086 GUIDELINES ADAPTATION IN LOW AND MIDDLE INCOME COUNTRIES (LMIC): RESULTS AND LESSONS LEARNT FROM AN 8-YEAR-CAPACITY BUILDING (CB) EXPERIENCE IN ARGENTINA (2005–2012)

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Background Capacity building (CB) is an essential element for guideline adaptation in the context of LMIC.

Objectives To describe the approach and results from a CB process for guidelines adaptation implemented by the National Academy of Medicine (NAM) in Argentina between 2005 and 2012.

Methods The CB process is described on the basis of the matrix of capacity-building strategies. Duration, objectives, entities targeted and results through the different stages of the CB process are provided.

Results The CB process has been supported on a “learning by doing” approach, and comprised 2 stages: a local capacity development stage (2005–2008) and a knowledge transfer (KT) stage (2008–2012). As a result of the 1st stage, 120 health professionals were involved during the adaptation process; 3 guidelines were produced and a guide to adapt guidelines was published. KT started in 2008 and was initially performed through e-learning courses targeted to individuals. In 2009, a strategy based on continuous online support through a virtual campus and workshops and targeted to institutions was adopted. Four institutions were involved: 1 did not progress; 1 completed the whole process and published an evidence-based guideline and 2 are ongoing.

Implications for Guideline Developers/Users In the context of LMIC, CB processes based on the “learning by doing” approach and focused to institutions seem to be more appropriate although challenging: not only technical capacities have to be built, but also those related to human resources management, group-working and use of Internet resources. Different level of achievement of these capacities could explain the results observed alongside the CB process implemented by NAM.

087 CAPACITIES, PRACTICES AND PERCEPTIONS OF EVIDENCE-BASED PUBLIC HEALTH IN EUROPE

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Evidence-based methodologies are used to synthesise systematic high-quality evidence and were first applied in clinical practice. Evidence-based public health, however, is still in its early stages. The European Centre for Disease Prevention and Control sought the insight of European organisations working in the field of public health on current practices, capacities, perceptions and predictions of evidence-based public health. A survey was sent to 76 organisations. A response rate of 36% was achieved, representing 27 organisations from 16 countries. Systematic reviews were the most commonly offered service, followed by health technology assessments and rapid assessments. Fifty-four per cent of respondents believed that evidence-based methodologies were poorly integrated into public health. The main perceived barriers to the further development of evidence-based public

health included ‘lack of formalised structure or system’, ‘resource constraints’ ‘lack of understanding of evidence-based methodologies by policy makers’ and ‘lack of data’. Nevertheless, 81% of respondents believed that evidence-based methodologies will play an increasingly important role in public health in future. However, several barriers need to be overcome. Consistent frameworks and consensus on best practices were identified as the most pressing requirements. Steps should be taken to address these barriers and facilitate integration and ultimately public health policies.

088 COHORT OF CLINICAL PRACTICE GUIDELINES FROM THE SPANISH NATIONAL GUIDELINE PROGRAMME: A SURVIVAL ANALYSIS

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Background Clinical Practice Guidelines (CPGs) recommendations need to be updated to maintain their validity.

Objectives To provide empirical estimates of the average time after which CPGs recommendations become obsolete.

Methods We developed a strategy to assess the validity of CPG recommendations, which included assessing their validity by surveying clinical experts, updating the literature search, screening references by pertinence and matching them with recommendations, and identifying pertinent, relevant and key references, and potential changes in each recommendation. A convenience sample of four CPGs was selected. We piloted our strategy in 20% of the recommendations from these CPGs (feasibility test) and we estimated our sample size. We performed a survival analysis and considered a CPG outdated when more than 20% of recommendations needed to be updated.

Results The four CPGs included 250 recommendations. A total of 39.133 (range 3.343–14.784) references were identified in the exhaustive literature search in a time frame of 3–5 years. The feasibility test identified 16 key references updating 8 recommendations. The number of recommendations required for the study was 113. A total of 674 references were marked as pertinent to these recommendations.

Discussion We developed a rigorous, replicable evaluation strategy to assess the validity of recommendations and estimate CPG obsolescence. Full final results will be present at the GIN meeting.

Implications for Guideline Developers/Users Our work is relevant for guideline developers because it provides information about the expected validity of CPGs recommendations.

089 AN INTERNATIONAL COMPARISON OF OCCUPATIONAL GUIDELINES FOR THE MANAGEMENT OF MENTAL DISORDERS

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Background To address the problem of sickness absence due to mental disorders, guidelines have been developed in various countries.

