1: Med Care 2002 Oct;40(10):941-50 Rela

LWWonline Lippincott Williams & Wilkins Online Full-text Local Print Collection

Cost-effectiveness of a program to prevent depression relapse in care.

Simon GE, Von Korff M, Ludman EJ, Katon WJ, Rutter C, Unutzer J, I T, Walker E.

Center for Health Studies, Group Health Cooperative, Seattle, Washington 98
simon.g@ghc.org

OBJECTIVE: Evaluate the incremental cost-effectiveness of a depression rel prevention program in primary care. MATERIALS AND METHODS: Prima patients initiating antidepressant treatment completed a standardized telephor 6-8 weeks later. Those recovered from the current episode but at high risk fo on history of recurrent depression or dysthymia) were offered randomization or a relapse prevention intervention. The intervention included systematic pa two psychoeducational visits with a depression prevention specialist, shared making regarding maintenance pharmacotherapy, and telephone and mail mo medication adherence and depressive symptoms. Outcomes in both groups w via blinded telephone assessments at 3, 6, 9, and 12 months and health plan c accounting data. RESULTS: Intervention patients experienced 13.9 additiona free days during a 12-month period (95% CI, -1.5 to 29.3). Incremental costs intervention were $273 (95% CI, $102 to $418) for depression treatment cost $160 (95% CI, -$173 to $512) for total outpatient costs. Incremental cost-effe was $24 per depression-free day (95% CI, -$59 to $496) for depression treatr and $14 per depression-free day (95% CI, -$35 to $248) for total outpatient c CONCLUSIONS: A program to prevent depression relapse in primary care y increases in days free of depression and modest increases in treatment costs. differences reflect high rates of treatment in usual care. Along with other rec these findings suggest that improved care of depression in primary care is a p investment of health care resources.

Publication Types:
- Clinical Trial
- Randomized Controlled Trial

PMID: 12395027 [PubMed - indexed for MEDLINE]

2: Gen Hosp Psychiatry 2002 Sep-Oct;24(5):328-35 Rela

ELSEVIER SCIENCE FULL-TEXT ARTICLE

Course of depression, health services costs, and work productivi international primary care study.

Simon GE, Chisholm D, Treglia M, Bushnell D; The LIDO Group.

Center for Health Studies, Group Health Cooperative of Puget Sound, Seattle
simon.g@ghc.org

The Longitudinal Investigation of Depression Outcomes (LIDO) Study exam outcomes and economic correlates of previously untreated depression among patients in Barcelona, Spain; Be'er Sheva, Israel; Melbourne, Australia; Porto Brazil; St. Petersburg, Russia; and Seattle, USA. Across all sites, 968 patient depressive disorder completed assessments of depression severity (Composit Diagnostic Interview and Center for Epidemiologic Studies Depression Scale and 9 months, and assessments of health services utilization and work days n baseline, 9 months, and 12 months. Follow-up depression status was characte persistent depression (n=345), partial remission (n=283), or full remission (n site, patients with more favorable depression outcomes had fewer days misse however, this relationship did not reach the 5% level of statistical significanc and reached the 10% significance level only at Porto Alegre. Patients with m depression outcomes also had lower health services costs, but this relationshi 5% significance level only in St. Petersburg. While the lack of statistical prec permit definitive conclusions, our findings are consistent with recent studies recovery from depression is associated with lower health services costs and l from work due to illness.

Publication Types:
- Multicenter Study

PMID: 12220799 [PubMed - indexed for MEDLINE]

3: Med Care 2002 Sep;40(9):752-60 Rela

LWWonline Lippincott Williams & Wilkins Online Full-text Local Print Collection

Effects of efforts to increase response rates on a workplace chro screening survey.

Wang PS, Beck AL, McKenas DK, Meneades LM, Pronk NP, Saylor JS, Walters EE, Kessler RC.

Department of Health Care Policy, Harvard Medical School, Boston, Massac USA.

OBJECTIVE: Expanded health risk appraisal (HRA) surveys can help emplo

chronic conditions for outreach or disease management interventions by prov
the prevalences of conditions and their effects on work performance. Howeve
exist about the accuracy of this data because most HRAs have low response r
evaluated these concerns by examining the prevalences and work impairment
with chronic conditions across four HRA subsamples that differed in intensit
recruitment effort. METHODS: Two thousand five hundred thirty-nine work
were invited to complete an expanded HRA survey that included questions al
conditions, work impairments, and demographics. Condition prevalences and
between conditions and work impairment were compared across subsamples
after a single mailing, after two mailings, and in a telephone interview after t
either with or without a 20 dollars incentive. RESULTS: Consistent with pre
response rates varied dramatically across the four subsamples (from 20.1% w
mailing to 67.7% with telephone administration and a financial incentive). H
estimated prevalences of chronic conditions, levels of work impairment, and
chronic conditions on work impairment did not differ with intensity of recrui
CONCLUSIONS: Expanded HRAs can provide useful data on the prevalenc
impairments associated with chronic conditions even if response rates are lov
Confirmation of these results is required, however, in new samples. Addition
also needed on innovative and cost-effective strategies to improve HRA resp

PMID: 12218766 [PubMed - indexed for MEDLINE]

☐ **4:** Am J Geriatr Psychiatry 2002 Sep-Oct;10(5):521-30 Rela

Depressive symptoms and mortality in a prospective study of 2,5 adults.

Unutzer J, Patrick DL, Marmon T, Simon GE, Katon WJ.

