

# Magellan Prevention Programs

## Preventive Health Program Descriptions

- **Postpartum Depression Program (PPD)** – This program is designed to educate new mothers on the risks of depression during the postpartum period and assist them in self-identifying symptoms of depression, to promote early detection and treatment. Conducted in collaboration with health plan customers, Magellan is notified by the health plan of new deliveries, which triggers a mailing to the new mother of a packet with educational information, an Edinburgh screening tool, and instructions to self-screen and mail the screen back to Magellan. A Magellan care manager scores the screening tool, contacts positive-scoring members by telephone or e-mail, and attempts to link the member with a provider for further assessment and treatment. The program also includes an education component for both behavioral and medical practitioners.
- **Perinatal Depression Program** - This program expands the scope of the Postpartum Depression program. The purpose and intent of the program is to reduce the severity and length of illness, as well as any associated morbidity, by increasing the rate of depression screening during the perinatal period. It is also hoped that by increasing the percentage of women who get early and effective treatment, the effects of maternal depression on the infant and family will be reduced. Identified members receive an intervention packet with an informational brochure on pregnancy-related depression, the Edinburgh Postnatal Depression Scale (EPDS) and a pre-paid envelope to return the completed screen to Magellan for scoring. All members with positive or *at risk* scales are contacted by a Magellan clinical reviewer to conduct a telephonic brief behavioral health evaluation. A referral can be initiated, if desired.
- **Depression in Cardiac Patients Program**- This program targets members who have had an acute cardiac event or procedure and other cardiac patients, who as a group are at extraordinarily high risk for depression. Adding to the importance of early identification and treatment in this high-risk group are the scientific studies that have demonstrated significantly increased morbidity and mortality in untreated depressed cardiac patients. The methodology involves the health plan screening cardiac patients with the brief Whooley questionnaire, and then notifying Magellan of positive scorers. A Magellan care manager calls the member and administers a more sensitive depression screening tool. If that screening is positive, the care manager attempts to link the member with an appropriate health provider for further assessment and treatment. The program also includes an education component for both behavioral and medical practitioners. A similar program is our **Depression Screening through Disease Management**.
- **Offspring Depression Program**- The Offspring Depression program is notable for having both secondary and primary prevention aspects. Similar to other Magellan programs, this program has secondary prevention features with a mailed screening tool, the Brief Screen for Adolescent Depression (BSAD), for the children of parents with depressive illness. The parents are mailed an educational letter with the screening tool, instructing them of the higher risk of depression in their children, and asking them to administer the screen to their children and return the screen to Magellan. Positive scorers are then contacted through the parents, and an evaluation referral made, if indicated. Additionally, the mailing includes a sheet with frequently asked questions that gives primary prevention advice to these parents. This material guides them on how to increase the resiliency of their children, and hence, lower the risk for the subsequent development of depression. The program also includes an education component for both behavioral and medical practitioners.

- **Follow-up after Hospitalization (FAH)** – An outpatient appointment with a behavioral health care practitioner soon after discharge from inpatient treatment helps to ensure that any recovery or stabilization that occurred during hospitalization is not lost and that further gains may continue in the least-restrictive environment possible. Effective management of post-discharge treatment has been demonstrated to prevent early re-hospitalization of patients, as well as increase member health and decrease relapse recidivism. By contrast, lack of ongoing follow-up has been identified as a predictor of re-hospitalization.

The targeted population is any member (child, adolescent or adult) hospitalized for a mental health or an alcohol or other drug disorder. The goal is to educate and support the member and their family in continued treatment engagement following hospitalization in order to maximize progress toward improvement. Measures of program success include seven-day discharge planning rates, and FAH rates (seven-day and 30-day). Interventions are designed to support a collaborative, multidisciplinary approach to the targeted population and focus on engaging the member in the discharge planning process by educating them in the importance of aftercare follow up, soliciting the input of the member and the hospital treatment team, including discharge planners, and providing post-discharge support.