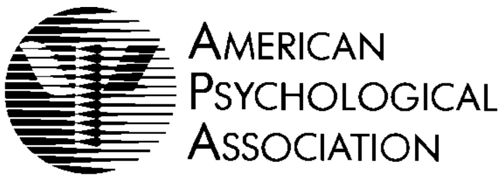

August 15, 2011

Centers for Medicare and Medicaid Services
Attn: Stuart Caplan, RN, MAS and Lawrence Schott, MD, MS
7500 Security Boulevard
Baltimore, MD 21244

Re: Proposed Decision Memo for Screening for Depression in Adults (CAG-00425N)

Delivered electronically via www.cms.gov

Dear Mr. Caplan and Dr. Schott:

The American Psychological Association (APA), the professional organization representing 154,000 members and affiliates engaged in the practice, research, teaching, and learning of psychology, appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed decision memo for screening for depression in adults. The APA strongly supports the CMS proposal to cover annual screening for depression for Medicare beneficiaries in primary care settings. As explained below, we recommend that such screening be provided even in the absence of staff-assisted depression care supports in the primary care setting. In such instances, the Medicare beneficiary could be referred to a psychologist or other qualified mental health professional in the community to assure accurate diagnosis, effective treatment, and follow-up. We urge CMS to include all aspects of its proposal in issuing a final decision memorandum.

Numerous studies have shown that depression is a serious and prevalent health problem for adults, especially older adults. Studies from Alexopoulos and Steffens and their colleagues have noted that "of the roughly 35 million Americans aged 65 and older, an estimated two million have a major depressive illness and another five million may have subsyndromal depressive symptoms" (as cited in Delano-Wood & Abeles, 2005). Thus, about 20 percent of older Americans are struggling with depressive disorder or its associated symptoms. The rate of depressive symptoms in older adults increases for those with chronic physical disorders and disabilities, and "the presence of comorbid medical illness can have an extensive impact on morbidity, mortality, and quality of life" (Delano-Wood & Abeles, 2005). Evidence has shown depression to be associated with many chronic disorders, such as endocrine disorders, cancer, and arthritis, and depression has a strong relationship with cardiovascular disease in older patients (Delano-Wood & Abeles, 2005). Screening and treatment for depression not only improves the quality of life for individuals and their families but also contributes to improved outcomes for a number of other health problems, including cardiovascular disease, diabetes, and kidney disease.

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Of particular concern, depression is one of the conditions most commonly associated with suicide in both adult and older adult populations and is often under-recognized and under-treated. Because the overwhelming majority of patients with depressive disorders are seen annually by their primary care physicians, the opportunity to diagnose and treat patients early in the course of their illness in the primary care setting is substantial, though largely unfulfilled by our current health care system (Trivedi, Lin, & Katon, 2007). Statistics demonstrate that suicide rates are highest in late life, with 19 percent of suicides completed by older adults (Delano-Wood & Abeles, 2005; Areán & Ayalon, 2005). Studies indicate that many older adults (up to 75 percent) who die by suicide visited a physician within a month before their death (Conwell, 2001). Likewise, depression appears to be a significant problem for caregivers. Estimates suggest that between 40 to 70 percent of caregivers have clinically significant symptoms of depression, with approximately one-fourth to one-half of these caregivers meeting the diagnostic criteria for major depression (Zarit, Reever, & Bach-Peterson, 1980).

Thus, the CMS proposal to cover annual depression screenings without cost sharing for Medicare beneficiaries will help improve the identification of depressed patients in primary care settings. As the U.S. Preventive Services Task Force (USPSTF) reported in its 2009 recommendation statement, appropriate treatment of depressed older adults identified through screening in primary care settings decreases clinical morbidity and improves clinical outcomes (USPSTF, 2009).

However, the USPSTF recommendation to screen only “when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up” may not prove strong enough to ensure that individuals with depression are identified and obtain needed access to care. Depression is a mental disorder for which effective treatments are available; yet such treatments cannot be delivered unless efforts are made to appropriately screen and refer those in need. The lack of treatment resources in the primary care setting should not serve as a disincentive for depression screening. Even in the absence of such primary care services, the Medicare beneficiary could be referred for treatment to psychologists and other qualified mental health professionals in the community. It is important to note that depression screening will yield objective data to help determine whether or not the primary care services should be expanded to offer depression treatment, particularly when such treatment is not available in the surrounding community.

Given our recognition that a broader provision for depression screening will need to be established by the USPSTF (as is already in effect for many other disorders), we will direct our concerns to them in a follow-up communication. With this understanding, we support the CMS provision as an interim measure.

Another critical issue to consider further is staff training. Presumably, the primary care clinical staff providing the depression care supports, as stipulated by the USPSTF and advanced by CMS, will be trained to properly manage depression screening results. We also recommend that CMS more clearly state the training that is required for primary care staff providing depression care supports. We make this recommendation because studies have shown that those who screen older adults for depression in primary care settings may need additional training by geriatric mental health specialists. As Unützer, Katon, et al. (2002) have noted, “the primary care system

is highly demanding, with care providers typically seeing 100 patients per week and generally having between 10 and 15 minutes to manage a host of chronic conditions. This rarely allows the time necessary to accurately assess and treat depression in their older patients" (as cited in Areán & Ayalon, 2005). Also, Glasser and Gravda's study has shown that "some physicians may lack adequate training in mental health and may feel uncomfortable working with depressed older adults" (as cited in Areán & Ayalon, 2005). Additional training by geriatric mental health specialists, such as geropsychologists, would help address some of these problems in primary care settings.

In its definition of more comprehensive depression care supports in a primary care setting, the APA is pleased to see CMS include "attention to patient preferences regarding counseling, medications, and referral to mental health professionals with or without continuing involvement by the patient's primary care physician." We concur with this statement, as data show older adults often prefer psychotherapy to psychiatric medications (Areán et al., 2002; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000; Gum et al., 2006; Koh et al., 2010; Landreville et al., 2001; Sirey et al., 2001; Unützer et al., 2002). However, older adults cite poor access to psychotherapy as a major problem with mental health services (Koh et al., 2010). Psychological interventions are often not offered as an alternative, and despite patient preferences, treatment has become increasingly pharmacotherapy-oriented (Olfson & Marcus, 2009; Mojtabai & Olfson, 2008). Recent research has demonstrated that psychotherapy can be effective for people diagnosed with late-life depression who are at high risk for poor response to antidepressant medication (Areán et al., 2010). We hope the above statement from CMS will result in greater access to appropriate and effective psychological interventions for Medicare beneficiaries.

Depression is a common, costly, and debilitating condition for older adults if left unrecognized and untreated. However, depression in older adults is treatable, and treatment can improve quality of life and clinical outcomes. It is imperative that depression screening be used to accurately identify depression in older patients in primary care. For reasons stated above, the APA strongly supports the CMS proposal to cover annual depression screening for Medicare beneficiaries in primary care settings and looks forward to its implementation. We are hopeful that the USPSTF will soon lift the requirement that staff-assisted depression care supports be in place in the primary care setting for such screening to be provided.

Please contact Doug Walter, J.D., Legislative and Regulatory Counsel, Government Relations, APA Practice Organization, at dwalter@apa.org or (202) 336-5889, if you have further questions regarding our comments.

Sincerely,

Norman B. Anderson, Ph.D.
Chief Executive Officer

Katherine C. Nordal, Ph.D.
Executive Director for Professional Practice

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