Identification, Review and Use of Health State Utility (HSU) Data in Cost-Effectiveness Models: 
**Good Practices for Outcomes Research Task Force**

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Task Force Members continued…

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Current Reporting Standards: recent review

**Objective:** to review reporting standards associated with HSUs used in recently published (2015-2018) cost-effectiveness analyses using case-study in cardiovascular disease
Current approaches to reporting HSUs used in models

• No literature review (too many hits, too much effort, no-one else does)

• Use outdated evidence (or just cite a value used in previous NICE submission)

• Don’t cite original source (requires a detective to identify actual source: 3/4 iterations)

• Don’t report actual values used (just cite any study & let reader find them if they really want to)

• Never, ever provide details of source study (e.g. patient characteristics, measure used, sample size etc.)

• ‘Tweak’ the values (several times)

Current approaches to reporting HSUs used in models

• Assume comparator has no benefit (equivalent to baseline of full health)

• Ignore adverse events (or make something up, or use evidence from a different treatment)

• Add clinical effects together when using two interventions, or ignore one (equivalent to using additive or minimum method to combine HSUs for concurrent events)

• Combine effects measured using different units (e.g. mmol/L & mg/dL) (equivalent to using SF-6D, HUI & EQ-5D within same model)

• Don’t bother using the values in the report in the cost-effectiveness model
Overview of session

Presentations
1. Searching, identifying & reviewing HSU for use in CE models
2. Synthesis of health state utilities
3. Using health state utilities in cost-effectiveness models
4. Minimum reporting standards - The SpRUCE checklist

Discussion

SECTION 1

Searching, Identifying & Reviewing HSU for Use in CE Models

Andrew Lloyd DPhil
Acaster Lloyd Consulting Ltd.
A working example – C/E analysis in cardiovascular disease

- Examined HSUs used in recently published (2015-2018) CE models
- Also examined the reporting standards from studies included in the review
- How thorough, transparent and reliable was reporting of values from literature?

Current Reporting Standards: Cardiovascular disease example

- 1/24 reported undertook literature review (limited details), 1 other referred to this review for their evidence
- 6/24 referenced original sources for all HSUs
  - 18/24 referenced previous CE studies (as opposed to original sources)
  - 7/24 required at least 3 iterations to track down original sources
  - 13/24 used at least some HSU collected in 1990s (studies all published after 2014)

Ara R et al., Are current reporting standards used to describe health state utilities used in cost-effectiveness models satisfactory? Does this matter? Unpublished manuscript
Current Reporting Standards: Cardiovascular disease example

- 4/24 correctly reported all HSUs when checked against original sources
- 20/24 at least some HSUs could not be matched in references or original sources, or original sources could not be identified due to incorrect referencing
- 0/24 provided all basic details of sources (e.g. study type, sample size, age, details of health condition, time of data collection etc.)

Ara R et al., Are current reporting standards used to describe health state utilities used in cost-effectiveness models satisfactory? Does this matter? Unpublished manuscript

- Often HSU identification and selection is not a straightforward process.
Searching

- Wide range of sources may be appropriate
  - Clinical trials
  - Observational studies
  - Registries
  - Surveys
  - Previous economic evaluations

- Methods must accommodate
  - Needs of the model
  - Needs of the decision maker

Model development

- Model development often proceeds in an iterative fashion.

- Searching & identifying utilities is similar; the scope may change as model develops
  - Modeller and information specialist must work together closely.

- Initial focused searches may be broadened in later iterations.
Scope of searches

• Evidence relevant to a model

• All health states and aspects of treatment and management that might impact on health-related quality of life (HRQL)
  e.g. prophylactic treatments must include possible events in the future

• Different to standard SR approach
  • Standard SR approach Population – Intervention – Comparison – Outcomes (PICO)
  • Focus here more constrained by model needs

Search scope

• Searches should consider:
  • Health state descriptions within the model
  • Treatment effects of interventions and comparators of interest (treatment benefits and adverse effects)
  • Treatment effects and management at all stages of the clinical pathway included in the model
  • Carer utilities
  • Comorbidities
  • Concurrent clinical events/sequelae
  • General population norms
  • Moderators that might affect quality of life e.g., method of administration, treatment setting
Considerations when searching

- Exhaustive searching for every parameter is not efficient.

