

Report

US Cochrane Center Conference

"Priority Setting for Systematic Reviews"

10 -11 July 2008

Baltimore's Tremont Suite Hotel

Baltimore, Maryland

This conference was sponsored by the Agency for Healthcare Research and Quality (Grant No. R13HS016868) and the Kaiser Permanente Institute for Health Policy.

Dr. David Moher's presentation was funded through the Canadian Institutes of Health Research and the University of Ottawa.

Table of Contents

| | |
|--|----|
| (I) Appendices | 4 |
| (ii) Abbreviations used | 5 |
| 1. Executive Summary | 6 |
| 2. Summary of Sessions | 7 |
| 2.1. Thursday, July 10, 2008 | 7 |
| 2.1.1. Plenary: The rationale and principles for prioritizing systematic reviews, as presented in the Institute of Medicine (IOM) report, <i>Knowing What Works in Health Care: A Roadmap for the Nation</i> | 7 |
| 2.1.1.1. Speaker | 7 |
| 2.1.1.2. Discussant | 8 |
| 2.1.2. Case Studies 1: Methods to Prioritize Systematic Reviews | 8 |
| 2.1.2.1. AHRQ's Effective Health Care Program | 8 |
| 2.1.2.2. The UK's National Health Service R&D and Department of Health Programmes | 9 |
| 2.1.2.3. The Cochrane Collaboration's Prioritization Approaches | 10 |
| 2.1.2.4. Canada's Approach: Canadian Institutes of Health Research | 11 |
| 2.2. Friday, July 11, 2008 | 11 |
| 2.2.1. Plenary debate: Models of priority setting for systematic reviews of clinical effectiveness | 11 |
| 2.2.1.1. Let 1000 flowers bloom: Support for the current "system" | 11 |
| 2.2.1.2. Both prioritization and review production should be centralized | 12 |
| 2.2.1.3. Discussant: How can we leverage the best of these two models? A hybrid model of centralized priority setting | 12 |
| 2.2.2. Panel: Knotty problems related to review prioritization | 13 |
| 2.2.2.1. Meaningful engagement of decision makers in priority-setting | 13 |
| 2.2.2.2. Considering adverse effects in prioritizing reviews | 13 |
| 2.2.2.3. A mid flight correction: Setting priorities | 14 |
| 2.2.2.4. Incorporating systematic reviews into other systematic reviews: Can we save time and be valid? | 14 |
| 2.2.3. Case Studies II: Methods to Prioritize Systematic Reviews | 15 |
| 2.2.3.1. Drug Effectiveness Review Project (DERP) | 15 |
| 2.2.3.2. The James Lind Alliance | 16 |
| 2.2.3.3. Centers for Disease Control and Prevention (CDC) Community Guide | 16 |
| 2.2.4. Open Discussion: Working together or working apart: Cross-group cooperation in priority setting | 17 |
| 2.2.4.1. Discussant | 17 |

| | |
|---|----|
| 2.2.4.2. Discussant | 17 |
| 3. Summary of Participant Evaluations | 18 |

(I) Appendices

- Appendix A: Conference Program
- Appendix B: Conference Planning Committee
- Appendix C: Conference Speakers
- Appendix D: Day 1 Evaluation Survey Instrument
- Appendix E: Day 2 Evaluation Survey Instrument
- Appendix F: Day 1 Evaluation Comments
- Appendix G: Day 2 Evaluation Comments

(ii) Abbreviations used

| Abbreviation | Full Name |
|---------------------|--|
| AHRQ | Agency for Healthcare Research and Quality |
| CDC | Centers for Disease Control and Prevention |
| CIHR | Canadian Institutes of Health Research |
| COE | Center for Outcomes and Evidence |
| DERP | Drug Effectiveness Review Project |
| EHC | Effective Health Care |
| IOM | Institute of Medicine |
| JLA | James Lind Alliance |
| NICE | National Institute of Health and Clinical Excellence |
| USCC | US Cochrane Center |

1. Executive Summary

This report summarizes the US Cochrane Center (USCC) Conference on Priority Setting for Systematic Reviews, held 10 - 11 July 2008 in Baltimore, Maryland (see Appendix A - Conference Program). The conference theme was selected in response to a global need to set priorities for systematic reviews, so as to conserve resources and ensure that systematic reviews address important questions. Numerous groups and individuals are currently engaged in conducting systematic reviews to assess intervention effectiveness, and among them a variety of priority setting systems are used. The conference aimed to provide a forum for learning about approaches in use around the world, and for discussion and debate on the issues raised. An important goal was to bring together participants from a cross-section of involved groups to explore areas for collaboration and minimization of unnecessary duplication of effort.

The Conference Planning Committee (see Appendix B - Conference Planning Committee) designed a program that would be of interest to North American clinicians, researchers, policy makers and consumers. Speakers (see Appendix C - Conference Speakers) from the US, UK, and Canada were invited to address different methods to prioritize systematic reviews, problems in priority setting and potential solutions, case studies of methodology for prioritizing systematic reviews and cross-group cooperation in priority setting. The conference agenda included plenary sessions, panel discussions, and a debate. Speakers and participants included representatives of the Cochrane Collaboration, educational and research institutions, government agencies, advocacy organizations, and journals, as well as public and private organizations.

The opening plenary provided a springboard for discussion by highlighting recommendations from the recent Institute of Medicine (IOM) Report *Knowing What Works in Health Care: A Roadmap for the Nation*. Throughout the two days of the conference, several recurrent themes emerged: there are multiple prioritization systems in use and considered to be effective; more research is needed on current systems including assessments of effectiveness; and stakeholders (including patients and clinicians) must be identified and integrally involved in deciding prioritization schemes. Prioritization issues cover topic selection, how best to use existing systematic reviews, and the tradeoffs between updating reviews versus taking on new topics. There was widespread support for development of a registry of systematic reviews, perhaps by re-framing the content already available in *The Cochrane Library*.

It was noted that by combining the best of centralized and decentralized systems, we would be well-positioned to leverage highly trained and experienced contributors and to meet both our scientific and practical goals. The challenge is now to create such a system. Given the many groups currently doing systematic reviews, questions remain on how best to achieve a productive balance between limiting unnecessary duplication of effort and necessary and productive replication.

Feedback from the conference evaluation indicates that presentations and the meeting overall met participants' expectations and was useful in crystallizing critical issues in priority setting for systematic reviews.

2. Summary of Sessions

2.1. Thursday, July 10, 2008

Dr. Kay Dickersin, Director of the US Cochrane Center, welcomed the conference attendees and summarized the objectives and goals of the conference.

2.1.1. Plenary: The rationale and principles for prioritizing systematic reviews, as presented in the Institute of Medicine (IOM) report, *Knowing What Works in Health Care: A Roadmap for the Nation*

Chair, Kay Dickersin, Johns Hopkins Bloomberg School of Public Health

2.1.1.1. Speaker, Hal Sox, *Annals of Internal Medicine*

Dr. Sox reviewed the background and recommendations from the Institute of Medicine (IOM) report, *Knowing What Works in Health Care: A Roadmap for the Nation*. The report was commissioned in response to growing recognition of the need for better knowledge about which health care services are most effective and which patients are most likely to benefit. This was coupled with the current movement away from reliance on expert opinion toward systematic reviews of the pertinent medical literature, and increasing recognition that a common language for rating the evidence is needed.

