Evidence in Practice Project

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Hypertension guideline recommendations in UK General Practice: survey of awareness, agreement, adoption and adherence

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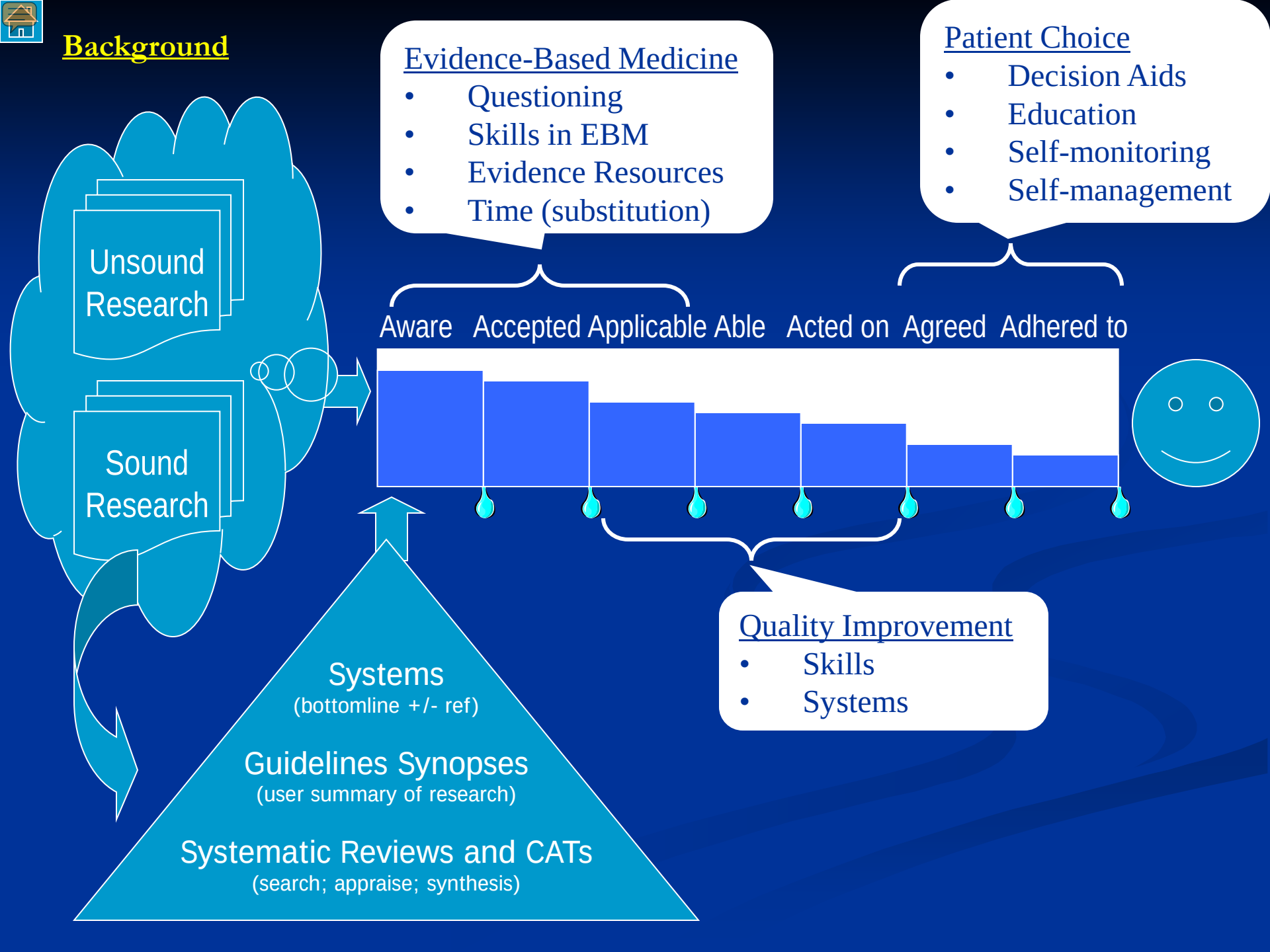
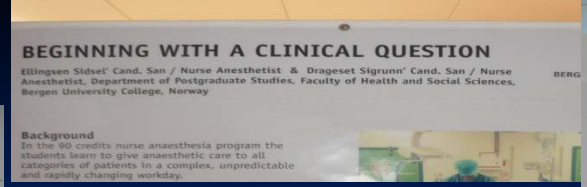
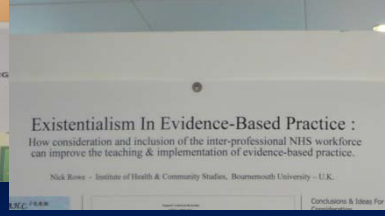
Background

