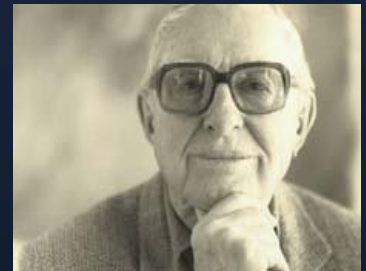


Mental Health & Medicare

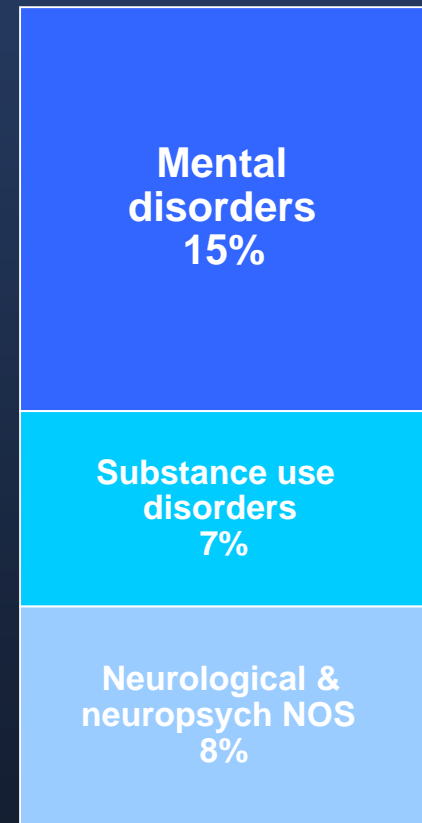
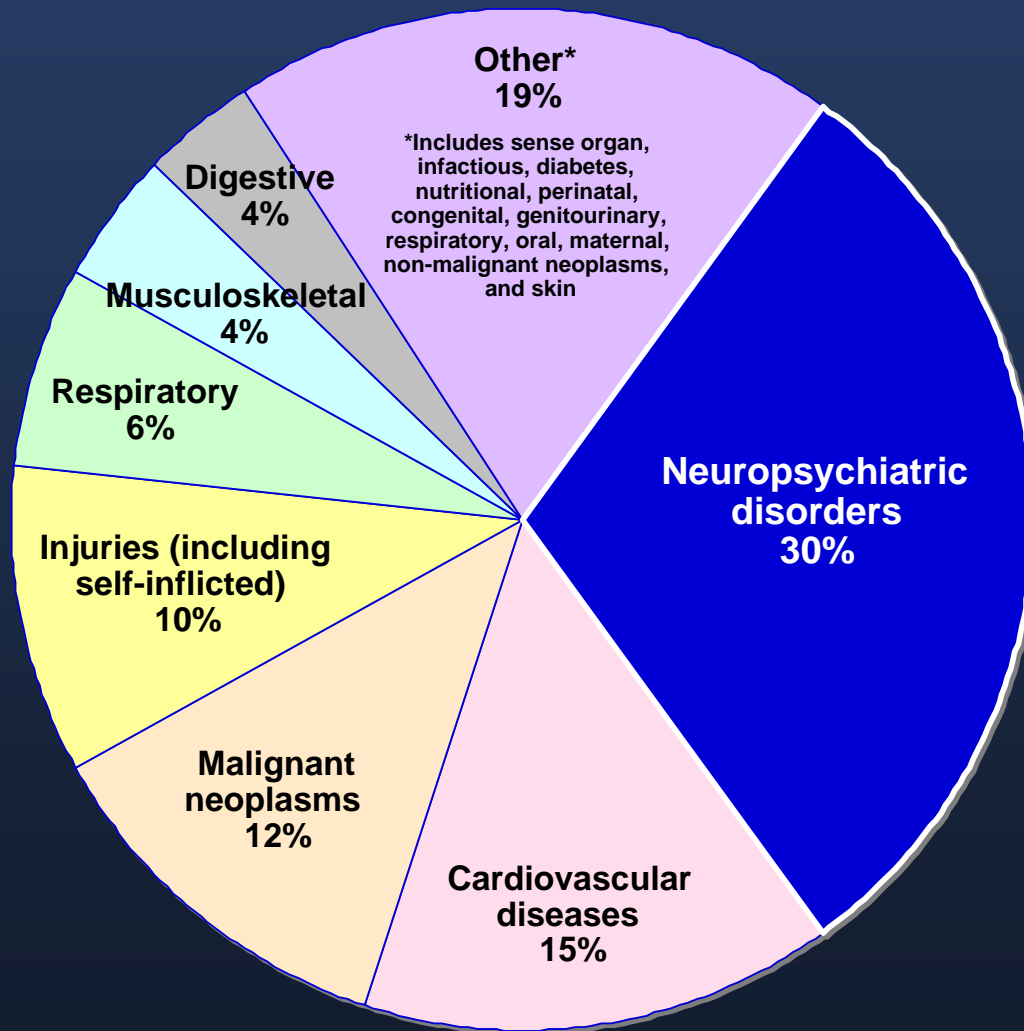
**Michael Schoenbaum, PhD
Senior Advisor**

