A Medical Education Program on Osteoporosis & Fall Prevention

Respectfully submitted to:

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EXECUTIVE SUMMARY:

The Ontario College of Family Physicians (OCFP) has reviewed the report of the Strategic Action Working Group on Osteoporosis entitled “A Framework and Strategy for the Prevention and management of Osteoporosis”. (1) The OCFP is fully supportive of the recommendations developed by the Working Group and wishes to participate in the implementation of key recommendations.

We recognize the key role that family physicians play in the prevention, assessment, diagnosis and treatment of osteoporosis and falls; however, osteoporosis is under-diagnosed and under-treated (see Appendix A) and opportunities to educate patients regarding fall prevention are often missed. Frequently, individuals are not diagnosed until a minimum trauma causes a collapsed vertebra or a fracture to occur. While physicians have tried to keep up with new information regarding osteoporosis and the prevention of falls through continuing medical education (CME), few have been exposed to a comprehensive, up-to-date curriculum on this subject.

To identify individuals at risk of developing osteoporosis or prone to falling, to improve the delivery of care for persons with osteoporosis and to ensure that research results are integrated into everyday practice, it is important to develop programs that use effective educational strategies. OCFP has completed a review of the literature (see appendix B) regarding the effectiveness of educational interactions. Our review demonstrates that CME can improve competence, performance and health outcomes; however, knowledge is easier to influence than performance. In addition, demonstrating performance improvements is easier than documenting improvements in health outcomes. The review indicates that the use of a single strategy is usually of limited value in effecting the performance and health outcomes that are needed to make a difference. Only a variety of well planned CME approaches used simultaneously have demonstrated abilities to leave a lasting impact.

As the professional voice of Family Medicine in this province, OCFP is the most appropriate sponsor of this vitally needed continuing medical education on osteoporosis and falls. The comprehensive medical education program that we are proposing was developed based on our review of approaches to CME with proven abilities to increase knowledge, improve professional practice and ultimately, improve patient health outcomes. This proposal includes a multi-faceted education program that uses a variety of educational methods to inform and change practices amongst medical students, family medicine residents and family/general practitioners. The educational objectives outlined in section 2.0 will be met through the following educational strategies:

1. Develop a MAINPRO®-C Peer Presenter Program:
OCFP will develop a MAINPRO®-C Peer Presenter Program. The Peer Presenters will be trained to facilitate workshops in their own home communities for practicing Family Physicians, Medical Directors of long-term care facilities and the Physician Advisors of CCACs. The program will be delivered close to home to reduce the cost of travel and reduce time away from practice. Cases will be tailored to the local community and reflect the Peer Presenter’s local experiences.
in adapting “best practice” to local conditions (see Appendix C). The Peer Presenters will also function as Opinion Leaders in their local communities and will further influence practice in their communities through informal “hall-way” consultants and modeling of “best practices”.

2. **Develop Small Group Practice-based Learning Modules, Self Learning Modules and Web-based Modules:**

OCFP will partner with the Foundation for Medical Education to develop tools for small groups, self-learning and web-based learning. These programs will be an important source of MAINPRO®-C credits for physicians and will provide well-regarded CME options for physicians who find it difficult to attend CME events or prefer these effective learning tools.

OCFP believes that the comprehensive program can be developed and implemented in its entirety during the next 2 years with a budget of approximately $100,000. We believe that the partners we will bring to the table to support this initiative have the expertise, drive and commitment to make a lasting contribution to the bone health of Ontarians. We are pleased to have been asked to submit this proposal to the Women’s Council for review and look forward to further input from the Women’s Council to further strengthen the proposal.

1.0 **INTRODUCTION & BACKGROUND:**

The Ontario College of Family Physicians (OCFP) was pleased to receive the report of the Strategic Action Working Group on Osteoporosis entitled “A Framework and Strategy for the Prevention and Management of Osteoporosis”. The OCFP is fully supportive of all nine (9) recommendations developed by the Working Group. Given our mandate (setting standards of practice and standards for the education of family physicians), we have the knowledge, skills and infrastructure to actively support the Ontario Women’s Health Council in the implementation of these recommendations.

Family physicians are key to the effective prevention, assessment, diagnosis and treatment of osteoporosis. Family doctors play key roles in providing families with guidance and advice during the earlier years and have excellent opportunities to advocate for health promotion regimens leading to maximum peak bone mass for our children and adolescents. They are able to advise adults, especially adult women, about the importance of a healthy diet, the need to maintain a healthy body weight and the importance of adequate physical activity throughout the life span. In addition, they are in the best position to provide assessments regarding gait and balance, feet and footwear, muscle strength, vision and hearing, as well as medication reviews and, thereby, prevent falls amongst seniors. The majority of persons with osteoporosis or who have experienced a fall are diagnosed, treated and receive follow-up from family doctors.

The role of family doctors in the prevention, assessment, diagnosis and treatment of osteoporosis is well established; however, osteoporosis is under-diagnosed and under-treated. Frequently, individuals are not diagnosed until a minimum trauma (a bump, a fall or a strong hug) causes a collapsed vertebra or a fracture to occur. While physicians have tried to keep up with new information regarding osteoporosis and falls prevention through
continuing medical education activities, few have had the opportunity to access a practical and comprehensive up-to-date curriculum on this subject. Many rely on pharmaceutical retailers rather than peer-reviewed guidelines to steer their practice decision-making processes. To overcome these barriers to “best practice”, innovative education strategies are required to facilitate the incorporation of new information into the actual delivery of medical services.

This proposal outlines a multi-faceted education program that will use a variety of educational methods to inform and change practice amongst family doctors.

2.0 EDUCATIONAL OBJECTIVES:

- To increase knowledge and skills amongst family medicine residents and practicing family physicians regarding the prevention and diagnosis management of osteoporosis
- To disseminate peer-reviewed clinical practice guidelines for:
  - Prevention, diagnosis and management of osteoporosis
  - Prevention of falls and fracture prevention in the community and long-term care facilities
- To promote the inclusion of osteoporosis and falls/fracture clinical risk assessment into periodic health reviews for pre- and post-menopausal women and nutritional assessment into the periodic health review for children and adolescents
- To develop and disseminate decision support tools to assist family physicians in patient counseling activities
- To raise awareness amongst patients and the public regarding personal risk factors, diagnosis and management options for osteoporosis and falls
- To facilitate research in primary care in the prevention and management of osteoporosis

3.0 EDUCATIONAL STRATEGIES:

3.1 Develop a MAINPRO®-C Peer Presenter Program in Osteoporosis:

OCFP will develop a MAINPRO®-C program on Osteoporosis & Falls Prevention and train eighteen family doctors to deliver the program in communities throughout the province. The Peer Presenter Program was developed to meet the diverse CME needs of family doctors in this province. Most CME is delivered in large academic centres. Travel time and travel costs are prohibitive for many family physicians and curriculum developed for academic centres may not reflect the realities of local practices. By training local physicians to deliver the program locally, physicians are able to access programs close to home and the program can be tailored to cases that best reflect these issues and the concerns of the local physicians and their communities (see Appendix C).

