td>• Amoxapine</td>
<td>• Phenelzine (Nardil)</td>
<td>• S-adenosyl methionine (SAM)</td>
</tr>
<tr>
<td>• Clomipramine</td>
<td>• Selegiline (Emsam)</td>
<td>• Omega-3 fatty acids</td>
</tr>
<tr>
<td>• Desipramine (Norpramin)</td>
<td>• Tranylcypromine (Parnate)</td>
<td>• Folate</td>
</tr>
<tr>
<td>• Doxepin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Imipramine (Tofranil)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maprotiline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nortriptyline (Pamelor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Protriptyline (Vivactil)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trimipramine (Surmontil)</td>
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<td></td>
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</tbody>
</table>
Partial list of medications that interact with antidepressants

- Serotonin syndrome
  - Other antidepressants
  - Linezolid
  - Tramadol, meperidine
  - Dextromethorphan
  - St. John’s wort

- Excessive sedation
  - Antihistamines
  - Benzodiazepines
  - Alcohol
  - Antipsychotics

- Bleeding risk w/ SSRIs
  - Warfarin or other anticoagulant or antiplatelet
  - NSAIDs
  - Aspirin
Additional potentially relevant drug interactions (partial list)

- Increased metabolism of antidepressants:
  - Barbiturates
  - Carbamazepine
  - Phenytoin
  - Rifampin
  - Ritonavir

- Decreased metabolism of antidepressants:
  - Fluconazole
  - Itraconazole
  - Ketoconazole
  - Omeprazole
  - Erythromycin
  - Grapefruit juice

- Additional potentially relevant drug interactions (partial list)
Medications associated with depression

- Cardiovascular agents (beta-blockers, clonidine, alpha methylldopa)
- Sedative-hypnotics (including alcohol)
- Steroids
- Interferon
- Isotretinoin (Claravis, Amnesteem)
- Varenicline (Chantix)
- Hormonal therapy
- Withdrawal from cocaine, anxiolytics, amphetamines
Common Barriers to Adherence
Stigma of depression

• Negative attitudes or beliefs towards people with a mental illness
  – Self, family, or friends
• Reluctance to start or continue treatment for fear of what others will think
• Belief that mental illness is a sign of weakness
Problems with adherence

• Forgetfulness
  – Confusion with if meds have been taken
• Dexterity issues
• Pill burden
• Health literacy → not understanding importance of taking medications every day
• Cost
Affordability

• Brand vs. generic
  – Extended release vs. immediate release
• High cost generics
• High cost sharing insurance plan
• Medicare coverage gap
Common side effects

• Sexual dysfunction (especially SSRIs and some TCAs)
• Weight gain (especially mirtazapine, doxepin, and imipramine)
• GI toxicity (nausea, diarrhea, GI discomfort)
  – Often with initiation and increase in dose
• Orthostatic hypotension (more with TCAs)
• Insomnia/agitation
• Drowsiness (mirtazapine, TCAs, trazodone)
## Anticholinergic side effects w/ TCAs

<table>
<thead>
<tr>
<th>Idiom</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blind as a bat</td>
<td>Blurred vision, mydriasis</td>
</tr>
<tr>
<td>Mad as a hatter</td>
<td>Confusion, memory loss, psychosis, hallucinations, memory loss</td>
</tr>
<tr>
<td>Red as a beet</td>
<td>Flushing</td>
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<tr>
<td>Hot as heat</td>
<td>Fever, hyperthermia</td>
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<tr>
<td>Dry as a bone</td>
<td>Dry mouth, dry eyes</td>
</tr>
<tr>
<td>Bowel and bladder lose their tone</td>
<td>Constipation, urinary retention</td>
</tr>
<tr>
<td>Heart runs alone</td>
<td>Tachycardia, hypertension</td>
</tr>
<tr>
<td>Medication</td>
<td>Side Effect</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Bupropion (Wellbutrin)</td>
<td>Lowers seizure threshold</td>
</tr>
<tr>
<td>Duloxetine (Cymbalta)</td>
<td>Increased risk of nausea or diarrhea</td>
</tr>
<tr>
<td>SSRIs; SNRIs; TCAs; mirtazapine</td>
<td>SIADH; check Na when starting/changing dose</td>
</tr>
<tr>
<td>(Remeron)</td>
<td></td>
</tr>
<tr>
<td>TCAs; paroxetine (Paxil)</td>
<td>Anticholinergic side effects, sedation, orthostatic hypotension</td>
</tr>
<tr>
<td>SSRIs in pts w/ Hx of falls or</td>
<td>Unsteady gait, psychomotor impairment, syncope</td>
</tr>
<tr>
<td>fractures</td>
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Efficacy issues/concerns

• Improvement may be seen as early as 1-2 weeks, but typically can take up to 4-8 weeks to see any effect

• In elderly patients, it may take up to 12-16 weeks to see benefit

• Elderly patients are more likely to experience relapse and less likely to see full response to treatment compared to younger patients
Medication Therapy Management (MTM)

What MTM pharmacists can do for patients
MTM Services

- MTM services are typically sponsored by the health plan or pharmacy benefits manager (PBM)
- MTM can occur through different channels (e.g., face-to-face, telephonic, home visit) -- options will vary by plan
- Patients referred by provider, nurse, care coordinator, employer group, health plan
Comprehensive Medication Management

• Review entire medication list, including OTC meds
  – Indication; Efficacy; Safety; Cost
  – Create updated comprehensive medication list
• Discuss lifestyle (diet, exercise)
• Address concerns expressed by patient
• Recommend medication changes to provider
• Provide counseling and education to patient, caregiver, and/or family members
Addressing Barriers to Adherence

- Patient, family, and/or caregiver education
  - Stigma of depression
  - Importance of adherence for efficacy and prevention of relapse
- Identify more affordable medication alternatives
- Minimize pill burden
- Side effect management
  - Recommend alternative antidepressant
  - Recommend treatments for side effects if patient does not want to switch antidepressant
Addressing Barriers to Adherence (slide 2)

• Pharmacy refill reminders
  – Automatic refills; phone call reminders from pharmacy
• Medication synchronization
  – All chronic medications refilled at the same time

• Identify ways to remember when to take medications
  – Alarms; association with daily routine
• Pill box set up and teaching
make good happen

Thank you!

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Perspectives from Two Care Coordinators

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- Cynthia Stevens, RN, Bluestone Physician Services
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