

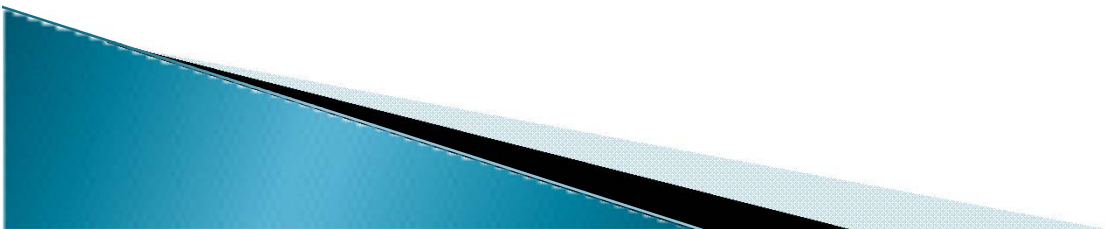
# DIAMOND, a Foundation for the Medical Home

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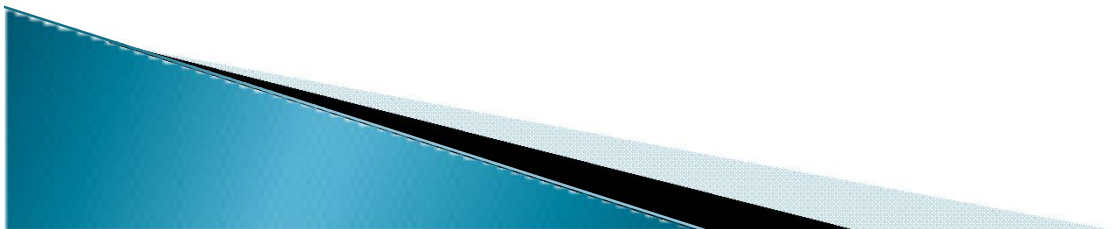
# Objectives

- ▶ Briefly describe the DIAMOND model
- ▶ Describe how the DIAMOND model transforms care
- ▶ Explain why it makes sense to use DIAMOND as a foundation for building the medical home.



# DIAMOND is Aligned with PCPCC Principles

- ▶ Preserves and fosters the patient/PCP relationship
- ▶ Team-based, led by the primary care physician
- ▶ Care manager and psychiatrist join with the PCP for team care
- ▶ Supported by 37 RCT's indicating the superiority of this model over "usual care"
- ▶ Supported by a new payment model



# ICSI

INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT

- ▶ Transforms Health Care through facilitation of collaborative work by bringing together providers, payers, patients, and purchasers to improve care based on evidence and innovation.
- ▶ 60 member organizations
- ▶ 9,000 physicians
- ▶ 7 sponsoring health plans

# DIAMOND: Transforming Health Care

Best Practice program = care practice  
redesign

Fair Payment for new services = care  
payment redesign



# The DIAMOND Model\*



## Four Processes:

1. Consistent method for assessment/monitoring (PHQ-9)
2. Presence of tracking system (registry)
3. Stepped care approach to intensify/modify treatment
4. Relapse prevention

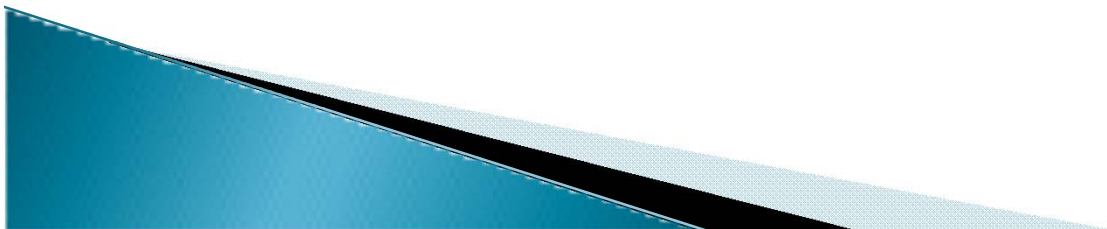
## Two Roles:

5. Care manager for follow up, support, coordination
6. Consulting psychiatrist for caseload review

\*Based on the Collaborative Care Model for depression by Wayne Katon, MD and the IMPACT study by Jurgen Unutzer, MD as well as numerous other controlled trials.

