Ottawa Hospital Research Institute

OHRI IRHO

Institut de recherche de l'Hôpital d'Ottawa

A methodology for conducting repaid evidence reviews

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Learning objectives

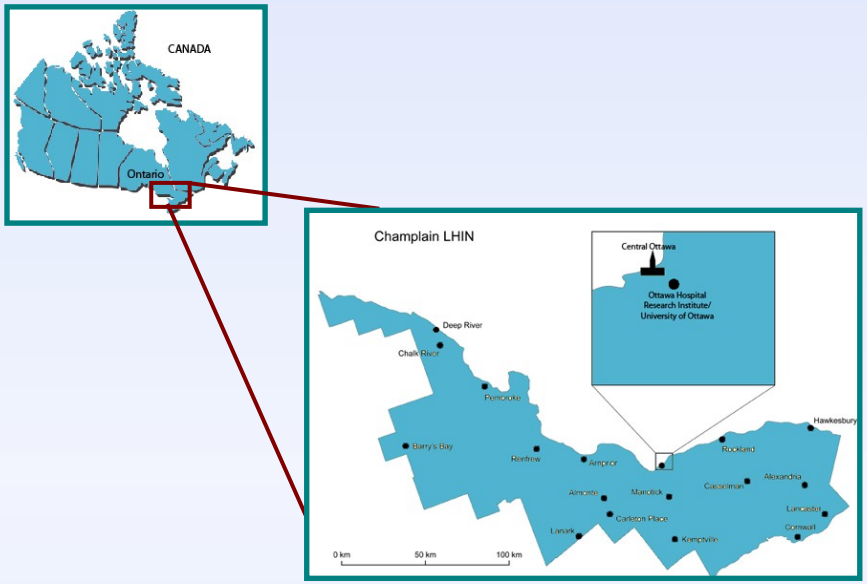
- To develop an understanding of the need for, and utility of, rapid reviews as a useful knowledge synthesis product
- To explore the Ottawa Hospital Research Institute (OHRI) methodology
- To discuss practical issues in providing a rapid review knowledge synthesis service

Financial support

- Canadian Institutes of Health Research
  - KS Canada grant [200906CSN-212307-ESN-AYDP-35581]
  - Knowledge to Action grant [KAL-86796]

- Development of rapid reviews in the context of the Knowledge to Action (KTA) program

Context



- **Champlain Local Health Integration Network (LHIN)**
  - 1 of 14 regional health care systems in Ontario, Canada
  - Population: 1.1 million
  - Responsibility to plan, coordinate and fund health systems to facilitate appropriate care

OHRI IRHO

- **Ottawa Hospital Research Institute (OHRI)**
  - Concentration of expertise in knowledge synthesis and translation

The problem

- While the LHIN is committed to the development of knowledge-based care, one of its major challenges is the development of knowledge capacity and infrastructure to achieve this.

- Knowledge syntheses and relationship-building between researchers and policymakers have been indicated as possible strategies for helping decision makers access and make use of research evidence.

- How can researchers and health services decision makers work together to build knowledge capacity and infrastructure that supports evidence informed policy and decision making in a regional context?

OHRI's approach

'Knowledge to Action' (KTA)

- *Timeline: Sept 2009- Oct 2011*
- *Objective: To develop and assess the impact of a regional knowledge infrastructure that supported evidence-informed decision making by managers, decision makers, stakeholders and policymakers in the Champlain LHIN*
- *Project team*

  3 Co-investigators

  - *2 Researchers (OHRI)*
  - *1 Decision maker (CEO Champlain LHIN)*

  1 Research Coordinator

OHRI's approach-2

Development of intervention

What is a "knowledge infrastructure"?

- Three key components proposed:
    1. "Push" activities – Knowledge intelligence services (e.g. rapid reviews, horizon scanning)
    2. "Pull" activities – Capacity building in evidence-informed decision making (e.g. capacity building training and workshops)
    3. "Linkage and exchange" activities – relationship building and involvement of decision makers in research process

Prioritization of activities directed through dialogue with LHIN participants

OHRI's approach-3

- Early linkage and exchange between the OHRI and LHIN participants indicated that the proposed "push" activities would be most useful in addressing the identified needs of the LHIN at that time.
- "Evidence Summaries" – a form of rapid review – was developed and was iteratively refined.
- A series of evidence summaries (n=18) were produced (~4-6wks each) in response to clinical and health services questions developed with LHIN managers and stakeholders.

Ongoing work and future directions post KTA

Publications:

- 1 methods paper outlining our approach

  Khangura S, Konnyu K, Cushman R, Grimshaw J, Moher D Evidence summaries: the evolution of a rapid review approach. Systematic Reviews 2012, 1(1):10

- 1 rapid review

  Konnyu K, Kwok E, Skidmore B, et al. The effectiveness and safety of emergency department short stay units: a rapid review. Open Med 2012;6(1).

- 1 process paper of our experience, including end-user feedback (in progress)

Ongoing rapid reviews with national stakeholders (e.g. Alberta Bone and Joint group)

Development of a sustained hospital-based technology assessment program with rapid review methodology at its core (The Ottawa Hospital Technology Assessment Program - TOHTAP)

Continued refinement and validation of methods through engaging with stakeholders and seeking funding opportunities

- Cochrane Innovations
- Cochrane College for Policy at George Mason

Rapid reviews ‘defined’

- Policymakers and healthcare stakeholders increasingly seeking evidence to inform the policymaking process
- Often require rapid access to high-quality evidence to inform decisions on emergent issues or questions
- Seen an increase in use of rapid review-type products
- However, no universally accepted definition or methodological protocol of Rapid Review (RR)
- Closest we’ve come to a definition:
  - Rapid review (RR) ≈ Literature review produced using accelerated and streamlined systematic review (SR) methods

Rapid review 'lay of the land'

Ganann et al. (2010)

http://www.implementationscience.com/content/5/1/56

Sought to do a review of:

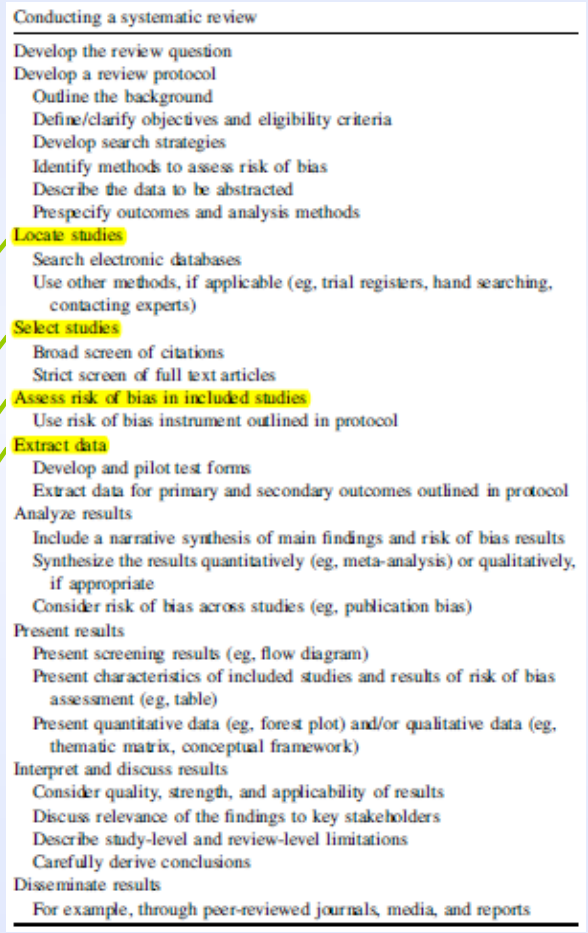
1. Articles related to methods or examples of how to conduct RRs or;
2. Studies that addressed comparisons (if any) of RRs vs. traditional SRs;
3. Hoped to find studies that looked at implications of taking methodological shortcuts

Findings:

- 45 methodological articles; 25 RR examples
- Despite expanding use of RRs
  - Very poor methodological transparency
  - Limited understanding of the impact of taking shortcuts

Ganann et al. (2010) Methods of Rapid Reviews (RRs)

- **Variable nomenclature**
  - Rapid Review
  - Rapid HTA
  - Rapid Evidence Assessment
  - Ultra rapid review….etc.
- **Variable timeframes**
  - 1-9 months
  - No time reported
- **Variable streamlining methods**
  - Restricted searching*
  - Restricted screening
  - Restricted quality appraisal
  - Restricted data extraction



Conducting a systematic review

Develop the review question
Develop a review protocol
- Outline the background
- Define/clarify objectives and eligibility criteria
- Develop search strategies
- Identify methods to assess risk of bias
- Describe the data to be abstracted
- Prespecify outcomes and analysis methods

