with Level I denoting strongly evidence-based statements and Level III denoting statements unsupported by evidence. In 2001, the level definitions were revised to denote the quality of specific study designs, and explicit guidance for synthesising bodies of evidence was developed. A third revision in 2006 tightened the criteria for Levels I and II, and created a Level IV to differentiate poor-quality studies from expert opinion. In 2011, the levels were revamped to be consistent with SIGN and GRADE methods.

Lessons The Academy has worked for years to make its evidence grading systems more rigorous. This has included using a level-based system to clearly link PPP recommendations to evidence quality, revising the level definitions for greater clarity, and providing explicit direction on evidence synthesis.

P224 ADAPTING GUIDELINES WITH CONFLICTING RECOMMENDATIONS: THE CASE OF MICROSCOPIC ASYMPTOMATIC MICROHEMATURIA

J Whittaker, R Loo. *Southern California Permanente Medical Group, Pasadena, USA*

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Background Existing clinical practice guidelines (CPGs) conflict on the best approach to the work-up of patients with asymptomatic microscopic hematuria who are at low risk of urinary tract cancer. Consequently, while adapting existing CPGs to a local context can be an attractive alternative to *de novo* development, when there are conflicting guidelines, disagreement with recommendations, or missing critical outcomes, potential time and resource gains are often minimised due to the need for additional evidence assessment and stakeholder consensus building activities.

Context To reconcile conflicting recommendations and address gaps in evaluation of critical outcomes, a Guideline Development Team (GDT) in a regional health care organisation used existing CPGs and systematic reviews, supplemented by additional evidence reviews, to develop recommendations for asymptomatic microscopic hematuria.

Description of Best Practice Based on review of evidence synthesised in external guidelines, supplemental *de novo* evidence reviews on critical outcomes, and risk assessment analysis of patient data, the GDT reached consensus on recommendations that differed from external guidelines, concluding that asymptomatic hematuria patients without risk factors were at sufficiently low-risk for urinary tract cancer to safely eliminate multiphase CT urograms from most urologic evaluations. Guidelines to reduce unnecessary CTs and radiation exposure in low-risk patients were developed, and knowledge transfer interventions aimed at the practitioner and healthcare system levels were implemented.

Lessons for Guideline Developers When adapting external guidelines with conflicting recommendations and gaps in critical outcomes, additional evidence searches, data analysis, and consensus building can negate anticipated gains in time and resources expected from guideline adaptation.

P225 THE DEVELOPMENT OF EVIDENCE BASED GUIDELINES FOR OPIOID PAIN TREATMENT

[1]A Effiong, [1]K Hegmann, [1]M Thiese, [2]C Wolfkiel, [2]J Ording, [3]J Harris, [1]K Schwei. *[1]Rocky Mountain Center for Occupational and Environmental Health, Salt Lake City, USA; [2]ACOEM, Elk Grove Village, USA; [3]The Permante Medical Group, San Rafael, United States*

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Background Opioid analgesic-related deaths more than tripled in the US from 1999 through 2006. According to the CDC, 27,000 unintentional drug overdose deaths occurred in the United States in 2007; the most potent epidemic in the past 100 years.

Objectives To develop opioid guidelines to improve opioid pain treatment and reduce fatalities.

Methods A systematic literature search (including Google Scholar and Medline) was conducted. Randomised controlled trials (RCTs) were categorised into acute, subacute (1–3mo), chronic, and mixed chronicity. The quality of RCTs was determined using previously developed guideline scoring methods; low quality (3.5 or less), moderate quality (4.0–7.5), and high quality (8.0–11.0).

Results A total of 153 RCTs were identified; 11 acute, 2 subacute, 137 chronic, and 3 of mixed chronicity. Of the 11 acute pain RCTs, 1 was low quality, 6 moderate quality, and 4 high quality. Both subacute pain RCTs were moderate quality. Of the 137 chronic pain RCTs, 28 were low quality, 95 moderate quality, and 14 high quality. The RCTs with mixed chronicities were of moderate quality. All trials were under 6 months, with most under 4-weeks duration, precluding statements on long-term safety.

Discussion These opioid guidelines provide more informed recommendations for prescribing opioids for pain treatment with details to be presented.

Implications These guidelines may have considerable implications among prescribing health professionals.

P226 A MULTIDISCIPLINARY APPROACH TO CREATING BEHAVIORAL HEALTH GUIDELINES: CHALLENGES OF ADHERING TO IOM STANDARDS

R Halfond, L Bufka, H Kurtzman, D Galper, S Beattie. *American Psychological Association, Washington, D.C., United States*

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Background In 2010 our organisation began creating evidence-based clinical practice guidelines for behavioural health, focusing initially on depression, PTSD, and obesity, following emerging IOM standards.

Context Selected challenges in five areas: 1. Terminology. For many years, our organisation used guideline terminology that was inconsistent with the field. 2. Representation. Given the diverse types of professionals in behavioural health and the breadth/depth of each topic, attaining sufficiently diverse panel membership has been challenging. 3. Stakeholders. Obtaining the patient perspective has been challenging, particularly given the stigma and privacy concerns often associated with mental health. 4. Systematic Reviews. The high cost of developing *de novo* systematic reviews, especially for large scope topic areas, is limiting. 5. Education. Professionals have varying knowledge and lexicons for the process, requiring education, particularly surrounding non-financial conflicts of interest.

