Report

US Cochrane Center Conference

"Stakeholder Summit on Using Quality Systematic Reviews to Inform Evidence-based Guidelines"

4-5 June 2009

Baltimore’s Tremont Suite Hotel
Baltimore, Maryland

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<td>ACP</td>
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USCC Stakeholder Summit 2009: Using Quality Systematic Reviews to Inform Evidence-based Guidelines (cont’d)

KDIGO  Kidney Disease Improving Global Outcomes  
KDOQI  Kidney Disease Outcomes Quality Initiative  
PCPI  Physician Consortium for Performance Improvement  
QUERI  Quality Enhancement Research Initiative  
USCC  US Cochrane Center  
USPSTF  US Preventive Services Task Force

(ii) Appendices

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1. Executive Summary

This report summarizes the US Cochrane Center (USCC) Stakeholder Summit on Using Quality Systematic Reviews to Inform Evidence-based Guidelines, held 4 - 5 June 2009 in Baltimore, Maryland (see Appendix A - Conference Program). The conference theme was selected in response to demands for high quality systematic reviews and greater use of quality systematic reviews in guidelines development. The conference aimed to provide a forum for exchange between systematic reviewers and guideline developers, particularly on methodological aspects of the work. The goal was to contribute to increased production of high quality systematic reviews that are responsive to the needs of user communities, and to enhance professional society adoption and application of these reviews to inform evidence-based guidelines.

The Conference Planning Committee (see Appendix B - Conference Planning Committee) designed a program that addressed current key issues for North American systematic reviewers, methodologists, guidelines developers, clinicians, consumers, policy makers, and researchers. Speakers (see Appendix C - Conference Speakers) were invited to address topics that included standards for systematic reviews from both the reviewer and user perspectives, current challenges in “grading” evidence for guideline development and strategies to make guidelines “actionable”. Presentations by reviewer and guideline developer teams who have worked together highlighted effective strategies and remaining challenges. The viewpoints of consumers and international colleagues were contributed, and the need for input by all stakeholders was endorsed.

The conference agenda included plenary sessions, panel discussions, and workshops. Speakers and participants included representatives of the Cochrane Collaboration, The Agency for Healthcare Research and Quality’s (AHRQ’s) evidence-based practice centers (EPCs), educational and research institutions, government agencies, advocacy organizations, professional societies, and public and private organizations.

Throughout the two days of the conference, a few recurrent themes emerged, most prominently, 1) guidelines developers, who are often unfamiliar with the process of performing a systematic review, are seeking standards for systematic reviews, and 2) there is a lack of available evidence on vital clinical questions. Speakers and audience members also emphasized the need for ongoing orientation and education in systematic review processes and evidence-based healthcare (EBHC) for guidelines development teams, increased transparency of documentation and procedures reporting in the work of all parties, explicit assessment of gaps in the evidence, and
careful reporting of and attention to conflicts of interest. Different systems to grade evidence were proposed and lively exchanges ensued between individuals using an established system or a self-designed hybrid system. Issues of quality of evidence, strength of recommendation and clinical judgement were raised in a number of presentations and discussion sessions. Concerns were voiced as to whether existing systematic reviews cover the many pressing clinical questions which guidelines must address.

Feedback from the conference evaluation indicates that the meeting overall met participants’ expectations, and was useful in crystallizing critical issues for advancing the production and use of clinical evidence.

2. Summary of Sessions

2.1 Thursday, June 4, 2009

Dr. Kay Dickersin, Director of the US Cochrane Center, welcomed the conference attendees and noted the conference objectives and goals. She highlighted the unique opportunity provided by the summit to have systematic reviewers and guidelines developers together tackle challenges in furthering the evidence base of clinical guidelines.

2.1.1 Standards for systematic reviews: Part 1 – Internal needs and perspectives from the guidelines producers

Chair: Steve Phurrough – Agency for Healthcare Research and Quality

2.1.1.1 Cystic Fibrosis Foundation guidelines: Starting from scratch - Karen Robinson - Johns Hopkins School of Medicine (for podcast see: http://apps1.jhsphs.edu/cochrane/NSvideopodcastol5.htm#robin.)

Ms. Robinson described the Cystic Fibrosis Foundation (CFF), and explained that although she is funded by the CFF she does not speak on their behalf. The CFF maintains a patient registry, works to increase patient participation in clinical trials, tracks variations in care across Cystic Fibrosis Centers, and develops guidelines. Approximately 20 consensus-based guidelines were produced by the CFF from the early 1990s through 2003. In late 2004/early 2005, the CFF moved to an evidence-
based guidelines development process; to date, they have produced and published four evidence-based CFF guidelines, two are in press, and another two are in progress.

Ms. Robinson articulated two major challenges in the professional society’s production of evidence-based guidelines 1) lack of familiarity with EBHC or systematic reviews, and 2) lack of available evidence on key questions. Lack of familiarity with EBHC leads to poorly defined questions, and impatience or confusion regarding the evidence-gathering process. Lack of available evidence on key questions leads to ‘missing’ recommendations, and many of the questions lacking evidence are comparative effectiveness questions. Ms. Robinson identified organizational buy-in to EBHC, guideline committee chairs with experience in EBHC processes, and guideline committee members familiar with EBHC as needed to meet the first challenge. She pinpointed a willingness to use the best available evidence (including evidence outside randomized controlled trials) as a potential solution to the second challenge. Next steps for CFF include providing ongoing orientation and education (possibly online) for people involved in guideline production, increased process documentation and transparency, and an explicit review of evidence gaps.

2.1.1.2 The quality of systematic reviews: Where do we go from here? –

Marguerite Koster – Kaiser Permanente (for podcast see: http://apps1.jhsph.edu/cochrane/NSvideopodcastol6.htm#koster)

Ms. Koster described Kaiser Permanente’s National Guideline Program, which is responsible for developing and maintaining a core set of evidence-based clinical practice guidelines. Guidelines are developed by in-house teams with multiple areas of expertise, including methodologists who review evidence documentation for inclusion of 1) a clearly defined clinical question, 2) a systematic evidence search, 3) critical appraisal of evidence, and 4) evidence grading and labeling of recommendations. Currently there are nine guidelines related to preventive care, primarily developed using systematic reviews produced by the USPSTF or Agency for Healthcare Research and Quality (AHRQ), and ten guidelines related to chronic condition management, developed using systematic reviews produced by AHRQ, the Cochrane Collaboration, and others.

Ms. Koster emphasized that quality systematic reviews should be the starting point for evidence-based guideline development; however, the quality with which the reviews were conducted and the completeness and transparency with which they were reported are critical. Ms. Koster noted that variation in methodological and reporting quality of published reviews creates a challenge for guideline developers. She advocated more collaboration between producers and users of systematic reviews in the US to 1) build
on existing efforts to improve the way systematic reviews are conducted and reported;  
2) develop a structured US-based systematic review peer review system; and  
3) encourage adoption of quality standards by systematic review producers, guidelines  
producers, and medical journals.  This collaboration would ultimately encourage greater  
confidence in the quality of systematic reviews, as well as provide opportunities to  
prioritize and coordinate topics.

