Puget Sound Health Alliance

Depression Clinical Improvement Team

Final Report

January 2007

Puget Sound Health Alliance

Depression CIT Final Report
Table of Contents

Depression CIT Final Report
Executive Summary

The Puget Sound Health Alliance Depression Clinical Improvement Team (CIT) was convened in March 2006, in the second round of clinical improvement efforts undertaken to implement the recommendations of the King County Health Advisory Task Force.[1] The Puget Sound Health Alliance (the Alliance) grew out of this task force, and is committed to building upon national, state and local efforts at healthcare quality improvement, and to act as a catalyst for change in the region.

One of the goals of the Alliance is to promote quality care for specific diseases known to have significant social and economic impact. Depression is a common disorder in the United States, affecting over 19 million Americans each year. Twenty to twenty-five percent of women and 7-12% percent of men will experience depression in their lifetimes. The emotional toll that depression takes on individuals and families is profound. Depression also has significant economic consequences. It is the most common cause of disability in the United States, and annually costs U.S. employers $80 billion in health care costs, absenteeism, and lost productivity.

Despite its high prevalence and costs, recent evidence indicates that not everyone with depression receives optimal care. Less than optimal adherence to evidence-based clinical guidelines is compounded by barriers to quality depression care, such as the stigma associated with mental illness, and the fragmented nature of the mental health care system. The Alliance and the Depression CIT undertook to address these issues, and to define strategies to improve the quality of care and optimize outcomes for people with depression in the Puget Sound Region.

The Depression CIT was composed of twelve members of the community, representing mental health and primary care providers, purchasers, health plans, and public health and quality improvement experts. The members met five times from March 2006 through September 2006. The focus of the meetings progressed sequentially from (i) defining the target population, setting and disease scope, to (ii) identifying quality improvement strategies at the point of care, such as reviewing evidence-based clinical guidelines, selecting and reaching consensus on clinical performance measures, and developing goals and strategies for patients and providers, and (iii) developing strategies to

[1] King County Health Advisory Task Force Final Report, June 2004

create a supportive environment for change among community stakeholders, such as health plans, pharmacy benefit managers and purchasers/employers.

The Depression CIT focused its efforts on Major Depressive Disorder (MDD) in adults, targeting especially the primary care setting.

The Depression CIT identified tools, resources and recommendations for quality improvement at the point of care, with a focus on the primary care setting. The CIT chose not to recommend a specific set of clinical guidelines for the management of depression, as there are a number of quality evidence-based guidelines available. However, given the emphasis on the primary care setting, the CIT recommends that the Alliance provide a link on its web site two sets of guidelines aimed at the primary care provider: (1) The Colorado Clinical Guidelines Collaborative Major Depression Disorder in Adults: Diagnosis and Treatment Guidelines (Short Version) and (2) the Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines.

The next step in the CIT process was the selection of clinical performance measures with which to measure the quality of care delivered. At the onset of the task, the CIT members made several key recommendations aimed at providers in order to improve the quality of care for depression. These recommendations were:

1. Appropriately diagnose Major Depressive Disorder (MDD)
2. Objectively monitor treatment effectiveness
3. Change strategies if treatment is ineffective at achieving desired clinical response within a defined time period
4. Continue antidepressant medication for a minimal period of time shown by evidence to be most effective at maintaining a response.

A priority for the Alliance has been to build upon and remain consistent with national efforts at quality improvement. For this reason, and with the above recommendations in mind, the Depression CIT selected the National Committee for Quality Assurance's (NCQA's) two HEDIS measures for Adherence to Treatment, and one HEDIS measure for Optimal Provider Contact. In addition, the Depression CIT selected a measure on the use of a standardized depression rating scale, and an outcome measure on the effectiveness of treatment.
The Depression CIT concluded its work by identifying specific goals for the Alliance and for each group of stakeholders in the community to promote positive change in the management of depression. The Depression CIT emphasized that each community stakeholder has an active role to play in quality improvement efforts around depression care in the Puget Sound Region. Collaboration between community stakeholders and patients and providers is key to reducing the stigma associated with depression and other mental illnesses, increasing the knowledge of evidence-based treatment options, and improving the integration and coordination of mental health care with general health care, and with other programs aimed at the well-being of employees and their dependents.

Puget Sound Health Alliance

Depression CIT Final Report

I. Background

In December 2003, King County Executive Ron Sims convened a broad-based leadership group, *The King County Health Advisory Task Force*, to develop an integrated strategy to address the systemic problems facing the health care system in the Puget Sound region. In particular, Executive Sims requested that the Task Force focus on three inter-related issues: the increase in health care costs for employees and employer purchasers, quality of care, and the importance of improving the health of the community.[2]

The Task Force described the current system of health care as a "series of disconnected strategies all working concurrently but without a system steward, or neutral leader, to coordinate them and ensure that they are achieving the optimal mix of cost, quality, and health outcomes."[1] As part of their recommendation to develop an integrated strategy, the Task Force advised creating a regional partnership to provide the necessary leadership to forge changes in the existing system.

The Puget Sound Health Alliance (the Alliance) was created to fill this role, with the bold vision to develop a state-of-the-art health care system that provides better care at a more affordable cost, resulting in healthier people in the Puget Sound Region. Its mission is to build a strong alliance among patients, doctors and other health care providers, hospitals, employers and health plans to promote health and improve quality and affordability by reducing overuse, under-use and misuse of health services.

The Alliance has developed an extensive membership of providers, employer/purchasers, hospitals, health care associations, health plans and individual consumers in a five county region composed of King, Snohomish, Pierce, Thurston and Kitsap Counties.

The strategic approach of the Alliance addresses several key elements to improve health, quality, and cost outcomes, including: chronic disease management, scientific evidence to guide providers and patients in their medical decision-making, decreased practice variation, and quality

[2] King County Health Advisory Task Force Final Report, June 2004 [Accessed online 3_06_06 at: ftp://extranet.metrokc.gov/exec/hatf/063004report.doc]

measurement and reporting to support practice improvement and allow patients to seek appropriate care.

At the June 2005 Alliance Board meeting there was consensus among Board members that the Alliance would initially focus on four conditions: heart disease, diabetes, back pain and depression. Later, pharmacy was added as a fifth area of focus. Clinical improvement teams (CITs) for each clinical priority have been formed. These CIT's report to the Quality Improvement Committee and develop recommendations to the Board on standard guidelines, performance metrics and measurement approaches, and implementation and monitoring strategies for quality improvement in each area.

II. Defining The Problem: Depression

Depression is common in the United States and around the world. Almost 19 million Americans suffer from major depression in any given year, and an estimated 35 million people, or 15% of the population, will suffer from depression in their lifetime.[3]

Women are more likely to suffer depression than men. The lifetime risk of depression for women is 20-25%, while for men it is 7-12%.[4] In addition to female gender, risk factors for depression include a family history of the disorder, the presence of a chronic disease, and unemployment.[5] However, risk factors alone do not predict who will develop depression, and many of those who experience an episode of depression have no specific identifiable risk factors.

Depression can have a devastating affect on individuals, families, employers and society. It can also be lethal. Suicide is the 11th leading cause of death in the United States, and major depression is the cause of more than two-thirds of all suicides.[6] One in six people with severe, untreated depression commit

---

[3] National Committee for Quality Assurance, State of Health Care Quality Report 2005. Available at: http://www.ncqa.org/Docs/SOHCQ_2005.pdf [accessed online June, 2006]

[4] University of Michigan Health System. Guidelines for Clinical Care: Depression. 2004. Available at: http://www.med.umich.edu/depression/depressguidelines04.pdf#search=%22University%20of%20Michigan%20Depression%20Guidelines%22 [accessed online July, 2006]

[5] U.S. Preventive Services Task Force (USPSTF) - Screening for Depression. Release Date: May 2002. Available at: http://www.ahrq.gov/clinic/uspstf/uspsdepr.htm [accessed online September, 2006]

[6] Physician Consortium for Performance Improvement. Clinical Performance Measures- Major Depressive Disorder. Available at: http://www.aadprt.org/training/tools/depression.pdf#search=%22Physician%20Consortium%20for%20Performance%20Improvement%20Clinical%20Performance%20Measures%20Major%20Depressive%20Disorder%22 [accessed online September, 2006]

suicide.[7] Each year, 30,000 Americans die by suicide and a further 730,000 people attempt suicide.[8]

The economic costs of depression are also high. Total direct and indirect costs of the disorder are estimated to be over $80 billion annually.[9] Depression is the leading cause of disability in the United States. Each year $17 billion dollars in lost workdays are attributable to depression. [10]

Despite the high prevalence and cost of depression, evidence shows that the disorder is not always recognized or treated effectively and appropriately. Evidence-based clinical guidelines for the treatment of depression have existed since the publication of the Agency for Healthcare Quality and Research's (AHRQ) guidelines in 1993. However, the National Committee for Quality Assurance (NCQA) has shown standards of care for depression, based on HEDIS measures, are often not met in clinical practice. For example, in commercially insured populations in 2004, only 60.9% of patients received and continued antidepressants during the 12-week acute phase of treatment for a new episode of depression, and only 44.3% of patients remained on antidepressants for at least six months following diagnosis. Only 20% of patients diagnosed with depression had at least 3 follow-up visits with a primary care physician or mental health provider during the 12-week acute phase of treatment. Scores on these measures for Medicaid and Medicare populations were even lower.[11]

Studies show that 70% of psychotropic medications, including antidepressants, are prescribed by primary care providers (PCPs), and PCPs treat more patients for mental disorders than do mental health specialists.[12] For these reasons much of emphasis of the work of the Depression CIT focused on the primary care setting. However, the CIT also wanted to emphasize the importance of coordinated care for depression between PCPs and mental health specialists, and this theme is reinforced throughout the report.

---

[7] National Committee for Quality Assurance, State of Health Care Quality Report 2005. Available at: http://www.ncqa.org/Docs/SOHCQ_2005.pdf [accessed online June, 2006]

[8] (DBSA).

[9] Ibid

[10] U.S. Preventive Services Task Force (USPSTF) - Screening for Depression. Release Date: May 2002. Available at: http://www.ahrq.gov/clinic/uspstf/uspsdepr.htm [accessed online September, 2006]; Finch RA. Phillips K. Center for Prevention and Health Services. An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services. Washington, DC: National Business Group on Health; 2005. Available at: http://www.wbgh.org/prevention/et_behavioralhealthreport.cfm [Accessed online September, 2006]

[11] National Committee for Quality Assurance, State of Health Care Quality Report 2005. Available at: http://www.ncqa.org/Docs/SOHCQ_2005.pdf [accessed online June, 2006]

[12] Steve Melak. Behavioral Prescription Drug Trends: Skyrocketing Utilization and Costs Milliman Behavioral Health Insight, October, 2006. Forwarded by email from Dr. Lucy Homans, September 28, 2006.

III. The Depression Clinical Improvement Team

The Depression Clinical Improvement Team (CIT) consisted of members of the mental health and primary care provider communities, health plans, purchasers, and academic institutions. The members of the Depression CIT are listed in Appendix 1.

The CIT process is described in detail below:

A. Define the Scope

1. **Disease Scope:** The Depression CIT chose to limit its focus to Major Depressive Disorder, as defined by the DSM-IV criteria (Appendix 2), ranging in severity from mild to severe clinical unipolar depression. Bipolar disorder and dysthymic disorder were excluded.

2. **Target Population:** The Depression CIT focused its work on working age adults (ages 18-65) who are commercially insured.

3. **Setting:** The Depression CIT chose to focus on outpatient management of depression, with an emphasis on the primary care setting.

4. **Clinical focus areas**: In choosing areas for clinical improvement, the collective expertise of the group was instrumental in identifying areas that historically have shown poor overall levels of performance, would be amenable to quality improvement efforts and, and whose improvement would be most likely to enhance patient outcomes.

At the outset of their task, the CIT members made several key recommendations aimed at providers in order to improve the quality of care for depression. These recommendations were:

- Appropriately diagnose Major Depressive Disorder
- Objectively monitor treatment effectiveness
- Change strategies if treatment is ineffective at achieving desired clinical response within a defined time period
- Continue antidepressant medication for a minimal period of time shown by evidence to be most effective at maintaining a response.

