Presentation Overview

- Introduction
- Process
- Evaluation
- Evolution/Reflections
- Conclusions
- Discussion/questions
Introduction

- Introduction :
  - Overview of the Ambassador Program
  - Approach for the development of the guideline
  - Structure and membership

- Process
- Evaluation
- Evolution/Reflections
- Conclusions
What is the Ambassador Program?

- A collaboration of individuals and agencies with an interest in improving chronic pain management in Alberta
- Providing support to primary care providers by developing provider knowledge and skills
- Process for moving research evidence into practice

Ambassador Program website: http://www.ihe.ca/research/ambassador-program/
Journey Back in Time

- Mar 2nd 2009: low back guideline available on TOP website
- Nov 2007: professional provincial agencies/organizations (buy in)
- Feb 2007: Research Team process options (generating the evidence)
- Jan 2007: Alberta Know Do Gap survey (do we need a guideline)
- Nov 2006: Guideline Development Group established (foundation)
- June 2006: needs assessment survey (do we need a guideline)
- Oct to Nov 2004: ambassador workshops (finding the right people)
- June to Sept 2004: Research Team Evidence in Brief (generating the evidence)
- Apr 2004: established infrastructure (foundation)
- Mar 2004: CADTH capacity building grant ($)
- June 2003: ISTAHC SBU ambassador program (idea)
The Spectrum of Guideline Development Processes

**LEAST RESOURCE**
- **ENDORSEMENT** (Guidelines Advisory Committee)
  - Do not develop guidelines
  - Endorse current guidelines selected for methodological rigour

**LESS RESOURCE**
- **ADAPTATION** (Ambassador Program II)
  - Adapt seed guidelines using a multidisciplinary development group
  - Seed guidelines selected for methodological and clinical relevance

**MOST RESOURCE INTENSIVE**
- **MIXED STRATEGY** (COMPUS)
  - Unbundle existing guidelines
  - Review and update pertinent evidence
  - New guideline constructed with expert review panel input

- **DE NOVO** (American Pain Society)
  - Construct new guideline from scratch
  - Systematic reviews of primary evidence conducted for all recommendations
  - Multidisciplinary development group
Reasons for Choosing the Adaptation Strategy

- Limited resources
- Commitment/involvement of local stakeholders
- Availability of published guidelines on similar topic
- Avoid unnecessary duplication of effort
- Improve guideline implementation
Collaborating Organizations
Guideline Development Project Structure

Steering Committee (SC)
- HTA researchers
- Clinical ambassador
- Communications & KT consultant
- Guideline development consultant

Operational oversight
Research information
Secretariat GDG & AC

Advisory Committee (AC)
- Sponsoring agency
- Ministry of Health
- Provincial research funder
- RHA
- Provincial Primary Care Network Program
- Physician regulatory agencies
- Provincial medical guideline group (TOP)
- Provincial KT programs
- Patient advocacy group

TOP Alberta Guideline

Guideline Development Group (GDG)
- Family physicians
- Specialist physicians
- Physical therapists
- Occupational therapists
- Pharmacists
- Registered nurse
- Psychologists
- Healthcare manager
- Knowledge transfer specialist
- HTA researchers

Sign off the guideline
Advise SC on strategic matters; General project oversight
Construct the guideline

Toward Optimized Practice
GDG: multidisciplinary team, rural/urban representation

- **South Zone**: physician (1), health care manager (1), physical therapist (1)

- **Calgary Zone**: family physician (2), specialist physician (2), psychologist (2), occupational therapist (1), pharmacist (1)

- **Central Zone**: family physician (3), physical therapist (1), occupational therapist (1)

- **Edmonton Zone**: family physician (3), occupational therapist (1) nurse-manager (1)

- **North Zone**: physical therapist (1), nurse (1)
Process (Overview)

- Introduction
- Process:
  - Selecting the seed guidelines
  - Critically appraising the seed guidelines (AGREE tool)
  - Extracting data
  - Formulating the recommendations
- Evaluation
- Evolution/reflections
- Conclusions
Selecting the Guidelines

- **Condition:**
  - Non-malignant, non-specific low back pain

- **Population:**
  - Patients ≥ 18 years; guidelines referring to “adult patients” without a specific age range also included

- **Intervention:**
  - Diagnosis, non-surgical treatment, or prevention in primary healthcare settings

- **Duration of pain** defined as (treatment and diagnosis only):
  - acute and subacute pain: pain <12 weeks
  - chronic pain: pain ≥12 weeks (IASP definition)

- **Publication limits**: from January 1996 to February 2008

- **Language**: English

- **Source**: countries with developed market economies
Appraising the Guidelines: AGREE Tool

“Appraisal of Guidelines Research and Evaluation.”

