The New Zealand Experience of Guideline Implementation

Prof Cindy Farquhar
Past Chairman
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The New Zealand Guidelines Group

NZGG is funded by government but is an independent incorporated society

Vision

Reduce inequalities and improve health outcomes for all New Zealanders

Mission

Lead the health and disability sectors in driving the effective use of reliable evidence

NEW ZEALAND GUIDELINES GROUP

The problem: the 'know-do'

'All breakthrough, no follow-through'

Stephen Woolf, Washington Post, 2006

'There is a gap between today's scientific advances and their application: between what we know and what is actually being done. Health work teaches us with great rigour that action without knowledge is wasted effort, just as knowledge without action is wasted resource'

LEE Jong-Wook, past WHO Director General

Implementation is complicated....

- Decisions are influenced by the clinicians personal and professional experience as well as by their knowledge of and relationship with the patient
- The clinicians are a major influence on patient's decisions about treatment

Freeman and Sweeney 2001

W

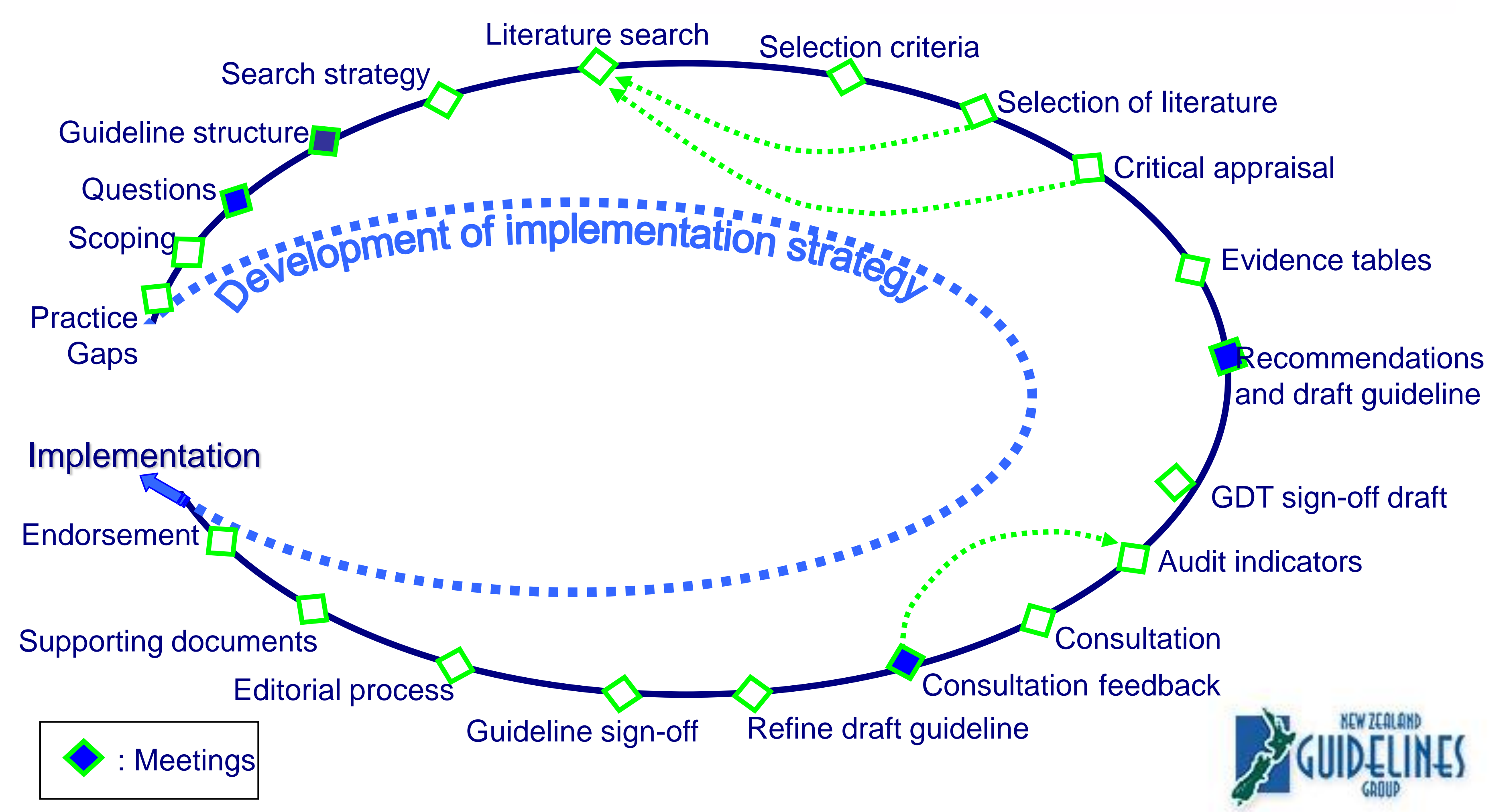
Levels of Implementation

- Policy changes
  - Funding requirements
  - Access to care
- System changes
  - Streamlining services
- Practitioner changes
  - Changing attitudes, knowledge base, decision support
- Patients
  - Media campaigns
  - Patient resources

Implementation starts with the guideline...

- Problems to avoid
  - unrealistic or impractical recommendations
  - a guideline that is too lengthy
  - a guideline that is not user friendly eg. no algorithm or short version

Guideline development and implementation process



Guideline features that encourage use

- Strong supporting evidence
- Flexible recommendations
  - Feasible in local context
  - consider patient needs and preferences
- Concise recommendations
- Supporting documents
  - Short summaries, leaflets for patients, checklists, pocket cards
- Explicit about resources
- Clinical vignettes

(Gagliardi et al 2011)

Policy and Funding Issues

- Get policy agencies involved early
- Provide opportunities to comment
- Actively discuss the implications of the recommendations
- Assess the costs of the recommendations (eg screening issues, recommendations for new drugs)

Clinicians: What are the barriers and enablers for changing practice?

- Barriers – stopping change to practice
  - Examples:
    - Cost of recommendations
    - Involves major change to services
