Continuity of Care Following Hospitalization for Bipolar Disorder in Private Payee Claims

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OBJECTIVES: Poor continuity of care occurs when patients do not follow-up after being discharged from the hospital. In bipolar disorder problems with continuity of care and medication adherence may lead to expensive relapses. The objectives of this research were to: 1) examine the frequency of poor continuity of care for individu- als with bipolar disorder; 2) identify the predictors of poor continuity of care; and 3) evaluate the potential increased psychiatric hospitalization costs. METHODS: Premier linked their PerspectiveTM Comparative Database (PCD), the largest, most detailed, U.S. hospital database, with the administrative claims from a large managed care organization. We identified 319 individuals who had a primary discharge diagnosis of bipolar disorder in the PCD and who maintained continuous eligibility for the 60 days prior and the 180 days following the hospitalization. Good continuity of care was operationally defined as the presence of a psychiatric visit in the 60 days following discharge. Propensity scores were used to correct for background differences between patients with good continuity of care and patients with poor continuity of care. RESULTS: A total of 34.5% of individuals had poor continuity of care. Prior to discharge, individuals who would later have poor continuity of care could be identi- fied. Some variables that independently predicted later poor continuity of care included no psychotherapy visits, no psychiatric visits, substance use diagnoses, and psychiatric hospitalizations. After correcting for background differences, patients with poor continuity of care had reduced mood stabilizer use (94 vs. 116 days, p = 0.008) and twice the psychiatric hospitalization charges ($10,027 vs. $4,892, p = 0.03). CONCLU- SIONS: One in three individuals with bipolar disorder did not have a psychiatric follow-up visit after discharge from the hospital. This poor continuity of care appears to lead to decreased medication adherence and increased psychiatric hospitalizations. An effective, targeted intervention could potentially prevent relapses and reduce health care costs.

TREATMENT PATTERNS BY RACE/ETHNICITY AND INCOME LEVELS AMONG ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD) SUBJECTS TREATED WITH SHORT-, INTERMEDIATE- AND LONG-ACTING STIMULANTS

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OBJECTIVES: This research examines the relationship of ethnicity and income with attention-deficit hyperactivity disorder (ADHD) treatment patterns among subjects on medications of different durations. METHODS: Claims of newly treated ADHD sub- jects, aged 26 years, initially treated with stimulants, and continuously enrolled in a US commercial health plan 6 months prior and 12 months after their first prescription (January 1, 2004 – September 30, 2006) were studied. Subjects took short- (SAS) intermediate: (IAS) and long-acting (LAS) stimulant medication for ADHD. Persistence was defined as the number of days on initial therapy. Adherence was defined as the number of days of initial therapy divided by persistent days. Differences in mean persis- tence and adherence was determined using analysis of variance among ethno- nomic groups. RESULTS: A systematic search of the literature found 42 studies (18–24, 25–34, 35–44, 45–54, 55–64, 65–74 years) in 22 countries. Fema- ne (18–24, 25–34, 35–44, 45–54, 55–64, 65–74 years; p < 0.05) was: the Netherlands: 6.4%, 8.5%, 8.1%, 10.9%, 11.0%, 10.4%, Italy: 11.3%, 8.5%, 8.0%, 11.5%, 16.6%, 18.9%; U.K: 9.8%, 10.8%, 16.4%, 18.1%, 17.0%, 12.9%; Germany: 12.8%, 14.1%, 17.1%, 19.6%, 18.0%, 11.1% France: 15.9%, 17.9%, 21.2%, 20.0%, 19.5%, 19.8%, distribution among female (18–24, 25–34, 35–44, 45–54, 55–64, 65+ yrs: % p-value: the Netherlands: 6.4%, 8.5%, 8.1%, 10.9%, 11.0%, 8.9%; Italy: 11.1%, 8.9%, 12.6%, 15.7%, 16.1%, 18.9%; U.K: 9.8%, 10.8%, 16.6%, 18.1%, 17.0%, 12.9%; Germany: 12.8%, 14.1%, 17.1%, 19.6%, 18.0%, 11.1% France: 15.9%, 17.9%, 21.2%, 20.0%, 19.5%, 19.8%, distribution among female (18–24, 25–34, 35–44, 45–54, 55–64, 65+ yrs: % p-value: the Netherlands: 6.4%, 12.5%, 15.5%, 23.7%, 23.4%, 25.6%; Italy: 16.9%, 19.1%, 22.4%, 28.0%, 27.2%, 27.2%; U.K: 17.1%, 18.2%, 23.0%, 30.1%, 30.0%, 24.8%; Germany: 23.3%, 28.5%, 32.8%, 35.6%, 32.8%, 28.5%, 26.2%; France: 28.5%, 26.2%, 4.5%, 40.3%, 37.5%, General Practitioners were the primary point of diagnosis and source of treat- ment, even though this statistic varied between the countries. CONCLUSIONS: Preva- lence of insomnia appears to be substantial in the studied European nations, with France bearing the most burden (one-in-five and one-in-three males and females respectively in France suffered from this condition). Prevalence peaked among the 45–64 age-group across the countries. Females had substantially higher disease burden across the countries, amounting to as much as 1.5 to 2.5 times more than their male counterparts in certain age groups.

CHRONIC MIGRAINE CRITERIA AND THEIR EFFECTS ON GLOBAL PREVALENCE ESTIMATES: A SYSTEMATIC REVIEW

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OBJECTIVES: The definition of chronic migraine (CM), as opposed to episodic migraine, has evolved over 20 years of clinical study. This systematic review summarized population-based studies reporting CM prevalence and examined how variations in definitions affected estimates. METHODS: We conducted a systematic search of PubMed, Cochrane, and EMBASE. Search terms included chronic migraine, transformed migraine, chronic headache, and prevalence. We included population- based studies in adults and mixed adults/adolescents that estimated CM prevalence (or provided information to calculate estimates). We defined chronicity as a minimum headache frequency of 10 per month or reported “daily” headache. Where available, we combined diagnostic criteria and definitions. Findings were qualitatively summa- rized. RESULTS: Sixteen publications representing 12 unique studies were identified.