support and focused behavioral interventions in 10 7-
minute calls over four months by specially trained
primary care nurses and peer support; telephone and
in-person supportive contacts by trained Health Plan
members recovered from depression. Primary outcome
measures were the Hamilton Rating Scale for Depression,
Beck Depression Inventory, Mental and Physical Func-
tioning, Short Form 12, and treatment satisfaction and
medication adherence questionnaires.

RESULTS: Nurse-based telehealth patients with or
without peer support more often experienced 50%
 improvement on the Hamilton at 6 weeks (50% vs. 37%,
P = .01) and 6 months (57% vs. 38%, P = .003), and on
the Beck at 6 months (48% vs. 37%, P = .05), and greater
quantitative reduction in symptom scores on the
Hamilton at 6 months (10.4 vs. 8.1, P = .006). Telehealth
care improved mental functioning at 6 weeks (47.1 vs.
42.6, P = .004) and treatment satisfaction at 6 weeks
(4.41 vs. 4.17, P = .004) and 6 months (4.20 vs. 3.94, P
= .001). Medication adherence was the same in all groups,
and adding peer support to telehealth care did not
improve the main outcomes.

CONCLUSION: Nurse Telehealth Care improves clinical
outcomes of antidepressant treatment, improves patient
satisfaction, and fits well in primary care. The nurse tele-
care program has been implemented in Maine, Ohio and
Southern California.

PMH6
RISK OF DIABETES FOR INDIVIDUALS WITH
SCHIZOPHRENIA TREATED WITH
ANTIPSYCHOTICS
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OBJECTIVES: To assess the incidence of diabetes
for individuals with schizophrenia treated with
antipsychotics.

METHODS: Retrospective analysis of a large, geo-
graphically diverse claims database of insured individuals
identified 815 enrollees aged 18 to 64 who: (1) were diag-
nosed with schizophrenia; (2) were initiated on typical
(n = 353) or atypical (n = 462) antipsychotics between
October 1, 1996 and December 31, 1998; (3) had no use
of any antipsychotics six-month prior-initiation; and (4)
had no diagnosis of diabetes and/or no use of antidi-
betics in the year prior. New onset diabetes was defined
as either two diagnoses for diabetes (ICD9 250.xx) or
prescription for antidiabetics in the year post-initiation.

Logistic regressions were used to compare the odds of
incidence of diabetes, controlling for demographics and
prior-medical comorbidities.

RESULTS: The probability of becoming diabetic was
not significantly different for atypical cohort compared to
typical cohort (odds ratio = 2.533; p = 0.088) or for olan-
zapine cohort versus typical cohort (odds ratio = 1.093,
p = 0.900). Risperidone-treated patients had significantly
higher incidence of diabetes compared to those treated
with typicals (odds ratio = 4.362, p = 0.016). Olanzap-
ine compared to risperidone cohort was associated with
a significantly lower incidence of diabetes (odds ratio =
0.277, p = 0.050).

CONCLUSIONS: The incidence of diabetes was similar
for individuals with schizophrenia receiving treatment
with atypical compared to typical antipsychotic agents.
Additionally, individuals receiving treatment with olan-
zapine compared to risperidone had a lower incidence of
diabetes.

PMH7
OUTCOMES AND COST OF TREATMENT WITH
RISPERIDONE VERSUS OLANZAPINE AMONG
PATIENTS WITH CHRONIC SCHIZOPHRENIA
OR SCHIZOAFFECTIVE DISORDERS
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Pharmaceutica Products, L.P, Titusville, NJ, USA

OBJECTIVES: To estimate clinical outcomes and
associated cost of care of treatment with risperidone
versus olanzapine in patients with chronic schizophrenia
or schizoaffective disorders up to one year following
therapy initiation.

METHODS: A Markov model was developed to estimate
the number of patients who experience side effects
(i.e., extrapyramidal symptoms [EPS], prolactin-related
disorders, weight gain, and diabetes) of antipsychotic
therapies, relapse of psychiatric symptoms as well as dis-
continuation of antipsychotic therapy following these
events at one year; associated costs of care were also cal-
culated. Parameter estimates were based on findings from
a randomized, controlled, clinical trial of risperidone
and olanzapine and other published and unpublished sources.

Analyses were undertaken using second-order Monte
Carlo simulation techniques with 10,000 individual
trials.

RESULTS: The expected number of patients remaining
on initial therapy at one year was higher for risperidone
(76.3% versus 44.7% for olanzapine); the expected
number of months on therapy was lower for olanzapine
(8.0 vs. 10.5 for risperidone). Therapy discontinuation
was primarily driven by patients experiencing increases
in body weight exceeding 5kg since therapy initiation.
Expected mean total costs per month on therapy were 8%
higher for olanzapine ($2,198 vs. $2,033 for risperidone).

CONCLUSIONS: Therapy discontinuation at one year
was lower for risperidone than for olanzapine. Expected
costs of care per month of therapy were also lower.