COLLABORATIVE PRIMARY CARE FOR OLDER ADULTS: THE CASPER STUDY

THE UNIVERSITY of York
H·Y·M·S THE HULL YORK MEDICAL SCHOOL

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Is it cost effective to prevent depression?

An interesting trial in a high risk population

A primer on health economics and cost-effectiveness

Some robust (trial based) cost effectiveness data

The nature of the problem

- Sub threshold depression in older populations
  - Associated with significant decrements in QoL & function
  - Risk factor for case-level depression
  - Antidepressants don't work
  - 'Distressed high utilisers'
  - Primary Care Physicians screen, but don't know what to do…
- Pim has already told us that this is an attractive strategy
- 'High risk' approach to population mental health, with the potential to be good VFM

CASPER

- Care for
- Screen
- Positive
- Elders

Who took part?

- 705 participants
- Mean age 77 (range 65 – 99 yrs)
- DSM-IV Subthreshold depression
- Very few exclusions
  - Recently bereaved
  - Alcohol dependence
  - Terminal illness
  - Cognitive impairment
- Co-morbidity – 80% or more had 2+ long term conditions

Collaborative care & behavioural activation for depression

- Case management
  - Brief psychological intervention – Behavioural Activation (BA)
  - Manualised and over the phone
  - Case managers trained and supervised
- Primary Care liaison
- Scheduled follow up
- Session by session symptom profiles

