5th International G-I-N Conference 2008

Implementation in Practice
October 1-3, 2008
Finlandia Hall, Helsinki, Finland

www.gin2008.org
5th International G-I-N Conference 2008
Implementation in Practice

Host
The Guidelines International Network

Organiser
Current Care, the Finnish Medical Society Duodecim

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Welcome Messages

Dear colleagues,

We are happy to welcome you at G-I-N’s 5th International Conference in Helsinki. Originally, this conference was intended to be a regional European meeting, as part of our conference policy. But the Finnish organizing team was so successful in preparing the program and attracting many people from all over the world, that the G-I-N board unanonymously decided to upgrade this meeting to our 5th annual conference. Congratulations!

The theme of the conference is implementation. This is an issue in which relatively small countries as Finland have shown to be large and successful. More than 90% of the Finnish general practitioners use evidence-based guidelines in their daily practice. Which country has similar figures?

International collaboration in guidelines is often focused on guideline development methods whereas implementation could be considered as a local issue. This is a serious misunderstanding. Implementation is a science that intends to enhance the knowledge on facilitators and barriers in using tools for healthcare improvement and to produce high standards on implementation strategies. These can be shared worldwide, as reflected in G-I-N’s preferred electronic journal Implementation Science, publishing full text articles in the public domain.

G-I-N is very interested in hearing your success stories of implementation and in the lessons learned from your experience. Please inform your international colleagues and friends, and ask them questions as well.

The scientific program offers many opportunities to exchange the topics of your interest among your colleagues and in the social program you can make them friends.

We hope that you will enjoy this conference very much. You are welcome!

Jako Burgers,
Chair of G-I-N
Welcome from the Current Care Guidelines!

Current Care Guidelines in the Finnish Medical Society Duodecim is very pleased to host the 5th International G-I-N Conference. We wish you warmly welcome to participate the conference in Finlandia Hall, Helsinki.

The Finnish Medical Society Duodecim, founded in 1881, promotes and supports medical research and continuous medical education. Duodecims’ Current Care is a bit younger: the national evidence-based guidelines have now been available for 15 years and been a great success, which hopefully continues. Finnish health care professionals and patients open our guidelines three times a minute every day. Focus will even more be in the implementation of the guidelines in the future. “Implementation in practice” is also the main theme of this conference. We hope that all the international experience of implementation practices will spread and every one of you will get some new ideas to take back home.

We hope that our meeting will fulfil your expectations from both scientific and social point of view and hope you will enjoy your time with us.

On the behalf of the organizing committee

Eeva Ketola
Chair of the organizing committee
Current Care
International Scientific Committee

Chair of the Scientific Committee:
Professor Marjukka Mäkelä
Director, Finnish Office for Health Technology Assessment (FinOHTA)/Stakes
Finland

Jako Burgers
MD, PhD, Guideline Program Director, Dutch Institute for Healthcare Improvement CBO
the Netherlands

Maaret Castrén
Professor, Department of Clinical Science and Education, Karolinska Institutet
Sweden

Signe Flottorp
Research director, Norwegian Knowledge Centre for the Health Services
Norway

Frode Forland
MD, DPH, Director Primary Health Care, Directorate for Health and Social Services
Norway

Minna Kaila
MD, PhD, Adjunct Professor, Senior Medical Officer, Finohta/Stakes
Finland

Jorma Komulainen
MD, Consultant pediatric endocrinologist, Development manager,
Current Care, the Finnish Medical Society Duodecim,
Finland

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

Angela Maienborn
G-I-N Principal Officer
Germany

Najoua Mlika-Cabanne
MD, PhD, French National Health Authority (HAS)
France

Taina Mäntyranta
Director, the Centre for Pharmacotherapy Development
Finland
Günter Ollenschläger  
MD, PharmD, PhD, FRCP Edin, German Agency for Quality in Medicine (AQuMed / AEZQ)  
Germany

Alan Pearson  
Professor, Joanna Briggs Institute / University of Adelaide  
Australia

Risto Roine  
MD, PhD, Helsinki and Uusimaa Hospital District  
Finland

Jean R. Slutsky  
Director, Center for Outcomes and Evidence, U.S. Agency for Healthcare Research and Quality  
USA

Airton Stein  
PhD, Coordinator of Guidelines at Conceição Hospital, Professor of Public Health FFFCMPA  
Brazil

Thorkil Thorsen  
PhD, Copenhagen Research Unit for General Practice  
Denmark

Juha Pekka Turunen  
MD, PhD, Head of Education, the Finnish Medical Society Duodecim  
Finland

Sara Twaddle  
Dr, Director, Scottish Intercollegiate Guideline Network  
Scotland

Liisa-Maria Voipio-Pulkki  
MD, PhD, the Association of Finnish Local and Regional Authorities  
Finland

Maritta Välimäki  
PhD, RN, Professor, Faculty of Medicine, University of Turku  
Finland
Floor Plan for Meeting Rooms
Finlandia Hall
Mannerheimintie 13 e, FI-00100 Helsinki, Finland
Information for Registrants

The Registration and Information desks are open in the Finlandia Hall lobby:
• on Thursday October 2, 2008 from 8.00 to 18.00
• on Friday October 3, 2008 from 8.00 to 16.00

To enter Finlandia Hall please use the door M3 for Helsinki Hall.

Name badges
Please wear your name badges throughout the conference. The name badge is your ticket to the sessions and also to the catering in Finlandia Hall.

Certificates of attendance
After the G-I-N Conference 2008 all participants are invited to print out a certificate using an online system. In order to print the certificate the participants are first asked to fill in a questionnaire. A link to this system is sent to all by email on October 3, 2008.

Internet, Messages and Phones
Internet terminals can be found from the Aalto-lounge and from the entrance hall on the Entrance level.
Messages will be placed on the notice board near the registration desk. Please keep your mobile phones turned off during conference sessions.

Catering
Morning and afternoon coffees will be served in the Helsinki Hall foyer. On Thursday lunch is served in the Finlandia Hall foyer and on Friday in the Restaurant (both on Auditorium level).
The caterer has been advised of any special dietary requirements. If you have requested a special diet in advance this will be available for you.

Coats
There is a coat rack near the registration desk at the Entrance level.

Parking
There is space for over 400 cars in the car park. Access is from Mannerheimintie via Karamzininkatu.

Please use the door K3 when entering Finlandia Hall from the car park.
Programme at a Glance

Wednesday, October 1, 2008
8.30–18.00  Registration
16.15–17.15  G-I-N Annual General Meeting – Helsinki Hall
17.15–18.00  Welcome and Cocktails – Finlandia Hall lobby

Thursday, October 2, 2008
8.00–18.00  Registration and Poster Set-up
9.00–9.30  Opening Ceremony – Helsinki Hall
9.30–10.15  Plenary 1 – Knowledge Translation and Guidelines – Helsinki Hall
   Plenary speaker: Professor Alison Kitson (Green College, University of Oxford, UK)
   Discussant: Dr. Taina Mäntyranta (The Centre for Pharmacotherapy Development ROHTO, Finland)
10.15–10.45  Coffee break, Exhibits and Poster viewing
10.45–12.30  Session 1
   Brief Presentations / Workshops
12.30–13.45  Lunch
13.45–15.00  Session 2
   Brief Presentations / Workshops
15.00–15.30  Coffee break, Exhibits and Poster viewing
15.30–17.00  Session 3
   Brief Presentations / Workshops
17.00–18.00  Plenary 2 – Guideline Implementation Research – Helsinki Hall
   Plenary speaker: Director Jean Slutsky (AHRQ, USA)
   Discussant: Professor Jeremy Wyatt, Director of the Health Informatics Centre, UK
19.00–00.30  The G-I-N 2008 Gala dinner, Ballroom, Hotel Scandic Continental

Friday, October 3, 2008
8.00–16.00  Registration
9.00–10.15  Plenary 3 – Guideline Implementation in Practice – Helsinki Hall
   Plenary speakers: Dr. Safia Qureshi (SIGN, Scotland) and Professor Bjørn Gulsvog (Norwegian Directorate for Health and Social Services, Norway)
10.15–10.45  Coffee break, Exhibits and Poster viewing
10.45–12.30  Session 4
   Brief Presentations / Workshops
12.30–13.45  Lunch
13.45–15.00  Session 5
   Brief Presentations
15.00–15.30  Closing Ceremony – Helsinki Hall
Plenary Speakers and Social Events

OPENING WORDS:

Minister of Health and Social Services Paula Risikko
Ministry of Social Affairs and Health, Finland

PLENARY SPEAKERS:

Professor Bjørn Gulvog
Norwegian Directorate for Health and Social Services, Norway

Professor Alison Kitson
Green College, University of Oxford, UK

Dr. Taina Mäntyranta
The Centre for Pharmacotherapy Development ROHTO, Finland

Dr. Safia Qureshi
SIGN, Scotland

Director Jean Slutsky
AHRQ, USA

Professor Jeremy Wyatt
Director of the Health Informatics Centre, UK

SOCIAL EVENTS:

Welcome and cocktails
Wednesday October 1, 2008
from 5.15 pm to 6.00pm
Finlandia Hall
Mannerheimintie 13e
FI-00100 Helsinki
Dress code: informal
Free for all the G-I-N Conference participants

Gala dinner
Thursday October 2, 2008
from 7.00 pm to 00.30 am
Ballroom, Hotel Scandic Continental Helsinki
Mannerheimintie 46
FI-00260 Helsinki
Dress code: White tie, evening dress
Programme – Implementation in Practice

WEDNESDAY OCTOBER 1, 2008

8.30–18.00 Registration
10.00–16.00 G-I-N Board Meeting
16.15–17.15 G-I-N Annual General Meeting – Terrace Hall
17.15–18.00 Welcome and Cocktails – Finlandia Hall lobby

THURSDAY OCTOBER 2, 2008

8.00–18.00 Registration and Poster set up
9.00–9.30 Opening Ceremony – Helsinki Hall
Opening words:
Minister of Health and Social Services Paula Risikko
Ministry of Social Affairs and Health, Finland

9.30–10.15 Plenary 1 – Knowledge Translation and Guidelines – Helsinki Hall
Chairs: Minna Kaila, Finland and Airton Stein, Brazil
Plenary speaker: Professor Alison Kitson
(Green College, University of Oxford, UK)
Discussant: Dr. Taina Mäntyranta
(The Centre for Pharmacotherapy Development ROHTO, Finland)

10.15–10.45 Coffee break, Exhibits and Poster viewing

10.45–12.30 Session 1 / Workshops and Brief Presentations

WORKSHOPS

W1 Rating the Quality of Evidence and Strength of Recommendations Using GRADE
Flottorp S, Norwegian Knowledge Centre for the Health Services; Vist G, Norwegian Knowledge Centre for the Health Services; Schünemann HJ, Dept. of Epidemiology, Italian National Cancer Institute Regina Elena; Kunz R, Basel Institute of Clinical Epidemiology, University Hospital Basel, Switzerland

W2 The Best of Both Worlds. Evidence and Practice: Making it Work
Palda V, Guidelines Advisory Committee, Centre for Effective Practice; Rogers J, Centre for Effective Practice; Lang K, Centre for Effective Practice; Kapur A, Guidelines Advisory Committee

W3 Disease Management Programmes: A Way to Implement Guidelines
Burnand B, IUMSP, CHUV and University of Lausanne, Switzerland; Ollenschläger G, German Agency for Quality in Medicine (AQuMed)

Boivin A, Center for Quality of Care Research, the Netherlands; Currie K, National Institute of Clinical Studies, National Health and Medical Research Council; Burgers
J, Dutch Institute for Healthcare Improvement (CBO), the Netherlands / Centre for Quality of Care Research (WOK), University Medical Centre Nijmegen, the Netherlands; Fervers B, SOR, FNCLCC, Centre Léon Bérard, Lyon, France; Gracia J, Agencia Lain Entralgo, Spain; Marshall C, Independent Guideline Advisor Thomas V, NICE; van der Weijden T, Center for Quality of Care Research, Department of General Practice, Universities of Maastricht and Nijmegen, the Netherlands

W5 Guidelines: Horses for Courses (Different needs, different solutions)
Hemming M*, Therapeutic Guidelines Ltd.; Kunnamo I*, The Finnish Medical Society Duodecim

BRIEF PRESENTATIONS / IMPLEMENTATION 1
HELSINKI HALL
Chairs: Jorma Komulainen and Arja Helin-Salmivaara, Finland

L1 Peri-operative Fasting Guideline Implementation Study Evaluation (PoISE); Understanding how we can change practice
Bullock I, Royal College of Nursing; on behalf of the PoISE study team, collaborating with the Royal College of Anaesthetists

B1 Implementation and Evaluation of a Breast Cancer Guideline by Use of Quality Indicators: 5 Year Results from the Institutional and the National Level in Germany
Albert US, Philipps-University, Faculty of Medicine, Breast Center Regio, Marburg; Reiter A, Federal Office of Quality Assurance (BQS gGmbH), Düsseldorf; Kopp I*, Association of the Scientific Medical Societies in Germany, Düsseldorf

B2 Implementing Guidelines Through Education; Multimedia a Must
Lakhanpaul M*, National Collaborating Centre for Women’s and Children’s Health and the University of Leicester; Blackwell N, Health Education Research and Development Unit, University of Leicester; Manikan L, University of Leicester

B3 Improving the Quality of Care for Patients with Chronic Kidney Disease: A Systematic Review
Irving MJ*, 1. Centre for Kidney Research, The Children’s Hospital at Westmead, Australia 2. School of Public Health, University of Sydney, Australia; Polkinghome KR, Nephrology Dept, Monash Medical Centre, Clayton, Victoria, Australia; Frommer M, School of Public Health, University of Sydney, Australia; Craig JC, 1. Centre for Kidney Research, The Children’s Hospital at Westmead, Australia 2. School of Public Health, University of Sydney, Australia

B4 Promoting Implementation of Current Care Guidelines - Dealing with Cardiovascular Risks in Päijät-Häme Region
Kuronen R*, Päijät-Häme Social and Health Care District; Patja K, National Public Health Institute
B5 Bridging the Gap: A Model for an Interdisciplinary Clinical Pathway in Primary Care in Belgium
Peremans L*, Domus Medica vzw, Belgium; Thijs G, Domus Medica vzw, Belgium Seuntjens L, Domus Medica vzw, Belgium; van der Stighelen V, Domus Medica vzw, Belgium; van Royen P, Domus Medica vzw, Belgium

12.30–13.45 Lunch

13.45–15.00 Session 2 / Brief Presentations

**ELECTRONIC DECISION-SUPPORT**
**AURORA HALL**
Chairs: Maaret Castrén and Alpo Vuorio, Finland

B6 Implementing Electronic Decision Support – Pilot Survey of Attitudes
Kortteisto TRH*, School of Public Health, University of Tampere; Kaila M, Finolta/Stakes and School of Public Health, University of Tampere; Kunnamo I, Health Centre Karstula and Duodecim Publication Ltd.; Mäkelä M, Finolta/Stakes; Rissanen P, School of Public Health, University of Tampere

B7 The Manitoba Project: Testing the Effect of Incorporating Diagnostic Imaging Guidelines into an Electronic Order Entry System
Reed M, Canadian Association of Radiologists; Bowen S, Research and Evaluation, Winnipeg Regional Health Authority; Johnson K, Research and Evaluation, Winnipeg Regional Health Authority; Zhang L, Research and Evaluation, Winnipeg Regional Health Authority; Curry L, CurryCorp Inc.

B8 Real-time Clinical Decision Support by Duodecim Integrated into Mediatri Electronic Health Records

B9 A Clinical Decision Aid in a Guideline: Easier for GPs to Implement?
vande Vyver N*, Domus Medica vzw, Belgium; van Linden A, Domus Medica vzw, Belgium; De Sutter A, Domus Medica vzw, Belgium; Michels J, Domus Medica vzw, Belgium

B10 Implementation of EBM Guidelines through a Portal Service

**INDICATORS**
**HELSINKI HALL**
Chairs: Katriina Kukkonen-Harjula and Marja Puurunen, Finland
B11 Quality Indicators as a Valuable Evaluation and Quality Improvement Tool in the Implementation of the German National Disease Management Guidelines
Fishman L, German Agency for Quality in Medicine (AQuMed); Nothacker M, German Agency for Quality in Medicine (AQuMed); Meyerrose B, German Agency for Quality in Medicine (AQuMed); Villarroel D, German Agency for Quality in Medicine (AQuMed); Weinbrenner S*, German Agency for Quality in Medicine (AQuMed); Ollenschläger G, German Agency for Quality in Medicine (AQuMed)

B12 Developing a Standardised and Efficient Procedure for Guideline Monitoring
Rutters D*, German Agency for Quality in Medicine (AQuMed); Rollig C, German Agency for Quality in Medicine (AQuMed); Weinbrenner S, German Agency for Quality in Medicine (AQuMed); Ollenschläger G, German Agency for Quality in Medicine (AQuMed)

B13 Translating Guideline Recommendations into Algorithms for Quality Indicators – an Example from Cardiac Pacemakers
Boy O, BQS (National Institute for Quality in Healthcare); Doebler K, BQS (National Institute for Quality in Healthcare); Veit C, BQS (National Institute for Quality in Healthcare)

B14 Adaption of QUALIFY to be Used for the Development of Indicators for Guidelines
Reiter A*, BQS Bundesgeschäftsstelle Qualitätssicherung gGmbH; Fischer B, BQS Bundesgeschäftsstelle Qualitätssicherung gGmbH Kötting BQS Bundesgeschäftsstelle Qualitätssicherung gGmbH; Geraedts M, University of Düsseldorf; Jäckel WH, University of Freiburg; Ollenschläger G, ÄZQ Ärztliches Zentrum für Qualität in der Medizin; Döbler K, BQS Bundesgeschäftsstelle Qualitätssicherung gGmbH

B15 Redistribution of Economic Resources by Implementing Guidelines and Agreement on Division of Tasks
Ketola E, The Finnish Medical Society Duodecim, Current Care; Sipilä R, The Centre for Pharmacotherapy Development

B16 Measuring Current Care with Indicators based on Evidence Based Guidelines for patients with non-Hodgkin Lymphoma
Wennekes L*, Radboud University Nijmegen Medical Centre, Centre for Quality of Care Research (WOK), The Netherlands; Hermens RPMG, Radboud University Nijmegen Medical Centre, Centre for Quality of Care Research (WOK), The Netherlands; Schouten HC, University Hospital Maastricht, Department of Hematology, The Netherlands; Raemaekers JM, Radboud University Nijmegen Medical Centre, Department of Hematology, The Netherlands; Punt Radboud CJ, University Nijmegen Medical Centre, Department of Oncology, The Netherlands; Wollersheim HCH, Radboud University Nijmegen Medical Centre, Centre for Quality of Care Research (WOK), The Netherlands; Ottevanger PB, Radboud University Nijmegen Medical Centre, Department of Oncology, The Netherlands
L2 Strength of Recommendations According to the GRADE System
Flottorp S, Norwegian Knowledge Centre for the Health Services; Vist G, Norwegian Knowledge Centre for the Health Services; Kunz R, Basel Institute of Clinical Epidemiology, University Hospital Basel, Switzerland; Schünemann HJ, Dept. of Epidemiology, Italian National Cancer Institute Regina Elena

B17 The Challenges in Transferring Systematic Methodologies to Develop Guidance from the Clinical Field to Health Protection (a Specialised Area of Public Health)
Sanchez-Vivar A, Health Protection Scotland (HPS) and Health Protection Network (HPN); James R*, Scottish Intercollegiate Guidelines Network (SIGN); Harbour R, SIGN; Murdoch H, HPS; Redman C, HPS; Blatchford O, HPN; Donaghy M, HPS

B18 Guideline Adaptation in Practice: Preliminary Results from the Evaluation of the use of the ADAPTE Framework and Process
Burnand B, IUMSP, CHUV and University of Lausanne, Switzerland; Rémy-Stockinger M, SOR, FNCLCC, Centre Léon Bérard, Lyon, France; Fervers B, SOR, FNCLCC, Centre Léon Bérard, Lyon, France; Collaboration ADAPTE

B19 Systematic Review, Adaptation and Consensus: Using a combination of methods to collaborate in the development of cancer guidelines in Ontario, Canada
McNair S, Cancer Care Ontario’s Program in Evidence-Based Care (CCOPEBC) and McMaster University; Brouwers M, Cancer Care Ontario’s Program in Evidence-Based Care (CCOPEBC) and McMaster University

B20 Guideline Adaptation – Not as Easy as it Sounds
Harstall C, Institute of Health Economics; Moga C, Institute of Health Economics; Scott A, Institute of Health Economics; Taenzer P, Calgary Health Region Chronic Pain Centre

L3 Grading and Summarizing the Quality of Evidence for Management Recommendations According to the GRADE System
Flottorp S, Norwegian Knowledge Centre for the Health Services; Vist G, Norwegian Knowledge Centre for the Health Services; Kunz R, Basel Institute of Clinical Epidemiology, University Hospital Basel, Switzerland; Schünemann HJ, Dept. of Epidemiology, Italian National Cancer Institute Regina Elena

QUALITY OF CARE
TERRACE HALL
Chairs: Alan Pearson, Australia and Kristiina Patja, Finland
B21 Comprehensive Medication Review by Pharmacist a Valuable Tool for GP to Improve Pharmacotherapy
Leikola S, Finnish Pharmacists’ Association

B22 AGREE Next Steps: Continuous Quality Improvement in the Evaluation of Clinical Practice Guidelines
Brouwers MC*, McMaster University, Canada; Browman GP, BC Cancer Agency, Canada; Burgers JS, Dutch Institute for Healthcare Improvement, Netherlands; Cluzeau FA, St George’s Hospital Medical School, London UK; Davis D, University of Toronto, Canada; Feder GS, Bart’s & the London Queen Mary’s School of Medicine, UK; Fervers B, FNCLCC, Lyon, France; Graham ID, Canadian Institutes of Health Research, Canada; Grimshaw JM, Ottawa Health Research Unit, Canada; Hanna SE, McMaster University, Canada; Kho ME, McMaster University, Canada; Littlejohns P, National Institute for Clinical Excellence, UK; Makarski J, McMaster University, Canada; Ollenschlaeger G, German Agency for Quality in Medicine, Germany; Rawski EM, McMaster University, Canada; Weinbrenner S, German Agency for Quality in Medicine, Germany; Zitzelsberger L, Ottawa Health Research Unit, Canada

B23 Quality Evidence on a Clinician’s Schedule: Meeting in the Middle with a BEST Best Evidence Statement
Clark E*, Cincinnati Children’s Hospital Medical Center; McGee S, Cincinnati Children’s Hospital Medical Center

B24 Effectiveness of Evidence-Based Clinical Practice Guidelines: Do They Improve Quality of Care?
Lugtenberg M*, Tilburg University, Department of Tranzo, the Netherlands; Burgers J, Dutch Institute for Healthcare Improvement (CBO), the Netherlands / Centre for Quality of Care Research (WOK), University Medical Centre Nijmegen, the Netherlands; Westert GP, Tilburg University, Department of Tranzo, the Netherlands / National Institute for Public Health and the Environment (RIVM), the Netherlands

IMPLEMENTATION 2
MEETING ROOM AINO
Chairs: Juha Pekka Turunen and Elina Heikkilä, Finland

L4 The NICE Implementation Programme – Recent Developments and Overall Impact
Leng G, National Institute for Health and Clinical Excellence

B25 Implementing PET Imaging According to Evidence-based Guidelines in Ontario, Canada
Evans W*, McMaster University and Hamilton Health Sciences
Laupacis A, University of Toronto; Levine M, McMaster University and Hamilton Health Sciences; Gulenchyn K, McMaster University and Hamilton Health Sciences
Levin L, Ministry of Health and Long-Term Care (MOHLTC) for the province of Ontario
B26 Evaluation of a Multifactorial Implementation Strategy of Three Clinical Practice Guidelines on Cardiovascular Risk (Hypertension, Diabetes And Hyperlipidemia) in Primary Health Care in the Autonomous Community of Basque Country

Etxeberria A, Osakidetza, Basque Health System; Rotaeche R, Osakidetza, Basque Health System; Perez-Irazusta I, Osakidetza, Basque Health System; Alcorta I, Osakidetza, Basque Health System; Reviriego E, Departamento de Sanidad-Gobierno Vasco; Rico R, Departamento de Sanidad-Gobierno Vasco

B27 Regional Model for the Systematized Lifestyle Counseling, Implementation of the Lifestyle Counseling Process


B28 Implementation of Stroke Rehabilitation Guidelines (Current Care) in Finland

Takala TO, Finnish Stroke and Dysphasia Association and Rehabilitation Centre Petrea, Turku; Viljanen T, Finnish Stroke and Dysphasia Association

B29 Improving Emergency Department Pain Management Based on Nationally Endorsed Guidelines

Huckson S, National Health and Medical Research Council; Bennett S, National Health and Medical Research Council

B30 Can a Snapshot of Guideline Attribute Reporting Be Used as a Proxy for Guideline Quality?

Nix M*, Agency for Healthcare Research and Quality; Coates V, ECRI Institute Monteforte M, ECRI Institute; Haskell L, ECRI Institute

B31 Interventions to Improve Adherence to Prescribed Medication – Using the Evidence with a Guideline Development Group

Nunes VD*, National Collaborating Centre for Primary Care, Royal College of General Practitioners, England; O’Flynn N, National Collaborating Centre for Primary Care, Royal College of General Practitioners, England; Neilson J, National Collaborating Centre for Primary Care, Royal College of General Practitioners, England

B32 The Use of Qualitative Research in Clinical Guidelines developed by the National Institute for Health and Clinical Evidence (NICE) in England & Wales

Tan TPY*, National Institute for Health and Clinical Evidence (NICE); Stokes T, National Institute for Health and Clinical Evidence (NICE)

METHODS 1
MEETING ROOM ALVAR
Chairs: Sara Twaddle, Scotland and Marjukka Mäkelä, Finland
B33 The Known Unknowns: Synthesis of Uncertainties and Evidence Gaps to Identify Priority Research Recommendations  
Garner S, NICE on behalf of the Coordination of Cancer Clinical Practice Guidelines in Europe (CoCanCPG) Consortium

15.00–15.30 Coffee break, Exhibits and Poster viewing

15.30–17.00 Session 3 / Workshops and Brief Presentations

WORKSHOPS

W6 Patient and Public Involvement in Guidelines (Part 2): Defining Strategies for the Future  
Boivin A, Center for Quality of Care Research, the Netherlands; Burgers J, Dutch Institute for Healthcare Improvement (CBO), the Netherlands; Centre for Quality of Care Research (WOK), University Medical Centre Nijmegen, the Netherlands; Fervers B, SOR, FNCLCC, Centre Léon Bérard, Lyon, France; Marshall C, Independent Guideline Advisor; Sänger S, German Agency for Quality in Medicine (AQuMed)

W9 German Language CPGS UPDATE 2008 Workshop in German Language  
Weinbrenner S, German Agency for Quality in Medicine (AQuMed); Ollenschläger G*, German Agency for Quality in Medicine (AQuMed); Kopp I, Association of the Scientific Medical Societies in Germany

W10 Barriers Identification in CPG Implementation Using Error Analysis Techniques Based in High Risk Domains  
Pardo R, Torres M, Tellez D, Stein A, National University of Colombia, Clinical Research Institute, School of Medicine, Clinical Practice Guidelines Project

W12 Best Practice Support Service: From Research Evidence to Implementation  
Salach L, Centre for Effective Practice; Rogers J, Centre for Effective Practice; Bean T, Centre for Effective Practice;

BRIEF PRESENTATIONS / GUIDELINE PROGRAMMES

HELSINKI HALL  
Chairs: Eeva Ketola and Antti Malmivaara, Finland

L5 Guidelines and Population-based Cancer Control: A Canadian Strategy  
Browman GP, Canadian Partnership Against Cancer; Brouwers M, Canadian Partnership Against Cancer; Harrison MB, Canadian Partnership Against Cancer; Poole B, Canadian Partnership Against Cancer; Temple W, Canadian Partnership Against Cancer; Fairclough L, Canadian Partnership Against Cancer; Zitzelsberger L, Canadian Partnership Against Cancer
B34 Implementing Clinical Practice Guideline External Review in Taiwan
Shih YH, Center for Health Policy Research and Development, National Health Research Institutes, Taiwan; Kuo K-N, Center for Health Policy Research and Development, National Health Research Institutes, Taiwan; Lo HL, Center for Health Policy Research and Development, National Health Research Institutes, Taiwan; Chen C*, Taipei Medical University-Wan Fang Hospital, Taiwan

B35 National Nursing Guidelines for Identifying and Intervening in Child Maltreatment
Flinck A*, Department of Nursing Science, University of Tampere; Paavilainen E, Department of Nursing Science, University of Tampere, Etelä-Pohjanmaa Hospital District

B36 The Use of Local Evidence for Guideline Development: The Example of the Japanese Guidelines for Cancer Screening
Hamashima C, National Cancer Center; Saito H, National Cancer Center

B37 Implementing from Evidence to Recommendations in a National Guideline Programme: The NICE Linking Evidence to Recommendations (LETTR) Project
Alderson P, National Institute for Health and Clinical Excellence (NICE), UK; Stokes T*, National Institute for Health and Clinical Excellence (NICE), UK; Lord J, National Institute for Health and Clinical Excellence (NICE), UK; Ruiz F, National Institute for Health and Clinical Excellence (NICE), UK

17.00–18.00 Plenary 2 – Guideline Implementation Research – Helsinki Hall
Chairs: Jako Burgers, the Netherlands and Liisa-Maria Voipio-Pulkki, Finland
Plenary speaker: Director Jean Slutsky (AHRQ, USA)
Discussant: Professor Jeremy Wyatt (Director of the Health Informatics Centre, UK)

19.00–00.30 The G-I-N 2008 Gala Dinner, Ballroom, Hotel Scandic Continental

FRIDAY OCTOBER 3, 2008

8.00–16.00 Registration and Poster set up

9.00–10.15 Plenary 3 – Guideline Implementation in Practice – Helsinki Hall
Chair: Frode Forland, Norway and Marjukka Mäkelä, Finland
Plenary speakers: Dr. Safia Qureshi (SIGN, Scotland) and Professor Bjorn Guldvog (Norwegian Directorate for Health and Social Services, Norway)

10.15–10.45 Coffee break, Exhibits and Poster viewing

10.45–12.30 Session 4 / Workshops and Brief Presentations

WORKSHOPS
W8 Guideline Adaptation: A Methodology to Enhance Efficiency in Guideline Development and Improve Utilization

W11 Patients and Guidelines - Is there a Living Connection?
Ketola E*, Current Care, the Finnish Medical Society Duodecim; Honkanen M, Current Care, the Finnish Medical Society Duodecim; Riikola T, Current Care, the Finnish Medical Society Duodecim; Tala T, Current Care, the Finnish Medical Society Duodecim

W13 Using Formal Consensus Methods to Engage Stakeholders in Guideline Development and Implementation
Lakhanpaul M, National Collaborating Centre for Women’s and Children’s Health and the University of Leicester; Ullman R, National Collaborating Centre for Women’s and Children’s Health

W14 Evidence Tables Phase II: Diagnostic Questions
Miika-Cabanne N*, French National Authority for Health (HAS), France; Laurence M, French National Authority for Health (HAS), France; Twaddle S, Scottish Intercollegiate Guidelines Network (SIGN), UK; For the Evidence Tables Working Group (ETWG)

W15 Identifying Barriers to the Implementation of Clinical Practice Guidelines Among Healthcare Professionals
Burgers J*, Dutch Institute for Healthcare Improvement (CBO), the Netherlands / Centre for Quality of Care Research (WOK), University Medical Centre Nijmegen, the Netherlands; Lugtenberg M, Tilburg University, the Netherlands; Westert GP, Tilburg University, the Netherlands

BRIEF PRESENTATIONS / IMPLEMENTATION 3
HELSINKI HALL
Chairs: Heikki Tikkanen and Tanja Laukkala, Finland

Nix M*, Agency for Healthcare Research and Quality; Consalvo J, Agency for Healthcare Research and Quality; Nieva V, Westat; Carpenter D, Westat; Mardon R, Westat

B55 Nurses’ Experiences of Guideline Implementation: a Focus Group Study
Alanen S*, Tampere University Hospital; Välimäki M, Department of Nursing Science, University of Turku
B56 Impact of Patients – Characteristics on the Effectiveness of Preventive Guideline Implementation Strategies in Primary Care: A Systematic Review

Boivin A, Center for Quality of Care Research; B57 A New Canadian Strategy for the Production and Implementation of Respiratory Guidelines; Van Dam A, Canadian Thoracic Society; Boulet L-P, Institut de cardiologie et de pneumologie de l’Université Laval

B58 Guideline for the Avoidance of Physical Restraints in Nursing Homes: A First Step to Establish Evidence-Based Nursing Guidelines in Germany

Gerlach A*, MIN-Faculty, Unit of Health Sciences and Education, University of Hamburg; Haut A, Faculty of Medicine, Department of Nursing Science, Private University of Witten/Herdecke; Mayer G, Faculty of Medicine, Department of Nursing Science, Private University of Witten/Herdecke; Köpke S, MIN-Faculty, Unit of Health Sciences and Education, University of Hamburg

B59 Education, Research and Clinical Practice – Centre for Clinical Practice Guidelines of Palacky University Faculty of Medicine

Licenik R*, Department of Social Medicine and Health Policy, Centre for Clinical Practice Guidelines, Palacky University Faculty of Medicine, Olomouc, Czech Republic and Grantham & District Hospital, Grantham, United Kindom; Ivanova K, Department of Social Medicine and Health Policy, Palacky University Faculty of Medicine, Olomouc, Czech Republic; Capova E, Department of Clinical Microbiology, Tabor District Hospital, Tabor, Czech Republic; Jelenova D, Department of Child and Adolescent Psychiatry, Motol University Hospital, Prague, Czech Republic; Khun T, Department of Paediatrics, Ostrava University Hospital, Ostrava, Czech Republic; Kurfurst P, Department of Foreign Languages, Palacky University Faculty of Medicine, Olomouc, Czech Republic; Michalcova A A, Department of Anaesthesiology and Resuscitation, University Hospital Olomouc, Czech Republic; Potomkova J, Information Centre, Palacky University Faculty of Medicine, Olomouc, Czech Republic

12.30–13.45 Lunch

13.45–15.00 Session 5 / Brief Presentations

PATIENTS

MEETING ROOM AINO

Chair: Tiina Varis, Finland

B43 Improving Information Provision in Subfertility Care

Mourad SM, Center for Quality of Care Research and Department of Obstetrics and Gynaecology, Radboud University Medical Center, Nijmegen, the Netherlands; Hermens R, Center for Quality of Care Research, Radboud University Medical Center, Nijmegen, the Netherlands; Nelen W, Department of Obstetrics and Gynaecology, Radboud University Medical Center, Nijmegen, the Netherlands; Kremer J, Department of Obstetrics and Gynaecology, Radboud University Medical Center, Nijmegen, the Netherlands; Grol R, Center for Quality of Care Research, Radboud University Medical Center, Nijmegen, the Netherlands
B44 Implementation of Local Guideline by Interactive Workshop Improves Anticoagulation Therapy and Patient Safety
Puhakka J, City of Helsinki Health Centre; Suvanto I, City of Helsinki Health Centre
Sipilä R, Centre for Pharmacotherapy Development Finland

B45 An Evaluation of 5 Guideline Programs with a New Framework for Assessing Consumer Involvement in Guidelines (FACING)
Tong A*, University of Sydney, The Children’s Hospital at Westmead; Sainsbury P, University of Sydney; Craig JC, University of Sydney, The Children’s Hospital at Westmead

B46 Did Practice Surveys and Patient Focus Groups Make Meaningful Contributions to the Recommendations in Clinical Practice Guidelines in Conservative Management of Tennis Elbow?
MacDermid JC, McMaster University

B47 Hoituretit – A Model of Continuously Cooperation for Care-Chains
Liski T, the Hospital District of Southwest Finland; Laine M, the Hospital District of Southwest Finland; Korvenranta H*, the Hospital District of Southwest Finland; Tunturi T, the Hospital District of Southwest Finland; Mertsola J, the Hospital District of Southwest Finland; Kivelä S-L, the Hospital District of Southwest Finland

B48 Evidence into Recommendations: An Interdisciplinary and Cross-Cultural Approach to Knowledge Translation in Health (ERICCA)
Fervers B*, Centre Léon Bérard, Université Lyon (EASIS 4129); Michie S*, Division of Psychology and Language Sciences, University College London; Castel P*, Centre de Sociologie des Organisations (UMR7116 Sciences Po/CNRS); Zuiderent-Jerak T*, Dept. of Health Policy and Management Erasmus MC University Medical Center Rotterdam; Bergeron H*, Centre de Sociologie des Organisations (UMR7116 Sciences Po/CNRS)

B49 Evaluation of clinical practice guidelines programme – Australasian collaboration
Sivasampu S*, Ministry of Health, Malaysia; Marshall C*, Independent Guideline Adviser

B50 The G-I-N Emergency Care Community – the first 12 months
Huckson SD, National Health and Medical Research Council; Marshall C, Independent Guideline Advisor; Buchan H, National Health and Medical Research Council
L7 A Strategic Approach to Clinical Practice Guidelines – An Australian Oncology Experience
Pearce AP*, National Breast and Ovarian Cancer Centre; Care O, National Breast and Ovarian Cancer Centre; Wilcoxon HC, National Breast and Ovarian Cancer Centre; Vagg R, National Breast and Ovarian Cancer Centre; Anderson KM, National Breast and Ovarian Cancer Centre; Luxford K, National Breast and Ovarian Cancer Centre; Zorbas H, National Breast and Ovarian Cancer Centre

B51 Implementing Psychosocial Care Guidelines for Adults With Cancer in Australia – A National Approach
Nehill C, National Breast and Ovarian Cancer Centre, Australia; Turner J, University of Queensland, Australia; Luxford K, National Breast and Ovarian Cancer Centre, Australia; Care O, National Breast and Ovarian Cancer Centre, Australia; Zorbas H, National Breast and Ovarian Cancer Centre, Australia; Pearce A*, National Breast and Ovarian Cancer Centre, Australia

B52 The American Society of Clinical Oncology’s (ASCO) “Signals” Approach to Updating Clinical Practice Guidelines
Einhaus K, American Society of Clinical Oncology; Hagerty K, American Society of Clinical Oncology; Somerfield M, American Society of Clinical Oncology

B53 Implementation of Guidelines for Oncology and Palliative Care in the Netherlands
Feller N*, The Dutch Association of Comprehensive Cancer Centres (ACCC); van den Bogert J, The Dutch Association of Comprehensive Cancer Centres (ACCC); Kersten S, The Dutch Association of Comprehensive Cancer Centres (ACCC); Middelburg M, The Dutch Association of Comprehensive Cancer Centres (ACCC); Vonk S, The Dutch Association of Comprehensive Cancer Centres (ACCC); de Boer M, The Dutch Association of Comprehensive Cancer Centres (ACCC); Heijbroek-de Clercq W, The Dutch Association of Comprehensive Cancer Centres (ACCC)

B39 Experience of Updating the NICE Guideline on Head Injury
B40 Can an Existing Knowledge System be Used as a Basis for Developing, Updating and Communicating Clinical Guidelines in Denmark?
Hoeg-Jensen L, National Board of Health, Denmark

B41 An Operationally Defined Tool for Applying the AGREE Instrument
Brouwers M, Cancer Care Ontario’s Program in Evidence-Based Care (CCOPEBC) and McMaster University; Cosby R, Cancer Care Ontario’s Program in Evidence-Based Care (CCOPEBC) and McMaster University; McNair S, Cancer Care Ontario’s Program in Evidence-Based Care (CCOPEBC) and McMaster University; Rawski E, Cancer Care Ontario’s Program in Evidence-Based Care (CCOPEBC) and McMaster University; Walker-Dilks C, Cancer Care Ontario’s Program in Evidence-Based Care (CCOPEBC) and McMaster University; Zwaal C, Cancer Care Ontario’s Program in Evidence-Based Care (CCOPEBC) and McMaster University

B42 Systematic Search for Guidelines and Extraction of Key Recommendations for the Update of the German Disease Management Programme “Asthma/Chronic Obstructive Pulmonary Disease”
Siering U, Institute for Quality and Efficiency in Health Care; Holzmann N, Institute for Quality and Efficiency in Health Care; Danner M, Institute for Quality and Efficiency in Health Care; Rüther A, Institute for Quality and Efficiency in Health Care

METHODS 3
ELISSA HALL
Chairs: Craig Lockwood, Australia and Annikki Savolainen, Finland

L9 Using Qualitative Studies in Guideline Development: A Worked Example
Nunes VD, National Collaborating Centre for Primary Care, Royal College of General Practitioners, England; O’Flynn N*, National Collaborating Centre for Primary Care, Royal College of General Practitioners, England; Neilson J, National Collaborating Centre for Primary Care, Royal College of General Practitioners, England

B60 Is There a Standard for Presenting Guideline Recommendations? An Analysis of Guidelines for Guidelines
Hasenbein U, Institute for Quality and Efficiency in Health Care, Cologne, Germany; Eikermann M, Institute for Quality and Efficiency in Health Care, Cologne, Germany; Rüther A, Institute for Quality and Efficiency in Health Care, Cologne, Germany

B61 A Method for an International Comparative Study of Non-Medical Factors’ Impact on Clinical Practise Guidelines Development in Oncology
Cazeneuve H, EA 4129; Knaapen L*, Mc Gill University, Montreal, Canada; Castel P, Centre de Sociologie des Organisations, Paris, France; Cambrosio A, Mc Gill University, Montreal, Canada; Paquet L, Direction de Lutte Contre le Cancer, Montreal, Canada; Remy-Stockinger M, FNCLCC-SOR, Lyon, France; Latreille J, Direction de Lutte Contre le Cancer, Montreal, Canada; Fervers B, EA 4129
B62 Guidelines Topics – How to Select and Prioritise
*Salmon M, National Institute for Health and Clinical Excellence*

B63 Making the Evidence To Recommendations More Transparent: A Case Study Of The Use of GRADE Approach in the NICE Respiratory Tract Infection Guideline
*Tan TPY*, National Institute for Health and Clinical Excellence (NICE); Stokes T, National Institute for Health and Clinical Excellence (NICE); McAllister R, National Institute for Health and Clinical Excellence (NICE); Little P, Short Guideline Programme (NICE)

**METHODS 4**
**TERRACE HALL**
**Chairs: Frode Forland, Norway and Anne Hiiri, Finland**

L10 Barriers to Developing Evidence-Based Guidelines in Hospitals in South East Asia and Australia
*Turner T*, Monash Institute of Health Services Research, Monash University, Australia; Green S, Australasian Cochrane Centre, Monash University, Australia; Harris C, Centre for Clinical Effectiveness, Southern Health, Australia

B64 Dissemination: SIGN Reviews its Process and Finds Room for Improvement
*Hamza-Mohammed F*, SIGN Guidelines, Edinburgh, Scotland; Robertson S, NHS Quality Improvement Scotland; Thompson L, SIGN Guidelines, Edinburgh, Scotland

B65 Diagnosis of Asthma In Young Children - Analysis Of Guideline Recommendations And The Current Evidence Base
*Eikermann M*, Institute for Quality and Efficiency in Health Care (IQWiG); Schäfer T, Department of Social Medicine, UK-SH, Campus Lübeck; Schramm S, Department of Social Medicine, UK-SH, Campus Lübeck; Hasenbein U, Institute for Quality and Efficiency in Health Care (IQWiG); Rüther A, Institute for Quality and Efficiency in Health Care (IQWiG)

*Hiiri A*, The Finnish Dental Society Apollonia

B68 Diagnostic Imaging Guidelines: the State of the Art
*Reed MH, Canadian Association of Radiologists*

B69 The Methodological Conundrum of Guideline Adaptation – How to Align Evidence Quality with Recommendations
*Scott A, Institute of Health Economics; Moga C, Institute of Health Economics*

15.00–15.30 Closing Ceremony – Helsinki Hall

15.30–18.00 G-I-N Board Meeting
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Plenary Speaker Abstracts
Knowledge Translation and Guidelines

Professor Alison Kitson, Green College, University of Oxford, UK

This opening paper explores the intersection between the processes of generating new knowledge into usable formats (guidelines) and its application and uptake in practice (knowledge translation). The gap between knowledge generation and knowledge use is coming under more scrutiny as health systems demand more adherence to agreed clinical guidelines. However, there seems to be a lack of innovative or new approaches to thinking about how to close the gap between generation and use.