**Division of Services and Intervention Research
National Institute of Mental Health**

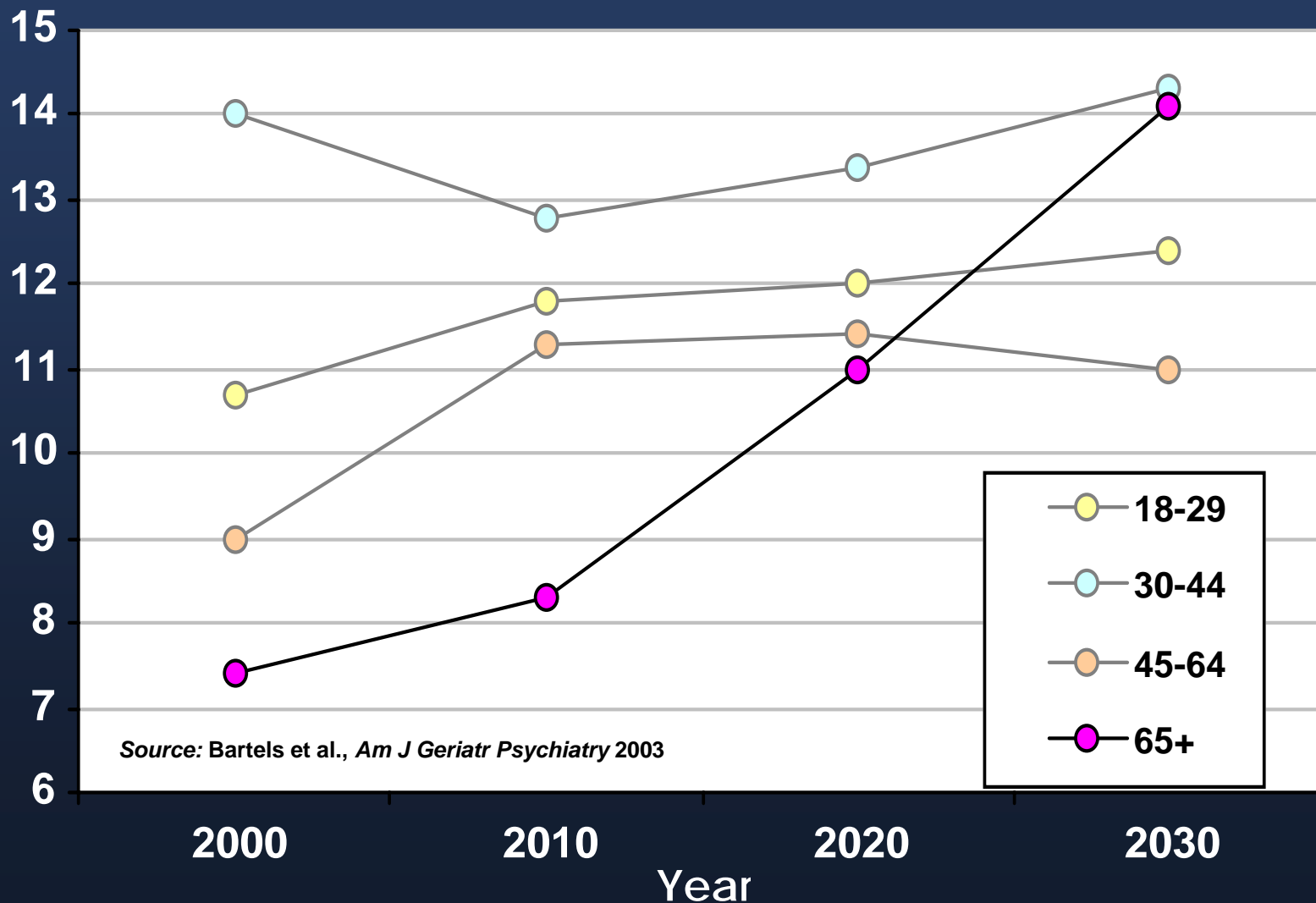
**Prepared for CMS MedCAC meeting
October 22, 2007**



