



Dissemination and Implementation of Clinical Practice Guidelines: A Longitudinal Evaluation of the Canadian Task Force on Preventive Health Care Knowledge Translation Efforts

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Keywords:	Clinical Practice Guidelines, Family medicine, general practice, primary care, Knowledge translation
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Abstract:	<p>Background: The Canadian Task Force on Preventive Health Care (CTFPHC) develops evidence-based preventive health care guidelines for primary care practitioners. Knowledge translation (KT) tools and strategies are created for each guideline to facilitate dissemination and implementation. We report a longitudinal evaluation from 2014-2020 of</p>

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	<p>CTFPHC dissemination and implementation efforts to determine practitioners' knowledge and awareness of guidelines and KT tools and barriers and facilitators to use of these guidelines and tools.</p> <p>Methods: Annual evaluations using surveys and interviews with primary care providers were conducted from 2014-2020 to assess practitioners' knowledge and awareness and determinants of use of CTFPHC guidelines and tools. Interviews were transcribed verbatim and double coded using a framework analysis approach.</p> <p>Results: A total of 1284 primary care practitioners completed surveys and 183 participated in interviews. On average, 79.9% of participants were aware of the 7 cancer screening guidelines, 36.2% were aware of the other 6 screening guidelines and 18.6% were aware of the 3 lifestyle/prevention guidelines. Thirteen barriers and seven facilitators to guideline and tool implementation were identified; these were consistent over time. Participants identified strategies at the public/patient, provider, and health systems levels to improve uptake of guidelines.</p> <p>Interpretation: Canadian primary care practitioners were more aware of CTFPHC cancer screening guidelines compared to its other preventive health guidelines. Barriers to guideline uptake including misalignment with patient preferences and other provincial or specialty guideline organizations were consistently reported over a six-year period. Further evaluations will assess tailored strategies to the barriers identified.</p>



COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
<i>Personal characteristics</i>			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	
Occupation	3	What was their occupation at the time of the study?	
Gender	4	Was the researcher male or female?	
Experience and training	5	What experience or training did the researcher have?	
<i>Relationship with participants</i>			
Relationship established	6	Was a relationship established prior to study commencement?	
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	
Domain 2: Study design			
<i>Theoretical framework</i>			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	
<i>Participant selection</i>			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	
Sample size	12	How many participants were in the study?	
Non-participation	13	How many people refused to participate or dropped out? Reasons?	
<i>Setting</i>			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	
<i>Data collection</i>			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	
Field notes	20	Were field notes made during and/or after the interview or focus group?	
Duration	21	What was the duration of the interviews or focus group?	
Data saturation	22	Was data saturation discussed?	
Transcripts returned	23	Were transcripts returned to participants for comment and/or	

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
<i>Data analysis</i>			
Number of data coders	24	How many data coders coded the data?	
Description of the coding tree	25	Did authors provide a description of the coding tree?	
Derivation of themes	26	Were themes identified in advance or derived from the data?	
Software	27	What software, if applicable, was used to manage the data?	
Participant checking	28	Did participants provide feedback on the findings?	
<i>Reporting</i>			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	
Data and findings consistent	30	Was there consistency between the data presented and the findings?	
Clarity of major themes	31	Were major themes clearly presented in the findings?	
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

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3 **the Canadian Task Force on Preventive Health Care Knowledge Translation Efforts**
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Contributor's Statement:

All authors contributed to the design, conduct and interpretation of the study; SES conceptualized, designed and interpreted the study; CF, AP, KS, AC, SES conducted the analysis; CF, AP, KS, AC, SES drafted the manuscript and all authors revised it critically. All authors gave approval for the manuscript to be published.

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Declaration of Author(s) competing interest:

The KT Program, Unity Health Toronto (Fahim, Prashad, Silveira, Chandraraj, Straus) and Barnhardt are contracted by the CTFPHC to conduct all knowledge translation work. Thombs, Tonelli, Theriault, Grad, Riva, Colquhoun are members of the CTFPHC. The CTFPHC is funded by the Public Health Agency of Canada.

1
2 Abstract
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4 **Background:** The Canadian Task Force on Preventive Health Care (CTFPHC) develops evidence-based
5 preventive health care guidelines for primary care practitioners. Knowledge translation (KT) tools and
6 strategies are created for each guideline to facilitate dissemination and implementation. We report a
7 longitudinal evaluation from 2014-2020 of CTFPHC dissemination and implementation efforts to
8 determine practitioners' knowledge and awareness of guidelines and KT tools and barriers and
9 facilitators to use of these guidelines and tools.
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19 **Methods:** Annual evaluations using surveys and interviews with primary care providers were conducted
20 from 2014-2020 to assess practitioners' knowledge and awareness and determinants of use of CTFPHC
21 guidelines and tools. Interviews were transcribed verbatim and double coded using a framework analysis
22 approach.
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29 **Results:** A total of 1284 primary care practitioners completed surveys and 183 participated in
30 interviews. On average, 79.9% of participants were aware of the 7 cancer screening guidelines, 36.2%
31 were aware of the other 6 screening guidelines and 18.6% were aware of the 3 lifestyle/prevention
32 guidelines. Thirteen barriers and seven facilitators to guideline and tool implementation were identified;
33 these were consistent over time. Participants identified strategies at the public/patient, provider, and
34 health systems levels to improve uptake of guidelines.
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43 **Interpretation:** Canadian primary care practitioners were more aware of CTFPHC cancer screening
44 guidelines compared to its other preventive health guidelines. Barriers to guideline uptake including
45 misalignment with patient preferences and other provincial or specialty guideline organizations were
46 consistently reported over a six-year period. Further evaluations will assess tailored strategies to the
47 barriers identified.
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Keywords