Generic instrument that is validated, easy to use, transparent, internationally developed, widely accepted, and easy to use, and has satisfactory reliability for most domains.

http://www.agreecollaboration.org/instrument
AGREE TOOL Limitations

- Does not assess the clinical content of the guideline.

- Does not assess the quality of evidence supporting the recommendations.

- Cannot set thresholds for the scores to classify a CPG as “good” or “bad”.
Modifying the AGREE User Guide

- Constructed a detailed set of instructions, or dictionary, using Boolean operators to reduce the ambiguity and subjectivity associated with item scoring.

- Identified seven “essential” criteria from the AGREE tool to categorize guideline quality as either good, average or poor.

“Essential” Criteria for a Good Quality Guideline
(Hayward et al. JAMA 1995;274:570-574)

- Item 8. Systematic search conducted
- Item 10. Methods used to formulate recommendations described
- Item 12. Link between recommendations and evidence
- Item 13. External review by experts
- Item 15. Specific, unambiguous recommendations
- Item 22. Editorially independent from founder
- Item 23. Conflicts of interest reported
Weeding Out Poor Quality Guidelines

The guidelines were rated as follows:

- **Good** – 22 to 28 points;
- **Average** – 15 to 21 points;
- **Poor** – 0 to 14 points.

Consistent with AGREE Overall Assessment

- Strongly recommend
- Recommend
- Would not recommend/Unsure
Selecting the Seed Guidelines

58 potential clinical practice guidelines (CPGs) on non-malignant LBP (identified by a comprehensive search)

First filter: predetermined inclusion criteria

9 CPGs on prevention and treatment (acute and chronic) LBP

Second filter: modified AGREE tool scores

Third filter: expert team (clinical relevance of acute LBP CPG’s)

7 seed CPGs selected

Predetermined inclusion criteria

- Condition: Non-specific low back pain
- Population: Adult patients (≥ 18 years)
- Intervention: Diagnosis, non-surgical treatment, or prevention in primary healthcare settings
- Duration of pain defined as (treatment and diagnosis only):
  - Acute and sub-acute pain: pain <12 weeks
  - Chronic pain: pain ≥12 weeks (IASP definition)
- Publication limits: Jan 1996 to Feb 2008
- Language: English
- Source: countries with developed market economies
### Evidence Inventory Tables

<table>
<thead>
<tr>
<th>Item</th>
<th>Guideline/Country/Synopsis of Recommendations</th>
<th>Supporting Evidence¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Return to work</td>
<td>G2 (USA) (p. 15)</td>
<td>G</td>
</tr>
<tr>
<td></td>
<td>Encourage early return to work. Consider nonphysiological factors that can significantly impact risk for ongoing disability and return to work.</td>
<td></td>
</tr>
<tr>
<td>Exercise therapy</td>
<td>G2 (USA) (p. 14)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Low stress aerobic and flexibility exercises can prevent debilitation due to inactivity during the first month of symptoms. Recommended exercise quotas that are gradually increased result in better outcomes than telling patients to stop exercising if pain occurs.</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Strengthening exercises for trunk muscles (especially back extensors), gradually increased, are helpful. Consult with a medical specialist who can evaluate individual symptoms and recommend a safe and effective program. Consider referral to a formal rehab program.</td>
<td></td>
</tr>
<tr>
<td>Ambassadors</td>
<td>G4 (Europe) (p. 22)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Do not advise specific exercises (e.g. strengthening, stretching, flexion, and extension exercises) for acute low back pain.</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>34:90, 71, 87,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>87</td>
</tr>
<tr>
<td></td>
<td></td>
<td>34:90, 71, 87,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40-51, 75, 80, 88</td>
</tr>
</tbody>
</table>