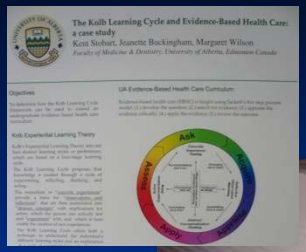

Evidence-Based Medicine
• Questioning
• Skills in EBM
• Evidence Resources
• Time (substitution)
Patient Choice
• Decision Aids
• Education
• Self-monitoring
• Self-management
Unsound Research
Sound Research
Aware
Accepted
Applicable
Able
Acted on
Agreed
Adhered to
Quality Improvement
• Skills
• Systems
Systems
(bottomline +/- ref)
Guidelines Synopses
(user summary of research)
Systematic Reviews and CATs
(search; appraise; synthesis)

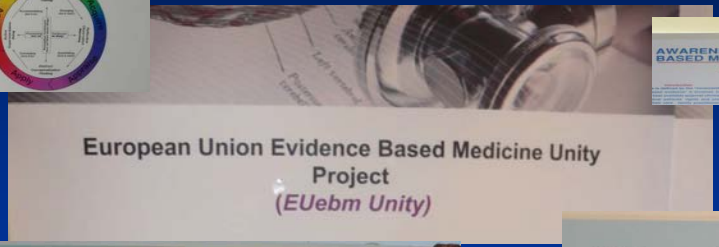
Evidence-Based Medicine

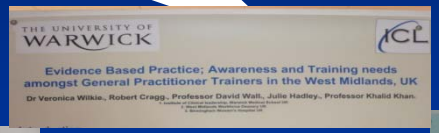
- Questioning
- Skills in EBM
- Evidence Resources
- Time (substitution)

