Facilities continues to achieve success. The existence and publication by the Canadian Institute for Health Information (CIHI) of the interRAI Resident Assessment Instrument (RAI-MDS 2.0) Quality Indicator (QI) - Percent of Residents on Antipsychotics without a Diagnosis of Psychosis provides a metric that can accessed and reported quarterly. By acquiring and integrating data from Emergency, Inpatients, Physician Claims, Pharmacy Information Network and the Resident Assessment Instrument-Home Care (RAI-HC), a similar metric can be developed to monitor and report on the use of Antipsychotics in Supportive Living environments.

Study Question: Can existing data be leveraged to create a metric to support improvements in inter-professional practice and care for residents and families by spreading the Appropriate use of Antipsychotics initiatives from Long Term Care Facilities to Supportive Living environments in Alberta?

Methods: Data sources include Home Care, RAI-HC, National Ambulatory Care Reporting System, Inpatient Discharge Abstract Database, Physician Claims and the Pharmacy Information Network. Data analytic, visualization and liberation tools include Oracle, SQL Developer, Excel and Tableau.

Results: Referencing the RAI-MDS 2.0 QI, similar core elements have been acquired and a comparable antipsychotic measure for community living clients has been generated.

Conclusions: This work allows for measuring, monitoring and reporting on the use of Antipsychotics for individuals residing in Supportive Living environments in Alberta.

Health Policy Implications: These antipsychotic utilization measures are designed to support improvements in inter-professional practice and the quality of care delivered to residents and their families.

Abstract 146
Building big data from experience: a new model for prems collection and utilisation

Ilaria Corazza, Kendall Jamieson Gilmore, Manila Bonciani, Sabina De Rosis
Sant'Anna School of Advanced Studies, Pisa, Italy
Correspondence: Ilaria Corazza
Israel Journal of Health Policy Research 2019, **8**(Suppl 1):146

Background: Patient-reported experience measures (PREMs) can help the design and management of healthcare services, and inform policymaking. However, the experience is typically measured using standard closed-ended questions, collected only periodically and unsystematically. This dearth of data is particularly problematic in pediatric settings due to exacerbated information and power asymmetries.

Study Question: How can healthcare providers make use of new technologies and analytical techniques to enable the systematic and continuous collection and utilisation of pediatric PREMs?

Methods: This study describes the cases of Meyer Hospital (Florence) and Children's Clinical University Hospital (Riga) that, from December 2018, adopted a digital PREMs survey. The questionnaire was developed by hospital managers and physicians, collaborating with researchers from the MeS Laboratory - Sant'Anna School of Advanced Studies (Pisa). It consists of open-ended and closed-ended questions, some of which are adopted from the pediatric Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). It can be answered directly by adolescent patients or by caregivers and includes a section specifically addressed to children. The questionnaire is administered digitally upon discharge to all enrolled patients. A web platform collects, analyses and illustrates data in aggregate and anonymous form to hospital staff in real time.

Results: This study sets out the development of a new pediatric PREMs questionnaire, plus a digital and automatic survey administration and data reporting system.

Conclusions: This model has several features which may be of interest to clinicians and administrators and can be replicated elsewhere: notably, inclusion of narrative sections, enabling greater richness of information; differential access for different staff groups and researchers through an online platform, enabling prompt use of data

and possibilities for action; dual implementation in two sites in different settings, enabling comparison and shared learning.

Health Policy Implications: This approach to PREMs can provide professionals at all levels in healthcare systems with a novel source of insight to support quality improvements.

Abstract 61
Barriers to completing colonoscopy after a positive fecal occult blood test

Liora Valinsky[1], Revital Azulay[1], Einat Elran[2], Fabienne Hershkowitz[1], Natan Lederman[1], Revital Kariv[2], Anthony Heymann[1]
[1]Meuhedet Healthcare Services, IL; [2]Maccabi Healthcare Services, IL
Correspondence: Liora Valinsky
Israel Journal of Health Policy Research 2019, **8**(Suppl 1):61

Background: Colorectal cancer leads to significant morbidity and mortality. Early detection and treatment are essential. Screening using fecal occult blood tests (FOBT) has increased significantly, but adherence to colonoscopy follow-up is suboptimal worldwide. Recently published papers have emphasized the increased risk of abstaining from colonoscopy after a positive FOBT.

Study Question: What are the barriers to colonoscopy following a positive FOBT at the level of the patient, physician, organization, and policymakers.

