Using CADTH recommendations for self-monitoring of blood glucose in Nova Scotia: Go fast alone or go far together

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CADTH Symposium  
April 2011  
Vancouver BC
Introductions
Introductions

• Michael Allen
  – Director Evidence-base Programs, Dalhousie CME

• Peggy Dunbar
  – Coordinator/Manager Diabetes Care Program NS

• Isobel Fleming
  – Senior Academic Detailer, Dalhousie CME

• Pam McLean-Veysey
  – Team Leader, Drug Evaluation Unit Capital Health
Introductions

• Health care professionals
  – Physicians / nurse practitioners
  – Pharmacists
  – Diabetes educators
  – Nurses
• Policy makers – hospital or government
• KT specialists / educators
• Others
Objective

Provide practical example of putting CADTH evidence report into practice
Outline

1. Evidence about self-monitoring of blood glucose
2. Nova Scotia context
3. Role of our organizations
4. Collaborative efforts
5. Results
6. Discussion
Based on

- Systematic review
- Meta-analyses
- Expert opinion
- Usual care
- Cost effectiveness
Type 2 diabetes not using insulin

- **A1C**
  - 7 RCTs with 2270 patients
  - Reduction 0.25% (95% CI: 0.15 to 0.36)
    - Patients using sulfonylureas
    - With or without instruction on interpreting results

- **Hypoglycemia**
  - 3 RCTs with 1752 patients found increase
    - No significant effect on severe or nocturnal hypoglycemia

- No improvement in satisfaction with care
- May be some decrease in quality of life

*Open Medicine 2010, Vol 4, No 2*
Type 2 diabetes controlled by **diet alone**

1 RCT (n=124) – moderate quality

Mean difference in A1C

- 0.05% (95% CI -0.33 to 0.23)
- Not statistically significant or clinically relevant
CADTH Key Message SMBG
Oral agents and diet alone

**Routine** use of SMBG is not recommended for most adults with type 2 diabetes using oral antihyperglycemic drugs. Strong recommendation; low to moderate level of evidence

Periodic testing to determine a course of action by the patient:

- Unstable glucose levels
- Acute illness, unplanned physical activity
- Pharmacotherapy changes
- Risk of hypoglycemia with insulin secretagogues (e.g., glyburide, gliclazide, etc.)
- Pregnant or planning pregnancy

Most adults with type 2 diabetes controlled by diet alone should not require routine SMBG.
### CDA and CADTH SMBG Recommendations

#### Similarities and differences

<table>
<thead>
<tr>
<th>Type 2</th>
<th>Controlling with diet alone or oral agents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CDA SMBG Recommendations 2008</strong></td>
<td><strong>CADTH SMBG Recommendations 2009</strong></td>
</tr>
<tr>
<td>Frequency of SMBG should be <em>individualized</em> depending on glycemic control and type of therapy.</td>
<td><strong>Routine</strong> use of SMBG is <em>not recommended</em> for most adults with type 2 diabetes using oral antidiabetes drugs or diet alone</td>
</tr>
<tr>
<td>Should include both <em>pre- and postprandial</em> measurements</td>
<td></td>
</tr>
<tr>
<td><em>Grade D, Consensus.</em></td>
<td></td>
</tr>
</tbody>
</table>

*Strong recommendation; low / moderate quality evidence*
And...
Nova Scotia, specifically
Self-Monitoring of Blood Glucose: What are Healthcare Professionals Recommending?*
Faculty of Medicine, Dalhousie University – Family Medicine

Interviews of Physicians, Pharmacists, Diabetes Educators within 2 hour drive from Halifax to determine:

1. Recommendations for SMBG in **well-controlled** adults (A1c ≤ 7.0%) with type 2 diabetes
   - controlling through **diet alone**
   - controlling through **diet and oral agents**
   - taking **secretagogues vs. non-secretagogues**
   - special circumstances