Center for Health Services Research, UCLA Neuropsychiatric Institute, 1092
Boulevard, Suite 300, Los Angeles, CA 90024, USA. unutzer@ucla.edu

OBJECTIVE: The authors report results from a 7-year prospective study of d
mortality in 2,558 Medicare recipients age 65 and older. METHODS: This re
on a secondary data analysis of a randomized controlled trial that evaluated t
effectiveness of preventive services for older enrollees in an HMO. RESULT
with mild-to-moderate depression at baseline did not have an increased risk c
compared with those without significant depression. The 3% of older adults v
severe depressive syndromes, however, had significant increases in mortality
adjusting for demographics, health risk behaviors, and chronic medical disor
CONCLUSION: The increase in mortality in this group of older adults was c
that in participants with chronic medical disorders such as emphysema or hea

Publication Types:
- Clinical Trial
- Randomized Controlled Trial

PMID: 12213686 [PubMed - indexed for MEDLINE]

☐ **5:** Bipolar Disord 2002 Aug;4(4):226-36 Rela

online

Design and implementation of a randomized trial evaluating sys for bipolar disorder.

Simon GE, Ludman E, Unutzer J, Bauer MS.

Center for Health Studies, Group Health Cooperative, Seattle, WA 98101, U
simon.g@ghc.org

OBJECTIVES: Everyday care of bipolar disorder typically falls short of evid practice. This report describes the design and implementation of a randomize evaluating a systematic program to improve quality and continuity of care fo disorder. METHODS: Computerized records of a large health plan were use patients treated for bipolar disorder. Following a baseline diagnostic assessm and consenting patients were randomly assigned to either continued usual ca multifaceted intervention program including: development of a collaborative monthly telephone monitoring by a dedicated nurse care manager, feedback results and algorithm-based medication recommendations to treating mental providers, as-needed outreach and care coordination, and a structured psycho group program (the Life Goals Program by Bauer and McBride) delivered by manager. Blinded assessments of clinical outcomes, functional outcomes, an process were conducted every 3 months for 24 months. RESULTS: A total o (64% of those eligible) consented to participate and 43% of enrolled patients current major depressive episode, manic episode, or hypomanic episode. An reported significant subthreshold symptoms, and 18% reported minimal or n symptoms. Of patients assigned to the intervention program, 94% participate monitoring and 70% attended at least one group session. CONCLUSIONS: I based sample of patients treated for bipolar disorder, approximately two-thir participate in a randomized trial comparing alternative treatment strategies. N patients accepted regular telephone monitoring and over two-thirds joined a s group program. Future reports will describe clinical effectiveness and cost-ef the intervention program compared with usual care.

Publication Types:
- Clinical Trial
- Evaluation Studies
- Multicenter Study
- Randomized Controlled Trial

PMID: 12190711 [PubMed - indexed for MEDLINE]

☐ **6:** Gen Hosp Psychiatry 2002 Jul-Aug;24(4):213-24 Rela

Comment in:
- Gen Hosp Psychiatry. 2002 Jul-Aug;24(4):194-6.

ELSEVIER SCIENCE FULL-TEXT ARTICLE

Evidence review: efficacy and effectiveness of antidepressant tre primary care.

Simon GE.

Center for Health Studies, Group Health Cooperative, Seattle, WA, USA

This review considers evidence for the efficacy of pharmacotherapy among p patients with depressive disorders and reviews knowledge regarding the effe current practice. Strong evidence supports the efficacy of antidepressant phar for primary care patients with major depression and dysthymia with some ev pharmacotherapy of less severe depression. In general, available antidepressa equal in both efficacy and effectiveness. Treatment selection for any individu remains largely empirical, with few clinical characteristics predicting better c response to specific treatments. Strong evidence supports continuation treatm least six months of pharmacotherapy) for all patients and maintenance treatm least 24 months of pharmacotherapy) for those with chronic or recurrent depr Unfortunately, few patients in primary care or specialty practice receive reco levels of pharmacotherapy or recommended frequency of follow-up care. A r recent studies have evaluated strategies to improve the quality of antidepressa primary care. Educational programs (including academic detailing and contir improvement) have had little impact on patient outcomes. Key elements of ef improvement programs include specific, evidence-based treatment protocols, patient education and active follow-up care.

Publication Types:
- Review
- Review, Tutorial

PMID: 12100832 [PubMed - indexed for MEDLINE]

☐ **7:** Am J Psychiatry 2001 Oct;158(10):1638-44 Rela

Full text article at ajp.psychiatryonline.org | Online Full-text | Local Print Collection

Cost-effectiveness of a collaborative care program for primary c with persistent depression.

Simon GE, Katon WJ, VonKorff M, Unutzer J, Lin EH, Walker EA, Bu C, Ludman E.

Center for Health Sudies, Group Health Cooperative, Seattle, Washington 98 USA. simon.g@ghc.org

OBJECTIVE: The authors evaluated the incremental cost-effectiveness of ste

collaborative care for patients with persistent depressive symptoms after usua
management. METHOD: Primary care patients initiating antidepressant treat
completed a standardized telephone assessment 6-8 weeks after the initial pre
Those with persistent major depression or significant subthreshold depressive
were randomly assigned to continued usual care or collaborative care. The co
care included systematic patient education, an initial visit with a consulting p
months of shared care by the psychiatrist and primary care physician, and mo
follow-up visits and adherence to medication regimen. Clinical outcomes we
through blinded telephone assessments at 1, 3, and 6 months. Health services
costs were assessed through health plan claims and accounting data. RESUL
receiving collaborative care experienced a mean of 16.7 additional depressio
over 6 months. The mean incremental cost of depression treatment in this pro
$357. The additional cost was attributable to greater expenditures for antidep
prescriptions and outpatient visits. No offsetting decrease in use of other heal
observed. The incremental cost-effectiveness was $21.44 per depression-free
CONCLUSIONS: A stepped collaborative care program for depressed prima
led to substantial increases in treatment effectiveness and moderate increases
findings are consistent with those of other randomized trials. Improving outc
depression treatment in primary care requires investment of additional resour
return on this investment is comparable to that of many other widely accepte
interventions.

