patients initiated at Lausanne University hospital (Switzerland). Items not sensitive enough to capture short-term costs and consequences will be removed. Translation into other major languages and adaptation to different settings after cultural validation is planned. CONCLUSIONS: Publication of this tool should facilitate additional knowledge about resource utilisation at the patient level and enable evaluation of short-term economic impact of pharmaceutical and non-pharmaceutical interventions.

**OBJECTIVES:** Migraine is a common and disabling condition. Real-world health care experiences of patients treated for a given time period, subject to the extent resource allocation scenario and constraints on the utilization of those resources. METHODS: Sampson is a software tool that uses a quantitative, goal oriented approach to optimize the utilization of health care resources. The Sampson optimization module accepts as input a numerical value, and selects a set of patients for treatment in a given time period that will keep waiting times below target Maximum Acceptable Waiting (MAW) times, subject to alternative allocation of health care resources. These resources include operating room (OR) time, Special Care Unit (SCU) time, or OR nurse time, anesthetist time, surgical cost and anesthetic cost. Additional determinants of system performance which are factored into the Sampson patient selection process are changes in staff availability, patient care policies and MAW values by surgical specialty. Evaluation of Sampson’s predictions of system performance under different resource allocation scenarios and vehicle availability and its ability to provide decision support to system managers. Furthermore, the use of the Sampson patient selection set is intended to optimize efficiency within a potentially complex organizational structure, including health regions, hospitals, surgical divisions and surgeons. The surgical waiting list used as an input by the Sampson optimization module may be extracted from a surgical center’s operative systems, or may be produced by a patient arrivals simulation process. The arrivals simulation is based on the historical arrival pattern and expected future changes to that pattern. RESULTS: An example scenario is presented which compares the predicted outcomes of three different resource allocation options for a two hospital surgical system. CONCLUSIONS: The results have significant implications for policy makers and health care researchers interested in optimization of resource allocation decisions and minimizing the waiting time for surgical treatment.

**CONCLUSIONS:** Underestimation of uncertainty in cost-effectiveness acceptability curves and expected value of information analyses may be biased by overestimating clinical effectiveness and underestimating uncertainty. Reasons are small randomized controlled trials (RCTs) as the underlying source of effectiveness data and the overoptimistic, albeit implicit, assumption that the prior probability of the null hypothesis being false is 50%. If clinical evidence is based on small RCTs with sensitivity and specificity of 65% and 70%, respectively (LeLorier 1997), the maximum probability of cost-effectiveness decreases to 68%, irrespective of the willingness to pay, H, in addition, a 10% prior probability of effectiveness is assumed (Sterne 2001), the maximum probability of cost-effectiveness drops to 19%. Similarly, the EVP is 8-fold if low sensitivity and specificity of small RCTs as well as a 10% prior probability of effectiveness are considered. Therefore, traditional CEAC and EVP analyses based on small RCTs and an implicit 50% prior probability of the null hypothesis being false should be reassessed.

**METHODS:** Linking person-level inpatient data to longitudinal records is intended to provide decision support to system managers. Furthermore, linking it to longitudinal histories from health plan administrative data. Judicious use of this resource for outcomes research requires understanding potential selection biases.

**RESULTS:** For 2006 there were 77,277 linked discharges. Compared with NIS, more were in Medicare (52% v. 20%) and fewer in Medicare (20% v. 37%) or commercial (29% v. 34%) health plans, reflecting the payer mix of the claims database. They were younger (44 v. 48 years) and more female (67% v. 58%) than NIS. Average length of stay was 4.6 days in both samples. Of the top 10 most frequent DRGs in NIS, accounting for 31% of US discharges, 8 were also in the top 10 of the linked sample. CONCLUSIONS: Patient-level hospital discharge data can be enhanced by linking it to longitudinal histories from health plan administrative data. Judicious use of this resource for outcomes research requires understanding potential selection biases.

**CONCLUSIONS:** This work addresses the problem that common measures of uncertainty of cost-effectiveness, ie, cost-effectiveness acceptability curves and the expected value of perfect information (EVP), may be biased by overestimating clinical effectiveness and underestimating uncertainty. Reasons are small randomized controlled trials (RCTs) as the underlying source of effectiveness data and the overoptimistic, albeit implicit, assumption that the prior probability of the null hypothesis being false is 50%. If clinical evidence is based on small RCTs with sensitivity and specificity of 65% and 70%, respectively (LeLorier 1997), the maximum probability of cost-effectiveness decreases to 68%, irrespective of the willingness to pay, H, in addition, a 10% prior probability of effectiveness is assumed (Sterne 2001), the maximum probability of cost-effectiveness drops to 19%. Similarly, the EVP increases 8-fold if low sensitivity and specificity of small RCTs as well as a 10% prior probability of effectiveness are considered. Therefore, traditional CEAC and EVP analyses based on small RCTs and an implicit 50% prior probability of the null hypothesis being false should be reassessed.