Based on these recommendations, cost-effectiveness considerations, and the input of the various stakeholder groups represented by the team, six clinical focus areas were selected (Table 1). These areas of focus provided the framework around which the team developed clinical performance measures and recommendations corresponding to evidence-based clinical guidelines for the treatment of depression.

Table 1: Depression CIT Clinical Focus Areas

	Clinical Focus Areas
1.	Screening for depression
2.	Adherence to treatment
4.	Objective Diagnosis and Monitoring of Treatment
5.	Effectiveness of Treatment
6.	Cost-effectiveness of treatment, including preference for generic over brand name antidepressant

B. Review Evidence-Based Clinical Guidelines

The Alliance is committed to promoting the use of evidence-based medicine in the Puget Sound Region. The Depression CIT identified and reviewed existing evidence-based clinical guidelines for the treatment of depression. Several organizations have developed such guidelines[13] and most are based on the Agency for Healthcare Research and Quality (AHRQ) 1993 Guidelines.[14] The Depression CIT chose not to endorse any specific set of guidelines, but rather to recommend that guidelines selected for use by providers be evidence-based, with the evidence graded as to quality and clearly referenced.

The Depression CIT also recognized the importance of facilitating the dissemination of guidelines to appropriate providers. Since much of depression diagnosis and management occurs in primary care, the Depression CIT chose to focus much of their efforts on this setting. As a tool for providers, the team selected two sets of guidelines targeted at the primary care setting to link on the Alliance web site for easy access. These include a short two-page guideline

[13] For example: American Psychiatric Association: Major Depressive Disorder 2000 and 2005 http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm; Kaiser Permanante Care Management Institute: Major Depressive Disorder in the Primary Care Population 2000 http://pkc.kp.org/deppub.html; Institute for Clinical Systems Improvement (Minnesota): Depression Major, Adults in Primary Care 2004 http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180; University of Michigan: Adult Depression Guidelines 2002 http://www.med.umich.edu/depression/guideadultdep.htm; Michigan Quality Improvement Consortium: Depression 2006 http://www.mqic.org/guid.htm; VA: Management of Major Depressive Disorder in Adults 2000 http://209.42.214.199/cpg/MDD/MDD_cpg/mdd_toc_fr.htm; Colorado Clinical Guidelines Collaborative. Major Depression Disorder in Adults: Diagnosis and Treatment Guidelines 2006, http://www.coloradoguidelines.org/pdf_files/Depression%20shortguideRGB%2010.30.06.pdf

[14] AHRQ Depression in Primary Care: Detection and Diagnosis, Volume 1 http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat6.chapter.14485 [accessed online 5-16-06]

and treatment algorithm from the Colorado Clinical Guidelines Collaborative[15] that can be used as a day-to-day reference, and a more extensive referenced set of guidelines from the Institute of Clinical Systems Improvement.[16]

The Colorado Clinical Guidelines Collaborative (CCGC) is a non-profit coalition of health plans, physicians, hospitals, employers, government agencies, and quality improvement organizations formed in 1996 to improve the quality of healthcare in Colorado. One of the main goals of the collaborative is to consolidate and coordinate efforts around the development of evidence-based clinical guidelines for specific disease entities. A number of organizations have joined CCGC in guideline development, and their efforts have received national recognition. The CCGC Short Version guideline (Appendix 3) provides a handy reference for providers, with a clear outline of diagnostic criteria, treatment steps and goals, and medications available for depression.

The Institute of Clinical Systems Improvement (ICSI) is based in Minnesota. ICSI was founded in 1993 by HealthPartners Medical Group, Mayo Clinic and Park Nicollet Health Services. Its mission is to facilitate collaboration on health care quality improvement by medical groups, hospitals and health plans in the state of Minnesota and in adjacent areas of surrounding states. One of its ICSI's component areas is scientific groundwork for health care, and it has become a national leader in the development and dissemination of evidence-based clinical guidelines. ICSI's guideline for the treatment of Major Depression in Adults in Primary Care was released in May 2004 and provides structured recommendations based on evidence around key clinical quality improvement goals in the diagnosis and treatment of depression. ICSI also provides a version of the guidelines translated into plain language for patients and families[17].

C. Select Clinical Performance Measures

One of the goals of the Alliance is to publish public report cards on providers' achievement on selected clinical performance measures. Towards that end, the Depression CIT was charged with the task of selecting clinical performance measures for the treatment of depression that reflect evidence-based clinical standards. In developing these measures, the CIT targeted the six clinical focus areas listed in Table 1 above, and reviewed existing published measures from a variety of sources, including the Institute of Medicine (which includes

[15] Colorado Clinical Guidelines Collaborative: Guidelines on Depression (Short Version): http://www.coloradoguidelines.org/pdf_files/Depression%20shortguideRGB%2010.30.06.pdf [2006 version accessed online November 2, 2006]

[16] Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180 [2006 version accessed online October, 2006]

[17] ICSI Major Depression in Adults in Primary Care (for Patients and Families): http://www.icsi.org/knowledge/detail.asp?catID=182&itemID=1294 [accessed online August, 2006]

the Ambulatory Quality Alliance and the National Committee for Quality Assurance metrics), the Bureau of Primary Health Care, the Physician Consortium for Performance Improvement, the Centers for Medicare and Medicaid Services, and the Institute for Clinical Systems Improvement. The existing measures were evaluated for their widespread dissemination and use, feasibility, ease of measurement, acceptability to providers, and their meaningfulness in a clinical sense. Those measures that were deemed appropriate were selected for inclusion in the Alliance measure set. When acceptable existing measures were lacking for specific clinical focus areas, the team developed new measures that would most effectively promote improved quality of care for depression.

Appendix 3 lists all of the clinical performance measures selected by the Depression CIT. Below, the rationale behind each of the clinical focus areas is described, along with the selected clinical performance measures where applicable.

1. Screening

The United States Preventive Services Task Force (USPSTF) recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and careful follow-up.[18] This caveat led the team to concentrate on improving the regional systems for managing depression rather than case finding and screening. Therefore the team did not choose to identify a clinical performance measure for depression screening, but nonetheless acknowledged the USPSTF recommendation and encouraged the Alliance to promote screening for depression in the clinical setting and in the workplace. Recommendations to providers and employers regarding depression screening are made in a subsequent section of this report.

2. Adherence to Treatment

No treatment plan is likely to be effective if it is not adhered to, and in depression the evidence shows that a majority of patients fail to complete the recommended course of treatment. The NCQA HEDIS[19] data set focuses on adherence to treatment, and thus provides us more information on this clinical focus area than on other areas. The NCQA data indicates that overall adherence to recommended treatment for depression is poor, both in terms of follow-up with a provider and completion of the recommended course of antidepressant medication.

---

[18] United States Preventive Services Task Force Recommendations on Screening for Depression http://www.ahrq.gov/clinic/3rduspstf/depression/depressrr.htm [accessed online August, 2006]

[19] National Committee for Quality Assurance, State of Health Care Quality Report 2005. Available at: http://www.ncqa.org/Docs/SOHCQ_2005.pdf [accessed online June, 2006]

It is common in the management of depression for patients and their providers to discontinue treatment when the patient begins to feel better. However, evidence-based clinical guidelines on depression, such as those developed by ICSI (referenced above), make recommendations on length of treatment that is based on evidence regarding the prevention or reduction of relapse. For example, ICSI recommends that the length of time a patient remains on an antidepressant be based upon the number of prior episodes of depression the patient has experienced. Evidence shows that the relapse rate for depression correlates with the number of previous episodes of depression, but that the relapse rate can be reduced with continuation of antidepressant medication for an appropriate length of time.

ICSI recommends that pharmacologic treatment be continued for 6-12 months for a first episode of depression, 3 years for a second episode, and lifelong for a third episode or second episode with complicating factors, such as pre-existing dysthymia, inability to achieve remission, or recurrence of symptoms in response to attempts to reduce dose or discontinue medication. Lifetime treatment may also be indicated for patients aged 60 and older at first episode, or aged 40 and over with 2 episodes[20]. Without long-term antidepressant treatment ICSI reports that major depressive relapses occur in 50-80% of patients. Data also indicates that patients who have three or more episodes of depression have a 90% risk of relapse.[21]

NCQA data examines only the first six months of treatment, but shows that 60% of patients received and continued antidepressants during the 12-week acute phase of treatment for a new episode of depression, and as few as 44% of patients remained on antidepressants for at least six months following diagnosis.[22] In Washington State, Department of Social and Health Services pharmacy data indicates that only 45% of clients with depression remained on antidepressant medication longer than 12 weeks, and a similar number remained on medication for 6 months.[23]

In order to effectively monitor treatment progression and adherence, ICSI guidelines also recommend that providers "establish and maintain initial follow-up contact intervals. Follow-up may be by office visit, phone, or electronic means. If symptoms are severe, weekly contacts are appropriate. Contact should be every 2-4 weeks if mild or moderate symptoms are present. This protocol should be in place until remission or best possible outcome is

---

[20] Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180 [2006 version accessed online October, 2006]

[21] Ibid

[22] National Committee for Quality Assurance, State of Health Care Quality Report 2005. Available at: http://www.ncqa.org/Docs/SOHCQ_2005.pdf [accessed online June, 2006]

[23] Dr. Jeff Thompson, Medical Director, Washington State Medical Assistance Administration, personal communication, July 17, 2006.

achieved, then treatment should be spaced out as clinically warranted. Office visits for maintenance medication can occur every 3-12 months if everything else is stable."[24] Despite these recommendations, the NCQA date indicates that only 20% of patients diagnosed with depression had at least 3 follow-up visits with a primary care physician or mental health provider during the 12-week acute phase of treatment.

Psychotherapy is also a recognized treatment option for depression, either alone or in combination with pharmacotherapy, and although the NCQA does not report on adherence to psychotherapy, ICSI guidelines state "outcomes support the efficacy of several psychotherapeutic approaches [cognitive-behavioral (CBT), interpersonal (IPT), structured educational group therapy (SEGT)]. Therapy can take 8-10 weeks to show an improvement. Psychotherapy helps protect against/prevent relapse."[25]

The Alliance has emphasized the importance of aiming for regional and national consistency on performance measures whenever possible. Towards that end, the Depression CIT chose to adopt the three NCQA HEDIS measures on adherence to treatment since these measures have been adopted by the Institute of Medicine, and HEDIS measures have been widely used to measure health plan performance across the country. Rather than targeting health plans, the Alliance will adopt the HEDIS measures to report on the performance of primary care providers.

Table 2: Adherence to Treatment Clinical Performance Measures

Category	Measure	Source of Data
Effective Acute Phase Treatment	The percentage of eligible members who were diagnosed with a new episode of depression, treated with antidepressant medication, and remained on antidepressant medication during the entire 12-week acute phase	Claim
Effective Continuation Phase Treatment	The percentage of eligible members who were treated with antidepressant medication and remained on antidepressant medication for 6 months after diagnosis of a new episode of depression	Claim
Optimal Practitioner Contacts for Medication Management	The percentage of eligible members who received at least 3 follow-up visits with a primary care physician or mental health provider in the 12-week acute treatment phase after a new diagnosis of depression and prescription of antidepressant medication.	Claim

*From National Academies Press. Performance Measurement: Accelerating Improvement (2006) http://darwin.nap.edu/books/0309100070/html/184.html and NCQA http://www.ncqa.org/Docs/SOHCQ_2005.pdf p. 24

[24] National Committee for Quality Assurance, State of Health Care Quality Report 2005. Available at: http://www.ncqa.org/Docs/SOHCQ_2005.pdf [accessed online June, 2006]
[25] Ibid

3. Objective Diagnosis and Monitoring of Treatment

Evidence-based clinical guidelines for depression[26] emphasize the importance of adequately diagnosing Major Depressive Disorder based on DSM-IV criteria (see Appendix 2), and the objective assessment of the severity of depression at diagnosis and at each follow-up visit using a standardized depression rating scale. The guidelines also indicate the need for changing treatment strategies when treatment goals are not met. Medication failures may be addressed by a change of medication, referral to a behavioral health specialist, addition of psychotherapy if not already included, combination drug therapy, and, in severe cases, electroconvulsive therapy (ECT).

