



MEDICARE HEALTH OUTCOMES SURVEY

National Pilot Project on Depression

FINAL REPORT
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TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
BACKGROUND AND HISTORY	3
METHODOLOGY	7
RESULTS.....	11
CONCLUSIONS AND RECOMMENDATIONS	22
REFERENCES	27
APPENDICES	

APPENDIX A: SURVEY OF DEPRESSION MANAGEMENT ACTIVITIES

THE MEDICARE HEALTH OUTCOMES SURVEY NATIONAL PILOT PROJECT ON DEPRESSION

FINAL REPORT

EXECUTIVE SUMMARY

BACKGROUND

The Medicare Health Outcomes Survey (HOS) provided Medicare + Choice Organizations (M+COs) and Quality Improvement Organizations (QIOs) with a unique opportunity to assist primary care providers in recognizing and treating depression in seniors. In 1999 the HOS contract between the Centers for Medicare & Medicaid Services (CMS) and Health Services Advisory Group (HSAG; the Arizona QIO) was expanded to include a National Pilot Project on Depression. Depression was chosen as the focus of the National Pilot Project because it: 1) is a prevalent condition; 2) is relatively easy to treat; 3) is often overlooked by the primary care provider (PCP); 4) increases utilization of physical health services; and 5) can have serious consequences if left untreated.

PROJECT GOALS AND PARTICIPANTS

The principal goals of the project were to help QIOs and M+COs develop a strategy for using the HOS results to identify beneficiaries with a high risk for depression, and to give the QIOs and M+COs practical experience in managing behavioral health issues. Sixteen M+COs and the QIOs from six states (Arizona, Florida, Michigan, New Mexico, New York, and Ohio) participated in the National Pilot Project.

METHODOLOGY

The QIOs obtained utilization data from each participating M+CO in their respective states. QIO staff then linked these data to demographic data, reports of chronic medical conditions, and mental status scores from the HOS, and used the resulting data file to generate a statistical profile of beneficiaries at high risk for depression. A separate risk profile was created for each of the M+COs. Each M+CO then provided their PCPs with a list of the high risk beneficiaries in his or her caseload, as well as educational programs, clinical guidelines, and treatment protocols for depression management. By using the HOS data to identify the high risk beneficiaries, the PCPs were not responsible for performing the initial screening of their caseloads. This allowed the PCPs to focus their screening and management efforts on their high risk patients.

RESULTS

Mental Component Summary (MCS) scores from the HOS were compared for the 16 participating (“pilot”) plans and 148 nonparticipating (“control”) plans, both before and after

project implementation. No significant differences were found, which may be due to the fact that only a small number of beneficiaries who might have received the interventions appeared in the HOS samples.

A follow up survey of M+COs regarding their depression management activities indicates that the pilot project had a positive impact on the number of depression management activities deployed by the participating plans, although this difference did not achieve statistical significance.

The National Pilot Project also stimulated the development of several other initiatives regarding behavioral health care, including a series of behavioral health care workshops for QIOs sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA).

RECOMMENDATIONS

QIO and M+CO experiences during the National Pilot Project suggest the following recommendations for future projects of a similar nature:

- Implement only those interventions that research has demonstrated to be effective. During the past few years, the effectiveness of the major depression management strategies has been thoroughly evaluated.
- Minimize the burden on the PCPs even further by using a short, easy to implement depression screener, and by refraining from screening asymptomatic beneficiaries.
- Increase the probability of treatment success by screening for substance abuse as well as depression. These two conditions are strongly associated, and attempting to treat a beneficiary's depression without also treating co-occurring substance abuse problems lessens the chances for success (Levin, Kruger, and Blow, 2000).
- Obtain expert legal advice regarding the proper interpretation of legislation related to confidentiality. Many M+COs report that efforts to share information regarding depressed beneficiaries have been stymied by legal concerns.
- Educate M+COs and providers regarding the five new procedure codes that permit reimbursement of behavioral health services at the physical health reimbursement rate (American Psychological Association, 2002a). These new codes provide an additional incentive to providers for recognizing and treating depression.
- To reduce the burden of data collection, provide M+COs with a simplified version of the National Pilot methodology. A User's Guide has been prepared to meet this need (HSAG, 2002).
- Provide M+COs with a paradigm for identifying opportunities for improvement. Such a paradigm is presented on page 25 of this report.

BACKGROUND AND HISTORY

INTRODUCTION

The Medicare HOS, the nation's first measure of health outcomes for the Medicare population in managed care settings, was designed to measure self-reported health status over a two year period for the two main components of health status: physical health and mental health. CMS, in collaboration with the National Committee for Quality Assurance (NCQA), has designated the HOS as a Health Plan Employer Data and Information Set (HEDIS^{®1}) reporting requirement. In addition, CMS' Quality Improvement System for Managed Care (QISMC) requires that all M+COs undertake regular quality assessment and performance improvement projects with the aim of showing demonstrable improvement in the outcomes of care provided to beneficiaries.

The HOS instrument consists of four components: the SF-36[®] Health Survey² (Ware, Snow, Kosinski, and Gandek, 1993), questions about chronic medical conditions, questions about activities of daily living, and questions designed to collect demographic information. Physical functioning and well being are measured with the Physical Component Summary (PCS) score and mental functioning and well being are measured with the Mental Component Summary (MCS) score, both of which are derived from the SF-36[®]. The HOS is designed to measure the physical and mental health functioning of Medicare beneficiaries over a two-year period.

Annual baseline collection of HOS data from a randomly selected sample of members from each M+CO began in 1998. Key tasks of HSAG's contract with CMS included conducting data analysis and reporting of the HOS results. It was subsequently determined that the HOS provided M+COs and QIOs with a unique opportunity to assist primary care providers in recognizing and treating depression in seniors. Consequently, in 1999, HSAG's HOS contract with CMS was expanded to include a National Pilot Project on Depression.

SELECTION OF DEPRESSION AS THE PROJECT FOCUS

Depression was chosen as the focus of the National Pilot Project because it:

- is prevalent among the senior population (Eaton, 1997; Gurland, Cross and Katz, 1996);
- responds well to treatment (Mulrow et al., 2000);
- is often overlooked by the primary care practitioner (Regier et al., 1993);
- increases the persistence and intensity of symptoms of physical illness (Vaccarino et al., 2001);

¹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

² SF-36[®] is a registered trademark of the Medical Outcomes Trust.

- results in increased consumption of resources for physical health care (Koenig and Kuchibhatla, 1998);
- increases the mortality rate for physical illnesses such as myocardial infarction (Frasure-Smith et al., 1995) and cancer (Penninx et al., 1998); and
- increases the mortality rate due to suicide (Conwell, 1996).

PROJECT GOALS

CMS established the following goals for the National Pilot Project:

1. Help QIOs and M+COs develop a strategy for using self-reported health data, such as the results from the HOS, to identify beneficiaries with a high risk for depression.
2. Provide QIOs and M+COs with practical experience in managing behavioral health issues.
3. Provide QIOs and M+COs with an understanding of how HOS data can be linked to M+CO administrative data to more precisely identify high risk beneficiaries.
4. Help M+COs more effectively focus quality improvement (QI) interventions on the beneficiaries most likely to benefit from these interventions.

