much better) measured on a six-point global perceived change scale, collected using regular SMS (with the alternative of brief phone calls for those where text messaging is not possible or missed) for the first 16 weeks for all participants, and thereafter monthly up to month 12, or until stable resolution of symptoms (defined as two consecutive SMS responses of patient-reported resolution).

Results

In total, 90% ($n = 283$) of participants opted for SMS follow-up and 10% ($n = 31$) for phone calls. There have been 4,299 valid responses via SMS out of the expected 4,787 (90% response rate), compared to 74% (417/567) telephone call responses. The median (IQR) weekly response rate over the first 16 weeks was 93% (90%, 95%) and 75% (71%, 77%) for texts and calls, respectively. There was no evidence of decrease in weekly response rate over time (i.e. pattern of missingness was intermittent). The median response rate for months 5 to 12 was 70% (62%, 80%) for SMS and 67% (63%, 82%) for telephone calls. 190/283(67%) and 3/31(10%) participants completed 100% of the expected texts and calls, respectively. 243/283 (86%) and 20/31 (65%) participants completed 80% texts and telephone calls, respectively.

Conclusion

Collecting frequent follow-up outcome data with SMS is feasible in an RCT and provides high response to both short and longer term follow-up. This could be an additional and/or alternative strategy to collecting data in large pragmatic trials, and is particularly useful for collecting regular primary outcome data, which is key to time-to-event and pragmatic ITT-evaluation.

O68

Causal inference with randomised clinical trials of chemotherapy: the importance of well-documented treatment side-effects

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Introduction

Randomised Controlled Trials (RCTs) are universally considered as the most reliable way to demonstrate and assess causal relationships between treatments and outcome; science-based medicine is rooted in them. Spurious relationships between the outcome and a time-fixed treatment-variable are eliminated by randomising patients over two or more arms of the trial. Hence, the randomisation procedure initiates the process by which treatment and outcomes of interest should be interpreted in a causal way. However, treatment is not always administered as intended, not least because of the occurrence of side effects and adverse events. In RCTs of chemotherapy, for example, the treatment administered may differ from the intended one because of the application of either cycle delays or dose reductions.

Background

Opposite to the *intention-to-treat approach*, a statistical analysis based on actual treatment data might be problematic due to the presence of the so-called *treatment-adjustment bias*. Exposure to chemotherapy agents may in fact be reduced and/or delayed as a consequence of previous-treatment side-effects. In particular, both reductions and delays contribute to lowering the value of the so-called Received Dose Intensity.

Methods

Inverse Probability-of-Treatment Weighting (IPTW) is a general methodology for removing treatment-adjustment bias. Working under the hypothesis of *No Unmeasured Confounding*, it creates a pseudo-population by weighting each patient with the inverse probability of observing a certain treatment administration given the past treatment and toxicity history. However, a review of data collected from RCTs on osteosarcoma suggests that treatment side-effects may not be sufficiently well-documented.

The pseudo-population created by IPTW has the following two properties:

1. Pseudo-patients' past toxicity-history no longer predicts exposure to chemotherapy in the next cycle; 2. The causal effect of treatment modifications on outcome is the same in both original and pseudo-populations.

Results

Using data from Medical Research Council trial BO06 (European Organisation for Research and Treatment of Cancer trial 80931) we will illustrate the use of IPTW and Marginal Structural Models (MSMs) for estimating the causal effect of dose reductions on Event-free Survival (EFS). The use of IPTW and MSMs allows to move beyond intention-to-treat and unbiasedly estimate the effect of treatment modifications on EFS.

Conclusions

We demonstrate that, even with complex and entangled data such as those collected in a RCT of chemotherapy, constructing and estimating a causal model is possible, provided that side-effects are well documented. When this is not the case, the removal of treatment-adjustment bias via IPTW might be problematic, if not prevented at all by the presence of unmeasured confounder. As such, good-quality toxicity data should be regarded as important enablers of causal modelling in RCTs of chemotherapy.

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The compass study - dynamic generation of patient-specific ecare plans in a pragmatic trial

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The COMPASS Study is a pragmatic, cluster-randomized trial of 41 hospitals in North Carolina designed to determine the effectiveness of a comprehensive model of post-acute stroke care (i.e. the COMPASS intervention) compared with usual care (Control).

The COMPASS intervention includes activities such as: a follow-up telephone call two days after having been discharged; a 7–14 post-acute stroke clinic evaluation and take a patient-reported functional assessment; and generation of a individualized patient-specific care plan that is clearly discussed by the clinical provider with the patient and caregiver; and follow up phone calls 30, 60, and 90 days post discharge.

In order to efficiently implement COMPASS in participating hospitals, Wake Forest Baptist Health developed a web-based application that manages assessment collection, generates a series of helpful reports for the clinical provider and most importantly, uses a series of proprietary decision algorithms to dynamically in real time generate a patient specific care plan that identifies current health concerns for a patient, coaches the patient and family to access resources and to self manage health behaviors to improve recovery, independence, and health.

In this presentation, we will describe and demonstrate the COMPASS web-based application including the dynamic generation of patient specific care plans. Implementation of this care plan is a model of value based clinical care, meeting numerous CMS quality metrics.

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Best practices for reporting safety data to data monitoring committees

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Background

Data Monitoring Committees (DMCs) are charged with evaluation of accumulating patient safety data in ongoing clinical trials. Periodic review involves scrutinizing rates of adverse event (AE) coded terms,