DIAMOND
A new care delivery model for depression

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Why Depression?

- Depression is one of the most common, costly, and disabling medical conditions.
- Current care is poor (only 1/2 of adults get treated, only 20-40% show substantial improvement over 12 months).
- However…
  - More than 37 good randomized trials have proven conclusively what is needed to improve remission and improvement rates by 40-60% - we know what to do.
  - Cost-effectiveness studies have also shown that improvement doesn't increase overall health care costs, and does increase patient productivity

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Then Why Aren’t We Doing It?

- Barriers:
  - Stigma (“don’t talk about it”)
  - Lack of time
  - Poor follow-up
  - No coordinated care
  - The biggest is clearly the lack of reimbursement for the kinds of team care demonstrated to be effective
- In the trials, after the research money goes away, care returns to its prior poor state.

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History of ICSI Depression Work

- Evidence-based Depression guideline developed and revised annually since 1994
- Action Group collaborative for 3 years
  - Primary care groups focusing on depression care improvement and sharing data and strategies tries
  - Focus was primarily around comfort level in talking with patients about depression and its implications, correct coding and documentation, and spreading the use of the PHQ-9 as the standard assessment tool.

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Depression Usual Care Results

Locally within our ICSI action group:

- PHQ-9 at time of diagnosis - averaged 60%
- 3 month follow-up - averaged 35%
- 6 month response rate - averaged 8%

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DIAMOND
Scope and Description

- Primary care outpatient adults
- Evidence-based care management program for depression based on collaborative care model
- All health plans and other payer groups will cover/fund the services covered in the care management program
- DIAMOND initiative active implementation phase is March 2008 - March 2010
- FUTURE – if successful, this program and service fee structure could be expanded to other chronic disease care or added to existing clinic-based care management

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Who’s At The Table?

- DIAMOND Steering Committee and six subgroups comprised of:
  - Primary care providers and mental health
  - All major MN health plans
  - Department of Health and Human Services (representing the Medicaid population)
  - Employers
  - Patients

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2 Key Areas of DIAMOND

- Best Practice program = care practice redesign
- Fair Payment for new services = care payment redesign

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Care Delivery - Best Practice*

- Standard and reliable use of the PHQ-9 for assessment and ongoing management of depression
- Systematic follow-up tracking and monitoring - repeat PHQ-9 msmts and use of a registry
- Use of the evidence-based guideline and a stepped care approach for treatment modification/intensification
- Relapse prevention when the patient is ready to move out of the care management program
- A specific role to educate, coordinate, and troubleshoot services for the depressed patient (care manager role)
- Psychiatric consultation and caseload review on a formalized basis

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

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Care Manager Role

- Overall coordination of depression care for patient
- Manages registry and follow-up contacts with:
  - Depression education
  - Self-mgmt support
  - Facilitation of stepped-care therapy
  - Coordination with primary care provider and psychiatrist
  - Relapse prevention
- Background of care managers have included: medical assistants, nurses, social workers, psychologists
- Each 1 FTE care manager generally covers 140 - 165 depressed patients

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Psychiatrist Role

- Consultation in the primary care setting to the care manager for 2 hrs/week.
- Formal caseload review (based on registry)
  - Focus on patients who are not improving
  - Recommendations for treatment changes based on evidence-based guidelines including mental health referral if clinically indicated

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What Looks Different for the Patient?

- Their PCP talking with them about this new program of care
- Frequent, routine contacts from a care manager within their primary care office - building a relationship
- Being asked frequently through these contacts the PHQ-9 questions, depression education, and goal setting
- Help they want in coordinating their care - external referrals, med changes, etc.

New Payment

- Creation of a depression care mgmt payment to be paid on a periodic basis to the participating primary care clinics for the complete set of services covered under the care mgmt program.
- A standard DIAMOND claims code used by medical groups certified by ICSI for the care management program.

