An evaluation of the Canadian Task Force on Preventive Health Care's 2018 knowledge translation activities

Prepared for the Canadian Task Force on Preventive Health Care

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Executive Summary

The knowledge translation (KT) team at St. Michael's Hospital (SMH) evaluated the impact and uptake of the Canadian Task Force on Preventive Health Care's ('Task Force') clinical practice guidelines (CPGs), KT tools, and KT resources during the period between January and December 2018.The evaluation focused on guidelines and associated KT tools related to topics released in 2018 (i.e. screening for impaired vision; screening for asymptomatic bacteriuria in pregnancy; and breast cancer screening update) as well as previously released guidelines that recommended significant practice change, including; breast cancer screening (released in 2011); cervical cancer screening (released in 2013); and prostate cancer screening (released in 2014). The results of this evaluation capture and assess the Task Force's activities, highlight the strengths of Task Force's KT efforts, and identify areas in which the Task Force can improve KT activities and uptake.

To gather data on key KT activities, we examined administrative data, tracking documents and reports, and engaged primary care practitioners (PCPs) through both surveys and semi-structured interviews to understand the uptake of Task Force recommendations and KT materials. Survey participants were recruited through advertisements promoted via Task Force communication channels (e.g. Task Force newsletter, Task Force Twitter, Task Force website, etc.), and responses were analyzed in SPSS[1] to determine response frequencies. Interview participants were identified through survey responses, and transcripts were analyzed in NVIVO using framework analysis[2].

Highlights of KT activities conducted by the Task Force in 2018 included (see infographic on page A1 for additional highlights):

- 3 guideline publications and 7 associated KT tools released,
- 7 presentations delivered,
- 101 patients and 17 clinicians engaged in guideline and tool development,
- 17 webinars delivered,
- 16 media interviews completed, and
- 19,192 KT tools disseminated

Survey results indicated that most participants were aware of the breast (75%; *n* = 182), cervical (82%; *n* = 199), and prostate (81%; *n* = 197) cancer guidelines. About half of participants (47%; *n* = 93) were aware of the newly released breast cancer update, one third (33%; *n* = 80) were aware of the asymptomatic bacteriuria guideline and few (17%; *n* = 41) were aware of the impaired vision guideline. Self-reported screening practices had varying degrees of consistency with Task Force recommendations. Self-reported breast and prostate cancer screening practices were most consistent with Task Force recommendations; 87% (*n* = 211) of survey respondents reported that they did not routinely screen women aged 40–49 years for breast cancer with mammography and 88% (*n* = 176) of survey respondents reported that they did not routinely screen men younger than 55 years for prostate cancer with the Prostate Specific Antigen (PSA) test. Cervical cancer screening practices were least consistent with Task Force recommendations; 51% (*n* = 123) of participants reported that they did not routinely screen women under 25 years old.

During interviews, participants offered suggestions for how the Task Force could improve the dissemination of their tools and guidelines, for example: enhancing strategies for providing regular updates on new guidelines, attending conferences, and increasing public awareness. Participants also discussed factors that contribute to the trustworthiness of an organization, including; organization reputation and values, composition of guideline developers, quality and strength of evidence, guideline presentation and usability, and endorsements or partnerships.

When asked what influences guideline uptake and adoption, PCPs identified: practitioner values and preferences, clinical experience, social/professional influence of colleagues, alignment with other recommendations, and feasibility of implementing guideline recommendations.

Based on this evaluation, we identified seven opportunities for enhancing the impact and uptake of the Task Force's CPGs, KT tools, and resources (see recommendations on pages 33-37):

1. Increase awareness of Task Force guidelines, Task Force KT tools, and Task Force organization among PCPs
    a. Build the "Task Force brand"
    b. Prioritize partnerships with, and promote endorsements by, professional organizations
    c. Integrate Task Force guidelines and KT tools into practitioner curricula
    d. Expand TF dissemination to reach a wider array of PCPs
2. Optimize existing Task Force guideline and KT tool dissemination activities
    a. Improve digital resource and website accessibility
    b. Optimize TF newsletter
    c. Develop KT tools that are not specific to individual guidelines
    d. Create material to support shared-decision making and conditional recommendations
    e. Update older KT tools and guidelines
3. Directly target and engage patients
4. Enhance Task Force French presence
5. Encourage alignment of provincial guidelines with Task Force
6. Expand CPL network activities
7. Stop high cost activities with low uptake
    a. Discontinue CME e-learning modules
    b. Stop video development
    c. Re-examine QxMD partnership following completion of free grant

1.0 Background

Evaluating the Task Force's activities is a key objective of the Task Force and a provision of the contribution agreement between the Jewish General Hospital and the Public Health Agency of Canada. We conducted an evaluation to assess the impact and uptake of the Task Force's CPGs, KT tools, and KT resources released between January and December 2018. Specifically, this evaluation focused on the guidelines and associated KT tools related to:

- Screening for impaired vision,
- Screening for asymptomatic bacteriuria in pregnancy, and
- Breast cancer screening update

We also examined three guidelines and associated KT tools released in previous years that recommended a substantial change in clinical practice for primary care practitioners (PCPs): screening for breast (2011), cervical (2013), and prostate cancer (2014).

This report describes the results of this evaluation and identifies strengths of the Task Force's current KT efforts, and opportunities for improvement.

2.0 Methods

This evaluation was guided by the RE-AIM evaluation framework,[3,4] a framework for evaluating public health interventions that assesses 5 dimensions; reach, effectiveness, adoption, implementation, and maintenance.

We used the RE-AIM framework to assess two components of the Task Force's KT efforts:

1. The Task Force's **KT activities**, specifically, the types and quantity of materials produced, how they were disseminated and implemented, and
2. The **uptake** of these materials by PCPs, namely, their awareness of materials, how they received them, and how they used or adopted them in practice.

2.1 KT Activities: Data collection and analysis

We evaluated how the Task Force disseminated and implemented its guidelines by examining data (e.g. administrative data, tracking documents, reports, and analytics) on key KT activities, including efforts to engage knowledge users and research projects that supported the uptake of Task Force guidelines. These data are presented using descriptive and summary statistics.

2.2 Uptake: Participant recruitment

We recruited PCPs to participate in online surveys and one-on-one telephone interviews to collect data on the uptake of Task Force KT efforts.

Survey

We recruited survey participants by advertising through the following channels:

- Family Medicine Forum,
- Task Force website,
- Emails to the Task Force mailing list and recruitment database,
- Snowball sampling through Task Force member's networks,
- Task Force newsletter,
- Task Force Twitter, and

- Stakeholder organization communications, including the Ontario College of Family Physicians Practicing Wisely e-news bulletin, Nurse Association of New Brunswick newsletter, Nurse and Nurse Practitioners of British Columbia social media channels, and Nurse Practitioner Association of Ontario's newsletter.

Interviews

We recruited PCPs through survey responses; specifically, at the end of the survey, participants were asked if they were willing to participate in an interview. From those who identified interest in participating, we selected interview participants to represent a range of demographic characteristics, including province or territory, age, years in practice, and self-reported gender identity.

2.3 Uptake: Data collection and analysis

Survey

We evaluated uptake of the guidelines by administering a survey in English to PCPs to assess self-reported current practices; awareness and use of Task Force guidelines, KT tools, and KT resources; and practice change. The Task Force plans to also conduct evaluation activities in French in future years.

We created two versions of the survey. The short version captured PCPs' current practices and awareness of Task Force Guidelines, (see page A3) whereas the long version captured more in-depth information about PCPs and their awareness and use of Task Force guidelines and recommendations (see page A17). The short version of the survey was administered at the Family Medicine Forum from November 14th – 17th, 2018. The long version of the survey was administered online from December 21st, 2018 to February 4th, 2019.

Short-form survey participants were entered into a drawing to win a $50 gift card. Long-form survey participants were entered into a drawing to win an iPad.

Responses from the short and long versions of the survey were combined and then analyzed in SPSS[1] to determine response frequencies.

Interviews

Building on the survey results, we conducted semi-structured, one-hour interviews via telephone with PCPs, to explore how they used guidelines and made preventive health care decisions. Interviews were conducted in English, between January 3rd and February 1st, 2019. Interview participants were compensated $100 for their time and were not eligible to enter the draw to win an iPad. See pages A52–A54 for the interview guide.

After each interview, the audio recordings were transcribed verbatim. A total of 20% of interview transcripts were double-coded in NVIVO using framework analysis[2]. A meeting followed where discrepancies were discussed to refine the coding framework and achieve consensus[2]. We targeted an inter-rater agreement of >0.6[5]. The remaining transcripts were single coded by two members of the research team.

3.0 Results

3.1 Guidelines

Results on the reach of Task Force KT efforts can be found below. Summary statistics can be found in presentation-ready tables and figures in the corresponding sections of the slide appendices (pages S1–S89). Page A1 shows highlights.

Guideline publications

The Task Force produced two new guidelines and one guideline update in 2018.

New guidelines released:

- Screening for impaired vision (May 2018)
- Screening for asymptomatic bacteriuria in pregnancy (July 2018)

Guideline updates released:

- Breast cancer update (December 2018)

All 2018 guidelines were published in *CMAJ* online and print editions. Pages S1–S7 present pre-release stakeholder engagement numbers and post-release dissemination activities and media hits for each 2018 guideline.

Guideline dissemination

In 2018, the Task Force conducted a number of activities to disseminate all of its guidelines and KT tools:

- Exhibiting and distributing hard copies of 14,348 KT tools at four conferences, as well as distributing 4844 electronic tools via email, for a total of 19,192 tools distributed
- Maintaining and updating the Task Force website,
- Making all Task Force materials available through mobile applications QxMD Calculate and Read, and
- Fulfilling a request for hard copies of tools for a nurse practitioner in Saskatchewan; this nurse practitioner was the only PCP in community of 1000

The Task Force routinely seeks endorsements for guidelines from the College of Family Physicians of Canada and the Nurse Practitioner Association of Canada, in addition to topic-specific stakeholders. Page S2, S4, and S6 list the endorsements and statements of support received for the guidelines released in 2018.

Additionally, guidelines and KT tools published in earlier years continued to be accessible through the *CMAJ* website, Task Force website, and QxMD mobile app. The KT tool pages on the Task Force website were viewed 50,711 times in 2018. See page S23 for a breakdown of the top 10 most viewed guideline KT tool pages.

Pages S8–S28 outline the 2018 dissemination activities for all Task Force guidelines.

3.2 Dissemination

In 2018, the Task Force disseminated its messages through publications and media coverage, presentations, newsletters, videos, and Twitter.

Publications

In 2018, the Task Force published four peer-reviewed publications; three guidelines were published in *CMAJ*, and one systematic review on screening for chlamydia and/or gonorrhea in sexually active individuals within primary care, was published in *Systematic Reviews*. See page S30 for publication details.

Additionally, a group affiliated with the Task Force published seven articles in 2018 as part of the ongoing article series, "Prevention in Practice," in *Canadian Family Physician* (*CFP*). This series intends to equip PCPs with strategies on how to implement preventive health evidence

into their work and engage in shared decision making. See page S31 for more details on the CFP article series, including number of views and downloads.

Media coverage

The breast cancer update guideline, released by the Task Force on December 10th 2018, received particularly large amounts of public interest and generated extensive media coverage. Between December 10th and December 31st, 2018, it generated 732 media stories and more than 17.2 million media impressions. This is more than three times more media coverage than the original breast cancer guideline, which was released in 2011, and almost 50% more coverage than the next most covered guideline, the prostate guideline, which was released in 2013. The breast cancer screening update generated the most Francophone media coverage of any Task Force guideline released to date, and was the first guideline to release a *CMAJ* author podcast in French. Podcast views for breast cancer update totaled 661 in French and 785 in English.

The Task Force appeared in news media interviews related to the release of the asymptomatic bacteriuria guideline and breast cancer screening update. Task Force members participated in 1 interview related to the release of the asymptomatic bacteriuria guideline, and 15 interviews related to the release of the breast cancer screening guideline update. See pages S3, S5, S7, and S32–S33 for more details on 2018 media coverage.

Presentations and webinars

Task Force members delivered 7 presentations across North America in 2018. See pages S34–S36 for a summary of the presentations.

Task Force also continued to engage stakeholders through webinars prior to guideline release. Stakeholders were identified by conducting a systematic internet search to identify key experts and key organizations within the guideline topic field. In 2018, the Task Force delivered 7 stakeholder webinars for 3 guidelines, engaging a total of 33 stakeholders in attendance. See page S37 for stakeholder webinar details.

Newsletter and Twitter

In 2018, the Task Force communicated updates on its work, such as new guideline publications, through its quarterly newsletter and Twitter. At the end of 2018, the quarterly newsletter had 2486 recipients (e.g., PCPs, patient advocacy groups, regional health authorities). This is approximately the same number of newsletter recipients as at the end of 2017. The number of Task Force Twitter account followers almost doubled this year, increasing from 205 followers at the end of 2017, to 395 Twitter followers at the end of 2018. However, only 11% of the 2018 annual evaluation survey participants indicated they were aware of the Task Force Twitter account. See page S38 for 2018 newsletter and Twitter details, and page S80 for survey results on the awareness and use of these resources. *(See Recommendation 2b).*

Videos

The Task Force released a 3-part video series on ‘Screening for Lung Cancer’ on YouTube in June 2018. The series was released in both English (‘Lung Cancer’) and French (‘Cancer du poumon’). The video series aims to provide PCPs with key information about lung cancer screening, and references the Task Force’s 2016 lung cancer screening guideline. In 2018, the number of YouTube views totaled 1581 for the English versions, and 393 for the French versions. See page S24 for more details on the Task Force’s top 8 most viewed videos in 2018. *(See Recommendation 7b).*

3.3 Implementation

The Task Force continued to support guideline uptake through its implementation efforts: the Clinical Prevention Leaders (CPL) Network and e-learning modules.

Clinical Prevention Leaders Network

Established in October 2017, the purpose of the CPL network is to promote the uptake of Task Force guidelines and to address local barriers to guideline implementation through educational outreach and other KT activities. The CPL network currently consists of 9 members from five provinces. No new members joined the CPL network, and one member, a resident, discontinued their participation in the CPL network in 2018 due to time constraints. The network held 10 sessions throughout 2018, and a CPL member attended the 'Congrès annuel de médicine 2018' conference in Montreal as a representative for the Task Force. The CPL network is a two-year pilot project; an evaluation of the pilot is planned for 2019. See page S40 to S41 for details on the CPL network. *(See Recommendation 6)*

E-Learning modules

In 2017, the Task Force released two e-learning modules; one on obesity prevention and management, and one on screening for cervical cancer. Each module had been certified by the College of Family Physicians of Canada for up to one MainPro+ credit. Only 10% (*n* = 20) of the 2018 annual evaluation survey participants were aware of these e-learning modules.

A 1-year evaluation report was prepared for the obesity prevention and management module in July 2018, after its MainPro+ accreditation expired in June 2018. In the year following its release, only 23 learners completed the module. Similarly, a 1-year evaluation report was prepared for the cervical cancer screening module in September 2018, after its MainPro+ accreditation expired in July 2018. In the year following its release, only 9 participants completed the cervical cancer screening module. See page S43 for details on the modules. *(See Recommendation 7a)*

3.4 Integrated knowledge translation

Integrated knowledge translation is the process of engaging knowledge users throughout the research process to increase the benefit and potential impact of research findings[6]. The Task Force applied integrated knowledge translation principles by engaging patients and clinicians in the development of its upcoming guidelines and tools.

Patient preferences

In 2018, the Task Force conducted patient engagement projects for five upcoming guideline topics. A total of 91 patients were engaged in surveys and interviews about their preferences and values around screening and preventive health care interventions. See page S46 for more details.

Usability testing

Once KT tools were developed, a sample of knowledge users were given draft versions of the tools and asked to provide feedback on their usability. In total, 17 clinicians and 10 patients were engaged in the development and refinement of three tools. See page S47 for more details.

3.5 Research projects

In 2018, the Task Force continued its work on several research projects to increase understanding of how best to support the uptake of Task Force guidelines and KT tools amongst PCPs and patients.

Prostate cancer screening tool co-creation and comparison

In 2017, with funding from the Ontario Institute for Cancer Research, the Task Force and the KT Program collaborated with members of the public. The goal of the project was to compare a conventional patient education tool and a co-created patient education tool and determine their impact on decision making and decisional conflict on PSA testing for prostate cancer. The KT Program compared the tools based on both their usability and their impact on patient knowledge and screening preferences. The development process for the conventional tool included public consultation at the end of the creation process through usability testing. The intervention tool was co-created by members of the public, clinicians and the KT Program. The public collaborators were members of the target audience for prostate cancer screening: males aged 40 years and older who had no symptoms or diagnosis of prostate cancer and were not health care professionals. This co-created tool was compared to the conventional prostate cancer screening tool developed by the Task Force in 2014.

The final report from this research project was prepared in January 2018. 472 participants were engaged across all phases of the project. Results showed that the **co-created patient education tool did not significantly differ in effectiveness from the patient education tool developed by experts**. The report recommends that patient education tool material developers choose the method that best fits their goals and resources. A manuscript "Are patient educational materials on cancer screening more effective when co-created with patients? A randomized controlled trial" was submitted to *Current Oncology* in October 2018 and accepted for publication in January 2019. Anticipated publication is in 2019.

Presenting GRADE guideline recommendation statements for clinical practice

The Task Force uses the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) system when creating guidelines. GRADE is an internationally recognized method for evaluating systematic review evidence for CPGs. Through previous annual evaluations and interactions with PCPs, the Task Force identified end-user challenges in understanding GRADE.

Beginning in 2015, the Task Force undertook a study to inform how to present recommendations for improved uptake. The study led to three main suggestions:

- Increase awareness of the guideline development process and GRADE;
- Incorporate remarks and justification statements into recommendations, including an explanation or rewording of “weak recommendations” and explicit references to “shared decision-making”; and
- Include definitions of terms.

A report on these findings and recommendations was prepared by the KT team at SMH for the Task Force in January 2018. The Task Force applied these findings by changing recommendation wording from ‘weak recommendation’ to ‘conditional recommendation’, to improve understanding and facilitate implementation of guidelines, and emphasize the value that the Task Force places on shared-decision making. Conditional recommendations based on patient values and preferences require clinicians to recognize that difference choices will be appropriate for different patients, and those decisions must be consistent with each patient’s values and preferences. These wording changes and revised definitions were updated on the Task Force website.

Electronic medical record integration pilot

In 2017, the Task Force piloted the integration of the Task Force cancer guideline and tools into the OSCAR electronic medical record (EMR) platform for one Ontario-based family health team. The pilot study took place from March to December 2017. The goal of the project was to understand if and how EMR integration could increase the reach and use of Task Force guidelines and KT tools. Features of the EMR plug-in included a color-coded screening prompt, easy access to Task Force cancer screening recommendations and KT tools, and an automatic display of the plug-in based on patient demographic information. The practice that participated in the pilot had a total of 15 clinicians (i.e. family physicians, nurse practitioners, and physician assistants) and 7928 patients. 571 were female patients over age 50 years. The results showed only half of practitioners interacted at all with the plug-in (non-ignore responses originated from 50% of userIDs). 'Ignore' was selected for 96% of clinician plug-in interactions (indicating a very high ignore rate).

Comparison of Task Force and provincial cancer screening recommendations

The Task Force continues to monitor how provincial screening recommendations align with those of the Task Force. See page S44 for a comparison of the provincial screening recommendations and Task Force recommendations for the three guidelines that recommend a substantial practice change; breast, cervical, and prostate cancer screening. Provincial guidelines had varying degrees of alignment with the three guidelines. Similar to previous years, few provinces were aligned with Task Force recommendations on cervical cancer screening.

3.6 Uptake

Survey

Participant demographics

A total of 244 people completed the 2018 annual evaluation survey: 44 completed the short version and 200 completed the long version.

Please note that not all questions were answered by all survey participants because the surveys used branching to guide participant responses (e.g., if participants did not know about a particular guideline, they were not asked further questions about it), the short version of the survey had fewer questions than the long version, and participants were not required to answer all questions. Additionally, some questions allowed participants to select more than one option; therefore, numbers may not add up to 244 within some categories. Note that the breast cancer update had not been released at the time the short survey was delivered; therefore, no questions about the breast cancer update were included in the short survey.

Survey participants practiced in urban (62%, *n* = 151), suburban (20%, *n* = 48), and rural (31%, *n* = 75) settings. They represented twelve provinces and territories and a range of years of experience (i.e. from five or fewer years to 36 to 40 years). See pages S49 –51 for full survey participant demographics.

Breast cancer screening (2011)

Awareness and use of Task Force guideline and tools

Many participants (75%; *n* = 182) were aware of the Task Force breast cancer screening guideline released in 2011. These participants were also fairly satisfied with the guideline, rating

Note: Participants from Ontario were overrepresented, making up 54% of the survey sample. However, when physicians in Quebec are excluded (as an estimate of Francophone physicians), 44% of family medicine physicians in Canada were located in Ontario in 2018 [7]

it a mean of 5.8 ±1.1 out of 7 (where 7 represented being "very satisfied"). When given the chance to explain their dissatisfaction, one participant expressed concern that self-breast examination was not recommended. Approximately half of participants (49.2%; *n* = 98) said they primarily used the Task Force breast cancer screening guideline. This number increased from 2017, where only 33% (*n* = 55) of participants said they primarily used the Task Force breast cancer screening guideline. Most other respondents (47%; *n* = 93) said they primarily followed provincial or territorial guidelines. About half of the participants who knew about the breast cancer screening guideline were aware of the three accompanying risks and benefits KT tools. See pages S52–S54 for more details on awareness and use of the Task Force breast cancer screening guideline and tools.

Current practice

Participants' self-reported screening practices for breast cancer were mostly consistent with Task Force recommendations. Specifically, 87% (*n* = 211) of survey respondents reported that they did not routinely screen women aged 40–49 years for breast cancer with mammography and 75% (*n* = 149) of participants reported that they did not routinely conduct clinical breast exams in their practice. A few participants noted that they conduct clinical breast exams based on patient preferences. 74% (*n* = 181) of participants indicated they routinely discuss the harms and benefits of breast cancer screening with patients between the ages of 50 – 69 years. See pages S55-S56 for more details on participant alignment with Task Force recommendations.

Cervical cancer screening

Awareness and use of Task Force guideline and tools

Most participants (82%; *n* = 199) were aware of the Task Force cervical cancer screening guideline. These participants reported that they were satisfied with the guideline, rating it a mean of 6.0 ±0.9 out of 7. When given the option to explain their dissatisfaction with the guideline, three participants stated that conflicting recommendations from different sources, such as provincial guidelines, were challenging to navigate *(See Recommendation 5),* and some mentioned that they tend to follow local or provincial recommendations. Less than one-third of participants (29%; *n* = 58) said they primarily used the Task Force cervical cancer screening guideline. Most respondents (67%; *n* = 133) said they primarily followed provincial guidelines. About half of participants (45%; *n* = 71) who knew about the cervical cancer screening guideline were aware of the cervical cancer screening clinician algorithm KT tool. See pages S57- S59 for more details on awareness and use of the Task Force cervical cancer screening guideline and tools.

Current practice

Participants' self-reported screening practices for cervical cancer had varying degrees of consistency with Task Force recommendations. Specifically, 87% (*n* = 173) of survey respondents reported that they screened women aged 30–69 years every three years while only 51% (*n* = 123) reported that they did not routinely screen women under 25 years old. See pages S60–S61 for more details on participant alignment with Task Force recommendations.

Prostate cancer screening

Awareness and use Task Force guideline and tools

Most participants (81%; *n* = 197) were aware of the Task Force prostate cancer screening guideline. These participants were somewhat satisfied with the guideline, rating it a mean of 5.73 ±1.1 out of 7. When given the option to explain their dissatisfaction with the guideline, two participants mentioned the conflicting recommendations on the prostate specific antigen (PSA)

test from various organizations to be confusing. One participant indicated that a joint position statement from the Task Force and Urologists of Canada would strengthen recommendations, and another noted that they felt screening was ultimately the patient's decision. One participant felt conflicted over the methods of guideline development, feeling that the risks and harms of unnecessary tests presumed by the guideline development group are not always valued by patients (i.e. they felt many patients would rather have extra tests, as opposed to risking a missed diagnosis). More than half of participants (59%; *n* = 117) said they primarily used the Task Force prostate cancer screening guideline. Most of the remaining respondents said they primarily followed provincial guidelines (17%; *n* = 34) or no guideline (11%, *n* = 22). Just over half of participants (53%; *n* = 85) who knew about the prostate cancer screening guideline were aware of the prostate cancer 1000-person KT tool. Of those who knew about the tool, most (69%; *n* = 59) said they had used it. See pages S62–S64 for more details on awareness and use of the Task Force prostate cancer screening guideline and tools.

Current practice

Participants' self-reported screening practices for prostate cancer were highly consistent with Task Force recommendations. Specifically, 88% (*n* = 176) of survey respondents reported that they did not routinely screen men younger than 55 years for prostate cancer with the PSA test. In addition, 79% (*n* = 192) of survey respondents reported that they did not routinely screen men aged 55–69 years with the PSA test. 65% (*n* = 130) of participants reported routinely discussing the harms and benefits of screening for prostate cancer with patients between the ages of 30 – 69 years. See pages S65-S66 for more details on participant alignment with Task Force recommendations.

Screening for asymptomatic bacteriuria in pregnancy

Awareness and use of Task Force guideline and tools

Only about one-third of participants (33%; *n* = 80) were aware of the Task Force asymptomatic bacteriuria in pregnancy screening guideline. Those who were aware of it were moderately satisfied with the guideline, rating it a mean of 5.8 ±0.85 out of 7. When given the option to explain their dissatisfaction with the guideline, one participant mentioned they had not read the asymptomatic bacteriuria guideline in its entirety. Only about one-third of participants (31%; *n* = 62) said they primarily used the Task Force asymptomatic bacteriuria screening guideline. Most of the remaining respondents stated they used a provincial or territorial guideline (22%; *n* = 44), a different national guideline (19%; *n* = 37), or they did not use any guideline (16%; *n* = 31). About one-third of participants (41%; *n* = 23) who knew about the asymptomatic bacteriuria screening guideline were aware of the accompanying frequently asked questions (FAQ) KT tool. See pages S67- S69 for more details on awareness and use of the Task Force asymptomatic bacteriuria in pregnancy screening guideline and tools.

Current practice

Participants' self-reported screening practices for asymptomatic bacteriuria in pregnancy were largely consistent with Task Force recommendations. Specifically, 70% (*n* = 170) of survey respondents reported that they screened pregnant women once during the first trimester or first pre-natal visit with a urine culture. About 13% (*n* = 31) of participants said they screened pregnant women more than once during pregnancy with urine culture. In the optional comments, some PCPs explained that they do not follow pregnant women; therefore, they do not apply this particular guideline in their clinical practice. See pages S70 - S71 for more details on participant alignment with the Task Force recommendations.

Screening for impaired vision

Awareness and use of Task Force guideline and tools

Very few participants (17%; *n* = 41) were aware of the impaired vision screening guideline. These participants were somewhat satisfied with the guideline, rating it a mean of 5.8 ±1.1 out of 7. When given the option to explain any dissatisfaction with the guideline, one participant expressed dissatisfaction over guidelines recommendations with 'weak evidence'. Most participants (72%; *n* = 144) reported that they did not follow any guideline for impaired vision screening. 40% (*n* = 67) of participants reported not using any guideline, and only 16% (*n* = 32) of participants reported using the Task Force guideline. Over one-third of the participants (38%; *n* = 11) who knew about the impaired vision screening guideline were aware of the accompanying FAQ KT tool. Of those who were aware of the FAQ KT tool, only one indicated they used the tool. See pages S72–S74 for more details on awareness and use of the Task Force impaired vision screening guideline and tools

Current practice

More than half of participants' self-reported screening practices for impaired vision were consistent with Task Force recommendations. Specifically, 58% (*n* = 142) of participants reported that they did not routinely screen adults aged 65 years and older for impaired vision. A total of 18% (*n* = 44) reported screening this population every two years, and 11% (*n* = 26) reported screening every year. A few other participants indicated that they screen patients at the time of driver's exams, or during periodic health exams. Some others indicated that they do not have patients older than 60 years and, therefore this guideline didn't apply to their practice; others said they would refer this population to an optometrist. See page S75 -S76 for more details on participant alignment with the Task Force recommendations.

Breast cancer update (2018)

Awareness of Task Force guideline and tools

Almost half of participants (47%; *n* = 93) were aware of the Task Force breast cancer screening guideline update released in December of 2018. These participants reported being somewhat satisfied with the new updated guideline, rating it a mean of 5.7 ±1.1 out of 7. Of participants who were aware of the updated guideline, 38% (*n* = 35) indicated their practice already aligned with Task Force recommendations, and 36% (*n* = 33) indicated they intend to change their practice to align. Just under half of participants who knew about the breast cancer update screening guideline were aware of the accompanying 1000-person KT tools. See pages S77–S78 for more details on awareness and use of the Task Force breast cancer update screening guideline and tools.

