for HUI3. At baseline, agreement between 6D and SG scores was quite low; agreement between 6D and HUI2 was moderate; and agreement between 6D and HUI3 was weak. Agreement at pre- and post-surgery was similar. The change in scores between post- and pre-surgery was lowest for 6D (0.10), intermediate for SG (0.16), and larger for HUI2 (0.22) and HUI3 (0.23). In general, responsiveness was highest for HUI3 followed by 6D, HUI2, and the SG. **CONCLUSIONS:** Agreement between SG scores and 6D and HUI scores was low. The estimate of change in utility associated with THA was lowest for 6D; 6D was less responsive than HUI3. Further studies that provide comparisons appear to be warranted.

PMD33

RELATIONSHIP OF QUALITY OF LIFE DOMAINS TO PREFERENCE-BASED MEASURES OF QUALITY OF LIFE

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OBJECTIVES: It is generally accepted that both the physical and the mental domains contribute to quality of life (QOL). However, the extent to which the domains/dimensions contribute to overall QOL or health state utilities remains controversial. The purpose of this study was to investigate how domains of health related quality of life (HRQOL) are associated with preference-based measures of QOL. **METHODS:** We employed a cross-sectional, supervised self-administered survey to 441 Caucasian-Americans and 341 African-Americans. For one of three hypothetical health state scenarios, each person rated the condition on 4 domains of QOL: Physical Pain/Discomfort, Independence, Social Relationships, Psychological Aspects. Respondents also assessed the condition using the Visual Analog Scale (VAS, 0–100) and time trade-off (TTO). Multiple linear regression models were constructed and analyzed. The outcome variables were VAS and TTO scores. The independent variables were the 4 domain scores, adjusting for current health. **RESULTS:** The independence and physical pain/discomfort domains were strongly associated with VAS (β estimates = –8.643 and –7.138; both $p < 0.0001$). The Social domain had less impact (β estimate = –1.819, $p = 0.0142$), and the Psychological domain was not a significant predictor of VAS. In contrast, the only significant predictor of utility score (TTO) was independence (β estimate = –0.0758, $p < 0.0001$). **CONCLUSIONS:** The psychosocial domains are more strongly related to HRQOL as measured by VAS, than to utility scores as measured by TTO. Only the independence domain translates from HRQOL to utilities. This supports previous work that suggests that HRQOL and utilities may measure different concepts. This raises questions about the appropriateness of quality adjustment using TTO, which deals with morbidity vs. mortality, in situations where there is no mortality factor.

PMD34

COMPARISON OF SF-36 SUMMARY AND PREFERENCE-BASED UTILITY SCORES ACROSS GROUPS DIFFERING IN DISEASE SEVERITY: RESULTS FROM THE MEDICARE HEALTH OUTCOMES SURVEY

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OBJECTIVES: To compare SF-36 psychometrically-based and preference-based utility scores across groups of elderly patients differing in disease severity. **METHODS:** Two cohorts of the Medicare Health Outcomes Survey (HOS), randomly sampled from each of 269 (1998) and 283 (1999) managed care plans, were analyzed at baseline (response rates = 60% and 67%) and 2 years (response rates = 82% and 83%). Severity of illness classifications were based on self-reported symptom severity for congestive heart failure (n = 11,192), ischemic heart disease (n = 29,666), respiratory disease (n = 19,414), diabetes (n = 25,131), and arthritis (n = 75,938). For each condition, respondents were also were classified as with or without current depressive symptoms. Baseline and change scores were compared across condition severity and depressive groups using SF-36 Physical (PCS) and Mental (MCS) Component Summary scores and the SF-6D health utility index. The relative validity (RV) of the SF-36 measures was evaluated by dividing the summary statistical result (F-ratio) for each measure by the result for the best measure (RV = 1.00), for each comparative test. **RESULTS:** When classified by severity of condition (worst to least), mean scores differed substantially from 30.2–45.8 (1.6 SD units) for PCS, 40.6–51.7 (1.1 SD units) for MCS and 0.54–0.75 (1.4 SD units) for SF-6D. For groups differing only in severity of condition, PCS (RV = 0.95–1.00) and SF-6D (RV = 0.89–1.00) showed similar levels of RV, while MCS was substantially lower (RV = 0.31–0.46). For groups differing in both severity of condition plus depressive symptoms, MCS and SF-6D had the highest RV. Similar patterns of similarities and differences in RV estimates were observed across measures in longitudinal comparisons of groups that changed in condition severity and/or depressive symptoms. **CONCLUSIONS:** Psychometrically-based SF-36 summary measures may discriminate/respond best when differences are concentrated in the health component that they best measure; a utility index may discriminate/respond best when multiple components differ across severity groups or change over time.

PMD35

QUALITY OF LIFE DIFFERENCES IN OLDER ADULTS WITH VARIED COMORBID CONDITIONS

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