Clinical Practice Guideline; Preventive Health Care; Primary Care; Knowledge Translation

Abbreviations

KT Knowledge Translation
Task Force Canadian Task Force on Preventive Health Care

Confidential

Introduction

Using evidence-based guidelines in practice is challenging. [1-3] Knowledge translation (KT) is the science and practice of using evidence in practice and policy. [4] Effective KT enables evidence-informed decision making, improved patient outcomes, and health system efficiency.[4] Evaluations of KT efforts are warranted to promote increased uptake of evidence-based guidelines.

The Canadian Task Force on Preventive Health Care (CTFPHC) was reconstituted in 2009 by the Public Health Agency of Canada (PHAC) to develop preventive health care guidelines, with the aim of supporting primary care practitioners and patients in practice and decision making. [5-7] The CTFPHC comprises 15 primary care and prevention experts from Canada including family physicians, specialist physicians, allied health professionals and methodologists and is supported by knowledge synthesis, guideline development, and KT methods experts. CTFPHC members are not paid for their contributions and a conflict of interest policy [8] is adopted by all CTFPHC members, content experts, peer reviewers, evidence centers, and KT experts. Since 2011, the CTFPHC has released over 20 guidelines on prevention and screening of cancer, chronic health and other conditions. The CTFPHC uses rigorous methods to identify evidence and develop recommendations.[9] Input from clinical experts, peer reviewers, and stakeholders (including practitioners and patients or the public) is included in guideline and KT tool development.[10] KT tools (resources to support guideline use) are created for each guideline.[10] The KT Program of St. Michael's Hospital conducts an annual evaluation of the CTFPHC dissemination and implementation methods to assess primary care practitioners' engagement with CTFPHC guidelines.

Our objectives were to (1) *assess the level of awareness of the CTFPHC guidelines among primary care practitioners from 2014-2020*; (2) *identify facilitators and barriers to implementation of CTFPHC guidelines and KT tools*; and (3) *identify strategies to improve the uptake of CTFPHC guidelines*.

Methods

1
2 *Study design:* Annual evaluations of CTFPHC activities were conducted between 2014-2020 using
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4 surveys and key informant interviews. Interviews and surveys were conducted and reported using the
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6 Consolidated criteria for reporting qualitative studies (COREQ) [11] and the Checklist of Selected
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8 Reporting Guidelines for Surveys, [12] respectively.
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11 *Setting and Context:* Evaluations were conducted nationally. CTFPHC guidelines and accompanying KT
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13 tools are disseminated using methods that include publications, presentations, direct distribution (e.g.,
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15 conferences), media, social media (e.g., Twitter, websites, YouTube videos, podcasts), and webinars.
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17 The annual evaluation occurs from January to March to measure the impact of the CTFPHC guidelines
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19 and KT tools from January to December of the preceding year (Appendix A). Each evaluation focuses
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21 on the guidelines and associated KT tools published that year, and on guidelines that recommended a
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23 substantial change in practice from previous years. The annual evaluations included assessment of 16
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25 CTFPHC guidelines published between 2011-2020 (Table 1). Seven guidelines focused on cancer
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27 screening, three focused on lifestyle and prevention (e.g., obesity, smoking), and six were categorized as
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29 ‘other screening’ (e.g., cognitive impairment). A total of 38 KT tools were developed with a range of 1-
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31 10 tools per guideline. Cancer screening guidelines, specifically two breast cancer screening guidelines,
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33 had the greatest number of KT tools (n=29 total; n=10 for breast cancer). Cancer screening guidelines
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35 included patient- and clinician-facing KT tools while other guidelines included clinician-facing KT tools
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37 only.
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43 The KT Program conducted annual evaluations of the CTFPHC and did not have any relationships with
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45 the evaluation participants.
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48 *Participant recruitment:* Each year, we recruited primary care practitioners, including primary care
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50 physicians and nurse practitioners, to participate through advertisements promoted via CTFPHC
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52 communication channels (e.g., newsletter, Twitter, website). Recruitment advertisements were
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54 disseminated via other organizations (e.g., Canadian Medical Association, Canadian Medical
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1 Association Journal, Canadian Family Physician Journal) using electronic newsletters, emails, and social
2 media messages. Participants were also recruited from the CTFPHC interview and survey listserv. The
3 listserv includes a database of emails from primary care practitioners who participated in previous
4 CTFPHC KT activities and demonstrated interest in being contacted to participate in future projects.
5 From 2014-2019, we also recruited practitioners to participate in a shortened evaluation survey at the
6 Family Medicine Forum conference, Canada's largest annual conference for family physicians. This
7 latter strategy was not done in 2020 because the conference was held virtually due to COVID-19.
8 Survey respondents were invited to participate in an interview. We aimed to include a sample of
9 interview participants that was representative of the Canadian primary practitioner population regarding
10 demographics (e.g., age, gender, language), province/territory, and years in practice. To enhance
11 participation, survey participants were entered into a draw to win an iPad. Interview participants were
12 compensated \$100 and were not eligible for the draw.

