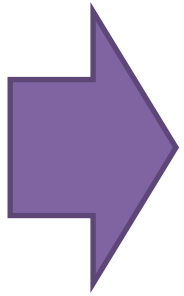
Next steps for Evidence Dissemination

Patrick Ryan, Martijn Schuemie, Nicole Pratt

Scaling evidence together

Current status quo:

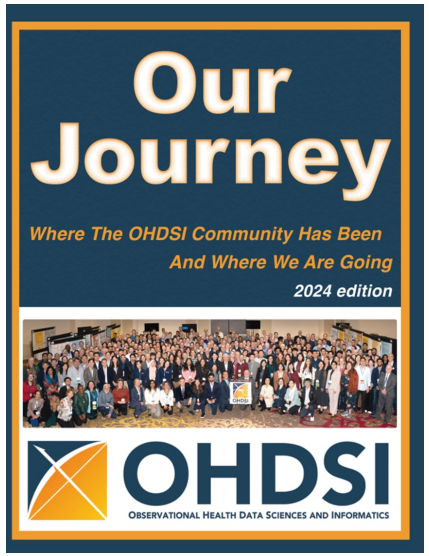
One Person
from **One Institution**
has **One Question**
about **One Exposure**
and **One Outcome**
applies **One Design**
to **One Database**
generating **One Result**
disseminated in **One Publication**
to communicate to **One Audience**



Future reality:

One Community of 1000s of persons
from **Many Institutions**
have **An Array Of Questions**
about **All Exposures**
and **All Outcomes**
applies **Standardized Framework**
Incorporating Multiple Designs
to **A Network of 100s of Databases**
Generating **Millions of Results**
disseminated across **Multiple Channels**
To **maximize the reach and impact across stakeholders**

Our Journey through OHDSI



... Dec 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | Oct 2024 ...

OHDSI
OBSERVATIONAL HEALTH DATA SCIENCES AND INFORMATICS

Reflecting on the Journey So Far

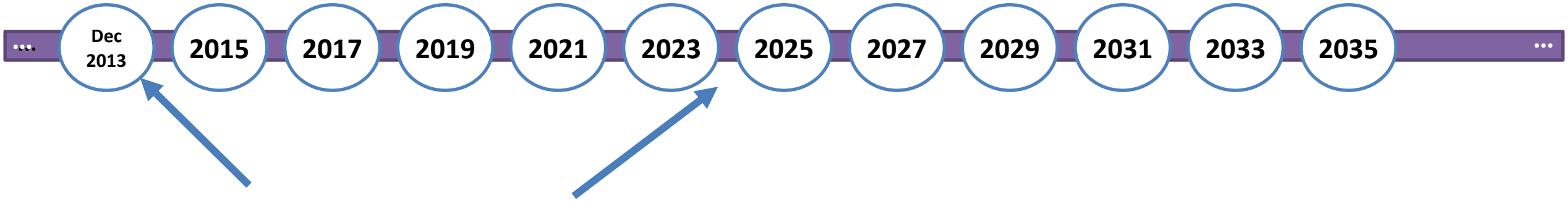
Initial OHDSI vision:

"OHDSI collaborators access a network of 1 billion patients to generate evidence about all aspects of healthcare. Patients and clinicians and other decisionmakers around the world use OHDSI tools and evidence every day"

OHDSI vision revised:

"A world in which observational research produces a comprehensive understanding of health and disease."

What is the Journey Ahead Together?



OHDSI

OBSERVATIONAL HEALTH DATA SCIENCES AND INFORMATICS

Join by Web **PollEv.com/patrickryan800** Join by Text Send **patrickryan800** to **22333**

How much do you agree that by 2034, we will achieve the following prediction:

Strongly disagree 0%

Disagree 0%

Neither agree or disagree 0%

Agree 0%

Strongly agree 0%

OHDSI's open science community approach to evidence generation becomes the expected behavior across stakeholders and disciplines to promote innovation, reproducibility, and collaboration.

The OMOP Common Data Model will evolve and become recognized as the preferred international data standard for real-world evidence generation, will be seamlessly interoperable with complementary clinical data exchange standards, and will be consistently adopted across academia, industry, and government around the world.

The number of unique data sources adopting the OMOP CDM will exceed 50,000, but organizations will also use the CDM as a mechanism to partner to advance cross-organizational data linkage and participatory patient self-reporting. This will increase the completeness and longitudinal continuity of patient records, enable connections across familial generations, and improve the fitness-of-use for each integrated source across a broader set of analytic use cases.

The OHDSI Standardized Vocabularies will provide the singular resource that maps all source terminologies and unstructured medical text into a common reference ontology, with real-time updating to reflect the current state of knowledge in medicine.

Every organization collecting patient-level data during the routine course of clinical care will have established systems to standardize the data to the OMOP CDM using the latest OHDSI standardized vocabularies on a nightly basis, enabling daily reporting for disease surveillance and quality improvement.

The OHDSI community will prove that real world evidence from real world data— when adhering OHDSI's best practices and passing all objective diagnostics—can be considered just as reliable as evidence from randomized clinical trials. Open-source systems that follow these practices will become trusted by health systems, payers, and regulators for guiding clinical care and policy decisions.

Advances in OHDSI's open-source analytic platform will decrease the time to generate reliable real-world evidence across the OHDSI distributed network; this process will be measured in minutes, not months.

The OHDSI Evidence Network will make it both commonplace and expected to see hundreds of databases, representing hundreds of millions of patients, be represented in network studies of every important public health question. This would ensure that the evidence we generate is replicable within similar populations and generalizable to patients across North and South America, Europe, Africa, Asia and Australia.

The OHDSI community will represent and support all clinical subspecialties and will become the primary source of real-world evidence to proactively fill evidence gaps needed to inform clinical guidelines around management of every disease.

The OHDSI community will design, implement, and deliver results from more than 10,000 network studies, with the majority of research questions coming directly from patients and clinicians seeking reliable evidence to address their needs at the point-of-care.

Discoveries across the OHDSI network about unrecognized effects of existing medical interventions will yield new indications that achieve regulatory approval due to the robustness of the real-world evidence produced within our community.

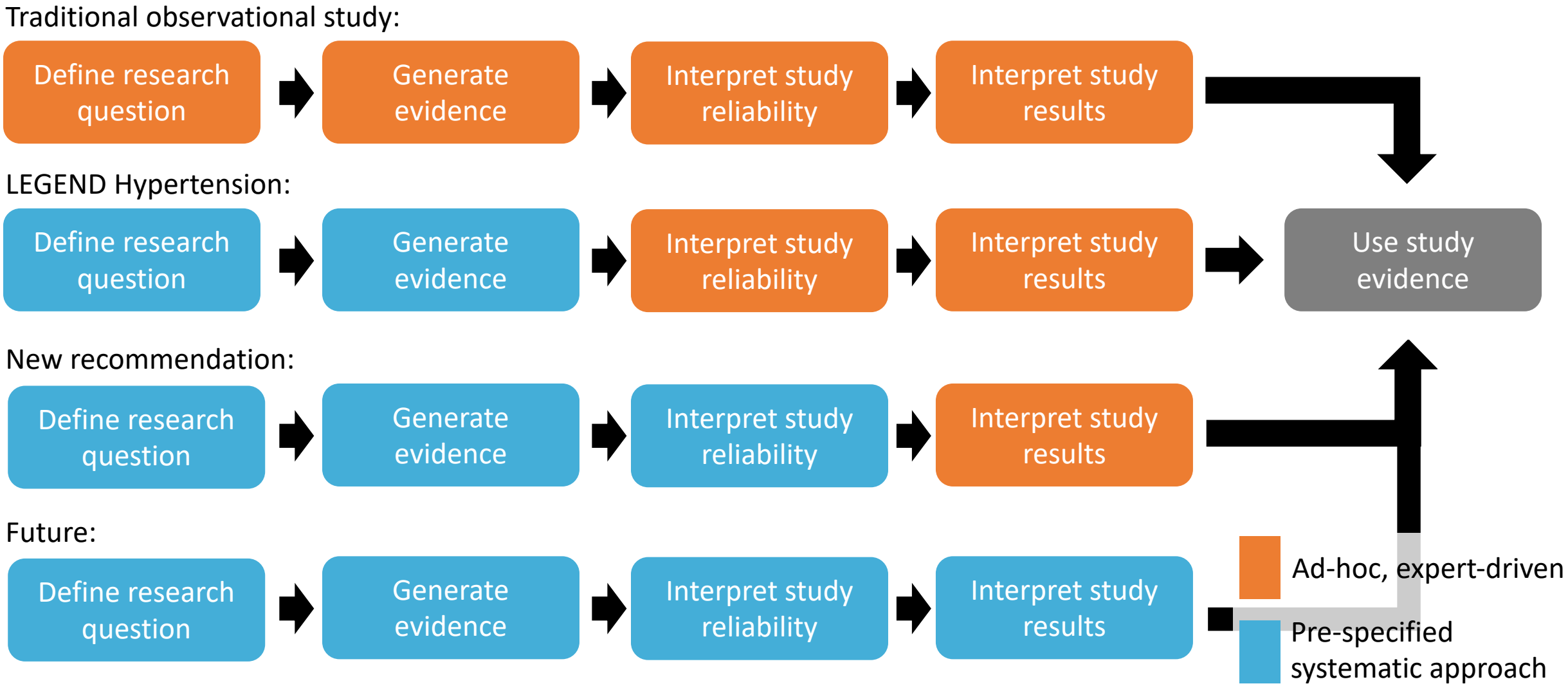
OHDSI will freely disseminate its evidence through more than 100,000 scholarly publications, but it will also establish new modalities for evidence dissemination to more directly support clinical practice.