2.1.1.3 Systematic reviews ≠ guidelines: Translation needs and challenges –  
Martha Faraday – American Urological Association (Consultant) (for podcast  
see: http://apps1.jhsph.edu/cochrane/NSvideopodcast5.htm#faraday .)

Dr. Faraday, speaking based on her experience as a consultant to the American  
Urological Association (AUA), delineated the challenges inherent in bridging the gap  
between systematic reviews, which are technical, academic documents, and guidelines,  
which are clinical documents.

She explained that AUA guidelines panels include members with different  
backgrounds and experience and varying degrees of familiarity and comfort with  
systematic reviews.  This poses a barrier to involving all stakeholders in evaluating and  
incorporating evidence into guidelines.  Dr. Faraday advocates that panel members  
participate in ongoing EBHC training. She discerns a need for translation of EBHC  
concepts and results into plain language suitable for a broad audience noting that  
graphic presentation of statistical concepts and complex relationships provides an  
approach for audiences lacking EBHC expertise. She advised that greater efforts be  
made to ensure that systematic reviews can be used effectively by all panel members.

2.1.2 Standards for systematic reviews: Part 2 – Meeting external standards

Chair: Cheryl Dennison – Johns Hopkins University School of Nursing

2.1.2.1 Performance measures related to guidelines – Mark Antman – American  
Medical Association (for podcast see:  
http://apps1.jhsph.edu/cochrane/NSvideopodcast5.htm#antman .)

Dr. Antman addressed the relationship between evidence, guidelines, and  
performance measures.  He described the Physician Consortium for Performance  
Improvement (PCPI), an American Medical Association initiative to develop, test and  
maintain evidence-based clinical performance measures.  Dr. Antman noted that  
increased rigor and consistency in guideline development was critical to better  
evidence-based performance measures and ultimately to improved patient care.  He
pointed out that performance measures must address clinically important topics, consider the need for exceptions, have face validity, be controlled by the clinician being assessed, and be measurable.

The PCPI, in response to the variability in methodology among guideline developers, developed draft criteria for acceptability of guidelines in clinical measure development. Key PCPI criteria are of two types: source criteria and content and process criteria. Source criteria include availability of the guideline in the English language, currency (completed within 5 years), and transparency of development panel members’ conflicts of interest and funding sources. Content and process criteria include clear recommendation statements, description of methods used for the literature search, and description of types of evidence. There are additional consensus-based proposed criteria for guideline recommendations. Dr. Antman noted that PCPI is following Institute of Medicine (IOM) recommendations for a “common language” that describes both the quality of the evidence and the strength of the recommendation.

2.1.2.2 Case study: Methadone & QTc prolongation: Time for guidelines? - Marc Gourevitch – New York University School of Medicine (for podcast see: http://apps1.jhsph.edu/cochrane/NSvideopodcastol5.htm#gvich.)

Dr. Gourevitch reviewed the challenges of developing guidelines in cases of limited randomized controlled trial evidence and used routine electrocardiogram (ECG) screening in methadone treatment as a case study. Based on literature indicating that prolongation of the ECG’s “QTc interval” in persons on methadone treatment may reflect an increased risk of sudden cardiac death, leading to 2006 issuance of a FDA manufacturer black box warning, the Center for Substance Abuse Treatment convened a panel to review existing evidence and to develop cardiac safety recommendations for the prescription of methadone. There were no published trials on whether screening of patients on methadone or other QTc-prolonging medications averts cardiac morbidity and mortality, thus a guideline based upon randomized trial evidence was not possible. The panel produced a consensus guideline with five recommendations.

Members of the clinical community, acting in response to the guideline, instituted a 100 mg cutoff point for methadone, already known to be often under-dosed. Dr. Gourevitch emphasized that the evidence on a balance between benefit and harm for QTc screening in methadone treatment remains unclear.

Dr. Gourevitch suggested that a decision analytic approach be undertaken to address this situation utilizing existing data sets, modeling competing harms, identifying gaps in the evidence, estimating costs and cost effectiveness, and analyzing the impact...
of ECG frequency and methadone dose cutoff points. In general, he urged consideration of downstream actions when deciding at what point adequate evidence exists to issue a guideline.

2.1.2.3  The Institute of Medicine’s report, Conflict of Interest in Medical Research, Education, and Practice: as related to practice guidelines -

Robert Krughoff – Consumer CHECK-BOOK/Center for the Study of Services (for podcast see:
http://apps1.jhsph.edu/cochrane/NSvideopodcast5.htm#krugoff .)

Mr. Krughoff reported on the framework recommended by the IOM report Conflict of Interest in Medical Research, Education, and Practice. He served as a member of the IOM committee developing the report, and specifically addressed in his talk how conflicts of interest in development of clinical practice guidelines should be identified, limited, and managed without damaging constructive industry collaborations. A conflict of interest is a risk, and not necessarily existence of a biased judgment or action. Mr. Krughoff underscored that disclosure of conflict of interest is a necessary but not sufficient element in managing such a conflict. He reviewed the IOM report recommendations on policies and procedures for managing conflict of interest, noting ambiguities such as definitions of “influence” and “indirect” funding. Of note, according to Mr. Krughoff, is that only financial conflicts related to drug, device, and biotechnology industries are considered, not conflicts related to payment or reimbursement systems, professional training and preferences, ownership interests in provider organizations and intellectual biases.

Mr. Krughoff recommends that the best practical solution to potential conflicts is for guideline panels to have a broad and diverse set of participants, and to combine this with disclosure and management of conflicts of interest as recommended by the IOM report. He stressed that guideline users should demand that conflict of interest standards are followed.

2.2  Friday, June 5, 2009

2.2.1  Plenary – Thorny problems for guidelines developers

Chair: Milo Puhan – Johns Hopkins Bloomberg School of Public Health

2.2.1.1  Is there a benefit to standardizing methods for grading the evidence and making recommendations – If so, is GRADE “the one”?- Yngve Falck-
Dr. Falck-Ytter stated the importance of standardizing methods for grading evidence, and argued that evidence alone is not sufficient for making recommendations. Rather, systematic and explicit approaches must be used to assess the quality of evidence and develop recommendations. He noted that expert opinion should not be considered a form of evidence, but a component of interpreting the evidence.

Dr. Falck-Ytter noted the difficulties in applying the systems that grade evidence. There are multiple available systems which tend to be limited by 1) lack of a conceptual framework, 2) criteria that are incomplete or not transparent, or 3) confusion of quality of the evidence with strength of a recommendation. Dr. Falck-Ytter prefers the GRADE approach which he believes provides a conceptual framework and comprehensive and transparent criteria, and produces separate assessments of the quality of the evidence and the strength of a recommendation. The GRADE approach is used to assess the relative importance of outcomes within a review, prepare a summary of the quality of the evidence for each outcome, produce an assessment of the overall quality of the evidence across outcomes, and decide the direction and strength of the recommendation. Dr. Falck-Ytter described four GRADE categories for quality of the evidence (high, moderate, low, or very low) and two GRADE categories for strength of the recommendation (strong or weak).

