Abstract ID: 0395446817119

Title: The Matrix – a tool for assisting with guideline implementation
First author: Dr Karen Luxford
Further authors: Prof D. Hill, Assoc. Prof R. Bell: for the Australian Cancer Network's Guideline Implementation Steering Committee
E-mail: karen.luxford@nbcc.org.au
Organisation: National Breast Cancer Centre
Address: 92 Parramatta Rd, Camperdown NSW 2050 ph: 61 2 9036 3048
Category: CPG Implementation

Abstract
Background:
A number of clinical practice guidelines are available in Australia intended to improve the management of cancer care. Research indicates that to improve practice in accord with clinical evidence, change is required by individual clinicians and teams of clinicians, policy change and organisational and structural changes in health systems. Using the theory of innovation adoption, a Matrix framework was developed, based around the characteristics of innovations that favour rapid adoption, with new guidelines equated to an 'innovation'. The Matrix aims to gain structured feedback from clinicians as 'users' of guidelines.

Objective:
To pilot the Matrix tool to assess the usefulness for groups aiming to promote guideline implementation.

Methods:
The Matrix was piloted at a workshop with 50 attendees, primarily colorectal surgeons and oncologists. Three examples of guideline recommendations for the management of colorectal cancer were used during the pilot covering evidence about best clinical care and psychosocial support. Frequency analysis was undertaken and thematic analysis was conducted on qualitative responses.

Results:
There was a high level of consistency in the perceived views of clinicians about six key areas investigated by the Matrix: compatibility with current practice, relative advantage over current practice, simplicity of use, trialability, observability of outcomes and perceived barriers. Barriers highlighted by clinicians included: lack of available resources (staff, equipment, funding), lack of multidisciplinary clinics, referral processes, access to appropriate services and lack of knowledge of benefit. Perceived facilitators of change included lead clinicians, consumer advocates, government, service administration, professional colleges and cancer organisations.

Conclusions and Implications:

The pilot process indicated that, with minor refinement, the Matrix is a tool that would be of use to groups aiming to promote guideline implementation and practice improvement through the use of targeted strategies.

Year: 2004-

Abstract ID: 0688342976842

Title: Online continuing medical education (CME) as a tool for guideline implementation in Germany
First author: Horst Christian Vollmar
Further authors: N. Koneczny; C.C. Schürer-Maly; S. Löscher; M.Butzlaff
E-mail: vollmar@evidence.de
Organisation: Medical Knowledge Network evidence.de of Witten/Herdecke University
Address: Alfred Herrhausen Str. 50, 58448 Witten, Germany, Phone: +492302926741, Fax: +492302926745
Category: CPG Implementation

Abstract
Background:
The available amount of information in medicine is increasing exponentially. Suitable strategies are necessary to separate the

Objective:
To analyse whether certified web-based CME-tools can facilitate and improve guideline implementation in general practice.

Methods:
The medical knowledge network evidence.de off Witten/Herdecke University publishes evidence-based guidelines for German physicians, with a special ocus on primary care (www.evidence.de). To support the implementation process of these guidelines, the knowledge network has developed an internet platform for CME. A content managemet system (CMS) facilitates the easy input of different multiple choice questions. One MC-block consists of 10 questions and refers to one of the knowledge network´s clinical practice guidelines (www.medizinerwissen.de).

Results:
Existing clinical practice guidelines allowed a swift development of questions concerning each medical indication. All questions were evaluated by an editorial group of General Practitioners (GPs) and Internists. Initial standardised evaluations (4 point likert scale) of the first 2000 physician users demonstrated that - 34% of participating physicians viewed the CME-tools as

Conclusions and Implications:
Initial evaluations of a web-based CME-platform as an additional incentive for guideline implementation are encouraging. CME in Germany is mandatory since Januar 2004. Whether a relevant and sustainable knowledge transfer and subsequent quality improvements in daily practice will follow, is subject to an ongoing study.

Year: 2004

Abstract ID: 0740522944354

Title: Quality in Allied Health Care: Where is the place for guidelines?
First author: Saravana Kumar
Further authors: -none-
E-mail: saravana.kumar@unisa.edu.au
Organisation: Centre for Allied Health Evidence, University of South Australia
Address: Doctoral candidate, School of Health Sciences (Physiotherapy), City East Campus, University of South Australia, Adelaide, South Australia 5000, Australia. Phone: (08) 8302 2085 Fax: (08) 8302 2766
Category: CPG Research

Abstract
Background:
The issue of quality has been of great concern in the health care system as we continue to witness dramatic changes in the structure and delivery of care.

Objective:
Unlike, the medical profession, the "quality movement" in allied health is in its infancy. Allied health professions, including Physiotherapy, routinely are now faced with issues of accountability and justification of care as part of the quality service delivery. As part of this process, increasingly, all stakeholders of allied health (providers, patients, and funders) are relying on evidence based practice and clinical guidelines to help guide the process of quality service delivery.

Methods:
A grounded-theory methodology of the qualitative research paradigm was selected. Semi-structured interviews were conducted with patients (n=100), physiotherapists (n=20) and funders of physiotherapy care (n=21), on constructs of quality in allied health care and the role of guidelines in quality care delivery. These tape-recorded interviews were then transcribed and key themes from these data sets identified.

Results:
Key findings were: • All stakeholders believed quality care is imperative • All stakeholders believed all health care should be quality care • Patients believed that the Physiotherapists should provide up-to-date treatment, based on best available evidence • Physiotherapists believed that guidelines help them to provide up-to-date treatment based on best available evidence • Funders believed, treatment, not based on best available evidence supported by clinical guidelines, should not be funded • Providers and funders, however, identified several barriers to uptake of evidence (such as access and quality of clinical guidelines)

Conclusions and Implications:
All stakeholders recognise the key role guidelines play in promoting and producing quality health care. While there are inherent challenges in applying evidence, based on guidelines, this research also highlights the need for ongoing partnerships between stakeholders for ongoing successful outcomes.
Year: 2004

Abstract ID: 075247692788

Title: Social Psychological and Cultural Factors relevant to Guideline Development: Lessons learned from the German Guideline System
First author: Ina Kopp MD
Further authors: W. Lorenz MD, C.Z. Margolis MD MA, G. Ollenschläger MD, M. Koller PhD
E-mail: kopp@mailer.uni-marburg.de
Organisation: Association of the Scientific Medical Societies in Germany (AWMF)
Address: c/o Institute of Theoretical Surgery, Philipps-University, Baldingerstrasse, D-35043 Marburg, Germany; Phone: 0049 6421 2862249, Fax: 0049 6421 2868926
Category: CPG Development

Abstract
Background:
Principles learned from social psychology might be helpful to identify and explain factors hindering Clinical Practice Guideline (CPG) development.
Objective:
A conceptual analysis based on the five most important areas of social psychology research provided insights into German attitudes towards CPGs: 1. Social cognition: intuition and its relation to empirical evidence; 2. Understanding ourselves and others: patient versus professional expectations of treatment; 3. Attitudes research and quality of life assessment; 4. Social motives, social influence, and their relation to resistance to using guidelines; 5. Social relations research, prosocial behavior and the effect of social expectations on adopting CPG recommendations.
Methods:
These conclusions helped to design a modular system for developing and monitoring CPG quality. The system relied on the definition of a systematic CPG development process that also defined three levels of CPG quality, levels 1-3. The rationale for this concept was to allow for gradual modulation from the first guideline development efforts by specific specialty associations to the development of evidence-based CPGs that adhered to defined standards. Aiming to achieve continuous quality improvement of CPGs the system provides an organisational structure for monitoring CPG quality and concept implementation.
Results:
Over the past 5 years, there has been a gradual but definite trend to move from level 1 CPGs characterized by expert-led specialty groups to level 2 CPGs characterized by formal consensus procedures and level 3 CPGs characterized by 5 CPG quality attributes: logic analysis; systematic consensus; rigorous evidence analysis; outcome analysis; decision analysis.
Conclusions and Implications:
Cultural and social psychological factors account for resistance to CPGs in Germany. Analyzing resistance to CPG development and acceptance from this perspective should provide helpful insights that will facilitate CPG use in any modern multicultural society.

Year: 2004

- Abstract ID: 0886859850237

Title: Partnerships in a national clinical practice guideline programme: primary and secondary care and the Iberoamerican Cochrane Centre
First author: Mercè Marzo Castillejo
Further authors: Alonso P, Bonfill X, Mascort JJ
E-mail: mmarzo@ics.scs.es
Organisation: Spanish Society of Family and Community Practice -semFYC-
Address: Puertaferrissa 8 pral; 08005 Barcelona; tel +34 93 317 03 33; fax +34 93 317 77 72
Category: CPG Development

Abstract
Background:
In the middle of the 90s Spain started to elaborate guidelines but these were in general projects from specialist societies, without a multidisciplinary approach and not evidence based.

Objective:
To describe the experience of the IbCC (Cochrane) and semFYC (primary care) in the development of evidence based clinical practice guidelines

Methods:
We describe the framework of the CPG program. We evaluate the relevant expertise of the guideline developers and their involvement in the process as well the external funding. We describe an alternative approach for developing GPC in Spain.

Results:
An approach involving the different societies representing the primary and secondary care together was a first step to start. The first project was done with the Spanish Gstroenterology Association and included 4 guidelines on gastrointestinal topics and had financial support from the pharmaceutical industry. The CPG are reaching as many as 20.000 practitioners. Their quality has been rated very high. Initially the authors were going to be involved in all the process, but several difficulties were found: a low critical appraisal skills, a non evidence based approach, not enough experience in writing these king of documents. These difficulties lead to the IbCC to be in charge of most of the stages of the process lowering the participation from the authors. Derived from the difficulties encountered an alternative approach has been recently designed. This approach will stem from semFYC, and their EBM group will provide the basis for the methodological training of the authors.

Conclusions and Implications:
Partnerships in guideline developing in the primary and secondary care interface are possible and have proved to be successful in Spain. The support of the IbCC has proven helpful. However the involvement of health professionals on the process is still low. Partnerships are necessary. More involvement from our governments and public institutions are needed. Fharmaceutical industry is one polemic but still needed parnership.

Year: 2004

- Abstract ID: 097892491431

Title: Assessment of Japanese cancer screening guideline using the AGREE instrument
First author: Chisato Hamashima
Further authors: Tomotaka Sobue
E-mail: chamashi@gan2.res.ncc.go.jp
Organisation: National Cancer Center
Address: 5-1-1 Tsukiji Chuo-ku Tokyo Japan
Category: CPG Research

Abstract
Background:
In Japan, the guideline for cancer screening programs has been developed and revised by a research group funded by the Ministry of Welfare and Labor since 1998. However, the procedure for developing guideline, such as literature searches and review process, remains immature.
Objective:
To evaluate the effectiveness of cancer screening, the guideline development process must be clarified. Thus, the existing guideline for cancer screening was assessed using the AGREE instrument.
Methods:
The assessment was conducted by the following three groups. The first group consisted of four persons who had summarized the evidence, but who had not been involved in formulating the recommendations. The second group consisted of four epidemiologists. Three clinicians were added as the third group. The members of the second and third groups did not participate in the development of the existing guideline. The results of the three groups for 23 key items in the AGREE instrument were compared.
Results:
Overall, the cancer screening guidelines were found to be acceptable. The scores for the 'scope and purpose' items were high, but these of the 'stakeholder involvement' items were low in all three groups. The evaluations for the 'rigor of development', 'clarity and presentation' and 'editorial independence' items differed between the group which participated in existing guideline development, and non-participated groups. The scores for the "applicability" items were lower than those of the other items. Both items of 'patient perspective' and 'external review 'were lack.
Conclusions and Implications:
The various problems of existing guideline were found when assessed using the AGREE instrument. A revision of the guideline for cancer screening is needed to confirm their suitability, especially regarding the relation between summarized evidence and the recommendation. A new program for guideline development has been initiated, and the guideline for colorectal cancer screening is now being revised.

Year: 2004

Abstract ID: 124605025865

Title: Implementation and evaluation of diabetes practice guidelines in Saxony by using a data pool of a shared care model
First author: Dr. med. Ulrike Rothe
Further authors: G. Müller, P. Schwarz, J. Schulze, H. Kunath
E-mail: rothe@imib.med.tu-dresden.de
Organisation: Medical Faculty of the Technical University of Dresden, Germany
Address: Fetscherstraße 74, 01307 Dresden, Tel. +49 351 3177 231, Fax +49 351 3177 233
Category: CPG Implementation

Abstract
Background:
A representative multidisciplinary diabetes commission in Saxony developed practice guidelines for an integrated evidence based care model.

Objective:
The aim of the study was to evaluate the Saxonian diabetes guidelines after implementation into a shared care structure.

Methods:
The practice guidelines were implemented into arrangements respectively contracts between the health insurances and the corporations of physicians. Evaluation was mandatory and performed by using the data pool of the participating physicians. Between 2000 and 2002 about 75% of all GP's (1 935 from 2 800) in Saxony and all 94 diabetologists in specialized practice participate in the contract arrangement. 275 804 patients, which is 80% of the diabetic patients in Saxony, were included in the program and managed based on the practice guidelines. A subgroup (cohort) of 117 635 patients was followed over 3 years.

Results:
The successfully state wide implementation of the practice guidelines resulted in a change of therapeutic strategies especially higher frequency of insulination and less use of oral antidiabetic drugs. HbA1c values decreased from 7,1 ± 1,3% in Jan/2000 to 6,8 ± 1,3% in Dec/2002 ($p < 0,001$), regional differences equilibrate. In Dec/2002 71% of the guidelines based managed patients had an HbA1c value less than 7%. We observed an association between on time transfer of the patient in specialist care and optimal HbA1c and blood pressure values. At the start of the program GP`s transferred the patients only with a median HbA1c of 8,5% but in Dec/2002 already by a median HbA1c of 7,5% -– evident with the guidelines. The number of potential not efficient treated patients – with HbA1c values above 7,5% and/or blood pressure values above 140/90 mmHg – decreased significantly over the 3 year period.

Conclusions and Implications:
Knowledge based consensus guidelines implemented into a diabetes contract arrangement in Saxony resulted in a substantial improvement of diabetes care and with that a potential reduction in diabetic complications.

Year: 2004

Abstract ID: 129329491261

Title: Clinical guidelines for low back pain: A physiotherapy perspective
First author: Karen Grimmer
Further authors: Steve Milanese, Andrea Bialocerkowski
E-mail: karen.grimmer@unisa.edu.au
Organisation: University of South Australia
Address: City East Campus, North Tce, Adelaide ph 08 83022769 fax 08 83022766
Category: CPGs and Consumers

Abstract
Background:
This paper systematically reviews clinical guidelines for the management of low back pain (LBP), particularly focusing on the perspective of physiotherapists. The data in this paper is presented with permission of Physiotherapy Canada, which published the full text paper in 2003.