Every disease will have a comprehensive real-world evidence summary that characterizes natural history and treatment pathways across the globe so we can understand patient heterogeneity, promote health equity, and recognize unmet medical needs.

Every medical product will have a comprehensive real-world evidence surveillance summary from OHDSI that provides characterization of the incidence of all outcomes, population-level estimation of the causally attributable risk of each outcome and comparative effectiveness with all alternative treatments, and patient-level prediction models so that individuals can accurately determine their personalized risk given their medical history.

OHDSI evidence repositories will become the primary source of knowledge underpinning foundational models to promote better health decisions and better care.

Pre-specification of a systematic approach



A rubric for interpreting studies

- Quality of study
  - Study design
    - Multiple designs to evaluate robustness (ex: comparative cohort and SCCS)
    - Multiple analyses within design (ex: PS matching vs stratification, on-treatment vs. ITT)
    - Objective diagnostics to test statistical assumptions, quantify residual error, and establish unblinding rules
  - Transparency
    - Pre-specified protocol
    - Publicly accessible analytic source code
    - Provenance of full resultset
  - Diversity of databases
    - Populations
    - Geographies
    - Data capture processes

A rubric for interpreting studies

- Strength of evidence
  - Continuum:
    - No evidence: No databases pass diagnostics
    - Weak: One database pass diagnostics, lots of databases fail
    - Strong: lots of diverse databases pass and few fail diagnostic (including diagnostic for heterogeneity)
- Certainty in estimate
- Size of effect

What you need to collaborate on evidence at scale

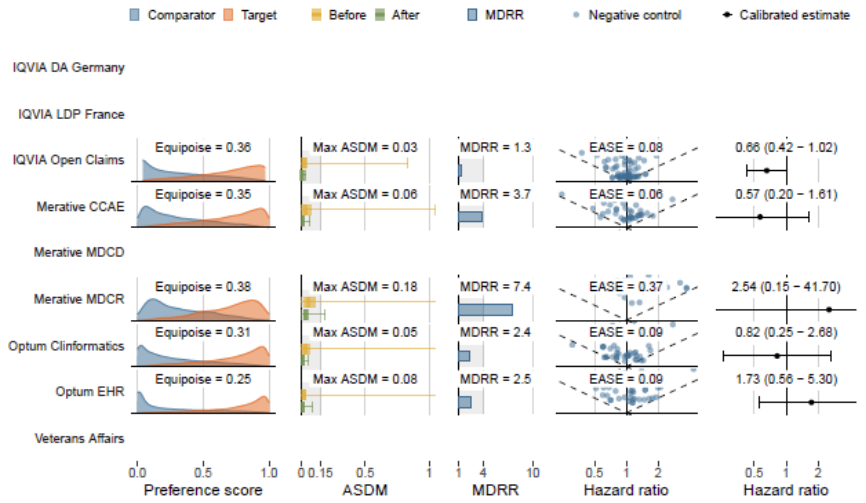
LEGEND-T2DM Evidence Dissemination Summary

- Target (class): **Semaglutide** (GLP-1 Receptor Agonists)
- Comparator (class): **Glimepiride** (Sulfonylureas)
- Outcome: **Acute pancreatitis**

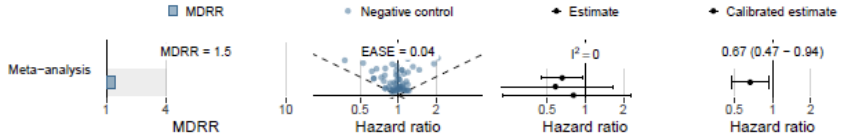
How Often? (Incidence rates in the PS-matched target cohorts)

Data source	Persons exposed	Person-time (yrs)	Persons with outcome	IR (/1,000 PY)
IQVIA DA Germany	-	-	-	-
IQVIA LDP France	-	-	-	-
IQVIA Open Claims	99,708	52,939	60	1.13
Merative CCAE	20,240	9,388	14	1.49
Merative MDCD	-	-	-	-
Merative MDCR	619	278	<5	<17.97
Optum Clinformatics	7,607	3,811	8	2.10
Optum EHR	6,717	2,098	7	3.34
Veterans Affairs	1,258	883	-	0.00

How Reliable Are the Effect Estimates? (Objective diagnostics)



What have we learned from the OHDSI Network? (Meta-analysis diagnostics and estimate)



Database diagnostics

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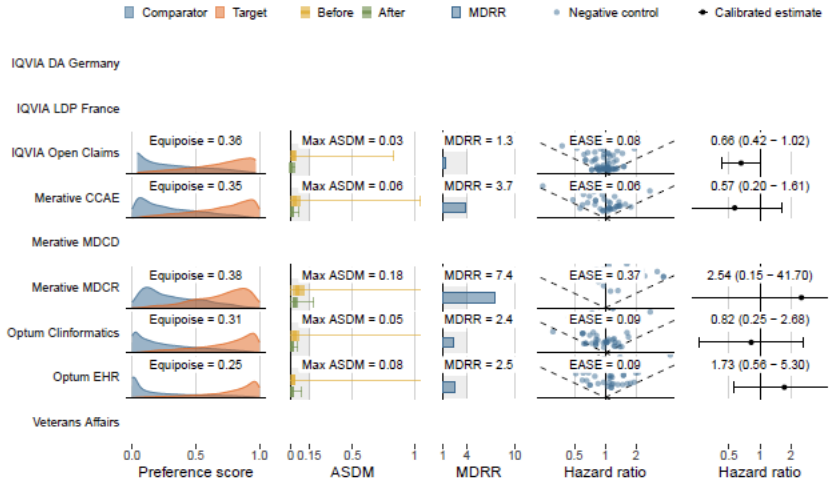

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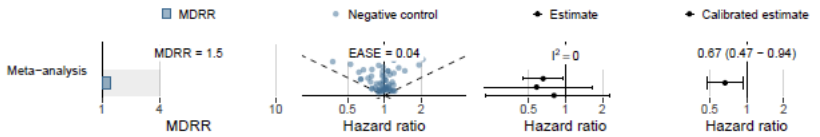

Meta-analysis diagnostics

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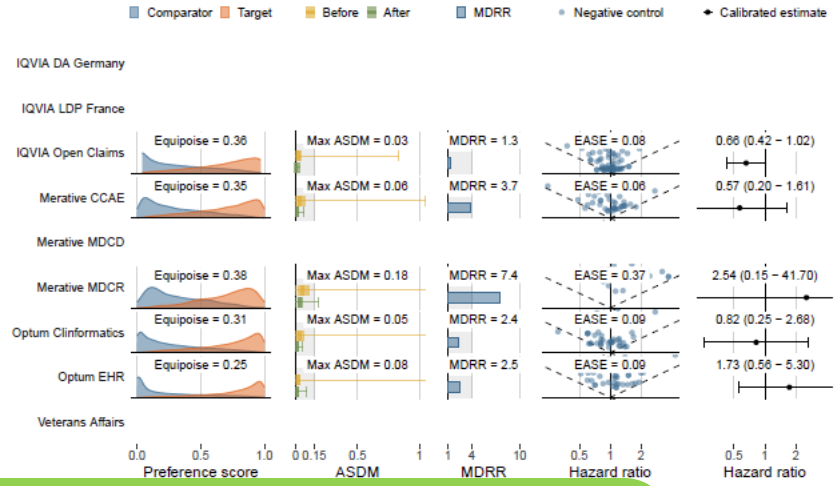

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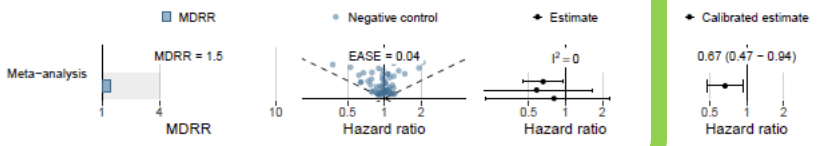