2.2.1.2 Making guidelines actionable: Overcoming obstacles – Richard M. Rosenfeld – American Academy of Otolaryngology – Head and Neck Surgery (for podcast see: http://apps1.jhsph.edu/cochrane/NSvideopodcast6.htm#rosen )

Dr. Rosenfeld discussed how to identify and overcome the obstacles inherent in making actionable guideline statements. Using the American Academy of Otolaryngology – Head and Neck Surgery guideline development process as a point of reference, he emphasized actionability, which requires a focused set of key statements that are action oriented prescriptions of specific behavior from a clinician in a specific set of circumstances. The anatomy of a guideline recommendation must include when (under what conditions), who (specifically), must, should or may (the level of obligation), do (what precisely), to (whom).
Dr. Rosenfeld used a guideline on treatment of acute sinusitis to illustrate overcoming obstacles. The definition of a condition may be variable (for example, acute sinusitis is defined in a variety of ways) and the definition of treatment failure may also be defined in different ways (for example, the decision about when initial treatment has failed is based on expert consensus rather than evidence). For guidelines to be actionable it is necessary for both the disorder and the criteria for success or failure to be operationalized.

In outlining the steps in quality-driven guideline development Dr. Rosenfeld emphasized the importance of existing quality systematic reviews and randomized trials. He underscored the need to involve all stakeholders, develop evidence profiles, and obtain internal and external review of proposed guidelines. He reported on the Academy’s positive experience working with a consumer representative from Consumers United for Evidence-based Healthcare (CUE) in the development of a guideline on hoarseness.

2.2.2 Panel: Collaborations between systematic reviewers and guideline developers

Chair: Susan Norris – Oregon Health and Science University

2.2.2.1 Evolution of the National Kidney Foundation – Tufts Evidence Review Team collaboration in developing kidney disease guidelines - Garabed Eknoyan – Baylor College of Medicine and Ethan Balk - Tufts Medical Center (for podcast see: http://apps1.jhsph.edu/cochrane/NSvideopodcastol7.htm#eknoyan and http://apps1.jhsph.edu/cochrane/NSvideopodcastol7.htm#balk .)

Dr. Eknoyan reviewed the history of kidney disease guidelines, beginning with the Dialysis Outcomes Quality Initiative (DOQI) in the 1990s. As it was understood that some of the problems encountered in treatment of end stage renal disease had roots very early in the disease process, the DOQI evolved into the Kidney Disease Outcomes Quality Initiative (KDOQI) (2000). The principles of scientific and methodological rigor, multi-disciplinary work groups and advisory board, independence of work groups, and open development processes were consistent between DOQI and KDOQI. Finally, Dr. Eknoyan described the formation of the Kidney Disease Improving Global Outcomes (KDIGO) group in 2003 to improve international cooperation in developing kidney disease guidelines. The first KDIGO guideline was published in April 2008.
Dr. Balk discussed the collaboration between KDOQI/KDIGO and the Tufts Medical Center Evidence Review Team which began in 2002. The Tufts Evidence Review Team primarily conducts systematic reviews to inform KDOQI/KDIGO guideline development. The KDIGO workgroup is responsible for refining the topic and key question, advising on complicated content issues, writing the recommendations, and composing the accompanying rationale text. The process culminates in a combined guideline/systematic review product. Dr. Balk also outlined evolution of an increasingly standardized and explicit approach to guidelines development. As part of this evolution, the KDIGO board voted in 2008 to implement the GRADE approach to assessment of quality of the evidence and levels of recommendation, with an additional category of “Not Graded”.

2.2.2.2 Diagnosis and treatment of low back pain: A joint clinical practice guideline from the American College of Physicians and the American Pain Society - Amir Qaseem – American College of Physicians and Roger Chou – Oregon Health and Science University (for podcast see: http://apps1.jhsph.edu/cochrane/NSvideopodcast7.html#qaseem and http://apps1.jhsph.edu/cochrane/NSvideopodcast7.html#chou.)

Dr. Qaseem presented a brief overview of the American College of Physicians (ACP) guideline development process. ACP produces two guideline products, clinical guidelines based on a review of evidence, and clinical guidance statements based on a review of available guidelines. The evidence review for clinical guidelines may be ACP-sponsored or conducted in collaboration with AHRQ EPCs or other entities. The evidence review for clinical guidance statements is done by ACP using MEDLINE and the AGREE instrument. Guidelines are disseminated by publication on the ACP website and in the Annals of Internal Medicine. ACP has adopted the GRADE classifications of quality of the evidence and strength of recommendation, with the exception of an additional category of insufficient evidence to determine net benefits or risks.

Dr. Chou described the partnership between the ACP and the American Pain Society (APS) in developing guidelines for treatment of low back pain. He began by describing the background and history of the APS guidelines program, which began in 1997. APS routinely seeks partnerships with other professional societies when developing guidelines, because such partnerships lead to efficient use of resources, improved credibility and impact, and reduced proliferation of discordant recommendations. The ACP/APS partnership to develop guidelines for treatment of low back pain began in 2004 and the guideline was published in 2007. The evidence
review was conducted at the Oregon EPC, with VA/DoD participation. Issues in developing the ACP/APS partnership were the source of funding, the assignment of copyright, and agreement on methods, leadership structure and approval processes.

Finally, Dr. Chou discussed the two key methodological challenges in developing the low back pain guidelines: how to synthesize evidence on a large body of literature, and how to select and adapt methods for grading recommendations. Evidence was synthesized by evaluating the quality of individual systematic reviews and then assessing consistency between higher quality reviews; in general they were found to be concordant. However, depending on published systematic reviews is not straightforward. For example, though the methods for grading recommendations were based on US Preventive Services Task Force (USPSTF) grades for individual interventions and GRADE for the final recommendations, USPSTF and GRADE systems overlap imperfectly. Dr Chou concluded that forming partnerships can be useful in developing guidelines, although they require flexibility and additional time, and that methodological issues in assessing a large body of literature and creating recommendations are complex.

2.2.3 Panel: Ensuring a better interface between systematic reviews and guidelines

Chair: Roger Herdman – Institute of Medicine

2.2.3.1 What have we learned about the quality of the underlying evidence from the National Guideline Clearinghouse – Vivian Coates – ECRI Institute and Mary Nix – Agency for Healthcare Research and Quality (for podcast see: http://apps1.jhsph.edu/cochrane/NSvideopodcast06.htm#nix.)

Ms. Nix presented information on AHRQ’s National Guideline Clearinghouse which is web-based. The Clearinghouse, which went live in 1999, provides access to guideline-related resources and to a repository of more than 2,400 guidelines that meet minimal evidence criteria for inclusion.

Ms. Coates noted that guidelines vary in how much information they include about the methodological processes used to produce the guideline. She added that many guideline users assert that only clinicians can evaluate the literature in their domain and therefore incorrectly discount the roles of methodology and methodologists. There is also variation in how recommendations are presented and how much supporting evidence is cited, even when systematic reviews have been conducted. She concluded
that there are significant opportunities for systematic reviews to be used by the
guideline developer community and there must be increased education about the
systematic review process to realize this opportunity. Ms. Coates posed a challenge to
the systematic reviewer community asking the question of whether existing systematic
reviews are relevant to the key clinical questions addressed by guidelines.

