

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

**AUTHORS:**

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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.

**CONCLUSIONS:**

These results may indicate the necessity of reviewing the public reimbursement policies for the service providers in Brazil. Besides that, these data may also serve as input for the economic evaluation in coronary artery disease.

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## PP26 Facial Palsy Therapy: Can Novel 'Smart Spectacles' Help People Smile?

**AUTHORS:**

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**INTRODUCTION:**

In the United Kingdom (UK), 23,000 people annually are diagnosed with facial palsy (acute onset facial paralysis). For nearly one third this will result in a permanent disability, including in some the inability to smile. In addition to initial pharmacological therapy, guidelines recommend tailored facial exercise (TFE) therapy repeated every day. However, not all patients are currently able to access such specialist physical therapy. 'Smart specs' (using miniaturized sensors in the frames to measure facial movement) are currently being developed. Linked to a smartphone, these could allow people to practice TFEs discreetly, provide immediate feedback, and supply data on outcomes to the patient and their clinician.

**METHODS:**

Modelling of introduction of Facial Remote Activity Monitoring Eyewear (FRAME) into treatment pathways for patients with facial palsy. This included: (i) review on effectiveness of TFE therapy; (ii) national surveys (medical staff, facial therapy specialists and patients) to gather data on access to TFE therapy; (iii) Delphi Exercise to identify consensus on key outcome measures; and, (iv) economic modelling to estimate cost-effectiveness and determine a range of acceptable costs for the technology. In parallel, research to examine target markets to inform product development, and production of integral commercialization plan.

**RESULTS:**

Searches short-listed ten studies to add to the three included in the 2011 Cochrane review. Surveys indicate

approximately thirteen percent of eligible UK patients access personalized TFE therapy. Estimated annual expenditure on hospital treatments for facial palsy patients is currently >GBP 80 million (>USD 106 million) compared with <GBP 0.5 million (<USD 0.66 million) on TFE therapy. Patients with permanent defects can suffer a loss of up to two quality-adjusted life years (QALYs).

**CONCLUSIONS:**

Findings from this study, particularly in relation to costs and benefits, will inform the design of a subsequent randomized controlled trial. A novel wearable technology could make a major difference to people's lives, as well as generating potential efficiencies for healthcare.

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## PP27 A Prototype Patient Advocate Decision Aid For Oncology HTA

**AUTHORS:**

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**INTRODUCTION:**

Patient advocates need to process vast amounts of information to accurately and effectively represent heterogeneous patient groups and make meaningful contributions to HTA decisions. Although a wealth of data is available from a variety of sources, it is not often curated in user-friendly ways. Patient representatives have frequently requested tailored resources that allow them to mine the existing literature in preparation for their engagements. Developing such resources constitutes a complex challenge that requires contributions and scrutiny from multiple stakeholders.

**METHODS:**

We previously developed the Continuous Innovation Indicators™ (CII), an evidence-based tool to assess treatments for twelve solid tumors (freely available at [www.scoringprogress.com](http://www.scoringprogress.com)). The foundation of the CII is a rigorous assessment of published evidence for increased overall survival. Based on feedback from patient advocates, we are expanding the framework to include information on adverse events and other patient-centered outcomes for selected prototype indications.