Quenching the thirst for access to Living guidelines
Holger Schünemann, MD, MSc, PhD, FRCPC
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On behalf of the eCOVID RecMap team

Disclosures

No direct financial conflicts
GRADE Working Group Co-Chair
Cochrane Canada - Director
Guidelines International Network – chair
INGUIDE – steering committee lead
Research grants from Canadian Institutes of Health Research (FRN VR4-172741, GA3-177732 & REC 183153), American Society of Hematology (ASH), WHO, Public Health Agency of Canada
Thank you: WHO Global TB program, ASH, RecMap team, CAN-PCC team & Elie Akl!
Views expressed my own
Land Acknowledgment

McMaster University sits on the traditional territories of the Mississauga and Haudenosaunee nations and within the lands protected by the Dish With One Spoon wampum agreement.
Today’s talk

Living guidelines....
What they are
Beyond single guidelines: Recommendation Mapping
One role for AI
Introduction of living guidelines (Cochrane Canada 2017):
In a living guideline, the unit of update is the individual recommendation and not necessarily the whole guideline (underlying principle).

Living systematic reviews: 4. Living guideline recommendations
Elie A. Akl\textsuperscript{a, *}, Joerg J. Meerpohl\textsuperscript{b}, Julian Elliott\textsuperscript{c}, Lara A. Kahale\textsuperscript{d}, Holger J. Schünemann\textsuperscript{e}, on behalf of the Living Systematic Review Network

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\textsuperscript{b}Cochrane Germany, Medical Center - University of Freiburg, Freiburg, Germany
\textsuperscript{c}Department of Infectious Diseases and Cochrane Australia, School of Public Health and Preventive Medicine, Monash University, Melbourne, Australia
\textsuperscript{d}Clinical Research Institute, American University of Beirut, Beirut, Lebanon
\textsuperscript{e}Department of Medicine and Department of Health Research Methods, Evidence, and Impact, Hamilton, Ontario, Canada

Accepted 17 August 2017; Published online 11 September 2017
Box 3 Elements necessary for producing living recommendations

- Living systematic review
- Living Evidence Profile
- Living Evidence to Decision (EtD) table
- Living guideline panel
- Living peer review process
- Living publication and dissemination
- Living budget
Definitions 2017

• Living practice guideline: an optimization of the guideline development process to allow updating of individual recommendations as soon as relevant new evidence becomes available.

• Living recommendation: a recommendation which is updated as soon as relevant new evidence becomes available.

• Living systematic review: a systematic review which is continually updated, incorporating relevant new evidence as it becomes available.
Cochrane’s first living systematic review: to inform guidelines...
Thirsty for “Living guidelines”
Definitions

- Living practice guideline: an optimization of the guideline development process to allow updating of individual recommendations as soon as relevant new evidence becomes available.
- Living recommendation: a recommendation which is updated as soon as relevant new evidence becomes available.
- Living systematic review: a systematic review which is continually updated, incorporating relevant new evidence as it becomes available.
Why too simple?
to not say naïve

Critically Ill Patients

In patients with COVID-19 related critical illness who do not have confirmed or suspected venous thromboembolism, should we use prophylactic-intensity vs. intermediate-intensity anticoagulation?

Access the guidelines published in Blood Advances on February 8, 2021:


RECOMMENDATION 1A (PUBLISHED IN BLOOD ADVANCES ON FEB 8, 2021)

The American Society of Hematology (ASH) guideline panel suggests using prophylactic-intensity over intermediate-intensity anticoagulation for patients with coronavirus disease 2019 (COVID-19)-related critical illness who do not have suspected or confirmed venous thromboembolism (VTE) (low certainty of evidence).
Living recommendation: a recommendation *which is updated as soon as relevant new evidence becomes available*.