In describing a national system for identifying highly effective health services, the IOM committee focused on specifying the principles to be used in deciding the methods for priority setting, evidence review, and developing practice recommendations. He noted that the committee did not make recommendations about funding for clinical effectiveness research or the institutional home of a national organization for clinical effectiveness.

The committee recommended that Congress should designate a single entity that would produce credible, unbiased information on comparative effectiveness of healthcare interventions. This entity should set priorities for, fund, and manage systematic reviews of clinical effectiveness; develop a common language and standards for conducting systematic reviews of the evidence and for generating clinical guidelines and recommendations; and provide a forum for addressing conflicting guidelines and recommendations.

The committee stated that priorities should reflect the potential to improve health outcomes across the life span, reduce the burden of disease and health disparities, and eliminate undesirable variation in practice. Principles to guide the priority setting process are consistency, efficiency, objectivity, responsiveness and transparency. The IOM committee's paramount criteria are that priorities should reflect what patients and health providers want to know, and the potential for an intervention to improve outcomes that are important to patients.

2.1.1.2. Discussant. Sharon Straus, *University of Calgary, Canada*

Dr. Straus highlighted the three "Rs" of conducting systematic reviews: (1) *relevance*, addressing the needs of end users; (2) *reliability*, ensuring that the evidence is valid and the methods for its generation are explicit, rigorous, and advance the science of doing different types of systematic reviews and enhance capacity in these areas; and (3) *readability*, presentation of reviews in a user-friendly format that facilitates uptake by policy makers and clinicians.

Dr. Straus talked about the Knowledge Translation Canada project which aims to develop a transformative research program to improve the health of Canadians and to strengthen the Canadian health care system. The project is a collaboration between community groups and researchers that will create new knowledge about how best to achieve knowledge translation across different decision maker groups, advance the theory, and enhance the field. The project goals are to improve uptake of reporting guidelines, identify barriers and facilitators for updating evidence resources, and improve usability of systematic reviews.

2.1.2. Case Studies 1: Methods to Prioritize Systematic Reviews

Chair: Steven Goodman, *Johns Hopkins Schools of Medicine and Public Health*

2.1.2.1. AHRQ's Effective Health Care Program. Evelyn Whitlock, *Kaiser Permanente, Oregon*

Dr. Whitlock noted the Effective Health Care (EHC) program's charge to increase the number of topic nominations to the Agency for Healthcare Research and Quality (AHRQ) that can be developed into quality systematic reviews. She reported on recent revisions to the topic nomination process.

The EHC program identifies and prioritizes topics based on five principles: clearly identify the goals/strategic purpose of the activity; involve stakeholders in the selection process; clearly define & implement criteria for selection; achieve transparency; and undertake process evaluation and improvement. Dr. Whitlock articulated that EHC aims for their research focus to be concerned with priority health conditions; important

potential decisions for consumers, clinicians, patients, payers, policymakers, and other stakeholders; and be stakeholder-driven. Five consistent and well-defined criteria are used in the topic selection process: appropriateness, importance, duplication, feasibility, and potential impact. Transparency is achieved by direct mapping of selection criteria to outcomes/decisions.

Dr. Whitlock identified ongoing challenges including addressing redundancy among nominations, ensuring relevance to stakeholders and accomplishing diverse tasks in a timely and transparent manner. She asserted that the EHC has made progress on each of the four process criteria set forth by the IOM report, *Knowing What Works in Healthcare: A Roadmap for the Nation*.

2.1.2.2. The UK's National Health Service R&D and Department of Health Programmes. Martin Burton, Oxford Radcliffe NHS Trust

The UK has several programs supporting systematic reviews of the evidence, the Cochrane Collaboration, the National Institute of Health and Clinical Excellence (NICE), and its health technology assessments.

The National Health Service allocates £1.7 billion to the research and development (R & D) budget in the UK. Of that, £3.5 million is spent each year on the Cochrane Collaboration (0.2% of the R&D budget). Those funds go mainly to the infrastructure of the Cochrane Collaboration, including support for the review groups based in the UK, the UK Cochrane Center, and a national license for *The Cochrane Library* for residents in the UK.

NICE is an independent organization set up by the government. NICE is responsible for providing guidance on the promotion of good health and prevention of ill health. It produces guidance in three areas: public health, health technology, and guidelines for clinical practice. NICE uses a variety of methods for identifying important topics for its work: horizon scanning, special mapping exercises in particular clinical areas to identify the most urgent need for guidance, individual patients and care givers, patient groups, professionals and professional groups, National Health Service organizations, and industry. It has used reviews from Cochrane review groups based in the UK in its guidance. Although NICE does not commission Cochrane reviews, they can provide useful information for NICE when it is considering a review, for example, when there is clear evidence that an intervention does not work.

The Department of Health also commissions its own health technology assessments (HTAs), and pays about £120,000 (\$US240,000) for each. Though many of the HTA reviewers are closely affiliated with the Cochrane Collaboration, the HTA assessments are not Cochrane reviews.

The Department of Health also has an incentive scheme for Cochrane reviews. They offer about \$10,000 per review for a given number of reviews (about 50), and Cochrane review groups suggest the new reviews they want to do or update. NICE then provides input on which reviews they want to see funded and Department of Health proceeds to fund 50 reviews through the UK Cochrane Center. The Department of Health feels it has gained from leveraging on the generosity of spirit present in the Cochrane Collaboration and this has meant added value from its support of Cochrane. The Department of Health has recognized the importance of Cochrane as central to accomplishing the UK's research mission, and this has been documented in "Transforming Health Research: The first 2 years," published in 2008.

2.1.2.3. The Cochrane Collaboration's Prioritization Approaches. Lorne Becker, Co-Chair Steering Group, Cochrane Collaboration

Dr. Becker reported that there is debate as to whether prioritization is compatible with the Cochrane Collaboration philosophy, which includes building on the enthusiasm of individuals from diverse backgrounds and skills, often with different priorities. The Cochrane Collaboration is characterized by a curiosity-driven, bottom-up, selection of topics. He raised concerns about the opportunity costs of prioritization, whether review production might decrease if time and resources are diverted to prioritization and whose priorities (clinicians, consumers, care givers, policy makers) should be considered.

The Cochrane Collaboration had no centralized prioritization process until 2006: Each of the 52 review groups was responsible for setting its own priorities. For example, Skin group members proposed 21 important topics, then the group voted on each, to prioritize the list. The Renal group reviewed its trials register, grouped the trials by clinical question posed, and prioritized reviews by where there are existing trials. The Infectious Diseases group used three criteria for prioritizing reviews, importance of the topic, number of trials addressing the question, and availability of an experienced author team. The Health Promotion group asked their global advisors to identify a list of policy urgent topics, then identified systematic reviews on the topics, and made a list of areas where there are knowledge gaps. This list was returned to their global advisors. In view of the enormous challenge of priority setting, the Cochrane Collaboration Steering Group allocated £100,000 to fund research projects, described by Dr. Becker.

