Improving Mental Health Outreach Plan

Medicare Advantage Star Ratings Campaign

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A depression and anxiety screening Member Outreach plan presents a compelling opportunity to improve Medicare Advantage plan profitability and member health. *Improving or Maintaining Mental Health* is one of only 9 out of 47 Star Ratings measures with a weight of 3. Moreover, the measure drives overall Star performance by serving as a barometer of members' ability to engage in managing their overall health. Yet at least 10% of Medicare Advantage members have undiagnosed depression and anxiety, and of those diagnosed with depression, only two-thirds receive any care.

Our action plan demonstrates how to design and execute a campaign to close the mental health care gap with seniors. Moreover, this action plan may be used as a general model for how to improve Star Ratings.

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Understanding the Depression and Anxiety Landscape

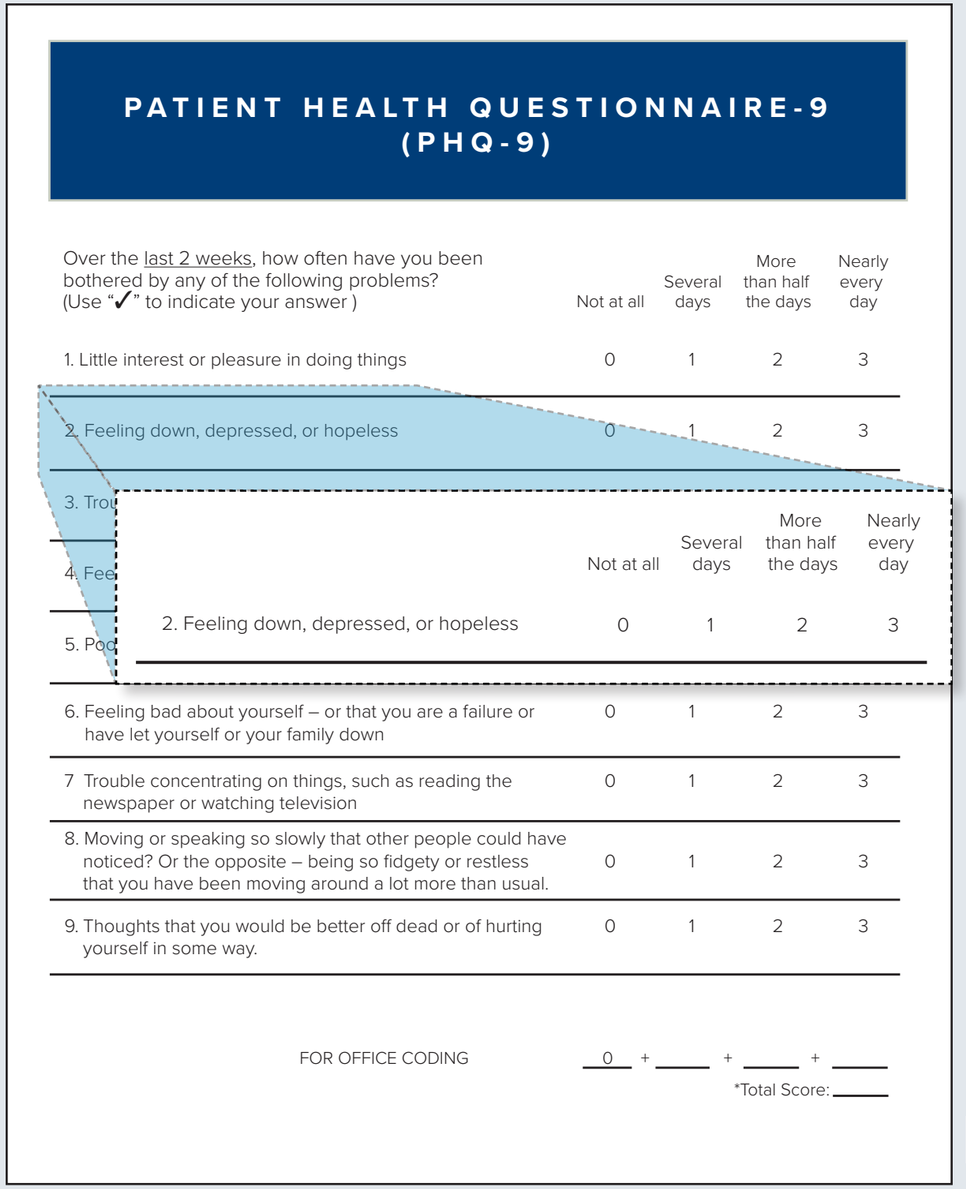
Making depression and anxiety screening reliable and cost efficient

The power of the PHQ-9 and GAD-7 assessments

The Patient Health Questionnaire-9 (PHQ-9) asks nine questions about the frequency of depression symptoms in order to determine a probable diagnosis of Major Depression along with the potential severity of depression. The Generalized Anxiety Disorder7 (GAD-7) parallels the PHQ-9 in format, question construction, purpose, and ease of administration, in order to determine a probable diagnosis of Generalized Anxiety Disorder in addition to the potential severity of anxiety.

Depression and anxiety screening with telephonic outreach

The PHQ-9 and the GAD-7 uncover results consistent with clinically administered screenings[1]. Moreover, there is a strong concordance between telephone administration and in-person administration of the PHQ-9 self-assessment[2]. Telephonic Member Outreach allows the health plan to cost-effectively reach more members over larger geographical regions.



PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trou				
4. Fee				
5. Poo				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

Not at all | Several days | More than half the days | Nearly every day
2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3

FOR OFFICE CODING 0 + ____ + ____ + ____

*Total Score: ____

[1] Spitzer, Robert L., Kurt Kroenke, Janet B. W. Williams, and Bernd Lowe, Dr. "A Brief Measure for Assessing Generalized Anxiety Disorder." JAMA Network. 2006. Accessed June 14, 2016.

