mCRC) was not recommended in the UK (until June 2009), but accepted under a price volume agreement scheme with prior authorization in Italy, and without restriction in France and Germany. These products are funded on top of DRG costs in France, but not in other countries. We reviewed how such differences might affect use of TRZ in IT, France, and UK. METHODS: Data on drug utilization from June 2006 to July 2009 were extracted from the Synovate Oncology Monitor, an ongoing database tracking prescribing of anti-cancer therapies. Sample sizes varied between countries and indications, from 1700 to 6200 patients. RESULTS: Of patients receiving TRZ from July 08 to June 09, 19% (UK) to 16% (Italy) in early BC, 12% (Italy) to 19% (France) in first-line advanced BC and 10% (France) to 34% (Italy) in second-line (irrespective of HER2 screening). For CTX, utilization rates ranged from 0% (UK) to 13% (France) in first-line advanced BC to 19% (Italy) in second-line utilization of TRZ in Italy, over time in early stage BC. Utilization of CTX was stable in France, increased in Germany, and decreased in Italy. Dosages and patient profiles were comparable across countries.

CONCLUSIONS: Funding on top of DRG does not appear to increase drug uptake. Health technology assessment committee decisions, which have limited enforcement power to overrule existing treatment guidelines, may not address important questions about the full range of benefits and harms of innovative drugs. The utilization patterns in Europe suggest that the mechanisms for controlling drug spending may need to be strengthened. Decisions on the potential for generics to provide cost savings may need to be re-examined.

MULTICRITERIA DECISION ANALYSIS (MCDA) FOR DRUG COVERAGE DECISION BY A PUBLIC HEALTH PLAN: CASE STUDY OF TRAMADOL FOR CHRONIC NON-CANCER PAIN (CNCP) IN CANADA

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OBJECTIVES: To field-test a decision support framework (EVIDEM) and explore its utility for a multi-stakeholder committee using trandol for CNCP (CNCP) as a case study. METHODS: The EVIDEM framework includes a multicriteria decision analysis matrix (MCDA) composed of 15 quantifiable components of decision including six domains (disease impact, context of intervention, intervention outcomes, type of benefit, economics and quality of evidence) and a qualitative tool including six components of decision regarding ethical considerations, system capacity and political/historical context. A synthesized health technology assessment (HTA) report tailored to investigate each component of decision was developed for tramadol for CNCP. MCDA weights and scores, and qualitative considerations were reviewed by each committee member to evaluate tramadol from a public health plan perspective.

RESULTS: The committee estimated the value of tramadol for CNCP at 44% (min: 36%, max: 61%) of maximum value on the MCDA scale. Main contributors to the MCDA value estimate were size of population affected by disease (15%) of total disease severity (11%) and impact on adverse event expenditures (8%). Limited improvement in efficacy, safety and patient reported outcomes were not significant contributors to MCDA value. For a majority of committee members, ethical considerations on utility, efficiency and fairness had respectively a positive, neutral and negative impact on the value of tramadol. CONCLUSIONS: By systematizing consideration of all components of decision and underlying evidence, the framework allows consistent approach to evaluating health care interventions. Further testing and validation is needed to advance MCDA approaches in health care decisionmaking.

EVALUATING THE MEASUREMENT PROPERTIES OF AN AUGMENTED EQ-SD WITH THE INCLUSION OF TWO SINGLE QUALITY-OF-LIFE (QOL) INDICATORS USING THE MEDICAL EXPENDITURE PANEL SURVEY (MEPS)

SRH; VAS

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OBJECTIVES: To evaluate the measurement properties of the EQ-SD profile augmented with its 0-100 mm visual analogue scale (VAS) and a 5-point summary self-rating of health (SRH). METHODS: We used data from 4,001 adults from the 2003 MEPS who had 2 of 7 most prevalent chronic conditions and completed the EQ-SD, VAS, and SRH. The original 101 VAS categories were collapsed into a 9-category item with sufficient responses in each category. Five SRH categories included “excellent”, “very good”, “good”, “fair” and “poor”. We used Rasch analysis and calculated error in the measurement scale.

RESULTS: Two items on the EQ-SD were found to be not interpretable, 2 on SRH, 1 on VAS and 1 on VAS/SRH. Scores for the items of the EQ-SD and SRH were highly correlated. DISCUSSION: The EQ-SD and SRH are well correlated and can be used interchangeably to measure QOL. A possible application is to derive QALYs in cost-effectiveness analyses.