2. Use of SMBG results

3. Sources of information for SMBG recommendations

### Key findings - recommendations

Recommendations for SMBG in people controlling **with diet alone**

<table>
<thead>
<tr>
<th>N= 21 7 per group</th>
<th>Range</th>
<th>Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Educators</td>
<td>&lt; 1/day to 1/day</td>
<td>varying (before meals and at bedtime); before and after meal; before or after a meal</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>&lt; 1/day to 4X day</td>
<td>varying; fasting + random; post prandial</td>
</tr>
<tr>
<td>Physicians</td>
<td>&lt; 1/day</td>
<td>fasting and post-prandial</td>
</tr>
</tbody>
</table>

- Recommendations in patients **on oral agents** similar to diet alone
- When asked specifically about secretagogues:
  - more cautious approach with more frequent monitoring.
Key findings – use of SMBG and resources

• Reasons for recommending SMBG
  – Empowering and fostering self-management skills
  – Preparing for progression
  – Opportunity to provide/receive positive reinforcement
  – Assists with management decisions

• Trusted sources of information
  – Guidelines – most frequently cited source
  – Other health professionals (colleagues, DECs)
  – On-line resources (such as CDA website)
  – Print materials (texts, journals)
  – Continuing education
  – Industry
Conclusions

1. There is variability within and between HCP recommendations
   - Guidelines cite lack of substantial evidence for SMBG in non-insulin using population
   - Latitude within the guidelines leaves them open to interpretation

2. There are opportunities to improve care
   - Interprofessional health care provider education
   - Clarity in recommendations and incorporation of a broader approach to patient care are required to improve consistency
   - Make recommendations in light of available evidence and cost considerations
   - Reducing inappropriate use of SMBG will allow reallocation of resources to interventions with proven benefit
Why is SMBG an important issue?

Canada public and private drug plans, 2006

- BG test strips > $330 Million
- BG test strips in top 5 classes of total expenditures
- Costs exceed all oral antidiabetes drugs combined

Nova Scotia Pharmacare program, 2008:

- Diabetes medications $8,532,000
- Glucose test strips $8,522,200
- > $4,000,000 (oral antidiabetes drugs or no drugs)
- $870,000 no diabetes drugs on file

Nova Scotia Policy

• February 26 2010
  – 100 strips per year for non-insulin users
    • Effective April 1

• Early March 2010
  – Communications made in error
  – Final decisions to be made after consultations with stakeholders

• March 2010
  – Not adopting policy now or any time in future
Summary

• Most adults not using insulin don’t have to test as much as they currently do
• Substantial spending
• Inconsistency among health care providers
• Departure from accepted practice
• Perceived disagreement with national guideline
• Provincial policy withdrawn
Discussion

• What would you do?
• What have you done?

• Clinician
• Policy maker
• KT specialists / Educator
# Dalhousie Continuing Medical Education (Dal CME)

## Programs → 1000 FPs
- Large conferences
- Community programs
- Videoconferences and webinars
- Academic detailing

## Partners
- Doctors Nova Scotia
- College Physicians and Surgeons of Nova Scotia
- Department of Health via Drug Evaluation Alliance of Nova Scotia
- Drug Evaluation Unit CH
- Diabetes Care Program of Nova Scotia
- College of Pharmacy

Research
Dalhousie Continuing Pharmacy Education (Dal CPE)

**Programs – 2000 pharmacists**
- Dal CPE Online-Webinars
- Large conferences
- Community programs
- Academic Detailing Rx
- Knowledge translation (Katie)
- Accreditation

**Partners**
- Drug Evaluation Alliance of Nova Scotia (DEANS)
- Drug Evaluation Unit, CH
- Diabetes Care Program of Nova Scotia
- Provincial Pharmacy Associations and Regulatory Bodies (NS, NB, PEI)
Drug Evaluation Alliance of NS (DEANS)
Encouraging Appropriate Utilization of Drugs in NS

Drug Evaluation Unit

Knowledge Translation
Knowledge Transfer

Informing policy
Reviews for Pharmacare
Expert Advisory Committee
Support for policy decisions

