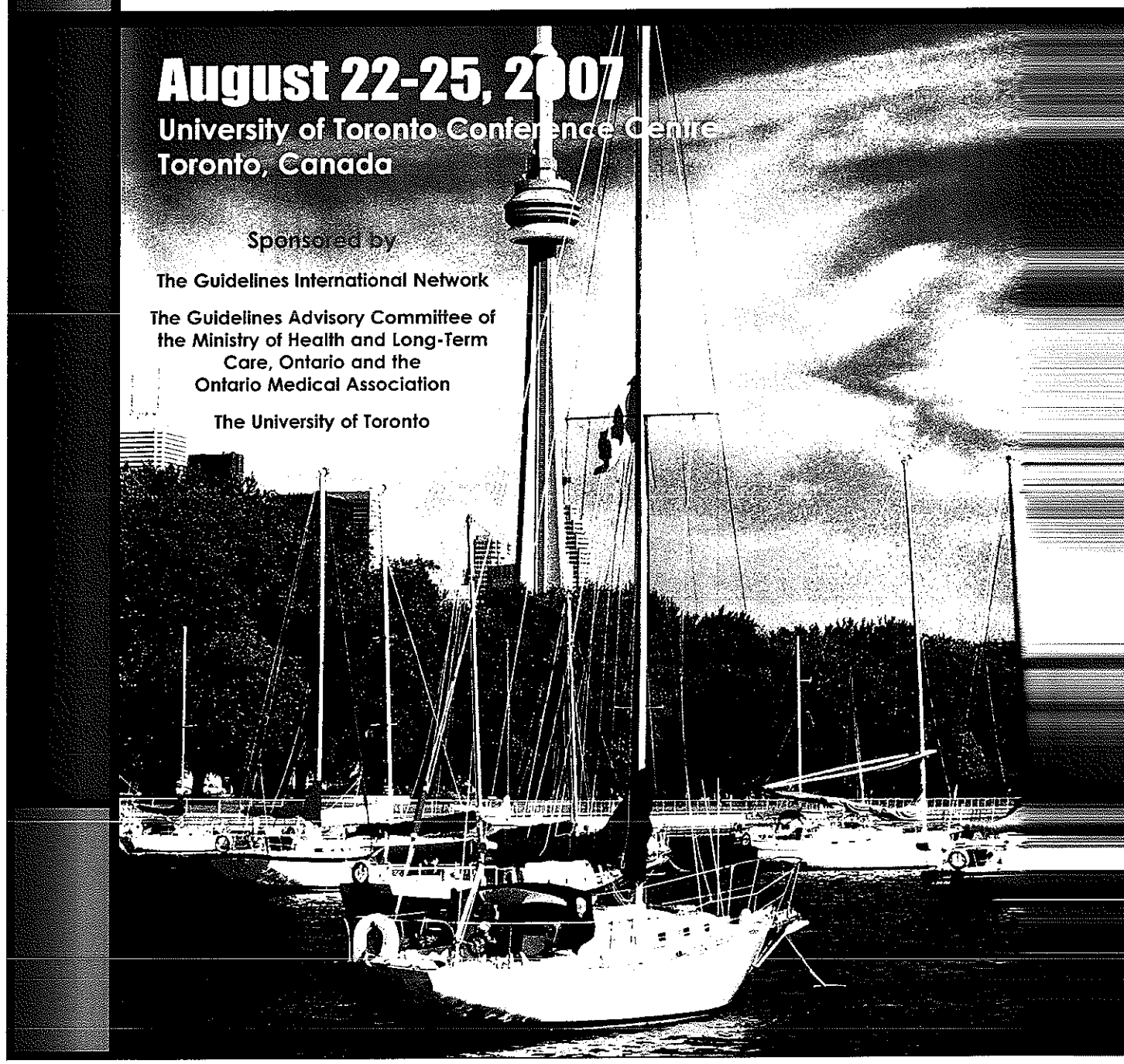
4th Annual G-I-N Conference

Collaboration in Clinical Practice Guidelines



August 22-25, 2007

University of Toronto Conference Centre
Toronto, Canada

Sponsored by

The Guidelines International Network

The Guidelines Advisory Committee of the Ministry of Health and Long-Term Care, Ontario and the Ontario Medical Association

The University of Toronto

We gratefully acknowledge our Supporters:

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This conference has been generously supported by a grant from the Ontario Ministry of Health and Long-Term Care. The views expressed do not necessarily reflect those of the ministry.

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CIHR IRSC
Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

The Canadian Institutes of Health Research's support for this conference was awarded through a Knowledge Translation Workshops and Symposia grant.

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4th Annual G-I-N Conference
Collaboration in Clinical Practice Guidelines

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The Guidelines International Network

Hosts:

The Guidelines Advisory Committee of the Ministry of Health and Long-Term Care, Ontario, and The Ontario Medical Association

The University of Toronto

Co-Sponsors:

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Canadian Cardiovascular Society

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Evidence Matters

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Ontario College of Family Physicians

Project Globe Consortium for Continuing Professional Development

Quality Healthcare Network, Canada

Registered Nurses' Association of Ontario

Royal College of Physicians and Surgeons of Canada

Society for Academic Continuing Medical Education

Welcome Message

Dear participants,

On behalf of the scientific committee and the Board of Trustees of the Guidelines International Network (G-I-N), we are very pleased to welcome you to the fourth G-I-N Conference in Toronto.

This is the first G-I-N conference in North-America, an event which celebrates the pioneering role of Canada and USA in evidence-based guideline development. The Canadian Task Force on Preventive Health Care designed the first system of evidence grading in 1979. The Agency for Health Care Policy and Research (AHCPR, now Agency for Healthcare Research and Quality, AHRQ) adapted the system and formulated quality criteria for guidelines in 1991. These criteria formed the basis for the development of the AGREE Instrument (2001), which is used in many countries around the world nowadays. G-I-N has adopted the principles of evidence-based guideline development and aims to promote the systematic development of guidelines and their application into practice worldwide.

G-I-N is grateful to our Canadian colleagues for hosting its fourth annual conference and for encouraging widespread communication of innovation in guidelines to the international community.

The theme of the conference is **Collaboration in Clinical Practice Guidelines.** This follows the theme in 2005 - 'Guidelines in Context' - which raised awareness of the influence of country and region specific factors in guideline development and implementation. Bearing this in mind, we believe that the next step in the guidelines movement is to collaborate!

This conference will offer many opportunities to meet and develop collaborations with people and organisations, through workshops, discussion, networking and informal sessions.

The annual conferences of G-I-N have proven to be essential for the success of G-I-N. Previous conferences in Edinburgh (2003), Wellington (2004) and Lyon (2005) have been much appreciated and attracted new organisations to become members of G-I-N. We attempted to design a program appealing to both organisations with well-established guideline programs and organisations that are in the beginning of evidence-based guideline development. The program should optimize the sharing of research findings, best practices and innovative ideas.

We would like to thank the members of the organising committee and the Office of Continuing Education and Professional Development for pulling together the program and the exciting social events. We also thank the generous support from our sponsors and are proud to have so many Canadian and US agencies supporting our work.

Get inspiration and enjoy your time at the fourth G-I-N conference in Toronto!
We are looking forward to welcoming you.

Jako Burgers
Chair of the Scientific Committee
Vice-chair of G-I-N
www.g-i-n.net

Dave Davis
Conference Host
Chair of G-I-N
www.gin2007.org

International Scientific Committee

Jeff Andrews, MD
Associate Professor of Medical Education
and Senior Fellow
Vanderbilt Center for Evidence-Based Medicine
Nashville, Tennessee, USA

Dave Atkins, MD, MPH
Chief Medical Officer
Center for Outcomes and Evidence
US Agency for Healthcare Research and Quality
Rockville, Maryland, USA

Jako Burgers, MD, PhD (Chair)
Guideline Program Director
Dutch Institute for Healthcare Improvement CBO
Utrecht, The Netherlands

Melissa Brouwers, BSc, MA, PhD
Associate Professor
Department of Clinical Epidemiology & Biostatistics
McMaster University
Director, Program in Evidence-Based Care
Cancer Care Ontario
Hamilton, Ontario, Canada

Heather Buchan, MBChB, MSc, FAFPHM
Chief Executive Officer
National Institute of Clinical Studies
Melbourne, Australia

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Technical Advisor
Centre for Clinical Practice
National Institute for Health and Clinical Excellence
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Ottawa, Ontario, Canada

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Helsinki, Finland

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Hon Patron G-I-N, New Zealand
Independent Guideline Advisor
and Health Sector Consultant
Wellington, New Zealand

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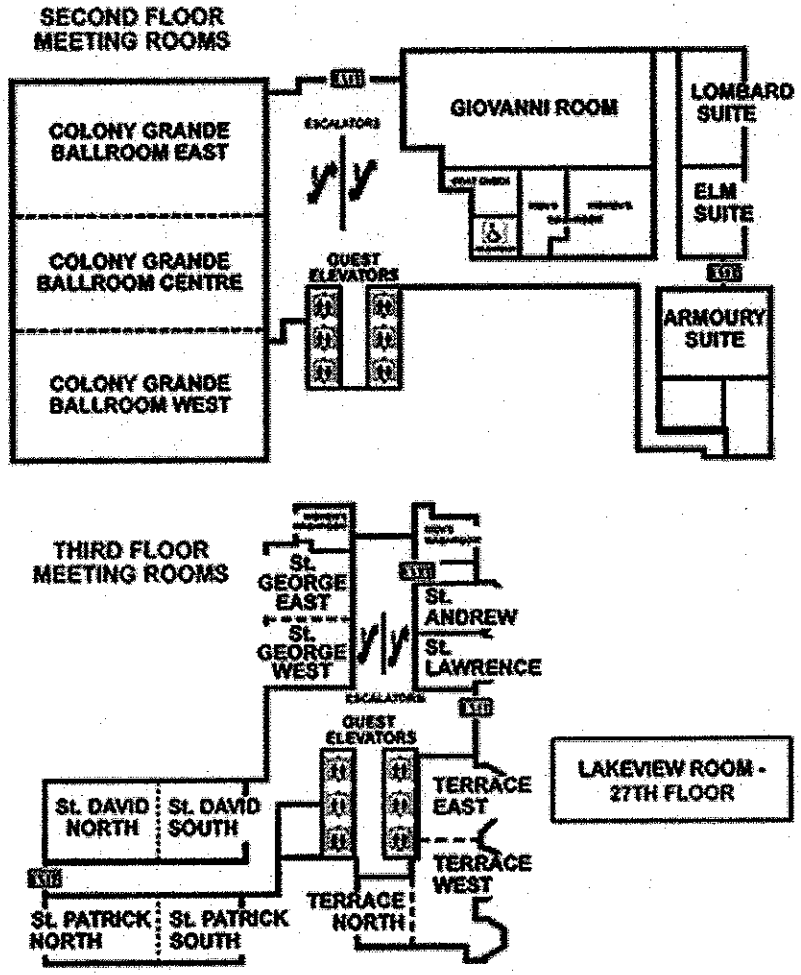
Managing Director
Sowerby Centre for Health
Informatics at Newcastle
Newcastle upon Tyne, United Kingdom

Rick Shiffman, MD, MCIS
Associate Director for Education
Yale Center for Medical Informatics
New Haven, Connecticut, USA

Jean Slutsky, PA, MSPH
Director
Center for Outcomes and Evidence
US Agency for Healthcare Research and Quality
Rockville, Maryland, USA

Floor Plan for Meeting Rooms

University of Toronto Conference Centre
89 Chestnut Street



All G-I-N 2007 Program Functions will be held at the University of Toronto Conference Centre:

Registration ..... Foyer, 2nd Floor
Welcome Reception ..... Lakeview Room, 27th Floor
Continental Breakfasts ..... Colony Grande (West) & Giovanni Room
Refreshment Breaks ..... Colony Grande (West) & Giovanni Room
Lunch ..... Colony Grande Ballroom (Centre & East)
Plenary Sessions ..... Colony Grande Ballroom (Centre & East)
Networking Sessions ..... Lakeview Room, 27th Floor
Thematic Discussion Sessions ..... Various Rooms (please see program)
Workshops ..... Various Rooms (please see program)
Posters ..... Colony Grande Ballroom (West)
Exhibits ..... Giovanni Room
Internet Café ..... St. Lawrence Room

Table of Contents

Program at a Glance

Each day will comprise plenary sessions with outstanding keynote speakers and concurrent sessions including oral presentations, workshops, discussion/ networking sessions and posters.

Wednesday, August 22, 2007

4:00 pm **Registration and Poster Set-up**

5:00 pm **Welcome Reception** (until 8:00 pm)
University of Toronto Conference Centre

Thursday, August 23, 2007

7:30 am Registration, Continental Breakfast & Poster Set-up

7:30 am Internet Café (until 6:00 pm)

8:30 am **Opening Ceremony:**

Welcome to G-I-N 2007, Welcome to Toronto! ..... Jako Burgers, MD, The Netherlands
Chair, G-I-N 2007

Brief Opening Remarks and a special Canadian welcome to Toronto ..... Dave Davis, MD
Conference Host

Adalsteinn Brown, PhD, Canada
Assistant Deputy Minister for Health Strategy
Ministry of Health and Long-Term Care, Ontario

9:00 am **Plenary 1 - Transferring Knowledge to Professionals**

Chair: Melissa Brouwers, PhD, Canada

From Best Evidence to Best Practice ..... Carolyn Clancy, MD
US Agency for Healthcare Research and Quality

9:40 am **Discussant:** What Can be Globalised or Shared Nationally and Internationally by Collaboration? ..... Ilkka Kunnamo, PhD, Finland

10:00 am Open Discussion

10:15 am Pause Café, Exhibits and Poster Viewing

10:45 am **Parallel Session 1:**

- Case Studies in Guideline Adaptation
- Quality Appraisal of Guidelines and Indicators
- Case Studies in Developing Guidelines (1)
- Making and Updating Recommendations
- Case Studies of Guideline Programs: Some National Examples
- Workshops, Thematic Discussion and Network Sessions
- Finding the Evidence - Process & Interpretation

12:15 pm Lunch

1:30 pm **Parallel Session 2:**

- Case Studies in Collaboration (1)
- New Methods in Guideline Development
- Diagnostic and Qualitative Evidence in Guidelines
- Issues in Risk Assessment and Preparedness
- Plans of Action: Supporting Knowledge Transfer
- Workshops, Thematic Discussion and Network Sessions

3:00 pm Pause Café, Exhibits and Poster Viewing

3:30 pm **Plenary 2 - Achieving Collaboration Through an International Guidelines Network: The G-I-N Story**

Chairs: Françoise Cluzeau, PhD, United Kingdom and Minna Kaila, MD, Finland
Coordinator: Angela Maienborn, MD, Germany

4:45 pm Open Discussion

5:00 pm **Annual General Meeting, G-I-N** (until 6:30 pm)

Friday, August 24, 2007

8:00 am Registration & Continental Breakfast

8:00 am Internet Café (until 6:00 pm)

9:00 am **Plenary 3 - Guidelines to Help Policy-Makers**

Chair: Heather Buchan, MD, Australia

The Need for Transparency in Guidelines ..... Peter Littlejohns, MBBS, BSc, MD
National Institute for Health and Clinical Excellence, UK

9:30 am **Discussants:** What Can the World Learn from NICE?
A Perspective from USA ..... Paul Shekelle, MD, PhD, USA
A Perspective from Canada ..... Andreas Laupacis, MD, Canada

10:00 am Open Discussion

10:15 am Pause Café, Exhibits & Poster Viewing

10:45 am **Parallel Session 3:**

- Guidelines from the Perspective of the Policy Maker
- Case Studies in Evaluating Guidelines
- Process and Frameworks for Implementation
- The Patient's Role in Guidelines
- Considering the Health Professional and the Setting in Guideline Implementation
- Workshops, Thematic Discussion and Network Sessions

12:15 pm Lunch

1:30 pm **Parallel Session 4:**

- Barriers to Implementing Guidelines
- Case Studies in Developing Guidelines (2)
- Educational Methods to Implement Guidelines
- Evaluating Guidelines - Some National Perspectives
- Imbedding Information Technology into the Guideline Process
- Workshops, Thematic Discussion and Network Sessions

3:00 pm Pause Café, Exhibits & Poster Viewing

3:30 pm **Plenary 4 - Implementation Programs: Some Success Stories**
Chairs: Jeremy Grimshaw, PhD, Canada
and Catherine Marshall, New Zealand

3:55 pm Introduction and Overview ..... Richard Grol, PhD, The Netherlands

4:05 pm A Successful Implementation Program in France ..... Jean Michel Chabot, France

4:15 pm Successful Regional Programs in Germany ..... Guenter Ollenschläger, MD, Germany

4:25 pm The Successful Use of Tools for Finnish Professionals ..... Minna Kaila, MD, Finland

4:45 pm Open Discussion

5:30 pm Transportation from the Delta Chelsea Hotel and 89 Chestnut street to The Liberty Grand (until 6:15 pm)

6:30 pm **The G-I-N 2007 Gala Reception, Dinner & Entertainment** (until 10:30 pm)

10:00 pm Transportation from the Liberty Grand to the Delta Chelsea Hotel and 89 Chestnut Street (until 11:00 pm)

Saturday, August 25, 2007

8:00 am Registration & Continental Breakfast

8:00 am Internet Café (until 2:00 pm)

Plenary 5 - Fitting Guidelines into the Real World
Chair: Jean Slutsky, PA, USA

9:00 am Transforming CPGS into Electronic Tools ..... Rick Shiffman, MD, USA

9:30 am Addressing Complexity in Guidelines ..... Paul Wallace, MD, USA

10:00 am Open Discussion

10:15 am Pause Café, Exhibits & Poster Viewing

10:45 am **Parallel Session 5:**

- Case Studies in Collaboration (2)
- Implementing Guidelines: Tools and Strategies
- Evaluating Guidelines Strategies: Tools and Methods
- Assessing the Impact of Guidelines: The North American Experience
- Guideline Implementation: Multiple Methods, Multiple Questions
- Achieving Sustainability in Guideline Development and Implementation
- Workshops, Thematic Discussion and Network Sessions

12:15 pm **Plenary 6 - Overview and Discussion** ..... Jako Burgers, MD, The Netherlands, *Chair G-I-N 2007*
..... Dave Davis, MD, USA, *Conference Host*
Evaluation and Adjournment

1:00 pm Post-Conference Meetings for G-I-N Board (until 5:00 pm)

Keynote Speakers

Carolyn Clancy, MD
Director
US Agency for Healthcare Research and Quality
Rockville, Maryland, USA

Peter Littlejohns, MBBS, BSc, MD, FRCP
Clinical Director
National Institute for Health
and Clinical Excellence
London, United Kingdom

Disclosure

Speakers have been requested to disclose to the audience and real or apparent conflict(s) of interest that may have a direct bearing on the subject matter of this program. At time of print, no one had anything to declare.

Accreditation

This event is an Accredited Group Learning Activity (Section 1) as defined by the Maintenance of Certification program of the **Royal College of Physicians and Surgeons of Canada**, approved by the University of Toronto (15 credits).

This program meets the accreditation criteria of the **College of Family Physicians of Canada** and has been accredited for 15 Mainpro-M1 credits.

Members of the **American Academy of Family Physicians** are eligible to receive up to 15 Prescribed credits for attendance at this meeting due to a reciprocal agreement with the College of Family Physicians of Canada.

The Office of Continuing Education and Professional Development, Faculty of Medicine, University of Toronto designates this educational activity for a maximum of 15 category 1 credits toward the **AMA Physician's Recognition Award**. Each physician should claim only those credits that he/she actually spent in the activity.

European Accreditation Council for Continuing Medical Education (EACCME). As a result of a reciprocal agreement between the EACCME and the AMA, European registrants may claim AMA Category 1 credits as equivalent.

Letters of Accreditation or Attendance
Letters of accreditation/attendance are distributed at the end of the program. If you are leaving earlier, you may request your letter from us at that time. We do not routinely mail out accreditation letters. Should you forget to pick up your letter at the conference, please contact the Office of Continuing Education and Professional Development.

Plenary Speakers & Discussants

Jean Michel Chabot
Paris, France

Richard Grol, PhD, FRCGP
Director, Centre for Quality of Care Research (WOK)
Nijmegen, The Netherlands

Minna Kaila, MD, PhD
Senior Medical Officer
Programme Manager/MUMM-programme
Finnish Office for Health Care Technology Assessment
Tampere, Finland

Ilkka Kunnamo, MD, PhD
Editor-in-Chief
The Finnish Medical Society Duodecim
Helsinki, Finland

Andreas Laupacis, MD
Director
Li Ka Shing Knowledge Institute, St. Michael's Hospital
Toronto, Ontario, Canada

Günter Ollenschläger, MD
Director
German Agency for Quality in Medicine
Berlin, Germany

Paul Shekelle, MD, PhD
Director
Southern California Evidence-Based Practice Center,
RAND Corporation
Los Angeles, California, USA

Rick Shiffman, MD, MCIS
Associate Director
The Center for Medical Informatics
at Yale University School of Medicine
New Haven, Connecticut, USA

Paul Wallace, MD
Medical Director for Health and
Reproductivity Management Programs
The Permanente Foundation, Kaiser Permanente
Oakland, California, USA

Social Events

Opening Reception
Wednesday, August 22, 2007
5:30 pm to 8:00 pm
University of Toronto Conference Centre,
89 Chestnut Street, Lakeview Room, 27th Floor

Join us for a relaxed and informal orientation to Toronto and the 4th Annual G-I-N Conference.

Gala Banquet
Friday, August 24, 2007
6:30 pm to 9:45 pm
Toronto's Liberty Grand

This delightful evening will include a four-course meal, wine and transportation to and from this beautiful Toronto landmark. Entertainment and food will reflect Canada's past and its exciting, multicultural future.

Family Attractions In Toronto

Family Fun Zone at The Delta Chelsea Hotel

The conference hotel, the Delta Chelsea, is known for its "Family Fun Zone" which features the "Corkscrew" waterslide. The 130-foot waterslide is encased in a four-storey glass tower and is suspended above Walton Street, just off downtown Toronto's famous Yonge Street. Swimmers slide through two loops inside the tower, exit the building over Walton Street and re-enter with a splash into the family pool. The "Corkscrew" is heated and operates year-round. A thrilling ride in any season!

The Family Fun Zone also features a separate family pool, Children's Creative Centre and Starcade Games Room.

The Canadian National Exhibition (CNE)

One of Canada's oldest, and its largest exhibition, calls Toronto home. During your visit to Toronto for G-I-N 2007, consider visiting the annual fair that we Torontonians fondly call the "Ex". A trip to the "Ex" is a wonderful opportunity for family fun.

Conveniently located in Downtown Toronto, the CNE features outdoor amusement park rides, indoor cultural shows, educational agricultural displays, carnival-themed "snacking" and multi-ethnic cuisines, shopping, fireworks and a wonderful sense of history.

Other family attractions:

Canada's Wonderland

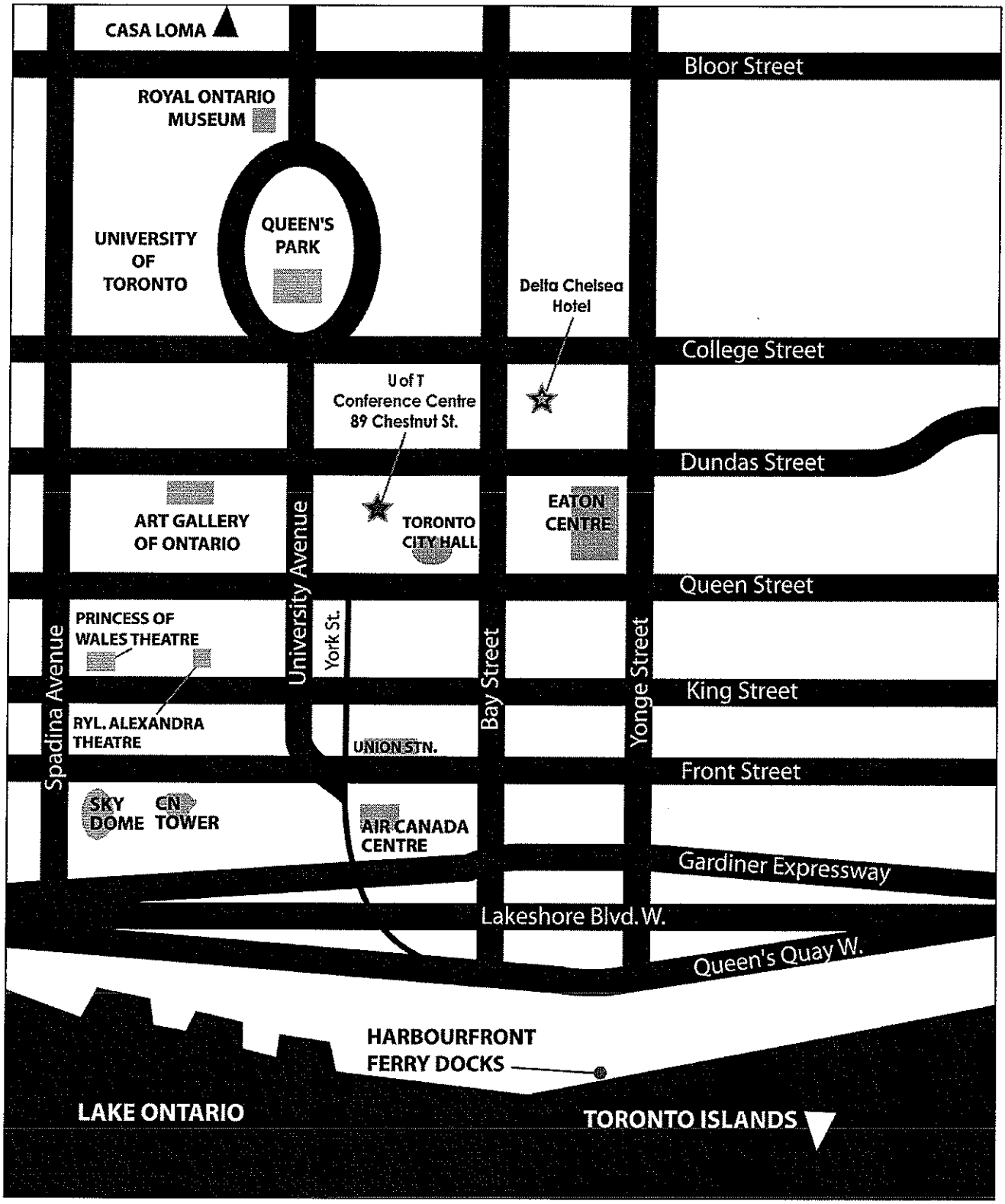
Centre Island

Ontario Place - Downtown Toronto's water park

The Royal Ontario Museum

Toronto Zoo

Area Map


CASA LOMA
Bloor Street
ROYAL ONTARIO MUSEUM
UNIVERSITY OF TORONTO
QUEEN'S PARK
Delta Chelsea Hotel
College Street
U of T Conference Centre 89 Chestnut St.
Dundas Street
ART GALLERY OF ONTARIO
TORONTO CITY HALL
EATON CENTRE
Queen Street
PRINCESS OF WALES THEATRE
RYL. ALEXANDRA THEATRE
UNION STN.
King Street
Front Street
SKY DOME
CN TOWER
AIR CANADA CENTRE
Gardiner Expressway
Lakeshore Blvd. W.
Queen's Quay W.
HARBOURFRONT FERRY DOCKS
LAKE ONTARIO
TORONTO ISLANDS
Spadina Avenue
University Avenue
York St.
Bay Street
Yonge Street

Each Brief Presentation is 15 minutes with 5 minutes for Questions and Answers.

Each Lecture is 30 minutes with 5 to 10 minutes for Questions and Answers.

FORMAT CODES:

B - Brief Presentation
L - Lecture
W - Workshop
N - Networking Session
T - Thematic Discussion Session

Wednesday, August 22, 2007

4:00 pm Registration and Poster Set-up ..... Foyer, 2nd Floor & Colony Grande (West)

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Poster Set-up ..... Colony Grande Ballroom (West)

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Chair, G-I-N 2007

Brief opening remarks and a special Canadian welcome to Toronto ..... Dave Davis, MD
Conference Host

Adalsteinn Brown, PhD, Canada
Assistant Deputy Minister for Health Strategy
Ministry of Health and Long-Term Care, Ontario

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Chair: Melissa Brouwers, PhD, Canada

From Best Evidence to Best Practice ..... Carolyn Clancy, MD
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9:40 am **Discussant:**
What Can be Globalised or Shared Nationally
and Internationally by Collaboration? ..... Ilkka Kunnamo, MD, PhD, Finland

10:00 am Open Discussion

10:15 am Pause Café, Exhibits and Poster Viewing ..... Giovanni Room & Colony Grande Ballroom (West)

10:45 am **Parallel Session 1** (session rooms subject to change)

Case Studies in Guideline Adaptation Armoury Suite

L01 GUIDELINES IN AN ABORGINAL COMMUNITY

Margaret B. Harrison, Fairleigh Seaton, Jennifer Medves, Susan McLeod, Susan Laschinger, Cheryl Pulling, Ian D. Graham (Queen's University School of Nursing, Community Health & Epidemiology, Queen's University .... School of Nursing, Weeneebayko Hospital, Moose Factory, Canadian Institutes of Health Research)

B01 HAS' EXPERIENCE IN ADAPTING INTERNATIONAL CLINICAL PRACTICE GUIDELINES FOR LOCAL USE
Najoua Mlika-Cabanne, Michel Laurence, Patrice Dosquet (Haute Autorité de Santé (HAS), Saint-Denis La Plaine, France)

B02 THE ADAPTE PROCESS: APPLICATION ON THE PERIOPERATIVE TREATMENT FOR RESECABLE NON SMALL CELL LUNG CANCER (NSCLC)
Clotilde Séblain El Guerche, Sylvie Guillo, Guillaume Gory Delabaere, Anne Bataillard, Béatrice Fervers (Fédération Nationale des Centres de Lutte Contre le Cancer (FNCLCC)-Lyon- France, FNCLCC- Paris-France, FNCLCC- Paris - France, FNCLCC-Lyon- France, FNCLCC and Centre Léon Bérard-Lyon- France)

B03 ADAPTATION OF CLINICAL PRACTICE GUIDELINES FOR THE LOCAL CONTEXT IN BELGIUM: AN EXPERIMENT WITH TWO TOPICS
Paul Van Royen, Lieve Peremans, Jan Michels, Kristien Dirven, Nathalie Van de Vyver, Hilde Philips, Frans Govaerts, Martine Goossens, An De Sutter (University of Antwerp, Antwerp, Belgium, Domus Medica, Antwerp, Belgium, University of Gent, Gent, Belgium)

B04 NICE AND SHORT? DEVELOPING BRIEF CLINICAL GUIDELINES FOR THE NATIONAL HEALTH SERVICE IN ENGLAND AND WALES
Tim Stokes, Toni Tan, Francis Ruiz, Janette Boynton, Michael Heath, Nicole Elliott (National Institute for Health and Clinical Excellence (NICE), Manchester and London)

Quality Appraisal of Guidelines and Indicators — Lombard Suite

B05 ASSESSMENT OF THE SCOPE AND QUALITY OF CLINICAL PRACTICE GUIDELINES IN BURN INJURY
E. Kis MD, I. Szegesdi MD, É. Dobos MD, Kemény MD, DSc (Burn and Plastic Surgery Unit of the Department of Dermatology and Allergology, Department of Anaesthesiology and Intensive Therapy of the University of Szeged, TUDOR Hungarian EBM Network)

B06 AN INTERDISCIPLINARY GUIDELINE DEVELOPMENT PROCESS: THE CLIP LOW-BACK PAIN GUIDELINES
Stéphane Poitras PT PhD , Michel Rossignol MD MSc , Clermont Dionne OT PhD , Michel Tousignant PT PhD , Manon Truchon PhD , Bertrand Arsenault PT PhD , Pierre Allard PT MBA , Manon Coté MD , Alain Neveu MD (Montreal Department of Public Health, McGill University, Montreal (Canada), Department of Rehabilitation, Laval University, Quebec City (Canada), Department of Rehabilitation, Sherbrooke University, Sherbrooke (Canada), Department of Industrial Relations, Laval University, Quebec City (Canada), School of Rehabilitation, University of Montreal, Montreal (Canada), Sir Mortimer B Davis Jewish General Hospital, Montreal (Canada), Jewish Rehabilitation Hospital, Montreal (Canada), Constance Lethbridge Rehabilitation Centre, Montreal (Canada)

B07 MAKING THE AGREE TOOL MORE USER FRIENDLY
Ann Scott, Carmen Moga, Christa Harstall, Paul Taenzer (Institute of Health Economics, Calgary Health Region Chronic Pain Centre)

B08 AGREE NEXT STEPS: CONTINUOUS QUALITY IMPROVEMENT IN THE EVALUATION OF CLINICAL PRACTICE GUIDELINES
Melissa Brouwers, Jako Burgers, Francoise Cluzeau, Dave Davis, Gene Feder, Beatrice Fervers, Jeremy Grimshaw, Steven Hanna, Michelle Kho, Peter Littlejohns, Julie Makarski, Guenter Ollenschlaeger, and the AGREE II Next Steps Group (Department of Clinical Epidemiology and Biostatistics, McMaster University, Hamilton, ON, Dutch Institute for Healthcare Improvement CBO, Utrecht, the Netherlands, St. George's Hospital Medical School, London, UK, University of Toronto, Toronto, ON, Bart's and the London Queen Mary's School of Medicine, London, UK, Federation Nationale des Centres de Lutte Contre le Cancer, Lyon, France, Clinical Epidemiology Program, Ottawa Health Research Unit, Ottawa, ON, National Institute for Clinical Excellence, London, UK, Agency for Quality in Medicine (AQuMed), Berlin, Germany)

B09 DEVELOPMENT AND VALIDATION OF A MEASUREMENT INSTRUMENT FOR APPRAISING INDICATOR QUALITY: APPRAISAL OF INDICATORS THROUGH RESEARCH AND EVALUATION (AIRE) INSTRUMENT
Johan de Koning, Anneke Smulders, Niek Klazinga (Department of Social Medicine, Academic Medical Centre, University of Amsterdam, the Netherlands / Centre for Public Health Forecasting, National Institute for Public Health and the Environment, Bilthoven, the Netherlands, Department of Social Medicine, Academic Medical Centre, University of Amsterdam, the Netherlands)

Case Studies in Developing Guidelines (1) — Elm Suite

B10 ELICITING PRIORITIES FOR GUIDELINE TOPICS FROM PATIENTS WHO HAVE CHRONIC KIDNEY DISEASE

Allison Tong, Peter Sainsbury, Bronwyn Hall, Stacy Carter, Jonathan Craig (NHMRC Centre for Clinical Research Excellence in Renal Medicine, Centre for Kidney Research, Children's Hospital at Westmead, Westmead, NSW 2145, School of Public Health, University of Sydney, Sydney, NSW 2006 , School of Public Health, University of Sydney, Sydney, NSW 2006, Centre for Values, Ethics and the Law in Medicine, University of Sydney, Sydney NSW 2006, NHMRC Centre for Clinical Research Excellence in Renal Medicine, Centre for Kidney Research, Children's Hospital at Westmead, Westmead, NSW 2145, School of Public Health, University of Sydney, Sydney, NSW 2006)

B11 WAVING- NOT DROWNING- IN THE GUIDELINES SEA

Andrew Boyden (National Heart Foundation of Australia, Canberra, Australian Capital Territory)

B12 FIELD TESTING NATIONAL PUBLIC HEALTH GUIDANCE ON SUBSTANCE MISUSE

Simon Ellis, Harry Sumnall, Lisa Jones, Karl Witty, Michelle Wareing, Kerry Woolfall, Jim McVeigh, Mark Bellis (National Institute for Health and Clinical Excellence (NICE), England, National Collaborating Centre for Drug Prevention (NCCDP), Liverpool John Moores University, England)

B13 CANADIAN BEST PRACTICE RECOMMENDATIONS FOR STROKE CARE (2006)– GUIDELINE DEVELOPMENT PROCESS

Patrice Lindsay, Alison McDonald, Stephen Phillips (Canadian Stroke Network, Queen Elizabeth II Health Sciences Centre)

B14 DEVELOPMENT AND VALIDATION OF AN EVIDENCE-BASED VENOUS ULCER GUIDELINE

Laura Bolton, Lisa Corbett, Laurie Bernato, Peggy Dotson, Scott Laraus, Diane Merkle, AAWC Gov./Regulatory Task Force (Department of Surgery (Bioengineering), UMDNJ, New Brunswick, NJ, Hartford Hospital, Hartford, CT, National Institute of Health, Bethesda, MD, Healthcare & Reimbursement Strategies, Yardley, PA, Medical Center at Princeton, Princeton, NJ, Griffin Healthcare, Milford, CT)

Finding the Evidence: Process and Interpretation — St. George West

B15 TESTING AND VALIDATING SEARCH FILTERS IN THE CONTEXT OF EVIDENCE-BASED GUIDELINE DEVELOPMENT

Rikie Deurenberg, Kitty Rosenbrand, Jako Burgers (Dutch Institute for Healthcare Improvement CBO, Utrecht The Netherlands, Dutch Institute for Healthcare Improvement CBO Utrecht The Netherlands)

B16 'SERVICE GUIDANCE': DEVELOPING RECOMMENDATIONS IN AN EVIDENCE-POOR ZONE

Andrew Cleves, Stephanie Arnold, Nathan Bromham, Karen Francis, Angela Melder, Fergus Macbeth (National Collaborating Centre for Cancer, Park House, Greyfriars Road, Cardiff, CF10 3AF, Wales)

B17 CLINICAL PRACTICE GUIDELINES AND MULTIMORBIDITY – IMPORTANT FOR DEVELOPERS AND PRACTITIONERS

Peter Rutherford, Mercia Page (National Institute for Health and Clinical Excellence, London, UK)

B19 THE NATURE OF EVIDENCE: HOW DOES EVIDENCE INFORM GUIDELINE RECOMMENDATIONS?

Sheila McNair, Melissa Brouwers, Manya Charette (Cancer Care Ontario & McMaster University)

B20 EVIDENCE BASED GUIDELINES REQUIRE A GOOD UNDERSTANDING OF THE UNDERLYING EVIDENCE – AN "INTEGRATED" CURRICULUM IN EBM FOR EUROPE

Susanne Weinbrenner, Regina Kunz, Günter Ollenschläger , Berit Meyerrose, Antje Vega-Perez, Euebm Project group (German Agency for Quality in Medicine, Berlin, Germany (AQuMed), Basel Institute for Clinical Epidemiology, University Hospital Basel, Switzerland, ÄZQ, Charité Universitätsmedizin Berlin)

Making and Updating Recommendations — Terrace West

L02 INCORPORATING GRADE WHILE UPDATING GUIDELINES: A BELGIAN EXAMPLE

Kristien Dirven, Paul Van Royen, Ann Van den Bruel, An De Sutter, Lieve Peremans, Nathalie Van de Vyver, Hilde Philips, Frans Govaerts, Jan Michels, Martine Goossens (University of Antwerp, Antwerp, Belgium, Belgian Health Care Knowledge Centre, Brussels, Belgium, University of Gent, Gent, Belgium, Domus Medica, Antwerp, Belgium)

L03 EVIDENCE INTO RECOMMENDATIONS: AN OBSERVATIONAL STUDY OF NICE GUIDELINE DEVELOPMENT GROUPS

Susan Michie, Stephen Pilling, Gene Feder, Paul Dieppe, Rosalind Raine, Francoise Cluzeau, Phil Alderson, Simon Ellis (University College London, Queen Mary's School of Medicine, MRC Health Services Research Collaboration, National Institute of Health and Clinical Excellence)

B21 UPDATING GUIDELINES: HAS' EXPERIENCE IN FRANCE

Michel Laurence, Patrice Dosquet (Haute Autorité de Santé, Saint-Denis La Plaine, France)

B22 KEEPING CLINICAL PRACTICE GUIDELINES UP TODATE USING A SYSTEMATIC MONITORING PROCESS

Sylvie Guillo, Lise Bosquet, Sophie Rousmans, Guillaume Gory-Delabaere, Anne-Gaëlle Gueganic, Anne Bataillard , SOR steering committee (National French Federation of Comprehensive Cancer Centres, Paris, France)

B18 NOT BY EVIDENCE ALONE

Eloise Clark, Edward Donovan (Cincinnati Childrens Hospital Medical Center)

Case Studies of Guideline Programs: Some National Examples — St. Patrick Room

L04 THE GUIDELINES ADVISORY COMMITTEE: ONTARIO'S APPROACH TO GUIDELINE APPRAISAL AND ADOPTION

Valerie Palda, Jess M. Rogers, Atul K. Kapur, Kelly Lang, Yale Drazin, Dave A. Davis (Guidelines Advisory Committee, Toronto, ON)

L05 AMERICAN COLLEGE OF CHEST PHYSICIANS EVIDENCE-BASED GUIDELINE METHODOLOGY

Carla Herrerias, Sandra Zelman Lewis, Doreen Addrizzo Harris, Ian Nathanson, Edwin Dellert, Julia Heitzer, David Gutterman (American College of Chest Physicans, American College of Chest Physicians, New York University School of Medicine, Nemours Clinical Management Program, Medical College of Wisconsin)

L06 10 YEARS OF EVIDENCE BASED HEALTHCARE IMPLEMENTATION IN GERMANY: THE RELEVANCE OF GUIDELINES

Guenter Ollenschlaeger (German Agency for Quality in Medicine (AQuMed))

Workshops, Thematic Discussion and Network Sessions

W01 PROMISES AND CHALLENGES OF INTERNATIONAL GUIDELINE COORDINATION — St. David North

Katrin Uhlig, Gordon Guyatt , Regina Kunz (Tufts-New England Medical Center, Boston, MA, McMaster University, Hamilton, ON, Institute for Clinical Epidemiology, University Hospital, Basel)

W02 WORKSHOP SEX-SPECIFIC ISSUES IN GUIDELINE DEVELOPMENT — Terrace East

Hans de Beer, Debby Keuken (Dutch Institute for Healthcare Improvement CBO, Utrecht, The Netherlands, Academic Medical Center / University of Amsterdam, Department of General Practice, The Netherlands)

W03 TURNING EVIDENCE INTO ACTION — St. David South

Sue Scobie, Nicole Coupe (NZ Guidelines Group)

W04 THE EVOLVING NATURE OF CLINICAL PRACTICE GUIDELINE UPDATING AND ATTRIBUTE-REPORTING: PERSPECTIVES FROM THE NATIONAL GUIDELINE CLEARINGHOUSE — Terrace North

Michelle Tregear, Mark Monteforte, Lisa Haskell, Vivian Coates, Mary Nix (ECRI, Plymouth Meeting, PA, U.S. Agency for Healthcare Research and Quality, Rockville, MD

T01 THE CCS HEART FAILURE CONSENSUS CONFERENCE PROGRAM: SHAPING THE FUTURE OF HEART FAILURE MANAGEMENT IN CANADA — St. George East

John H. Parker, J. Malcolm O. Arnold, Jonathan Howlett, Heather Ross (Canadian Surgical Technologies and Advanced Robotics, London, Ontario, University of Western Ontario, London, Ontario, Dalhousie University, Halifax, Nova Scotia, University Health Network, Toronto, Ontario)

N01 SHARING AND EVALUATING BEST PRACTICE GUIDELINES: CROSSING CONTINENTS AND DISCIPLINES — Lakeview Room

Tazim Virani, Doris Grinspun, Irmajean Bajnok, Barbara Davies, Heather McConnell, Debra Bick (Registered Nurses' Association of Ontario, Toronto, Ontario, University of Ottawa, Ottawa, Ontario, Debra Bick, Thames Valley University, London, England)

12:15 pm Lunch ..... Colony Grande Ballroom

1:30 pm **Parallel Session 2** (session rooms subject to change)

Case Studies in Collaboration (1) — Armoury Suite

B23 COCANCPG: THE COORDINATION OF CANCER CLINICAL PRACTICE GUIDELINES IN EUROPE

Magali Remy-Stockinger , Béatrice Fervers, Valérie Mazeau, Christine Bara, for CoCanCPG (French Federation of Comprehensive Cancer Centres - Lyon - France, French Federation of Comprehensive Cancer Centres and Centre Léon Bérard - Lyon - France, National Cancer Institute - Boulogne Billancourt - France, National Cancer Institute - Boulogne Billancourt - France)

B24 COLLABORATIVE DEVELOPMENT AND IMPLEMENTATION OF EVIDENCE-BASED GUIDELINES, PROTOCOLS AND ORDER SETS TO ACCELERATIVE IMPROVEMENT IN HEALTH CARE DELIVERY

Sherri Huber, MT (ASCP), Cally Vinz, RN (Institute for Clinical Systems Improvement (ICSI), Bloomington, MN)

B26 NO ONE WANTS ADVICE, ONLY COLLABORATION: THE EXPERIENCE OF AN AUSTRALIAN/NEW ZEALAND COLLABORATION TO IMPLEMENT GUIDELINES

Sue Scobie, Nicole Coupe, Sue Huckson, Jan Davies (New Zealand Guideline Group, New Zealand Guideline Group , National Institute of Clinical Studies, Australia)

New Methods in Guideline Development — Lombard Suite

B27 CONSENSUS BUILDING IN THE DEVELOPMENT OF THE PURPOSE AND SCOPE FOR A NEW SELF-MANAGEMENT SUPPORT GUIDELINE

Janet Chee, Patrick McGowan, Suzanne Fredricks (Registered Nurses Association of Ontario, University of Victoria- Centre on Aging, Ryerson University)

B28 FORMAL CONSENSUS METHODS AND THE PRODUCTION OF CLINICAL PRACTICE GUIDELINES

Frédéric De Bels, Patrice Dosquet (Haute Autorité de santé)

B29 USING DELPHI CONSENSUS IN A NICE CHILDREN'S GUIDELINE

Monica Lakhanpaul, Martin Richardson, Richard Bowker, Françoise Cluzeau, Chia-Wen Lee (1. National Collaborating Centre for Women & Children's Health/Leicester University, 2. Peterborough and Stamford Hospitals NHS Foundation Trust, 3. Nottingham University Hospitals NHS Trust, 4. National Institute for Health & Clinical Excellence, 1. National Collaborating Centre for Women & Children's Health)

B30 PRAGMATIC EVIDENCE-BASED GUIDELINE DEVELOPMENT: A RESEARCH PROTOCOL IN AUSTRALIA AND SOUTH EAST ASIA

Tari Turner, Claire Harris, Sally Green (Monash Institute of Health Services Research, Centre for Clinical Effectiveness, Monash Institute of Health Services Research, Australasian Cochrane Centre, Monash Institute of Health Services Research)

B31 AUDIT, FEEDBACK AND CONSENSUS: AN ALTERNATIVE WHEN THERE IS NO EVIDENCE

Stephen Hall (Queen's Cancer Research Institute, Kingston, ON)

Diagnostic and Qualitative Evidence in Guidelines — Elm Suite

B33 FEASIBILITY OF THE QUADAS TOOL FOR QUALITY ASSESSMENT OF DIAGNOSTIC STUDIES IN GUIDELINE DEVELOPMENT

Philippa Davies, Anita Fitzgerald, Phil Alderson (National Institute for Health and Clinical Excellence (NICE), London, National Collaborating Centre for Women's and Children's Health, London)

B34 TOWARDS SYNTHESIZING AND INTEGRATING QUALITATIVE EVIDENCE IN THE CONTEXT OF GUIDELINE DEVELOPMENT

Hans de Beer, Ton Kuijpers, Rikie Deurenberg, Annemarie Hagemeijer (Dutch Institute for Healthcare Improvement CBO, Utrecht, The Netherlands)

B35 INTRODUCING QUALITATIVE EVIDENCE INTO CLINICAL PRACTICE GUIDELINES: A PILOT PROJECT IN CANCER PAIN

Harbour, R T, Gillespie, A, Gordon, Rev T, Graham, K, Jones, D, Wilson, G (SIGN, Edinburgh, UK, Patient representative, Glagow, UK, Fairmile Marie Curie Centre, Edinburgh, UK, Queen Margaret University, Edinburgh, UK, Patient representative, Edinburgh, UK)

B36 USING QUALITATIVE STUDIES IN GUIDELINE DEVELOPMENT: AN EXAMPLE

Vanessa Nunes, Norma O'Flynn, Elizabeth Shaw, Gary Britton (National Collaborating Centre for Primary Care, London)

B37 EVIDENCE PROFILES FOR TRANSPARENT GUIDELINE RECOMMENDATIONS

Richard Rosenfeld, Richard Shiffman (SUNY Downstate Medical Center, Brooklyn, NY, Yale Center for Medical Informatics, New Haven, CT)

Issues in Risk Assessment and Preparedness — St. Patrick Room

B38 HOW CAN WE DETERMINE RISK THRESHOLDS FOR PREVENTIVE TREATMENTS? A CASE STUDY FROM A NICE GUIDELINE

David Wonderling, Enrico de Nigris, Jennifer Hill, Tom Treasure (Royal College of Surgeons, London, UK, Guys Hospital, London, UK)

B39 INSTRUMENT FOR THE DEVELOPMENT AND APPRAISAL OF SCIENTIFIC ADVICE ON OUTBREAK CONTROL MEASURES

Aura Timen, Marlies Hulscher, Jim van Steenbergen, Jos van der Meer, Richard Grol (National Institute for Public Health and the Environment (RIVM), Centre for Infectious Disease Control, The Netherlands, Radboud University Nijmegen Medical Centre, Centre for Quality of Care Research, The Netherlands, Radboud University Nijmegen Medical Centre, Department of General Internal Medicine, The Netherlands)

B40 CHALLENGE IN DEVELOPING PUBLIC HEALTH PREPAREDNESS GUIDELINES - A JAPANESE EXAMPLE

Keika HOSHI, Rintaro MORI, Kenji HAYASHI, Toru DOI (National Institute of Public Health, Japan, National Collaborating Centre for Women's and Children's Health, UK)

Plans of Action: Supporting Knowledge Transfer — Colony Grande Ballroom

L07 A PLAN FOR ACTION: DEVELOPING A NATIONAL GUIDELINE IMPLEMENTATION PLAN FOR DIABETES

Kay Currie, Janice Davies (National Institute of Clinical Studies)

L08 THE NICE IMPLEMENTATION PROGRAMME - ADDRESSING BARRIERS AND ENCOURAGING CHANGE

Gillian Leng, Nicola Bent, Annie Coppel, Jennifer Field, Julie Royce (National Institute for Health and Clinical Excellence, London)

L09 SUPPORTING KNOWLEDGE TRANSFER IN GUIDELINE IMPLEMENTATION

Cindy Hoerger, Paul Taenzer, Monique Assi (Calgary Health Region ,Calgary, Alberta)

Workshops, Thematic Discussion and Network Sessions

W05 FREQUENT CHALLENGES FOR GUIDELINE DEVELOPERS AND FACILITATORS – SPOTTING AND OVERCOMING OBSTACLES IN GUIDELINE GROUPS — Terrace East

Kunz Regina , Leigemann Monika, Ollenschläger Günter (Basel Institute for Clinical Epidemiology; Basel, Switzerland, HTA-Center University Bremen; Institute for Health Law and Medical Law, Bremen, Germany, Agency for Quality in Medicine, Berlin, Germany)

W06 GUIDELINE ADAPTATION: A METHODOLOGY TO ENHANCE EFFICIENCY IN GUIDELINE DEVELOPMENT AND IMPROVE UTILIZATION — Terrace West

Béatrice Fervers (1), Jako S Burgers (2), Melissa Brouwers (3), Magali Remy-Stockinger (4), Anita Simon (5), Najoua Mlika-Cabanne (6), Bernard Burnand (7), for The ADAPTE Collaboration (1 SOR, Fédération des cen tres de lutte contre le cancer; Centre Léon Bérard - Lyon - France, 2 Dutch Institute for Healthcare Improvement, CBO - Utrecht - The Netherlands, 3 Program in evidence-based Care, Cancer Care Ontario, McMaster University - Hamilton - Canada; Cancer Control Guidelines Action Group, 4 SOR, Fédération des centres de lutte contre le cancer - Lyon - France, 5 Alberta Cancer Board - Calgary - Alberta, 6 Haute autorité de santé, Service des recommandations Professionnelles - Paris - France, 7 Health Care Evaluation Unit and Clinical Epidemiology Centre, IUMSP - Lausanne - Switzerland)

W07 ASKING FOR LESS AND GETTING MORE: SIMPLIFYING CLINICAL PRACTICE GUIDELINES AS A COMPONENT OF IMPLEMENTATION STRATEGIES — St. George West

Onil Bhattacharyya, Merrick Zwarenstein (Li Ka Shing Knowledge Institute, University of Toronto, Toronto, Ontario)

W08 INTEGRATING EVIDENCE INTO ELECTRONIC HEALTH RECORDS — St. David North

Minna Kaila, Ilkka Kunnamo, Jorma Komulainen (Finnish Office for Health Technology Assessment, Finnish Medical Society Duodecim)

T02 DEVELOPING INTEGRATED PUBLIC HEALTH AND CLINICAL GUIDANCE: THE NICE GUIDELINE ON OBESITY — St. David South

Adrienne Cullum, Tim Stokes, Elizabeth Shaw, Vanessa Nunes, Mike Kelly, Jim McEwen, Simon Ellis, Francoise Cluzeau (Centre for Public Health Excellence, National Institute of Health and Clinical Excellence, UK, National Collaborating Centre for Primary Care, University of Leicester and Royal College of General Practitioners, UK, Chair, National Institute for Health and Clinical Excellence Obesity Guidance Development Group, UK)

T03 AN INTEGRATED APPROACH TO IMPLEMENTING CLINICAL GUIDELINES FOR PRIMARY CARE AT AN ACADEMIC HEALTH CENTER: AN INSTITUTIONAL CASE STUDY — Terrace North

R. Van Harrison, PhD, Steven J. Bernstein, MD, MPH, William E. Chavey, MD, MS, Connie J. Standiford, MD (University of Michigan, Ann Arbor, Michigan)

N02 TOWARDS EFFICIENT LITERATURE SEARCHING FOR GUIDELINES: CASE STUDY ON COLON CANCER GUIDELINE — Lakeview Room

Rikie Deurenberg, Jako Burgers, Kitty Rosenbrand, Margriet Moret, Ton Kuijpers (Dutch Institute for Healthcare Improvement CBO, Utrecht, the Netherlands)

3:00 pm Pause Café, Exhibits and Poster Viewing .....Giovanni Room & Colony Grande Ballroom (West)

3:30 pm **Plenary 2 - Achieving Collaboration Through an International Guidelines Network: The G-I-N Story** — **Colony Grande Ballroom**

Chairs: Françoise Cluzeau, PhD, United Kingdom
and Minna Kaila, MD, Finland

Coordinator: Angela Maienborn, MD, Germany

4:45 pm Open Discussion

5:00 pm **Annual General Meeting, G-I-N** (until 6:30 pm)

Friday, August 24, 2007

8:00 am **Registration and Continental Breakfast**
Registration ..... Foyer, 2nd Floor
Continental Breakfast ..... Giovanni Room & Colony Grande Ballroom (West)

8:00 am Internet Café (until 6:00 pm) ..... St. Lawerence Room

9:00 am **Plenary 3 - Guidelines to Help Policy-Makers** — **Colony Grande Ballroom**
Chairs: Heather Buchan, MD, Australia and Sue Phillips, PhD, Australia

The Need for Transparency in Guidelines ..... Peter Littlejohns, MBBS, BSc, MD
National Institute for Health and Clinical Excellence, UK

9:30 am **Discussants:** What Can the World Learn from NICE?
A Perspective from USA ..... Paul Shekelle, MD, PhD, USA
A Perspective from Canada ..... Andreas Laupacis, MD, Canada

10:00 am Open Discussion

10:15 am Pause Café, Exhibits and Poster Viewing ..... Giovanni Room & Foyer, 2nd Floor

10:45 am **Parallel Session 3** (session rooms subject to change)

Guidelines from the Perspective of the Policy Maker — Armoury Suite

L10 NICE COMMISSIONING GUIDES –SUPPORTING THE COMMISSIONING OF EVIDENCE-BASED CARE
Annie Coppel (National Institute for Health and Clincal Excellence, Manchester, UK)

B41 HEALTH CARE MANAGERS' OPINIONS ABOUT THE USABILITY OF CLINICAL GUIDELINES IN FINLAND
Tiina Kortteisto, Minna Kaila, Marjukka Mäkelä, Jorma Komulainen, Pekka Rissanen (University of Tampere, Finland, University of Tampere and The Finnish Office for Health Technology Assessment at the National Research and Development Centre for Welfare and Health, Finland, The Finnish Office for Health Technology Assessment at the National Research and Development Centre for Welfare and Health, Finland, The Finnish Medical Society Duodecim, Finland)

B32 THE EVIDENCE BASE TO MAKE RECOMMENDATIONS ON DIAGNOSTIC PRACTICES IS LIMITED: AN ANALYSIS OF 73 CLINICAL PRACTICE GUIDELINES
Eeva Ketola, Minna Kaila, Mari Honkanen (Current Care, Finnish Medical Society Duodecim, , FinOHTA, Current Care, Finnish Medical Society Duodecim, , Current Care, Finnish Medical Society Duodecim)

B43 ECONOMIC BENEFITS FROM ADHERENCE TO SUBFERTILITY GUIDELINES
Willianne L.D.M. Nelen, Esther C. Haagen, Rosella P.M.G. Hermens, Eddy M. Adang, Jan A.M. Kremer, Richard P.T.M. Grol ((1) Centre for Quality of Care Research (WOK) and (2) Department of Obstetrics and Gynecology at the Radboud University Nijmegen Medical Centre, Nijmegen, The Netherlands, (1) Centre for Quality of Care Research (WOK) at the Radboud University Nijmegen Medical Centre, Nijmegen, The Netherlands, (3) Department of Medical Technology Assessment at the Radboud University Nijmegen Medical Centre, Nijmegen, The Netherlands, (2) Department of Obstetrics and Gynecology at the Radboud University Nijmegen Medical Centre, Nijmegen, The Netherlands)

B44 A 'LEVELS OF CARE' APPROACH TO GUIDELINE DEVELOPMENT
Stephen Colagiuri, Philip Home (University of Sydney, Australia, University of Newcastle, UK)

Case Studies in Evaluating Guidelines — Lombard Suite

B45 THE IMPLEMENTATION OF GUIDELINES ON DELIRIUM AND ASSESSMENT OF THEIR IMPACT ON CLINICAL PRACTICE IN AN ACUTE CARE GENERAL HOSPITAL

Rachel Voellinger, Alexandre Berney, Patrik Michel, Yves Dorogi, Laurent Michaud, Christiane Ruffieux, Patrick Taffé, Friedrich Stiefel, Bernard Burnand (Institute of Social and Preventive Medicine (IUMSP), University of Lausanne, Consultation-Liaison Psychiatry Service, CHUV, University of Lausanne, Switzerland, Service of Neurology, CHUV, University of Lausanne, Switzerland)

B46 ADHERENCE TO SURVEILLANCE GUIDELINES FOLLOWING CURATIVE RESECTION FOR STAGE II OR III COLORECTAL CANCER

Winson Cheung, Gregory Pond, Mark Rother, Monika Krzyzanowska, James Brierley, Carol Swallow, Leonard Kaizer, Jeffrey Myers, Sandy Phillips, Lillian Siu (University of Toronto, Toronto, Ontario, Princess Margaret Hospital, Toronto, Ontario, Credit Valley Hospital, Mississauga, Ontario)

B47 OSTEOARTHRITIS OF THE KNEE CLINICAL PRACTICE GUIDELINES – HOW ARE WE DOING?

Melanie N. DeHaan, Jaime Guzman, Mark Theodore Bayley, Mary J. Bell (Division of Physical Medicine and Rehabilitation, Department of Medicine, University of Toronto, Toronto, Ontario, Canada, Department of Medicine, University of British Columbia, Vancouver, British Columbia, Canada, Toronto Rehabilitation Institute, Division of Physical Medicine and Rehabilitation, Department of Medicine, University of Toronto, Toronto, Ontario, Canada, Sunnybrook Health Sciences Centre, Division of Rheumatology, Department of Medicine, University of Toronto, Toronto, Ontario, Canada)

B48 A MULTIFACETED INTERVENTION FOR THE IMPLEMENTATION OF A CPG IN OSTEOPOROSIS IMPROVES PRIMARY CARE MANAGEMENT

Eunate Arana-Arri, Iñaki Gutiérrez-Ibarluzea, Mª Luisa Gutiérrez-Ibarzabal, Anabel Giménez-Robredo, Pedro Ortueta Chamorro, José Asua Batarrita, Angel Sánchez Mata, Elena Fernández Díaz (Cruces Hospital, Osakidetza, Basque Health Service, Barakaldo/Basque Country , Osteba, Basque Office for Health Technology Assessment, Vitoria-Gasteiz, Basque Country, Health Plan, Department of Health, Vitoria-Gasteiz, Basque Country, Uribe Primary Setting. Osakidetza, Basque Health Service, Leioa. Basque Country, Basurto Hospital, Osakidetza, Basque Health Service, Barakaldo/Basque Country)

B49 SYSTEMATIC MONITORING PROCESS FOR UPDATING CLINICAL PRACTICE GUIDELINES: EXAMPLE WITH THE USE OF ERYTHROPOIETIC PROTEINS (RHUEPO) IN ANEMIC CANCER PATIENTS

Diana Kassab-Chahmi, Isabelle Ray-Coquard, Nicole Casadevall, Christian Marchal, Perrine Marec-Bérard, Jean-Louis Misset , The SOR steering committee (FNCLCC-Paris, Centre Léon Bérard-Lyon, Hôpital Hôtel Dieu-Paris, CHU de Fort de France-Martinique, Hôpital Saint-Louis-Paris)

Process and Frameworks for Implementation — Elm Room

L11 CHANGING PROFESSIONAL BEHAVIOUR: AN UPDATED OVERVIEW OF SYSTEMATIC REVIEWS

Jeremy Grimshaw, Alain Mayhew, Adrienne Stevens, Stephen Graham (Clinical Epidemiology Program, Ottawa Health Research Institute, Ottawa, Ontario, Cochrane Effective Practice and Organisation of Care, Ottawa, Ontario, Canadian Cochrane Network and Centre, Ottawa, Ontario, Canadian Agency for Drugs and Technologies in Health, Ottawa, Ontario)

B50 IMPLEMENTATION OF EVIDENCE BASED PRACTICES IN THE ALBERTA CANCER BOARD

Anita Simon, Lubna Baig, Dianne Bray (Alberta Cancer Board)

B51 UNDERSTANDING ADHERENCE TO CLINICAL PRACTICE GUIDELINES IN THE INTENSIVE CARE UNIT: A COMPREHENSIVE AND INTEGRATED FRAMEWORK

Naomi Jones, Jeanette Suurdt, Helene Ouellette-Kuntz, Daren Heyland (Department of Community Health and Epidemiology and Clinical Evaluation Research Unit, Queen's University, Kingston, ON Canada, School of Nursing and Clinical Evaluation Research Unit, Queen's University, Kingston, ON Canada, Department of Community Health and Epidemiology, Queen's University, Kingston, ON Canada, Department of Community Health and Epidemiology, Department of Medicine, and Clinical Evaluation Research Unit, Queen's University, Kingston, ON Canada)

B52 ADHERENCE TO PHYSIOTHERAPY CLINICAL GUIDELINE ACUTE ANKLE INJURY AND DETERMINANTS OF ADHERENCE: A COHORT STUDY

Philip Van der Wees, Erik Hendriks, Mariette Jansen, Hans van Beers, Rob de Bie, Joost Dekker (Maastricht University, Maastricht, Netherlands, Dutch Institute for Allied Health Care (NPi), Amersfoort, Netherlands, VU University Medical Center, Amsterdam, Netherlands)

B53 INFLUENCING IMPLEMENTATION

Jayne Chidgey, Chris Connell, Gillian Leng, Jenny Lewis, Val Moore, Steve Sparks (National Institute for Health and Clinical Excellence, London, UK)

The Patient's Role in Guidelines — St. Patrick Room

B55 EFFICIENT USE OF RESOURCES AND INCLUSION OF PATIENT PREFERENCES IN THE REFERRAL DECISION - A PARADOX IN POLICY?

Nyokabi Musila, Jan van der Meulen, Martin Underwood, Andrew McCaskie (Health Services Research Unit, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, London, UK and Clinical Effectiveness Unit, Royal College of Surgeons of England, London, UK, Queen Mary University of London, University of Newcastle)

B54 FROM CLINICAL PRACTICE GUIDELINES TO PATIENT INFORMATION: THE FRENCH APPROACH FOR PATIENT INVOLVEMENT

Julien Carretier, Anne Bataillard, Béatrice Fervers, Thierry Philip (French Federation of Comprehensive Cancer Centre, Paris, Centre Leon Berard, Lyon)

B56 DECISION AIDS DERIVED FROM EVIDENCE-BASED GUIDELINES - A FRAMEWORK FOR DEVELOPMENT AND MAINTENANCE

Ilse Raats, Haske van Veenendaal, Marion Grol, Jako Burgers (Dutch Institute for Healthcare Improvement CBO, Utrecht, The Netherlands)

B57 INCREASING PUBLIC ACCESS TO CLINICAL PRACTICE GUIDELINES FOR RHEUMATOID ARTHRITIS AND OSTEOARTHRITIS (PHASE II)

Lucie Brosseau, Sydney Lineker, Mary Bell, George Wells, Mary Egan, Lynn Casimiro, Peter Tugwell, Ann Cranney, Keith Wilson (School of Rehabilitation Sciences, University of Ottawa, Ottawa, Ontario, The Arthritis Society - Ontario Division, Arthritis Rehabilitation Education Program, Toronto, Ontario, Canadian Rheumatology Association & Sunnybrook Health Sciences Centre, Toronto, Ontario, Department of Epidemiology and Community Medicine, University of Ottawa, Ottawa, Ontario, Centre for Global Health, Institute of Population Health, University of Ottawa, Ottawa, Ontario, Clinical Epidemiology Program, Ottawa Health Research Unit, Ottawa Hospital, Civic Campus, Ottawa, Ontario, The Rehabilitation Centre, Ottawa, Ontario)

B58 PARTICIPATION OF PATIENT REPRESENTATIVES IN THE DEVELOPMENT OF GUIDELINES – ARE PATIENT ORGANIZATIONS READY FOR THIS TASK?

