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Lowering Health Care Cost Through
Managing Behavioral Health:

Influencing Primary Care Practices

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Statement of the Problem

The incidence of depression and other behavioral health co-morbidities within a common primary care practice is about 10 -25%

Studies have indicated about 6% of primary care patients will screen positive for depression using validated instruments.

PCP missed the diagnosis in over 67% of the case of moderate depression.

HEDIS results on antidepressant medication management has demonstrated that care follow up and medication adherence is not regularly followed according to practice guidelines.

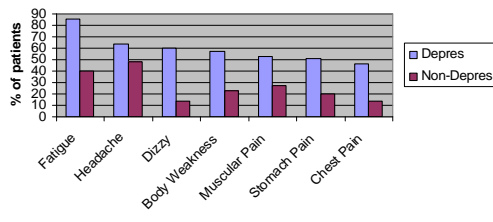
Major barriers to primary care physicians operationalizing practice guidelines has been integrating the guideline requirements into their practice flow and process.

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Physical Symptom Presentation of Depression

Common Physical Symptoms in Depressed Patients



Kellner and Sheffield, 1973, Am J Psych

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Hidden Cost of Depression

Medical cost due to the presence of depression in patients within a typical PCP practice is elevated.

- According to key studies,
 - For the typical PCP office patient
 - the elevated cost difference averages between \$949 to \$1,200 per case per year
 - prevalence rate of 6- 7% in a general practice Rost,UBH et al.
 - For patients with chronic medical illnesses there is a higher cost differences
 - in an observational study of medical claims done by Milliman average cost difference exceeded 20% or greater than \$2,000 per case per year.
 - prevalence rate of 22-35% in patients with chronic medical illnesses.

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TABLE 1 Impact of depression: comorbidities

Condition	Annual medical costs per patient without depression	Annual medical costs per patient with depression
Heart failure	\$2.56	\$6.74
Allergic rhinitis	\$3.27	\$8.46
Asthma	\$3.73	\$10.56
Migraine	\$3.82	\$15.47
Back pain	\$11.61	\$33.25
Diabetes	\$13.06	\$27.28
Hypertension	\$13.38	\$27.16
Ischemic heart disease	\$62.40	\$110.94

Actual annual medical costs per patient, based on claims data for 229,776 patients, 1995–1998. SOURCE: OCI 2001

Medical Cost-Offset Projected Results Opportunities for Medical Cost Offset

Chronic Medical Condition	Total Healthcare Costs PMPM			Total Healthcare Costs PMPM			Anxiety Cost Differential
	A Co-Existing Depression	B & C Without Diagnosis	Depression Cost Differential	A Co-Existing Anxiety	B & C Without Anxiety	Anxiety Cost Differential	
Arthritis	\$ 1,118	\$ 594	\$ 524	\$ 965	\$ 615	\$ 350	
Hypertension	1,125	611	515	932	626	307	
Chronic Pain	1,576	1,003	573	1,585	1,021	563	
Diabetes Mellitus	1,351	856	495	1,309	871	439	
Asthma	1,111	497	614	968	517	451	
Coronary Artery Disease	1,616	987	629	1,314	1,006	308	
COPD	1,485	847	638	1,366	873	493	
Cancer (Malignant)	1,365	1,045	320	1,325	1,054	271	
Congestive Heart Failure	2,539	1,936	603	2,381	1,961	420	
Ischemic Stroke	1,731	1,295	436	1,574	1,314	260	

Three Groups Included in this Analysis:

- Group A: Members with a diagnosed and treated co-morbid depression and/or anxiety condition – 6% of chronically ill members;
- Group B: Members with an un-diagnosed and un-identified co-morbid depression and/or anxiety condition – 33% of chronically ill members;
- Group C: Members without a co-morbid depression or anxiety condition – 61% of chronically ill members;

The data suggest that there are significant cost savings opportunities for programs focused on narrowing the cost gap between members with and without a co-morbid psychological disorder.

Source: Based on an analysis of a 5.5M member MedStat sample set of US healthcare data by Milliman, Inc.; prevalence rates based on Milliman research and actual MedStat data (Group A prevalence)

Hidden Cost of Behavioral Health Co - Morbidities

What are the clinical tributaries to increase medical cost?

