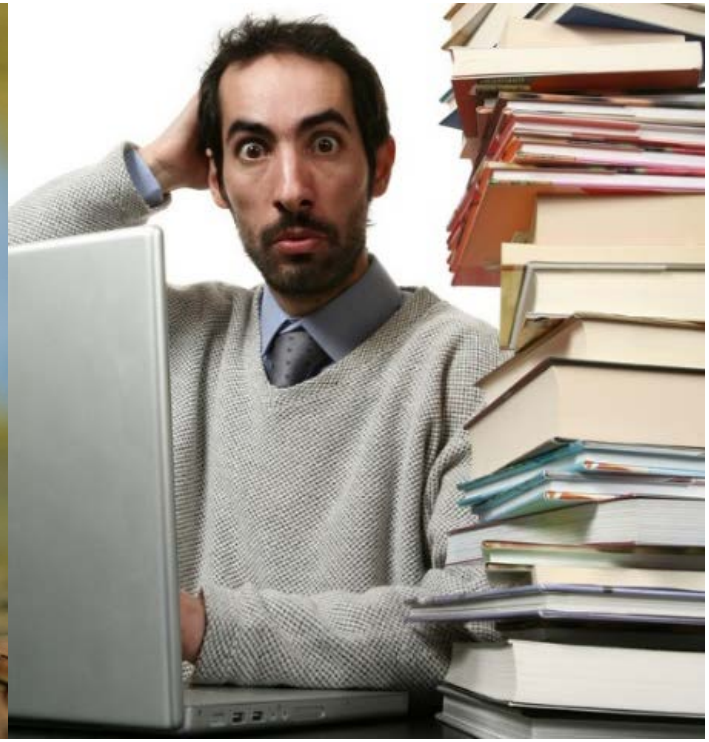
KCE REPORT 284Cs

Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

SYNTHESIS

BETTER TAILORING KCE GUIDELINES TO USERS' NEEDS



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METHOD

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SYNTHESIS

BETTER TAILORING KCE GUIDELINES TO USERS' NEEDS

NADIA BENAHMED, JEF ADRIAENSSENS, WENDY CHRISTIAENS, DOMINIQUE PAULUS

FOREWORD

The KCE examining itself – that's certainly an unusual situation. The impetus for this was an almost existential issue among our researchers, who had voiced their concern about the actual impact of their practical guidelines. As usual, this concern lead to challenge our internal working method. To do this, we first needed the input of our guidelines' users. We launched a large online survey among our main potential audience – doctors, nurses, midwives and physical therapists. One thing leading to another, the survey has received wide media coverage and the response rate was excellent. It is, therefore, important to give a feedback to everyone who made the effort to answer the survey rather than to limit our work to an internal self-assessment.

In the meantime, our Minister of Health, Maggie De Block, decided to formulate an 'EBP plan'. The objective of this plan is to merge and to coordinate the development, dissemination and implementation of guidelines – which are currently a bit scattered – within one coherent network that promotes 'Evidence-Based Practice'*. KCE received a specific request: to draw a plan and coordinate it. These prospects definitely gave our current thought process an additional boost.

Our proposal for the EBP plan will be finalised in a few months, but the broad strokes of the plan are contained in this report. The central idea is that a guideline alone, as robustly as it may be developed, is not sufficient to bring about a change in behaviour if not sufficiently supported by dissemination efforts. An example is to work more in a spirit of co-development with scientific societies as well as with patients. In addition, another example is the opportunity offered by information technology: for the new generations, ICT tools are unavoidable.
But all of this requires different skills, players and tools and incentives. In short, Evidence-Based Practice is entering a new era…

** The concept of Evidence-Based Practice is gradually replacing the concept of Evidence-Based Medicine due to the increasing tendency towards multidisciplinary health care services.*

Christian LÉONARD
Adjunct General Manager

Raf MERTENS
General Manager

SYNTHESIS

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1. CONTEXT

Evidence-Based Medicine (EBM) is a concept that has become increasingly important over the past 20 years and has since become well-known among health care providers – with varying degrees of appreciation. We have David Sackett to thank for the EBM, who defined the concept in 1996 as follows[a]: "The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients." For a health care provider, applying EBM means combining three aspects on a daily basis:

- one's own clinical knowledge and experience,
- the 'proof' or 'demonstrable data' (= evidence) provided by scientific literature and
- the preferences and values of each individual patient.

In recent years, increasing emphasis has been placed on a multidisciplinary approach to medical care. The term EBM has therefore also undergone a semantic shift to *Evidence-Based Practice* (EBP).

The concepts of EBM and EBP are based on two 'subjective' pillars – the knowledge and experience of the health care provider and the preferences of the patient – and on one 'objective' pillar – the knowledge gleaned from scientific literature. The latter is extensive, complex and nuanced by definition and hence cannot be applied randomly. Tools are needed for structuring and summarising the knowledge and making it suitable for practice. These tools are called 'recommendations for good practice', 'guidelines for clinical practice' or simply 'guidelines'.

The effectiveness of guidelines is far from optimal.

Nowadays guidelines are viewed all over the world as one of the foundations for improving health care quality. But despite large investments in guideline development and dissemination, research has shown that their effectiveness is far from optimal; and this also applies to Belgium. A KCE[1] study in 2013 examined why our health care providers are so cautious about guidelines. The researchers presented four cornerstones for improving the situation (see box).

The cornerstones proposed by the KCE for improving the dissemination of guidelines (KCE report 212)

- A unique platform for dissemination of guidelines among health care providers.
- Clear messages in different formats that allow recommendations to be consulted in practice and in real time.
- Examination as to whether guidelines are necessary to more efficiently distribute resources between guideline development and dissemination in Belgium.
- A quality label for the guidelines by a recognised Belgian or foreign institution.

The Belgian guideline landscape is very splintered.