Outcomes @ 4 and 12 months

PHQ9 – continuous measure

Case level depression in the follow up period

SF12

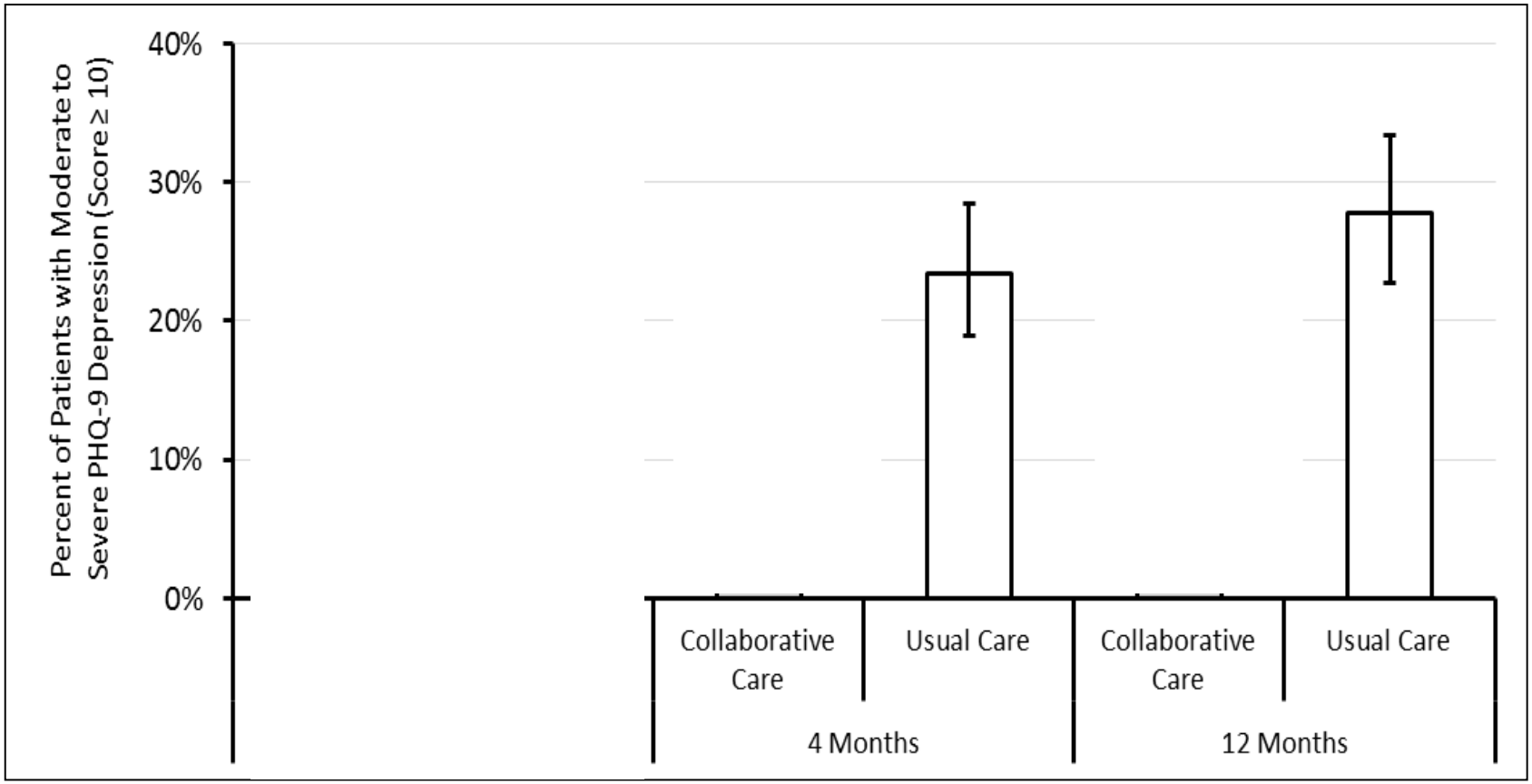
GAD7

PHQ15

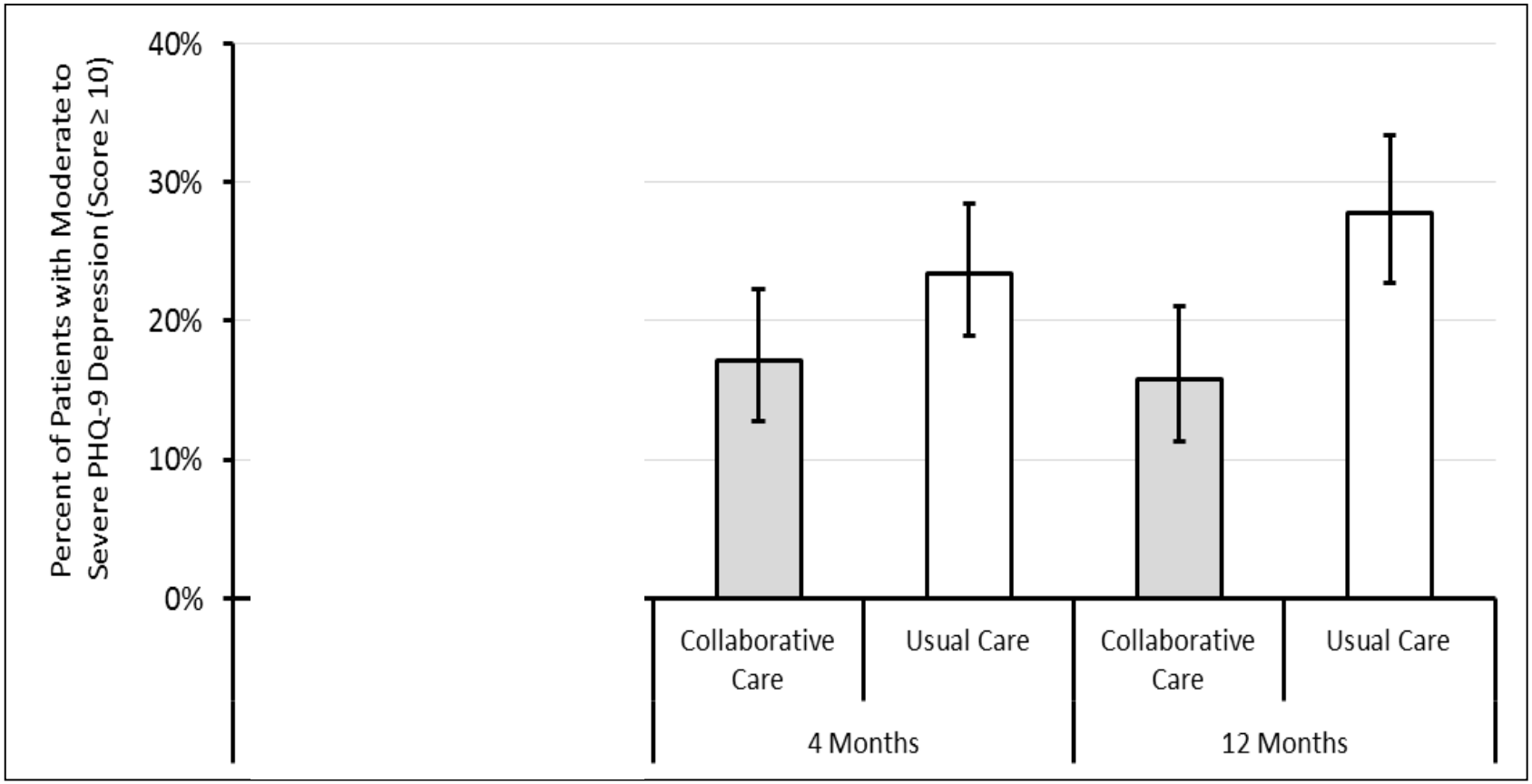
RISC2

Does collaborative care prevent the onset of depression?

