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Benefits and limitations of the ADAPTE method

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Use of ADAPTE for VTE Prevention

- NHMRC undertook to develop a VTE prevention guideline for adult surgical patients, medical patients or pregnant women admitted to Australian hospitals
- We used ADAPTE because:
  - Of the number of international evidence-based VTE prevention guidelines
  - To test ADAPTE for broader use in Australia

Plan

- We planned to use and evaluate all modules in the ADAPTE manual
- We established a 16-member committee
- Aimed to develop the guideline over a 12 month time frame (from identification of source guidelines)
- Aimed to meet NHMRC guideline standards

Define health questions

- **Committee identified 143 clinical questions:**
  - 3 broad questions on risk of VTE and appropriate VTE prophylaxis in 35 clinical categories = 105
  - 2 broad questions on patient risk and appropriate VTE prophylaxis in 13 at-risk patient categories = 26
  - 5 questions specific for anaesthesia
  - 7 other broad questions related to patient acceptability, implementation and cost effectiveness

Search and screen for guidelines

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- A search revealed 48 international guidelines
  - 13 of these were evidence based:
    - 8 discipline/disease specific
    - 5 across-discipline/across-disease
  - 4 short listed and appraised by AGREE (4 appraisers)
    - 2 guidelines selected: NICE and ACCP
      - However: found that neither guideline fully met our needs

Problems with source guidelines

- Variable consistency between evidence and recommendations
- No clear link (limiting our ability to directly adapt recommendations)
- Incompatible structure – e.g. NICE arranged by intervention, whereas our questions were arranged by clinical category

Evidence searching

- Evidence from the NICE guideline was used as a starting point but required updating and re-casting (per clinical category and not agent)
- 149 evidence tables were produced from evidence searches (over 700 pages) over 6 months
- All the evidence tables (and associated forest plots) were reviewed by the committee to produce a total of 62 recommendations across 19 clinical categories in the final guideline

How long did it take?

- 73 hours meeting time (71 hours face to face, 2 hours teleconference) – including 10 days of committee meetings
- Average of 92% attendance rate at meetings
- 51.5 hours spent formulating recommendations
- Countless staff hours and methodologists' time
- 18 months from beginning to end

How much did it cost?

- Total budget = $150,000 AUD for methodologists and committee meetings primarily (staff salary – extra cost around $200,000 AUD)
- The majority of the costs were attributed to methodologist and committee costs

Benefits of ADAPTE

- Set-up phase worked well – especially guidance on establishing organising committee and emphasis placed on governance (e.g. conflict of interest and consensus processes)
- Good guidance on gaining agreement on the scope of the guideline before establishing the committee
- Good advice on the development of an adaptation plan
- Practical guidance on developing a guideline

Limitations of ADAPTE

- Use of AGREE to assess suitability of guidelines
- Incorporating other issues, e.g. clinical context
- Variation in ‘systematic’ searching
- Little guidance on the development of recommendations once a source guideline has been identified
- ADAPTE had limited value in areas where no evidence existed (e.g. risk of VTE, cancer, pregnancy)