Our investigation showed that a case group also had significant lower risks of heart failure, myocardial infarction for over 12 months among patients newly diagnosed with diabetes who participated in the program. The outcomes were the comparisons between these two groups. The results were the increase in the comparatives between these two groups. The pay-for-performance program and received the comprehensive care over 12 months with LDL-c lower than 160 mg/dL (target level for low risk hyperlipidemia population). Despite these high LDL-c values, which fall under Drug Price Control Order (DPCO) 2013 are majorly prescribed as generics (Telmisartan and Ramipril) which do not fall under DPCO 2013 is 0.02USD (1.5%)

CONCLUSIONS: 1. Amlodipine and Atenolol which fall under Drug Price Control Order (DPCO) 2013 are majorly prescribed as combinations (Telmisartan and Amlodipine) which do not fall under DPCO 2013. The drugs which fall under DPCO 2013 are 5 times less expensive than those that do not fall under DPCO 2013. Thus, the initiative taken by Government of India by devising this policy has made it economically viable for patients with palleiative hypertension to meet their daily requirement of drugs.

### MENTAL HEALTH – Clinical Outcomes Studies

**PMH1**

**ETIOLOGY AND SAFETY OF FIVE NEW ANTIDEPRESSANT DRUGS A NETWORK META ANALYSIS**

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**OBJECTIVES:** To estimate the effectiveness and adverse effect rate of five antidepressant drugs: fluoxetine, venlafaxine, maprotiline, mirtazapine and bupropion; and to systematically review those common used new antidepressant drugs efficacy and safety in China. **METHODS:** We retrieve clinical research paper through Chinese Journal Full Text Database (1994-2014.2), Chinese Biomedical Literature Database (1978-2014.2), Chinese Technology Journal Full-text Database (1989-2014.2), Wanfang Data of Medical Information Mirror System (1997-2014.2), Digital Journal Full Text Database (1997-2014.2), Cochrane Library (2014.2), EMBASE (1974-2014.2), ISI database (1974-2014.2). We screen these papers according the inclusion and exclusion criteria and assess the quality of these included researches. **RESULTS:** Meta-analysis shows that fluoxetine improves effectiveness more obviously than venlafaxine and mirtazapine. OR_{fluoxetine-venlafaxine} = 0.6741 [95% CI: 0.5311, 0.8307], OR_{fluoxetine-mirtazapine} = 1.5887 [95% CI: 1.2369, 2.0220], P<0.05. In terms of adverse effects, maprotiline leads to the least adverse effects rate. OR_{maprotiline-bupropion} = 0.6945 [95% CI: 1.496, 2.4642], OR_{maprotiline-fluoxetine} = 0.2086 [95% CI: 0.0627, 0.4958], OR_{maprotiline-mirtazapine} = 0.2109 [95% CI: 0.0607, 0.5422]. OR_{mirtazapine-mirtazapine} = 0.2521 [95% CI: 0.0737, 0.6173], P<0.05. Based on these results, network meta-analysis also ranks these five interventions. Results show that fluoxetine, bupropion and maprotiline have better effectiveness; but maprotiline, fluoxetine, mirtazapine have less adverse effect rates. **CONCLUSIONS:** Fluoxetine, as a new antidepressant drug, has higher clinical efficiency and lower adverse effect rates. Although maprotiline has a high grade of recommendation, we have few researches integrated into the model, further prospective studies are needed for strong evidence to support analogous research.

**PMH2**

**DRUG CLINICALLY IMPORTANT DIFFERENCE IN THE GLOBAL ASSESSMENT FUNCTIONING IN PATIENTS WITH SCHIZOPHRENIA**

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**OBJECTIVES:** Minimum Clinically Important Difference (MCID) can aid to assess the quality of improvement being assessed by the Global Assessment Functioning (GAF). It is the concept that the subject rates global, occupational, and psychological functioning of adults. The objective of this study was to generate MCID for GAF, based on a longitudinal cohort of patients with schizophrenia. **METHODS:** Two methods exist to assess MCID in scales such as GAF: the Anchor-based approach and effect size). Both methods were implemented in a longitudinal cohort study with 3 years of parameter values (LDL-c, etc.) were used to assess their longitudinal patterns was assessed using a multiple linear regression (MLR) model. All data were analyzed using R software and R package, and the statistical analysis software. **RESULTS:** 1. Out of the total prescriptions received by Retail Pharmacies; Amlodipine accounted for 42%, Telmisartan: 27%, Atenolol: 20% and Ramipril: 10%. The same trend was followed by the General Practitioners. The pay-for-performance program (SBP and DBP) and diastolic blood pressure (DBP) were significantly different among the three groups. When SBP and DBP were considered independently, waist-hip ratio was significantly different between the good and poor controls in both SBP and DBP. Therefore, BP was predicted as a significant predictor of the three groups considering for waist-hip ratio. The R² for the MLR model was 0.02, indicating that 2% of the variance in SBP and DBP were accounted for by the independent variables. The three groups were predicted to be a significant predictor of SBP (p=0.14, p<0.02) and DBP (p=0.15, p=.02). **CONCLUSIONS:** The dietary pattern is a predictor for the SBP and DBP outcome in Taiwanese females.

