

OBJECTIVES: Treatment-resistant depression (TRD) occurs in 10%–20% of all diagnosed cases of major depression. There are currently no specific codes to identify TRD in administrative databases. The objectives of this study were to: (1) apply an algorithm to identify TRD-likely patients among a population of Saskatchewan Health (SH) recipients who had a claim with a depression diagnosis and at least one antidepressant prescription between January 1, 1993 and December 31, 1995; (2) determine the prevalence of TRD in this population; and (3) assess differences in costs and resource utilization for TRD-likely versus TRD-unlikely patients.

METHODS: A TRD-likelihood algorithm based on antidepressant switches, titrations and augmentation therapy was applied in a SH claims sample of 13,533 pharmacologically treated depressed patients to determine which were likely to have TRD. Comparisons between the TRD-likely and TRD-unlikely groups in resource utilization and annualized costs were made using Wilcoxon tests for continuous variables and chi-square tests for categorical variables.

RESULTS: 863 patients (6.4%) were identified as TRD-likely. TRD-likely patients had significantly higher costs and resource utilization compared to the TRD-unlikely patients for all measured outcomes. Median annualized costs per patient for hospital, physician and prescription services were CAD\$1403 for TRD-likely and CAD\$548 for TRD-unlikely ($p < .0001$). The median number of health claims per patient was 51 for TRD-likely compared to 27 for TRD-unlikely ($p < .0001$). TRD-likely patients had more physician visits ($p < .0001$) and hospital admissions ($p < .0001$) and had a longer median length of stay (8 days vs. 4 days, $p < .0001$).

CONCLUSION: Patients who have TRD consume significantly more medical resources and have higher medical costs associated with their treatment than non-TRD patients. Additional research is needed to understand the biological and behavioral differences between these populations. Successful management of this sub-population of depressed patients may reduce treatment costs and resource consumption for depression.

PMH16

PREVALENCE AND COSTS OF ACCIDENTS AMONG ATTENTION-DEFICIT/HYPERACTIVITY DISORDER PATIENTS

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OBJECTIVES: This study investigates the impact of Attention-Deficit/Hyperactivity Disorder (“ADHD”) on the prevalence and costs of accidents. The unique contribution of this research is that it estimates a model that predicts the probability of having an accident for individuals with and without ADHD.

METHODS: Administrative claims data from a large employer ($n > 100,000$) were analyzed. ADHD patients were identified as beneficiaries with one or more claims for ADHD in the study period (1996–98). The ADHD patient sample was compared to a matched control sample. In addition to descriptive analysis, multivariate analysis involving logistic regression was used to estimate a model of the probability of having an accident.

RESULTS: ADHD patients have a greater incidence of accidents than their controls (32% v. 20%). However, given that a patient has an accident, the average number of accident claims is the same between both groups (3.6 v. 3.5). Accident specific costs are greater for ADHD patients than controls (\$209 vs. \$131) because patients with this condition are more likely to have accidents. Among patients with accident claims, ADHD patients and controls had statistically similar costs. The multivariate analysis confirms the utilization patterns found in the descriptive analysis. The odds of having an accident for ADHD patients are 1.7 times as great as that for controls after taking account of all the other variables.

CONCLUSIONS: ADHD is a significant predictor of having an accident. However, given that a person has an accident, ADHD patients generally have a similar number of accident claims and costs as their controls.

PMH17

ECONOMICS OF PERSISTENCE WITH INITIALLY PRESCRIBED ANTIPSYCHOTIC IN OLDER PSYCHOTIC PATIENTS AND IN PATIENTS WITH BIPOLAR DISORDER

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OBJECTIVE: To evaluate persistency with various antipsychotic monotherapies and whether improved persistency translates into cost savings.

METHODS: We use longitudinal claims data from 180 MCOs to identify 220 quetiapine patients who were new to therapy and initiated on monotherapy between October 1, 1997 and March 31, 1999 and tracked through June 2000. Matched patients were randomly selected to populate three comparator groups: haloperidol, risperidone, and olanzapine. Primary endpoint was the duration on monotherapy. Secondary endpoint was whether costs decreased with greater duration on monotherapy. Psychiatric related costs were also aggregated by type of service. Analyses consisted of Cox proportional hazard models for time on monotherapy and linear regressions for cost. Three subset analyses were performed: patients aged 45 to 64, psychotic patients 65 or older, and patients with bipolar disorder.

RESULTS: For psychotic patients 45 to 64 years old, quetiapine-treated patients remained on treatment for 284 days vs. 261 days for risperidone ($P = 0.71$), 284 vs. 144 for haloperidol ($P < 0.01$), and 284 vs. 147 for olanzapine ($P < 0.01$). Corresponding cost savings for this age