**Update as soon as new evidence becomes available?**

- Update meaning what exactly?
- And what evidence?
  - E.g., systematic reviews on baseline risk – pretty complicated…
  - On EtD factors that determine a recommendation
- And even if there was evidence… working with trialists was challenging
  - Did not really share data
  - Different outcomes then what we needed for guidelines
  - Disagreement on analytical approaches
If the chairs decide to move forward with reconsidering a recommendation, the panel will be asked whether or not the new evidence will warrant discussion of a revised EP and EtD based on the following criteria:

- Information on a critical outcome that previously had no included studies
- Magnitude of the absolute effect changed importantly for at least one critical outcome
  - The panel will be asked to make judgments of the magnitude of effects for individual outcomes going forward and subsequently if this magnitude of effect may change (including the direction of change), e.g. from moderate to large for a critical outcome
- Certainty of the evidence for absolute effect increased for at least one critical outcome
  - Suggestion: increase from Very low or Low to Moderate or High
- Potential change in the judgments regarding any other criteria that had an important bearing on the recommendation (costs, feasibility, acceptability, equity)
How we determined if we should update a recommendation

- If >50% of panel members agree, we will proceed to update.
- Introduced decision thresholds for magnitudes of effect to ensure internal consistency
Evaluation

- Panelview tool
  - Evaluation of the process etc by panel
- Scores on a 7-point scale
  - All means > 6.2!
  - A whole lot of love in the panel

Table 1: PANELVIEW evaluation at the initial and living phase of developing recommendations

<table>
<thead>
<tr>
<th>PANELVIEW Item Ratings</th>
<th>December 2020 Rating (n=15)</th>
<th>March 2022 Rating (n=15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1 — strongly disagree; 7 — strongly agree)</td>
<td>Mean (n=15)</td>
<td>Mean (n=15)</td>
</tr>
<tr>
<td>1. The logistical support provided for organization of the guideline project and panel meeting was appropriate (e.g. scheduling of meeting)</td>
<td>6.9 (0.3)</td>
<td>6.6 (0.6)</td>
</tr>
<tr>
<td>2. There was adequate preparatory work and meetings/teleconferences prior to the final panel meeting.</td>
<td>6.9 (0.5)</td>
<td>6.6 (0.5)</td>
</tr>
<tr>
<td>3. Adequate time was given for guideline group members to complete tasks (e.g. surveys, providing feedback) throughout the development of the guideline, and to review the evidence summary and other material prior to the panel meeting.</td>
<td>6.5 (1.5)</td>
<td>6.4 (0.7)</td>
</tr>
<tr>
<td>4. Adequate time was allotted for the final panel meeting for all guideline questions to be discussed and recommendations to be formulated.</td>
<td>6.9 (0.3)</td>
<td>6.6 (0.5)</td>
</tr>
<tr>
<td>5. The panel meeting(s) had a clearly defined agenda and objectives.</td>
<td>6.9 (0.2)</td>
<td>6.9 (0.4)</td>
</tr>
<tr>
<td>6. Information was provided about the specific methodology and framework to ensure understanding of the overall process and steps that would be used to develop the guideline.</td>
<td>6.9 (0.5)</td>
<td>6.5 (0.7)</td>
</tr>
<tr>
<td>7. The panel chair(s) was able to provide clinical and methodological guidance during the meeting, providing direction and support for decision-making.</td>
<td>6.9 (0.2)</td>
<td>6.8 (0.4)</td>
</tr>
<tr>
<td>8. The panel chair(s) was able to manage the group process, establishing an atmosphere of support that ensured involvement of all panel members in the discussion and free expression of opinions.</td>
<td>6.9 (0.5)</td>
<td>6.7 (0.5)</td>
</tr>
<tr>
<td>9. There was appropriate management of potential interests (financial, academic) of guideline group members, of the organization, and in the evidence synthesis being free from bias.</td>