Meta-analysis estimate

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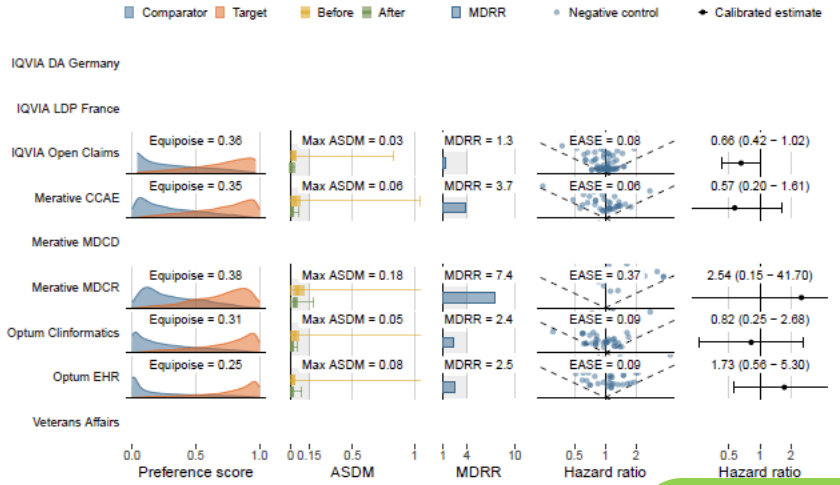

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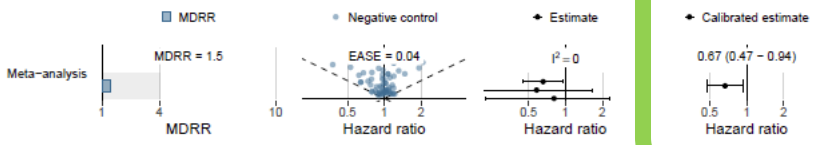


Next steps

- Most of you have in your hand a piece of reliable evidence that could be published and make a difference
- All of you have permission to disseminate that evidence, and explicit encouragement from the LEGEND leadership and OHDSI community to do so (just coordinate with the LEGEND team and stick to our OHDSI authorship guidelines)
- Or even better, all of you made friends today and a dream team to move forward on the opportunity together to impact the health of millions of patients

Anatomy of JACC publication

Introduction from the Editor

JACC publishes peer-reviewed articles highlighting all aspects of cardiovascular disease, including original clinical studies, experimental investigations with clear clinical relevance, state-of-the-art papers, and viewpoints.

At JACC, we value the time you spend preparing your submissions and aim to give you a rapid decision. Toward this goal, we have minimal formatting requirements on initial submissions. If your submission progresses toward publication, we may ask for more information and some specific formatting.

We are always open to suggestions about process improvements and appreciate your support of JACC.

Harlan M. Krumholz
Editor-in-Chief

Quick Submission Guide

At JACC, submit your paper your way. Authors may submit their manuscript (text, figures and tables) as a single file at www.jaccsubmit.org. This can be a Word or PDF file, in any format or layout, and figures and tables can be placed within the text. The only requirements for initial review are:

- Please list all author names, institutional affiliations, and relationships with industry and other entities on your title page and in the online submission system (see also Relationships with Industry).
- Please consider the word and author limit for your article type (see Article Types table below); initial submissions may exceed the word limit, but our published papers, with few exceptions, need to adhere to the requirements.

JACC now partners with JACC: Case Reports to publish their top case reports and vignettes in a one issue per week. Authors should refer to the JACC: Case Reports instructions for authors for submission and formatting.

JACC Instructions for Authors

minimize 1. Article Types

Article Type	Description	Requirements
Original Research	Should relate to cardiovascular science and medicine that may include studies conducted in humans or analyses of human data that significantly advance the field.	• **Note: for initial submissions, please see the quick submission guide above; additional requi… requested at revision** • Word Count: ≤5,000, excluding references and figure legends • Author Count: Unlimited • Table/Figure Count: ≤6 tables and/or figures , including Central Illustration • Reference Count: Unlimited • Central Illustration: Optional • Structured Abstract ≤350 words with the headings: Background, Objectives, Methods, Results, Conclusions • Data Sharing Statement • Follow EQUATOR Reporting Guidelines

General publication format:

- Abstract (<350 words)
- Body: (<5000 words)
  - Background
  - Methods
  - Results
    - <=6 tables/figures
  - Conclusions
- Supporting information:
  - References
  - Supplemental Materials

https://www.jaccsubmit.org/cgi-bin/main.plex?form_type=display_auth_instructions#content

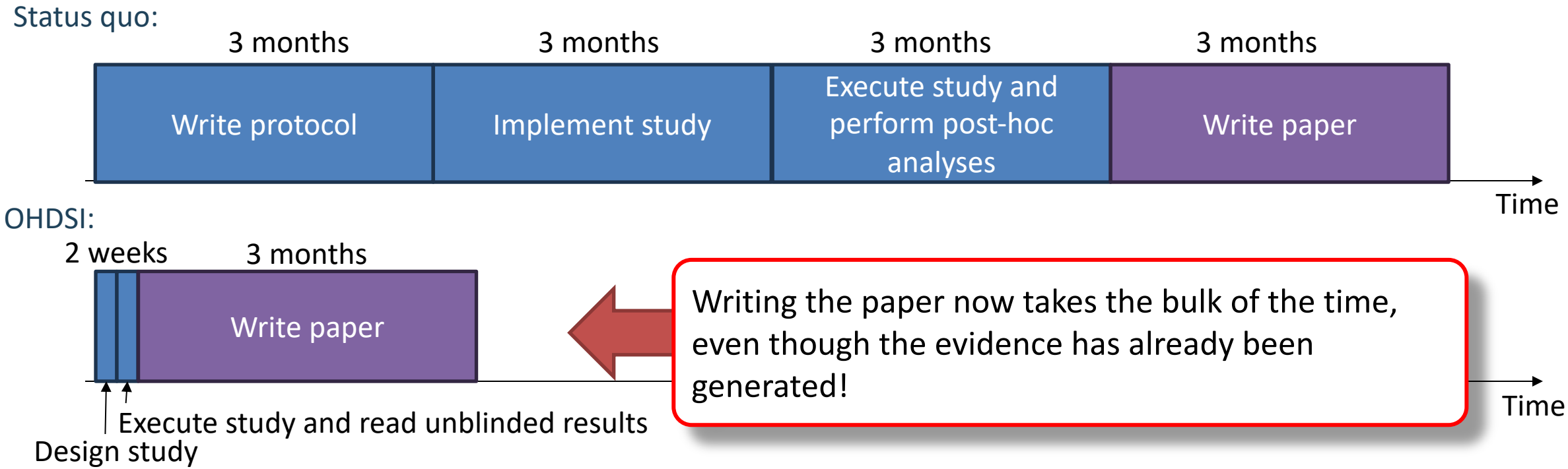
OHDSI community efforts toward supporting publications

Martijn Schuemie

Major improvements to observational research

In OHDSI, we have

- Vastly **reduced time to perform observational studies** (days instead of months)
- Vastly **increased the reliability of observational studies** through use of standardized analytics, objective diagnostics, and generative evidence at scale



What's in a (OHDSI) scientific paper?

