predominantly due to the fact that the NHMRC standards are based on physically published guidelines.
Discussion A model of rapid guideline updates utilising a wiki platform is able to accommodate robust methodology and meets most of the current Australian standards.

035 WHAT DO GUIDELINE APPRAISAL TOOLS ASSESS? A SYSTEMATIC REVIEW

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Background Clinical practice guidelines should provide a rational basis for healthcare decisions; however, their quality is often poor.
Objectives To systematically identify and describe guideline appraisal tools and draw conclusions for guideline appraisal.
Methods We conducted a systematic search in MEDLINE, EMBASE and the Cochrane Library for English and German-language guideline appraisal tools published after 1995. Reference lists of included publications were also screened. Dimensions of guideline quality were then generated from these publications and from articles by Cluzeau 1999, Graham 2000 and Vlayen 2005. Finally, the questions contained in the appraisal tools were allocated to the quality dimensions and summarised.
Results Overall, 40 appraisal tools were included and 13 quality dimensions identified. The main focus was the identification, assessment and presentation of evidence in guidelines. Questions on dealing with norms and values in guideline development, patient involvement, conflicts of interest, or implementation of guidelines into clinical practice were rare. The tools often assessed the appropriate documentation of the guideline development process (e.g. reporting of the search strategy), without addressing the appraisal of content of the development process (e.g. appropriateness of the search strategy) and the appraisal of clinical content.
Discussion Because many appraisal tools do not contain questions on norms and values or on potential conflicts of interest of guideline authors, important aspects potentially influencing the reliability of guidelines are not covered. In addition, an appraisal of content of the guideline development process and an appraisal of clinical content are often lacking.

036 DEVELOPMENT OF A STATEWIDE GUIDELINES PROGRAM USING THE ADAPTE FRAMEWORK

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Background The legislature passed comprehensive health reform legislation in 2009 directing the state to "set standards for safe and effective care", including development of "best practice guidelines and standards that can be uniformly applied across public and private health care".
Objectives Develop guideline methodology and guidelines for statewide clinicians and payers.
Methods Employed ADAPTE framework for guideline development. Initial guidelines selected for development included three low back pain (LBP) topics: general evaluation and management of LBP (results described below), advanced imaging for LBP, and percutaneous interventions for LBP. Existing (seed) guidelines identified by searching 17 databases. Quality evaluated using modified AGREE II instrument. Multidisciplinary guideline development group selected and adapted seed guidelines. Stakeholder, peer review and public comments were solicited.
Results Thirteen seed guidelines were identified and 10 met minimal inclusion criteria for LBP evaluation and management topic. Dual quality rating found five of good or fair quality. Final seed guideline selected based on quality and scope. Key recommendations were adopted for state Medicaid programme, including conservative and chiropractic care only in first month and no advanced imaging without clinical "red flags". A consumer booklet was developed and distributed to consumer, provider, and payer groups. Over 2500 booklets were distributed, with over 11,000 page views on the website. The initial guideline process took over one year to complete.
Discussion Starting a new multi-stakeholder guideline development programme requires substantial investments of methodological expertise, staff time, funds and political capital, but can substantially impact state health policy decisions.

037 UPDATING AN ADAPTED CPG: WHEN IS ENOUGH ENOUGH?

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Background Within 2 years of releasing a low back pain clinical practice guideline (CPG), the Alberta Ambassador Guideline Adaptation Programme was required to update its adapted guideline. No guidance or 'how to' manuals were located.
Objectives To develop a process for updating an adapted guideline. To expedite the process by determining which components can be removed without compromising rigour.
Methods CPGs and systematic reviews published since the release of the CPG were identified and appraised, and discordant and new recommendations were tabulated. The Guideline Development Group (GDG) was surveyed to identify new interventions of interest. Evidence from systematic reviews was included for 'do not know' recommendations and new interventions.
Results The original guideline had 50 recommendations, eight of which were in the 'do not know' category. This expanded to 85 recommendations in the update: 43 unchanged, 32 on GDG-nominated new interventions, and 10 revised. The updated CPG has 33 'do not know' recommendations. One of the original eight 'do not know' recommendations was changed based on new evidence.
Discussion The challenge of maintaining the integrity and high standards of the original guideline meant that the update consumed more time and resources than planned. Clearly, some components of the process can be jettisoned without jeopardising the methodological rigour and comprehensiveness of the final product.
Implications The next update will be streamlined, including only new seed guidelines that meet the quality criteria of the

modified AGREE and using systematic reviews to supplement the evidence base when there is discordance among recommendations.

