

response to treatment and to detect complications. There is currently no robust evidence to inform recommendations on monitoring. Creating this evidence base is challenging because the benefits and harms of testing are dependent on what is done in response to the test results.

Methods: We identified a list of commonly used tests. We defined a series of filtering questions to determine whether there was evidence to support the rationale of monitoring, such as “Can the general practitioner do anything in response to an abnormal test result?” Through a series of rapid reviews we identified evidence to answer each question. The evidence was presented at a consensus meeting where clinicians and patients voted for inclusion, exclusion, or further analysis. A process evaluation was performed alongside this. Further analyses were performed using routinely collected healthcare data and by performing incidence analyses, emulating randomized controlled trials (RCTs), and modeling disease progression.

Results: We tested this methodology on three common LTCs: chronic kidney disease (CKD), type 2 diabetes mellitus (T2DM), and hypertension. We found sufficient evidence to include hemoglobin A1C and estimated glomerular filtration rate (eGFR) for monitoring patients with T2DM; hemoglobin and eGFR for patients with CKD; and eGFR for patients with hypertension. The consensus panel excluded four tests, while 10 tests were selected for further analysis. The emulated RCTs will investigate the effect of regular monitoring with certain tests on health outcomes among routinely monitored patients. In addition, we will investigate the signal-to-noise ratio of each test over time using a modeling approach.

Conclusions: The cost effectiveness of the evidence-based testing panels needs to be tested in clinical practice. We are currently developing an intervention package and are planning to run a feasibility trial. This program of work has the potential to change how LTCs are monitored in primary care, ultimately improving patient outcomes and leading to more efficient use of healthcare resources.

PD50 Does The New Healthcare Reform Improve Job Satisfaction Among Village Clinic Doctors In China? A Meta-Analysis

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Introduction: Since 2009, the Chinese government has launched a new health system reform that affected primary healthcare significantly. We aimed to analyze the factors associated with job satisfaction among village clinic doctors since the new healthcare reform, and to provide a reference for the next stage of reform.

Methods: We systematically searched one English (PubMed) and two Chinese literature databases (CNKI and Wanfang Data). Cross-sectional studies containing information related to job satisfaction among village clinic doctors in China were included. The total job

satisfaction among village clinic doctors was estimated using a random effects meta-analysis. Differences in study-level characteristics among groups were estimated using subgroup analysis and meta-regression.

Results: We identified 17 cross-sectional studies investigating a total of 28,468 village clinic doctors in China. The pooled job satisfaction value was 0.40 (95% confidence interval [CI]: 0.32, 0.49). The results showed that lower job satisfaction was reported in the period from 2016 to 2020 (0.33, 95% CI: 0.23, 0.42) than in the period from 2010 to 2015 (0.51, 95% CI: 0.33, 0.70). The main factors influencing job satisfaction among village clinic doctors were salary (odds ratio [OR] 1.71, 95% CI: 1.23, 2.36), number of training sessions (OR 2.56, 95% CI: 1.68, 3.90), age (OR 3.45, 95% CI: 2.22, 5.35), and level of education (OR 0.68, 95% CI: 0.40, 1.15).

Conclusions: Since the new health system reform, only 40 percent of village clinic doctors in China are satisfied with their work and it is likely this figure will continue to decrease. Those with higher salaries, more training sessions, and greater age had higher job satisfaction. In contrast, village clinic doctors with a higher level of education had lower job satisfaction.

PD51 Effectiveness And Safety Of Vitamin D For COVID-19: A Living Evidence Synthesis Informing A Health Technology Assessment Report

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Introduction: An evidence synthesis developed to inform decision-making on the use of vitamin D for preventing and treating COVID-19 showed that current available evidence is of low to very low quality. We set up a rigorous living evidence to inform health decisions (LE-IHD) approach to provide timely updates of this health technology assessment (HTA) report and aid decision-making.

Methods: Following the LE-IHD framework, we developed a baseline synthesis and evidence monitoring on the effects of high-dose vitamin D for the prevention and treatment of severe COVID-19 on all-cause mortality, COVID-19-related hospitalization, intensive care unit admission, length of hospital stay, quality of life, adverse events, and long COVID-19. The evidence identification, screening, and selection processes were supported by Epistemonikos technological enablers and the Living Overview of Evidence platform. We searched for ongoing studies in trial registries every three months. New eligible studies were assessed using a systematic and reproducible process to update the HTA report.

Results: For the baseline synthesis we identified nine randomized control trials (RCTs) assessing high dose vitamin D2, vitamin D3,