

DIAMOND in the Rough

A program that is changing depression management is showing impressive remission rates. But sustaining it is proving to be a challenge.

Tim Hernandez, M.D., recalls how just two years ago, only a fraction of patients treated for depression in his primary care practice experienced remission of their disease within six months. Hernandez, medical director for quality at Family HealthServices Minnesota, which has 13 locations in the east metro, cites a number of reasons for the poor improvement rate.

“Patients were stopping meds [because they were] experiencing side effects, not filling their prescriptions, not giving the medication enough time to work, not having enough money, and having no outreach to make sure that they returned,” he recalls.

The phenomenon wasn’t unique to Hernandez’ group. According to MN Community Measurement, only between 4 percent and 20 percent of patients who receive treatment for their depression are better half a year later.

In 2007, aware of such dismal statistics, a group of providers, payers, patients, and purchasers convened by the Institute for Clinical Systems Improvement (ICSI) began trying to find a more effective way to manage depression in the primary care setting. From their work a model emerged that changes both how care for

depression is delivered and how it is paid for.

That model, called DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction), encourages and equips primary care providers to screen for, treat, and then monitor patients with depression by employing a care manager and contracting with a psychiatrist, who oversees each patient’s treatment regimen. Clinics began testing the model in March of 2008.



Participants in the DIAMOND program are in contact with care managers who check on their progress between clinic visits.

Between Care

In a traditional approach to treating depression, the physician makes a

diagnosis and prescribes therapy and/or medication, then schedules follow-up visits with the patient, the frequency of which depends on the severity of the patient's depression and whether there are comorbidities. Between visits, the patient is typically on his or her own.

Patients who participate in the DIAMOND program might receive the same prescription for medication or referral to talk therapy that any other patient with depression might receive.

What's different is how they're followed. Patients are assigned a care manager who monitors their condition through frequent (weekly, on average) phone calls. Clinics have hired psychiatric nurses, social workers, or medical assistants to provide the service.

"What makes the program unique is its emphasis on between-visit care," explains Hernandez, who serves on the ICSI steering committee for DIAMOND. "The care manager can come up to my work station and say, 'I talked to John, and he's doing great' or 'Did you know Susie stopped taking her medication because she wasn't sleeping well?' Knowing what's happening between visits helps us to make changes to the patient's treatment regimen much more rapidly. It helps intensify therapy and maintain continuity of care."

Currently, 59 clinics offer their primary care patients access to the DIAMOND program, and another 24 are training to be certified as DIAMOND providers. By March 1, 2010, 83 clinics are expected to be participating.

To be eligible for DIAMOND, patients must score 9 or above on the Personal

Health Questionnaire (PHQ-9) depression scale. Since DIAMOND's inception, more than 3,000 patients have enrolled in the program.

Outcomes data gleaned from electronic medical records are promising. Results, based on patients' retaking the PHQ-9, indicate a six-month remission rate of 40 percent and a 12-month rate of 56 percent. "We are seeing as much as a four- or five-fold increase in remission rates by six months compared with those receiving usual primary care treatment," says Nancy Jaeckels, vice president of member relations and strategic initiatives for ICSI.

In addition, response rates (defined as having at least a 50 percent reduction in the severity of depression) among DIAMOND participants were 65 percent and 75 percent at six months and 12 months, respectively.

Hernandez attributes the improved remission and response rates not only to patients receiving counseling between clinic visits but also to the fact that they get more intensive treatment. A consulting psychiatrist meets with the care manager once a week to oversee treatment decisions and protocols.

Hernandez says the psychiatrist might suggest augmenting a patient's medication dose, for example. "Those clues are really helpful to us," he says. "As primary care providers, we're often reluctant to up the intensity of any medication, but that mantra of 'start low, go slow' does not always lead to the most optimal treatment response when it comes to depression."

The Payment Problem

Although the DIAMOND model appears to work, challenges to implementing it on a larger scale remain. The biggest obstacle is paying for care coordination. Neither Medicare nor Medicaid reimburses for those services. Only some of Minnesota's health plans will cover the cost, and patients with high-deductible health insurance policies sometimes end up paying the cost of care coordination themselves.

"From the patients' perspective, out-of-pocket costs can often be high for DIAMOND," says Dave Thorson, M.D., a primary care physician with Family HealthServices Minnesota who participates in the program.

In addition, clinics are struggling with such practicalities as how many care managers to bring on. Family HealthServices Minnesota is losing several thousand dollars per month because none of its six care managers has a full caseload of patients.

Long-term Outlook

Despite such struggles, more clinics are planning to adopt the DIAMOND model, and health care providers, government agencies, and employer groups around the country are taking note of the program.

"The DIAMOND model is serving as a national model that's being closely scrutinized," says Roger Kathol, M.D., a

psychiatrist and past-president of the Minnesota Psychiatric Society.

The federal government has provided funding to study the program. In October 2007, six months before the first 10 clinics rolled out DIAMOND, the National Institute of Mental Health awarded the HealthPartners Research Foundation a \$3 million, five-year grant to evaluate all aspects of the initiative, including patient outcomes, the program's cost effectiveness, and its overall effect on care delivery.

HealthPartners is looking at patient surveys, claims data analyses, feedback from medical leadership, and costs for payers, clinics, and ICSI, which is in charge of implementing DIAMOND. Kathol believes the results of that study could go a long way toward securing reimbursement for clinics that take part in DIAMOND or similar programs.

But for the clinics currently participating in DIAMOND (and losing money each month in some cases), five years is a long time to wait.

"Other studies have demonstrated that if you treat depression appropriately, you will reduce hospitalizations, reduce morbidity and mortality associated with chronic diseases, and increase productivity in the workplace—and this study is trying to reinforce those findings at the state level," Hernandez says. "But the question is, can we hold out for five years? I just don't know the answer."—

Jeanne Mettner