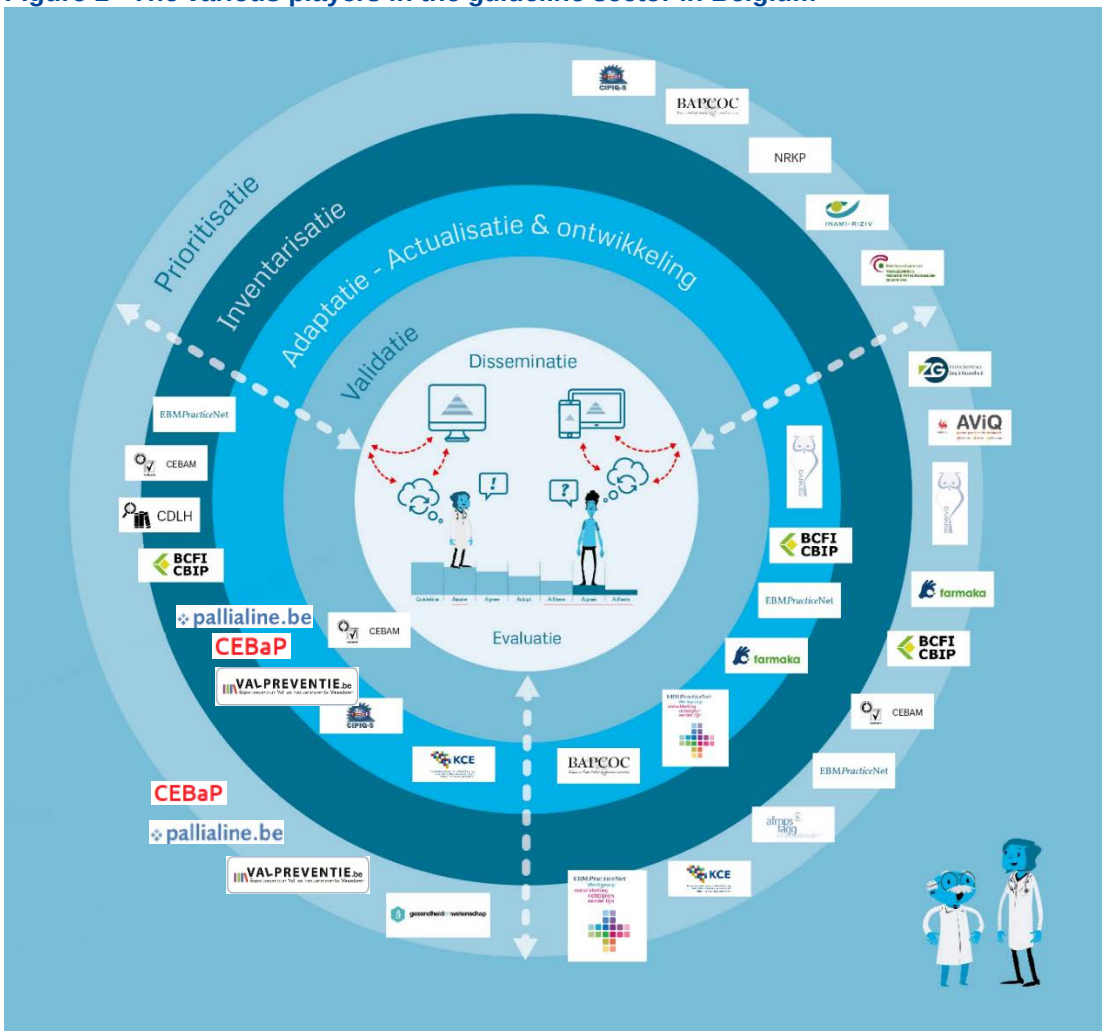
The KCE is one of many players in our country that issue guidelines.[b] It was the researchers of the KCE themselves who wondered within the scope of a self-evaluation process (*Common Assessment Framework* or *CAF*[c]) whether these guidelines adequately meet the needs of end users. That is why, as the 2013 KCE report had recommended, the researchers examined how their guidelines were being disseminated and received.

[a] "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients"

[b] The KCE has developed 31 guidelines since 2009, 21 of them specifically for the oncology field.

[c] http://www.eipa.eu/en/topic/show/&tid=191: a tool used by the public sector to improve performance.

Figure 1– The various players in the guideline sector in Belgium



Source: EBMPracticeNet, 2015.

The launch of a national EBM plan

Another new initiative has been rolled out since the launch of our study: the 'EBP plan' by Minister Maggie De Block. The objective of this plan is to unite and coordinate all existing initiatives regarding guidelines in Belgium under one cohesive network. The plan will also develop guidelines, whose quality will be ensured by a central body, and evaluate tools intended to improve practical application.

The EBP plan is based on two existing initiatives: EBMPracticeNet and CEBAM. EBMPracticeNET is a network of 'developers' and 'disseminators' of guidelines. They want to offer a platform for centralising all Belgian guidelines, adapting foreign guidelines to the Belgian situation and integrating all recommendations in electronic medical files (*contextual aids*, *evidence linkers*). EBMPracticeNet is financed by the National Institute for Health and Disability Insurance (RIZIV) and is accessible to all health care providers working in Belgium. CEBAM (*Belgian Centre for Evidence-Based Medicine*) is responsible for coordination and methodological supervision, in cooperation with the Belgian issuers of guidelines and the National Council for Quality Promotion (Nationale Raad voor Kwaliteitspromotie or NRKP).
The KCE was asked to conduct a preparatory study for development of the EBP plan. The results are expected to be available around June 2017, but the course and conclusions of the current study are already being impacted by this.

2. RESEARCH QUESTIONS AND METHODS

The questions formulated during the CAF were translated into four research questions:

1. How do health care providers view the (KCE) guidelines ?
2. What are the expectations and needs of the various health care providers in terms of content and presentation?
3. What can be improved with respect to content, presentation and dissemination of the KCE guidelines in order to meet the health care providers' expectations and needs?
4. Which methods and tools can be used to improve the perception, content and format of the guidelines in order to meet the health care providers' expectations and needs?

To answer these research questions, we developed a **multimodal approach** consisting of a combination of the following:

- A search in the **international literature**, in order to give our research a theoretical framework and to possibly discover new tools for implementing and disseminating knowledge. This field is currently undergoing some revolutionary developments. We limited our research to the last five years. The methodological details and the complete, detailed results of this research can be found in Chapter 3 of the Scientific Report.
- A survey among **European issuers of guidelines**, in order to become familiar with their procedures and tools. The methodological details and the complete, detailed results of this survey can be found in Chapter 4 of the Scientific Report.

- A survey among the **end users** of guidelines, in order to take stock of their view of existing guidelines and their needs and expectations. This online survey was conducted among **four health care professions for which the KCE has previously developed guidelines**: doctors, nurses, physical therapists and midwives. The methodological details and the complete, detailed results of this survey can be found in Chapter 5 of the Scientific Report.
- A survey among four previous participants in GDGs (*Guideline Development Groups*) of the KCE, about the organisation of the GDGs.
- The KCE procedures were thoroughly re-examined based on these four steps. The various aspects of this critical revision were then discussed **in an internal KCE work group** and ultimately integrated in this report.

3. FROM EVIDENCE TO PRACTICE

3.1. From knowledge generation to knowledge transfer

In the health care area, it is clear that merely generating knowledge (by means of primary clinical studies) in order to then 'distil' it (in the form of systematic reviews or guidelines) and communicate it to the target audience (e.g. through presentations at congresses) does not suffice for helping practices evolve. Many more specific integrated processes for knowledge transfer are needed, and guidelines form the cornerstone for this.

Guideline development has evolved enormously in recent years into a detailed, precise and structured method. The flip side of the coin, however, is that the end-result of this long process is long reports with an analysis of all relevant publications and methodological elements. This is very important for evaluating the quality of a guideline, but it is anything but user-friendly for the end-user (the health care provider).

We are aware that the speed with which guidelines can be consulted and their user-friendliness are crucial for good knowledge transfer. Health care providers must be able to find information at any time and wherever they are. Only then will they make daily use of the information in their clinical decision-making. The lack of applicability of the current guidelines is one of the weak points of the entire knowledge transfer process. It partly explains the relative lack of success of guidelines.

Another crucial factor is trust in the organisation that developed the guideline. That's because we've noticed – and this is confirmed by the survey among Belgian health care providers – that health care providers tend to prefer guidelines from their own professional association (local, national or international). Therefore, there should be closer collaboration between experts in methodology and professional associations when developing guidelines.

