the Beck at six months (48% vs. 37%, P = .05). Greater quantitative reduction in symptom scores on the Hamilton at six months (10.4 vs. 8.1, P = .006) were observed. Telehealth care improved mental functioning at six weeks (47.1 vs. 42.6, P = .004) and treatment satisfaction at six weeks (4.41 vs. 4.17, P = .004) and six months (4.20 vs. 3.94, P = .001). Medication adherence was the same in all groups and adding peer support to telehealth care did not improve the main outcomes.

CONCLUSION: Nurse Telehealth Care improves clinical outcomes of antidepressant treatment, improves patient satisfaction, and fits well in primary care. The nurse telehealth care program has been implemented in Maine, Ohio and Southern California.

RECENT WEIGHT GAIN AND THE COST OF ACUTE SERVICE USE AMONG INDIVIDUALS WITH SCHIZOPHRENIA

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OBJECTIVE: Newer antipsychotics have been associated with increased weight gain. There is also mounting evidence that this leads to noncompliance and a lower quality of life. Gaining weight is also undesirable for health reasons and may lead to increased use of health-care resources. This study considers the association between weight gain and acute service use for patients with schizophrenia.

METHODS: Questionnaires were mailed to people with schizophrenia identified through National Alliance for the Mentally Ill and the National Mental Health Association in spring 2000 (n = 390). Data presented here are from the 345 respondents who reported weight loss (n = 94, 27%), no weight change (n = 106, 31%), some weight gain (1–14lbs; n = 70, 20%), and significant weight gain (≥15lbs; n = 75, 22%) within the last six months. Acute service use was defined as emergency room (ER) visit or hospitalization. Cost values were those reported in Ernst and Hay (1994). For each individual, total costs were computed by summing across categories.

RESULTS: The group reporting significant weight gain was significantly more likely to use acute services than the other three groups (p < .001 for hospitalization, p < .005 for ER visit). The association remained significant when controlling for other variables in multivariate analyses, including age, gender, ethnicity, and overall distress. Overall costs were highest for those who gained 15 or more pounds ($9,486). Those who lost weight incurred costs of $7,400, those who did not change weight incurred costs of $4,095, and those who gained 1–14 pounds incurred costs of $3,647.

DISCUSSION: Our preliminary results suggest that recent weight gain is associated with greater use of acute services and higher costs. There are several plausible explanations. For example, physicians might change medications for people doing poorly (e.g., start a new medication after an acute psychiatric episode). Another possibility is that acute medical services are more likely to be needed after an episode of rapid weight gain.

QUALITY OF LIFE

CAN HEALTH STATE VALUES BE PREDICTED FROM HEALTH-RELATED QUALITY OF LIFE MEASURES?

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OBJECTIVE: To predict Health State Values (HSV) from health-related quality of life (HRQL) assessments could, if possible, be a fruitful way to use HRQL values for health-economic evaluations. With this in mind, we investigated to what degree values from the EuroQol instrument, the EQ-5D index, and the EQ-VAS visual analog scale, could be predicted using HRQL measures for patients with respiratory diseases.

METHODS: Data from two surveys of patients with respiratory disease were used for this evaluation. The first data set was from 206 patients in Hungary suffering from asthma, and the other was from 120 patients in the northern part of Sweden with COPD. Both surveys included patients with different severities of the diseases. The HRQL instruments used in both surveys were the SF-36, a generic instrument, and St George’s Respiratory Questionnaire (SGRQ), a disease-specific instrument. The two data sets were analyzed separately using a multiple logistic regression model in a stepwise manner to predict EQ-5D and EQ-VAS from the eight domains of SF-36 and the three domains of SGRQ, after transformation of EQ-5D and EQ-VAS to a 0–1 range.

RESULTS: The amount of variation in both the EQ-5D and EQ-VAS that could be explained from the combined HRQL measures was at most 56%. EQ-5D had larger values than EQ-VAS. Using SF-36 domains only as predictors gave marginally lower values. The two domains from SF-36 with best predictability explained about 90% of the reduction achieved with all 11 domains together from the two HRQL-measures, indicating correlation between the different domains.

CONCLUSION: Values for EQ-5D and EQ-VAS predicted from SF-36 and SGRQ have moderate precision and should be used cautiously.

