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November 14, 2007

AGENDA ITEM 5

TO: MEMBERS OF THE HEALTH BENEFITS COMMITTEE

I. SUBJECT: CalPERS Health Plans Mental Health Services Overview (Panel Discussion)

II. PROGRAM: Health Program

III. RECOMMENDATION: Information Only

IV. BACKGROUND:

In September 2007, the CalPERS staff presented an overview of the booklet "Your Health Plan, Your Doctors, and You: The Prescription for Quality Health Care". This annual publication is designed to help members make more informed health care choices, and to encourage them to be active partners in their good health. The publication contains information on clinical performance measures for medical and mental health services. CalPERS collects clinical performance measures, developed by the National Committee on Quality Assurance (NCQA), for health plan monitoring to determine what percentage of members in each plan received care according to accepted standards.

At the October 2007 CalPERS Health Benefits Committee meeting it was noted that there was significant variance among the health plans in the area of mental health services and it was requested that plan representatives provide additional information regarding their mental health programs, services and outcomes, as well as proposed actions to improve scores and accountability. The following information is being presented by each of our health plan partners:

Blue Cross (PERSCare/PERSChoice)

Blue Cross of California provides integrate behavioral health into the overall CalPERS member management program.

- Pre-authorization and utilization management for PERS Care and PERS Choice plans. Psychiatric and Substance Abuse acute, partial and intensive outpatient programs
- Clinical review of unusual outpatient treatment patterns

- Discharge planning and coordination of care through episode of intensive services
- Follow up after discharge to facilitate appropriate continuation of care
- Behavioral Health Case Management for complex psychiatric and substance abuse conditions.
- Care Coordination with medical case management for co-morbid mental health/substance abuse and medical conditions.
- Depression screening for all members in health improvement programs – Co-existing Depression and Anxiety program
- Maternity Depression Program.
- Blue Cross is working to improve timely outpatient follow-up after discharge from Psychiatric Hospitalization which is key to successful treatment.

Blue Cross of California will continue to improve upon on our overall integrated programs while initiating dialogue on the following programs.

- Antidepressant Medication Program can be implemented in coordination with MEDCO – Blue Cross will initiate discussion
- Bipolar Program can also be extended to CalPERS in coordination with MEDCO – Blue Cross will initiate discussion

Attachment 1

Attachment 1 is the PowerPoint presentation provided by Blue Cross as part of their presentation.

Blue Shield

Depression is a serious chronic disease which is commonly seen in the primary care setting. According to the World Health Organization (WHO), Major Depressive Disorder is the leading cause of disability in the United States. The National Institute of Mental Health (NIMH), indicates the prevalence of Depressive disorders is estimated at 9.5% of Americans (18.8 million people) ages 18 and over in a given year. Nearly twice as many women as men are affected each year.

Blue Shield, in collaboration with US Behavioral Health Plan, California (USBHPC), provides access to services designed to improve depression care for its members. The goal of Blue Shield's depression program is to increase awareness, identification, and treatment of depression among Blue Shield members. As a managed behavioral health care organization, USBHPC designs and implements an array of interventions for both patients and providers. Blue Shield collaborates with USBHPC in the design and implementation of these interventions but also supplements these efforts with its own preventive and educational activities.

Primary care physicians provide most of the treatment for depression. The condition is only recognized and accurately diagnosed in about half of patients with depression. Because depression often goes undetected in the primary care setting, improving diagnosis and detection is critical. Suggested ways to improve depression care include: 1) increase the availability of depression case management services in the primary care setting; 2) provide primary care providers with greater support from mental health specialists for the management of depressed patients; 3) reduce the stigma associated with depression treatment through education and outreach; and 4) increase the availability of education and services that serve to activate and empower patients managing a depressive illness.

While Blue Shield's 2007 mental health HEDIS measures have increased from the 2006 HEDIS reporting, the plan recognizes the need to continually identify and implement strategies that will improve mental health outcomes for its members. As such Blue Shield has developed and implemented a variety of actions to improve upon its performance on the HEDIS mental health measures, particularly in the areas of Follow-up After Hospitalization for Mental Illness and Antidepressant Medication Management. In addition, in a focused effort to improve upon performance on the HEDIS measures in the area of mental health, Blue Shield has increased its expectations of USBHPC by tying a contractual performance guarantee to each measure and establishing quarterly meetings to discuss quality and progress toward meeting the performance goals. Blue Shield believes that these action steps will result in increased performance on HEDIS measures in 2008.