Dr. Becker noted that Cochrane views prioritization as desirable, while remaining cognizant of potential questions and difficulties. The Collaboration is proceeding to explore prioritization with deliberation and is hoping to learn from its experiences.

2.1.2.4. Canada's Approach: Canadian Institutes of Health Research. Ian Graham,
Canadian Institutes of Health Research

The Canadian Institutes of Health Research's (CIHR) mandate includes creation of new knowledge and its translation into improved health for Canadians. CIHR funds the Canadian Cochrane Center (\$1.5 million) to oversee coordination of systematic reviews. Funding for systematic reviews is available through two open grant competitions each year, as well as two open grant competitions related to knowledge synthesis.

CIHR has also developed methods for obtaining rapid response syntheses to address needs for immediate advice.

In Canada, the many institutions doing research synthesis and knowledge translation are linked via a loose network with research funding coming from various sources (federal government, provincial governments, health charities and voluntary health organizations). Synthesis and health technology assessments are funded by federal as well as provincial government agencies with each agency defining its own priorities. The Canadian hybrid approach, comprising the Canadian Cochrane Network, health technology agencies, CIHR syntheses funding opportunities, and other groups, exemplifies a viable decentralized model.

2.2. Friday, July 11, 2008

2.2.1. Plenary debate: Models of priority setting for systematic reviews of clinical effectiveness

Chair: Lisa Bero, *School of Pharmacy and Institute for Health Policy Studies, School of Medicine, University of California, San Francisco*

2.2.1.1. Let 1000 flowers bloom: Support for the current "system". Doug McCrory, Center for Clinical Health Policy Research at Duke University

Dr. McCrory described the current "system" for priority setting as uncoordinated, diverse, and adaptive. A number of entities currently produce systematic reviews, including health professional organizations, federal agencies, state/local governments, health industry groups, and others. Selection of topics for review occurs through a variety of methods. Some programs solicit nominations from stakeholders, the public, subscribers to their services, or member organizations, while others have internal mechanisms for gathering suggestions from staff. He predicted that prioritization will remain important for as long as the resources and manpower available to perform systematic reviews are scarce.

Dr. McCrory proposed different measures of the success of a prioritization scheme, including usefulness to an intended audience, return on investment, and opportunity costs. He observed that the topics nominated by consumers are often vaguely stated and so their questions may not be selected as priority topics. He questioned whether all duplication in systematic reviews is wasted effort, noting that often the reviews represent different questions and different decision contexts.

2.2.1.2. Both prioritization and review production should be centralized. Gail Wilensky, *Project Hope*

Dr. Wilensky began by stating that systematic reviews of comparative effectiveness can help achieve improved clinical outcomes and lead to smarter spending. From an economist's perspective, investment in a centralized system for conducting reviews, such as an institute of comparative effectiveness, makes the most sense. While supporting centralization, she does not want to create a monopoly and sees a continuing role for organizations such as Cochrane, BCBS, OHSU, etc.

Dr. Wilensky recommends that prioritization of reviews of comparative effectiveness start with high cost medical treatments with geographic variations in application, a sign that there is little evidence-based delivery of service. The focus should be on conditions rather than specific pharmaceuticals. She noted that because all data have limitations, systematic reviews of effectiveness should include data from many types of research. While the randomized clinical trial is the gold standard, they may not always be available.

2.2.1.3. Discussant: How can we leverage the best of these two models? A hybrid model of centralized priority setting. Sally Morton, *Research Triangle Institute*

Dr. Morton questioned whether a centralized system is politically viable given that in the past, pressure on Congress from interested parties has led to reductions in funding of evidence-based guideline research. She voiced concern that a centralized system may exclude some potential contributors and fail to build on existing capacity, already in short supply.

Dr. Morton noted that developing a priority-setting system is challenging. Reviews should answer a question of interest that has the potential for major impact. An ideal priority-setting model should include input from a broad cross-section of stakeholders, topic selection methods that are both responsive and curiosity-driven, be devoid of bias, and lead to the advancement of science. Increases in training and manpower will be critical, both to produce systematic reviews and to continue research on appropriate review methods.

She observed although there is duplication of effort in conducting systematic reviews, duplication may be unavoidable because reviews are often tailored for particular needs. She asked how much time should be invested on “ideal” priority setting and what the opportunity costs are of spending this time?

By combining the best of centralized and decentralized systems, we would be well-positioned to leverage highly trained and experienced contributors and to meet both our scientific and practical goals.

2.2.2. Panel: Knotty problems related to review prioritization

Chair: Nananda Col, *Center for Outcomes Research and Evaluation, Maine Medical Center*

2.2.2.1. Meaningful engagement of decision makers in priority-setting. Sean Tunis, *Center for Medical Technology Policy*

Dr. Tunis argued that meaningful engagement of decision makers at each step of the systematic review process is critical to developing a successful product. Any new institute for comparative effectiveness should be a vehicle for involving stakeholders in the systematic review process.

Dr. Tunis provided an example from the Center for Medical Technology Policy and a project on the effectiveness of coronary computed tomography angiography to demonstrate obstacles encountered in stakeholder engagement. He noted that involvement of all stakeholder groups is essential to identifying important perspectives, even though it may impede consensus building. He concluded that decision makers would engage in evidence review and development if they believe their perspective is valued and that the activity is likely to have an impact.

2.2.2.2. Considering adverse effects in prioritizing reviews. Andrew Herxheimer, *UK Cochrane Centre, Oxford, England*

Dr. Herxheimer argued that although assessment of adverse effects is critical to a complete assessment of an intervention’s effectiveness, this step is often neglected. Systematic reviewers face numerous challenges when appraising adverse effects. Adverse effects are frequently not reported, searching for the available evidence is complicated, and there is no clear method to assess the benefit/harm balance. The “best evidence” hierarchy of study designs is not always practical in application.

Dr. Herxheimer concluded by noting that methods to incorporate assessment of adverse effects into systematic review prioritization have not been adequately addressed. Some existing reviews and protocols may need urgent revision to include

adverse effects. Interventions with ill-understood adverse effects are also a review priority, especially when the intervention is widely-used, regardless of whether it is an important intervention or of doubtful or marginal effectiveness.

2.2.2.3. A mid flight correction: Setting priorities. David Moher, *University of Ottawa*

Dr. Moher highlighted a number of issues relevant to systematic reviews priority setting, including the quality of existing systematic reviews, registration of systematic reviews, non-publication and selective outcome reporting of reviews, and keeping reviews up-to-date. He noted that although there is room for improvement for reporting of all reviews, Cochrane reviews are appreciably better than non-Cochrane reviews. Review quality could be improved by agreement on characteristics that define a systematic review, uptake of and adherence to guidelines for improving systematic reviews, and adoption of templates for conducting reviews.