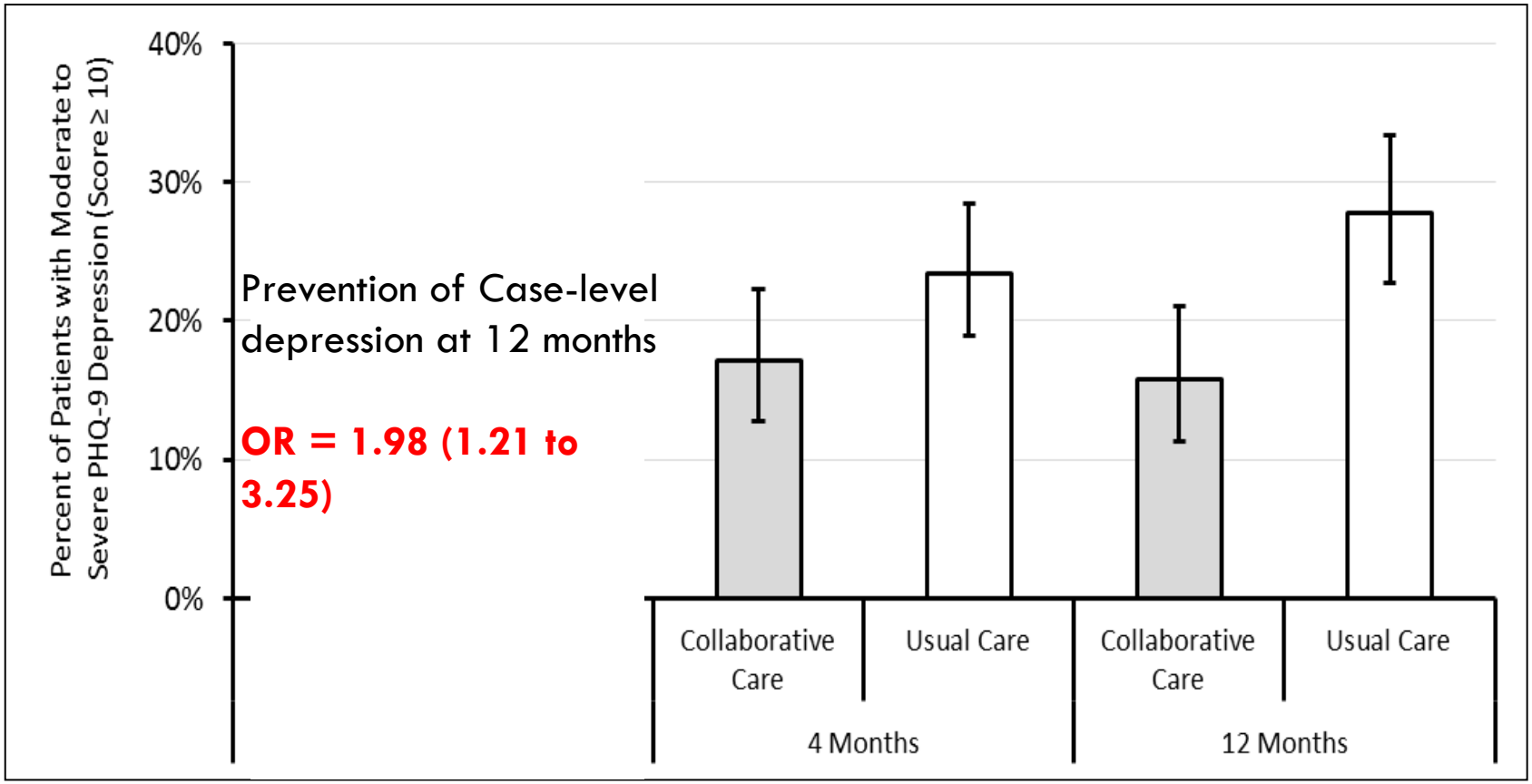
Did collaborative care prevent case level depression?



Did collaborative care prevent case level depression?



Did collaborative care prevent case level depression?



Value for money?.....

