

DIAMOND Initiative Charter
Depression Improvement Across Minnesota – Offering a New Direction
Proposed Plan – November 2006 – Final Approval January 2007

Goal: To implement through a systematic and coordinated plan, an evidence-based care management program for patients with depression in primary care medical groups in Minnesota. A key component of this project also is the implementation of a care management fee, which will be paramount in supporting and sustaining the care management program as well as the establishment of a formal consultative role for the psychiatric specialty linked to the primary care environment.

The elements of this program also fit well into Wagner's Chronic Care Model, which provides a framework for what is needed for best chronic disease management. At the macro level, this project focuses on the health care system as a whole including the community by bringing all the involved parties to the table and working together to combine patients, care givers, health plans, purchasers, related associations, and consumers to align incentives, improvement processes and structures, and activated patients. At the micro level, described below, it will demonstrate how the individual elements of the care management program support the various components of the chronic care model (CCM).

Scope of patient population: Patients age 18 and older that are diagnosed and managed in the primary care setting with a diagnosis of major depression.

DIAMOND Depression care management program elements:

- A reliable and consistent method for initial assessment for depression criteria, suicidality, and comorbidities. Within the DIAMOND project, PHQ-9, as a reliable and consistent method for assessment and ongoing management of depression, will be an essential tool required of the participating organizations. An additional assessment needs to be added for comorbidities and signs of suicidality. *This is a key element to aid in decision support – one of the components of the CCM, providing support for the care manager role as well as other health care providers.*
- Systematic follow-up tracking and monitoring for treatment problems and effectiveness. The use of repeated PHQ-9 measurements will be key to monitoring treatment effectiveness. The development of a registry system within the participating organizations will be a significant component to support this element. *This component, once developed, can be easily spread to include other chronic diseases and make follow-up and management much more effective. Registries are directly linked to the area of clinical information systems in the CCM and are important for the timely information on patients for follow-up and tracking and reinforcement of self-management for all chronic diseases.*
- Use of the ICSI evidence based guideline and the IMPACT study protocols will be key in the support of this element of the model within DIAMOND. A stepped care approach for treatment modification/intensification to overcome clinical

inertia and to treat persistent depression. *Use of any evidence-based guidelines are significant tools used for decision support.*

- Relapse prevention once a patient is improved. The components noted above will be of value in supporting this essential element.
- A care manager role (Level 1) to coordinate the disease management for patients with depression. Specific duties will include education, self-management support, coordination of care with primary care and behavioral health providers, facilitation of changes in treatment identified by the stepped care approach developed as a part of the model. The specific duties of a Level 1 care manager are based on work done in multiple other evaluations of a collaborative care approach, primarily from the IMPACT study referenced earlier. This role could be a nurse, health educator, or medical assistant that works in the primary care setting and will primarily operate at a local level. There may be some variability based on local environmental and cultural differences between provider organizations. Within the DIAMOND project participants, this role will be essential in supporting the process changes identified throughout the model. *This role could also be expanded to manage the care of other chronic diseases using similar tools and structures and is a crucial part in redesigning the care delivery system for chronic care.*
- Psychiatric consultation and caseload supervision on a formalized basis. A collaborative relationship between primary care and the psychiatric specialty will be essential to support the elements identified in the collaborative approach. This will require 1-2 hours of designated time weekly depending on the patient load, and will represent a different body of work for the psychiatrist involved. The staff serving the care manager role coordinates with psychiatry by way of a weekly meeting to discuss patients that are not improving. The care manager will provide communication when appropriate with the primary care provider involved in the patient's care, and ensure continuity as appropriate with the primary care provider for those patients enrolled in the program. This may result in a change in treatment in which the care manager follows up with the patient or an actual patient visit with mental health.

The coordination of care between primary and specialty care is a piece of delivery system redesign that is needed to support chronic care management.

DIAMOND Depression care management payment and coverage elements:

- Creation of a depression care management payment to be paid on a periodic basis to the primary care clinics for all services provided under the DIAMOND depression care management program as outlined above. The payment excludes patient visits with primary care providers and/or mental health providers.
- Medical groups will need to meet basic requirements in order to qualify for the care management payment:
 - o Part of the DIAMOND implementation process
 - o Have a DIAMOND certified care manager(s) (level 1)

- Have implemented the depression care management program elements mentioned above.
- Patients are enrolled in the depression care management program by the medical group. Criteria for potential enrollment includes:
 - Primary care patients
 - Age 18 years and older
 - Includes all payor types with the exception of Medicare FFS
 - Either newly diagnosed major depression (PHQ9> or equal to 10) or chronically depressed patients that are enrolled at the physician's discretion.

Criteria for discontinuation of this program will be developed as well.

- This fee does not cover physician services (primary care or mental health) which are billed separately.
- The periodic care management payment will be initiated for the first twelve months of enrollment for a patient and after that initial year this model would be adjusted to add payment based on achieving set targets with the outcome measures with a set number of patients. This would be determined between the primary care group and the individual health plan.

DIAMOND depression care management measurements:

Proposed measurements for medical group collection:

1. Patient with major depression, response rate at 3 months (+/- 30 days) after enrollment in the depression care management program
2. Patient with major depression, remission rate at 3 months (+/- 30 days) after enrollment in the depression care management program
3. Patient with major depression, response rate at 6 months (+/- 30 days) after enrollment in the depression care management program
4. Patient with major depression, remission rate at 6 months (+/- 30 days) after enrollment in the depression care management program

Measurement specifications:

- Patient is 18 years of older and enrolled in the care management program
- Patient has diagnosis code of 296.2, 296.3, or 300.4
- Measures will be collected monthly by medical groups and submitted to ICSI for aggregation and analysis.

Other measures that could be added:

- Measures from the health plans could be around cost saving per capita for patients with one of the three codes (296.2, 296.3, 300.4) for depression care in primary care prior to the care management program and then post-care management program.
- Measure could be developed from the purchasers perspective through employee surveys for quality of life measures

Final revisions 1.24.07

- Percent of active patients in each medical group that are enrolled in the depression care management program.
- Other cost saving and Quality of Life (QOL) measures may also come through the NIH research project
- Documentation of Care manager time at different steps of the process.