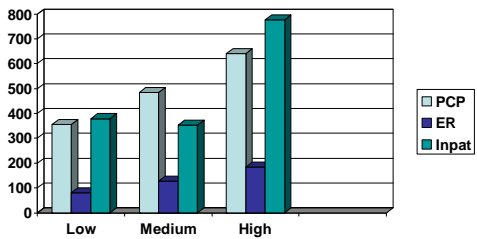
- Medical cost has been shown to increase:
 - Incrementally with the severity of depression
 - In the presence of poor response to first line treatments.
 - When there is switching of antidepressant medication regimes three or more times within short periods of time

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Depression in Diabetes

Unadjusted medical related cost by severity of depression at six months



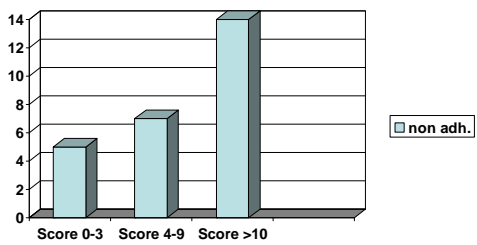
Katon W 2000

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Depression in Cardiac Patients

Non - Adherence Stratified by PHQ 9 Scores



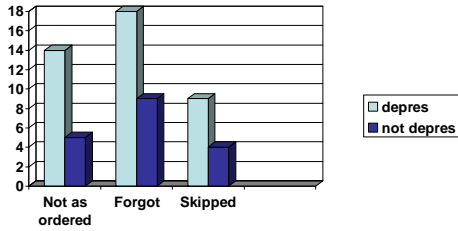
Gehi A, Haas D 2005

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Cardiac Patients with Depression

Adherence to cardiac medication in 240 patients



Gehi A, Haas D 2005

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Effective Medical – Behavioral Interventions

Several studies demonstrate that interventions supporting PCP management of depressed medical patients can successfully reduce excess medical utilization and cost with the use of behavioral case management wrap around or “enhanced care”

- Rost study 2005 – Depression within a PCP practice with any medical diagnosis demonstrated avg. \$980 savings per case within **two years**
- UBH LifeSolutions study 2005 – High risk medically ill patients within medical case management who screened positive for behavioral health co-morbidity demonstrated a 7% decrease in medical cost for the intervention population with in **one year**
- UBH LifeSolutions study 2006 – High risk medical patients as in 2005 plus data driven referrals demonstrated a \$105 per member per month cost reduction for those in the program
- UBH study 2006 – Medicare population screened positive for depression with intervention suggest a substantial decrease in medical cost, (average \$3,000 decrease) with in **one year**.
- UBH/Kessler JAMA 2007 study released – Indications of positive effects on reducing workplace absenteeism (a gain of on an average of two weeks of productivity) via intervention with employees identified from a HRA with behavioral co-morbidities and psychosocial issues interfering with work
- Simon 2006 - suggest that successful behavioral treatment (achieving remission) has a positive effect on reducing medical cost

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Looking for a Practice Level Solution

VEBA has expressed a desire to engage in an intervention focused on improving depression management focused on primary care practice by providing a CME educational session.

Through a collaborative effort, we have taken VEBA's idea, researched and identified evidenced based practices that utilize an educational approach to effect physician practice change.

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Basic Premise

The original IOM Crossing the Quality Chasm: A Health Care System for the 21st Century reported

- It takes 17.3 years for evidenced base practices to be adopted and utilized in general practice (Balas and Boren, 2000)
- Translation of research findings to date has been characterized as "slow and haphazard" (Grol and Grimshaw, 1999)
- Medicine has traditionally relied on cognitive testing of knowledge, not on judgment or skills
- Variability in practice patterns and therefore outcomes is indication of poor quality and poor quality controls

Finding Solutions

- Ensuring new knowledge is incorporated into practice requires an understanding of how change is managed most effectively in health care, including barriers to and facilitators of change.
- Elements to facilitate change include education, process to support change, incentives/penalties, feedback and social marketing
- Organization researchers described "**learning organizations**" as those organizations that can facilitate learning quickly and accurately, and be able to translate the learning into demonstratable outcomes (Argyris and Schon – 1978, Senge 1990).
- "**Learning environment**" is a systematic set of processes that facilitates, guides and ensures the translation of knowledge into action and organizational practice changes (Berwick 1994)

Interventions that Improve HEDIS Scores – a population measure of depression

An analysis of health plan performance on the HEDIS antidepressant medication management measures demonstrated with statistical significance that the following interventions contribute to better HEDIS scores on acute and continuation phase medication management

- The following are a few of the interventions that showed a higher correlation to higher HEDIS scores on the acute and continuation measures⁹
- The presence of a depression disease management program,
- Provider feedback on prescriber patterns and
- Provider feedback on patients non adherent to medications
- Providing training on depression guidelines alone was associated with a lower rate of optimal provider contact.