Methods: This mixed methods study was conducted at two health care organizations in Israel. The study included retrospective analyses of 45,281 50-74-year-old members with positive FIT's from 2010-2014, and a survey of 772 patients with positive FIT during 2015, with and without follow-up. The qualitative part of the study included focus groups with primary physicians and gastroenterologists and in-depth interviews with opinion leaders in healthcare.

Results: Patient lack of comprehension regarding the test was the strongest predictor of non-adherence to follow-up. Older age, Arab ethnicity, and lower SES (socio-economic status) significantly reduced adherence. We found no correlation with gender, marital status, patient activation, waiting for time or distance from gastroenterology clinics.

Primary care physicians underestimate non-adherence rates. They feel responsible, but lack the time and skills to ensure adherence. Gastroenterologists do not consider FIT an effective tool for CRC detection. Lack of agreement between screening recommendations and gastroenterologist opinion and lack of awareness among healthcare authority figures negatively impact the screening program.

Conclusions: Interventions to improve follow-up after a positive FOBT should be targeted at all levels within the health care system. Individually tailored patient interventions that are educationally and culturally appropriate prior to testing completion is essential. Strategies to support primary care physicians in the test and follow-up process, as well as improving communication between physicians, and finally, increasing awareness among healthcare leaders will all improve outcomes.

Health Policy Implications: We have clearly defined avenues to improve colorectal cancer screening outcomes at all levels of the system.

Abstract 237
Partial smoking ban breaks the promise of smoke-free environment in Kazakhstan

Jamilya Sadykova[1], Ardak Baizhaxynova[2]
[1]National Coalition "Smoke free Kazakhstan", Kazakhstan; [2]Nazarbayev University, Kazakhstan
Correspondence: Jamilya Sadykova
Israel Journal of Health Policy Research 2019, **8**(Suppl 1):237

Background: The fundamental human rights and principles of Article 8 of the WHO Framework Convention on Tobacco Control (FCTC) requires 100% smoke-free public places. Kazakhstan ratified the FCTC in 2006 but only has a partial smoke free policy; current law allows designated smoking rooms (DSR) in public dining establishments, while other public places must be 100% smoke free.

Study Question: Assess the effectiveness of specially designated places for smokers, in protecting people from second-hand smoking exposure, in the public dining venues of Kazakhstan by means of air quality monitoring.
Methods: A cross-sectional study of indoor air quality was conducted from September to October 2017 in the largest city of Kazakhstan. A total of 29 public dining establishments with different smoking policy were monitored in the evenings. The real-time measurement of PM2.5 particulate matters was conducted by TSI SidePak AM510 Personal Aerosol Monitor and was ranked using the WHO target air quality guideline.
Results: The highest mean PM2.5 level was detected inside the DSRs (648 μg/m3), followed by venues with similar results where smoking was allowed throughout the venue (180,3 μg/m3) and inside the smoking hall (182 μg/m3). The third rank belongs to non-smoking areas venues which allows smoking only in DSRs (73.1 μg/m3). The lowest mean PM2.5 level was observed in 100% smoke-free venues (26 μg/m3).
Conclusions: PM2.5 concentrations at DRSs which comprise hazardous level severely undermines the smoke-free environment national agenda. Unhealthy levels of PM2.5 concentrations at smoking areas confirm that a partial smoking ban violates the fundamental human right to be protected from second-hand smoke.
Health Policy Implications: Air quality monitoring data confirms that anything less than 100% smoke-free policies is hazardous to people and must be amended to eliminate DRSs and other exemptions from public places, as mandated by the Framework Convention on Tobacco Control.

Parallel 2

Abstract 214
Using quality data to strengthen routine immunization in Nigeria; experience with routine immunization (RI) lots quality assurance sampling (LQAS)
Rilwan Raji
World Health Organization, Nigeria
Israel Journal of Health Policy Research 2019, **8(Suppl 1):**214