Dr. Moher asked whether systematic reviews might be subject to reporting biases and selective outcome reporting, similar to what has been observed for trials. At this point in time, no reviews are “registered”, i.e., none have a formal registration number assigned, so we have no way of knowing which reviews were implemented and never reported. To know what’s already been done and to set priorities, we need a system for registration of systematic reviews, similar to the system we have for clinical trials.

Dr. Moher emphasized the importance of updating reviews, noting that out-of-date reviews can have an impact on clinical practice, policy recommendations, and future primary research. He argued for ensuring that existing reviews are updated before embarking on setting priorities for new reviews. He urged centralization of aspects of updating and encouraged journals to have an explicit policy on publishing systematic review updates.

2.2.2.4. Incorporating systematic reviews into other systematic reviews: Can we save time and be valid? Evelyn Whitlock, *Kaiser Permanente, Oregon*

Dr. Whitlock addressed the question of whether and when it is acceptable to base a new review on an existing systematic review. Will this approach be consistent with adherence to comprehensive, transparent, and unbiased systematic review methods? Will it save time and resources? Are there instances where this approach should be avoided? Will this approach be acceptable and useful to decision makers? Dr. Whitlock noted that starting with an existing review can save effort and resources, achieve more timely products, and reduce confusion and duplication. For example, incorporating search strategies of existing systematic reviews is a reasonable first step in using existing reviews. New reviews may be needed when there are discordant reviews, high-profile topics, substantial differences in methods employed and

substantial differences in research questions. Reviews based on existing reviews assume the validity of the prior review. She emphasized that resolution of these issues is critical to utilization of resources and prioritizing new systematic reviews.

In conclusion, she recommended development of protocol and review registries, formal updating and sun-setting processes, and refinement/ standardization of methods related to incorporating existing reviews into new reviews.

2.2.3. Case Studies II: Methods to Prioritize Systematic Reviews

Chair: Luis Gabriel Cuervo, *Promotion and Development Unit, Pan American Health Organization (PAHO)/World Health Organization (WHO)*

2.2.3.1. Drug Effectiveness Review Project (DERP). Alison Little, *Drug Effectiveness Review Project (DERP), Oregon Health & Science University*

Dr. Little highlighted the Drug Effectiveness Review Project (DERP) mission to obtain and synthesize evidence on the comparative effectiveness and safety of drugs within classes, and to support decision makers in using that evidence to inform policy in local decision making. The project includes fifteen states and two other organizations and is housed at the Center for Evidence-based Policy. Since its creation in 2003, it has produced 34 reviews and 60 updates of these reviews. She described DERP's topic selection process (1) consideration of dollar and prescription volume, variation of cost within a class, timing of new releases and changes to generic or over the counter status, likelihood of good quality evidence, expected workload of the review, and drugs in the class, (2) solicitation of five most pressing topics from each participating organization, (3) narrowing topic list to ten priority areas, and (4) review of criteria for each topic including disease burden, alternative therapies, clinical impact, budget impact, economic impact, evidence review (completed by the Oregon Evidence-based Practice Center), marketing, and benefit/policy issues. Final topic choices are made at a governance conference.

Dr. Little reported that some process changes have been made; The number of topics solicited is based on the number of reports to be chosen, economic impact was eliminated as a criterion, and a three-year limit was set for reviewed evidence. Although reports are required to be updated on an annual basis not all have been updated. In response, a more formal annual scanning takes place to prioritize which reports must be updated. The scans review new drugs, new indications, new safety alarms and include a literature search on Medline since the date of the last search.

2.2.3.2. The James Lind Alliance. Lester Firkins, *James Lind Alliance*

Mr. Firkins highlighted his journey to becoming a consumer health advocate. He noted that his son died of variant Creutzfeldt Jacobs Disease in 2001 and that in response to this personal tragedy he became active in exploring new therapies for the disease. His growing understanding of the need to know what has been done in the past, led to the creation of the James Lind Alliance (JLA).

The JLA mission is to support working partnerships of patients and their care givers and clinicians to prioritize “treatment uncertainties” into a list for research funders to address, to support and raise the profile of proper involvement for all people with an interest in medical research and to gain evidence on how best to prioritize with patient and clinician collaboration. He noted that JLA partnerships work in different ways: The asthma partnership is made up of only two organizations, the urinary incontinence partnership is made up of 30 related organizations, of which 21 are formal partners. Other partnerships address schizophrenia, vitiligo and diabetes. JLA has funds from the Department of Health until 2010: To continue beyond 2010, it needs to find a permanent home. Mr. Firkins challenged the consumers/patients in the US to consider establishing a similar organization.

2.2.3.3. Centers for Disease Control and Prevention (CDC) Community Guide. Shawna Mercer, *Centers for Disease Control and Prevention*.

Dr. Mercer noted the Guide to Community Preventive Services (Community Guide) contains systematic reviews of the available evidence on the effectiveness of population-based public health interventions. The Guide is intended to complement the CDC Guide to Clinical Preventive Services.

Dr. Mercer noted that a task force of internationally renowned experts in health research, practice and policy oversees topic and intervention priority setting. The task force solicits input on prioritization, reviews, recommendations and dissemination from intended users and those who will be affected by the research results. The guide has been organized by topics rather than individual interventions in order to produce systematic reviews on sets of related interventions.

Dr. Mercer highlighted the priority setting process: Teams are selected to develop a conceptual approach, decide breadth versus depth, and develop a priority list of interventions within a topic to bring to the task force. Liaisons, partners and stakeholders provide input on priorities and ultimately the task force assigns priority topics using established criteria for systematic reviews. Existing reviews that need updating and new public health topics are also part of the priority work list. Input is sought from stakeholders and new topics are combined with the existing list of

candidate topics. Topics are then prioritized and voted on in meetings open to the public.

2.2.4. Open Discussion: Working together or working apart: Cross-group cooperation in priority setting

Chair: Eric Bass, *Evidence-based Practice Center, Johns Hopkins University*

2.2.4.1. Discussant, Lisa Bero, University of California San Francisco.

Dr. Bero highlighted the principles of cross-group collaboration emphasizing the need to ensure relevance to stakeholders, avoid unnecessary duplication, and define priorities for involved groups. She identified common ground in the mission statements of the CC, WHO and AHRQ as an example of a starting point for collaboration. She illustrated cross-collaboration principles with the example of a Cochrane convened working party to identify evidence summaries for interventions relevant to health care in natural disasters and other healthcare emergencies. She emphasized the need to be proactive and strategic rather than reactive.

Dr. Bero noted that communication, timeliness, transparency and financial support have emerged as significant issues in group collaborations. Cross-group communication requires moving beyond a top-down approach and involving leadership and people on the ground.

2.2.4.2. Discussant, Jean Slutsky, *Center for Outcomes and Evidence (COE), Agency for Healthcare Research and Quality (AHRQ)*

To establish collaborative relationships between different organizations requires first setting ground rules and sharing information about what each organization does. Transparency and trust are very important to the process. To illustrate, Ms. Slutsky talked about AHRQ efforts to understand the needs of stakeholders through ongoing consultation to identify priorities. AHRQ rarely commissions a systematic review without a request from a user.