2.2.3.2 Transparency of guidelines – What do we mean and how do we get there? - Jeffrey Harris – Kaiser Federation Care Management Institute (for podcast see: http://apps1.jhsph.edu/cochrane/NSvideopodcast6.htm#harris)

Dr. Harris discussed the importance of transparency in reporting the conduct of
systematic reviews. A consensus document produced at Kaiser Permanente outlines
key aspects of transparency: documentation of a standard development methodology,
documentation of progression from clinical question through final recommendation, and
inclusion of explicit value statements.

He emphasized the direct link between high quality systematic reviews and high
quality guidelines noting user specifications for systematic reviews: clear, accessible
and assessable methodology, well documented evidence searches, standard objective
critical appraisal of studies, and easily interpretable evidence tables. Dr. Harris outlined
specifications for the guideline development process as well and emphasized
documentation and transparency. He highlighted the clinical significance of results and
patient values. In closing, Dr. Harris proposed that guidelines could be leveraged via
links to electronic medical records and posed the potential use of guidelines as a basis
for clinical quality improvement.

2.2.3.3 The American Urological Association guidelines: On the cutting edge – Heddy Hubbard – American Urological Association (for podcast see: http://apps1.jhsph.edu/cochrane/NSvideopodcast7.htm#hubbard)

Dr. Hubbard presented an overview of the American Urological Association (AUA)
guideline development structure and processes. The AUA Practice Guidelines
Committee, established in 1989, oversees guideline development and shapes overall
guidelines policies for the AUA. In the early 1990s a decision was made to incorporate
evidence into guidelines. Between 2000-8, in response to Board directive, the AUA
guidelines committee began evaluating existing AUA guidelines on a regular basis for
currency, focusing on topics that were prevalent, costly and characterized by significant
practice variation, and developing a more cost-efficient methodology. Methods for
guidelines include linking three levels of recommendation to three levels of evidence, based upon the ACP’s hybrid version of GRADE. AUA guideline principles aim to be transparent, rigorous, cost-efficient and timely. To date, AUA has produced 11 guidelines, 10 practice statements and seven patient guides; all are reviewed annually for currency.

Dr. Hubbard outlined the nine phases in AUA guideline development. They are 1) nominate the topic, 2) identify panel members, 3) define research questions and develop a work plan, 4) conduct the literature review, 5) extract, synthesize and analyze the data, 6) develop the systematic review report, 7) write the guideline, 8) arrange for peer review, and 9) obtain formal AUA approval and publish.

2.2.4 Breakout Workshops

2.2.4.1 GRADE Profiler: How to make it work for you – Yngve Falck-Ytter – Case Western Reserve University School of Medicine and Nancy Santesso – McMaster University

GRADE Profiler is a software program which is widely used to standardize methods for grading evidence. There are two components to GRADE: 1) assessing the quality of the evidence, and 2) assigning the strength of the recommendation. Workshop participants were divided into two groups. Dr. Falck-Ytter led one group through an exercise in grading the quality of the evidence using the GRADE software, and Ms. Santesso led the second group through an exercise in assigning the strength of a recommendation.

2.2.4.2 Options for formal consensus processes: The steps to success – Catherine MacLean – WellPoint, Inc.

Dr. MacLean introduced the RAND/UCLA Appropriateness Method, developed in the 1980s to integrate the best available evidence (randomized clinical trials) with clinical expertise and patient values when making clinical decisions in everyday practice. This method combines the best available scientific evidence with the collective judgment of experts to yield a statement regarding whether a diagnostic test, drug or other treatment is appropriate for a patient with certain test results, symptoms and medical history. She noted that it is the most studied group judgment method for creating practice guidelines. Dr. MacLean outlined the basic steps in the process (see below) and then discussed applications of the RAND/UCLA Appropriateness Method.
The Rand Appropriateness Method uses elements of the Delphi technique and nominal group process. Its key features include it being 1) literature informed - panelists are provided with a state of the art literature review, 2) specific - all key terms have specific definitions, 3) democratic - each panelist has an equivalent weight in producing the final result, and 4) iterative - panelists rate the appropriateness of care for specific clinical situations twice.

A panel is selected made up of six to 15 members with a balance of relevant clinical disciplines. Before the panel begins work a literature search is performed and clinical scenarios are constructed to reflect all possible combinations of potentially relevant clinical indicators. Panelists then independently rate the appropriateness of the care process for each clinical scenario, using their own judgement as informed by the literature review. A rating scale from 1 - 9 is used, 1 = least appropriate, 9 = most appropriate and 5 = risks and benefits are about equal. The panel then has a face-to-face meeting where each scenario is discussed, reviewing first round ratings and discussing those scenarios with divergent ratings. After the discussion each scenario is rated a second time. At the end of the process each indication is classified as "appropriate", "uncertain", or "inappropriate" for the intervention under review in accordance with the panelists’ median score and defined levels of allowable disagreement among panelists.

Dr. MacLean also discussed the use of the Appropriateness Method for developing quality indicators noting that in the US the method is currently more commonly used for developing quality measures than for assessing appropriateness.

2.2.4.3 Getting physicians on-board with guideline development – Henry Jampel – Johns Hopkins School of Medicine

Dr Jampel posed two questions to the group: 1) Why is it important to get physicians on board with guidelines development? and 2) Why is it so difficult to do so? Discussion points included the current medical-legal-reimbursement environment which may make physicians view guidelines as potentially punitive. Physician input to guidelines development was recognized as critical; one model was to have an experienced physician with content expertise lead the guidelines committee. A need for methodological expertise on the panel was also emphasized. It was noted that if evidence is inconclusive and the guideline reflects expert opinion, this should be clearly documented.
2.2.4.4  Incorporating systematic reviews into practice guidelines – Karen Robinson – Johns Hopkins School of Medicine and Roberta Scherer – Johns Hopkins Bloomberg School of Public Health

Ms. Robinson and Dr. Scherer provided a forum for discussion about the use of existing systematic reviews in the guidelines development process. As background, the model for considering the use of existing systematic reviews in systematic reviews developed by Whitlock et al. (2008) (PMID: 18490690), and adapted in a draft chapter of the Methods Guide for Comparative Effectiveness Reviews (http://effectivehealthcare.ahrq.gov/healthInfo.cfm?infotype=rr&ProcessID=60), was described. The leaders posed discussion questions about when and whether to incorporate existing systematic reviews and group members added questions: 1) Is hand searching to identify new evidence necessary when using existing systematic reviews? and 2) Can existing systematic reviews be used when the current questions are related to unique populations? That is, how practical is it to assume that subgroup information can be found in existing systematic reviews?

It was noted that using existing reviews can save time and resources; however, the narrow focus of systematic review questions may limit applicability to the broader questions usually addressed in guidelines. Concerns were raised about the frequent lack of documentation of processes and methods in systematic reviews. There were also questions about the level of information and detail found in a systematic review that should be presented to a guidelines panel. A registry of systematic reviews that could incorporate detailed information about methods was recommended to help potential users identify usable existing reviews.

