Summary: An evaluation of Canadian Task Force on Preventive Health Care's 2017 knowledge translation activities

Prepared for the Canadian Task Force on Preventive Health Care

Submitted 5/1/2018

Prepared by:
Kasha Pyka & Danica Buckland

Knowledge Translation Program
Li Ka Shing Knowledge Institute
St. Michael's Hospital

Contact:
Danica Buckland

E: bucklandd@smh.ca
T: 416-864-6060 ext. 77566

1.0 Background and Methods

This report provides a condensed overview of the Canadian Task Force on Preventive Health Care's (CTFPHC) 2017 evaluation report. The 2017 evaluation measured the impact and uptake of the CTPFHC's clinical practice guidelines and associated knowledge translation (KT) tools and resources released; including (1) prevention and treatment of tobacco smoking in children and youth; (2) hepatitis C (HCV) screening; and (3) abdominal aortic aneurysm (AAA) screening. In addition to examining data on key KT activities, we engaged primary care practitioners (PCPs) through both surveys and semi-structured interviews to understand the uptake of these KT activities. The results of this evaluation provide feedback on the CTFPHC's activities, highlight the strengths of the CTFPHC's KT efforts, and identify areas in which the CTFPHC can improve KT activities and uptake.

2.0 Results

Guidelines and Dissemination

For highlights of 2017 guidelines and KT activities, please refer to the Appendix at the end of this report.

Survey

A total of 198 PCPs completed the survey. Participants practiced in urban (58%, *n* = 114), suburban (18%, *n* = 35), and rural (27%, *n* = 53) settings. They represented 11 provinces and territories, and a range of years of experience (i.e., from five or fewer years to 41 or more years) Participants were asked questions about: (a) awareness and use of CTFPHC guidelines, KT tools, and resources; and (b) current practices.

(a) Awareness and use of CTFPHC guidelines and KT tools

Of screening guidelines published in 2017, the majority of PCPs (63%, *n* = 124) were aware of the AAA guideline. Less than half of PCPs were aware of the HCV and tobacco smoking in children and youth guidelines (38%, *n* = 76; and 16%, *n* = 31, respectively). Of participants who were aware of the guidelines, nearly half used both the AAA and HCV screening guidelines (49%, *n* = 61; and 44%, *n* = 33, respectively); while less than a quarter used the tobacco smoking in children and youth guideline (22%, *n* = 7). See *Table 1* for participant awareness and use comparisons.

Table 1: Participant Awareness and Use of CTFPHC Guidelines (*n* = 198)

Guideline	# Aware	% Aware	# Use	%Use
AAA	124/198	63%	61/124	49%
HCV	76/198	38%	33/76	44%
Tobacco	31/198	16%	7/31	22%

A clinician frequently asked questions (FAQ) KT tool was created for both the tobacco smoking in children and adolescents and HCV guidelines. Roughly one-third of PCPs who were familiar with these guidelines were also familiar with the FAQs (39%, *n* = 10; and 33%, *n* = 23, respectively); however, more PCPs used the HCV FAQ than the tobacco smoking in children and adolescents FAQ (35%, *n* = 8; vs. 10%, *n* = 1). Two KT tools were created for the AAA

guideline: a 1000-person tool and clinician recommendation table. More PCPs were aware of the 1000-person tool (36%, *n* = 45; vs. 27%, *n* = 33). Of PCPs who were aware of the AAA KT tools, nearly an equal amount of PCPs used both (34%, *n* = 15; and 32%, *n* = 11, respectively). See *Table 2* for participant use comparisons.

Table 2: Participant Awareness and Use of KT Tools (*n* = 198)

KT Tool	# Aware	% Aware	# Use	%Use
AAA 1000-Person Tool	45/124	36%	15/45	34%
AAA Clinician Recommendation Table	33/124	27%	11/33	32%
HCV FAQ	23/76	33%	8/23	35%
Tobacco FAQ	10/31	39%	1/10	10%

(b) Current practice

Over one-third of PCPs (36%, *n* = 60) routinely asked about smoking in children 5-12 years of age as recommended by the CTFPHC. In addition, approximately three-quarters of PCPs (78%, *n* = 130) asked youth (ages 13-18 years) about smoking. The majority of PCPs (60%, *n* = 118) reported practices that are consistent with the CTFPHC HCV screening recommendations. Over half of PCPs (58%, *n* = 115) reported screening men aged 65-80 years for AAA and over three-quarters of participants (87%, *n* = 145) reported not screening females for AAA; both of which are practices that align with the CTFPHC recommendations

Interviews

We conducted 28 semi-structured interviews with PCPs across Canada, to explore four themes: (1) how and what PCPs first learned about the CTFPHC; (2) sources PCPs used for screening and preventive health care recommendations; (3) how PCPs made the decision to adopt CTFPHC guidelines; and (4) how PCPs implemented CTFPHC guidelines in their practice.

