

Hawaii Primary Care Association Annual Conference 2010

An Innovative Depression Approach as
Foundation to Patient Centered Primary Care

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ICSI

Transforming Health Care Through Collaboration

ICSI

- Independent non-profit organization (501c.3)
- Established 1993
- A collaboration of 60 medical groups & hospital systems (members) with approximately 9000 physicians in Midwest
- Professional Partnerships consulting work across the country and Canada
- Transforms Health Care through facilitation of collaborative work by bringing together providers, payers, patients, and purchasers to improve care based on evidence and innovation.
- Sponsored by seven health plans



Health Care Environment

- IOM Report - Crossing the Quality Chasm

There will be no quality health care unless mental health and substance use are integrated into primary care

- AHRQ – evidence report/technology assessment Dec 08

Integration of Mental Health/Substance Abuse and Primary Care

- Chronic Disease Mgmt – Chronic Care Model
- PCMH/NCQA/PCPCC – Health care home models

Integrating Behavioral Health in Primary Care Meets the Triple Aim

- Need for Improved Quality
 - High prevalence of Behavioral Health disorders seen in Primary Care
 - Large gap of unmet Behavioral Health needs in Primary Care

Integrating Behavioral Health in Primary Care Meets the Triple Aim

- 80% of patients with a behavioral health disorder will visit primary care at least 1 time in a calendar year
- 50% of all behavioral health disorders are treated in primary care
- 48% of the appointments for all psychotropic agents are with a non-psychiatric primary care provider 67% with a behavioral health disorder do not get behavioral health treatment
- 30-50% of referrals from primary care to an outpatient behavioral health clinic don't make first appt
- Two-thirds of primary care physicians (N=6,660) reported not being able to access outpatient behavioral health for their patients. Shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage were all cited by PCPs as important barriers to mental health care access

Integrating Behavioral Health in Primary Care Meets the Triple Aim

- **Need for Decrease Costs**

- High costs of unmet Behavioral Health needs and other unsuccessful chronic disease management due to the BH needs
- High costs of fragmented and uncoordinated care from PC to BH and inpatient settings
- BH disorders account for half as many disability days as “all” physical conditions
- Annual medical expenses--chronic medical & behavioral health conditions combined cost 46% more than those with only a chronic medical condition
- Top five conditions driving overall health cost
 - (work related productivity + medical + pharmacy cost)
 - Depression
 - Obesity
 - Arthritis
 - Back/Neck Pain
 - Anxiety

Cost of Unmet Needs Continued

- Healthcare use/costs twice as high in diabetes and heart disease patients with depression

	Annual Cost – those without MH condition	Annual Cost – those with MH condition
Heart Condition	\$4,697	\$6,919
High Blood Pressure	\$3,481	\$5,492
Asthma	\$2,908	\$4,028
Diabetes	\$4,172	\$5,559

- Untreated mental disorders in chronic illness is projected to cost commercial and Medicare purchasers between \$130 and \$350 billion annually
- Approximately 217 million days of work are lost annually to related mental illness and substance use disorders (costing employers \$17 billion/year)

Cost of Unmet Needs Continued

Lower Cost

- Medical use decreased 15.7% for those receiving behavioral health treatment while controls who did not get behavioral health medical use increased 12.3%
- Depression treatment in primary care for those with diabetes \$896 lower total health care cost over 24 months
- Depression treatment in primary care \$3,300 lower total health care cost over 48 months

Integrating Behavioral Health in Primary Care Meets the Triple Aim

- Need for improved patient satisfaction and engagement
 - Multiple references on improved pt satisfaction and engagement in co-management of their care plan:

Chen et al., American Journal of Geriatric Psychiatry. 2006; 14:371-379.

Unutzer et al., JAMA. 2002; 288:2836-2845.

Katon et al., JAMA. 1995; 273:1026-1031.

Katon et al., Archives of General Psychiatry. 1999; 56:1109-1115.

Katon et al., Archives of General Psychiatry. 1996; 53:924-932.

Gallo et al., Annals of Family Medicine. 2004; 2:305-309.