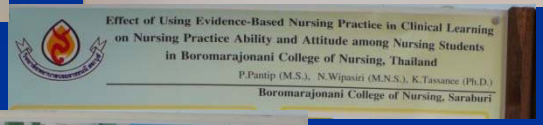


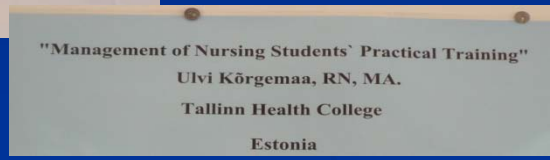


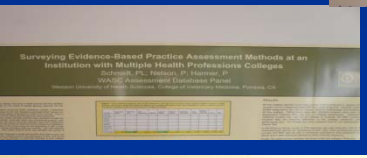


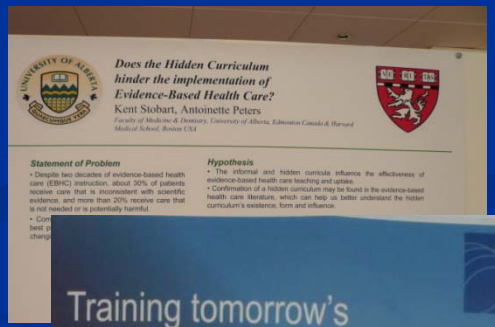


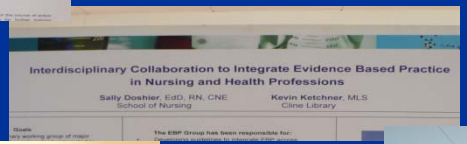


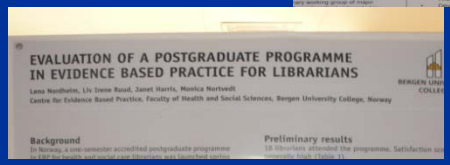


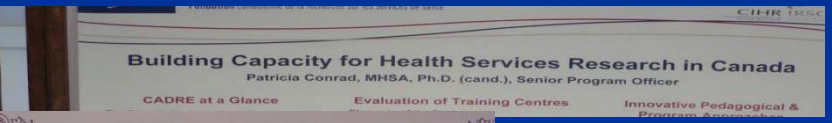


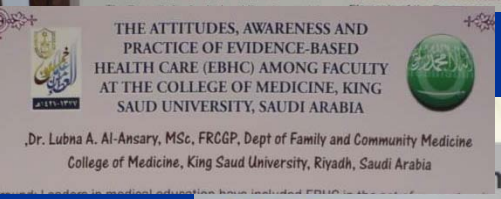


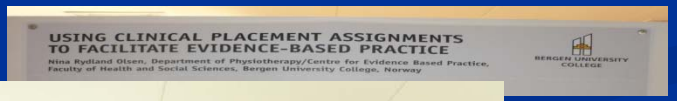


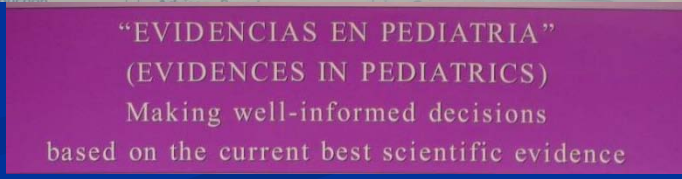


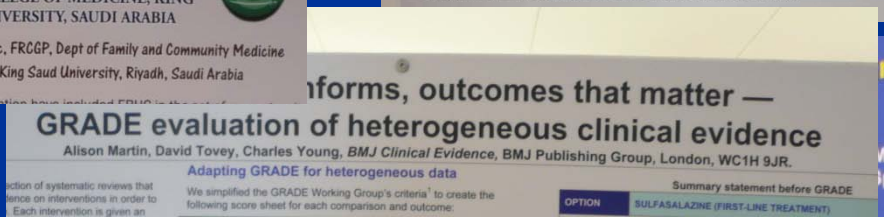


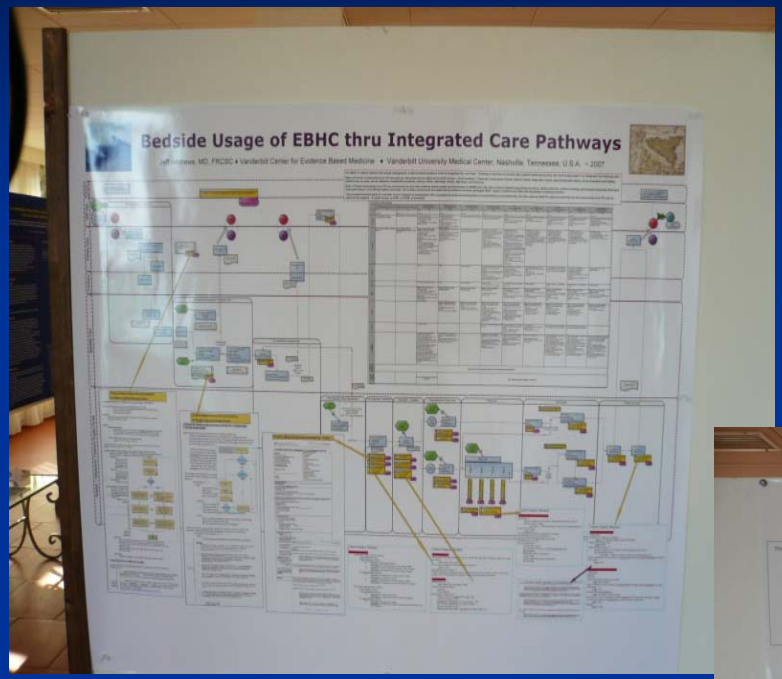


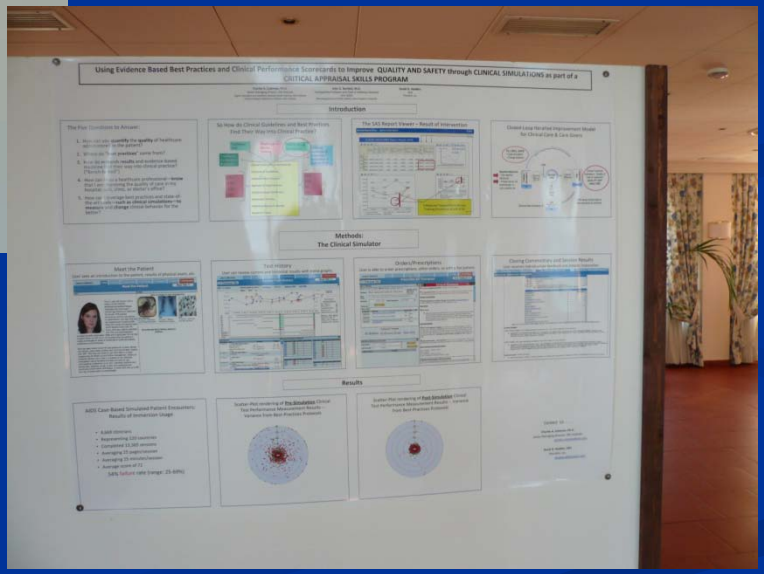












Quality Improvement