The purpose of this address therefore, is to ask some different questions. Do we need to change the way we conceptualise knowledge generation, knowledge use and knowledge translation? Do we need to consider different systems of engagement, particularly in the adoption and uptake phase of guideline implementation? What is the role of the end user and at what point should they be engaged in guideline development in order to optimise uptake and use? How do we define successful translation of a guideline into practice? Where do concepts such as ownership, adaption and adoption fit into the debate?

Drawing on existing studies and illustrating some of these conceptual, theoretical and methodological questions by case study material from a project being undertaken in South Australia (1), the paper concludes by offering a set of questions to stimulate the research and practice agenda.

Knowledge Translation and Guidelines; Comments

Dr. Taina Mäntyranta, The Centre for Pharmacotherapy Development ROHTO, Finland

The opening paper raised several important theoretical and practical questions. These comments are based on our experiences in promotion rational pharmacotherapy in Finland. Do we need to change the way we conceptualise? What is the role of the end user? Knowledge translation (or transformation) often seems to understand professionals as targets of various guideline implementation interventions. In our experience health care professionals rather use guidelines to solve problems they face with patients or in processes of care. Professionals can analyze and solve problems in interactive interprofessional workshops using guidelines.

Do we need to consider different systems of engagement? How do we define successful translation of a guideline? Our experience is that different users of guidelines may face different hinders in using a guideline. Evidence based clinical guidelines aim to improve the quality of care. Our practical experience is that specific need for change, concrete objectives, sufficient structures and processes supporting learning and change are elements of successful translation of a guideline into practice.
Guideline Implementation Research

Director Jean Slutsky, AHRQ, USA

There have been remarkable gains in the field of guideline development, more rigorous evidence standards, explicit methods, broad disciplinary participation, and recognition of the importance of understanding patient perspectives. The knowledge that guidelines alone don’t change behavior, has spurred new and creative interest into where they can be strengthened to move the quality of patient care forward by getting them integrated seamlessly into clinical practice.

Recognition that medical decision-making is complex, in part because patients are complex, often presenting with multiple co-morbid conditions, makes the integration of guidelines into the fabric of clinical care imperative. How to do this well is a challenge from an evidence, work flow, and a multi-disciplinary perspective. But since patients are increasingly presenting with chronic conditions, this will soon become the “next frontier” in guideline development and implementation.

And as guideline development moves from addressing discrete interventions to more coordinated care so will the appearance of guidelines change. Lessons learned from using paper-based guidelines show that access to knowledge must be close to the point of decision. Health information technology is increasingly making relevant information available at the point of decision-making. This will eventually transform how guidelines influence decision making and effect patient outcomes. True implementation of guidelines into practice, is getting the recommendations used at the right time for the right patient and to do this, the guideline may no longer look like what it began as – the information is the same but the delivery is very different. This session will explore the critical role of guideline implementation and how it is the lever between science and action.
Should We Primarily Publish Electronic Guidelines as Reminders?

Professor Jeremy Wyatt, Health Informatics Centre, Dundee

I believe that creating guidelines as word processed documents primarily for paper publication leads to a number of problems:

• There is a risk of the document expanding into a lengthy evidence based textbook which takes years to write and is expensive to revise [Eccles 02]
• The bulk makes it hard for users to find the specific page, paragraph and sentence that applies to this patient this visit. It also makes it hard for human authors to ensure that the guideline is complete and that words are used consistently
• Any versions for different audiences (eg. patients, nurses, audit clerks) need to be written separately and kept by hand synchronised with the master version
• The evidence shows that it is rare for such guideline documents themselves to change clinical practice or patient behavior [Grimshaw 04]
• The material is designed to be read linearly, limiting our ability to extract text fragments to populate computer screens. To use the knowledge contained in the guideline for reminders or decision support, someone must spend weeks trying to locate and model small parts of the guideline as a knowledge base, only to find that it lacks detail or even disagrees with itself in places

I will argue that we should instead focus our evidence search and authoring process around proven clinical problems (ie. health decisions or actions with demonstrated and unexplained variation or deviation from evidence or patient preferences), rather than on a large number of questions spread out along the patient pathway. In addition, I believe we should publish guidelines primarily as a set of well structured computer reminders and alerts, with a secondary hypertext version reserved for browsing on screen.

References:
Implementation in Practice

Dr. Safia Qureshi, SIGN, Scotland

The leading cause of death in Scotland is coronary heart disease (CHD) and tackling this is a priority for the NHS. The Scottish Intercollegiate Guidelines Network (SIGN) has been producing guidelines to support healthcare professionals working in this field since 1998. In November 2002 we agreed to revise our CHD guidelines. Healthcare professionals told us that they were still needed, as CHD will become more common as the Scottish population ages and survival rates from acute events are improving. A scoping search found that 301 935 relevant studies had been published since the original guidelines were issued, including over 43 000 randomised controlled trials. In February 2007, SIGN launched a comprehensive package of guidelines covering the CHD spectrum from primary prevention to end-stage heart failure. The first patient versions of SIGN guidelines, developed to accompany the clinical guidelines were also launched. These were designed as a tool to empower patients and help drive implementation.

This initiative involved an enormous effort from hundreds of healthcare professionals and lay representatives across the whole of Scotland and received major supportive publicity from the media.

So have the new guidelines been implemented? At an event to launch the guidelines, 87% of the 620 delegates reported that the quality of information provided was good or very good and only 4% thought there was a poor or very poor likelihood of the new guidelines affecting their practice.

This presentation will discuss the strategies used to support the implementation of the CHD guidelines, looking at how our theoretical knowledge of implementation translated into practice. Did we hit the target of affecting 96% of practice?
Guidelines for Carrying Out Legal Regulations for Priority Setting in Norway

Professor Bjørn Guldvog, Norwegian Directorate for Health and Social Services, Norway

In Norway legal regulations states that each patient shall be judged individually according to the severity of the patient’s health, the expected benefit and the cost-effectiveness of treatment.

However, evidence shows politically unacceptable variations in the priority setting: Similar patients face different legal rights.

The Ministry of Health mandated the Norwegian Directorate of Health to cooperate with the regional health authorities in developing national guidelines to ensure that prioritisation comply with legal provisions. Regional representatives from 30 specialities together with general practitioners and user representatives worked in groups, one for each speciality, to develop the guidelines. The project was divided in three rounds of 5 month’s work, each round having three workshops of two days.

Each speciality described and evaluated the most common medical conditions within their speciality according to dimensions of criteria for priority setting using a structured questionnaire and listed references in support of their views. After a month with reflections and peer discussions, they concluded whether a “typical” patient within each condition group should be recommended prioritised health care, and if so, a maximum waiting time was given. To ensure individual judgement of each patient, the groups supplemented the descriptions of the “typical” patient with additional characteristics of relevance. These have to be taken into consideration before concluding on the legal rights of the individual patient.

An expert group has reviewed the work. Four guidelines were tested in five hospitals and adjustments were made. The guidelines have also been on a national consulting round and will be implemented in the end of 2008. To implement the guidelines is the responsibility of the regional health authorities. The National Directorate of Health will provide tools to support the implementing.
Lecture Abstracts
L1
Peri-operative Fasting Guideline Implementation Study Evaluation (PoISE); Understanding how we can change practice

Bullock I, Royal College of Nursing; on behalf of the PoISE study team, collaborating with the Royal College of Anaesthetists

Background and purpose: Evidence supporting the effectiveness of guideline implementation strategies is lacking (Grimshaw, 2004; Thompson et al. 2007). The PoISE study, theoretically informed by the PARiHS framework (Rycroft-Malone et al., 2004), investigates the effectiveness of three implementation strategies of a national peri-operative fasting guideline. Evidence based recommendations establishes fluid fasting times of 2 hours and 6 hours for food. This presentation will present pre and post intervention results following the three separate implementation intervention strategies.

Methods: Randomised trial using interrupted time series (ITS) (4 measurements pre- and post) and mixed methods process evaluation. This will evaluate the effectiveness of three implementation strategies and explore the process of implementation. 19 UK Acute NHS Hospitals were randomised to one of three implementation strategies: standard dissemination; web based resource with opinion leader support and a quality improvement strategy (Plan Do Study Act). Pre-intervention data feedback.

Primary outcome: Fasting time

Process evaluation: Barriers and facilitators to implementation; Impact on patient experiences; Context characteristics; Economic cost consequences

Data Collection: Pre and post anaesthetic fasting times. Process evaluation data includes face to face, telephone and focus group interviews; pre-post Learning Organization Survey, patient questionnaire and interviews, and documentary evidence. Analysis: SPSS, thematic content analysis, data synthesis informed by key questions and theoretical framework.
Results and discussion:

Preliminary pre-intervention findings include:
• No significant differences between intervention groups
• Mean food fasting time: 13.97 hours (IQR 11–16.5)
• Mean fluid fasting time: 9.59 hours (IQR 5.25–13)

Emerging themes from patient interviews include:
• Variable pre-operative information provision
• Challenges with management of delays
• Influence of patients’ knowledge and understanding of fasting

Emerging themes from staff interviews include:
• Challenges to change
• Issues with inter-professional ways of working
• Failed previous attempts to improve fasting practice

Post intervention preliminary findings will be shared at the Conference.
L2
Strength of Recommendations
According to the GRADE System

Flottorp S, Norwegian Knowledge Centre for the Health Services; Oslo; Norway, Vist G, Norwegian Knowledge Centre for the Health Services; Oslo; Norway, Kunz R, Basel Institute of Clinical Epidemiology, University Hospital Basel, Switzerland, Schünemann HJ, Dept. of Epidemiology, Italian National Cancer Institute Regina Elena, Rome, Italy

Background: Many grading systems do not clearly separate rating of the quality of evidence and decisions regarding the strength of a recommendation. Some systems have used quite complex systems for grading recommendations.

Purpose: To develop a system that explicitly separates assessment of quality of evidence and strength of a recommendation, and that provides recommendations with clear implications to guideline users.

Methods: Four key factors determine the strength of recommendations:
• The balance between the desirable and undesirable consequences of the alternative management strategies, based on the best estimates.
• The quality of the evidence.
• Uncertainty regarding values or preferences for those affected by the recommendation.
• Costs.

Recommendations are expressed in a binary grading system, called strong and weak.

Results: The strength of a recommendation reflects the extent to which we can be confident that desirable effects of an intervention outweigh undesirable effects. The strength of recommendations has direct implications for clinical practice. For strong recommendations, nearly all informed patients will make the same choice and physicians can confidently recommend treatment. For weak recommendations, different patients will choose different approaches to treatment. The management options associated with strong recommendations are candidates for quality criteria. When a recommendation is weak, it may become a quality criterion to discuss with patients and families the relative merits of the alternative management strategies. Thereby the binary system gives simple but specific guidance to patients, clinicians and policymakers.

Discussion: There are limitations to formal grading of recommendations. As with the quality of evidence, assessing the balance between desirable and undesirable effects requires judgments. Labelling particular recommendations as strong and weak implies some arbitrariness. The GRADE approach strongly emphasises transparency on how judgment and arbitrariness influenced the recommendation. Using examples we will argue that the merits of an explicit grade of recommendation outweigh the disadvantages.
L3
Grading and Summarizing the Quality of Evidence for Management Recommendations According to the GRADE System

Flottorp S, Norwegian Knowledge Centre for the Health Services; Oslo; Norway, Vist G, Norwegian Knowledge Centre for the Health Services; Oslo; Norway, Kunz R, Basel Institute of Clinical Epidemiology, University Hospital Basel, Switzerland, Schünemann HJ, Dept. of Epidemiology, Italian National Cancer Institute Regina Elena, Rome, Italy

Background: In guideline development it is necessary to trade off advantages and disadvantages of alternative strategies to manage patients. Therefore guideline developers have to consider not only the best estimates of expected benefits and harms, but also the confidence they have in these estimates. Many guideline organisations do so by rating the quality of evidence and provide strength of strength of recommendations. However, they apply different methods, which is confusing for users. Furthermore, many systems suffer from shortcomings.

Purpose: To come up with a system that balances simplicity and the need to take into account all factors that influence the quality of evidence.

Methods: The GRADE working group has developed a system for grading the quality of evidence. Here, ‘quality of evidence’ reflects the extent to which our confidence in an estimate of the effect is adequate to support a particular recommendation.

Results: Using the GRADE system, guideline developers should start by specifying all patient important outcomes. Next, the GRADE approach involves making separate ratings for quality of evidence for each important outcome, and finally considers the overall quality of evidence for a recommendation. Study design is important in determining the quality of evidence. Randomized controlled trials without important limitations constitute high quality evidence, whereas observational studies usually constitute low quality evidence. According to the GRADE system, five factors can reduce the quality of evidence: study limitations, inconsistent results, indirectness of evidence, imprecision and reporting bias. In well done studies three factors can increase the quality of evidence: large effect size, presence of a dose-response gradient or a situation in which all plausible biases would decrease the magnitude of the effect.

Discussion: Judgments will always be required in rating the quality of evidence for guideline development. The systematic and explicit GRADE approach facilitates scrutiny and debate regarding these judgments.
L4
The NICE Implementation Programme – Recent Developments and Overall Impact

Leng G, National Institute for Health and Clinical Excellence

Background: In 2004, the National Institute for Health and Clinical Excellence (NICE) established an implementation programme to support the uptake of its clinical guidelines. NICE produces guidelines for the National Health Service based on the best available evidence of clinical and cost effectiveness.

Purpose: The aim of the NICE implementation programme is to ensure patient care is based on evidence of best practice by ensuring mechanisms for implementing guidelines 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 evaluating uptake and feedback on barriers to inform future work. Recent new initiatives have been the introduction of a practical audit tool, developing evidence-based indicators to monitor change and publishing a guide for health service staff on overcoming the barriers to change. The work is overseen by an external implementation strategy group.

Results: At a national level, feedback from inspection mechanisms in the NHS indicate that over 90% of organisations have a systematic approach to handling NICE guidance. To support monitoring at a local level, the availability of indicators and audit tools will potentially have a big impact on supporting use of guidelines – indicators can also enable local benchmarking and be used to inform financial incentive systems. To help overcome barriers to change, a team of field-based consultants provides practical advice backed up by evidence-based resources on effective strategies for change.

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.
Guidelines and Population-based Cancer Control: A Canadian Strategy

Browman GP, Canadian Partnership Against Cancer, Brouwers M, Canadian Partnership Against Cancer, Harrison MB, Canadian Partnership Against Cancer, Poole B, Canadian Partnership Against Cancer, Temple W, Canadian Partnership Against Cancer, Fairclough L, Canadian Partnership Against Cancer, Zitzelsberger L, Canadian Partnership Against Cancer

Background: The Canadian Partnership Against Cancer (Partnership) was established by Canada’s federal government in response to a grass-roots movement—the Canadian Strategy for Cancer Control. The ‘Strategy’ identified eight areas for action, one of which is guidelines. The Cancer Guidelines Action Group (CGAG) of the Partnership includes cancer control professionals, guideline experts and representatives of the public and industry.

Purpose: To describe the role of guidelines as part of a national strategy for cancer control in Canada.

Methods: The CGAG envisions guidelines as a vehicle to promote optimal use of evidence in cancer control. The mandate is to develop a national strategy for guidelines in cancer, addressing efficiency of development, redundancy and implementation.

The challenge for Canada is eleven quasi-independent health systems within the country, most of which have parallel cancer systems, all of which develop guidelines of variable quality and with limited data on outcomes. Alternative approaches were either a centralized model for guideline activities, or capacity building and collaborative action across regions. The latter approach was selected.

Five interdependent projects address three requirements: i) technology infrastructure to enable pan-Canadian collaboration; ii) social platforms for commitment to sustainable action; and iii) accountability – measuring effectiveness of the strategy.

Results: The five projects are: 1) capacity enhancement – education strategy to build capacity across regions; 2) guidelines adaptation – efficient collaborative action for locally relevant guidelines; 3) resource allocation – improve use of guidelines at the policy level; 4) network performance – indicators to measure the effectiveness of evolving social networks; and 5) synoptic reporting – embedding guideline recommendations into structured reporting templates in cancer surgery.

Discussion: The presentation will demonstrate the interdependence of these projects for cancer control and report on progress. Effective guidelines development and implementation requires attention to both technological and social innovations.
L6
Avoiding Duplication of Effort: Defining Common Tools and Formats as a Basis for Sharing Cancer Guideline Development


Background: Clinical practice guidelines are an important tool to enhance the quality of healthcare, supporting the timely and pertinent integration of new knowledge into clinical practice. However, the quality of guidelines is heterogeneous and similar strategies are undertaken to achieve similar goals worldwide. As transnational collaboration could reduce duplication of effort. CoCanCPG aims to foster equitable access to high quality cancer care in Europe through cooperation. A pre-requisite for the implementation of long term cooperation is the development of common formats which will enlarge the possibilities for shared development.

Purpose: Reducing duplication of effort and improving guideline and healthcare quality throughout Europe.

Methods: CoCanCPG partners identified steps in the guideline development process where common formats were most needed to reach high quality guidelines and to allow transnational collaboration. Partners’ guideline development protocols and existing international initiatives (GIN, PICO, ADAPTE) were compared. Results of the comparison were presented and allowed the drafting of common formats. After being submitted for review to the Consortium, remarks were accounted for and the final versions sent for validation.

Results: The CoCanCPG partners expressed a wish for the utilisation of ‘PICO’ to identify key questions and of ‘ADAPTE’ for transnational exploitation of results. A common format for an evidence table, a common protocol for searching the literature and synthesizing the evidence, and a common checklist for critical appraisal were developed.

Discussion: The implementation of the common tools and formats will be assessed in a pilot study for joint development. This study will provide insight in the benefits and limitations of the tools and will allow CoCanCPG to adjust them to foster their utilisation. As a whole, these common formats will contribute to more efficient and effective high quality guideline development, offering the opportunity for partners to share tasks while having gained confidence in each other’s work.
L7
A Strategic Approach to Clinical Practice Guidelines—an Australian Oncology Experience

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Background: Clinical practice guidelines (CPGs) for oncology have a unique context in Australia. Challenges include a mixed care model between public and private, geographic remoteness limiting access to centralised specialist care, and the rapid emergence of new trial evidence in oncology. National Breast and Ovarian Cancer Centre (NBOCC) has a long history of successful CPG development within this context, including world-first guidelines and high levels of acceptability.

Purpose: To describe and review the strategic approach to NBOCC CPGs, which aims to address the challenges of CPG work in the Australian health care setting, including currency, applicability, implementation and evaluation.

Methods: Revision of NBOCC CPG processes identified strengths and weaknesses in the system, and led to the development of a strategic framework based on "lessons learnt". The framework aims to enhance collaboration in guideline development, improve implementation strategies for guidelines and evaluate guideline quality and effectiveness. The use of information technology to create living documents is investigated as a way of maintaining CPG currency.

Results: The process of NBOCC CPG development has been evolutionary, with implementation of a new phase of strategic methodologies. NBOCC CPGs are high quality evidence based information to assist clinicians in clinical decision making, with associated guidance documents for consumers and general practitioners. A significant component of the success of NBOCC guidelines, both in development and implementation, can be attributed to the multidisciplinary and collaborative approach to development. An evaluation strategy has been developed to determine the effectiveness of NBOCC guidelines in both appropriateness and in meeting the challenges of providing timely evidence and cost effectiveness.

Discussion: CPG development in Australia has some particular challenges, in addition to the global challenges faced by all organisations. The NBOCC CPG framework aims to address these in an efficient, effective, and strategic way.
L8


Background: Barriers to implementing evidence-based clinical practice guidelines exist throughout the world. Improvements in health care quality in the United States (U.S.) have been slow. Making a deeper commitment to accelerating quality improvement, the U.S. Agency for Healthcare Research and Quality (AHRQ) developed the Health Care Innovations Exchange.

Purpose: This new, publicly-accessible, interactive, Web-based resource presents innovative health care delivery changes spanning many diseases/conditions, care processes, settings, and populations. It also presents tools used in quality improvement efforts, including guideline implementation. Learning networks, bringing innovators and adopters/implementers together, are offered.

Methods: Inclusion criteria and a template of service innovation attributes were established, tested, and put into use. The template captures what was done to what type of patients and in what clinical setting, what the results were, how it was done, and what others should consider in adoption of the innovation. Innovations that succeeded and those that did not are included. When guideline implementation is part of the service delivery innovation, the template captures the specific guideline and a link to the guideline’s summary in AHRQ’s National Guideline Clearinghouse (NGC).

Results: The dynamic version of the AHRQ Innovations Exchange debuted in April 2008 with 100 innovations and over 750 tools, 2 and 97 of which, respectively, show explicit relationships to guidelines in NGC. Reflecting biweekly publication of additional innovations and tools, these numbers will be updated and presented at the conference along with the number and other details of the guidelines implemented in these service delivery improvements. Key characteristics and contexts of the guideline implementers will also be presented.

Discussion: The AHRQ Health Care Innovations Exchange could be a rich resource for guideline implementers everywhere. By publishing successful and unsuccessful innovations, users can learn about important contexts of implementation; by offering learning networks, users gain knowledge and insight from others.
L9
Using Qualitative Studies in Guideline Development: a Worked Example

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Background: The National Institute of Health and Clinical Excellence (NICE) is developing a guideline on Medicines Concordance. Research evidence on medicines taking is both qualitative and quantitative, with the patient perspective particularly represented by qualitative work. Previously, we explored how qualitative evidence could be summarized and incorporated within an evidence-based guideline. Now we discuss the process that was followed and illustrate how evidence was used to inform the guideline development group (GDG) deliberations.

Purpose: To discuss how the qualitative findings were used within the guideline development to inform evidence statements and recommendations.

Methods: We identified a meta-synthesis of qualitative studies which explored patient’s medicine taking. We treated this as a systematic review and planned to update this review. Searches were undertaken to identify relevant qualitative research published after the meta-analysis cut-off. Relevant information from the selected studies was then extracted.

Results: Qualitative findings suggest that people do not take medicines as prescribed because of concerns about medicines themselves including worries about dependence. This may range from the potential harm from taking medicines on a long term basis; issues with disclosure and stigma and is not necessarily a result of failures from the doctors, patients or systems.

Discussion: The use of a meta-synthesis and a plan to update this had considerable challenges. The technical team working on the guideline had minimal experience of meta-synthesis techniques and the work was extremely time consuming. The GDG varied in their response to the work with a minority suggesting that corroboration with quantitative methods was required. The lack of knowledge of the GDG members concerning qualitative methods made it difficult for many to judge the research. The findings however had considerable face validity for most professional and patient representatives on the GDG and allowed an understanding of patient behavior which influenced the recommendations made.
L10
Barriers to Developing Evidence-based Guidelines in Hospitals in South East Asia and Australia

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Background: Guidelines are increasingly being developed in many settings, including hospitals. Studies have shown that the development of many of these guidelines does not follow established evidence-based processes. The reasons for this discrepancy between the recommended development processes and the actual processes are unclear.

Purpose: To explore the views of clinicians in hospitals in South East Asia and Australia as to the value of and the barriers to development of evidence-based guidelines.

Methods: We interviewed clinicians working in maternal and neonatal care in 11 hospitals in Indonesia, Malaysia, the Philippines, Thailand and Australia. At each hospital we aimed to interview 2 junior and 2 senior doctors, and 2 junior and 2 senior nurses or midwives. Ethics approval was granted in each of the countries.

Interviews were audio recorded and the data analysed thematically using a theoretical framework for assessing barriers to and enablers of implementing evidence-based change.

Results: Clinicians frequently noted that while guidelines were potentially useful, their impact on practice was limited by substantial barriers to development and implementation in hospital settings.

Lack of time, skills and access to evidence were frequently mentioned barriers to evidence-based guideline development. Interviewees also noted difficulties in facilitating multi-disciplinary and consumer involvement in guideline development.

While many interviewees were familiar with the concept of adapting existing guidelines, they also identified many barriers to this process.

Discussion: Despite the wide variety of hospital contexts in which the interviews were undertaken and the varying availability of resources and levels of skill and experience in guideline development, similar themes emerged from the interviews.

This data highlights that there are substantial barriers to be overcome, if evidence-based guideline or protocol development is to be widespread in hospital settings in South East Asia and Australia.
Brief Presentation Abstracts
B1
Implementation and Evaluation of a Breast Cancer Guideline by Use of Quality Indicators: 5 Year Results from the Institutional and the National Level in Germany

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Background: Guideline implementation aims to improve the quality of structures, processes and outcomes of care. Quality assessment in the area of breast health care is challenging since a multitude of potential domains for measurement and perspectives need to be considered. Additionally, measures need to be identified that assess the function of the diagnostic and therapeutic chain in terms of cooperation and coordination of care.

Methods: Quality indicators were derived from evidence-and consensus-based breast cancer guidelines and used as performance measures on the institutional and national level. Two major strategies were followed:
1. Establishing certified breast cancer centres meeting guideline goals and requirements
2. Establishing a standardised external, hospital based nationwide quality assessment.

Results: Between 2003 and 2007, 143 breast cancer centres could be certified. We report in detail the results of a longitudinal evaluation of 2000 hospitals in Germany for the following indicators:
• intraoperative specimen x-ray examination after pre-operative wire marking of mammographically occult lesions to assure cooperation of three disciplines (imaging, pathology and surgery)
• patients with pathology reports about the tumor margins for safety distance
• patients with hormone receptor analysis to allow for hormonal treatment decisions
• patients with pT1 receiving breast conserving therapy.

Discussion: Major improvements could be achieved within a 5 year period indicating a raise in the quality of care. For continuing quality improvement, guidelines need to be implemented and evaluated in every day clinical practice. Besides new evidence, evaluation of guideline-based quality indicators is necessary to inform the updating process of guidelines.
Clinical guidelines are being developed in increasing number. Though the idea of guidelines is to integrate them into routine clinical practice, various factors such as rapidly changing information and volume of information contained within them create barriers to their implementation. The end product therefore is the development of vast numbers of clinical guidelines with very few being implemented. There is a need for alternative and innovative strategies to be considered.

We aimed to use the recommendations within guidelines as a framework on which to build multimedia educational packages containing traditional text supplemented with audio cues and visual images so that the content within a guideline can be subconsciously adopted by the health professional. The presentation of the guideline, through audiovisual stimuli provides a concrete foundation on which the very basics of the subject can be built. The educational material contained within the packages has been presented through three learning modalities or interfaces; the first being a problem-based stepwise approach (passive approach), the second being illness reference and generic skills (active process) and finally case presentation and knowledge assessment. The development of these tools allows access to educational material at all times of the day when the learner themselves anticipates their engagement with the material to be useful e.g. after having seen a patient with a particular problem on the ward. Following successful local developments we have been nationally funded to develop a variety of multimedia tools incorporating presentations of clinical signs, evidence based educational material and in built assessment tools to complement the traditional written guidelines. Examples of topics include “Management of a child with acute breathing difficulty” and “spotting the sick child”.

The developments illustrated are costly however we consider them to be cost effective since they can be used as an educational tool alongside existing implementation strategies.
Background: Audits of clinical care of patients with Chronic Kidney Disease (CKD) consistently shows a gap between evidence and clinical practice. Implementation of evidence-based medicine in CKD faces similar difficulties as seen in many other chronic diseases.

Purpose: To evaluate methods of implementation of evidence-based medicine (EBM) in the CKD clinical setting.

Methods: A comprehensive search was completed to identify all studies which involved CKD, showed data for before and after the intervention and described the intervention in detail. Studies were assessed for significant association with the implementation strategy. A mean effect of the intervention (%) was determined for each study. A median effect of the interventions (%) was determined for each category. Quality of the included studies was assessed against EPOC group quality checklist.

Results: Studies fell into 4 main categories: audit and feedback, CDSS, opinion leader/multi-disciplinary team and dissemination. Audit and feedback was significantly associated with 14 of the 25 study outcomes and had a median improvement in study outcomes of 7% (range: 0.20–25.5%). CDSS was significantly associated with 3 of the 4 study outcomes and had a median improvement in study outcomes of 21% (range: 4.5–42.0%). Opinion leader/multi-disciplinary team were significantly associated with 24 of the 30 study outcomes and had a median improvement in study outcomes of 11.3 % (range: 1.6–35.3%). Dissemination of guidelines had a median improvement in study outcomes range from 1.7–15.0%. The quality of the study was significantly associated with the effect size.

Discussion: Most well planned and executed interventions are effective to some degree in the management of CKD. CDSS is effective for changing prescribing behaviour and the use of an opinion leader was successful for many outcomes. High quality interventions that address all the barriers to implementation, and provide adequate assistance and support are needed to assist the implementation of EBM.
B4
Promoting Implementation of Current Care Guidelines
Dealing with Cardiovascular Risks in Päijät-Häme Region

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Background: Physicians use guidelines in diagnosing and treating diseases, but less often in preventive actions. Preventive work concerns all health professional, though there is a little information of guideline use of nurses. Recent recommendations stress lifestyle change and emphasize firstly the evidence base of prevention and secondly the role of general practitioners and primary care nurses in cardiovascular prevention. Current Care Guidelines Implementation Program (VALTIT) was conducted between spring 2006 and 2007 in Päijät-Häme Health and Social Care District in Finland.

Purpose: This study explores the familiarity with and use of the guidelines on cardiovascular risks among primary care professionals and can the familiarity and use be enhanced with a training intervention.

Method: Data for the study was collected by questionnaires before and after the intervention. It included items e.g. attitudes and use of the current care guidelines in general and specially the guidelines on cardiovascular risks which were in use in year 2004 (Hypertension, Dyslipidemia, Adult obesity and Smoking cessation). Intervention included regional training session and local workshops.

Results: Among nurses the reported familiarity with all the guidelines studied here and use of the “medication centred” guidelines (hypertension and dyslipidemia) increased. An association between use of the guidelines and participation in VALTIT- training was noticed. Perceptions concerning readiness to take the guidelines in use changed positively during the study period among nurses and were more positive among those who had taken part in at least one centralized training session or a local workshop.

Discussion: There seems to be a need for guideline training for primary care nurses in this district. Increased reported use among nurses happened in respect of the medication centred guidelines: is the focus still on treating single risk factors than on global risk and lifestyle change.
B5
Bridging the Gap: a Model for an Interdisciplinary Clinical Pathway in Primary Care in Belgium

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Background: Based on the Plan-Do-Study-Act cycle of Deming, a 30 steps plan for the implementation of clinical pathways in hospital setting was developed and evaluated. For Primary care no adapted procedures were developed until now.

Purpose: Develop a stepwise strategy and test its feasibility/usefullness for implementing guidelines into clinical pathways for primary care setting.

Method: A central group developed a strategy, based on the existing 30 steps program. Two interdisciplinary groups of GPs, gynaecologists and midwives tested the strategy by developing a clinical pathway for the guideline: follow-up of pregnancy

Results: The plan-stage consisted of a description of the current situation, a formulation of the aims, the target population, the indicators of the guideline, the funding and the risks of the project. In the do-stage we contacted partners and looked if they agree with the guideline and the formulated indicators. Due to a different target population in the two regions there was a local adaptation of the guideline: in urban region screening for hepatitis C was added. We used for the study-stage a modified Delphi-method with a score list for the different indicators from 0 to 9. There was a strong agreement on the assignment of tasks for most indicators. In the act-stage the implementation was performed by local peer review, patient websites and continuous evaluation. As in the urban region the hospital units and GP-groups were larger, more time for practical implementation is needed.

Conclusion: As this topic is a very delicate one in Belgian health context, it is a success that this model works in practice. This project will be one of the models for future implementation of guidelines in clinical pathways in primary care. A manual is made for other GP-groups and a steering group on this topic starts now to organise a larger project.
Implementing Electronic Decision Support – Pilot Survey of Attitudes

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Background: Current Care Guidelines (CCG) and EBM Guidelines are the basic knowledge sources of the Evidence-Based Medicine electronic Decision Support (EBMeDS) system. The general attitudes of Finnish physicians and nurses towards guidelines are positive (survey 2006). For successful implementation we need information of the barriers and facilitators for the adoption of CCG and EBM Guidelines in healthcare practices.

Purpose: In this study, we analyzed the attitudes of healthcare professionals towards CCG and EBM Guidelines to find out the importance of various perceived barriers and facilitators for adoption of guidelines.

Methods: A web-mail survey was carried out in November 2006 – May 2007 in two Finnish hospital district areas and one rural primary care centre. We targeted 2 252 professionals in 28 organizations, the number of responses being 806. Thus, overall response rate was 36 %.

Attitudes were measured by the Attitudes towards Guidelines Scale (AGS) including seven dimensions, each varying between one (totally disagree) and seven (totally agree). Statistical analyses were performed using the SPSS 15.0 software.

Results: The strongest facilitator for the adoption of guidelines was reliability of guidelines in all profession groups. Other facilitators were positive general attitudes towards guidelines and usefulness of guidelines both in nurses’ and allied professionals’ groups.

The strongest barrier for the adoption of guidelines was impracticality in physicians’ and allied professionals’ groups and poor availability of guidelines in nurses’ group.

The physicians did not consider poor individual or organizational competence as barriers for the guideline adoption, contrary to the other professionals.

Discussion: There were (statistically) significant differences in various dimensions of attitudes towards guidelines between profession groups. These differences should be paid attention to and taken advantage of in the implementation of decision support systems, such as EBMeDS, into healthcare practices.
B7
The Manitoba Project: Testing the Effect of Incorporating Diagnostic Imaging Guidelines into an Electronic Order Entry System

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Background: In 2005 the Canadian Association of Radiologists (CAR) published Diagnostic Imaging Referral Guidelines based, with permission, on the guidelines published by the Royal College of Radiologists (Making the Best Use of a Department of Clinical Radiology).

Purpose: The Manitoba Project was designed to determine if the incorporation of the CAR guidelines into an electronic order entry system would improve physicians’ ordering of diagnostic imaging.

Methods: CAR guidelines were incorporated into an electronic order entry system. The physician orders an imaging study and provides clinical data using a standardized list of history, signs and symptoms and differential diagnoses. If the imaging study ordered is not consistent with the guidelines, based on the clinical information provided, the physician gets a decision prompt recommending a different imaging study or no imaging at all. The order entry system was started in July 2006 without the decision support which was activated in October 2006. Data was collected up until the end of August 2007.

Results: A total of 9,925 orders were placed through the software. 8,757 of these were placed after the guidelines were activated. 1,678 (19.2%) of the orders had relevant guidelines, and 957 (57%) of those orders activated guidelines. Therefore, at least 11% of the orders placed were potentially inappropriate according to the guidelines. The advice was accepted by the ordering physician in only 19 (2%) cases.

Conclusions:
1. At least 11% of diagnostic imaging orders placed at the Children’s Hospital may be inappropriate.
2. As implemented in this setting, decision support had little effect on physician behavior, as only 2% of orders were changed.
3. A combination of qualitative and quantitative evaluation methods provided insights into these findings and guidance for other interventions to change and improve ordering of diagnostic imaging.
B8
Real-time Clinical Decision Support by Duodecim Integrated into Mediatri Electronic Health Records


Background: The use of electronic decision support systems in clinical practice can significantly improve the efficiency and quality of health care. In Finland, the Finnish Medical Society Duodecim has developed the EBMeDS electronic clinical decision support (DS) service. Clinical DS combines evidence-based medical knowledge with individual patient data and delivers real-time guidance to the health care professional. So far, the clinical use of decision support has been very limited. The Mediatri software, developed by Mediconsult Ltd, uses highly structured and standardized patient data, which are suitable input for the DS system. The Mediatri electronic health records (EHR) software is widely used in Finnish primary and specialized health care.

Purpose: Our aim was to implement a real-time DS by enabling automatic transfer of data between the EHR and DS system through a service interface. Special attention was paid to the usability of the integration in clinical settings.

Methods: Four trigger events were defined, where the EHR automatically sends patient data in a structured format (nationally agreed to be utilized by all health care provider organisations in Finland, and is supported by the National Code Server) to the DS system. After the execution of relevant scripts based on the patient data the DS system sends immediate feedback, which is shown to the user in the EHR user interface.

Results and discussion: The EBMeDS system was successfully implemented in the software. The implementation of DS into the EHR resulted in active and real-time evidence-based and individually tailored guidance, reminders, and alerts based on diagnoses, laboratory results, and medications recorded in the EHR. To our knowledge, this is the first active integration of a real-time clinical decision support system into a full-scale EHR system in Finland. To further develop active DS in the process of care, further studies are warranted among professionals using the EHR-integrated DS service.
B9
A Clinical Decision Aid in a Guideline: Easier for GPs to Implement?

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Background: Two surveys show inappropriate implementation of cardiovascular prevention guidelines by GPs in Belgium. Obstacles mentioned being lack of time and practical tools. To improve implementation GPs requested for electronic health record (EHR) as practice aid and tools for risk communication.

Purpose: To optimize cardiovascular prevention in general practice in Flanders by offering tools and activities who focus on the barriers to implement the guidelines.

Methods: A guideline is written that incorporates a validated clinical decision algorithm to facilitate fast and accurate case-finding and therapeutic follow-up of patients at high risk of cardiovascular disease. This guideline is the start of a large implementation plan based on a multifaceted strategy targeting individual GPs, associations of GPs and peer review groups, including: 1) development of supportive tools with summaries, risk communication tools, patient information etc, 2) training program based on teach the teacher approach done by and for GPs, 3) e-learning program for individual GPs, 4) implementation of clinical algorithm in the electronic health record (EHR), 5) bottleneck analysis on cardiovascular care at peer group level and formulation of solutions.

Results: The guideline was validated and published in the journal of the association in September 2007. A summary sheet is developed and distributed to all members. A target of 1000 GPs trained in a period of 3 years is set. Two associations of 50 GPs should have resolved their bottlenecks after a period of 3 years. Incorporation of the guideline in the EHR should be field-tested and operational.

Discussion: Preventive care in the Belgian context is not easily implemented. With this very GP tailored guideline, we are hopeful that implementation will be easier. In the diverse offer of activities to support the implementation of the guideline, each Flemish GP should find something that fits him.
Implementation of EBM Guidelines through a Portal Service


Background: A comprehensive collection of Evidence-Based Medicine Guidelines (EBMG) has been established in Finland during the past twenty years. The strength of evidence is reported using the criteria of the GRADE Working Group. The database contains more than 1000 guidelines and 3400 evidence summaries providing links to Cochrane reviews and other reliable EBM sources.

Purpose: In the year 2001 a commercial health portal was founded to promote the usage of EBMG in daily practice. The portal also provides access to the national Current Care guidelines and has other useful contents such as the Finnish drug formulary, the Cochrane Library, code search programs (such as ICD-10) etc.

Methods: The architecture and launch of the portal service were planned in close cooperation with the key representatives of the major customers, the 21 health care districts of Finland. The annual licence entitled the customers to a number of training sessions for the employees. The use of the guidelines was monitored through log file analysis (search terms used, guidelines read).