13 *Surveys:* Surveys were designed using the Theoretical Domains Framework [13,14] to assess
14 participants' awareness of, barriers and facilitators to use of CTFPHC guidelines, as well as self-
15 reported use of the guidelines and KT tools. Each year, participants were asked about newly released
16 CTFPHC guidelines and the CTFPHC's most popular guidelines. The most popular guidelines were
17 selected by media impressions and website analytics and included breast, colorectal and prostate cancer
18 screening guidelines. Survey items included multiple choice, Likert-scale, and open-ended questions.
19 Each year, surveys were piloted for clarity with primary care physicians prior to use. Surveys were
20 administered in English (2014-2020) and French (2019-2020) using an online survey platform
21 (Qualtrics). Surveys were accessible for 4 weeks and required 20-30 minutes to complete. Survey
22 responses were anonymous.

23 *Interviews:* Experienced KT Program researchers conducted the key informant interviews in English.
24 Key informant interviews used a descriptive qualitative approach [15] to build on survey findings.

1 Survey data were used to identify interview questions to probe for further detail. A semi-structured
2 interview guide (Appendix B) was used to assess participants' perceptions and use of CTFPHC
3 guidelines, barriers and facilitators to guideline and KT tool use, and suggestions on how to improve
4 uptake of CTFPHC guidelines. One hour interviews were conducted by telephone or teleconference
5 computer software. Following participant consent, interviews were recorded and transcribed verbatim.
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13 Interviewing continued each year until data saturation was reached.

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15 *Data Analysis:* Survey data were analyzed in SPSS to generate descriptive statistics. Overall mean
16 awareness scores for guidelines categories (e.g., cancer screening guidelines) were calculated by
17 averaging awareness scores for each year. Using thematic analysis, a coding framework was generated
18 using a sample of five interviews to start and was iteratively updated to reflect the interview data.
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*Researchers leading the interviews reflected on their biases and positions on guideline dissemination and
evaluation as part of the coding process. The same coding structure was used for each annual evaluation,
using the previous years' coding framework as a base codebook. Interview data were double-coded by
two experienced KT Program researchers using a framework analysis approach on NVIVO qualitative
software. Coders targeted an inter-rater agreement of >0.65. Discrepancies were discussed until
consensus was reached. Themes were derived from the coded data and coded using the Theoretical
Domains Framework. [13,14]*

Outcomes: The overall evaluation focused on awareness of CTFPHC guidelines, barriers and facilitators
to use of CTFPHC guidelines and KT tools and participants' suggested strategies to improve uptake of
CTFPHC guidelines among primary care practitioners.

Ethics Approval: This study received REB approval from the Unity Health Toronto Research Ethics
Office (REB# 17-372).

Results

Characteristics of Study Participants

1 A total of 1284 practitioners contributed to the surveys and 183 of them participated in interviews
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4 between 2014 and 2020. Sixty-seven percent of participants were female and 61% were in practice for
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6 1-10 years at time of participation. Participants from Ontario comprised 47% of the sample (n=689).
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8 Approximately 58% of participants worked in urban regions (n=842), 59% in community-based, and
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10 27% in multipractitioner clinics (n=668). Table 2 provides details of participant characteristics.
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12 ***Awareness of Guidelines***

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15 Survey data indicated that awareness of cancer screening guidelines ranged from 27-93%; mean
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17 awareness scores for cancer screening guidelines was 80% (Table 3). On average, 81% of participants
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19 reported being aware of both breast cancer guidelines, 87% being aware of cervical cancer and 82%
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21 being aware of prostate cancer guidelines. Only 27% of participants were aware of the 2020 esophageal
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23 adenocarcinoma guideline. Forty-seven percent of participants were aware of the 2018 breast cancer
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25 guideline update in its year of release (the survey was conducted in January 2019 and the guideline was
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27 released in December 2018), however awareness rose to 84% the following year. Awareness of
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29 lifestyle/prevention guidelines ranged from 16-22% (mean awareness = 18%) and for other guidelines
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31 ranged from 17-62% (mean awareness = 36%).
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36 ***Barriers and Facilitators impacting guideline uptake***