<td>6.9 (0.3)</td>
<td>6.8 (0.4)</td>
</tr>
<tr>
<td>10. There was appropriate management of potential bias in panel members’ interpretation of evidence and alignment with prior beliefs.</td>
<td>6.8 (0.4)</td>
<td>6.6 (0.5)</td>
</tr>
<tr>
<td>11. The panel was given sufficient opportunity to be involved in the prioritization of questions and scope of the guideline.</td>
<td>6.8 (0.4)</td>
<td>6.5 (0.8)</td>
</tr>
<tr>
<td>12. The final scope of the guideline was clearly communicated to the guideline development group and dissent was sought.</td>
<td>6.8 (0.4)</td>
<td>6.7 (0.5)</td>
</tr>
<tr>
<td>13. The evidence synthesis was rigorous.</td>
<td>6.8 (0.4)</td>
<td>6.6 (0.6)</td>
</tr>
<tr>
<td>14. A transparent and usable summary of the evidence was made available for the panel discussion.</td>
<td>6.7 (0.6)</td>
<td>6.6 (0.6)</td>
</tr>
<tr>
<td>15. Appropriate consideration was given to the evidence, including all relevant types, and balanced with panel members’ input and opportunity to use their expertise to interpret the evidence.</td>
<td>6.8 (0.4)</td>
<td>6.6 (0.5)</td>
</tr>
<tr>
<td>16. The method or process used for decision making with the available evidence was appropriate.</td>
<td>6.7 (0.6)</td>
<td>6.6 (0.5)</td>
</tr>
<tr>
<td>17. There was appropriate involvement and consultation with key stakeholders during the guideline development.</td>
<td>6.8 (1)</td>
<td>6.2 (1)</td>
</tr>
<tr>
<td>18. Appropriate consideration was given to patients’ views, perspectives, values and preferences.</td>
<td>6.5 (0.6)</td>
<td>5.6 (1.5)</td>
</tr>
<tr>
<td>19. An appropriate method was used for formulating the recommendations with transparency of judgements made.</td>
<td>6.7 (0.5)</td>
<td>6.5 (0.6)</td>
</tr>
<tr>
<td>20. Appropriate consideration was given to relevant external factors (e.g. policy implications, setting specific healthcare factors, acceptability of recommendation) in formulating the guideline recommendations.</td>
<td>6.6 (0.6)</td>
<td>6.5 (0.7)</td>
</tr>
<tr>
<td>21. The consensus method used by the panel was appropriate, allowing ability to reach consensus.</td>
<td>6.7 (0.5)</td>
<td>6.5 (0.6)</td>
</tr>
<tr>
<td>22. The wording of the guideline recommendations formulated was clear and actionable.</td>
<td>6.8 (0.4)</td>
<td>6.5 (0.6)</td>
</tr>
<tr>
<td>23. There was transparency in going from the panel’s recommendation to the final recommendations that appear in the guideline report and notice was given about any changes made.</td>
<td>6.8 (0.4)</td>
<td>6.7 (0.5)</td>
</tr>
<tr>
<td>24. There was diversity in membership and adequate representation of backgrounds, specialties and balance of expertise in the panel composition.</td>
<td>6.8 (0.4)</td>
<td>6.2 (1.4)</td>
</tr>
<tr>
<td>25. The panel size was appropriate.</td>
<td>6.8 (0.5)</td>
<td>6.6 (0.5)</td>
</tr>
<tr>
<td>26. The required commitment was at an appropriate level for the guideline group members.</td>
<td>6.8 (0.4)</td>
<td>6.6 (0.5)</td>
</tr>
<tr>
<td>27. The contributions of the guideline group members were valued and appropriate credit was given.</td>
<td>6.8 (0.4)</td>
<td>6.7 (0.5)</td>
</tr>
<tr>
<td>28. There was mutual respect between guideline group members with friendly and professional conduct.</td>
<td>6.9 (0.3)</td>
<td>6.8 (0.4)</td>
</tr>
<tr>
<td>29. Appropriate consideration was given to the discussion of research gaps and needs for future research.</td>
<td>6.8 (0.4)</td>
<td>6.2 (1.1)</td>
</tr>
<tr>
<td>30. Appropriate consideration was given for the planning of dissemination and implementation of the guideline.</td>
<td>6.8 (0.4)</td>
<td>6.3 (1.3)</td>
</tr>
<tr>
<td>31. The writing of the guideline was well planned, with emphasis on the format(s) and opportunity for panel members to provide input and review the guideline draft.</td>
<td>6.7 (0.7)</td>
<td>6.7 (0.5)</td>
</tr>
</tbody>
</table>
Qualitative study