To enhance the value of the National Pilot Project, steps were taken to ensure that the QI activities directed towards depression could be used to satisfy the QISMC standards. At the time of the project launch, the QISMC standards called for each M+CO to conduct two Quality Assessment Performance Improvement (QAPI) projects: one focused on a condition specified by CMS and one on a condition to be chosen by the plan. Accordingly, it was decided that the participating M+COs could use their National Pilot Project activities as their discretionary QAPI project.

According to the QISMC guidelines, measures of quality improvement activities must be expressed in the form of rates. However, the MCS scores from the HOS are not rate data. Therefore, for the National Pilot Project participants, CMS approved the use of MCS change scores as a QISMC measurement.

PARTICIPANTS

In December 1999, the QIOs in Arizona, Florida, and New York began implementing the National Pilot Project. In 2000, the QIOs from Michigan, New Mexico, and Ohio joined the project. These QIOs recruited a total of 22 M+COs into the project. Over the course of the project, four of these plans dropped their senior products and two plans decided that they did not have sufficient resources to continue, leaving a total of 16 plans that remained in the project. Table 1 lists the participating QIOs and plans.

TABLE 1
NATIONAL PILOT PROJECT PARTICIPANTS

QIO	M+COs
Health Services Advisory Group (Arizona)	CIGNA Healthcare of Arizona Health Net of Arizona Humana Health Plan Maricopa Integrated Health System
Florida Medical Quality Assurance, Inc.	Health First Health Plan VISTA Health Plan United HealthCare of Florida
MPRO (Michigan)	Health Alliance Plan of Michigan M-CARE
New Mexico Medical Review Association	Lovelace Health Systems
IPRO (New York)	Elderplan Healthfirst HIP Health Plan of New York Univera Healthcare
KePRO (Ohio)	Hometown Health Plan PrimeTime Health Plan

ROLES AND RESPONSIBILITIES

HSAG

For the National Pilot Project, CMS charged HSAG with accomplishing the following tasks:

- 11.10 Finalize the project methodology and develop a tool for participating QIOs to use in documenting and reporting plan interventions (submitted August 7, 2000).
- 11.11 Coordinate activities with all participating QIOs, monitor progress, support communications, and host monthly conference calls of participants (in process, will be completed by October 31, 2002).
- 11.12 Develop a draft version of a User's Guide to assist plans in using HOS data in QI studies (submitted July 15, 2002).

- 11.13 Develop a final version of the User's Guide based on feedback from CMS (submitted August 15, 2002).
- 11.14 Provide technical assistance to participating QIOs and conduct analysis of participating plans' MCS and PCS scores (in process, will be completed by October 31, 2002).
- 11.15 Produce a comprehensive final report on the project, including background and history, a summary of plan and QIO responsibilities, a description of the methodology used, results of the project, and a paradigm for identifying QI opportunities at the plans (submitted September 30, 2002).

THE QIOs

The six participating QIOs were charged with providing technical support to the participating M+COs in their respective states. This support included analysis of the M+COs' HOS and utilization data, development of a statistical model for identifying high risk beneficiaries (using statistical analysis programs written by HSAG staff), a standard format for construction of the necessary data files, advice and consultation regarding potential interventions, and the coordination of meetings and conference calls to share experiences and issues.

THE M+COs

The M+COs' responsibilities included:

1. Using the statistical model developed by their QIO to identify high risk beneficiaries;
2. Furnishing their PCPs and office staff with a list of the high risk beneficiaries in their respective caseloads;
3. Providing the PCPs and office staff with information, educational meetings, clinical guidelines, and decision protocols relevant to the management of these high risk beneficiaries; and
4. Participating in teleconferences and meetings organized by the QIO in their respective states.

By giving the PCPs a list of high risk beneficiaries, the M+COs removed much of the burden of identifying potentially depressed seniors from the PCPs. This allowed the PCPs to concentrate their efforts on follow up activities with those beneficiaries most likely to suffer from depression.

METHODOLOGY

POPULATION

The population consisted of Medicare beneficiaries currently enrolled in the participating M+COs.

PROFILING HIGH RISK BENEFICIARIES

DATA SOURCES

The existing annual HOS random samples of M+CO beneficiaries were the main source of data for conducting the National Pilot Project. The raw data from the HOS respondents provided to the QIOs formed the analysis data set for the pre- and post-measures of the pilot project. Utilization data from the M+COs' databases were used to supplement the respondent data file. Utilization data were obtained for inpatient stays, emergency room visits, PCP visits, mental health provider visits, and prescriptions for antidepressant medications.

DATA ANALYSES

The data sources described above were used to identify the characteristics of HOS respondents with depression. The QIOs carried out a series of analyses and shared the results with each participating M+CO.

1. Using SAS® System code provided by HSAG staff, respondents of the HOS survey were segmented into two groups: those with an MCS score of 42 or below and those with an MCS score above 42.

Research has established a clear relationship between MCS scores and levels of depression; the threshold value of 42 was established as the optimal cut-off score in previous evaluations of MCS as a screening tool for clinical depression (Ware et al., 1994). Using receiver operating curve (ROC) analysis, a cut-off score of 42 or below achieves an area under the ROC curve of 0.77 and a sensitivity and specificity of 73.7% and 80.6%, respectively (Berwick et al., 1991). Therefore, HOS respondents with an MCS score less than or equal to 42 were operationally defined as having a "high risk" for depression.

2. Statistical (chi-square) tests were conducted to compare the respondents above the threshold MCS score, and the respondents at or below this threshold, using SAS® code provided by HSAG. These comparisons were performed for each item on the HOS. This analysis was used for initial identification of HOS items that significantly discriminate between the two groups.

3. The QIOs requested utilization data from each participating M+CO, using a standard data request form developed by HSAG. Data were requested for inpatient stays, ER visits, PCP visits, mental health visits, and prescriptions for antidepressant medications for all beneficiaries enrolled during the 1998 HOS data collection period. Each M+CO's HOS sample of 1,000 beneficiaries was embedded in a larger group of 3,000 beneficiaries. In order to ensure the anonymity of the beneficiaries in the HOS sample, the M+COs provided utilization data for all of these 3,000 beneficiaries to the QIO.
4. The QIOs integrated and matched, at the beneficiary level, this M+CO data to the data for the 1,000 HOS respondents contained in the larger sample of 3,000. The resulting "enhanced data set" contained both HOS survey responses and utilization data at the beneficiary level.
5. The QIOs then developed a predictive model from the enhanced data set, using SAS® code prepared by HSAG. This model used logistic regression analysis to predict MCS status (MCS score above or below 42) from beneficiary demographic characteristics, comorbidities and utilization patterns. A separate model was developed for each M+CO.
6. The QIOs supplied this statistical model to the participating M+COs in their respective states. Beneficiaries from the *total* plan population whose demographics, chronic conditions, and utilization matched those of the high risk beneficiaries in the enhanced data set were then targeted by the M+COs for case finding and interventions.

