efficacy profile. Persistence at 6 months is recommended to maximize chances of sustained remission and to avoid relapse; interestingly these results show that persistence is also associated with decreased health care costs. Efforts should be made to promote persistence on antidepressant treatment.

**PMH49**

**EARLY DISCONTINUATION ON TREATMENT AND ITS CONSEQUENCES IN PATIENTS TREATED WITH VENLAFAXINE OR ESCITALOPRAM**

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**OBJECTIVE:** Two-month head-to-head clinical trials of escitalopram and venlafaxine demonstrated similar efficacy and better tolerability for escitalopram. As routine practice may differ from controlled trial, policy makers wonder how clinical trial findings translate into real life outcomes in community practice. This work compares early treatment discontinuation (ETD) rates at 1 and 2 months and its economic consequences at 6 months, for patients with depression treated with venlafaxine and escitalopram. **METHODS:** Using US denominator-based claims database PharMetrics (includes data from 86 managed care health plans covering 45 million patients), we included adult patients diagnosed with depression who started venlafaxine or escitalopram between January 1, and December 31, 2004. We compared ETD at 1 and 2 months using Cox proportional hazard models and health care costs at 6 months, using log-linear regression. Propensity scoring was used to account for channeling by indication. **RESULTS:** A total of 13,227 patients started escitalopram; 5,922 patients started venlafaxine. ETD at 2 months was 47% for venlafaxine, 45% for escitalopram. At 1 month, venlafaxine patients had a 50% greater risk of ETD than escitalopram patients (Hazard Ratio = 0.493 [95%CI 0.432–0.564]); this difference decreased at 2 months (Hazard Ratio = 0.955 [95%CI 0.912–0.999]). Six-month health care costs were higher with venlafaxine (+USD626, p < 0.01). Patients continuing treatment at 2 months had 36% chance of still being on treatment at 6 months. Patients (all treatments) with ETD at 2 months incurred more costs over 6 months (+USD350) compared to patients continuing treatments. **CONCLUSION:** Early treatment discontinuation rate was higher with venlafaxine than escitalopram, possibly due to intolerance to venlafaxine. Absence of ETD was associated with long term persistence and lower total treatment costs.

**PMH50**

**MEDICATION SWITCHING AND THERAPEUTIC POSSESSION RATIO (MPR) IN THE PRESENCE OF MULTIPLE BARRIERS TO THERAPEUTIC ADHERENCE IN VETERANS WITH BIPOLAR DISORDER**

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**OBJECTIVE:** Patients with bipolar disorder are often poorly medication adherent, resulting in deteriorating symptomology, higher admission rates, and diminished quality of life. Many factors are strongly associated with adherence, including financial burdens and multiple psychosocial barriers. However, analyses typically consider these barriers independently rather than conjointly from the patient’s perspective. Such approaches neglect the complex interplay of risk factors, many of which are amenable to health policy or clinical interventions. This study evaluates the differential and cumulative impact of nine barriers upon medication adherence. **METHODS:** We recruited 435 patients from the Continuous Improvement for Veterans in Care—Mood Disorders study (FY04–06). Surveys collected information on multiple adherence barriers: medication copayments, foregoing treatment due to cost, binge drinking, access difficulty, social support problems, poor therapeutic alliance, and low medication insight. Multivariable logistic regression modeled adherence as a function of perceived adherence barriers, controlling for demographics, homelessness, and affectsymptomology. **RESULTS:** Nearly half of the respondents reported adherence difficulty. Patients experienced an average of 2.8 barriers, with 41% perceiving at least 3. Minority veterans reported poorer adherence than white patients (56% versus 40%, p = .01), while claiming more overall barriers, particularly financial burden, binge drinking, and difficulty obtaining psychiatric care when needed. Multivariable models indicated the total number of barriers was significantly associated with poor adherence (OR = 1.24 per barrier). The most significant were low medication insight, binge drinking, and problems accessing care (ORs of 2.41, 1.95 and 1.73, respectively). **CONCLUSION:** Veterans with bipolar disorder experience multiple barriers to medication adherence, a scenario possibly exacerbated by recent copayment increases. Certain psychosocial and financial obstacles proved especially pernicious in connection to worse adherence. Recognizing multiple barriers can assist developing tailored clinical interventions to improve poor adherence by reducing psychosocial risk factors. The interaction with health benefit policies potentially contributes to burdens faced by patients already experiencing adherence problems.

**PMH51**

**A NEW MEASURE OF ADHERENCE—THE DAILY POSSESSION RATIO (DPR): COMPARISONS WITH THE MEDICATION POSSESSION RATIO (MPR) IN THE PRESENCE OF MEDICATION SWITCHING AND THERAPEUTIC DUPLICATION**

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**OBJECTIVE:** The objectives of this study are to describe and define a new adherence measure, the Daily Possession Ratio (DPR), and to contrast that measure with two variants of the Medication Possession Ratio (MPR, truncated MPR). **METHODS:** This study was a retrospective analysis of the North Carolina Medicaid administrative claims data from July 1999 to June 2000. Data for non-HMO, non-hospitalized, non-pregnant schizophrenia patients (ICD-9-CM = 295.4) with at least one antipsychotic were aggregated to the person-quarter level. The daily possession ratio was defined as the number of days one or more antipsychotics was available divided by the total days in the quarter. Adherence rates were also estimated for subjects that switched medications or had therapeutic duplication in the quarter. **RESULTS:** The final sample consisted of 25,200 person-quarters from 7,069 individuals. For person quarters with single antipsychotic use, adherence to antipsychotics as a class was: DPR = 0.607; truncated MPR = 0.640; MPR = 0.695 (p < 0.0001). For person quarters with therapeutic duplication, the following adherence measures were observed: DPR = 0.669; truncated MPR = 0.774; MPR = 1.238 (p < 0.0001). **CONCLUSION:** The DPR provides a more conservative estimate of adherence than the MPR across all type of users, however the differences between the two methods are more substantial for persons switching therapy and prescribed therapeutic duplica-