Objective:
The objective of this review is to consider the quality of currently available full text guidelines, the evidence sources on which the guideliens were based, the nature and interpretation of the evidence included in the guidelines, and the usefulness of these guidelines to physiotherapists.

Methods:
Guidelines were eligible for inclusion in this study if they were in full text, fully referenced and in English. A systematic search was conducted of library databases and the Internet, using search terms of ‘low back pain’ ‘physiotherapy’, ‘clinical guidelines’. Guideline quality was assessed by two assessors using the AGREE scoring instrument..

Results:
Nine eligible guidelines were identified, four from USA, two from UK, and one each from New Zealand, Australia and the Netherlands. The guidelines differed in quality, rationale, construction, evidence sources and recommendations. The guidelines also differed in description of strength of evidence, diagnostic criteria, interventions and measures of outcome. These differences constrained their clinical utility.

Conclusions and Implications:
Good guideline features included clinical decision-making systems, clinical care recommendations, and best practice management strategies such as patient handouts and clinical indicators for quality improvement. Whilst any of the reviewed guidelines offer useful mechanisms for physiotherapists to access structured collations of research findings, further work is required to develop physiotherapy-specific guidelines that are comprehensive, and are underpinned by appropriately identified and evaluated evidence.
Year: 2003-4

Abstract ID: 140475093448

Title: Evidence Into Action Using a Best Practice Tool – The Clinical Governance Management System (CGMS)
First author: Mr. Stephen George Bloomer
Further authors: Jeff Ewen
E-mail: stephen.bloomer@health.wa.gov.au
Organisation: Sir Charles Gairdner Hospital
Address: Hospital Avenue, Nedlands, Perth, Western Australia. 6009. Ph: (08) 9346 3333 (Page 4999), Fax: (08) 9346 1527
Category: CPGs and Information Technology

Abstract
Background:
Cardiovascular disease is the leading cause of death in Australia and most other developed economies. There are very few clinical indicators reflective of care in cardiovascular medicine (CVM). Patients attending a tertiary hospital, Sir Charles Gairdner Hospital, should be provided with best evidence care.
Objective:
To develop clinical indicators in CVM based on the department's compliance with Class I evidence for the major diagnoses of Myocardial Infarction (STEMI, Non-STEMI), Unstable Angina, Heart Failure and Atrial Fibrillation/Flutter. The recommendation is that, with Class I evidence, the procedure/treatment should be performed/administered. If not, then there should be a valid contraindication recorded.
Methods:
Originally information from a datasheet was transferred to a database; the Clinical Governance Management System (CGMS). In order to make the collection of information self-sustaining an electronic discharge summary was created, with the Best Practice audit built into it. The audit for each patient is recorded in the discharge summary, demonstrating transparent accountability. At the end of the summary there is a link to the Hospital web-page where the patient/carer and G.P.can review the evidence supporting their treatment. An electronic prompt is built into the system to alert the clinician to the existence of an appropriate Best Practice guideline. Clinicians can, at any time, review the reporting mechanism on compliance with Best Practice, over any time period, for any diagnosis.
Results:
Compliance with Best Practice in the department for all the diagnoses mentioned and demonstrably so. These results are evident to all and open to internal and external audit
Conclusions and Implications:
A self-sustaining methodology for implementing Best Practice guidelines, and measuring their compliance, has been introduced to the Hospital. It is transferable to other specialities. The Respiratory Medicine Department is using the system to measure compliance with Best Practice in patients with COPD.

Year: 2004

Abstract ID: 161895099563

Title: Internet-based discussion forums as a tool to involve patients and consumers in the development of national guidelines in Germany
First author: Dietrich Sonntag
Further authors: H. Trapp, U. Lampert, L. Heymans, S. Saenger, G. Ollenschlaeger
E-mail: d.sonntag@snafu.de
Organisation: Agency for Quality in Medicine
Address: Aachener Str. 233 - 237
Category: CPGs and Consumers

Abstract
Background:
In accordance with internationally accepted quality criteria patients should be involved in the development process of clinical practice guidelines. There are, however, various methods for seeking patients views and preferences. The use of internet-based guideline discussion forums for patient and consumer involvement has not been described in Germany so far.

Objective:
To describe the establishment of an open internet-based guideline discussion forum and its use for participation of patients and consumers in the development of National Disease Management Guidelines in Germany.

Methods:
Publicly accessible internet discussions forums were established and promoted at the same time as the guideline development group began its work. For the purpose of evaluation users were asked to give some personal details and to explain their interest prior to receiving access data. After registration comments and proposals on any issue relating to the guideline could be entered a) as free text, b) as files and c) as internet links. Discussion threads to the topics could develop. After a defined period of time the respective group of authors incorporated the input from the forum into the guidelines using a formal consensus technique. Every draft was again placed in the internet for further discussion.

Results:
The internet-based forums provided all technical neccesities to sample and discuss patients' and consumers' views and preferences. The number of patients registered in the forums was little and no comment or proposal was made.

Conclusions and Implications:
The approach to collect the perspectives of single patients for the development of national guidelines with the help of internet-based discussion forums failed. In future patients organisations rather than individuals will be involved to provide consumers' input. The described internet tool will further be used as a communication platform.

Year: 2004

- Abstract ID: 184007681894

Title: Clinical Guidelines, HTA and EBM in Denmark
First author: Lisbeth Høeg-Jensen
Further authors: F. Børlum Kristensen
E-mail: lhj@sst.dk
Organisation: Danish Centre for Evaluation and Health Technology Assessment (DACEHTA)
Address: National Board of Health, Islands Brygge 67, DK-2300 Copenhagen S. Phone: +45 72227731, fax: +45 72227413
Category: CPG Development

Abstract

Background:

There has been an increasing focus at national level in Denmark on developing Health Technology Assessments (HTA's) and clinical guidelines based on Evidence Based Medicine (EBM).

Objective:

To nationally develop EBM-products as input for decision making at national and local level.

Methods:

A Standing Committee on HTA was set up under the National Board of Health in 1994, leading to a national strategy for HTA in 1996. The Danish Institute for HTA (DIHTA) was established under the National Board of Health in 1997 as well as three regional HTA-entities financed by the national institute. In 2000, the Danish Secretariat for Clinical Guidelines was established under the auspices of the Danish Medical Society; but fully funded by DIHTA. In 2001, DIHTA became the Danish Centre for Evaluation and HTA (DACEHTA), also covering national evaluation tasks. A year later DACEHTA also included an entity working with knowledge on evidence based health promotion methods and the library function of the National Board of Health. From 2004 the Guidelines Secretariat is also a part of DACEHTA.

Results:

At national level there has been a focus on and integration of decision-making tools based on EBM. DACEHTA is today responsible for a number of evidence-based decision-making products to the Danish health sector such as: Clinical Guidelines, HTAs, Knowledge on evidence-based health promotion methods, Early Warnings on new and emerging technologies and Systematic literature searches as input to the work of the National Board of Health.

Conclusions and Implications:

In placing all of the above-mentioned EBM-based activities in one division of the National Board of Health it has been made possible to create a strong national knowledge base for developing and implementing EBM-based products - among these clinical guidelines - in Denmark.

Year: 2004

Abstract ID: 241191687515
Title: Dr.
First author: Cheng Lisa Pui-kwan
Further authors: Clinical Audit and Guideline Working Group, Professional Development and Quality Assurance, Department of Health, Government of Hong Kong (SAR)
E-mail: chenglisa@graduate.hku.hk
Organisation: Professional Development and Quality Assurance, Department of Health, Government of Hong Kong (SAR), China
Address: Professional Development and Quality Assurance, Kowloon Families Clinic, 6thFl., Yau Ma Tei Jockey Club Clinic, Battery Street, Yau Ma Tei, Kowloon, Hong Kong
Category: CPG Development
Abstract
Background: Low back pain occurs in about 80% of people (evidence C). Within 6 weeks 90% of episodes will resolve satisfactorily regardless of treatment (C) It is an important and practical topic in primary health care. According to Andersson et al , over 70% of people in developed countries will experience low back pain at the same time in their lives. Each year, 15-45% adults suffer low back pain, and 1/20 people present to hospital with a new episode. Low back pain is most common between the ages of 35 to 55 years. Given that most episodes of back pain settle with minimal intervention it is particularly important that clinical guidelines promote proved interventions and also help identify individuals with serious disease who need referral.

Objective: Few management strategies for back pain have been proved in primary care, partly because most cases settle within a few weeks. The aim of this guideline on the management of acute simple low back pain is to acilitate primary care team to practice evidence-based medicine in making diagnosis, examining, treating and giving advice to patients with acute simple low back pain, thus improving the quality of care in acute simple low back pain.
Methods: Evidence based guidelines developed by international researchers and organizations were studied and adopted according to the setting of our primary care service. The guidelines include: 1. National Guideline Clearinghouse.1997 (revised 2003 Apr) 1 2. Low Back Pain Evidence Review Royal College of General Practitioners (1999)2 3. Cochrane Review. The Cochrane Library, Issue 1, 2004 4 4. Clinical Standards Advisory Group. Management guidelines for back pain (1994) 5 5. Quebec Task Force guidelines6 6. US Agency for Health Care Policy and Research.
Results: The guidelines are listed below with level of evidence according to Canadian Task Force: Diagnosis Systemic symptoms noted (level 3 evidence, level C recommendation) Nerve root symptoms noted (level 3 evidence, level C recommendation) Examine for spinal deformity (level 3 evidence, level C recommendation) Management Diagnosis: acute simple low back pain documented (level 3 evidence, level C recommendation) NSAID/analgesics/opiates/muscle relaxants were given on regular basis (level 1 evidence, level A recommendation) Follow-up of 1-3 weeks on prn basis offered No X ray of lumbar spine was ordered (level 3 evidence, level C recommendation) No physiotherapy referral No orthopaedics specialist referral Advice Advise against bed rest (level 1 evidence, level A recommendation) Advice on staying active and continue daily activities (level 1 evidence, level A recommendation) Reassurance
Conclusions and Implications: As back pain is one of the commonest conditions managed in primary care, it is responsible each year for about 12 million general practitioner consultations, over 50 million work days lost, and almost pounds sterling500m costs to the NHS. The implications of this guideline is to ensure the practice evidence-based medicine in the management of low back pain and to improve quality of management of low back pain

Year: 2004

Abstract ID: 243999714296

Title: Coordinated Approach to Implementation of Preoperative Testing Clinical Practice Guidelines in Ontario Hospitals
F**irst author:** Dr. Dave Davis
Further authors: Dr. J. Hux; Y. Drazin; I. Ciurea
E-mail: dave.davis@gacguidelines.ca
Organisation: Guidelines Advisory Committee
Address: 500 University Avenue, Ste 650, Toronto, Ontario M5G 1V7 Canada. Tel: 416-946-7900
Category: CPG Implementation

Abstract
Background:
Data suggest substantial inappropriate or over-utilization of routine preoperative testing for low and intermediate risk surgery in Ontario, specifically electrocardiograms and chest radiographies. The Guidelines Advisory Committee (GAC), a joint initiative of the Ministry of Health and Long Term Care and the Ontario Medical Association, undertook a guideline-based initiative to promote utilization of these tests consistent with best available evidence.

Objective:
To implement evidence-based recommendations and reduce inappropriate use of preoperative testing.

Methods:
Strategy consisted of multi-pronged interventions, including a Hospital Feedback Study, development of relevant clinical policies and practice tools (such as a preoperative testing grid), training of local Opinion Leaders, and Continuing Medical Education. It relied on GAC's unique partnerships through the Ontario Guideline Collaborative, representing the licensing authority for the province, the five medical schools' continuing education divisions, the provincial hospital association and others. Through the Feedback Study, hospitals received individual preoperative testing utilization profiles, guideline summaries, practice tools, and two follow-up reminders.

Results:
Preliminary evaluation through a hospital survey conducted with Chiefs of Staff or designates indicates that the multi-faceted implementation strategy employed has influenced change in hospital policy for, and utilization of, routine preoperative testing.

Conclusions and Implications:
Three essential factors contributed to the success of this first large-scale implementation project of its kind in Ontario – strong collaboration with members of the Ontario Guideline Collaborative and project partners; integration of interventions in a multi-level, multi-prong fashion; adaptability and ability to employ alternate strategies to increase the impact of planned activities.

Year: 2003-2004

Abstract ID: 249943308834

Title: The creation and utilisation of a diabetes disease register for improved chronic disease management in primary care – a Practice Nurse led initiative
First author: Anne Davies Practice Nurse The Doctors, Masterton
Further authors: Dr D Nixon General Practitioner
E-mail: david@mn.thedoctors.co.nz
Organisation: The Doctors, 43 Chapel Street, Masterton, New Zealand
Address: The Doctors, 43 Chapel Street, Masterton, New Zealand Tel 06-3700067 Fax 06-3701069
Category: CPG Implementation

Abstract
Background:
Application of evidence-based guidelines in relation to diabetes management relies upon a practice's ability to identify all their diabetics. Without this, evidence based care becomes opportunistic. This was reflected in our poor performance in completing the structured (NZGG/WIPA) annual diabetic reviews during 2003 (42.5%).

Objective:
The creation of a validated diabetes disease register and the development of nurse led interventions to improve completion of diabetic annual reviews.

Methods:
The disease register was created using computer searches on the basis of prior Read coding and disease specific drugs (e.g. metformin, Humalog etc). The 258 patients identified had their computer and paper records reviewed by a nurse to validate the diagnosis ('uncertains' were sent to lead GP). Each was Read coded (C10) for diabetes, producing a register of 249 patients (3.4% of the enrolled practice population). A computer search of the diabetes register identified 149 patients with an overdue annual review. They were invited them to attend the nurse led diabetes clinic. Non attendees or non responders were flagged and the review completed opportunistically by the nursing team e.g. when attending for blood tests etc.

Results:
Our nurse offered all the diabetics on the register a free structured annual check (between 6/03 and 6/04). This nursing initiative resulted in 237 (95%) of all our diabetics receiving their annual diabetes check. This means 95% of all our diabetics have had their feet, height, weight, BP, smoking status, Hba1c, lipids and microproteinuria checks within the year. The data led to a significant number of interventions e.g. 94% of our sixty-six diabetic patients who have micro/macro albuminuria are now on ACE/ACEII inhibitors

Conclusions and Implications:

Nurse led initiatives can result in the creation of robust disease registers and this in turn facilitates the provision of evidence based interventions as testified by the improved performance in completed annual diabetes reviews (42.5% 6/03 vs 95% 6/04).
Year: 2004

Abstract ID: 339780237203

Title: Improving flu vaccination performance– a Practice Nurse led initiative
First author: Fiona Samuel Practice Nurse The Doctors, Masterton
Further authors: Dr David Nixon General Practitioner, The Doctors, Masterton
E-mail: david@mn.thedoctors.co.nz
Organisation: The Doctors, Masterton, New Zealand
Address: The Doctors, 43 Chapel Street, Masterton, New Zealand Tel 06-3700067 Fax 06-3701069
Category: CPG Implementation

Abstract
Background:
Flu vaccination of the target populations as per New Zealand guidelines has been shown to reduce morbidity, hospital admissions and mortality. As a consequence GP performance in this area features as part of the PHO Clinical Performance Indicators.