Objectives To assess available guidelines on the management of mental disorders in an occupational health care setting on their quality and to compare recommendations.

Methods Guidelines were selected by systematically searching PubMed, Guidelines International Network Library, and National Guideline Clearinghouse. In addition, members of the International Commission on Occupational Health were consulted. Quality of guidelines was assessed with the AGREEII instrument and recommendations were compared.

Results Fifteen guidelines were included: 1 Japanese, 1 Danish, 2 Finnish, 2 South-Korean, 2 British and 7 Dutch. The quality of the guidelines varied. Barriers and facilitators for implementation (Applicability), competing interests (Editorial independence), and the process to gather and synthesise evidence (Rigour of Development) were poorest described. The domain Scope and Purpose scored highest. Recommendations concerning assessment refer to diagnostic classification, inventory of performance problems, causal factors and barriers for recovery. Specific workplace factors are often mentioned. Guidelines agree on work adaptation if necessary, psychological treatment and communication about treatment plan between involved actors.

Discussion Guidelines are difficult to find since they are commonly exclusively available in local languages. Therefore probably more guidelines exist than found. To learn from each other, guidelines should be translated into world languages and be accessible via international databases.

Implications Guideline developers can use AGREEII to increase quality. Although social context may differ among countries and can influence guideline recommendations, developers can learn from each other through reviews of this kind.

090 N OF ONE GUIDELINES - A NEW METHOD TO MANAGE MULTIMORBIDITY?

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Background Adherence to current monomorbidity-focused, mono-disciplinary guidelines may result in undesirable effects for persons with several comorbidities, in adverse interactions between drugs and diseases, conflicting management strategies, and polypharmacy. As yet no satisfactory approaches exist to address multimorbidity (MM) in clinical guidelines since this patient group is too heterogeneous as to be met by guideline recommendations.

Objectives to develop a set of case-based (N=1) guidelines for common disease combinations identified through epidemiological research and expert (GP) consultations.

Methods We followed a new 5-step, mixed methods approach comprising: (1) review of epidemiological data on MM patterns; (2) interdisciplinary focus groups developed case vignettes according to both internal evidence and the results of step 1; (3) development of case-based recommendations according to case vignettes (N of one guidelines); (4) informal consensus of recommendations; (5) formal consensus.

Results Step one revealed three different approaches for the selection criteria of case vignettes: first, cases addressing MM disease patterns from epidemiological studies (MM clusters); second, cases addressing triads of the 6 most prevalent chronic conditions; third, cases according to a problem-oriented prioritisation of focus group participants. All in all 10 N-of-one guidelines according to 10 cases could be developed according to the new 5-step-process.

Discussion We present a new approach in order to capture the complex and heterogeneous problems of MM through evidence-based and case-based recommendations. This set of N-of-one guidelines may serve as a framework of evidence-based recommendations for MM patients as the base for the development of meta-tools for both guideline developers and clinicians.

091 IF WE BUILD IT, WILL YOU SEARCH FOR IT? FINDING MULTIPLE CHRONIC CONDITION GUIDELINES IN THE NATIONAL GUIDELINE CLEARINGHOUSE

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Background In the US, it is estimated more than 25% of Americans have multiple chronic conditions (MCCs) and their care accounts for approximately 66% of total health care spending. Few clinical practice guidelines address MCCs.

Objectives Determine the number and scope of guidelines represented in the National Guideline Clearinghouse (NGC), funded by the Agency for Healthcare Research and Quality, addressing MCCs and provide strategies to identify these guidelines and facilitate quick retrieval by NGC users.

Methods We searched for guidelines within NGC to identify those that address MCCs. We characterised these guidelines defining the number and type of MCCs addressed, the number of recommendations addressing MCCs, whether they addressed treatment, diagnosis, prevention or counselling, whether they graded the level of evidence, and whether the MCCs were concordant/discordant with the guideline's primary disease/condition.

Results Final analysis of information collected and recommendations and strategies for facilitating retrieval of this content in NGC will be completed by June 2013.

Discussion Traditionally, guidelines focus on individual diseases so their application to the growing MCC population is limited. At the same time, evidence supporting recommendations for MCCs is lacking. Although our preliminary findings indicate that there are some guidelines addressing MCCs, there has been no obvious way to locate them on NGC.

Implications for Guideline Developers/Users Guideline developers need to create guidelines addressing MCCs. NGC aims to create ways to highlight MCC guidelines and make them easier to find and use.