the ENGINE
The newsletter of the Guidelines International Network

APR
2011

Contents

Chair's column

Dear Colleagues,

A few weeks ago the G-I-N Board held its midterm meeting to assess the past year and to make plans for the coming financial year. NICE hosted the meeting and generously provided facilities at their office in London. Our main conclusion was that we are very proud of the amount of important work that is being done by our committees, working groups and communities. For instance the Evidence Tables Working Group recently published their work in BMJ Quality and Safety[1], and the implementation working group developed an excellent program for a pre-conference course in Seoul on guideline implementation.

The G-I-N Board was happy to confirm the working plans of the various groups for the coming year. And we have more good news: the financial results of the past year were excellent, partly because of the positive outcome of our conference in Chicago.

We decided to reinvest some of our surplus by allocating a line in the budget to each of the working groups and communities to support their work and by prioritizing projects from our 'deliverable list': investigating in the development of online courses, strengthening the content and accessibility of our website and developing a clear communication strategy. Günter Ollenschläger decided that this was a good moment to stop his activities as Treasurer. As of 1st April, at the start of the new financial year, we have a new Treasurer: Fergus Macbeth. I would like to thank Günter for his tremendous contribution in creating a healthy financial position for G-I-N. I also wish Fergus all the best in his new position!

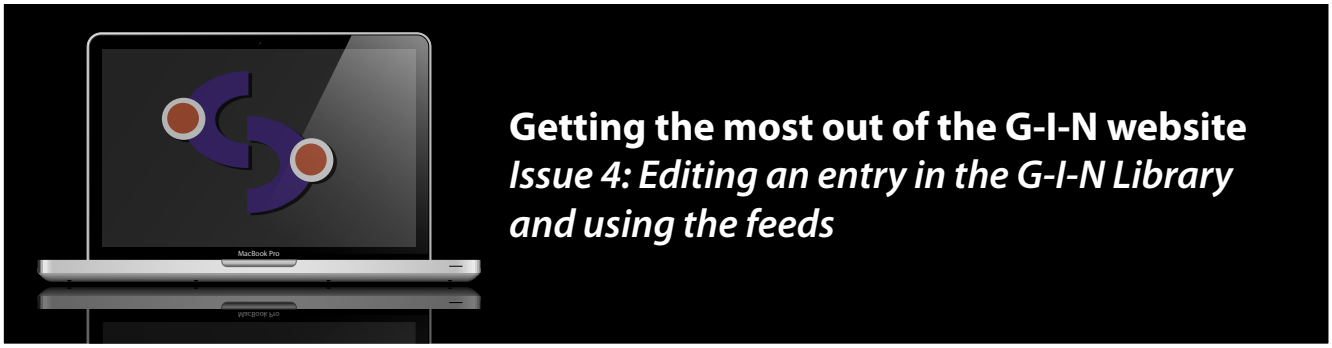
To continue the positive theme I am pleased to record that 212 abstracts have been submitted from 36 different countries for our forthcoming conference in Seoul. It will be the first G-I-N conference in Asia and we are delighted to see that individuals and organisations from a great variety of countries wish to be represented. I am certain that Richard Rosenfeld, Chair of the scientific committee, will do an outstanding job in creating a wonderful program.

I look forward to meeting you in August in Seoul!

Philip van der Wees, PT, PhD, Chair of G-I-N

[1] Mlika-Cabanne N, Harbour R, de Beer H, Laurence M, Cook R, Twaddle S. Sharing hard labour: developing a standard template for data summaries in guideline development. BMJ Quality and Safety 2011;20(2):141-145

G-I-N website



Are you getting the most from the new G-I-N website? Here is the fourth part of a series of articles to help familiarise you with the features available on the website.

How can I add or edit an entry in the G-I-N Library

Who can manage your organisation's entries?

Every G-I-N member organisation must appoint one primary contact. By default, only this primary contact person has the permission to add and edit any entry in the G-I-N library. Nevertheless, the primary contact can choose to delegate the editing permission to other members of his/her organisation.

Please note that we use the word "entry" for guidelines, evidence reports and related documents.

How to grant permission to edit

Note: This section applies to primary contacts only.

- Click on the name of your organisationon your Dashboard.
- You will now notice a green border around the main content of the page
- Click on the "Sharing" tab in the green management links.

- On the "Sharing" page use the search function to search for the user whom you want to grant edit permissions.

- Check the boxes "**can add**", "**can edit**" for the desired user and save.

Add a new entry

Note: Requires edit permission.

- On your dashboard click on "Guidelines" to get directly to the place where your existing entries are stored and listed.
- Click on "Add new guideline" on the right side of your screen. Fill out the form with all available information about the entry and save.
- As a last step, **do not forget to change the status "Pending" into "Active"** otherwise the entry will not be listed in the G-I-N Library

Edit an entry

Note: Requires edit permission

- On your dashboard click on "Guidelines" to get directly to the place where your existing guidelines are stored and listed.
- Click on the pen symbol next to the entry that you want to edit.
- Perform the desired changes in the entry form and save.

My searches – subscribe to notifications

Every time you perform a search in the Library as a G-I-N member, your search criteria are temporarily stored in a section "Recent Searches" above the search form.

If you want to permanently store previous searches you can use the "Save As" button in the "Recent Searches" section. After saving a search, it is removed from the section "Recent Searches" and placed in "My Searches". Both "Recent Searches" and "My Searches" can be found in the G-I-N Library section and on your Dashboard.

In the section "My Searches" you have the possibility to "Enable update notification" for one or all of your searches. If enabled, this functionality will allow you to receive an email notification when an entry matching your specific search criteria is added or modified.

RSS Feeds

What's New

Documents in the library

In the sections "Relevant Literature" and "Literature updates" you have the possibility to subscribe to an always-updated feed of your search terms. These sections of the website provide you with a selection of papers on guideline methods, development and implementation thus leading you to key studies in the area.

How can I get more help?

Last but not least the Help Section (http://www.g-i-n.net/help) gives you more detailed information about how to use the features of the G-I-N Library and of other sections of the website.

Send your comments

In order to improve the functionality and user friendliness of the website and to better answer to your needs we would be pleased to receive your comments on the website in general, its usability, tools, etc.

Updating the international guideline library

As always, to ensure that the international guideline library is kept up to date, we ask our members to please let our webmaster, Inga Koenig, know about any new or updated publications (guidelines, systematic reviews, evidence reports, guideline clearing reports), changes to your organisation's contact details, newsletter services or any other information you would like to present on the website, such as training materials or projects.

Don't forget to send your annual programmes or a link toward it.

As always we are dependent on members to keep the website up-to-date ensuring that the library also includes the list of documents under development to better inform all G-I-N members and reduce duplication.

Inga Koenig: Phone: +49-30-4005-2522 • Email: webmaster@g-i-n.net

News from members

SIGN guideline recommendations are now available on the move with the new, free SIGN iPhone app

Developed by the SIGN Executive in collaboration with Root Creative, Glasgow, the app for the Apple iPhone, iPod Touch and iPad launches with quick reference guides (QRG) of these recently published SIGN guidelines:

- Early rheumatoid arthritis
- Venous thromboembolism
- Psoriasis and psoriatic arthritis in adults
- Chronic venous leg ulcers
- Stroke: identification and management of dysphagia
- Stroke: rehabilitation, prevention and management of complications, and discharge planning
- Management of sore throat and indications for tonsillectomy
- Diabetes
- Obesity
- Non-pharmaceutical management of depression
- Diagnosis and pharmacological management of Parkinson's disease.

The QRG content is enhanced with material from the main guideline and online resources, linked to the SIGN website. Each new SIGN QRG will be available as an update through the Apple App Store as it is published, building into a complete library of SIGN QRGs. This new format will be particularly useful for front line healthcare professionals. The app features keyword search and bookmarking and access to the SIGN website.

New generation smart phones and tablet devices have the usability and straightforward access to content that provide users with a portable and easily updated means of accessing SIGN guideline material. The format and content of the QRGs are perfectly suited to the screen size of smart phones. SIGN is now looking at utilising the larger screen of the iPad as a platform for full guidelines and an Android version of the SIGN app will be ready in May.

http://itunes.com/apps/signguidelines

G-I-N Spotlight

An update from the G-I-N Board

During its two day meeting in London the Board discussed a number of topics including the working groups and communities and their deliverables, developing further collaborations, the conferences and last but not least, better ways of communicating with G-I-N members and stakeholders.