A third critical factor is access to tools for facilitating communication with patients. The concept of *'shared decision-making'* means that patients themselves should be well aware of the consequences of their choices. This demands additional communication skills from health care providers. To assist health care workers in this process, decision-making tools and patient information is needed, all based on scientific evidence.

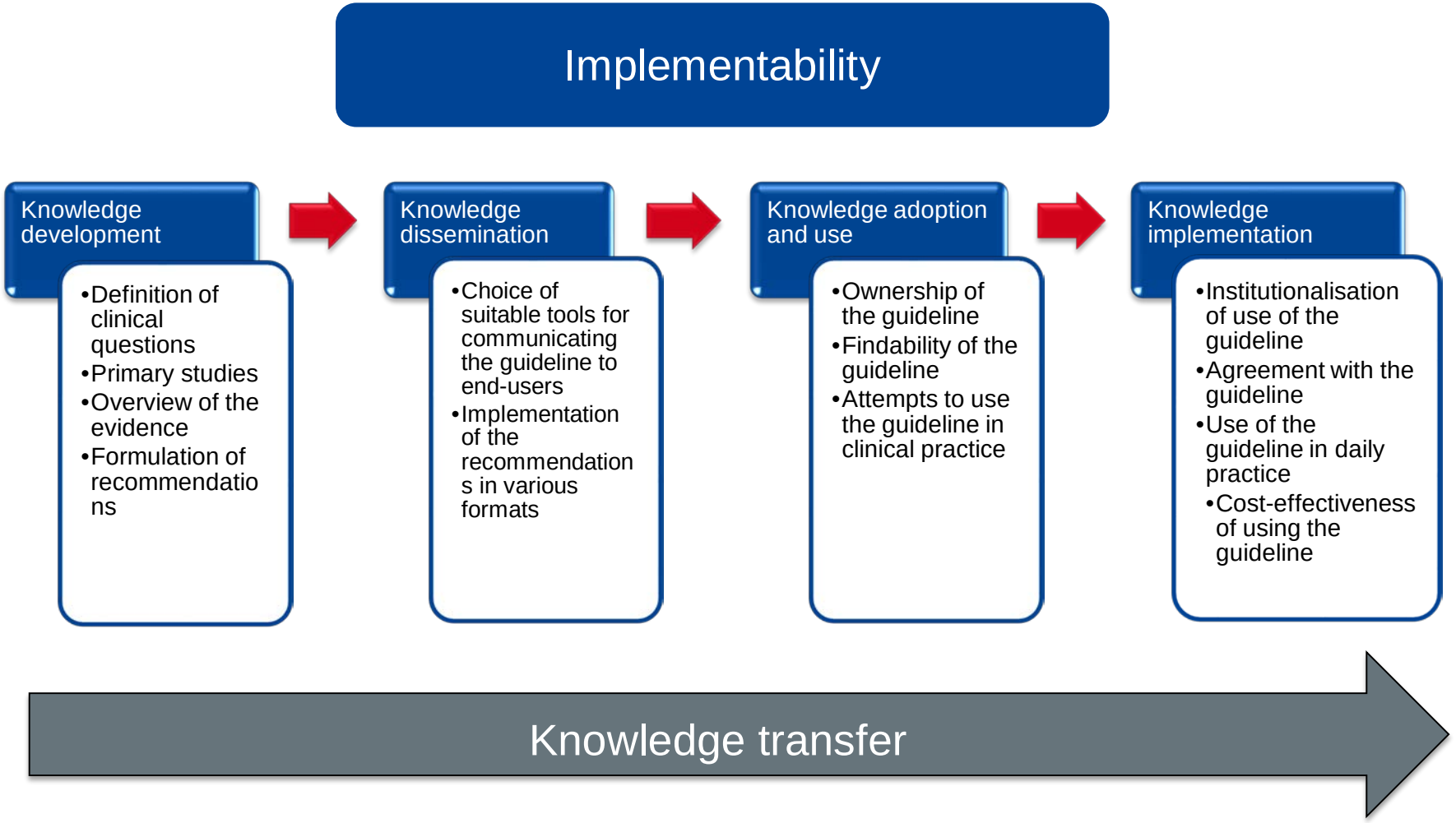
The patient's values and preferences must be included in guideline development early on. These are not only essential for developing and formulating guidelines but also for designing tools for shared decision-making.

The various success factors mean that certain measures must be taken **from the start of the process,** which may bring about far-reaching changes in the procedure.

3.2. The various knowledge transfer steps

Figure 2 contains an overview of the various knowledge transfer steps, from the discovery of new knowledge to its implementation. The four consecutive steps (knowledge development, dissemination, adoption and use, and implementation) are closely intertwined. Each step can influence the ultimate impact of the process.

Figure 2 – Model of the global Evidence-Based Practice process



3.2.1. *Knowledge development*

Development and distillation of the knowledge forms the precise, strict process for formulating an evidence-based guideline. The latter is taken from primary studies, which should provide an answer to clearly defined research questions. The methods for this initial step are described in detail in the KCE *process book*.[2]

3.2.2. *Knowledge dissemination*

With 'dissemination', the knowledge is actively shared with a pre-determined target audience (in contrast to 'diffusion', which refers to spontaneous distribution of the information). According to the EPOC (*Cochrane Effective Practice and Organisation of Care*) classification, which the KCE used for its 2013 report about dissemination and application of the guidelines in Belgium, no single strategy has a proven major impact (e.g. dissemination of didactic material, independent medical sales representatives, local opinion leader, etc.). Multifactorial interventions are more interesting, but it is difficult to determine the optimal combination.

3.2.3. *Knowledge adoption and use*

The usability of the recommendations is tested in this phase. This is related, among other things, to the practical feasibility of the recommendations and their format. In addition, there are factors that have to be considered from the beginning of the process, such as involving the players and paying attention to the values and preferences of health care providers and patients.