Sylvia Saenger, Gerhard Englert, Frank Brunsmann, Bernd Quadder, Günter Ollenschlaeger (German Agency for Quality in Medicine, German Patient Forum (Standing Committee of the National Boards of Disabled People Associations, Health Care Consumers Associations, Self-Help Groups Associations, the German Medical Association and the National Association of Statutory Health Insurance Physicians)

B59 ARE CLINICAL PRACTICE GUIDELINES COMPATIBLE WITH RESPECTING PATIENT PREFERENCES? A CONCEPTUAL FRAMEWORK AND RESEARCH AGENDA

Antoine Boivin, France Légaré, Trudy van der Weijden, Victoria Thomas, Nyokabi Musila, Jan van der Meulen, Aileen Clarke (London School of Hygiene and Tropical Medicine, UK, Canada Research Chair in Implementation of Shared Decision Making in Primary Care, Université Laval, Canada, Maastricht University, Netherlands, Programme Manager. Patient and Public Involvement Programme, National Institute for Health and Clinical Excellence, UK)

Considering the Health Professional and the Setting in Guideline Implementation

St. George West

L12 DEVELOPING CLINICAL GUIDELINES IN LUNG CANCER FOR LIMITED RESOURCE SETTINGS: A NOVEL METHODOLOGY, SUPPORTED BY THE INTERNATIONAL ATOMIC ENERGY AGENCY (IAEA)

Fergus Macbeth, Raymond Abratt, Kwan Cho, Branislav Jeremic, Richard Stephens (Velindre Hospital, Cardiff UK, University of Cape Town, South Afica, National Cancer Center, Goyang, Korea, IAEA, Vienna, Austria, MRC Cancer Trials Unit, London, UK)

B60 ADAPTATION OF TOBACCO GUIDELINES TO HOSPITALS IN NW ONTARIO AND NORTHERN CALIFORNIA

Patricia M. Smith, C. Barr Taylor, Scott M. Sellick, Smita Das (Northern Ontario School of Medicine, Thunder Bay, ON, Stanford University School of Medicine, Palo Alto, CA, Thunder Bay Regional Academic Health Sciences Centre, Thunder Bay, ON, Stanford University School of Medicine)

B61 UNDERSTANDING GROUP PRACTICES IN CANADA: HOW DOES THE EVOLUTION OF PRIMARY CARE PRACTICES INFLUENCE THE DEVELOPMENT AND IMPLEMENTATION OF CLINICAL PRACTICE GUIDELINES?

Suzanne Murray, Dave Davis, Dilip Patel, Martin Dupuis, Ivan Silver (AXDEV Group, Brossard, Quebec, University of Toronto, Toronto, Ontario, Merck Frosst Canada, Kirkland, Quebec, University of Toronto, Toronto, Ontario)

B62 IDENTIFYING GENERAL PRACTITIONER BELIEFS, INTENTIONS AND BEHAVIOUR TOWARD A GUIDELINE FOR ACUTE LOW-BACK PAIN USING THE THEORY OF PLANNED BEHAVIOUR

Denise O'Connor, Sally Green, Simon French, Sharon King, Jill Francis, Jeremy Grimshaw, Susan Michie, Joanne McKenzie, Neil Spike, Peter Schattner, and the IMPLEMENT Study Group (Australasian Cochrane Centre, Institute of Health Services Research, Monash University, Australia, University of Aberdeen, Scotland, UK, Clinical Epidemiology Program, Ottawa Health Research Institute, Canada, University College, London, UK, Department of Preventive and Social Medicine, University of Otago, Dunedin, New Zealand, Department of General Practice, School of Primary Health Care, Monash University, Australia)

B63 ACCEPTANCE AND IMPLEMENTATION OF GENERAL PRACTITIONER GUIDELINES IN QUALITY CIRCLES FOR GP-CENTRED CARE

Ingrid Schubert, Veronika Lappe, Joachim Fessler, Guenter Ollenschlaeger (PMV Research Group, University of Cologne, Cologne, Germany, GP, Floersheim, Germany, Agency for Quality in Medicine, Berlin, Germany)

Workshops, Thematic Discussion and Network Sessions

W09 IMPROVING GUIDELINE IMPLEMENTABILITY USING 'GLIA'

Terrace East

Richard Shiffman, Catherine Marshall (Yale Center for Medical Informatics, Independent Guideline Adviser & Health Sector Consultant)

W10 GUIDELINE ADAPTATION: A METHODOLOGY TO ENHANCE EFFICIENCY IN GUIDELINE DEVELOPMENT AND IMPROVE UTILIZATION

Terrace West

Béatrice Fervers (1), Jako S Burgers (2), Melissa Brouwers (3), Magali Remy-Stockinger (4), Anita Simon (5), Najoua Mlika-Cabanne (6), Bernard Burnand (7), for The ADAPTE Collaboration (1 SOR, Fédération des cen tres de lutte contre le cancer; Centre Léon Bérard - Lyon - France, 2 Dutch Institute for Healthcare Improvement, CBO - Utrecht - The Netherlands, 3 Program in evidence-based Care, Cancer Care Ontario, McMaster University - Hamilton - Canada; Cancer Control Guidelines Action Group, 4 SOR, Fédération des centres de lutte contre le cancer - Lyon - France, 5 Alberta Cancer Board - Calgary - Alberta, 6 Haute autorité de santé, Service des recommandations Professionnelles - Paris - France, 7 Health Care Evaluation Unit and Clinical Epidemiology Centre, IUMSP - Lausanne - Switzerland)

W11 SUCCESSFUL IMPLEMENTATION AND EVALUATION OF GUIDELINES THROUGH PERFORMANCE INDICATORS AND CARE PATHWAYS

Terrace North

Mona van de Steeg, Teus van Barnveld, Ruben van Zelm (Dutch Institute for Healthcare Improvement, Utrecht, the Netherlands)

W12 E-BASED SOLUTIONS TO PROMOTE THE USE OF CLINICAL PRACTICE GUIDELINES St. David North

Tazim Virani, Heather McConnell, Janet Nevala, Lisa Valentine, Cindy Bolton (Registered Nurses' Association of Ontario, Toronto, Ontario, The Program Training and Consultation Centre, Ottawa, Ontario, Sunnybrook Health Sciences Centre, Toronto, Ontario, Kingston General Hospital, Kingston, Ontario)

T04 THE DEVELOPMENT OF A CONSENUS-BASED GUIDE MAP FOR KNOWLEDGE TRANSLATION IN EMERGENCY MEDICINE St. David South

Eddy Lang, Peter Wyer, Susan Huckson, Michelle Biros, James Adams, Christos Tselios, Marc Afilalo, Richard Sinert, Gary Gaddis (McGill University, Columbia University, National Institute for Clinical Studies, University of Minnesota, Northwestern University, State University of New York, University of Missouri-Kansas City)

B114 A RESEARCH AGENDA DEVELOPED BY A THEMATIC GROUP FOR IMPROVING THE IMPLEMENTATION OF CPGS, CLINICAL PATHWAYS AND DECISION RULES IN EMERGENCY MEDICINE St. David South

Gary M. Gaddis MD PhD, Peter Greenwald MD (St. Luke's Hospital of Kansas City and University of Missouri-Kansas City School of Medicine, NewYork-Presbyterian Emergency Medicine Weill Medical College of Cornell University)

T05 KNOWLEDGE TRANSFER USING A PEER-SELECTED OPINION LEADER NETWORK St. George East

Rhoda Reardon, Jane Gibson, Daniel Way, Jess Rogers, Dave Davis (College of Physicians and Surgeons of Ontario, Toronto, ON, Institute for Work & Health, Toronto, ON, Guidelines Advisory Committee, Toronto, ON)

N03 GUIDELINE IMPLEMENTATION IN GERMAN-SPEAKING COUNTRIES: RESULTS, BARRIERS, OPPORTUNITIES FOR DEVELOPMENT Lakeview Room

Guenter Ollenschlaeger, Ina Kopp, Monika Lelgemann (German Agency for Quality in Medicine (AQuMed), Ass. of the Scientific Medical Societies in Germany (AWMF), HTA Unit, University of Bremen)

12:15 pm Lunch ..... Colony Grande Ballroom

1:30 pm **Parallel Session 4** (session rooms subject to change)

Barriers to Implementing Guidelines — Armoury Suite

B64 WHY ARE CLINICAL PRACTICE GUIDELINES NOT SO EFFECTIVE IN ONTARIO ACUTE CARE HOSPITALS?

Moriah Ellen, Ross Baker, Adalsteinn Brown (University of Toronto, Toronto, Ontario)

B65 IMPLEMENTATION OF CLINICAL PRACTICE GUIDELINES: OVERCOMING BARRIERS TO IMPLEMENTATION OF IRON MANAGEMENT GUIDELINES IN CHRONIC KIDNEY DISEASE PATIENTS

Michelle Irving, Martin Gallagher, Rowan Walker, Michael Frommer, Jonathan Craig (Centre for Kidney Research, The Children's Hospital at Westmead, Australia, School of Public Health, University of Sydney, Australia, Senior Research Fellow, The George Institute for International Health, Renal Unit, Royal Melbourne Hospital, Melbourne Australia, School of Public Health, University of Sydney, Australia)

B66 STRATEGIES TO OVERCOME BARRIERS TO ABDOMINAL AORTIC ANEURYSM SCREENING

Douglas Wooster, Andrew Dueck, Elizabeth Wooster (University of Toronto and University Health Network--Toronto General Hospital, Toronto, ON, University of Toronto and University Health Network--Toronto General Hospital, Toronto ON)

B67 BARRIERS TO AND FACILITATOR OF THE CLIP GUIDELINE

Anne-Marie Cote, Michel Tousignant, Marie-José Durand, Stéphane Poitras (Rehabilitation department, Medicine and Health Science Faculty, Université de Sherbrooke, Sherbrooke, Québec, Research center on aging, Sherbrooke Geriatric University Institute, Sherbrooke, Québec, Centre for Action in Work Disability Prevention and Rehabilitation, Montréal, Quebec, Epidemiology and biostatistics department, McGill University, Montréal, Quebec)

B68 COMPETING NORMS: EXPLORING RURAL FAMILY PHYSICIANS' PERCEPTION OF CLINICAL PRACTICE GUIDELINES AND SHARED DECISION-MAKING

Antoine Boivin, France Légaré, Marie-Pierre Gagnon (CSSS Rouyn-Noranda, Canada Research Chair in Implementation of Shared Decision Making in Primary Care, Université Laval, Canada, Université Laval, Québec, Canada)

Case Studies in Developing Guidelines (2) — Elm Suite

B70 SYSTEMATIC GUIDELINE REVIEW AS AN EFFICIENT METHOD IN EVIDENCE BASED GUIDELINE DEVELOPMENT: THE PRIMARY CARE MANAGEMENT OF CHRONIC HEART FAILURE AS A MODEL

Christiane Muth, Jochen Gensichen, Martin Beyer, Ferdinand M. Gerlach (Institut für Allgemeinmedizin, Johann Wolfgang Goethe-Universität, Frankfurt am Main, Germany)

B71 EFFICIENCY IMPROVEMENT IN EVIDENCE-BASED GUIDELINE DEVELOPMENT IN THE NETHERLANDS

InezJoung, Erwin van der Harst, Jako Burgers (Association of Comprehensive Cancer Centres (ACCC), The Netherlands, National Working Group Gastro-intestinal Tumors / Department of Surgery, MCRZ, The Netherlands, Dutch Institute for Healthcare Improvement CBO, The Netherlands)

B72 USING THE GRADE SYSTEM TO PRODUCE CLINICAL RECOMMENDATIONS FOR ANTICANCER DRUGS

Rossana de palma , Alessandro liberati (Agenzia Aanitaria Regionale, Bologna,Italy, University of Modena-Agenzia Sanitaria Regionale, Bologna, Italy)

B73 AN EXAMPLE OF USE OF THE EGLIA TOOL IN DEVELOPING GUIDELINES FOR ACUTE STROKE MANAGEMENT IN AUSTRALIA

Kelvin Hill, Erin Lalor (National Stroke Foundation of Australia)

B74 GUIDELINES FOR A RARE DISORDER: AN EVIDENCE-BASED CONSENSUS PROCESS

Marie Faughnan, Valerie Palda, Sharon Straus, HHT Guidelines Working Group (University of Toronto, Toronto, Ontario)

Educational Methods to Implement Guidelines — Lombard Suite

B75 USING CONFERENCES AS STRATEGIC EVENTS TO SUPPORT KNOWLEDGE MOBILIZATION

Marc White, Dave Davis, John Holland, Lawrence Green, Matthew Liang (Brigham & Women's Hospital & Harvard Medical School, Boston, MA, University of Toronto Health Policy Management and Evaluation & Family and Community Medicine, Toronto, ON, University of Washington, Department of Environmental and Occupational Health Sciences, Seattle, WA, UCSF Dept of Epidemiology and Biostatistics; UCSF Comprehensive Cancer Center, Population Sciences, University of California at San Francisco, CA)

B76 QUALITY CIRCLES IS AN EFFECTIVE KNOWLEDGE TRANSLATION APPROACH TO INCREASE PRIMARY CARE PHYSICIANS' ADHERENCE TO THE OSTEOPOROSIS CANADA 2002 GUIDELINES

George Ioannidis, Lehana Thabane, Amiran Gafni , Alexandra Papaioannou, Brent Kvern , Anthony Hodsman , Dan Johnstone , Lena Salach , Famida Jiwa, Jonathan Adachi (McMaster University, Hamilton, Ontario, University of Manitoba, Winnipeg, Manitoba, University of Western Ontario, London, Ontario, 4Procter and Gamble Pharmaceuticals, Toronto, Ontario, Ontario College of Family Physicians, Toronto, Ontario, Osteoporosis Canada, Toronto, Ontario)

B77 IMPROVING PREVENTION GUIDELINE IMPLEMENTATION USING BEST PRACTICES IN CONTINUING MEDICAL EDUCATION: A RANDOMIZED-CONTROL TRIAL

Réjean Laprise, Robert L. Thivierge, Gilbert Gosselin, Maja Bujas-Bubanovic, Sylvie Vandal, Daniel Paquette, Micheline Luneau, Pierre Julien, Serge Goulet, Jean Desaulniers, Paule Maltais (CPD, Faculty of Medicine, University of Montreal, Quebec, Montreal Institute of Cardiology, Quebec, Sanofi-aventis, Laval, Quebec)

B78 AGIRPREV: A MULTI-FACETED EDUCATIONAL PROGRAM SUPPORTING PRIMARY CARE TEAMS IN THE IMPLEMENTATION OF CARDIOVASCULAR PREVENTION GUIDELINES

Robert L. Thivierge, Réjean Laprise, Gilbert Gosselin, Daniel Paquette, Micheline Luneau, Francine Borduas, Francine Robinson, Paule Maltais (CPD, Faculty of Medicine, University of Montreal, Quebec, Montreal Institute of Cardiology, Quebec, CPD, Faculty of Medicine, University Laval, Quebec QC, Sanofi-aventis)

Evaluating Guidelines - Some National Perspectives — St. Patrick Room

B79 COMPLIANCE WITH NATIONAL BREAST CANCER GUIDELINES IN THE NETHERLANDS
Harriët Blaauwgeers, Tinie Benraadt, Otto Visser, Margriet van der Heiden-van der Loo (Comprehensive cancer centre Amsterdam, Amsterdam, Comprehensive cancer centre Middle Netherlands, Utrecht)

B80 THE IMPACT OF CLINICAL GUIDELINE ON TONSILLECTOMY IN ITALY
Enrico Materia, Lorenza Rossi, Riccardo Di Domenicantonio, Giovanni Baglio, Sergio Marletta, Lucia Lispi (Agency for Public Health, Rome, Italian Ministry of Health)

B81 AWARENESS OF AND ADHERENCE TO CANCER SCREENING GUIDELINES AMONG HEALTH PROFESSIONALS IN JAPAN
Chisato Hamashima, Hiroshi Saito, Tomotaka Sobue (Research Center for Cancer Prevention and Screening, National Cancer Center, Japan, Center for Cancer Control and Information Services, National Cancer Center)

B82 EXAMINING THE RELATIONSHIP BETWEEN CLINICAL PRACTICE GUIDELINES AND LENGTH OF STAY THROUGH A SECONDARY DATA ANALYSIS
Moriah Ellen, Adalsteinn Brown, Rhonda Cockerill (University of Toronto, Toronto, Ontario)

B83 KNOWLEDGE, ATTITUDES AND USE OF CURRENT CARE GUIDELINES AMONG FINNISH PRIMARY HEALTH CARE PHYSICIANS
Pekka Jousilahti, Jorma Komulainen, Tiina Hanski, Eeva Ketola (National Public Health Institute, Helsinki, Finland, The Finnish Medical Society Duodecim, Current Care, Helsinki, Finland)

Imbedding Information Technology into the Guideline Process — St. George West

B84 DIAGNOSTIC IMAGING PATHWAYS: ACHIEVING STANDARDS IN GUIDELINE DEVELOPMENT?
Phillip Bairstow, Richard Mendelson, Adrian Yesuratnam (Royal Perth Hospital, Perth, WA, Royal Perth Hospital, Perth WA)

B85 GUIDELINES FOR RADIOLOGY: A DEMONSTRATION PROJECT
Martin Reed (Deprtment of Radiology, University of Manitoba, Winnipeg, Manitoba)

B86 'SIB OP MAAT': AN ONLINE DATABASE FOR PATIENT INFORMATION ON ANTICANCER DRUGS
Joke van den Bogert, Marion van Oirschot, Dorien van Benthem, Monique Kroeze, Maureen de Boer (The Dutch Association of Comprehensive Cancer Centres)

B87 EVIDENCE MATTERS (EM): A NEW TECHNOLOGY PROVIDING CUSTOMIZED, UP-TO-DATE EVIDENCE-TABLES AND EVIDENCE-GRAPHS FOR DIVERSE PATIENT POPULATIONS
Ofer Avital (Evidence Matters, Montreal, Quebec)

B88 INNOVATION FOR SUSTAINABLE QUALITY PATIENT CARE: THE ROLE OF ELECTRONIC FORMULARIES IN CREATING VALUE
Michelle Goulbourne (Department of Health Policy Management and Evaluation, Faculty of Medicine, University of Toronto)

Workshops, Thematic Discussion and Network Sessions

W13 THE PROMOTION OF INTERNATIONAL GROUPS AND NETWORKING: THE IBEROAMERICAN NETWORK EXPERIENCE — Terrace East
Ignacio Marín León, António Vaz Carneiro, Airton Tetelbom Stein (Coordinator of Red Iberoamericana de Guias de Pratica Clínica, Member of the Coordination of Red Iberoamericana de Guias de Pratica Clínica)

W14 EVIDENCE TABLES - THE "HOLY GRAIL" FOR LITERATURE REVIEWERS — Terrace West
Najoua Mlika-Cabanne, Sara Twaddle, Michel Laurence (HAS, Saint Denis, France, SIGN, Edinburgh, Scotland)

W15 IMPLEMENTING GUIDELINES: FROM EVIDENCE TO ROUTINE CLINICAL PRACTICE Terrace North

Susan Phillips (National Institute of Clinical Studies)

W16 THE USABILITY OF SEARCH FILTERS FOR GUIDELINES St. David North

Rikie Deurenberg, Kitty Rosenbrand, Tom Oliver, Sylvie Guillo (Dutch Institute for Healthcare Improvement CBO, Utrecht, The Netherlands, Cancer Care Ontario Program in Evidence-based Care, McMaster University, Hamilton, Canada, Fédération Nationale des Centres de Lutte Contre le Cancer, Paris, France)

T06 IMPLEMENTING GUIDELINES IN THE REAL WORLD - HOW G-I-N SPECIAL INTEREST COMMUNITIES (COMMUNITIES OF PRACTICE) IN EMERGENCY CARE, DIABETES OR CANCER MIGHT WORK St. George East

Catherine Marshall, Hon Patron of G-I-N Independent Guideline Adviser and Health Sector Consultant, Sue Huckson, National Health Medical Research Council's National Institute of Clinical Studies (Australia) Heather Buchan, National Health Medical Research Council's National Institute of Clinical Studies (Australia), Michael Fung Kee Fung, Cancer Care Ontario (Canada)

T07 HEALTHY WORK ENVIRONMENT BEST PRACTICE GUIDELINES: FACILITATING EVIDENCE BASED MANAGEMENT DECISION MAKING IN HEALTH CARE St. David South

Irmajean Bajnok, Linda O'Brian Pallas , Alan Pearson, Tazim Virani, Doris Grinspun (Registered Nurses' Association of Ontario (RNAO), Universtiy of Toronto, Johanna Briggs Institute)

N04 DEVELOPING GUIDELINES FOR HEALTH AND COMMUNITY MANAGEMENT: CHALLENGES FOR MULTIFACETED DISEASES WITH MODERATE TO RARE PREVALENCE Lakeview Room

Gagnon Cynthia, Chouinard Maud-Christine, Mathieu Jean , Jean Stéphane (University of Montreal, Montréal, Québec, Canada, Université du Québec à Chicoutimi, Chicoutimi, Québec Canada, Clinique des maladies neuromusculaires, CSSS de Jonquière, Jonquière, Canada)

3:00 pm Pause Café, Exhibits and Poster Viewing ..... Giovanni Room & Colony Grande (West)

Plenary 4 - Implementation Programs: Some Success Stories — **Colony Grande Ballroom**

Chairs: Jeremy Grimshaw, PhD, Canada and Catherine Marshall, New Zealand

3:55 pm **Introduction and Overview** ..... Richard Grol, PhD, The Netherlands

4:05 pm A Successful Implementation Program in France ..... Jean Michel Chabot, France

4:15 pm Successful Regional Programs in Germany ..... Guenter Ollenschläger, MD, Germany

4:25 pm The Successful Use of Tools for Finnish Professionals ..... Minna Kaila, MD, Finland

4:45 pm Open Discussion

5:30 pm Transportation from the Delta Chelsea and 89 Chestnut Street to The Liberty Grand (until 6:15 pm)

6:30 pm **The G-I-N 2007 Gala Reception, Dinner & Entertainment** (until 10:30 pm)

10:00 pm Transportation from the Liberty Grand to the Delta Chelsea and 89 Chestnut Street (until 11:00 pm)

Saturday, August 25, 2007

8:00 am Continental Breakfast ..... Giovanni Room & Colony Grande Ballroom (West)

8:00 am Internet Café (until 2:00 pm) ..... St. Lawrence Room

Plenary 5 - Fitting Guidelines into the Real World — **Colony Grande Ballroom**

Chair: Jean Slutsky, PA, USA

9:00 am Transforming CPGS into Electronic Tools ..... Rick Shiffman, MD, USA

9:30 am Addressing Complexity in Guidelines ..... Paul Wallace, MD, USA

10:00 am Open Discussion

10:15 am Pause Café, Exhibits & Poster Viewing ..... Giovanni Room & Colony Grande Ballroom (West)

10:45 am **Parallel Session 5** (session rooms subject to change)

Case Studies in Collaboration (2) — Armoury Suite

B89 SETTING THE STANDARD: DEVELOPING BENCHMARKS FOR COLLABORATION IN GUIDELINE DEVELOPMENT

Farida Hamza-Mohamed, Michele Hilton-Boon, Joan Vlayen, Safia Qureshi, Beatrice Fervers, Magali Remy - Stockinger, Sylvie Guillo, for CoCanCPG (SIGN, Edinburgh, U.K., KCE, Brussels, Belgium, SOR- FNCLCC and Centre Léon Bérard, Lyon, France, SOR, FNCLCC, Lyon, France, SOR, FNCLCC, Paris, France)

B90 A MULTIDISCIPLINARY APPROACH TO DEVELOPING LOW BACK PAIN GUIDELINES FOR PRIMARY CARE PRACTICE IN ALBERTA

Paul Taenzer, Christa Harstall, Carmen Moga, Ann Scott (Calgary Health Region Chronic Pain Centre, Institute of Health Economics)

B91 PROGRAMS OF CARE: A CONSENSUS APPROACH TO EVIDENCE-BASED CARE

Donna Bain (Workplace Safety and Insurance Board, Toronto, Ontario)

B92 COLLABORATION TECHNOLOGY TO ACHIEVE GUIDELINE CONSENSUS AND CARE STANDARDIZATION: CONTEMPORARY TOOLS, TRENDS, AND LESSONS LEARNED

Timothy McNamara, MD, MPH (CMO, HealthGate Data Corp., Burlington, MA and Medical Director, Center for Healthcare Informatics, University of Kansas Medical Center, Kansas City, KS)

B93 A COMPARATIVE STUDY OF INTERNATIONAL GUIDELINES FOR THE MANAGEMENT OF HYPERTENSION

Gersende Georg, Pierre Meneton, Isabelle Colombet, Pierre Durieux, Joël Ménard (INSERM UMR_S 872, Eq. 20, SPIM, Paris, France, INSERM UMR_S 872, Eq. 20, SPIM, Paris, France;Université René Descartes, Paris, France, Université René Descartes, Paris, France)

B94 COMPARATIVE STUDY OF THE QUALITY OF THE CLINICAL PRACTICE GUIDELINES

Iñaki Gutiérrez-Ibarluzea, Mª Eugenia Esandi, Asun Navarro Puerto, Airton Stein, Sonia Guterres (Osteba, Basque Office for Health Technology Assessment, Centro de Investigaciones Epidemiológicas de la Academia Nacional de Medicina. Argentina, Valme Univerty Hospital. Sevilla. Andalucian Health Service, Grupo Hospitalar Conceição. Porto Alegre, Brasil, Secretaria de Saúde do estado do Rio Grande do Sul- BRASIL)

Implementing Guidelines: Tools and Strategies — Lombard Suite

B25 THE CANADIAN COALITION FOR SENIORS' MENTAL HEALTH NATIONAL GUIDELINES: FROM PAPER TO PRACTICE

Dr. David Conn (Psychiatrist-in-Chief, Baycrest Geriatric Health Care System; Associate Professor, Department of Psychiatry, University of Toronto; Co-Chair, Canadian Coalition for Seniors' Mental Health; Past President, Canadian Academy of Geriatric Psychiatry, Toronto, Ontario)

B96 PARTNERING FOR SUCCESS: GETTING MUSCULOSKELETAL (MSK) CLINICAL PRACTICE GUIDELINES INTO PRACTICE THROUGH THE GETTING A GRIP ON ARTHRITIS ™ PROGRAM

Mary J. Bell, Sydney C. Lineker, Jennifer M. Boyle, Elizabeth M. Badley (University of Toronto, Toronto, Ontario, The Arthritis Society – Ontario Division, Toronto, Ontario, The Arthritis Community Research & Evaluation Unit, Toronto, Ontario)

B97 CREATING A ROAD MAP TO ENHANCE THE CONTINUUM OF CARE FOR RA PATIENTS

Marc White, Patience White, Diane Lacaille, Matthew Liang (Brigham & Women's Hospital, Harvard Medical School, Boston, MA, Arthritis Foundation & George Washington University School of Medicine and Health Sciences, Washington, DC, University of British Columbia, and Arthritis Research Centre of Canada, Vancouver, British Columbia)

B98 MYTH-BUSTING NEWSLETTERS: A STRATEGY TO TRANSFER KNOWLEDGE FROM EVIDENCE-BASED GUIDELINES TO PRACTITIONER CHANGES AT THE BEDSIDE

Mary-Lou van der Horst, Shannon Buckley (Ontario Ministry of Health and Long-term Care/ The Village of Wentworth Heights LTC Home, Hamilton, Ontario, Canada, Hamilton LTC Resource Centre / St. Peter's Hospital, Hamilton, Ontario, Canada)

B99 AN IMPLEMENTATION SUPPORT TOOL FOR NATIONAL NICE GUIDANCE ON SCHIZOPHRENIA AND ATYPICAL ANTI-PSYCHOTICS

Jane Moore, Geraldine Strathdee, Stuart Pack, Michael Pyne (Oxleas NHS Foundation Trust, Dartford, Kent, UK)

Evaluating Guidelines Strategies - Tools and Methods — Elm Suite

B100 SHOULD GUIDELINE REVIEW INCLUDE ASSESSMENT OF ADHERANCE?

Stephen Hall, Stephanie Johnson (Queen's Cancer Research Institute, Kingston, Ont, University of Ottawa, Ottawa, Ont)

B101 DEVELOPING REVIEW CRITERIA TO EVALUATE THE IMPLEMENTATION OF CLINICAL GUIDELINES IN PRIMARY CARE

María-Pilar Pérez, Javiera Léniz, Tomás Pantoja (Departamento de Medicina Familiar, Pontificia Universidad Católica de Chile. Santiago, Chile)

B102 DEVELOPMENT AND EVALUATION OF MEASURES FOR ASSESSING GUIDELINE IMPACT

Kirsten Woodend, Dianne Groll, Barbara Davies (University of Ottawa, Queen's University)

B103 GUIDELINE BASED DEVELOPMENT OF QUALITY INDICATORS FOR SUBFERTILITY CARE

Selma Mourad, Rosella Hermens, Willianne Nelen, Didi Braat, Richard Grol, Jan Kremer (dept. of Obstetrics & Gynaecology and Centre for Quality of Care Research (WOK), Radboud University Medical Centre Nijmegen, Centre for Quality of Care Research (WOK), Radboud University Medical Centre Nijmegen, dept. of Obstetrics & Gynaecology, Radboud University Medical Centre Nijmegen)

B104 ACTUAL AND DESIRED INFORMATION PROVISION IN SUBFERTILITY CARE

Selma Mourad, Rosella Hermens, Willianne Nelen, Didi Braat, Richard Grol, Jan Kremer (Dept. of Obstetrics&Gynaecology and Centre for Quality of Care Research (WOK), University Medical Centre Nijmegen, Centre for Quality of Care Research (WOK), University Medical Centre Nijmegen, Dept. of Obstetrics&Gynaecology, University Medical Centre Nijmegen, and Centre for Quality of Care Research (WOK), University Medical Centre Nijmegen, Dept. of Obstetrics&Gynaecology, University Medical Centre Nijmegen)

Assessing the Impact of Guidelines: The North American Experience — St. Patrick Room

B105 EVALUATION OF PERINATAL CLINICAL PRACTICE GUIDELINES IN BC

Diane Sawchuck

B106 CANADIAN CLINICAL PRACTICE GUIDELINES: EVALUATING THE IMPACT OF A GUIDELINE RESOURCE FOR CLINICIANS

Maria Muraca, Angela Smith, David Greenberg, John Horne

B107 LUNG CANCER GUIDELINE DEVELOPMENT IN ONTARIO: IMPACT ON POLICY, PRACTICE, AND RESEARCH

Dr. William K. Evans, Dr. Christopher A. Smith, Dr. Yee C. Ung, Cancer Care Ontario Lung Disease Site Group (Juravinski Cancer Centre at Hamilton Health Sciences and McMaster University, Hamilton, McMaster University, Hamilton, Toronto Sunnybrook Regional Cancer Centre, Toronto, Cancer Care Ontario,Toronto)

B108 THE DEVELOPMENT OF THE AMERICAN COLLEGE OF SURGEONS GUIDELINE PROGRAM: PRELIMINARY RESULTS FOR CENTRAL VENOUS ACCESS

Andrew Freel, Mira Shiloach, Clifford Ko, John Weigelt (American College of Surgeons, Chicago, IL, Medical College of Wisconsin, Milwaukee, WI)

Guideline Implementation: Multiple Methods, Multiple Questions — St. George East

B109 INTEGRATING A DOCUMENT ENGINEERING ENVIRONMENT INTO THE FRENCH GUIDELINES DEVELOPMENT PROCESS

Gersende Georg, Anne-Françoise Pauchet-Traversat , Joëlle André-Vert, Christine Geffrier-d'Acremont (French National Authority for Health, Paris, France; INSERM UMR_S 872, Eq. 20, SPIM, Paris, France, French National Authority for Health, Paris, France)

B110 USING AN ONLINE RESOURCE TO DEVELOP AND PUBLISH EVIDENCE-BASED NUTRITION PRACTICE GUIDELINES

Kari Kren (American Dietetic Association)

B111 DEVELOPING A GUIDELINE IMPLEMENTATION STRATEGY USING A THEORETICAL FRAMEWORK: THE INTERVENTION FOR THE IMPLEMENT TRIAL

Simon French, Denise O'Connor, Susan Michie, Jill Francis, Jeremy Grimshaw, Joanne McKenzie, Rachelle Buchbinder, Neil Spike, Sally Green, and the IMPLEMENT Study Group (Australasian Cochrane Centre, Institute of Health Services Research, Monash University, Australia, University College, London, UK, University of Aberdeen, Scotland, UK, Clinical Epidemiology Program, Ottawa Health Research Institute, Canada, Department of Preventive and Social Medicine, University of Otago, Dunedin, New Zealand, Monash Department of Clinical Epidemiology at Cabrini Hospital and Department of Epidemiology and Preventive Medicine, Monash University, Australia, Department of General Practice, School of Primary Health Care, Monash University, Australia)

B112 IMPLEMENTING GUIDELINES IN THE MEDICAL CARE OF A REGIONAL TUMOR CENTER AND A UNIVERSITY HOSPITAL: COLORECTAL CANCER AS AN EXAMPLE

Monika Klinkhammer-Schalke, Christoph Ehret, Brunhilde Steinger, Ferdinand Hofstädter (Tumor Center Regensburg e.V.,Regensburg, Germany, Institut of Pathology University of Regensburg, Germany)

B113 IMPLEMENTATING A NATIONAL WHOLE-OF-HOSPITAL VENOUS THROMBOEMBOLISM PREVENTION PROGRAM

Susan Phillips, Zoe Kelly, Maggie Reid, Martin Gallagher (National Institute of Clinical Studies, The George Institute for International Health)

Achieving Sustainability in Guideline Development and Implementation — St. George West

L13 CAPTURING 'LEARNINGS' DURING GUIDELINE DEVELOPMENT AND IMPLEMENTATION TO IMPROVE PRACTICE AND MAINTAIN MORALE

Claire Harris, Fiona Wilkinson, Tari Turner (Centre for Clinical Effectiveness, Monash Institute of Health Services Research, Melbourne, Australia)

L14 DEVELOPING NATIONAL CHRONIC DISEASE GUIDELINES

Jill Parnham (National Collaborating Centre for Chronic Conditions, Royal College of Physicians, London, UK)

L15 THE SUSTAINABILITY OF GUIDELINE IMPLEMENTATION

Barbara Davies, Nancy Edwards, Jenny Ploeg, Evangeline Danseco, Tazim Virani, Maureen Dobbins (University of Ottawa, Ontario, Canada, McMaster University, Hamilton, Ontario, Canada

Workshops, Thematic Discussion and Network Sessions

W17 THE APPRAISAL OF INDICATORS TROUGH RESEARCH AND EVALUATION (AIRE) INSTRUMENT — Terrace East

Johan de Koning, Jako Burgers (Department of Social Medicine, Academic Medical Centre, University of Amsterdam, the Netherlands / Centre for Public Health Forecasting, National Institute for Public Health and the Environment, Bilthoven, the Netherlands, Dutch Institute for Healthcare Quality CBO, Utrecht, The Netherlands)

W18 HETEROGENEITY IN EVIDENCE-BASED CLINICAL PRACTICE GUIDELINE AND HEALTH CARE QUALITY MEASURES DOCUMENTATION: WHY IT IS PROBLEMATIC, HOW IT COULD BE STANDARDIZED? Terrace West

Mary Nix, Vivian Coates, Mark Monteforte, Michelle Tregear, Melanie Swan (U.S. Agency for Healthcare Research and Quality, Rockville, MD;, ECRI, Plymouth Meeting, PA)

T08 GUIDELINES IN ONCOLOGY St. David South

Melissa Brouwers, George Browman, Beatrice Fervers, Joan McClure, Mark Somerfield (Cancer Care Ontario & McMaster University, Hamilton, Canada, BC Cancer Agency & Canadian Partners Against Cancer, Victoria, Canada, Federation Nationale Des Centre de Lutte Contre Le Cancer, Lyon, France, National Comprehensive Cancer Network, Jenkintown, USA, American Society of Clinical Oncology, Alexandria, USA)

N05 IMPROVING COMMUNICATION BETWEEN DEVELOPERS, DISSEMINATORS, AND USERS OF PUBLISHED GUIDELINES Lakeview Room

Michael Allen, Shawn Bugden (Dalhousie University Continuing Medical Education, Halifax, NS, Prescription Information Services of Manitoba, Winnipeg, MB)

Plenary 6 — Colony Grande Ballroom

12:15 pm **Overview and Discussion**
Jako Burgers, MD, The Netherlands, *Chair G-I-N 2007*
Dave Davis, MD, USA, *Conference Host*

Evaluation and Adjournment

1:00 pm **Post-Conference Meetings** (until 5:00 pm)
G-I-N Board Meeting (New)

Keynote Speaker Abstracts

Thursday, August 23, 2007
Plenary 1 - Transferring Knowledge to Professionals

9:00 am **Carolyn Clancy**, MD
Director, US Agency for Healthcare Research and Quality
Rockville, Maryland, USA

From Best Evidence to Practice

Clinical practice guidelines are an essential tool to help clinicians apply scientific evidence to patient care by presenting scientific information in a clinically relevant context. In the US, the conceptual and scientific foundation of guidelines has matured in parallel with increased policy concern regarding inappropriate practice variation and the leisurely pace at which scientific advances 'trickle down' to everyday practice. These same policy concerns converged to create the Agency for Health Care Policy and Research (now AHRQ) in 1989. Today, increases in health expenditures that consistently exceed improvements in quality, coupled with increased diffusion of health information technology, reinforce the vital role of continued enhancements in the production and use of practice guidelines.

This presentation will review the evolution of clinical practice guidelines in the US, and describe current and future challenges and opportunities for continued refinements to guideline development, implementation and updating as a vital component of current policy interest in performance transparency and accountability. In particular, the presentation will focus on the need for a bridge between evidence-based guidelines and the development and use of performance measures for improvement and external accountability, the use of incentives and supportive practice environments, and the new collaborations required to make sure that electronic health records in corporate effective guideline-derived clinical decision support and easy export of performance information to multiple audiences. Last, the presentation will describe lessons from the US experience for other countries, and challenge the audience to address remaining steps required to make evidence assessment in practice as indispensable as monitoring vital signs.

Friday, August 24, 2007
Plenary 3 - Guidelines to Help Policy-Makers

9:00 am **Peter Littlejohns**, MBBS, BSc, MD, FRCP
Clinical Director, National Institute for Health and Clinical Excellence
London, United Kingdom

The Need for Transparency in Guidelines

Plenary Speaker & Discussant Abstracts

Thursday, August 23, 2007

Plenary 1 - Transferring Knowledge to Professionals

9:40 am **Discussant:** Ilkka Kunnamo, MD, PhD
Editor-in-Chief, The Finnish Medical Society Duodecim
Helsinki, Finland

What Can be Globalized or Shared Nationally and Internationally by Collaboration

Sharing guidelines and evidence summaries (and possibly also authoring tools) improves efficiency and saves duplication of efforts. The success of international sharing of guidelines seems to depend on the following characteristics:

- Publishing in the users' native language by a respected publisher;
- Review and editing by a dedicated local team of trusted colleagues;
- Collaboration with the original publisher on a continuous basis;
- Regular updating that is sufficiently financed;
- Several publishing formats, including printed and electronic versions.

In Finland, electronic guidelines (EBM Guidelines) are used extensively. The number of Finnish language guideline documents opened daily is about 1.6 times the total number of working-aged physicians in the country. Authored originally in Finnish, the EBM Guidelines have been translated into five languages.

According to user surveys, the most important determinants of successful guideline use include the following:

- The guideline set is comprehensive (high probability of finding guidance for any clinical problem) and well indexed for searching;
- The guidelines are concise (readable within one minute) and give clear recommendations that are backed by evidence summaries;
- The guidelines are produced by trusted peers (scientific society of all physicians);
- The guidelines are available within a comprehensive health portal for professionals;
- Local protocols and care pathways are based on the guidelines and linked to them;
- Multi-faceted implementation is a continuous activity;
- User feedback and log files are used for improvement;
- Guideline development and licenses are paid by health care organizations.

The implementation is enhanced by a citizens' health portal based on the guidelines. In the near future, as structured electronic patient records are available to both professionals and to citizens themselves, guidelines in the form of patient-specific decision support will improve the quality of care and ensure transparency of clinical decisions.

Plenary 2 - Achieving Collaboration Through an International Guidelines Network: The G-I-N Story

3:30 pm **Coordinator:** Angela Maienborn, MD
Chairs: Françoise Cluzeau & Minna Kaila

1. Introduction G-I-N and G-I-N projects - **Dave Davis**

2. Working with other networks - **Sara Twaddle & Najoua Mlika-Cabanne**
The aim of the Evidence Tables working group and the planned project "Translation of Evidence" is to promote international collaboration in guideline activities and to improve coordination with other health care quality initiatives. G-I-N is working on organizing and promoting trans-national project groups, training courses, events and conferences: these are just two examples

3. G-I-N Communities - **Catherine Marshall & Heather Buchan**
Virtual Communities share an interest relating to their areas of work. Communities in emergency care, type 2 diabetes and cancer have been established to support interaction and improved collaboration.

G-I-N communities will:

- provide an opportunity to develop an international network
- generate new knowledge
- sharing existing knowledge
- enable and foster opportunities to publish collaboratively

4. News on the G-I-N Website - **Günter Ollenschläger & Airton Stein**
Changes, enhancements and new pages on www.g-i-n.net like Guidelines Tool Inventory, new search functions, multilingual options

5. Discussion, suggestions and questions from the audience.
Your ideas...in what areas can G-I-N help you or your organization?
What tools, meetings, web-activities and other resources can we provide?

Friday, August 24, 2007

Plenary 3 - Guidelines to Help Policy-Makers

9:30 am **Discussants:**

Paul Shekelle, MD, PhD
Director, Southern California Evidence-Based Practice Center, RAND Corporation
Los Angeles, California, USA

Andreas Laupacis, MD
Director, Li Ka Shing Knowledge Insititute, St. Michael's Hospital
Toronto, Ontario, Canada

What Can the World Learn from NICE?

- A Perspective from USA
- A Perspective from Canada

Plenary 4 - Implementation Programs: Some Success Stories

3:55 pm **Prof. Richard Grol**, PhD, FRCGP
Scientific Institute for Quality and Safety in Health Care (WOK)
The Netherlands

Many patients do not receive recommended (evidence based) care (estimated 30-45%) and a large, unexplained variation in use of clinical guidelines between sites and providers can be observed. Many methods for implementation of guidelines are available, but their impact is at best moderate (8-10% on average) and improvements in practice are often not sustained.

This lecture presents 12 principles for sustained implementation of evidence and other best practices, based on research and experiences around the world.

1. substantial and sustained change is mostly achieved by continuous step-by-step approaches with change intervention continuously adapted on the basis of evaluations
2. optimal preparation of the implementation is needed with a good plan, division of tasks, time schedule, budget, enthousiastic team with different types of expertise and consistent support of leaders and policy makers
3. the evidence or guideline to be implemented need to be translated into clear and attractive 'messages', which can create interest and commitment
4. targets for improvement should be defined: a limited number of very concrete and achievable target
5. the change plan is based on valid data on performance, feedback must create a 'sense of urgency' (this is a problem and we are responsible)
6. most of the time a combination of interventions with actions at different levels (professionals, patients, teams, organizations, legal and financial structures) are needed, tailored to the target group and setting
7. local support is often critical: external experts come and help teams to set up improvement and teach them how to do it
8. learning through peer influence and modeling best practice using experienced colleagues can be very effective
9. assure necessary structural, financial and political conditions before starting with implementing evidence
10. a receptive environment and culture of learning in the team or organization is also crucial: involve and train the target group at all stages of the implementation process
11. embed plan within local/familiar (educational) activities and take care that is is also 'fun'
12. invest in young professionals: teach improvement competencies in under- and postgraduate training

These principles will be explained and examples from practice an research will be presented.

Plenary 4 - Implementation Programs: Some Success Stories

4:05 pm **Jean Michel Chabot**
Paris, France

A Successful Implementation Program in France

4:15 pm **Günter Ollenschläger**, MD
Director, German Agency for Quality in Medicine
Berlin, Germany

Successful Regional Guideline Programmes in Germany
Günter Ollenschläger, Marga Cox, Liat Fishman, Monika Nothacker,
Julia Rohe, Achim Wöckel (German Agency for Quality in Medicine (AEZ/AQuMed)

Background
In Germany, strategies for implementation of evidence based healthcare were introduced by the Physicians' Self Governmental Bodies (German Medical Association and National Ass. of Statutory Health Insurance Physicians) in 1995. Against this background, a joint scientific institution, the Agency for Quality in Medicine äzq, was established to act as a National Centre for Evidence based Medicine and Guideline Implementation. Within this framework a national disease management guidelines programme (DM-CPG) was developed between 2000 and 2002 to produce and disseminate evidence based guidelines linking prevention, acute care, rehabilitation and chronic care for high priority healthcare topics (asthma, diabetes, COPD, CHD, depression, back pain, CHF etc.). In order to implement these strategies and tools, the German parliament passed a legal framework for disease management programmes institutionalised on regional level. Until 2007 DM-CPG programmes have been established in all German States (Laender). The presentation gives an overview on background, approaches and first results of the implementation of evidence based disease management guidelines.

Methods
(1) Adaptation and dissemination of international methodologies, (2) business plan for a national guideline programme; (3) lobbying within stakeholders of physicians' scientific and political organisations; (4) establishment of a national guideline bureau; (5) guideline adaption; (6) multidimensional dissemination; (7) structured implementation on regional level; (8) outcome research.

Results
In 2003 the umbrella organisations of the scientific medical associations (n=150) and of all German panel physicians (n = 120,000) joined the programme and consented on a national guideline methodology. Guidelines for asthma, COPD, CHD, Diabetes were developed and disseminated 2003-2006 to all German physicians (n=400,000). Consumer involvement started in 2005 by means of a national patient forum, with 3 patient guidelines disseminated in 2006 and 2007. Regional panel physicians' quality circles have been developing and using guideline based pathways for use in primary care practices. Evaluation studies on diabetes and CHD guideline implementation started in 2006.

Discussion
While consenting on needs, methodological and organisational issues, a countrywide disease management guideline programme was established within 4 years. Development & dissemination of national & regional DM-CPG programmes were main driving forces for expansion and institutionalisation of evidence based healthcare in Germany. Follow-up studies show trends toward CPG recommended patient care. Controlled trials measuring efficiency and effectiveness of guideline use are underway.

Ref.: Ollenschläger G, Kopp I. The German program for disease management guidelines. Results and perspectives. Med Klin (Munich). 2007 May 15;102(5):383-7

Plenary 4 - Implementation Programs: Some Success Stories

4:25 pm **Minna Kaila**, MD, PhD
Senior Medical Officer, Programme Manager/MUMM-programme
Finnish Office for Health Care Technology Assessment
Tampere, Finland

The Successful Use of Tools for Finnish Professionals
Finohta /STAKES - National Research and Development Centre for Welfare and Health

Two sets of national guidelines are being produced in Finland. The first is a collection of more than 1200 concise, primary care focused guidelines that have been in production since 1989 (Evidence Based Medicine Guidelines, EBMG). The second includes 75 comprehensive clinical guidelines targeting the entire health care system. The first of these was published in 1997 (Current Care guidelines, CC). The home of the guidelines is the physicians' scientific association, Finnish Medical Society Duodecim. Both sets use the same electronic production line that allows easy multichannel publication. The EBMG are available in certain types of mobile phones and in the most traditional handbook format. The CC can be freely accessed via Internet in Finnish, with English summaries (www.kaypahoito.fi), and can be read in the Medical Journal Duodecim. Practically all health professionals have access to both sets via a health portal for professionals purchased by almost every health care organization.

The guidelines are produced by physicians for physicians, which has probably improved use and at least attitudes. Of the 18 000 physicians, more than 600 - 700 have been involved in guideline development. Other professionals have had a lesser role. Especially for the CC, the main strategy in implementation has been to use the guidelines as basis for developing local care pathways. In these local projects, professionals other than physicians have been actively involved.

The collective experience of the physicians in producing practice guidelines made it easier to embark on a national effort to control queing for treatment. Long ques were considered an important equity issue, and in 2005 a set of 200 criteria for non-emergency treatment was published and endorsed by the Ministry of Social Welfare and Health. A major proportion of these were based on the existing guidelines.

The Finnish guidelines are actively and widely disseminated - and used according to the Internet statistics. Accessibility is easy, the guidelines aim to be concise and clear, and evidence summaries and even Cochrane reviews are available. The next step is to start using the evidence (the electronic guidelines) in conjunction with an electronic patient record to produce e.g. individualized right-on-time reminders to help the physician (professional, patient) remember important matters and to ease their workload.

Saturday, August 25, 2007

Plenary 5 - Fitting Guidelines into the Real World

9:00 am **Richard N. Shiffman**, MD, MCIS
Yale University School of Medicine
New Haven, CT USA

Guideline implementation comprises a critical step in the transformation of scientific knowledge into systems that influence clinicians' behavior toward best practices. However, dialog and interaction between the developers of guideline recommendations and those charged with operationalizing them have been limited. The Guidelines International Network can provide opportunities for communication between these groups.

Guideline recommendations that are clearly stated, patient-specific, and delivered at the point of care have the highest likelihood of being effective. Information technology offers a capability to deliver patient-tailored advice to the site where clinical decision making occurs. This plenary presentation will explore a range of electronic clinical decision support tools, including Web-based guidelines, alerts, reminders, prompts, order sets, diagnostic and management assistants that have been applied internationally to improve care delivery. Challenges to effective electronic implementation include how best to represent knowledge about appropriate practice in electronic form, standardization of interactions between knowledgebases and electronic health records, and effective integration of guidance into clinical workflow.

We will also describe a number of electronic tools that can facilitate guideline development, such as GEM-Q to examine guideline quality, EXTRACTOR to promote accurate translation of recommendations, and the Guideline Implementability Appraisal (GLIA) to identify potential obstacles to successful implementation.

Plenary 5 - Fitting Guidelines into the Real World

9:30 am **Paul Wallace**, MD
Medical Director for Health and Reproductivity Management Programs
The Permanente Foundation, Kaiser Permanente
Oakland, California, USA

Fitting Guidelines into the Real World: Addressing Complexity in Guidelines

While the underlying methodology, acceptance, use and impact of disease based guidelines has progressed in the last 20 years, a major future opportunity is to extend this experience to provide empirically based advice for the management of the patient with multiple conditions. Much of health care resource utilization is concentrated on a very small subset of patients - generally with less than 5% of patients consuming over 50% of resources used and often one third of resource use by no more than 1% of the population. This pivotal subset of patients is largely distinguished by the frequent presence of multiple advanced and co-morbid medical diagnoses and conditions. A critical aspect of clinical management of this diverse population of patients is prioritization among all that could be done, even among interventions with a sound disease-oriented evidence base, to focus on interventions most likely to maximize health outcomes for that patient. Empirical support for the management of the complex co-morbid patient ideally requires awareness of both how conditions co-occur within a population and as conditions coincide or preferentially cluster, which of the multiple possible interventions will have the highest yield for improving health outcomes. This presentation will share preliminary work to identify common patterns of co-morbidity and their linkage to overall resource utilization, discuss possible approaches for evolving an increasingly empirical basis for prioritization among possible interventions, and propose a framework for leveraging this evidence into patient management and performance assessment.

Brief Presentation Abstracts

B01

HAS' EXPERIENCE IN ADAPTING INTERNATIONAL CLINICAL PRACTICE GUIDELINES (CPGS) FOR LOCAL USE

Najoua Mlika-Cabanne, Michel Laurence, Patrice Dosquet (Haute Autorité de Santé (HAS), Saint-Denis La Plaine, France)

Background
An international collaboration of independent researchers, CPG developers, users and implementers has developed a process for adapting CPGs (ADAPTE). Its aim is to ensure the production of relevant, applicable and up-to-date CPGs without unnecessary duplication of effort (http://www.adapte.org). The HAS annual CPG development programme includes about 25 CPGs.

Purpose
To test the process for two CPGs: (1) "active management of labor" (several CPGs published), (2) "management of syncope" (a high-quality European CPG used by most French physicians).

Methods
A working group assessed the feasibility of the process with minor modifications. We noted their opinions and the results of the process.

Results
Members were not keen to participate (time needed, fear of insufficient expertise) but discovered with pleasure that the process provided them with a better understanding of CPG development. Moreover, less time was spent searching for and acquiring documentation. The results for CPG 1 were: (a) Search for source CPGs: 13 references selected, of which 7 rejected; (b) clinical content: HAS had framed 24 questions (3 never yet addressed, 3 irrelevant and deleted); 4 relevant questions added; (c) methodological quality (AGREE): 1 CPG rejected (score for rigor domain: 4.8%); (d) search quality: no CPG rejected but start date omitted in 1 CPG; (e) methods for selecting evidence: 1 CPG rejected as selection criteria inappropriate; (f) coherence between literature review, conclusions, and recommendations: all 4 remaining CPGs coherent; (g) work on CPG selection endorsed by working group; (h) literature review updated (2006); (i) HAS' recommendations drafted using the most appropriate responses in the 4 CPGs.

Discussion
The adaptation process was well accepted once the work had been accomplished. The time for CPG production was no shorter because of lengthy recruitment and administrative procedures but workload was reduced. The quality of the derived CPG has yet to be assessed.

B02

THE ADAPTE PROCESS: APPLICATION ON THE PERIOPERATIVE TREATMENT FOR RESECABLE NON SMALL CELL LUNG CANCER (NSCLC)

Clotilde Séblain El Guerche, Sylvie Guillo, Guillaume Gory Delabaere, Anne Bataillard, Béatrice Fervers (Fédération Nationale des Centres de Lutte Contre le Cancer (FNCLCC)-Lyon- France, FNCLCC- Paris- France, FNCLCC- Paris - France, FNCLCC-Lyon- France, FNCLCC and Centre Léon Bérard-Lyon- France)

Background
The ADAPTE Working Group is an international collaboration of guidelines developers initiated between the department "Standards & Options: Recommendations" of the French Federation of Comprehensive Cancer Centres and the Quebec Cancer Control Department. The group developed in 2004 a systematic approach for the adaptation of existing guidelines to different contexts and settings: the ADAPTE process.

Purpose
-Using the ADAPTE process to update SOR recommendations on adjuvant chemotherapy of stage I to IIIA NSCLC.
- Testing the ADAPTE process.

Methods
Six main phases of the ADAPTE process were performed in cooperation with clinicians:
- Search and screen of existing guidelines using PIPOH (Population, Intervention, Professionals, Outcomes, Health care setting);
- Assessment of the source guidelines' quality using the AGREE Instrument;
- Assessment of consistency between study results, conclusions of the literature review, and recommendations;
- Evaluation of applicability to French cancer care;
- Decision about using or not the existing guideline;
- Search of evidence published after publication date of the source guideline.

Results
- A guideline from Cancer Care Ontario published in 2005, addressed our clinical question. Its quality assessment led to its acceptance by the working group while its applicability directed us toward the need for precision of the concerned population and adaptation of drug regimens to the French context;
- Duration of development was reduced from 17 months with the usual SOR process to 10 months with ADAPTE;
- The process was well accepted by the clinicians.

Discussion
The process seems to shorten the development of SOR-Clinical Practice Guidelines (CPG) and to allow the development of experts' confidence on pre-existing CPGs.
The main restrictions were linked with a lack of level of evidence in the CCO guideline. These positive results in terms of efficiency of guideline production and acceptance by the expert panel should be further evaluated systematically.

B03

ADAPTATION OF CLINICAL PRACTICE GUIDELINES FOR THE LOCAL CONTEXT IN BELGIUM: AN EXPERIMENT WITH TWO TOPICS

Paul Van Royen, Lieve Peremans, Jan Michels, Kristien Dirven, Nathalie Van de Vyver, Hilde Philips, Frans Govaerts, Martine Goossens, An De Sutter (University of Antwerp, Antwerp, Belgium, Domus Medica, Antwerp, Belgium, University of Gent, Gent, Belgium)

Background
The de novo development and updating of high-quality clinical practice guidelines (CPG) is costly and time consuming. One effective option of using resources more efficiently and avoiding unnecessary duplication of effort would be to adapt published, evidence based CPGs to the local context. A method and instrument for such transcontextual adaptation is developed and validated within Guidelines International Network (GIN).

Purpose
Because in Belgium we face pressure to produce and update more guidelines and resources are lacking for this process de novo, we took the opportunity to test the feasibility of a systematic approach for adapting guidelines.

Methods
As no validated process for the adaptation of guidelines is yet available, we used the Practice Guidelines Adaptation and Evaluation cycle (Graham et al, 2005), the approaches reported by Fervers (IJQHC 2006) and the ADAPTE group as references

Results
Based on the mentioned references, we developed a procedure with 10 steps, including searching for existing guidelines, updating literature and/or addition of clinical questions, quality appraisal, analysis of the evidence and the recommendations, testing the recommendation in the target group and adaptation of the recommendations to the target context of use. The procedure and its feasibility is tested for: a) the development of a new guideline on 'the management of harmful alcohol use in general practice' and b) the full updating of the guideline 'hypertension'.

Discussion
The tested approach for adapting guidelines is considered an alternative to de novo guideline development. We will report on the encountered difficulties and obstacles, such as the need for expertise in information gathering and critical appraisal of guidelines, time needed for each step and lack of tools. This supports the need for clear but flexible instructions.

B04

NICE AND SHORT? DEVELOPING SHORT CLINICAL GUIDELINES FOR THE NATIONAL HEALTH SERVICE IN ENGLAND AND WALES

Tim Stokes, Toni Tan, Francis Ruiz, Janette Boynton, Michael Heath, Nicole Elliott (National Institute for Health and Clinical Excellence (NICE), Manchester and London)

Background
The National Institute for Health and Clinical Excellence (NICE) has recently established a short clinical guideline programme. This programme will allow the rapid (12 month) development of clinical guidelines that address a small number of key clinical questions and will allow NICE to address topics on which the National Health Service in England and Wales requires urgent guidance. The World Health Organisation, in its recent review of the NICE guidelines programme, has also recommended that NICE undertake the development of short clinical guidelines. A challenge for this new programme is to maintain NICE's key principles of transparency, inclusiveness and robust assessment while markedly shortening all steps of guidance production.

Purpose
To present the key methodological issues encountered from adapting current NICE clinical guideline methods for short clinical guideline development.

Methods
The interim process guide for the short clinical guidelines programme is the subject of public consultation from February to April 2007. The first short clinical guideline, care of the acutely ill in hospital, is currently in development and will be published in July 2007.

Results
The results of the public consultation on the short clinical guidelines programme process and methodological issues encountered during the development of the first short clinical guideline by NICE will be presented.

Discussion
The key issues national guideline developers need to consider when planning a programme of short or rapid clinical guidelines will be highlighted and discussed.

B05

ASSESSMENT OF THE SCOPE AND QUALITY OF CLINICAL PRACTICE GUIDELINES IN BURN INJURY

E. Kis MD, I. Szegesdi MD, É. Dobos MD, Kemény MD, DSc (Burn and Plastic Surgery Unit of the Department of Dermatology and Allergology, Department of Anaesthesiology and Intensive Therapy of the University of Szeged, TUDOR Hungarian EBM Network)

Purpose

To provide an evidence-based background for developing the Hungarian Burn Association burn injury guidelines, a systematic review of the literature was performed to identify published guidelines in burn injury and evaluate their quality.

Methods

A systematic search was performed for relevant literature from MEDLINE, SCOPUS, the Cochrane Library, the websites of several related journals and general medical journals, electronic databases of major guideline development agencies, and reviewing the reference lists of review articles and included guidelines. We also searched for guidelines of several websites of burn associations. Each guideline was evaluated by three reviewers using the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument and was coded for clinical topics covered. Clinical topics were identified by reviewing burn practice guidelines.

Results

From 546 citations, 21 relevant guidelines were identified.Of the 21 guidelines evaluated, 8(38%) were evidence-based. The AGREE instrument rates guidelines along six domains. As a group, the guidelines performed well in the scope and purpose domain, with only 3 guidelines (14%) scoring < 50%, and in the clarity and presentation domain, 1 guideline (5%) scored <50%. For the remaining domains, however, the guidelines did not perform as well: for stakeholder involvement, 17 guidelines (81%); for rigor of development, 13 guidelines (62%); for applicability, 20 guidelines (95%); and for editorial independence, 18 guidelines (86%) scored < 50%. After considering the domain scores, the reviewers recommended 12 of the guidelines (57%).

Discussion

All major burn injury topics are covered by at least one guideline, but no single guideline addresses all areas. Furthermore, although existing guidelines may accurately reflect clinical practice, most performed poorly when evaluated for quality. Future guideline efforts that address each item of the AGREE instrument would add substantially to the better management of burn injury patients.

B06

AN INTERDISCIPLINARY GUIDELINE DEVELOPMENT PROCESS: THE CLIP LOW-BACK PAIN GUIDELINES

Stéphane Poitras PT PhD , Michel Rossignol MD MSc , Clermont Dionne OT PhD , Michel Tousignant PT PhD , Manon Truchon PhD , Bertrand Arsenault PT PhD , Pierre Allard PT MBA , Manon Coté MD , Alain Neveu MD (Montreal Department of Public Health, McGill University, Montreal (Canada), Department of Rehabilitation, Laval University, Quebec City (Canada), Department of Rehabilitation, Sherbrooke University, Sherbrooke (Canada), Department of Industrial Relations, Laval University, Quebec City (Canada), School of Rehabilitation, University of Montreal, Montreal (Canada), Sir Mortimer B Davis Jewish General Hospital, Montreal (Canada), Jewish Rehabilitation Hospital, Montreal (Canada), Constance Lethbridge Rehabilitation Centre, Montreal (Canada))

Background
A review of the quality of low-back pain (LBP)guidelines, using the AGREE instrument, concluded that stakeholder involvement and guideline applicability needed to be improved(1).

Purpose
To develop, with family physicians, physiotherapists and occupational therapists, interdisciplinary guidelines aimed at the clinical management of LBP in primary care.

Methods
Five inter-dependent groups were created: the project team (n=9), stakeholder representatives (n=10), extended group of clinicians (n=136), scientific committee (n=7) and clinical synthesis team (n=9). Clinicians were drawn from the following professions: physiotherapists (46%), occupational therapists (37%) and family physicians (17%). Stakeholders represented clinician licensing boards and associations. Using previously published guidelines, systematic reviews and meta-analyses, clinical management recommendations for LBP were developed by the project team. A structured process facilitating discussions on these recommendations among members of the five groups was created. Four communication tools were provided for these exchanges: a web-based discussion forum, anonymous questionnaires, meetings and symposia. Participants were prompted for comments on clarity and applicability of the recommendations. Clinical management recommendations were revised following these exchanges, without deviating from the evidence. At the end of the project, a questionnaire was sent to the participants to assess satisfaction towards the guidelines and the development process.

Results
Twelve clinical management recommendations on management of LBP and persistent disability were developed. A clinical algorithm summarizing the guidelines was also elaborated. A response rate of 75% was obtained for the questionnaire. The majority of respondents were satisfied with the guidelines and the development process.

Discussion
Primary care interdisciplinary guidelines aimed at returning patients with LBP to their usual activities and preventing persistent disability were developed and endorsed by relevant stakeholders.

(1) van Tulder MW et al. Quality of primary care guidelines for acute low back pain. Spine 2004;29:E357-E362.

B07

MAKING THE AGREE TOOL GUIDANCE MORE USER FRIENDLY

Ann Scott, Carmen Moga, Christa Harstall, Paul Taenzer (Institute of Health Economics, Calgary Health Region Chronic Pain Centre)

Background

A literature review revealed that knowledge-practice gaps exist among primary care practitioners regarding low back pain. The Alberta HTA Chronic Pain Ambassador Program is addressing this gap by gathering the best quality guidelines on low back pain management to construct evidence-based, Alberta-specific guidelines and clinical care pathways on the prevention, diagnosis, and treatment of low back pain.

Purpose

The AGREE tool was used to appraise selected guidelines. The tool was modified to reduce the ambiguity and subjectivity in item scoring, and to enable the differentiation of good from poor quality guidelines.

Methods

Three modifications were made.

1) The three criteria in the Scope and Purpose domain were considered mandatory for a good quality guideline. Guidelines not scoring 100% in this domain were excluded from further appraisal.
2) A detailed set of instructions, or dictionary, based on the AGREE guidance was constructed that utilized logical operators (AND, OR, NOT).
3) Seven "essential" criteria were identified for categorizing guidelines as good, moderate, or poor quality. The average quality score (maximum possible of 28) was then rated.

Good -score of 22 to 28;
Average -score of 15 to 21;
Poor -score 0 to 14.

The dictionary was tested by three reviewers using three randomly selected guidelines on low back pain management.

Results

Pearson correlation coefficients ranged from 0.27 to 0.81 for pairs of reviewers. For the three guidelines, 7/9 inter-reviewer comparisons were statistically significant ($P<0.01$). Discussion of discrepancies increased the level of agreement (range 0.95-1.00). Items 7, 19, and 20 generated the most disagreement.

Discussion

The modified AGREE tool was useful, particularly the dictionary, which is undergoing further reliability testing. More prescriptive instructions cannot eliminate subjective judgment, but they do reduce ambiguity and discourage the autopilot effect that inevitably occurs when reviewers examine multiple guidelines.

B08

AGREE NEXT STEPS: CONTINUOUS QUALITY IMPROVEMENT IN THE EVALUATION OF CLINICAL PRACTICE GUIDELINES

Melissa Brouwers, Jako Burgers, Francoise Cluzeau, Dave Davis, Gene Feder, Beatrice Fervers, Jeremy Grimshaw, Steven Hanna, Michelle Kho, Peter Littlejohns, Julie Makarski, Guenter Oilenschlaeger, and the AGREE II Next Steps Group (Department of Clinical Epidemiology and Biostatistics, McMaster University, Hamilton, ON, Dutch Institute for Healthcare Improvement CBO, Utrecht, the Netherlands, St. George's Hospital Medical School, London, UK, University of Toronto, Toronto, ON, Bart's and the London Queen Mary's School of Medicine, London, UK, Federation Nationale des Centres de Lutte Contre le Cancer, Lyon, France, Clinical Epidemiology Program, Ottawa Health Research Unit, Ottawa, ON, National Institute for Clinical Excellence, London, UK, Agency for Quality in Medicine (AQuMed), Berlin, Germany)

Background
The Appraisal of Guidelines Research and Evaluation instrument (AGREE 1.0) was designed to assess the quality of clinical practice guidelines (CPGs). It is widely used by many organizations across the world. However, further refinement is required to enhance its measurement properties (reliability, validity, and usability) and increase its pertinence to different user groups (e.g., clinicians, researchers, and policy makers).

Purpose
1. Introduce a 7-point scaling system and establish its reliability.
2. Test the relationship between the quality domain scores and various global assessments of quality.
3. Evaluate users' perceptions of the value, helpfulness, and relevance of the AGREE 1.0 instrument items to their decision-making.

Methods
Based on a sample size calculation, we anticipate recruiting >200 study participants, including guideline developers/researchers, practicing clinicians, and policy makers. Based on a randomized design, participants will evaluate a guideline using AGREE 1.0, complete a series of new global rating measures, and provide ratings and rankings regarding the usefulness of items, domains and scales to decision making.

