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


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

Publication Types:
- Clinical Trial
- Randomized Controlled Trial

PMID: 12395027 [PubMed - indexed for MEDLINE]
Course of depression, health services costs, and work productivity: international primary care study.

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The Longitudinal Investigation of Depression Outcomes (LIDO) Study examined 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 (Composite 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 characterized as persistent depression (n=345), partial remission (n=283), or full remission (n=332). Patients with more favorable depression outcomes had fewer days missed due to illness, however, this relationship did not reach the 5% level of statistical significance. Patients with more favorable depression outcomes also had lower health services costs, but this relationship did not reach the 5% significance level only in Porto Alegre. While the lack of statistical significance precludes definitive conclusions, our findings are consistent with recent studies that have reported recovery from depression is associated with lower health services costs and less time missed from work due to illness.

Publication Types:
- Multicenter Study

PMID: 12220799 [PubMed - indexed for MEDLINE]

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

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OBJECTIVE: Expanded health risk appraisal (HRA) surveys can help employ...
chronic conditions for outreach or disease management interventions by providing the prevalences of conditions and their effects on work performance. However, there is limited evidence about the accuracy of this data because most HRAs have low response rates. We evaluated these concerns by examining the prevalences and work impairments associated with chronic conditions across four HRA subsamples that differed in intensity of recruitment effort. METHODS: Two thousand five hundred thirty-nine workers were invited to complete an expanded HRA survey that included questions about chronic conditions, work impairments, and demographics. Condition prevalences and work impairments were compared across subsamples after a single mailing, after two mailings, and in a telephone interview after either with or without a $20 incentive. RESULTS: Consistent with previous studies, response rates varied dramatically across the four subsamples (from 20.1% with one mailing to 67.7% with telephone administration and a financial incentive). However, estimated prevalences of chronic conditions, levels of work impairment, and work impairments associated with chronic conditions did not differ with intensity of recruitment effort. CONCLUSIONS: Expanded HRAs can provide useful data on the prevalences and work impairments associated with chronic conditions even if response rates are low. Confirmation of these results is required, however, in new samples. Additional research is also needed on innovative and cost-effective strategies to improve HRA response rates.

PMID: 12218766 [PubMed - indexed for MEDLINE]
OBJECTIVES: Everyday care of bipolar disorder typically falls short of evidence-based practice. This report describes the design and implementation of a randomized trial evaluating a systematic program to improve quality and continuity of care for bipolar disorder. METHODS: Computerized records of a large health plan were used to identify patients treated for bipolar disorder. Following a baseline diagnostic assessment, consenting patients were randomly assigned to either continued usual care or a multifaceted intervention program including: development of a collaborative diagnostic plan, monthly telephone monitoring by a dedicated nurse care manager, feedback of diagnostic results and algorithm-based medication recommendations to treating mental health providers, as-needed outreach and care coordination, and a structured psychoeducational group program (the Life Goals Program by Bauer and McBride) delivered by a dedicated care manager. Blinded assessments of clinical outcomes, functional outcomes, and process measures were conducted every 3 months for 24 months. RESULTS: A total of 99% (64% of those eligible) consented to participate and 43% of enrolled patients reported a current major depressive episode, manic episode, or hypomanic episode. An additional 34% reported significant subthreshold symptoms, and 18% reported minimal or no symptoms. Of patients assigned to the intervention program, 94% participated in monthly telephone monitoring and 70% attended at least one group session. CONCLUSIONS: In a community-based sample of patients treated for bipolar disorder, approximately two-thirds participated in a randomized trial comparing alternative treatment strategies. Nearly all patients accepted regular telephone monitoring and over two-thirds joined a structured psychoeducational group program. Future reports will describe clinical effectiveness and cost-effectiveness of the intervention program compared with usual care.

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

PMID: 12190711 [PubMed - indexed for MEDLINE]
Evidence review: efficacy and effectiveness of antidepressant treatment in primary care.