Publication Types:
- Clinical Trial
- Randomized Controlled Trial

PMID: 11578996 [PubMed - indexed for MEDLINE]

☐ **8:** Arch Gen Psychiatry 2001 Apr;58(4):395-401 Rela

ARCH GEN PSYCH Online Full-text Local Print Collection

Treatment process and outcomes for managed care patients rece antidepressant prescriptions from psychiatrists and primary car physicians.

Simon GE, Von Korff M, Rutter CM, Peterson DA.

Center for Health Studies, Group Health Cooperative, 1730 Minor Ave, Suite
WA 98101-1448, USA. simon.g@ghc.org

BACKGROUND: While many studies describe deficiencies in primary care
treatment, little research has applied similar standards to psychiatric practice.
compares baseline characteristics, process of care, and outcomes for manage
who received new antidepressant prescriptions from psychiatrists and primar
physicians. METHODS: At a prepaid health plan in Washington State, patien
initial antidepressant prescriptions from psychiatrists (n = 165) and primary c
(n = 204) completed a baseline assessment, including the Structured Clinical
DSM-IV depression module, a 20-item depression assessment from the Symp

Checklist-90, and the Medical Outcomes Survey 36-Item Short-Form Health functional status questionnaire. All measures were repeated after 2 and 6 mor Computerized data were used to assess antidepressant refills and follow-up v months. RESULTS: At baseline, psychiatrists' patients reported slightly high functional impairment and greater prior use of specialty mental health care. D up, psychiatrists' patients made more frequent follow-up visits, and the propo or more visits in 90 days was 57% vs 26% for primary care physicians' patier proportion receiving antidepressant medication at an adequate dose for 90 da similar (49% vs 48%). The 2 groups showed similar rates of improvement in symptom severity and functioning. CONCLUSIONS: In this sample, clinical between patients treated by psychiatrists and primary care physicians were m Shortcomings in depression treatment frequently noted in primary care (inade up care and high rates of inadequate antidepressant treatment) were also com specialty practice. Possible selection bias limits any conclusions about relativ or cost-effectiveness.

PMID: 11296101 [PubMed - indexed for MEDLINE]

☐ **9:** J Occup Environ Med 2001 Jan;43(1):2-9 Rela

Local Print Collection

Depression and work productivity: the comparative costs of trea versus nontreatment.

Simon GE, Barber C, Birnbaum HG, Frank RG, Greenberg PE, Rose R Kessler RC.

Center for Health Studies, Group Health Cooperative of Puget Sound, USA. simon.g@ghc.org

This article discusses the impact of depression on work productivity and the improved work performance associated with effective treatment. We underto the literature by means of a computer search using the following key terms: d work loss, sickness absence, productivity, performance, and disability. Publis were considered in four categories: (1) naturalistic cross-sectional studies tha self-reported work impairment among depressed workers; (2) naturalistic lon studies that found a synchrony of change between depression and work impa uncontrolled treatment studies that found reduced work impairment with suc treatment; and (4) controlled trials that usually, but not always, found greater work impairment among treated patients. Observational data suggest that pro following effective depression treatment could far exceed direct treatment co Randomized effectiveness trials are needed before we can conclude definitiv depression treatment results in productivity improvements sufficient to offset treatment costs.

Publication Types:
- Review
- Review, Tutorial

PMID: 11201765 [PubMed - indexed for MEDLINE]

10: Arch Gen Psychiatry 2001 Feb;58(2):181-7 Rela

Comment in:
- ACP Journal Club 2001 Sep-Oct;135(2):49

ARCH GEN PSYCH Online Full-text Local Print Collection

Cost-effectiveness of systematic depression treatment for high u general medical care.

Simon GE, Manning WG, Katzelnick DJ, Pearson SD, Henk HJ, Helstad

Center for Health Studies, Group Health Cooperative, 1730 Minor Ave, Suite WA 98101-1448, USA. simon.g@ghc.org

BACKGROUND: Expanding access to high-quality depression treatment wi the balance of incremental benefits and costs. We examine the incremental c effectiveness of an organized depression management program for high utiliz care. METHODS: Computerized records at 3 health maintenance organizatio to identify adult patients with outpatient medical visit rates above the 85th pe consecutive years. A 2-step screening process identified patients with current disorders, who were not in active treatment. Eligible patients were randomly continued usual care (n = 189) or to an organized depression management pr 218). The program included patient education, antidepressant pharmacothera primary care (when appropriate), systematic telephone monitoring of adheren outcomes, and psychiatric consultation as needed. Clinical outcomes (assesse Hamilton Depression Rating Scale on 4 occasions throughout 12 months) we measures of "depression-free days." Health services utilization and costs wer using health plan-standardized claims. RESULTS: The intervention program adjusted increase of 47.7 depression-free days throughout 12 months (95% c interval [CI], 28.2-67.8 days). Estimated cost increases were $1008 per year $1383) for outpatient health services, $1974 per year for total health services $848-$3171), and $2475 for health services plus time-in-treatment costs (95% $4138). Including total health services and time-in-treatment costs, estimated cost per depression-free day was $51.84 (95% CI, $17.37-$108.47). CONCL Among high utilizers of medical care, systematic identification and treatment produce significant and sustained improvements in clinical outcomes as well increases in health services costs.

Publication Types:
- Clinical Trial
- Randomized Controlled Trial

PMID: 11177120 [PubMed - indexed for MEDLINE]

11: Gen Hosp Psychiatry 2000 May-Jun;22(3):153-62 Rela

ELSEVIER SCIENCE FULL-TEXT ARTICLE

Recovery from depression, work productivity, and health care c primary care patients.

Simon GE, Revicki D, Heiligenstein J, Grothaus L, VonKorff M, Katon TR.