- Skills
- Systems

Patient Choice

- Decision Aids
- Education
- Self-monitoring
- Self-management

Awareness to Adherence for Hypertension Guidelines

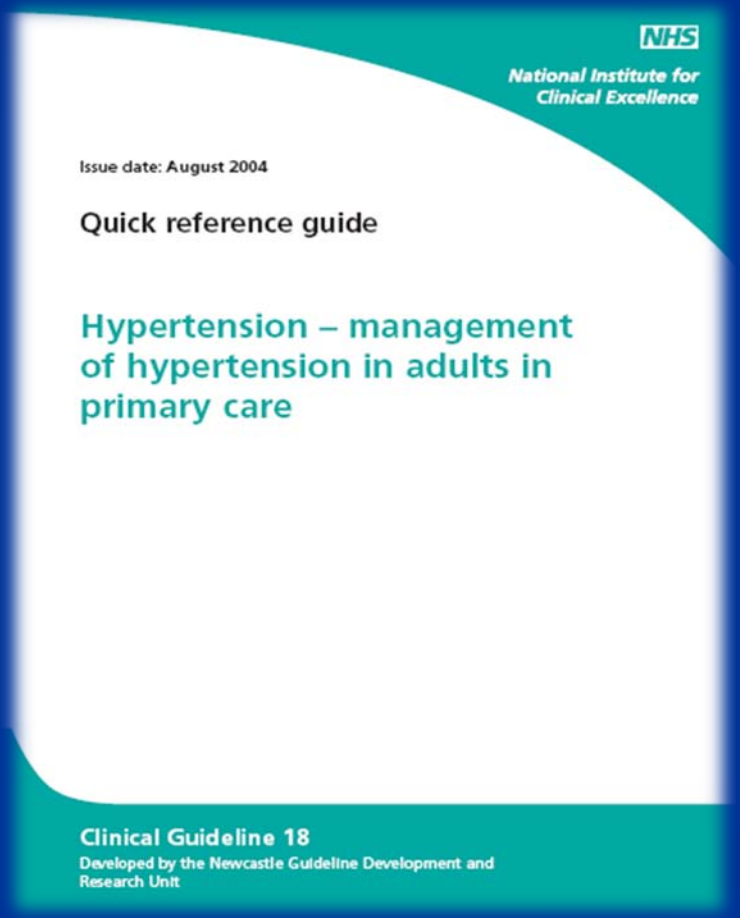
Non-application of guidelines may be due to several factors*:

- Lack of awareness,
- Lack of agreement,
- Lack of belief that one can actually perform a behaviour,
- Lack of outcome expectation
- The inertia of previous practice
- External barriers.

*Cabana MD, et al Why don't physicians follow clinical practice guidelines? A framework for improvement. JAMA 1999; 282(15):1458-1465.