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This review considers evidence for the efficacy of pharmacotherapy among patients with depressive disorders and reviews knowledge regarding the effectiveness of current practice. Strong evidence supports the efficacy of antidepressant pharmacotherapy for primary care patients with major depression and dysthymia with some evidence of pharmacotherapy of less severe depression. In general, available antidepressant treatments are equal in both efficacy and effectiveness. Treatment selection for any individual remains largely empirical, with few clinical characteristics predicting better response to specific treatments. Strong evidence supports continuation treatment (at least six months of pharmacotherapy) for all patients and maintenance treatment (at least 24 months of pharmacotherapy) for those with chronic or recurrent depression. Unfortunately, few patients in primary care or specialty practice receive recommended levels of pharmacotherapy or recommended frequency of follow-up care. A recent study has evaluated strategies to improve the quality of antidepressant treatment. Educational programs (including academic detailing and continuing medical education) have had little impact on patient outcomes. Key elements of 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]

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


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OBJECTIVE: The authors evaluated the incremental cost-effectiveness of st
collaborative care for patients with persistent depressive symptoms after usual management. METHOD: Primary care patients initiating antidepressant treatment completed a standardized telephone assessment 6-8 weeks after the initial prescription. Those with persistent major depression or significant subthreshold depressive symptoms were randomly assigned to continued usual care or collaborative care. The collaborative care included systematic patient education, an initial visit with a consulting psychiatrist and primary care physician, and monthly follow-up visits and adherence to medication regimen. Clinical outcomes were assessed through blinded telephone assessments at 1, 3, and 6 months. Health services costs were assessed through health plan claims and accounting data. RESULTS: Receiving collaborative care experienced a mean of 16.7 additional depression-free days over 6 months. The mean incremental cost of depression treatment in this practice was $357. The additional cost was attributable to greater expenditures for antidepressant prescriptions and outpatient visits. No offsetting decrease in use of other health services was observed. The incremental cost-effectiveness was $21.44 per depression-free day. CONCLUSIONS: A stepped collaborative care program for depressed primary care patients led to substantial increases in treatment effectiveness and moderate increases in costs. The findings are consistent with those of other randomized trials. Improving outpatient depression treatment in primary care requires investment of additional resources, but the return on this investment is comparable to that of many other widely accepted interventions.

Publication Types:
- Clinical Trial
- Randomized Controlled Trial

PMID: 11578996 [PubMed - indexed for MEDLINE]

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

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

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BACKGROUND: While many studies describe deficiencies in primary care treatment, little research has applied similar standards to psychiatric practice. This study compares baseline characteristics, process of care, and outcomes for managed care patients who received new antidepressant prescriptions from psychiatrists and primary care physicians. METHODS: At a prepaid health plan in Washington State, patients receiving initial antidepressant prescriptions from psychiatrists (n = 165) and primary care physicians (n = 204) completed a baseline assessment, including the Structured Clinical Interview for DSM-IV depression module, a 20-item depression assessment from the Symptom Checklist 90-R (SCL-90-R), and a 42-item assessment of indices of medical illness. Results: Despite similar rates of depression severity, patients seen in primary care were significantly more medically ill than those seen by psychiatrists. Patients seen in primary care received fewer antidepressant visits, spent less time in treatment, and had lower rates of remission and recovery. CONCLUSIONS: These findings suggest that primary care patients are not receiving optimal care for their depression, and that interventions are needed to improve patient outcomes.
Checklist-90, and the Medical Outcomes Survey 36-Item Short-Form Health functional status questionnaire. All measures were repeated after 2 and 6 months. RESULTS: At baseline, psychiatrists' patients reported slightly high functional impairment and greater prior use of specialty mental health care. Follow-up, psychiatrists' patients made more frequent follow-up visits, and the proportion receiving antidepressant medication at an adequate dose for 90 days was 57% vs 26% for primary care physicians' patients. 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 made more frequent follow-up visits, and the proportion receiving antidepressant medication at an adequate dose for 90 days was 57% vs 26% for primary care physicians' patients. 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 made more frequent follow-up visits, and the proportion receiving antidepressant medication at an adequate dose for 90 days was 57% vs 26% for primary care physicians' patients. Shortcomings in depression treatment frequently noted in primary care (inadequate follow-up care and high rates of inadequate antidepressant treatment) were also common in specialty practice. Possible selection bias limits any conclusions about relative or cost-effectiveness.

