PATIENT-VALUED HEALTH STATE UTILITIES FOR BIPOLAR DISORDER: DIFFERENCES THAT CAN BE MEASURED

Hanlon JT1, Mannix S1, Kleinman L1, Martin S2, Revicki D1
1MEDTAP International, Inc, Bethesda, MD, USA; 2J&J Pharmaceuticals Services, LLC, Raritan, NJ, USA

OBJECTIVE: Patients with bipolar disorder experience problems with functioning and well-being, or health related quality of life (HRQL). Utilities, reflecting the impact of psychopathology and treatment on patient HRQL, are needed to estimate outcomes in economic evaluations. Our objective was to elicit utility scores for health states associated with bipolar disorder and side-effects of treatment. METHODS: Patients with a DSM-IV defined diagnosis of Bipolar I Disorder who were currently stable, but had experienced two previous manic or mixed episodes in the last five years, were recruited and interviewed at three clinical research sites in the US. Health states used in the interview were derived from literature, clinical experience and clinical trial data. They included attributes of clinical psychopathology (stable, mania or major depression), HRQL (physical, social, and role functioning), treatment-related side effects, and treatment setting (inpatient or outpatient). In a one-time standard gamble interview, each patient valued a subset of the total number of health states. RESULTS: Inpatient mania mean utility scores for moderate severity, ranged from 0.14 (S.D. 0.20) to 0.37 (S.D. 0.33) and for mild severity, utility scores ranged from 0.13 (S.D. 0.16) to 0.83 (S.D. 0.21). Utility scores for outpatient mania, moderate severity, ranged from 0.15 (S.D. 0.19) to 0.60 (S.D. 0.07) and for mild severity scores ranged from 0.79 (S.D. 0.11) to 0.36 (S.D. 0.16). Stable state scores ranged from 0.36 (S.D. 0.16) to 0.95 (S.D. 0.00) and depression was 0.30 (S.D. 0.33). Treatment related side-effects appear to decrease patient utilities and have a larger impact in stable states. CONCLUSIONS: Health state utility scores can be obtained from patients with bipolar disorder. The utility scores provided by patients for hypothetical states demonstrate differences by disease severity and treatment.

IMPACT OF WEIGHT GAIN ON HEALTH-RELATED QUALITY OF LIFE (HRQL) OF BIPOLAR PATIENTS

Bolge SC1, Meletiche DM2
1Consumer Health Sciences, Princeton, NJ, USA; 2Janssen Pharmaceutical, Inc, Titusville, NJ, USA

OBJECTIVES: To determine whether patients with bipolar disorder with weight gain have different HRQL than those without weight gain. METHODS: In June 2001, 373 persons reported being diagnosed with bipolar disorder on a self-administered questionnaire. Of these, 377 provided information on their weight gains or losses during the past six months. A cross-sectional comparison of the HRQL among patients with bipolar disorder who gained weight and those who did not was performed. Weight gain was defined as gaining six or more pounds (2.73 Kg) over the past six months. HRQL was measured using two validated scales, the Psychological General Well-Being scale (PGWB) and the SF-8. RESULTS: Out of 377 patients included in the analysis, 168 (44.6%) reported weight gain. Patients who reported weight gain had significantly lower mean PGWB scores, 47.4 (SD = 21.9) vs. 53.2 (SD = 23.6) p = 0.015 and lower scores on Anxiety, Self-Control and Vitality subscales compared to those without weight gain. Patients with weight gain had statistically lower scores in the mental health summary scale, and the role emotional and mental health domains of the SF-8. CONCLUSION: Patients with bipolar disorder and weight gain appear to have a lower HRQL compared to patients without weight gain.
Mental health comorbidity is common among veteran populations. Its patterns resemble those found in the general U.S. population. Mental health comorbidity is strongly related to decreased quality of life among military veterans. Improvements in diagnosis and treatment of mental health comorbidity may lead to enhanced HRQoL.

DO HEALTH EXPERIENCES IN DEPRESSION CHANGE PATIENTS’ VALUES?
Elnitsky CA1, Lenert LA1, Sherbourne C2
1University of California, San Diego, San Diego, CA, USA; 2RAND Corporation, Santa Monica, CA, USA

OBJECTIVES: Debate continues regarding the stability of preferences across time and illness. The purpose therefore was to determine if the experience of depressive disorder changes patients’ risk attitudes and elasticity for time, components of their standard gamble (SG) and time trade-off (TTO) utilities. This study tests the explanatory power of the Medical Care System Access Framework for depression experience impact on patient preferences while controlling for patient population characteristics.

METHODS: This study used two years of data from Partners in Care, a group-level randomized controlled trial of quality improvement programs for depression. For 1218 primary care patients with depression, we examined single-item SG and TTO utilities at baseline and 24 months. Logistic regressions identified factors associated with patients’ willingness to take risks and trade time and examined trends in utilities of individuals with and without remission of depression as measured by the Center for Epidemiologic Studies Depression screener and the World Health Organization Composite International Diagnostic Instrument.

RESULTS: A dose-response gradient indicating greater willingness to take risks or trade time was found as depression increased. Patients who continued to be depressed at 24 months were nearly 3 times more likely to be willing to assume risk or trade time than patients whose depression remitted. Willingness to assume risk or trade time increased in patients who continued to be depressed at 24 months. However, the SG appeared to lack sensitivity in patients whose depression remitted. Remission of depression was associated with a decrease in willingness to trade time as expected and a paradoxical increase in willingness to assume risk.

CONCLUSIONS: Patients with depression appear to use a single-item SG measure differently at baseline and 24 months. This could be due to changes in risk attitude resulting from health experiences. Changes in values may confound the use of single-item SG utilities as measures of outcomes.

QUALITY OF LIFE TRAJECTORIES AMONG MASSACHUSETTS ADULTS WITH SUBSTANCE USE DISORDERS
Smith KW, Zhang A, Larson MJ
New England Research Institutes, Watertown, MA, USA

OBJECTIVES: This analysis was designed to characterize longitudinal changes in quality of life in adults receiving publicly-funded treatment for substance use disorders.

METHODS: Clients were randomly sampled from 13 Massachusetts facilities providing publicly-funded detoxification and outpatient drug treatment services. A total of 206 adult clients completed an in-person baseline interview and follow-up telephone interviews 1 year and 3 years later. Quality of life (QOL) was measured by the SF-12 Physical Component Score (PCS) and Mental Component Score (MCS). Latent growth modeling was used to estimate the effects of five factors—age, gender, detox status, managed care status, and drug treatment services—on QOL trajectories over time.

RESULTS: Seventy percent of the clients were recruited from detoxification facilities, 52% were males, 52% were enrolled in Medicaid managed care plans, and 50% received drug treatment services during the year prior to the last interview. The growth models provided excellent fits for both trajectories. MCS scores increased from 31.0 at baseline to 38.9 at the time of the one year follow-up and remained stable at year 3 (39.0). Clients recruited from detox centers had significantly lower MCS scores at baseline and much higher slopes over time. The MCS trends were essentially flat for outpatients. The mean PCS score increased from 43.6 to 46.1 after 1 year but then declined back to 43.0 by the time of the 3-year follow-up. Baseline physical functioning was negatively correlated with client age and managed care status. PCS slopes declined more rapidly for older clients than for younger respondents.

CONCLUSIONS: The results indicate that emotional well-being for substance abusers improves after one year and that this gain is maintained over the next two years. Physical functioning rises and then falls. Managed care and drug treatment during the intervening period had little impact on QOL trajectories.