Aim

We surveyed UK general practitioners to better understand their reasons for not adopting specific guidance within the NICE and BHS hypertension guidelines



BRITISH HYPERTENSION SOCIETY GUIDELINES

Guidelines for management of hypertension: report of the fourth working party of the British Hypertension Society, 2004—BHS IV

B Williams[1], NR Poulter[2], MJ Brown[3], M Davis[4], GT McInnes[5], JF Potter[6], PS Sever[7] and S McG Thom[7]

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Summary of recommendations

- Provide advice on life-style modifications for all people with high blood pressure (BP) and those with borderline or high-normal BP. Advice on effective nonpharmacological interventions is provided (A).
- Initiate antihypertensive drug therapy in people with sustained systolic BP (SBP) ≥160 mmHg or sustained diastolic BP (DBP) ≥100 mmHg (A).
- Make treatment decisions in people with sustained SBP between 140 and 159 mmHg and/or sustained DBP between 90 and 99 mmHg according to the presence or absence of cardiovascular disease, other target organ damage, or an estimated cardiovascular disease (CVD) risk of ≥20% over 10 years, according to the Joint British Societies CVD risk assessment programme/risk chart (A).
- CVD risk replaces CHD risk estimation to reflect the importance of stroke prevention as well as CHD prevention. The new CVD risk threshold of ≥20% is equivalent to a CHD risk of approximately ≥15% over 10 years.
- In people with diabetes mellitus, initiate antihypertensive drug therapy if SBP is sustained ≥140 mmHg and/or DBP is sustained ≥90 mmHg (B).
- In nondiabetic people with hypertension, the optimal BP treatment goals are: SBP <140 mmHg and DBP <85 mmHg. The minimum acceptable level of control (Audit Standard) recommended is <150/<90 mmHg. Despite the best practice, these levels will be difficult to achieve in some hypertensive people (B).
- In people with diabetes and high BP, optimal BP goals are: SBP <130 mmHg and DBP <80 mmHg. The minimum acceptable level of control (Audit Standard) recommended is <140/<80 mmHg. Despite the best practice, these levels will be difficult to achieve in some people with diabetes and hypertension (B).
- Meta-analyses of BP-lowering trials have confirmed that, in general, the main determinant of benefit from BP-lowering drugs is the achieved BP, rather than choice of therapy. In some circumstances, there are compelling indications and contraindications for specific classes of antihypertensive drugs, and these are specified (A).
- Most people with high BP will require at least two BP-lowering drugs to achieve the recommended BP goals. A treatment algorithm (AB/CD) is provided to advise on the sequencing of drugs and logical drug combinations (C). When there are no cost disadvantages, fixed drug combinations

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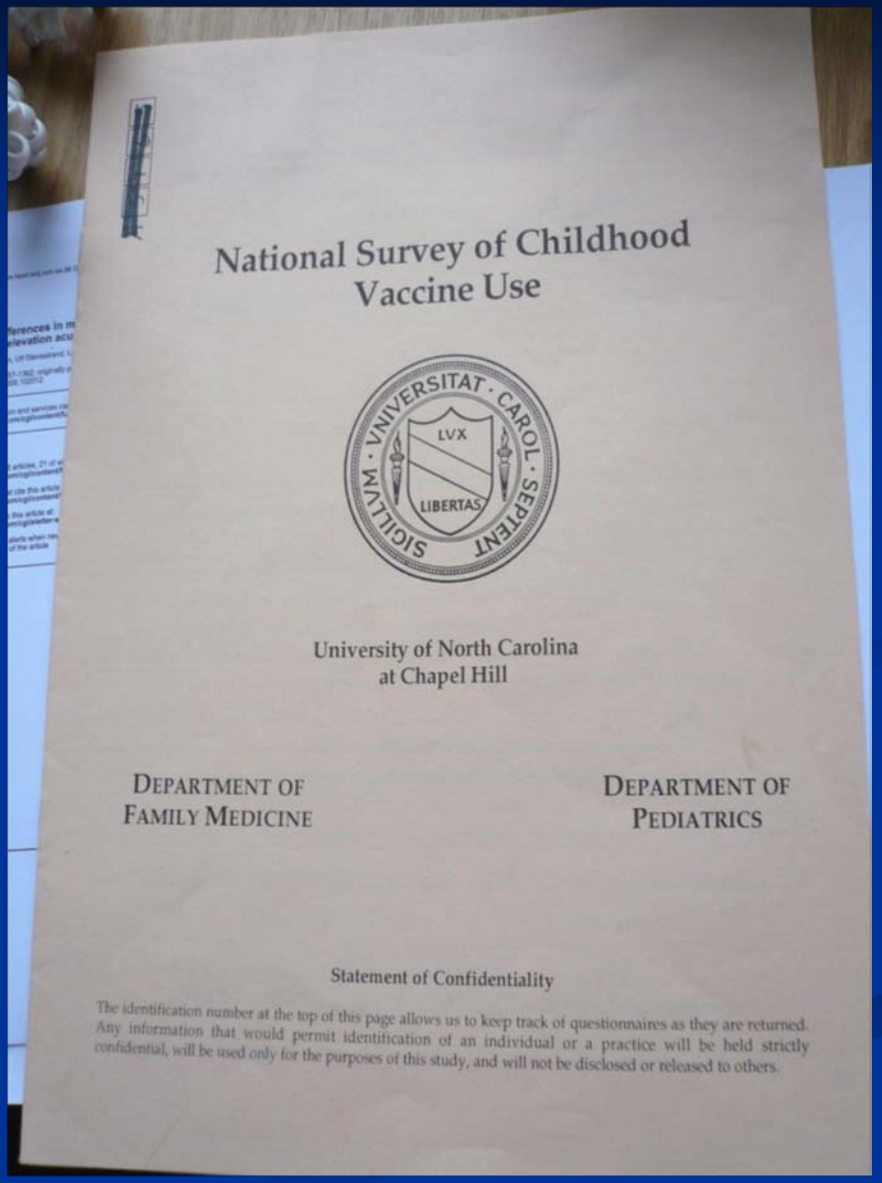
Guideline Working Party Chairman: Professor Bryan Williams, MD FRCP, University of Leicester. Guideline Working Party Members: Professor Neil R Poulter, MSc FRCP, Imperial College London. Professor Morris J Brown, MD FRCP FMedSci, University of Cambridge. Dr Mark Davis, MRCGP, General Practitioner, Leeds. Professor Gordon T McInnes, MD FRCP, University of Glasgow. Professor John F Potter, MD FRCP, University of Leicester. Professor Peter S Sever, PhD FRCP, Imperial College London. British Hypertension Society member: Dr Simon McG Thom, MD FRCP, Imperial College London.