Improving Clinical Care Scores – Chronic Care Management Populations

Study surveyed practices to identify the key practice level tools and processes that contributed to successful chronic care management (based on diabetic management and management of patients with chronic illness).

The study identified the following:

- validated assessment tools to aid in identification,
- chart level patient monitoring tools – Documentation formats and follow up parameters
- feedback on individual physician prescribing results especially in comparison to regional physicians and national benchmarks.
- Systems that alert physicians to the absences or presences of key disease or treatment markers to facilitate speedier follow through
- Practice level incentives, (payment, purchaser leverage, recognition/differentiation)

Looking for the Solutions

Effective methodologies that change physician practice behaviors are:

- Multifaceted
- Dependent on access to coordinated clinically relevant data,
- Access to useful practice level information specific to facilitate provider actions,
- Availability of quantitative tracking mechanisms that are sensitive to measure change.

To maximize the effect of any educational event, we are making efforts to incorporate as many of evidenced based interventions and preparatory activities to facilitate practice change as possible

Looking for the Solutions

To assure the effectiveness of the educational events, it is proposed that several interventions be included and coordinated for implementation.

- With access, use of actual physician claims data from the care of VEBA members with depression to profile practice patterns pre and post interventions
- Specially designed curriculum and delivery process focused on obtaining knowledge on depression management and implementation of a systematic approach in a office practice
- Use of provider tools to enhance clinical management and outcomes – PHQ 9, specially designed progress notes, patient level feedback information, patient registries, patient level supports and self help materials and others
- Use of surveys of physicians to obtain practice level information pre and post education on know gained and practice changes
- Offering adding CEU credits to include the involvement of office nurses and office managers since they are generally the facilitators of office base practice changes and systematizing the process in the office flow.

Start of the Project – Prior to the Kick Off Events

Meet with purchaser to scope out goals and parameters of the project.

Identify all the key players and data sources needed for the project involved

Appropriately leverage purchasers position to clarify

- key players to be involved
- Roles and accountability
- Contract terms and/or performance expectations
- Team working environment amongst disparate e
- Coordination of the key players in executing the
- Frequent follow up meetings to monitor progress



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Prior to the Kick Off Events

Identify High volume PCP practices that service VEBA members
Evaluate the practices to identify the key targeted practices and opportunities

- Identify high volume antidepressant prescribing physician practices servicing VEBA members
 - High volume prescribers of antidepressants and high one time fill rates
- Identify low volume antidepressant prescribing physician practices servicing VEBA members
 - High volume physicians with below average diagnosis of depression and/or prescribing antidepressant medication
- Physician's patient population that is adherent to antidepressant medication refills for 3 and/or 6 months
- Population with high levels of antidepressant switching at least three times over 6 months
- Physician's specific patient population on augmentation therapies
- Identification of best regional/local practice
 - performance high in comparison to national norms,
 - recruit representative(s) from the practice (physician, nurse, office manager) to speak at education sessions/ case presentations on practice implementation and maintenance of antidepressant management flow

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Educational Kick Off Events

Meet with the physician and/or practice managers from the high volume key large practices to:

- Present the antidepressant profile data,
- Explain the project to stimulate interest,
- Identify key personnel for project implementation within the office
- Survey office staff to:
 - Understand structure,
 - Identify practice supports
 - Understand office flow
 - Elicit feedback on office materials,
 - Obtain attestation of intent to join project and change practice flow

Identify consultants and develop content for the continuing medical educational/detailing events/s (CME and CEU)

Identify practice specific office based material for use by physicians and importantly their nurses and other office staff

Given the structure of the provider practices determine best mechanism for kick off educational initiatives

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Kick Off Events

Educational Kick Off Event may be implemented either as a regional meeting or as a practice/provider system specific

Half Day Regional Meeting

Half day symposium will be three hours in length

Hours – 1 to 2

- informal discussion with faculty and moderator
 - Introduce case study vignettes.
 - Consultation from the expertise of the faculty.
 - Mini didactic slide presentation, which will be followed by interplay between the moderator and faculty presenter.
- Open panel discussion with emphasis on key learning objectives and conclusion.