Some basic axioms of health economics

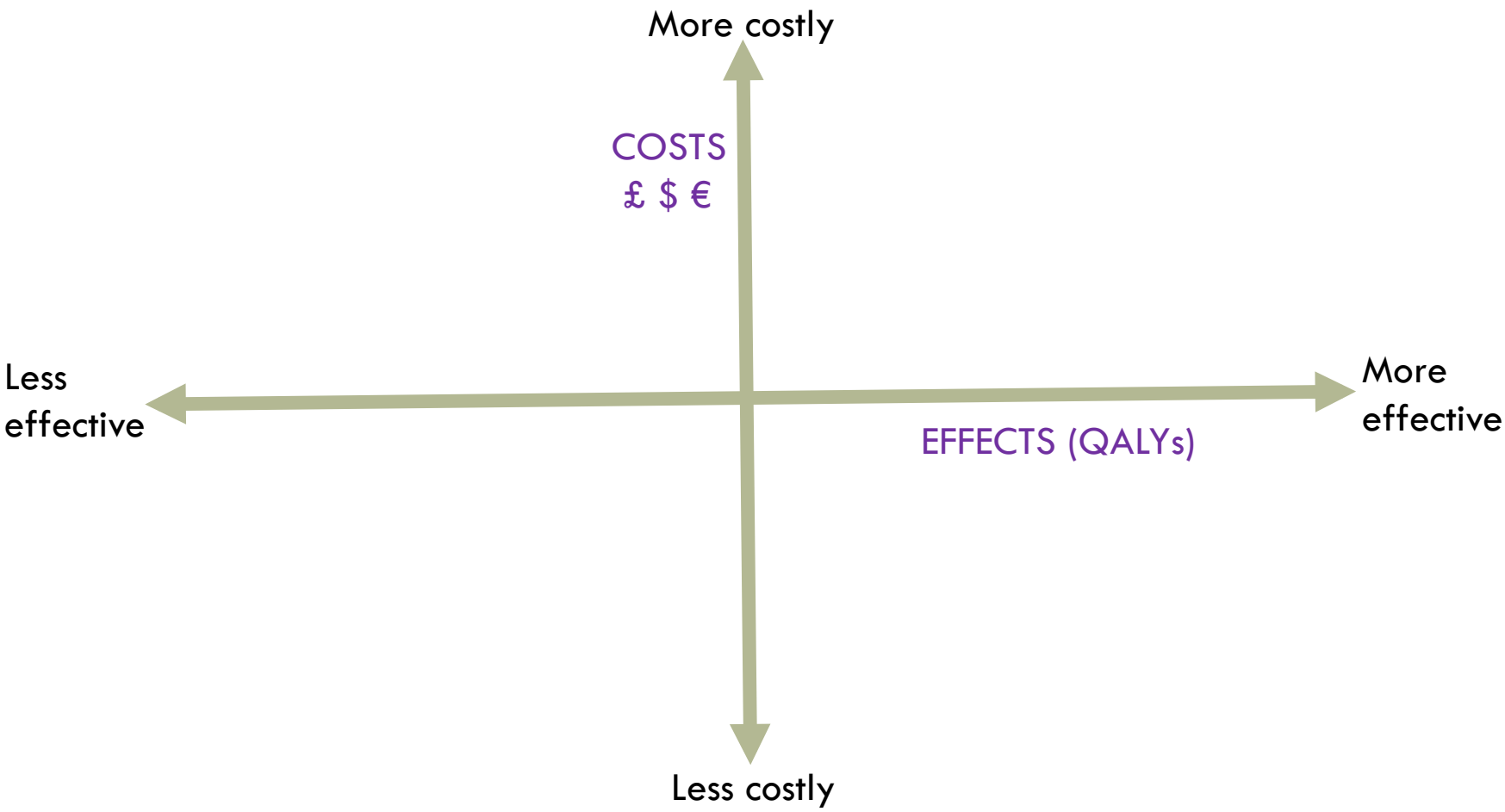
- Resources are finite; decisions and priorities need to be set
- Ensure the 'greatest good for the greatest number of people'
- 'Bang for your buck'
- Economic study only as good as the clinical data
- Trial-based economic evaluations – top level evidence, but few and far between

CASPER trial-based cost effectiveness analysis

- Costs
  - Primary care and hospital costs for participants over 12 months (from patient records)
    - Visits, drugs, admissions
    - Apply unit costs
  - Costs of employing, training case managers and delivering the intervention
- Benefits
  - Quality Adjusted Life Years (QALYs)
  - Derived from the EuroQol over 12 months
- A number of scenarios

$$ICER = \frac{\Delta C}{\Delta E} = \frac{\bar{C}_I - \bar{C}_C}{\bar{E}_I - \bar{E}_C}$$

