Local implementation of national guidelines on lower urinary tract symptoms: what do general practitioners in Sydney, Australia suggest will work?

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Abstract

Objectives. Systematic reviews demonstrate that local initiatives are vital to implement nationally developed clinical practice guidelines. Evidence-based guidelines on the management of lower urinary tract symptoms in men were launched by the National Health and Medical Research Council in Sydney in April 1997. A study was conducted through interviews to establish patterns of care in the catchment area before the guidelines were implemented and general practitioners were surveyed in order to ascertain the most useful strategies for local implementation.

Design. A four-page questionnaire asked respondents to rate nine items about guideline dissemination; six items relating to the marketing of the guidelines and 15 implementation strategies: conventional educational activities (six); innovative educational strategies (four); quality improvement approaches (two) and patient-based approaches (three).

Setting. Sydney, Australia.

Study participants. Eighty-three randomly selected general practitioners (50 males; 33 females).

Results. Eighty-three out of 108 surveys were returned (77%). Respondents placed high value upon endorsement by eminent individuals and organizations other than the organization developing the guidelines; this was likely to gain their initial attention. One hundred per cent of respondents would be encouraged to use the guidelines if they were promoted as improving quality of care. Implementation strategies preferred by respondents included small group continuing education with a urologist and a general practitioner as a facilitator, lectures and patient education materials. Internet access, interactive computer systems, ‘academic detailing’ and distance education modules were of least interest.

Conclusions. Our method is feasible as a first step in planning local dissemination and implementation for national guidelines. While useful in identifying preferred strategies, its longer-term predictive validity for improving patient outcomes through better guideline implementation needs to be established.

Keywords: behaviour change, guidelines, needs assessment, urology

Evidence-based clinical practice guidelines have the potential to promote more effective health care and improve patient outcomes [1–3]. However, publication of guidelines alone is insufficient to change clinical behaviour. It is generally accepted that ‘dissemination’ and ‘implementation’ must follow [4]. ‘Dissemination’ refers to those activities which ensure that a specific guideline is available to all relevant ‘end-users’, encourage positive attitudes towards the guideline and redress gaps in clinicians’ knowledge or skills. ‘Implementation’ refers to activities designed to support changes in actual clinical behaviour. Effective implementation strategies include giving clinicians feedback about current practice compared with guideline recommendations, paying financial incentives for clinical practice consistent with guideline recommendations, withdrawing payments for practice outside the guidelines as well as providing information, checklists or prompts directly to patients [5,6]. Research to evaluate the impact of dissemination and implementation strategies continues to be recommended [4,5,7,8].

Address correspondence to Prof. Jeanette Ward, Locked Bag 8, Newtown, New South Wales 2042, Australia. Tel: +61 2 9515 3245. Fax: +61 2 9515 3348. E-mail: jward@nah.rpa.csiro.nsw.gov.au
There has also been a growing interest in Australia in clinical practice guidelines to improve outcomes of health care. Through its Quality of Care and Health Outcomes Committee, the National Health and Medical Research Council (NHMRC) initiated the development of evidence-based guidelines in 20 clinical areas in 1995 [9]. A working party was convened through 1996 to develop guidelines about the management of lower urinary tract symptoms in men for general practitioners. A draft of these guidelines was released for comment in August 1996. Endorsed national guidelines were launched in April 1997 [10].

Whereas NHMRC imprimatur lends credibility to clinical guidelines [11], it is not well-placed to organize dissemination and implementation at the local level [9]. Furthermore, very little is known of the effectiveness of implementation strategies in Australian general practice. In response, the working party recommended a randomized trial involving matched localities to compare different implementation approaches, emphasising evaluation of changes in clinical behaviour and, if possible, patient outcomes [10]. To develop the trial protocol, it commissioned a two-part needs assessment [10]. The first part examined patterns of care in general practice by interviewing local general practitioners before the publication of the guidelines (J. Ward, unpublished data). The second part, reported here, required these general practitioners to complete a self-administered questionnaire to identify useful dissemination and implementation strategies.

Method

Subject selection and recruitment

A complete list of general practitioners in our catchment area was purchased from a commercial mailing house and a random sample selected by using computer software. Of the random sample selected, those who were deceased, retired, uncontactable after six attempts or away from their practice for more than 1 month were considered ineligible. Of 248 eligible general practitioners, 108 (44%) agreed to participate in an extensive telephone interview in which two case scenarios were discussed. At the end of this interview, these 108 general practitioners were asked to complete a self-administered questionnaire to identify useful dissemination and implementation strategies.

Questionnaire content

Dissemination strategies

The four-page self-administered questionnaire first asked respondents to rate each of nine characteristics of guidelines for its importance in gaining their initial attention, using a five-point scale (extremely, very, somewhat, a little or not at all important). Items derived from dissemination research were included as follows: the importance of the organization sponsoring the development of the guidelines (n=1 item), endorsement by specific professional or government organizations (n=5), endorsement by a respected urologist (n=1) or by a respected professor of general practice (n=1) and membership of the group developing the guideline (n=1) [11,12]. Respondents then were asked to rate each of six items relating to the format and marketing of the guidelines for importance in encouraging them to use the guidelines, using the same five-point scale.