(1) Learning about the CTFPHC

The majority of PCPs were first exposed to the CTFPHC in their training, such as during medical school or residency. Other sources of exposure included conferences (specifically, Family Medicine Forum), publications (e.g., *CMAJ*), and Choosing Wisely. In terms of staying informed on new CTFPHC materials, PCPs discussed interacting with students or residents who were learning new things, participating in peer study groups, and looking for new materials online. In addition to these general methods, PCPs also mentioned visiting the CTFPHC booth at *FMF*, subscribing to the CTFPHC newsletter, and participating in CTFPHC guideline usability testing as strategies to remain updated. To ensure they maintained alignment with the guideline recommendations, PCPs reported keeping printed KT tools in their offices, visiting the CTFPHC website, and using the CTFPHC mobile app.

(2) Sources of screening and preventive health care recommendations

Participants stated that they looked for sources from organizations that are trustworthy, well-known, and used by peers. When describing what makes a source trusted, PCPs mentioned that guideline development processes, use of evidence, and transparent guideline presentation (e.g., links to original studies, summaries, and an appropriate amount of information for clinicians and patients) were important components. Most PCPs stated that the CTFPHC was one of their most trusted sources for guidelines.

(3) Adopting CTFPHC guidelines

When deciding to use a CTFPHC guideline, PCPs described four main factors that influenced their decision-making: values and preferences, clinical experience, influence of colleagues, and other recommendations. When first evaluating a guideline, PCPs valued the quality of the evidence, the strength of the recommendation, what the possible benefits were to patients, and the rate of false positives. In terms of clinical experience, PCPs stated that they were most willing to follow guidelines that recommended their current practice. With respect to colleague influences, many PCPs said they looked to what their peers were doing to set the guideline adoption norm. Lastly, PCPs described the importance of comparing CTFPHC guidelines to other provincial recommendations. In cases where discrepancies between provincial and national screening recommendations are observed, PCPs stated that they use the discrepancy as a conversation point for shared decision-making, or ask preceptors or trusted colleagues what they recommend.

(4) Implementing guidelines

Participants described general supports and challenges in implementing CTFPHC guidelines. Participants described reminders and contextual factors (such as EMRs) as two supports for the use and implementation of CTFPHC guidelines. However, PCPs expressed challenges due to limited time for consulting patients on preventive health care. As a result, PCPs stated that they prioritize screening tests that offer the largest potential for benefit or that they are paid to provide. Additionally, many PCPs who worked in multiple settings described their implementation of guidelines depended on their work location. Several PCPs working alongside specialists stated that they aligned their practices with them, which may not be aligned with guideline recommendations, yet the PCPs followed CTFPHC recommendations in other settings. Similarly, PCPs who were new to a practice and were either temporarily or permanently taking over another PCP's patients, continued to practice in the way the previous PCP practiced to provide continuity of care. Additional barriers to following specific CTFPHC guideline recommendations included: a lack of clarity about how to implement the recommendations; not remembering recommendations; no prompts for screening during typical appointments; no provincial billing codes for some screening tests; and not considering screening to be valuable.

With respect to patient interactions, most PCPs agreed that only some guidelines and only some patients required shared decision-making. In assessing if a patient should be presented with screening options, PCPs looked at previous care received by the patient, assessed the patient's understanding of the issue, and presented evidence. Many PCPs stated that ultimately, any care or intervention was the patient's decision. Additionally, many PCPs stated that they are conscious of how much time they spend on screening and preventive health care. Some said they had to remember that inserting screening or preventive health care into a visit meant the patient had less time to talk about their reason for the visit. To combat this, some PCPs passively exposed patients to screening prompts by having information in their waiting rooms or including information about screening in letters they sent to patients. Others said they made time for screening and preventive health care when new patients joined the practice or during annual check-ups.

3.0 Limitations

The survey and interview participant samples were small and may not be representative of all PCPs in Canada. Also, due to resource limitations, we administered the surveys and interviews

