

and condition-specific GIttools could make efficient use of resources.

# 065 PUBMED VS. GOOGLE SCHOLAR: A DATABASE ARMS RACE?

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**Background** Currently there are two widely used databases, PubMed and Google Scholar, are used for guidelines development. Research suggests PubMed is superior, however recent evidence suggests Google Scholar may have closed that gap. One family of journals reports 60% of their traffic is coming from Google Scholar.

**Objectives** Assess efficiency and completeness of searching for known moderate and high quality RCTs in PubMed and Google Scholar.

**Methods** Searches were performed by two experienced researchers using the same search terms to identify RCTs for a specific treatment. In a crossover design, one researcher performed the search in PubMed (PM1), the other in Google Scholar (GS1). Subsequently each performed the same searches in the other database (PM2 and GS2). Total numbers of articles identified, relevant articles found, and the time to complete were collected. Articles were compared to a known comprehensive list of 5 RCTs used for guideline preparation that was drawn from 6 exhaustive database searches.

**Results** GS1 identified 2 and GS2 identified 3 of the RCTs. PM1 identified 2 and PM2 identified 2 RCTs. PubMed and Google Scholar searches averaged 63 and 194 minutes to complete respectively.

**Discussion** Each database consistently identified one of the two highest quality studies, but neither database identified both. Difference search time is nearly 3-fold. No single search identified all quality studies. Additional trials are planned.

**Implications for Guideline Developers/Users** For comprehensive literature searches both databases should be searched.

# 066 HOW ARE WE FEELING TODAY? THE SENSITIVITY OF A LITERATURE SEARCH FILTER FOR PATIENTS' VALUES AND PREFERENCES

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**Background** The patient perspective in guideline development is of vital importance. To find out what this perspective entails, different methods may be considered, such as participation of patients or their representatives in guideline development groups or in focus group discussions, or by conducting patient surveys addressing specific problems and needs. In addition, a review of the literature in the early stages of guideline development can provide relevant information. Literature search filters for patients' perspectives and preferences applicable for Medline (OVID), PubMed, and Embase were developed and validated in 2012. The specificity was 98% but the sensitivity was only 90%.

**Objectives** To verify the sensitivity of the filters by means of a newly available 'gold standard'.

**Methods** We re-estimated the sensitivity of the search filters by using the references of a recent Cochrane Review, Interventions for providers to promote a patient-centred approach in clinical consultations 2012;(12):CD003267, as a gold standard.

**Results** The search filters for patients' values and preferences retrieved 72 (Medline (OVID/Pubmed) and 67 (Embase) titles, respectively, out of 73 references included in the Cochrane Review (mean sensitivity 96%).

**Discussion** Applying filters for patients' perspectives and preferences retrieved almost all references. Minor adaptations to the Embase filter were needed to enhance the sensitivity without compromising the specificity. Validation of filters is an iterative process, illustrating that filters are dynamic tools.

**Implications for Guideline Developers/Users** Availability of a validated tool for retrieving literature on patients' values and preferences can support integration of the patient perspective in guideline development.

# 067 CHALLENGES OF DEVELOPING RAPID GUIDANCE FOR COMPLEX INTERVENTIONS

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**Background** Rigorous guideline development requires extensive time and resources. Rapid review—a streamlined approach to synthesising evidence—offers an attractive alternative to systematic review for informing decision-making on complex interventions in a timely manner. Complex interventions are those that contain extensive number of interacting components.

**Context** A rapid evidence assessment service of a large US-based health care organisation developed guidance through rapid review on transitional residential recovery services (TRSS) for substance abusers.

**Description of Best Practice** Complex interventions present unique challenges for evaluation by rapid review. Significant scoping and upfront communication with end users was undertaken to understand the target populations, intervention-related components, outcomes, timing and settings associated with TRSS. Thorough refinement of Ovid search algorithms using date-based limits was needed to generate a feasible and appropriate literature database. Issues relating to complex interventions—such as limited generalisability, lack of effect may be driven by poor implementation rather than ineffectiveness of intervention, variability in outcomes, etc.—were communicated to end users in conjunction with findings. Changes to existing programmes were enacted based on findings and will be discussed.

**Lessons for Guideline Developers, Adaptors, Implementers, and/or Users** Studies of complex interventions are notoriously difficult to evaluate and summarise through traditional evidence assessment methods. Rapid review offers an attractive option for providing evidence for timely decision-making; however, its application to complex interventions requires careful planning, execution and understanding.