- N = 15 panel members

### Table 2: Highlights of key themes identified by the guideline panel and evidence synthesis team as barriers, challenges, and facilitators in the living guideline process:

<table>
<thead>
<tr>
<th>Evidence Synthesis and Formulating Recommendations</th>
<th>Challenges and Barriers</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handling of pre-prints, concerns about inaccuracy of data, and waiting for full publication and access to full data</td>
<td>Dealing with very low certainty evidence</td>
<td>Applying rigorous evidence synthesis methods following a priori protocol.</td>
</tr>
<tr>
<td></td>
<td>o &quot;The time frame and the pace of the movement in this area have combined to increase pressure to produce guidelines even in the absence of adequate data.&quot;</td>
<td>Clear triggers for updating recommendations.</td>
</tr>
<tr>
<td>Tracking of changes in inclusion and exclusion criteria through living process. Information overload with volume of evidence to screen.</td>
<td>Use of online systematic review tools, detailed data abstraction forms, guidance documents.</td>
<td></td>
</tr>
<tr>
<td>Changing evidence and changing baseline risk estimates for health condition in question</td>
<td>Weekly meetings with evidence synthesis team and methods advisory group.</td>
<td></td>
</tr>
<tr>
<td>Panel Group Process</td>
<td>Maintenance of patient representative engagement</td>
<td>Virtual meetings</td>
</tr>
<tr>
<td></td>
<td>o &quot;It was challenging to include input from patient representatives. I think the virtual format made this more difficult.&quot;</td>
<td>o &quot;I think the virtual format was key. The living phase would not have been possible if in person meetings had been required.&quot;</td>
</tr>
<tr>
<td>Maintaining frequency of panel meetings, and requiring ad hoc meetings</td>
<td>Chairing of group process and panel meetings. Central coordination of guideline development and evidence synthesis.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o &quot;Issue of timing and bandwidth. We can only do so many updates and have monthly meetings organized, can we have weekly updates and panel meetings?&quot;</td>
<td>o &quot;Nobody tried to be leader and impose his opinions.&quot;</td>
</tr>
<tr>
<td>Publication and Dissemination of Living Recommendations</td>
<td>Delays in publication of updated recommendations</td>
<td>Arrangement, discussion and submission of publication to host journal.</td>
</tr>
<tr>
<td></td>
<td>o &quot;The articles took much too long to be published. ASH could consider streamlining approval and publication processes.&quot;</td>
<td></td>
</tr>
<tr>
<td>Speed at which primary studies and trials are published and made available.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A. J. S. Schuemann, MD, PhD; Joanna Kloska, MPA; Karin Sidel, MD; C. M. K. Khamis, MD; R. E. A. L. Hulsebos, MD; Andrea J. Beshara, MD, PhD; Erin A. Mustafa, MD; and D. J. Schuemann, MD

Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis


Safe management of bodies of deceased persons with suspected or confirmed COVID-19: a rapid systematic review


Ventilation Techniques and Risk for Transmission of Coronavirus Disease, Including COVID-19

A. J. S. Schuemann, MD, PhD; Joanna Kloska, MPA; Karin Sidel, MD; C. M. K. Khamis, MD; R. E. A. L. Hulsebos, MD; Andrea J. Beshara, MD, PhD; Erin A. Mustafa, MD; and D. J. Schuemann, MD
Many SR are not actually kept up to date

76 eligible LSRs:
32 with ≥ 1 update
35 used GRADE
21 machine learning
Thirst quenched
Updates and living process possible but ...

Certainly, not when new evidence becomes available

There is loads of “not so good” evidence or evidence that is not consequential
Updated way of thinking about "living"

1. Living recommendation: a recommendation that is kept current by an optimized guideline-updating process that accounts for potentially consequential evidence as soon as or shortly after it becomes available.

2. Living guideline: a guideline that includes 1 or more related recommendations that are kept current by an optimized guideline-updating process that accounts for potentially consequential evidence as soon as or shortly after it becomes available. In a living guideline, the unit of update is the individual recommendation and not necessarily the whole guideline.
A Framework for the Development of Living Practice Guidelines in Health Care

Modelled on the GIN-McMaster checklist for guideline development - used for the ISO certified guideline training & certification program INGUIDE
Organizational planning process for living practice guidelines

Organizational adoption of living guideline methodology
- Trigger for considering the living mode
- Assess readiness of the organization
- Establish structures & processes
- Prioritize topic(s) for the living mode

Launching a specific living guideline
- Develop a protocol including living parameters
- Assess capacity for & sustainability of the project
- Form living working groups
- Prioritize PICO question(s)

Feedback loop
- Engagement of the guideline panel
- Step may be revisited
Production process for a living practice recommendation

- Prioritized PICO question
- Set living parameters
- Revisit PICO question
- Revisit living mode parameters
- Surveillance
  - Assess body of evidence
- Draft recommendation
- Revisit recommendation

Living evidence synthesis

Uptake and impact evaluation

Dissemination

Recommendation version 1
Recommendation version 2
Recommendation version n

Fig 3

Key processes:
- COI management
- Quality control
- Stakeholder engagement
- Sustainability assessment
- Crediting contribution

Initiation of living mode
Maintenance of living mode
Retirement from living mode
Retirement note
Three possible scenarios for the maintenance phase

