may refer both to a paid job and voluntary work, other languages may require different expressions to convey this global notion. The reference to "daily activities" may be an alternative facilitating international harmonization across languages and pooling of data. Similarly, reference to “patient initials” being inappropriate for Chinese languages, replacing the original with “patient record number” can improve international acceptability.

CONCLUSION: The Translatability Assessment may be a practical and easy way to integrate an international component in the design of new measures, thereby facilitating the subsequent translation by anticipating and solving its difficulties.

EVALUATING THE STRUCTURE OF PHARMACOECONOMIC FELLOWSHIP PROGRAMS

Maio V, Lofland JH, Crawford AG

Thomas Jefferson University, Philadelphia, PA, USA

OBJECTIVE: There is limited information about the structure of current pharmacoeconomic fellowship programs. The purpose of this study is to describe the structure of pharmacoeconomic fellowship programs from the fellow perspective.

METHOD: This was an observational cross-sectional web-based study. A questionnaire was administered to fellows currently enrolled in a pharmacoeconomic fellowship program. A list of fellows was identified from the American College of Clinical Pharmacy (ACCP) and the International Society for Pharmacoeconomics and Outcomes Research (ISPOR) directories, and personal contact information. An email, which included a description of the study along with an ISPOR web-site link for accessing the survey, was sent to each identified fellow. In addition, all ISPOR members were sent an email describing the study and an advertisement was posted on the ISPOR web-page to increase survey participation.

RESULTS: A total of 34 fellows completed the web-based survey. Of these, 79% had a PharmD degree before applying for a fellowship program and 79% indicated that the fellowship program was located in at least two sites, predominantly an academic institution and pharmaceutical industry. In terms of available resources, all sites had a medical library, while 88% had computer centers, and only 56% had data analysis centers from clinical studies. Regarding staff qualifications, respondents stated that 97% of preceptors had an advanced degree, such as PharmD or PhD, and 72% had 5 years or more of experience in pharmacoeconomics and outcomes research. In addition, 28% of preceptors had completed at least one fellowship training experience.

CONCLUSIONS: This study described the current structure of pharmacoeconomic fellowship programs from the fellow perspective. Such results may be beneficial for organizations and institutions wishing to modify and improve the structure of their fellowship programs.

THE USE OF DRG-RELATED DATA ON KNEE PROCEDURES IN THE ANALYSIS OF UTILISATION OF RESOURCES BETWEEN BELGIAN HOSPITALS

Putman K1, Corens D1, Nieberding P2, Schots J1, Beeckmans J1

1Centre of Health Economics and Hospital Policy—Vrije Universiteit Brussel, Brussel, Belgium; 2University Hospital—Vrije Universiteit Brussel, Brussel, Belgium; 3Centre of Health Economics and Hospital Policy—University Hospital, Vrije Universiteit Brussel, Brussel, Belgium

Comparison of utilisation of resources between hospitals is a common procedure in benchmarking. Although to be able to compare, homogeneous groups of patients should be selected.

OBJECTIVES: This paper verifies the comparison of utilisation of resources for knee procedures.

METHODS: A sample of 13 hospitals was selected to compare patients who were treated for knee procedures. Only patients admitted in DRG 222 were recruited for the study. Data on utilisation of resources concerning medical procedures, medical imagery, use of drugs and clinical biology was studied.

RESULTS: After data validation 2.076 patients were included in the study. Between the hospitals a significant difference in the use of resources was notified. Nevertheless a general conclusion was too confounding because of the case-mix in the hospitals. Further analysis found that the main reason was the difference in operating technique. The differentiation between groups could not be made on the basis of the ICD-9 code only. Based on the national coding system of procedures additional grouping techniques were possible. Those hospitals in which the arthroscopy is a common technique, the use of resources is significant lower in all the resource domains studied. In the use of conventional radiology, the group of patients with arthroscopy had lower correlations with the volume of resources (r = .89 vs. r = .95). The analysis of operating procedures showed even more differences in the correlation between the use of resources and the group of patients (with arthroscopy (r = .409) versus without arthroscopy (r = .904)).

CONCLUSION: When the use of resources is compared between patients with knee procedures it is very important to differentiate in the technique that is used. The use of DRG and ICD-9 codes is not specific enough to make the comparison possible.
Guidance on the choice of data sources for cost weights in cost-effectiveness analyses in the literature is scarce with few empirical examples of cost weights derived from different approaches.