The program will be developed as a MAINPRO®-C program (i.e. small-group highly interactive program; however, the course materials will also be organized so that key information can be shared in a MAINPRO®-M1 format for larger group presentations such as hospital rounds.
The Opinion Leader/Peer Presenters will be supported by the OCFP to provide workshops, presentations at hospital rounds, and at the Universities to provide education for practicing family doctors and residents alike. The Peer Presenters will work to strengthen community linkages and to organize educational activities for other healthcare professionals and the public in local communities to foster information sharing. This component of the program will include practice tools and patient education tools to support the incorporation of knowledge into practice. The MAINPRO®-C format and the evaluation process will increase the likelihood that practice change will occur in keeping with best practices. Given the evidence of positive impact on outcomes especially through the guidelines process this process can be assumed to impact positively on health outcomes. Funding will be used to develop and launch the program and will be self-sustaining after the initial start-up phase.

3.2 **Develop Small Group Practice-based Learning Modules, Self-learning Modules, Web-based Training Modules and Library Resources:**

OCFP will partner with the Foundation for Medical Education to develop small group practice-based learning modules, self-learning modules and web-based training modules. These tools are important sources of MAINPRO®-C credits for physicians and provide well-regarded CME options for physicians. Information regarding osteoporosis prevention, assessment, diagnosis, treatment and support services will be displayed on the OCFP website and linked to other websites displayed with Peer Reviewed Information. This program already has over 3000 family doctors and 900 family medicine residents enrolled across Canada, most of whom are in Ontario.

4.0 **EVALUATION:**

All components of the program will be eligible for MAINPRO®-M1 and/or MAINPRO®-C credits. The process of acquiring CME credits from the College of Family Physicians requires Pre- and Post tests to determine knowledge, skills and current practices compared with a delineation of the participants’ success in incorporating new knowledge and skills into practice. The MAINPRO®-C evaluation process will include a self-audit tool that will allow physicians to review their practices prior to the program, to incorporate the knowledge and skills shared during the educational process into practice and to use the same tool to self-audit three months later to evaluate progress in changing knowledge into action.

In addition, the evaluation process will measure:

- the number of physicians who access the curriculum through each of the strategies
- the activities of the Peer Presenters including areas of lower and higher activities and barriers / incentives to uptake
- satisfaction with the educational process, tools and materials (how well the content is delivered and received; as well as the ease of incorporation within practice)
5.0 ONTARIO COLLEGE OF FAMILY PHYSICIANS:

The Ontario College of Family Physicians is a Chapter of the College of Family Physicians of Canada. The College was founded in 1954 for the express purpose of setting standards for the new and emerging discipline of family medicine and to oversee the establishment of the family medicine residency programs at the sixteen medical universities across Canada. Over the years, we have stayed very close to our original roots and promote the quality of Family Medicine in Ontario through leadership, education and advocacy.

The OCFP represents almost 6300 Family Doctors in this province and is the official professional voice of Family Medicine in this province. We provide the majority of continuing medical education developed for Family Doctors. Our Annual Scientific Assembly held in November of each year attracts close to 1000 Family Physicians. The program this year includes a workshop on Osteoporosis. Our CME Committee has overseen the development of strong Peer Presenter Programs (Sexual Abuse/Spousal Assault, HIV/AIDS, Stress without Distress, Palliative Care Pain & Symptoms Management, Environment & Health, Complementary & Alternative Medicine/CAMline, Healthy Child Development) and accredits close to 450 other CME programs. These MAINPRO®-C accredited programs are required for Maintenance of Certification with the College. The accreditation process provides family doctors with assurance that the program has been peer-reviewed and meets the rigid standards that are set for quality education programs.

The OCFP has close linkages to each of the five universities in Ontario. The five Chairs of the Departments of Family Medicine meet frequently throughout the years as a Committee of the OCFP. The Program Directors who oversee undergraduate and postgraduate education in Family Medicine also meet as an OCFP Board Committee. Our Family Medicine Residency Committee brings together representation from clerkship, first year, second year and third year family medicine residents from each of the six universities.

OCFP is a founding partner in the Foundation for Medical Practice Education at McMaster University and a member of the Ontario Guidelines Collaborative. We are the sponsors of the following Ministry of Health and Long Term Care initiated projects:

- Alzheimer Strategy – Physician Training Strategy
- Stroke Strategy – Stroke Prevention Strategy (Public and Physician Education Program in Conjunction with the Heart and Stroke Foundation)
- Collaborative Mental Healthcare Network
- Diabetes Guidelines (dissemination of diabetes guidelines in collaboration with the Ontario Guidelines Collaborative)
- Diabetes Type II Prevention Project with the National College
- Healthy Child Development (dissemination of Antenatal, Rourke & Nippissing Records funded by the MOHLTC & MCSS’s Integrated Children Services)
The models that OCFP has developed have been well-tested through these projects that are in various stages of completion by the OCFP. We have the infrastructure in place to effectively sponsor the osteoporosis & falls prevention CME program. Our greatest strength is our ability to develop effective partnerships and positive working relationship to ensure success.

6.0 **STEERING COMMITTEE MEMBERS:**

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<tr>
<th>Name</th>
<th>Title/Position</th>
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<tbody>
<tr>
<td>Dr. Brendan Dempsey, CCFP, FCFP</td>
<td>Chair, OCFP’s CME Committee Family Physician - London, Ontario</td>
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<tr>
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</tbody>
</table>
7.0 BIBLIOGRAPHY:


3. A Proposal to Establish a Comprehensive Medical Education Program to Advance the Care of Persons with Alzheimer’s Disease and Related Dementias: OCFP/Physician Education Project Steering Committee – August 20, 2001


**APPENDIX A**

**Osteoporosis: An Overview**

**Osteoporosis**

Osteoporosis is a disease characterized by low bone density and bone tissue deterioration, leading to bone fragility and increased risk of fracture, particularly for the hip, spine and wrist (Osteoporosis Society of Canada, 2001).