Task Force resources

When asked if they were aware of or had used any of the Task Force resources, participants were most likely to identify the Task Force website (45%; *n* = 91), the periodic preventive health visits article (43%; *n* = 85), and QxMD (34%; *n* = 67). They were less likely to identify *CMAJ* podcasts (23%; *n* = 45), the Task Force newsletter (21%; *n* = 42), Twitter (11%; *n* = 22), and lung cancer videos (3%; *n* = 6). See page S80 for details on Task Force resource awareness and use. *(See Recommendation 2b and 7b)*

When asked how they accessed the Task Force KT tools, the most popular methods reported were visiting the Task Force website (71%; *n* = 141) and receiving copies at conferences (33%; *n* = 65). Some participants accessed the KT tools by printing them from the website (22%; *n* =

Note that the breast cancer update was released December 10th, 2018, therefore this annual evaluation report has only collected data on this guideline from Dec. 10th to Dec. 31st. Further information on breast cancer update awareness, use, and dissemination will be reported in the 2019 Annual Evaluation

43), and very few participants by viewing them through QxMD (6%; *n* = 12). See page S81 for details on Task Force KT tool access. *(See Recommendation 2a and 7c)*

Interviews

We conducted 30 interviews with PCPs from across Canada. These interviews explored four main themes:

1. How and what PCPs first learned about the Task Force, as well as how they hear about new or updated guidelines,
2. Sources PCPs used for screening and preventive health care recommendations,
3. How PCPs made the decision to adopt guidelines and
4. How PCPs implemented Task Force guidelines in their practice, including barriers and facilitators to implementing these guidelines

We chose participants with diverse demographic characteristics. Interview participants represented ten provinces and territories. Eighteen participants identified as female (60%), eleven identified as male (37%), and one participant preferred not to say (3%). Participants ranged from 5 or fewer years of practice to 26–30 years of practice. Participants' years of age ranged between 20 and 59 years. We interviewed eighteen (60%) primary care physicians, seven (23%) nurse practitioners, and five (17%) residents. See pages S83 –S85 for interview participant demographics.

Theme 1: Reach and maintenance

We asked PCPs to describe how they were first exposed to the Task Force, what types of information they first learned about the Task Force, and how they continue to learn about new or updated guidelines. Participants were also asked to provide suggestions on how the Task Force could improve its KT activities.

How PCPs were first exposed to the Task Force

Most interview participants first learned about the Task Force in their training, such as during nurse practitioner programs, medical school, family medicine residency, and clinical sessions or modules. Several noted that knowing Task Force guidelines was an exam requirement during family medicine residency, and that they used the Task Force website and tools as study aides for exam preparation. In many cases, participants' preceptors, mentors or fellow students had recommended the Task Force as a source for screening information and guidelines. *(See Recommendation 1c)*

Participants also reported first learning about the Task Force through:

- Speaking with colleagues
- Attending conferences (e.g. Receiving Task Force KT tools at FMF and attending Task Force member presentations);
- Reading Task Force materials in *CMAJ* publications;
- Continuing education (i.e. Practicing Wisely's *Reducing Unnecessary Testing and Treatment* course)
- Looking for information on a particular health topic, or seeking sources for clinical or patient decision aides
- Receiving email notifications from other organizations (i.e. CMA)
- Attending seminars/newsletters/rounds led by their own heath units and organizations

A few longer practicing PCPs recalled first learning about the Task Force's Red Brick. One nurse practitioner participant was not aware of the Task Force until seeing the Task Force 2018

annual evaluation survey advertisement, distributed through the Nurse Association of New Brunswick newsletter.

Types of information PCPs first learned about the Task Force

We asked participants to describe the types of information they learned about Task Force when they were first exposed to the organization. Most participants mentioned how they first interacted with the Task Force's cancer screening guidelines, specifically, breast cancer, prostate cancer, colorectal cancer, and cervical cancer. Some PCPs recalled specific KT tools that were part of their introduction to the Task Force, particularly, the 1000-person tools. Other participants described more general first impressions of the Task Force. For example, they learned that the Task Force was a trusted and respected source for evidence-based screening and preventive health care guidelines, and that they produced helpful resources for clinicians and patients to make screening decisions. Some participants recalled being surprised and excited to find a Canadian resource that would be more applicable to their local context, as opposed to having to refer to American or international guidelines.

One participant stated they had *not* been taught about the Task Force in their medical school training, and that they had discovered the Task Force through their own research into over-diagnosis. A few PCPs specifically mentioned that they had learned that the Task Force had a reputation for being more 'restrictive' with their recommendations (i.e. tended to promote NOT screening more often than other organizations). They also recalled learning that the Task Force emphasizes the risks of screening, in addition to the benefits, and is an organization committed to the prevention of overdiagnosis and overtreatment.

Continuous learning and maintaining practices

We asked participants to discuss how they stayed up to date with new guidelines and materials in general, as well as how they stayed up to date with Task Force guidelines specifically. Many PCPs felt they needed to keep themselves informed by doing their own research to stay up to date; they felt they did not passively get information about new or updated guidelines. However, others emphasized the significant time constraints PCPs experience, and that they did not have the time to keep themselves informed about every new guideline.

Participants also identified the following avenues for hearing about new or updated guidelines:

- Receiving informal updates from peers, colleagues, or preceptors (word of mouth). This included participating in peer study or practice groups.
- Searching online for new materials, information, or updates (either on a specific topic or in general to stay up to date)
- Attending conferences, seminars, presentations, or continuing education sessions
- Receiving updates or newsletters from other organizations (i.e. Association for Nurse Practitioners, Nurse Practitioner's Association of Ontario, Registered Nurses' Association of Ontario, MD briefcase, Psychiatry Advisor, Dermatology Advisor, CMA Joule and Info POEMs)
- Receiving Tools for Practice (TFP) sponsored by the Alberta College of Family Physicians
- Subscribing to medical journals (i.e. CMAJ), or CFP magazine
- Participating in Practice Based Small Group Learning (PBSGL)
- Participating in E-learning course such as the College of Family Physicians of Canada's Self-Learning program, Continuing Professional Development (CPD) courses, or Med-Case

- Using Apps on their phone or tablet (i.e. journal apps)
- Completing continuing medical education (CME) modules
- Viewing general media
- Following social media (i.e. Twitter)

In addition to these general methods, many participants named ways they keep up to date with Task Force guidelines specifically. Many PCPs indicated that the Task Force booth at the Family Medicine Forum is one of the main ways they hear about and keep up to date with new Task Force guidelines and tools, noting that they appreciated the laminated tools distributed at these conferences. Other methods included subscribing to *CMAJ* or visiting the Task Force website. While several PCPs mentioned the Task Force newsletter as the primary avenue where they hear about new guidelines, other PCPs were not aware of this resource, and asked to be added to the mailing list following their participation in the interview. PCPs also described strategies for reminding themselves of Task Force recommendations, including keeping printed KT tools in their offices or frequently visiting the Task Force website. *(See Recommendation 2a and 2b)*

Suggestions for further dissemination

Participants offered suggestions for how the Task Force could improve the dissemination of their tools and guidelines. These suggestions fell into four main categories; enhancing strategies to share regular updates on new guidelines, attending conferences, increasing public awareness, and improving accessibility to guidelines or tools.

Explore ways to share regular updates on new guidelines

Some participants spoke about how difficult it was to stay up to date with new guidelines while others thought it was quite straightforward. Some PCPs indicated that email was a useful way to inform PCPs of new or updated guidelines, while a few others emphasized that they already received extensive amounts of email from other organizations, and doubted the utility or effectiveness of emailed newsletters and updates.

Some participants suggested partnering with existing organizations that already have extensive reach with PCPs to improve integration and reduce time required for PCPs to stay up to date *(See Recommendation 1b).* For example, participant 16 mentioned:

> *"The more integrated it is, involved it is in other societies that already have good distribution and access to the physician, the higher the uptake is because…the more amalgamated we can make things, the easier it is. So, instead of…if I had like, if the Task Force was combined with another newsletter that I already trusted and was reading, that would be great' – Participant 16*

Some participants who were not aware that the Task Force had a newsletter asked to be added to the recipient list after participating in the evaluation, and suggested promoting the newsletter to increase distribution and awareness of new guidelines. Some PCPs suggested providing an email blast with a simple subject line and summary whenever a new guideline was released; they suggested PCPs were more likely to interact with emails or newsletters with succinct and simple content. *(See Recommendation 2b)*

Explore additional conferences to exhibit and distribute Task Force tools

Conferences were consistently named as one of the main ways PCPs hear about new or updated guidelines. However, one participant suggested that the Task Force should consider attending conferences that serve under-targeted demographics of PCPs (e.g. Society of Rural Practitioners conference or nurse practitioner conferences) *(See Recommendation 1d).* One participant also felt that certain populations of PCPs were not adequately reached by attending conferences:

> *"General practitioners need to be able to access differently than just FMF. Because the problem is the people who go to FMF are usually not the ones they want to reach. They want to reach the ones that don't have time to get to the conferences etc." - Participant 31*

Increase public awareness of Task Force and its guidelines

Many PCPs felt that relatively few people know about the Task Force and their guidelines, and that the public could benefit from more exposure. Specifically, interview participants often mentioned that the Task Force should engage in public awareness campaigns about their guidelines, screening, and overdiagnosis, to combat misinformation.

> *"….when they come in and say 'well, I want the test and I'm paying for it', that's another problem because you can't say ' no you can't have it'... it's not a test that's coming out of the OHIP so a lot of times they'll insist on it and you can explain why it's not a good test, but at the end of the day it's their money and they have a right to ask for it. Particularly with the PSA test I have to say for the Canadian Task Force, [news provider;8:08] and all the news media outlets are the worst there because… I've been at the gym and I watch these urologists come on and say 'every man should have a PSA' and I sit there and I think 'are you kidding? I've just finished explaining to all these men why they shouldn't have a PSA and then the head of urology in the [association name; 8:28] says every man should get a PSA every single year. Don't listen to anybody else'. So, what are they doing? They're listening to the news and then they're coming in and insisting that they get a PSA every year." - Participant 21*

Suggested approaches for increasing awareness of the Task Force, as well as their guidelines, included targeting patients via direct to consumer advertisements (e.g. on public transit), or hanging posters in PCP offices. Some PCPs felt public advertisement was important for increasing awareness not only among patients, but also among PCPs and other care providers. *(See Recommendation 1a, 1d, and 3)*

> *"I think educating the public themselves in general, like you see various breast cancer promoting screening on the sides of buses and whatnot. So, just keeping the messages in public accessible to both…the patient population themselves as well as the other members of the interdisciplinary team I think is probably the best approach." - Participant 13*

Improve accessibility to guidelines and tools

Many PCPs said they were interested in accessing Task Force materials through a mobile app, but did not mention using or being aware of the Task Force tools and guidelines on the QxMD app *(See Recommendation 7c*). Some participants felt that the website could benefit from simplifying access to specific tools (e.g. reducing number of clicks needed), as well as having easy to find plain language summaries for patients and the general public. Search engine optimization was also mentioned as one method for improving dissemination of Task Force tools and guidelines, since many PCPs described having difficulty searching online for specific tools (e.g. unable to quickly find the Task Force PSA tool by Googling). *(See Recommendation 2a)*

Theme 2: Sources of screening and preventive health care recommendations

When asked what sources they used or referred to for screening and preventive health recommendations, almost all participants named the Task Force as one of their main trustworthy sources. PCPs also named several other specialist, disease-specific, provincial, or national organizations that they used in their practice (see full list on page S86). When asked to describe what makes a guideline trustworthy, participants referred to: organization reputation and values, composition of guideline developers, quality and strength of evidence, guideline presentation and usability, and endorsements or partnerships*. (See Recommendation 1a)*

Organization reputation and values

Participants generally placed more trust in guideline organizations that were popular, well-known, and trusted among their peers and colleagues. Many PCPs mentioned that they tended to follow what the majority of their colleagues are doing*. (See Recommendation 6)*

> *"…let's face it, we don't always have time to look at the studies behind the guidelines. So if, like, 3 or 4 people looked at it and …found it was, you know, a good guideline then sometimes yeah, you do say "Okay, well I've got colleagues who think this is a good guideline and you know it looks ok" so then you feel like,..I might feel it's more trustworthy than another guideline that no one knows about or no one uses." – Participant 1*

Residents trusted guidelines and organizations that were recommended in medical school, and those that their mentors or preceptors followed. Many participants also said they trusted Canadian sources over international sources, as they felt they were more applicable to the local context.

Some PCPs considered organizations that understand and emphasize overdiagnosis and overtreatment, as well as take patient values and preferences into account, to be more trustworthy *(See Recommendation 1a and 3).* Participants generally agreed that independent and non-profit organizations, with no industry, private company or pharmaceutical affiliations or funding, were less biased and more trustworthy.

Composition of guideline development panel

Participants preferred guideline development panels that consisted of members with diverse opinions and perspectives, and that included experienced clinicians practicing primary care, with no pharmaceutical influence. While some PCPs felt that having specialists included on panels strengthened a recommendation, others felt specialists didn't understand the context in which PCPs practice, and tended to have more biases or conflicts of interest. Those participants

therefore placed more trust in guidelines that were not developed by specialists. *(See Recommendation 1a)*

> *"The Task Force is mainly composed of, I think – correct me if I'm wrong, but of primary care providers so no vested interest in doing a PSA test that will eventually lead to a biopsy that will eventually lead to a prostatectomy. You know …there's no surgical bias. It's very much preventative health care and I guess if you were to ask urologists they would probably side with the Canadian Urological society, but I side with my primary care brethren." - Participant 28*

Quality and strength of evidence

PCPs evaluated the trustworthiness of guidelines by the rigor of methods used in the guideline development process, and the quality of evidence that was examined. PCPs placed a lot of weight on the number and quality of studies supporting a guideline; they considered systematic reviews and large randomized control trials to be gold standards. However, many PCPs also mentioned that they don't have the time to critically examine the studies or evidence behind the guidelines. PCPs tended to trust guidelines that were more recent, consistent with newest literature, and based on up to-date evidence applicable to their local context *(see Recommendation 2d and 3*).

> *"Nothing annoys me and northerners more than something that says Canadian and they've actually not asked anybody in the Northwest Territories. So even when we do public…you know, Health Canada does public surveys and they'll say Canadian and they never…they never actually surveyed anybody in the Northwest Territories. That is no way to offend a…group of people even though we are small." - Participant 19*

Participants evaluated a guideline on its level or grade of evidence; they were more likely to trust guidelines with strong or very strong evidence and recommendation, as opposed to a weak recommendation. PCPs appreciated guidelines that were transparent about both the sources of evidence and its limits of application.

Most participants placed more trust in guidelines that do not take a cost-based analysis approach, and agreed that they did not want money to be a deciding factor about whether something is recommended. However, one participant mentioned that they would like to see guidelines consider cost.

Format and presentation of guidelines

Interview participants considered the presentation of a guideline to be an important element of trustworthiness. Clear and practical recommendations that use simple language, and include summaries that are easy for both patients and clinicians to understand, were deemed more trustworthy. Participants were more likely to trust guidelines that were transparent, and openly disclosed their methods, biases, conflicts of interest, and the sources and grade of evidence. A few participants mentioned that their level of trust in a guideline was associated with the reputation of the journal in which a guideline is published, recognizing that some journals have a more rigorous review process than others. *(See recommendation 1a)*

Endorsements or partnerships

Participants mentioned that guidelines or organizations that were endorsed by trusted colleagues, professional organizations (i.e. medical associations or colleges), or leaders in the field, also strengthened perceived trustworthiness of the guideline organization and guidelines themselves *(See Recommendation 1b and 6)*. Several participants also noted that they tended to place more trust in guidelines that were standardized or consistent across organizations, or partnered with or endorsed by other reputable organizations. *(See Recommendation 1b and 5)*

> *"The more consensus there is, the more trust we have. So if two societies agree on a guideline then I'm going to be implicitly more inclined to do that….like if you had 'we recommend this and this and this' and then you have 'this also agrees with X and X society,'; that automatically ties in my trust in these societies and the more consensus I see, the more trust I have with the guidelines" – Participant 16*

Theme 3: Adopting guidelines

When asked about the factors that influence guideline adoption, PCPs described several main decision-making factors and influencers of guideline uptake:

- Practitioner values and preferences
- Clinical experience
- Social/professional influence of colleagues
- Alignment with other recommendations
- Feasibility of implementing guideline recommendations

Practitioner values and preferences

Interview participants described how their values and preferences influenced their willingness to follow a guideline. Some PCPs described how they examined and evaluated the evidence behind recommendations. In particular, participants were interested in the quality of the evidence, the strength of the recommendation and whether patient values and preferences were considered *(see Recommendation 3).*

> *So, one thing is the reputation of the authors of the guidelines. So, if it is someone reputable then [I tend] to use them. The other thing is if they are Canadian or not. So I tend to use more Canadian guidelines as opposed to foreign guidelines. I tend to use guidelines which are more up to date.. so, things which are more recent get priority. I tend to use guidelines which are more practical as well so, if they were evidence based and more patient centered then they get higher priority if I'm going to use them or not. It also depends on what my preceptors use and what my colleagues use as well…so, if everyone is using one guideline then is it alright if I use something else?.. So, I tend to, you know, see what everyone else is doing as well." – Participant 4*

Others described how if they had determined an organization itself was trustworthy, they would tend to follow the recommendations released by that organization without continuing to evaluate the quality of individual guidelines, to minimize decision-making time and effort *(see Recommendation 1a).* Most PCPs were inclined to follow newer guidelines over older guidelines

on the same topic, because they considered more recent recommendations to be based on the most up-to-date evidence. *(See Recommendation 2d).*

Many PCPs mentioned that they were more likely to follow Task Force recommendations if they aligned with their practice style and values as a physician, and supported their current practice methods. For example, some PCPs mentioned adopting and implementing the Task Force periodic preventive health visits recommendation, because it aligned with their own practice values and emphasis on overdiagnosis. Some PCPs said that if they thought their practice was already similar to a recommendation or guideline, they did not feel the need to review or follow a guideline.

Clinical experience

Interview participants stated that their own clinical experience affected their adoption of screening and preventive health care guidelines. Many PCPs described how past experiences with certain types of screening and outcomes, specifically, diagnosing numerous cases through screening or missing significant diagnoses, influenced their decision on whether or not to follow guidelines that recommend reduced screening. Many PCPs talked about the fear of missing a diagnosis, and therefore, favoring more screening over less.

> *"I think if you had a patient who had a very bad outcome when you followed a recommendation, that would make it hard. If for example, I had a patient who I didn't screen for prostate cancer who then had it, that would probably make me a little more anxious and I would remember that patient when I saw similar patients and I'd have an instinct to screen them more… if I felt that by changing my screening habits or by screened the way I was I was missing people or I'd done someone harm by acting that way I might change my practice." – Participant 20*

Social/professional influence of colleagues

Many interview participants described how interactions with colleagues were a critical component of their screening and preventive health care practice decisions and use of guidelines. In particular, several PCPs felt unable to dedicate valuable time to reviewing every new guideline, and therefore, relied on the advice of their trusted colleagues. Several PCPs said they were more likely to follow a guideline if the majority of their peers and colleagues, particularly more senior clinicians or leaders in the field, were using it. A few felt that this helped keep things consistent for patients and that when joining a new practice, they would continue to practice similarly to the previous PCP to provide continuity of care, and align with patient expectations. Some PCPs mentioned that presentations by colleagues at conferences were particularly influential in their decision. Residents noted that they were more likely to use the guidelines recommended and used by their preceptors, especially considering preceptors who were responsible for grading their performance. Preceptors described how teaching offered them the opportunity to also learn from their students about new guidelines, evidence, and practice change recommendations. *(See Recommendations 1c and 6).*

A few PCPs stated that they tend not to be influenced by their colleagues' practices, particularly specialists. A few PCPs mentioned following the status quo to protect themselves in legal situations.

Alignment with other recommendations

PCPs described how alignment with other guidelines and recommendations, especially provincial guidelines, influenced their adoption of guidelines. Many PCPs described how they were more likely to adopt guidelines with overlap in recommendations across organizations. PCPs said they tended to use what the majority of sources recommended. Many PCPs expressed interest in joint statements from groups, or wished organizations would work to align their recommendations. When guidelines aligned with other organizations, PCPs generally considered them easier to adopt and implement, as they would be consistent with patients' and other colleagues' expectations, as well as organizational policies. *(See Recommendation 5).*

Many PCPs discussed the difficulties associated with navigating conflicting guidelines. Many were frustrated by the confusion created by the overwhelming number of different organizations and guidelines, and did not have a clear process for deciding which to use. In cases where provincial and Task Force recommendations differed, PCPs described referring to patients' preferences as the determining factor, following what preceptors or trusted colleagues used or recommended, or choosing what they perceived to be the 'more conservative' option (i.e. option that recommended more screening or intervention). *(See Recommendation 5).*

When recommendations are not concordant, PCPs provided several reasons for following provincial recommendations over Task Force recommendations:

- Many PCPs considered provincial recommendations to be the expected standard of care
- Provincial screening programs automatically invite patients for screening according to provincial guidelines
- Health unit or organizational policies, incentives, or targets are associated with provincial guidelines
- Patients are more likely to be familiar with and/or expect screening according to provincial guidelines
- Some PCPs believed provincial guidelines are more suited to the local context and population
- Some PCPs felt influenced by peer pressure from colleagues, and felt the need to follow what the majority were practicing
- EMR notifications tend to use provincial guideline recommendations

PCPs also shared reasons for following Task Force recommendations over provincial recommendations:

- Some PCPs felt using a national guideline helps keep their practice consistent and minimize practice change when training or working in different provinces
- Many PCPs believed that the Task Force has a better understanding of overdiagnosis

Feasibility of implementing guideline recommendations

PCPs expressed that they were more likely to follow and adopt recommendations that are practical, easy to implement, and require minimal practice change. PCPs consider guidelines easier to adopt and implement if they had clear summaries and steps or calls to action, aligned with resources available, and were supported and well-known by patients. The following section and Table 1 further describe factors that PCPs considered to be supports and challenges in implementation.

Theme 4: Implementing guidelines

When asked to describe their screening and preventive health care practices, PCPs spoke about general supports and challenges in implementing Task Force guidelines, examples of how their current practice aligned with specific Task Force guidelines, and how they engaged patients in discussions about preventive health care guidelines and recommendations.

Supports and challenges in Task Force guideline implementation

PCPs described factors that influence their ability to implement guidelines (Table 1):

Table 1 : Factors that influence guideline implementation

Factor	Example
Facilitator/barrier – **Patients' preferences**	When patients are aware of, understand and accept a guideline or recommendation, PCPs noted it was easier to implement. Patient preferences can often be the determining factor in which guideline a PCP follows. One participant described having patients leave their practice to find an alternative physician, because these patients disagreed with the Task Force prostate and breast cancer recommendations that this participant was trying to implement. *(See Recommendation 3).*
Facilitator –**Guideline recommendations based on strong evidence**	When recommendations are based on strong evidence, it is easier to justify practice change to other colleagues and patients.
Facilitator/barrier– **Automated screening programs**	PCPs saw automated screening programs as both a facilitator and barrier; In some cases PCPs saw these programs as helpful tools to remind people when to get screened. However others felt these programs restricted their opportunities for discussion with patients, and limited their ability to decide which guidelines to follow, as patients were automatically enrolled based on the provincial guidelines.
Facilitator – **Public and PCP awareness of guideline organization and recommendations**	Several PCPs mentioned awareness was a key factor for implementation of guidelines. The more well-known a guideline or guideline development organization is, the greater the uptake of those recommendations. *(see Recommendation 1a)* *"Well, basically if a guideline has a lot of money it pushes it everywhere. So, I think it does boil down to this. You know, they'll get…to conferences and influencers, and local meet ups in clinical settings. So, unfortunately I think it does boil down to the amount of money and resources you have behind it. So, if a guideline are very few, if… it's excellent, it will still permeate, but not probably as quickly as you think. So, when a very wealthy organization like Diabetes Canada releases new guidelines, it's everywhere. You might not go to conferences. You might not go to any pharma-funded conferences. You're still going to have to hear about it, because they're going to send flyers and booklets, and emails, and ask people to post it on groups, and… So, unfortunately I think some guidelines get a lot more attention than they probably deserve, because they have this power behind them." – Participant 3*

Facilitator – **Perceptions of practicality and feasibility**	PCPs described how the practicality of a guideline can improve ease of implementation. Recommendations that have easy to use and clearly defined steps and summaries, and that are feasible to apply within their local context and given resources, were considered easier to implement.
Facilitator/barrier – **Guideline and tool integration with EMRs**	Many PCPs felt EMR reminders could be effective at cueing their screening and preventive health care practices and having tools and guideline readily accessible on EMRs could help alleviate time constraints. However, some PCPs questioned EMR integration, because they were unsure how they would be able to tailor EMR notifications to their own specific practice and guidelines they wanted to follow. They felt this could impede their ability to implement guidelines if they differed from the guidelines their organization or health unit had integrated into the EMR (e.g. provincial guideline screening timelines)
Facilitator/barrier – **Guideline alignment with policies**	Some PCPs indicated their organizational policies, such as quotas, targets, and standards of care impacted their ability to implement alternative guidelines. Guidelines that aligned with these policies were considered easier to implement.
Facilitator – **Accessibility of guidelines and tools for patients and clinicians**	Many PCPs stressed a lack of time to search for guidelines and tools; therefore, having them readily available and easily retrievable impacted implementation. Having clinician- and patient-facing tools that explain recommendations can make implementing guidelines easier. Tools that can be distributed (e.g. through EMR integration) or easily accessible to patients were noted as being particularly useful; PCPs felt time constraints limited their ability to have lengthy discussions with patients, and having resources they can direct patients to review outside of their appointment was particularly helpful. *(See Recommendation 2a)*
Barrier – **Lack of resource availability and local context considerations**	Some PCPs, especially those practicing in northern and remote communities, stressed that implementing screening and preventive health care depended a lot on resources available and their local context. They needed to consider the accessibility and availability of tests and follow-up care. Some felt that due to limited time, they had to prioritize sick patients over preventative practices in rural contexts where there are limited practitioners serving high numbers of patients within large geographical areas.

Alignment of current practice with Task Force guidelines

Many PCPs spoke of practicing in alignment with Task Force guidelines, specifically prostate cancer, colorectal cancer, and breast cancer. Many PCPs mentioned that because they felt that their practice was pretty much already in line with the guidelines, that they didn't feel the need to specifically 'follow' a guideline, and would just continue how they normally practice. When significant practice changes were recommended, PCPs said they would sometimes implement a compromise between their former practice and the new recommendation, or refer to patient preferences.

Participants noted several barriers to implementing specific Task Force guidelines. See Table 2 for the reasons PCPs provided for not fully aligning their practice with the Task Force recommendations. See pages S87–S89 for some quotes that support these findings.

Table 2: Barriers to implementation for specific Task Force guidelines	
Task Force guideline	**Reason for not aligning practice with recommendations**
Cervical cancer	*Barrier* – **Clinicians prefer 'more-conservative' recommendation based on past clinical experience and fear of missed diagnoses**. • Many PCPs pointed to following what they felt were 'more conservative' provincial recommendations over the Task Force cervical cancer screening recommendations. *Barrier* – **Provincial guidelines perceived as 'standard of care'** • PCPs felt obligated to follow their provincial guideline because they perceived this to be the standard of care in their province, and is what patients expect. *Barrier* – **Automated screening programs follow provincial recommendation timelines, and limit opportunities for shared-decision making conversations** • Participants discussed how automated screening programs in place in their province automatically send screening invitations to women at the age of 21 years (based on provincial recommendations); they felt this left them with little control of who gets screened or when. *Barrier* – **Patients' preferences for earlier screening** • Participants talked about how they would often refer to patient preferences and discuss the different screening recommendations from their province and the Task Force for this guideline with their patients; if the patient preferred earlier screening they would follow the provincial recommendation
Hypertension	*Barrier* – **Guideline is considered out of date** • Some participants considered this guideline out of date; residents specifically mentioned having to use the most recent guidelines for exams in residency, therefore the Hypertension Canada guidelines for hypertension were used over the 2012 Task Force Hypertension guideline. (See Recommendation 2e)
Prostate cancer	*Barrier* – **Practice of peers and colleagues doesn't align with Task Force recommendations** • Many participants noted that many of their colleagues or mentors do not follow this guideline or recommendation, and this impacts their decision on whether or not to follow it; it's easier to follow what their peers and colleagues practice *Barrier* – **Pressure from specialists and other colleagues** • Participants noted pressure from peers, specialist colleagues, and specialist groups impacted their implementation of this recommendation**.** In particular, participants who were residents noted that they needed follow what preceptor was using. *Barrier* – **Clinicians prefer 'more-conservative' option based on past clinical experience and fear of missed diagnoses** • Participants cited fear of missing diagnoses as a main barrier, and discussed how some PCPs are simply unwilling to change their practice. *Barrier* – **Patients' preferences for earlier screening** • Participants also noted this guideline was particularly difficult to follow because patients tend to be adamant about getting screened.
Lung Cancer	*Barrier* – **Evidence behind the recommendation is perceived as weak** • Many participants did not follow the Task Force lung cancer recommendation because they felt the weak evidence and weak recommendation did not convince them that a practice change would benefit patients.