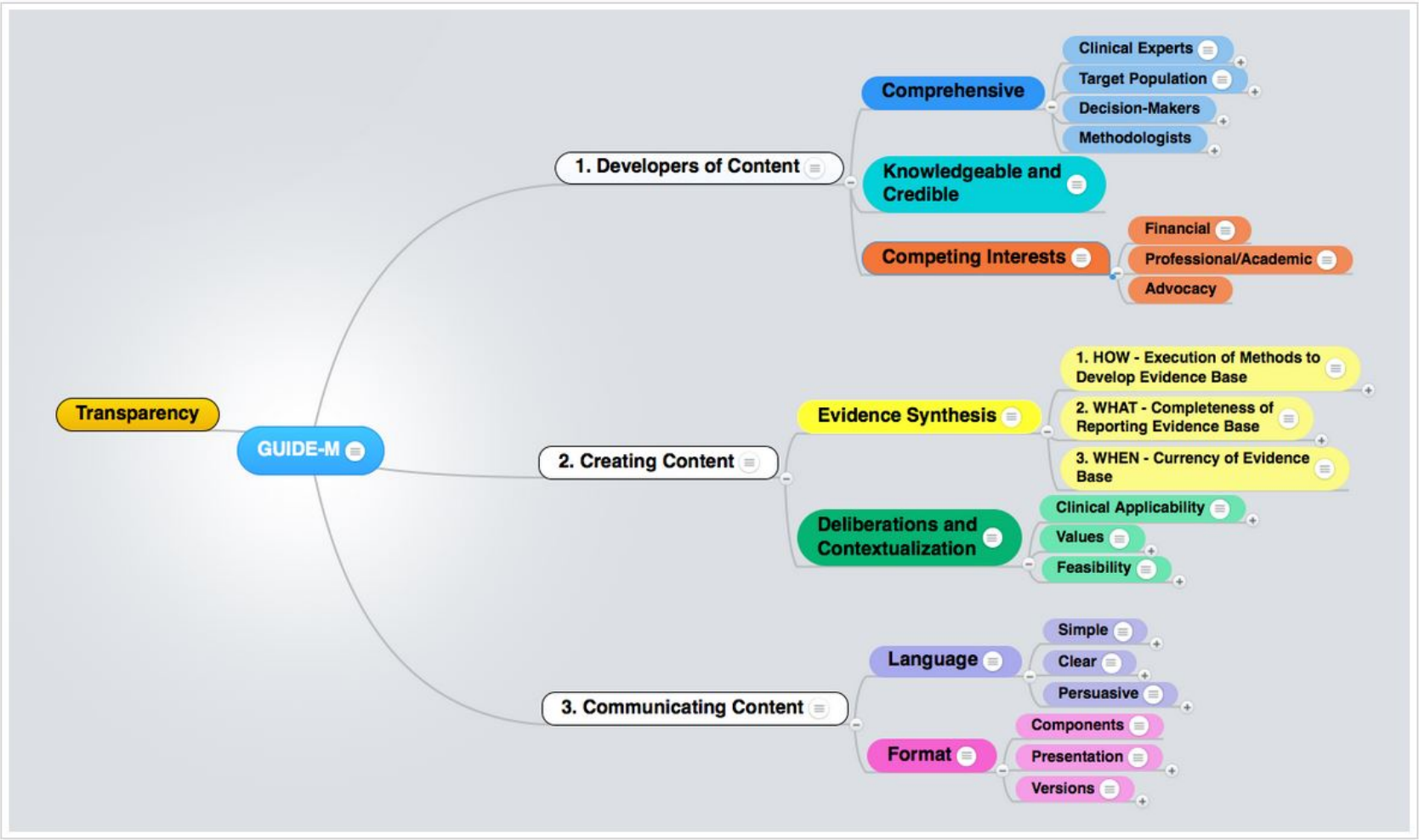
3.2.4. *Knowledge implementation in practice*

Implementation is the last stage of a guideline's life cycle. It is measured based on audits and feedback in the field.

3.3. Implementability of the guidelines

Various models have been developed to 'forecast' the ease (or difficulty) with which a guideline will reach its audience and will motivate people to change their practices. This document does not elaborate on these models (interested readers can find a description of three of the models in Chapter 2.2 of the Scientific Report). The most recent model, the GUIDE-M (*Guideline Implementability for Decision Excellence Model*), developed by Brouwers & Bhattacharyya, is based on 7 focus areas that must be taken into consideration in the three important phases of the model: 1) Who developed the content? 2) How was the content developed and 3) How was the content communicated?

Figure 3 – Diagram of the GUIDE-M model



Source: Brouwers et al.

4. ADAPTATION OF THE GUIDELINE DEVELOPMENT PROCESS

4.1. Description of the topics that need to be addressed in a guideline

4.1.1. Collection of the topics for which guideline development is needed

According to a survey among Belgian health care providers, more than one-third (37%) of them believe that they do not have sufficient guidelines available to them. This applies primarily to the nurses (51%) and physical therapists (45%). The literature also confirms that there is a demand for guidelines that meet the specific needs of users and patients. Furthermore, there appears to be a demand for new topics (e.g. use of external defibrillators).

The topics that are eligible for guideline development are typically chosen after the field has been extensively consulted. The need for a *de novo* development or an update of antiquated guidelines is examined during the consultation process.

At the KCE, topics are selected by means of a public call for topics when the annual programme is formulated. Each citizen can submit a proposal for the development or updating of a guideline for various topics. The proposals then undergo a strict selection process according to pre-determined criteria (see below). Here it is important for the KCE's call for topics to not only concern guideline projects but HSR (*Health System Research*) and HTA (*Health Technology Assessment*) projects as well. During the internal selection procedure, the submitted topics are classified into one of these three research categories. This classification can deviate from what the submitter had initially proposed.

The survey among other European guideline developers shows that this phase – the collection of topics – can be organised in very different ways. Some developers, such as KCE, use open consultation while others work with pre-formulated lists of topics. The lists are formulated in cooperation with the professional associations based on a library of health objectives and quality standards that must be complied with. Such a library is not yet available in Belgium, but the KCE is currently conducting a study on health objectives (see the future project on Health [care] objectives).

Certain institutions, such as NICE[d] and NHG[e] have developed a proactive process for updating existing guidelines. The KCE does not have a comparable proactive process, but the internal work group has urged its development.

In the future, and keeping in mind the arrival of the EBP plan, collecting new topics for guidelines will have to take place centrally at the national level in order to prevent an excess of initiatives about the same topic. A national call for proposals would have to be aimed at the broadest possible audience (e.g. professional associations, patient associations, policy-makers, the RIZIV, developers of national and international guidelines, health care providers, etc.).

The need for updates of existing guidelines should be identified using systematic and centralised analysis. The topics that are eligible for an update can then be added to the list of topics. The procedures employed by NICE and NHG can serve as an example for such a systematic examination. Experts in literature research (*information specialists*) can offer added value for this process.

[d] National Institute for Health and Care Excellence (https://www.nice.org.uk/)

[e] Netherlands Society of General Medical Practitioners (Nederlands Huisartsengenootschap) (https://www.nhg.org)

4.1.2. Prioritisation of guideline topics

As soon as the topics have been collected, NICE (UK) prioritises the topics. This is done by a committee consisting of representatives of the health authorities, the professional associations, the organisations of service users and their families and the health care providers.

According to the KCE procedure, the topics (including GCP topics) are first classified for the work programme, based on the following criteria (if applicable):

- Political relevance for assistance with decision-making;
- Frequency of the pathology or the health problem;
- Severity of the pathology or the health problem;
- Possibility of improving current treatment;
- Feasibility of the research.

At the KCE, topics for oncological guidelines are traditionally prioritised in collaboration with the College of Oncology (College voor Oncologie).

The *short list* of topics is then submitted to the KCE's Board of Directors for approval.

With the exception of the *National Health Authority (Haute Autorité de Santé or*[f] HAS), which employs no formal procedure for selecting research topics, all of the surveyed guideline developers make their selection based on criteria comparable to those of the KCE. The selection is usually done by a group of experts whose composition varies depending on the developer. Exceptions to this are NICE and SIGN[g], where policy-makers make the definitive selection.