OBJECTIVES: This paper describes the large differences that can be found in cost weights derived from different data sources and analytic approaches. We highlight the implications of the choice of costing data source and the magnitude of error that could be introduced by assuming data parity in direct comparisons of different studies. Though our examples focus on HIV disease treatment, the issues we explore are generic to cost estimation for all conditions.

METHODS: We compared annual HIV disease treatment cost weights from two data sets, the HIV Cost and Services Utilization Study (HCSUS) survey and South Carolina Medicaid data. Cost weights for hospital and nursing home stays and emergency room and physician visits were included in the analyses.

RESULTS: The cost weights for Medicaid patients with AIDS were $15,033 in HCSUS and $10,281 in SC Medicaid data. Within the HCSUS data set, cost weights also varied greatly depending on whether the patient was covered by Medicaid ($15,033), Medicare ($8,487), private ($4,200), or other public insurance ($19,347). Further analysis of the HCSUS data found that the mean cost estimates for patients were larger when viral load (VL) data was missing ($8,413) than when it was included ($5,362). This difference was especially pronounced at higher CD4 cell count ranges. For example, the mean cost for patients with CD4 200–499 was $3,829 when VL was reported and $6,458 when it was missing, a difference of 67%.

CONCLUSION: As this research illustrates, there may be large differences in cost weights that are derived from different data sources and analytic approaches. Accordingly, they should be given careful consideration when determining the external validity of economic studies.

SATISFACTION WITH SMOKING CESSATION TREATMENTS—A SYSTEMATIC REVIEW OF THE DIMENSIONS

Holdford DA
Virginia Commonwealth University, Richmond, VA, USA

A major weakness of the literature on treatment satisfaction is the lack of rigor in the development of satisfaction measures. Part of this problem lies in the absence of an accepted conceptual model for treatment satisfaction.

OBJECTIVES: This paper presents a conceptual model for treatment satisfaction and uses it to identify the underlying dimensions associated with smoking cessation treatments.

METHODS: A systematic literature review of databases including MEDLINE, ABI-INFORM, Current Contents, and IPA was conducted. Key words used for the literature search included drug, patient, smoking, physician, pharmacist, placebo effect, and treatment satisfaction. Articles included in the review focused on drug and provider attributes shown in the literature to be significantly associated with overall perceptions of treatment experiences. Treatment satisfaction attributes involving high levels of patient-provider contact were emphasized due to their relevance to smoking cessation treatments.

RESULTS: A conceptual model for treatment satisfaction, based upon the review, was considered to consist of a patient’s assessment of salient aspects of the process and outcome of treatment experiences. Since treatment experiences often contain the administration of both products and services, the conceptual model was considered to consist of both product and service attributes. Support was found in the literature for this conceptualization since evidence showed that both product and service attributes have significant impact on overall evaluations of treatment experiences. Product-related attributes significantly impacting overall treatment satisfaction were categorized under four of the product quality dimensions defined by Garvin (1984): Performance, Features, Aesthetics, and Perceived Quality. Service-related attributes of treatment were classified under the dimensions: Attitude, Responsiveness, Communication, Trust, Access, Motivation, Expertise, and Tangibles.

CONCLUSION: The literature demonstrated support for a conceptual model of treatment satisfaction with both product- and service-related attributes. The inclusion of service attributes is particularly important for treatments consisting of high levels of patient-provider contact such as with smoking cessation treatments. The dimensions in this conceptual model can assist in the development of treatment satisfaction measures.

DESIGN AND VALIDITY OF AUTOMATED HEALTH CARE DATA SCREENS TO DETECT IN-HOSPITAL ADVERSE DRUG EVENTS

Sauer BC, Winterstein AG, Mattenklotz AM
University of Florida, Gainesville, FL, USA

The Institute of Medicine Report on Patient Safety requests a 50% reduction of adverse events. This however, poses a challenge from a measurement perspective. Incidence estimates of adverse events have traditionally been based on medical case review, which is exhaustive and costly. Furthermore, the reliability of this method has been challenged. Recent studies have applied information technology to screen for adverse drug events (ADEs) in order to replace chart review.

OBJECTIVE: To explore the extent to which automated health care data screens can be used to measure the incidence of in-hospital ADEs.

METHODS: Systematic literature review. Keyword search of MEDLINE (1980–2001) electronic database and hand search. Included studies had to describe specific screens that were applied to clinical or administrative databases to detect in-hospital ADEs. They also had to