	Barrier – **Difficulties associated with accessing necessary resources** • Participants also noted the logistical difficulties of accessing CT scans, specifically in rural areas, and discomfort with potentially causing unnecessary delays for those who require CT scans for diagnostic testing.
Breast Cancer	*Barrier* – **Patients' preferences for earlier screening** • Patients want to be screened and many patients are used to previous screening schedules. *Barrier* – **Automated screening programs follow provincial recommendation timelines, and limit opportunities for shared-decision making conversations** • Automated screening programs in some provinces limit the opportunity for screening discussions with patients; PCPs feel they have little control over who gets screened, regardless of whether they agree with the recommendation or not.
Diabetes	*Barrier* – **Guideline is considered out of date** • Some participants felt the Task Force Diabetes guideline is out of date, and tended to use the Diabetes Canada recommendations; these PCPs felt this organization's recommendations included more recent evidence and research. (See Recommendation 2e)

How patients are engaged in discussions about preventive health care guidelines and recommendations

Many participants expressed support for the Task Force's recent emphasis on shared-decision making. However, others found the change towards shared decision making language to be ambiguous, and would appreciate more concrete directions. For example when discussing the newly released 2018 breast cancer screening update, one participant said:

> *"Yeah, so 'Some women 40-49 may wish to be screened based on their values and preferences. In this circumstance, care providers should engage in shared decision making with women who express an interest in being screened' and yet the first bullet is 'not screening for this age group' and so the guideline has indicated they're not to be screened but now we're talking about patient values and preferences. I mean, that's fine if they still feel strongly that they want to have the assessment done then I suppose we can do that. I mean, we've always done that before but that type of ...having people with certain wishes and aspirations and values and preferences and putting that into a guideline I think is tough because you're trying to capture the art of the medicine and putting it in the paper and I ... I just find that tricky to follow. – Participant 17*

Some PCPs mentioned that training in shared decision making is necessary for physicians and other allied health professionals; they expressed a need for more direction and resources. *(See Recommendation 2c)*

> *"I think they have to be trained about how to have them, and medical students still need to be trained a lot more about how to use them. You can't just [say]'Yeah explain those pros and cons. Make a decision.' Otherwise it ends up that we kind of vomit a lot of information on the patient, and we're like, 'What do you want to do,' and then they're like, 'I don't know. What do*

> *you want to do,' and then we still choose for them. So, I think there needs to be proper training about what is shared decision-making, how it happens, how to explain risks and benefits in words and figures that patients can actually wrap their mind around, and then practicing those interviews." – Participant 3*

Participants also considered a lack of time as one of the most significant barriers to having effective conversations. Logistical considerations such as automated screening programs that limit access to patients and opportunities to have preventive health care conversations also impacted patient interactions. Patient interest, literacy level, and language barriers also impacted PCPs' ability to participate in shared decision-making conversations with their patients. *(See Recommendation 4)*

Almost all participants described engaging patients about their values and preferences to some extent, although some reportedly did this more extensively than others. Nurse practitioners tended to report having more extensive discussions with patients about screening and preventive health care decisions, and their values and preferences. Many PCPs stated that if they were deciding between conflicting guidelines, they would present both options to patients and have a discussion around which guideline recommendations better suits their values and preferences. Most PCPs felt patients were the decision maker in any screening or interventions, and they respected their patients' decisions even if they disagreed with them *(see Recommendation 3).* Some PCPs felt shared decision making conversations help build patient trust, and provide a better standard of care.

> *"Yes. Actually, I find that... and this is why I really like the Canadian Task Force website, you know, the handouts and the PDFs that you can print out and the tools there. When a patient understands, like, the pros and the cons then it is really easier for them to take a decision but as well as to accept it and I feel that they feel they get... like, better care in the end. There is a better bond between physician and patient because the decision was shared and made, you know, with patient." – Participant 1*

When describing how they currently involve patients in preventive health care discussions, many PCPs routinely referred patients to the Task Force website and appreciated that the content is publicly available online *(see Recommendation 2a).* Some also described sending automated screening letters or information to patients through EMRs.

Suggestions for others who could involve patients

When asked who could assist with discussing screening and preventive health care with patients, PCPs identified the following people: nurses, pharmacists, physiotherapists, occupational therapists, registered dietitians, medical administrative staff, specialists, and optometrists *(see Recommendation 1d).* Participants also identified supports that these health professionals would need, including training and education in screening guidelines, tools, overdiagnosis, and shared-decision making *(see Recommendation 2c).* Physician participants often emphasized that nurse practitioners are significantly involved in preventive health care and screening discussions with patients. Additionally, PCPs described how in rural communities, clinicians (often nurses) overseeing care were not necessarily familiar with the Task Force guidelines or trained in shared decision making. Training for these clinicians was identified as an opportunity to improve Task Force guideline implementation.

KT tools

When discussing the implementation of the Task Force guidelines with patients, many PCPs confirmed that they appreciated and frequently used Task Force KT tools, particularly in discussions around screening with patients. The cancer screening 1000-person tools were most frequently referenced. Participants noted that the following tools were useful for engaging patients: the Framingham Best Science 100 smiley faces tool, Institut national d'excellence en santé et en services sociaux (INESSS) prostate cancer screening tool, Harding Centre for Risk Literacy screening tools, and the Tools for Practice.

PCPs described accessing Task Force KT tools through several avenues, including; viewing them online through the Task Force website, receiving hard copies from conferences, searching for specific tools online via search engines and printing copies from the Task Force website *(see Recommendation 2a).* Only one participant mentioned accessing the Task Force KT tools through the QxMD app *(see Recommendation 7c*). Many PCPs mentioned they mainly used KT tools with their patients electronically, on their mobile phone or tablet. Some mentioned they lack physical office space and hard copies of tools were inconvenient to store. However, others noted that some PCPs lack computer or internet access, and were limited to using hard copies of tools. Several talked about routinely directing patients to the Task Force website for more information and patient facing tools *(See Recommendation 2a).*

Improving KT tools and tool access

Participants noted several ways the Task Force could consider improving KT tools access and usefulness:

- Make tools available in additional languages besides French and English (e.g. Arabic)
- Improve readability of tools and summaries
- Develop a summary tool clearly and simply outlining all recommendations (for example organized by age, gender, and frequency)
- Develop a complimentary 1000-person tool that demonstrates what happens in the 1000 people who are not screened (since patients are being asked to choose between two options, having the ‘alternative’ tool can help make it easier for patients to understand both choices)
- Reduce number of clicks to view and download tools on the Task Force website
- Improve search engine optimization so KT tools come up in web search results
- Make KT tools readily available on phone or tablet apps
- Integrate KT tools with EMRs
- Fulfill orders of hardcopies of tools
- Improve awareness of KT tools and how to access them by:
    - Distributing tools (physically and electronically) at conferences
    - Sending email reminders about new or existing tools
    - Integrating into medical or nurse practitioner schools and curriculums

4.0 Limitations

Although this is the largest sample we have had of any Task Force annual evaluation, the numbers of survey and interview participants were small given the diverse Canadian context, and may not be representative of all PCPs in Canada. It is possible that a larger and more diverse sample would have produced different results. For example, PCPs may have been more likely to complete the survey or interview if they were aware of the Task Force and its

guidelines. As such, the results may suggest that awareness of the Task Force, and its guidelines and associated KT tools, is higher than it is in the general PCP population.

Due to resource limitations, we administered the surveys and interviews in English only. Although there were survey and interview participants who worked primarily in French, the results of this evaluation may not represent the awareness and use of Task Force guidelines and KT tools among French-speaking PCPs *(see Recommendation 4).*

The survey and interview data collected in this evaluation were based on participants' self-reported awareness and use of Task Force guidelines, KT tools, and KT resources. It is therefore possible that participants' responses were affected by social desirability and recall biases.

5.0 Recommendations

Based on this evaluation, we have identified seven opportunities for enhancing the impact and uptake of the Task Force's CPGs, KT tools, and resources. We recommend the following:

1. Increase awareness of Task Force guidelines, Task Force KT tools, and Task Force organization among PCPs

a. Build the "Task Force brand"

Many PCPs indicated that when they trust a guideline development organization as a whole, they will use and adopt new guidelines released by that organization. Participants identified key factors for trustworthiness of a guideline organization including: methodological rigor, transparency, minimal conflicts of interests, guideline developers who are experienced primary care physicians, and organizations that are reputable and recognized among their peers. The Task Force should highlight these elements of the Task Force organization as part of Task Force communication strategies (e.g. in presentations and media engagement), in order to increase familiarity with the Task Force organization among PCPs. For example:

- Highlight the Task Force COI policy, transparency, and rigorous methodology in communications and online; specifically this item could be addressed as part of the communications plan being developed by Kim Barnhardt, the communications strategist.
- Emphasize that Task Force guidelines are created 'by primary care for primary care'

b. Prioritize partnerships with, and promote endorsements by, professional organizations

Many PCPs commented that guideline endorsements influence their awareness and adoption of guidelines. PCPs often hear about new guidelines through their existing relationships with other professional organizations, such as the College of Family Physicians, and are more likely to trust and use guidelines that are endorsed by reputable organizations. Examples of prioritizing endorsements and promoting partnerships include:

- Partner with organizations that reach PCPs to promote and disseminate Task Force guidelines and tools; the Task Force chair now meets regularly with a senior leader at the College of Family Physicians Canada to strengthen their partnership for this purpose
- Seek endorsements from professional organizations and advertise endorsements received

c. Integrate Task Force guidelines and KT tools into practitioner curricula

Most participants indicated they first learned about the Task Force during their training. Preceptors and course curricula were influencers of guideline awareness, perceptions of trustworthiness, and adoption; many interviewees mentioned they were more likely to trust and adopt guidelines that were cited in medical school or nurse practitioner programs, or that were recommended or used by preceptors. The Task Force should build relationships and work with nurse practitioner programs, medical school programs, residency training programs and exam boards, in order to embed Task Force CPGs into curricula and training. For example:

- Have Task Force members join the College of Family Physicians exam committee
- Make Task Force guidelines and tools accessible to students for studying via conferences and website
- Expand the Task Force member or CPL network activities to reach schools and residency training programs

d. Expand Task Force dissemination to reach a wider array of PCPs

Many participants suggested extending the reach of Task Force guidelines, KT tools, and KT resources to a wider variety of audiences, specifically other members of health care teams including: nurses, midwives, pharmacists, physiotherapists, physician assistants, and dieticians. In addition to continuing to target primary care clinicians and nurse practitioners through presentations, conferences, and training programs *(see Recommendation 1c),* the Task Force should consider expanding these dissemination strategies to reach a wider variety of health professionals delivering front line preventive care. For example:

- Expand dissemination activities to reach underserved PCP groups (e.g. rural practitioners)
- Partner with guideline-specific professional organizations (e.g. Canadian Association of Midwives, Dieticians of Canada) to disseminate guidelines and seek endorsement

2. Optimize existing Task Force guideline and KT tool dissemination activities

a. Improve digital resource and website accessibility

The Task Force website is the number one place PCPs reported accessing Task Force KT tools. Many participants regularly accessed the website and KT tools not only from desktop computers, but also from mobile phones and tablets. Many described regularly searching online for specific tools and topics. Electronic tool packages, distributed for the first time at 2018 conferences, were very well received. The Task Force could consider strategies for improving digital accessibility of guidelines and tools. For example:

- Expand availability of electronic tool packs at conferences alongside printed copies
- Reduce the number of clicks needed to access and download KT tools on the Task Force website
- Explore search engine optimization (SEO) strategies to make tool and topic search faster
- Ensure website is responsive (i.e. optimized for use on tablets and smartphones)

b. Optimize Task Force newsletter

Many PCPs were not aware of the existing Task Force newsletter, but expressed interest in this type of resource. The number of subscribers did not grow between January 2018 and December 2018. Participants noted that due to time constraints they would be more likely to engage with newsletters or communications that have simple, clear, and succinct subject lines and content. Working to increase the reach and awareness of the newsletter, as well as improve newsletter communication strategies, may help to increase engagement and awareness of new or updated guidelines. These strategies could also be applied to social media communications. For example, the Task Force may:

- Promote the newsletter at conferences, presentations or rounds delivered by Task Force members, and on the Task Force website (e.g. pop-up newsletter sign-up widget)
- Simplify newsletter content and include in email body instead of an attachment
- Send alerts to the mailing list when a new guideline is released (separate from the quarterly newsletter) or send reminders of existing Task Force KT tools at strategic times (e.g. ‘Mo-vember’)
- Distribute an annual summary of new guidelines with the associated tools for download

c. Develop KT tools that are not specific to individual guidelines

Several participants suggested the development of a summary tool that provides all of the relevant Task Force guideline recommendations, organized by key demographic characteristics such as age and gender. Ideally this tool would be embedded in an electronic health record. The Task Force may consider exploring how best to create these types of tools. For example:

- Develop summary tools for related conditions (e.g. all cancer guidelines)
- Develop summary tools for demographic groups (e.g. seniors, women, etc.)

d. Create material to support shared-decision making and conditional recommendations

Training in shared decision making was identified as an opportunity to improve Task Force guideline implementation; many PCPs considered it necessary for physicians and other allied health professionals. Several participants specifically expressed a need for more direction and resources related to shared decision making. Participants also evaluated a guideline on its level or grade of evidence and were less likely to trust or know how to implement a 'weak' recommendation. The Task Force may consider exploring how best to support PCPs in these areas. For example:

- Work with others to provide training in shared decision making using the Task Force guidelines
- Develop tools to support PCPs in having shared decision making conversations
- Continue re-framing 'weak' recommendations as 'conditional' in future guidelines

e. Update older KT tools and guidelines

Many survey and interview participants felt several of the Task Force guidelines were out of date. Participants were likely to turn to more recent guidelines from other organizations, which they felt were based on up-to-date evidence. However in some cases, older Task Force recommendations may still be aligned with newer guidelines from other organizations. The Task Force may want to:

- Highlight alignment of Task Force recommendations with other organizations' recommendations, in particular with older Task Force guidelines (e.g. hypertension and diabetes)
- Update older existing Task Force tools to be consistent with style and format of new materials
- Develop a strategy to allow for more frequent publications and updates

3. Directly target and engage patients

Many PCPs described how patient awareness, understanding, and acceptance of guidelines affected their ability to implement recommendations. A lack of time was considered one of the most significant barriers to having effective conversations with patients**.** A common suggestion from interview participants was for the Task Force to develop and deliver more public and patient education. Some participants also indicated they are more likely to trust guidelines that have taken patients' preferences into account (in particular, perspectives that include a representative sample of Canadian contexts). The Task Force could consider targeting education efforts to patients and expanding patient engagement opportunities. For example:

- Create patient-oriented tools (e.g. decision aids) that would support PCPs in shared-decision making conversations

- Create tools to educate patients about preventive health care concepts (e.g. overdiagnosis)
- Improve existing patient engagement in guideline development (e.g. allocate more time to patient education during patient engagement activities)
- Involve patients earlier and more consistently throughout the guideline development process

4. Enhance Task Force French presence

To date, the Task Force has conducted most of its KT activities in English only. The hiring of a French member of the KT team is an opportunity for the Task Force to expand its KT activities to include French-speaking clinicians and patients. This will enhance the reach and accessibility of the Task Force guidelines, KT tools, and KT resources. The Task Force may also consider translating existing tools into additional languages beyond French and English to further improve accessibility and usefulness of the KT tools. Next steps could include:

- Translate older English-only guidelines (from 2010 to 2017) into French
- Conduct patient preferences and evaluation activities in French
- Develop French dissemination and media strategies

5. Encourage alignment of provincial guidelines with Task Force

Many participants indicated that they were less likely to implement Task Force recommendations that conflict with other guidelines, particularly provincial guidelines or specialist recommendations. Many also pointed to consensus across organizations as a facilitator for implementation and indicator of perceived guideline trustworthiness. Relationships with other guideline-producing organizations are critical to minimize the confusion and frustration among PCPs generated by navigating conflicting recommendations. The Task Force could explore opportunities to align efforts with organizations and partners working on similar objectives as the Task Force to minimize duplication and address discordant messaging. For example:

- Foster relationships with provincial partners (i.e. provincial stakeholder meetings)
- Create a summary tool that compares the Task Force with provincial and other recommendations, and outlines the reasons for any discrepancies

6. Expand CPL network activities

Participants reported that colleagues are one of the main influencers for practice change, guideline uptake, and evaluating guideline trustworthiness. They described how interactions with colleagues, and the practice and opinions of their peers, largely contributed to their screening and preventive health care practice decisions and use of guidelines. The Task Force may consider expanding the CPL network and its activities, to grow their circle of influence and interactions with peers. For example:

- Have CPL network members attend additional conferences on behalf of the Task Force
- Support CPL network members to deliver presentations and training modules more widely

- Expand CPL membership to include more diverse groups of practitioners (i.e. rural practitioners, nurse practitioners, preceptors); in particular PCPs within each residency training program, and those with large networks and circles of influence

7. Stop high cost activities with low uptake

a. Discontinue CME e-learning modules

The two Continuing Education Modules (CMEs) had particularly low levels of participation, completion, and impact in 2018. CMEs have direct costs associated with the maintenance of MainPro+ accreditation. Given the relatively high cost of producing e-learning modules and maintaining accreditation, and considering their low uptake, the Task Force should explore alternative avenues for e-learning. For example, the Task Force could focus on offering the following activities for MainPro+ credit:

- Webinars and partnerships with other professional organizations (i.e. Canadian Partnership Against Cancer, College of Family Physicians)
- POEMs or brief reflective e-learning activities, including those already available through CMAJ

b. Stop video development

Of the KT tools produced to accompany the Task Force guidelines we evaluated, videos were always the least used tool (see page S54, S64, and S80). Conversely, videos are highly resource intensive. Many PCPs reported using KT tools, but none of the 30 PCPs who were interviewed mentioned using videos with patients. We recommend the Task Force:

- Stop the production of videos in order to allocate resources to more impactful activities

c. Re-examine QxMD partnership following completion of free grant

Costs associated with hosting Task Force guidelines and tools on the QxMD platform are currently low, due to a recently renewed grant. However interview and survey results indicate low uptake for this application; few PCPs accessed Task Force guidelines and tools on QxMD. If costs associated with maintaining this partnership increase in the future, we recommend the Task Force stop this low impact activity.

6.0 References

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Canadian Task Force
on Preventive Health Care

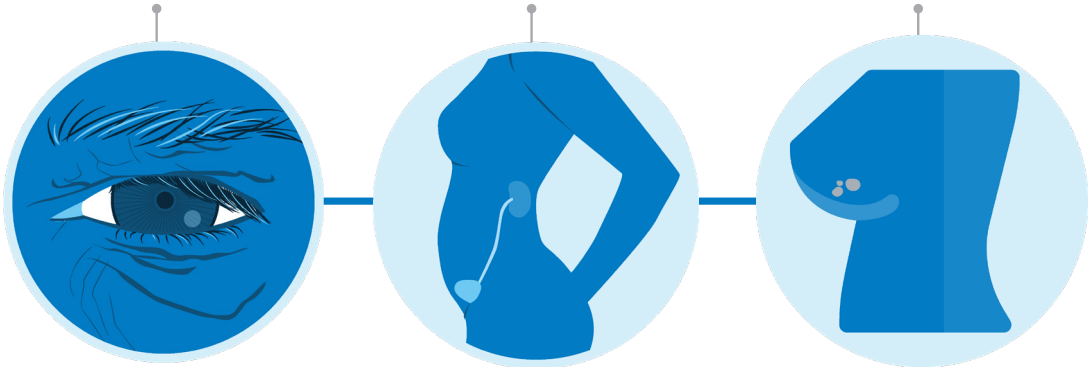
2018 ANNUAL EVALUATION HIGHLIGHTS

3
Guidelines published

MAY
Impaired Vision

JULY
Asymptomatic Bacteriuria in Pregnancy

DECEMBER
Breast Cancer Update



7
Presentations

17
Webinars

50,711
KT Tool Web Page Views

16
Media Interviews

19,192
Tools Disseminated

101 Patients + **17** Clinicians
Engaged in Guideline and Tool Development

93%
Increase in Twitter Followers

5,514
Podcast Plays

402,363
Website Visits

Breast Cancer
Most Visited Guideline on TF Website

732
Media Stories Generated by Breast Cancer Update

Abbreviations

CFP	Canadian Family Physician
CFPC	College of Family Physicians Canada
CPGs	Clinical practice guidelines
CPL	Clinical Prevention Leaders
CT	Computed tomography
EMR	Electronic medical record
FMF	Family Medicine Forum
iKT	Integrated knowledge translation
KT	Knowledge translation
PCP	Primary care practitioner
PSA	Prostate-specific antigen
Task Force	Canadian Task Force on Preventive Health Care

Short version of TF 2018 annual evaluation survey

This survey was distributed at FMF in November 2018

Start of Block: Screening

Thank you for your interest in the Canadian TF on Preventive Health Care (CTFPHC) annual evaluation!

Please answer the following question to determine your eligibility to participate.

What is your profession?

- ○ Primary care physician
- ○ Nurse practitioner
- ○ Nurse
- ○ Resident
- ○ Medical student
- ○ Allied health care professional (e.g. physiotherapist, occupational therapist, physician assistant)
- ○ Researcher
- ○ Other, please specify: _____

Thank you for your interest in participating in the Canadian TF on Preventive Health Care (CTFPHC) annual evaluation. Unfortunately you are not eligible to participate in this study. If you would like to receive newsletters and announcements from the CTFPHC, please enter your contact information below and you will be added to our mailing list.

- Name _____
- Email _____

End of Block: Screening

Start of Block: Letter of Information

The Canadian TF on Preventive Health Care (CTFPHC) is funded by the Public Health Agency of Canada to develop clinical practice guidelines that support primary care practitioners in delivering preventive health care.

In this survey, you will be asked about your preventive health care practices and your awareness and use of CTFPHC guidelines. This survey will take about 5 minutes to complete.

Once you have read through the letter of information on the next page, please click next to proceed.

If you have any questions, concerns, or technical difficulties, please see one of the CTFPHC booth attendants.

Letter of information and consent to participate

Title of research study: Canadian TF on Preventive Health Care Annual Evaluation

Principal Investigator: Sharon E. Straus, MD, MSc, FRCPC, Director of Knowledge Translation Program, St. Michael's Hospital, and Professor, University of Toronto, Tel: 416-864-3068

Study Team members:

Alekhya Mascarenhas, Research Manager, Knowledge Translation Program, St. Michael's Hospital, Tel: 416-864-6060 x 77327

Lynsey Burnett, Research Coordinator, Knowledge Translation Program, St. Michael's Hospital, Tel: 416-864-6060 x 77566

Rossella Scoleri, Research Assistant, Knowledge Translation Program, St. Michael's Hospital, Tel: 416-864-6060 x 77337

You are being asked to consider participating in the Canadian TF on Preventive Health Care annual evaluation. Before agreeing to participate, it is important that you read and understand the following explanation of the proposed study procedures. The following information describes the purpose, procedures, benefits and risks associated with the study. It also describes your right to refuse to participate or withdraw from the study at any time. To decide whether you wish to participate in this study, you should understand enough about its risks and benefits to be able to make an informed decision.

Background and Purpose of the Research: The annual evaluation is being conducted by the research study team at the Knowledge Translation (KT) Program at the Li Ka Shing Knowledge Institute, St. Michael's Hospital (SMH), in collaboration with the Canadian TF on Preventive Health Care (CTFPHC). Evaluating CTFPHC activities is a key objective of the CTFPHC. The objective of this evaluation is to measure the impact of dissemination activities and uptake of clinical practice guidelines, KT tools, and KT resources (e.g., website, videos, and mobile app) from January to December each year. The annual evaluation focuses on the guidelines and associated KT tools that are released each year. Clinical practice guidelines and KT tools released during previous years that recommend a substantial change in clinical practice (i.e., screening for breast, cervical, and prostate cancer) are also evaluated each year. Our goal is to provide feedback on the CTFPHC's activities, highlight the strengths of the CTFPHC's KT efforts, and identify areas in which the organization can improve uptake and implementation for future clinical practice guidelines. We are aiming to have approximately 100-150 primary care practitioners participate in our annual evaluation through surveys and interviews.

Eligibility: You are being asked to consider taking part in this evaluation because you are a primary care practitioner in Canada.

Procedure: If you choose to participate, you will be asked to complete a 5-minute survey. The online surveys will be used to determine primary care practitioners current screening practices; awareness of CTFPHC clinical practice guidelines, KT tools, and KT resources; use of CTFPHC clinical practice guidelines, KT tools, and KT resources; and barriers and facilitators to implementing CTFPHC clinical practice guidelines, KT tools, and KT resources. The survey is hosted by an online survey platform called

Qualtrics.

Potential Harms (Injury, Discomforts or Inconvenience): There are no known harms associated with this study. If a question is not applicable to you or you feel uncomfortable answering, please skip the question.

Potential Benefits: You may not experience any personal benefits from participating in this evaluation; however, you will have the opportunity to enter a draw to win a $50 gift card or you may choose to schedule an interview for $100 honourarium. By participating you will also help improve the way that the CTFPHC develops and disseminates clinical practice guidelines, KT tools, and KT resources.

Privacy & Confidentiality: The principal investigator and study team at St. Michael's Hospital will protect the study records and keep all the information confidential to the greatest extent possible. The evaluation survey is anonymous and does not require any personal information that will be linked to your responses. At the end of the survey you will be asked to provide your contact information if you are interested in being entered into a draw for a $50 gift card or you may choose to schedule an interview for $100 honourarium. Your contact information will be stored in a secure electronic file accessible to the principal investigator and study team at St. Michael's Hospital only. No information identifying you will be transferred outside the study team unless required by law. The St. Michael's Hospital Research Ethics Board may look at the evaluation information collected for the purpose of monitoring the study. Data will be retained for no more than 7 years. It is important to understand that despite these protections being in place, there continues to be the risk of unintentional release of information. The chance that this information will be accidentally released is small.

Participation and Withdrawal: Your participation in this study is voluntary. You can choose to not participate or you may withdraw at any time. Your participation, or choice to not participate, will not affect your current and future care or relationships at St. Michael's Hospital. If you withdraw early from the study, any data collected up to that point will be used in the analysis portion of this study. Once you submit your responses, you will not be able to withdraw your consent. Your consent to participate is implied by checking the consent box below and advancing to the survey.

Publication of research findings: The results of this evaluation will be circulated to the CTFPHC and collaborating organizational partners. The results of this evaluation may also be presented at conferences, seminars or other public forums, and published in journals. We will not be using direct quotes in. We will publish our results in aggregate form only– you will not be identified by name anywhere.

Study Results: You may be provided with a copy of the study report to review upon request.

Potential Costs and Reimbursement: Participation in this study will not have any costs to you. There is no monetary reimbursement for participation in this study. At the end of the survey you can choose to enter your contact information and be entered into a draw to win a $50 gift card or you may choose to schedule an interview for $100 honourarium.

Study Contact: For further information, please call or e-mail Lynsey Burnett, Research Coordinator, at 416-864-6060 x 77566 or BurnettLy@smh.ca.

Research Ethics Board Contact: If you have any questions regarding your rights as a research participant, you may contact the Chair of Providence St. Joseph's and St. Michael's Healthcare Research Ethics Board at (416) 864-6060 ext. 2557 during business hours.

Do you consent to participate in the CTFPHC 2018 annual evaluation survey?

- ○ I **consent** to participate in the annual evaluation survey
- ○ I **do not** consent to participate in the annual evaluation survey

End of Block: Letter of Information

Start of Block: Current health care practices

Please respond to the following questions based on your **current health care practices**.

Please note that preventive health care practices, often screening, target those who are **asymptomatic and are not identified as high risk.**

How often do you screen for **breast cancer** with mammography in a woman aged 40 to 49 years?

- ○ Screen the patient every year
- ○ Screen the patient every two years
- ○ Screen the patient every three years
- ○ Screen the patient every four years
- ○ Do not routinely screen the patient

How often do you screen for **cervical cancer** in a woman younger than 25 years?

- ○ Screen the patient every year
- ○ Screen the patient every two years
- ○ Screen the patient every three years
- ○ Screen the patient every four years
- ○ Do not routinely screen the patient

How often do you screen for **prostate cancer** with the PSA test in a man aged 55 to 69 years?

- ○ Screen the patient every year
- ○ Screen the patient every two years
- ○ Screen the patient every three years
- ○ Screen the patient every four years
- ○ Do not routinely screen the patient

How often do you screen for **impaired vision** in adults aged 65 and older?

- ○ Screen the patient once
- ○ Screen the patient every year
- ○ Screen the patient every two years
- ○ Screen the patient every three years
- ○ Do not routinely screen the patient

How often do you screen for **asymptomatic bacteriuria** with a urine culture in pregnant patients?

- ○ Screen the patient once in the first trimester or during the first pre-natal visit
- ○ Screen the patient more than once throughout pregnancy
- ○ Do not routinely screen the patient
- ○ Other: _____

Page Break

We will now ask you some questions about the Canadian TF on Preventive Health Care (CTFPHC) clinical practice guidelines.

Which CTFPHC clinical practice guidelines are you aware of? **Select all that apply.**

- [ ] Breast cancer screening
- [ ] Cervical cancer screening
- [ ] Prostate cancer screening
- [ ] Asympotomatic bacteriuria in pregnancy screening
- [ ] Impaired vision screening
- [ ] I am not aware of any of the above CTFPHC clinical practice guidelines

Page Break

Since the release of the CTFPHC **breast cancer** screening guideline in 2011, have you made changes in your practice regarding breast cancer screening specifically to **align with** the CTFPHC recommendations?

- ○ Yes, I have made changes in my practice to specifically align with the CTFPHC breast cancer screening guideline
- ○ No, I have not made changes in my practice to specifically align with the CTFPHC breast cancer screening guideline
- ○ My practice was already consistent with the guideline

Since the release of the CTFPHC **cervical cancer** screening guideline in 2013, have you made changes in your practice regarding cervical cancer specifically to **align with** the CTFPHC recommendations?

- ○ Yes, I have made changes in my practice to specifically align with the CTFPHC cervical cancer screening guideline
- ○ No, I have not made changes in my practice to specifically align with the CTFPHC cervical cancer screening guideline
- ○ My practice was already consistent with the guideline

Since the release of the CTFPHC **prostate cancer** screening guideline in 2014, have you made changes in your practice regarding prostate cancer screening specifically to **align with** the CTFPHC recommendations?

- ○ Yes, I have made changes in my practice to specifically align with the CTFPHC prostate cancer screening guideline
- ○ No, I have not made changes in my practice to specifically align with the CTFPHC prostate cancer screening guideline
- ○ My practice was already consistent with the guideline

Since the release of the CTFPHC **asymptomatic bacteriuria in pregnancy screening guideline** in 2018, have you made changes in your practice regarding asymptomatic bacteriuria screening in pregnancy specifically to **align with** the CTFPHC recommendations?

- ○ Yes, I have made changes in my practice to specifically align with the CTFPHC asymptomatic bacteriuria in pregnancy screening guideline
- ○ No, I have not made changes in my practice to specifically align with the CTFPHC asymptomatic bacteriuria in pregnancy screening guideline
- ○ My practice was already consistent with the guideline

Since the release of the CTFPHC **impaired vision** screening guideline in 2018, have you made changes in your practice regarding impaired vision screening specifically to **align with** the CTFPHC recommendations?

- ○ Yes, I have made changes in my practice to specifically align with the CTFPHC impaired vision screening guideline
- ○ No, I have not made changes in my practice to specifically align with the CTFPHC impaired vision screening guideline
- ○ My practice was already consistent with the guideline

What is your gender?

