May 1, 2024

Diabetes Depression Screening Initiative

Executive Summary

Despite spending more than double on healthcare expenditures than the average of other developed countries, the U.S. continues to lag in key health outcomes, such as average life expectancy, infant mortality, and diabetes-related hospital admissions.

To be sustainable, there must be transformative changes in the way healthcare is administered and delivered. We must shift from our current sick/treatment model to one where prevention, health, and wellness is fostered and incentivized.

Background

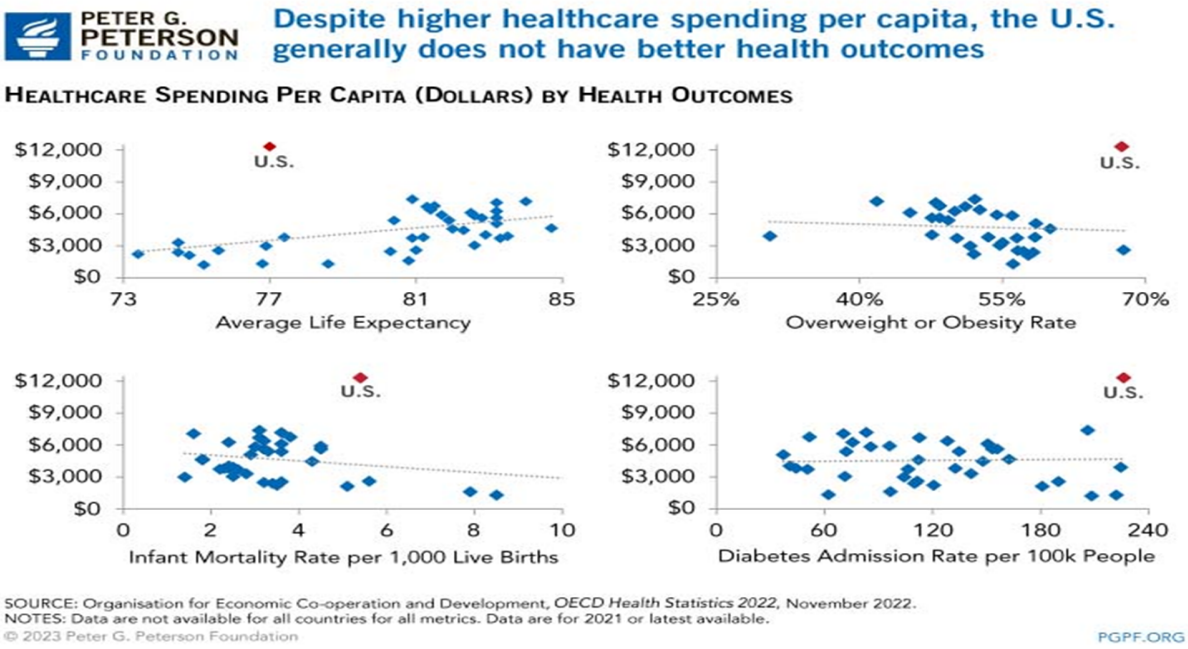
According to the Centers for Disease Control and Prevention (CDC), more than 37 million Americans have diabetes mellitus (about 1 in 10), with 90-95% of them having type 2 diabetes (T2DM). It most often develops in people over age 45, but more and more children, teens and young adults are also developing it.

CDC data shows that people with diabetes are 2 to 3 times more likely to have depression than people without diabetes.

Only 25% to 50% of people with diabetes who have depression to get diagnosed and treated for depression. As with other diseases and conditions, without treatment, depression often gets worse, not better. Treatment is usually very effective.

According to Mental Health America, 87% of patients with behavioral health conditions have one or more medical conditions, including circulatory, endocrine, or musculoskeletal disorders. In the same report, patients with both a medical and behavioral health condition face two to three times higher medical costs than patients without a behavioral health condition.

The report also found that 22% of patients with a behavioral health condition account for 41% of all healthcare spending.



Economic Impact

The American Diabetes Association (ADA) reports that in 2017, the total direct costs of diabetes in the U.S. were $237 billion. That analysis also documents substantial indirect costs related to lost productivity due to diabetes and its complications.

The cost of care for people with diabetes now accounts for a quarter (1 in 4) health care dollars spent in the U.S. (an average of $16,752 per year).

No depression = $10,016

Unrecognized depression = $15,155

Symptomatic depression = $20,105

Patients with Type 2 diabetes and major depressive disorder who receive behavioral treatment save $1,649 per member per year on care compared to patients without sufficient behavioral care.

Methodology

Using claims data, CHRISTUS identified all USFHP beneficiaries with a diagnosis of Type 2 Diabetes mellitus. A claim query was then performed to determine which beneficiaries with diabetes completed a depression screening (using a standardized screening instrument) within the previous twelve months.

