Tech enablers for living evidence - Covidence & MAGICapp

Living Evidence Network "state of the science" webinar

18 Sep 2019

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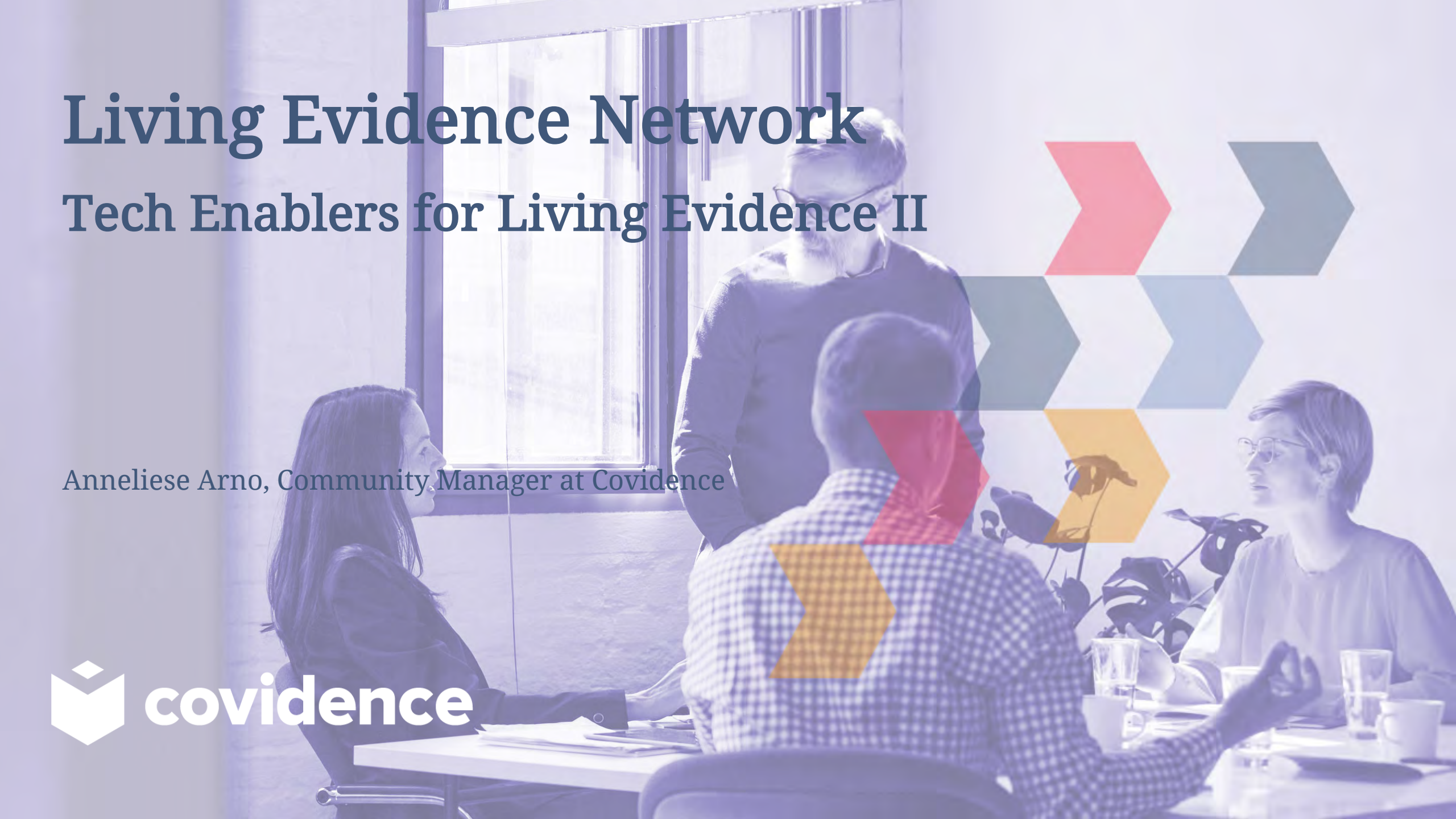
MAGIC Evidence Ecosystem Foundation
Board Member,

Trusted evidence.
Informed decisions.
Better health.

Living Evidence Network

Tech Enablers for Living Evidence II



Anneliese Arno, Community Manager at Covidence

covidence

Contents

- What is Covidence?
  - Background
  - Current capabilities
- How does Covidence support Living Evidence?
  - Now
  - Soon
  - Later

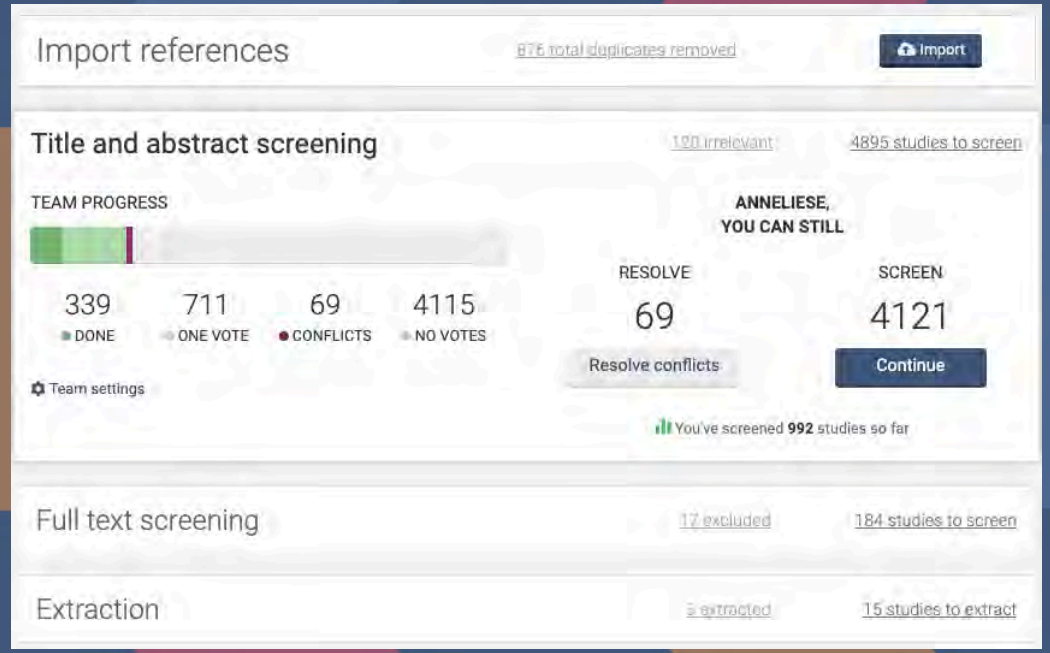
What is Covidence?

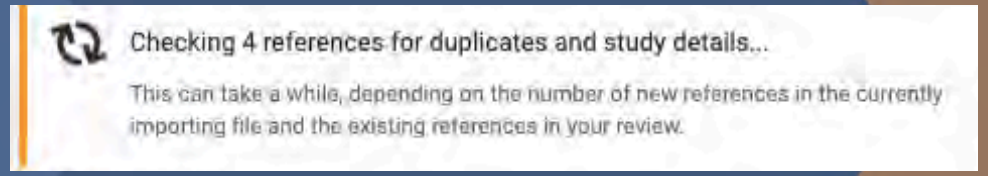
- Covidence is an online platform for systematic review production
- Our vision is a world shaped by the best evidence possible
- Our mission is to create tools to make systematic reviewing faster, easier, and more enjoyable
- Part of Cochrane toolkit

covidence

What can I do in Covidence?

- Covers the systematic review process from screening through the beginning of meta-analysis
- Currently can import EndNote formatted XML, or RIS text files
- Currently can export to RevMan 5 or to Excel





How does Covidence support Living Evidence?

- Reduction in time to create a review: average 35% efficiency gain
- Supporting review training through partnerships
  - Early career researchers
  - Low and Lower-middle income country partnerships

How does Covidence support Living Evidence?

- Available now:
  - Study triage
  - RCT classifier
- In progress:
  - Living PRISMA
  - CRS importer
  - RevMan Web integration
- Longer term ideas

Available now

Some context

- All Covidence reviews have three main stages: Title/Abstract Screening, Full Text Review, and Extraction
- During screening, customised tags may be added to studies

Study Triage

- Problem: researchers duplicating effort by having to screen each question separately
- Solution: allow for studies to be included in multiple reviews simultaneously
- Aim: increased data re-use

Study Triage

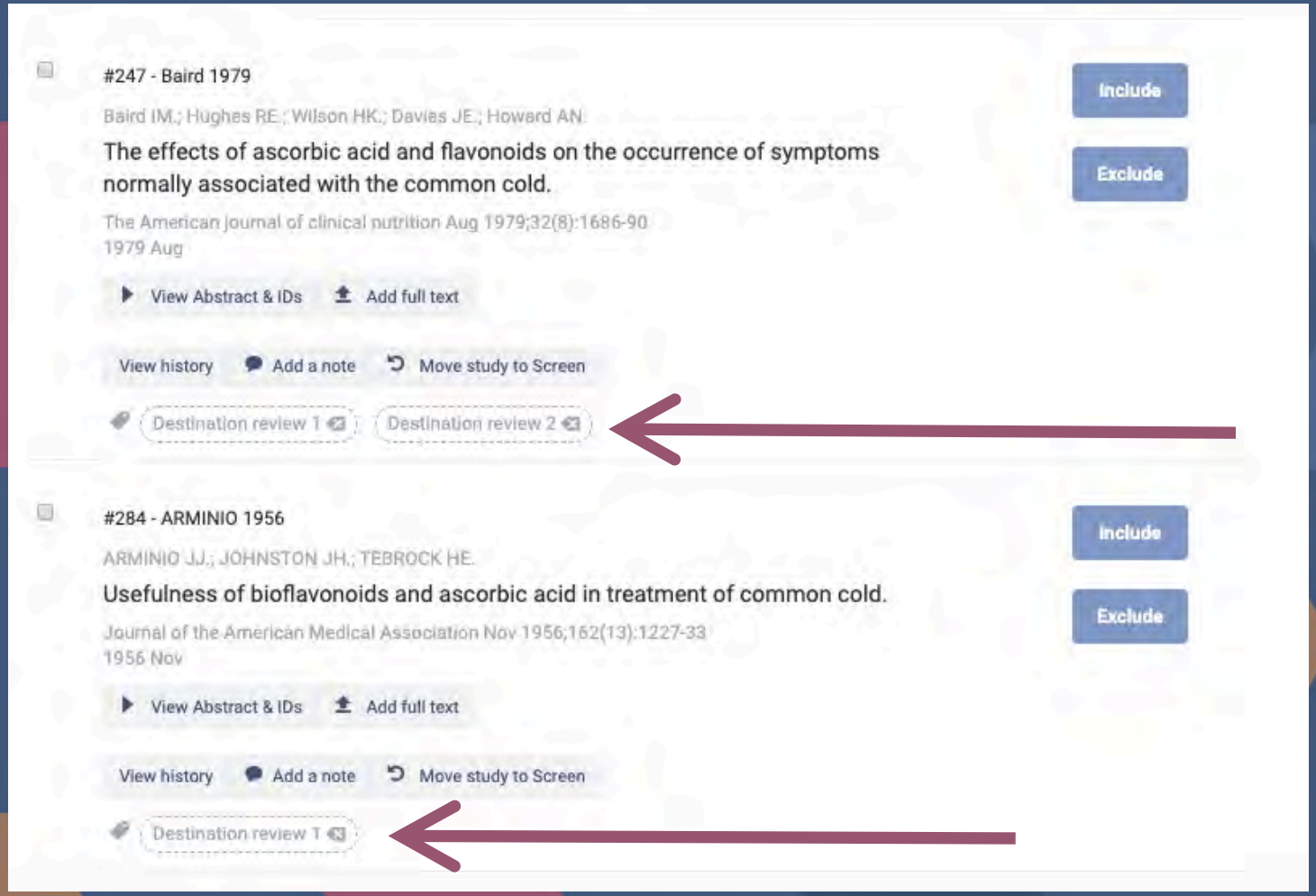
Tags present during Full Text Review

→

Included vote

→

Study imported to destination review(s)

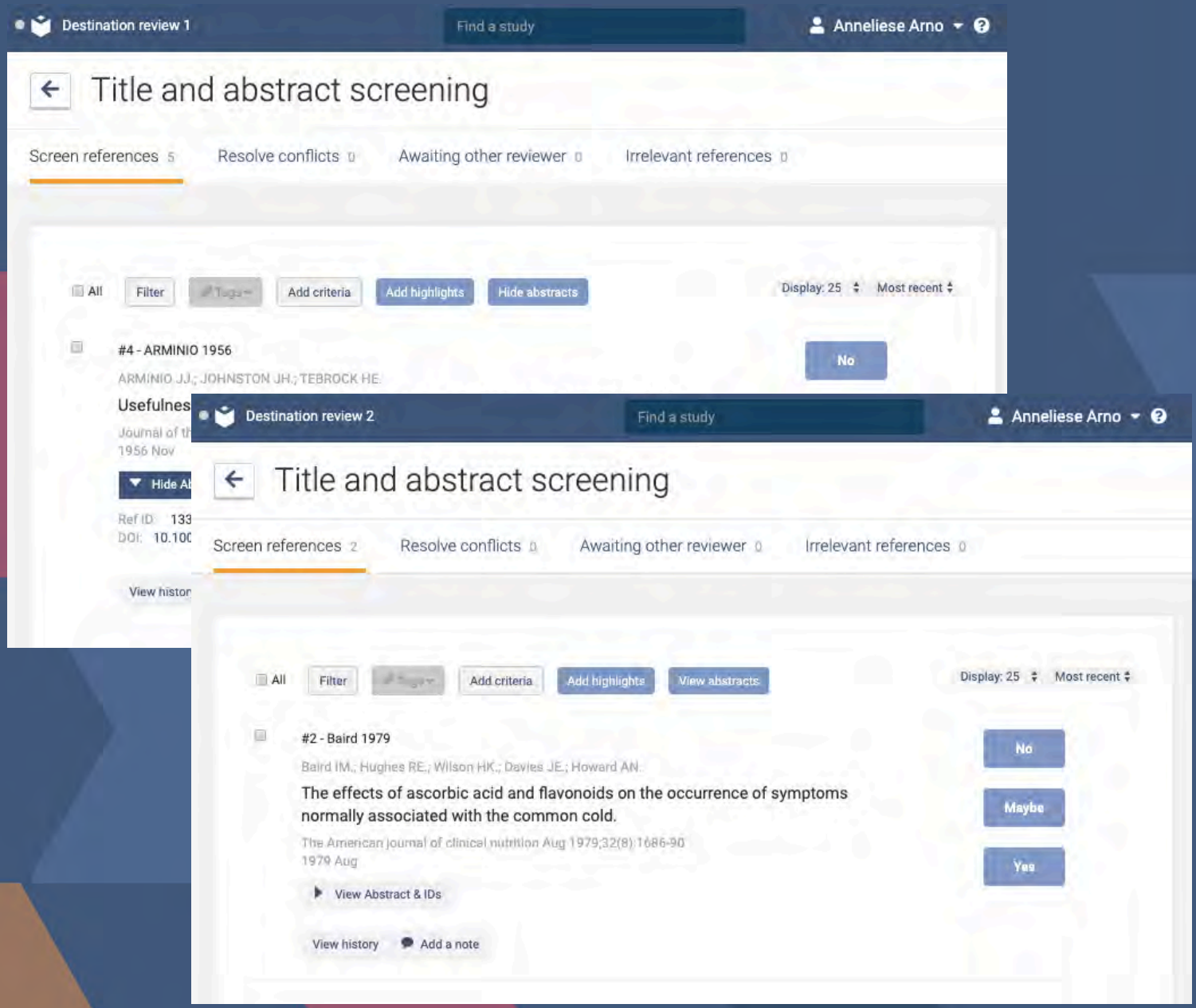


Study Triage

Currently in use for several living guidelines

To access:

