substitution model), and (iii) the community coordination model.

RESULTS:

In general, Australia emphasizes rural/remote paramedics, whereas Canada, the UK, and the US implement expanded paramedic practice within different environments including rural, remote, regional, and metropolitan settings. Extended care provider programs have been intensively investigated and widely implemented in the UK. While the identified CP programs vary in terms of program components, designation of providers, skill mix, target population, and funding model, the majority of these CP programs fall under the primary health care category of the Australian framework.

CONCLUSIONS:

Transitioning from hospital-based to community-based health care requires careful consideration of all key factors that could contribute to future program success. Delineating key components of CP programs using the Australian framework will help Alberta decision-makers design, develop, and implement appropriate CP programs that adequately address local needs.

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PP98 Efficacy Of The Multi-Attribute Utility Instruments To Reflect Quality Of Life Of Cancer Patients

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INTRODUCTION:

Health state utilities measured by the generic multi-attribute utility instruments (MAUIs) differ. Empirical evidence suggests that some MAUIs are more sensitive than others in reflecting the quality of life (QoL) of patients in particular disease areas. Additionally, in order to estimate utilities based on cancer-specific health-related quality of life instruments (CSQoLs), a number of mapping functions have emerged. Although it is common practice to apply a CSQoL instead of a MAUI in clinical trials, CSQoL cannot be

used to estimate utility values for economic evaluations. Mappings based on MAUIs that are not sensitive to changes in cancer patients' QoL may result in misleading approximations of utilities that could affect allocation of resources. The study objective is to explore the validity and sensitivity of the major MAUIs to variation in the QoL measured by cancer-specific instruments. We aimed to investigate (i) the sensitivity of the general MAUIs scores to changes in the CSQoL, and (ii) whether particular dimensions of the general instrument are more sensitive.

METHODS:

A two stage systematic literature review is conducted. First, an update of the review done by McTaggart-Cowan et al. (2013) on the mapping methods used to determine utilities from cancer-specific instrument. Second, an analysis of studies that measure the relationship between CSQoLs and general MAUIs.

RESULTS:

The literature suggests that differences exist between MAUIs in their capacity to capture the QoL dimensions of the CSQoLs. Additionally, the main challenge to build an appropriate mapping function for deriving utilities values from CSQoL is the definition of an appropriate methodology that (i) responds to the distribution of the selected sample and (ii) can successfully be validated in additional samples.

CONCLUSIONS:

In the context of health technology assessment and cost effectiveness analysis, it is crucial to carefully select and report the CSQoL and MAUI involved in the estimation of the additional benefits. Policy makers need to be awarded of the sensitivity of the instruments to changes in QoL in relation to the CSQoL dimensions QoL.

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PP100 Rapid Evidence Assessment In Hospital Health Technology Assessment

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INTRODUCTION:

Systematic reviews (SRs) are the most valid and reliable scientific evidence to evaluate the effectiveness of healthcare interventions. However, substantial resources and months are required to conduct such a review. Most hospital-based health technology assessment (HB-HTA) units don't have the time and the academic team to produce SRs. Rapid evidence assessment (REA) may represent, in this local context, an interesting avenue. The aim was to evaluate characteristics of REA and their impacts on healthcare decision making.

METHODS:

A SR was performed in several databases and grey literature to search data on REA including Mini-HTA and rapid reviews methodologies through March 2017. Data selection, extraction and quality assessment were performed by two independent researchers. Outcomes were about REA's methodology including question, search strategy, inclusion criteria, study selection, data extraction, quality assessment, critical appraisal and impacts on decision making.

RESULTS:

Twelve publications on REA have been included. More similarities were found in the methodology between rapid review and SR than with Mini-HTA. Shortcuts in performing rapid reviews included evaluation scope, number of databases, gray literature websites, studies design mainly SR, reviewers number, critical appraisal and production time (3 to 6 months). Study selection and data extraction by two independent reviewers in rapid reviews were seen in thirty-four percent to thirty-eight percent and ten percent to twenty-two percent, respectively. Furthermore, assessment quality was optional. Although it is performed within a short timeframe (2 months), methodology to conduct Mini-HTA is not well defined in the literature. The scope is mainly to support decision making in the introduction of new medical devices. Impacts of REA on local health decision making process are not well documented.

CONCLUSIONS:

Methodology to conduct REA is quite diverse. According to the data available, rapid review is a more robust methodology for HB-HTA producers than Mini-HTA. Although impacts were not well reported, rapid reviews could be more useful to support health decision making in local context.

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PP102 Developing A Contextually-Informed Deprescribing Intervention

AUTHORS:

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INTRODUCTION:

Deprescribing – a process for reducing or stopping drugs when the balance of benefits and harms may no longer be in a person's interests – is a key aspect of managing multimorbidity and polypharmcacy in older people. Several deprescribing interventions have been developed (e.g. in Australia and Canada), although significant challenges for successful implementation remain. Through key stakeholder consultation in the care home setting in South West England, we take the initial steps to develop a context-informed deprescribing approach. Engaging stakeholders from the outset gains insight into acceptability, feasibility, and relevance of deprescribing interventions developed elsewhere informing co-production of an effective, implementable approach.

METHODS:

Consultation workshops were held with two groups of stakeholders: (i) care home residents and their families; (ii) care home staff and health care professionals (general practitioners, medical specialists, pharmacists, nurses, allied health professionals). Focus groups were held with each group separately to understand perspectives on: deprescribing in general; contextual considerations; and, perspectives on deprescribing interventions developed in other countries. A combined focus group then considered components of a deprescribing intervention for care homes. Qualitative data were audio recorded, transcribed, and thematically coded.

RESULTS:

Participants described the nature of local relationships, dynamics, structures, and resources, as important considerations in the development of a deprescribing approach in care homes. Perspectives and concerns around deprescribing among the stakeholder groups varied, although the importance of eliciting local stakeholder feedback in the early stages of developing a deprescribing intervention was a common thread.