PMID: 11296101 [PubMed - indexed for MEDLINE]


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

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This article discusses the impact of depression on work productivity and the improved work performance associated with effective treatment. We undertook the literature by means of a computer search using the following key terms: work loss, sickness absence, productivity, performance, and disability. Publications were considered in four categories: (1) naturalistic cross-sectional studies that included self-reported work impairment among depressed workers; (2) naturalistic longitudinal studies that found a synchrony of change between depression and work impairment; (3) uncontrolled treatment studies that found reduced work impairment with successful treatment; and (4) controlled trials that found greater work impairment among treated patients. Observational data suggest that programs following effective depression treatment could exceed direct treatment costs. Randomized effectiveness trials are needed before we can conclude definitively that depression treatment results in productivity improvements sufficient to offset treatment costs.

Publication Types:
- Review
- Review, Tutorial
Cost-effectiveness of systematic depression treatment for high utilizers of general medical care.

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BACKGROUND: Expanding access to high-quality depression treatment will have the balance of incremental benefits and costs. We examine the incremental cost-effectiveness of an organized depression management program for high utilizers of medical care. METHODS: Computerized records at 3 health maintenance organizations were used to identify adult patients with outpatient medical visit rates above the 85th percentile in the prior 12 consecutive years. A 2-step screening process identified patients with current major depressive disorders, who were not in active treatment. Eligible patients were randomly assigned to continue usual care (n = 189) or to an organized depression management program (n = 218). The program included patient education, antidepressant pharmacotherapy, systematic telephone monitoring of adherence to treatment, and psychiatric consultation as needed. Clinical outcomes (assessed with the 17-item Hamilton Depression Rating Scale on 4 occasions throughout 12 months) were defined as "depression-free days." Health services utilization and costs were estimated using health plan-standardized claims. RESULTS: The intervention program produced a 27.7 depression-free days throughout 12 months (95% CI, 28.2-67.8 days). Estimated cost increases were $1008 per year (95% CI, $1383-$1383) for outpatient health services, $1974 per year for total health services costs ($848-$3171), and $2475 for health services plus time-in-treatment costs (95% CI, $4138-$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). CONCLUSION: Among high utilizers of medical care, systematic identification and treatment of depression produce significant and sustained improvements in clinical outcomes as well as increases in health services costs.

Publication Types:
- Clinical Trial
- Randomized Controlled Trial

PMID: 11177120 [PubMed - indexed for MEDLINE]
Recovery from depression, work productivity, and health care costs in primary care patients.


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We describe a secondary analysis of data from a randomized trial conducted in primary care clinics of a Seattle area HMO. Adults with major depression (n=75) beginning antidepressant treatment completed structured interviews at baseline and at 12, 18, and 24 months. Interviews examined clinical outcomes (Hamilton Depression Rating Scale and depression module of the Structured Clinical Interview for Depression), employment status, and work days missed due to illness. Medical comorbidity was assessed using computerized pharmacy data, and medical costs were assessed using the computerized accounting data. Using data from the 12-month assessment, patients were classified as remitted (41%), improved but not remitted (47%), and persistent (12%). After adjustment for depression severity and medical comorbidity at baseline, patients with greater clinical improvement were more likely to maintain paid employment (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 during the year of follow-up (P=.06). We conclude that recovery from depression is associated with significant reductions in work disability and possible reductions in health care costs. Although observational data cannot definitively prove any causal relationship, longitudinal results strengthen previous findings regarding the economic burden of depression on employers and health insurers.