Locate studies
- Search electronic databases
- Use other methods, if applicable (eg, trial registers, hand searching, contacting experts)

Select studies
- Broad screen of citations
- Strict screen of full text articles

Assess risk of bias in included studies
- Use risk of bias instrument outlined in protocol

Extract data
- Develop and pilot test forms
- Extract data for primary and secondary outcomes outlined in protocol

Analyze results
- Include a narrative synthesis of main findings and risk of bias results
- Synthesize the results quantitatively (eg, meta-analysis) or qualitatively, if appropriate
- Consider risk of bias across studies (eg, publication bias)

Present results
- Present screening results (eg, flow diagram)
- Present characteristics of included studies and results of risk of bias assessment (eg, table)
- Present quantitative data (eg, forest plot) and/or qualitative data (eg, thematic matrix, conceptual framework)

Interpret and discuss results
- Consider quality, strength, and applicability of results
- Discuss relevance of the findings to key stakeholders
- Describe study-level and review-level limitations
- Carefully derive conclusions

Disseminate results
- For example, through peer-reviewed journals, media, and reports

***Limit by accessibility; language; date; # of sources searched; geographical location and setting to increase applicability**

Ganann's take home message

- RRs employ a variety of methodologies
- Vary in depth of description of methods used to make the process rapid
- Very few discussed limitations (what was lost) or what bias was potentially introduced by using RR methods
- Currently, no minimum reporting standards for RRs
- Need for research comparing full SRs with RRs to enhance our understanding of the RR limits

Rapid reviews: From start to finish
OHRI's 8-stage approach

1. Needs assessment
2. Question development and refinement
3. Proposal development and approval
4. Literature search
5. Screening and selection of studies
6. Narrative synthesis of included studies
7. Report production
8. Ongoing follow-up with end users

Objective: high rigor, transparency, and usability

1. Needs assessment

- Stage starts with a probing consultation with a knowledge user with a problem/question (1 hr of upfront time);
- Purpose is to ascertain the following:
  - Scope of the question
  - Purpose for which it will be used
  - Availability and commitment of the knowledge user over the course of the project
- This phase forms the cornerstone of the evidence report from the beginning
- Serves the dual role of 1) determining if scope fits our proposed methods, and 2) ensures final product is meaningful for intended audience (beneficial, dynamic approach)

Setting the stage

- The rapid reviewers might:
  - define the importance of the review question from different perspectives (e.g., public health, individual patient, or health policy)
  - briefly mention the current state of knowledge and its limitations
  - whet readers' appetites by clearly stating what the review aims to add
- The rapid reviewers also could discuss the extent to which the limitations of the existing evidence base may be overcome by the review.

2. Question development and refinement

- Generally, formulating appropriate research questions not a strong suit of knowledge users
- Usually clear about broad strokes in terms of what they want to ask but less able to provide critical details that make a research question precise and answerable
- Routinely now require an additional 1-2 hrs upfront to flesh out question, and applicability of RR approach
- Work to operationalize questions collaboratively (vetting process):
  - Use the PICOT/S framework as reasonably as possible (effectiveness)
  - Modify accordingly (health systems and/or health services related questions)
  - Aim for a manageable questions within the condensed timeframe, but still able to provide a meaningful answer to the end user

Helping to develop the research question(s): the PICOT/S approach

- Mnemonic
  - Participants
  - Interventions
  - Comparator
  - Outcome

  - Timing
  - Study design

The symmetry of research

- PICOT/S
  - Framing the question
  - Defining the eligibility criteria
  - Implementing data extraction forms
  - Reporting generation

Remembering

- That the only difference between a knowledge synthesis and a primary research study is the unit of analysis
- Primary study
  - It is usually a participant
- Knowledge synthesis
  - It is usually a ‘paper’

Question construction

- To examine whether topical or intraluminal antibiotics reduce catheter-related bloodstream infection, we reviewed randomized, controlled trials that assessed the efficacy of these antibiotics for primary prophylaxis against catheter-related bloodstream infection and mortality compared with no antibiotic therapy in adults undergoing hemodialysis

Types of participants

- “Participants of any age with chronic renal failure (CRF) or receiving dialysis (haemodialysis or peritoneal dialysis) were considered. CRF was defined as serum creatinine greater than 200 µmol/L for a period of more than six months or individuals receiving dialysis (haemodialysis or peritoneal dialysis)… Renal transplant patients were excluded from this review as these individuals are immunosuppressed and are receiving immunosuppressant agents to prevent rejection of their transplanted organs, and they have essentially normal renal function ...”

The interventions (exposures)

- If the rapid reviewers are interested in a question regarding the association between a woman's prenatal exposure to folic acid and subsequent offspring's neural tube defects, the question should consider:
  - the dose, frequency, and duration of folic acid used in different studies
- Is likely to be important for readers to interpret the review's results and conclusions.
- Other interventions (exposures) might include diagnostic, preventative, or therapeutic treatments, arrangements of specific processes of care, lifestyle changes, psychosocial or educational interventions, or risk factors

Comparator (control) group intervention(s)

- Such as usual care, drug, or placebo, is essential to fully develop the question
- The same precision used to describe the interventions is required for the comparator Sources heterogeneity investigators have to deal with.

The outcomes of the intervention

- What outcomes are the rapid reviewers interested in:
  - mortality
  - morbidity
  - symptoms
  - quality of life improvements
- The rapid reviewers should be clearly specified as they are required to interpret the validity and generalizability of the systematic review's results

Study design(s)

- Some reviews only include reports of randomized trials whereas others have broader design criteria and include randomized trials and certain types of observational studies
- Other reviews, such as those specifically answering questions related to harms, may include a wide variety of designs ranging from cohort studies to case reports

PICOT/S

- Settings and locations where the data were collected
  - “Volunteers were recruited in London from four general practices and the ear, nose, and throat outpatient department of Northwick Park Hospital. The prescribers were familiar with homoeopathic principles but were not experienced in homoeopathic immunotherapy”

3. Proposal development and approval

- Need for a formal document to succinctly summarize the outcomes of the needs assessment and question refinement stages
- Formal summary of discussed question and methods
- Use template to maximize efficiency (2-4 pages)

  [Sections: background; finalized research question(s); proposed methods; deliverables; timelines; 'knowledge user role' section – few lines of text that emphasizes the importance of their involvement – what is required of them]
- Serves as a point of reference for the end users and research team (and allows early identification of possible misinterpretation)
- Informs extended members of the research team (e.g. information specialist, research assistants)

4. Literature search

- A comprehensive search is conducted by an information specialist;
- Depending on search outcomes, can be a possible point at which to revisit the eligibility criteria based on identified evidence base (e.g., magnitude, complexity, available study designs).

COMMON ELIGIBLITY RESTRICTIONS		
Criteria	**Include**	**Justification**
LANGUAGE	1. English only	1. No time to translate
PUBLICATION STATUS	1. Full text only 2. Electronically available from UOttawa library 3. Grey literature	1. Potential bias from abstracts 2. No time for ILL 3. Greater depth; curb publication bias
PUBLICATION DATE	1. Published ≥ [date]	1. Increase clinical relevance; reduce evidence to manageable load
GEOGRAPHICAL LOCATION	1. 'Western' context	1. Increase clinical relevance

5. Screening and selecting studies

- First, download searches to Reference Manager® - a bibliometric database management software
- Search strategies, dates, yields and duplicate counts recorded in a formal search log
- References then uploaded to an Internet-based systematic review software (DistillerSR®) to facilitate screening
- Screening undertaken by two independent reviewers
  - title/abstracts (level 1); full-texts (level 2)
- Another point at which the eligibility criteria may need to be refined. This will depend on:
  - Volume of evidence
  - Applicability of evidence to end users context and needs