The Star*D trial, a recent large randomized control trial funded by the National Institutes of Health's (NIH) National Institute on Mental Health (NIMH), looked at the effectiveness of antidepressant treatment for Major Depressive Disorder. The study showed that only 30% of patients achieved full remission of their symptoms, and an additional 10-15% achieved partial remission, after being treated with a single antidepressant agent, citaprolam. In a second phase of the trial, 25% of non-responders achieved remission when switched to one of several second antidepressants. In the final phase of the trial, 16% of patients achieved remission when switched to a third antidepressant. In total, 60% of patients achieved complete remission by the time they had tried three drugs. In a separate arm of the trial, some patients also achieved remission through combination therapy. These data indicate that initial treatment choices for depression are not always effective, and that it is important for providers to monitor treatment effectiveness, and to change treatment strategies when treatment fails. The Depression CIT emphasized the importance of objective measurement of depression severity and treatment efficacy using standardized rating tools. While these standardized tools, such as the PHQ-9 and others, were developed for the purpose of depression screening, they have been validated as objective means of measuring depression severity and for monitoring and follow-up of depression.[27]

---

[26] Colorado Clinical Guidelines Collaborative: Guidelines on Depression (Short Version): http://www.coloradoguidelines.org/Guidelines/depression.html, Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180, American Psychiatric Association: Major Depressive Disorder 2000 and 2005 http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm

[27] Lowe, Unutzer, Callahan, et al. Monitoring depression treatment outcomes with the patient health questionnaire-9, Med Care 42(12): 1194-201 Abstract availabel at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15550799&query_hl=1&itool=pubmed_docsum [accessed online October, 2006]; Spitzer R, Kroenke K, Williams J. Validation and utility of a self-report version of PRIME-MD:the PHQ Primary Care Study. Journal of the American Medical Association 1999; 282: 1737-1744. Abstract available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids= [accessed October, 2006]

Table 3: Diagnosis and Monitoring of Depression Clinical Performance Measure

Category	Measure	Source of Data
Diagnosis and Monitoring of Depression		
Appropriate diagnosis and monitoring of treatment for depression	The percentage of patient visits for major depressive disorder in which a standardized depression rating scale* was administered.**	Chart (Claim if a reproducible code for administering a depression rating scale is selected)

*Such as the PHQ-9, the Zung scale, the Hamilton Depression Rating Scale, the Beck Depression Inventory, or the Geriatric Depression Scale

** Adapted from the following measures: (1) ICSI: Percentage of patients whose symptoms are reassessed by the use of a quantitative symptoms assessment tool(such as PHQ-9) within three months of initiating treatment"[28]; (2) Health Disparities Collaborative: "Percent of CSD patients who have a documented current PHQ between 4-8 weeks after their last New Episode PHQ" and "Percent of patients in the registry with a diagnosis of depression and a documented PHQ score within last 6 months."[29]

4. Effectiveness of Treatment

Measuring the effectiveness of treatment involves measuring actual clinical outcomes in a systematic and objective way. It was recognized by the CIT that clinical outcomes are more difficult to assess than processes, and that while process measures are usually available from claims data, outcome measures must be obtained by chart audit or through electronic health records or patient registries. Because of these difficulties, outcome measures will not be reportable by the Alliance in the short term. However, providers tend to view outcome measures as more clinically relevant than process measures, and are therefore more likely to recognize their importance. The Depression CIT chose to select an outcome measure for depression so that future efforts of the Alliance can focus on methods of obtaining such data.

[28] Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180 [accessed online August, 2006]

[29] Health Resources and Services Agency (HRSA) Health Disparities Collaborative: Depression. Available at: http://www.healthdisparities.net/hdc/html/collaboratives.topics.depression.aspx [accessed online October, 2006]

Table 4: Effectiveness of Treatment Clinical Performance Measure

Category	Measure	Source of Data
Effectiveness of Treatment		
Effectiveness of treatment	a) Percentage of patients with major depressive disorder who had the severity of their depression measured by a standardized rating scale by 8 weeks after diagnosis, and b) Percentage of patients in (a) who had a documented 50% improvement on objective rating scale, or who received a documented change in treatment* strategy.	Chart

This measure reflects a positive response to treatment[30] and is adapted from the following outcome measures: (1) ICSI:* "Percentage of Patients whose results on 2 quantitative symptom assessment tools (such as PHQ-9) decrease by 50 percent within six months of initiating treatment"[31]; (2) The Health Disparities Collaborative: "Percent of clinically significant depression patients with a 50% reduction in PHQ (comparing last New Episode PHQ to the most recent Current PHQ). The Current PHQ must be dated later than the New Episode PHQ."[32]

5. Cost-effective Care: Preferential use of Generic Antidepressants

Review of the literature fails to support the superiority of one second-generation antidepressant over another for first line treatment of depression in randomized controlled trials. The Drug Effectiveness Review Project[33] summarizes an extensive review of the literature by stating, "Fifty-five head to head trials compared the effectiveness and efficacy of one SSRI or other second

[30] Definitions: Response- significant level of improvement; or clinically significant reduction of more than 50% on a severity scale such as the PHQ-9 or the Hamilton Depression rating scale; Remission- a condition where only minimal signs of illness remain, or Hamilton Depression rating scale <7 or PHQ-9 score ≤4; Recovery- a sustained period of remission representing resolution of the index episode; Relapse- condition where symptoms return during the current episode of depression; Recurrence- a new episode of depressive illness following recovery (one must be symptom free for at least 6 months from previous episode of depression). From: Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180

[31] Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180 [accessed online August, 2006]

[32] Health Resources and Services Agency (HRSA) Health Disparities Collaborative: Depression. Available at: http://www.healthdisparities.net/hdc/html/collaboratives.topics.depression.aspx [accessed online October, 2006]

[33] Oregon Health and Sciences University Drug Effectiveness Review Project (2006): Drug Class Review on Second Generation Antidepressants Final Report. Available at: http://www.ohsu.edu/drugeffectiveness/reports/documents/Antidepressants%20Final%20Report%20Update%202.pdf [accessed online August, 2006]

The study adds the caveat, "the only exception is the comparison of citaprolam to escitaprolam. Four fair-to-good trials indicate consistently that escitalopram has a greater efficacy for the treatment of MDD that citaprolam. However, it may be significant that both citaprolam and escitaprolam are produced by the same manufacturer who has funded all the trails available. Citaprolam is available as a generic whereas escitaprolam is still patented." The report also notes the second generation antidepressants may differ in rate of onset of action or side effect profiles, and that there may be individual variation in response to any given agent.

generation antidepressant to another. All studies addressed the initial use of antidepressants. Overall, effectiveness and efficacy were similar and the majority of trials did not identify substantial differences among drugs."

Despite the above findings, however, many providers continue to prescribe brand name only medications for the treatment of depression. Data from the Washington State Department of Social and Health Services (DSHS)[34] indicate that, despite formulary restrictions, nearly 50% of antidepressant prescriptions filled by DSHS clients are for brand name products. The cost-saving potential is significant, and the Depression CIT recommends that providers be encouraged to choose preferentially select generic antidepressant medication when possible.

The Depression CIT chose not to select a clinical performance measure around antidepressant generic fill rate, but recommendations to encourage generic use were made for providers and plans (see below).

D. Develop Quality Improvement Strategies *at the Point of Care*

1. Patients:

Goals for patients:

2. Actively participate in depression care and treatment programs
3. Be aware of clinical expectations in the treatment of depression
4. Adhere to chosen treatment plans
5. Participate in discussions on cost-effective treatment options

Strategies for Quality Improvement:

1. **Patients** should be active and knowledgeable participants in the management of their major depression, and should be aware of all available choices of treatment. Offering choices increases adherence[35].
    i. The Institute for Clinical Systems Improvement (ICSI) Guidelines for Major Depression in Adults in Primary Care[36] emphasizes that "Successful care of major depression as an illness requires active engagement of each patient and their family and on-going patient education."

[34] Dr. Jeffrey Thompson, Medical Director, Washington State Medical Assistance Administration, personal communication, July 17, 2006.
[35] Lin et al (2005) The influence of patient preference on depression treatment in primary care. Ann Behav. Med. 30(2): 164-73. Available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=16173913&dopt=Abstract [accessed online September, 2006]
[36] Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines: Available at: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180 [accessed online July, 2006]

ii. "Patient information should include diagnosis, prognosis, and treatment options including costs, duration, side effects and expected benefits.

iii. "Education materials should include:

- The cause, symptoms and natural history of major depression
- Treatment options (trial and error approach)
- Information on what to expect during the course of treatment
- How to monitor symptoms and side effects
- Follow-up protocol (office visits and/or telephone contacts_
- Early warning signs of relapse or recurrence
- Length of treatment"

iv. Matching patients with their treatment preferences appears to contribute to improved outcomes in depression treatment.[37]

v. The Alliance recognizes that financial and benefit constraints may limit patient choices for treatment.

2. **Patients** should adhere to recommended and agreed upon treatment plans.

i. According to the ICSI guidelines, "patient adherence is critical. Often the depressed patient's pessimism, low motivation, low energy, and sense of social isolation and guilt may lead to noncompliance with treatment."[38] Lack of adherence to the recommended course of treatment leads to inadequate response and high relapse rates.

[37] Lin et al (2005) The influence of patient preference on depression treatment in primary care. Ann Behav. Med. 30(2): 164-73. Available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=16173913&dopt=Abstract [accessed online September, 2006]

[38] Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180 [accessed online July, 2006]

Tools and Resources for Patients

- **Patient Education**

- Clinical guidelines for patients and families:
  ICSI Major Depression in Adults in Primary Care (for Patients and Families):
  http://www.icsi.org/knowledge/detail.asp?catID=182&itemID=1294
- General patient education materials on depression.
  - National Alliance on Mental Illness: NAMI (the National Alliance on Mental Illness) is the nation's largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families.

    http://www.nami.org/template.cfm?section=By_Illness
  - The National Mental Health Association http://www.nmha.org/. The National Mental Health Association is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. With more than 340 affiliates nationwide, NMHA works to improve the mental health of all Americans, especially the 54 million people with mental disorders, through advocacy, education, research and service.
  - Journal of the American Medical Association (JAMA): JAMA 2006 295(3): 348 www.jama.com
  - Park Nicollette patient brochure: Understanding Depression
    http://www.icsi.org/knowledge/detail.asp?catID=240&itemID=2030
  - The MacArthur Initiative on Depression in Primary Care Toolkit. Patient Education Materials available in Appendix II: http://www.depression-primarycare.org/
  - Cognitive Therapy for Depression: What you should know. American Family Physician January, 2006 Patient Education Page.
    http://www.aafp.org/afp/20060101/90ph.html

- **Patient self-assessment and self-monitoring tools**
  - Mayo Clinic depression self assessment:
    http://www.mayoclinic.com/health/depression/MH00103_D

2. Providers:

The Depression CIT's work focused on the treatment of Major Depressive Disorder in the primary care setting when highlighting evidence-based clinical guidelines and in the selection of clinical performance measures. However, in the management of patients with major depression, primary care providers often refer patients to mental health specialists to augment or manage their care. Mental health specialists may include licensed clinical psychologists, psychiatrists and other licensed allied mental health clinicians (i.e. school psychologists, professional counselors, clinical social workers, and mental health nurse practitioners or clinical nurse specialists in mental health). In the interaction between primary care and mental health specialists, it is important to emphasize appropriate communication and cooperation, keeping the interests of the patient as a priority. The Depression CIT chose to emphasize this cooperative environment by developing quality improvement goals and strategies for both primary care and mental health specialty providers.

Goals for Providers:

Primary Care Providers (PCPs):

- Provide care or mental specialty referral for the treatment of depression based on evidence-based clinical guidelines
- Track and follow-up with patients who are started on antidepressant medication
- Achieve high performance on the clinical performance measures set by the Alliance
- Communicate referral and treatment goals to referred behavioral health specialists

Mental Health Specialists:

- Provide care for the treatment of depression based on evidence-based clinical guidelines and within their scope of practice
- Track and follow-up with patients who initiate psychotherapy or pharmacotherapy
- Achieve high performance on the clinical performance measures set out by the Alliance
- Communicate timely feedback to referring PCPs on patient progress in a manner that is sensitive to privacy issues, and limited to:
  - When treatment is initiated
  - Expected course and goals of treatment
  - Completion or termination of treatment

Strategies for Quality Improvement:

1. **Providers** should adhere to recognized evidence-based clinical guidelines in the management of major depression.
   i. The Alliance is committed to fostering the use of evidence-based medicine in the treatment of depression, and recommends the use of nationally recognized clinical guidelines that are supported by clearly referenced and graded evidence.
   ii. The Alliance does not endorse one set of guidelines over another, but highlights two sets of guidelines aimed at the primary care physician: the Colorado Clinical Guidelines Collaborative Guidelines on Depression Short Version,[39] as an easy reference for day-to-day use, and the Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines,[40] as a more complete reference guide to evidence-based practices.