Results: In eight years the usage of the portal has dispersed over the Finnish health care. All the 21 health districts licensed the portal from the very first year and nowadays > 98% of the 250 health centres have licensed the portal for their employees. In 2007, more than 12 million guideline documents were opened by approx. 17 000 practicing physicians and other health care professionals.

Discussion: To our understanding the success of the implementation of EBM Guidelines has been promoted by some specific features of Finnish cultural and technical infrastructure, eg.:

• high penetration of the Internet technology
• one dominant culture and value basis of all health care
• single municipal ownership of all public health care facilities
• a respected publisher (Finnish Medical vSociety Duodecim)
B11
Quality Indicators as a Valuable Evaluation and Quality Improvement Tool in the Implementation of the German National Disease Management Guidelines

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**Background:** The modularised German National Disease Management Guidelines (NDMGs) for Diabetes Type 2 aim at the implementation of evidence-based recommendations for the integrated care of diabetic patients, focusing on the aspects prevention, diagnostics, acute care, rehabilitation, chronic care and health care coordination. Quality indicators serve as evaluation tools for the implementation of these guidelines. The use of NDMG-based quality indicators can provide valuable information about the acceptability and application of the NDMG and the effects of the NDMG on structures, processes and outcomes in health care. So far no validated internationally applied approach for choosing suitable quality indicators has been established.

**Purpose:** To develop a methodology for the identification and selection of quality indicators for the Diabetes Type 2 NDMGs based on the Diabetic Neuropathy NDMG Module.

**Methods:** The NDMG Diabetic Neuropathy authors identified deficits in the care of diabetic patients at risk or with manifestation of neuropathy. On this basis, quality of care goals were defined and recommendations derived. These recommendations were operationalised by measurable quality indicators. Additionally, a database search was undertaken for internationally applied indicators. The methodological quality of the indicators identified by the database search and by operationalisation of recommendations will be assessed using six criteria of the QUALIFY appraisal instrument (e.g. relevance, clarity, scientific basis, availability of data). Final selection of quality indicators for the NDMG Diabetic Neuropathy Module will be achieved by formal consensus (Delphi process).

**Results:** 19 quality of care goals were determined mainly for the aspects diagnosis, pharmacotherapy, chronic care, quality of life and interdisciplinary cooperation. The international database search rendered 6 partly overlapping process indicators for diagnosis and 1 outcome indicator.

**Discussion:** The selection process for an appropriate set of quality indicators is underway. The results of the appraisal and selection process will be presented at the conference in October 2008.
B12
Developing a Standardised and Efficient Procedure for Guideline Monitoring

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Background: One of the crucial factors in guideline implementation is the alignment with up-to-date evidence. In order to maintain a living guideline, regular monitoring of the relevant published evidence seems a necessary procedure to keep up with the rapid development of new medical technologies. Little research has been done on efficient standardised strategies to identify recent information for guideline update.

Purpose: To review the methodological literature and to develop a comprehensive and feasible automated alert service.

Methods: According to our literature review the use of regular searches of databases like PubMed is the most common practice for evidence update. Potential disadvantages of this approach include identifying an excess of irrelevant literature, missing of relevant literature due to the time lag between publication and database entry and problems with indexing. Furthermore, release of new guidelines is often missed. We attempted to overcome these potential problems by developing a standardised way of identification of new relevant documents from a range of sources.

Results: An automated literature search was implemented using different strategies in parallel. Newsletters of guideline databases and content alerts of key journals identified for the respective guideline issue were monitored. Additionally, we incorporated email alerts by PubMed and asked clinical experts and patient representatives to supply new literature by email. The output was reviewed for relevance by an information specialist on a weekly basis. Relevant data were compiled for the guideline coordinator. This new approach was tested on two of our current guidelines and proved to be manageable.

Discussion: Our new standardised procedure for guideline monitoring is a feasible approach which uses various sources of information and is able to identify and assess relevant papers with reasonable effort. Validation of the results using commonly accepted systematic search strategies is necessary in order to establish or further improve this new approach.
B13
Translating Guideline Recommendations into Algorithms for Quality Indicators – an Example from Cardiac Pacemakers


**Background:** Quality indicators can largely support the implementation of guidelines by monitoring the adherence to them in current medical practice. Through documentation they make the care givers aware of the new standards and feed back the achieved level of conformity. Especially for complex recommendations the modelling of guideline-based-indicators is challenging and requires complex algorithms.

**Purpose:** A German national guideline for cardiac pacemakers was published in 2006. To enhance the speed of implementation indicators for the mandatory national indicator project for hospitals, organized by BQS (National Institute for Quality in Healthcare) were simultaneously implemented. For this the recommendations for the indication of cardiac pacemakers needed to be exactly transformed into algorithms.

**Methods:** The indicators were developed by an expert team including some of the guideline authors.

First the evidence-based recommendations were summarized into "indicated" (Recommendation grades I and II) and "not indicated" arrhythmic medical situations (Grade III).

For each type of arrhythmia all parameters of the guideline were transferred into data items, e.g. "ECG finding". Then algorithms for calculation were developed for all types of arrhythmia in all mentioned clinical constellations with a given indication.

**Results:** First results from 2006:
- Indication: 87,3% (31,3–100%)
- System selection: 92,3% (38,5–100%).
- Hospitals receive their results for each specific key figure with a reference to the correlating part of the guideline.

**Discussion:** Recommendations in guidelines often are complex and not always understandable even for medical experts. The reduction of this complexity into single numbers requires a high level of expertise and analytic work.

In some cases this work shows that recommendations are not precise enough or even contradictory. This allows recommendations for the improvement of upcoming updates.

Our dialogue with hospitals shows that the close link between guidelines and quality indicators supports the understanding of the recommendations as well as the public awareness of the guideline.
B14
Adaption of QUALIFY to be Used for the Development of Indicators for Guidelines

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Background: Quality indicators are promising tools to support and monitor a successful guideline implementation. To be effective indicators have to meet quality criteria themselves.

Purpose: In 2007 BQS (National Agency for Quality Assurance in Germany) published the tool "QUALIFY" that allows to assess the methodological quality of quality indicators already in use (http://www.bqs-online.com/public/leistungen/qualify). QUALIFY was applied to select indicators for mandatory public reporting of about 2,000 German hospitals. The tool includes 20 criteria assigned to the three categories relevance, scientific soundness and feasibility. It differs from existing assessment tools by clear definitions, a consistent information basis and a standardized and transparent approach throughout the assessment process.

Now QUALIFY was to be adapted in order to guide the development of new indicators.

Method: QUALIFY authors scrutinized and prioritized the tool’s methodological quality criteria.

Results: QUALIFY criteria were arranged as an algorithm according to the guideline development process. Time-consuming criteria are assessed later in indicator development. Quality indicators should be developed simultaneously to guideline statements. Application of QUALIFY criteria leads to a continuous shaping of the indicator. Experiences showed that methodological deficiencies in quality indicators may reflect obvious deficiencies of the underlying guideline statements. So it is important to give this feed back quickly to the guideline developers. By that way guidelines and indicators move step by step to a sound quality. Fully assessed indicators show a detailed and objective profile of strengths and weaknesses.

Discussion: Using the rearranged version of the QUALIFY tool enables developing and selecting indicators with required properties for defined purposes. Dependent on immediate use and on available resources indicators may be developed as a draft, preliminary or ready for use version. The instrument is designated to guide the development of new quality indicators in the National German Guideline Project (http://www.versorgungsleitlinien.de/themen).
B15
Redistribution of Economic Resources by Implementing Guidelines and Agreement on Division of Tasks

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Background: Clinical evidence based guidelines have been published in order to help health care professionals in decision making, but guidelines do not usually include directions on who is the caregiver. Physicians alone cannot deliver all of the services recommended without the collaboration of other professionals. In Helsinki there was a two-year multiprofessional and educational programme to implement hypertension guideline by intrinsic facilitation in primary care.

Purpose: To estimate the financial benefits of implementation of national evidence-based hypertension guideline agreeing on task division.

Methods: Cross-sectional audit on blood pressure (BP) recordings at nurses’ outpatient consultations before and after the implementation intervention. Modelling of annual rate and expenses of BP recording visits. It was assumed that all nurses conducted a mean number of BP measurements during each single week and each week (five days) of the year were assumed to be similar for each nurse. Four weeks’ vacation per nurse was accounted for.

Results: At baseline the mean number of BP measurements for one nurse was 18 recordings per week and the approximation of BP recordings during one year by all nurses in the City of Helsinki corresponded to 487 000 measurements. Corresponding figures after the follow up were nine recordings per week and 250 500 measurements per year. These changes can be translated into rough estimates of the financial benefits. An appointment with a nurse costs 31 euros (2003). Based on our study, there would be 237,000 fewer BP appointments, corresponding to redistribution in expenses of a maximum of 7.3 million euros.

Discussion: Through local agreement on task division it would be possible to better manage working hours and redistribute both personnel and economic resources. Furthermore, we suggest that experts presenting national guidelines take the workload and financial consequences into consideration.
B16
Measuring Current Care with Indicators Based on Evidence Based Guidelines for Patients with Non-Hodgkin Lymphoma

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Background: The non-Hodgkin Lymphomas (NHL) are a heterogeneous group of more than 30 lymphoproliferative malignancies, for which new diagnostic and treatment options are continuously being developed. Guidelines may assist in care decisions, however adherence to guidelines should be ensured by implementation strategies. For implementation, the first step is to gain insight into adherence by measuring current care.

Purpose: Development and testing of indicators to measure, monitor and improve care for patients with NHL.

Methods: From (inter)national evidence-based guidelines for NHL, we collected recommendations concerning diagnostics and staging (D&S), treatment and follow-up (T&F) and referrals and coordination (R&C). Indicators were developed from these recommendations with a multidisciplinary panel of fourteen experts, using a three round Rand-modified Delphi procedure. The indicators were tested in 600 patients from 22 hospitals. Actual care was assessed by calculating an overall and per hospital percentage indicator score. For feasibility, improvement potential and missing data were assessed per indicator.

Results: From 99 key recommendations from six evidence-based guidelines for NHL, twenty indicators were selected: eight for D&S, five for T&F and seven for R&C. Measurements of current care with the indicators showed variable adherence rates (from 11% to 100%). Several indicators showed large improvement potential; ten out of twenty showed overall scores of 70% or lower, of which six were lower than 50%. The majority concerned indicators for T&F and R&C. Between hospitals, indicator scores were also variable. For four indicators, differences in scores were 60% up to 100% between the lowest scoring hospital and the highest. Concerning missing data, all indicators were acceptable, except for three indicators (32, 41 and 65% missing data).

Discussion: In this study, indicators were developed to measure current care for patients with NHL. All indicators, particular those with improvement potential, can be used to design implementations strategies for guideline adherence.
B17
The Challenges in Transferring Systematic Methodologies to Develop Guidance from the Clinical Field to Health Protection (a Specialised Area of Public Health)

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Background and purpose: The challenge for practice guidelines and recommendations designed for the health protection workforce is to transform a plethora of both tacit knowledge and explicit evidence into robust evidence-based guidance. Although basing clinical practice guidelines on a systematic review of current evidence is well established, health protection, a highly specialised area of public health, is only now learning to apply this systematic methodology to develop recommendations and evidence informed policies.

While the development of clinical guidelines mainly involves evidence traditionally considered as robust (RCTs, cohort studies, etc), using the traditional hierarchy of evidence in the context of health protection is open to question. Randomised controlled trials and interventional studies in health protection activities are potentially unfeasible and/or unethical.

Methods: Health Protection Scotland (HPS) and the Scottish Health Protection Network (HPN) have worked with the Scottish Intercollegiate Guidelines Network (SIGN) to better understand the process and implications of developing guidance systematically. A valid common framework to develop, adapt and update evidence based guidance for health protection has been constructed from this collaboration.

Results and discussion: By developing several different guidelines to piloting this framework, the HPN intends to become a robust professional platform to prioritise topics and develop guidance and policies for health protection. A number of challenges, unique to health protection, were identified during the process, which include:

- identification and assessment of evidence
- the grading of recommendations
- how extrapolated and inducted evidence from incidents and outbreaks management may construct valid decision-making processes
- the recognition that experiential evidence may compete in quality with other levels of evidence that support recommendations.

The rationale of understanding and implementing evidence based guidance for health protection is critical to improving professional competency in the future.
B18
Guideline Adaptation in Practice: Preliminary Results
From the Evaluation of the Use of the ADAPTE Framework and Process

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Background: Developing and updating high-quality guidelines requires substantial time and resources. To reduce duplication of effort, enhance efficiency and promote the translation of evidence into practice, the ADAPTE collaboration has developed a framework and process for guideline adaptation which translate into a series of tasks in modules supported by different tools. An evaluation study has been launched to test and refine the framework and its components.

Purpose: To report the evaluation of the process, modules and tools by the early participants in the evaluation study.

Methods: Organisations interested in the use of ADAPTE framework to support the adaptation of a guideline have registered and obtained the material. We report the descriptive analysis of the opinions of the users when they examined the content of the ADAPTE concept and process, reported in a Manual, and the detailed modules and support tools, presented in the Resource toolkit. Survey forms have been filled in by the participants.

Results: Among 127 organisations and individuals from 30 countries who have registered to obtain the ADAPTE documents, 67 have evaluated the Manual. Fourty-five (67%) of the latter were planning to use the ADAPTE framework. A majority of them have found the ADAPTE process (very) clear (81%, very) comprehensive (70%) and (very) feasible (60%), and the Manual (very) useful (73%). However, 21% found the ADAPTE process complex, 45% and 37% feared that they will miss appropriate guidelines or find only low quality guidelines, respectively.

Discussion: The launch of the ADAPTE framework and process has generated a large interest among guidelines developers. The majority of the oragnisations/individuals who have evaluated the process concluded that it could be feasible and useful, although limitations in the process and the quality of source guidelines were expected. This evaluation will help improving the ADAPTE guideline adaptation process and the related support tools.
B19
Systematic Review, Adaptation and Consensus:
Using a Combination of Methods to Collaborate
in the Development of Cancer Guidelines in Ontario, Canada

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Background: Cancer Care Ontario’s Program in Evidence-based Care (CCOPEBC) develops clinical and organizational guidelines. In order to make the best use of our resources, we choose the most effective methods for applying the best available evidence to develop recommendations. Systematic review is our core methodology, but for all new topics we identify existing guidelines for adaptation, and employ formal consensus methods when published evidence is poor.

Purpose: To report on the use of adaptation and consensus methods in two recent CCOPEBC guidelines.

Methods:
Example A: Thymoma is a rare disease treated by a small number of physicians in Ontario. ’The Management of Thymoma’ guideline was developed by a multidisciplinary working group of 9 clinicians and 2 CCOPEBC staff using systematic review and a modified Delphi consensus process.

Example B: The ‘Management of Head and Neck Cancer in Ontario’ guideline was developed by a multidisciplinary working group of 4 clinicians and 2 CCOPEBC staff. Recommendations that were adapted from SIGN (2005) and NICE (2004) guidelines were reviewed in an online consensus process.

Results:
A: Twenty-two clinicians reached consensus on 38 of 40 recommendations for systemic, radiological and surgical treatment for all stages of disease over an 20-month period.
B: Health care professionals (N=116) from several disciplines participated in an online consensus process to develop recommendations from diagnosis to post-treatment. Estimated time for completion is < 12 months.

Discussion: Using a combination of methods we have successfully engaged a variety of health care providers in the guideline development process. By making timely use of the work of other guideline developers, utilizing the expert opinion of collaborating practitioners and learning from our experiences we aim to make the best use of our time and human resources.
B20
Guideline Adaptation – Not as Easy as it Sounds

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Background: Adapting pre-existing guidelines in lieu of de novo development purportedly offers the advantages of reduced duplication, decreased resource commitment, increased efficiency, and enhanced local uptake. However, the challenges of adapting existing ‘seed’ guidelines are rarely addressed.

Purpose: The Alberta Health Technology Assessment Chronic Pain Ambassador Program created a unique process to expedite the development of a provincial low back pain guideline and keep busy clinicians engaged in its genesis.

Methods: Relevant seed guidelines were identified and appraised using a modified AGREE tool. A multidisciplinary development committee used the AGREE scores to select the best guideline(s), which were then adapted to the provincial context.

Results: Using seed guidelines minimised resource commitment and the expedited development process ensured the continued engagement of clinical experts. Stakeholder buy-in was also fostered by the contextualization process. However, several challenges were identified.

• 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 needed for overlapping, discordant, or absent recommendations.
• The strength and quality of the underlying empirical evidence was not formally assessed and could not be defined by terms such as good, fair, poor, insufficient, or conflicting, which made categorising the strength and type of recommendations problematic.
• Faith in the process can be undermined by the fear of using inferior seed guidelines.
• Recently published evidence is not necessarily incorporated.

Discussion: Guideline adaptation is useful when good quality seed guidelines exist and resources are limited. While guideline adaptation saves time initially, unforeseen methodological issues can counteract this benefit. A flexible and transparent approach, multidisciplinary stakeholder input, and careful consideration of potential methodological pitfalls can ensure that guideline adaptation is not mired by the inadequacies inherent in this deceptively straightforward approach.
B21
Comprehensive Medication Review by Pharmacist – a Valuable Tool for GP to Improve Pharmacotherapy

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Background: Finnish pharmacists have been able to acquire special competencies in conducting medication reviews in collaboration with GPs through a long-term continuing education course since 2005.

Purpose: This presentation describes the Finnish model of pharmacist provided comprehensive medication review (CMR) that GPs can utilize as a tool to improve pharmacotherapy.

Methods: The Finnish medication review is always problem-based. The person to be in charge of the initiation of the review process is the physician. The reason for the need of the medication review can be e.g. polypharmacy, suspected side-effects or poor adherence.

Results: The current CMR process includes the following steps: 1) physician identifies a patient needing a CMR and provides the accredited pharmacist with an assignment and sufficient patient background information; 2) pharmacist interviews the patient; 3) pharmacist conducts the CMR utilizing collected data and writes a report with findings and clinical recommendations; 4) case conference between the pharmacist and the physician who is responsible for all medical decisions; and optionally 5) follow-up.

The matters to be considered in the CMR are e.g., treatment being in line with the national Current Care Guidelines; side-effects; drug-drug interactions; practical problems in taking the medications; poor adherence; economical considerations (drug costs); unnecessary and missing medications; potentially harmful medications for the elderly according to Beers criteria and other inappropriate drug choices, particularly to avoid anticholinergic, sedative and serotonergic load. EBM and the national guidelines are extremely important in justifying the created recommendations.

Discussion: The collaborative medication review procedure developed in Finland is currently under several evaluations to assess its clinical and pharmacoeconomical value in medicines management and integration to health services.
B22

AGREE Next Steps: Continuous Quality Improvement in the Evaluation of Clinical Practice Guidelines

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Purpose: AGREE Next Steps aims to improve the reliability, validity and usability of the AGREE Instrument.

Questions: Do AGREE domain scores and Global Rating Scale (GRS) scores vary as a function of guideline appraiser? Do ratings of AGREE and GRS usefulness and importance vary as a function of guideline appraiser?

Methods: Appraisers (developers or clinicians) were randomized to one of two conditions. In Condition 1, participants read and evaluated a guideline using the AGREE (23 items) and GRS (5 items), and completed questionnaires regarding characteristics of the usefulness of the AGREE and GRS tools. Condition 2 methods were identical, except only GRS was explored.

Results: Guideline Assessment–Interim analysis of data (n=57) identified significant differences between developers and clinicians on Rigour of Development (61.3% vs. 77.5%; p=0.007) and Editorial Independence (52.1% vs. 72.1%; p=0.023) AGREE domains. A borderline difference was found between appraisers in Clarity of Presentation (62.3% vs. 73.1%; p=0.059). From the GRS, mean Completeness of Reporting scores were significantly higher for clinicians than for developers (5.2 vs. 4.1; p=0.019).

Usefulness Ratings–Except for two items, there were no significant differences in AGREE and GRS item usefulness ratings between the appraisers. For all items, the mean usefulness rating was over the mid-point of the 5-point scale.

Importance Ratings–By AGREE domain, Rigour of Development was rated as most important by developers and clinicians (45.7% and 45.0%, respectively). By GRS item, however, developers were more apt to rank Overall Quality of the Guideline Development Methods most important (52.9%) whereas clinicians ranked Overall Quality of the Recommendations most important (55.0%).

Conclusions: Quality scores on guidelines were higher for clinicians than for developers; the AGREE instrument yielded more differences than the GRS. With respect to assessments of the usefulness of the instruments items, virtually no differences emerged by the appraiser types. Importance rankings align with the perspective of the appraiser.
B23
Quality Evidence on a Clinician’s Schedule: Meeting in the Middle With a BESıp – Best Evidence Statement

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Background: The goal of evidence-based health care is to bring current research findings to the decision-making process of patients and clinicians. Because busy clinicians and guideline developers have been challenged to link each other’s work, a multidisciplinary group collaborated to facilitate this connection.

Purpose: To develop tools to guide point-of-care clinicians in the efficient evaluation of research evidence.

Methods: With a goal of providing quality evidence-based care recommendations, three groups’ needs were considered: evidence summary developers, independent reviewers, and clinicians. A multidisciplinary group, guided by the AGREE criteria, developed a process to enable clinicians to learn efficient methods to develop evidence-based care recommendations. Feedback was solicited from clinicians and experienced evidence evaluators and was incorporated into the process.

Results: Three integrated tools were developed. A Form for Reporting Results (FRR) guides clinicians developing care recommendations through the process. Ten required and five optional AGREE criteria were built into this form. Subjective decisions were made regarding the omission of the remaining 8 AGREE criteria to balance the need for minimizing turnaround time. A tool (Best Evidence Statement, BESıp) presents the same information as the FRR while affording front page access to specific and unambiguous care recommendations(s) to answer a specific clinical question. The Checklist is a one page review tool to determine if the document will be accepted, based on meeting the 10 required AGREE criteria.

Discussion: The BESıp process has been used at our institution since October 2006 to answer a diverse set of clinical questions. An increasing number of clinicians have been able to learn and apply skills for evidence evaluation due to a reduced turnaround time using the BESıp process. Further evaluation and validation of the BESıp process should be conducted prior to widespread use of the process.
B24
Effectiveness of Evidence-based Clinical Practice Guidelines: Do They Improve Quality of Care?

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Background: Evidence-based clinical practice guidelines are regarded in theory as promising tools for quality improvement. However, it is uncertain whether and to what extent they are effective in daily practice.

Purpose: In this review we assessed the evidence for the effectiveness of evidence-based guidelines in improving the quality of care in the Netherlands, a country with a long tradition in the area of evidence-based guideline development and implementation.

Methods: A systematic review using the electronic databases Medline and Embase (1990–2007) and relevant scientific journals was conducted. Controlled trials, interrupted time series and before and after studies evaluating the effects of Dutch evidence-based guidelines on the process or structure of care or on patient health outcomes, were included.

Results: A total of 20 studies met the inclusion criteria. In 17 out of 19 studies that measured the effects on the process or structure of care significant improvements were reported. The majority of these studies reported improvements with respect to some of the recommendations studied and the size of the effects varied largely across recommendations within guidelines. Six out of nine studies that measured the effects of clinical guidelines on patient health outcomes showed significant but small improvements.

Discussion: Dutch evidence-based clinical practice guidelines can be effective in improving the process and structure of care. The effects of guidelines on patient health outcomes were far less studied and less convincing. The observed variation in effects across recommendations suggests that it is useful to develop implementation strategies tailored to individual recommendations within guidelines. More studies with a robust design are needed to identify determinants of successful guideline implementation.
B25
Implementing PET Imaging According to Evidence-based Guidelines in Ontario, Canada

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The evidence base for the clinical utility of PET is modest. A systematic review of the oncology literature conducted by the Institute for Clinical Evaluative Sciences (ICES) in 2001, supported its use in the diagnosis of the solitary pulmonary nodule and in tumors with positive and rising seromarkers (CEA, AFP, beta HCG, thyroglobulin) when standard imaging is negative.

The provincial Hematology Disease Site Group (HDSG) recently completed a systematic review on PET in malignant lymphomas. Recommendations were limited to the evaluation of residual masses following curative chemotherapy in malignant lymphomas and to limited stage Hodgkin’s disease after two to three cycles of chemotherapy to determine whether mono-therapy should continue alone or be supplemented by radiation therapy.

To generate evidence of clinical utility, five clinical trials have been supported by the MOHLTC in early and locally advanced lung cancer (2 studies), early-stage breast cancer, head and neck cancer following radiotherapy treatment and colorectal cancer metastatic to liver in patients being considered for hepatic resection. The lung trial has demonstrated that PET found extra thoracic spread in 17% of patients who were considered operable on the basis of standard workup.

Access to PET in Ontario has been limited to those indications approved by the Ontario Health Technology Committee on the basis of the evidence generated in Ontario trials or systematic reviews conducted by ICES or the Program in Evidence based Care. This approach to the introduction of a new health technology is unique to Ontario and serves as a model for the introduction of new and expensive health technologies.
B26
Evaluation of a Multifactorial Implementation Strategy of Three Clinical Practice Guidelines on Cardiovascular Risk (Hypertension, Diabetes and Hyperlipidemia) in Primary Health Care in the Autonomous Community of Basque Country


Introduction: Rationale and relevance of the study. The development of clinical practice guidelines (CPG) in our country needs supplementation by assessing their impact. This is essential to know which are the most effective strategies for dissemination and implementation.

Two CPG on Arterial Hypertension (2002) and Asthma (2005) were implemented in the Basque Country. Three other GPC on hypertension, diabetes type 2 and Lipids will be implemented in the near future. So, there is a unique opportunity to undertake a study whose aim is to evaluate a multifactorial strategy for implementing the three CPG.

Materials and methods: Type of study and selection of subjects: a randomized clinical trial by clusters in 70 outpatient dispensaries (OPD) in two districts of Osakidetza (Basque Health System). Both have similar characteristics in terms of population attended and also in the achieved health results.

A randomization of OPDs will take place stratifying according to the number of physicians from each center. Each cluster includes patients assigned to each OPD. Three independent samples will be taken to assess each of the guidelines. The study will assume a beta risk of 80%, a alpha risk of 5%, and an interclass correlation coefficient between 0.05 and 0.01. There is a need of 50 patients per each of the 70 centers to detect differences of 1% in HbA1c, 8% in the degree of control of blood pressure and 8% in the correct prescription of statins.

Interventions: Control group: diffusion of the CPG plus an interactive introduction in each centre. There will also be the inclusion of indicators in management contract-program and also, presentations in Workshops or Conferences.

Intervention Study: in addition to the above, interactive website on CPG, with a prior feedback of indicators, reminder meetings and specific workshops.

Outcomes:
Diabetes: Percentage of patients with HbA1C done in the last 6 months, glycosylated hemoglobin values, % of patients with risk stratification of diabetic foot. Hypertension: Systolic arterial pressure(SAP) in mmHg, % of patients with SAP <140 and Diastolic Arterial pressure (DAP) <90 mmHg Lipids: % of patients with a prescription of statins who undertook a coronary risk. Follow up: The results will be measured at 6 and 12 months after the intervention.

Analysis: It will take place independently for each sample of each guideline. A multivariate analysis (taking into account characteristics of patients and doctors) and a multilevel analysis
will be done. For this purpose we will use the STATA statistics package. We will use the intention to treat analysis.

Possibility of innovation on current knowledge: We propose effective and feasible strategies in the implementation of CPG in the Spanish primary care setting. Moreover, moving the CPG design forward into an electronic format.
B27
Regional Model for the Systematized Lifestyle Counseling, Implementation of the Lifestyle Counseling Process


In the county of Päijät-Häme in Finland, a reorganization of the social and health care services has taken place. One of the main aims has been systematization of promotion of health and social well-being in the area covering 15 municipalities and over 200,000 inhabitants. The systematic approach is piloted in prevention of type 2 diabetes. It is based on an earlier developed regional model for prevention, including a group-based lifestyle counseling program and re-definition of responsibilities of both the professionals and the patient. The entire lifestyle counseling process has been defined, from identification of those at high risk of T2DM, to ways to deliver lifestyle counseling and to organize follow-up.

The high-risk patients will be screened from the primary care patients by using the Finnish diabetes risk test. Oral glucose tolerance test will be done to these patients. Default method for lifestyle counseling is a group-based structured program with six sessions. Follow-up will be arranged in group sessions every half a year and oral glucose tolerance test will be repeated in every 1-3 years. As a result of the systematization of the lifestyle counseling process, all high-risk patients in the health care should be identified, and 80% of them should be reached by the group-based lifestyle counseling.

A crucial part of the process is data collection, making prevention of T2DM visible and measurable. Systematically collected data in the electronic patient register will provide information about the functioning and effectiveness of the lifestyle counseling process.

Implementation of the process has been carried out in close co-operation with local health care professionals in order to keep the process as simple as possible and to guarantee feasibility in the routine health care environment. Preliminary results on the successfulness of the implementation and on the functioning of the lifestyle counseling process will be presented.
B28
Implementation of Stroke Rehabilitation Guidelines
(Current Care) in Finland

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Background: Stroke is a leading cause of disability and approximately 40 percent of stroke survivors are left with functional impairment. The Finnish guidelines (Current Care, Käypä hoito, Duodecim 2006) for the treatment of ischemic stroke state that the stroke patients should get treatment and rehabilitation in a well-organized, multidisciplinary rehabilitation unit. The benefits of organized stroke care are seen equally for old and young patients, male or female, and for all severity grades of stroke. There are no earlier systematic studies of stroke rehabilitation resources in Finland.

Purpose: The aim of the study is to clarify the current state of stroke rehabilitation in Finland and how current care guideline implementation is done in practise.

Methods: In the first phase of the study (yr 2007) we interviewed the key-persons of stroke rehabilitation in 24 Finnish central hospitals and in their 9 rehabilitation wards. In the second phase of the study written questionnaires were send to local hospitals and local health centres.

Results: All central hospitals and 64 percent of health centres answered to our questions within requested time. We are still analysing data, but preliminary results show that rehabilitation procedures vary markedly between hospital districts and different cities in Finland. Only few percent of stroke patients have access to multidisciplinary rehabilitation in certain hospital districts in comparison to more than forty percent in other hospital districts. The results of health centre questionnaires show that outpatient physiotherapeutic rehabilitation services are thought to be adequate in 64 percent of health centres, occupational therapeutic in 16 percent, speech therapeutic in 19 percent, neuropsychological in 8 percent and social work rehabilitation services in 51 percent of health centres.

Discussion: Our results show that implementation of stroke guidelines in practise has started. There are differences in rehabilitation practise and there is a clear need for education.
Improving Emergency Department Pain Management Based on Nationally Endorsed Guidelines

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Background: The Emergency Care Community of Practice (EC CoP) was initiated to support health professionals to implement best practice. As the program has developed there has been an increasing focus on evidence based guidelines to improve emergency care. With pain as the primary complaint in 75% of emergency department presentations causing significant distress for patients, clinicians identified pain as a priority area. An national audit showed there is wide variation in practice which is not consistent with current evidence based guideline recommendations.

Purpose: The aim of the EC CoP pain initiative is to improve emergency department pain management based on Australia’s National Health and Medical Research Council endorsed guidelines, the ‘Acute Pain Management: Scientific Evidence’ (2005). These guidelines include a specific chapter on acute pain management in emergency departments.

Method: In 2007 a national audit was conducted to identify the current practice in pain management across Australian public hospital emergency departments. In 2008, the 2nd phase of this initiative commenced to implement the guideline recommendations nationally. A comprehensive literature review and series of focus groups of emergency care clinicians has been undertaken to develop a targeted intervention based on identified barriers and enablers. The intervention aims to influence change at the policy, organizational, team and individual level.

Results: The results of the audit of 36 emergency departments showed that the median time to analgesia was twice the recommended time and the use of pain scores to assess and reassess pain was not consistently documented to effective pain management. In the fractured neck of femur cohort The recommended pain management only occurred in 10% of patients.

Discussion: This presentation provides an overview of the EC CoP pain initiative from identifying evidence practice gaps to the development of strategies for guideline implementation to improve pain management in Australian emergency departments.
B30
Can a Snapshot of Guideline Attribute Reporting
Be Used as a Proxy for Guideline Quality?

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Background: The template used to develop abstracts of guidelines included in the National Guideline Clearinghouse (NGC) was designed to facilitate critical appraisal of guideline quality. This and other tools are available world-wide to assist in assessing the quality of evidence-based clinical practice guidelines using documentation provided in or with the guideline. However, these tools are limited by their length, prerequisite skills, training time, and other factors. NGC users around the world have expressed concern that using such tools is not feasible and have repeatedly requested help in determining the quality of guidelines included in NGC.

Purpose: To review results of attribute reporting of guidelines included in NGC from 2000 to 2007 and the utility of a proxy for guideline quality.

Methods: Descriptive statistics were used to analyze guideline attribute reporting. Literature was reviewed and expert guidance sought on mechanisms to report quality. Capitalizing on guideline attribute abstraction by the NGC team, NGC repurposed attribute information using a binary approach and aggregated it for presentation into a short view, called a "snapshot". Critical feedback on this new way to facilitate judgment about quality was obtained from experts. NGC seeks feedback from conference participants, an important group of NGC users, to improve the usefulness of the snapshot to all users.

Results: The NGC snapshot addresses guideline methodology, recommendations, implementation, and transparency, and provides that quick assessment of quality desired by NGC users. After consulting with NGC experts, the snapshot was shortened.

Discussion: NGC’s 10-year experience in abstracting guidelines into a template representing important guideline attributes coupled with analysis of attribute reporting and desire to help users quickly assess guideline quality led to the creation of an NGC-provided snapshot of guideline attribute reporting serving as a proxy for guideline quality. Input from conference participants into the snapshot’s utility is critical.
B31

Interventions to Improve Adherence to Prescribed Medication – Using the Evidence with a Guideline Development Group

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Background: Reviews conducted across disease areas and countries suggest that at least 30–50% of prescribed medication is not taken as prescribed. This behaviour is often undisclosed by patients and unrecognised by prescribers. It can however lead to worse health outcomes in terms of morbidity or mortality for the patient and to an increased economic burden on the healthcare system. A broad range of interventions have been designed to improve patient’s non-adherence.

Purpose: To assess the effectiveness of interventions in improving medication adherence as part of the development of the Medicines Concordance guideline for the National Institute for Health and Clinical Excellence (NICE).

Methods: We conducted an update of a Cochrane review.
B32
The Use of Qualitative Research in Clinical Guidelines developed by the National Institute for Health and Clinical Evidence (NICE) in England & Wales

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Background: Clinical guidelines often use qualitative evidence to inform practice recommendations. There is, however, no one widely accepted approach to using such evidence in guideline development.

Purpose: To describe the use of qualitative research within a national clinical guideline programme (NICE) and to identify training needs for guideline developers.

Methods: Phase I: a data extraction form was used to extract information on qualitative evidence used in published NICE guidelines from 2002 to June 2007. Phase II: a semi-structured questionnaire was used to collect information on qualitative evidence to be used in guidelines in development (due to be published June 2007 – March 2008).
All information collected was presented with simple statistical and narrative summaries.

Results: A total of 49 clinical guidelines were published by NICE within the study period. 24 (49%) guidelines used qualitative studies as an evidence base for developing practice recommendations. The main issues identified were: inconsistencies in defining what constitutes “qualitative research”, the lack of standardised search strategies and/or targeted selection processes and the lack of a standardised quality appraisal method.
The training needs identified from the questionnaire were: training in the identification, quality appraisal and synthesis of qualitative studies; guidance on what kind of clinical questions would predominantly require qualitative evidence; how to guide the GDG when using qualitative evidence; and how to translate qualitative evidence into recommendations.

Discussion: There is no consistency in how qualitative evidence is utilised in the development of NICE clinical guidelines. Further research and consensus on the methodology is needed to provide guidance on a standard approach and to improve quality assurance.
B33
The Known Unknowns: Synthesis of Uncertainties and Evidence Gaps to Identify Priority Research Recommendations

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Background: ‘as we know, there are known knowns: there are things we know we know. We also know there are known unknowns: that is to say we know there are some things we do not know.’ Donald Rumsfeld, Defence Secretary, USA

The foundation of guideline development is the synthesis of the evidence to identify the ‘known knowns’. However, it is rare that all recommendations can be supported by high-quality research evidence; uncertainties in guideline development are common, and often arise from gaps in the evidence-base.

Purpose: The failure to identify evidence is often seen as the end of the story; a few of the ‘known unknowns’ may be highlighted as recommendations for research. If there is any process of prioritisation, it is rarely made explicit and is arguably open to bias. The role of formal ‘Value of Information Analysis’ remains to be established. Indeed there is controversy over the role of guideline developers: to identify the uncertainties or recommend the best way to resolve them?

Methods and Results: CoCanCPG (Coordination of Cancer Clinical Practice Guidelines in Europe) is a European Commission funded consortium of 17 institutional partners from 11 countries. The UK’s National Institute of Health and Clinical Excellence (NICE), working with the consortium, is developing a database of uncertainties in the management of cancer that have been identified during guideline development. A cross-consortium framework will be developed to synthesise the information the evidence gaps, allowing these uncertainties to be collated, prioritised and communicated.

Discussion: The framework will enable collaboration with relevant stakeholders from the research community, for example the European Organisation for Research and Treatment of Cancer (EORTC), to ensure the research is undertaken.
B34
Implementing Clinical Practice Guideline External Review in Taiwan

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Background: With the development of quality appraisal for clinical practice guidelines (CPGs) in 2007, the Center for Health Policy Research and Development (CHPRD), National Health Research Institutes (NHRI) in Taiwan proposed review protocol of developed CPGs.

Purpose: This study aimed to establish a dual external review protocols for CPG development, to exam the implication of review process, and to provide suggestions for further implementation.

Methods: Focus group approach was used to review and establish the review protocol for guideline development. We applied nominal group technique to obtain a consensus in required CPG review content. We use both internal and external reviews to each guideline developed. There were 7 guidelines subjected to this process. The guideline developer appointed their own internal reviewer according to the format by our center. The CHPRD review group managed external review. The Appraisal of Guidelines for Research and Evaluation (AGREE) instrument was used as review criteria in both reviews.

Results: We identified 62 items for CPG review content. Among them, 32 items were selected as mandatory items to be included in CPG review, with other 30 items as optional. In seven selected guidelines, 4 guidelines gained same final approval by both reviews. The remaining 3 guidelines had different results from internal and external reviews. There were different viewpoints among reviewers related to some dimensions of AGREE instrument, such as, stakeholder involvement, rigor of development, editorial independence. Guideline applicability and stakeholder involvement, according to the reviewers, deserve more room for improvement.

Discussion: CPGs’ quality can be significantly improved by setting a transparent standard. The two review group approach is a better way to cover all aspects of guideline development. In terms of methodology, in some aspects, such as stakeholder involvement, rigor development, and applicability, requires a better attention in our future work.
B35
National Nursing Guidelines for Identifying and Intervening in Child Maltreatment

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Background: The last twenty years have witnessed an increase in the risk factors and incidence of maltreatment of children. Social and health care workers play a crucial role in identifying child abuse and intervening in it, but the skills and knowledge continue to be inadequate. Development of National Nursing Guidelines is part of the research project funded by Academy of Finland and were developed together with Finnish Nurses’ Association and Nursing Research Foundation.

Purpose: The purpose of the guidelines is to develop multiprofessional care of child maltreating families. Guidelines are developed especially for nurses to facilitate identification and early intervention for child maltreatment but they are also useful for other professionals working with children and their families.

Methods: The guidelines are based on systematic literature search in different nursing, medical and social sciences databases. The search produced almost 7 500 studies and other scientific articles. According to titles, abstracts and finally full texts, 77 articles from health and social sciences were chosen to create the basis of systematic review. The articles were carefully analysed, and guidelines were developed.

Results: The guidelines include knowledge concerning the risk factors of children, their parents and the family situation. There are guidelines also concerning markers and symptoms of maltreatment, and principles and means of identifying and intervening. The guidelines are available in www.hotus.fi.

Discussion: Nursing guidelines were prepared to facilitate the identification of child maltreatment and intervening in it. In addition to guidelines identifying child abuse demands meticulousness, tact, interaction and skills in raising the subject based on ethical principles. In addition to being capable of recognising the physical signs of abuse, nurses and physicians need training in identifying psychological abuse, neglect and sexual abuse and also in raising difficult issues for discussion. Multiprofessional collaboration is emphasized, as well as multiprofessional education.
The Use of Local Evidence for Guideline Development:
The Example of the Japanese Guidelines for Cancer Screening

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Background: Japanese guidelines for cancer screening have been developed since 2003. These guidelines recommended 3 screening programs based on observational studies conducted in Japan.

Purpose: To clarify basic requirements for using local evidence.

Methods: The Japanese recommendations and the evidence dealing with gastric, lung and colorectal cancer screenings were compared with those of other guidelines.

Results:
1. Gastric cancer screening: There were no recommendations for gastric cancer screening. However, based on 4 case-control studies conducted in Japan and 1 Venezuelan study, we recommended photofluorography. Although observational studies conducted in Japan were discussed in the PDQ in the U.S., their conclusion differed from ours.
2. Lung cancer screening: Based on the results of classical RCTs, most guidelines concluded that lung cancer screening was not recommended. However, based on the results of 5 case-control studies conducted in Japan, we recommended a combination of chest radiography and sputum cytology (limited to the high risk group).
3. Colorectal cancer screening: In our guidelines, colorectal cancer screening using immunological fecal occult blood testing (IFOBT) was recommended based on 3 case-control studies conducted in Japan and 1 Italian study. The American Cancer Society recommended IFOBT screening based on studies that compared the sensitivity and specificity of IFOBT and chemical FOBT.