Methods

Pathman DE

Model of the cognitive and behavioural steps physicians take when they comply with national clinical practice guidelines



Pathman, postulated that

physicians, who are initially unaware of a specific piece of research or guideline recommendation, must first become *aware* of it, then *agree* with it in principle, then decide it is appropriate and feasible to use in their own practice - *adopt* it, and finally succeed in following it at appropriate times -*adhere* to it.

Pathman DE et al. The awareness-to-adherence model of the steps to clinical guideline compliance. The case of pediatric vaccine recommendations. Med Care 1996; 34(9):873-889.

Methods

- A questionnaire was sent as a link in a targeted electronic clinical bulletin distributed through *doctors.net.uk*.

- The questionnaire was adapted from the original four steps of Pathman's 'awareness-to-adherence' questionnaire

- We focused the questions on seven recommendations from the British Hypertension guidelines and the NICE guidelines

- The questionnaire was piloted on a sample of GPs from the Department of Primary Health Care, University of Oxford

Methods

Respondents were classified as unaware of a recommendation if they had heard or read ‘nothing at all’ about the recommendation.

They were considered to have adopted a guideline when they reported implementing it more ‘than half of the time’.

They were considered to adhere to a guideline when they ‘always’ or ‘more than half the time’ applied it in clinical practice and specified in their free text response the system they had in place to promote or monitor application.

