DOES THE SHORT-TERM ADMINISTRATION OF A BENZODIAZEPINE IMPROVE COMPLIANCE WITH ANTIDEPRESSANT THERAPY?

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OBJECTIVES: Several recent clinical guidelines recommend using benzodiazepines as a bridging agent with antidepressants. Studies show that benzodiazepines may reduce the initial side effects associated with antidepressants such as jitteriness and therefore increase compliance. The goal of this study is to examine whether compliance or persistence is higher in patients taking benzodiazepines and antidepressants as compared to those taking antidepressants alone.

METHODS: Data came from the Medstat Markset insurance claims database which includes claims from several million persons with private health insurance. Individuals were included if they met the following inclusion criteria: 18 years of age or older on January 1, 1999; prescribed an antidepressant within a 2 year time frame (1999 to 2000); enrolled for at least 60 days after the first date of the first antidepressant prescription, and not prescribed an antidepressant within a baseline period of 60 days. Individuals were defined as benzodiazepine and antidepressant users if they had filled a prescription for benzodiazepines in the 30 days prior or 30 days after the prescription for the antidepressants. Individuals were considered as having persistence if they either: had at least 2 prescriptions for an antidepressant occurring within 60 days of each other, or had one antidepressant prescription with a greater than a 30-day supply. Multivariate logistic regression analysis was estimated where persistence was the dependent variable and the controls included age, gender, and diagnosis.

RESULTS: Persons taking benzodiazepines in conjunction with antidepressants had 1.11 times the odds of having persistence versus persons taking an antidepressant as a monotherapy.

CONCLUSIONS: Physicians should consider using benzodiazepines to improve compliance with antidepressant therapy.

POLYPHARMACOTHERAPY OF INPATIENTS WITH SCHIZOPHRENIA

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OBJECTIVE: To examine recent pharmacologic treatment patterns for hospitalized schizophrenia patients.

METHODS: Premier’s PerspectiveTM database, the largest U.S. hospital drug utilization database, was used to identify hospitalized schizophrenia patients discharged between January 1999 and September 2001. Treatment regimens for five classes of psychotropics were analyzed. Regressions examined relationships between polypharmacy patterns and diagnoses, illness severity, and patient and institution characteristics.

RESULTS: Of 42,233 patients (55% male, mean age 42 years), 94.9% received antipsychotics; 74.4% atypicals, most commonly olanzapine (46.5%). Mood stabilizers were used by 40.9% of patients, antidepressants by 47.6%, anxiolytics by 66.8%, and hypnotics by 23.4%. Only 7.9% of patients received monotherapy. On average, patients received 3.67 psychotropics; 74.2% received 3 and 27.4% received 5 psychotropics. Most common regimens were antipsychotic and anxiolytic combinations (13.6%); this combi-
nation plus either antidepressants (12.2%), mood-stabilizers (10.5%), or both (9.9%); and antipsychotics alone (9.6%). Greater severity, female, paranoid or schizoaffective diagnoses, non-teaching and for-profit hospitals were associated with increased polypharmacy use. Patients in public programs (Medicaid/Medicare) received less atypical antipsychotics but more polypharmacy compared to those in managed care and commercial programs. Atypical antipsychotic use increased and lithium use decreased from 1999–2001. CONCLUSIONS: Polypharmacy is common among hospitalized schizophrenia patients. Patient and institution characteristics influenced treatment.

**PMH14**

**CLINICAL PROFILES OF SSRI USERS: FACTS EXTRACTED FROM HEALTH CARE CLAIMS DATA**

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**OBJECTIVES:** The Clinical Care Groups™ (CCG) software transforms fragmented claims data into episodes of medical conditions. The results of health care claims data grouped by CCG indicate that many SSRI claims are not grouped into a medically related episode. Our objective is to describe the clinical profiles of SSRI users who have ungrouped SSRI claim(s).