At present, there are 1.4 million Canadians with osteoporosis (Osteoporosis Society of Canada, 2001). Although the disorder can strike at any time, it tends to be a condition of advanced age, with one in four women and one in eight men over 50 suffering from osteoporosis (Scientific Advisory Board, Osteoporosis Society of Canada, 1996).

Nationally, it was estimated that the cost of treating fragility fractures in 1993 was $1.3 billion, while in Ontario the cost was $400 million (Goree et al. 1996). Such fractures can have serious long-term effects. It is believed that hip fractures (of which 70% are associated with osteoporosis) can lead to death in up to 20% of cases, and disability in 50% of survivors (Osteoporosis Society of Canada, 2001). Residual effects of an osteoporotic fracture can include pain, physical restriction, fear of falling, anxiety, depression, and social limitations that can decrease quality of life or lead to an exacerbation of the condition (Strategic Action Working Group on Osteoporosis, 2000).

The Canadian population is aging, and unless preventive steps are taken now, the cost of osteoporosis is expected to increase substantially in coming years. It is estimated that the national health care system will face exponential growth in hip fracture rates (Figure 5) (Papadimitropoulos et al. 1997).

*Figure 5: Current and Projected Rates of Hip Fracture in* 

![Figure 5: Current and Projected Rates of Hip Fracture in Canada](image)
As demonstrated, osteoporosis is a costly condition, however the expense estimates cited do not account for additional costs of the disorder, which include lost productivity and wages, rehabilitation and private treatment, home care services or post-fracture discharge of previously independent persons into long-term care facilities (Strategic Action Working Group on Osteoporosis, 2000).

Considering the fact that chronic illnesses are increasing in prevalence, are of a progressive or unchanging nature, and that their management presents a significant burden to the health care system, it is logical that focus be placed on prevention of these diseases.

### Table 2: Risk Factors for Selected Chronic Diseases, based on a review of selected primary prevention strategy documents

Adapted from: Papadimitropoulos, E.A et al. Current and projected rates of hip fracture in Canada. Canadian

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Asthma*</th>
<th>Cancer</th>
<th>Diabetes (type 2)</th>
<th>Heart Disease</th>
<th>Osteoporosis</th>
<th>Stroke</th>
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<td>X 8, 3</td>
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<td>Alcohol intake</td>
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<td>Sun exposure</td>
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<td>Heart problems (incl. hyperhomocysteinemia and atrial fibrillation)</td>
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<td>High blood pressure, Dyslipidemia</td>
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<td>Previous stroke, transient ischemic attack, carotid stenosis</td>
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1Risk factors for asthma are complex, involving the interaction of predisposing, causal and contributing factors. For individuals with asthma, triggers (which include causal factors, included here) exacerbate the disorder.

1Implicit in dietary guidelines

2Diabetes in Canada: National Statistics and Opportunities for Improved Surveillance, Prevention and Control.
4The Prevention and Management of Asthma in Canada: a major challenge now and in the future.
5Mandatory Health Programs and Services Guidelines.
APPENDIX B

Review of the CME Literature

Review of the Effectiveness of Educational Interventions
Promoting the Quality of Family Medicine through Leadership, Education & Advocacy
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1.0 OVERVIEW:

To improve the delivery of healthcare and to ensure that research results are integrated into everyday practice, it is important to use effective educational strategies. Physicians spend on average more than 50 hours per year on continuing medical education (CME) activities. These hours are ostensibly aimed at improving their performances and optimizing health outcomes for their patients. A review of the literature regarding the effectiveness of educational interventions demonstrates that CME can improve competence, performance, and patient health outcomes; however, knowledge is easier to influence than performance, which is easier to influence than patient outcomes. (Beaudry 1989, Davis 1992, 1994). Furthermore, certain types of behaviours are more difficult to change. Patient counseling techniques and general clinical management procedures that incorporate investigation, diagnosis, and management of a complex disorder are more difficult to change than simple behaviours such as prescribing behaviours, because a number of skills and procedural adjustments must be co-ordinated amongst a number of individual practitioners and co-workers. In addition, defensive attitudes, practical problems, and organizational barriers may limit the integration of knowledge in practice. In developing a plan for addressing knowledge gaps amongst Family Physicians in regards to the assessment, diagnosis, and treatment of hypertension, the Ontario College of Family Physicians conducted a literature review regarding effective CME strategies that could be used to increase knowledge, improve performance on the management of hypertension and result in positive patient outcomes (i.e. more patients diagnosed easily and in good control). The main questions we wished to answer were:

- Which strategies or combinations of strategies have been proven effective in increasing knowledge?
- Which strategies or combination of strategies have proven to be most effective with regards to implementing practice changes?
- Which strategies or combination of strategies are associated with positive health outcomes?

A number of meta-analyses were reviewed and our findings are as follows:

2.0 LITERATURE REVIEW RE:
CME EFFECTIVENESS:

Printed educational materials: effects on Professional practice and health care outcomes.
Freeman N, Harvey E, Wolf F, Grimshaw J, Grilli R, Bero LA
Centre for Health Economics, University of York, Heslington, York, Yorkshire, UK
BACKGROUND: It is often assumed that merely providing information in an accessible form will influence practice. Although such a strategy is still widely used in an attempt to change behaviour, there is a growing awareness that simply providing information may not lead to appropriate changes in the practice of healthcare professionals. OBJECTIVES: To assess the effects of printed educational materials in improving the behaviours of health care professionals and patient outcomes. SEARCH STRATEGY: We searched the
Cochrane Effective Practice and Organization of Care Group specialized register, reference lists of articles, and contacted content area experts. SELECTION CRITERIA: Randomized trials, interrupted time series analysis and non-equivalent group designs with pre-post measures of interventions comparing 1. Printed educational materials versus a non-intervention control; and 2. Printed educational materials plus additional implementation strategies versus printed educational materials alone. The participants were any healthcare professionals provided with printed educational materials aimed at improving their practice and/or patient outcomes. DATA COLLECTION AND ANALYSIS: Two reviewers independently extracted data and assessed study quality. MAIN RESULTS: Eleven studies were included involving more than 1848 physicians. It proved impractical to examine the impact of interventions quantitatively because of poor reporting of results and inappropriate primary analysis. Nine studies examined comparison 1. Estimates of the benefit from printed educational materials ranged from –3% to 243.4% for provider outcomes, and from –16.1% to 175.6% for patient outcomes, although the practical importance of these changes is, at best, small. Six studies (seven comparisons) examined comparison 2. Benefits attributable to additional interventions ranged from –11.8% to 92.7% for professional behaviour and –24.4% to 74.5% for patient outcomes. Two of the 14 estimates of professional behaviour, and two of the 11 estimates of patient outcomes were statistically significant. REVIEWERS CONCLUSIONS: The effects of printed educational materials compared with no active intervention appear small and of uncertain clinical significance. These conclusions should be viewed as tentative due to the poor reporting of results and inappropriate primary analysis. The additional impact of more active interventions produced mixed results. Audit and feedback and conferences/workshops did not appear to produce substantial changes in practice; the effects in the evaluations of educational outreach visits and opinion leaders were larger and likely to be of practical importance. None of the studies included full economic analysis, and thus it is unclear to what extent the effects of any of the interventions may be worth the costs involved.

