

children's health, we analyzed and compared the burden of disease and risk factors among children under 5 years in China and other regions.

Methods. Indicators were gathered from the Global Burden of Disease 2019, which included the standardized rates and risk factors of mortality and DALYs of children under 5 years in China, Western Europe, North America and the world from 1990 to 2019. Paired t-test or Wilcoxon test were used to compare the rates based on gender. A joinpoint regression model was used to analyze the trend, and the Annual Percent of Change (APC) was calculated and statistically tested.

Results. From 1990 to 2019, the all-cause mortality and DALYs of children under 5 years in China decreased from 1 153.81/100 000 to 160.39/100 000 and 104 426.40/100 000 to 16 479.01/100 000, respectively. The top 3 causes of both death and DALYs were neonatal preterm birth, congenital heart anomalies, lower respiratory infections. The top 3 risk factors of both death and DALYs were low birth weight, short gestation, child wasting. Unintentional injuries, behavioral and environmental risks posed greater threats to children compared with other regions. The rates of mortality and DALYs of the top 15 diseases and injuries in boys and girls showed a downward trend ($p < 0.05$), and most of them were higher in boys than girls ($p < 0.05$).

Conclusions. The burden of diseases among children under 5 years in China has decreased significantly from 1990 to 2019. Compared to other regions, it remains to strengthen the prevention and control of preterm birth, birth defects and unintentional injuries, and to adopt targeted gender-specific interventions. Promoting the parenting behavior and multiple social security may also affects children's health status.

PD55 Evidence-Based Practices To Support Well-Being And School Success Of Children And Youth In Out-Of-Home Care

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Introduction. Children and youth in out-of-home care face many challenges regarding their development and general well-being. It is necessary to put in place best practices to support them where they are most vulnerable. Providing recommendations to health and social services for best practices regarding social and academic success interventions, this study puts forward a synthesis method that combines empirical data and the expertise of key practitioners in the context of Quebec social services.

Methods. A systematic review was first undertaken to identify the most effective interventions. Included studies ($n = 31$) were analyzed according to their methodological quality, collaboration processes, and type of care (foster home vs. residential care). To ensure the applicability of the recommendations made in the context of Quebec social services, contextual data, and clinical expertise were collected. Contextual data was gathered through local research reports, administrative data, and government documents. The expertise of multiple

stakeholders was obtained in follow-up committees and semi-structured interviews ($n = 4$). In addition, to ensure their relevance and scope, recommended guidelines were debated in a deliberation committee.

Results. The analysis between expert, contextual and empirical data led to several recommended evidence-based practices. In accordance with expert opinions, experimental and quasi-experimental studies show that various types of collaboration are beneficial for children and youth in out-of-home care. Notably, intersectoral collaborations were warranted in more complex situations (i.e., youth in residential centers), while partnership agreement was sufficient in less complex situations (i.e., children in foster homes). However, even if effective, some interventions are difficult to apply in real life and certain considerations must be taken into account (e.g. confidentiality issues, availability of resources).

Conclusions. Utilizing three sets of data, guidelines have been proposed to help health and social services to identify best practices and promote the academic development of out-of-home care children and youth.

PD56 Conceptual Issues In The Valuation Of Health States In Children

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Introduction. Assessing the cost utility of health technologies for pediatric patients requires robust utility values for child health states, but the methods for valuing these pediatric health states are much less established than those for valuing adult health states. This is partly because the elicitation of preferences for child health states poses many normative, ethical, and practical challenges.

Methods. This presentation examines the conceptual issues in the valuation of health states in children by addressing the following questions.

- (i) Normative theories of health state values: What are we attempting to elicit?
- (ii) Sources of preferences: Whose preferences should we elicit, and from which perspective?
- (iii) Valuation methodologies: How should we elicit preferences?
- (iv) Attaching different values to child and adult health: Is a lack of consistency problematic?

To answer these questions, we used desk research (non-systematic literature reviews) and findings from a two-part workshop held in April 2021. The workshop included 25 participants with expertise in health economics, health state valuation, child health, health technology assessment (HTA) decision-making, and ethics.