[2] PintoMeza, Alejandra, Antoni SerranoBlanco, Maria T. Peñarrubia, Elena Blanco, and Josep Maria Haro. "Assessing Depression in Primary Care with the PHQ-9: Can It Be Carried Out over the Telephone?" Journal of General Internal Medicine. Accessed August 2. 2016.

Understanding the Depression and Anxiety Landscape

Depression diagnoses more prevalent in women and dual eligibles

Gender gap between women and men persists until age 85

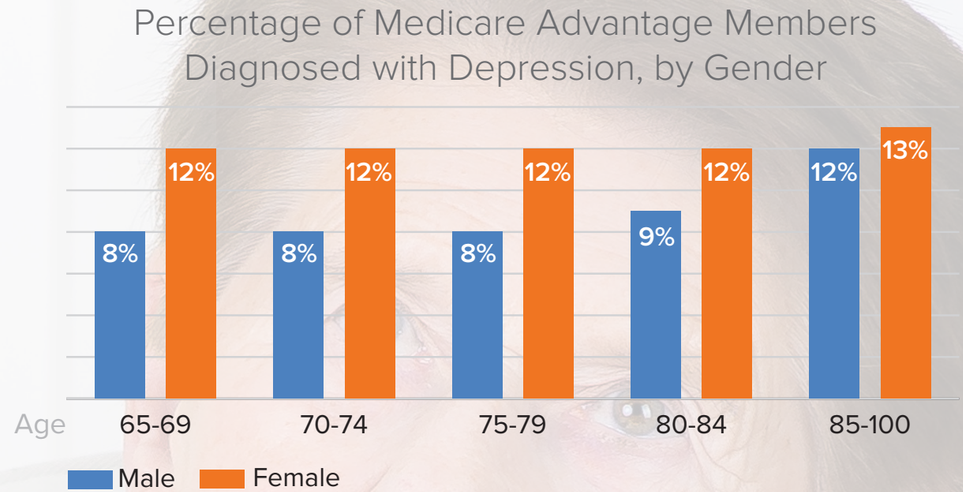
The share of female Medicare Advantage beneficiaries over 65 diagnosed with depression is 12%, compared to 8% for men. The gap persists until men turn 85[5]. Men suffering from depression may demonstrate higher rates of aggression, risk-taking, and substance abuse, and are less likely to report symptoms measured in traditional depression screenings[6], perhaps leading to the gap's origin.

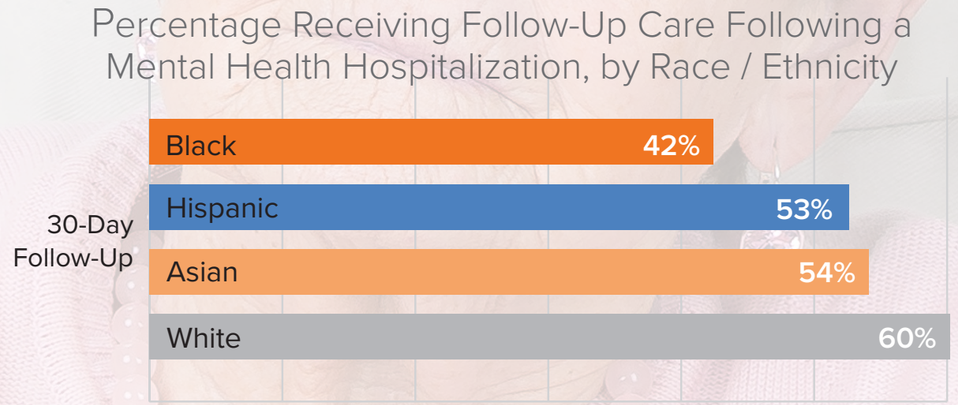
Evidenced correlation between low-income and depression

The prevalence of depression more than doubles in low-income households. When a member of Medicare Advantage is also eligible for Medicaid, rates of depression increase to 23% of males and 26% of females.

Differences in depression care by race/ethnicity

Within the first 30 days following a mental health hospitalization, 60% of whites received follow-up care, compared to only 42% of African Americans[7]. An effective outreach program will attempt to address these biases.





[5] Bierman, Arlene S., Beth Hartman Ellis, and David Drachman. "HOS Highlights: Depressed Mood and Mental Health Among Elderly Medicare Managed Care Enrollees." Health Care Financing Review. 2006. Accessed June 14, 2016.

[6] Ibid

[7] Virnig, Beth, Dr., Zhen Huang, and Nicole Lurie. "Does Medicare Managed Care Provide Equal Treatment for Mental Illness Across Races?" JAMA Network. 2004. Accessed June 14, 2016.

Understanding the Depression and Anxiety Landscape

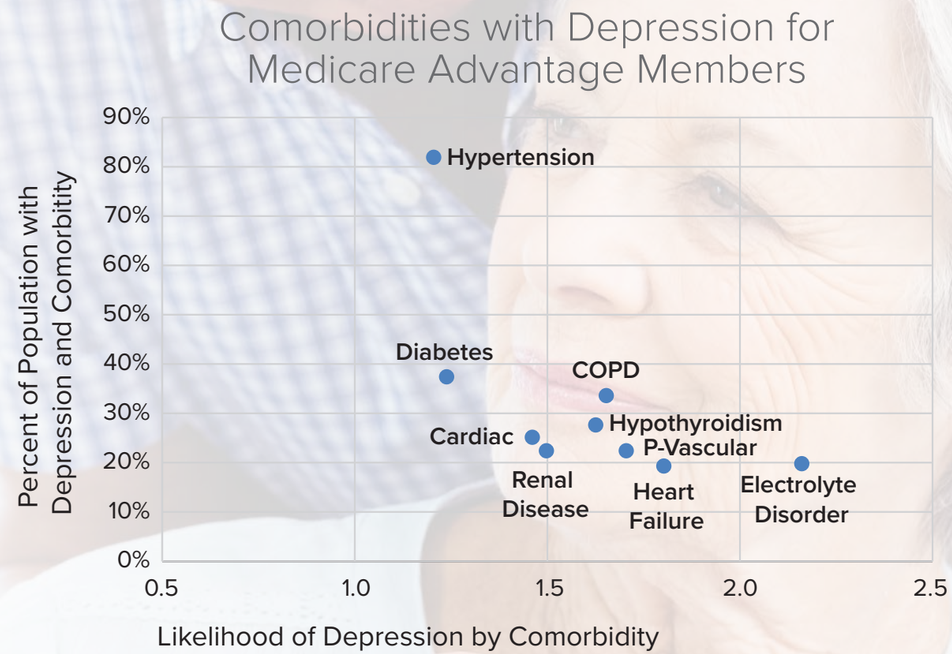
Physical comorbidities help identify at-risk members