Publication Types:
- Clinical Trial
- Controlled Clinical Trial

PMID: 10880708 [PubMed - indexed for MEDLINE]
Simon GE, VonKorff M, Rutter C, Wagner E.

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OBJECTIVE: To test the effectiveness of two programmes to improve the treatment of acute depression in primary care. DESIGN: Randomised trial. SETTING: Primary care 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 provided feedback and algorithm based recommendations to doctors on the basis of data from computerised records of pharmacy and visits. Feedback plus care management involved systematic follow up by telephone, sophisticated treatment recommendations support by a care manager. MAIN OUTCOME MEASURES: Blinded interviews at 3 and 6 months after the initial prescription included a 20 item depression module 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 usual care, feedback only had no significant effect on treatment received or patient outcomes. Receiving feedback plus care management had a higher probability of both receiving moderate doses of antidepressants (odds ratio 1.99, 95% confidence interval 1.01 to 3.94) and a 50% improvement in depression scores on the symptom checklist (odds ratio 2.22, 95% confidence interval 1.76 to 2.80) compared to lower mean depression scores on the symptom checklist at follow up, and a 40% probability of major depression at follow up (0.46, 0.24 to 0.86). The incremental cost of feedback plus care management was about $80 (pound50) per patient. CONCLUSION: Monitoring and feedback to doctors yielded no significant benefits for patients starting antidepressant treatment. A programme of systematic follow up management by telephone, however, significantly improved outcomes at most.

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

PMID: 10688563 [PubMed - indexed for MEDLINE]


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

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OBJECTIVE: The study examined health care utilization and costs among patients with bipolar-spectrum disorders in an insured population. METHODS: Computerized prescriptions and on outpatient and inpatient diagnoses from a large health plan were used to identify patients treated for cyclothymia, bipolar disorder, or schizoaffective disorder. Three age- and sex-matched comparison groups consisting of general medical patients treated for depression, and patients treated for diabetes were selected from plan members. Utilization and cost of health services for the four groups over a period were assessed using computerized accounting records. RESULTS: Total costs for patients in the bipolar disorder group ($3,416+/-$6,862) were significantly higher than those in any of the comparison groups. Specialty mental health and substance abuse services accounted for 45 percent of total costs in the group with bipolar disorder (SD=$1,566+/-$3,243), compared with 10 percent in the group with depression. Patients treated for bipolar disorder, 5 percent of patients accounted for approximately 20 percent of the costs for specialty mental health and substance abuse services, and 90 percent of inpatient costs for specialty mental health and substance abuse services, and 90 percent of out-of-pocket costs for inpatient care. In the bipolar disorder group, parity in mental health and substance abuse services would increase overall costs by 6 percent. CONCLUSIONS: Health care costs for patients with bipolar disorder exceed those for patients treated for depression or diabetes, and specialty mental health and substance abuse treatment costs account for this difference. Costs to the insured by patients are accounted for by a small proportion of patients. Eliminating discriminatory mental health coverage would have a small effect on overall health costs.

PMID: 10506298 [PubMed - indexed for MEDLINE]

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

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

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

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We analyzed data from two national surveys to estimate the short-term work associated with thirty-day major depression. Depressed workers were found to have between 1.5 and 3.2 more short-term work-disability days in a thirty-day period than workers had, with a salary-equivalent productivity loss averaging between $1,566+/-$3,243). These workplace costs are nearly as large as the direct costs of successful depression treatment, which suggests that encouraging depressed workers to obtain treatment is cost-effective for some employers.

PMID: 10495604 [PubMed - indexed for MEDLINE]

Depression among high utilizers of medical care.