- Contact support@covidence.org
- Name of review
- Names of destination reviews

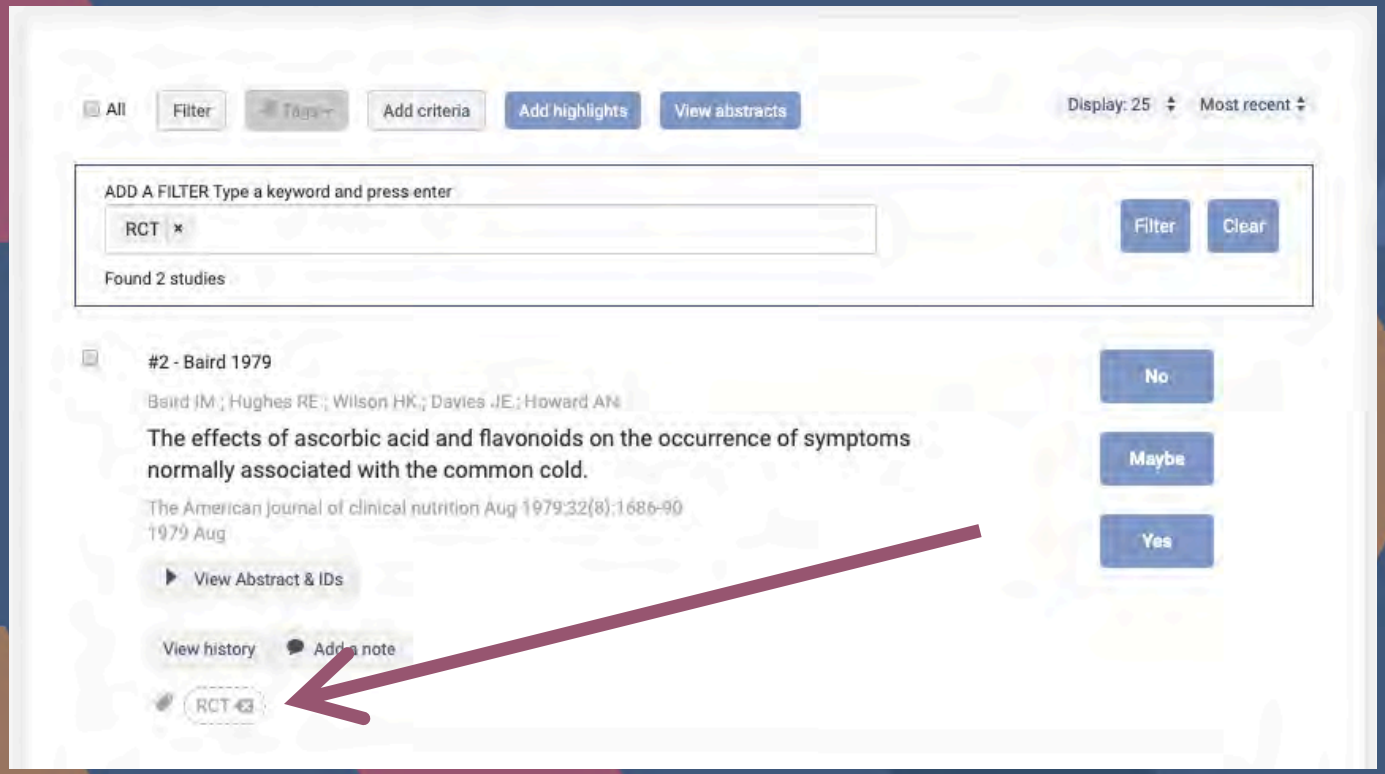


RCT classifier

- Problem: researchers spend too much time on screening
- Solution: Integrate Cochrane-developed machine assistance into Covidence screening
- Aim: faster screening
  - Previously demonstrated at 60-80% reduction in effort

RCT classifier

- Uses natural language processing assign score to studies
- Covidence creates “RCT” tag and applies it to studies with score of 99% or higher
- Tags can be used to filter screening list
- All voting still done by user



RCT classifier

- Currently active on several reviews
- To access:
  - Contact support@covidence.org
  - Name(s) of review(s)

In progress

Living PRISMA

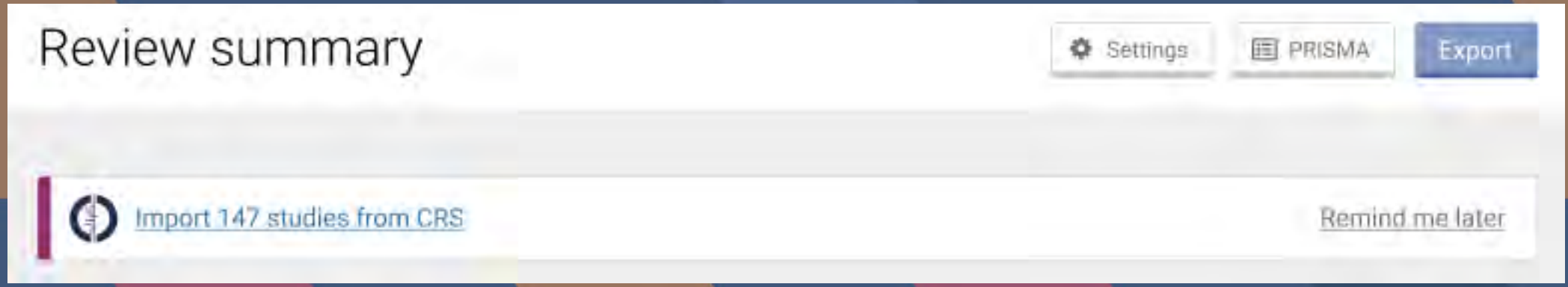
- Problem: reviewers are unsure of rate of eligible study publication
- Solution: store data over time relating to PRISMA flowchart
- Long term aim: allow users to view date-specific PRISMA

Living PRISMA: current state

- Covidence collects information on when citations are imported down to the day
- This data is stored in a spreadsheet
- To access this, please contact support@covidence.org

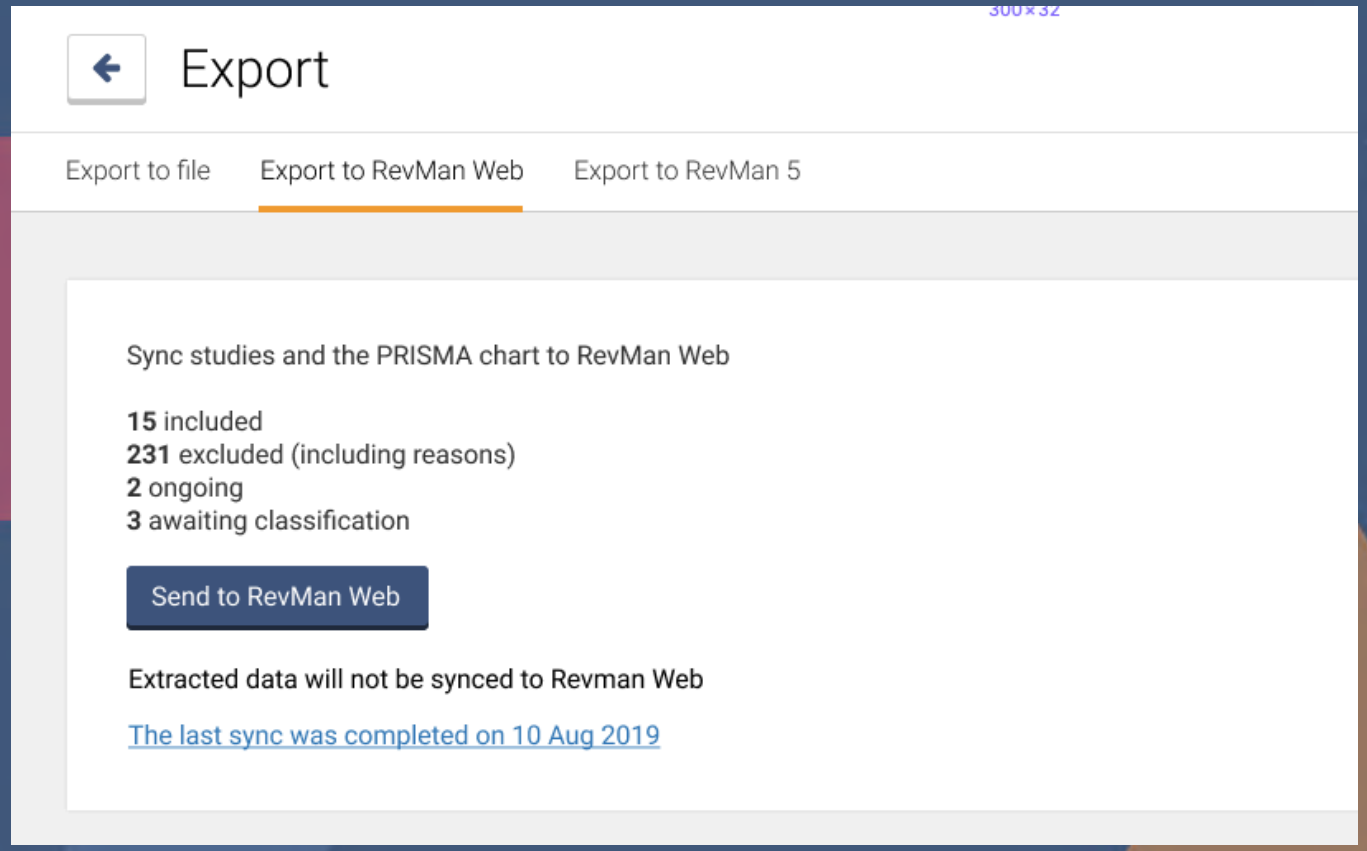
CRS import

- Problem: users are unaware of new studies to screen
- Solution: better integration between Covidence and CRS
- Long term aim: more timely screening updates



RevMan Web

- Problem: reviewers can't easily export data to existing reviews
- Solution: integration between Covidence and RevMan Web
- Aim: increased visibility of currency of data



Longer term ideas

- Covidence as a platform for collaboration
- Sharing of data and work
- Increased visibility of ongoing research
- More machine learning
- Crowd sourcing

Thank you!

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Using the MAGICapp to enhance the Evidence Ecosystem

Reproduced from cover page of JAMA, Users' Guide to the Medical Literature, 3rd ed.

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Assistant Professor,
Department of HEI, McMaster University

@ThomasAgoritsas

MAGIC Evidence Ecosystem Foundation

➢ http://magicproject.org

Improving patient care through a trusted evidence ecosystem

MAGIC is a non-profit foundation, our goal is to increase value and reduce waste in healthcare through a digital and trustworthy evidence ecosystem. MAGICapp is our core platform in the evidence ecosystem bringing digitally structured guidelines, recommendations and decision aids to patients and clinicians.

MAGIC Evidence Ecosystem Foundation

➢ http://magicproject.org

Improving patient care through a trusted evidence ecosystem

MAGIC is a non-profit fo
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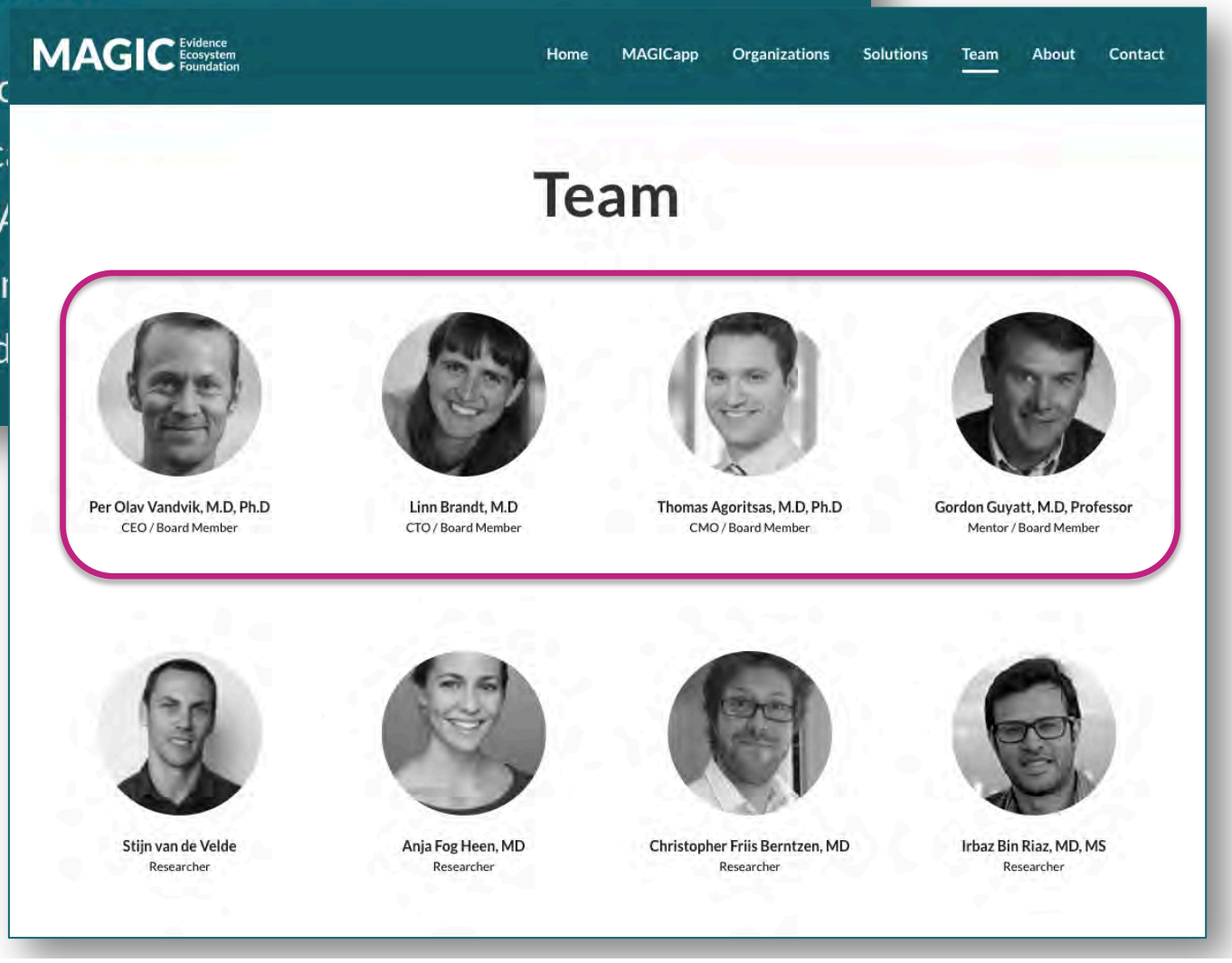

MAGIC Evidence Ecosystem Foundation

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- **https://app.magicapp.org**

Authoring & Publication Platform

MAGIC authoring and publication platform (MAGICapp) - for guidelines and evidence summaries - is developed through our research and innovation program.