**METHODS:** A random sample (N = 1,400,000) of individuals was generated for the study from de-identified health care claims data of a large U.S. health plan. Individuals who had been continuously enrolled in the health plan for the 24-month full period between April 1, 1999 and March 30, 2001 were eligible for the study. Those with at least 1 SSRI pharmacy claim were selected (N = 74,739). An equal number of individuals without SSRI claims were also selected. Medical and pharmacy claims data were run through CCG version 3.1 and generated the following groups of individuals: Group A consisting of non-SSRI users; Group B consisting of individuals with grouped SSRI claims; and Group C consisting of individuals with at least one ungrouped SSRI claim.

**RESULTS:** The average age in each group was: A—36, B—42, and C—45. Prevalence of SSRI indicated disorders in each group were: A—54, B—724, and C—56 (cases/1000 members). On average, individuals in group C had 7 SSRI prescriptions whereas individuals in group B had 9. The average health care utilization for each group was: A—$4051, B—$9574, and C—$7920. The average number of unique providers visited for each group was: A—9.5, B—16.5, and C—13.4. Of the grouped SSRI prescriptions, psychiatrists prescribed 23.0% whereas only 7.6% of the ungrouped SSRI were prescribed by psychiatrists. **CONCLUSION:** Significant differences exist between individuals with and without ungrouped SSRI prescriptions and may illuminate the cause of ungrouped SSRI prescriptions.

**PMH15**

**PREDICTORS OF DURATION OF VISITS AMONG PATIENTS DIAGNOSED WITH DEPRESSION IN THE AMBULATORY MEDICAL CARE SETTINGS**

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**OBJECTIVE:** This study was designed to identify predictors of duration of visits among patients diagnosed with depression in the ambulatory medical care settings.

**METHOD:** Data from the 1999 National Ambulatory Medical Care Survey (NAMCS) were used to identify patients 10 to 75 years old with a documented diagnosis of depression (ICD-9-CM = 296.2–296.36; 300.4 or 311). The unweighted sample size was 826. Multivariate linear regression was used to identify the predictors. Model variables included patients’ characteristics, treatment patients received, and physicians’ characteristics. **RESULTS:** Among the factors predictive of the duration of visits, significant factors include female patients, Medicaid patients, capitated payment, seen by other providers and receipt of psychotherapy. After controlling for other factors, physicians spend about 2.19 (95% CI: 0.03, 4.35) minutes longer with female patients during the visit than male patients; physicians spend 8.13 (95% CI: 1.93, 14.32) minutes less with Medicaid patients compared with patients with private insurance; Physicians spend 8.57 (95% CI: 3.96, 13.18) minutes less with patients in a capitated visit compared to a non-capitated visit; Established patients receive 12.30 (95% CI: 5.30, 19.31) minutes less with the physician provider compared with non-established patients; Patients who receive care from other providers besides a physician such as a physician assistant, a nurse practitioner, a nurse midwife, a R.N., a L.P.N., a medical or nursing assistant spend 6.96 minutes (95% CI: 3.14, 10.77) less with the physician compared with patients who don’t receive care from other providers. Patients who receive psychotherapy spend 15.60 (95% CI: 11.04, 20.06) minutes more than patients who don’t receive psychotherapy. **CONCLUSION:** Medicaid, capitation payment and seen by other providers were three significant and negative predictors of the duration of the visit. Economic incentives may cause providers to spend less time with patients or substitute with relative cheaper health care professionals.

**PMH16**

**PREVALENCE AND TRENDS IN ANTIPSYCHOTIC POLYPHARMACY AMONG MEDICAID ELIGIBLE SCHIZOPHRENIA PATIENTS IN CALIFORNIA AND GEORGIA, 1998–2000**

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**OBJECTIVES:** To estimate the prevalence and trends of antipsychotic polypharmacy, categorize polypharmacy according to the type of antipsychotic and duration of use, and contrast polypharmacy usage patterns with pub-