    - Clinician resistance to change
- Enablers – making it easy to change practice
  - Examples:
    - Regulations or incentives to change
    - Patients want the change
    - Implementation is interactive

What works for clinicians?

- Printed educational materials
- Educational meetings – should be interactive and multidisciplinary
- Educational outreach
- Local opinion leaders
- Audit and feedback
- Reminders

Dissemination & Awareness Campaigns

- Create awareness of the guideline release date
- Provide information about what the guideline involves and what is new and surprising
- Explain the guideline development process – independent, trusted evidence-based advice
- Use at least three different media to the same target audience

Some examples…different products for different audiences

- For policy makers
- For clinicians
- For patients

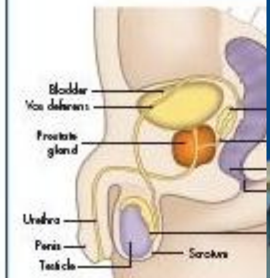
Testing for prostate cancer

This is a consultation resource for primary care practitioners

Discussion points

- What is your main concern?
- What is prostate cancer and what tests are there?
- What is your risk?
- What are the possible benefits and harms of being tested for prostate cancer?
- What is most important to you?

The prostate



A national screening programme for prostate cancer has not been established b
good-quality research studies are required to confirm whether the benefits outwe
Although a national screening programme for prostate cancer is not appropriat
information, every man has the right to decide for himself whether or not to be t
prostate cancer. Information about prostate cancer and prostate cancer testing r
by the Ministry of Health and interested groups. Doctors and other health practit
under the Code of Health and Disability Services Consumers' Rights Regulations
good, balanced information on prostate cancer and the possible benefits and ha
and treatment.

The two resource cards (four sides) have been adapted from a resource developed and produced in 2005 and updated in 2007 by the Cancer Council Queensland and Australian Prostate Cancer Collaboration in consultation with the Northern Section of the Urological Society of Australia and New Zealand (http://www.andrologyaustralia.org/docs/PSAdecisioncard20041007.pdf). Content has been modified for local use by the New Zealand Guidelines Group, except where otherwise indicated.

Testing for Prostate Cancer

Information for men and their families

ing prostate cancer.
men are more likely
e for the cancer to
die of other causes.

ate cancer?

