of SSRI therapy in PCP settings. Eligible depressed patients were randomized to treatment (N = 601) and naturally followed for 9 months. Medication use was determined by self-report questionnaire. Adequate treatment was defined as six months continuous medication. Clinical response was determined by use of the SCL-20. Patients were classified as achieving remission (score ≤ 6), partial response (50% decrease in symptoms), or non-response. Baseline and end-of-study depression severity and functioning were compared between groups defined by response and treatment classifications.

RESULTS: Clinical response in this setting was less than optimal with 45% of adequately treated patients classified as non-responders. For remitters and partial responders, the greatest decreases in depression severity were by the third month. Partial responders had greater depression severity and lower functioning at baseline and more severe depression and lower level of functioning than remitters at the 9-month evaluation.

CONCLUSIONS: A substantial number of patients were classified as non-responders despite adequate treatment for six months. These patients may be considered undertreated according to treatment guidelines recommending dose increases or medication switches for non-responders. Partial responders are often considered clinically improved in studies, however they were significantly more ill than remitters following treatment.

ECONOMIC IMPACT OF TREATMENT OF DEMENTIA FOR GERMANY—A PROGNOSIS TO 2050
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OBJECTIVE: To assess the development of costs for dementia in Germany until the year 2050 under different demographic scenarios and the possible impact of treatment interventions with AChE inhibitors from various perspectives.

METHODS: A model to estimate cost differences in dementia treatment with AChE inhibitors compared to a placebo scenario was developed. The model projects the number of dementia patients in Germany until 2050 under the assumption of extended life expectancy and immigration. Markov modeling allows to document the progression of dementia patients into more severe stages. Data of the population development were supplied by the Federal Bureau of Statistics and the German Institute for Economic Research. Number of patients were calculated from demographic prognoses considering prevalence of disease data from a published meta-analyses of the epidemiology of dementia. Data about transition probabilities between different disease stages were derived from a randomized clinical trial of an AChE inhibitor. Disease stage specific costs were taken from a cost of illness study previously published.

RESULTS: The number of dementia patients will increase from 1 million to 2.5 million over the next 50 years in Germany. With treatment there will be 30% less patients in the most severe, and hence most costly disease stage. Costs for treatment are offset by cost savings through a shift of patients to less severe disease stages, if indirect family and caring costs are included. Reduction of direct costs due to treatment increase from 0.5 to 1.5 billion Euro per year and indirect cost reductions are 4-fold these figures. For 2000 net savings of 1.4 billion Euro are demonstrated for the societal perspective. Results are stable for extensive sensitivity analysis.

CONCLUSION: Results document that the dimension of cost for care should make dementia a health policy priority. In an ageing society dementia treatment is also economically highly attractive.

DIABETES

THE VALUE OF MULTIPLE YEARS HISTORY IN IDENTIFYING COMORBID CONDITIONS IN A RETROSPECTIVE DATA ANALYSIS
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OBJECTIVE: To examine the extent to which length of observation affects appropriate identification of comorbid diagnoses.

METHODS: Study was conducted using IMS HEALTH’s LifeLinkTM database, a U.S. employer claims database consisting of more than 1.8 million covered lives, with linked medical and pharmacy claims for employees, dependents, and retirees from 1991 forward. All patients who had at least one claim for Type II diabetes between April 1, 2000 and September 30, 2000 were selected. Additionally, patients were required to be continuously eligible for the entire 36 months preceding their diagnosis to ensure complete data. All diagnoses recorded on medical claims in 6, 12, 24, and 36-month periods preceding the diabetes diagnosis were summarized at the 3-digit ICD-9-CM level. Each time period was cumulative, such that, patients in the 6-month period also were observed in the 12-, 24- and 36-month periods, and the number of patients identified with a comorbid condition accumulated across the periods.

RESULTS: 43,640 patients met the inclusion criteria. In comparing the percent of patients with comorbid conditions in a six-month observation period versus a 36-month observation period, the percent of patients with comorbid conditions increased dramatically. Large percentage increases between the 6-month to 36-month observation periods were found for numerous chronic comorbidities. For example, the percentage of type II diabetics with transient cerebral ischemia increased from 1.9% to 6.5% (243% increase). Other increases included: depressive disorder (228%), angina (227%), hypertensive...
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heart disease (207%), myocardial infarction (204%), asthma (186%), peripheral vascular disease (184%), stroke (144%), chronic ischemic heart disease (96%), and essential hypertension (74%).

CONCLUSIONS: The percent of patients with comorbid conditions increases as the observation window increases. Restricting a search of concomitant diagnoses to a short timeframe or timeframes of non-continuous enrollment can result in inaccurate identification of chronic comorbid conditions of a study population.

QOL INDICATORS OF SATISFACTION AND IMPACT ASSOCIATED WITH WEB-ENABLED DIABETES SELF-MANAGEMENT TOOLS

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According to the California Healthcare Foundation, 40 percent of Americans will suffer from a chronic disease by 2010. To reach and positively impact this growing segment of healthcare consumers, many health plans have initiated some form of disease management. In attempting to deliver the most effective and targeted intervention possible, many plans are turning to the Internet and online tools for patient-directed self-management.

OBJECTIVES: The purpose of this research is to evaluate the efficacy and patient outcomes associated with an online disease self-management tool for diabetics.

METHODS: During 1999–2001, 15,600 unique individuals registered as participants in MyDiabetes.com, completing two or more visits. Of these, 160 participants completed a baseline and follow-up DQOL survey online. Using the median number of visits (median = 25 visits) during their participation, this group was then equally divided into low and high volume visitors to the website. DQOL scale scores are based on a scale of 100 units derived from instrument question responses.

RESULTS: Among the high volume users (more than 25 visits), we found evidence of improvement over baseline in DQOL scale indicators for satisfaction (Bonferroni pairwise test = 3.7, p < 0.001) and impact (Bonferroni pairwise test = 1.7, p < 0.09). Because this group of participants was not randomly assigned to this intervention, some caution is advised in interpreting these results. It may be that healthier and more health-conscious patients with diabetes choose to engage in disease management programs and report improvement based on subjective factors. However, among those patients with diabetes who choose to register and participate in web-enabled disease self-management programming, this evaluation provides preliminary evidence of self-reported improvement in patients’ satisfaction and perceived disease impact associated with an Internet-based program.

CONCLUSIONS: Web-enable disease self-management programming for patients with diabetes may therefore be an effective model for health plans eager to engage their “at risk” members in patient-directed care. Given the magnitude of chronic disease prevalence in the US, more study of the impact and efficacy associated with these ‘new technology’ interventions is needed.