Objective:
To improve the flu vaccination performance of the practice, as we had only immunised 703 patients from the designated target populations (1303) derived from our total practice population of 7219 enrolled patients in 2003. Producing a flu vaccination performance of 54%.

Methods:
A practice nurse volunteered to become the practice lead for immunisation performance. She created a flu vaccination register based upon our recently validated disease registers (Diabetes - 249, IHD - 197, CCF - 53, Asthma - 1063, COPD - 114 etc) and all patients over the age of 65. Letters inviting these patients to attend for free immunisation were sent with telephone follow up of non-responders.

Results:
We dramatically increased the number of over-65's receiving flu vaccinations. 99% of all over 65's were contacted and offered flu vaccination but 28.8% refused, 0.56% were not contactable producing a vaccination rate of 70.56% within this target group. In terms of our flu vaccination performance for all patients eligible for free flu vaccinations, recently released PHO figures revealed an improvement from 54% in 2003 to 80 % (1040/1303) in 2004 – the greatest increase for any practice in the Wairarapa.

Conclusions and Implications:
The development and support of the extended role of the nurse, in this case as an immunisation lead, can significantly improve flu vaccination performance which in turn may improve the health of the community.
Year: 2004

Abstract ID: 343807696868

Title: EBM in two German hospitals: How does training in clinical epidemiology affect doctors' knowledge of and attitude towards evidence based medicine?
First author: Frank Thalau
Further authors: W. Zielinski, M. Perleth, S. Müller-Lissner
E-mail: Thalau@azq.de
Organisation: Agency for Quality in Medicine
Address: Wegelystr. 3, D-10623 Berlin, fon +49 30 4005 2500, fax +49 30 4005 2555
Category: CPG Research

Abstract
Background:
In contrast to primary care physicians little is known about the attitude of clinicians towards evidence based medicine. While there is empirical evidence that EBM courses are effective in improving short-term knowledge and skills, their sustainability and influence on doctors' attitude and behaviour is still unclear.

Objective:
Assessing doctors' knowledge of and attitude towards evidence based medicine in a hospital setting and linking it to their previous training in clinical epidemiology.

Methods:
144 doctors from two Berlin hospitals took part in a survey between November 2002 and March 2003 (overall response rate 83%). A standardised questionnaire was used for documenting their clinical position, previous training and attitude towards EBM and their own estimate of their familiarity with three clinical epidemiological terms. Finally a knowledge test using four multiple-choice questions was performed.

Results:
Doctors who had attended EBM courses showed better results than colleagues without such training. The difference increased with the number of courses attended. Doctors with a surgical background performed less well in the EBM knowledge test but, perhaps surprisingly, reported a higher proportion of evidence based measures in their daily work compared with colleagues from non-surgical backgrounds in our study sample. The benefit of EBM for patient care was widely acknowledged among doctors throughout all disciplines. Doctors with EBM training showed an even higher acceptance rate (76%) compared with others (68%, $p<0.05$).

Conclusions and Implications:
German hospital doctors showed a positive attitude towards evidence based medicine. Participants of EBM courses not only showed better results in an EBM knowledge test, but were even more convinced that EBM improves patients' outcome. Further research on the consequences for clinical decision making and the implementation of guidelines is required.

Year: 2004

- Abstract ID: 346991923223

Title: Acceptance and willingness to use CPG - an evaluation of primary care physicians attitudes towards evidence based medicine
First author: Lothar Heymans
Further authors: H. Kirchner, G. Ollenschlager
E-mail: heymans@azq.de
Organisation: Agency for Quality in Medicine (AQuMed)
Address: Agency for Quality in Medicine (AeZQ), Wegelystr. 3, D 10623 Berlin, Phone: +49 (0)30-4005-2500. Fax: +49 (0)30-4005-2555
Category: CPG Implementation

Abstract

Background:

In order to improve the quality of care and to optimise the pharmacotherapy a focus group of primary care physicians with budget overshoot were invited to a guided program to tailor best available evidence-based guidelines to the need in daily practice. The adaptation process included the following topics: Asthma, diabetes (type 2), hyperlipidaemia and hypertension.

Objective:

There is however little information about the barriers impending CPG implementation and about the present attitude of physicians towards CPG which are core-questions to be answered in order to realise the potential benefits.

Methods:

The regional Association of Statuatory Health Insurance Physicians (Hesse) performed the prescription analysis and selected 136 high prescribers. AQuMed recommended content and format for CPG with the experience of the German Guideline Clearinghouse. The acceptance and willingness to use CPG by their intended users was examined by a questionnaire and related to the individual structural data. The initial answers were compared with the final results after the 15 months study.

Results:

Regarding the media used to get relevant information in a given therapeutic situation the majority of physicians preferred medical journals, discussion with colleges and scientific books. After finishing the 15month tailoring period a clear increase in the preference of CPG as information source was found replacing scientific books in the ranking. Likewise the validity and practicability of CPG started to compete with the classical sources of information.

Conclusions and Implications:

The acceptance increases with the quality of CPG which are tailored for the practical use by peers. The study showed that the acceptance and the chance of a successful implementation increase with the intensity and duration of training.

Year: 2003

Abstract ID: 368669735389

Title: Ibero-American guidelines: Useful resource or unnecessary workload in the German Guideline Clearinghouse (GGC) process?
First author: Elizabeth Bandeira-Echtler
Further authors: O. Weingart, B. Richter, H. Kirchner, C. Thomeczek, G. Ollenschläger
E-mail: E.Bandeira-Echtler@uni-duesseldorf.de
Organisation: Cochrane Metabolic and Endocrine Disorders Review Group Heinrich-Heine University Duesseldorf
Address: Moorenstraße 5 40225 Duesseldorf Tel +49 211 81 18692 Fax +49 211 81 18693
Category: CPG Development

Abstract
Background:
The GGC was established at the Agency for Quality in Medicine in 1999 in order to assure and improve the quality of clinical practice guidelines. GGC's evaluation focuses on the English and German languages (EGL). Little is known about the quality and methodology of guidelines being established in other regions, such as the Ibero-American language (IAL) area.

Objective:
To find out whether IA guidelines should be included in future GGC evidence-based clearing processes.

Methods:
An adapted GGC systematic literature search published between 1990 and 2003 was performed in medical databases (Medline, LILACS), special guideline databases (leitlinien.de, ngc.gov, g-i-n.net) and the Internet (Google). Inclusion criteria: Diabetes mellitus type 2; Spanish or Portuguese language; newest version of guideline. The methodological appraisal was performed by using the GGC checklist (version 2000) comparing IAL with EGL guidelines, the latter being appraised in the GGC report on type 2 diabetes mellitus.

Results:
730 IAL references were tracked down. According to inclusion criteria 10 IAL guidelines were compared to 16 EGL guidelines. Main outcomes: The mean methodology scores concerning guideline development, content, practicability and total sum for EGL guidelines did not show statistically significant differences compared to IAL guidelines. Description of selection methods for identification of evidence was reported in 19% of EGL and 40% of IAL guidelines.

Conclusions and Implications:
No relevant methodological differences could be detected between IAL and EGL type 2 diabetes mellitus guidelines. It appears to be useful for future GGC projects to include guidelines from the IAL area. A pilot study should be initiated to investigate the influence of the inclusion of IAL guidelines on the quality and results of the GGC practice. Theoretical socio-cultural differences could be elucidated to reduce possible language bias.
Year: 2004

Abstract ID: 375656508856

Title: Dr.
First author: Lisa CHENG pui-kwan
Further authors: to be provided ASAP
E-mail: chenglisa@graduate.hku.hk
Organisation: Professional Development and Quality Assurance, Department of Health, Governement of Hong Kong (SAR), China
Address: Professioanl Developement & Quality Assurance, Kowloon Families Clinic, 6/Fl., Yau Ma Tei Jockey Club Clinic, Battery Street, Yau Ma Tei, Kowloon, Hong Kong
Category: CPG Development

Abstract
Background:
Coronary and other heart diseases are the second leading cause of death in Hong Kong, accounting for 14.1% of all deaths in the year 2001.1 From the public health standpoint, much of the burden of coronary heart disease is preventable since many predisposing risk factors can be prevented or controlled through the adoption of appropriate lifestyle changes and treatment. In order to optimize the control of coronary risk factors, the active involvement of the medical profession as a whole, and primary care physicians in particular is of utmost importance. As doctor, we are in a very good position to reinforce healthy lifestyle messages to our patients, and to encourage them to take appropriate actions. Hyperlipidaemia is a major risk factor for coronary heart disease, which is very commonly encountered in general practice. At present, the management of hyperlipidaemia especially in relation to the indication of drug treatment is not unified among the four clinics of PDQA Department of Health. In view of this, the clinical audit/ guideline development group of PDQA produces this clinical practice guideline to assist primary care doctors in the assessment and management of these patients

Objective: This is an evidence-based guideline using the best available evidence in development. The aim of this guideline is to assist primary care physicians in clinical decision making by providing well-balanced information on the lipid management in primary prevention of coronary heart disease and to encourage a unified approach to the management of hyperlipidaemia among clinics of PDQA. This is only a guideline to clinical practice without restricting the physician's individual clinical judgment. Each physician is ultimately responsible for the management of his/her unique patient based on the clinical data presented by the patient and the diagnostic and treatment options available.

Methods: In preparing this guideline, the guideline development group has identified and make reference to local and international guidelines including (1) Clinical management guidelines of Department of Medicine & Therapeutics, The Chinese University of Hong Kong (2) Joint British recommendation on prevention of coronary heart disease in clinical practice (3) Recommendation of the second joint task force of European and other societies on coronary prevention (4) Clinical practice guidelines on lipid from Singapore (5) Third report of the National Cholesterol Education Program (NCEP) expert panel on detection, evaluation, and treatment of high blood cholesterol in adults (Adult Treatment Panel III) (6) National Clinical Guideline for Type 2 Diabetes, National Institute of Clinical Excellence (7) Guideline on lipids and primary prevention of coronary heart disease, Scottish Intercollegiate Guidelines Network. In relation to the recommendation on indication of drug therapy in hyperlipidaemia, the working group decided to adopt the National Clinical Guideline (1999) Scottish Intercollegiate Guidelines Network and modified to suit the local situation.

Results: A A lipid profile consisting of total cholesterol (TC), low-density lipoprotein cholesterol (LDL-C), high-density lipoprotein cholesterol (HDL-C) and triglyceride (TG) should be obtained in the following individuals: Patients with coronary heart disease (CHD), cerebrovascular or peripheral artery disease (PVD) Diabetic patients Individuals with a family history or clinical evidence of familial hyperlipidaemia A Lifestyle measure remain the first priority in the primary prevention of coronary heart disease C Before considering lipid lowering drug therapy for primary prevention, lifestyle measures to reduce CHD risk should normally be pursued for a period of 3-6 months, and should be continued irrespective of the need for drug treatment B Smokers should be advised to stop smoking B Repeated brief and supportive advice on smoking cessation should be given to patients by primary care team A Advice to reduce or modify dietary fat intake should be given to all patients B For those who are currently inactive or not regularly active, aim to accumulate 30 minutes of moderate intensity physical activity on most days. B For those who are already active, vigorous intensity aerobic exercise of 20-30 minutes three times per week is recommended. B Men drinking more than 21 units weekly and women drinking more than 14 units weekly should reduce their consumption C A patient should be considered for lipid lowering drug therapy for primary prevention, usually following a trial of lifestyle measures and other appropriate interventions for at least 3 months, when the serum total cholesterol is >= 5.0 mmol/L AND the 10-year risk of CHD is >= 30% using the Joint British Societies Coronary Risk Prediction Chart. (C) C The Sheffield and New Zealand scoring methods could also be considered for risk factor assessment, if preferred. B The treatment target total cholesterol level for primary prevention in patients on drug therapy should be less than 5.0 mmol/l, together with a fall in total cholesterol of at least 1 mmol/l. A Treatment of hypertension is recommended to reduce the risk of both CHD and stroke. (C In well controlled hypertensives patients aged 50 years or older with an estimated CHD risk of >or = to 15% over 10 years, prophylactic aspirin (75 mg) may be considered if there is no contraindication for its use. B For primary prevention, advance age is not a contraindication for lipid lowering drug therapy. C Lipid lowering treatment should not be stopped at any particular age. C Lipid lowering drug therapy should be considered for primary prevention in Type 2 diabetic without evidence of nephropathy when the 10 year risk of CHD is >= 30 % using the Joint British Chart. C In Type 2 diabetic with nephropathy, lipid lowering drug therapy should be considered at a lower risk threshold in these individuals.

Conclusions and Implications: This guideline on management of hyperlipidaemia produces this clinical evidence-based practice guideline with emphasis of the level of evidence to assist primary care doctors in the assessment and management of these patients.

Year: 2004

- Abstract ID: 380080092128

Title: Usable guidelines: supporting the diversity of general practice
First author: Elizabeth Deveny
Further authors: M Hemming, J Dartnell
E-mail: edeveny@tg.com.au
Organisation: Therapeutic Guidelines Limited
Address: Ground floor 23-47 Villiers St North Melbourne 3051 Australia
Category: CPG Implementation

Abstract

Background:

Therapeutic Guidelines Limited (TGL) is an independent, not-for-profit organisation that publishes guidelines based on the best available evidence, the intention being to provide prescribers with independent and unbiased information on best practice. Guidelines are developed in iterative cycles by national expert writing groups with feedback from an extensive user evaluation network with the texts comprehensively covering all common disorders seen in general practice.

Objective:

The aim was to improve guideline usability by adapting their presentation to the clinical environment and the common pathways used to access information resources. This poster illustrates the range of possible clinical use contexts in which guidelines are used in the Australian GP environment.

Methods:

Three methods of data collection were used for the study: ethnographic observations, interviews and questionnaires. Through a detailed analysis of the data collected common patterns of interactions with guidelines in the general practice environment were identified. These clinical information-based workflows in general practice provide TGL with information upon which further guideline development activity can be undertaken

Results:

The accessibility and portability of information resources was important for such mobile practitioners. Resources were specifically designed for handheld computers (PDAs), which is useful for clinician-users that work more often with electronic, rather than paper-based, CPGs. Integrating guidelines into clinical software is another way of making them more useful and usable.

