The purpose of this article is to analyze the efficiency of the Brazilian system of kidney transplant, in the years 2006 and 2011; and the socio-economic impact of mental disorders like anxiety and depression at the workplace.

OBJECTIVES: To identify the evidence-based interventions available to prevent depression at the workplace, to explore in what extent these interventions have impact on reducing the socio-economic effects of mental disorders. METHODS: A search based on depression, anxiety, interventions, prevention, workplace, absenteeism, presenteeism, induction costs was performed using Medline database. Studies were included if they described the interventions and method and their effects on absenteeism, presenteeism and costs at workplace. RESULTS: Five main interventions were identified: workplace screening for anxiety and depression disorders and care management. Interventions are usually delivered through cognitive behavioral therapy (CBT), offered by external psychological service providers; CBT through web-based program: it is offered a web-based program to selected employees. Benefits come out of tackling the disorder and increasing productivity levels due to the reduction of absenteeism, interventional promoting well-being in the workplace: it includes flexible time schedules, career growth opportunities and mental health risk factors recognition training program for managers, financial education workshop for selected employees to advise them on how to better manage their debts, reducing financial burden and consequently, reducing mental health problems; antidepressant drugs for anxiety and depression: these medicines have a positive impact on the work performance and on the decrease of absenteeism rate. CONCLUSIONS: The studies selected demonstrated a clear benefit of five interventions for depression and anxiety at workplace: improvement in employees' performance, in quality of life, reduction of health services costs, decrease in absenteeism rate, in accidents, in sick leave benefits and in early retirement.

PHS68

EFFICIENCY OF THE BRAZILIAN SYSTEM OF RENAL TRANSPLANTATION: AN ANALYSIS USING DEA AND MALQUIST INDEX METHOD (2006-2011)

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OBJECTIVES: The purpose of this article is to analyze the efficiency of the Brazilian system of kidney transplant, in the years 2006 and 2011, and evaluate the performance of the efficiency of these States throughout this period of time. Thus sought to analyze the behavior of States in this sector, before and after the institutional changes adopted by SUS in December of 2009.

METHODS: The methodology used was data envelopment analysis (DEA) based on Slack (Slack et al. 1995), the pooled samples DEA model (Coelli et al., 1998), and the Malmquist index method (Malmquist et al., 1991). Turkey was used as the benchmark to compare the Brazilian States. Considering the variables used in the DEA model, the time period of analysis was in five years, 2006 and 2011, for the 26 States of Brazil. The evaluation of the efficiency of the DEA was performed in two steps: first, using the slacks (slack variables) and second, using the Malmquist index. The slacks were used to determine if the efficiency was due to differences in production levels (scale effect) or due to the presence of inefficient producers (technological effect) in the sample. The Malmquist index was used to determine if the changes in the efficiency were due to technical progress or due to changes in the productivity function. The study also sought to identify if there were changes in the efficiency of the States during the study period of time.
OBJECTIVES: Diagnosis and monitoring of lymphoma includes lymph node assessment, evaluation of multi-organ involvement, and health care resource use among lymphoma patients. METHODS: Patients with ≥2 claims for Hodgkin lymphoma (HL) or non-Hodgkin’s (NHL) lymphoma from 1/06–12/31/12 were identified from a large US claims database, the index date was the first observed diagnosis code(s). Patients were retained in the health plan for ≥12 months before and after the index date, were not diagnosed with lymphoma during the pre-index period or diagnosed with cancer other than NHL during the 2-year study period. Indication of receipt of biopsy included ≥1 claim for a lymph node biopsy (core needle, fine needle, surgical, other), pathology, or tumor excision (bone marrow biopsy not included). Health care cost and utilization was examined among patients with ≥2 claims indicating biopsy was identified for each biopsy type. RESULTS: 20,813 newly diagnosed lymphoma patients met all inclusion criteria. 16,557 (80%) had ≥1 claim indicating biopsy, 12,920 (62%) had ≥2 and 8,785 (42%) had ≥3. The percentage of patients with ≥3 biopsies was highest among patients with ≥3 claims (52%, 53%) compared with patients with 2 (33%, 41%), 1 (25%, 34%), or 0 biopsies (26%, 42%). Total health care cost was greatest among patients with ≥3 biopsies ($102,465) compared to $2 (51,565), 1 ($25,614), or 0 biopsies ($35,435). Costs for patients with ≥3 biopsies were $32,986 for a complex surgical biopsy and $12,353 for other biopsies. Biopsies involving the mediastinum cost $10,554 on average. CONCLUSIONS: Lymphoma patients incur significant health care cost and utilization. Increasing the efficiency of lymph node diagnosis could avoid the need for repeat biopsies and reduce health care costs.