2.2.5  Panel: Ensuring the guideline is a trusted source

Chair: Kay Dickersin – US Cochrane Center

2.2.5.1  What is a meaningful consumer voice? – Carol Matyka – National Breast Cancer Coalition (for podcast see: http://apps1.jhsph.edu/cochrane/NSvideopodcast5.htm#matyka )

Ms. Matyka outlined the role of the National Breast Cancer Coalition in representing over 600 grassroots organizations that influence breast cancer policy and research. The National Breast Cancer Coalition trains advocates in both advocacy and science. The role of the consumer voice is to remind clinicians and methodologists that the ultimate goal of their activities is better patient care.
She emphasized the importance of getting the right care at the right time based on the highest level of evidence available. Ms. Matyka noted that guideline development must be transparent, understandable, explicit about the level of evidence, and must disclose all conflicts of interest. She remarked that widely used breast cancer screening guidelines are often based on lower levels of evidence. Ms. Matyka ended with a strong assertion that consumer advocates must be involved at every step of the decision making process in guideline development.

2.2.5.2 US government approaches to guidelines: What I have learned in 15 years at the intersection of science, public health and politics – David Atkins – United States Department of Veterans Affairs (for podcast see: http://apps1.jhsph.edu/cochrane/NSvideopodcast06.htm#atkins).

Dr. Atkins presented a brief time line of the USPSTF, Agency for Health Care Policy and Research (AHCPR) and AHRQ guidelines activities, and proposed explanations for why the USPSTF guideline activities have thrived while AHRQ guideline activities did not. The most important reasons for the USPSTF’s success were that primary care societies (stakeholders) were at the table and supported USPSTF, USPSTF matched its scope to its audience and recognized its competitive advantage in that nobody else was addressing the complete package of preventive services, and USPSTF defused occasional negative messages by focusing on the overall positive mission of disease prevention.

Dr. Atkins next discussed his current position at the VA Quality Enhancement Research Initiative (QUERI), where the focus is on using evidence to improve quality. He noted that guidelines are one way that all sources of information can be brought together and used to inform performance measures and quality improvement. Dr. Atkins closed by stating that while the guidelines process is not always necessary to translate new evidence into action, it is an important way to bring relevant parties to the table.

2.2.5.3 G-I-N: An international initiative to promote systematic development of clinical practice guidelines – Jako Burgers – Harvard School of Public Health and Dutch Institute for Healthcare Improvement CBO (for podcast see: http://apps1.jhsph.edu/cochrane/NSvideopodcast05.htm#burgess).

Dr. Burgers emphasized that the main aim of guidelines is to support and promote good clinical practice, and that guidelines are not ends in themselves. Guidelines incorporate evidence, values and resources in prescribing decisions. In Dr. Burgers’ opinion, the most difficult part of creating a guideline is the considered judgement about
clinical relevance, safety, impact on costs and other matters when there is a lack of information. Dr. Burgers discussed use of the GRADE and the AGREE instruments in assessing evidence and making recommendations.

Dr. Burgers then discussed the Guidelines International Network (G-I-N). G-I-N was created in November 2002 to reduce duplication of effort, maximize the most effective use of resources and spread the work of producing good-quality guidelines. One significant aim was to outline best methods for patient participation in guideline development and to articulate an international research agenda. Some aspects of guideline development can be shared in multinational collaborations: literature searches, critical appraisal and systematic review and literature monitoring to identify needed updates. Aspects that require local input include constitution of multidisciplinary working groups, formulation of recommendations, and external review.

Dr. Burgers described G-I-N's next steps as collaboration with the Cochrane Collaboration through use of Cochrane reviews, development of a common framework for evidence tables, exchange and prioritization of topics for systematic reviews, and enhanced contacts with Cochrane review groups. Finally, Dr. Burgers summarized the current size and composition of G-I-N and invited conference participants to the 6th G-I-N conference November 1-3, 2009, in Lisbon.

3. Summary of Participant Evaluations

The 113 individuals who attended the conference represented the diverse communities of systematic reviewers and guidelines developers, including clinicians, researchers, policymakers, consumer advocates, and funding agency representatives. Participants were asked to complete an evaluation form for each of the two days of the conference, including evaluations of each speaker, session, and day, and an evaluation form for the workshop that they chose to attend. (see Appendices D and E - Day 1 and Day 2 Evaluation Survey Instruments and Appendix F for Workshop Evaluation Survey Instrument) 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/suggestions were more time for discussion, more information on workshops prior to selection, sessions that would compare methodologies such as GRADE and AGREE, and more time devoted to GRADE (see the following Appendices for Evaluation Comments; Appendix G - Day 1, Appendix H - Day 2 and Appendix I - Workshops).

Sixty-six evaluations were returned on Day One and 62 on Day Two. Of those responding to the question "Did the meeting meet your expectations?", 91% (51/56)
responded yes on Day One, and 86% (38/44) responded yes on Day Two. Similar proportions of respondents believed that the meeting was free from commercial bias, 97% (56/58) responded yes for Day One and 98% (47/48) responded yes for Day Two.

Mean scores for each segment of the meeting are reported in Table 1. Eighty-four percent of responses were excellent or very good for individual sessions both days on “Informative content”, “Adequate time allotted” and “Questions answered to satisfaction”.
## Table 1. Evaluation Summary

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<td>Workshop 1 - GRADE Profiler: How to make it work for you</td>
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¹5 = excellent, 4 = very good, 3 = good, 2 = fair, 1 = poor
Participant comments generally reflected the high evaluation scores, with many positive comments (see Appendices G, H, and I). Several suggestions (noted above) provide opportunities for improvement in future meetings.
Appendix A
US Cochrane Center
Stakeholder Summit on Using Quality Systematic Reviews to Inform Evidence-based Guidelines
June 4 -5, 2009
Tremont Grand - Mirror Room

June 4

11:00 am - 5:00 pm  Topic
Registration

1:00 - 1:15 pm  Welcome and introductions - Kay Dickersin - Director, US Cochrane Center

1:15 - 2:30 pm  Standards for systematic reviews: Part 1 - Internal needs and perspectives from the guidelines producers
Chair: Steve Phurrough - Agency for Healthcare Research and Quality

Cystic Fibrosis Foundation guidelines: Starting from scratch - Karen Robinson - Johns Hopkins School of Medicine

From systematic review to clinical practice guideline: The Kaiser Permanente perspective - Marguerite Koster - Kaiser Permanente

Systematic reviews ≠ guidelines: Translation needs and challenges - Martha Faraday - American Urological Association (Consultant)

Discussion

2:30 - 3:00 pm  Break

3:00 - 5:00 pm  Standards for systematic reviews: Part 2 - Meeting external standards
Chair: Cheryl Dennison - Johns Hopkins University School of Nursing

Performance measures related to guidelines - Mark Antman - American Medical Association
Case study: Screening new methadone patients for cardiac risk: When are practice recommendations ready for prime time? **Marc Gourevitch** - New York University School of Medicine

The Institute of Medicine’s report, *Conflict of Interest in Medical Research, Education, and Practice*: Advice on conflict of interest to guidelines producers. **Robert Krughoff** - Consumer CHECK-BOOK/Center for the Study of Services

Discussion

**June 5**

7:00 - 8:00 am  Registration  
Breakfast on your own

8:30 - 9:30 am  **Plenary - Thorny problems for guidelines developers**  
Chair: **Milo Puhan** - Johns Hopkins Bloomberg School of Public Health