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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 of Three HMOs located in different geographic regions of the United States. PA total of 12,773 HMO members were identified as high utilizers. Eligibility criteria for 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. Depression screening was completed in 7,203 patients who were high utilizers of medical care. One thousand six hundred fifty (20.3%) screened positive for current major depression or major partial remission. Among depressed patients, 621 (42.4%) had a visit with a health specialist or a diagnosis of depression or both within the previous 2 years. The prevalence of well-defined medical conditions was the same in patients with and without evidence of depression (41.5% vs 41.5%, p = .87). However, high-utilizers who had not made a visit for a nonspecific complaint during the previous 2 years had a significantly lower risk of depression (13.1% vs 22.4%, p < .001). Patients with depression or depression in partial remission had significantly higher numbers of office visits and hospital days per 1,000 than patients without depression. Although there was evidence that mental health problems had previously been common in many of the patients, a large percentage of high utilizers still suffered from a depression that either went unrecognized or was not being treated successfully. Patients who had not made visits for nonspecific complaints were at significantly lower risk of depression. Depression among high utilizers was associated with higher resource utilization.

PMID: 10491229 [PubMed - indexed for MEDLINE]

Comment in:
- Arch Fam Med 1999 Jul-Aug;8(4):319-25

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

OBJECTIVE: To compare the long-term clinical, quality-of-life, and economic outcomes after an initial prescription for fluoxetine, imipramine hydrochloride, or desipramine hydrochloride. DESIGN: Randomized, controlled trial. SETTING: Primary care staff-model health maintenance organization in the Seattle, Wash, area. PATIENTS: One hundred seventy-one adults beginning antidepressant drug treatment for depression. INTERVENTION: Random assignment of initial medication (desipramine, fluoxetine), 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 outcomes (Depression Rating Scale and depression subscale of the Hopkins Symptom Check List), quality of life (Medical Outcomes Study SF-36 Health Survey). Medical costs assessed using the health maintenance organization's accounting data. RESULTS: Patients assigned to fluoxetine therapy were significantly more likely to continue taking antidepressant but no more likely to continue any antidepressant therapy. This group did not differ significantly from either tricyclic drug group on any measure of depression severity or quality of life. For 24 months, antidepressant drug costs were approximately $250 higher for patients assigned to fluoxetine therapy, but total costs were essentially identical. CONCLUSIONS: Initial selection of fluoxetine tricyclic antidepressant drug should lead to similar clinical outcomes, functional status, and overall costs. Differences in antidepressant prescription costs are blunted by the minority of tricyclic-treated patients who switch to use of more expensive medication. Restrictions on first-line use of fluoxetine in primary care will probably not reduce treatment costs.

Publication Types:
- Clinical Trial
- Randomized Controlled Trial

PMID: 10418538 [PubMed - indexed for MEDLINE]
Depression, health-related quality of life, and medical cost outcomes of primary care patients receiving recommended levels of antidepressant treatment.

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BACKGROUND: We evaluated depression severity, health-related quality of life, and medical cost outcomes of primary care patients receiving recommended levels of antidepressant treatment. METHODS: We performed analysis of clinical trial data from primary care clinics in a staff-model managed organization. The trial included patients with Diagnostic and Statistical Manual of Mental 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 depression scores, the Medical Outcomes Study 36-Item Short-Form Health Survey (SF-12) physical component summary scores, and the total outpatient and inpatient medical costs. RESULTS: Of 358 patients starting antidepressant treatment, 195 (54.5%) received recommended by the Agency for Health Care Policy and Research for 90 days. Mean HDRS score decreased from 14.1 to 8.8 in patients receiving less-than-recommended treatment and decreased from 13.8 to 8.9 in patients with minimum recommended treatment (P = .761). No significant differences in improvement of HRQL outcomes were observed between patients receiving recommended or less-than-recommended antidepressant therapy. Mean total medical costs over 6 months for patients receiving recommended levels of antidepressant treatment were $1872 +/- 140 compared to $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 $413, P = .004). CONCLUSIONS: Patients receiving minimum recommended levels antidepressant therapy for 3 months showed improvement in depression severity comparable with patients receiving less-than-recommended treatment. Patients receiving minimum recommended treatment had lower total costs and nonmental health-inpatient costs. Antidepressant treatment in primary care patients may have a positive impact on the frequency of health care visits and on costs for medical conditions.
Treating major depression in primary care practice: an update of the Agency for Health Care Policy and Research Practice Guidelines