DIAMOND Services Covered

- Included in the bundle of services:
  - Care manager tracking and use of a registry
  - Care manager contacts with patients active in the program
  - Care manager administration of PHQ-9 during the active phase & at 6 months and 12 months - even if patient is no longer in the care mgmt program
  - Care manager Relapse Prevention visit
  - Psychiatric consultation and caseload review

- Not included in the bundle of services (billed separately):
  - Patient visits with the primary care physician
  - Care by mental health providers

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Measurement

- Four levels:
  - Care delivery process measures (patient enrollment, PHQ-9 administered)
  - Care delivery outcome measures (response and remission rates)
  - Patient satisfaction and productivity (quality of life survey) - from NIH study
  - Cost effectiveness measures - from NIH study

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Next Steps

- 5 waves of ICSI medical groups are signed on over the next 18 months (23 different medical groups and 87 clinic sites and 554 primary care physicians)
- Msmt results will be reviewed monthly by the DIAMOND steering committee
- Beyond 2010, program will be extended to other ICSI member groups as well as non-ICSI member groups across the state
- MNCM and ICSI are consistent on measures and depression data will be submitted once for both groups
- Other opportunities?

Questions?

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How is it really working?

- Hear from a couple member groups that were in the first groups implementing DIAMOND starting March 1, 2008

  - Family HealthServices Minnesota (FHSM)

    Sherry Behm, Director of Clinical Practice
  - HealthPartners Medical Group (HPMG)

    Michael Trangle, MD, Associate Medical Director

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Family HealthServices Minnesota P.A. (FHSM)

- Independent, Physician-owned, Community-based
- Originally a joint venture between East Metro Family Practice and MinnHealth Family Physicians
- 69 Family Practice Providers
- 13 Clinics located on the east side of the Twin Cities

DIAMOND implementation

- 4 Pilot Clinics in Sequence 1--Implemented March 3, 2008
- Sequence 2 implementation September 2008
- Sequence 3 implementation March 2009

**FHSM goal is to have all sites fully implemented by March of 2009*

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Commitment and Participation

- ICSI Steering Committee
- ICSI Physician and Care Manager Sub-groups
- ICSI Collaborative Training Sessions
- FHSM DIAMOND Team (oversight)
- FHSM Internal Work Groups

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“Operationalizing” DIAMOND

- Identified pilot sites and physician champions for Sequence 1
- Identified project leaders
- Created internal multi-disciplinary DIAMOND Team (oversight)
- Developed Implementation Plan
- Identified Internal Work Groups
- Communication and Follow up

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Multi-disciplinary Oversight Team

- Project Leaders—Medical Director and Director of Clinical Practice
- Physician champion and Clinic Manager from each pilot site
- Billing, Coding and Referral Staff
- QI Project Staff and Data Analyst
- IT Staff
- Care Managers (once hired)
- Psychiatrist (before implementation)

Developing the Implementation Plan

- Identified the work to be done
- Identified key stakeholders
- Timeline
- Communication Plan
- Training and Education

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FHSM Internal Work Groups

- Coordinated and facilitated by one person
- 3 internal work groups
    - Clinical/Care Manager work flow
    - Billing and Coding work flow
    - Data—registry, measures and reporting
- Frequent meetings, check-ins, and follow up with key stakeholders
- Report back to Multi-disciplinary DIAMOND Team
- Merged work groups before implementation

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Follow up After Implementation

- Weekly meetings with Care Managers
- Follow up with Physicians and Clinic Managers
- Progress report at each leadership and CQI meeting
- Monitor number of patients being activated
- Tracking and measuring outcomes
- Course corrections and "remodeling"

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Must Haves for Success

- Physician and Administration Commitment
- Leaders for the project
- MD and management champion at each pilot site
- Dedication to making time
- Patience and commitment to clearly define the plan
- Strong channels of communication
- Multi-disciplinary Team and Key Stakeholders
- Ability to make course corrections in timely manner
- Comfort level with evolutionary process--building the plane as you fly

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What We’ve Learned So Far

- Physician participation
- Care manager work flow
- Patient response to the project
- Communication
- Measurements

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Would We Do This Again?

