OBJECTIVES: To assess the cost-consequences of cardiometabolic effects of lurasi-done versus other atypical antipsychotics in schizophrenia.

METHODS: A discrete economic decision simulation model was developed to simulate the economic outcomes based on cardiometabolic parameter changes after 1-year treatment. With a 3-year time horizon, the model predicted the number of: 1) incident diabetes cases using each of the risk equations, and 2) cardiovascular events (e.g., coronary heart disease) (CHD), stroke) based on updated cardiometabolic values at 1 year, and estimated the costs associated with each event. Data were drawn from comparative clinical trials of luraside versus risperidone and quetiapine, and from the literature for olanzapine. Cost data in 2011 values were obtained from published clinical trials of luraside, risperidone, and quetiapine, and from a national representative annual survey of non-institutionalized US residents. Generalized Linear Models (GLM) regression was used to evaluate the relationships between the independent variables and costs. RESULTS: There were 317 patients (weighted frequency = 2.75 million) with schizophrenia-related costs. Based on the logistic regression model, it was estimated that for every one-year increase in age, patients were 6.4% less likely to have high costs (odds ratio [OR] = 0.936). Patients with a spouse were 83.0% less likely than those without a spouse to be in the high-cost group (OR = 0.170). The GLM regression procedure showed that age, race, and region of residence are significantly associated with costs. On controlling for other factors, with a one-year increase in age, costs decreased by $127 (p < 0.001). Caucasians spent $3,831 ($5,019) less than African Americans, and patients living in Southern US spent $3,718 ($5,019) less than those living in the Northeast. CONCLUSIONS: Identifying the high-risk population may help policy makers allocate resources more efficiently. Community healthcare providers manage patients more effectively through assignment of high-risk patients to case managers and appropriate monitoring and treatment.

PMH12 IDENTIFYING CHARACTERISTICS OF PATIENTS WITH HIGH SCHIZOPHRENIA-RELATED COSTS

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OBJECTIVES: The objective of this study was to identify the demographic and clinical characteristics of schizophrenia patients who experience high schizophrenia-related direct medical costs. METHODS: Patients with a diagnosis for schizophrenia disorder (ICD-9-CM code 295) or other non-organic psychoses (ICD-9-CM code 298) were identified from the 2005-2008 Medical Expenditure Panel Survey (MEPS), a nationally representative annual survey of non-institutionalized US residents. Schizophrenia-related direct medical costs were calculated for the following utilizations: inpatient hospitalization, emergency department visits, office-based physician visits, outpatient, physician office-based visits, and prescription medications. The University of Texas at Austin, Austin, TX, USA

OBJECTIVES: To estimate the schizophrenia-related direct medical costs using the attributable and incremental cost approaches. METHODS: Patients with a diagnosis for schizophrenia disorder (ICD-9-CM code 295) and other non-organic psychoses (ICD-9-CM code 298) were identified from the 2005-2008 Medical Expenditure Panel Survey (MEPS), a nationally representative annual survey of non-institutionalized US residents. Schizophrenia-related direct medical costs were calculated for the following utilizations: inpatient hospitalization, emergency department visits, office-based physician visits, and prescription medications. The attributable cost approach was calculated to yield the schizophrenia-associated incremental costs. RESULTS: We identified 348 patients with schizophrenia (weighted frequency = 3.03 million). The mean schizophrenia-related direct medical cost per patient-year using the attributable cost approach was $5,538 (SE = $570). The incremental cost approach, the mean cost per patient-year was $12,369 (SE = $1,205) for schizophrenia patients and $3,198 (SE = $47) for non-schizophrenia patients. Thus, the incremental cost associated with schizophrenia was $9171 (SE = 1207) per patient-year. When demographic and clinical factors such as age, sex, marital status, insurance status, income, education, state of residence, and presence of comorbidities were controlled for using ordinary least squares regression, the mean schizophrenia-related incremental direct medical cost per patient-year was $5115 (SE = $1249). CONCLUSIONS: This study highlights the high financial burden of schizophrenia. Although the mean cost per patient-year estimated using the incremental cost approach was higher than that obtained using the attributable cost approach, the incremental cost approach is more informative as it adjusts costs for schizophrenia patients compared to non-schizophrenia patients.