Working groups and communities

The Board validated work plans and allocated funds to the G-I-N Groups and Communities. There was a sense that the groups are really moving forward. During 2011-2012 a number of deliverables will be emerging, thanks to the work of all those involved. The Board had a discussion around intellectual property, deciding to seek legal advice to ensure that the work of G-I-N and its groups is well protected and benefits the members.

Education

Having discussed the idea for some time, the Board now decided to focus on education. In previous years a number of workshops and courses were delivered under the auspices of G-I-N. However, there has been no coordination and little discussion around what should be offered and how. Dave Davis agreed to lead a taskforce to assess needs and to develop an education strategy for G-I-N. Ideas are to develop *ad hoc* as well as online courses in addition to the pre and post conference courses first organized in Chicago. To support Dave's work, Minna Kaila agreed to take over chairing G-I-N's Membership committee.

Finances and deliveries of the Network

After careful planning and use of resources we can now use some of the surplus generated to support the activities of the groups and to work on even better communication. In London the Board decided to allocate a line in the budget to the working groups to facilitate their work and delivery of planned toolkits, registries and papers.

Communication

We need to improve communication, both internally and externally. The Board decided to explore ways of using enGINe more effectively and to develop new strategies to reach out to our members and stakeholders. Some of the ideas for further discussion are: developing a blog and/ or a technical forum; using social medias and the G-I-N facebook page; better use of the website and ensuring that the pages related to the working groups and activities are kept up to date; adding a session at the time of the conference where we could present their work and deliverables; and participating to other conferences and meetings representing G-I-N.

G-I-N annual members' survey

To improve and evolve our network and to make sure that the activities and products continue to serve all members, we are once again asking for your help. Please give up about ten (10) minutes of your valuable time to answer these questions and feedback your reflections, ideas and thoughts.

Survey link: http://www.g-i-n.net/about-g-i-n/2011-g-i-n-members-survey

The deadline to complete the survey is 15 May 2011.

Note: this is a G-I-N members only survey, and to answer, please log-in to the website. If you have difficulties logging in or have lost your password please let us know: office@g-i-n.net. Non-members are also encouraged to provide us with comments and suggestions for improvements by email: office@g-i-n.net

Evolution of enGINe

One real opportunity is to improve this newsletter, enGINe, and to ensure that it answers the needs and wishes of its readers. Here are some of the Board's ideas from the meeting in London: providing a monthly update on the latest entries in the guideline library; providing the literature update as currently (i.e. every 3 months); providing updates from the working groups every other month, 2 to 3 groups at a time; publishing a conference issue 3-4 times a year (call for abstracts, preliminary programme and registrations, feedback from the conference). Also they suggest that one issue could be more strategy oriented.

We would really appreciate your input and ideas. If you think about anything or would like to participate in the editorial team of enGINe, please contact Magali (eo@g-i-n.net)!

Development of a position paper

Guidelines may fall short of meeting basic quality criteria or have major inconsistencies in their development methods. A standard guideline development process is essential when developing valid, usable, and reliable guidelines as well as for the users to judge the quality of guidelines. The G-I-N Board of Trustees recognizes the importance of such a rigorous and standardised process. We are in the process of developing a paper that will identify key components of a guideline to aid guideline developers to ensure that guideline recommendations are methodologically sound and based on evidence derived from best available research. In addition, the users of a guideline can utilize these criteria to evaluate the validity and quality of a guideline.

If you have any questions or comments, please contact the G-I-N Office at office@g-i-n.net.

G-I-N Working groups

Evidence Tables Working Group

The group is conducting a pilot study on the two templates under development: for summarising economic evaluation and for summarising prognostic studies. We have now also started the technical work to develop GINDER: G-I-N Data Extraction Resource. It is a tool for extracting and presenting data from various individual studies using a standardised template. This resource is the foundation for developing the evidence tables which group and summarise data on a defined question. If you wish to learn more about GINDER before its official launch in Seoul (GIN2011) please download the presentation available on the G-I-N website.

Performance measures

G-I-N has established a new working group that will focus on the development of performance measures during or after guideline development and their use in implementation cycles**.**

The group is chaired by Dr. Patrice Lindsay (Canada) and Dr. Fergus Macbeth (UK, G-I-N Board Member).

We are currently looking for G-I-N members who are interested and experienced in performance measurement and would like to participate. Membership would mean participation in email dialogues and conference calls to define and carry out the activities of this group, including developing and preparing an educational workshop for the 2012 G-I-N conference.

If you are interested in participating on this working group, please send a brief outline of your experience in this area to Patrice Lindsay (*patty.lindsay@me.com*) by April 18th, 2011.

Networking with G-I-N

8th G-I-N Conference: "Linking evidence, policy, and practice" Seoul, Korea • 28th-31st August 2011

Plenary sessions

Linking evidence to practice: guidelines and alternatives	
Tsuguya Fukui (Japan)	Quality improvement by measuring and disclosing quality indicators
Gillian Leng (UK)	How effective are national strategies for getting evidence in practice?
Dave Davis (US)	The hidden intervention: using an effective educational strategy to ensure the uptake of best evidence in practice
Guidance in the absence of evidence: what can – and cannot – be done?	
Paul Glasziou (Australia)	When are randomised trials not needed?
Nicola Magrini (Italy)	How to make weak recommendations more transparent: what we have learnt from the use of GRADE
Hans Messersmith (Canada)	What do you do when you have done all the easy stuff? – Developing guidelines in the absence of good quality evidence
Adapting guidelines for resource-constrained settings	
Zulma Ortiz (Argentina)	Building capacity in clinical guidelines adaptation: lessons learned from Latino-American countries
Leonila Dans (Philippines)	Experiences in the Philippines: Adapting the essential newborn care guidelines: failures and successes
Karen Daniels (South Africa)	Translating evidence into policies and guidelines: findings from 3 southern African countries
Sustainable guidelines: maintaining relevance to health policy	
Ken Kuo (Taiwan)	Policy priority in sustaining guideline development
Lisa Askie (Australia)	International collaboration, individual patient data and prospective meta-analysis - the best evidence base for sustainable guidelines
Ilkka Kunnamo (Finland)	Implementing guidelines on populations by means of clinical decision support
Promoting quality of evidence and guidelines in the international community	
Tamara Kredo (South Africa)	Agreement and Alignment - guidelines for five priority diseases in the Southern African Development Community
Richard Shiffman (USA)	Can the New IOM Standards for Guideline Development Improve Guideline Quality?
Philip van der Wees G-I-N Chair 2010-2011	Promoting quality of evidence and guidelines: what is G-I-N's role?

Parallel sessions

Sincere thanks to the submitters of the 212 abstracts received! The Scientific Committee has now carefully reviewed and graded all of them and is now in the process of making decisions on acceptance as well as designing about 30 parallel sessions. Abstract submitters should receive a notification by the end of the month.

Pre-conference courses

- 26th-27th August: Evidence synthesis
- 28th August: Guideline implementation

Join us for a one day practical introduction to the art and science of implementing evidence-based practice and guidelines with experts who have both developed and implemented guidelines. During the course you will:

- explore and understand the process for implementation through:
  - ~ identifying barriers and enablers,
  - ~ selecting appropriate interventions, and
  - ~ selecting measures to demonstrate practice change
- start developing a plan for implementation
- network and share practical experience with experts in the implementation of guidelines.

Over the course of the day we will draw on real examples from emergency care and primary care. All participants will be encouraged to work on and develop a practical implementation plan for their own evidence-based projects which will meet the needs of policy makers, health practitioners, patients and consumers. The course will be led by Heather Buchan, Sue Huckson and Catherine Marshall, with Dave Davis and Sue Phillips as invited speakers.