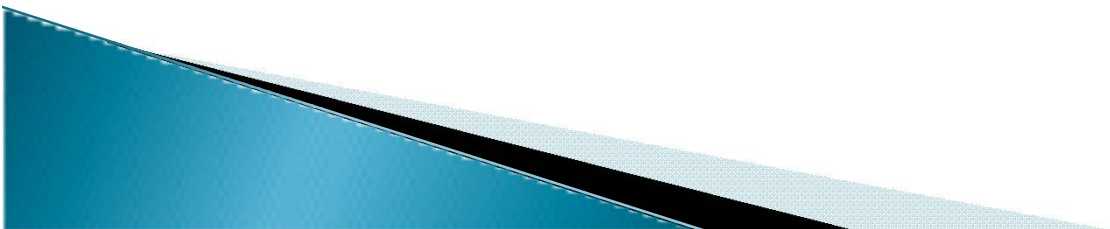
# Transforming the Payment for Depression Care

- ▶ Health Plans paying DIAMOND clinics for a bundled set of care management services
- ▶ The creation of a code for reimbursement for DIAMOND patients on a monthly basis
- ▶ In the future, payment for clinical outcomes



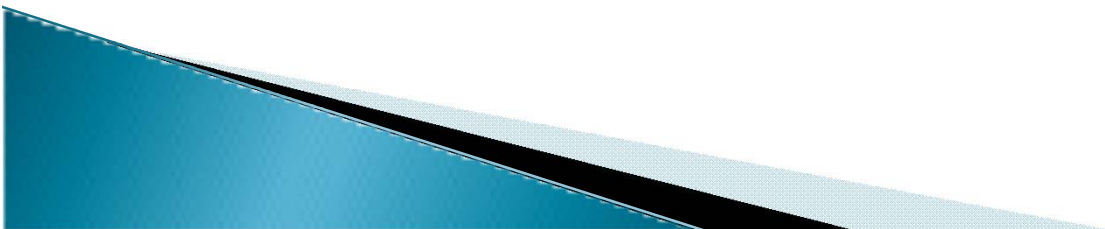
# DIAMOND Services Covered

- ▶ Coverage include the following *bundle* of services:
  - Care manager tracking and use of the registry
  - Care manager contacts with patients active in the program
  - Care manager use and administration of the PHQ-9
  - Care manager relapse prevention visit with the patient
  - Psychiatrist weekly consultation and caseload review with care manager
  - Ongoing communication to the PCP
  - PHQ-9 at 6 months and 12 months – even if patient is no longer in the care mgmt program



# Payments Outside of DIAMOND

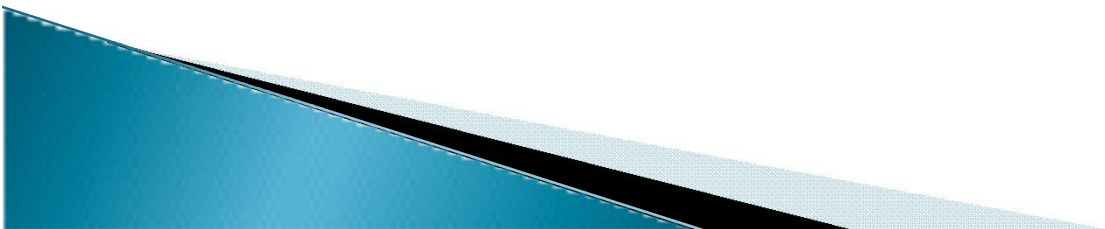
- ▶ Physician visits
- ▶ Visits to mental health providers



# Who is Involved?

- ▶ At FHSM 13 clinics and 68 providers involved for the past 1–2 years
- ▶ FHSM providers have enrolled over 2000 patients
- ▶ Across Minnesota, 490 FTE's in 80 different sites
- ▶ Total patients activated, 4914

*-Data through April, 2010*



# DIAMOND Outcomes

(as of 4/30/10)