Conclusions and Implications:

Guidelines need to be comprehensive and provide succinct and practical answers to common and not-so-common clinical questions; to take into account the multiple pathways used to access information in diverse clinical environments and be provided in different formats and be developed with sensitivity to, and a sensibility for, the clinical context, guidelines can be sympathetic to the dynamic nature of clinical practice.

Year: 2004

Abstract ID: 396314293032

Title: Sharing guideline knowledge:helping to set standards
First author: Sharon Smart
Further authors: Ian Purves, Richard Hall
E-mail: s.r.s.smart@ncl.ac.uk
Organisation: SCHIN
Address: Bede house, All Saints Business Centre, Newcastle-upon-Tyne, NE1 2ES, UK. Tel +44191 243 6100 Fax +44191 243 6101
Category: CPGs and Information Technology

Abstract
Background:
There is large amount of time and resource used in many different countries to produce clinical practice guidelines. There are already many guidelines on similar topics, yet overall the number of topics is limited and many areas of clinical practice are not yet covered. One solution would be to share guidelines, or even parts of guidelines across health care systems, but this is a difficult task since there is a lack of commonality in the structure of guideline documents. In addition there is often ambiguity, inconsistency, inaccuracy, incompleteness of recommendations and poorly specified applicability of the guideline. These problems often arise not through lack of rigour in the process of identifying the evidence but in expressing recommendations and presenting supporting the narrative appropriately.

Objective:
Our objective is to collectively define a standard architecture for clinical practice guidelines that: - All stakeholders in the community can freely sign up to and use - Enable sharing of guidelines or parts of guidelines - Improve clarity of recommendations - Facilitate guideline amendments and modifications (living guidelines) - Facilitate implementation

Methods:
Many individuals interested in computable guidelines have come together within the HL7 Clinical Decision Support Technical Committee. The Clinical Practice Guideline – Reference Architecture (CPG-RA) was created in this environment and is an XML Schema (see www.cpga-ra.net) that aims to represent narrative clinical practice guidelines in a form that enables different views and configurations for the variety of uses that guidelines are put to. The Guidelines International Network (GIN) has identified the requirement to share guidelines and has developed a standards committee to progress this aspiration. This CPG-RA team is focused on defining the use cases and refining the CPG-RA XML-schema for discussion with the HL7 community.

Results:
The workshop will discuss the work to date and the way forward.

Conclusions and Implications:

Year: 2004

Abstract ID: 401393035148

Title: Localising clinical guidelines: some advantages of GLARE's computer-based approach
First author: Paolo Terenziani
Further authors: A. Bottrighi, G. Correndo, G. Molino, S. Montani, M. Torchio
E-mail: terenz@di.unito.it
Organisation: Dipartimento di Informatica, Universita' del Piemonte Orientale "Amedeo Avogadro"
Address: Spalto Marengo 33, 15100 Alessandria, Italy. Phone: +39 0131 287447 – Fax: +39 0131 287440
Category: CPGs and Information Technology

Abstract
Background:
A relevant obstacle to the dissemination of clinical guidelines (CG) is the gap between the generality of CG and the peculiarities of the local context of application. In particular, national CG do not consider that the tools needed for laboratory tests might be unavailable for a local hospital. Moreover, considering computer-based guideline managers (CGM), also software contextualization is needed: a CGM must be integrated with the DBMSs containing patient's data, and different DBMS can be used by different hospitals. GLARE (Guideline Acquisition, Representation and Execution) is a CGM that has been built in a joint project between the University of Alessandria and Az. Osp. S. Giovanni Battista in Turin, Italy.
Objective:
We have aimed at extending GLARE (i) to provide automatic resource-based tailoring of CGs to the local needs, and (ii) to facilitate its integration with local DBMSs.
Methods:
First, we have extended GLARE's formalism to represent the resource needs associated with each action. Second, we have devised an algorithm to visit an input CG, and to prune all paths that contain actions whose resources are not locally available. GLARE's architecture consists of three layers, so that the interaction between the system and the DBMS is mediated through an intermediate XML layer. Thus, changing the DBMS only requires an adaptation of the software module (Java package) relating the DBMS to the XML layer.
Results:
GLARE provides an automatic tool which takes in input a general CG and the list of local resources, and gives in output a localised CG, in which all non-executable actions (paths) have been pruned. Moreover, GLARE can be integrated with different DBMS.
Conclusions and Implications:
The GLARE experience shows that computer-based approaches may simplify the process of tailoring a CG to the local needs. Moreover, the automatic execution of a CG on a specific patient can be conceived as a further level of tailoring, i.e., tailoring to the specific patient.

Year: 2004

Abstract ID: 430302826573

Title: What strategies are effective when implementing evidence based clinical guidelines?
First author: Dr Ian Bullock
Further authors: Dr Jo Rycroft-Malone; Dr Maggie Westby;
E-mail: ian.bullock@rcn.org.uk
Organisation: Royal College of Nursing Institute
Address: Royal College of Nursing Institute, Radcliffe Infirmary, Woodstock Road, Oxford. OX2 6HE United Kingdom. 0044 1865 224705 and Fax: 0044 1865 246787
Category: CPG Implementation

Abstract
Background:
The Royal College of Nursing Institute has for many years been committed to the development of evidence based guidance. The role of clinical guidelines within contemporary healthcare practice within the UK has increased rapidly. This has led to an increase in evidence based guidance in many subject areas, with high quality products emerging from NICE, SIGN, international groups and other professional groups such as the Royal College of Nursing. Finding ways to effect implementation of such guidance however remains an ongoing challenge. Previous work such as the PARIHS framework has laid a solid foundation to explore ways of reducing the gap between research and practice, and continues to inform our thinking in responding to this challenge.

Objective:
The project has two objectives: 1) to measure the success of implementing the 'Perioperative Fasting' clinical guideline (due for publication in early 2005), and 2) to evaluate a range of implementation strategies. To work with NHS partner organisations in producing a variety of implementation packages will allow the research team to evaluate their potential in producing change in perioperative fasting practice, building on previous work in this area.

Methods:
An evaluative study is planned, comparing intervention strategies for implementation of clinical guidance for perioperative fasting using a purposive sample. Measurement of effect will be determined by pre and post intervention data collection. Intervention packages will include: * Facilitation * Enhanced education and training * Enhanced audit and feedback * Web based guidance and the use of information technology/algorithms * Standard and enhanced dissemination

Results:
N/A

Conclusions and Implications:
Planned research seeks to further explore the relationship between the nature of evidence, the quality of the context in responding to clinical guidance and the type of facilitation employed in determining the potential of a variety of interventional packages.
Year: 2004-2006

Abstract ID: 44064885151

Title: Demonstration of Clinical Guideline Content Management System
First author: Sharon Smart
Further authors: Ian Purves, Hal Robinson
E-mail: s.r.s.smart@ncl.ac.uk
Organisation: SCHIN Ltd
Address: Bede House, All Saints Business Park, Newcastle upon Tyne, NE1 2ES, UK. Tel: +44 191 243 6100 Fax: +44 191 243 6101
Category: CPGs and Information Technology

Abstract
Background:
There are many organisations in the world that read the medical literature and interpret clinical best practice to produce synthesised knowledge for a variety of channels (e.g. books, web, computerised decision support). This knowledge can be presented in a number of forms; clinical practice guidelines (e.g. PRODIGY), drug monographs (e.g. BNF), evidence summaries (e.g. Clinical Evidence) or computerised knowledge bases on which to build decision support systems (e.g. iDrug). These separate presentations of knowledge often overlap in their content but it is often not possible to re-use information from one ‘publication’ in another even within the same organisation. Where organisations have achieved re-use there is often in-house built systems holding things together. In addition many organisations around the world (e.g. NICE in the UK, AZQ in Germany, NZGG in New Zealand) undertake the same task time and time again with no possibility of collaborating on their ‘publications’. To complicate matters further these organisations often have geographically distributed staff who work together on the knowledge synthesis creating complex use cases.

Objective:
To produce an enviroment which sharable clinical knowledge is authored, edited, managed and published to a variety of channels.

Methods:
Software design

Results:
A new clinical content management system, ideal for guideline production.

Conclusions and Implications:
This demonstration will highlight how using clinical content management tools can implement potenital guideline standards such as CPG-RA.

Year: 2004

- Abstract ID: 45363088437

Title: Demonstration of a decision support system; meeting the challenge of chronic disease manage chronic
First author: Sharon Smart
Further authors: Ian Purves, Peter Johnson
E-mail: s.r.s.smart@ncl.ac.uk
Organisation: SCHIN
Address: Bede House, All Saints Business Centre, Newcastle-upon-Tyne, NE1 2ES, UK. Tel +44191 243 6100. Fax +44 191 243 6101
Category: CPGs and Information Technology

Abstract
Background:
The team at SCHIN have developed a new decision support system that has been designed to support the challenge of chronic disease management. Through years of experience and user feedback we identified the need for a system that integrates more closely with the electronic record and is able to take account of the patient's past history, the severity of the condition, co-morbidity, and past and current medication before recommending treatment or management options.

Objective:
To create an easy to use system by which healthcare professionals can access and use guidelines. To utilise a knowledge base that can be created by clinicians with little technical training, and is scaleable. To present the clinical knowledge in different ways to suit the needs of different healthcare professionals.

Methods:
The system consists of a number of integrated components that link though a Virtual Medical Record (vMR) server and a host system Application Programme Interface (API) into the medical record. The vMR server passes information to and from a number of inference or execution engines that access the knowledge bases to do a number of tasks: for example: - Trigger an alert or reminder - Work out which scenario is relevant for the patient - Select the relevant management choices and rate them in order of preference - Record all decisions and actions taken by the healthcare professional back into the patient's electronic record

Results:
A decision support system that demonstrates: - Better support of chronic disease management - Alerts, prompts, and reminders provided only when relevant - Intuitive and configurable user-interface

Conclusions and Implications:
This is an exciting decision support prototype that guides management through condition pathways, facilitates data collection in an ‘intelligent’ way, and supports the user with alerts, prompts, and reminders. We believe that this should now be further developed and made more widely available.

Year: 2004

Abstract ID: 469587294129

Title: Delivering gender specific health care information: The development of a guideline for guidelines

First author: Ina Kopp, MD
Further authors: K.-D. Schulz, D. Alt, V. Beck, J. Doherty, K. Holsteg, E. Kalbheim, J. Müller, I. Nass-Griegoleit, J. Nill, G. Nioduschewski, et al.
E-mail: kopp@mailer.uni-marburg.de
Organisation: Association of the Scientific Medical Societies in Germany (AWMF)
Address: c/o Institute of Theoretical Surgery, Philipps-University, Baldingerstrasse, D-35043 Marburg, Germany; Phone: 0049 6421 2862249, Fax: 0049 6421 2868926
Category: CPG Development

Abstract
Background:
Reliable and accurate medical information is necessary for patients who want to take an active part in medical decision-making.
Objective:
The aim of this work was to define the requirements helping to assure the development of good qualified information material relevant for women and female patients as “a guideline on women information”. An example of its use is given by embedding this guideline in the guideline for early detection of breast cancer in Germany by defining the specific elements required for developing qualified information.
Methods:
A systematic, stepwise methodological process according to a level two guideline of the German Association of the Scientific Medical Societies and the Agency for Quality in Medicine was performed with the following elements: 1) establishing an expert panel; 2) generating the guideline statements in a formal consensus process (Nominal Group Process) with participation of representatives from patient self-help groups; 3) external review process and identification of supportive partners for the guideline on women information; 4) using the guideline for guidelines: application of the concept in the guideline for early detection of breast cancer in Germany
Results:
The “guideline women information” comprises nine elements of quality assuring requirements for the development of gender-specific information material and twelve specific elements which directly relate to statements in the guideline “Early detection of Breast Cancer in Germany”. After external review 30 organisations gave their written support for future implementation of the guideline.
Conclusions and Implications:
A systematic, consensus-based recommendation “Guideline for Women Information” was developed defining gender-specific aspects required for good lay information and its evaluation. Its use is demonstrated by applying this guideline for gender-specific guidelines to develop a lay version of the guideline “Early Detection of Breast Cancer in Germany” to improve quality of guideline compliant lay information.

Year: 2004

Abstract ID: 473527770451

Title: Screening of Hearing Loss in Infants
First author: J Rusilawati
Further authors: S Sheamini, S Sivalal, MK Thong, TM Chew, PY Tam, S Zamratul, B Aminah
E-mail: dr_rusilawati@yahoo.com
Organisation: Ministry of Health Malaysia
Address: Medical Development Division, Ministry of Health Malaysia, 21st Floor, PERKIM Building, Jalan Ipoh, 51200, Kuala Lumpur, Malaysia, Tel: + 6 03 4045 7670; Fax: + 6 03 4045 7740
Category: CPG Development

Abstract
Background:
There is a growing health policy for neonatal hearing screening in an attempt to diagnose hearing impairment as early as possible. Early identification and intervention of children with hearing loss can prevent or minimize these effects.

Objective:
To ascertain the following - accuracy of screening tests, effectiveness of screening program, effectiveness of early detection, potential adverse effects of Universal Neonatal Hearing Screening, benefits of early treatment, cost-effectiveness of Newborn Hearing Screening Program and its implications on the organization.

Methods:
Health technology assessment

Results:
Screening all newborns before discharge increases identification of hearing impaired infants and increases the chance that diagnosis and treatment will begin before 6 months of age. Screening of high risk infants, instead of universal screening, will identify only 50% of newborns with hearing loss. OAE and ABR are highly accurate and are superior to the Health Visitor Distraction Test. OAE has the shortest time, followed by Automated ABR and the behavior test. TEOAE/AABR combined screens have better specificity and program sensitivity. Positive predictive results are higher for tests done on high-risk babies (20%) compared to those without (2.2%). Better results are obtained when the test is carried out after 24 hrs. There is not much difference in pass rates when using OAE in infants after 72 hours of age or at 3-4 weeks. Re-screening can reduce false positive and unnecessary referrals for diagnostic assessment. PPV is also higher with a 2 step screenin g protocol using AABR. The cost of screening hearing loss in newborns is far less than screening other commonly inherited diseases.

Conclusions and Implications:
Screening of infants should be part of a continuum care till rehabilitation. Management should start soon after confirmed diagnosis and is multifaceted where programs for speech therapy, family-based therapy, provision of hearing aids and cochlear implants, and auditory trainers should be incorporated.