Scenario 1: no new evidence

Scenario 2: new evidence with no potentially consequential change

Scenario 3: new evidence with potentially consequential change
Reporting and dissemination processes

**Reporting element(s)**
- Evidence surveillance time stamp
- Outcome of reassessment of body of evidence
- Outcome of recommendation revisit

Different combination of elements, different level of details go into different dissemination formats

Dissemination

Venue 1

Venue 2

Venue n

Raising awareness
Versioning and accessibility

Recommendation A

Recommendation B

Recommendation C

Recommendation D

Recommendation E

Recommendation G

Guideline version 1

Guideline version 2

Guideline version n

Recommendation view

Guideline view

New recommendation

Maintained recommendation

Retired recommendation
Example of reporting living recommendation development

In population X, intervention Y is recommended over intervention Z. (conditional recommendation, moderate certainty of evidence)

- **Evidence surveillance current to**: November 7, 2021;
- **Outcome of recommendation revisit**: Modified/Unmodified;
- **Whether this version is the latest**;
- **Link to latest version** (if applicable).
But there is a much bigger problem...
Many organizations produce guidelines or some organizations produce many guideline (recommendations)
Living recommendation maps

- Provide decision-makers and other stakeholders (including the public) with:
  - an easy-to-navigate
  - living
  - freely accessible
  - digital platform
    - that includes all available trustworthy COVID-19 recommendations and allows for easy contextualization

- Developed for WHO global tuberculosis recommendations
Recommendation mapping of the World Health Organization’s guidelines on tuberculosis: A new approach to digitizing and presenting recommendations

Trial to learn how if recommendation mapping is a good idea...

Comparing the usability of the World Health Organization’s conventional tuberculosis guidelines to the eTB recommendations map: A two-arm superiority randomised controlled trial

Micyala Matthews1,2, Tamara Lotfi1,2, Nancy Santesso1,2, Mark Loeb1,2, Dominik Mertz1,2, Zain Chagla3,4, Anisa Hajizadeh1,4, Thomas Piggott1, Bart Dietl5, Holger J. Schünemann1,2,6*

1 McMaster University Department of Health Research Methods, Evidence and Impact, Hamilton, Ontario, Canada. 2 McMaster University Michael G. DeGroote Cochrane Canada and GRADE Centre, Hamilton, Ontario, Canada. 3 Department of Medicine, McMaster University, Hamilton, Ontario, Canada. 4 Department of Primary Care, Oxford University, Oxford, United Kingdom. 5 Evidence Prime Incorporated, Hamilton, Ontario, Canada. 6 Department of Biomedical Sciences, Humanitas University, Milano, Italy

* schuneh@mcmaster.ca

ClinicalTrials.gov (NCT04745897)
Table 3. Overall accessibility of information [mean (SD)].

<table>
<thead>
<tr>
<th></th>
<th>WHO eTB(^a) (n = 122)</th>
<th>WHO TB(^a) (n = 122)</th>
<th>MD (95% CI)(^b) p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Accessibility(^c)</td>
<td>5.6 (1.0)</td>
<td>4.7 (1.5)</td>
<td>0.9 (0.6, 1.2) &lt; 0.001</td>
</tr>
<tr>
<td>It was easy to find the information</td>
<td>5.6 (1.1)</td>
<td>4.4 (1.9)</td>
<td>1.1 (0.7, 1.5) &lt; 0.001</td>
</tr>
<tr>
<td>This website was easy to navigate</td>
<td>5.6 (1.2)</td>
<td>4.3 (1.8)</td>
<td>1.3 (0.9, 1.7) &lt; 0.001</td>
</tr>
<tr>
<td>It was easy to understand the information</td>
<td>5.6 (1.0)</td>
<td>5.0 (1.6)</td>
<td>0.6 (0.3, 0.9) 0.001</td>
</tr>
<tr>
<td>The information was presented in a way that would help me make a decision</td>
<td>5.7 (1.0)</td>
<td>5.0 (1.5)</td>
<td>0.7 (0.3, 1.0) &lt; 0.001</td>
</tr>
</tbody>
</table>

Abbreviations: SD, standard deviation; WHO, World Health Organization; TB, tuberculosis; MD, mean difference; CI, confidence interval.
\(^a\) Likert-scale from 1 = strongly disagree to 7 = strongly agree.
\(^b\) Equal variances could not be assumed using Levene’s test, degrees of freedom adjusted.
\(^c\) Composite of four domains (primary outcome).

