## Disseminating Cochrane evidence to the public health workforce via author-led webinars

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**Background:** Health Evidence™ is a free searchable repository of 4500+ quality-appraised public health relevant reviews, including nearly 700 Cochrane Reviews. Author-led webinars is one knowledge translation strategy to disseminate the findings of Cochrane Reviews. **Objectives:** 1. Disseminate the findings of Cochrane Reviews via webinars 2. Evaluate the impact of Cochrane author-led webinars **Methods:** Webinars are 60-90 minutes in length and include: an overview of the principles of evidence-informed decision making (15 mins), presentation of the findings by the review author (30 mins), and a Q&A period (30 mins). Web-conferencing software monitors participant registration, attendance, engagement, poll responses, and questions. Standard poll questions are asked throughout each session to assess familiarity with and use of systematic reviews (SRs), as well as familiarity and agreement with session-specific review findings. **Results:** Since January 2015 Health Evidence has hosted six Cochrane author-led webinars. Webinar participants include: nurses, health promoters, physicians, dietitians, and knowledge brokers. On average, participants in each session were attentive and engaged 68.8% of the time. Google Analytics reflected an average 572% increase in users accessing the Cochrane Review featured in each webinar on the day of the session compared to average daily access the month prior. On average, each session attracted 177 registrants, of which approximately half joined on the session date. Poll response data reveal 59.6% attendees use SRs to inform their practice. Data collected pre/post webinar on participant's knowledge of the effectiveness of an intervention, suggest that this is an effective way to influence participant's knowledge about intervention effectiveness (participant knowledge improved 10%-31.8%, measured via pre/post poll questions). During the Q&A period, attendees submitted 5-12 questions per session. **Conclusion:** Webinars are an interactive and effective mechanism for promoting public health relevant Cochrane evidence to decision makers. Data from webinars highlight a high level of interest and engagement with Cochrane author-led sessions.

# Short Oral Session 7 Review methods non-statistical I

## Integrating randomized and non-randomized studies in systematic reviews and its implications for GRADE: rationale, perceptions, and proposed methods

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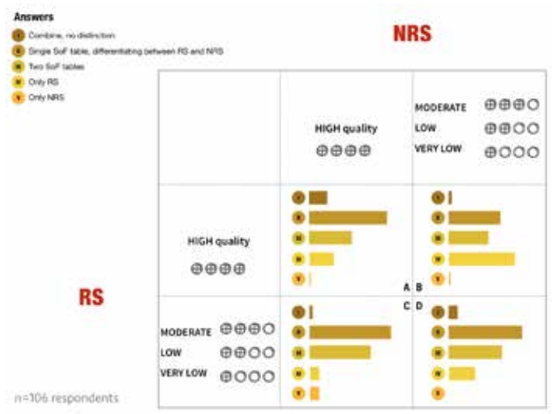
**Background:** Randomized studies (RS) are considered the ideal individual source of research evidence. Non-randomized studies of interventions (NRS) are critical to many areas of evaluation, yet they are commonly disregarded or separated from RS, and considered less certain due to confounding and bias. Using new tools for the assessment of NRS included in systematic reviews (eg, ROBINS-i) and GRADE (Grading of Recommendations, Assessment, Development and Evaluations) criteria, the integration of NRS with RS in systematic reviews could be more feasible. **Objectives:** as part of a Cochrane Methods project, we set out to obtain the rationale, perceptions and methods used to integrate RS and NRS from a group of experts for integrating both bodies of evidence using GRADE. **Methods:** We invited experts from different organizations (e.g. Cochrane, G-I-N (Guidelines International Network), GRADE members) to participate in a web-based survey to obtain their understanding, attitudes, and perceptions about integrating NRS with RS in a systematic review, and the integration within a summary of findings (SoF) table using GRADE. We assessed respondents' preferences and rationale regarding the integration of RS and NRS on different possible GRADE scenarios based on certainty of the evidence. **Results:** Of 187 initial responses, 137 (73.2%) were complete; 85% of respondents were highly experienced in systematic reviews and 65% had conducted at least one systematic review integrating RS and NRS. From presented scenarios, most experts favour a single SoF table differentiating RS from NRS (Fig). The situation most favourable for combining RS and NRS was when both bodies of evidence were of high certainty. A conceptual framework was drafted based on scenarios' assessments, feedback, and individual responses. **Conclusions:** Although most experts would prefer a single SoF table differentiating RS from NRS, we discuss other situations that are feasible for the RS/NRS integration based on the GRADE criteria. With more information and guidance on new methodological tools, the RS/NRS integration could help increase the certainty in the estimates in systematic reviews of interventions.




## Determinants for successful de-implementation of low-value services: a systematic review

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**Background:** Stopping proven ineffective medical practices is important for improving the quality of healthcare. These low-value services (LVS) have no added value for patients or have shown to be only effective for a limited group. De-implementation of LVS is likely to face different challenges than implementation of new practices. Even with strong evidence against the use of an intervention or test, action is often required to restrict its use. **Objectives:** To investigate determinants for successful de-implementation strategies and to identify gaps in knowledge and areas for future research. **Methods:** MEDLINE, Embase, Cochrane, and Rx for Change databases were searched on 1 November 2015. Additional studies were found through checking references and healthcare websites. Studies of interest focused on the reduction or elimination of a LVS for clinical - rather than financial - reasons. Information on characteristics and effectiveness of de-implementation strategies, study design, and perceived/measured barriers and facilitators to these strategies were extracted. **Results:** About 120 studies were included: 65% on interventions (of which, drugs 80% vs non-drugs 20%); 25% on diagnostics; and 10% others (e.g. follow-up care or screening). Only 10% were randomized trials, most were before-after studies followed by interrupted time series. Most studies focused on adequate care or restricted use rather than total stoppage. About 70% claimed 'success' e.g. decreased use of LVS; 20% presented patient-health related outcomes. Only 1% considered the sustainability of the de-implementation. Most de-implementation strategies were multi-faced, with successful elements being patient education and empowerment, physician education and feedback, and organizational interventions. Serious barriers influencing the effectiveness of de-implementation were negative attitude towards change and continuing reimbursement. Strong facilitators were involvement of a medical leader and interaction with patients. **Conclusions:** We provide suggestions for quality improvement of future studies on de-implementation and give guidance for best practices to decrease LVS in health care.

## Reporting and application of minimally important differences in randomized controlled trials evaluating patient reported outcomes: a systematic survey

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**Background:** Despite the increasing use of patient reported outcomes (PROs) in randomized controlled trials (RCTs), interpreting treatment effects (trivial, small but important, or large) remains a challenge. The minimal important difference (MID) provides a measure of the smallest change in a PRO that patients would perceive as important, and can facilitate interpretation of RCT results. **Objectives:** We conducted the first comprehensive systematic survey of published RCTs to determine the extent to which trialists