AHRQ's criteria for establishing priorities include prevalence of a condition, burden of a condition, cost of care, disproportionate representation of the condition in the Medicare, Medicaid, S-CHIP populations and the potential for impact.

AHRQ funds the US Cochrane Center directly for training and dissemination and the Rocky Mountain Evidence-based Health Care Workshop. It has open funding cycles for organizations seeking funding to perform systematic reviews under the Evidence-based Practice Center Program. There are also funding opportunities for methods research and training. In terms of opportunities for collaboration, different organizations can establish common priorities, perform joint methods research, collaborate on

commissioned reviews, compete for dedicated funding and work together to interpret and translate reviews.

There is an urgent need to develop a robust registry of protocols and completed reviews. Ms. Slutsky noted that systematic reviews must not only drive practice change but also funding priorities for new research.

3. Summary of Participant Evaluations

The 112 individuals who attended the conference represented a broad range of experience and disciplines, including clinicians, researchers, policymakers, consumer advocates, and funding agency representatives. Participants were asked to complete an evaluation form for each of the 2 days of the conference, including evaluations of each speaker, session, and day. (see Appendices D and E - Day 1 and Day 2 Evaluation Survey Instruments) Overall, respondents were enthusiastic about their experience, rating most aspects of the meeting 5.00 to 4.00 on a scale where 5 = excellent, 4 = very good, 3 = good, 2 = fair, and 1 = poor. The most frequent (open ended) comments were an appreciation for the many different perspectives (including international) on both conducting and prioritizing systematic reviews, requests to get the speakers' slides and appreciation for ample question and answer and discussion time. Suggestions for improvement included even more discussion time, increasing the number of interactive sessions and a greater focus on prioritization. (see Appendices F and G - Day 1 and Day 2 Evaluation Comments)

Eighty evaluations were returned on Day One and 73 on Day Two. Of those responding to the question "Did the meeting meet your expectations?" 89% (58/65) responded positively on Day One, with only 2% choosing no and 87% (48/55) responded positively on Day Two, with only 2% choosing no. Similar numbers of respondents believed that the meeting was free from commercial bias, 91% (61/67) for Day One and 92% (54/59) for Day Two.

Mean scores for each segment of the meeting are reported in Table 1. Eighty to ninety percent of responses were excellent or very good for individual sessions both days on "Informative content", "Adequate time allotted" and "Questions answered to satisfaction". (Exceptions were Day 1 Plenary "Questions answered to satisfaction", 75% of responses were excellent or very good, and Day 2 Plenary debate "Informative content", 70% of responses were excellent or very good.)

Table 1. Evaluation Summary¹

| Plenary sessions | Informative content | Adequate time allotted | Questions answered |
|---|----------------------------|-------------------------------|---------------------------|
| | mean (n) | mean (n) | mean (n) |
| Plenary 1: The IOM rationale and principles for prioritizing systematic reviews | 4.21 (76) | 4.27 (75) | 4.03 (75) |
| Case Studies 1: Methods to Prioritize Systematic Reviews | 4.28 (69) | 4.23 (69) | 4.26 (66) |
| Plenary Debate: Models of priority setting for systematic reviews of clinical effectiveness | 4.05 (64) | 4.08 (64) | 4.20 (61) |
| Panel: Knotty problems related to review prioritization | 4.32 (63) | 4.26 (62) | 4.35 (58) |
| Case Studies II: Methods to prioritize systematic reviews | 4.29 (58) | 4.28 (57) | 4.15 (52) |
| Open Discussion: Working together or working apart: cross-group cooperation in priority-setting | 4.25 (53) | 4.25 (53) | 4.33 (45) |
| ¹ 5 = excellent, 4 = very good, 3 = good, 2 = fair, 1 = poor | | | |

Participant comments generally reflected the high evaluation scores, with many positive comments (see Appendices F and G). Several suggestions indicated opportunities for improvement for future meetings.

US Cochrane Center presents
Priority Setting for Systematic Reviews
July 10-11, 2008

| July 10 | Topic |
|--------------------|---|
| 11:00 am - 5:00 pm | Registration |
| 1:00 - 1:15 pm | Welcome and introductions - Kay Dickersin - Director, US Cochrane Center |
| 1:15 - 2:30 pm | Plenary: The Institute of Medicine's (IOM's) rationale and principles for prioritizing systematic reviews Chair: Kay Dickersin - Director, US Cochrane Center Speaker: Hal Sox - Editor, Annals of Internal Medicine Discussant: Prioritizing Evidence Syntheses - Sharon Straus - University of Calgary, Canada |
| 2:30 - 3:00 pm | Break |
| 3:00 - 5:00 pm | Methods to Prioritize Systematic Reviews: Case Studies I Chair: Steve Goodman - Johns Hopkins Oncology Biostatistics AHRQ's Effective Health Care Program - Evelyn Whitlock - Kaiser Permanente, Oregon The UK's National Health Service R&D and Department of Health Programmes - Martin Burton - Oxford Radcliffe Hospitals NHS Trust The Cochrane Collaboration - Lorne Becker - Co-Chair, Cochrane Collaboration Steering Group Canada's Approach: Canadian Institutes of Health Research - Ian Graham - Canadian Institutes of Health Research |

5:00 - 6:30 pm Reception

July 11

7:00 - 8:00 am Registration

8:30 - 10:00 am Plenary debate: Models of priority setting for systematic reviews of clinical effectiveness

Chair: **Lisa Bero** - University of California San Francisco

Let 1000 flowers bloom: Support for the current “system” -
Doug McCrory - Duke University Medical School

Both prioritization and review production should be
centralized - **Gail Wilensky** - Project Hope

Discussant: How can we leverage the best of these two
models? A hybrid model of centralized priority setting - **Sally
Morton** - Research Triangle Institute

10:00 - 10:15 am Break

10:15 am - 12:00 pm Panel: Knotty problems related to review prioritization

Chair: **Nananda Col** - Maine Medical Center

Meaningful engagement of decision makers in priority-setting-
Sean Tunis - Center for Medical Technology Policy

Considering adverse effects in prioritising reviews - **Andrew
Herxheimer** - Cochrane Collaboration Adverse Effects
Methods Group

A mid flight correction: setting priorities - **David Moher** -
University of Ottawa

| | |
|-----------------|---|
| | Incorporating systematic reviews into other systematic reviews: Can we save time and be valid? - Evelyn Whitlock - Kaiser Permanente, Oregon |
| 12:00 - 1:00 pm | Lunch |
| 1:00 - 2:15 pm | Methods to Prioritize Systematic Reviews: Case Studies II Chair: Luis Gabriel Cuervo - Pan American Health Organization Drug Effectiveness Review Project - Alison Little - Oregon Health & Science University The James Lind Alliance and I - Lester Firkins - James Lind Alliance Centers for Disease Control & Prevention Community Guide - Shawna Mercer - Centers for Disease Control and Prevention |
| 2:15 - 2:30 pm | Break |
| 2:30 - 3:30 pm | Open Discussion: Working together or working apart: Cross-group cooperation in priority setting Chair: Eric Bass - Johns Hopkins University Department of General Internal Medicine Jean Slutsky - Agency for Healthcare Research and Quality Lisa Bero University of California San Francisco |
| 3:30 - 3:45 pm | Evaluation and adjourn |

USCC Conference on Priority Setting for Systematic Reviews
July 10 - 11, 2008
Baltimore, Maryland

***Conference Planning Committee**

Eric B. Bass, MD, M.P.H.