Center for Health Studies, Group Health Cooperative, Seattle, Washington 98 USA.

We describe a secondary analysis of data from a randomized trial conducted primary care clinics of a Seattle area HMO. Adults with major depression (n= beginning antidepressant treatment completed structured interviews at baseli 12, 18, and 24 months. Interviews examined clinical outcomes (Hamilton De Rating Scale and depression module of the Structured Clinical Interview for employment status, and work days missed due to illness. Medical comorbidit using computerized pharmacy data, and medical costs were assessed using th computerized accounting data. Using data from the 12-month assessment, pa classified as remitted (41%), improved but not remitted (47%), and persisten (12%). After adjustment for depression severity and medical comorbidity at b patients with greater clinical improvement were more likely to maintain paid (P=.007) and reported fewer days missed from work due to illness (P<.001). better 12-month clinical outcomes had marginally lower health care costs du year of follow-up (P=.06). We conclude that recovery from depression is ass significant reductions in work disability and possible reductions in health car Although observational data cannot definitively prove any causal relationshi longitudinal results strengthen previous findings regarding the economic bur depression on employers and health insurers.

Publication Types:
- Clinical Trial
- Controlled Clinical Trial

PMID: 10880708 [PubMed - indexed for MEDLINE]

12: BMJ 2000 Feb 26;320(7234):550-4 Rela

Comment in:
- ACP J Club. 2000 Sep-Oct;133(2):73
- BMJ. 2000 Feb 26;320(7234):526-7.
- BMJ. 2000 Feb 26;320(7234):527-8.

Randomised trial of monitoring, feedback, and management of telephone to improve treatment of depression in primary care.

Simon GE, VonKorff M, Rutter C, Wagner E.

Center for Health Studies, Group Health Cooperative, Seattle, WA 98101, U
simon.g@ghc.org

OBJECTIVE: To test the effectiveness of two programmes to improve the tre
acute depression in primary care. DESIGN: Randomised trial. SETTING: Pri
clinics in Seattle. PATIENTS: 613 patients starting antidepressant treatment.
INTERVENTION: Patients were randomly assigned to continued usual care
interventions: feedback only and feedback plus care management. Feedback
feedback and algorithm based recommendations to doctors on the basis of da
computerised records of pharmacy and visits. Feedback plus care manageme
systematic follow up by telephone, sophisticated treatment recommendations
support by a care manager. MAIN OUTCOME MEASURES: Blinded interv
telephone 3 and 6 months after the initial prescription included a 20 item dep
from the Hopkins symptom checklist and the structured clinical interview for
DSM-IV depression module. Visits, antidepressant prescriptions, and overall
care were assessed from computerised records. RESULTS: Compared with u
feedback only had no significant effect on treatment received or patient outc
receiving feedback plus care management had a higher probability of both re
moderate doses of antidepressants (odds ratio 1.99, 95% confidence interval
and a 50% improvement in depression scores on the symptom checklist (2.22
lower mean depression scores on the symptom checklist at follow up, and a l
probability of major depression at follow up (0.46, 0.24 to 0.86). The increm
feedback plus care management was about $80 (pound50) per patient. CON
Monitoring and feedback to doctors yielded no significant benefits for patien
care starting antidepressant treatment. A programme of systematic follow up
management by telephone, however, significantly improved outcomes at mo

Publication Types:
- Clinical Trial
- Multicenter Study
- Randomized Controlled Trial

PMID: 10688563 [PubMed - indexed for MEDLINE]

☐ **13:** Psychiatr Serv 1999 Oct;50(10):1303-8 Rela

Health care utilization and costs among patients treated for bipo in an insured population.

Simon GE, Unutzer J.

Center for Health Studies of the Group Health Cooperative of Puget Sound, S
Washington 98101, USA. simon.g@ghc.org

OBJECTIVE: The study examined health care utilization and costs among pa
for bipolar-spectrum disorders in an insured population. METHODS: Compu
prescriptions and on outpatient and inpatient diagnoses from a large health pl
to identify patients treated for cyclothymia, bipolar disorder, or schizoaffecti
Three age- and sex-matched comparison groups consisting of general medica
patients treated for depression, and patients treated for diabetes were selected
plan members. Utilization and cost of health services for the four groups ove
period were assessed using computerized accounting records. RESULTS: To
costs for patients in the bipolar disorder group ($3,416+/-$6,862) were signif
than those in any of the comparison groups. Specialty mental health and subs
services accounted for 45 percent of total costs in the group with bipolar diso
SD=$1, 566+/-$3,243), compared with 10 percent in the group with depressi
patients treated for bipolar disorder, 5 percent of patients accounted for appro
percent of costs for specialty mental health and substance abuse services, 90
inpatient costs for specialty mental health and substance abuse services, and
out-of-pocket costs for inpatient care. In the bipolar disorder group, parity co
inpatient mental health and substance abuse services would increase overall h
costs by 6 percent. CONCLUSIONS: Health care costs for patients with bipo
exceed those for patients treated for depression or diabetes, and specialty me
substance abuse treatment costs account for this difference. Costs to the insu
borne by patients are accounted for by a small proportion of patients. Elimina
discriminatory mental health coverage would have a small effect on overall h
costs.

PMID: 10506298 [PubMed - indexed for MEDLINE]

☐ **14:** Health Aff (Millwood) 1999 Sep-Oct;18(5):163-71 Rela

Depression in the workplace: effects on short-term disability.

**Kessler RC, Barber C, Birnbaum HG, Frank RG, Greenberg PE, Rose R
GE, Wang P.**

Department of Health Care Policy, Harvard Medical School, Massachusetts,

We analyzed data from two national surveys to estimate the short-term work
associated with thirty-day major depression. Depressed workers were found t
between 1.5 and 3.2 more short-term work-disability days in a thirty-day peri
workers had, with a salary-equivalent productivity loss averaging between $1
These workplace costs are nearly as large as the direct costs of successful dep
treatment, which suggests that encouraging depressed workers to obtain treat
cost-effective for some employers.