Results. We identified a lack of consensus on what is being elicited for both adults and children. Many HTA agencies recommend that the public be involved in utility generation exercises, but some criteria for defining who constitutes a member of the public exclude children. Of the many candidate sample types, perspectives, and methodologies,

only a few were deemed relevant, acceptable, and feasible for use in the child health context. In addition, there were diverging views on whether it is possible to compare and integrate adult and child value sets with different properties.

Conclusions. Several questions remain to be answered before the public and other stakeholders can have confidence in child health state valuation protocols. We propose a research agenda, including both empirical and conceptual work, to inform future methodological development and to help HTA agencies make recommendations about how child utility values should be generated.

PD58 Implementation And Assessment Of A Lung Cancer Screening Pilot Project In Québec Through Multi-Stakeholder Collaboration

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Introduction. In 2019, the Québec provincial health technology assessment body (INESSS) recommended that lung cancer screening with low-dose computed tomography (LDCT) be accessible in Québec only within the context of an evaluation in the ‘real-world’ care setting. Based on this recommendation, the ministry of health (MSSS) decided, in 2020, to implement a screening pilot project and to conduct a formal evaluation, partnering with a clinical leader (principal investigator), participating hospitals, the provincial public health agency (INSPQ) and INESSS. The goal of this evaluation is to facilitate decision-making regarding the implementation of a province-wide screening program.

Methods. To support the implementation of the pilot project, algorithms and recommendations were developed to guide management of screening program participants. This material, based on Lung-RADS (Lung Computed Tomography Screening Reporting and Data System of the American College of Radiology), was developed by reviewing the literature and by consulting clinical experts. The evaluation plan proposes various indicators, focusing on six main topics: (i) costs, (ii) screening and investigation processes, (iii) clinical effectiveness and other effects on health, (iv) effects on smoking cessation, (v) organizational impact and (vi) implementation issues.

Results. INESSS has developed 12 algorithms and close to 50 recommendations for lung cancer screening and investigation, a tool for assessing lung cancer risk and a benefits/risks table. For the evaluation of the pilot project, MSSS, INSPQ and INESSS developed more than 100 indicators; short-term indicators are currently being

measured and others will follow in the longer term. Since starting in June 2021, the pilot project is progressing well (as of November 28, 2021): 2,365 people have been referred, 1,272 were eligible for screening, 678 have had their first LDCT and 19 were Lung-RADS 4B or 4X. Results on indicators will help the ministry decide on the feasibility of scaling up screening to the provincial level and will highlight aspects to be improved.

Conclusions. This project shows how health technology assessment products can elicit changes in the health system, and how multi-stakeholder collaboration can actively support practice implementation and inform decision-making.

PD60 What Are The Opportunities And Challenges To Implementing Value Based Healthcare Pilots In The Brazilian Private Healthcare System?

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Introduction. The Brazilian National Agency for private healthcare system (ANS) regulates the private healthcare system in Brazil. ANS, since 2019, has been running the pilot value-based new payment models project. In total, 13 projects were selected by ANS. This investigation aims to identify opportunities and challenges to implement value based healthcare (VBHC) in Brazil.

Methods. We interviewed managers participating in the ANS’ Value-Based Payment Models. Data were collected through semi-structured interviews during 2021. Twelve managers were invited to participate in the interview and eight accepted the invitation. The key questions were: “what are the main factors that facilitate – or limit - the transition from the fee for service model to a value-based model in the private healthcare system? And “will the payment models be scalable?” For data analysis, Bardin’s content analysis was chosen. Data validation was performed using the debriefings technique.

Results. The interviews identified two key facilitating factors: people (identified by 50% of respondents) and processes (identified by 50% of respondents). Responses relating to people nominated the need for professionals with VBHC knowledge (33%), support of senior management (25%), support from the provider (25%) and care team (17%). Responses relating to processes nominated the need for partnership (58%), health-driven management (25%) and results (17%). We also identified that limiting factors (49%) were: providers (39%), in details: non-support from the provider, (56%), fear of financial loss (22%) and provider only wanting profit (22%); information system (30%), with data management; culture (17%), current versus innovative models; and peoples (13%), knowledge. More than 90 percent found it to be scalable, particularly, in vertical health plans (38%), large operators (38%); and provide diagnostic services (13%). We found that non-scalable situations are those where fee for service is hegemonic in terms of payments.