Burden of disease (DALYs) United States & Canada



Projected population with major mental illness, by age



Evidence-based opportunities to strengthen mental health in the US

- Evidence reviewed by:
 - Institute of Medicine, *Improving the Quality of Health Care for Mental & Substance-Use Conditions* (2006)
 - President's New Freedom Commission on Mental Health (2003)
 - DHHS, *Mental Health: A Report of the Surgeon General* (1999)
- Many common QI issues
 - Across mental health
 - Between medical & mental health
- Illustrate with two major conditions
 - Depression
 - Schizophrenia/psychosis

Depression is common in Medicare

- 4% overall (age 60+)
- 10% in primary care
- 15-40% in medically ill
- Prevalence rises with severity of medical illness
- 15% of SSDI awards

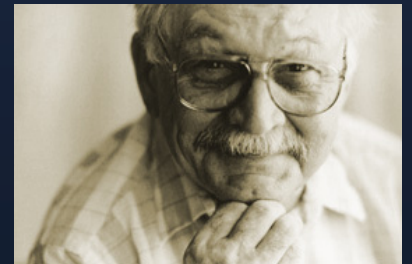
Depression impedes chronic care

- Adherence to medications
- Self-care
- Energy / activation
- Concentration & memory
- Hopelessness/nihilism
 - “Part of aging / medical illness”
 - “Nothing will help”



Depression is harmful

- **Physical symptom burden**
- **Disability**
- **Poor disease control (HbA1c, MI, stroke)**
- **Mortality (CAD, diabetes, suicide)**
- **Cost (all health services)**



‘Usual’ depression care is not effective

- **Most cases of depression can be treated effectively in primary care**

But currently...

- **Half of Medicare beneficiaries with depression are not recognized or treated**
- **Among those treated, care is often ineffective**
- **Overall, only 1 in 5 get better in ‘usual care’**

Key components of effective care

- Screening & assessment
- Patient education and activation
- Treatment
 - Antidepressant medication
 - Brief/structured psychotherapy
- Care management in primary care
 - Support treatment (e.g., medication)
 - Proactive tracking of outcomes
 - Support tx change if patients don't improve
- Mental health consultation to primary care
 - Refer to mental health specialist, as needed

Key components of effective care

- Screening & assessment
- Patient education and activation
- Treatment
- Care management
- Mental health consultation