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The Depression Guideline Panel of the Agency for Health Care Policy and Research published recommendations for treating major depression in primary care in 1993. These recommendations were often based on studies of tertiary care psychiatric patients. We reviewed randomized controlled trials in primary care settings published between 1992 and 1998. This evidence indicates that both antidepressant pharmacotherapy and time-limited depression-targeted psychotherapies are efficacious when transferred from tertiary care settings to primary care settings. In most cases, the choice between these treatments should be based on patient preference. Studies to date suggest that improving treatment of depression in primary care requires properly organized treatment programs, regular patient monitoring of treatment adherence, and a prominent role for the mental health educator, consultant, and clinician for the more severely ill. Future research should focus on how guidelines are best implemented in routine practice, since conventional compliance strategies have little impact.

Publication Types:
- Review
- Review, Tutorial

PMID: 9862556 [PubMed - indexed for MEDLINE]

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


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

PMID: 9866670 [PubMed - indexed for MEDLINE]
OBJECTIVE: The report estimates the treatment costs, cost-offset effects, an effectiveness of Collaborative Care of depressive illness in primary care. STI Treatment costs, cost-offset effects, and cost-effectiveness were assessed in randomized, controlled trials. In the first randomized trail (N = 217), consult 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-behavioral enhanced patient education. Consulting psychologist provided brief psychotherapy 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 cost reduction in 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. Collat was more costly and not more cost-effective than Usual Care. CONCLUSIONS Collaborative Care increased depression treatment costs and improved the cost-effectiveness of treatment for patients with major depression. A cost offset in mental health costs, but not medical care costs, was observed. Collaborative Care 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]

Cost implications of initial antidepressant selection in primary care

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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 fc primary-care patients beginning antidepressant treatment with fluoxetine or c imipramine or desipramine. Comparison was based on initial medication pre regardless of subsequent switches or discontinuation. Patients treated with fl older, with a higher burden of medical illness and higher overall health-ser starting antidepressant treatment, compared with patients receiving the other choice of fluoxetine was associated with approximately $US140 higher mear costs and approximately $US300 higher mean costs for all other health serv

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 signi-
Subgroup analyses suggested that the use of fluoxetine was associated with lo-
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]


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

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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 ex-
amine how changes in depression influence utilization. Some quasi-experi-
experimental studies support a "cost-offset" effect due to mental health treat-
experimental data directly address the specific impact of depression treatmen-
t 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 i-
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]


Comment in:
- ACP J Club. 1997 Jan-Feb;126(1):16
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 of prescribing fluoxetine with outcomes of initially selecting imipramine or desipramine.

DESIGN: Randomized controlled trial.


Random assignment of initial antidepressant prescription (desipramine, fluoxetine, imipramine). Subsequent antidepressant treatment (doses, medication change, discontinuation, specialty referral) was managed by the primary care physician.

OUTCOME MEASURES: Assessments after 1, 3, and 6 months examined clinical 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 maintenance organization's computerized data. RESULTS: Patients assigned to receive fluoxetine reported fewer adverse effects, were more likely to continue the original medication, and were more likely to reach adequate doses than patients beginning treatment with a tricyclic drug. The fluoxetine group reported marginally better clinical outcomes, but these differences were not statistically significant and disappeared at the 6-month assessment. Quality-of-life outcomes in the 3 groups did not differ. Total costs over 6 months were approximately equal for the 3 groups, with higher outpatient costs in the fluoxetine group balanced by lower outpatient visit and inpatient costs.