Is there a benefit to standardizing methods for grading the evidence and making recommendations -- If so, is GRADE "the one"? - **Yngve Falck-Ytter** - Case Western Reserve University School of Medicine


Discussion

9:30 - 11:30 am  **Panel: Collaborations between systematic reviewers and guideline developers**  
Chair: **Susan Norris** - Oregon Health and Science University
9:30 - 10:20 am  Evolution of the National Kidney Foundation - Tufts Evidence Review Team collaboration in developing kidney disease guidelines - Garabed Eknoyan - Baylor College of Medicine and Ethan Balk - Tufts Medical Center

Discussion

10:20 - 10:40 am  Break

10:40 - 11:30 am  Diagnosis and treatment of low back pain: A joint clinical practice guideline from the American College of Physicians and the American Pain Society - Amir Qaseem - American College of Physicians and Roger Chou - Oregon Health and Science University

Discussion

11:30 am - 1:00 pm  Lunch on your own

1:00 - 2:15 pm  Panel: Ensuring a better interface between systematic reviews and guidelines

Chair: Roger Herdman - Institute of Medicine

What have we learned about the quality of the underlying evidence from the National Guideline Clearinghouse - Vivian Coates - ECRI Institute and Mary Nix - Agency for Healthcare Research and Quality

Transparency of guidelines --- What do we mean and how do we get there? - Jeffrey Harris - Kaiser Federation Care Management Institute

The American Urological Association guidelines: How we identified a workable process - Heddy Hubbard - American Urological Association

Discussion
Appendix A - Stakeholder Summit on Using Quality Systematic Reviews to Inform Evidence-based Guidelines  June 4 - 5, 2009 (cont’d)

2:15 - 3:20 pm  Breakout Workshops

GRADE Profiler: How to make it work for you - Yngve Falck-Ytter - Case Western Reserve University School of Medicine and Nancy Santesso - McMaster University (Edinburgh Hall - 5th floor)

Options for formal consensus processes: The steps to success - Catherine MacLean - WellPoint, Inc. (Chapter Room - 4th floor)

Getting physicians on-board with guideline development - Henry Jampel - Johns Hopkins School of Medicine (Doric Room - 4th floor)

Incorporating systematic reviews into practice guidelines - Karen Robinson - Johns Hopkins School of Medicine and Roberta Scherer - Johns Hopkins Bloomberg School of Public Health (Mirror Room - 5th floor)

3:20 - 3:30 pm  Break

3:30 - 4:30 pm  Panel: Ensuring the guideline is a trusted source

Chair: Kay Dickersin - US Cochrane Center

What is a meaningful consumer voice? - Carol Matyka - National Breast Cancer Coalition

US government approaches to guidelines: Experience of the US Preventive Services Task Force and QUERI - David Atkins - United States Department of Veterans Affairs
Stakeholder Summit on Using Quality Systematic Reviews to Inform Evidence-based Guidelines
June 4-5, 2009

G-I-N: An international initiative to promote systematic development of clinical practice guidelines - Jako Burgers - Harvard School of Public Health and Dutch Institute for Healthcare Improvement CBO

Discussion

4:30 - 4:45 pm Evaluation and adjournment
Appendix B
Stakeholder Summit on Using Quality Systematic Reviews to Inform Evidence-based Guidelines
June 4 - 5, 2009
Baltimore, Maryland

* Conference Planning Committee

Eric B. Bass, MD, MPH
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Maureen Corry, MPH
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Appendix B - Planning Committee (cont’d)

**Timothy Wilt, MD, MPH**  
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*Not everyone was able to participate.*
Appendix C – Conference Speakers

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## Session I: (1:15 - 2:30 pm) Standards for systematic reviews: Part 1 - Internal needs and perspectives from the guidelines producers

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Comments:

## Session 2: (3:00 - 5:00 pm) Standards for systematic reviews: Part 2 - Meeting external standards

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## Overall Evaluation for DAY ONE

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3. Please provide comments or suggestions:

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### Session 1: (8:30 - 9:30 am) Plenary - Thorny problems for guidelines developers

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<td>Is there a benefit to standardizing methods for grading the evidence and making recommendations -- if so, is GRADE “the one”? - Yngve Falck-Ytter</td>
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<td>Making guidelines actionable: How to identify and overcome obstacles - Richard Rosenfeld</td>
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### Session 2: (9:30 - 11:30 am) Panel: Collaborations between systematic reviewers and guideline developers

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<td>Diagnosis and treatment of low back pain: A joint clinical practice guideline from the American College of Physicians and the American Pain Society</td>
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### Session 3: (1:00 - 2:15 pm) Panel: Ensuring a better interface between systematic reviews and guidelines

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<td>process - Heddy Hubbard</td>
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Comments:

### Session 4: (2:15 - 3:20 pm) - Breakout Workshops (Evaluations completed at workshop)

### Session 5: (3:30 - 4:30 pm) Panel: Ensuring the guideline is a trusted source

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Appendix E - Evaluation DAY TWO (cont'd)

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<th>What is a meaningful consumer voice? - Carol Matyka</th>
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<td>US government approaches to guidelines: Experience of the US Preventive Services Task Force and QUERI - David Atkins</td>
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<td>G-I-N: An international initiative to promote systematic development of clinical practice guidelines - Jako Burgers</td>
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Comments:

Overall Evaluation for DAY TWO

1. The program was presented without evident commercial bias or influence. ☐ ☐ ☐

2. The program for DAY TWO met my expectations ☐ ☐ ☐

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Session 4: (2:15 - 3:20 pm) Workshops:

Workshop # 1. GRADE Profiler: How to make it work for you - Yngve Falck-Ytter and Nancy Santesso

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Comments/Suggestions:

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Appendix F - Workshop Evaluations (cont'd)

Program Evaluation for DAY TWO - Friday, June 5, 2009
US Cochrane Center Stakeholder Summit on Using Quality Systematic Reviews
to Inform Evidence-based Guidelines

Session 4: (2:15 - 3:20 pm) Workshops:

**Workshop # 2. Options for formal consensus processes: The steps to success - Catherine MacLean**

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Program Evaluation for DAY TWO - Friday, June 5, 2009  
US Cochrane Center Stakeholder Summit on Using Quality Systematic Reviews to Inform Evidence-based Guidelines

**Session 4: (2:15 - 3:20 pm) Workshops:**

**Workshop # 3. Getting physicians on-board with guideline development - Henry Jampel**

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Program Evaluation for DAY TWO - Friday, June 5, 2009  
US Cochrane Center Stakeholder Summit on Using Quality Systematic Reviews 
to Inform Evidence-based Guidelines

Session 4: (2:15 - 3:20 pm) Workshops:

Workshop # 4: Incorporating systematic reviews into practice guidelines - Karen Robinson and Roberta Scherer

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Appendix G: Day One Evaluation Comments

Session 1: Standards for systematic reviews: Part I - Internal needs and perspectives from the guidelines producers
• All was informative and good follow-up discussion
• Good representation from a variety of perspectives. Good questions
• Highly informative
• Would be helpful for 1st 2 speakers to have specific examples of problematic vs. excellent systematic reviews
• Well conducted session. Could benefit from presenters knowing each others presentations at least at macro level ahead of time. Faraday’s presentation focused on one aspect covered by prior 2 speakers so info may have seemed less useful by comparison. Would have liked to hear why AHRQ favors AMSTAR.
• [Speaker] was not very clear - regarding discussion to clinical, non-research audience.

