At the end of 2005, 10.1% of dialysis pts lived in a NH. Pts residing in a NH had mortality rates more than double that of those who did not (RR=2.19*). We found significantly higher mortality rates in the 2% of facilities where NH pts comprised over 30% of treated pts, but no differences in mortality among remaining facilities.

Patient Group	RR
Non NH Pt in Facility w/ <30% NH pts	1.00 [Ref]
Non NH Pt in Facility w/ ≥30% NH pts	1.26*
NH Pt in Facility w/ <30% NH pts	2.18*
NH Pt in Facility w/ ≥30% NH pts	2.52*

* p < 0.0001

Mortality risk for NH pts is about twice that of non-NH pts, regardless of % of NH pts treated at the facility (RR=2.18* for <30% NH; RR=2.52/1.26=2.0* for >30% NH). Non-NH pts in facilities treating more than 30% NH pts have a 26% higher mortality risk than those in facilities treating fewer NH pts.

That NH pts have a higher mortality is not surprising. The high mortality for non-NH pts at facilities with a higher proportion of NH pts suggests that treating more NH (sick) pts has the potential to impact the care delivered to the relatively less sick pts, but this requires further study.

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PUB410

The Quality of Life, Work Ability and Working Conditions of Hemodialysis Patients. Luca Neri,[1] Lisa A. Rocca Rey,[1,2] Maurizio Gallieni,[2] Diego Brancaccio,[2] Thomas E. Burrhoughs.[1] *[1]Center for Outcomes Research, Saint Louis University, St. Louis, MO; [2]Chair of Nephrology, University of Milan, Milan, Italy.*

Introduction: employed hemodialysis (HD) patients often need significant workplace accommodations: exposures to xenobiotics, biological agents and physical workloads should be minimized; flexible working times are needed to allow therapy adherence. We examined the health related quality of life (HRQOL), working conditions, functional status, and annualized sick leave rate (aSLR) in HD patients. **Methods:** we enrolled 40 HD employed patients and measured their HRQOL (SF-12, KDQOL, SF-6D), Work Ability Index (WAI), Occupational Stress (ERI), Control Over Working Times (COWT), Work-Family Conflict (WFC). We calculated Spearman's non-parametric correlation coefficients between HRQOL and ERI, WFC, WAI, COWT. We estimated the aSLR over 4 weeks and the associated economic loss. **Results:** 75% of patients worked in the service sector and none in agriculture. More than 80% were employees, 45% blue-collar and 20% benefited from workplace Occupational, Safety and Health (OSH). The average WAI was moderate (mean=33; SD=±7.9); 78% reported high or very high COWT and job rewards were higher than efforts in 93% of subjects (ERI<1). Work-family conflict was moderate (median WFC=2.7; IQR=2-5.2; scoring range: 1-6). Twenty-eight subjects (70%) reported severe limitation at least in 1 of the SF-6D domains. The overall average utility was 0.63±0.085 (scoring range 0-1.00). All QOL scales and the SF-6D were strongly correlated to ERI (range ρ= -0.35 to -0.52; $p<0.01$) and WAI (range ρ= 0.45 to 0.59; $p<0.01$). The mean aSLR was 51 days/year per person but 40% of patients accounted for all sick-days. The yearly absenteeism cost was US $6300 per person. **Conclusion:** many subjects worked in physically demanding and potentially dangerous occupations without adequate OSH services. Most patients enjoyed flexible working hours and little occupational stress, allowing a sustainable work/family balance. Nevertheless, we observed only moderate WAI. HRQOL and occupational adjustment are highly related in HD patients. Major effort should be devoted in promoting the productivity of employed HD patients.

PUB411

Patient Preference Types (PT) for "Shared Decision Making" (SDM) in Dialysis. Sabine Loeffert,[1] Christine Kuch,[1] Holger Pfaff,[1] Andrej Woehrmann,[3] Guido Reinecke,[2] Claudia Barth,[3] Conrad Baldamus.[2] *[1]Institute for Occupational and Medical Sociology, University of Cologne, Germany; [2]Clinic IV for Internal Medicine, Nephrology; University of Cologne, Germany; [3]Kuratorium fuer Dialyse und Nierentransplantation (KfH), Neu Isenburg, Germany.*

Based on the internationally largest SDM-study in dialysis patients (n=4.117) possible PTs were tested. For this purpose the basic population was divided into two halfs at random. For the first half a configural frequency analysis (CFA) was performed. The 144 identified PTs were considered as hypothesis for an inferential prediction CFA of the second half (n=1914), using five predictor variables and control preferences (Degner's) scales as predictand variables. Adjusting $\alpha = 0,05$ for multiple testing was conducted by the Holm procedure.