2. **Providers** should consider both psychotherapy and antidepressant pharmacotherapy in the treatment of major depression according to evidence-based clinical guidelines, and offer patients treatment choices that are sensitive to individual and cultural preferences.
   - ICSI guidelines[41] indicate that when the presenting symptoms of depression are severe, treatment should be with antidepressant medication and psychotherapy. If the initial presentation is mild to moderate, then either an antidepressant or psychotherapy (or both) is indicated. Evidence-based psychotherapy, such as Cognitive Behavioral Therapy (CBT) and Interpersonal Therapy (IPT), can significantly reduce symptoms, restore psychological and occupation functioning, and prevent relapse in patients with major depression[42] Some studies have shown no difference in outcomes between psychotherapy and pharmacotherapy. [43] The combination of drug

---

[39] Colorado Clinical Guidelines Collaborative: Guidelines on Depression (Short Version): http://www.coloradoguidelines.org/Guidelines/depression.html [accessed online May, 2006; new version available October, 2006]

[40] Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180 [accessed online May, 2006]

[41] Ibid

[42] Friedman, Michael A. et. al. "Combined Psychotherapy & Pharmacotherapy for the Treatment of Major Depressive Disorder." Clinical Psychology: Science & Practice. 2004. 11:47-68; Hollon, SD, Thase, ME, & Markowitz JC. Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180 [accessed online October, 2006]

[43] Robert J et al. Cognitive Therapy vs Medications in the Treatment of Moderate to Severe Depression Arch Gen Psychiatry. 2005;62:409-416, Abstract available at: http://archpsyc.ama-assn.org/cgi/content/abstract/62/4/409 [accessed online October, 2006]; Robinson et al., Psychotherapy for the treatment of depression: A comprehensive review of controlled outcome research. Psychological Bulletin. 1990 108(1) 30-49, Abstract available at: http://content.apa.org/journals/bul/108/1/30 [acessed online October, 2006]; Bedi et al. Assessing effectiveness of treatment of depression in primary care. The British Journal of Psychiatry (2000) 177: 312-318 http://bjp.rcpsych.org/cgi/content/full/177/4/312; FPIN's Clinical Inquiry: Counseling or

therapy and psychotherapy has been shown to better than either therapy alone, especially for patients with more severe, chronic, or recurrent depression.[44]

- The Surgeon General's Report on Mental Health (1999) states that: "To be effective, the diagnosis and treatment of mental illness must be tailored to individual circumstances, while taking into account, age, gender, race, and culture and other characteristics that shape a person's image and identity".[45]

3. **Providers** should screen for major depression in their patients, with a particular focus on patients at high risk for depression, such as those with chronic diseases, a history of alcohol or drug abuse, or prior history of depression.
   i. The U.S. Preventive Services Task Force (USPSTF)[46] recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up:
      - "The USPSTF found good evidence that screening improves the accurate identification of depressed patients in primary care settings and that treatment of depressed adults identified in primary care settings decreases clinical morbidity. Trials that have directly evaluated the effect of screening on clinical outcomes have shown mixed results. Small benefits have been observed in studies that simply feed back screening results to clinicians. Larger benefits have been observed in studies in which the communication of screening results is coordinated with effective follow-up and treatment. The USPSTF concluded the benefits of screening are likely to outweigh any potential harm.

---

antidepressants in the treatment of depression? Amer Fam Physican 72(11):2309 http://www.aafp.org/afp/20051201/fpin.html [accessed online September, 2006]; Hollon, SD, Jarrett, RB, Nierenberg, AA, Thase, ME, Trivedi, M, & Rush, AJ. "Psychotherapy & Medication in the Treatment of Adult & Geriatric Depression: which monotherapy or combined treatment?" J. Clin. Psychiatry. 2005, April; 66(4):455-68, Available at: http://www.psychiatrist.com.offcampus.lib.washington.edu/privatepdf/2005/v66n04/v66n0408.pdf, [accessed online October, 2006]; "Treatment & Prevention of Depression." Psychological Science in the Public Interest. 2002. November, 2002. V. 3(2) 39-77.

[44] California Healthcare Foundation, Treatment Options for Depression in Adults: A Scientific Review http://www.chcf.org/documents/chronicdisease/DepressionTOR.pdf [accessed online August, 2006]; Pampallona S, Bollini P, Tibaldi G, Kupelnick B, Munizza C. "Combined Pharmacotherapy & psychological treatment for depression: a systematic review. Arch. Gen. Psychiatry. 2004 July; 61(7): 714-19. Comment in Evid, Based Mental Health. 2005 Feb; 8(1):12, Available at: http://ebmh.bmjjournals.com/cgi/content/extract/8/1/12 [accessed online October, 2006];

[45] Surgeon General's Report on Mental Health (199). Available at: http://www.surgeongeneral.gov/library/mentalhealth/chapter8/sec1.html#tailor [Accessed online September, 2006]

[46] U.S. Preventive Services Task Force (USPSTF) - Screening for Depression. Release Date: May 2002. Available at: http://www.ahrq.gov/clinic/uspstf/uspsdepr.htm [accessed online September, 2006]

- Many formal screening tools are available (e.g., [the Patient Health Questionnaire-9 (PHQ-9)], the Zung Self-Assessment Depression Scale, Beck Depression Inventory, General Health Questionnaire [GHQ], Center for Epidemiologic Study Depression Scale [CES-D]). Asking two simple questions about mood and anhedonia ("Over the past 2 weeks, have you felt down, depressed, or hopeless?" and "Over the past 2 weeks, have you felt little interest or pleasure in doing things?") may be as effective as using longer instruments. There is little evidence to recommend one screening method over another, so clinicians can choose the method that best fit their personal preference, the patient population served, and the practice setting.
- All positive screening tests should trigger full diagnostic interviews that use standard diagnostic criteria (i.e., those from the fourth edition of *Diagnostic and Statistical Manual of Mental Disorders* [DSM-IV]) to determine the presence or absence of specific depressive disorders, such as major depression and/or dysthymia. The severity of depression and co-morbid psychological problems (e.g., anxiety, panic attacks, [bipolar disorder] or substance abuse) should be addressed."[47]
- The Depression CIT recommends that depression screening be a routine part of the management of chronic diseases such as heart disease, diabetes, chronic obstructive pulmonary disease, chronic renal disease, and rheumatoid arthritis. Patients with chronic diseases are at high risk for major depression, and major depression can adversely impact the management of their chronic disease. The correlation between depression and chronic disease is well documented in the literature.[48]

4. **Providers** should utilize an objective standardized depression severity rating scale in the evaluation and ongoing management of patients with depression.
    i. The Alliance recommends use of the PHQ-9 for consistency with other national quality improvement efforts, but other recognized and tested scales, such as the Quick Inventory of Depression Symptomatology- Self Report (QIDS-SR), the Hamilton Depression Rating Scale, the Zung scale, the Beck Depression Inventory or the Geriatric Depression scale are valid alternatives.

[47] Ibid.

[48] Eg. Lin, et al. Effects of enhanced depression treatment on diabetes self care, Ann. Fam. Med. (2006) 4:46-53; Katon and Sullivan (1990). Depression and chronic medical illness. J. Clin Psychiatry 51 (Suppl): 3-11; Sacks CR, Peterson RA, Kimmel PL (1990). Perception of illness and depression in chronic renal disease. Am J Kidney Dis. 15(1): 31-9.

5. **Providers**, when prescribing second-generation antidepressant medications (e.g. SSRIs and SNRIs)[49] for first line therapy, should preferentially select medication for which there is a generic equivalent.
    2. Providers should determine that a patient has failed to respond to two generic antidepressants over adequate dose and duration before prescribing a branded medication, unless the patient has had prior successful treatment with a branded medication. [Note: Each medication should be titrated to appropriate dose (FDA maximum) and duration (6-8 weeks) when evaluating efficacy].
    3. Review of the literature fails to support the superiority of one second-generation antidepressant over another for first line treatment of depression in randomized controlled trials.
    4. The Drug Effectiveness Review Project[50] summarizes an extensive review of the literature by stating "Fifty-five head to head trials compared the effectiveness and efficacy of one SSRI or other second generation antidepressant to another. All studies addressed the initial use of antidepressants. Overall, effectiveness and efficacy were similar and the majority of trials did not identify substantial differences among drugs."
    5. The large STAR*D antidepressant effectiveness trial,[51] funded by the National Institutes of Mental Health, looked at first, second and third-line treatment of major depression. In the trial, citaprolam was used as a first line agent. It produced a complete remission rate of approximately 30%. Patients who failed citaprolam were allowed to voluntarily enter the second phase of the trial, in which they could choose to be randomly assigned to one of three second generation antidepressants: sertraline (an SSRI), buproprion-SR (a non-SSRI antidepressant) and venlafaxine-XR (an SNRI). There were no significant differences in effectiveness between these three drugs in second-line treatment, with each achieving remission in approximately 25% of patients who switched to a new medication.

---

[49] SSRI= Selective Serotonin Reuptake Inhibitor; SNRI= Serotonin Norepinephrine Reuptake Inhibitor

[50] Oregon Health and Sciences University Drug Effectiveness Review Project (2006): Drug Class Review on Second Generation Antidepressants Final Report. Available at: http://www.ohsu.edu/drugeffectiveness/reports/documents/Antidepressants%20Final%20Report%20Update%202.pdf [accessed online August, 2006]
The study adds the caveat, "the only exception is the comparison of citaprolam to escitaprolam. Four fair-to-good trials indicate consistently that escitalopram has a greater efficacy for the treatment of MDD that citaprolam. However, it may be significant that both citaprolam and escitaprolam are produced by the same manufacturer who has funded all the trails available. Citaprolam is available as a generic whereas escitaprolam is still patented." The report also notes the second generation antidepressants may differ in rate of onset of action or side effect profiles, and that there may be individual variation in response to any given agent.

[51] Rush et al (2006). Buproprion-SR, Sertraline, or Venlafaxine-XR after failure of SSRI's for treatment of depression. NEJM 354: 1231-1242 Available at: http://content.nejm.org/cgi/content/abstract/354/12/1231 [accessed online August, 2006]

6. **Providers** should strive for appropriate diagnostic coding when treating depression and prescribing antidepressant medications.
   i. ICSI has identified improper coding for major depression as one of the challenges in quality improvement efforts. Without appropriate diagnostic coding, patients cannot be readily identified or tracked. The Depression CIT recommends that providers appropriately and specifically code for major depression when it is diagnosed.
      - "Proper coding of patients posed challenges to action group teams at multiple levels of care – identification of newly diagnosed patients, clinically appropriate assessment of symptoms and follow-up, data collection, and reimbursement. Within ICD-9 coding, major clinical depression is coded as 296.2 if it is the first episode and 296.3 if is for a recurrent episode. Historically, the most commonly used diagnosis has been "depression, not otherwise specified (311)", which is a heterogeneous grouping of conditions that do not meet any other criteria. There is no evidence- based treatment specific to patients coded as 311. The tendency to code using 311 prevented the identification of patients newly diagnosed with depression and hence, data collection and follow-up."[52]
   ii. Antidepressant medication can be effective for the treatment of depression, as well as certain other conditions recognized by the Food and Drug Administration (FDA), such as anxiety and panic disorder, obsessive-compulsive disorder, premenstrual dysphoric disorder, social phobia and certain eating disorders. However, a number of studies have shown that antidepressant medications, including costly brand name second generation antidepressants, are frequently prescribed for inappropriate conditions, or conditions for which there is no approved indication.[53] While some off-label use of antidepressants may be appropriate, Washington State's Department of Social and Health Services (DSHS) pharmacy data is able to identify an appropriate diagnostic code from claims data for only 5.7% of antidepressant prescriptions.[54] This low number may reflect coding errors, limited coding, inappropriate or off-label prescribing, or other confounding factors, but it serves as a "Red Flag" to suggest further investigation and may reflect a need for improved documentation of appropriate indications when prescribing antidepressants.