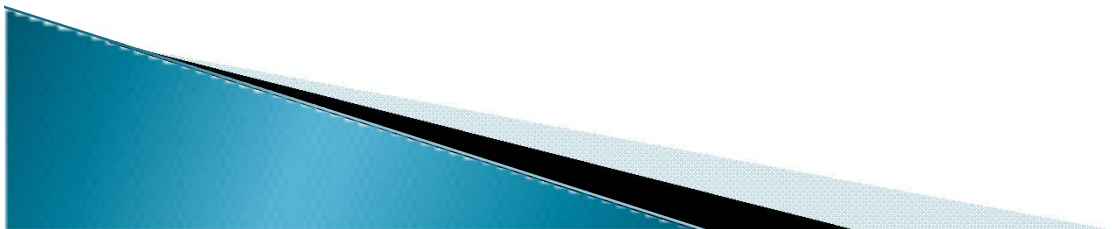
	Remains Active	Initially Activated	Community (*MNCM)
<b>At Six Months</b>			
n →	1759	3049	
PHQ9 Re-measured	69%	59%	
<b>Response</b>	<b>61%</b>	<b>45%</b>	
<b>Remission</b>	<b>45%</b>	<b>26%</b>	<b>6%</b>
<b>Activation</b>	<b>22%</b>	<b>22%</b>	
<b>At 12 month</b>	n=409	n=1719	
<b>Response</b>	<b>67%</b>	<b>29%</b>	
<b>Remission</b>	<b>50%</b>	<b>22%</b>	

\*Minnesota Community Measurement



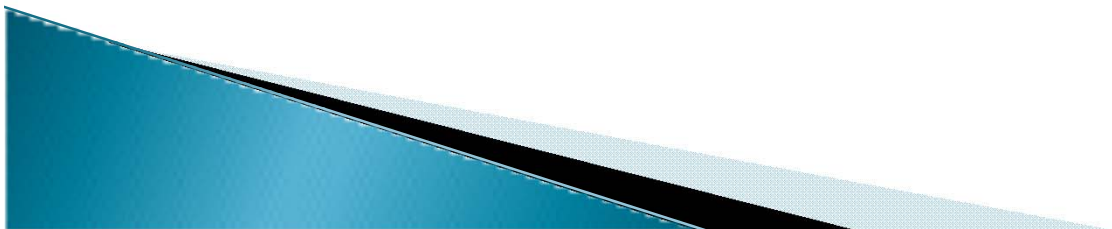
# NIH Funded Study

- ▶ Results over a 5 year experience
- ▶ Evaluating the effects of the DIAMOND model on work productivity
- ▶ Evaluating absenteeism and presenteeism



# Why begin with DIAMOND as the Foundation for the Medical Home?

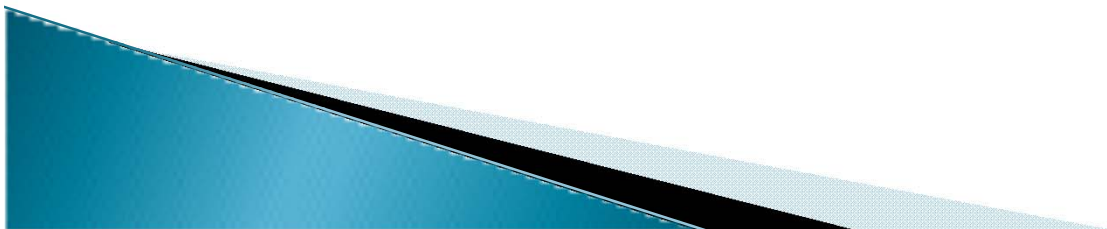
- ▶ Evidence based
- ▶ Significantly improves care
- ▶ Provides a structured transition to team based care
- ▶ Evidence presented by Dr W. Katon et.al. indicates that depression severity is highly correlated with the complexity of other co-morbid conditions



# As the Depression Increases in Severity

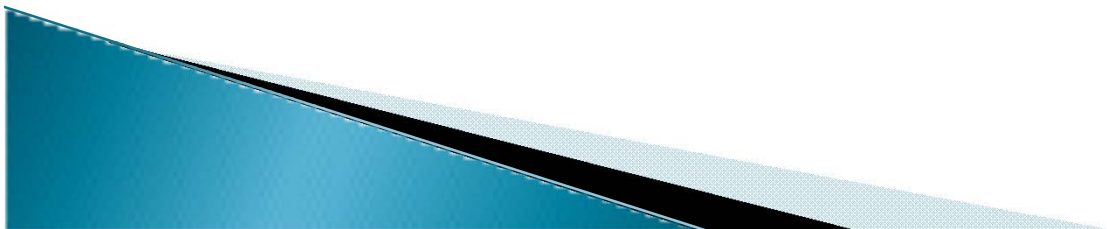
- ▶ There is a higher % of smokers
- ▶ There is a higher BMI's
- ▶ Diabetes is more poorly controlled (% of patients with their A1c > 8)
- ▶ Higher % of Diabetics who are non-adherent to their medications

