Promoting effective guideline use in Ontario

Walter W. Rosser, Dave Davis, Erin Gilbart, on behalf of the Guideline Advisory Committee

The Ministry of Health and Long-Term Care and the Ontario Medical Association (OMA) negotiate 3-year agreements for funding medical services in Ontario. The quality of care provided to the population of Ontario and accountability regarding the utilization of services paid for by the system is of interest to both parties. During the 1997 negotiations, it was agreed that a committee with 3 representatives from the ministry, 3 from the OMA and 1 ex-officio member of the Institute for Clinical Evaluative Sciences should be formed to promote the adoption of evidence-based clinical practice guidelines in the province and to consult widely with the profession in the process. The Guideline Advisory Committee (GAC) was thus established; it reports to the Physician Services Committee, another joint initiative resulting from the negotiations.

In producing a list of priority topics for guideline assessment, the committee took the following factors into account: feedback from the OMA sections indicated that there was considerable confusion for practitioners over conflicting advice for appropriate practice; utilization data from the ministry demonstrated that the use of numerous procedures had increased rapidly over previous years; and feedback from practising physicians identified areas in which they felt that there was a need for guidelines to aid practice.

In this article we describe the methods that have been developed over the last 4 years to identify well-developed guidelines and some of the strategies being proposed for their dissemination, implementation and evaluation.

Clinical practice guidelines are “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.” Practice guidelines have become widely available through Internet technology. Most guidelines are produced by specific interest groups and are disseminated by publication in a medical journal or by traditional mail; however, seldom have guidelines had any noticeable impact on clinical practice. The large volume of guidelines creates confusion for practitioners, who often follow none of them because of the time required to assess the quality of each. The GAC thus determined that its first priority was to identify the highest quality guidelines available on selected topics and then to promote their dissemination across the province.

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sections, involved a half-day session on the objectives of the
GAC and how to assess and validate guideline scores. At
the end of the session interested participants were provided with an additional 5 guidelines to assess in the subsequent 2
weeks. Their appraisals were evaluated for consistency and
interrater reliability. To date, 34 trained assessors are re-
viewing guidelines. Each guideline is evaluated by 3 inde-
pendent assessors, and guidelines identified as warranting
further review are assessed for clinical relevance. Over 250
published guidelines addressing 25 clinical areas are cur-
rently being assessed. Recommended guidelines in the ini-
tial 10 clinical areas are available on the GAC Web site
(www.gacguidelines.ca).
The GAC anticipates that guidelines found to be of ex-
cellent quality but not convenient for use in clinical practice
will need to be reformatted into user-friendly summaries.
Volunteer physicians from the community will be asked to
evaluate such summaries and provide feedback for improve-
ment. Only the most rigorously developed guidelines will be
posted on the Web site in the form of structured abstracts, although interested practitioners can obtain the scores of
other guidelines reviewed in a particular clinical area.
Continuing medical education (CME) literature on dissemi-
nation strategies indicates that a single method, such as
mass mailing, has a minimal effect on changing medical practice. The GAC is currently considering a number of
options to enhance the dissemination of the best available
guidelines.
One option is the Ontario Guideline Collaborative, a
group of representatives from provincial licensing bodies,
government, university and hospital sectors that convenes 3–4 times per year to discuss dissemination and implemen-
tation of recommended guidelines. Other provincial initia-
tives of interest include a community-based intervention strategy developed by the Partners for Appropriate Anti-
Infective Community Therapy to disseminate guidelines
on the appropriate use of anti-infectives using the train-
the-trainer model, opinion leaders from 50 communities
across Ontario have been prepared to implement the pro-
gram in their respective regions. The GAC is considering
using this model to disseminate a chosen guideline on 3 or
4 occasions during the year.
Over the past 10 years more than 3000 small groups of
physicians have been formed to work together over care-
fully prepared, evidence-based materials designed to im-
prove practice on a variety of topics. Participants select the
topic of most interest to the group and meet to determine
how they could modify their practice according to the evi-
dence presented.2 Adapting this format of the practice-
based small group CME session offers the GAC a further strategy for guideline dissemination.
The Ontario College of Family Physicians has devel-
oped a train-the-trainer method of facilitating small groups
adapting new practice strategies.3 Identifying evidence-
based guidelines and modifying them to fit the template
produced for this program is yet another potential dissemi-
nation strategy for the GAC.
From the current CME literature, we believe that the combination of initiatives in Ontario has the potential to
improve clinical practice in the province. The GAC hopes
to use provincial data sets to measure the impact of particu-
lar guideline dissemination strategies on physician prac-
tices. We look forward to reporting on the results of these projects as they unfold.

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Competing interests: None declared.

Contributors: Dr. Rosser was the primary author, contributed to the conception and design, and reviewed subsequent revisions. Dr. Davis and Ms. Gilbart contributed to the writing of the article and reviewed subsequent revisions.

Acknowledgements: We thank the members of the Physician Services Committee and the Guideline Advisory Committee as well as the Ontario Medical Association and the Ministry of Health and Long-Term Care for their support in these initiatives.

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