Results
Recruitment, data acquisition, and analysis are ongoing at the time of writing. We will present data addressing our hypotheses, including reliability of the new scaling and correlations between global measures and AGREE 1.0 domain scores. It is expected that the perceptions of ratings and rankings of instrument item and domain usefulness will vary significantly across appraiser type. The process of applying the AGREE instrument to evaluate a guideline may affect global ratings of the guideline and the perceived usefulness of the AGREE.

Discussion
This project will inform the next version of the instrument (AGREE 2.0) and provide the foundation to design AGREE-Shorts, abridged versions of the AGREE instrument tailored to appraiser type and useful in certain contexts for specific objectives.

This project is funded by the Canadian Institutes of Health Research.

B09

DEVELOPMENT AND VALIDATION OF A MEASUREMENT INSTRUMENT FOR APPRAISING INDICATOR QUALITY: APPRAISAL OF INDICATORS TROUGH RESEARCH AND EVALUATION (AIRE) INSTRUMENT

Johan de Koning, Anneke Smulders, Niek Klazinga (Department of Social Medicine, Academic Medical Centre, University of Amsterdam, the Netherlands / Centre for Public Health Forecasting, National Institute for Public Health and the Environment, Bilthoven, the Netherlands, Department of Social Medicine, Academic Medical Centre, University of Amsterdam, the Netherlands)

Background
In recent years, performance measurement in health care has become top priority for all major stakeholders in health care systems worldwide. Large numbers of quality indicators have emerged from many sources. However, despite the availability of hundreds of indicators, the quality of many of them often is questioned.

Purpose
The aim of this study was to develop and validate an instrument for assessing the quality of indicators.

Methods
The AIRE Instrument was developed and tested through a multi-staged process including; -a literature study, -item generation, selection and grouping, -consultation rounds with experts in the field of performance measurement in health care, -investigation of its reliability and validity by an expert panel (n=8) using a set of clinical indicators, and -a questionnaire survey on the instrument's relevance and usability.

Results
We developed an instrument similar to the AGREE Instrument, developed to appraise clinical practice guidelines. The AIRE Instrument consists of 20 quality criteria (items) grouped into four quality domains: 1. Purpose, relevance and organizational context, 2. Stakeholder involvement, 3. Scientific evidence, 4. Additional evidence, formulation and usage. All panellists found the instrument useful for appraising indicator quality. Reliability was acceptable for most domains (Cronbach's alpha 0.69-0.94). All domains were rated consistently (ICC), however for different numbers of appraisers. As some items could be interpreted differently in domain 1 and 2, further refinement of these items was needed. Quality indicators produced as part of established indicator programs or by specialized organizations had significantly higher scores on domain 1 (p=,016), 3 (p=,046), and 4 (p=,001).

Discussion
The AIRE Instrument can be used consistently to appraise indicator quality. Application of this instrument enhances uniformity in indicator development procedures that will lead to improved indicator quality. In 2007, the AIRE Instrument will be validated in an international setting.

B10

ELICITING PRIORITIES FOR GUIDELINE TOPICS FROM PATIENTS WHO HAVE CHRONIC KIDNEY DISEASE

Allison Tong, Peter Sainsbury, Bronwyn Hall, Stacy Carter, Jonathan Craig (NHMRC Centre for Clinical Research Excellence in Renal Medicine, Centre for Kidney Research, Children's Hospital at Westmead, Westmead, NSW 2145, School of Public Health, University of Sydney, Sydney, NSW 2006 , School of Public Health, University of Sydney, Sydney, NSW 2006, Centre for Values, Ethics and the Law in Medicine, University of Sydney, Sydney NSW 2006, NHMRC Centre for Clinical Research Excellence in Renal Medicine, Centre for Kidney Research, Children's Hospital at Westmead, Westmead, NSW 2145, School of Public Health, University of Sydney, Sydney, NSW 2006)

Background
The inclusion of consumer preferences in the selection process of research topics and guideline topics is widely advocated. However, the choice for research and guideline topics is largely driven by professional agendas and the preferred mechanisms for consumer involvement remains unclear.

Purpose
This study was conducted to elicit priorities for guideline and research topics from patients who have chronic kidney disease (CKD). We also aimed to explore and identify the reasons underlying their selection of guideline and research topics.

Methods
Patients with CKD were purposively sampled from four kidney dialysis and transplant centres in 3 major cities in Australia to participate in one of 9 focus groups - 3 for pre-dialysis patients, 3 for patients on dialysis and 3 for transplant patients. The focus groups were conducted from July - September 2006. Each 2-hour focus group involved 6-8 participants. Focus groups transcripts were coded and thematically analysed to identify recurrent research topics and the participants' logic for their choices.

Results
Important topics identified included: prevention of kidney disease, better access to and improvement in kidney transplantation, reduction and elimination of side effects associated with treatment, and more advanced technological therapies. We derived 5 reasons or logic that patients used to select their topics: normalising logic (developing therapies and regimens that fit into daily living), altruistic logic (considering the welfare of others before personal needs), economic logic (channelling resources for maximum economic efficiency), personal logic (preferences based on feelings, values, personal needs), and clinical logic (improving clinical outcomes and the physiological condition of patients with CKD).

Discussion
We have identified topics recurrently nominated by patients and developed 5 'patient-logics' that can be considered in the broader context of selecting what guideline topics to cover. Decision-making processes for selecting guideline topics should be made explicit and should incorporate consumer values and perspectives.

B11

WAVING NOT DROWNING IN THE GUIDELINES SEA

Andrew Boyden (National Heart Foundation of Australia, Canberra, Australian Capital Territory)

Background
In Australia, various bodies develop and implement clinical guidelines. Their work has been supported by a national organisation that sets standards and provides support. However despite these useful inputs, implementation and improved health outcomes are hindered by the absence of a national framework to prioritise, coordinate, and fund the development and implementation of clinical guidelines. Organisations including the National Heart Foundation of Australia (NHFA) have undertaken important work, albeit while largely working independently of each other. Recognising the difficulties associated with the isolated development of guidelines, and that implementation requires coordinated activities across multiple sectors, the NHFA has reviewed its strategy. It has defined new approaches that aim to optimise outcomes in the absence of a much-needed national guidelines framework.

Purpose
To present a case study of a leading Australian non-government organisation that has adopted new strategies to work in the area of clinical guidelines in the absence of a national guidelines framework.

Methods
Commentary

Results
N/A

Discussion
A program logic approach was used to help define a clinical guidelines strategy. The starting point was to define the short, medium and longer health outcomes sought by the organisation. Consideration was then given to how the NHFA with its limited resources could best work to help achieve these outcomes. Key features of the strategy include: -A focus on government relations work and advocacy to influence health policy and funding -A greater emphasis on implementation through the reorientation of internal work programs with an emphasis on multi-sectoral interventions and integration, and the formation of working partnerships with bodies such as the National Institute of Clinical Studies (NICS) and the National Prescribing Service (NPS) -An aim to maintain the evidence-base across a range of CVD prevention and management guidelines efficiently and in collaboration with other stakeholders -Plans to identify and prioritise gaps in evidence based care and to address these using a key message approach supported by tools for health professionals

B12

FIELD TESTING NATIONAL PUBLIC HEALTH GUIDANCE ON SUBSTANCE MISUSE

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Background
In 2005, the National Institute for Health and Clinical Excellence (NICE) began developing public health guidance for England. The process and methods were based on NICE's clinical guidelines - with a new 'fieldwork' phase for focused consultation with practitioners about draft recommendations.

Purpose
The fieldwork considered: Content - are the recommendations appropriate, accessible and clear? Practice - what is current practice and how might the recommendations build on or change it? Impact - what are the barriers to / opportunities for implementation and what further resources or training might be needed?

Methods
The draft recommendations were developed based on findings from a review of effectiveness and an economic appraisal. The National Collaborating Centre for Drug Prevention (NCCDP) was commissioned to field-test the draft recommendations. Three meetings were held in Liverpool, Manchester and Bristol with practitioners in health, education, social welfare and criminal justice delivering drug prevention for vulnerable young people. Discussions were transcribed and themes categorised within and between groups. An online questionnaire was used with professionals who could not attend the field meetings. This provided supplementary data about the effectiveness, relevance and utility of the draft recommendations.

Results
Delegates supported the general objectives of the recommendations. Some were already being conducted, however several could not be delivered through current structures and practices without appropriate funding and support. There was concern the specified interventions would be prescriptive and take precedent over current activities, with implications for service funding or the support offered to young people. Funding and professional development were two of the major barriers to the introduction of new interventions. The recommendations would need to be supported by different government departments to be delivered across sectors.

Discussion
The data from fieldwork was used in re-drafting the recommendations. Fieldwork can provide useful context data to inform the specificity of recommendations and increase their likelihood of implementation.

B13

CANADIAN BEST PRACTICE RECOMMENDATIONS FOR STROKE CARE 2006)- GUIDELINE DEVELOPMENT PROCESS

Patrice Lindsay, Alison McDonald, Stephen Phillips (Canadian Stroke Network, Queen Elizabeth II Health Sciences Centre)

Background
The Canadian Stroke Strategy (CSS) recently released the Canadian Best Practice Recommendations for Stroke Care (CSSBPR), developed through a structured evidence review and consultation process.

Purpose
The goal of these recommendations is to increase consistency and standardization of the delivery of stroke care across Canada.

Methods
The CSSBPR was developed through a systematic process following the Practice Guidelines Evaluation and Adaptation Cycle framework (Graham, 2005). This process built upon previous Canadian stroke studies to identify, review and select recommendations from existing stroke guidelines. All guidelines considered for inclusion were rated with the AGREE tool, and only guidelines with high ratings were maintained for ongoing consideration. Multidisciplinary task groups, created within clinical specialties (e.g., acute, rehabilitation, prevention), reviewed these existing guidelines to select, adapt or develop stroke care recommendations for final consideration. All proposed recommendations were based on the highest levels of evidence or were considered critical system drivers, appeared in more than one guideline, and were relevant to the Canadian context. A multi-disciplinary consensus meeting was held with broad national representation to review the proposed recommendations, evaluate the merits and value of each, refine content and wording, and propose final selections. External consultations were held with key informant individuals and professional groups for final input, critique and validation. Unique to these guidelines was the development and inclusion of 'system implications' and specific performance measures associated with each recommendation.

Results
Using valid and reliable tools and methods, 24 recommendations were selected for the Canadian Best Practice Recommendations for Stroke Care 2006.

Discussion
The CSSBPR provides evidence-based recommendations that focus on both systems and processes of care that will help support care delivery and decision making across disciplines and across the stroke care continuum. Adherence to these guidelines is anticipated to improve care and outcomes for stroke patients and their families.

B14

DEVELOPMENT AND VALIDATION OF AN EVIDENCE-BASED VENOUS ULCER GUIDELINE

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Background
Venous ulcers (VU) pose significant quality of life, clinical, and economic burdens on society. Evidence-based practice for managing them may improve healing and reduce recurrence and costs of care.

Purpose
The Association for the Advancement of Wound Care (AAWC) Government and Regulatory Task Force (the Task Force) developed a content-validated venous ulcer guideline based on the best available evidence supporting each aspect of venous ulcer care.

Methods
The task force compiled an exhaustive list of elements in VU algorithms published before August, 2003. The Task Force then used pre-defined criteria to rate and summarize up to 5 "best" references from MEDLINE, CINAHL and EMBASE literature searches, covering each aspect of care. Sixteen multi-disciplinary wound care professionals and educators used judgment quantification to validate the content, logic and sequence of the algorithm. A 2005 survey of AAWC members clarified effects of under-reimbursement on evidence-based VU practice.

Results
The VU Guideline may be obtained from the AAWC and AHRQ National Guideline Clearinghouse websites. The guideline consists of all elements with the highest level evidence plus those with a Content Validity Index > 0.75. Some steps in the guideline supported by the highest level evidence (sustained graduated high compression, autolytic debridement and moist wound environments) are so poorly reimbursed that some United States clinicians using them have closed their practices due to loss of revenue.

Discussion
There is a significant gap between VU care in the United States and practices supported by evidence. One reason for this gap is inadequate and/or inconsistent reimbursement policies. Such inadequacies and inconsistencies may contribute to continued delay of venous ulcer healing, increase recurrence, magnify the burden of venous ulcers to society and unnecessarily increase patient suffering.

B15

TESTING AND VALIDATING SEARCH FILTERS IN THE CONTEXT OF EVIDENCE-BASED GUIDELINE DEVELOPMENT

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Background
For retrieving evidence for quality guidelines, systematic literature searches are needed. For identification of articles search filters are used

Purpose
The aim of this study is to test performance of different, available filters for systematic reviews for Medline received from different G-I-N organisations.

Methods
A validation database was created with cited references from evidence tables of three recently produced guidelines on breast cancer. The filter performance of five different filters for systematic reviews, validation step-1, was measured. We also tested performance of the same filters in "real life" (=validation phase-2), measured in a limited part of Medline. This sample was constructed by searching breast cancer (focus), limiting to diagnosis and last years (from January 2005), restricting to articles published in high impact journals from Science Citation Reports 2005 of relevant subject categories (Medicine general and internal, Medicine research and experimental, Oncology).

Results
The applicability and validity of tested filters during validation phase-1 did not show much variation. The sensitivity of all five filters ranged from 84% to 100%. The systematic review filter, used by "CBO" showed a sensitivity of 93%.
This standard filter retrieved 8 articles in the sample whereas the combination of five filters retrieved 52 articles. From those 8 articles only three fitted the guideline topic, two were systematic reviews. Additional results of 44 articles showed that 26 fitted the guideline topic and three described results of potentially relevant studies.

Discussion
Validation phase-1 shows if standard methodological filters can retrieve key articles but does not show precision of filters in "real life". Validation phase-2 is important to measure filter precision. The test shows that precision was 60% for this topic and within this group only five systematic reviews were retrieved. Adding more filters did not retrieve more systematic reviews. More tests are needed.

B16

SERVICE GUIDANCE: DEVELOPING RECOMMENDATIONS IN AN EVIDENCE-POOR ZONE

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Background
The National Collaborating Centre for Cancer (NCC-C) is responsible for developing National Institute of Health and Clinical Excellence (NICE) guidelines on cancer for the National Health Service (NHS) in England and Wales. Service guidance differs from a clinical guideline in that it makes recommendations to the NHS on how a whole service should be configured rather than on individual interventions. There is often very little conventional research evidence on which to base recommendations for such guidance and so other methods need to be used.

Purpose
This abstract explores how the NCC-C approached this problem when developing cancer service guidance.

Methods
We report our experience, using examples from service guidance published to date. The focus will be firstly on evidence and service guidance:

- the type of evidence used;
- how the evidence is identified;
- how the evidence is appraised.

In addition we present methods that we employ when little or no evidence is identified, in order to achieve the aim of making useful recommendations for cancer services.

Results
Evidence from clinical studies has limited potential to directly inform recommendations in service guidance. Additional methods employed include:

- citing existing, current guidelines;
- including grey literature e.g. audit data submitted by stakeholders;
- requesting expert position papers;
- undertaking bespoke research e.g. 'Needs Assessment';
- making recommendations for research.

Discussion
Service guidance differs from clinical guidelines in its relationship with the evidence base. The additional methods employed by the NCC-C permit the development of recommendations for areas where evidence is weak, but where recommendations are much needed. The end results are recommendations to improve service provision and guidance that is fit for purpose.

B17

CLINICAL PRACTICE GUIDELINES AND MULTIMORBIDITY - IMPORTANT FOR DEVELOPERS AND PRACTITIONERS

Peter Rutherford, Mercia Page (National Institute for Health and Clinical Excellence, London, UK)

Background
Clinical practice guidelines typically concentrate on single conditions, rigorously examining evidence and assessing cost effectiveness using trials which exclude patients with co-morbidity. Difficulties arise when recommendations are then applied to typical patients in clinical practice who are older and have multimorbidity - there is a risk of adverse events, excessive patient burden with interventions and increased cost. This may lead to non-implementation or if guideline recommendations are transformed into performance management, inappropriate interventions being implemented in frail patients.

Purpose
To review the literature relating to multi-morbidity and clinical practice guidelines. To assess how multimorbidity is addressed in NICE clinical guidelines. To determine potential strategies to aid the guideline developer and health practitioners and allow guideline recommendations to facilitate decision making in patients with multimorbidity.

Methods
Literature searches of MEDLINE and other databases were performed using 2 strategies, terms related to multimorbidity/comorbidity and combinations of diseases (eg diabetes and heart failure). A formal review of NICE guidelines was performed to determine if they addressed multimorbidity in recommendations.

Results
The literature review demonstrated that there is little published evidence relating to multimorbidity with respect to clinical trials of interventions or consideration in guidelines. Searching for combinations of diseases yielded minimal studies except for Dual Diagnosis (mental health). A review of NICE clinical guidelines demonstrated that multimorbidity is not addressed consistently in scoping and guideline generation. From the literature, there are approaches to clinical guideline production for the multimorbid patient - to focus around considering patients goals and life expectancy alongside the evidence to form recommendations .

Discussion
Multimorbidity is not addressed thoroughly or consistently in the literature or clinical guidelines and the problem remains of relating average trial effects to typical patients via guideline recommendations. A patient focused approach to guideline generation could aid in the management of the many patients with multimorbidity.

B18

NOT BY EVIDENCE ALONE

Eloise Clark, Edward Donovan (Cincinnati Childrens Hospital Medical Center)

Background
Evidence-based, clinical practice guidelines (EBGs) represent the confluence of current, valid evidence, clinician expertise and experience, and patient preferences. Because research evidence accumulates, clinical practice evolves and preferences change, EBGs must be frequently updated.

Purpose
To classify and evaluate changes that were made during revisions of Cincinnati Children's Hospital Medical Center (CCHMC) practice guidelines.

Methods
Retrospective case studies of five revisions of three CCHMC guidelines were conducted: management of bronchiolitis in infants, acute gastroenteritis in infants and young children, and fever of uncertain source in infants 0 to 60 days of age. Revised guidelines were compared to the most recent prior version. Changes were classified into selected domains: (1) responses to validated quality criteria for guidelines (Quality); (2) usefulness in the clinical setting, including responses to clinician feedback (Clinician); (3) incorporation of technology to improve effectiveness or efficiency of guideline use and the revision process itself (Technology); and (4) incorporation of new evidence, based on published studies (Evidence). In each domain, changes in the guidelines resulting from revision processes were stratified by degree of change: substantial, noticeable, supporting citation, or minor.

Results
In the five revisions studied, 312 changes were identified. Approximately 80% were not associated with new evidence (Evidence). Of the 20% that were related to new evidence, approximately one-third were classified as minor or addition of supporting citations with no change in care. Among non-evidence domains, most changes were related to usefulness in the clinical setting (Clinician), and approximately 40% of these were classified as substantial.

Discussion
This study suggests that ongoing review of current research may not be sufficient to keep guidelines useful for clinicians and families. Recent literature suggests that future generations of EBGs focus guideline revisions on implementability, measurement of improved patient outcomes, and transformation into electronic formats.

B19

THE NATURE OF EVIDENCE: HOW DOES EVIDENCE INFORM GUIDELINE RECOMMENDATIONS?

Sheila McNair, Melissa Brouwers, Manya Charette (Cancer Care Ontario & McMaster University)

Background
Since 1997, the Cancer Care Ontario Program in Evidence-based Care (CCOPEBC) has developed clinical practice guidelines to inform oncology practice in Ontario. We now address topics beyond treatment, ranging from screening to end of life care, and organizational standards of care. We are encountering more variability in the availability and quality of evidence, and this presents challenges to how we obtain, synthesize and present evidence.

Purpose
To identify common principles in the use, application, and interpretation of evidence for CCOPEBC recommendations.

Methods
We surveyed 45 CCOPEBC documents produced in 2006 to identify the type of study design, frequency of abstract reports and outcome measures that formed the basis of each recommendation.

Results
Of 153 recommendations made, 63% were supported by trial evidence, with 78% for systemic therapy topics, compared to 30% for radiation/surgery and 7% for other (e.g. screening, nursing, follow-up). The evidence base included Phase III RCTs (91%), Phase II RCTs (8%), and non-randomised studies (4%). Abstract reports informed 38% of recommendations. On rare occasions, full report data have contradicted earlier abstract data, leading to substantive change in recommendations.
Recommendations were based on survival outcomes (50%), response outcomes (39%), adverse effect/toxicity (33%) and quality of life (14%). In some cases, direct linkages between evidence and recommendations were difficult to determine.

Discussion
The evidentiary base for guidelines about treatment using drug therapies (80% of the 2006 sample) is largely Phase III RCTs. In order to address important clinical and organizational questions for which the evidence is less clear, the following principles were identified for CCOPEBC document development.
1. State explicitly when a recommendation is based on a consensus of clinical opinion.
2. Adopt new strategies for more efficiently obtaining, interpreting and applying non-Phase III evidence.
3. Make linkages between evidence and recommendation more explicit in the documents.

B20

EVIDENCE BASED GUIDELINES REQUIRE A GOOD UNDERSTANDING OF THE UNDERLYING EVIDENCE - AN "INTEGRATED" CURRICULUM IN EBM FOR EUROPE

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Background
Ebm is a fundamental knowledge basis for guideline developers. In order to overcome recognised barriers to translate evidence into practice guidelines or clinical pathways, the European Union has funded the development of a pilot project for a European-wide curriculum in ebm.

Purpose
- To identify the needs of individual countries, national surveys have mapped existing learning and teaching opportunities in ebm.
- To develop an ebm-curriculum that is integrated in the working environment of health care professionals which enables them to learn ebm-concepts in the context of patient care and to apply them for developing practice guidelines or clinical pathways.
- To design and pilot an ebm-teaching and -learning unit integrated in daily patient care using systematic reviews (SR)/meta-analyses (MA).

Methods
On the basis of the national surveys we
- defined learning objectives for the curriculum.
- designed adequate e-learning tools, using systematic reviews as example
- developed a portfolio for the learner and tailored handbooks for learners and local facilitators
- piloted an ebm-teaching/-learning unit in daily patient care using SR / MA.

Results
Eight countries participate in the project. (UK, Germany, Hungary, Italy, Netherlands, Poland, Spain and Switzerland). By now, the ebm-curriculum has been finalised, the e-learning tools including handbook and portfolio has been developed. The evaluation of the learning system on physicians-in-training is currently under way in all participating countries. We will present the e-learning module on systematic reviews/ MA and the results of the evaluation.

Discussion
E-learning on ebm might be a very beneficial tool to enable physicians even in remote areas with very little resources to gain basic knowledge in ebm for active participation in developing evidence based practice guidelines. Allied health professionals have expressed great interest in the programm and it might be worth exploring the programs potential for consumers.

B21

UPDATING GUIDELINES: HAS' EXPERIENCE

Michel Laurence, Patrice Dosquet (Haute Autorité de Santé, Saint-Denis La Plaine, France)

Background
New evidence and/or changes in clinical practice or resource availability may mean that changes have to be made to recommendations in clinical practice guidelines (CPGs), but it is difficult to predict when a CPG needs updating. Published methods based on literature searches and expert opinion need to be validated before widespread use.

Purpose
To identify CPGs for updating using a method based on expert opinion.

Methods
Experts named by medical associations were sent a questionnaire relating to 18 CPGs and 12 consensus conferences (CCs) (1993-2000) that had never been updated. They had to specify which recommendations in the guidelines needed updating and why (e.g. omission of new information that has already changed practice could be detrimental to patients), and provide evidence from the literature.

Results
Within 3 months of being contacted, 69% of the medical associations (77/111) had responded and named 435 experts. A total of 226 experts (52%) returned the questionnaire (only 106 (47%) on time). The opinion of 166 experts (74%) was that updates were necessary; 115 (69%) provided evidence from the literature. Updates were needed for 11 CCs (92%) and 12 CPGs (66%); they were unnecessary for 3 CPGs; there was no consensus opinion on 1 CC and 3 CPGs. Recruiting experts and collecting data took much longer than expected (15 months).

Discussion
This method based on expert opinion does not always provide definitive answers to the question whether an update is needed. In addition, it requires time and resources (in particular expert availability). Because of these restrictions, a second scheduled questionnaire asking the experts to prioritise the CPGs to be updated was not sent out.

B22

KEEPING CLINICAL PRACTICE GUIDELINES UP-TO DATE USING A SYSTEMATIC MONITORING PROCESS

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(National French Federation of Comprehensive Cancer Centres, Paris, France)

Background
Keeping clinical practice guidelines up-to-date, thus ensuring their validity, while being an essential quality criteria represents a major challenge for guidelines developers. The guidelines department (Standards, Options and Recommendations: SOR) from the National French Federation of Comprehensive Cancer Centres has therefore set up a systematic monitoring process.

Purpose
To develop and implement a method aimed at: 1) identifying new data which are likely to modify existing recommendations, 2) evaluating their impact and 3) enlightening potential users on the validity of pre-existing recommendations.

Methods
The methodology defined is based on our experience of updating already completed SOR guidelines and on published experiences of other guidelines programs. The steps, the roles of actors (clinicians, systematic reviewers, stakeholders) and the duration of each task have been formalized.

Results
The methodology developed is based on 3 main phases realised in collaboration with experts: collecting data, selecting and classifying information, analysing information. Focusing on evidence that will potentially change recommendations, the collect is performed periodically or as a response to alerts received (eg. from experts). Analysing the information retrieved consists in comparing the results of new data with the conclusions of the initial report and then identifying the recommendations that need to be updated.
The entire procedure takes 4 to 8 months depending on the quantity of data retrieved. It involves a limited panel of experts. This new process was routinely implemented in the SOR programme in February 2005. Nine projects followed this format, with an average duration of 6 months. Three of them led to inform users that recommendations were still valid (http://www.fnclcc.fr).

Discussion
This procedure appears to be time saving, allowing the restriction of the whole updating process to the invalid recommendations. Consequently to an internal audit realized two years after first implementation, the process will be slightly revised.

B23

COCANCPG: COORDINATION OF CANCER CLINICAL PRACTICE GUIDELINES IN EUROPE

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Background
Many guideline programs throughout the world use comparable strategies to achieve similar goals, thus providing a basis to collectively set up solutions to improve the efficiency of the production and updating of high quality cancer guidelines. This is the aim of CoCanCPG, a Coordination Action project funded by the European Union. CoCanCPG started in 2006 and is coordinated by the French National Cancer Institute. It involves 17 national or regional organisations from 10 European countries, Israel and Canada.

Purpose
CoCanCPG aims to reducing the unnecessary duplication of efforts and overcome fragmentation in cancer guideline development and research; foster mutual learning and exchange of best practices; develop innovative approaches for the trans-national exploitation of research results to foster the relevance of new knowledge to policy decisions and cancer care in Europe.

Methods
The CoCanCPG partners will perform systematic surveys of the guideline programs, implement a framework for sharing information and best practices and define steps in the guideline development process which can be performed collectively at the trans-national level.

Results
Although key methods of guideline development are similar among the CoCanCPG partners, a great disparity appears between the organisations in term of program size, organisational structure, distribution of capacity and budget. The latter, to develop a single CPG, ranges from € 4.000 to € 450.000.
Eight organisations develop CPGs for various disease domains while five organisations focus specifically on cancer guidelines and four organisations have as their central mission coordination and improvement of cancer care and research. The majority of CoCanCPG organisations is already involved in various international or inter-organisational collaborations and information exchange.

Discussion
Despite convergence of key methods, there is a great disparity between CPG programs. Yet, existing collaborations will facilitate the set up of joint trans-national activities for guideline development and research.

B24

COLLABORATIVE DEVELOPMENT AND IMPLEMENTATION OF EVIDENCE-BASED GUIDELINES, PROTOCOLS, AND ORDER SETS TO ACCELERATIVE IMPROVEMENT IN HEALTH CARE DELIVERY

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Background
The Institute for Clinical Systems Improvement (ICSI) is an independent, non-profit organization dedicated to championing health care quality and to accelerate improvement in the value of health care that is delivered. ICSI is a statewide collaboration of nearly 80% of the hospitals, health care systems, and clinics in Minnesota, encompassing nearly 8,300 physicians.

Purpose
ICSI guideline development and implementation process aims to:
- Provide evidence-based health care guidelines for health care system design and point of care reference.
- Narrow the gap between the care clinicians provide and the care that scientific evidence indicates should be provided.
- Address the failure to rapidly translate research findings into clinical practice more quickly.
- Provide implementation recommendations for care delivery system design that support clinicians in delivering evidence-based care.

Methods
ICSI scientific documents are developed through a rigorous, systematic process using the principles of fair process. The ICSI process of revising and updating guidelines by involving expert panels form the ICSI membership, promotes consensus and acceptance of the evidence-based guidelines. Strategies are then used to redesign care delivery systems allowing implementation in ICSI member organizations.

Results
The benefits include evidence-based guidelines that are broadly accepted by clinicians. The benefit to health care organizations is the using some of their own clinicians - saving time, resources, and duplication of work. For the health care community, the benefit is consistent, effective health care based on an accepted set of evidence-based recommendations, thus improving outcomes and value (cost/benefit).

Discussion
ICSI documents developed for use must be evidence-based and provide value to both the clinician and community. Using a collaborative approach for the development and implementation of guidelines improves the likelihood they will be implemented,improves value, and accelerates improvement in the delivery of health care.

B25

THE CANADIAN COALITION FOR SENIORS' MENTAL HEALTH NATIONAL GUIDELINES FOR SENIORS' MENTAL HEALTH: FROM PAPER TO PRACTICE

Dr. David Conn (Psychiatrist-in-Chief, Baycrest Geriatric Health Care System; Associate Professor, Department of Psychiatry, University of Toronto; Co-Chair, Canadian Coalition for Seniors' Mental Health; Past President, Canadian Academy of Geriatric Psychiatry, Toronto, Ontario)

Background
In January 2005, the Canadian Coalition for Seniors' Mental Health (CCSMH) received funding from the Public Health Agency of Canada, Population Health Fund, to lead and facilitate the development of evidence-based recommendations for best-practice National Guidelines in the key areas of seniors' mental health:

- The Assessment and Treatment of Delirium
- The Assessment and Treatment of Depression
- The Assessment of Suicide Risk and Prevention of Suicide
- The Assessment and Treatment of Mental Health Issues in Long Term Care Homes (Focus on Mood and Behaviour Symptoms)

In June 2006 Guidelines were disseminated, with 7500 copies distributed to Canadian hospitals and long term care (LTC) facilities. Between June 2006 and March 2007 over 8600 copies of the Guideline were downloaded from the CCSMH website (www.ccsmh.ca).

Reception of the guidelines has been overwhelmingly positive and resulted in collaborations across the country and disciplines to implement the guidelines.

Purpose
Research has indicated that dissemination alone does not transfer into the uptake of guideline recommendations. As a result the CCSMH has engaged in an implementation phase for the National Guidelines project. The purpose of this presentation is to inform participants of strategies that have been used in implementing guideline recommendations into clinical practice.

Methods
CCSMH pilot teams have been created, each with a specific focus, projects goals and purposes. All teams follow the CCSMH phases of implementation which include:

I: Preparation & pre-implementation
II: Knowledge transfer & knowledge utilization
III: Knowledge retrieval & evaluation
IV: Sharing & collaboration

Results
Seven pilot projects have been created with specific focuses including: LTC homes, provincial training tools, family physician tool kits, interactive training programs for community mental health outreach teams, and an adaptation of recommendations for palliative patients.

Discussion
These pilot projects are the beginning of a comprehensive strategy for the implementation of the CCSMH Guidelines into programs and policies across Canada.

B26

NO ONE WANTS ADVICE, ONLY COLLABORATION:THE EXPERIENCE OF AN AUSTRALIAN/NEW ZEALAND COLLABORATION TO IMPLEMENT GUIDELINES

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Background
In 2005, the New Zealand Guidelines Group (NZGG) and the National Institute of Clinical Studies (NICS) established a partnership to improve the care of people in New Zealand who present to emergency departments, mental health and Mäori health services with self-harm or at risk of suicide. NZGG promotes evidence-based practice in the health and disability sector in New Zealand. NICS is Australia's leading agency for closing practice gaps identified by evidence-based research.

Purpose
NICS provided the collaborative model to implement key recommendations from NZGG's self-harm and suicide prevention evidence-based, best practice guideline. NZGG then adapted the model for a New Zealand context by overlaying a strong consumer focus, and the Mäori (indigenous people of New Zealand) concept of 'whakawhanaungatanga' - connected relationships and shared responsibilities between the individual, the family and the service provider

Methods
NICS provided NZGG with tools, training and mentoring to establish a collaborative with half the hospitals in New Zealand with the emergency departments, and mental health and Mäori health services working together to implement based on the guideline recommendations.

Results
This presentation will discuss the benefits of collaboration between agencies for moving guidelines into practice, including:
- a method to accelerate learning to establish models for implementation
- the foundation for further collaboration between both agencies
- results of the guideline implementation, and
- involving consumers in the development and implementation of the guideline

Discussion
The international collaboration provided the opportunity for both NZGG to develop their understanding of implementation methodologies, and gave NICS the opportunity to observe the adaptation of their methodology to include cultural and consumer perspectives.

Entering into a collaboration requires an openness to share knowledge and a willingness to learn in an environment that encourages each party to seek advice, ask questions, and give support to try new ideas.

B27

CONSENSUS BUILDING IN THE DEVELOPMENT OF THE PURPOSE AND SCOPE FOR A NEW SELF-MANAGEMENT SUPPORT GUIDELINE

Janet Chee, Patrick McGowan, Suzanne Fredricks (Registered Nurses Association of Ontario, University of Victoria- Centre on Aging, Ryerson University)

Background
Achieving consensus towards a common goal is often an arduous road. With a range of expertise, opinions and personalities at play, discussions are often rich with ideas and full of debate. It is the facilitation of this process that encourages consensus and creates transparency in the guideline development process.

Purpose
The Registered Nurses' Association of Ontario (RNAO) embarked on the creation of the 'Self-Management Support' guideline based on a needs assessment of RNAO stakeholders, including RNAO members. It was identified that there are no other guidelines that address self-management support and thus, it is the responsibility of our guideline team to develop the purpose, scope and clinical questions to address this gap in the literature.

Methods
This guideline development team is quite unique in that it is comprised of two panels of multi-disciplinary experts. The development panel consists of 15 individuals; registered nurses, other health care professionals with expertise in the area of self-management support, patient advocates, and two past patients. The mandate of this group is the development of the guideline recommendations - the first step of which is defining the purpose and scope. The advisory panel is composed of 10 multidisciplinary health care professionals whose role is to provide input to the development panel from a multi-disciplinary and systems perspective. Throughout this process, the RNAO program coordinator is responsible for facilitating the guideline development process and building and documenting consensus among both panels.

Results
It is the rich discussion, debate and sharing amongst these individuals as well as the facilitation of the consensus building process that has moved the self-management support guideline forward.

Discussion
This presentation will provide a glimpse into the various consensus building techniques and facilitation methods that were utilized to develop the purpose and scope for the Self-management Support guideline.

B28

FORMAL CONSENSUS METHOD AND PRODUCTION OF CLINICAL PRACTICE GUIDELINES

Frédéric DE BELS, Patrice DOSQUET (Haute Autorité de santé)

Background
Guideline production may be hampered when scientific evidence is scarce or conflicting.

Purpose
The aim was to describe, especially in this context, a structured approach to embody the opinions of professionals on a topic in line with their practical experience.

Methods
After a literature review a working group of the French Haute Autorité de santé, in collaboration with health professionals, proposed to derive a formal consensus (FC) method from the Rand appropriateness method. The method has been tested over about ten projects.

Results
Two versions of FC are proposed : a short version for narrow and technical topics or for topics that concern only a few professionals ; a full version which includes an additional large panel of peer reviewers.
Briefly, a steering group produces a critical review of the literature and submits draft guidelines to a group of professionals well conversant with the topic. On the basis of the available level evidence and their practical experience these professionals rate the draft guidelines using a 9-point rating scale. This phase includes two rounds of rating separated by a meeting of professionals. The steering group analyses responses and finalises the guidelines. The rules for retaining guidelines are established beforehand and are similar to those of the Rand appropriateness method.
In the full version the guidelines are submitted to external reviewers to help ensure they are widely acceptable (form and content) and to reduce any group effect.

Discussion
FC may be used to produce guidelines when the results of the literature are inconclusive or controversial. It allows the quantification of agreement or disagreement (strong or relative) and ensures that agreement may be reach objectively and that the guideline development process is transparent. It is also useful to identify areas for future clinical research and to extract review criteria from guidelines to evaluate the quality of care.

B29

USING DELPHI CONSENSUS IN A NICE CHILDREN'S GUIDELINE

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Background
NICE clinical guidelines are based on a rigorous review of evidence using explicit and transparent methods. The Feverish Illness in Children (FIC) guideline revealed major deficiencies with the evidence for key clinical prognostic questions and raised questions about applicability of evidence to UK practice.

Purpose
To obtain opinions from professionals and patients/carers to help the FIC Guideline Development Group (GDG) make reliable recommendations where evidence was deficient to enhance implementation.

Methods
A two-round modified postal/electronic Delphi survey using a scale of 1-9 (one = strongly disagree, nine = strongly agree). Evidence summaries and statements were produced for each selected question. Statements were worded as recommendations. Ground rules were agreed (consensus was defined as 75% of ratings in 7-9 category: agreement; 75% in 1-3: disagreement). Potential participants were nominated by professional and patients stakeholder organizations, aiming for equal representation from primary and secondary care and parents/carers. Statements were piloted with 10 people. Participants were given two weeks to respond at each round. Statements with no consensus at Round 1 were discussed by the GDG, reworded if necessary and sent for Round 2.

Results
Sixty one out of 79 (77%) of nominees agreed to participate. Of these 57(93%) completed their ratings for both rounds. Out of 35 statements sent at first round 15 reached consensus. 25 achieved consensus after two rounds (22 were agreement and 3 disagreement). Statements were retained as recommendations. Some were reworded . Three statements (on routine use of rectal thermometers) were reworded into one negative recommendation to reflect strength of disagreement.

Discussion
The Delphi survey ensured that the FIC guideline was clinically applicable, addressed parents/carers' concerns and supported translation of evidence to UK practice. This approach requires meticulous planning and execution to achieve results that are robust and to fit with the guideline development's timelines.

B30

PRAGMATIC EVIDENCE-BASED GUIDELINE DEVELOPMENT: A RESEARCH PROTOCOL IN AUSTRALIA AND SOUTH EAST ASIA

Tari Turner, Claire Harris, Sally Green (Monash Institute of Health Services Research, Monash University, Centre for Clinical Effectiveness, Monash Institute of Health Services Research, Australasian Cochrane Centre, Monash Institute of Health Services Research)

Background
Increasingly, hospitals are developing guidelines to standardise and improve the quality of patient care.

In hospitals, guideline development is often the responsibility of clinicians who rarely have the knowledge, skills or time to carry out the systematic reviews of research required for rigorous evidence-based guideline development. As a result, guidelines are often based on clinical experience and knowledge and rarely include systematically identified and appraised evidence.

There is a need for an evidence-based guideline development process which is feasible given limited time and resources.

Purpose
To present for discussion a research protocol through which a pragmatic process for evidence-based clinical guideline development will be investigated and refined.

Methods
The research will be undertaken at 9 hospitals in South East Asia who are partners in the SEA ORCHID (South East Asia Optimising Reproductive and Child Health in Developing Countries, www.seaorchid.org) project and 2 Australian hospitals to explore the needs of clinicians and guideline developers in these different settings.

An appropriate contact at each hospital will complete a survey outlining their current guideline development process.

Face-to-face interviews will be held with 5 people at each site: a senior and a junior doctor, a senior and a junior nurse and a member of the hospital unit responsible for guideline development. In these interviews the current guideline development process will be discussed in detail, the interviewee's perspective on what makes a guideline useful will be elicited and barriers to following an evidence-based guideline development process identified and explored.

Results
Interviews will be recorded and transcribed and the data analysed thematically. Results will be used to refine current evidence-based guideline development models to make them more practical in the context of limited time and resources.

Discussion
We would appreciate thoughts and comments about potential strengths and weaknesses of this research approach.

B31

AUDIT, FEEDBACK AND CONSENSUS: AN ALTERNATIVE WHEN THERE IS NO EVIDENCE

Stephen Hall (Queen's Cancer Research Institute, Kingston, Ont)

Background
The guideline cycle functions best when level 1 evidence is available but what do we do when clinical trials have not been done and will not be done ? One alternative is to use audit and feedback in a process towards consensus especially for a clinical problem where there is controversy and known treatment variation.

Purpose
To describe our experience with a process of audit and feedback to the head and neck site groups of the Ontario cancer treatment centers, as approved by the CCO PEBC Disease Site Group

Methods
A retrospective population-based study on the treatment variation and treatment effectiveness of 596 patients with cancer of the hypopharynx treated across Ontario from 1990 to 2000 was used. Each center was presented with their case mix, their treatments and their results compared to all other centers.

Results
In Ontario, the treatment and outcome for patients with cancer of the hypopharynx depends on their address. Practice varied widely, outcomes varied and the reaction varied

Discussion
Audit and feedback could be an effective way to lead to discussion, consensus and the development of guidelines in areas of controversy when other sources of evidence are lacking and treatment varies.

B32

THE EVIDENCE BASE TO MAKE RECOMMENDATIONS ON DIAGNOSTIC PRACTICES IS LIMITED: AN ANALYSIS OF 73 CLINICAL PRACTICE GUIDELINES

Eeva Ketola, Minna Kaila, Mari Honkanen (Current Care, Finnish Medical Society Duodecim, , FinOHTA, Current Care, Finnish Medical Society Duodecim, , Current Care, Finnish Medical Society Duodecim)

Background
Much of the evidence-base for clinical practice guidelines consists of randomized controlled trials (rct) of interventions, in many cases drugs. Since 1995 the number of published rcts has increased 20-fold. An important clinical decision point is making the diagnosis, categorizing people to three groups: healthy, may be healthy or ill, and starting the chain of treatment. Many of these decisions seem eminence-, or experience-based.

Purpose
We aimed to assess the evidence base of clinical practice guidelines, especially statements on diagnosis and treatment, by using the available evidence summaries.

Methods
We used the 73 published Current Care guidelines (February 2007) and their evidence summaries as the source material. We currently have an automated system producing follow-up data on the electronic evidence summaries online such as frequencies of evidence summaries falling under topics in the guidelines.

Results
There were in all 2946 evidence summaries, on average 41 summaries per guideline. Of these, summaries backing recommendations on treatment made up 62.7% and those on diagnosis 20.3%. The proportions for prevention (5.6%), epidemiology (1.7%), rehabilitation (1.7%) and level of care (0.2%) were much smaller. Surprisingly, the evidence summaries under the topics of diagnosis and treatment were practically identically divided into levels of evidence from A to D. The greatest proportion of evidence summaries of different topics backing statements on diagnosis were in pediatric topics (41.1%), then in cancer diagnostics (38.4), and thirdly in digestive system disorders (30.8%), the fewest were included in mental health topics (6.7%).

Discussion
Two-thirds of the evidence summaries back up statements on treatment, probably reflecting the available evidence. Only one fifth of the total relate to diagnosis. We need more primary studies focusing on diagnosis to produce better guidelines helping clinicians to base their diagnostic practices on good evidence

B33

FEASIBILITY OF THE QUADAS TOOL FOR QUALITY ASSESSMENT OF DIAGNOSTIC STUDIES IN GUIDELINE DEVELOPMENT

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Background
Clinicians and guideline developers need to be able identify good quality evidence about the precision and accuracy of diagnostic tests to guide the development of practice recommendations. The QUADAS (Quality Assessment of Diagnostic Accuracy Studies) tool was developed as part of a project funded by the UK NHS R&D programme.

Purpose
The objectives of this study were to test inter-observer reliability for individual items on the QUADAS diagnostic checklist and to document reviewers' experience of using QUADAS.

Methods
Two reviewers independently completed a QUADAS checklist for each study from a sample of 34 diagnostic test accuracy studies included in a clinical practice guideline. Agreement between reviewers was calculated for each item on the QUADAS checklist and reviewers' experiences of using QUADAS were documented.

Results
Agreement between reviewers for individual QUADAS items ranged from 9% to 94%, with a median of 76%. Inter-rater reliability (kappa) ranged from poor (k<0.20) to good (k=0.61), with a median of 0.36 (fair). Most disagreements occurred for items relating to uninterpretable/intermediate results, withdrawals and patient spectrum. Poor inter-rater reliability was also found for items relating to accuracy of the reference standard and availability of clinical data, although percentage agreement between reviewers on these items was very high. QUADAS was generally easy to use. Items relating to missing results and patient selection were most difficult to answer.

Discussion
The QUADAS tool demonstrates fair inter-relability, good face validity and is clear and easy to use. Kappa scores were affected by the prevalence of responses on some items. Reviewing studies of diagnostic test accuracy is not easy and the quality of both study design and reporting is often low. QUADAS represents a useful tool to help identify good quality studies upon which to base guideline recommendations.

B34

TOWARDS SYNTHESIZING AND INTEGRATING QUALITATIVE EVIDENCE IN THE CONTEXT OF GUIDELINE DEVELOPMENT

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Background
Given the growing interest in issues concerning patient involvement and shared decision making qualitative studies are increasingly relevant for clinical practice guidelines and their implementation. Therefore, there is a need of synthesizing findings of qualitative research in guidelines. One approach is meta-synthesis, aiming at integrating findings from a number of qualitative studies in a stepwise process: assembling findings, categorizing these findings, producing a single comprehensive set of synthesized findings. Meta-synthesis can be considered as complementary to meta-analysis of quantitative research findings.

Purpose
The objective of this study is to assess the value of meta-synthesis in the context of guideline development.

Methods
In February 2007 a Dutch guideline working group started developing an evidence-based guideline "Domestic Violence". One of the key questions is: do male and female victims of sexual abuse during their youth have different perceptions of victimhood? To answer this question a systematic search for qualitative evidence will be performed. Two independent reviewers will appraise and synthesize the evidence, using a software tool supporting meta-synthesis (QARI prepared by the Joanna Briggs Institute). Separately two members of the working group will summarize the findings of the same studies without meta-synthesis using the software tool; they will produce a narrative synthesis.
The summaries of findings will be evaluated by the individual members of the working group through a questionnaire with semi-structured questions on the added value of meta-synthesis. The results will be discussed in the working group in order to formulate a group based opinion.

Results
The outcomes of this study will guide the CBO guidelines development group in the decision whether or not to use meta-synthesis as a tool beyond the narrative synthesis.

B35

INTRODUCING QUALITATIVE EVIDENCE INTO CLINICAL PRACTICE GUIDELINES: A PILOT PROJECT IN CANCER PAIN

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Background
The Scottish Intercollegiate Guidelines Network (SIGN) is seeking to develop ways of using qualitative evidence in guidelines. As part of the review of existing guidelines on the management of cancer pain, a pilot project was carried out looking at the contribution qualitative evidence could make to the patient focused sections of the guideline

Purpose
To review the range and quality of qualitative evidence available to support guideline recommendations in relation to cancer pain.

Methods
A literature search covering issues of importance to patients suffering from pain associated with cancer or its treatment was conducted. Results were analysed to identify the key themes present in the literature. The overall range and quality of the available evidence was assessed, and the range of the evidence available in relation to each of the themes was considered. An attempt was made to relate the strength of the evidence base to the perceived importance of the themed issues from a patients perspective. Quantitative literature was reviewed for studies that addressed the themes identified from this process with a view to making recommendations on how to improve the patient experience in relation to the issues discussed.

Results
At the time of writing, this process is part way through. Results will be included in a preliminary draft of the revised guideline to be presented at a public meeting in April 2007. Following this meeting, an assessment will be made of the impact of this approach on the coverage of the guideline.

B36

USING QUALITATIVE STUDIES IN GUIDELINE DEVELOPMENT: A WORKED EXAMPLE

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Background
Qualitative studies are traditionally considered of low importance in the hierarchy of evidence used in guideline development. The National Institute of Health and Clinical Excellence are currently developing a guideline on Medicines Concordance: how to involve people in shared decisions about medication. Research evidence on medicines taking is both qualitative and quantitative, with the patient perspective particularly represented by qualitative work. We set out to explore how qualitative evidence could be summarised and incorporated within an evidence-based guideline context.

Purpose
To aggregate qualitative findings on barriers and facilitators to decision making and medicine taking in people with epilepsy. To consider how qualitative research findings can be used in guideline development.

Methods
Searches were undertaken to identify relevant qualitative research. We then conducted a meta-summary of the findings on barriers and facilitators to decision making and medicine taking in people with epilepsy.

Results
Initial findings suggest there are many reasons why people may (or may not) be non-adherent to medication.

Discussion
Within the context of evidence based medicine and guideline development, the use of qualitative studies can provide a broader picture of clinical reality and patient views. This guideline is an example of one in which the use of this type of evidence may be of considerable importance and may provide some further insight on medication use and why patients with epilepsy may be non-adherent to prescribed medication.

B37

EVIDENCE PROFILES FOR TRANSPARENT GUIDELINE RECOMMENDATIONS

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Background
Guideline development must be systematic and evidence-based, yet transparent in linking evidence to recommendations.

Purpose
To describe "evidence profiles" as part of an explicit and transparent process for linking research to clinical decisions, especially when evidence is weak, sparse, or has limited generalizability.

Methods
Evidence profiles are added after each key guideline recommendation to describe succinctly decisions made by the development panel regarding (a) aggregate evidence quality, (b) benefits, (c) harms, (d) costs, (e) benefits-harms assessment, (f) value judgments and vagueness, (g) role of patient preferences, and (h) policy strength. The profiles add clarity that yields efficiency by avoiding repeated discussions or reminders about why decisions were originally made.

Results
We have successfully applied evidence profiles in developing 3 multi-disciplinary U.S. guidelines [1-3] and a guideline manual [4]. Two guidelines are being used by the AMA Consortium to create performance measures, a process that has been facilitated by evidence profiles.

[1] Rosenfeld RM, Culpepper L, Doyle KJ, et al. Clinical practice guideline: otitis media with effusion. Otolaryngol Head Neck Surg 2004; 130:S95-S118.
[2] Rosenfeld RM, Brown L, Cannon CR, et al. Acute otitis externa clinical practice guideline. Otolaryngol Head Neck Surg 2006; 134(Suppl):S4-S23.
[3] Rosenfeld RM, Andes D, Bhattacharyya N, et al. Adult sinusitis clinical practice guideline. Otolaryngol Head Neck Surg 2007; In press.
[4] Rosenfeld RM, Shiffman RN. Clinical practice guideline manual. Otolaryngol Head Neck Surg 2006; 135(Suppl 4S):S1-S28.

Discussion
Evidence profiles add a level of transparency to guideline development that promotes efficiency and allows users to understand how and why clinical decisions were made. This transparency is of crucial import when evidence is weak or lacking, and decisions are based more on consensus, benefits-harms assessments, value judgments, and patient preference.

B38

HOW CAN WE DETERMINE RISK THRESHOLDS FOR PREVENTIVE TREATMENTS? A CASE STUDY FROM A NICE GUIDELINE

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Background
As with many conditions, for venous thromboembolism (VTE) there is a continuum of risk arising from surgery: patients do not naturally fall in to high and low risk groups. For patients at low risk of VTE the hazards of prophylaxis could outweigh the benefits. And even if there is a net benefit to the patient, at moderate risk, the health gain may not be large enough to justify the cost.

Purpose
We describe how cost-effectiveness can be used to determine which patients get single prophylaxis and which get combination prophylaxis, according to their risk level.

Methods
We estimated the VTE relative risk of mechanical, drug and combination prophylaxis by mixed treatment comparisons analysis of 250 RCTs. We did the same for the major bleeding relative risks. Baseline risk was taken from the no prophylaxis arms of the same trials. We then estimated the costs of administering prophylaxis and the treatment costs associated with symptomatic VTEs and major bleeding events. We also estimated the number of quality-adjusted life-years lost due to fatal and non-fatal events under each strategy. We applied a cost-effectiveness threshold of £20,000 per QALY gained.

Results
For general surgery patients, combination prophylaxis was almost but not quite cost-effective at £25,000 per QALY gained. The baseline pulmonary embolism risk (2%) was almost high enough to justify combination prophylaxis and therefore combination prophylaxis was recommended for general surgery patients with additional risk factors, or mechanical-only prophylaxis without. Our 2-way sensitivity analysis shows how the optimal strategy changes with baseline risk of VTE and major bleeding.

Discussion
Cost-effectiveness can be used to determine the risk threshold for VTE prophylaxis. The main problem lies with assessing the risk level of patients, especially the risk of the rarer symptomatic events.

B39

INSTRUMENT FOR THE DEVELOPMENT AND APPRAISAL OF SCIENTIFIC ADVICE ON OUTBREAK CONTROL MEASURES

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Background
Crisis situations in infectious disease control are characterized by high complexity and uncertainty. The crisis sense depends on how the risks are assessed and perceived by policy makers, professionals, public and press. Our study focuses on situations that require national scientific advice on outbreak control measures and in which systems have to be put in place in order to avoid omissions. What defines in such a complex and uncertain situation a 'good' scientific advice on outbreak management during national crises? The international AGREE instrument for the appraisal of guidelines turned out to be not optimally applicable to this kind of guidelines.

Purpose
Our aim is to build up an instrument for developing and appraising scientific advice on outbreak management in crisis situations due to infectious diseases. Once this instrument is developed and tested, it can be used as a 'template', applicable irrespective the nature of the infectious agent.

Methods
We systematically adapted the AGREE instrument in five steps.
1. we systematically searched the literature (MEDLINE) on lessons from practice and research on outbreak management;
2. we consulted a group of international experts on SARS;
3. we performed in-depth interviews with 6 Dutch key experts on outbreak management advices;
4. we pre-tested (parts of) the instrument in an international study on lymphogranuloma venereum;
5. we performed an international 2-round consensus procedure (9-point Likert scale, RAND). The expert panel consisted of 37 key scientists and policy makers from 22 countries (Europe, WHO, Singapore, China).

Results
Our instrument includes (1) items on the definition of crisis situations (when is scientific advice needed?), (2) items on the composition of the outbreak advice team (who should always be part of it?), and (3) items on the content of scientific advice (what should be in it?).

Discussion
We will apply and test the instrument in practice.

B40

CHALLENGE IN DEVELOPING PUBLIC HEALTH PREPAREDNESS GUIDELINES - A JAPANESE EXAMPLE

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Background
Evidence-based approach in developing Clinical Practice Guidelines (CPG) has become more common, though methodology in public health guidelines (PHG) is still relatively new in Japan. Many areas in public health guidelines adopted those from CPG such as evidence level and grading recommendations, but there are some areas that are difficult to adopt them. We have been commissioned to develop a web-based archiving system of public health preparedness guidelines.

Purpose
To evaluate guideline methodology used in previously developed Japanese public health preparedness guidelines.

Methods
To develop the new web services, scientific journals, text books, health policy acts, reports from ministry, and web contents were searched to identify both CPGs and PHGs that address public health preparedness. Terminology on health-crisis (Preparation for a contingency, Biochemical terrorism, Disaster mental health , Child abuse, Communicable diseases, Drug/ pharmaceutical products/food safety, water supply safety, Environmental pollution etc) were included in the search strategy. The guideline development methodologies in identified guidelines were examined against pre-defined criteria.

Results
Approximately 1200 guidelines and/or recommendations in policy acts/health legislations/reports including those from ministry were identified in the guideline working group in Public Relations Committee at National Institute of Public Health (NIPH). According to the criteria, 565 contents were extracted as initial web information. Some of guidelines in Japan did not apply the evidence grading system.

Discussion
The newly developed web-based archiving service in NIPH-Japan provides not only CPGs but also PHGs that offer health-crisis information. Use of systematic approach has been well penetrated in neither CPGs nor PHGs for public health preparedness in Japan. Evidence grading systems used in CPG might need further modification to explore wider use in neighboring areas, e.g. PHGs. In the future, information archives will also be developed to support health service guideline developer in this web site.

B41

HEALTH CARE MANAGERS' OPINIONS ABOUT THE USABILITY OF CLINICAL GUIDELINES AND CLASSIFICATIONS IN FINLAND

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Background
The Finnish Medical Society Duodecim launched the Evidence Based Medicine Decision Support (EBMeDS) project in 2005. It aims at creating, piloting, and evaluating a generic electronic support system for clinical decision-making, which can be integrated with a variety of patient record systems. In Finland, 96% of primary health centres (PHCs) use and 95% of hospital districts have initiated to use an electronic patient record system.

Purpose
The objective of this survey was to gather information on the use and usability of guidelines and information technology (IT) in the PHCs and hospitals at the pilot sites of the EBMeDS -project.

Methods
A telephone interview was conducted with 42 PHC and 15 hospital managers using a structured form. They were asked whether the physicians' and nurses' clinical decision making should be based on guidelines, whether the physicians and nurses use the classification of diagnoses (ICD-10, ICPC or other coding), and how satisfied the managers are with IT education and -support.

Results
Of the healthcare managers, 68 % considered it important or very important that guidelines are used in clinical decision making. However, 38 % of the managers in PHCs commented that guideline recommendations should be tailored for individual patients. The ICD-10 classification was the most frequently used (58 %), but the managers could not be certain of actual use. One third of the managers thought that no classification was used. The majority of the managers, 68% were content with IT education and -support from their organizations.

Discussion
Healthcare managers find guidelines to be important in clinical decision making. However, use of the classification of diagnoses is often inadequate. Thus, utilization of these basic requirements for electronic decision support should be stressed.

B43

ECONOMIC BENEFIT FROM SUBFERTILITY GUIDELINE ADHERENCE

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Background
Health care expenditures rise enormously, particularly in subfertility care due to the use of assisted reproduction technologies. Clinical subfertility guidelines containing recommendations based on the best available (economic) evidence aim to improve the cost-effectiveness of subfertility care. However, whether subfertility care delivered according to such guideline recommendations is indeed more cost-effective is unknown.

Purpose
To investigate if clinical care according to the main guideline recommendations about intrauterine insemination (IUI) is more cost-effective in achieving an ongoing pregnancy.

Methods
The economic evaluation was conducted from a societal perspective. Guideline adherence was reported for three process aspects of IUI care that have been proven to be associated with patient outcome in a previous retrospective cohort study (conditions and indications for IUI treatment and medication dosage). Effectiveness of IUI treatment was estimated as an ongoing pregnancy and reported for actual IUI practice performance as well as ideal IUI practice performance, defined as 100% guideline adherence. Costs were expressed in 2006 euros (EUR). Data were retrieved by medical record analysis and patients' questionnaires. IUI costs per ongoing pregnancy, were calculated and an incremental cost-effectiveness analysis was performed.

Results
412 Couples with 1800 treatment cycles were analysed. The average costs (95% CI) for one insemination cycle is estimated at 857 (832-882) EUR. The average IUI costs (95% CI) made per couple and the average costs per ongoing pregnancy are 3186 (340 - 8246) and 9511 (1015 - 24.618) EUR, respectively.
Ideal practice performance regarding the conditions and indications for IUI saves on average 6101 EUR and 63 EUR per ongoing pregnancy, respectively. However, ideal practice performance regarding medication dosage results in an increase of the average costs per ongoing pregnancy of 1700 EUR.

Discussion
Subfertility guideline adherence has a substantial effect on the reduction in costs per pregnancy. Therefore, improvement of guideline implementation is recommended

B44

A LEVELS OF CARE APPROACH TO GUIDELINE DEVELOPMENT

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Background
The International Diabetes Federation (IDF) is a worldwide alliance of diabetes associations in 158 countries covering the full spectrum of stages of development. The IDF produces guidelines intended for use by member organisations. Most clinical guidelines come from relatively resource rich countries, and may be of limited practical use in less well-resourced countries.

Purpose
To develop a global guideline for the care of people with type 2 diabetes that is sensitive to resource and cost-effectiveness issues.

Methods
The development of a system for linking human and material resources to guideline recommendations.

Results
A levels of care approach was developed which defined the following 3 levels of care:
Standard care - evidence-based care which is cost-effective in most nations with a well developed service base, and with health-care funding systems consuming a significant part of national wealth. This level of care should be available to all people with diabetes and the aim of any health-care system should be to achieve this level of care. However, in recognition of the considerable variations in resources throughout the world, other levels of care were developed which acknowledge low and high resource situations.
Minimal care - the lowest level of care that anyone with diabetes should receive. It acknowledges that standard medical resources and fully-trained health professionals are often unavailable in poorly funded health-care systems. Nevertheless this level of care aims to achieve with limited and cost-effective resources a high proportion of what can be achieved by Standard care. Only low cost or high cost-effectiveness interventions are included at this level.
Comprehensive care - includes the most up-to-date and complete range of health technologies that can be offered to people with diabetes, with the aim of achieving best possible outcomes. However the evidence-base supporting the use of some of these expensive or new technologies is relatively weak.

Discussion
This approach is intended to increase the global relevance of guideline recommendations. Work is currently in progress to use this approach to assist individual countries to adapt and adopt the guideline for local use.

B45

IMPLEMENTATION OF GUIDELINES ON DELIRIUM AND ASSESSMENT OF THEIR IMPACT ON CLINICAL PRACTICE IN AN ACUTE CARE GENERAL HOSPITAL

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Background
Acute delirium is under-diagnosed and under-treated in patients hospitalised in acute care wards.

Purpose
To improve its prevention and management, evidence-based guidelines were developed by a multidisciplinary team of experts. A study evaluated the impact of their implementation in two wards of an Academic teaching centre.

Methods
Guidelines were presented to the nurses and medical staff during small group interactive sessions. A summary and an algorithm were distributed. Guidelines were also broadcasted on the hospital intranet and posters were put in the services. Knowledge about delirium was assessed by means of a multiple choice questionnaire (MCQs) before and 3 months after the intervention. Indicators such as diagnosis formulation in discharge letters, length of hospital stay pre- and post-intervention and a workload indicator were assessed.

Results
25 one-hour sessions were organised to teach 80% (110/137) of the staff. Knowledge about delirium improved in each professional category after the intervention. 1523 discharge letters were analysed after study completion, representing all admissions during 3½ months before and after the intervention in the targeted wards. Delirium was diagnosed 12 times before and 12 times after intervention in the discharge letters, representing a stable detection rate of 1.6%. Length of stay did not differ significantly between both periods. The workload indicator did not decrease.

Discussion
Despite an obvious interest of the medical and nursing staff for acute delirium guidelines, organizing the intervention was a real challenge because of a lack of availability for the training sessions. There was a significant improvement in the knowledge after the intervention. However, reporting delirium in discharge letters, workload and length of stay did not show any improvement. Materializing the impact of such guidelines with those indirect indicators remains difficult. Further research is needed to develop feasible guidelines implementation strategies and the means to evaluate their impact.

B46

ADHERENCE TO SURVEILLANCE GUIDELINES FOLLOWING CURATIVE RESECTION FOR STAGE II OR III COLORECTAL CANCER

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Background
The risk of disease recurrence in stage II and III colorectal cancer (CRC) patients (pts) following curative resection underscores the need for post-operative surveillance. However, there is controversy as to whether an intensive or conservative strategy is more appropriate.

Purpose
Our aims were to determine adherence in the "real world" to American Society of Clinical Oncology (ASCO) guidelines on CRC surveillance and to evaluate differences in practice patterns and outcomes between an academic institution (Princess Margaret Hospital; PMH) and a community cancer hospital (Credit Valley Hospital; CVH).

Methods
Stage II and III CRC pts diagnosed between 1999-2001 were identified from hospital cancer registries. Surveillance practices and outcomes in the first 5 years of follow-up were retrospectively reviewed.

Results
A total of 244 and 97 pts were identified at PMH and CVH, respectively: 80 stage II and 119 stage III colon cancers (CC) and 66 stage II and 76 stage III rectal cancers (RC). Median age at diagnosis was 61.8 years. Surveillance patterns over a 5-year period, adherence to ASCO guidelines and comparisons between hospitals were tabulated (see table). There were a total of 70 CRC recurrences: 53/244 (22%) at PMH and 17/97 (18%) at CVH. Among them, 53 (76%) were detected by surveillance (44 PMH, 9 CVH) and 17 (24%) by symptoms (9 PMH, 8 CVH). For recurrences detected by surveillance, 20/53 (38%) were resectable, whereas only 3/17 (18%) of those detected by symptoms were resectable. Of the 20 resectable recurrences detected by surveillance, 40% were CC and 60% were RC, CT scan was the method of detection in 55% of cases, and sites of recurrence included liver (7), lung (6), local (5) and nodes (2).

Discussion
CRC surveillance revealed significant departures from ASCO guidelines with a large academic institution employing a more intensive surveillance strategy with imaging than a community cancer centre. Surveillance was associated with a higher proportion of resectable tumor recurrences than detection by symptoms.

	*ASCO Guidelines:	Median Number Performed:			Percentage (%) of Patients With Surveillance: Below Recommendations		Above Recommendations	
		PMH	CVH	p-value	PMH	CVH	PMH	CVH
Clinic Visits	8-14	11	9	<0.001	22.5	22.7	16.8	0
CEA	8-30	9	9	0.67	40.9	28.9	0	0
CBC	NRR	7	9	0.011	–	–	94.3	99.0
LFT	NRR	7	9	0.001	–	–	91.4	100
Chest XR	NRR	1	0	<0.001	–	–	70.4	37.1
Chest CT	NRR	0	0	<0.001	–	–	41.8	14.4
Abdo CT	NRR	4	0	<0.001	–	–	92.6	38.1
Pelvic CT	NRR	3	0	<0.001	–	–	91.4	34.0
Colonoscopy	1	2	2	0.43	14.8	3.1	66.8	76.3

*Recommended number of visits/tests as per 2000 ASCO Guidelines over the first 5-year period of surveillance; LFT: liver function tests; XR: x-ray; NRR: not routinely recommended; –: not applicable.

B47

KNEE OSTEOARTHRITIS CLINICAL PRACTICE GUIDELINES - HOW ARE WE DOING?

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Background
Osteoarthritis (OA) is a leading cause of long-term disability. A large body of research evidence exists supporting various OA treatment regimens. Recently several OA clinical practice guidelines (CPG) have been published as a strategy to facilitate the use of this research evidence in clinical practice.

Purpose
To determine the degree to which documented knee OA care in a teaching rheumatology clinic corresponds to evidence-based treatment guidelines.

Methods
The charts of 105 randomly selected patients meeting criteria for knee OA were reviewed. The patients received care from three rheumatologists working in a major Canadian teaching centre between 2002 and 2005. The chart abstraction tool was based on the European Union League Against Rheumatism, American College of Rheumatology and The Arthritis Society CPG for OA treatment. Descriptive statistics were used for patient demographics and the proportion of patients receiving recommended care.

Results
The most frequently recommended nonpharmacologic treatments were any exercise (58.1%), weight loss in those overweight (50.0%), physiotherapy (42.9%) and strengthening exercise (40.0%). Other nonpharmacologic treatments were documented in less than 30% of patient charts. The most frequently prescribed pharmacologic treatments were acetaminophen (68.6%), intraarticular corticosteroids (65.7%), NSAIDs/COXIBs (50.5%) and intraarticular hyaluronans (43.8%). Topical pharmaceuticals, glucosamine/chondroitin and opioid analgesics were recommended to less than 20% of the patients. Exploratory analyses suggested the following factors may be associated with increased documentation of recommended care: female gender, younger age, overweight, more clinic visits, decreased symptom length and the individual rheumatologist.