4.1.3. Selection of guideline topics

In order to remain coherent with regard to the above points, the definitive selection of guideline topics should be done centrally as well. The above-mentioned criteria can be used for the initial selection. According to the KCE work group, the following three elements must be taken into account:

- There is currently no recent and high-quality guideline about this topic:
  - At the Belgian level

    Before a guideline is developed, it must first be determined what guidelines are already in place in Belgium, both at the federal and the state level. In addition, the database of ongoing or planned research projects of the various partners of the Health Research System (*Planned and Ongoing Projects* – POP database), must be consulted. The EBP plan should also include a prior consultation of the patient representatives and representatives of the professional associations. These organisations' choice must depend on the topics that are collected after the central call for topics. Ultimately, a possible update of the Belgian guidelines will have to be considered.

  - At the international level

    Before a Belgian guideline is developed, it must be determined whether there are international guidelines in place for the same topic. These can be guidelines formulated by professional associations or by guideline developers. The EBP plan must hence elaborate a procedure for a systematic check and quality measurement of the international guidelines. GIN (*Guidelines International Network*), for example, offers a library of 6,400 guidelines, developed and approved by the members of this international organisation. If a decision is made to use foreign guidelines, these must be adapted to the Belgian situation. The

[f] http://www.has-sante.fr/portail/

[g] Scottish Intercollegiate Guidelines Network, http://www.sign.ac.uk

survey among Belgian health care providers indicates that adapting a high-quality foreign guideline promotes the use of the guideline.

- Possibility of international collaboration
  - The EBP plan can also envisage a procedure for European and/or international collaboration for comparing possible topics and work programmes of other developers. This is to prevent research on topics about which other developers are set to publish. It can also decrease costs for the development of *de novo* guidelines (at least if the developers employ quality standards that are comparable to Belgian ones).
- Agreement on health objectives and the needs of health care providers
  - The topics for which a *de novo* guideline must be developed (so no update, an adjustment or international collaboration) would have to be prioritised according to a clearly defined procedure within the EBP plan. This can take place based on a list of pre-defined health objectives and (unfulfilled) needs, taking into account the viewpoints of the scientific associations, patients, citizens[3] and the federal and federated policy-makers.

The governance platform of the EBP plan can then assign the selected topics to the Belgian guideline developers based on criteria that are still to be determined. The definitive list of guidelines that are assigned to the KCE would then be submitted to the Board of Directors for approval.

4.2. Guideline development

4.2.1. Composition and organisation of the Guideline Development Groups (GDGs)

- Composition of the GDG

The literature stresses the importance of the manner in which the GDG is composed. The composition must be as broad as possible and consist of health care providers' representatives and experts in methodology. The patient viewpoint must also be taken into account.

The KCE follows the regulations specified in the literature for composing its GDGs[4].

The representatives of the health care providers' **professional associations** must be invited to participate in the GDG. It is important to include them from the beginning of the process so that they can be fully involved in elaborating the guideline. This is an absolute condition in order to promote adoption by members of the professional associations. According to the survey among Belgian health care providers, the health care providers place a great deal of importance on the fact that a guideline is published or approved by their professional association. But as the KCE's internal work group stresses, a balance needs to be found between the added value of the assistance provided by the professional associations on the one hand and a workable number of GDG members on the other hand. It is very difficult to deliver high quality work with large groups. This is especially a problem for multidisciplinary guidelines, for example, in which a broad range of professional associations are involved.

The **patients** and their **representatives** play an important role in determining the research questions, in the deliberation and contextualisation and in formulating the recommendations. However, their participation also brings with it a number of practical challenges. The language is one such challenge (the meetings are often conducted in French/Dutch or in English), as is the technical level of the meeting. It would therefore be useful to develop specific modalities in order to let patients and representatives participate in the debates. For example, individual patients could be consulted through monolingual groups at the start (determination of the

research questions) and at the end (contextualisation recommendations) of the project. These consultations could be a supplement to the stakeholder meetings which are currently being organised and could be reported separately to the GDG.

- Organisation of GDG meetings

  Several former GDG members stressed their strong intrinsic motivation to participate in a GDG, despite the great amount of work it takes to prepare these meetings. They find that extrinsic motivation elements – other than financial compensation – can also be beneficial, such as the attribution of credit points.

  The KCE's internal work group proposes testing meeting methods with new communication technologies. They got their inspiration from the method employed by international organisations[5], telemedicine[6-8] and distance learning[9]. They suggest a more seamless organisation of the GDGs by alternating meetings requiring physical presence of members with asynchronous online consultations and synchronous videoconferences. Criteria such as the number of participants, their individual technical skills, the frequency of the meetings, the distances, the maintenance of a pleasant atmosphere during debates, etc. must all be evaluated. These innovative modalities can be tested within the scope of the KCE's next guideline project.

- Role of the GDG in guideline dissemination

  The GDG plays an important role in guideline dissemination. But according to the surveyed former GDG members, the role is not explicit enough and is also not adequately used. In the spirit of co-creation, the members of the GDG who represent the professional associations can assume the role of reporters in their organisation and promote approval of the definitive guideline by their colleagues.

4.2.2. Selection of research questions in every guideline (scoping)

The objective of the first meeting of a GDG is to determine the research questions *(scoping)*. The available resources play an important role in this. As already mentioned above, the information, considerations and testimonials of the individual patient are also taken into account.

Using the NICE procedures as an inspiration[10], the two additional elements can be taken into account in this *scoping* phase:

- Collecting the data required for economic contextualisation of the clinical questions. The former GDG members stated that the economic context for the patient, such as the personal cost, is given insufficient attention compared to the economic contextualisation of NICE (where every question is viewed from the economic, individual and social viewpoint). Therefore, the EBP plan must define in advance the importance ofeconomic contextualisation in the Belgian guidelines.

- As soon as the scope of the guideline has been determined by the GDG, the scope has to be integrated into a cartography of all existing national guidelines. The reach of certain research questions may be limited by this in terms of other guidelines, and the results of certain research questions can, in turn, be used for other guidelines. The cartography is best centralised within the EBP plan. The NICE procedure can be used as a source of inspiration for the elaboration of this plan.

The choice of the term *Evidence Based Practice* (EBP) instead of *Evidence Based Medicine* (EBM) has a major impact on the *scoping*. The objective of this conceptual shift is to expand production of the guidelines to all health care professions instead of restricting them solely to physicians. For future guidelines, this often implies a more holistic approach which includes interventions that are more psychosocial than medical (lifestyle, return to the labour market, etc.). This can cause the amount of research questions to increase significantly, with fields for which studies of much lower quality exist also being discussed. A precise description of the type of intervention that falls under the 'Practice' denominator will therefore be of crucial importance to the prospect of a national network of guidelines coordinated by the EBP plan.

4.2.3. Overview and analysis of scientific literature (evidence)

The way in which scientific data are summarised in a scientific report[4] is important for better acceptance and implementation of a guideline. This overview must describe the methodology, contain all pertinent evidence and mention the period for which this evidence is collected.

The procedures employed by the KCE for the evidence analysis and overview are described in the *process book*[10] and fulfil the same standards as those of the other guideline developers who took part in our survey. According to the internal work group, the processes can be accelerated with the help of technical tools for selecting articles and extracting evidence (e.g.: GRADEPro GDT[11, 12] Magic App[13], Covidence[14]…).

