ventional, none). RESULTS: Mean age of the sample (N = 1058) was 38 years; 42% were male. The 6-month risk of discontinuation was significantly greater in patients with a Low vs. a High initial dose (HR 0.74; 95% CI 0.58–0.94; P = 0.012) and trended toward significance when comparing a Medium vs. a High initial dose (HR 0.86; 95% CI 0.69–1.10; P = NS). The largest difference in discontinuation rates between dose groups occurred after the first prescription. CONCLUSIONS: Patients initiating ziprasidone therapy with an initial dose of at least 120mg/day demonstrated better medication adherence compared with those initiating at lower doses. This finding may reflect improved efficacy at daily doses ≥120mg.

PMH25

EMERGENCY DEPARTMENTS: THE FRONT LINE OF SCHIZOPHRENIA MANAGEMENT?

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OBJECTIVES: To examine utilization of Emergency Departments (ED) for schizophrenia-related problems during a 1-year period. METHODS: Data from 2001 and 2002 statewide Massachusetts ED and hospital databases were examined for cases with a principal diagnosis of schizophrenia (ICD-9: 295.00–295.95). Cases where injury or non-related medical conditions were coded were excluded. Data were examined for demographics, visit status, arrival time, duration, disposition, cost and repeat visits. Patients admitted were tracked by identifiers in the hospital database. Cost estimates include accommodations, ancillary and physician services, were adjusted for national values and using 0.61 cost-to-charge ratio reported in 2004 in US$. RESULTS: Of 5686 cases identified, 72% were male. Mean age was 46 years (range: 9–90). Visits were distributed evenly Monday through Friday, but decreased on weekends. Almost half (48%) of all visits occurred between 3:00–11:00 PM. Visitation was coded as emergency for 57% of cases. Most (46%) were admitted to acute hospitals, 22% transferred to other facilities, 31% were treated and released from ED, 1% died in ED or left AMA. Mean duration of ED visit was 5.3 hours (median: 4.1). Mean cost per ED visit was $573 (median: $480) for those released or transferred, and $366 for those admitted (median: $329). In 2002, 45% of schizophrenia cases discharged from Massachusetts acute hospitals came through ED. In one year, 28% of those visiting an ED for a schizophrenia-related problem had at least one other schizophrenia-related ED visit (mean revisit: 2.1; range 1–22). Cumulative 1-year ED cost for schizophrenia-related cases was roughly $2.6 million. CONCLUSIONS: The ED is a front line for schizophrenia management, as it provides evaluation and referral services for non-emergent patients, as well as acute treatment. Further research is needed to determine if lack of availability, or access to other mental health services prompted ED use.

PMH26

SSRI UTILIZATION AND PERSISTENCE IN A CALIFORNIA MEDICAID POPULATION

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OBJECTIVES: To investigate utilization and persistence in Zoloft patients versus those on other antidepressants. METHODS: Using a 20% sample of California Medicaid claims data from 1999 to 2003, patients on antidepressants were identified and tracked for 12 months from the first fill date of an antidepressant medication. Utilization patterns (discontinuation, gap, switch, and augmentation events), medication possession ratio (MPR), days covered (DC), and persistence (proportion of patients on initial medication at least 80% of the time) were analyzed. Differences were tested using normal approximation with a 2-sample test. Odds ratios were computed with respect to Zoloft and tested using logistic regression models with propensity scores. RESULTS: A total of 1403 patients were initiated on Celexa, 1309 on Effexor, 10,758 on Paxil, 4631 on Prozac, and 2429 on Zoloft. Proportionally, more Zoloft patients were event-free than Effexor or Paxil patients (p < 0.05), but less so than Celexa. Adjusted odds ratios suggest that patients initiated on Zoloft were more likely to persist with their medication than patients on Effexor, Paxil or Prozac (OR = 0.824, 0.732, 0.762, respectively; p < 0.05). Differences between Zoloft and Celexa (OR = 1.040) were not statistically significant. Zoloft had a higher average MPR than Effexor, Paxil or Prozac, but slightly lower than Celexa (p = 0.0259). All cohorts experienced a decline in days covered (DC) on Day 31, 61, 91, and 181. At the end of follow-up, 29.6% of patients initiated on Zoloft were still taking the medication, which was significantly higher than patients on Effexor (24.3%), Paxil (24.9%) or Prozac (23.7%), but slightly lower than patients on Celexa (32.6%, p = 0.0502). CONCLUSIONS: Patients initiated on SSRI's continue to have relatively fast declines in medication adherence and persistence within the recommended timeline for therapy.

PMH27

THE EFFECT OF RAISING THREE TIER CO-PAYMENTS ON SSRI ANTIDEPRESSANT COMPLIANCE RATES

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OBJECTIVES: 1) To characterize the design of drug benefits of SSRI antidepressants in health plans offered by employers in the United States, and 2) determine the effect of raising co-payments on compliance rates of SSRI antidepressants. METHODS: Data comprised benefit information and claims from Medstat's MarketScan database for 2000–2003. Benefit information was compiled from approximately 135 different plans. Any patient who filled a prescription for an SSRI antidepressant in 2000 and was continuously enrolled through 2001 was identified. A difference in difference approach was used to examine the change in the days supplied and number of claims filled for an employer that raised their 3 tiered co-payments as compared to an employer that kept constant one tier co-payment rates. RESULTS: Three tier co-payment structures were increasingly common among employers. Most SSRI's fall in tier 2 although some of the newer SSRI's are commonly found in tier 3. The average co-payment for tier 1 increased from $5.40 to $7.40. The average co-payment for tier 2 increased from $13.60 to $16.80. The average co-payment for tier 3 increased from $25.40 to $31.20. When the study employer raised their copayments by 50%, they experienced a 25% decline in the number of prescriptions per person filled (from 5.2 to 3.9 prescriptions) from 2000 to 2001, while the control employer demonstrated a 20% decline (from 6.0 to 4.8) in the number of prescriptions filled. Days supplied fell by 41.3 days or 24% in the employer that raised copayments and by 36.3 days or 17% in the control employer. CONCLUSIONS: Benefit structure and co-payments have trended towards 3-tier plans with increasing co-payments. As such, increasing co-payments may have a negative effect on compliance and possibly outcomes.