NATIONAL CULTURE AND EQ-SD VALUE SETS

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Background Despite the growing importance of the EQ-SD descriptive system as a basis for the valuation of QALYs in cost-utility analysis, for most countries there are no EQ-SD descriptive or social value sets. Many researchers and policy makers wishing to use the EQ-SD descriptive system in a country for which there is no value set are advised to use one from a nearby or ‘similar’ population. Factors other than geographic proximity can affect the relative values of EQ-3D states. Objective This study explores the links between national culture and EQ-SD values.
between national culture and EQ-SD value sets. Method Rank correlation analysis is used to explore relationships between the relative values of a set of EQ-SD states and dimensions of national culture. The latter are taken from Hofstede’s framework which operationalizes national culture in 5 dimensions. The analysis is carried out using data from 20 countries for which EQ-SD value sets and scores on Hofstede’s dimensions of culture both exist: Argentina, Denmark, Germany, Japan, Korea, The Netherlands, Poland, Spain, UK, USA. Results Some relationships among the EQ-SD dimensions and culture are observed. Eg. the culture dimension: Power-Distance correlates strongly with the EQ-SD dimension: Anxiety-Depression (Spearman’s rho for Power-Distance indices and TTO valuations of EQ-SD states 11112 and 11113 are 0.523 and 0.815 respectively). Strong and moderate relationships are observed among other culture dimensions (Individualism, Masculinity, Uncertainty-Avoidance) and EQ-SD dimension (Health-Care). Discussion Differences in cultures appear to value EQ-SD dimensions differently. The correlation patterns observed in this study are generally consistent with a priori expectations based on the nature of the dimensions of culture and the EQ-SD model. This analysis demonstrates the potential of national culture in providing insights into the drivers of the relative values of EQ-SD dimensions from different countries, and in informing decisions about which EQ-SD value sets to use in situations where one does not exist.

**PR4 ARE HEALTH STATES “TIMELESS”?: A TEST OF THE UTILITY INDEPENDENCE ASSUMPTION: COMPARING A REPEATED MEASURES DESIGN AND LATENT GROWTH MODELING**
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OBJECTIVES: Primary study objective was to test whether individuals’ responses to standard gamble (SG) questions do not depend on the duration of time spent in the health scenario presented (“timelessness”). Secondary objective of the study was to test the “timelessness” of SG responses. METHODS: Face-to-face interviews were conducted in a convenience sample of healthy volunteers (n = 59) aged 20 to 63. Individuals rated their preferences for three health states of varying post chemotherapy nausea and vomiting (PCNV) severity and current health, assuming six different time horizons. Repeated measures analysis of variance (RM-ANOVA) was conducted (SxXsx2) to determine the affect of time (6 levels: 3 days, 3 months, 1-, 5- and 20-year(s) and rest of life). health state (4 levels: mild, moderate and severe PCNV and current health), and method (2 levels: SG and VAS) on preference. RESULTS: Results were analyzed using RM-ANOVA and latent growth modeling (LGM). Both showed that preferences decreased over time for SG and VAS (p < 0.05). For the RM-ANOVA, all main effects and interaction terms were significant (p < 0.05). LGM showed acceptable fit and significant slope parameters for all PCNV. The slopes were decreasing over time with significant latent variances for LGM showed that not all individuals change at the same rate over time (p < 0.05). CONCLUSIONS: There is a clear advantage in the use of LGM over RM-ANOVA because LGM can evaluate group differences in addition to individual changes over time. For the majority of the respondents the utility independence assumption for SG and VAS did not hold both at the group and the individual level. Similar to Bala et al (1999) and Franze et al (2003) the results of this study indicated preferences as measured by SG and VAS are not timeless. Regardless of the preference measure used: both SG and VAS yield higher preferences for shorter time horizons.

**PODIUM SESSION I: RISK MANAGEMENT STUDIES**

**RM1 COMPARATIVE PERFORMANCE OF RISK ADJUSTMENT MEASURES IN A SAMPLE OF COMMERCIALLY-INSURED PATIENTS UNDER AGE 65—TWO SIMPLE MEASURES OUTPERFORM CURRENT STANDARDS**
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OBJECTIVES: Numerous studies have compared risk adjustment measures (RAMs), yet none have done so across various outcomes in multiple acute and chronic conditions in a single database with uniform programmatic operationalization. This study compares the performance of 7 RAMs and highlights practical considerations in a single database with uniform programmatic operationalization.