Patient Experience

I was in the DIAMOND program, which was covered by my insurance, for one year. Along with phone calls from her, I visited monthly with Mary Licktor, my care manager. I went through a series of different antidepressant medications until my doctor and I found the right one. I am now in remission from my depression and have never been happier. It turned out to be one of the best things I've ever done. In my mother's generation, depression was one of those things you never talked about, but I found help when I opened up and talked to my primary doctor. Now, my life is fantastic."

My care manager may have saved my life from suicide. Thank God I had her to call when this unbelievable experience happened to me. I was on the edge; I thought that my only hope was calling her. She talked me through

"My words cannot describe the gratitude I feel for what DIAMOND has done for me and my family. It literally saved my life. My care team treated me with respect, dignity and genuine compassion. I was part of every decision made. My caregivers gave advice and hope to my wife as well.

The DIAMOND care manager especially helped with my prescriptions, appointments, and disability paperwork. In my condition, these simple tasks were absolutely overwhelming. She also continuously updated the rest of the team on my condition. Most important, she was always there when I needed help.

Today, my mind and spirit are as healthy as they have ever been. This is in contrast to feeling hopeless, helpless and having no desire to live. This program works—I am living proof. My heartfelt gratitude to the DIAMOND program and its amazing staff for their part in this miracle of healing."

John, patient, Park Nicollet Health Services.

What's Needed to Get There? - Transformation

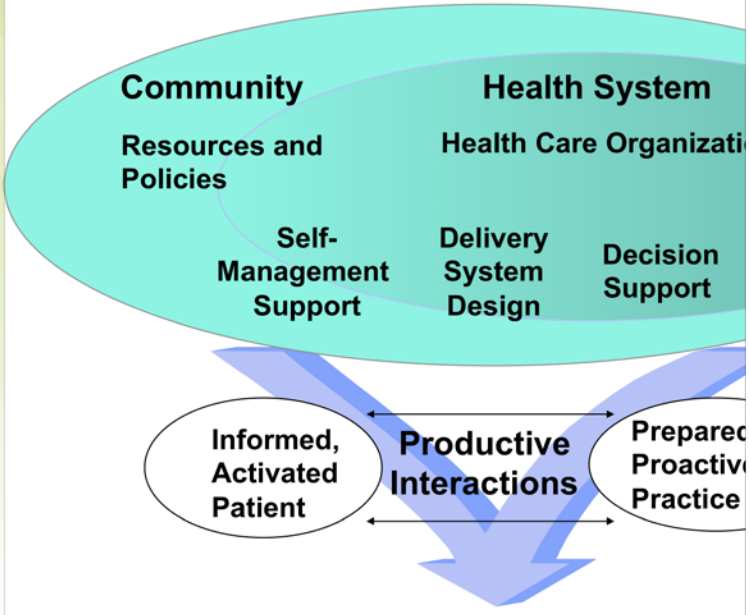
- Paradigm shift in thinking and culture of whole person orientation and cross-specialty teams
- Training and education on team approach and new work flows for care from both primary care and behavioral health
- Information technology to support care coordination/management, care plans, and communication across transitions of care
- Awareness and engagement of patients in their care
- Changes in payment models
- Changes in employer benefit sets



Models for Transformation

- Just about every state has some sort HCH/MH pilots going on
- But only a small amount of those pilots are integrating behavioral health in some way into their primary care model
- And only a few of those pilots have actually shown clinical outcomes and cost savings

Chronic Care Model



IMPACT Integrated Care



Effective Collaboration



Imp



DIAMOND: Transforming Health Care

Best Practice program = care practice
redesign

Fair Payment for new services = care
payment redesign



The DIAMOND Model*



Four Processes:

1. Consistent method for assessment/monitoring (PHQ-9)
2. Presence of tracking system (registry)
3. Stepped care approach to intensify/modify treatment
4. Relapse prevention

Two Roles:

5. Care manager for follow up, support, coordination
6. Consulting psychiatrist for caseload review

*Based on the Collaborative Care Model for depression by Wayne Katon, MD and the IMPACT study by Jurgen Unutzer, MD as well as numerous other controlled trials.

