sensitivity analysis (PSA) results. METHODS: Decision analytic models were developed in Excel and R to assess the cost-effectiveness of a hypothetical therapy for a hypothetical, chronic disease. The models consisted of a decision tree (22 branches) for the first year of therapy and of a Markov model to capture long-term costs and effects. We considered 24 decision model nodes, 54 decision model parameters, and 44 health utilities. Parameter estimation and utility parameters were hypothetical. Probabilistic sensitivity analysis was used to assess decision uncertainty by performing 10,000 Monte Carlo simulations. RESULTS: The incremental cost-effectiveness ratio (ICER) of the new therapy was $75,962/QALY when calculated with R and $75,962,147/QALY when calculated with Excel. At a threshold value of $50,000 per QALY, the probability that the hypothetical treatment is cost-effective was 14.5% when calculated with Excel and 13.6% when using R. At higher thresholds of $100,000 and $150,000 per QALY, the probability estimates increased to 80.4% (Excel) and 80.6% (R) and 98.0% (Excel) and 98.1% (R), respectively. CONCLUSIONS: Excel and R allow building and analyzing complex decision models. As we showed, both model implementations yield the same results when calculating an ICER, up to 14 digits. The benefit-risk tradeoff data of post-transplant outcomes among chronic kidney disease patients at risk for kidney transplant and estimate maximum acceptable adverse-event risks for specified efficacy improvements. METHODS: IS US residents aged 18 years or older with a self-reported diagnosis of chronic kidney failure or end-stage kidney disease completed a web-enabled survey instrument that presented a series of trade-off questions, each including a pair of hypothetical post-transplant outcome profiles. Each profile was defined by five efficacy attributes and three life-threatening adverse-event attributes. Each subject answered 9 trade-off questions based on a pre-determined experimental design with known statistical properties. RESULTS: A total of 233 subjects completed the survey. Subjects judged life expectancy to be more than three times more important than the next most important outcome. There were no significant differences in preferences between older and younger subjects. Subjects over age 54 judged risks of impaired renal function, graft loss, acute rejection, infection, and malignancy as similarly important and progressive multifocal leukoencephalopathy (PML) risk as much less important. Subjects under age 54 judged risks of acute rejection, malignancy, and PML as unimportant. Maximum acceptable risk of serious infection for a one-year increase in expected survival was 8.5% (5.1%–17.7%) and 1.6% (0.9%–3.1%) for older and younger subjects, respectively. CONCLUSIONS: The benefit-risk tradeoff data of post-transplant outcomes among chronic kidney disease patients at risk for kidney transplant and estimate maximum acceptable adverse-event risks in different patient populations. These estimates of risk tolerance provide a useful quantitative approach to identifying treatments where acceptable risk levels exceed actual risk levels by significant margins.

PODIUM SESSION II: PATIENT PREFERENCE STUDIES

PP1 A SYSTEMATIC REVIEW OF THE ANALYTIC HIERARCHY PROCESS IN HEALTH CARE DECISION MAKING

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OBJECTIVES: Many cost-effectiveness analyses in rheumatoid arthritis (RA) rely on statistical models relating Health Assessment Questionnaire Disability Index (HAQ) scores to health utilities. Linear models can produce out-of-bound estimates of Health Utilities Index Mark 3 (HUI3) scores. We estimated bounded, nonlinear relationships between HAQ and HUI3 based on patient-level data. METHODS: Bayesian generalized linear models (GLMs) were developed to predict baseline HUI3 conditional on baseline HAQ using patient-level data from the PREMIER (2-year controlled study in early RA) and ARMADA (24-week controlled study in longstanding RA) trials. HUI3 was rescaled to the interval [0,1] and modeled using a beta distribution and logistic link function. Normal-linear models were also estimated. Alternative specifications included age, sex, and HAQ-squared as additional predictors. Model parameters were estimated using Markov Chain Monte Carlo (MCMC) methods and compared using the deviance information criterion (DIC); lesser values imply better fit. Predicted values from beta-logistic models were linearly retransformed to the original HUI3 scale. RESULTS: Results were similar in early and later RA. Based on DIC, the beta-logistic models were more likely to generate the observed data than were the normal-linear models (PREMIER: $673.0 vs. $614.4; ARMADA: $226.1 vs. $215.8). Qualitatively, predictions from the beta-logistic models differed modestly from the normal-linear model. At low disability (HAQ = 0.0), predicted HUI3 utilities were 0.75 vs. 0.81 (PREMIER) and 0.74 vs. 0.79 (ARMADA) for the beta-logistic and normal-linear models, respectively. At high disability (HAQ = 3.0), predicted HUI3 utilities were 0.03 vs. 0.05 (PREMIER) and 0.01 vs. 0.01 (ARMADA). Age, sex, and HAQ-squared did not improve DIC. CONCLUSION: There is a strong negative relationship between HAQ and HUI3. Although the overall relationship is nonlinear, the linear approximation seems close over the relevant range of HAQ scores (0–3). Considering the complexity of the GLM approach, normal-linear regression may be adequate for cost-effectiveness analyses.

PP3 WHAT DIMENSIONS ARE IMPORTANT TO PATIENTS IN THEIR EXPERIENCE OF CONTINUITY OF CARE? A STUDY OF PATIENTS’ PREFERENCES USING A DISCRETE CHOICE EXPERIMENT

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OBJECTIVES: Many patients experience complex disease courses raising concerns about fragmentation of care and continuity. The objective of the present study was to explore which dimensions that are important to patients in their experience of continuity of care. Patients’ preferences were elicited using a discrete choice experiment (DCE). METHODS: 1800 patients were invited to participate in the DCE. Each subject was asked to evaluate 9 pairs of hypothetical post-transplant outcome profiles including three patient groups; diabetics, heart patients and cancer patients. Random samples of each of the defined patient groups were recruited through Odense University Hospital given at least one admission during the last two years. The DCE contained 4 attributes; 1) Involvement of GP in the patient’s course of diseases; 2) Arrangement of a contact person at the hospital; 3) Involvement of the patient in the decision; 4) Yearly consultation at hospital; and 5) Distance to hospital. RESULTS: Data was collected in the period April-June 2009 and resulted in an overall response rate of 67%. Primary analyses of DCE data are promising. All respondents value patient involvement in the treatment decision highly whereas the involvement of GP matters less—in particular to diabetic patients and cancer patients. We observe some differences in preferences among diabetes compared to the two other patient groups. Notably heart and cancer patients find the offer of yearly consultation unimportant and find the arrangement of a contact person objectionable. These two differences likely indicate patients’ (dis)satisfaction with the health care system and the current organisation of treatment and as such may reflect some lack of continuity of care. CONCLUSIONS: Worldwide there has been a policy focus on enhancing patients’ satisfaction and enhancing continuity of care among patients. The present study contributes to this work by examining what dimensions that are deemed important by patients in their experience with the health care system during their disease courses.

PP4 LIVES WORTH LIVING: OLDER SMOKERS’ STATED PREFERENCES FOR LONGEVITY

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The US Food and Drug Administration recently was granted new authority to regulate tobacco-related risks. While the morbidity and mortality benefits of smoking cessation