Background: Studies emphasize the importance of quality data for effective planning, monitoring, and evaluation. The 2015 National Immunization Coverage Survey (NICS) in Nigeria revealed data quality issues across all 36 states, (worse in 18 states) of the Country with National Penta3 Coverage at 33% as against Administrative (Admin) Coverage of 98%, hence the importance of RI LQAS to identify reasons for disparities.
Study Question: Does the RI data from health facilities (HFs), aggregated at districts (LGAs) reflect true performance? What reasons explain disparities? What are the primary sources of information that guide vaccination amongst caregivers?
Methods: 18 priority States were selected. Using a probability proportionate to population size, all LGAs in a State, 6 HFs and 6 settlements were selected. Within each settlement, 10 households (HH) were selected from which 1 child 0-11 months per HH was selected for assessment by reviewing the immunization card and/or mother's recall. Reasons for partially/not immunized for age and sources of information about vaccination were ascertained.
Using cumulative binomial probabilities, a district (Lot) was said to have passed (accepted at 80% coverage or more) if at least 8 of 60 children sampled were fully immunized for age.
Results: A total of 2,292 sites, 22,920 households, 22,920 children 0-11months sampled in 382 districts. Only 3% of the districts passed, with 56% of the States having < 80% coverage. At the individual level, only 1 of 3 children in the Country was fully immunized for age.
The main reasons for none/incomplete immunization was weak demand for immunization with Health Workers (HWs) being the major source of information about vaccination in the Country.
Conclusions: The RI LQAS confirmed findings of the NICS that admin data did not reflect RI performance in Nigeria. Subsequently, a State of Emergency on RI with RI Coordinating Centers set up across States with RI LQAS conducted quarterly to review performance.

Health Policy Implications: Instituting frequent low budget surveys as RI LQAS is effective in ensuring reliable data for planning to improve vaccination of children and enshrine accountability amongst erring HWs that falsify data.

Abstract 103
First year of the first population-based biobank in Israel
Daniella Beller
Maccabi Institute for Research and Innovation, IL
Israel Journal of Health Policy Research 2019, **8(Suppl 1):**103

Background: Maccabi Healthcare Services (MHS) has set for itself the target of creating the first population-based biobank in Israel, thus providing an ideal platform for Precision Medicine research. MHS is the second largest healthcare provider in Israel. MHS serves 2.3 million members which constitutes a representative quarter of the Israeli population. Electronic health records have been implemented in MHS for over a quarter of a century. With less than 2% annual member turnover, MHS records have a longitudinal history of many patients throughout their entire lives. In 2017 the Tipa Biobank (Tipa) was launched, a nationwide biobanking program to link samples and EHR data for broad research use.
Study Question: We describe the initial phases of implementation of a large-scale population-based biobank initiative within the setting of a public healthcare fund.
Methods: Patients are approached by trained concenters and offered to participate. Samples are collected in a standardized manner and transported daily using the existing nationwide infrastructure of MHS.
Results: As of March 2019, over 70,000 MHS patients consented to participate in Tipa and over 100,000 vials have been stored. Of the patients approached, over 50% consent to participate. Tipa participants are slightly older (mean age of 49.7) and are more likely to be female (60%). 23% of participants are diagnosed with hypertension and 18% of them suffer from diabetes of pre-diabetes.
Conclusions: With virtually no funding MHS succeeded in creating the first population-based biobank in Israel. Tipa is a resource that enables a new model for translational research that is faster, more flexible, and more cost effective than traditional clinical research approaches. The model is scalable, and will increase in value as resources grow.
Health Policy Implications: Findings from using this resource will impact the development of personalized medicine tools and which will not only impact Tipa participants but will change the way patients are treated.

Abstract 276
Innovative adoption of technology for improving population based screening of common non communicable diseases in India
Aman Kumar Singh[1], Rajeev Kumar[2], Manas Pratim Roy[2], HSD Srinivas[3], Sita Ram Budaraju[3]
[1]Tata Trusts; Ministry of Health and Family Welfare, India; [2]Ministry of Health and Family Welfare; Government of India, India; [3]Tata Trusts, India
Correspondence: Aman Kumar Singh
Israel Journal of Health Policy Research 2019, **8(Suppl 1):**276

Background: India is witnessing a rapid health transition with a rising burden of Non-Communicable Diseases (NCDs) which account for around 5.8 million or 61% of all deaths annually.
The Government of India has launched the world's largest government-funded health Programme "Ayushman Bharat" to strengthen comprehensive primary health care, reduce out of pocket expenditure and conduct Population-Based Screening (PBS) for Diabetes, Hypertension & Common Cancers (oral, breast and cervical) for population aged>30 years; targeting 500 million population annually.
Study Question: Does adoption of Technology hasten and standardize prevention, control and management of Non-Communicable Diseases?
Methods: A NCD application software has been developed and deployed by Tata Trusts and Dell (as development partner) for the Government of India to facilitate PBS of common NCDs. It automates