Yes!

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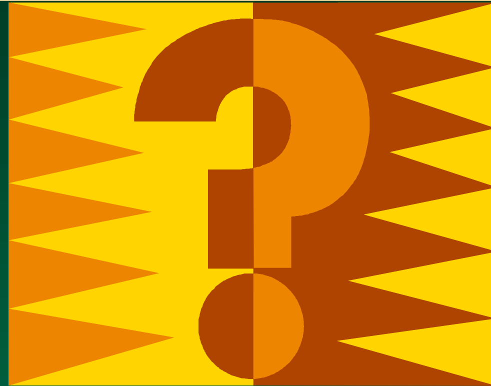

Questions?

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HPMG - fears, hopes, and early reactions

- Primary care physicians
- Psychiatrists
- Care Managers
- Other staff

Other learnings from implementation

- Patient Reactions
- Quality Issues
- Communication Issues
- Teamwork Issues
- Other Issues and Troubleshooting

Questions?

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The DIAMOND Study: An Evaluation of an Important Natural Experiment

Leif I. Solberg, MD

HealthPartners Research Foundation

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An Initiative and a Study

What is Known From Controlled Trials?

- Patient depression outcomes are 50% better
- Patients are more satisfied with care
- Work productivity improves
- Total health care cost savings at 4 years
- Little about:
  - relation between care changes and outcomes
  - How care changes occur

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But -

Randomized controlled trials are <u>not</u> reality:

- Patients are found by screening and subject to inclusion/exclusion criteria
- The intervention is often controlled
- Intervenors know who are study subjects
- Participation costs are often covered

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This Change is Different

- Patients are selected and entered by clinics by whatever approach they wish
- Payment approach varies by payer and won’t cover all costs, development, or all patients
- Although training is the same, actual care will vary greatly among clinics
- Clinics have no idea which subjects are being studied

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What Will This Study Add?

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Everyone Wants to Know

Will DIA. improve patient depression more?

- DIAMOND will learn how much improvement occurs with this new approach
- The study will learn whether that is more than occurs before this approach begins

Payers and Purchasers Want to Know

How are health care costs affected?

- DIAMOND or individual payers can't know
- The Study will learn how 12 month costs before compare with after the intervention

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Purchasers Want to Know

How will worker productivity be affected?

- DIAMOND or individual purchasers can't know

- The study will compare productivity improvement before and after the change occurs

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Medical Leaders Want to Know

What care changes occurred? Which ones are most important? How should they be introduced? What organizational features are important for success?

- DIAMOND can only guess
- The Study will have data about this

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Policy Makers Want to Know

How much does it cost to implement these changes? (+ everything on prior slides)

DIAMOND won't know

The Study can learn this

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How Will the Study Learn These Things?

- Monthly surveys of depressed patients at all 87 clinics over 3 years
- *Before/after* surveys of clinic leaders
- *After* interviews of medical group leaders
- Records from ICSI
- Health care cost data from payers for surveyed patients
- Implementation cost estimates from payers and medical groups

Patient & Medical Group Surveys

	2008											2009												2010											
Seq	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
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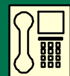
Key
I = Implementation  Phone = Patient survey Computer = Medical group survey

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But the Study is Worthless

Without the active cooperation and contributions of payers, medical groups, ICSI, and patients

So – they really are all part of the Study Team

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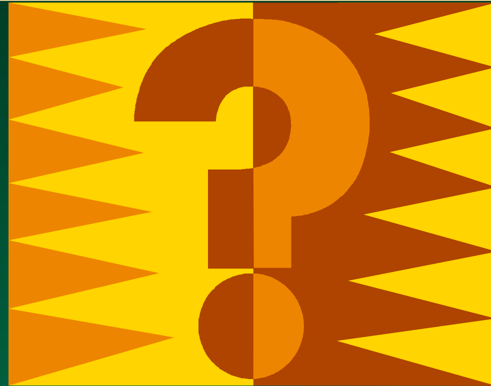

Questions?

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