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38 The most commonly reported barrier to CTFPHC guideline implementation was a perceived
39
40 misalignment of the guideline recommendation with patient expectations or preferences. (Table 4)
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42 Misalignment of the guideline with other provincial or specialty guidelines, perceptions of evidence
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44 strength (e.g., of CTFPHC or weakness of recommendation) and lack of consensus among healthcare
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46 practitioners on guideline recommendations were also commonly reported barriers over the evaluation
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48 period. Additional barriers included misalignment of CTFPHC recommendations with provincial or
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50 territorial health care coverage or fee-for-service billing scheme, out of date guidelines, time constraints
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52 to implementing guideline recommendations (e.g. given that annual preventive health exams are no
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1 longer recommended, some practitioners stated that they had less opportunity to engage with patients in
2 discussions around preventive health care), complexity of guideline (e.g. a lack of support on how to
3 implement recommendations), and lack of awareness of the guideline or KT tools.
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8 Facilitators to use guidelines were the converse of the reported barriers. Specifically:
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10 availability/awareness of updated guidelines and tools, public/patient awareness of guideline
11 recommendations, consensus among health care providers/colleagues on recommendations, ease of
12 guideline use and strength of guideline evidence were identified as facilitators. The integration of
13 guidelines into electronic prompts, EMR reminders and/or mobile apps for patients was the most
14 commonly reported facilitator (Table 4). Additionally, financial incentives for screening were reported
15 as a facilitator; this was not a common theme, reported only in 2014 and 2019.
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24 ***Participants' suggested strategies to improve uptake of CTFPHC guidelines***

25 A number of strategies to overcome barriers and leverage facilitators to improve guideline uptake were
26 suggested by participants. These are presented in Box 1. These were categorized as strategies to raise
27 public/patient awareness of and buy-in for CTFPHC guidelines, promote practitioner awareness/use of
28 CTFPHC guidelines, and overcome health system constraints to implementing guideline
29 recommendations.
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38 **Interpretation**

39 This study presents the first longitudinal evaluation of KT efforts of the CTFPHC. Over a 6-year study
40 period, our findings suggest that primary care practitioners are most familiar with cancer screening
41 guidelines, particularly for breast, cervical and prostate cancers. Familiarity with other preventive health
42 guidelines varied, with participant awareness of other CTFPHC guidelines ranging from 17-62%. The
43 timeline between the release of the guidelines and when the evaluation survey was conducted may have
44 influenced awareness such as with the 2019 survey (guideline was released in late 2018). The breast,
45 cervical and prostate cancer guidelines had the greatest number of corresponding KT tools; it is possible,
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1 though unclear, whether the prevalence of KT tools increased participant awareness of these guidelines.
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4 Evidence exploring the effectiveness of KT tools used by guideline producers to improve uptake of
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6 guidelines suggests practitioners who receive both a guideline and a corresponding tool are more likely
7
8 to follow guideline recommendations as compared to practitioners who receive a guideline only.[16]
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10 Similarly, a Cochrane review determined that printed educational materials disseminated to healthcare
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12 professionals may slightly improve healthcare professionals' practice outcomes.[17]
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14 Our data provide additional insight on factors impacting Canadian practitioners' use of CTFPHC
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16 guidelines. Perceived misalignment of the guideline with patient preferences was the most commonly
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18 reported barrier to guideline implementation. These findings are consistent with other Canadian studies
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20 [18] as well as a systematic review, [19] which suggest that practitioners perceive the application of
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22 guideline recommendations to individual patients to be impractical. Given the prevalence of this barrier
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24 over the past two decades, it is imperative to identify strategies to support use of guidelines alongside
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26 shared decision making. Tools that support shared decision making and practical interpretation of
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28 guideline recommendations may support discussion of guideline recommendations with patients. The
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30 CTFPHC has recently focused on developing such tools (e.g., shared decision making tool for the 2018
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32 breast cancer guideline) and work is underway to support practitioners to utilize these in practice. [20]
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34 Improving efforts to include patient values and preferences in guideline development and transparency
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36 about these processes may also improve guideline use. [21,22]
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39 Misalignment with other guidelines, perceptions of evidence strength behind guideline
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41 recommendations, and lack of clarity on how to interpret guideline recommendations (particularly for
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43 weak/conditional recommendations) were prevalent barriers. There is an opportunity to develop KT
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45 tools to support practitioners to interpret 'weak' recommendations.[23] For instance, the 2018 CTFPHC
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47 breast cancer screening guideline language changed recommendations from "weak" to "conditional"
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49 depending on a woman's preferences and values around screening benefits and harms. Framing
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1 recommendations in this manner may improve clarity while emphasizing the importance of shared
2 decision making. [23,24] Complementary shared decision making tools were also created by the
3
4 CTFPHC to facilitate discussions between patients and providers. [25]
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8 Participants suggested developing partnerships with professional organizations, particularly provincial
9 and specialty guideline developers, to encourage alignment of guideline recommendations. Avoiding
10 duplication of effort in creating guidelines on the same topics is also an issue that should be considered
11 by various guideline developing organizations. While the CTFPHC engages relevant stakeholder groups,
12 it does not partner with other organizations due to challenges navigating potential conflicts of interest in
13 guideline development.
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17 Other reported barriers to guideline implementation included time constraints, complexity of guidelines,
18 lack of awareness of guideline/corresponding tools, lack of agreement among practitioner colleagues,
19 and lack of resources to facilitate recommendation (e.g., lung cancer screening access). These barriers
20 are consistent with existing literature, including a recent metareview of 25 systematic reviews of barriers
21 and facilitators to guideline implementation. [26]
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25 There exist multiple opportunities at the patient/public, provider, and health systems levels to improve
26 uptake of preventive health guidelines. However, the impact of these strategies is unknown given the
27 paucity of high-quality research assessing their impact. [27] There is limited literature that reports on the
28 implementation quality or development processes of KT tools particularly with respect to preventive
29 health guidelines. Improved reporting on strategies and testing to implement and evaluate interventions
30 to promote guideline uptake, in partnership with key stakeholders, is warranted. [6]
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33 ***Limitations***