Cochrane Database Syst Rev 2000; (2):CD000259
Audit and feedback: effects on professional practice and health care outcomes. Thomson O’Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL McMaster Evidence-based Practice Centre, McMaster University, Department of Clinical Epidemiology and Biostatistics, HSC 3H7, Hamilton, Ontario, Canada.
BACKGROUND: Audit and feedback has been identified as having the potential to change the practice of health care professionals. OBJECTIVES: To assess the effects of audit and feedback on the practice of health professionals and patient outcomes. SEARCH STRATEGY: We searched MEDLINE up to June 1997, the Research and Development Resource Base in Continuing Medical Education, and reference lists of related systematic reviews and articles. SELECTION CRITERIA: Randomised trials of audit and feedback (defined as any summary of clinical performance of health care over a specified period of time). The participants were health care professionals responsible for patient care. DATA COLLECTION AND ANALYSIS: Two reviewers independently extracted data and assessed study quality. MAIN RESULTS: Thirty-seven studies were included, involving more than 4977 physicians. The reporting of study methods was inadequate for almost all studies. In 31 out of 37 studies the randomisation process could not be determined. Information regarding data analysis was also lacking. For example, power calculations were not mentioned in 27 out of 37 studies. A variety of behaviours
were targeted including the reduction of diagnostic test ordering, prescribing practices, preventive care, and the general management of a problem, for example hypertension. Twenty-eight studies measured physician performance, one study targeted patient outcomes in diabetes and the remaining eight studies measured both physician performance and patient outcomes. The relative percentage differences ranged from –16% to 152%. The clinical importance of the changes was not always clear. REVIEWER’S CONCLUSIONS: Audit and feedback can sometimes be effective in improving the practice of health care professionals, in particular prescribing and diagnostic test ordering. When it is effective, the effects appear to be small-to-moderate but potentially worthwhile. Those attempting to enhance professional behaviour should not rely solely on this approach.

Educational outreach visits; effects on professional practice and health care outcomes.
Thomson O’Brien MA, Oxman AD, Haynes RB, Freemantle N, EL McMaster Evidence-based Practice Centre, McMaster University, Department of Clinical Epidemiology and Biostatistics, HSC 3H7, Hamilton, Ontario, Canada.
BACKGROUND: Outreach visits have been identified as an intervention that may improve the practice of health care professionals, in particular prescribing. This type of ‘face to face’ visit has been referred to as university-based educational detailing, public interest detailing, and academic detailing. OBJECTIVES: To assess the effects of outreach visits on improving health professional practices or patient outcomes. SEARCH STRATEGY: We searched MEDLINE up to March 1997, the Research and Development Resource Base in Continuing Medical Education, and reference lists of related systematic reviews and articles. SELECTION CRITERIA: Randomized trials of outreach visits (defined as a personal visit by a trained person to a health care provider in his or her own setting). The participants were health care professionals. DATA COLLECTION AND ANALYSIS: Two reviewers independently extracted data and assessed study quality. MAIN RESULTS: Eighteen studies were included, involving more than 1896 physicians. All of the outreach visit interventions consisted of several components, including written materials and conferences. Reminders or audit and feedback complemented some visits. In 13 studies, the targeted behaviours were prescribing practices. In three studies, the behaviours were preventive services, including counseling for smoking cessation. In two studies, the outreach visits were directed toward improving the general management of common problems encountered in general practice, including asthma, diabetes, otitis media, hypertension, anxiety, and acute bronchitis. All studies examined physician behaviour and in three studies other health professionals such as nurses, nursing home attendants or health care workers were targeted. Positive effects on practice were observed in all studies. Only one study measured a patient outcome. Few studies examined the cost effectiveness of outreach. REVIEWER’S CONCLUSIONS: Educational outreach visits, particularly when combined with social marketing, appear to be a promising approach to modifying health professional behaviour, especially prescribing. Further research is needed to assess the effects of outreach visits for other aspects of practice and to identify key characteristics of outreach visits that are important to its success. The cost-effectiveness of outreach visits is not well evaluated.

CMAJ 1999 Oct 19;161(8): 965-70
Institute for Clinical Evaluative Sciences, Toronto, Ont.

BACKGROUND: Structured feedback of information can produce change in physician behaviour. The objective of this study was to assess the effectiveness of 2 educational interventions for improving the quality of care provided by family physicians in Ontario: the Practice Assessment Report (PAR) and the Continuing Medical Education Plan (CMEP) with a follow-up visit by a mentor. METHODS: The study was a randomised controlled trial. Physicians in the control group received only the PAR, whereas those in the experimental group received the PAR, CMEP and mentor interventions. The participants were 56 family physicians and general practitioners (27 in the PAR group and 29 in the CMEP group) in southern Ontario who agreed to participate in the interventions and provide data. A total of 2395 patients randomly sampled from the practices returned questionnaires and consented to have their medical records abstracted. The outcome measures were global scores in 4 areas-quality of care, charting, prevention and overall use of medications-and patient ratings of satisfaction with care and preventive practices. The measures were applied at the beginning (phase 1) and end (phase 2) of the study.

RESULTS: The mean global scores at the end of the study for the PAR group were 70.1 for quality of care, 84.7% for prevention, 77.7 % for the CMEP group were 68.3%, 82.1% 76.4% and 83.2%. In the patient satisfaction component, the personal care scores at phase 2 were 93.6% for the PAR group and 94.6% for the CMEP group. Examples of the scores for prevention for the PAR group were 98.3% for children’s current immunization, 96.6% for blood pressure measured within the previous 5 years, 79.4% for referral of women of the appropriate age for mammography within the previous 2 years and 58.4% for discussion about alcohol use. The corresponding scores for the CMEP group were 95.8%, 97.6%, 77.6% and 64.6%. The changes in mean scores between phase 1 and phase 2 ranged from −1.9 to 2.3 points. There were no significant differences between the 2 groups in phase 1 or phase 2 scores or in change in scores. A total of 64.3% of the physicians rated the PAR as useful, 26.5% found the CMEP to be useful, and 41.0% considered the mentor strategy to be a useful form of continuing medical education. Although changes in practice related to the PAR, CMEP or mentor were reported by some physicians, they were not related to chart audit or patient scores.

