

folio concept was developed. Apart from “traditionally” used variables, key health economics parameters were additionally included to examine their potential impact on the overall product portfolio matrix. **RESULTS:** Several papers concluded that human judgment combined with assessments of standard financial parameters and market attractiveness were the most frequently used approaches in portfolio management. Increasingly, and especially with regard to the flood of molecules and technologies due to advances in science, health outcomes parameters are being considered as important decision-making variables in early portfolio assessment. When including these parameters in the portfolio model, the potential significance of health economics in strategic product development decisions can be demonstrated. **CONCLUSIONS:** This review indicates that the integration of health economics in portfolio management is currently not state of the art. The example underlines the strategic importance of these variables to biotech vaccine companies in the assessment of licensing opportunities, compound selection, and research termination decisions. Further research seems indicated to measure the added value of health economics in portfolio management.

**PHP24**

**USE OF POLICY MODELING TO PROMOTE INFORMED DECISION MAKING: DEVELOPMENT AND APPLICATION OF THE CANADIAN STROKE POLICY MODEL**

Matchar DB<sup>1</sup>, Samsa GP<sup>1</sup>, Nichol G<sup>2</sup>, Peters KP<sup>1</sup>, Shurr E<sup>1</sup>, Engelhart L<sup>1</sup>, Bushnell CD<sup>1</sup>

<sup>1</sup>Duke University, Durham, NC, USA; <sup>2</sup>University of Ottawa, Ottawa, ON, Canada

**OBJECTIVES:** Stroke affects over 40,000 Canadians each year at an aggregate cost in excess of 2.7 billion Canadian dollars. An acute stroke treatment service (ASTS) represents an organized approach to the management of stroke patients and has been shown to be effective: approximately 4 of 5 stroke patients are candidates for ASTS care, and for every 18 patients treated in this way, one will avoid death or dependence, compared to usual care. Nevertheless, ASTS care is not widely available; in part, it requires financial resources and thus active participation of busy local policy makers. **METHODS:** To promote informed policy level decision-making we developed the Canadian Stroke Policy Model (CSPM), a comprehensive simulation model of stroke development and outcome tailored to the Canadian context. Programmed in SAS-IML, the CSPM was linked to a web based, interactive education program designed for use by local policy makers. Based on user inputs (local demographics and resource costs), the software takes the user through three steps aimed at: 1) illustrating the overall burden of stroke in a province or region, 2) defining an ASTS, including the scientific evidence of efficacy and an estimated cost of creating and sustaining such a service

locally, and 3) describing the potential impact of an ASTS on mortality, disability, and cost for a particular population. **RESULTS:** An alpha version of this software has been assessed for face validity by representative regional policy makers and subsequently revised. **CONCLUSIONS:** This application serves as a proof of concept, demonstrating how a comprehensive disease simulation model can be tailored to local conditions, linked to an educational interface, and made engaging to relevant policy makers. The strategy of using a comprehensive disease model to develop an effective “hands-on” experience for decision makers is promising and deserves a formal evaluation of its impact.

**PHP25**

**METHODOLOGICAL ISSUES: RESOURCE-BASED ZERO WORK HOUR PROCEDURES IN U.S. PHYSICIANS' OFFICES**

Baker JJ

University of Rochester, Pickton, TX, USA

**OBJECTIVE:** The Centers for Medicare and Medicaid Services (CMS) compute clinical staff incident-to-services in physician offices under a zero work hour alternative method. This study compares the results of CMS alternative method computations with the actual resource-based level of effort observed in U.S. physicians' offices. **METHODS:** Phase I: CMS methods used for zero work hour rate-setting were identified. Underlying assumptions were examined and formal methodology evaluations were collected. Phase II: On-site activity analyses were performed in 38 physicians' offices located in 16 states. An activity database was created from study data obtained through direct observation and on-site interviews. Analyses employing descriptive statistics identified activities, tasks, level of effort, and staff level involved in each specific task. Zero work hour activity analysis findings were compared to the CMS resource-based assumptions about these activities. **RESULTS:** A database of methodology explanations, visuals, and evaluations was created. An evolution time line of CMS methodologies and underlying assumptions was created. Study analyses revealed a statistically significant differential between actual and assumed use of clinical labor versus administrative labor for particular zero work pool tasks. Over one-half of tasks assumed to be performed by administrative personnel were routinely performed by clinical personnel, at a standard labor cost differential exceeding 155%. **CONCLUSIONS:** CMS zero work hour methodology employing an average for all specialties is flawed. In addition, the basic cost pool assumptions about division of labor within the zero work hour procedures do not align with actual practice within the physicians' offices. These findings will be of use to economists, cost accountants and policy makers interested in arriving at an equitable resource-based method for zero work hour procedures performed by clinical staff in physicians' offices.