PMID: 10495604 [PubMed - indexed for MEDLINE]

Rela

☐ **15:** J Gen Intern Med 1999 Aug;14(8):461-8

Depression among high utilizers of medical care.

Pearson SD, Katzelnick DJ, Simon GE, Manning WG, Helstad CP, Henl

Department of Ambulatory Care and Prevention, Harvard Pilgrim Health Cai 02215, USA.

OBJECTIVE: To determine the prevalence of unrecognized or unsuccessfull depression among high utilizers of medical care, and to describe the relation depression, medical comorbidities, and resource utilization. DESIGN: Survey Three HMOs located in different geographic regions of the United States. PA total of 12,773 HMO members were identified as high utilizers. Eligibility cr depression screening were met by 10,461 patients. MEASUREMENTS AND RESULTS: Depression status was assessed with the Structured Clinical Inter Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition. Depr screening was completed in 7,203 patients who were high utilizers of medica whom 1,465 (20.3%) screened positive for current major depression or majoi partial remission. Among depressed patients, 621 (42.4%) had had a visit wit health specialist or a diagnosis of depression or both within the previous 2 ye prevalence of well-defined medical conditions was the same in patients with without evidence of depression (41.5% vs 41.5%, p = .87). However, high-ut who had not made a visit for a nonspecific complaint during the previous 2 y significantly lower risk of depression (13.1% vs 22.4%, p < .001). Patients w depression or depression in partial remission had significantly higher numbei office visits and hospital days per 1,000 than patients without depression. CC Although there was evidence that mental health problems had previously bee many of the patients, a large percentage of high utilizers still suffered from a depression that either went unrecognized or was not being treated successfull who had not made visits for nonspecific complaints were at significantly low depression. Depression among high utilizers was associated with higher reso

PMID: 10491229 [PubMed - indexed for MEDLINE]

☐ **16:** Arch Fam Med 1999 Jul-Aug;8(4):319-25 Rel

Comment in:

- Arch Fam Med. 1999 Jul-Aug;8(4):326-7.

Long-term outcomes of initial antidepressant drug choice in a "r randomized trial.

Simon GE, Heiligenstein J, Revicki D, VonKorff M, Katon WJ, Ludman L, Wagner E.

Center for Health Studies, University of Washington, Seattle, USA. simon.g(

OBJECTIVE: To compare the long-term clinical, quality-of-life, and econom after an initial prescription for fluoxetine, imipramine hydrochloride, or desip hydrochloride. DESIGN: Randomized, controlled trial. SETTING: Primary c staff-model health maintenance organization in the Seattle, Wash, area. PATI hundred seventy-one adults beginning antidepressant drug treatment for depr INTERVENTION: Random assignment of initial medication (desipramine, f imipramine), with treatment (dosing, medication changes or discontinuation, visits) managed by a primary care physician. MEASUREMENTS: Interviews and at 6, 9, 12, 18, and 24 months examined medication use, clinical outcom Depression Rating Scale and depression subscale of the Hopkins Symptom C quality of life (Medical Outcomes Study SF-36 Health Survey). Medical cost assessed using the health maintenance organization's accounting data. RESU assigned to fluoxetine therapy were significantly more likely to continue taki antidepressant but no more likely to continue any antidepressant therapy. The group did not differ significantly from either tricyclic drug group on any mea depression severity or quality of life. For 24 months, antidepressant drug cost approximately $250 higher for patients assigned to fluoxetine therapy, but tot costs were essentially identical. CONCLUSIONS: Initial selection of fluoxet tricyclic antidepressant drug should lead to similar clinical outcomes, functio and overall costs. Differences in antidepressant prescription costs are blunted minority of tricyclic-treated patients who switch to use of more expensive me Restrictions on first-line use of fluoxetine in primary care will probably not r treatment costs.

Publication Types:
- Clinical Trial
- Randomized Controlled Trial

PMID: 10418538 [PubMed - indexed for MEDLINE]

☐ **17:** J Clin Psychiatry 1999;60 Suppl 7:19-26; discussion 27-8 Rela

Local Print Collection

Best clinical practice: guidelines for managing major depression medical care.

Schulberg HC, Katon WJ, Simon GE, Rush AJ.

Department of Psychiatry, University of Pittsburgh School of Medicine, PA,

Practice guidelines such as those of the United States Public Health Service A Health Care Policy and Research have been instrumental in addressing the si problem of how best to manage major depression in primary medical care set this set of guidelines was published in 1993, new findings from randomized c and extensive clinical experience permit us to reevaluate trends in treatment c depression in primary medical care. This review suggests guidelines for achi clinical practice given current knowledge.

Publication Types:
- Review
- Review, Tutorial

PMID: 10326871 [PubMed - indexed for MEDLINE]

18: J Fam Pract 1998 Dec;47(6):446-52 Rel

Local Print Collection

Depression, health-related quality of life, and medical cost outco receiving recommended levels of antidepressant treatment.

Revicki DA, Simon GE, Chan K, Katon W, Heiligenstein J.

Center for Health Outcomes Research, MEDTAP International, Bethesda, M USA.