EVALUATION DESIGN

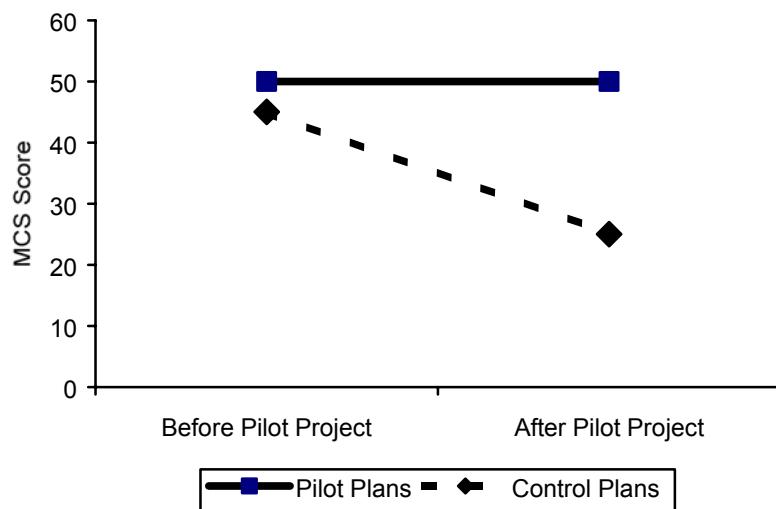
DATA SOURCES

It is reasonable to expect that the case finding and intervention activities stimulated by the National Pilot Project would: 1) increase M+CO programs and initiatives directed at depression; and 2) improve the mental well being of senior beneficiaries. A Survey of Depression Management Activities, administered via e-mail to M+CO staff, was used to measure depression management activities. A copy of this questionnaire is in Appendix A. The MCS scores from the HOS were used to determine if the mental well being of the senior beneficiaries had improved.

ANALYTICAL PLAN

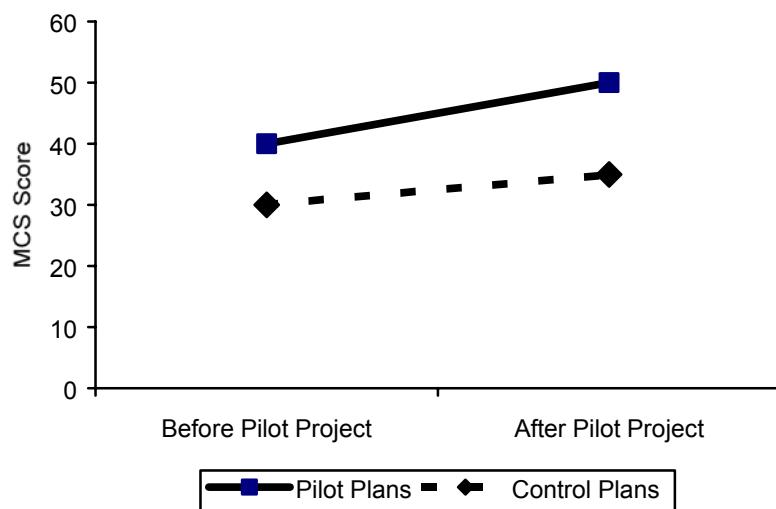
To aid in the interpretation of the results from the participating plans, data were collected from additional plans that did *not* participate in the National Pilot Project. Results from these nonparticipating ("control") plans can potentially change the conclusions that are drawn regarding the project's impact. Figure 1 shows one way that this could occur.

FIGURE 1
MENTAL COMPONENT SUMMARY TRENDS
(Hypothetical SF-36® Data)



If data were only available from the pilot plans, one would conclude that the pilot project has had no impact on MCS scores. However, the results for the control plans suggest that the project succeeded in *preventing a decrease* in MCS scores; i.e., that the project had a favorable impact on MCS scores. Figure 2 shows another possible scenario.

FIGURE 2
MENTAL COMPONENT SUMMARY TRENDS
(Hypothetical SF-36® Data)



In this scenario, MCS scores for the pilot plans improved by 10 scale points. This initially suggests that the National Pilot Project has had a favorable impact of 10 points on the MCS score. However, the control plans showed an improvement of five points, which suggests that the *net* impact due to the pilot is only five points.

DATA ANALYSES

To assess the project's impact on mental well being, *Cohort II Baseline* MCS scores (collected in 1999) were used as the pre-measure, and *Cohort IV Baseline* MCS scores (collected in 2001) were used as the post-measure. Among the M+COs that have participated in one or more HOS administrations, a total of 164 participated in both the *Cohort II Baseline* and *Cohort IV Baseline* HOS. Sixteen of these were the pilot plans, leaving a total of 148 plans to serve as the control plans.

Proxy respondents (family members, friends, or caregivers of the beneficiaries) were excluded from all of the pilot project analyses of the MCS scores. This was done for two reasons: 1) to reduce the variability in the data; and 2) because feelings of depression are very often not reported to others (Gallo et al., 1997).

The 1990 standard scoring method for the SF-36® was used to compare the *Cohort IV Baseline* results to the *Cohort II Baseline* results. This scoring method was used because the revised scoring method, based on a Missing Data Estimation (MDE) methodology, was not introduced until after the *Cohort II Baseline* data had been collected and scored.

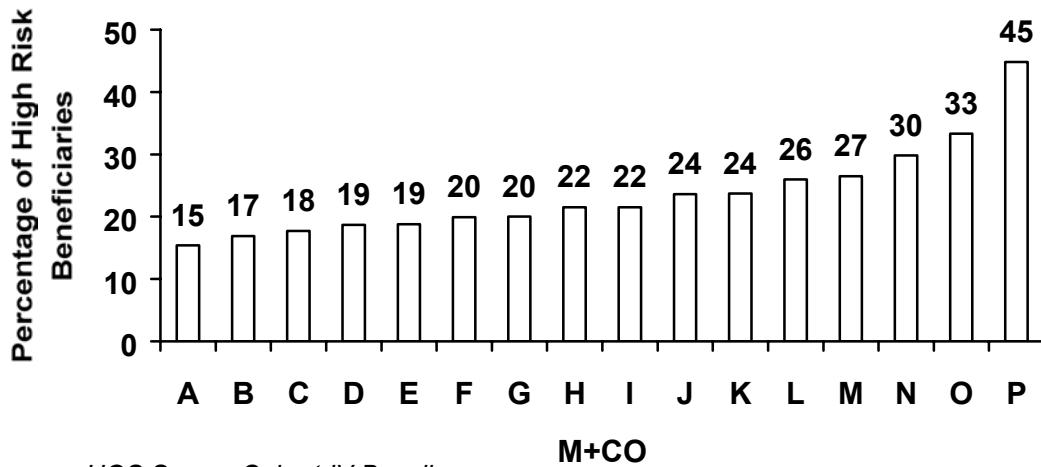
Data from control plans also are useful for interpreting the results of the Survey of Depression Management Activities. Therefore, this survey was e-mailed to a random sample of 41 M+COs that did not participate in the National Pilot Project. Completed surveys were received from a total of 13 pilot plans and 22 control plans.