Discussion: Gastric, lung, and colorectal cancers are the leading causes of cancer death in Japan. To reduce cancer mortality, these cancer screening programs have been a major issue. Although RCTs to evaluate the effect of cancer screening have not been conducted in Japan, observational studies have been done. For original guideline development, local evidences must be considered. When the results of the observational studies were consistent, we used them to formulate recommendations. If clear evidence based on RCTs is not available, the results of observational studies should be cautiously employed after assessing their quality.
Implementing "from Evidence to Recommendations" in a National Guideline Programme: The NICE Linking Evidence to Recommendations (LETR) Project


**Background:** The National Institute for Health and Clinical Excellence (NICE) develops clinical guidelines for the National Health Service of England and Wales based on best available evidence of clinical and cost effectiveness.

**Purpose:** One of the challenges of guideline development is to present the consideration of the evidence in a way that is accessible to a range of guideline users. NICE has been working on ways to make the presentation of evidence and its interpretation more transparent, through a project called Linking Evidence to Recommendations (LETR).

**Methods:** This project includes reviewing the structure of the guideline documents, the content of the sections describing and summarising evidence, and the clarity of presentation of the interpretation of the evidence to develop recommendations. LETR is a collaborative effort between NICE and its National Collaborating Centres, involving the practical application of tools designed to improve transparency (such as GRADE evidence profiles) as well as change management.

**Results:** The main methodological and change management issues encountered during the development of the LETR project to date will be presented. This will include a review of the use of GRADE profiles for evidence of cost effectiveness as well as of clinical effectiveness.

**Discussion:** The key issues national guideline developers need to consider when planning a programme of making the links between evidence and recommendations more transparent will be discussed.
B39
Experience of Updating the NICE Guideline on Head Injury


Background: The National Collaborating Centre for Acute Care (NCC-AC) developed a guideline on the early management of head injury for the NHS in England and Wales in 2003. This was one of the first guidelines to be produced by the National Institute for Health and Clinical Excellence (NICE) within the current guidelines program. New data emerged after publication of the guideline and a decision was made to perform a partial update and reissue the guideline.

Purpose: We will discuss our experience of managing this process and reflect on lessons learnt to help plan future updates.

Method: The methods outlined in the NICE manual on guideline development methods were followed, however as this was the first NICE guideline to be updated to this extent new processes were developed. We aimed to keep the work manageable to enable a quicker development time. A new scope was not developed. A guideline development group was convened consisting of a mixture of original and new members. A limited number of the clinical questions were chosen for update. The final updated guideline was published in September 2007.

Results: The guideline was successfully reissued. We found however that there were challenges in containing the work required for the update. Although we had kept to the original scope and identified only a limited set of questions to update, there was a tendency for the work to creep into areas that we had not originally anticipated. Integrating old and new reviews was also sometimes challenging since terminology, methodology and editorial style had evolved since the original guideline was issued.

Discussion: We will discuss the specific challenges that can arise and examine ways of improving efficiency in updating guidelines.
Can an Existing Knowledge System be Used as a Basis for Developing, Updating and Communicating Clinical Guidelines in Denmark?

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Background: In Denmark there is an ongoing discussion on how to increase the production and systematic updating of national clinical guidelines – with less time and manpower used per guideline. Furthermore, there is a wish to coordinate the development of clinical guidelines with the development of decision support in clinical IT-systems.

Purpose: The National Board of Health and the national organisation Digital Heath in Denmark have planned a pilot project/a "Proof of Concept" (PoC) on using Map of Medicine (www.mapofmedicine.com) as a tool to achieve the above goals.

Methods:
The primary parts of the pilot project will be:
- Analysis of clinical content in the UK MoM: what is the level of concordance with clinical practise in Denmark?
- Development of 5 Danish clinical guidelines (cancer) using UK MoM pathways as the basis
- The use of Danish MoM pathways in clinical practise: the integration of "a Danish MoM" (including UK pathways and 5 Danish MoM pathways) with the clinical IT-systems used in one clinical department (cancer) and primary care.

Results: The results of the Proof of Concept regarding Map of Medicine in Denmark are planned to be published in an evaluation report in Spring 2009.

Discussion: Some of the previewed challenges of implementing Map of Medicine in Denmark are:
- Does the clinical content in MoM to an acceptable degree reflect clinical practise in Denmark – and does it address the right health professionals?
- Will the present implementation of the Norwegian electronic medical handbook in Denmark be an obstacle to using Map of Medicine – especially in primary health care?
- Will there be any added benefits by using MoM in achieving digitalisation of the health sector?
- How does MoM integrate with present regional/local guidelines-systems?
B41
An Operationally Defined Tool for Applying the AGREE Instrument

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Background: The AGREE tool is a useful, transparent and accepted method for evaluating clinical practice guidelines. Cancer Care Ontario’s Program in Evidence-based Care (CCOPEBC) regularly uses it in guideline development but we have identified some inconsistencies in its application that are due to variability in the interpretation of the 4-point rating scale.

Purpose: To facilitate consistency in the application of the AGREE instrument within CCOPEBC by developing operational definitions for each level of the AGREE 4-point scale for each item in the instrument.

Methods:
1. A committee of six CCOPEBC staff drafted and reviewed operational definitions for each of 23 items in six domains of the AGREE instrument.
2. Definitions were compiled in a tool (table format) to be used as an accessory to the AGREE instrument.
3. A pilot study was conducted with 10 CCOPEBC research staff. Participants were asked to apply AGREE to a guideline on a topic outside of their area of expertise in cancer care using the operational definitions.

Results: Overall, users found the operational definitions easy to use and apply and felt that it helped them to use the AGREE instrument more effectively. Quantitative analysis of the pilot study is pending at time of abstract submission but will be presented. Minor refinements were made based on user comments.

Discussion: In this limited pilot study, the tool presented here helped our CCOPEBC users to apply AGREE more easily and to arrive at a more consistent appraisal of guidelines.
B42
Systematic Search for Guidelines and Extraction of Key Recommendations for the Update of the German Disease Management Programme "Asthma/Chronic Obstructive Pulmonary Disease"

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Background: The Institute for Quality and Efficiency in Health Care published the preliminary results of a systematic search for guidelines on asthma/chronic obstructive pulmonary disease (COPD).

Purpose: To identify standards of care in patients with asthma/COPD and present potentially relevant recommendations for the revision of the area-wide German disease management programme (DMP) "Asthma/COPD".

Methods: A systematic search for asthma/COPD guidelines was conducted in the guideline databases "leitlinien.de" and G-I-N, as well as in Medline and EMBASE. The main inclusion criteria were: publication between January 2004 and September 2007; English, German, and French language; and documentation that guidelines were evidence-based. Guidelines were evaluated using the German Guideline Appraisal Instrument (DELBI), and core recommendations were extracted. After comparison with the specifications of the DMP "Asthma/COPD", recommendations were identified that demonstrated a potential need for DMP update or supplementation.

Results: 16 asthma and 14 COPD guidelines were included. The appraisal according to DELBI showed that many guidelines displayed methodological deficiencies, particularly concerning the documentation of the guideline development methodology. No new aspects could be identified that implied a DMP update was essential. However, many aspects were presented in more detail in the guidelines. There was a potential need to supplement the DMP asthma section, e.g. regarding drug therapy and the treatment of acute asthma attacks. In the COPD section, the same applied to recommendations on the treatment of acute exacerbations and on the administration of systemic corticosteroids.

Discussion: The comparison of the DMP "Asthma/COPD" with systematically extracted guideline recommendations enabled the identification of DMP sections needing supplementation. The identification of current standards of care by means of guidelines is a feasible and useful approach. However, methodological challenges are evident regarding the appraisal of guideline quality with DELBI, the handling of current primary literature, and the transferability of foreign standards to the German system.
B43
Improving Information Provision in Subfertility Care

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Background: The Dutch Society for Obstetrics and Gynaecology issued 10 national subfertility guidelines to facilitate professionals in providing effective and evidence-based care. These guidelines also describe the minimal degree of patient information that should be given prior to or during subfertility treatment (14 recommendations). The information recommendations concern information on treatment in general, and on specific topics like complications, risks of treatment, lifestyle-advise, and emotional or psychological support. Implementation of the guidelines needs a change in professional behavior as current practices often do not comply with the guidelines.

Purpose: To develop an implementation strategy and to test its effectiveness to improve guideline adherence on information-provision in subfertility care.

Methods: A combined implementation strategy was developed consisting of a professional intervention (feedback to professionals about their current practice and a fact-sheet on shared decision making in the subfertility consultation) and a patient intervention (a patient leaflet explaining the guideline contents and encouraging active participation in decision making). The effectiveness of this strategy was tested by a clustered randomized controlled trial in 16 Dutch subfertility clinics (8 control and 8 intervention). After a 6-month implementation-period, an after-measurement was conducted among ca. 1500 subfertile couples. Data were analyzed using multilevel analysis techniques.

Results: A baseline-measurement showed that adherence to the guideline recommendations ranged from 13%–95% (mean adherence = 57%). The results of the after-measurement will be available by October 2008. We expect that the combined professional and patient-centred approach will significantly improve guideline adherence on information provision.

Discussion: Tailored and multi-faceted implementation strategies are known to have more effects than single interventions. We investigated whether patient empowerment (e.g. explanation of professional guideline contents) could be a driving force in changing professional behaviour and information provision attitudes.
B44
Implementation of Local Guideline by Interactive Workshop Improves Anticoagulation Therapy and Patient Safety

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Background: Helsinki Health Centre and Centre for Pharmacotherapy Development have co-operation to improve clinical practices through workshops organized by trained facilitators. Anticoagulation therapy has potential life threatening complications and multiple interactions. To improve anticoagulation therapy and patient safety we organised a ROHTO workshop at Töölö health station. (12 GPs and eight nurses providing primary care for 27 000 inhabitants).

Purpose: The aim was to enhance knowledge on anticoagulation, to improve recording of patient data of anticoagulation therapy and to agree on mutual clinical practices. In addition to evaluate the effect of the workshop.

Methods: A multiprofessional workshop handling anticoagulation, local guideline and common treatment practices.
An audit of patient data recordings (indication, duration and target level recording, and treatment levels) by a random sample of data of hundred patients visiting laboratory for INR control during one week before, and six and twelve months after the workshop. Feedback of the changes in anticoagulation therapy, and of the results of the audit were provided and discussed in weekly staff meetings.

Results: The recording of patient data was improved. The indication was recorded for 54% of patients before the workshop, and for 73% and 82% at follow-ups. The planned duration of the therapy was recorded for 54%, 46% and 58% of patients, and the target level of the therapy 50%, 58% and 73%, respectively. The dose of warfarin was recorded in first follow-up for 68% of patients, and in second for 89%. INR was within therapeutic range for 66%, 65% and 77% of the cases.

Discussion: Well planned implementation by a workshop, evaluation and feedback can improve anticoagulation therapy and patient data recordings. The improvement may lead to better patient safety.
B45
An Evaluation of 5 Guideline Programs with a New Framework for Assessing Consumer Involvement in Guidelines (FACING)

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Background: Guideline organisations espouse the virtues of involving patients and consumers in guideline development, but little guidance exists on how to plan, develop and evaluate consumer involvement in guideline development.

Purpose: To evaluate the operational methods of consumer involvement in 5 guideline programs with a framework for assessing consumer involvement in guidelines (FACING).

Methods: Guideline development manuals of 5 prominent guideline programs were reviewed: National Institute for Health and Clinical Excellence (NICE), National Health and Medical Research Council (NHMRC), New Zealand Guidelines Group (NZGG), Scottish Intercollegiate Guidelines Network (SIGN), and World Health Organization (WHO). For each guideline program, we assessed their reported structures and working methods for consumer involvement for the following domains: 1) definition of consumer, 2) degree of involvement, 3) stage of involvement, 4) recruitment, 5) training and support, and 6) financial and practical support.

Results: All 5 guideline programs involved patient representatives in guideline working groups and sought consumer input externally (e.g. focus groups, citizen juries, interviews) to feed back into the guideline program. Three programs involved informal caregivers and 1 program discussed representation of specific demographic or shared interest groups. Three programs included data from patient surveys and qualitative research. One program (NICE) included consumers at all stages of guideline development. Two programs (NICE, SIGN) provided training workshops, published guides on contributing to guidelines and ongoing support. Financial reimbursement was offered by 2 programs (NZGG, SIGN). Few details on how consumers were involved in guideline development were provided by the WHO and NHMRC.

Discussion: While guideline programs support principles of consumer involvement, explicit and comprehensive guidelines for reporting on consumer involvement is needed to allow guideline developers and users to be more thoroughly informed when assessing: consumer engagement in practice, deciding whether consumers were appropriately and adequately involved, and developing consumer involvement strategies.
B46
Did Practice Surveys and Patient Focus Groups Make Meaningful Contributions to the Recommendations in Clinical Practice Guidelines in Conservative Management of Tennis Elbow?

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Background: Tennis elbow, is a common condition typically managed conservatively. Several challenges present in CPG development. A systematic review indicated gaps in the evidence. Furthermore, rehabilitation emphasizes multimodal customized treatment, but evidence did not address this approach.

Purpose: To evaluate whether practice surveys and qualitative patient focus groups provide meaningful contribution to guideline development.

Methods: Two specific approaches were used to address these deficiencies. A practice survey (hand therapists) was used to identify commonly used interventions, prognostic variables and outcome, and their perceived importance. In addition, patient focus groups were conducted to establish treatment priorities/needs using semistructured interviews. Members of the guideline development process completed a survey to indicate the usefulness of these sources of information. In addition, we evaluated the type of information used to make recommendations in the final guideline.

Results: Respondents (n=454; 85% OT 15% PT) indicated that education, exercise and activity modification were the most commonly used intervention. Systematic reviews supported this basic approach, although no specific trials on education or activity modification were identified, exercise trials usually failed to describe the specific exercise. Some commonly used interventions did not appear in the evidence review, whereas other effective interventions were not reported in the practice survey. Patient focus groups indicated the need for client centered care as the patients primarily expressed needs for understanding their problem, the importance and rationale for rehabilitation interventions and specific recommendations around prognosis. The guideline developers found practice survey and summary patient information useful (mean = 7.6/10), but were unsure how to integrate it into their final recommendations. Specific recommendations in the guideline that could be tracked back to this process included recommendations around prognosis, use of outcome measures, and prognostic variables.

Discussion: Practice survey and patient focus groups can augment the guideline development process.
B47
Hoitoreitit – a Model of Continuously Cooperation for Care-Chains

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A comprehensive care-chain development project was carried out in the Hospital District of Southwest Finland 2005–2007 with support from the Ministry of Social Affairs and Health. The aim was to improve and standardize care-chaining and the treatment of the patients. The municipalities of the district took part in the project.

The aim was to enhance and develop cooperation between the primary and the specialized healthcare. Another goal was to describe the care-chains for the most common diseases in a standardized way to be easily utilized by healthcare professionals in a www-portal.

A regional care-chain-team was assembled for the optimization of each care-chain. The team consisted of professionals from at least four healthcare-centres and connected specialties from the regional hospitals and the Turku University Hospital. The care-chain-team analyzed the patient’s care-chain-process stage by stage. The process was portrayed as a flow-chart in html-files. Intratextual hyperlinks to reliable databases were utilized enabling inclusion of specific instructions to the descriptions.

44 care-chains were described and a regional Hoitoreitit portal was formed. It is available for use by all healthcare professionals in Southwest Finland. The Hoitoreitit functional-model was formed and documented, enabling future implementation of the care-chain-work.

The Hoitoreitit-portal and functional-model has received good feedback. An unit was formed in Hospital District on January 2 008 to continue the activity. New care-chains will be described annually and existing care-chains will be updated. Hoitoreitit constitutes part of the basic-training of professionals in the area. Young physicians are well acquainted with the portal which is experienced as useful. Privatesector physicians have activated themselves in acquiring the service to their use. Approximately 1 200 users use the site monthly. Hoitoreitit activity enhances awareness of regional and national care recommendations and works continuously to improve cooperation between health care professionals.
Evidence into Recommendations: an Interdisciplinary and Cross-Cultural Approach to Knowledge Translation in Health (ERICCA)

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Background: Although enormous efforts have been put into developing evidence-based guidelines in many countries, there are striking variations in recommendations and policies based on the same or similar evidence. While there is considerable research about the synthesis of scientific evidence and the implementation of guidelines, little is known about how evidence is translated into recommendations. The domain of formulating recommendations therefore requires evolution of guideline methods and a better understanding of decision-making and knowledge translation practices in the guideline development process.

Purpose: Study the mechanisms that influence the translation of research evidence into guideline recommendations and policies to provide guidance for improving the understanding of decision-making processes in guideline and policy development.

Methods: ERICCA brings together European research teams of high scientific quality from the behavioural and social sciences and humanities to set up an interdisciplinary research network that provides benefit to existing mono-disciplinary national initiatives.

Results: ERICCA has currently brought together recognized research teams from 6 social and behavioural science disciplines: Sociology (specialism in science and technology studies; organizations and professional practice), Psychology, Health Services Research, Health Management, Ethics, Economics from 16 European countries. Participants have expertise and current national funding in studying and improving development, implementation and evaluation of guidelines and policies. The aim of our presentation is to present and discuss the project’s objectives and activities foreseen as well as to engage with likely end-users (guideline developers and implementers, researchers, policy makers, and the public) to ensure that the activities and future research agenda reflect the perceived needs of a wide range of stakeholders throughout Europe.

Conclusions: The results of ERICCA will explore the potential for practical guidance of more reflexive decision making in guideline development and implementation. The network will foster interdisciplinary research capacity in the field of evidence translation and implementation studies.
B49
Evaluation of Clinical Practice Guidelines Programme – Australasian Collaboration


Background: Since April 2001, Clinical Practice Guidelines (CPG) have been brought under the purview of the Health Technology Assessment (HTA) programme within the Ministry of Health Malaysia (MOH). Currently there are 44 evidence-based guidelines developed by the HTA programme or in collaboration with professional societies in Malaysia.

In recent years there has been a growing emphasis on ensuring that CPGs have an evidence-based footing and new processes in formulating guidelines have been established. For example, currently attention is placed on implementing CPG, and audit indicators are being adopted as an integral part of the guideline development process. The acceptance of this new strategy and implementation orientation is facing some resistance from the health care professionals.

As a lot of effort and resources is utilised in the development of evidence-based national guidelines, the MOH, decided that an external evaluation of existing methodologies would provide an opportunity to strengthen both the guideline development and implementation processes.

Methods: The World Health Organisation awarded the Malaysian MOH with an agreement of Performance of Work (APW) for biennium 2006–2007 to strengthen the formulation and implementation of CPG in Malaysia. The APW involved a review of the current strategies in particular the development and implementation of CPGs in Malaysia and provided recommendations in improving formulation and implementation of guidelines.

Results: Based on the evaluation report in July 2007.

Discussion: Sheamini Sivasampu (MOH, Malaysia) and Catherine Marshall (Independent Guideline Adviser) will:
• provide an outline of the recommendations in the review
• give an update on the timeframes and processes for implementing the review recommendations (including an analysis of both potential barriers to implementing the recommendations and opportunities for supporting the new approaches) and
• identify learnings from the review process that could be applicable to other emerging guideline development agencies.
B50
The G-I-N Emergency Care Community – the First 12 Months

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Background: In 2007 Guideline International Network (G-I-N) established two special interest communities based on a community of practice model in the clinical areas of emergency care and diabetes. This initiative is a collaboration between The National Health and Medical Research Council of Australia and G-I-N, bringing together their individual expertise to support the practical application of guidelines.

Purpose: The purpose of the G-I-N Emergency Care Community was to provide an international forum for health practitioners, researchers and guideline developers with an interest in emergency care focused development and implementation of guidelines.

Method: Communities of practice are networks of individuals who share a common interest or passion and who deepen their knowledge and expertise through their collaboration. To support this community a wiki space has been established to provide a ‘virtual’ place where tools, resources, and other information can be accessed by the group. Communication is maintained through group email and teleconferences.

Results: To date the community has a total membership of 30 people from Canada, Australia, New Zealand, Singapore, UK, US, Brazil and Germany. The membership is diverse including emergency clinicians both medical and nursing, emergency care researchers and policy makers. Two activities currently in progress include:

- Review of guidelines recommendations for the management of Community Acquired Pneumonia that could have broad application across the emergency care setting.
- Collaboration and sharing of expertise to support the implementation of guideline recommendations for the use of CT scanning in cases of minor head injury in Brazil.

Discussion: The G-I-N Emergency Care Community is at an early stage where the group is establishing its direction and purpose. The results of the current activities will demonstrate the value of collaboration and assist in developing the momentum required to maintain and grow into the future.
B51
Implementing Psychosocial Care Guidelines for Adults with Cancer in Australia – A National Approach

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Background: The Clinical practice guidelines for the psychosocial care of adults with cancer1, developed by Australia’s National Breast Cancer Centre (NBCC) and National Cancer Control Initiative were published in 2003. These guidelines were a world first for health professionals who treat, or are involved with, cancer patients. Implementation of the guidelines has the potential to improve health outcomes for patients with cancer.

Purpose: To describe and review the comprehensive and multifaceted implementation strategy developed to facilitate uptake of the recommendations into routine clinical practice.

Method: Implementation strategies have been developed that extend beyond the traditional educative approaches directed at individual clinician behaviour change. These strategies include tools to support clinicians in the multidisciplinary setting, for health service providers to measure performance and subsequently promote change in service delivery, and an information resource that empowers consumers with the expectation that psychosocial and supportive care should be a routine component of their care.

Results: Four implementation strategies have been undertaken. These include:
• A summary card for health professionals providing a timely reference to the recommendations and actions relevant to the appropriate stage of care.
• A structured Psychosocial care referral checklist3 designed to facilitate consideration of psychosocial risk factors by all health professionals and encourage appropriate referral.
• A set of Indicators for psychosocial care4 that enable individual health professionals, teams and health services to measure the delivery of best practice in relation to psychosocial care.
• Cancer – how are you travelling? a consumer resource that provides a compact information resource about psychosocial care, the effectiveness of interventions and their contribution to overall treatment outcomes.

Discussion: A comprehensive, multi-faceted implementation strategy can result in appropriate promotion to facilitate uptake of recommendations into routine clinical practice. A review of the national implementation strategy for the psychosocial guidelines will be presented.
B52
The American Society of Clinical Oncology’s (ASCO) “Signals” Approach to Updating Clinical Practice Guidelines

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Background: The American Society of Clinical Oncology (ASCO) clinical practice guidelines (CPGs) have been criticized for being out of date. In some circumstances, this is true, but in many other cases there is either no new evidence available or new evidence does not change the validity of the guideline recommendations. Therefore, ASCO plans to explore new mechanisms for annual update of guidelines, so they are viewed as valid and “up to date”.

Purpose: To propose a methodology for updating CPGs by adapting the "signals" approach for updating systematic reviews outlined by Shojania et al.

Methods: ASCO will perform annual literature searches for each existing CPG. After a preliminary screening of the results, the relevant abstracts will be sent to the guideline panel co-chairs or steering committee. The groups will be provided with a standardized questionnaire that aids in the identification of the relevant signals for updating.

Results: If, based on identified signals, the co-chairs or steering committee decide a full update is warranted, the full panel will reconvene and the outdated recommendations will be updated in a full guideline update. If no new evidence is identified, or if new evidence does not change any recommendations, a 3–4 page publication in the Journal of Clinical Oncology (JCO) will describe the literature search and new evidence, if any. The date on the guideline will subsequently be updated.

Discussion: Updating guidelines regularly, using the signals approach, should provide current information to our membership and the general public. We anticipate that, if searches are done on a truly annual basis, the time required for each guideline update search will not be onerous. As our library of guidelines grows, the investment of time for updates will grow proportionately, so we plan to re-assess on an annual basis the feasibility of this new approach.
Background: The goal of the nine comprehensive cancer centres (CCC’s) in the Netherlands is to provide cancer patients and patients in the palliative stadium access to comprehensive and high-quality care as close to home as possible. Nationally, comprehensive cancer centres work together within the Association of Comprehensive Cancer Centres (ACCC). The ACCC facilitates the development, implementation and evaluation of clinical practice guidelines for oncology and palliative care in The Netherlands.

Purpose: Patients are treated according to the guidelines.

Methods: Guidelines are developed by national working groups for tumours and for palliative care subjects. Development is supervised by the ACCC and guidelines are disseminated via the online database Oncoline (www.oncoline.nl) and Pallialine (www.pallialine.nl). Implementation of guidelines occurs regionally by the CCC’s and their regional working groups. The compliance of guidelines can be measured by implementation projects in which null and endpoint measurements are performed with the cooperation of the Netherlands Cancer Registry (www.cancerregistry.nl).

Results: When guidelines are developed or revised, they will be published on Oncoline/Pallialine. All relevant scientific and professionals societies and CCC’s become informed by e-mailing. Also individual professionals become alerted about revisions of the guideline via an online-mailing service. Until January 2008 over 150 guidelines have been published. Oncoline was consulted over 500 000 times in 2007.

At the time point of publication on Oncoline/Pallialine, CCC’s start activities for guideline implementation. Relevant regional working groups of the CCC’s and oncology boards within hospitals are informed. Furthermore, about 58 implementation projects for different guidelines have been started of which 37 projects are now still ongoing.

Discussion: The ACCC has a unique network to implement guidelines for oncology and palliative care. Implementation projects give insight into the compliance of guidelines, which can be the bases for guideline revision or the start of other implementation projects, such as break-through projects.
B54
Deep Vein Thrombosis Management in Oncology: Use of a High Quality Clinical Practice Guideline at the National, Regional and International Levels


Background: The Standards, Options: Recommendations (SOR) programme develops clinical practice guidelines (CPGs) to improve the quality of healthcare and the outcome of cancer patients. Deep vein thrombosis (DVT) is a usual complication and a significant cause of morbidity and mortality for cancer patients. In oncology, the management of DVT is disparate, sometimes inappropriate. In 2007–08, following a request of experts in the field, the SOR has developed a CPG on DVT.

Purpose: Developing different levels of collaboration around a CPG.

Methods: National level: The SOR methodology combines systematic review with multidisciplinary experts' judgement. Prior publication, the CPG is review by independent clinicians. Regional and international level: The ADAPTE framework provides a systematic approach for the adaptation of guidelines produced in one setting to be used in a different context (www.adapte.org).

Results:
National level: To produce unanimously recognized recommendations at the national level, different specialties have been included in the working group: oncology, vascular medicine, internal medicine, cardiology, lung diseases and anaesthesia. Three Learned Societies (SNFMI, SFMV, SFAR) were involved, and two have endorsed the final work (http://www.sor-cancer.fr/index.php?tg=articles&topics=70).
Regional level: Several regional cancer networks (ONCORA and ONCOLOR) have chosen to work on the SOR-CPG on DVT to implement national recommendations at the regional level.
International level: As part of a collaboration with Quebec, the SOR-CPG on DVT has been chosen as the source document to be adapted to the Quebec context using an ADAPTE-like methodology.

Discussion: The SOR project has produced a high quality CPG on DVT which has been endorsed by all relevant French specialties while attracting the interest of clinicians for the adaptation and implementation of the recommendations at the regional and international levels. Producing high quality systematic reviews is the first step to avoid duplication of effort and facilitate the transfer of data from one level to another.
B55
Nurses’ Experiences of Guideline Implementation: a Focus Group Study

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Background: The implementation of clinical guidelines seems to be dependent on multiple context-specific factors. This study sets out to explore the experiences of primary care nurses concerning guideline implementations.

Purpose: The aim of the study was to address the following questions:
• What kind of experiences do primary care nurses have of guideline implementations?
• What do nurses think are the most important factors affecting the adoption of guidelines?

Methods: The data were generated by four focus group interviews involving nurses working in out-patient services in primary health centres in Finland. Purposive sampling was used to select health centres. Inductive content analysis was used to identify themes emerging from the data.

Findings: Four main factors were identified from the analysis of data: (1) Factors related to nurses, (2) Factors related to the organisation, (3) Factors related to the patient group, and (4) Factors related to the anticipated consequences. Nurses’ awareness and acceptance of guidelines and the anticipated positive consequences facilitate the implementation of guidelines. Organisational support, especially the adapting of guidelines to local circumstances, seems to be most crucial to successful implementation.

Discussion: Clinical guidelines can be promising tools in enhancing evidence-based nursing practice, since nurses see them as practical work tools in patient care and so are willing to adopt them. However, support from management and physicians is needed to ensure the successful implementation of guidelines into nursing practices. Based on the findings of this study and previous knowledge of guideline implementation some practical recommendations are suggested to guideline implementers: Select the most relevant guidelines to clinical practice, organise the adaptation of guidelines to local circumstances, inform all practitioners involved in treatment, and give clear instructions for the adoption of the guideline.
**B56**  
**Impact of Patients´ Characteristics on the Effectiveness of Preventive Guideline Implementation Strategies in Primary Care: a Systematic Review**

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**Background:** Patients´ preferences and attitude toward treatment has been reported by health professionals as a key barrier for the implementation of clinical practice guidelines (CPG) in clinical practice. Whether this perceived barrier translates into actual impact on the effectiveness of CPG implementation strategies is unknown.

**Purpose:** Describe how patients´ attitude toward treatment modifies the effectiveness of clinical practice guidelines implementation strategies for preventive interventions in primary care.

**Method:** Systematic literature review of randomized controlled trials published between 1966 and 2007. CPG implementation strategies included education, reminder, decision support, audit or feedback targeting primary care physicians. Studies needed to include change in blood cholesterol as an outcome and an analysis of the interaction effect of patients´ characteristics.

**Results:** 570 abstracts were scanned for inclusion. Of the 18 full-text articles analyzed, 13 (72%) were excluded because they did not report any interaction analysis of the effect of patients´ characteristics. Five studies met our inclusion criteria, all of which included a reminder component in the intervention group. None of the subgroup analysis were planned in advance, and only one used interaction tests to assess if observed differences were statistically significant. Two studies reported increased intervention effectiveness in patients with high cardiovascular risk and baseline cholesterol level. No studies directly assessed the impact of patients´ attitude.

**Discussion:** Implementation strategies targeting the management of hypercholesterolemia in primary care appear to be more effective in high-risk patients and in those with higher baseline cholesterol levels. We cannot conclude that this is due to patient’s attitude toward treatment given. This pilot review shows that systematic reviews of interaction effects is a promising approach to quantify the impact of barriers and facilitators to CPG implementation. It is limited, however, by the inconsistent use and reporting of subgroup analysis in RCT.
B57
A New Canadian Strategy for the Production and Implementation of Respiratory Guidelines

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Background: Guidelines on management of respiratory diseases have been produced in Canada since the late 1980’s. Although evidence-based recommendations on optimal respiratory care have been disseminated, guidelines have had variable formats and have not been adequately integrated into current care.

Purpose: The CTS has recently developed a new infrastructure and process to help produce uniform evidence-based guidelines and review current recommendations annually, in addition to facilitating their implementation into care, particularly in primary care settings.

Methods: A national expert committee devises a regularly updated action plan and agenda to ensure yearly revisions and rapid dissemination of the guidelines. Models for implementation have been proposed and are promoted regionally; an evaluation of their impact will be performed. Financial and human resources are shared by all CTS disease-specific sub-committees and originate from multiple sources.

Results: The development of this new structure has been considered useful by the CTS leaders to help share resources and produce regularly updated guidelines on respiratory care. All also agreed to focus our efforts on effective translation of these recommendations into care.

Discussion: Hopefully, this new initiative will help to improve respiratory care and reduce the burden of respiratory diseases in Canada.
B58
Guideline for the Avoidance of Physical Restraints in Nursing Homes: a First Step to Establish Evidence-based Nursing Guidelines in Germany

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Background: Physical restraints are routinely used in nursing homes in Germany. An evidence-based practice guideline (EBPG) could be an appropriate measure to reduce physical restraints. Internationally, EBPGs in nursing have been developed for a wide range of topics. In Germany, mono-disciplinary so-called ‘nursing expert standards’ have been advocated, which do not fulfil methodological requirements of EBPG.

Purpose: To develop and evaluate an EBPG for the avoidance of physical restraints in nursing homes and to firstly develop a nursing guideline in Germany according to internationally discussed methodological standards.

Methods: A methodological framework has been set up and published, based on internationally discussed methodological prerequisites for the development of EBPGs. After a structured survey of patients’ and relatives’ opinions a multi-disciplinary group was established. Based on the survey, relevant topics were identified. The evidence has been systematically assessed and appraised following the recommendations of the GRADE working group. After completion, the guideline draft will be reviewed by external experts, patients and relatives. A cluster-randomised controlled trial will be carried out in 36 nursing homes to evaluate the guideline’s effectiveness.

Results: So far, four meetings of the guideline development group have taken place. The first draft of the guideline will be available in summer 2008. For most of the pre-defined topics only weak evidence could be found, emphasising the need for a multi-disciplinary group and for future development of innovative implementation aids e.g. educational programmes for nurses, patients and relatives.

Discussion: In Germany, discussion is ongoing whether nursing guidelines should follow standards for ‘medical’ EBPGs. Recent recommendations in health care politics have been ambiguous whether to favour mono-disciplinary ‘nursing expert standards’ or multidisciplinary EBPGs. Hopefully, our guideline will not only substantially reduce the use of physical restraints in German nursing homes, but also set a milestone for nursing guideline development in Germany.
B59

Education, Research and Clinical Practice – Centre for Clinical Practice Guidelines of Palacky University Faculty of Medicine

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Background: The Centre for Clinical Practice Guidelines of Palacky University Faculty of Medicine (CCPG) was established as one of the working groups of the Department of Social Medicine and Health Policy in 2007 as the first centre around the country, which is concerned with development, implementation and evaluation of clinical practice guidelines (CPG). The CCPG is based on the outstanding partnership within medical faculty departments and university and district hospitals.

Purpose: Our broad aim is to develop, teach and disseminate methods for development, adaptation, implementation and evaluation of CPGs and provide support and resources to anyone who wants to make use of clinical practice guidelines. One of the most important goals is adaptation of international generic tools for development, implementation and evaluation of CPGs as well as their use within the Czech health care and educational system.

The main issues are:
1. methodology of CPG development and adaptation;
2. methodology and strategies for implementation and dissemination of CPGs;
3. methodology of evaluation of CPGs and their critical appraisal;
4. use of CPGs in undergraduate and continuing medical education;
5. CPGs as an important tools for health care managerial decision making;
6. multidisciplinary aspects of CPGs; sociological, economical, psychological, ethical and legal focus;

Methods:
1. implementation of a new medical educational programme focus on CPGs into the curricula;
2. use of ADAPTE instrument for CPG adaptation;
3. use of AGREE instrument for CPG evaluation;
4. attitude survey;
Results:
1. "Workshop on critical appraisal of CPG" for medical, nursing and health economics students;
2. "Introduction to clinical practice guidelines" – textbook for undergraduate medical educational programmes;
3. Adaptation, implementation and evaluation of CPG for antibiotherapy of bile duct infections;
4. Evaluation of existing Czech CPGs;
5. Health care professionals and medical students attitudes toward CPGs and their compliance
B60
Is There a Standard for Presenting Guideline Recommendations?
An Analysis of Guidelines for Guidelines

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Background: (Key) recommendations are fundamental elements of guidelines and are relevant to medical practice. Therefore, their easy identifiability and precise, clear wording are characteristics of the methodological quality of guidelines [1,2]. Whereas short guidelines often comprise recommendations only, it can be difficult to identify recommendations in long versions.

Purpose: To compare the specifications included in manuals on guideline development regarding the presentation of (key) recommendations in guidelines.

Methods: An analysis of manuals on guideline development (full versions) published by G-I-N members was performed. Specifications regarding the placement, comprehensiveness, structure, and labelling of guideline recommendations were compared.

Results: Ten manuals were analysed. The document length and length of chapters referring to recommendations varied greatly. The term “recommendation” was defined roughly in one manual; “key recommendation” or “core recommendation” was not defined at all. Specifications on the structure of recommendations were hardly described. Recommendations were primarily presented as a result of an appraisal process of the available evidence. Some manuals distinguished between various types of recommendations. Only a few manuals suggested highlighting recommendations by using headings or including tables or graphs (e.g. flowcharts). Concepts regarding the optimal placement of recommendations and the connection of multiple recommendations varied. There was agreement that recommendations should be presented in a concise and clear way, but without guidance for operationalisation.

Discussion: In manuals on guideline development, specifications on the presentation of (key) recommendations are inconsistent. There is a need for an international consensus on the standards for guideline recommendations.

References:
A Method for an International Comparative Study of Non-medical Factors – Impact on Clinical Practise Guidelines Development in Oncology

Background: While rigorous methods are available for analysis and synthesis of research evidence, the mechanisms that lead to a shared decision between members of guideline development groups (GDG) and formulation of recommendations remains insufficiently explored, in particular how values and context variables are taken into account. This leads to both legitimate and unacceptable variations in guideline recommendations based on the same scientific evidence.

Purpose: In order to better understand this process, the French SOR (Standards, Options et Recommandations) guideline programme and la Direction de la Lutte Contre le Cancer (Quebec), in collaboration with sociologists from the Centre de Sociologie des Organisations (France) and McGill University (Quebec), are currently exploring how scientific evidence is translated into guideline recommendations by two independent GDGs in two different contexts, France and Canada.

Methods: CONTEXTE will be based on a comparative approach and make use of qualitative methods: observation of GDP and semi-structured interviews with panel members in each context. Investigators will confront their observations and interviews for each meeting and then for each guideline development process in order to refine the analysis.

Results: Our presentation will describe the study protocol which is currently applied on the development process of two GDGs in France and Québec that develop independent recommendations for “Management of thromboembolic disease in patients with cancer”, on the basis of the same evidence synthesis. We will present the results of the comparison and discuss the method used, consequences for the conduct of GDGs and decision making as well as implications for future research.

Discussion: It is expected that the results of our study will provide guidance for guideline developers to improve the transparency of decision making in CPG development. This in turn will contribute to improve the applicability and acceptability of guidelines and thus their use by targeted professionals.
B62
Guidelines Topics – How to Select and Prioritise

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Purpose: The purpose of the topic selection process at NICE is to identify and prioritise those topics that will have the greatest impact on the health of the nation.

Methods: Topics may be suggested via the NICE website. Typical suggestors include clinical and professional bodies, NHS clinicians, policymakers and patient and carer groups.

All topic suggestions are subject to initial elimination and filtering, taking advice from clinical and advisory networks. Topics that progress are reviewed by one of 7 topic consideration panels composed of experts in the topic area, generalists with a good knowledge of the health service, public health and the public sector, and patient and carer representatives.

The selection criteria take into account:
- burden of disease (population affected, morbidity, mortality)
- resource impact (i.e. the cost impact on the NHS or the public sector)
- policy importance (i.e. whether the topic is in a government priority area)
- whether there is inappropriate variation in practice across the country
- factors affecting the timeliness or urgency for guidance to be produced

The panels' recommendations go to the Department of Health and a health Minister makes the final decision on which topics are referred to NICE for guidance to be produced.

Results: During the first full year of the process – January to December 2007, the numbers and progress of all topics were as follows:
- 991 were received for consideration
- 787 were rejected

Of those topics that progressed, the number of clinical guidelines topics were:
- 71 considered and prioritised by the consideration panels
- 13 referred onto the NICE work programme

Discussion: As NICE now has over 100 pieces of clinical guidelines topics either published or in development careful consideration must be given to deciding what new work is done compared to the need to update what has already been produced.
B63
Making the Evidence to Recommendations More Transparent: – a Case Study of the Use of GRADE Approach in the NICE Respiratory Tract Infection Guideline

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Background: The GRADE approach is a newly developed evidence grading system that has the potential to provide standardization and transparency in the process from evidence to recommendations in clinical guidelines.

Purpose: To pilot the use of the GRADE approach in developing recommendations for the NICE Respiratory Tract Infection (RTI) guideline and to assess the applicability and practicality of the method for the NICE short clinical guidelines programme.

Methods: The GRADE approach was applied to relevant evidence when assessing and summarizing the evidence. Key outcomes relating to antibiotic management strategies were graded and summarized using GRADE evidence profiles and were presented to the Guideline Development Group (GDG). The GDG was encouraged to discuss and draft evidence statements based on the evidence profiles, and to generate recommendations. The utility, applicability and practicality of the GRADE approach were observed and documented during the guideline development process.

Results: The use of GRADE approach provided a clear structure and direction for the GDG to discuss the quality of evidence. Communication among GDG and efficiency in clinical decision-making appeared to be improved. The use of GRADE also provided transparency in the process of evidence to recommendations. However, a few issues on applicability and practicality were identified. They were: training needs for the GDG on the GRADE approach prior to the guideline development process; the use of a small number of key outcomes; and the increased reviewing time to generate the GRADE evidence profiles. Examples of how GRADE approach was used in the RTI guideline will be presented.

Discussion: The GRADE approach was found to be a useful tool in the development of guidelines. Some applicability and practicality issues need to be addressed in order to accommodate the complex process of guideline development and to provide a more effective mechanism for generating recommendations from relevant evidence.
Dissemination: SIGN Reviews its Process and Finds Room for Improvement


Background: Scotland is a small country with a Health Service workforce of some 158,000 staff organised across 14 local health regions. Dissemination of SIGN guidelines is mainly carried out in liaison with coordinators based in these local areas. Concerns over the consistency of distribution and the challenges of paper vs electronic dissemination suggested that dissemination of SIGN guidelines could be improved.