40–49 years, not per year

r 2001, published in 2006.

her if a close relative
5 years) or more than

s higher

p you assess your

Health practitioner consultation show card

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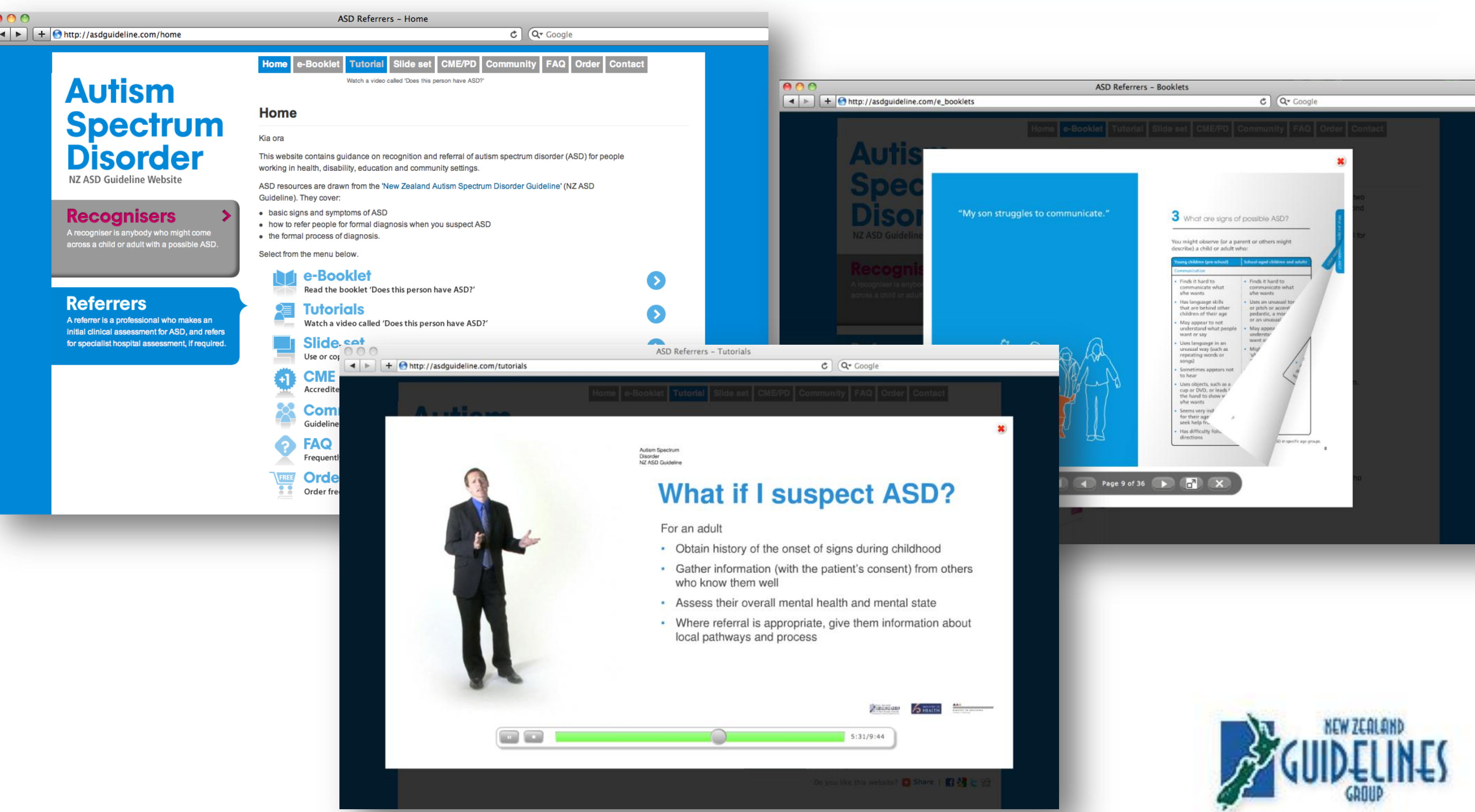
Several Different Approaches



whakawhanaungatanga

www.nzgg.org.nz

Self-harm and suicide prevention collaborative

BEST PRACTICE
EVIDENCE-BASED
GUIDELINE
SUMMARY

THE ASSESSMENT AND MANAGEMENT OF PEOPLE AT RISK OF SUICIDE

EMERGENCY DEPARTMENTS

KEY MESSAGES

- Anyone who talks about suicide should be taken seriously.
- People who present following a suicide attempt are usually in a state of extreme distress.
- Asking about suicide does not create risk in people who do not have suicidal thoughts.
- Training in suicide assessment improves staff performance, appropriate referrals and overall care.
- Case Notes should be augmented with structured assessments (such as the Rapid Assessment tool).
- Clinicians should involve whānau/family/support people of the suicidal person whenever possible.
- Information from significant others is helpful when assessing a