The cost effectiveness plane



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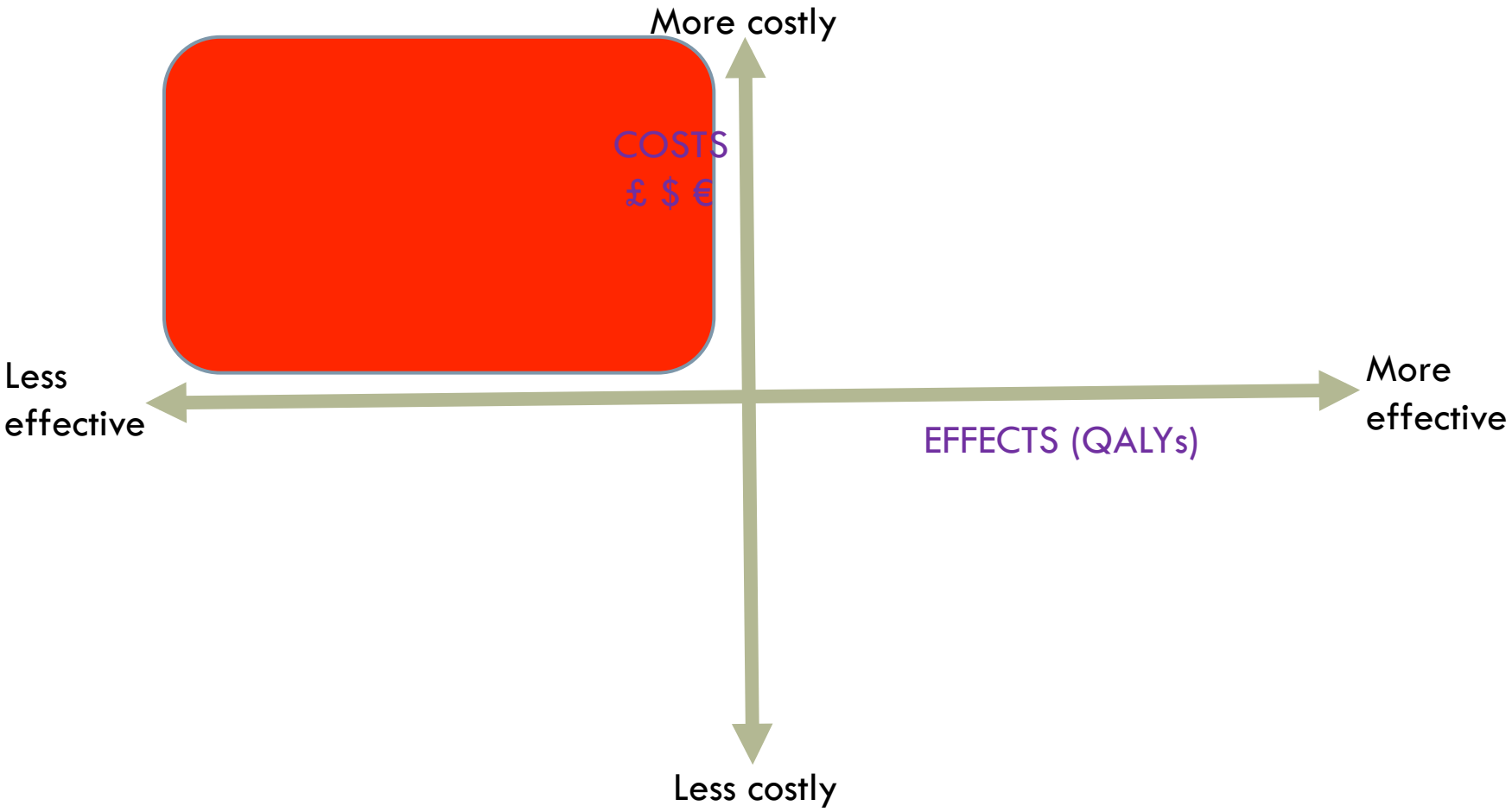