4.2.4. Deliberation and contextualisation of the evidence

Clinical and economic aspects play a role in the deliberation and contextualisation of evidence, as do the values and preferences of patients (which need to be ascertained better; see section 4.2.1). Just as with the other surveyed developers, this takes place at KCE through consultation with stakeholders. However, some developers place more emphasis on economic aspects. They are also conducting a study on the tools for implementing the recommendations, a cost analysis of the health care system and patient and a cost-effectiveness study of the recommended interventions.

The scope of the economic part must be defined from the project's *scoping* phase. Decisions made at the national level (EBP plan) must be taken into account. Therefore, a health economist must be part of the guideline development team.

4.2.5. Formulation of recommendations

The recommendations are formulated according to the strict editorial rules of the KCE's *process book* [2]. These rules are comparable to those of the other surveyed guideline developers.

NICE formulates its recommendations in cooperation with the members of the GDG, who are trained in the writing rules. Two to 15 meetings are organised per guideline, in an co-creative effort . The evidence is discussed during these meetings, which last one or two consecutive days. The GDG members' approval of the formulated recommendations and their involvement in the subsequent dissemination of the recommendations by means of their professional association is in relation to the degree to which the members were involved in elaborating the recommendations.[10, 15]

It would be difficult to apply the NICE strategy in Belgium due to the multi-language nature of our country and the fundamental differences in benefit reimbursement modalities. At the KCE, the first version (in English) of the recommendations is discussed, together with the evidence, online with the members of the GDG. Then the various comments by the members are discussed in a face-to-face meeting. Only the definitive version of the recommendations is translated to Dutch and French.

Use of standardised tools could facilitate online consultation of the GDG members. One example is the DECIDE[h] tool, which was developed by the GRADE group[i].[12] This tool makes it possible to:

- inform panel members about the advantages and disadvantages of each studied intervention;
- verify whether all factors that are needed for the decision-making process have been considered;
- provide a concise summary of the evidence, with which the panel's advice can be documented;

h **D**eveloping and **E**valuation **C**ommunication strategies to support **I**nformation **D**ecisions and practice based on **E**vidence

i **G**rading of **R**ecommendations **A**ssessment, **D**evelopment and **E**valuation

- structure the discussions within the panel and identify the reasons for differences of opinion;
- increase transparency in the decision-making process for users or policy-makers.

4.3. Validation and approval of the guidelines

4.3.1. Validation

Validation of KCE guidelines is done in two phases: one methodological validation by the CEBAM and one content-related validation by external validators. This validation is important for increased credibility, acceptance and transparency, which are important factors for improved implementation, according to the literature[4, 16, 17].

Within the scope of the future EBP plan, a validation by CEBAM should guarantee uniform quality for all Belgian guidelines.

As mentioned above, the health care providers indicated in the survey that there is a demand for a unique platform where all Belgian guidelines are available for review, along with a quality guarantee. EBMPracticeNet, which is mentioned as a central distribution platform in KCE report 212[1], would be able to assume this task, more so because GPs commonly use it. An expansion for other groups is currently underway.

4.3.2. Approval of KCE guidelines

The KCE guidelines must be approved by its Board of Directors before they are published on the KCE website (with communication to the media) and are distributed among the end users by the professional associations. But this strategy is often not very well elaborated and therefore not that effective.

In order to obtain more cooperation in guideline development, approval by the participating professional associations would be a great advantage. In that case, possible conflicts of interest will have to be properly managed. This approval can be formalised by placing the organisation's logo clearly visible on the cover of the guidelines. This will meet the health care providers' request for guidelines stemming from (and approved by) their professional association. The combination of the KCE's methodological expertise and the professional association's experience in the respective field could be an additional quality guarantee for all end users.

The KCE work group proposed not to change the KCE's policy regarding guideline authorship but rather to clearly mention the professional associations that have approved the guideline, together with their logo, with the names of the KCE researchers and the GDG members.

4.4. Presentation of the guideline

4.4.1. Report format

The current format of KCE guidelines is very well aligned with their methodological validation. The order of the structure is logical and clearly depicts the development process.

From the scientific standpoint this manner of structuring is adequate, but this does not appear to be user friendly. That's because the order in which the elements are presented does not correspond to the health care providers' priorities. This was confirmed by the survey results. Neither does the order meet the requirements of the literature regarding communicating evidence-based information to end users[16-22].

Nowadays there are IT tools available (e.g. Magic App) that can be used to quickly organise information from guidelines in order to develop various communication tools. Use of these tools at the national level can enable a certain standardisation in order to communicate guidelines from diverse sources to health care providers and facilitate inclusion of the recommendations in electronic files. This could be a focal point for the EBP plan.

4.4.2. Products specifically intended for end users

The survey among health care providers showed that a summary of the recommendations and their level of evidence are deemed to be the most important elements of a guideline. All of this is mentioned in the synthesis of every KCE guideline.

The survey also illustrated that there is a demand for practical tools based on the guidelines. Examples of this are tools for the health care provider's decision-making process, such as clinical decision trees, brochures and other tools for communication between health care providers and patients. The KCE has already developed several tools as an accompaniment to its guidelines (e.g. an app for the smartphone, tablet and PC for determining pre-operative tests[23], tools for the physician's decision-making process, simplified cards for patients when they ask to be screened for prostate cancer[24], information for making informed choices about breast cancer screening[25]), etc. But these are not generally used.

The literature confirms that developing such tools promotes dissemination and implementation of the guidelines[26, 27]. NICE understands this very well, indeed. It organises online access to its guidelines based on a navigation system. This gives the visitor a choice between the simplest information (the guide intended for the patient) and increasingly specialised tools and documents. The entire scientific document is provided at the end of the chain. It bears mentioning that NICE and NHG have a specific department with communication and marketing specialists who develop these tools and their dissemination channels. What's more, development of a NICE guideline is always associated with a communication plan.

The EBP plan must hence develop a strategy for disseminating the guidelines with the help of tools that promote adoption of these guidelines by end users. Development of these tools should be entrusted to specialists in communication and social marketing. They have to work closely together with the Belgian guideline developers and with the structure that is responsible for centralised distribution of the guidelines. The literature offers numerous examples of tools.[16, 17, 19, 21, 22, 26, 28-36]. A work group within the KCE can be set up to identify the resources needed for developing these tools.

4.5. Dissemination, communication and practical application

The Belgian health care providers want to have a unique access point to guidelines whose quality is guaranteed. This access point must be easy to use and be easily accessible and shared by all developers. Central dissemination will hence also be the task of the future EBP plan.

In the survey, only one-third of health care providers stated that they were informed about the publication or updating of guidelines. The information channels they mentioned the most were conferences and mailings. The professional associations that approved a guideline must be encouraged to organise conferences or other events aimed at dissemination. Mailings, which the KCE already uses for distributing its own guidelines, are very practical, provided that the health care providers subscribe.