- ○ Male
- ○ Female
- ○ Non-binary
- ○ Prefer to self-describe _____
- ○ Prefer not to say

In which province or territory do you practice?

- ○ BC
- ○ AB
- ○ SK
- ○ MB
- ○ ON
- ○ QC
- ○ NB
- ○ NS
- ○ NL
- ○ PE
- ○ YT
- ○ NT
- ○ NU

How old are you?

- ○ 20 to 29
- ○ 30 to 39
- ○ 40 to 49
- ○ 50 to 59
- ○ 60 to 69
- ○ 70 to 79
- ○ 80 or older

How many years have you been practicing?

- ○ 5 or fewer
- ○ 6-10
- ○ 11-15
- ○ 16-20
- ○ 21-25
- ○ 26-30
- ○ 31-35
- ○ 36-40
- ○ 41 or more

What is your clinic setting? Select all that apply.

- ☐ Urban
- ☐ Suburban
- ☐ Rural
- ☐ Other, please specify _____

What is your clinic type? Select all that apply.

- [ ] Hospital-based
- [ ] Community-based
- [ ] Multidisciplinary clinic
- [ ] Physician group clinic
- [ ] Single practitioner clinic
- [ ] Other, please specify _____

What language do you primarily practice in?

_____

End of Block: Demographics

Start of Block: Follow-up

Are you interested in participating in a follow-up conversation about how you use guidelines in your practice? If yes, we will contact you in early 2019 to schedule a phone meeting. Your contact information will be kept confidential.

- ○ Yes
- ○ No

Would you like to be entered into a draw to win a $50 gift card? Your contact information will be kept confidential.

- ○ Yes
- ○ No

Name

_____

Email

_____

Phone number

_____

Thank you for taking the time to respond to this survey. Please click the arrow button to submit your responses.

End of Block: Follow-up

Long version of TF 2018 annual evaluation survey

This survey was distributed online from December 21st, 2018 to February 4th, 2019.

Start of Block: Screening Survey

Thank you for your interest in the Canadian TF on Preventive Health Care (CTFPHC) annual evaluation! Please answer the following questions to determine your eligibility to participate.

What is your profession? (Select all that apply)

- ☐ Primary care physician
- ☐ Nurse practitioner
- ☐ Nurse
- ☐ Resident
- ☐ Medical student
- ☐ Allied health care professional (e.g. physiotherapist, occupational therapist, physician assistant)
- ☐ Researcher
- ☐ Other, please specify: _____

Are you practicing primary care in Canada?

- ○ Yes
- ○ No

Page Break

I have conflicts of interest relating to CTFPHC clinical practice guidelines (e.g., owning shares in a company that sells screening tests).

- ○ Yes
- ○ No

Page Break

I completed a survey for the CTFPHC at Family Medicine Forum 2018 in Toronto.

- ○ Yes
- ○ No
- ○ I don't know

Page Break

Thank you for your interest in participating in the Canadian TF on Preventive Health Care (CTFPHC) annual evaluation. Unfortunately you are not eligible to participate in this study. If you would like to receive newsletters and announcements from the CTFPHC, please enter your contact information below and you will be added to our mailing list.

- ○ Name _____
- ○ Email _____

Thank you for your interest in participating in the Canadian TF on Preventive Health Care (CTFPHC) annual evaluation. Unfortunately you are not eligible to participate in this survey because you completed a survey at Family Medicine Forum (FMF) this year. If you would like to participate in a 60-minute telephone interview, please enter your contact information below. Interview participants will receive a $100 honorarium.

- ○ Name _____
- ○ Email _____
- ○ Telephone _____

End of Block: Screening Survey

Start of Block: Letter of Information

Letter of information and consent to participate

The Canadian TF on Preventive Health Care (CTFPHC) is an organization funded by the Public Health Agency of Canada (PHAC) to develop clinical practice guidelines that support primary care providers in delivering preventive health care. We are currently conducting an evaluation of the CTFPHC's activities in 2018 to assess the reach and uptake of these clinical practice guidelines in primary care settings.

You are invited to participate our evaluation because you are a primary care practitioner in Canada who may have experience with the CTFPHC's clinical practice guidelines. During the survey, you will be asked about your knowledge and perceptions of the CTFPHC use of the CTFPHC's clinical practice guidelines, tools, and resources, and barriers/facilitators for clinical practice guideline implementation in your clinic.

We estimate the survey will take you 20-30 minutes.

If you have any questions, concerns, or technical difficulties, please contact the study Research Coordinator, **Lynsey Burnett**, at **416-864-6060 x77566** or **burnettly@smh.ca**.

If you wish to withdraw your consent to participate at any time, simply stop answering the questions and close your browser. Any information collected up to the point that you withdraw will be used. You may skip questions you prefer not to answer.

You will have the opportunity to enter a draw for an iPad. Draw entry is at the end of the survey. Contact information provided for the draw will not be linked to survey answers provided.

The results of this evaluation will be circulated to the CTFPHC and collaborating organizational partners. The results of this evaluation may also be presented at conferences, seminars or other public forums, and published in journals. We will not be using direct quotes from the surveys. We will publish our results in aggregate form only – you will not be identified by name anywhere.

If you have any concerns about this study, you may contact the Providence St. Joseph's and St. Michael's Healthcare Research Ethics Board at 416-864-6060 Ext. 2557.

Do you consent to participate in the CTFPHC 2018 annual evaluation survey?

- ○ I **consent** to participate in the annual evaluation survey
- ○ I **do not** consent to participate in the annual evaluation survey

End of Block: Letter of Information

Start of Block: Current preventive health care practices

Please respond to the following questions based on your **current preventive health care practices**.

Please note that preventive health care practices, which include screening, target those who are **asymptomatic and not identified as high risk**.

How often do you screen for **breast cancer** with mammography in a woman aged 40 to 49 years?

- ○ Screen the patient every year
- ○ Screen the patient every two years
- ○ Screen the patient every three years
- ○ Screen the patient every four years
- ○ Do not routinely screen the patient
- ○ Other: _____

How often do you screen for **breast cancer** with mammography in a woman aged 50 to 69 years?

- ○ Screen the patient every year
- ○ Screen the patient every two years
- ○ Screen the patient every three years
- ○ Screen the patient every four years
- ○ Do not routinely screen the patient
- ○ Other: _____

How often do you screen a woman for **breast cancer** by conducting a clinical breast exam?

- ○ Screen the patient every year
- ○ Screen the patient every two years
- ○ Screen the patient every three years
- ○ Screen the patient every four years
- ○ Do not routinely screen the patient
- ○ Other: _____

With which age groups of women do you routinely discuss the harms and benefits of **breast cancer screening**? Select all that apply.

- ☐ 39 and younger
- ☐ 40 to 49
- ☐ 50 to 69
- ☐ 70 to 74
- ☐ 75 and older
- ☐ I do not routinely discuss the harms and benefits of screening for breast cancer with patients

How often do you screen for **cervical cancer** in a woman aged 30 to 69 years?

- ○ Screen the patient every year
- ○ Screen the patient every two years
- ○ Screen the patient every three years
- ○ Screen the patient every four years
- ○ Do not routinely screen the patient
- ○ Other: _____

How often do you screen for **cervical cancer** in a woman younger than 25 years old?

- ○ Screen the patient every year
- ○ Screen the patient every two years
- ○ Screen the patient every three years
- ○ Screen the patient every four years
- ○ Do not routinely screen the patient
- ○ Other: _____

With which age groups of women do you routinely discuss the harms and benefits of **cervical cancer screening**? Select all that apply.

- [ ] 19 and younger
- [ ] 20 to 24
- [ ] 25 to 29
- [ ] 30 to 69
- [ ] 70 and older
- [ ] I do not routinely discuss the harms and benefits of screening for cervical cancer with patients

How often do you screen for **prostate cancer** with the PSA test in a man younger than 55 years old?

- ○ Screen the patient every year
- ○ Screen the patient every two years
- ○ Screen the patient every three years
- ○ Screen the patient every four years
- ○ Do not routinely screen the patient
- ○ Other: _____

How often do you screen for **prostate cancer** with the PSA test in a man 55 to 69 years old?

- ○ Screen the patient every year
- ○ Screen the patient every two years
- ○ Screen the patient every three years
- ○ Screen the patient every four years
- ○ Do not routinely screen the patient
- ○ Other: _____

How often do you screen for prostate cancer with the PSA test in a man older than 69 years old?

- ○ Screen the patient every year
- ○ Screen the patient every two years
- ○ Screen the patient every three years
- ○ Screen the patient every four years
- ○ Do not routinely screen the patient
- ○ Other: _____

With which age groups of men do you routinely discuss the harms and benefits of **prostate cancer screening**? Select all that apply.

- [ ] 54 and younger
- [ ] 55 to 69
- [ ] 70 and older
- [ ] I do not routinely discuss the harms and benefits of screening for prostate cancer with patients

Page Break

How often do you screen for **impaired vision** in an adult patient older than 64?

- ○ Screen the patient every year
- ○ Screen the patient every two years
- ○ Screen the patient every three years
- ○ Screen the patient every four years
- ○ Do not routinely screen the patient
- ○ Other: _____

With which age groups do you routinely discuss the harms and benefits of **impaired vision screening**?
Select all that apply.

- ☐ 50 and younger
- ☐ 50-64
- ☐ 65 and older
- ☐ I do not routinely discuss the harms and benefits of screening for impaired vision with patients

Page Break

How often do you screen for **asymptomatic bacteriuria** in pregnant women with a urine culture?

- ○ Screen the patient once during first trimester or first prenatal visit
- ○ Screen the patient more than once throughout pregnancy
- ○ Do not routinely screen the patient
- ○ Other: _____

With which age groups of pregnant patients do you routinely discuss the harms and benefits of screening for **asymptomatic bacteriuria** in pregnancy with a urine culture? Please select all that apply

- ☐ 24 and younger
- ☐ 25-39
- ☐ 40-64
- ☐ 65 and older
- ☐ I do not routinely discuss the harms and benefits of screening for asymptomatic bacteriuria with pregnant patients

---

Page Break

End of Block: Current preventive health care practices

Start of Block: Use and satisfaction with guidelines

For the following preventive health topics, please indicate which clinical practice guidelines you primarily use.

Breast cancer screening

- ○ CTFPHC national guideline
- ○ Other national guideline
- ○ Provincial/territorial
- ○ Other guideline
- ○ I do not follow a guideline

Cervical cancer screening

- ○ CTFPHC national guideline
- ○ Other national guideline
- ○ Provincial/territorial
- ○ Other guideline
- ○ I do not follow a guideline

Prostate cancer screening

- ○ CTFPHC national guideline
- ○ Other national guideline
- ○ Provincial/territorial
- ○ Other guideline
- ○ I do not follow a guideline

Asymptomatic bacteriuria in pregnancy screening

- ○ CTFPHC national guideline
- ○ Other national guideline
- ○ Provincial/territorial
- ○ Other guideline
- ○ I do not follow a guideline

Impaired vision screening

- ○ CTFPHC national guideline
- ○ Other national guideline
- ○ Provincial/territorial
- ○ Other guidleline
- ○ I do not follow a guideline

Page Break

We will now ask you some questions about the Canadian TF for Preventive Health Care (CTFPHC) guidelines, tools, and resources.

Which CTFPHC clinical practice guidelines are you **aware** of? Select all that apply.

- [ ] Breast cancer screening (released 2011)
- [ ] Breast cancer screening update (released December 2018)
- [ ] Cervical cancer screening
- [ ] Prostate cancer screening
- [ ] Asymptomatic bacteriuria screening
- [ ] Impaired vision screening
- [ ] I am not aware of any of the above CTFPHC screening guidelines

Page Break

How **satisfied** are you with the following CTFPHC guideline recommendations?

1 – Not at all satisfied
4 – Neither satisfied nor dissatisfied
7 – Very satisfied.

	1	2	3	4	5	6	7
Breast cancer screening (released 2011)	○	○	○	○	○	○	○
Breast cancer screening update (released December 2018)	○	○	○	○	○	○	○
Cervical cancer screening	○	○	○	○	○	○	○
Prostate cancer screening	○	○	○	○	○	○	○
Asymptomatic bacteriuria screening	○	○	○	○	○	○	○
Impaired vision screening	○	○	○	○	○	○	○
⊗ I am not aware of any of the above CTFPHC screening guidelines	○	○	○	○	○	○	○

Please explain any dissatisfaction you have with CTFPHC guideline recommendations.

_____

_____

_____

_____

_____

Page Break

Since the release of the CTFPHC **breast cancer screening** guideline in 2011, have you made changes in your practice regarding breast cancer screening specifically to **align with** the CTFPHC recommendations?

- ○ Yes, I have made changes in my practice to specifically align with the CTFPHC breast cancer screening guideline
- ○ No,I have not made changes in my practice to specifically align with the CTFPHC breast cancer screening guideline
- ○ My practice was already consistent with the guidelines
- ○ I began practicing after the guideline was released

The CTFPHC breast cancer screening **guideline UPDATE** was recently released in December 2018. Do you **intend** to make changes in your practice regarding breast cancer screening specifically to align with the CTFPHC recommendations?

- ○ Yes, I intend to make changes in my practice to specifically align with the CTFPHC breast cancer screening guideline update
- ○ No, I do not intend to make changes in my practice to specifically align with the CTFPHC breast cancer screening guideline
- ○ My practice is already consistent with the guidelines
- ○ I have not decided yet
- ○ I am not familiar with the updated breast cancer screening guideline recommendations

---

Since the release of the CTFPHC **cervical cancer screening** guideline in 2013, have you made changes in your practice regarding cervical cancer screening specifically to **align with** the CTFPHC recommendations?

- ○ Yes, I have made changes in my practice to specifically align with the CTFPHC cervical cancer screening guideline
- ○ No, I have not made changes in my practice to specifically align with the CTFPHC cervical cancer screening guideline
- ○ My practice was already consistent with the guidelines
- ○ I began practicing after the guideline was released

Since the release of the CTFPHC **prostate cancer screening** guideline in 2014, have you made changes in your practice regarding prostate cancer screening specifically to **align with** the CTFPHC recommendations?

- ○ Yes, I have made changes in my practice to specifically align with the CTFPHC prostate cancer screening guideline
- ○ No, I have not made changes in my practice to specifically align with the CTFPHC prostate cancer screening guideline
- ○ My practice was already consistent with the guideline
- ○ I began practicing after the guideline was released

Since the release of the CTFPHC guideline on **asymptomatic bacteriuria screening in pregnancy** in 2018, have you made changes in your practice regarding asymptomatic bacteriuria in pregnancy screening specifically to **align with** the CTFPHC recommendations?

- ○ Yes, I have made changes in my practice to specifically align with the CTFPHC asymptomatic bacteriuria in pregnancy screening guideline
- ○ No, I have not made changes in my practice to specifically align with the CTFPHC asymptomatic bacteriuria in pregnancy screening guideline
- ○ My practice was already consistent with the guideline
- ○ I began practicing after the guideline was released

Since the release of the CTFPHC guideline on **impaired vision screening** in 2018, have you made changes in your practice regarding impaired vision screening specifically to **align with** the CTFPHC recommendations?

- ○ Yes, I have made changes in my practice to specifically align with the CTFPHC impaired vision screening guideline
- ○ No, I have not made changes in my practice to specifically align with the CTFPHC impaired vision screening guideline
- ○ My practice was already consistent with the guideline
- ○ I began practicing after the guideline was released

The following table lists the CTFPHC screening guidelines for which you indicated you have **not** made changes in your practice to specifically align with the CTFPHC recommendations. Do you **intend** to make practice changes to align with any of the following CTFPHC guidelines?

	I **intend** to align my practice regarding this topic with the CTFPHC guideline	I **do not intend** to align my practice regarding this topic with the CTFPHC guideline	I haven't decided yet
Asymptomatic bacteriuria in pregnancy	○	○	○
Impaired vision	○	○	○
Cervical cancer	○	○	○
Prostate cancer	○	○	○
Breast Cancer	○	○	○

End of Block: Use and satisfaction with guidelines

Start of Block: Tools and resources

Are you **aware of** or **have you used** any of the following CTFPHC tools that accompany the clinical practice guidelines? Select all that apply.

Breast cancer screening (2011) tools

	I am **aware** of this tool	I have **used** this tool
Patient algorithm	☐	☐
Patient FAQ	☐	☐
Risks & benefits, age 40-49	☐	☐
Risks & benefits, age 50-69	☐	☐
Risks & benefits, age 70-74	☐	☐
Breast cancer screening video for clinicians	☐	☐

Breast cancer screening update (2018) tools

	I am **aware** of this tool	I have **used** this tool
1000-person tool	☐	☐
1000-person tool, age 40-49	☐	☐
1000-person tool, age 50-59	☐	☐
1000-person tool, age 60-69	☐	☐
1000-person tool, age 70-74	☐	☐

Cervical cancer screening tools

	I am **aware** of this tool	I have **used** this tool
Clinician algorithm	☐	☐
Clincian FAQ	☐	☐
Patient algorithm	☐	☐
Patient FAQ	☐	☐

Prostate cancer screening tools

	I am **aware** of this tool	I have **used** this tool
Clinician FAQ	☐	☐
Patient FAQ	☐	☐
1000-person tool	☐	☐
Infographic	☐	☐
CTFPHC prostate-specific antigen screening video	☐	☐

Asymptomatic bacteriuria in pregnancy screening tools

	I am **aware** of this tool	I have **used** this tool
Clinician FAQ	☐	☐

Impaired vision screening tool

	I am **aware** of this tool	I have **used** this tool
Clinician FAQ	☐	☐

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How do you access the CTFPHC tools? Select all that apply.

Digital

- [ ] I view them on the CTFPHC website
- [ ] I view them on the CTFPHC mobile app (*Please note: CTFPHC mobile app is no longer being updated. Our guidelines and tools are now included in the app QxMD Calculate.*)
- [ ] I view them on the QxMD mobile app

Print

- [ ] I printed copies for myself
- [ ] I have printed copies that came with my CMAJ publication (*Please note: printed copies of CTFPHC tools are no longer sent with CMAJ publications, as of 2018*)
- [ ] I received laminated copies at a conference (i.e. FMF)

Other

_____

Page Break

Are you **aware of** or **have you used** any of the following CTFPHC resources? Select all that apply.

	Newsletters	CTFPHC Twitter account	CTFPHC website	Lung Cancer Screening video	QxMD Calculate mobile application	Cervical Cancer Screening e-learning module	Obesity Prevention and Management e-learning module	CTFPHC Canadian Family Physician (CFP) article series: 'Prevention in Practice'	Periodic Preventive Health Visits article in Canadian Family Physician (CFP)	CMAJ Clinical Practice Guideline author podcasts
I am **aware** of this resource	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
I have **used** this resource (e.g. read it, referred to it)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Page Break

Did you take part in any of the following CTFPHC activities in 2018? Select all that apply.

An interview or focus group to give your feedback on a draft tool (e.g. usability testing)

- [ ] Asymptomatic bacteriuria in pregnancy screening
- [ ] Impaired vision screening
- [ ] Breast cancer screening (2018 update)

2017 annual evaluation interviews or survey

- ○ Yes
- ○ No

Guideline stakeholder webinars

- [ ] Asymptomatic bacteriuria in pregnancy screening
- [ ] Impaired vision screening
- [ ] Breast cancer screening update (Dec. 2018)

Clinical Prevention Leaders (CPL) Network training sessions

- ○ Yes
- ○ No

Online topic suggestion process

- ○ Yes
- ○ No

Page Break

Please provide any additional comments or feedback you have on the CTFPHC guidelines, tools, or resources.

_____

_____

_____

_____

_____

End of Block: Tools and resources

Start of Block: Demographics

What is your gender?

- ○ Male
- ○ Female
- ○ Non-binary
- ○ Prefer to self-describe _____
- ○ Prefer not to say

In which province or territory do you practice?

- ○ British Columbia
- ○ Alberta
- ○ Saskatchewan
- ○ Manitoba
- ○ Ontario
- ○ Quebec
- ○ New Brunswick
- ○ Nova Scotia
- ○ Newfoundland
- ○ Prince Edward Island
- ○ Yukon
- ○ Northwest Territories
- ○ Nunavut

How old are you?

- ○ 20 to 29
- ○ 30 to 39
- ○ 40 to 49
- ○ 50 to 59
- ○ 60 to 69
- ○ 70 to 79
- ○ 80 or older

How many years have you been practicing?

- ○ 5 or fewer
- ○ 6 to 10
- ○ 11 to 15
- ○ 16 to 20
- ○ 21 to 25
- ○ 26 to 30
- ○ 31 to 35
- ○ 36 to 40
- ○ 41 or more

What is your clinical setting? Select all that apply.

- ☐ Urban
- ☐ Suburban
- ☐ Rural
- ☐ Other, please specify: _____

What language do you primarily practice in?

_____

What is your clinic type? Select all that apply.

- ☐ Hospital-based
- ☐ Community-based
- ☐ Multidisciplinary clinic
- ☐ Physician group clinic
- ☐ Single practitioner clinic
- ☐ Other, please specify: _____

Are you willing to participate in a one hour follow-up interview? The interview will ask you about your experiences with the TF and about how you use guidelines in your practice.
If you complete an interview, you will receive a $100 honorarium. If you do not want to participate in the interview, you can enter a draw for an iPad.

- ○ Yes, I will participate in an interview
- ○ No, I am not willing to participate in an interview

Page Break

Would you like to be entered into the draw to win an iPad? The winner will be drawn randomly in Spring 2019. Your contact information will be kept confidential.

- ○ Yes
- ○ No

The Canadian TF on Preventive Health Care has a mailing list that we use to send occasional emails about our work, including guideline and tool updates. We also send emails to the mailing list to recruit primary care practitioners to review tools and provide input into our research projects. Would you be interested in being added to our mailing list?

- ○ Yes
- ○ No

Page Break

Thank you for completing the survey and agreeing to a follow-up interview! Please provide your contact information. We will email you to provide more information and to schedule your one hour interview shortly. Your contact information will be kept confidential.

- Name _____
- Phone: _____
- Email _____

Thank you for completing the survey. The draw for the iPad will happen in spring, 2019. Your contact information will be kept confidential.

- Name _____
- Phone: _____
- Email _____

Thank you for completing the survey. You will be added to our email list shortly. Your contact information will be kept confidential.

- Name _____
- Phone: _____
- Email _____

Page Break

Please share widely! We appreciate your support! If you know any primary care practitioners who would be interested in participating in this survey, please send them to our website.

Page Break

Thank you! If you have any questions, please contact Kyle Silveira, Research Coordinator, at 416-864-6060 x76218 or SilveiraK@smh.ca

End of Block: Demographics

TF 2018 annual evaluation interview guide

Note to the interviewer: Before the interview, you will need:

- Summary of the interviewee survey responses about CTFPHC guidelines they know about and use, and their preference for provincial vs. national guidelines
- Summary of CTFPHC recommendation statements

Intro - [~5 min]

Thank you for agreeing to speak with us. My name is [name] and I am a [title] with the Knowledge Translation Program at St. Michael's Hospital in Toronto. We are evaluating the 2018 activities of the Canadian TF on Preventive Health Care. As part of this evaluation, we are conducting interviews with practitioners about your experiences with the TF.

The interview will ask you about

- Your knowledge and perceptions of the TF
- Your use of TF clinical practice guidelines, tools, and resources
- How preventive health care decisions get made
- How preventive health care happens in your practice

Do you have any questions?

*[*If participant asks for more information: 'The TF develops and disseminates evidence-based guidelines on preventive health services for primary care practitioners. The survey you completed, as well as this interview, are a part of the annual evaluation of TF 2018 activities, and the feedback you provide will helps us to improve the TF's impact and identify new opportunities. As a primary care practitioner, we are interested in your knowledge of, and experiences with, the TF, how you use guidelines in your practice, as well as what factors influence preventive health care in your practice']*

I will now go over the interview agreement.

- Your participation in this interview is voluntary.
- You can choose not to participate or you may withdraw at any time, even after the interview has started.
- This interview is confidential.
- We will record this interview.
- We will summarize the interview results. Summary results may be included in presentations and publications. Quotes from your interview may also be used. Any quotes or summary results will be de-identified.
- If you would like a report of the results, we can provide you with a summary when our analysis is complete.

Do you have any questions?

Do you agree to the interview and to the audio recording?

I will now turn on the audio recorder.

Today is [date] and I am conducting TF 2018 evaluation interview number [number].

Note to interviewer: The headings are for your use only. What appears in brackets is the construct from RE-AIM we are targeting with the questions.

1 Introduction to the TF (Factors affecting Reach) [~5 -10 min]

- How did you first learn about the TF?
    - Probes: Were you exposed to the TF in medical school or your residency training? If so, what did they teach?
- How do you typically hear about new or updated guidelines?

2 Experiences with TF over time (Effectiveness, factors affecting Adoption) [~5 -10 min]

(Note to interviewer: For this area of questioning, important to consider survey results – esp. which guidelines they use.)

- Describe the extent to which you use/follow recommendations from the TF?
    - Do you intend to change your practice to follow any recommendations from the TF, and if so, how do you intend to change your practice?
- When did you first start following recommendations from the TF? *[*if they do follow TF guidelines]*
- Could you describe how you make decisions on which recommendations to use/follow?
    - Probe: When a new TF recommendation comes out, how do you make a decision on whether or not to follow it?

- What influences your decision to change your preventive health care practices, such as screening?
    - Probe: Can you describe any instances where you changed your practice because of TF recommendations?
    - Probe: Have you ever started following a TF recommendation and then stopped?
        - Probe: What made you decide to stop? OR What could make you decide to stop following a recommendation?

3 Guideline decision making (Effectiveness, factors affecting Adoption) [~ 5 – 10 min]

- From your perspective, where is the main decision-making power for guideline uptake? Who are the influencers that drive guidelines becoming practice?
    - Probe: The practitioner, colleagues, the practice, leaders in the profession, the professional organization, the government, the public?
- What makes a guideline trustworthy?
    - Probes: What are your trusted sources for guidelines?
    - Probe: In your opinion, how does TF compare to other sources for guidelines?
    - Probe: Is TF trustworthy? Why or why not?

- Probe: What makes implementing a guideline easier?
- What makes a guideline easier to implement?
  - Probe: What makes it difficult to implement?

- When you have multiple sources of conflicting information on a preventive health care topic, how do you evaluate which information to follow?
  - Probe: *(Note to interviewer: For this probe, important to consider survey responses.)* Think about a topic where the TF and provincial guidelines are different. How did you decide which recommendations to follow?

4 Engaging patients (Factors affecting Implementation) [~ 5 – 10 min]

- In your work setting(s), how are patients engaged in discussions about preventive health care?
  - Probe: How do you engage patients in discussions about the TF recommendations?
  - Probe: (Do you use TF KT tools?) How do you use TF KT tools?
- In your work setting(s), who else do you think could engage patients in discussions about TF recommendations? (*for example nurse practitioners, nurses, specialists etc.*)
  - Probe: How do you think that would work? What support would those people need to engage patients successfully?
  - Probe: Are there any other members of your health care team who engage patients in these discussions?

5 Accessing TF materials (Suggestions for improving Reach and Implementation) [~5 – 10 min]

- How can the TF improve your access to the guidelines and tools?
  - What are the current barriers, if any?
  - What are some recommendations the TF could consider to make it easier to access these guidelines/tools?

6 Final thoughts and thank you [~5 min]

- Do you have anything else you would like to share?

