Integrated Disease and Depression Management for Insureds in Medicare Supplement Plans

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Psychiatrists, primary care providers, and other professionals have a great collaborative opportunity to improve the healthcare of older adults suffering from chronic illness and mental health disorders. Almost one in five Americans 55 years or older are estimated to have mental disorders. Depression, in particular, is very problematic among this group. Nearly 6% of Medicare beneficiaries who were 65 years or older were diagnosed with depression in 1998, while other estimates have reported prevalence as high as 18% in high-risk groups of older adults.

There are various schools of thought related to the mind-body connection, and the direction of causality for comorbid physical and mental health problems is not always clear. Nevertheless, evidence shows that depression often occurs with other chronic illnesses. Prevalence estimates of major depression among diabetes patients range from 9% to 11%, and elevated depression symptoms have been found in up to 31% of diabetes patients. The prevalence of depression among people with coronary artery disease (CAD) and among those with arthritis is also much higher than among people without these diseases. Depression is an independent risk factor for cardiac events, and major depression has been found in at least 17% of those with CAD.

The mind-body interactions that go hand-in-hand with chronic illnesses and comorbid depression have many consequences. For example, older adults with depressive symptoms have healthcare costs that may be 50% higher, on average, than those without depressive symptoms. These beneficiaries have more inpatient admissions, outpatient visits, and emergency department visits, and use more prescription medications. Minorities may also have provider contacts that are less patient-centered and less conducive to depression management. With regard to age, the quality of depression treatment delivered to older Americans is often substandard, particularly with regard to acute-phase treatment, treatment continuation, and the number of practitioner contacts.

There are considerable consequences for depression that goes untreated or is poorly managed. Along with being a major source of distress, depression in older adults can lead to physical and mental impairment and decrements in social functioning, including social isolation and loss of independence. Depression can also complicate the treatment of other conditions. For example, depression has been associated with poor glycemic control in patients with diabetes. Depression is also associated with higher mortality from heart disease and cancer, and death due to suicide is an important concern. The highest rates of completed suicide are among older adults.

**BARRIERS TO DEPRESSION IDENTIFICATION AND TREATMENT**

Despite the seriousness of depression in older Americans, the condition is underdiagnosed, due to many significant barriers in this population occurring at the patient, provider, and delivery system levels. One of the most prominent patient-level barriers is the stigma associated with mental illness. Perceptions of stigma have been associated with early treatment discontinuation among elderly patients.

Because depression is comorbid with many other disorders, older patients may be more likely to emphasize their somatic problems and less likely to discuss their psychological symptoms. Older adults may not seek treatment for depression because they feel that depression is a “normal” part of aging. They also face financial barriers to treatment that reduce their likelihood of
being treated by mental health specialists.13,19 Many older adults also prefer to address mental health issues in the primary care setting,2,10,20 but the rates of proper identification and treatment in this setting are typically low.2

Many barriers also exist at the provider and delivery system levels. The role of the primary care physician has largely included responsibility for the diagnosis, treatment, and management of mental disorders for older patients.10 It can be challenging for primary care providers to correctly recognize and diagnose depression, however, due to the complexity of distinguishing mental illness from other disease processes faced by the elderly.19,20

Provider-held stereotypes about normal aging, such as depression, hopelessness, and cognitive decline, may also reduce the identification and assessment of mental disorders2 and lead to a focus on other problems instead of depression.11 Primary care providers have also noted time pressure in the clinical setting as one of the largest barriers to recognizing and effectively treating geriatric depression.11,24 Better coordination of care among doctors, with help from non-physician mental health specialists, may relieve some of the time pressures.

Successful treatment of depression is complex.2,13 Medication or psychological therapies must be closely monitored and patients require careful observation over long periods for adequate treatment. The patient and his or her family should be engaged as active participants in treatment. Successful treatment requires not only knowledge about depression but also the time and resources to carefully track patients from treatment initiation and then adjust treatment as necessary. Many of these factors are problematic in primary care settings.13,20

At the delivery system level, mental health is generally not integrated with primary care, even though that is the setting where patients are most likely to present with depression symptoms. Therefore, communication is often limited between primary care and specialty health providers.2,13 Finally, system-level barriers may be due to limited reimbursement for depression treatment and management.2

There have been many calls to improve mental health care for the elderly. Enhanced treatment includes better methods to detect depression and more consistent use of treatment guidelines to treat this condition.1 Additionally, models integrating mental health and medical services are needed, as are rigorous evaluations of the cost-effectiveness of such strategies.25