For more information please download the flyer: http://www.g-i-n.net/document-store/g-i-n-conferences/seoul-2011/flyer-implementation-course.pdf

- 28 August: GRADE

In the next issue of enGINe we will present the plenary speakers and provide further information on the programme. To learn more about the conference and Seoul please visit the G-I-N website or the conference website: www.gin2011.org

Register now and save! Early registration end on 6 June 2011

	Early Registration Before 6 June 2011	Full fee After 6 June 2011
G-I-N members*	USD 610	USD 710
APEBMN** members	USD 650	USD 750
Non-members	USD 760	USD 860
G-I-N members from lower income countries***	USD 375	USD 475
Non-members from lower income countries***	USD 450	USD 550
Consumers, students, residents****	USD 280	USD 425
Gala dinner	USD 110	

* Includes the gala dinner

** Asia-Pacific Evidence-Based Medicine Network

*** Based on World Bank Classification

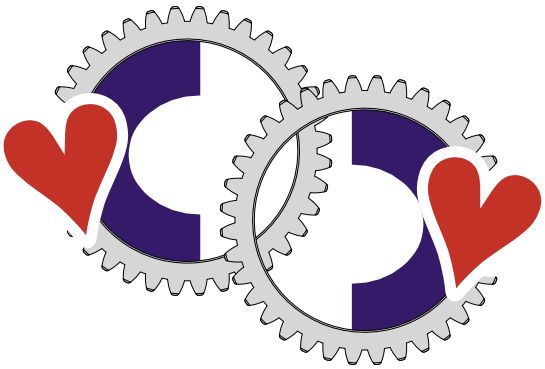
**** "Consumer" is used to address all groups of lay people (people who are not healthcare professionals, nor G-I-N member) who contribute to or could potentially contribute to evidence-based clinical practice guidelines. This includes people who have a condition or disability relevant to guidelines in use, in development or in need of development, or being implemented. It also includes people such as family and friends who provide unpaid care for them. And, it includes individuals from organisations representing consumers' interests, including voluntary sector or non-governmental organisations. Synonyms of consumer include 'patients', 'carers' 'Consumer advocates', 'service user', 'user representative' or 'patient representative'.

9th G-I-N Conference

We are pleased to announce that three very good expressions of interest to host the 2012 annual conference were received. G-I-N extends gratitude and thanks to all for their efforts and involvement. After a thorough examination of the proposal the Board decided that the 9th G-I-N Conference will take place in Berlin, Germany in August 2012.

Other events

2011	
21-25 May	**16th Annual Meeting of the International Society for Pharmacoeconomics and outcomes research** Baltimore, Maryland, USA
9-10 June	**3rd annual AAMC Integrating Quality Meeting** Chicago, Illinois, USA The 3rd annual AAMC Integrating Quality Meeting will showcase innovative approaches to integrating quality across the continuum of medical education and clinical care in academic medical centers. For more information, please visit: www.aamc.org/meetings/157666/2011_integrating_quality_meeting.html
20-23 June	**16th International Congress of the World Confederation for Physical Therapy** Amsterdam, The Netherlands
25-29 June	**8th HTAi Annual Meeting: HTA for health systems sustainability** Rio de Janeiro, Brazil
6 July	**3rd International Workshop: Knowledge representation for health care** Bled, Slovenia http://banzai-deim.urv.net/events/KR4HC-2011/
24-26 August	**6th Singapore Public Health and Occupational Medicine Conference** **Theme: Innovations in Public Health and Occupational Medicine – The Next Frontier** Venue: Furama Riverfront, Singapore Organised by the Chapter of Public Health and Occupational Medicine, Academy of Medicine, Singapore, the conference will be filled with many exciting lectures and workshops. It will feature over a dozen international speakers who will share with participants the leading edge insights on a plethora of issues ranging from the use of new media in public health, innovative health financing models, well-being and mental health promotion, workplace wellness and many others. www.phom-singapore.org
8-11 September	**17th Wonca Europe Conference: 'Family Medicine - Practice, Science and Art'** Warsaw, Poland
14-17 September	**28th ISQua Conference** • Patient Safety: Sustaining the Global Momentum Hong Kong, China
18-21 September	**AHRQ Annual Conference**
19-22 October	**19th Cochrane Colloquium** Madrid, Spain
22-26 October	**33rd Annual meeting: Society for Medical Decision Making** Chicago, Illinois, USA The meeting theme is "From Evidence to Decision Making: Role of Behavioral Economics in Medicine." The theme focuses on understanding and influencing health and health care behaviors from insights into the complexity of underlying human behavior drawn from the confluence of economics, psychology, sociology, biology, and neuroscience. Meeting attendees will have the opportunity to interact with the international leaders in behavioral economics and be exposed to the latest research methods and medical decision making applications. Submissions for oral, poster and short course proposals accepted until 6 May 2011. www.smdm.org
2012	
23-27 June	**HTAi Annual Meeting: HTA in Integrated Care for a Patient-Centered System** Bilbao, Spain



Dating agency

From Robin Harbour, SIGN: the DECIDE project (Developing and Evaluating Communication Strategies to Support Informed Decisions and Practice Based on Evidence):

A collaboration led by the University of Dundee, UK, and the Norwegian Knowledge Centre for the Health Services has been given €3 million by the EC's 7th Framework Programme to improve the way healthcare evidence and recommendations are presented in guidelines.

Who is involved? The five-year project started in January 2011 and will build on the work of the GRADE Working Group. It involves guideline producers such as NICE and SIGN, as well as the Cochrane Collaboration, groups such as Duodecim Medical Publications Ltd from Finland, and the World Health Organisation. By the end of the project, DECIDE will have produced a range of dissemination strategies that have been rigorously evaluated in diverse settings, supported the transfer of research into practice and are adapted to real-world healthcare systems.

Background. The guidance within guidelines may not be presented in a way that is easily used by different decision-makers, and DECIDE will work with them to develop and evaluate dissemination strategies that are tailored to their needs. For example, earlier work done by DECIDE partners found that while policymakers were interested in precision, there was confusion around what the different numbers referred to. Work with health professionals revealed difficulties with presenting continuous outcomes.

The project is being run in a series of work packages, each dealing with a different set of decision makers. Specific audiences addressed by the work packages are healthcare professionals; policy makers and managers; patients and the general public; and health system policy makers. Other packages look at communicating evidence-based decisions about diagnostic tests, and developing co-operation between European guideline developers and health technology assessment agencies.

Currently. Each work package has begun by brainstorming the key issues to be addressed, and then working with stakeholder groups to refine these ideas further and come up with potential strategies for improving communication in each of the areas addressed.

Key elements of the project are user-testing (what do guideline users think of the ideas coming from the brainstorming and stakeholder work) and evaluating potential strategies in trials. The latter will involve randomising users (family doctors, say) to receive research evidence and recommendations presented in different ways and then measuring attitudes and understanding, among others. This will be done in at least seven European countries. At the end of this process, promising strategies will be tested in real guidelines.

Deliverables. Project results will be packaged into a toolkit for developing and disseminating evidence-based recommendations. Part of the package will be an updated version of GRADEPro, the tool used to generate GRADE Summary of Findings tables. By developing and evaluating targeted dissemination strategies, DECIDE aims to increase the use of evidence-based interventions in a sustainable way and to reduce the use of interventions where benefits are uncertain.

For more details see www.decide-collaboration.eu, or contact Dr Shaun Treweek, University of Dundee, at streweek@mac.com.

Developing Clinical Guidelines Course – A NCC-WCH short course on using NICE methodology to develop clinical guidelines

Courses on systematic reviewing are offered by a number of universities and centres worldwide. Linking the learning achieved in these courses with clinical guideline development is complex. Through expert-led sessions this course aims to shed light on this process by discussing:

- the theory, purpose and practicalities of clinical guideline development
- different approaches to the systematic synthesis of evidence
- the quality appraisal of reviews
- health economic modelling
- the development of recommendations for clinical practice

This survey aims to explore the level of interest in the proposed short course "Developing Clinical Guidelines Course". It will take approximately 5 minutes to complete.

To access the survey please follow this link: http://nccwch-guideline-course.surveyconsole.com/

An overview of the results will be shared in a future issue of enGINe.

If you have any questions about the survey please email Short_Course@ncc-wch.org.uk

As always the enGINe would like to know more about you!

Please get in touch to tell us about you, your organisation, your work programme, your ambitions. Perhaps even your problems – the G-I-N community could have the answers you are looking for!

Literature update • 13th January - 31st March 2011

Susan Flannery Wainwright, Katherine F. Shepard, Laurinda B. Harman, and James Stephens. Factors That Influence the Clinical Decision Making of Novice and Experienced Physical Therapists. *Phys Ther* 2011;91:87-101.

Background. The depth and breadth of prior experience informs clinical decision making in novice and experienced physical therapist clinicians. **Objectives.** The aims of this research were to identify differences in clinical decision-making abilities and processes between novice and experienced physical therapist clinicians and to develop a model of the factors that influence clinical decision making. **Design**. Qualitative research methods and grounded theory were used to gain insight into the factors and experiences that inform clinical decision making. **Methods.** Three participant pairs (each pair consisted of 1 novice physical therapist and 1 experienced physical therapist) were purposively selected from 3 inpatient rehabilitation settings. Case summaries from each participant provided the basis for within- and across-case analyses. The credibility of the results was established through checking of the case summaries by the participants, presentation of low-inference data, and triangulation across multiple data sources and within and across participant groups. **Results.** The factors that influenced clinical decision making were categorized as informative or directive. Novice participants relied more on informative factors, whereas experienced participants were more likely to rely on directive factors. An intermediate effect beyond novice practice was observed. **Conclusions.** The results of this study may be used by educators and employers to develop and structure learning experiences and mentoring opportunities for students and novice learners with the aim of facilitating the development of skills and abilities consistent with expert clinical decision making.