The platform allows authors to write and publish their guidelines and evidence summaries in a highly structured fashion, using the GRADE methodology, new technology and a host of recent developed frameworks. MAGICapp is a web based collaborative tool that does not require any software installation and allows publication on all devices.

All researchers in MAGIC are practicing physicians devoted to evidence-based medicine and clinical epidemiology. We are also members of the GRADE working group and know from first hand experience that writing a guideline is a complex task and that many struggle with the methodology and the processes around.

MAGICapp includes features to guide you through the process of writing and publishing a guideline. A lot of research and effort has gone into improving the user interface of the platform – both for authors and readers.

- **https://app.magicapp.org**

I have no financial conflict of interest in relation to this presentation.

My intellectual conflict of interests:

- Board member of the **MAGIC** organization http://magicproject.org
- Member of the **GRADE** Working Group http://www.gradeworkinggroup.org
- **Deputy editor ACP journal club** – McMaster PLUS Evidence Alerts
- Co-founded the **BMJ RapidRec** http://www.bmj.com/rapid-recommendations
- **Living Evidence Network** Steering Group

Cochrane

Trusted evidence.
Informed decisions.
Better health.

Cochrane and MAGIC announce partnership

Cochrane and MAGIC (http://magicproject.org/) are delighted to announce the launch of an official partnership, aimed at supporting and further strengthening the use of health evidence within the context of a digital and trustworthy evidence ecosystem for health care.

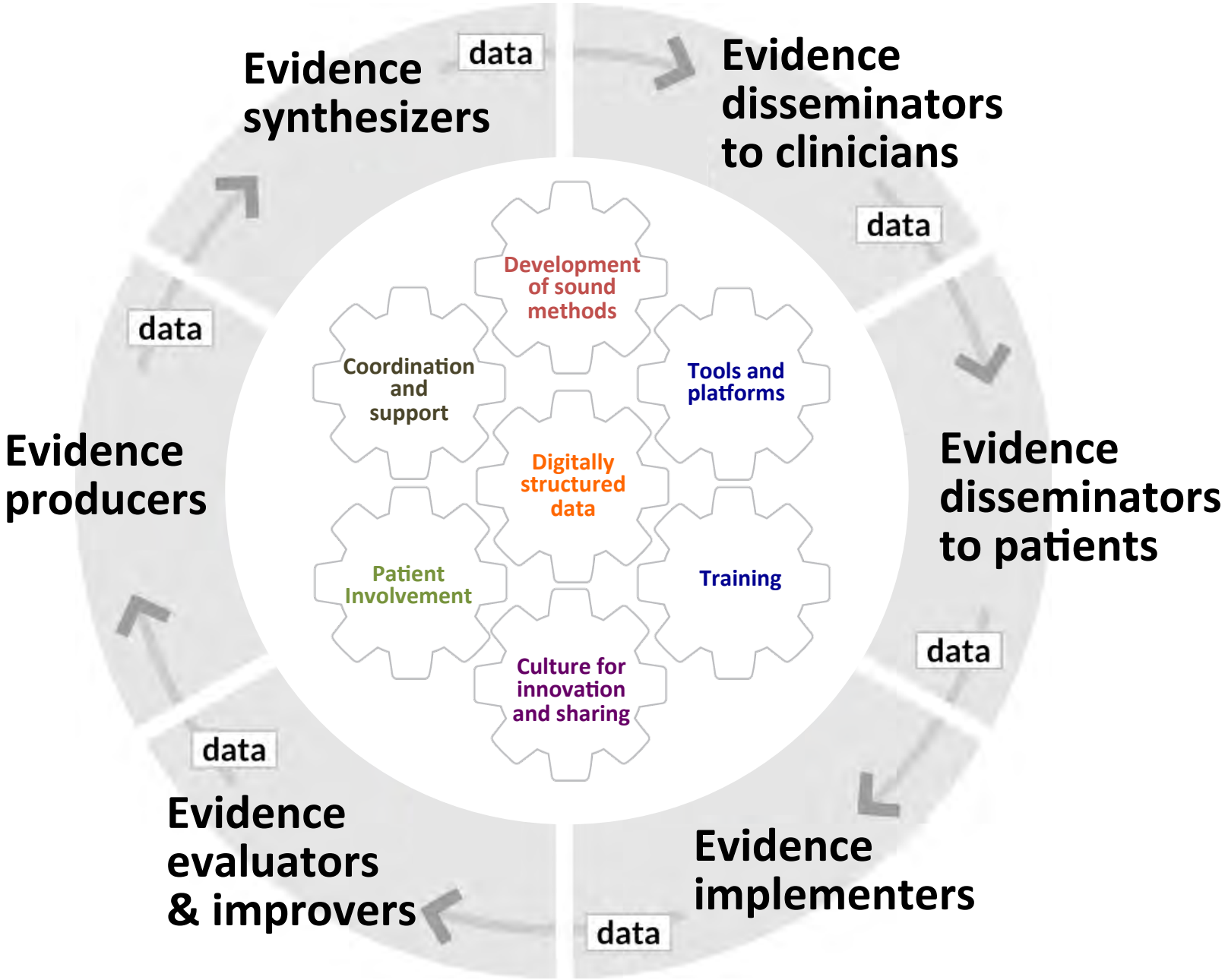
MAGIC (formally known as the MAking GRADE the Irresistible Choice (MAGIC) organization) is a non-profit research and innovation programme set up to make evidence summaries and recommendations that work for clinicians at the point of care and to facilitate shared decision-making with patients. Established in 2010, the MAGIC project has, among a number of other initiatives, developed the MAGICapp, a web-based platform for preparing guidelines using structured data systems and validated methods.

Cochrane and MAGIC wish to continue a history of working together by establishing a formal partnership to harmonize the flow of data from systematic reviews to guidelines development and decision support systems. To this end, the organizations have signed a Memorandum of Understanding to structure and focus our collaborative work for the next three years.

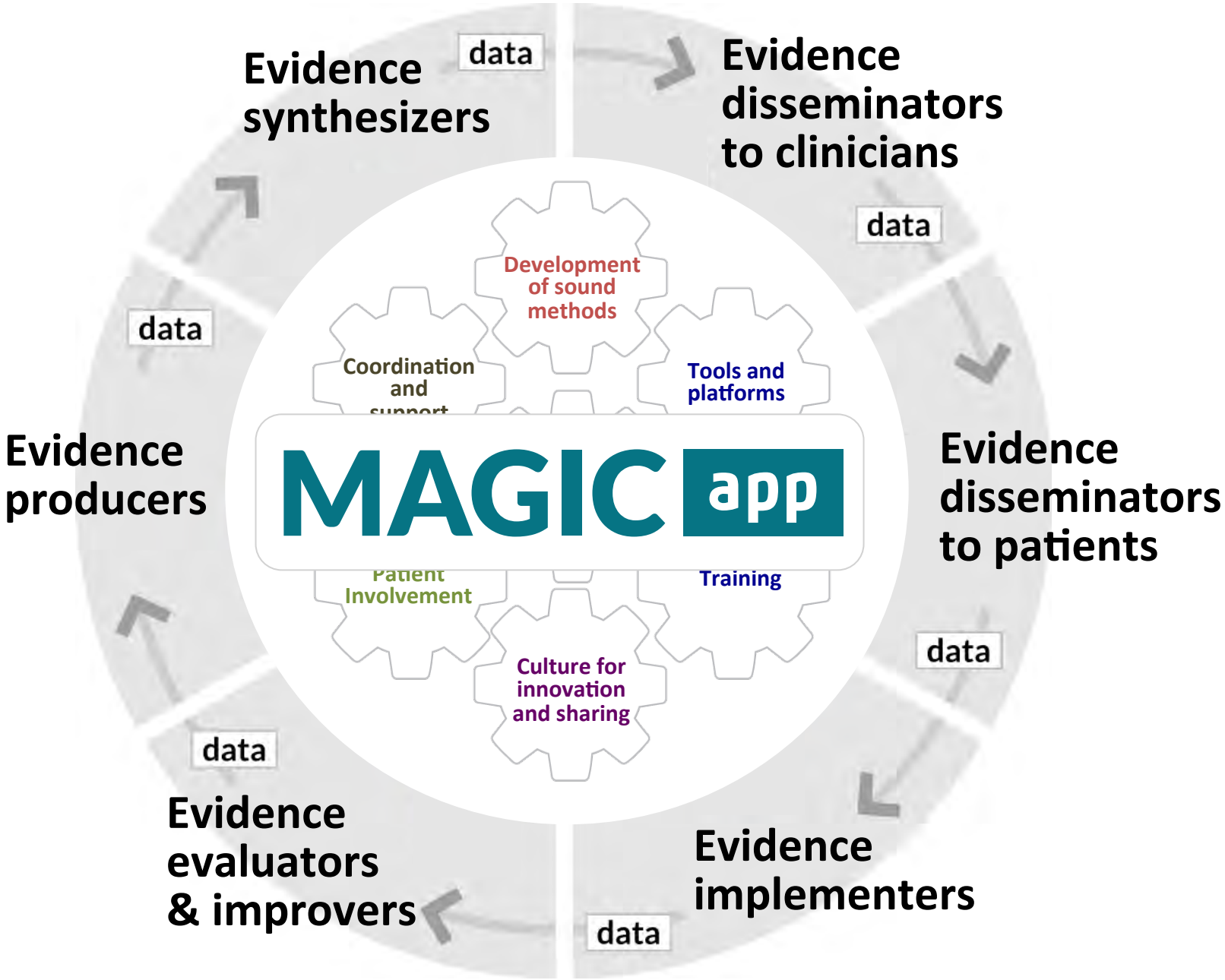
Mark Wilson, Cochrane CEO, said: 'We are delighted to be deepening our relationship with MAGIC through this new partnership. Cochrane and MAGIC share a passion for innovation, collaboration and commitment to making health and healthcare evidence more accessible and usable. I'm excited that by