Research from several large, randomized controlled trials in diverse practice settings during the past 10 years suggest that primary care-based, collaborative care programs for depressed older adults can be successful. The best programs are those in which depression care managers, with consultation from a psychiatrist, support primary care physicians in managing depression, providing patient education and closely tracking treatment outcomes. The depression care managers in these programs also facilitate treatment adjustments or referrals if needed; as a result, they can more than double the effectiveness of usual care for depression.12 Such interventions can be cost-effective,30 especially for patients with chronic medical disorders, such as diabetes.31 Cost savings may accrue over several years.32

**MEDICARE BENEFICIARIES, DISEASE MANAGEMENT PROGRAMS, AND DEPRESSION MANAGEMENT**

The majority of older Americans rely on Medicare to finance their healthcare.33 For mental healthcare, coverage is provided for services from psychiatrists and other physicians, clinical psychologists, other professionals, clinical social workers, clinical nurse specialists, nurse practitioners, and physician assistants.34 However, Medicare beneficiaries still face a high financial burden for their care.3 Until 2006, prescription drug use was not covered by the original Medicare program. Care was, and still is, limited in psychiatric hospitals, and a 50% copayment is required for outpatient psychotherapy.3,13 (This higher copayment is slated to be phased out as a consequence of recent Federal parity legislation.) Care coordination or disease management services for depression are not yet covered by fee-for-service Medicare,35,36 but both may be important for effective depression treatment. In contrast, beneficiaries enrolled in managed care (ie, in Medicare Advantage plans) may have easier access to disease management programs designed to offer such services.

Although most original Medicare program beneficiaries do not have access to structured disease management programs,37 such programs have been introduced through pilot and demonstration programs.35,37 A critical review of all seven disease management initiatives that have been financed by the Centers for Medicare and Medicaid Services (CMS) is contained in a recent paper by Bott et al.38 These initiatives reflect 35 programs conducted in 22 states, with about 316,000 original Medicare beneficiaries (less than 1% of the total Medicare population). These disease management programs promote self-care management, helping beneficiaries to cope with the complexity and fragmentation of their care, with the expectation of improved quality of life and reduced costs for the chronically ill.37,39 Such programs typically offer beneficiaries phone calls from program staff, feedback on self-care, access to 24 hour nurse call centers, and educational tools and materials, although program details differ widely.37

Although these 35 Medicare disease management programs were designed to improve care for beneficiaries with chronic disease, any focus on depression management, either directly or indirectly,
was limited. The majority of these demonstrations were limited to coronary heart disease, congestive heart failure (CHF), and/or diabetes. The new program we describe also integrates depression management into the care of these conditions.

Although Medicare Advantage beneficiaries may benefit from disease and case management, and some pilot programs have been tried for those in the original fee-for-service program, beneficiaries with Medigap coverage have not yet been a target population for such efforts. These beneficiaries make up a large number of Medicare enrollees. In 2004, 22% of Medicare beneficiaries were in a Medigap plan, which is more than those enrolled in comprehensive Medicare Advantage plans.49 The program we describe is for AARP members who are covered by AARP-branded Medigap plans.

Medicare beneficiaries purchase Medigap plans to reduce their out-of-pocket payments for healthcare services. Even so, Medigap beneficiaries still face many of the same difficulties as those in the original Medicare program, including fragmentation of care and lack of care coordination across provider types and settings.35,41 Too little time may be devoted to patient education or to provide support services for busy primary care providers.35

INTEGRATED DEPRESSION MANAGEMENT PROGRAMS

In collaboration with AARP Services, UnitedHealth Group (UHG) developed new programs to care for those in Medicare Supplement plans who are coping with chronic conditions. These programs began in December 2008 and will be offered until at least December 2010 in five pilot markets to all Medigap members consenting to program participation.

These new programs are explained briefly below. They rely to a great extent on computer-based searches and analyses of diagnosis codes and demographic information (age and gender) that can be found in health insurance claims and enrollment data. To date, about 80% of program participants have been found by analyzing these types of data. Recognizably, such data are not the gold standard for case finding, but an advantage is that these data can be searched from millions of people very quickly, therefore enhancing the replicability and scalability of the programs.

The clinical programs described below use Episode Treatment Group (ETG) technology to mine claims and enrollment data and find people with diabetes, CAD, CHF, and some of those who have depression. In an effort to enhance transparency, a complete set of information about exactly how diagnoses and other information are used in the ETG technology to help find patients with the diseases of interest is available at www.ingenix.com/transparency.