CS - case series study; G - guideline; NR - non-systematic/narrative review; NRCS – non-randomized comparative study; RCT – randomized controlled trial; SR/MA – systematic review/meta-analysis

Making the GDG Meetings Productive

- Agenda and materials in advance
- Video- & teleconference option
- Orchestration:
  - Chair
  - On the fly consultation
  - Frequent ‘roundtables’
  - ‘Parking lot’ items and subcommittees
  - Process reviews
Addressing the Parking Lot Items

- Examination of individual research studies cited by the seed guidelines
- Examination of additional systematic reviews identified by a supplementary literature search
Formulating the Recommendations

Seed guidelines on LBP (N=7)

Seed guideline recommendations
(N = 57)
(GDG)

Recommendations TOP AB Guideline
(N = 50)
(GDG)

Accept or accept with minor modification
Accept but supplement with expert opinion
Reject original recommendation and create new one based on expert opinion

More information required

Draft recommendations

Parking lot recommendations
(N = 32)
(Subcommittees)

Primary studies cited in seed guidelines
Systematic reviews from special database
Ad hoc expert group discussions

Draft recommendations
<table>
<thead>
<tr>
<th>Exercise Therapy</th>
<th>DISCUSSION/DECISION</th>
<th>REVISED (DRAFT)</th>
<th>EVIDENCE SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G2 (USA)</strong> (p. 14)</td>
<td>Low stress aerobic and flexibility exercises can prevent debilitation due to inactivity during the first month of symptoms. Recommended exercise quotas that are gradually increased result in better outcomes than telling patients to stop exercising if pain occurs. Strengthening exercises for trunk muscles (especially back extensors), gradually increased, are helpful. Consult with a medical specialist who can evaluate individual symptoms and recommend a safe and effective program. Consider referral to a formal rehab program.</td>
<td>June-July/07. Subcommittee established to examine this recommendation. Sept 24/07 Subcommittee meeting: The recommendation will encourage exercise, without emphasizing on a specific type of exercise. Nov 13/07: Wording change – “spinal specialist” changed to “physical therapist, chiropractor, osteopath or physician who specializes in MSK medicine.” Feb 13/08: No additional comments. Feb 25/08: The guidelines were reviewed for statements re: potential adverse effects. The Steering Committee added the last phrase re: harm. May 1/08: SC added the word “physician” to osteopath. May 13/08 Subcommittee meeting: Moved “Physical exercise is recommended” to the advice to stay active recommendation. Change title “Therapeutic exercise.” June 18/08 Subcommittee meeting: Further revisions. The following sentence was added: Clinical experience suggests that supervised or monitored therapeutic exercise may be useful following an individualized assessment by a spine care specialist. Also few words to make the recommendation more clear. Decision to move the recommendation in the “do not know” section and to add the expert opinion symbol.</td>
<td>Physical exercise is recommended. There is insufficient evidence to recommend for or against any specific kind of exercise, or the frequency/intensity of training. Clinical experience suggests that supervised or monitored therapeutic exercise may be useful following an individualized assessment by a spine care specialist. For patients whose pain is exacerbated by physical activity and exercise, refer to a physical therapist, chiropractor, osteopathic physician, or physician who specializes in MSK medicine for more specific therapeutic exercise recommendations. Patients should discontinue any activity of exercise that causes spread of symptoms (peripheralization). Self-treating with an exercise program not specifically designed for the patient may aggravate symptoms.</td>
</tr>
<tr>
<td><strong>G4 (Europe)</strong> (p. 22)</td>
<td>Do not advise specific exercises (for example strengthening, stretching, flexion, and extension exercises) for acute low back pain.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>G7-update (Australia)</strong> (p. 31 &amp; 48)</td>
<td>McKenzie therapy provides similar pain and function outcomes compared to usual care in acute low back pain. There is conflicting evidence for the efficacy of back exercises in reducing pain and disability compared to other active and inactive treatments in mixed populations with low back pain. McKenzie therapy reduces pain and sick leave compared to one back school session, results in similar global improvement compared to manipulation and provision of an educational booklet and provides better functional and pain outcomes compared to flexion exercises in mixed populations with low back pain. Lateral multifidus muscle exercises reduce recurrences of low back pain compared to usual care in mixed populations (acute and chronic) with low back pain.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The following, while not a recommendation, was mentioned in G2 re: potential harm:*

Patients should discontinue any activity or exercise that causes spread of symptoms (peripheralization). Self-treating with an exercise program not specifically designed for the patient may aggravate symptoms.

