Depression in Primary Care: Quality Improvement and Economics

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Overview of Presentation

- Why is improvement so hard?
- Where shall we look for improvement?
- What stands in the way of adoption of evidence based treatment in primary care?
- Some practical steps to consider

Improving Treatment for Depression in the U.S.

- Focus on primary care
- Why?
  - Growth in treated prevalence has come from primary care
  - Share of primary care in mental health care has grown to 53% of cases
  - Technical change in drugs and manualized therapies especially significant for PCPs
  - PCP historically weak in recognizing and treating depression

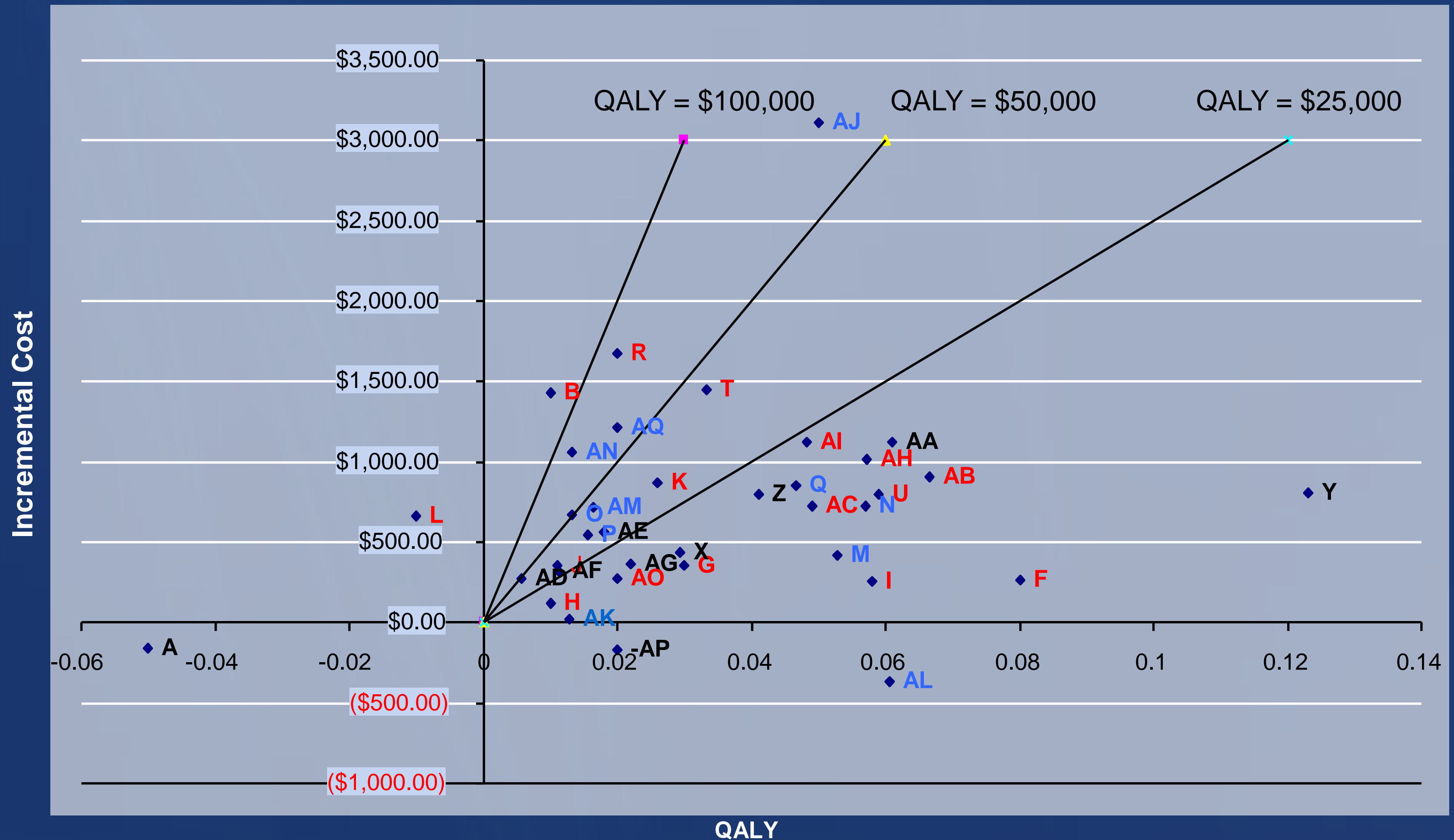
Elements of Evidence Based Treatment of Depression for PCPs

- Physician time
- Care manager services
- Specialty consultation
- Registry-decision support

Learning About Impacts of Evidence Based Care

- Effectiveness: Meta Analysis (Gilbody et al Arch Int Med 2006)
  - Six month gains ~ 0.25
  - Five year gains ~ 0.15
- Key elements of treatment
  - Medication adherence
  - Credentials and supervision of care managers