Comorbidities, depression, and anxiety often go hand in hand

Medicare Advantage members are nearly five times more likely to report a depressed mood in the HOS survey when they suffer from four or more chronic conditions (as opposed to members with no chronic conditions[8]). For Medicare Advantage members diagnosed with depression, the most common comorbid diseases are hypertension, diabetes, COPD, electrolyte disorders and renal disease[9]. The list of comorbidities for members with anxiety is similar, with the addition of heart failure, and the subtraction of diabetes.

Comorbidities may be used to identify at-risk members

Comorbidities correlated with depression and anxiety may be used to identify members most likely to be suffering from undiagnosed depression and anxiety. In the graphic to the right, 34% of Medicare Advantage members who are depressed also have COPD. Looked at from the opposite perspective, members diagnosed with COPD are over 1.5 times more likely to be diagnosed with depression[10]. Electrolyte disorders, found in patients suffering from extreme dehydration, kidney disease, and cancer, increases the likelihood of a member suffering from depression by 120%[11].



[8] Bierman, Arlene S., Beth Hartman Ellis, and David Drachman. "HOS Highlights: Depressed Mood and Mental Health Among Elderly Medicare Managed Care Enrollees."
[9] Ibid.
[10] McAvay, Gail, and Erik Goetz. "Late Life: Depression and Anxiety in Four Types of Medicare Advantage Plans: Comorbidity with Other Medical Diseases and Resource Utilization."
[11] Ibid.

Understanding the Depression and Anxiety Landscape

Depression and anxiety members have 3x higher costs

Depression and/or anxiety results in significantly higher utilization...

Medicare Advantage members with a diagnosis of either depression or anxiety make over 50% more primary care and specialist office visits each year than members with neither diagnosis. For members with both depression and anxiety, the differential jumps to 100%[12].

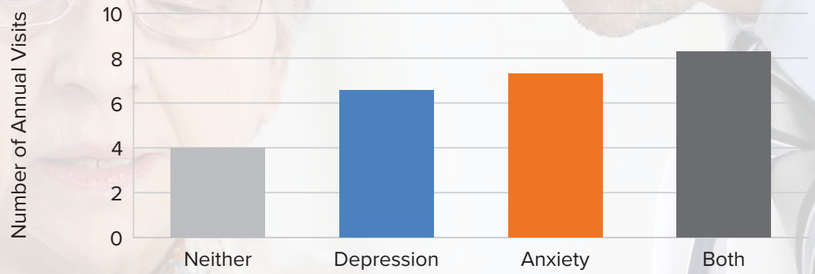
...increasing costs across the board

Compared to approximately $7,000 for members without either disorder, a diagnosis of either depression or anxiety doubles the cost to treat a Medicare Advantage member. The average member with both diagnoses incurs over $21,000 in annual medical costs[13].

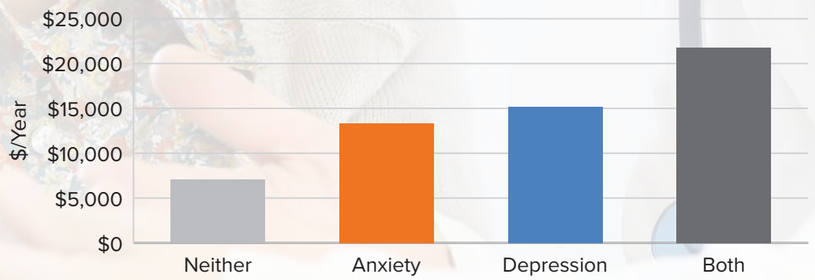
A 'tipping point' may play a role

Depression and anxiety can affect the 'tipping point' of whether or not to use a certain health care service. This occurs both at the member level, and the provider level. Members may be seen as over utilizing health care resources due to their diminished ability to cope with stressors that most people manage in their daily lives; and doctors may be concerned that patients who are experiencing depression or anxiety may be less likely to take follow-up recommendations. Consequently, the physician may take a more conservative approach and drive-up costs by doing so.

Medicare Advantage Members Utilization of Primary Care and Specialist Office Visits...



... and Total Annual Cost



[12] Ibid.
[13] Ibid.

Planning Your Depression and Anxiety Campaign

Mental health Stars measure has weight of 3

Improving or Maintaining Mental Health **accounts for nearly 6% of a plan's Part C performance...**

Measure CO5, ***Improving or Maintaining Mental Health***, is one of only five Part C measures with a weight of 3. The measure scores members' perceptions of their emotional health via four questions on the HOS, as opposed to aggregating claims data. Further complicating the picture, the measure compares member responses from the previous baseline year, in order to examine whether their perception of their emotional health has stayed the same or improved.