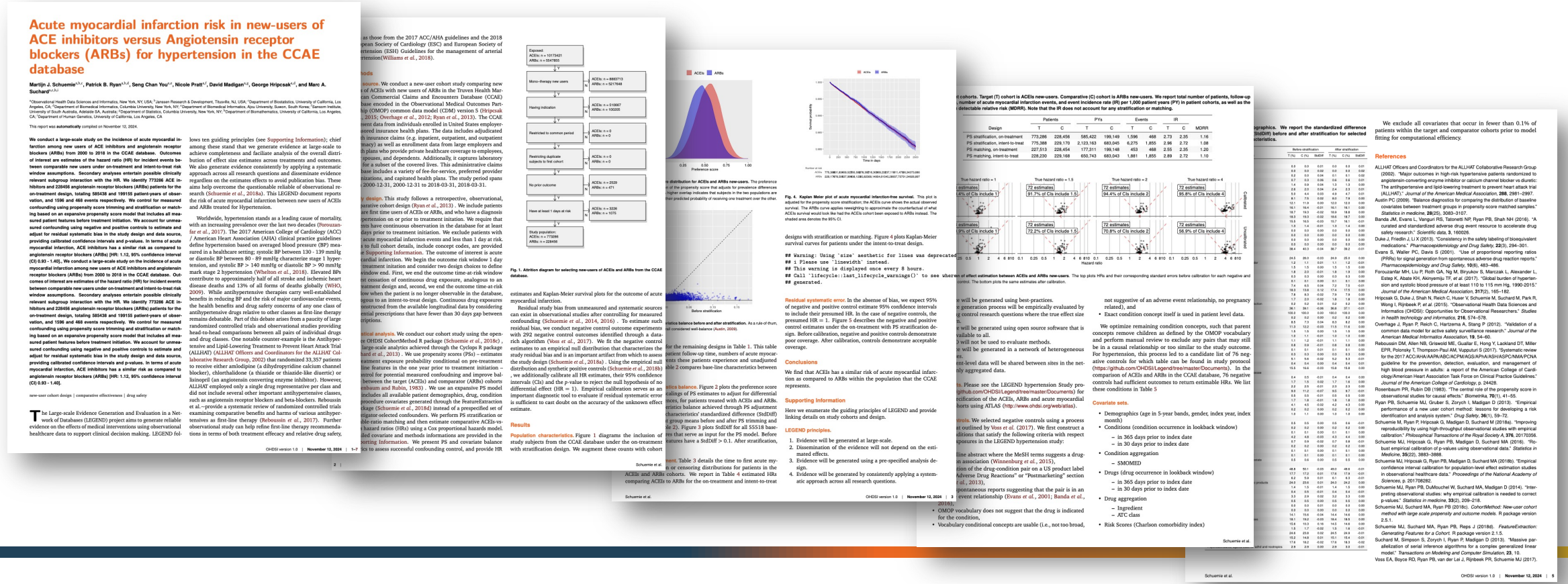
- Background
  - What question did we seek to answer?
  - Why is it important?
  - What is already known?
- Methods
  - What data were used?
  - How were the exposures and outcomes defined?
  - What statistical analysis was performed?
  - What objective diagnostics were used?
- Results
  - Which analyses passed diagnostics?
  - What were the results?
- Discussion
  - What have we learned?
  - How does that fit with what we already knew?

Methods and Results should be **objective descriptions** of what was done and what was observed.

When using **standardized analytics** with **standardized analysis specifications** and **standardized outputs**, this becomes a **fill-in-the-blanks** exercise that can be automated.

LEGENDMed Central was a proof of concept

- Uses Rmarkdown to convert LEGEND Hypertension results to draft papers
- Select a target-comparator-outcome-database, and it would generate a PDF for you
- Still alive, but a bit buggy: https://data.ohdsi.org/LegendMedCentral

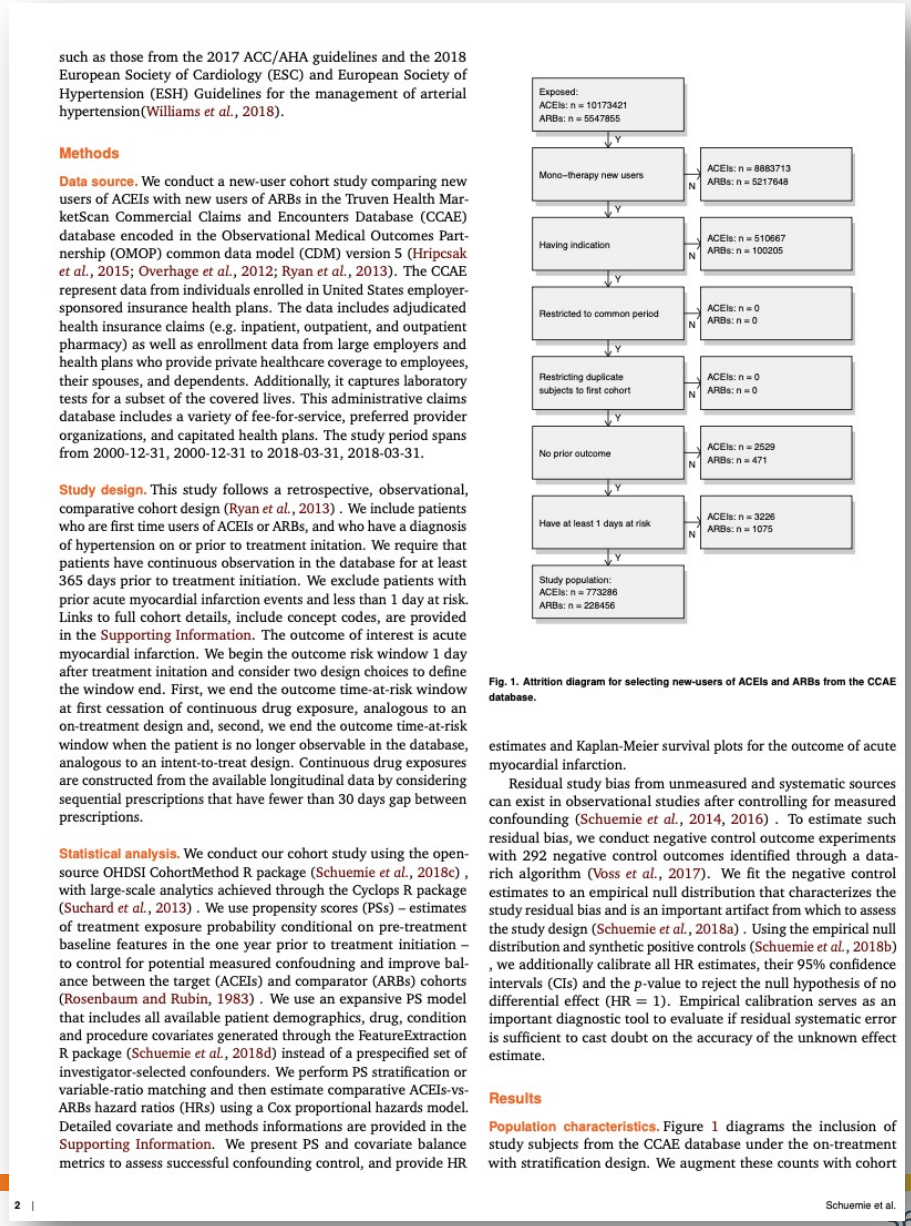


LEGENDMed Central Methods sections

- Pulled in a description of the database
- Referred to the protocol for exposure and outcome definitions
- Study design was fixed (it's a LEGEND study), so used standard text
- We did not yet use objective diagnostics at the time

OHDSI cohort definitions can be converted to human-readable text

Could modify to reflect design choices



such as those from the 2017 ACC/AHA guidelines and the 2018 European Society of Cardiology (ESC) and European Society of Hypertension (ESH) Guidelines for the management of arterial hypertension(Williams *et al.*, 2018).

Methods

Data source. We conduct a new-user cohort study comparing new users of ACEIs with new users of ARBs in the Truven Health MarketScan Commercial Claims and Encounters Database (CCAE) database encoded in the Observational Medical Outcomes Partnership (OMOP) common data model (CDM) version 5 (Hripcsak *et al.*, 2015; Overhage *et al.*, 2012; Ryan *et al.*, 2013). The CCAE represent data from individuals enrolled in United States employer-sponsored insurance health plans. The data includes adjudicated health insurance claims (e.g. inpatient, outpatient, and outpatient pharmacy) as well as enrollment data from large employers and health plans who provide private healthcare coverage to employees, their spouses, and dependents. Additionally, it captures laboratory tests for a subset of the covered lives. This administrative claims database includes a variety of fee-for-service, preferred provider organizations, and capitated health plans. The study period spans from 2000-12-31, 2000-12-31 to 2018-03-31, 2018-03-31.

Study design. This study follows a retrospective, observational, comparative cohort design (Ryan *et al.*, 2013) . We include patients who are first time users of ACEIs or ARBs, and who have a diagnosis of hypertension on or prior to treatment initation. We require that patients have continuous observation in the database for at least 365 days prior to treatment initiation. We exclude patients with prior acute myocardial infarction events and less than 1 day at risk. Links to full cohort details, include concept codes, are provided in the Supporting Information. The outcome of interest is acute myocardial infarction. We begin the outcome risk window 1 day after treatment initation and consider two design choices to define the window end. First, we end the outcome time-at-risk window at first cessation of continuous drug exposure, analogous to an on-treatment design and, second, we end the outcome time-at-risk window when the patient is no longer observable in the database, analogous to an intent-to-treat design. Continuous drug exposures are constructed from the available longitudinal data by considering sequential prescriptions that have fewer than 30 days gap between prescriptions.

Statistical analysis. We conduct our cohort study using the open-source OHDSI CohortMethod R package (Schuemie *et al.*, 2018c) , with large-scale analytics achieved through the Cyclops R package (Suchard *et al.*, 2013) . We use propensity scores (PSs) – estimates of treatment exposure probability conditional on pre-treatment baseline features in the one year prior to treatment initiation – to control for potential measured confoudning and improve balance between the target (ACEIs) and comparator (ARBs) cohorts (Rosenbaum and Rubin, 1983) . We use an expansive PS model that includes all available patient demographics, drug, condition and procedure covariates generated through the FeatureExtraction R package (Schuemie *et al.*, 2018d) instead of a prespecified set of investigator-selected confounders. We perform PS stratification or variable-ratio matching and then estimate comparative ACEIs-vs-ARBs hazard ratios (HRs) using a Cox proportional hazards model. Detailed covariate and methods informations are provided in the Supporting Information. We present PS and covariate balance metrics to assess successful confounding control, and provide HR

Fig. 1. Attrition diagram for selecting new-users of ACEIs and ARBs from the CCAE database.

estimates and Kaplan-Meier survival plots for the outcome of acute myocardial infarction.