The Evidence Ecosystem

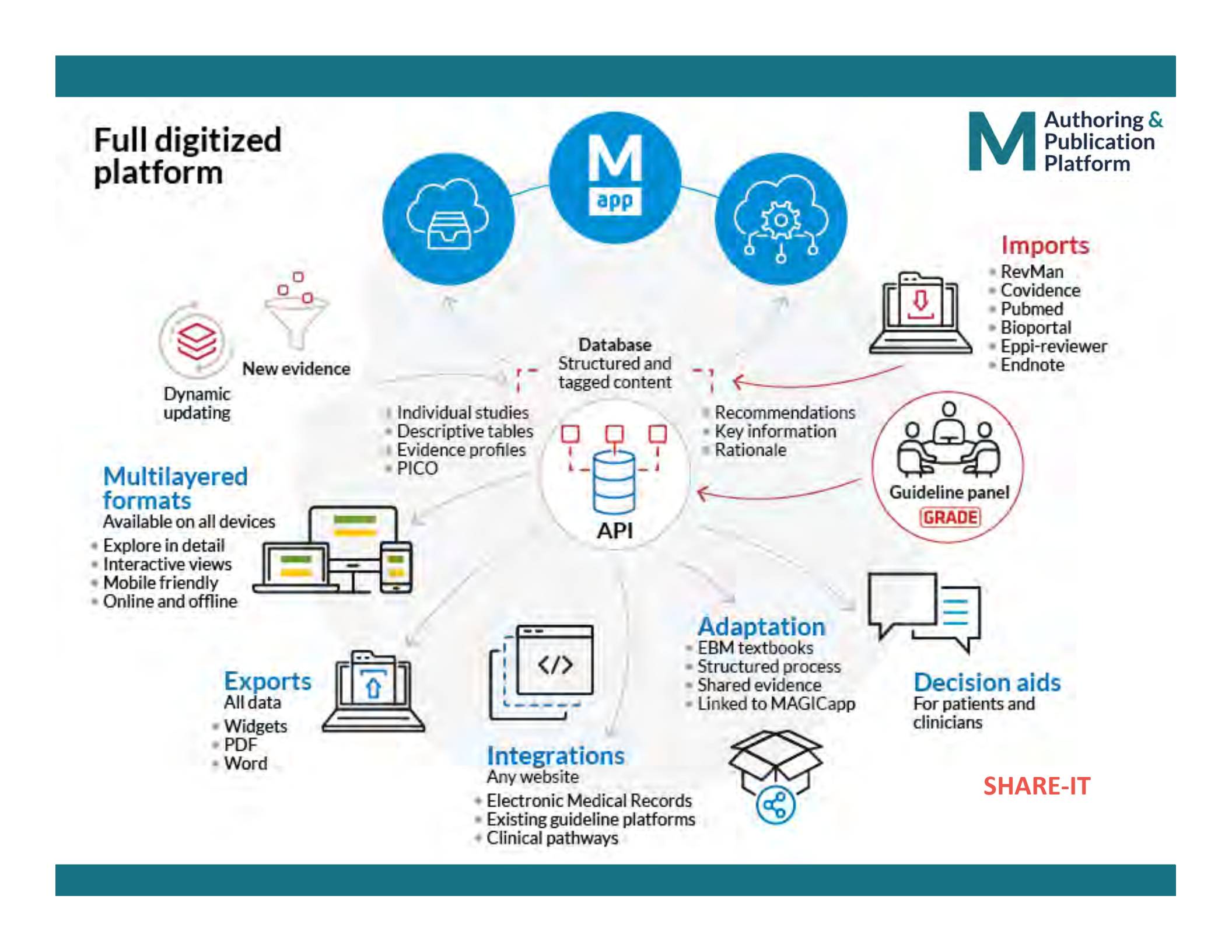
The Evidence Ecosystem

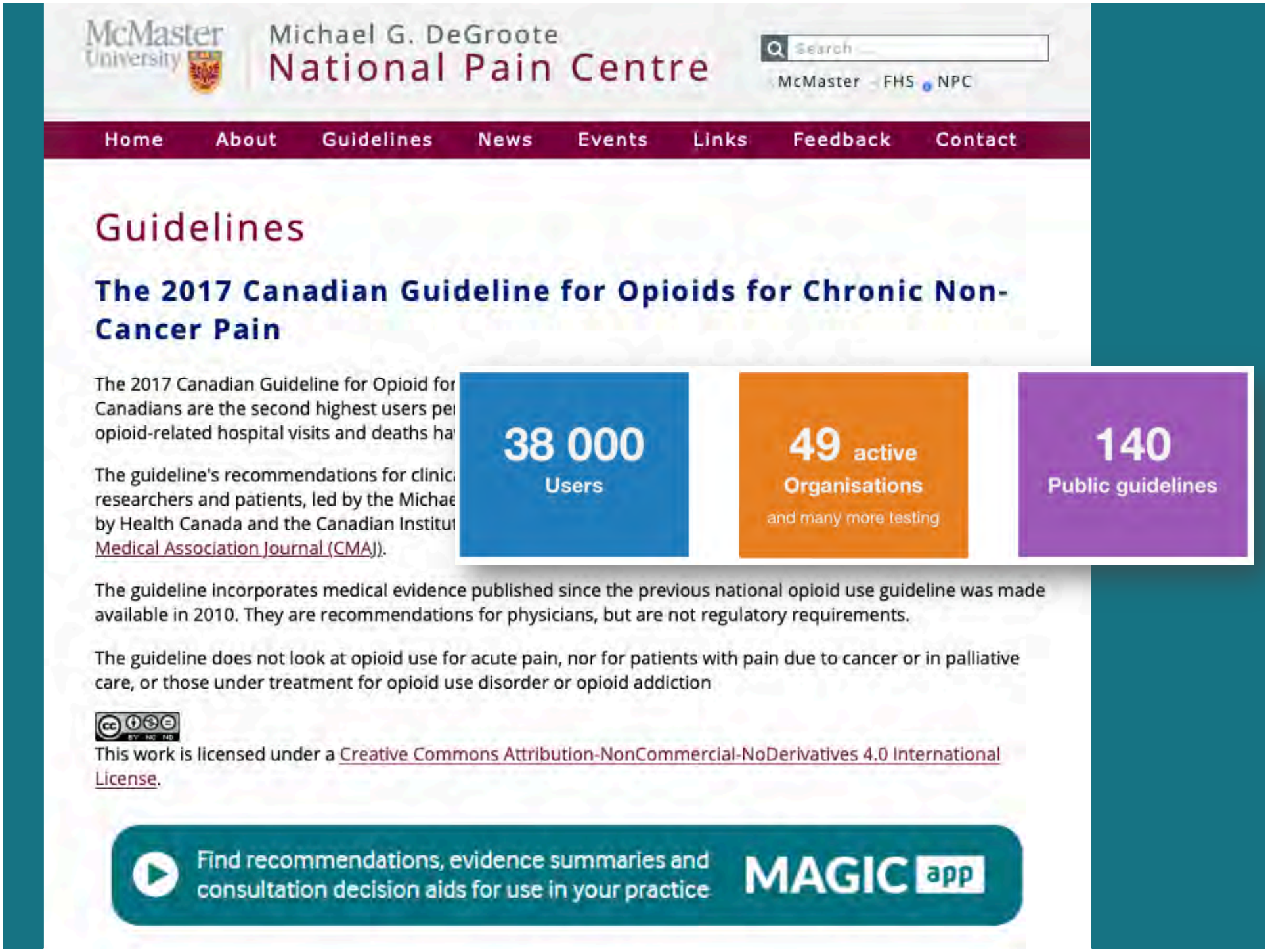


The Evidence Ecosystem



Full digitized platform




McMaster University
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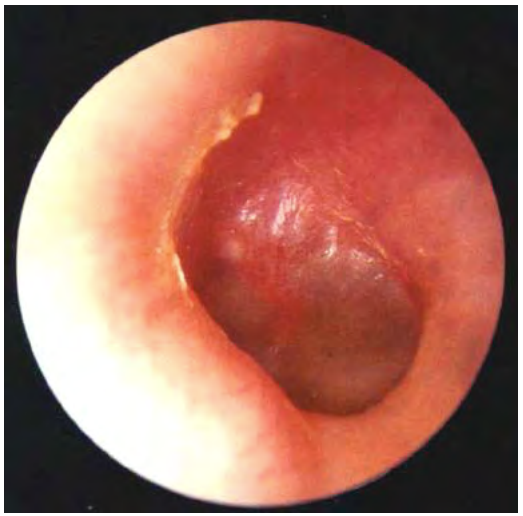
The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain
The 2017 Canadian Guideline for Opioid for
Canadians are the second highest users per
opioid-related hospital visits and deaths hav
The guideline's recommendations for clinic
researchers and patients, led by the Michae
by Health Canada and the Canadian Institut
Medical Association Journal (CMAJ).
38 000
Users
49 active
Organisations
and many more testing
140
Public guidelines
The guideline incorporates medical evidence published since the previous national opioid use guideline was made available in 2010. They are recommendations for physicians, but are not regulatory requirements.
The guideline does not look at opioid use for acute pain, nor for patients with pain due to cancer or in palliative care, or those under treatment for opioid use disorder or opioid addiction
This work is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License.
Find recommendations, evidence summaries and consultation decision aids for use in your practice
MAGIC app

A pair of siblings are seen in consultation…

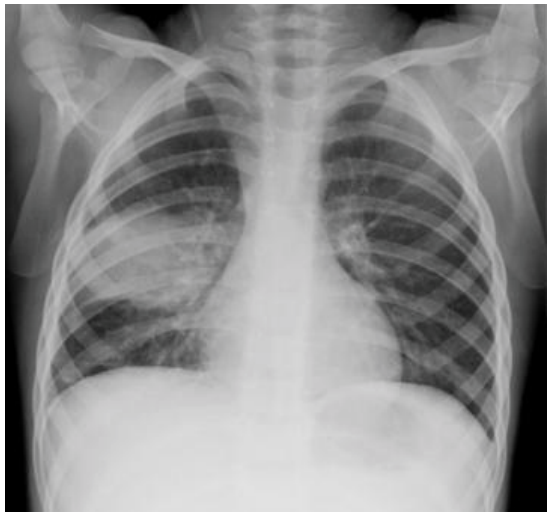
Peter, 14 months
Fever two days
38.9°



Otitis media

Laura, 4 years old

- Cough and fever 5 days
- 39.5°, saturation 96%



Pneumonia

→ Amoxicillin 80mg/kg/j

A pair of siblings are seen in consultation…

Peter, 14 months
Fever two days
38.9°

Laura, 4 years old
•

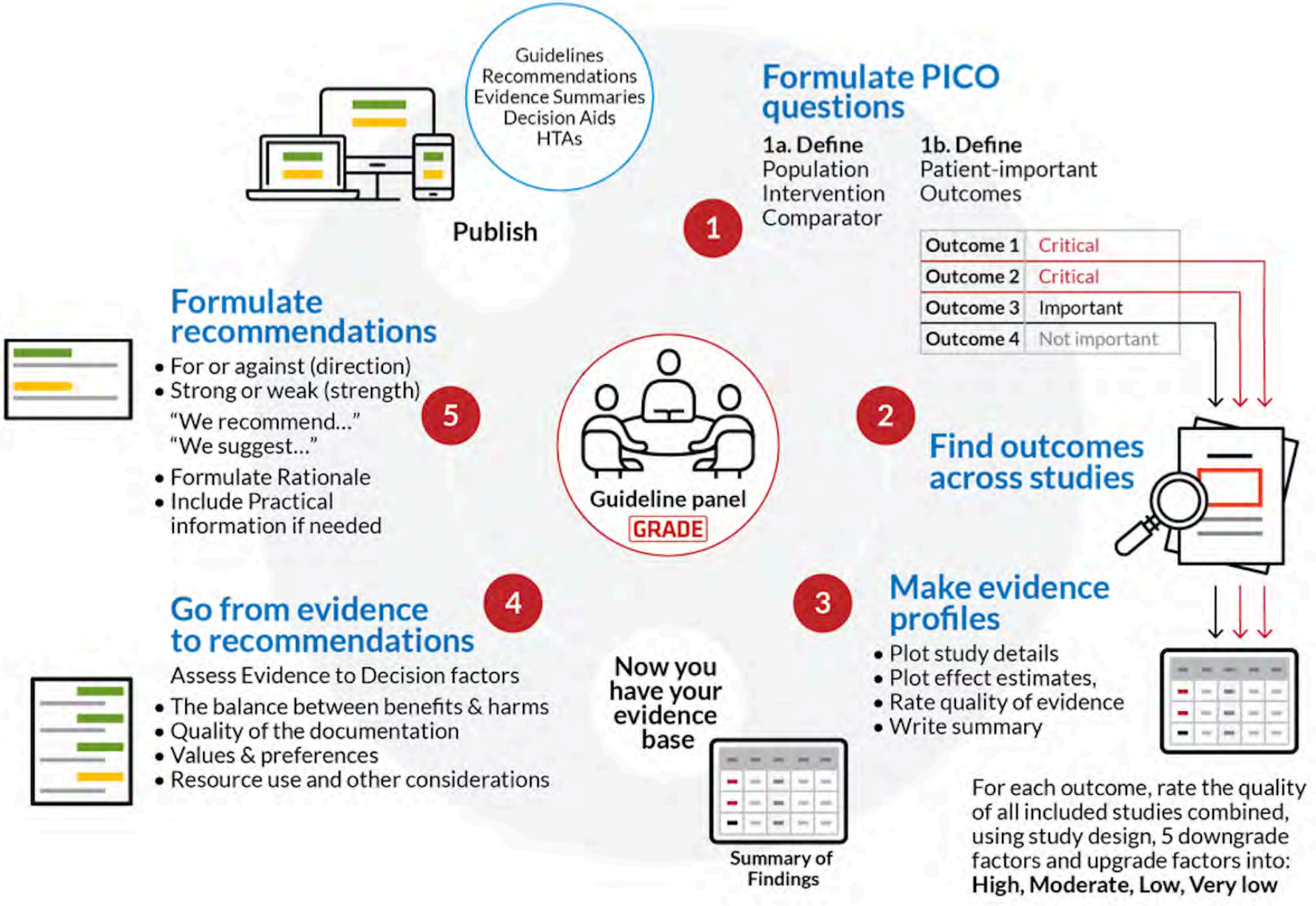
"Doctor, do you think my children should take **probiotics**? Laura had them last time that she had antibiotics, and I think it helped."

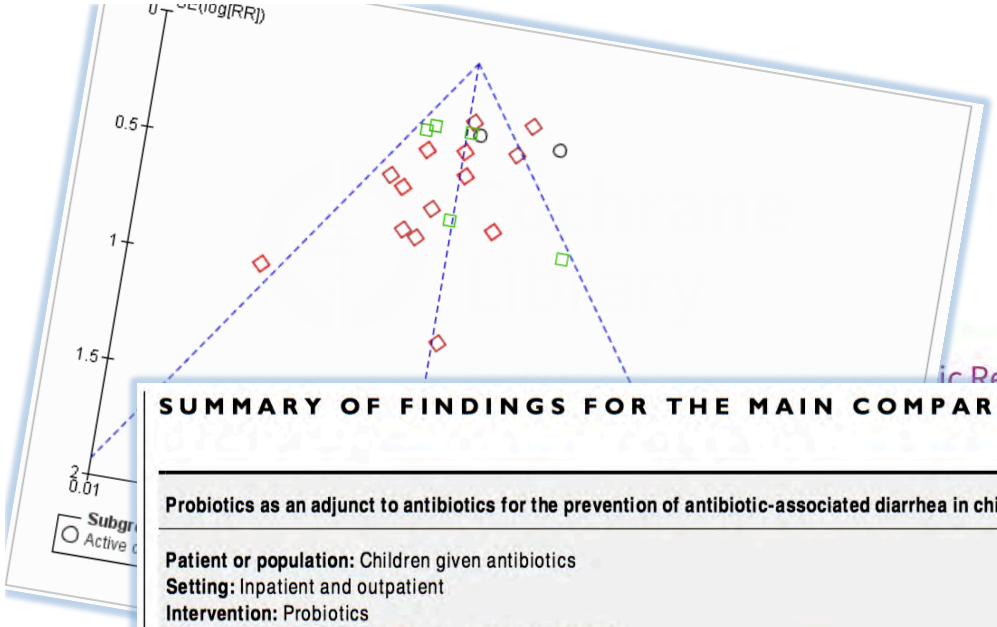
How can we get **trustworthy and usable recommendations**?

Pneumonia

→ **Amoxicillin 80mg/kg/j**

Guideline development in MAGICapp





SUMMARY OF FINDINGS FOR THE MAIN COMPARISON *[Explanation]*

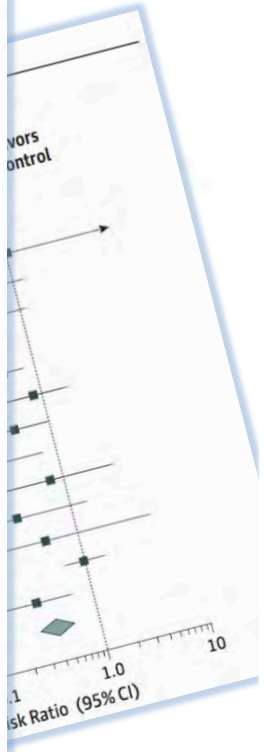
Probiotics as an adjunct to antibiotics for the prevention of antibiotic-associated diarrhea in children

Patient or population: Children given antibiotics
Setting: Inpatient and outpatient
Intervention: Probiotics
Comparison: Control (placebo or no active treatment)

Outcomes	Anticipated absolute effects* (95% CI)		Effect size (95% CI)	Number of participants (studies)	Quality of the evidence (GRADE)	Comments
	Risk with control	Risk with Probiotics				
Incidence of diarrhea Follow up: range 1 week to 12 weeks	191 per 1000	88 per 1000 (67 to 116)	RR 0.46 (0.35 to 0.61)	3898 (22 RCTs)	⊕⊕⊕◯ MODERATE[1,2]	
Adverse events Follow up: range 1 week to 4 weeks	35 per 1000	33 per 1000 (15 to 72)	RD 0.00 (-0.01 to 0.01)	2455 (16 RCTs)	⊕◯◯◯ VERY LOW[3,4,5]	
Duration of diarrhea Follow up: range 10 days to 12 weeks		The mean duration of diarrhea in the intervention group was 0.6 days fewer (1.18 fewer to 0.02 fewer)		897 (5 RCTs)	⊕⊕◯◯ LOW[6,7]	
Stool frequency Follow up: range 10 days to 12 weeks		The mean stool frequency in the intervention group was 0.3 lower (0.6 lower to 0)		425 (4 RCTs)	⊕⊕◯◯ LOW[,8,9]	

***The risk in the intervention group** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: Confidence interval; **RR:** Risk ratio; **RD:** Risk difference;



References | Evidence | Recommendations

Search for recommendations

Changed fields | Undo all changes

1 Relative effect of intervention vs. comparator

SOURCE OF EVIDENCE

Systematic review/ meta

Systematic review:
Studies: 0

Add and show evidence

DATA FROM INCLUDED STUDIES Autofill from added studies

3,898 patients in 22 Studies.