- Which states drive model results?
  - Focus resources here
  - *Value of information (VOI)* could inform when to stop searching*.

- Transparency
  - Not cherry picking

* ISPOR publishing 2 VOI Good Practices Task Force Reports in August issue of *Value in Health.*

Reviewing

- Study population matches model?

- Sample size/ response rates/ loss to follow up/ missing data

- Proximity of data collection to event?

- Appropriateness of the measure (e.g. EQ-5D etc)

- Any evidence that the measure is inappropriate for disease area?
Selection

- Standardisation
  - Same measure used for all states in a model.
  - May be better to prefer a source study that describes more of the required health states.
  - But maintain minimum standards

- May require a trade off between different issues

- Selection rationale must be documented.
Why undertake synthesis?

• Often multiple published values for a given health state.

• Want to use all available evidence

• Synthesis should generate a more accurate estimate of the mean value and uncertainty and improve generalizability.

Measures and methods used to quantify utility
Should we undertake HSU synthesis?

- Difference in HSUs instruments / methods
- General preference based measures / condition-specific preference based measures
- Techniques used to elicit weights differ
- Mode of collection may differ
- Who completes the questionnaires – proxy, patient, general public, clinician
- Preference weights
- Statistical techniques

EQ-5D-5L differences by country value set

- Different value sets on the same data produce significantly different results.
- Authors conclude that different country value sets are not interchangeable.

<table>
<thead>
<tr>
<th>Tariffs</th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Median</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinese</td>
<td>608</td>
<td>0.828</td>
<td>0.184</td>
<td>0.879</td>
<td>-0.297</td>
<td>1.000</td>
</tr>
<tr>
<td>Japanese</td>
<td>608</td>
<td>0.802</td>
<td>0.164</td>
<td>0.823</td>
<td>0.062</td>
<td>1.000</td>
</tr>
<tr>
<td>Korean</td>
<td>608</td>
<td>0.831</td>
<td>0.137</td>
<td>0.829</td>
<td>0.010</td>
<td>1.000</td>
</tr>
<tr>
<td>UK</td>
<td>608</td>
<td>0.838</td>
<td>0.154</td>
<td>0.866</td>
<td>-0.213</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Note: The difference among the four national tariffs was statistically significant ($\chi^2=438.952, P<0.001$).
Abbreviation: EQ-5D-5L, five-level EuroQol-5 dimensions.

Liu et al. Patient Preference and Adherence 2017; 11: 1049-1056
Different measures can produce vastly different results

Table 3. Comparison of Health State Utility Scores by Medical and Socioeconomic Factors

<table>
<thead>
<tr>
<th>Variable (No. of Cases)</th>
<th>Health State Utility Score by Measurement Method</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SG</td>
</tr>
<tr>
<td>Surgery type</td>
<td></td>
</tr>
<tr>
<td>Primary (n = 54)</td>
<td>0.93 (0.17)</td>
</tr>
<tr>
<td>Salvage (n = 5)</td>
<td>0.98 (0.04)</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>Yes (n = 13)</td>
<td>0.92 (0.10)</td>
</tr>
<tr>
<td>No (n = 37)</td>
<td>0.91 (0.16)</td>
</tr>
<tr>
<td>Oral cavity tumor stage</td>
<td></td>
</tr>
<tr>
<td>T1 or T2 (n = 47)</td>
<td>0.95 (0.13)</td>
</tr>
<tr>
<td>T3 or T4 (n = 20)</td>
<td>0.87 (0.22)</td>
</tr>
<tr>
<td>Tracheotomy and/or fistula</td>
<td></td>
</tr>
<tr>
<td>Yes (n = 6)</td>
<td>0.92 (0.02)</td>
</tr>
<tr>
<td>No (n = 94)</td>
<td>0.91 (0.17)</td>
</tr>
</tbody>
</table>

0.07 vs 0.21 diff in utility

Different mapping methods produce varied utilities for the same performance level

- Models may utilize functional levels such as HAQ DI levels of KPS levels, but the utility value assigned to that level can vary widely depending on the method used for utility


26 Rowen et al. VIH 2012; 15: 1059-1068
When undertake synthesis?

• Are there enough HSU estimates?
• Are studies sufficiently homogeneous?
• Are they using the same HSUV measurement system?