Thank you so much for taking the time to share with us today. We will be processing and mailing your compensation soon. Please know that the payment processing can take a few weeks. If you have any questions about the evaluation, you can contact Kyle Silveira, who emailed you to set up this interview

2018 Guideline Publications

Guideline publications

Impaired Vision

Pre-release: Stakeholder engagement

Released MAY 2018

- Engaged **78 stakeholders**
  - 16 generalist organizations
  - 18 disease-specific organizations
  - 26 academic reviewers
  - 16 peer reviewers
- Hosted 2 guideline preview webinars
  - Presented by Dr. Brenda Wilson
  - Attendance: 8 stakeholders

Endorsements

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

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Guideline publications

Impaired Vision

Post-release: Dissemination & media

Dissemination	
CMAJ journal subscribers (received guideline)	72,521
CMAJ guideline downloads	5292
Task Force website English page visits	1207
Task Force website French page visits	95
Podcast plays	1079
Media	
Interviews with Task Force members	0
Altmetric score	77

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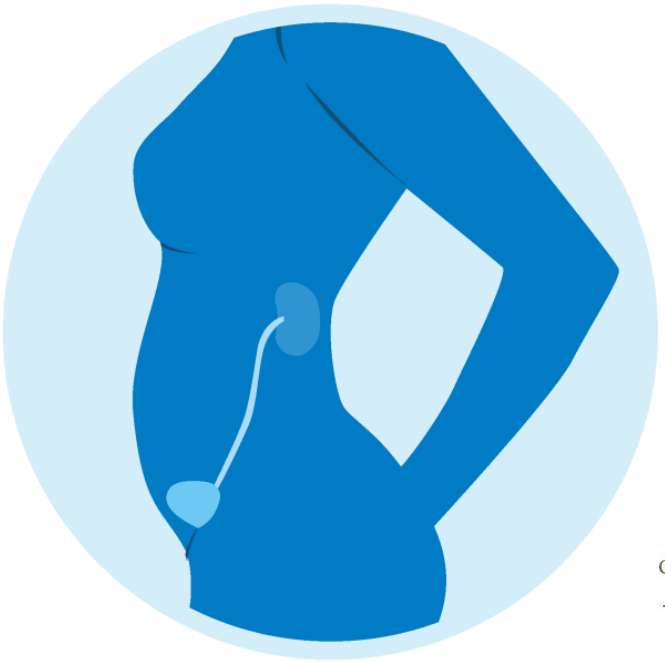
Note: Numbers are based on data from January 1, 2018 to December 31, 2018.
Media data are based on media reports from Hill & Knowlton (H&K) Strategies

Guideline publications

Asymptomatic Bacteriuria in Pregnancy

Pre-release: Stakeholder engagement

Released JULY 2018



- Engaged **41 stakeholders**
  - 16 generalist organizations
  - 12 disease-specific organizations
  - 13 peer reviewers
- Hosted 3 guideline preview webinars
  - Presented by Dr. Ainsley Moore
  - Attendance: 3 stakeholders

Endorsements

The Society of Obstetricians and Gynaecologists of Canada / La Société des obstétriciens et gynécologues du Canada

CAM ACSF
Canadian Association of Midwives
Association canadienne des sages-femmes

Nurse Practitioner Association of Canada

Canadian Association of Perinatal and Women's Health Nurses
CAPWHN
Association canadienne des infirmières et infirmiers en périnatalité et en santé des femmes

Knowledge Translation Program

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The College of Family Physicians of Canada / Le Collège des médecins de famille du Canada

Guideline publications

Asymptomatic Bacteriuria in Pregnancy

Post-release: Dissemination & media

Dissemination	
CMAJ journal subscribers (received guideline)	72,521
CMAJ guideline downloads	9,060
Task Force website English page visits	2,824
Task Force website French page visits	315
Podcast plays	1,171
Media	
Overall Media Impressions	2,300,000
Interviews with Task Force members	1
People exposed to print coverage	209,000
People exposed to online coverage	2,045,000
People exposed to television or radio coverage	0
Altmetric score	104

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Note: Numbers are based on data from January 1, 2018 to December 31, 2018.
Media data are based on media reports from Hill & Knowlton (H&K) Strategies

Guideline publications

Breast Cancer Update

Pre-release: Stakeholder engagement

Released DEC 2018

- Engaged **83** stakeholders
  - 18 generalist organizations
  - 19 disease-specific organizations
  - 19 peer reviewers
  - 14 Federal/Provincial/Territorial organizations
- Hosted 3 guideline preview webinars
  - Presented by Dr. Scott Klarenbach
  - Attendance: 22 stakeholders

Endorsements

Nurse Practitioner Association of Canada

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Statements of Support

Canadian Cancer Society

ONTARIO COLLEGE OF FAMILY PHYSICIANS

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Guideline publications

Breast Cancer Update

Post-release: Dissemination & media

Dissemination	
CMAJ journal subscribers (received guideline)	72,521
CMAJ guideline downloads	8,940
Task Force website guideline page visits*	--*
Podcast plays	785
French podcast plays	661
Media	
Overall Media Impressions	172, 200,000
Interviews with Task Force members	15
People exposed to print coverage	4,888,400
People exposed to online coverage	31,787,700
People exposed to television or radio coverage	3,246,200
Altmetric score	196

Note: Numbers are based on data from January 1, 2018 to December 31, 2018.
*Note that analytics for the breast cancer guideline update webpage in December are unavailable.
Media data are based on media reports from Hill & Knowlton (H&K) Strategies

Guideline Dissemination

Guideline dissemination

Conferences & KT tools

- The Task Force disseminated **14,384** KT tools at **4** conferences

Conference	Dates	Location	Delegates attended	KT tools disseminated	
				EN	FR
CISSS Annual Conference of the Outaouais 2018	Feb 2 - 3	Montebello, QC	?	--	**2895**
Choosing Wisely Canada National Meeting 2018	Apr 23	Toronto, ON	300	**938**	**70**
Congrès annuel de medicine 2018	Oct 10 -12	Montreal, QC	>700	--	**2001**
Family Medicine Forum (FMF) 2018	Nov 15 -17	Toronto, ON	4000	**8000**	**480**

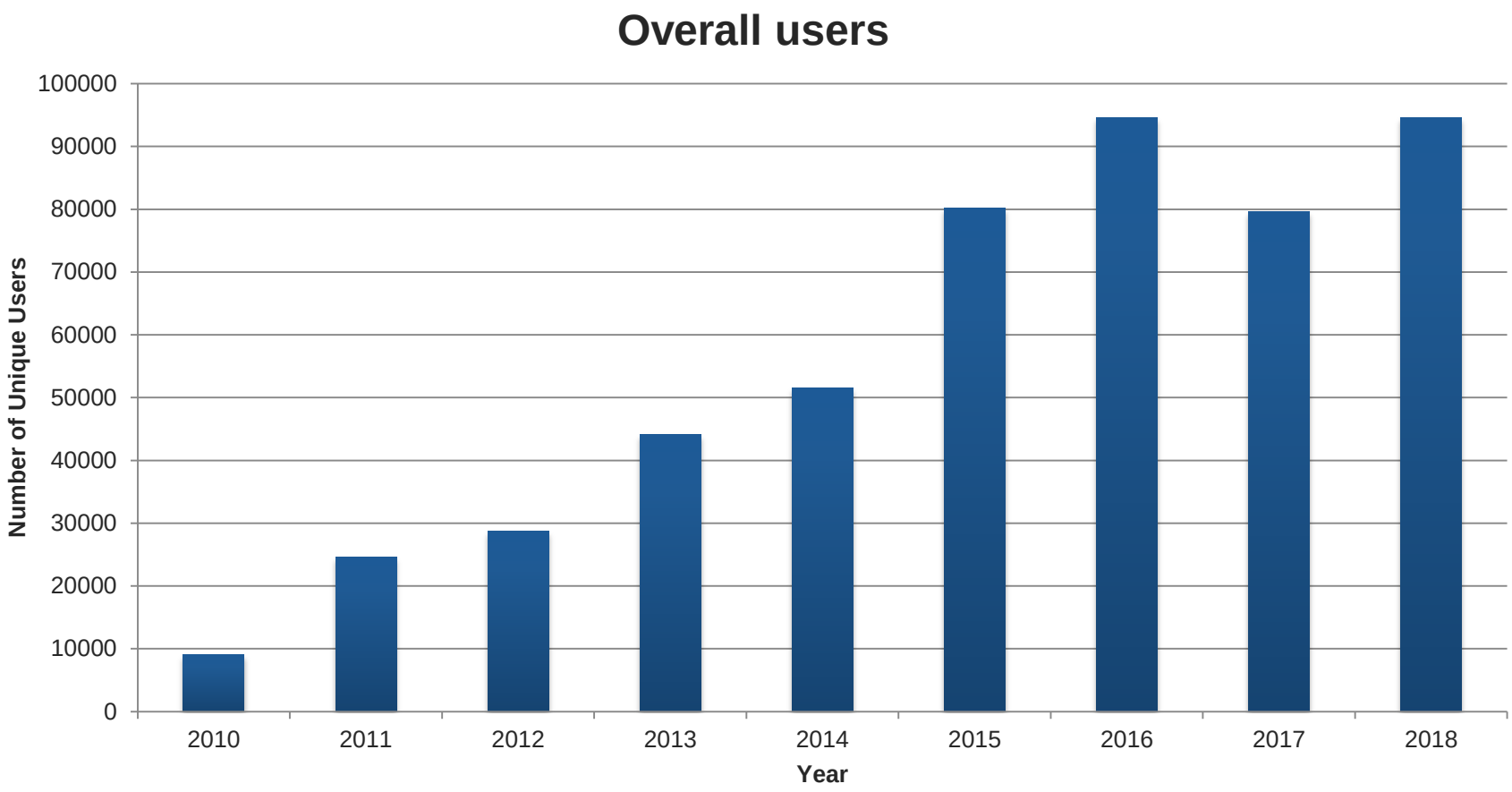
Guideline dissemination
Conferences & KT tools

- The Task Force disseminated **4,808** KT tools electronically via email to interested parties

Tools sent	Date sent	Total tools distributed
Traditional and simplified Cantonese tools	Nov 28	14
French KT Tools	Nov 29	180
English KT tools	Nov 29	2,052
Breast cancer update tools	Nov 30	52
Breast cancer update - all ages tool	Dec 4	71
Breast cancer update - all ages tool	Dec 10	57
Breast cancer update tools	Dec 19	1950
Updated tool pack	Dec 19	432

Guideline dissemination

Task Force website annual users



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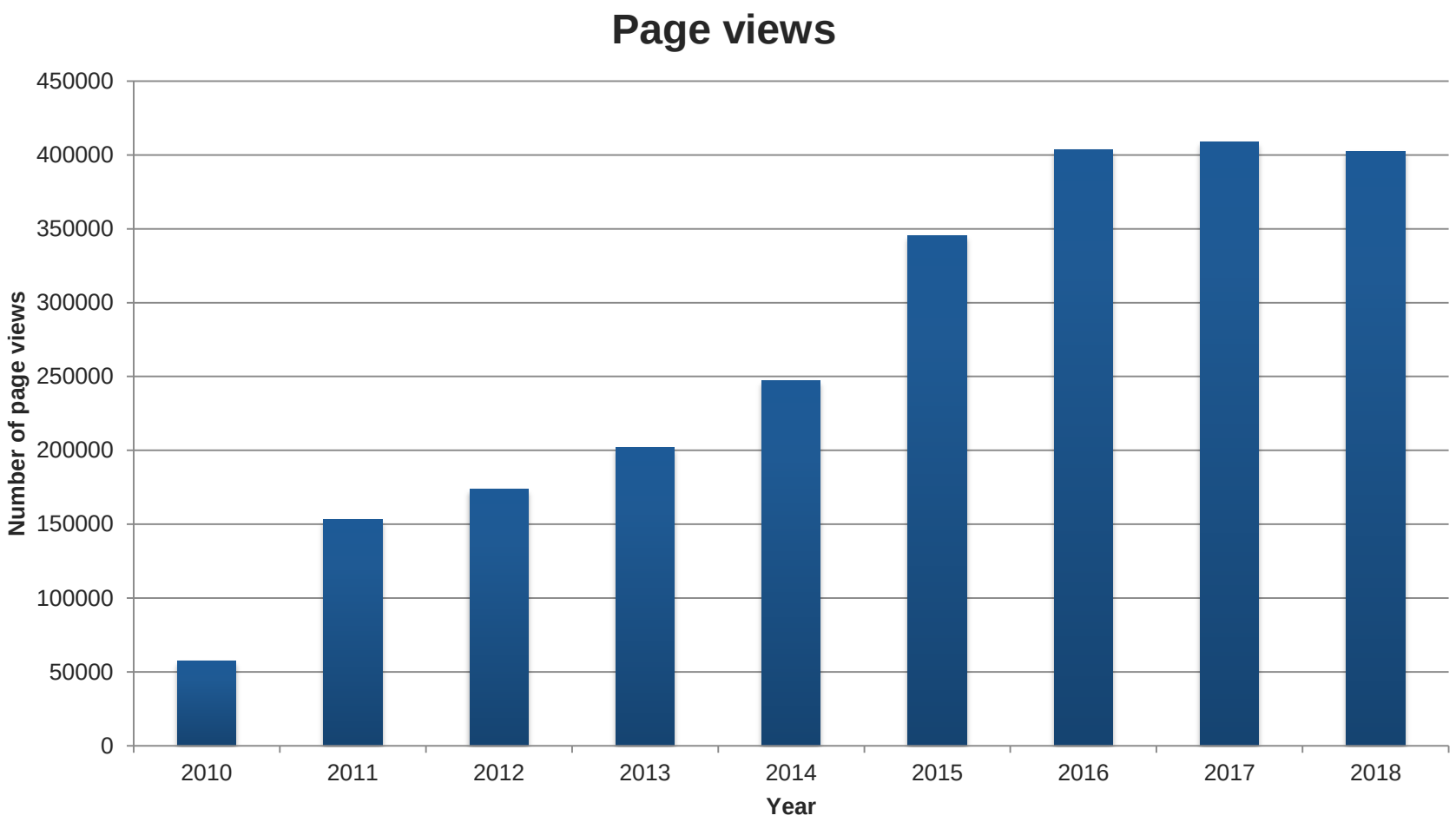
Note: The data reported is combined for both the English and French website platforms.

Guideline dissemination

Task Force website annual page views



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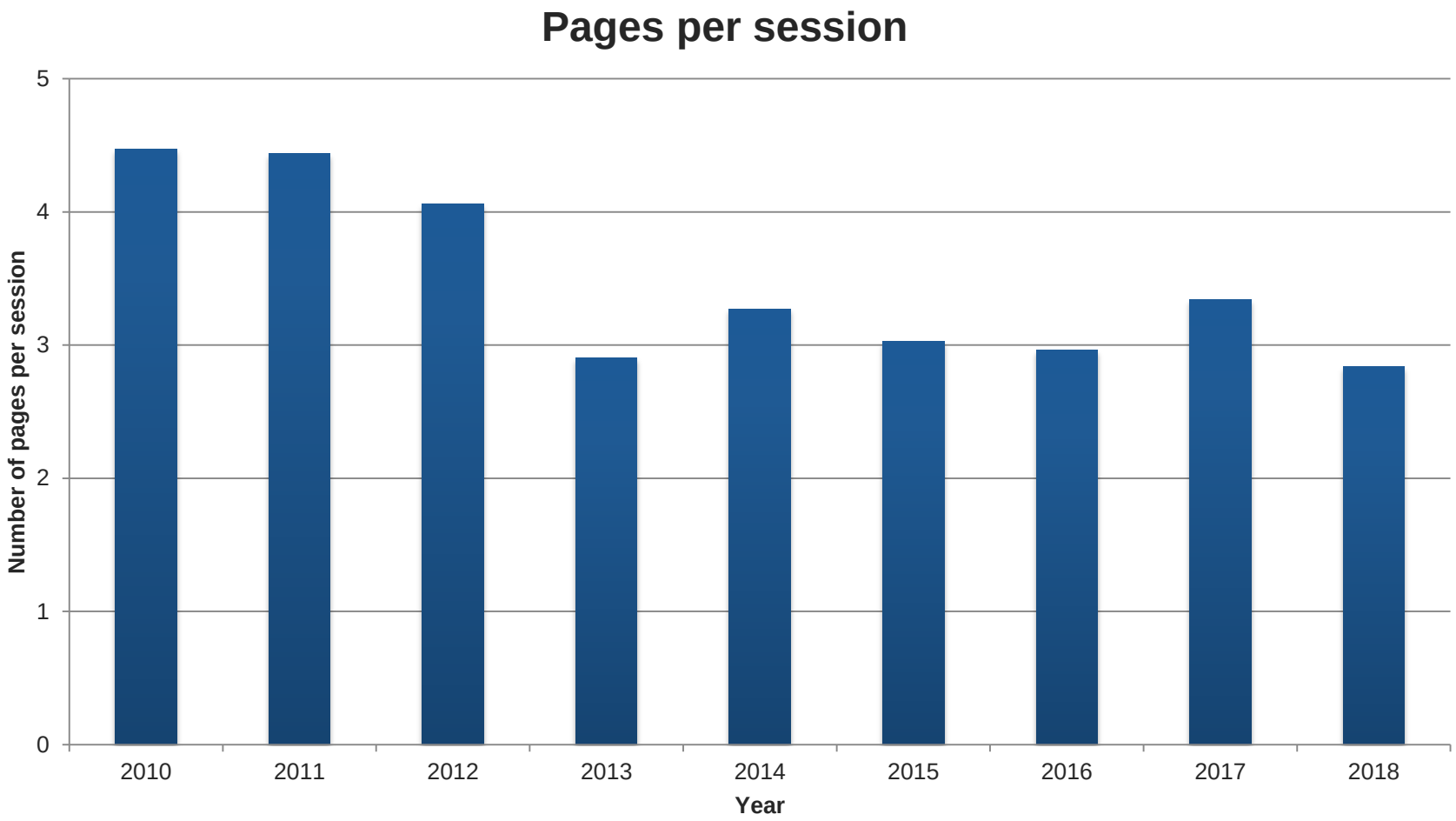
Note: The data reported is combined for both the English and French website platforms.

Guideline dissemination

Task Force website average pages viewed per session



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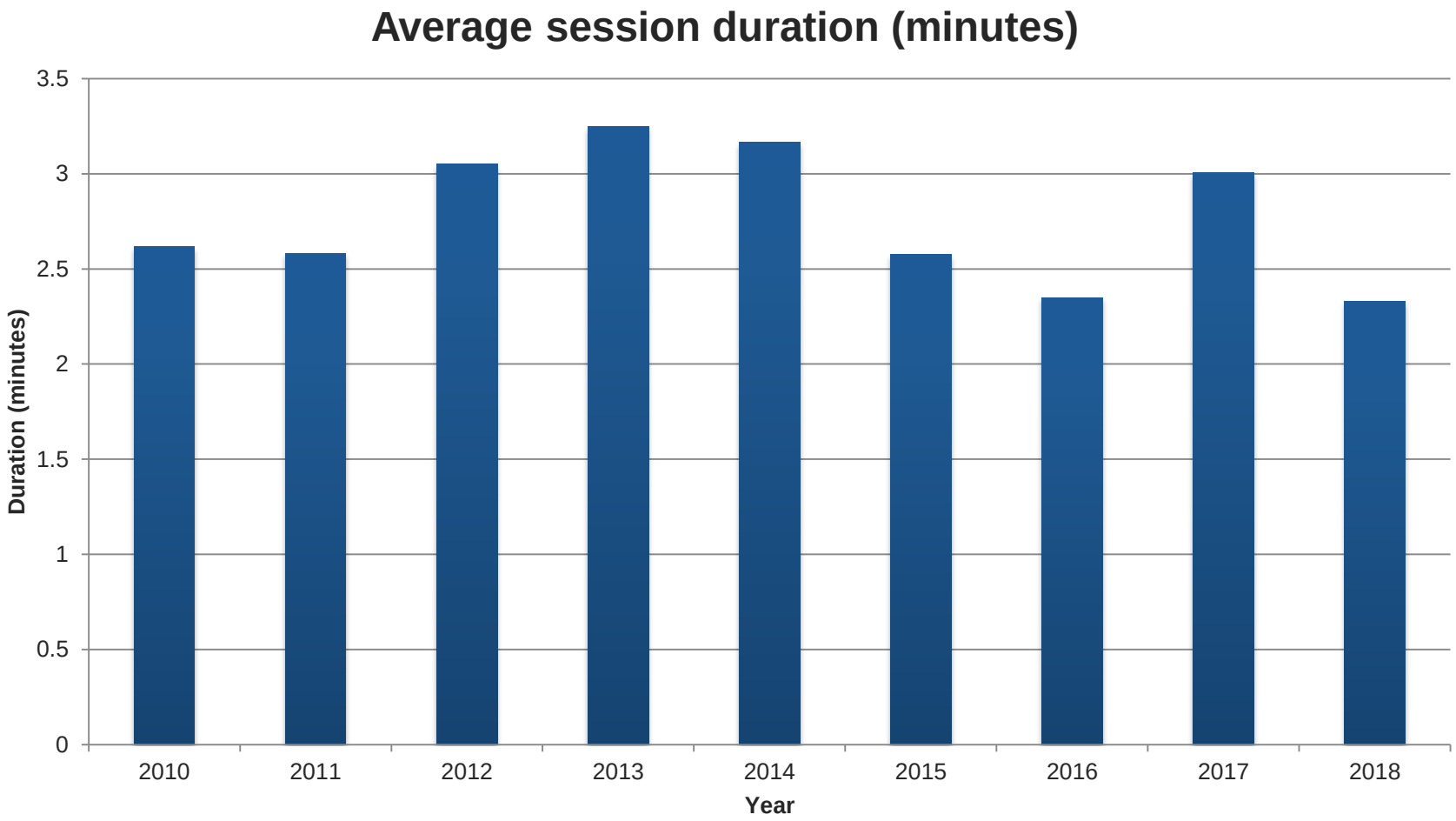
Note: The data reported is combined for both the English and French website platforms.

Guideline dissemination

Task Force website annual average session duration



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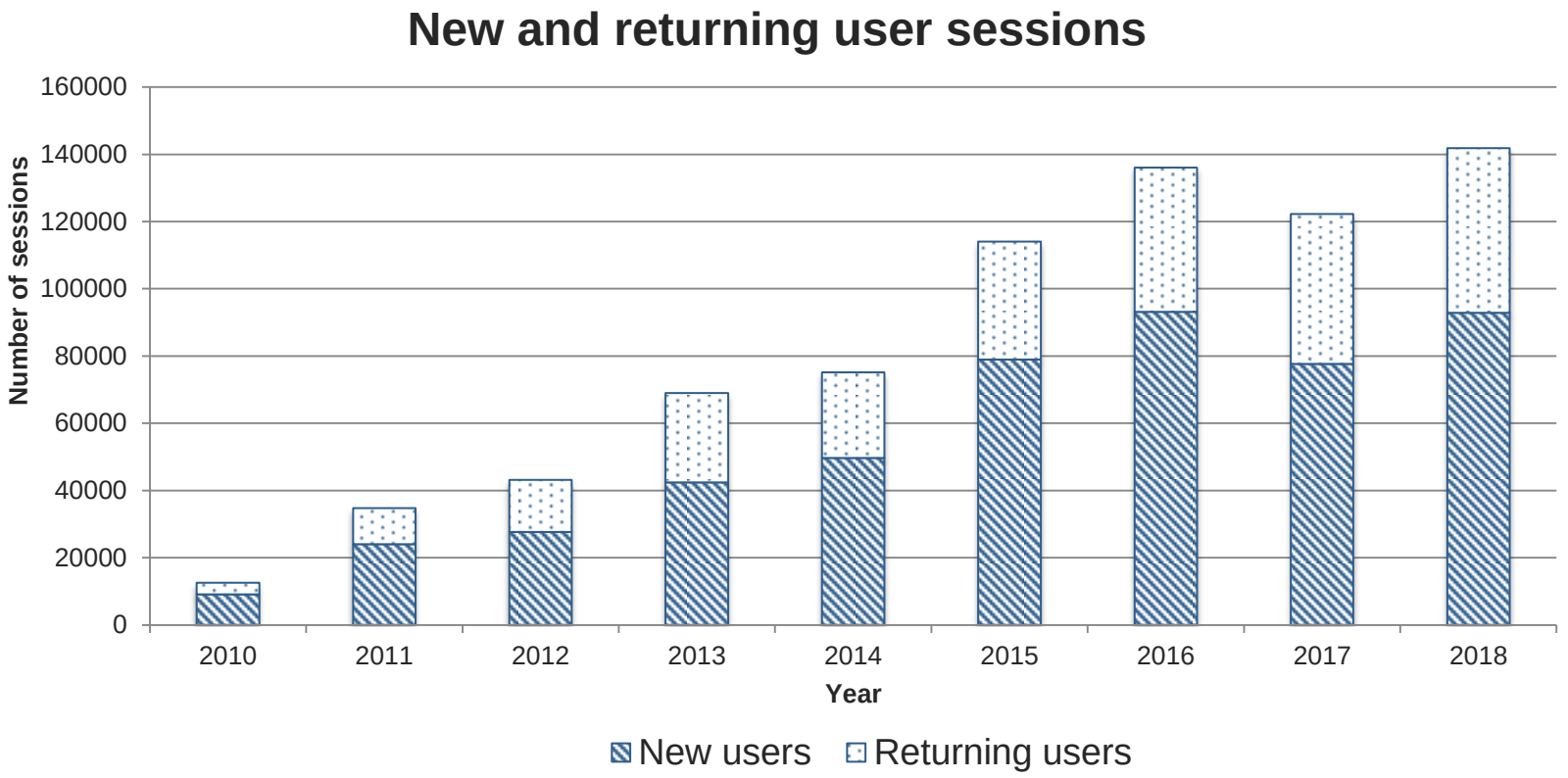
Note: The data reported is combined for both the English and French website platforms.

Guideline dissemination

Task Force website sessions by new and returning users



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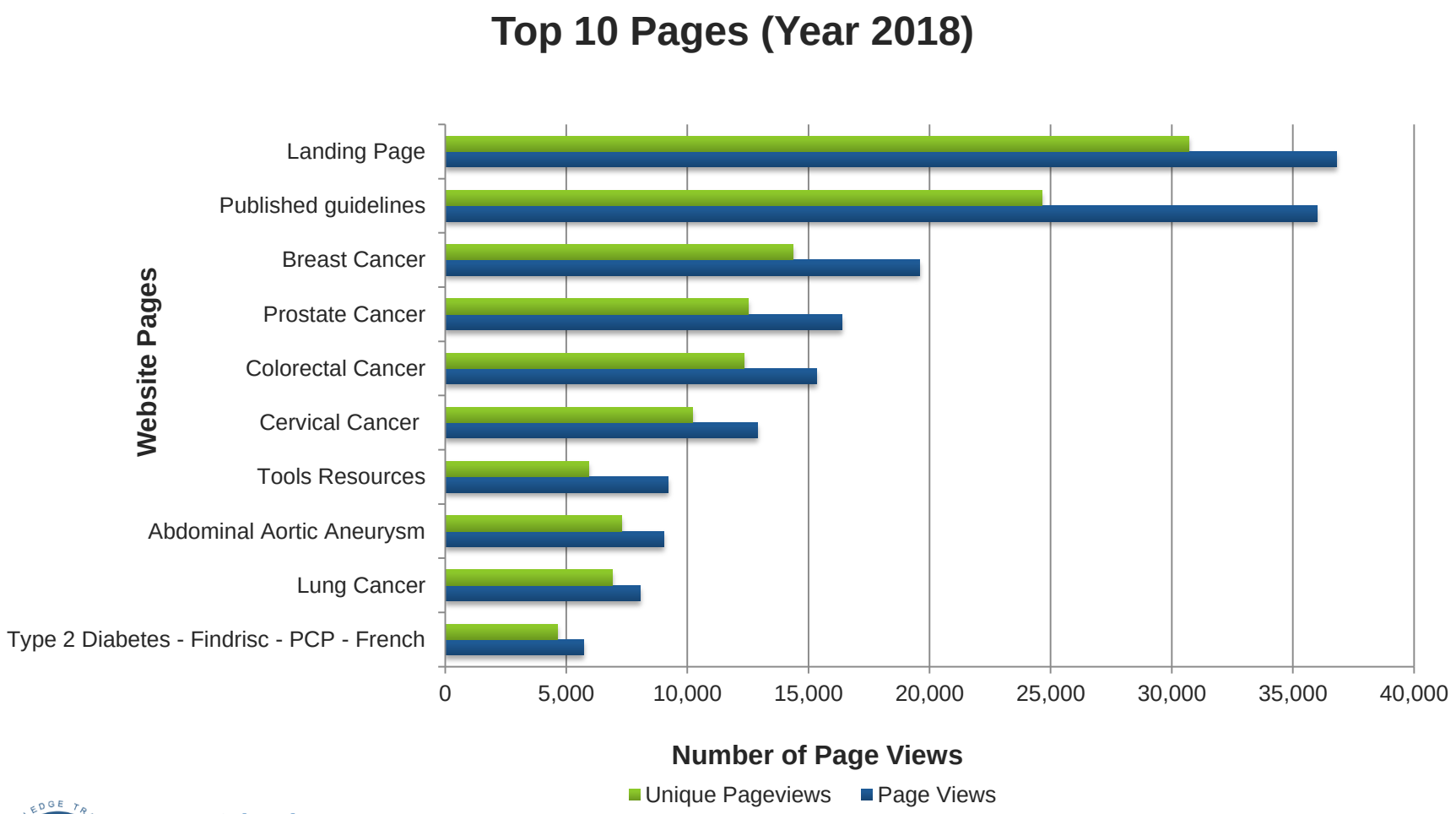
Note: The data reported is combined for both the English and French website platforms.