Case finding efforts also use technologies developed for the federal government, with the same data, to assess patients’ risk for future serious medical or psychiatric problems.

Among these, the High Risk Case Management program is designed to find the sickest and most frail elderly and apply face-to-face and/or telephonic chronic illness management. The highest risk members will receive face-to-face interventions (home health visits), while those at moderate risk will be treated primarily over the telephone. Program enrollees will have individualized care plans and interventions based on assessment of their condition, needs, strengths, and preferences. The program also will provide a care coordination component to facilitate communication between case management nurses, physicians, members, and their caregivers.

The High Risk Case Management Program targets Medigap insureds who are expected to be very costly to treat in the coming year, based upon their predictive hierarchical condition category (HCC) score. HCC scores, calculated from software provided by CMS, predict how expensive a member is likely to be in the following year, relative to all members in the population of interest, based on their age, gender, and diagnoses. Members with very high HCC scores (eg, above 3.75) typically have a variety of chronic conditions and, therefore, do not fit as well within a disease management program, which is designed to focus on a single condition or a small number of conditions.

Disease Management Program

The Disease Management Program is designed to support members with CHF, CAD, or diabetes. Similar to the High Risk Case Management Program, all enrollees will have individualized care plans and interventions based on assessments of their conditions, needs, and preferences. The program will include telephonic and Web-based screening, assessment, self-management support, and problem solving solutions for caregivers, physicians, and members.

Physicians will be provided with current, relevant information about their patients through Web-based tools. Such tools (eg, “Ask a Nurse/MD”) will also be used to reinforce patient/physician communication and patient education. Individuals will be enrolled in one program, even if they have more than one of these conditions. Individuals with CAD and diabetes will be managed in the CAD program and individuals with CHF and diabetes will be managed in the CHF program. Members with all three conditions will be enrolled in the CHF program. The highest-risk CHF members will be provided an electronic scale that records and transmits daily body weight values and responses to questions about CHF symptoms.

Disease Management Program participants are identified using a variety of methods, including internal referrals (eg, 24-hour nurse support line), external referrals (eg, self-referral, caregiver referral), or data-based methods. Data used to identify patients will include monthly updates to medical and pharmacy claims, laboratory claims when available, and HCC scores. Health Risk Assessments, to be completed annually at the time of member enrollment

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or re-enrollment, will also be used to find potential program participants.

The High Risk Case Management and Disease Management programs have an integrated component designed to find and treat members with depression. Members enrolled in either program will be screened for depression using the two-item Whooley scale. These two items assess depressed mood and loss of interest or pleasure in activities. Those who screen positive for depression will be assessed further with the Patient Health Questionnaire (PHQ)-9, which is widely used to screen for depression. Additional services may be offered to those who complete the PHQ-9, based upon their answers to those nine questions, as described below.

**Depression Management**

The Depression Management program is designed on the premise of integrated medical/behavioral service delivery. This program will include several elements that are critical for successful collaborative care provided by medical and behavioral health professionals. A cross-professional care team that includes primary care physicians, nurses, and mental health specialists will be established. Evidence-based protocols for treatment will be used, and active monitoring of adherence to treatment and member outcomes will be used, via systematic 8-week reassessments using the PHQ-9 instrument. Program staff will identify and reach out to individuals with depression throughout the delivery system and provide depression management support services. In addition, program staff will offer referrals to community resources and to other relevant programs or information sources.

After the case finding process, members will be contacted by telephone to assess their interest in participating. Those who complete the PHQ-9 will then be stratified into low-, moderate-, or high-risk depression management, based on their PHQ-9 scores. Members with low depression risk (with PHQ-9 scores less than or equal to 4) will be offered a Web-based program, consisting of tools, tip sheets, and educational materials. These Web-based tools will be accessible from physician offices, the member or caregiver home, or from any other location offering Web access.

Members with moderate-risk depression (with PHQ-9 scores from 5 to 9) or high-risk depression (with PHQ-9 scores of 10 or higher) will receive an individualized treatment plan, developed from an initial assessment of gaps in care that are noted from patient and physician perspectives. Depending on individual needs, these members may receive nurse- or case manager-led education, PHQ-9 monitoring, or telephonic outreach. In severe cases, these members may receive face-to-face visits. For individuals with high risk depressive symptoms (ie, with PHQ-9 scores of 15 or higher) along with CAD, CHF, or diabetes, a behavioral health advocate will collaborate with clinical nurses, the primary physician, and other behavioral health providers.