Year: 2004

- Abstract ID: 489311032747

Title: Is community based primary care evidence based?
First author: Hyeong Sik Ahn
Further authors: YM Lee, HY Lee, JA Jang, DS Ahn
E-mail: ahnhs@korea.ac.kr
Organisation: Dept of Preventive Medicine, College of Medicine, Korea University
Address: 126-1 AnamDong, Sungbug Gu, Seoul, Korea, T)822-920-6404,F)822-927-7220
Category: CPG Research

Abstract

Background:

There should be information that how much portion of medical interventions has solid scientific foundation. one may doubt primary care practice are less evidence-based than larger hospital base practice. Most of previous studies have been done in hospital settings,and few informatin on community based primary care setting is available.

Objective:

The purpose of this study was to estimate the proportion of therapeutic interventions supported by scientific evidence in community based primary care clinics in Korea.

Methods:

The study settings a are ten primary care clinics in Seoul. The clinics are located in urban area serving for the neighboring community and one or two general physicians are working at the clinics.Retrospective review of patient medical records was done according to primary diagnosis and treatment. The evidence for the intervention was searched for in Medline, standard textbooks and evidence based medicine on-line database including ACP journal club and Cochrane database of systematic reviews. The evidence was then classified as one of three categories developed by the Oxford Centre for Evidence-Based Medicine : 1) evidence from randomized controlled trials(RCTs); (2) convicing non-experimental evidence; and (3) interventions without substantial evidence.

Results:

Of the 838 primary diagnosis and treatment pairs, 44.6% were supported by evidence from at least one randomized controlled trials. 13.7% were supported by convincing non-experimental evidence, and 39.7% were classified as intervention without substantial evidence. As a result, 58.3 % of interventions (491/838) were based on evidence meeting our criteria.

Conclusions and Implications:

Approximately 45% of the interventions in ten primary care clinics were were supported by evidence from at least one RCTs. Although this result is limited in a region in Seoul, it could serve as a baseline reference for future assessments of evidence-based practice.

Year: 2004

Abstract ID: 490382814435

Title: Quality Assurance in Clinical Practice Guideline Development: Early Detection of Breast Cancer in Germany
First author: Dr. med. Ute-Susann Albert
Further authors: K. D. Schulz, I. Kopp
E-mail: albertu@med.uni-marburg.de
Organisation: Klinik für Gynäkologie, gynäkologische Endokrinologie und Onkologie. Klinikum der Philipps-Universität
Address: Pilgrimstein 3; 35037 Marburg; Tel.: 0049 6421 286 6432; Fax: 0049 6421 286 6432
Category: CPG Development

Abstract
Background:
Breast cancer is one of the leading causes of death of women in Germany. Diagnosis of breast cancer at an early stage promises a better prognosis, with a better chance to maintain or improve quality of life and to be cured. The efficacy of early detection depends on concomitant quality assuring arrangements within the interdisciplinary diagnostic chain including risk evaluation, clinical examination, technical diagnostic procedures with the use of interventional techniques, histo-pathologic analysis in combination with excellent surgical and oncological treatment and follow-up.
Objective:
To establish an effective, quality assured, inter- and multidisciplinary early detection program for breast cancer in Germany a multidisciplinary clinical practice guideline has been developed. To make the assessment of quality assurance in everyday practice feasible, quality indicators have been proposed as a new aspect to integrate in guideline development.
Methods:
Stepwise process of guideline development according to the German Manual for Clinical Practice Guidelines (GERM-CPG).
Results:
10 consensus-statements for an early breast cancer detection program adopted by 17 scientific and medical societies and organisations, patient self-help groups and advocacy in a formal process were the basis of the stepwise guideline development process: 1. Systematic evidence review for the 10 statements and revision of the statements according to best available evidence; 2. Writing an algorithm on the diagnostic chain for early diagnosis of breast cancer; 3. Description of quality assuring management with defined core clinical data for reporting relevant aspects of clinical care (resource- and process management); 4. Linking the recommendations explicitly to the supporting evidence, discussion of potential harms and risks; 5. Development of a Guideline for lay information; definition of key areas on which information for patients has to be provided in respect to quality of life aspects and informed consent/shared decision making; 6. Definition of outc ome measures and clear targets for quality of care indicators; 7. Definition of procedures for dissemination, implementation and scheduled review; 8. Final consensus conference as part of the systematically process of guideline development.
Conclusions and Implications:
A guideline on “Early Detection of Breast Cancer in Germany” with the new aspects of quality assurance by quality indicators for early breast cancer detection has been finalised. These quality indicators are an important tool for evaluating guideline implementation and effectiveness by assessing change in breast health care.

Year: 2004

Abstract ID: 515183438729

Title: What is the most appropriate breast screening interval for women aged 45 to 49 in New Zealand?
First author: Simon Baker
Further authors: Ashley Bloomfield, Madeleine Wall
E-mail: simon_baker@moh.govt.nz
Organisation: National Screening Unit
Address: Private Bag 92-522, Wellesley Street, Auckland
Category: CPG Implementation

Abstract
Background:
In February 2004, The Minister of Health announced an extension to the eligible age-range of BreastScreen Aotearoa (BSA). This age extension would significantly increase the required capacity of breast screening services in New Zealand, particularly if an annual screening interval were adopted in women under 50. Biennial screening was also being considered in this age group. However, it was important to ensure that any increase in the screening interval did not reduce the quality of BSA.
Objective:
To objectively search and review the evidence on the most appropriate breast screening interval for women aged 45 to 49 years, and to present this in a way that would support an Advisory Group to make a clear recommendation to the Minister.
Methods:
An electronic systematic search and review of the medical literature was carried out in May 2004. A web-based literature search and retrieval service was also used to access articles.
Results:
There is no concrete trial evidence on which to base a decision on the screening interval for women aged 45 to 49 years, and it is unlikely that definitive trial evidence will ever emerge. Evidence from less robust studies suggest a screening interval of one year, or eighteen months is most appropriate, although in the randomised controlled trials, shorter screening intervals did not produce greater benefits among women aged 45 to 49 years, and there is some evidence that two-yearly screening still produces benefit. Overseas screening programmes recommend intervals of twelve, eighteen or twenty-four months in women aged 40 to 49 years. There is some evidence, in a situation of limited capacity, that screening 100 women every two years produces a greater mortality benefit than screening 50 women every year.
Conclusions and Implications:
In the absence of definitive evidence, decision-makers need to weigh up the available evidence, and consider it alongside other relevant factors, in particular, available capacity
Year: 2004

Abstract ID: 516423674136

Title: Board game for teaching guideline development and implementation (poster)
First author: Marjukka Mäkelä
Further authors: Kaila M, Ketola E, Lepistö M, Mäkelä V, Mäntyranta T, and Rasilainen H
E-mail: marjukka.makela@stakes.fi
Organisation: FinOHTA (Finnish Office for Health Technology Assessment) and Finnish Medical Society Duodecim
Address: FinOHTA/Stakes, P.O.Box 220, 00531 Helsinki, Finland. Phone: +358 9 3967 2290, Fax +358 9 3967 2278
Category: CPG Implementation

Abstract
Background:
In guideline work and especially guideline programs, it is necessary to teach the basic principles of systematic development and implementation of evidence based guidelines to a number of experts.
Objective:
To develop a learning package for Finnish Current Care (CC) guidelines based on a board game, in order to facilitate learning of guideline methodology in an atmosphere that supports team building.
Methods:
Based on the original idea of three successive chief editors of CC and the director of the Centre for Pharmacotherapy Development, the game was developed jointly with CC secretariat and a game board enthusiast as designer. The board was divided into guideline development (treetop) and implementation (roots). Several rounds of test playing were used to polish the game for suitable length and detail. After discussion, redundant steps were discarded, resulting in 39 steps in development and 34 in implementation. In addition, there are 67 action cards describing specific situations that may occur, e.g. television interviews.
Results:
The Current Care game can be played by 2-6 persons or teams, and a round can cover guideline development, implementation, or both. Players discuss and learn the topic of each square they arrive in by using the background package. The game will be published on the 10th anniversary of the guidelines and distributed to guideline development teams, hospital districts, and other guideline actors for use. The package includes the AGREE instrument, the CC guideline handbook and an implementation handbook. A poster of the game board will be distributed widely.
Conclusions and Implications:
The CC game development team greatly enjoyed creating this learning package. We probably should try to get feedback about the game and evaluate its facilitating effect on guideline development. This will be difficult, however, as playing can't be blinded and we doubt that guideline teams would consent to being randomized into a non-playing control group.

Year: 2004

Abstract ID: 540219367184

Title: Successful Evidence Implementation - the Basics (a workshop)
First author: Janice Davies
Further authors: Ruth Cornish, Catherine Marshall
E-mail: jdavies@nicsl.com.au
Organisation: National Institute of Clinical Studies
Address: 5/499 St Kilda Road Melbourne, VIC 3004 Australia
Category: CPG Implementation

Abstract
Background:
Early guideline developers thought that publication was sufficient to get adoption. We now know that implementation is a multifaceted, complex process requiring skills, resources, creativity and time.

Objective:
This practical skills based workshop will provide participants with an overview of current knowledge on guideline/ evidence implementation, and the opportunity to apply this knowledge.

Methods:

The workshop includes an overview of implementation methods, including barrier analysis; examples of best practice; essential elements in successful guideline/ evidence implementation, including the role of teams and health leaders; lessons from National Institute of Clinical Studies programs; and hands on practice in planning guideline/ evidence implementation.

Results:

see above

Conclusions and Implications:

see above

Year: see above

Abstract ID: 545168776544

Title: CPGs and Consumers - How and Why?
First author: Fiona Wilkinson
Further authors: Harris, C., Turner, T., Warnock, J., Kermond, S., Mazza, D.
E-mail: Fiona.Wilkinson@med.monash.edu.au
Organisation: Southern Health
Address: Centre for Clinical Effectiveness, Level 1 Block E, Monash Medical Centre, Locked Bag 29, Clayton Victoria 3168 Australia Ph: +61 3 9594 7557, Fx: +61 3 9594 7552
Category: CPGs and Consumers

Abstract
Background:
It is widely agreed that evidence-based guideline development should include consumers. However little guidance is available about how consumers can or should be involved, and the intended outcomes of their involvement. Health for Kids in the South East is a Victorian Government funded project designed to improve health care for children. A major aspect of the project is development of guidelines for asthma, bronchiolitis, croup and gastroenteritis.
Objective:
A key project strategy was to develop, implement and evaluate a Consumer Participation Plan to facilitate the involvement consumers in the guideli
ne development process, in other areas within the project, and in the wider clinical setting.
Methods:
A Consumer Participation Plan was developed based on available evidence, previous experience and information from relevant organisations. We undertook an extensive recruitment process. Consumers were invited to join a group and were provided with training about the project and the role of consumer representatives.
Results:
After 13 enquiries, a 10 member Consumer Group was formed, including consumers with varying degrees of familiarity with the health care system. The training sessions were well attended. Consumers gave feedback that focused on the process of care. Information was elicited from them through surveys, focus groups, and through their experience of the journey of a child who comes to hospital with asthma. Two consumer representatives are on the Asthma Guideline Development Group. The Project Team supports them, and having 2 consumers on the group means they also support each other. Consumers have contributed in unexpected and valuable ways to the asthma guideline and clinical path. Being involved has given them greater insight into the clinical decision making process.
Conclusions and Implications:
Involving consumers in guideline development is complex and time consuming. It is also immensely rewarding for the consumers and the development team, and enhances the quality of the guidelines developed.
Year: 2004

- Abstract ID: 551974921609

Title: Korean primary physicians' perceptions and attitudes to Clinical Practice Guidelines
First author: Nam-Soon Kim
Further authors: EJ Park, SY Kim, HY Lee, HS Ahn
E-mail: artemine@hanmail.net
Organisation: Korea Institute for Health and Social Affairs
Address: San 42-14, Bulkwang-Dong, Eunpyung-Gu, Seoul 122-705, Korea. Phone: 82-2-380-8216 Fax: 82-2-353-0344
Category: CPG Research

Abstract

Background:

As quality of medical practice is increasingly emphasized worldwide, the concern for Clinical Practice Guidelines (CPGs) increased in South Korea recently. Since 1990s CPGs have been developed in South Korea but little is known as to which guideline primary physicians use and how they think about it.

Objective:

The objective of this study is to assess Korean primary physicians' perceptions and attitudes to CPGs.

Methods:

1,175 primary medical clinics (about 5% of all primary medical clinics) were randomly sampled using stratified probability sampling method. The self-reported questionnaire was mailed in April 2004 to primary physicians working for selected medical clinics. 712 primary physicians (60.6%) responded.

Results:

Korean primary physicians regarded various guidelines as CPGs. Of the respondents, 86.5% responded that they thought the guidelines developed by physician's own specialty society were CPGs, while 67% answered that they regarded expert opinions as CPGs. Among resources that were used as guidelines, only 8.8% were CPGs. The respondents agreed that CPGs were helpful in making medical decisions (86.7%), improving knowledge (86.4%) and CPGs were developed to improve the quality of medical service (78.8%). But many primary physicians pointed out negative aspects of CPGs; reduction of physician autonomy (62.6%), being useless in applying for individual patient (59.2%) and development for medical expenditure containment (58.7%). The older the primary physicians were, the more they had positive attitudes towards CPGs. 93.9% primary physicians agreed that it is needed to collect their opinions to evaluate the applicability of CPGs.

Conclusions and Implications:

There was variation in the understanding for CPGs among primary physicians. They showed some negative attitudes but wanted to take part in development and to reflect their opinions in CPGs. Our results suggest that to expand the application of CPGs in medical practice, education for CPGs and primary physicians' participation in development process are needed.

Year: 2004

Abstract ID: 558222663654
Title: hypeetension guideline (2nd edition)
First author: Clinical Audit and guidelines working group, Professional Development and Quality Assurance, Dept of Health, Hong Kong, (SAR), China
Further authors: Clincal Audit and guidelines working group, Professional Development and Quality Assurance, Dept of Health, Hong Kong, (SAR), China
E-mail: chenglisa@grauate.hku.hk
Organisation: Prodessional Development and Quality Assurance, Dept of Health, Hong Kong, (SAR), China
Address: +852 27839035
Category: CPG Development

Abstract
Background: Hypertension is common and is an important cause of strokes, coronary heart disease and premature death1. In the 1995 – 1996 Hong Kong Cardiovascular Risk Factor Prevalence Study2, about 1 in 10 men and 1 in 9 women had definite hypertension (defined as systolic BP ≥ 160 and/or diastolic BP ≥ 95 mmHg or on treatment for hypertension); about 1 in 12 men and 1 in 16 women had borderline hypertension (defined as systolic BP 140 – 159 and/or diastolic BP 90 – 94 mmHg). 6% of men and 8% of women were on treatment for hypertension overall. Among individuals with definite hypertension, 66% of men and 71% of women were on treatment. Conversely 34% of men and 29% of these women were untreated.