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35 While we aimed to recruit a representative sample of Canadian primary care practitioners, our sample
36 included an over-representation of female practitioners, young practitioners who were in early practice
37 (1-5 years), and participants from Ontario (though this reflects the geographical distribution of primary
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1 care providers in Canada). There was an underrepresentation of practitioners from rural areas, single
2 practitioner clinics and French-speaking practitioners; therefore, it is possible the perceptions are not
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4 representative of all primary care practitioners in Canada. Participants who engaged in these evaluations
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6 were more likely to complete the survey or interview if they were aware of the CTFPHC; as such, our
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8 findings may overestimate awareness of practitioners' awareness of CTFPHC guidelines and tools.
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10 Additionally, data were based on participants' self-reported awareness and use of Task Force guidelines
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12 and tools. It is possible that participants' responses were impacted by social desirability and recall
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14 biases.
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19 **Conclusion**

20 Primary care practitioners are generally aware of national cancer screening guidelines, specifically for
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22 prostate, breast and cervical cancers. Knowledge of other screening and preventive health guidelines
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24 vary significantly. Consistently-reported barriers to guideline uptake over six years reflect challenges
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26 described in the Canadian and international literature. Opportunities to develop innovative strategies to
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28 improve uptake of clinical practice guidelines and corresponding KT tools exist at the public/patient,
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30 provider and health systems levels.
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38 **Data Sharing Statement**

39 Data from CTFPHC's annual evaluations are publicly available on the Task Force's website:
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41 <https://canadiantaskforce.ca/get-involved/annual-evaluation/>. Interview and survey data are available
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43 upon request.
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Dissemination and Implementation of Clinical Practice Guidelines: A Longitudinal Evaluation of
the Canadian Task Force on Preventive Health Care Knowledge Translation Efforts

Table 1: CTFPHC Guidelines and Knowledge Translation (KT) Tools

Guideline	Guideline release date	Associated KT tools	Year(s) assessed (via interviews, surveys)
Cancer Screening Guidelines			
Breast Cancer	November 2011	Patient algorithm Patient FAQ Risks & Benefits, Age 40-49 Risks & Benefits, Age 50-69 Risk & Benefits, Age 70-74	2014-2018
Breast Cancer (Updated Guideline)	December 2018	1000 Person Tool 1000 Person Tool, Age 40-49 1000 Person Tool, Age 50-59 1000 Person Tool, Age 60-69 1000 Person Tool, Age 70-74 Patient algorithm Shared decision-making tool, Age 40-49 Shared decision-making tool, Age 50-59 Shared decision-making tool, Age 60-69 Shared decision-making tool, Age 70-74	2018-2020
Cervical Cancer	January 2013	Clinician algorithm Clinician FAQ Patient algorithm Patient FAQ	2014-2020
Prostate Cancer	November 2014	1000 Person Tool Clinician FAQ Infographic Patient FAQ	2014-2020
Colorectal Cancer	March 2016	Clinician recommendation table Patient FAQ	2016
Lung Cancer	April 2016	1000 Person Tool Clinician FAQ	2016
Esophageal Adenocarcinoma	July 2020	Clinician FAQ Patient FAQ	2020
Lifestyle/ Prevention Guidelines			
Obesity in Children	April 2015	Clinician recommendation table	2015
Obesity in Adults	February 2015	Clinician algorithm Clinician FAQ	2015
Tobacco Smoking in Children and Adolescents	February 2017	Clinician FAQ	2017
Other Guidelines			
Cognitive Impairment	January 2015	Clinician FAQ	2016
Developmental Delay	May 2016	Clinician FAQ	2016
Hepatitis C	April 2017	Clinician FAQ	2017

Asymptomatic Bacteriuria in Pregnancy	July 2018	Clinician FAQ	2018, 2019
Impaired Vision	May 2018	Clinician FAQ	2018
Asymptomatic Thyroid Dysfunction	November 2019	Clinician FAQ	2019, 2020