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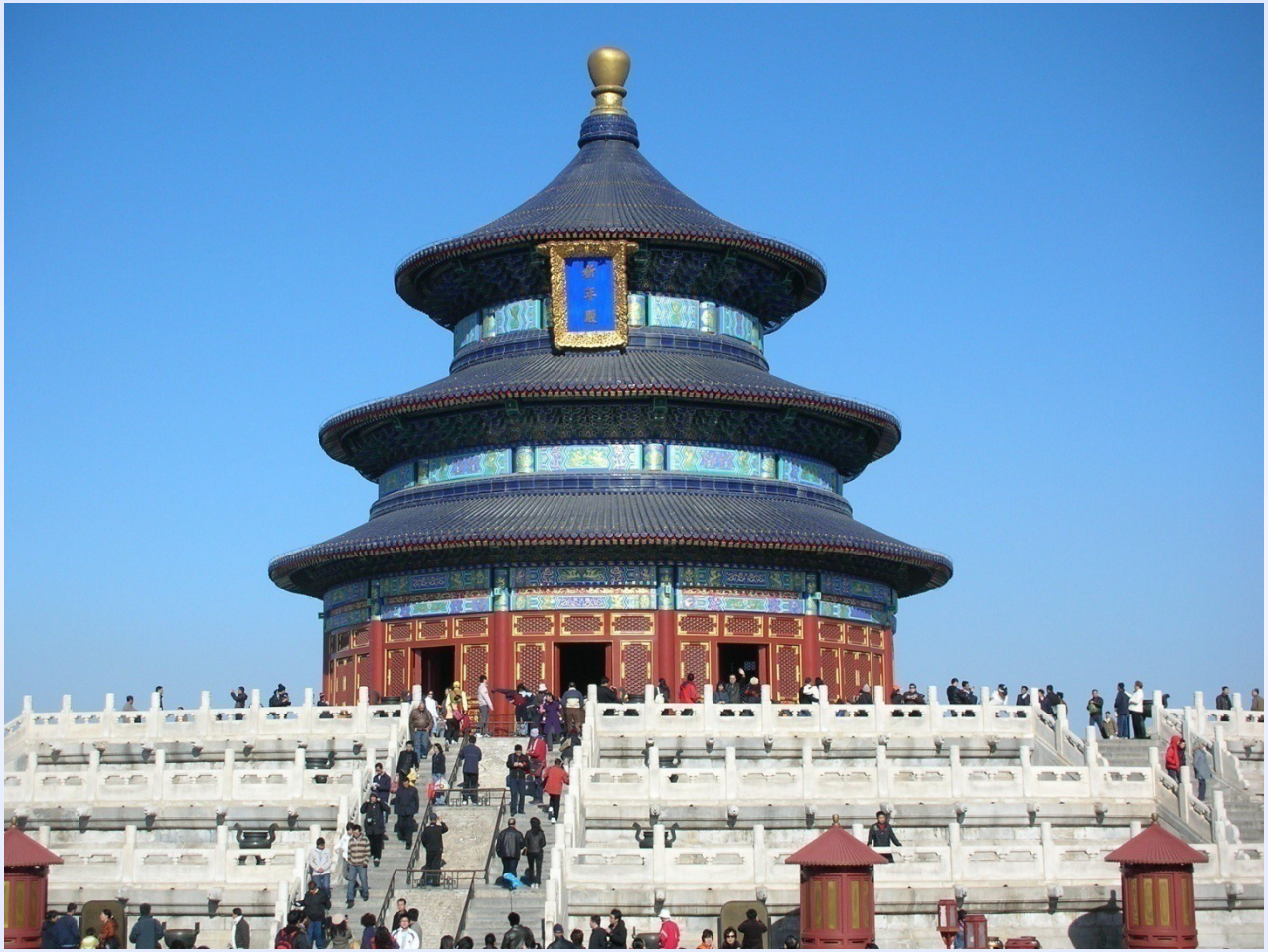
  - Applicability of evidence to end users context and needs

5. Screening and selecting studies

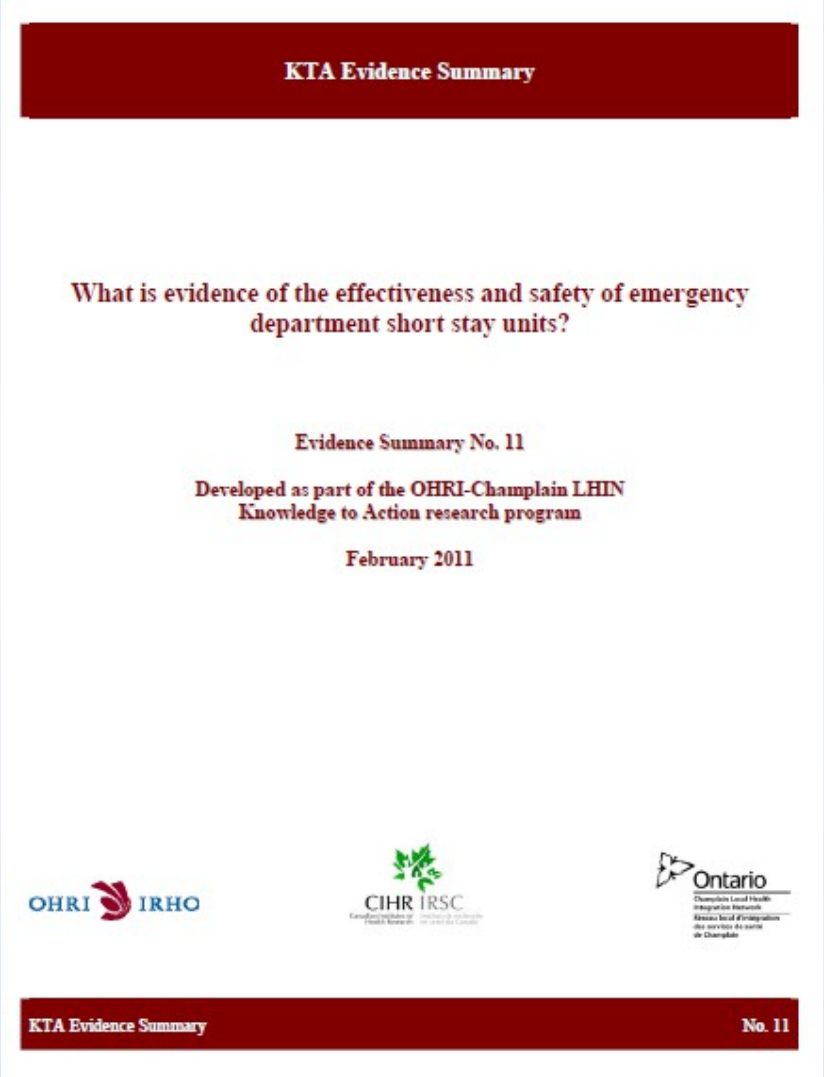
- For questions of treatment effectiveness –emphasis placed on locating & summarizing evidence from relevant, high quality SRs
- Aims to:
  - Limit unnecessary duplication of also including primary studies
  - Minimize resources needed to screen and summarize primary studies quickly
  - Minimize potential for bias and/or error that could be incurred by reviewing primary studies rapidly
- In absence of SRs, our approach may cautiously include:
  - High quality RCTs
  - High quality quasi-experimental and/or observational studies
  - Landmark, recent, and/or oft-cited studies
- However, with refinement of our approach and emphasis on more narrow questions, recent summaries have almost exclusively drawn from evidence reported in SRs.

6. Narrative synthesis of included studies

- Designed to provide knowledge users with a sense of the volume and direction of the available evidence
- No formal quantitative synthesis (e.g., meta-analysis)
- Synthesis presents main components of included studies (e.g., SRs):
  - Primary objectives
  - Primary methods
  - Primary findings
  - Main conclusions
  - Limitations – when applicable
  - Risk of bias assessment (AMSTAR scores)
- Bottom line summaries provided – each section question
- Overall report – key messages



7. Report production



Disclaimer page

The information in this report is a summary of available material and is designed to give readers (health systems stakeholders, policy and decision makers) a starting point in considering currently available research evidence. Whilst appreciable care has been taken in the preparation of the materials included in this publication, the authors do not warrant the accuracy of this document and deny any representation, implied or expressed, concerning the efficacy, appropriateness or suitability of any treatment or product. In view of the possibility of human error and advances of medical knowledge, the authors cannot and do not warrant that the information contained in these pages is current, accurate or complete. Accordingly, they shall not be responsible or liable for any errors or omissions that may be found in this publication. You should consult other sources in order to confirm the currency, accuracy and completeness of the information contained in this publication and, in the event that medical treatment is required you should take professional expert advice from a legally qualified and appropriately experienced medical practitioner.