Objective: After the implementation of the first edition of the hypertension protocol in 2003, newer guidelines were published. The Clinical Audit and Guideline group in PDQA decided to adopt the Seventh Report of the Joint National Committee (JNC 7) on Prevention, Detection, Evaluation and Treatment of High Blood Pressure. We based our decision on firstly, that JNC 7 is one of the most current evidence based guidelines in the management of Hypertension in which stricter control and earlier intervention are the key points, with the aim to reduce the overall mortality and morbidity of these patients, as high blood pressure is proven to be an important independent cardiovascular factor. Secondly, we found that JNC 7 is clear and concise that would be easier to use and understand for clinicians.

Methods: We used the most updated and best available evidence to revise the existing guideline on management of hypertension in primary health care. Apart from the existing guidelines and recommendations from international organizations e.g WHO hypertension guidelines (1999) (Chalmers J et al. 1999 World Health Organization - International Society of Hypertension Guidelines for the Management of Hypertension. J Hypertens, 1999, 17:151-185), we modified and adopted the following latest guidelines available since the 1st edition of hypertension guidelines: 1. JNC VII: National Institutes of Health, May 2003. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. 2. BHS guidelines (2004) (Ramsay LE et al. Guidelines for management of hypertension report of the fourth working party of the British Hypertension Society, 2004. J Human Hypertens 2004; 18.139-185) 3. WHO IOTF (2004) (The Asia-Pacific perspective: Refinding obesity and its treatment Feb 2003) We used the Canadian Task Force level of evidence as our reference.

Results: The followings are examples of advised recommendations in the guideline (to be supplies upon request): 1. In JNC 7, the classification of blood pressure for adults ages 18 and older is based on the average of two or more properly measured, seated BP readings on each of two or more office visits. 2. A new category designated prehypertension (systolic BP of 120-139mmHg or a diastolic BP of 80-89mmHg) has been added. Adults with prehypertension are at twice the risk to develop hypertension as those with lower values 3. Principles in the use of anti-hypertensive drugs: Thiazide-type diuretics should be used in drug treatment for most patients with uncomplicated hypertension, either alone or combined

with drugs from other classes. Most patients with hypertension will require two or more antihypertensive medications to achieve goal blood pressure (<140/90mmHg, or < 130/80mmHg for patients with diabetes or chronic kidney disease.) 4. JNC 7 suggested serum potassium & creatinine should be monitored at least 1-2 times/year. 5. We included a chapter on white-coat hypertension and the use of 24 hour ambulatory BP to assessment (evidence II-2)

Conclusions and Implications:
This updated evidence-based hypertension guideline could facilitate primary care team to deliver optimal care to clients with hypertension as recommended by the best current available evidence (poster presentation)

Year: 2004

Abstract ID: 596825253628

Title: Validating Clinical Guidelines with the AGREE-instrument: the establishment of validation committees
First author: Hannes Karin (presented by Dirk Ramaekers)
Further authors: Paul Van Royen, Bert Aertgeerts, Pierre Chevalier, Frank Buntinx, Dirk Ramaekers
E-mail: karin.hannes@med.kuleuven.ac.be
Organisation: Belgian Centre for Evidence-Based Medicine
Address: Kapucijnenvoer 33, blok J, 3000 Leuven, Belgium, tel: +32 16 332693, tel: +32 16 337480
Category: CPG Research

Abstract
Background:
Over recent decades, the number of available clinical practice guidelines has grown enormously. Guidelines should meet specific quality criteria to ensure good quality. The AGREE-instrument was developed as a set of criteria to critically appraise clinical guidelines.

Objective:
The Belgian Centre for Evidence-Based Medicine (CEBAM) was assigned by government to establish validation committees. These committees are set up to ensure that potential biases inherent in guideline development are addressed properly and that the Belgian recommendations for practice are valid and reliable. The AGREE-instrument is used to support these validation processes.

Methods:
For each clinical guideline submitted to CEBAM a validation committee of 5 members is established, appointed by the direction board. These committees consist of at least 2 methodological experts and 3 experts familiar with the content of the guideline. Each of them scores the criteria set out in the AGREE-instrument individually. The overall judgement is made in a meeting between the experts. Guidelines that fulfil the AGREE-criteria are given an official CEBAM-label.

Results:
Between June 2002 and June 2004 ten guidelines were submitted. Five of them received an official label, 4 are still in progress and one was not resubmitted after being negatively evaluated.

Conclusions and Implications:
The AGREE-instrument has shown itself valuable in evaluating Belgian clinical guidelines. More efforts should be made to train experts to gain certain skills for a critical appraisal of clinical practice guidelines.

Year: 2004

Abstract ID: 597835847862

Title: Advanced searching for guideline developers: “Systematic” means “fit for purpose” not “everything”
First author: Marjukka Mäkelä
Further authors: Eeva Ketola (Current Care, Finnish Medical Society Duodecim), Susan Bidwell (NZHTA)
E-mail: marjukka.makela@stakes.fi
Organisation: FinOHTA (Finnish Office for Health Technology Assessment)
Address: FinOHTA/Stakes, P.O.Box 220, 00531 Helsinki, Finland. Phone: +358 9 3967 2290, Fax +358 9 3967 2278
Category: CPGs and Information Technology

Abstract
Background:
Many people believe (incorrectly) that the term “systematic review” means “Cochrane review.” While searches for evidence-based literature reviews should follow the principles of being systematic, transparent, and repeatable, this does NOT mean that one must look for everything. Searches often can and must be limited in useful ways; for example by restricting to a limited time frame or to major study designs; by looking at summary documents only (for example a review of reviews); or as a planned chain of searches, progressing from a few high-quality studies covering a large field, and narrowing down to a specific question and possibly including studies with more risk for bias.
Objective:
To demonstrate that high quality guidelines can be completed within a realistic time frame and budget, leaving a clearly documented foundation for revision when appropriate.
Methods:
Three different approaches are presented for retrieving the most relevant literature and therefore allowing optimum use of available resources. Firstly we will demonstrate how to maximize search precision using limits and filters for the major databases such as Medline, and how to focus on sources with the likelihood of greatest yield by the use of the COSI search protocol - (core, standard, and ideal sources of information). (SB) This will be followed by an example of a review of reviews, comparing several different treatments for coronary heart disease (MM). Finally, experience from Finnish Current Care guidelines on “concentric searches” on the same topic, going from wide to narrow focus will be demonstrated. (EK)
Results:
Using the techniques demonstrated it is possible to avoid time- intensive searching with overwhelmingly large results and to tailor one’s search to the resources available, without compromising the guiding principles for systematically reviewing the literature.
Conclusions and Implications:
Workshop participants will be invited to discuss the usefulness of the different approaches by using examples of guideline questions.

Year: 2004

Abstract ID: 600766082492

Title: Can “Best Practice” Guidelines lead to worse care?
First author: Stewart Mann
Further authors:
E-mail: stewart.mann@wnmeds.ac.nz
Organisation: Wellington School of Medicine and Health Sciences
Address: PO Box 7343 Wellington South 6002, New Zealand +64 4 918 6793
Category: CPG Development

Abstract
Background:
Voltaire (1764) raised the proposition – “Le mieux est l'ennemi du bien” – suggesting that in striving for excellence we may achieve less than we would with a pragmatic compromise. “Best practice” has become an almost unchallengeable principal in modern medicine and a goal in the formulation of guidelines and their implementation. Guidelines are frequently drawn up focused exclusively on the published evidence base. Problems arise when such guidelines are not implementable because of limited resources.

Objective:
In New Zealand (NZ) guidelines for the management of acute coronary syndromes (ACS) are currently under development. Management of such cases is already following implicit guidelines based on those developed in other countries. These guidelines advise a number of expensive options including newer drugs and frequent referral of patients to a tertiary centre for coronary angiography with a view to intervention where appropriate.

Methods:

Results:
A recently published nationwide audit of the care of patients with ACS showed that the rates of angiography and coronary intervention in NZ were lower than in comparable countries and that patients presenting initially to a tertiary centre were much more likely to undergo these procedures than those presenting to other hospitals. The GRACE registry has confirmed this pattern in a wider mix of countries. The consequent diversion of resources may have resulted in deficiencies of care even in other cardiac areas.

Conclusions and Implications:
Clinicians are naturally reluctant to abandon the “best practice” principle as this would not be an internationally respectable stance. Some also see “best practice” definition as a way of highlighting deficiencies in resourcing and shaming funders into providing substantially more. However, setting such guidelines in an environment where they are not fully achievable because of resource constraints leaves health practitioners medicolegally vulnerable. Partial implementation is also leading clearly to major inequities of care.
Year: 2004

Abstract ID: 617703311078

Title: Clinician perceptions of clinical practice guidelines
First author: Alison Evans
Further authors: K Luxford, C Nehill, A Power, H Zorbas
E-mail: alison.evans@nbcc.org.au
Organisation: National Breast Cancer Centre
Address: Locked Bag 16, Camperdown, NSW 1450, Australia
Category: CPG Implementation

Abstract
Background:
In 2001 the NBCC released Clinical Practice Guidelines for the Management of Women with Advanced Breast Cancer. The guidelines were sent to Australian clinicians involved in the care of women with breast cancer and seminars were held to promote their uptake. A 1-page guide was developed for GPs outlining key recommendations relevant for general practice.

Objective:
To assess clinician perceptions of the Clinical Practice Guidelines for the Management of Women with Advanced Breast Cancer and GP guide.

Methods:
A questionnaire was mailed to 471 medical and radiation oncologists identified through the Royal Australian and New Zealand College of Radiologists and the Medical Oncology Group of Australia. Clinicians attending the seminars and GPs involved in a trial of the GP guide were also surveyed.

Results:
Of the 127 respondents to the medical and radiation oncologist survey, over 70% agreed that the guidelines are a good summary of the most recent evidence, easy to understand and evidence-based. Only 8% found the guidelines not useful. However, only 7% reported that their practice has or will change as a result of the guideline recommendations, while 77% reported no changes resulting from the recommendations The majority of respondents (92%) cited being evidence based as the most important aspect of guideline credibility and more respondents considered the credibility of the organisation developing guidelines to be more important than endorsement by a national body or professional college. Of the 571 seminar attendees, 83% indicated the guidelines would have a very high to moderate impact on their practice. Of the 46 GPs in the GP guide trial, 85% believed the recommendations were relevant/very relevant to their role and 91% indicated the guide provided them with new information.

Conclusions and Implications:

The guidelines were well received by clinicians; however, their impact on practice requires further study. Opinions about guideline endorsement have implications for future guideline development.

Year: 2004

Abstract ID: 623670716807

Title: Review of the effectiveness of infrared thermography for population screening and diagnostic testing of breast cancer
First author: Dr Jane Elizabeth Kerr
Further authors: Dr S. Baker
E-mail: jane.kerr@chmeds.ac.nz
Organisation: New Zealand Health Technology Assessment
Address: Department of Public Health and General Practice, Christchurch School of Medicine and Health Sciences, PO Box 4345, Christchurch
Category: CPG Implementation

Abstract
Background:
Infrared thermal imaging (thermography) has been considered for various uses in medical imaging since the 1960's, including breast cancer management. However, it has never become established in conventional medical practice. Modern digital infrared thermal imaging (thermography) has become available to patients in New Zealand over the last few years through privately financed providers. The National Screening Unit has been receiving inquiries about this technology, and requested a formal review of the evidence to provide them with independent information from which to respond to these queries.

Objective:
The aim of this project was to review the evidence for the effectiveness of infrared thermography for population screening and diagnosis of breast cancer.

Methods:
To identify potentially relevant articles for this review, a systematic literature search was conducted, using appropriate search terminology.

Results:
The literature search identified 1,154 potentially relevant articles in abstract form. After a series of selection criteria were applied to the abstracts of the articles, 85 were retreived in full text, from which a final group of three papers were identified as eligible for inclusion in the review. A significant finding of this review was that there were no studies that evaluated the effectiveness of the infrared devices that are currently available in New Zealand, and few evaulating comparable devices, or those that may become available in the future.

Conclusions and Implications:
There was insufficient evidence available to provide support for the role of currently available infared thermography for either population screening or diagnostic testing of breast cancer. The major gaps in knowledge at this time can only be addressed by large-scale, prospective randomised trials. At this stage the implications of this finding are not clear, but they will be discussed further at the conference.

Year: 2004

Abstract ID: 63674136393

Title: Using guidelines: electronic guidelines in Australian General Practice
First author: Elizabeth Deveny
Further authors: Nil
E-mail: edeveny@tg.com.au
Organisation: The University of Melbourne
Address: c-/ Ground Floor 23-47 Villiers St North Melbourne Australia 3051
Category: CPG Implementation

Abstract
Background:
Prescribing is one of the research domains where most work has been undertaken on developing clinical decision support software. Evidence–based approaches to practice encourage clinicians to access current clinical evidence in order to provide the best quality of care. Producing clinical practice guidelines in an electronic format.

Objective:
The overall aim of the research project was to identify how clinicians determine their needs for information when making clinical decisions. This paper describes some computer interactions between GPs and CPGs during consultations.

Methods:
Three methods of data collection were used for the study overall: ethnographic observations, in–depth interviews and questionnaires. The data collection focused on the themes of clinical decision-making, clinical prescribing practices, information resource use and computer use.

Results:
Firstly, when guidelines are integrated into clinical software, they usually provide prompts to clinicians which are intended to encourage clinical adherence to the guidelines. The focus of such information, as it is based on CPGs, tends to be on the clearly evidenced clinical aspects of the disease domain. Secondly, sometimes GPs check computer's knowledge bases, for example, to see if there are any recorded side effects for a particular drug. Such practices allow opportunities for just-in-time continuing medical education. Thirdly, with GPs using the screen as a site of 'knowledge', patients also are likely to want to view it. As one GP puts it, 'we have to get used to patients having the ability to look at the screen and read for themselves what is happening because [then] they ask more questions.'

Conclusions and Implications:
When the format of a CPG changes so do the patterns of interaction between users and such information resources. Because of the implications for clinical practice that these changes may have, it is critical that such matters are given due consideration during the design, implementation and evaluation of any new forms of CPGs.

Year: 2004

Abstract ID: 687159416153

Title: Evidence-based guideline on management of hypertension
First author: Drs. MY Ng and Charmaine Tse (or vice versa)
Further authors: Drs. Christie Chan, LPK Cheng, Anthony Ho, KT Lau, WK Lam, Linda Hui and Luke CY Tsang
E-mail: chenglisa@graduate.hku.hk
Organisation: Clinical Audit and Guideline Working group Professional Development and Quality Assurance (PDQA)
Address: Professional Development and Quality Assurance, Kowloon Families Clinic, 6thFl., Yau Ma Tei Jockey Club Clinic, Battery Street, Yau Ma Tei, Kowloon, Hong Kong (phone +852 23882351, mobile +852 93063881, fax +852 27839035)
Category: CPG Development

Abstract
Background:
no. 558222663654 Hypertension is common and is an important cause of strokes, coronary heart disease and premature death. In the 1995 – 1996 Hong Kong Cardiovascular Risk Factor Prevalence Study2, about 1 in 10 men and 1 in 9 women had definite hypertension. 6% of men and 8% of women were on treatment for hypertension overall.