**RESULTS:**

- **Impact of Adherence with Statin Therapy on Hospitalization Risk and Mortality Among Patients with Diabetes**
  - **Yong T, Banahan BF, Face FF**
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  - **OBJECTIVES:** The objective of this study was to evaluate the impact of adherence with statin therapy on diabetes-specific hospitalization and all-cause mortality among patients with diabetes enrolled in a state Medicaid program. METHODS: The authors conducted a retrospective cohort study of patients with diabetes who were continuously enrolled in a state Medicaid program from January 2002 to December 2004. The date of the first medication claim for statin during the first six months of 2002 was the index date. Adherence to statin was assessed within one year following the index date. Adherence was assessed using the proportion of days covered (PDC) and patients with a PDC of 0.8 or greater considered being adherent. The primary outcomes of interest were diabetes-specific hospitalization and all-cause mortality during the follow-up period (end of adherence measurement to December 31, 2004). Multivariate regression analyses were performed to assess the impact of adherence with statin therapy on outcomes.
  - **RESULTS:** A total 10,839 patients were included in the study. Mean age 60.3 ± 10.0 years, 23.8% male, 76.2 females; 31.7% white, 50.4% black. At 12 months after the index prescription, only 23.9% of patients were adherent with their prescribed statin therapy. During follow-up after controlling for age, gender, race, prior hospitalization, and Charlson comorbidity index, patients who were adherent to statin therapy were 48.7% (OR: 0.51; 95% CI: 0.421–0.624) less likely to have diabetes-specific hospital admission compared to nonadherent patients. Adherence with statin therapy had no statistically significant impact on all-cause mortality (OR: 0.801; 95% CI: 0.454–1.412). CONCLUSIONS: Adherence with statin therapy was poor among patients with diabetes enrolled in a Medicaid program. Adherence with statin therapy was associated with significantly lower risk for diabetes-specific hospitalization. Greater efforts are needed to facilitate diabetes self-management behaviors to improve patient outcomes.

**RM2 IMPACT OF ADHERENCE WITH STATIN THERAPY ON HOSPITALIZATION RISK AND MORTALITY AMONG PATIENTS WITH DIABETES**

**RM3 RISK OF FALLS AND FRACTURES IN OLDER ADULTS USING ATYPICAL ANTIPSYCHOTIC AGENTS: A PROPENSITY-MATCHED RETROSPECTIVE COHORT STUDY**
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- **OBJECTIVES:** To examine the risk of falls/fractures associated with atypical antipsychotic use compared to typical antipsychotic use in community dwelling older adults. METHODS: The population based retrospective cohort analysis based on propensity score matching was conducted using IMS LifeLink™ Health Plan claims data. Patients were included in the cohort if they met following criteria: ≥ 50 years of age, new users of atypical or conventional antipsychotics who began taking antipsychotics between July 2000 and December 2007, and continuously enrolled for six months before and at least six months after initiation of antipsychotic treatment. Patients taking atypical antipsychotics were matched with those taking typical antipsychotics using propensity score greedy matching technique. Kaplan-Meier survival curves and Cox proportional hazard model stratified on matched pair was employed to examine risk of hospitalization/emergency visit due to falls or femur fractures within one year. Duration of antipsychotic therapy and exposure to other psychotropic medications were controlled for in the final model. RESULTS: A total of 11,160 older adults (5,580 atypical and 5,580 typical users) were identified as new users of antipsychotics after matching. Within one year of follow up period, 456 patients (8.06 %) in atypical drug group had falls/femur fractures compared to 373 (7.62%) in typical antipsychotic group. No significant difference was found between atypical users compared to typical agents with respect to risk of falls/fractures [Hazard Ratio (HR) 1.01, 95% CI: 0.83–1.22]. However, duration of therapy more than 90 days was significantly (HR, 1.81, CI, 1.35–2.43) associated with increased risk of falls/fractures compared to less than 30 days. CONCLUSIONS: The study results show no significant differences in the risk of falls/fractures between atypical and typical antipsychotic use among older adults. However, there is a need to be cautious while prescribing atypical and typical antipsychotics in older adults for longer periods of time.

**RM4 CONFOUNDING EFFECT OF AGE IN THE ASSOCIATION OF CARDIOVASCULAR RISK AND DIETARY SUPPLEMENT USE AMONG US ADULTS**
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- **OBJECTIVES:** Dietary supplement (DS) use has been found to be associated with cardiovascular disease (CVD) risk. This study assessed whether age moderates or confounds the association between CVD risk and DS use. METHODS: Data were taken from the 1999–2004 waves of the National Health and Nutrition Examination Survey. Inferences were restricted to US population members ≥20 years of age as