ESTIMATING PATIENTS’ PREFERENCES IN TREATMENT CHOICES INVOLVING RISK: A NEW MODIFIED STANDARD GAMBLE METHOD

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OBJECTIVE: Cost-effectiveness, -utility and -benefit analyses have made a substantial impact on health care. Current approaches are methodologically coherent and provide a basis for improved resource allocation. As has been noted before, they are based on expected (average) outcome and do not take into account patients’ risk preferences, which are important aspects of clinical decision-making. From a patient’s perspective, a treatment associated with a lower level of expected clinical benefit may be preferred if it has better worst-case scenario than a treatment with higher expected (average) benefit. We analyze decision-scientific methodology in order to incorporate risk preferences into the framework of outcome and utility studies.

METHODS: Concepts of risk preferences in decision-making from economics and management science are described, and their applicability to a clinical context is tested using a decision tree model. Methods analyzed include the Bayes-Principle of expected value (m-principle), the m-s-principle, risk restriction with given outcome and the Bernoulli-Principle. The absence of risk preferences in the QALY (quality adjusted life years) and HYE (healthy years equivalent) concepts is shown mathematically.

RESULTS: Current methodological concepts used in outcomes research do not adequately incorporate patients’ risk preferences. On the basis of a modified standard gamble approach a method of obtaining risk preferences for given treatment outcome is developed. It leads to the determination of relative marginal utilities and may be used in choosing health-care interventions by considering relative marginal costs.

CONCLUSION: Patients’ risk preferences should be taken into account in outcome and utility analyses involving substantial risks. The approach proposed here may improve the empirical estimation of patients’ preferences and the quality of resource allocation in health care.

PSYCHOMETRIC PERFORMANCE OF THE MEDICAL OUTCOMES STUDY SLEEP SCALE IN THE US GENERAL POPULATION

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OBJECTIVE: Support for the reliability and validity of the Medical Outcomes Study (MOS) Sleep Scale was provided in the MOS sample of 3445 individuals with chronic illness. We sought to extend this work by evaluating the psychometric properties of the MOS-Sleep Scale in the US general population.

METHODS: The MOS-Sleep Scale is a 12-item, self-reported survey that yields six subscales: sleep disturbance, snoring, awaken short of breath or with headache, quantity of sleep, sleep adequacy, and somnolence as well as a nine-item sleep problem index. The subscales and problem index are scored on a 0 to 100 range, with higher scores indicating more of the domain being measured. We administered the MOS measure by telephone to a nationally representative sample of 1011 US adults aged 18 and older in January 2001.

RESULTS: The average age of the sample was 46; 51% were female and 74% were white. Internal consistency reliability estimates for the MOS-Sleep scales tended to be adequate: sleep disturbance (4 items, alpha = 0.80); sleep adequacy (2 items, alpha = 0.82); sleep somnolence (3 items, alpha = 0.63); and nine-item sleep problems index II (alpha = 0.83). Adjusting for age and gender, MOS patients reported significantly more quantity of sleep (t = 3.27, P < .002), but significantly worse sleep disturbance (t = 5.08, P < .001), snoring (t = 2.16, P < .05), shortness of breath (t = 4.59, P < .001), sleep adequacy (t = -2.39, P < .05), somnolence (t = 5.10, P < .001), and sleep problems (t = 3.27, P < .002) than the general US population.

CONCLUSIONS: The MOS-Sleep Scale was found to have good internal consistency reliability and to discriminate between patients with chronic illness and the US general population. Further work is needed to compare the MOS-Sleep Scale results with objective measures of sleep such as polysomnography.

SESSION IV

MENTAL HEALTH II

SLEEP DISORDERS AND HEALTH RELATED QUALITY OF LIFE— AN EPIDEMIOLOGICAL SURVEY

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OBJECTIVE: To analyze health-related quality of life among people with sleeping problems from an epidemiological perspective.

METHOD: A cross-sectional survey on a sample aged between 20 and 84 years in the county of Uppland, Sweden yielded a response in 5404 patients (68%). A recall period of two weeks was used for sleeping problems and use of sleeping medication. The SF-36, used to measure HRQoL, covers eight domains of health: physical function (PF); role limitation because of physical health (RP); bodily pain (BP); general health perception (GH); vitality (VT); social functioning (SF); role limitation because of emotional health problem (RE), and mental health (MH). Linear regression analysis was employed for the multivariate analyses.

RESULTS: In all, 20.3% of the population reported sleeping problems. Sixteen percent had experienced sleeping problems but had not used sleeping medication while 4.3% had used medication. The prevalence of sleeping problems was of the same magnitude between the ages of 20 to 74 years (around 20%) but higher among those aged 75 to 84 years (29.5%). Sleeping problems were more prevalent among women (23.8%) than men (16.1%). The use of sleeping medication increased by age. Among