RESULTS

IDENTIFYING HIGH RISK BENEFICIARIES

The proportion of the beneficiary population classified as high risk for depression (those with an MCS score less than or equal to 42) varied greatly from plan to plan (see Figure 3).

FIGURE 3
PERCENTAGE OF M+CO ENROLLMENT
WITH HIGH RISK FOR DEPRESSION



Source: HOS Survey Cohort IV Baseline

A separate risk profile was developed for each plan. Consequently, the specific risk factors identified varied from plan to plan. The risk factors most commonly identified by the statistical models are shown in Table 2.

TABLE 2
MOST COMMON RISK FACTORS FOR LOW MCS SCORES

COMORBID CONDITIONS	OTHER FACTORS
Diabetes	Dual eligibility
Heart disease	Female gender
Stroke	Age 75 or older

INTERVENTIONS IMPLEMENTED

This project gave each individual M+CO the latitude to implement the depression management activities that plan staff considered most appropriate and practical for their unique circumstances. The key interventions and activities stimulated by the project are listed below by QIO.

QIO #1

A bilingual educational poster was displayed in the physicians' offices. The poster listed common symptoms of depression and encouraged individuals to speak with their doctor.

- A diagnostic flow chart, based on information from the MacArthur Initiative on Depression in Primary Care (MacArthur Foundation, 2002), was distributed to PCPs.
- The plans implemented a depression screening audit tool to monitor physician documentation of screenings.

QIO #2

- A member education brochure, including a "call to action" in the form of a mail back postcard, was sent to the beneficiaries.
- A multi-agency work group was established by the QIO. The agencies belonging to this group are the QIO, the M+COs in the region, the department of psychiatry at the state university, and the area's behavioral health organizations (BHOs). The achievements of this group included:
 - The same depression management guidelines were adopted by each of the participating agencies. Guidelines were developed for both PCPs and behavioral health providers.
 - Two educational conferences on depression management for physicians were held in October and November of 2001 at the local university, for which CME credits were awarded. The university's department of psychiatry provided the faculty for these conferences. Over 2,000 PCPs and members of their office staffs were invited.
 - A pharmacy subcommittee was formed to develop ways to improve compliance with antidepressant treatment.
 - The various agencies' legal counsels established a consensus regarding the handling of confidentiality issues.

QIO #3

- A resource manual on depression, including fact sheets for PCPs and office staff, was distributed to participating M+COs.
- A depression advisory committee, comprising behavioral health experts from each of the participating M+COs, local community providers, QIO staff, and a representative from the state Mental Health Association, met periodically to plan and discuss interventions.
- Local area PCPs were invited to a presentation on depression in the primary care setting, for which CME credits were awarded.
- The QIO partnered with the state Mental Health Association to conduct screenings at area clinics and private businesses on National Depression Screening Day in both 2000 and 2001. The number of participating facilities increased from approximately 20 in 2000 to over 60 in 2001. Depression screenings at private businesses were particularly successful. This is probably due to the anonymity that a private business setting provides to a depressed individual making a visit to the screening site.
- One of the plans examined pharmacy claims to identify high volume prescribers of antidepressants. These providers were given a condensed clinical guideline for treatment and referral along with a depression screening instrument. Another plan incorporated three depression screening questions into the health risk assessment administered to each new enrollee.

QIO #4

- Depression and its treatment have been featured in the QIO's newsletter for seniors.
- A physician education video has been incorporated into a CME course. An additional CME course was offered to physicians via teleconference. This course is based on Dr. Steven Cole's depression management training seminar for PCPs (Cole et al., 2000).
- The QIO conducted monthly teleconferences with staff from the M+COs that participated in the National Pilot Project.
- The QIO "fine-tuned" the statistical profiling process by securing diagnostic codes from the M+CO utilization files and using these codes to develop the profile (rather than the self-reports of chronic conditions from the HOS).

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QIO #5

- The QIO, several M+COs, and the state university launched a statewide anti-stigma campaign for National Depression Screening Day on October 11, 2001.
- One of the participating plans adapted the screening flow chart and clinical practice guidelines developed by AHRQ.

QIO #6

- The QIO developed a toolkit on depression, educational posters, and beneficiary brochures. The toolkit was presented at a conference with all of the state's participating M+COs.
- The QIO partnered with a major radio station geared to the senior audience. A discussion on depression aired twice on the station's Medicare-oriented radio program, just prior to National Depression Screening Day. The audience for this program was estimated at 21,000 plus an additional 175,000 community access television viewers.
- A depression registry was developed and tested at one of the M+COs. This is a Microsoft Access database that allows plan staff to record diagnoses, medications, and dates of treatments. The database automatically calculates compliance with HEDIS requirements regarding the treatment of depression.

MEASURES OF IMPACT

HOS DATA

In an attempt to document the effects of the National Pilot Project on beneficiary well-being, pilot plan beneficiaries and control plan beneficiaries were compared on three different HOS measures: the MCS score, the PCS score, and the depression screen. Analyses of these three measures did not succeed in detecting a change in any of these scores as a result of the National Pilot Project. It may well be the case that, if utilization and/or outcomes data had been collected from the specific individuals affected by the depression management activities, these measures would have revealed an impact of the National Pilot Project activities. The results for each of these measures are summarized and discussed in turn.

MCS Scores

Table 3 compares MCS scores for the pilot and control plans for the pre-measure (*Cohort II Baseline*) and the post-measure (*Cohort IV Baseline*).

TABLE 3 ANALYSIS OF MCS SCORES PILOT PLANS VERSUS CONTROL PLANS (ALL BENEFICIARIES)			
GROUP	TIME PERIOD		
	COHORT II BASELINE (MARCH-JUNE 1999)		COHORT IV BASELINE (MAY-SEPTEMBER 2001)
PILOT PLANS (16 PLANS)	Mean (N)	52.2 (8,776)	51.9 (8,104)
CONTROL PLANS (148 PLANS)	Mean (N)	52.5 (88,930)	52.6 (73,111)

Summary of Significance Tests

Difference between Time Periods	Not significant
Difference between Groups	$p < .0001$
Interaction between Time Period and Group	$p < .033$

This analysis was not able to detect an impact on MCS scores among the participating plans. This may be due to the fact that these results are based on a sample of beneficiaries, of which many may not have come into contact with any depression management activities, because they were not classified as high risk. MCS scores derived from a random sample of all the plan's beneficiaries may not have been sensitive enough to detect changes in mental health status due to the pilot project.

