nation plus either antidepressants (12.2%), mood-stabilizers (10.5%), or both (9.9%); and antipsychotics alone (9.6%). Greater severity, female, paranoid or schizophrenic diagnoses, non-teaching and for-profit hospitals were associated with increased polypharmacy use. Patients in public programs (Medicaid/Medicare) received less atypical antipsychotics but more polypharmacy compared to those in managed care and commercial programs. Atypical antipsychotic use increased and lithium use decreased from 1999–2001. CONCLUSIONS: Polypharmacy is common among hospitalized schizophrenia patients. Patient and institution characteristics influenced treatment.

**CLINICAL PROFILES OF SSRI USERS:**
**FACTS EXTRACTED FROM HEALTH CARE CLAIMS DATA**
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**OBJECTIVES:** The Clinical Care Groups™ (CCG) software transforms fragmented claims data into episodes of medical conditions. The results of health care claims data grouped by CCG indicate that many SSRI claims are not grouped into a medically related episode. Our objective is to describe the clinical profiles of SSRI users who have ungrouped SSRI claim(s).

**METHODS:** A random sample (N = 1,400,000) of individuals was generated for the study from de-identified health care claims data of a large U.S. health plan. Individuals who had been continuously enrolled in the health plan for the 24-month full period between April 1, 1999 and March 30, 2001 were eligible for the study. Those with at least 1 SSRI pharmacy claim were selected (N = 74,739). An equal number of individuals without SSRI claims were also selected. Medical and pharmacy claims data were run through CCG version 3.1 and generated the following groups of individuals: Group A consisting of non-SSRI users; Group B consisting of individuals with grouped SSRI claims; and Group C consisting of individuals with at least one ungrouped SSRI claim.

**RESULTS:** The average age in each group was: A—36, B—42, and C—45. Prevalence of SSRI indicated disorders in each group were: A—54, B—724, and C—56 (cases/1000 members). On average, individuals in group C had 7 SSRI prescriptions whereas individuals in group B had 9. The average health care utilization for each group was: A—$4051, B—$9574, and C—$7920. The average number of unique providers visited for each group was: A—9.5, B—16.5, and C—13.4. Of the grouped SSRI prescriptions, psychiatrists prescribed 25.0% whereas only 7.6% of the ungrouped SSRI were prescribed by psychiatrists. CONCLUSION: Significant differences exist between individuals with and without ungrouped SSRI prescriptions and may illuminate the cause of ungrouped SSRI prescriptions.

**PMH15**

**PREDICTORS OF DURATION OF VISITS AMONG PATIENTS DIAGNOSED WITH DEPRESSION IN THE AMBULATORY MEDICAL CARE SETTINGS**
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**OBJECTIVE:** This study was designed to identify predictors of duration of visits among patients diagnosed with depression in the ambulatory medical care settings.

**METHOD:** Data from the 1999 National Ambulatory Medical Care Survey (NAMCS) were used to identify patients 10 to 75 years old with a documented diagnosis of depression (ICD-9-CM = 296.2–296.3; 300.4 or 311). The unweighted sample size was 826. Multivariate linear regression was used to identify the predictors. Model variables included patients’ characteristics, treatment patients received, and physicians’ characteristics.

**RESULTS:** Among the factors predictive of the duration of visits, significant factors include female patients, Medicaid patients, capitated payment, seen by other providers and receipt of psychotherapy. After controlling for other factors, physicians spend about 2.19 (95% CI: 0.03, 4.35) minutes longer with female patients during the visit than male patients; physicians spend 8.13 (95% CI: 1.93, 14.32) minutes less with Medicaid patients compared with patients with private insurance; Physicians spend 8.57 (95% CI: 3.96, 13.18) minutes less with patients in a capitated visit compared to a non-capitated visit; Established patients receive 12.30 (95% CI: 5.30, 19.31) minutes less with the physician provider compared with non-established patients; Patients who receive care from other providers besides a physician such as a physician assistant, a nurse practitioner, a nurse midwife, a R.N., a L.P.N., a medical or nursing assistant spend 6.96 minutes (95% CI: 3.14, 10.77) less with the physician compared with patients who don’t receive care from other providers. Patients who receive psychotherapy spend 15.60 (95% CI: 11.04, 20.06) minutes more than patients who don’t receive psychotherapy.

**CONCLUSION:** Medicaid, capitation payment and seen by other providers were three significant and negative predictors of the duration of the visit. Economic incentives may cause providers to spend less time with patients or substitute with relative cheaper health care professionals.