# 068 INTEGRATING GUIDELINES INTO LOCAL CLINICAL PRACTICE AND POLICY USING HOSPITAL-BASED HEALTH TECHNOLOGY ASSESSMENT

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**Background** Most existing centres for health technology assessment (HTA) are associated with payers or government agencies, and review and analyse emerging and costly technologies. Yet, such centres can exist within individual medical centres as well, and can use HTA methods locally to synthesise, disseminate and implement best clinical practices to improve the quality, safety and value of patient care.

**Objectives** Describe the structure, processes and outcomes of a model of hospital-based HTA (HB-HTA) in the US, such that it can be applied elsewhere.

**Methods** Our academic medical centre established the centre for Evidence-based Practice (CEP) in 2006. CEP synthesises guidelines and studies for clinical and administrative leaders to inform decision-making, integrates select syntheses into practice through clinical decision support (CDS), and provides education in evidence-based practice. Local utilisation and cost data are incorporated where appropriate.

**Results** Nearly 200 evidence reports have been completed to date, and over 35 reports have been integrated into CDS. The median time from project opening to first draft is 4 weeks. CEP also contracts with external organisations such as the CDC and AHRQ on systematic reviews and guidelines.

**Discussion** To complete reviews rapidly, we work closely with requestors to define the questions up front and limit the scope, use experienced analysts to perform high yield searches with single study reviews and extraction, and use best available evidence and existing guidelines and reviews.

**Implications for Guideline Developers/Users** An HB-HTA centre can develop, adapt and implement guidelines locally to support a culture of evidence-based practice and decision-making.

## 069 FACILITATING IMPLEMENTATION OF GUIDELINES FOR THE PREVENTION OF VASCULAR DISEASE IN GENERAL PRACTICE

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**Background** Although evidence based guidelines have been developed and disseminated, up to a half of patients do not receive guideline based preventive care.

**Objectives** This study aims to evaluate a model for the implementation of preventive care guidelines in general practice.

**Methods** Following a development process for the intervention involving a mixed method study and a pilot carried out in three practices a cluster randomised controlled trial is being conducted in 31 practices across four states. The intervention involves training, preventive care audit, and visits from a facilitator based in

the local primary care support organisation. The facilitator assists practices to review their clinical audit and implement a practice plan structured around the 5As to improve the reach and quality of preventive care. Quantitative and qualitative evaluation methods are being used to assess impact on planned change within the practice, recalled and recorded preventive care, and patient behaviours and risk factors for cardiovascular disease.

**Results** Baseline data collection has been completed from practice staff and patients and the intervention is now complete. The recorded and patient recalled preventive care varied within and between practices resulting in a varied set of priorities for improvement. Early findings suggest that facilitation visits to review and plan improvements to the implementation of preventive guidelines are feasible, acceptable and can support organisational strategies to address gaps in care.

**Discussion** Our results may provide a model for local primary care support organisations to assist practices to improve their quality of preventive care.

## 070 STRATEGIES FOR HEALTH SYSTEM IMPLEMENTATION OF GUIDELINES ON OVERWEIGHT AND OBESITY

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**Background** Evidence-based clinical practice guidelines (CPGs) for adult obesity and overweight provide recommendations to clinicians on interventions for weight loss and maintenance. organisation-wide implementation of these guidelines is critical to achieve changes in practice and patient health outcomes.

**Context** To describe novel guideline implementation strategies used by a large US health care organisation to improve the care of obese and overweight adults.

**Description of Best Practice** An evidence-based CPG was developed to address management strategies for a rapidly increasing number of obese and overweight patients. Interventions aimed at practitioner, patient and systems levels were tailored to facilitate implementation of CPG recommendations. Practitioner interventions included basic knowledge dissemination via electronic distribution of CPGs, presentation of CPGs at clinician champions' meetings; and development of point-of-care job aids, such as in-clinic access to online CPGs and office prompts to refer obese patients to weight management classes. Patient-level interventions included proactive outreach for health education classes and telephone-based coaching; point-of-care educational publications; and after-visit summaries with weight management recommendations. Interventions at the systems level included proactive office encounter recording of patient BMI and exercise regimen; clinical performance goals; reporting of health outcomes of participants in weight management programmes; and, a physician continuing medical education (CME) course. Continued improvements in clinician/patient communication about weight, collection of patient weight information, and patient health outcomes have been observed.

**Lessons for Guideline Developers, Adaptors, Implementers, and/or Users** Novel approaches to integrating guidance on the management of obesity and overweight into practice can achieve significant changes in clinical practice and patient health outcomes.