Grading the Recommendations

Key to Evidence Categories

- Incorporates evidence source information from the inventory tables
- Indicates evidence type rather than evidence level
- Reflects the studies cited in the guidelines and the approach without creating a false impression that the quality of the studies was assessed
‘There is insufficient evidence to recommend for or against…’

Need to define:

- Do
- Do not do
- No effect
- Conflicting evidence
- Do not know
# Recommendation Categories

<table>
<thead>
<tr>
<th><strong>Do</strong></th>
<th><strong>GDG accepted the original recommendation and preserved the original wording where possible.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>The original guideline recommended or provided a prescriptive direction to perform the action, or used the term “effective” to describe it.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>GDG supplemented a recommendation or created a new one based on expert opinion.</strong></td>
</tr>
<tr>
<td><strong>Do Not Do</strong></td>
<td><strong>GDG accepted the original recommendation and preserved the original wording where possible.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>The original guideline recommended against or provided a prescriptive direction not to perform the action; used the term “ineffective” to describe it; or stated that the evidence does “not support” it.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>GDG supplemented a recommendation or created a new one based on expert opinion which did not support the action.</strong></td>
</tr>
<tr>
<td><strong>Do Not Know</strong></td>
<td><strong>GDG accepted the original recommendation and preserved the original wording where possible.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>The original guideline did not recommend for or against the action or stated that there was “no evidence”, or “insufficient or conflicting evidence”, or “no good evidence” to support its use.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>GDG supplemented a recommendation or created a new one based on expert opinion which was equivocal with respect to supporting the action.</strong></td>
</tr>
</tbody>
</table>
Tools Used to Formulate the Recommendations

- GLIA
  (GuideLine Implementability Appraisal)
  - 31 items grouped into 10 dimensions
    - Critical: decidability and executability
    - Others: global, presentation and formatting, measurable outcomes, apparent validity, flexibility, effect on process of care, novelty/innovation, and computability

## Sample of Guideline Recommendations

<table>
<thead>
<tr>
<th>Do</th>
<th>Advice to Stay Active</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td>Patients should be advised to stay active and continue their usual activity, including work, within the limits permitted by the pain. Physical exercise is recommended. <strong>Patients should limit/pace any activity or exercise that causes spread of symptoms (peripheralization). Self-treating with an exercise program not specifically designed for the patient may aggravate symptoms.</strong></td>
</tr>
<tr>
<td></td>
<td>SR (G2 &amp; G4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not Recommended</th>
<th>Diagnostic Imaging</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗</td>
<td>For non-specific acute low back pain (no red flags), diagnostic imaging tests, including X-ray, CT and MRI, are not indicated. <strong>In the absence of red flags, routine use of X-rays is not justified due to the risk of high doses of radiation and lack of specificity.</strong></td>
</tr>
<tr>
<td></td>
<td>SR (G4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do Not Know</th>
<th>Acupuncture</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The evidence does not allow firm conclusions about the effectiveness of acupuncture.</td>
</tr>
<tr>
<td></td>
<td>SR (G7)</td>
</tr>
</tbody>
</table>
Development Timeline

June: Needs assessment survey (Do we need a guideline?)

Nov: Guideline Development Group (GDG) established (foundation)

Jan: Alberta know-do gap survey (Do we need a guideline?)

