This briefing was prepared as part of a primary health care research collaboration between Griffith University and General Practice Queensland.

Background

This briefing provides a summary of key issues affecting the uptake of clinical guidelines by General Practitioners in Australia and internationally. This briefing is part of a research review paper, which identifies strategies for improving the adoption of chronic disease clinical guideline evidence. The full article (in review) can be found at www.gpqld.com.au/Programs/Collaborative_Research_Hub

A number of areas were identified as key aspects to support the uptake and adoption of guidelines and pathways in practice. This includes improving the quality, the dissemination and uptake strategies. Supporting GPs in the practice settings in deciphering and adapting clinical guidelines and proposing a change framework around developing ‘learning communities’ to support development of localized guidelines that can more flexibly cater to the full spectrum of GP knowledge.

Improving Quality

Practitioners value guidelines which involve straight-forward measurable action, which are simple, on demand and require little effort to implement. Trusted sources of information are critical (eg advice of a colleague) and flexibility to meet the individual style of the practitioner are all essential in supporting uptake and dissemination of guidelines for chronic disease management.

The Guideline Elements Model (GEM)\(^1\) was developed to support evidenced based strategies to improve quality improvement practices. The GEM contains logical fields for systematically translating guidelines into consistent useable electronic documents. The same research team in 2002 at the Conference of Guideline Standardisation developed a framework\(^2\) that could be applied to guideline development to improve quality. A checklist of 18 components was developed. To support the 18 components, it was recommended that a graphical description (algorithm) of the stages and decision points were identified and include a plan for updating the guidelines according to new evidence and an implementation plan to support adoption.

Improving Dissemination Practices

The passive dissemination alone is generally ineffective in altering practice or policy translation. The opportunities for adoption are increased if practitioner motivation, skills, attitude and behaviours around guideline use are increased. A two phase approach\(^3\) has been recommended.

Phase One
Guideline must:
- Be developed in response to locally driven need
- Approved by a credible body
- Disseminated as widely as possible

Phase Two
Guideline must:
- Enable and reinforce change in the practice setting (including training & support in the practice setting)
Approach to Guideline Uptake

Traditional approaches to knowledge transfer apply a linear model as a one-way, teacher learner interaction (e.g., continuing professional development). The realistic practice setting for General Practitioners' (GP's) knowledge is developed over time, with non-linear processes of learning and reflection that flow in multiple directions to and from physicians, patients, policy makers and health care providers. This reinforces the notion that clinical guidelines are but one of many tools used by clinicians in their daily practice, and supports Falzer et al. (2008) proposed process-focused model which supports implementation strategies which provide clinicians with useful processes for making complex decisions.

“Learning Communities”

Learning communities are made up of people who share a common purpose and collaborate to draw on individual strengths, respect a variety of perspectives, and actively promote learning opportunities. They are voluntary, self-organising and focused groups of individuals and organisations that work towards a common understanding of an issue, focus on the efficient use of resources and develop knowledge that is grounded in the specific context.

Systematic reviews have confirmed that the most successful form of knowledge transfer involves complex, multi-faceted approaches based on active learning, outreach and interaction, such as that occurring in learning communities. A learning community might be comprised of GPs and/or practice staff within one practice, a network of practices, or a district. Learning communities can be virtual or physical and may cross sectors, even engaging consumers as an integral part of the learning environment.

Supporting GP’s to Evaluate Guidelines

In an attempt to overcome some of the persistent barriers to guideline usage (such as limited applicability to individual patients; local prevalence of chronic illness; cultural factors; economic limitations, etc.), Graham et al. (2002) developed a framework for evaluating and adapting existing clinical guidelines for local use. The framework is operationalized at a local level, through a learning community or network that includes a range of local representatives and stakeholders. Graham et al. developed a ten-step process via which learning communities can “determine which existing guidelines are worthy of adoption” (p. 599) and facilitate local use. The emphasis of this framework is on creating an ongoing group process for evaluating guidelines in a systematic and localized way. (See Briefing Number 3 which has the 10 steps for evaluating guideline use and endorsed by the World Health Organisation).

The framework and guideline whilst a time-intensive process, aims to ultimately save time at the individual practitioner level in deciphering and adapting clinical guidelines. To support ‘normalisation’ of knowledge and guideline adoption, partnerships, consensus and engagement are essential and underpinned by communication strategies, technology and a learning orientation. It is also necessary to recognize that change as a result of innovation can occur at three levels, macro-level change (e.g., adaptive learning systems that respond to new knowledge), meso-level change (e.g., embedding of new concepts into systems and processes) and micro-level change (e.g., modified practices or attitudes among practitioners and policy-makers). For knowledge to be transferred into practice or health system change, each of these levels must be addressed.

Change Framework – Facilitating Normalisation

Sustainable change can be facilitated if it is generated from the ground up and in incremental steps (i.e., small changes over sustained period of time). To effect change within a health system and to influence policy into practice change needs to occur at:

- Individual (micro-level) – strategies aimed at individual change (e.g., Education, leadership and competency development)
- Group (meso-level) – team development, task re-design and collaboratives. Organisational development based on capacity building strategies and partnership development
- System (macro-level) – Health system, policy and political environment.
To deliver health system change and reform, individual-level change is critical. To influence change and sustainable success, there needs to be alignment between individual goals and group/organisational/system goals. Leadership, advocacy and opinion leaders play a critical role during this process.

A sequence of change events supports the change process. The Primary Care Collaboratives are example of the circular process which aims to ultimately influence and strengthen the delivery of care, the consumer experience, improved health outcomes and improved health system costs.

The core task of any guideline uptake strategy should not only be to ensure the efficacy of guidelines and diffusion strategies themselves, but also to provide strategies that will assist GPs to effectively filter and evaluate the array of communications that come their way. Thus, the question becomes not “how can we increase GPs’ use of guidelines?” but, rather, “how can we help GPs to identify effective guidelines and use them effectively?” The answer to this latter question comes from the “naturalistic” approach to knowledge transfer through localized learning communities. This approach to guideline dissemination can promote suitable adaptation and uptake of guidelines by involving key members of the learning community in evaluation processes. Any guideline dissemination strategy needs to attend to local learning variables such as:

i) How GPs develop knowledge via dialogic interaction with multiple sources and forms of information and experience;

ii) How GPs retain new information as part of an already expansive and constantly growing narrative knowledge base; and

iii) How GPs manipulate and incorporate multiple knowledge forms and sources to make complex clinical decisions.

Professional associations and peak bodies are in a prime position to facilitate guideline uptake in a localized way due to their ongoing role in network development at the district level. A naturalistic learning community approach to guideline uptake will produce localized guidelines that can more flexibly cater to the full spectrum of GP knowledge sources such as consumer experiences and preferences; advice from other health professionals; GPs’ case knowledge; and local insight, wisdom, and experience.
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This briefing is a summary of a research paper (in journal publication review)

Paper Title: When guidelines need guidance: Considerations and strategies for improving the adoption of chronic disease evidence by General Practitioners

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