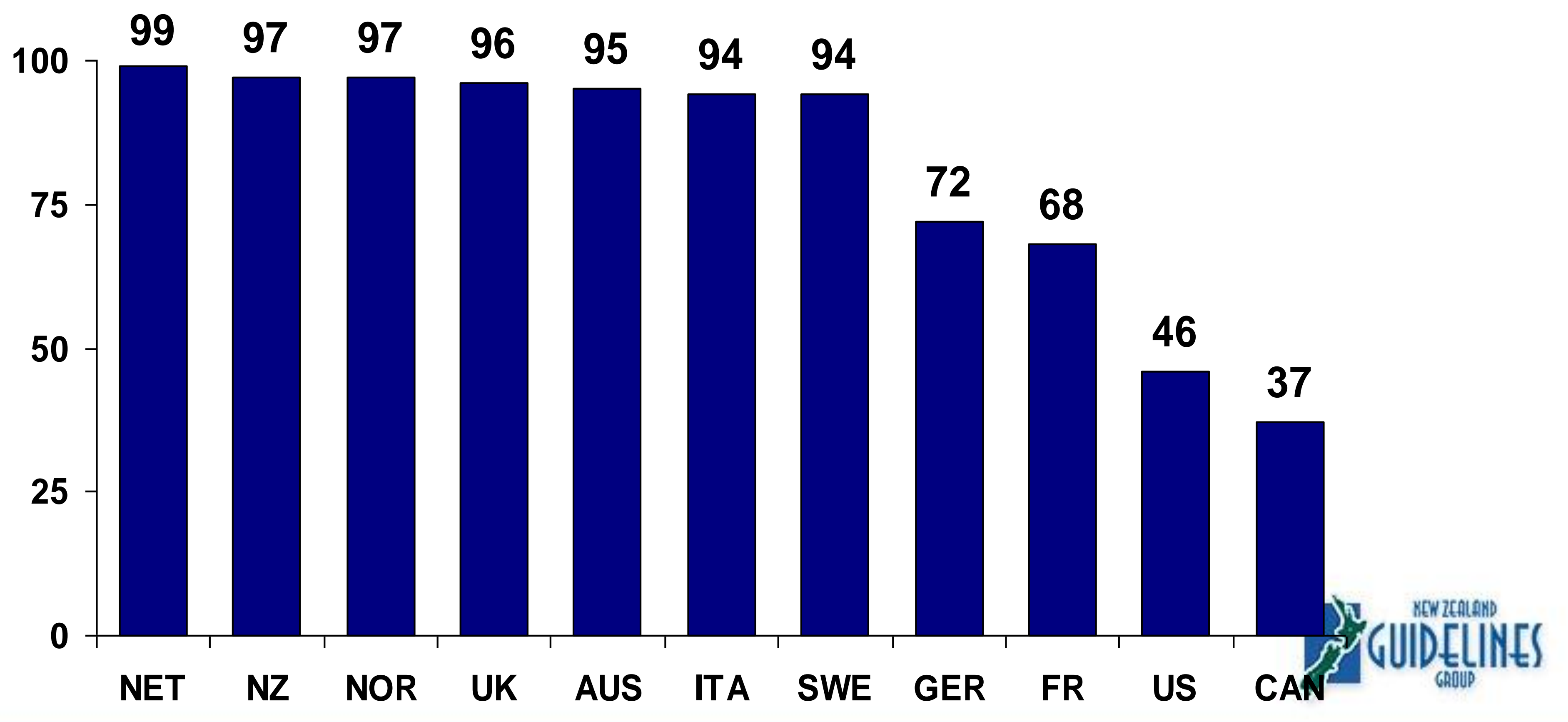
- Implementing guideline
- 11 district health boards
  - mental health, emergency departments, Māori health, consumers
- What we did?
  - Bi-cultural model
  - Set targets
  - Map consumer experiences to blockages
  - Plan-Do-Study-Act Cycle (PDSA)

What was NZGG's role?