Residual study bias from unmeasured and systematic sources can exist in observational studies after controlling for measured confounding (Schuemie *et al.*, 2014, 2016) . To estimate such residual bias, we conduct negative control outcome experiments with 292 negative control outcomes identified through a data-rich algorithm (Voss *et al.*, 2017). We fit the negative control estimates to an empirical null distribution that characterizes the study residual bias and is an important artifact from which to assess the study design (Schuemie *et al.*, 2018a) . Using the empirical null distribution and synthetic positive controls (Schuemie *et al.*, 2018b) , we additionally calibrate all HR estimates, their 95% confidence intervals (CIs) and the *p*-value to reject the null hypothesis of no differential effect (HR = 1). Empirical calibration serves as an important diagnostic tool to evaluate if residual systematic error is sufficient to cast doubt on the accuracy of the unknown effect estimate.

Results

Population characteristics. Figure 1 diagrams the inclusion of study subjects from the CCAE database under the on-treatment with stratification design. We augment these counts with cohort

LEGENDMed Central Results sections

- Pulled figures and tables from the results database
  - Standard set of results artifacts, including ‘Table 1’
- Use simple logic to modify text
  - E.g. if max(SDM) > 0.1, would call this out
- Did not use blinding when diagnostics failed

Nowadays we’d review all diagnostics and blind when appropriate

Could re-use a lot of the one-pager we printed for the closing session here!

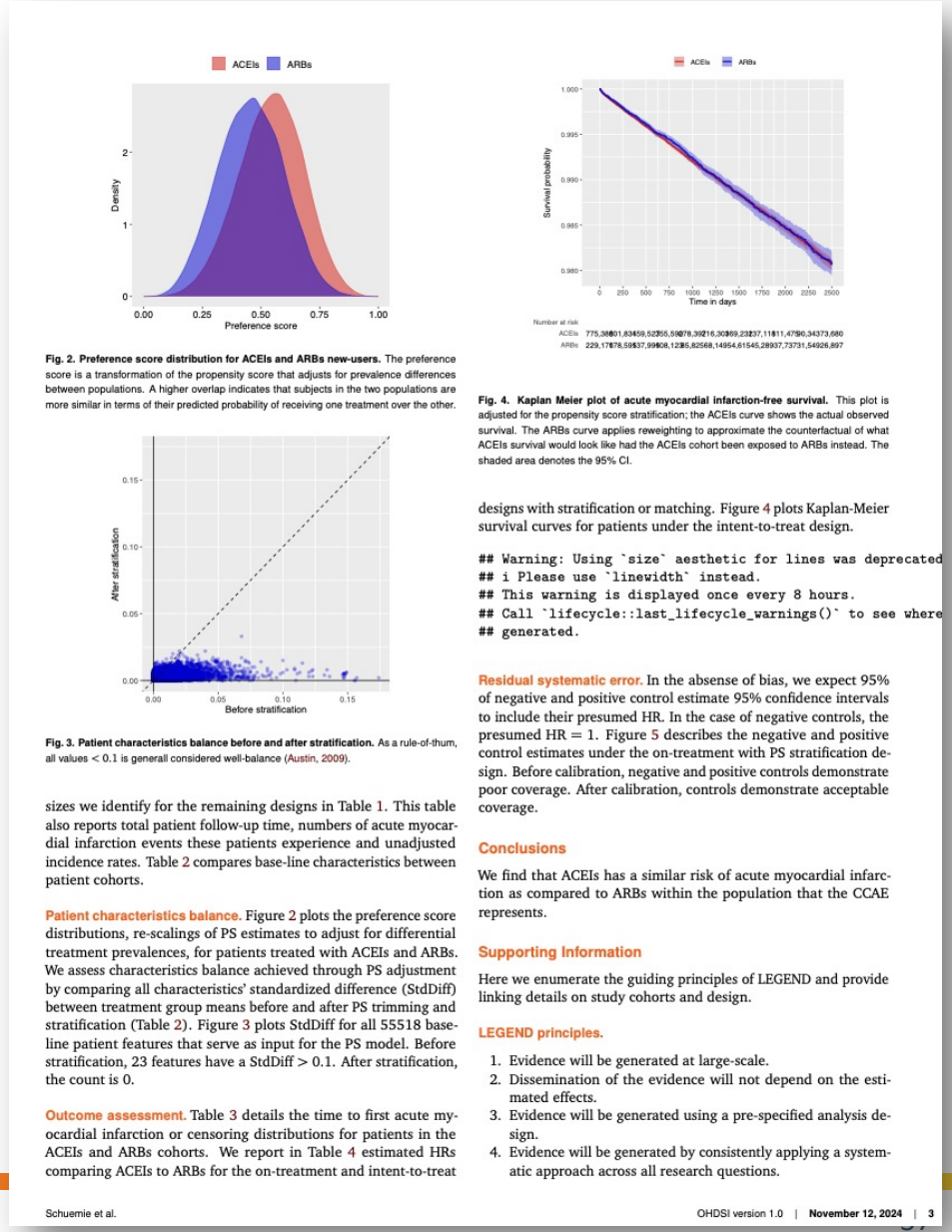


Fig. 2. Preference score distribution for ACEIs and ARBs new-users. The preference score is a transformation of the propensity score that adjusts for prevalence differences between populations. A higher overlap indicates that subjects in the two populations are more similar in terms of their predicted probability of receiving one treatment over the other.

Fig. 3. Patient characteristics balance before and after stratification. As a rule-of-thum, all values < 0.1 is generall considered well-balance (Austin, 2009).

sizes we identify for the remaining designs in Table 1. This table also reports total patient follow-up time, numbers of acute myocardial infarction events these patients experience and unadjusted incidence rates. Table 2 compares base-line characteristics between patient cohorts.

Patient characteristics balance. Figure 2 plots the preference score distributions, re-scalings of PS estimates to adjust for differential treatment prevalences, for patients treated with ACEIs and ARBs. We assess characteristics balance achieved through PS adjustment by comparing all characteristics' standardized difference (StdDiff) between treatment group means before and after PS trimming and stratification (Table 2). Figure 3 plots StdDiff for all 55518 base-line patient features that serve as input for the PS model. Before stratification, 23 features have a StdDiff > 0.1. After stratification, the count is 0.

Outcome assessment. Table 3 details the time to first acute myocardial infarction or censoring distributions for patients in the ACEIs and ARBs cohorts. We report in Table 4 estimated HRs comparing ACEIs to ARBs for the on-treatment and intent-to-treat

Fig. 4. Kaplan Meier plot of acute myocardial infarction-free survival. This plot is adjusted for the propensity score stratification; the ACEIs curve shows the actual observed survival. The ARBs curve applies reweighting to approximate the counterfactual of what ACEIs survival would look like had the ACEIs cohort been exposed to ARBs instead. The shaded area denotes the 95% CI.

designs with stratification or matching. Figure 4 plots Kaplan-Meier survival curves for patients under the intent-to-treat design.

```
## Warning: Using `size` aesthetic for lines was deprecated
## i Please use `linewidth` instead.
## This warning is displayed once every 8 hours.
## Call `lifecycle::last_lifecycle_warnings()` to see where
## generated.
```

Residual systematic error. In the absense of bias, we expect 95% of negative and positive control estimate 95% confidence intervals to include their presumed HR. In the case of negative controls, the presumed HR = 1. Figure 5 describes the negative and positive control estimates under the on-treatment with PS stratification design. Before calibration, negative and positive controls demonstrate poor coverage. After calibration, controls demonstrate acceptable coverage.

Conclusions

We find that ACEIs has a similar risk of acute myocardial infarction as compared to ARBs within the population that the CCAE represents.

Supporting Information

Here we enumerate the guiding principles of LEGEND and provide linking details on study cohorts and design.

LEGEND principles.

1. Evidence will be generated at large-scale.
2. Dissemination of the evidence will not depend on the estimated effects.
3. Evidence will be generated using a pre-specified analysis design.
4. Evidence will be generated by consistently applying a systematic approach across all research questions.

What about other sections?