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One way to increase the sensitivity of the MCS analysis is to look at MCS scores derived only from those beneficiary subgroups that were classified as high risk by the statistical profile. For example, one plan targeted primarily its diabetic beneficiaries. It stands to reason that MCS scores derived from this plan's diabetic beneficiaries are more likely to show a project impact than MCS scores derived from all of the plan's beneficiaries. For this reason, HOS measures were also examined for the specific subgroups targeted by each plan for depression management activities. However, the analyses of these specific subgroups were not able to detect a project impact either.

PCS Scores

Since depression can amplify symptoms of physical illnesses such as myocardial infarction (Frasure-Smith et al., 1995) and cancer (Penninx et al., 1998), PCS scores were also analyzed. Once again, the analysis did not detect evidence of a project impact (see Table 4).

TABLE 4
ANALYSIS OF PCS SCORES
PILOT PLANS VERSUS CONTROL PLANS
(ALL BENEFICIARIES)

GROUP		TIME PERIOD	
		COHORT II BASELINE (MARCH-JUNE 1999)	COHORT IV BASELINE (MAY-SEPTEMBER 2001)
PILOT PLANS (16 PLANS)	Mean (N)	40.9 (8,776)	40.3 (8,104)
CONTROL PLANS (148 PLANS)	Mean (N)	40.7 (88,930)	40.3 (73,111)

Summary of Significance Tests

Difference between Time Periods	$p < .0001$
Difference between Groups	Not significant
Interaction between Time Period and Group	Not significant

Depression Screen

The “depression screen” measure from the HOS was also examined. This measure is based on three questions from the survey instrument:

Question 38	In the past year, have you had two or more weeks during which you felt sad, blue or depressed; or when you lost interest or pleasure in things that you usually cared about or enjoyed?
Question 39	In the past year, have you felt sad or depressed much of the time?
Question 40	Have you ever had two or more years in your life when you felt depressed or sad most days, even if you felt okay sometimes?

If the survey respondent answers one or more of these questions affirmatively, then the respondent is considered to have a “positive depression screen.” Table 5 reports the percentage of respondents with a positive depression screen for both the pilot and control plans. No evidence for improved depression screen scores among the pilot plans was observed.

TABLE 5
ANALYSIS OF DEPRESSION SCREEN
PILOT PLANS VERSUS CONTROL PLANS
(ALL BENEFICIARIES)

GROUP		TIME PERIOD	
		COHORT II BASELINE (MARCH-JUNE 1999)	COHORT IV BASELINE (MAY-SEPTEMBER 2001)
PILOT PLANS (16 PLANS)	Mean (N)	27.6% (8,977)	28.5% (8,229)
CONTROL PLANS (148 PLANS)	Mean (N)	26.2% (90,859)	25.8% (74,317)

Summary of Significance Tests

Difference between Time Periods	Not significant
Difference between Groups	$p < .0001$
Interaction between Time Period and Group	Not significant

DEPRESSION MANAGEMENT ACTIVITIES

The Survey of Depression Management Activities asked M+CO program staff to report whether they had implemented any of 19 different depression management activities during the calendar years 2000 and 2001. The results for the 13 pilot plans and 22 control plans that responded to the survey are found in Table 6.

TABLE 6
DEPRESSION MANAGEMENT RESOURCES OFFERED BY PLANS

DEPRESSION MANAGEMENT RESOURCE	PERCENTAGE OF PLANS OFFERING THIS RESOURCE	
	PILOT PLANS (N=13)	CONTROL PLANS (N=22)
<i>RESOURCES FOR PROVIDERS</i>		
Clinical practice guidelines	77%	91%
Conferences or courses for CME credits	23%	36%
Depression registry	23%	18%
Depression screening tools and algorithms	77%	59%
Flow charts for diagnosis and treatment	69%	59%
Information on prescribing of antidepressants	69%	68%
Information regarding diagnosis and treatment	77%	59%
Referral guidelines, processes or tools	62%	55%
Resources for handling suicide or crisis situations	38%	36%
Newsletters or other mailings	62%	59%
<i>RESOURCES FOR BENEFICIARIES</i>		
Exercise programs	38%	36%
Stress management programs	46%	27%
Bereavement support groups	15%	23%
Social activities	15%	27%
Web site with links to information on depression	31%	41%
Telephone support	54%	41%
<i>RESOURCES FOR THE COMMUNITY</i>		
Articles/broadcasts in local news media	8%	14%
Newsletters or other mailings	54%	41%
Screenings at health fairs or other events	38%	23%

Source: Survey of Depression Management Activities

This survey revealed that many of the depression management resources were more prevalent at the pilot plans than at the control plans. This difference was most pronounced for resources aimed at providers. However, these differences did not quite reach the conventional level of statistical significance ($p < .05$; see Table 7).

TABLE 7
STATISTICAL ANALYSIS OF
DEPRESSION MANAGEMENT RESOURCES OFFERED

CATEGORY	TOTAL RESOURCES	TOTAL COMPARISONS THAT FAVOR THE PILOT PLANS	PROBABILITY OF OBTAINING THIS RESULT BY CHANCE ALONE ¹
<i>RESOURCES FOR PROVIDERS</i>	10	8	.055
<i>RESOURCES FOR BENEFICIARIES</i>	6	3	.656
<i>RESOURCES FOR THE COMMUNITY</i>	3	2	(insufficient N)
<i>ALL RESOURCES</i>	19	13	.084

¹ Calculated using the binomial sign test for two dependent samples (Sheskin, 1997)

Source: Survey of Depression Management Activities

OTHER PROJECT IMPACTS

The National Pilot Project stimulated several other behavioral health care developments that are worthy of mention. These include:

Dissemination of Best Practices

The monthly teleconferences among the participating plans and QIOs have speeded the adoption of various best practices, such as use of a depression registry. As a result of these teleconferences, a depression registry developed by one of the QIOs and piloted among the the plans in the QIO's state is now in use at two of the plans in another state. Guest experts who have participated in the conference calls have led a number of plans to adopt specific depression screening instruments, such as the Patient Health Questionnaire (Cole et al., 2000). It was also through the teleconferences that the project participants became aware of the five new procedure codes that permit reimbursement of behavioral health services at the physical health reimbursement rate.

“Shadow” Plans

In addition to the 16 plans that officially participated in the project, two other plans that learned about the project decided to copy or “shadow” the key elements of the project. These two plans, which were in different states, worked with their QIOs to obtain the necessary HOS data for profiling their high risk beneficiaries.

SAMHSA Workshops

The National Pilot Project came to the attention of staff at the Substance Abuse and Mental Health Services Administration (SAMHSA) in Washington, DC. In an effort to coordinate more closely with regional behavioral health initiatives, SAMHSA sponsored a series of workshops designed to introduce QIOs to the “state of the art” in behavioral health treatment, administration, and policy. Four of the six QIOs that participated in the workshops were also participants in the National Pilot Project.