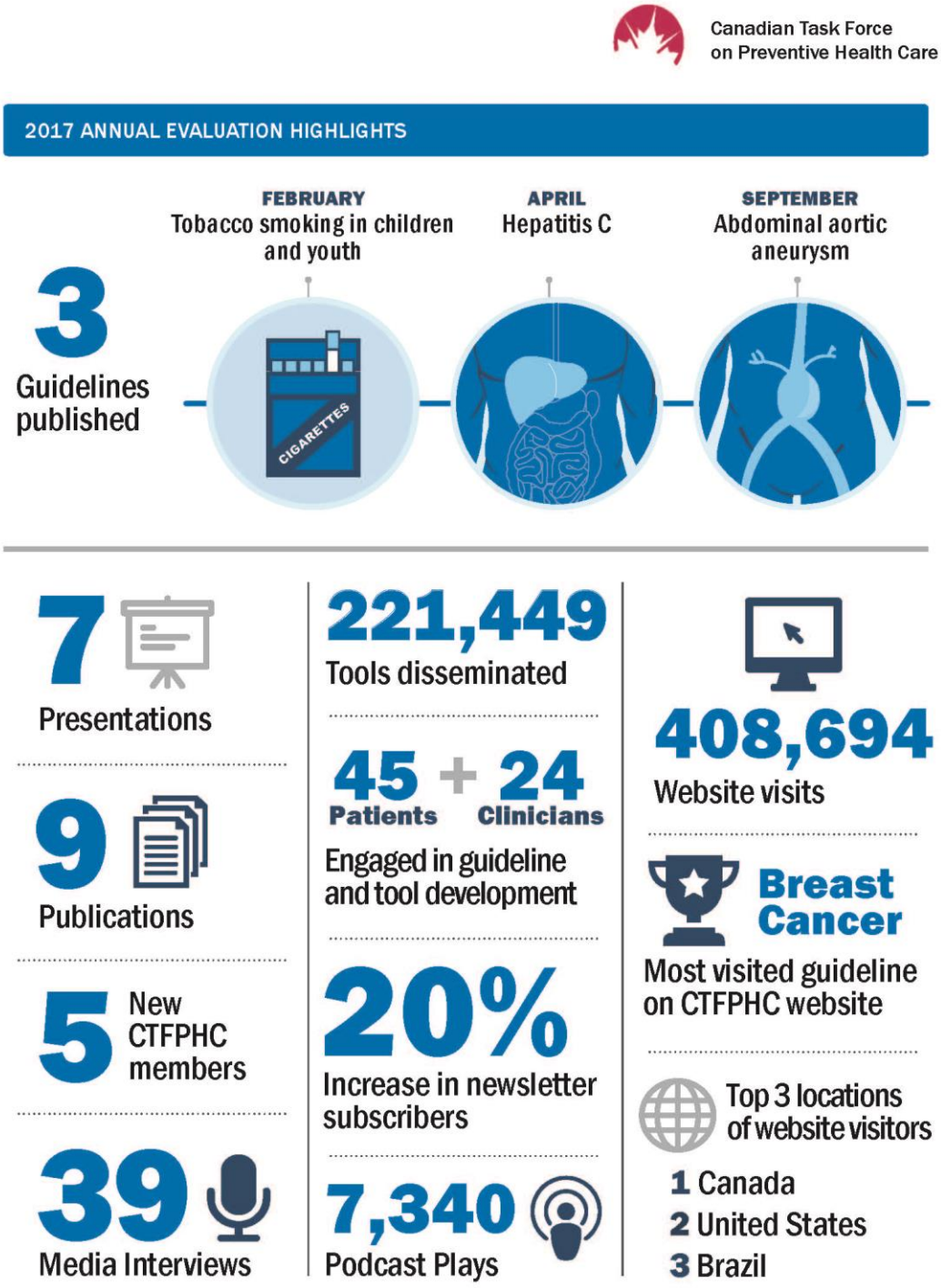
in English only. Lastly, the survey and interview data collected in this evaluation were based on participants' self-reported awareness and use of CTFPHC guidelines, KT tools, and KT resources.

4.0 Recommendations

This report provides a condensed overview of the CTFPHC 2017 annual evaluation report. Based on this evaluation, we have identified six opportunities for growth and improvement:

1.0 We recommend that the CTFPHC continues to prioritize the relationships with other guideline organizations to facilitate better alignment with CTFPHC recommendations
2.0 We recommend that the CTFPHC develops a strategy to embed CTFPHC guidelines in PCP training programs
3.0 For KT tools and dissemination:
    a. We recommend that the CTFPHC explores how to increase its online presence and KT tool dissemination
    b. We recommend the CTFPHC discontinues activities with low reach such as mailing printed materials with the CMAJ
    c. We recommend the CTFPHC considers disseminating to new target audiences such as nurse practitioners, pharmacists, and physician assistants.
    d. We recommend the CTFPHC explores developing new types of KT tools such as shared decision making tools or tools that combine multiple guidelines' recommendations
4.0 We recommend that the CTFPHC targets information more directly to patients
5.0 We recommend that the CTFPHC enhances its presence in French
6.0 We recommend that the CTFPHC develops strategies for growth

Appendix


Canadian Task Force on Preventive Health Care
2017 ANNUAL EVALUATION HIGHLIGHTS
FEBRUARY
Tobacco smoking in children and youth
APRIL
Hepatitis C
SEPTEMBER
Abdominal aortic aneurysm
3
Guidelines published
CIGARETTES
7
Presentations
9
Publications
5
New CTFPHC members
39
Media Interviews
221,449
Tools disseminated
45 Patients + 24 Clinicians
Engaged in guideline and tool development
20%
Increase in newsletter subscribers
7,340
Podcast Plays
408,694
Website visits
Breast Cancer
Most visited guideline on CTFPHC website
Top 3 locations of website visitors
1 Canada
2 United States
3 Brazil