employed to predict the probability of having mania-related visits in pre-index or post-index period from treatments and time fixed-effect, controlling for other covariates. **RESULTS:** The ordinary regression indicated a protective effect on mania-related visits from antidepressant monotherapy compared to mood stabilizer monotherapy (OR = 0.66, 95% CI: 0.49–0.90), without good control of baseline disease severity. Both propensity score weighting and matching generated statistically indifferent outcomes when background characteristics are quite different and/or not all potential confounders can be correctly measured and fully controlled in the model. DD model may be considered in outcome studies when pre-and-post data structure is available.

**OBJECTIVE:** To assess treatment adherence to antipsychotic monotherapy in bipolar/manic disorder. **METHODS:** A total of 18,158 antipsychotic monotherapy treatment episodes for bipolar and manic disorders were identified from a claims database (1999–2003) representing 50 million US insured. Adherence measures included treatment compliance, captured by regularity of prescription refills, and treatment duration. Atypicals included risperidone, olanzapine, quetiapine, and ziprasidone; conventional agents included haloperidol, perphenazine, thioridazine, and thiothixene. Multiple regression adjusted for patient characteristics. **RESULTS:** Quetiapine alone had significantly (P < 0.05) greater compliance than the conventional agents and had the highest compliance among the atypicals, which was significantly greater than for risperidone or olanzapine. Olanzapine and ziprasidone demonstrated significantly greater compliance than risperidone. Daily dose was negatively associated with compliance for all agents except quetiapine (P < 0.05 for risperidone and the conventional agents), which had a positive, but non-significant association (P = 0.074). Quetiapine and risperidone had significantly longer treatment duration than olanzapine, ziprasidone, and the conventional agents. All atypicals, except ziprasidone, had significantly lower odds of switching to another psychotropic compared with conventional agents; quetiapine had the lowest estimated odds ratio. **CONCLUSION:** According to claims data, treatment adherence for quetiapine appears higher than for other agents commonly prescribed for bipolar/manic disorder, possibly due to more favorable tolerability.

**Mental Health—Depression**

**PMH18**

**AN EXPLORATORY STUDY TO DEVELOP A MODEL OF QUALITY OF LIFE FOR BIPOLAR DISORDER**

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**OBJECTIVES:** To derive a patient-based model of quality of life (QoL) for bipolar disorder (BDP). **METHODS:** Qualitative research methods were employed to investigate the impact of BPD on QoL. Specifically, to identify how patients perceive their condition to affect their life quality and how they define “QoL.” Semi-structured interviews were conducted with women with a clinical diagnosis of BPD. Interpretive phenomenological analysis (IPA) was used to explore and interpret participants’ perceptions of QoL impact. IPA involves two stages: a case-by-case thematic analysis, and an interpretive analysis to connect and cluster themes. For the latter, emphasis was placed on interpreting the meaning and importance ascribed by patients to the impact of BPD. The data were then compared to existing models of QoL to derive a QoL model for BPD. **RESULTS:** As IPA requires small sample sizes, interviews were conducted with four women (26–92 (mean 49.5) years). Psychometric tests were employed to ensure that the women were not currently depressed (BDI) or manic (SCAN, MRS). Analysis revealed that BPD has a profound impact on affected individuals. Thematic analysis identified key areas of impact including; social life, personal relationships, self-esteem, work life, fear of rejection and impact on day-to-day activities. Interpretive analysis revealed eight key thematic clusters including; intimate personal relationships, social impact and personal development/fulfillment. Relating these to existing models of QoL suggested that a needs-based model of QoL impact was the most appropriate for BPD. The model suggested that areas of need adversely affected by BPD related to; safety and security, belongingness and love needs; esteem; cognitive needs and self-fulfillment. **CONCLUSION:** BPD impacts many life areas. Application of IPA revealed that the needs-based model of QoL can successfully be used to explain the patient’s perception of, and response to, the symptomatic and functional impact of the condition.