Action Steps To Address Follow-up After Hospitalization for Mental Illness

HEDIS Follow-Up after Hospitalization for Mental Illness Measure:

MEASURE	2007	2006	2006 90th Percentile
7-Day Follow-up (C)	50.04%	46.22%	71
30-Day Follow-up (C)	70.00%	67.67%	86

Some facilities are challenged by workflow barriers such as newly established admitting and discharge processes. To help alleviate these challenges Blue Shield and USBHPC in September 2006 initiated mailings to its acute facilities with individualized reports showing their performance on the follow-up after hospitalization measure and provided a tip sheet of ways to improve on their workflow processes to better ensure the scheduling and tracking of appointments (tips include details of how to more effectively work with USBHPC to more regularly secure an outpatient follow up appointment prior to member discharge).

At 40 high volume facilities USBHPC has partnered with the facility to carry out followup appointment-setting responsibilities. In March 2007, USBHPC amended its contracts with these facilities to require on-site scheduling of follow-up appointments at the time the patient is discharged from the hospital. Additionally, in January 2007, USBHPC initiated a new program called Securing Aftercare for Excellence (SAFE). The SAFE program reaches high utilization underperforming hospitals in an effort to improve their compliance with the 7-day post discharge follow-up standard. Under the SAFE program two discharge specialists are specifically assigned to assist patients with making their follow-up appointments. Members suffering from a depressive illness often are challenged with making and/or keeping follow-up appointments, and many members also are unaware of the clinical value of these appointments. Blue Shield and USBHPC have continued these outreach efforts to increase member attention to and engagement in follow-up visits.

Clinicians often face challenges when trying to schedule new, highly acute patients in the midst of conducting their ongoing outpatient practice. Office management adherence to follow-up appointment standards also vary. In April 2007 USBHPC contracted with clinicians designated to manage all admissions at local area facilities in order to provide a 7-day follow-up. This effort was focused around facilities where the consistency of mental health follow up was below network average. By November 1, 2007 this intervention will have expanded from ten facilities to seventeen facilities. In addition to that, USBHPC has increased its overall network capacity to ensure access to follow-up appointments

In order to facilitate mental health follow up after hospitalization, it is crucial that USBHPC have early and accurate notification of every mental health admission. One area for improvement resulted from the fact that reliable admission notification was not occurring when a member was admitted to a medical facility with a primary mental health diagnosis. To improve in this category Blue Shield began a daily notification to USBHPC regarding all HMO member admittance to a medical facility with a mental health diagnosis. The intent of this notification is to increase USBHPC awareness of the admissions in order to proactively outreach to members who should receive mental health follow-up post discharge. Another area where better handling of data could result in an improvement in post hospital mental health follow up occurred in situations where there was a facility to facility transfer during the course of an admission. To improve the quality of the data, Blue Shield and USBHPC have refined the data query to capture exclusions and intra-facility admits and discharges.

Action Steps To Address Antidepressant Medication Management

HEDIS Antidepressant Medication Management Measure:

MEASURE	2007	2006	2006 90th Percentile
Depression Visits	18.71%	19.68%	31
Acute Phase	57.31%	57.80%	70
Continuation Phase	43.7%	42.09%	53

Many members are not aware of the clinical importance of adhering to their medication. To increase member awareness and understanding of the importance of medication adherence, an outreach and education campaign was launched in 2007. The Antidepressant Medication Management Program was implemented to increase compliance with antidepressant medication for patients newly started on antidepressants and to improve optimal contacts between identified patients and their providers with regard to medication and disease management. Members identified as “new starts” on antidepressant medication receive educational material indicating the importance of staying on antidepressant medication. Members receive two targeted letters. The first letter provides an FAQ section with answers on medication adherence, highlighting the importance of taking medication as directed by their physician. The second letter reinforces the first letter’s message and answers additional questions commonly asked after a member has been on the medication for some time.

Providers face multiple challenges surrounding the management of depression disorders and patient adherence to antidepressant medication. To help providers overcome these challenges, Blue Shield and USBHPC in March 2007 began implementing a variety of interventions designed to increase physician awareness of depression disorders, enhance their understanding of practice guidelines, and provide them with better data about their patients. Tool kits are mailed to all Blue Shield contracting primary care physicians.