---

[52] Jackels, N, Lee, C. 2005. Institute for Clinical Systems Improvement : Action Group Summary Report: Depression Action Group 2004 ,

[53] Pomerantz Jm (2003). Medscape. Behavioral Health Matters. Antidepressants Used as Placebos: Is That Good Practice? Available at: http://www.medscape.com/viewarticle/461430 [accessed online September, 2006]; Croghan TW (2001). The Controversy of Increased Spending for Antidepressants. Health Affairs 20(2): 129. Available at: http://content.healthaffairs.org/cgi/reprint/20/2/129.pdf#search=%22inappropriate%20use%20of%20antidepressants%22 [accessed online September, 2006)

[54] Dr. Jeff Thompson, Medical Director, Washington State Medical Assistance Administration, personal communication, July 17, 2006.

7. **Providers** should be encouraged to utilize patient tracking systems, either in the form of electronic health records or disease-specific patient registries, to proactively follow patients with major depression as recommended in the Chronic Care Model. [55]

    i. The clinical performance measures adopted by the Depression CIT for the management of Major Depression focus on adherence to treatment, and objective monitoring and follow-up of the effectiveness of treatment. Patient tracking systems and pro-active management of patients will facilitate quality performance in these measures.

8. **Providers,** both PCP's and Mental Health Specialists, should aim for coordinated care of patients with depression.

    i. Communication is encouraged between mental health providers - such as licensed clinical psychologists, psychiatrists and other allied behavioral health clinicians (i.e. licensed school psychologists, licensed professional counselors, licensed clinical social workers, and mental health nurse practitioners or clinical nurse specialists in mental health) - and primary care providers (PCPs):

    - When referring to mental health specialists, the PCP should provide information on the purpose and goals of the referral.
    - The mental health specialists should provide feedback to the PCP on a patient's progress, including information on when therapy or treatment is initiated, the expected course, when therapy has been completed, adherence or the lack of adherence or follow-up with the treatment plan, and whether treatment goals were met. Such feedback should not include detailed information on the contents of therapy sessions.
    - Given HIPAA and Washington State RCW requirements on mental health, patient written consent should be obtained prior to initiating communication between providers.[56]

---

[55] Chronic Care Model: Wagner (1998). What will it take to improve care of chronic illness? Eff. Clin Pract 1(1): 2-4

[56] The Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) allows the disclosure of protected health information by covered entities for the purposes of treatment, payment, health care operations or for certain other purposes, such as public health necessities. HIPAA's Privacy Rule also specifically prohibits the sharing of mental health counseling session notes without the consent of the patient. Further information is available at: http://www.hhs.gov/ocr/hipaa/privacy.html and http://www.cms.hhs.gov/hipaageninfo/01_overview.asp? [accessed online September 2006].
In Washington State, RCW 71.05.390, RCW 71.24.035, and RCW 71.05.630 protect the confidentiality of mental health records. RCW 71.05.630 provides that "except as otherwise provided by law, all treatment records shall remain confidential and may be released only to the persons designated in this section, or to other persons designated in an informed written consent of the patient." "Treatment records" include "include registration and all other records concerning persons who are receiving or who at anytime have received services for mental illness, which are maintained by the department, by regional support networks and their staffs, and by treatment

9. **Providers,** when prescribing antidepressant medication, should document an appropriate diagnostic code for depression, anxiety disorder, or any condition for which antidepressant medication is Food and Drug Administration (FDA) approved.
   i. A number of studies have shown that antidepressant medications, including costly brand name second generation antidepressants, are frequently prescribed for off-label use for which there is not evidence for efficacy.[57]

Tools and Resources for Providers
▪ **Provider education on guidelines for depression treatment** o Links on Alliance web site to: o The ICSI guidelines: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180 o The Colorado Clinical Guidelines Collaborative short version: http://www.coloradoguidelines.org/Guidelines/depression.html o Clinical Evidence Concise: Depressive Disorders. American Family Physician (2006) 73:1999 http://www.aafp.org/afp/20060601/ ▪ For family physicians, the American Board of Family Medicine offers a Maintenance of Certification Program Self Assessment Model in Depression. This module contains referenced evidence-based clinical guidelines. https://www.theabfm.org/MOC/sam.aspx
▪ **Depression rating scales** o Links on Alliance web site to: ▪ PHQ-9: http://www.coloradoguidelines.org/pdf_files/PHQ9andQIDSsr.pdf ▪ QIDS-SR: http://www.coloradoguidelines.org/pdf_files/PHQ9andQIDSsr.pdf ▪ Zung scale: http://healthnet.umassmed.edu/mhealth/ZungSelfRatedDepressionScale.pdf

facilities."

[57] Pomerantz Jm (2003). Medscape: Behavioral Health Matters. Antidepressants Used as Placebos: Is That Good Practice? Available at: http://www.medscape.com/viewarticle/461430 [accessed online September, 2006]; Croghan TW (2001). The Controversy of Increased Spending for Antidepressants. Health Affairs 20(2): 129. Available at: http://content.healthaffairs.org/cgi/reprint/20/2/129.pdf#search=%22inappropriate%20use%20of%20antidepressants%22 [accessed online September, 2006)

Tools and Resources for Providers

- Hamilton Depression Rating Scale: http://healthnet.umassmed.edu/mhealth/HAMD.pdf
- Geriatric Depression Scale: http://www.emedicinehealth.com/etools/geriatric-depression-scale.asp

- **Patient tracking systems and registries for depression (and other chronic diseases), such as:**
  - **Electronic health records**
    - There are a number of ongoing efforts aimed at promoting the dissemination of electronic health records (EHR's) in the Puget Sound Region. The Depression CIT recommends that the Alliance identify these regional efforts. Recognizing that the acquisition, implementation and maintenance of EHRs and registries is expensive, the CIT further recommends that the Alliance look for sources of funding subsidies for these activities, especially for small practices.
      - HCA/First Choice/Qualis Health Grants: The Washington State Health Care Authority, First Choice, and Qualis Health will distribute grants of up to $20,000 each to small clinical practices in the region for the acquisition or upgrading (to include registry function) of electronic health records (EHRs). Total funding of $1 million has been committed to this effort. Grants are to be awarded in the fall of 2006. http://www.qualishealth.org/news/WHIC.cfm
      - Qualis Health DOQ-IT: The Doctors Office Quality-Information Technology program was initiated by the Centers for Medicare and Medicaid Services (CMS) to accelerate the transition to EHRs in medical clinics across the country. In Washington and Idaho, Qualis Health has been contracted by CMS to provide assistance to select and implement EHR systems in participating practices. DOQ-IT participants are required to report on clinical measures to CMS. This effort is distinct from Qualis' participation in the grants for EHR's discussed above, and might present an opportunity for coordination with other efforts. Web link to DOQ-IT: http://www.qualishealth.org/doqit/index.cfm

Tools and Resources for Providers
▪ **Disease registries** o WSMA grants: The Alliance has been approached by the Washington State Medical Association (WSMA) to collaborate with them on the development of patient registries for the disease conditions that form the Alliance's four initial areas of focus, i.e. diabetes, heart disease, depression and back pain, as well as asthma and antibiotic use. WSMA has obtained funding for this venture, and plans to contract with a data vendor to set up pre-populated patient registries for these disease conditions.
▪ **Paper flow sheets** o Individual patients can be tracked manually using paper flow sheets. Examples of paper flow sheets can be linked to the Alliance web site for providers to download: o http://www.jfponline.com/pdf/5410JFP_OriginalResearch-upt1.pdf o http://www.aadprt.org/training/tools/depression.pdf (flow sheet on pg 5)
▪ **Feedback from mental health providers to PCPs regarding patient progress** o Mental health providers, such as psychiatrists, psychotherapists and counselors should be encouraged (or required by plans) to provide feedback to a patient's Primary Care Provider (PCP) on the initiation, progress, and termination of care for depression, using the model of feedback provided by medical specialists and allied health professionals (egg. home health nurses, physical therapists, etc.).
• **Self-auditing of charts** o Included in the depression clinical performance measures is an outcome measure that can be measured only through chart review. The CIT recognizes the expense and burden of extensive manual chart review when EHRs are lacking. However, the Bridges to Excellence Program of provider incentives encourages manual self-audits of charts. This provides immediate feedback to providers on their performance on an individual patient and patient population basis. Family physicians are familiar with the self-audit process, as they must complete a disease-specific self-audit of charts every 7 years for board recertification through the ABFM.

Tools and Resources for Providers
• **Coding information and/or toolkits to providers in preparation for public reporting of performance measures** o The Alliance's initial efforts at public reporting will be based on claims data. Therefore, measurement of provider performance will be dependent on appropriate coding for depression care and follow-up. Small practices and those without EHR's will be at a disadvantage, as appropriate and accurate coding is often not a priority. The Alliance can provide educational information and develop coding toolkits that can help providers identify and use appropriate codes. o A discussion on coding issues is provided in ICSI Depression Action Group Summary Report, 2004. http://www.icsi.org/knowledge/detail.asp?catID=105&itemID=2257

E. Creating a Positive Community Environment for Change

The purpose of the Alliance is to not only encourage regional consistency on point-of-care issues, such as clinical performance measures, but also to act as a catalyst to affect change and improve the quality of healthcare services delivered in the Puget Sound Region. After developing goals and recommendations for stakeholders *at the point of care*- patients and providers- the Depression CIT's next challenge was to identify and recommend strategies to change behaviors of the stakeholders in the community represented by the Alliance to improve the quality of care for major depression. The key stakeholders, in addition to the Alliance, were identified as:

- Health Plans
- Pharmacy Benefit Managers
- Purchasers/Employers

The Alliance is committed to evidence-based decision-making, and the recommendations for quality improvement at the point of care are based on the best available evidence for the management of major depression. However, there is less research available on supportive practices by community stakeholders in improving the management of depression or other mental health disorders. In the discussion to follow, the Depression CIT has cited evidence when it exists, but has also used the opinions and advice of national and local experts in crafting recommendations for community stakeholders.

1. The Alliance:

The published goals for the Alliance are listed below. These general goals may also be applied specifically to quality improvement efforts in the management of major depression.

Goals for the Alliance:

- Improve quality of health care services
- Improve health outcomes
- Slow the rate of health care cost increase
- Strengthen partnership between patients and providers to manage personal health
- Increase evidence-based decision-making
- Ensure collaboration, not duplication

Options for Change by the Alliance:

a. **The Alliance** should encourage the use of a common set of clinical performance measures for the management of Major Depression, as developed by the Depression CIT, throughout the Puget Sound Region, and publish a single report card on provider performance, using data combined from regional health plans.

b. **The Alliance** should promote the alignment of mental health benefits to optimize care of depression and other mental illnesses, and support efforts to remove existing barriers to mental health care.

   i. The Depression CIT recognized that the management of mental illness, including major depression, is complicated by specific barriers to care, such as the stigma associated with mental illness, limited or lack of access to mental health services, limited mental health training of primary care providers (who provider the bulk of mental health care), and the restrictive, heavily managed, and complex structuring of mental health benefits.[58] These barriers must be addressed if quality improvement in depression is to be realized. This document addresses the issue of primary care provider training and education, as well as patient education, but the CIT also recommends that the Alliance support community efforts to improve access to mental health care and to align mental health benefits to achieve optimum quality of care for depression.

[58] Unutzer J, et al. 2006. Transforming mental health care at the interface with general medicine: report for the President's Commission. Psychiatric Services 57: 37-47.

2. Health Plans:

Goals for Health Plans:

- Align mental health benefits to foster and facilitate the appropriate evidence-based disease management of depression
- Facilitate and foster communication and coordination between health plans, mental health vendors, mental health specialists, and primary care.
- Encourage cost-effective prescribing practices for antidepressant medications

Options for Change by Health Plans:

a. **Plans** should consider the adoption of a specific procedure code for administering and interpreting a structured depression severity rating scale, such as PHQ-9 or others.

   i. The Alliance recommends the use and dissemination of a specific code set that would capture the administration of a depression rating scale from claims data. Ideally, the code should also be reimbursable so as to encourage providers to perform the task and to utilize the code, although there is no clear evidence on the amount of reimbursement, if any, would provide an incentive to providers to learn and use the code

   ii. With input from representatives of regional health plans, the combination of an E/M 99420 code (prevention code- administration and interpretation of a health risk assessment) with an ICD-9 Procedure Code V79.0 code (depression screening) appears to be one of the most appropriate and specific options for this purpose.[59] Thus, the Alliance recommends that plans consider the use of the 99420/V79.0 combination to capture the administration of a standardized depression rating scale.