https://doi.org/10.1371/journal.pgh.0001166.t003
Then came ...
Living map of guideline recommendations on COVID19 (covid19.recmap.org)
Quality appraisal


Source: World Health Organization (WHO)

Intent: Infection control

In settings where there is community or cluster transmission of SARS-CoV-2, irrespective of vaccination status or history of prior infection, wearing a well-fitting mask that covers the nose and mouth is recommended for the general public when interacting with individuals who are not members of their household.
## Covid19 Extraction

**NICE - COVID19 rapid guideline: Interstitial lung disease - Joanne/Elizabeth**

### General information

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link to the source document</td>
<td><a href="https://www.nice.org.uk/guidance/ng177">https://www.nice.org.uk/guidance/ng177</a></td>
</tr>
<tr>
<td>ISBN (International Standard Book Number)</td>
<td>Not Reported</td>
</tr>
<tr>
<td>DOI (Digital Object Identifier)</td>
<td>Not Reported</td>
</tr>
<tr>
<td>PMID (PubMed Identifier)</td>
<td>Not Reported</td>
</tr>
<tr>
<td>Were guideline group details provided?</td>
<td>NO</td>
</tr>
<tr>
<td>Declaration of interest</td>
<td>YES</td>
</tr>
<tr>
<td>Described as rapid</td>
<td>NOT</td>
</tr>
<tr>
<td>Described as living</td>
<td>YES</td>
</tr>
<tr>
<td>Did the search include non-English databases? (e.g., Chinese, others)</td>
<td>YES</td>
</tr>
<tr>
<td>Latest date of literature search</td>
<td>Not reported dd-mm-yyyy</td>
</tr>
<tr>
<td>Method of grading evidence</td>
<td>Not graded</td>
</tr>
</tbody>
</table>

*In case of "NO COI" reported, classify as "YES".*
List view

Recommendation
In settings where there is community or cluster transmission of SARS-CoV-2, irrespective of vaccination status or history of prior infection, wearing a well-fitting mask that covers the nose and mouth is recommended for the general public when interacting with individuals who are not members of their household.

Certainty of evidence
 Moderate

Recommendation strength
 strong

Good Practice Statement
Commercial vehicle operators who are federally regulated for Occupational Health and Safety should ensure that their Hazard Prevention Program is current to address the hazards of COVID-19 in their workplaces, including in truck cabs.

Good Practice Statement
Commercial vehicle drivers should be aware of the public health requirements and advice of the areas they are in and should follow local public health advice (e.g., travel restrictions, wearing of non-medical masks in various settings).

Additional Guidance
The network of SARS-CoV-2 testing facilities should leverage and build on existing capacities and capabilities, be able to integrate new diagnostic technologies and adapt capacity according to the epidemiological situation, available resources and country specific context.
### Map view

#### Intent

#### Population

<table>
<thead>
<tr>
<th>Category</th>
<th>All</th>
<th>Infection control</th>
<th>Vaccination</th>
<th>Screening</th>
<th>Diagnosis</th>
<th>Treatment and rehabilitation</th>
<th>Prognosis</th>
<th>Planning and monitoring</th>
<th>Health services and systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 confirmed</td>
<td>1907</td>
<td>303</td>
<td>49</td>
<td>42</td>
<td>87</td>
<td>1244</td>
<td>6</td>
<td>86</td>
<td>90</td>
</tr>
<tr>
<td>Healthcare professional</td>
<td>861</td>
<td>432</td>
<td>112</td>
<td>45</td>
<td>72</td>
<td>38</td>
<td></td>
<td>20</td>
<td>140</td>
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<tr>
<td>Public</td>
<td>800</td>
<td>350</td>
<td>159</td>
<td>43</td>
<td>49</td>
<td>9</td>
<td></td>
<td>82</td>
<td>108</td>
</tr>
<tr>
<td>COVID-19 suspected</td>
<td>664</td>
<td>291</td>
<td>14</td>
<td>58</td>
<td>136</td>
<td>76</td>
<td>1</td>
<td>28</td>
<td>60</td>
</tr>
<tr>
<td>Patient</td>
<td>593</td>
<td>121</td>
<td>85</td>
<td>26</td>
<td>66</td>
<td>215</td>
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- **Publication Year**
- **Adolopment**
- **AGREE II score**
- **World region**
- **Age group**
# Linkage between living platforms

<table>
<thead>
<tr>
<th>Population/Health problem</th>
<th>Patients with COVID-19</th>
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<tr>
<td><strong>Intervention</strong></td>
<td>Interferon β-1a plus lopinavir-ritonavir</td>
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<tr>
<td><strong>Links to WHO Model List of Essential Medicines</strong></td>
<td>Lopinavir + ritonavir</td>
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<td><strong>URL to evidence table</strong></td>
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<tr>
<td><strong>URL to L-OVE portal</strong></td>
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Plain language recommendations

PLRs are easy-to-read summaries of up-to-date, published, and quality-checked recommendations from guideline organizations.

