neck fracture) and the Hungarian Diagnosis Related Groups. Patients with polytrauma or severe comorbidities were excluded. Our retrospective analysis includes patients under 60 with femoral neck fracture identified with Social Security Identification number (SSN) and discharged in 2000. RESULTS: A total of 518 patients met the selection criteria and 23.7% of them (N = 123) had impaired ability to work. The proportion of patients with impaired ability to work was 41.3% in patients with further treatment, 50% in patients with secondary prosthesis and 20% in patients with one definitive treatment. The proportion of patients with impaired ability to work according to the method of primary surgery was 27.1% in arthroplasty, 23.7 in screw fixation and 20.6% in DHS. A total of 16.3% of disabled patients received rehabilitation treatment. The proportion of disabled patients increased in higher age groups. We found higher than national average disability ratio in regions with higher unemployment rate and lower employment rate. CONCLUSIONS: We found higher impaired ability to work ratio in patients with secondary prosthesis than in arthroplasty. In order to reduce the impaired ability to work, the sick-pay period should be used more efficiently. The frequency of impaired ability to work is not only a health related problem but it is an effect of social and economic processes.

OSTEOPOROSIS—Health Care Use & Policy Studies

PRICE AND UTILIZATION OF OSTEOPOROSIS MEDICATIONS IN U.S. MEDICAID PROGRAMS
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OBJECTIVES: Approximately eight million women and two million men in the U.S. suffer from osteoporosis, a disease that causes over 1.5 million fractures each year. The cost to Medicaid for anti-osteoporosis medications topped $85 million in the first quarter of 2004. The objective of this study is to analyze price, cost, utilization, and market shares of oral anti-osteoporosis medications in U.S. Medicaid programs, with the specific purpose of assessing interbrand competition in a tightly oligopolistic market. METHODS: There are five oral medications for osteoporosis, including Didronel® (etidronate), Skelax® (tiludronate), Actonel® (risedronate), Fosamax® (alendronate), and Evista® (raloxifene). Data from the First DataBank® were used to calculate the monthly Average Wholesale Price (AWP) per daily dose for each drug over the period 1990–2004. Data from the National Medicaid Pharmacy claims were used to calculate quarterly drug prescriptions, market shares, and reimbursements over essentially the same time period. RESULTS: The three most frequently prescribed drugs are alendronate (utilization reached 600,000 scripts in the 1st quarter 2004); risedronate whose use increased from 90 scripts in the 2nd quarter 1999 to 400,000 in the 1st quarter 2004; and raloxifene with utilization of 190,000 scripts in the 1st quarter 2004. Each of these drugs has an AWP for alendronate of $15.00 per daily dose.

OSTEOPOROSIS—Methods and Concepts

TRENDS IN THE CLINICAL MANAGEMENT OF FRAGILE FRACTURE BEFORE AND AFTER THE NEW HEDIS OSTEOPOROSIS MANAGEMENT MEASURE IN A MEDICARE POPULATION
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OBJECTIVE: To examine the trend in clinical management of patients with fragile fractures before and after the implementation of the Health Plan Employer Data and Information Set (HEDIS) osteoporosis measure. METHODS: Two cohorts of Medicare Beneficiaries with continuous enrollment for at least 18 months and a fracture during the measurement year and no use of osteoporosis medication or BMD screening in the preceding 12 months were identified in the MarketScan Medicare Supplemental and COB database for the measurement years 2000–2005. Per HEDIS, each measurement year began on July 1st of the preceding year and continues through June 30th of the measurement year. The first cohort consisted of women aged 67 and older, while the second cohort consisted of men and women aged 65 and older. Fractures were identified according to HEDIS definitions. Clinical management was assessed by the presence of a claim for BMD screening and/or a prescription for a bisphosphonate or other osteoporosis-specific medication in the year following the fracture. Adjusted rates of change in screening and treatment were estimated using multivariate logistic regression. RESULTS: In the measurement year 2000, 8.4% of Cohort 1 underwent BMD screening and 11.2% received pharmacological treatment. For Cohort 2, the rates were 6.5% and 8.3%, respectively. By 2005, BMD screening had increased by 21% and treatment increased by 15% for Cohort 1. For Cohort 2, the rates increased by 42% and 22%, respectively. After adjusting for patient age, sex, fracture location, provider specialty, geographic region and capitated versus non-capitated health plan, the rates for screening and treatment had increased by 21% and 15% for Cohort 1, and by 41% and 15% for Cohort 2. CONCLUSION: While slow progress has been made in the clinical management of fracture since the implementation of the HEDIS osteoporosis measure, there is still an opportunity for significant improvement.

OSTEOPOROSIS—Methods and Concepts

TREATMENT PATTERNS AND RESOURCE UTILIZATION IN PATIENTS WITH PAGET’S DISEASE TREATED WITH RISENDRONATE
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OBJECTIVES: After the recommended two-month treatment course of risedronate for the treatment of Paget’s disease, patients should be followed to assess the need for re-treatment. We examined real-world treatment patterns and resource utilization in patients treated with risedronate for Paget’s disease. METHODS: Patients enrolled in a nationally representative multi-managed care plan claims database (1998–2004; PharMetrics) with a diagnosis of Paget’s disease (>1 ICD-9 code), >1 risedronate prescription at the Paget’s dose (30 mg; daily dosing), no osteoporosis, and >1 year of follow-up after initial risedronate therapy were identified. For this cohort, we evaluated: 1) Proportion of patients with risedronate use >1 month after the recommended treatment regimen in the approved label (i.e., additional use); 2) Proportion of patients without risedronate prescription (i.e., gap) from days 61 to 180, followed by use after