Purpose: A multiapproach project was undertaken to identify mechanisms with the potential to improve the efficacy of dissemination of SIGN guidelines, as the recognised first step towards successful implementation.

Methods: A literature search was conducted to identify existing knowledge and experience.

A review of the current operating procedures was undertaken.

Semistructured interviews were conducted with staff at each of the local health regions to ascertain ongoing practice and current allocated resource. These interviews also provided an opportunity to collect ideas for additional support that could be provided by SIGN.

Pilot dissemination initiatives were undertaken in two health regions.

Results: An inconsistent approach to guideline distribution in Scotland was identified, resulting in incomplete dissemination of guidelines to appropriate healthcare professionals.

Areas for improved dissemination and guideline accessibility included:

- Support for a movement towards a mix of electronic and hard copy distribution of guidelines
- The need for multichannel targeted dissemination activities
- A need for increased emphasis on the design and accessibility of quick reference guides
- Improving the interactivity of the SIGN website.

Discussion: A multistranded review of SIGN’s dissemination process has been undertaken, including, for the first time, interviews with users of guidelines to generate ideas on distribution and dissemination.

With a wide range of issues identified, SIGN needs to embrace the opportunity for improvement into its organisational culture (structure, workplans and budget) to fully incorporate dissemination into the guideline development process.
B65
Diagnosis of Asthma in Young Children – Analysis of Guideline Recommendations and the Current Evidence Base

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Background: The possible inclusion of young children in the German asthma disease management programme (DMP) is currently being discussed. The Institute for Quality and Efficiency in Health Care (IQWiG) was commissioned to assess the accuracy of procedures for diagnosing asthma in 2- to 5-year-olds.

Purpose: (1) to determine the current diagnostic (gold) standard for asthma; and (2) to assess the accuracy of various diagnostic procedures.

Methods: (1) Current guideline recommendations were analysed. A systematic literature search (2000–2007) was conducted in guideline databases as well as in MEDLINE and EMBASE. Guideline quality was assessed using the German Instrument for Methodological Guideline Appraisal (DELBI). A standardized extraction and comparison of recommendations was performed. (2) A systematic review of diagnostic studies and prospective cohort studies was undertaken following the Institute’s methods. A systematic literature search (2000–2007) was conducted in MEDLINE, EMBASE, and MEDION. The outcomes assessed were sensitivity, specificity, predictive values, likelihood ratios and diagnostic odds ratios.

Results: (1) 14 relevant guidelines were identified. No uniform diagnostic (gold) standard for asthma could be determined. There was agreement between guidelines that asthma in young children should be diagnosed in various steps. However, this recommendation was not operationalized by means of diagnostic algorithms. Typical asthma symptoms and medical history were used for diagnosis. Recommendations were rarely supported by evidence levels and recommendation grades or by citations. (2) The systematic review is currently being prepared investigating the accuracy of individual diagnostic procedures and algorithms that could, for example, be implemented in a DMP.

Discussion: Even though asthma in young children is an important public health issue, the evidence base of guideline recommendations is poor. Accurate diagnosis is required in order to initiate optimal preventive and therapeutic procedures and avoid labelling due to misdiagnosis. An evidence-based diagnostic standard is therefore needed.
B66
Implementation of Clinical Guidelines in Oral Health Care
– Strategies of the Finnish Dental Society Apollonia

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The Finnish Dental Society Apollonia was founded in 1892 and almost all Finnish dentists are members of the society. Apollonia supports dental research, arranges continuing education and disseminates research information on oral health topics for its members.

Apollonia has been actively involved into elaboration of the Finnish Current Care guidelines together with the Finnish Medical Society Duodecim since 2004. Before that, one guideline was prepared as a pioneer for the later guidelines in oral health. By the end of 2008, altogether four clinical guidelines concerning oral diseases (Oral cancer, Temporomandibular disorders, Third molars and Management of dental caries) will be ready and two guidelines (Periodontal diseases and Antibiotics in dental care) are in progress.

After elaboration of the guidelines, it is essential to get the guidelines as a part of the every day practice in oral health care. This presentation concentrates on strategies of the Finnish Dental Society Apollonia to get the Current Care guidelines as a part of the actions of oral health care.

The presentation will especially focus on the possibilities of basic, continuing and postgraduate education in implementation, on marketing the readily available education and discussion materials and on benefiting of the networks, opinion leaders and early adapters in implementation.
B67
Diagnostic Imaging Guidelines: 
the State of the Art

Reed MH, Canadian Association of Radiologists,

Background: The utilization of diagnostic imaging (DI), particularly the more complex and costly imaging such as CT and MRI, is increasing rapidly in many countries, but there is concern that this is increasing costs but not improving health care outcomes commensurately. There is also an increasing awareness of the radiation risks from DI, particularly from CT. In response to these concerns national radiological societies are developing guidelines for diagnostic imaging.

Purpose: The purpose is to review the current status of DI guidelines produced by radiological societies and to discuss some of the issues related to the development of these guidelines.

Methods: There are difficulties in developing evidence-based guidelines in radiology, and I will review the reasons for this and some of the methods of developing evidence-based guidelines in DI. Developing DI guidelines also requires collaboration, and national radiological societies have developed their guidelines in a collaborative manner, involving other specialties. I will review the current sets of guidelines available and discuss how radiological societies have approached these issues.

Discussion: Because DI plays an integral role in the initial diagnosis and ongoing management of many clinical conditions, and because DI technology is expensive and advancing very rapidly, guidelines for its use are very important. However, DI is also incorporated into many clinical practice guidelines (CPGs) and collaboration between developers of CPGs and radiologists will be increasingly important to ensure that DI guidelines do not conflict with the way DI is incorporated into CPGs. DI guidelines are also now being incorporated into computerized order entry systems and other forms of Information-Communication technology (ICT) for a variety of reasons including the rapid conversion of DI to a completely electronic specialty. DI may therefore play a leading role in determining the role of ICT in the implementation of guidelines.
B68
The Methodological Conundrum of Guideline Adaptation – How to Align Evidence Quality with Recommendations

Scott A, Institute of Health Economics, Moga C, Institute of Health Economics

Background: The strength and quality of evidence used to formulate practice guidelines are usually encapsulated by formally defined terms such as good, fair, poor, insufficient, or conflicting, which then determine the strength and type of recommendations made (do, don’t do, don’t know, no effect, conflicting/insufficient). However, when adapting existing 'seed' guidelines, the quality of the underlying empirical evidence is not assessed and these terms cannot be formally defined, leading to a significant methodological conundrum.


Methods: The AGREE tool was used to identify the best quality guidelines on low back pain, from which a multidisciplinary committee constructed Alberta-specific guidelines. In many cases additional evidence was required, particularly when recommendations were overlapping, discordant, or absent. Development committee subgroups comprising clinical and methodological experts interpreted the additional information.

Results: Although seven average to good quality guidelines were found, the AGREE tool could not verify the validity of the recommendations and the underlying evidence, or reconcile differences in evidence rating scales. A process was developed to systematically meld the seed guideline recommendations with subjective input from the development committee subgroups into valid, consistently worded recommendations. Symbols were used to denote the level of interpretation underlying each final guideline recommendation. Rather than construct newly worded recommendations that could not be supported by formal definitions for the strength and quality of the underlying evidence, the original wording of the seed guidelines was used to avoid ambiguity.

Discussion: The lack of sophisticated evidence analysis inherent in guideline adaptation can be overcome with credible seed guidelines, a consistent, transparent methodology, and clear documentation of the often subjective contextualization process.
Workshop Abstracts
W1
Rating the Quality of Evidence and Strength of Recommendations Using GRADE

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Short description of workshop
Guideline developers currently use varying approaches to grading the quality of evidence and recommendations. Many of the systems have shortcomings. It is difficult for guideline users to understand the messages that the grading systems attempt to communicate, and the different ways of grading evidence and recommendations create confusion. Since 2000 more than 60 methodologist, clinicians, guideline developers and systematic reviewers have participated in the Grading of Recommendations Assessment, Development and Evaluation (GRADE) working group, to develop and refine the GRADE system. GRADE is being used by an increasing number of organizations.

Using examples we will explain how users can apply the GRADE system to rate the quality of evidence and strength of recommendations in guideline development. Participants will learn how judgments about the strength of a recommendation require consideration of the quality of the evidence, the balance between benefits and harms, translation of the evidence into specific circumstances, and the certainty of the baseline risk. It is also important to consider costs (resource utilisation) before making a recommendation. We will demonstrate how the software application (GRADEpro) will facilitate the development of guidelines based on the GRADE system.

Main goals of the workshop
At the end of the workshop participants will have learned how to use the GRADE system to guide the complex judgments involved in grading evidence and recommendations, balancing the need for simplicity with the need for full and transparent consideration of all important issues.

Target groups
Guideline developers. Basic knowledge about the GRADE system is an advantage.
W2
The Best of Both Worlds.
Evidence and Practice: Making it Work

Palda V, Guidelines Advisory Committee, Centre for Effective Practice, Rogers J, Centre for Effective Practice, Lang K, Centre for Effective Practice, Kapur A, Guidelines Advisory Committee

Short description of workshop
As a leading source for guideline evaluation for more than a decade, the Guidelines Advisory Committee (GAC) brings an internationally recognized approach to assessing evidence and guidelines. Combined with Centre for Effective Practice’s (CEP) strength in dissemination, practitioner engagement and behaviour change, this partnership is uniquely positioned to address clinical care gaps by providing effective, practical interventions. This approach can be applied in the day-to-day setting of groups who may have minimal extra funding to engage in evidence implementation.

This workshop will include case studies of implementation projects undertaken by the GAC and CEP as a way of introducing three interactive exercises:
1. Information support: Finding and reviewing the evidence you need
2. Setting targets and a plan: Defining the messages and goals
3. Implementation support: Helping local groups to make it work within their resources

Main goals of the workshop
1. Knowledge goal: Learn which points in the evidence-to-practice cycle are most at risk of being led by personal preference and group opinion rather than published implementation evidence.
2. Skill goal: Develop skills at facilitating group learning of key clinical evidence components while maintaining local adaptation relevance, engagement and problem-solving creativity.
3. Workshop discussion goal: Discuss how the integrity of clinical and implementation evidence can be maintained while being realistic with the resources available in the practice setting.

Target groups
Any groups or individuals interested in local adaptation and implementation of clinical practice guidelines; specifically the optimal integration of both implementation evidence and clinical evidence into the realities of practice.
W3
Disease Management Programmes: a Way to Implement Guidelines

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Short description of workshop
Chronic diseases are responsible for about eighty percent of ambulatory care in developed countries. Chronic disease management programmes are being developed and implemented in many places to improve the management and quality of care in patients suffering chronic diseases. Clinical practice guidelines constitute a major vector to transfer evidence-based interventions to daily practice activities in the framework of disease management programmes applied by multidisciplinary teams. The Guideline International Network Working Group on Clinical Practice Guidelines and Disease Management Programmes aims to support the exchange of best practices in disease management.

This interactive workshop will include: 1) a presentation on disease management programs, their effectiveness, their application in practice and the use and integration of guidelines in these programs; 2) small group discussions on examples and experiences with disease management programs in clinical practice with the aim to define determinants of success or failure. 3) a general discussion to summarize discussions among participants and identify priorities for the G-I-N working group.

Main goals of the workshop
Participants will achieve practical understanding of the opportunity of using guidelines to transfer evidence-based knowledge to the point of care within chronic disease management programmes.

Target groups
Individuals and organisations with various degrees of experience in guideline implementation interested in gaining knowledge about the use of evidence-based guidelines in disease management programmes.
W4

Patient and Public Involvement in Guidelines (Part 1):
Sharing International Experiences

Boivin A, Center for Quality of Care Research, the Netherlands, Currie K, National Institute of Clinical Studies, National Health and Medical Research Council, Burgers J, Dutch Institute for Healthcare Improvement (CBO), the Netherlands / Centre for Quality of Care Research (WOK), University Medical Centre Nijmegen, the Netherlands, Fervers B, SOR, FNCLCC, Centre Léon Bérard, Lyon, France, Gracia J, Agencia Lain Entralgo, Spain, Marshall C, Independent Guideline Advisor, Thomas V, NICE, van der Weijden T, Center for Quality of Care Research, Department of General Practice, Universities of Maastricht and Nijmegen, the Netherlands

Short description of workshop

Background: Existing involvement programs have been inspired largely by international collaborations and a wealth of innovative approaches are being developed by individual guideline organizations. There is currently wide variations in the ways patients and the public are involved in guideline development and implementation. The Guideline International Network patient and public involvement working group (GINPPI) was set-up in October 2007 to support best practice on patient and public involvement in guidelines.

Methods: 1) Key issues in patient and public involvement will briefly be introduced by members of GINPPI, and discussed in rotating small groups. Rotating small group discussions will be lead by members of GINPPI and will focus on key issues in patient and public involvement (ex. recruitment and training of patient and public representatives; integrating patient decision aids and information material in guidelines; evaluation of patient and public involvement programs; expectations about patient and public involvement); 2) large group discussions will summarize the key learning points raised by participants as well as priorities for future international collaboration on this topic.

Main goals of the workshop

Promote the exchange and sharing of experiences between participants on the methods and effects of patient and public involvement in guidelines.

Target groups

Patient, consumers, carers and public representatives; guideline and decision aids developers; researchers in the field of patient and public involvement
W5
Guidelines: Horses for Courses
(Different Needs, Different Solutions)

Hemming M*, Therapeutic Guidelines Ltd, Kunnamo I*, The Finnish Medical Society Duodecim

Short description of workshop
The theme for the workshop is implementation, the rationale being that if a guideline is neither useful nor helpful then it is unlikely it will be used.

The specific aim of the workshop will be to explore the usefulness/helpfulness of guidelines by looking at different types of guidelines on a single given topic with regard to detail, scope, target audience (authorities, specialists, community practices, students...), format (print, electronic, mobile), to review the usability and helpfulness to the target audience.

Participants could study and discuss the different types of guidelines and make a list of key features that affect usability.

Main goals of the workshop
The main goal would be to identify different users of guidelines, and match them with their required features of guidelines with regard to detail scope, accessibility, format etc.

Target groups
Target group for workshop would be guideline developers.
W6
Patient and Public Involvement in Guidelines (Part 2): Defining Strategies for the Future

Boivin A, Center for Quality of Care Research, the Netherlands, Burgers J, Dutch Institute for Healthcare Improvement (CBO), the Netherlands / Centre for Quality of Care Research (WOK), University Medical Centre Nijmegen, the Netherlands, Fervers B, SOR, FNCLCC, Centre Léon Bérard, Lyon, France, Marshall C, Independent Guideline Advisor, Sänger S, German Agency for Quality in Medicine (AQuMed)

Short description of workshop
Background: Patient and stakeholder involvement is recognized as an essential component of guideline development by international organizations like the AGREE collaboration or WHO, and guideline organizations have set-up a number of mechanisms for involving patients in the development and implementation of guidelines. These initiatives, however, suffer from a critical lack of conceptual clarity and rigorous evaluations of their effectiveness. The Guideline International Network patient and public involvement working group (GINPPI) was set-up in October 2007 to support best practice and develop standards on how to involve patients and the public in guideline development and implementation.

Methods: Interactive workshop including: 1) a short presentation of GINPPI aims, structure and current membership; 2) small group discussions on priority issues for the working group (ex. what can be harmonized at the international level and the importance of national context; current priorities for knowledge synthesis and literature review; best forums and approaches to exchange international experiences and support emerging patient and public involvement programs; how to effectively involve consumers, patient and public representatives within GINPPI); 3) a general discussion will summarize discussions among participants and identify priorities for GINPPI.

Main goals of the workshop
This workshop will allow participants to learn and discuss about GINPPI aims, structure, priorities and workplan.

Target groups
Person interested in the activities of this working group e.g. patient, consumers, carers and public representatives; guideline and decision aids developers; researchers in the field of patient and public involvement.
W8
Guideline Adaptation: a Methodology to Enhance Efficiency in Guideline Development and Improve Utilization


Short description of workshop
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.

The workshop will subsequently present the ADAPTE process, a systematic method developed by the ADAPTE Collaboration, and how it works in practice.

We will present the ADAPTE process with practical examples and insist on topics raised from the intermediary results of the evaluation study which assess the ADAPTE program implementation, its use, acceptability and benefit to different user groups (e.g., guideline developers, health care professionals, decision makers).

Main goals of the workshop
Through the workshop participants will achieve practical understanding of applying the ADAPTE process and using the manual and resource toolkit. 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.

Target groups
Individuals and organisations with various degrees of experience in guideline development and/or adaptation (guidelines agencies and novices), with varying levels of resources available, interested in gaining knowledge of a systematic approach to guideline adaptation. The ADAPTE process may be used both as an alternative to de novo guideline development as well as for implementation through, for example, locoregional adaptation.
W9
German Language CPGS – UPDATE 2008 – Workshop in German Language

Weinbrenner S, German Agency for Quality in Medicine (AQuMed), Ollenschläger G*, German Agency for Quality in Medicine (AQuMed), Kopp I, Association of the Scientific Medical Societies in Germany

Short description of workshop
Moderated networking session of guideline developers and healthcare experts from Austria, Germany and Switzerland in German language. Pre-conference information on session topics. Expected results: At the end of the session, participants will (1) be informed about recent and ongoing guideline projects in the German speaking countries and the potential for collaboration with quality managers; (2) have identified key experts in the field of quality management in healthcare; (3) be prepared to work on protocols for collaboration between guideline and quality experts in the German speaking countries; (4) be prepared to initialize joint projects.

Main goals of the workshop
Purpose:
1. To enhance guideline implementation by improving the connection between guidelines and quality management
2. To exchange experiences concerning quality management, guideline methodology, production and use in Austria, Germany and Switzerland.
3. To identify opportunities for development in collaboration between experts in the fields of evidence based guidelines and quality management in healthcare.
4. To initialize joint projects concerning issues around the currently most relevant guideline topics (e.g. implementation in IT-systems, organization of feedback mechanisms, guideline maintenance).

Target groups
Guideline developers and healthcare experts from German speaking countries Austria, Germany and Switzerland.
W10
Barriers Identification in CPG Implementation Using Error Analysis Techniques Based in High Risk Domains

Pardo R, Torres M, Tellez D, Stein A, National University of Colombia, Clinical Research Institute, School of Medicine, Clinical Practice Guidelines Project

Short description of workshop
In the implementation of Clinical Practice Guidelines (CPGs) it is of high importance to identify barriers that arise during this process. High Risk Domains such as airline companies have developed error analysis techniques, some of which have been successfully adapted to Clinical Settings (1). Health care organizations are high-risk domains by virtue of their increasing technical complexity, and fundamental dependence on human beings to execute care.

There are several techniques used to analyze implementation barriers including: adaptations to RCA (Root Cause Analysis) and MORT (Management Oversight and Risk Trees). These are designed to identify practices, procedures and processes prone to clinical errors1. RCA is a technique used to identify, understand barriers and to help researchers analyze not only immediate events but subsequent ones. MORT is used to identify barriers using flow diagrams. It takes into consideration causes and interactions between them with different areas of the organizational environment. This method has been used to identify barriers such as communication failures and clinician attitudes issues (2).

Main issues concerned with barriers in CPG implementation include: Design problems and adaptation to local context. The elimination of these barriers is often related to the introduction of attitude and practice changes in every stakeholder involved, including patients (3).

The aim of this workshop is to identify barriers in the process of implementation of CPGs and to help solve them through the use of error analysis techniques based in High-Risk domains. The workshop will start identifying the facilitators as individuals who support the implementation process in a specific CPG. It will be developed using a clinical scenario proposed by us. Every other participant will take the role of a different stakeholder and consequently will recognize barriers using checklists provided by the organizing group. These tools have been designed particularly on RCA adaptations. Barriers such as slips, trips, lapses, organizational problems and latent system failures, will then be sort into categories. At the end, mechanisms to overcome barriers will be extracted and consequently analyzed (4). This last step will use MORT as an adapted technique based in clinical settings. The whole process will be academically described and diffused to any individual interested. Participants in this session can expect to receive a short paper copy version of the proposal and actively engage in lively discourse about the purpose, direction and methodologies we propose to meet our project objectives.
We expect to have no more than twenty participants.

References


Main goals of the workshop

1. To promote and generate knowledge through the identification of barriers for CPG implementation.
2. To establish plausible ways of mechanisms to overcome barriers in this process.
3. To identify key stakeholders and facilitators to the process.
4. To use error analysis techniques in the process of CPG implementation.

Target groups

Stakeholders such as:

- Government agencies
- Groups of patients
- Clinicians associations
- CPGs developers
- Policy makers
W11
Patients and Guidelines
– Is There a Living Connection?

Short description of workshop
Lay persons and guidelines. How to construct, develop and enhance the use of patient versions.

Main goals of the workshop
Aim: to gather experiences and success stories abroad to make better guidelines, to facilitate guideline implementation via patients

Topics:
1. What kind of content does a patient expect from a guideline lay version?
2. What does the patient expect from a guideline lay version if the version is in paper/online? Describe the key components, so that it is attractive for the patient and easy to use.
3. How should the implementation of the patient versions be promoted in respect of patients, professionals, organisations and political decision makers?

Target groups
Guideline makers and implementers.
W12
Best Practice Support Service: From Research Evidence to Implementation

Salach L, Centre for Effective Practice, Rogers J*, Centre for Effective Practice, Bean T, Centre for Effective Practice

Short description of workshop
Clinicians do not have easy access to well maintained multifaceted educational interventions. There is no comprehensive network to support their decision-making. A variety of barriers, including knowledge translation, time, rapidly-changing evidence, and shifting priorities, challenge clinicians from applying current guidelines in their practices.

To overcome these issues, the Centre for Effective Practice has implemented a Best Practice Support service to optimize knowledge delivery and patient care; with a focus on Type 2 Diabetes; specifically management of complex issues. This Best Practice Support service is based on the concept of academic detailing. Academic detailing is a service by which a trained health educator visits a clinician’s office to provide a 20 minute evidence based educational session on a specific topic.

This session will examine the process, evaluation and challenges associated with the development and functioning of an academic detailing program that provides primary care clinicians with face to face, one to one educational support. Facilitators will concentrate on various elements that are most important to consider when seeking positive outcomes in knowledge exchange and transfer: duration of the educational intervention, relationship development, active participation of the learners and the integration of educational interventions into the clinician’s clinical context.

Main goals of the workshop
Participants will learn the essential steps required for establishing their own academic detailing program. Participants will gain an understanding of the systemic and academic challenges encountered in developing such a collaborative initiative, as well as the strategies employed to overcome them.

Target groups
• Program Managers
• Clinicians
• Funders
W13
Using Formal Consensus Methods to Engage Stakeholders in Guideline Development and Implementation

Lakhanpaul M, National Collaborating Centre for Women’s and Children’s Health and the University of Leicester, Ullman R, National Collaborating Centre for Women’s and Children’s Health

Short description of workshop
Guideline recommendations may not always be supported by strong evidence and not be acceptable to the health professionals. Delphi consensus methods and formal consensus conferences can be used to engage health professionals and highlight their clinical opinion or experience of an area of clinical practice that may be contentious or where the Gdg require more insight. Early involvement of stakeholders and use of transparent consensus methods helps to support implementation of the guideline.

Main goals of the workshop
• Highlight when to use consensus
• When to use consensus methods Which methods exist
• How to use them
• How to use consensus methods

Target groups
Guideline developers, all organizations involved in implementation, individuals wishing to learn more about how to use consensus methods.
W14
Evidence Tables Phase II: Diagnostic Questions


Short description of workshop
The first step in undertaking systematic reviews to inform recommendations (about interventions or actions that affect health), is to critically appraise the existing literature. 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 summarising the appraised literature would be the easiest way to achieve this.

This workshop will present:
• very briefly the work to date of the Evidence Tables Working Group (ETWG)
  (i.e. work on defining an evidence table and the ETWG template (standard data format) for summarising studies addressing intervention studies).
• the results of the evaluation study of the proposed template for summarising studies addressing a diagnostic question

This will be followed by a discussion about the usefulness and clarity of the items to include and the selection of the definitive list of items in the final template for summarising diagnostic studies.

Main goals of the workshop
The expected outcomes from the workshop are to:
• discuss the results of the evaluation study (i.e. items contents in term of relevance, clarity of the instructions and the table completion) and have the attendees’ feedback on it.
• take forward the work in defining the final version of the template (i.e. agreeing the list of items that should be included).

Target groups
This workshop will be of most interest to those who deals with literature review (i.e. guidelines or HTA developers, researchers, etc.) and those who wish to adapt other’s work.
W15
Identifying Barriers to the Implementation of Clinical Practice Guidelines Among Healthcare Professionals

Burgers J*, Dutch Institute for Healthcare Improvement (CBO), the Netherlands / Centre for Quality of Care Research (WOK), University Medical Centre Nijmegen, the Netherlands, Lugtenberg M, Tilburg University, the Netherlands, Westert GP, Tilburg University, the Netherlands

Short description of workshop
An analysis of barriers to implementation of guidelines among target users is advocated before implementing guidelines in practice. As different recommendations within one guideline can have different barriers, it has been suggested that this barrier analysis should preferably focus on the level of the individual recommendations, rather than on the guideline as a whole.

In this workshop we focus on identifying barriers to the implementation of the key recommendations of clinical practice guidelines. By providing an example of a recently conducted study in the Netherlands, in which barriers to 56 key recommendations within 12 national guidelines among general practitioners were identified, the following themes will be discussed:
• How to derive key recommendations from guidelines
• How to identify barriers to the implementation of key recommendations
  -conducting focus groups
  -analysing data using thematic content analysis techniques and existing frameworks of barriers.
• How to translate the barriers of the key recommendations into tailored implementation strategies.

Main goals of the workshop
At the end of the session participants will have a practical understanding of how to perform a barrier analysis to implementation of guidelines and a strategy is suggested of how to translate these barriers into tailor-made interventions.

Target groups
This workshop may be of interest to health care providers, policy makers, researchers, and other participants with experience or interest in guideline implementation.
Poster Abstracts
P1
The Current Development of Clinical Guidelines in Taiwan

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Background: An analysis of the National Health Insurance (NHI) research database shows that the medical fees for the ten top resource-exhausting diseases consumed more than 20% of our NHI budget in Taiwan. On account of the limit resources in the NHI system, cost containment becomes important. On one hand, the NHI has adopted a global budget system as a mean to cap the cost; on the other hand, it encourages development of evidence-based practice guidelines (EBPG) to improve the quality of medical treatment.

Purpose: In this project, the development of the ten top clinical practice guidelines (CPG) followed the Haute Autorite De Sante (HAS) adaptation process and its well known methodology. These CPG features consist of medical information construction, a systematic literature review of medical knowledge, grading of recommendations, consultation, peer review in agreement with feasibility, accuracy and fitness, which provide bases for clinical decision-making and further clinical application.

Methods: This project has coordinated major medical professional associations to built EBPG. Assessment quality of the CPGs is made by applying Appraisal of Guidelines for Research & Evaluation (AGREE) instrument (2 assessors per CPG). Most domain scores lie between 30 and 60%, which indicates that the guidelines are recommendable.

Results: Ten CPGs will be released in 2008 and conformed with the NHRI platform standard. The CPG development group continues to promote the work task of new five guideline topics, No.11th-15th CPG.

Discussion: The establishment of the ten top disease CPGs can reflect local medical care research findings objectively. The guidelines also come to reflect local values, disease burdens, priorities and resources.
P2
Interactive Implementation – from Clinical Guidelines for Depression to Practical Tools in Occupational Health Care

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Background: Ministry of Social Affairs and Health has introduced a policy programme for enhancing the health of workers. In line with the aims stated in the programme, the Finnish Institute of Occupational Health has prepared new evidence-based clinical guidelines for the treatment of depression in occupational health services.

Purpose: The aim is to, via effective interaction, build concrete and practical tools and models for practice in order to overcome the general and specific obstacles in the implementation of the clinical guidelines.

Methods: A field inquiry is was prepared in collaboration with a specialist network collaboration. The aims of the inquiry are to determine the structural, educational, and motivational obstacles for evidence-based and clinically adequate treatment process and to encourage the field to re-evaluate their practices, and to share their experience of the best practical models and tools. A 3-year series of national conference is designed on the basis on new clinical guidelines and the field response. Each conference brings together good local treatment or collaboration models and presents them to the audience. Each conference is preceded and followed by an inquiry to participants.

Results: The responses to the inquiry gave us relevant and necessary information for planning the national conferences to be organized in the near future. The inquiry seemed to activate reflection of the problems in treatment of depression and inspire creative solutions. The following problems emerged, for example: lack of acute phase psychosocial interventions provided by occupational health services and lack of dialogue and models of collaboration between psychiatrists and specialists in occupational medicine. Further results are forthcoming.

Discussion: Knowledge of what is needed in the field, how the guidelines work in practice, and what are the general interests with regard to learning is best gained directly from the field. The implementation must be focused on the concrete and practical needs of the field, and based not just on scientific evidence, but on clinicians’ experience and the existing structures.
P3
NCCN

McClure J*, National Comprehensive Cancer Network, Lepisto E, National Comprehensive Cancer Network

NCCN Clinical Practice Guidelines in Oncology™ are the centerpiece of a set of integrated tools used to improve and monitor the quality of cancer care in the United States. The guidelines describe the complete clinical decision-making pathways used by physicians to manage cancers and its major supportive care issues. The Guidelines are developed and maintained by volunteer multidisciplinary faculty from NCCN’s 21 academic cancer centers. There are more than 100 separate algorithms covering more than 95% of cancer patients. Each guideline is reviewed and updated continuously, at least annually, to incorporate new data and evolving technology.

NCCN is migrating its guidelines to a database-driven, web-based system to display the guidelines and explicitly link evidence to each recommendation. Additionally, NCCN has responded to safety concerns about administration of chemotherapeutic agents with a set of NCCN Chemotherapy Order templates which outline regimens recommended in the Guidelines. Each regimen template includes indication, agents, doses, routes of administration, schedules, any required ancillary interventions such as administration of antiemetics, growth factors, hydration, monitoring, hold parameters, and citations for studies that evaluated the regimens. These order templates will be linked to the specific treatment recommendations in the Guidelines so that recommended treatments can be implemented using standardized protocols.

NCCN also translates treatment recommendations into the NCCN Drugs and Biologics Compendium, alphabetically listing agents used in oncology care by generic name for the convenience of payors and billing staff. Updated continuously to reflect new data, the compendium provides agent names, brand names, U.S. FDA regulatory indication, disease, NCCN recommended use, route(s) of administration, therapeutic class, and links to NCCN Chemotherapy Orders, and the approved label from the FDA.

Adherence of practice to guidelines is monitored via NCCN’s Outcomes Program following patients in 5 disease sites longitudinally using over 250 data elements to supply quality-of-care data.
P4
Hungarian HPV Vaccination Program

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Background: Hungary has a well functioning, outstanding vaccination program. The main part of this program is the obligatory age-related vaccinations like BCG (against TB), MMR (Measles, Mumps and Rubella.), Hepatitis B etc. The newest challenge is the age-related HPV vaccines for the prevention of cervical intraepithelial neoplasia, and cervical cancer.

Purpose: We demonstrate the present situation of Hungarian HPV vaccination highlighting the view of policymakers, patients and professionals according to guidelines and recommendations. The following main questions arise about HPV vaccines: who should be vaccinated and at what age?

Methods: We investigated the Hungarian rule and administration of vaccinations, and reviewed the previous studies and international guidelines and recommendation about HPV vaccines.

Results: According to the international situation in Hungary two prophylactic HPV vaccines are available. One of the vaccines is quadrivalent, the other is bivalent. These vaccines are available for patients, but they have not been reimbursed yet by National Health Insurance.

Health professionals recommend these vaccines according to international recommendations for routine HPV vaccination for girls 12 years old.

HPV vaccines are also recommended for girls and women between the ages of 9 to 26. Cervical cancer screening recommendations have not changed for females who receive the HPV vaccine.

The patients get widespread information about HPV vaccines since there is much presentation in the media.

In Hungary the obligatory age-related vaccination is reimbursed by the National Budget. The introduction of a new vaccine is the responsibility of the National Epidemiologic Center.

Discussions: In Hungary, similarly to any other countries, the major implementation challenges in the administration of the HPV vaccine are concerned with how to choose the target population for obligatory vaccination.

Even as HPV vaccination for the prevention of cervical cancer is introduced, it remains critical that women undergo regular cervical cancer screening.
P5
Delphi Consensus Process to Identify Process Indicators for the Improvement of the Quality of CPGs Development

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Background: CoCanCGP (Coordination of Cancer Clinical Practice Guidelines in Europe) is a Coordination Action under the ERA-Net scheme. It counts 17 partners from 11 countries involved in the funding and management of Cancer Clinical Practice Guidelines programmes. It aims to foster equitable access to high quality cancer care throughout Europe while avoiding duplication of efforts.

Purpose: To identify and select relevant process indicators to assess the quality of Clinical Practice Guidelines and facilitate joint guideline development.

Method: A previous exercise allowed the identification of benchmarks within 3 phases of the guideline life cycle: literature search, critical appraisal and monitoring. The 29 identified benchmarks were validated as process indicators for the Consortium using a Delphi method. In order to perform the Delphi rounds an online questionnaire, enabling the partners to provide their answers on the 58 indicators, was set up. Participants had to define the importance of the indicators for developing high quality guidelines. In the first round the 14 experts/organisations rated each item between 1 and 9, with the possibility of adding free limited text comments. We calculated the frequency and median values of the ratings, as well as the intervals. It was considered that participants agreed when <= 4 experts rated outside the 3 points of the interval containing the median value and that they disagreed if at least 5 experts rated in the lower third (ratings 1–3) or upper third (ratings 7–9). When there was not agreement or disagreement the result was considered uncertain.

Results: This abstract shows the results of the Delphi first round. The 14 experts agreed in considering 50 process indicators (86.2%) as standards for guideline development. Eight process indicators (13.8%) were considered uncertain. The analysis of the first round results showed no disagreement. Uncertain values were mainly linked to the monitoring.
P6
Supporting Guideline Implementation and Individual Treatment Decisions – Are Patient Guidelines Sufficient?

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Background: National disease management guidelines are systematically developed statements to assist decisions about the appropriate clinical measures for specific health problems within the scope of structured health care. Primarily, they address physicians. Therefore guideline based patient information are being developed according to defined methods in cooperation with representatives from patient organizations. These patient guidelines are meant to assist patients and their family with making individual health decisions on the basis of evidence. In addition, they are an important tool for implementing national disease management guidelines in practice.

Purpose: So far, patient guidelines have met these two goals (implementation and individual decision support) to a limited degree only. The barriers which patient guidelines face are that (1) they are quite voluminous, (2) that they contain information which would not be equally relevant to all patients and at all times, and (3) that they exist along with disease management guidelines, but as an independent product. This is why material is being developed on the basis of patient guidelines allowing to provide the right information at the right time and to give assistance with individual decisions and the doctor-patient interview.

Methods and Results: Patient guidelines are split into several modules. Each of these modules contains only the information which is actually discussed during the doctor-patient encounter and which can afterwards be handed out to the patient as written information material. The evidence-based treatment options of patient guidelines form the basis of individualized decision aids which doctor and patient may want to discuss together. The empowerment modules of the patient guidelines are translated into interview guides for physicians.

Discussion: Subject-related patient handouts, individualized decision aids and interview guides are an important addition to evidence-based patient guidelines and may significantly support the implementation of both disease management guidelines and patient guidelines.
P7
Implementation of an Evidence Report into a National Breast Cancer Guideline


Background: High quality guidelines should be based on independent systematic reviews. For an update of a national guideline for early diagnosis of breast cancer published 2/2008, an evidence report was issued focusing on selected topics. The report was prepared by an organization distinct from the guideline group.

Purpose: To analyze how guideline recommendations and accompanying text refer to and reflect the underlying evidence.

Methods: 7 topics were selected in a first consensus conference by the interdisciplinary guideline group. For these topics, key questions to be answered by systematic literature search as well as inclusion and exclusion criteria were defined prospectively by the authors of the evidence report together with the particular expert groups. The evidence report was given to each expert group, who developed guideline recommendations and underlying text. Recommendations were voted on by a nominal group process during a second consensus conference in which the authors of the evidence report did not take part.

Results: The evidence report was cited as literature source of recommendations concerning all 7 issues. Even though benefits and harms were explicitly cited for all interventions within the evidence report, they were only outlined for 4 issues in the guideline (recommendations/accompanying text). Limitations of studies were specified for 3 topics. Upgrading the strength of recommendation in relation to the level of evidence given in the evidence report was done for 2 topics, but was not explained in the accompanying guideline text. Recommendations for 1 issue comprised contents not stated in the evidence report.

Discussion: The implementation of the evidence within one guideline appeared heterogeneously. There is a need for a standard how to consider the underlying evidence in high quality guideline. We propose that authors of evidence reports should take part in expert group meetings when recommendations are developed.
P8
Applicability and Clinical Relevance of Results in Randomized Controlled Studies and Systematic Reviews of Physiotherapy Interventions in Children with Cerebral Palsy

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Background: The demand for evidence based rehabilitation has increased the number of randomized controlled studies (RCT) and systematic reviews on physiotherapeutic interventions on children with cerebral palsy (CP). We employed clinical expert perspectives to analyze how well the results of RCTs and systematic reviews are applicable and relevant in current clinical practice in Finland.

Participants: Five to 11 clinical experts specialized in pediatric rehabilitation (physical therapists, occupational therapists and child neurologists) participated in five 4-hour workshops to discuss 3–5 RCTs in each. The reviews were independently analysed by six clinical experts (3 physiotherapists, 1 occupational therapist, 2 pediatric neurologists; expertise in CP ranged from 7 to 31 years).

Methods: The research papers (18 RCTs and 14 reviews) were distributed to workshop and individual participants, respectively. In the workshops the participants were asked to give a consent answer and for the systematic reviews the participants were asked to give an independent answer to the following questions.

1. Are the patients described in detail so that you can decide whether they are comparable to those that you see in your practise?
2. Are the interventions described well enough so that you can provide the same for your patients?
3. Are the treatment settings described well enough so that you can provide the same for your patients?
4. Were all clinically relevant outcomes measured and reported?
5. Is the size of the effect clinically important?
6. Are the likely treatment benefits worth potential harms?

Results: The percentages of "yes" answers to the six questions were 72%, 39%, 33%, 22%, 50%, and 39% for RCTs and 29%, 11%, 5%, 20%, 1% and 28% for systematic reviews.

Conclusions: Populations, interventions, comparison interventions, settings and outcomes need to be described in detail both in the RCTs and in the reviews to allow applicability into clinical practise.
P9
Clinical Guideline Development in England and Wales: an Overview of the Role of the Information Specialist at the National Institute for Health and Clinical Excellence and the National Collaborating Centres


Aim: To describe the respective roles of the information specialists at the National Institute for Health and Clinical Excellence (NICE) and the National Collaborating Centres (NCCs) in the development of standard and short clinical guidelines for England and Wales.

NICE and the NCCs: Standard and short clinical guideline topics are referred to NICE by the Department of Health. The NCCs are commissioned by NICE to oversee the development of the standard clinical guidelines upon which NICE guidance is based. The development of short clinical guidelines is overseen by a technical team at NICE. Occasionally, an NCC is commissioned by NICE to develop a short guideline.

The information specialist role: Topic selection: the information specialists at NICE support the process of selecting topics for clinical guidelines, by identifying topics for elimination and gathering information to guide the filtering of topics according to the Department of Health’s selection criteria.

Guideline development: information specialists at the NCCs support the development of the standard clinical guidelines, and information specialists at NICE, and occasionally at the NCCs, support the development of short clinical guidelines. The core role of the information specialists on both programmes is to identify the evidence base to answer guideline questions. Following the methods set out in the NICE ’Guidelines manual’ this includes: contributing to question formulation; identifying the sources to search; developing search strategies to search sources effectively and efficiently; creating and maintaining reference management databases and documenting the search process.

Collaboration: Best practice is shared and further developed between the information specialists at NICE and the NCCs by a dedicated discussion list and bi-annual meetings. Joint working groups are set up as necessary to take forward specific methodological issues. In addition, the information specialists collaborate with a range of professional interest groups, both national and international, and including SEARCH.
P10
Evidence-based Patient Information Materials: the French Approach

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Review of information material for cancer patients showed that informations provided often is not evidence-based and does not involve cancer patients and their family members in the development process.

French federation of the 20 Comprehensive Cancer Centers (FNCLCC), with the National Cancer Institute and the National League Against Cancer, provide evidence-based patient information with the SOR Savoir Patient program (http://www.sor-cancer.fr) to develop patient information materials, based on the international quality criteria’s, to improve their knowledge of cancer treatments and to facilitate their participation in clinical decisions.

French clinical practice guidelines 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. This process has to actively involve them to satisfy specific information needs.

Good quality patient information materials represent a supplement for verbal information during the clinical encounter; combining verbal and written information is more effective than verbal information alone.

These materials can be disseminated in information areas dedicated to patients and their family members and also can be used in therapeutic patient education programs.

Greater attention needs to be paid to improve access to patient information materials (booklets and online versions) and to assess their impact in the doctor-patient communication.
P11
The Application Research on Sharable Evidence-Based Guideline Representation in CPOE System

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Background: Guideline-based, computer-mediated decision support systems have been demonstrated to improve clinical care and patient outcomes in some diseases. This program will build an on-line system, which based on Protégé to construct the ontology of clinical guideline.

Purpose: The system integrates the evidence-based guideline into the electronic patient records. The evidence-based guideline is established by the conclusion of major evidence databases.