BACKGROUND: We evaluated depression severity, health-related quality o and medical cost outcomes of primary care patients receiving recommended recommended levels of antidepressant treatment. METHODS: We performec analysis of clinical trial data from primary care clinics in a staff-model mana organization. The trial included patients with Diagnostic and Statistical Manu Disorders, Third Edition, Revised (DSM-III-R) criteria for major depression starting antidepressant treatment. The primary outcomes measures used were Hamilton Depression Rating Scale (HDRS), Hopkins Symptom Checklist de scores, the Medical Outcomes Study 36-Item Short-Form Health Survey (SF· physical component summary scores, and the total outpatient and inpatient m RESULTS: Of 358 patients starting antidepressant treatment, 195 (54.5%) re recommended by the Agency for Health Care Policy and Research for 90 da Mean HDRS score decreased from 14.1 to 8.8 in patients receiving less-than· treatment and decreased from 13.8 to 8.9 in patients with minimum recomme (P = .761). No significant differences in improvement of HRQL outcomes du were observed between patients receiving recommended or less-than-recomn antidepressant therapy. Mean total medical costs over 6 months for patients t recommended levels of antidepressant treatment were $1872 +/- 140 compar +/- 413 for patients taking less-than-recommended treatment (P = .032). The total medical costs were attributable to significantly lower nonmental health- inpatient costs in the recommended antidepressant treatment group ($104 vs = .004). CONCLUSIONS: Patients receiving minimum recommended levels antidepressant therapy for 3 months showed improvement in depression seve comparable with patients receiving less-than-recommended treatment. Patien minimum recommended treatment had lower total costs and nonmental healt inpatient costs. Antidepressant treatment in primary care patients may have t impact on the frequency of health care visits and on costs for medical conditi impairments.

Publication Types:
- Clinical Trial

- Multicenter Study
- Randomized Controlled Trial

PMID: 9866670 [PubMed - indexed for MEDLINE]

☐ **19:** Arch Gen Psychiatry 1998 Dec;55(12):1121-7 Rela

Local Print Collection

Treating major depression in primary care practice: an update c Agency for Health Care Policy and Research Practice Guideline

Schulberg HC, Katon W, Simon GE, Rush AJ.

Department of Psychiatry, University of Pittsburgh School of Medicine, PA, schulbergh@msx.upmc.edu

The Depression Guideline Panel of the Agency for Health Care Policy and R 1993 published recommendations for treating major depression in primary ca were often based on studies of tertiary care psychiatric patients. We reviewed randomized controlled trials in primary care settings published between 1992 This evidence indicates that both antidepressant pharmacotherapy and time-li depression-targeted psychotherapies are efficacious when transferred from ps primary care settings. In most cases, the choice between these treatments sho patient preference. Studies to date suggest that improving treatment of depres primary care requires properly organized treatment programs, regular patient monitoring of treatment adherence, and a prominent role for the mental healt educator, consultant, and clinician for the more severely ill. Future research s how guidelines are best implemented in routine practice, since conventional strategies have little impact.

Publication Types:
- Review
- Review, Tutorial

PMID: 9862556 [PubMed - indexed for MEDLINE]

☐ **20:** Psychosom Med 1998 Mar-Apr;60(2):143-9 Rela

Treatment costs, cost offset, and cost-effectiveness of collaborati management of depression.

Von Korff M, Katon W, Bush T, Lin EH, Simon GE, Saunders K, Ludm E, Unutzer J.

Center for Health Studies, Group Health Cooperative of Puget Sound, Seattle USA.

OBJECTIVE: The report estimates the treatment costs, cost-offset effects, an
effectiveness of Collaborative Care of depressive illness in primary care. STU
Treatment costs, cost-offset effects, and cost-effectiveness were assessed in t
randomized, controlled trials. In the first randomized trail (N = 217), consulti
psychiatrists provide enhanced management of pharmacotherapy and brief
psychoeducational interventions to enhance adherence. In the second random
153). Collaborative Care was implemented through brief cognitive-behaviora
enhanced patient education. Consulting psychologist provided brief psychoth
supplemented by educational materials and enhanced pharmacotherapy mana
RESULTS: Collaborative Care increased the costs of treating depression larg
the extra visits required to provide the interventions. There was a modest cos
reduced use of specialty mental health services among Collaborative Care pa
of ambulatory medical care services did not differ significantly between the i
and control groups. Among patients with major depression there was a mode
cost-effectiveness. The cost per patient successfully treated was lower for Co
Care than for Usual Care patients. For patients with minor depression. Collab
was more costly and not more cost-effective than Usual Care. CONCLUSIO
Collaborative Care increased depression treatment costs and improved the co
effectiveness of treatment for patients with major depression. A cost offset in
mental health costs, but not medical care costs, was observed. Collaborative
provide a means of increasing the value of treatment services for major depre

Publication Types:
- Clinical Trial
- Randomized Controlled Trial

PMID: 9560861 [PubMed - indexed for MEDLINE]

21: Pharmacoeconomics 1998 Jan;13(1 Pt 1):61-70 Rela

Cost implications of initial antidepressant selection in primary c

Simon GE, Fishman P.

Center for Health Studies, Group Health Cooperative of Puget Sound, Seattle
USA. simon.g@ghc.org

While fluoxetine is considerably more expensive than tricyclic antidepressan
some previous studies have suggested that general medical expenditures are l
patients treated with fluoxetine. In this study, computerised pharmacy and co
records of a large health plan were used to examine overall treatment costs fo
primary-care patients beginning antidepressant treatment with fluoxetine or c
imipramine or desipramine. Comparison was based on initial medication pres
regardless of subsequent switches or discontinuation. Patients treated with flu
older, with a higher burden of medical illness and higher overall health-servi
starting antidepressant treatment, compared with patients receiving the other
choice of fluoxetine was associated with approximately $US140 higher mean
costs and approximately $US300 higher mean costs for all other health servi

costs). Alternative methods of accounting for baseline differences (age, medi comorbidity, prior costs) indicated that adjusted 'non-antidepressant' costs (tc costs of antidepressant therapy) in the fluoxetine group were $US75 to $US3 in either of the TCA groups, but these differences were not statistically signif Subgroup analyses suggested that the use of fluoxetine was associated with l costs only among those incurring high costs in the pretreatment period. These support earlier studies suggesting that the use of fluoxetine as a first-line anti primary care will increase antidepressant drug costs, but will not significantly treatment costs.