The toolkit includes the following pieces:

- A list of tools for primary care physicians such as the clinical practice guideline and the behavioral health provider directory.
- A tip sheet on antidepressant medication management for depression.
- Fact sheet of Frequently Asked Questions about Antidepressant Medication
- Fact sheet on Depressive Disorders

Monthly reports are sent to providers identifying which of their patients may not be adherent with their antidepressant medication and a quarterly Benchmark report comparing their patients’ cumulative adherence rates to the California Cooperative Healthcare Reporting Initiative (CCHRI) 2007 average. Blue Shield

is conducting a prescriber-focused intervention to improve HEDIS Antidepressant Medication Management measures. Blue Shield distributes the following reports to targeted high-volume prescribers to assist them in managing their patients being treated with antidepressants:

- **Antidepressant Medication Adherence Benchmark Report** – a quarterly report containing their patients' cumulative adherence rates compared with all Blue Shield patients served by providers in their practice specialty.
- **Monthly Patient Antidepressant Non-Adherence Report** – a monthly report that lists a prescriber's patients who are likely non-adherent to their antidepressant medication based on pharmacy claims data.

Blue Shield and USBHPC will continue to implement interventions targeted at both Follow-up after Hospitalization for Mental Illness and Antidepressant Medication Management and are optimistic that the plan's measures will continue to rise in 2008 and 2009.

Attachment 2

Attachment 2 is the PowerPoint presentation provided by Blue Shield as part of their presentation.

Kaiser

At the October 16th CalPERS HBC meeting it was noted from the 9/11/2007 HBC meeting minutes that "Kaiser Permanente achieved the highest scores for both the medical and mental health composite, at 83% and 64%, respectively. Staff believes that Kaiser Permanente's higher scores are due to its integrated delivery system and information technology. As a result, Kaiser Permanente can more consistently identify gaps in care, inform members and providers of these gaps, deliver the care, and obtain documentation that the member received the care."

The mental health issue is a challenge and we want to work together with Kaiser and our members to improve services in this important area. Additional information was requested by the HBC to be provided at the November 14th meeting. HBC members would like to hear from Kaiser on how to improve performance in antidepressant medication management and in follow up after mental illness hospitalization." The HBC would like information to more broadly address the mental health measures, including any barriers to improved performance, how Kaiser and CalPERS can address these barriers, and improvement goals.

COMMENTS

Since the last HBC meeting, other publicly reported clinical performance results are available from the State of California Office of the Patient Advocate (OPA), as well as the California Cooperative Healthcare Reporting Initiative (CCHRI) and the National Business Coalition on Health (NBCH) and Pacific Business Group on Health (PBGH) eValue8, again showing that Kaiser Permanente is the top performer in the Behavioral Health domain in California and nationally (eValue8).

Kaiser Permanente (KP) welcomes the opportunity to demonstrate the value of its integrated health care delivery system that provides Complete Care for Depression, as well as other chronic conditions and our entire member population. Behavioral health care is integrated within KP as part of our total integrated health care delivery system. There is no Behavioral Health "carve out". There is no requirement for pre-authorization or pre-certification for care. Patients may self-refer to behavioral health services (without a PCP referral) and may be referred by any clinician in Kaiser Permanente. We feel strongly that this supports better access, follow-up care, care coordination, personalized care, and continuity of care. Our pharmacy benefits and KP pharmacy operations within our integrated delivery system are also key factors. These fundamental structural facts underlay KP's success and market leading performance.

The Depressing Facts

Depression is a significant health and cost problem, as the 4th leading contributor to the global burden of disease. (http://www.who.int/mental_health/management/depression/definition/en/) It affects 7% of the population, including 10% of the population over 18, during a single year. In the CalPERS Kaiser membership (2005), the prevalence of depression was about 5.6% and 9.3% in the Commercial and Medicare populations, respectively.

Depression is a common aggravating risk factor (co-morbidity) in patients with cardiovascular disease, and is common among patients with chronic pain, liver disease, end-stage kidney disease, and arthritis. Patients with depression after heart attack or stroke are more likely to die. Depressed diabetes patients have worse glycemic control and higher rates of complications (costs). Recent evidence is also suggesting that depression may also increase the risk for subsequent development of other health conditions, including osteoporosis, coronary heart disease, diabetes, and cerebral vascular disease. (Annals of Internal Medicine, June 15, 2004)

Kaiser Permanente Complete Care for Depression

Depression is primarily recognized and managed in primary care, but is supported by readily available mental health professionals and services in

Departments of Psychiatry and Chemical Dependency. But Kaiser Permanente has other success factors to highlight about its robust Complete Care Programs for Depression.