      - It has also been suggested that a further modifying code, such as V82.89 (Special screening - other specified condition), may add additional specificity to the code set, to allow for cleaner data collection[60].
      - The 99420/V79.0 code set is technically for depression screening in the general patient population, as opposed to ongoing monitoring of treatment in patients diagnosed with depression. However, unofficial communication with regional health plans has indicated that they would consider reimbursing this code set on an ongoing and recurrent basis for the same patient.

[59] Drew Oliveira, Medical Director, Aetna US Healthcare, email communication, August 11, 2006; David Ladwig, Medical Service Analyst, Premera, email communication, August 17, 2006; Richard Whitten, MD, Noridian Administrative Services, email communication 9/22/06 and personal communication 9/23/06.

[60] Richard Whitten, MD, Noridian Administrative Services, email communication 9/22/06 and personal communication 9/23/06.

- Plans may or may not choose to reimburse providers for administration of a standardized depression rating scale separately from a standard visit. However, it should be noted that many plans' software programs would eliminate codes not attached to a dollar value. In order to prevent that from occurring, the Alliance suggests the insertion of at least a $1.00 reimbursement value to the 99420/V79.0 code combination.[61]
- The Alliance also plans to follow the development and dissemination of the American Medical Association (AMA) Category II CPT codes, which are codes designed specifically for data collection in quality improvement and pay-for-performance efforts.[62] Once these codes are more widely disseminated and captured by plans, the Alliance recommends their use for data collection purposes. Currently, there is not a Category II CPT code that relates to the administration of a standardized depression rating scale, but the Alliance plans to submit an application to AMA for such a code. The procedure for requesting additional Category II CPT codes is outlined on the AMA website.[63]

b. **Plans** should consider a tiered co-pay system and/or other system of patient incentives to encourage the preferential use of second-generation antidepressant medications for which there is a generic equivalent.
   i. The differential cost to the patient between brand name and generic medication in a tiered co-pay system must be significant in order for the incentive to be effective. It is suggested that a price differential between brand and generic of $20 per month is a minimum requirement to affect behavior.[64]
   ii. Plans should consider that there be a minimum of 2 generic second-generation antidepressants trials, at adequate dose and duration, prior to allowing coverage for a brand name medication, regardless of whether or not a patient has a tiered co-pay drug benefit.

c. **Plans** and mental health vendors should coordinate and integrate mental health care with primary health care through:
   i. Structuring of benefits:

---

[61] Ibid

[62] Per the American Medical Association: "It is anticipated that the use of tracking Category II codes for performance measurement will decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians, other health care professionals, hospitals, and entities seeking to measure the quality of patient care. These codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care. The use of these codes is optional. The codes are not required for correct coding and may not be used as a substitute for Category I codes." Available at: http://www.ama-assn.org/ama/pub/category/12886.html [accessed online September, 2006]

[63] American Medical Association CPT codes: http://www.ama-assn.org/ama/pub/category/12892.html

[64] Dr. SuAnn Stone, Director, Pharmacy Services, Regence BlueShield, personal communication, July 17, 2006

- Carve-out mental health benefits should be avoided, or, if used, should align seamlessly with other health benefits.
- Mental health benefits should allow providers to be reimbursed for administering mental health care in the primary care setting.
- Purchasers and plans should structure mental health benefits to enrollees or employees so that mental health issues may be appropriately addressed and managed in both primary care and mental health specialty settings.

ii. Facilitating referrals:

- The primary care physician (PCP) should be able to directly refer to mental health specialists so that the PCP is integrated into the patient's mental health care treatment structure.
- Networks of approved mental health providers and their areas of specialization should be provided to primary care physicians and plan enrollees on an area or zip code specific basis.

iii. Communication should be encouraged between primary care providers (PCPs) and licensed mental health practitioners, such as clinical psychologists, psychiatrists, professional counselors, clinical social workers, and mental health nurse practitioners or clinical nurse specialists in mental health. Communication is also encouraged with allied behavioral health clinicians (e.g. school psychologists) who may be intervening on behalf of the patient.

- When PCP referral to mental health specialists is within a plan design, the PCP should be required by the plans to provide information on the purpose and goals of the referral.
- Health plans should consider ways of encouraging mental health specialists to provide feedback to the PCP. This could be done by a reimbursement requirement, when within the benefit design, that mental health specialists provide feedback to the PCP on a patient's progress, including information on when therapy or treatment is initiated, the expected course, when therapy has been completed, adherence or the lack of adherence or follow-up with the treatment plan, and whether treatment goals were met. Such feedback should not include detailed information on the contents of therapy sessions.
- In the case of self-referrals, or referrals from Employee Assistance Programs (EAPs), notification should be sent to the PCP identified by the patient.
- Given HIPAA and Washington State RCW requirements on mental health, patient written consent should be obtained prior to initiating communication between providers.[65]

[65] The Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) allows the disclosure of protected health information by covered entities for the purposes of treatment, payment, health care operations or for certain other purposes, such as public health necessities. HIPAA's Privacy Rule also specifically prohibits the sharing of mental health counseling session notes without the consent of the patient. Further information is

Tools and Resources for Plans
▪ **Establish a CPT billing code for the administration of an objective depression rating scale.** o Utilize the existing code combination 99420/V79.0. o Apply for a new CPT Category II code from the AMA. The Alliance can assist in this process by submitting the application for a new Category II (performance measurement) code for the administration of a depression rating scale from the American Medical Association's (AMA's) Performance Measures Advisory Group. The procedure for requesting additional Category II CPT codes is outlined on the AMA website http://www.ama-assn.org/ama/pub/category/12892.html.

3. Pharmacy Benefit Managers:

Goals for PBM's:

- Utilize PBM data systems to provide timely feedback to providers on prescription filling patterns of patients on antidepressant medications (including polypharmacy, multiple prescribers, and failure to refill prescriptions)

Options for Change for PBM's:

a. **Pharmacy benefit managers (PBMs)** should provide timely feedback to providers on patients prescribed antidepressant medication, including information on polypharmacy, multiple providers prescribing, and failure to refill prescriptions.

i. Pharmacy benefit managers collect and process prescription data with a rapid turn-around, and are therefore a potential source of timely feedback to providers on patient prescription patterns, with the aim of improving appropriateness of treatment and adherence to treatment.

ii. The Washington Business Group on Health's Linking Pharmacy and Mental Health Benefits Project (2002)[66] collected data from PBM representatives on prescribing patterns for antidepressants. "The PBMs found that 60% of prescriptions for antidepressants were written by primary care physicians. One PBM's data showed that 50% of antidepressant use was for single prescriptions only, while another's

---

available at: http://www.hhs.gov/ocr/hipaa/privacy.html and http://www.cms.hhs.gov/hipaageninfo/01_overview.asp? [accessed online September 2006].
In Washington State, RCW 71.05.390, RCW 71.24.035, and RCW 71.05.630 protect the confidentiality of mental health records. RCW 71.05.630 provides that "except as otherwise provided by law, all treatment records shall remain confidential and may be released only to the persons designated in this section, or to other persons designated in an informed written consent of the patient." "Treatment records" include "include registration and all other records concerning persons who are receiving or who at anytime have received services for mental illness, which are maintained by the department, by regional support networks and their staffs, and by treatment facilities."

[66] Washington Business Group on Health's Linking Pharmacy and Mental Health Benefits Project http://www.businessgrouphealth.org/pdfs/mentalhealthfinal.pdf

found that only 22% of those being treated by a primary care physician fill more than one prescription. The average number of days of antidepressant use for patients receiving their prescription for an antidepressant from a primary care physician was approximately 45 to 60 days. However, the average number of days of use was longer (170-180 days), for those individuals with a depression diagnosis who were being treated by a psychiatrist. Currently, the PBMs do not collect data on physician follow-up for prescriptions of antidepressants, although they do have the capacity to profile physician-prescribing behavior and to send reminders regarding follow-up or other related treatment matters."

Tools and Resources for PBMs

- **Adapt the PBM data source to provide real-time feedback to prescribing providers**
  - Washington Business Group on Health's Linking Pharmacy and Mental Health Benefits Project concludes that this is feasible as data is already collected by PBMs.
    - Washington Business Group on Health's Linking Pharmacy and Mental Health Benefits Project http://www.businessgrouphealth.org/pdfs/mentalhealthfinal.pdf

4. Purchasers/Employers:

Goals for Purchasers/ Employers:

- Provide mental health benefits to all employees
- Provide Employee Assistance Programs with ease of access, proactive approach, and coordination of care
- Encourage employee wellness, including mental health

Options for Change for Purchasers/ Employers:

a. **Purchasers** should offer mental health benefits to all employees.

i. Cost of Depression to Employers.

Depression and other forms of mental illness have a large impact on worksite productivity, absenteeism and direct and indirect health care costs to the employer. There is therefore a significant potential for Return on Investment (ROI) for purchasers who invest in mental health services and benefits for their employees.[67]

Estimates on the actual cost of depression to employers vary widely. According to the National Business Group on Health, "mental illness and substance abuse disorders cause more days of work loss and work impairment than many other chronic conditions, such as diabetes,

[67] Langlieb AM, Kahn, JP. 2005. How Much Does Quality Mental Health Care Profit Employers? JOEM Volume 47(11): 1099 Available at: http://www.workplacementalhealth.org/nov_joem11282005.pdf [accessed online September, 2006].

asthma, and arthritis. Major depression alone is associated with 136.9 million lost days of work, and a total cost to employers of $9.9 billion annually (2002 data). [68] The NBGH goes on to say that "The workplace costs of mental illness and substance abuse disorders, otherwise known as indirect costs, include metrics such as excess turnover, lost productivity (also known as work loss, work impairment, or presenteeism), absenteeism (incidental absences, etc), and disability (short- and long-term). Unlike other medical conditions such as heart disease or diabetes, the indirect costs associated with mental illness and substance abuse disorders commonly meet or exceed the direct treatment costs. In fact, some researchers estimate that the indirect costs of behavioral health disorders account for nearly 75% of the total costs of mental illness to employers."[69]

Another recent survey showed that the annual prevalence of major depression in the workforce was approximately 6.4%, and that major depressive disorder was estimated to be responsible for 8.7 absent days and 18.7 days of lost productivity per person per year, at a cost of $4426 per person annually. Extrapolated to the entire U.S. adult population, this amounted to an estimated cost of $36.6 billion annually.[70]

Another survey of American workers estimated the annual cost of depression to be $44 billion, with $8.27 billion in lost productivity due to absenteeism in depressed workers, and $35.73 billion due to the cost of lost productivity due to presenteeism of depressed workers.[71] Yet another report puts the total annual direct and indirect costs of major depressive disorder in the United States in 2000 at $81 billion. In this report, many of the costs were born by employers, either in health care expenses or in lost productivity, although non-employer-based societal costs were also included in the figure.[72] The various studies cited differ in their methodology and results, but, regardless of the exact figures,

---

[68] Finch RA. Phillips K. Center for Prevention and Health Services. An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services. Washington, DC: National Business Group on Health; 2005. Available at: http://www.wbgh.org/prevention/et_behavioralhealthreport.cfm [Accessed online September, 2006]

[69] Ibid

[70] Kessler, RC. 2006. Prevalence and effects of mood disorders on work performance in a nationally representative sample of U.S. workers. Am J. Psych. 163(9): 1561-6. Abstract available online at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=16946181&itool=pubmed_AbstractPlus [accessed Novermber 6, 2006]

[71] Walter F. Stewart; Judith A. Ricci; Elsbeth Chee; Steven R. Hahn; David Morganstein
Cost of Lost Productive Work Time Among US Workers With Depression
JAMA, Jun 2003; 289: 3135 – 3144 Abstract available online at: http://jama.ama-assn.org/cgi/content/abstract/289/23/3135?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=1&author1=Walter+F.+Stewart&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT [accessed November 6, 2006]

[72] Langlieb AM, Kahn, JP. 2005. How Much Does Quality Mental Health Care Profit Employers? JOEM Volume 47(11): 1099 Available at: http://www.workplacementalhealth.org/nov_joem11282005.pdf [accessed online September, 2006].

there is no question that depression among workers has a profound impact on U.S. employers.