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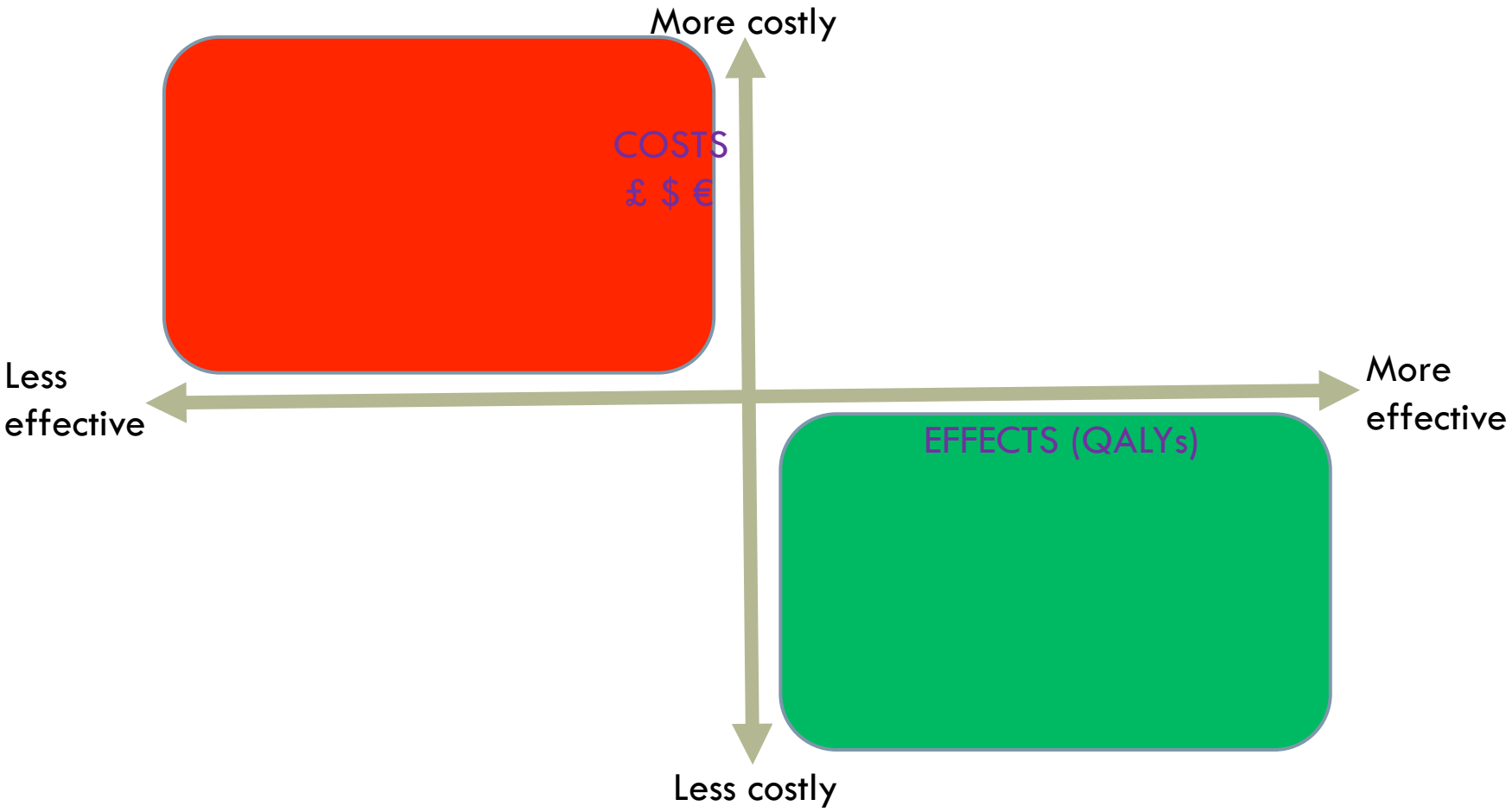