21 possible PTs were the result of the exploratory prediction CFA. Just four of them could be confirmed in the inferential prediction CFA of the second half ($p<0,001$):

I. rather passive: less desire for information, above-average faith in the physician, feeling comfortable with physician's participatory decision making (PDM) style, lower level of education, age between 56-75 years

II. rather passive: age over 75 years

III. rather active: high need of information, high level of education, age under 55 years, substandard faith in the physician and perceive the PDM style negative

IV. rather active: high desire for information, high level of education, age under 55 years, but above-average faith in the physician and feeling comfortable with the PDM style

As a result of the high PT-variability the collaborative PT could not be definitely characterized.

Especially patients who don't belong to one of the four defined PTs may change their SDM influenced by their specific state of the disease at time of interview or can potentially be influenced by individual training programs for active SDM.

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PUB412

Cost-Effectiveness and Cost-Utility Analysis of Twice and Thrice Weekly Hemodialysis in End Stage Renal Disease Patients. Amnart Chaiprasert, Wongsawan Wongprasert, Ouppatham Supasyndh, Naiyarat Prasonsook, Lersan Luesutthiviboon, Thanom Supaporn. *Department of Medicine, Phramongkutklao Hospital, Bangkok, Thailand.*

Background: End stage renal disease (ESRD) is a public heath problem with high costs of treatment. Thrice weekly hemodialysis (HD) is recommended; however, most of Thai ESRD patients receive twice weekly HD. Due to limited health care resources and budgets, the economic evaluation between twice and thrice weekly HD was studied.

Methods: The recorded data of patients with ESRD at HD unit of Veteran Hospital in Bangkok was studied. Newly diagnosed ESRD patients with stable HD for 6 months during 1 January 1998 to 31 December 2004 were enrolled and they were followed up for survival until 31 December 2006. Unit cost analysis (cost per HD session) was done. Annual costs and the survival of both twice and thrice weekly HD were retrieved, and the incremental cost-effectiveness ratio (ICER) was analyzed. This study maintained a societal perspective.

Results: Fifty-three eligible patients from 115 registered ESRD patients were studied. Eleven of 24 patients in twice weekly and 10 of 29 patients in thrice weekly HD were death with the mean survival of 57.0 ± 10.0 and 84.4 ± 6.1 months, respectively. The cost per HD session was 1434.40 Baht. The cost-effectiveness of twice weekly HD was superior when compared with the thrice weekly HD (291,252 VS 474,601 Baht per life year). After adjusted with the utility of 0.558 in twice weekly HD and 0.512 in thrice weekly HD; the cost-utility ratio was 521,957 and 926,955 Baht per QALY, respectively. The ICER of twice weekly HD when compared with the trice weekly HD was 855,137 Baht per life year or 2,059,229 Baht per QALY gained.

Conclusion: The cost-effectiveness and cost-utility ratio of twice weekly hemodialysis was more favorable than the thrice weekly hemodialysis for the treatment of end stage renal disease patients.

PUB413

Start Hemodialysis with Once-Weekly Treatment: Quality of Life and Residual Renal Function. Carmelo Libetta, Vincenzo Sepe, Pasquale Esposito, Laura Cosmai, Nicoletta Bellotti, Valentina Portalupi, Michele Canevari, Antonio Dal Canton. *Nephrology and Dialysis, Università e Fondazione IRCCS Policlinico S. Matteo, Pavia, Italy.*

The role of residual renal function (RRF) is well known in the peritoneal dialysis population as studies have clearly demonstrated a survival benefit with preservation of RRF. However, there are data suggesting that RRF is also important in HD patients. Diuretics appear to have a role in maximizing urine output and minimizing the need for aggressive ultrafiltration but did not influence the decline of RRF. In order to assess the impact on clinical, RRF and quality of life of once-weekly hemodialysis in patients that start treatment, 17 stable patients on regular dialysis treatment for at least 10 months were studied. 9 patients (age 63.4±9.7 yrs) were on standard bicarbonate dialysis (SHD), and 8 patients (age 69.1±6.4 yrs) were on once-weekly dialysis (OWD). The dialysis tratment of OWD consisted of a 4-hour, high efficiency, euvolemic HD session per week. Blood and urine were collected just before the dialysis session at basal (BAS) and monthly. Serum levels of C-reactive protein (CRP), albumin and BMI were measured. RRF was assessed by average renal urea and creatinine clearances. The health related quality of life (HRQOL) of dialysis patients was evaluated 3 months after the start of chronic dialysis treatment. HRQOL was measured using the Kidney Disease Quality of life questionnaire (KDQOL). Only one patients after 10 months was shifted to SHD. In OWD group RRF declined significantly after 6 months (BAS: 10.32±2.69, 6 months: 7.09± 2.21 ml/min, $p<0.05$), whereas in SHD group only after one month. From the KDQOL results scores significantly better in OWD patients compared to SHD group The number of hospitalizations was significantly lower in OWD when compared to SHD ($p<0.05$) during the first year of treatment whereas albumin, CRP and BMI were no significantly different. In conclusion start HD with once-weekly treatment significantly better quality of life, reduces hospitalization, allows an easier acceptance of dialysis treatment and lenghten the presevation of the RRF.