038 DEVELOPMENT OF MULTIDISCIPLINARY SYMPTOM MANAGEMENT TOOLS USING THE ADAPTE APPROACH

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Background Evidence-based tools for symptom management were developed to assist healthcare providers in comprehensive assessment and appropriate management of symptoms. These evidence-based tools consist of comprehensive guides-to-practice, quick reference pocket guides, algorithms and smart phone apps.
Objectives The symptom management tools promote an interdisciplinary model of care that enables early identification and assessment of symptoms, appropriate documentation and communication regarding symptoms, optimal symptom management, and coordinated care throughout the illness trajectory. The tools are intended to be user-friendly, and are available in print, web and smart phone applications.
Methods The tools were developed by an interdisciplinary panel of healthcare providers using the ADAPTE guideline adaptation approach. This included a literature search for recent guidelines and systematic reviews, guideline appraisal using the AGREE tool and selection, and in some instances modification, of recommendations. Expert feedback was obtained and subsequently appropriate revisions were made.
Results The symptom management tools provide recommendations based on the best available evidence and expert consensus, for assessing, determining aetiology, diagnosing potential problems and for recommending non-pharmacological and pharmacological interventions.
Implications for Guideline Developers/Users The ADAPTE approach offers a comprehensive and rapid process of developing evidence-based tools for the cancer patient population. Following the global trend of creating user-friendly clinical guidance, the guides-to-practice, quick reference pocket guides, algorithms and smart phone apps are an innovative set of tools that are accessible to a diverse group of care providers, in a manner that would suit the individual's clinical needs.

039 GUIDELINE DEVELOPERS' SELF-PERCEPTIONS OF ADHERENCE TO AND INTENTIONS TO ADHERE TO THE IOM STANDARDS

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Background The 2011 IOM report called for more rigorous and transparent development of guidelines. Compliance with the IOM Standards may be challenging for developers. Developer perception of their current adherence to the Standards gives insight into their understanding of them and the likelihood of adhering to them in the future.
Objectives (1) Assess developers' self-perceptions of adherence to the IOM standards (2) Assess developers' intentions to adhere to the IOM standards.
Methods This AHRQ funded work used a mixed-methods approach. We performed semi-structured telephone interviews and surveys to query developers about impressions of and intentions to implement the IOM standards in their CPGs. We also performed our own assessments of guidelines and compared them with developer self-ratings.
Results Of 14 developers, 43% utilised a systematic review to underpin their guidelines, and 57% felt they would in the future. Funding sources were not disclosed by 46% of the developers. While 80% utilised an evidence rating scheme, fewer rated the recommendations. Notable differences between developer self-ratings and researcher assessments of adherence occurred in several areas.
Discussion While some developers intend to improve processes to meet the Standards, others acknowledged they will not. Yet still others felt they already met the standards, but our assessment suggested a different estimation, revealing varying understanding among developers of the Standards.
Implications for Guideline Developers/Users The IOM standards will help identify rigorous and transparent evidence-based guidelines, but will pose implementation challenges. Education of developers on the Standards and expectations around them will be critical.

040 CAN SYSTEMS FOR RATING EVIDENCE QUALITY AND RECOMMENDATION STRENGTH BE HARMONISED

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Background In 2011 the IOM recommended that every guideline recommendation should be accompanied by an indication of Evidence Quality and Recommendation Strength and called for strategies to encourage harmonisation of development processes.
Objectives To characterise the differences in systems for rating Evidence Quality and Recommendation Strength as a prelude to possible standardisation.
Methods We examined 17 international, English-language guideline development systems to identify rating parameters and applied descriptive statistics. We also searched for conceptual linkages in the rating system descriptions and identified systems where Strength of Recommendation was stated as an Evidence Quality parameter.
Results Rating systems were remarkably inconsistent in their application of category indicators—using letters, Arabic and Roman numerals and combinations. The modal and median number of Evidence Quality categories was 3 (range 0 to 10) and Recommendation Strength categories was 4 (range 0 to 6). 13/17 used randomised trials as indicators of highest quality evidence. 7 systems used "expert opinion," 6 used "case reports" or "case series," and 4 described "reasoning from first principles" to define lowest evidence quality. Definitions of intermediate levels varied considerably. 7 systems judged benefits and harms in deriving Recommendation Strength. In 7 rating systems, Strength of Recommendation was described entirely in terms of Evidence Quality.
Implication There is considerable disagreement about the requisite granularity and definition of categories of Evidence Quality and Recommendation Strength. Application of the concept of Recommendation Strength consonant with the IOM standard is limited. A straightforward mapping of rating systems to one another is elusive.