Randomized controlled

Follow up (in studies)

1-12 weeks

RELATIVE EFFECT (FROM STUDIES)

Relative risk 0.46

CI 95% (0.35 - 0.61)

2 Baseline risk (result of the outcome in the comparison group): No probiotics

SOURCE OF EVIDENCE

Single/primary stud(ies)

Studies: 0

Add and show evidence

DATA FROM INCLUDED STUDIES

336 control participants in 1 Studies.

Observational (non-randomized)

Follow up (in studies)

1 week after antibiot

control events 61
(18.15%)

BASELINE RISK/ EFFECT WITH COMPARATOR

180

per 1000

3 Expected difference and best estimate of effect with intervention: Probiotics

Calculate estimates

CALCULATED ESTIMATE WITH INTERVENTION

83

per 1000

ESTIMATED ABSOLUTE DIFFERENCE OF INTERVENTION VS. COMPARATOR (CALCULATED)

Difference: 97 fewer per 1000

CI 95% (117 fewer - 70 fewer)

Get data from Cochrane (RevMan file)

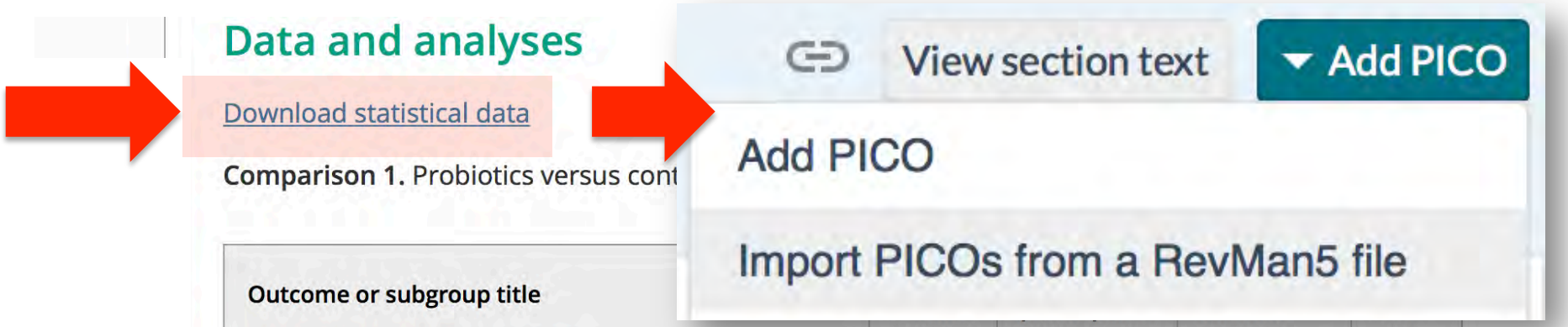
Data and analyses

Download statistical data

Comparison 1. Probiotics versus control

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Incidence CDAD: complete case	31	8672	Risk Ratio (M-H, Random, 95% CI)	0.40 [0.30, 0.52]
2 Incidence CDAD: complete case - fixed effects	31	8672	Risk Ratio (M-H, Fixed, 95% CI)	0.38 [0.30, 0.50]
3 Incidence CDAD: Sensitivity (1.5:1)	31	9637	Risk Ratio (M-H, Random, 95% CI)	0.41 [0.32, 0.54]
4 Incidence CDAD: Sensitivity (2:1)	31	9637	Risk Ratio (M-H, Random, 95% CI)	0.44 [0.34, 0.58]
5 Incidence CDAD: Sensitivity (3:1)	31	9637	Risk Ratio (M-H, Random, 95% CI)	0.48 [0.36, 0.63]

Get data from Cochrane (RevMan file)



Data and analyses

Download statistical data

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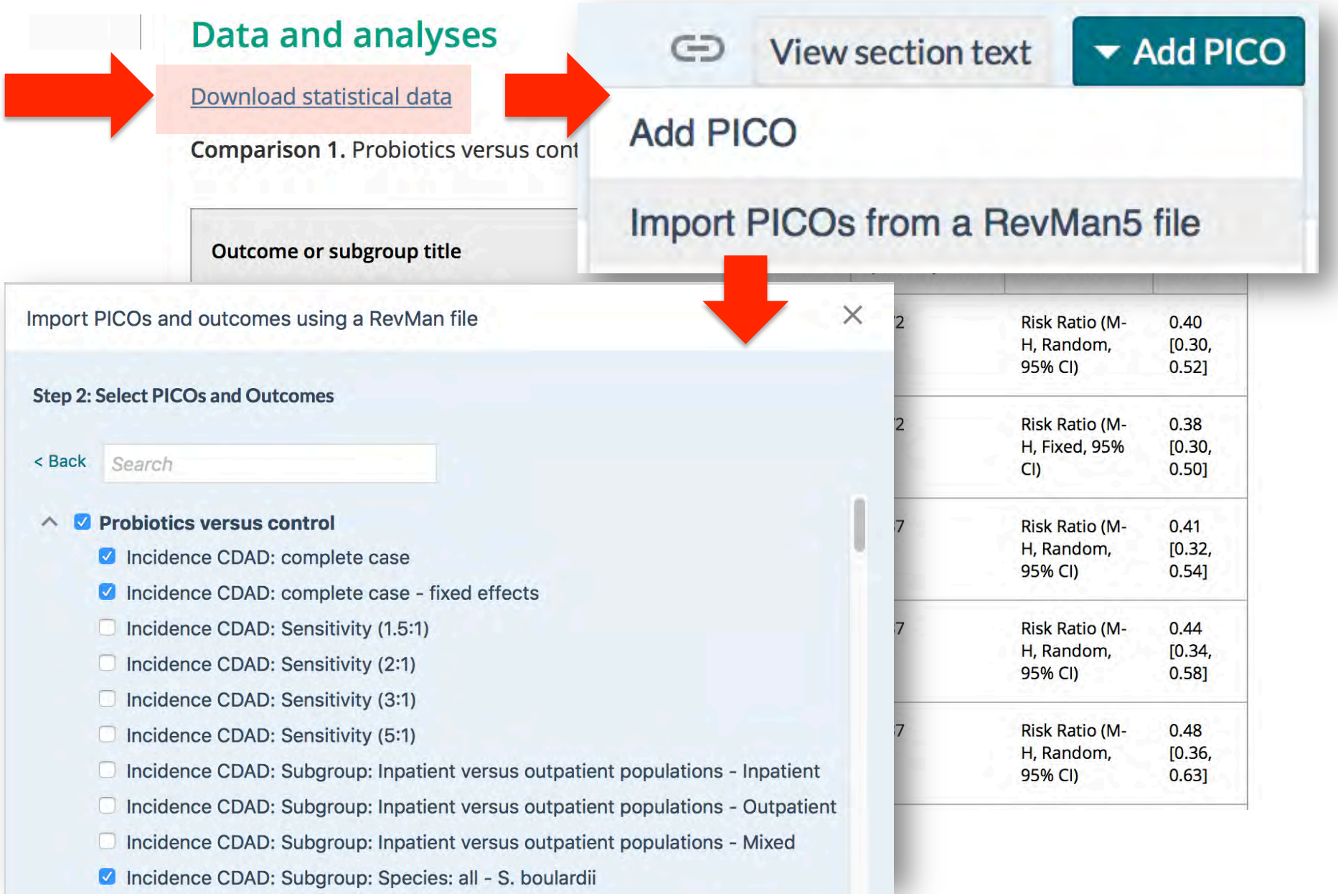


Strong recommendation

Children 1 month to 2 years old receiving antibiotics for an infection.

Evidence profile | Summary | References

Outcome Timeframe	Study results and measurements	Absolute effect estimates No probiotics	 Probiotics	Certainty in effect estimates (Quality of evidence)	Summary
AAD <2 years	Relative risk 0.46 (CI 95% 0.35 - 0.61) Based on data from 3898 patients in 22 studies Follow up: 1-12 weeks.	**180** per 1000	**83** per 1000 Difference: 97 fewer per 1000 (CI 95% 117 fewer - 70 fewer)	**Moderate** Due to serious inconsistency.	Probiotics appear to decrease the incidence of AAD.
Severe AAD <2 years	0.46 (0.35 - 0.61) Based on data from 3898 patients in 22 studies Follow up: 1-12 weeks.	**18** per 1000	**8** per 1000 Difference: 10 fewer per 1000 (CI 95% 12 fewer - 7 fewer)	**Low** Due to serious inconsistency and indirectness.	Probiotics may decrease the incidence of severe AAD by a small amount.
GI side effects	Relative risk 1 (CI 95% 0.71 - 1.29) Based on data from 2455 patients in 16 studies Follow up: 1-4 weeks.	**35** per 1000	**35** per 1000 Difference: 0 fewer per 1000 (CI 95% 10 fewer - 10 more)	**Moderate** Due to serious indirectness.	Probiotics do not appear to increase the risk of gastrointestinal side effects.
Probiotic-related sepsis	Relative risk 1 (CI 95% -) Based on data from 2455 patients in 16 studies Follow up: 1-4 weeks.	**0** per 1000	**0** per 1000 Difference: 0 more per 1000 (CI 95% 0 - 3 more)	**Moderate** No probiotic-related sepsis events reported in the 16 of 22 studies reporting adverse events. Rated down due to risk of bias from selective outcome reporting.	Probiotics do not appear to increase the risk of sepsis.
Clostridium difficile diarrhea	Relative risk 0.4 (CI 95% 0.17 - 0.96) Based on data from 605 patients in 3 studies Follow up: 2 weeks.	**59** per 1000	**24** per 1000 Difference: 35 fewer per 1000 (CI 95% 49 fewer - 2 fewer)	**Very Low** Due to serious imprecision, risk of bias (possible selective outcome reporting), and indirectness in baseline estimate.	Probiotics could reduce the risk of CDAD.

Probiotics for children receiving antibiotics for an infection

Children 1 month to 2 years old receiving antibiotics for an infection.

Strong recommendation

GRADE

Benefits outweigh harms for almost everyone. All or nearly all informed patients would likely want this option.

We recommend adjunctive probiotics rather than no probiotics.

Children 2 to 18 years old receiving antibiotics for an infection.

Weak recommendation

GRADE

Benefits outweigh harms for the majority, but not for everyone. The majority of patients would likely want this option

We suggest adjunctive probiotics rather than no probiotics.

MAGIC app

Strong recommendation **Children 1 month to 2 years old receiving antibiotics for an infection.**

Benefits and harms

Benefits of probiotics include a reduced incidence of antibiotic associated diarrhea (AAD), severe AAD, and *Clostridium difficile*-associated diarrhea (CDAD). Among otherwise healthy children, probiotics do not increase the risk of gastrointestinal side effects or of probiotic-related sepsis.

Quality of evidence

For probiotics, we have moderate certainty that the estimated effects for reduced incidence of AAD, gastrointestinal side effects, and probiotic-related sepsis are close to the true effects, low certainty for severe AAD, and very low certainty for CDAD.

Preference and values

Patients and their caregivers are likely to place a relatively higher value on preventing AAD, particularly severe AAD than on the relatively minimal costs and burden of probiotics.

Resources and other considerations

Probiotics are generally inexpensive and accessible throughout the world. Many caregivers with lower disposable income, particularly those without socialized pharmacare or private insurance, may not have the means to afford probiotics.

Weak recommendation

Children 2 to 18 years old receiving antibiotics for an infection.

Evidence profile | Summary | References

Outcome Timeframe	Study results and measurements	Absolute effect estimates No probiotics	 Probiotics	Certainty in effect estimates (Quality of evidence)	Summary
AAD 2-18 years	Relative risk 0.46 (CI 95% 0.35 - 0.61) Based on data from 3898 patients in 22 studies Follow up: 1-12 weeks.	**30** per 1000	**14** per 1000 Difference: 16 fewer per 1000 (CI 95% 19 fewer - 12 fewer)	**Moderate** Due to serious inconsistency.	Probiotics appear to decrease the incidence of AAD by a small amount.
Severe AAD 2-18 years	Relative risk 0.46 (CI 95% 0.35 - 0.61) Based on data from 3898 patients in 22 studies Follow up: 1-12 weeks.	**3** per 1000	**1** per 1000 Difference: 2 fewer per 1000 (CI 95% 2 fewer - 1 fewer)	**Low** Due to serious inconsistency and indirectness.	Probiotics may decrease the incidence of AAD by a small amount.
GI side effects	Relative risk 1 (CI 95% 0.71 - 1.29) Based on data from 2455 patients in 16 studies Follow up: 1-4 weeks.	**35** per 1000	**35** per 1000 Difference: 0 fewer per 1000 (CI 95% 10 fewer - 10 more)	**Moderate** Due to serious indirectness.	Probiotics do not appear to increase the risk of gastrointestinal side effects.
Probiotic-related sepsis	Relative risk 1 (CI 95% -) Based on data from 2455 patients in 16 studies Follow up: 1-4 weeks.	**0** per 1000	**0** per 1000 Difference: 0 more per 1000 (CI 95% 0 - 3 more)	**Moderate** No probiotic-related sepsis events reported in the 16 of 22 studies reporting adverse events. Rated down due to risk of bias from selective outcome reporting.	Probiotics do not appear to increase the risk of sepsis.
Clostridium difficile diarrhea	Relative risk 0.4 (CI 95% 0.17 - 0.96) Based on data from 605 patients in 3 studies Follow up: 2 weeks.	**59** per 1000	**24** per 1000 Difference: 35 fewer per 1000 (CI 95% 49 fewer - 2 fewer)	**Very Low** Due to serious imprecision, risk of bias (possible selective outcome reporting), and indirectness in baseline estimate.	Probiotics could reduce the risk of CDAD