Methods: When doctors prescribe medicine through the computerized physician order entry (CPOE), or retrieve abnormal data, which will trigger the system. The system will measure different action threshold of medical decision, it could be a tailor made clinical service. A just-in-time decision support system in office can contribute to the future development of CPOE system.

Results: With the system, 65% of our patients reach the LDL-C (low density lipoprotein-cholesterol) goal in 175±98 days after the treatment in average.

Discussion: The project will build the clinical decision support systems automatically for guidelines of moderate complexity. Hopefully, the experience of the study can be applied to the Taiwan Electronic Medical Record Template (TMT).
P12
Letting Evidence Guide Every New Decision (LEGEND): An evidence evaluation system for point-of-care clinicians and guideline development teams

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Systems available to evaluate the quality of evidence and judge the strength of clinical care recommendations have been designed to work best for treatment questions with evidence from randomized controlled trials (RCTs). Organizations often have clinician groups and recommendation teams from different disciplines adapting systems independently to evaluate evidence answering other types of clinical questions with varying availability of published evidence.

We present a system developed to standardize organizational processes for evaluating evidence quality and judging the strength of clinical care recommendations. We describe and demonstrate the four parts of the system: A) critical appraisal of the individual study article and assigning a quality level; B) grading the quality, quantity and consistency of a body of evidence to answer a clinical question; C) judging the strength of a recommendation; and D) how this is all communicated in the recommendation document.

We explain how the evidence evaluation system was designed to meet the needs of clinicians in any discipline (e.g. nursing, occupational therapy, medicine) and to answer clinical questions in any domain (e.g. diagnosis, meaning, treatment). Additionally, we explain how the system helps guideline development teams judge the strength of recommendations within the context of the evidence and other relevant factors (e.g. harm, barriers to adherence).

This system is useful for healthcare professionals involved with evidence evaluation and healthcare professionals involved with recommendation development, and is appropriate for all clinical disciplines. We present the following: A) a comprehensive system for evaluating evidence and judging the strength of recommendations, B) an illustration of the flexibility and robustness of the system regardless of the clinical question or the quality of evidence, and C) an advocate that informal groups of point-of-care clinicians, as well as formal guideline development teams, may find the system useful.
One of the promises of guideline adaptation is less resource usage than in de novo development of guidelines. In the last two years CBO undertook several adaptation projects with respect to guidelines with a broad as well as a small range of topics. Some evidence suggests that guideline projects with a small range of topics consume a little bit less resources. However in the case of broad range guideline projects other determinants of resource usage seem more decisive.

For guideline adaptation to be feasible a necessary condition is the wide availability of good quality guidelines. It remains to be seen if this reflects reality. To assess the feasibility of an (ongoing) adaptation project (a guideline on Parkinson's Disease) 13 guidelines (national and international) were appraised with the AGREE-instrument. The AGREE-scores were in 11 cases below a score of 50%. Besides using AGREE, it was found necessary to assess whether clinical questions were explicitly linked to scientific evidence, to other considerations like patient and professional values, and to recommendations. After doing so just one guideline (a NICE guideline) turned out to be feasible to adapt.
P14
Medical Perception of the New Medical Tools for Chronic Conditions in France

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In France, 30 chronic conditions are eligible for 100% coverage of health care expenditures and presently 8 million patients are concerned. From 2005, in order to involve the primary care physician (PCP) and the patient in better care management, the law has enforced an individual health care protocol signed by each patient who claims for full coverage by the National Health Insurance. Accordingly, the HAS has produced for each chronic condition a medical guide focusing on the medical pathway, a list of products and procedures and a patient guide.

In order to collect the PCPs’ opinion on these tools, the HAS has conducted a survey during the main PCP congress and two focus groups in large cities.

The survey consisted in an structured interview of the PCPs presenting themselves at the HAS booth. The PCPs know the guides and quote spontaneously the guide on diabetes. They consider the documents are useful for self or continuous medical education. They are particularly interested in the follow-up section of the medical guide, by lists of key points and decision trees. They favor a printed version they keep on their shelves. Few use e-documents during the patient visit.

The focus groups are diffident about an information produced by a body they consider in charge of constraining the costs. They adress their patients to a specialist when needed and consider that the guides should be shorter as some sections are not useful for GPs. The patient guide fullfills a demand and permits to save time during the patient’s visit.

This is the first attempt in France to set up a clinical pathway where the role of the PCP is reinforced and the patient actively involved. These surveys suggest that extra tools such as summaries of the medical guide and reminders could help.
P15
Arthroscopic Rotator Cuff Repair: Agreement on Indications But Not Practice

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Background: Rotator cuff tears are very common and, in 2005, about 45 000 patients were admitted to hospital for surgery. Surgical techniques and indications have evolved over recent years with the development of arthroscopic procedures. The lack of visibility on current practice and a request by the French Ministry of Health to assess the fixation devices used in arthroscopic surgery prompted the drafting of guidelines, despite the fact that published data on the subject is known to be limited.

Purpose: To produce guidelines on (i) the indications and limitations of open surgery and arthroscopic repair, (ii) and on the use of fixation devices in arthroscopic rotator cuff repair.

Methods: We performed a systematic review of the literature (2000–2007). This was submitted to a multidisciplinary working group of experts in the field (n=14) who drafted a set of recommendations. The final report was amended in line with the comments of 36 peer reviewers.

Results: Published data on indications were limited but tended to be convergent. Even so, most recommendations had to be based on expert opinion. Arthroscopy was indicated for non-reconstructive surgery or debridement, and for partial tear debridement or repair. Open surgery, mini-open surgery or arthroscopy could be used for a full-thickness tear accessible to direct repair by suture. A humeral prosthesis or total reversed prosthesis was indicated for cuff tear arthropathy. On the other hand, the working group was unable to define the number of fixation devices to be used according to tear size either on the basis of the literature or of a consensus opinion.

Discussion: Despite the weak evidence available, the experts were able to agree on a set of guidelines with regard to indications for arthroscopic rotator cuff repair but were unable to agree on a key point of practice.
P16
The Knowledge Base for Clinical Pathways: a Review

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Background: Clinical pathways can be defined as “structured multidisciplinary care plans which detail essential steps in the care of patients with a specific clinical problem”. They are utilized to support the implementation of clinical practice guidelines, and with the intention to improve coordination of care, length of stay and to reduce costs. Clinical pathways are now prioritized in the strategies of the largest regional health authority of Norway.

Purpose: To give an overview of the evidence base for clinical pathways.

Methods: We searched for systematic reviews about the effect of clinical pathways, focusing on reviews about the effect of clinical pathways in general. The search also identified systematic reviews about the use of clinical pathways in specific clinical conditions.

Results: We identified one Cochrane protocol and two systematic reviews about the effect of clinical pathways in general. The conclusions of the two reviews are partly contradictory. We identified eight systematic reviews about the effect of clinical pathways within specific, clinical fields. These reviews are contradictory and encompass positive effects, negative effect, moderate/small effect, uncertain effect and effect in a limited number of situations.

Discussion: The results of this review were presented in a dialogue seminar where the health authorities participated and presented their point of view. The enthusiasm and good intentions in the health trust contrasts with the incomplete knowledge base concerning the effect and implementation of clinical pathways. The need for further research concerning clinical pathways is not evident to all that are responsible for producing and implementing pathways. The view that the prioritizing, production and implementation of clinical pathways should be based on the best available knowledge can still be controversial.
P17
CHAIN – a Mature and Respected International e-Network
Connecting Researchers, Practitioners, Educators and Managers

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Background: CHAIN is a multi-professional mutual support network of more than 5,700 members, in health and social care, education and research. It began in England in 1997 within the NHS Research and Development programme, aiming to connect research with practice. It is now international, with wider focus, however sharing knowledge and networking for mutual benefit remain priorities. CHAIN is voluntary and free.

Purpose/Methods: Online directories and e-mail are used to connect people with common interests or complementary aspirations. The 4 main components are: CHAIN1 for people interested in research; CHAIN2 focusing on learning; CHAIN3 for innovation and improvement; and CHAIN4 for cancer care. Cross-cutting subgroups enable members to link-up on issues of common interest eg. Quality Improvement, Public and Patient Involvement, and E-learning. Precise targeting and rigorous filtering of messages ensures that members receive only material relevant to their interests. Searches may be local; National; or Global.

Results: CHAIN has twice been externally evaluated. The first, (published BMJ 2004:328:1174-7), noted that CHAIN was creating important new linkages to bridge the gap between research and practice. The second focused on the Innovation and Improvement part of the network, concluded that CHAIN was a valued and effective resource.

Discussion: CHAIN is a non-hierarchical e-network of volunteer collaborators, many of whom have considerable experience of developing and using guidelines. It is funded by 12 supporters including the UK’s National Institute for Health Research, NHS Institute for Innovation & Improvement, and the Scottish Government Health Directorate. Components have also been established in Ireland, Canada, Australia, and Scandinavia (launched 2008), forming an international pool of tacit knowledge and mutual support. Though CHAIN has pioneered use of the web as a means of networking, it is determinedly low tech. Adding value and simplicity of use take precedence over sophisticated technology; creating dialogue between people is paramount.
How can CHAIN Support Patients, Professionals and Policymakers in Developing, Implementing and Improving Guidelines and Encouraging their Use

Evans D, Nilsson A

Short description of workshop
The Workshop will explore the ways in which the combined experience and enthusiasm of CHAIN members can be deployed to enable local, national and international collaboration in pursuit of improving guidelines, facilitating their implementation and encouraging widespread uptake.

Main goals of the workshop
To alert participants to the possibilities offered by CHAIN and demonstrate simple ways in which they might use the network. To tease out new ideas as to ways in which such a diverse but supportive online community might be used to create and maintain momentum in the field of guideline development, implementation and increased usage.

Target groups
All interested in online networking as a mechanism for self-help and a driver for improvement among health care professionals.
P19
The National Implementation of Youth Health Care Guidelines in the Netherlands

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Background: Evidence-based guidelines in youth health care are developed and implemented at the request of the Dutch Ministry of Health, Welfare and Sport. From 1998, five guidelines have been published; three are being implemented. The guidelines are aimed at doctors, nurses and assistants (n=±7200), working in preventive youth health care for 0–19 year-olds.

Purpose: For the national implementation a comprehensive implementation plan is developed by TNO, that is fine-tuned, based on a determinant analysis of a specific guideline. A collaborative network was established, consisting of representatives of the national associations of municipal health care services, professional associations, and TNO. The network requested regional youth health care organisations to recruit so-called ‘implementation co-ordinators’, who were subsequently trained to implement the guideline in their own organisation.

Methods: Evaluations are performed for all guidelines to assess the level of dissemination, adoption, implementation, continuation and their determinants. The first guideline on hearing disorders (HD) was only disseminated. Guidelines on visual disorders (VD) and congenial heart disorders (CHD) are systematically implemented. Questionnaire studies took place in 2001 for HD, in 2005 for VD and in 2006 for CHD among a random sample of ± 700 doctors, nurses and assistants. Adherence to the key recommendations was assessed on different levels; the completeness, frequency and intensity of use.

Results: Awareness of the guideline increased from 72% for HD, to 90% for VD, and 97% for CHD. On average 32% and 52% performed a specific recommendation of respectively the VD-guideline and CDH-guideline for all children. Self-efficacy is the most important determinant of the performance.

Discussion: It is possible to establish an implementation-infrastructure. A systematic introduction seems to have a positive effect on the level of dissemination, adoption and implementation. At the Conference, we will outline how we designed the implementation process and present results of effect evaluations.
Towards the Integration of 3D Biomechanical Measures in the Development of a New Clinical Guideline for Knee Osteoarthritis Patients

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Background: Critical appraisals of existing treatment guidelines for managing patients with knee osteoarthritis (OA) show that strengthening exercises are highly recommended; however, their efficacy on pain and function remains questionable. Exercise prescription is predominantly based on clinical measures of static strength and range of motion. Since dynamic biomechanical factors play an important role in the development of knee OA due to altered loading distribution, we hypothesize that efficacy of exercise programs would increase if such programs were developed according to measures obtained from a three-dimensional (3D) dynamic biomechanical assessment of the knee. Therefore, we believe that these measures should be included in the clinical evaluation of knee OA patients and a new clinical guideline for knee OA should be developed with consideration for these measures.

Purpose: As a prelude to developing a new clinical guideline, the rational for integrating new evidence-based biomechanical measures in the evaluation and treatment of knee OA, is presented here.

Methods: Previous work conducted at the investigator’s laboratory demonstrates that some parameters derived from our biomechanical method can 1) discriminate between asymptomatic subjects and knee OA patients; 2) show responsiveness to changes following physiotherapy; and 3) be used in a clinical setting. The next step is to conduct a study in a clinical environment to assess whether a specific rehabilitation program based on these outcome measures modifies the biomechanical profile of knee OA patients. Moreover, the feasibility and applicability of integrating 3D dynamic evaluation of the knee into a clinical setting will be assessed using knowledge translation research methods. Based on the results of these studies, a clinical guideline will be elaborated considering all domains of the Appraisal of Guidelines Research and Evaluation (AGREE) instrument. Conclusion: These steps will lead to a properly developed guideline integrating evidence-based biomechanical outcomes.
P21
Exploring the Perception of Recommendations with Next-generation Multimedia Systems

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Background: One main challenge associated to the production of clinical guidelines is to be able to anticipate the impact of the specific recommendations they contain. Physicians do not always identify the most important information when they read guidelines because of the variable quality of their formulation, and phenomena of ambiguity, imprecision, and vagueness.

Purpose: We investigated how the perception of the actual strength of recommendations could be improved using state-of-the-art Multimedia systems incorporating real-time 3D animated characters “reading aloud” recommendations.

Methods: We devised a study involving 14 medical experts from HAS (the French National Authority for Health) and INSERM (French National Institute for Health), to determine the level of consensus between experts about the strength of a given recommendation. These experts rated the strength of 37 prototypical recommendations according to a predefined 6-point scale. We then determined whether their ratings were similar when they were presented recommendations via a virtual character "reading aloud" recommendations and displaying appropriate non-verbal behaviour. Character animation is controlled by the automatic analysis of the linguistic formulation of recommendations (based on the G-DEE software previously presented at the GIN conference).

Results: This preliminary experiment shows that all experts perceived differently the strength of recommendations. Only one of the 37 recommendations is perceived with a similar strength. The standard deviation for the ratings varied from 0.2 to 2.5 (sometimes reflecting lack of consensus). We then observed a significant effect of the virtual character on the standard deviation of recommendations strength, for intermediate categories where consensus is most difficult to reach (P < 0.0474).

Discussion: The "visual" extension to guidelines’ computational analysis presented here intends to restore the link between the wording of a recommendation and its intended impact on the reader. This innovative form of "dramatization" or recommendations is an efficient way to visualize implicit, multi-dimensional, information.
P22

Patient Involvement in Clinical Practice Guidelines: Experiences in the Community of Madrid


**Background:** There is generalized agreement to incorporate patient’s perspective in CPG, although there is not a common methodology. There is also a controversial point about which is the best moment to involve patients in CPG.

**Purpose:** To describe experiences of patient involvement in the CPG development process in the Community of Madrid.

**Methods:** We have involved patients from the beginning of the developing process of a CPG for anxiety disorders. Techniques used include participant observation, focus groups and in-depth interviews. Moreover, patients have been an important part of the guideline development group. To produce the information for patients in the mentioned guideline as well as in other CPG (osteoarthritis of the knee), subgroups with patients were created to assess comprehensibility and applicability of the information.

**Results:** Patient participation gave us the possibility to develop a CPG for mental health in primary care including patients’ interests. Also, in terms of patient information in CPG, patients’ involvement led us to develop useful advice for knee osteoarthritis and anxiety disorders patients.

**Discussion:** The used methodology allowed incorporating patient’s perspective from the beginning of the development of a CPG and this methodological approach considers in the research questions issues regarding the interest of patients. These experiences can introduce common methods for incorporating patient’s preferences in the development of any CPG.
Evaluation of a Guideline Development Group Process

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Background: Evaluation of the group process during guideline development remains a challenge and standardised instruments are not available. It has been widely acknowledged that participation of patients, their representatives and professionals is of major concern for successful guideline development and implementation in practice. Currently, we are developing the first evidence-based guideline on physical restraints in nursing homes in Germany.

Purpose: We aim to describe and analyse the roles and interaction of the group members and their impact on the guideline development process and implementation.

Methods: The guideline group (n=17) implies representatives from nursing science and practice, nursing advisory boards and quality assurance, insurance companies, medicine, law, ethics and patients’ representatives. So far, four of five guideline meetings, each lasting two days, have taken place. Process data were collected by unstructured observation and written documentation of each meeting concerning frequency, content and mode of the group members’ contributions and their understanding of the guideline’s aim and underlying methods. Observation protocols will be content-analysed according to methods of Grounded Theory. Depending on the results these will be verified through focus groups or individual interviews with the group members.

Results: First impressions of the four observation protocols point out the decisive role of the moderator, the difficulties of the group members to understand the methodology of evidence-based nursing and the challenge of interdisciplinary interaction and communication within the group process.

Discussion: Preliminary results raise questions concerning required competencies of the moderator and optimisation of the two-days lasting methodological training of group members with predominantly academic backgrounds. This refers to the group members’ understanding of evidence-based nursing and their understanding of the methodological procedures of the guideline development process.
P24
Role and Attitudes of Stakeholders in Guideline Implementation

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Background: Guideline implementation activities rarely depend exclusively on the parent organisation. The activities of stakeholders can be of great help in introducing new treatment practices, targets, and increasing evidence-based knowledge of best practice behaviour on certain diseases.

Purpose: Our aim is to describe the role and conception of the interest group leaders in guideline implementation. Their opinion on the roles of patients and patient organisations is considered also of interest. The query is also aimed to gather the best implementation strategies and channels to facilitate future implementation of Current Care guidelines.

Methods: A short web-based questionnaire with 12 questions, which took about five minutes to answer, was sent to relevant interest group leaders in Finland. Questions included background data, attitudes to both current and potential use of guidelines in healthcare decision-making, role of patients and patient organisations in guideline promoting process and key-activities in implementation. Types of the answers on the questionnaire was mainly on a scale from 1–5. For additional comments a free text field was added to the end.

Results and Discussion: Based on the results, future plans of activities for implementation strategies and prioritisation will be discussed and added to the action plan.
P25
Cancer Screening Guideline Information in Local Government Office Web Sites in Japan


Background: Cancer screening programs were conducted by local government offices in Japan. It was observed that local government officers have the lack of knowledge concerning the evidence based cancer screening guideline to use for population-based screening programs (Hamashima C. et al. 2007). Local public health center officers can play a role of implementing the cancer screening guideline as a medical knowledge manager for local government officers and general populations. As guidelines implementing tool, health center web sites can be used, and linked URL to evidence based cancer screening guideline web pages provided by the National Cancer Center (Japan) will be appropriate information.

Purpose: To analyze disseminated information through local health centers, a quantitative and qualitative investigation was carried out.

Methods: 512 health centers’ web sites were surveyed. “Cancer, carcinoma, neoplasm, tumor, screening (in Japanese)” were selected as the search term and navigated through the site or on the front pages. Descriptive contents about cancer screening were analyzed. Reference literatures and provided linked URL’s from health centers’ web sites were recorded. These were confirmed as evidence based cancer screening information or narrative documents.

Results: Of the 512 health centers, 37 centers have web pages on cancer screening and most of contents have instructed how to access cancer screening examinations. However two sites have links URLs to the National Cancer Center web pages, no sites linked directly to evidence based cancer screening guideline page.

Discussion: The lack of evidence based cancer screening guideline information was observed in local government office web sites in Japan. It is necessary to enlighten local public health center officers and mission officials.
P26
Is the Theoretical Basis of Changing Clinical Practices Forgotten?


Background: Implementation of clinical practice guidelines has been a fast growing field of research during the past twenty years. The need for theory behind implementation strategies has been noticed. Does the ongoing discussion of the theoretical basis have any effect on the published intervention studies?

Purpose:
1. What kind of implementation strategies have been used in intervention trials?
2. On what kind of (theoretical) approaches to changing practice those strategies are based on?

Methods: The research data was gathered from guideline implementation articles published in year 2004. A systematic analysis of the identified 31 articles was carried out by two researchers (SH and TM) independently. To that aim we formulated a set of questions to help to identify implementation strategies and possible underlying theories described in the articles. The primary analysis showed that many articles lacked an explicit description of the implementation strategy and its underlying theory. We therefore traced that information from the article texts using content analysis, performed by SH.

Results: Only one in six studies stated an explicit theoretical model of changing clinical practice motivating the chosen implementation strategy. Even in those cases the theoretical considerations were superficial referrals to the relevant literature. The actual implementation of the intervention (process evaluation) was described only in 13% of the studies.

As a result of the content analysis, the implementation strategies in the articles were divided into five categories: local adaptation, feedback, dissemination, decision support and marketing.

Discussion: When choosing an implementation strategy it is important to consider the action theory behind the change process from the current practice to a new one. The approach and strategy should be defined by situational and contextual factors. For the development of the field of guideline implementation the describing and evaluation of the processes and arguments provided for implementation strategies are essential.
P27
Adherence to Hypertension Guideline in Primary Care

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Background: Hypertension treatment has become a multidisciplinary task requiring integration of work processes between professionals. Clinical leaders are in charge of implementing multidisciplinary improvements of clinical practice. They should also be familiar with the contents of evidence based practise and able to adapt them in order to achieve best practise.

Objective: To describe the adherence to the Finnish Hypertension Guideline in primary care and the consistency of the views of the chief executives on its impact to clinical practices in their health centres.

Subjects: Health centres where both chief executives responded to a national survey.

Methods: A computer assisted telephone interview was conducted in 2004. Clinical practices based on Hypertension Guideline recommendations were selected indicators for implementation.

Results: Responses were available from 143 health centers in Finland (49%). Changes in division of labour had been implemented in 2/3 of health centres. Head physicians more often than senior nursing officers (44% vs. 29%, p<.001) reported that agreements on registering target blood pressure in patient records have not been made. A similar discrepancy was seen regarding in registering cardiovascular risk (64% vs. 44%, p<.001). Best agreement between chief executives was found regarding the calibration of sphygmomanometers and provision of weight-control group counselling.

Conclusions: The chief executives thought that the Hypertension Guideline had an impact on some clinical practices, but there were inconsistencies between the opinions of head physicians and senior nursing officers working in the same health centre. Support to multidisciplinary collaboration would benefit from good communication between these leaders.
P28
Evidence of Physiotherapeutic Interventions in Adults with Cerebral Palsy: A Systematic Review

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Background: Cerebral Palsy (CP) is the main childhood onset diagnosis that requires rehabilitation throughout life. The healthcare system provides services mainly for children, even though there are reports showing deterioration of function with age.

Purpose: The purpose of this study was to identify evidence of effective physiotherapeutic interventions in order to develop guidelines for good rehabilitation practice for adults with CP.

Methods: A comprehensive review of the clinical peer-reviewed literature was conducted using Medline, EMBASE, Cinahl, PEDro and the Cochrane library databases for the period 1950 to 2007. Key words were cerebral palsy in combination with adolescents, adult, intervention and physiotherapy. Inclusion criteria were physiotherapy interventions with subjects 16 years or older with CP diagnosis. Interventions combined with pharmacological treatment and surgery, various devices such as biofeedback, orthotic or other devices were excluded. Two reviewers independently assessed the methodological quality.

Results: 675 abstracts were found of which ten studies were included in the analysis. Five examined strength training, one a functional work training program, one aerobic training, one stretching, one passive ROM exercise, one whole body vibration and one vibroacoustic therapy. Two were Randomized Controlled Trials, two interventions with a control group, and six single-group or case studies. Evidence of effectiveness was established for strength training and its effect on walking ability, body image and functional ability. Moderate evidence of ineffectiveness was found in passive ROM training. For the other interventions evidence was limited due to low methodological quality.

Discussion: Evidence on physiotherapy for adults with CP is limited due to lack of research with good methodological quality. Development of guidelines for rehabilitation practice for adults with CP must therefore take into accounts also other study types and methods than randomized controlled trials.
Objective: Cancer guidelines in Norway has up to 2006 been developed by oncologists, without resources and support to engage in evidence based processes. In 2006 NOKC was given funds to support these groups, and the guidelines given national authority through the Directorate for Health affairs.

We have developed a program with the following key function:
• support guideline developing with HTA reports, systematic reviews and evidence based guidelines
• provide support on the evidence based processes including grading the level of evidence
• identify new and costly cancer interventions for rapid HTA reviews and cost effectiveness modelling.

Methods: We search for systematic reviews in CRD and Cochrane databases. For international guidelines we search in NICE, SIGN, AHRQ, cancer care Ontario etc. to update cancer clinical teams on international guidelines.

Results: Collaboration has been established that facilitate the adaption of technology assessment and systematic reviews conducted internationally. We have also established a rapid HTA process when there is a need for updating guidelines on new and costly interventions. In December 2007 we finish updating evidence based guidelines for 6 different cancer types, this included breast cancer, kidney cancer, palliative cancer, stomach cancer, oesophagus cancer and small intestine cancer.
P30
The National Development of (preventive) Youth Health Care Guidelines in the Netherlands

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Background: In the Netherlands, preventive programmes are offered to all children from birth to the age of 19 years to promote and protect health, growth and development of children. The services are free of charge. Many of the preventive programmes are used without having discussed the evidence level of the activities. In a nation-wide conference (1995), it was concluded that guidelines should be developed to ensure the quality of the care provided. In 1996, the Ministry of Health, Welfare and Sport, requested to development and implement 20 guidelines.

Purpose: Development of 20 evidence-based guidelines aimed at doctors, nurses and assistants (they are working as a team, n=±7200), working in youth health care (YHC).

Methods: From 1998, five guidelines have been published. The guidelines are systematically developed according to an established method (working evidence-based) that was evaluated and updated in 2006. This procedure includes a pilot. All guidelines were developed multi-disciplinary including the view from the YHC doctor, nurse and assistant. Also, the content of the guideline should be compatible with those of other specialists, such as general practitioners, paediatricians and patients. Therefore, they take part in the developing process. When evidence from research is lacking, it is tried to reach consensus.

Results: During the past 10 years, several problems were encountered in developing the guidelines. Among these are: time schedule, finding evidence on preventive programmes, patients participation and cost effectiveness. Examples based on the experiences with the so far developed guidelines will be given.

Discussion: At the GIN Conference, we will outline the past and future developments, obstacles encountered in guideline development and solutions. During the presentation we would like to discuss the problem of lack of evidence in preventive health care, how to make the process for the development more efficient and possibly, how to collaborate with other countries.
P31
Peer-review Publication of a New Drug Technology Following Initial Appearance at a Large Hematology Conference: Implications for Patients, Clinicians, Researchers and Policy-makers

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Background: Conference abstracts, often the first public record of a study, serve as a catalyst to initiate clinical and policy change. Evidence from conference abstracts may be used to inform clinical practice guidelines. On average, 45% of all conference abstracts subsequently appear in the peer-review literature, however the generalizability of this finding to studies of one intervention, in one population, is unknown.

Purpose: Our objectives were to determine the full publication rate of a cohort of abstracts, median time to publication and predictors of these relationships.

Methods: We included the first 5 years of clinical abstract reports of rituximab for non-Hodgkin lymphoma from American Society of Hematology meetings (1997–2001), identified all unique studies, and used electronic databases to identify full publications. We determined the full publication rate, median time to publication and predictors of these outcomes.

Results: Of 109 abstracts representing 86 unique studies, the publication rate was 52.3% (45, 95% CI [41.3, 63.2]), and the median time to publication, 1.4 years with 6.8 years median follow-up. Author affiliation with industry (odds ratio, OR, 95% CI=4.60 [1.32,16.08], and presentation type (oral OR=5.94 [1.31, 26.88], poster OR= 3.39 [1.24, 9.25]) independently predicted subsequent full publication in the adjusted analysis. We identified no predictors of time to publication.

Discussion: We suggest cautious consideration of data from conference proceedings to inform new technology clinical or policy decisions. Future work needs to examine the generalizability of our results to other diseases and technologies.
P32
Implementation of S3 Clinical Practice Guidelines for Treating Colorectal cancer in Different Health Care Settings

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Background: The challenge of implementing clinical practice guidelines (CPG) into routine care attracts increasing attention. This project aims at implementing S3-CPGs for treating colorectal cancer in a regional network (system Regensburg) and a university center (system Erlangen) and to compare effects on knowledge, attitude and behavior of the physicians within an ecological cross-sectional study.

Purpose: The aim is to find the most effectiv strategy of guideline implementation in different health care systems.

Methods: Quality indicators for the treatment of all patients in both study regions between 09/2005 and 08/2006 stated baseline data. The implementation of the CPGs started in 09/2006 by combining four established strategies: interactive CME, barrier analysis, reminders and feedback to the involved physicians. Their effects were analyzed in a second sample recruited between 09/2007 and 08/2008. Sample size calculation is based on the proportion of patients with tumor stages cT3, cT4 and cN+ respectively with neoadjuvant radiochemo-therapy: 40 patients for the system Erlangen, 80 for Regensburg (alpha=0.05 [two-sided], beta=0.20), requiring one year for recruiting.

Results: A detailed flow chart comprises all steps for implementation and evaluation.

Discussion: This project promises to yield valuable information about how to implement CPGs into two care systems commonly found in Germany. The suggested strategies can as well be utilized when high quality CPGs for different indications are to be implemented into routine care.
P33
Use and Usefulness of Second Generation Decision Support – Survey at the Pilot Sites of the Evidence-Based Medicine Electronic Decision Support (EBMeDS) Project

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Background: Three generations of decision support (DS) can be discerned: (1) print sources, (2) electronic, searchable databases, (3) electronic, automatic context-sensitive. In 2000, a 2nd generation DS health portal for professionals was launched, with national coverage and easy access to guidelines and databases. It is used in 96% of health care organizations; specifically, physicians’ database (EBM Guidelines) was used in 92 % and nurses’ database in 64 % (survey in 2005).

Purpose: The aim of the study was to survey the use and perceived usefulness of the health portal databases in practice among professionals, to assist in developing, implementing and evaluating the 3rd generation computerized DS system of the EBMeDS project.

Methods: A web-mail survey was carried out in November 2006 – May 2007 in two Finnish hospital district areas and one rural primary care centre. We targeted 2 252 professionals in 28 healthcare organizations, the number of responses being 806. Thus, overall response rate was 36 %. We measured absolute use of the database and its perceived usefulness by using a categorical scale varying between one (not at all) and four (very useful). Statistical analyses were performed using the SPSS 15.0 software.

Results: Current Care Guidelines, CCG, were extensively used by all professions (over 85 %), as were Local Care Pathways (at least 77 %). Physicians used EBM Guidelines (97 %), and nurses used Nurse Databases (87 %). Perceived usefulness of the databases varied: in the physicians’ group the highest points, 3.5, were given to EBM Guidelines and in the nurses’ group the highest points, 3.1, to CCG.

Discussion: The majority of professionals used several guideline databases. This suggests that using national databases as the evidence base, 3rd generation computerized DS systems can be tailored to meet the needs of all healthcare professional groups.
P34
The Evolution, Action and Results of a National Implementation Network of Trained Rohto-facilitators

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Background: Actively implemented Clinical Guidelines may help to close the wide gap between clinical practices and evidence. Opinion leaders, interactive learning, audit and feedback are shown to be effective methods of implementation.

Purpose: Purpose is to describe the strategy used when governmental Centre for Pharmacotherapy Rohto has built a national network of trained implementers (Rohto-facilitators) to promote rational pharmacotherapy.

Methods: The network was built following these steps:
- National planning and coordination
  - Piloting project
  - National general plan
  - Recruiting personnel and developing their competence
  - Developing and branding of products: Rohto-workshop, training, educational material
- Regional partnership and coordination
  - Recruiting regional partners (Hospital Districts)
  - Recruiting Rohto-coordinators to support local Facilitators
- Action at local level
  - Recruiting local partners (Primary Health Care Centres)
  - Recruiting Rohto-facilitators to organize workshops
- Centralized coordination, training and support
  - Training the Rohto-coordinators and facilitators
    * a system for support and continuing development of Coordinators and Facilitators
    * a database to manage operational workshop activities

Results:
- Competent team of implementers in the Rohto-centre
- 8 regional partners (Hospital Districts, big cities)
- Network of 8 regional coordinators
- Network of 176 local GP-facilitators and 48 nurse-facilitators
- 696 Rohto-workshops arranged since 2004 with 11 146 participants
- 7 842 (70%) of participants have provided feedback: 4 606 (59%) reported a need to change his/her practices
- 15 evaluated local implementation projects indicating the positive effects of Rohto-activities
Discussion: Active and wide-spread implementation may be achieved by a central coordinating body. Effectiveness of implementation is supported by combinations of evidence based implementation methods. Sustainability is enhanced by local Rohto-facilitators organizing the workshops. Continuous support by national and regional bodies is crucial to catalyze local activities. The real challenge is to ensure the commitment of health care organizations and managers struggling in the rapid changes.
P35  
Has the Updated Current Care Guideline for Schizophrenia Reached Physicians Treating Schizophrenic Patients?

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Background: Schizophrenia is a serious mental illness, and its prevalence in the general population ranges from 0.5 to 1.5%. Thus it is estimated that there are approximately 50 000 patients with schizophrenia in Finland. The evidence-based Finnish Current Care guideline for Schizophrenia was first published in 2001. It was updated in the beginning of 2008, and in the updated guideline early recognition and treatment of persons at risk of psychosis, the role of antipsychotic medication, psychoeducation, family psychoeducation and social skills training are emphasised.

The purpose of the present study is to find out whether the updated Current Care guideline for Schizophrenia has reached physicians who care for patients with schizophrenia.

Methods: An internet-based webropol-questionnaire with thirty-two questions, which takes about five minutes to answer, was created, based on the updated Schizophrenia guideline. Members of the Finnish Psychiatric Association whose contact information include e-mail address will receive the questionnaire. They will be asked are they aware of the updated Current Care Schizophrenia guideline, have they read it, has it had an impact on their work and few other questions about schizophrenia. Included background questions ask for example the physician’s age, gender, specialization status (specialist/in training) and area of working in Finland.

Results and Discussion: The awareness of the members of the Finnish Psychiatric Association on the updated Schizophrenia guideline will be reported. Based on the results, future plans of action for the implementation of the updated Current Care Schizophrenia guideline will be discussed.
P36
Practice Survey on Application of Fundal Pressure After Publication of Formal Consensus Guidelines


Background: Application of pressure to the fundus of the uterus during the second stage of labour is a common practice in France but is rarely noted in the medical record. In January 2007, HAS published guidelines (formal consensus method) recommending that either instrumental delivery (forceps, ventouse cap) or a caesarean section should be used if the second stage of labour needed to be shortened and that a record should be made if pressure was applied despite this recommendation.

Purpose: To assess whether midwives were aware of these guidelines and implemented them.

Methods: An 11-item closed questionnaire (with one open question and space for comments) was handed to the 400 participants attending the 2-day National Midwife Meeting (Paris, February 2008) for completion and collection at the meeting.

Results: The response rate was 47% (62.3% from healthcare organisations, 24.7% in independent practice, 13% not practising). Of the 170 respondents, 145 (86%) knew of the guidelines, 138 (95%) agreed with them, and 111 (77%) considered them applicable to their practice. Before guideline publication, 152 midwives (89%) had applied fundal pressure at some time but only 9 (5.8%) had recorded the fact. Since guideline publication, 41 (24%) reported still applying pressure, when expulsion efforts were ineffective (41.5%), when foetal heart rate was abnormal and the obstetrician was not present (26.8%), and when no obstetrician was available (22%). However, only 9 of these midwives recorded the fact. Open comments (65 respondents) were highly diverse.

Discussion: Our survey has highlighted a significant decrease (73%) in the use of fundal pressure after guideline publication. However, because the response rate was low and respondents may not have been representative of the overall midwife population, these results need to be confirmed.
P37
Implementing the Foetal Screening Programme in Finland


Background: Before 2007, over 400 Finnish municipalities decided independently how to screen for foetal abnormalities during pregnancy. This resulted in a large diversity of screening methods and inequity of care. In December 2006, based on an HTA report of Finohta, a statute on screening for foetal abnormalities was given. It is to be implemented by 2010 (1).

Objective: The Ministry of Social Affairs and Health requested Finohta to plan and organize an education system to promote the local implementation of the national statute.

Methods: Finohta assembled a group of 15 experts to construct education material, plan training for regional instructors, and to compile information booklets for parents. Customer-oriented information was acquired with focus group interviews (Bikva-method).

Results: An information booklet was composed for all expectant parents and another one for situations in which the foetus is suspected to have an abnormality. Six training packages on e.g. principles of screening and informing the parents were produced for health care professionals. Two national training seminars were organized. Based on the feedback of the group interviews, a further information package on how to communicate with the parents at various situations will be compiled. All materials are available for free on the internet. The results of the focus group interviews will be analysed by the end of 2009 and the final evaluation of the implementation performed in 2010.

Discussion: The role of Finohta has expanded from producing evidence to health care decision makers to producing evidence based education material both to health care professionals and parents. The strong commitment of the clinical experts to attain a uniform screening programme is crucial for the successful completion of this novel task.

P39
How to Support Effective Implementation

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Background: Rohto (Centre for Pharmacotherapy Development) is a governmental expert unit, which promotes rational pharmacotherapy. Rohto has built a national implementation network consisting of local GPs covering half of Finnish primary health care centres. Our purpose is to describe and evaluate the material support Rohto provides for facilitators conducting workshops for implementation.

Support consists of articles published in a national medical journal or in the Rohto newsletter and versatile educational packages to help facilitators plan and perform interactive Rohto-workshops.

The material packages contain the following components:

• Things to consider in planning a workshop
• Examples of workshop compositions and ideas for interactive working methods
• Power Point slides based on national guidelines and other evidence
• List of relevant literature and Internet links
• Case examples and supplementary material to be used or handed out
• Selected data from prescribing statistics
• Standardised evaluation tools for local interventions
• Sometimes an article draft for local newspapers

The material is compiled by Rohto consulting national experts.

Methods: Focus group interviews in summer 2007 (N=14) and electronic questionnaire in spring 2008 (N=201) were conducted to determine how useful these implementation support tools were for facilitators.

Results: Rohto material packages were evaluated useful (mean 8, scale 4–10) and they were widely used by facilitators. Prescribing data (mean 6.6) and articles published by Rohto (mean 9.4) are also appreciated, but used less in workshops. Facilitators adapt the material to local circumstances. Material packages have enhanced supply of workshops and regional co-operation. The facilitators wanted more information about new national guidelines and new drugs.

Discussion: Nationwide implementation of guidelines requires centralised production of material and other support. Material packages should be produced to cover all essential guidelines, which our facilitators also requested. Centrally produced material can be effectively used by a national network.
P40


Introduction: Since year 2002, when it was created, GuíaSalud has developed a catalogue of clinical guidelines, a website, and has promoted and coordinated the methodological development for clinical guidelines elaboration in the Spanish National Health System (NHS). As a result of the advance in the development of guidelines, new goals and needs have been generated and GuíaSalud has turned into a larger project to meet all these needs.

Objectives: To improve the offer of resources, services and products based on scientific evidence to support decision making of the professionals and the patients in the NHS, as well as to promote the creation of collaboration networks and the cooperation between organizations related with clinical guidelines and the Evidence-Based Medicine.

Methods: GuíaSalud-Library takes into account the participation of all the Spanish Regions, the Health Technologies Assessment Agencies, the Scientific Societies, Universities, Associations of Patients and other institutions from Spain and its management is carried out by The Aragon Health Sciences Institute.

Results: Coordination of the development of a Methodological Handbook for development of clinical guidelines, common to all the NHS and twenty-one clinical guidelines, thirteen of them are currently being elaborated. Also, an organizational structure has been created and it is formed by:

• Means of Management: constituted by the Executive Board, with participation of representatives from the seventeen regions of Spain, the Scientific Committee, composed of thirteen members with wide experience in clinical guidelines, the Consultative Board, which includes Scientific Societies, Universities, Associations of Patients and other institutions from Spain, and the Management Unit, composed of twenty professionals from The Aragon Health Sciences Institute.

• Work areas which are structured in five Programs: Clinical Guidelines Elaboration Program, Other Evidence-Based Medicine Products Development Program, Qualification and Dissemination Program, Clinical Guidelines Implementation Program and Research Program.

• A Collaborative Network constituted by professionals from the NHS.
Conclusion: GuíaSalud-Library is strengthening and increasing its range of products to achieve a more use in the NHS and to be a reference in Evidence-Based Medicine. Its website is a key tool for the development of the programs and at the moment it is being transformed to be a reference website in Evidence-Based Medicine, which makes easier collaborative work and knowledge management.

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P41
Doctor Certification: a French Initiative for the Implementation and Development of Guidelines in High-risk Specialities

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Background: Two national surveys in France carried out in operating theatres and recovery rooms showed that it was possible to reduce the incidence of adverse events despite an increase in volume of activity. A third survey showed that one-third of adverse events in hospitals could be avoided.

Purpose: To encourage the implementation of existing clinical practice guidelines by hospital doctors working in 21 high-risk specialities and the drafting of new risk-reduction guidelines based on real-life experience.

Methods: Between September 2005 and March 2006, HAS designed a certification scheme for the reporting of near-misses based on risk management Improvement methods. It was pilot tested between March and May 2006 by about 100 doctors in 7 high-risk specialities.