- Background
  - What question did we seek to answer?
  - Why is it important?
  - What is already known?
- Methods
  - What data were used?
  - How were the exposures and outcomes defined?
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- Discussion
  - What have we learned?
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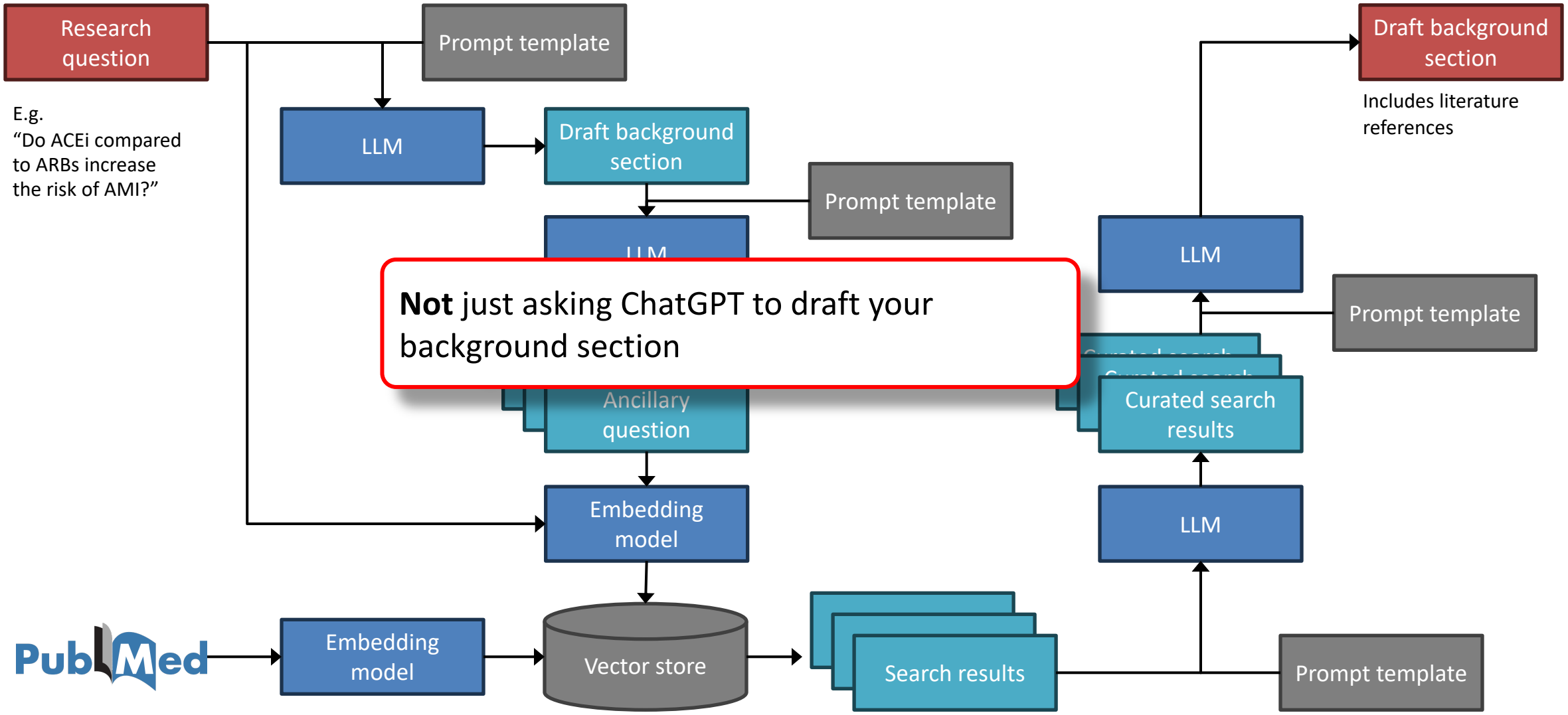
Background section is primarily a **synthesis of the context of the research question**

Large language models could nowadays help with this

CLIO: background writer proof of concept



Draft background section writer using generative AI

- Proof-of-concept suggests this is feasible
- Needs thorough evaluation
  - Initial results to reproduce background sections in PubMed Central show large variability in background sections
  - Will require human review
- Several methodological questions remain open
  - E.g. Should we pull in full-text articles?
- Non-trivial computational costs

Conclusions

- Writing papers has become the bottleneck in generating and disseminating evidence
- There are opportunities for increasing efficiency
  - Methods and Results: We could create a template that is filled in with (standardized) analysis specifications and results
  - Background section: generative AI could help here, but more research is needed
- These are great opportunities for the OHDSI community!

Join the Journey of the Evidence Translation Workgroup

Nicole Pratt

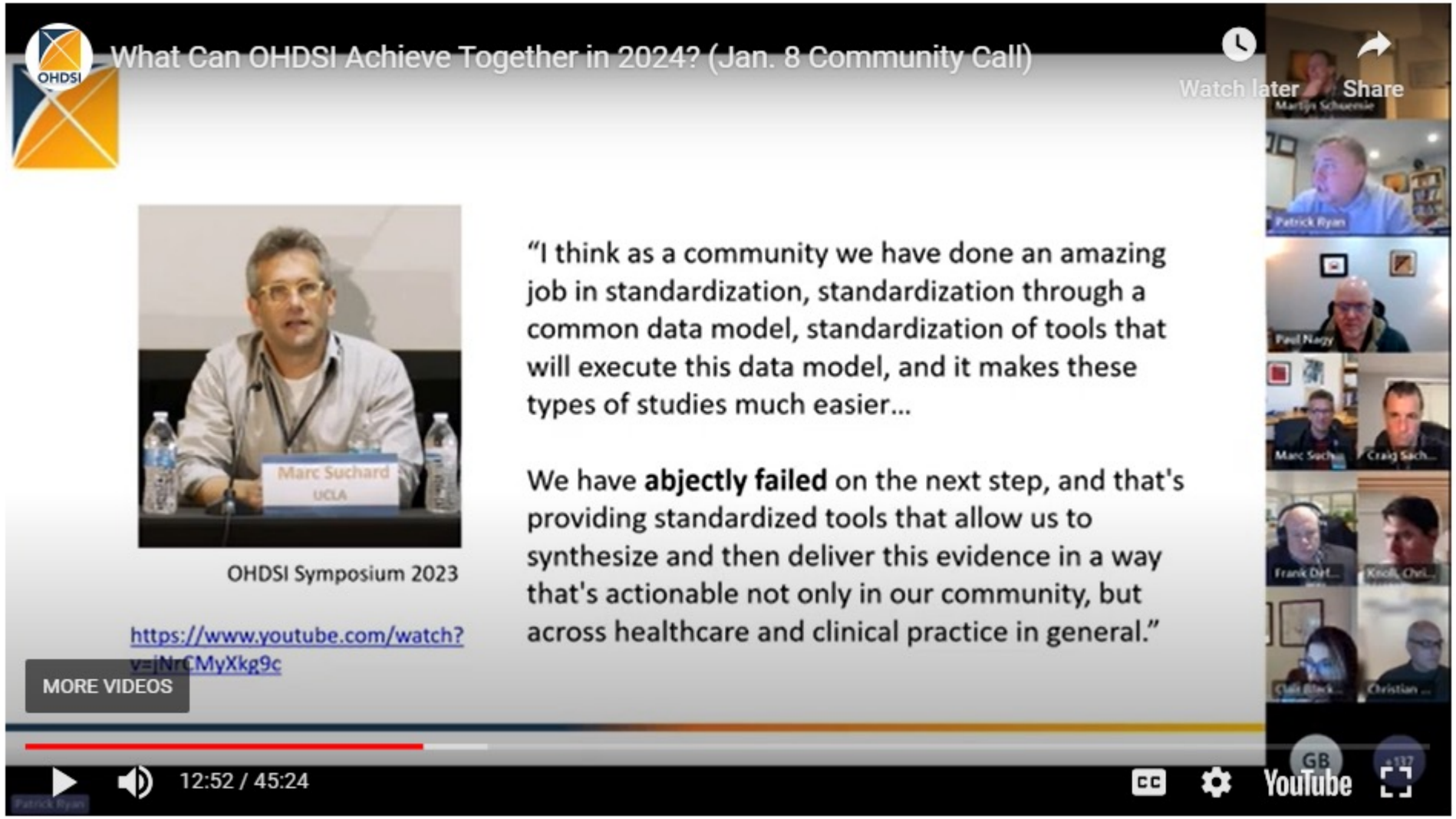
Flashback...OHDSI APAC 2023

Our ingredients are data

Our craft is science

Our brew is evidence

Our duty is to share it



"Making evidence actionable" Patrick Ryan What can OHDSI Achieve Together in 2024 Jan 9
https://ohdsi.org/community-calls/

How can OHDSI ***improve the use and uptake*** of the real world evidence we produce so that it is “actionable” and can be readily consumed to aid in decision making?

We need everyone at the table to not only consume the evidence but also to **set the menu!**

Regulator | Clinician | Consumer | Researcher

How can OHDSI help *[you]* by generating evidence for the ***questions that matter*** to *[you]*?