Methods of synthesis of HSUs

• Apply strict eligibility criteria to reduce heterogeneity
  • Same measurement instrument used
  • Same patient group (e.g., mild, moderate, severe depression; same KPS or HAQ-DI range)
• Strict eligibility is useful, but considerable heterogeneity often remains.
• Often there are not enough studies to restrict to a single measurement instrument.
• Use meta-regression
  • Limited to parameters reported in each manuscript
  • It has been suggested that 10 studies per covariate should be used, but this is often not feasible.
Conclusions

• Currently, formal synthesis is very limited for HSUs due to heterogeneity of valuation methods, country differences, population differences, etc.

• Research still needed for methods of meta-regression in HSUV synthesis and when appropriate

• When conducting synthesis:
  • Limit to a single measure if possible; converting / mapping to a single measure may be useful, but be aware of the additional variance introduced.
  • Carefully evaluate heterogeneity and model the impact if using meta-regression.
Identifying the most appropriate health state utility (HSU) is just the beginning …………..

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity analysis (SA)</td>
<td>Always begin with SA</td>
</tr>
<tr>
<td>Discrete health states or discrete event simulation</td>
<td></td>
</tr>
<tr>
<td>Individual mean HSUs or function-based HSUs</td>
<td></td>
</tr>
<tr>
<td>Comorbidities &amp; age</td>
<td></td>
</tr>
<tr>
<td>Concurrent clinical events or conditions</td>
<td></td>
</tr>
<tr>
<td>Treatment related adverse effects</td>
<td></td>
</tr>
<tr>
<td>Acute clinical events</td>
<td></td>
</tr>
<tr>
<td>Sensitivity analyses (again)</td>
<td>Always end with SA</td>
</tr>
</tbody>
</table>

Begin: sensitivity analysis

- Look at the effect of each health state in model individually to inform level of literature searches.

- Which HSUs influence the ICER?

- Communicate with search/review team which HSUs really matter.
Model health states

• Decide the format of the model in terms of numbers and types of health states that differ according to HSU
  • Use clinical expertise & availability of evidence to inform decision

• If simple model structure implemented that may not represent all important HSUs
  • Examine & discuss expected effects of such omissions

Individual HSUs or function based:

Clinical events – acute? chronic? fluctuating? progressive?

Simple ‘acute’ events:
• Bone fractures (e.g. hip, wrist, vertebrae)
• CVD (e.g. MI, angina, stroke)

Less obvious in chronic progress conditions:
• Arthritic conditions ‘flares’
• Asthma exacerbations (hospitalised?)
• Crohn’s disease
• Age related macular degeneration

Consider:
• Frequency of events
• Severity of effect on QoL
• Duration of time effect lasts
• ‘Rebound’ HSU after recovery
• Timing of data collection matches acute period of event?
• Explore likely effect if collection time does not match event
Discrete mean HSUs, or function based HSUs

Rheumatoid arthritis, measure clinical status using HAQ

RA: HAQ strong relationship with utility. Could use 3-30 discrete HS, depending on sample size for subgroups.

Ankylosing Spondylitis, measure clinical status using both BASFI & BASDAI

AS: Both BASDAI & BASFI have strong relationship with utility. 3-D matrix, substantial sample size reqd. Use function to predict utility conditional on BASDAI & BASFI (plus age, gender .......

Comorbidities, age & role of general population norms (i.e. Baseline HSUs vary over model lifetime horizon)

Mean EQ-5D scores by age from HSE

Mean HSU is never equal to full health irrespective of measure, preference weights, age, condition or sample. Baseline of full health overestimates effects of avoiding events or conditions.
Combining HSUs when using age-adjusted baseline.

