are people with lived experience in navigating complex mental health systems and whose unique perspective helps guide peers on their journey to wellness. In the same manner that CPSS knowledge has improved clinical outcomes, partnering with CPSSs during CNS drug development may provide wellness outcomes in clinical trials that are more meaningful for people with lived experience. To this end, a CPSS Ambassador program was initiated.

Methods. Of 85 peer support specialists identified by internet searches, Linked-In, and peer support specialists' registries, 7 CPSSs met our criteria (i.e., having lived experience of psychosis and being a member of a treatment team) and agreed to be part of our ambassador program. Interactions included 6 monthly virtual meetings and a live roundtable meeting. The objectives of the program were to: 1) understand unmet needs in people with lived experience and identify impediments to effective treatment, 2) learn best practices for discussing medication use to support wellness, 3) identify resources that can help educate people and families with lived experience, and 4) highlight the importance of CPSSs within healthcare teams to optimize treatment outcomes.

Results. This CPSS ambassador program emphasized the need for shared decision making and partnership to forge a positive treatment team alliance. As such, treatment goals should be tailored to patients' needs ("nothing about me without me"). A major obstacle to effective treatment is the presence of bias or stigma among health care practitioners. Specifically, certain language used by clinicians has the potential to ostracize patients and negatively impact treatment. Medications should be discussed as one pillar of a larger treatment plan and not as a "fix" for symptoms. Educational resources written in layman's terms are needed to explain treatment algorithms and medication side effects. And finally, CPSSs make a significant contribution to person-focused positive outcomes and are an essential part of the treatment team. CPSSs are a conduit of lived experience and advocate for the individual

Conclusions. The following key outcomes were illuminated because of this work together: CPSS's are liaisons that facilitate the intersection between the treatment team and people utilizing mental health systems. CPSS's are critical to successful navigation of the mental health care system and reaching desired outcomes. Best practices for treatment teams are about effective, person-based and stigma free partnerships for positive and patient focused outcomes.

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Prevalence of Concomitant Medications Among Patients with Schizophrenia Prescribed Atypical Antipsychotics

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Introduction. Typical and atypical antipsychotics (AAPs) are the main treatment options among patients with schizophrenia. However, AAPs have been associated with several side effects and comorbid conditions. To manage side effects, often patients are prescribed concomitant medications to manage their condition, increasing polypharmacy. Though common in practice, the prevalence of concomitant medication use in patients with schizophrenia is not well established. This study evaluated the annual prevalence of concomitant medications among patients with schizophrenia who were prescribed AAPs.

Methods. This retrospective study was conducted using the PharMetrics database (01/2019 – 12/2021). Patients were included in the analyses if they had a diagnosis of schizophrenia, were continuously enrolled in pharmacy and medical claims for the full year and were prescribed AAPs. A sensitivity analysis was also conducted among patients who demonstrated ≥50% adherence to their prescribed AAPs (with a grace period of 30 days). For both the main and sensitivity analyses patient populations, the concomitant drugs prescribed were labeled at the drug class (GPI2) and generic drug level. Prevalence for drug class and each drug was calculated as a percentage of patients who were prescribed ≥1 of the agent among those who met the inclusion and exclusion criteria within the given year.

Results. For the year 2019, 2020 and 2021, 12,360; 13,242 and 14,780 patients met the inclusion and exclusion criteria, respectively. The mean age of the cohort ranged from 43.5 - 45.4 years. Patients were predominantly male and commercially insured. Antidepressants were the most prevalent concomitant medication prescribed (2019: 61.2%, 2020: 61.2%, 2021: 62.0%). Other highly prevalent drug classes identified were - anticonvulsants (2019: 44.2%, 2020: 44.5%, 2021: 45.0%), antianxiety agents (2019: 36.3%, 2020: 37.6%, 2021: 38.9%), antihyperlipidemics (2019: 26.3%, 2020: 28.1%, 2021: 30.7%), antihypertensives (2019: 25.7%, 2020: 27.2%, 2021: 28.1%), antiparkinson agents (2019: 61.2%, 2020: 61.2%, 2021: 62.0%), anticholinergics (2019: 61.2%, 2020: 61.2%, 2021: 62.0%) and analgesics (2019: 61.2%, 2020: 61.2%, 2021: 62.0%). At the individual drug level, benzotropine mesylate (2019: 19.5%, 2020: 18.7%, 2021: 18.8%), atorvastatin (2019: 14.5%, 2020: 16.7%, 2021: 18.4%), lorazepam (2019: 14.1%, 2020: 14.7%, 2021: 14.3%), gabapentin (2019: 13.7%, 2020: 13.9%, 2021: 14.8%), and metformin (2019: 13.2%, 2020: 13.7%, 2021: 15.4%) were the most prevalent prescribed concomitant medications. There was no difference when similar analyses were conducted in the adherent patient population.

Conclusions. These results indicate a high prevalence of concomitant antidepressants, antihyperlipidemics, antihypertensives and anticholinergics among patients with schizophrenia who are prescribed AAPs.