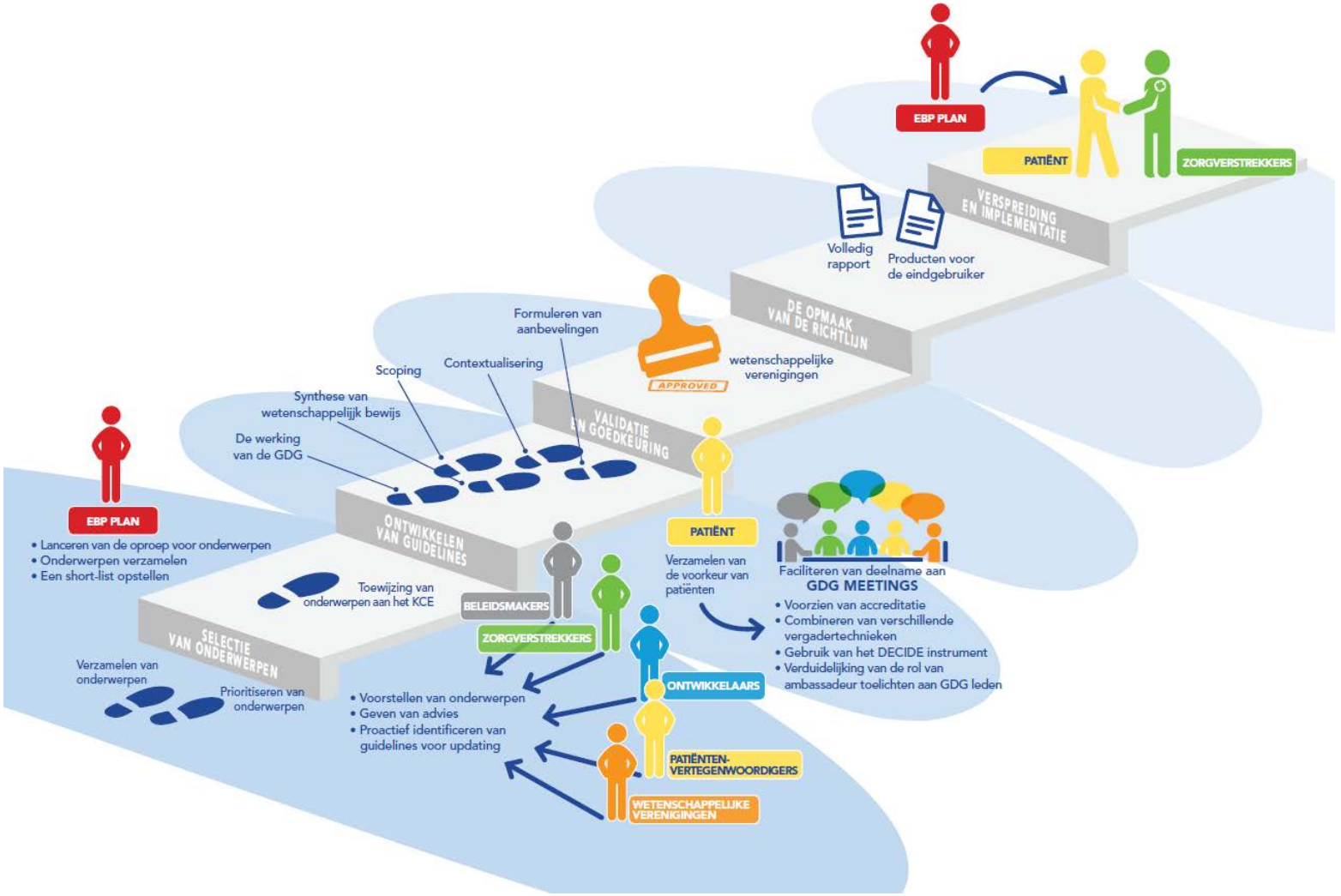
The survey participants also found it essential for an implementation plan for the recommendations to be added to the guidelines (the resources required for implementation of the recommendations). The KCE guidelines already contain such a plan in abridged format, but it could benefit from further elaboration. It is logical for a national implementation plan, developed and coordinated by the EBP plan, to be introduced for all Belgian guidelines.

The survey revealed an additional hindrance for health care providers working at hospitals (especially for nurses and midwives): hospital protocols prevail over guideline use. A centralised implementation plan can facilitate fast and automatic translation of the guidelines into hospital protocols in order to eliminate this obstacle.

5. CONCLUSIONS

Adaptation of the KCE guidelines to the needs of end users will require organisational changes within the KCE and at the national level. All process changes are depicted in the diagram in Figure 4.

Figure 4 – Diagram of the adaptations in the development process of KCE guidelines



5.1. Proposals for adapting the KCE's organisational procedures

5.1.1. Organisation and functioning of the GDGs

Participation of experts in GDG meetings is not only essential for the deliberation and contextualisation of the evidence, but also for the dissemination and implementation of the guidelines[4]. The following measures may be considered to facilitate and encourage this participation:

- Offer accreditation points/credit points as a supplement to financial compensation for participating in the GDG meetings;
- Alternative methods for organising meetings, such as a combination of meetings requiring physical presence, asynchronous online consultations and synchronous discussions during video conferences.

The GDG currently has multiple tasks. Examples are: determining what the clinical questions are, identifying the most important *outcomes*, deliberating about the selection and content of the evidence and setting up and contextualising recommendations[2]. The following aspects can support the GDG's tasks:

- When describing the clinical questions, the information that is necessary for the economic contextualisation must be defined with the help of a specialised KCE economist. This expert can also actively participate in the economic contextualisation of the guideline's recommendations.
- Collecting the patients' preferences can be improved by consulting the individual patients in monolingual groups. The results of these consultations can be reported to the GDG by the patient representatives and/or by the KCE researchers.
- The formulation of the recommendations can be facilitated through the use of validated electronic tools such as DECIDE. This tool can also be tested and potentially used for all KCE guidelines.

The role of the GDG and the stakeholders in developing, disseminating and implementing the guidelines would have to evolve into a more collaborative model by:

- increasing participation of the professional associations in the GDGs and asking their representatives to assume the role of reporters in their organisations so that we can request approval of the definitive version of the guidelines from these organisations.
- encouraging communication about the guidelines during conferences and congresses.

5.1.2. Production, validation and approval of the guidelines

To increase the production of guidelines, technical tools can be used for selecting articles and extracting evidence.

The current format of the scientific report about the guidelines would have to be preserved in order to facilitate validation, but the implementation needs further thought. The use of technical tools for converting the information into tools for health care providers has to be studied (e.g. Magic App, DECIDE). The existing technical possibilities can be identified and tested by a work group within the KCE.

In addition, formal approval and the definitive version of the guidelines or a label can be requested from the professional associations that participated in the GDG. This approval, in combination with the validation by CEBAM, should increase confidence among end users and improve their compliance with the guidelines. The organisation's name and logo must be placed clearly and visibly on the cover of the guideline.

5.1.3. *Communication, dissemination and implementation of the guideline*

At the moment, communication about the KCE guidelines consists above all of distributing the entire report and its synthesis. However, the health care providers' needs are evolving more towards information prioritisation, with communication tools such as clinical decision trees, tools for the decision-making process and patient communication. Developing these tools requires specific skills and resources.