Damon C. Scales, Katie Dainty, Brigette Hales, Ruxandra Pinto, Robert A. Fowler, Neill K. J. Adhikari, Merrick Zwarenstein. A Multifaceted Intervention for Quality Improvement in a Network of Intensive Care Units: A Cluster Randomized Trial. *JAMA* 2011;305(4):363-372.

Context Evidence-based practices improve intensive care unit (ICU) outcomes, but eligible patients may not receive them. Community hospitals treat most critically ill patients but may have few resources dedicated to quality improvement. **Objective** To determine the effectiveness of a multicenter quality improvement program to increase delivery of 6 evidence-based ICU practices. Design, Setting, and Participants Pragmatic cluster-randomized trial among 15 community hospital ICUs in Ontario, Canada. A total of 9269 admissions occurred during the trial (November 2005 to October 2006) and 7141 admissions during a decay-monitoring period (December 2006 to August 2007). **Intervention** We implemented a videoconference-based forum including audit and feedback, expert-led educational sessions, and dissemination of algorithms to sequentially improve delivery of 6 practices. We randomized ICUs into 2 groups. Each group received this intervention, targeting a new practice every 4 months, while acting as control for the other group, in which a different practice was targeted in the same period. **Main Measure Outcomes** The primary outcome was the summary ratio of odds ratios (ORs) for improvement in adoption (determined by daily data collection) of all 6 practices during the trial in intervention vs control ICUs. **Results** Overall, adoption of the targeted practices was greater in intervention ICUs than in controls (summary ratio of ORs, 2.79; 95% confidence interval [CI], 1.00-7.74). Improved delivery in intervention ICUs was greatest for semirecumbent positioning to prevent ventilator-associated pneumonia (90.0% of patient-days in last month vs 50.0% in first month; OR, 6.35; 95% CI, 1.85-21.79) and precautions to prevent catheter-related bloodstream infection (70.0% of patients receiving central lines vs 10.6%; OR, 30.06; 95% CI, 11.00-82.17). Adoption of other practices, many with high baseline adherence, changed little. **Conclusion** In a collaborative network of community ICUs, a multifaceted quality improvement intervention improved adoption of care practices.

Paul C. Schroy III, Karen Emmons, Ellen Peters, Julie T. Glick, Patricia A. Robinson, Maria A. Lydotes, Shamini Mylvanaman, Stephen Evans, Christine Chaisson, Michael Pignone, Marianne Prout, Peter Davidson, and Timothy C. Heeren. The Impact of a Novel Computer-Based Decision Aid on Shared Decision Making for Colorectal Cancer Screening: A Randomized Trial. *Med Decis Making* 2011;31:93-107.

Background. Eliciting patients' preferences within a framework of shared decision making (SDM) has been advocated as a strategy for increasing colorectal cancer (CRC) screening adherence. Our objective was to assess the effectiveness of a novel decision aid on SDM in the primary care setting. **Methods.** An interactive, computer-based decision aid for CRC screening was developed and evaluated within the context of a randomized controlled trial. A total of 665 average-risk patients (mean age, 57 years; 60% female; 63% black, 6% Hispanic) were allocated to 1 of 2 intervention arms (decision aid alone, decision aid plus personalized risk assessment) or a control arm. The interventions were delivered just prior to a scheduled primary care visit. Outcome measures (patient preferences, knowledge, satisfaction with the decision-making process [SDMP], concordance between patient preference and test ordered, and intentions) were evaluated using prestudy/poststudy visit questionnaires and electronic scheduling. **Results.** Overall, 95% of patients in the intervention arms identified a preferred screening option based on values placed on individual test features. Mean cumulative knowledge, SDMP, and intention scores were significantly higher for both intervention groups compared with the control group. Concordance between patient preference and test ordered was 59%. Patients who preferred colonoscopy were more likely to have a test ordered than those who preferred an alternative option (83% v. 70%; $P < 0.01$). Intention scores were significantly higher when the test ordered reflected patient preferences. **Conclusions.** Our interactive computer-based decision aid facilitates SDM, but overall effectiveness is determined by the extent to which providers comply with patient preferences.

Chris Cammisa, Gregory Partridge, Cynthia Ardans, Katrina Buehrer, Ben Chapman, and Howard Beckman. Engaging Physicians in Change: Results of a Safety Net Quality Improvement Program to Reduce Overuse. *American Journal of Medical Quality* 2011;26: 26-33.

Identifying, understanding, and addressing clinical variation is a useful tool to promote appropriate care while helping control health care costs. Although accurate, relevant, and useful data are important in the process, successfully engaging physicians to change behavior is often the most significant challenge. Using a commercially available variation analysis process, a California Medicaid managed care plan identified significant network practice pattern variation. A team of panel practitioners then developed a strategy to reduce overuse of 5 identified behaviors. The intervention was evaluated using a pre—post comparison of the panel's use of the 5 behaviors. During the preintervention period, narcotics, muscle relaxants, magnetic resonance imaging (MRI), and spinal injections increased between 8% and 18% per month. Postintervention, the trends reversed. The differences were statistically significant ($P < .0001$) for muscle relaxant use, narcotic use, overall MRI use, and spinal injections. Peer comparison data and respectful feedback was associated with significant change in patterns of overuse.

Zoe A. Michaleff, Leonardo O.P. Costa, Anne M. Moseley, Christopher G. Maher, Mark R. Elkins, Robert D. Herbert, and Catherine Sherrington. CENTRAL, PEDro, PubMed, and EMBASE Are the Most Comprehensive Databases Indexing Randomized Controlled Trials of Physical Therapy Interventions. *Phys ther* 2011;91:190-197.

Background Many bibliographic databases index research studies evaluating the effects of health care interventions. One study has concluded that the Physiotherapy Evidence Database (PEDro) has the most complete indexing of reports of randomized controlled trials of physical therapy interventions, but the design of that study may have exaggerated estimates of the completeness of indexing by PEDro. Objective The purpose of this study was to compare the completeness of indexing of reports of randomized controlled trials of physical therapy interventions by 8 bibliographic databases. **Design** This study was an audit of bibliographic databases. **Methods** Prespecified criteria were used to identify 400 reports of randomized controlled trials from the reference lists of systematic reviews published in 2008 that evaluated physical therapy interventions. Eight databases (AMED, CENTRAL, CINAHL, EMBASE, Hooked on Evidence, PEDro, PsycINFO, and PubMed) were searched for each trial report. The proportion of the 400 trial reports indexed by each database was calculated. Results The proportions of the 400 trial reports indexed by the databases were as follows: CENTRAL, 95%; PEDro, 92%; PubMed, 89%; EMBASE, 88%; CINAHL, 53%; AMED, 50%; Hooked on Evidence, 45%; and PsycINFO, 6%. Almost all of the trial reports (99%) were found in at least 1 database, and 88% were indexed by 4 or more databases. Four trial reports were uniquely indexed by a single database only (2 in CENTRAL and 1 each in PEDro and PubMed). **Limitations** The results are only applicable to searching for English-language published reports of randomized controlled trials evaluating physical therapy interventions. **Conclusions** The 4 most comprehensive databases of trial reports evaluating physical therapy interventions were CENTRAL, PEDro, PubMed, and EMBASE. Clinicians seeking quick answers to clinical questions could search any of these databases knowing that all are reasonably comprehensive. PEDro, unlike the other 3 most complete databases, is specific to physical therapy, so studies not relevant to physical therapy are less likely to be retrieved. Researchers could use CENTRAL, PEDro, PubMed, and EMBASE in combination to conduct exhaustive searches for randomized trials in physical therapy.

N Mlika-Cabanne, R Harbour, H de Beer, M Laurence, R Cook, S Twaddle. Sharing hard labour: developing a standard template for data summaries in guideline development. BMJ Qual Saf 2011;20:141-145.