Guideline dissemination

Top 10 most viewed Task Force website pages



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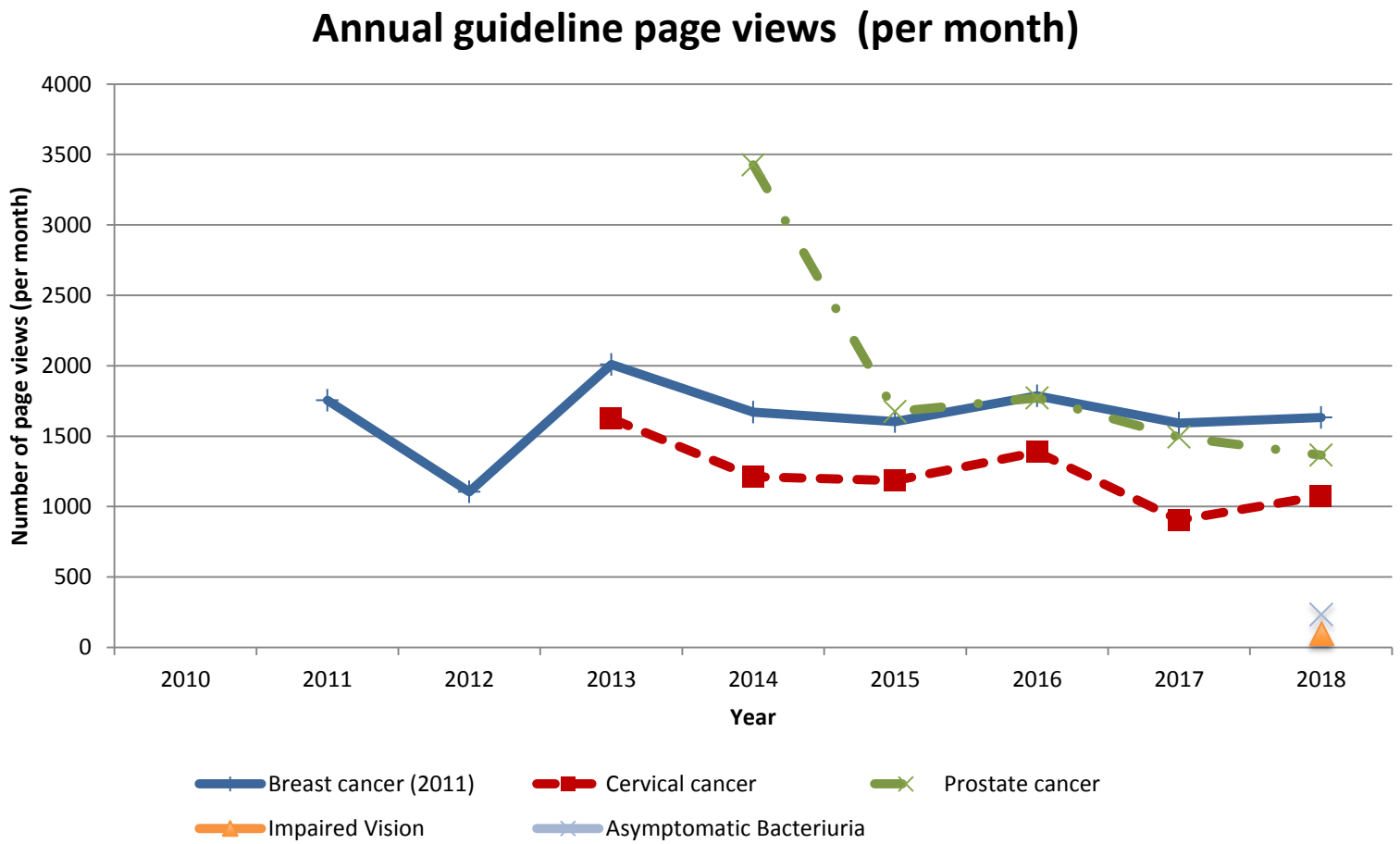
Guideline dissemination

Average guideline page views per month (Task Force English website)



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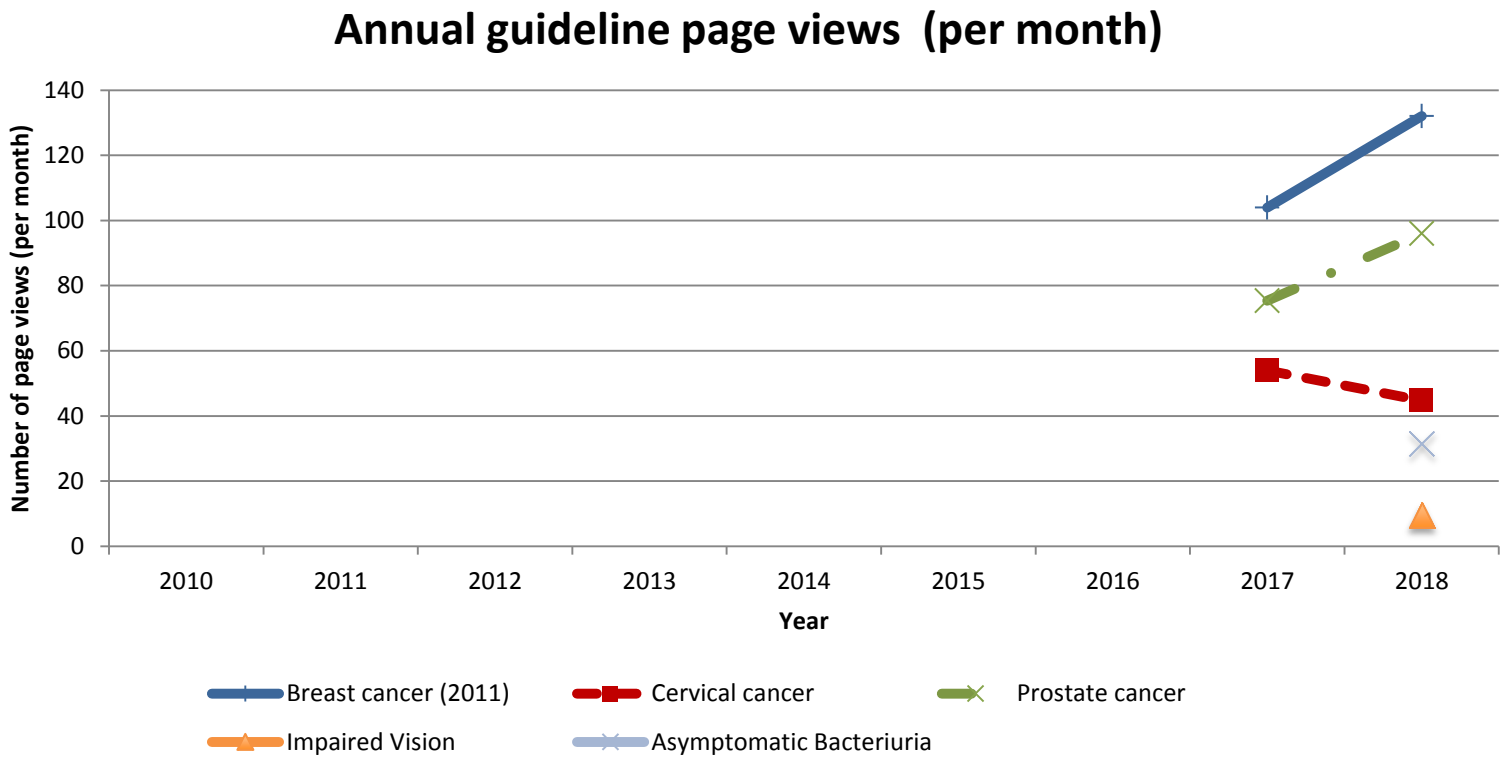
Note: For more accurate comparisons, guideline page views are shown as counts per month. This is because in the year of guideline publication, pages were only available for part of the year.
Note: The breast cancer guideline update webpage data is unavailable for the month of Dec.2018

Guideline dissemination

Average guideline page views per month (Task Force French website)



Note: Date for the French website platform is only available from 2017 onwards. For more accurate comparisons, guideline page views are shown as counts per month. This is because 2018 guideline pages were only available for part of the year.
Note: The breast cancer guideline update webpage data is unavailable for the month of Dec.2018

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Guideline dissemination

Task Force website user locations

Top 5 countries	Sessions
Canada	111,181
United States	13,792
Brazil	2066
France	1500
Spain	965

Top 5 cities	Sessions
Toronto	14,218
Montreal	11,452
Calgary	6328
Ottawa	6738
Vancouver	4107

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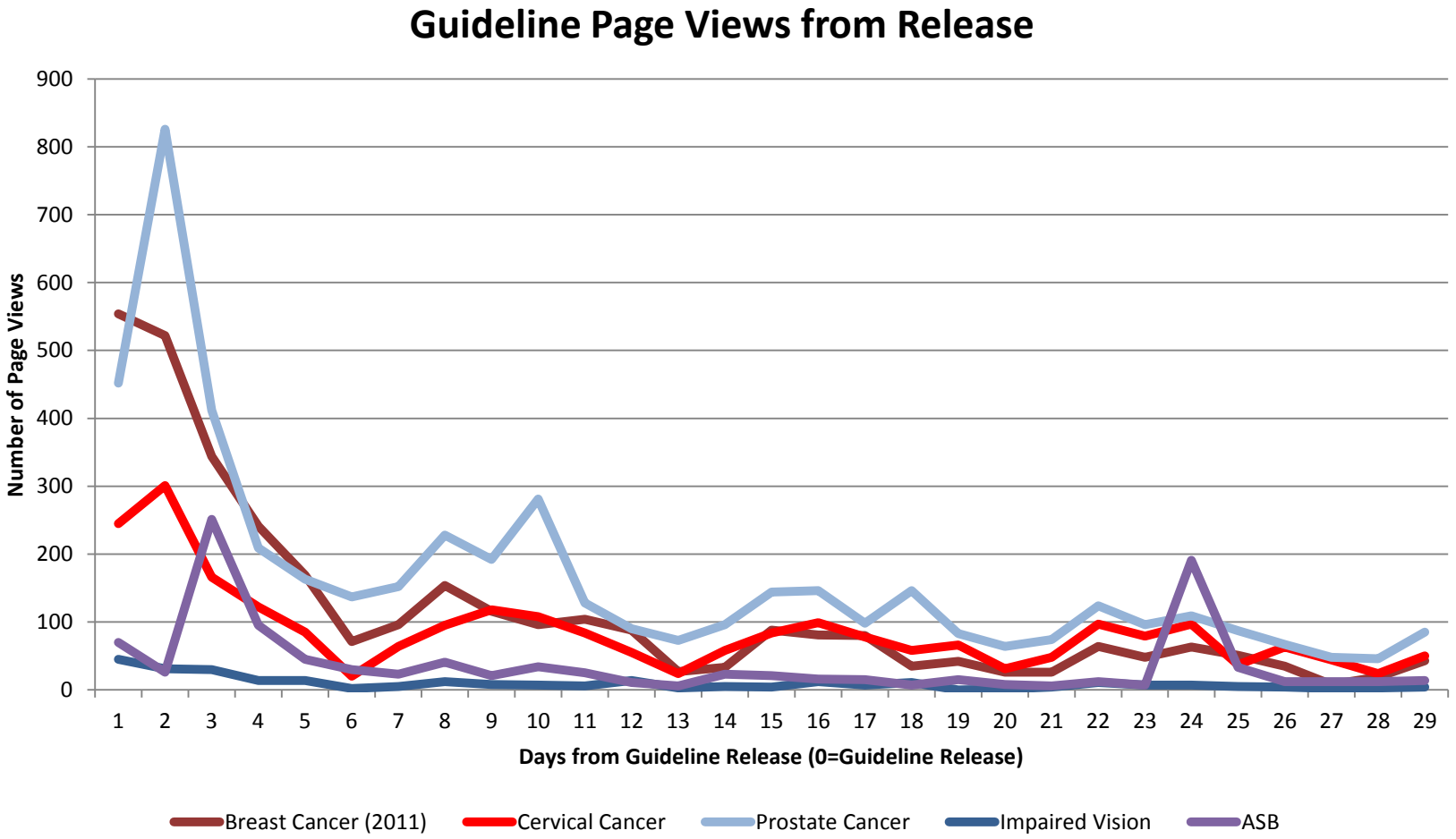
Note: The data reported is combined for both the English and French website platforms.

Guideline dissemination

Task Force English website guideline page views after release



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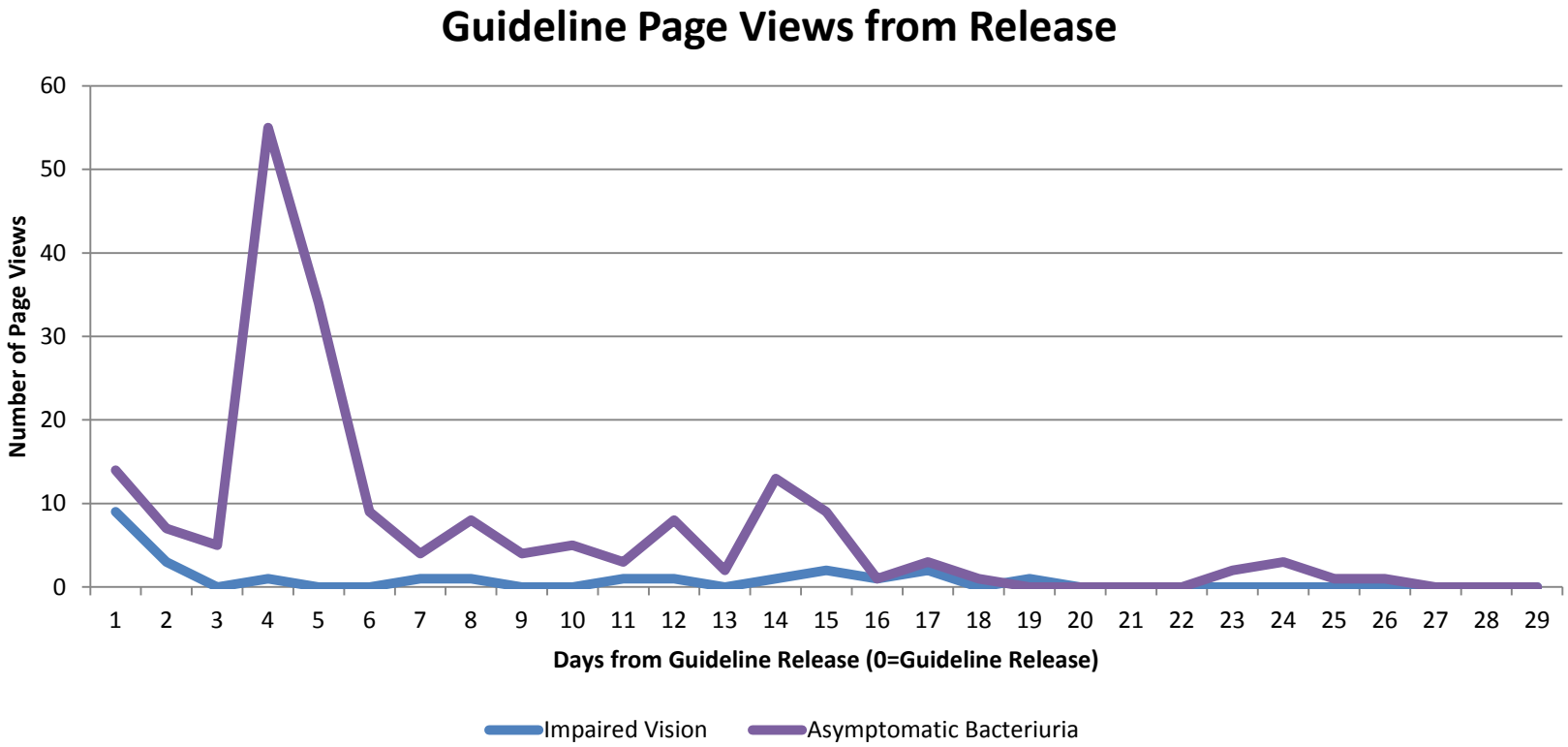
Note: The breast cancer guideline update webpage data is unavailable for the month of Dec.2018

Guideline dissemination

Task Force French website guideline page views after release



Note: Guideline page view data for the French website platform is only available for guidelines released in 2017 onwards

Note: The breast cancer guideline update webpage data is unavailable for the month of Dec.2018

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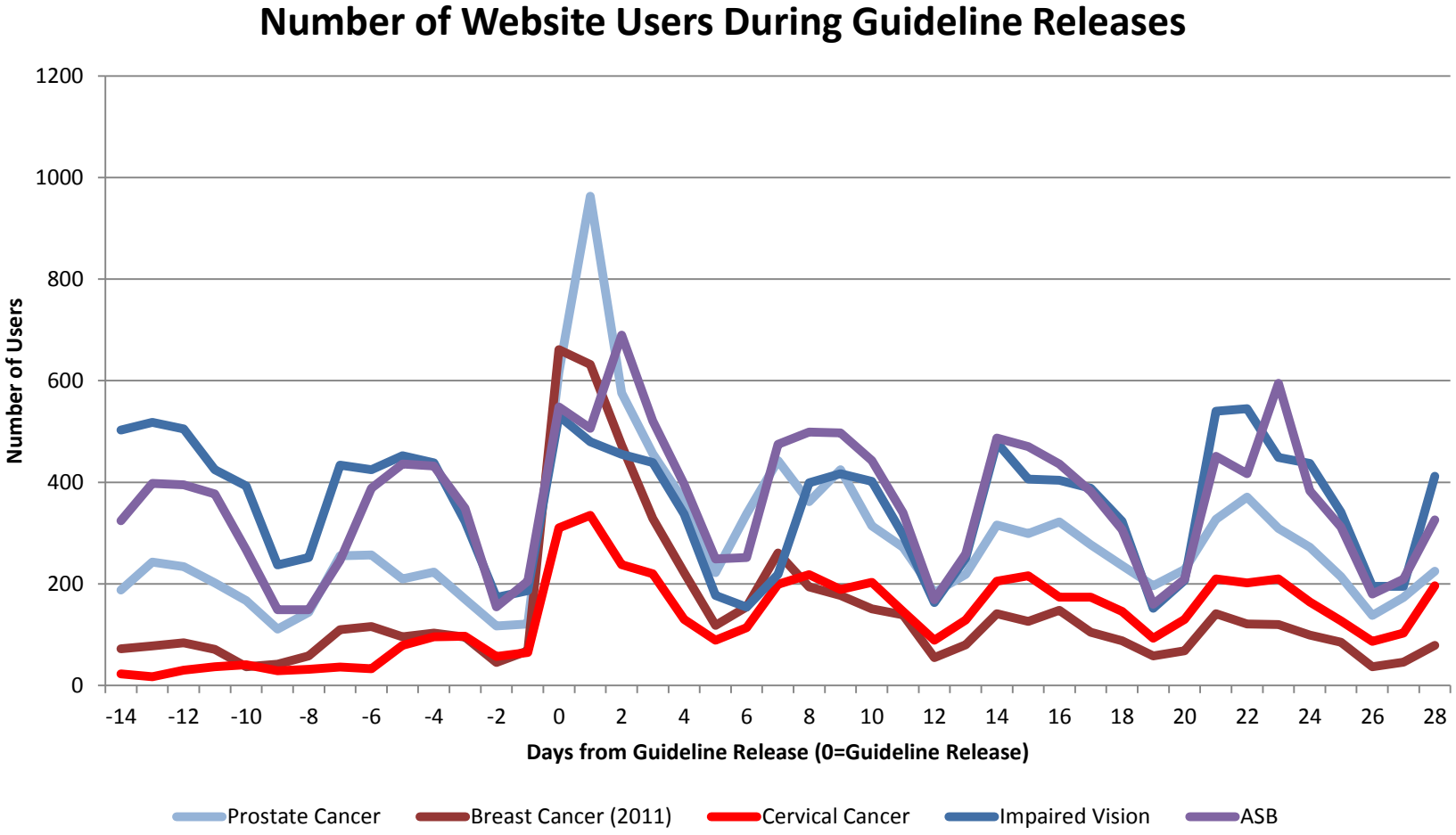
Guideline dissemination

Task Force website users before and after guideline releases



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Note: The breast cancer guideline update webpage data is unavailable for the month of Dec.2018
Note: The data reported is combined for both the English and French website platforms.

Guideline dissemination

KT Tool Page Views

- Total KT tool page views in 2018: **50, 711** (73 % English; 27% French)

Top 10 Most Viewed KT Tool Pages in 2018				
Guideline	**Tool**	**English**	**French**	**Total tool page views**
Diabetes, Type 2	Clinician FINDRISK	1719	5722	**7441**
Prostate Cancer	Harms & Benefits	4177	418	**4595**
	Clinician FAQ	2939	169	**3108**
	1000-person	1502	243	**1745**
Hypertension	Clinician Algorithm	2477	2106	**4583**
Breast Cancer	Harms and Benefits, 40-49	2076	368	**2444**
	Harms and Benefits, 50-59	1765	612	**2377**
	Patient Algorithm	2019	221	**2240**
Colorectal Cancer	Clinician Recommendation Table	2021	212	**2233**
Cervical Cancer	Clinician Algorithm	1874	157	**2031**

Guideline dissemination
2018 YouTube Video Views

Top 8 Most Viewed Videos (2018)	# YouTube Views
Cancer Screening	1274
Lung Cancer - Overview, risk factors & screening (Part 1 of 3) (2018) *	**940**
Lung Cancer - Should I be Screened? (Part 2 of 3) (2018) *	**361**
Prostate Cancer—Video for Physicians (2014)	348
Breast Cancer—Screening Guideline Video (2011)	300
Lung Cancer - Harms & Benefits - (Part 3 of 3) (2018) *	**280**
Dépistage du cancer	268
Cancer du poumon - Vue d'ensemble, facteurs de risque et dépistage – (Vidéo 1) (2018)*	**162**

* = released in 2018

Guideline dissemination

QxMD: Calculate

- Calculate by QxMD is a free digital application
- Clinical calculator & decision support tool for clinicians worldwide
- Task Force account offers guidelines and accompanying resources

Task Force account	
Total users in 2018	171,260
New users	50%
Returning users	50%
Total sessions	315,513

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Guideline dissemination

QxMD: Read

- Read by QxMD is a paid digital application
- Personalized medical & scientific library for Canadian users
- Task Force account offers guideline publications

Task Force account		
Total impressions	78,052	65% email 35% feed
Total views	4,840	71% abstract views 29% paper views
Total shares	104	99% email 1% Twitter
Professions	Physician	74%
	Resident	15%
	Nurse Practitioner	6%

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Note: This data is cumulative, from the start of the campaign in 2016

Guideline dissemination

CMAJ – Guidelines released in 2018

Guideline topics	2018 CMAJ guideline downloads	Citations (Scopus)
Asymptomatic bacteriuria in pregnancy	9,060	0
Breast cancer update (2018)	**8,940***	2
Impaired vision	5,292	1

* Note that breast cancer guideline update was released in December 2018, therefore 8,940 represents the number of guideline downloads in only one month; this is the most downloads per month of any guideline

Guideline dissemination

CMAJ – Previously released guidelines

Guideline topics	2018 CMAJ guideline downloads	Citations (Scopus)
Colorectal cancer	13,227	56
Prostate cancer	10,804	66
Breast cancer (2011)	9,938	207
Abdominal aortic aneurysm	9,762	4
Adult obesity	9,158	52
Hepatitis C	8,899	10
Cervical cancer	8,193	86
Lung cancer	6,535	37
Child obesity	5,803	38
Adult depression	5,690	84
Cognitive impairment	5,523	13
Type 2 diabetes	5,200	75
Developmental delay	4,532	10
Tobacco smoking in children & youth	3,596	2
Hypertension*	-	-

**The hypertension guideline was published in CFP, not CMAJ*

Dissemination

Dissemination

Publications: Peer-reviewed

Publication	Dates	Source
For community-dwelling adults aged 65 years and over we recommend against screening for impaired vision in primary care settings	May 14	*CMAJ*
Recommendations on screening for asymptomatic bacteriuria in pregnancy	July 9	*CMAJ*
Recommendations on screening for breast cancer in women aged 40–74 years who are not at increased risk for breast cancer	December 10	*CMAJ*
Screening for Chlamydia and/or in Primary Health Care: Protocol for Systematic Review	December 26	*BMC Systematic Reviews*

Dissemination

Publications: “Prevention in Practice” article series

- CFP print subscribers as of January 2019:
  - 34,000 in Canada
  - 1000 US and international

Article topics	Published	Total online views*	PDF downloads*
Patient values and preferences in shared decision making	January	5618	911
Patient perspectives	January	2306	277
Understanding and communicating risk	March	4017	787
Choosing guidelines	May	3584	4102
Screening: When things go wrong	July	4550	908
Overdiagnosis: causes and consequences in primary health care	September	5103	700
Practice organization for preventive screening	November	2626	338

*Note: Total online views and downloads combines both French and English article views and downloads

Dissemination

Breast cancer guideline update: Media coverage

Breast cancer guideline update: Interview requests	
Dr. Ainsley Moore	• The Canadian Press • CBC New Brunswick • MedicalResearch.com • Reuters Health • The Lynn Martin Show/AM800 • Chat TV • Global Radio
Dr. Donna Reynolds	• The Globe and Mail • Global TV • Zoomer Radio/Fight Back with Libby Znaimer • CTV Winnipeg
Dr. Guylène Thériault	• La Presse Canadienne • CBC Home Run Radio • TVA • ICI Radio-Canada Premiere

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Note: This represents the breast cancer guideline update media coverage between Dec. 10th - Dec. 31st; additional media coverage in 2019 may be included in the 2019 Annual Evaluation

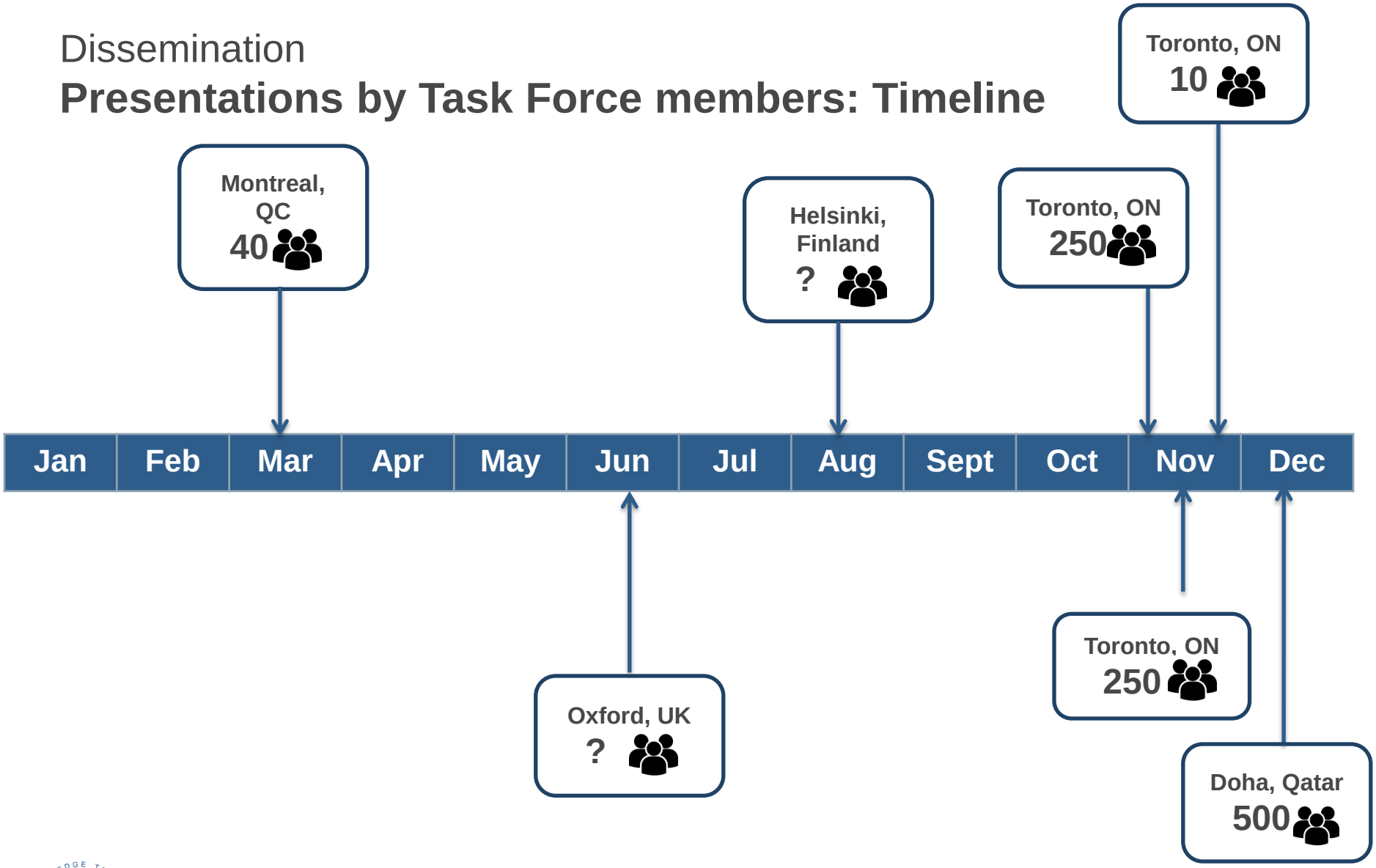
Dissemination

Breast cancer update: Media coverage

Top Media Coverage	
Article Title	**Reach**
Women don't need rigid breast cancer screening schedule: new guidelines (Globeandmail.com)	6,081,000
Updated mammography guidelines in Canada consider woman's preference not only age (Torontostar.com)	5,665,000
Updated mammography guidelines in Canada consider woman's preference not only age (Nationalpost.com)	3,141,000
Canadian doctors urge women to weigh pros and cons of breast cancer screening (Businessinsider.com)	3,489,000
Depistage du cancer du sein nouvelles directives avec laccent sur les valeurs et preferences des femmes (journaldemontreal.com)	2,857,000

Dissemination

Presentations by Task Force members: Timeline



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Dissemination

Presentations by Task Force members: Summary

Date	Title	Location	Attendance	Presenters
March 13	Who Needs the Canadian Task Force on Preventive Health Care? Why Task Force Guidance Matters	Herzl Family Practice Centre, Jewish General Hospital (*Montreal, QC)*	40	Brett Thombs
June	Decision Support and Knowledge Translation Tools to Highlight the Benefits and Harms of Screening: An Analysis of Online Access and Dissemination of the Canadian Task Force for Preventive Healthcare Resources	BMJ Evidence Based Medicine (*Oxford, UK)*	?	Eddy Lang
August 16	Decision support and knowledge translation tools to highlight the benefits and downstream harms of screening: Resources from the Canadian Task Force for Preventive Healthcare	Too Much Medicine: Paulo Foundation International Medical Symposium (*Helsinki, Finland)*	?	Eddy Lang

Dissemination

Presentations by Task Force members: Summary (cont.)

