Conclusions EBM+ is shown to provide a promising programme for making better use of existing evidence when assessing interventions and exposures. Concerns about infeasibility, bias and subjectivity can be allayed, although some attempts to tackle these concerns are unsuccessful.

A MULTIFACETED, CLINICALLY INTEGRATED EVIDENCE BASED MEDICINE CURRICULUM IMPROVES MEDICAL STUDENTS’ COMPETENCY AS MEASURED BY THE FRESNO TEST

The University of Buckingham Medical School (UBMS) is an independent medical school in the UK. Following feedback from students that they struggled to understand the relevance of Evidence Based Medicine (EBM) to clinical practice, the EBM curriculum was revised. A longitudinal, competency based, multifaceted, clinically integrated curriculum, with assessments has been designed and implemented. The aim of this study was to assess the effectiveness of the new EBM curriculum to improve students’ competency using the validated Fresno test and their attitudes.

Method Blended learning approaches have been incorporated with a mix of didactic lectures, facilitated small group discussions and peer teaching of phase I (years one and two) students of the relevance of EBM to clinical practice by phase II (years three and four) students using their personal experiences in clinical rotations. Formative and summative assessments have been designed to capture written demonstration of EBM knowledge and skills as applied to clinical scenarios in short answer format.

All students from the 2017 cohort that experienced the first iteration of the integrated curriculum were invited to participate. The Fresno test of EBM competence was administered as a formative assessment test before and after the EBM teaching through our virtual learning environment. Self-reported students’ attitudes and knowledge of EBM, its relevance to clinical practice were assessed and students were invited to participate in a focus group discussion at the end of EBM teaching.

Results Of the 83 students invited, 31 participated at baseline (37.3%) and 55 participated at the end of the study (66.3%). 18 students attempted the Fresno test at baseline as well as at follow-up. The average score for the test was significantly higher after teaching than at baseline, with the average score increasing by 38.7 marks, from 29.3 at baseline to 68.0 after teaching ($p<0.001$). Analyzing responses to questionnaires from the same 18 students, showed that compared to baseline, after EBM teaching, a higher proportion of students felt confident in critically appraising journal articles and in formulating clinical questions to search for evidence. Five students participated in the focus group discussion and key themes identified were increased students’ perceptions of the relevance of EBM to clinical practice, preference for interactive workshops over didactic lectures for literature searching skills and incorporating EBM teaching across the curriculum.

Conclusions It has been feasible to design and implement a multi-faceted, clinically integrated EBM curriculum in undergraduate medical education. Early evaluation of the curriculum using the Fresno test and focus group discussions has shown an improvement in EBM knowledge, skills and students’ perceptions of the clinical relevance of EBM. The Fresno test has been a useful formative assessment to assess medical students’ competency in EBM- the first three steps- ask, acquire and appraise.

CHILDHOOD CANCER HEALTH OUTCOMES IN EGYPT: TEN-YEAR REAL-WORLD EVIDENCE FROM CHILDREN’S CANCER HOSPITAL 57357 – EGYPT (CCHE) AND COMPARISON WITH RESULTS FROM ENGLAND

To study childhood cancer survival and health outcomes over the last ten years in one Egyptian hospital CCHE (Children’s cancer Hospital 57357 Egypt); determine the variations in survival by demographic, cancer type, and disease severity differences and the reasons behind these variations; and compare childhood cancer survival outcomes with results from England.

Method A retrospective observational cohort study was conducted for children (age 0-18 years) with confirmed cancer diagnosis who presented at CCHE for treatment from 2007 until 2017 and were followed up until July 2018. Confirmed diagnosis of childhood malignancy followed the WHO/ICCC-3 criteria. Patients’ demographic data were extracted from hospital-based cancer registry, while disease-related and health outcomes data were extracted from hospital disease-specific registry. Health outcomes included 5-year survival rates, age-standardized mortality rates, and trends in disease relapse/progression. Five-year overall survival was calculated for each childhood cancer type using Kaplan Meier analysis. The five-year overall survival rates at CCHE were compared to population-based 5-year survival of children with cancer in England [2001–2015]. Comparable survival was defined as < 10% difference and > 10% as inferior survival. Patients’ demographics were described for the full-analysis population, and health outcomes evaluation was done for the evaluable population, based on intention-to-treat analysis.