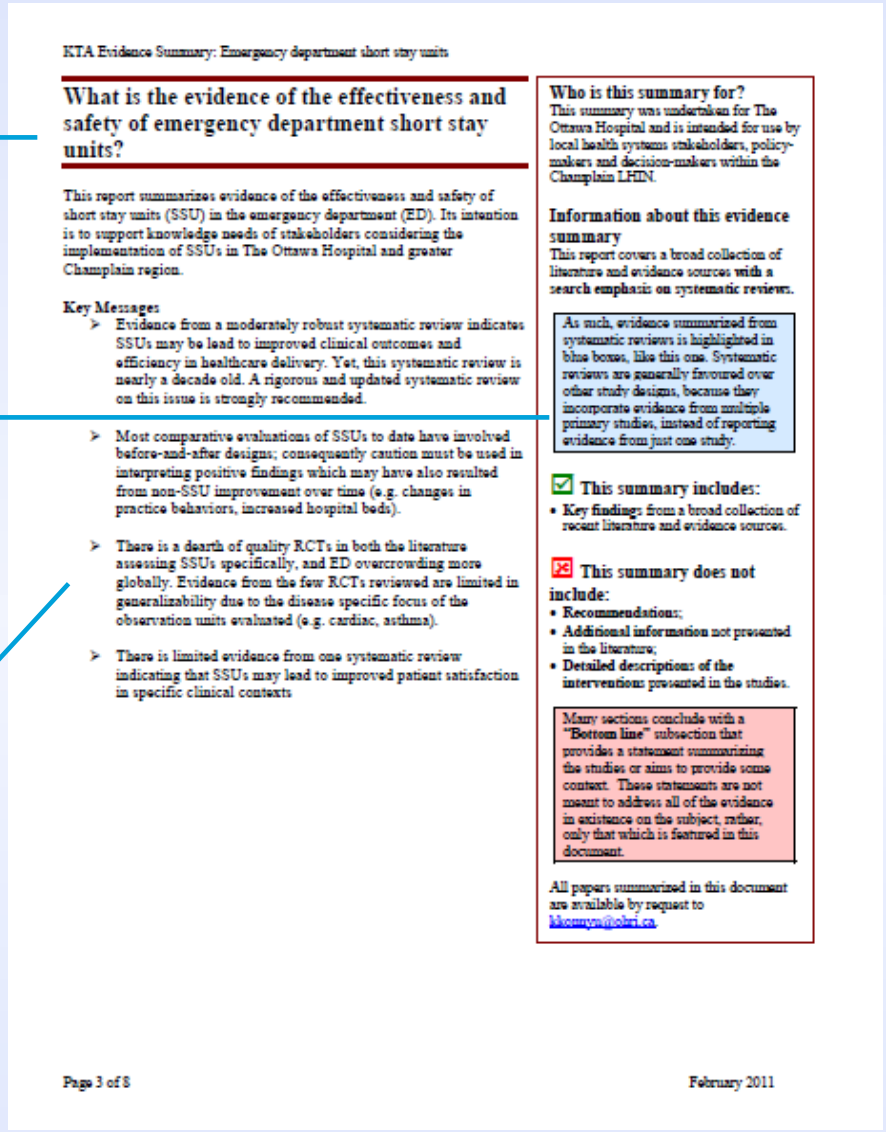
Disclosure upfront that this is not intended to be a gold standard SR, and therefore needs to be interpreted with caution and viewed within a specific context for a specific end user

Primary research question as the title

Informative sidebar outlines the intended audience and explains the nature of included content

"Key messages" section aims to summarize overall findings

Intended to capture the attention of the end user as it may be all they read



KTA Evidence Summary: Emergency department short stay units

What is the evidence of the effectiveness and safety of emergency department short stay units?

This report summarizes evidence of the effectiveness and safety of short stay units (SSU) in the emergency department (ED). Its intention is to support knowledge needs of stakeholders considering the implementation of SSUs in The Ottawa Hospital and greater Champlain region.

Key Messages

- Evidence from a moderately robust systematic review indicates SSUs may be lead to improved clinical outcomes and efficiency in healthcare delivery. Yet, this systematic review is nearly a decade old. A rigorous and updated systematic review on this issue is strongly recommended.
- Most comparative evaluations of SSUs to date have involved before-and-after designs; consequently caution must be used in interpreting positive findings which may have also resulted from non-SSU improvement over time (e.g. changes in practice behaviors, increased hospital beds).
- There is a dearth of quality RCTs in both the literature assessing SSUs specifically, and ED overcrowding more globally. Evidence from the few RCTs reviewed are limited in generalizability due to the disease specific focus of the observation units evaluated (e.g. cardiac, asthma).
- There is limited evidence from one systematic review indicating that SSUs may lead to improved patient satisfaction in specific clinical contexts

Who is this summary for?
This summary was undertaken for The Ottawa Hospital and is intended for use by local health systems stakeholders, policy-makers and decision-makers within the Champlain LHIN.

Information about this evidence summary
This report covers a broad collection of literature and evidence sources with a search emphasis on systematic reviews.

As such, evidence summarized from systematic reviews is highlighted in blue boxes, like this one. Systematic reviews are generally favoured over other study designs, because they incorporate evidence from multiple primary studies, instead of reporting evidence from just one study.

This summary includes:
- Key findings from a broad collection of recent literature and evidence sources.

This summary does not include:
- Recommendations;
- Additional information not presented in the literature;
- Detailed descriptions of the interventions presented in the studies.

Many sections conclude with a "Bottom line" subsection that provides a statement summarizing the studies or aims to provide some context. These statements are not meant to address all of the evidence in existence on the subject, rather, only that which is featured in this document.

All papers summarized in this document are available by request to kkomaye@ohri.ca.

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February 2011

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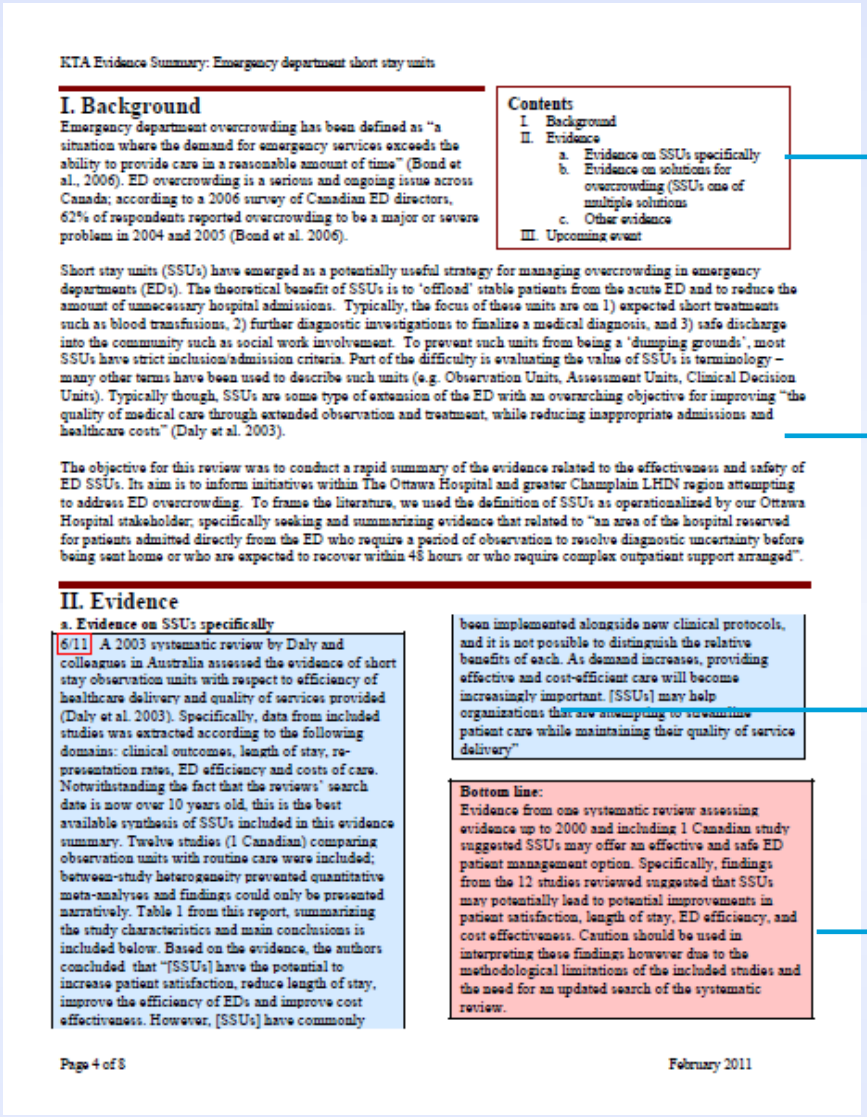


KTA Evidence Summary: Emergency department short stay units

I. Background

Emergency department overcrowding has been defined as "a situation where the demand for emergency services exceeds the ability to provide care in a reasonable amount of time" (Bond et al., 2006). ED overcrowding is a serious and ongoing issue across Canada; according to a 2006 survey of Canadian ED directors, 62% of respondents reported overcrowding to be a major or severe problem in 2004 and 2005 (Bond et al. 2006).