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Table 2: Participant characteristics

	Survey n=1284	Interview n=183
Gender		
Male	351 (27.3%)	64 (35.0%)
Female	855 (66.6%)	116 (63.3%)
Non-binary	17 (1.3%)	-
Prefer not to say	116 (0.9%)	-
Not reported	50 (3.9%)	3 (1.6%)
Age		
20-39	731 (56.9%)	89 (48.7%)
40-59	407 (31.7%)	38 (20.7%)
60-79	80 (6.2%)	7 (3.9%)
80+	0.0	0.0
Not reported	65 (5.1%)	49 (26.8%)
Years of practice		
1 to 10	783 (61.0%)	121 (66.1%)
11 to 20	182 (14.2%)	28 (15.4%)
21 to 30	140 (10.9%)	22 (12.0 %)
31 to 40	80 (6.2%)	10 (5.5%)
40+	12 (0.9%)	2 (1.1%)
Not reported	87 (6.8%)	0.0
Region		
Urban	749 (58.3%)	93 (50.8%)
Suburban	191 (14.9%)	14 (7.7)
Rural	340 (26.5%)	37 (20.3%)
Not Reported	59 (4.2%)	49 (26.8%)
Clinic Type*		
Hospital based	239 (18.6%)	25 (13.7%)
Community based	758 (59.0 %)	98 (53.6%)
Multidisciplinary clinic	347 (27.0 %)	60 (32.8%)
Not reported	80 (6.2%)	49 (26.8%)
Number of clinicians*		
Single practitioner clinic	72 (5.6%)	4 (2.2%)
Multipractitioner clinic (physician group clinic/family health team)	582 (45.3%)	86 (47.1%)
Not reported	630 (49.1%)	49 (26.8%)
Province/Territory*		

Ontario	606 (47.2%)	83 (45.4%)
British Columbia	119 (9.3%)	20 (11.0 %)
Manitoba	86 (6.7%)	10 (5.5%)
Saskatchewan	39 (3.0%)	13 (7.1%)
Alberta	110 (8.6%)	14 (7.7%)
Quebec	92 (7.2%)	13 (7.1%)
Northwest Territories	8 (0.6%)	13 (7.1%)
Nova Scotia	60 (4.7%)	2 (1.1%)
New Brunswick	41 (3.2%)	6 (3.3%)
Prince Edward Island	21 (1.6%)	9 (5.0%)
Yukon	1 (0.1%)	1 (0.5%)
Newfoundland	30 (2.3%)	2 (1.1%)
Not reported	73 (5.7%)	2 (1.1%)

*Number of participants within a category may not add up to the total number of participants because some PCPs provided demographic characteristics for multiple clinics in which they work and some did not select certain options.

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Table 3: Survey participants' awareness of guidelines

NR – guideline not released

Guideline	Evaluation Year						
	2014	2015	2016	2017	2018	2019	2020
<i>Cancer Screening Guidelines [% surveyed who were aware of guideline]</i>							
Breast Cancer	85	89	91	90	75	-	-
Breast Cancer - Update	NR	NR	NR	NR	47	84	90
Cervical Cancer	88	89	93	89	82	83	87
Prostate Cancer	77	81	83	88	81	84	82
Lung Cancer	NR	NR	49	-	-	-	-
Colorectal Cancer	NR	NR	84	-	-	-	-
Esophageal Adenocarcinoma	NR	NR	NR	NR	NR	NR	27
Mean awareness score across cancer screening guidelines							79.9%
<i>Lifestyle/ Prevention Guidelines [% surveyed who were aware of guideline]</i>							
Obesity in Children	NR	18	-	-	-	-	-
Obesity in Adults	NR	22	-	-	-	-	-
Tobacco Smoking in Children and Adolescents	NR	NR	NR	16	-	-	-
Mean awareness score across lifestyle prevention guidelines							18.6%
<i>Other Guidelines [% surveyed who were aware of guideline]</i>							
Cognitive Impairment	NR	NR	24	-	-	-	-
Developmental Delay	NR	NR	24	-	-	-	-
Hepatitis C	NR	NR	NR	38			
Asymptomatic Bacteriuria in Pregnancy	NR	NR	NR	NR	33	48	-
Asymptomatic Thyroid Dysfunction	NR	NR	NR	NR	NR	62	44
Impaired Vision	NR	NR	NR	NR	17	-	-
Mean awareness score across other CTFPHC guidelines							36.2%

-- guideline not evaluated that year

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Table 4: Barriers and Facilitators to CTFPHC Guideline Implementation

