therapy months ranged from $452–$921 for discontinued patients and from $423–$483 for non-switched, continued patients. CONCLUSIONS: Patients who discontinued SSRI therapy early tended to have higher costs than patients who continued therapy. It is unclear whether these increased costs stem from treatment of medication side effects or increased utilization related to lack of efficacy of the initial antidepressant. Alternatively, early switchers may simply be more clinically complex patients.

PMH23
DEINSTITUTIONALIZATION OF SCHIZOPHRENIC PATIENTS: COST-CONSEQUENCES AND POLICY IMPLICATION OF INTENSIVE CASE MANAGEMENT VERSUS STANDARD CASE MANAGEMENT
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OBJECTIVES: In France a large part of acute hospitalisation beds are occupied by long-term hospitalisation of schizophrenic patients. A model was developed to compare Intensive Case Management (ICM) to Standard Case Management (SCM) for long-term hospitalised chronic schizophrenic patients. METHODS: A model was used to evaluate the number of patients that are either successfully dechronized, experiencing failure, or are readmitted to hospital within a year for a cohort of 100 chronic schizophrenic patients. With these figures, it was possible to estimate the needs in terms of number of beds and employees in the catchment area of Clermont-Ferrand in France, for the 1st, 2nd and 3rd year after the ICM strategy have been implemented. RESULTS: At the beginning of the first year, 100 hospitalisation beds, 30 nurses, 10 psychologists and 5 psychiatrists were needed. After 1 year these numbers were respectively reduced to 50, 15, 10 and 2.5 due to the success of the ICM strategy. This positive trend is also recorded for the second year of implementation. At the end of the 3rd year a steady point level is nevertheless reached with the model, due to the fact that there will always be patients that can not be dechronized; the numbers at this point will be 11 beds, 3 nurses, 1 psychologist and a half-time psychiatrist. CONCLUSIONS: Due to the important caseload of ICM, it remains more costly than SCM at implementation, but will reduce cost from year 1, and be less costly than SCM from year 3. This model can therefore evaluate the economic impact of creating a dechronization unit in a catchment area and make budgetary provision for large-scale implementation of ICM in France.

PMH24
THE COST OF ACUTE HOSPITALIZATION FOR ANOREXIA NERVOSA AND BULIMIA
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BACKGROUND: It has been reported that approximately 1% of young women have anorexia nervosa and 4% bulimia. Managing eating disorders requires a multi-disciplinary approach including acute hospitalization, when necessary. This study was undertaken to assess the cost of acute hospital care for these disorders. METHODS: Inpatient cost estimates, adjusted for medical inflation and cost-to-charge ratios, were developed using data from all-payer 1998 discharge databases from five states, supplemented with national fee schedules. ICD9 codes were used to identify those with a principal diagnosis of anorexia (307.1) or bulimia (307.51). Cases where both diagnoses were coded are excluded from results reported here. Log transformation was used to address highly skewed distributions. Length-of-stay (LOS), disposition and psychiatric unit care (PSYU) were also examined. Hospital costs (i.e., accommodation, ancillary, physician) are reported in 2000 US$. RESULTS: The state databases yielded 641 cases of anorexia and 326 of bulimia. The overwhelming majority (>96%) were females. For anorexia: the mean age was 25 years (45% <20 years); mean LOS was 13; 24% received care in a PSYU; 87% were discharged home; 7% went to a rehab or mental health facility (MHF) and 3% left against medical advice (AMA). For bulimia, the mean age was 27 years (25% <20 years); mean LOS was 9; 39% received care in a PSYU; 90% were discharged home; 4% to rehab or MHF; 3% left AMA. The mean total cost per hospital stay was $12,390 for anorexia and $9,120 for bulimia. On average, the number of annual admissions was 1.6 and 1.2 for anorexia and bulimia, respectively. Managed care was the largest primary payer. CONCLUSIONS: Although hospitalization is not the primary site of medical care for managing serious eating disorders, it’s sometimes required. We believe that this information provides an essential piece in understanding the economic consequences of these conditions.

