a hospital performing 50 knee and 50 hip surgeries every year, this potential for cost- offsets would be of ( £108,850). This would vary a lot for the perspective of HMOS and hospitals of different sizes, as well as depending on the costs of each decision maker, demanding constant customization of parameters. CONCLUSIONS: The use of 2,19,529 of the pharmaeconomic studies results more intelligible to decision makers, permitting them to foresee their actual application on a real practice, in different scenarios.

LINKAGE OF ADMINISTRATIVE AND MEDICAL RECORDS DATABASES FOR INVESTIGATING PHARMACEUTICAL USE AND OUTCOMES

Baser O1, Gust C2, Akin C3

BACKGROUND: Use of electronic health care databases to examine pharmaceutical use and effects faces limitations inherent in the source of data. Medical records document prescribing but not consumption of medication; administrative databases document dispensing but not the original intent of the prescriber. OBJECTIVES: To evaluate a patient-level linked database of electronic medical records (EMR) and administrative claim for use in measuring both prescribing and dispensing of pharmaceuticals. METHODS: Claims data from Thomson Reuters MarketScan database were linked to the GE Centricity EMR database using probabilistic methods to overcome the de-identification required of both databases under US privacy laws. Patient-level records were matched based on demographic characteristics and calendar dates of physician visits. Multiple visits were required to reduce the likelihood of mismatches. The agreement between prescribing records in the EMR and claims for dispensing of medication was explored in the context of self-administered medication for osteoporosis, including bisphosphonates and raloxifene. RESULTS: Using data from 2004–2009, 219,329 patients were matched between the two data sources. Mean age was 43 years and 57% were female. We identified 2,331 patients whose medical records showed new prescriptions for bisphosphonates or raloxifene (no evidence of use in the prior 180 days). Pharmacy claims indicated these prescriptions were filled by 56% of patients within 7 days, 73% within 30 days, and 86% within 90 days. CONCLUSIONS: It is to be expected that there will be some degree of noncompliance, hence incomplete filing of prescriptions, as observed. The lag from dispensing to prescribing among many patients is also consistent with use of samples for initial prescriptions. Overall, the example of osteoporosis therapy shows consistency between prescribing in EMR data and dispensing in claims data among a sample of probabilistically linked patient records.

CLAIMS-BASED SEVERITY INDEX FOR RHEUMATOID ARTHRITIS FROM HEALTH CARE CLAIMS DATA

Baser O1, Gust C2, Akin C3

OBJECTIVES: Controlling for disease severity in observational studies is crucial to get an estimate with no selection bias. However, outcomes research studies using claims data, contain no information about disease severity. Therefore, comorbid scores are used for a proxy for the disease severity. There exists no severity score specific for rheumatoid arthritis (RA). The goal of this study was to develop a severity index for rheumatoid arthritis (SIFRA) for private health care claims data. METHODS: We extracted the following variables related to rheumatoid arthritis from the claims data: total number of synthetic disease-modifying anti-rheumatic drugs (DMARDs), total number of biological DMARDs, tests for C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR) ordered, rehabilitation visits, rheumatology visits, FeJy’s syndrome and Sjogren’s syndrome, pulmonary, soft tissue nodules, joint surgery, number of platelet counts and chemical panels ordered, and rheumatoid factor testing. A linear regression model was used to create the severity score. The severity score was compared with the rheumatoid arthritis medical records-based index of severity (RARRBS) and currently-used comorbidity scores to proxy severity in outcomes research studies related with rheumatoid arthritis. RESULTS: According to the Akaike Information Criterion (AIC), Bayesian Information Criterion (BIC), log likelihood function, R-squared values and average squared prediction error, SIFRA performed better than RARRBS, Charlson Comorbidity Score (CCI), Elshafey comorbidity score and Chronic disease score. Spearman correlation with RARRBS was 0.65 and significant. However, the correlation with the Charlson Comorbidity Index (0.1, p = 0.6521), Elshafey Index (0.15, p = 0.5312) and Chronic disease score (0.13, p = 0.6011) were low and insignificant. CONCLUSIONS: Comorbidity scores (Charlson, Elshafey or Chronic Disease Scores) commonly used in outcomes research are inadequate to be proxy variable for RA patients. SIFRA, at least for rheumatoid arthritis, controls for disease severity better than any other commonly used measure.

THE DETERMINANTS OF SOCIAL ROLES AMONG RHEUMATOID ARTHRITIS PATIENTS—DATA FROM THE NDB PORTUGAL COHORT

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BACKGROUND: An important consequence of rheumatoid arthritis (RA) is disability, traditionally assessed by the Health Assessment Questionnaire (HAQ), which captures the physical component. Disability can also be evaluated by restricted performance of social roles and those predictors haven’t been extensively studied. OBJECTIVES: Determinants of social roles, among RA patients, as evaluated by paid work and social functioning were studied. METHODS: A total of 1,140 RA patients from the NDB-Portugal longitudinal cohort were analyzed. Univariate (UV) and Multivariate (MV) generalized estimating equations were used to assess whether the following factors were determinants of paid work (1 = yes = 0, no; OR; 95%CI) and of SF-36 social functioning (0–100, 100 is best; β; 95%CI); age, sex, marital status, educational level, number of people living in patient’s household, dependence on others, RA duration, number of major comorbidities, and financial status. RESULTS: RA disease activity (RADAI), quality of life (VASQOL), pain, fatigue and sleep disturbances (VAS scales, 0–10, 10 is worst). RESULTS: In MV analysis the odds of having a form of paid work increased with higher education (1.17; 1.12, 1.22) and better VASQOL (1.92; 1.15, 3.20) and decreased with higher age (0.91; 0.90, 0.93),