INTERPRETATION: Educational interventions based on quality-of-care assessments and directed to global improvements in quality of care did not result in improvements in the outcome measures. Educational interventions may have to be targeted to specific areas of the practice, with physicians being monitored and receiving ongoing feedback on their performance.

JAMA 1999 Sep 1;282(9):867-74

Impact of formal continuing medical education: do conferences, workshops, rounds, and other traditional continuing education activities change physician behaviour or health care outcomes?
Davis D, O’Brien MA, Freemantle N, Wolf FM, Mazmanian P, Taylor-Vaisey A Continuing Education and the Centre for Research in Education, University of Toronto, Faculty of Medicine, Ontario, Canada. [dave.davis@utoronto.ca]

CONTEXT: Although physicians report spending a considerable amount of time in continuing medical education (CME) activities, studies have shown a sizable difference between real and
ideal performance, suggesting a lack of effect of formal CME. OBJECTIVE: To collate and interpret the effect of formal CME interventions on physician performance and health care outcomes. DATA SOURCES: Sources included searches of the complete Research and Development Resource Base in Continuing Medical Education and the Specialized Register of the Cochrane Effective Practice and Organization of Care Group, supplemented by searches of MEDLINE from 1993 to January 1999. STUDY SELECTION: Studies were included in the analysis if they were randomized controlled trials of formal didactic and/or interactive CME interventions (conferences, courses, rounds, meetings, symposia, lectures and other formats) in which at least 50% of the participants were practicing physicians. Fourteen of 64 studies identified met these criteria and were included in the analysis. Articles were reviewed independently by 3 of the authors. DATA EXTRACTION: Determinations were made about the nature of the CME intervention (didactic, interactive, or mixed), its occurrence as a 1-time or sequenced event, and other information about its educational content and format. Two of 3 reviewers independently applied all inclusion/exclusion criteria. Data were then subjected to meta-analytic techniques. DATA SYNTHESIS: The 14 studies generated 17 interventions fitting our criteria. Nine generated positive changes in professional practice, and 3 of 4 interventions altered health care outcomes in 1 or more measures. In 7 studies, sufficient data were available for effect sizes to be calculated; overall, no significant effect of these educational methods was detected (standardized effect size, 0.34; 95% confidence interval [CI], -0.22 to 0.97). However, interactive and mixed educational sessions were associated with a significant effect on practice (standardized effect size, 0.67; 95% CI, 0.01-1.45). CONCLUSIONS: Our data show some evidence that interactive CME sessions that enhance participant activity and provide the opportunity to practice skills can effect change in professional practice and, on occasion, healthcare outcomes. Based on a small number of well-conducted trials, didactic sessions do not appear to be effective in changing physician performance.

Portfolios in continuing medical education—effective and efficient? {see comments}
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INTRODUCTION: A cross-over comparison between ‘traditional’ continuing medical education (CME) activities and portfolio-based learning in general practice is described. METHOD: Thirty-two volunteer general practitioners (GPs) were divided into two cohorts; each cohort spent six months following a ‘traditional’ route to postgraduate educational accreditation (PGEA) and six months following a portfolio-based learning route supported by three CME tutors. OUTCOME MEASURES: These were the submission of a completed portfolio with evidence of the completion of learning cycles and participants reflections on the educational process. Qualitative and quantitative evaluation data were collected by questionnaire, semi-structured interview, participant observation and review of completed portfolios. RESULTS: The themes identified by GPs as hopes for the portfolios were largely fulfilled and the anxieties generally confounded. The flexibility of the portfolio learning process was particularly important to the participants. The breadth of topics covered by the portfolios was extremely wide and comparison with the submissions for ‘traditional’ PGEA showed much smaller spread of learning activities and fewer subjects of study. EFFECTIVENESS: The use of the
portfolios of critical incidents and the completion of learning cycles with application to practice provided evidence of the effectiveness of such learning. EFFICIENCY: The mean number of hours spent by GPs preparing the portfolios was 24.5 +/-12 (SD) which was significantly more than the 15 hours of PGEA awarded. CONCLUSIONS: This study demonstrates that a portfolio-based learning scheme can meet the needs of FPs relevant to their professional practice; it can give learners control over how, what and when they learn and encourage active and peer-supported learning; it can build personal and professional confident and be thought both valid and reliable by participants. Learning outcomes can also be reliably assessed by PGEA within the context of an individual created learning plan.

Br J Gen Pract 1998 Oct; 48(435):1689-95
General practitioners’ continuing education; a review of policies, strategies and effectiveness, and their implications for the future.
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BACKGROUND: The accreditation and provision of continuing education for general practitioners (GPs) is set to change with new proposals from the General Medical Council, the Government, and the Chief Medical officer. AIM: To review the theories, policies, strategies, and effectiveness in GP continuing education in the past 10 years. METHOD: A systematic review of the literature by computerized and manual searches of relevant journals and books. RESULTS: Educational theory suggests that continuing education (CE) should be work-based and use the learner’s experiences. Audit can play an important role in determining performance and needs assessment, but at present is largely a separate activity. Educational and professional support, such as through mentors or co-tutors, has been successfully piloted but awaits larger scale evaluation. Most accredited educational events are still the postgraduate centre lecture, and GP Tutors have a variable role in CE management and provision. Controlled trials of CE strategies suggest effectiveness is enhanced by personal feedback and work prompts. Qualitative studies have demonstrated that education plays on a small part in influencing doctor’s behavior. CONCLUSION: Maintaining good clinical practice is on many stakeholders’ agendas. A variety of methods may be effective in CE, and larger scale trials or evaluations are needed.