Discussion
Non-pharmacologic knee OA treatments currently recommended by CPG were seldom documented in patients' charts in this Canadian rheumatology teaching centre. These findings are similar to studies conducted before the practice guidelines became available which suggests the need for strategies to promote physician adherence to current guidelines.

B48

MULTIFACETED INTERVENTION FOR THE IMPLEMENTATION OF A CPG OF OSTEOPORISIS IMPROVES THE MANAGEMENT IN PRIMARY CARE

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Background
Osteoporosis is a screenable condition which is important due to its prevalence and one of its consequences hip fractures. It has a long pre-clinical phase during which interventions can affect the clinical outcome. Implementation of Evidence Based Clinical Practice Guidelines could be a suitable intervention to improve the management.

Purpose
To evaluate clinical treatment and diagnostic request suitability after a multifaceted intervention to improve the management of osteoporosis in primary care.

Methods
Educational multifaceted approach including evidence-based recommendations, audit and feedback, interactive educational sessions and patient prompts in a primary care setting constituted by 106 teams in 9 clusters covering a population of 276.000. For each primary team, we chose the first six women that went to obtain a prescription of drugs to treat osteoporosis, before the intervention and 12 months after. Eligible women completed a standardized questionnaire which included risk factors, anthropometric information, lifestyle factors, previous pharmacological treatments for osteoporosis and specialist that prescribed the treatment and request the diagnosis. Family physicians received the full educational intervention, including Clinical Practice Guideline based educational sessions.

Results
The prescription was mostly induced before (83.1%) and after (75.1%) the intervention. Two out of three treatments were prescribed by the gynaecologists and traumatologists. A significant improvement of the prescription supported on DEXA was detected 57.6% of the treatments were correctly prescribed before and 73.8% after the intervention ($p<0.05$). We obtained better improvement ratios in the professionals that received the full intervention (family physicians), no improvement was observed in the case of traumatologists (64% vs 62,5% incorrectly prescribed treatments).

Discussion
Osteoporosis is managed in primary care but most of the prescriptions and diagnostic request are induced by other specialists. CPG based educational interventions and primary care management of postmenopausal osteoporosis improve the suitability of prescription and diagnostic requests.

B49

SYSTEMATIC MONITORING PROCESS FOR UPDATING CLINICAL PRACTICE GUIDELINES: EXAMPLE WITH THE USE OF ERYTHROPOIETIC PROTEINS (RHUEPO) IN ANAEMIC PATIENTS WITH CANCER

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Background
The guidelines department (Standards, Options and Recommendations: SOR) from the National French Federation of Comprehensive Cancer Centres, aiming to ensure quality criteria of clinical practice recommendations, has set up a systematic monitoring process.

Purpose
To report of the implementation of this process to the SOR guideline: "Use of rHuEPO in oncology" last validated in 2003.

Methods
The methodology developed was based on 3 main phases realized in collaboration between a methodologist and clinicians. New high level evidence (Randomized Controlled Trials (RCT), meta-analysis and systematic reviews) were first searched in the Medline® database and on EBM web sites. Papers were then selected and classified according to predefined selection criteria. Subsequently, conclusions of the new data were compared to those of the initial report and invalid recommendations were identified.

Results
The monitoring process was initiated in June 2006. Among the 90 new references retrieved, 27 RCTs and 14 meta-analyses or systematic reviews were selected and analyzed. The monitoring process took 5 months. It showed that, for two clinical questions - use of rHuEPO in non-anaemic patients with cancer and use of rHuEPO in anaemic patients undergoing radiotherapy - recommendations were still valid and that for three clinical questions - use of rHuEPO in anaemic patients undergoing chemotherapy, use of rHuEPO in anaemic patients undergoing surgery and use of rHuEPO in children with cancer - recommendations needed to be updated. The resulting modifications were either major (new options) or minor (increased level of evidence). These results are available on the SOR web site (http://www.fnclcc.fr/sor/structure/index-sorspecialistes.html).

Discussion
This method allowed us to prioritize this update within the SOR Guidelines program in 2006. Due to the systematic monitoring, our updating process was restricted to those recommendations found invalid. It was resultantly a time saving procedure.

B50

IMPLEMENTATION OF EVIDENCE BASED PRACTICES IN THE ALBERTA CANCER BOARD

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Background
Successful implementation of evidence based clinical practice guidelines (CPGs) is a complex process. Efforts to enhance guideline effectiveness have focused on improving methods and approaches of dissemination and implementation, in the presence of different barriers and effect modifiers. There is weak evidence supporting the utilization of evidence for the practice of health care. The most commonly cited reasons include: a knowledge gap between researchers and practitioners, differences in their understanding of research, a lack of realism and pragmatism in knowledge translation as well as pre-existing and opposing beliefs or attitudes of practitioners and consumers towards the emerging medical evidence.

Purpose
It is imperative that a robust and a multidimensional approach is adopted to overcome these and other potential barriers for knowledge translation to succeed and for guidelines to positively impact health practice and, ultimately, quality of patient care.

Methods
The guideline utilization resource unit (GURU) of the Alberta Cancer Board (ACB) was initiated in 2006 to assist oncologists in developing and providing standardized evidence-based cancer care across Alberta. In consultation with local and provincial tumor teams, GURU is taking a multifaceted approach for both guideline implementation and evaluation to facilitate the translation of evidence into practice.

Results
Some of the approaches to be utilized include: provide ongoing audit and feedback to practitioners with respect to how current practice compares with guidelines, engage highly-respected clinicians and opinion leaders as change agents in the guideline development process as well as its evaluation, provide ongoing education related to evidence-based decision making, supply organizational and process of care resources and tools to facilitate the application of guidelines into multidisciplinary health care practice.

Discussion
This paper will describe the framework and processes being used at the Alberta Cancer Board for the implementation and evaluation of evidence based cancer care.

B51

UNDERSTANDING ADHERENCE TO CLINICAL PRACTICE GUIDELINES IN THE INTENSIVE CARE UNIT: A COMPREHENSIVE AND INTEGRATED FRAMEWORK

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Background
Clinical Practice Guidelines (CPGs) have been hailed as a useful method of translating evidence into critical care practice. A few studies conducted in the Intensive Care Unit (ICU), have demonstrated that CPGs improve the processes, outcomes, and reduce the costs of caring for critically-ill patients. Despite these promising results the impact of guidelines on critical care practice has been modest.

Purpose
The aim of this study was to develop a comprehensive framework for understanding adherence to CPGs in the critical care setting.

Methods
Case studies were completed at 4 Canadian ICU sites with differing organizational characteristics. Semi-structured interviews were conducted with 7 key informants at each ICU (e.g. physicians, nurses, dietitians). During the interviews, the key informants were asked about their perceptions of the barriers and enablers to guideline adherence. The implementation of the Canadian Nutrition Support CPGs was used as an illustrative example to facilitate probing regarding both general and specific issues. Interview transcripts and supporting documents were analyzed qualitatively, using the knowledge-attitude-behaviour framework for physician adherence to guidelines.

Results
The five key components of the developed framework were 1) characteristics of the CPGs, 2) the implementation process, 3) institutional factors, 4) individual provider behaviour and 5) the clinical condition of the patient. These key themes encapsulate numerous itemized factors that further contribute to adherence either as barriers or enablers.

Discussion
Guideline adherence is determined by a complex interaction of multiple factors that act as barriers or enablers. Our comprehensive and integrated framework for adherence to CPGs in the ICU helps to increase our understanding of this process, and provides a useful template for future research. Tailoring quality improvement initiatives to address these barriers will potentially improve guideline adherence and ultimately lead to better quality of care for critically ill patients.

B52

ADHERENCE TO PHYSIOTHERAPY CLINICAL GUIDELINE ACUTE ANKLE INJURY AND DETERMINANTS OF ADHERENCE: A COHORT STUDY

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Background
The clinical guideline Acute ankle injury was the first evidence-based guideline published by the Royal Dutch Society for Physical Therapy (KNGF).

Purpose
This study was performed to investigate the ability for adherence to recommendations of the physiotherapy clinical guideline Acute ankle injury, and to identify determinants of adherence.

Methods
Twenty-two physiotherapists collected data of 174 patients in a prospective cohort study, in which the course of treatment was systematically registered. Process and outcome indicators were used to investigate adherence to recommendations in the guideline. Patient characteristics were used to identify prognostic factors that may determine adherence to the guideline. Correlation between patient characteristics and adherence to three outcome-indicators (number of treatment sessions, functioning of the patient, accomplished treatment goals) was calculated using univariate logistic regression analysis. To calculate explained variance of combined patient characteristics, multivariate analysis was performed.

Results
In 99 patients (57%) the physiotherapists showed adherence to all indicators. Adherence to the preset maximum of six treatment sessions for patients with severe ankle injury was 81%.
Five patient characteristics were included in multivariate analysis: gender, sport activity, load in ADL, recurrent sprain, co-morbidity. The odds to receive more than 6 treatment sessions were statistically significant for three patient characteristics: females (OR:3.89; 95%CI: 1.41-10.72), recurrent sprain (OR: 6.90; 95%CI: 2.34 - 20.37), co-morbidity (OR: 25.92; 95% CI: 6.79 - 98.93). All five factors together explained 40% of the variance.

Discussion
Adherence to the guideline Acute ankle sprain by a specific group of physiotherapists showed that the guideline is applicable in daily practice and the results are promising for further implementation. Specific patient characteristics (co-morbidity, recurrent sprains, females) predict non-adherence to the number of treatment sessions as recommended in the guideline.

B53

INFLUENCING IMPLEMENTATION

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Background
In late 2005 NICE identified the need to engage more effectively with the healthcare and local government organisations putting guidelines into practice. It agreed to recruit a team of five Implementation Consultants to work directly with organisations to help them to put guidelines into practice.

Purpose
The Implementation Consultants offer:
- updates and advice to help senior management implement NICE guidance
- support to raise the profile of NICE guidance with other local organisations,
- problem solving, by sharing examples of how organisations have successfully worked together to implement guidance
- advice on how to use implementation support tools
- feedback to NICE on local issues, ideas for new topics and suggestions for improvement

Methods
Visits were made to all 392 NHS commissioning and providing organisations in England. A standard template was developed for the meetings to ensure consistency and a balance between information provided to the organisation and feedback to NICE. Meeting outputs are recorded in a database that enables regular reporting to inform the ongoing work programme of the Institute.

Results
An evaluation of the impact of the work of the Implementation Consultants with the NHS is currently taking place. This is based upon qualitative feedback from within the Institute and a quantitative email survey of all NHS organisations visited. The results from this evaluation will be available in May and will be included within the presentation.

Discussion
The NICE implementation consultants have provided an innovative local resource for guideline implementing organisations. The next stages of the engagement strategy are in development. Phase two will involve meeting with 150 local government organisations in England and focus upon their role in implementing NICE public health guidance. Phase three will involve clinical and managerial networks and their role in providing collaborative approaches to guideline implementation.

B54

FROM CLINICAL PRACTICE GUIDELINES TO PATIENT INFORMATION: THE FRENCH APPROACH FOR PATIENT INVOLVEMENT

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Background
Since 1993 the French Federation of Comprehensive Cancer Centres (FNCLCC) with the 20 French regional cancer centres, public and private hospitals, learned societies and national institutions, have run the Standards, Options and Recommendations (SOR) program for the development and dissemination of evidence-based clinical practice guidelines (CPG) in oncology. The methodology is based on a literature review and critical appraisal by a multidisciplinary group of experts, with feedback from specialists in cancer care delivery.

Purpose
In 1998, in response to the evolution of patient information-seeking behaviour, the FNCLCC initiated the SOR SAVOIR Patient program for developing evidence-based patient information according to international quality criteria's, to improve the knowledge of cancer patients and help them to participate in clinical decisions...SORs are used as primary information sources and adapted in plain language by a multidisciplinary team (methodologist, linguist, clinicians). Then, patients' groups (included caregivers) are constituted to meet their expressed information needs, review the information and reformulate the content.

Methods
Most French CPGs don't take into account patients' perceptions and values. And absence of patient preferences in CPGs have been identified to be a factor of non-compliance. SOR program has adapted methods for patient involvement in the French setting, taking into account methods that have been already validated in other contexts. This study was the first of an innovative approach in France.

Results
The observations allowed us to understand some of the parameters that intervene in patient involvement in CPG development. This study laid ground for a comparison between similar studies on recommendations formulation which will be centred on testicular cancer and breast cancer.

Discussion
Greater attention needs to be paid to improve access to patient information materials so they can be used by patients and clinicians to inform their decisions.

B55

EFFICIENT USE OF RESOURCES AND INCLUSION OF PATIENT PREFERENCES IN THE REFERRAL DECISION - A PARADOX IN POLICY?

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Background
Two conflicting policy initiatives can be recognised in the English health service. General practitioners (GPs) are expected to uphold patients' preferences in referral decisions and also to reduce numbers of patients referred from primary to secondary care.

Purpose
To develop guidelines to support referral decisions for patients with osteoarthritis of the knee that take patient preferences into account.

Methods
We conducted systematic reviews on outcomes after knee replacement and evidence summaries on conservative management and role of radiographs in confirming indication for surgery. A guideline development group (GDG) representing patients, surgeons, GPs, health commissioners and allied health professionals participated in consensus development based on the nominal group technique. Group members rated the appropriateness of referral for 108 randomised case scenarios containing all possible combinations of severity of knee symptoms (3 levels), age (3 levels), comorbidities (2 levels), body mass index (2 levels)and patient preferences (3 levels) on a scale ranging from 1 (fully disagree) to 9 (fully agree). Referral was considered to be unanimously rejected if group ratings ranged from 1 to 3, and supported if these ranged from 7 to 9.

Results
Referral was unanimously supported for scenarios describing severe knee symptoms with strong preference for referral, and unanimously rejected in scenarios describing mild knee symptoms with strong preference against referral or no preference. The greatest differences in the group ratings were observed for scenarios describing mild symptoms with strong preference for referral and moderate or severe symptoms with a strong preference against referral or no preference. The 3 patient representatives were more likely to support referral in scenarios with mild symptoms and strong preference for referral, but their scores were equivocal in scenarios with severe symptoms and strong preference against referral.

Discussion
Conflicting policy initiatives will contribute to variation in practice which will in turn affect equity of access.

B56

DECISION AIDS DERIVED FROM EVIDENCE-BASED GUIDELINES - A FRAMEWORK FOR DEVELOPMENT AND MAINTENANCE

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Background
Patient education and involvement of patients in medical decision making (shared decision making) is suggested to have a beneficial effect on the process and outcome of health care. The use of decision support materials, such as decision aids, is particularly useful for preference-sensitive decisions. Ideally, they should be based on up-to-date evidence-based clinical practice guidelines.

Purpose
To develop a pragmatic framework for development and maintenance of decision aids derived from evidence-based guidelines.

Methods
Available decision aids, evidence-based guidelines and the standards from the International Patient Decision Aid Standards (IPDAS) Collaboration were used as a basis for a generic format for decision aids. Patient focus groups were organized to assess patients' information needs, their expectations and personal values in relation to the decision as well as their preferences for presentation of the information.

Results
We developed a framework for decision aids and 5 specific decision aids derived form evidence-based guidelines, on the following topics: cardiovascular risk management, breast cancer, depression, screening for prostate cancer, post-menopausal symptoms. The decision aids were tested by patient focus groups and a user panel and were published on the national healthcare portal (website: www.kiesbeter.nl). Furthermore, we reached formal agreement on ownership and maintenance of the decision aids with all relevant organizations and parties.

Discussion
A common framework was developed to facilitate the production of specific decision aids derived form evidence-based guidelines. Strategies for dissemination and implementation in clinical practice need to be explored.

B57

INCREASING PUBLIC ACCESS TO CLINICAL PRACTICE GUIDELINES FOR RHEUMATOID ARTHRITIS AND OSTEOARTHRITIS (PHASE II) Lucie Brosseau, Sydney Lineker, Mary Bell, George Wells, Mary Egan, Lynn Casimiro, Peter Tugwell, Ann Cranney, Keith Wilson (School of Rehabilitation Sciences, University of Ottawa, Ottawa, Ontario, The Arthritis Society - Ontario Division, Arthritis Rehabilitation Education Program, Toronto, Ontario, Canadian Rheumatology Association & Sunnybrook Health Sciences Centre, Toronto, Ontario, Department of Epidemiology and Community Medicine, University of Ottawa, Ottawa, Ontario, Centre for Global Health, Institute of Population Health, University of Ottawa, Ottawa, Ontario, Clinical Epidemiology Program, Ottawa Health Research Unit, Ottawa Hospital, Civic Campus, Ottawa, Ontario, The Rehabilitation Centre, Ottawa, Ontario)

Background
The prevalence of Rheumatoid Arthritis (RA) and Osteoarthritis (OA) will increase significantly as the population ages. Optimization of care / treatment outcomes will lessen the burden. Providing patients (pts) with self-management strategies (SMS) reduces health care costs. Clinical Practice Guidelines (CPGs) assist health professionals and pts with selecting treatment regimens to improve rehabilitation and health outcomes. Pts who are involved in management decisions experience better health.

Purpose
Evaluate the impact of "influential" people with arthritis (IPWA) and the media on the dissemination of evidence-based (EB) arthritis SMS through knowledge translation (KT) activities.

Methods
CPGs were adapted and delivered to a lay audience through two interactive workshops. Workshop #1 (WS1): multidisciplinary faculty delivered to selected IPWA, and Workshop #2 (WS2): trained IPWA from WS1 delivered to a local PWA group. Pre- and post-workshop questionnaires evaluated the impact of intensive EB educational training programs on knowledge, skills, and self-efficacy by pts and their efforts to disseminate the CPGs more broadly. The general public with RA or OA were invited, through press media, to access online workshop educational materials and complete pre- and post-website questionnaires.

Results
WS1 was composed of 23 IPWA. Nine IPWA from WS1 received additional training then delivered the same content to 26 new PWA in WS2. Website viewed by 197 individuals. Results showed: statistically significant levels of acquisition of new knowledge in WS pts, high levels of intent to use and actual use of arthritis SMS in RA and OA pts, increased self-efficacy post WS, and high interest in KT activities.

Discussion
KT can be achieved through IPWA intensive EB education programs. Press media is an effective method for raising public awareness of CPGs. Further research is needed on how to refine the media strategy so it can become a more successful KT method.

B58

PARTICIPATION OF PATIENT REPRESENTATIVES IN THE DEVELOPMENT OF GUIDELINES - ARE PATIENT ORGANIZATIONS READY FOR THIS TASK?

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Background
In Germany, National disease management guidelines have been produced by representatives of the scientific medical societies and patient representatives since 2005. One of the most important tasks of the patient representatives is to point out the deficits of healthcare from their point of view. As a prerequisite patient experiences must be systematically collected and processed. Patient organizations are not yet sufficiently prepared to do so.

Purpose
Our aim is to support patient representatives to fulfill their tasks regarding the guideline programe. In order to get a general idea whether and how patient organizations collect patient experiences in a systematic way and to identify the organizations demand of support a survey among member organizations of the national umbrella association for patient organizations was conducted. Based on the results of this survey we produced support tools (checklists, questionnaires, training programs, etc.) for patient representatives involved in guideline development.

Methods
The survey was conducted from October 2006 to January 2007 among 112 member organizations of the national umbrella association for patient organizations. A questionnaire was sent out about the procedures of collecting, structuring and preparing patient experiences. The organizations were asked which mode of collecting patient experiences they considered the most effective and what kind of support was required to systematically determine patient experiences.

Results
21 of 112 patient organizations responded to the survey. At present, patient experiences are not yet systematically collected. Procedures greatly vary and are not comparable. So far, the determination of deficits in healthcare has played a subordinate role.

Discussion
Patient organizations need support in order to be able to perform the tasks implied by their participation in setting healthcare standards. Based on the results of the survey we developed a "patient participation handbook." It contains practical instructions, checklists an recommendations for training.

B59

Are clinical practice guidelines compatible with respecting patient preferences? Conceptual framework and research agenda. Antoine Boivin, MD, CCFP. London School of Hygiene and Tropical Medicine, UK; France Légaré, MD, PhD. Tier 2 Canada Research Chair in Implementation of Shared Decision Making in Primary Care, Université Laval, Canada; Trudy van der Weijden, PhD. Maastricht University, Netherlands; Victoria Thomas. Programme Manager. Patient and Public Involvement Programme, National Institute for Health and Clinical Excellence, UK; Nyokabi Musila, PhD. London School of Hygiene and Tropical Medicine, UK; Jan van der Meulen, PhD. London School of Hygiene and Tropical Medicine, UK.

Context : Implementation of clinical practice guidelines (CPGs) remains a challenge in part because of patients' attitudes and preferences toward health interventions. Observers have highlighted the potential for conflict that exists between appropriateness of intervention, as judged by experts, and patients' own choice. A recent systematic review by the World Health Organisation has called attention to the paucity of research in this area. Objective : To provide a conceptual framework and research agenda on ways to take patients' preferences into account in CPGs' development and implementation. Design: This presentation reports on the discussions from a workshop held at the International Shared Decision-Making Conference in Germany in June 2007. The workshop was organized by a panel of six international experts. A total of 18 clinical practice guidelines developers, clinicians, researchers and patients' representatives from 6 different countries participated in the workshop. Findings: Findings from implementation studies suggest that practice guideline does not currently foster patient involvement in decision-making. Considering patients' values in guideline development appears most important when there is either a lack of good evidence of benefit, or high disagreement regarding how potential outcomes are valued. Three main approaches have been used internationally to incorporate patients' preferences in guideline development: 1) the direct involvement of patients' representatives in the scoping, development and implementation of guidelines; 2) the use of formal methods of considering patients' preferences in guideline development; 3) the promotion of shared decision-making and patients decision-aids in practice guidelines recommendations. These methods involve different assumptions regarding the role of patients in health decision-making and quality improvement. There is a need to clarify those assumptions before the small body of comparative research in this area can be expanded to inform how best to incorporate patients' preferences in guideline development and implementation.

B60

ADAPTATION OF TOBACCO GUIDELINES TO HOSPITALS IN NW ONTARIO AND N. CALIFORNIA

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Background
The United States Department of Health and Human Services (USDHHS), Ontario Medical Association, and the Ontario Ministry of Health and Long Term Care support the USDHHS tobacco use and dependence clinical practice guidelines for hospitals and clinicians. Addressing tobacco use in hospitals is important due to the high costs to treat tobacco-related illness. Yet following the clinical practice guidelines for tobacco use can be difficult for clinicians in hospitals, due, in part, to the acute care nature of hospitals. Adaptation of clinical practice guidelines by hospitals often benefits from the input of a research program.

Purpose
The purpose of this presentation to share the results of two research programs designed to assist 19 hospitals in NW Ontario and N. California adapt tobacco clinical practice guidelines into standard practice.

Methods
Pre-program evaluations at the organizational, clinician, and patient levels were performed,. As part of the research program, hospitals were helped to expand tobacco services consistent with the guidelines, including clinician training. A post-implementation evaluation will be performed to determine the progress made with compliance with the guidelines and to assess further steps.

Results
Guidelines were successfully implemented in all 6 hospitals in N. California, including a VA, large and small community hospitals, a teaching hospital, and a non-profit HMO. Wave 1 of the Ontario study resulted in a centralized electronic system for identifying and documenting tobacco use (a systems-level guideline) in all 12 rural hospitals and 1 regional hospital in NW Ontario, in addition to an analysis of the level of clinician compliance with the guidelines. Wave 2 is currently underway and involves expanding tobacco services in all 13 NW Ontario hospitals consistent with the guidelines and tailored to each hospital's needs.

Discussion
A novel approach to using guidelines to influence compliance will be presented.

B61

UNDERSTANDING GROUP PRACTICES IN CANADA: HOW THE EVOLUTION OF PRIMARY CARE PRACTICES INFLUENCES THE DEVELOPMENT AND IMPLEMENTATION OF CLINICAL PRACTICE GUIDELINES?

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Background
Current Canadian primary care reform emphasizes interdisciplinary healthcare provider teams, health promotion, and developing accountable systems that are patient-centred and community-focused to provide comprehensive, accessible, and coordinated care. A 2006 study examined professional practice performance (knowledge, attitudes, skills, clinical practice behaviours) and performance gaps of interdisciplinary, community-based group healthcare practices across Canada. Findings give directions as to how the development and proactive dissemination of guidelines needs to be reconsidered in this new paradigm of healthcare.

Purpose
(1) To review results of a mixed method study of group practices in Canada conducted in 2006. (2) To conduct an interactive group discussion of the emerging trends in group practices. (3) To discuss the influence of emerging trends in group practices on guideline development, adaptation, and adoption.

Methods
Findings that point to trends in structure and performance of group practices including the need for (1) appropriate and identified group leaders, (2) role clarity of professionals, (3) team practice management skills, and (4) appropriate technology. Interactive small group discussions will be facilitated to encourage attendees to explore how clinical practice guidelines' development and adoption are influenced by new practice realities and if current practice guidelines are taking into account the new collaborative paradigm of care.

Results
This workshop will enable participants to have a better understanding of current challenges toward true collaborative healthcare team. This session will also inform participants how emerging trends of current group practices may influence guidelines' development, adaptation, and adoption. Suggestions for best practices in guidelines' development in this new practice reality will be explained and documented.

Discussion
This workshop is critical to inform leaders and participants engaged in reform initiatives to harmonize guidelines development with current trends in the healthcare system.

B62

IDENTIFYING GENERAL PRACTITIONER BELIEFS, INTENTIONS AND BEHAVIOUR TOWARD UPTAKE OF AN EVIDENCE-BASED GUIDELINE FOR ACUTE LOW-BACK PAIN USING THE THEORY OF PLANNED BEHAVIOUR

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Background
We examined the uptake of an evidence-based guideline for managing acute low-back pain (LBP) in general practice. We wanted to understand why GPs were or weren't using this guideline and identify targets for change suitable for inclusion in an implementation intervention. We used a psychological theory, the theory of planned behaviour (TPB), to understand GP behaviour and identify targets for change.

Purpose
To (1) develop a questionnaire to measure GP attitudes, beliefs and intentions toward implementing the guideline; (2) test the reliability and validity of the questionnaire; (3) identify factors predictive of GPs intention and adoption of behaviours recommended by the guideline.

Methods
We constructed the questionnaire using the TPB to measure the beliefs, intentions and behaviour of a random sample of Australian GPs toward two behaviours; managing patients without referring for plain x-ray and advising patients to stay active. We administered the questionnaire on two occasions to examine test-retest reliability, conducted confirmatory factor analyses to examine validity, and performed regression analyses to test for associations between intention and behaviour outcomes and the TPB variables.

Results
528 GPs completed the questionnaire (rr 17.6%). The instrument demonstrated good psychometric properties. All TPB variables predicted intention to manage patients without plain x-ray (expl. 68% of variance) and give advice to stay active (52% of variance). Significant differences in beliefs were found between intending and non-intending GPs. The best discriminator (for x-ray) was confidence in not missing important underlying pathology in absence of x-ray; and (for advice) a stronger belief that patients would improve at a faster rate with advice about activity.

Discussion
TPB provides a useful summary of the psychological variables influencing GP behavioural intentions. An intervention targeting the predictive psychological variables identified using this instrument is likely to increase the implementation of this guideline.

B63

ACCEPTANCE AND IMPLEMENTATION OF GENERAL PRACTITIONER GUIDELINES IN QUALITY CIRCLES FOR GP-CENTRED CARE

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Background
The study involves Quality Circles for General Practitioner-Centred Carefrom the Hessen Regional Association of Statutory Health Insurance. Members of the circles are introduced in a number of sessions to the general practitioner guidelines developed by the Guideline Group of General Practitioners (GPs) in Hessen. Personal prescription data are discussed against this backdrop.

Purpose
To survey participants with respect to general acceptance of the guidelines as well as relevance and practicability of the recommendations.

Methods
Survey administered in written form in the year 2006. Topics included dyslipidemia (342 questionnaires, 69% rate of return), bronchial asthma/COPD (296, 73%), hypertension (325, 72%) and cardiac insufficiency (256, 84%).

Results
Over the course of the quality circle sessions, the comprehensiveness of the guidelines was increasingly rated as "just right" (54-79%), the practicability increasingly as "simple" (67-86%) and practical relevance increasingly as "high" (67-79%). Participants increasingly stated that they would recommend the guidelines to fellow colleagues (75-86%). Ratings of the relevance of individual guideline recommendations for the assurance of therapeutic quality ranged from 37% to 98% and ratings for the practicability of individual recommendations between 35% and 97%. The question "What have you modified since the last session?" revealed which of the recommendations had been well implemented in practice, e.g. assignment to dyslipidemia risk categories, and how the guideline supported their decisions

Discussion
A trend of growing acceptance of the guidelines was observed. This trend should be validated in the further course of quality circle sessions. In the case of individual recommendations which were met with low levels of participant acceptance, guideline authors should look to examine whether these recommendations are dispensable, whether the relevance of such recommendations for therapeutic success requires greater elucidation or whether more support in implementing the recommendations should be provided.

B64

WHY ARE CLINICAL PRACTICE GUIDELINES NOT AS EFFECTIVE IN ONTARIO ACUTE CARE HOSPITALS?

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Background
Previous research has demonstrated that clinical practice guideline (CPG) usage is not related to hospital length of stay (LOS) in Ontario, which is in stark contrast to a systematic review that found a relationship between CPGs and LOS (Shamian-Ellen M., Brown, AD, Leatt, P, 2006, Shamian-Ellen M., Brown, AD, Cockerill R, 2006).

Purpose
To explore possible barriers and facilitators in the CPG adoption process and to determine why CPG usage does not influence LOS in Ontario hospitals.

Methods
Semi-structured qualitative interviews were conducted. Interview questions were based on the AGREE tool and a list of exploratory questions developed based on the literature and discussions with experts in the field. The interviewees worked in Ontario acute care hospitals and dealt with one or all of the following responsibilities: developing, implementing, monitoring, updating, or evaluating CPGs.

Results
Nine interviews were conducted and small, community, and teaching hospitals were represented. The interviewees stated that hospitals predominantly use pre-existing CPGs and include multidisciplinary teams. Lack of organizational support, financial resources, and tools, were cited as the largest barriers for implementation. Tailoring pre-existing CPGs to the organization was viewed as extremely labour intensive and the proper supports were not in place to ensure success. Perceptions of the effectiveness of CPG on a variety of outcomes are reviewed.

Discussion
The interviews explained some possible factors why CPGs are not realizing their full potential in Ontario hospitals. The CPG itself is not perceived to be the reason why CPGs are not effective, mostly because they are evidence based. The barriers are perceived to be at the organizational level and individual level. There is pressure in health care for institutions to develop and implement CPGs. Policy makers need to spend more funds and provide assistance to managers and employees required to implement such a considerable change.

B65

IMPLEMENTATION OF CLINICAL PRACTICE GUIDELINES: OVERCOMING BARRIERS TO IMPLEMENTATION OF IRON MANAGEMENT GUIDELINES IN CHRONIC KIDNEY DISEASE PATIENTS.

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Background
The correct management of iron in chronic kidney disease patients decreases mortality and morbidity. An audit of iron management practices and iron indices was analysed for six renal units (labelled 1-6) in Australia in 2004 and barriers and enablers to implementation of the Caring for Australasians with Renal Impairment (CARI) iron guideline were documented for the guideline in general.

Purpose
To review pre-implementation iron practices, improve the management of iron according to the CARI guideline and assess the effectiveness of active guideline implementation.

Methods
Feedback from the iron management audit was sent to each unit. Each unit assessed their results and three of the six units agreed to participate in the implementation phase. For each unit, an opinion leader was selected and a barrier analysis performed. We offered a computerised decision support system for iron management to each unit. We conducted a preliminary audit of iron indices in March 2006 after 5 months from the first feedback. The final audit is currently being analysed.

Results
Wide variation of iron indices was observed across the units. Unit 2's median ferritin improved from 165 to 233?g/L (p=0.007) and median haemoglobin changed from 119 to 122g/L(p=0.02).Unit 3 showed improvement in their median ferritin levels from 163 to 216?g/L (p=0.007). Units 4's median ferritin levels dropped in the period of observation from 376 to 319?g/L although this was not significant (p=0.10).

Discussion
Based on our observations, the variation in results between the three units are due to differences in the upper management support for the project, workplace culture and selection of opinion leaders ie-work load, level of authority. Support from an external source such as the CARI implementation staff, good staff motivation and seniority of the opinion leader are critical for the successful implementation of guidelines.

B66

GUIDELINE IMPLEMENTATION STRATEGIES TO OVERCOME BARRIERS TO ABDOMINAL AORTIC ANEURYSM SCREENING

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Background
In response to published guidelines for Abdominal Aortic Aneurysm (AAA) screening, we surveyed primary care physicians to determine attitudes and identify barriers to screening. Responses indicated support for identifying AAAs: 60.4% were aware of recommendations. Neither access to a vascular surgeon nor knowledge about the importance of AAAs is a limiting factor. Respondents screened more frequently for breast (79.1%), prostate (80.5%), colon cancer (80.9%), and hypertension (83.7%) than AAAs (20.9%).

Purpose
Identify strategies to overcome barriers to screening.

Methods
We identified barriers with respect to primary (family medicine and selected specialties), secondary (ultrasound specialists) and tertiary (vascular surgeons) care providers, as well as, target group 'patients'. These barriers included information gap, communication, advocacy, ethical and management issues. Semi-structured focus sessions were organized for each group. A structured questionnaire was developed for each group. An informal feasibility poll was undertaken to address the appropriateness of this approach. Common theme analysis and semi-quantitative scoring (Liekert scale) will be applied to identify the best approach to each barrier. Innovative ideas will also be sought. The documentation was submitted to the Research/Ethics Committee for approval.

Results
The poll showed the focus groups-survey combination to be a practical approach. The results of the focus groups and structured approaches to address the implementation of this guideline will be ongoing over the next 2 months and will be finalized for presentation.

Discussion
Screening for AAAs lags significantly behind other major screening programs. Although primary practitioners are routinely exposed to the target population, only the minority of patients are screened. Of those who were aware of guidelines, only one third follow them. Further research and development of educational strategies is ongoing to overcome the barriers to screening.

B67

BARRIERS TO AND FACILITATOR OF THE CLIP GUIDELINE

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Background
In April 2006, clinical guidelines for the management of low back pain (LBP) and prevention of long term disability were developed and entitled the Clinic on Low Back Pain in Interdisciplinary Practice (CLIP). Studies show that guidelines alone have little effect on improving clinical practice. To enhance adherence to clinical guidelines by health care professionals, the literature suggests identifying and addressing factors that impede or facilitate their utilisation.

Purpose
Identify the barriers to and facilitators of using the CLIP guidelines, as perceived by the physiotherapists in the province of Quebec.

Methods
This is a descriptive study using a qualitative approach. A sample of 16 physiotherapists from varied professional backgrounds will use the CLIP guidelines with two patients suffering from LBP over a six-week period. Data will then be collected during two semi-structured interviews in order to identify the barriers to and facilitators of both understanding and utilisation of the guidelines. The interview guide and the coding chart will be elaborated using a conceptual framework adapted from the Physician Guideline Compliance Model by Maue et al. (2004) and from a classification of barriers to and facilitators of guidelines utilisation by Saillour-Glennisson et al. (2003). The transcripts of the interviews will be analysed following a thematic content analysis with a mixed coding chart. To ensure the coding reliability, two coders will train until they achieve a confidence ratio of 95 %.

Results
Data will be collected and analysed during the winter and spring of 2007. A list of environmental, individual and guidelines related barriers and facilitators will be presented in relation to our conceptual framework. The results will also be contextualised with regards to the current physiotherapy practice.

Discussion
This study constitutes a necessary precondition designing an optimal implementation strategy, in order to improve adhesion of the physiotherapists to the CLIP guidelines.

B68

COMPETING NORMS: EXPLORING RURAL FAMILY PHYSICIANS' PERCEPTION OF CLINICAL PRACTICE GUIDELINES AND SHARED DECISION-MAKING

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Background
Implementation of clinical practice guidelines (CPGs) and shared decision-making are both advocated in primary care. Some authors argue that CPGs can enhance informed decision-making between patients and physicians, while others warn that a standardized implementation of CPGs could hinder patients' involvement in decision-making.

Purpose
To explore rural family physicians' perception of the interaction between clinical practice guidelines and shared decision-making in medical practice.

Methods
A qualitative study using semi-structured focus-group interview was conducted with seventeen family medicine physicians and residents in Rouyn-Noranda, a Canadian rural town in northern Quebec. Interviews were audio taped and transcribed verbatim. Analysis was guided by the template organizational style and performed by the principal investigator. Interpretation was validated by constant comparative method, member-checking and debriefing among the research team.

Results
Two distinct conceptions of how clinical practice guidelines should assist decision-making emerged from the discussions. On the one hand, guidelines were seen as helping clinicians to make decisions, on behalf of their patient, about the best course of action. However, especially in the context of chronic disease management, physicians expected guidelines to inform the decision-making process between clinicians and patients by providing details about risks, benefits, costs and treatment alternatives. Current guidelines were considered as often lacking such information. The pressure to apply CPGs' recommendations was perceived as a potential barrier to patient participation in decision-making.

Discussion
In circumstances requiring patient participation in decision-making, physicians perceive a direct tension between what they consider as two competing norms of good practice: the need to consider patients' preferences, and the pressure to apply guidelines recommendations. To facilitate patient involvement in decision-making, these physicians report that clinical practice guidelines should include relevant information about risks, benefits and costs of interventions.

B70

A SYSTEMATIC GUIDELINE REVIEW AS AN EFFICIENT METHOD IN EVIDENCE BASED GUIDELINE DEVELOPMENT. PRIMARY CARE MANAGEMENT OF CHRONIC HEART FAILURE AS A MODEL.

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Background
Clinical guidelines potentially improve healthcare. However, de-novo-development of evidence based guidelines requires remarkable resources - especially in complex conditions like chronic heart failure (CHF), and adaptation may be biased by contextual influenced recommendations in source-guidelines.

Purpose
To design a systematic guideline review (SGR) method, and to apply it to the development of an evidence based guideline on CHF.

Methods
A systematic search for guidelines was performed. Eligibility of guidelines was assessed on predefined criteria by two reviewers. Methodological quality of selected guidelines was appraised using the AGREE-instrument. A framework of relevant clinical questions was derived. Data were extracted and systematically compared in consistency analysis. Uncertain recommendations (inconsistency and/or weak evidence) were postponed for further research. In less uncertain recommendations (strong evidence based consistencies and minor inconsistencies) relevant publications were re-evaluated. Information was synthesized in a preliminary draft.

Results
A total of 16 CPGs was included (Kappa=0,95), partial of high quality. Within a framework of 27 questions we identified 35 complex recommendations: 25/35 consistent, 9/35 inconsistent, 1/35 not rateable (derived from a single guideline). Out of 25 consistencies N=7 based on strong evidence, N=14 on expert opinion, and N=4 was consistent in content but differed in grading. Three major inconsistencies (e.g. Brain Natriuretic Peptides) and 14 opinion based statements needed further research. In 17 statements we re-evaluated the evidence, the majority was congruent. However, sometimes we found incongruence (e.g. no evidence for ß-blockers in asymptomatic non-ischaemic CHF). After six months the first draft was completed.

Discussion
Main limitation of SGR is a lacking actuality - update research is necessary , and in our approach only single review (in data extraction / analyses). Chances are in our view the systematic approach incl. validation, transparency, efficiency, and enhanced objectivity in 'grey zones of clinical practice'.

B71

EFFICIENCY IMPROVEMENT IN EVIDENCE-BASED GUIDELINE DEVELOPMENT IN THE NETHERLANDS

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Background
The development of evidence-based guidelines in the Netherlands was lengthy (? 3 years), and rather labor-intensive for the professionals participating in de guideline development group.

Purpose
To improve the efficiency in guideline development by shortening the duration and decreasing the workload for the professionals in the guideline development group.

Methods
The process was adapted in several ways regarding the development of guidelines for colorectal cancer. Clinical questions were formulated by the National Working Group Gastro-intestinal Tumors of the Association of Comprehensive Cancer Centres (ACCC). For each question one clinical expert on this topic was requested to participate in the guideline development group. The literature search was performed by an information specialist from CBO in close collaboration with the clinical experts, using existing high-quality international guidelines and systematic reviews as starting point. Epidemiologist from CBO summarized the evidence under auspices of the experts. Experts were responsible for formulating the recommendations. The guideline development process was coordinated by the ACCC.

Results
We found 25 recent guidelines on the topic. In particular those guidelines including systematic reviews or evidence tables were used. Summaries of evidence and draft recommendations were discussed during six meetings, starting February 2006. The final draft of the guideline was finished in March 2007. Experts of the guideline development group who had previous experience with guideline development indicated a substantial decrease in their workload.

Discussion
It is feasible to develop an evidence-based guideline on a broad cancer topic in approximately one year. Summarizing the evidence can be efficiently performed by epidemiologists under auspices of clinical experts, thus decreasing the workload for these experts. Preferably, the epidemiologists should have previous experience within oncology. Official endorsement of the guideline should be planned in advance in order to prevent delay at the final phase.

B72

USING THE GRADE SYSTEM TO PRODUCE CLINICAL RECOMMENDATIONS FOR ANTICANCER DRUGS

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Background
The search for more effective interventions raises concerns in the area of anticancer drugs where fast track approval may hinder full assessment of their benefit risk profile.

Purpose
The aims of this project were: a) provide a common ground for health professionals and policy makers/administrators for deciding on appropriate use of resources in an area characterised by high expectation and incomplete efficacy/side effects information; b) create a mechanism to identify clinical questions where clinical research is needed

Methods
We used the GRADE system to develop recommendations for the use of specific anticancer drugs/regimens in 12 clinical questions relevant to adjuvant treatment of breast (3), colorectal (4) and lung (5) cancer. Multidisciplinary panels including different cancer specialists, public health doctors and patient representatives worked with the support of a group of methodologists.

Results
Panels produced 9 recommendations (1 strong and 6 weak in favour of the index treatment and 1 weak and 1 strong against) and concluded that no specific course of action could be recommended for the other 3 clinical questions. The perceived benefits to risk balance of the treatment was the most important and statistically significant ($p<0.01$) predictor of the direction and strength of the recommendations, while panellists' personal (age, sex) and professional (specialty) characteristics did not play a significant role

Discussion
Producing evidence-based recommendations in the rapidly evolving field of anticancer treatments poses methodological and practical challenges. In our experience GRADE combines methodological rigour and interdisciplinary participation allowing for an explicit assessment of the different components (evaluation of the quality of evidence and of the benefits risk profile, judgement of the strength of recommendations) that are at stake in defining evidence based clinical policies. GRADE seems able to reconcile the distance between methodologists and clinicians when clinical policies are to be set

B73

AN EXAMPLE OF USE OF THE EGLIA TOOL IN DEVELOPING GUIDELINES FOR ACUTE STROKE MANAGEMENT IN AUSTRALIA

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Background
The eGLIA tool was developed to assist guideline developers in making guidelines easier to apply in the real world. However time is needed to become familiar with such a tool which may reduce its usefulness and widespread application

Purpose
To determine the usefulness of incorporating the eGLIA tool into the systematic process involved in peer review and consultation and to highlight the application of the eGLIA tool in Australia.

Methods
Health professionals who had no previous experience with the eGLIA tool but who are involved in implementing guidelines were recruited. These health professionals were given a brief overview of the tool and asked to use to tool when reviewing specific recommendations during the consultation phase of the guideline development process. Time spent, numbers of recommendations reviewed and subjective feedback of the process will be collected along with the summary developed by the eGLIA.

Results
Health professionals are currently being recruited and results are pending.

Discussion
It is believed this process will demonstrate the value in the systematic evaluation of draft guidelines using the eGLIA tool. Further information of the use of the GLIA tool will enable guideline implementers and developers a robust tool to improve implementability of guidelines especially assessing the effect on adherence for guidelines who have used the GLIA tool.

B74

GUIDELINES FOR A RARE DISORDER: AN EVIDENCE-BASED CONSENSUS PROCESS

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Background
International experts have identified significant care gaps in diagnosis and management of a rare genetic disorder, Hereditary Hemorrhagic Telangiectasia (HHT).

Purpose
To develop evidence-based recommendations for diagnosis and management of HHT.

Methods
An internationally representative sample of HHT experts developed key questions reflecting the important aspects of HHT care using a modified Delphi process. Systematic searches of the medical literature plus polling of experts identified studies addressing these questions. Study quality was appraised and results from studies meeting inclusion criteria were extracted into evidence tables. HHT Experts, guideline methodologists and HHT patients participated in a structured consensus process. Working sub-groups generated recommendations for the key questions using evidence tables generated from systematic searches. All participants then voted anonymously on the recommendations. Those recommendations achieving < 80% agreement were further discussed with a facilitator and re-voted.

Results
Fifty key questions were developed. Literature searches identified 2694 abstracts, of which 171 articles were found suitable for full review. Six subroups representing expertise in the areas of HHT diagnosis, epistaxis, central nervous system vascular malformations, pulmonary arteriovenous malformations, gastrointestinal bleeding and liver vascular malformations generated 31 recommendations. Twenty-one/31(67%) recommendations received >=80% agreement on first vote. Ten recommendations were further discussed, re-worded and re-voted, resulting in a final 34 evidence-based recommendations, with >=80% agreement in 31/34(91%). Post-conference feedback from participants suggested a high level of satisfaction with the process.

Discussion
In conclusion, this evidence-based consensus recommendation process for a rare disorder allowed development of 31 recommendations which met with >=80% expert approval. The process integrated evidence with valid expert and patient values. The group is now planning an implementation strategy to enhance care for this patient population.

B75

USING CONFERENCES AS STRATEGIC EVENTS TO SUPPORT KNOWLEDGE MOBILIZATION

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Background
Systematic reviews have concluded that conferences consisting of traditional didactic sessions have little impact on practice change or changes in patient outcomes. However certain conferences can become focal events creating awareness and interest in upcoming systematic reviews and create excitement in participating in post-congress knowledge mobilization.

Purpose
To illustrate intended and unintended outcomes of using conferences as strategic and purposeful vehicles to build coalitions to support knowledge mobilization.

Methods
Planning and evaluation tools used include modified PRECEDE-PROCEED model, KTE intervention mapping, application of personal and organizational change theories and principles, and social marketing constructs.

Results
Conference planners explicate working assumptions and refinements to a planning framework for an upcoming World Congress on Neck Pain (January 2008) building on lessons learned from three other case studies and implementation research. To-date organizers have cultivated and engaged 26 national and international organization co-sponsors specifically seeking their interest and participation in post-congress dissemination. The case study demonstrates that congress organizers could potentially play an important role in promoting awareness, interest and provisional commitment to review and potentially incorporate findings from systematic reviews addressing costly public health issues, across disciplines, professions and regulatory bodies - prior to their publication! Using intervention mapping the idea of meaningful engagement of multiple stakeholders before, during and post congresses is explored, working assumptions and linkages to change theory and social marketing are explicated.

Discussion
Conference organizers can use pending or recently published systematic reviews /guidelines or other means to generate awareness, get buy-in from targeted stakeholders, attract opinion leaders and government stakeholders to lay the foundation for post-congress KTE activities. If this is the case, then purposeful KTE-directed conferences should - in theory at least - be more effective than more traditional didactic fare

B76

QUALITY CIRCLES IS AN EFFECTIVE KNOWLEDGE TRANSLATION APPROACH THAT INCREASES PRIMARY CARE PHYSICIANS ADHERENCE WITH THE OSTEOPOROSIS CANADA (OC) 2002 GUIDELINES WHEN TREATING HIGH RISK PATIENTS WITH OSTEOPENIA AND FRACTURE

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Background
The Quality Circles (QCs) project was developed to improve primary care physicians' (PCPs) management of osteoporosis in accordance with the Osteoporosis Canada (OC) 2002 Guidelines.

Purpose
The study evaluated the change in treatment administration in high risk patients with bone mineral density (BMD) t-scores in the osteopenia range and prior fragility fracture at the hip, wrist or spine.

Methods
The study consisted of five phases: wave I data collection, 1st educational intervention, wave II data collection, 2nd educational intervention, and wave III data collection. During the educational intervention QCs met to discuss physician profiles (snapshots of how they managed osteoporosis) and to participate in an osteoporosis workshop. A total of 340 (wave I) and 301 (wave II) PCPs formed 34 QCs. For each wave, PCPs collected data from different patients via chart reviews and a standardized collection form. A total of 8376 (wave I) and 7354 (wave II) patient records were selected. All patients were women 55 years and older. This interim analysis (wave I & II) used the generalized estimating equations method to evaluate differences in bisphosphonate use in these high risk patients pre and post educational intervention. Odds ratios (OR) and 95% confidence intervals (CI) were calculated.

Results
A total of 21, 82, 74 and 169 osteopenia patients during wave I and 45, 144, 133 and 290 ostopenia patients during wave II had hip, spine, wrist or any (hip, spine or wrist) fractures, respectively. The likelihood of bisphosphonate use increased following the educational intervention for patients with spine (OR: 1.74; 95% CI: 0.1.04, 2.91), wrist (OR: 2.56; 95% CI: 1.34, 4.90) and any fracture (OR: 2.19; 95% CI: 1.47, 3.26).

Discussion
QCs is an effective knowledge translation approach that increases PCPs adherence with the OC guidelines when treating high risk patients.

B77

IMPROVING PREVENTION GUIDELINES IMPLEMENTATION USING BEST PRACTICES IN CONTINUING MEDICAL EDUCATION: A RANDOMIZED-CONTROL TRIAL.

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Background
Whereas numerous studies have demonstrated that treating high-risk cardiovascular patients improve morbidity and mortality, others reveal that only 20% to 61% are treated according to clinical practice guidelines (CPGs). In addition to knowledge, lack of clinical time, tools and reminder systems are the main factors explaining GPs' performance in preventive care.

Purpose
To report on the CIME Project, a randomized-control trial on the effectiveness of a strategy developed to improve GPs' performance using best CME practices: dissemination, enabling and reinforcement.

Methods
122 GPs were recruited in Quebec. After attending a 2h interactive workshop (dissemination), half were randomly assigned to the intervention group. This group was provided with a nurse who: 1) reviewed charts of patients >= 55 y with an upcoming visit from Feb. to Aug. 2005; 2) labeled charts of potentially undertreated patients (enabling); and, 3) enclosed a chart summary and treatment algorithm (reinforcement). Control GPs practiced as usual during this period. Changes in performance during the intervention period were assessed retrospectively in both groups using chart audit for consenting patients.

Results
Screening of 16,050 charts revealed that 35% of patients >= 55 y were at high risk and that 69% of these were potentially undertreated according to CPGs. The retrospective chart audit of patients that were potentally undertreated at baseline demonstrated that the intervention significantly improved CPGs' implementation and that the size of the impact varied according to the specific guideline studied.

Discussion
CME providers can improve CPGs' implementation if they go beyond dissemination and include in their interventions strategies that facilitate knowledge integration in the practice. Here, a nurse-led collaborative workplace intervention successfully supported and increased the likelihood of practice change. This clinical approach and the tools developed in this projet were later used to build a multidisciplinary educational program for primary care practice teams.

B78

AGIRPREV: A MULTI-FACETTED EDUCATIONAL PROGRAM SUPPORTING PRIMARY CARE TEAMS IN THE IMPLEMENTATION OF CARDIOVASCULAR PREVENTION GUIDELINES

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Background
Numerous studies have shown the difficulty of implementing prevention guidelines in primary care. Part of the problem arises from the guidelines themselves: too many, too specific, too complex, often conflicting with each other. Traditionally, CME educators' role has been to tackle factors that pertain to the physician, i.e. knowledge of and attitudes towards expert concensus. However, they tend to disregard major problems associated to guideline implementation in the busy clinical environment: lack of time with patients looking for quick fixes; lack of reminding and detection systems.

Purpose
To describe AGIRPREV, a multi-facetted educational intervention which provides, in addition to knowledge, practical tools and continuing support to help primary care teams integrate cardiovascular prevention guidelines in their working environment.

Methods
To register, a GP team must attend an interactive workshop where it is updated on guidelines. Then, the clinic is granted access to enablers and reinforcers that facilitate guideline implementation in the workplace: nurses are trained to detect high-risk patients, sketch a relevant chart summary, prompt charts and insert a patient management algorithm. Continuing support is provided through a dedicated web site where each team member can download updated guidelines and tools, consult an expert, discuss implementation with other clinics, consult literature or initiate a review to foster practice reflection. Clinics are automaticaly alerted to changes by e-mail.

Results
Each component of the program as well as results on web site use and implementation of the clinical approach in participating practices after 3 months will be described.

Discussion
The literature suggests that CME could have more impact on guideline implementation in primary care if, in addition to knowledge dissemination, it facilitated and supported its integration in the practice environment. The project's approach, which impact is being demonstrated in a random-control trial, illustrates how educators may achieve this.

B79

COMPLIANCE TO THE NATIONAL BREAST CANCER GUIDELINES IN THE NETHERLANDS.

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Background
In the Netherlands, there are evidence based national guidelines on screening, diagnosis (update 2000) and treatment (update September 2005) of breast cancer.

Purpose
We studied the compliance to these guidelines on a population based level in order to identify potential bottlenecks in the use of the guidelines in daily practice.

Methods
The national guidelines working group formulated indicators in order to pinpoint the important decision moments in the guidelines. These indicators give information on diagnosis, treatment, organisation and accessibility of care. We used data of the cancer registry to evaluate the compliance to the guidelines, supplemented with extra items which were not available in the registry. In two comprehensive cancer regions (CCCA and CCCMN) these extra items were collected for patients diagnosed from November 2005 till March 2006. Registrars collected in the hospitals all information directly from the patient files, including the pathology reports. The description of the extra items was formulated in a codebook to avoid lack of clarity.

Results
All 28 hospitals, including general hospitals, three university hospitals and a specialized cancer hospital, gave permission to collect extra items for this study. More than 1000 breast cancer patients were included. Data were missing in less than 2 percent. We will show results on diagnosis and various treatments. We will present the results concerning surgical treatment, including lymph node staging. Furthermore, the results regarding radiotherapy and systemic therapy with chemotherapy or biologicals will be presented. We will report on the analysis of subgroups based on relevant clinical and pathological factors such as age, stage, estrogen and progresterone receptor status and Her2Neu receptor status. Also, waiting times will be reported.

Discussion
The preliminary results are very promising: the compliance to the national guidelines seems remarkably well. The final results will be presented at the meeting and can be a reason for revision the guidelines.

B80

IMPACT EVALUATION OF CLINICAL GUIDELINE ON TONSILLECTOMY IN ITALY

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Background
Tonsillectomy is a common procedure with large geographical variations. In Italy, within the National System Clinical Guidelines, a guideline was developed to promote appropriateness of surgery for (adeno)tonsillectomy. It dealt with indications for (adeno)tonsillectomy, surgical/ anaesthesiology techniques, perioperative management, organisational issues. Since April 2003 the guideline was implemented using a multifaceted approach that included massmedia campaign, internet and journal publications, discussion and distribution during national conferences and local educational meetings, use of opinion leaders, mailing to regional health authorities, hospital trusts, paediatricians and otolaryngologists, and formal adoption in several Italian child hospitals.

Purpose
To evaluate the impact of guideline at national level, monitoring the overall rate and geographical variation of tonsillectomy rates across Italian regions.

Methods
We used data from the hospital information system of Italian Ministry of Health, which collects information on all hospitalisation occurring in public and private hospitals. We calculated the rates of (adeno)tonsillectomy in the 21 regions from 1998-2004. Regional rates were standardised by age and gender, using 2001 population as reference, to allow comparability across regions and time.

Results
Overall tonsillectomy rate in Italy ranged from 10.5 to 10.9 x 10,000 in 1998-2002 period, and it dropped to 9.1 in 2003 and 9.4 in 2004. Standardised regional rates showed a marked geographical variability with a North-South gradient: the range was quite stable from 1998 to 2001, and the variability decreased in 2003 due to reductions in regions where the rates were higher (1998: 3.9-19.0; 2002: 5.4-18.3; 2003: 4.1-16.7; 2004: 4.2-16.6).

Discussion
Italian experience on guideline implementation showed a successful change in tonsillectomy practice and inappropriate variations. Effective implementation was fostered by comprehensive interventions, participative discussions on guideline, and enthusiasm featuring the transfer of evidence into practice.

B81

AWARENESS OF AND ADHERENCE TO CANCER SCREENING GUIDELINES AMONG HEALTH PROFESSIONALS IN JAPAN

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Background
In Japan, guidelines for cancer screening have been developed and revised by a research group funded by the Ministry of Welfare and Labor since 1998. The latest guidelines recommended six cancer screening in 2001. However, little is known about awareness of and adherence to the cancer screening guidelines among health professionals.

Purpose
We conducted survey for 2 groups of health professionals and compared awareness of the guidelines, related knowledge and the attitude towards cancer screening.

Methods
The surveys were conducted by mailing questionnaires to the two target groups: local government officers of municipal cancer screening programs (mainly public health nurses, n=3,327); and experts of an academic society for gastroenterological cancer screening (mainly physicians; n=195). The questionnaire contained inquiries about: 1) awareness of and adherence to the cancer screening guidelines published in 2001, and 2) basic knowledge of and attitude to cancer screening. Differences in the responses between the 2 groups were assessed using chi-square test.

Results
The response rate in both groups was approximately 65%. Although over 70% of the respondents were aware of the cancer screening guidelines, 20% of the local government officers and 35% of the experts responded that non-recommended screening methods by the guidelines could be introduced for population-based screening as part of public policy. Fifty-seven percent of the local government officers and 75% of the experts responded that there was no problem with using non-recommended methods for opportunistic screening. More than 95 % of both groups believed that screening was `almost always a good idea'

Discussion
The survey revealed that there were simple enthusiasms for cancer screening and lack of fundamental knowledge needed to promote evidence-based cancer control program even among the health professionals. It is necessary to develop educational systems for health professionals to provide appropriate knowledge related to cancer screening.

B82

EXAMINING THE RELATIONSHIP BETWEEN CLINICAL PRACTICE GUIDELINES AND LENGTH OF STAY THROUGH A SECONDARY DATA ANALYSIS

Moriah Ellen, Adalsteinn Brown, Rhonda Cockerill (University of Toronto, Toronto, Ontario)

Background
Efficiency of care is an important topic in Canadian health care. One common measure of efficiency is length of stay (LOS) Clinical practice guidelines (CPGs) are an intervention used to reduce LOS. To date, no large scale research analysis has been conducted to examine the relationship between CPG use and LOS.

Purpose
To examine the relationship between the use of CPGs and LOS across numerous medical and surgical disease states throughout the province of Ontario.

Methods
This research conducted statistical analyses on secondary data that was obtained from two different data sources: CPG usage was obtained from the Hospital Report Research Collaborative (HRRC) and LOS data was obtained from the Canadian Institutes for Health Information (CIHI). Descriptive statistics, correlations, and longitudinal analyses were conducted.

Results
Ten clinical areas were examined in 88 acute care hospitals over a two year period (2002-2003 and 2003-2004). Differences in responses based on hospital type (small, community, teaching) were examined and minimal differences were found. CPGs are used in Ontario hospitals to a varying degree in most disease states: both medical and surgical. CPG usage and LOS did not change dramatically over the two years. The relationship between CPG usage and LOS was only statistically significant in two disease states: pneumonia ($p=.033$) and prostatectomy ($p=.008$). There were no significant relationships found in the longitudinal analysis.

Discussion
This secondary data analysis did not find a strong relationship between CPG usage and LOS. Possible reasons for this are discussed, as are limitations and future research suggestions. This study adds to previous research by examining CPG usage across a wide range of disease states and in a large number of Ontario hospitals. The results here are counterintuitive to other studies and systematic reviews that demonstrate a strong inverse relationship between CPGs and LOS.

B83

KNOWLEDGE, ATTITUDES AND USE OF CURRENT CARE GUIDELINES AMONG THE FINNISH PRIMARY HEALTH CARE PHYCISIANS

Pekka Jousilahti, Jorma Komulainen, Tiina Hanski, Eeva Ketola (National Public Health Institute, Helsinki, Finland, The Finnish Medical Society Duodecim, Current Care, Helsinki, Finland)

Background
Since it's launching in 1994, the Finnish Current Care (Käypä hoito) has produced 73 guidelines.

Purpose
The aim of the present study is to assess the knowledge, attitudes and use of 21 selected guidelines on common diseases and disorders among the Finnish primary health hare physicians.

Methods
An electronic web-based questionnaire was sent to 1500 randomly selected working-age physicians. 619 physicians replied and 119 of them were working in primary health care. The questionnaire included questions about the knowledge and use of and attitudes to the guidelines. The following 21 guidelines were considered as most relevant for general practice: alcohol dependency, anti-inflammatory analgesics, asthma, bronchitis, bacterial skin infections, deep vein thrombosis, depression, dyslipidaemias, fungal infections, helicobacter infection, hypertension, lower back conditions, migraine, neck pain, obesity, otitis media, osteoporosis, sinusitis, smoking cessation, tonsillitis, urinary tract infection.

Results
The guidelines were well known among the physicians; the average figure for all 21 guidelines was 83%. Hypertension guideline was the best known, 98% knew it, and the following guidelines were known at last 90% of the respondents: acute otitis media, asthma, dyslipidaemias and urinary tract infection. 66% of the physicians replied that the guidelines (average for all 21 guidelines) affected their clinical decision making fairly much (28%) or very much (38%). In this respect the most important guideline was hypertension (84%), followed by asthma (81%), dyslipidaemias (77%), urinary tract infection (77%), and otitis media (76%). Of the respondents, 90% agreed (agree or fully agree) that the guidelines are useful tools for the physicians. Furthermore, 82% agreed that the guidelines improve the quality of care and are based on the best available scientific knowledge.

Discussion
Current Care Guidelines are well known among the Finnish primary health care physicians. The guidelines have a remarkable effect on physicians' clinical decision-making. Primary health care physicians consider the guidelines very valuable for their work.

B84

DIAGNOSTIC IMAGING PATHWAYS: ACHIEVING STANDARDS IN GUIDELINE DEVELOPMENT?

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Background
Diagnostic imaging in Australia accounts for approximately 15% of Medicare benefits paid and has become a major driver of rising health care costs. Inappropriate use of diagnostic imaging amplifies the growth and exposes patients to risks without benefits. Studies have indicated that up to 33% of radiological examinations are totally or partially inappropriate.

A significant threat to appropriate imaging is lack of knowledge. In response to a 'medical knowledge crisis' Diagnostic Imaging Pathways (DIP) was developed as a web-based (www.imagingpathways.health.wa.gov.au) education and decision support tool for requesting clinicians. More than 100 pathways are based on consensus opinion and the best available graded evidence, and provide advice aimed at minimising inappropriate imaging and maximising diagnostic yield.

Purpose
A question posed by the developers of DIP and (presumably) any potential user is whether DIP meets suitable and acceptable standards for guidelines. This paper explores whether this question can be answered at present.

Methods
A range of potential indices of suitability and acceptability were considered for application to DIP, namely:
- conformity to an independent 'guideline on the development of guidelines' (NHMRC)
- frequency of review, revision and development of content
- multi-stakeholder engagement and editorial independence
- support from published evidence
- user acceptance and satisfaction
- professional endorsement
- independent accreditation (HON Foundation)
- an assessment of quality (AGREE Instrument)
- an assessment of practicability (GLIA)

Problems with the indices were documented.

Results
There were difficulties with the potential indices including, measurability, applicability, credibility, practicability and scope.

Discussion
An instrument for measuring whether DIP meets appropriate standards has not been found. There are other diagnostic guideline packages broadly similar to DIP, and it is important to be able to carry out comparative assessments. We seek to collaborate with conference participants in the establishment of a standard for suites of diagnostic guidelines.

B85

GUIDELINES FOR RADIOLOGY: A DEMONSTRATION PROJECT Martin Reed
(Department of Radiology, University of Manitoba, Winnipeg, Manitoba)

Background
The number of diagnostic imaging studies being performed in Canada is increasing steadily. This trend has also been documented in many other countries. Generally between 10 and 20% of these studies do not help in the management of patients. Several factors contribute to these inappropriate studies: duplicate examinations, self-referral and an information gap. Information gap refers to the fact that because of the amount of new information continually presented to them, physicians cannot keep their knowledge current about the most appropriate use of diagnostic imaging.

For this reason the Canadian Association of Radiologists (CAR) has published a set of guidelines for the use of diagnostic imaging. However, the printed format is not as effective a method of presenting guidelines as providing them at the point of care.

Purpose
The purpose of this study is to determine the effectiveness of incorporating imaging guidelines into an electronic order entry system.

Methods
An electronic order entry system has been implemented at the Children's Hospital of Winnipeg which uses the CAR guidelines to advise a physician of a more appropriate examination if his order is inappropriate. An independent qualitative and quantitative analysis of the effectiveness of this program is being undertaken.

Results
The qualitative analysis indicates that physicians like the program.

Of the 4180 orders placed in the system to the end of February, 6% were duplicates and 15% triggered advice.
The compliance rate was 10% for cancelling a duplicate order and 32% for directions to change or abandon an ordered test.

Discussion
The percentage of inappropriate orders is not as high as in some previous studies probably because the physicians at the Childrens' Hospital have a close relationship with the radiologists and a concern about radiation risks in children and therefore they order imaging studies more appropriately than other physician groups might do.

B86

'SIB OP MAAT': AN ONLINE DATABASE FOR PATIENT INFORMATION ON ANTICANCER DRUGS

Joke van den Bogert, Marion van Oirschot, Dorien van Benthem, Monique Kroeze, Maureen de Boer (The Dutch Association of Comprehensive Cancer Centres)

Background
The ACCC is an alliance of the nine CCC's in the Netherlands, its purpose is to provide cancer patients and their families' access to comprehensive and high-quality care as close to home as possible. The services of the CCC's are directed towards improving the professional, organisational and relational quality of care.

Purpose
The goal of the ACCC was to develop al tool to support the health professionals in giving patient information on anticancer drugs.

Methods
The ACCC developed an online database on anticancer drugs called 'SIB op maat' (www.ikcnet.nl/sib), which contains side effects of prescribed drugs such as cytostatic, immunotherapeutic drugs and hormones. The drug information consists of side effects occurring in more than 10% of the patient population and supportive measures, safe handling of excreta and the means of administration.