PMH25
A MODEL COMPARING OLANZAPINE AND ZIPRASIDONE IN PATIENTS WITH SCHIZOPHRENIA
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OBJECTIVE: To estimate and compare the efficacy, treatment-emergent adverse events, costs and outcomes of olanzapine and ziprasidone for treatment of schizophrenia. METHODS: A decision-analytic model was used to determine outcomes for patients treated over a 1-year period. Model parameters were based on clinical trial data and published medical literature. Data from different trials were compared only when patient populations were similar. Comparative studies were available for weight gain and cardiovascular events. For essential parameters with no relevant study results, assumptions were made that the medications would be similar. RE-
OBJECTIVE: Comparative cost-effectiveness was assessed in an open-label, randomized trial (QUEST) that compared the efficacy and safety of quetiapine with risperidone in an outpatient population with schizophrenia or other psychotic disorders. METHOD: Based on the overall Positive And Negative Syndrome Scale (PANSS) scores, patients in QUEST were categorized into one of three health states—mild (PANSS <74.5), moderate (PANSS >74.5 and ≤106.5), or severe (PANSS score >106.5)—at baseline and at 2 months and 4 months. Utilities and expected utilities from baseline were calculated. RESULTS: At baseline, 297 (54.0%), 206 (37.5%), and 47 (8.5%) quetiapine patients, had mild, moderate or severe symptoms compared to 102 (59.0%), 55 (31.8%), and 16 (9.2%) in the risperidone group. For patients in the mild or moderate states at baseline, improvements were seen in both treatment groups. For severe patients, more quetiapine patients improved: 21.2% versus 7.7% in the mild state and 60.6% versus 30.8% in the moderate state (p = 0.020) at 2 months and 46.9% versus 0.0% in the mild state and 40.6% versus 62.5% in the moderate state (p = 0.023) at 4 months. Overall, when weighted by utilities, quetiapine treated patients attained greater gains in health state utilities at each follow-up visit for the mild (0.61 ± 0.069), moderate (0.36 ± 0.073) and severe (0.29 ± 0.071) states. At 2-months, quetiapine patients enjoyed a gain of 0.239 from their baseline level compared to 0.175 for the risperidone group. At 4-months, the gains were 0.329 versus 0.184 for the quetiapine and risperidone groups (p < 0.05). Average daily doses were 253.9mg quetiapine and 4.4mg risperidone, yielding average daily costs to US consumers of $6.38 and $7.85. At average retail costs to consumers in the US, quetiapine reduces costs by $1.47/day or $536.55 annually. CONCLUSION: Patients with schizophrenia or other psychotic disorders, treatment with quetiapine resulted in significant effectiveness and cost savings compared with risperidone.

PMH16
OUTPATIENT ANTIPSYCHOTIC USE: COMPARING ATYPICAL AND CONVENTIONAL ANTIPSYCHOTIC ADHERENCE USING A NATIONAL RETAIL PHARMACY DATA BASE
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OBJECTIVES: We report on trends in medication adherence for patients who received conventional and atypical antipsychotics under routine outpatient care during a 9-month period in 1998–9. METHODS: Refill records were analyzed for over 25,000 patients at a national retail pharmacy chain. Persistence was defined as a patient’s possession of medication at 30 day intervals from a patient’s initial prescription. Persistence was taken as a proxy for medication adherence. RESULTS: The percentage of patients adhering to therapy at nine months was 44.4% for atypical agents; 47.6% for conventional agents; and 71.1% for clozapine. CONCLUSIONS: Improved clozapine adherence was associated with a closely supervised medication administration process that ensured patient tracking and frequent and sustained patient-provider contact. Atypical agents, with their improved side-effect profile relative to conventional agents, were not associated with better adherence. These results suggest that improved side-effect profiles alone may not insure higher levels of medication adherence and that improved medication administration processes may facilitate higher levels of outpatient medication adherence for patients with major mental illness.

PMH27
COST-UTILITY ANALYSIS OF QUETIAPINE COMPARED TO RISPERIDONE IN THE TREATMENT OF PATIENTS WITH SCHIZOPHRENIA OR OTHER PSYCHOTIC DISORDERS
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RESULTS: Compared to patients treated with ziprasidone, data seem to suggest that olanzapine patients had a higher response rate, a higher incidence of weight gain, and a lower incidence of QTc prolongation. Total medical cost was higher for ziprasidone patients when the medication cost of ziprasidone was assumed to be more than half the price than that of olanzapine. The olanzapine group’s costs were more sensitive to changes in drug costs, whereas the ziprasidone group’s costs were more sensitive to the response rate of the medication used for those patients not responsive to ziprasidone.

CONCLUSIONS: Compared to ziprasidone patients, olanzapine patients may have a higher response rate, a higher incidence of weight gain, and a lower incidence of QTc prolongation, with lower total costs as long as ziprasidone is more than half the price of olanzapine.

PMH28
DEPRESSION AND HOMELESSNESS, A FRENCH INITIATIVE
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CONTEXT: So-called chronic depression, a limiting factor in terms of social reinsertion, must be diagnosed to enable its management and to prevent a decline towards a profound, desocialised state. OBJECTIVE: To determine the incidence of depression in populations of the homeless, who are users of the Samu Social de Paris—Paris Social Emergencies Unit—(SSP). METHOD: Once an individual had been assessed and a response found to his or her need, it was suggested that patients calling the SSP free-phone number should agree to complete the CES-D questionnaire. Developed in the US by Randloff (1977), this questionnaire enables the detection of depressive symptoms in a given population. Its use over the