Date	Title	Location	Attendance	Presenters
November 16	Update on screening recommendations: What is new, what is controversial?	FMF *(Toronto, ON)*	250	Roland Grad
November 16	Prevention in practice: What to do less often, or not at all?	FMF *(Toronto, ON)*	250	Roland Grad
November 17	Assessing the quality of guidelines to choose for family practice.	FMF *(Toronto, ON)*	10	Roland Grad
December 1	How Primary Care Can Support Health from your Perspective	Annual Conference of the Primary Care Corporation (*Qatar)*	500	Michael Kidd

Dissemination

Guideline Release Webinars

Subject	Date	Stakeholders in Attendance	Presenter
Impaired vision	May 7th	4	Brenda Wilson
	May 8th	4	
Asymptomatic bacteriuria	July 5th	1	Ainsley Moore
	July 6th	2	
Breast cancer update	December 3rd	14	Scott Klarenbach
	December 3rd	6	
	December 5th	2	

Dissemination

Task Force Newsletter & Twitter

Task Force Newsletter			
Issue	**Date**	**Total recipients**	**Opened**
16	March	2530	40%
17	July	2503	40%
18	September	2491	42%
19	December	2486	43%

Task Force Twitter	2018	2017
Posts	**291**	121
Total followers	**395**	205

Implementation

Implementation

Clinical Prevention Leaders (CPL) Network

- 9 Clinical Prevention Leaders

- Professions
  - 6 primary care practitioners
  - 3 nurse practitioners

- Locations
  - Ontario
  - Quebec
  - Alberta
  - Manitoba
  - Saskatchewan

Implementation

Clinical Prevention Leaders (CPL) Network Webinars

Session	Date	Attendance	Facilitator
Breast Cancer	January 25th	5	Scott Klarenbach
Colorectal Cancer	February 12th	8	Richard Birtwhistle
Prostate Cancer	March 12th	5	Neil Bell
Lung Cancer	April 24th	5	Gabriel Lewin
Hep C	May 30th	4	Roland Grad
Depression	June 13th	3	Eddy Lang
Adult Depression	September 4th	5	Paula Brauer
High Blood Pressure	October 10th	7	Marcello Tonelli
Child Obesity	November 6th	3	Patricia Parkin
Breast cancer update	December 4th	4	Scott Klarenbach

Research Projects

Research projects

E-learning: Continuing Education Modules (CME)

Obesity prevention and management	CME module	Screening for cervical cancer
June 2018	MainPro+ Accreditation Expiration	July 2018
23	Total Learners completed	9
July 2018	1-year evaluation report submitted	September 2018

2018 Annual Evaluation Survey Results		
Task Force Resource	**% Aware of resource (*n* = 200)**	**# who USE resource / # aware**
Cervical Cancer Screening e-learning module	**10%**	**6/20**
Obesity Prevention and Management e-learning module	**11%**	**3/21**

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Research projects

Comparison of Task Force and provincial cancer screening recommendations

Province	Breast cancer screening	Cervical cancer screening	Prostate cancer screening
Alberta	✓	✓	--*
British Columbia	✓[1]	✓	X*
Manitoba	✓	X	--*
New Brunswick	✓[1]	X	--*
Newfoundland & Labrador	✓	X	--*
Nova Scotia	✓[1]	X	--*
Ontario	✓	X	--*
Prince Edward Island	✓	X	--*
Quebec	✓	X	X*
Saskatchewan	✓	X	--*
Northwest Territories	✓[1]	X*	--*
Nunavut	--*	X*	--*
Yukon	✓	X*	--*

✓ Provincial recommendation aligns with Task Force
X Provincial recommendation does not align with Task Force
-- No screening recommendations
* No organized screening program
[1] Some women under 50 years old are accepted with self or physician referral

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This information is from the 2018 environmental scans from the Canadian Partnership Against Cancer on breast, cervical, and prostate cancer screening in Canada. Available on cancerview.ca.

Integrated Knowledge Translation

Integrated knowledge translation

Patient preferences

- **91 patients** were engaged in patient preferences activities for 5 guidelines:

Guideline	Patient participants
Adult Depression	16
Pregnant and Post-Partum Depression	15
Chlamydia and Gonorrhea	16
Adult Tobacco	19
Osteoporosis	25

Integrated knowledge translation

Usability testing

- Usability testing was completed for 3 KT tools from 3 guidelines:

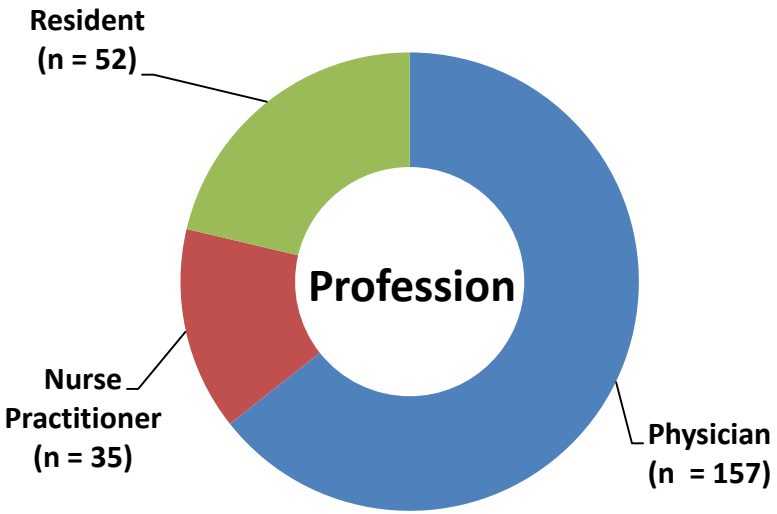
Guideline	Tool	Clinician participants	Patient participants	
			EN	FR
Impaired vision	Clinician FAQ	9	--	--
Asymptomatic bacteriuria	Clinician FAQ	8	--	--
Breast cancer update	1000-person tool	--	8	2*

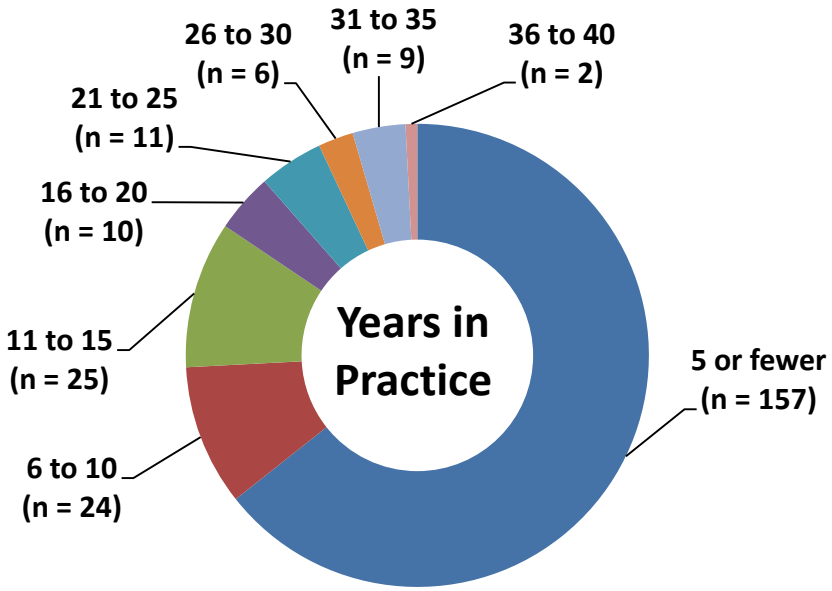
*Note: This was the first time usability testing was conducted in French for any guideline KT tool

Survey

Survey

Participant demographics (*n* = 244)





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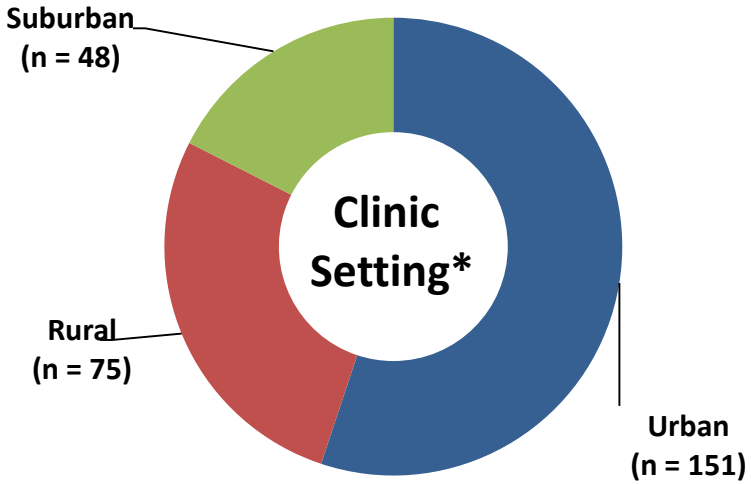
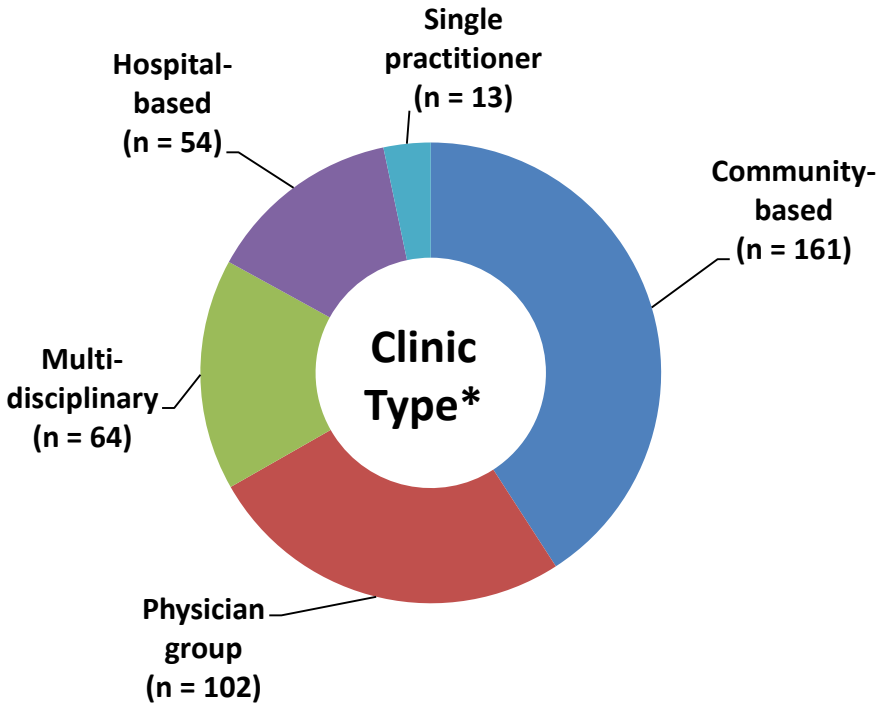
Survey
Participant demographics (*n* = 244)





*Numbers may not add up to 244 within a category because some PCPs provided demographic characteristics for multiple or none of the clinics in which they work.

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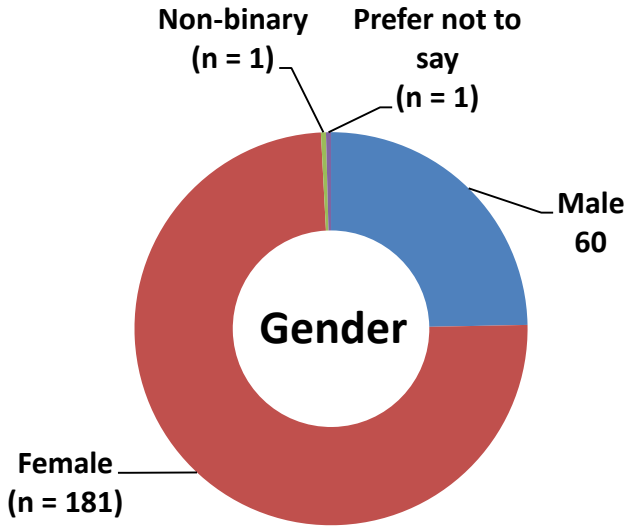
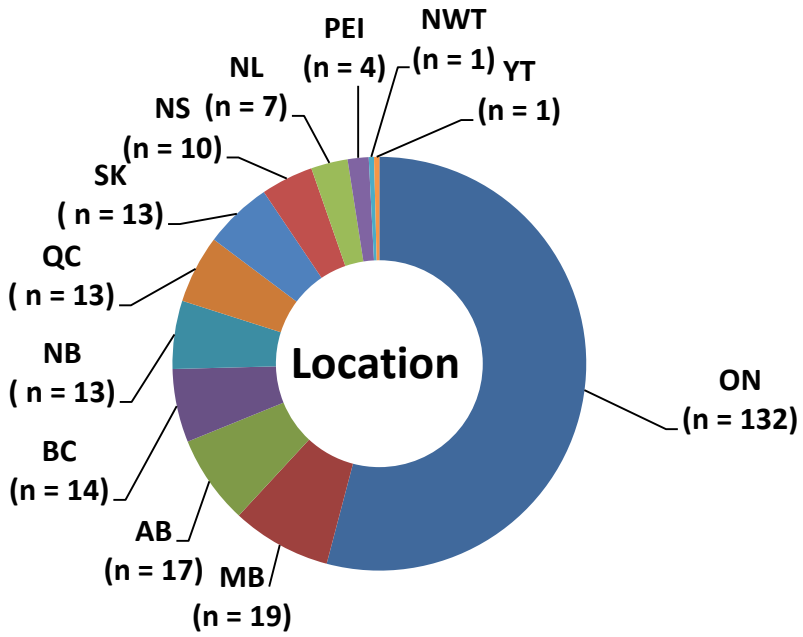
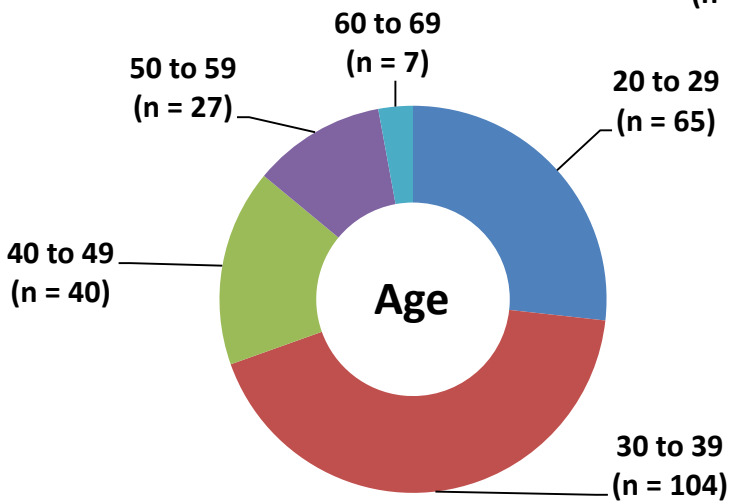
Survey

Participant demographics (*n* = 244)







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Survey
Breast cancer screening

2011

- Awareness and use of Task Force guideline

Breast cancer guideline	Responses	2017 Responses*
% of respondents **aware** of Task Force guideline	**75%** (n = 244)	90% (n = 198)
% who primarily **use Task Force guideline** (over other guidelines or no guidelines)	**49%** (n = 199)	33% (n = 167)
Satisfaction with guideline (out of 7)	**5.8 ±1.1** (n = 140)	6.2 ±1.1 (n = 152)

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*These results were retrieved from the Task Force 2017 Annual Evaluation report

Survey

Breast cancer screening

2011

- Practice change and intent to change

Breast cancer guideline	Responses	2017 Responses*
% who **changed their practice** to specifically align with Task Force guideline since its release	**49%** (n = 125)	47% (n = 113)
% whose practice was **already in line** with Task Force guideline	**44%** (n = 125)	45% (n = 113)
# who **intend to change** their practice / # who indicated they did not change their practice	3/6	--**

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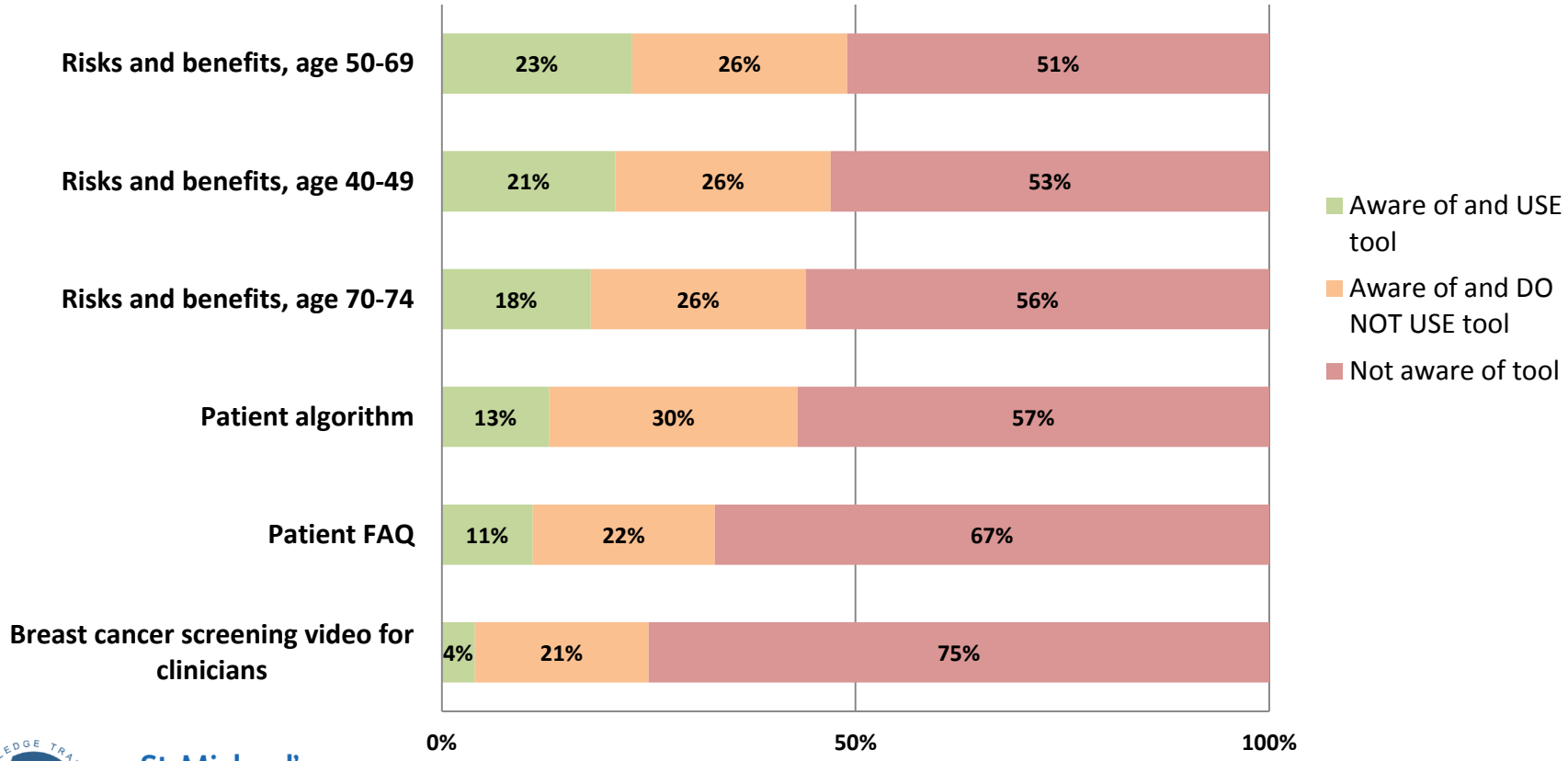
* These results were pulled from the Task Force 2017 Annual Evaluation report
**Note: This question was not asked in the 2017 annual evaluation survey

Survey

Breast cancer screening

2011

Awareness and Use of KT Tools (*n* = 141)



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Survey

Breast cancer screening

2011

- Current practice

Task Force recommendation	Practice aligns with Task Force recommendations	2017 Responses*
For women aged 40–49, we recommend not routinely screening with mammography	**87%** (n = 243)	78% (n =198)
For women aged 50-69 years, we recommend screening with mammography every 2-3 years	**89%** (n = 198)	--**
We recommend not routinely performing a clinical breast exam alone or in conjunction with mammography to screen for breast cancer	**75%** (n = 199)	82% (n= 167)

*These results were retrieved from the Task Force 2017 Annual Evaluation report
**This question was not asked in the 2017 annual evaluation survey

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Survey
Breast cancer screening

2011

- Current practice

Patient age group	Respondents who routinely discuss the harms and benefits with patients in each age group (*n* = 244)
39 and younger	15%
40 to 49	54%
50 to 69	74%
70 to 74	45%
75 and older	19%

Note: Numbers may not add up to the total as PCPs could provide multiple responses.

Survey
Cervical cancer screening

2013

- Awareness and use of Task Force guideline

Cervical cancer guideline	Responses	2017 Responses*
% of respondents **aware** of Task Force guideline	**82%** (n = 244)	89% (n = 198)
% who primarily **use Task Force guideline** (over other guidelines or no guidelines)	**29%** (n = 199)	22% (n = 167)
Satisfaction with guideline (out of 7)	**6.0 ± 0.9** (n = 155)	6.3 ±1.0 (n = 146)

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*These results were retrieved from the Task Force 2017 Annual Evaluation report

Survey

Cervical cancer screening

2013

- Practice change and intent to change

Cervical cancer guideline	Responses	2017 Responses*
% who **changed their practice** to specifically align with Task Force guideline since its release	**58%** (n = 143)	61% (n = 113)
% whose practice was **already in line** with Task Force guideline	**25%** (n = 143)	27% (n = 113)
# who **intend to change** their practice / # who indicated they did not change their practice	3/13	--**

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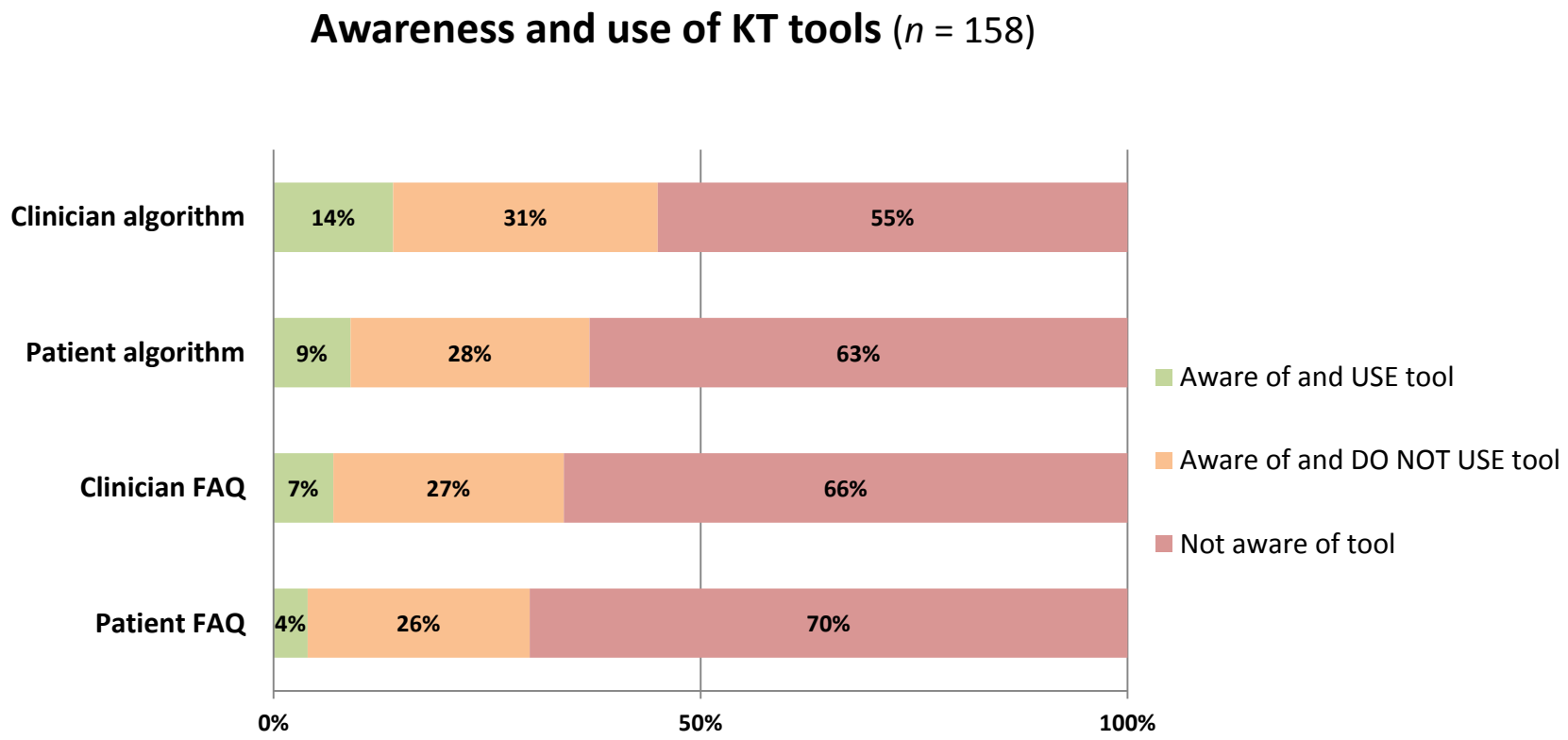
*These results were retrieved from the Task Force 2017 Annual Evaluation report
**This question was not asked in the 2017 annual evaluation survey

Survey

Cervical cancer screening

2013



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Survey
Cervical cancer screening

2013

- Current practice

Task Force recommendation	Respondents aligned with Task Force practice recommendations	2017 Responses*
For women aged 30 to 69, we recommend routine screening for cervical cancer every 3 years	**87%** (n = 200)	92% (n = 167)
For women aged 24 or younger, we recommend not routinely screening for cervical cancer	**51%** (n = 243)	45% (n = 197)

*These results were retrieved from the Task Force 2017 Annual Evaluation report

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Survey
Cervical cancer screening

2013

- Current practice

Patient age group	Respondents who routinely discuss the harms and benefits with patients in each age group (*n* = 200)
19 and younger	22%
20 to 24	60%
25 to 29	64%
30 to 69	65%
70 and older	21%

Note: Numbers may not add up to the total as PCPs could provide multiple responses.

Survey

Prostate cancer screening

2014

- Awareness and use of Task Force guideline

Prostate cancer guideline	Responses	2017 Responses*
% of respondents **aware** of Task Force guideline	**81%** (n = 244)	88% (n = 198)
% who primarily **use Task Force guideline** (over other guidelines or no guidelines)	**59%** (n = 199)	55% (n = 166)
Satisfaction with guideline (out of 7)	**5.7 ± 1.1** (n = 158)	5.6 ±1.5 (n = 149)

*These results were retrieved from the Task Force 2017 Annual Evaluation report

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Survey

Prostate cancer screening

2014

- Practice change and intent to change

Prostate cancer guideline	Responses	2017 Responses*
% who **changed their practice** to specifically align with Task Force guideline since its release	**53%** (n = 143)	47% (n = 118)
% whose practice was **already in line** with Task Force guideline	**41%** (n = 143)	36% (n = 118)
# who **intend to change** their practice / # who indicated they did not change their practice	2/8	--**

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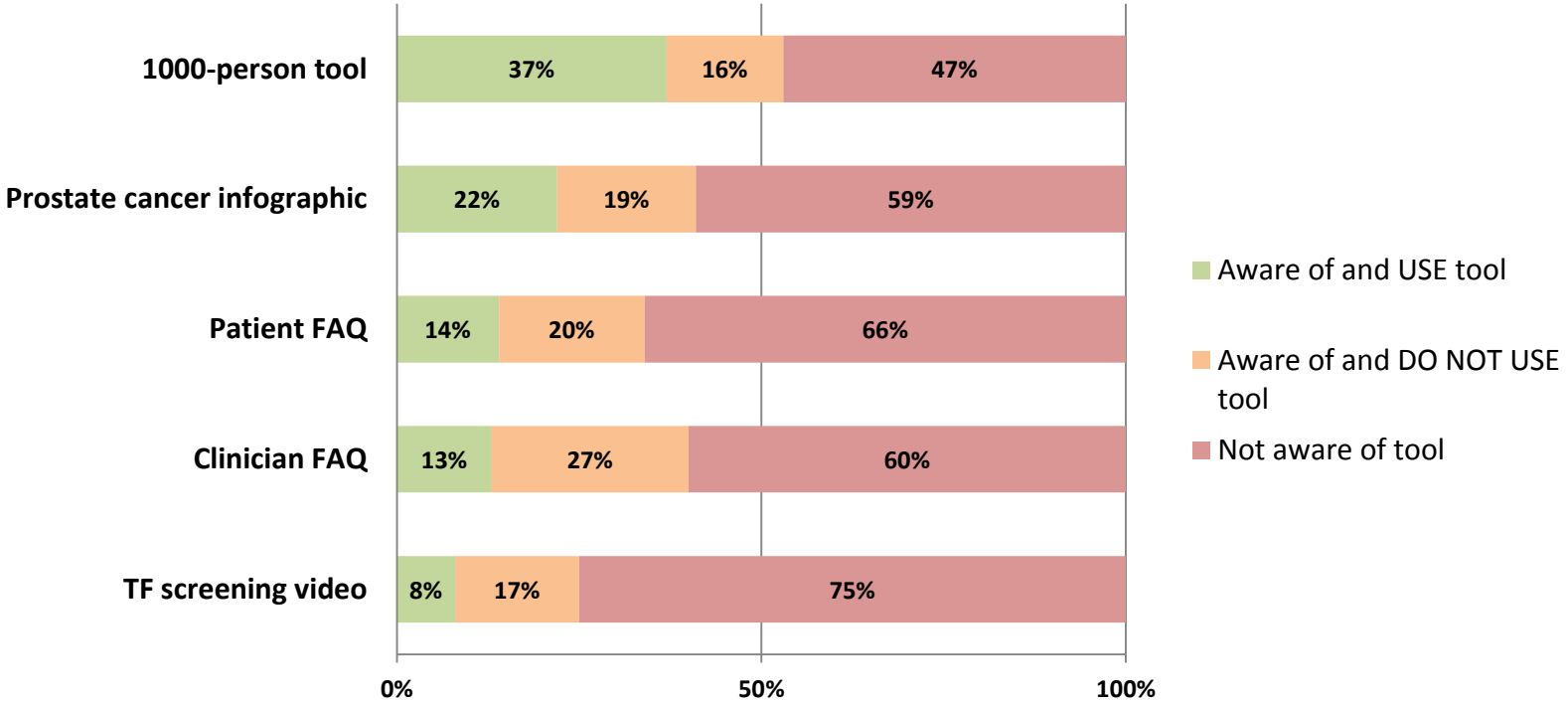
*These results were retrieved from the Task Force 2017 Annual Evaluation report
**This question was not asked in the 2017 annual evaluation survey

Survey

Prostate cancer screening

2014

Awareness and use of Task Force KT Tools (*n* = 160)



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Survey
Prostate cancer screening

2014

- Current practice

Task Force recommendation	Respondents aligned with Task Force practice recommendations	2017 alignment*
For men aged 54 or younger, we recommend not screening for prostate cancer with the prostate-specific antigen test	**88%** (n = 199)	84% (n = 167)
For men aged 55–69 years, we recommend not screening for prostate cancer with the prostate-specific antigen test	**79%** (n = 243)	84% (n = 31)

*These results were retrieved from the Task Force 2017 Annual Evaluation report

Survey
Prostate cancer screening

2014

- Current practice

Patient age group	Respondents who routinely discuss the harms and benefits with patients in each age group (*n* = 200)
54 and younger	49%
55 to 69	76%
70 and older	38%

Note: Numbers may not add up to the total as PCPs could provide multiple responses.