Results
'SIB op maat' gives tailor-made, printable information to support the oral information given to patients by health professionals. The website is accessible for professionals and patients and can be used as an information source. 'SIB op maat' has a lot of innovative features compared to other known databases and information sources. The database has a search engine and can generate a combination of drugs, without doubling the side-effects. The ACCC allocate authorisations to make hospital database. Authorised users can save drug combinations in this hospital database as a treatment plan. Also, authorised users can adjust their database by adding their logo and hospital specific information according to their needs, such as telephone numbers. Central editorship guarantees up to date data. More specialized features include an email service to send the information to other caregivers and contact with the webmaster for questions. The ACCC offer implementation support to the hospitals.

Discussion
With 'SIB op maat' the ACCC provides the health professionals with an excellent tool for patient information on anticancer drugs. (www.ikcnet.nl/sib)

B87

EVIDENCE MATTERS (EM): A NEW TECHNOLOGY PROVIDING CUSTOMIZED, UP-TO-DATE EVIDENCE-TABLES AND EVIDENCE-GRAPHS FOR DIVERSE PATIENT POPULATIONS

Ofer Avital (Evidence Matters, Montreal, Quebec)

Background
To provide evidence-based care, guidelines developers, clinicians, and other decision-makers need help managing the flood of new research. Instead of using out-of-date reviews, EM's technology allows creation of an instant, up-to-date, customized, evidence table (or graph) synthesizing the literature answering a particular question.

Purpose
With the PICO-structured "ask-a-question" interface, a user can instantly organize old and new trial results into custom formats. For example:
- Sorting by the outcome result, timing of the measurement, or the year of publication;
- Organizing by strength of research design, year, and journal of publication;
- Filtering for patient age, sex, nationality, disease stage, co-morbidities, blinding characteristics and many other characteristics.

Methods
EM is an online database of indexed results from thousands of peer-reviewed clinical trials.
Trial results have been hand-abstracted, and digitized, according to a novel evidence-based outcomes taxonomy allowing comparisons across many trials. Links are available to multilingual, bullet-point summaries of every article.

Results
The system self-updates daily, with up to ten new trials added daily, from secondary databases covering over 14,000 journals. EM contains over 150,000 outcomes in 10 specialty areas, representing 75% of admissions to hospitals, based on reports from the U.S. CDC.

EM is used in eight countries in English, French, and Spanish.

Discussion
EM significantly speeds and facilitates the production of evidence tables and guidelines. EM also makes keeping evidence tables and guidelines up-to-date much easier. A wide range of users may benefit from the system, including health guideline developers, clinicians, policy-makers, librarians, and teachers.
EM was designed by physicians and epidemiologists from academic centres in North America, with $2million in funding, including competitive federal R&D grants from CANARIE (Telehealth Canada) as well as the Canadian Medical Discoveries Fund.

B88

INNOVATION FOR SUSTAINABLE QUALITY PATIENT CARE: THE ROLE OF ELECTRONIC FORMULARIES IN CREATING VALUE

Michelle Goulbourne (Department of Health Policy Management and Evaluation, Faculty of Medicine, University of Toronto)

Background
Cancer Centre formularies contain systemic therapy regimens approved for oncology patient care. Formulary regimens standardize chemotherapy treatments and help to guide the care delivery process. However, once printed, they are soon out of date as new regimens are added to the treatment arsenal.

The Regional Cancer Program Formulary Software (RECAP-FS®) was developed in order to fill this quality gap. RECAP-FS® is a user-friendly software that automates the process of editing, updating, archiving and printing chemotherapy regimen information. Within a year of its formal deployment, RECAP-FS® has more than 600 users.

Purpose
The journey that takes an innovation from being a novelty to having a sustained impact on day-to-day clinical practice is an important one. This presentation examines the development, deployment and evaluation of RECAP-FS® in order to shed light on key factors that influence its rate of adoption and level of clinical use over time.

Methods
This presentation will:
1. Describe the patient centric approach that was taken in the development and deployment of RECAP-FS®.
2. Summarize the results of interim beta tester surveys, web statistics and a confirmatory evaluation.
3. Discuss the relative impact of the following variables on the rate of RECAP-FS adoption: (i) characteristics of the innovation, (ii) communication network structure (iii) cultural context and (iv) promotion efforts.
4. Assess the importance of agents of change in taking RECAP-FS® beyond the "tipping point" so that it can have an impact at the cultural level.

Results
Technological innovations such as RECAP-FS® can facilitate the development of positive and sustainable changes in clinician culture and practice.

Discussion
Tools such as RECAP-FS®, when supported by clinical practice changes, can have a positive impact on the quality of patient care locally and within the global oncology community.

B89

SETTING THE STANDARD: DEVELOPING BENCHMARKS FOR COLLABORATION IN THE GUIDELINE DEVELOPMENT PROCESS

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Background
The collection and interpretation of the evidence are key components in guideline development and updating, but they are also costly and time-consuming. The CoCanCPG project was set up to improve collaboration between cancer CPG programmes and reduce duplication of effort. Although the diversity of healthcare structures in different countries can lead to legitimate variability in guideline recommendations, the evidence on which they are based should be the same. CoCanCPG aims to set up shared development among cancer CPG programmes, while recognising the cultural and organisational diversity of the participating organisations and countries.

Purpose
To develop standards for identified shareable steps of CPG development in a format that could be used to benchmark CPG programmes.

Methods
Questionnaire identified general overview of existing cancer CPG processes. A working group from three countries (Task leaders, information specialists and CoCanCPG management), identified steps and tasks for searching, selection and synthesis of current evidence and monitoring of new evidence. The proposed steps and standards were refined through peer review by international CPG specialists and all CoCanCPG members. Benchmarking of CoCanCPG members against these standards through external review and self analysis.

Results
28 Standards have been set for literature review, critical appraisal, and monitoring and updating of evidence. These standards are being piloted in a benchmarking exercise of the CoCanCPG organisations.

Discussion
Collaborative benchmarking involves comparisons of processes, practices and performances with similar institutions in the same field and enables organisations to share learning and knowledge as a basis for collaborative approaches. The long-term aim is to get everyone working to the same standard so that work is readily exchangeable between programmes, reducing costs and duplication of effort. Our methodology and the agreed standards will be applicable to CPG development in other disease areas as well as other evidence-based programmes such as ICPs and HTAs that use the same shareable components.

B90

A MULTIDISCIPLINARY APPROACH TO DEVELOPING LOW BACK PAIN GUIDELINES FOR PRIMARY CARE PRACTICE IN ALBERTA

Paul Taenzer, Christa Harstall, Carmen Moga, Ann Scott (Calgary Health Region Chronic Pain Centre, Institute of Health Economics)

Background
Practice patterns for treating low back pain (LBP) vary widely among primary care physicians and are notoriously intransigent. One way of promoting stakeholder ownership and increasing uptake is to adapt existing guidelines to the local healthcare system.

Purpose
The Alberta Health Technology Assessment (HTA) Chronic Pain Ambassador Program is constructing evidence-based, Alberta-specific guidelines to assist primary care physicians in the management of LBP and reduce unnecessary referrals.

Methods
An Advisory Committee (provides oversight), a Working Committee (constructs the guidelines), and a Research Team (provides research information) were formed through a multidisciplinary partnership of clinical experts, HTA researchers, and representatives from physician associations, the provincial government, and regional health authorities. The Research Team identified relevant guidelines on the prevention, diagnosis, or non-surgical treatment of adult non-malignant, non-specific LBP in primary healthcare settings. Guidelines were appraised using a modified AGREE tool. The recommendations, number and type of studies forming the evidence base, and study citations were summarised in evidence inventory tables. A physician sub-group of the Working Committee used these tables and the AGREE scores to select, according to pre-determined criteria, the best guideline(s), which the Working Committee will then adapt to the provincial context.

Results
Seven guidelines met the inclusion criteria: two on prevention; four on acute and two on chronic LBP treatment. The AGREE tool identified well-developed and reported guidelines, but could not verify the validity of the recommendations and the underlying evidence, or reconcile differences in evidence rating scales. Clinical judgement was essential when there were overlapping, discordant, or absent recommendations.

Discussion
The key elements for creating clinically relevant local guidelines are: a flexible, consist, and transparent methodology; credible research; involvement of clinical and policy experts to ensure clinically meaningful guidance that reflects local treatment options; and an open, trusting relationship among all contributors.

B91

PROGRAMS OF CARE: A CONSENSUS APPROACH TO EVIDENCE-BASED CARE

Donna Bain (Workplace Safety and Insurance Board, Toronto, Ontario)

Background
Guideline development is most commonly considered as an activity undertaken within academic, clinical and research settings. In this case study, a third party payer, the Workplace Safety and Insurance Board of Ontario (WSIB) has taken a leadership role in the development and implementation of evidence-based care protocols for the treatment of common workplace injuries. Participants in this guideline development initiative include multidisciplinary community-based clinicians, researchers, workers and employers and the WSIB as a payer.

Purpose
A key purpose of the work described in this case study is the effective utilization of collaboration and consensus to develop evidence-based delivery care programs that reflect science as well as the realities of practice in the Ontario environment.

Methods
This case description explores the development of these programs which begins with the identification of search terms for the critical appraisal of the literature. Once consensus is reached with multidisciplinary participants on the literature review, a knowledge translation phase follows which culminates in the publication of a program with algorithms to facilitate implementation and reference to the scientific literature. The final step is the introduction of the new evidence-based protocol to a multidisciplinary health care community across Ontario.

Results
The WSIB 'Program of Care' initiative is an interesting case study that highlights the challenges and opportunities created by adopting a consensus based approach to guidelines while maintaining a high standard of methodological rigour.

Discussion
In 2006, more than 8,000 workers with musculoskeletal injuries were treated according to these evidence-based protocols that identify recommended and non-recommended interventions and include diagnostic-specific outcome measurement. A hallmark of these programs is the role of individual clinician judgement in evidence-based health care delivery.

B92

COLLABORATION TECHNOLOGY TO ACHIEVE GUIDELINE CONSENSUS AND CARE STANDARDIZATION: CONTEMPORARY TOOLS, TRENDS, AND LESSONS LEARNED

Timothy McNamara, MD, MPH (CMO, HealthGate Data Corp., Burlington, MA and Medical Director, Center for Healthcare Informatics, University of Kansas Medical Center, Kansas City, KS)

Background
Many hospitals and health systems are attempting to standardize clinical guidelines, protocols, and order sets both to improve the quality of healthcare services and prepare for initiatives like electronic health record deployments. However, most hospitals and health systems struggle in such standardization initiatives.

Effective standardization requires effective teamwork among clinicians and staff from multi-disciplinary backgrounds--often from geographically dispersed facilities--to reach consensus on local care practices. Yet most hospitals and health systems have no precedence or formal mechanisms for managing the kind of large-scale, sustained collaboration, decision-making, and consensus-building activities that are necessary for successful guideline standardization and ongoing update.

Purpose
This presentation provides an overview of contemporary collaborative technologies that are being deployed by health systems to standardize care, improve committee efficiency, reduce committee work, and achieve consensus on clinical guidelines and order sets. This presentation also reports results from a large survey of healthcare executives regarding attitudes, experiences, and requirements for collaborative technologies.

Methods
From December 2006 to January 2007, 60 executives representing 60 health systems in 27 states were interviewed using a standardized phone survey. The survey gathered data regarding participant involvement in committee work and assessed approaches to team-based interaction and decision-making used at the facilities represented.

Results
Of the executives interviewed, 40% were Chief Medical Officers (CMOs) or Chief Medical Information Officers (CMIOs), 18% were Vice Presidents of Medical Affairs (VPMAs), 10% were Medical Directors and the remaining 24% filled other executive positions. The survey identified significant inefficiencies in committee work, guideline/order set standardization, and other activities. Full details of the results will be provided during the presentation.

Discussion
There is a need for improved tools and technologies for collaboration among survey participants working on care standardization. Examples from representative health systems that have invested in such tools will be described.

B93

A COMPARATIVE STUDY OF INTERNATIONAL GUIDELINES FOR THE MANAGEMENT OF HYPERTENSION

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Background
We compared four Clinical Guidelines (CG) (US, European, French and UK) published between 2003 and 2006 on the management of hypertension.

Purpose
Differences across countries in CG produced on the same topic warrant a comparative study to understand where differences originate from.

Methods
We analyzed the structure and all steps of CG development: blood pressure stratification, method of self-measure, methods of cardiovascular risk estimation, place and role of lifestyle modification, choice of antihypertensive therapeutic class, frequency of follow up and, finally list of references of the full report. We then analyzed their differences in the full report, and differences in deriving recommendations from the full report. Finally, we analyzed similarities and discrepancies in the selection of scientific references across CG.

Results
We observed differences between CG at almost every step of the guideline development. Whereas the definition of hypertension was consistent across CG, they differ in grade stratification. Differences in the number and intervals of recommended follow-up were found between CG, despite similar full reports. Differences in recommendations for self-measurements of blood pressure were found in both the CG and their full report. We noticed differences in cardiovascular risk estimation or its absence in one case. Selection of antihypertensive drugs varies across CG. The differences in the full report may be explained by different publication dates of CG or by the choice of references (1.2% are common to all four CG, 2.2% to three CG, and 8.8% to two CG).

Discussion
Substantial differences exist in the national and international recommendations for the management of hypertension across all CG. These differences can be explained by the different publication dates of CG, discrepancies in the translation of full report to guidelines and differences between the full reports that can be traced back to the use of different references.

B94

COMPARATIVE STUDY OF THE QUALITY OF THE CLINICAL PRACTICE GUIDELINES

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Background
As it has been stated before, Clinical Practice Guidelines (CPG) are valuable tools for improving the decision-making process. There is an enthusiastic involvement of professionals in the elaboration of CPG. Nevertheless, proliferationis not linked to quality ; in fact, inconsistencies and discrepancies between guidelines focused on the same topic have been observed.

Purpose
To analyse, catalogue and compare the quality of the CPGs produced in Argentina, Brasil and Spain.

Methods
Systematic bibliographic and complementary search in: generic databases EMBASE, Medline, Lilacs, IBECS and IME; clinical practice guidelines clearinghouses (NGC, NeLH, NICE, GIN, CMA Infobase, Guiasalud) and potential producers (scientific societies, health related portals and web-sites of potential producers). Guidelines produced from 1995 to 2005 in Brasil, Argentina and Spain that could be recovered in full text format were considered elegible (potential CPG -pCPG-). CPG were independently selected by two reviewers on the basis of explicit criteria. Final quality assessment and catalogue was independently performed by 4 reviewers (AGREE instrument) and 2 reviewers (CPP), respectively, using the EGOKi software.

Results
4,990 pCPG were identified: 1,037 were obtained from international databases, 2,910 from national databases, 443 from different guidelines clearinghouses and 600 from Internet searching. Almost 1000 potential producers belonging to the macro, meso and micro level of the health system of the participant countries were identified: 417 were located in Spain, 368 in Argentina and 214 in Brazil. Among all pCPG that were retrieved, 535 were considered CPG. More than a half of CPG were produced in Spain.

Discussion
There are several producers and country generic databases; nevertheless CPGs are scarcely distributed in different sources of information. Those arguments define the need for a Spanish/Portuguese language Guideline clearinghouse. CPG production and quality could be a good index to measure the level of development of a National Health System.

B96

PARTNERING FOR SUCCESS: GETTING MUSCULOSKELETAL (MSK) CLINICAL PRACTICE GUIDELINES (CPGS) INTO PRACTICE THROUGH THE GETTING A GRIP ON ARTHRITIS ™ PROGRAM

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Background
Arthritis is a Canadian population health issue. Awareness, agreement, adaptation and adoption of published Osteoarthritis (OA) and Rheumatoid Arthritis (RA) CPGs in practice has been suboptimal because the knowledge translation and exchange plan for these guidelines was non-existent.

Purpose
In partnership with stakeholders in arthritis care, to design, implement and evaluate a national, community-based, inter-professional (IP) educational program to introduce, adapt, and support the use of OA and RA CPG's in Canadian primary care (PC) practice.

Methods
People with arthritis and an IP healthcare team translated OA and RA CPGs into best practices (BPs). Paper, electronic and telephone surveys determined the learning needs of arthritis patients and their primary care providers (PCPs) and community capacity to deliver arthritis care. Over an 18 month period, a needs-based, multifaceted educational program that embedded the OA and RA care BPs, was delivered across Canada. Multiple reinforcement methods were used. Baseline, 6 and 12 month patient and providers surveys evaluated change in awareness and use of arthritis BPs. Key informant interviews defined system change.

Results
900 PCPs attended one of 30 workshops. Immediate post-workshop evaluation revealed high satisfaction with the program. At 6 months, 80% PCPs indicated a high to medium positive influence of the program on patient self-management, access to specialty care, collaborative care, early detection, and arthritis prevention. Patients (n= 567) reported statistically significant change in their use of arthritis BPs. The program has been recognized at the local, provincial and federal government levels. Enduring materials are available on The Arthritis Society website www.arthritis.ca/gettingagrip. Twelve month outcomes will soon be available.

Discussion
The Getting a Grip on Arthritis ™ program successfully increased awareness, agreement, adaptation and adoption of OA and RA CPGs in the Canadian primary healthcare environment and has proven impact at the patient, provider and system levels.

B97

CREATING A ROAD MAP TO ENHANCE THE CONTINUUM OF CARE FOR RA PATIENTS

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Background
Given major advances in RA treatment and the ability to mitigate disease severity in the majority of patients, and evidence of existing gaps in RA care, the Arthritis Foundation decided to create a roadmap to enhance primary care interest and participation in early identification and co-management of RA patients.

Purpose
To describe the planning process for developing a stakeholder-centered, theory-driven, evidence-informed roadmap.

Methods
A previously modified PRECEDE-PROCEED model for continuing medical education was employed as a framework to guide formal and informal discussions with opinion leaders in US and Canada, to assess readiness for change and inform planning decisions. Other data collected included a review of strategic plans of stakeholders, identification of related RA initiatives, review of current research on shared care initiatives, published literature regarding early identification of RA and access to care.

Results
Factors identified included low prevalence of RA patients in primary care practice; generally underdeveloped rheumatology education programs throughout the continuum of education; limited history of positive collaboration between target groups; strong negative attitudes and beliefs regarding knowledge, roles and responsibilities of stakeholders; need for accessible validated decision-making tools; ability to order diagnostic tests to identify early RA, and fee payment barriers. Information needs of primary care practitioners included the desire for clear and transparent (i) evidence tables derived from multiple journal sources and disciplines, (ii) risks and benefits of various treatment regimes from a public health perspective. Further research is planned to assess generalizability of these initial findings. These findings informed planning decisions. A strategic workshop is planned at NIH featuring primary care continuum of care initiatives for other chronic diseases.

Discussion
The application of the modified PPM framework assisted in the identification of factors which could potentially enable or hinder primary care and specialist interest and participation in collaborative activities to enhance early identification and co-management of RA.

B98

MYTH-BUSTING NEWSLETTER: A STRATEGY TO TRANSFER KNOWLEDGE FROM EVIDENCE-BASED GUIDELINES TO PRACTITIONER CHANGES AT THE BEDSIDE

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Background
Evidence-based practice (EBP) has evolved as a dominant theme within healthcare. Despite considerable investment in EBP guidelines, 30-40% of patients do not receive care that reflects the current evidence and 20-25% of that care is unnecessary or potentially harmful. The transfer of EBP to the bedside is a long complex process. What works in one setting may not work in another. Printed materials alone can result in a moderate change in practitioner behaviour and improve patient outcomes.

Purpose
To detail the implementation and feedback on the "BP Blogger", a newsletter targeting long term care (LTC) frontline staff, designed to debunk common care myths using information from EBP guidelines.

Methods
The BP Blogger was created in response to the numerous barriers to adopting EBP in LTC and the attitudes, traditions, and myths that permeate bedside care. Practitioners complain that interpreting EBP guidelines is problematic. The BP Blogger is a knowledge tool that translates and adapts EBP guidelines into a format that LTC practitioners can understand, manage and use. It is a knowledge uptake strategy that promotes easy handling of evidence and fits with LTC norms, values, and attitudes.

Results
Monthly issues of the BP Blogger have been posted on the web since December 2006. The positive feedback from LTC has been overwhelming. The myth-busting, easy to read and understand, and appealing information layout appears well-accepted.

Discussion
Turning EBP guidelines into actions that change clinical practice is critical in healthcare. However, guidelines do not implement themselves. The BP Blogger confirms that knowledge transfer tools that lessen information complexity, allow for quick uptake of bite-size pieces of information, link values and traditions with evidence, are timely and accessible, have emotional appeal, go beyond relaying facts, and use an attention-grabbing format can lessen EBP resistance and promote changes at the bedside.

B99

AN IMPLEMENTATION SUPPORT TOOL FOR NATIONAL NICE GUIDANCE ON SCHIZOPHRENIA AND ATYPICAL ANTI-PSYCHOTICS

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Background
Guidance from the National Institute for Health and Clinical Excellence (NICE) should be implemented in all National Health Service (NHS) Trusts in England and Wales. In 2002 NICE produced a guideline on schizophrenia which all NHS clinicians must consider in their practice, and a technology appraisal on atypical anti-psychotics which is mandatory for all trusts to implement.

Purpose
As an NHS mental health foundation trust in South East London we considered how to implement this guidance, monitor its use and link this to education and practice improvement in a way which was useful for busy clinicians, rather than an additional burden.

Methods
A clinical audit of practice was conducted, comprising a retrospective case note audit. Following this an implementation support tool was developed and agreed for use by clinicians to support them in understanding the guidance and in changing practice accordingly. An accompanying database was developed for clinicians to continue to monitor their own practice using the tool.

Results
Re-audit demonstrated an improvement in adherence to the guidance, and the implementation support tool has now been adopted by clinicians. It has been adopted by other mental health trusts in London. The tool has also been used for a national audit by the Healthcare Commission, an independent national body set up to promote and drive improvement in the quality of healthcare and public health.

Discussion
This project originally aimed to ensure the implementation of national guidance in one team in a mental health trust through clinical audit. As a result of this, an implementation tool was developed which was then adopted by the rest of the organisation, then other local organisations, and then by a national body. It is an innovative project which has improved implementation of national guidance within the local healthcare community, and promoted collaboration between organisations.

B100

SHOULD GUIDELINE REVIEW INCLUDE ASSESSMENT OF ADHERANCE ?

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Background
The Guideline Development Cycle is an 8 step process that begins by selecting a problem and ends wuth a plan for review. Review should include the assessment of new or updated knowledge of the recommended treatments, the assessment of compliance with the guideline and validation.
In 2002, based on the examination of 20 small published trials with different populations, different drugs, different regimes and different outcomes, CPG #5-6a suggested 2 alternative chemoradiotherapy regimes for the treatment of patients with locally advanced squamous cell carcinoma of the head and neck.

Purpose
Present feasibility, toxicity and outcomes of regime A

Methods
Retrospective cohort study with historical controls based on all eligible patients at tertiary care regional cancer treatment center in Ontario Canada from 1990 to 2005. We describe our experience with 55 patients treated with regime A as chosen by our site group (low-dose daily platin based chemotherapy with conventional radiotherapy)

Results
The regime A is a feasible, toxic but tolerable and effective treatment for the patient population.

Discussion
There has been no province-wide assessment on compliance with the guideline for either regime A or B and the state of chemoradiotherapy practice in Ontario is not known. No further trials or studies on the regime A have been published since 1997 and the best or ideal regime has not been identified in the literature. If CCO produces guidelines, should review, including studies of adherance, be mandated as part of the cycle ?

B101

DEVELOPING REVIEW CRITERIA TO EVALUATE THE IMPLEMENTATION OF CLINICAL GUIDELINES IN PRIMARY CARE

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Background
The Chilean health sector reform has put emphasis in the development of clinical guidelines. However, guidelines should be implemented through specifically-designed strategies considering different factors. Likewise, the effectiveness of those strategies should be evaluated using validated methods.

Purpose
To develop a method for evaluating the effectiveness of guidelines implementation strategies in Chilean primary care.

Methods
The process was based on an adaptation of the methodology proposed by the NICE and the Dutch College of General Practitioners for the development of quality indicators in a systematic way. The process was developed in five stages: Selection of the topic; Mapping the recommendations from the depression guideline; Prioritisation of the recommendations according to the strength of research evidence and impact on patients' outcomes; Reformulation of the recommendation as review criteria; and external peer review using Delphi methodology.

Results
The mapping of the recommendations in the Chilean depression guidelines resulted in the identification of 24 statements. We searched for depression guidelines in websites of guidelines developments agencies, the US Clearinghouse and the GIN website. We found and critically appraised 10 guidelines using the AGREE instrument. The high-quality guideline selected was the 2004 NICE guideline for depression. After mapping the recommendations out in both guidelines, 11 were selected as those with the maximum strength. These recommendations were reformulated as review criteria and currently they are being reviewed by an external panel of evaluators.

Discussion
The use of guidelines has become common place in Chilean health organisations. However, their level of implementation in our health system has not been evaluated. We have developed a method based on review criteria mapped from a specific guideline to evaluate the effectiveness of the implementation efforts carried out for different healthcare organisations. We expect to use this method to develop review criteria for another guidelines prioritised in our health sector reform process.

B102

DEVELOPMENT AND EVALUATION OF MEASURES FOR ASSESSING GUIDELINE IMPACT

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Background

The Nursing Best Practice Research Unit, a Canadian collaboration, is developing and testing tools useful in the evaluation of the implementation of clinical nursing best practice guidelines. To carry out this work, teams of researchers, administrators and clinicians form DREAM teams (Developing, Reviewing, Evaluating and Analyzing Measures).

Purpose

This thematic discussion session will explore the concept of using DREAM teams to develop and test tools and will use the example of two teams developing measures related to two guidelines produced by the Registered Nurses' Association of Ontario (RNAO) about Chronic Obstructive Pulmonary Disease (COPD) and Vascular Access Complications (VAD).

Methods

DREAM teams were constituted to develop and test measures for each of these BPGs. The first team modified and tested a measure of inhaler device technique (IDAT); two outpatient pulmonary rehabilitation settings and 60 adults with COPD participated. The second team focused on assessing two scales measuring the extent and severity of phlebitis and infiltration. These were evaluated in an acute care hospital and a visiting home healthcare agency.

Results

The IDAT had good inter-rater reliability and the construct validity of the tool is supported. Nurses rated the tool as highly acceptable and easy to use. VAD: For both the phlebitis and infiltration scales inter-rater reliability was good. There were more cases of both phlebitis and infiltration identified by the study nurses than recorded in the patient charts.

Discussion

Both of these tools involve the observation of actual patient behaviours/complications. Typically the evaluation of the implementation of clinical guidelines involves chart audit data; chart audits may not include relevant indicators and may have missing data. A DREAM team partnership approach involving clinicians, professional association staff, managers and researchers is vital so that the impact of guidelines can be assessed with confidence and measures will be relevant to care.

B103

GUIDELINE BASED DEVELOPMENT OF QUALITY INDICATORS FOR SUBFERTILITY CARE

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Background
Internationally, several institutions developed clinical guidelines for supplying patients with best achievable subfertility care. However, guidelines are not self-implementing. To facilitate implementation, we first need to gain insight in the application of clinical guidelines in daily practice. Therefore, valid quality indicators are necessary to estimate the quality of actual subfertility care. However, none of the existing subfertility guideline programmes is accompanied by a satisfactory set of quality indicators.

Purpose
In this study we aimed to develop a set of valid quality indicators for subfertility care, based on 10 Dutch guidelines and international literature.

Methods
A systematic 6-step RAND-modified Delphi-method was conducted. After extraction of key-recommendations, experts' opinion (n=47) was used to appraise recommendations regarding efficacy, level of health gain, applicability and improvement potential.

Results
Out of 303 recommendations, a representative set of 39 key-recommendations was selected. These covered structural (2) and procedural (37) aspects, the latter encompassing 'indications for treatment', 'diagnostic procedures', 'treatment procedures' and 'patient information'. Selected key-recommendations were for example: "Clinics should evaluate their intra uterine insemination results annually" and "No more than two embryos should be transferred per cycle of IVF treatment". No outcome measures were selected.

Discussion
The current study describes the systematic stepwise method for the development of 39 process and structure indicators for subfertility care. The lack of outcome indicators is not necessarily a flaw; process and structure indicators are of particular value within quality improvement programmes, because they carry the advantage of assessing exactly where changes in care can be made. Therefore, the monitoring of actual subfertility care by means of the presented quality indicators may guide the development of effective implementation strategies. Accordingly, it will support clinicians in their striving for best achievable care. (Results of a practice test with this indicator set will be available by august.)

B104

ACTUAL AND DESIRED INFORMATION PROVISION IN SUBFERTILITY CARE

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Background
The Dutch Society for Obstetrics and Gynaecology issued national subfertility guidelines to facilitate professionals in providing effective, evidence-based care. These guidelines also describe the minimal degree of patient-information that should be given prior to or during subfertility treatment. However, little is known about the actual adherence to such information-recommendations.

Purpose
To assess the extent of guideline-recommended information provision in subfertility care.

Methods
All recommendations concerning patient-information were extracted from the 10 Dutch subfertility guidelines. Recommendations were edited into patient-questionnaires and sent to 2698 couples frequenting one of 16 participating clinics. Questions assessed the extent of guideline-recommended information provision to couples. A transversal data-analysis was performed on returned questionnaires.

Results
15 information-recommendations were extracted from the guidelines and returned questionnaires (n=1499)were analyzed. Selected recommendations regarded different stages of subfertility care: initial assessment of fertility (n=4), ovulation induction (Ovl) (n=5), intra uterine insemination (IUI) (n=1) and in vitro fertilisation (IVF) (n=5). Information-recommendations comprised several domains; general treatment-information, possible risks and complications, lifestyle-advise, psycho-social and medical aftercare. Only 67.3% of couples reported to have received any written information from their clinic. The amount of couples that reported to be fully informed ranged from 13.3% to 95.7% per selected guideline-recommendation. Averagely, the percentage of couples that received the required information was 57.9% for the initial assessment of fertility, 48.1% for Ovl, 92.0% for IUI and 47.4% for IVF.

Discussion
The reported levels of received information is far less than recommended in the guidelines. Even when taking recall bias into account, we conclude that patients do not sufficiently know what professionals agreed upon in their guidelines. This underlines the need for tailor-made implementation strategies to improve information provision in subfertility care.

B105

EVALUATION OF PERINATAL CLINICAL PRACTICE GUIDELINES IN BC

Diane Sawchuck ()

Background

Guideline evaluation has historically been the weakest component in guideline programs in health care.

Purpose

The purpose of this study was to evaluate the BC Perinatal Health Program, guidelines program. The study was conducted in two parts: a) to determine the level of awareness and utilization of perinatal guidelines in BC, and b) to examine maternal/newborn population outcomes related to five obstetrical guidelines.

Methods

A survey was distributed to a sample interidsciplinary perinatal practitioners in BC. Their awareness of perinatal guidelines and use in their practice, and the extent to which organizational policies supported the implementation of these guidelines was examined. The facilitators and barriers to guideline implementation were examined, and predictors of guideline use were explored.
b) This consisted of a retrospective cohort study using maternal and fetal/newborn outcome indicators derived from the Perinatal Database Registry for singleton births for the period between April 1, 2000 and March 31, 2003.

Results

Results were compiled from 313 of 1,206 surveys and indicated a high level of awareness (92%)and positive attitudes towards the guideline program. Three significant predictors of guideline use emerged: guidelines being readily available (OR, 7.8; 95% CI, 2.9-21.1), an eagerness for the uptake of new information (OR, 3.2; 95% CI, 1.8-5.7), and time to read guidelines (OR, 1.9; 95% CI, 1.1-3.5). The population outcome findings for two guidelines suggested outcomes as would be expected with appropriate guideline use. For three guidelines, the maternal-newborn findings were not in the direction suggested with appropriate guideline use.

Discussion

The findings reflect positive attitudes towards the BCPHP guideline program, and emphasize the need for guidelines to contain clear outcome objectives and baseline indicators/ measures so that they may be effectively utilized in evaluating population health outcomes.

B107

LUNG CANCER GUIDELINE DEVELOPMENT IN ONTARIO: IMPACT ON POLICY, PRACTICE, AND RESEARCH

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Background
The provincial LDSG includes medical (17) and radiation (11) oncologists, thoracic surgeons (4) and research coordinators (1). A medical sociologist, patients, pathologists, and nurses have participated in specific PG development activities.

Purpose
To demonstrate how guideline development has impacted health policy, clinical practice, and research.

Methods
The LDSG uses the practice guideline (PG) development cycle described by Browman GP et al (JCO 1998; 16(3):1226-31).

Results
Over 10 years, 31 reports, including 25 PGs have been published in peer-reviewed journals and posted on CCO's website, www.cancercare.on.ca. Guideline topics have been selected on the basis of practice variation, controversy in practice, or new data with potential to change practice. PGs on chemotherapy drugs (6) have dominated DSG activity and have informed provincial funding decisions. 5 PGs on radiotherapy (RT) alone and as part of combined modality therapy (3) have been completed. Analysis of RT practice shows increasing use of the combined modality approach and fraction number recommended by the guideline.
A review of evidence on Positron Emission Tomography (PET) in lung cancer supported its use in the diagnostic assessment of solitary pulmonary nodules (SPN), but the evidence was conflicting on its role in the clinical management of lung cancer. As a consequence, the provincial government funded PET for SPN and two clinical trials have been initiated to evaluate the clinical utility of PET in non-small cell lung cancer.

Discussion
LDSG PGs have informed Ontario government funding decisions for chemotherapy drugs, influenced radiation therapy practice in Ontario cancer treatment centres and resulted in evaluative studies of PET in lung cancer.

B108

DEVELOPMENT OF THE AMERICAN COLLEGE OF SURGEONS GUIDELINE PROGRAM: PRELIMINARY RESULTS FOR CENTRAL VENOUS ACCESS

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Background
Many professional organizations help their members identify and use quality guidelines. These efforts include developing new guidelines as well as evaluating existing guidelines for their clinical usefulness. The American College of Surgeons Guideline Program (ACSGP) recognizes useful surgical guidelines and identifies research questions that will help clarify existing clinical guidelines.

Purpose
We used existing guidelines to develop "best practice recommendations" that could be used by practitioners interested in establishing guidelines for clinical care. Our first project tackled existing guidelines for central venous access.

Methods
A comprehensive literature search identified existing clinical guidelines for short term central venous access. Two reviewers independently rated the guidelines using the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument. Guidelines that scored highly were analyzed for content and their recommendations were compiled into a summary table. The summary table was reviewed by an independent panel of experts for clinical utility.

Results
32 guidelines were identified and 23 met inclusion criteria. The AGREE rating resulted in 4 guidelines that were strongly recommended, and 5 that were recommended with alterations. Kappa between the two reviewers was 0.673, $p < 0.001$. Three comprehensive tables of recommendations were produced: procedural, maintenance and infectious assessment. 50 summary recommendations were included in the table. A panel of experts came to consensus agreement on the final format of the best practice recommendations.

Discussion
Our process consolidated numerous methodologically high quality guidelines covering a broad range of topics into a comprehensive table that is clinically useful to practicing physicians. The ACSGP will use this process to help validate the clinical utility of guidelines for practicing surgeons.

B109

INTEGRATING A DOCUMENT ENGINEERING ENVIRONMENT IN THE FRENCH GUIDELINES DEVELOPMENT PROCESS

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Background
Clinical Guidelines (CG) are sometimes criticized for their structure and the quality of their content, and this has led to difficulties in their computerization. In this context, we propose a Document Engineering Environment (G-DEE), which analyzes guidelines to automatically identify recommendations using Natural Language Processing techniques in order to present users with a fast visualization of structure and contents.

Purpose
We present experiments carried out at the French National Authority for Health (the French organization in charge of CG production) to assist the CG development process.

Methods
We analyzed CG with G-DEE, and discussed the results with their project manager (PM). We focused on discrepancies between G-DEE and the PM in the identification of recommendations. Each recommendation for which there is disagreement is discussed and depending on this analysis, corresponding sections of the CG are reformulated, modified or validated by the PM.

Results
We checked with the PM that recommendations marked-up are concordant to those identified by experts totalling over 100 pages of CG text. We observed, for example, that false negative sentences, i.e. sentences that were not marked-up by G-DEE but identified as recommendations by PM, tend to occur as supporting sentences for recommendations preceding them in the text. We also found that false positive sentences are often misplaced within the document in terms of sections.

Discussion
Visualizing CG structure around recommendations proves to be useful for their analysis. It has been successfully used to rewrite problematic expressions, in order to reduce the risk of ambiguity. G-DEE may also be used to facilitate the CG synthesis authoring, generation of decision algorithms, and the elaboration of a list of evaluation criteria. We are currently developing metrics based on the occurrence of recommendations within CG and their ratio to background text.

B110

USING AN ONLINE RESOURCE TO DEVELOP AND PUBLISH EVIDENCE-BASED NUTRITION PRACTICE GUIDELINES

Kari Kren (American Dietetic Association)

Background
American Dietetic Association (ADA) is the nation's largest organization of food and nutrition professionals (65,000 members). ADA serves the public through its members by promoting optimal nutrition, health and well-being. One of the ADA's most valued resources is the Evidence Analysis Library at www.adaevidencelibrary.com which houses the synthesis of the best nutritional research and the ADA Evidence-based Nutrition Practice Guidelines for various diseases and conditions.

Purpose
ADA has adopted its own process for developing guidelines using a rigorous multi-step process that involves multiple contributors throughout the various phases (analysts, experts, oversight commmittees, etc.). The objectives of this presentation are to:

- Describe ADA's evidence analysis process for developing guidelines
- Review companion documents created to assist practitioners in applying the guidelines
- Describe methods used to develop and publish materials using an electronic medium

Methods
The ADA's process for guideline development includes the following steps, which involve the use of an online tool for documenting and publishing the guideline materials:

1. Selection of an expert panel
2. Question development
3. Systematic literature review
4. Analysis of research
5. Development of conclusions grade assignment
6. Formulation of recommendations
7. Development treatment algorithms
8. Creation of companion Toolkits
9. Review/revision

Results
Since 2005, ADA has published three guidelines in the online library on Disorders of Lipid Metabolism, Adult Weight Management, and Critical Illness. The Pediatric Weight Management and Oncology guidelines will be published in 2007 and others such as Diabetes Type 1 and 2, Hypertension and Heart Failure are under development.

Discussion
The ADA guidelines are accessible and useful to a variety of health professionals who work with registered dietitians and care for patients with nutrition-related concerns. The electronic medium is an efficient means for creating and publishing guidelines and allows for creative formatting and dissemination opportunities.

B111

DEVELOPING A GUIDELINE IMPLEMENTATION STRATEGY USING A THEORETICAL FRAMEWORK: THE INTERVENTION FOR THE IMPLEMENT TRIAL

Simon French, Denise O'Connor, Susan Michie, Jill Francis, Jeremy Grimshaw, Joanne McKenzie, Rachelle Buchbinder, Neil Spike, Sally Green, and the IMPLEMENT Study Group (Australasian Cochrane Centre, Institute of Health Services Research, Monash University, Australia, University College, London, UK, University of Aberdeen, Scotland, UK, Clinical Epidemiology Program, Ottawa Health Research Institute, Canada, Department of Preventive and Social Medicine, University of Otago, Dunedin, New Zealand, Monash Department of Clinical Epidemiology at Cabrini Hospital and Department of Epidemiology and Preventive Medicine, Monash University, Australia, Department of General Practice, School of Primary Health Care, Monash University, Australia)

Background
The IMPLEMENT trial is a cluster randomised controlled trial to assess the effectiveness of implementing an evidence-based clinical practice guideline (CPG) for managing patients with acute low-back pain (LBP) in general practice.

Purpose
To develop a targeted implementation strategy for the IMPLEMENT trial that consists of behaviour change techniques based on theoretical constructs (predictors of the target behaviours) to increase the uptake of an evidence-based CPG.

Methods
Barriers and enablers for implementation of the guideline were identified by conducting focus groups with GPs underpinned by a theoretical framework grounded in behavioural theory (Michie 2005) and by a review of the literature. The intervention was developed by applying behaviour change techniques to overcome the identified barriers. The individual behaviour change techniques were chosen because there is evidence of their effectiveness and/or an expert consensus process suggests that this technique would be useful (Francis 2005).

Results
The intervention will concentrate on delivering the CPG's key messages and will consist of two facilitated face-to-face small group workshops. There will be a pre-course reflective activity where GPs will document their management of some of their patients with acute LBP over the two weeks preceding the workshop. The workshops will involve a combination of didactic lectures and small group interaction that will utilise different behavioural change techniques including small group discussion and reflection, persuasive communication, modelling, role playing and rehearsal, scripting and action planning.

Discussion
By basing the implementation strategy on a behaviour change framework and linking this to effective interventions we can investigate both whether the strategy works and how it works. This will inform the development of more effective interventions and increase our understanding of the generalisability of the strategy. This is the first project we are aware of that has used this framework to develop an implementation strategy.

B112

IMPLEMENTING GUIDELINES IN THE MEDICAL CARE OF A REGIONAL TUMOR CENTER AND A UNIVERSITY HOSPITAL: EXAMPLE COLORECTAL CANCER

Monika Klinkhammer-Schalke, Christoph Ehret, Brunhilde Steinger, Ferdinand Hofstädter (Tumor Center Regensburg e.V.,Regensburg, Germany, Institut of Pathology University of Regensburg, Germany)

Background
Guidelines can be utilized as an instrument to implement quality standards. Yet, unsolved is the problem of their implementation into routine care in hospitals and practices.
One example of a successful implementation in a regional tumor center (2.2 Mio inhabitans, 46 regional hospitals, 1500 practionars) is standard chemotherapy of colon cancer UICC stage III. After implementation the application of chemotherapy increased from 45% (1993) to 80% (2004).

Purpose
The study strives for two goals:
- Comparison of the effects of the implementation in practice based and clinical systems
- Measurement of knowledge about guidelines and quality-indicators that were derived from guidelines (e.g. rate of TME and primary adjuvant (radio)chemotherapy)

Methods
To implement a guideline or standard therapy no less than 5 strategies should be conducted:
Project-group as quality circle with CME, development of the clinical pathway, pocket version of the clinical pathway as a daily (routine) reminder, barrier analysis, questionnaires to measure initial knowledge about S-3 guideline. The process of implementing the national guideline for colorectal cancer treatment was based on follow up tumor documentation (100.210 patients) by the tumor center Regensburg.

Results
Three objectives have been achieved: The implementation in the project group was successful: all members agreed to participate in the study and developed the clinical pathway. The pocket version and questionnaire were developed and sent out. Data of the initial state (2005/ 2006) are currently being evaluated.

Discussion
The follow up documentation of a regional tumorcenter allows a precise registration of defined quality indicators. Comparison of the two systems shows differences of implementation onto a center of maximum medical care and the structure of regional practice based medical care. Big variance in guideline adherence within different institutions (adj. radio-chemo-therapy for rectal carcinoma phase 2 and 3: 30-70%) demonstrates the potential to enhance quality of care.

B113

IMPLEMENTATION OF A NATIONAL WHOLE-OF-HOSPITAL VENOUS THROMBOEMBOLISM PREVENTION PROGRAM

Susan Phillips, Zoe Kelly, Maggie Reid, Martin Gallagher (National Institute of Clinical Studies, The George Institute for International Health)

Background
The prevention of venous thromboembolism (VTE) in hospitalised patients is recognised internationally as a serious patient safety issue. Numerous clinical practice guidelines on the prevention of VTE have been published and yet many of their recommendations are still underutilised.

Purpose
Using the findings of a systematic review of effective interventions to improve VTE prophylaxis in hospitalised patients, the National Institute of Clinical Studies implemented a national quality improvement program aimed at improving the prevention of VTE at a whole-of-hospital level in 40 participating hospitals.

Methods
Design: A prospective study of the effectiveness of multiple targeted interventions aimed at developing whole-of-hospital policies, raising awareness, educating clinicians, providing timely unit/ward-specific audit data feedback, using risk assessment tools and electronic or paper-based prompts and reminders.

Measures: Monthly or quarterly prospective audits of compliance with VTE prophylaxis policies in 20 consecutive admitted patients per participating unit or ward per hospital. An organisational survey conducted1 month before and 10 month into the program on Organisational systems to support best practice VTE prophylaxis in participating hospitals.

Setting: 32 multidisciplinary teams covering 40 public acute care hospitals with 50-450 acute care beds.

Results
The proportion of participating hospitals with whole-of-hospital policies on VTE prophylaxis increased from 41% at baseline to 72%. On average across all participating hospitals, compliance with best practice VTE prophylaxis in high risk patients increased from 54% at baseline (n=2818 pts audited) to 71% (n= 2227 pts audited) at 10 months in target areas. Qualitative improvements measured using the organisational survey included improved access to risk assessment and management tools, better defined accountabilities in policies and procedures, better defined indications and contra-indications, increased use of VTE prophylaxis information in staff orientation programs and improved monitoring and reporting of VTE prophylaxis usage and outcomes.

Discussion
This national quality improvement program provides evidence after 10 months that trained and supported multidisciplinary hospital teams can achieve on average a 30% improvement in compliance with best practice VTE prophylaxis using a whole of hospital approach combined with multiple targeted interventions.

B114

A RESEARCH AGENDA DEVELOPED BY A THEMATIC GROUP FOR IMPROVED IMPLEMENTATION OF CLINICAL PRACTICE GUIDELINES, CLINICAL PATHWAYS, AND DECISION RULES OF RELEVANCE TO THE PRACTICE OF EMERGENCY MEDICINE

Gary M. Gaddis MD PhD, Peter Greenwald MD (St. Luke's Hospital of Kansas City and University of Missouri-Kansas City School of Medicine, NewYork-Presbyterian Emergency Medicine Weill Medical College of Cornell University)

Background
Implementation of Clinical Practice Guidelines (CPG), Clinical Pathways (CP), and Clinical Decision Rules (CDR) by emergency physicians is sub-optimal, whether for relatively simple outpatient DRs (exemplified by Ottawa Ankle Rules) or for more complex, multidisciplinary CPs for inpatient management (exemplified by Sepsis Bundles).

Purpose
We developed one of 13 designated themes at a Consensus Conference (CC) convened to develop a research agenda designed to advance Knowledge Translation (KT) in Emergency Medicine (EM). Our theme title is, "Toward Improved Guideline and Critical Pathway Implementation".

Methods
Experts in the development and implementation of selected CPG, CP, and CDR were invited to participate in consensus-building. Thematic consensus was developed via "Google Groups", which included these content experts, and interested others from around the world, to facilitate and refine ongoing e-discussions of themes suggested and managed by theme leaders. Live discussion to finalize the agenda, developed electronically, was held at the 2007 Academic Emergency Medicine (AEM) Consensus Conference in Chicago, on May 15, 2007. The agenda will be published in the November issue of AEM.

Results
Our research recommendations centered upon various cognitive, social, organizational, and motivational factors that influence not only physicians, but also nurses and patients. These factors are to be studied to inform the general themes of "Getting the Evidence Straight" and "Getting the Evidence Used". The entire set of approximately 10 final research recommendations will be presented, along with key e-discussion and CC discussion items that greatly influenced specification of the final agenda.

Discussion
Enlisting a variety of individuals of varying expertise in an electronic discussion format, followed by in-person discussions, derived a consensus to develop a "road map" of promising strategies to investigate, regarding means to improve the KT of CPG, CP, and CDR in the specialty of EM.

B115

Consumer Involvement in Guidelines Development: Results of An International Survey

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2Medical Student, University of Edinburgh (Presenting)

Background
While theoretical issues for consumer involvement in guideline development have been well described, less is known about the methods that are being used internationally, or their experienced benefits, barriers and facilitators.

Purpose
To address this niche.

Method
A mixed format questionnaire was emailed to 55 members of the Guidelines International Network, representing organisations involved in guideline development, implementation and/or research in 28 countries.

Results
34 organisations responded of which 27 were developers of guidelines. Of these, 18 had a consumer involvement policy. Most used a combination of methods. Most sought consumer feedback on draft guidelines and developed lay versions, around a third involved consumers on the development panel, in writing the guideline, and provided training, while few included consumers at a strategic level or in the process of literature review. Selection was usually via nomination by a disease-specific or generic patient organisation, while nomination by clinicians occurred less often. 2-3 consumer representatives were generally involved and payment was common. Most strategies were based on those used by other guideline developers, although trial and error played a role. Consumer involvement was perceived to have improved the scope of questioning, identification of relevant literature, guideline wording and consumer awareness. Perceived barriers included lack of literature review skills and medical language, while perceived facilitators included establishing clear and realistic expectations and ground rules from the start and providing appropriate training.

Discussion
A number of guideline development organisations have consumer involvement strategies, which deploy a range of methods. Secondary appraisal appears to be the most common, although many organisations are actively involving consumers as members of guideline development panels. There is evidence of inter-organisational learning around consumer involvement methods and the process is perceived to have yielded benefits. These results suggest that an international consensus on consumer involvement strategies would be well received.

Lecture Abstracts

L01

ADAPTATION OF PRACTICE GUIDELINES FOR LOCAL USE IN AN ABORIGINAL COMMUNITY

Margaret B. Harrison, RN, PhD, Fairleigh Seaton, RN, MSc, Jennifer Medves, RN, PhD, Susan McLeod RN, Susan Laschinger, RN, MSc(A), , Cheryl Pulling, RN, MScN, Ian D. Graham, PhD (Queen's University School of Nursing, Community Health & Epidemiology, Queen's University School of Nursing, Weeneebayko Hospital, Moose Factory, Canadian Institutes of Health Research)

Background
Canadian nurses in a remote northern Ontario Aboriginal community recognized a need for a culturally appropriate clinical practice guideline (CPG) related to gestational diabetes mellitus (GDM) adapted specifically for the women in their community. Due to their aboriginal background women in this community are considered at high risk for developing GDM during their pregnancies.

Purpose
We set out to assess the quality and content of current guidelines on GDM and adapt recommendations for local use in a remote Cree community.

Methods
A clinical-academic partnership was formed between the community and Queen's University. Guided by the 10-step Practice Guideline Evaluation and Adaptation Cycle, a systematic search was conducted to identify guidelines and then quality and content appraisal were conducted. Quality of guidelines was appraised using the Appraisal of Guidelines and Research and Evaluation (AGREE) instrument. This was followed by a qualitative process of assessing the content of recommendations.

Results
From 111 citations, 14 relevant guidelines were identified. Based on "rigour of development" on the AGREE instrument scores and overall assessment, 6 guidelines were excluded from content appraisal. Eight guidelines were included in the process of content appraisal and the adaptation process. The recommendations matrix was organized by aspects of care and allowed for qualitative comparison of recommendations across the 8 guidelines.

Discussion
The Practice Guideline Adaptation and Evaluation Cycle provided a systematic process to lead the adaptation of guidelines and effectively engaged a team of frontline healthcare providers with the faculty members and researchers. The Cycle promoted local skill and expertise for future guideline adaptations. Whilst recommendations varied widely amongst guidelines, the process allowed for selection and discrimination of rigorously developed guidelines for adaptation, and ultimately use, in the remote Aboriginal community. We found it lead to development of a contextually and culturally appropriate guideline for care of women in this community.

L02

INCORPORATING GRADE WHILE UPDATING GUIDELINES: A BELGIAN TRY-OUT

Kristien Dirven, Paul Van Royen, Ann Van den Bruel, An De Sutter, Lieve Peremans, Nathalie Van de Vyver, Hilde Philips, Frans Govaerts, Jan Michels, Martine Goossens (University of Antwerp, Antwerp, Belgium, Belgian Health Care Knowledge Centre, Brussels, Belgium, University of Gent, Gent, Belgium, Domus Medica, Antwerp, Belgium)

Background
As most guideline developers, we recognize the importance of grading medical evidence. However many different grading schemes and systems are available making it often very difficult to interpret or compare, let alone adapt recommendations of guidelines from different sources. To avoid confusion a single system for grading quality of evidence and strength of recommendations is called for. The GRADE working group aims to develop a sensible and systematic grading system in order to address this need.

Purpose
Since some of our guidelines needed updating, we took the opportunity to abandon our own grading system and in lieu incorporate the adjusted "GRADE scheme", allowing us to make weak or strong recommendations, based on high, moderate or (very) low quality of supportive evidence

Methods
As the GRADE software application was not yet available, we followed the approaches reported in Chest [2006; 129: 174-181] and BMJ [2004; 328: 1490-1498]

Results
After performing literature updates, we assessed the quality of 49 selected articles, using validated Cochrane checklists. Subsequently evidence tables were made and per article the criteria for assigning grades of evidence (study design, study quality, directness and consistency) were assessed.
After categorizing the articles per guideline keymessage, an overall (high, moderate, low or (very) low) grade of evidence was assigned to each key message, and based on the tradeoffs between benefits and risks, burdens, and potential costs a consensus-based recommendation was formulated.

Discussion
By explicitely stating what (not) to consider and how, GRADE offered us a systematic, transparant and easy-to-interpret grading system. It furthermore allowed and even stimulated communication around the judgments being made.

L03

EVIDENCE INTO RECOMMENDATIONS: AN OBSERVATIONAL STUDY OF NICE GUIDELINE DEVELOPMENT GROUPS

Susan Michie, Stephen Pilling, Gene Feder, Paul Dieppe, Rosalind Raine, Francoise Cluzeau, Phil Alderson, Simon Ellis (University College London, Queen Mary's School of Medicine, MRC Health Services Research Collaboration, National Institute of Health and Clinical Excellence)

Background
There are considerable literatures on evidence synthesis and implementation, but little on how guideline development groups (GDGs) produce recommendations. This is a complex process, with many influences on communication and decision-making e.g. the quality of evidence, methods of presentation, practical/resource constraints, individual values, professional and scientific interests, social and psychological processes. To make this process more replicable and effective, we need to understand these influences.

Purpose
This study investigates the processes by which GDGs formulate recommendations on the basis of the research evidence they receive, using theoretical frameworks to guide the analyses.

Methods
Meetings of three National Institute of Health and Clinical Excellence (NICE) GDGs, one from each of acute, mental health and public health, are tape recorded and transcribed. Interviews with a sample of GDG members who both do and do not contribute influentially to discussion are interviewed at the beginning, middle and end of the GDG's work. Site documents including relevant e-mail interchanges, GDG meeting minutes and stake-holder comments on recommendation drafts are being collected. Data are selected for analysis if they refer to either evidence or recommendations; the focus is on "hot spots" e.g. dilemmas, conflicts, uncertainty. Data are analysed thematically and by content analysis, drawing on psychological theories of decision-making and social influence.

Results
Thematic and content analyses of the first eight meetings of the acute care GDG will be presented.

Discussion
The findings will inform GDG practice e.g. GDG composition and procedures for presenting evidence, conducting discussion and formulating recommendations.

L04

THE GUIDELINES ADVISORY COMMITTEE: ONTARIO'S APPROACH TO GUIDELINE APPRAISAL AND ADOPTION

Valerie Palda, Jess M. Rogers, Atul K. Kapur, Kelly Lang, Yale Drazin, Dave A. Davis (Guidelines Advisory Committee, Toronto, ON)

Background
The individual physician does not have time to assess the extensive proliferation of clinical practice guidelines. Since guidelines vary in quality, guideline consumers would benefit from a service which compares published guidelines by providing consistent, validated guideline methodologic rating as well as a summative opinion as to applicability and validity of content.

Purpose
To present best practice recommendations, from guidelines endorsed through a rigorous process, in a clear format which highlights supporting evidence.

Methods
The Guidelines Advisory Committee (GAC) identifies guidelines on topics appropriate for Ontario physicians. Guidelines identified are sent out for rating by 4 independent reviewers using the AGREE instrument. The guideline(s) that have the best evidence base and have recommendations most appropriate for the physicians of Ontario, are endorsed by committee vote. Endorsed guidelines are summarized in a structured summary format which is published on the GAC website.

Results
Initial guideline searches for a topic typically identify 47.5 (range 7-105) guidelines, of which Medical Advisors select 9.75 (range 6-13) for appraisal by reviewers. On average, 3 or 4 guidelines that scored highly with reviewers are considered by the GAC for endorsement. The committee places greater emphasis on strong AGREE scores in the domains of rigour of development and editorial independence, as well as applicability to the Ontario practice setting.

Endorsed guidelines are summarized in a standard format highlighting the key points of the endorsed guideline(s), recommendations in the active tense, an identified level of evidence for every recommendation, and hyperlink reference to the actual guideline for interested readers.

Discussion
GAC provides a structured guideline review and endorsement process using validated review instruments, a sufficient number of reviewers to decrease bias, and independent committee review to provide practice-specific expertise and health system input, and summarizes these guidelines in a brief format for access by clinicians.

L05

AMERICAN COLLEGE OF CHEST PHYSICIANS EVIDENCE-BASED GUIDELINE METHODOLOGY

Carla Herreras, Sandra Zelman Lewis, Doreen Addrizzo Harris, Ian Nathanson, Edwin Dellert, Julia Heitzer, David Gutterman (American College of Chest Physicans, American College of Chest Physicians, New York University School of Medicine, Nemours Clinical Management Program, Medical College of Wisconsin)

Background

Background: The American College of Chest Physicians (ACCP) has developed an evidence-based methodology for the development, dissemination, and implementation of clinical practice guidelines. This system consists of a simple, user-friendly grading system that generates recommendations based on a balance of benefits and harms as well as the quality of research. Two important newer components of this methodology are the inclusion of resource allocation and patient preferences

Purpose

Purpose: The ACCP guideline methodology and grading system are quite versatile and have been successfully used for a variety of clinical diagnostic, preventive, and therapeutic topics, eg, lung cancer and pulmonary rehabilitation. However, the same methodology and grading system are now being implemented in the development of a non-clinical guideline with recommendations for developing evidence-based CME.

Methods

Methods: In 2005, the ACCP's Health and Science Policy Committee convened two working groups: (1) to develop a grading system that would be user-friendly and consistent across all ACCP guidelines; and (2) to develop methods of incorporating resource allocation and patient preference into guideline development.

Results

Results: The ACCP methodology has proven to be very effective. It has been cited in the literature and other institutions have adopted it or adapted it to fit their needs. Reviewers report that the grading system is easily understood and the methodology is rigorous and thorough.

Discussion

We present a very stringent and systematic system for developing, evidence based guidelines that facilitates the processes of dissemination and implementation. This methodology could support evidence-based guideline development efforts from other societies and organizations.

L06

10 YEARS OF EVIDENCE BASED HEALTHCARE IMPLEMENTATION IN GERMANY: THE RELEVANCE OF GUIDELINES

Guenter Ollenschlaeger (German Agency for Quality in Medicine (AQuMed))

Background
Evidence based Medicine and the significance of clinical practice guidelines were mentioned in a German article for the first time in 1995. Ten years after, the German Social Laws require healthcare to rely explicitely on scientific evidence, and physicians' professional bodies focus on implementing evidence based guidelines.

Purpose
1) To outline the contribution of EB-Guidelines Programmes to EBHC implementation in Germany over a period of 10 years.
2) To discuss the barriers against guideline use resulting from a top down nation wide EBHC implementation using guideline programmes as a key implementation tool.

Methods
1) Narrative description of the expansion and institutionalisation of EBHC and guideline programmes in Germany during the last decade. 2) Discussion of positive and negative results.

Results
First German articles on significance of EBM and guidelines published in 1995/1996. AQuMed develops "Guideline for EB Guidelines" (1996), "German Guideline Clearinghouse" (1997). State Ministers of Health endorse officially EBHC (1998). HC scientists establish the German EBM Network (1998 - more than 700 members 2005). AQuMed and Ass. of Scient. Med. Soc. in Germany (AWMF) agree on a national guideline methodology (2000). National Social Law requires to rely on EB guidelines (2000). AQuMed and AWMF establish joint programme for national EB guidelines (2003). The majority of primary care physicians in Berlin are worried about guidelines interfering with clinical judgement and being primarily used as tools for cost containment (2005).

Discussion
Development of EB-Guideline Programmes was a main driving force for expansion and institutionalisation of EBHC in Germany. After a decade of guideline and EBMC implementation, the majority of outpatient care physicians seem to be worried about the legal and economic consequences of guideline use. More effective implementation programmes are needed with special respect to reinforce the use of guidelines as quality management tools, and to reduce its use for cost containment regulations.

L07

A PLAN FOR ACTION: DEVELOPING A NATIONAL GUIDELINE IMPLEMENTATION PLAN FOR DIABETES

Kay Currie, Janice Davies (National Institute of Clinical Studies)

Background
Australian clinical practice guidelines are developed by a range of organisations including professional Colleges, peak bodies and individual consortia. The Government has also commissioned guidelines in its seven health priority areas to improve patient outcomes and reduce variations in practice. The National Health and Medical Research Council, Australia's peak body for supporting health and medical research, endorses guidelines which meet its standards based criteria.

Purpose
The National Institute of Clinical Studies was selected to develop a national implementation plan for nine guidelines on diabetes, a key health priority area. Currently, the diabetes guidelines are not routinely followed and there are gaps between best evidence and practice on all indicators. The implementation plan had to be generic and be doable over time with limited funds.

Methods
Development of the plan involved a literature review, service mapping, barrier and facilitator identification, an analysis of the gaps between evidence and practice and wide stakeholder consultation.
The implementation plan, based on theoretical models, has four principal components:

1. systems of care;
2. communication strategy;
3. education and training; and
4. local and regional evidence based strategies.

Implementation of the plan is predicated on the formation of an independent implementation group to coordinate, quantify, modify, and evaluate the outcomes over time.

Results
The resultant plan is a national blueprint for multi-level implementation and is currently being considered by Government within the context of political and population health imperatives for action to address the increasing prevalence of diabetes.

Discussion
Development of a national plan for the implementation of diabetes guidelines is a formidable undertaking. Lessons learned suggest that we needed to place more emphasis on winning support from interested parties, organisations and powerful lobby groups, government bodies and target populations in spite of the very short time lines.

108

THE NICE IMPLEMENTATION PROGRAMME - ADDRESSING BARRIERS AND ENCOURAGING CHANGE

Gillian Leng, Nicola Bent, Annie Coppel, Jennifer Field, Julie Royce (National Institute for Health and Clinical Excellence, London)

Background
The National Institute for Health and Clinical Excellence (NICE) produces guidelines based on the best available evidence of clinical and cost effectiveness. Changing clinical practice to put these guidelines into practice can be challenging, and in recognition of this NICE launched an implementation programme in 2004.

Purpose
The aim of the NICE implementation programme is to ensure mechanisms for implementing guideline recommendations are embedded within quality improvement systems throughout the NHS.

Methods
The implementation strategy has three elements: encouraging change by working through other organisations/mechanisms within the NHS to generate 'leverage'; providing practical support; and monitoring uptake of the recommendations to inform future work. Approaches to leverage involve engaging with systems for financial regulation, inspection mechanisms, continuing professional development and efficient use of information technology.

Practical support is provided in a number of areas:

- A monograph for organisations on "How to" implement NICE guidance,
- A forward planner to summarise NICE's future work programme and provide indicative costs
- Practical implementation tools (cost impact tools, audit criteria, slide sets and implementation advice).
- Commissioning guides in an interactive web-based format.
- A team of implementation consultants to provide practical local support
- A shared learning database on the NICE website

Results
To monitor the uptake of guidance recommendations, NICE analyses data and collates published and unpublished reports to build up a comprehensive overview. Assessment of NHS trusts in England in 2006 showed that only 4% did not have a system for implementing NICE guidance.

Discussion
Since the launch of the NICE implementation strategy in 2004, significant steps have been made to address some of the barriers to uptake and to respond to the practical needs expressed by healthcare staff. The programme continues to monitor challenges to uptake and to adapt its methodology in line with feedback and evidence.

L09

SUPPORTING KNOWLEDGE TRANSFER IN GUIDELINE IMPLEMENTATION

Cindy Hoerger, Paul Taenzer, Monique Assi (Calgary Health Region ,Calgary, Alberta)

Background
Knowing that the prevalence and longevity of chronic conditions is rising, and that the current health care system was designed for acute, episodic care that does not meet the needs of people with chronic disease; clinical leaders within the Calgary Health Region developed and implemented a Chronic Disease Model as a strategy to evolve from a reactive 'find it and fix it' system to one that is proactive, and provide comprehensive and coordinated care.

While effective interventions exist for most of the major chronic conditions, data indicate that less than 50% of patients with chronic conditions receive appropriate treatment.

Purpose
Develop a 'clinical decision support'/knowledge transfer framework as a key strategy to supporting comprehensive, coordinated care.

Methods
Over the past 2 - 3 years multidisciplinary teams of local experts interpreted the best evidence for specific chronic conditions to:

- Embed evidence-based guidelines into daily clinical practice,
- Share evidence-based guidelines and information with patients to encourage their participation, self management, and
- Integrate specialist and primary care expertise into clinical practice across the health continuum.

Results
Evidence based clinical tools were developed to communicate and support integration of evidence into practice at 'point of care'. Coordination of care for patients with chronic conditions was improved through targeted communication and clear definition of provider roles. Educational programs for primary care physicians and frontline providers were planned and delivered extensively to the provider community.

Discussion
Case examples of two specific chronic conditions (Diabetes and COPD) will highlight the evolution of the Clinical Decision Support/Knowledge Transfer framework to provide a valid, consistent approach to supporting knowledge translation at point of care, while improving outcomes.

L10

NICE COMMISSIONING GUIDES -SUPPORTING THE COMMISSIONING OF EVIDENCE-BASED CARE

Annie Coppel (National Institute for Health and Clincal Excellence, Manchester, UK)

Background
NICE is an independent organisation responsible for providing national evidence-based guidance on promoting good health and preventing and treating ill health. To support the effective commissioning of services in line with NICE guidance, NICE is producing new web-based, topic-specific resources - commissioning guides - targeted at commissioners.

Based on NICE clinical guidelines, these guides signpost and provide information on key clinical and service-related issues for consideration during the commissioning process, and provide an indicative benchmark to help commissioners determine local service levels needed. Each guide contains an interactive commissioning tool to estimate and inform the cost of local commissioning decisions.

Purpose
The commissioning guides:
osupport the commissioning of evidence-based care through the implementation of NICE clinical guidelines
osupport general commissioning decisions on potential service reconfiguration
oassist financial modelling and costing
oassist with the preparation of a business case
oprovide a framework for investment decisions.

Methods
The strategic direction of the NICE commissioning programme is advised by a multidisciplinary Steering Group of key national and local stakeholders. The content of each topic-specific guide is underpinned by relevant NICE clinical guideline recommendations; and is informed, and peer reviewed, by relevant clinical experts, national policy leads and commissioners. The commissioning tool is produced in partnership with an independent provider of health information for the National Health Service.

Results
Initial user feedback is extremely positive. Use of the guides increases monthly. 73% of primary care organisations in England have registered to access the commissioning tools. A formal evaluation of the impact of the commissioning guides is planned for late 07/08.

Discussion
Five commissioning guides have been produced. NICE aims to produce 10 guides a year, and to update these annually. Content and functionality will continue to evolve in line with commissioners' needs. Guideline developers need to consider providing appropriate information to support commissioners.

