through the first assessment following a CV event were retained. Patients who experienced multiple events or died prior to the next EQ-5D assessment were excluded from the main analysis. Random-effects regression models, specified with random intercepts and slopes, were used to model linear trajectories of utility weights and VAS scores across time. To evaluate the impact of a CV event (hospitalization for heart failure, recurrent acute myocardial infarction, stroke, and resuscitated sudden death/cardiac arrest), the mean trajectory change between the observed HRQL scores following the CV event and the expected HRQL scores based on the patients’ pre-event trajectories were estimated. RESULTS: Among 14,703 adult patients enrolled in VALIANT, 2,556 patients were eligible for HRQL sub-study and completed baseline EQ5D. Among the 504 patients who experienced a nonfatal CV event, the trajectory-adjusted mean change following the event was −0.07 (95% CI: −0.1 to −0.03; P = 0.0007) based on UK utility weights, −0.05 (95% CI: −0.08 to −0.01; P = 0.0082) based on US utility weights, and −0.06 (95% CI: −0.08 to −0.03; P < 0.0001) based on VAS scores. Differences between results using utility weights and VAS scores were most notable for patients suffering a non-fatal stroke with trajectory-adjusted mean change scores of −0.26 with UK utility weights, −0.22 with US utility weights, and −0.06 with VAS. CONCLUSION: Post-MI patients who suffered a subsequent cardiovascular event experienced a significant decrease in HRQL.

RESPONSIVENESS OF PROXY-RATED PREFERENCE-BASED MEASURES OF HEALTH-RELATED QUALITY OF LIFE
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OBJECTIVE: Our aims were: 1) to determine whether proxy responses to generic health related quality of life (HRQL) measures are responsive to meaningful patient improvement in the six months following ischemic stroke; 2) to compare the responsiveness of generic measures by proxy assessment; and 3) to compare proxy to patient responsiveness. METHODS: This secondary analysis of a longitudinal cohort study of ischemic stroke patients and caregivers (n = 124 at baseline; n = 98 at 6 months) included the following HRQL measures: EQ-5D Index, EQ-5D VAS, HUI2, HUI3, and SF-6D. Patients were categorized as improved from baseline to 6 months based on improvement in Barthel Index (BI) categories (mild: ≤85; moderate: ≤60 to ≤85; severe: ≤60). Responsiveness was compared on the basis of effect size (ES) statistics for the baseline to 6 month interval. RESULTS: Stroke patients were primarily male (52%), average 67 (SD 15) years, and had primarily severe stroke (59% categorized as severe by BI). Proxies tended to be female (67%) and either a spouse (48%) or child (32%) of the stroke patient. Among patients who improved according to the BI, all proxy-assessed measures demonstrated large magnitudes of change (ES > 0.80). The SF-6D was the most responsive measure (ES = 1.36; bootstrapped 95% CI: 0.95–1.89), while the HUI3 was least responsive (ES = 0.99, bootstrapped 95% CI: 0.69–1.40), although bootstrapped 95% CIs overlapped for all measures. ES estimates were not significantly different for proxy raters compared to patient self-report (all bootstrapped CIs overlapped). However, the ES for proxy-rated VAS scores was 30% greater than patient report while indirect utility measures tended to produce comparable levels of responsiveness or were larger according to patient report. CONCLUSION: Proxy assessments of stroke patients were responsive to meaningful change using the VAS, EQ-5D, SF-6D, HUI2, and HUI3 during the initial post-stroke recovery process, capturing large magnitudes of changes similar to patient assessments.