Background A key objective of the Guidelines International Network (GIN) is to reduce duplication of effort. To address this objective, a working group was established to define a minimum dataset for inclusion in all evidence tables. **Methods** A literature review was conducted to identify existing evidence tables, and GIN member organisations were asked to provide the tables they use. The results were used to develop a minimum dataset (template) for studies addressing intervention questions. The template was pilot-tested by a group of guideline developers and reviewed at GIN conferences. **Results** The literature search yielded 65 articles. These dealt with reporting standards and trial quality (eg, CONSORT statement) rather than which data should be extracted from studies. However, the checklist items given were considered useful. Nineteen GIN members provided evidence tables; 17 tables were used for analysis. The number of items included in the tables ranged from 8 to 19, with several items common to all tables. Within individual items, the level of detail varied widely. The draught template included a majority of items relating to objective data. Pilot testing revealed that the median time to read a paper and complete the template was 2 h for a randomised controlled trial and 2½ h for a non-randomised, controlled intervention study. The median rating for both relevance and clarity of items was high. **Conclusion** The template listing the items needed to summarise an interventional study is now available for large-scale testing by all organisations.

B Carlsen, B Bringedal. Attitudes to clinical guidelines—do GPs differ from other medical doctors? BMJ Qual Saf 2011;20:158-162.

Background Clinical guidelines are important for ensuring quality of treatment and care. For this reason, it is essential that clinicians adhere to guidelines. Review studies conclude that barriers to using guidelines are context specific. Nevertheless, there is a lack of studies that compare the attitudes of different groups of doctors to guidelines. **Objectives** To survey the attitudes of Norwegian medical practitioners to clinical guidelines and the reasons for any scepticism, and to compare general practitioners (GPs) with other medical doctors in Norway in this respect. **Method** Postal questionnaire to a panel of 1649 Norwegian medical doctors. **Results** 1072 doctors responded (65%). 97% claimed to be familiar with and following guidelines. A majority expressed confidence in guidelines issued by the health authorities and the medical association. GPs are significantly more uncertain about the legal status of, accessibility of and evidence in guidelines than other doctors. The most important barriers to guideline adherence are concerns about the uniqueness of individual cases and reliance on one's own professional discretion. Both groups rank attitudinal constraints higher than practical constraints, but GPs more often report practical issues as reasons for non-adherence. **Conclusion** It is suggested that creating trust in guidelines could be more important than more efforts to improve guideline format and accessibility. It may also be worth considering whether guidelines should be implemented using different processes in generalist and specialist care.

Salomeh Keyhani, Azalea Kim, Micah Mann, and Deborah Korenstein. ANALYSIS & COMMENTARY: A New Independent Authority Is Needed To Issue National Health Care Guidelines. Health Aff 2011;30:2256-265.

Health experts emphasize that getting doctors to follow clinical guidelines can save both lives and money. Less attention has been paid to how the guidelines are developed and the variability in the recommendations they include. We examined the quality and content of screening guidelines as a proxy for guidelines in general and found that the source of the guidelines affects their quality. Guidelines with inconsistent recommendations are unlikely to serve patients or physicians well. The creation of an independent organization that would work with multiple stakeholders to develop guidelines holds the potential to improve their quality.

Douglas K. Owens, Amir Qaseem, Roger Chou, Paul Shekelle, and for the Clinical Guidelines Committee of the American College of Physicians. High-Value, Cost-Conscious Health Care: Concepts for Clinicians to Evaluate the Benefits, Harms, and Costs of Medical Interventions. Ann Intern Med 2011;154:174-180.

Health care costs in the United States are increasing unsustainably, and further efforts to control costs are inevitable and essential. Efforts to control expenditures should focus on the value, in addition to the costs, of health care interventions. Whether an intervention provides high value depends on assessing whether its health benefits justify its costs. High-cost interventions may provide good value because they are highly beneficial; conversely, low-cost interventions may have little or no value if they provide little benefit.

Thus, the challenge becomes determining how to slow the rate of increase in costs while preserving high-value, high-quality care. A first step is to decrease or eliminate care that provides no benefit and may even be harmful. A second step is to provide medical interventions that provide good value: medical benefits that are commensurate with their costs. This article discusses 3 key concepts for understanding how to assess the value of health care interventions. First, assessing the benefits, harms, and costs of an intervention is essential to understand whether it provides good value. Second, assessing the cost of an intervention should include not only the cost of the intervention itself but also any downstream costs that occur because the intervention was performed. Third, the incremental cost-effectiveness ratio estimates the additional cost required to obtain additional health benefits and provides a key measure of the value of a health care intervention.

Zhao-xiang Bian and Hong-cai Shang. CONSORT 2010 Statement: Updated Guidelines for Reporting Parallel Group Randomized Trials. Ann Intern Med 2011;154:290-291.

Manuela De Allegri, Matthias Schwarzbach, Adrian Loerbroks, Ulrich Ronellenfitsch. Which factors are important for the successful development and implementation of clinical pathways? A qualitative study. BMJ Qual Saf 2011;20:203-208.

Introduction Clinical pathways (CPs) are detailed longitudinal care plans delineating measures to be conducted during a patient's treatment. Although positive effects on resource consumption and quality of care have been shown, CPs are still underutilised in many clinical settings because their development and implementation are difficult. Evidence underpinning successful development and implementation is sparse. **Methods** The authors conducted semistructured face-to-face interviews with key staff members involved in the design and implementation of CPs in a large surgery department. Interviewees were asked to provide opinions on various issues, which were previously identified as potentially important in CP development and implementation. The transcribed text was read and coded independently by two researchers. **Results** Respondents highlighted the importance of a multidisciplinary participatory approach for CP design and implementation. There was a strong initial fear of losing individual freedom of treatment, which subsided after people worked with CPs in clinical everyday life. It was appreciated that the project originated from people at different levels of the department's hierarchy. Likewise, it was felt that CP implementation granted more autonomy to lower-level staff. **Conclusion** The structured qualitative approach of this study provides information on what issues are considered important by staff members for CP design and implementation. Whereas some concepts such as the importance of a multidisciplinary approach or continuous feedback of results are known from theories, others such as strengthening the authority especially of lower-level health professionals through CPs have not been described so far. Many of the findings point towards strong interactions between factors important for CP implementation and a department's organisational structure.

Maartje Willekens, Paul Giesen, Erik Plat, Henk Mokkink, Jako Burgers, Richard Grol. Quality of after-hours primary care in the Netherlands: adherence to national guidelines. BMJ Qual Saf 2011;20:223-227.

Objective To assess the quality of after-hours clinical care as delivered by general practitioner (GP) cooperatives in the Netherlands. **Methods** A cross-sectional analysis was undertaken of patient health records of five GP cooperatives during 1 year. We used quality indicators derived from national guidelines for the appropriate prescription of pain medication and antibiotics, clinical performance in emergency cases and referral to medical specialists. Data were collected from electronic health records. **Results** We analysed 7660 patient contacts. Average adherence to the guidelines was 77%. The guidelines on referrals to medical specialists and prescription of pain medication had the highest adherence scores (92% and 90%, respectively). Prescribing antibiotics and treatment in emergency cases had the lowest scores (69% and 71%, respectively). Antibiotics were overprescribed in 42% of the cases and underprescribed in 21%. **Conclusions** In general, GPs adhered well to after-hours service national guidelines. There is room for improvement in care for people with acute illnesses and in the prescription of antibiotics.

B Fervers, J S Burgers, R Voellinger, M Brouwers, G P Browman, I D Graham, M B Harrison, J Latreille, N Mlika-Cabane, L Paquet, L Zitzelsberger, B Burnand, The ADAPTE Collaboration. Guideline adaptation: an approach to enhance efficiency in guideline development and improve utilisation. BMJ Qual Saf 2011;20:228-236

Background Developing and updating high-quality guidelines requires substantial time and resources. To reduce duplication of effort and enhance efficiency, we developed a process for guideline adaptation and assessed initial perceptions of its feasibility and usefulness. **Methods** Based on preliminary developments and empirical studies, a series of meetings with guideline experts were organised to define a process for guideline adaptation (ADAPTE) and to develop a manual and a toolkit made available on a website (http://www.adapte.org). Potential users, guideline developers and implementers, were invited to register and to complete a questionnaire evaluating their perception about the proposed process. **Results** The ADAPTE process consists of three phases (set-up, adaptation, finalisation), 9 modules and 24 steps. The adaptation phase involves identifying specific clinical questions, searching for, retrieving and assessing available guidelines, and preparing the draft adapted guideline. Among 330 registered individuals (46 countries), 144 completed the questionnaire. A majority found the ADAPTE process clear (78%), comprehensive (69%) and feasible (60%), and the manual useful (79%). However, 21% found the ADAPTE process complex. 44% feared that they will not find appropriate and high-quality source guidelines. **Discussion** A comprehensive framework for guideline adaptation has been developed to meet the challenges of timely guideline development and implementation. The ADAPTE process generated important interest among guideline developers and implementers. The majority perceived the ADAPTE process to be feasible, useful and leading to improved methodological rigour and guideline quality. However, some de novo development might be needed if no high quality guideline exists for a given topic.