**“Collaborative
Care”**

“Collaborative care” has been tested

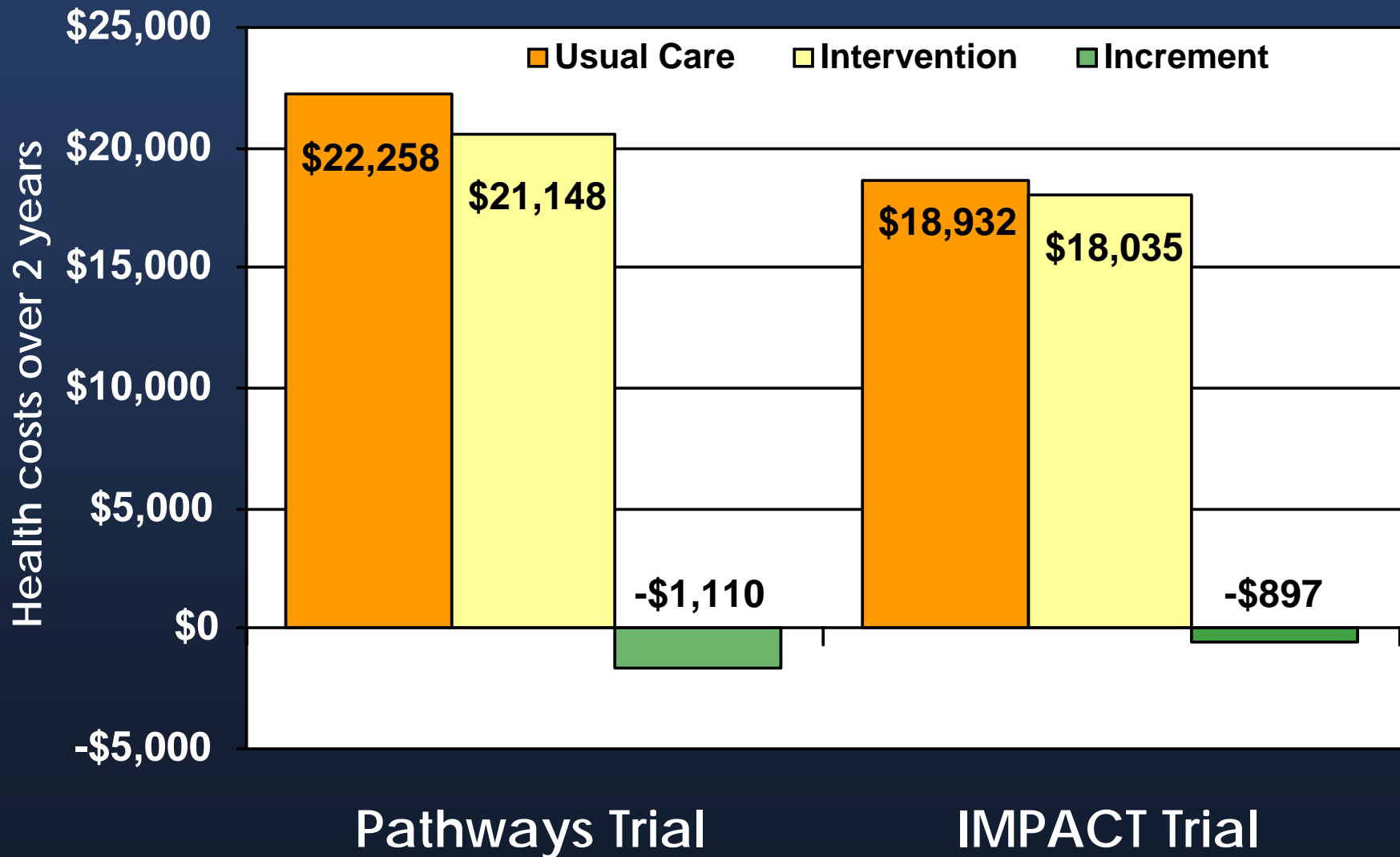
- **30+ randomized control trials** (reviewed in Gilbody et al., *Arch Intern Med* 2006)
- **Benefits of effective care**
 - Less depression
 - Less physical pain
 - Better functioning
 - Increased employment & productivity
 - Higher quality of life
 - Greater patient & provider satisfaction
 - More cost-effective than usual care (cost-saving in high risk groups)



Photo credit: J. Lott, Seattle Times

“I got my life back”

Depression QI among diabetics is cost-saving



Sources: Simon et al., *Arch Gen Psych* 2007; Katon et al., *Diabetes Care* 2006

“The Commission suggests that **collaborative care models** should be widely implemented in primary care settings and reimbursed by public and private insurers.”



