migraineurs with or without N/V using Chi-square test. Adjusting for demographic and comorbidity differences, generalized linear models were conducted to compare HRU. **RESULTS:** Of the N=7855 migraine participants, 58% reported N/V symptoms, female= 73%, white= 72%, mean age= 41.8 (SD=14.0), mean Charlson-comorbidity index=0.55 (SD= 1.26) and mean migraine episodes (past 30 days)= 3.27(SD=5.33). Compared with migraineurs without N/V, significantly greater proportion of migraineurs with N/V reported depressive symptoms (39.2% vs 45.2%, p<0.001), sleep problems (e.g. sleep difficulty, 43.6% vs 54.1%; daytime sleepiness, 30.9% vs 40.4%; poor sleep quality, 28.9% vs 38.9%; nighttime awakening, 33.9% vs 44.2%, all p<0.001). Mean emergency room (ER) visits increased significantly by about 20% in migraineurs with N/V than without N/V [0.48 (95% CI = 0.41, 0.57) vs 0.38, [95% CI= 0.32, 0.45]; p<0.01). Between migraineurs with and without N/V, no significant increase in the mean number of physician [5.24 (95% CI = 4.82, 5.69) vs 4.93 (95% CI= 4.54, 5.35); p=0.06] and hospital visits [0.20 (95% CI = 0.16, 0.25) vs 0.19 (95% CI= 0.15, 0.24), p=0.65] were detected. **CONCLUSIONS:** Migraineurs with N/V reported worsened sleep and depressive symptom outcomes, and higher ER visits than those without N/V. Future research must evaluate the relationship of N/V severity on these outcomes. Study findings highlight opportunities for treatment options that may alleviate these unmet medical needs in migraineurs with N/V.

PHS86

DO DEPRESSION RATES DIFFER BY CONFLICT ERA AMONG WAR VETERANS?

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OBJECTIVES: Depressive and anxiety disorders are the most common mental disorders and are very common among individuals with a history of military service. The aims of this study were to examine the prevalence of depression among respondents with a history of military service, and examine if self-reported lifetime depression diagnosis in veterans differs by the major conflicts/war they served in, using the 2012 Behavior Risk Factor Surveillance System (BRFSS). **METHODS:** 28,077 participants with a history of military service from 2012 BRFSS were used for the analysis. The outcome variable was self-reported lifetime depression and the independent variable was researcher defined conflict era using participant age and a positive reply to veteran status. These variables were used to group participants into the different conflicts in history (World War II, Korean, Vietnam, and the Gulf Wars). A logistic regression model was constructed to evaluate the association between conflict era and socio-demographic factors and depression. **RESULTS:** Depression prevalence among veterans was 15.1%. The distribution of conflict era was World War II (8.3%), Vietnam War (12.8%), Vietnam War (39.1%) and Gulf War (39.8%). After controlling for the effects of other variables, veteran participants in the Vietnam War and Gulf War were 3.13 (95% CI, 1.46 – 1.63) and 2.55 (95% CI, 1.07 – 1.27) times more likely to report a lifetime depression diagnosis compared to World War II veterans respectively. However, veterans that participated in the Korean War were not significantly associated with lifetime depression. **CONCLUSIONS:** Depression rates vary by conflict era among war veterans. Understanding the burden of depression among veterans that participated in different conflict eras provides insightful distribution of clinical and programmatic resources. Future studies should attempt to use VA data to effectively include veteran or active duty status, dates of service, branch of service, combat exposure, trauma exposure, and physician diagnosed depression.

PHS87

PATIENT REPORTED OUTCOMES REVEAL DISCORDANCE BETWEEN PATIENT AND PHYSICIAN ASSESSMENT OF DISEASE BURDEN IN PATIENTS WITH RHEUMATOID ARTHRITIS

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OBJECTIVES: Patient-reported outcomes (PROs) are critical to advancing patient centered care. Recording PROs in real-time concurrent with clinician-reported outcomes represents the most direct and accurate comparative assessments of disease and treatment impact. This study sought to compare patient-generated global assessment (PGA) and physician global assessment (PhGA) rheumatoid arthritis (RA) scores to determine patient-physician discordance for rates of disease and treatment impact on perceived well-being. **METHODS:** From 1/1/2012 to 12/31/2013, 79 rheumatologists in 35 practices participating in a payer-sponsored rheumatologist-developed RA pathway program incorporated use of a point-of-care DST, which required a clinical disease activity index (CDAI) assessment at each physician visit. Components of the CDAI included PhGA and PGA scores, which were captured over the study period; lower scores are associated with better patient status. Paired t-tests and linear regression were used to analyze and compare scores for discordance. **RESULTS:** 3406 patients had 9769 physician visits during the study period where both PGA and PhGA were captured. The mean age of the study population was 57 years; 77% of patients were female. The unadjusted mean PGA score was 3.26 (standard deviation [SD]: 2.69) compared to the mean PhGA score of 2.51 (SD: 2.24); p<.0001. Linear regression revealed that for every 1-unit increase in PGA score, the PhGA score only increased by 0.69 (p<.0001); the R-squared value was 0.326, indicating a moderate correlation. **CONCLUSIONS:** This research affirms the role of PRO at point of care. Our data demonstrate discordance between physician and patient global assessments. Although there was a linear correlation between the PGA and PhGA scores, the significant difference in mean scores indicates that physicians underestimated disease severity and treatment related adverse events and their impact on patient perceived well-being. Additional analyses, including adjustment for covariates, are planned.