*Professor, Johns Hopkins School of Medicine and Bloomberg School of Public Health , and
Director, Evidence-Based Practice Center*

Lorne Becker, MD

*Co-chair, Cochrane Collaboration Steering Group and Emeritus Professor in the Department of
Family Medicine at SUNY Upstate Medical University*

Lisa Bero, PhD

*Co-Director, US Cochrane Center, San Francisco Branch, and Professor of Clinical Pharmacy
& Health Policy, University of California, San Francisco*

Kay Dickersin, PhD

*Director, US Cochrane Center, and Director and Professor, Center for Clinical Trials, Johns
Hopkins Bloomberg School of Public Health*

Dan Fox, PhD

President Emeritus, Milbank Memorial Fund

Steve Goodman, MD, PhD

Associate Professor, Johns Hopkins Bloomberg School of Public Health and School of Medicine

Janie Gordon, ScM

Cochrane Outreach Coordinator, US Cochrane Center

Jeremy Grimshaw, MBChB, PhD, FRCGP

*Professor Department of Medicine, University of Ottawa and Director, Clinical Epidemiology
Program, Ottawa Health Research Institute*

Mark Helfand, MD, MPH, FACP

*Professor of Medicine, Department of Medicine, Oregon Health and Science University and
Director, Evidence-Based Practice Center*

Joseph Lau, MD

Professor of Medicine, Tufts University Sackler School of Graduate Biomedical Sciences and Director, Evidence-Based practice Center

Shawna Mercer, MSc, PhD

Director, The Community Guide to Preventive Services, Centers for Disease Control and Prevention

Sally Morton, PhD

Vice President, Statistics and Epidemiology, RTI International

Cindy Mulrow, MD, MSc

Professor, University of Texas Health Science Center at San Antonio and National Program Director, Robert Wood Johnson Foundation Generalist Physician Faculty Scholars Program

Maryann Napoli

Associate Director, Center for Medical Consumers

Samuel R Nussbaum MD

Chief Medical Officer/Executive VP, Divisional at WellPoint, Incorporated

Diana Petitti, MD, MPH

Director of Research, Kaiser Permanente Southern California

Hannah Rothstein, PhD

Professor of Management, Baruch College Zicklin School of Business and Co-Chair of the Methods Group, Campbell Collaboration

Roberta Scherer, PhD

Associate Director, US Cochrane Center, and Associate Scientist, Johns Hopkins Bloomberg School of Public Health

Harold Sox, MD, MACP

Editor, Annals of Internal Medicine

Jean Slutsky, PA, MSPH

Director, Center for Outcomes and Evidence, Agency for Healthcare Research and Quality

Sean Tunis, MD, MSc.

Director, Center for Medical technology Policy

Appendix B. Conference Planning Committee

Frances M. Visco

President, National Breast Cancer Coalition

*Not everyone was able to participate.

Appendix C. Invited Speakers

**Speakers for the
USCC Conference on Priority Setting for Systematic Reviews**

**July 10 - 11, 2008
Baltimore, Maryland**

Eric B. Bass, MD, MPH. *Director, Evidence-based Practice Center, and Professor of Medicine, Johns Hopkins School of Medicine*

Lorne Becker, MD. *Co-Chair, Cochrane Collaboration Steering Group, and Emeritus Professor of Family Medicine, SUNY Upstate Medical University*

Lisa A. Bero, PhD. *Co-Director, United States Cochrane Center, San Francisco Branch, and Professor, School of Pharmacy and Institute for Health Policy Studies, University of California, San Francisco*

Martin Burton, MA, DM, FRCS. *Consultant, Otolaryngologist Oxford Radcliffe NHS Trust, Senior Clinical Lecturer, University of Oxford, Co-ordinating Editor, Cochrane Ear, Nose & Throat Disorders Group*

Nananda Col, MD, MPP, MPH, FACP. *Director, Center for Outcomes Research and Evaluation, Maine Medical Center*

Luis Gabriel Cuervo MD, MSc. *Chief, Research Promotion & Development, Pan American Health Organization*

Kay Dickersin, PhD. *Director, United States Cochrane Center, and Director and Professor, Center for Clinical Trials, Johns Hopkins Bloomberg School of Public Health*

Lester Firkins. *Chair, James Lind Alliance*

Steven Goodman, MD, MHS, PhD. *Associate Professor, Oncology, Pediatrics, Biostatistics and Epidemiology, Johns Hopkins Schools of Medicine and Public Health*

Ian Graham, PhD. *Vice-President, Knowledge Translation, Canadian Institutes of Health Research*

Appendix C. Conference Invited Speakers (cont'd)

Andrew Herxheimer, FRCP. *Emeritus Fellow, United Kingdom Cochrane Centre, and Consultant, World Health Organization*

Alison Little, MD, MPH. *Medical Director, Drug Effectiveness Review Project, Center for Evidence-based Policy, Oregon Health and Science University*

Douglas C. McCrory, MD. *Associate Professor, Division of General Medicine, Research Fellow, Center for Clinical Health Policy Research, and Co-Director, AHRQ-designated Evidence-based Practice Center (EPC), Duke University*

Shawna L. Mercer, MSc, PhD. *Director, Guide to Community Preventive Services (Community Guide), US Centers for Disease Control and Prevention*

David Moher, MSc, PhD. *Director, Chalmers Research Group, University of Ottawa and the Children's Hospital of Eastern Ontario Research Institute, and Director, University of Ottawa's Evidence-based Practice Centre*

Sally C. Morton, PhD. *Vice President, Statistics and Epidemiology, RTI International*

Jean R. Slutsky, PA, MSPH. *Director, Center for Outcomes and Evidence, U.S. Department of Health and Human Services*

Harold Sox, MD, MACP. *Editor, Annals of Internal Medicine*

Sharon Straus, MD. *Associate Professor, Departments of Medicine, University of Calgary and University of Toronto/LiKaShing Knowledge Institute*

Sean Tunis, MD, MSc. *Founder and Director, Center for Medical Technology Policy, San Francisco*

Evelyn P. Whitlock, MD, MPH. *Senior Investigator, Center for Health Research, Director, Research-Healthcare Integration, and Associate Director, Oregon Evidence-based Practice Center*

Gail Wilensky, PhD. *Senior Fellow, Project HOPE*

Appendix D: Day One Evaluation Survey Instrument

Program Evaluation for DAY ONE - Thursday, July 10, 2008
 US Cochrane Center Conference on Priority Setting for Systematic Reviews