Eval Health Prof 1996 Jun;19(2):148-74
Impact studies in continuing education for health professionals. A critique of the research syntheses.
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Documenting impact has been a continual pursuit in continuing education (CE) for health professionals. Hundreds of primary impact studies have been published, along with 16 impact study syntheses that have sought to generalize about the effectiveness of CE and sometimes how and why the effects occur. This article describes and critiques the methodology of the 16 syntheses and summarizes their findings. A first wave of syntheses established a general causal connection between CE and impacts, but explained impact variability only in the dependent variable-knowledge, competence, performance, or outcome. A second wave added a search for casual explanation through analysis of
variables that moderate impact. This wave has begun to identify the most appropriate types of programs for promoting performance changes. The article concludes by suggesting questions and methods for future primary studies and meta-analyses, including improved experimental and meta-analytical methods, along with case and naturalistic studies and action research.

**Can Fam Physician 1996 Feb;42:272-6**  
Measuring the effectiveness of a pilot continuing medical education program.  
Moran JA, Kirk P, Kopelow M  
St Boniface General Hospital, Family Practice Residency Training Program.  
OBJECTIVE: To evaluate a learner-centred, small group CME program intended to improve the clinical performance of family physicians identified as having serious practice deficiencies by the University of Manitoba’s Clinical Assessment and Enhancement Program. DESIGN: Nonrandomized control trial in which data were collected from patients’ charts and physician performance was evaluated. Differences in subjects’ scores were tested at program entry and at 6 months and 18 months later using a two-way analysis of variance. SETTING: Family medicine practices in Manitoba. PARTICIPANTS: Fifteen family physicians: five study subjects and 10 control subjects. The five study subjects were identified as needing CME to improve their clinical performance. The 10 control subjects were randomly selected. INTERVENTIONS: Participants attended a 10-session, learner-centred, small group CME program. MAIN OUTCOME MEASURES: Clinical care, preventive care, charting, and the use of drugs were the variables assessed. RESULTS: Study subjects’ initial scores were much lower than those of controls, but improved significantly during the CME program. CONCLUSION: A learner-centred, small group CME program can improve clinical performance.

No magic bullets: a systematic review of 102 trials of interventions to improve professional practice  
Andrew D. Oxman, MD, MSc; Mary Ann Thomson, BHS(PT); David A. Davis, MD; R. Brian Haynes, MD, PhD  
OBJECTIVE: To determine the effectiveness of different types of interventions in improving health professional performance and health outcomes. DATA SOURCES : MEDLINE, SCISEARCH, CINAHL and the Research and Development Resource Base in CME were searched for trials of educational interventions in the health care professions published between 1970 and 1993 inclusive. STUDY SELECTION: Studies were selected if they provided objective measurements of health professional performance or health outcomes and employed random or quasi-random allocation methods in their study designs to assign individual subjects or groups. Interventions included such activities as conferences, outreach visits, the use of local opinion leaders, audit and feedback, and reminder systems. DATA EXTRACTION: Details extracted from the studies included the study design, the unit of allocation (e.g., patient, provider, practice, hospital); the characteristics of the targeted health care professionals, educational interventions and patients (when appropriate); and the main outcome measure. DATA SYNTHESIS: The inclusion criteria were met by 102 trials. Areas of behaviour change included general patient management, preventive services, prescribing
practices, treatment of specific conditions such as hypertension or diabetes, and diagnostic service or hospital utilization. Dissemination-only strategies, such as conferences or the mailing of unsolicited materials, demonstrated little or no changes in health professional behaviour or health outcome when used alone. More complex interventions, such as the use of outreach visits or local opinion leaders, ranged from ineffective to highly effective, but were most often moderately effective, (resulting in reductions of 20% to 50% in the incidence of inappropriate performance).

CONCLUSION: There are no “magic bullets” for improving the quality of health care, but there are a wide range of interventions available that, if used appropriately, could lead to important improvements in professional practice and patient outcomes.

JAMA 1995 Sep 6;274(9):700-5
Davis DA, Thomson MA, Oxman AD, Haynes RB
Faculty of Medicine, University of Toronto, Ontario, Canada.
OBJECTIVE—To review the literature relating to the effectiveness of education strategies designed to change physician performance and health care outcomes.
DATA SOURCES—We searched MEDLINE, ERIC, NTIS, the Research and Development Resource Base in Continuing Medical Education, and other relevant data sources from 1975 to 1994, using continuing medical education (CME) and related terms as keywords. We manually searched journals and the bibliographies of other review articles and called on the opinions of recognized experts. STUDY SELECTION—We reviewed studies that met the following criteria: randomized controlled trails of education strategies or interventions that objectively assessed physician performance and/or health care outcomes. These intervention strategies included (alone and in combination) educational materials, formal CME activities, outreach visits such as academic detailing, opinion leaders, patient-mediated strategies, audit with feedback, and reminders. Studies were selected only if more than 50% of the subjects were either practicing physicians or medical residents. DATA EXTRACTION—We extracted the specialty of the physicians targeted by the interventions and the clinical domain and setting of the trial. We also determined the details of the educational intervention, the extent to which needs or barriers to change had been ascertained prior to the intervention, and the main outcome measure(s). DATA SYNTHESIS – We found 99 trials, containing 160 interventions, that met our criteria. Almost two thirds of the interventions (101 of 160) displayed an improvement in at least one major outcome measure;70% demonstrated a change in physician performance, and 48% of interventions aimed at health care outcomes produced a positive change. Effective change strategies included reminders, patient-mediated interventions, outreach visit, opinion leaders, and multifaceted activities. Audit with feedback and educational materials were less effective, and formal CME conferences or activities, without enabling or practice-reinforcing strategies, had relatively little impact.
CONCLUSION—Widely used CME delivery methods such as conferences have little direct impact on improving professional practice. More effective methods such as systematic practice-based interventions and outreach visits are seldom used by CME providers.

Single and combined strategies for implementing changes in primary care: a literature review.
Wensing M, Grol R
Centre for Research on Quality in Family Practice, Nijmegen University, The Netherlands.
Doubts have been raised about the effectiveness of traditional types of continuing medical education. Different strategies or combinations of strategies could prove to be more effective for improving the care provided by the general practitioner. For this reason a systematic literature analysis was carried out involving 75 studies of different strategies applied in primary health care. The strategies most often studied were feedback, reminders and group education. Educational material or group education combined with feedback was the combination most frequently studied. One third of all studies could be characterized as randomized controlled trials. Individual instruction, feedback and reminders seem to be most effective single strategies. The most effective combined strategies appeared to be all combinations with individual instruction and the combination of peer review and feedback.

