concomitant antipsychotic therapy, 60 day overlap); concomitant psychotropics (30 day overlap, no polypharmacy); polypharmacy + psychotropics; or monotherapy (no polypharmacy or psychotropics). ICD-9 codes (290.xx-319.xx) were used to identify mental health diagnoses and related hospitalizations. Total health care and drug costs were calculated for 365 days after the index antipsychotic claim. Groups were compared using chi-square and ANOVA tests. RESULTS: A total of 53.1% receiving antipsychotics began and stayed on monotherapy; 39.8% received concomitant psychotropics only; 3.2% polypharmacy only; and 3.9% polypharmacy + psychotropics. Polypharmacy rates varied by year (p < 0.001), declining between 1998 and 2000, then increasing through 2002. Patients receiving polypharmacy were more likely to be male (p < 0.001), have diagnosed schizophrenia (p < 0.001) and a mental health-related hospitalization (p < 0.001). Median total healthcare costs varied by therapy regimen (Mono, $3156; Psycho, $5133; Poly, $6396; Poly + Psycho, $9342; p < 0.001). Median total drug costs varied by therapy regimen (Mono, $1575; Psycho, $3169; Poly, $3838; Poly + Psycho, $5833; p < 0.001). The weighted contribution of total health care costs by regimen was: Mono, 49%; Psycho, 41%; Poly, 4%; Poly + Psycho, 6%. CONCLUSION: Polypharmacy rates were low during the study period, were higher in patients with more severe mental illness, and represented a small yet significant component of health care costs. Future research will investigate predictors of polypharmacy and health care costs.

PMH23

HEALTH CARE RESOURCE UTILIZATION PRE/POST RISPERIDONE LONG-ACTING INJECTABLE TREATMENT INITIATION IN A MANAGED CARE POPULATION

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OBJECTIVE: To assess healthcare utilization and associated cost in schizophrenia and schizoaffective patients pre/post risperidone long-acting injectable (RLAI) treatment initiation. METHODS: A retrospective evaluation utilized pharmacy and medical claims to assess healthcare resource utilization and costs of adult schizophrenia patients from a mental health subset of managed care data. Inclusion criteria required a diagnosis of schizophrenia or schizoaffective disorder, at least one claim for RLAI between December 2003 and June 2004, and six months of continuous eligibility criteria pre and post the initial RLAI claim. The initial RLAI claim served as the index date. The observation period was 12 months, including 6-month pre and 6-month post RLAI treatment initiation where patients served as their own control. Healthcare utilization outcome variables included hospitalizations, emergency room use, outpatient visits, and medications. Costs represent the amount paid by the health plan for services. RESULTS: Results are available for the 26 patients meeting inclusion criteria. Mean patient age was 37 ± 13.4 years, and 53.8% of the population were male. The mean number hospitalizations per patient decreased from 0.77 in the pre-period to 0.35 in the post-period (p = 0.06). The costs for hospitalizations decreased from $14,456 ± $28,745 in the pre-period to $4,201 ± $13,876 (p < 0.05). Outpatient utilization remained statistically unchanged between the pre and post period, while the costs for psychoactive medications significantly increased in the post period. Total healthcare costs trended downward, from an average of $22,650 ± $30,856 in the pre-period to $15,182 ± $18,209 in the post-period (p = 0.09). Sensitivity analyses conducted around the index date resulted in a statistically significant decrease in total health care costs in the post period. CONCLUSIONS: In this US managed care patient population, hospitalization costs significantly decreased post (RLAI) treatment initiation. Future studies with larger sample sizes are needed to confirm findings.

MENTAL HEALTH—Health Care Use & Policy Studies

PMH24

INCREASING FORMULARY ACCESS TO INNOVATIVE DRUGS: EFFECTS ON THE TREATMENT FOR SCHIZOPHRENIA IN A MEDI-CAL POPULATION

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OBJECTIVES: Evaluate the effects of open access to atypical antipsychotics on patients with schizophrenia recently discharged from a hospital. METHODS: Retrospective database analysis of episodes of antipsychotic drug therapy using data from the California Medicaid (Medi-Cal) program. Episodes initiated between January 1994 and August 2000 were included in this analysis. Open access was implemented in October 1997. Selection criteria include a schizophrenia diagnosis; 6 months of data prior to and 12 months of data post episode start and institutionalization in an acute or psychiatric hospital within the prior 30 days. The final data set consisted of 3290 post-discharge episodes of treatment. Multivariate logistic regression models were estimated for the likelihood of using an atypical antipsychotics post-discharge and the likelihood of re-institutionalization in an acute or psychiatric hospital or nursing home. RESULTS: Open access increased the use of atypical antipsychotics by discharged patients by 8-fold (CI: 6.154–10.636). Moreover, use of atypical antipsychotics increased disproportionately for blacks (OR 0.514 vs. 0.914) and for other minorities (OR 0.933 vs. 1.194) relative to white patients. While access to atypical antipsychotics improved for black patients with open access, their use rates were still not equal to white patients. However, the estimated changes in access for other minority patients after implementation of open access did achieve statistical significance such that there was no statistically significant difference compared to whites in the open access period. But, more importantly, open access decreased the risk of re-institutionalization in an acute or psychiatric hospital (OR 0.67, CI: 0.557–0.816) and long term care (LTC) facilities (OR 0.67, CI: 0.493–0.916). CONCLUSIONS: Granting open access to innovative drugs reduced racial disparities in the use of atypical antipsychotics for minority patients upon hospital discharge. Open access reduced the risk of re-institutionalization in acute hospitals and long term care facilities.

PMH25

LEARNING FROM NICE TECHNOLOGY ASSESSMENTS: A CASE STUDY OF ITS RECENT APPRAISAL OF ADHD TREATMENT STRATEGIES

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1Health care policy makers need valid, objective, unbiased, and methodologically sound technology assessments. Frequently the approach established by the National Institute for Health and Clinical Excellence (NICE) is regarded as a reference standard internationally. OBJECTIVE: To use the recent appraisal of attention-deficit/hyperactivity disorder (ADHD) treatments as a case study to explore whether NICE technology appraisals meet quality expectations when addressing complex clinical problems. METHOD: Tracking the ADHD treatment appraisal by NICE