Contents

I. Background
II. Evidence
  a. Evidence on SSUs specifically
  b. Evidence on solutions for overcrowding (SSUs one of multiple solutions
  c. Other evidence
III. Upcoming event

Short stay units (SSUs) have emerged as a potentially useful strategy for managing overcrowding in emergency departments (EDs). The theoretical benefit of SSUs is to 'offload' stable patients from the acute ED and to reduce the amount of unnecessary hospital admissions. Typically, the focus of these units are on 1) expected short treatments such as blood transfusions, 2) further diagnostic investigations to finalize a medical diagnosis, and 3) safe discharge into the community such as social work involvement. To prevent such units from being a 'dumping grounds', most SSUs have strict inclusion/admission criteria. Part of the difficulty is evaluating the value of SSUs is terminology – many other terms have been used to describe such units (e.g. Observation Units, Assessment Units, Clinical Decision Units). Typically though, SSUs are some type of extension of the ED with an overarching objective for improving "the quality of medical care through extended observation and treatment, while reducing inappropriate admissions and healthcare costs" (Daly et al. 2003).

The objective for this review was to conduct a rapid summary of the evidence related to the effectiveness and safety of ED SSUs. Its aim is to inform initiatives within The Ottawa Hospital and greater Champlain LHIN region attempting to address ED overcrowding. To frame the literature, we used the definition of SSUs as operationalized by our Ottawa Hospital stakeholder; specifically seeking and summarizing evidence that related to "an area of the hospital reserved for patients admitted directly from the ED who require a period of observation to resolve diagnostic uncertainty before being sent home or who are expected to recover within 48 hours or who require complex outpatient support arranged".

II. Evidence

a. Evidence on SSUs specifically

6/11 A 2003 systematic review by Daly and colleagues in Australia assessed the evidence of short stay observation units with respect to efficiency of healthcare delivery and quality of services provided (Daly et al. 2003). Specifically, data from included studies was extracted according to the following domains: clinical outcomes, length of stay, re-presentation rates, ED efficiency and costs of care. Notwithstanding the fact that the reviews' search date is now over 10 years old, this is the best available synthesis of SSUs included in this evidence summary. Twelve studies (1 Canadian) comparing observation units with routine care were included; between-study heterogeneity prevented quantitative meta-analyses and findings could only be presented narratively. Table 1 from this report, summarizing the study characteristics and main conclusions is included below. Based on the evidence, the authors concluded that "[SSUs] have the potential to increase patient satisfaction, reduce length of stay, improve the efficiency of EDs and improve cost effectiveness. However, [SSUs] have commonly been implemented alongside new clinical protocols, and it is not possible to distinguish the relative benefits of each. As demand increases, providing effective and cost-efficient care will become increasingly important. [SSUs] may help organizations that are attempting to streamline patient care while maintaining their quality of service delivery"

Bottom line:
Evidence from one systematic review assessing evidence up to 2000 and including 1 Canadian study suggested SSUs may offer an effective and safe ED patient management option. Specifically, findings from the 12 studies reviewed suggested that SSUs may potentially lead to potential improvements in patient satisfaction, length of stay, ED efficiency, and cost effectiveness. Caution should be used in interpreting these findings however due to the methodological limitations of the included studies and the need for an updated search of the systematic review.

Table of contents indicated each sub-section pertaining to the question

Brief background information on the subject matter is presented

Systematic review evidence is highlighted per question (includes AMSTAR rating)

"Bottom line" subsections aim to summarize the evidence under each sub-section

Brief summary of the methods used:

searches; sources;

eligibility criteria;

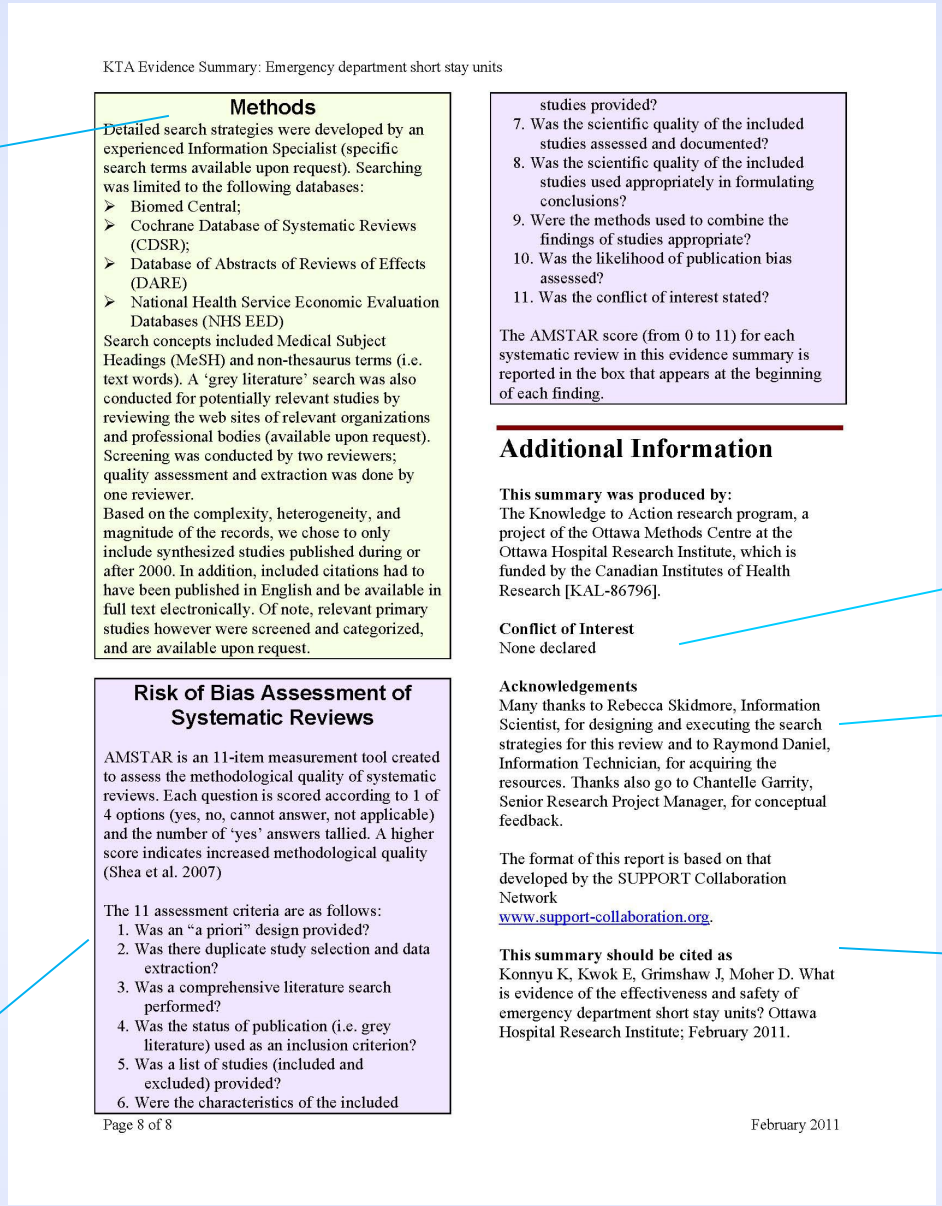
screening/

extraction methods;

study types included;

reference to ROB

Reference to AMSTAR tool



Methods

Detailed search strategies were developed by an experienced Information Specialist (specific search terms available upon request). Searching was limited to the following databases:

- Biomed Central;
- Cochrane Database of Systematic Reviews (CDSR);
- Database of Abstracts of Reviews of Effects (DARE)
- National Health Service Economic Evaluation Databases (NHS EED)

Search concepts included Medical Subject Headings (MeSH) and non-thesaurus terms (i.e. text words). A 'grey literature' search was also conducted for potentially relevant studies by reviewing the web sites of relevant organizations and professional bodies (available upon request). Screening was conducted by two reviewers; quality assessment and extraction was done by one reviewer.

Based on the complexity, heterogeneity, and magnitude of the records, we chose to only include synthesized studies published during or after 2000. In addition, included citations had to have been published in English and be available in full text electronically. Of note, relevant primary studies however were screened and categorized, and are available upon request.

Risk of Bias Assessment of Systematic Reviews

AMSTAR is an 11-item measurement tool created to assess the methodological quality of systematic reviews. Each question is scored according to 1 of 4 options (yes, no, cannot answer, not applicable) and the number of 'yes' answers tallied. A higher score indicates increased methodological quality (Shea et al. 2007)

The 11 assessment criteria are as follows:

1. Was an "a priori" design provided?
2. Was there duplicate study selection and data extraction?
3. Was a comprehensive literature search performed?
4. Was the status of publication (i.e. grey literature) used as an inclusion criterion?
5. Was a list of studies (included and excluded) provided?
6. Were the characteristics of the included studies provided?
7. Was the scientific quality of the included studies assessed and documented?
8. Was the scientific quality of the included studies used appropriately in formulating conclusions?
9. Were the methods used to combine the findings of studies appropriate?
10. Was the likelihood of publication bias assessed?
11. Was the conflict of interest stated?