1. KP recognizes depression as a major chronic condition and co-morbidity with other chronic conditions. It is a priority chronic condition in Kaiser Permanente, which is included on our performance scorecards at all levels in the organization. KP also regularly reports on Depression care and costs to CalPERS.
2. KP has a formal, coordinated Depression Care Management (Complete Care) Program, which includes :
   - Routine screening with the PHQ-2 and PHQ-9, especially targeting high risk patients, e.g., cardiovascular disease (CVD) patients
   - Tracking systems (IMPACT and BHC Tracking) that allow care team members to know whether a member diagnosed with depression has made a follow-up appointment and picked up any prescribed medications. If members miss any of these, they receive a follow-up call. The tracking systems also monitor members with depression for improvement.
   - Active Outreach programs for depression screening
   - Clinical decision-support (prompts/reminders) for physicians and staff at the point of service to screen or follow-up on patients with depression.
   - Electronic Medical Record (KP HealthConnect) with readily available PHQ-9 for structured documentation and follow-up monitoring
   - Evidence-based clinical practice guidelines, which are widely communicated, and more importantly, embedded within KP HealthConnect and our other Complete Care Programs.
   - An integrated, collaborative Model of Care for Depression that includes:
     - Care managers and primary care providers (PCPs)
     - Patient education/self-management and follow-up support
     - Medication management
     - Brief counseling, i.e., behavioral activation therapy (BAT) and Problem Solving Therapy (PST)
     - Relapse prevention
     - Nurse Tele-Care uses trained clinical nurses, supported by primary care and mental health clinicians, to provide additional monitoring, promote medication adherence, offer emotional support, and provide advice on other concerns.
     - Consulting Psychiatrists
     - Diagnostic consultation on difficult cases
     - Escalation in treatment with referrals, according to guidelines
3. Depression drug utilization management programs (DUAT and DRUG), which for 9 years have raised awareness about medication management for depression with the most cost-effective medications (generic prescribing).
4. Behavioral Health Care Member Help Line: Members can call 1-800-900-3277 after hours, weekends, and holidays for direct and immediate access to crisis intervention and guidance, referrals, and other resources.

5. Member engagement tools on our kp.org website, that include information, screening tools (*Are You Depressed?*), and interactive self-management programs for chronic conditions, stress management, smoking cessation, exercise (which is therapeutic for depression), and more (secure e-mail messaging with physicians' offices, access to lab test results, ability to schedule appointments on-line, refill prescriptions on-line).
6. Health Education Departments with programs, classes, including group appointments; and materials, such as *Self-Care While You Recover from Depression, Antidepressant Tip Sheet*, and *Dealing with Feelings of Depression* (in English and Spanish); videos, such as *Celebrating Life: A Guide to Depression for African Americans.*
7. Routine reporting/feedback loop: Performance measurement and feedback to clinicians, chiefs of clinical departments, and administrators.
8. Hospital tracking: Within each of our Psychiatry Departments, there are staff that focus on patients while they are hospitalized. The Behavioral Health Care (BHC) Tracking System serves as both a utilization data reporting system, but also a case management tool. There are policies and procedures for timely follow-up after hospitalization for any mental health condition.

Information and recommendations to more broadly address the mental health measures and barriers to improved performance

1. Insist on more coordination of care and integrated, collaborative health care delivery models.
2. Avoid Behavioral Health Carve Outs
3. Avoid requirements for pre-authorization, pre-certification, or "gate-keeper" referrals for mental health issues.
4. Avoid other barriers to care, such as high and/or multiple co-pays. For example, a) some patients will not pick up their medications due to high or sequential costs of co-pays with refills, and b) some treatment programs require patients to have multiple visits, sometimes within the same week, each with a co-pay. Options exist to design benefits for treatment episodes (not encounters) and to discount or waive co-pays for chronic care medications.
5. Promote electronic tracking systems, electronic medical records, and automated clinical decision-support
6. Promote evidence-based clinical practice guidelines, including routine screening, especially for high risk patients, assessment, management, and follow-up.
7. Promote polices and procedures for appropriate mental health care management, referral guidelines/protocols (without barriers like pre-authorization), follow-up after diagnosis and hospital discharge.
8. Promote member/employee education to increase awareness about depression, self-management, and self-referral for care and services.

9. Address patient non-compliance with care and treatment.
10. Increase public reporting and accountability for clinical performance in mental health and other chronic disease areas.
11. Cultural sensitivity as part of programs and materials.

How Kaiser and CalPERS can address these barriers and improvement goals.

Kaiser Permanente continues to offer its expertise, experience, and resources to partner with CalPERS to address these barriers and improve the health outcomes of all CalPERS members.

Attachment 3

Attachment 3 is the PowerPoint presentation provided by Kaiser as part of their presentation.

V. STRATEGIC PLAN:

This item supports CalPERS Strategic Plan goal 10 – "Develop and administer quality, sustainable health benefit programs that are responsive to, and valued by, enrollees and employers" and, Strategic Plan Goal 11 – "Promote the ability of members and employers to make informed decisions resulting in improved lifestyle choices and improved health outcomes."

VI. RESULTS/COSTS:

There are no costs associated with this agenda items.

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Attachments