At the workshops, staff from the U.S. Army Medical Command reviewed the comprehensive guidelines they have developed for depression, substance abuse, and suicide (U.S. Army Medical Command, 2002). In addition, these workshops educated the QIO staff on the importance of screening for substance abuse, which is highly comorbid with depression, and introduced the participants to a variety of screening instruments and strategies for dealing with substance abuse in the primary care setting.

Statewide Prevention and Support (SPAS) Project

HSAG’s leadership role in the National Pilot Project was one of the reasons that the Center for Substance Abuse Prevention (CSAP), a division of SAMHSA, selected the state of Arizona to participate in a multi-state, multi-agency project focused on substance abuse prevention in the elderly. CSAP invited teams that included staff from the QIO, state department of behavioral health services, and state department of aging in each of six states to a meeting on July 30 and 31, 2002. The purpose of the meeting was to develop integrated approaches to identifying and treating substance abuse problems in the elderly. In Arizona, the Arizona Behavioral Health and Aging Coalition has adopted substance abuse management in seniors as one of its key initiatives.

CMS-SAMHSA Coordination on Behavioral Health Issues

Staff from CMS attended several of the SAMHSA workshops. As a result, CMS and SAMHSA staff have begun to share information and discuss collaborative approaches to behavioral health issues. As a first step, CMS and SAMHSA, along with other federal agencies, will participate in a National Policy Academy on behavioral health issues among the aging population.

BARRIERS ENCOUNTERED

The National Pilot Project also served to identify key barriers to successful depression management. The national scope of the project facilitated the identification of impediments to successful project implementation.

Each of the participating plans encountered similar obstacles when implementing their depression management strategies. Despite efforts to educate the PCPs, there remain significant incentives for the *underdiagnosis of depression*. The continuing stigma that exists with regard to depressive illness motivates beneficiaries to either disguise their illness or to ask their PCP not to record the diagnosis. The fact that Medicare only reimburses behavioral diagnoses at 50% (compared to 80% for physical diagnoses), motivates physicians to avoid providing a large number of behavioral health visits. The introduction of five new Current Procedural Terminology (CPT) codes for psychological services with medical patients may begin to alleviate this problem. These codes are for psychological services rendered as part of treatment of a medical condition, and as such can be billed under the physical illness benefits of the plan, thereby receiving 80% rather than 50% reimbursement (American Psychological Association, 2002a). New mental health parity legislation has been proposed (American Psychological Association, 2002b), which if successful could also address this issue.

Confidentiality concerns, already of major interest to the plans and their BHO partners, have intensified due to the recent Health Insurance Portability and Accountability Act (HIPAA) legislation. Many plans have been advised by their legal counsels not to reach out to depressed beneficiaries identified from claims data, and not to share information about depressed beneficiaries with their BHO partners, without first obtaining specific informed consent. This represents a major obstacle to continuity of care for beneficiaries with behavioral health problems. Current HIPAA regulations state that information sharing that supports "treatment," "payment," and "healthcare operations" does *not* require prior written consent from the patient. Furthermore, the requirements for information sharing *between* organizations are not any more strict than for information sharing *within* an organization (Workgroup for Electronic Data Interchange, 2002). Nevertheless, many house counsels regard HIPAA as a barrier to information sharing. Federal legislation, in particular 42CFR2.1, is also cited as a reason for restricting communications regarding these beneficiaries.

Although the National Pilot Project methodology used the HOS for the initial phase of screening, thereby relieving the PCPs of this task, the methodology nevertheless places significant demands upon *plan staff time and resources*. During an era when many M+COs are downsizing and cutting both staff and programs, condensed clinical guidelines, short form depression screening tools, and simplified data file protocols are more important than ever.

CONCLUSIONS AND RECOMMENDATIONS

CHOICE OF INTERVENTIONS

DISCUSSION

When the National Pilot Project began, there were far fewer studies indicating which depression management interventions were most likely to be successful. Therefore, it made a good deal of sense to allow the plans wide latitude in their choice of the interventions to implement. During the past several years researchers have more clearly identified the depression management strategies most likely to be successful. The evidence for the principal strategies is briefly summarized in Table 8.

TABLE 8 WHAT WORKS AND WHAT DOESN'T WORK IN DEPRESSION MANAGEMENT

- Explicit clinical guidelines improve clinical practice and increase the ability to recognize depression, especially if they incorporate patient-specific reminders (Grimshaw and Russell, 1993).
- A simple two question depression screener identifies at risk beneficiaries and minimizes the burden on the PCPs with little loss of screening sensitivity (Whooley et al., 1997).
- Provider education by itself, even in a CME context, has little impact on provider behavior (Davis, 1998) or on the ability to recognize depression (Thompson, Kinmouth, Stevens et al., 2000).
- Interactive provider education, with case studies and role playing, is very effective in changing provider behavior (Cole, Raju, Barrett, Gerrity, and Dietrich, 2000).
- Periodic contacting of patients who initiated antidepressant therapy but who have not refilled their prescriptions helps identify relapsing patients quickly (Katon et al., 2001).
- Use of care managers to monitor the progress of depressed beneficiaries decreases the burden on the PCPs (Sherbourne et al., 2001).
- Training physicians to recognize “red flags” for depression increases the number of potentially depressed beneficiaries that they identify (Institute for Health Care Improvement, 2002).
- A depression registry improves the consistency with which depressed patients are identified and followed (IHI, 2002).

RECOMMENDATION

Now that “what works” in depression management has been well delineated in the literature, the above evidence-based interventions, subject to availability of plan resources, should be essential components of any future depression management projects. Plans and QIOs should not expend

valuable resources implementing practices that have only a marginal impact on depression. Plans and QIOs must focus their efforts on proper implementation of proven practices.

SCREENING FOR DEPRESSION

DISCUSSION

Routine screening of all adults for depression can lead to a substantial number of false positives that will incur unnecessary diagnosis and treatment costs. A typical depression screening instrument has a specificity of 80%, meaning that for every 100 non-depressed patients who are screened with the instrument, 20 of these patients will screen positive for depression despite their non-depressed status. If such a screener were applied to a population of 1,000 beneficiaries, 900 of whom are not depressed, the result would be 180 false positives that will needlessly consume staff time and resources. In populations where the prevalence of depression is known in advance to be high, such as post-AMI patients or diabetics, there will be fewer such false positives. In Part D of the US Preventive Services Task Force recommendations (USPSTF, 2002), the USPSTF specifically recommends against routine screening of asymptomatic patients.

RECOMMENDATION

Restrict depression screening to beneficiaries who show symptoms of depression, and beneficiaries with other characteristics or chronic conditions known to be strongly associated with depression.

SCREENING FOR SUBSTANCE ABUSE

DISCUSSION

Substance abuse (including nicotine addiction) is very strongly associated with depression, and optimal outcomes cannot be achieved for depression treatment unless co-occurring substance abuse problems are also diagnosed and treated (Levin, Kruger, and Blow, 2000). Easy to administer and psychometrically valid screening instruments are available for screening beneficiaries for alcohol and substance abuse in the primary care setting (Blow, 1998).