1. Assessment and Monitoring

- PHQ-9 for depression
- Systems and processes in place automatic use of these assessments and monitoring for each chronic disease

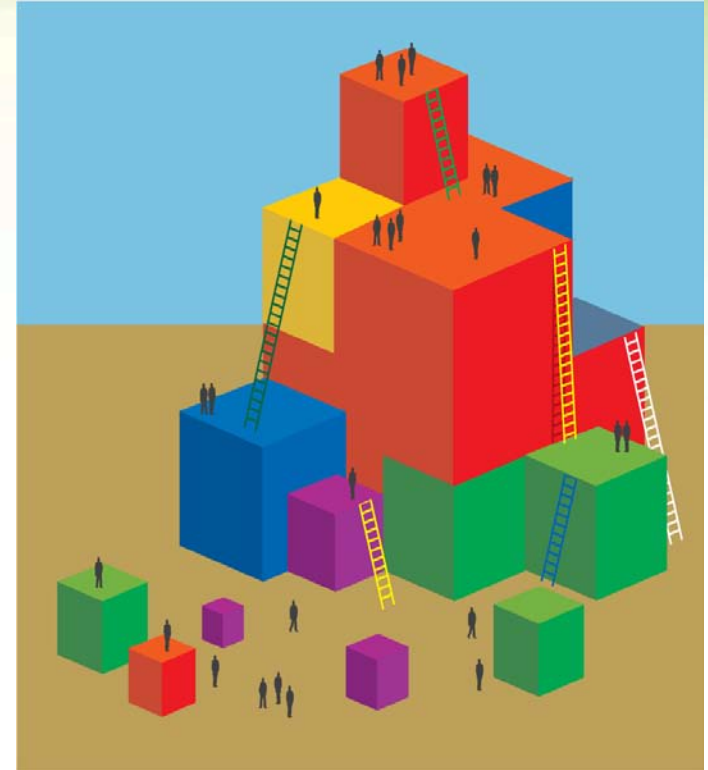
2. Tracking System



- The main tool for the care manager
 - Track progress
 - Make follow-up contacts
 - Data collection

3. Stepped Care Approach - appropriate treatment

- Treatment adjustments based on clinical outcomes (PHQ-9 scores)
- ICSI Depression guideline
- How to embed evidence based GL's and decision support into the care team approach



4. Relapse Prevention

- Care plan
- After patient is in remission and need maintenance
- Patient & care manager create together
 - Risk factors
 - Continuing treatment
 - Warning signs
- This applies not only to depression but what is the care plan for each patient with a chronic disease(s)

5. Care Manager Role



- Uses the registry and follows up with patients for:
 - Education
 - Supporting self management goals
 - Liason for appropriate treatment
 - Coordination of care
 - Relapse prevention/care plans
- Background of Diamond care managers have been medical assistants, nurses, behavioral health.

6. Consulting Psychiatrist

- Two hrs/wk caseload review with care manager
- Focus on new patients and those not improving
- Build relationship with primary care team
- Treatment recommendations based on evidence-based guidelines

- Bring in other specialist in this same team care approach or another PCP that is specifically for review and advisement of a specific case load

DIAMOND: Transforming Health Care

Best Practice program = care practice
redesign

Fair Payment for new services = care
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New Payment

- Health plan payment to the participating DIAMOND clinics for the bundled set of care management services
- Initial payment for delivery of service, eventually to be linked to clinical outcomes

DIAMOND Initiative

Integrated depression care management

- **supported by 9 health plans**

Institute for Clinical Systems Improvement (ICSI)

- (http://www.icsi.org/news/diamond_news)

Common payment code for evidence-based collaborative depression care management

State-wide P4P (Bridges to Excellence)

State-wide implementation

- 83 primary care clinic sites implemented over the last two and a half years
- **Integrating with State medical home model**