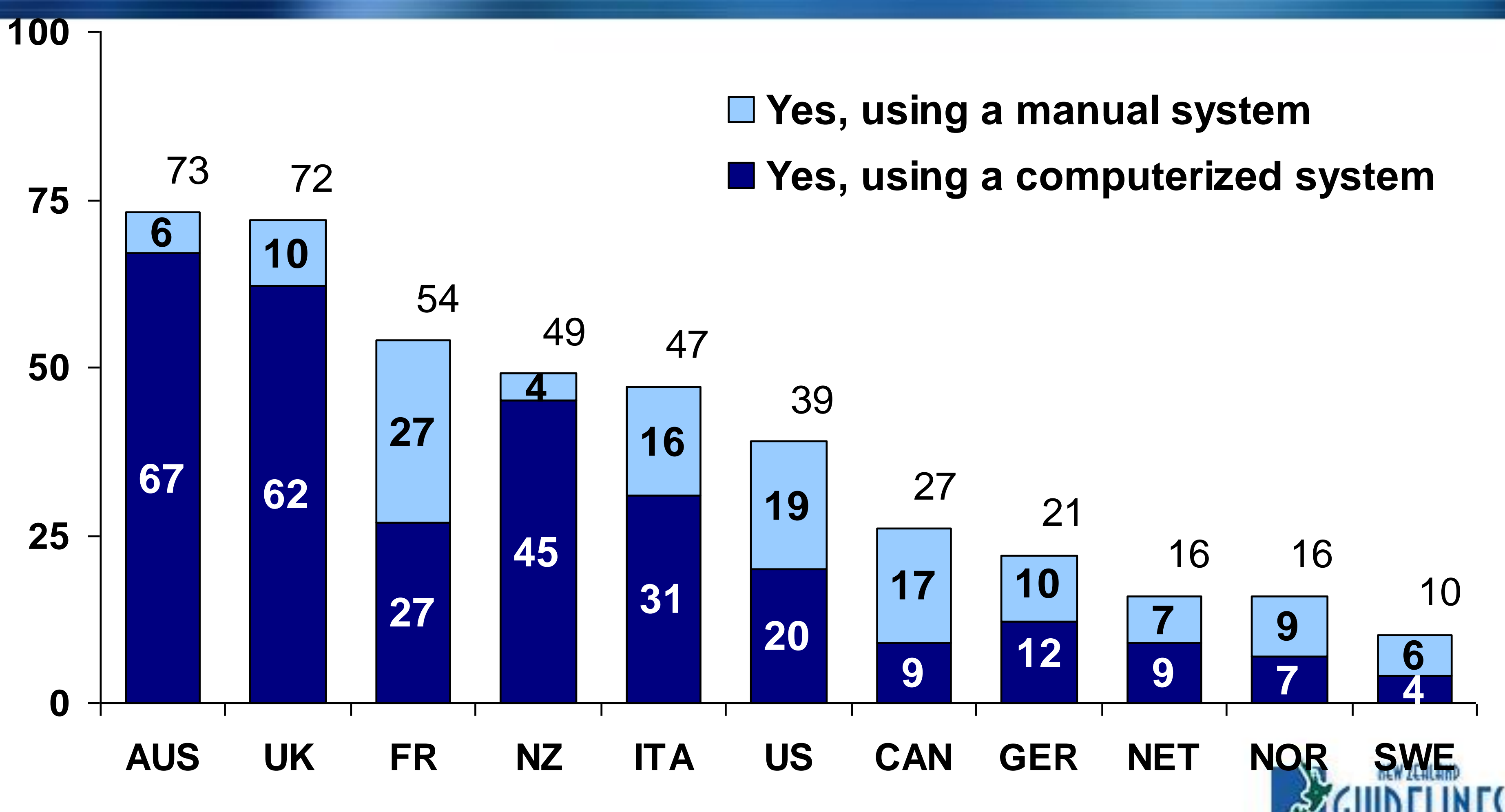
- Training in skills in quality improvement methods, change management techniques and collaborative management
- Site visits to DHBs to support training
- Scheduled teleconferences and workshops
- Web-based reporting system
- Ongoing advice for participating teams

Using our electronic connections...