Education
CME Academic Detailing
CPE Academic Detailing Rx Students

Consultants
Guideline Development Research

Informing policy, influencing practice, Improving health
Diabetes Care Program of Nova Scotia (DCPNS)

• One of 9 Provincial Programs (DoH-funded)
  – Act in advisory capacity to the health system
  – Recommend service delivery models
  – Establish standards/guidelines
  – Monitor uptake of approved standards and systems outcomes.
  – Knowledge transfer and exchange--CMEs; telehealth; newsletters

DCPNS Works….
- Across the continuum—all populations, all providers, all settings
- In partnership
- To inform change
DIABETES CARE PROGRAM OF NOVA SCOTIA (DCPNS)

- 39 Diabetes Centres (DCs) DHA-funded
- Nurse and dietitian teams with local Medical Advisor
- Monitor for complications development/progression

Standardized:
- Documentation/data collection forms
- Guidelines for:
  - Special populations
  - Comorbid conditions (HTN)
  - Visit frequency (triage criteria)
Access to DCPNS Fixed/Satellite Centres - 30km
Access to DCPNS Fixed/Satellite Centres - 50km

50 Km Service Areas for Fixed & Satellite Diabetes Centres in Nova Scotia

Legend
- Diabetes Centres
  - Full-time
  - Part-time, >2.5 days/week
  - Part-time, <2.5 days/week
  - Satellite

50 Km Service Areas
- Full-time
- Part-time, >2.5 days/week
- Part-time, <2.5 days/week
- Satellite

* Some road networks overlap for service areas; only the top-most layer is visible for these cases

Sources: Statistics Canada (2001 Census, 2005 DHAs), DMTI, ESRI, Diabetes Care Program of Nova Scotia

June 13, 2006

GIS Infrastructure, Office of Public Health Practice
Knowledge-to-Action Framework

Knowledge Creation

Figure 1: The knowledge-to-action framework.

Graham et al. JCEHP 2006
Knowledge-to-Action Framework

1st generation knowledge: Primary publications

2nd generation knowledge: Systematic reviews, meta-analyses

3rd generation knowledge: CPGs, decision aids, care pathways

COMPUS Tools
Decision aids
- Newsletter
- Brochure

For Providers with Patients:
- Action planning
- Quick reference prescribing aid
- Alternate prescription pad
- Clinical flow sheet

Graham et al JCEHP 2006
Knowledge-to-**Action** Framework

**Action:** Select, tailor
Implement interventions

**Action:** Assess barriers to knowledge Use

**Action:** Adapting knowledge to the local context
Nova Scotia Activities

COMPUS Report Released (06/09)

Café Scientifique:
• Public
• Providers (02/10)

DCPNS SMBG Working Group

Provider: Decision Tool Development

DCPNS Provincial Workshop—DEs)

Academic Detailing—MDs &DEs

Academic Detailing Rx—Pharmacists

Videos Development (1 & 2)

Inter-professional Workshops (Community-based) 02/11....
DCPNS’s Process

• Working group formed (SMBG Interventions)-July 2009

• DCPNS Workshop delivered Jan/10
  • With Clinical Champions (key)
  • Consensus building….plenary sessions (4), used draft decision tool, case-based discussions
  • Publication submission (Chronic Diseases Can)

• Newsletter articles

• Provincial conference (April /10)

• Refined the provider decision tool (to May/10)

• Video Development (May to Jan/11)

• Draft patient-focused tool

Champions For Change

- Diabetes Educators from each of 9 DHAs
- Community Pharmacists
- MDs—generalists and specialists
- Observers (CADTH, CDA, DoH, FNIH, Dal CME/College of Pharm, CH Behavior Change institute)
Features of the Decision Tool

This tool can be used to guide, and focus, group discussion and individual decision on issues of greatest concern when considering SMBG.