Description of Best Practice •Terminology- Implemented organisation-wide systemic change in lexicon via change in organisation policy and routine dissemination. •Representation- Used multi-step consensus nomination process to assemble

multidisciplinary panels. •Stakeholders- Using multi-tiered approach to involve stakeholders via Consultation, Participation, and Communication models and outreach to mental health peer support programmes. •Systematic Reviews- Applied Delphi poll method in topic scoping/refinement to work within organisational resources. Other mechanisms to enhance resources include topic nominations to AHRQ, possible organisational partnerships, and developing products from guidelines. •Education- Creating a series of self-study educational modules on guideline development.

Lessons for Guideline Developers and Others Our challenges and resolutions could be helpful to others in guideline development.

P227 CAPACITY ENHANCEMENT THROUGH A DISTANCE LEARNING COURSE FOR PRIMARY HEALTH CARE (PHC) PROFESSIONALS: THE FIRST APPROACH FOR A GUIDELINE DEVELOPMENT

A Stein, E Wendland, M Pinto, O D'Avila, A Dahmer. *Department of Public Health UFCSPA, Porto Alegre, Brazil*

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Background There is a need to develop strategies for guideline development. It is essential to learn educational needs of health professionals who work at PHC level. Evidence based guidelines should be applied for these health professionals taking into account their context.

Objectives To identify skills and resources of primary health professionals in a distance learning course (UNASUS from UFCSPA – Federal University of Health Science of Porto Alegre).

Methods A quasi-experiment study had been carried out and the inclusion criteria were dentists, nurses and family physicians that provide PHC. Data had been collected in the beginning of the distant course, as a baseline and one year after the enrollment. This course enables specialisation for primary health care. A web-based questionnaire was applied to these subjects.

Results The sample size was 251 eligible subjects. The mean age of the responders was 35.2±8.27DP (range: 25–68), from 48 different towns from South Brazil. The majority (88.8%) were women and 67.3% had nurse degree. 94% of the subjects reported that the distance course was a good strategy to change their practice. Interactive activities resembling their daily routine had a higher impact.

Discussion The results have shown that distance learning is effective to enhance primary health care professional's behaviour, especially when simulating real cases.

Implications for guideline developers/users The present research has identified that it is essential to improve access to evidence-based clinical practice guidelines and resources across Brazil, and to increase skill capacity in using evidence to inform clinical decision-making.

P233 HOW CONFIDENT ARE YOU IN THE RESULTS GIVEN ONLY ONE RCT? TICAGRELOR VS CLOPIDOGREL: CASE REPORT BY CLINICAL GUIDELINE ON ACUTE CORONARY SYNDROME IN COLOMBIA

N Acosta-Baena, L Lugo, A Mejia, J Senior. *Universidad de Antioquia, Medellin, Colombia*

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Background Ticagrelor is oral antagonist of adenosine diphosphate receptors of subtype P2Y12. It is indicated for the prevention of atherothrombotic events in adults with acute coronary syndromes (ACS) and it act faster and shorter than clopidogrel.

Objectives The authors review and discuss clinical findings and health-economic evidence of ticagrelor compared with clopidogrel to reduced myocardial infarction, stroke or death, major bleeding, in patients with ACS in Colombia, when only one RCT has been published comparing both drugs.

Methods This question was part of the guideline development. The process included search, assessment, rating the quality of evidence and economic evaluation. The recommendations were classified according to the methodology described by GRADE Working Group: consideration benefit/harm, preferences and resources.

Results 1 clinical study was identified. The efficacy outcome was favourable for the group of patients receiving ticagrelor. The result of the economic analysis suggests that the probability of ticagrelor is a cost effective alternative in the Colombian health system is more than 76.6%.

Discussion We recommend ticagrelor plus ASA for patients with non-STEMI, intermediate to high-risk, and for patients with STEMI if they have not received fibrinolysis in the last 24 hours.

Implications for Guideline Developers/Users Our results hold in different scenarios and sensitivity analyses, as long as the time horizon is not limited to short-term assessment because may underestimate the costs and benefits and therefore lead to erroneous conclusions with a single primarily study. Our recommendation is strong, although there was a single RCT owing to time horizon and high quality of evidence.

P235 FROM CLINICAL PRACTICE GUIDELINES TO THE COMPREHENSIVE CARE GUIDELINE FOR PATIENTS: BEYOND THE SCIENTIFIC PROCESS, A TASK OF CULTURAL CONSTRUCTION

L Bonilla Mahecha, M Moreno, P Mosquera, H Gaitan. *Universidad Nacional de Colombia, Bogota, Colombia*

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Background Patients guideline development is a complex process that must combine harmoniously clinic expert knowledge, values, preferences and patient's information needs; it means in itself the possibility of transforming social imaginary, practices, beliefs and behaviours health. The design of a qualitative methodology systematic and rigorous a guideline for patients would allow producing efficient results. The paper contains the design of a systematic and rigorous type of qualitative methodology, a guidelines for patients, was allowed producing efficient results.

Objective Design a methodology for patients' guidelines development in the Colombian context.

Methods A qualitative type study was developed in three phases: 1) Review of materials and patients guidelines targeting populations, creating an array of identification of information needs. 2) Development of a proposal for a context-sensitive communication expert team. 3) Validation of contents.

Results Designed a methodology with ten steps and developed the guidelines for patients which included scientific evidence, socio-cultural practices and participation of patients. The validation of the sexually transmitted infections the Guide was attended to people with a variety of gender, age and educational