NB. For multiplicative DO NOT multiply HSUs together!
Estimate ‘multiplier’ = observed mean HSU / baseline mean HSU (at age of sample).

Concurrent clinical events or conditions

*Ideally collect evidence from persons of interest*

Only have mean HSUs from samples with just one of conditions (condition A, or condition B).
Estimate the HSU for the concurrent health state using HSU from Condition A, and Condition B:

Additive = 0.5903
Multiplicative = 0.6215
Minimum = 0.7304

It is recommended that the multiplicative method is used.
Treatment related adverse events (AE)

**CONSIDER:**
- Are AEs prevalent?
- Do treatment related AEs have substantial effect on QoL?
  - Check potential effect on ICER using SA in model.
- Is effect captured in evidence used for HSUs in model?
  - Those experiencing AE less likely to complete QoL measure.
  - Take care not to double count effect if using trial data
- What is likely duration of effect?
  - Chronic long term/ discrete short term & treatment withdrawal.

TEST extreme values in model.

End: sensitivity analysis (again)

- ALL HSU represented by parametric probability distributions.
- Sample random values for PsA using Beta: rescale if –ve values possible
- Consistency: for ordered values, sample using 'difference method' [Ren 2017]

- Univariate: Test which HSUs influence ICER using CIs.
- Multi-variate: Test LCI & UCI that move ICER in same direction.
## Recommendations when using health state utilities in models

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<thead>
<tr>
<th>Issue</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity analysis</td>
<td>Use to determine which HSUs influence the ICER &amp; report these analysis if applicable.</td>
</tr>
<tr>
<td>Discrete health states</td>
<td>Expected effects of excluding potentially relevant HSUs from a cost-effectiveness model structure should be examined &amp; discussed.</td>
</tr>
<tr>
<td>Individual mean HSUs or function-based HSUs</td>
<td>Relevance of data (e.g., study population, utility measures, alignment with model’s health states) &amp; Reliability of analyses (e.g., precision of mean HSUs, validity of estimated utility functions) see Wailoo et al ISPOR TF</td>
</tr>
<tr>
<td>Comorbidities &amp; age (baseline)</td>
<td>Mean HSU values represent comorbidity utility effects at the mean age of the utility study population. Age-specific comorbidity effects should be estimated using age-specific population norms.</td>
</tr>
<tr>
<td>Concurrent clinical events or conditions</td>
<td>The multiplicative method should be used to handle the utility effects of concurrent clinical events.</td>
</tr>
<tr>
<td>Treatment related adverse effects</td>
<td>Assess the extent utility effects of AEs are captured by the utility data used to estimate a model’s non-adverse event. If AE HSUs are required, the range of HSUs required should be informed by expected effect on ICER.</td>
</tr>
<tr>
<td>Acute clinical events</td>
<td>In the absence of data collected around the event, plausible HSUs for the direct effects of acute events should be multiplied by the expected duration to assess the sensitivity of ICER to these utility effects.</td>
</tr>
<tr>
<td>Sensitivity analyses (again)</td>
<td>One way &amp; multi-way SA of HSU, Beta (scaled) distributions. Difference method to account for ordering in PsA.</td>
</tr>
</tbody>
</table>
Current approaches to reporting HSUs used in models

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- Use outdated evidence (or cite a value used in previous NICE submission)
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- Never, ever provide details of source study (e.g. patient characteristics, measure used, sample size etc.)
- ‘Tweak’ the values (several times)
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- Ignore adverse events (or make something up, or use evidence from a different treatment)
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- Combine effects measured using different units (e.g. SF-6D, HUI & EQ-5D within same model)
- Don’t bother using the values in the report in the cost-effectiveness model

HSU identification and selection is often not a straightforward process

- Challenges to being explicit
- Iterative search and sifting process
SpRUCE Checklist

- Provides minimum reporting standards for the Systematic Review of Utilities for Cost-Effectiveness (SpRUCE checklist).
- Criteria intended to help model reviewers identify if HSU selection for the model was transparent and appropriate.
- A greater level of detail is likely needed to proceed to peer-reviewed publication of a systematic review.