L11

CHANGING PROFESSIONAL BEHAVIOUR: AN UPDATED OVERVIEW OF SYSTEMATIC REVIEWS

Jeremy Grimshaw, Alain Mayhew, Adrienne Stevens, Stephen Graham (Clinical Epidemiology Program, Ottawa Health Research Institute, Ottawa, Ontario, Cochrane Effective Practice and Organisation of Care Group, Ottawa, Ontario, Canadian Cochrane Network and Centre, Ottawa, Ontario, Canadian Agency for Drugs and Technologies in Health, Ottawa, Ontario)

Background
The Cochrane Effective Practice and Organisation of Care Group (EPOC) supports systematic reviews of professional, organizational, financial and regulatory interventions to improve healthcare delivery and care systems. It has conducted two previous overviews of systematic reviews of professional behaviour change interventions published in 1998 (n=18) and 2002 (n=41). We are currently updating these overviews. and have identified over 150 potentially relevant reviews.

Purpose
Overview of systematic reviews of professional behaviour change.

Methods
Systematic reviews published between 1966 and 2006 were identified from Pubmed and the Cochrane Library by EPOC. Two reviewers independently abstracted data on the quality and results of the reviews. Vote counting was used as the common metric for data synthesis. Interventions were classified as effective if more than two thirds of studies showed benefit, mixed effects if between one third and two thirds showed benefit and ineffective if less than one third demonstrated benefit. In addition, we present the median absolute improvement in process of care measures (for example compliance with guidelines) if possible. The results are available in a searchable website at:
http://www.cadth.ca/index.php/en/compus/optimal-ther-resources/interventions.

Results
Over 150 potentially relevant reviews were identified and the results of 50 key reviews were analysed for this project. Generally effective interventions included: printed educational materials (median absolute improvement +4%), interactive educational meetings, educational outreach (+5%), local opinion leaders (+10%), audit and feedback (+10%). The results varied considerably within intervention categories. Multifaceted interventions were not more effective than single interventions.

Discussion
There are a number of interventions that are generally effective for changing professional behaviour. The local applicability of these findings should be informed by considerations of the potential barriers, mechanisms of action and resources available.

L12

DEVELOPING CLINICAL GUIDELINES ON LUNG CANCER FOR LIMITED RESOURCE SETTINGS: A NOVEL METHODOLOGY, SUPPORTED BY THE INTERNATIONAL ATOMIC ENERGY AGENCY (IAEA).

Fergus Macbeth, Raymond Abratt, Kwan Cho, Branislav Jeremic, Richard Stephens (Velindre Hospital, Cardiff UK, University of Cape Town, South Afica, National Cancer Center, Goyang, Korea, IAEA, Vienna, Austria, MRC Cancer Trials Unit, London, UK)

Background
Lung cancer is an increasing problem in developing countries, where access to medical resources may be limited. It is essential that effective and cost effective use is made of those resources, based on good evidence. Guideline recommendations from developed countries may not be appropriate or implementable, and so a different approach is needed.

Purpose
To develop relevant clinical recommendations for these settings.

Methods
An international panel, with a special interest in lung cancer and experience of guideline development, was invited to a meeting organised by the IAEA, at which the main approaches were drafted. Recent English language evidence-based clinical guidelines and other recent systematic reviews, meta-analyses and research were consulted. Drafts were circulated around the group members, a telephone conference held and a final version approved. We assumed that minimum baseline resources for diagnosis and treatment would be available. Tables were constructed that showed a baseline 'standard' treatment for different clinical situations and the additional benefits, risks and resource use from other treatment options. Accompanying text summarised the evidence and justification for these options.

Results
Six tables were devised, each one giving between 3 and 6 options of varying complexity, resource use, toxicity and effectiveness. A comprehensive list of 65 relevant references to current clinical guidelines, systematic reviews and primary research was included. The resulting paper has been published in an international journal.

Discussion
This is an innovative approach because it does not give definitive recommendations. It summarises the research evidence but makes clear the additional resource use and risks as well as benefits of different treatment options. This would enable people to make local decisions about best use of their available resources or to develop more sophisticated cost effectiveness models for their local health services. It will also allow those without even the baseline resources to lobby for their provision.

L13

CAPTURING 'LEARNINGS' DURING GUIDELINE DEVELOPMENT AND IMPLEMENTATION TO IMPROVE PRACTICE AND MAINTAIN MORALE

Claire Harris, Fiona Wilkinson, Tari Turner (Centre for Clinical Effectiveness, Monash Institute of Health Services Research, Melbourne, Australia)

Background
There are many guides that set out the steps required for methodologically rigorous development, implementation and evaluation of guidelines. However the steps can often be broad and fairly non-specific eg 'establish a multidisciplinary group' or 'involve consumers' with limited practical information to assist the guideline development team in how to actually go about the task and how to make each step work effectively and efficiently.

Purpose
To capture 'learnings' in an ongoing, systematic way throughout the development, implementation and evaluation of evidence-based guidelines within a health service and actively use the lessons learnt to improve the process.

Methods
A variety of methods were employed to capture our practical experiences. 'Learnings' and decisions about subsequent action were documented at every team meeting. A retreat day was held at the conclusion of each guideline development process to review what worked, what didn't work and how things could be improved. Members of the Guideline Development Groups were surveyed and 'Clinical Scholars in EBP' acting as guideline coordinators were interviewed. Focus groups, surveys and clinical audit were used in the piloting phase of clinical paths used to implement the guidelines.

Processes for subsequent guidelines were adapted to utilise enabling factors and either prevent identified problems recurring or minimise their impact if they were inevitable. The changes introduced were then evaluated using the methods above.

Results
The process was repeated for six guidelines. The findings can be categorised into systems and documentation, the influence of project context, project management, communication, working with clinicians and working with consumers.

Discussion
An action learning approach enabled more effective and efficient guideline development processes. An additional unexpected benefit was the effect of turning a negative incident into a positive outcome - the action from our learning. Focusing on learning enabled the project team to maintain morale during difficult experiences.

L14

DEVELOPING NATIONAL CHRONIC DISEASE GUIDELINES

Jill Parnham (National Collaborating Centre for Chronic Conditions, Royal College of Physicians, 11 St Andrews Place, Regents Park, London, NW1 4LE)

Background
The National Collaborating Centre for Chronic Conditions (NCC-CC) accepts commissions from NICE to develop chronic disease guidelines. The NCC-CC has considerable experience having publishing 10 guidelines with another five in development.

Purpose
To specifically focus upon guideline development for chronic disease guidelines
and:
- Reflect upon and evaluate the lessons learnt
- Share tips and pitfalls
- Evolve and make recommendations for chronic disease guideline development

Methods
The NCC CC technical team including the chair, clinical advisor, project managers, information scientists, research fellows and health economists reflected upon the guidelines published to date and addressed:

Guideline questions:
- What constitutes a well focused question
- Poorly worded or structured questions - how these were dealt with
- Complex questions - recommendations for how to predict and address these
- How to cope with question 'creep'
- How to achieve group buy-in

Effective writing for guidelines:
- How to plan and organising the writing
- Research fellow techniques for organising evidence statements?
- Project manager techniques for developing the guideline?

What have we learnt?
- What would the technical team do differently for newly commissioned chronic disease guidelines?
- What are the top five learning points?

Results
Findings focus specifically on the issues of relevance to chronic disease guidelines

Discussion
The session aims to share NCC CC chronic guideline development experiences, highlighting successes and limitations

L15

SUSTAINABILITY OF GUIDELINE IMPLEMENTATION

Barbara Davies, Nancy Edwards, Jenny Ploeg, Evangeline Danseco, Tazim Virani, Maureen Dobbins (University of Ottawa, Ontario, Canada, McMaster University, Hamilton, Ontario, Canada, Registered Nurses Association of Ontario, McMaster University, Hamilton, Ontario Canada)

Background
Little research has been conducted on the long-term perspective of clinical guideline implementation.

Purpose
To determine the patterns of use of 17 guidelines developed by the Registered Nurses Association of Ontario in Canada at two and three years after initial implementation. Topics included health promotion (e.g. smoking cessation, fall prevention) and chronic disease care (e.g. asthma, diabetes, venous leg ulcers, pressure ulcers). Healthcare organizations, responding to a call for proposals, were selected from acute care, home care, long-term care, and community health services. Government funding was received for the initial 1 year implementation project.

Methods
A mixed-methods study was conducted using data from interviews with key informants, site visits and document review at 2 and 3 years after the original 1-year implementation project. Definitions and indicators of sustainability were reviewed by an international panel (Australia, Canada, England, Scotland, USA) with 80% agreement and useful suggestions for subsequent revisions.

Results
Participation by organizations was excellent (90%, 37/41) with 87% (189/218) of key informants (administrators, staff). After 2 years, 43% (16/37) of organizations continued to actively sustain and/or expand guideline implementation and at 3 years there was 59% (22/37) sustainability. Leadership, defined as recognizable role models, leaders, champions or administrative support for the continuing implementation of the guideline, was the main predictor explaining 47% of the variance in how strongly the guideline permeated the organization.

Discussion
Implementing changes in practice using evidence-based guidelines takes time and is a dynamic iterative process requiring ongoing leadership and multiple implementation strategies. Some organizations report lulls in activity and may take up to 3 years to show that guideline recommendations are a routine part of care. Interesting patterns of expansion of guideline recommendations to other disciplines and other agencies provides insight about systems impact of guideline implementation.

Networking Session Abstracts

N01

SHARING AND EVALUATING BEST PRACTICE GUIDELINES: CROSSING CONTINENTS AND DISCIPLINES

Tazim Virani, Doris Grinspun, Irmajean Bajnok, Barbara Davies, Heather McConnell, Debra Bick (Registered Nurses' Association of Ontario, Toronto, Ontario, University of Ottawa, Ottawa, Ontario, Debra Bick, Thames Valley University, London, England)

Background
A Nursing International Collaborative in Evidence-Based Implementation and Research with Guidelines (NICEBIRG) was founded in 2002 to share and evaluate Clinical Best Practice Guidelines (BPGs). Members of NICEBIRG come from various countries and meet both face to face and virtually to address issues of development, dissemination and evaluation of BPGs. Example of topics addressed to date include the sharing of methodologies for guideline development, determining best strategies to promote uptake of BPGs and identifying joint funding opportunities for projects and research on impact of BPGs.

Purpose
In this networking session, members of NiCEBIRG will facilitate an interactive dialogue for the purpose of learning how different individuals/groups/disciplines/countries have addressed BPG evaluation.

Methods
Using a structured focus group methodology, participants will engage in sharing and learning from each other, related to BPG evaluation. Each member of these groups will then take on the role of communicator and relay key themes discussed to re-configured groups. The re-configured groups will further debate and refine a final set of themes. The final findings will be shared with the larger group. The goal will be to collectively develop a synthesis report that would serve as the basis for a publication on the topic and methodology. This report would be shared with the broader delegation.

Results
A synthesis report with key findings from the networking session identifying important strategies for evaluating the impact of guidelines.

Discussion
There is much that can be learned through structured and meaningful networking sessions. It is hoped that the stated objective of sharing and learning will benefit future work conducted by participants.

N02

TOWARDS EFFICIENT LITERATURE SEARCHING FOR GUIDELINES: CASE STUDY ON COLON CANCER GUIDELINE.

Rikie Deurenberg, Jako Burgers, Kitty Rosenbrand, Margriet Moret, Ton Kuijpers (Dutch Institute for Healthcare Improvement CBO, Utrecht, the Netherlands)

Background
For retrieving best evidence for guidelines, literature is searched in existing high quality guidelines or in databases as Medline and Embase. This study analyses how "key publications" were found for a multidisciplinary guideline on colon cancer.

Purpose
To enhance efficiency in literature searching for developing guidelines.

Methods
This guideline was produced with methodological support by epidemiologists and an information specialist. A working group of clinical experts formulated eight key questions.
For each question, we searched for:
-Paragraphs of existing guidelines with evidence tables
-Relevant papers in Medline and Embase with detailed input from clinical experts. Additional high quality literature could be added by clinicians from own sources.
We analysed steps in the process of selection from the list of 250 references to final "key publications" cited in the guideline. For each clinical question the "retrieval source" of cited references in evidence tables was determined.

Results
For two questions evidence (16 references) from existing guidelines was sufficient, for one question this evidence was completed with search results, for five questions search results from databases were used (50 references) or a limited number of articles (7) was added by clinicians. The database searches resulted in a mean of 250 references (127-282) per question, a range of 30 articles (22-40) were ordered full text and critically appraised. In the final guideline 2,7% of articles were cited.
The total citations (66) in the guideline included 26 systematic reviews, 14 randomised controlled trials and 21 observational studies.

Discussion
Only a minority of articles retrieved by literature searching are used as supporting evidence of 70% of recommendations in this guideline. Efficiency could be enhanced by specifying clinical questions and by using predefined selection criteria.

N03

GUIDELINE IMPLEMENTATION IN COUNTRIES OF GERMAN LANGUAGE: RESULTS, BARRIERS, OPPORTUNITIES FOR DEVELOPMENT

Guenter Ollenschlaeger, Ina Kopp, Monika Lelgemann (German Agency for Quality in Medicine (AQuMed), Ass. of the Scientific Medical Societies in Germany (AWMF), HTA Unit, University of Bremen)

Background
During the G-I-N Lyon Conference 2005, the first G-I-N Networking Session for Countries of German Language took place focussing on guideline development in medicine and dentistry. The participants expressed their interest in a follow up session during the Toronto Conference 2007.

Purpose
1) To exchange experiences concerning successful guideline implementation projects, as well as barriers against guideline use in Austria, Germany and Switzerland. 2) To identify opportunities for guideline implementation improvement in countries of German language. 3) To discuss proposals for country specific implementation improvement plans.

Methods
Moderated networking session of healthcare experts from Austria, Germany and Switzerland in German language.
Pre-conference information on session' topic (Recommended reading: Kunz A.U. Leitlinien in der Medizin: Anwendung, Einstellungen und Barrieren - eine Befragung Berliner Hausaerzte. Berlin, AQuMed 2006.
Internet: http://www.leitlinien.de/implementierung/pdf/magisterarbeitrk.pdf)

Results
Expected results: At the end of the session, participants (1) are informed about recent and ongoing guideline implementation projects in the German speaking countries; (2) are able to network with implementation experts; (3) moght be interested in contributing to the development of national guideline implementation improvement plans.

Discussion
The German Language Networking Session's final goal is to prepare country specific action plans for improvement of guideline implementation in Austria, Germany and Switzerland.

N04

DEVELOPMENT OF GUIDELINE FOR HEALTH AND COMMUNITY MANAGEMENT: CHALLENGES FOR MULTIFACETED DISEASES WITH MODERATE TO RARE PREVALENCE

Gagnon Cynthia, Chouinard Maud-Christine, Mathieu Jean , Jean Stéphane (University of Montreal, Montréal, Québec, Canada, Université du Québec à Chicoutimi, Chicoutimi, Québec Canada, Clinique des maladies neuromusculaires, CSSS de Jonquière, Jonquière, Canada)

Background
Development of guidelines for multifaceted diseases with moderate to rare prevalence presents unique challenges and illustration with neuromuscular disorders will be discussed. On several management aspects of such complex disease, few literatures have been published to date. For example, in myotonic dystrophy, an ongoing systematic literature review (1980-2005) reveals that less than 40 articles addressed clinical services out of 4597 articles about this disease. Expert knowledge need to be sought. This type of evidence is referred as colloquial evidence and calls for innovative synthesis strategies. Secondly, services are often organized around an outpatient clinic requiring guidelines for community management including interventions related to work or leisure. However, it is difficult to develop clinical guidelines for such complex area of interventions and research synthesis need to address several key questions.

Purpose
This networking session will present and discuss with the audience the challenges face with elaboration of clinical guidelines in moderate to low prevalence diseases. A presentation of the adaptation of recognized methods made by our research group will be done.

Methods
4 subjects will be discussed with the audience:
Guidelines with multiple key questions, Poor quality of the literature, Considering or grading clinical expertise, Environment of the clients. Promising solutions developed by our groups will be presented. Handouts will be given with each subject and further solutions will be sought in small groups and then share with the entire group.

N05

IMPROVING COMMUNICATION BETWEEN DEVELOPERS, DISSEMINATORS, AND USERS OF PUBLISHED GUIDELINES

Michael Allen, Shawn Bugden (Dalhousie University Continuing Medical Education, Halifax, NS, Prescription Information Services of Manitoba, Winnipeg, MB)

Background
The discussants are members of the Canadian Academic Detailing Collaboration, a group that facilitates knowledge translation by providing evidence-based education to health providers in their practice settings. During topic development, we sometimes find discrepancies between peer-reviewed evidence and clinical guidelines or find that uncertainties in evidence are not acknowledged in recommendations. However we have found it difficult to engage in meaningful communication with guideline developers. Letters expressing our concerns are unanswered. Commentaries to the journals where guidelines were published may or may not be published depending on editorial priorities or the length of time between our comments and the publication of the guidelines. When guidelines are published there appears to be no systematic way to make comments and suggestions to those who developed them.

Purpose
To discuss how users and disseminators of guidelines can provide feedback to guideline developers.

Methods
We will present some examples of our experiences and invite the audience to discuss questions such as:
1. What are your experiences with developing, disseminating, or using guidelines?
2. How can guideline disseminators and users provide ongoing feedback to guideline developers?
3. What are the advantages and disadvantages of such ongoing feedback?

Results
We expect to promote discussion among those who develop, disseminate, and use guidelines and come up with concrete suggestions to facilitate ongoing feedback.

Discussion
Developing a system for feedback on guidelines will allow identification of uncertainties or discrepancies that can be considered when interpreting guidelines and addressed in subsequent updates.

Thematic Discussion Session Abstracts

T01

THE CCS HEART FAILURE CONSENSUS CONFERENCE PROGRAM: SHAPING THE FUTURE OF HEART FAILURE MANAGEMENT IN CANADA

John H. Parker, J. Malcolm O. Arnold, Jonathan Howlett, Heather Ross (Canadian Surgical Technologies and Advanced Robotics, London, Ontario, University of Western Ontario, London, Ontario, Dalhousie University, Halifax, Nova Scotia, University Health Network, Toronto, Ontario)

Background
The Canadian Cardiovascular Society (CCS), comprised of 1400 cardiology, surgery and cardiovascular research specialists, has embarked upon a multi-year knowledge translation program to evaluate the impact of its Canadian Heart Failure Consensus Recommendations on clinical practice patterns and health outcomes.

Purpose
In this session, the CCS will present its experiences with this innovative development model.

Methods
To do so, CCS has established a number of precedents with respect to the guideline development process. Among these is the adoption of a 'closed-loop' performance model which enables ongoing performance measurement and quality improvement of all processes associated with guidelines development including:

- end-user needs assessment, including those of patients
- technical specifications
- development and deployment
- evaluation
- impact assessment on clinical practice patterns and health outcomes working group

Each of these stages has occurred at the national level and has involved the collaborative and interdisciplinary participation of eight national health professional organizations, eleven Federal health organizations, both Federal and Provincial governments, policy and administration professional organizations as well as information technology, pharmaceutical and medical device industries.

Results
To date, the CCS Heart Failure Consensus Recommendations Program, through its multi-disciplinary Primary and Secondary Panels and various development teams, has completed two annual cycles of its closed-loop approach wherein each of the above stages has been carefully assessed.

In addition, CCS has introduced a number of 'quality-control' measures in its guideline development process including development of a standardized literature review protocol, developed in collaboration with the Canadian Cochrane Network, as well as introduction of annual Appraisal of Guidelines Research and Evaluation (AGREE) reviews, in collaboration with the Ottawa Health Research Institute and the Canadian Institutes for Health Research.

T02

DEVELOPING INTEGRATED PUBLIC HEALTH AND CLINICAL GUIDANCE: THE NICE GUIDELINE ON OBESITY

Adrienne Cullum, Tim Stokes, Elizabeth Shaw, Vanessa Nunes, Mike Kelly, Jim McEwen, Simon Ellis, Francoise Cluzeau (Centre for Public Health Excellence, National Institute of Health and Clinical Excellence, UK, National Collaborating Centre for Primary Care, University of Leicester and Royal College of General Practitioners, UK, Chair, National Institute for Health and Clinical Excellence Obesity Guidance Development Group, UK)

Background
Obesity is a priority for action in England but there is significant variation in service provision. Many health professionals are uncertain about what interventions are effective. Guidance produced in other countries to date has only fully addressed either prevention or management.

Purpose
The National Institute for Health and Clinical Excellence (NICE) was commissioned to develop the first comprehensive, integrated guidance on obesity prevention, identification and management, covering the National Health Service and the wider community (including schools and workplaces).

Methods
The National Collaborating Centre for Primary Care led on the clinical aspects and the Centre for Public Health Excellence at NICE led on the public health aspects of the guidance development.
The Guidance Development Group was split into two sub-groups, working in parallel with a joint chair. Final recommendations (including economic considerations) were developed jointly to ensure an integrated approach. Standard NICE methodology for clinical guidelines was used or adapted as appropriate (particularly in relation to the types of evidence and range of outcomes considered).

Results
The recommendations emphasise the responsibility of a range of settings and audiences to tackle obesity, highlight opportunities for action and provide pointers to best practice. As well as recommendations for health professionals and staff in various settings, the Guidance stresses the need to take a strategic approach, focusing on high level decisions to overcome fundamental barriers to action (such as time, training). Communication between agencies is stressed, and dissemination of the guidance acknowledges the broad audience. Although the guidance focuses on local action, supportive action at a national level will facilitate uptake of recommendations and their likely impact. Research recommendations are considered.

Discussion
This is the first guideline tackling both the prevention and management of obesity. Standard methodology can be successfully adapted for the development of rigorous, integrated clinical and public health guidance.

T03

AN INTEGRATED APPROACH TO IMPLEMENTING CLINICAL GUIDELINES FOR PRIMARY CARE AT AN ACADEMIC HEALTH CENTER: AN INSTITUTIONAL CASE STUDY

R. Van Harrison, PhD, Steven J. Bernstein, MD, MPH, William E. Chavey, MD, MS, Connie J. Standiford, MD (University of Michigan, Ann Arbor, Michigan)

Background
The development and implementation of a single clinical guideline in a clinical setting is often not simple. When guidelines for 10 to 20 medical conditions are being addressed in the same clinical setting, the process becomes extremely complex. Individual health care providers can be overwhelmed by the inconsistencies between guidelines and the inability to coordinate the infrastructure of clinical care simultaneously to support implementation of multiple guidelines.

Purpose
This session describes a successful institutional approach to developing and implementing clinical guidelines for primary care at an academic health center. This approach exemplifies a system-based perspective to enhance care across many common medical conditions.

Methods
This case study describes efforts in a largely integrated academic health care system where the health care providers and health care facilities are owned and operated by a university.

Four presentations describe the broad institutional coordination of processes across several common medical conditions managed by primary care clinicians:
- the development, content, format and dissemination of clinical guidelines (Chavey)
- the measurement of clinical performance and provision of feedback (Bernstein)
- performance improvement and coordination across units involved in implementing changes (Standiford)
- developing an institutional culture that fosters clinical care improvement (Harrison)

Results
Each of the presentations will describe results regarding the topic:
- 23 clinical guidelines developed and ongoing updates; acceptance and use
- more than 60 aspects of performance routinely measured with feedback to clinicians
- examples of coordination across units and enhanced performance across time
- examples of enhanced institutional and individual ability to implement needed change

Discussion
For the last third of the session the presenters will be a panel responding to audience questions. This discussion will address:
- institutional factors supporting a systematic approach to guideline-based improvement
- principles relevant to health care providers implementing multiple guidelines

T04

THE DEVELOPMENT OF A CONSENUS-BASED GUIDE MAP FOR KNOWLEDGE TRANSLATION IN EMERGENCY MEDICINE

Eddy Lang, Peter Wyer, Susan Huckson, Michelle Biros, James Adams, Christos Tselios, Marc Afilalo, Richard Sinert, Gary Gaddis (McGill University, Columbia University, National Institute for Clinical Studies, University of Minnesota, Northwestern University, State University of New York, University of Missouri-Kansas City)

Background
Gaps between research and clinical practice exist in Emergency Medicine (EM) as they do in other specialties. The EM context presents unique challenges and opportunities for consistent evidence uptake. Knowledge Translation (KT) is a critical area of expertise in approximating these gaps. The journal Academic Emergency Medicine (AEM) selected KT as the subject of its 2007 Consensus Conference (CC).

Purpose
The mission of the AEM CC was to stimulate the development of a research agenda in KT. By bringing together experts in evidence-based medicine with a diverse cross-section of EM physicians we plan on finding optimal routes into clinical practice for consistent and reliable implementation of the highest quality interventions.

Methods
Before the conference 13 theme leaders used Google group technology to lead discussion forums charged with developing a research agenda and recommendations for advancing KT in EM. Draft recommendations underwent refinement and consensus-based endorsement at the May 15th meeting.

Results
Representatives from 18 endorsing organizations as well as other interested participants were invited to contribute their input. Financial support was provided by the Agency for Healthcare Research and Quality and the Canadian Institutes for Health Research. Over 200 participants, with expertise in the field of EM and evidence-based medicine contributed to the online forums. All 13 groups, covering topics as diverse as guideline implementation to health policy to international EM applications of KT generated a series of recommendations that were incorporated into proceedings papers. All proceedings papers including original contributions are to be published in a free access issue of AEM in November of 2007.

Discussion
EM has taken a lead role in developing a consensus-driven process to establish priorities and set direction for KT to close evidence practice gaps and support guideline implementation. We describe the first such exercise in a process sponsored by a scientific journal.

	Global question
Theme I: Evidence Implementation	
Ia. Guideline implementation and clinical pathways	How can emergency medicine optimize evidence implementation and uptake through the use of CPG implantation strategies and critical pathways?
Ib. Evidence syntheses and other promising KT methods.	What are the most effective pre-appraised and synthesized evidence formats available in Emergency Medicine and what supplemental techniques (e.g., academic detailing, audit and feedback, reminders) will enhance this KT?
Theme II: The EM Practitioner and KT	
IIa. CME/CPD and self improvement	What self improvement strategies and continuing professional development initiatives are most conducive to the incorporation of evidence based interventions into the individual emergency physician's practice?
IIb. Cognitive , social and behavioral	How can cognitive, social, and behavioural issues inform the study of knowledge translation in emergency medicine?
Theme III: The Emergency Department and Clinical Teaching Unit	
IIIa. Undergraduate, Postgraduate and Continuing Medical Education	How can medical education strategies both at the undergraduate, postgraduate and continuing medical education level promote evidence implementation in graduating and future emergency physicians?
IIIb. Informatics and KT	What are the characteristics of an ED-based informatics and decision support system that can most effectively facilitate knowledge translation?
Theme IV: Macro view: Issues and perspectives at the broader level	
IVa. Health Policy and KT	What are the characteristics of health policy programs (local, regional and national) that promote the incorporation of research evidence into the clinical practice of emergency medicine?
IVb. Medicolegal and ethical considerations in KT	At the macro level, what are the contributions that Bioethics can make toward closing the evidence to practice gap?
Theme V: Contextually specific challenges to KT	
Va. International EM	What are the most promising avenues to pursue in approximating the gap between knowledge and practice in the delivery of emergency medical care within the context of developing nations?
Vb. Emergency Medical Services	What are the most promising avenues to pursue in approximating the gap between knowledge and practice in the delivery of emergency medical care in the pre-hospital setting?
Vc. Public Health	What are the unique contextual elements that need to be addressed in order to bring proven preventative and other public health initiatives into the ED setting?
Theme VI: The science of evidence implementation/dissemination of innovation	
VIa. Research principles and methodology of KT research	What research directions and methodologies should be employed to identify the most effective strategies for approximating the research to practice gap in emergency medicine?
VIb. Capacity development and research networks	What approaches should be emphasized in order to develop capacity and multi-center consortiums that will promote knowledge translation research in emergency medicine?

T05

"KNOWLEDGE TRANSFER USING A PEER-SELECTED OPINION LEADER NETWORK"

Rhoda Reardon, Jane Gibson, Daniel Way, Jess Rogers, Dave Davis (College of Physicians and Surgeons of Ontario, Toronto, ON, Institute for Work & Health, Toronto, ON, Guidelines Advisory Committee, Toronto, ON)

Background
Accessing clinicians to enhance guideline implementation is the 'holy grail' of knowledge transfer. We will report on a project designed to build a sustainable network of family physicians to enable an ongoing knowledge transfer and exchange to improve health care. This project was supported by five partners involved with using research evidence to improve health care. This thematic discussion will invite audience input on their own experience and ideas about linking directly with health practitioners to move knowledge and implement guidelines.

Purpose
The five project partners are involved with professional practice leadership/continuing education, knowledge translation research, guideline selection/implementation, quality improvement and work/health research. The overall goal of the project now known as 'POCKET' (Physicians of Ontario Collaborating for Knowledge Exchange and Transfer) is to move guidelines and other useful knowledge into family practice to improve patient care and to direct practice-based information and ideas back to research and policy initiatives.

Methods
This project uses a proven survey technique (Hiss) for identifying informal opinion leaders (educationally influential physicians - EIs) who have an important although often unrecognized role in influencing their peers. The peer-identified individuals were recruited to the network and a clinical topic was selected to test the concept. A series of workshops with customized practice materials were delivered. Focus group and survey methods were used to collect EI physician participant opinion on the initiative as well as advice on continued development of the network.

Results
This is a formative evaluation shows the EI physicians have benefited from the initial workshops and materials. There is modest evidence that information provided to them has been moved outwards to their colleagues.

T06

Implementing Guidelines in the Real World - How G-I-N Special Interest Communities (communities of practice) in Emergency Care, Diabetes or Cancer Might Work.

Catherine Marshall, Hon Patron of G-I-N
Independent Guideline Adviser and Health Sector Consultant
Sue Huckson,
National Health Medical Research Council's National Institute of Clinical Studies (Australia)
Heather Buchan,
National Health Medical Research Council's National Institute of Clinical Studies (Australia)
Michael Fung Kee Fung,
Cancer Care Ontario (Canada)

G-I-N wants to support special interest communities who wish to collaborate on practical activities involving the development and implementation of guidelines. The workshop will start with a practical demonstration of how a community of practice approach has worked in Australia for emergency care practitioners, and in Canada in the area of cancer care, followed by interactive discussion & table top exercises.

This session will be chaired by Catherine Marshall, a member of the G-I-N Board, and will draw on the experience of Sue Huckson, of the National Institute of Clinical Studies Emergency Care Community of Practice (Australia) and Dr Michael Fung Kee Fung, of the Cancer Care Ontario Surgical Oncology Program Community of Practice (Canada) who have successfully used this method to implement evidence based guidelines.

People attending the discussion session will gain an understanding of:

- Participating in a G-I-N. special interest community - what are the benefits and what is involved for participants
- Co-ordination, infrastructure and resources to support international networking and activities
- Challenges in meeting participants' priorities
- Using different forums for communication, knowledge transfer and exchange

Workshop participants will then break into groups focusing on particular specialty areas to discuss recommendations for potential activities for G-I-N special interest communities. The outcomes of this discussion forum will guide the development and future agenda of the GIN special interest communities currently being established in areas of diabetes, emergency care and cancer care.

T07

HEALTHY WORK ENVIRONMENT BEST PRACTICE GUIDELINES: FACILITATING EVIDENCE BASED MANAGEMENT DECISION MAKING IN HEALTH CARE

Irmajean Bajnok, Linda O'Brian Pallas , Alan Pearson, Tazim Virani, Doris Grinspun (Registered Nurses' Association of Ontario (RNAO), Universtiy of Toronto, Johanna Briggs Institute)

Background
The RNAO Healthy Work Environments Best Practice Guideline Program offers six guidelines to assist in the creation of healthy work environments in areas such as leadership, collaborative practice, professionalism, workload and staffing, embracing cultural diversity, and workplace health, safety and well being. This guideline development program was established as an evidence based strategy to support sustained implementation of clinical best practices.

Purpose
The presentation will provide the framework of healthy work environments used to guide the development process for all six guidelines. Following an outline of the process of guideline development, and implementation strategies there will be a focus on the value of such guidelines in supporting evidence based management decision making in health care.

Methods
The healthy work environment best practice guidelines featured a development process that included collaboration with the Johanna Briggs Institute, of Australia for conduction of the systematic reviews in each of the guideline development areas. National expert panels utilized the systematic reviews in development of the guidelines which were subject to extensive stakeholder reviews. The guideline development, implementation and evaluation methodology was adapted from the highly successful RNAO nursing best practice guidelines program.

Results
The resulting guidelines have become important tools for use in nursing and other health care professional groups to create quality health care environments and positive outcomes for nurses and other professional groups, patients and organizations. Strategies for guideline dissemination, implementation, and evaluation will be highlighted during the presentation.

Discussion
A discussion of evaluation of the guidelines through pilot implementation in 10 different health care sites will be incorporated. The presentation will conclude with a dialogue about the importance of guidelines such as these that support evidence based management decision making in health care to enable evidence based practice, despite the inherent challenges in their development.

T08

GUIDELINES IN ONCOLOGY

Melissa Brouwers, George Browman, Beatrice Fervers, Joan McClure, Mark Somerfield (Cancer Care Ontario & McMaster University, Hamilton, Canada, BC Cancer Agency & Canadian Partners Against Cancer, Victoria, Canada, Federation Nationale Des Centre de Lutte Contre Le Cancer, Lyon, France, National Comprehensive Cancer Network, Jenkintown, USA, American Society of Clinical Oncology, Alexandria, USA)

Background

Guidelines and other evidence-based products can be extremely useful tools to advance a quality care agenda forward. They have shown their capacity to improve quality of care and outcome of cancer patients. In the oncology field, there are unique issues relevant to the guideline enterprise, from the perspectives of guideline development, evaluation and application.

Some of these issues include:

- significant duplication in effort
- challenges integrating new evidence in a timely fashion
- strong advocacy by patients, clinicians, and industry
- limitations with quantity, quality and completeness of data
- controversies regarding relative benefits and harms
- providing guidance to different targets who may have competing agendas

Purpose

This thematic - networking session has two primary goals:

- to examine these issues from an international perspective and to learn about the successes and challenges of different oncology guideline programs
- to explore the development of a GIN-sponsored international community of interest (COI) specific to oncology

Methods

Panelists representing different oncology guideline programs will present their experiences with the issues presented. These discussions will be used a spring-board for a larger networking session whereby the concept of developing an international COI will be explored.

Specifically, we will explore:

- what problems could be addressed by an international COI that would lead to improvements in quality of cancer care?
- what strategies could an international COI use to address these problems?
- how can we move forward to concept to action?

Results

The outcomes of this session will be:

- identification of major challenges of cancer guideline programs
- defining of an outline of an international cancer COI
- development of an agenda of activities and questions to be addressed by the COI

Workshop Abstracts

W01

PROMISES AND CHALLENGES OF INTERNATIONAL GUIDELINE COORDINATION

Katrin Uhlig, Gordon Guyatt , Regina Kunz (Tufts-New England Medical Center, Boston, MA, McMaster University, Hamilton, ON, Institute for Clinical Epidemiology, University Hospital, Basel)

Background

Clinical practice guidelines are widely used to improve patient care. While they aim to reduce unjustified practice variability, guideline development often proceeds in local, regional and national initiatives in a fragmented or parallel manner. Processes and methods vary and guideline recommendations may be redundant or incongruent. This variability indicates a need for coordination. Kidney Disease Improving Global Outcomes Initiative (KDIGO) is an international guideline initiative in nephrology. It aims to promote coordination, collaboration, and integration of initiatives in guideline development and implementation to improve care and outcomes of kidney disease patients worldwide. Yet on a practical level, international guideline programs face important challenges, such as how to pool resources, coordinate efforts and develop guidelines that are mindful of the differences among patients and health care systems.

Purpose

- Review promises and challenges of KDIGO as a case study of an international guideline initiative
- Critique and refine concepts for international guideline coordination, identifying what efforts should be centralized or decentralized and how this should be done.

Methods

The facilitators will provide an introduction and an overview over KDIGO. Then participants will be asked to participate in a discussion of the following issues:

- What topics or problems should be addressed by internationally developed guidelines?
- How can we develop evidence reports that can be shared?
- How can we grade applicability and directness of evidence when reference populations and contexts vary?
- How can we determine net medical benefit or make trade-offs transparent when alternatives, values and resources differ across countries and settings?
- How can we facilitate local adoption of international guidelines?
- What efforts are best decentralized, or coordinated and streamlined in local initiatives?

This seminar targets participants with experience or an interest in guideline development, implementation or quality improvement initiatives and who are willing to share their perspective.

W02

WORKSHOP SEX-SPECIFIC ISSUES IN GUIDELINE DEVELOPMENT

Hans de Beer, Debby Keuken (Dutch Institute for Healthcare Improvement CBO, Utrecht, The Netherlands, Academic Medical Center / University of Amsterdam, Department of General Practice, The Netherlands)

Background
Guideline-developing organizations do not focus systematically on differences between men and women when developing guidelines, even though there is increasing evidence that being male or female may have an effect on health and health outcomes. In the Netherlands a training course was developed that aims to enhance attention to differences between in-patient characteristics, with a focus on differences between men and women, in guideline-development procedures (1). This training course was rated highly on knowledge, practical value and effect on awareness about sex differences. This workshop is based on the training course.

(1) 'Attention to sex differences in guideline development'. A training course developed Hellema MJ, Haafkens JA, Ter Riet G, Moerman CJ for the project 'Diversity consultation for Guideline developers' in 2005, granted by the Netherlands Organisation for Health Research and Development.

Purpose
The aims of this workshop is to improve awareness and competence by systematically considering sex differences in the various steps of guideline development.

Methods
Outline of the workshop
We will present a few examples from the literature to illustrate the feasibility of a sex-specific approach in guideline development. The workshop will continue with an interactive session, using the example of applicability of screening instruments to identify alcohol dependence in various subpopulations. It will follow the steps that are commonly used in guideline develop-ment. This means formulating a clinical question that allows sufficient attention to potential sex differences; constructing a literature search strategy that allows the identification of potentially relevant literature on sex differences; assessing the retrieved studies on relevant information about sex differences; integrating information on sex differences into recommendations.

Results
Participants will learn how sex differences can be incorporated in several key steps in guide-lines development, ranging from formulating clinical questions to formulating sex-specific recommendations.

W03

TURNING EVIDENCE INTO ACTION

Sue Scobie, Nicole Coupe (NZ Guidelines Group)

Background

Relevant to conference themes: Transferring knowledge; implementing guidelines, collaboration between relevant stakeholders and organizations, innovative cases studies in specific countries, involving consumers.

In 2005, The New Zealand Guidelines Group (NZGG) was commissioned by the Ministry of Health to run an innovative multi-year project designed to implement key recommendations from the Assessment and Management of People at Risk of Suicide guideline.

Purpose

The three main objectives of the project were to:

1. work with emergency departments, Maori health and mental health services to improve emergency mental health care for the prevention of suicide and self-harm
2. promote collaboration within services and amongst clinicians to achieve and sustain change
3. contribute to the knowledge base regarding methodologies needed for the successful implementation of guidelines.

Methods

NZGG adapted the Australian implementation model for a New Zealand context by overlaying a strong consumer focus, and the Maori (indigenous people of New Zealand) concept of 'whakawhanungatanga' - connected relationships and shared responsibilities between the individual, the family and the service provider. Nearly half the hospitals in New Zealand were supported by NZGG to participate in this 12 month collaborative.

Results

The results include sustainable changes based on the guideline. The relationships between services and systems to support clinicians have significantly improved to achieve best practice.

Discussion

This workshop will discuss the results of using a collaborative approach between services and across hospitals to implement guidelines into the clinical setting including:

- improved results from involving consumers
- the impact of operating within an indigenous framework
- changes in attitudes of clinical staff about self-harm and suicide prevention
- power of the pathway maps to highlight gaps and areas for improvement
- changes in systems and processes (ranging from administration to assessment processes)
- improved collaboration and relationships between services
- accelerated learning from sharing of resources nationally.

W04

THE EVOLVING NATURE OF CLINICAL PRACTICE GUIDELINE UPDATING AND ATTRIBUTE-REPORTING: PERSPECTIVES FROM THE NATIONAL GUIDELINE CLEARINGHOUSE.

Michelle Tregear, Mark Monteforte, Lisa Haskell, Vivian Coates, Mary Nix (ECRI, Plymouth Meeting, PA, U.S. Agency for Healthcare Research and Quality, Rockville, MD)

Background
Since the inception of the U.S. Agency for Healthcare Research and Quality's National Guideline Clearinghouse (NGC) in 1997, ECRI, as AHRQ's contractor, has reviewed and abstracted nearly 6,000 clinical practice guidelines for inclusion in its online repository. A principal component of this work has entailed assessing guidelines along a number of primary guideline attribute domains that collectively comprise the NGC Complete Summary Template (www.guideline.gov/about/CompleteSummaryDescrip.aspx), including attributes that characterize: Guideline Scope, Development Methodology, Key Recommendations and Supporting Evidence, Implementation Mechanisms, and Committee Characteristics/Financial Disclosures. During this time, there has been an increasing demand from key guideline stakeholders (both developers and implementers) for transparency in reporting that would permit an assessment of a guideline's rigor. Likewise, there has been increasing demand for more frequent review and updating of existing guidelines to ensure that guidelines keep pace with accumulating evidence.

Purpose
In this session, we will report on observed trends and changes in both guideline reporting characteristics and updating practices employed by guideline developers over the nine years following the launch of the NGC Web site, and how reporting along these five attribute domains, as well as "currency review" practices, have changed. Additionally, we explore how transparency and completeness in reporting as characterized in the NGC Template might be used to gauge guideline rigor along the above-mentioned guideline attribute domains

Methods
We will analyze data collected over the history of the NGC initiative, quantifying changes in updating and attribute reporting.

Results and Discussion
At the end of the session, attendees will have a better sense of how reporting and updating has changed over the last decade, and how the NGC template might be used to assess guideline rigor. Attendees will be asked to share their experiences and challenges.

W05

FREQUENT CHALLENGES FOR GUIDELINE DEVELOPERS AND FACILITATORS - SPOT AND OVERCOME OBSTACLES IN GUIDELINE GROUPS

Kunz Regina , Leigemann Monika, Ollenschläger Günter (Basel Institute for Clinical Epidemiology; Basel, Switzerland, HTA-Center University Bremen; Institute for Health Law and Medical Law, Bremen, Germany, Agency for Quality in Medicine, Berlin, Germany)

Background
Facilitators for guideline groups regularly face obstacles during the development of a guideline. Impeding questions can arise from methodological topics, ("What to do if systematic reviews do not provide sufficient information?"), process issues ("How to enable lay people to become a full member of the guideline group"), content issues ("How to build a hierarchy of endpoints for the clinical question") or communication issues ("How to communicate the GRADE system to the public?"). Ignoring those issues can endanger the group dynamic, threat the internal validity of the guideline, prevent dissemination and implementation among the professional target group, and impede general acceptance by consumers and patients. While those problems are common, little is published about successful approaches to tackle them. Guideline facilitators often need to find their own solutions.

Purpose
Focus of the Train The Trainer workshop is on challenges, questions and problems that commonly arise in guideline groups. Aim is to exchange techniques, experiences and viewpoints on issues generally not discussed in guideline manuals.

Methods
We will perform an informal survey among recognised guideline organisations to identify common day-to-day challenges in the guideline work. Three to four miscellaneous topics will be selected. Various experienced guideline group facilitators will shortly outline a specific challenge using examples from their own background and run a discussion about the experience among the workshop participants.

Results
The interactive format should offer a low threshold platform for exchange, joint analysis of the problem, its roots and consequences, and options / experiences for handling those problems. Thereby, the workshop should increase awareness for common challenges, perceived obstacles and unsolved problems among guideline group facilitators and members and expand their approaches to tackle them.

Discussion
Target group: Participants are expected to have some experience in guideline development activities (facilitator; participants) and to share their approaches and concepts.

W06

GUIDELINE ADAPTATION: A METHODOLOGY TO ENHANCE EFFICIENCY IN GUIDELINE DEVELOPMENT AND IMPROVE UTILIZATION

Béatrice Fervers (1), Jako S Burgers (2), Melissa Brouwers (3), Magali Remy-Stockinger (4), Anita Simon (5), Najoua Mlika-Cabanne (6), Bernard Burnand (7), for The ADAPTE Collaboration (1 SOR, Fédération des centres de lutte contre le cancer; Centre Léon Bérard - Lyon - France, 2 Dutch Institute for Healthcare Improvement, CBO - Utrecht - The Netherlands, 3 Program in evidence-based Care, Cancer Care Ontario, McMaster University - Hamilton - Canada; Cancer Control Guidelines Action Group, 4 SOR, Fédération des centres de lutte contre le cancer - Lyon - France, 5 Alberta Cancer Board - Calgary - Alberta, 6 Haute autorité de santé, Service des recommandations Professionnelles - Paris - France, 7 Health Care Evaluation Unit and Clinical Epidemiology Centre, IUMSP - Lausanne - Switzerland)

Background
Development and updating of high-quality guidelines requires substantial time and resources. In an effort to reduce duplication of effort, enhance efficiency, and promote the translation of evidence into practice, we advocate taking advantage of existing high-quality guidelines as an alternative to de novo guideline development and for tailoring guidelines to the local context in the implementation process.

Purpose
Workshop to present ADAPTE and how it works.

Methods
Outline of workshop: Part 1: We will present the ADAPTE process with practical examples. Part 2: We will present the evaluation study and raise interest in participation. This includes a two-part perception survey of the manual and the resource toolkit and an evaluation of the use of ADAPTE in various contexts.

Results
ADAPTE is a systematic approach to adapt existing guidelines to a different setting. The ADAPTE process is designed to ensure that the adapted guideline is relevant to the new context of use and its cultural and organizational environment. The process has been pilot tested in Canada and France. ADAPTE is supported by a manual and resource toolkit. The evaluation study will assess the ADAPTE program implementation, its use, acceptability and benefit to different user groups (e.g., guideline developers, health care professionals, decision makers).
Through the workshop participants will achieve practical understanding of applying the ADAPTE process and using the manual and ressource toolkit. They will be offered participation in the evaluation study.

Discussion
The ADAPTE process has been designed to assist groups with varying resources interested in developing or implementing guidelines. The participatory approach of the ADAPTE process will foster users' sense of ownership with adapted guidelines. ADAPTE also provides an opportunity for national and international collaborations among organisations to share common issues and investigate more efficient ways to develop and implement guidelines.

W07

ASKING FOR LESS AND GETTING MORE: SIMPLIFICATION OF CLINICAL PRACTICE GUIDELINES AS A COMPONENT OF IMPLEMENTATION STRATEGIES

Onil Bhattacharyya, Merrick Zwarenstein (Li Ka Shing Knowledge Institute, University of Toronto, Toronto, Ontario)

Background
Within a clinical practice guideline, the evidence base for individual recommendations varies, the health impact of different recommendations varies, as does the feasibility of consistently following them. Reducing the complexity of guidelines may be an effective way of increasing the uptake of key recommendations.

Purpose
Propose methods for simplifying guidelines as part of an implementation strategy.

Methods
Two case studies of mixed method controlled trials of implementation including guideline simplification will be presented as the basis for elaboration of a general approach. Workshop participants will review the literature on clarity and simplicity in clinical practice recommendations and attempt to extract key points from a guideline.

Results
A randomized controlled trial of introducing a simplified guideline for lung health increased tuberculosis case detection in nurse-led primary care centres in South Africa. A controlled before-after trial of guideline simplification increased statin prescription in diabetes in remote aboriginal communities in Canada. Both studies involved reducing the guideline to key points and prioritizing them. These approaches were well-received by nurses, though criticized by doctors in the latter case. Reducing complexity may increase uptake, but it may be perceived to be incompatible with physician's values, particularly their interest in individualizing care.

Discussion
Guideline simplification requires rigorous methods for comparing the health impact and ease of implementation of different recommendations to determine which ones to emphasize. Implementation strategies may vary between physicians and nurses, in order to accommodate the work styles and professional cultures of different classes of professionals. Simplifying guidelines may be the most cost-effective approach to increasing quality of care, not only in areas with shortages of health human resources, but in any setting where coping with provider workload requires a focus on some aspects of care at the expense of others.

W08

INTEGRATING EVIDENCE WITH ELECTRONIC HEALTH RECORDS - WORKSHOP OF 1.5 HRS

Minna Kaila, Ilkka Kunnamo, Jorma Komulainen (Finnish Office for Health Technology Assessment, Finnish Medical Society Duodecim)

Background
Electronic patient records (EPR) are being developed and used around the world. All expected advantages have not yet been realized. There are challenges with structuring the contents of the EPR and using the data stored in the EPR. Clinical practice guidelines have been produced in guideline programmes, and there the challenge is implementation into clinical practice. Electronic Decision Support Systems (EDSS) show promise in bridging between the EPR and implementation of guidelines/integrating evidence into the everyday clinical practice.

Purpose
Aim of the workshop is sharing experiences of building and studying EDSS, discussing highlights of ongoing projects and learning from others how to overcome obstacles. The target group consists of guideline implementers and those interested or involved in EDSS.

Methods
Short presentations by EDSS experts attending the congress of e.g. highlights or an overview of Open Clinical and presentation of EBMeDS (Evidence Based Medicine Electronic Decision Support), an ongoing EDSS-development and -research project (title How to integrate guidelines with electronic health records?). The idea is to have short, max 15 -minute presentations followed by discussion. There is room for two or three presentations; the programme will be finalized once people attending the congress are known.

Results
Networking with others interested in EDSS. Learning from each other. A short paper on the presentations and main discussions.

Discussion
Conclusions will be made after the workshop and in the paper that will be circulated to those present in the workshop and if deemed useful, to others as well.

W09

IMPROVING GUIDELINE IMPLEMENTABILITY USING GLIA

Richard Shiffman, Catherine Marshall (Yale Center for Medical Informatics, Independent Guideline Adviser & Health Sector Consultant)

Background

The GuideLine Implementability Appraisal Instrument (GLIA) identifies 10 dimensions that affect whether a guideline can be readily implemented and was developed to assist guideline developers to remedy defects in their guidelines prior to publication. A 2006 review by the (Australia) National Institute of Clinical Studies of tools used to assess whether guidelines could be implemented, identified that GLIA was currently the only validated instrument that covered most parameters of implementability. The GLIA instrument is in use in the USA and is being trialed in the UK and Australia.

Purpose

The purpose of the workshop is:

- To review the development of the GLIA instrument
- To introduce the instrument
- To apply GLIA to a "demonstration" guideline to demonstrate its capabilities.

Methods

Rick Shiffman and Catherine Marshall will run a 90 minute workshop suitable for both guideline developers and implementers (up to 30 participants).

A 30-40 minute presentation on the background to the development of the tool will be followed by each participant conducting an appraisal of a "demonstration" guideline. The workshop leaders will then facilitate a discussion amongst workshop participants to review the different perspectives and comments made by the participants and to stimulate a discussion on the merits and deficiencies of the "demonstration" guideline.

Results

At the end of the workshop, participants will have a practical understanding of how the GLIA instrument can be applied and understand factors that impede successful implementation.

Discussion

GLIA is designed to help improve draft guidelines. Therefore the emphasis of the workshop will be on both identifying logical and clinical deficiencies, as well as providing constructive and positive advice to guideline authors. This workshop is open to people from all backgrounds. We have found it useful to have a mix of participants with clinical as well non-clinical backgrounds. Clear thinking and a positive approach are the only essentials.

W10

GUIDELINE ADAPTATION: A METHODOLOGY TO ENHANCE EFFICIENCY IN GUIDELINE DEVELOPMENT AND IMPROVE UTILIZATION

Béatrice Fervers (1), Jako S Burgers (2), Melissa Brouwers (3), Magali Remy-Stockinger (4), Anita Simon (5), Najoua Mlika-Cabanne (6), Bernard Burnand (7), for The ADAPTE Collaboration (1 SOR, Fédération des centres de lutte contre le cancer; Centre Léon Bérard - Lyon - France, 2 Dutch Institute for Healthcare Improvement, CBO - Utrecht - The Netherlands, 3 Program in evidence-based Care, Cancer Care Ontario, McMaster University - Hamilton - Canada; Cancer Control Guidelines Action Group, 4 SOR, Fédération des centres de lutte contre le cancer - Lyon - France, 5 Alberta Cancer Board - Calgary - Alberta, 6 Haute autorité de santé, Service des recommandations Professionnelles - Paris - France, 7 Health Care Evaluation Unit and Clinical Epidemiology Centre, IUMSP - Lausanne - Switzerland)

Background
Development and updating of high-quality guidelines requires substantial time and resources. In an effort to reduce duplication of effort, enhance efficiency, and promote the translation of evidence into practice, we advocate taking advantage of existing high-quality guidelines as an alternative to de novo guideline development and for tailoring guidelines to the local context in the implementation process.

Purpose
Workshop to present ADAPTE and how it works.

Methods
Outline of workshop: Part 1: We will present the ADAPTE process with practical examples. Part 2: We will present the evaluation study and raise interest in participation. This includes a two-part perception survey of the manual and the resource toolkit and an evaluation of the use of ADAPTE in various contexts.

Results
ADAPTE is a systematic approach to adapt existing guidelines to a different setting. The ADAPTE process is designed to ensure that the adapted guideline is relevant to the new context of use and its cultural and organizational environment. The process has been pilot tested in Canada and France. ADAPTE is supported by a manual and resource toolkit. The evaluation study will assess the ADAPTE program implementation, its use, acceptability and benefit to different user groups (e.g., guideline developers, health care professionals, decision makers).
Through the workshop participants will achieve practical understanding of applying the ADAPTE process and using the manual and ressource toolkit. They will be offered participation in the evaluation study.

Discussion
The ADAPTE process has been designed to assist groups with varying resources interested in developing or implementing guidelines. The participatory approach of the ADAPTE process will foster users' sense of ownership with adapted guidelines. ADAPTE also provides an opportunity for national and international collaborations among organisations to share common issues and investigate more efficient ways to develop and implement guidelines.

W11

SUCCESSFUL IMPLEMENTATION AND EVALUATION OF GUIDELINES THROUGH PERFORMANCE INDICATORS AND CARE PATHWAYS

Mona van de Steeg, Teus van Barnveld, Ruben van Zelm (Dutch Institute for Healthcare Improvement, Utrecht, the Netherlands)

Background
The Belgian-Dutch Clinical Pathway Network is a collaboration of over hundred Belgian and Dutch healthcare organizations (mainly hospitals), focused on development, implementation and evaluation of clinical pathways (CP's). In the perspective of this network CP's are tools to achieve high quality care by both standardization and a patient-focused approach on healthcare processes. CP's describe so called 'key interventions' that have impact on outcome and/or process time. These interventions can be derived from evidence based guidelines by selecting 'key recommendations'.
Recently we have included performance indicators in the development of clinical practice guidelines and CP's, and in the evaluation of their use in practice. Indicators are measurable aspects of care which provide an indication about the quality of care.

Purpose
The objective of this session is to offer participants knowledge and tools to derive indicators from guidelines and to develop clinical pathways in order to implement guidelines in their own organization.

Methods
In this workshop, the following questions will be addressed:
1. How to search for and derive 'key recommendations' from guidelines?
2. How to integrate selected recommendations in clinical pathways?
3. How to evaluate the embedding of clinical pathways in the organization?
4. How to achieve that indicators present in a correct and objective manner what we intend to measure?
We will ask participants to answer these questions from their own experience and will provide examples of best practices.

Results
Our answers on these questions will be presented. These include selection criteria, integrating guidelines with the same scope as the clinical pathway (e.g. diagnosis and treatment of breast cancer) and guidelines with a more generic scope (e.g. postoperative pain management), the use of the AIRE-instrument and The Leuven Clinical Pathway Compass.

Discussion
Using guidelines in the development of clinical pathways is a promising strategy to improve the implementation of guidelines.

W12

E-BASED SOLUTIONS TO PROMOTE USE OF CLINICAL PRACTICE GUIDELINES

Tazim Virani, Heather McConnell, Janet Nevala, Lisa Valentine, Cindy Bolton (Registered Nurses' Association of Ontario, Toronto, Ontario, The Program Training and Consultation Centre, Ottawa, Ontario, Sunnybrook Health Sciences Centre, Toronto, Ontario, Kingston General Hospital, Kingston, Ontario)

Background
Promoting the current knowledge in clinical practice is a challenging task. This is further complicated by the nature of health care settings in the ability to create forums for translating, imparting and ensuring the successful and sustainable uptake of knowledge. The use of web-based solutions is one way of addressing these challenges.

Purpose
In this presentation, we will illustrate the translation of clinical practice guideline in e-learning, self-directed learning tools, using three distinct demonstrations.

Methods
The framework and methodology used to translate knowledge from best practice guidelines to electronic medium will be outlined. Demonstrations of three e-learning modules include: 1) Helping People Quit Smoking; 2) Vascular Access Devices - Assessment, Selection and Care Strategies to Reduce Complications; 3) Managing Hypertension. The steps used to develop the e-based solution will be highlighted as well as the key use of educational concepts and strategies to delivery the content to clinical nurses.

Results
E-based solutions have been developed and disseminated broadly. All are accessible through a website at no cost. One of the e-learning modules has been formally evaluated with point of care clinical nurses. Overall, the course was well received by all participants, who found it to be interesting, enjoyable and easy to use. There were few technical problems and the modular format allowed users to use the e-learning at their own pace. Users reported preference for a variety of interactive media, availability of more printable materials as well as an accompanying manual.

Discussion
Making available e-based guidelines in an educational, interactive, self-directed format allows ease of access to clinicians and students and has the potential for large scale knowledge transfer.

W13

PROMOTION OF INTERNATIONAL GROUPS AND NETWORKING: IBEROAMERICAN NETWORK EXPERIENCE

Ignacio Marín León, Antônio Vaz Carneiro, Airton Tetelbom Stein (Coordinator of Red Iberoamericana de Guias de Pratica Clinica, Member of the Coordination of Red Iberoamericana de Guias de Pratica Clinica)

Background
The ibero-american Network has been in operation since the GIN Conference in Edinburgh and it has been pushing forward guideline culture in Latin America, Portugal and Spain environment.

Purpose
To facilitate a closer contact between ibero-americans in order to raise cooperative and partnership initiatives.
To move from the step of developing guidelines to the implementation one, by sharing implementation experiences.
To build a cooperative network to increase the quality of the guidelines development process, putting methodological tools available.

Methods
The workshop will last for two hours and will be divided in three parts:

a)Round-table type - duration of 60 minutes

The aim of this section will be to brain storming main topics on how to achieve the specific objectives in the region.

b)Panel on Lessons learned from CPG Adaptation and Implementation Experiences and innovative case studies in specific countries or regions - duration of 30 minutes

Results
Four speakers will make 10 minutes presentations of real experiences in Latin American, Portugal or Spain settings of adaptation or implementation of guidelines, trying to answer three questions: What kind of things you would not repeat anymore? What tools have been used, and they could be available to others? What is the main lesson that you have learned from your experiences?

Discussion
This workshop will develop a specific communication strategy for Latin America, Spain and Portugal. It will also provide health decision-makers information about GIN and what it could offer to them.

W14

EVIDENCE TABLES - THE "HOLY GRAIL" FOR LITERATURE REVIEWERS

Najoua Mlika-Cabanne, Sara Twaddle, Michel Laurence (HAS, Saint Denis, France, SIGN, Edinburgh, Scotland)

Background
The first step in undertaking systematic reviews to inform recommendations (about interventions or actions that affect health), is to critically appraise the existing literature and to determine if it provides evidence of the effects of the different options under consideration.
Systematic reviews require capacity, resources and are time consuming. Therefore, to reduce duplication of effort existing reviews should be used when possible and updated if needed. A standard format for summarizing the appraised literature would be the easiest way to achieve this.

Purpose
The aim of the workshop is to promote the concept of information sharing in guidelines development and usability of a minimum dataset for summarizing the appraised literature.
This workshop will be of most interest to those who deals with literature review (I.e. guidelines or HTA developers) and those who wish to adapt other's work.

Methods
This workshop will present the work so far done of the ETWG. It will present:
- Work on defining an evidence table
- The ETWG template (standard data format) for summarizing studies addressing intervention studies
- An example of completing the template.

This will be followed by a discussion about the usefulness and the difficulties encountered in completing the proposed format.

Results
The expected outcome from the workshop is to train the attendees in using the proposed format and have their feedback on it.

Discussion
Attendees will be expected to discuss the proposed template for summarizing studies appraised and discuss the items contents in term of relevance, clarity of the instructions and the table completion.

W15

IMPLEMENTING GUIDELINES: FROM EVIDENCE TO ROUTINE CLINICAL PRACTICE

Susan Phillips (National Institute of Clinical Studies)

Background
Implementing best practice guidelines involves influencing change at multiple levels: clinicians, patients, health care settings and the health care system. Reviews of systematic reviews of effective interventions tell us how well different strategies for changing practice work, but knowing how to apply this knowledge when faced with the task of implementing best practice guidelines in complex health care settings or across a number of different health care settings is a daunting task.

Purpose
This workshop aims to increase participants' understanding of evidence implementation by summarising what we know about what works best to improve evidence implementation; to look at some of the available models that can help participants apply this knowledge in a structured way; and to practice applying this approach to the problem of venous thromboembolism (VTE) prevention in hospitalised patients.

Methods
The workshop will include an initial presentation of the evidence on effective interventions for influencing clinicians to adopt best practice and on knowledge translation models and will be followed by two facilitated interactive small group sessions that will enable participants to practice identifying and analysing barriers to best practice VTE prophylaxis in hospital settings and to practice designing implementation strategies that best match the identified barriers.

Results
Examples from the National Institute of Clinical Studies' VTE Prevention program will be used to illustrate how this approach can result in significant improvements in compliance with best practice VTE prophylaxis in 40 participating hospitals from metropolitan and rural areas in Australia.

Discussion
Participants can expect to learn how to take a more effective approach to the implementation of clinical practice guidelines by using knowledge translation models and adopting a structured approach to the preparation and design of guideline implementation programs.

W16

Workshop "Usability of Search Filters for Guidelines"

Rikie Deurenberg, Kitty Rosenbrand, Tom Oliver, Sylvie Guillo, Michele Hilton Boon.
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Tom Oliver
Cancer Care Ontario Program in Evidence-based Care, McMaster University, Hamilton, Canada
Sylvie Guillo Fédération Nationale des Centres de Lutte Contre le Cancer, Paris, France
Michele Hilton Boon
SIGN, NHS Quality Improvement Scotland, Glasgow, Scotland

Background
Most papers about "search filters" focus on the development of filters. Only a limited number tell more about the issue of usability.

Purpose
To discuss criteria that are important to determine if using a specific search filter is effective for searching evidence for guidelines.

Methods

Questionnaire:
The workshop will start with multiple choice questions to introduce a standard terminology. Jenkins (2004) mentions in her review 'Evaluation of methodological search filters' how confusing current terminology is and she strongly recommends standardization for this issue. The final multiple choice question for the participants will be: "What do you consider as the most important search filter for Medline?"

Results of this final question will be summarized immediately and will be used for the discussion part.

Discussion in subgroups:
- Benefits of applying a filter.
- Standards in applying a filter
- Inventarisation of selection steps to select the most optimal filter.
- Limitations of filters, for which intervention is the use of specific filters not recommended.
- Is it possible to solve this problem and how?

Questions to answer:
- What are important checklists/tests to know if a filter is applicable?
- What are important checklists/tests to know if a filter is valid?
- What are important checklists/tests to know if a filter is specific enough?
- What are important checklists/tests to know if a filter is sensitive enough?
- Is standardization possible?

Results:
Inventarisation of checklists/tests to decide if a specific filter is effective.

Conclusions:
Concrete steps to standardise the use of specific search filters.

Jenkins, M. Evaluation of methodological search filters--a review. Health Info Libr J 2004;21:148-63.

W17

APPRAISAL OF INDICATORS TROUGH RESEARCH AND EVALUATION (AIRE) INSTRUMENT

Johan de Koning, Jako Burgers (Department of Social Medicine, Academic Medical Centre, University of Amsterdam, the Netherlands / Centre for Public Health Forecasting, National Institute for Public Health and the Environment, Bilthoven, the Netherlands, Dutch Institute for Healthcare Quality CBO, Utrecht, The Netherlands)

Background
This workshop is to promote the concept and understanding of 'good' indicators by using a structured method (AIRE Instrument) for assessing their quality. The Appraisal of Indicators through Research and Evaluation (AIRE) Instrument has been developed and validated by researcher from the Academic Medical Center of the University of Amsterdam. Presently, the instrument is validated internationally. This workshop will be relevant to any conference participant involved in developing or using quality indicators.

Purpose
1. To identify and understand the essential elements of 'good' quality indicators.
2. To Assess the usability and practicality of the AIRE Instrument based on the practical experience from the workshop.
3. To identify potential partners for participation in an international validation study.

Methods
The workshop will comprise three parts:

1. Welcome and introduction (20 minutes)
A brief background to the AIRE Instrument. It will outline the structure and content of the instrument and will present a summary of its development process and preliminary validation.

2. Small group appraisal (45 minutes)
Interactive session in which participants will be divided into small groups of 6-8 people. All groups will appraise two pre-selected indicators using the AIRE Instrument. Their work will be facilitated by the workshop leaders.

3. Group feedback, plenary discussion & summary (25 minutes)
Presentation of results by participants, followed by a structured discussion about the usefulness of the AIRE Instrument and its application in practice. Feedback about the workshop will be obtained from the participants by means of a short evaluation questionnaire. This will include a few questions about interest in active participation in further validation of the instrument.

Each participant will be given a pack containing:
- The AIRE Instrument
- Two selected indicators for appraisal
- Handouts of presentation
- An evaluation form

W18

HETEROGENEITY IN EVIDENCE-BASED CLINICAL PRACTICE GUIDELINE AND HEALTH CARE QUALITY MEASURES DOCUMENTATION: WHY IT IS PROBLEMATIC, HOW IT COULD BE STANDARDIZED

Mary Nix, Vivian Coates, Mark Monteforte, Michelle Tregear, Melanie Swan (U.S. Agency for Healthcare Research and Quality, Rockville, MD;, ECRI, Plymouth Meeting, PA)

Background
The U.S. Agency for Healthcare Research and Quality (AHRQ), sponsor of the National Guideline Clearinghouse™ (NGC) and the National Quality Measures Clearinghouse™ (NQMC), and ECRI, technical contractor for NGC and NQMC, have the unique advantage of reviewing thousands of evidence-based clinical practice guidelines and quality measures. Documentation of scope, rationale, methodology, recommendations (guidelines), specifications (measures), implementation, conflicts of interest, etc. is heterogeneous and is sometimes missing. These are essential elements, however, for end users of guidelines and measures (not just users of NGC and NQMC) to evaluate quality and fit for potential adoption or adaptation. Additionally, as guideline developers also pursue the development of quality indicators (or as they consider contracting with other organizations for measure development), understanding what the essential elements of measure documentation are becomes more important.