RECOMMENDATION

Incorporate substance abuse screening into the depression screening process. Provide PCPs with condensed guidelines for diagnosis and referral of substance abuse problems.

CONFIDENTIALITY ISSUES

DISCUSSION

The legal counsels at many of the M+COs believe that federal law and the recent HIPAA guidelines severely restrict plan-beneficiary and plan-BHO communications regarding beneficiaries with behavioral health problems. Attorneys are “playing it safe” in spite of the broad protections that HIPAA currently provides for such activities. By so doing, these attorneys may actually be increasing their plan’s exposure to certain forms of liability. When plans elect not to communicate with or about beneficiaries showing indications of depression, this event could potentially be construed as an avoidable medical error.

RECOMMENDATION

Obtain advice from legal experts in behavioral health and confidentiality law. These experts could interpret HIPAA and other relevant legislation for the plans’ house counsels and provide them with a consensus regarding various types of legal risks in the confidentiality arena.

REIMBURSEMENT ISSUES

DISCUSSION

The Medicare reimbursement differential for treatment of physical versus behavioral illness is a significant road block to PCP cooperation in depression management endeavors, and furnishes the PCPs with an incentive to either overlook or “refer away” behavioral health problems.

RECOMMENDATION

Increase provider awareness of the new CPT codes available for treating psychological aspects of physical illnesses. Note: if the proposed Mental Health Equitable Treatment Act passes, this issue will be largely resolved. Updates: Medicare is reimbursing for five out of the six codes, with the exception of code 96155 (family intervention without the patient present). Currently only a few private health insurance plans have begun to pay for these codes (APA, 2004). As of March 2004, the Mental Health Equitable Treatment Act, now called the Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003, remained stalled in Congress.

USE OF HOS DATA TO MANAGE DEPRESSION

DISCUSSION

Some of the participating M+COs reported that the National Pilot Project methodology was somewhat time-consuming to implement. Discussions with QIO and plan staff led to a series of recommendations for simplifying this methodology. These recommendations were presented in detail in the User’s Guide (HSAG, 2002). The guide’s principal recommendations are summarized below.

RECOMMENDATIONS

1. Make the use of utilization data optional, and develop the statistical profile of at risk beneficiaries from the HOS data only.
2. Focus depression management activities on only those PCPs who treat the majority of the high risk beneficiaries. Use the remaining PCPs as a control group to measure the success of the depression management tools provided to the first group of PCPs.
3. Measure success with easy to collect administrative indicators of depression identification, treatment, and compliance, and also collect data on the PCPs' total charges to determine the cost-effectiveness of these efforts.

DEVELOP A PARADIGM FOR IDENTIFYING OPPORTUNITIES FOR IMPROVEMENT

DISCUSSION

In an era of diminishing resources for M+COs, successful management of conditions such as depression depends on precisely identifying those beneficiaries most likely to benefit from screening and treatment. An overly broad definition of this subgroup will cause the plan to expend valuable time and resources following up on beneficiaries who will later prove to be not depressed. A key contribution of the National Pilot Project methodology was to use the HOS as the first step in this process. Rather than burden M+CO staff with the necessity of screening the entire beneficiary population, a statistical profile based on the plan's HOS data was used to identify the subgroups in the general beneficiary population most likely to be suffering from depressive illness. As a result, plan staff could allocate scarce resources to just this subset of the overall population of beneficiaries.

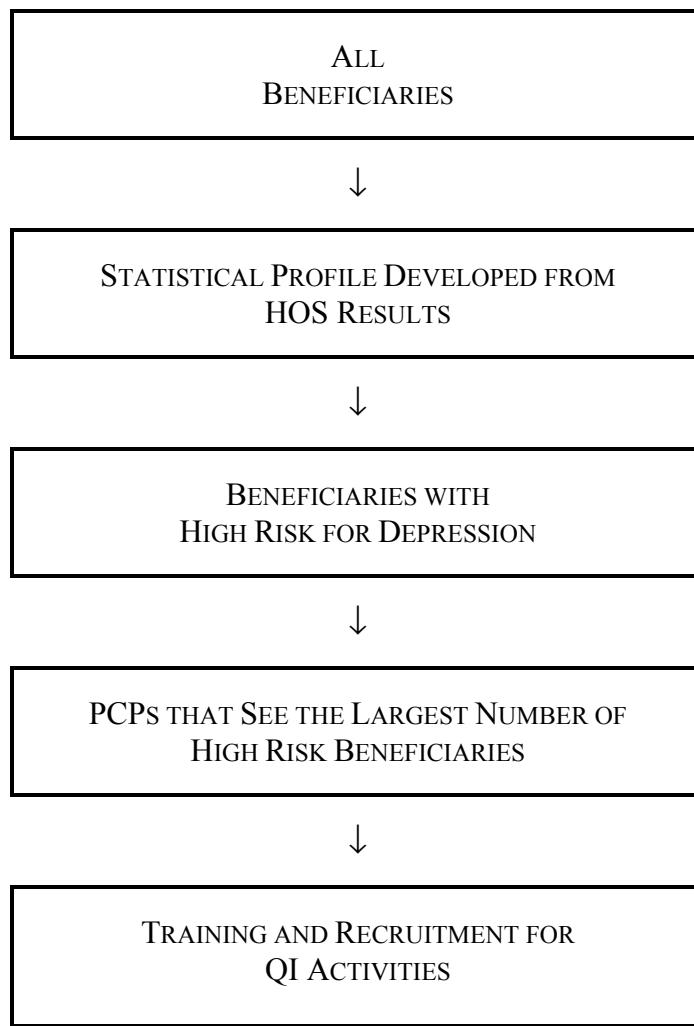
The HOS statistical profile can be used to allocate resources even more precisely by examining the profile's results at the *provider* level. Just as it is more efficient to focus plan efforts on specific subgroups of beneficiaries, it is likewise more efficient to focus these efforts on specific subgroups of the providers. Certain PCPs, by virtue of their specialty and/or the composition of their caseloads, will see a larger than average number of high risk beneficiaries in their practices.

RECOMMENDATION

The M+CO can maximize the impact of its depression management activities by focusing these activities on the subgroup of PCPs with the largest number of patients that need depression care. These PCPs, along with the support staff and case managers that work with them, should play a central role in the QI committee charged with improving depression care.

Figure 4 summarizes this approach to maximizing the utility of the HOS results.

FIGURE 4
PARADIGM FOR IDENTIFYING OPPORTUNITIES FOR IMPROVEMENT USING THE HOS



The above approach to identifying opportunities for improvement will ensure that scarce plan resources are directed where they are most needed.

SUMMARY

The above recommendations grew out of the practical experiences of 16 M+COs and 6 QIOs during the course of the National Pilot Project. It is hoped that the recommendations made in this document will assist plan and QIO staff to more effectively deal with some of the impediments the project participants encountered, and to more rapidly implement effective depression management strategies.