Feb: Research Team process options (generating the evidence)

Nov: Professional provincial agencies/organizations (buy in)

Oct: Begin dissemination activities (ongoing)

Mar: Update guideline

Mar 2: Guideline on TOP web site

Apr: GDG begin work on the recommendations

Apr to Dec: Guideline externally reviewed and refined

Feb: Last Advisory Committee meeting

Jan: Last GDG meeting

Mar 2: Guideline on TOP web site

Jan to June: Evaluation (consulting firm)

Jan: Patient materials developed

Apr: GDG begin work on the recommendations

Feb: Research Team process options (generating the evidence)

Nov: Professional provincial agencies/organizations (buy in)

Jan: Alberta know-do gap survey (Do we need a guideline?)

Nov: Guideline Development Group (GDG) established (foundation)

June: Needs assessment survey (Do we need a guideline?)
Evaluation

- Introduction
- Process
- Evaluation:
  - The approach
  - ADAPTE framework
  - Benchmark to ADAPTE
  - Success factors and challenges identified by participants
- Evolution/Reflections
- Conclusions
Guideline Evaluation

Purpose

- Conduct a transparent process evaluation by an external consultant
- Identify opportunities for improvement to the process for the development of a new headache CPG
- Benchmark the process to the ADAPTE framework
Evaluation Framework

Consisted of two components

- Document review
- Semi structured telephone interviews
Document Review:
Benchmark the Ambassador Process to the ADAPTE Framework

- **ADAPTE collaboration**
  - International collaboration of researchers, guideline developers, and guideline implementers
  - Developed a manual & resource toolkit (launched first version in April 2007)

[Diagram of ADAPTE process phases and tasks]

[Link to ADAPTE website: http://www.adapte.org/www]
Benchmark the Ambassador Process to the ADAPTE Framework

- **Similarities**
  - A comparison of the process, tools, and deliverables reveals a high degree of alignment

- **Differences**
  - Novel recruitment process
  - More complex committee structure with altered responsibilities
  - Use of modified AGREE tool
  - Evaluation of underlying evidence
  - Documentation of decision paths
  - More comprehensive review of draft guideline
Semi Structured Telephone Interviews

Project Team: Steering Committee (SC) & Research Team (RT)

Guideline Development Group (GDG)
- Family physicians
- Specialist physicians
- Physical therapists
- Occupational therapists
- Pharmacists
- Registered nurse
- Psychologists
- Healthcare manager
- Guideline Development consultant
- HTA researchers

Advisory Committee (AC)
- Provincial HTA program
- Ministry of Health
- Physician education experts
- Zone program leaders
- Provincial Primary Care Network Program
- Physician regulatory agency
- Provincial clinical practice guideline program (TOP)
- Provincial KT network
- Patient advocacy group

* Non-responders
Evaluation Results

- Overall feedback extremely positive

- Strong consensus that the process was sound and rigorous; resulted in an evidence informed guideline applicable to multiple health disciplines
Success Factors

- Strong project leadership
- Multidisciplinary approach
- Province wide representation
- Important topic of interest
- Project team support
- High level of net benefits
- Commitment to transparency
Major Challenges

- Balancing highly participatory approach with efficiency
- Confusion regarding the overall governance, roles and responsibilities
Conclusions Evaluation

- All members of the GDG indicated they would participate in the Program again if they had the capacity available in their fulltime positions.

- Success will be determined by the implementation and uptake of the low back pain guideline and its effect on changing current clinical practice.
Evolution/Reflections

- Introduction
- Process
- Evaluation

- Evolution/Reflections:
  - Development of a guideline
  - Partnership of clinicians and researchers
  - Engaging the clinicians
  - Challenges

- Conclusions
Evolution: Development of a Guideline
Choices for a Starting Point

- Comprehensive Literature review
- Seed Guidelines
Comprehensive Literature Review

Advantages
- Credible
- Satisfying
- Interesting

Disadvantages
- Work volume
- Expertise needed (meta-analyses, etc.)
Comprehensive Literature Review

- Develop a comprehensive search strategy
- Screen references in articles found
- Have several reviewers independently screen all the abstracts, full length articles if necessary
- Grade all relevant studies in terms of methodological quality
- Do meta-analysis where possible
Comprehensive Literature Review: Example of Results

- The search strategy yielded 883 abstracts and 3 Cochrane systematic reviews.
- After analysis of the abstracts and systematic reviews, only 59 studies and 1 Cochrane systematic review met our inclusion criteria and were included.
Seed Guidelines