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Healthcare Resource Use and Cost Associated with Negative Symptoms of Schizophrenia

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Introduction. Schizophrenia is a chronic neurodevelopmental disorder characterized by positive, negative, and cognitive symptoms. While current antipsychotic (AP) medications are generally effective in treating positive symptoms, they don't effectively manage the negative symptoms of schizophrenia (NSS). This study examined the healthcare resource utilization (HCRU) and cost among patients with NSS in the United States.
Methods. This retrospective longitudinal observational study utilized de-identified administrative claims data from STATinMED RWD Insights (01/01/2016-09/30/2022). Study sample included patients with schizophrenia identified using ICD-10-CM: F20.XX, diagnosed with NSS (cases; ICD-10-CM: F20.5; index=first NSS diagnosis) or not (controls; random date assigned as index); identification period: 01/01/2017-09/30/2021. Patients were 13 years or older at index, had 12-month of continuous capture data pre-(baseline) and post-(follow-up) index date, and had evidence of AP use at baseline. Outcomes were prevalence of NSS, mental health (MH)-related, schizophrenia-related, and all-cause HCRU and costs per patient per year (PPPY). Patients' demographic, clinical characteristics, and other psychiatry and neurodevelopmental comorbidities were assessed at baseline. Unadjusted and Inverse Proportional Treatment Weighted (IPTW) comparison were conducted for baseline characteristics and outcomes followed by Generalized Linear Models (GLMs) for HCRU and costs.
Results. The final study sample had 5,691 NSS and 236,895 non-NSS patients. Prevalence rate of NSS was estimated at 24.66 per 1000 patients of Schizophrenia. Patients with NSS were significantly older (mean: 50 vs 48 years), less commercially insured (10% vs 15%), and had greater comorbidities including alcohol abuse (12% vs 8%), depression (30% vs 24%), diabetes without chronic complications (22% vs 17%), drug abuse (21% vs 16%), uncomplicated hypertension (41% vs 32%), and psychoses (80% vs 58%); all p-values<0.001. After controlling for baseline characteristics, patients with NSS had significantly higher all-cause inpatient admissions (mean: 5.2 vs 4.2), outpatient emergency room (ER) visits (mean: 2.8 vs 2.0), inpatient stay costs ($23,830 vs $20,669), outpatient ER visit costs ($1,738 vs $1,167.20) and less prescriptions (mean: 49.2 vs 51.4); all p-values<0.05. GLM analysis also showed patients with NSS had significantly higher all-cause inpatient admissions (mean: 4.8 vs 3.7), number of outpatient visits (mean: 14.3 vs 13.8), and inpatient stay costs ($20,853 vs $17,809); all p-values<0.05. MH- and schizophrenia-related HCRU and costs PPPY were consistent with all-cause HCRU and cost results.
Conclusions. Patients with predominant NSS had higher HCRU and healthcare costs compared to patients without predominant NSS. New therapies that improve negative symptoms may reduce the burden of schizophrenia.
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TeleSCOPE 2.0: A Follow-Up Real-World Study of Telehealth for the Detection and Treatment of Drug-Induced Movement Disorders (DIMD)

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Introduction. Since COVID-19, mental healthcare telehealth services have increased. A 2021 online survey (TeleSCOPE 1.0 [T1]) identified challenges evaluating, diagnosing, and monitoring DIMDs with telehealth (via video or phone). TeleSCOPE 2.0 (T2) was conducted to understand the telehealth impact post-COVID restrictions.
Methods. T2 was fielded (5/18-6/9/2023) to neurologists (neuro), psychiatrists (psych), and nurse practitioners (NP)/physician assistants (PA) affiliated with neuro/psych practices who prescribed vesicular monoamine transporter 2 inhibitors or benztropine for DIMD in the past 6 months and saw ≥15% of patients via telehealth at peak and post-COVID.
Results. 100 neuros, 100 psychs, and 105 NP/PAs responded. More patients were seen in-person post-COVID (12-27% vs 31-53%), but percentage seen by video remained largely unchanged (54-62% vs 37-53%). Issues influencing appointment setting in T2 remained access to care, technology, and digital literacy although T2 clinicians reported less patients had issues connecting for a video visit. In T2, clinicians used multiple telehealth methods to evaluate DIMDs including personal phone videos (48-66%), telemedicine apps (36-45%), health/fitness trackers (6-13%), and other (2-5%). Common T2 diagnostic telehealth issues included determining signs of difficulty with gait, falls, walking, and standing; difficulty writing, using phone, computer; and painful movements. In patients evaluated for DIMD, more received an eventual diagnosis in T2 vs T1 both in-person (34-53% vs 26-46%) and video (32-51% vs 29-44%) but, on average, neuros and psychs required 1 more telehealth visit to confirm a DIMD diagnosis vs in-person. Over half of clinicians on average recommended patients come in-person to confirm a DIMD diagnosis. Most clinicians reported ongoing difficultly diagnosing patients via phone. Neuros were less comfortable than psychs/NP/PAs with telehealth visits due to risk of misdiagnosis and liability. While all clinicians saw telehealth advantages, neuros expect to see more of their patients in person post-COVID. However, in T2, the number of clinicians who found it difficult to manage DIMDs cases by video had significantly decreased (T1 52-54%; T2 28-36%). Half of clinicians reported the non-presence of a caregiver as a significant barrier to diagnosis and treatment via telehealth. Clear guidelines and provider education

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