PLRs go through a multi-stakeholder process before it is published on the eCOVID19 RecMap. Hope to avoid this in the future by creating them in the first place.
Living gateway to contextualization of recs

• Request access to Adolopment module
• Contribute back to map
• Others benefit from your decision-making
• Labelled as ‘adoloped’ on map
Health and equity have a central place in the 2030 Agenda for Sustainable Development that was adopted by all United Nations Member States. Implementation of evidence-based practice (EBP) principles has resulted in major advances in improving the quality of delivered health care. One of the EBP instruments are evidence-based trustworthy guidelines. The Pan American Health Organization (PAHO), the World Health Organization (WHO) and indexed and hard to find which threatens the extent evidence is used. Several scientific repositories such as Health Systems Evidence, Evidencelinkmetro or Top database are available for those interested in public health or clinical practice. BIGG from the acronym in Spanish "International Database of Grade Guidelines", includes a comprehensive list of worldwide guidelines developed with the GRADE system and classified according to the Sustainable Development Goal.
But many of low credibility 😎
RecChat

AI supported identification and summaries of guidelines recommendations

- Filter for credibility
- Based on RecMaps: chat.recmap.org
- In testing but **pronto** very soon

The IDSA panel suggests using remdesivir over no antiviral treatment in hospitalized patients with severe COVID-19 [1]. They specifically recommend treatment with five days of remdesivir for patients on supplemental oxygen but not on mechanical ventilation or ECMO [2]. Additionally, remdesivir can be used in the early phase of COVID-19 (within 7 days of symptom onset) for patients who are not vaccinated and have at least one risk factor for a severe course [3].

**Source 1:** ▶️ (high AGREE score)

Formal recommendation from *Infectious Diseases Society of America* published in *Infectious Diseases Society of America Guidelines on the Treatment and Management of Patients with COVID-19* (2023)

In hospitalized patients with severe* COVID-19, the IDSA panel suggests remdesivir over no antiviral treatment. *Severe illness is defined as patients with SpO2 ≤94% on room air.

[Open in eCOVID-19 RecMap]

**Source 2:** ▶️ (high AGREE score)

Formal recommendation from *Infectious Diseases Society of America* published in *Infectious Diseases Society of America Guidelines on the Treatment and Management of Patients with COVID-19* (2023)

In patients on supplemental oxygen but not on mechanical ventilation or ECMO, the IDSA panel suggests treatment with five days of remdesivir rather than 10 days of remdesivir.

[Open in eCOVID-19 RecMap]

**Source 3:** ▶️ (high AGREE score)

Formal recommendation from *The Association of the Scientific Medical Societies of Germany (AWMF)* published in *Recommendations for the treatment of patients with COVID-19* (2023)

Remdesivir can be used in the early phase (≤7 days after the onset of symptoms) in patients with COVID-19 who are not vaccinated and have at least one risk factor for a severe course.

[Open in eCOVID-19 RecMap]
Canadian Guidelines on Post-COVID-19 Condition

The McMaster University team, with financial and scientific support from the Public Health Agency of Canada (PHAC), will develop six evidence-based guidelines on post-COVID-19 condition using rigorous scientific methods.

Our goal is to use the best available evidence to provide clinicians, decision-makers, policymakers, and the public in Canada with detailed guidance to make informed health decisions about post-COVID-19 condition (PCC). We intend to prioritize topics that are most important to these audiences through a careful and inclusive process, while also considering the needs of equity-deserving groups.
Summary

• Living guidelines – what they are and aren’t
  • Definitions help with understanding what they are
  • Change over time
  • Consequential evidence
  • Learnings along the way

• Better approaches to cataloguing in a live fashion and allowing for adaptation → RecMaps: Tb, eCOVID, BiggRec

• A taste of RecChat