Objective:
After the implementation of the first edition of the hypertension guideline in 2003, newer guidelines were published. e.g. JNC VII We revised and updated the guideline based on the most current evidence based guidelines e.g. JNC VII, in the management of hypertension with the aim to reduce the overall mortality and morbidity of these patients, as high blood pressure is proven to be an important independent cardiovascular factor.

Methods:
We used the most updated and best available evidence to revise the existing guideline on management of hypertension in primary health care. Apart from the existing guidelines from e.g WHO hypertension guidelines (1999) We modified and adopted the following latest guidelines available since the 1st edition of hypertension guidelines: 1. JNC VII: National Institutes of Health, May 2003. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, 2.BHS guidelines (2004) 3. WHO IOTF (2004)

Results:
The followings are examples of advised recommendations in the guideline (to be supplies upon request): 1. In JNC 7, the classification of blood pressure for adults ages 18 and older is based on the average of two or more properly measured, seated BP readings on each of two or more office visits. 2. A new category designated prehypertension (systolic BP of 120-139mmHg or a diastolic BP of 80-89mmHg) has been added. 3. Principles in the use of anti-hypertensive drugs: Thiazide-type diuretics should be used in drug treatment for most patients with uncomplicated hypertension, either alone or combined with drugs from other classes. 4. JNC 7 suggested serum potassium & creatinine should be monitored at least 1-2 times/year. 5. We included a chapter on white-coat hypertension and the use of 24 hour ambulatory BP to assessment (evidence II-2)

Conclusions and Implications:

This updated evidence-based hypertension guideline could facilitate primary care team to deliver optimal care to clients with hypertension as recommended by the best current available evidence

Year: 2004

Abstract ID: 718841913342

Title: An Innovative IT Solution for Population-Based Cardio Vascular Disease Risk Assessment and Management within Primary Care- Jumping the Clinical Performance Indicator Hurdle

First author: Dr David Nixon, General Practitioner, The Doctors Masterton
Further authors: Dr M Smith General Practitioner, Mr K Preston (Primary Care IT Solutions Ltd)
E-mail: david@mn.thedoctors.co.nz
Organisation: The Doctors, 43 Chapel Street, Masterton, New Zealand
Address: The Doctors, 43 Chapel Street, Masterton, New Zealand Tel 06-3700067 Fax 06-3701069
Category: CPGs and Information Technology

Abstract
Background:
PHO Clinical Performance Indicators (CPIs) are an indirect measure of the application of evidence-based medicine. Targeted population based CVD risk assessment, as apposed to individual 'face to face' assessment, is a key component to these CPIs.

Objective:
To develop a piece of software capable of extracting the data from GP computing systems and calculating the CVD risk of the patient, targeted subpopulations or the whole practice population-at the touch of a button. It would identify and collate patients who are missing data to help the GP develop simple strategies for data acquisition and better CPI performance and CVD risk management.

Methods:
We developed a piece of computing software, which is able to extract the data and calculate the patient's or practice population's CVD risk and provide data gap reporting for targeted data acquisition strategies. In June 2004 this was applied to our Enrolled Patient population of 7219 patients and targeted to select the males >35 years & females >45 years of Maori, Pacific Island ethnicity and >45 years males and > 55 years females of European or Pakeha ethnicity - as per NZGG.

Results:
Initially it was able to calculate the CVD risk of 621 patients constituting 36% of the target population. Application of the data gap reporting tool allowed us to identify patients who simply required a smoking status or a blood pressure etc to complete the data set for CVD risk assessment. A nurse led initiative, in which our nurses invited this subgroup of patients to attend over the four weeks prior to the CPI July deadline, improved our performance enabling 912 patients of the targeted 1724 patients to the have their CVD calculated (53% of the target population).

Conclusions and Implications:
The software has helped us, in just a few weeks, to jump an important CPI hurdle - with more time our performance will improve significantly. It has also enabled us to target higher risk individuals and populations for evidence based interventions, to reduce their CVD risk burden.

Year: 2004

Abstract ID: 725816198259

Title: A Selection and translation of Evidence based clinical practice guidelines for primary care physician in respiratory disease field
First author: Soo Young Kim. M. D.
Further authors: Hwang Inhong M.D., Yoon Jong Lull, M.D.
E-mail: pclove@hallym.or.kr
Organisation: hallym university medical college
Address: department of family medicine, Kangdong Sacred heart hospital, #445 Gil dong, kangdong gu, seoul, korea, 82-2-224-2406(phone), 82-2-2224-2409(fax). **Category:** CPG Development

Abstract
Background:
One method for achieving medical practice to be more evident, especially in the field of primary care, is to encourage the use of clinical guidelines. If development of guidelines is difficult because of time and cost, an evidence based foreign guidelines can be selected and translated into Korean for application.

Objective:
To select evidence based foreign guidelines in respiratory disease field and to translated them into korean for appication

Methods:
A team was formed, consisting of 11 family physician experts on evidence based medicine and clinical practice guidelines. We selected six respiratory diseases requiring clinical guidelines because of variability in practice. We searched several clinical practice guideline databases and selected one guideline per disease according to currency, scope of guideline, whether it was evidence based, and its feasibility in the field of primay care. We translated selected guideline's full-texts or summaries which were done by authorized organization into Korean.

Results:
The selected respiratory diseases were chronic obstructive pulmonary disease, asthma, pneumonia, sinusitis, rhinitis, and influenza. According to criterion, we selected GOLD (Global Initiative for Chronic Obstructive Lung Disease) for chronic obstructive lung disease, GINA (Global initiative for asthma) for asthma, CDC (Center for disease control) guideline for influenza, IDSA (Infectious Diseases Society of America) guideline for pneumonia, AAP (American Academy of Pediatrics) guideline for sinusitis, and JCAAI (Joint Council of Allergy, Asthma and Immunology) for rhinitis.

Conclusions and Implications:
We selected six common respiratory diseases and the most appropriate evidence based guidelines for those particular diseases.

Year: 2004

Abstract ID: 801098765909

Title: Medical-problem solving in the internet: a new incentive for guideline implementation
First author: Horst Christian Vollmar
Further authors: C.-C. Schürer- Maly, H. Kirchner, N. Koneczny, J. Engelbrecht, W. Kunstmann, S. Löscher, G. Ollenschläger, M. Butzlaff
E-mail: vollmar@evidence.de
Organisation: Medical Knowledge Network evidence.de of Witten/Herdecke University
Address: Alfred-Herrhausen-Str. 50, 58448 Witten, Germany, Phone: +492302926741, Fax: +492302926745
Category: CPG Implementation

Abstract
Background:
Based on the medical online platform www.leitlinien-wissen.de that was successfully implemented in May 2004, the Agency for Quality in Medicine (AQUMED) and the German Medical Association (GMA) joined educational forces with Witten/Herdecke University (UWH).

Objective:
To strengthen the transfer of the web-based National Disease Management Guidelines (NDMGs) provided by AQUMED into clinical practice, virtual interactive cases are offered for guideline-based medical training.

Methods:
Based on NDMGs, interactive virtual patient histories are constructed and complemented with appropriate media, e.g. ECG's, etc. Different learning modules allow various interactions between users and their virtual patients. Each module ends with a detailed feed-back on the user's false or correct decisions. All case histories are supplemented with 10 questions. In the case of 70% correct answers, CME-points can be obtained. Each patient history is evaluated by an editorial group of GPs and Internists.

Results:
The virtual case-histories were well received when first demonstrated during the 107th German Medical Assembly Day in May 2004. Physicians appreciated the way of learning which resembles, albeit virtual, their daily routine. Out of their experience with the first cases, the users delivered many useful pieces of advice, which are very valuable for further improving the patient histories.

Conclusions and Implications:

For a rapidly growing number of physicians the internet is part of their daily life and web-based medical-problem solving complements medical education on the web. According to individual preferences, physicians can study medical topics by either reading the NDMGs or by diagnosing and treating a virtual patient. Facing the rapid turnover of medical knowledge and the fact, that CME has recently been made mandatory in Germany, it is expected medical doctors will appreciate these new learning tools. Further studies are necessary to compare the learning impact and effectiveness of case oriented versus text-based teaching methods.

Year: 2004

Abstract ID: 803175700514

Title: Associate Professor
First author: Johanna Westbrook
Further authors: Professor Enrico Coiera
E-mail: J.Westbrook@unsw.edu.au
Organisation: Centre for Health Informatics
Address: University of New South Wales
Category: CPG Research

Abstract
Background:
Improving clinicians' access to evidence such as clinical guidelines via online information retrieval systems has been advocated as a key step in advancing evidence-based practice. There is little empirical evidence of the impact of system use on clinical decision-making.

Objective:
To assess the impact of use of an online information retrieval system on clincians' performance in answering clinical questions.

Methods:
We used a pre-post experimental design to assess the impact of use of an online information retrieval system on the performance of 75 clinicians in answering 8 scenario questions (600 answers). We examined the proportion of correct answers pre and post intervention, direction of change in answers and differences between professional groups.

Results:
System use resulted in a 21% improvement in clinicians' answers, from 29%(95%CI 25.4-32.6) correct prior- to 50%(95%CI 46.0-54.0) post-system use. In 33%(95%CI 29.1-36.9) answers were changed from incorrect to correct. In 21%(95%CI 17.1-23.9) correct pre-test answers were supported by evidence found using the system, and in 7%(95%CI 4.9-9.1) correct pre-test answers were changed incorrectly. For around 50% of searches clinicians selected journal articles in order to answer questions. This was following by the use of therapeutic guidelines in 14% of searches. However when clinicians were asked how confident they were in the evidence found using the online evidence system clinicians were most confident in information obtain from MIMs (83% confident or very confident in evidence) and therapeutic guidelines (73%), compared with journal articles (60%).

Conclusions and Implications:
The use of an online information retrieval system was associated with a significant improvement in the quality of answers provided by clinicians to typical clinical problems. Online information retrieval systems can be an effective tool in improving the quality of clinical decisions.

Year: 2003

Abstract ID: 839718775254

Title: Implementation of the Dutch STD practice guideline for general practitioners
First author: Jan van Lieshout
Further authors: MT Mastboom, Dr L Pijnenborg, Dr AN Goudswaard
E-mail: j.vanlieshout@nhg-nl.org
Organisation: Dutch College of General Practitioners
Address: PO Box 3231, 3502 GE Utrecht, The Netherlands; phone +3130-2881700 / fax +3130-2870668
Category: CPG Implementation

Abstract
Background:
The Dutch College of General Practitioners (DCGP) has published about 80 practice guidelines specific for the general practitioner. These guidelines are widely appreciated and accepted both by general practitioners and other professionals in the health care system. A study using specific indicators showed that GP's act in line with these guidelines in on average 74% of the cases. This percentage is reached by spending much attention to acceptance of the guidelines by GP's and by an implementation programme.

Objective:
To inform about the specific way the DCGP enhances implementation of practice guidelines, illustrated by the development of our new guideline Sexually Transmitted Diseases (STD).

Methods:
An overview of the procedure both during and afterwards the development of the guideline with focus on aspects that enhance implementation.

Results:
DCGP-staff members and GP's working in every day practice with expertise on the topic developed a concept-guideline. During a conference, 23 GP's and medical specialists discussed this concept in 3 groups and plenary afterwards. They gave comments and stated which recommendations should be supported by materials for implementation. This led to adaptations. Finally, the guideline was authorized by a committee of GP's. After publication the DCGP Department of Implementation will develope materials to enlarge knowledge on the topics of the guideline. This includes an individual CME programme and a 'teach-the-teachers' programme. In cooperation with a national organization for STD/AIDS: a 'STD-suitcase' including a diagnostic flow chart and all necessary diagnostics will be offered to all Dutch GP's. GP performance during patient contacts is supported by integrating the guideline in the electronic medical record system as well as the electronic pharmacological advice system, wich both are ICPC guided. Finally written information for the patient is available.

Conclusions and Implications:
We showed an example of the way the DCGP gave attention to implementation during the STD guideline development, and what should be done after publication. The development of a practice guideline and implementation materials are equally important in a clinical practice guideline programme.

Year: 2004

Abstract ID: 855764523978

Title: Evidence analyses as third base of the German Guideline Clearinghouse methodology
First author: Henning Thole
Further authors: H. Trapp, I. Kopp, L. Heymans, F. Thalau, H. Kirchner, all Expert-Panels of the German Guideline Clearinghouse, G. Ollenschläger
E-mail: thole@azq.de
Organisation: Agency for Quality in Medicine, AQuMed
Address: Wegelystr. 3, D-10623 Berlin, +49 (221) - 4005-2500, +49 (221) - 4005-2555
Category: CPG Development

Abstract
Background:
The German Guideline Clearinghouse was established by AQuMed in 1999. The CPG production policy of the German scientific medical societies was taken into consideration. Main goal was to change the strategy from expert to evidence-based CPG production. Part of the contents of the clearing reports (CR) are examples taken from appraised CPGs to show best practice in CPGs. The resulting CRs are “virtual guidelines”. Up to now evidence analyses were not implemented.

Objective:
To integrate evidence analyses into the German Clearing House’s methodology, to aid in the formulation of national CPGs based on international CPGs and taking relevant evidence into account, as well as to adress the needs of national health policy based on best available evidence and national or international CPGs.

Methods:
The methodology used was based on international methodology. Main steps are critical appraisal of CPGs and the expert-based guideline appraisal of included CPGs. Eventually, 15 National CRs will have been published between 1999 and 2004, containing hundreds of citations from CPGs. The citing-only of EBM-examples was no longer fullfilling the needs of CR users. Up to 85% of the examples cited in CRs were cited from EBM CPGs, but guideline producers had to analyse and search evidence again because of missing evidence analysis in the CRs. To adress guideline authors needs, methods will be modified with evidence analyses as a third side, which will identify best evidence. The CRs then will be a compilation of existing national and international CPGs as well as evidence analyses of local needs.

Results:
Missing evidence analyses have been identified as lack of information in CRs. These will be complemented with evidence research and analyses. Thus, CRs will aid this way to enforce the information basis for CPG authors.