Results

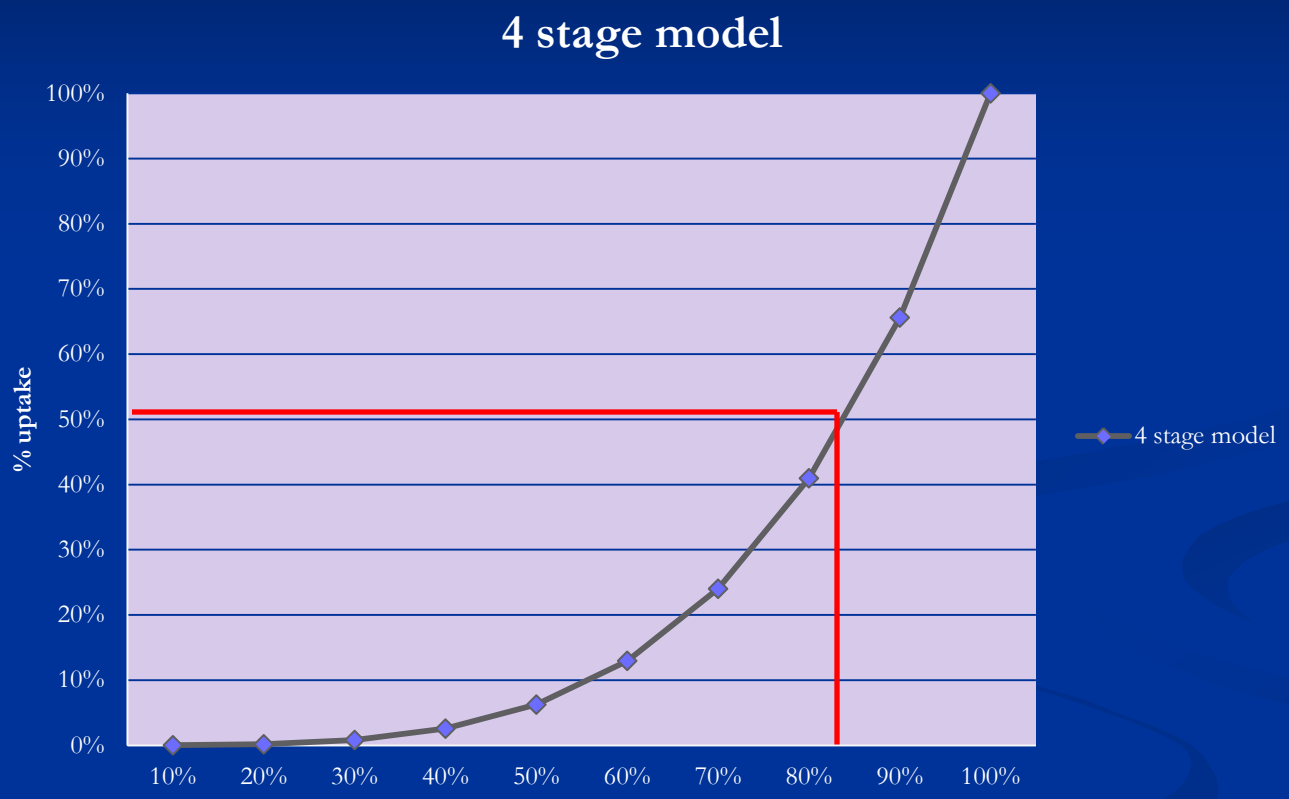
Respondents were similar to the GP population in terms of gender , employment status but Differed in terms of GP partner principal (57% in the survey versus 83%)

	Female (%)	Male (%)	Total
Total	161 (40.1%)	240 (59.9%)	n =401
Current position			
GP registrar	16 (4.0)	24(6.0)	40 (10.0)
GP partner principal	71(17.7)	156 (38.9)	227 (56.6)
Non principal	71 (17.7)	57 (14.2)	128 (31.9)
Other	3 (0.7)	3(0.6)	6 (1.4)
Year of qualification			
pre 1960			0 (0)
1960 - 1969	1 (0.2)	6 (1.5)	7 (1.7)
1970 - 1979	17 (4.2)	36 (9.0)	53 (13.2)
1980 - 1989	41 (10.2)	73 (18.2)	114 (28.4)
1990 - 1999	70 (17.5)	85 (21.2)	155 (38.7)
2000+	32 (8.0)	40 (10.0)	72 (18.0)