  - Five sections:
    1. search strategy
    2. review process
    3. data extracted from each study
    4. basis for obtaining the final HSU
    5. use in cost-effectiveness models

SpRUCE Checklist: Search Strategy

<table>
<thead>
<tr>
<th>Search Strategy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Search terms and scope</td>
<td>The final search strategy should be adequately defined and appropriate databases included in the search.</td>
</tr>
<tr>
<td>Study selection criteria</td>
<td>Explicit criteria for study identification/inclusion should be described and applied, such as patient group of interest, relevant age range and stage of disease/severity etc.</td>
</tr>
</tbody>
</table>
## SpRUCE Checklist – Review Process

### Quality check
- Quality criteria for reviewing studies explicitly stated and applied.

### Assessment of relevance
- Relevance of HSUs to model and target reimbursement agency described.

## SpRUCE Checklist: Key Data Extraction

<table>
<thead>
<tr>
<th>Data Extracted (reporting of variables)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population/patient characteristics</td>
<td>Relevant patient characteristics (e.g. age, sex, comorbidities, diagnosis, severity of condition).</td>
</tr>
<tr>
<td>Measure used to describe the HSUs</td>
<td>The measure used to obtain the HSUs.</td>
</tr>
<tr>
<td>Valuation technique for preference weights</td>
<td>The technique used to value the health state (e.g. TTO, SG), and the country (provide reference).</td>
</tr>
<tr>
<td>Descriptive statistics of HSUs</td>
<td>The mean and variance around any HSU used in the model.</td>
</tr>
<tr>
<td>Response rates to the measure used*</td>
<td>Report if response rates are likely to be a threat to validity.</td>
</tr>
<tr>
<td>Loss to follow-up/missing data*</td>
<td>Loss to follow-up (e.g. 1 year after fracture) and missing data should be reported, especially if they may threaten the representativeness of the HSUs.</td>
</tr>
<tr>
<td>Original reference</td>
<td>The original source for the HSUs should be referenced (not a previous economic study that has used the evidence).</td>
</tr>
</tbody>
</table>
**SpRUCE Checklist**

<table>
<thead>
<tr>
<th>Selection/estimation of final health state value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basis for selecting HSUs</strong></td>
</tr>
<tr>
<td>The rationale for selecting the HSUs used in the model should be justified.</td>
</tr>
<tr>
<td><strong>Method used to combine estimates</strong></td>
</tr>
<tr>
<td>Where HSUs are combined, the analytic methods should be described e.g. meta-analysis.</td>
</tr>
</tbody>
</table>

**Methods used when applying the health state utilities in model**

<table>
<thead>
<tr>
<th>Actual HSUs used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report all actual HSUs used in the model together with associated measure.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adjustments or assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clearly describe any adjustments or assumptions relating to the use of HSUs in the model, reporting both the raw and final values used with worked examples if required to clarify the method used to adjust the data.</td>
</tr>
</tbody>
</table>
Discussion

Slides are available on the ISPOR 2018 Baltimore webpage
https://www.ispor.org/Event/index/2018Baltimore
Please JOIN our review group!
Being a member will keep you abreast of ISPOR HSU activities, too!

Task Force’s Final Draft Report is available on our webpage for comment:


Final Draft for Review: Comments are due by: Thursday, May 31st
Download Excel Comments Template.
Please send the comments spreadsheet to: HSU@ispor.org

Your insight and expertise contributes to the high quality, multi-perspective, and consensus nature of ISPOR Good Practices Task Force Reports. Those who contribute substantive comments are acknowledged by name in the report.
References
Fryback DG, Lawrence WG. Dollars may not buy as many QALYs as we think: A problem with defining quality of life adjustments. MDM 1997;17;276-284

Ara R, Brazier J. Using health state utility values from the general population to approximate baselines in decision analytic models when condition specific data are not available. ViH 2011;14(4):539-545