Session 2: Standards for systematic reviews: Part 2 - Meeting external standards
• Would be helpful for Gourevitch to have specific examples of problematic vs. excellent systematic reviews
• Gourevitch case study presentation was excellent - showing the impact of guidelines based on lack of evidence
• The Gourevitch presentation seemed very out of place!
• Interested in more specific measure in Antman talk. Really appreciated Koster talk and materials/sources provided.
• Question of interpretation of evidence to move from systematic reviews to guidelines might have been more effectively framed and addressed
• IOM COI a very important topic, but not presented well
• Very informative
• Having speakers who primarily just read their power point slides is not very effective or interesting
• Would have liked two afternoon presenters to speak a) less clinically and more of the implications of developing a PICO-related question for guideline development and b) offer more insight into the implications of COI
• Would like more on measurement
• I would have preferred more focus on systematic review process standards
• Important topics - good representation of unique challenges.
• Last speaker read slides, which didn’t make presentation very interesting

Day 1 - General Comments
• Overall: not sure what I was expecting. There is a definite bias that systematic reviews are essential to guidelines development.
• Excellent topics and speakers
• Consider including nursing measures and guideline presentations next time
• Room temperature uncomfortably cold - even for a warm-natured person
Appendix G: Day One Evaluation Comments (cont’d)

- Limited time for discussion. May be improved by shorter presentation - longer Q & A session
- Great day
- Overall: Consider offering a workshop on Day 1 to get interaction among participants early that may lead to discussion/collaboration/ etc. over dinner while attendees are available to meet and discuss in person. Great program. Many thanks.
Appendix H: Day Two Evaluation Comments

Session 1: Plenary - Thorny problems for guidelines developers
  • Falck - Ytter - Presenter very knowledgeable - I wanted this information but it was
too much in too little time. GRADE is important enough and complex enough to
warrant longer or more presentation time. - Too information dense without handouts.
I really wanted this information.
  • Would have liked more time allotted to Mr. Falck-Ytter's presentation. It was great
information and it would have been nice for him to go into more detail.
  • Needs copy of Yngve's slides - lots of useful material
  • Would have liked much more time with examples devoted to GRADE. If not
discussed in this group where will it be taught? Presentations led me to want to hear
much more!
  • Falck-Ytter excellent content and use of examples in slides
  • More time for GRADE!
  • Dr Ytter - I'd suggest that the presentation - at least facts - should compare USPSTF
vs. GRADE.
  • GRADE speaker didn't stick to topic. These 2 topics were on 2 very important topics.
Would have been good to have some of the other speakers address them rather
than just discuss details of their own guideline process.
  • Falck Ytter - only one side presented. I would have liked to see pros and cons of diff
systems - a debate?
  • Needed more time for this section - GRADE especially
  • [Presentation] not focused - scattered nonlinear
  • Dr. Rosenfeld - Provocative, brings up an important topic that should be pursued in
a separate session
  • Somewhat vague - more concrete description of process would have been helpful.
  • Not enough time . Need more microphones.
  • Overall: more time for "big picture" discussion "use of SRs" - costs - use of GRADE
more brainstorming/ suggestion time. More small group breakouts
  • Excellent overview of issues / Overall: Good meeting. Strong panels. Raised the
issues. Thank you!

Session 2: Panel - Collaborations between systematic reviewers and guideline
developers
  • Qaseem and Chou had some of the best slides. Easy to view, read and follow. Not
too much info on slides. Chou has a terrific presentation style. Qaseem did equally
well.
  • Too much detail about the specifics of the process followed in developing
guidelines, would have been nice to have more time devoted to discussion and
interaction, re some specific issues in the SR-Guideline interaction.
  • Perhaps to much background on subject matter particulars. Questions about
differences in grading might have been more explicitly framed, with time allotted to
Appendix H: Day Two Evaluation Comments (cont’d)

discuss.

• The APC/APS is a good template
• [Speaker] didn’t seem passionate about work - maybe he's ill or tired? As a result presentation seeded to be focusing on limitations of resources and challenges in a depressing way. Too much detail on process since 2 collaborations presented. Would have been good to have the 2 collaborative partnerships compare and contrast differences in their methodologies.
• Too long; focus on important stuff. Too much detail / Overall: SR does not equal guidelines guidelines does not equal SR - perhaps more diversity in agenda;
• More time to have allowed further presentation of methods and issues would have been better
• Very interesting to hear from 2 partners in collaborative guideline effort. Important question: implementation/use of guidelines - What is the status? How to encourage utilization
• Similar speakers between yesterday and today re: society speakers on guideline development... slightly redundant
• History of kidney disease speech superfluous
• "NKF slides" were difficult to read/understand. First portion of presentation could have been streamlined. These presentations are all saying, in essence, the same thing. Systematic reviews vary.. Lack of consistency and quality.

Session 3: Panel: Ensuring a better interface between systematic reviews and guidelines

• [Speaker] should be careful about making potential inflammatory statements that can alienate audience members.
• Interesting but getting redundant at this point
• Residual question - can the public see the assessment of guidelines? Id like to see some
• Slides were hard to see due to colors used, e.g. gray on gray. Please do not copy and paste something if the viewer will not be able to read the slide
• Distinguish differences between clinical guidelines and measurement guidelines, e.g., criteria.
• Too much detail re individual organizations guidelines process from the last 2 speakers
• This session still did not get directly at issue of moving from SRS to guideline recommendations.
• [Speakers] should not read slides!
• NGC - Provided little information of interest not actionable. Would have liked NGC to acknowledge ways to improve the quality of guidelines accepted
• Excellent question on rating of guidelines in NGC. Another good question on distinction/application of "guidelines" and "best practice statements."
Appendix H: Day Two Evaluation Comments (cont’d)

- [Speaker] talked about tension between some clinicians vs methodologists, but her tone seemed demeaning to clinicians - that doesn't help!
- Would prefer use of specific guideline examples to illustrate general approaches; in some cases, PowerPoint animation slide transitions were distracting
- Few insights. too much focus on steps
- Would be helpful to have copies of PowerPoint presentation during the time of presentation. Thanks for those being placed on the web-site.
- Too much in the time slot. Too broad topic, focus needed.