Advantages

- “You stand on the shoulders of giants” (Someone else has done much of the work)
- Not only is a literature review available, but the thoughts and conclusions of “experts” are available as well
- An already done organizational framework can be assessed
Seed Guidelines

Disadvantages

- The most recent seed guideline may not be completely current and you must do updating anyway
- You are starting further from the source and therefore the product is potentially less credible
- A seed guideline may have regional, cultural, and personal biases
How to Overcome the Disadvantages of Using Seed Guidelines

- Choose the seed guidelines carefully, using a standardized tool
- Find (hopefully) a good recently developed guideline
- Have someone with a finger on the pulse of the literature and current clinical practice on the committee who will know when things are out of date or have the wrong emphasis (bias)
On Balance . . .

- Using seed guidelines means a less intensive effort if several good and at least one up to date guideline are available
Some of Our Seed Guidelines

- Scottish Intercollegiate Guidelines Network (SIGN), 2008
- European Federation of Neurological Societies guideline on the drug treatment of migraine (EFNS), 2009
The Research Team
– Clinician Partnership
Partnership: Clinicians and the Research Team

“He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all.”

Sir William Osler
Some Roles of the Research Team

- Find and evaluate seed guidelines and systematic reviews
- Evaluate and produce reports on specific topics, including delving into the references in the guidelines if necessary where things are not clear
- Keeping track of the recommendations and the underlying evidence
Engaging The Clinicians
Some Roles of the Clinicians

- Helping to assess the evidence
- Making sure statements are truly up to date and in accordance with current thinking and practice
- Guiding where energy needs to be directed to produce truly useful guidelines
- Phrasing statements so that they will be meaningful and helpful to clinicians
Engaging the Clinicians

- Clinicians must feel that the guidelines will serve a useful purpose
- It helps if the process will be educational for them and will assist in personal development
  - working with a research team knowledgeable and experienced in literature evaluation and guideline production
  - for family physicians, working with specialists in the field, i.e. knowledge transfer
  - for specialists, learning how things really work on the ground in a disease field
Organization of Human Resources

- Steering committee
- Research Team
- Guideline Development Group (includes many primary care providers)
- Subcommittees to deal with “parking lot” items
- Committee chairs to move things forward
Making Committees Work: The Task at Hand

- Judging what the best approach is to a given topic
- Expressing the necessary concepts clearly for good recommendations
- Putting it all on paper (or on the computer screen)
How to Avoid This?

- “A camel is a horse designed by committee”

Attributed to Sir Alec Issigonis, July 1958
Or, maybe to University of Wisconsin philosophy professor Lester Hunt
Using a Straw Man: That is... 

- For committee meetings, bringing forward:
  - The relevant recommendations in the most pertinent seed guidelines
  - A draft statement produced by a subcommittee or expert which seems to embody the necessary concepts in as clear a manner as possible for use in our guideline
  - Accepting, criticizing, modifying, or rejecting in committee discussion (Guideline Development Group)
The Straw Man

- An argument or opponent set up so as to be easily refuted or defeated.

It may have its origin in a human figure made of straw, such as practice dummies used in military training. Such a dummy is supposed to represent the enemy, but it is considerably easier to attack because it neither moves nor fights back.
Maybe not a Straw Man . . .

- Our draft recommendations that are brought to committee meetings are meant to focus discussion and make it more productive.
- Most Straw Men are modified to some extent by the committee, but the discussion seems much more productive than it otherwise might be, provided that all committee members feel free to express their opinions and to criticize as necessary.
- Mutual respect is critical.
Face to Face Meetings vs WebEx

- Face to face meetings would be ideal but are not practical in a province-wide initiative
- WebEx provides a good alternative
WebEx

Advantages

- All committee members can view the same document
- The group can switch from one document to another easily and many times. A coordinator does this at the request of the Chair.
- Members can vote at decision points with a check mark or an “x”
- Dissenting or supporting members for a statement are easily identified and can be asked to comment, state their views by the Chair so that they can be debated
WebEx