The AMSTAR score (from 0 to 11) for each systematic review in this evidence summary is reported in the box that appears at the beginning of each finding.

Additional Information

This summary was produced by:
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Conflict of Interest
None declared

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The format of this report is based on that developed by the SUPPORT Collaboration Network
www.support-collaboration.org.

This summary should be cited as
Konnyu K, Kwok E, Grimshaw J, Moher D. What is evidence of the effectiveness and safety of emergency department short stay units? Ottawa Hospital Research Institute; February 2011.

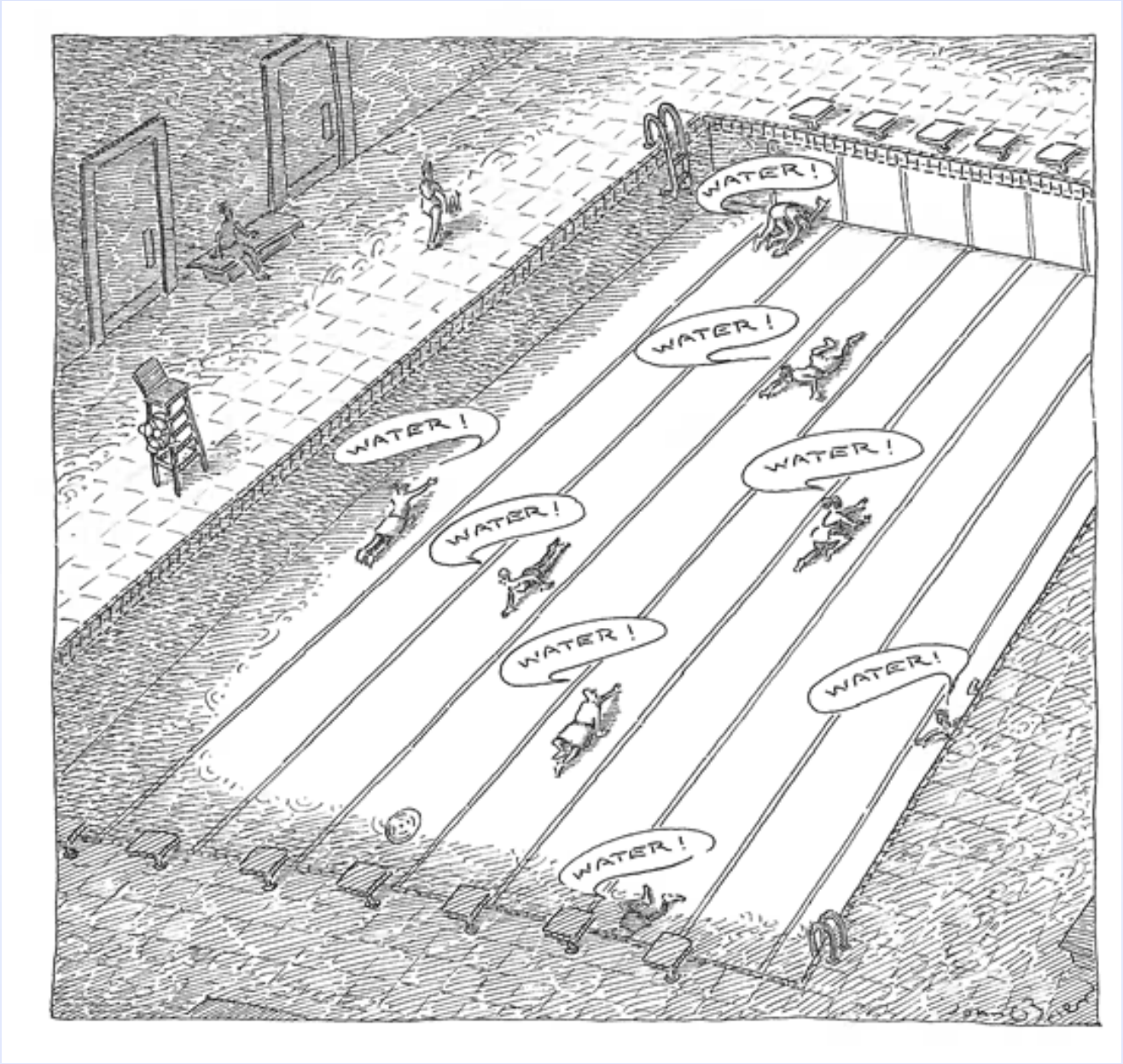
Conflicts of interest

Acknowledgements

Authors

8. Ongoing follow-up with end users

- Input on final edits of penultimate draft
- Confirmation no material missing/misinterpretation of the evidence
- Ascertain (informal) feedback on the quality and usability of the report (email, conversation)
- Post-hoc have sought formal feedback on summaries and the KTA program in general during 30min-1hr interviews with end users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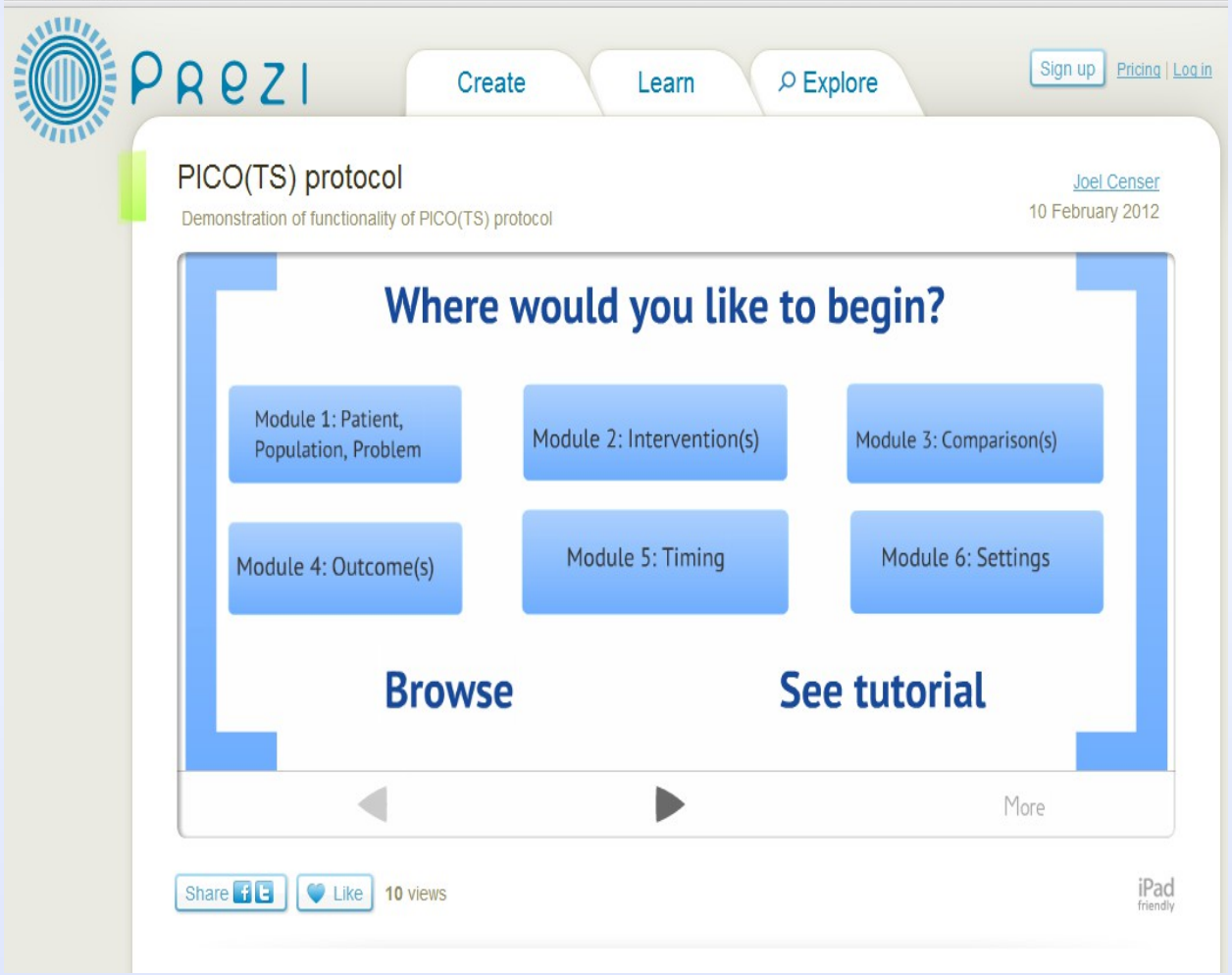
Short circuiting the process

- Are decision makers getting the “truth”?

