response too burdensome. We set out to determine whether reducing the information provided or burden of response would improve the engagement of clinicians with our processes, and hence improve the quality of advice provided, and the research available to health services.

METHODS:

We undertook a factorial randomized controlled trial (University of Southampton Faculty of Medicine Ethics Committee #8192, Trial registration: ACTRN12614000167662). Each participant was randomized to receive one of two types of material to comment on, and one of two means to respond. In the first allocation participants were randomised in a 1:1 ratio between receiving a 'vignette' (a briefing paper of up to ten pages discussing possible research = usual practice), or a 'commissioning brief' (a single page summarising the proposed research). In the second allocation, the method of response was randomized, between a structured form and free text email.

RESULTS:

We randomized 460 clinical experts, and 356 (77.4 percent) responded. The responses were graded for quality on a scale of 0 to 4 (higher scores better). Non-response was scored as 0. Analysis using ANOVA gave results of a structured response scoring .34 points (Standard Deviation, SD .36) over a freeform response ($p = .02$); and the commissioning brief as .04 points over a vignette ($p = .81$).

CONCLUSIONS:

This was the first randomized trial to take place inside the secretariat of the HTA program. The difference in quality score between the brief and the vignette allocations was neither statistically nor practically important. The difference between the structured and freeform response was statistically significant, and sufficiently large to be important in practice. While the choice of material to share with clinicians seems unimportant we have shown that it is worth sending a structured response form to experts.

OP22 Societal Perspective On Cost Drivers For Health Technology Assessment

AUTHORS:

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INTRODUCTION:

Understanding cost drivers and estimating societal costs are important challenges for economic evaluation of health technologies in low-and-middle-income countries (LMICs) (1). This study assessed community experiences of health resource utilization and perceived cost drivers from a societal perspective to inform the design of an economic model for the Community Level Interventions for Pre-eclampsia (CLIP) trials (2).

METHODS:

Qualitative research was undertaken alongside the CLIP trial in two districts of Sindh province, Pakistan. Nine focus groups were conducted with a wide range of stakeholders, including pregnant women, mothers-in-law, husbands, fathers-in-law, healthcare providers at community and health facility-levels, and health decision-/policy-makers at the district-level. The societal perspective included out-of-pocket (OOP), health system, and program implementation costs related to CLIP. Thematic analysis was performed using NVivo software.

RESULTS:

Most pregnant women and male decision makers reported a large burden of OOP costs for in- and out-patient care, informal care from traditional healers, self-medication, childbirth, newborn care, transport to health facility, and missed wages by caretakers. Many healthcare providers identified health system costs associated with human resources for hypertension risk assessment, transport, and communication about patient referrals. Health decision-/policy-makers recognized program implementation costs (such as the mobile health infrastructure, staff training, and

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monitoring/supervision) as major investments for the health system.

CONCLUSIONS:

Our investigation of care-seeking practices revealed financial implications for families of pregnant women, and program implementation costs for the health system. The societal perspective provided comprehensive knowledge of cost drivers to guide an economic appraisal of the CLIP trial in Sindh, Pakistan.

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OP24 A Framework For Improved Systems Of Care In Myocardial Infarction

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INTRODUCTION:

In the past decade numerous efforts have been made to enhance quality of care in the province of Québec for patients with ST-elevation myocardial infarction (STEMI). Despite two prior field evaluations and diffusion of a systematic review as well as recommendations, a third audit revealed persistent gaps in care, specifically excessive treatment delays. Our cardiovascular evaluation unit thus aimed to develop a more comprehensive quality improvement framework that further engaged healthcare professionals.

METHODS:

A literature update identified best practices and ways to reduce treatment delays and improve outcomes. This review, combined with the latest evaluation results, was used to establish structural and process quality standards adapted to the Québec context, via a consensus process with a panel of clinical experts. The standards identified quality-of-care targets and key elements of a governance structure to guide the improvement process. Quality indicators to monitor change were also developed. An implementation plan was then created, likewise based on literature and evaluation results.

RESULTS:

For the first time, the unit publicly disseminated the results of the third evaluation according to region, in addition to standard individual hospital "report cards". A summit conference was held during which the standards and indicators were presented to clinicians and other stakeholders, in collaboration with the health ministry and a panel of cardiovascular experts. Site visits are planned to facilitate change and establishment of local improvement plans and committees. A "tool kit" was developed containing a treatment algorithm, a drug protocol, five quality indicators each for processes and care networks, and measurement tools for indicators. A 75 percent minimal achievement target was set for treatment times.

CONCLUSIONS:

A comprehensive framework aimed at improving quality of care for STEMI patients and monitoring change was created by combining evidence from the literature and "real world" data and mobilizing key stakeholders.

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