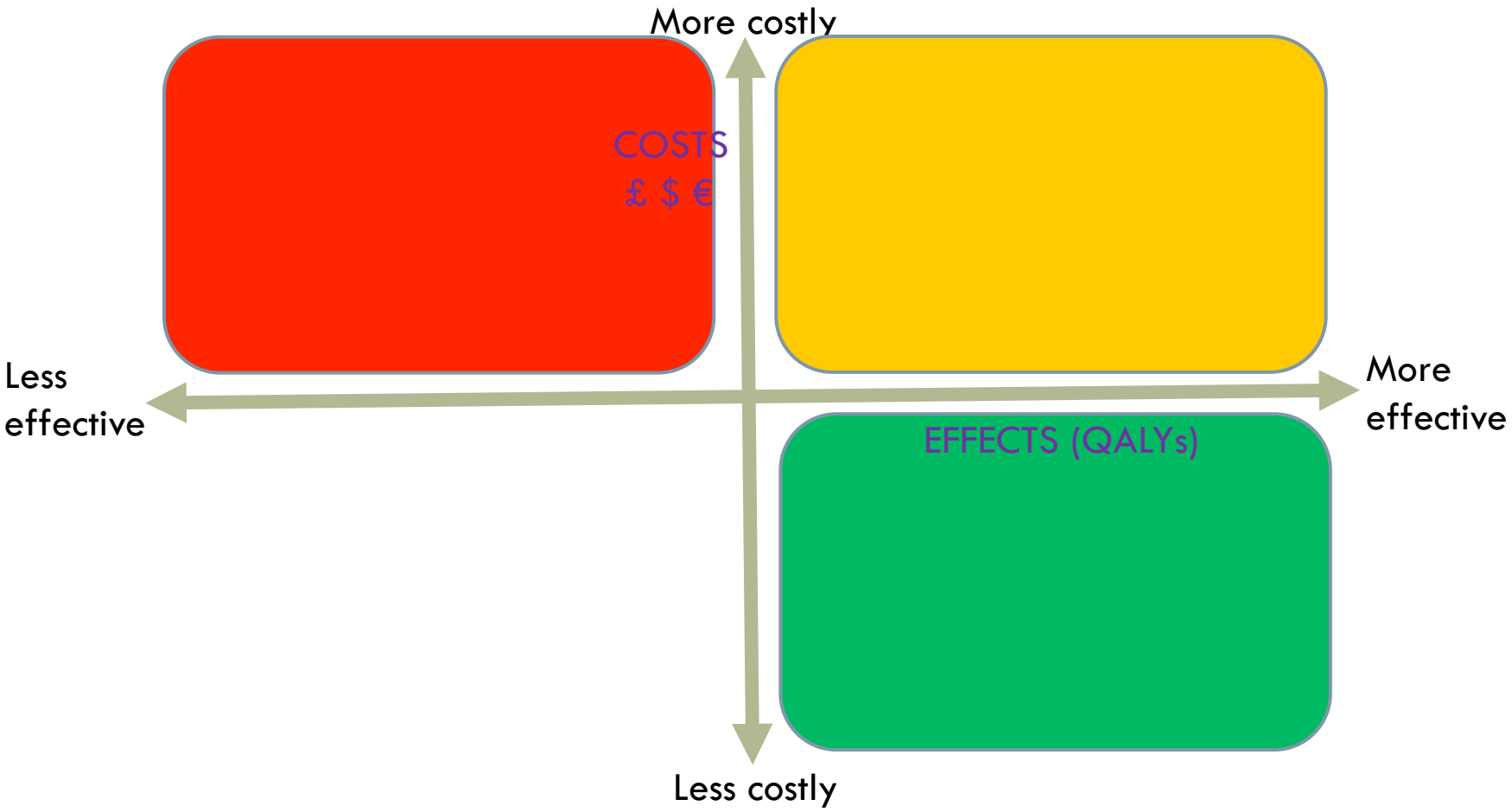
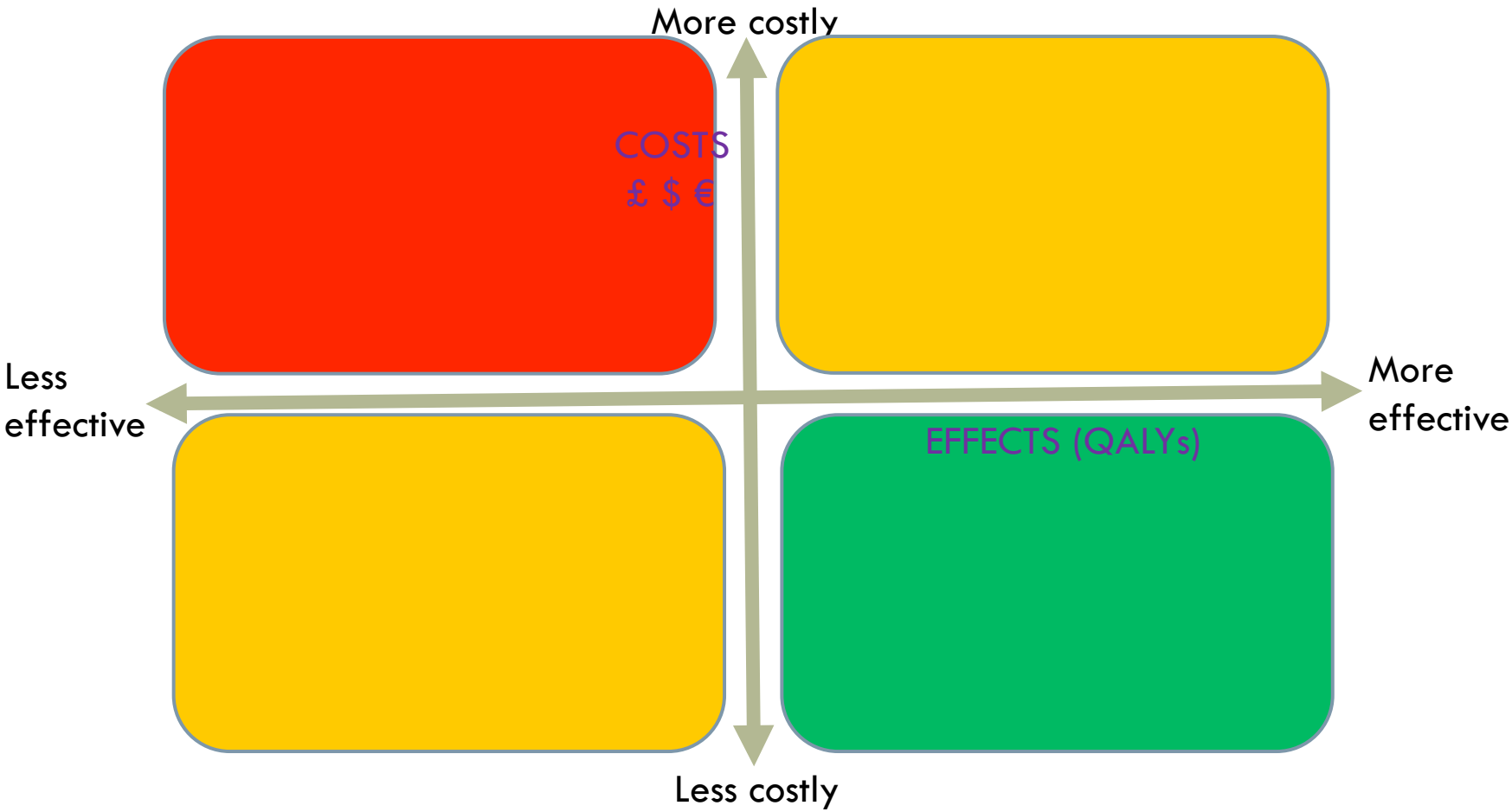