The NBGH suggests that limiting mental healthcare services can increase employers' non-behavioral direct and indirect healthcare costs.

ii. One study of a large employer found that a reduction in employer-sponsored behavioral health services increased the direct medical costs of beneficiaries who used behavioral healthcare services by as much as 37%. Further, the behavioral health service limitation substantially increased the number of sick days taken by employees with behavioral health problems. The study concluded that savings attributed to limiting behavioral health benefits were fully offset by increased use of other medical services and lost workdays.[73]

iii. The MacArthur Initiative on Depression and Primary Care makes the point that "carefully conducted studies show that [employers'] pro-active efforts to address [depression] can result in a return on investment for companies."[74] This group provides a web-based tool that allows employers to estimate the annual cost of depression to their businesses.[75]The NBGH has developed a blue-print for employers for optimizing the identification and treatment of employees with mental health disorders. They recommend that employers equalize medical and mental health benefit structures, and reimburse primary care and other non-psychiatrist physicians for screening, assessing, and diagnosing mental illness and substance abuse disorders.[76]

iv. In Washington State, it should be noted that the Mental Health Parity Law (2005) requires that all employers with more than 50 employees offer mental health services in a manner comparable in scope and limitations to other health services.[77]

---

[73] RosenbeckRA et al. . 1999. Effects of declining mental health servicxe use on employees of a large corporation. Health Affairs 18(5): 193-203.

[74] The MacArthur Initiative on Depression and Primary Care at Dartmouth and Duke. http://www.depression-primarycare.org/ [Accessed online August, 2006]

[75] The MacArthur Initiative on Depression and Primary Care at Dartmouth and Duke. Interactive Depression Calculator for Employers. http://www.depression-primarycare.org/organizations/employers/calculator/ [Accessed online August, 2006]

[76] Ibid

[77] Washington State Mental Health Parity Law (2005) http://www.paritywa.org/Text/ParityConsumerDocument.pdf#search=%22Washington%20State%20Mental%20Health%20Parity%20Law%22 [accessed online September, 2006]

"Mental health parity means health carriers must limit co-payments and co-insurance for mental health services to no more than those charged for other health services and must treat mental health services the same as other health services when determining annual or lifetime dollar limits, deductibles, out-of-pocket maximums, and day/visit limits." The law will be phased in between January 2006 and July 1, 2010.

b. **Purchasers** should provide their employees with confidential mechanisms through which to address symptoms of depression or other behavioral health issues.
   i. Such mechanisms may include Employee Assistance Programs (EAPs), health plans, mental health benefits provided through mental health vendors, work-life programs, disability programs and/or wellness programs.
   ii. Larger employers often consider their Employee Assistance Program (EAP) as the primary access point to mental health services for employees. However, smaller employers without contracted EAPs should recognize and promote other modalities, as listed above, for access to mental health services. All employers should consider that employee preference and socio-cultural factors may influence choice of access to and effectiveness of mental health services.

c. **Purchasers** should provide integrated mental health services to their employees.
   i. Given the multiple possible access points for employer-based mental health services described above, coordination and integration of services is an important consideration in improving quality of care and reducing redundancy of services. According to the NBGH, "it is not customary for employers to integrate behavioral healthcare benefits offered through the health plan with behavioral health benefits offered through disability management, employee assistance, or health promotion programs. The result is that employer-sponsored behavioral benefits are fragmented, uncoordinated, duplicative, and uneven in terms of access and quality." [78]
   ii. The NBGH recommends that EAPs functionally coordinate with other health services including health plans, disability management services, mental health vendors and health promotion activities.

d. **Purchasers** should actively promote and increase the visibility and acceptability of their mental health services through visibility campaigns, marketing, and other outreach activities designed to decrease the stigmatization of mental health services and to increase utilization rates of those services.
   i. An important aspect of outreach and promotion of mental health services is destigmatization. Several companies have successfully "re-branded" their EAPs and integrated them into broader programs that

[78] Finch RA. Phillips K. Center for Prevention and Health Services. An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services. Washington, DC: National Business Group on Health; 2005. Available at: http://www.wbgh.org/prevention/et_behavioralhealthreport.cfm [Accessed online September, 2006]

include general wellness and work-life programs to improve employee perception and acceptance of the services.[79, 80]

ii. Purchasers should provide supervisors or managers with training on how to identify signs of possible depression in an employee, and how to offer assistance to that employee in an appropriate and confidential manner. Organizations such as the National Institute of Mental Health offer information for employers and supervisors on how to respond to employees with depression.[81]

e. **Purchasers** should encourage employees to become active participants in the diagnosis and management of their depression.

i. Employers should provide informational tools and resources to employees to encourage them to be informed consumers of mental health services.

f. **Purchasers** should offer depression screening to employees.

i. Screening for depression may be accomplished through Health Risk Assessment Questionnaires, a standardized depression rating scale such as the PHQ-9 or others, or the USPSTF 2-question screen (see Provider recommendation 4).

ii. Follow-up to depression screening should be through a third party, such as the health plan, mental health vendor, or EAP, rather than directly through the employer, in order to ensure employee confidentiality and trust.

iii. Employee incentives could be offered to increase participation in mental health screening. Such incentives could be included as part of employee wellness incentive programs, such as the King County Employees Healthy Incentives Program that provides reductions in out-of-pocket health care costs to employees who participate in the program.[82] The King County program currently does not include mental health. Incentives to promote increased physical activity can also have a positive impact on the mental health of employees.

g. **Purchasers,** through third party vendors, should actively identify employees at high risk for depression, and promote screening and case management activities for them.

---

[79] Marilyn Guthrie – Assistant Vice President, Manager, Health Promotion Health & Wellness Benefits, Washington Mutual, personal communication, August, 2006.

[80] Kelley M. Butler. Employee Benefit News, September 2006. Bending Mind and Body: EAP services expand to address employee physical health. http://www.benefitnews.com/detail.cfm?id=9405&terms=|eaps| [accessed online 9-15-06]

[81] National Institute of Mental Health. What to do when an employee is depressed: A guide for supervisors. http://healthyplace.com/Communities/Depression/nimh/employers.asp

[82] King County Employees Health Incentives Benefit Plan http://www.metrokc.gov/employees/default.aspx

i. Screening for depression may be most cost-effective in employees at high risk for the disorder. The National Business Group on Health emphasizes screening employees at high risk for depression: "Anyone with a chronic or persistent (i.e. 4-12 weeks or longer) medical illness or symptom(s), that results in a functional impairment that lasts for two weeks or longer, should be screened for depression. If screening is not initiated by the employee or his or her provider, the employer (i.e. the employee's supervisor or manager) must be trained how to facilitate this screening through their employee wellness program and/or EAP." [83]

ii. Purchasers are encouraged to use predictive modeling programs or clinical algorithms administered by third party vendors (such as health plans, mental health vendors, disease management vendors, or EAPs) for the identification of employees at high risk for depression.[84]

iii. Health plans, mental health vendors, and EAPs should initiate and coordinate case management activities for high-risk employees diagnosed with depression.

iv. Chronic disease management programs offered through employers should include depression screening as a routine part of their practice.

- "Individuals with certain chronic, general medical conditions are at high risk for developing, or already have, co-morbid depression. Co-morbid depression and other common mental health and substance abuse conditions can affect the severity of the primary medical condition and/or reduce an individual's ability to comply with his/her treatment regimen."[85]
- The NBGH recommends that "Employers should require their disease management vendors, as part of their regular practice, to periodically screen all patients enrolled in their respective programs for depression and other common behavioral health disorders, such as substance abuse and anxiety disorders, and coordinate care with other providers as indicated."[86]

---

[83] Finch RA. Phillips K. Center for Prevention and Health Services. An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services. Washington, DC: National Business Group on Health; 2005. Available at: www.wbgh.org/prevention/et_behavioralhealthreport.cfm [accessed online September, 2006]

[84] Denise Podeschi, PhD, Mercer Human Resource Consulting, PowerPoint Presentation: "Behavioral Health Workplace Depression Management," June 2006, and personal communication, August 29, 2006.

[85] Finch RA. Phillips K. Center for Prevention and Health Services. An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services. Washington, DC: National Business Group on Health; 2005. Available at: www.wbgh.org/prevention/et_behavioralhealthreport.cfm [accessed online September, 2006]

[86] Ibid

h. **Purchasers** should require that Employee Assistance Programs (EAPs) with whom they contract meet specified performance criteria.

i. Criteria for successful EAPs have been identified by organizations such as National Business Group on Health and through interviews with leading EAP vendors and consulting organizations in the Puget Sound Region. They are listed in Appendix 4.

Tools and Resources for Purchasers/Employers

- **Organizational web sites on mental health for employers**:
  - The National Partnership for Workplace Mental Health - The Partnership for Workplace Mental Health advances effective employer approaches to mental health by combining the knowledge and experience of the American Psychiatric Association and employer partners. http://www.workplacementalhealth.org/
    - Depression Toolkits for Employers and Employees, Depression Calculators, Brochures, and more: http://www.workplacementalhealth.org/toolsandresources/index.cfm
  - The National Business Group on Health - Employer's Guide to Behavioral Health Services: A Road map and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services http://www.wbgh.org/prevention/et_behavioralhealthreport.cfm
  - Global Business and Economic Roundtable on Addiction and Mental Health - "2006 Business and Economic Plan for Mental Health and Productivity" http://www.mentalhealthroundtable.ca/
    - Based in Canada, the Roundtable consists of business, health and education leaders who have undersigned the proposition that mental health is a business and economic issue.
    - Website includes modules and training sessions for managers (CEOs and senior executives) to build a top-down approach to addressing workplace depression:
      - Module Two - "CEOs and Managing Mental Health in the Workplace" includes a ten-phase plan for CEOs to address mental health and productivity in the workplace. Recommendations also include incentives for managers who successfully assist their employees in seeking help and returning to work.
  - Healthy Place.com Depression Community: A site sponsored by people living with depression and their family members.
  - "What to do when an employee is depressed: A Guide for Supervisors" http://www.healthyplace.com/Communities/Depression/nimh/employers.asp

- Employee self-assessment tools relating to the workplace
  - Mayo Clinic Self-Assessment of Workplace Stress: http://www.mayoclinic.com/health/stress/WL00064

Appendix 1: Depression CIT Members

Title	First Name	Last Name	Job Title	Organization
Ms.	Laura	Boyd	President	Health Care Purchasers Association
Dr.	Ronald	Cohen	Medical Director	Valley Medical Center
Dr.	Bob	Crittenden	Professor and Chief	Family Medicine Service, Harborview Medical Center
Ms.	Jennifer	Graves	Administrative Director, Operations	Virginia Mason Medical Center
Dr.	Lucy	Homans	Director of Professional Affairs	Washington State Psychological Association
Mr.	David	Ladwig	Medical Service Analyst II	Premera
Dr.	Paul	Schoenfeld	Director	The Everett Clinic Center for Behavioral Health
Dr.	Greg	Simon	Senior Investigator, Center for Health Studies	Group Health Cooperative
Dr.	Diane	Stein	Medical Director, Behavioral Health	The Regence Group
Dr.	Jeffery	Thompson	Medical Director	Medical Assistance Administration
Dr.	Jurgen	Unutzer	Professor and Vice-Chair of Psychiatry	University of Washington
Dr.	Elaine	Walsh	Assistant Professor	University of Washington, School of Nursing
Dr.	Lori	Whittaker	Consultant, Depression CIT Lead	Puget Sound Health Alliance

Appendix 2: DSM-IV criteria

DSM-IV Criteria for Major Depressive Episode and Major Depressive Disorder

Criterion/Symptom Description

Major depressive episode

A. At least five of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure (do not include symptoms that are clearly due to general medical condition or mood-incongruent delusions or hallucinations)

