

---

## INDUSTRY PERSPECTIVES: Depression in Managed Care

---

*To obtain a health care industry perspective on management of depression in managed care, JCOM spoke to Dr. Steven Locke.*

A striking problem in primary care is that patients with depression in the primary care setting frequently go undetected, and even when they are detected they are undertreated. Overall less than 1 in 10 depressed people is receiving effective treatment. Things have become somewhat better in the last few years, but I think that the people who have been trying to deploy programs that train primary care doctors to screen patients for depression and to use guideline-driven treatment approaches for pharmacologic management have not made sufficient inroads in solving this problem. My interpretation from having worked in a managed care organization (MCO) and from talking with medical directors is that primary care doctors are too busy to take the time to do these things and they don't have enough support—either informatics support or psychiatric care management support.

Most primary care doctors are reluctant to use combinations of antidepressants beyond making some upward dosage adjustments. If the patient doesn't respond within a few weeks to the initial or adjusted dose, they tend to refer the patient to a psychiatrist. I believe that under the current conditions that's probably the appropriate thing to do. However, I think that a carefully selected population of patients with uncomplicated depression could be managed by their primary care doctors with some assistance. This would involve clinical nurse specialists with training in psychopharmacology to oversee patient care, as well as a computer-assisted decision support system that could provide home monitoring of patients' symptoms and adverse events using the telephone. These interventions would give the primary care doctor greater confidence in making dosage adjustments, or adding a second or even third agent to the regimen, for patients whose depression is not complicated by substance abuse, psychosis, suicidality, and so on.

It's only a matter of time until population-based depression screening becomes a HEDIS measure. Currently, HEDIS depression measures are related to post-hospitalization follow-up care for depression and documentation of a minimal course of outpatient treatment for depression, but there is not a requirement that health plans screen for depression. As an industry observer, I would be surprised if it did not become a HEDIS measure within 3 years, maybe as soon as 2 years.

Also in the next 2 to 3 years I think we'll see a lot more data indicating that disease management programs are not only clinically effective but cost-effective as well. I don't think that we have enough published data yet to convince most corporate decision makers to implement these programs widely. Studies have yet to prove that there are medical cost savings that can be captured that will compensate for the cost of the better quality care that's provided. Now, as more of that care is shifted to oversight by care managers who can

assist the primary care doctor, along with decision support tools and home monitoring as I mentioned earlier, and as the cost of drugs is reduced as SSRIs come off patent, one should see the cost of care dropping and the efficiency and quality of care improving. I believe that we will soon see research studies showing convincingly that interventions that combine technology enhancements with care management and case finding in high-risk populations are both clinically effective and cost-effective and that the cost-effectiveness in part comes from medical cost offset savings. So far that's kind of the holy grail of depression disease management, finding convincing data that demonstrate the capture of medical cost offset savings. When you have done that, the world will beat a path to your door.

I think that the biggest challenge in depression management for MCOs comes from the potential conflict that arises from the misalignment of incentives in the care of patients who have comorbid medical conditions and depression. Let's say you have a patient with diabetes. We know that 20% to 25% of diabetic patients have depression. If an MCO has carved out their mental health benefit to a managed behavioral health care organization (MBHO), they've in essence already paid for the care of their patients with depression through the contract with the MBHO. If the MCO then decides to undertake a screening program and an intervention for people who have comorbid depression and diabetes, then as far as they're concerned they ought to be able to just refer them to the MBHO and have the MBHO provide the care. The MBHO on the other hand probably feels that when they negotiated their per member per month rate, they didn't bargain for an active screening program targeting high-risk patients, with patients being referred at a higher rate than had been historically true. Certainly, I assume that in the contract negotiations historical data are made available, upon which the MBHO actuaries calculate their exposure and factor in their profit. So if suddenly after the fact an MCO decides that they want to provide better care for a high-risk population, which they certainly should do, then who's going to be responsible for the cost of that care? I think that's the biggest challenge, and it's becoming a bigger and bigger challenge because in the last 5 years there has been accumulating data indicating that among patients with certain chronic medical conditions, especially congestive heart failure, diabetes, and coronary artery disease, the presence of comorbid depression is associated with worse clinical outcomes for the underlying medical condition. Therefore, if you don't identify those patients or treat them, you're not providing the care that they need and you're putting them at risk for death and disability.

*Steven Locke, MD  
Associate Professor, Department of Psychiatry  
Harvard Medical School, Boston, MA  
CEO, Veritas Health Solutions, Wayland, MA*

Copyright 2003 by Turner White Communications Inc., Wayne, PA. All rights reserved.