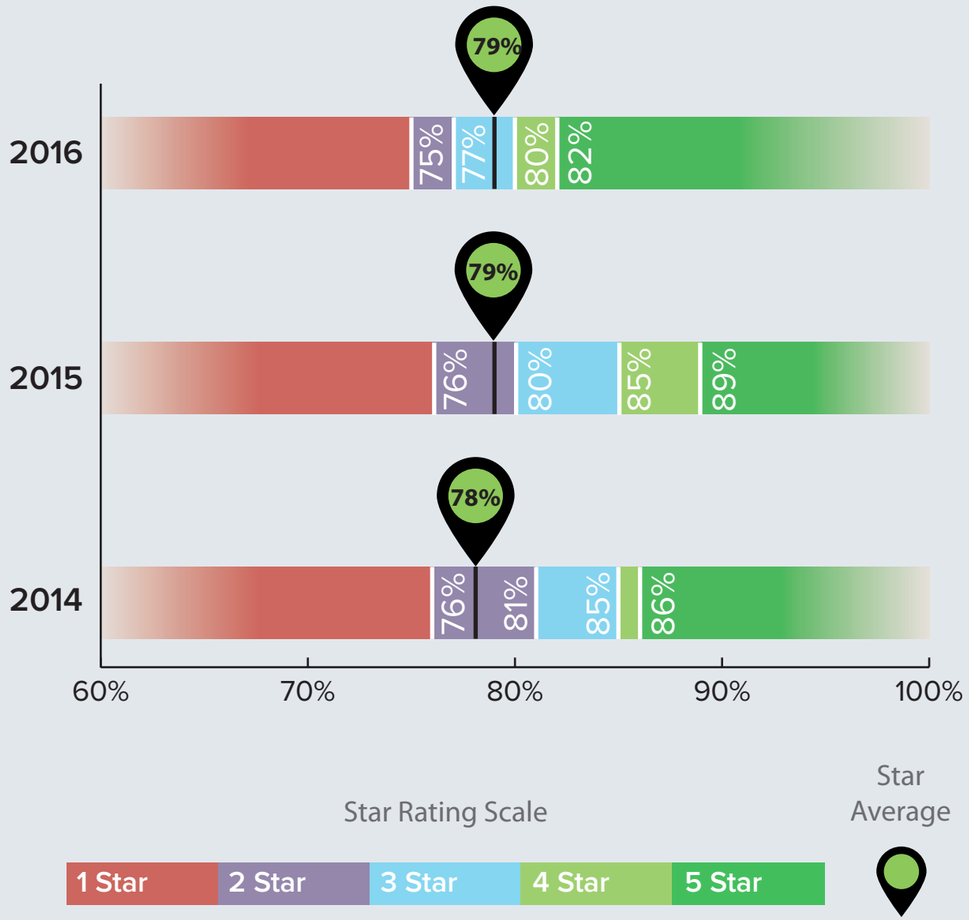
...suggesting importance of a targeted outreach campaign.

In 2016, the 4-Star cut point for C05 slipped from its previous benchmark of 85%, suggesting that the cut point is vulnerable to increase again for 2017 or 2018[14]. Yet only two thirds of Medicare Advantage patients receive any type of depression care[15]. Better management of mental health conditions has the potential to improve members' emotional and overall health.

[14] CMS Medicare 2016 Part C & D Star Rating Technical Notes

[15] Huang, Hsiang, YaFen Chan, Amy M. Bauer, and Joji Suzuki. "Specialty Behavioral Health Service Use Among Chronically Ill Medicare Advantage Patients with Substance Use Problems." National Center for Biotechnology Information. 2013. Accessed June 14, 2016.