Systematic vs. Rapid Reviews

	SYSTEMATIC REVIEW	RAPID REVIEW
TIMEFRAME	6 months – 2 years	**≤5 weeks; 6-8 wks**
QUESTION	Focused clinical question, narrow parameters	Focused to broad, clinical or health services question; possibly broader parameters
SOURCES AND SEARCHES	Comprehensive sources searched and explicit strategies	Sources may be limited but sources/strategies made explicit;
SELECTION	Exclusion/inclusion defined *a priori*	Exclusion/inclusion defined *a priori* and *post hoc*
APPRAISAL	Rigorous; Critical appraisal	Rigorous; Critical appraisal (SRs only)
SYNTHESIS	Narrative synthesis +/- Quantitative synthesis	Narrative synthesis/ categorization of the data
INFERENCES	Evidence-based – generates a conclusion to answer the research question	Limited/cautious interpretation of the findings to answer the research question

Wire-framed topic refinement program:
A look at the logic and interface of our question builder
EXAMPLE: adapting computer assisted survey interview techniques to individual and group PICO/TS refinement



A Web Page

http://cochrane.gmu.edu

PICO Question Builder ©

Welcome. You are logged on as UserName.
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Home > Build Question

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Build Your Question

These modules are designed to help you think through the important components of an issue you want to know more about and offer recommendations where useful. (Recommendations will be based on user generated data). In essence, these modules are about a process of refining topics to closely reflect the interventions and conditions you are interested in learning more about. The questions you build help inform researchers what to look for when retrieving evidence, which will in turn help you make informed decisions.

Guided text appears when mouse hovers over icon

elect any module as a starting point.

Questions in this section will ask you the particular patient, population, or problem you are interested in. You can choose to specify all three—patient, population, or a problem or just one.

O Population O Intervention O Comparison O Outcome O Timing O Setting

User can start building by selecting any module above

Start Building

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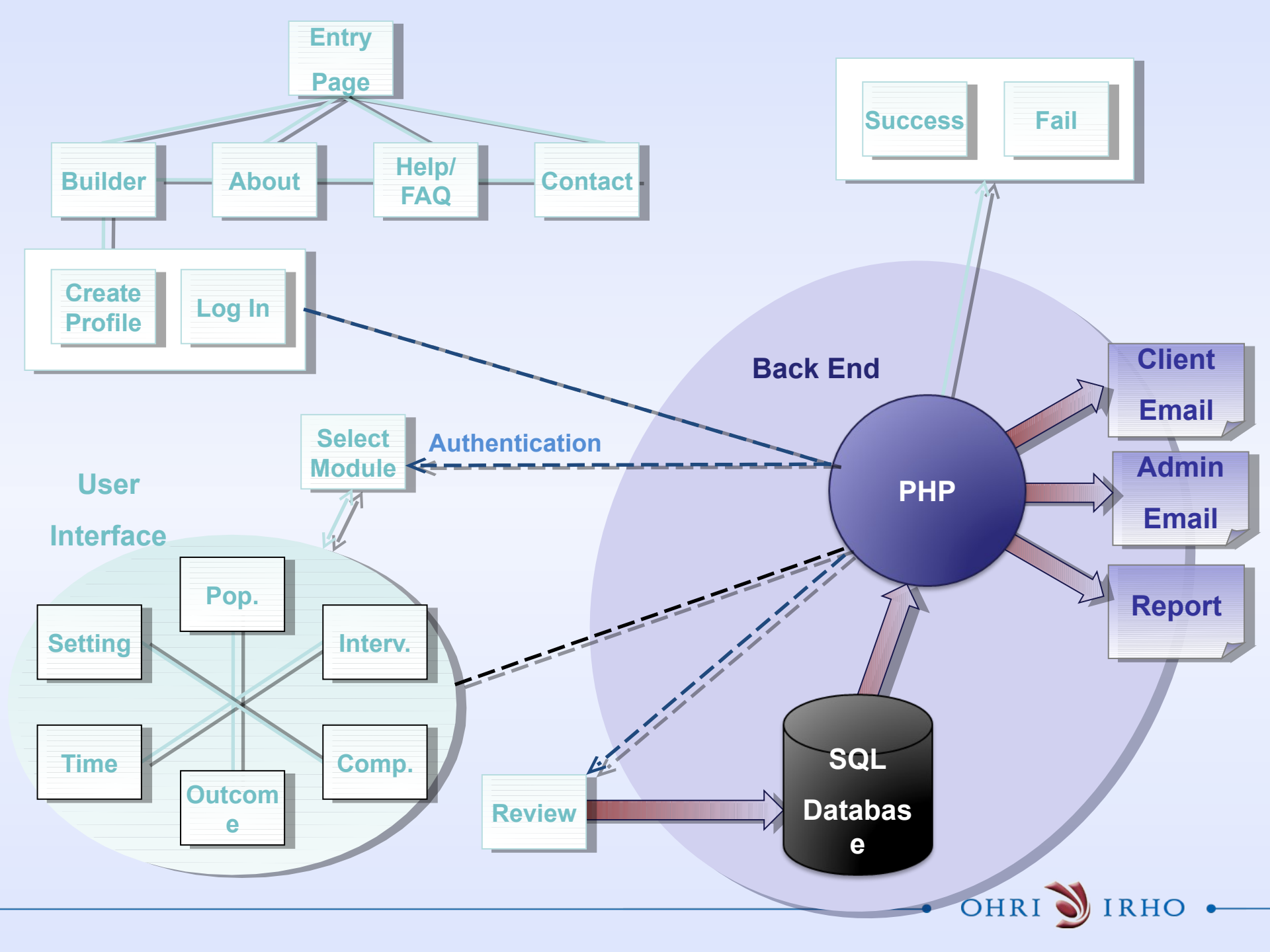

Entry Page
Builder
About
Help/ FAQ
Contact
Create Profile
Log In
Success
Fail
Back End
Client Email
Admin Email
Report
PHP
Select Module
Authentication
User Interface
Pop.
Setting
Interv.
Time
Comp.
Outcom e
Review
SQL Databas e

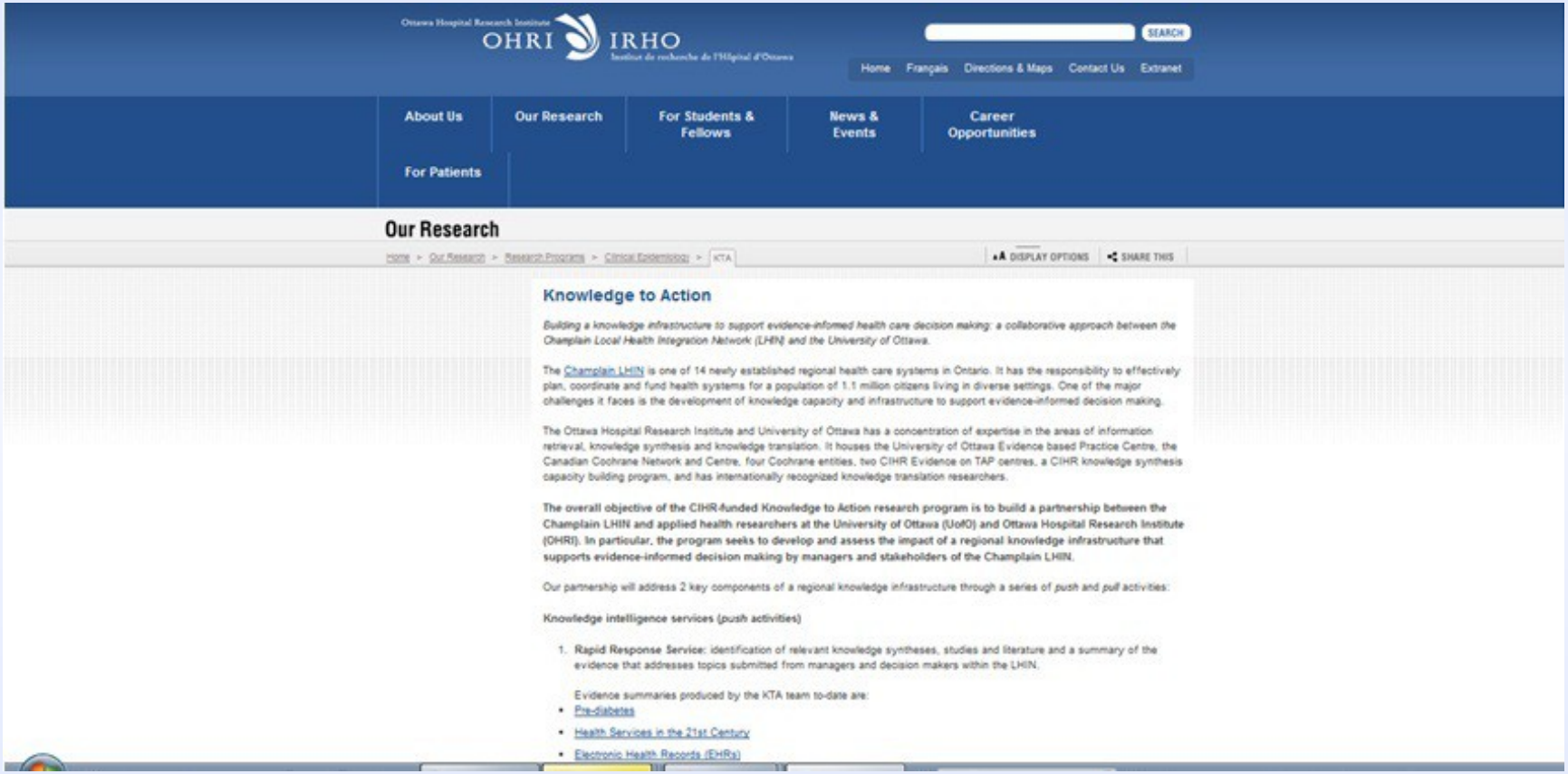
Cochrane Response Option

- Cochrane innovations
  - Rapid review option
  - Developed/consolidated various approaches
  - Awaiting pilot