Further enhancing dissemination: BMJ RapidRecs

Evidence synthesizers

data

Evidence disseminators to clinicians

data

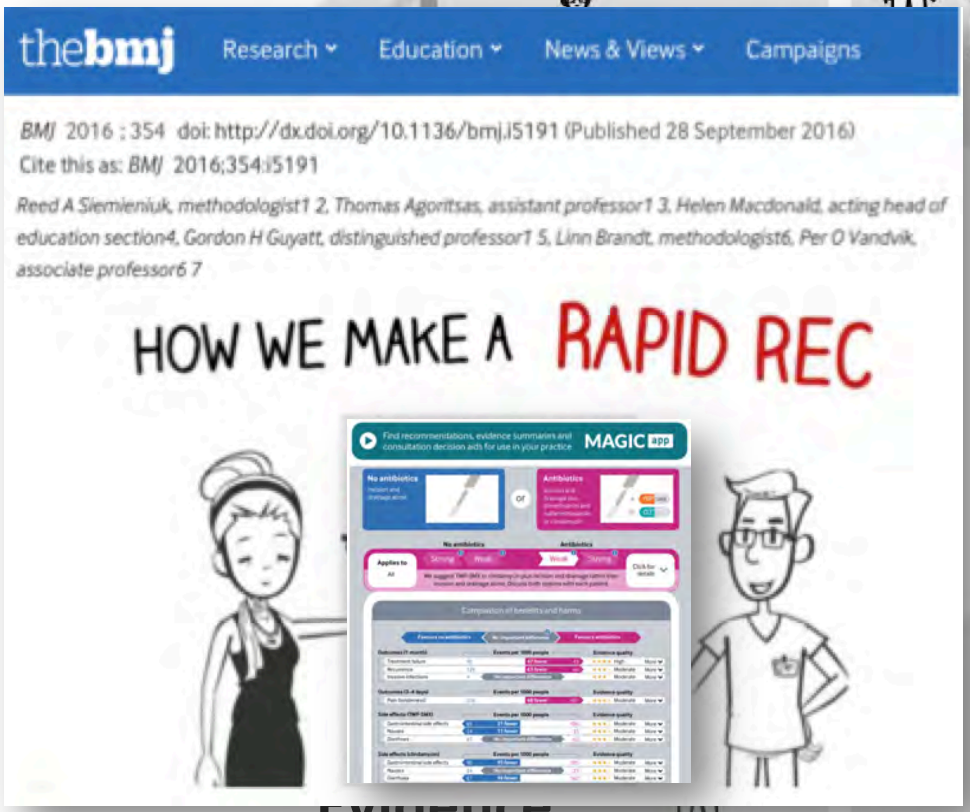
Evidence disseminators to patients

Evidence evaluators & improvers

data

Evider imple

SHARE-IT



The BMJ RapidRecs

GRADE

Patient partners


A Placebo-Controlled Trial of Antibiotics for Smaller Skin Abscesses

Day 45: Network
Submit updated
Synthesize evidence
Systematic reviews

data

Day 90: Updated
recommendation
Disseminate evidence to clinicians
Trustworthy guidelines

data

BMJ Rapid Recommendations
Enhancing the Evidence Ecosystem

NEW EVIDENCE
Primary studies

EvidenceAlerts

Day 90: Available for SDM
Disseminate evidence to patients
Decision aids for the clinical encounter

data

Day 90: Available at point of care
Implement evidence
Personalized decision support in the EMR

data

Evaluate and improve practice
Recording practice & population-based data
EMR, Registries,
Quality indicators,
Shared decisions

data

Prostate cancer screening

Screening

www.bmj.com/rapid-recommendations

n=14 guidelines in 3 years
n=25 recs
n=18 SR

Corticosteroids for treatment of sore throat

Antibiotics for uncomplicated skin abscesses

Primary Care

Antiretroviral therapy in pregnant women living with HIV

Altmetric *

Dual vs single antiplatelet therapy

Drugs
Acute care

Corticosteroid therapy for sepsis

Thyroid hormones treatment for subclinical hypothyroidism

Strong Recs Against

Oxygen therapy for acutely ill medical patients

Low intensity pulsed ultrasound (LIPUS) for bone healing

Subacromial decompression surgery for adults with shoulder pain

De-implementation

Arthroscopic surgery for degenerative knee arthritis and meniscal tears *

Atraumatic (pencil-point) versus conventional needles for lumbar puncture

Devices

Transcatheter versus surgical aortic valve replacement

Patent foramen ovale closure or drug therapy for management of cryptogenic stroke

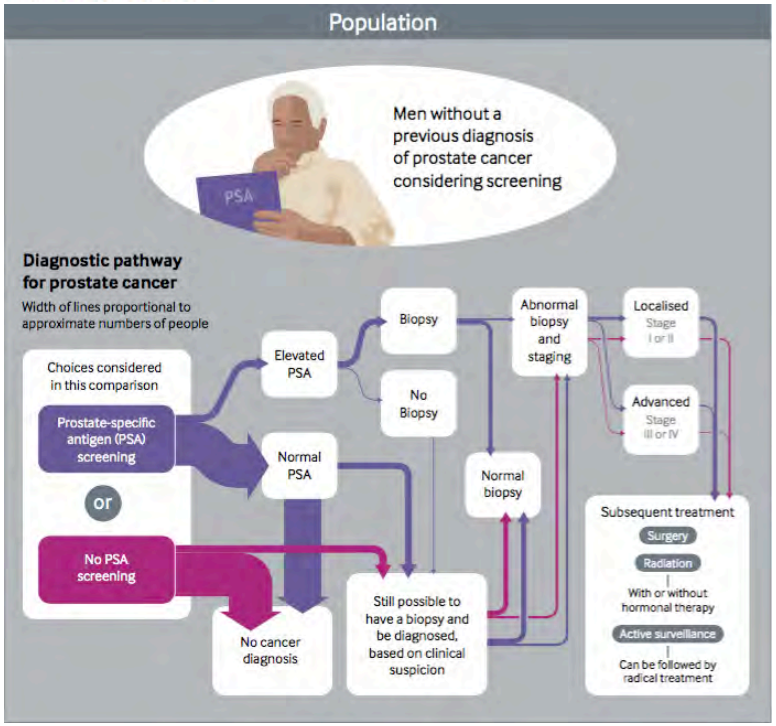
thebmj RAPID RECOMMENDATIONS

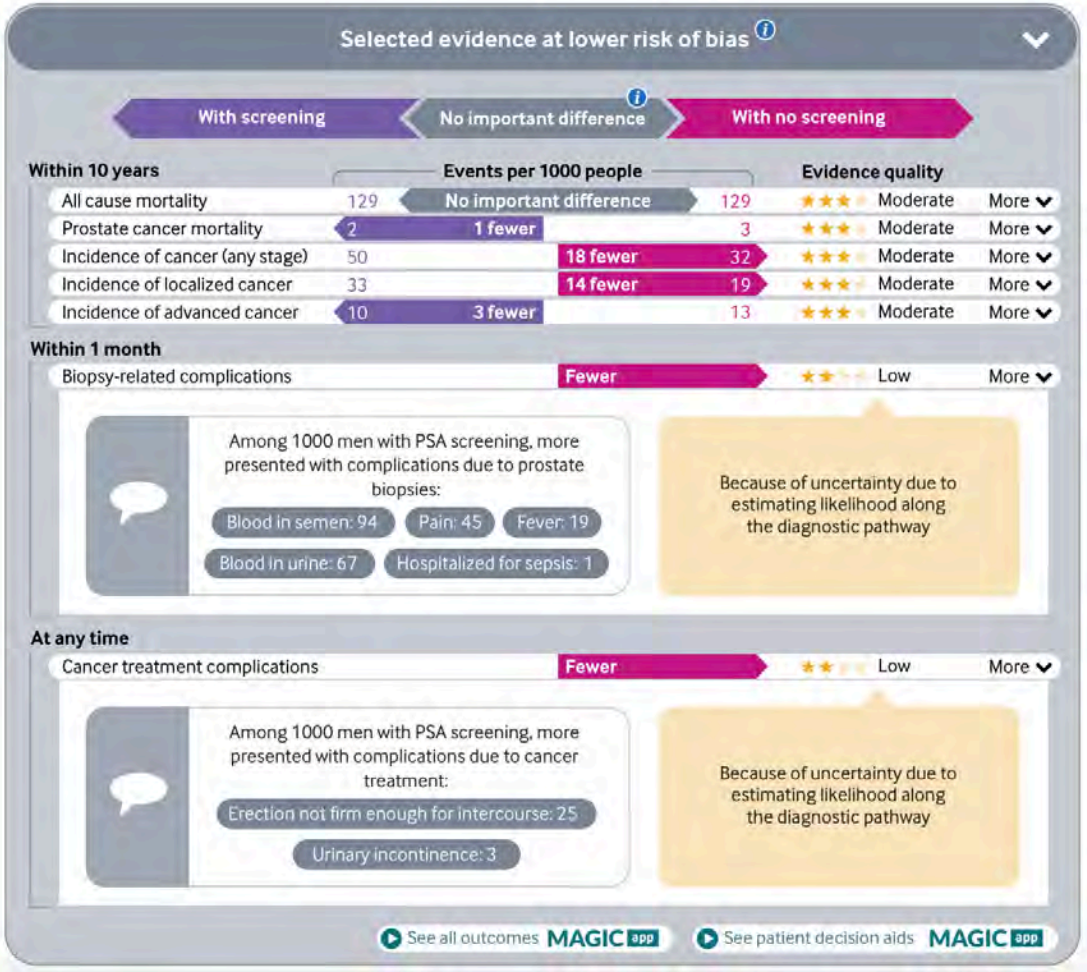
Prostate cancer screening with prostate-specific antigen (PSA) test: a clinical practice guideline

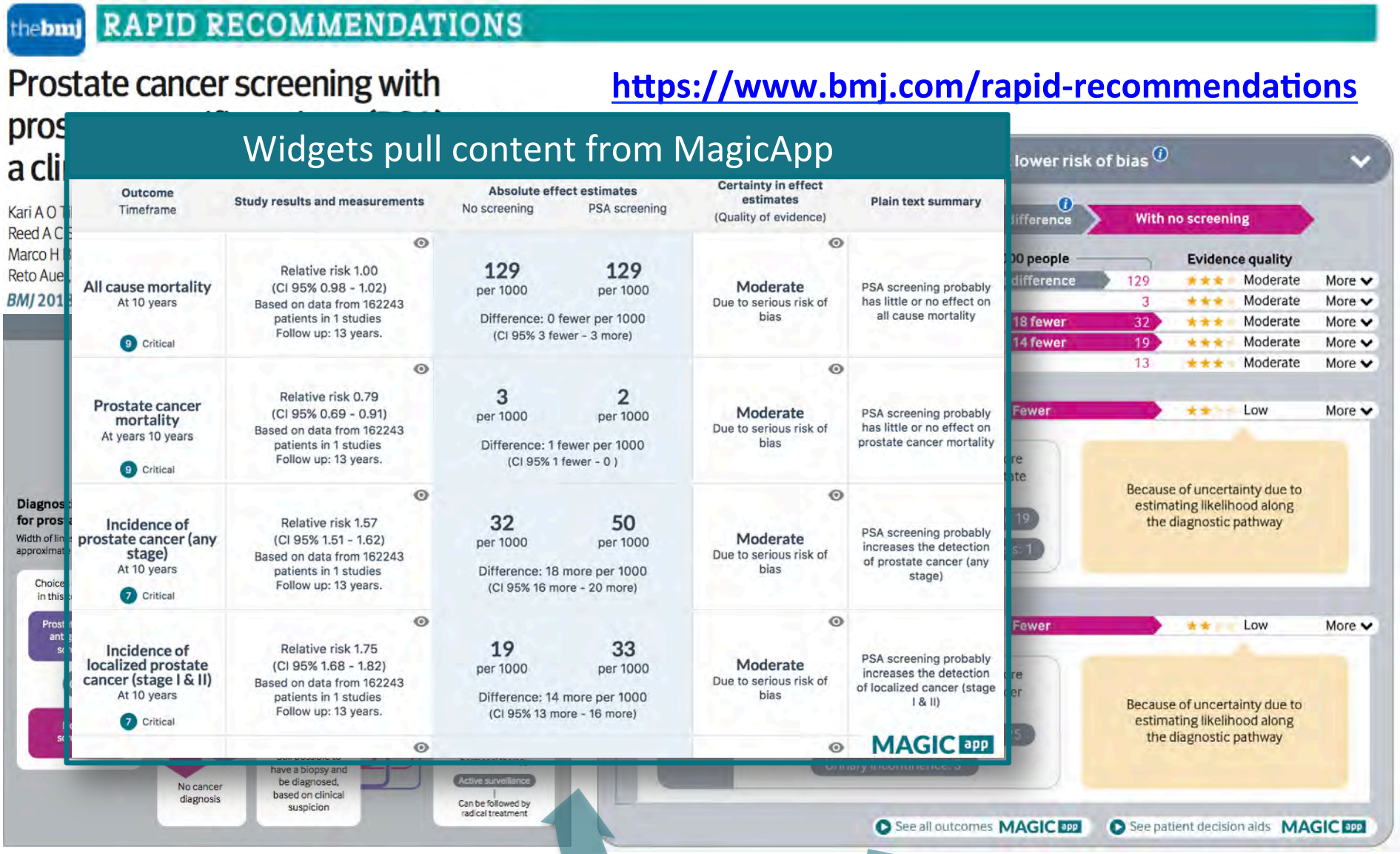
Kari A O Tikkinen,[1 2] Philipp Dahm,[3] Lyubov Lytvyn,[4] Anja F Heen,[5] Robin W M Vernooij,[6] Reed A C Siemieniuk,[4] Russell Wheeler,[7] Bill Vaughan,[8] Awah Cletus Fobuzi,[9 10] Marco H Blanker,[11] Noelle Junod,[12] Johanna Sommer,[13] Jérôme Stirnemann,[14] Manabu Yoshimura,[15] Reto Auer,[16 17] Helen MacDonald,[18] Gordon Guyatt,[4] Per Olav Vandvik,[5] Thomas Agoritsas[4 14 19]

BMJ 2018;362:k3581

https://www.bmj.com/rapid-recommendations







Widgets that pull data from MAGICapp to embed on other plateforms

thebmj RAPID RECOMMENDATIONS

Prostate cancer screening with pros… a cli…

https://www.bmj.com/rapid-recommendations

Kari A O T…
Reed A C…
Marco H …
Reto Aue…
BMJ 201…

Widgets pull content from MagicApp

Outcome Timeframe	Study results and measurements	Absolute effect estimates No screening	 PSA screening	Certainty in effect estimates (Quality of evidence)	Plain text summary
All cause mortality At 10 years 9 Critical	Relative risk 1.00 (CI 95% 0.98 - 1.02) Based on data from 162243 patients in 1 studies Follow up: 13 years.	129 per 1000	129 per 1000 Difference: 0 fewer per 1000 (CI 95% 3 fewer - 3 more)	Moderate Due to serious risk of bias	PSA screening probably has little or no effect on all cause mortality
Prostate cancer mortality At years 10 years 9 Critical	Relative risk 0.79 (CI 95% 0.69 - 0.91) Based on data from 162243 patients in 1 studies Follow up: 13 years.	3 per 1000	2 per 1000 Difference: 1 fewer per 1000 (CI 95% 1 fewer - 0)	Moderate Due to serious risk of bias	PSA screening probably has little or no effect on prostate cancer mortality
Incidence of prostate cancer (any stage) At 10 years 7 Critical	Relative risk 1.57 (CI 95% 1.51 - 1.62) Based on data from 162243 patients in 1 studies Follow up: 13 years.	32 per 1000	50 per 1000 Difference: 18 more per 1000 (CI 95% 16 more - 20 more)	Moderate Due to serious risk of bias	PSA screening probably increases the detection of prostate cancer (any stage)
Incidence of localized prostate cancer (stage I & II) At 10 years 7 Critical	Relative risk 1.75 (CI 95% 1.68 - 1.82) Based on data from 162243 patients in 1 studies Follow up: 13 years.	19 per 1000	Difference: 14 more p… (CI 95% 13 more - 16…		

lower risk of bias

With no screening

Evidence quality

Moderate More

Low More

Because of uncertainty due to estimating likelihood along the diagnostic pathway

See patient decision aids MAGIC app

No cancer diagnosis

have a biopsy and be diagnosed, based on clinical suspicion

Active surveillance

Can be followed by radical treatment

Find recommendations, evidence summaries and consultation decision aids for use in your practice