Results: The scheme has three important features: (i) near-misses are clustered into types on the basis of a review of the literature which will be regularly updated; (ii) doctors have to report 2 to 6 near-misses/year to the approved body of their specialty. An expert of the approved body analyses the near-miss, provides feedback including guidelines to be implemented, and enters the near-miss (anonymously) into a central database set up by HAS; (iii) the information on the near-misses in the database is regularly analysed by both the approved body and HAS. On the basis of this information, the approved body will draft risk-reduction guidelines using a method developed by HAS. In April 2008, nearly 2 700 doctors from 13 of the 21 high-risk specialities had entered the scheme. A total of 300 near-misses have been reported.

Discussion: Participation in the scheme provides doctors with certification for 4 years, contributes to their continuous medical education credits, and in particular should lead to improvements in practice and patient care.
P42
Peer Review of Evidence-based Clinical Practice Guidelines in Flanders (Belgium)

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Background: Systematically developed clinical practice guidelines (CPG) assist general practitioners in providing the best possible healthcare in specific clinical circumstances. Before validation and publication, draft clinical practice guidelines are getting input from experts, patients and GPs as target users of the guideline.

Purpose: To collect feedback on the acceptability and applicability/feasibility in practice, assessment of the usefulness of the guideline as a working tool for the Flemish general practitioners.

Methods: Two methods for field testing are used: a post inquiry or field testing in local quality groups of GPs. The Guideline Development Group (GDG) identifies 4 topics of the CPG on which feedback is needed. These topics are presented as propositions (post inquiry) or incorporated in a patient case (local quality group). After the testing in local quality groups of GPs, the guideline is also distributed among GPs for additional feedback. All responses, peer review reports and comments are compiled and discussed within the GDG, who decides afterwards if modifications are to be made to the guideline.

Results: Identification of the need of additional clarifications, preconditions, points for the research agenda or the need of further training. The local quality group seems the preferable approach, since members of the GDG enter into discussion with a group of future users (GPs) by presenting particular patient cases. This method guarantees the link with the GP’s daily practice and promotes acceptance of the guidelines. However, the testing scenario must be rigorously built up to obtain enough information about the implementation of the draft guideline, in 90 minutes time.

Discussion: Peer review testing the guideline prior to publication in a local setting of general practitioners provides a lot of valuable information on its applicability and feasibility. However, it needs a well-structured approach.
P43
Advantage of a Modified Delphi Consensus Method in a Small Guideline Developing Group

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Background: The Dutch National Working Party on Infection Prevention (WIP) decided to use a modified Delphi consensus method prior to her conventional open discussion in plenary meetings to establish her guidelines. The modified Delphi method was introduced for strengthening individual input in the formulation of the recommendations by requiring written comment, and for quantification of group consensus and the strength of recommendations. The WIP comprises ten members.

Purpose: To gain an insight into the WIP members’ experiences in establishing their guidelines by additional use of a modified Delphi consensus procedure.

Method: Experience was measured by a questionnaire which contained thirteen statements each with a five point response scale ranging from 1 (= disagree) to 5 (= strongly agree). Eight statements were related to the items reproducibility, transparency and objectivity of the guideline developing process, two statements were related to quantification of group consensus, and three statements were related to efficiency and feasibility.

Results: The response rate was 90 percent. More than 50% of the respondents experienced that 1) the use of the modified Delphi consensus method improved the reproducibility, transparency and objectivity of the guideline developing process; 2) the mean scores were considered good measures for the strength of recommendations, and the ranges of the scores good measures for the extent of agreement. Nearly all (8/10) agreed that the modified Delphi method was easy to use. Most respondents indicated that the modified Delphi procedure took more personal time (7/10) but saved time in plenary meetings (6/10).

Conclusion: Establishing guidelines in a small group (ten members) by the modified Delphi technique in addition to open discussion in plenary meetings improves the quality of the guideline developing process but requires greater personal efforts.
P44
Guidelines for Carrying out Legal Regulations for Priority Setting in Norway

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In Norway legal regulations states that each patient shall be judged individually according to certain priority criteria. These are the seriousness of the patient’s health state, the expected benefit and the cost-effectiveness of the treatment. Nevertheless there are politically unacceptable variations in the priority setting: Similar patients face different legal rights depending on where they live.

The Ministry of Health mandated the Norwegian Directorate of Health to cooperate with the regional health enterprises in developing national guidelines to ensure that prioritisation comply with the legal provisions. Regional representatives from 30 specialities together with general practitioners and user representatives worked together in groups, one for each speciality, to develop the guidelines. The work took place in three rounds of 4 months each and with 3 workshops of two days in each round.

Each speciality group listed the most common medical conditions of the referrals within their speciality. Thereafter each condition was described and evaluated according to various dimensions of the three criteria for priority setting using a structured list of questions to be answered. The groups listed references in support of their views. After a month with reflections and peer discussions, they concluded whether a ‘typical’ patient within each medical group should be recommended prioritised health care, and if so, a maximum waiting time was given. To ensure individual judgement of each patient, patient characteristics of relevance within each of the medical groups, in an addition to the group characteristics, were listed. These have to be taken into consideration before concluding on the legal rights of the individual patient.

An expert group has reviewed the work, and the first version of the guidelines is on a national consulting round.

The guidelines will be implemented in the end of 2008.

Questions about the method of developing the guidelines are welcome.
P45
Patient Safety Culture in Acute Hospitals.
A Web-based Survey to Hospital Staff

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Health care is beginning to be identified as high hazard industry which is inherently risky. Hospitals as health care organizations are becoming aware of the importance of transforming organizational culture in order to improve patient safety. The basis for a culture change is the measurement of prevailing beliefs and behaviour surrounding patient safety issues, and errors in organizations.

The aim of this study was to assess the safety culture climate from hospital staff perspective in acute hospital care in Finland.

In the beginning of 2008 web-based surveys in four acute hospitals were implemented to assess patient safety climate. Hospital Survey on Patient Safety Culture (HSPSC) -instrument (by AHRQ) was used. The surveys were administered to hospital staff (N=6 700). The data were analyzed with statistical methods.

Altogether 1 064 HSPSC surveys were received giving a response rate of 16 percent. Most of the survey respondents were registered nurses (68%) or other nurses (10%), and doctors (7%), nursing leaders (8%) as well as other staff members (5%) the rest. The overall patient safety grade of excellent or very good was given in every second response, and satisfactory or less in other half. Majority (61%) reported no adverse events over the past year. Mistakes were assumed (41%) to turn against staff. Teamwork within units with respectful behaviour towards others (69%) was an area of strength, when as heavy workloads with less than optimal staffing, use of temporary staff and loss of information in patient transfers formed threats for patient safety.

This survey is one of the first efforts to measure institutional culture of patient safety in Finland. The results of the survey will be communicated to hospitals and used to form an action plan to improve the patient safety culture.
P46
How to Structure a Therapeutic Patient Education Programme for Patients with Chronic Disease

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Background: Structured therapeutic patient education (TPE) helps patients acquire the skills needed for self-care. However, healthcare providers are little aware of this key component of disease management.

Purpose: To produce a methodological guide on how to structure TPE programmes for patients with chronic disease and on how to implement these programmes in routine care.

Methods: We performed a systematic review of the literature (1996–2007) to retrieve existing guidelines on TPE programmes as well as reports of surveys performed in either a hospital or ambulatory setting, interviewed experts in education studies, sociology and psychology, convened a patient focus group, and set up a 17-member multidisciplinary working group to help draft a guide. This guide was submitted to 68 peer reviewers for comment.

Results: The guide (published online in June 2007) contains sections targeted at different audiences: (i) Healthcare providers, patients and patient associations: what is TPE, who can teach it, how should it be organised and coordinated; (ii) Healthcare providers: how to implement tailored TPE programmes to help patients acquire and maintain skills, with taking into account their past experience and disease management (i.e. Why propose TPE, what is a TPE programme, how to present and propose a TPE programme, how to teach TPE to patients); (iii) Healthcare providers, specialty societies and professional organizations: how to establish, jointly with patients and their representatives, the procedures needed to implement a programme for a specific disease.

Discussion: There is insufficient evidence to recommend a particular type of TPE programme. Good practice principles should be followed for maximum effectiveness. To this end, we have developed an instrument to assess TPE programme quality. TPE programmes based on our methodological guide have yet to be set up. Their impact will be measured through local policy and practice reviews and auditing of healthcare providers.
Assessing the Quality of a Therapeutic Patient Education (TPE) Programme

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Background: The literature does not provide instruments to assess the quality (contents and recommended implementation procedures) of a structured TPE programme for patients with a specific chronic disease.

Purpose: To propose an instrument for assessing the quality of structured TPE programmes in order to incite healthcare providers to improve educational practices with the help of patients and their representatives.

Methods: A list of objectives and assessment criteria was drawn up on the basis of a systematic review of the literature (1980–2007) and published assessment reports, and then amended by a multidisciplinary working group of 10 experts who drew on their experience and that of 17 peer reviewers who judged the readability, relevance, and usefulness of the instrument with regard to their own practice (6 items).

Results: A total of 36 objectives and 215 assessment criteria were derived from coordinated series of educational actions. These actions were pursued by healthcare providers or educational teams assisted by professionals and patients and were targeted at patients and their close relatives. Their predefined goals were to acquire and maintain self-care skills, and adopt coping or psychosocial skills. The objectives and criteria were based on approaches and procedures implemented in a given setting during a given time-period. The readability, relevance, and usefulness of the objectives were considered to be good (90%, 82% and 80%, respectively); 10% of the objectives were redrafted. The readability and relevance of criteria were considered good (88% and 92%, respectively); 15% of the criteria were redrafted and 5% were deleted.

Discussion: The instrument was considered useful but too long (too many objectives and criteria). Users will therefore be invited to select those objectives and criteria that best meet their needs. Assessment of the instrument’s feasibility will continue in 2008–2009.
P48


Introduction: Rationale and relevance of the study Methodological development of GPC has made significant progress in our country. Since 2002, we have published several CPG of good quality. However, the aim of these guidelines is to produce changes in behaviour of professionals and patients health. Therefore, it is important to identify barriers and facilitating factors that allow designing effective strategies for the CPG dissemination and implementation.

Objectives:
1. To identify barriers perceived by physicians in relation to the implementation of CPG.
2. Based on the previous results, to develop and validate a questionnaire designed to measure the attitudes of physicians towards the guidelines

Materials and methods: Analysis of barriers and facilitating factors done through a technical consensus (Delphi). 35 family physicians were selected, with knowledge on the GPC of hypertension and/or asthma due to their experience, participation or involvement in this issue. The sample was chosen looking for the highest representation, taking into account the place, gender and age in Osakidetza (Basque Public Health System). Initially a questionnaire was sent including open and closed questions about the following aspects of the guidelines: format, utility, usefulness, internal and external barriers. Previously, the questionnaire went under a qualitative validation.

Results: Internal barriers have been identified and have made us to use them to build up the questionnaire on attitudes of physicians towards GPCs. Possibility of innovation on the current understanding.

Knowledge of barriers and facilitating factors for the dissemination of a particular clinical practice guideline would allow us to overcome such barriers and ultimately achieve changes in clinical practice.
Background: Clinical guidelines are systematically developed statements, which assist in decision making. The most recent Finnish current care evidence-based guidelines on Diagnosis and pharmacotherapy of multiple sclerosis (MS) were updated on July 2006. Two major changes in clinical practice were suggested; early diagnosis of multiple sclerosis using new diagnostic criteria and the use of neutralizing antibody measurement in monitoring the beta-interferon treatment.

Purpose: To examine whether the new guidelines are adopted in clinical practice and what are the neurologists’ attitudes concerning the guidelines.

Methods: The group of MS experts created a web-based questionnaire that the participating doctors will fill up for 10 consecutive MS patients. The questionnaire was planned to identify the decision points at which evidence needs to be integrated with individual clinical experience in deciding on a course of action. Altogether 22 doctors collected information concerning the care of 469 MS patients.

Results: Almost half (45.5%) reported that they knew the new guidelines well, half considered that the guidelines were clear and 81.8% of the doctors were satisfied with the guidelines. All doctors reported that the guidelines have influenced the practice in measurement of neutralizing antibodies. However, only two thirds actually measured the antibodies in their patients and 26.9% reported that the presence of the antibodies does not influence treatment decisions although the new guidelines suggest that treatment with interferon should be stopped in a patient who has permanently high antibody levels. Over one fourth (26.7%) of the doctors had not adopted the new diagnostic criteria in their practice.

Conclusions: These preliminary results show that the guidelines are reasonably well adopted in practice but the more detailed analyses of data are underway.

Sanofi-Aventis supported study by covering the costs of data collection and transfer that was performed by Digium Oy and Pharma Forum Oy.
P50
The American College of Physicians Clinical Guidelines Program – An Overview of the Process

Qaseem A, American College of Physicians

Background: The American College of Physicians (ACP) is one of the pioneer organizations in the field of evidence-based medicine in the United States. ACP established its clinical guidelines program in 1981. The program has evolved over the years, starting initially developing guidelines addressing diagnostic tests and techniques and in the current program addresses screening, diagnosis, and treatment of various diseases.

Purpose: The goal of this presentation is to provide highlights of ACP’s guideline program and its process.

Methods: Utilization of systematic reviews and application of the AGREE instrument.

Discussion: ACP guidelines are intended to aid clinicians in medical decision making and ensure that they are based on and consistent with good evidence of effectiveness and benefit. This presentation will emphasize our guideline topic selection criteria, our grading system, and discuss the two products developed by ACP i.e. Clinical Practice Guidelines and Clinical Guidance Statements; the former involving primary systematic review and the latter involving assessing available guidelines on various topics utilizing the AGREE instrument and ACP’s guideline evaluation criteria. We will describe the process behind the systematic literature reviews that follow a strict protocol for article assessment using standardized scoring techniques. For the ACP’s guidance statements, each guideline is evaluated and scored followed by a summary statement. Both the background evidence review paper and the guideline undergo a lengthy and thorough review process (internal and external) at ACP.
P51
Guidelines for Diagnostic Imaging: the Issues

Reed MH, Canadian Association of Radiologists

The utilization of diagnostic imaging (DI) is increasing rapidly in many countries, and there is growing concern that a significant number of DI studies are not contributing to the management of patients. These inappropriate studies often subject patients to unnecessary radiation and they add further strain to the already strained resources of many health care systems. In response to this situation several radiological associations, including the Royal College of Radiologists, the American College of Radiology and the Canadian Association of Radiologists, have developed guidelines for DI.

However, there are difficulties in developing guidelines for DI, and currently there are three important issues related to their development:

1. Difficulties in finding the evidence for evidence-based guidelines for DI.
2. Fostering interspecialty collaboration which is essential for the development of DI guidelines.
3. The development of two separate streams of DI guidelines: DI incorporated into clinical practice guidelines and DI guidelines produced by radiological societies.

This poster will summarize the present state of DI guidelines and discuss these issues.
P52
Including Organisation of Care within Clinical Practice Guidelines: the Example of the Management of Sudden Unexpected Death in Infancy


Background: Clinical practice guidelines may be concerned not only with medical issues but also with the organisation of care. This is because of the multidisciplinary nature of medical management and because of legal and institutional regulations. An example is the management of sudden unexpected death in infancy which often has many shortcomings in France and which has to take place within the legal framework established in 1986.

Purpose: To adapt our method of producing clinical practice guidelines to cover organisation of care.

Methods: A working group of experts on sudden infant death, together with members of HAS staff, identified current ways of organising care and current needs in terms of organisation of care. They then developed a method that would provide answers to the organisational issues raised and improve implementation.

Results: The addition of the following items to the current method of guideline production was considered necessary: (i) an analysis of the results of a national epidemiological survey (2005) relating to professional practices in cases of sudden infant death; (ii) the participation of a foreign (Canadian) expert to assess whether lessons learnt abroad could be transposed to France; (iii) a search for documents published by public bodies or by associations (legal documents, government reports, documents retrieved from national databases or produced by patient associations, practice surveys, etc); (iv) the inclusion of professionals other than health professionals in the working group (legal experts, local government representatives, undertakers, grief support groups) and patients´ representatives; (v) the setting up of a study to assess the feasibility and acceptance of the method.

Discussion: Implementation of the proposed changes to the method of guideline production led to the development of a detailed management protocol intended for all the professionals concerned, which met the requirements of the law and of national clinical practice.
P53
Developing Guidance in a Highly Contested and Evidence Limited Area: the NICE Prophylaxis Against Infective Endocarditis Short Clinical Guideline

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Background: Infective endocarditis (IE) is a rare condition with considerable mortality and morbidity. It has been accepted clinical practice to use antibiotic prophylaxis before dental or other interventional procedures in those with cardiac conditions considered to be at risk of developing IE. This practice has been increasingly questioned notably in the context of the efficacy of antibiotic prophylaxis, the safety of antibiotic use and concerns about increasing levels of antibiotic resistant organisms. The NICE short clinical guideline on prophylaxis against IE was published in March 2008.

Purpose: To describe how the guideline was completed and recommendations were developed in this area of limited evidence where health professional groups held divergent views.

Methods: The NICE short clinical guideline development process was followed. This included the development of a new health economic model of prophylaxis before dental procedures.

Results: The methodological issues encountered during the development of this clinical guideline will be presented. These include using observational studies to assess clinical effectiveness, the impact of using health economic modelling to set out the benefits and harms of antibiotic prophylaxis and the way in which Guideline Development Group consensus was achieved.

Discussion: Areas where there is limited clinical evidence and widely divergent professional views pose challenges to guideline developers. This will highlight the steps that need to be undertaken by developers when undertaking the planning and development of such guidance.
P54
How to Introduce Gender Perspective in the CPG´s Evaluation and Elaboration


Introduction: Already in the 19th century, it was recognized differences in health status between rich and poor people, and its interaction with other factors as ethnics. However, only recently, Health Sciences considered the inequities based on gender discrimination. Making concepts from Difference, Inequity and Discrimination due to gender, moved the interest towards a wider focus and got the name of “gender perspective”. This point of view can improve the research methodology and it could elude gender bias in the data analysis as well as in the CPG elaboration.

Objective:
To develop an instrument for detecting gender bias in the CPGs and other tools based on scientific evidence.

Methodology:
1. Systematic search of criteria made to identify gender bias in biomedicine and related areas
2. Creation of a criteria list and depuration of a draft, including aspects of gender in the language uses
3. Integrating a Model: Bias Free Framework of Eichler M and Burke MA that was developed to identify and elude bias in health research which can flow from any social hierarchy: social class, ethnics, age, sexual orientation, income and handicap/health status. The model considers three bias sources: a) maintenance of the existing hierarchy, b) failure in the examination of the existing differences and c) the use of double standards keeping the differences
4. Pilot test on 4 CPGs, to identify overlaps and ambiguities for improving the clarity of the instrument

Results: A list of questions are proposed to allow identifying gender problems in each phase of the CPG: Participation on the elaboration, Scope and Objectives, Clinical questions and methodological rigour (evidence search, critical appraisal) including values and preferences when making recommendations.
P55
Improving Access to and Implementation of Evidence Based Guidance Through Electronic Systems


Background: Clinicians and other users should be able to directly access the information they need from NICE guidance via the NICE website and third party sources.

The aims of the electronic guidance access project (EGAP) are to:

• produce NICE guidance in a format that can be used by the NICE website and external information systems
• evaluate the impact on the NICE guidance development process

Purpose: EGAP is exploring how to provide our guidance information in smaller ‘knowledge nuggets’ that are arranged and indexed in a way that makes active dissemination easier.

Methods: EGAP has:

• assessed needs of users and third party information suppliers
• investigated technologies for defining guideline information, for authoring guidance and for disseminating content
• developed a mechanism for producing and coding guidelines electronically using templates
• user tested prototype authoring tools and new dissemination methods
• evaluated the impact on the guidance development processes and usefulness of the prototypes

Results: A variety of users expressed broadly similar needs, including:

• searching for particular sections of NICE content
• "drill down" or linking between content
• extracting user defined content.

EGAP has:

• developed an XML schema that describes NICE guidance
• developed Word 2007 to capture guideline content in accordance with this schema and created indexing tools
• imported content and indexing data from the template into a pilot website
• allowed recommendation, evidence and considerations to be searched for and accessed via an online document viewer or syndicated to third party information providers.

Discussion: EGAP suggests that a greater role could be performed by information authoring agencies such as NICE in the active dissemination and syndication of content. The impact of these developments in terms of improved uptake or adherence to guidance recommendations has yet to be proved.
P56
Many Voices, One Song – The Fine Art of Collaboration in Guideline Adaptation


Background: Stakeholder buy-in is essential for implementing and disseminating guidelines, particularly for those adapted from pre-existing guidelines. A unique collaborative process was established to ensure that all stakeholders had a voice in the guideline adaptation process.

Purpose: To unify the message received by low back pain patients, the Alberta Health Technology Assessment (HTA) Chronic Pain Ambassador Program constructed a single evidence-based provincial guideline for physicians that could be used by all professionals in community practice.

Methods: An Advisory Committee (provided oversight), a Working Committee (WC; constructed the guidelines), and a Research Team (RT; provided 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 WC drafted Alberta-specific guidelines from seven seed guidelines in a series of 10 half-day videoconferences that ensured maximum Health Region participation. Alliances were formed with relevant provincial professional associations and clinical practice guideline programs to endorse, promote, and disseminate the nascent guideline.

Results: The RT worked with the WC to ensure that an appropriate balance was struck between methodological rigour and clinical relevance in the final guideline. Establishing a multidisciplinary WC to construct the guidelines guaranteed buy-in and cooperation among the various clinical disciplines. Care was taken to ensure that the guideline development process was rigorous enough to meet the standards of provincial professional organisations and guideline programs whose endorsement was formally sought toward the end of the process.

Discussion: The innovative use of seed guidelines expedited the development process and kept busy clinicians actively engaged. Multidisciplinary ownership of the final guideline was achieved by making it overarching and relevant to each of the community practice disciplines. Seeking input from professional organisations and guideline programs near the end of the process gave credibility to the final product with minimal bureaucratic interference.
P57
Implementation of Osteoarthritis Guidelines by Rohto Workshops

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Background: To implement national and regional guidelines of osteoarthritis in Kymenlaakso area the Hospital District and The Centre for Pharmacotherapy Development Rohto planned and performed a collaborative project. The Hospital District covers three hospitals and eight Primary Health Care Centres serving population of 179,200. The synergy to other development projects was assured.

Purpose: To explore the problems in the process of care, to test and evaluate methods of guideline implementation.

Methods: A baseline evaluation was performed by a web-based structured questionnaire, and is to be repeated in April 2008. Eight workshops were organized. Participant feedback was collected from all workshops.

Results: In the baseline evaluation the response rate was 61% (56 GPs, 40 physiotherapists), and
• 33% stated that the division of labour in the primary health care was unclear
• 38% of GPs and 15% of physiotherapists thought that the model for rehabilitation was unclear
• 78% recognized a need to clarify the co-operation between secondary and primary care
• All GPs reported in a structured question that drug therapy is clear. However, 77% of GPs reported numerous problems in an open-ended question.

There were 122 participants in the workshops, and 93% of them gave feedback after the workshops. Almost all of responders (94%) regarded the theme of osteoarthritis as interesting, and 60% stated a need to change their clinical practices. Local house rules were developed in five health centres.

Discussion: Baseline evaluation revealed problems in care, and professionals could be recruited to improve practices. Workshops resulted in mutually agreed house rules as local modifications of guidelines seeking wide commitment to new practices. After the workshops most professionals reported a need to change their own practices. This is shown to predict real changes. The after intervention evaluation will be reported later.
P58
Facilitating Implementation Planning by a Competition


Background: The Evidence Based Current Care Guidelines are implemented in Kymenlaakso Hospital District by producing regionally adapted clinical pathways supported by a regional coordinator (LS).

A competition to health professionals was declared at the beginning of 2007 to catalyze implementation activities. Health professionals were invited by an email to make a plan for implementation of any of the 24 existing regional clinical pathways. The elements needed for implementation were defined earlier in a regional seminar based on scientific literature.

Purpose: To test competition as an implementation planning method.

Methods: Qualitative analysis of the implementation plans according to pre-defined elements.

Results: Seven competing plans were analysed. No plan included all the elements, but all defined the aims and the target group. Prevalence of pre-defined elements in brackets:

- a local plan for information and marketing the regional clinical pathways (0/7)
- definition of need to implement the selected clinical pathway (5/7)
- definition of the aims for implementation (7/7)
- definition of the target group (7/7)
- defined implementation methods (e.g. workshops, lectures) (6/7)
- timetable (5/7)
- responsibilities of actors (5/7)
- evaluation plan (4/7)

Discussion: Successful implementation is a complex process and new approaches are needed. The competition facilitated by a regional implementation coordinator enhanced planning of implementation. The results reveal how the health professionals need competence development and guidance in planning effective implementation. Regional implementation coordinator as a consultant may be valuable. Interventions with a bit of humour may be needed in distributing the state of art in implementation.
P59
Improving Coordination of Polypharmacy by Series of Workshops, Evaluation and Feedback

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Background and purpose: Uncoordinated polypharmacy and unsystematic recording of medication are frequent problems in pharmacotherapy. The Centre for Pharmacotherapy Development ROHTO has built up a network of local facilitators who use interactive workshops to improve clinical practices. To improve coordination of polypharmacy a project was launched at seven health care stations in Helsinki, Finland. Our purpose here is to describe and evaluate the project.

Methods: The intervention consists of a series of three workshops, evaluation and feedback. The workshops deal with recording, interactions, assessment of medication, and reduction of medication.

The before-after evaluation contains 1. a questionnaire surveying participants’ opinions, attitudes and experiences, 2. auditing of patient charts, and 3. data from national Prescription Register. Feedback of the results is delivered to the participants in workshops and in staff meetings.

Results: Respond rate to the baseline questionnaire was 61%. Two thirds (64%) reported that the main problem in pharmacotherapy was lack of responsibility. Only 26% reported that there was an agreement on division of tasks, and 61% for recording of medication data.

In the 15 workshops there were 277 participants, of which 237 (86%) gave feedback. The topic was interesting for 217 (92%), and for 200 (75.5%) the workshop was useful. Due to the workshops 141 participants reported an intention to change their clinical practices. There is a detailed evaluation plan and the after intervention results will be reported later.

Discussion: The baseline questionnaire revealed many problems in pharmacotherapy. To solve these problems we combine evidence-based implementation methods: goal oriented and participant-centred workshops, evaluation, and feedback. The workshops proved to be useful and participants reported a high rate of need to change their own practices. The change in clinical practices will be measured by questionnaire and auditing.
P60 Evaluation of an Innovative Approach to Developing Multidisciplinary Guidelines

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Background: Recently, a new program for multidisciplinary guideline development was established in the Netherlands. The program encourages innovative approaches to involve a wide variety of professionals and other important stakeholders, such as patients, health insurers, occupational physicians, epidemiologists, and experts in budget impact analysis. In addition, the total duration of the guideline development project was restricted to a maximum of 12 months. The program started in 2007 with three pilot projects.

Purposes:
1. To evaluate the process of guideline development, including the experiences of participants (process evaluation)
2. To evaluate the methodological quality of the guidelines (outcome evaluation)

Methods: Information on the projects was gathered by participatory observation of the group meetings, by extracting data from the project proposals and minutes of meetings, and by interviews with project leaders. After the project, all participants received a structured questionnaire, including the perceived factors related to success or failure.

The methodological quality of the guidelines was assessed using the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument. Three researchers independently rated the quality of the guidelines.

Results: The guidelines covered Parkinson disease, heart failure, depression and anxiety disorders. One of the main findings was that a 12-month period appeared to be too short for the development of high-quality guidelines. Setting up the working group took 3-4 months, which reduced the time for summarizing the evidence and formulation of recommendations. The funding body was asked to allow for prolongation of all three guideline projects. In October 2008, further results will be available.

Discussion: Important lessons for future guideline development initiatives can be drawn from these pilot projects. For instance, this evaluation provides information on both the feasibility to produce guidelines within a limited time period and the utility of innovative tools for guideline development (for example, a virtual work environment).
Quality of Care for Primary Care Patients with Depression and Anxiety

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Background: The lifetime prevalence of all depressive disorders in the community among adults in the Netherlands was 19.0% while the lifetime prevalence of all anxiety disorders was 19.3%. Their effects on well being and daily functioning are large and comparable to those of major chronic physical illnesses. In economic terms, their cost ranks among the top-five of all disorders. Consequently, depressive and anxiety disorders are relevant candidates for efforts to improve public health.

Purposes:
1. To assess the degree of appropriate care (adequate diagnosis and treatment), delivered by general practitioners to patients with depression and anxiety;
2. To identify factors (on the level of patient, provider and practice organisation) obstructing the delivery of appropriate care.

Methods/Results: Using a modified Delphi-procedure, we developed a set of 12 indicators measuring the quality of care for depression and anxiety. The indicators were based on key recommendations from the national clinical depression and anxiety guidelines issued by the Dutch College of General Practitioners. Actual care delivery was derived from the computerized medical record system and the Perceived Need for Care Questionnaire. Determinants were measured with self-administered questionnaires. It was possible to assess both the appropriateness of care and the variation in general practices in this respect. Furthermore, it was possible to measure which factors influenced this variation.

Our study included 1 610 patients within primary care; 743 had a current depression or anxiety disorder. Those patients were recruited from 21 general practices (65 general practitioners).

Data have been collected from Augustus 2003 to February 2008. In October 2008, results will be available for presentation.

Discussion: It’s too early to draw conclusions, but examination of quality of actual health care delivery and its determinants is a prerequisite for the development of specific interventions, which aim to increase appropriate care and thus optimise care.
P62
Implementation of Pulmonary Tuberculosis Clinical Guideline in a Primary Care Health Service

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Background: The dissemination of tuberculosis (TB) is closely linked to the living conditions of the population. It is estimated that between 100,000 and 129,000 cases per year occur in Brazil. The average incidence coefficient of TB in Porto Alegre is 100/100,000.

Purpose: To provide the tools to Primary Health Care (PHC) providers of the Serviço de Saúde Comunitária (SSC) to accomplish the screening, the diagnosis, the front line treatment, the follow up, and the referral of the cases.

Methods: The actions to control TB were expanded to 12 Health Care Units (HCU) of the SSC. The annual goal of the Service is to identify and follow up 80% of the expected cases of TB. There were strategies applied for implementation of the guideline, such as definition of indicators for evaluation.

Results: In 2006, 62% of the TB cases were identified, being 66% reported by the hospital, and 34% by the HCU. The SSC treated and followed up 30% of these cases. In September of 2007, the actions of control of TB were expanded to all HCU, and 75% of the cases were identified, being that 50% were reported by the hospital and 50% by the HCU. The SSC treated and followed up 42% of these cases. After the implementation of the guideline there was an improvement in the indicators of the Program, and in 4 months there was a decrease of 16% in the diagnosis of the cases of TB by the hospital, and an increase of 12% in the cases treated and followed up by the HCU.

Discussion: The health care improvement is linked to the implementation of the guideline.
P63
National Guidelines as Part of a Cancer Disease Management Programme in Norway


Background: Cancer is a national challenge in Norway. The primary goal of the Norwegian National Cancer Strategy (2006–2009) is to meet the cancer challenge in a proactive and holistic manner by facilitating improved treatment quality, adequate capacity and equal access, appropriate organization, and improved cooperation.

Purpose: As part of the Cancer Strategy the Norwegian Directorate of Health (NDH) initiated a project which main goal is to develop national guidelines for cancer diagnosis, treatment and medical rehabilitation, and to establish a system for updating the guidelines by rapid evaluation and introduction of new expensive methods with documented effect.

Methods: The recommendations for diagnosis and treatment developed by professionals in the specialist health care were reviewed, revised, and updated using systematic reviews as the basis for developing National guidelines. The guidelines were developed, in accordance with the Agree-instrument, by professional groups (multidisciplinary), with support from the Norwegian Knowledge Centre for the Health Services (NKC) and the NDH. External reviews and hearings, including relevant stakeholders, were carried out as part the process.

Results: Six National guidelines for diagnosis, treatment and medical rehabilitation have been developed, including one guideline for palliative treatment. Work has been started on six more guidelines. Due to introduction of new expensive drugs the guideline for breastcancer is being revised. Work has also been started to develop recommendations for general practice, nursing, and physiotherapy, supplementing the National guidelines.

Discussion: The new structure of collaboration, between NDH, professional groups and NKC for developing and updating National guidelines, is a strategy for improving cancer disease management in Norway. The system facilitates the use of best evidence for decisions at different levels, it supports treatment of high quality, and reduces variation in treatment offered to patients with the same cancer disease.
P64
Health Education in the Maternity Health Centres
– Client´s, Service System´s and Education Organization´s
Point of View

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Background: In Finland, maternity health clinics (MHC) are important health promotion places, and practically all pregnant women use the services. The demands of the MHC work are increasing. The professionals should possess qualifications to detect psychosocial problems. The need for counselling and support should be assessed by the public health nurse with the family. After the assessment the visits should be arranged according to the special needs. This requires the evaluation of working methods in MHC services and remarkable reform for education institutions.

Purpose: The study clarifies how pregnant women experience the health education in MHCs in normal and risk pregnancies. The risk bases on the pregnant woman´s own evaluation. The risk seen by the public health nurse and the resources needed to support the pregnant woman´s health promotion ideally are also clarified. We also study how the education system is able to respond to those challenges coming up from society and from nurses’ everyday work, as well as how the syllabuses and practical methods of teaching corresponds the methods and ideology of health education.

Methods: Data is based on a quantitative survey and qualitative theme interviews of pregnant women and public health nurses. The interviews and collection of background information will start in autumn 2008. The survey information will be analyzed with quantitative methods. The theme interviews, syllabuses and teaching methods will be analyzed with qualitative methods.

Conclusions: The results of the study are expected to point out the black spot in the individual health education. They are as well expected to help in creating the ideal model of health education in maternity health centres and improve the education system.
P65
Involving Patients and Carers in NICE Clinical Guidelines – an Evaluation Study

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Background: The UK National Institute for Health and Clinical Excellence (NICE) routinely involves at least 2 patients and/or carers as members of the groups it convenes to develop its topic-specific clinical guidelines. The patient/carer members are supported by the group chairs, technical staff and by NICE’s Patient and Public Involvement Programme (PPIP). An evaluation study is currently underway looking at patients and carers experiences of being involved in these groups.

Purpose: The purpose of the study is to identify what does and does not work well in terms of individuals’ experiences and the support they need to fulfil their role as lay members of the group, with a view to identifying improvements.

Method: The study is being carried out via a confidential questionnaire, asking both qualitative and quantitative questions. Participants have been selected from groups which developed guidelines for NICE, and which were published between 2005 and 2007. The participants include the patient/carer members of the groups (n=91), and the group chairs (n=40). The participants have also been asked to provide information about their age, gender, disability status, education and ethnicity.

Results: At the time of writing the study is in the data collection phase. Initial results should be available during summer 2008, and the study will be finalised by the end of September 2008. The demographic data will be analysed first, followed by the quantitative, then the qualitative.

Discussion: The study should reveal interesting data of both a quantitative and qualitative nature, reflecting people’s experiences as lay members of these groups. It should also offer some insight into health professionals’ experiences of chairing guideline groups which comprise patients and carers. Both strands of the study should offer the opportunity to develop recommendations for improving patients’ and carers’ experiences of involvement in guideline development, and the support offered to them.
P66
Are Cochrane Systematic Reviews Being Used in National Clinical Practice Guidelines for Chronic Kidney Disease?

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Background: Ideally clinical practice guidelines (CPGs) should be based on high quality evidence such as Cochrane reviews. However, there is concern that only few reviews are used to support guideline recommendations.

Purpose: To estimate the proportion of Australian-New Zealand Guidelines for Chronic Kidney Disease (CKD) supported by Cochrane reviews and identify strategies for improving the contribution Cochrane reviews can make to guidelines.

Methods: All CPGs (2004–2007) produced by the Caring for Australasians with Renal Impairment (CARI) were reviewed. We assessed the guidelines for the following: 1) Was a Cochrane or non-Cochrane review used? 2) Did guideline recommendations concur with Cochrane recommendations? 3) Were relevant Cochrane reviews available not used in the guideline, if so what were the reasons?

Results: We identified 131 CARI guidelines for CKD. Of the 30 guidelines which cited systematic review evidence, 17 cited Cochrane reviews. Ten guideline recommendations were consistent with Cochrane recommendations. One guideline recommendation offered a different recommendation to the review. The guideline author stated that one large, well-designed RCT was not included in the review. The remaining 6 guidelines cited outdated reviews, of which 5 reviews have since been updated after the guidelines were published. Cochrane reviews were not cited in 114 (87.0%) guidelines for 4 reasons: no reviews were available on the guideline topic (64/131), the guideline did not address an intervention question (28/131), the guideline was written before the review was published (21/131) and the guideline did not cite the review (1/131).

Discussion: Less than 25% of CARI guideline recommendations were supported by systematic reviews. No relevant Cochrane reviews existed for 70% of guidelines and less than 1% was due to non-citing of a published review. If reviews are to inform guidelines, we need a more comprehensive range of reviews on interventions and develop reviews of non-intervention topics including diagnostic tests.
P67
Implementation and Knowledge Translation in Improving Clinical Practices

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Short description of workshop
The workshop is a combination of a mini-lecture, interactive and participant centred components. It will provide the participants an overview of
• what are clinical gaps? Why so they exist? How can we close them? (Interactive lecture by D Davis)
• hierarchy of actions needed in implementation : an example of a national implementation strategy (Interactive presentation by Rohto-team)
• potential innovations to be applied in their own settings (participant centred brainstorming lead by the facilitators)
• take home messages (wrap up by D Davis)

The participants will have opportunity to introduce themselves and their own implementation projects.

Outcome of the workshop will be: Reservoir of practical implementation models to be applied in participants own settings, developed by specialists in GIN 2008.

Main goals of the workshop
1. to network international implementators
2. to promote understanding the concepts and actions of implementation
3. to provide forum for changing ideas and experiences

Target groups
• Clinicians
• Guideline producers
• Policymakers
• Implementators
P68
Patient Safety in Acute Hospital.
Finnish Nurses’ and Nurses Managers´ Opinions

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Patient safety is the key principle in the work of health professionals. It is, however, well known that errors occur and there is need to develop procedures and systems to prevent errors and to ensure the safety and high quality care.

The purpose of this study was to find out what kind of opinions do Finnish nurses and nurse managers have related to error prevention and are there differences between the two groups.

The data were collected in four Finnish acute hospitals at the beginning of 2008 using the Hospital Survey on the Patient Safety Culture scale developed by Sorra and Nieva (AHRQ) and analysed statistically. The respondents were registered nurses (N=723) and nurse managers (N=109). Most of them were women (89%) and they had over 6 years experience in the current occupation (78%), in the same hospital (71%) and in the same unit (55%).

Majority of the nurse managers (89%) and rather many of the nurses (69%) agreed with the item “we are actively doing things to improve patient safety” (p=.000). However, 33% of nurse managers and 27% of nurses disagreed with the item “our procedures and systems are good at preventing errors from happening” (p=.003). More nurses (38%) than nurse managers (25%) felt that “it is just by chance that more serious mistakes don’t happen in the unit” (p=.020). Many of the nurse managers (74%) assessed that “in this unit, we discuss ways to prevent errors from happening again” while less nurses (51%) thought so (p=.000).

Nurse managers’ and nurses´ opinions concerning patient safety and error prevention differed in many issues. The results of the study will be shared with the hospital staff to find out reasons for different views and to further develop procedures and practices to guarantee the safety of patients.
P69
Development of Valid Quality Indicators to Improve Care in Recurrent Miscarriage

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Background: Recurrent miscarriage (RM) is a complex clinical problem, concerning a heterogeneous group of patients. To guide evidence-based clinical practice in RM, several national and international guidelines have been published. However, development and dissemination of evidence based guidelines alone has proved to be insufficient to achieve adherence. Quality indicators are a necessary instrument to measure guideline adherence.

Purpose: This study aimed 1) to develop a set of quality indicators for the Dutch guideline on RM (2007); 2) to explore the relationship between evidence-level of guideline recommendations and their percentage of acceptance as quality indicator; and 3) to explore the potential of the indicatorset for international use.

Methods: The RAND-modified Delphi method was used to develop the indicatorset from the Dutch guideline on RM. Opinions of 15 gynaecologists were used to appraise, rank and select the recommendations. For all guideline recommendations was recorded, per evidence-level, the percentage of acceptance as an indicator. Furthermore, recommendations that formed the base of the indicatorset were compared to those in the ESHRE guideline on RM.

Results: Consensus on a representative set of 23 key recommendations out of 39 guideline recommendations was obtained within one questionnaire round. The degree of acceptance declined with a decrease of evidence-level, except for evidence-level D. All recommendations of evidence-level A and D were accepted as indicators, while 64% of level B and 22% of level C was accepted. Thirteen indicators (57%) are directly applicable for the ESHRE guideline on RM, while six indicators (26%) were based on similar subjects but the content differed from the Dutch guideline. Four (17%) indicators were not mentioned in the ESHRE guideline.

Conclusion: The developed set of process indicators can be used to measure, monitor and improve care delivered to patients with RM. The majority of the indicatorset has a potential for international use.
P70
The Effectiveness of a Decision Aid and Additional Reimbursement Offer to Stimulate the Use of Elective Single Embryo Transfer in In Vitro Fertilisation

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Introduction: For clinicians and subfertile couples undergoing in vitro fertilisation (IVF), the decision for the number of embryos for transfer is an important issue. The transfer of only one embryo, elective single embryo transfer (eSET), prevents twin pregnancies and the associated higher risks for mother and children. However, eSET could also reduce the pregnancy rate of IVF. It is therefore not surprising that eSET has not disseminated easily in clinical practice. Previous studies suggested lack of knowledge of couples about eSET consequences and presence of a financial incentive against eSET as barriers for eSET use.

