OD22 Innovating Patient Involvement In Health Technology Assessments To Enable More Sustainable Involvement From Patient Stakeholders

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Introduction: The National Institute for Health and Care Excellence (NICE) heard from small organizations how resource intensive and difficult it is for them participate in medicines health technology assessments (HTA) since the COVID-19 pandemic. To provide additional support for these organizations or to provide alternative patient input, NICE explored implementing surveys directly with patients to share with patient stakeholder organizations and NICE's HTA medicines committees.
Methods: Patient organizations and colleagues at NICE were included in the background investigation. Informal interviews were conducted with the HTA bodies in Wales and health technology colleagues in NICE about their experience of this method of patient input.
Two approaches were piloted:
(i) Developing the online questionnaire using the Summary of Information for Patients.
(ii) Developing a jointly branded questionnaire collaboratively with the patient organization and implementing a data-sharing agreement to share the raw data.
The survey was distributed by the patient organization, analyzed by NICE, and shared with the patient organization to inform their submission to NICE.
Results: The results of the background investigation showed that the option to include this additional method of input could provide valuable support for patient organizations and has the potential to increase the amount and quality of patient input to an HTA committee.
Both pilots were successful in:

- Supporting patient organizations' input into a medicines HTA
- Reducing the resources required from patient organizations.

The second pilot added more value due to:

- Collaboration, relationship, and building trust
- Joint development of the survey
- Data sharing and potential to add to patient evidence about a disease and treatments.

Conclusions: Surveys conducted directly with patients can help patient organizations participate in medicines HTAs, but they are only one element of developing more innovative and sustainable patient involvement in the process. HTA bodies need to innovate and work collaboratively with patient stakeholders to produce a menu of options for involvement so that it can be tailored to stakeholders' resources.

OD23 Evolving Prostate Cancer Screening Strategies In Germany: A Cost–Utility Analysis Comparing Traditional And Emerging Modalities

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Introduction: In 2021, approximately 15,000 men in Germany died from prostate cancer (PCa). The national health policy is considering shifting from annual digital rectal examination (DRE)-based screening to an age-related prostate-specific antigen (PSA)-based risk-adapted and organized screening strategy. Our research investigated the cost–utility of the current DRE-based strategy versus organized age-related PSA-based risk-adaptive PCa screening strategies in Germany.
Methods: We adapted the Swedish Prostata model to the German context, recalibrating it with PCa clinical and epidemiological data from the national and state registries. The model includes preclinical and clinical disease health states defined by tumor, nodal, and metastatic stages and Gleason scores, and assumes that the benefits of screening arise from stage shift. We assessed the cost–utility of 14 strategies, ranging from no screening to DRE, and age-related, PSA-based, risk-adapted screening. Health state utility values and test characteristics were sourced from the literature. Inpatient and outpatient care costs were derived from the German diagnostic-related groups and uniform-based valuation systems.
Results: Among all strategies evaluated and compared with no screening, the "DRE only" strategy led to substantial overdiagnosis, the highest incremental cost, and minimal quality-adjusted life years (QALY) gains. PSA testing starting at 50 to 60 years with reflex MRI for PSA greater than 3 ng/mL cases followed by combined systemic and targeted biopsy reduced the number of biopsies and overdiagnosis by 75 percent and 26 percent, albeit for fewer QALYs and higher costs (dominated) than the same strategy without reflex MRI. The PSA-based risk-adaptive strategy, starting at 50 to 60 years without reflex MRI, demonstrated an 85 percent probability of being cost effective within the EUR30,000 (USD32,211) to EUR100,000 (USD107,369)/QALY willingness-to-pay range.
Conclusions: While Germany's HTA emphasizes clinically added benefits and health-related quality of life, cost-effectiveness analysis substantiates this evidence. As a standalone early detection tool, DRE leads to substantial overdiagnosis, unnecessary biopsies, and

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increased healthcare costs. Overall, this study demonstrated the importance of age-related PSA risk-adaptive PCa screening. The value of MRI deserves further investigation, considering MRI's positive effect on screening acceptability.

OD24 Scalability Analysis Of Multimodal Prehabilitation For Frail Elderly Patients Before Elective Surgery In Germany

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Introduction: Multimodal prehabilitation, including interventions like physiotherapy, combined with frailty screening and a shared decision-making conference for frail elderly patients before elective surgery is an innovative approach currently under investigation (PRAEP-GO RCT, NCT04418271). The PRAEP-GO intervention aims to enhance postoperative outcomes and prevent care dependency. Our aim is to systematically assess the scale-up potential of PRAEP-GO within the German healthcare system.
Methods: We are conducting a scalability analysis using the Intervention Scalability Assessment Tool (ISAT). The ISAT questionnaire comprises two parts: (A) "Setting the scene," describing the current health service situation (e.g., intervention characteristics, political context), and (B) "Intervention implementation planning," outlining future requirements (e.g., workforce, infrastructure), with open-ended questions and a scalability readiness assessment using a scale. Our analysis involves three stages: (i) health economists from the PRAEP-GO research team individually answering ISAT questions, (ii) trialists from the PRAEP-GO research team interviewed in a group, and (iii) external experts representing relevant stakeholders for future implementation interviewed in an advisory board meeting.
Results: Data collection for stage (i) and (ii) has been completed, while data collection for stage (iii) is expected to be completed in February 2024. The preliminary findings for part (A) highlight the need for a sustainable approach to manage an aging and increasingly frail patient population requiring surgery. There is no clinical guideline available for the management of this population group. Regarding part (B), the current infrastructure (e.g., therapy facilities) and personnel structures might need to be adapted and should be expanded for large-scale application. Employing professionals to coordinate the patient pathway was recommended, along with adjustments to reimbursement structures.
Conclusions: In PRAEP-GO, we are pursuing a multidisciplinary process with the aim of supporting health decisions that promote an equitable, efficient, and high-quality healthcare system meeting the challenges of an aging population due to demographic change. The PRAEP-GO trial is currently exploring this approach on a small scale. Existing infrastructure and personnel structures would need to be adapted and expanded for scale-up.

OD26 Comparing Health Technology Developers' Proposed Indication To An Estimated Indication Generated By An International Horizon Scanning Database

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Introduction: Detail on a technology's projected therapeutic use is required for horizon scanning. The International Horizon Scanning Initiative (IHSI) database will utilize natural language processing (NLP) augmented by human curation to generate an estimated indication for technologies in development. We compared the estimated indication, generated as a test-set for NLP, with health technology developers' (HTDs) proposed indications identified from Ireland's horizon scanning system (HSS).
Methods: Eight oncology technologies common to both Ireland's HSS and the IHSI database were analyzed. The analysis included unlicensed technologies in late-stage development that have not submitted a European marketing authorization application. Ireland's HSS receives data on proposed indications for technologies from HTDs. IHSI database curators extract and convert terms from clinical trials into structured inputs (condition, combination therapy, stage of disease, place in treatment, patient/disease-specific subgroups) to produce an estimated indication for a technology. We sought to identify, by structured input, the degree of alignment between HTDs' proposed indications with the IHSI database's estimated indication.
Results: There was 100 percent alignment between the HTD's proposed indication and the estimated indication generated in the IHSI database for five of the eight included technology records. There was 83 percent alignment for two records and 67 percent alignment for one record. Across all records there was full alignment on condition, combination therapy details, patient-specific subgroup, disease-

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