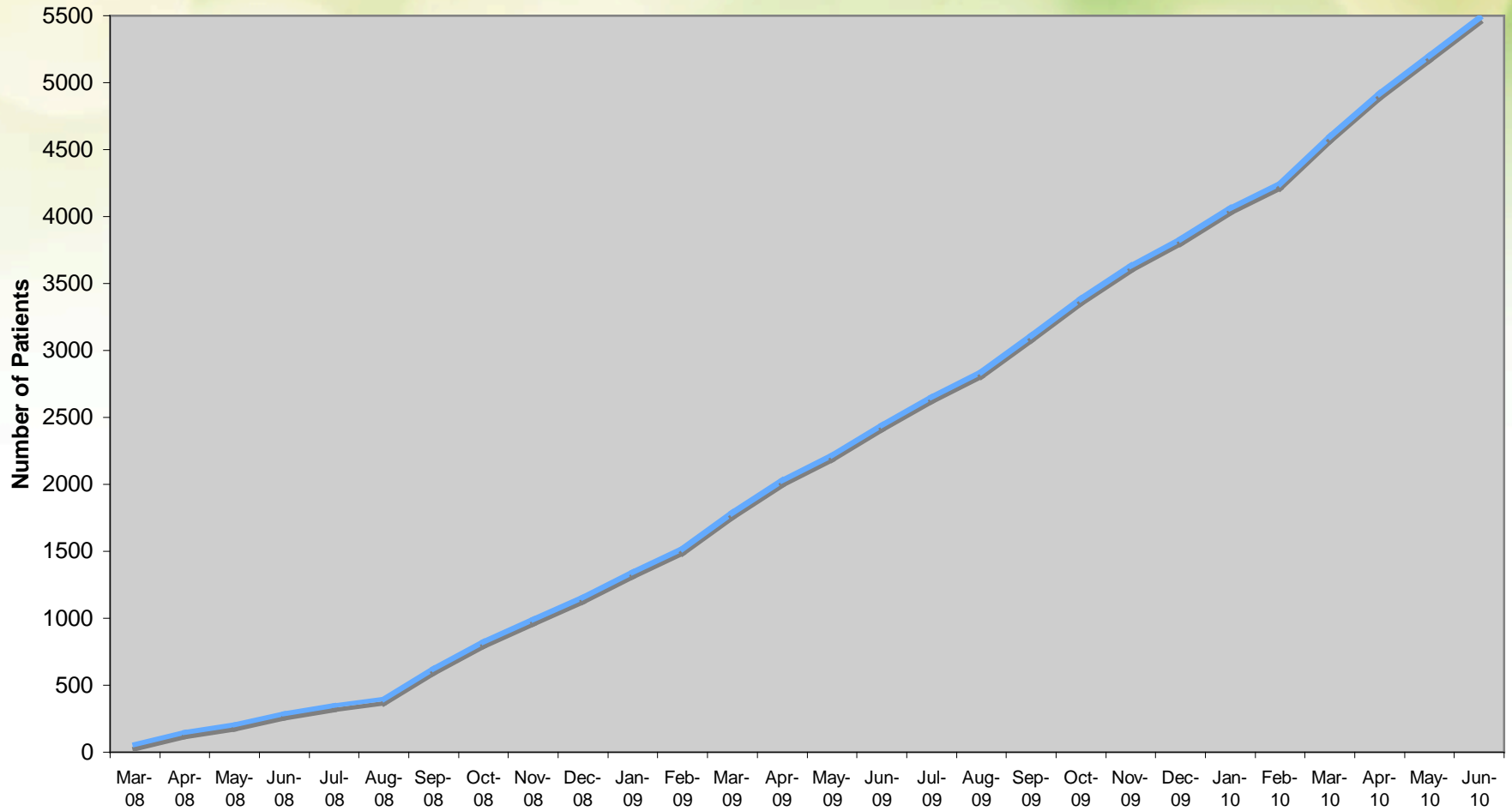


Measurement

Four types of measurement:

- Care delivery process (patient enrollment, PHQ-9s administered)
- Care delivery outcome (response and remission)
- Patient satisfaction and productivity (from NIH study)
- Cost effectiveness (from NIH study)