CONCLUSIONS: Clinical outcomes, quality-of-life outcomes, and overall treatment costs 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]
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OBJECTIVE: The authors examined the impact of increasing cost sharing on outpatient mental health services. METHOD: A quasi-experimental design was used to study outpatient utilization by members of a health maintenance organization who were subject to increasing copayments for mental health visits (state government and dependents). Their outpatient mental health utilization was compared with similar HMO members who were not subject to cost sharing (federal government employees and dependents). Analyses compared both likelihood of any service use and the number of visits per year among service users. RESULTS: Institution of $20 copayments was associated with a 16% decrease in likelihood of service use and a 9% decrease 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% decrease in visit rate among those using services. The impact of the first copayment change on the likelihood of using services did not vary according to level of clinical need (e.g., prior service use and psychotropic drug use). CONCLUSIONS: In this staff-model HMO, modest visit copayments significantly reduced initial access to mental health care, had a smaller effect on treatment intensity. Copayments restricted access regardless of clinical need. Designers of mental health benefits must consider the impact on those with the greatest need for treatment.

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Health care costs of primary care patients with recognized depression

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BACKGROUND: While an extensive literature documents the influence of general medical services utilization, estimates of the economic burden of depression focused on the direct costs of depression treatment. Higher use of general medical services may contribute significantly to the true cost of depressive illness. METHOD: Computerized record systems of a large staff-model health maintenance organization (HMO) were used to identify consecutive primary care patients with a diagnosis of depression (n = 6257) and a comparison sample of primary care patients with a diagnosis (n = 6257). The HMO accounting records were used to compare health care costs. RESULTS: Patients diagnosed as depressed had higher annual health care costs ($4246 vs $2371, P < .001) and higher costs for every category of care (medical specialty, medical inpatient, pharmacy, laboratory). Similar cost differences were observed for each of the subgroups examined (patients treated with antidepressants, those not treated with antidepressants, and those diagnosed at routine physical visits). Pharmacy records indicated greater chronic medical illness in the diagnosis depression group, but large cost differences remained after adjustment ($397 Twofold cost differences persisted for at least 12 months after initiation of treat
CONCLUSIONS: Diagnosis of depression is associated with a generalized increase in health services that is only partially explained by comorbid medical conditions. In the primary care sector, this greater medical utilization exceeds direct treatment of depression. The persistence of utilization differences suggests that recognition of treatment alone are not adequate to reduce utilization differences.

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A chronic disease score with empirically derived weights.

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

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

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

Publication Types:
- Review
- Review, Tutorial

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

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OBJECTIVE: The authors examined the volume and predictors of outpatient utilization among primary care patients in a large staff-model health maintenance organization (HMO). METHOD: Consecutive primary care patients (N = 1,800) screened by using the 12-item General Health Questionnaire, and a stratified sample (N = 373) completed the 28-item General Health Questionnaire and International Diagnostic Interview. Telephone interviews and computerized r
used to examine use of mental health services inside and outside the HMO over 3 months. RESULTS: Over 3 months, 6.7% of the screened patients used mental health services within the HMO. Utilization increased with higher General Health Questionnaire score (2.9% among those scoring 0, 22.3% among those scoring 1, and decreased with higher out-of-pocket cost for mental health visits (7.5% for no change, 3.3% for those paying $30/visit). Among the interviewed subjects, 8.9% used mental health services within the HMO (mean = 2.92 visits) and 8.9% used mental health services (mean = 8.86 visits). Use of outside services was more strongly related to sociodemographic factors, and use of inside services was more related to severity of psychological disorder. CONCLUSIONS: Among these subjects, use of men was high and services purchased outside the HMO exceeded those inside the HMO. Increasing copayment levels progressively reduced demand without respect for illness. Attempts to control outpatient mental health costs must address equity in need.

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