Results A total of 15,997 children with cancer were analyzed; 58% were males and 42% females. Most of the patients (48%) were in the youngest age group [0–4 years]. Fifty-nine percent of patients had solid tumors and 41% had hematologic malignancies. The most common cancers were Leukemia, Lymphoma, CNS tumors, and Neuroblastoma. Survival was calculated for 14,553 patients, representing 92.2% of full study population. 5-year survival rates at CCHE were comparable for some cancer types; 95.6% for Hodgkin’s Lymphoma; 81% for Non-Hodgkin’s Lymphoma; 92.3% for Retinoblastoma; 82% for Renal tumors; 66.4% for CNS tumors; 65.9% for Ewing Sarcoma; 86.9% for Germ cell tumors; 61% for Rhabdomyosarcoma; 77.1% for other soft tissue tumors; and 91.2% for CML. Whereas for other cancer types, overall
survival rates at CCHE were inferior; 79.9% for ALL; 53.8% for AML; 56.5% for Neuroblastoma; 56.4% for Hepatoblastoma; 49.1% for Osteosarcoma. Trends in age-adjusted mortality rates will presented.

Conclusions Studying 5-year survival in childhood cancer health outcomes at CCHE would help generate real-world evidence about those having inferior outcomes and identify priority areas that need future improvements. Making better use of the evidence generated at CCHE would enhance real-world practice through making informed decisions that are adapted to a local context setting– CCHE.

ACHIEVING EVIDENCE INTEROPERABILITY IN THE COMPUTER AGE: SETTING EVIDENCE ON FHIR

1,2Brian Alper, 1Martin Mayer, 5Khalid Shahin, 3Joshua Richardson, 5Lisa Schilling, 6Mario Tristan, 4Nils Salas. EBSCO Health, Ipswich, MA, USA; 1University of Missouri-Columbia School of Medicine, Columbia, MO, USA; 3Cone Health, Greensboro, NC, USA; 4RTI International, Chicago, USA; 5University of Colorado, Aurora, USA; 6IHCAI, San Jose, Costa Rica; 7Cochrane Central America and Spanish-speaking Caribbean, San Jose, Costa Rica

Objectives Evidence-based practice requires the use of research results to inform care. Computers can add capacity for evidence-based practice by making the information from research results, appraisals, and summations searchable and re-usable without labor-intensive manual screening and repetition of data entry. Such interoperability can be achieved by establishing universal standards for data exchange for communicating evidence concepts in machine-interpretable formats.

Method Health Level 7 (HL7) is a standards development organization that has developed a standard for electronic exchange of healthcare information called Fast Healthcare Interoperability Resources (FHIR). We are using the HL7 standards development methodology to extend FHIR to create an Evidence Resource for exchanging descriptive, statistical and certainty concepts related to evidence.

Results The FHIR Resources for Evidence-Based Medicine Knowledge Assets (EBMonFHIR) project is in active development with a substantial coalition of international organizations and coordination with other standards development groups. The Statistic Resource currently supports explicit descriptions of the populations and subgroups (exposureBackground elements), interventions or exposures and comparators (exposure-Variant elements), the outcomes (measuredVariable elements), and for each statistic the sample size, the value with unit of measure, the precision estimate, the p value, and the certainty of the statistic. The project website (http://wiki.hl7.org/index.php?title=EBMonFHIR) includes multiple examples and information on how to participate.

Conclusions Working together we can achieve interoperability for evidence in the electronic era to realize the technological breakthroughs we see in other domains such as navigation support. A common information architecture will also facilitate breakthroughs we see in other domains such as navigation support. A common information architecture will also facilitate

THE USE OF EVIDENCE IN HUMANITARIAN RESPONSE DECISION MAKING

1Dell Saulnier, 2Claire Allen, 3Arenli Ellisson, 2Ben Heaven Taylor. 1Karolinska Institutet, Stockholm, Sweden; 2Evidence Aid, London, UK

Objectives The need to use evidence in humanitarian settings is recognized yet utilising that evidence to make decisions about humanitarian response remains a challenge. The objective of the study was to identify how, when, and why decision makers in humanitarian response use scientific, peer-reviewed evidence to make decisions.

Method An online cross-sectional survey of fifteen open- and closed-ended questions on demographics, experience and role in humanitarian response was developed by Evidence Aid (EA) and Karolinska Institutet (KI). The online survey was available on the EA website from 20 August-15 October 2018. Participants were self-selected, recruited through social medial channels and mailing lists of EA and KI. All respondents and responses were anonymized. Responses were analyzed with descriptive statistics and content analysis.

Results Forty-seven people responded, primarily working in Europe or North America with roles of humanitarian response director/manager, independent consultant, or policy maker. Personal assessment of the quality of information, trust in the source, and information that was contextually relevant or based on field experience were factors for deciding whether information should be considered evidence. Reasons for using evidence when making decisions included adhering to good practice to maximize impact and effectiveness of aid, reassurance that the right decisions were being made, personal or organizational values, and using evidence as a tool to protect beneficiaries and organizations from poor quality decisions and program content.

Conclusions Using evidence for decision making was common practice during the process of designing implementing and evaluating humanitarian response content, yet reasons for use varied. The importance of evidence developed and validated from field experience and trust in the source reported by this sample suggests that strengthening collaborative efforts between decision makers and evidence generators could be one approach to improve evidence and evidence use in humanitarian response.