Disadvantages

- Documents are not easily modified in real time, at least not if the Chair is not the coordinator.
- This makes it all the more important to have a draft document to discuss. Modifications can be recorded by the Chair or Coordinator, and the modified recommendation can be recirculated later.
WebEx

- WebEx brings many, although not all, of the advantages of a face to face meeting to a widely separated working group
Challenges in Producing a Guideline

- Every disease area likely has its own particular features that require a unique approach
- Example: The International Classification of Headache Disorders is 151 pages long (not counting the index)
- How do you produce meaningful headache management guidelines useful to the primary care provider?
Challenges (cont’d)

- Most headaches are primary headaches (e.g. migraine), that is, not due to something else (like a brain tumour)
- They can be disabling, but not life threatening
- A small minority of patients presenting with headache do have life threatening and at times very urgent disorders
Challenges (cont’d)

- Special sub-populations must be treated differently
  - the woman of child-bearing potential
  - the pregnant headache sufferer
  - the lactating mother
  - children
Challenges (cont’d)

- Headache is treated in many settings:
  - the physician’s office
  - the physiotherapy clinic
  - the emergency department
  - at home by the patient
  - the chiropractor’s clinic
  - the psychologist’s office
  - etc.

- You need many different players on your team to develop guidelines
Solutions to Challenges

- Define your target population (i.e. adults)
- Define your practice setting (i.e. the primary care provider’s office/clinic in the community)
- Guideline organization: have specific sections dealing with specific settings and sub-populations
Section 1: Approach to the patient with headache: Headache diagnosis and investigation

Diagnostic criteria for the different common headache types are needed

Example: Patients with recurrent headache attacks and a normal neurological examination should be considered to have migraine if they have at least two of:

1) nausea during the attack;
2) light sensitivity during the attack;
3) some of the attacks interfere with their activities.
Section 1: (cont’d)

- Red Flags: when to send the patient to the emergency department
- Clinical indicators of secondary headache: when to do neuroimaging or refer to a specialist
- When not to do neuroimaging
- When to do other tests
Section 1: Red flag example

- **Background:** Emergent investigation for possible subarachnoid hemorrhage should be considered . . .

- **Recommendation:** The patient with thunderclap headache should be sent to an emergency department with urgent CT capability for immediate investigation
Section 2: Management of migraine headache

- General approach to management
- Pharmacologic therapy
- Behavioral and physical therapies
- Management during pregnancy
Section 3: Management of tension-type headache (TTH)

- General approach to management
- Pharmacologic therapy
- Behavioral and physical therapies
- Management during pregnancy
Section 4: Management of medication overuse headache

- General approach to management
- Pharmacologic therapy
- Behavioral and physical therapies
Section 5: Management of cluster headache

- General approach to management
- Pharmacologic therapy
Section 6: Other headache disorders

- Cervicogenic headache
- Temporomandibular disorders
- Others
Section 7: Resources and tools

- Medication tables with doses, side effects, etc.
- Sample headache diary sheets
- Sample disability measures
- Information on behavioral therapies
- Patient education resources
- Others
Conclusions

- Introduction
- Process
- Evaluation
- Evolution/reflections

Conclusions:
- Status of LBP guideline
- Status of headache guideline
April 20, 2009 - Alberta “Guideline for the evidence-informed primary care of low back pain” was posted on the CMA website http://www.cma.ca/index.php/ci_id/54490/la_id/1.htm?cpgId=9361
March 26, 2010 - Alberta “Guideline for the evidence-informed primary care of low back pain” was accepted for inclusion in the National Guidelines Clearinghouse

http://www.guideline.gov/content.aspx?id=15668
March 2\textsuperscript{nd} 2009, Low Back Pain Guideline available on TOP website

http://www.topalbertadoctors.org
Status of the Ambassador Headache Guideline: National Perspective

- Well crafted up-to-date guidelines will be adopted, or adapted by others
- The Ambassador Program brought together resources not usually available to national disease-oriented societies like the Canadian Headache Society
- How much influence they have nationally and internationally will be determined by the quality of the guidelines (and dissemination strategies)
Thank you!

http://www.ihe.ca/research/ambassador-program/