Cost Effectiveness of Evidence Based Care for Depression in Primary Care



Cost-Effectiveness

Evidence based treatment increases treatment costs and improves outcomes

- Estimates of incremental costs per QALY $11,270 to $19,510 when Canadian cut offs were $20,000 to $30,000 (Lave et al 1998)
- Little evidence of general medical offsets
- Results in improved work outcomes; probability of working; hours of work (Timbie et al, 2006)
- Finding replicated in several different settings

Usual Care for Depression Differs from EBT

- PCPs still frequently fail to recognize depression
- PCPs visit duration increases by 1.8 minutes with cases of depression/anxiety (Frank and Zeckhauser, 2007)
- High percentages of usual care patients do not have follow-up contact
- Typical PCP treating depression adjusts treatment according to *level* of symptoms not *change* in symptoms (Henke et al, 2007)

What Stands In The Way Of Adoption Of Evidence Based Treatment?

- PCP attitudes and habits
- Organization of PCP practices
- Implementation of quality improvement efforts
- Payment policies
- Use of decision supports

Attitudes and Habits

- Physicians do not devote extra time
  - Average visit 17 minutes; depression cases get less than 19 minutes on average
  - When mental health problems are raised with PCP; video tape evidence suggests subject is changed in about 1 minute (Tai-Seale et al, 2007)
- Cases of depression less likely to have return visits than other chronic conditions

Organization of Physician Practice

- Approximately 30% of PCPs are in solo practice and 20% to 30% more are in small groups (<5)
- The costs of a care manager are typically higher in small groups and solo practices
  - Difficult to spread quasi fixed cost of care manager
- Small groups less likely to use electronic records

Payment Policies

- Carve-outs can be an impediment to evidence based treatment in primary care
  - Some plans that carve-out behavioral health do not pay PCPs for treatment of mental disorders
  - Referral networks between PCP and carve-out may not overlap (although this is a declining problem)
- Medicare and other payers do not pay for care management or some types of consults

Plan Quality Improvement Programs

- Results from a national survey of health plans
- Surveyed 242 individual plans
- Sixty six percent for-profit
- Distributed across all regions of U.S.
- Fifty three percent had over 50,000 lives

Data Collection and QI Activities

	Anti-depressant medication	Cholesterol Management	Asthma Medication
Plan level Data			
Collects Data	91.3%	92.1%	95%
Target Measures	84.3%	83.1%	87.6%
Demonstrate Improvement	47.5%	73.1%	81.4%
Physician/Group Data			
Collects Data	53.7%	68.2%	79.8%
Feedback	38.4%	58.3%	68.6%
Uses in P4P	17.4%	28.9%	33.1%
Uses in Report Cards	13.6%	19.0%	21.5%

Author's calculation : Value Based Purchasing Survey 2005

Use of Reminders

	Capitated	FFS
Anti-depressant medication	55.9%	34.3%
Diabetes Care	89.9%	79.5%

Author's calculation : Value Based Purchasing Survey 2005

Observations

- Plans consistently devote less QI effort to depression performance
- Plan-physician interactions on depression QI are low relative to other chronic conditions
- Fewer financial and non-financial incentives tied to performance on treatment of depression
- Incentive effects: a) less of a positive effect; and b) multi-tasking impact (diversion of effort away from unpaid outcomes or "teaching to the test")

Towards Renewed Improvement: Care Management

- Spreading costs/ training are key
- Generic chronic disease care managers
- Experiences in 6 major demonstrations suggest case loads of 40-80 patients per care manager
- Use of carve-outs for virtual/telephonic care management
  - UCSF-UBH-BCBS Model
- Only virtual model compatible with solo/small group practices

Physician Time

- Altering scheduling is very difficult
- UCSF experimented with adjustment to productivity formula to give PCP more time for depression care
  - Adjustment allowed 30 minute depression visit to count as two visits
- Few PCPs availed themselves of extra time
  - Suspect that since only a share of patients were eligible for adjustment habits did not change (Feldman et al 2006)

Carve-Outs

- Can be structured to promote EBT
  - Credential and pay PCPs FFS for EBT
  - Serve as care manager
  - Aid in constructing referral network

Plan QI Programs

- Plans can help motivate effort aimed at improved performance
- Consistent Measurement (HEDIS)
- Feed Back to PCPs
- Use in Report Cards
- Include in incentive schemes

Decision Support

- PCPs do not typically measure depressive symptoms longitudinally
- PHQ-9 convenient tool (there are others)
- Tracking symptoms appears to alter treatment adjustment behavior
- Low cost spread sheets are available
  - Apple II+ could support software

Bottom Line

- Path to improving depression care is clear
  - Improved care management
  - Longitudinal tracking of symptoms by PCP
- Plans have key role to play in motivating performance
- Improving depression care will improve health
- Likely raises costs modestly
- Results in some productivity improvements (captured by partly employers mostly by households)
- Few medical offsets should be expected