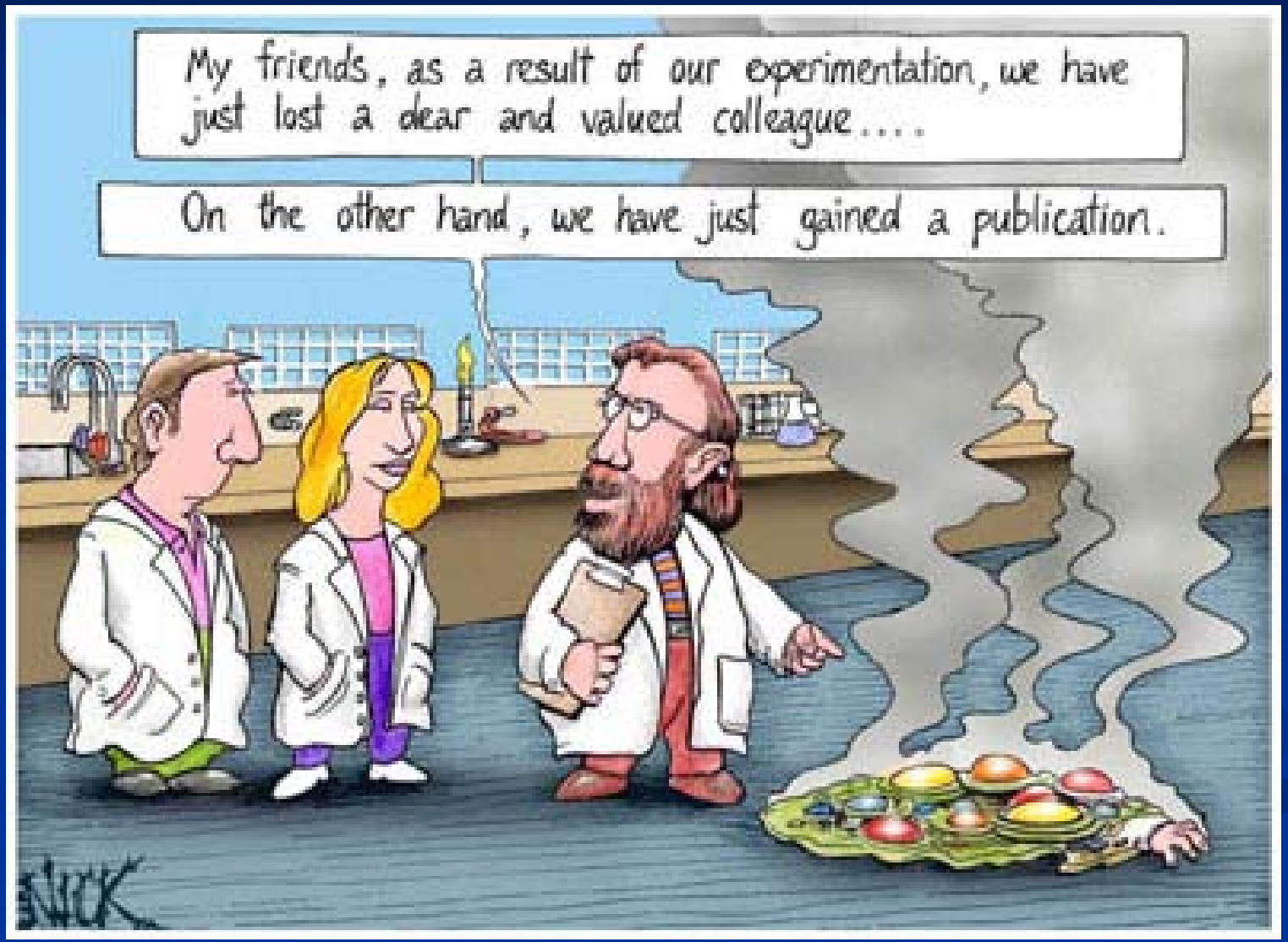
71 % Awareness and Agreement leads to 50% application

% implementation at each stage

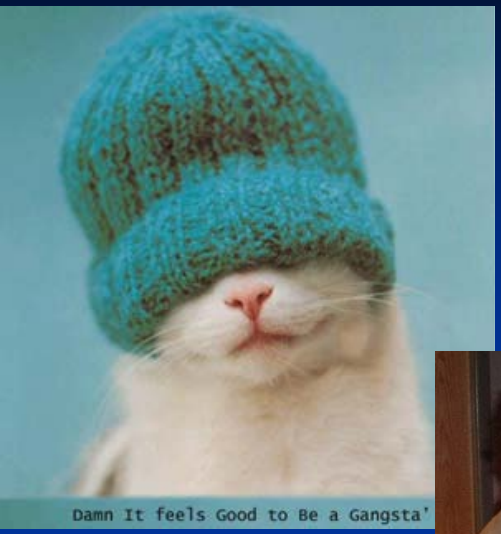
84 % Awareness, Agreement, Adoption and Adherence at every stage leads to implementation of 50%



Why might practitioners not agree with recommendations



Thank You



Awareness, Agreement, Adoption, Adherence