Plenary I: (1:15 - 2:30 pm) The Institute of Medicine's rationale and principles for prioritizing systematic reviews

Check here if you did not attend this session. All others: Circle the best answer for each item.

| | Excellent | Very Good | Good | Fair | Poor |
|---|-----------|-----------|------|------|------|
| A. Quality of session | | | | | |
| Informative content | 5 | 4 | 3 | 2 | 1 |
| Adequate time allotted | 5 | 4 | 3 | 2 | 1 |
| Questions answered to satisfaction | 5 | 4 | 3 | 2 | 1 |
| B. Quality of presentation by speakers | | | | | |
| The IOM Report - Knowing What Works in Health Care - Hal Sox | 5 | 4 | 3 | 2 | 1 |
| Prioritizing Evidence Syntheses - Sharon Straus | 5 | 4 | 3 | 2 | 1 |

Comments:

Case Studies I: (3:00 - 5:00 pm) Methods to prioritize systematic reviews

Check here if you did not attend this session. All others: Circle the best answer for each item.

| | Excellent | Very Good | Good | Fair | Poor |
|---|-----------|-----------|------|------|------|
| A. Quality of session | | | | | |
| Informative content | 5 | 4 | 3 | 2 | 1 |
| Adequate time allotted | 5 | 4 | 3 | 2 | 1 |
| Questions answered to satisfaction | 5 | 4 | 3 | 2 | 1 |
| B. Quality of presentation by speakers | | | | | |
| Case Studies I Chair - Steve Goodman | 5 | 4 | 3 | 2 | 1 |
| AHRQ's Effective Health Care Program - Evelyn Whitlock | 5 | 4 | 3 | 2 | 1 |
| The UK's National Health Service R&D and Department of Health Programmes - Martin Burton | 5 | 4 | 3 | 2 | 1 |
| The Cochrane Collaboration - Lorne Becker | 5 | 4 | 3 | 2 | 1 |
| Canada's Approach: Canadian Institutes of Health Research - Ian Graham | 5 | 4 | 3 | 2 | 1 |

Comments:

Appendix D: Day One Evaluation Survey Instrument, continued

Overall Evaluation for DAY ONE

| | Yes | No | Not Certain |
|--|--------------------------|--------------------------|--------------------------|
| 1. The program was presented without evident commercial bias or influence. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. The program for DAY ONE met my expectations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Please provide comments or suggestions: _____ | | | |
| _____ | | | |
| _____ | | | |

Appendix E: Day 2 Evaluation Survey Instrument



Program Evaluation for DAY TWO - Friday, July 11, 2008
 US Cochrane Center Conference on Priority Setting for Systematic Reviews

Plenary debate: (8:30 - 10:00 am) Models of priority setting for systematic reviews of clinical effectiveness

Check here if you did not attend this session. All others: Circle the best answer for each item.

| | Excellent | Very Good | Good | Fair | Poor |
|--|-----------|-----------|------|------|------|
| A. Quality of session | | | | | |
| Informative content | 5 | 4 | 3 | 2 | 1 |
| Adequate time allotted | 5 | 4 | 3 | 2 | 1 |
| Questions answered to satisfaction | 5 | 4 | 3 | 2 | 1 |
| B. Quality of presentation by speakers | | | | | |
| Let 1000 flowers bloom: Support for the current "system" - Doug McCrory | 5 | 4 | 3 | 2 | 1 |
| Both prioritization and review production should be centralized - Gail Wilensky | 5 | 4 | 3 | 2 | 1 |
| How can we leverage the best of these two models? A hybrid model of centralized priority setting - Sally Morton | 5 | 4 | 3 | 2 | 1 |

Comments:

Panel: (10:15 am - 12:00 pm) Knotty problems related to review prioritization

Check here if you did not attend this session. All others: Circle the best answer for each item.

| | Excellent | Very Good | Good | Fair | Poor |
|---|-----------|-----------|------|------|------|
| A. Quality of session | | | | | |
| Informative content | 5 | 4 | 3 | 2 | 1 |
| Adequate time allotted | 5 | 4 | 3 | 2 | 1 |
| Questions answered to satisfaction | 5 | 4 | 3 | 2 | 1 |
| B. Quality of presentation by speakers | | | | | |
| Meaningful engagement of decision makers in priority-setting - Sean Tunis | 5 | 4 | 3 | 2 | 1 |
| Considering Adverse Effects in prioritizing reviews - Andrew Herxheimer | 5 | 4 | 3 | 2 | 1 |
| A mid flight correction: setting priorities - David Moher | 5 | 4 | 3 | 2 | 1 |
| Incorporating systematic reviews into other systematic reviews: Can we save time and be valid? - Evelyn Whitlock | 5 | 4 | 3 | 2 | 1 |

Comments:

Appendix E: Day Two Evaluation Survey Instrument, continued

Case Studies II: (1:00 - 2:15 pm) Methods to prioritize systematic reviews

Check here if you did not attend this session. All others: Circle the best answer for each item.

| | Excellent | Very Good | Good | Fair | Poor |
|--|-----------|-----------|------|------|------|
| A. Quality of session | | | | | |
| Informative content | 5 | 4 | 3 | 2 | 1 |
| Adequate time allotted | 5 | 4 | 3 | 2 | 1 |
| Questions answered to satisfaction | 5 | 4 | 3 | 2 | 1 |
| B. Quality of presentation by speakers | | | | | |
| Drug Effectiveness Review Project - Alison Little | 5 | 4 | 3 | 2 | 1 |
| The James Lind Alliance - and I - Lester Firkins | 5 | 4 | 3 | 2 | 1 |
| Centers for Disease Control & Prevention, Community Guide - Shawna Mercer | 5 | 4 | 3 | 2 | 1 |

Comments:

Open Discussion: (2:30 - 3:30 pm) Working together or working apart: Cross-group cooperation in priority setting

Check here if you did not attend this session. All others: Circle the best answer for each item.

| | Excellent | Very Good | Good | Fair | Poor |
|--|-----------|-----------|------|------|------|
| A. Quality of session | | | | | |
| Informative content | 5 | 4 | 3 | 2 | 1 |
| Adequate time allotted | 5 | 4 | 3 | 2 | 1 |
| Questions answered to satisfaction | 5 | 4 | 3 | 2 | 1 |
| B. Quality of presentation by discussants | | | | | |
| Jean Slutsky | 5 | 4 | 3 | 2 | 1 |
| Lisa Bero | 5 | 4 | 3 | 2 | 1 |

Comments:

Overall Evaluation for DAY TWO

- | | Yes | No | Not Certain |
|--|--------------------------|--------------------------|--------------------------|
| 1. The program was presented without evident commercial bias or influence. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. The program for DAY TWO met my expectations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Please provide comments or suggestions: _____ | | | |

Appendix F: Day One Evaluation Comments

Plenary: The Institute of Medicine's (IOM's) rationale and principles for prioritizing systematic reviews

- Would be interested to know a bit more about how the IOM reached its recommendations for the principles for prioritizing reviews but found the topic and recommendations very interesting.
- Appreciated Sharon Straus' references to literature- a simplified or slower version of the talk would be great for me!
- Presenters were great
- Good way to start the meeting with these varied experiences-perspectives
- Good to have intro session to lay groundwork & define the issue
- A bit boring topic, too much time allotted
- Both the quality and the style of answering the questions was good- the speakers treated each question as important.

