(48%), and energy/activity level (36%) for Physical; juvenileonialization (51%) and teasing/bullying (20%) for Social; and self-confidence (45%) and anxiety (16%) for Emotional. Emotional and social impacts were often related to others’ perception or treatment of the child as younger, and all impacts were moderated by physical growth. Additionally, children who began treatment later in life experienced more emotional and social impairment (62%) than did children who started at an earlier age, and caregivers reported consistent symptoms/impacts. Modifiers to the degree of impact of GHD were identified and include age at treatment, growth velocity, and having previously been diagnosed with GHD. Respondents did not differ substantially among countries. CONCLUSIONS: Concept elicitation of the burden of disease for children with GHD identified key concepts that should be included in PRO/ObSRO measures to assess the impact of GHD and treatment.

PDB81

OBJECTIVE: To identify and compare the health outcomes profiles of adults receiving medical care at specialty clinics for symptomatic chronic pain and largely asymptomatic (diabetes) chronic conditions. METHODS: Respondents receiving care at pain or diabetes clinic completed the PROMIS-29 instrument that measures 7 health domains. Item response theory-based scores are on the T-score with a mean of 50 and standard deviation (SD) of 10 based on the general United States population (norm). RESULTS: A total of 227 participants in the study (n=128 chronic pain; n=99 diabetes). The mean age was 46.7 years (SD=13.7), 56% were women, 48.6% were non-white, and 31% had ≥12 years of education. Pain clinic patients were significantly older and less educated than diabetes clinic patients, however there were no other demographic differences between patient groups. All 7 domains scores were statistically significantly worse for the chronic pain clinic sample compared to diabetes clinic patients (P<0.001 for all comparisons). The smallest and largest differences between clinics were observed for anxiety (mean difference for all diagnostic groups for anxiety was 1.7 SDs worse than the norm). Pain clinic patients compared with diabetes clinic patients (P<0.001 for all comparisons). Adjustment for age, sex, and education only slightly attenuated differences between the two patient populations. For example, the unadjusted mean difference between diagnostic groups for physical function was 17.7 (P<0.001), while the mean difference was 11.7 (P<0.001) when adjusted for pain interference. All other health domains were significantly worse in the pain clinic sample than diabetes clinic patients. CONCLUSIONS: Compared with patients with diabetes, chronic pain clinic patients had a substantially poorer PROMIS-29 health outcome profile. Findings indicate that not only are health outcome profiles for chronic pain clinic patients poor relative to the US population, but also poor relative to patients with a different chronic but relatively asymptomatic condition (diabetes) suggesting that severe symptoms may have a more significant impact than chronic disease per se.

PDB82

OBJECTIVE: To utilize the SF-36V2 MENTAL COMPONENT SUMMARY SCORE TO DESCRIBE MENTAL WELL-BEING EXPERIENCED BY PATIENTS WITH TYPE 2 DIABETES METHODS: Data were from the 2013 U.S. National Health and Wellness Survey. The survey population was ≥18 years old and included those self-reporting a T2D diagnosis. Mental well-being scores were calculated using the SF-36v2 mental component summary score. RESULTS: The analytic sample included those self-reporting a T2D diagnosis. Mental well-being (Work Productivity and Activity impairment questionnaire) and healthcare utilization in the past 6 months. Multivariable analyses were performed to adjust for baseline differences (e.g., age, gender, ethnicity, household income, insurance status, comorbidity burden, etc.) RESULTS: Among respondents with T2DM and SD, 7.06% were obese, 23.0% had SD, and 17.4% had obesity and SD. Multivariable analyses showed significantly worsening health status and greater productivity loss and healthcare utilization among respondents with T2DM and SD compared to those with T2DM only. CONCLUSIONS: Multivariate analyses showed significantly worsening health status and greater productivity loss and healthcare utilization among respondents with T2DM and SD compared to those with T2DM only. More work is needed to understand how these findings translate to real-world settings.