Overview of our reports:

- Conducted a total of 19 rapid evidence summaries to date
- 13 – focused on clinical initiatives
  - 9 across the field of obstetrics/gynaecology
  - 6 – focused on health systems/ health services initiatives
  - Requests came from various stakeholders (n=9)

www.ohri.ca/kta



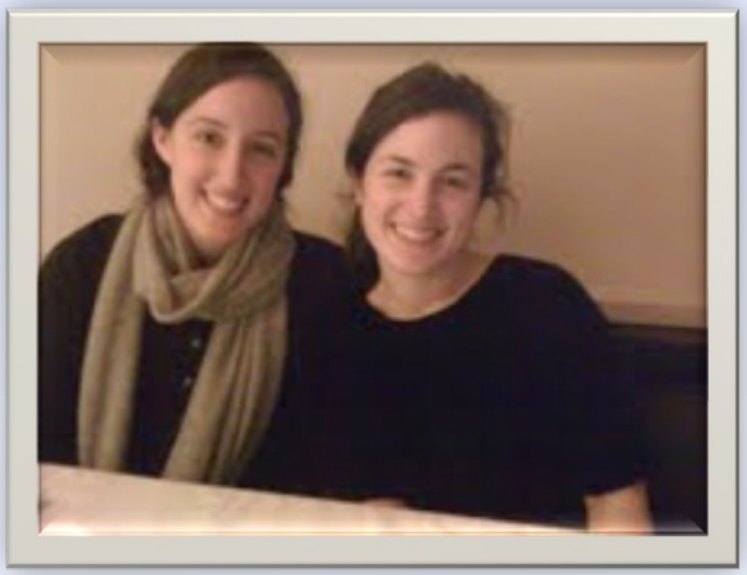
Evidence summaries to date

COMPLETED		
REVIEW	**REQUESTED BY**	**USED FOR**
1. Pre-diabetes	Champlain Diabetes Strategy Advisory Committee	Backgrounder for clinical initiatives
2. Health system reform/integration	LHIN CEO	Backgrounder for system changes
3. Electronic health records	LHIN CEO	Backgrounder for system changes
4. Post-partum care for GDM	Champlain Diabetes Strategy Advisory Committee	Backgrounder for clinical initiatives
5. Timing of Elective, repeat C-section <39wks	BORN Ontario	Evidentiary support for quality indicator 'dashboard'
6. Intrapartum management of GDM	Champlain Diabetes Strategy Advisory Committee	Backgrounder for clinical initiatives
7. Pedometers & CD	LHIN CEO; Chronic disease collaborative	Backgrounder for clinical initiatives
8. Formula supplementation in-hospital	BORN Ontario	Evidentiary support for quality indicator 'dashboard
9. 3rd/4th degree lacerations	BORN Ontario	Evidentiary support for quality indicator 'dashboard
10. Elective induction of term pregnancies	BORN Ontario	Evidentiary support for quality indicator 'dashboard

Evidence summaries to date

REVIEW	REQUESTED BY	USED FOR
11. ED short stay units	The Ottawa Hospital	Backgrounder for system changes
12. Models of patient flow	The Ottawa Hospital	Backgrounder for system changes
13. Unsatisfactory blood spot samples for newborn screening of congenital diseases*	BORN Ontario	Evidentiary support for quality indicator 'dashboard
14. Episiotomy	BORN Ontario	Evidentiary support for quality indicator 'dashboard
15. Screening to prevent newborn group B streptococcal infection	BORN Ontario	Evidentiary support for quality indicator 'dashboard
16. Models of elderly care†	Regional Geriatric Program of Eastern Ontario	Backgrounder for policy/program planning
17. Physical activity and chronic disease†	LHIN chronic disease collaborative	Backgrounder for policy/program planning
18. Pre-op rehabilitation interventions for total knee arthroplasty	Alberta Bone and Joint Group	Backgrounder for policy/program planning
19. Antimicrobial stewardship programs	The Ottawa Hospital – Patient Safetey	Backgrounder for policy/program planning

*Evidence brief; † Evidence map



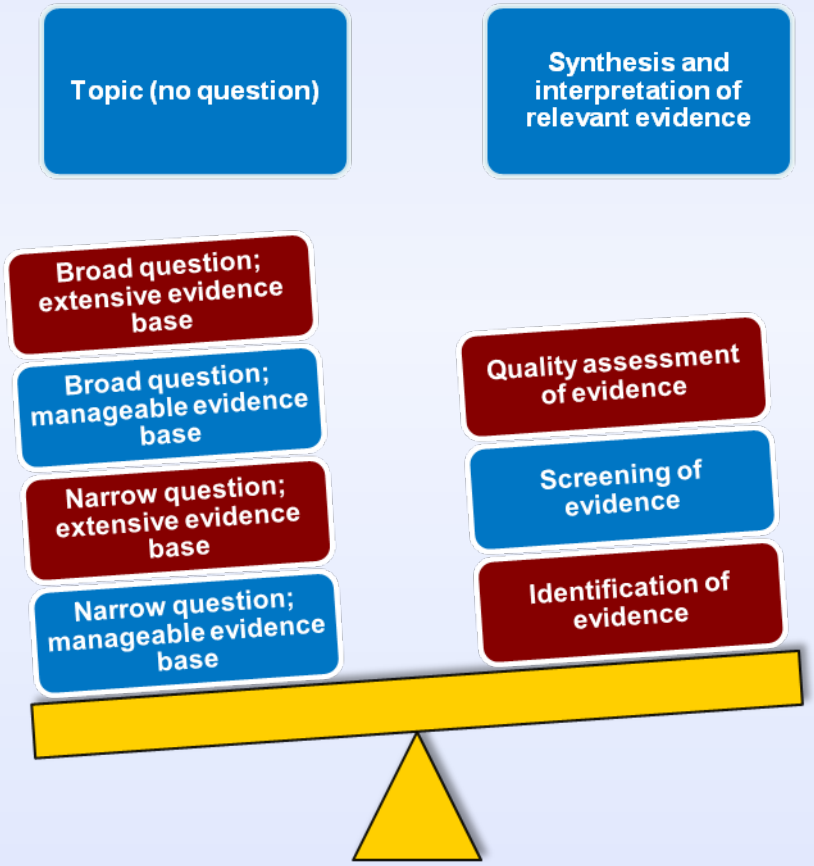
Thinking more deeply about Ottawa's approach to rapid reviews

- Methodology
- Reporting

- Local context
  - Assessing generalizability to stakeholder setting
- Health equity
  - Whose going to be disadvantaged?
- Economic evidence
  - Possibly relevant - dependent of requester)

Things to consider…

1) Existence of evidence to summarize
   - Evidence exists and *is* reported
   - Evidence exists, but *is not* reported (or is reported poorly)
   - Evidence *does not exist*
2) Balance between breadth of evidence and depth of rapid review synthesis for particular question (tradeoff between going deeper if Q is more narrow vs. only touching the surface if Q is broader)
3) Size of team conducting rapid review – what resources are available for short, intense period of time?



4) Important to anticipate the level of engagement/availability of end user – especially during protocol development and screening of records

- Vital component to this process
- Need to identify **a go to person** within your stakeholder group; someone willing to be on call to answer your questions; relay information back and forth from knowledge users

5) Access (internally or externally) to skilled resources

- Information specialists
- Data managers
- Content experts
- Other?

6) Access to library subscriptions for resources

- If not, alternative sources/approaches? Limits on interpretation?