- Provides indications for testing (who should test).
- Provides required conditions for testing (what needs to be in place for meaningful testing).
- And, addresses the role of self-management education.
- Provides examples of low and high intensity testing and reinforces the need for “time limited” testing.
Instructions “How to Use”

Indications for Testing:
• Patient safety
• Health care team action
• Individual—knowledge, skills, willingness to act and interpret

Recommendations:
• Low and high intensity
• Time limited testing

NON-INSULIN USING TYPE 2 DIABETES
Decision Tool for Self-Monitoring of Blood Glucose (SMBG)

Routine, ongoing testing is not necessary in most non-insulin managed type 2 diabetes. This decision tool will help to identify exceptions.

Instructions: Considering the individual, indicate with a Yes or No if the specific issue/consideration has an impact on the need for SMBG. The “prompting” considerations in italics should help in formulating your response.

• “Yes” in either of the pink areas is an indication for SMBG.
• “Yes” in all of the green areas, along with a Yes in the pink area, are required conditions before SMBG is recommended.
• “Yes” in the white area, in conjunction with Yes in all the green areas, may indicate the need for “low intensity” SMBG.

SAFETY
Hyperglycemia: Is there moderate to severe hyperglycemia (A1C ≥ 8.5% and/or before meal BG >10-12 mmol/L)?
• Y N

Hyperglycemia: Is there a risk of hypoglycemia?
• Y N

HEALTH CARE TEAM (HCT)
Will the HCT take appropriate timely action (management change) based on SMBG results?
• Y N

INDIVIDUAL’S KNOWLEDGE, SKILLS, AND WILLINGNESS
Is the individual willing and able to test and record SMBG results?
• Y N

Individually willing and able to interpret and ACT on results?
• Y N

SELF-MANAGEMENT EDUCATION
Is education in SMBG essential at this point due to “safety” and/or other provider identified reasons?
• Y N

RECOMMENDATION (Based on shared decision-making by the individual with diabetes and the provider):
• No SMBG required at this time.
• Low intensity testing (time limited).
• High intensity testing (time limited).

Low Intensity Testing
• Used with individual’s and provider’s understanding of effects of treatment.
• May assist clinicians in guiding therapeutic adjustments, providing more timely feedback regarding potential medication changes, and to identify potential hyperglycemia, if in question.

Examples of use at diagnosis and ongoing follow-up (times can vary for 1 to 3 wks, depending on the purpose [prior to office visit, new dx]):
• 3 test/day—one, once weekday, and one weekend day (fasting and prior to the smallest meal, usually breakfast). For 2-3 wks.
• 2 tests/day—once times (ac, breakfast/supper; ac lunch/supper, etc.) for 1 wk.
• 1 test/day at staggered times (ac breakfast, lunch, supper, or bedtime) for 1-2 wks (prior to office visit).
• 1 test/week between office visits.

High Intensity Testing
• Used for “pattern analysis” to create BG profiles that can identify daily BG patterns that lead to action based on results. Should be used only for a specific time and for a specific purpose, e.g., change in treatment (adding insulin or changing time of insulin), acute illness (flu, GI upset, etc.) resulting in symptoms or added risk, etc.

Examples:
• Generally 5-7 times/day for 1-3 days.
• Staggered testing, 2-3 day (ac and pc: testing for alternating meals) x 1 wk, or over a 2-3 wk period.
• Duration of testing depends on medication and degree of hyperglycemia (what change is expected over what period of time).
• Results should be reviewed by phone or during an office visit immediately after the testing period.

NOTE: Gestational diabetes or women with type 2 diabetes planning for pregnancy or in the early stages of pregnancy will be required to test more frequently for extended periods of time.

1 International Diabetes Federation. Self-Monitoring of Blood Glucose in Non-insulin-Treated Type 2 Diabetes: Brussels, Belgium: Author; 2009.
Summary

• According to working group members…
  – “this tool allows for a more objective look at each individual case and removes emotion and subjectivity from the equation.”

