mendations reduced 57% the probability of uncontrolled blood pressure. Having uncontrolled blood pressure at the baseline stage increased the probability of loss of control in 166%, and per each unit of increase in body mass index the loss of control increased 7%. CONCLUSIONS: CME intervention improved the medical decision-making process, thus increasing the probability of hypertensive patients to have blood pressure under control.

PCV85 TREATMENT FOR DEPRESSION IN WOMEN WITH HYPERTENSION

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OBJECTIVES: To examine rates of depression treatment and variations in depression treatment by demographic, socioeconomic, access to care, health status, and lifestyle characteristics among women with hypertension.

METHODS: The study design was cross-sectional, using data from the Medical Expenditure Panel Survey (MEPS), large-scale surveys of families and individuals to provide nationally representative estimates of health care use and expenditures. The study included 1304 women aged 22 and older with hypertension and depression, identified from MEPS medical condition files. Antidepressants were identified from prescription drug reports and psychotherapy was identified from outpatient visits files. Depression treatment patterns by demographic, socioeconomic, healthcare access and health status were analyzed using chi-square tests, logistic regression and multistage logistic regressions. All analyses accounted for the complex design of the MEPS using SAS 9.2.

RESULTS: In our study sample, 23.9% had no depression treatment, 56.8% had antidepressant use only, and 19.3% had psychotherapy with or without antidepressants. Among women with hypertension and depression, African Americans (AOR = 0.47), Latina (AOR = 0.50), and those insured (AOR = 0.39) were significantly less likely to report any treatment for depression compared to Whites and those with private insurance. Compared to no treatment, psychotherapy with or without antidepressants was less likely among those with less than high school education and more likely among women reporting fair/poor health. CONCLUSIONS: Nearly one-quarter of women with hypertension did not have treatment for depression. Disparities in depression treatment by race/ethnicity, health insurance, and education status were noted. Further studies need to explore reasons for not receiving depression treatment and whether such lack of treatment for depression is associated with poor health outcomes in these women.

PCV86 INSURANCE STATUS AND THE USE OF ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs) AND ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS AMONG POST-MYOCARDIAL INFARCTION (MI) PATIENTS

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OBJECTIVES: To evaluate the effect of insurance status on the use of ARBs and ACE inhibitors among post-myocardial infarction (MI) patients.

METHODS: The 2007 full-year consolidated data from the Medical Expenditure Panel Survey (MEPS), nationally representative survey, was used and linked with the prescribed medicine data. A cross-sectional survey data analysis was performed to evaluate the use of ARBs and ACE inhibitors in patients diagnosed with Myocardial Infarction (MI) and at least one of the following conditions: patients’ insurance status included the binary variables of ACE inhibitor and ARB usage. A total of 464 post-MI patients were included in the analyses by conducting multivariable logistic regression, controlling for socio-economic and demographic variables.

RESULTS: Out of 464 patients with MI, 67 (14.4%) used only ARBs, 244 (52.5%) used only ACE inhibitors, 15 (3.23%) used both drugs, and 138 (29.74%) used neither ARBs nor ACE inhibitors. Patients with Medicare coverage only and patients without insurance were less likely to use ARBs, compared to patients with private insurance (adjusted OR 0.26, p=0.018; adjusted OR 0.03, p=0.064, respectively). There was no significant difference between health insurance status and use of ACE inhibitors. Furthermore, health insurance status was not significantly different among patients who used neither ARBs nor ACE inhibitors. Among MI patients who used both ARBs and ACE inhibitors, patients with Medicare coverage only were less likely to use both drugs (adjusted OR 0.02, p=0.001), relative to patients with private insurance. Additionally, patients with educational attainment of higher than college degrees were more likely to use both drugs than those who did not finish college degrees (adjusted OR 19.61, p=0.001). CONCLUSIONS: Health insurance significantly affected the usage of ARBs and ACE inhibitors but not less expensive ACE inhibitors. Policy makers need to be aware of the moral hazard arising from the insurance coverage in drug use.

PCV87 FACTORS ASSOCIATED WITH SELECTIONS OF STATINS AMONG ELDERLY PATIENTS

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OBJECTIVES: To assess demographic and clinical factors associated with statin selection among elderly patients.

METHODS: A retrospective cohort study was conducted to examine predictors of statin selection among patients aged 65 years and older who initiated pravastatin (PS) vs simvastatin (SS), atorvastatin (AS), or rosuvastatin (RS) between March 2007 and December 2007. Index statin use was defined as the first statin claim following at least 90 days of no statin access. Multiple logistic regression models were employed to assess predictive factors of PS initiation versus other statin initiations.

RESULTS: Of 96,945 statin users identified, there were 8,165 PS initiators, 38,099 AS initiators, 11,520 RS initiators, and 38,866 SS initiators. Compared to other statin users, a higher percentage of PS initiators were aged 75-85 (PS: 42.3%; SS: 41.0%; AS: 41.1%; RS: 38.0%; P<0.001) and more likely to be female (PS: 56.6%; SS: 51.3%; AS: 51.5%; RS: 55.7%; P<0.001). PS initiators were more likely to have atrial fibrillation (PS: 10.0%; SS: 9.4%; AS: 9.6%; RS: 8.6%; P<0.001) and take warfarin (PS: 10.8%; SS: 10.4%; AS: 10.9%; RS: 9.9%; P<0.001) and triamterene (PS: 3.1%; SS: 2.4%; AS: 2.8%; RS: 2.8%; P<0.001 in the baseline period. A higher percentage of PS initiators took more than 3 unique medications 90-day prior to the index date (PS: 85.4%; SS: 81.8%; AS: 83.0%; RS: 83.9%; P<0.01). After controlling for demographic and clinical characteristics, use of warfarin was associated with initiating PS compared with SS, AS, and RS. Other predictors of PS initiation included prior history of atrial fibrillation, HIV infection and use of calcium channel blockers, ezetimibe, and fenofibrate over the 1-year pre-index period compared with AS and SS. CONCLUSIONS: Patient profiles were different among PS users compared to other statin users. Selection of certain medications were significant predictors of PS initiation among a cohort of Medicare patients.