**JAMA 1992 Sep 2;268(9):1111-7**
Evidence for the effectiveness of CME. A review of 50 randomized controlled trials.
Davis DA, Thomson MA, Oxman AD, Haynes RB
Department of Family Medicine, School of Occupational Therapy and Physiotherapy, Faculty of Health Sciences, Mcmaster University, Hamilton, Ontario, Canada.
OBJECTIVE—To assess the impact of diverse continuing medical education (CME) interventions on physician performance and health care outcomes. DATA SOURCES—Using continuing medical education and related phrases, we performed regular searches of the indexed literature (MEDLINE, Social Science Index, the National Technical Information Service, and Educational Research Information Clearinghouse) from 1975 through 1991. In addition, for these years, we used manual searches, key informants, and requests to authors to locate other indexed articles and the nonindexed literature of adult and continuing professional education. STUDY SELECTION – From the resulting data base we selected studies that met the following criteria: randomized controlled trials; educational programs, activities, or other interventions; studies that included 50% or more physicians; follow-up assessments of at least 75% of study subjects; and objective assessments of either physician performance or health care outcomes. DATA EXTRACTION – Studies were reviewed for data related to physician specialty and setting. Continuing medical education interventions were classified by their mode(s) of activity as being predisposing, enabling, or facilitating. Using the statistical tests supplied by the original investigators, physician performance outcomes and patient outcomes were classified as positive, negative or inconclusive. DATA SYNTHESIS—We located 777 CME studies, of which 50 met all criteria. Thirty-two of these analyzed physician performance; seven evaluated patient outcomes; 11 examined both measures. The majority of the 43 studies of physician performance showed positive results in some important measures of resource utilization, counseling strategies, and preventive medicine. Of the 18 studies of health care outcomes, eight demonstrated positive changes in patients’ health care outcomes. CONCLUSION—Broadly defined CME interventions using practice-enabling or reinforcing strategies consistently improve physician performance and, in some instances, health care outcomes.
Comment: the efforts are cumulative and significant.
Literature search by: The Canadian Library of Family Medicine

Br J Gen Pract 1999 Jul; 49(444): 522-6
Addressing barriers to change: an RCT of practice-based education to improve the management of hypertension in the elderly.
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Department of Pharmacology and Therapeutics, Infirmary, Liverpool.
BACKGROUND: In the future, primary care groups (PCG) will have to consider how best to apply audit and education to fulfil their commitment to clinical governance and to facilitate the implementation of research findings. AIM: To establish whether an exploration of “barriers to change” can enhance the effectiveness of an educational intervention designed to improve the management of hypertension in the elderly. METHOD: A parallel-arm, randomized single-blind, controlled trial of practice-based educational visits in 18 practices. These practices had previously taken part in a multipractice audit of the management of hypertension in the elderly. Both groups received outreach visits in their own practices, during which they received the results of the previous audit. The nine “intervention” practices were encouraged to explore barriers that would prevent them from implementing pertinent research findings. The control group was not encouraged to do this. The main outcome measure of the trial was determined in advance as ‘the stated management of systolic hypertension in patients aged 70 to 79’. A secondary endpoint was the stated management of a specific patient scenario. The endpoints were tested by questionnaire before and after the educational intervention. RESULTS: For the primary endpoint, there was a statistically significant difference in the stated threshold for treating systolic hypertension between intervention and control groups after the visits (161.8 mmHg versus 167.2 mmHg; P=0.007). For the secondary endpoint, there was also a statistically significant difference between the two groups, after the visits, in their willingness to treat a 70-year old male with mild hypertension (89 % of doctors would treat in the intervention group versus 57 % in the control group; P=0.047). CONCLUSION: The effectiveness of an educational intervention is significantly improved by addressing the barriers preventing practitioners from implementing the findings of research.

Conducting a randomized controlled trial of CQI and academic detailing to implement clinical guidelines.
Horowitz CR, Goldberg HI, Martin DP, Wagner EH, Fihn SD, Christensien DB, Cheadle AD
Department of Health Policy, Mount Sinai Medical Center, New York, NY 10029 USA
BACKGROUND: A multisite, randomized controlled trail was conducted from August 1994 through January 1996 to compare the impact of two strategies-academic detailing (AD) and continuous quality improvement (CQI) teams-on the implementation of national guidelines for the primary care of hypertension and depression. STUDY: Twelve small groups of providers at four clinics –two at Group Health Cooperative of Puget Sound (Seattle) and two at academic medical centers – were randomized in blocks along with their primary care patients to receive AD alone, AD plus CQI , or usual care. A detailing session conducted by a physician and two follow-up sessions conducted by a pharmacist lasted an average of 8-9 minutes. Each CQI team, which met, on average, 14
times in nine months, devised at least one intervention (for example, weight loss counseling for hypertensives by nurse practitioners.) RESULTS: The detailing endeavors differed greatly across organizations. Although all teams generally worked well together, organizational factors such as staff layoffs and reorganization competed for the teams’ attention. Team leaders differed in their ability to inspire members to “run with” ideas and to motivate personnel outside the team to implement interventions. SUMMARY AND CONCLUSION: Surveys and semi-structured interviews suggest that both the AD and CQI interventions involved complex social interactions that resulted in varied implementation across the different organizations. Final analyses will need to focus on identifying factors associated with the relative success or failure of both clinical change techniques.

3.0 CLINICAL PRACTICE GUIDELINES:

Clinical Practice Guidelines are an important component of an effective CME program on hypertension; however, we must begin by overcoming some of the difficulties encountered in previous attempts to disseminate hypertension guidelines.

Clinical practice guidelines have been developed to assist physicians with assessment, diagnosis and treatment of disorders. They are an attempt to translate the scientific literature into evidence-based protocols that can help guide decisions regarding specific clinical conditions and by doing so, improve quality of care for patients. However, just 32% of Canadian physicians think that guidelines have changed their practice and only 44% actually use guidelines even though most physicians agree that they are useful tools. There are many factors that influence physicians’ use of guidelines:

- lack of knowledge about guidelines
- lack of opinion leaders to provide knowledge about them
- lack of familiarity with evidence-based medicine
- lack of agreement with the guideline and personal preferences
- multiple conflicting guidelines for the same condition
- lack of time at the point of patient care to access the information easily
- few incentives to change
- influences from the pharmaceutical industry

To improve management, there is a continuing need to keep family doctors updated in the diagnosis and management of hypertension. Physicians also need to be provided with an increased awareness about practice guidelines. Guidelines need to be developed in a family physician-friendly manner that allows for “just-in-time” access to clinically-orientated information. Prior to implementing a major public education campaign, we need to provide an effective, affordable educational program that will enhance our family doctors’ ability to adopt clinical guidelines and further advances as they occur.

