ments. The Transactional Model of Stress and Coping was used as the theoretical framework for the study and self-report data on diabetes-related stress, views of diabetes, coping and HRQoL were obtained. The Short-Form 8 (SF-8) was used to measure HRQoL by determining the overall mental component (MCS) and physical component scores (PCS). Path analysis via multiple regression analysis was used to evaluate the relationships proposed in the study model. Age, gender, race, education, marital status, insurance, smoking, insulin use, body mass index, Charlson comorbidity score, history of depression, duration of diabetes and HbA1C values were incorporated into the model as control variables. RESULTS: A total of 217 surveys were collected with a usable response rate of 93%. The mean age of the overall sample was 57.3 years (SD = 11.9), 62.2% were female and 61% were Hispanic. High diabetes-related stress was associated with a negative view of diabetes (β = 0.60, p < 0.001). A negative view of diabetes was associated with decreased use of problem-focused coping (β = -0.23, p < 0.05), increased use of avoidance (β = 0.32, p < 0.001), passive resignation (β = 0.64, p < 0.001) and poor diabetes integration (β = 0.57, p < 0.001). Passive resignation coping was in turn associated with a lower PCS (β = -0.20, p < 0.01). Lower MCS was associated with passive resignation (β = -0.21, p < 0.01) and poor diabetes integration (β = -0.20, p < 0.01). CONCLUSIONS: Passively resigning oneself to diabetes was found to be associated with a lower PCS and MCS. Poor integration of diabetes into one's life was also associated with lower MCS. Stress management and coping skills training may improve HRQoL in patients with T2DM.

FORMULARY/PRESCRIBING

USE OF MEDICATION COVERAGE METHODOLOGY IN MEASUREMENT OF PATIENT COMPLIANCE WITH PHARMACOTHERAPY
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OBJECTIVES: The measurement of patient compliance to medications in a large database analysis presents inherent challenges, such as concomitant prescriptions, switches and add-ons. The Medication Coverage (MC) methodology is an application of the Medication Possession Ratio (MPR) that allows for consideration of multiple prescriptions simultaneously or serially. The benefits of this approach to outcomes research are explored. METHODS: In 3864 patients with primary open-angle glaucoma (POAG), a prescription for a glaucoma medication, and a minimum 2 years of continuous enrollment post-index date (date of first glaucoma therapy) were identified within the PharMetrics database. MC was calculated as the proportion of days a medication was filled divided by the number of days in the month. The Mc was 0.47 and 75th percentile MC was 0.67. Coverage was normally distributed. Logistic regression models showed that as severity of POAG patients increases, compliance with pharmacotherapies is increasingly associated with a reduced risk of glaucoma surgery. CONCLUSIONS: MC can be used to examine patient compliance with medication in large retrospective data-base analyses. This technique allows for analysis of patient compliance to medication while considering concomitant medications and various treatment patterns.

COST-EFFECTIVENESS OF A GLAUCOMA-SCREENING PROGRAM: A MODEL EVALUATING THE RELATIVE CLINICAL AND ECONOMIC IMPACT IN COMMERCIAL VS. SENIOR MEMBER POPULATIONS
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OBJECTIVES: Positive return on investment (ROI) for disease management (DM) programs has generally been limited to those managing congestive heart failure or multiple disease conditions. It is the objective of this model to evaluate the ROI of a glaucoma-screening DM program in Commercial vs. Senior member populations. METHODS: An interactive Excel-based 14-year economic model previously developed to assess the payer costs associated with screening and early treatment of glaucoma patients vs. non-screening of asymptomatic progressive disease was extended to dynamically model the drug treatment component. Treatment costs and disease progression rates were taken from the published literature. Drug costs were based on average wholesale price cost with consideration of contractual discounts and patient co-payment. The primary economic endpoint was the ratio of reduced annual treatment costs compared to annual program costs. Multi-factor sensitivity analyses were conducted. RESULTS: In a Commercial population, total annual costs to “screen and treat” vs. a strategy of no screening was estimated to be $0.62 PMPM vs. $0.80 PMPM respectively (a difference of $0.12 PMPM in favor of screening). In the Senior population, these costs were estimated to be $6.66 PMPM vs. $7.94 PMPM respectively (a difference of $1.28 PMPM in favor of screening). With estimated program costs of $0.009 PMPM and $0.167 PMPM in the Commercial vs. Senior populations respectively, the calculated potential ROI was estimated to be 2.6 and 1.7 respectively for these programs. CONCLUSION: The early identification and treatment of glaucoma in accordance with established evidence-based clinical practice guidelines represents a more cost-effective strategy as compared to non-screening of at-risk populations. Total annual costs for a glaucoma-screening disease management program are estimated to demonstrate a positive ROI in both Commercial and Senior populations. These findings may help promote the interest of payers in implementing pertinent quality improvement and HEDIS-related efforts.