**DIAMOND
Monthly Cummulative
Enrollment
March 08-June10**



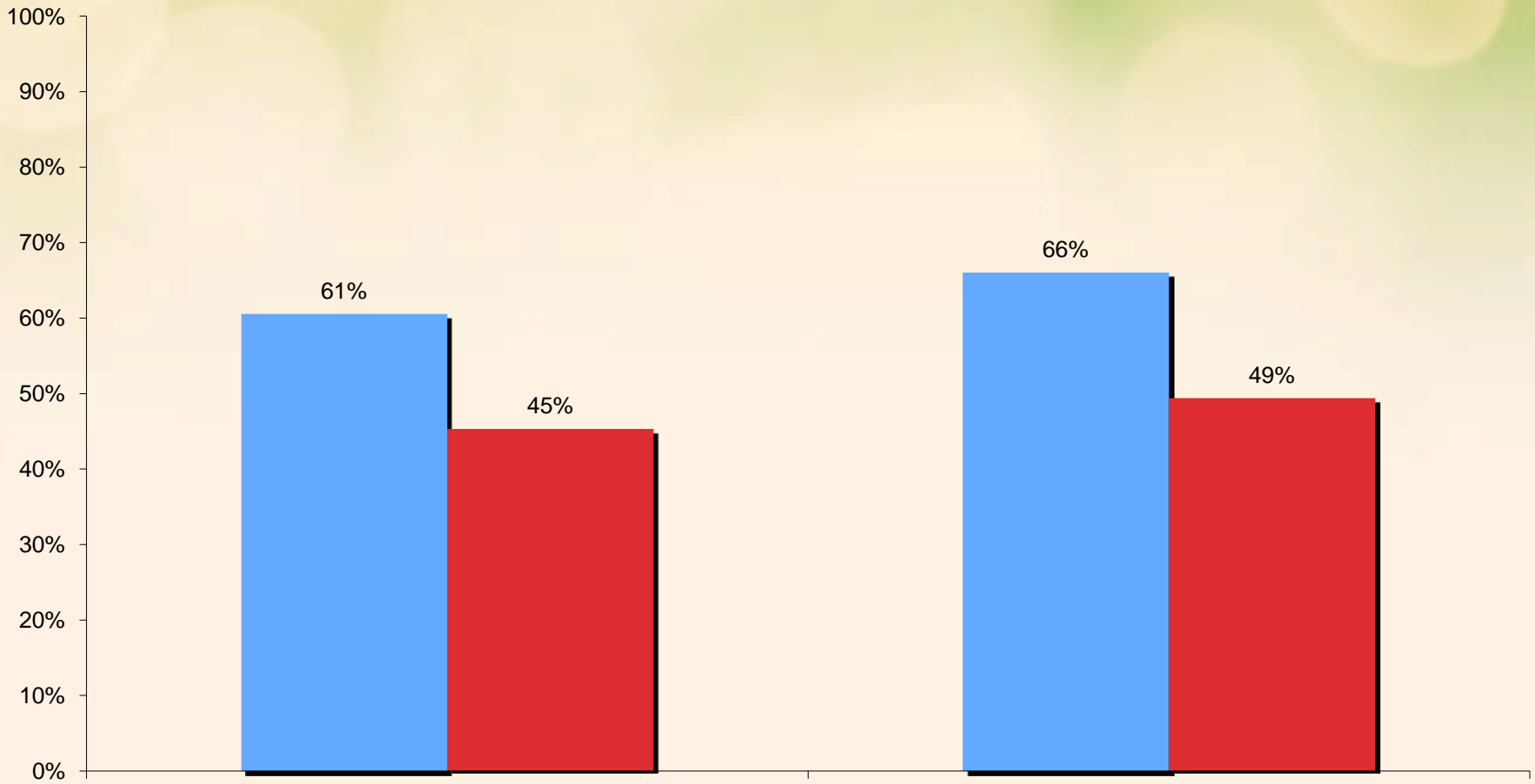
Total Number of Patients Enrolled
during this Period=5485



The Numbers

(as of 8/31/10)

- **Patients enrolled:** **just under 5700**
- **Clinics participating:** **83**
- **DCM (FTEs)** **25**
- **Physicians** **490**