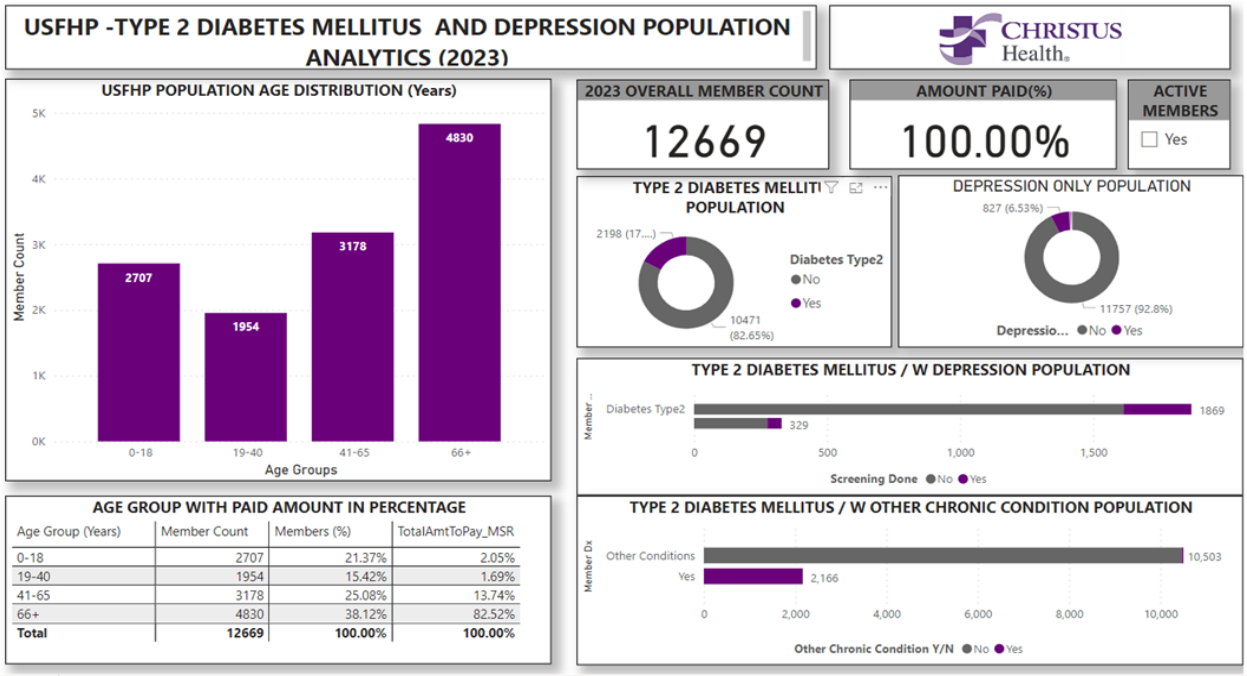


Figure 1. **BI Quantitative Data Collection Tool.** Snapshot in time of beneficiary data.

For beneficiaries with a diagnosis of diabetes who have associated claims for a depression screening, a CHRISTUS Health USFHP Behavioral Health Case Manager (BHCM) will contact the beneficiaries' primary care providers to:

i. Confirm that a depression screening was performed within the previous twelve months. If yes, and positive, the BHCM will inquire about (and document) treatment, i.e., antidepressants, psychologist, psychiatrist.
ii. Get date and results of HgbAlc performed within the previous 12 months.

For beneficiaries with a diagnosis of diabetes who do not have associated claims for a depression screening, a BHCM will contact them telephonically to:

i. Conduct a depression screening using the PHQ-9.
ii. Provide diabetes education and resources.

iii. Invite the beneficiary to enroll in either the CHRISTUS Health USFHP Diabetes Disease Management or BH Case Management Program.

For beneficiaries who have a positive depression screening, the BHCM will:

i. Notify the beneficiaries that the BHCM will contact their primary care providers to inform them of the positive depression screening and recommend and facilitate treatment initiation.
ii. Upon outreaching the beneficiaries' primary care provider, the BHCM will also request the date and results of a HgbA1c performed within the previous 12 months. ***NOTE:*** *This data will be shared with the CHRITUS Health USFHP Quality Management Team.*

The BHCM case will track referrals to a psychologist and/or psychiatrist via follow-up calls to the primary care providers.

For beneficiaries who have a positive depression screening, but do not have an identified primary care provider, the BHCM will refer them to Forefront Telecare for evaluation and/or treatment by a virtual behavioral health care provider. The BHCM will track referrals to a psychologist via regular reports provided by the vendor.

Within 30 days of enrollment into the CHRISTUS Health USFHP Diabetes Mellitus Depression Screening Initiative, the BHCM will have beneficiaries complete a Health Outcomes Survey (HOS) and a follow-up HOS 12 months from the date the initial questionnaire is completed.

Outcomes & Key Performance Indicators

Short-term (0-6 months)

- Achieve better blood glucose control.
- Require less insulin.

Intermediate (6-12 months)

- Achieve HgbA1c <8% (Goal: 63%/75th percentile).
- Require less ED utilization and hospital admissions/readmissions.
- Increase overall quality of life.

Long-term (12+ months)

- Maintain HgbA1c <8% (Goal: 63%/75th percentile).
- Experience less diabetes-related complications.

- Increase life expectancy.
- Reduce the overall healthcare costs.

Additional Key Performance Indicators

- Admission and readmission rates.
- Cost of direct diabetes care.
- Emergency Room utilization rate.
- Total cost of care.
- CAHPS Satisfaction with Plan and Plan Services Measure

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