Improving or Maintaining Mental Health Cut Points



Planning Your Depression and Anxiety Campaign

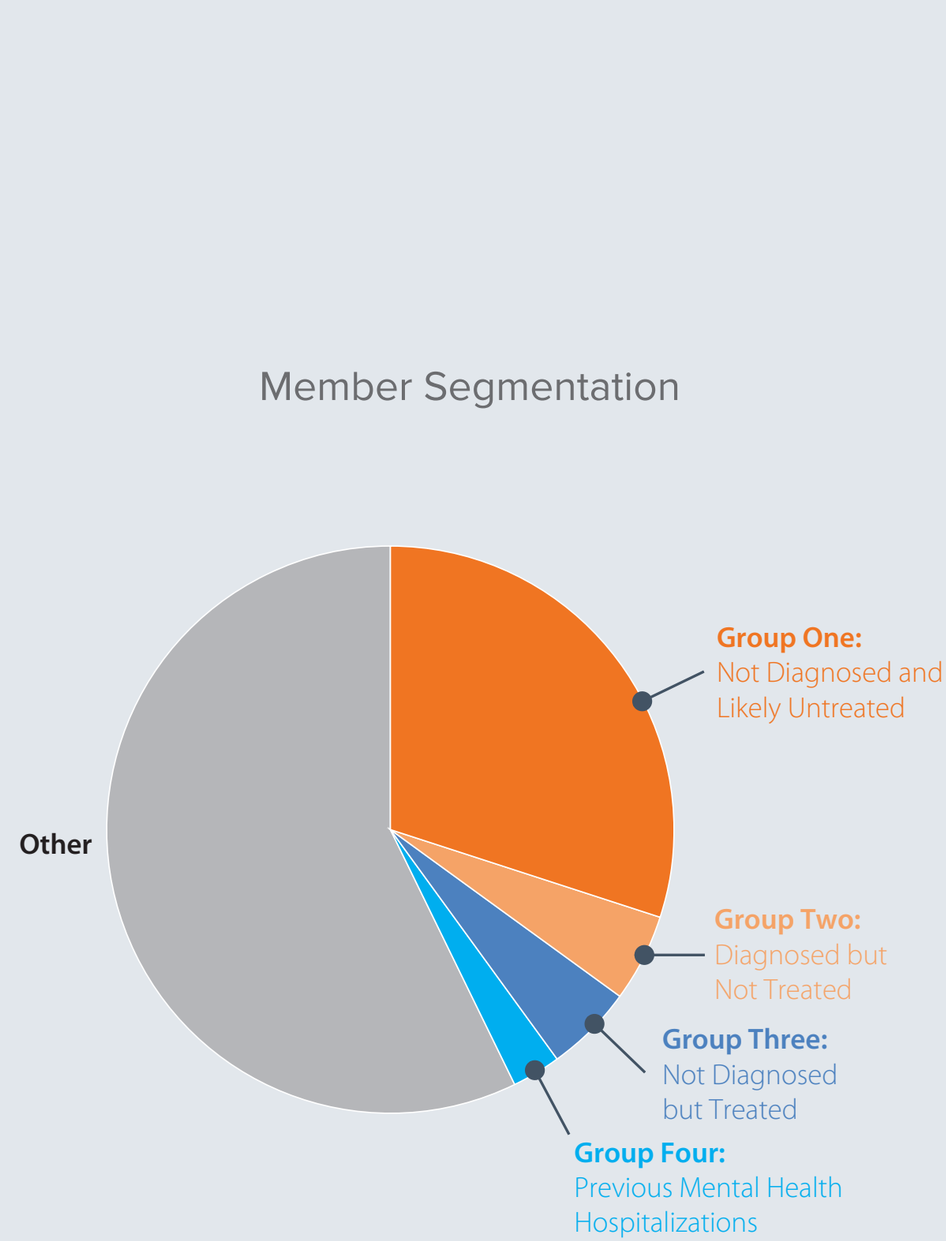
Use data analytics to segment members

First step: embrace need for segmentation

Visiting or personally calling every member to recommend screening for depression and anxiety is neither practical nor affordable. Your targeted outreach campaign should focus on members who have the greatest need for mental health treatment. Remove members with previous mental health hospitalizations from your targeted pool because this group needs specific care and should only be contacted by a clinical resource.

Divide members into actionable groups

Segment your remaining member base. The core of your outreach program will come from Group One, members who, due to their comorbidity profile, may be suffering from undiagnosed depression or anxiety. In addition, your program may reach out to members in Group Two, who have been diagnosed with depression or anxiety, but are not currently receiving treatment. Work with your Chief Medical Officer to establish a definition for treatment in terms of fills for a pharmaceutical for mental disorder, and psychotherapy or psychiatric sessions in the last two years. Finally, identify members with no diagnosis of a mental disorder who, nonetheless, are receiving treatment. Pull them from your targeted outreach campaign, and send them to your Risk Adjustment team for appropriate coding.



Planning Your Depression and Anxiety Campaign

Segment your provider base to uncover opportunities

Segment PCPs as well as members

PCPs are on the front line of diagnosing and treating depression and anxiety. But visiting or personally calling every PCP to discuss the importance of screening is not an effective use of resources. Your outreach campaign needs to focus on that subset of providers where members are likely to go undiagnosed.

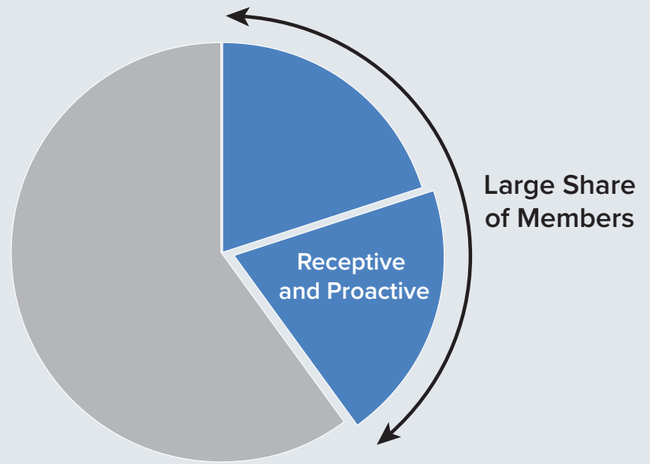
Calculate for each provider a diagnosis score...

Examine the percentage of your members diagnosed with either depression or anxiety over the past two years for each provider in your network. Layer over that diagnosis rate those demographic factors and comorbidities which signal a higher likelihood of depression. Providers in the lowest tertile by diagnosis rate who, nonetheless, serve members with a strong likelihood of depression or anxiety, offer the best opportunity to close the care gap.

. . .and factor in your relationship with providers

In addition, you may want to create a relationship score for each of your providers. PCPs who are proactive, receptive to partnership with your health plan, and who serve a relatively larger share of your members, are more likely to embrace change at the plan's recommendation.