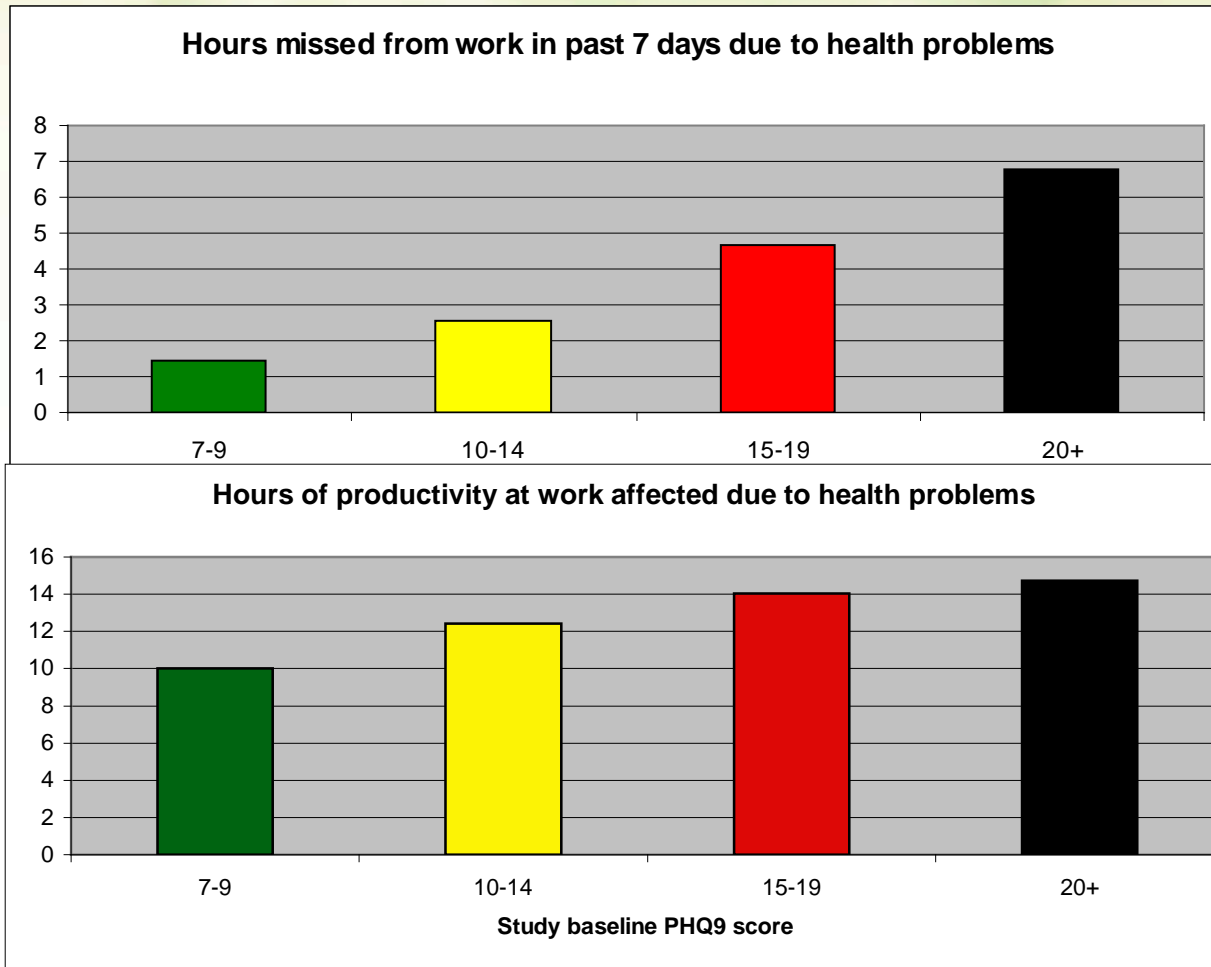
Value - Quality Improvement and Cost Savings

- Clinical outcome data are significantly improved from usual care
- IMPACT HealthCare Cost per year per patient

	Usual Care	Care Mgmt
Total cost/50% improvement	\$30,634	\$18,290
Total cost/remission	\$53,994	\$29,957

- We are collecting data for DIAMOND total costs of care and project same if not better cost savings
- And the DIAMOND study is collecting productivity data as well

Work Productivity



Next Steps - spread and sustain

- ICSI is working on DIAMOND and HCH integration pilots that started in Feb 2010
- ICSI will continue post-implementation networking opportunities, sharing of successes, etc.
- Continue work on collecting cost of care and ROI data and the DIAMOND study continues and gives preliminary reports
- ICSI is part of work at SAMHSA and PCPCC with BH/PC integration
- MN is one of the states that applied for a HCH demo project grant

Thank you.



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