for 1 to 5 years in a US Medicare Health Maintenance Organization. The study population was identified using ICD-9 codes (332;332.0) for PD and a claim for at least one filled PD prescription identified using NDC codes. Medication Possession Ratio (MPR) was estimated as proxy for adherence to PD medications, with a threshold of 0.80 indicating adherence. PD symptom progression was defined as increase in prescription strength, addition of another PD medication, an emergency room visit or hospitalization related to PD. Demographic, clinical, and economic variables were extracted from the dataset. Prevalence of non-adherence was calculated over all years and for each year of eligibility. Logistic regression was used to assess relation between medication adherence and PD symptom progression. Sensitivity analyses were conducted for MPR scores less than 0.6, 0.4, and 0.2. **RESULTS:** The study population (N = 470 patient-years) had mean MPR score of 0.49 (±0.38). An average of 66% of study population was not adherent to their PD medications (MPR < 0.8 implies non-adherence). Sensitivity analysis with MPR scores less than 0.6, 0.4, and 0.2 indicated an average of 56%, 46% and 35% were not adherent to their PD medications respectively. Subjects adherent to their PD medications (MPR >= 0.8) had 67% less odds of experiencing PD symptom progression (OR = 0.33; CI:0.12–0.85) compared to people not adherent to PD medications. All subjects with MPR < 0.2 experienced PD symptom progression. **CONCLUSION:** High prevalence of non-adherence to PD medication and its association with PD symptom progression, irrespective of MPR threshold chosen, indicates it is a significant problem. There is a need for mechanisms to improve medication adherence in PD, namely improved patient understanding, simplified treatment regimens and improved tolerability profiles.

DETERMINANTS OF EMERGENCY DEPARTMENT UTILIZATION FOR MIGRAINE CARE

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OBJECTIVES: Over-utilization of emergency department (ED) services for non-urgent medical conditions has been noted as a problem for decades. Headache is the sixth most common reason for ED visits. This study examined factors of ED use in a migraine population. **METHODS:** Medical and Rx claims of Georgia Medicaid beneficiaries who had at least one migraine medical claim (ICD-9 of 346.xx) or one triptan/ergot claim between Jan 2002 and Dec 2005, and were continuously eligible from 6 months before to 12 months after first migraine claim were analyzed. Subjects who had a narcotic claim and a medical claim for cancer (ICD-9 140–239), fractures (800–829), musculoskeletal and connective tissues disease (710–739), or sickle cell anemia (282.6x) 6 months before index date were excluded. Likelihood of a migraine ED visit during the 12 months after index date was estimated using logistic regression while controlling for age, gender, race, metropolitan status of county of residence, physician supply in county, butalbital and narcotic medication use 6 months before index date. **RESULTS:** Data from 43,791 subjects were analyzed. Mean age was 31 years (SD = 17), 23% were male and 55% were Caucasians. Six percent of subjects had used butalbitals and 28% had used narcotics 6 months before index date, and 3% subjects had at least one migraine ED visit 12 months after index date. Females, non-Caucasians, residents of metro counties or counties that had lower than average physician per 10,000 population ratio were more likely to have an ED visit (adjusted odds ratio, AOR = 1.68, 1.51, 2.37, and 3.10 respectively, p < 0.05). Prior narcotic use significantly increased the risk of ED visit (AOR = 1.82, p < 0.001).

Age and butalbital use had no effect on ED use. **CONCLUSION:** Local physician shortage and easy ED access encouraged ED use for non-urgent medical problems. Improving access to primary care facilities is crucial for reducing non-urgent ED use.

DEVELOPING A MIGRAINE QUALITY OF CARE MEASUREMENT SET

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OBJECTIVES: To develop a migraine quality of care measurement set at the health plan level, in order to begin measuring and improving migraine care processes and outcomes. **METHODS:** The measurement set was developed through: 1) review of migraine care guidelines; 2) literature review of quality measurement for migraine care; 3) telephone interviews with thought leaders in migraine care and quality improvement; and 4) assembly of a national advisory board consisting of prominent leaders within migraine care, quality measurement and managed care. The advisory board reviewed collected information from tasks 1–3, discussed candidate measures, and established a consensus on target measures to be included in the set. **RESULTS:** The advisory board selected 19 potential measures that could be implemented at the health plan level using administrative (claims) data. These measures capture information on: migraine diagnosis and prevalence; use of preventive and therapeutic medications; and, primary care, specialist, emergency, diagnostic radiologic, and inpatient service utilization. The measurement specifications have been developed to mirror technical specifications for administrative measures in the Health Plan Employer Data and Information Set (HEDIS). **CONCLUSION:** Development of an evidence-based set of quality measures for migraine care is an important advance in seeking to measure and improve care for migraineurs. Despite its prevalence, and impact on direct and indirect costs, migraine is not currently being addressed in the national quality measurement movement. The measurement set is now being pilot tested in health plans to assess feasibility of data collection, properties of the measures, and correlation among the measures.

UNDERSTANDING LIMITATIONS OF PATIENT REPORTED CLINICAL OUTCOMES IN LUPUS

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OBJECTIVES: Patient knowledge is associated with their ability to manage their disease (self-efficacy). The objective of this study was to examine the extent to which patients with systemic lupus erythematosus (SLE) reported specific organs/system involvement that was consistent with medical records. **METHODS:** In a cross-sectional study, patients with SLE were asked to indicate whether the following organ systems were affected by their lupus: skin/hair/scalp, joints, kidneys, brain, heart/lungs, (abnormal) blood counts, blood clots (including stroke). A retrospective chart review was undertaken to examine organ involvement and tests as recorded by their physician. Exact and kappa measures of agreement between physician and patient report were calculated for each organ system. **RESULTS:** The patient sample (n = 70)