PMID: 10175986 [PubMed - indexed for MEDLINE]

22: J Psychosom Res 1997 Apr;42(4):333-44 Rela

ELSEVIER SCIENCE FULL-TEXT ARTICLE

Depression, use of medical services and cost-offset effects.

Simon GE, Katzelnick DJ.

Center for Health Studies, Seattle, WA 98101-1448, USA.

This review considers evidence that depression is associated with increased u medical services and that more intensive treatment of depression might be ex reduce medical expenditures. Cross-sectional studies strongly support an asso between depression and medical utilization, but cannot establish a causal rela Available longitudinal studies lack the sample size and duration of follow-up examine how changes in depression influence utilization. Some quasi-experi experimental studies support a "cost-offset" effect due to mental health treatn experimental data directly address the specific impact of depression treatmen utilization. The available data identify the potential for large cost savings thr treatment of depression but do not clearly establish that such savings can be r Definitive proof of a cost-offset due to depression treatment will require a ne of experimental studies adapted to assess economic outcomes.

Publication Types:
- Review
- Review, Tutorial

PMID: 9160273 [PubMed - indexed for MEDLINE]

23: JAMA 1996 Jun 26;275(24):1897-902 Rela

Comment in:
- ACP J Club. 1997 Jan-Feb;126(1):16
- JAMA. 1996 Oct 23-30;276(16):1301-2; discussion 1302.
- JAMA. 1996 Oct 23-30;276(16):1301; discussion 1302.

Local Print Collection

**Initial antidepressant choice in primary care. Effectiveness and
fluoxetine vs tricyclic antidepressants.**

**Simon GE, VonKorff M, Heiligenstein JH, Revicki DA, Grothaus L, Kat
Wagner EH.**

Center for Health Studies, Group Health Cooperative, Seattle, WA 98101-14

OBJECTIVE: To compare the clinical, functional, and economic outcomes o
prescribing fluoxetine with outcomes of initially selecting imipramine or des
DESIGN: Randomized controlled trial. SETTING: Primary care clinics of a
area staff-model health maintenance organization from 1992 through 1994. P
total of 536 adults beginning antidepressant treatment for depression. INTER
Random assignment of initial antidepressant prescription (desipramine, fluox
imipramine). Subsequent antidepressant treatment (doses, medication change
discontinuation, specialty referral) was managed by the primary care physici
OUTCOME MEASURES: Assessments after 1, 3, and 6 months examined c
outcomes (Hamilton Depression Rating Scale and the depression subscale of
Symptom Checklist) and quality-of-life outcomes (Medical Outcomes Study
Medication use and health care costs were assessed using the health maintena
organization's computerized data. RESULTS: Patients assigned to receive flu
reported fewer adverse effects, were more likely to continue the original med
were more likely to reach adequate doses than patients beginning treatment w
tricyclic drug. The fluoxetine group reported marginally better clinical outco
month, but these differences were not statistically significant and disappeared
month assessment. Quality-of-life outcomes in the 3 groups did not differ. To
costs over 6 months were approximately equal for the 3 groups, with higher a
costs in the fluoxetine group balanced by lower outpatient visit and inpatient
CONCLUSIONS: Clinical outcomes, quality-of-life outcomes, and overall tr
provide no clear guidance on initial selection of fluoxetine or tricyclic drugs.
and physicians' preferences are an appropriate basis for treatment selection.

Publication Types:
- Clinical Trial
- Randomized Controlled Trial

PMID: 8648870 [PubMed - indexed for MEDLINE]

☐ **24:** Am J Psychiatry 1996 Mar;153(3):331-8 Rela

Local Print Collection

**Impact of visit copayments on outpatient mental health utilizati
members of a health maintenance organization.**

Simon GE, Grothaus L, Durham ML, VonKorff M, Pabiniak C.

Center for Health Studies, Group Health Cooperative of Puget Sound, Seattle
1448, USA.

OBJECTIVE: The authors examined the impact of increasing cost sharing on
outpatient mental health services. METHOD: A quasi-experimental design w
study outpatient utilization by members of a health maintenance organization
were subject to increasing copayments for mental health visits (state governn
and dependents). Their outpatient mental health utilization was compared wit
similar HMO members who were not subject to cost sharing (federal governn
employees and dependents). Analyses compared both likelihood of any servi
number of visits per year among service users. RESULTS: Institution of $20/
copayments was associated with a 16% decrease in likelihood of service use
in visit rate among service users. A subsequent copayment increase to $30/vi
no significant change in likelihood of use but was associated with a 9% decre
per year among those using services. The impact of the first copayment chan
likelihood of using services did not vary according to level of clinical need (a
prior service use and psychotropic drug use). CONCLUSIONS: In this staff-m
modest visit copayments significantly reduced initial access to mental health
had a smaller effect on treatment intensity. Copayments restricted access rega
clinical need. Designers of mental health benefits must consider the impact o
on those with the greatest need for treatment.

PMID: 8610819 [PubMed - indexed for MEDLINE]

☐ **25:** Arch Gen Psychiatry 1995 Oct;52(10):850-6 Rela

Local Print Collection

Health care costs of primary care patients with recognized depr

Simon GE, VonKorff M, Barlow W.