Methods to Prioritize Systematic Reviews: Case Studies I

- Quality of session informative content: Not as much on prioritization
- Good broad perspective. Good to have more input on UK process of rapid reviews
- Some presentations seemed off-theme; too much description about a parochial program, too little on prioritization.
- Interested to know more about relationship between external funding and prioritization- hopefully this will be covered tomorrow as promised. Enjoyed perspectives from those outside the US.
- We got into a more Cochrane-focused discussion by the second plenary session. That is the only thing I felt was missing from the beginning of the day- we sort of jumped into discussion of all of these other organizations without sort of "setting the context" of this being a Cochrane conference. Small point.
- Generally informative; good to see international perspective on difficult issue
- Examples presented in AHRQ presentation were very helpful
- Appreciated the competing perspectives
- Good to have international perspective, but its still limiting to have only US/Canada/UK. Would be great to hear a broader perspective.
- Excellent, good range of speakers
- There was too much repetition in terms of time allocated to different organisations detailing how they prioritise systematic reviews.
- I wish the speakers- especially from Canada and Dr. Burton- had been more explicit about how reports are selected and prioritized. A lot of people talk about how important it is, but methods used seem to go rarely beyond modified Delphi processes. This kind of process doesn't really answer the IOM's 2008 mandate.
- The diagrams & graphs were particularly helpful. The questions were also nicely addressed
- All well done, clear, & kept on time.

General

- Discussion was very high level. Great! Reception very nice. Liked the opportunity to talk.
- Would like a copy of the slides- can they be made available
- Excellent! Thank you!
- I found little connection between much of the information presented and the theme of "priority setting". I don't need an overview of how systematic reviews are done.
- I think today was a very good opening day. I will be interested to see if tomorrow presents more concrete ideas about prioritization. I also appreciate the self-evaluation from Cochrane. I respect Cochrane and see this as a wonderful way to become even better.
- More loyalty to the conference theme needed in presentations, but interesting stuff in general.
- Very interesting sessions.
- More interactive work with the delegates would be appropriate for the focus of the conference.
- Very thought provoking
- I would have liked it if you had provided abstracts as it helps you to know what is going to be presented and any Qs you need to ask.

Appendix G: Day Two Evaluation Comments

Plenary debate: Models of priority setting for systematic reviews of clinical effectiveness

- More clarity on objective of session would have been helpful. Better coordination between speakers would have improved the 'debate'- is the issue a new agency or how to prioritize SR- while related the issues are different. Sally Morton: to the point and clear.
- Nice to hear such a variety of perspectives
- The two distinct approaches that were under debate were not apparent to me. I guess I need (or prefer) a more pro-con discussion.
- Sally Morton's presentation really was a great summary of the discussion to this point- very helpful.
- Would allot more time for questions; also would appreciate other perspectives on prioritization (purchasers, additional pt groups)
- Overall, I didn't feel I learned a lot from this session with the exception of the discussion after it.
- Interesting talks but did not seem on target- not debate of different views. Dr. Morton- great summary of issues. Very interesting discussion

Panel: Knotty problems related to review prioritization

- Dr. Moher's had a lot of good discussion- a little too much- as it was to quick to read the rich content of his slides. Dr. Herxheimer was good but I was looking more for the focus on review prioritization
- Very important topic and important information- I just wondered about the applicability to these sessions.
- This is where it all started to come together for me- great.
- Dr. Tunis needed more time
- Everyone talks about stakeholder involvement. Interesting to hear what happens when stakeholders are engaged/ especially when consensus is not reached. Review of reviews an interesting topic.
- All were excellent!
- Struggled with this group of speakers apart from Sean as I felt unable to separate "the wheat from the chaff"- possibly too many key points
- Session was more of soliciting support for topics of interest to be included in prioritizing and less of "problems related to review prioritizing
- I think David Mother and Evelyn Whitlock gave the most substantive talks of the entire conference. They were wonderful.

Methods to Prioritize Systematic Reviews: Case Studies II

- Thank you for inviting Mr Firkins. Consumer input is so important.
- Great session, really focused on priority setting
- Would appreciate more time devoted to explanation of how priorities are set
- Moderator did not leave enough time for discussion

Appendix G: Day Two Evaluation Comments (cont'd)

- Lester Firkins' presentation was clear, practicable, personable, of a nice balance of detail & connecting the audience to where to go for more information, and well-delivered with an exceptional blend of the information in context. Shawna Mercer gave a very great overview showing the actual process.
- Could use a whole panel of patient/consumer representatives a/la Lester Firkins.

Open Discussion: Working together or working apart: Cross-group cooperation in priority setting

- Great discussion but even more time needed for discussion!
- The discussion time was excellent! Loved the opportunity to hear so many perspectives
- Dr. Slutsky's presentation was clear & she answered questions very well. Dr. Bero's presentation was also very clear, a little less relevant to my needs but I recognize the importance of the topic.
- Lisa Bero's presentation included a nice interwoven bulleted list, diagrams & document figures; was clearly delivered; & was both a nice amount of detail of the actual relationships among the organizations of concepts she was describing & pulled everything together through questions & statements of progress within the presentation & from the rest of the conference.
- Really liked how having Lisa Bero wrap it up highlighted & brought it back to Cochrane & wkg w/in what exists
- The presentations regarding various constructs of prioritization were informative but a more directed discussion of the "ideal" mechanism might have been quite useful.

General Comments

- Overall, an excellent and thought-provoking meeting
- Overall this was a decent conference. However, I found the didactic format less engaging than the option of breakout rooms for smaller discussion of (for example) experience engaging with researchers. I think the richness of experience in the room could have contributed to the learning process for all more than having only a few selected speakers. This may be a personal opinion...however I don't know that I am taking home the new level of knowledge I thought I would. I did learn a lot though! Thank you!
- Should begin and end sessions on time!
- Overall, invigorating mix of participants- great discussions- thanks for leaving adequate time for Q&A.
- Q&A sessions most helpful after all speakers have spoken. Good organization and time management for conference.
- The use of acronyms should be banned.
- The same people dominated question period & spent a lot of time offering views not questions. Much could be learned from participatory research approaches to engage decision makers in research & SR.

Appendix G: Day Two Evaluation Comments (cont'd)

- Overall, it is helpful to know approximately where we are with respect to priority setting. Naively, I thought I might leave with specific priorities or concrete methods for setting priorities, but I do have an idea of how to go about it as methods evolve.
- Thank you for bringing to forum the many political vested interests- enlightening, hopeful & frustrating all at once!! Provocative dialogue= a very good conference
- Clear political influence in many presenters devoid of science and other useful information
- The presentation of the work & processes of some organizations was at times monotonous.