assessed the dossier and the opinion of stakeholders (i.e. professionals and patient associations) in order to determine the actual clinical benefit of this software. At the same time, HAS set technical features in particular to secure patient data and limit access to only those involved in telemonitoring. Terms of prescription and use of this connected software had also been defined.

RESULTS:

Two feasibility studies and one randomized controlled trial were analyzed. Specific clinical data demonstrated that the risk-benefit balance was positive in type 1 diabetic patients.

CONCLUSIONS:

In addition to the need to keep personal data confidential and to integrate the technology in the organization of healthcare, this assessment shows that randomized clinical trials are feasible and necessary to demonstrate the clinical benefit of connected software; however, specificities exist regarding data collection methods and the scope of healthcare organization that should be taken into account. A specific guide to connected medical devices for industry has been developed by HAS to help them build their application dossier for reimbursement. The second step for HAS is to develop guidelines on the specificities of the assessment of these connected devices.

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PP21 Reassessment Of Cochlear Implantation For Children In Kazakhstan

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INTRODUCTION:

Cochlear implantation (CI) is a standard technology for the management of children with sensorineural hearing loss. In the Republic of Kazakhstan (RK), CI was introduced in 2007. In 2012, a report for the Ministry of Health (MoH) of the RK considered the effectiveness of CI, age of implantation, use of clinical protocols, and availability of audiological screening and rehabilitation services. We assessed the influence of the report findings on the provision of medical care in the RK for children with sensorineural hearing loss.

METHODS:

Information was collected in a survey of all RK health regions on issues related to CI, audiological screening and rehabilitation. Administrative data relevant to the provision of CI in the RK were obtained from the MoH. Data obtained were compared with those available for preparation of the 2012 report.

RESULTS:

The proportion of medical organizations with equipment to provide audiological screening had improved, from 29 percent in 2012 to 90 percent in 2018. The proportion of children under two receiving CI increased from 12 percent to 36 percent, while that for children over five years decreased from 48 percent to 17 percent. A clinical protocol for CI in children was developed by a center in the MoH. Progress with post-CI rehabilitation of children was limited by a lack of specialists in the health regions. The proportion of school-age children with implants who have attended general schools remains low.

CONCLUSIONS:

The findings of the HTA report had a positive influence on availability of screening services and a protocol for CI. The average age of children receiving an implant has decreased, though it is still higher than in other countries. The need for improvements in post-CI rehabilitation and placement of children with implants in general schools is recognized but these await further resources.

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PP22 How Do Health System Leaders Use Evidence To Inform Action?

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INTRODUCTION:

The US Agency for Healthcare Research and Quality (AHRQ) Evidence-based Practice Center (EPC) program

sponsors the development of systematic reviews to inform clinical policy and practice. The EPC program sought to better understand how health systems identify and use this evidence.

METHODS:

Representatives from eleven EPCs, the EPC Scientific Resource Center, and AHRQ developed a semi-structured interview script to query a diverse group of nine Key Informants (KIs) involved in health system quality, safety and process improvement about how they identify and use evidence. Interviews were transcribed and qualitatively summarized into key themes.

RESULTS:

All KIs reported that their organizations have either centralized quality, safety, and process improvement functions within their system, or they have partnerships with other organizations to conduct this work. There was variation in how evidence was identified, with larger health systems having medical librarians and central bureaus to gather and disseminate information and smaller systems having local chief medical officers or individual clinicians do this work. KIs generally prefer guidelines, especially those with treatment algorithms, because they are actionable. They like systematic reviews because they efficiently condense study results and reconcile conflicting data. They prefer information from systematic reviews to be presented as short digestible summaries with the full report available on demand. KIs preferred systematic reviews from reputable entities and those without commercial bias. Some of the challenges KIs reported include how to resolve conflicting evidence, the generalizability of evidence to local needs, determining whether the evidence is up-to-date, and the length of time required to generate reviews. The topics of greatest interest included predictive analytics, high-value care, advance care planning, and care coordination. To increase awareness of AHRQ EPC reviews, KIs suggest alerting people at multiple levels in a health-system when new evidence reports are available and making reports easier to find in common search engines.

CONCLUSIONS:

Systematic reviews are valued by health system leaders. To be most useful they should be easy to locate and available in different formats targeted to the needs of different audiences.

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PP25 Direct Costs Of Ischemic Heart Disease: Real World Data From Brazil

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INTRODUCTION:

In Brazil, cardiovascular disease accounted for twenty-eight percent of deaths in 2013 with an estimated prevalence of five to eight in adults over forty years of age. Health care costs have quadrupled in the last decade, reaching USD 125 billion in 2013, of which forty-four percent were paid by the public system. The objective of this study was to estimate the direct costs associated with inpatient stay for myocardial infarction in a public teaching hospital from the perspective of the service provider.

METHODS:

We used a bottom up microcosting methodology for collecting data from computerized hospital records and patients' hospital bills. The costs included salaries of health professionals, medications, consumables, laboratory and diagnostic tests performed during hospitalization and maintenance expenses. Mean, standard-deviation, median and total costs were calculated. The costs were presented as mean and median values in Brazilian currency and converted to US dollars by the exchange rate.

RESULTS:

A total of eighty-one patients were included in this study. The mean population age was 60 ± 10.6 years, the follow-up period were 107 ± 2.6 months; fifty-four percent were male, eighty-four percent had hypertension, thirty-six percent had diabetes, and twelve percent had previous cerebrovascular accident. During follow-up, there were 101 hospitalizations for myocardial infarction, of which fifty-seven with intensive care unit (ICU) days. The total cost with hospitalizations was USD 177,288, of which fifty-two percent were the health professionals' costs. The average cost for hospitalization was USD 1,755 (median USD 1,221). However, the average reimbursement paid by the public system was USD 1,188 (median USD 1,044) per hospitalization, generating a deficit of thirty-two percent for the hospital.