Purpose and Methods
In this session, AHRQ and ECRI will report on just how heterogeneous the documentation is for the guidelines and measures submitted to the Clearinghouses, identify though interative case studies why this is problematic, and lead a discussion on the use of the attributes specified in the NGC and NQMC structured abstract (complete summary) as efficient and effective tools in standardizing guideline and measure documentation, respectively. A comparison will be made to other tools also available to assist in standardizing documentation (e.g., Guideline Element Model [GEM] for guidelines, National Quality Forum [NQF] requirements for measures).

Results and Discussion
At the end of the session, attendees will be able to explain the importance of documentation standardization and offer ideas for applying existing tools to their own guideline and measure development efforts.

Poster Abstracts

P01

MANAGING CENTRAL VENOUS ACCESS DEVICES

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Background

Central venous access devices (CVADs) have been used over the past 20 years to ensure the safe delivery of chemotherapy and supportive therapies for individuals with cancer. Catheter related complications, such as thrombosis or infection, are common. There is a wide variation in oncology nursing practice among care settings.

Purpose

The following questions were answered by this systematic review:

1.In order to prevent catheter-related intraluminal thrombosis and local or systemic catheter-related infection, minimize the need to replace devices, and enhance quality of life of adults with cancer:
Should CVADs be locked with heparin or saline?

- What volume and strength of solution should be used to lock CVADs?
- How frequently should CVADs be locked or flushed?
- What type of catheter should be used?

2.In patients who require systemic therapy for cancer, what are the indicators that have an impact on the decision to insert a central venous access device?

Methods

The MEDLINE, CINAHL, EMBASE and Cochrane Library databases were systematically searched for relevant guidelines and studies. Recommendations were formed based on the evidence reviewed and where that lacked through consensus. External review of the recommendations by Ontario practitioners was obtained though a mailed survey; the recommendations were then revised by the CVAD Working Panel. Final approval of the systematic review and recommendations was obtained from the PEBC Report Approval Panel.

Results

There was insufficient evidence for or against the choice of a particular protocol in the adult cancer population. Recommendations by the panel regarding the schedule of solutions, volumes, concentrations, and frequencies are based on a consensus of the expert clinical opinion and the experience of the CVAD Panel in their practices and the best available evidence.

Discussion

Research institutions need to develop trials that can supply evidence to inform decision-making on these issues.

P02

A CONTENT ANALYSIS OF CLINICAL PRACTICE GUIDELINES

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Background
In Japan, the official movement to develop Clinical Practice Guidelines (CPGs) began in 1999 with the financial support of the Ministry of Health and Welfare (presently, the Ministry of Health, Labour and Welfare). Since then, CPGs in various fileds, have been developed or are now under development, and developmental methods using the principles of evidence-based medicine are becoming popular. Now about 40 CPGs are developed already.

Purpose
The objectives of the study is to clarify how many CPGs developed in Japan, and to evaluatge the CPGs analysically.

Methods
We have searched the existing CPGs developed in Japan from both electronic and manual searches. Out of the 400 retrieved CPGs, well-formulated ones were selected if they met the following criteria: defining clinical questions to be addressed, reviewing evidence, and determining grade of recommendation. We have compared the developing methods, developing cost, grade of recommendation, patient involvement, economic analysis, number of the developers, style of the products, revision translation, distribution.

Results
Over 40 of them are well-formulated, and almost all of them they have searched only 2 or 3 databases. Using Medline, Igaku-Chuo-Zasshi (Japana Centra Revuo Medicina), and Cochrane Library is most popular. Each GPGs cited on average 600 references that includes 150 Japanese literatures. Over 90% of them are published by commercial company. 1/3 of them are supported by the fund from the Ministry of Health Labour and Welfare.

Discussion
Almost those CPGs are supported by both the Academic Society, and the government indirectory. Our study revealed that there are few Japanese CPGs that include relevant information about patient involvement.

P03

A SUCCESS EXPERIENCE ON TOBACCO CESSATION PROGRAM IN A PUBLIC INSTITUTION IN BRAZIL

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Background
Tobacco addiction programs traditionally present a low indicator of success, in which the quit rate had been around 30%. The aim of these programs is to have tobacco cessation.

Purpose
To determine the effectiveness of interventions for smoking cessation guideline in an outpatient setting.

Methods
Conceição Hospital has a referral service for smoking cessation. 269 patients have participated in the smoking cessation program. A quasi-experiment was designed and three evaluation (enrollment, two and twelve months) were carried out. Those who did not show up were contacted by telephone. The inclusion criteria were patients who had followed the program for at least 4 weeks and a clinical consultation was performed (including medication for smoking cessation). The outcome variable was abstinence of nicotine for at least 72 hours. The other variables were: age, sex, physical dependence grade through Fagerström test. Cox multivariable analysis was carried out and odds ratio (OR) and Confidence Interval (CI) were calculated.

Results
84% of the group of patients who participated in the program was female. The quit rate was 57%. There were 50 patients (19%) who continued to smoke and and 66 patients (24.5%) had returned to smoke. In relation to the use of medication, 123 patients (45%) had used Nicotine Replacement Therapy (NRT), 113 patients (42%) had used bupropion and 33 (12%) had not used any medication at all. A Cox multivariate analysis had shown the following factors associated in relation to relapse: female sex OR=1,1 (CI 95% 0,7-1,6); NRT OR =0.47 CI 95% (0,26-0,83), bupropione OR 0.58 CI 95% (0.33-1.04); Fagerström test >=6 OR= 1.49 (CI 95%0.94-2.36).

Discussion
High intensity behavioural interventions and free medication access and follow-up contact were effective in promoting smoking cessation.

P04

APPROPRIATENESS OF INITIAL TREATMENT FOR MILD-TO-MODERATE LUMINAL CROHN'S DISEASE: APPLICATION OF EPACT CRITERIA TO THE EC-IBD EUROPEAN COHORT

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Background
The appropriate use of therapy for mild-to-moderate luminal Crohn's Disease has never been formally assessed. The European Panel on the Appropriateness of Crohn's Disease Therapy (EPACT) has developed appropriateness criteria to guide physicians in clinical practice.

Purpose
These criteria were applied, retrospectively, to the EC-IBD prospectively-assembled, uniformly-diagnosed European population-based inception cohort of inflammatory bowel disease (IBD) patients diagnosed between 1991 and 1993, to evaluate appropriateness of given therapies.

Methods
EPACT criteria were developed using an explicit method based on published evidence combined with expert opinion). 426 Crohn's Disease (CD) patients from 13 European participating centres (10 countries) were included at the time of diagnosis (first flare, naive patients, no maintenance treatment, not steroid-dependant or refractory). EPACT definition of mild-to-moderate luminal CD and disease location were used to classify patients. The initial drug prescription of this cohort was analysed, according to the EPACT criteria.

Results
163 (38%) of the cohort patients initially suffered from mild-to-moderate luminal CD. The disease location was ileal or ileocolonic for 92 patients (56%) and colonic only for 71 (44%). A single treatment was given in 89 cases (55%) and 74 patients received >1 drug simultaneously or successively during the acute episode. 96 patients (60%) received at least an appropriate treatment, while for 66 patients (40%) the treatment was uncertain and in 1 case (<1%) inappropriate.

Discussion
The EPACT panel criteria (www.epact.ch) were applied, retrospectively, for the first time to a European population-based IBD patient cohort. An appropriate treatment was given in the majority of cases for the initial treatment of mild-to-moderate luminal CD, but was associated with a treatment of uncertain value for two-thirds of the patients, thus increasing the potential risk of adverse events and decreasing (cost-)effectiveness.

P05

ARE TRIAL-BASED GUIDELINES POSSIBLE IN CHRONIC KIDNEY DISEASE?

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Background
Ideally clinical practice guidelines (CPGs) are supported by high quality evidence. However, in comparison with other specialties in internal medicine, randomised controlled trials (RCTs) in nephrology are relatively few in number.

Purpose
To assess the proportion of Caring for Australians with Renal Impairement (CARI) guideline recommendations supported by high quality evidence compared with suggestions for clinical care based on low or missing evidence.

Methods
All Australian CPGs (published 2004-2006) for topics in chronic kidney disease (CKD), dialysis and transplantation were reviewed. For each guideline topic, we referred to the Australian National Health and Medical Research Council's (NHMRC) levels of evidence to assist our data collection on the guideline author's reported use of Level 1 (systematic review), Level 2 (RCTs), Level 3 (pseudo-RCTs, cohort studies, case control studies) and Level 4 evidence (case series), and author opinion.

Results
Of the 129 guideline subtopics reviewed: 56 (43.4%) are supported by at least Level 1 or 2 evidence, 33 (25.6%) are supported by at least Level 3 evidence, 11 (8.5%) are supported by at least Level 4 evidence and 29 (22.5%) are not supported by trial evidence. There was little difference in the proportion of subtopics supported by at least Level 1 or 2 evidence across the CKD, dialysis and transplantation areas.

Discussion
Less than half of the CARI guideline and clinical care statements are supported by high level evidence, confirming the need for more high quality RCT evidence in nephrology. Our results highlight the need for guideline groups to collaborate closely with trial and systematic review organisations (e.g. trial networks, Cochrane Collaboration) to ensure that clinically important topics are investigated, evidence gaps are identified and all high quality evidence is included in a CPG. Ultimately, this will lead to more cost-effective processes and clinically useful CPGs.

P06

BARRIERS TO IMPLEMENT STROKE CPG

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Background
Five stroke rehabilitation units from across Canada participated in a 6-month pilot implementation of evidence-informed practice recommendations (EIPR). Immediately following the implementation, the health care providers (HCP) (occupational therapists, physiotherapists, nurses and hospital management) participated in focus groups to discuss their experiences during the pilot implementation project.

Purpose
The objective of this study was to discuss the barriers that were encountered by the HCP when implementing evidence-informed practice in stroke rehabilitation.

Methods
At each site, a separate 60-90 minute focus group was held with 4-6 participants from each discipline. The groups were facilitated by an individual who was experienced leading focus groups with HCP. Two research team members observed the focus groups and took notes. All groups were audio-recorded and both researchers took detailed notes. Emerging themes were identified and a code book was developed. Two researchers independently reviewed and coded the notes using the code book to verify the emerging themes.

Results
Twenty-one focus groups of 3-6 HCP were held in total. The sessions were held within 2-4 weeks after each site completed the implementation. All groups combined included 79 HCP: 23 OTs, 17 PTs, 23 nurses and 16 directors/managers. There were 6 emerging themes of common barriers that HCP encountered during the pilot implementation. These included lack of time, staffing issues, training/education, provider/ patient safety, equipment, and team functioning/communication.

Discussion
Overall, HCP were receptive to implementing the evidence-informed practice recommendations. However, a variety of barriers were identified at the patient, provider and organizational level. While the issues are categorized into six major themes in this study, it is evident that these categories are not mutually exclusive. Future investigations should examine feasible solutions to overcome the barriers HCP face when translating EIPR into stroke rehab practice.

P07

BENCHMARKING CANCER GUIDELINE DEVELOPMENT ACTIVITIES IN THE COCANCPG CONSORTIUM USING THE AGREE INSTRUMENT

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Background
The CoCanCPG project aims towards cooperation between cancer CPG programmes, and therefore, guideline development methods need to converge. However, important heterogeneity exists for key elements in guideline development. Guideline quality is the result of the methodological rigor of the guideline development processes. By promoting international standards for guideline development and benchmarking cancer CPG programmes against these standards, it is hoped that the standards will be adopted by most programmes leading to higher quality end products.

Purpose
To benchmark 15 CPG development programmes using the AGREE instrument as the standard.

Methods
Based on the information of a systematic survey, the 15 CPG programmes were matched against the AGREE instrument. Nine items (1-3, 7, 15-18, 21), referring to the information contained in the report of a specific guideline rather than to the process used for its development, were excluded.

Results
Although 11 programmes declare using the principles of the AGREE instrument for guideline development, application of the AGREE criteria varies. For example, only one organisation (7%) completely follows the standards in the domain 'Rigour of development'. Five other organisations (33%) follow at least 5 of the 7 items. Seven organisations (47%) follow two or less standards. Item 8 (systematic evidence search) is applied by 9 organisations (60%), 11 organisations search in at least 4 databases. Item 12 (link between evidence and recommendation) is applied by 9 organisations (60%), while item 11 (health benefits, side effects and risks considered when formulating recommendations) is applied by only 4 organisations (27%).

Discussion
This is the first benchmarking exercise of CPG development processes. These results provide a basis for future collaboration and might stimulate organisations to adjust their procedures. The next steps of the CoCanCPG project are a detailed benchmarking of search, selection and synthesis of the evidence to define common procedures for CPG development to facilitate future collaboration.

P08

BRAZILIAN GUIDELINES: CEBM-OXFORD GRADES OF RECOMMENDATION AND THE IMPACT-FACTOR

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Background
The guidelines developed by Brazilian Medical Association (http://www.projetodiretrizes.org.br/) provide evidence-based recommendations that are graded by Oxford-CEBM levels of evidence (http://www.cebm.net/levels_of_evidence.asp)

Purpose
Appraise the JCR-2005 "Impact Factor" of the journals related to the articles that support the recommendations of the guidelines, and compare it with CEBM-Oxford grades of recommendation, since these grades speak directly to the validity of evidence, considering only the methodological quality of original articles.

Methods
The scientific articles were selected by the physicians of the national specialty societies, to develop the guidelines. Independently, two clinical epidemiologists recorded the grades of recommendation A, B, C and D. For each one of these grades, we calculate the mean of the "impact factor" of the journals where the articles were published.

Results
We search 11 guidelines with the total of 395 bibliographic citations. The guidelines was about thyroid cancer, endometrial cancer, turner syndrome, surgical complicated kidney transplantation, congenital neck neoplasm, nutritional treatment of obesity, pharmacological treatment of obesity, acute medial otitis, postmenopausal osteoporosis and fibromyalgia. The narrative review articles published in high "impact factor" journals (13) and the Cochrane Reviews (19) was discarded. We find 79 articles with grade A, 131 grade B, 53 grade C and 99 grade D. The mean of the Impact-Factors was respectively 9.187 for articles graded A, 4.978 for grade B, 2.952 for grade C and 2.006 for grade D.

Discussion
The processes of developing Brazilian Guidelines allowed us to show that CEBM Oxford criteria for evaluate the methodological quality of the articles that support the recommendations are directly related with the traditional criteria to asses the impact of the journal where these articles were published.

P09

CANCER CARE ONTARIO PROGRAM IN EVIDENCE-BASED CARE: 10 YEAR REVIEW

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Background
The Cancer Care Ontario Program in Evidence-based Care (CCOPEBC) is a publicly funded program that has existed since 1997. The CCOPEBC's core responsibility is the development and dissemination of oncology-related evidence-based products for health care professionals in the province of Ontario, Canada.

Purpose
The purpose of this abstract is to highlight the past, present and future activities of the CCOPEBC.

Methods
A review was undertaken to determine the activities and productivity of the Program over the last 10 years and to identify areas for future development.

Results
The Program began with the formation of 10 standing committees of volunteer health care professionals supported by PEBC staff. These committees represented the major cancer disease sites and their work mainly focused on the development of treatment-related clinical practice guidelines (CPGs). These committees still exist, but the CCOPEBC recently has undertaken collaborations with nine Cancer Care Ontario programs to broaden the scope of its activities. In addition to treatment guidelines, there are now guidelines representing other aspects of the continuum of cancer care including prevention, diagnosis, screening and palliative care.
The number of products completed in any given year has increased from 10-12 at the beginning to 42 for 2006. At the end of 2006, the CCOPEBC had completed a grand total of 173 products.
CPGs were and still are the primary product produced by the CCOPEBC. However, recently, the Program has begun to develop methodologies for organizational and practice standards.

Discussion
After 10 years, the CCOPEBC is recognized as a leader in the production of oncology-related CPGs and has contributed significantly to the development of an evidence-based culture of learning and sharing for oncology professionals. The CCOPEBC plans to continue production of CPGs and organizational standards and to further refine the use of environmental scan, adaptation and formal consensus methods.

P10

GUIDELINE IMPLEMENTATION: A CANMEDS PERSPECTIVE

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Background
The Royal College of Physicians and Surgeons of Canada CanMEDs initiative has identified the roles of a physician: medical expert, communicator, collaborator, scholar, manager, advocate and professional. Each role has specific competencies described. Implementation of guidelines impacts on practice in each of these roles. Effective guideline implementation requires that each role be addressed.

Purpose
To identify and discuss how the implementation of guidelines impacts on each of the CanMEDS roles in a practical scenario.

Methods
A panel of physicians, an ethicist, psychologist and educator with an interest in education and guideline implementation has been assembled to address each of the CanMEDs roles in the practical setting of the recently published guidelines for screening for aortic aneurysms.

Results
This scenario will be used to relate the CanMEDs initiative, guideline implementation strategies and education opportunities. As a specific example, professional and ethical issues relate to physician self-referral, societal responsibilities and individual patient's access, freedoms and limitations imposed within the guidelines. Specific crossover to scholarly, advocacy, communication, collaboration and management issues arise from this.

Discussion
Brief formal presentations based on case examples related to each role will be followed by open discussion amongst the panelists and participants.

Specific areas of focus to be addressed include: guideline development and implementation, achieving consensus, linking guidelines to education, Continuing Professional Development, monitoring use of guidelines and networking

P11

CLINIPEARLS: COLLABORATION FOR ELECTRONIC DECISION SUPPORT AT THE POINT OF CARE

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Background
Family physicians are becoming increasingly competent using information and communication technologies. Many have come to expect clinically relevant content to be available in formats such as PDAs. Previous research done by the UBC Faculty of Medicine, Division of Continuing Professional Development and Knowledge Translation (UBC CPDKT) suggested a strong need for clinical practice guidelines (CPGs) that were both easy to use and suited to point-of-care (POC) decision support. A recent survey of B.C. physicians' learning needs found over 50% currently use PDAs; 60% desired training in the usage of handheld technologies to access CPGs. Further; compliance in the use of guidelines is poor.

Purpose
UBC CPDKT was engaged by the Ministry of Health, B.C. Guidelines and Protocols Advisory Committee, B.C. Medical Association, and B.C. Cancer Agency to develop a software system to deliver reformatted guidelines to healthcare providers for POC use via PDA and web interface. To increase uptake and adherence of CPGS this initiative aimed to create a common platform accessible and effective for all physicians.

Methods
Building on existing research the partners collaboratively developed a system to facilitate condensing, entering and updating of guideline content through a web/desktop interface. The development process involved building consensus around standardized presentation of the guidelines so they are easily accessible and usable for physicians.

Results
To date, we have developed CPGs for nine chronic diseases and two for cancer in a format suitable for delivery via PDAs. The resulting product complements existing guidelines and provides a new format specifically addressing practitioners' POC needs.

Discussion
Future directions include developing additional modules and integrating content from other groups. We aim to evaluate the uptake of these guidelines, their impact on physicians' practice patterns and the usability and efficacy of CliniPearls software as well as understand its potential for facilitating ehealth integration.

P12

COMPARISON OF GUIDELINE DEVELOPMENT METHODOLOGIES USED BY 7 GUIDELINE GROUPS

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Background
There are many clinical practice guidelines (CPGs) available for consumers and practitioners to refer to. The process of developing evidence-based CPGs is labour-intensive and expensive. There are calls for guideline organisations to pool their resources and develop guidelines collaboratively.

Purpose
To compare the CARI Guidelines development process with the process used by a number of major guideline organisations.

Methods
Six guideline organisations (APRAC, NZGG, SIGN, NICE, KDOQI, EBPG), apart from CARI, had their guideline development process reviewed. The latest Australian NHMRC guidance on essential steps in guideline development was used as a benchmark. A sample recent guideline from each organisation was also assessed using the AGREE criteria.

Results
Of the 15 process steps suggested by the NHMRC, one group (APRAC) performed 13 steps; two groups performed 11 (NZGG, NICE) and the remainder carried out only nine of the recommended actions. A comparison of four selected process steps showed that 5 of 7 groups have a rigorous process for topic selection, 5 of 7 group members received critical appraisal training, 2 of 7 groups conduct adequate economic evaluations, while all groups hold adequate stakeholder consultations. The sample guideline assessment revealed the variable quality of guidelines with only 2 of 7 groups getting a high overall score (NZGG = 18/23; NICE = 17/22).

Discussion
There are wide variations in the process used by different groups and some of these are due to the difference in resources available to groups, but not all. For example, many of the well-funded groups did not have an economic analysis done for their guideline. The updated NHMRC suggested process is extensive and some steps were commonly not performed by most groups (e.g. determination of benefits/harms). Some steps such as cost-effectiveness analysis will be hard for groups to achieve because of resource issues.

P13

CONSUMER INPUT INTO GUIDELINES: THE CONSUMER ROLE IN SETTING STANDARDS AND TRANSFERRING KNOWLEDGE

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Background
Consumers are finding their voice. The internet features consumer opinion on a range of products and services. Healthcare, however, has lagged. "If I have breast cancer, or you have prostate cancer, where do we find the data we need? Ironically, data about performance-not feelings-are readily available for cars, mutual funds, cereals, but not for the most important consumer purchase, the one that will determine whether we live or die." (R Herzlinger, quoted in The Wall Street Journal, September 14, 2006).

Guidelines are most often developed by experts, with input from the librarian and research community. Patient input is limited at best. The current online IOM News (April 16, 2007) notes "there is a growing appreciation for the centrality of patient involvement as a contributor to positive healthcare outcomes, and as a catalyst for change in healthcare delivery."

There are several sites that systematically seek input from the consumers of healthcare, and a few are have gained some traction, especially in focused markets

Purpose
The purpose is to showcase the contribution of web-based patient input. This poster will provide an overview of current development efforts, and will focus on specific examples that are directly or potentially applicable to the process of guideline development and update.

Methods
The poster will feature online review of selected sites along with an evaluation of the impact or potential impact on existing guideline efforts.

Results
The evaluation of the impact or potential impact on existing guideline efforts will be limited to specific examples.

Discussion
The discussion is an extension of the IOM's "Learning Healthcare System" theme, "opportunities for consumer engagement."

P14

DEVELOPING EVIDENCE-BASED BIPOLAR DISORDER CLINICAL PERFORMANCE MEASURES

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Background
The STAndards for BipoLar Excellence (STABLE) Project is a quality improvement initiative to advance the care of persons with bipolar disorder through the development of evidence-based process performance measures. A National Coordinating Council (NCC) comprised of national content experts in bipolar disorder, psychiatric practice, primary care practice, and quality measurement was convened to guide and direct the STABLE Project. The Project developed measures that were important, scientifically acceptable, valid, reliable, feasible, useable and actionable.

Purpose
STABLE Project Goals:
1. Identify, develop, and test evidence-based clinical performance measures for bipolar disorder
2. Develop a quality improvement mechanism, STABLE Resource Toolkit, to support use of the measures in out-patient practice
3. Seek endorsement and promote adoption and use of the performance measures by public and private national stakeholders

Methods
Phase I: Select concept statements using RAND Appropriateness Method
Phase II: Operationalize the measures; develop specifications and data collection strategy
Phase III: Pre-pilot data collection strategy
Phase IV: Pilot Test, collection of data, determine feasibility and inter-rater reliability
Phase V: Field Study: 800 records in 80 Out Patient sites, geographically dispersed in U.S.A. Continue data feasibility and inter-rater reliability
Phase VI: Analyze findings using data algorithms
Phase VII: Final NCC review and selection

Results
15 evidence-based performance measures

5 measures endorsed by the National Quality Forum; December 2006

Field test results suggest need for significant improvement in following evidence-based guidelines

Discussion
Evidence-based clinical performance measures were developed by an expert panel. Measures were derived from following guidelines:
American Psychiatric Association, Practice Guideline for the Treatment of Patients with Bipolar disorder (2002)
2004 Expert Consensus Guideline for Treatment of Bipolar Disorder
Texas Implementation of Medication Algorithms; 2005
2005 Canadian Network for Mood and Anxiety Treatments (CANMAT) Guidelines for the Management of Patients with Bipolar Disorder
Rigorous process resulted in 15 performance measures available in the public domain.

P15

DEVELOPMENT OF CANADIAN GUIDELINES FOR THE PREVENTION AND MANAGEMENT OF COMMUNITY-ASSOCIATED METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS IN CANADA: AN EXAMPLE OF MEDICAL EDUCATION IN A CANMEDS FRAMEWORK

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Background
Community-Associated Methicillin-Resistant Staphylococcus aureus (CA-MRSA) has emerged in epidemic proportions in several US communities, and has already made inroads in Canada. To address this urgent problem, new Canadian guidelines for the prevention and management of CA-MRSA have been developed, with the participation of infectious diseases trainees.

Purpose
To describe the process of CA-MRSA guideline development, as an illustration of a medical education initiative satisfying CanMEDS objectives.

Methods
Sources of information for the guidelines included a comprehensive literature review, a multi-disciplinary Working Group meeting of Canadian experts, and a writing committee who debated and revised the objectives in a rigorous iterative process. In order to disseminate information from this expert consensus document to frontline practitioners, the following methods were used: (1) publication of full guidelines with online access; (2) publication of a public health commentary in the Canadian Medical Association Journal with wide readership among Canadian practitioners, with media coverage including CTV News, the Toronto Star, and the National Review of Medicine; (3) numerous oral presentations targeting pediatric residents, practicing pediatricians, infection control practitioners, and infectious disease trainees and specialists. Infectious diseases trainees participated in the guideline process at all stages, including as principal authors of the full guidelines.

Results
Knowledge translation of expert consensus recommendations has been undertaken through publication in scholarly journals and mainstream media and through numerous oral presentations to critical stakeholders (frontline practitioners and trainees). The guideline development process reflects the CanMEDS essential physician competencies of Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar, and Professional.

Discussion
Participation in the development of practice guidelines may be an effective tool for medical education.

P16

ECONOMIC IMPACT OF IMPLEMENTATION OF REGIONAL GUIDELINES FOR HIP FRACTURE IN THE HEALTHCARE SYSTEM OF MARCHE REGION-ITALY

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Background
Regional Healthcare Agency of Marche Region (Italy) planned and delivered implementation of regional guidelines to improve clinical outcomes for all people with hip fracture

Purpose
This study assesses the potential economic impact of implementation of the regional guidelines for hip fracture using integrated clinical pathway

Methods
The study's perspective is that of a target hospital trust. The study is based on the analysis of the production costs to treat patients with hip fracture.
Costs are estimated by reviewing medical records of patients with hip fracture treated in the target hospital trust from 31st March 2006 to 30th June 2006, under the following criteria:
1.surgery within 72 hours from admission;
2.length of hospital stay between 25° and 75° percentiles of hospital length stay for hip fracture (in the target hospital in the same period);
The theoretical cost of clinical pathway is estimated on the basis of consumptions of health care as recommended by the regional guidelines. The theoretical cost of clinical pathway is compared to the median cost per patient sustained by the hospital trust.

Results
It is estimated that the introduction of the clinical pathway would decrease the median cost per patient, from 2,841 euro to 2,746 euro. The decrease is the consequence of the following factors:
- reduction in the consumption of drugs
- reduction in the use of laboratory test and of diagnostic imaging
- elimination of non recommended procedures (e.g. routine vescical catheterization and routine use of temporary leg traction)
- introduction of new recommended procedures (e.g. multidisciplinary assessment by a geriatric team)

Discussion
Implementation of clinical pathway, based on the regional guidelines, could save resources by improving health care based on scientific evidence. Costs for treating patients according to clinical pathway will be closely monitored to verify achievements of its implementation over a period of time.

P17

EVALUATION OF A MULTI-CENTRE EMERGENCY DEPARTMENT ADULT ASTHMA CARE PATHWAY PILOT PROJECT

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Background
Gaps between current practice and guidelines for asthma management in the emergency department (ED) exist in Ontario. The Ontario Hospital Association (OHA)'s Asthma Care Pathway (ACP) includes pre-printed orders, medication guidelines, a teaching checklist and discharge instructions.

Purpose
To evaluate whether the OHA's ED ACP improves adherence with Canadian ED asthma management guidelines and outcomes.

Methods
10 Ontario hospital EDs (5 intervention (I), 5 control (C)) participated in a pre-post intervention study of adults (>19 years of age) with asthma. Asthma care was compared by intention-to-treat analysis (change (post-pre) at I versus (vs.) C sites) and by ACP use vs. non-use at I sites.

Results
Participation rates were 356/647 (55%) pre, 384/553 (69%) post; 340/653 pre (52%), 349/540 (65%) post for I and C respectively. 101/383 visits at I sites used the ACP (26%; range 6-60%). I vs. C sites increased use of salbutamol by MDI (+28% vs -16%, p<0.0001), ipratropium by MDI (+18% vs. -20%, p<0.0001), documented more inhaler teaching (+10% vs. -0.2%, <0.0001) and made more referrals to specialized asthma services (+21% vs. +4%; p<0.0001). At I sites, patients on vs. not on the ACP had increased use of peak flow recordings (71% vs. 27%, p<0.0001), systemic steroids in ED (63% vs. 36%, p<0.0001) and on discharge (62% vs. 35%, p=0.0007), as well as documentation of any teaching (47% vs 24%, p<0.0001) and follow-up care arrangements (61% vs. 45%, p=0.005).

Discussion
The OHA's Adult Asthma ED ACP increased adherence with ED management guidelines, education and referrals. Since use of the ACP varied widely, even greater improvements may be observed if barriers to use can be overcome.

P18

AN EMERGING PARTNERSHIP MODEL: COLLABORATION BETWEEN A REGULATORY BODY AND MEMBERS TO ENHANCE APPLICATION OF STANDARDS AND GUIDELINES IN THE DIMENSIONS OF NURSING PRACTICE

Czerniawski, Barbara, Adler, Lori, Kreick, Myra, Levesque, Linda, Stec, Sandra, McNabb, Angela (College of Nurses of Ontario, Toronto, Ontario)

Background
The College of Nurses of Ontario (CNO) mission is to protect the public's right to quality nursing services by providing leadership to the nursing profession in self regulation. A new Outreach Program was developed to address the nurse's needs in integrating standards into practice. This unique practice sector specific program is based on a collaborative model with nurses across the province.

Purpose
The goal of the program is to link the CNO with the continuously evolving practice setting realities of nurses.

Methods
CNO, through the Outreach Program, is developing communities of practice drawing on sector expertise to establish priorities and enhance policy development.
Environmental scans, accomplished by seeking feedback from nursing leadership, sector advisory groups and individual consultation, have identified trends and issues that are impacting the specific sectors. The Nursing Leadership Advisory Group is comprised of nurse leaders from each sector. Sector Advisory Groups (SAG) are made up of a diverse cross section of nurses working in all categories, roles and practice sectors across Ontario.

Results
An overview of this innovative partnership from the perspectives of the College of Nurses, nurse leaders and nurses from a variety of practice settings will be presented. A brief overview of trends and issues from sector groups will be presented.

Discussion
The fit between current practice realities and the regulatory body's practice standards and guidelines will be explored from the CNO and nurse perspectives. Discussion will address the potential of this program to strengthen CNO's role within the many dimensions of practice and to actively engage nurses in self regulation. Discussion from a SAG member will incorporate how this strategic partnership has enhanced practice and impacted on the dissemination of information from the CNO.

P19

EVALUATING GUIDELINE IMPLEMENTATION STRATEGIES OF A PRIVATE HEALTH PLAN

Jussara Munareto, Jorge Azevedo, Airton Tetelbom Stein, Ronaldo Bordin (Unimed Porto Alegre, Epidemiology Postgraduation Ufrgs, Epidemiology Postgraduation Ufrgs)

Background
Inappropriate laboratory utilization (overuse and underuse) have been wasting health limited resources and there is a need to rationalize the use of diagnostic test in ambulatory settings.

Purpose
To evaluate guideline implementation strategies on diagnostic tests that is requested in ambulatory setting. To compare ordered tests between intervention and control groups based on guidelines

Methods
A randomized controlled trial will be carried out in a stratified sample to evaluate the adhesion by physicians of two diagnostic guidelines in patients seen at ambulatory care linked to a Private Health Plan in Southern Brazil (Unimed Porto Alegre). In the intervention group a guideline will be presented to clinicians on the evaluation of thyroid and the other for obstetricians guiding on the collection of streptococcus of the vagina and anus in the last month of pregnancy. Academic detailing based on these guidelines will be performed at the physician's office (the intervention group) and those in the control one will be evaluated without any teaching.

Results
Guidelines on rational use of thyroid tests and how frequent to collect streptococcus tests in pregnant women have already been developed. The average number of tests ordered per patient
during six months for each physician's group (intervention and control) will be performed.

Discussion
The choice of thyroid tests and streptococcus tests were based on well known identification that the first is overused and the latter is underused. Both recommendations are regarded as highly recommended. This randomized control trial will evaluate the application of academic detailing on the rational use of diagnostic tests in Brazil.

P20

EVALUATION OF THE IMPLEMENTATION OF HYPERTENSION GUIDELINE IN A POOR POPULATION

Stein AT, Gleice Gatti Bottarelli, Mauro Binz Kalil (Guideline Coordinator of Conceição Hospital, Public Health Professor of FFFCMPA and ULBRA , Family Practice Resident of Community Health Service of Conceição Hospital)

Background
There are abundant data showing a link between poverty and ill health. The problem of inequality in health is very relevant in every country. Authors have shown that hypertension accounts for nearly 6% of the global burden of deaths. Several studies have shown that individuals with lower socioeconomic status, as measured by education and/or occupation, are more likely to have cardiovascular disease than are individuals with higher socioeconomic status.

Purpose
To evaluate the implementation of a hypertension guideline in a poor community.

Methods
A home based cross-sectional study in order to identify every hypertension that lives in a shanty town was carried out in the North area of Porto Alegre, Brazil where 206 adults older than 20 years old live. The Community Health Service of Conceição Hospital provides comprehensive primary health care to this community. The hypertension program implemented is based on the Seventh Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure.

Results
The hypertension prevalence in the shanty town was 16%. The description of the population identifies that 25 (76%) were women, the mean age was 51 years old, 18.18% were diabetes, 21.21% were smokers and 84.84% had used the local primary health care unit. In the last 12 months, 33% of the patients did not seek medical care and 54.55% reported to use regularly the medication. Systolic pressure was higher than 140 mmHG in 51.52% and 27% of the patients had the tests ordered according to the Seventh Report of JNC.

Discussion
The urban poor in the developing world has a high prevalence of hypertension and there is a need to implement effectively guidelines on this vulnerable population. This study has supported the poor management of hypertension in the most vulnerable population.

P21

EVIDENCE BASED INDICATIONS OF DRESSINGS: SYSTEMATIC REVIEW AND FORMAL CONSENSUS

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Background
Current clinical practice guidelines on the treatment of chronic or surgical wounds have not established a care strategy for each type of wound.

Purpose
To derive a consensus on the use of modern dressings in healing wounds by secondary intention.

Methods
Critical review of studies with the following endpoints: rate of complete healing, time to complete healing, rate of change in wound area, and general performance criteria (MEDLINE, EMBASE, Cochrane trials register; Jan. 1990-Jun. 2006).
Consensus process (derived from the nominal group technique adapted by RAND/UCLA): A questionnaire on chronic wounds and one on acute wounds including burns were sent to experts with long-standing experience of wound care. The two panels were selected from lists of nursing staff and physicians (specialists/general practitioners) provided by 15 French learned societies. They scored the value of each possible dressing/indication combination in two rounds of rating. The final recommendations were peer reviewed by a Working Group.

Results
Systematic review: (i) Hydrocolloid dressings proved superior to saline gauze or paraffin gauze for the complete healing of chronic wounds; (ii) alginates were better than other modern dressings at the debridement stage; (iii) hydrofiber and foam dressings, when compared with other traditional dressings or a silver dressing, respectively, reduced time to healing of acute wounds; (iv) no dressings had special clinical value in terms of general performance criteria.
A strong consensus was reached for the following combinations: For chronic wounds: (i) debridement stage, hydrogels; (ii) granulation stage, foam and low-adherence dressings; (iii) epithelisation stage, hydrocolloid and low-adherence dressings. For the epithelisation stage of acute wounds, low-adherence dressings. For fragile skin, low-adherence dressings; for hemorrhagic wounds, alginates; for malodorous wounds, activated charcoal dressings.

Discussion
This work constitutes a sound basis for establishing guidelines for the use of modern dressings in the treatment of chronic and acute wounds.

P22

IDENTIFYING, ASSESSING, SUMMARISING AND PRESENTING EVIDENCE FOR PRESCRIBING AND DRUG USE INTERVENTIONS DIRECTED TO CONSUMERS

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Background
The Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) aims to identify and promote best practices in drug prescribing and use by health care professionals and consumers. The Cochrane Effective Practice and Organisation of Care (EPOC) and the Consumers and Communication Review (CC&CRG) Groups have expertise to synthesise and summarise this evidence.

Purpose
Identify, assess and summarise synthesised evidence of the effects of interventions directed to consumers to change prescribing and drug use. Facilitate access to and use of this evidence in an on-line database.

Methods
EPOC and CC&CRG systematically searched for systematic reviews in the Cochrane and DARE databases. A taxonomy to organise the literature was developed. Review quality was assessed using AMSTAR. Methods to summarise the evidence into useful summaries with statistics, and to standardise statements of the effectiveness of interventions were developed. The database was designed to facilitate access.

Results
A database of summaries of systematic reviews of interventions directed to consumers and professionals to improve drug prescribing and use was created (http://www.cadth.ca/index.php/en/compus/optimal-ther-resources/interventions). The taxonomy organsises the database into easy-to-browse categories. The overall effects of the interventions are summarised and user-friendly summaries of the individual reviews highlight key information and relevant evidence for decision makers. Evidence focuses primarily on adherence, additional research evaluating other outcomes is needed. Practical medication management strategies, self-monitoring, reminders and simplified dosing are generally effective, although successful elements of those interventions are not well understood. Mixed results were found for interventions such as mass mailings, packaging changes and patient support. No evidence for consumer participation was found; more research is needed.

Discussion
A user-friendly and useful resource was developed for decision makers by using rigorous methods to identify, assess, summarise and present synthesised evidence.

P23

EVIDENCE FOR QUALITY (EQUAL) IN MALAYSIAN CLINICAL PRACTICE GUIDELINES FOR TB DISEASE (PHASE 1)

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Background
There is great reason to believe that the translation of evidence to high quality care encounters peculiar difficulties in the health care systems of developing countries. Therefore a study was conducted to examine the development of Evidence Based tools for Tuberculosis Management in Malaysia as part of a similar intercountry (Philippines, Thailand. Indonesia, Vietnam and Australia) effort for comparison

Purpose
To assess the methodological quality of 3 clinical practice guidelines (CPGs) on tuberculosis: 1994 - Guidelines for chemotherapy, 1996 - Guidelines on management of TB, 2002 - CPG

Methods
Each guideline was assessed independently within one month by four appraisers using Shaneyfelt and Appraisal of Guidelines for Research & Evaluation (AGREE) Instruments.

Results
There seems to be good agreement among the appraisers using the Shaynefelt instrument than using the Agree instrument. The appraisers agreed in 76% (19/25) of the items in the Shaynefelt instrument whereas for the Agree instrument, the appraisers agreed in 39% (9/23) of the items for the 1994 CPG. The appraisers agreed in 68% (17/25) of the items in the Shaynefelt instrument whereas for the Agree instrument, the appraisers agreed in 35% (8/23) of the items for the 1996 CPG. The appraisers agreed in 60% (15/25) of the items in the Shaynefelt instrument whereas for the Agree instrument, the appraisers agreed in 30% (7/23) of the items for the 2002 CPG.

Discussion
Qualitatively, the appraisers choose the Agree instrument. However, quantitatively, there were more agreements among appraisers using the Shaynefelt instrument. Owing to the strengths and weaknesses of each instrument, the reviewers decided to use both. Using the AGREE instrument the reviewers would recommend the CPG with some alterations to some improvements of the domains. Although these guidelines may accurately reflect clinical practice, few adhere to the standards set forth by the AGREE instrument.

P24

PROCESS AND PROGRESS EXPERIENCED WITH DEVELOPMENT OF GUIDELINES FOR UPPER EXTREMITY MUSCULOSKELETAL DISORDERS IN TWO REHABILITATION-FOCUSED PROFESSIONAL ORGANIZATIONS

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Background
There are challenges in developing clinical practice guidelines (CPGs) that deal with upper extremity musculoskeletal(MSK) disorders. Currently available CPGs are of low quality. Challenges include a lack of strong evidence on the effectiveness of either specific interventions or overall approaches, inconsistent use of reliable and valid outcome measures in reported studies, that rehabilitation varies at different stages of a disorder, the lack of classification scales to sort different prognostic, severity or staging subgroups and the multimodal/ patient-specific nature of rehabilitation interventions

Purpose
The purpose of this presentation is to share the challenges, approaches and progress towards developing CPGs in the area of MSK upper extremity disability in collaboration with 2 different profession groups: the American Physical Therapy Association and the American Society of Hand Therapists.

Methods
Review of current experience,process/outcomes in two different organizations developing CPGs in this area.

Results
Both professional associations have supported guidelines development committees, but success in moving forward has been related to funding and number/expertise of leaders. The lack of RCTs has been dealt in one group by using critical appraisal forms that address quality of lower levels studies and in others by making evidence review less formal. A strategy used by some groups has been to survey used/valued interventions to identify current "standard" professional practice. Even in higher quality studies descriptions of interventions, particularly exercise and education were so poor they were not reproducible. Patient input was variable but some groups used "qualitative" interviews with success. One organization decided to link guideline development to an ICF framework, and focused to a greater extent on prognostic classification/factors and outcome measures. All groups struggled with how to define practice in grey areas and how to provide specific, useable information

Discussion
It is difficult to create specific and usable CPGs for MSK practice

P25

GUIDELINE ADAPTATION: ALBERTA CANCER BOARD PROVINCIAL BREAST TUMOUR GROUP INITIATIVE ON THE OPTIMAL USE OF TAXANES IN THE MANAGEMENT OF METASTATIC BREAST CANCER

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Background
A current, evidence-based practice guideline pertaining to taxane utilization in the management of metastatic breast cancer has not yet been taken on by the Alberta Cancer Board.

Purpose
The purpose of this initiative is to create a provincial guideline on the optimal use of taxanes in the management of metastatic breast cancer using a formal guideline adaptation method, and to evaluate the process.

Methods
A multidisciplinary panel was assembled in January 2007. Panel co-chairs developed a protocol based on the Phases and Modules of the ADAPTE Manual, Version 1.0. The process will be assessed before initiation and after completion using preliminary ADAPTE Second Perception and Final Evaluation forms respectively.

Results
Inter-rater reliability for assessment of items in the Second Perception Form was excellent(Cronbach's alpha = 0.96). The ADAPTE process was perceived as being clear, useful, comprehensive, and appropriate in design. Confidence in feasibility was highly rated. Set-Up Phase was completed and Adaptation Phase started in February 2007. Cancer Care Ontario (CCO) and National Institute for Clinical Excellence (NICE) guidelines were selected and assessed for quality using the AGREE instrument and ADAPTE Tool 13. Inter-rater reliability for assessment of the CCO guideline was high but low for the NICE guideline. Most panel members recommended both guidelines for use in clinical practice with provisos. The main proviso raised was currency and hence, relevant literature published since the CCO and NICE guidelines has also been considered. Recommendations have been adapted, and de novo recommendations added. Final Production Phase will commence in April 2007.

Discussion
At the outset of this initiative, the ADAPTE method was perceived to be a feasible process for local guideline development. An adapted guideline for use by the Alberta Cancer Board is pending external review. Results from the Final Evaluation form will be presented.

P26

TEACHING HOSPITAL AND A GUIDELINE COORDINATION CENTER: STRATEGIES FOR DECISION MAKING BASED ON THE BEST EVIDENCE

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Background
Having a guideline sector and providing easy access for up-to-date information is important for a teaching hospital. Guideline can provide a foundation for assessing and evaluating the quality and effectiveness of health care.

Purpose
To stimulate the implementation of guidelines by residents as well as by health professional staff.

Methods
Grupo Hospitalar Conceição includes 4 hospital (a General Hospital with 882 beds, a Gynecology and Obstetric Hospital with 189 beds, a Pediatric Hospital with 222 beds and a Trauma Hospital with 282 beds) and a Community Health Service with a catchment's area of 125.000 inhabitants. This Group belongs to the Ministry of Health and the staff comprises 6685 people. Care provision is free of charge and is part of Brazilian Unified Health System. A specialist on evidence based medicine is available to provide support to use this evidence on the development of guidelines. There is a documentation center, where there is easy access for Cochrane Database, a number of full text digital journals, a virtual library of Bireme which includes Scielo, Lilacs and Medline. The documentation center has librarians who are in charge of the organization of the material and also offer continuing education on how to search the literature.

Results
All publications that have been developed by the Conceição Health Professionals are listed online, including the guidelines produced by these professionals. There are 40 guidelines that have been developed in the last three years. These guidelines are available in the internet and are discussed during clinical rounds for adjustments. This is a way to disseminate the local scientific products by the health professionals and a strategy to achieve sustainability for the implementation of guidelines.

Discussion
The development and implementation of guidelines is a way to enhance the application of the best evidence for the decision process.

P27

GUIDELINE IMPLEMENTATION IN GERMANY

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Background
In Germany, a national disease management (DM) programme was established in 2000 to link prevention, acute care, rehabilitation and chronic care for high priority healthcare topics. Against this background AQuMed developed a strategy to institutionalise a "National DM CPG Programme" in 2002.

Purpose
Key goals: (1) Physicians' key organisations to consent on rational, methods, organisation of a guideline programme within 1 year; (2) guideline development for 4 topics to start within 2 years involving relevant stakeholders, (3) consumer participation to start within 3 years, (4) 4 EB-CPGs to be disseminated within 4 years, (5) evaluation of 1 implementation to be started within 5 years.

Methods
(1) Adaptation and dissemination of international methodologies, (2) business plan for a national guideline programme; (3) lobbying within stakeholders of physicians' scientific and political organisations; (4) establishment of a national guideline bureau; (5) guideline adaption; (6) multidimensional dissemination; (7) structured implementation on regional level; (8) controlled evaluation study.

Results
A national guideline bureau was established by the German Med. Ass. in 2002. In 2003 the umbrella organisations of the scientific medical associations (n=150) and of all German panel physicians (n = 120,000) joined the programme and consented on a guideline methodology. Guidelines for asthma, COPD, CHD, Diabetes were developed and disseminated 2003-2006. Consumer involvement started in 2005 with 3 patient guidelines disseminated in 2006,2007. Regional panel physicians' quality circles have been developing and using guideline based pathways for use in primary care practices. An evaluation study on the asthma guideline implementation started in 2006.

Discussion
While consenting on needs, methodological and organisational issues, a countrywide disease management guideline programme was established within 4 years, Until 2008 12 living guidelines will be finalized and implemented into national quality management and regional care settings. programmes.

P28

GUIDELINES AND THE ICT IN HUNGARY

Csilla Dobai M.D. (Medical Center of University of Debrecen/Hungary)

Background

Nowadays there is a reform of the health care system going on in Hungary. What the professional background of reform changes is in Hungary, and what changes we could expect in the quality of primary care

Purpose

To give a more common position for EBM in the PHC system , using, development. and adaptation. of the clinical guidelines

Methods

What the best option is for introducing of clinical guidelines into the practice and for the everyday use by more and more GP.-s.

Results

1. The GP software connected to a special server, providing a semantics-based healthcare information infrastructure, to seamlessly integrate services and information, that, through a proper level of care Knowledge Management and a Decision Support System, supporting knowledge driven collaborative practices in Networks of Healthcare Professionals of new member States, in order to minimise medical errors in diagnosis and treatment. (The RIGHT project will gather the technical and scientific partners, users and multipliers coming from across the Europe and in particular from the new member States allowing the necessary integration of the research effort in ICT in an enlarged Union.)

2. The GP software is based upon the protocol managed healthcare ICT, which is strictly managing the problem solving and the patient care. Advantage of this system is that the protocols and clinical guidelines continuously help the work of GP-s and nurses.

System could connect to the other servers or databases.

Combined use of both systems, which solution has opportunity.

The developing process of both systems had been started, running parallel with adaptation of foreign clinical guidelines and their development by own.

Discussion

There isn't any organisation of the condition for accreditation of the softwares.

P29

GUIDELINES ARE EASY TO CREATE: PUTTING THEM INTO PRACTICE IS ANOTHER MATTER: THE OCFP'S COMPREHENSIVE MEDICAL EDUCATION PROGRAM

Jan Kasperski (CEO, Ontario College of Family Physicians)

Background

The Ontario College of Family Physicians (OCFP) has been significantly successful in working with the Guideline Advisory Committee (GAC) in Ontario to implement comprehensive medical education programs anchored in GAC's approved guidelines. The presentation will walk the audience through our journey and discovery from the Collaborative Mental Health Care Network to our standardized 18 Months Visit.

The practical application of guidelines through multiple educational formats including peer presenter workshops, facilitated small groups learning opportunities and web-based interactive education programs, focus on physician practice tools kits and patient education tools to translate guidelines into practice change.

P30

GUIDELINES FOR ADOLESCENT DEPRESSION IN PRIMARY CARE (GLAD PC): ADAPTATION FOR THE CANADIAN PRIMARY CARE SETTING

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Background

Depression in adolescence is a serious disorder that causes significant morbidity and mortality. However, primary care(PC) practitioners have not been trained to identify and treat adolescent depression. Thus, a substantial gap exists between the need for effective treatment of adolescent depression and the capability of PC practitioners to meet this need.

To meet this need, GLAD PC was developed by a group of stakeholders consisting of: experts in adolescent depression; PC practitioners; patient/parent groups; and policy makers from the United States and Canada. Their goal was to develop a set of evidence based guidelines, and toolkit that could be used by PC practitioners to identify, and manage adolescent depression.

Purpose

We will pilot the GLAD-PC toolkit in the Canadian setting with the purpose of adapting it for use in the Canadian primary health care context.

Methods

The research plan has four components: content review; initial refinement; feasibility application and final refinement. After our convenience sample of 40 PC practitioners from 2 provinces completes the content review and provides feedback through focus groups, the toolkit will go through initial refinement to reflect the feedback. The revised toolkit will then be applied in everyday clinical settings by the same set of practitioners (feasibility application) for 3 months. The participants will then provide feedback regarding the application of the toolkit in their practices and the toolkit will be revised based on this final feedback (final refinement).

Results

Key modifications of the toolkit, based on practitioner feedback, will be presented.

Discussion

This study represents the first step in a research program to improve the mental health of adolescents in the PC setting. Based on this study, the GLAD-PC toolkit will be modified and then tested in an appropriate RCT to aid in our understanding of the models of care needed to meet the needs of Canadian youth with depression.

P31

COLLABORATIVE EFFORT. HARMONIZING GUIDELINE DEVELOPMENT IN THE SPANISH HEALTH SYSTEM

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Background
Nowadays in Spain, only few Clinical Practice Guidelines (CPG) are being systematically developed and based on the best scientific evidence available. This fact is confirmed by several researches and by the scarce number of guidelines included in the GuiaSalud (Health Guide) Project Clearinghouse: up-to-date just 39 guidelines have been accepted, representing an 11% of the reviewed documents. In order to improve this current situation a Collaboration Agreement has been signed among the Quality Agency of the Spanish Ministry of Health and Consumer Affairs and the Units and Agencies of Health Technology Assessment (AUniETS) and other organizations, in order to elaborate evidence-based CPG.
The Aragon Institute of Health Science, manager of GuiaSalud, is responsible for the coordination of the present national project.

Purpose
1. Define a common methodology for developing evidence-based CPG for the Spanish National Health System (NHS).
2. Elaborate, update and adapt the existing CPG basing them on the best scientific evidence available, which could tackle NHS priority areas in a coordinated manner and using the agreed common methodology

Methods
The development of the methodology for producing guidelines was performed by a Methodological Group and an MBE expert collaboration network. The development of Training Programmes for CPG developer teams, according to their needs. Besides, coordination and follow-up of the process has also been accomplished.

Results
A Methodological Document has been elaborated which will allow to harmonize the methodology on CPG production in the NHS. Six AUniETS work along in the development of eight CPG on: Primary and secondary prevention of brain stroke, Eating disorders, Schizophrenia, Diabetes II, Palliative care, Anxiety disorders in primary care, Depression in adults and Prostate cancer treatment.

Discussion
The present collaborative and multidisciplinary project aims to bring: a reduction on the variability of the clinical practice and a major improvement of both the methodological quality and health care in Spain.

P32

THE GERMAN DISEASE MANAGEMENT GUIDELINE FOR HEART FAILURE - THE ISSUE OF IDENTIFICATION THE 'RIGHT' GUIDELINES FOR ADAPTATION

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Background
The German "National Disease Management Guidelines Programme" (DM-CPG-P) is based on a guideline adaptation approach. Following such an approach identification of guidelines subsequently used as primary sources is crucial. We present our Four-Step-Model to select appropriate guidelines for a National Disease Management Guidelines on heart failure.

Purpose
To identify methodically high quality guidelines on the management of heart failure representing the international and national standard of evidence-based health care.

Methods
We used a four step approach, consisting of the following stages:
1. Searching - to find current guidelines on the management of heart failure
2. Filtering - to exclude guidelines which do not meet inclusion criteria
3. Appraisal - to assess the quality of included guidelines using the German Instrument for Methodological Guideline Appraisal - DELBI (an adaptation of the AGREE instrument)
4. Identification - to finally select those guidelines which will be the primary basis for guideline development

Results
Through systematic searching in Medline and guideline databases we identified 12 current guidelines dealing with heart failure. Four guidelines, which did not meet our inclusion criteria were subsequently excluded. After assessment of eight guidelines we selected four guidelines as principle sources. One guideline is used as primary sources, whereas the other three are used as additional references. Two of these guidelines including the one used as primary source were developed in Germany representing the national setting. International evidence will be incorporated through recently published guidelines from SIGN (UK) and CCS (CAN).

Discussion
Adaptation of guidelines as an alternative to developing guidelines from scratch is increasingly important. Identification of suitable guidelines for adaptation is a very critical issue to meet demands of methodical quality and appropriateness. A systematic approach comprising a tool supporting assessment of guideline characteristics is able to enhance transparency and objectiveness of such judgements.

P33

GUIDELINES IMPLEMENTATION IN PRIMARY CARE - IMPACT OF A LOCAL APPROPRIATION PROCESS BY PEERS: A PROSPECTIVE COMPARATIVE STUDY

Philippe BLANCHARD (Haute Autorité de Santé, Saint-Denis La Plaine, France)

Background
Methodology for elaboration of clinical guidelines is well established, assuring a good level of quality and accuracy for most of them, allowing to hope for an improvement in diseases management.
Though the implementation process is still looking forward for innovation, assessment and validation, peer workgroups and local appropriation are some of the most promising tools.

Purpose
To assess the feasibility and effectivness of guidelines appropriation using local adaptation by peer groups within GP's associations, since guideline dissemination without implementation strategies is proved to be inefficient.

Methods
Local association members choose to either enter an Adaptation workgroup (AG) or be Passive. GPs from a similar association receives the guidelines as simple sending (Controls).
At reception of 3 guidelines every GP fills a questionnaire to assess there practice (baseline). Regarding results, a guideline is chosen and AG meets to build an operating summary (OS) considering main or not reached objectives, local facilities and discussion in groups of peer, with support from a methodologist. The OS is presented to AG and Passives.
Practice assessment: at baseline, M1, M3, M6,M12 for Passives and AG ; at M0 and M12 for Controls.
Statistical analysis : Mean differences in quotation from M0:

- AG versus Controls at M3 (main criteria) and M12
- AG versus Passives
- For this guideline versus two other not processed

Results
Study in progress. Main results expected on 15/09/2007

Discussion
The implementation of clinical guidelines requires specific validated processes. Peer workgroups and local appropriation are some of the most promising tools. This study is tailored to assess the efficacy of a local peer-managed adaptation of guidelines. Its design separates personnel (AG) and collective (Passives) appropriations. It will contribute to decide if this process has to be widely disseminated and supported

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IMPLEMENTATION OF A NEW MULTIDISCIPLINARY METHOD TO DETECT MORE PATIENTS WITH HEREDITARY COLORECTAL CANCER

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Background
Lynch syndrome is the most common type of hereditary colorectal cancer and accounts for about 5% of colorectal cancers. Identification of Lynch syndrome by family history alone is insufficient. Therefore, we have developed a new multidisciplinary approach, which identifies over two times more Lynch syndrome patients compared to current practice. In this new method, the pathologist applies microsatellite instability analysis (MIPA) on tumors of young patients with colorectal cancer. Next, the treating physician discusses the result of MIPA and referral to genetic counseling with the patient. The question is how this new method can be implemented in routine clinical practice.

Purpose
To compare the effectiveness of two strategies to implement MIPA in routine clinical practice.

Methods
We performed a clustered randomized controlled trial in 12 Dutch pathology laboratories and the 29 hospitals in their catchment area. An intensive implementation strategy was compared to a minimal implementation strategy. The intensive strategy consisted of dissemination of the protocol and supporting materials. Furthermore, the pathologists received a monthly reminder by Email and 3-monthly feedback, and the treating physicians received education and a reminder. The minimal strategy consisted of dissemination of the protocol with references to published papers.
We measured the effectiveness of the two strategies on application of MIPA by the pathologist and on referral of patients to genetic counseling by the treating physician. Process evaluation was used to assess the successful parts of the implementation strategies.

Results
Preliminary data shows that pathology laboratories of the intensive implementation strategy performed MIPA in 75% of patients fulfilling the criteria for MIPA compared to 46% in pathology laboratories of the minimal strategy. Data about the referral to genetic counseling and data from process evaluation will also be presented.

Discussion
The most effective strategy can be used to implement MIPA in routine clinical practice in the Netherlands.

P35

IMPLEMENTATION OF CLINICAL PRACTICE GUIDELINES THROUGH A NATIONAL, COLLABORATIVE PROJECT

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Background
The Norwegian National Electronic Health Library (NEHL) is a government-funded website which provides free access to scientific journals, major databases and clinical practice guidelines (CPGs), for all Norwegian health practitioners. In collaboration with a trust of six Norwegian hospitals, NEHL/the Norwegian Knowledge Centre for the Health Services pilot local adaptation and implementation of CPGs.

Purpose
To test whether easily comparable collections of CPGs and their AGREE scores on the internet can facilitate the use of CPGs in a health trust that actively supports their local use.

Methods
NEHL identifies Norwegian CPGs by regularly hand-searching internet sites, contacting stakeholders, and subscribing to e-mail alerts. In 2007 we also conduct systematic searches for international CPGs. Only international guidelines published from 2005 onwards, with an explicit policy of frequent updating, are included. The guidelines are assessed by NEHL with the AGREE instrument. All national guidelines, and all recommended, international CPGs, are then presented at the NEHL website, accompanied by their AGREE scores. In the health trust, clinical groups adapt the best, recommended guidelines, to a local context. The groups are supported by a task force within the trust which provides evidence-based training, searches by medical librarians and a toolkit including a manual.

Results
A comparison of the AGREE scores of the national and international guidelines, the experiences of the local groups, and preliminary results of the adaptation and implementation process, will be presented.

Discussion
CPGs of high quality made easily available through the Internet have the potential to improve the quality of local guidelines, and increase transparence concerning clinical practice. Adapting CPGs in a health trust on a broad scale will probably have to be a simplified process compared to elaborate adaptations of a limited number of CPGs.

P36

LINKING GUIDELINES AND BEST EVIDENCE THROUGH CAPRE ON LINE EDUCATION

Dr. Walter Rosser (Queen's University)

Background

CAPRE: Critically Appraised Practice Reflection Exercise, is an on line medical education program which delivers the most recent evidence based literature into the hands of healthcare providers and patients.

Purpose

CAPRE provides healthcare professionals (HCPs) and patients with critically appraised information in an on-line format on a variety of medical topics thereby transferring knowledge through the implementation of current guidelines and research.

Methods

Registrants:

1. Choose a topic and review the critical appraisal information.
2. Search the literature including guidelines with differing information than that in the critique. If there are conflicting views, assess the literature to determine impact.
3. Complete the Reflection Exercise and forward electronically for credits.

Results

A focus group of HCPs and a patient tested the program. Suggestions included reducing the amount of text and adding more visuals and tables. The HCPs liked having immediate access to research abstracts and guidelines. The patient suggested a separate body of information with less medical jargon. User feedback is also being solicited through the site. Results will be shared.

Discussion

As this is an evolving process in on-line education, more focus groups will be used to test revisions and explore further options. This program met the needs of HCP's, allowing them to review various modules, download and review the literature and guidelines, thus enabling them to make better-informed decisions.

What are the benefits and challenges of involving the patient in this exercise OR should we go there at all?

P37

AN IMPROVED METHOD FOR GUIDELINE DEVELOPMENT IN ONCOLOGICAL AND PALLIATIVE CARE IN THE NETHERLANDS

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Background
The Association of Comprehensive Cancer Centres facilitates the development, implementation and evaluation of guidelines for oncological and palliative care in the Netherlands. In the constant changing field of medicine, development of guidelines has to become more efficient to stay accurate.

Purpose
The goal of the ACCC is to provide professionals with up-to-date, multidisciplinary guidelines based on the highest level of evidence.

Methods
The ACCC has developed and implemented a new method of guideline development in the field of cancer care and palliative care to control development time and financial means. Long-range planning for the development and revision of our guidelines is based on a survey among professionals and the following criteria: high incidence/prevalence of the disease, diagnosis and treatment in both academic and general hospitals, involvement of multiple disciplines and clinical controversies in diagnoses or treatment.
The improved guideline development process includes:

- short development time
- small, multidisciplinary guideline working groups
- limited number of clinical questions
- publication of guidelines on the websites Oncoline/Pallialine
- existing guidelines are the basis for literature search
- cross-links between clinical practice guidelines and care practice guidelines
- implementation is an important topic during development
- establishment of indicators is part of development

Results
Guidelines are developed faster en cheaper, resulting in a development time of 1-1,5 years. Currently 17 guidelines are being developed using this method. Thus far two guidelines were completed (colon carcinoma and rectal carcinoma). This year at least ten will be published on our websites, which enhances guideline dissemination. The compliance to guidelines can be measured, with use of the indicators, which in turn can be reason for revision.

Discussion
With this new method of guideline development, the ACCC provides healthcare professionals with up-to-date and to-the-point guidelines, thus giving them useful tools to improve the quality of health care.

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THE ACCC DEMONSTRATES THAT PATIENT PERSPECTIVE CAN BE INCLUDED IN ALL STEPS OF ONCOLOGICAL GUIDELINE DEVELOPMENT

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Background
Development, implementation and evaluation of guidelines for oncological and palliative care in The Netherlands is facilitated by the Association of Comprehensive Cancer Centres (ACCC). Patient participation is of crucial importance in the development of guidelines. The ACCC approach shows congress delegates an example of how patient perspective in guidelines can actually be achieved.

Purpose
To create an achievable, realistic method for including patient perspective in guidelines.

Methods
In collaboration with the Dutch Cancerpatients Federation (DCF) patient perspective is incorporated in the ACCC method, in every step of guideline development as described by Grol et al *.

Results
Patient perspective in the ACCC method includes:
- An inventory among patients which clinical questions should be addressed in the guideline
- Forwarding patient related clinical questions
- Patient involvement in the selection of clinical questions
- Patient membership in the guideline working group
- DCF support of patients who are members of a working group
- Patient participation in the evaluation of the draft of the guideline
- Authorization of the guideline by DCF
- Identifying indicators on the level of patient care that can be used for evaluation of the guideline

Discussion
Patient related issues are extremely important. When patients raise clinical questions concerning issues that are not appropriate for a guideline these issues are not disregarded. During their regular meetings DCF and ACCC decide how to deal with the not-selected patient related questions. Evaluation of the ACCC method is a continuous process, aiming at further fine-tuning to achieve the best results possible.

*) R. Grol and M. Wensing, Implementatie: effectieve verbetering van de patiëntenzorg. (Elsevier gezondheidszorg 2006)

P39

DEVELOPMENT OF QUALITY INDICATORS FOR DIAGNOSIS AND TREATMENT OF PATIENTS WITH NON-SMALL CELL LUNG CANCER: A FIRST STEP TOWARD IMPLEMENTING A MULTIDISCIPLINARY, EVIDENCE-BASED GUIDELINE

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Background
While developing and disseminating clinical guidelines are important to optimise healthcare, insight into actual performance is necessary to achieve successful guideline implementation. To measure performance, quality indicators have to be developed. Although much about the need and usefulness of indicators has been published in recent years, good examples of procedures to be followed are rare.

Purpose
Based on guidelines and previous experiences with indicator development, we aimed to 1) systematically develop indicators to assess quality of care and 2) test these in clinical practice. We used the Dutch multidisciplinary guideline "Non-small cell lung cancer (nsclc)" as an example.

Methods
To develop a set of indicators covering three quality dimensions (professional, organisational and patient-oriented) a Rand-modified-Delphi procedure was performed in three rounds: 1) extraction of all recommendations from the guideline; 2) scoring of these recommendations on a 9 point Likert-scale by a national expertpanel; 3) a panel consensus meeting to assess the final set. Next, we tested these indicators on their clinimetric characteristics (measurability, room for improvement, discriminatory capacity) among patients with nsclc in 6 hospitals in the south-eastern part of The Netherlands by a medical record search and patient questionnaires.

Results
Thirty-two of 83 recommendations were selected in the first round; 8 recommendations met the final criteria. These recommendations were translated into 15 indicators (5 professional, 3 organisational and 7 patient-oriented). In the practice test, 14 out of the 15 indicators turned out to be measurable. Most indicators (10) had an improvement potential of at least 40%. For eleven indicators the variation between hospitals was 20% or more.

Discussion
To measure performance, quality indicators should be developed from evidence-based guidelines applying a solid procedure, covering the three dimensions of quality of care. Most indicators in our study were measurable, had improvement potential and discriminatory capacity.

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INTEGRATE CLINICAL GUIDELINE IN A COMPUTERIZED PHYSICIAN ORDER ENTRY SYSTEM

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Background
Clinical practice guidelines (CPG) provide a standard method and a collection of clinical experiences as a reference to help physicians dealing with a specific medical condition. Physicians, however, usually do not comply with guidelines. It is sometimes impossible to follow the steps in CPG, especially when the rule is complicated.

Purpose
To help physicians using CPG effectively, we developed a clinical decision support system (DSS) which integrated CPGs, assisting physicians prescribing medicine.

Methods
In this study, we took the hyperlipidemia treatment guideline ATP III (Adult Treatment Panel III) as knowledge to express. It was established in a regional hospital. When the anti-hyperlipidemia medication is keyed in, the system is activated. The pop-up window showed the previous important data and be able to assist doctors to make appropriate decisions on prescription.

Results
There were more than 10000 records included in this study from Aug. 2003 to Mar. 2005. We categorized the reasons of exiting DSS system into 4 parts. The most frequent reason is "too busy to use".

Discussion
Although not all the procedures of the DSS system are required, it is still a useful reminder for physicians on lipid management.

