months prior to duloxetine initiation (defined as no duloxetine pill coverage in the previous 90 days) were identified via administrative claims. The use of pain related medications during the 6 months prior to duloxetine initiation was compared between cohorts, but highest among patients with DPNF (60.0%) and FM (54.7%), and between 47.0-52.4% among other cohorts. There was varied use of opioids across cohorts, ranging from 63.3% (GAD) to 84.7% (LB). Non-steroidal anti-inflammatory drugs utilization varied with the lowest use among GAD patients (30.2%) and the highest among OA patients (45.8%). Utilization of muscle relaxants widely ranged from 22.0% (DPNF) to 40.4% (FM). Use of pain medication during the 6 months prior was similar, but was generally 10-15% lower. Use patterns in 2007 and 2008 were similar. CONCLUSIONS: Across disease states, patients used a variety of medications prior to the initiation of duloxetine. Patterns of use have largely stayed the same from 2007 through 2010.

PMS73

EPIEIDOLOGY, THERAPY PATTERNS AND FUNCTIONAL STATUS OF PATIENTS WITH JUVENILE IDIOPATHIC ARTHRITIS (JIA) IN RUSSIA

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OBJECTIVES: For distribution biologic agents in patients with JIA in Russia, data about epidemiology, used drugs and their impact on functional status are necessary. METHODS: Data were collected via medical chart review by rheumatologists from 11 regions of Russia. Functional status was assessed with CHAQ questionnaire. Inclusion criteria: age (younger than 18 years), minimum 6 months since diagnosis of JIA and available claim data of 6 months retrospectively. RESULTS: A total of 21 independent variables were collected for each of the 15 European countries, including demographic, economic, funding-related, disease-related and biologics-related data. Model results (Adjusted R2 = 0.953, SE = 0.0456) indicated that a country’s share of prevalent RA patients treated with biologics is mostly explained by GDP per capita (β = 0.006, p = 0.00), the share of biologics treatments per dispensing channel - hospital vs. Retail (β = 0.046, p = 0.149) and the usage of methotrexate (β = 0.026, p = 0.05). Based on these variables and their expected evolution we estimated the overall market potential for the Portuguese market, define 4 country clusters and understand Portugal’s relative position among the 15 countries. Share of RA prevalent patients treated with methotrexate in Portugal may be standing 5 years behind comparable countries such as UK, Germany or Spain, thus impacting the shape of patients treated with biologics. CONCLUSIONS: Portugal presents the lowest share of RA prevalent patients treated with biologics. The usage of methotrexate is much higher among subjects followed by a rheumatologist. Patients with RA or MDD, GAD, DPNP, FM, OA, and low back pain (LBP) cohorts in 2009-2010. Antidepressant use during the 12 months prior was common, and was high among MDD patients (30.2%) and the highest among OA patients (45.8%). Utilization of muscle relaxants widely ranged from 22.0% (DPNF) to 40.4% (FM). Use of pain medication during the 6 months prior was similar, but was generally 10-15% lower. Use patterns in 2007 and 2008 were similar. CONCLUSIONS: Across disease states, patients used a variety of medications prior to the initiation of duloxetine. Patterns of use have largely stayed the same from 2007 through 2010.

PMS76

TREATMENT PATTERNS AMONG PATIENTS WITH SHOULDER OSTEOARTHRITIS

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OBJECTIVES: To assess treatment patterns among patients with shoulder osteoarthritis (OA). METHODS: Data from Thomson MarketerScan, a large national managed care population, was used to identify patients with a shoulder OA diagnosis in the first 6 months of 2005 (i.e., the index date). The 360 days post index (identification period) was used to establish baseline treatments (i.e., conservative management (physical therapy and/or medical therapy), steroid injections and shoulder surgery). Patients were required to be continuously eligible for 54 months post-index and were excluded if they had a shoulder surgery claim in the identification period. Four cohorts were followed based on the baseline treatments: C1- conservative treatment; C2- conservative treatment and at least one steroid injection, C3- at least one steroid injection; C4- no treatment claims. Progression to additional treatment was evaluated descriptively from day 361 to 1260 in 180 increments. Logistic regression was used to model the odds or having a claim for a treatment. RESULTS: A total of 3646 patients met the analysis criteria (C1, n = 2,815(77.2%); C2, n = 171(4.7%); C3, n = 270(7.0%); C4, n = 633(17.4%)). The distribution was split evenly between males (50.2%) and females (49.8%). Patients who received steroid injections in the identification period had the greatest likelihood of having a steroid injection in the observation period (C1-19.2%;C2-43.9%;C3-44.4%;C4-14.1%). The percentage who should surgery was 6.4%; 15.2%; 11.1% and 6.5% for C1 to C4, respectively. Patients with steroids in the observation period (C2 and C3) were more likely to have surgery in the first year of observation. Logistic regression showed that females who had steroid injections (C2 and C3 combined) had odds of surgery 2.8 times greater than males with no steroid injections. The most significant predictor of surgery was presence of steroid injections. Rates of steroid injections and surgery differed based on presence of pre-existing treatments.

PMS77

IMPROVING QUALITY AND REDUCING COSTS IN WORKERS’ COMPENSATION

Healthcare: A Population-Based Intervention Study

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OBJECTIVES: To evaluate the effect of a quality improvement intervention that provided financial incentives to physicians to adopt evidence-based practices, coupled with organizational support to improve care management. The intervention, implemented at two pilot sites in Washington State, was aimed at reducing work disability for patients with occupational injuries or illnesses treated within workers’ compensation system. METHODS: At each pilot site, a Center for Occupational Health and Education (COHE) physician team was provided access to evidence for the pilot and to implement the intervention. We conducted a prospective non-randomized intervention study, with a non-equivalent comparison group, using difference-in-differences models. The intervention group included patients (31,520) treated by COHE physicians from July 2004 through June 2007 (n=31,520) and the comparison group included patients (30,176) treated by non-COHE physicians practicing in the pilot target areas. The baseline (pre-intervention) period was specified as July 2001 to June 2003 and included 33,910 patients treated by COHE and non-COHE physicians. Both groups were used logistic regression models and general linear models to analyze four outcomes at one year following injury: off work and on disability, disability days, and disability costs and medical costs per claim. RESULTS: COHE patients were less likely to be off work or on disability at one year post injury (OR = 0.79, P = 0.003). The COHE was associated with a statistically significant (p < 0.01) reduction in disability days (16.5%) and disability costs (23.7%), and with a non-significant (p = 0.13) reduction of 6.7% in medical costs. Patients treated by