Perceived barrier	Year Barrier Reported						
	2014	2015	2016	2017	2018	2019	2020
Misalignment of guideline with patient expectations/preferences	X	X	X	X	X	X	X
Misalignment of CTFPHC guideline with other provincial/specialty guidelines	X	X	X		X	X	X
Perceptions of evidence strength or lack of consensus among health care professionals about recommendation	X	X	X		X	X	X
Time constraints to implement guideline/ recommendation	X	X	X			X	X
Complexity of guideline / tool or lack of clarity on how to implement recommendation	X			X		X	X
Lack of awareness of guideline/ KT tools	X		X			X	X
Misalignment of CTFPHC recommendation and provincial/territorial health care coverage/ fee-for-service billing scheme		X		X	X	X	
Unsure which guideline to follow/use	X						
Guideline out of date/ not recently updated					X		
Concern about overlooking a diagnosis		X			X		
Unintended outcomes of reduced screening				X			
Patient misinformation on screening (sometimes propagated by social media)				X			
Lack of resources to facilitate screening (e.g., limited in northern/remote communities)		X			X		
Perceived facilitator	Year Barrier Reported						
	2014	2015	2016	2017	2018	2019	2020
Electronic prompts/EMR reminders/ Mobile apps for patients	X	X	X		X	X	X
Availability/awareness of updated guidelines/ tools	X	X	X		X	X	
Public/patient awareness of guideline recommendations	X				X	X	
Consensus on recommendation among health care practitioners / colleagues	X					X	
Financial incentive for screening	X					X	
Ease of guideline use		X	X		X	X	
Strength of guideline evidence		X			X	X	

Box 1: Suggested strategies to facilitate uptake of CTFPHC guidelines

Strategies to raise patient/public awareness of and buy-in for CTFPHC guidelines

- Practitioners should
 - aim to discuss screening with patients OR not raise the issue of screening when CTFPHC does not recommend
 - use patient tools to facilitate decision making
- CTFPHC should
 - use media campaigns and build the CTFPHC brand (emphasis on methodology)
 - use media campaigns to orient patients/public to preventive health concepts
 - develop patient-facing tools not tied to a single guideline (e.g., a tool for screening for older adults, people who are pregnant)
 - develop shared decision making tools

Strategies to raise practitioner awareness/use of CTFPHC guidelines

- Embed recommendations into EMRs
- Practitioner education on how to assess quality of guideline evidence; emphasize that evidence may evolve over time
- Media campaigns and building the CTFPHC brand (emphasis on methodology)
- Build partnerships with professional organizations to encourage alignment of provincial/territorial and speciality guidelines with the CTFPHC
- Expand dissemination of guidelines and KT tools to practitioners
- Develop tools to support interpretation of conditional recommendations and provide pragmatic guidance on how to implement recommendations
- Ensure guidelines are updated frequently, particularly if another body produces a guideline on the same topic

Strategies to overcome health system constraints to implement guidelines

- Try to align health exams with screening intervals, if feasible
- Place printed copies of KT tools in visible locations in the clinic
- Improve involvement of nurse practitioners in screening processes, if feasible

Appendix A

Year being evaluated	Year evaluation completed (January to March)	Guidelines evaluated	Guideline Publication Date
2014	2015	Breast Cancer	November 2011
		Cervical Cancer	January 2013
		Prostate Cancer	November 2014
2015	2016	Breast Cancer	November 2011
		Cervical Cancer	January 2013
		Prostate Cancer	November 2014
		Obesity in Adults	February 2015
		Obesity in Children	April 2015
2016	2017	Breast Cancer	November 2011
		Cervical Cancer	January 2013
		Prostate Cancer	November 2014
		Cognitive Impairment	January 2015
		Colorectal Cancer	March 2016
		Lung Cancer	April 2016
		Developmental Delay	May 2016
2017	2018	Breast Cancer	November 2011
		Cervical Cancer	January 2013
		Prostate Cancer	November 2014
		Tobacco Smoking in Children and Adolescents	February 2017
		Hepatitis C	April 2017
2018	2019	Breast Cancer	November 2011
		Cervical Cancer	January 2013
		Prostate Cancer	November 2014
		Impaired Vision	May 2018
		Asymptomatic Bacteriuria in Pregnancy	July 2018
		Breast Cancer Update	December 2018
2019	2020	Cervical Cancer	January 2013
		Prostate Cancer	November 2014
		Breast Cancer Update	
		Asymptomatic Bacteriuria in Pregnancy	July 2018
		Asymptomatic Thyroid Dysfunction	November 2019
2020	2021	Cervical Cancer	January 2013
		Prostate Cancer	November 2014
		Breast Cancer Update	December 2018

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		Asymptomatic Thyroid Dysfunction	November 2019
		Esophageal Cancer	July 2020

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Appendix B: Task Force Annual Evaluation Interview Script

Note to the interviewer: Before the interview, you will need:

- Summary of the interviewee survey responses about CTFPHC guidelines they know about and use, and their preference for provincial vs. national guidelines
- Summary of CTFPHC recommendation statements

Intro [~5 min]

Thank you for agreeing to speak with us. My name is [name] and I am a [title] with the Knowledge Translation Program at St. Michael's Hospital in Toronto. We are evaluating the [year] activities of the Canadian Task Force on Preventive Health Care. As part of this evaluation, we are conducting interviews with practitioners about your experiences with the Task Force.

