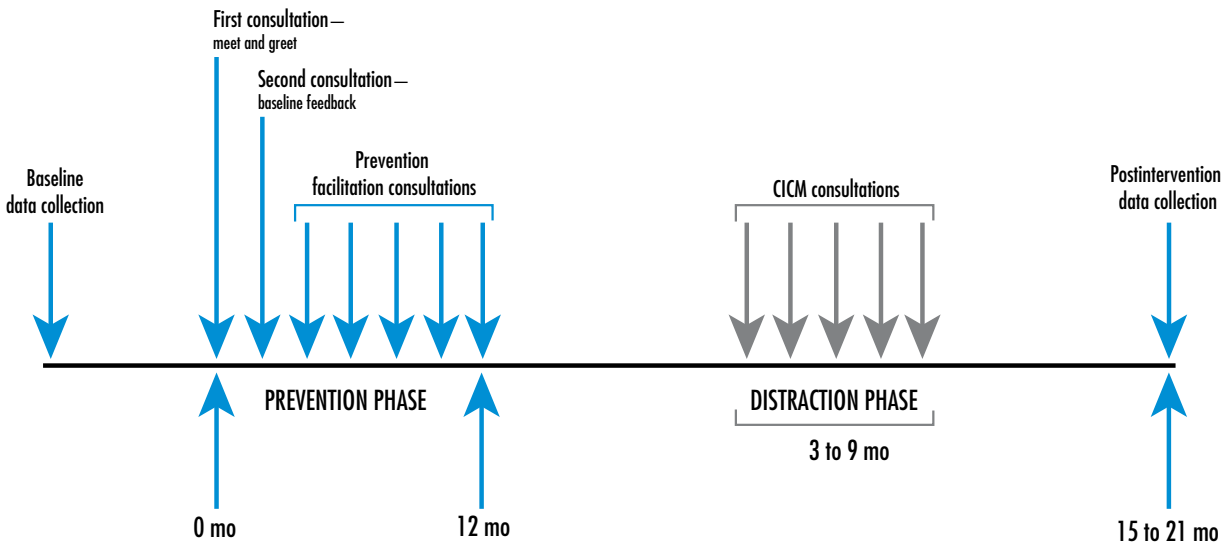
Improving prevention in primary care

Evaluating the sustainability of outreach facilitation

William Hogg MSc MCISc MD FCFP **Jacques Lemelin** MD CCFP FCFP **Isabella Moroz** PhD **Enrique Soto** PhD **Grant Russell** MD
Can Fam Physician 2008;54:712-20.

Figure 2. Timeline of the intervention



Data collection process

Preventive maneuver selection. A total of 8 grade A, 14 grade B, and 4 grade D preventive maneuvers were chosen from the Canadian Task Force on Preventive Health Care (CTFPHC) recommendations. Grade A recommendations are given when there is good evidence to recommend a maneuver; grade B recommendations are given when there is fair evidence to recommend a maneuver; and grade D recommendations are given when there is fair evidence to recommend against a maneuver. For grade A and B recommendations, larger proportions indicate better performance.

This selection was made by a decision-making panel of principal investigators, most of whom were also practising physicians, to represent a broad spectrum of preventive services for both male and female adult patients. Criteria used to select preventive maneuvers included the following: the strength of evidence supporting the maneuver's use or discontinuation, the importance of the maneuver for Canadians' health, reliability of its measurement, room for variation in performance of the maneuver across practices, and room for improvement. Exclusion criteria included pediatric and prenatal guidelines, those that encompassed public health issues, and those that were not easily measured.

Continued ➡ 2

CFP CANADIAN FAMILY PHYSICIAN LE MÉDECIN DE FAMILLE CANADIEN

Chart review process. Trained reviewers collected all information using a *Data Collection Handbook* specially designed for this purpose, which specified coding for each of the maneuvers. The patient eligibility criteria for both chart review and patient interviews included being 17 years of age or older, being a regular patient of the practice, and having been seen at the practice once in the previous month. Data from chart reviews were used to determine which services patients were eligible to receive based on the age- and sex-specific and time-interval recommendations made by the CTFPHC. For services for which the CTFPHC did not specify a time frame, an interval of 1 year was chosen. Preventive maneuvers were excluded if there was any indication that they were done for diagnostic rather than screening reasons. Chart auditors reviewed 70 charts per practice before the prevention intervention (more than necessary in order to provide practices with more accurate feedback on their baseline preventive care performance) and 30 charts per practice after the distractor intervention. The charts were randomly selected. To assess implementation of maneuvers related to health counseling in the areas of exercise, smoking or drinking cessation, and healthy eating patterns, preintervention and postintervention patient interviews were conducted with randomly selected patients. A total of 50 patients per practice, contacted by the practice by mail to consent to participate in the interviews, were asked questions regarding the health prevention services they received from their practitioners over the course of the past 12 months.

Interrater reliability of the chart audit was determined through assessment of sample practices by an independent reviewer. If any discrepancies were found in more than 20% of the sample charts, all charts were reviewed again. The verification continued until all charts obtained from 2 practices reviewed successively had passed validation. Afterward, spot verifications were carried out.