- NZ Primary Care Doctors use electronic patient medical records



Doctor Routinely Receives Reminders for Guideline-Based Interventions or Screening Tests

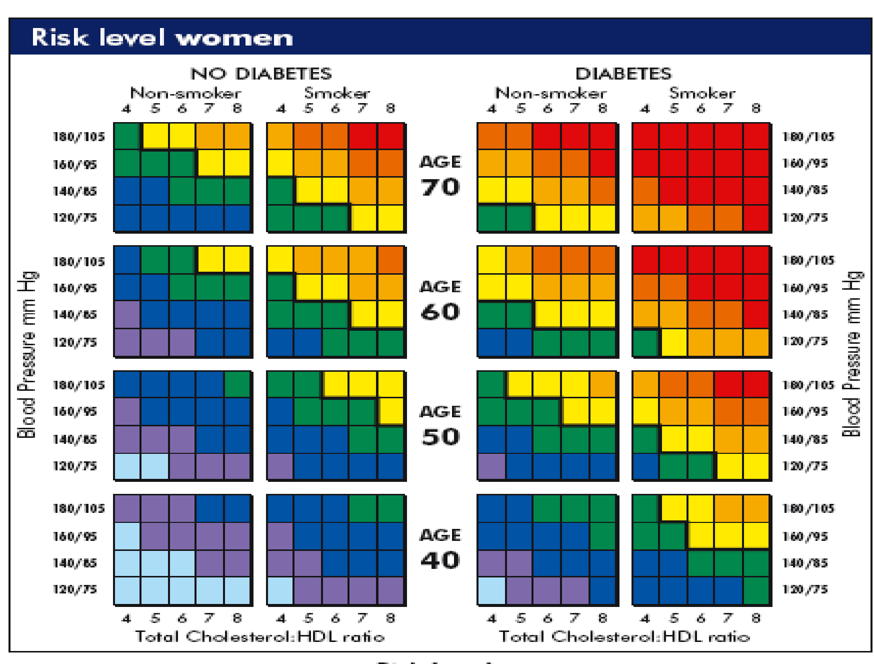


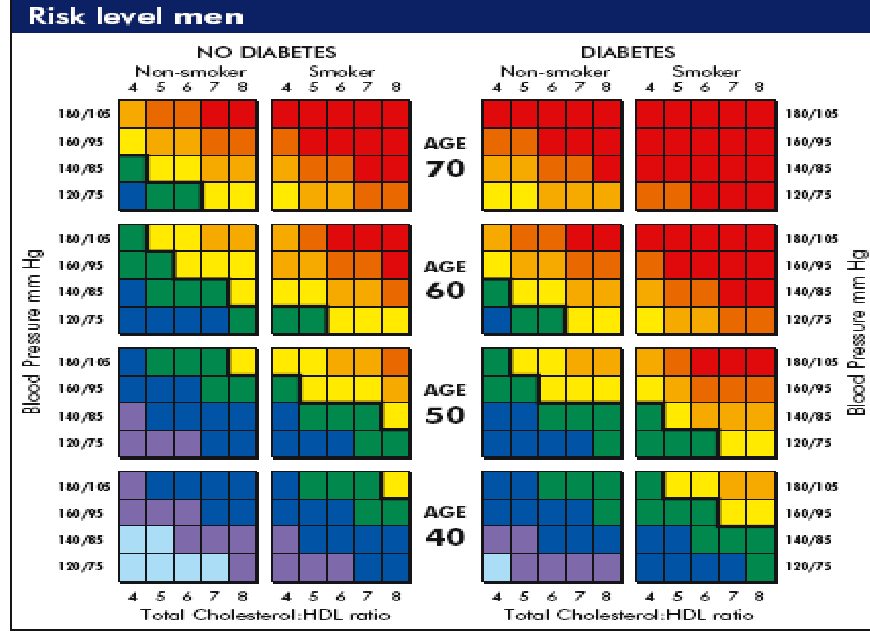
Percentages may not sum to totals because of rounding.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

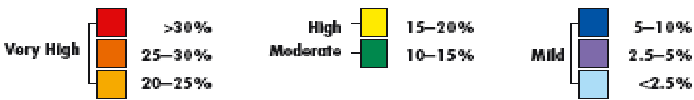
From CVD Risk Charts ....