Survey

Screening for asymptomatic bacteriuria in pregnancy

2018

- Awareness and use of Task Force guideline

Asymptomatic bacteriuria guideline	Responses
% of respondents **aware** of Task Force guideline	**33%** (n = 244)
% who primarily **use Task Force guideline** (over other guidelines or no guidelines)	**31%** (n = 198)
Satisfaction with guideline (out of 7)	**5.8 ± 0.8** (n = 55)

Survey

Screening for asymptomatic bacteriuria in pregnancy

2018

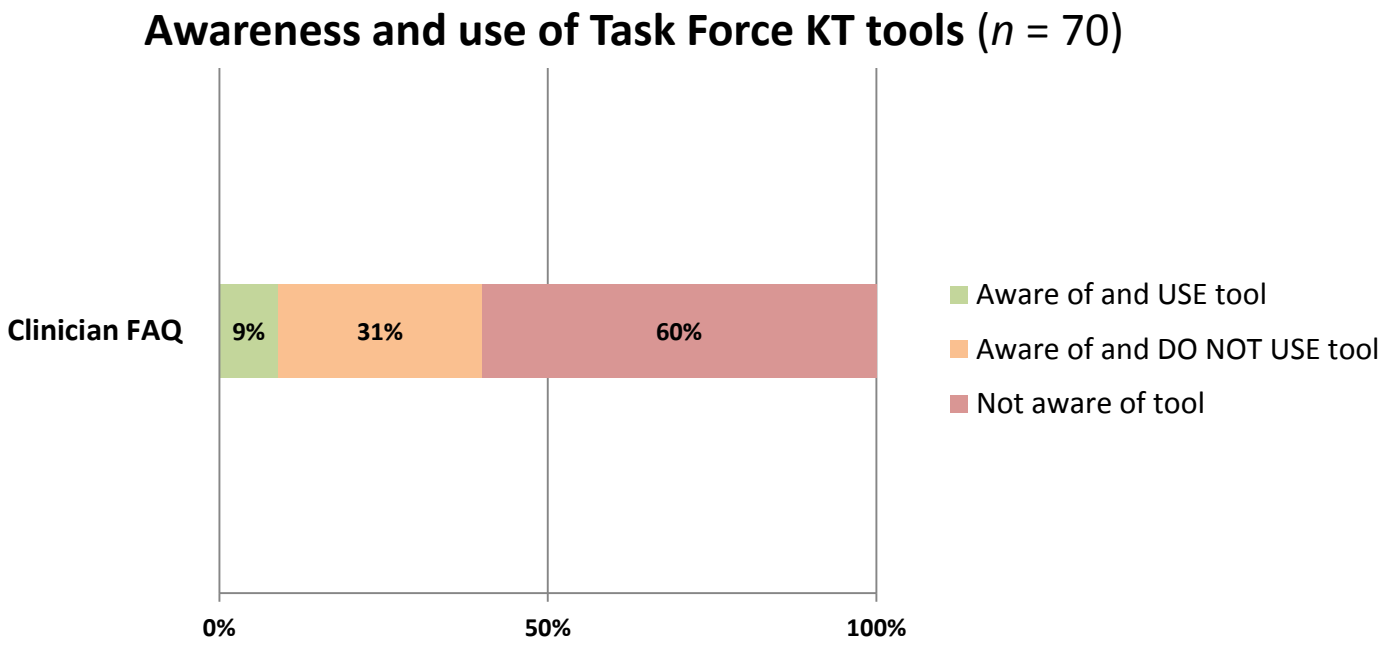
- Practice change and intent to change

Asymptomatic bacteriuria guideline	Responses
% who **changed their practice** to specifically align with Task Force guideline since its release	**34%** (n = 71)
% whose practice was **already in line** with Task Force guideline	**49%** (n = 71)
# who **intend to change** their practice / # who indicated they did not change their practice	2/9

Survey

Screening for asymptomatic bacteriuria in pregnancy

2018



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Survey

Screening for asymptomatic bacteriuria in pregnancy

2018

- Current practice

Task Force recommendation	Respondents aligned with Task Force practice recommendations
We recommend screening pregnant women once during the first trimester with urine culture for asymptomatic bacteriuria	**70%** (n = 243)

Survey

Screening for asymptomatic bacteriuria in pregnancy

2018

- Current practice

Patient age group	Respondents who routinely discuss the harms and benefits with patients in each age group (*n* = 200)
Under 25	33%
25 to 39	37%
40 to 64	16%
65 and older	1%
Do not routinely discuss the harms and benefits of screening with patients	59%

Survey

Screening for impaired vision

2018

- Awareness and use of Task Force guideline

Impaired vision guideline	Responses
% of respondents **aware** of Task Force guideline	**17%** (n = 244)
% who primarily **use Task Force guideline** (over other guidelines or no guidelines)	**16%** (n = 199)
Satisfaction with guideline (out of 7)	**5.8 ±1.1** (n = 28)

Survey

Screening for impaired vision

2018

- Practice change and intent to change

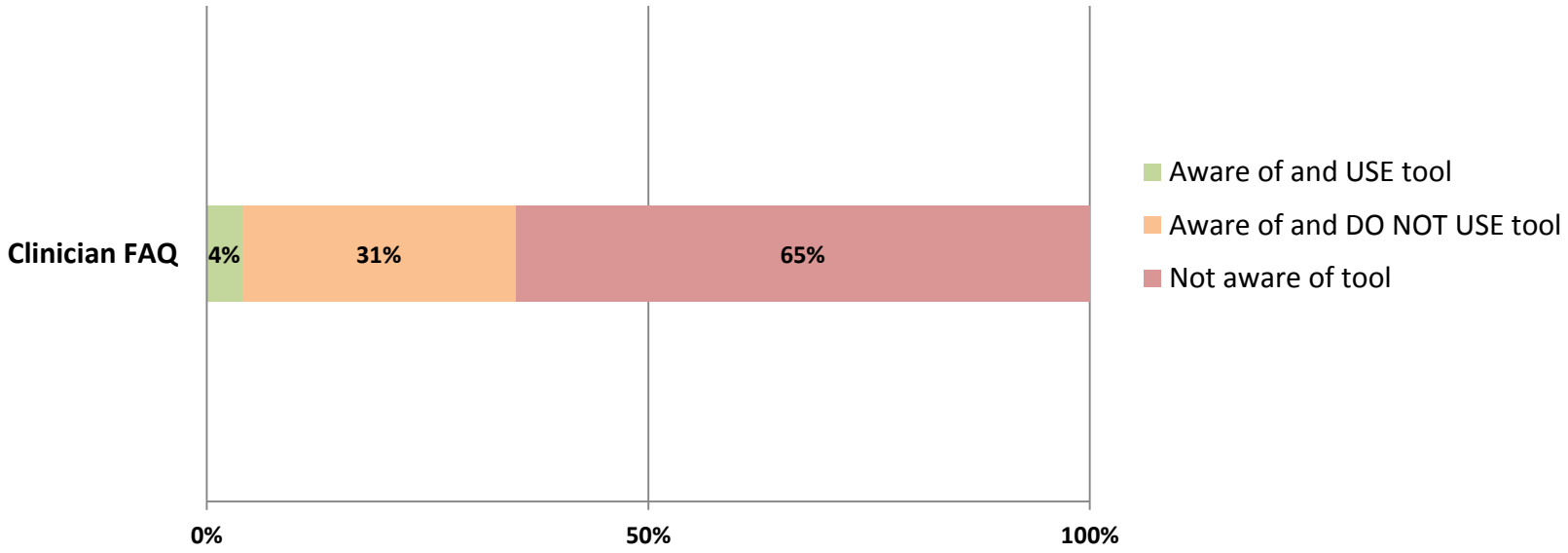
Screening for impaired vision guideline	Responses
% who **changed their practice** to specifically align with Task Force guideline since its release	**22%** (n = 37)
% whose practice was **already in line** with Task Force guideline	**46%** (n = 37)
# who **intend to change** their practice / # who indicated they did not change their practice	2/6

Survey

Screening for impaired vision

2018

Awareness and use of Task Force KT tools (*n* =29)



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Survey

Screening for impaired vision

2018

- Current practice

Task Force recommendation	Respondents aligned with Task Force practice recommendations (*n* = 243)
We recommend against screening for impaired vision for community-dwelling adults aged 65 years and over, in primary care settings	**58%** (n = 243)

Survey

Screening for impaired vision

2018

- Current practice

Patient age group	Respondents who routinely discuss the harms and benefits with patients in each age group (*n* = 200)
50 and younger	17%
50 to 64	17%
65 and older	27%
Do not routinely discuss the harms and benefits of screening with patients	68%

Survey

Breast cancer screening update

2018

- Awareness and use of Task Force guideline update

Breast cancer screening guideline update	Responses
% of respondents **aware** of Task Force guideline update	**47%** (n = 200)
% of respondents who **intend to change** their practice to align with Task Force guideline update	**38%** (n = 86)
% of respondents whose practice was **already in line** with Task Force guideline update	**40%** (n = 86)
% respondents who **haven't decided** whether they intend to change their practice to align with Task Force guideline update	**17%** (n = 86)
Satisfaction with guideline update (out of 7)	**5.7 ±1.1** (n = 92)

Note: The breast cancer guideline update was released in December 2018; survey data was collected less than one month after its release

Survey

Breast cancer screening update

2018

- Awareness of updated Task Force tools

KT tool	Aware of tool (*n* = 105)
1000-person tool	46%
1000-person tool, age 40-49	39%
1000-person tool, age 50-59	39%
1000-person tool, age 60-69	37%
1000-person tool, age 70-74	35%

Note: The breast cancer guideline update was released in December 2018; survey data was collected less than one month after its release

Survey

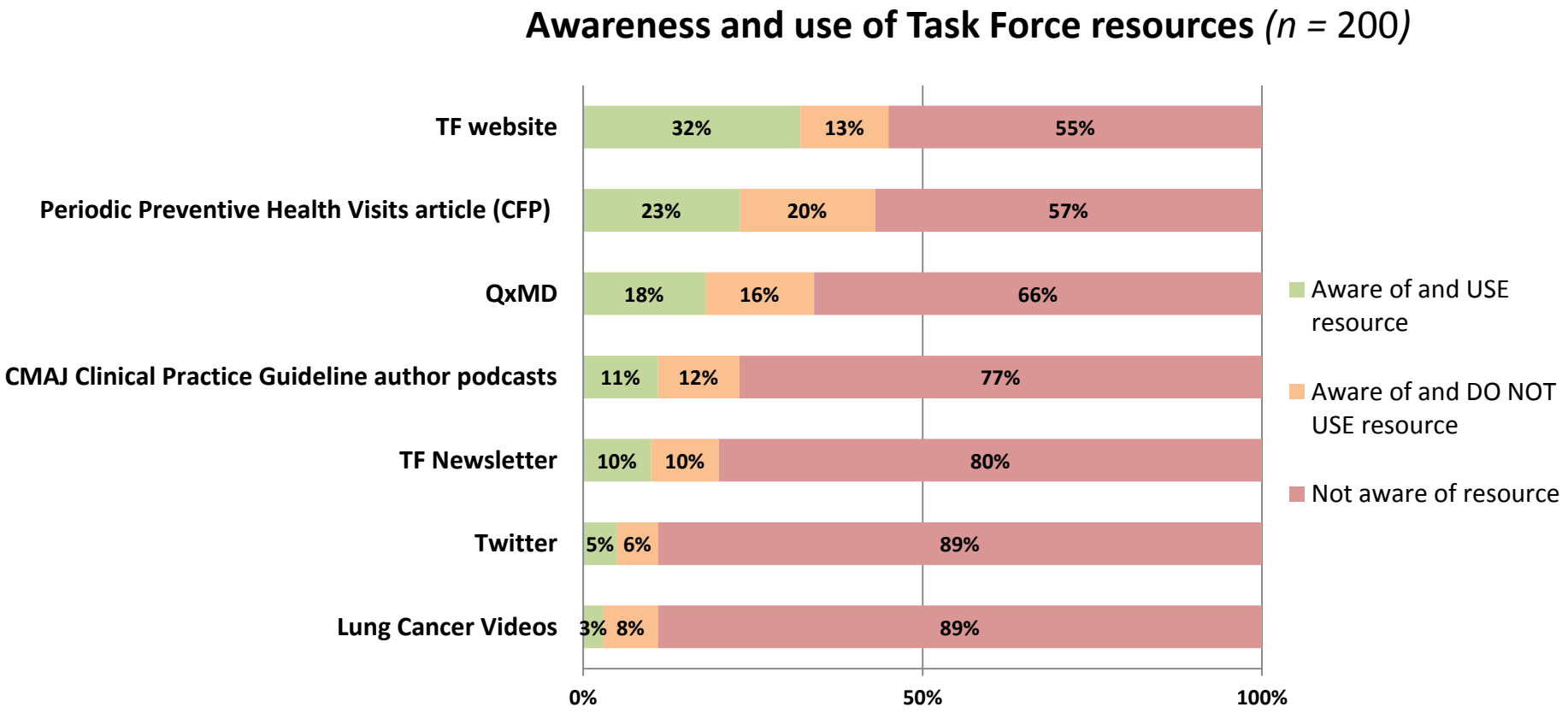
Awareness, use and satisfaction across guidelines

Guideline	Aware of guideline	Primarily use Task Force guideline	Satisfaction (out of 7)
Cervical cancer	**82%** (n = 244)	**29%** (n = 199)	**6.0 ± 0.9** (n = 155)
Prostate cancer	**81%** (n = 244)	**59%** (n = 199)	**5.7 ± 1.1** (n = 158)
Breast cancer	**75%** (n = 244)	**49%** (n = 199)	**5.8 ± 1.1** (n = 140)
Asymptomatic bacteriuria	**33%** (n = 244)	**31%** (n = 198)	**5.8 ± 0.8** (n = 56)
Impaired vision	**17%** (n = 244)	**16%** (n = 199)	**5.8 ± 1.1** (n = 28)
Breast cancer update*	**47%** (n = 200)	--*	**5.7 ± 1.1** (n = 92)

*Note that since the breast cancer guideline update was only released Dec. 10th, only participants who completed the long form survey were asked about awareness, and no questions were asked about use

Survey

Awareness and use of Task Force resources



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Survey

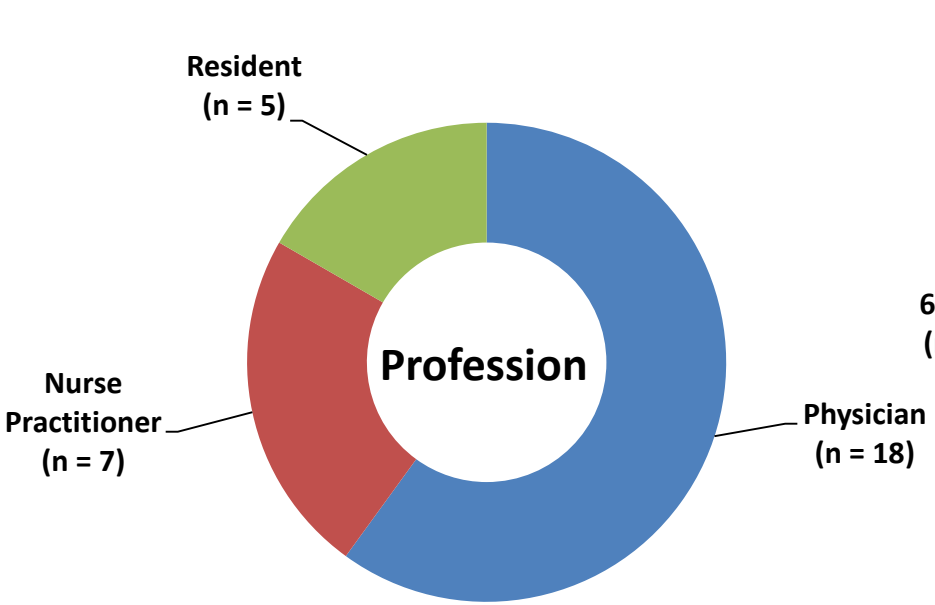
Task Force KT Tool access

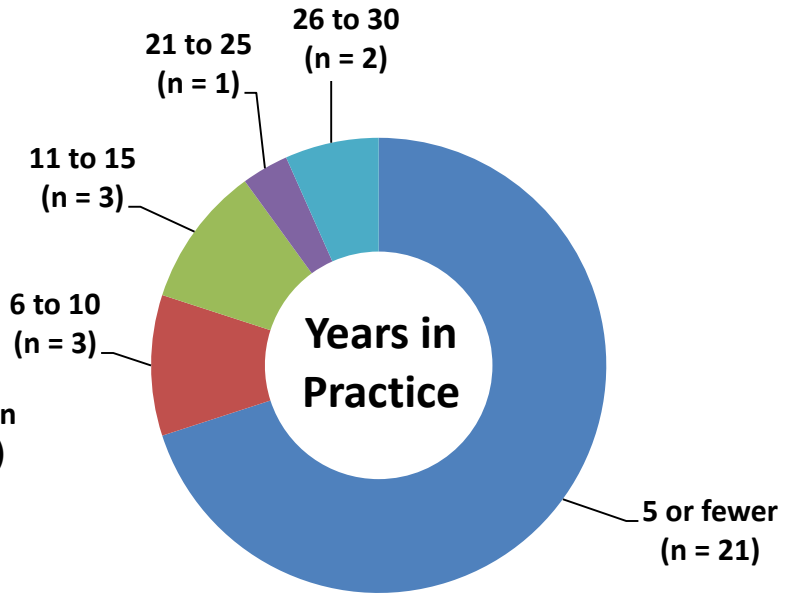
Source	% of PCPs that use this source to access KT tools (*n* = 200)
Website	71%
Printed copies (conferences)	33%
Printed copies (personal)	22%
Printed copies (CMAJ)	12%
QxMD	6%

Interviews

Interviews

Participant demographics (*n* = 30)





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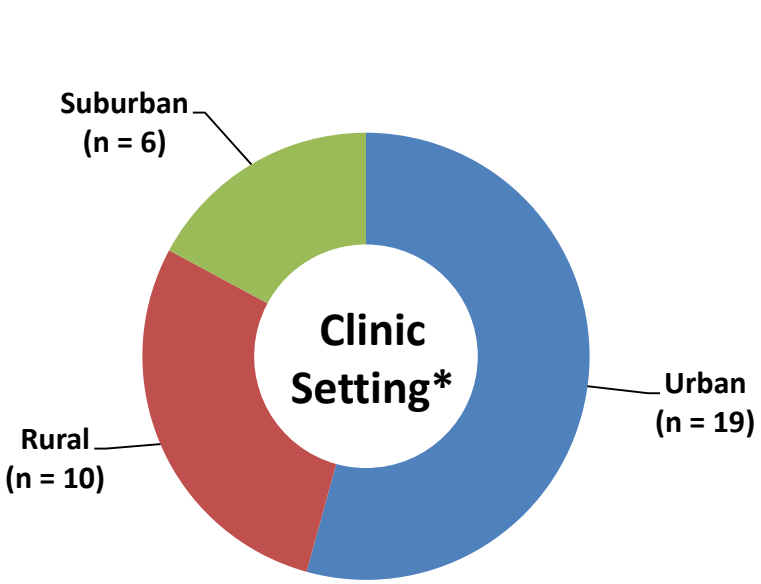
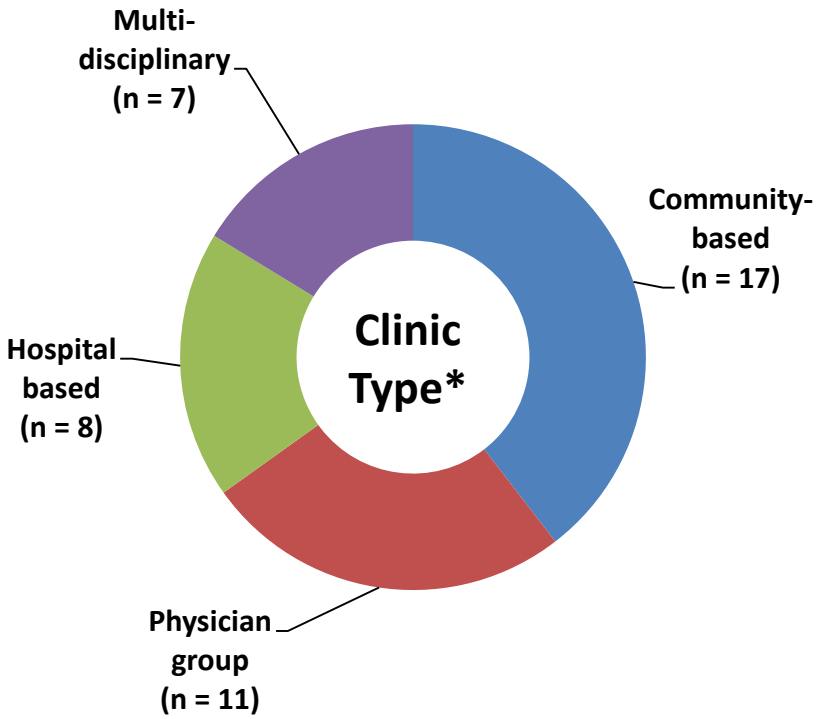
Interviews
Participant demographics (*n* = 30)





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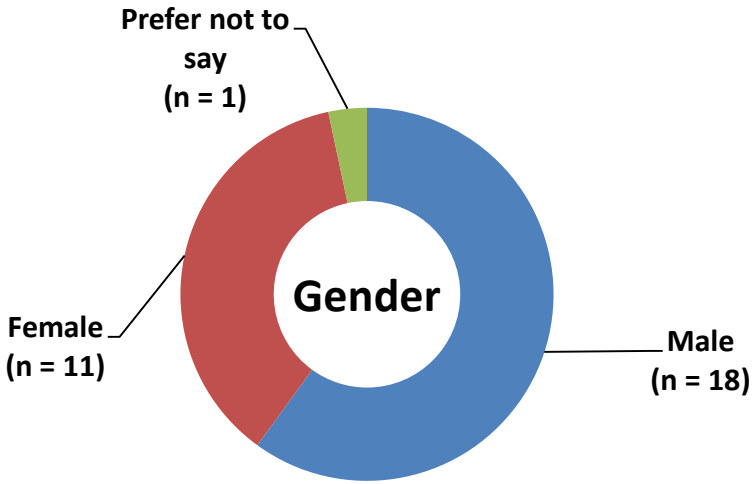
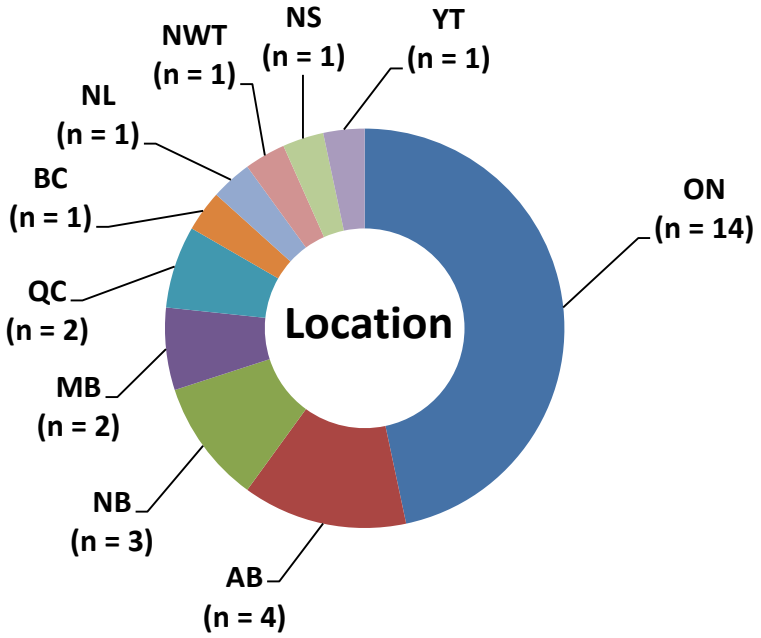
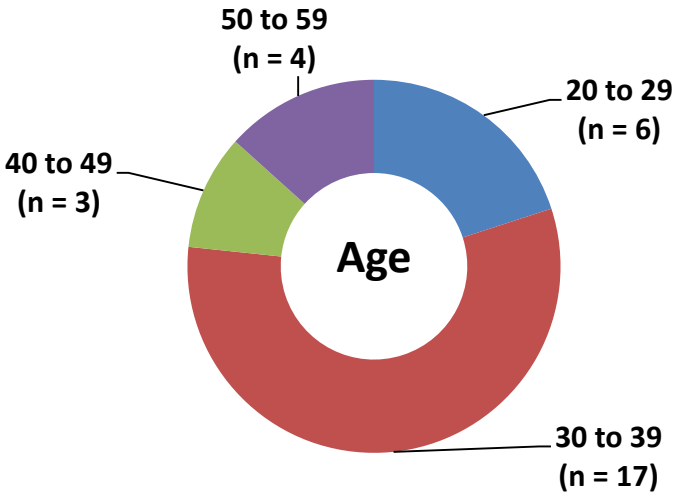
*Numbers may not add up to 30 within a category because some PCPs provided demographic characteristics for multiple or none of the clinics in which they work.

Interviews

Participant demographics (*n* = 30)







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Interviews

Theme 2: Sources of screening and preventive health care recommendations

- Along with the Task Force, PCPs named other trusted sources for screening and preventive health care recommendations

Specific sources	
Osteoporosis Canada	The Society of Obstetricians and Gynecologists of Canada
BC Cancer Agency	Hypertension Canada
Heart and Stroke Foundation	CMAJ
Cancer Care Ontario	North American Menopause Society
Towards Optimized Practice (Alberta)	Canadian Society for Pediatrics
United States Preventive Services Task Force	Canadian Urological Society
Canadian Nurses Association	Canadian Cardiovascular Society
Choosing Wisely	Centre for Effective Practice
Practicing Wisely	College of Family Physicians
Heart and Stroke Foundation	Institut national d'excellence en santé et en services sociaux

Interviews

Theme 4: Implementing guidelines

- PCPs practicing in alignment with Task Force guidelines

Task Force guideline	Reason for not aligning practice with recommendations
Cervical cancer	"I have seen cervical cancer in younger women before that was pretty advanced and **I think that guides my bias because you never want to miss something like that**...I also think that **I don't really see any downside to starting any earlier** other than maybe a slight increasing cost to the system, but **when you have guidelines with conflicting numbers I would choose earlier rather than later**…you know, if it was my sister, my mom, I would rather them do it earlier rather than later so I just approach it that way." – *Participant 28* "For cervix, it's a little bit more difficult, because in my area, [it's] the nurses that manage cervical cancer screening in general….So, they do invite women as of age 21, but you know, if I end up seeing one woman in that age group, I typically make a point of at least mentioning to her that it's not necessarily a consensus everywhere, and some bodies recommend more 25 [years old], and if it's not something she's not comfortable about, she shouldn't feel pressured into doing it. So, yeah, I would say that generally if I'm not following at all recommendations, like for cervical cancer, **it's not so much because I don't agree, or don't believe it's accurate, but that my logistical situation make me not the person in charge of this**." - *Participant 3*

Interviews

Theme 4: Implementing guidelines

- PCPs practicing in alignment with Task Force guidelines

Task Force guideline	Reason for not aligning practice with recommendations
Prostate cancer	" So, I have one [patient] who insists he needs a prostate exam every year, every year, every year. He has no risk, probably doesn't need it, but he's very insistent and it's the only way you can calm him down. **So, in the end, is it really doing that much harm? No. So, this is what he needs to have sanity, so this is what we'll do**." - *Participant 29*
Lung cancer	"In my clinical site, **accessing a CT is a big issue,** and I have my own queasiness about the lung cancer recommendation. So, I am currently, until at least one of the Quebec bodies puts out a position on lung cancer screening, I'm not offering lung cancer screening to my patients in Quebec, because **we have too [many] issues accessing imaging through diagnostics needs, and I don't feel like I can, from a system point of view, start drawing patients for screening there without inducing unnecessary delays for people that need diagnostic ability**. So, that's one that I'm willfully ignoring for now, and only talking about when patients want to discuss with themselves, which I must say is pretty rare in my rural area." - *Participant 3*

Interviews

Theme 4: Implementing guidelines

- PCPs practicing in alignment with Task Force guidelines

Task Force guideline	Reason for not aligning practice with recommendations
Breast Cancer	"So, I think, I mean in the breast cancer one is interesting because it ultimately…is recommending more of a conversation with patients... I haven't had the conversation about the mammogram yet but I think patients come in with questions cause I think for the most part people... if they're up to date in their screening and they are aware of screening and they are doing it then, you know, they will come in for a periodic health review and they may ask questions [about] whether anything has changed, and that would be an opportunity to have a conversation. **I don't imagine that I would... you know, for example, with the new guidelines, *deter* anyone who is already undergoing screening to change what they are doing.** Unless they brought it up. Then otherwise, I think, when people turn a certain age and …when screening is meant to begin based on the guideline then... I'd try to, you know, make a note to myself to have that conversation when the patient is in front of me." – *Participant 10* "We can want to follow the recommendations all we want. In most provinces in Canada, women get their breast cancer screening whether they have a family doctor, or not. Whether they know about it or not, because **all of this happened before they see us in the office**. So, for sure we can try to discuss screening in general when we see them, but generally speaking they've already started to screen before we met them, and if we would want as a country, or whatever, to truly do shared decision-making**, then a woman should never get an invitation to a mammogram.** They should get invitation to an information session with nurses and physicians about what screening does, and if it's the right choice for them. So, I feel like …there's a kind of a policy aspect to this, that most physicians will not be able to follow this recommendation until something changes in that aspect." – *Participant 3*