Andrew Tomlin, Susan Dovey, Robin Gauld, Murray Tilyard. Better use of primary care laboratory services following interventions to 'market' clinical guidelines in New Zealand: a controlled before-and-after study. BMJ Qual Saf 2011;20:282-290.

Context Laboratory tests for inflammatory response, thyroid function and infectious diarrhoea were not being ordered as recommended by clinical guidelines. **Objective** To measure changes in community laboratory-test ordering following marketing programmes promoting guidelines recommendations. **Design** Controlled before-and-after study involving 2 years of national laboratory payment data before and after each intervention. Comparisons were with doctors ordering the same tests but not receiving interventions. **Setting** New Zealand primary care. Participants 3161, 3140 and 3335 general practitioners and 2424, 2443 and 2766 Comparison doctors ordering inflammatory response, thyroid function and acute diarrhoea tests from community laboratories, July 2003 to March 2009. **Interventions** Three separate marketing programmes to general practitioners, each comprising written material advising of guidelines recommendations, individual laboratory-test use feedback and professional development opportunities. Main outcome measures Number of tests, tests/doctor, patients having tests and tested patients/doctor/year before and after each intervention. Change in expenditure from before each intervention to after. **Results** For Intervention doctors, erythrocyte sedimentation rate tests decreased 60.0% after the intervention; tests for C-reactive protein increased 63.1%; simultaneous erythrocyte sedimentation rate and C-reactive protein orders decreased 32.6%. Tests for free thyroxine and free triiodothyronine decreased 44.1% and 36.0%. The proportion of thyroid function tests where thyroid-stimulating hormone was the sole test ordered increased from 43.2% before the intervention to 65.2% afterwards ($p<0.001$; 95% CI 21.7% to 22.2%). Testing for faecal culture decreased 31.5%, giardia and cryptosporidium 31.5%, and ova and parasites 56.9%. Faecal culture as the sole initial test increased from 31.4% to 39.1% ($p<0.001$; 95% CI 7.2% to 8.2%). Testing by Comparison doctors changed in the same direction but with significantly less magnitude. The estimated reduction in expenditure for study tests was 23.5%. **Conclusions** Clear information marketed to general practitioners improved the quality of laboratory test ordering for patients in New Zealand.

Désirée A. Lie, Elizabeth Lee-Rey, Art Gomez, Sylvia Bereknyei and Clarence H. Braddock. Does Cultural Competency Training of Health Professionals Improve Patient Outcomes? A Systematic Review and Proposed Algorithm for Future Research. Journal of General Internal Medicine 2011;26(3):317-325.

Background Cultural competency training has been proposed as a way to improve patient outcomes. There is a need for evidence showing that these interventions reduce health disparities. **Objective** The objective was to conduct a systematic review addressing the effects of cultural competency training on patient-centered outcomes; assess quality of studies and strength of effect; and propose a framework for future research. **Design** The authors performed electronic searches in the MEDLINE/PubMed, ERIC, PsycINFO, CINAHL and Web of Science databases for original articles published in English between 1990 and 2010, and a bibliographic hand search. Studies that reported cultural competence educational interventions for health professionals and measured impact on patients and/or health care utilization as primary or secondary outcomes were included. **Measurements** Four authors independently rated studies for quality using validated criteria and assessed the training effect on patient outcomes. Due to study heterogeneity, data were not pooled; instead, qualitative synthesis and analysis were conducted. Results Seven studies met inclusion criteria. Three involved physicians, two involved mental health professionals and two involved multiple health professionals and students. Two were quasi-randomized, two were cluster randomized, and three were pre/post field studies. Study quality was low to moderate with none of high quality; most studies did not adequately control for potentially confounding variables. Effect size ranged from no effect to moderately beneficial (unable to assess in two studies). Three studies reported positive (beneficial) effects; none demonstrated a negative (harmful) effect. **Conclusion** There is limited research showing a positive relationship between cultural competency training and improved patient outcomes, but there remains a paucity of high quality research. Future work should address challenges limiting quality. We propose an algorithm to guide educators in designing and evaluating curricula, to rigorously demonstrate the impact on patient outcomes and health disparities.

Ivan Moschetti, Daniel Brandt, Rafael Perera, M Clarke, Carl Heneghan. Adequacy of reporting monitoring regimens of risk factors for cardiovascular disease in clinical guidelines: systematic review. BMJ 2011;342:d1289.

Objective To assess the reporting of monitoring recommendations in guidelines on the prevention and treatment of cardiovascular disease. **Data sources** Medline, Trip database, National Guideline Clearinghouse, and databases containing guidelines published from January 2002 to February 2010. **Data selection** Three major risk factors for cardiovascular disease: cholesterol level, smoking, and hypertension. The primary outcome was the frequency with which the guidelines dealt with monitoring of risk factors. Secondary outcomes were completeness of monitoring recommendations, defined by the presence of what to monitor, when to monitor, what to do if the targets or variables were not met, and the reported level or strength of the evidence. **Results** 117 guidelines were identified, 84 (72%) of which contained a section on lipids. Of those guidelines with a section on lipids, 53% (n=44) provided no information or specific recommendations on what to monitor, 51% (n=43) provided no information on when to monitor, and 64% (n=54) provided no guidance on what to do if the target was out of range. Guidelines for hypertension (n=79) and smoking (n=65) were little better, with 63% (n=50) and 54% (n=35), respectively, providing no recommendation for what to monitor. The number of guidelines that explicitly referenced the level of evidence for monitoring was low, with most of the recommendations based on weak levels of evidence. **Conclusion** Many guidelines for cardiovascular disease do not report clearly what to monitor and what to do if a change is detected. If no evidence is available to support a specific monitoring schedule, this should be explicit in the guideline, with a description of the new research that would fill the gap.

Squires JE, Hutchinson AM, Bostrom AM, O'Rourke HM, Cobban SJ and Estabrooks CA. To what extent do nurses use research in clinical practice? A systematic review. Implementation Science 2011; 6:21 (17 March 2011)

Background. In the past forty years, many gains have been made in our understanding of the concept of research utilization. While numerous studies exist on professional nurses' use of research in practice, no attempt has been made to systematically evaluate and synthesize this body of literature with respect to the extent to which nurses use research in their clinical practice. The objective of this study was to systematically identify and analyze the available evidence related to the extent to which nurses use research findings in practice. **Methods.** This study was a systematic review of published and grey literature. The search strategy included 13 online bibliographic databases: Cochrane Database of Systematic Reviews, Cochrane Central Register of Controlled Trials, MEDLINE, CINAHL, EMBASE, HAPI, Web of Science, SCOPUS, OCLC Papers First, OCLC WorldCat, ABI Inform, Sociological Abstracts, and Dissertation Abstracts. The inclusion criteria consisted of primary research reports that assess professional nurses' use of research in practice, written in the English or Scandinavian languages. Extent of research use was determined by assigning research use scores reported in each article to one of four quartiles: low, moderate-low, moderate-high, or high. **Results.** Following removal of duplicate citations, a total of 12,418 titles were identified through database searches, of which 133 articles were retrieved. Of the articles retrieved, 55 satisfied the inclusion criteria. The 55 final reports included cross-sectional/survey (n = 51) and quasi-experimental (n = 4) designs. A sensitivity analysis, comparing findings from all reports with those rated moderate (moderate-weak and moderate-strong) and strong quality, did not show significant differences. In a majority of the articles identified (n = 38, 69%), nurses reported moderate-high research use. **Conclusions.** According to this review, nurses' reported use of research is moderate-high and has remained relatively consistent over time until the early 2000's. This finding, however, may paint an overly optimistic picture of the extent to which nurses use research in their practice given the methodological problems inherent in the majority of studies. There is a clear need for the development of standard measures of research use and robust well-designed studies examining nurses' use of research and its impact on patient outcomes. The relatively unchanged self-reports of moderate-high research use by nurses is troubling given that over 40 years have elapsed since the first studies in this review were conducted and the increasing emphasis in the past 15 years on evidence-based practice. More troubling is the absence of studies in which attempts are made to assess the effects of varying levels of research use on patient outcomes.