• It allows for a focus on patient safety, available evidence, individual capability, and HCT use of results

• Continuous use of the tool will be unnecessary as the concepts are quickly embedded in thinking/practice
VIDEOS

Part 1: *SMBG Decision Tool for Health Care Providers*

Provides: rationale for the decision tool with the help of key opinion leaders

Part 2: *Use of the SMBG Decision Tool and Case Studies*

It introduces:

- the features of the tool,
- works through a sample case,
- provides summary caveats and principles to guide future application of the tool, and
- leaves three cases for the viewers to work through on their own.

To locate the videos:
DCPNS website—www.diabetescareprogram.ns.ca
Introduction to the Decision Tool for Providers

Video
Academic Detailing Service
Family Physicians

- Reviewed evidence for SMBG
- Discussed the clinical question
  - Who should be self-monitoring their blood glucose and how frequently?
- Visited family physicians and Diabetes Centers
- Distributed CADTH SMBG cards

May to November 2010 . . .
Academic Detailing Rx
Pharmacists

• Several webinars and live programs
• Delivery of same key messages
• Consistent patient counselling re SMBG between health care professionals

June 2010
Interprofessional Program

Community Based

Panel
• Local specialist
• Physician
• Pharmacist
• Diabetes educator

Audience
• Physician
• Pharmacist
• Diabetes educator
  – Nurses
  – Dieticians
• Others
Overview

• Role play
• Evidence about SMBG
  – Nova Scotia context
• Coordinated approach to the SMBG in **non insulin dependent type 2 diabetes**
• Diabetes Care Program decision support tool
• Case presentations and discussion
• Local strategies to apply evidence to practice
Role Play

Are we Singing from the Same Song Sheet?

Doctors Office
+ Pharmacy
+ Diabetes Education Centre
= Confused Patient

- Cost
- Evidence
- Mixed messages
- Retention of information
Case 1: Newly Diagnosed Type 2 DM (Elderly)

<table>
<thead>
<tr>
<th>Age:</th>
<th>75</th>
<th>Gender:</th>
<th>Female</th>
<th>Occupation:</th>
<th>Widowed Homemaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting PG:</td>
<td>8.3 mM</td>
<td>A1C:</td>
<td>7.7%</td>
<td>BMI:</td>
<td>29</td>
</tr>
<tr>
<td>Diet:</td>
<td>Makes healthy meal choices; no major changes required</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity:</td>
<td>Generally inactive; enjoys short walks. Socially active (bridge)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Targets:</td>
<td>5 to 9 mM ac meals; A1C: &lt; 8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td>Experiencing some recent short-term memory loss. Daughter reports that she at times repeats herself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal/Plan:</td>
<td>Maintain weight; continue social activities. Encouraged to increase frequency of short walks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM Medication:</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Case 1**

<table>
<thead>
<tr>
<th>SAFETY</th>
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<tbody>
<tr>
<td><strong>Hyperglycemia:</strong> Is there moderate to severe hyperglycemia (A1C ≥ 8.5% and/or before meal BG &gt;10-12 mmol/L)? Y N ✔ ✔ ✔ ✔ ✔ ✔</td>
</tr>
<tr>
<td>• Consider if treatment change; i.e., adding insulin or a secretagogue* is imminent.</td>
</tr>
<tr>
<td><strong>Hypoglycemia:</strong> Is there a risk of hypoglycemia? Y N ✔</td>
</tr>
<tr>
<td>• Consider if the medication, in combination with extra activity, alcohol, or lifestyle choice, may increase risk of hypoglycemia.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH CARE TEAM (HCT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will the HCT take appropriate/timely action (management change) based on SMBG results? Y N ✔ ✔ ✔</td>
</tr>
<tr>
<td>• Consider if the HCT or provider will make a treatment change based on SMBG, or will the A1C be the telling factor.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INDIVIDUAL’S KNOWLEDGE, SKILLS, AND WILLINGNESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the individual willing and able to test and record SMBG results? Y N ✔ ✔ ✔ ✔</td>
</tr>
<tr>
<td>• Consider age (&gt; 75), frailty, finances, and/or cognition before recommending SMBG.</td>
</tr>
<tr>
<td>Is the individual willing and able to interpret and ACT on results? Y ✔ ✔ ✔ ✔ ✔ ✔</td>
</tr>
<tr>
<td>• Consider if this individual is able to ACT on the SMBG results with lifestyle changes (targeted exercise, further food restrictions, etc.).</td>
</tr>
<tr>
<td>• Consider if lifestyle changes related to food intake (diet) and/or exercise will really have an impact on the SMBG results.</td>
</tr>
</tbody>
</table>