1. Depressed mood most of the day, nearly every day, as indicated either by subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation made by others)
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide

B. The symptoms do not meet criteria for a mixed episode

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)

E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation

Major depressive disorder, single episode

a. Presence of a single major depressive episode
b. The major depressive episode is not better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified
c. There has never been a manic episode, a mixed episode, or a hypomanic episode

Major depressive disorder, recurrent

a. Presence of two or more major depressive episodes (each separated by at least 2 months in which criteria are not met for a major depressive episode)
b. The major depressive episodes are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified
c. There has never been a manic episode, a mixed episode, or a hypomanic episode

Appendix 3: Clinical Performance Measures for Depression

Category	Measure	Type of Data Collection
I. Adherence to Treatment		
NCQA HEDIS Measures (in IOM Starter Set)*		
Effective Acute Phase Treatment	The percentage of eligible members who were diagnosed with a new episode of depression, treated with antidepressant medication, and remained on antidepressant medication during the entire 12-week acute phase	Claim
Effective Continuation Phase Treatment	The percentage of eligible members who were treated with antidepressant medication and remained on antidepressant medication for 6 months after diagnosis of a new episode of depression	Claim
Optimal Practitioner Contacts for Medication Management	The percentage of eligible members who received at least 3 follow-up visits with a primary care physician or mental health provider in the 12-week acute treatment phase after a new diagnosis of depression and prescription of antidepressant medication.	Claim

*Institute of Medicine. From National Academies Press. Performance Measurement: Accelerating Improvement (2006) http://darwin.nap.edu/books/0309100070/html/184.html
and NCQA http://www.ncqa.org/Docs/SOHCQ_2005.pdf p. 24
**

I. Diagnosis and Monitoring of Depression*		
Appropriate diagnosis and monitoring severity of depression	The percentage of patient visits for major depressive disorder in which a standardized depression rating scale** was administered.	Chart (Claim if a reproducible standard code for administering a depression rating scale is selected)

* Adapted from the following measures: (1) ICSI: Percentage of patients whose symptoms are reassessed by the use of a quantitative symptoms assessment tool(such as PHQ-9) within three months of initiating treatment"[87]; (2) Health Disparities Collaborative: "Percent of CSD patients who have a documented current PHQ between 4-8 weeks after their last New Episode PHQ" and "Percent of patients in the registry with a diagnosis of depression and a documented PHQ score within last 6 months."[88]

** Such as the PHQ-9, the Zung scale, the Hamilton Depression Rating Scale, the Beck Depression Inventory, or the Geriatric Depression Scale

III. Effectiveness of Treatment*		
Effectiveness of treatment	c) The percentage of patients with major depressive disorder who had the severity of their depression measured by a standardized rating scale by 8 weeks after diagnosis, and d) The percentage of patients in (a) who had a documented 50% improvement on objective rating scale, or who received a documented change in treatment strategy.	Chart

This measure reflects a positive response to treatment[89] and is adapted from the following outcome measures: (1) ICSI:* "Percentage of Patients whose results on 2 quantitative symptom assessment tools (such as PHQ-9) decrease by 50 percent within six months of initiating treatment"[90]; (2) The Health Disparities Collaborative: "Percent of clinically significant depression patients with a 50% reduction in PHQ (comparing last New Episode PHQ to the most recent Current PHQ). The Current PHQ must be dated later than the New Episode PHQ."[91]

---

[87] Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180 [accessed online August, 2006]

[88] Health Resources and Services Agency (HRSA) Health Disparities Collaborative: Depression. Available at: http://www.healthdisparities.net/hdc/html/collaboratives.topics.depression.aspx [accessed online October, 2006]

[89] Definitions: Response- significant level of improvement; or clinically significant reduction of more than 50% on a severity scale such as the PHQ-9 or the Hamilton Depression rating scale; Remission- a condition where only minimal signs of illness remain, or Hamilton Depression rating scale <7 or PHQ-9 score $\leq$4; Recovery- a sustained period of remission representing resolution of the index episode; Relapse- condition where symptoms return during the current episode of depression; Recurrence- a new episode of depressive illness following recovery (one must be symptom free for at least 6 months from previous episode of depression). From: Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180

[90] Institute for Clinical Systems Improvement (ICSI) Major Depression in Adults in Primary Care Guidelines: http://www.icsi.org/knowledge/detail.asp?catID=29&itemID=180 [accessed online August, 2006]

[91] Health Resources and Services Agency (HRSA) Health Disparities Collaborative: Depression. Available at: http://www.healthdisparities.net/hdc/html/collaboratives.topics.depression.aspx [accessed online October, 2006]

Appendix 4:

Recommendations for Successful Employee Assistance Programs (EAPs)

Definition: "An Employee Assistance Program (EAP) is an employer-sponsored service designed to assist employees, their spouses and their dependent children, in finding help for emotional, drug/alcohol, family, and other personal or job related problems."[92]

The following list of recommendations for EAP services and accountability are based on review of material from national business organizations and on extensive interviews with local representatives of companies or organizations engaged in EAP services or consultations.

1. EAPs should support management in addressing issues of productivity and absenteeism that may be caused by psychosocial problems:
    i. Support effective supervisory practices
    ii. Assist employees with deteriorating performance relating to behavioral or other health problems
    iii. Address work-related issues influencing disability or return to work
    iv. Assist in the identification of stress-related problems that may be a result of work organization
    v. Assist the organization in its response to drug-free workplace policies and regulations and disaster planning and terrorism preparedness as it relates to psychosocial issues
    vi. Serve as an internal consultant to management regarding issues of employee behavioral health.
    vii. EAPs should assist in the design and development of a structured program to deliver health promotion and healthcare education tools that significantly affect employee health and productivity and lead the effort to deliver behavioral healthcare education programs.[93]
2. EAPs should provide assessment and short-term counseling for individuals at risk of mental illness and substance abuse disorders and those with problems of daily living (e.g. divorce counseling).[94] The role of the EAP is to provide behavioral health screening and brief interventions, with referral to

[92] Finch RA. Phillips K. Center for Prevention and Health Services. An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services. Washington, DC: National Business Group on Health; 2005. Available at: www.wbgh.org/prevention/et_behavioralhealthreport.cfm [accessed online September, 2006]
[93] Ibid
[94] Ibid

appropriate primary care providers or behavioral health specialists for ongoing evaluation and management of identified conditions.[95]

3. Employers should conduct periodic organizational assessments to evaluate effects of work organization on employee health status, productivity, and job satisfaction. EAP staff, Human Resources, and Organization Development personnel should collaborate to determine appropriate interventions when necessary.[96]
4. EAPs should offer comprehensive services, including stress-related issues, physical issues, substance abuse, lifestyle choices, relational issues[97]
5. EAPs should offer employees 5-6 free in-person visits for screening and referral.
    i. Nationally, 77% of large employers (>500 employees) offered EAP services in 2005. Of that group, 74% offered an in-person model, with an average of 5 visits. In the West, the average number of EAP visits was only 4.[98]
    ii. In order to match the employee to the right provider, the provider's areas of expertise and their insurance carriers should be identified prior to making a referral.[99]
    iii. EAPs should provide web-based and/or toll-free telephone assistance, allowing immediate employee access to a master's or doctoral level behavioral health clinician who conducts screening and referral.[100] Telephone consultation must not be a substitute for in-person visits.
    iv. The EAP should also offer employees the ability to schedule appointments online and offer an online basic orientation as to how the EAP works.[101]
6. EAPs should use tools from general healthcare services – quality measures, review processes, evaluation tools, and other means of promoting quality of mental healthcare services.
7. EAPs should offer an array of web tools for members such as: provider network directories with search and self-referral capabilities, condition-specific tools (articles, risk assessments, wellness information, and self-care tools), and interactive coaching modules.[102]

---

[95] Consensus opinion of Depression CIT members

[96] Finch RA. Phillips K. Center for Prevention and Health Services. An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services. Washington, DC: National Business Group on Health; 2005. Available at: www.wbgh.org/prevention/et_behavioralhealthreport.cfm [accessed online September, 2006]

[97] Brian Whitney, CoHear EAP, personal communication, August, 2006

[98] Denise Podeschi, PhD, Mercer Human Resource Consulting, PowerPoint Presentation: "Behavioral Health Workplace Depression Management," June 2006, and personal communication, August 29, 2006.

[99] Tom Maschhoff, Vice President, EAP Services - First Choice Health. Personal Communication: August 9, 2006.

[100] Denise Podeschi, PhD, Mercer Human Resource Consulting, PowerPoint Presentation: "Behavioral Health Workplace Depression Management," June 2006, and personal communication, August 29, 2006.

[101] Tom Maschhoff, Vice President, EAP Services - First Choice Health. Personal Communication: August 9, 2006

[102] Ibid

8. Purchasers should build EAP-specific performance guarantees into contracts with the EAP vendor, managed behavioral health vendor, or other appropriate party, in order to assure that incentives for quality standards are in place.

Examples of performance guarantees include:

EAP utilization-

a. Three or four different metrics should be used to determine the most accurate EAP utilization rate[103]. Utilization cannot be summarized into one number.[104]
   i. **User Rate:** The number of unique callers to the EAP Line as a percentage of eligible employees. Benchmark should be at least 5.5% (varies depending on historical utilization and employee demographics). If user rate is less than 5.5%, then aim for an increase of any amount.[105]
   ii. **Rate of Referral** to Face-Face Counseling: The percentage of employees using the EAP who were directly referred. Varies by industry, and will increase as user rate increases. Midpoint benchmark is typically 71%.
   iii. **Visits per Referral**: For a 5-6 session EAP, midpoint benchmark is 4.2 visits / referral.
   iv. **Percent of Contracts with Performance Guarantee:** Midpoint benchmark is 7.3%.[106]

Management reports: "Delivered within 45 days of each quarter's close at 100% accuracy."[107]

Client Satisfaction: The employer completes a balanced survey to rate their level of satisfaction with the EAP's performance. A balanced survey has a 5-point scale (e.g. very satisfied, satisfied, neutral, unsatisfied, very unsatisfied), and a neutral rating should not be counted as a "satisfied" score. Example of performance guarantee: "90% positive response on balanced survey."[108]

---

[103] Denise Podeschi, PhD, Mercer Human Resource Consulting, PowerPoint Presentation: "Behavioral Health Workplace Depression Management," June 2006, and personal communication, October 10, 2006

[104] The Employee Assistance Professionals Association (EAPA), "EAP Utilization," http://www.eapassn.org/public/articles/utilization06.pdf. [Accessed online: October 23, 2006]

[105] Denise Podeschi, PhD, Mercer Human Resource Consulting, PowerPoint Presentation: "Behavioral Health Workplace Depression Management," June 2006. Mercer Information Channel, 2006 Survey of EAP Vendors indicates the midpoint user rate (callers to EAP line) was 4.9% in 2005, with a low of 1.1% and a high of 9.2%.

[106] Denise Podeschi, PhD, Mercer Human Resource Consulting, PowerPoint Presentation: "Behavioral Health Workplace Depression Management," June 2006, and personal communication, October 10, 2006.

[107] Ibid

[108] Ibid

Plan Implementation (for the EAP's first year only): "95% to 100% of implementation milestones are met by due date."[109]

Member Satisfaction: Employees who use the EAP should complete a member satisfaction survey. Example of performance guarantee: "90% positive response on overall service quality, provider quality, and ease of access to convenient appointment time and location." [110]

Telephone Responsiveness: Two telephone performance guarantees are recommended for the EAP:

a. **Average Speed of Answer** is 30 seconds or less.
a. **Abandonment Rate** is less than 5%.[111]

Integration with vendor partners (recommended for large employers only): Identify incentives that will increase the rates of referral from other health and wellness vendors to the EAP. These are often identified through Mercer's "vendor partner" approach - a meeting with the employer and all vendors, including the EAP, health plan, wellness programs, obesity management, and others. The strategy is to get the employer and all mental health vendors in the room to determine where overlap occurs and where coordination is needed in order to meet a certain referral rate metric (e.g. Where is patient hand-off needed? Who does screening?). A referral is defined as an in-person visit to the EAP (not just a telephone consultation). Integration performance guarantee language may include employer specific return on investment (ROI) expectations or other program milestones.[112]

[109] Ibid
[110] Ibid
[111] Ibid
[112] Ibid