5.2. Focal points for the EBP plan

The main objective of the EBP plan is to coordinate the various initiatives in the area of evidence-based practices in Belgium.

The points below summarise the KCE's expectations about this plan.

5.2.1. *Description of the plan's range*

A condition of the introduction of the EBP plan is that a consensus be reached about the concept of *'practice'*. This will be decisive for the topics that are covered in the guidelines. Examples of this are the information needed for the economic contextualisation, or the inclusion or exclusion of questions about psychosocial interventions.

5.2.2. *Selection of guideline topics*

Topic selection for a guideline must go through the following phases:

- A centralised call for topics should be aimed at the broadest possible audience (e.g. professional associations, patient associations, policy-makers, the RIZIV, developers of national and international guidelines, health care providers, etc.).
- In addition, a systematic search must be performed on existing guidelines that require revision because they are outdated, which greatly hinders their implementation. The procedures employed by NICE and NHG can serve as an example for finding such guidelines.
- The selection of the guideline topics:

  The topics can be selected based on criteria depending on national priorities. The criteria employed by the KCE are the same as those used by the other surveyed international developers. The following elements are taken into account in this respect:

  - Political relevance for assistance with decision-making;
  - Frequency of the pathology or the health problem;
  - Severity of the pathology or the health problem;
  - Possibility of improving current treatment;
  - Feasibility of the research.
- The withheld topics should then be examined with respect to:
  - the existence of a recent and high-quality guideline about the same topic;
  - the opportunity for international collaboration for developing a guideline;
  - agreement on the health objectives and the needs of health care providers.
- The topics should also be assigned to the various guideline developers based on criteria that need to be defined within the framework of the EBP plan.
- Every developer must determine the scope of each of his/her guidelines and share this with a centralised structure (POP database). The objective of this is to identify all future guidelines and their integration into the network of existing guidelines. The pathways developed by NICE for this purpose can be used as an example.

To ensure successful completion of this task, a platform may be organised within the scope of the EBP plan that includes representatives of the public authorities, Belgian guideline developers, representatives of the professional associations and patient representatives. This structure must also be able to call on experts in literature research (*information specialists*), in order to identify needs with respect to updating and prioritisation.

5.2.3. Dissemination of the guidelines

The EBP plan should organise the centralisation of communication tool development. Communication tools are needed for disseminating guidelines and for health care providers to use them. Developing these tools requires specific skills. These skills can be bundled in order to produce guidelines with the same format and presentation. Communication about all guidelines can also be coordinated by the EBP plan, in close cooperation with the developers.

Ultimately, the EBP plan could organise the dissemination of guidelines among all end users through a central platform that can be accessed quickly and easily. It can also make implementation tools available. In addition, it must guarantee the quality of the guidelines for end users. Coordination of the validation process may be envisioned for this, from both the methodological and the content viewpoint.

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COLOPHON

Title:	Better tailoring KCE guidelines to users' needs – Synthesis
Authors:	Nadia Benahmed (KCE), Jef Adriaenssens (KCE), Wendy Christiaens (KCE), Dominique Paulus (KCE)
Project Coordinator:	Dominique Paulus (KCE)
Synthesis Editorial Office:	Karin Rondia (KCE); Nadia Benahmed (KCE); Gudrun Briat (KCE)
Reviewers:	Pascale Jonckheer (KCE), Geneviève Veereman (KCE), Raf Mertens (KCE)
Stakeholders:	Jan Bosteels (CEBAM – Centre for Evidence-Based Medecine Cochrane Belgium), Gudrun Briat (KCE), Patrice Chalon (KCE), Sam Cordyn (Collaboration Internationale des Praticiens et Intervenants en Qualité (dans le domaine de la) Santé – CIPQs), Leen De Coninck (Ergotherapie.be), Geert De Loof (Belgian Centre for Pharmacotherapeutic Information), Nicolas Delvaux (Domus Medica, EBMPracticeNet), Alfons De Schutter (SCientific Association of Flemish Physical Therapists, Pro-Q-Kine), Anja Desomer (KCE), Estelle Di Zenzo (Union Professionnelle des sages-femmes belges – UpSfb), Nicolas Fairon (KCE), Benjamin Fauquert (EBMPracticeNet), Siegfried Geens (CEBAM Digital Library for Health), Régine Goemaes (Flemish Professional Association of Midwives – VBOV), Martine Goossens (CEBAM), Germaine Hanquet (KCE), Ana Hernandez (Office de la naissance et de l'enfance), Pascale Jonckheer (KCE), Marlène Karam (Université catholique de Louvain, CEBAM), Didier Martens (Farmaka), Marlene Reyns (VBOV), Ward Rommel (Kom op tegen Kanker), Karin Rondia (KCE), Hans Van Brabandt (KCE), Thierry Van der Schueren (Société Scientifique de Médecine Générale – SSMG), Didier Vander Steichel (Fondation contre le cancer), Michel Vanhalewyn (SSMG), Inez Vanoverschelde (EBMPracticenet), Geneviève Veereman (KCE), Leen Verleye (KCE), Mieke Vermandere (Catholic University of Leuven, CEBAM, EBMPracticeNet), Joan Vlayen (KCE), Patrick Wérrion (Association de défense professionnelle de la kinésithérapie – AXXON), Vanessa Wittvrouw (UpSfb)
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Other reported interests:	Membership of a stakeholder group on which the results of this report could have an impact: Nicolas Delvaux (Domus Medica, EBMPracticeNet), Marlène Karam (Cebam, CDLH), Mieke Vermandere (Domus Medica),

	Patrick Werrion (Association de défense professionnelle de la kinésithérapie – AXXON), Vanessa Wittvrouw (Union Professionnelle des sages-femmes belges – UpSfb) Fees or other compensation for writing a publication or participating in its development: Nicolas Delvaux (Domus Medica, Guidelines) Participation in scientific or experimental research as an initiator, principal investigator or researcher: Régine Goemaes (PhD study researcher "Advanced Midwifery Practice" - Social Health Medicine– University of Ghent), Inez Vanoverschelde (EBMPracticeNet: coordinator FOD project for EBMplatform development), Mieke Vermandere (EBMPracticeNet: coordinator FOD project for EBMplatform development) Consultancy or employment for a company, an association or an organisation that may gain or lose financially due to the results of this report: Nicolas Delvaux (EBMPracticeNet, Domus Medica), Marlène Karam (CEBAM training regarding EBP and use of CDLH) Presidency or accountable function within an institution, association, department or other entity on which the results of this report could have an impact: Nicolas Delvaux (EBMPracticeNet, Domus Medica), Inez Vanoverschelde (Coordinator, EBMPracticeNet), Mieke Vermandere (Coordinator, EBMPracticeNet), Patrick Werrion (President of Axxon Qualité en kinésithérapie asbl), Vanessa Wittvrouw (UpSfb) Other possible interests that could lead to a potential or real conflict of interests: Mieke Vermandere (post-doc scientific associate at the University Centre for Family Medicine – Catholic University of Leuven)
Layout:	Joyce Grijseels, Ine Verhulst
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