Hour - 3

- Compliance/adherence workshop facilitated by experts in this area. The proposed dates for these activities will be Q1-Q2 2008.
- Local practice level and physician specific profiles distributed and discussed
- Identification of practice level work team
- Attestation to practice change

Practice Specific Approach

Series of event meetings to review

- practice specific case vignettes
- Practice level profiles presented compared to regional or national benchmarks
- Physician level profiles presented compared to local of best internal practice
- Problem solving discussions looking at office process and workflows
- Practice/physician level attestation for change
- Establish work team and meeting schedule to review feedback

Course Material available through CD ROM or Live telecast

Educational Kick-off Event

Learning Objectives for the CME/CEU accreditation:

- Clear learning objectives –
 - Demonstrated change in practice management of depression
 - Demonstrated clinical improvement in depressed population by practice
- Processes for the distributions of necessary information to support learning objective
 - Educational sessions
 - Detailing (individual discussions based on data)
 - Group consultation sessions
- Documentation of time spent in educational process
 - Sessions
 - Practice changes (planning, execution and measurement)
- Documentation of resultant change
 - Attestations of practice change
 - Process measurement of change
 - Clinical outcome changes

Post Kick Off Events

Post educational event participant survey

- Assess knowledge acquired
- Attestation of intent to change practice flow

Monthly/ biweekly registries of patients to high volume practices for action:

- Non adherent to antidepressant medications
- Frequent switching of antidepressant medications
- On augmentation therapies

Quarterly

- reports of physician level profiles highlighting prescribing behavior and performance
- meeting with practice group leads problem solve

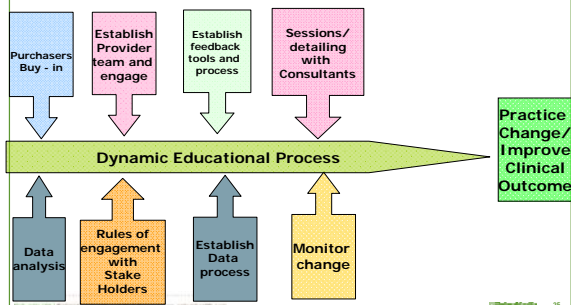
Follow up survey to physician, nurses and/or office managers in 3 and/or 6 months focused on physician practice change.

Post Kick Off Events

- Resurvey on practice to identify process changes –
 - Use of a validated tool,
 - Adoption of the evidence base follow up regime,
 - Adoption of STAR D or Texas Algorithm as a medication strategy,
 - Referral to behavioral health for psychotherapy or high risk case medication management
- Facilitate identification and working through barriers to implementation of practice change with administrative team
- With appropriate funding have follow up meetings with physician moderator identified through the evaluation process to facilitate discussion on best office implementation practices and clinical outcomes

Project Overview – Key Milestones

Critical to the project is success in key events in the time-line



Demonstration of Success

The success of this series of interventions could be measured by the following depending on access to data and resources:

- Number of practice level attestations to join the project
- Survey submission pre, post and at 3 and/or 6 months
- Percent indicating improved learning
- Percent indicating intent to change practice
- Percent that attest to practice changes
- Change in pharmacy data prescribing profile after 6 and 12 months
- Change in the percent of one time fills of antidepressant prescriptions for new starts
- Percent of physician or practice specific patient population that is adherent to antidepressant medication refills for 3 and/or 6 months
- Percent of physician or practice specific patient population on augmentation therapies and involved in behavioral health psychotherapy
- Percent of physicians or practice specific patient population that has switched antidepressant medications at least three times over 6 months and have behavioral health claims indicating behavioral health specialist involvement.

Member Focused Interventions

Member focused interventions

- Internal education campaign to VEBA employees around depression
- Communication to general population through work place vehicles
- Targeting messaging to those who filled their antidepressant prescriptions with focused on:
 - medication adherence,
 - side effects of medications,
 - opportunities and issues to discuss with prescriber and self management
- Systematic refill reminders
- Engagement of a depression disease management program approach

At 12 Months Post Kick Off Event

- Resurvey practices on process changes
- Re-profile practices and physicians to identify practice and prescriber changes

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