Conclusions and Implications:
The adding of evidence analyses will give all information for CPG producers to formulate a CPG based on best information. This will ensure the production of methodologically good CPGs in less time.
Year: 2004

Abstract ID: 874202506802

Title: Health for Kids Asthma Management: Adapting the best available guidelines to ensure the best possible care
First author: Tari Turner
Further authors: F. Wilkinson, C. Harris
E-mail: tari.turner@med.monash.edu.au
Organisation: Centre for Clinical Effectiveness, Monash Institute of Health Services Research
Address: Monash Medical Centre, Locked Bag 29, Clayton, Victoria, Australia 3168, Phone +61 39594 7568, Fax +61 3 9594 7552
Category: CPG Development

Abstract
Background:
'Health for Kids in the South East' is a Victorian Government funded project designed to improve healthcare for children through best practice and partnerships. A major aspect of the project is the development of evidence-based practice guidelines for common conditions.

Objective:
To pilot an evidence-based process for guideline development by adapting existing high quality asthma guidelines for local use by a tertiary paediatric hospital, local GPs and community health providers.

Methods:
We searched for existing evidence for developing evidence-based guidelines and distilled an evidence-based process for guideline development. We formed a multidisciplinary guideline development group (GDG) which included hospital staff, consumers and general practitioners. Existing guidelines were identified and appraised, then adapted to create a locally appropriate evidence-based practice guideline for the management of asthma in children.

Results:
We identified 2 guidelines, the British Thoracic Society Guideline on the Management of Asthma and the Royal Children's Hospital Melbourne Asthma Best Practice Guidelines, as representing the best in evidence-based management and the best in local consensus management of asthma, respectively. Adaptation involved further literature searches, changes to medications and dosing to reflect differing availability of drugs in Australia, removal of sections pertaining only to adult asthma, and changes of emphasis in consensus based recommendations. Although the changes to the content (and particularly the recommendations) were relatively minor, the GDG made substantial changes to the format and language to reflect local practice.

Conclusions and Implications:
Adapting existing high quality evidence-based guidelines is an appropriate, efficient way of creating local guidelines. Adaptation may involve substantial changes to layout and language, even if few changes are made to the recommendations of the existing guidelines.

Year: 2004

- Abstract ID: 935612656616

Title: Developing Guidelines for Clinical Implementation
First author: Tom Reeve
Further authors: none
E-mail: tom.reeve@cancer.org.au
Organisation: Australian Cancer Network
Address: GPO Box 4708, Sydney NSW 2001, Australia Ph: 02 9036 3120 Fax: 02 9036 3121
Category: CPG Development

Abstract

Background:

The Australian Cancer Network is a subsidiary of The Cancer Council Australia and the Clinical Society of Australia.

Objective:

To involve a wide spectrum of health professionals in guideline development. To develop guidelines that are affordable, readable, credible and adaptable to clinical problems.

Methods:

Telephone, letters, email to appropriate representative players to encourage them to volunteer their skills to develop usable guidelines. Face to face meetings to promote the need to embrace evidence and establish a camaraderie among the developers who collate relevant and available evidence.

Results:

Colorectal Cancer Guidelines Survey - 37.5% reading the guidelines noted that they would be changing some part of their practice in response to them.

Conclusions and Implications:

The important factor is that if professionals are involved in developing guidelines, they develop a sense of ownership of them and continue to promote them in patient care. It is important to have guideline developers understand that the most quoted

Year: 2004

Abstract ID: 96606526671

Title: Towards a standard for computer-based guidelines representation and execution: the GLARE proposal
First author: Paolo Terenziani
Further authors: A. Bottrighi, G. Correndo, G. Molino, S. Montani, M. Torchio
E-mail: terenz@di.unito.it
Organisation: Dipartimento di Informatica, Universita' del Piemonte Orientale "Amedeo Avogadro"
Address: Spalto Marengo 33, 15100 Alessandria, Italy. Phone: +39 0131 287447 – Fax: +39 0131 287440
Category: CPGs and Information Technology

Abstract
Background:
Clinical guidelines (CG) may provide crucial advantages to patients, physicians, and hospitals. The adoption of computer-based approaches provides additional advantages. Thus, many computer-based managers of CG (CGM) have been devised.
Objective:
GLARE (Guideline Acquisition, Representation and Execution) is a CGM, built from 1997 in a joint project between the University of Alessandria and Az. Osp. S. Giovanni Battista in Turin, the second largest hospital in Italy. GLARE aims to be a user-friendly, domain-independent (i.e., it must be able to manage CG from different domains) and task-independent (i.e., it might be used for decision support, education, critique, or evaluation) tool to acquire, represent, store and execute CGs.
Methods:
GLARE has been built according to the following principles/methodology: (1) the representation formalism has been devised in such a way that clinical knowledge is independent of its use (2) the formalism has been devised in a strict cooperation between computer scientists and physicians. We identified a limited number of " physician-oriented" primitives. (3) GLARE has a modular architecture. It distinguishes between acquisition, execution, and graphical interface.
Results:
A prototype of GLARE has been built in Java. It has been successfully used in order to manage CG about bladder cancer, reflux esophagitis, heart failure and ischemic stroke. The most advanced features of GLARE are its decision making facilities and its treatment of temporal constraints. Several papers about GLARE have been published in the Proc. of AMIA and MedInfo (see also Artificial Intelligence in Medicine 23, 249-276, 2001).
Conclusions and Implications:
The acquisition phase is the most critical one, requiring the assistance of a knowledge engineer. On the other hand, user-physicians have appreciated the possibility of executing guidelines on patients, exploiting GLARE's simulation and decision-making facilities. The project has now obtained a new grant from the hospital.

Year: 2004

- Abstract ID: 970241899785

Title: Evidence-based guidelines on management of acute simple low back pain
First author: Dr. CHENG Lisa pui-kwan (LPK CHENG)
Further authors: Drs. Christie Chan, KT Lau, MY Ng, Charmaine Tse, WK Lam, Linda Hui and Luke CY Tsang
E-mail: chenglisa@graduate.hku.hk
Organisation: Clinical Audit and Guideline Working Group, Professional Development and Quality Assurance (PDQA) , Department of Health, Government of Hong Kong, Hong Kong
Address: Professional Development and Quality Assurance, Kowloon Families Clinic, 6thFl., Yau Ma Tei Jockey Club Clinic, Battery Street, Yau Ma Tei, Kowloon, Hong Kong (phone +852 23882351, mobile +852 93063881, fax +852 27839035)
Category: CPG Development

Abstract
Background:
no. 241191687515 Low back pain occurs in about 80% of people (evidence level C). Within 6 weeks 90% of episodes will resolve satisfactorily regardless of treatment (level C) It is an important and practical topic in primary health care.
Objective:
Few management strategies for back pain have been proved in primary care, partly because most cases settle within a few weeks. The aim of this guideline on the management of acute simple low back pain is to facilitate primary care team to practice evidence-based medicine in making diagnosis, examining, treating and giving advice to patients with acute simple low back pain, thus improving the quality of care in acute simple low back pain.
Methods:
Evidence based guidelines developed by international researchers and organizations were studied and adopted according to the setting of our primary care service. The guidelines include: 1. National Guideline Clearinghouse.1997 (revised 2003 Apr) 2. Low Back Pain Evidence Review Royal College of General Practitioners (1999) 3. Cochrane Review. The Cochrane Library, Issue 1, 2004. 4. Clinical Standards Advisory Group. Management guidelines for back pain (1994) 5. Quebec Task Force guidelines6 6. US Agency for Health Care Policy and Research.

Results:
The guidelines are listed below with level of evidence according to US Agency of Health Care Policy and Research: Diagnosis Systemic symptoms noted (level 3 evidence, level C recommendation) Nerve root symptoms noted (level 3 evidence, level C recommendation) Examine for spinal deformity (level 3 evidence, level C recommendation) Management Diagnosis: acute simple low back pain documented (level 3 evidence, level C recommendation) NSAID/analgesics/opiates/muscle relaxants were given on regular basis (level 1 evidence, level A recommendation) Follow-up of 1-3 weeks on prn basis offered No X ray of lumbar spine was ordered (level 3 evidence, level C recommendation) No physiotherapy referral No orthopaedics specialist referral Advise against bed rest (level 1 evidence, level A recommendation) Advice on staying active and continue daily activities (level 1 evidence, level A recommendation) Reassurance

Conclusions and Implications:
As back pain is one of the commonest conditions managed in primary care, it is responsible each year for about 12 million general practitioner consultations, over 50 million work days lost, and almost pounds sterling500m costs to the NHS. The implications of this guideline is to ensure the practice evidence-based medicine in the management of low back pain and to improve quality of management of low back pain.
Year: 2004

Abstract ID: 971557282782

Title: Constructing Validated Chronic Disease Registers – a General Practice Team Initiative
First author: David Nixon General Practitioner The Doctors Masterton
Further authors: F Samuel Practice Nurse, The Doctors Masterton; K Preston, Primary Care IT Solutions Ltd.
E-mail: david@mn.thedoctors.co.nz
Organisation: The Doctors, 43 Chapel Street, Masterton, New Zealand
Address: The Doctors, 43 Chapel Street, Masterton, New Zealand Tel 06-3700067 Fax 06-3701069
Category: CPG Implementation

Abstract
Background:
Effective Chronic Disease Management (CDM) has been shown to reduce both morbidity and mortality. Consequently practice performance in CDM has become a national priority, consituting a significant part of the recent New Zealand PHO Clinical Performance Indicators (CPI's).

Objective:
To design and implement a robust system for creating and validating Chronic Disease Registers (CDR's). To use CDR's to audit clinical performance with respect to the proposed CPI's.

Methods:
A team was convened, comprising nursing, administration and medical staff. A structured medication review protocol was developed which was triggered by patients requesting repeat prescriptions. Their medical and drug records were reviewed and the Read code summaries updated, using standardised Read codes. Nurses screened all incoming mail and flagged patients identified as suffering from a CDM for GP Read coding. We produced database queries which selected patients that may have been previously erroneously coded or who where on disease-specific medications which indicated the diagnosis, e.g. thyroxine for hypothyroidism.

Results:
Within nine months from inception we were able to produce validated CDR's for 13 chronic diseases. Our CDR's compared favourably with National Prevalence rates: Asthma Register = 1063 patients 14.7% of practice population (National Prevalence 15%); Hypertension Register = 794 patients 11.0% (10 to 15%); Diabetes Register = 249 patients 3.4% (2.5-5%). By using these registers with refined database tools we were able to demonstrably improve our performance in selected areas e.g. within the last twelve months 98% of out IHD register patients have had their BP checked, 96% had their smoking status documented and 94% had their lipids checked.

Conclusions and Implications:
Our validated CDR's fit with the national prevalence rates for their respective conditions and have proved very useful for allowing an audit of performance and facilitating call/recall and identifying patients who are non-responders or who have been lost to recall.
Year: 2004

Abstract ID: 976323297656

Title: Evidence-based information for health practitioners: dilemmas and solutions from an Australian perspective
First author: Ms Katherine Vaughan
Further authors: Dr Alison Evans, Dr Karen Luxford, Dr Elmer Villanueva, Dr Helen Zorbas
E-mail: kath.vaughan@nbcc.org.au
Organisation: National Breast Cancer Centre (NBCC) Australia
Address: Locked Bag 16, Camperdown NSW 1450 Australia; Phone: +612 9036 3049; Fax: +612 9036 3077
Category: CPG Development

Abstract
Background:
The NBCC has been a leader in Australian CPGs, developing and implementing 9 comprehensive sets of breast and ovarian cancer-related CPGs since its establishment in 1995. However, as experienced by other CPG developers, development and updating of CPGs has been slow and resource intensive, each taking about 3 years to complete, including peer-review and endorsement by the Australian government. These comprehensive, paper-based CPGs quickly become out-of-date in areas with rapidly emerging evidence. The NBCC shares challenges faced by other information providers in supplying stakeholders with up-to-date evidence-based information in a timely and cost-effective manner.

Objective:
Explore approaches to ensuring Australian health practitioners are kept up-to-date about evidence impacting on clinical practice in breast and ovarian cancer within budgetary constraints.

Methods:
Approaches employed by local and international organisations to develop, update and disseminate evidence-based information were examined. These widely varying approaches were used to inform an NBCC strategy for maintaining the currency of evidence-based information for health practitioners.

Results:
As no single approach appeared to be more effective or used more frequently than any other, the NBCC developed a strategy to pilot a range of approaches, including: • a move from complete, paper-based sets of CPGs to searchable, topic-specific web-based CPGs • prioritisation of topics for systematic ongoing surveillance • alternative methods of CPG endorsement • alternative avenues for publishing CPG updates, such as supplements to clinical journals and the NBCC website • dissemination of key emerging clinical evidence directly to health practitioners via e-alerts and fax-alerts.

Conclusions and Implications:
New approaches are required to ensure evidence-based information is developed and updated in a timely manner within budgetary constraints. Ongoing lessons learned will have broad implications for CPG development, dissemination and implementation.

Year: 2004

Abstract ID: 97851366629

Title: Guidelines International Network (G-I-N) and its website – A set of tools for international cooperation and information on guideline development and implementation
First author: Henrike Trapp
Further authors: Maienborn A, Ollenschlaeger G, Marshall C, Wrapson C, Barlow A, Dechant K
E-mail: trapp@azq.de
Organisation: Agency for Quality in Medicine
Address: Wegelystr. 3; 10623 Berlin; Germany; Phone 030 40052500; Fax 030 40052555
Category: CPGs and Information Technology

Abstract
Background:
Around the world many organisations work in the field of clinical practice guidelines (CPGs). G-I-N supports international collaboration of such organisations and seeks to improve the quality of health care by promoting systematic development of CPGs and their application into practice. G-I-N's major tool is its website www.g-i-n.net.

Objective:
To provide a platform for G-I-N members to share information and collaborate in projects as well as to inform the public.

Methods:
G-I-N has had a web presence for more than 18 months and the current database driven site represents a cooperative effort by visionary, technical and editorial contributors. The site consists of public and member-only areas containing informative resources as well as databases (members, guidelines), interactive features supporting international collaboration (Discussion Forum, online AGREE Instrument) and administrative tools for G-I-N members to manage their own content.

Results:
A major feature of the members' area is the Guideline Library. Since the site's 'go-live' date in November 2003, more than 2400 guideline programmes have been entered. They can be searched by MeSH based subject headings, formal criteria (e.g. language), and other refining options (e.g. publication scope). An example of international collaboration through the website is Clinical Practice Guidelines Reference Architecture, a project to develop an XML Schema that aims to represent narrative CPGs. A discussion forum has been established to allow members to share views and experiences. Another example is the online AGREE instrument which allows members to post their guidelines for public evaluation. Public sections contain links to training and consumer materials and extracts of the Guideline Library.

Conclusions and Implications:
Starting with 37 Founder Members from 20 countries, membership has increased to 52 organisations and 8 individual members from 29 countries. This indicates that G-I-N, through its website, has assisted in closing a gap in international guideline collaboration.
Year: 2004