**Session 4: Workshops - (see Appendix I)**

**Session 5: Panel: Ensuring the guideline is a trusted source**
- Good topics for final session
- Matyka good overview, would have liked to hear about Project LEAD
- [Speaker] stumbled in reading slides.
- [Speaker] was hard to understand.
- Consumer participation in guidelines could have been better explored (more generally)

**Day 2 - General Comments**
- I'd like to see some actual recommendations from the speakers to get at whether practices make sense (PSA testing comes to mind) More discussion on non-overt bias among proceduralist developing guidelines - this wasn't really addressed
- There was not enough information describing the breakout sessions to select accordingly.
- Overall: One major issue of particular concern to clinicians - that was not addressed was the medico legal impact of guideline documents; while some participants cited confusion regarding the use of "guideline" and "recommendation" interchangeably, imagine the problems that arise when a plaintiff's attorney uses "guideline" interchangeably with "standard of care" - without regard for level of evidence or strength of recommendation. This, perhaps, is the source of the words "consider" and "should"... And a source of skittishness among clinicians asked to embrace the evidence based medicine process.
- Workshop disappointing, but panelists overall good. There needs to be sufficient information on the agenda that describes the workshops in greater detail. e.g. objectives so an informed decision could be made to select the best workshop based on need. Lastly you need to have presentations about nursing. Very physician centric.
- Might have been better to have had a panel of the various guideline developers where they could all approach a series of relevant questions - e.g. "How do you link quality of evidence to guideline needs?" - pros and cons of the various methods?
Appendix H: Day Two Evaluation Comments (cont’d)

rather than having each one walk us through the details of their own process. Overall another very good meeting. Great job of bringing people with opposite viewpoint and backgrounds together

• I feel that there was specific promotion of systems/process that may be influenced by their use by the presenters
• Continue efforts to bring in multi-disciplinary members - allied health, nursing etc.
• Would have liked the speakers who talked about their specific guideline process to make more big picture pitfalls to avoid type of statements - Would also appreciate these groups delving into specifics about how they sped up their guideline production while reining in cost.
• Focus was too much on guideline development and not on implementation
• Keep speakers on time or build in more time to allow for more questions/discussion (see AHRQ as example) - more microphones. Brief time and room layout limited number of people and number of different people asking questions or making comments.
• I had hoped to come out of this meeting with some good approaches to how to improve our guidelines methods. Unfortunately, the presentations and discussions were too generic. Too little on how to improve.
• In general better method needed to keep speakers to their specified time. Several went over. Electrical plugs and tables to plug in laptops would be helpful.
• Temperature much better on second day. Thank you! Time for lunch is plenty
• Really appreciated speaker handouts. In general, I was a bit disappointed because several sessions did not really match the title of the talks. Felt like several talks could include additional material.
• The most prominent thing for me was that many/most guidelines (at least those presented) were really based on consensus versus evidence and how few committees work w/advocates/consumers. It was a real eye opener. I really appreciate that Cochrane put this together because of their focus on evidence based medicine they showed the dichotomy that currently exists.
• Translation of guidelines into medicine and training; audits to determine the penetration of guidelines into medical practice
• Interesting that AHRQ not more of a presence. Thanks! Great conference. Some people (most vocal & nearest to microphone) asked majority of questions - better to have more microphones or different method to ensure more representation.
• I would be interested in learning from AAFP and how they determine what are acceptable guidelines and go about dissemination.
• SR does not equal guidelines/guidelines does not equal SR - perhaps more diversity in agenda
• It was an excellent meeting. Thanks.
• More time for workshops? - Future idea, optional paid-by-participant lunch to encourage conversation, interaction. (reception last year was great!) - Even more
Appendix H: Day Two Evaluation Comments (cont’d)

- consumer participation would be a plus. - some kind of follow-up activity?
- Very good meeting.
- More GRADE would be helpful given rapid scale-up of this methodology
Appendix I: Workshop Evaluation Comments

Workshop 1 - GRADE Profiler: How to make it work for you

• Good session, but I would have liked twice as much time.
• I registered late so was really not prepared, but it would help to come with questions in addition to those that came up as a result of the workshop.
• Needs more time!! Please, please, please include GRADEPro workshop in Systematic Review July 22-24 conference. Would be helpful to have more hands-on time and experienced people.
• May be better to have presenter show use of program on overhead so participants can more easily follow the navigation within the GRADEPro program.
• Wonderful tutorial. Provided good hands on with good examples to raise important issues in use and understanding of how programming works.
• Very good, Important to me.
• Not enough time allocated to cover software and transition to guidelines.
• She became defensive on responding to an attendees observation. There was an assumption made that people had used the system before. Format for instruction was poor. There needed to be one computer projected so everyone could see/understand what was being reviewed. The break out session was disappointing. Never become defensive when an attendee is expressing an opinion!

Workshop 2 - Options for formal consensus processes: The steps to success

• This wasn't a workshop - it was a breakout lecture - maybe because it was about one method.
• Everything was good for what it was. Workshop was well presented and informative. However, the topic/session title was "options for formal consensus process," while only one option was discussed. As I was already familiar with this one option (the rand appropriateness method), this session was not useful to me. I wish the title had been more accurate so I could have chosen a different session.
• Only 1 option presented; anticipated multiple options and pros/cons of different processes. Session would be better with less examples and presentation of other process in addition to Rand.
• Topic was presented clearly, though its level of interest was low for me personally.
• In addition to presentation, more examples and perhaps hands-on.
• I thought we would discuss more than one consumer process. There was no indication in the title that this would focus only on Rand's appropriateness criteria.
• Content was good and interesting. Cathy did a great job presenting, BUT the workshop title was misleading. It was not about OPTIONS…but a review of a specific novel method.
• Catherine McLean - used a very nice presentation on appropriateness method.
• Only 1 option presented and title indicated several "options". For consumers. Also, no systematic "steps to success" outlined. This was more of an "introduction to RAND appropriateness method." Overall, presenter very knowledgeable and did a great job.
Appendix I: Workshop Evaluation Comments (cont’d)

Workshop 3 - Getting physicians on-board with guideline development

- Awful - did not have time to complete evaluation in workshop. - speaker/facilitator was late replacement using someone else's slides didn't address the topic. Only covered topics already discussed in other areas of conference - speaker hadn't attended these posters - It wasn't a workshop - mostly lecture, some small group discussion but not on topic
- Moderator was very biased.
- The speaker did not focus on the topic at all.
- Mainly a presentation.
- Very parochial attitude to guidelines.
- Didn’t really address topic. Another description of a guideline process.

Workshop 4 - Incorporating systematic reviews into practice guidelines

- Idea of follow up a good one. Would have liked a take-away. Information on success/use of GPG? Specific goal/outcome would have improved. Interesting discussion! More time would have been great.
- Could have used more time for discussion.
- Good discussion. Active conversation.
- I had not realized that the subjects discussed were to be what was discussed.
- Change in topic was substantial.
- Excellent - I thoroughly enjoyed this topic and thought the session was managed well.
- Please do forward the discussions to all on the email list!
- I felt that the topic needed much more time. The questions were not answered. I feel this topic was the one reason for me attending this conference. It clarified in my mind systematic reviews need careful evaluation regardless of source and that it is likely the references will be the most valuable/visible part of the SR. In the last session (3:30 - 4:40) I had to keep referring to the agenda to remember what we were supposed to be discussing.
- Needs a better more focus - perhaps how to abstract SR data - would be less theoretical and more practical.
- Not enough time to really delve into solutions only problems - good effort, but we needed more time!
- Very interesting session. Might make an interesting workshop to take a question, show what reviews were found, and then see what opinions were about using the review. Should be 90 minutes.
- Difficult to assess - this was more a "commiseration" session that an informative one. It raised the may unanswered questions related to using existing systematic reviews.