Center for Health Studies, Group Health Cooperative of Puget Sound, Seattle

BACKGROUND: While an extensive literature documents the influence of d
general medical services utilization, estimates of the economic burden of dep
focused on the direct costs of depression treatment. Higher use of general me
may contribute significantly to the true cost of depressive illness. METHODS
Computerized record systems of a large staff-model health maintenance orga
(HMO) were used to identify consecutive primary care patients with visit dia
depression (n = 6257) and a comparison sample of primary care patients with
diagnosis (n = 6257). The HMO accounting records were used to compare co
health care costs. RESULTS: Patients diagnosed as depressed had higher ann
costs ($4246 vs $2371, P < .001) and higher costs for every category of care
care, medical specialty, medical inpatient, pharmacy, laboratory). Similar cos
were observed for each of the subgroups examined (patients treated with anti
those not treated with antidepressants, and those diagnosed at routine physica
visits). Pharmacy records indicated greater chronic medical illness in the diag
depression group, but large cost differences remained after adjustment ($397
Twofold cost differences persisted for at least 12 months after initiation of tre

CONCLUSIONS: Diagnosis of depression is associated with a generalized ir
of health services that is only partially explained by comorbid medical condit
primary care sector, this greater medical utilization exceeds direct treatment
depression. The persistence of utilization differences suggests that recognitio
of treatment alone are not adequate to reduce utilization differences.

PMID: 7575105 [PubMed - indexed for MEDLINE]

☐ **26:** Med Care 1995 Aug;33(8):783-95 Rel

Local Print Collection

A chronic disease score with empirically derived weights.

Clark DO, Von Korff M, Saunders K, Baluch WM, Simon GE.

Indiana University Department of Medicine, Indianapolis, USA.

Different types of medication prescribed during a 6-month period for the trea
management of chronic conditions were utilized in the refinement and valida
chronic disease score. Prescription data, in addition to age and sex, were utili
a chronic disease score based on empirically derived weights for each of thre
total cost, outpatient cost, and primary care visits. The ability of the revised c
score to predict health care utilization, costs, hospitalization, and mortality w
an earlier version of the chronic disease score (original) that was derived thro
judgments of disease severity. The predictive validity of the chronic disease s
compared to ambulatory care groups, which utilize outpatient diagnoses to fo
exclusive diagnostic categories. Models based on a concurrent 6-month perio
month prospective period (ie, the 6-month period after the chronic disease sc
ambulatory care group derivation period) were estimated using a random one
250,000 managed-care enrollees aged 18 and older. The remaining one half o
population was used as a validation sample. The revised chronic disease scor
improved estimation and prediction over the original chronic disease score. T
in variance explained prospectively by the revised chronic disease score vers
ambulatory care groups, conversely, was small. The revised chronic disease s
better predictor of mortality than the ambulatory care groups. The combinatio
chronic disease score and ambulatory care groups showed only marginally gr
predictive power than either one alone. These results suggest that the revised
disease score and ambulatory care groups with empirically derived weights p
improved prediction of health care utilization and costs, as well as hospitaliza
mortality, over age and sex alone. We recommend the revised chronic diseas
total cost weights for general use as a severity measure because of its relative
predicting mortality compared to the outpatient cost and primary care visit w

PMID: 7637401 [PubMed - indexed for MEDLINE]

Rel

27: J Occup Med 1994 Jul;36(7):731-7

Comment in:
- J Occup Environ Med. 1995 Dec;37(12):1323.

Local Print Collection

Multiple chemical sensitivity syndrome: a clinical perspective. II Evaluation, diagnostic testing, treatment, and social considerati

Sparks PJ, Daniell W, Black DW, Kipen HM, Altman LC, Simon GE, T

Providence Medical Center, Seattle, Washington 98122.

Multiple chemical sensitivity syndrome (MCS) does not appear to fit establis of toxicology. Social, political, and economic forces are demanding that MC medically, even though scientific studies have failed as yet to identify pathog mechanisms for the condition or any objective diagnostic criteria. Consequen definition of MCS can only rely on a person's subjective symptoms of distres attribution to environmental exposures rather than currently measurable obje of disease. Nevertheless, patients labeled with MCS are clearly distressed an functionally disabled. Without reconciling the different theories of etiology o discussed in Part I of this report, and recognizing that the cause of the syndro multifactorial, strategies are proposed for clinical evaluation and managemen with MCS using a biopsychosocial model of illness. The social implications are also discussed.

Publication Types:
- Review
- Review, Tutorial

PMID: 7931737 [PubMed - indexed for MEDLINE]

28: Am J Psychiatry 1994 Jun;151(6):908-13 Rel

Local Print Collection

Predictors of outpatient mental health utilization by primary ca in a health maintenance organization.

Simon GE, VonKorff M, Durham ML.

Center for Health Studies, Group Health Cooperative of Puget Sound, Seattle

OBJECTIVE: The authors examined the volume and predictors of outpatient utilization among primary care patients in a large staff-model health mainten organization (HMO). METHOD: Consecutive primary care patients (N = 1,8 screened by using the 12-item General Health Questionnaire, and a stratified sample (N = 373) completed the 28-item General Health Questionnaire and C International Diagnostic Interview. Telephone interviews and computerized

used to examine use of mental health services inside and outside the HMO ov following 3 months. RESULTS: Over 3 months, 6.7% of the screened patien health services within the HMO. Utilization increased with higher General H Questionnaire score (2.9% among those scoring 0, 22.3% among those scorir and decreased with higher out-of-pocket cost for mental health visits (7.5% f no change, 3.3% for those paying $30/visit). Among the interviewed subjects mental health services within the HMO (mean = 2.92 visits) and 8.9% used o health services (mean = 8.86 visits). Use of outside services was more strong sociodemographic factors, and use of inside services was more related to sev psychological disorder. CONCLUSIONS: Among these subjects, use of men was high and services purchased outside the HMO exceeded those inside the Increasing copayment levels progressively reduced demand without respect t illness. Attempts to control outpatient mental health costs must address equit need.

PMID: 8185002 [PubMed - indexed for MEDLINE]

Display Abstract Show: 50 Sort Send to Text

Items 1-28 of 28