Provider Base Segmentation



Planning Your Depression and Anxiety Campaign

Create Awareness Campaign content

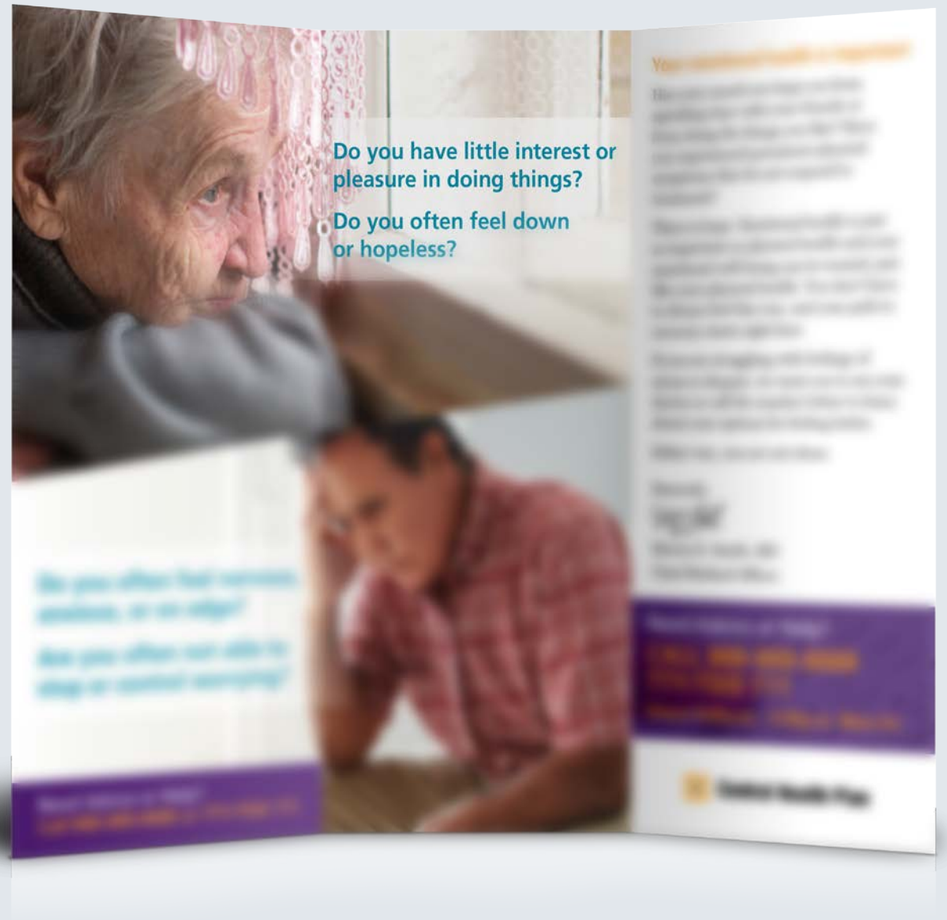
Focus on “emotional health,” not “mental illness”

The first step in implementing your Member Outreach campaign is to execute your Awareness Campaign in order to alert members that you will be contacting them to discuss their emotional well-being. Seniors prefer to be notified before being called. In your mailer or email copy, avoid using stigmatized terms such as “mental illness” and even “mental health.” Instead, describe the ***feelings*** a member experiences as a result of poor emotional health. Also, inform the member that the health plan will be calling, and provide an inbound toll-free number for the member as well.

Leverage the PHQ-2 and GAD-2 questions to resonate with members

The first two questions of the PHQ-9 and of the GAD-7 are screener questions designed to rule out members who do not have a probable diagnosis of either depression or anxiety, respectively. The PHQ-2 and GAD-2 are broader in nature than the remaining questions on the PHQ-9 and GAD-7. As a result, they serve as a good starting point for designing your messaging and copy.

Sample Mailer



Implementing Your Depression and Anxiety Campaign

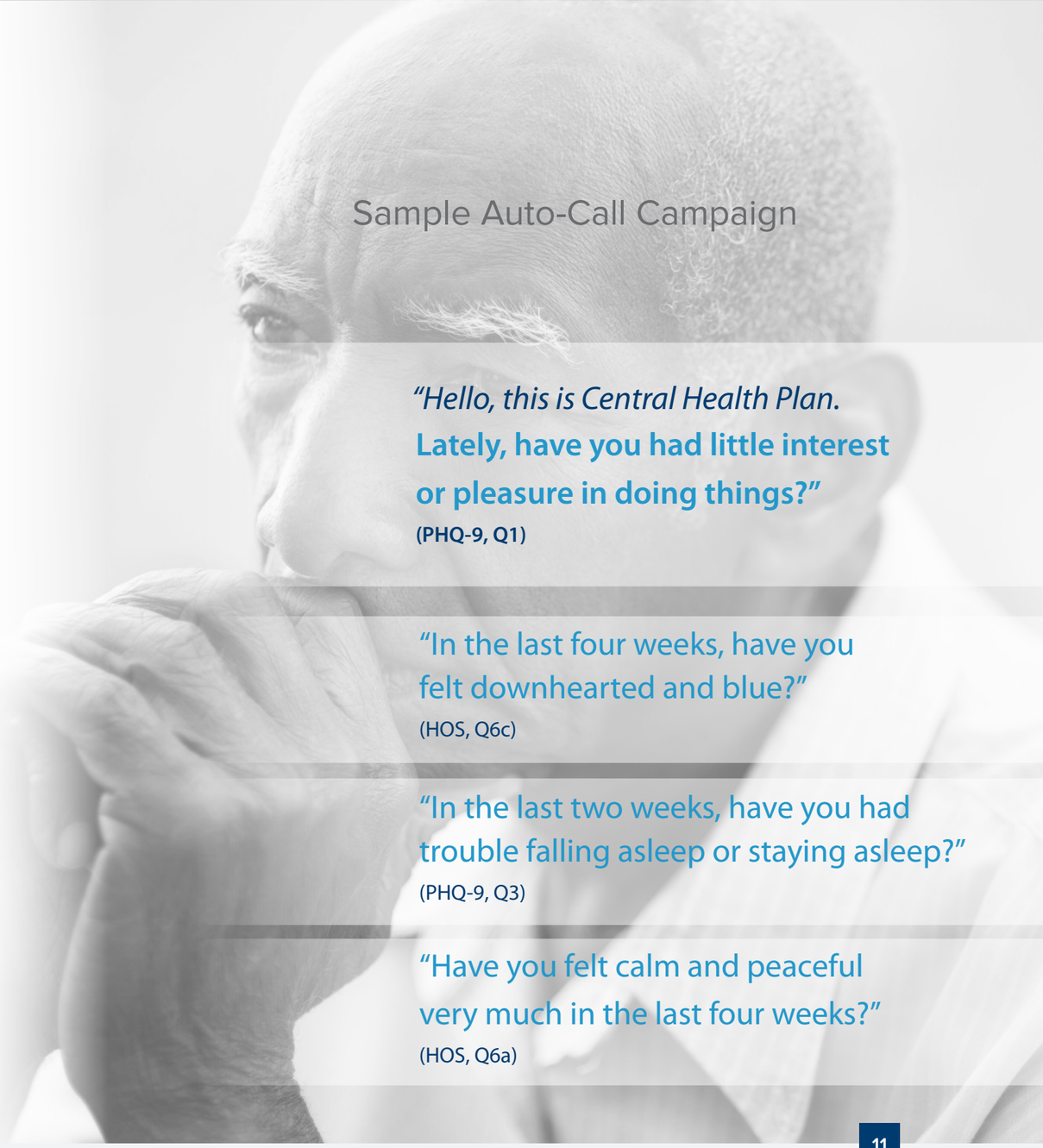
Optimize Awareness Campaign delivery based on member preferences