PHS73
COSTS OF PILOT PROGRAMS IN CHICAGO-BASED CENTERS FOR POPULATION HEALTH AND HEALTH DISPARITIES: A CASE FOR TEAM-CARE
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OBJECTIVES: To measure the costs of two team-care based pilot interventions. These initiatives were part of the National Institutes of Health-funded Centers for Population Health and Health Disparities (CPHHD) designed to improve health outcomes in medically underserved communities. METHODS: The data come from two Chicago-based CPHHD randomized controlled trials. Use of a virtual team-care based approach (BRIGHTEN Heart) and cardio-metabolic syndrome and use of a patient navigator to improve diagnostic follow-up of mammography screening for breast cancer. The programs collected detailed data regarding service delivery and resource use. Costs were measured from a provider perspective. Actual time spent with patients was estimated in the navigator program using details on activities performed and previous time study data for those activities in similar programs. Time was converted to costs based on average time spent by the BRIGHTEN Heart by occupational title. BRIGHTEN Heart involved multiple services along with time and travel cost estimates for each occupation and service. RESULTS: There were 483 patients that received patient navigator services and 16 patients in the virtual team-based BRIGHTEN Heart intervention. The patients were almost all minorities and were below average in terms of income and education. The operating cost of the Navigator program was $14,292 following diagnostic screening. The operating cost for the year of virtual team care in BRIGHTEN Heart was $575 13. CONCLUSIONS: Costs are an important consideration for evaluating team-care based interventions to improve patient health in the underserved. The two programs evaluated here offer insight into the cost-effectiveness of team-based care strategies employing allied health workers. Given the low cost of care, the programs offer promise of being cost effective. Future work will examine these costs in comparison to the effectiveness of the program.

PHS74
TREATMENT PATTERNS AND HEALTH CARE RESOURCE UTILIZATION OF PATIENTS WITH NEUROENDOCRINE TUMORS IN THE UNITED STATES
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OBJECTIVES: To examine patient characteristics, treatment patterns, and health care resource utilization of patients with neuroendocrine tumors (NETs) in the US. METHODS: Using a US administrative claims database, commercially-insured adults newly diagnosed with carcinoid tumors (ICD-9-CM: 157.4 and 211.7) between 07/01/2007 and 12/31/2010 were identified (the date of the first observed diagnosis as the index date). Patients were required to have 6-month pre-index and 12-month post-index continuous enrollment. Descriptive analysis was performed to describe demographic and clinical characteristics, treatment patterns for NETs, and health care resource utilization during the 12-month post-index period. Similar analysis was conducted for Medicare-eligible individuals with the supplemental private insurance. RESULTS: This study included 9,340 commercially-insured individuals (mean age: 52.3 years, 55.4% female) and 1,658 Medicare-eligible individuals (mean age: 74.9 years; 49.0% female) with NETs. In the commercial population, carcinoid syndrome (33.2%, liver metastasis (14.4%), and neuroendocrine tumor (18.2%) were the most prevalent comorbidities evaluated. While 19.5% of individuals received surgical therapy and 17.5% received medical therapy (somatostatin analogue treatment) as the first-line treatment, the newly two-thirds of individuals had 10 month in the 12-month post-index period, about half of individuals had individual hospitalization and 35.4% had emergency room visits; the mean physician office visit was 19.9. In the Medicare population, carcinoid syndrome (27.4%), liver metastasis (20.7%), and neuroendocrine tumor (16.1%) were the most prevalent comorbidities. While 13.2% received surgical therapy and 19.8% received medical therapy, over two-thirds received neither. Approximately half of individuals had individual hospitalization and 37.3% had emergency room visit during the 10 month index period; the mean physician office visit was 26.1. CONCLUSIONS: This exploratory study described real world