Assessing Cardiovascular Risk and Treatment Benefit





Risk Level
5 year CVD risk (non-fatal and fatal)



How to use the Tables

- Identify the table relating to the person's sex, diabetic status, smoking history and age.
- Within the table choose the cell nearest to the person's age, blood pressure and TC:HDL ratio. When the systolic and diastolic values fall in different risk levels, the higher category applies.
- For example, the lower left cell contains all non-smokers without diabetes who are less than 45 years and have a TC:HDL ratio less than 4.5 and a blood pressure less than 130/80 mm Hg. People who fall exactly on a threshold between cells are placed in the cell indicating higher risk.

Discuss your risk with your GP. Refer to the *Pharmaceutical Schedule* and www.nzgg.org.nz for details.

Risk level: 5-year CV risk (fatal and non-fatal)	**Benefits: NNT for 5 years to prevent one event** (CVD events prevented per 100 people treated for 5 years)		
	1 intervention (25% risk reduction)	2 interventions (45% risk reduction)	3 interventions (55% risk reduction)
30%	13 (7.5 per 100)	7 (14 per 100)	6 (16 per 100)
20%	20 (5 per 100)	11 (9 per 100)	9 (11 per 100)
15%	27 (4 per 100)	15 (7 per 100)	12 (8 per 100)
10%	40 (2.5 per 100)	22 (4.5 per 100)	18 (5.5 per 100)
5%	80 (1.25 per 100)	44 (2.25 per 100)	36 (3 per 100)

Based on the conservative estimate that each intervention: aspirin, blood pressure treatment (lowering systolic blood pressure by 10 mm Hg) or lipid modification (lowering LDL-C by 20%) reduces cardiovascular risk by about 25% over 5 years.

To this.....PREDICT

- Electronic decision support for cardiovascular risk assessment in primary care
- Joint project with software company, NZGG and the University of Auckland
- Part of the patient management system
- Data from patient record is collected
- Risk calculation performed automatically

CVD Risk Assessment

DEMOGRAPHICS | CVD RISK ASSESSMENT | CVD RISK MANAGEMENT | DIABETES MANAGEMENT

ACTIONS | RECOMMENDATIONS | PATIENT INFORMATION | RISK ASSESSMENT INFO

Risk Assessment:

Send | Print

This page was made specifically for **FRED BLOGGS *(ABC1234)***: 20-Jun-2006 15:32 hrs

Estimated risk of having a CVD event in the next 5 years: 25%

Estimated risk level: 5-year CV risk (fatal and non-fatal)	**Estimated Benefits: NNT for 5 years to prevent one event** (CVD events prevented per 100 people treated for 5 years)		
	1 intervention (25% risk reduction)	**2 interventions (45% risk reduction)**	**3 interventions (55% risk reduction)**
25%	16 (6.3 per 100)	9 (11.3 per 100)	7 (13.8 per 100)

Based on the conservative estimate that each intervention: aspirin, blood pressure treatment (lowering systolic blood pressure by 10 mm Hg) or lipid modification (lowering LDL-C by 20%) reduces CV risk by about 25% over 5 years.

CVD risk has been moved up one risk category (5%), as cardiovascular risk may be underestimated in the Framingham risk equation; based on:

- family history of premature coronary heart disease or ischaemic stroke in a first-degree male relative before the age of 55 years or a first-degree female relative before the age of 65 years
- Maori or Pacific ethnicity or people from the Indian subcontinent

Cardiovascular Disease: Baseline Risk and Treatment Benefit

DIABETES

(With a 5% upward risk adjustment applied)

Nonsmoker | Smoker

Ratio of Total Cholesterol:HDL

	4	5	6	7	8
180/105					
160/95		X			
140/85					
120/75					

4	5	6	7	8

Risk Level

5 year CVD risk (non-fatal and fatal)