What else can OHDSI do to ***build trust*** that the evidence we provide is reliable and can be used in decision making?

How can OHDSI ***improve understanding*** about real world evidence we produce so that it can be used in decision making?

New OHDSI Work Group:
Evidence Translation

CMAJ REVIEW

Defining knowledge translation

Sharon E. Straus MD MSc, Jacqueline Tetroe MA, Ian Graham PhD

We cannot pick up a magazine or surf the Internet without facing reminders of the challenges to health care and the "sorry state" of health systems.[1] All health care systems are faced with the challenges of improving quality of care and reducing the risk of adverse events.[2] Globally, health systems fail to use evidence optimally. The result is inefficiency and a reduction in both quantity and quality of life.[3,4] For example, McGlynn and colleagues[5] found that adults in the United States received less than 55% of recommended care. Providing evidence from clinical research (e.g., through publication in journals) is necessary but not enough for the provision of optimal care. Recognition of this issue has created interest in knowledge translation, also known as KT, which we define as the methods for closing the gaps from knowledge to practice. In this series of articles, we will provide a framework for implementing knowledge for clinicians, managers and policy-makers.

Key points

- Gaps between evidence and decision-making occur at all levels of health care, including those of patients, health care professionals and policy-makers.
- Knowledge translation involves using high-quality knowledge in processes of decision-making.
- The knowledge-to-action framework provides a model for the promotion of the application of research and the process of knowledge translation.

Knowledge creation (i.e., primary research), knowledge distillation (i.e., the creation of systematic reviews and guidelines) and knowledge dissemination (i.e., appearances in journals and presentations) are not enough on their own to ensure the use of knowledge in decision-making.

We should also clarify what knowledge translation isn't.

knowledge translation framework

Medium
The Knowledge-to-Action Framewo…

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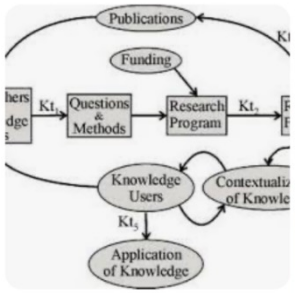
Section 5.1 Knowledge disseminati…



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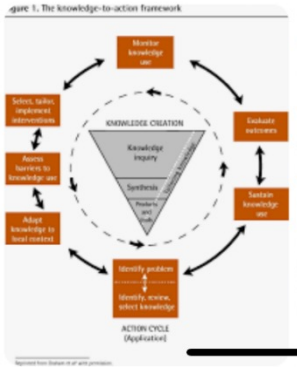
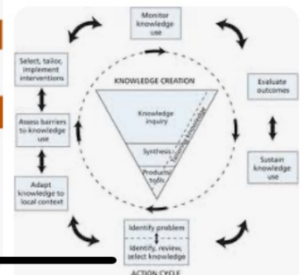
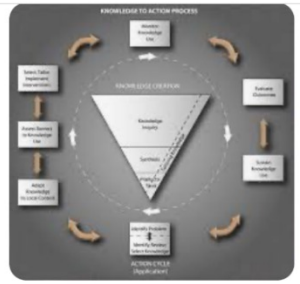
Insert title





knowledge translation framework



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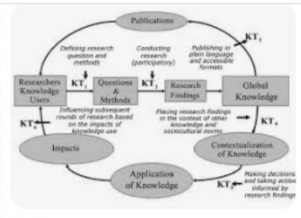
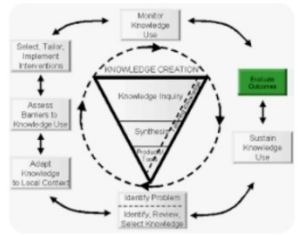


ktdrr
Knowledge Translation: Introduction…



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Section 6.1: Methodologies to Eval…

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Knowledge-To-Action Cycle …

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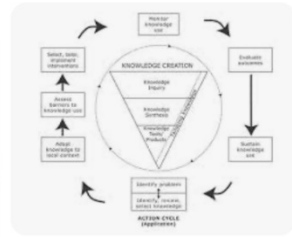
Knowledge-To-Action Cycle …



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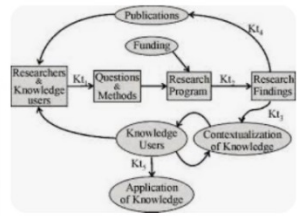

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knowledge translation framework

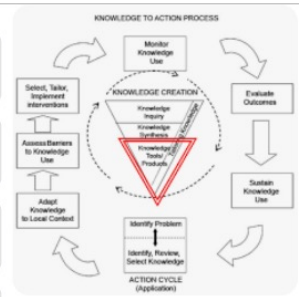
Related searches

knowledge translation **strategies**

research knowledge translation

knowledge translation **process**

knowledge translation **healthcare**



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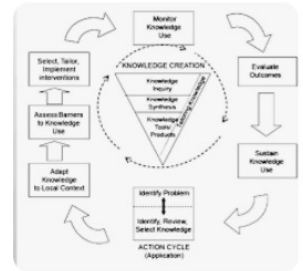
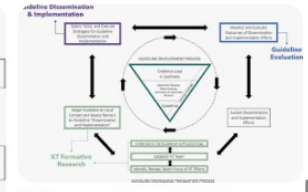
Tools are Emerging to Move Neck P…



Semantic Scholar
Knowledge translation: putting the …



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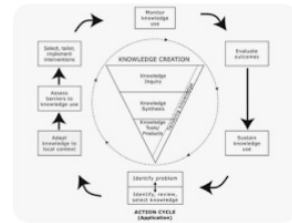
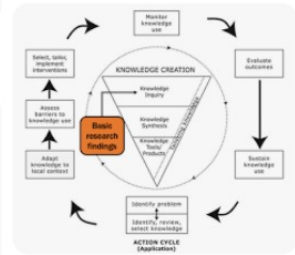


ktdrr
Knowledge Translation



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Knowledge Translation & Translatio…

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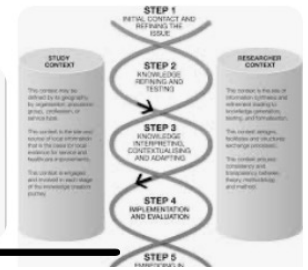

knowledge translation framework

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CIHR Knowledge to Action Process…

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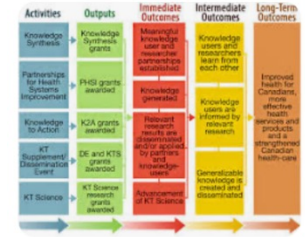
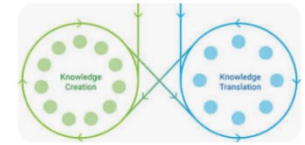
Section 5.1 Knowledge disseminati…



Instituts de recherche en santé d…
Knowledge Translation Funding Pro…



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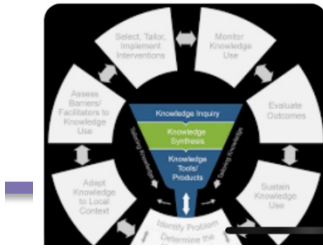
Knowledge-To-Action Cycle …



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The Knowledge-to-Action Framewo…

Related searches

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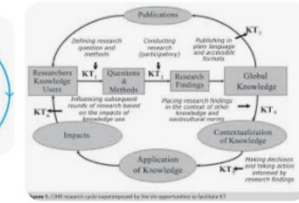
knowledge **to action** framework