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<tr>
<th>SELF-MANAGEMENT EDUCATION</th>
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</thead>
<tbody>
<tr>
<td>Is education in SMBG essential at this point due to “safety” and/or other provider identified reasons? Y N ✔ ✔ ✔ ✔</td>
</tr>
<tr>
<td>• Consider if it would be better at this time to focus on monitoring physical activity (steps or time spent being active), food choices/portion sizes, weight, etc.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RECOMMENDATION (Based on shared decision-making by the individual with diabetes and the provider):</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ No SMBG required at this time.</td>
</tr>
<tr>
<td>❑ Low intensity testing (time limited).</td>
</tr>
<tr>
<td>❑ High Intensity testing (time limited).</td>
</tr>
</tbody>
</table>

*Note:* A1C will be the telling factor; cognition is a possible issue; not much to be gained through tightening meal plan and activity – she does the best she can.

* Sulfonylureas: glyburide, gliclazide, glimepiride; meglitinides: nateglinide, repaglinide.
Lessons Learned

• Challenges of practice belief
• Cases and discussion
  • Simple $\rightarrow$ complex
• Anticipate audience
• Local champion
Questions?
Knowledge-to-Action Framework

Action: Monitoring and evaluation

1 - Attendance
2 - Satisfaction
3 - KSA
4 - Practice change
5 - Patient health
6 - Population health

- Self-report
- Commitment to change
- Utilization data

Graham et al. JCEHP 2006
Evaluation

• Evaluation data
  – Attendance
  – Commitments to change
  – Utilization data
**Attendance**

<table>
<thead>
<tr>
<th>Academic Detailing (Family Physicians)</th>
<th>Academic Detailing Rx (Pharmacists)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Family physicians 375</td>
<td>• Community 82</td>
</tr>
<tr>
<td>• Medical students 21</td>
<td>• Hospital 10</td>
</tr>
<tr>
<td>• Nurse practitioners 20</td>
<td>• Government 2</td>
</tr>
<tr>
<td>• Nurses 36</td>
<td>• Other 14</td>
</tr>
<tr>
<td>• Others 16</td>
<td>• Unknown 44</td>
</tr>
<tr>
<td>• Total 468</td>
<td>• Total 152</td>
</tr>
</tbody>
</table>

DCPNS workshop ~ 120
Nova Scotia hospital pharmacist network – 26
Interprofessional workshop – 12
Most adults with type 2 diabetes not requiring insulin do not require routine monitoring of blood glucose, except in certain circumstances or special populations.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Confirmed knowledge</th>
<th>Useful knowledge</th>
<th>Confirmed practice</th>
<th>Will change practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>44%</td>
<td>52%</td>
<td>35%</td>
<td>36%</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>16%</td>
<td>84%</td>
<td>20%</td>
<td>76%</td>
</tr>
</tbody>
</table>

Physicians  N = 180
Pharmacists  N = 111
NS Pharmacare Programs
Blood Glucose Strip Utilization Data 2008-2011

-1% # strips
-2.4% amount paid vs. 2009/10
Knowledge-to-Action Framework

Figure 1: The knowledge-to-action framework.

Action: Sustainability

Sustain ongoing knowledge use
Barriers
Enablers
Resources

Graham et al JCEHP 2006
Sustainability

1. What could we have done early in the process to promote sustainability?

2. What factors might erode sustainability?

3. What could we be doing now to promote sustainability?
Discussion Questions

• What could we have done better?
• What are your experiences putting HTA reports into practice?
Thank you for your interest!