Decision Aids
Widgets

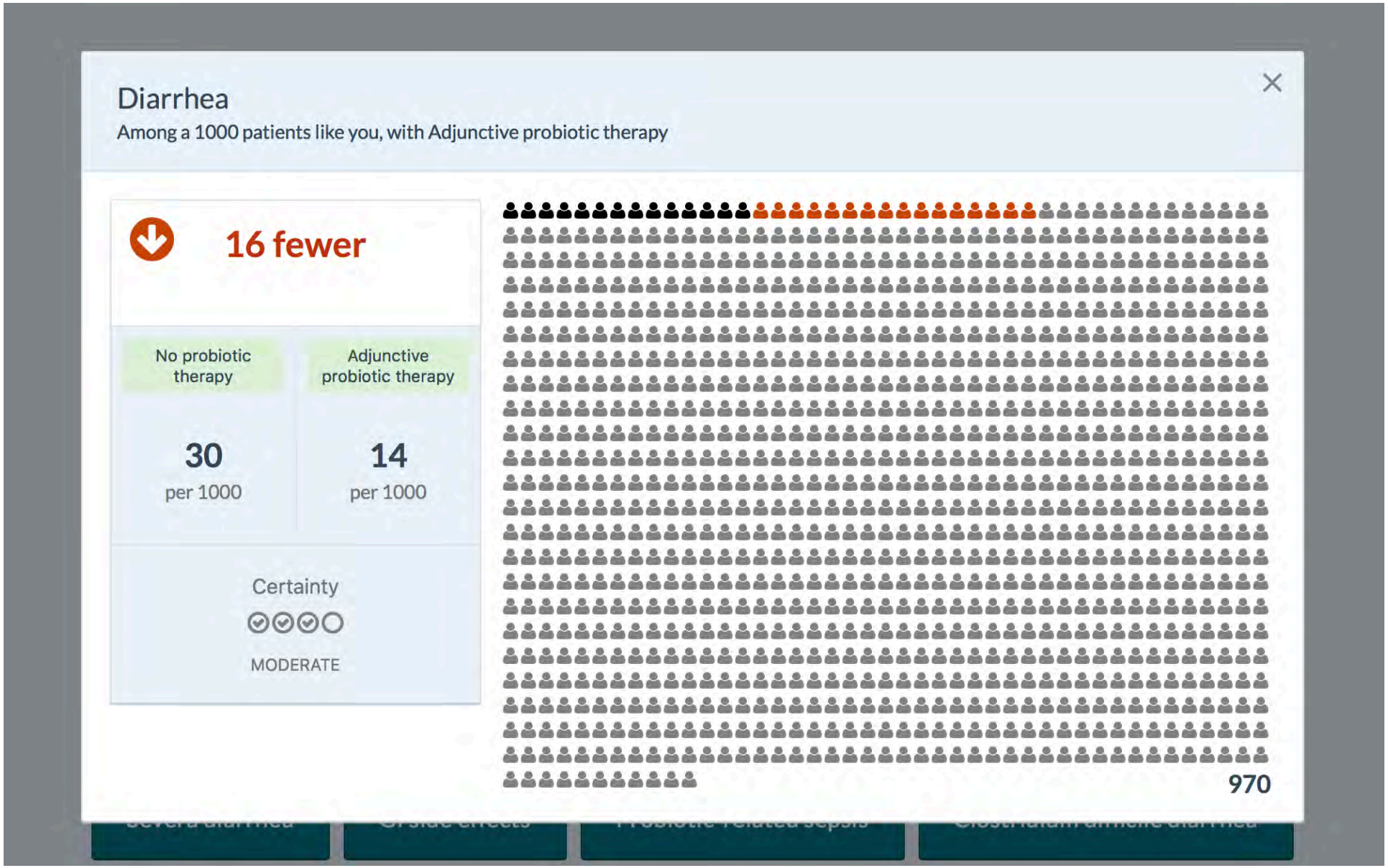
SHARE-IT Decision Aids

What aspect of your treatment would you like to discuss next?

Diarrhea | Severa diarrhea | GI side effects | Probiotic-related sepsis

Clostridium difficile diarrhea | Practical issues

SHARE-IT Decision Aids



SHARE-IT Decision Aids

Among a 1000 patients like you, on average with Adjunctive probiotic therapy

Diarrhea	Severa diarrhea	Clostridium difficile diarrhea
16 fewer	2 fewer	35 fewer
No probiotic therapy: 30 per 1000	No probiotic therapy: 3 per 1000	No probiotic therapy: 59 per 1000
Adjunctive probiotic therapy: 14 per 1000	Adjunctive probiotic therapy: 1 per 1000	Adjunctive probiotic therapy: 24 per 1000
Certainty: ⊘⊘⊘○ MODERATE	Certainty: ⊘⊘○○ LOW	Certainty: ⊘○○○ VERY LOW

GI side effects | Probiotic-related sepsis | Practical issues

healthtalk.org
youthhealthtalk.org

RCGP ACCREDITED

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UNIVERSITY OF OXFORD

A-Z | Categories | Young people | Search

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Health Professionals

Patients' experiences shared on film.

Related:

- Using healthtalk.org for training
- Trigger films for service improvement
- Patients tell us what makes good healthcare

PEOPLE'S EXPERIENCES OF HEALTH

A problem shared

Reliable health information from patients, for patients.

SHARE-IT Decision Aids

Practical issues

Medication routine

Tests and visits

Procedure and device

Recovery and adaptation

Coordination of care

Adverse effects, interactions and antidote

Physical well-being

Emotional well-being

Pregnancy and nursing

Costs and access

Food and drinks

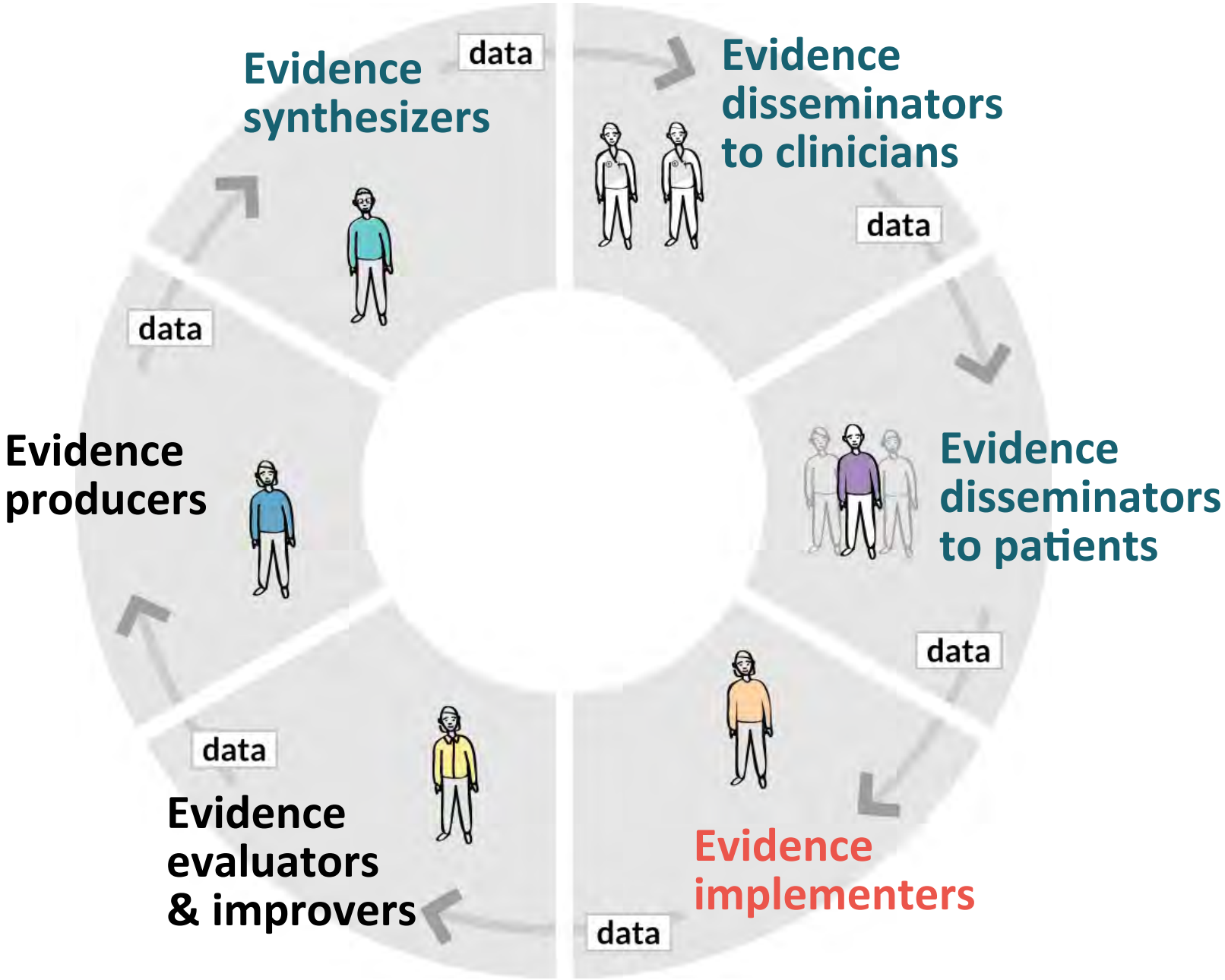
Exercise and activities

Social life and relationships

Work and education

Travel and driving

The Evidence Ecosystem

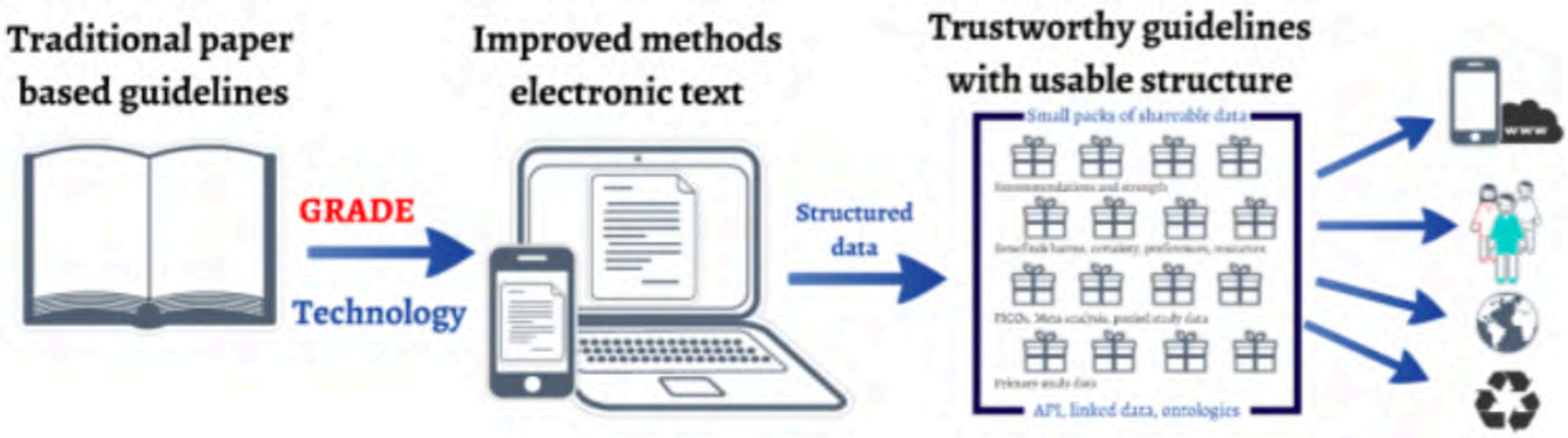


Plugging-in to Electronic Health Records (EHR)

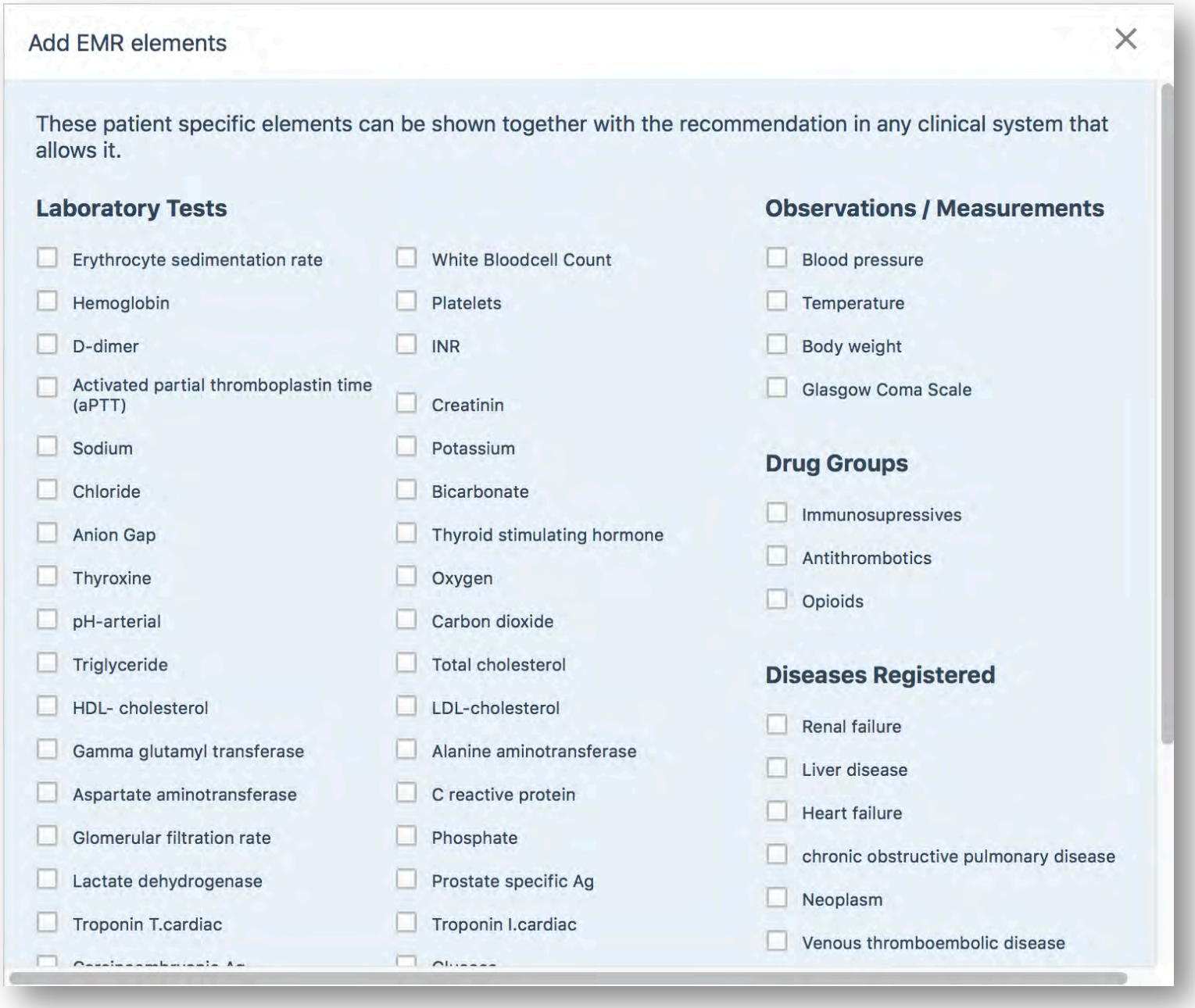
Computerized Decision Support Systems (CDSS)