**PMH19**

**TREATMENT ADHERENCE WITH ANTIPSYCHOTICS AMONG BIPOLAR AND MANIC PATIENTS**

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**OBJECTIVE:** To assess patterns of dementia/Alzheimer management among elderly patients in US ambulatory care. **METHODS:** A cross-sectional study was conducted using 2000–2002 National Medical Care Survey among elderly patients over the age of 60. Dementia/AD status was defined according to dementia-related ICD-9 codes; additionally, patient visit characteristics and CEA prescriptions associated with dementia/AD status were evaluated using a logistic regression model. **RESULTS:** A total of 25,561 patient visit records were identified. Majority of the visits were from white patients (90.2%) and approximately half of them were made by male individuals (45.9%). Of the total visits, only 0.6% (155) had dementia/AD status. Most of the dementia/AD visits were made by women (60.0%) and persons over the age of 75 (67.7%). Dementia/AD visit records were predominantly from white patients (93.5%) and were associated with public insurance (74.8%; Medicare/Medicaid). Of the dementia/AD visits, about half (46.6%) were prescribed with one or more CEA and donepezil HCl was the most prevalent agent that was prescribed (31.6%). Our logistic regression model evaluating predictive factors of CEA prescription revealed that physician’s specialty was a strong predictor in the model; as psychiatrists (OR = 5.5; p < 0.01) and neurologists (OR = 2.6; p < 0.03) were more likely to prescribe CEA as compared to other physicians. No other visit characteristics showed significant association with CEA use. **CONCLUSION:** Early detection and treatment of dementia delays the progression of cognitive impairment. Considering the high prevalence of dementia/AD among the elderly (8–10%) in the US, the study’s results show that dementia man-
agement in ambulatory care setting is suboptimal as less than 1% of the visits were diagnosed with dementia/AD and only half of them had CEA therapy. Additionally, our findings demonstrate that physicians specialized in psychiatry and neurology predominantly provide ambulatory care services for dementia patients.

COSTS OF DEMENTIA AMONG COMMUNITY DWELLING PATIENTS

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OBJECTIVES: Analysis was conducted to estimate annual direct medical costs for community dwelling persons with dementia and to determine the proportion of costs in various categories paid by various payers. METHODS: Retrospective analysis was conducted of the 2001 Medical Expenditure Panel Survey. The survey provided data from a sample of 33,556 respondents and is representative of the civilian, non-institutionalized population of the United States. Dementia patients were identified using ICD-9-CM codes. For each patient with dementia, one patient without dementia was randomly selected matched on age, gender, race, and number of medical conditions. Medical care costs for each service component were calculated and compared. The proportion of medical care costs paid by each payer was calculated for dementia patients. Sample estimates were projected to the population and standard errors were calculated using the Taylor expansion method. RESULTS: In 2001, the mean total health care expenditure per patient with dementia was $12,310, while the mean total expenditure for a matched patient without dementia was $7,300. Among dementia patients, the highest proportion of costs were for inpatient hospital stays at $4,709 (SE = $727), followed by home health care at $3,703 ($450). Patients with dementia had a significantly higher mean number of home health provider days at 74.6 days (10.5), compared to patients without dementia, 3.8 days (1.0). The major sources of payments for health care expenditures of dementia patients were Medicare (38.3%) and out-of-pocket payments (32.6%). Approximately 62% of prescription drug expenditures among dementia patients were paid out-of-pocket. Incremental costs per patient with dementia were $5010, or a total cost of $8.3 billion attributable to dementia in community dwelling patients. CONCLUSIONS: Community dwelling dementia patients cost approximately 1.7 times more than similar patients without dementia. A high proportion of total expenditures, especially prescription drug expenditures among dementia patients were paid out-of-pocket.

PREDICTORS OF HEALTH RELATED QUALITY OF LIFE AMONG DEMENTIA CAREGIVERS: A LONGITUDINAL EXAMINATION

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OBJECTIVES: Poorer health related quality of life (HRQOL) has been observed among dementia caregivers relative to the general population. However, the temporal stability of and factors associated with caregiver HRQOL have been little studied. METHODS: Dementia caregivers were randomized to one of two treatment arms: a multi-component, psychosocial intervention aimed at increasing social support (n = 69) or to a usual care, control group (n = 65). Caregiver HRQOL was assessed over a two-year period using a Visual Analogue Scale (VAS), the Health Utilities Index Mark III (HUI), and the SF-36 (physical health [PCS] and mental health [MCS] summary scores). Patient-specific and caregiver-specific data were collected every four-months during the first year and every six-months thereafter. A step-wise, mixed-model approach was employed to assess the association of treatment-, patient-, and caregiver-specific variables to caregiver HRQOL. RESULTS: None of the patient demographic variables was associated with caregiver HRQOL. Caregiver gender, health status and depression along with patient dementia severity were all inversely associated with the VAS, but patient nursing home placement was positively associated. Caregiver age, health status and depression were inversely associated with the HUI. Dementia severity and caregiver depression were inversely associated with the MCS. Caregiver gender and health status were inversely associated with the PCS. Time since enrollment was positively associated with caregiver MCS but inversely associated with caregiver PCS; time was not significantly associated with the VAS or HUI. CONCLUSIONS: A number of patient-, caregiver-, and time-related variables were differentially associated with the disparate measures of HRQOL. Caregiver depression and health status are consistently associated with poorer HRQOL regardless of instrument used to measure it. The VAS and HUI appear to be more stable measures of HRQOL than the summary scores from the SF-36. However, small sample size and methodological limitations temper these findings.