THE PRESIDENT'S NEW FREEDOM
COMMISSION ON MENTAL HEALTH

Achieving the Promise:

TRANSFORMING
MENTAL HEALTH CARE
IN AMERICA

FINAL REPORT
JULY 2003

“Core components” of evidence-based collaborative care

- **Care manager time**
 - In-clinic or telephone contact
 - Independently or incident to clinician
- **Mental health specialty consultation**
 - Caseload supervision
 - Without face-to-face patient contact
- **Screening / outcome tracking as “lab test”**
- **(Primary care & MH visits on same day)**

Priorities for evidence

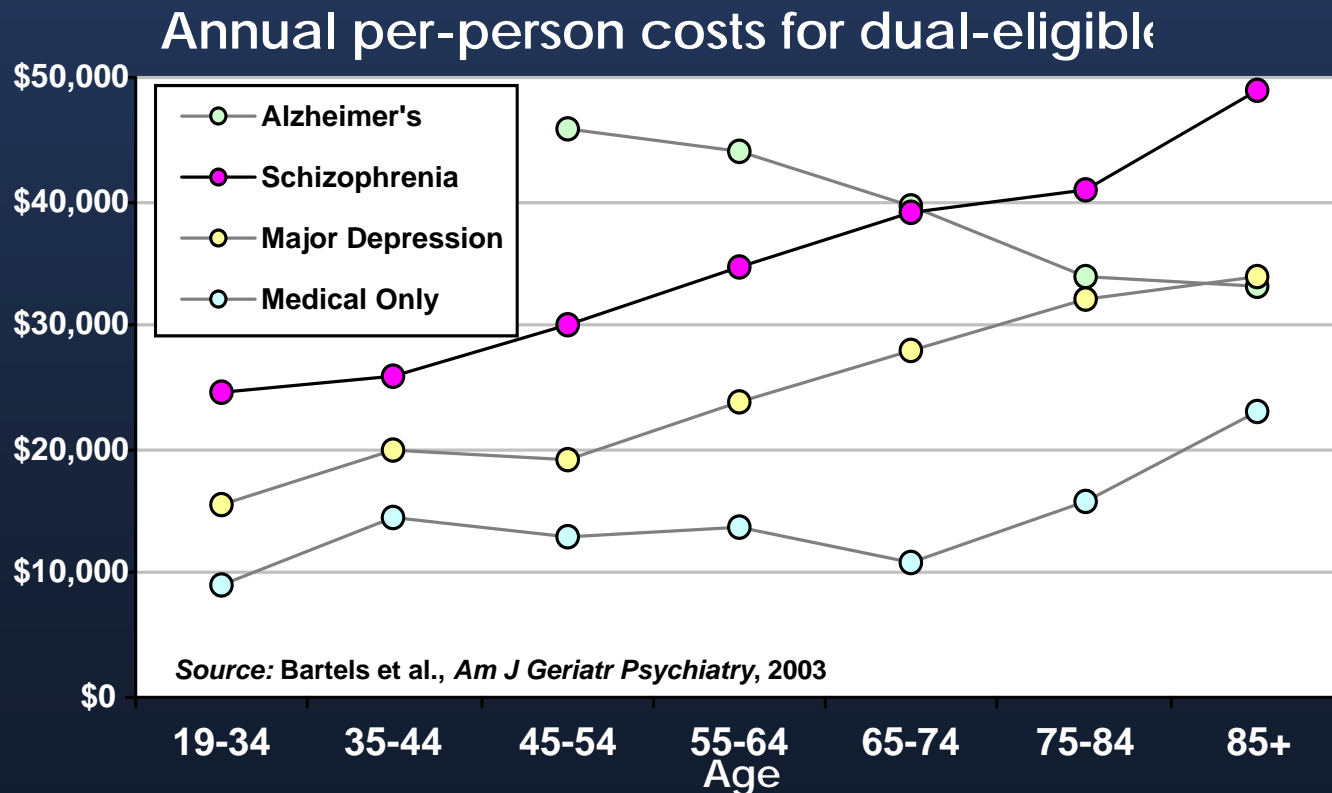
- **Delivering at population level**
 - Practice-based
 - Via 3rd party
- **Financing**
 - FFS vs. case rate
 - Cost-sharing?
- **Incentivising quality**
 - Developing & testing measures
 - PQRI / CPT Category 2
- **Other barriers to dissemination**
 - E.g, provider/manager knowledge
- **Extending to “whole patient”**