Most physicians in Ontario have encountered several different hypertension clinical guidelines. Many of the guidelines disagree on the thresholds for the initiation of anti-hypertension therapy. Relatively few provide guidance for strategies to identify and treat patients at risk of development hypertension; indeed, there is a prevailing sense from our
research that it is easier to treat than it is to prevent. There are several other examples demonstrating that guidelines often fail to address clinically-relevant issues.

Even the most rigorously developed guideline will not be used if the format is not user-friendly. Physicians in clinical situations use the 30 seconds rule; if they cannot get the information they need in 30 seconds or less, they will move on. Lack of local involvement, poorly-designed implementation strategies, failure to incorporate patient-physician values, coupled with poor methodologic quality, reduce the likelihood that physicians will use a particular guideline.

A scoring system has been developed to rank guidelines and provide family doctors with the guidelines that rank highest and deemed to be most useful. A format to summarize the most important recommendations in each guideline has been developed so that doctors can gain quick access to information during clinical consults. The guidelines are also on a website for easy access and will be launched for “palms” in the very near future.


4.0 RESEARCH FINDINGS:
In reviewing all of the above research studies of those interventions that were developed to increase knowledge, improve professional practice and ultimately improve patient health comes, we have come to the following conclusions:

- There is no evidence that the passive distribution of guidelines, brochures or other printed materials will change performance on health outcomes
- Traditional didactic presentations at conferences will not change behaviours; however, interactive, practice rehearsal or reinforcing strategies that are utilized in small group workshops are effective
- Academic detailing is very effective especially if it is combined with audits and feedback loops
- Supporting local opinion leaders to lead change processes is usually seen as a positive force for change
- Patient education when combined with physician education can be very effective and lead to clinically important changes
- Audit, feedback and reminders can be effective
- Mass marketing may be effective; however, it is difficult to separate out the effects of marketing from other strategies
- Multifaceted interventions and local consensus-building processes were shown to produce changes in professional performance and less consistently in health outcomes

The literature suggests that most CME interventions have, at best, modest effects when used above; however, when coupled with other strategies results are usually positive.

5.0 SUMMARY:

The improvements being made in the review and formatting of hypertensive guidelines needs to be combined with an effective CME program utilizing the lessons learned from the review of the CME literature to prepare Family Physicians to effectively assess,
diagnose and treat patients a variety of disorders. The components that will most likely be successful are as follows:

1) Identify Opinion Leaders and support them with a mentoring program so that they have ready access to specialists
2) Provide Interactive Learning Opportunities through Peer Presenters strategically drawn from the various regions of the province
3) Develop and disseminate small group practice-based learning modules, self learning modules and web-based training modules, reminders and other practice tools
4) Use academic details, audits and feedback loops to reinforce practice changes
5) Support patient education as a key tool in performance changes and positive health outcomes

APPENDIX C

Overview of OCFP’s Peer Presenter Program

In 1992, the OCFP launched a very successful Peer Presenter Program. The Ontario College recognized that some educational materials were not suitable for presentation at a conference, especially if delivered in a didactic manner. We also recognized that Ontario is a large and diverse province. Resources, infrastructure and patient populations differ from region to region. Family Doctors practice in remote, rural, suburban, urban and inner-city settings; yet, most educational programs are designed as “one size fits all.” As the physician shortage increased, the costs of travelling to larger centers for CME became prohibitive in both time away from practice and in travel expenditures. The Peer Presenter Programs deliver CME as close to home as possible and, because the program is delivered by Family Physicians from the region, the program can be tailored to the practice setting. In developing a Peer Presenter Program, the OCFP established a Steering Committee of experts in the field. Family Doctors representing the bulk of the doctors in the province are added to the committee to ensure that the program content is practical and reflects the learning needs of doctors throughout the province.

The Steering Committee members develop a day-long workshop on the subject matter. A binder is also developed that includes the core educational materials, key articles and research to back-up the materials and tools to assist Family Doctors to assess, diagnose, treat and access needed community resources. The binder is distributed to each Peer Presenter at a facilitated 2½ day workshop.

When the curriculum has been developed, the OCFP issues a call for Peer Presenters. Forty to fifty Family Doctors answer the call from all over the province. The Steering committee reviews the CV of each physician and fifteen to twenty doctors are chosen. The OCFP has divided the province into six regions and 3–4 physicians are chosen from each of the six regions. These Peer Presenters are brought to Toronto and trained in the principles of Adult Education, as well as the core curriculum content during a weekend workshop. Previous workshop materials have been pre-tested amongst Family Medicine Residents, and faculty from the University have been
invited to attend the 2½ day workshop to gain familiarity with the core curriculum. Through this process, the materials are integrated into the medical schools and into practice simultaneously.

Following the Peer Presenter weekend, the Peers are given a period of time to become familiar with the materials, especially the back-up materials and are then assisted to develop programs in their own regions. The materials are developed into five to six modules. Each module can be delivered separately for presentation at a one to two hour CME event or together as ½ or 1 day workshops. The Peer Presenters are provided with audiovisual materials to aid in presentation and trained to present the materials in a variety of learning styles to meet participants’ learning needs. Handout materials are provided to the Peer Presenters so that participants receive tools to aid in changing practice patterns. All of these CME programs are open to any physician in the community, not only our members.

The Peer Presenters are required to present the core material provided by the OCFP, but adapt the examples to local conditions. Participants who may have discounted a “made in Toronto” program are able to see the relevance of a program that is adapted to the uniqueness of the region in which the materials are being presented. As a result, uptake of the materials is higher. Programs developed by Family Doctors and presented by Family Doctors tend to reflect much more appropriately information that is practical and easily incorporated within actual practice – and they are!

The Peer Presenters perform an educational function in their communities but, more importantly, they become “opinion leaders” who influence practice. They become local experts who provide consultations to their peers. It is these “hallway” consultations that impact the most on practice. As advocates locally, they often engage in community-building experiences that lead to positive results in identifying and finding creative ways to fill the gap and provide better care for patients.

The OCFP has successfully launched the following Peer Presenter programs:

- Sexual Assault and Spousal Abuse
- HIV/AIDS
- Palliative Care Pain and Symptom Management
- Stress Without Distress/Physician Change and Management Program
- Complementary and Alternative Medicine
- Environment and Health
- Healthy Child Development

These programs have been very successful. Peer Presenters receive MAINPRO®–C credits and participating MAINPRO®–M1. These credits are valuable to physicians in meeting criteria for Maintenance of Certification in the College and, therefore, attractive to our members as an indication of a quality program.