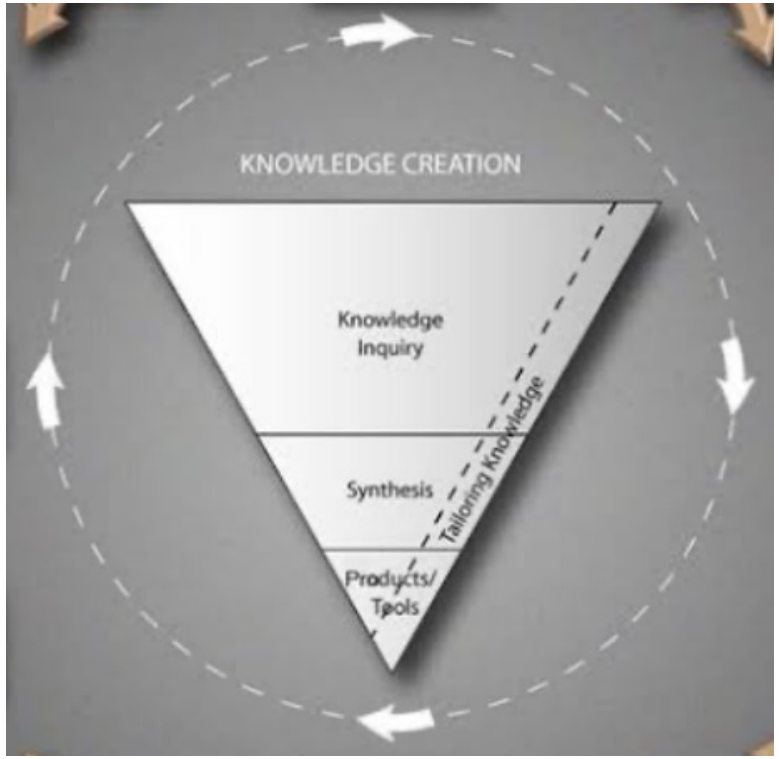
health care knowledge translation

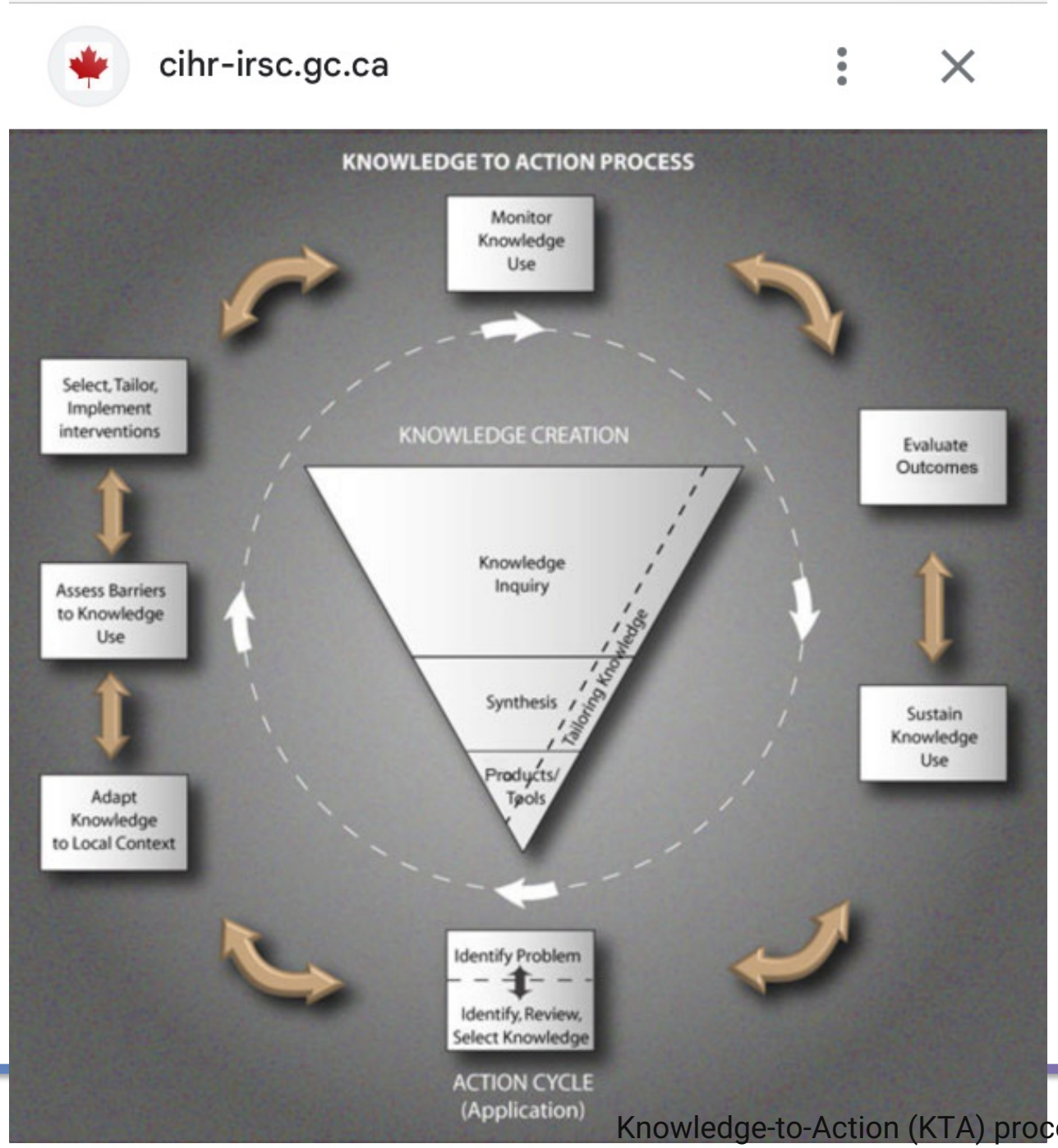
integrated knowledge translation



Semantic Scholar
PDF] Knowledge Translation …

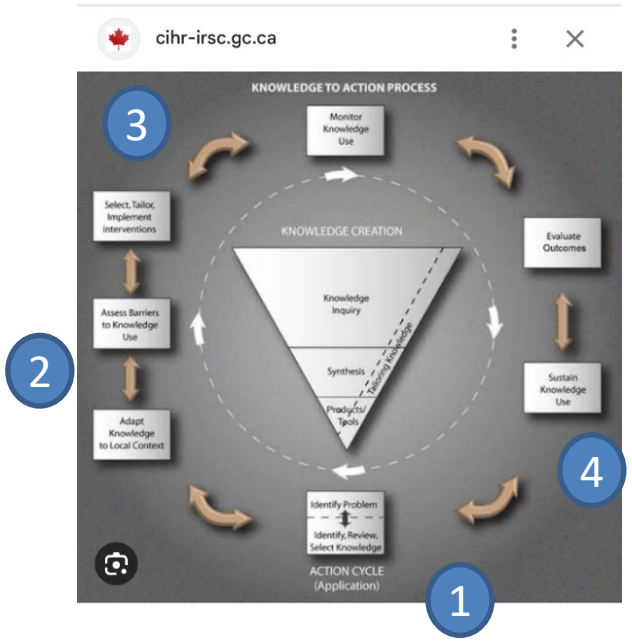
Medium
Say “Knowledge Translation …

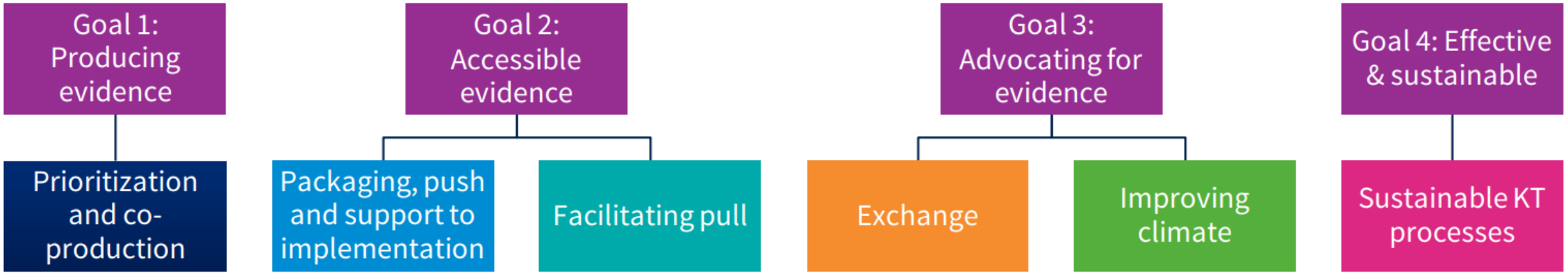

KNOWLEDGE CREATION
Knowledge Inquiry
Synthesis
Products/ Tools
Tailoring Knowledge



Knowledge-to-Action (KTA) process. Source: Graham et al. (2006)

Source: Cochrane Knowledge Translation Framework April 2017





Producing the Evidence	Making it accessible	Making evidence palatable	Measuring the uptake
• ***Prioritisation*** Identify the questions that are important to different stakeholders • ***Co-production*** Identify opportunities for stakeholder involvement throughout the evidence generation pipeline to ensure alignment of needs	• ***Packaging, push and support to implementation*** Identify methods and pathways for evidence dissemination • ***Facilitating pull*** Making evidence findable accessible and developing capacity in end-users finding and using evidence	• ***Exchange*** Develop consumable evidence communications that are tailored to the needs of different stakeholders. Develop strategic partnerships, forums to exchange ideas	• ***Monitoring*** the uptake, reach and impact of OHDSI research into policy and/or practice
Objectives			
Create an appetite	Set the table	Make it palatable	Are they eating it?
Key Results			
Consumer forums Engagement with regulators	Create user friendly findable, open-source tools “evidence libraries”	Create evidence briefs, lay summaries	Create impact stories, diffusion of evidence, audiences reached

Next Steps

- Join the work group: WG sign up for the community to Teams channel
- Set up a schedule of Meetings
- Set Objectives & Key Result (OKR)

- **Purpose**: The Evidence Translation workgroup exists to promote and facilitate the dissemination and uptake of evidence generated by the OHDSI community into all aspects of health care decision-making.