**PMH16**

**PREVALENCE AND TRENDS IN ANTIPSYCHOTIC POLYPHARMACY AMONG MEDICAID ELIGIBLE SCHIZOPHRENIA PATIENTS IN CALIFORNIA AND GEORGIA, 1998–2000**
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**OBJECTIVES:** To estimate the prevalence and trends of antipsychotic polypharmacy, categorize polypharmacy according to the type of antipsychotic and duration of use, and contrast polypharmacy usage patterns with pub-
lished treatment guidelines. METHODS: Medicaid recipients at least 16 years of age with at least one primary diagnosis of schizophrenia (ICD-9-CM = 295) between 1998–2000 were identified from the Georgia and California (20% random sample) Medicaid claims databases. Polypharmacy cohorts were built in a hierarchical fashion based on the antipsychotic use profile of the schizophrenic patients and in accordance with published treatment guidelines i.e. any polypharmacy, clozapine (clozapine + atypical; clozapine + conventional), non-clozapine (atypical + atypical; conventional + conventional; and atypical + conventional) and long-term i.e. duration of use >2 months. Total 3-year prevalence of polypharmacy, mean/median duration of episodes and year wise trends in usage were estimated. All results were reported by state and in aggregate. RESULTS: Out of a total of 31,435 persons with schizophrenia, the overall prevalence of antipsychotic polypharmacy was 40% (n = 12,549, mean age: 43 years, Caucasian: 47%, female: 48%) over 1998–2000 and was 46% in California compared to 35% Georgia (p < 0.0001). Long-term polypharmacy (exposure > 2 months) had a prevalence rate of 23% (n = 7222) with a long-term episode lasting a median of 197 days. Among the long-term groups, non-clozapine polypharmacy was around 8 times more prevalent than clozapine polypharmacy (p < 0.0001) and long term non-clozapine atypical + conventional had the highest prevalence of 16%. Except for clozapine + conventional (no change) and conventional + conventional (decreased) polypharmacy, all polypharmacy prevalences increased from 1998 through 2000 (Cochran-Armitage test; p < 0.0001). CONCLUSIONS: The overall polypharmacy prevalence rate of 40% is similar to that observed in other studies. Average long-term polypharmacy with a median duration of over 6 months and significantly higher prevalence of non-clozapine vs. clozapine polypharmacy contradicts treatment guidelines and may be a cause for concern.

PMH17

USE OF SEDATIVE/HYPNOTIC AGENTS BY AN ELDERLY AMBULATORY POPULATION
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OBJECTIVES: The purpose of this study was to investigate use of sedative/hypnotic drugs in a generally ambulatory population of persons 65+ years of age. Clinical literature suggests that use of these agents is accompanied by physical and mental functioning declines that pose particular concerns for non-institutionalized older individuals. METHODS: Retrospective analysis of sedative/hypnotic claims from a database. Persons with at least one prescription for a sedative/hypnotic in a 12-month study period (January 1, 2001–December 31, 2001), who were 65 years of age or older and were continuously enrolled in the 6 months prior to the end of the study period were included. Sedative/hypnotic agents included barbiturate and non-barbiturate sedative hypnotics alone or in combinations. Claims histories were used to identify naïve users; current use was categorized as acute, limited, or continuous based on days supply and refill patterns. RESULTS: Eight and a half percent of the 313,038 persons meeting inclusion criteria had at least one claim for sedative/hypnotic agents. Of these 38% (n = 10,010) were classified as naïve users. For these patients the mean number of days of therapy for the initial prescription was 28.0 ± 15.1. Only 9% of naïve users received an initial prescription for less than a 10 day supply; 8% received initial prescriptions for >31 days; some up to a 90-day supply. Short-term use was identified in less than 1/3 of naïve users; 15% continued sedative/hypnotic use for greater than 3 months. Twenty-eight percent of naïve users received prescriptions for agents identified as potentially inappropriate in elderly patients (21% received a “never-use” drug). CONCLUSIONS: Sedative/hypnotic utilization patterns in elderly ambulatory patients, particularly the evidence of non-adherence to clinical prescribing recommendations related to initial drug selection and days of therapy, should be of concern.

PMH18

RETROSPECTIVE DRUG USE EVALUATION OF ANTIPSYCHOTIC AGENTS IN THE VETERANS ADMINISTRATION SYSTEM: A POPULATION BASED APPROACH
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OBJECTIVES: To examine treatment and pharmaceutical utilization patterns for patients receiving risperidone, olanzapine or quetiapine in a VA system. METHODS: This study used electronic claims data (VISTA system) to identify subjects prescribed atypical antipsychotics between January 1, 1996 and June 30, 2001. Included subjects were prescribed at least one study medication and had at least two markers for any of the following mental health disorders: bipolar, depression, schizophrenia, schizoaffective disorder, dementia, or PTSD. Demographics, average dose by diagnosis, adherence to VA Guidelines, duration of therapy, concomitant medication use, and switching were analyzed descriptively. RESULTS: Of 7658 total study patients, the following number of patients received at least 1 prescription for the following drugs: olanzapine (4363), risperidone (3878), quetiapine (1387). The proportion of subjects with a schizophrenia diagnosis receiving dose ranges consistent with VA published guidelines for olanzapine, risperidone, and quetiapine were 90, 75 and 41% respectively, but varied greatly by diagnosis. Mean duration of therapy for