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FINAL REPORT MODIFIED FOR PUBLICATION DISTRIBUTION
MAY 3, 2004

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APPENDIX A

SURVEY OF DEPRESSION MANAGEMENT ACTIVITIES

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Dear M+CO Representative:

In 1998, the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, contracted with Health Services Advisory Group (HSAG) to conduct data analysis, reporting and education for the Medicare Health Outcomes Survey (HOS) project. In 2000 the HOS project was expanded to include a **National Pilot Project on Depression**. HSAG developed a methodology for this pilot project that utilizes HOS data to identify depressed seniors and plan treatment interventions at participating M+COs.

The purpose of this survey is to record your M+CO's activities and strategies for the management of depression in your Medicare beneficiaries. Your plan is one of a sample of M+COs that is being asked to provide this information. This sample includes plans that did not participate in the National Pilot Project as well as plans that did. Your responses to this survey will help us to document the "state of the art" in depression management. Each individual who completes this survey will receive a summary of the findings. This survey has been pilot tested and should take approximately 20 minutes to complete.

To begin, please save this document to your home directory under the name ***sdma.doc***. Then, scroll down to the first question. You can select choices using the mouse, and you can use the mouse or the tab key to move between questions. Answer each question by checking the box, selecting from the drop down menu, or by typing your answer in the shaded space. When finished with the survey, click "Save", print out a copy of the survey for your records, then return your survey by e-mail to ddrachman@azqio.sdp.org.

If you have any questions, please contact me at 602-665-6122 or at the e-mail address provided above.

Thank you for your help!

David A. Drachman, PhD
Project Coordinator
Medicare HOS National Pilot Project on Depression
Health Services Advisory Group
301 East Bethany Home Road, Suite B-157
Phoenix, AZ 85012

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WHO IS COMPLETING THIS SURVEY?

NAME:

TITLE:

TELEPHONE NUMBER:

NAME OF THE
MEDICARE + CHOICE
PLAN:

E-MAIL ADDRESS:

PLEASE ANSWER THE FOLLOWING QUESTIONS FOR YOUR PLAN'S MEDICARE + CHOICE POPULATION ONLY.

PART I: FEATURES OF THE MEDICARE + CHOICE PLAN

1. NUMBER OF CARE MANAGERS OR CASE
MANAGERS ON STAFF AS OF DECEMBER 31,
2001 (*include both LCSW and nurse case
managers*) _____

 2. ARE BEHAVIORAL HEALTH SERVICES YES No
SUBCONTRACTED TO A SEPARATE
ORGANIZATION?
-
-

PART II: BENEFITS AND PROGRAMS

3. ARE ANTIDEPRESSANTS INCLUDED IN THE FORMULARY? Yes No
4. ARE BEHAVIORAL HEALTH SERVICES A COVERED BENEFIT FOR ALL SENIORS? Yes No
5. HOW ARE YOUR PCPs REIMBURSED FOR BEHAVIORAL HEALTH SERVICES? CAPITATION SALARY FEE SCHEDULE

NOT REIMBURSED
6. IF YOU ANSWERED "FEE SCHEDULE" TO Q5, IS THE LEVEL OF REIMBURSEMENT THE SAME AS OR LESS THAN FOR OTHER SERVICES? SAME AS
 LESS THAN

PART III: STATISTICS ON PLAN ACTIVITY

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR CALENDAR YEAR 2001

7. NUMBER OF SENIORS ENROLLED IN MEDICARE + CHOICE PLAN AT END OF YEAR _____
 8. DOES YOUR PLAN USE A FORMAL INSTRUMENT OR PROCESS TO SCREEN BENEFICIARIES FOR DEPRESSION? YES NO—SKIP TO Q. 11
(E.G., CES-D, PHQ, ZUNG, ETC.)
INCLUDE SCREENINGS CONDUCTED VIA TELEPHONE OR FACE-TO-FACE INTERVIEWS, AS WELL AS WRITTEN QUESTIONNAIRES
 9. HOW MANY BENEFICIARIES WERE SCREENED FOR DEPRESSION USING FORMAL SCREENING CRITERIA? _____ DATA NOT AVAILABLE
 10. HOW MANY BENEFICIARIES SCREENED POSITIVE FOR DEPRESSION? _____ DATA NOT AVAILABLE
 11. HOW MANY BENEFICIARIES WERE DIAGNOSED WITH DEPRESSION? _____ DATA NOT AVAILABLE
 12. HOW MANY BENEFICIARIES WERE PRESCRIBED ANTIDEPRESSANTS FOR AT LEAST 15 DAYS? _____ DATA NOT AVAILABLE
-

PART IV: RESOURCES FOR DEPRESSION MANAGEMENT

During 2000 and 2001, which of the following depression management resources has your Medicare + Choice plan provided to PCPs or their office staff? (Check all that apply.)

13. CLINICAL PRACTICE GUIDELINES
 14. CONFERENCES OR COURSES FOR CME CREDITS
 15. DEPRESSION REGISTRY
 16. DEPRESSION SCREENING TOOLS AND SCORING ALGORITHMS
 17. FLOW CHARTS ON THE DIAGNOSIS AND TREATMENT PROCESS
 18. INFORMATION ON PRESCRIBING OF ANTIDEPRESSANTS
 19. INFORMATION FOR PROVIDERS THAT ADDRESSES DEPRESSION DIAGNOSIS AND TREATMENT
 20. REFERRAL GUIDELINES, PROCESSES OR TOOLS
 21. RESOURCES FOR HANDLING SUICIDE OR CRISIS SITUATIONS
 22. NEWSLETTERS OR OTHER MAILINGS
 23. OTHER (*please describe*)

 24. OTHER (*please describe*)
-

PART IV: RESOURCES FOR DEPRESSION MANAGEMENT (CONTINUED)

During 2000 and 2001, which of the following depression management resources has your Medicare + Choice Plan provided to *its senior beneficiaries*? (Check all that apply.)

25. EXERCISE PROGRAMS
26. STRESS MANAGEMENT PROGRAMS
27. BEREAVEMENT SUPPORT GROUPS
28. SOCIAL ACTIVITIES
29. WEB SITE WITH LINKS TO INFORMATION ON DEPRESSION
30. TELEPHONE SUPPORT
31. OTHER (*please describe*)

32. OTHER (*please describe*)

During 2000 and 2001, which of the following depression management resources has the Medicare + Choice plan provided to *members of the community*? (Check all that apply.)

33. ARTICLES/BROADCASTS REGARDING DEPRESSION IN THE LOCAL NEWS MEDIA
 34. NEWSLETTERS OR OTHER MAILINGS
 35. SCREENINGS AT HEALTH FAIRS OR OTHER EVENTS
 36. OTHER (*please describe*)

 37. OTHER (*please describe*)
-

PART IV: RESOURCES FOR DEPRESSION MANAGEMENT (CONTINUED)

Please describe below any other programs or strategies your Medicare + Choice plan has developed to manage depression in primary care.

38.

Is there anything else you would like us to know?

39.

Thank you for your participation. A summary of the results will be sent to each individual that completes and returns this survey.

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