P41

INTEGRATION OF NATIONAL DISEASE MANAGEMENT GUIDELINES INTO IT-BASED QUALITY MANAGEMENT SYSTEMS

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Background
The German National Disease Management Guidelines Program (NVL) was established to link prevention, acute care, rehabilitation and chronic care for high priority healthcare topics. One implementation strategy aims at transferring the content of these guidelines into IT-based quality management systems (e.g. QEP®, the quality management system of the Association of Statutory Health Insurance Physicians).

Purpose
1) To address the needs of potential users.
2) To align structure and content of the NVL guideline and QEP®.
3) To assign NVL content to specific quality management goals.
4) To prioritise and select the most relevant documents.
5) To integrate the NVL quality management documents into the web presence of the National Disease Management Guidelines Program and the documentation of QEP®.

Methods
Integration of the most relevant contents of NVL into the QEP® system was performed as a stepwise procedure. First guideline and quality management developers identified the crucial goals, contents and documents. Next steps were discussion and adaptation according to the requests of potential users. Finally integration into QEP® and usability tests were performed.

Results
A pilot project on NVL Asthma and NVL COPD identified numerous contents of the respective guidelines which could easily be linked to quality management goals. This showed in principle the possibility of integrating evidence-based guidelines into quality management systems. Algorithms and stepwise therapy schemes could smoothly be transferred into quality management systems. Other implementation tools like decision aids also proved to be simple to integrate into quality management handbooks.

Discussion
Transfer of the most relevant content of National Disease Management Guidelines into quality management systems is feasibly. Describing the ideal evidence based workflow with emphasis on resolving problems at the interface of different health care sectors has a high potential of improving health care outcomes. As quality management is compulsory within the German health care system this might be a very effective strategy for guideline implementation.

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DESIGNING STRATEGIES FOR IMPLEMENTING CLINICAL PRACTICE GUIDELINES IN PRIMARY CARE: THE USE OF INTERVENTION MAPPING

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Background
Clinical practice guidelines (CPG) are a strategy to help healthcare professionals in keeping up-to-date with the fast growing volume of new research. However, the development of CPG does not automatically improve clinical practice and they have to be implemented through specific strategies to impact in professional behavior. A number of factors should be considered in designing implementation strategies, such as the evidence of effectiveness of different strategies, health professionals' behavioral change theories, and the context in which guidelines will be implemented. Intervention Mapping allows the incorporation of these different factors in the design of CPG implementation strategies.

Purpose
To design a strategy for implementing a CPG for depression in Chilean primary care.

Methods
Based on the Intervention Mapping framework, we firstly identified the barriers and facilitators to the implementation of a depression guideline in our health centre. Secondly, we created a matrix using the barriers and facilitators previously identified and the recommendations from the depression CPG. We asked a sample of health professionals to identify in the matrix the relevance of each barrier and facilitator regarding each recommendation. Finally, the research team formulated intervention activities based on the areas identified in the previous stage, the theories of professional change, and the evidence of effectiveness of different guidelines implementation strategies.

Results
A matrix with 15 recommendations and 18 barriers and facilitators was handed out to the sample of health professionals. They identified a number of specific areas where to focus the design of the implementation strategy. Currently the research team is designing a multifaceted intervention incorporating the information obtained previously.

Discussion
CPG have to be implemented through specifically designed strategies considering contextual factors and the existing evidence about professional behavioral change theories and intervention effectiveness. Intervention Mapping offers a framework to incorporate these different areas in the design of guidelines implementation strategies.

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A COLLABORATIVE, MULTI-DIMENSIONAL EDUCATIONAL MODEL

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Background
The Ontario College of Family Physicians (OCFP), supported by the Ontario Women's Health Council, has collaborated in the development of educational initiatives aimed at improving care for women with a number of benign uterine conditions. The BUC Initiative was conceived with the working assumption that improving the knowledge and skills of providers and patients dealing with these conditions would improve care.

Purpose
This session will examine the process, benefits and challenges associated with the development of a collaborative, multi dimensional educational initiative for primary care providers, trainees, and patients to achieve optimal care for a variety of benign uterine conditions. Facilitators will also focus on the evaluation component and illustrate how to effectively monitor program success and impact on clinician knowledge and practice.

Methods
Facilitators will provide an overview of the OCFP Benign Uterine Conditions Initiative and the implementation components required to execute such an initiative, as well as a comprehensive overview of evaluation data on the impact of the initiative. Audience participation will be strongly encouraged.

Results
Participants will acquire an understanding of the utility, benefits, and challenges of collaboration in educational program development and implementation in primary care. They will also have the opportunity to consider application of this model to other clinical areas to foster collaborative professional relationships.

Discussion
Key elements of the BUC Initiative include:

- Two Problem Based Small Group (PBSG) modules to be presented via face to face and on-line workshops
- Adaptations of these modules to be utilized with undergraduate medical and NP trainees
- A Skills Transfer workshop aimed at improving competence and confidence in performing several office gynecologic procedures
- An information toolkit for primary care practitioners and their patients that supports optimal care
- An on-line mentoring program that provides primary care practitioners with timely access to specialists to deal with individual clinical questions.

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LAPAROSCOPIC SURGICAL SKILLS AND PRIMARY CARE OUTCOMES IN COLON SURGERY: A FRAMEWORK FOR ADOPTING A GUIDELINE

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Background
The Laparoscopic (LAP) Mentoring Project was created from the need to ensure the quality and accessibility of laparoscopic colon resection surgery. The best evidence available indicates that primary outcomes are not statistically different between laparoscopic and open surgery for colon cancer after at least one member of the team has performed twenty laparoscopic colon resections for either benign or malignant disease. Therefore, one of the recommendations from the Laparoscopic Surgery for Cancer of the Colon Guideline, published by Cancer Care Ontario in September 2005, is that either this number is adhered to or an equivalent process, including peer evaluation, be undertaken (the published guideline can be accessed at http://www.cancercare.on.ca/pdf/pebc2-20-2f.pdf).

Purpose
In partnership with the Ontario Association of General Surgeons, the LAP Mentoring Project was established to ensure the safe and sustainable adoption of laparoscopic colon surgery in general of which colon cancer surgery makes up a large proportion. The project strives to do this by, i) fostering quality and accessibility by supporting the surgeons in meeting the provincial LAP guideline; ii) assisting Ontario hospitals in the drive to increase cancer surgeries; and iii) building a sustainable network of surgeons across the province for future communities of practice, educational and project-based initiatives, and for the advancement of LAP surgery.

Methods
We formed a collaboration of provincially disparate surgeons, administrators, and researchers, with the goal of supporting a longitudinal mentorship project and a community of practice. Additionally, this group worked together to develop an evaluation framework for laparoscopic surgical skills and primary care outcomes in cancer care.

Results
The work of this group will result in an evaluation framework that can be used for laparoscopic surgical skills and primary care outcomes across the Province of Ontario.

P45

EXPERIENCE OF GAINING CONSUMER INPUT INTO ACUTE STROKE GUIDELINES: EXAMPLE FROM AUSTRALIA

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Background
Clinical guidelines must consider the evidence, current working practice and the experience of those receiving care. Adherence to guidelines is often impacted by the beliefs and expectations of consumers themselves and there is often a divide between what health professionals believe is important for their patients and what the patients actually experiences and therefore believes is important.

Purpose
Consumer involvement in the guideline development process is currently recommended. However it is often unclear how this is reflected in the finalised guideline document. Previous consumer involvement revolved around seeking feedback from consumer organisations along with a small number of individual consumers. The purpose of this program was to review the effect of a more systematic process for seeking consumer feedback.

Methods
A consumer questionnaire was developed to reflect the recommendations of the draft Acute Stroke Guidelines. This questionnaire was widely distributed via several consumer networks. Feedback was collated and topics were given a consumer importance rating.

Results
Consumer feedback is currently being collected.

Discussion
It is believed this process will demonstrate the value in engaging a wide range of consumers in a systematic way. Further evaluation regarding the value of such a consumer valuing system should be further explored to understand the impact of this information on adherence to guidelines.

P46

USING CRITICAL DATA ELEMENTS TO DEFINE AND MEASURE STANDARDS OF CARE IN CHILDREN

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Background
Measuring standards of care in pediatrics requires creation of precise variables that fit operational workflows. Although healthcare systems benchmark process measures (e.g. waiting times), these measures do not evaluate clinical judgment. Typically, clinical pathways are too rigid to account for all variations, and clinical practice guidelines lack precision for detailed analysis. A measurable standard of care would be useful for comparing clinical performance.

Purpose
Nemours Clinical Management Program (NCMP) developed a unique approach to define specific, measurable standards of care in a large (>400 physicians) multi-specialty pediatric practice with clinical sites in 4 states.

Methods
NCMP's standard of care creates disease specific critical data elements (CDEs) essential for the care of children. CDEs are identified by linking content experts to experts in evidence-based medicine, informatics, business applications, and research design. The strength of recommendation for CDEs uses the grading system developed by the American College of Chest Physicians. CDEs are steeped in evidence, stored electronically and downloaded into a data warehouse for future analysis.

Results
Standards of care which are in various stages of enterprise-wide implementation have been identified for 17 conditions. Challenges to developing and implementing standards of care in a large healthcare system include low-quality evidence, overcoming experience based practice, technical issues related to electronic fingerprinting of CDEs, and clinical and administrative workflows.

Discussion
CDEs can serve to measure standards of care. Implementation will not succeed if collection of CDEs impairs workflow. Robust, measurable standards of care using common data sets could lead to standardized benchmarks for internal use and external comparison.

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THE CONFUSION OF MULTIPLE COMPARISONS: MAKING SENSE OF THE DATA IN THE NICE GUIDELINE ON VENOUS THROMBOEMBOLISM

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Background
In April 2007, NICE published a guideline on the prevention of venous thromboembolism in inpatients undergoing surgery. This was developed by the National Collaborating Centre for Acute Care.

Purpose
The guideline examined the clinical and cost effectiveness of 9 different mechanical and pharmacological methods of prophylaxis for venous thromboembolism in surgical patients. A systematic review of the literature revealed that there were several hundred randomised controlled trials (RCTs) comparing various combinations of these methods. Simple pooling by intervention and outcome produced more than 160 different meta-analyses. Recommendations about the most effective strategy were therefore hard to determine as some pairs of strategies had not been compared at all and there were many examples of overlapping comparisons.

Methods
A systematic review of the literature was conducted and all papers were quality assessed following NICE guideline methodology (ww.nice.org.uk). Data was extracted on the number of deep vein thromboses (DVT) and incidence of major bleeding. Over 200 RCTs were pooled and analysed using a mixed treatment comparison meta-analysis.

Results
The mixed treatment comparison produced a ranking of the different prophylactic methods in order of efficiency at reducing risk of DVT and in order of the risk of major bleeding. It also allowed us to develop point estimates of effect for each intervention that were essential for the cost effectiveness analysis. However, the complexity of the data analysis meant that maintaining the transparency and understanding of the analysis and results with the guideline development group required more time.

Discussion
In guideline topics such as venous thromboembolism with large quantities of data and multiple comparisons, a mixed treatment comparison approach does offer advantages. The mixed treatment comparison allowed the guideline development group to compare and rank the clinical and cost effectiveness of all the different interventions which they used to inform the recommendations.

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ONCOLINE AND ITS SPIN-OFF'S ARE HIGHLY APPRECIATED APPLICATIONS FOR GUIDELINE CONSULTATION

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Background
The Dutch Association of Comprehensive Cancer Centres facilitates the development, implementation and evaluation of clinical practice guidelines for oncological and palliative care in the Netherlands. Medicine is dynamic. Therefore, guidelines should be up-to-date and easy to adjust.

Purpose
The ACCC has developed a tool for guideline dissemination, consultation and adaptation: Oncoline.

Methods
Www.oncoline.nl is an online database, ensuring health care professionals easy access to the most recent version of a guideline. To improve guideline compliance; navigation, consultation and search options in Oncoline are easy to use. All guidelines can be downloaded to portable devices (PDA's), giving the professional the opportunity to retrieve diagnostic and treatment information anywhere, anytime, free of costs. References are linked to online articles, to enable direct consultation of the literature. Cross-links allow professionals to switch between clinical practice guidelines and care practice guidelines, thus stimulating the multidisciplinary approach required for cancer care.

Results
Oncoline is highly appreciated by health care professionals. The database, with nearly 200 guidelines incorporated, is consulted 2000 times a day and the number of visitors increases every day. The ACCC has made the application software available to other developers of health care guidelines. Guidelines for mental health, gynaecological and palliative care can be consulted via 'Oncoline spin-off's'.
User options and features on Oncoline are continuously improved based on the opinion of health care professionals. As a new feature, decision trees are currently incorporated in Oncoline guidelines, both for desktop and PDA.

Discussion
Oncoline, as well as its spin-off's, provide health professionals in the Netherlands with up-to-date guidelines in a user-friendly system.

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DEVELOPING LEADERS IN GUIDELINE IMPLEMENTATION

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Background
The National Institute of Clinical Studies (NICS) established a Fellowship Program in 2003 to develop leaders in implementation science in Australian health care.

Purpose
A key component needed to implement evidence, including clinical practice guidelines, is leadership and know-how from individuals working in the field. To build Australia's own cohort of experts and leaders in the science and practice of implementation requires a concerted and targeted effort.

Methods
Each year the Institute invites applications from talented early-to-mid career professionals who demonstrate leadership potential in improving health care. The two-year half-time Fellowships provide an annual stipend as well as an implementation science curriculum, and a mentoring program. Applicants must propose an evidence implementation project and must nominate a host organisation and a project mentor. Successful applicants have the opportunity to network and work one-on-one with Australian and international implementation experts. Each Fellow is also appointed a NICS Mentor, usually a senior figure in Australian health, to work with them on issues such as leadership in improving health care and influencing health policy.

Results
To date 17 Fellowships have been awarded with many of the Fellows nominating practical projects to implement clinical practice guidelines, ranging from evidence-based management of paediatric asthma to diagnostic imaging. There is a growing awareness of the importance of implementation science in the uptake of guidelines and increasingly NICS is partnering with other leading health organisations to offer the Fellowships.

Discussion
The NICS Fellowship Program is developing leadership capacity in Australia in evidence implementation. NICS Fellows are being recognised regionally and nationally as having expertise in how to implement clinical practice guidelines, and a number of them are contributing to the published literature. The experiential learning component of the Fellowship means that the Fellows have practical and credible experience. Increasingly they are being asked to present their work at regional and national conferences, to deliver workshops on guideline implementation, and to work with other organisations to inform guideline implementation programs. Peak bodies and organisations aiming to implement guidelines are recognising the value of the NICS Fellowship Program and have become co-sponsors. The number of partners increases yearly and currently includes the Department of Veterans' Affairs, Medical Colleges, Quality Councils, and Health Departments.

P50

DO EVIDENCE-BASED GUIDELINES REQUIRE CONSENSUS? RESULTS FROM THE NOMINAL GROUP PROCESS OF THE DEGAM GUIDELINE ON CHRONIC HEART FAILURE.

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Background
As a systemic disease, chronic heart failure (CHF) requires healthcare from both General Practitioners and Specialist Physicians. For the development of the DEGAM Guideline the evidence-based draft of the Systematic guideline review and additional new evidence had passed through a multilevel review process.

Purpose
To achieve a formal consensus on evidence based recommendations on primary care management of CHF

Methods
Medical societies and a patients' self-help-organisation (MS/PS) were invited to take part in a nominal group process (NGP). Authorized participants received the guideline draft including a method report and a list of central guideline recommendations for a personal rating (44 items, 6-step Likert scale). At a consensus meeting, disagreement was identified on the basis of the initial rating (Likert<4), alternative suggestions were then included in order of importance and voted upon. Consent was then reached on the revised draft in a second rating (Delphi technique).

Results
Around 35 questions were discussed as part of a coordination process involving 10 representatives from 11 MS/PS. In seven cases, which lacked evidence, a differing consensus was reached to that found in international guidelines (e.g. ß-Blockers for asymptomatic patients only after myocardial infarction). Four value judgements concerning BNP determination were deleted in favour of a negative recommendation, two recommendations were coordinated with the German Vaccination Committee (STIKO) on pneumococcal immunization and influenza vaccination, and in 15 cases the wording changed. Five clinical questions were addressed from scratch (eg counterindicated medicines) and 14 recommendations were not modified. Consensus was reached for all but three of the Guideline's recommendations (eg flow diagrams: inappropriate simplification vs. practicability).

Discussion
The NGP is a suitable approach for evidence-based guidelines. Interdisciplinarity is particularly useful to combat uncertainty (missing or inconsistent evidence), and to define interfaces. Main limitation was the involvement of the patients' representative.

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ORAL HYGIENE: GUIDELINE DEVELOPMENT AND PARTICIPATION APPROACH STRATEGIES

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Background
In Canada, oral health care accounts for 7% of all healthcare expenditures, second only to cardiovascular disease. Unfortunately, oral health is usually a low priority within healthcare organizations. For some patients/clients, the nurse maybe the first health professional to identify oral hygiene concerns. Access to routine oral care maybe challenging due to cost and access; and inadvertently may lead to prolonged pain and health consequences. Healthcare organizations can show commitment and accountability to quality oral hygiene by implementing oral hygiene best practices. It is important that oral hygiene best practice guidelines (BPG) are available for nurses and healthcare providers so that oral health assessment, screening and oral hygiene strategies become part of quality healthcare services to clients and that the BPG is developed through a collaborative, networking, multidisciplinary, international and stakeholder participation approach.

Purpose
To detail the development and participation approach of the Registered Nurses Association of Ontario's (RNAO) oral hygiene BPG.

Methods
RNAO responded by forming a multidisciplinary international panel of experts who developed an evidence-based guideline. The panel evaluated existing evidence-based guidelines using the AGREE Tool and completed a rigorous review of published literature. Lessons were learned from working with a diverse group of professionals and coordinating the panel's work by using meeting efficiency strategies. Stakeholder participation was extensive and included multidisciplinary, networking and international feedback. They also conducted several front-line focus groups.

Results
RNAO recently released its 30th BPG on Oral Hygiene with several electronic-based resources. In addition, this BPG includes education and policy recommendations.

Discussion
Oral health is integral and essential to general health and is a determinant factor for quality of life. This oral hygiene BPG diminishes a barrier to achieving and maintaining optimal oral health for healthcare clients especially those unable to meet their own oral hygiene needs.

P52

ORGANIZATIONAL LEARNING THEORY: EXPLAINING KNOWLEDGE UPTAKE

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Background
The gap between research and practice is an ever growing concern among practitioners, researchers and policy makers. Research studies have been conducted to understand what sources of knowledge nurses use, how they access the knowledge and how they use it. Little, however, is known about the influencing factors and strategies at the organizational level in bringing new knowledge to the organization, integrating the knowledge with existing clinical experience and sustaining the knowledge in organizational memory. Clinical practice guidelines as one form of packaging or codifying knowledge from research and expert opinion have become a popular vehicle to transfer knowledge to organizations. However, the impact of guidelines in changing practice and on patient outcomes is mixed. Why are some health care organizations able to implement guidelines and positively influence patient outcomes while other organizations are faced with numerous challenges? One promising theory to understand how health care organizations access and use research or evidence- based guidelines is the organizational learning theory.

Purpose
In this presentation, the author will present a literature review on organizational learning theory in the context of a study to explore the factors that influence the full utility and impact of clinical practice guidelines in health care organizations.

Methods
Literature review and theoretical modeling methods have been used using the guideline on prevention of falls in the older adult population as the clinical context.

Results
A theoretical framework has been developed along with a set of hypothesis for research testing.

Discussion
The issue of facility-based patient falls will be used to model the efficacy of organizational learning theory as one way of understanding the transfer of knowledge in health care organization.

P53

PAIN RELIEF AFTER CESAREAN SECTION: A PROSPECTIVE COHORT STUDY

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Background
Women should receive adequate analgesia after cesarean section. The Royal College of Anaesthetists1 has proposed standards for post C/S analgesia, including the following: 1)90% women to have a worst pain score of <3 on a VAS of 0-10, 2)100% women to be prescribed NSAIDs, and 3)>90% women to be satisfied with pain management.

Purpose
We sought to compare our practice with the standards.

Methods
After ethics approval, we recruited a convenience sample of healthy patients who had elective C/S under spinal anesthesia. Questionnaires were administered by interview. Data collected included analgesic consumption, pain scores, side effects, and satisfaction with pain management. Descriptive statistics were used for group data. Non parametric tests were used for comparative data.

Results
100 women were interviewed in hospital between 42 and 119hrs postoperatively. The mean age was 34+/-4 years. 41/100 women were primiparous. All women without allergies to NSAIDS received them(N=98). The mean overall VAS worst pain score was 6.43+/-2.12. No significant differences were seen in worst pain scores as a function of spinal morphine dose. Women who received 0.2mg of spinal morphine experienced more itching than those who received 0.15mg (p=0.01). 94%(94/100) of women were satisfied with their pain management.

Discussion
The VAS pain scores were significantly higher than those recommended by the College, despite appropriate administration of analgesia. However, maternal satisfaction with analgesia exceeded the recommendation. Our results suggest that the analgesic target, derived from the general surgery literature2, is not appropriate for obstetric patients. Post C/S patients require separate guidelines for analgesia, which should consider maternal and neonatal safety, mother's wishes and activity.

References:
1http://www.rcoa.ac.uk/docs/arb-section8.pdf Last accessed: Dec. 22, 2006.
2Gould et al. BMJ, 305, 1992.

P54

PATIENT INVOLVEMENT IN A TREATMENT GUIDELINE FOR NON-SMALL CELL LUNG CANCER (NSCLC): BARRIERS AND FACILITATORS

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Background
Although patient involvement is regarded as a major quality factor for clinical guidelines, patients have seldom been associated to the development of guidelines in France. The French Standards, Options and Recommendations (SOR) program has developed a method for involving patients in guideline development groups (GDG) based on experiences of other guidelines programs. The methodology was applied and assessed on a SOR treatment guideline for early-stage NSCLC.

Purpose
To identify the factors affecting patient involvement in the GDG for NSCLC

Methods
Key features of patients' involvement are: recruitment through clinicians and patient associations, training sessions before each GDG meeting, participation in every GDG meeting, psychological and methodological support.
To evaluate the motivations of patients' involvement, we conducted a qualitative study using direct observations of meetings and semi-structured interviews.

Results
Between January 2006 and March 2007, 8 observations and 12 interviews were performed with GDG members (patients and experts).
The participation of patients impacted very little on recommendations.
Patients' involvement depended on four dimensions:

- The disease itself: the prognosis, societal views and mortality of NSCLC are barriers
- SOR method: good training and close support are facilitators, but small number of patients and expert status (gap between the role assigned to patients and their ability to participate) are barriers.
- Patients' characteristics: availability and status (patients, carers, association members)
- Patients' interactions with other GDG members: interplay of their perceptions of the guideline development process and role of patients therein.

Discussion
This study improved our understanding of key issues to be taken into account when involving patients in GDG in the context of cancer care in France. We have refined the methodology, which can now be applied to other diseases. Further studies will explore how different perceptions and value judgments of patients and experts influence the development of guidelines.

P55

PINAS STUDY (PRACTICE GUIDELINE IMPACT ON ACS SURVIVAL) - ASSESSMENT OF ADHERENCE TO CLINICAL PRACTICE GUIDELINES ON ACUTE CORONARY SYNDROME AT MANILA DOCTORS' HOSPITAL (PHILIPPINES)

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Background
Adoption of clinical practice guidelines developed in western countries is problematic in a developing country setting. This is particularly true in acute coronary syndrome (ACS) where several level I recommendations are not feasible in majority of hospitals. This study looked into the practice patterns before and after hospital dissemination strategies of the ACC-AHA CPG in Manila Doctors' Hospital(MDH).

Purpose
To determine 1) practice patterns in ACS and 2) mortality rates, duration of ICU and total hospital stay of ACS patients in MDH before and after dissemination of the guidelines.

Methods
This is a quasi-experimental study with three phases. Phase I was a review of practice patterns in ACS involving 124 patient charts. After some dissemination strategies (Phase II) of the CPG based on the ACC-AHA 2002 Guidelines on the Management of Unstable Angina and NSTEMI and the 2004 Guidelines on the Management of ST Elevation AMI, Phase III was done involving 120 patients. Percentage of usage of specific diagnostics and interventions; mortality rates, length of hospital and ICU stay were analyzed.

Results
Before dissemination, usage rates for nitrates, betablockers, ACE-I, statins, antiplatelet/anti-coagulant agents were 93.6%, 80.7%, 70.7%, 93.6% and 98.4%%, respectively. These became 97.5%, 84.8%, 70%, 91.4% and 100% after dissemination. Fibrinolytics, GPIIbIIIa and invasive procedures were hardly used. They were either unavailable or not affordable. However, several agents not recommended such as omega3 fatty acid, L-carnitine, co-enzyme Q10 and trimetazidine were given to some patients. Finally, there was a statistically significant decrease in mortality rates (15% - 3%) post-dissemination.

Discussion
There were relatively high compliance rates to several Class I recommendations. These further increased and might be related to increased survival rates after dissemination. Economic constraint hindered usage of other Class I diagnostic and therapeutic interventions.

P56

PRESENT CPG USE AND DEVELOPMENT IN TAIWAN

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Background
Since 1996, the concept of EBM (Evidence Based Medicine) has been introduced to Taiwan. EBPG (Evidence Based Practice Guideline), emphasizing systematical review and epidemiology research, has become an important medical issue in National Health Insurance (NHI) system development.

Purpose
Top 10 resource-exhausting diseases cost more than 20% of National Health Insurance budget. Due to the limitation of resources in NHI system, cost containment becomes important. On the one hand, NHI has adopted global budget system as a mean to cap the cost; on the other hand, it encourages development of EBPG to improve the quality in medical treatments. In addition, EBPG also serves as a tool of communication between patients and doctors, and as a reference that reduces variation among treatments.

Methods
In order to know more about present CPG (clinical practice guideline) use and development in Taiwan, we sent out 633 questionnaires in July 2006 to medical centers, hospitals, associations and experts in related fields all over Taiwan.

Results
The results indicated that people did not know much about CPG, and there weren't enough resources, time and human resources of ideal development. Thus, we're convinced that CPG development in Taiwan requires more education, instruction and resources.

Discussion
In 2006, this project has coordinated major medical professional associations to promote the concept of EBM, built EBPG, and showed the results of medical research, in order to provide treatment recommendation, to improve the communication between patients and physicians and finally become part of the patient education materials. Furthermore, EBPG can be developed as quality control indicators and eventually improve medical environment.

P57

PRIORITISING TOPICS IN THE DEVELOPMENT OF NATIONAL CLINICAL GUIDELINES

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Background
The National Collaborating Centre for Cancer (NCC-C) has been commissioned by NICE to develop evidence-based guidelines for the NHS in England and Wales on the diagnosis and management of prostate and breast cancer. These guidelines will make recommendations on best practice based on evidence of clinical and cost effectiveness. The scope of both guidelines is broad and, given the time and resources available, it will only be possible to cover about 30 priority topics within each guideline. It is important that this choice should not be based solely on the opinions of the guideline development groups but should be informed by the views of clinicians and patients.

Purpose
To describe and present the results of the process used in prioritisation of topics to be included in a guideline.

Methods
A list of 63 (prostate) and 140 (breast) potential topics covering the scope of both guidelines was developed in consultation with expert clinicians. This was sent out in questionnaire form to relevant patient organisations and also to breast and prostate cancer advisory groups in 37 locality-based cancer networks across England and Wales, which are responsible for the organisation and quality of care in their area. They were asked to prioritise each topic on the basis of its clinical and cost impact.

Results
At the close of the consultation period 33 from 48 prostate questionnaires (68.8%) and 35 from 46 breast questionnaires (76.1%) had been returned. A far higher response rate was observed from cancer networks compared to patient organisations. Data from the questionnaires were aggregated and scored to generate a prioritised list that was presented to each guideline development group at their first meeting.

Discussion
An evaluation of the methodology used, and the effect of prioritising topics on guideline content are now being evaluated and the findings will be presented.

P58

PROJETO DIRETRIZES - BRAZILIAN GUIDELINES

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Background

The Guideline Project is an initiative of the Brazilian Medical Association (AMB) and the Federal Medical Council, having its beginning in the year 2001, aiming the elaboration of recommendations that help the medical decision making.

Purpose

To share the trajectory of a Brazilian elaboration program of evidence based clinical guidelines.

Methods

Description of: the methodology used in the elaboration; the number of guidelines elaborated; the specialties that joined the process; the obstacles to the adhesion; and the perspectives to the program.

Results

Forty One Specialization Societies, from the fifty one associated to the AMB, participated in the elaboration, under the coordination of two specialists in Evidence Based Clinical Practices and in the elaboration of Clinical Guidelines.

After choosing the theme, the authors participated in a Workshop for the training in the elaboration of Clinical Guidelines, starting with the structured question (PICO), search and critical evaluation of evidence, and answering that question (recommendations).

Independently of the authorship, all the Societies have the possibility to participate in the elaboration, through an interface electronic process.

The authors fill a questionnaire manifesting conflicts of interest that may have influenced the guideline content.

The final version of the Guideline is obtained through a critical evaluation, done by the technical committee, with an emphasis in the evidence based language.

It has been elaborated 240 guidelines.

Discussion

Within the obstacles for the adhesion of the Societies, there are the difficulties of resources, the intimacy with the method and mostly, the time left for the specialists.

The process of use of the Guidelines has been motivated by the press and electronic media, and a teaching process. There are already studies evaluating the level of adhesion to the Guidelines, preceding actions of result evaluation, centered in the patient, as well as implementation.

P59

THE IMPROVEMENT OF X-RAY ORDERING IN PATIENTS WITH HEIGHT LOSS OR KYPHOSIS IN ACCORDANCE WITH THE OSTEOPOROSIS CANADA 2002 GUIDELINES: CANADIAN QUALITY CIRCLE (CQC) NATIONAL PROJECT

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Background
The CQC project is an integrated disease management study designed to improve primary care physicians' (PCPs) adherence with the Osteoporosis Canada 2002 guidelines.

Purpose
The study examined the change in x-ray ordering.

Methods
The project consists of five phases: wave I data collection, 1st educational intervention, wave II data collection, 2nd educational intervention, and wave III data collection. During the educational intervention QC's met to discuss physician profiles on how they managed osteoporosis and to participate in an osteoporosis workshop. The guidelines recommend that x-rays be ordered in patients with kyphosis or height loss. A total of 340 (wave I) and 301 (wave II) PCPs formed 34 QCs. For each wave, PCPs collected data from different patients (women 55 years and older) via chart reviews and a standardized collection form. There were 8376 (wave I) and 7354 (wave II) patient records selected at random. This interim analysis (wave I & II) used the generalized estimating equations technique to evaluate differences in x-ray ordering in patients with kyphosis or height loss before and after the educational intervention. Odds ratios (OR) and 95% confidence intervals (CI) were calculated.

Results
During wave I, 54.3% (662/1220), 56.2% (654/1163) and 53.1% (958/1804) of patients with kyphosis, height loss, or either had a x-ray ordered compared to 63.9% (726/1136), 61.0% (834/1367) and 60.2% (1130/1877) of patients during wave II. The likelihood of x-ray ordering increased following the educational intervention for patients with kyphosis (OR: 1.35; 95% CI: 1.07, 1.70), height loss (OR: 1.28; 95% CI: 1.04, 1.57) or either (OR: 1.32; 95% CI: 1.12, 1.55).

Discussion
More patients with kyphosis or height loss had x-rays done following the educational intervention. Ordering x-rays according to the guidelines may result in more fractures being detected. Patients with vertebral fractures may benefit with osteoporosis therapies.

P60

Taking into account patients' preferences: what does it mean to clinical practice guidelines developers?
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Context: There is an increasing recognition that clinical practice guidelines (CPGs) should consider patients' preferences, both in their development and implementation phase. However, there is no shared understanding of how this should be done and what should be the ultimate goal of this process. Goal: Describe how CPGs developers perceive the need to incorporate patients' preferences in the process of CPG development. Design: Qualitative study using semi-structured individual interviews. Analysis is being carried-out using template analysis and has been validated using group debriefing and member-checking. Setting: This study draws on work done in the United Kingdom by the REFER project team (Realistic Effective Facilitation of Elective Referral), which aims at developing CPGs for referral of adults with non-urgent conditions to surgical outpatients, taking into account patients' own preferences and assessments of their health status and quality of life. Participants: Guideline development group members from the REFER project, including health care professionals, patients' representatives, health care managers and researchers. Preliminary results: Although all participants appeared to agree with the need to incorporate patients' preferences in CPG development, preliminary analysis of data reveals a number of different and potentially conflicting understandings of the rationale for doing so. For some, patients' preferences are instrumental in developing more effective CPGs that patients and practitioners will better comply to. For others, respecting patients' preferences involves an active role of patients in defining what is an appropriate treatment and should be considered a goal in itself, even if it contradicts with other CPGs' purposes such as the promotion of effective and cost-effective care.

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SCOPING REVIEWS AS A METHOD TO INFORM GUIDING PRINCIPLES FOR THE DEVELOPMENT OF BEST PRACTICE GUIDELINES: AN EXAMPLE FROM THE FIELD OF HIV AND REHABILITATION

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Background
HIV is increasingly experienced as a lifelong, episodic disease, characterized by unpredictable cycles of wellness and illness. There is a need to develop the field of research, clinical practice, and related policy for HIV rehabilitation, to address the range of impairments, activity limitations, and participation restrictions associated with HIV and its treatments.

Purpose
To describe methods used to identify key principles for the development of best practice guidelines for rehabilitation professionals working with people living with HIV. These principles will then be used to inform the identification and development of best practices in this area.

Methods
Phase One included a scoping review of the published and grey literature pertaining to HIV and rehabilitation, seminal works on best practice and guideline development, and examples from other disease areas. Phase Two will include qualitative consultation (focus groups and interviews) with a range of stakeholders. The interview guide will address the quality criteria set forth by the AGREE Research Trust to facilitate the identification of clinical area(s) to promote best practice, level of stakeholder involvement, and rigor of development. Results are reported for Phase One.

Results
Using a broad search strategy for rehabilitation and HIV, we identified 4,724 publications in MEDLINE, EMBASE, CINAHL and PsychINFO databases. We reviewed the MEDLINE abstracts (N = 1260) and coded their content according to the Episodic Disability Framework which considers dimensions, contextual factors, and, triggers of disability. We identified 615 relevant abstracts and classified content as addressing: disablement, effectiveness of interventions, and provider roles; 147 were pulled for full review.

Discussion
Scoping reviews offer a comprehensive approach for reviewing the literature to inform future consultation with stakeholders. Collectively this methodology will help to identify principles for the development of best practice guidelines for HIV rehabilitation.

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SHARING EXPERIENCES FROM THE DEVELOPMENT OF A MULTIDISCIPLINARY GUIDELINE

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Background
The Clinical Audit and Guideline Working Group of Professional Development and Quality Assurance (PDQA) of Department of Health had published different evidence based guidelines in management of common primary health care problems like hypertension, diabetes mellitus, hyperlipidaemia, obesity, asthma, etc. In the past, our guidelines were developed by doctors only. However, according to the AGREE instrument, the guideline development group should include individuals from all the relevant professional groups and the patients' views and preferences should have been sought. To this end, we have involved other health care professionals than family physicians in the development of multidisciplinary guideline on management of tennis elbow.

Purpose
To share the experiences from the development of a multidisciplinary guideline on management of tennis elbow in primary care.

Methods
The Clinical Audit and Guideline Working Group of PDQA is taking the lead and participates in the co-operations with other disciplines for the development of tennis elbow guideline. The team consists of 3 family physicians, 1 occupational physician, 1 physiotherapist, 1 occupational therapist, 2 nurses and 1 patient. Throughout the process, all health care professionals, allied health professionals as well as the patient co-operated intensely so that evidence is synthesized and formatted into pragmatic recommendations.

Results
We found the experiences very good in the following ways:-

1. To learn about some of the specific patient-centre issues that the patient representatives considered important: enabling patient to participate as partner in decisions about their healthcare.
2. To have more in-depth knowledge about different modalities in physiotherapy and occupational therapy and their efficacy in management of tennis elbow.
3. To learn how to solve conflicts when it occurred during the development.
4. To learn how to deal with the absence of team members in our meetings.

Discussion
We have overcome the hindrances and successfully developed a multidisciplinary guideline.

P63

CAN SOCIO-ECONOMIC EVIDENCE BE USED IN CLINICAL GUIDELINES?

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Background
Clinical guidelines have traditionally taken little account of socio-economic factors when reviewing the evidence and formulating recommendations, even for conditions that show a steep social class gradient, such as obesity.

Purpose
To systematically review the literature on the impact of socio-economic differences on the effectiveness of dietary interventions for weight management in primary care.

Methods
A systematic review of randomised controlled trials evaluating the effectiveness of dietary interventions for weight loss was undertaken for the National Institute for Health and Clinical Excellence (NICE) clinical guideline on the identification and management of overweight and obesity in adults and children. The included studies were reviewed to determine if the effect of deprivation and its influence on outcomes in primary care populations had been evaluated. Additional searches were done to identify any qualitative studies that explored how socio-economic status and deprivation may affect the results of dietary weight loss interventions in primary care populations.

Results
Few randomised controlled trials that evaluated how the effectiveness of dietary interventions for weight management varied with differences in socio-economic status in primary care populations were identified and none applied to a UK primary care population. In addition, limited qualitative evidence was found giving an insight into some of the barriers and problems reported by people from deprived areas when trying to follow dietary advice for weight loss.

Discussion
No evidence-based statements or recommendations could be formulated on to how to minimise the impact of socio-economic differences on the effectiveness of dietary interventions for weight management in primary care populations. The absence of evidence meant it was not possible to pilot how such evidence could be incorporated into the recommendation development process for a national clinical guideline on obesity.

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PREPARING AN INFORMATION BROCHURE ON STRUCTURED EDUCATION FOR ADULT ASTHMATIC PATIENTS

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Background
Structured education helps asthmatic patients acquire the skills needed for self-care. It diminishes symptoms and the number of episodes, emergency calls and hospital admissions. However, patients have little awareness of this key component of disease management.

Purpose
To prepare a brochure informing asthmatic patients of the content and value of structured education.

Methods
A working group (5 experts, 4 patients' representatives) established the aims, key messages, format and means of diffusion of the brochure. Content was based on a literature review, guidelines for doctors, and a patient focus group. The first draft, written by a project manager, was amended by the working group. Its readability was judged using Flesch software. Its clarity and format were tested in face-to-face structured interviews (14 items) with 15 asthmatic patients. Content quality was judged by 10 health professionals. Impact and satisfaction were studied by telephoning professionals and pharmacies, and a satisfaction survey by asthma schools.

Results
The 16-page colour brochure describes 4 steps: (i) assessing needs; (ii) developing a tailored educational programme; (iii) acquiring self-care skills; (iv) assessing knowledge about asthma and its treatment. Readability was good (Flesch score: 84). The target of 80% of satisfactory responses/item was met in the patient interviews. The health professionals agreed with the content, but considered that the brochure should be accompanied by oral information. Aspects of the format were criticized and duly modified. Diffusion was as follows: 75,000 copies (doctors and pharmacists; 54% uptake), 5000 copies (patient association), posting on 10 websites, and presentation at a World Congress. The brochure was considered useful (78%) and well presented (85%) in the satisfaction survey.

Discussion
The brochure was a success but its production was costly and its impact was insufficiently evaluated. Its preparation led to the writing of a guide on how to prepare patient information.

P65

STANDARDS OF PRACTICE FOR SUICIDE RISK ASSESSMENT AND INTERVENTION FOR NURSES: A MULTI-PROFESSIONAL APPROACH TO DEVELOPMENT

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Background
Assessment and intervention for suicide, although imprecise, is fundamental to save lives. Frequently, a sole professional, a nurse, must astutely bring to the clinical situation, the empirical evidence to guide practice. The evidence, however, is multi-professional, as is this practice specialty.

Purpose
The Registered Nurses' Association of Ontario has created a multi-professional team to develop the best practice guideline for suicide risk assessment and intervention for Registered Practical Nurses and Registered Nurses.

Methods
As part of the RNAO Nursing Best Practice Guidelines Program, the topic for guideline development was selected based on a needs survey of RNAO stakeholders, including RNAO members. In January 2007, a multidisciplinary panel with expertise in practice, education and research from hospital, community, and academic settings was convened under the auspices of the RNAO. Guideline development processes followed the established methodology of the NPBG program.

Results
An extensive review of the literature and guidelines across professions has produced a clinical practice guideline that is empirically based and has ease of use for nurses across all domains of practice.

Discussion
This inter-professional process has produced rich dialogue and debate to refine the scope, the review, and the recommendations for this guideline, for a clinical specialty in which empiricism speaks less to finite 'truths' and more to clinical acumen. The unique opportunity, for inter-professional collaboration, is portrayed.

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AN EVALUATION, BY GUIDELINE USERS, OF AUSTRALIAN/NEW ZEALAND GUIDELINES IN KIDNEY DISEASE

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Background
Although guidelines are widely used internationally to summarise evidence for practice, few studies have evaluated the attitudes and opinions of the guideline users on guideline content, usage, effect and structure.

Purpose
To determine guideline users' views on the content and structure and effectiveness of the guidelines and to determine if there were any changes in their views since a survey in 2002.

Methods
A self administered survey was distributed to all Australian/New Zealand nephrologists and renal nurses requesting feedback on the Caring for Australasians with Renal Impairment (CARI) guidelines. This survey had 7 questions in common with the 2002 survey.

Results
211 nephrologists (70%) and 173 renal nurses (22%) responded. Over 90% of respondents agreed/strongly agreed that the guidelines were a useful summary of evidence. Nearly 60% of nephrologists and 85% of renal nurses reported that the CARI guidelines had significantly influenced their practice. The proportion of nephrologists reporting that the CARI guidelines had improved patient outcomes rose from 14% in 2002 to 38% in 2006. The proportion of nephrologists indicating confidence that the guidelines matched best available evidence increased from 51% in 2002 to 71% in 2006. Increasing age and male gender was associated with the 8% that lacked confidence that the guidelines matched best available evidence.

Discussion
In general Australian/New Zealand nephrologists and renal nurses valued the CARI guidelines more in 2006 than in 2002. The impact of the guidelines on patient outcomes indicates active implementation of the guidelines into practice. Uncovering and addressing concerns associated with age and male gender responses to the survey, may further increase confidence in the evidence base of the guidelines. The assessment of user's opinions is integral in the development of guidelines and can, for example, assist in the defining of content, use, effect and structure.

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THE CCS NATIONAL WORKSHOP INITIATIVE : A DISSEMINATION AND IMPLEMENTATION PROGRAM OF THE CCS HEART FAILURE CONSENSUS CONFERENCE

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Background
The National Workshop Initiative is a key strategy for the overall dissemination and implementation of the CCS Heart Failure Consensus Recommendations. This novel CCS workshop program is designed to actively engage the Canadian cardiovascular community in the ongoing usage and refinement of these evidence-based recommendations.

Purpose
In this session, the CCS is excited to share its experiences with this National Workshop Initiative and share our initial measurements and observations relating to dissemination and implementation of these guidelines.

Methods
The highly innovative and interactive workshops are developed and delivered in a standard format of three to four case-based presentations which capture key recommendations and practical tips published in the current iteration of the guidelines. Audience knowledge and understanding is assessed throughout the workshop with questions/answers via interactive response devices. Each workshop is evaluated by participants' volunteer response to a paper-based post-workshop evaluation. A series of six workshops were hosted in 2006 at the following venues:

- Annual Cardiovascular Conference,Lake Louise - March 2006
- Heart Failure Summit,Toronto - June 2006 oNew Brunswick Heart Meeting, St. John - September 2006
- Canadian Coucil of Cardiovascular Nurses, Vancouver - October 2006
- Canadian Cardiovascular Congress,Vancouver - October 2006
- College of Family Physicians Meeting, Montreal - November 2006

Results
Attendees (physicians, nurses, pharmacists and other health care professionals) from across Canada have already responded enthusiastically to this national initiative:

- 80% of workshop participants have rated the workshops as very good or excellent
- 82% of workshop participants increased their knowledge of heart failure
- 86% of workshop participants recommended it to their colleagues

Discussion
Overall feedback and evaluations of these 2006 workshops contributed significantly to the continuous improvement and sustainability of the CCS National Workshop Initiative as a strategic component of the CCS Heart Failure Consensus Conference Program. They have also been instrumental in helping define the needs of the Canadian heart failure care community and the relevance of content for the 2008 CCS HFCC Update. As we move into 2007, 2 additional workshops have been added (total of 8)and these will continue to be part of an ambitious CCS program designed to identify best practices in Knowledge Translation and how they might impact both clinical practice patterns and health outcomes. In addition, we have measured the year-over-year measurements of awareness and knowledge of these guidelines.

P68

DEVELOPMENT OF THE FIRST EVIDENCE-BASED GUIDELINE IN BOSNIA AND HERZEGOVINA: COUNSELING AND PROCEDURES ON ABORTION CARE

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Background
Agency for Health Care Quality and Accreditation in the Federation of Bosnia and Herzegovina have recognized the need to use more rigorous processes to ensure that health care recommendations in B&H are informed by the best available research evidence.

Purpose
to develop the first evidenced-based clinical guideline designed to assist health care providers in B&H on counseling and procedures of abortion care.

Methods
systematic review and critical appraisal of existing evidence based guidelines and remaining research applicable to the local settings. We searched PubMed and three databases for existing guidelines, systematic reviews and remaining research relevant to the local settings. Variation in values, needs, costs and resources were considered systematically in order to answer what should be done locally. Appraisal of Guidelines for Research and Evaluation (AGREE) were used to assess the guideline development for purposes of assuring methodological quality.

Results
RCOG guideline has been identified as the most appropriate evidence for our settings. After, permission has been achieved, electronic searches of medical databases were performed for the research performed in international settings similar to ours or after publishing of RCOG guideline. Selected as evidence were 226 articles yielding 68 recommendations aligned to clinical assessment questions.

Discussion
using expert consensus and external reviews, recommendations were generated that provided guideline development group with the best possible practice available to prevent further harm. Counseling on abortion as well as information on medical abortion procedures is achieved through understanding the risks of the woman and her fetus,while respecting the woman's intention.
For the first time in B&H, the evidenced-based clinical guideline development process fostered a supportive environment for educating health care providers on evidence based methodology, and new evidence based guidelines can be initiated for potential health care providers.

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THE FIRST STEPS FOR IMPLEMENTATION OF GUIDELINES SHOULD BE TAKEN DURING GUIDELINE DEVELOPMENT

Nicole Feller , Joke van den Bogert, Sonja Kersten, Saskia Vonk, Maureen de Boer , Willeke Heijbroek-de Clercq (The Dutch Association of Comprehensive Cancer Centres, Utrecht, The Netherlands)

Background
The Association of Comprehensive Cancer Centres (ACCC) facilitates the development, implementation and evaluation of clinical practice guidelines for oncological and palliative care in The Netherlands. Guideline implementation is a crucial step for creating awareness for new guidelines, which in turn increases guideline compliance. During guideline development many tools for creating awareness of the guideline are already available but are often not recognised as such. Therefore, opportunities for creating growing awareness of the new guideline during guideline development are missed.

Purpose
To create awareness for new guidelines during guideline development.

Methods
The ACCC creates awareness for new guidelines as follows:

- Founding of an active nation-wide, multidisciplinary tumour working group with key representatives from regional comprehensive cancer centres (CCC) working groups and/or from scientific and professional societies.
- Formulating clinical questions based on problems in daily practice by members of the tumour working group. A survey of these clinical questions is sent to patients and relevant professionals in the field with the request to give feedback reaction.
- Sending a draft of the guideline to all participating societies and asking for feedback and/or approval.
- Organising discussion meetings of CCC tumour working groups.

After guideline development, more awareness for the guideline is created by publication of the authorised guideline on the ACCC website Oncoline/Pallialine. Dissemination is enhanced by using the network of the CCCs with among others a specific notification system to inform users about new releases, publications, national and regional seminars. Furthermore, more awareness is created by using the CCCs consultation services, implementation- and break-through projects.

Results
In conclusion, at different stages of guideline development awareness of the new guideline can be created by communication and information to professionals in the field.

Discussion
The degree of guideline compliance can be measured using a number of indicators, established during guideline development.

P70

THE INCIDENCE OF GENERAL ANESTHESIA FOR CESAREAN SECTION IN PARTURIENTS WITH A PREVIOUS LABOR EPIDURAL: A PROSPECTIVE STUDY

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Background
The incidence of general anesthesia (GA) for cesarean section (CS) in women with a previously placed labor epidural has been estimated to be between 5.2% and 19.8%(1;2). Recent guidelines from the Royal College of Anaesthetists suggest that the incidence should be <3%(3).

Purpose
The purpose of this ongoing study is to determine the incidence of conversion of epidural analgesia to GA in a busy high-risk obstetric setting.

Methods
After ethics approval, we prospectively studied all women who had an epidural placed for labor and required a CS. The total sample size is 1000 women. Data collected included type of anesthesia and previously identified determinants of failure of epidural anesthesia1;2;4. The primary outcome was incidence of GA. The proportion of GAs was calculated and compared to 3%. We used descriptive statistics to analyze the demographics.

Results
As of December 2006, we recruited 327 patients. The mean maternal age was 33+/-4.3 years. The mean body mass index was 29+/-6.9. The incidence of GA was 13/327 (4.0%, 95% confidence interval 2.1% to 6.7%, p=0.31). The total incidence of failure was 20/327 (6.1%, 95% confidence interval 3.7 to 9.2%).

Discussion
Labor epidural analgesia can be successfully converted to anesthesia for CS in most patients. The incidence of GA in our sample was not statistically different from the College's suggested guidelines. Definition of factors that are associated with failure may help in early prediction and allow time to use other forms of regional anesthesia instead of GA in selected patients.

References

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P71

TRANSPARENCY AND COMMUNICATION = A ROADMAP TO CONSENSUS. INTRODUCTION OF CLINICAL GUIDELINES TO PERINATAL CARE IN ROMANIA

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Background
In spite of the high variation in Quality of Care delivered in Romanian maternities, the development and use of Clinical Practice Guidelines (CPG) is a relatively new feature. A consortium of Romanian stakeholder institutions, supported by international partners, including the Swiss funded Neonatology Project (RoNeonat), UNFPA, WHO, engaged in a multifaceted approach to guideline development and consensus building within a Quality Management framework.

Purpose
To assist in the development of modern CPGs, facilitate the consensus building process through transparency and active participation of a broad spectrum of experts and potential users and document the lessons learnt for further use.

Methods
A stepwise procedure was used: o Sensitisation and training on CPG development. o Needs assessment, identification of working groups, a steering committee and production of draft guidelines. o Consensus building through the involvement of all relevant stakeholders using stakeholder reviews, working groups, IT-platforms, national meetings. o Large scale pre-testing to maximise consensus. o Final approval and integration into a national training program.

Results
CPG development was initiated within the Romanian Neonatology Society. The experience gained and the induction of quality processes generated the support of the national authorities and professional bodies, which created the favorable framework for the extension of this work to the obstetrical community. At present 8 neonatology guidelines are currently applied and 24 obstetrical guidelines are under development.

Discussion
- Involving all relevant stakeholders - key to developing a successful process and to achieving consensus.
- Strategic communication, transparency of the process and producing successful examples facilitate the discussion.
- There is a strong need to understand the processes and work on consensus building in order to build trust and a sense of involment.
- The incorporation of CPGs into a QM process and the integration into national continuous education programs may considerably reduce the delay between development and application of CPGs.

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A UNIQUE STRATEGY FOR GUIDELINES IMPLEMENTATION

Francine Borduas, Richard Ward (Office of Continuing Professional Development, Faculty of Medicine, Université Laval, Office of Continuing Medical Education and Professional Development, University of Calgary)

Background
Despite the fact that many organizations continue to develop quality, evidence-based guidelines, translation into clinical practice remains a challenge. In 2006, a unique, flexible continuing professional development program was created to help disseminate recently developed national guidelines to general practitioners and family physicians across Canada.

Purpose
This poster will describe a unique strategy for guideline dissemination using adult educational principles.

Methods
Based on educational needs identified through a needs assessment process, a multifaceted program was developed to help disseminate guidelines regarding prescribing non-steroidal anti-inflammatory drugs (NSAIDs). Within this program format, an on-the-spot needs assessment identifies unrecognized learning needs and determines which of 13 controversial statements should be covered. Reinforcing tools help in disseminating key messages.

Results
In the first three months of 2007, approximately 40 sessions were held. This program encourages clinical questioning, helps participants identify knowledge gaps and promotes linking learning to practice. Its modular nature allows for flexibility in terms of session length, and permits the program to be easily adapted and updated as new learning needs arise.

Discussion
This program is an innovative method for disseminating guidelines that may aid in translating guidelines into clinical practice. Though this program format requires some background knowledge on the part of participants, the platform allows learning needs to be effectively and efficiently targeted. This concept can also be applied to other themes or topics.

P73

USING DATA FROM CRITICAL INCIDENT REPORTING SYSTEMS TO INTRODUCE PATIENT SAFETY ASPECTS IN THE GERMAN DISEASE MANAGEMENT GUIDELINE PROGRAMME. CHANCE AND CHALLENGE

C. Thomeczek, J. Rohe, G. Ollenschläger ()

Background
Critical Incident Reporting Systems (CIRS) offer the opportunity to health care workers to safely discuss critical incidents and learn from each other. Thus CIRS can identify system related latent errors and typical pitfalls in patient care. In the last couple of years the demand to integrate patient safety aspects into all aspects of health care grew stronger. To accomplish this in the area of guidelines, we use the data of CIRS during the process of guideline development.

Purpose
To describe the process of using CIRS-data to integrate patient safety aspects in the German Disease Management Guideline programme.

Methods
The German CIRSmedical.de is an open access web-based system for users from all specialties from inpatient as well as outpatient care. Besides the CIRSmedical.de there are further specialty-specific CIRS implemented in Germany.
During guideline development open access CIRS are screened for reports concerning the disease in focus. Pitfalls and latent errors are extracted from relevant reports and discussed with the authors of the guideline. If consensus is reached that it is an important pitfall, these error-prone situations are mentioned in the guideline. If a possibly very dangerous pitfall is identified, it is marked as a "red flag" patient safety item.

Results
As this project is still in progress an example is provided: The report in the CIRS describes the prescription of diclofenac to a patient with a known diclofenac allery. Since allergies to diclofenac and other medications used to treat lower back pain are frequent a specific reminder to ask for allergies could be integrated in the guideline. Even though it is clearly understood that the question about allergies is always necessary.

Discussion
The use of CIRS to name important pitfalls and errors provides the chance to integrate the aspect of patient safety in guideline development. However, the challenge to identify the relevant incident reports and to extract the important error-prone tasks is huge.

P74

USING THE G-I-N DATABASE TO FACILITATE COLLABORATION ACROSS EUROPE

Gerd Guido Hofmann, Angela Maienborn, Cornelia Jaursch-Hancke, Viktor Büber (Liaison Officer European Union of Medical Specialists (UEMS), Munich, Germany, Principal Officer Guidelines International Network, Germany, Department of Endocrinology, German Clinic for Diagnostics, Wiesbaden, Germany, UEMS Section of Internal Medicine, Berlin, Germany)

Background
In 2002 the European Manual of Internal Medicine was published by the Editorial Board of the European Board of Internal Medicine of the UEMS. This compendium for diagnosis and treatment of internal diseases was based on the consensus of scientists and clinician from all European countries organised in the UEMS and represents a common standard for management of internal diseases in all of Europe. The next run of the manual will be published on the website of UEMS. To ensure the integration of best evidence links to clinical practice guidelines will be integrated in the online version aiming at implementing and disseminating evidence based guidelines for Internal Medicine in Europe.

Purpose
Main goals of this project are to:
1)bring evidence to daily practice
2)put together guidelines from different European countries outlining differences and similarities
3)developing the compendium chapter by chapter starting with a top priority topic
4)involve all relevant European scientific associations

Methods
All European clinical practice guidelines related to diabetes available at the International Guideline Database (www.g-i-n.net) will be reviewed by representatives of the European Boards for Internal Medicine and checked concerning completeness. The Board will designate authors to design the different chapters starting with diabetes. The chapters will be then be reviewed by experts.

Results
The first chapter is expected to be finalised at the end of 2007. There is planned to evaluate the use by clinicians and to take up their suggestions for the update.

Discussion
Providing clinicians with a compendium for daily practice will enable clinicians to get fast and easy access to best practice. Main problems expected will be to get authors to provide chapters for the different specialities in real time, as experienced during the first run of publication.

P75

WHO-Rules on Missed Contraceptive Pills Adapted to A New Dutch Guideline

Boukes FS, Wiersma Tj.

Background

The combination pill is a very reliable contraceptive method. Guidelines on missed pills were based on the 'rule of seven'. Emergency contraception (EC) could be necessary in case of missing a pill in the first seven days after the pill-free interval (PFI). EC is available without prescription in the Netherlands since 2005. In guidelines of the Dutch College of General Practitioners (NHG), the scientific organizations of pharmacists (WINAp) and gynaecologists (NVOG) confusingly different recommendations were given on EC in case of missed pills. This seemed to be an undesirable situation.

Methods

In 2004 the WHO constructed new, simplified rules on missed pills, which stated that only when 3 or more (sub50) or 2 or more (sub30) pills are missed, action is needed. A multidisciplinary group (GP's, pharmacists, gynaecologists) agreed to take the WHO-advice as a starting point and adapt it to a new Dutch guideline.
The evidence consists of 20 studies among 5-120 women. The risk of ovulation when missing one or two pills seemed to be very small, and pregnancy almost impossible because of the cervical mucus-factor and endometriumatrophy caused by the pill.

Results

Not everyone judged the evidence convincing enough, especially in case of two missed pills directly following the PFI. The WHO-group was asked to give us background information about their decisions, which they did in an e-mail correspondence. The process of adaptation took approximately six months. It was possible to reach consensus on the following guideline: In case of one missed pill no extra precautions are needed. The group also reached consensus on the recommendation that EC is only indicated in case of two or more missed pills in the first week after PFI and unprotected sex in the last 72 hours.

Discussion

The new guideline gives an simple recommendation in the far most common situation: one missed pill. NHG is working hard on the implementation of that new rule, in collaboration with other Dutch organizations. In the meantime progress is made in reaching consensus on a simple advice in the situation that more pills are missed.

P76

ADAPTING AND IMPLEMENTING GUIDELINE TO IMPROVE MORTALITY DATA

Fawzi Amin, Jamal Alsayyad, Ahmed Omran (Ministry of Health)

Background
Health Decisions and policies will depends on current, timely information about health problems. Mortality data one of the most used and important source of information. Most of the countries have committed to report internationally statistics on who dies from what cause. Several international reports that few countries have good-quality data on mortality, our country Bahrain was classified among other countries with low quality of Mortality data. Preliminary investigation shows that medical residents were mainly responsible to certify most Death certificate, with no under-or post- graduate formal training, no identified guideline were used, thus many certificate were not filled according to accepted and correct cause of death, the ill defined codes represent 25%.

Purpose
An investigation was conducted in 2005 to analyze and recommends the appropriate action to improve the quality of Mortality data.

Methods
Literatures review identify and select the appropriate guideline, followed by reprint and developing local version based on death certificate with bilingual language (Arabic and English). Mini-workshop to introduce the guideline was developed, incomplete and wrongly made certificate, Case studies and several scenarios were used in the workshop. It was introduce in the Undergraduate Medical student curriculum, and most residency programs, other specific course were given to post-graduate Physicians.

Results
The results of the first Audit in 2005 will be introduce, the contents of the workshop and the guideline will be presented.

Discussion
Guidelines have an important role in changing the behavior of health workers, if it designed and disseminated in appropriate, acceptable and attractive way. The involvement and ownership of the guideline contribute to its implementation and adapting the required changes.

P77

EBM AND CLINICAL TRIAL IN KOREAN ORIENTAL MEDICINE

In-Hwa, CHOI (Kyung Hee University, East-West Neo Medical Center)

Background
The concept of evidence-based medicine(EBM) ensures that physicians are familiar with using a calculated estimate of the patient's probability of having a disease, and to understand potential risks and benefits of tests and treatments. However, Korean Oriental medicine still has many problems with clinical trials, for instance; lack of funding from pharmaceutical companies and government and lack of standardized research methodology. Generally in Oriental Medicine, it is very important to assess patients' individually. So it's more difficult to design a clinical trial and make guidelines about a certain disease.

Purpose
The aim of this study is to examine the situation of EBM and clinical trials in Oriental Medicine in Korea up to January 2007.

Methods
I checked how hospitals are nominated to offer clinical trials; phases 1, 2 and 3; ; currently used in Korea. After that I established how many oriental hospitals are included in this system. I also tried to search for both the completed clinical trials of these hospitals and other on-going trials.

Results
1. Phase 1; clinical trials hospitals (until January 2007): 33 hospitals
2. Phase 2 ; clinical trials hospitals (until January 2007): 87 hospitals (including 4 Oriental hospital, 0.05%)
3. Phase 3; clinical trials hospitals (until January 2007): 109(including 9 Oriental hospital, 12.1%)
4. 9 hospitals among 73 Oriental hospitals recieved permission for phase 3; clinical trials.
5. Study subject:
1)related to acupuncture-14
2)related to herb-medicine -30
3)related to medical devices - 9
4)related to food - 2
5)others - 6

Discussion
It's very important to develop mechanisms for re-embedding knowledge shaped by practice back into our professional knowledge base so that it becomes richer and deeper. Therefore we should do our best to increase and improve the development of methodology for EBM and clinical trial in Korean Oriental Medicine.

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PROVINCIAL GUIDELINES FOR PREPAREDNESS FOR PANDEMIC INFLUENZA IN JAPAN

Yuichiro Yahata, Yoshiharu Fukuda, Hiroyuki Nakao, Hirohisa Imai (National Institute of Public Health)

Background
Preparedness for and response to Pandemic Influenza H5N1 is an extremely important concern around the world. The Ministry of Health, Labor and Welfare (MHLW) of Japan distributed a Pandemic Influenza Preparedness Action Plan in November 2005, and then requested similar plans from provincial government offices. Almost all provincial governments had prepared a Pandemic Influenza Preparedness Action Plan by 2006. However, many of these plans do not have grading of alert levels or detailed plans for action.

Purpose
We discussed the most useful grading of alert level for response and distributed the standardized manual on the Pandemic Influenza Response Plan based on non-pharmacologic intervention at each level.

Methods
We collected pandemic response plans from the web sites of WHO and many countries. We discussed which plans were most useful for grading of alert levels and the detailed responses they outlined for non-pharmacologic intervention.

Results
We compared several countries' plans. The definition of alert level by Singapore was the most useful and detailed, as was Singapore's grading of the pandemic situation of H5N1 infection. Singapore has described the details of non-pharmacologic intervention at each alert level. We have referred to describe in the provincial office for response.

Discussion
The Pandemic Influenza preparedness and response plan developed by Singapore included the most useful grading for alert level and details of preparedness and response by non-pharmacologic intervention, of the plans that we studied. We have been important for non-pharmacologic intervention. For example, Tamiflu would be deficiency to prescribe for H5N1 virus infection of person post novel influenza occurred. Therefore, we concluded that Singapore has planned the most useful grading system and preparedness and response plan.

Abstract Author Index

G-I-N Abstract Author Index

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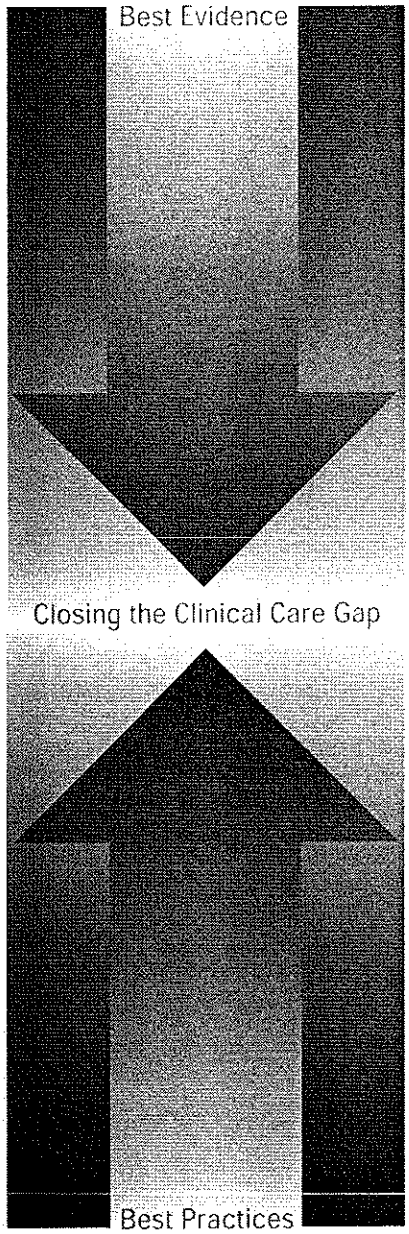

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About the GAC

The Guidelines Advisory Committee (GAC) was established by the Ontario Ministry of Health and Long-Term Care and the Ontario Medical Association to promote evidence-based health care in Ontario, by encouraging physicians to use the best available clinical practice guidelines.

Objective

GAC assists physicians by identifying the best evidence-based guidelines for a topic area, and summarizing them for ease of use. The GAC's guideline review process has resulted in our endorsement of over 70 guidelines to date.

Review Process

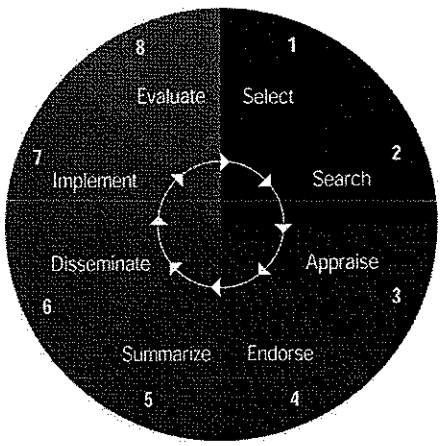
Topic areas are selected based on the needs of community-based physicians, the availability of quality evidence, the clinical significance of the topic and other factors. An international search for guidelines is performed and selected guidelines are assessed by 4 independent physicians, using the Appraisal of Guidelines Research and Evaluation (AGREE) instrument.

Endorsement

Following an in-depth review of the physician assessments, the GAC endorses those guidelines deemed the best developed and most applicable in Ontario. Summaries of the GAC endorsed guidelines are developed and posted on the GAC website, along with tools for implementation. (**www.gacguidelines.ca**). Links to all other assessed guidelines are also provided, where available.

Implementation

The GAC also develops and recommends appropriate strategies for guideline dissemination, implementation and evaluation, working closely with the Ontario Guidelines Collaborative, a multi-stakeholder, inter-disciplinary network of organizations and associations involved in educating physicians and improving the processes and outcomes of health care in Ontario.



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