-Katon et. al., Diabetes 2004



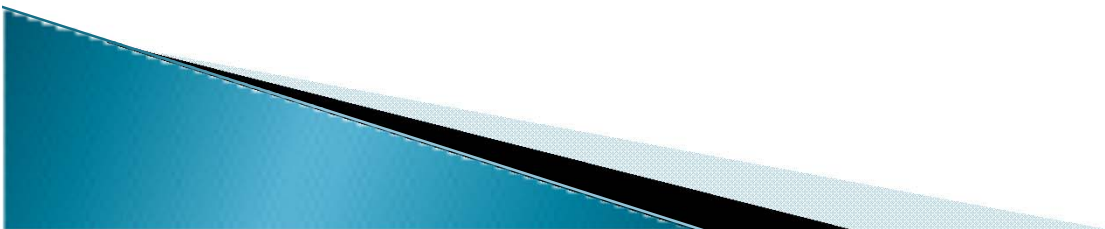
# DIAMOND Requires a Change in Culture

- ▶ The model facilitates the transition to team care
- ▶ Promotes the integration and embeds a role for a specialist, the psychiatrist, in primary care
- ▶ Facilitates the change from only the physician being accountable for improvement to team accountability



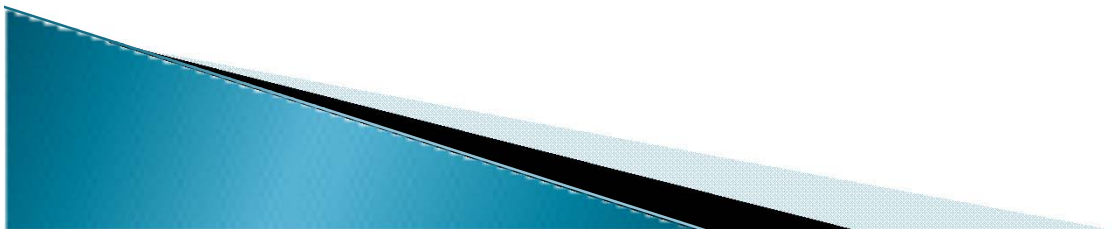
# Why DIAMOND Works at FHSM

- ▶ It supports the PCP/patient relationship through a collaborative approach using the expertise from several members of the team.
- ▶ It leverages a scarce resource, psychiatry, in a collaborative model.
- ▶ It tests a new payment model and pays for between visit care.
- ▶ The coordination of care requires innovative tools, or use of those tools, like a registry, to coordinate care and track outcomes.
- ▶ There is overwhelming evidence of improved outcomes.



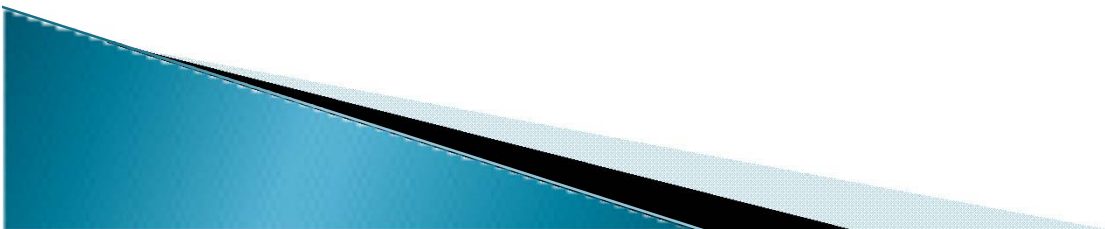
# What's Next?

- ▶ Several DIAMOND clinics are working with ICSI to add other disease “clusters” for care coordination
- ▶ Continue to try and engage CMS and the State of Minnesota to begin paying for DIAMOND
- ▶ Planning for the transition of DIAMOND into a medical home payment model
- ▶ Eagerly waiting for the NIH study results to use as leverage to convince the business community to incorporate DIAMOND, and like care management payments, into their benefit design



# Thanks!

- ▶ To the committee for the PCPCC Stakeholder meeting for inviting me
- ▶ To Nancy Jaeckels, the lead at ICSI for the DIAMOND initiative
- ▶ TO YOU FOR YOUR ATTENTION



# Contact Information

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