Leverage full array of communication modes

In addition to a mailer, you may also choose to deliver your Awareness Campaign more cost effectively via auto-call, text, or email. (An auto-call is a professionally recorded message that plays when the member picks up the phone. Appointment reminders are a good example of auto-calls.) If members have expressed a preference for one of these four communication modes, follow their preference(s).

Develop iterated, shorter content for auto-call and text

Auto-calls and texts present a special challenge because less material can be covered during a 30 second call, or a short text. The solution is to chunk your content and deliver it sequentially over time, creating a linked campaign. The graphic on the right lists four questions eliciting members' symptoms, which can be used as the core of a linked campaign. For members who want more information, give them the option to either text back to receive a call, or to press zero during an automated message to speak with a care coordinator. Whichever mode you use, be sure to give members an opportunity to opt out from future campaigns.



Implementing Your Depression and Anxiety Campaign

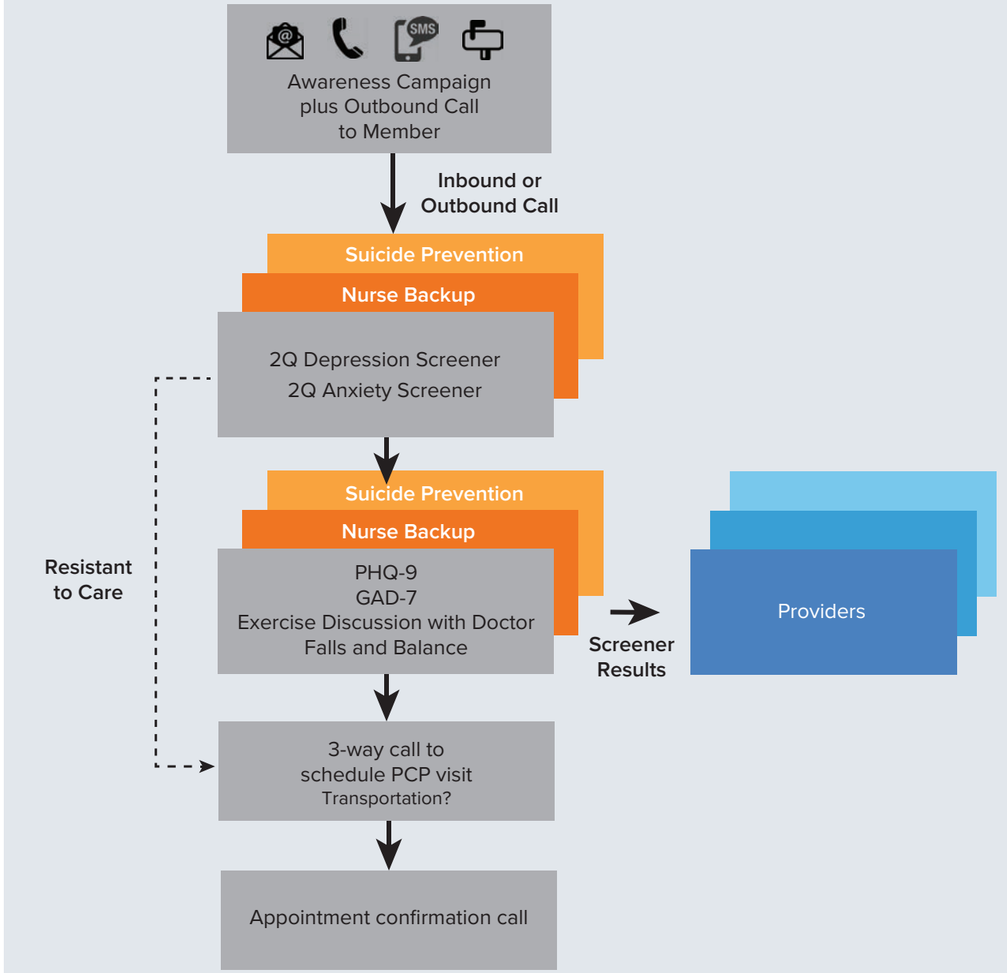
Map call flow for outbound calling campaign

Consider best member experience when designing call flow

Mapping the call flow prior to launching your outbound calling campaign is particularly crucial when addressing mental health conditions like depression and anxiety. Determine the appropriate scripting to ease members into the mental health questionnaires. Ensure that you have sufficient care coordinators to perform the outbound calling campaign, as well as to accept any inbound calls generated from your Awareness Campaign.

Plan for clinical outcomes based on member need

The simplicity of PHQ-9 and GAD-7 questionnaires lend themselves readily to scoring. Working with your clinical team, and with input from the Chief Medical Officer, you will also need to determine your care coordinators' subsequent actions on the call based on scoring ranges for these assessment tools. For example, a score of ten or above on the PHQ-9 would indicate the need to recommend follow-up care. For care coordinators, create a clinical escalations protocol, including any mention of suicide, as the last question of the PHQ-9 deals with suicide ideation.