Did you have a chance to review the project information sheet we sent?

The interview will ask you about

- Your knowledge and perceptions of the Task Force
- Your use of Task Force clinical practice guidelines, tools, and resources
- How preventive health care decisions get made
- How preventive health care happens in your practice

Do you have any questions?

*[*If participant asks for more information: 'The Task Force develops and disseminates evidence-based guidelines on preventive health services for primary care practitioners. The survey you completed, as well as this interview, are a part of the annual evaluation of Task Force 2018 activities, and the feedback you provide will help us to improve the Task Force's impact and identify new opportunities. As a primary care practitioner, we are interested in your knowledge of, and experiences with, the Task Force, how you use guidelines in your practice, as well as what factors influence preventive health care in your practice']*

I will now go over the interview agreement.

- Your participation in this interview is voluntary.
- You can choose not to participate or you may withdraw at any time, even after the interview has started.
- This interview is confidential.
- We will record this interview.
- We will aggregate the survey results. Aggregated results may be included in presentations and publications.
- If you would like a report of the results, we can provide you with a summary when our analysis is complete.

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2
3 Do you have any questions?
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7 Do you agree to the interview and to the audio recording?
8

9 I will now turn on the audio recorder.
10

11
12
13 Today is [date] and I am conducting Task Force [year] evaluation interview number [number].
14
15

16
17 *Note to interviewer: The headings are for your use only. What appears in brackets is the construct from*
18 *RE-AIM we are targeting with the questions.*
19

20 Introduction to the Task Force (Factors affecting Reach) [~5 -10 min]

- 21 • How did you first learn about the Task Force?
22 ○ Probes: Were you exposed to the Task Force in medical school or your residency
23 training? If so, what did they teach?
24
- 25 • How do you typically hear about new or updated guidelines?
26 ○
27

28 Experiences with Task Force over time (Effectiveness, factors affecting Adoption) [~5 - 29 10 min]

30 *(Note to interviewer: For this area of questioning, important to consider survey results – esp. which*
31 *guidelines they use.)*
32

- 33 • Describe the extent to which you use/follow recommendations from the Task Force?
34 ○ Do you intend to change your practice to follow any recommendations from the
35 Task Force, and if so, how do you intend to change your practice?
36
- 37 • When did you first start following recommendations from the Task Force? [**if they do follow*
38 *TF guidelines*]
- 39 • Could you describe how you make decisions on which recommendations to use/follow?
40 ○ Probe: When a new Task Force recommendation comes out, how do you make a
41 decision on whether or not to follow it?
42
- 43 • What influences your decision to change your preventive health care practices, such as
44 screening?
45 ○ Probe: Can you describe any instances where you changed your practice
46 because of Task Force recommendations?
47 ○ Probe: Have you ever started following a Task Force recommendation and then
48 stopped?
49 ■ Probe: What made you decide to stop? OR What could make you decide
50 to stop following a recommendation?
51

52 Guideline decision making (Effectiveness, factors affecting Adoption) [~ 5 – 10 min]

- 53 • From your perspective, where is the main decision-making power for guideline uptake? Who are
54 the influencers that drive guidelines becoming practice?
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- Probe: The practitioner, colleagues, the practice, leaders in the profession, the professional organization, the government, the public?
- What makes a guideline trustworthy?
 - Probes: What are your trusted sources for guidelines?
 - Probe: In your opinion, how does Task Force compare to other sources for guidelines?
 - Probe: Is Task Force trustworthy? Why or why not?
- What makes a guideline easier to implement?
 - Probe: What makes it difficult to implement?
-
- When you have multiple sources of conflicting information on a preventive health care topic, how do you evaluate which information to follow?
 - Probe: *(Note to interviewer: For this probe, important to consider survey responses.)* Think about a topic where the Task Force and provincial guidelines are different. How did you decide which recommendations to follow?

Engaging patients (Factors affecting Implementation) [~ 5 – 10 min]

- In your work setting(s), how are patients engaged in discussions about preventive health care? (if at all?)
 - Probe: How do you engage patients in discussions specifically about Task Force recommendations?
 - Probe: (Do you use Task Force KT tools?) How do you use Task Force KT tools?
 -
- In your work setting(s), who else do you think could engage patients in discussions about Task Force recommendations?
 - Probe: How do you think that would work? What support would those people need to engage patients successfully?
 - Probe: Are there any other members of your health care team who engage patients in these discussions?

Accessing Task Force materials (Suggestions for improving Reach and Implementation) [~5 – 10 min]

- How can the Task Force improve your access to the recommendations and tools?
 - What are the current barriers, if any?
 - What are some recommendations the Task Force could consider to make it easier to access these guidelines/tools?

Final thoughts and thank you

- Do you have anything else you would like to share?

Thank you so much for taking the time to share with us today. We will be processing and mailing your compensation soon. Please know that the payment processing can take a few weeks. If you have any questions about the evaluation, you can contact [name] at [contact info].