Implementation strategies

Respondents next were asked to rate the usefulness of each of 15 implementation strategies derived from the international literature [4-6] for usefulness in assisting the adoption of guidelines in clinical practice, again using a five-point scale. Six local educational strategies were listed (lecture; small group meetings; local adaptation with colleagues and practice visits by a peer from general practice or a nurse (academic detailing) or a pharmaceutical representative); four innovative educational strategies (Internet access; interactive computer program; video; distance learning module); two strategies based on a quality improvement approach [feedback on quality of care through the development of a Practice Assessment Activity accredited by the Royal Australian College of General Practitioners (RACGP) [13]; and the peer review groups and three patient-oriented approaches (public campaign about the guidelines; written consumer information; a video for men). An open-ended question asked respondents to write any additional comments about guidelines in general or the need for guidelines on urinary tract symptoms in men. Copies of the questionnaire are available upon request.

Questionnaire administration and analysis

Two and 4 weeks after initial mail-out, any non-responder was telephoned and reminded to return the questionnaire. Participating general practitioners were mailed a ‘thank you’ letter at the end of the study. As this was hypothesis-generating research, descriptive statistical analysis only was performed, using Epi Info [14].

Ethics approval

The protocol was approved by the Royal Prince Alfred Hospital Institutional Ethics Committee.

Results

GP sample

Of those 108 local general practitioners who participated in the telephone survey about treatment patterns, 83 (77%) participated in this second part. Table 1 lists their demographic and professional characteristics. There was no evidence of bias in our sample when these characteristics were compared with available data for the national reference population [15, 16].

Questionnaire findings

Respondents placed high value upon endorsement of guidelines as likely to gain their initial attention. Endorsement by the Urological Society, respected local urologist, the RACGP
Themes in their comments included an expectation that guidelines need to be developed by multidisciplinary panels with more than one representative from general practice; that guidelines should be evidence-based but acknowledge ‘grey zones’; that, in format, guidelines should be precise, brief and useful as ‘memory joggers’; and that guidelines should be used only as an aide and not in litigation.

**Discussion**

Despite an increasing international interest in clinical practice guidelines, it is rare for studies to be conducted in order to identify the preferences of the intended target group regarding dissemination and implementation strategies. As local support is essential if nationally developed guidelines are to change clinical practice [12,17], regional studies using the survey method described here represent a useful preparatory step by which to strengthen local implementation by identifying strategies of particular interest and acceptability. We recognize the potential for non-representativeness of our sample, given its small size and low response rate but balance these methodological concerns against our having contacted a larger number of practitioners than has been reported before and obtained their views in a timely manner.

In this instance, general practitioners’ initial awareness of guidelines on the management of lower urinary tract symptoms in men will be heightened by promoting their clinical usefulness and basis in evidence rather than expert consensus. Where data were missing, columns will not add to 100%. While the imprimateur of the national health authority which has sponsored the development of the guidelines was well-received, endorsement by other organizations and eminent individuals appears to be essential. Use of guidelines in Australia might be increased by emphasizing their usefulness in improving quality of care rather than reducing litigation or health costs.

Our method also revealed interesting preferences among this target group for implementation strategies. Small group meetings with a urologist and facilitator outranked all others. The methodological integrity of the evidence-based recommendations of the guidelines could be assured by providing standardized teaching materials for such small group meetings. While lectures represent conventional fare in guidelines implementation, a consumer version of the guidelines, a video for men and a public campaign were rated highly by respondents. In contrast, some implementation strategies thought to hold great promise received only low ratings in the present study [18]. Academic detailing was not highly rated. In addition, the low level of interest in Internet access is consistent with the low rate of computer uptake in Australian general practice [11]. These latter strategies should be introduced only cautiously.

In conclusion, we recommend this survey method to others involved in the dissemination and implementation of guidelines as a means of ascertaining preferred strategies for local activity. Documentation of local activity is recommended to add to knowledge of guidelines implementation [19,20]. Demonstration of better outcomes for men with lower urinary tract symptoms has been achieved with the use of guidelines.
Table 2 Strategies rated by respondents as ‘extremely’ or ‘very’ useful for local guideline implementation

<table>
<thead>
<tr>
<th>Strategy</th>
<th>n</th>
<th>%</th>
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<tbody>
<tr>
<td>Small group meetings with urologist and GP facilitator</td>
<td>60</td>
<td>72</td>
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<tr>
<td>Lecture</td>
<td>44</td>
<td>53</td>
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<tr>
<td>Video for general practitioners</td>
<td>43</td>
<td>51</td>
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<tr>
<td>Consumer (patient) guide</td>
<td>43</td>
<td>51</td>
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<tr>
<td>Video for patients</td>
<td>43</td>
<td>51</td>
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<tr>
<td>Patients being made aware of guidelines</td>
<td>39</td>
<td>47</td>
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<tr>
<td>Practice assessment activity</td>
<td>39</td>
<td>47</td>
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<tr>
<td>Interactive computer program</td>
<td>23</td>
<td>28</td>
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<tr>
<td>Local adaptation of guidelines</td>
<td>22</td>
<td>27</td>
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<tr>
<td>Internet access to experts for queries</td>
<td>19</td>
<td>23</td>
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<td>Peer review groups</td>
<td>19</td>
<td>23</td>
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<td>Distance learning module</td>
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<td>23</td>
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<tr>
<td>Peer Visit</td>
<td>15</td>
<td>18</td>
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<tr>
<td>Nurse visit</td>
<td>6</td>
<td>7</td>
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<tr>
<td>Pharmaceutical representative visit</td>
<td>3</td>
<td>4</td>
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</table>

1Specific quality improvement initiatives which must be accredited prospectively by the RACGP as a component of its QA&CE Programme.

Urinary tract symptoms would represent a ‘gold standard’ with which to evaluate the impact of local efforts [17]. Such a study would establish the predictive validity of a local survey for planning purposes if outcomes improve after the introduction of preferred strategies.

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References


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