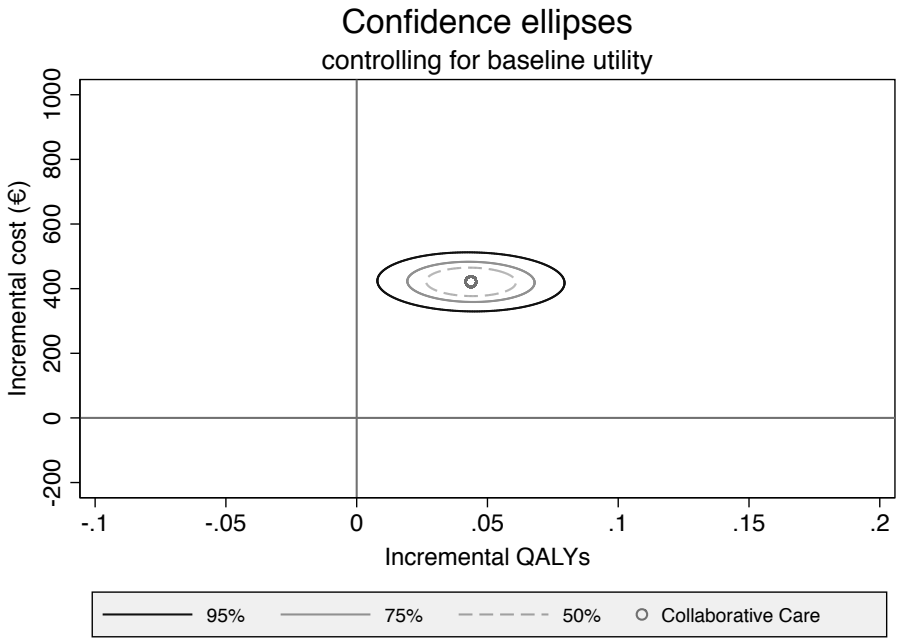
The cost effectiveness plane



The cost effectiveness plane



Was it cost effective?



- ITT costs of CC/BA = £494
- As delivered costs = £292
- Some evidence of cost offset - £55
- Worst case cost/QALY £9,633
- CC/BA as delivered cost/QALY £3328

Would a decision maker be willing to pay for a preventative strategy?

- Willingness to pay (WTP)
- Decision making bodies £20,000 to £30,000 per QALY
- 'Revealed preferences'
- Compares very favourably with other things that society or healthcare systems pay for
- Smoking cessation, treatments for acute depression, cancer treatments

Summary of findings

- Prevented the onset of case level depression
- Cost effective
- Largest UK trial of collaborative care/BA to date
- Largest ever trial of CC/BA for subthreshold depression

Acknowledgements

Too many to mention

Team-CASPER

CASPER participants

@SimonGilbody

Disclaimer...

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The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HTA programme, NIHR, NHS or the Department of Health.