PHS88

FEASIBILITY OF REAL-TIME COLLECTION OF PATIENT REPORTED OUTCOMES AT POINT OF CARE

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OBJECTIVES: Patient-reported outcomes (PROs) are critical to advancing patient centered care (PCC). Recording PROs in real-time represents the most direct and accurate assessment of disease and treatment impact. However, the collection of PROs in real-time, where they can best influence disease management, is challenging. We report real-time PRO collection at point of care in patients with rheumatoid arthritis (RA) through use of a decision support tool (DST). **METHODS:** From 1/1/2012 to 12/31/2013, 79 rheumatologists in 35 practices participating in a payer-sponsored rheumatologist-developed RA pathway program incorporated use of a point-of-care DST, which required a clinical disease activity index (CDAI) assessment at each physician visit. The CDAI is comprised of 4 components: swollen joint count (SJC), tender joint count (TJC), physician global assessment (PhGA), and patient global assessment (PGA). Patient rates of CDAI reporting and their correlation to CDAI score were calculated. CDAI disease burden interpretation: ≤ 2.8 remission, CDAI 2.9-10 low, 10.1-22 moderate, 22.1-76 high. **RESULTS:** 3185 active patients, defined as ≥2 physician visits over the study period, contributed PRO information for 13,723 visits. At least 1 CDAI component was documented in 90% of visits. PGA and PhGA were both documented in 66% of visits. SJC and TJC were least likely to be documented. Almost all patients (99%) not in remission, with a CDAI score greater ≥ 2.8, had all 4 CDAI components documented. **CONCLUSIONS:** PROs at point of care is a necessary component for full realization of PCC. We have demonstrated the feasibility of collecting real-time PROs from patients with RA during physician visits. For 99% of patients who were not in remission, all 4 components of CDAI were captured at a high rate by DST. A 90% rate of documentation for any CDAI component demonstrates the ease and potential for point of care data collection via DST.

PHS89

IMPACT OF PATIENT REPORTED OUTCOMES ON MEDICATION THERAPY MANAGEMENT FOR HIGH-COST SPECIALTY DRUGS

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OBJECTIVES: Managing high-cost and highly toxic orphan and ultra-orphan drugs of precision medicine presents medication therapy management (MTM) problems for payers and their pharmacy benefit management and specialty pharmacy vendors who increasingly leverage volume throughput to lower cost. The rapid expansion of this drug class, fragmentation between pharmacy and medical benefit, and increasing use of pathways-based disease management add urgency to finding a solution to these problems. Patient-reported outcomes (PROs) may be the most direct and accurate assessment of disease and treatment impact. We report on an MTM pilot program using a PRO-based intervention algorithm. **METHODS:** OncoSource Rx (OSRx), a wholly owned specialty pharmacy of Cardinal Health, conducted a 1-month pilot study of a novel PRO-based MTM solution in conjunction with a regional Mid-Atlantic insurer. Patient-risk stratification by diagnosis and drug resulted in a scripted specialty pharmacy technician phone call triage. All patients were contacted at initial fill of a specialty pharmacy prescription and periodically thereafter based on their risk profile. Patient queries were designed to identify barriers to medication possession **RESULTS:** From 3/1/14 to 3/31/14, OSRx received specialty pharmacy prescriptions directly from providers for 239 patients with either a rheumatologic or oncologic diagnosis. A total of 956 phone calls by pharmacy technicians were required to initially reach all 239 patients. The PRO algorithm identified 68 patients (28%) experiencing problems that either restricted possession or limited adherence to the prescribed drug. Remediation resulted in a positive outcome for 65 patients (95%) who were then able to initiate or continue their prescribed treatment. **CONCLUSIONS:** PROs are believed to be a critical component of patient centered care. Incorporating PROs into daily practice is being actively studied. This pilot affirms that direct patient engagement via PRO can successfully overcome barriers to initiation of and adherence to prescribed treatment distributed by a specialty pharmacy.

PHS90

GEOGRAPHIC PATTERNS OF SELF-REPORTED LIFETIME DEPRESSION DIAGNOSIS

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OBJECTIVES: Depressive and anxiety disorders are the most common mental disorders and often lead to costly mental distress in the US. The aim of this study was to determine if there are variations in the geographic distribution of self-reported lifetime depression using data from the 2012 Behavior Risk Factor Surveillance System (BRFSS). **METHODS:** Data were from the 2012 BRFSS, a cross-sectional random-digit-dialed telephone survey of 475,687 noninstitutionalized adult population aged 18 years or older. The outcome variable was self-reported depression and the independent variable was geographic region as defined by the US Census Bureau (Midwest, Northeast, South, and West). A logistic regression model was constructed to examine the association between geographic region and socio-demographic factors and depression. **RESULTS:** There was a significant relationship between geographic region and lifetime depression in the bivariate analysis (p < 0.0001). After adjusting for the effects of other variables, geographic region was not significantly associated with lifetime depression. However, there was a significant relationship between geographic region and race in a bivariate analysis (p < 0.0001). Therefore, race was removed from the multivariate model. Thereafter, geographic region became significantly associated with lifetime depression (p < 0.0001). Participants living in the West and Northeast regions were 1.14 (95% CI, 1.06 – 1.18) and 1.11 (95% CI, 1.05 – 1.18) more likely to report lifetime depression compared to participants living in the South. The Midwest region was not significantly associated with lifetime depression. **CONCLUSIONS:** There was no association between lifetime depression and geographic region with race in the model, but the association became significant after removing race. Because removing race resulted in a significant association, racial distribution may be more indicative of lifetime depression than geographic region. Public health services should consider the racial distribution of a geographic region when addressing the burden of lifetime depression.