Gagliardi AR, Brouwers MC, Palda VA, Lemieux-Charles L and Grimshaw JM. How can we improve guideline use? A conceptual framework of implementability. Implementation Science 2011;6:26 (22 March 2011)

Background. Guidelines continue to be underutilized and a variety of strategies to improve their use have been suboptimal. Modifying guideline features represents an alternative, but untested way to promote their use. The purpose of this study was to identify and define features that facilitate guideline use, and examine whether and how they are included in current guidelines. **Methods.** A guideline implementability framework was developed by reviewing the implementation science literature. We then examined whether guidelines included these, or additional implementability elements. Data were extracted from publicly available high quality guidelines reflecting primary and institutional care, reviewed independently by two individuals, who through discussion resolved conflicts, then by the research team. **Results.**The final implementability framework included 22 elements organized in the domains of adaptability, usability, validity, applicability, communicability, accommodation, implementation and evaluation. Data were extracted from 20 guidelines on the management of diabetes, hypertension, leg ulcer and heart failure. Most contained a large volume of graded, narrative evidence, and tables featuring complementary clinical information. Few contained additional features that could improve guideline use. These included alternate versions for different users and purposes, summaries of evidence and recommendations, information to facilitate interaction with and involvement of patients, details of resource implications, and instructions on how to locally promote and monitor guideline use. There were no consistent trends by guideline topic. **Conclusions.** Numerous opportunities were identified by which guidelines could be modified to support various types of decision making by different users. New governance structures may be required to accommodate development of guidelines with these features. Further research is needed to validate the proposed framework of guideline implementability, develop methods for preparing this information, and evaluate how inclusion of this information influences guideline use.

Robin Gauld, Jedediah Horwitt, Sheila Williams, and Alan B. Cohen. What Strategies Do US Hospitals Employ to Reduce Unwarranted Clinical Practice Variations? American Journal of Medical Quality 2011;26: 120-126.

Little is known about unwarranted clinical practice variations within US hospitals. The objectives of this study were to investigate whether hospitals are concerned about variations and their experiences with strategies to reduce variations. Case studies were conducted at 5 hospitals, and a survey of acute care hospitals was conducted in 4 states. Each of the case studies presented a different experience. Unwarranted variations were a concern for 90% of survey respondents, with no differences by state (P = .7) or hospital size (P = .2). Of these, 75% had a strategy in place to reduce variation. The likelihood of a multipronged approach was significantly higher in larger hospitals (P = .0009). This study revealed disparate approaches to reducing unwarranted clinical practice variations and also highlighted barriers to reducing variation. The case studies identified some models that could be emulated, but questions remain about whether there is a single best way forward.

Kylie A. McIntosh, David J. Maxwell, Lisa K. Pulver, Fiona Horn, Marion B. Robertson, Karen I. Kaye, Gregory M. Peterson, William B. Dollman, Angela Wai, and Susan E. Tett. A quality improvement initiative to improve adherence to national guidelines for empiric management of community-acquired pneumonia in emergency departments. Int J Qual Health Care 2011; 23(2): 142-150.

Objective The objective of this study was to improve the concordance of community-acquired pneumonia management in Australian emergency departments with national guidelines through a quality improvement initiative promoting concordant antibiotic use and use of a pneumonia severity assessment tool, the pneumonia severity index (PSI). Design and Interventions Drug use evaluation, a quality improvement methodology involving data collection, evaluation, feedback and education, was undertaken. Educational interventions included academic detailing, group feedback presentations and prescribing prompts. Setting and Participants Data were collected on 20 consecutive adult community-acquired pneumonia emergency department presentations by each hospital for each of three audits. Main **Outcome Measures** Two process indicators measured the impact of the interventions: documented PSI use and concordance of antibiotic prescribing with guidelines. Comparisons were performed using a Chi-squared test. **Results** Thirty-seven hospitals, including public, private, rural and metropolitan institutions, participated. Twenty-six hospitals completed the full study (range: 462–518 patients), incorporating two intervention phases and subsequent follow-up audits. The baseline audit of community-acquired pneumonia management demonstrated that practice was varied and mostly discordant with guidelines. Documented PSI use subsequently improved from 30/518 (6%, 95% confidence interval [CI] 4–8) at baseline to 125/503 (25%, 95% CI 21–29; P < 0.0001) and 102/462 (22%, 95% CI 18–26; P < 0.0001) in audits two and three, respectively, while concordant antibiotic prescribing improved from 101/518 (20%, 95% CI 16–23) to 132/462 (30%, 95% CI 26–34; P < 0.0001) and 132/462 (29%, 95% CI 24–33; P < 0.001), respectively. **Conclusions** Improved uptake of guideline recommendations for community-acquired pneumonia management in emergency departments was documented following a multi-faceted education intervention.

Susanne Heiwe, Kerstin Nilsson Kajermo, Raija Tyni-Lenné, Susanne Guidetti, Monika Samuelsson, Inga-Lena Andersson, and Yvonne Wengström. Evidence-based practice: attitudes, knowledge and behaviour among allied health care professionals. Int J Qual Health Care 2011;23(2):198-209.

Objective To explore dieticians', occupational therapists' and physical therapists' attitudes, beliefs, knowledge and behaviour concerning evidence-based practice within a university hospital setting. Design Cross-sectional survey. Setting University hospital. Participants All dieticians, occupational therapists and physical therapists employed at a Swedish university hospital (n = 306) of whom 227 (74%) responded. **Main Outcome Measures** Attitudes towards, perceived benefits and limitations of evidence-based practice, use and understanding of clinical practice guidelines, availability of resources to access information and skills in using these resources. **Results** Findings showed positive attitudes towards evidence-based practice and the use of evidence to support clinical decision-making. It was seen as necessary. Literature and research findings were perceived as useful in clinical practice. The majority indicated having the necessary skills to be able to interpret and understand the evidence, and that clinical practice guidelines were available and used. Evidence-based practice was not perceived as taking into account the patient preferences. Lack of time was perceived as the major barrier to evidence-based practice. **Conclusions** The prerequisites for evidence-based practice were assessed as good, but ways to make evidence-based practice time efficient, easy to access and relevant to clinical practice need to be continuously supported at the management level, so that research evidence becomes linked to work-flow in a way that does not adversely affect productivity and the flow of patients.

Guyatt G, Akl EA, Hirsh J, Kearon C, Crowther M, Gutterman D, et al. The vexing problem of guidelines and conflict of interest: a potential solution. Ann Intern Med. 2010;152:738-41. [PMID: 20479011]

Abstract: Issues of financial and intellectual conflict of interest in clinical practice guidelines have raised increasing concern. Professional organizations have responded by more rigorous regulation of conflict of interest. Nevertheless, tension remains between the competing goals of optimizing guideline quality by using the experience and insight of experts and ensuring that financial and intellectual conflicts of interest do not influence recommendations. The executive committee of the American College of Chest Physicians' Antithrombotic Guidelines has developed a strategy comprising 3 innovative aspects to address this tension: First, place equal emphasis on intellectual and financial conflicts and provide explicit criteria for both; second, a methodologist without important conflicts of interest should have primary responsibility for each chapter; and third, experts with important financial or intellectual conflicts of interest can collect and interpret evidence, but only panel members without important conflicts can be involved in developing the recommendation for a specific question. These strategies may help to achieve the benefits of expert input without conflicts of interest influencing recommendations.