Implementing Your Depression and Anxiety Campaign

Augment Member Outreach with a provider campaign

Focus on providers identified with segmentation

Based on your provider segmentation scheme, you can identify that subset of providers with whom the plan has a productive relationship, AND who have the largest number of patients likely to suffer from undiagnosed depression or anxiety. Plan on reaching out to those providers. Additionally, use newsletters or other provider communications to recognize physicians who make depression and anxiety screening a routine part of their patient care.

Support providers with resources

Plan on reaching out to your providers to coordinate with them prior to the start of your depression and anxiety campaign. Work with them to establish a process for receiving the data results of the PHQ-9 and GAD-7 screeners. Consider also offering providers a poster on depression and anxiety consistent with the thematic and approach of your Awareness Campaign.

Sample Poster for Providers' Offices

Implementing Your Depression and Anxiety Campaign

Leverage technology to gain intelligence on call outcomes

Capture data and outcomes during the call

During your outbound calling campaign, every interaction with a member is an opportunity to learn more about that member's needs and preferences, in order to provide better treatment in the future. Capture members' scores on the PHQ-9 and GAD-7, and the date of their scheduled follow-up care (if needed). Combine that data with the number of call attempts, percentage of members reached, and average call length, for a full picture of your campaign.

Learn from members' refusals for care

Members may object to accepting a call from their health plan, answering the questions in the mental health screening tools, or agreeing to a follow-up appointment with their PCP. Leverage a CRM (Customer Relationship Management) application to capture those reasons for refusal with as much specificity as possible, using an interface such as the one shown at right. Understanding which refusals predominate will enable you to fine tune your approach as the campaign progresses.

Commit to building a Member Communications Database

Use this campaign as an opportunity to start capturing members' email addresses and cell phone numbers, along with permissions, and their preferences for communication. Work with your sales and marketing enrollment counterparts to also capture this information during enrollment and inbound customer service encounters. This database will enable you to perform more effective campaigns in the future.

Member Objections to Doctor Appointment

"Based on the fact that you're having trouble sleeping at night, I'd like to ask you a couple of questions about your everyday life...

...May I help you schedule an appointment with your primary care physician?"

- [ ] Yes
- [x] No

If no, reason(s) given:

- [ ] I don't like my doctor
- [x] I don't like going to the doctor in general
- [ ] I don't have time
- [ ] I don't have a problem
- [ ] I've been to the doctor recently
- [ ] I already have an appointment scheduled

Methodology

HPOne's Comprehensive and Modular Stars Solutions

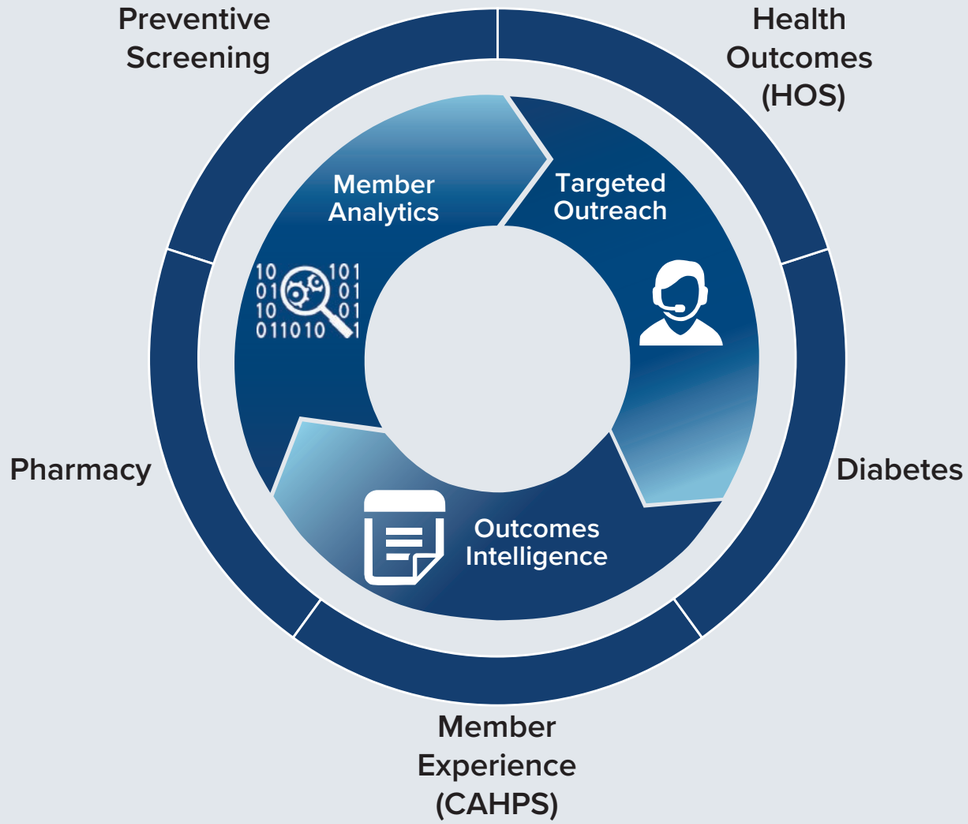
HPOne's Stars Solutions program helps plans close the gaps in care to improve their CMS Stars Ratings.

This comprehensive and modular solution has three interlocking components. Engage with us for one or all three.

Performance-based pricing takes into account whether clients have improved their targeted Stars measures, relative to established CMS cut points.

HPOne's state of the art call centers coordinate care through **Targeted Outreach** campaigns, and capture **Outcomes Intelligence** from member interactions. Our highly-trained care coordinators specialize in working with seniors.

HPOne partner, Health Care Excel, provides **Data Analytics** and incorporates **Outcomes Intelligence**.



Methodology

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