

Serious Mental Illness Treatment Research and Evaluation Center (SMITREC)
Health Services Research and Development Center of Excellence
P.O. Box 130170
Ann Arbor, MI 48113-0170
Phone: 734-769-7100, extension 6247
Fax: 734-761-2617

**Specialty Care for Veterans with
Depression in the VHA**

2002 National Registry for Depression (NARDEP) Report

Frederic C. Blow, PhD, Director, SMITREC
Richard E. Owen, MD Director, VA Mental Health QUERI

Investigative Team:
Marcia Valenstein, MD, MS
Karen Austin, MPH
Kiran Khanuja, MD
John F. McCarthy, PhD

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Chapter 1: Report Overview, Structure, and Background

Rationale for a Depression Registry

Depression is one of the most common medical disorders, with a point prevalence of 4.8% to 8.6% among community residents. Men have a lifetime prevalence of 7% to 12% and women have a lifetime prevalence of 20% to 25% (Kessler et al. 1994). Depressive disorders are associated with functional impairment and increased health care utilization (Johnson, Weissman, and Klerman 1992; Murray and Lopez 1996; Simon, VonKorff, and Barlow 1995).

Depressive symptoms and disorders are common among the veteran population. According to the Veterans Health Study, the prevalence of significant depressive symptoms among veterans is 31%; two to five times higher than in the general US population, depending upon the age group and locale of diagnosis (Hankin et al. 1999). In 2002, more than 4.5 million people were treated in VA healthcare facilities (<http://www.va.gov/opa/fact/docs/vafacts.htm>); 542,075 or 12% of these patients were diagnosed with depression.

Recognizing the widespread prevalence, morbidity, and high costs of depression, the Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) collaborated with the Mental Health Quality Enhancement Research Initiative (QUERI) to develop a VA National Depression Registry in 2001. This activity was consistent with SMITREC's mission of monitoring and evaluating the care of seriously mentally ill veterans and providing policy makers with data to assist them in improving care. The activity was also complementary to the mental health QUERI's goal of creating a data-driven national program to improve the quality of care for veterans with major depression disorder (MDD) and schizophrenia.

The VA National Registry for Depression (NARDEP) is modeled after SMITREC's first national patient registry, the VA National Psychosis Registry (NPR), and is a comprehensive database of veterans with depressive disorders receiving treatment in the VA..

Overview and Structure of the Depression Registry

Patients with depressive disorders were identified for the Depression Registry, using data from the VA Patient Treatment File (PTF), Bed Census Files, and Outpatient Care Files (OPC) located at the Austin Automation Center in Austin, Texas. All veterans diagnosed with depressive disorder (qualifying ICD-9 codes, 311, 296.3, 300.4, 296.2, 309.0, 293.83, 296.90, 309.1, 296.99, 301.12) in either inpatient or outpatient settings from Fiscal Year 1997 through 2002 (FY97- FY02) were included in the registry. The majority of patients had diagnoses of MDD, single and recurrent; dysthymia, or depressive disorder not otherwise specified (NOS). (See appendix A for list of qualifying diagnoses).

NARDEP includes data on patients' demographics, inpatient and outpatient services use, medication use, health care costs, and mortality. Data come from a variety of VA administrative datasets, including the PTF and OPC datasets (demographic, diagnostic, services utilization data), the Allocation Resource Center (cost data), the Pharmacy Benefits Management Group (outpatient medications), the Beneficiary Identification and Records Locator System (mortality data), and the Planning Systems Support Group (distance to service facilities).

A total of 542,075 veterans were diagnosed with depression during a visit to specialty care or primary care in FY02. 331,399 of these patients had at least one visit with a diagnosis of depression in specialty mental health settings, while 210,676 had a visit with a diagnosis of depression only in primary care. We excluded patients from the depression registry who had a diagnosis of Bipolar I during the year, leaving 305,122 patients receiving treatment in specialty mental health and 204,272 receiving treatment only in primary care. Approximately 47,860 patients who received a diagnosis of depression only in primary care setting were seen in specialty care, but received a different psychiatric diagnosis.

Given SMITREC's focus on the patients with serious mental illness, the 2002 NARDEP Report focuses on the 305,122 of the 542,075 patients with depressive disorders who were seen at least once in specialty mental health settings in FY02. Specialty patients are more likely to have moderate to severe depressive disorders (Kessler et al. 2003). However, we present limited information in Chapter 8 on the 204,272 patients who received a diagnosis of depression only in a primary care setting.

Note: (Mental health and primary care settings were defined using VA clinic stops and bed section codes; see Appendix A for the list of clinic stops and bed section codes used to define locale of mental health care).

Limitations

Using administrative data to monitor patient care has both advantages and disadvantages. Administrative data are readily available, relatively inexpensive to obtain, and can be used to monitor large populations, such the population of patients receiving depression treatment in the VA.

However, administrative data have significant limitations. VA administrative data contain few clinical or functional data, aside from diagnostic information (ICD-9 codes) and Global Assessment of Functioning (GAF) scores. Chronic medical conditions are often undercoded and diagnostic codes inadequately convey information about the severity of patients' illnesses. Procedures may also be undercoded, particularly in the VA setting where reimbursement is not tied to coding and billing. Coding of clinical events is retrospective, and the timing of clinical events may not be reflected in administrative

data. Finally, coding may vary across VAMCs and VISNs, decreasing the comparability of these data.

Because patients were included in the National Depression Registry on the basis of a depression diagnosis, we did not include patients whose depression was not recognized by their physicians or patients who were recognized and treated with antidepressants but did not receive a formal depression diagnosis. . Data from primary care studies of depression in the VA indicate that between 30- 50% of depressed veterans had not spoken with their provider about depression, been referred for therapy, or treated with antidepressants in the last 6 months." (Chaney and Rubenstein, personal communication). Using diagnoses as inclusion criteria increases specificity, with fewer "false positive" patients, but also decreases sensitivity. We note that patients who receive depression diagnoses may also be treated by physicians who are more attuned to depression care and more likely to provide treatment that approximates guideline recommendations (Spettel et al. 2003).

Because of these limitations, the NARDEP report should be used primarily for descriptive purposes and to identify areas of care for depressed veterans that may need further examination. With the growing availability of electronic clinical information, the limitations of administrative data will decrease in the future, increasing its utility for quality management activities.

Key Registry Findings for FY 2002

- In FY02, the VHA provided care to nearly 305,122 veterans with a depression diagnosis in specialty mental health settings. An additional 204,272 patients with a depression diagnosis were seen only in primary care.
- The majority (54%) of veterans in the NARDEP had an additional psychiatric diagnosis in FY02; 40% had one comorbid psychiatric diagnosis and 20% had two or more comorbid diagnoses.
- PTSD and substance abuse were the most commonly diagnosed comorbid psychiatric conditions.
- 88% of depressed veterans had a comorbid medical condition, with the most common disorders being hypertension and arthritis

- 87% of NARDEP patients received an antidepressant prescription in FY02. Trazodone was the most widely used antidepressant, likely because of its hypnotic effects. Sertraline was the second most widely used antidepressant.
- 20% of all patients in the depression registry had some hospital-based utilization in FY02, with 10% of patients having a psychiatric admission and 12% having a non-psychiatric admission.
- The average number of outpatient mental health clinic stops per patient in FY02 was 13 (median of 4). The average number of non-mental health clinic stops in FY02 was 21 (median of 14).
- Approximately \$3 billion was spent in FY02 on this population for medical and psychiatric care. Twenty-seven percent of these costs were for psychiatric care.