Guideline Library update

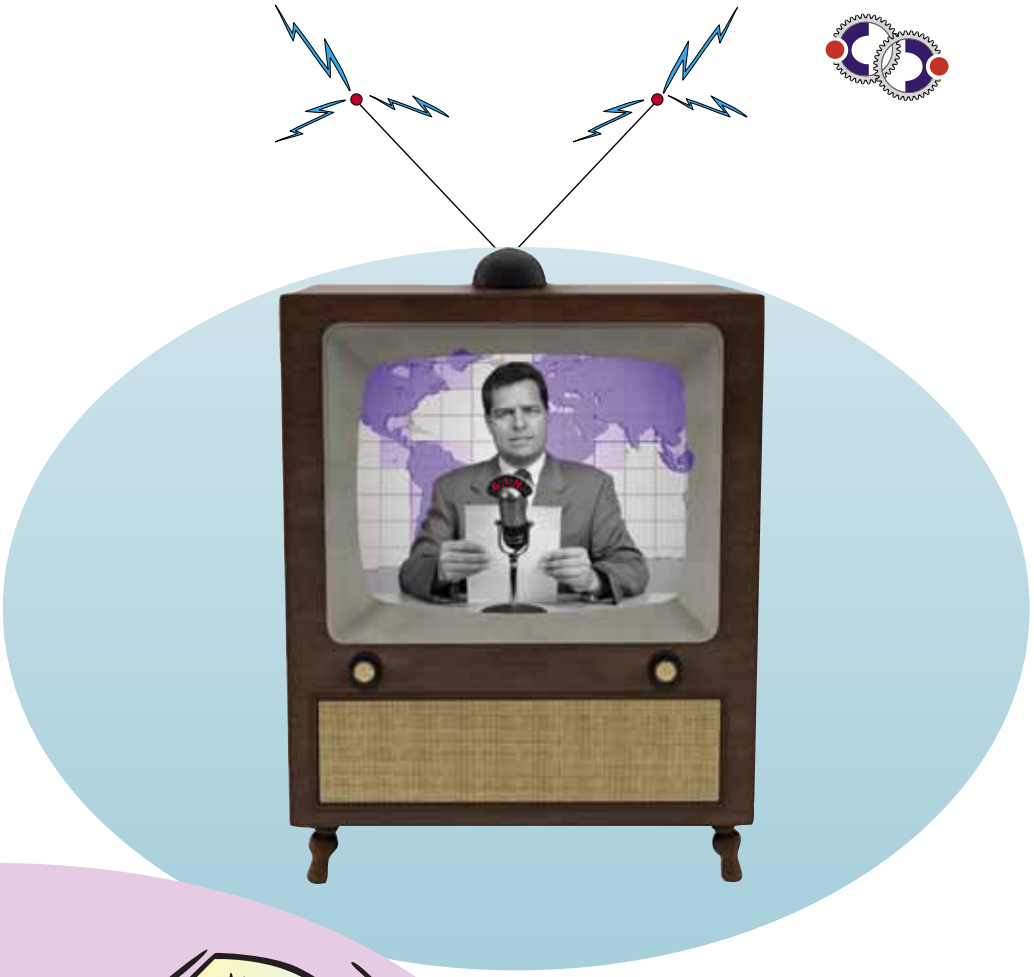
New data in the International Guideline Library –16th December 2010 to 8th April 2011

Organisation	Title
ACP (US)	Diagnostic Imaging for Low Back Pain: Advice for High-Value Health Care From the American College of Physicians
ACP (US)	High-Value, Cost-Conscious Health Care: Concepts for Clinicians to Evaluate the Benefits, Harms, and Costs of Medical Interventions
ACP (US)	Use of Intensive Insulin Therapy for the Management of Glycemic Control in Hospitalized Patients: A Clinical Practice Guideline From the American College of Physicians
ADA (US)	Disorders of Lipid Metabolism (DLM) Evidence-Based Nutrition Practice Guideline Update
AHRQ (US)	Osteoporosis - primary prevention: Alendronate, etidronate, risedronate, raloxifene and strontium ranelate for the primary prevention of osteoporotic fragility fractures in postmenopausal women (TA160)
CARI (AU)	CARI Guidelines: Early chronic kidney disease: screening
CARI (AU)	CARI Guidelines: Living Kidney Donors: Donors at risk: haematuria
CARI (AU)	CARI Guidelines: Living Kidney Donors: Potential child bearing donors
HAS (FR)	Maladies bulleuses auto-immunes: Dermatite herpétiforme. Guide ALD
HAS (FR)	Maladies bulleuses auto-immunes: Dermatose à IgA linéaire. Guide ALD
HAS (FR)	Maladies bulleuses auto-immunes: Épidermolyse bulleuse acquise
HAS (FR)	Maladies bulleuses auto-immunes: Pemphigoïde bulleuse
HAS (FR)	Maladies bulleuses auto-immunes: Pemphigoïde cicatricielle. Guide ALD
HAS (FR)	Maladies bulleuses auto-immunes: Pemphigoïde de la grossesse
HAS (FR)	Maladies bulleuses auto-immunes: Pemphigus
HAS-INCa (FR)	Recommandations pour la surveillance médico-professionnelle des travailleurs exposés à l'action cancérigène des poussières de bois
IQWiG (DE)	Aussagekraft von Surrogatparametern in der Onkologie (Rapid Report) [Validity of surrogate parameters in oncology (Rapid report)]
NICE (GB)	Alcohol dependence and harmful alcohol use (CG115)
NICE (GB)	Anaemia management in people with chronic kidney disease (CG114)
NICE (GB)	Anxiety: Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults (CG113)
NICE (GB)	Alzheimer's disease - donepezil, galantamine, rivastigmine and memantine (TA217)
NICE (GB)	Breast cancer - bevacizumab (in combination with a taxane) (TA214)
NICE (GB)	CardioQ-ODM (oesophageal Doppler monitor) (MTG3)
NICE (GB)	Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas (CG118)
NICE (GB)	Deep brain stimulation for intractable trigeminal autonomic cephalalgias (IPG381)
NICE (GB)	Deep brain stimulation for refractory chronic pain syndromes (excluding headache) (IPG382)
NICE (GB)	Diabetic foot problems - inpatient management (CG119)
NICE (GB)	Distal iliotibial band lengthening for refractory greater trochanteric pain syndrome (IPG375)
NICE (GB)	Extracorporeal shockwave therapy for refractory greater trochanteric pain syndrome (IPG376)
NICE (GB)	Food allergy in children and young people (CG116)
NICE (GB)	Hand allotransplantation (IPG383)
NICE (GB)	Increasing the uptake of HIV testing among black Africans in England (PH33)
NICE (GB)	Increasing the uptake of HIV testing among men who have sex with men (PH34)
NICE (GB)	Laser correction of refractive error following non-refractive ophthalmic surgery (IPG385)
NICE (GB)	Leukaemia (lymphocytic) - bendamustine (TA216)

NICE (GB)	MoorLDI2 Burns Imager a laser Doppler blood flow imager for the assessment of burn wounds (MTG2)
NICE (GB)	Myelodysplastic syndromes - azacitidine (TA218)
NICE (GB)	Off-pump coronary artery bypass grafting (IPG377)
NICE (GB)	Osteoporosis - secondary prevention including strontium ranelate: Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women (TA161)
NICE (GB)	Percutaneous laser coronary angioplasty (IPG378)
NICE (GB)	Percutaneous retroperitoneal endoscopic necrosectomy (IPG384)
NICE (GB)	Psychosis with coexisting substance misuse (CG120)
NICE (GB)	Renal cell carcinoma (first line metastatic) - pazopanib (TA215)
NICE (GB)	Schizophrenia - aripiprazole: Aripiprazole for schizophrenia in people aged 15 to 17 years (TA213)
NICE (GB)	Skin cancer prevention: information, resources and environmental changes: Skin Cancer: how the NHS and local authorities can help prevent skin cancer using public information, sun protection resources and by making changes to the environment (PH32)
NICE (GB)	Therapeutic hypothermia following cardiac arrest (IPG386)
NICE (GB)	Thoracoscopic repair of congenital diaphragmatic hernia in neonates (IPG379)
NICE (GB)	Transaxial interbody lumbosacral fusion (IPG387)
NICE (GB)	Tuberculosis. Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (CG117)
SCHIN (GB)	Alopecia, androgenetic - male (CKS Topic)
SCHIN (GB)	Antenatal care - uncomplicated pregnancy (CKS Topic)
SCHIN (GB)	Benign paroxysmal positional vertigo (CKS Topic)
SCHIN (GB)	Boils, carbuncles, and staphylococcal carriage (CKS Topic)
SCHIN (GB)	Breastfeeding problems (CKS Topic)
SCHIN (GB)	Chest pain (CKS Topic)
SCHIN (GB)	Delirium (CKS Topic)
SCHIN (GB)	Hyponatraemia (CKS Topic)
SCHIN (GB)	Knee pain - assessment (CKS Topic)
SCHIN (GB)	Melanoma and pigmented lesions (CKS Topic)
SCHIN (GB)	Meningitis (bacterial) and meningococcal septicaemia (CKS Topic)
SCHIN (GB)	Otitis media with effusion (CKS Topic)
SCHIN (GB)	Paronychia - acute (CKS Topic)
SCHIN (GB)	Prostate cancer (CKS Topic)
SCHIN (GB)	Pulmonary embolism (CKS TOPIC)
SCHIN (GB)	Whitlow (staphylococcal and herpetic) (CKS Topic)
SCHIN (GB)	Vestibular neuronitis (CKS TOPIC)

Watch for the next issue. The next issue of enGINe will be published in July 2011

If you wish to include some information please send your pieces by 20th June to office@g-i-n.net



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