Cases will be closed when members are deemed clinically stable and when PHQ-9 scores are less than 10 or show at least 50% reduction. At case closure, a relapse prevention plan will be developed and implemented, which will support ongoing improvement in the members’ health situation, provide self-management strategies, and include a relapse prevention plan and a crisis plan in the event of patient relapse.

An essential element of the Depression Management Program is care coordination between medical and behavioral healthcare professionals. Aspects of the program supporting coordination will include the use of clinical protocols, interdisciplined clinical rounds involving nurses and behavioral health professionals, and the use of clinical templates for member interviews that promote coordination across disciplines. In addition, the same Disease Management or High Risk Case Management nurse will work with the member and their physician to effectively manage all needs.

Structured communication will also support care coordination. Disease Management and High Risk Case Management nurses will be required to communicate care plans, PHQ-9 scores and changes in these scores over time, and the relapse prevention plan, to treating primary care providers.

**Program Implementation and Evaluation**

In 2009 and 2010, the integrated disease/case/depression management programs are being operated on a pilot-test basis in five markets. These include the New York City area; the central region of North Carolina; the Los Angeles area; the Cleveland and Youngstown areas in Ohio; and the Tampa, FL, area. All of the new AARP-branded programs from UHG will be broadly culturally sensitive and will have materials focused on the needs and expectations of diverse populations. Telephonic translation services through the AT&T Language Line will be available to support the needs of members. Additionally, enrollees who transition to another AARP-branded insurance product in the UHG suite of programs will be able to continue in the program without disruption.

Participation in these programs and care management processes will be monitored throughout the 2-year pilot phase, as will changes in health status. A statistically rigorous evaluation of program effects on costs and patient outcomes will be conducted at the end of the pilot phase. We will compare program participants with non-participants, after adjustments are made for differences in demographics, health status, insurance plan type (ie, there are 12 different types of standard Medigap plans and some special “waiver” plans offered in some states) and location.
Intent-to-treat analyses will be used, and analyses will also control for the intensity of the services that are received (see the Figure for examples of these). Outcome measures will focus on medical expenditures, other health status and quality-of-care metrics, and measures of the burden of physician office staff in treating chronically ill beneficiaries. Results of the evaluation will guide future positioning of the program and should be of broad interest to federal policymakers and other insurers.

CONCLUSIONS

Mind-body interactions play a role in how patients with chronic diseases present symptoms and discuss those with their doctors or other professionals. Those symptoms and discussions may vary by age, race, ethnicity, and other factors. Tailoring screening and diagnostic processes accordingly may help increase treatment success rates.

Dealing with mental health problems in the presence of other physical ailments is problematic. Depression, in particular, is a substantial and increasingly recognized public burden among older adults and is commonly present among those who also suffer from other serious chronic illnesses. This places great strain on healthcare delivery systems and has an enormous effect on public health and quality of life of Medicare recipients. Alleviating the burden of geriatric depression requires several types of interventions, including patient and provider education, integration of medical and behavioral health, and care coordination across treatment settings. Although comprehensive depression management programs have been shown to improve outcomes in academic trials, systematic integration of depression management into clinical programs has not occurred widely for beneficiaries in Medicare Supplement Insurance plans.

The new integrated disease management, case management, and depression management program developed by UHG and AARP Services Inc. focuses on the critical needs of older Americans suffering from chronic illnesses and depression. It has the potential to lead to major improvements in health outcomes for large numbers of fee-for-service Medicare recipients. As described, various methods will be employed to ensure that patients receive adequate screening, treatment, and management of their depression diagnosis, as they are treated for other vexing health problems.

Many of the barriers to adequate treatment will be addressed by the program, including time constraints faced by physicians and the lack of integrated medical and behavioral healthcare. These barriers will be reduced by coordinating care and supporting treating physicians with specially trained nursing and behavioral health staff. Medical and behavioral health staff will learn more about each other’s disciplines through an integrated care model, which should enhance the quality of care delivered to the patient. Expanding such programs to Medigap members could benefit a population in need of coordinated care and depression management. Continual monitoring of care processes and clinical outcomes,
and rigorous statistical evaluations of program performance will be conducted. These will guide the development of each program and provide useful information for federal and other policymakers who are charged with enhancing the lives of older Americans.

REFERENCES