**PCV56**

**EFFECTS OF THE PAY-FOR-PERFORMANCE PROGRAM ON HEALTH OUTCOMES OF DIABETIC PATIENTS**

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**OBJECTIVES:** A number of studies have examined the impacts of pay-for-performance programs on quality of care, but little is known about long-term effects of these programs on the health care outcomes. This study aimed to examine the effects of the pay-for-performance program for type 2 diabetes patients on diabetes-related complications under the National Health Insurance in Taiwan. **METHODS:** A longitudinal cohort study with 5-year follow-up was used to evaluate the effects of the pay-for-performance program on diabetes-related complications. Research materials came from claims files of the Longitudinal Health Insurance Database (LHDII) 2005 released by the National Health Research Institute in Taiwan. Patients newly diagnosed with diabetes in 2004 and who were included in the study population of the pay-for-performance program and received the comprehensive care over 12 months during 2004 to 2010 were categorized as the case group. Patients who never joined the pay-for-performance program during follow-up period were categorized as control group. Since patients who enrolled in the pay-for-performance program or not is not randomization, we apply the propensity score matching (PSM) to increase the comparatives between these two groups. The outcomes were the incidences of cardiovascular event significantly later than control group. The marginal hazard ratios of different propensity score method ranged from 0.60 to 0.63. Patients in the case group also had a significant lower risks of myocardial infarction, stroke and death than patients in the control group. **CONCLUSIONS:** The pay-for-performance program may have reduced the incidence of cardiovascular events among patients newly diagnosed with diabetes who participated in the program for over 12 months.

**PCV57**

**A RETROSPECTIVE, LONGITUDINAL STUDY TO INVESTIGATE THE CHANGE OF LDL-C LEVEL AND PHARMACEUTICAL INTERVENTION BY USING JAPANESE HEALTH CARE CHECKUP DATABASE**

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**OBJECTIVES:** to investigate the LDL-C levels and pharmaceutical interventions in Japanese subjects under real life settings based on longitudinal data from a Japanese health care checkup database developed by MinaCare Co. Ltd. **METHODS:** Data of those subjects with annual health checkup from 2010 to 2012 were extracted from MinaCare database (cutoff November 2013). From these data, 11830 subjects with 3 years of parameter values (LDL-c, etc.) were used to assess their longitudinal changes and the self-reported use of medications. The reliability of MinaCare database has been evaluated in a separate investigation to be presented at ISPOR 19th Annual International Meeting. The final report of this investigation will be based on the latest of the periodically updated database at reporting time. **RESULTS:** At baseline (2010), 11.9% (1410/11830) of the subjects reported LDL-c<160 mg/dL (target level for low risk hyperlipidemia population). Despite these high LDL-c values, 96.4% (1140/11830) of the subjects answered “untreated” by a hypolipidemic drug (including one non-responder). Among these 1145 subjects, 127/93.5% answered “untreated” again in 2011; and among these “untreated”, the proportions of subjects with LDL-c<140 (diagnostic level for low risk hyperlipidemia population) and LDL-c<180 in 2011 were 13.5%(n=170), 32.9%(n=413) and 22.9%(n=228), respectively. In contrast, among those who answered “treated” in 2011, the proportion answering “untreated” in 2012 (i.e. “untreated” in 3 consecutively years) was 94.1% (n=1183). Among these subjects, the proportions of subjects with LDL-c<140, LDL-c<180 and LDL-c<200 in 2012 were 16.7%(n=195), 29.8%(n=352) and 25.0%(n=296), respectively. **CONCLUSIONS:** Our investigation showed that >90% of subjects self-reported no treatment with anti-hyperlipemia drugs, despite LDL-c levels above 160 mg/dL. Many reported themselves untreated for these results revealed a potentially critical gap between health care checkup results and subject’s behavior to access medical treatment, suggesting more effective interventions to modify behavior is required.