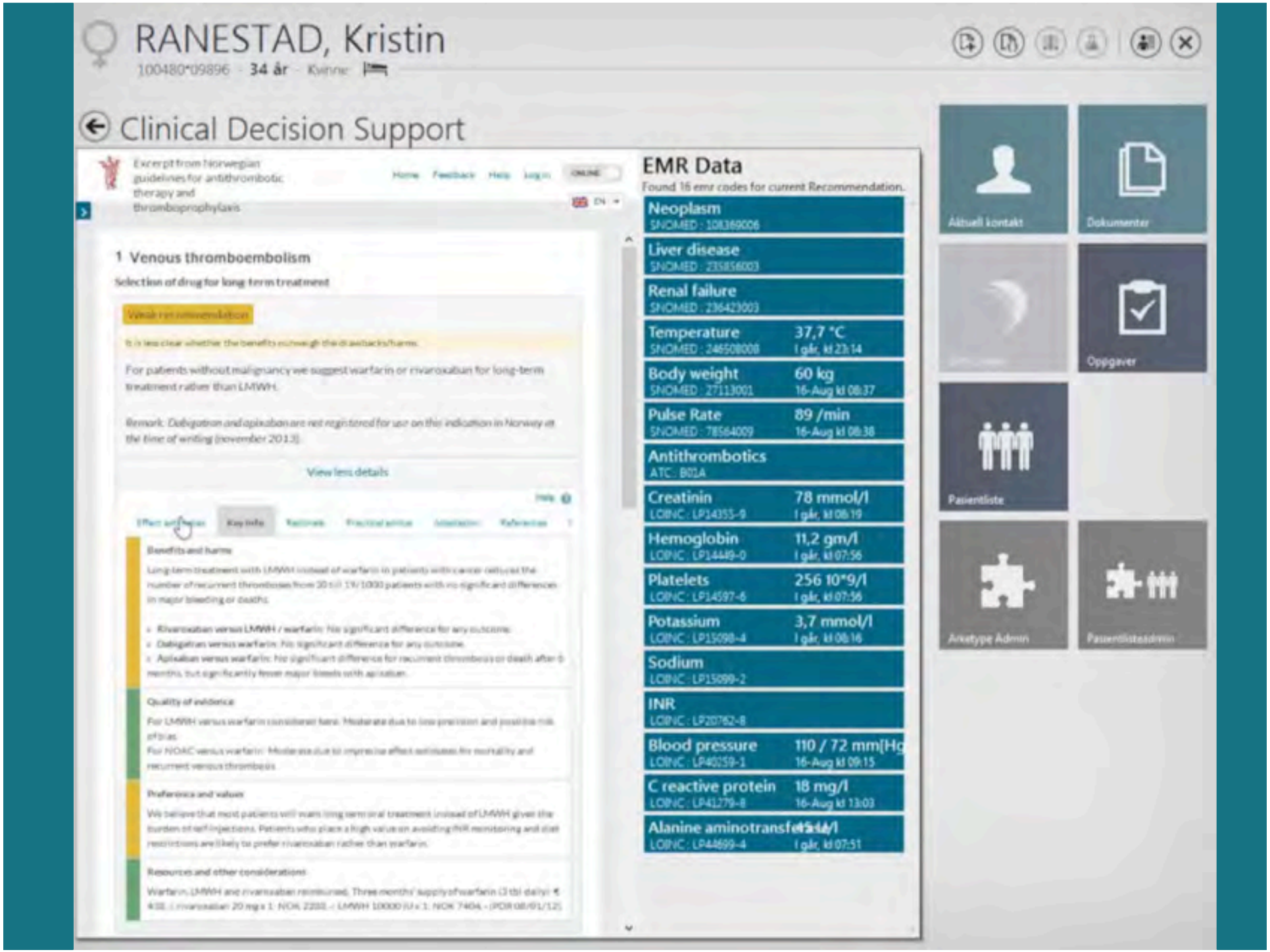
- take the advice from a published guideline away from its original place of publishing
- are time consuming to create and update
- rely too much on algorithms and reminders, which have limitations

MagicApp moves guidelines from a text-based format to an electronic structure

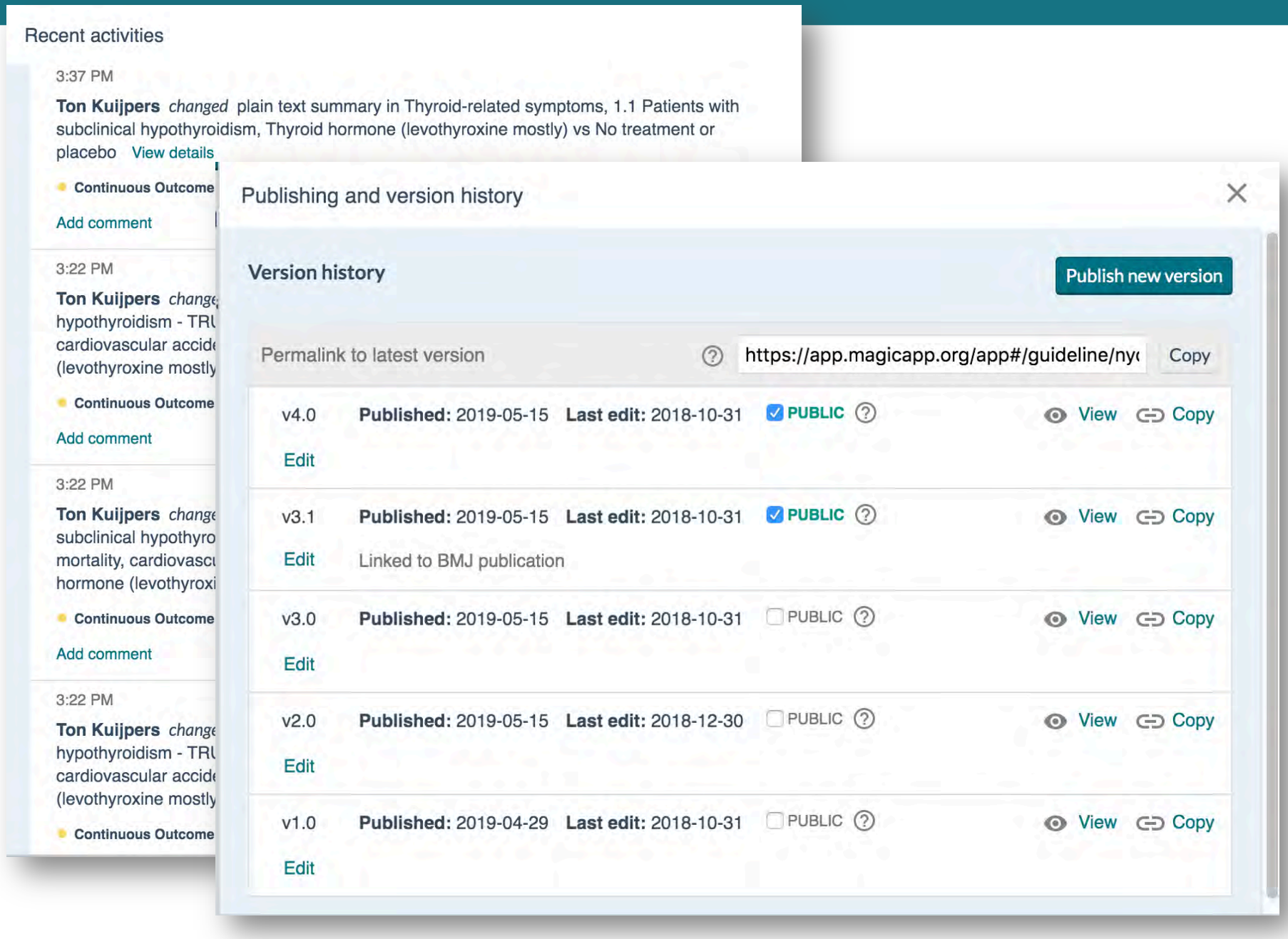


Plugging-in to Electronic Health Records (HER)

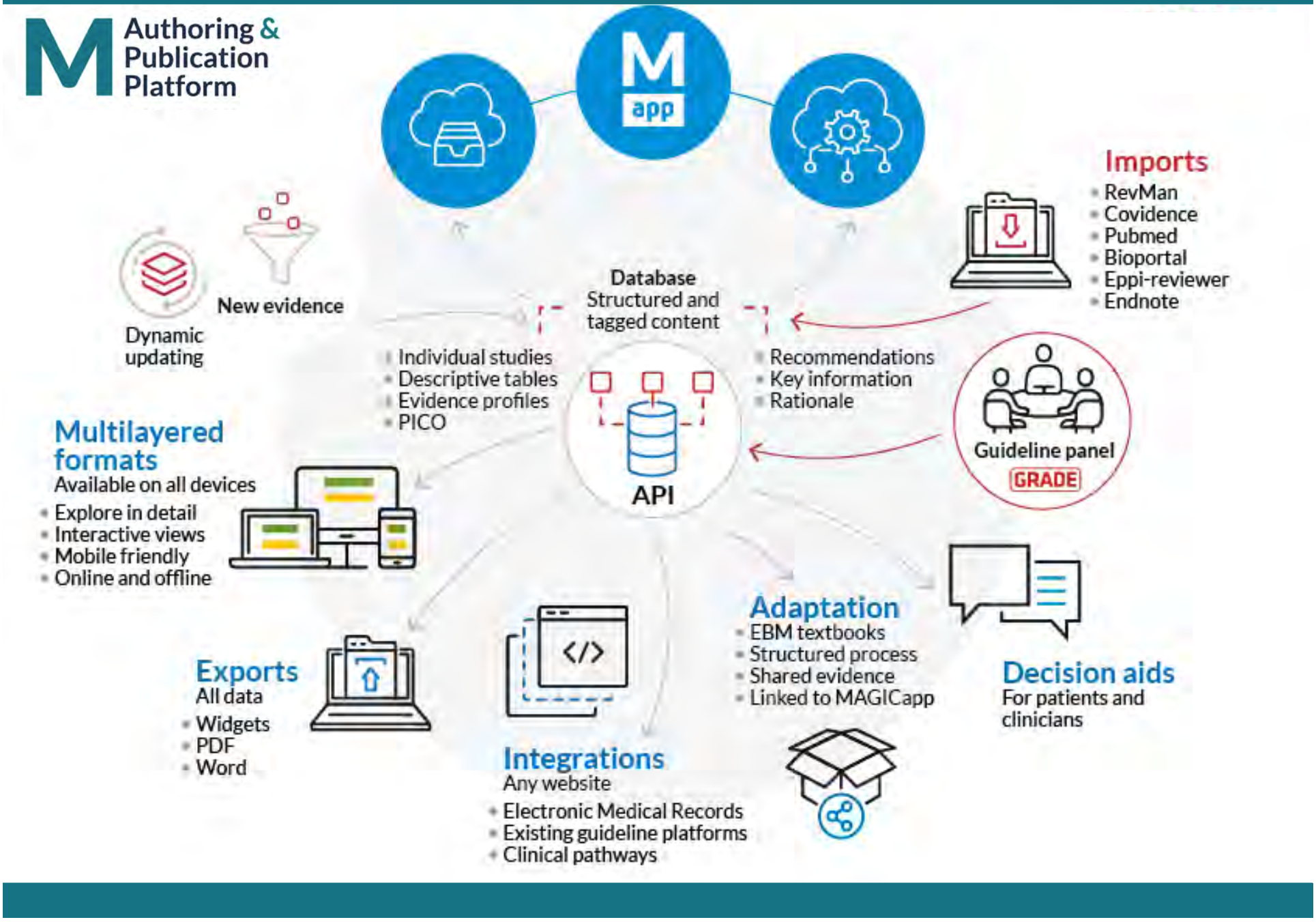



RANESTAD, Kristin
100480*09896 · 34 år · Kvinne
Clinical Decision Support
Excerpt from Norwegian guidelines for antithrombotic therapy and thromboprophylaxis
Home
Feedback
Help
Log in
ONLINE
EN
1 Venous thromboembolism
Selection of drug for long term treatment
For patients without malignancy we suggest warfarin or rivaroxaban for long-term treatment rather than LMWH.
Remark: Dabigatran and apixaban are not registered for use on this indication in Norway at the time of writing (november 2013).
View less details
Help
Benefits and harms
Quality of evidence
Preference and values
Resources and other considerations
EMR Data
Found 16 emr codes for current Recommendation.
Neoplasm
SNOMED : 108369006
Liver disease
SNOMED : 235856003
Renal failure
SNOMED : 236423003
Temperature 37,7 °C
SNOMED : 246508008 I går, kl 23:14
Body weight 60 kg
SNOMED : 27113001 16-Aug kl 08:37
Pulse Rate 89 /min
SNOMED : 78564009 16-Aug kl 08:38
Antithrombotics
ATC : B01A
Creatinin 78 mmol/l
LOINC : LP14355-9 I går, kl 08:19
Hemoglobin 11,2 gm/l
LOINC : LP14449-0 I går, kl 07:56
Platelets 256 10*9/l
LOINC : LP14597-6 I går, kl 07:56
Potassium 3,7 mmol/l
LOINC : LP15098-4 I går, kl 08:16
Sodium
LOINC : LP15099-2
INR
LOINC : LP20762-8
Blood pressure 110 / 72 mm[Hg
LOINC : LP40359-1 16-Aug kl 09:15
C reactive protein 18 mg/l
LOINC : LP41279-8 16-Aug kl 13:03
Alanine aminotransf
LOINC : LP44699-4 I går, kl 07:51
Aktuell kontakt
Dokumenter
Oppgaver
Pasientliste
Arketype Admin
Pasientlisteadmin

Living Evidence: MAGIC “time machine” and track change



Thank you ! *http://magicproject.org/contact/* *@ThomasAgoritsas*



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