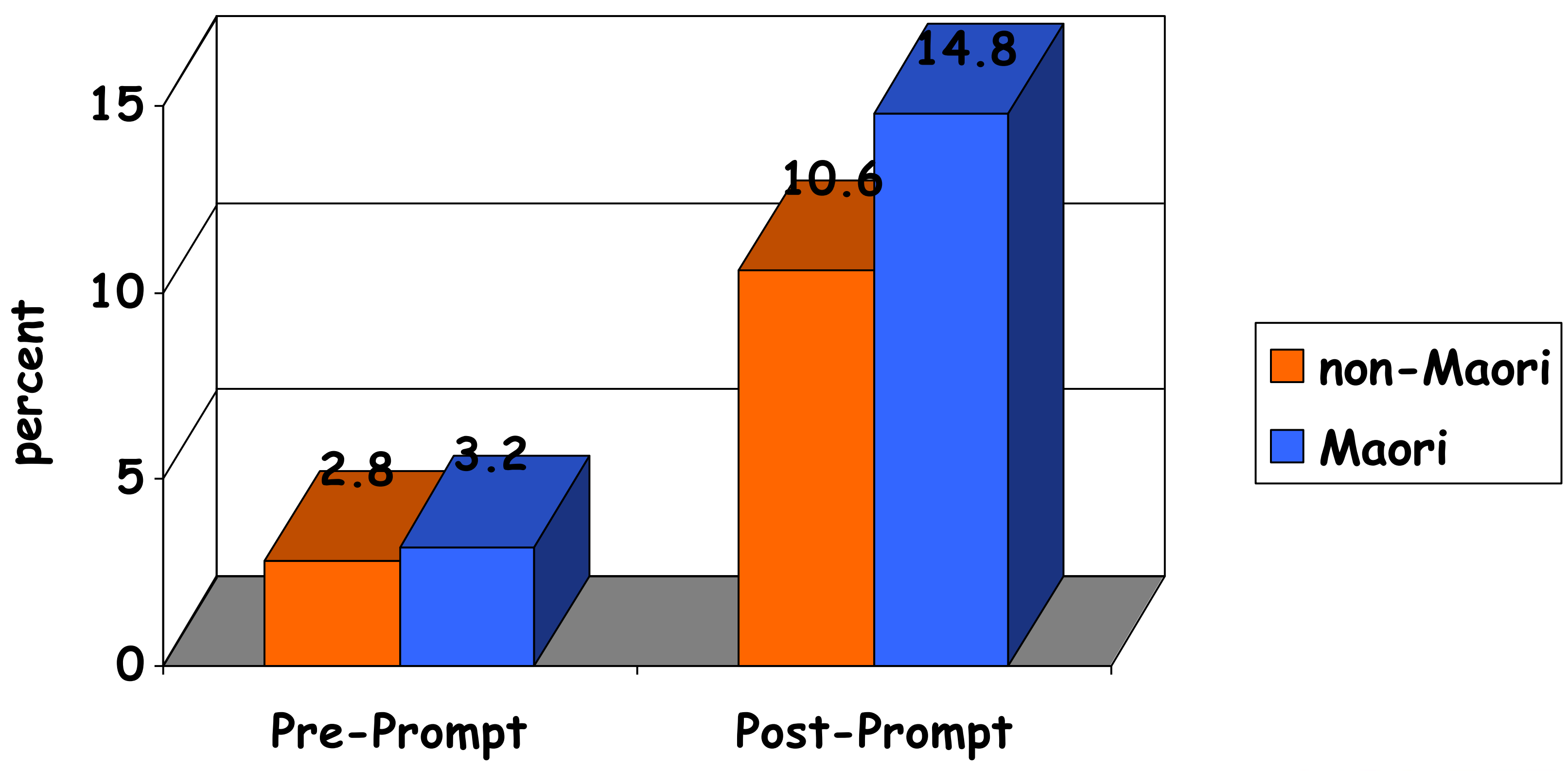
Very High: >30%, 25-30%, 20-25%

High: 15-20%

Moderate: 10-15%

Mild: 5-10%, 2.5-5%, <2.5%

Predict-Prompt



Risk Assessment by GPs before and after introduction of Prompt

4-5 fold increase in using predict after introduction of electronic approach

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A final word on implementation….

- Often
  - we know what to do…..but we just don’t do it
- Why?
  - The path of least resistance is likely to be the one taken
- Solution
  - Make it easy to do the right thing, not the wrong thing

www.nzgg.org.nz