Possible “leverage points”

- Coverage
- Procedure codes & quality measures
 - Information systems
- Demonstration / pilot programs
 - Medicare Health Support
 - Medical Home
 - ICSI “DIAMOND” initiative?
- QIO scope of work / special projects
 - eRAP for Depression (nursing home pilot)
- Other initiatives, e.g.,
 - Social Security Administration demos
 - VA initiatives

Epidemiology of schizophrenia

- ~1% in Medicare overall (0.7% age 65+)
- 7% of SSDI awards
- Very high costs



Premature mortality in schizophrenics

- Average lifespan reduction of ~25 years
- 30-40% due to suicide & injuries
- 60% due to “natural” causes
 - Cardiovascular disease (2.3x stand. mort. ratio)
 - Diabetes (2.7x SMR)
 - Respiratory diseases (3.2x SMR)
 - Infectious diseases (3.4x SMR)
- Cardiovascular disease accounts for largest number of excess deaths

Poor 'usual' care for people with severe mental illness

- Fewer routine preventive services¹
- Worse diabetes care²
 - Fewer HbA1c tests, LDL tests, eye exams
 - Lower rate of monitoring
 - Poor glycemic control
 - Poor lipemic control
- Lower rates of cardiovascular procedures³
- High rates of nursing home use⁴

Sources: 1. Druss et al., Medical Care, 2002; Desai et al., J Gen Intern Med, 2002; Druss et al., Arch Gen Psych, 2001; 2. Desai et al., Am J Psychiatry, 2002; Frayne et al., Arch Intern Med, 2005; 3. Druss, JAMA, 2000; Druss et al., JAMA, 2000; Desai et al., J Nerv Ment Dis, 2002; 4. Bartels et al., Am J Geriatr Psychiatry 2003

Effective strategies exist

- **Medication management** (e.g., Rosenheck et al., *Am J Psychiatry* 2006)
- **Assertive community treatment (ACT)**
 - **25+ trials** (Phillips et al., *Psych Services* 2001)
- **Psychosocial interventions (incl. family interventions)** (e.g., Lehman et al., *Schizophrenia Bulletin* 1998)
- **Integrated care**
 - **Primary care embedded in mental health program** (e.g., Druss et al., *Arch Gen Psych* 2001)
 - **Unified primary care & mental health program** (e.g., Cherokee Health System in TN)
 - **“Linkage” care management - improved PCP-MH collaboration** (e.g., Bartels et al., *Comm Ment Health J* 2004)
- **Core elements not always / fully available**

“The Commission supports **coordinated** and, where appropriate, **integrated** mental health and substance abuse screening, assessment, early intervention, and treatment for co-occurring disorders...”



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Priorities for evidence

- Effectiveness
- Scalability
- Financing evidence-based interventions
- Boundaries of “health care”
- Measuring quality & outcomes

Possible “leverage points”

- Coverage
- Procedure codes & quality measures
- Demonstration / pilot programs
- QIO scope of work / special projects
- Other initiatives

For more information:

Michael Schoenbaum, PhD

Senior Advisor for Mental Health Services, Epidemiology, and Economics [C]

Division of Services and Intervention Research

National Institute of Mental Health

6001 Executive Blvd, Room 7142 MSC 9629

Bethesda, MD 20892-9669

Tel. 301-435-8760

Fax 301-443-0118

Email: schoenbaumm@mail.nih.gov

www.nimh.nih.gov