Purpose: The aim of this study is to determine the effectiveness of a patient decision aid and reimbursement offer on the eSET use of couples at risk for twin pregnancies.

Materials and Methods: We performed a multi-centred randomized controlled trial among couples at risk for a twin pregnancy (couples with a minimum of two embryos with at least one embryo of good quality available for transfer). The control group received usual care. The intervention group received an evidence-based decision aid (designed according to the International Patient Decision Aid Standards) with the opportunity to discuss its content with a research nurse and an offer for reimbursement of an extra IVF cycle.

Results: A total of 149 couples were identified as at risk for a twin. In the intervention group 63% of the couples chose eSET and 37% transferred two embryos. In the control group these percentages were 51% and 49% respectively (P=0.12). Couples in the intervention group scored significantly better on a knowledge test (P<0.01).

Conclusions: This study demonstrates that a decision aid significantly improves knowledge about twin related risks and eSET aspects. No significant difference in eSET use was identified, but a promising trend was observed among couples at risk for a twin pregnancy.
P71
Costs of an Adapted Breast Cancer Guideline

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Background: Guideline adaptation is promoted as an approach to improve efficiency in guideline development. However, cost implications of using this approach are still unclear at present.

Purpose: To calculate the used resources in terms of time and costs for the development of a Belgian breast cancer guideline using the guideline adaptation approach at the Belgian Healthcare Knowledge Centre (KCE).

Methods: Working hours and costs of the internal experts (methodologists) were recorded in an administrative database, as were the duration and costs of the expert group meetings. Volunteer time spent by external experts was estimated using documentation and email messages related to this project. A hypothetical overhead rate of 10% was used to estimate total overhead costs (volunteer time excluded).

Results: The guideline development group consisted of 2 methodologists, 10 clinical experts and 1 administrator, and met on 3 occasions. Fifteen other clinicians served as external experts (1 additional meeting), three clinicians validated the guideline (1 additional meeting).

Total costs amounted € 62,281, including € 56,881 for internal experts and € 5,400 for external experts (including € 1,500 for validation). In total, 825 hours were spent, of which 95 hours were volunteer time. If all external experts were paid as an internal expert (€ 88,88 per hour), total costs would have been € 73,323 (including volunteer time).

Discussion: Little information is available in the literature on the costs and duration of guideline development. However, guideline development costs of CoCanCPG partners (www.cocancpg.eu) ranged from € 4,000 to € 450,000 (unpublished data).

Conclusion: Guideline adaptation is a relatively efficient approach for developing guidelines.
P72
Different Target Groups One Methodology:
Health Information Based on Breast Cancer
Guidelines from Screening to Follow-up

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Background: The medical societies in Germany develop evidence based guidelines for early diagnosis of diseases as well as for symptomatic diseases. Doctors and patients are to be supported in specific decisions concerning adequate diagnostic or therapeutic interventions. Therefore part of these systematically developed guidelines is information for laypersons, which is prepared in cooperation with patients.

Purpose: Healthy women addressed by breast cancer screening programmes and women with different stages of cancer will need different decision aids and a different approach for providing information about the disease and about therapeutic options. Specific decision aids, health information and lay guidelines shall be developed for healthy women as well as for women who are breast cancer patients. The guideline based information for early diagnosis of breast cancer constitutes the first available lay information for healthy persons.

Methods: The health information and the patient guideline are based on the evidence based guidelines 'early diagnosis of breast cancer' and 'diagnostic, therapy and follow up of breast cancer'. The methodology considers requests of the following position papers: (1) Methods of patient participation and preparation of patient guidelines for national disease management guidelines, (2) guideline for information of women, developed by patients and consumer organizations in cooperation with medical societies, (3) exemplary education for early diagnosis of diseases by the German self-government bodies. The process of developing involves from the very first representatives of the target groups, patients and consumer organizations as well as women’s health organizations.

Discussion: Patient guideline and health information focus on different target groups with different needs of information. The program for national disease management guidelines developed a method for patient guidelines emphasizing participation of patients. The example ‘early diagnosis of breast cancer’ is indicative of the usefulness of this method for other guidelines and even information of healthy people.
P73
“Less is MORE”: Delivering the Irritable Bowel Syndrome
guideline on one side of A4!

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Nursing

Background: The National Collaborating Centre for Nursing and Supportive Care is com-
missioned by NICE to produce evidence based guidance for the NHS. Hosted by the Royal
College of Nursing, it is committed to quality improvement work. In 2005, agreement was
reached that member funding should be redirected from College clinical guideline develop-
ment to focussed creative implementation activity.

Purpose: Organisational learning over the last seven years informs the content of this pres-
entation, which demonstrates the creativity and innovation relating to both the synthesis and
interpretation of evidence in guideline development, and the importance of thinking early
about the challenges relating to implementation.

Methods: “Less is MORE”, uses the Irritable Bowel Syndrome guideline published in February
2008 to demonstrate, the emerging trends from within the NCC-NSC, in developing Guideline
Development Group (GDG) members understanding and awareness of how to maximise the
guideline impact on changing clinician behaviour and improving patient outcomes. Standard
NICE guideline development methodology was used, with both clinical and cost effectiveness
informing recommendations.

Results: The search strategy relating to clinical questions generated the following:
• Sifted titles: 39 565 references (not all unique items, approx 25 000 which was
  an underestimate when preparing the guideline scope by 10 000)
• Ordered papers: 1400 papers critically appraised
• Included papers supporting the reviews: 230 papers

Discussion: The full guideline has only 25 recommendations covering the whole patient
pathway, presented in algorithm format. This includes key messages for clinicians and patients
on diagnosis; red flags; lifestyle and diet; drug therapy; symptom management and referral.
Key aspects to achieving this synthesis of evidence are senior clinical and technical team
input across critical stages of development, continuing development of a bespoke data base
that we believe really brings added value and early development of GDG member ‘EBHC’
knowledge and understanding, supported by the use of GRADE.
Objective: Atopic dermatitis (AD) is a chronic inflammatory disorder of the skin characterized by three or more of the following features: pruritus, distribution of typical exanthema during any course of chronic recurrence, and atopic predisposition. Nowadays AD shows increasing prevalence and has rising financial costs in many countries. Although AD is a common condition, there are no entirely satisfactory treatments. Conservative treatments are frequently insufficient or impractical. Corticosteroids, although frequently effective, cannot be used continuously because of significant adverse effects. Newer modalities, such as oral cyclosporine, are effective but likewise limited by adverse effects. And the number of patients requiring other therapeutic methods have also increased.

To observe the efficacy and safety of CheungYeolYiSeup-tang and Hwangbaek external dressings on damp-heat type atopic dermatitis in a non-comparative study.

Methods: 10 patients with AD were included for 4 weeks of treatment. Efficacy and safety assessment included the scoring atopic dermatitis index (SCORAD), typical signs and symptoms of AD, results of some laboratory tests related to toxicity, and the incidence of adverse events.

Results: Improvements in efficacy parameters were observed and produced no significant changes in laboratory tests related to toxicity in these patients. Their SCORAD results significantly decreased after 4 weeks (P value<.01, according to the Wilcoxon sum of ranks test).

Similarly, significant reductions from baseline in subjective pruritus scores and (P value <.05, by the Wilcoxon sum of ranks test) and the mean average of individual signs and symptoms of AD were reported after 4 weeks (P value<.05, P<0.01, P<0.001 by the Wilcoxon sum of ranks test).

There were no significant changes in eosinophil, neutrophil, lymphocyte, Immunoglobulin E and ESR in blood serum(by paired t test).

Conclusion: CheungYeolYiSeup-tang administration and Hwangbaek external dressings are an effective and safe treatment for the management of damp-heat type atopic dermatitis (AD).
"The management of Influenza Like Illness"
Clinical Practice Guideline: the First Phase of the Implementation Strategy

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**Background:** Influenza and influenza like illness (ILI) epidemics represent a relevant health care problem in terms of negative impact on the resources of the National Health Systems and on the patient management. During the so-called influenza season a high number of prescriptions/consumption of drugs as well as an increased rate of hospital admission are registered in Italy.

**Purpose:** The "Management of influenza like illness" Clinical Practice Guideline (CPG) was released and the first phase of an implementation strategy (IS) of that CPG was also designed by the Italian Ministry of Health (IMH–SNLG–March 2008/ www.snlg–iss.it) with the purpose to reduce the inappropriate prescription/consumption of drugs and inappropriate hospitalizations as well.

**Methods:** The first phase of IS has two main strands of actions depending on the target audience: the realization of courses for clinicians and the designing of the CPG dissemination plan for citizens. 

Selected from the Guideline Development Group (GDG), a small multidisciplinary group was involved to realize clinicians courses. The technological partner prepared e-learning courses. Scientific journalists projected a dissemination plan of the CPG-citizen version through mass-media.

**Results:** Recommendations focus on medication (efficacy/safety of antivirals, antibiotics, antipyretics/NSAIDs, complementary medicine). Hospitalisation standard criteria for adult and child were also developed by GDG. On these bases small scale in-house and e-learning courses – i.e. educational pathways on ILI clinical scenarios – were prepared. A press campaign will be in October.

**Discussion:** The IS first phase drawing on the previous experience of implementation of ILI recommendation, which demonstrated that information/education activities are effective per se (De Marco G. Pediatrics, 2005). Furthermore building education/information activities on this topic is an important feature of the IS because is functional to prepare a supportive cultural environment for the audit cycle.
P76
Integration of Work-related Aspects in Clinical Practice Guidelines

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Background: Work in a healthy and safe environment, can promote health and help to recover from illness. Most guidelines do not deal with work-related aspects. In 2004, the NVAB and CBO published an outline ("Blueprint") on how to integrate work-related aspects into multidisciplinary clinical practice guidelines.

Purpose: To evaluate experiences of participants in guideline development and to review the results of attention for work-related aspects in guidelines.

Methods: Focus group meeting and interviews with occupational physicians and insurance physicians, interviews with chairs of development groups, and review of guidelines.

Results: Information from 11 occupational and insurance physicians, and 6 chairs was received. In one third of the cases, no clinical questions about work and health were formulated. Other participants in the guideline groups were often not well-informed about the tasks of occupational and insurance physicians. Many participants mentioned a low level of evidence on work-related interventions as a problem. Still the majority was positive about the results.

From 9 out of 13 guidelines, in which occupational and/or insurance physicians participated, clinical questions on work could be derived. This resulted in a separate chapter about health and work. In all guidelines, the major topics of the above-mentioned Blueprint were captured. 70% of the evidence for the work-related recommendations was based on level 2–3.

Discussion: In preparing a guideline, attention for work-related aspects should be well-considered. The recently improved Blueprint provides important guidance. High-level evidence on effectiveness of many work-related interventions is often lacking but the activities of the Cochrane Occupational Health Field are promising. Integration of work related aspects in guidelines may play an important role in bridging the gap between general health care and occupational health.
P77
A New DELBI Domain for Quality Assessment of Adapted Guidelines

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Background: Both internationally and in Germany, an increasing number of adapted guidelines is derived from pre-existing guidelines. The process of adaptation differs considerably from the de novo development of guidelines and so far there are no existing quality criteria for the special features of adapted guidelines. The German Instrument for Methodological Guidelines Appraisal (DELBI) was developed by a multidisciplinary group of experts and is based on items from the appraisal instrument of the AGREE collaboration for de novo guidelines.

Purpose: To develop a new DELBI domain for special methodological quality criteria of adapted guidelines.

Methods: The development of the new domain was based on two main sources of information. Firstly, national and international manuals for guideline adaptation were used to identify quality criteria for the adaption of guidelines (ADAPTE, PMV). Additionally, we asked experts and stakeholders in German guideline development to separately identify special needs for transparency and quality in guideline adaptation. The results were discussed in expert meetings and used for the phrasing of new questions for quality assessment.

Results: A pilot version was developed between June 2007 and January 2008. It includes modifications in three of the existing seven questions for methodology and three added new items covering issues such as deviations from original guideline recommendations and updated literature search. The pilot version is currently in the process of validation. In order to assess applicability and reliability, the instrument is applied repeatedly to six different guidelines. Results will be ready for evaluation in autumn 2008.

Discussion: The new domain for adapted guidelines extends the applicability of the DELBI instrument and allows quality assessment also for the increasing number of adapted guidelines. In order to further improve the applicability of the DELBI instrument, an additional tool for the assessment of content validity is under development.
P78
Implementation of Guidelines in Outpatient Osteoporosis Care and Positive Feedback


Issue: Guidelines for osteoporosis outpatient treatment were updated and presented in October 2005. Implementing the guidelines for osteoporosis treatment is followed by this study, i.e., measuring quality which is defined as providing care according to the guidelines.

Description: Development of referral habits for diagnostic bone density measurement in the target group (women 65+, men 70+), prescription for drugs by physicians in Austria, and hospital admission data for bone fractures linked to osteoporosis, are evaluated before and after implementation of guidelines and positive feedback to those physicians who show the highest reaction in their prescription behaviour required in the guidelines. Calculations are based on the reimbursement data of the social insurance companies including pharmaceuticals, hospital admissions and diagnostic tests. The number of hospital admissions with bone fractures relevant to osteoporosis is analysed at the same time in order to compare the effect of osteoporosis therapy on patient and physicians level.

Lessons: Quality is measured by a relative point rating system; for each measurable part one point per patient is given to the treating physician. The relation between possible points and these definitely reached represents the basis for the changed treatment quality over the periods in which they were compared.

Results: After guideline implementation
- a higher amount of osteoporosis care is provided to patients at risk age
- room for improvement in medication can be noticed for patients after osteoporosis related fracture.

Conclusions: A method for measuring guideline conforme treatment of patients with osteoporosis was created and tested. After two evaluations the tool has been adapted for generic trend analyses in guideline conformity of osteoporosis care for any time periods.
Background: Suicide effects people across all sectors of society and remains a significant international health problem. Adults, who may be at risk for suicidal ideation and behavior, are frequently in the care of Registered Nurses (RNs) and Registered Practical Nurses (RPNs). RNs and RPNs repeatedly have asked the Registered Nurses Association of Ontario (RNAO) to develop a best practice guideline to inform and guide their care of patients at risk for suicide. In response to this request, RNAO, with funding from the Ontario Ministry of Health, Ontario, Canada, convened an inter-professional panel of practice, education, and research experts to design a Best Practice Guideline for Adults at Risk of Suicide.

Purpose: This evidenced based guideline targets RNs and RPNs, who may not be experts in mental health, across a variety of practice settings and the continuum of care. The guideline’s writing style supports knowledge translation to positively influence practice and reduce suicide.

Methods: The panel conducted a systematic literature search and review of relevant research and other evidences based on five clinical questions pertaining to assessment, intervention, post-vention, prevention and risk reduction as they relate to suicidal ideation and behaviour. The standard Levels I through IV ranked the evidence and subsequently guided the design of this document. Advisory and stakeholder panels reviewed the guideline and contributed revisions.

Results: Twenty-six recommendations inform nursing practice for patients at risk for suicide. For ease of use in busy clinical practices, this guideline includes unique strategies: vignettes, practice boxes, 'light bulbs', 'STOP' signs and frameworks.

Discussion: This requested guideline is directed to the specific learning and clinical needs of this practice audience. The presenters explore strategies for its dissemination, implementation, and measurement of its influence to lower the impact of suicide in society.
P80
Guideline Knowledge Transformation for Electronic Decision Support

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**Background:** Computer-mediated clinical decision support can reliably improve the delivery of effective, evidence-based health care. Practice guidelines encapsulate current, authoritative clinical knowledge, which must be accurately transformed into a format that can be processed by computers.

**Purpose:** To define a systematic and replicable approach to guideline knowledge transformation and implementation in electronic systems.

**Methods:** We have developed a transformation system based on the Guideline Elements Model (GEM), an international standard for the representation of guideline documents. Stakeholders first define clinical objectives that they plan to achieve. Next, relevant guideline recommendations are identified. Guideline quality may be ascertained using AGREE or COGS (the Conference on Guidelines Standardization checklist) and potential obstacles to implementation may be identified and highlighted using GLIA (the Guideline Implementability Appraisal). The relevant recommendations are ‘marked up’ using GEM Cutter II to create an XML translation of the guideline document. This file is submitted to EXTRACTOR (an online series of XSLT transforms) to create reports that show the recommendations’ decision variables (which serve as triggers for decision support and contribute to denominators for performance measures), actions (which define the activities to be performed and contribute to numerators for performance measures), and rules defined in statement logic. Next steps include categorization of each recommendation’s action-types and definition of when rule triggers become available and when actions should be performed.

**Results:** We applied this approach to guidelines for chronic management of asthma and for prevention of obesity in children that were recently published in the US. The guideline knowledge is currently being implemented at several sites on 2 different electronic health record platforms.

**Discussion:** This step-wise approach systematizes the process of knowledge transformation. Multiple artifacts that are produced mitigate the likelihood of local adaptation obscuring the intent of the original recommendations.
P81
Evaluating the Process of Clinical Practice Guideline Development and Implementation at Alberta Cancer Board


Background: Provincial standards of care can be optimally achieved by development and adherence of practitioners to evidence based clinical practice guidelines (CPGs). The commonly cited reasons for sub-optimal uptake include: gap between researchers and practitioners, lack of realism and pragmatism in knowledge translation and personal biases. The Guideline Utilization Resource Unit (GURU) of ACB was established in 2006–2007 to support the provincial tumour teams in the development of provincial CPGs for cancers.

Objectives: To evaluate/assess the process of guideline development and implementation.

Methods: Development of CPGs was assessed by the ADAPTE tools and a modified guideline satisfaction survey was sent out to members of provincial tumour teams before web-posting the new guidelines. Survey also included questions on their present practices. The uptake of guidelines was also assessed electronically through medical records.

Results: The response rate for the survey ranged from 14% to 30% for different tumour teams inclusive of physicians and nurses. The professional and guideline development experience of the respondents varied. Few had participated in development of CPGs and all were aware of the presence of provincial standards of care and said that they discuss it with their patients nevertheless some do it more diligently if the patients request it. Concerns about CPGs included: lack of guidelines for some conditions; rapid upsurge of evidence compelling continuous development and updating; perceived means of cost control by the organization. The treatment practices varied between different centres in Alberta.

Lessons Learned: The response rate was poor despite repeated reminders from different sources. The utilization of electronic patient records for assessing uptake of guidelines should be assessed further for quality assurance purposes.

Scepticism exists among practitioners related to CPG development. Uptake of the guidelines therefore has to be dealt with sensitivity realizing that it does lead to better patient care.
P82
The Physiotherapeutic Role in Multiprofessional Guideline Development and Implementation – The Nordic Collaboration

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Objectives: The physiotherapy associations in five Nordic countries have decided to cooperate in developing clinical guidelines as an attempt to bridge the gap between research and practice. In order to rationalize the guideline development process we plan to share our evidence finding processes and the experiences of preparing and implementing national guidelines. The overall aim would be to prepare a common method for developing national guidelines and to divide the themes for guidelines between the countries. The other aims are to strengthen the existing network of clinical guideline developers in health care for guideline development and implementation and to facilitate involvement in multiprofessional guideline development.

Methods: Each country will describe their level of guideline development and the methods of literature searching, study quality assessment, analysis of the results, grading the evidence, implementation strategy, and the updating processes of the guidelines. A strategy as outlined in the European Region of the World Confederation for Physical Therapy (ER-WCPT) in 2004 will form the common frame of reference to discuss each country’s method for preparing clinical guidelines.

Results: PT associations in the Nordic countries have already developed more intense collaboration with the national authorities to develop multiprofessional guidelines. In Finland PT’s have also taken part of developing the multiprofessional Current Care guidelines. In Finland, Sweden, Denmark and Island the physiotherapy associations have taken the main responsibility of organizing the physiotherapy guideline development, although the approaches are somewhat different between the countries.

Conclusions: Cooperation between PT associations in the Nordic countries is considered beneficial especially concerning systematic reviews and experience of implementing guidelines. In addition to multidisciplinary guidelines there is still a need to develop physiotherapy specific guidelines.
A Grounded Theory of the Registered Nurses Association of Ontario (RNAO), Canada Breastfeeding Best Practice Guideline Implementation and System Impact

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Background: Practice guideline implementation does not occur in a vacuum. It is essential to understand the whole system impact of guideline implementation yet little is known about this. The proposed research can contribute important insights to the field.

Purpose: The purpose of this study is to move beyond description and generate a grounded theory to assist health care decision makers, nurse leaders and policy makers to understand and facilitate the complex processes involved in the implementation of Breastfeeding Best Practice Guidelines (BPG). The intentional and unintentional consequences of the BPG implementation process will be explored in community, rural and urban teaching hospitals. Consequences at the client and systems level will be assessed.

Methods: Client consequences, processes involved as well as impact on the system as a whole will be examined using grounded theory (Charmaz, 2006). This will include impact at the unit and organizational levels. Organizational outcomes include consequences for: other disciplines, interdisciplinary relationships, changes in policies and practice in other units that care for babies (e.g. pediatrics, emergency) as well as administrators/educators. Impact beyond the organization will be explored considering Public Health, community referral agencies, other organizations, and wherever the data leads. Interviews will be conducted to understand the ripple effect of BPG implementation and the effect on the BPG implementation and uptake. Approximately 60 interviews are anticipated.

Results:
1. Enhanced understanding of: the processes of effective/ineffective knowledge translation (KT) initiatives, and of "whole system" impact of KT work.
2. An inductive KT theory sensitive to context and processes to inform future KT and BPG implementation work will be gained from this innovative grounded theory approach.

Funding: the RNAO PhD Fellowship program and the Ontario Ministry of Health and Long Term Care (Canada).
P84
Perception, Utilization and Evaluation of the National Guideline “Diabetic Foot” in the National Disease Management Program Diabetes Mellitus Type 2 in Germany

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Background: According to a Cochrane Review the implementation of guidelines in medical practice is influenced by different factors. In 2007, in Germany the evidence-based national guideline 'Diabetic Foot' was published as a result of an interdisciplinary consensus procedure by different institutions of the health care system. The Central Research Institute of Ambulatory Health Care in Germany (ZI), in cooperation with the Agency for Quality in Medicine (AEZQ) conducted a study about the perception of this guideline among predominant general practitioners.

Purpose: Examination of perception, utilization and evaluation of this guideline and accompanied materials for the use in medical practice.

Method: Written examination (structured questionnaire), 2 000 by chance selected physicians of about 4 000 participating at the national disease management program Diabetes mellitus type 2 in North Rhine who had received a feedback-report before, which referred to this guideline.

Results: 394 questionnaires could be analysed (Response: 20 percent), among these 19 from diabetologists. 47% of the physicians knew the guideline; of these 35% through the internet, 28% through other media and 23% through recommendations of colleagues. 10% of those who knew the guideline didn’t applied it. Most frequently the physicians used check lists and the short form guideline. Accordingly, these materials got the comparatively best evaluations regarding intelligibility and practice-relevance. While nearly all diabetologists knew the guideline (other physicians: 44%), 83% of them applied it (other physicians: 46%).

Discussion: The apparently low degree of perception of the guideline among the physicians may result from only half a year, that had passed since it was published. On the other hand, physicians in North Rhine might have been sensitized for this topic by the feedback-report. Especially materials which take into account the scarce time in daily routine, were judged positively. A statement about the actual adherence of the physicians to the guideline isn’t possible.
P85
Clinical Practice Guidelines Portal:
Improving Access for Australians

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In February 2006 the National Institute of Clinical Studies (NICS) began writing to a number of professional colleges, federal and state governments, not-for-profit organisations and advocacy groups with the intention of forming a complete collection of Australian clinical practice guidelines. This collection formed the basis of the Australian guidelines audit project and the subsequent Australian Guidelines Portal. The portal is a searchable web-based database with links to all Australian clinical practice guidelines which meet all four NICS inclusion criteria, based on those developed by the National Guidelines Clearinghouse and modified for Australian use. The portal is Australia’s first attempt at systematically selecting all clinical practice guidelines produced for Australian practice against predetermined criteria. Further development of the portal will include tools and resources for clinicians to make better use of guidelines, and to assist the Australian guideline development community to make high quality, implementable and relevant guidelines.

One resource developed to support developers and funders is the Australian Guideline Register, a register comprising Australian guidelines in development stages or planned for development in the future. The aims of the register are to prevent duplication of effort and foster collaboration among developers, and to reduce the possibility of the development of competing or conflicting guidelines. The register also gives guideline developers access to appropriate tools and resources to help them produce better quality guidelines, in turn raising the standard of Australian clinical practice guidelines.
The first Australian trial of ADAPTE: Adaptation of Guidelines for the Prevention of Venous Thromboembolism

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Background: Development of high quality guidelines requires substantial time and financial investment. Worldwide, there is considerable interest in finding suitable ways to use existing international guideline resources and tailor them to the local context. ADAPTE is a systematic approach to adapt existing guidelines to different cultural and organisational environments.

Purpose: The National Health and Medical Research Council (NHMRC) will test the ADAPTE methodology for suitability as a rapid, cost-effective guideline development methodology for use in Australia. The prevention of VTE in hospitalised patients is the clinical topic that the NHMRC will be trialling.

Methods: Existing international VTE prevention guidelines will be assessed and adapted to the Australian health care context using the recommended modules of the ADAPTE methodology (www.adapte.org). The adaptation process is expected to be completed within 12 months.

Results: To enable thorough evaluation of the suitability of ADAPTE for the Australian context, we will be tracking a number of factors such as the resources required for guideline adaptation (including time commitment and cost) and the benefits and limitations of using an adaptation process as opposed to de novo guideline development. Preliminary results of this evaluation will be presented.

Discussion: In a variety of disease groups there is a significant need for access to guidelines that are suited to the local context. Financial and time constraints mean there is pressure for guidelines to be produced rapidly whilst maintaining high quality. The main driver of this is to reduce duplication by leveraging off existing efforts in guideline development. The recent availability of the ADAPTE methodology is a promising solution to this issue. This project aims to test the ADAPTE methodology for the Australian context, and will assess the potential value of this method for other countries seeking to reduce duplication of effort and cost in guideline development.
P87
From Clinical Question to Search Strategy:
the role of the information scientist

Bakhshi L*, National Collaborating Centre for Chronic Conditions, London, UK

Aim: To show how a clinical question about interventions formulated using the PICO (Population, Intervention, Comparison, Outcome) framework is turned into a systematic search by the Information Scientist in guideline development

Abstract: The Information Scientist is at the core of the NICE guideline development process and follows the methods set out in the NICE ‘Guidelines manual’. This poster will show the role the information scientist plays as part of a technical team, how they contribute to the setting of evidence-based clinical questions and how they construct and conduct literature searches by utilising their specialist skills in understanding databases and the balance between sensitivity and precision. This will be demonstrated by providing an example from the Type 2 Diabetes Update guideline to show evolution of a clinical question from PICO (Patient, Intervention, Comparison, Outcome) to a systematic literature search.

This abstract is complementary to the submission: Boynton J, Pledge D and Richards A. Clinical guideline development in England and Wales: an overview of the role of the information specialist at the National Institute for Health and Clinical Excellence and the National Collaborating Centres.
P89
Implementation of Regional Guidelines for Stroke to Improve Quality of Healthcare System of Marche Region – Italy: the Stroke Marche Regional Audit Project (smarap)


Background: Regional Healthcare Agency of Marche Region (Italy) developed a strategy to improve, at regional level, standards of care for patients suffering of major pathological conditions affecting population (Stroke, AMI, hip fractures, etc.)

Purpose: Implementation of regional guidelines for stroke by development of integrated clinical pathways (ICPs) and evaluation of performance indicators and clinical outcomes

Methods: The SMaRAP project was developed in 3 steps: 1) May 2006, establishment of a multidisciplinary and multiprofessional regional experts panel with the mission to develop regional guidelines for Stroke selecting and sharing the best evidence-based interventions and indicators to measure performances; 2) September 2006, development of ICPs for Stroke and of a web-based monitoring system; 3) December 2006, start up of data collection and evaluation of results.

Results: Results refer to years 2006 and 2007. Data collection was conducted for two consecutive months, random selected, both in 2006 and 2007 (8 out of 13 centers of Marche Region, 182 patients in 2006, 178 patients in 2007). Table show 2006 and 2007 results as regional media.

Discussion: On the basis of such results, activities of clinical audit at local level and benchmarking at central level was undertaken. Several actions are already ongoing to better fit standards of care.
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Establishing Appropriate Antenatal Care Pathways According to Risk During Pregnancy

Petitprez K*, Guidelines department, HAS (i.e. French National Authority for Health), France, Astruc K, Department of Epidemiology and hygiene in hospital. University Hospital of Dijon, France, Shojai R, Department of Obstetrics and Gynaecology, North University Hospital of Marseille, France, D'Ercole C, Department of Obstetrics and Gynaecology, North University Hospital of Marseille, France

Background: A perinatal care programme was developed in 2005–2007 in France to meet demographic and cost constraints, safety needs, and women’s expectations. Its aim was to improve the quality of care and provide a more humane environment during childbirth. In France there were 830 900 births in 2006.

Purpose: To develop guidelines for improving the organization of care by (i) identifying at-risk situations during pregnancy, (ii) assigning an appropriate antenatal care pathway for each at-risk situation.

Methods: We performed a review of the literature (1995–2007) covering essentially epidemiological studies (to identify frequency and maternal and/or foetal complications for each at-risk situation) and the organization of antenatal care in France. After all we consulted the expert opinion of a multidisciplinary working group.

Results: For each at-risk situation (n=120), the guidelines recommend a specific antenatal care pathway (A or B): (1) pathway A (no or low level of risk): antenatal care may be provided in the primary sector by a midwife, general practitioner, or specialist in Obstetrics and Gynaecology (Ob/Gyn), according to the woman’s preference; (2) pathway B (high-risk situations): management by an Ob/Gyn specialist is mandatory. However, situations may arise in pathway A where there is a need for a further opinion: (1) opinion A1 referral to an Ob/Gyn and/or other specialist is recommended; opinion A2: referral to an Ob/Gyn specialist is mandatory, with further referral to another specialist when necessary.

Discussion: The next national population-based survey of prenatal care in 2009 will evaluate the impact of these guidelines and indicate the number of pregnant women covered by pathway A (especially management by a midwife or general practitioner).
P91
Assessing the Use of Evidence Based Methods in Developing Guidelines Published by Specialty Societies in Korea

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Background: As guidelines are increasingly used in Korea, there is also increasing concern whether guidelines are developed by evidence-based methods.

Purpose: The objectives of this study was to systematically examine guidelines published by medical specialty societies to determine to what degree they are based on scientific evidence and use methodological standard in developing guidelines.

Methods: Guidelines produced by medical specialty societies in Korea published between 1998 and 2006 were identified through database search and questionnaires. Their qualities and validities were assessed by AGREE instrument in terms of the strategy to identify primary evidence, literature selection, evaluation of evidence, data synthesis, links strength of evidence to recommendation.

Results: A total of 54 guidelines were assessed by independent appraisers per guideline using established criteria. Small numbers of guidelines did not meet the criteria. 29.6% of them report information on searchers for published studies. 16.7% give information on the evaluation of evidence or data synthesis, 9.3% report any explicit grading of the strength of recommendations. There was improvement over time in adherence to standards on identification and summary of evidence 18.6% prior to 2000 to 33.0 % after 2000.

Discussion: Some specialty societies in Korea still did not use rigorous evidence-based methods in developing guidelines. Professional organizations or specialty societies that aim to develop guidelines should adopt explicit methodological criteria including identification, evaluation and synthesis of scientific evidence.
P91
Implementation of the New Guideline for the Diagnosis and Treatment of Patients with Colorectal Tumours

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Background: In July 2007, a new guideline for colorectal tumours was published in the Netherlands (www.oncoline.nl). To implement this guideline in seven hospitals in the North eastern part of the Netherlands a patient-pathway from the suspect of cancer to treatment was developed with regional consensus.

Purpose: Implementation of the guideline for patients diagnosed with rectal carcinoma using a patient-pathway in order to reduce hospital variation in diagnosing and treatment of rectal tumours.

Methods: Using the method of Business Process Re-engineering the ideal care process was described. Quality standard targets and indicators to evaluate the pathway were defined. A pre-measurement was performed using data from 2007 of the cancer registry. The post measurement started in June 2008 and lasts a year. Cancer registry data concerning patient characteristics, tumour characteristics and treatment were extended with indicators as diagnostic procedures and multidisciplinary team meetings. Indicators as time to first hospital visit and time to diagnosis are calculated.

Results: Regional consensus was achieved about the quality standard indicators and process of care. Targets are:
- First scopy within 3 weeks for the high risk patients
- Diagnostic procedures should include MRI, CT abdomen/liver multiple phases, and (endo-echo)
- Time to final diagnosis: two weeks
- All patients are discussed in a multidisciplinary patient consultation before start of treatment
- Time to first radiotherapy: three weeks

Discussion: Development of care programs gave new insights into opportunities to implement guidelines and is a promising method to improve quality of care and reduction of hospital variations.
P92
Electronic Health Records:
A Tool to Guideline Distribution

Martinez MA, Centro Nacional de Excelencia Tecnologica en Salud

Every day, across the world, electronic information make improvements in health as a direct benefit of information and communication technologies, electronic health records computer assisted are one of the strategies to support clinical care. They provide a platform for prescription systems and clinical databases.

The aim of the Centro Nacional de Excelencia Tecnologica en Salud is to link his guidelines catalogue with the electronic health record as a key action to facilitate the integration of both, offering information will lead to a best practice, and the possibility to improve the standard of care.

Now, with a national effort to integrate this catalogue with the participation of 50 guideline development centers distributed along the country, and using as reference the most common diseases in Mexico, using our site as a link between all centers to offer an electronic version of each guideline, with essential information, to use as reference in daily practice.

Our first action was to integrate our most important health services, in a coordinated guideline production, avoiding duplication and using a standard methodology.

We have a catalogue of twenty guidelines in electronic version, with a goal to include more than one hundred guidelines at the end of 2008.

With a first initiative, to use a electronic platform to his distribution, we hope that this strategy will put all the information available, in all the hospitals in the country with access to a computer or internet connection.

The development of this proyect is the first national initiative to organize and integrate clinical guidelines in another mayor strategy of health improvement, the electronic health record, with a first scope of provide patient information, adding to this tool the ability to participate in the training of health-care professionals.
P93
Nurses’ Attitudes Towards National Resuscitation Guidelines – a Follow-up Survey in a Secondary Hospital

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Introduction: The national resuscitation guidelines were published in Finland in 2002. After publication a significant change has occurred in resuscitation practices. The purpose of this study was to analyze the effect of education on attitudes towards cardiopulmonary resuscitation (CPR-D) guidelines in a secondary hospital.

Methods: In 2003 before CPR-D education and in 2007 after education a 48 item questionnaire was sent to the medium-size secondary hospital. Seven point Likert scale was used (1= totally disagree, 7=totally agree). Factor loading of the questionnaire was made using maximum likelihood factor analysis with varimax rotation; five scales were built from the items of the questionnaire (Hesitating defibrillation, Positive attitudes, Negative attitudes, Implementation, Nurses role).

Results: The questionnaire was answered by 82% percent of the nurses (297 / 361) in year 2003 and 55% (199 / 361) in 2007. There were statistically significant differences in attitudes between nurses after intensive CPR-D education. Education changed attitudes toward Hesitating defibrillation scale (scale mean 4.40 vs. 3.61, 95% CI 3.93–4.25, p<0.000). Nurses were slightly more positive toward Positive attitudes scale (scale mean 5.54 vs. 5.56, 95% CI 5.52–5.69, p<0.356). Education race negative attitudes towards guideline in the organisation (scale mean 2.94 vs. 3.92, 95% CI 3.16–3.56, p<0.000). Education did not improve attitudes toward Implementation scale (scale mean 3.30 vs. 2.43, 95% CI 2.71–3.15, p<0.000).

Conclusions: Intensive education of cardiopulmonary resuscitation and defibrillation has taught skills to nurses and change their attitudes, but it did not change attitudes in the organisation.

References:
P94
The Importance of a Well Performed problem Analysis: 
Dutch Examples of Methods Used in Guidelines on Medical 
Unexplained Physical Symptoms and Domestic Violence

Hagemeijer JW, Dutch Health Care Institute, Fischer ER, Trimbos Institute

Background: The process of developing guidelines should include participation of representatives from all relevant key groups and disciplines. An important condition for successful implementation of a guideline in practice is the need for a guideline perceived by the (potential) users. To ensure that the guideline covers real problems in daily practice it is necessary to perform a problem analysis.

A well performed analyse should meet the following criteria:
- all relevant groups are invited and represented, also including patients
- includes medical, organisational and patient issues
- should be performed before the first meeting of the working group.

Based on the key problems identified in practice, the clinical questions are formulated.

Purpose: To design a structured and efficient approach to the problem analysis with the aim to identify key problems in practice.

Methods: In the guideline projects Medical Unexplained Physical Symptoms (MUPS) and Domestic Violence are invitational conference organized to speed up the phase of problem analyse to clinical questions. Representatives from all relevant stakeholders were invited for this Invitational Conference (IC). During the preparation of IC relevant subjects has been stipulated and these subjects formed the framework during the discussion. The results of IC has been described in a report.

Results: Because of this method the problem analyse went more rapidly than using the method in which this discussion takes place at the first meetings of the working group.

Discussion: The authors claim that using this more top down method have no a negative effect on the basis and involvement of the professionals at the guideline development. It is a structured and efficient approach of problem analysis and the relevant key problems are addressed.
P95
Dissemination and Implementation of a Dutch Guideline on Management of Pain with Cancer Patients Using a Multimedia Approach with Live WebTV and E-learning

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Background: Pain is underdiagnosed and undertreated in patients with cancer. Evidence-based guideline development is useless without effective dissemination and implementation to change clinical practice. A multimedia approach with online education could raise interest among the professional target groups.

Purpose: Guideline implementation. Evaluate a multimedia strategy as an implementation tool.

Methods: Before the release of a Dutch evidence-based guideline on the management of pain with cancer patients, a working group with media, guideline and medical experts designed a dissemination and implementation strategy using a multimedia approach including: 1) two journal articles, 2) a live WebTV broadcast to discuss the impact of the guideline, 3) an e-learning module, 4) online dossiers with E-interviews.

WebTV broadcast and E-learning were promoted with press releases, advertisements in professional journals, newsletters, e-mail and SMS alerts and 200 posters in hospitals.

A questionnaire was used to assess the knowledge before and after the educational activities and the usefulness of the educational methods.

Results: The professional target group included 14 000 doctors and 2 500 oncology nurses. The WebTV broadcast was viewed more than 3 000 times. 519 of them viewed the live broadcast on January 24th 2008. The e-learning module was used by 400 doctors and 200 nurses until April 10th 2008. Both the WebTV broadcast and e-learning module were considered as (very) useful methods by 82 percent of the participants. The questionnaire survey showed significant improvement of knowledge. Online education is considered as very convenient due to the ability to use them at any time and at home.

Discussion: A large audience can be reached by a massive multimedia approach. A strong media campaign is necessary to raise awareness and interest among the professional target groups. A guideline implementation program with regular web TV broadcasts and e-learning may enhance the familiarity with these educational methods.
P96
Do Family Doctors Follow Antenatal Guides in Moldova?

Zarbailov N, State University of Medicine and Pharmacy Nicolae Testemitanu, Public Health Center Durleshty, Moldova, Grimut A, State University of Medicine and Pharmacy Nicolae Testemitanu, Public Health Center Durleshty, Moldova

In Moldova, during last years, attempts on introduction of new forms and methods of the organization of Mother and Child Care are undertaken. More often these changes have had administrative character and were spent due to increase in volume of work on various stages of Prenatal Care. Since the implementation of Primary Health Care based on family doctors practice in Moldova were developed and updated National Guides A, B, C for Prenatal Care. However, it is observed that in their routine practice physicians don’t follow the recommendation and as a result complications and less good maternity mortality indicators registered in Moldova.

Study includes assessment of 464 medical records of pregnant women randomly selected from 10 Public Health Centers, 4 urban and 6 from rural area. Depending on current recommendations the risk assessment at the beginning of pregnancy and at 28–30 weeks, frequencies of visits to family doctor and to obstetrician, hospitalization rate were evaluated. For data analysis we used Epi Info.

The received results show, that, the estimation of risk factors and, accordingly, definition of group of maternal risk is not made in 31.5 % of cases that conducts to inadequate forecasting an outcome of pregnancy and irrational use of medical institutions resources.

The average of visits to the family doctor (6, 16) and an average of visits to the ob-gyn specialists (5, 24) during pregnancy mismatch existing recommendations and did not differ in group with physiological and pathological pregnancy.

The difference in a level of hospitalization of pregnant women in city and a countryside, on visible, might be explained by insufficient conditions in the rural centers for diagnostics and treatment of pregnant women. The analysis of hospitalization depending on groups of parent risk, allows to assume non-observance of reports of conducting pregnant women from various groups of risk.
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<td>Vist Gunn Elisabeth</td>
<td>Norwegian Knowledge Centre for the Health Services</td>
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<td>Vlayen Joan</td>
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<td>Vuorela Plia</td>
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<td>Vuori Ilkka</td>
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<td>Wyatt Jeremy</td>
<td>Health Informatics Centre University of Dundee</td>
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**Local Organizing Committee**

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<tr>
<th>Name</th>
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<tr>
<td>Ketola Eeva</td>
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<td>Honkanen Mari</td>
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<td>Kyrönaho Pirjo</td>
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**Total registrants (September 10, 2008): 366**
6th International G-I-N Conference

Lisbon, Portugal

Sunday 1st – Wednesday 4th November 2009