Strengthening lifestyle interventions in primary health care

- The challenge of change and implementation of guidelines in clinical practice

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Akademisk avhandling
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Background: Lifestyle habits like tobacco use, hazardous use of alcohol, unhealthy eating habits and insufficient physical activity are risk factors for developing non-communicable diseases, which are the leading, global causes of death. Furthermore, ill health and chronic diseases are costly and put an increased burden on societies and health systems. In order to address this situation, governmental bodies and organizations have encouraged healthcare providers to reorient the focus of healthcare and undertake effective interventions that support patients to engage in healthy lifestyle habits. In Sweden, national clinical practice guidelines (CPGs) on lifestyle interventions were released in 2011. However, the challenges of changing clinical practice and introducing guidelines are well documented, and health interventions face particular difficulties. The overall purpose of this thesis is to contribute towards a better understanding of the complexities of shifting primary health care to become more health oriented, and to explore the implementation environment and its effect on lifestyle intervention CPGs. The specific aims are to investigate how implementation challenges were addressed during the guideline development process (Study I), to investigate several dimensions of readiness for implementing lifestyle intervention guidelines, including aspects of the intervention and the intervention context (Study II), to explore the extent to which health care professionals are working with lifestyle interventions in primary health care, and to describe and develop a baseline measure of professional knowledge, attitudes and perceived organizational support for lifestyle interventions (Study III), and to assess the progress of implementing lifestyle interventions in primary care settings, as well as investigate the uptake and usage of the CPGs in clinical practice (Study IV).

Methods and results: Interviews were conducted with national guideline-developers (n=7). They were aware of numerous implementation challenges, and applied strategies and ways to address them during the guideline development process. The strategies adhered to four themes: (a) broad agreements and consensus about scope and purpose, (b) systematic and active involvement of stakeholders, (c) formalized and structured development procedures, and (d) openness and transparent development procedures. At the same time, the CPGs for lifestyle interventions challenged the development-model at the National Board of Health and Welfare (NBHW) because of their preventive and non-disease specific focus (I).

A multiple case study was also conducted, using a mixed methods approach to gather data from key organizational individuals that were accountable for planning the implementation of CPGs (n=10), as well as health professionals and managers (n=340). Analysis of this data revealed that conditions for change were favorable in the two organizations that served as case studies, especially concerning change focus (health orientation) and the specific intervention (national guidelines on lifestyle interventions). Somewhat limited support was found for change and learning, and change format (national guidelines in general). Furthermore, factors in the outer context were found to influence the priority and timing of the intervention, as well as considerable inconsistencies across the professional groups (II). A cross-sectional study among physicians and nurses (n=315) in Swedish primary healthcare showed that healthcare professionals have a largely positive attitude and thorough overall knowledge of lifestyle intervention methods. However, both the level of knowledge and the involvement in patients' lifestyle change, differed between professional groups. Organizational support like CPGs and the development of primary health care (PHC) collaborations with other stakeholders were identified as potential strategies for enhancing the implementation of lifestyle interventions in PHC (III).

In addition to interviews and case studies, a longitudinal survey among health professionals (n=150; n=73) demonstrated that their use of methods to encourage patients to reduce or eliminate tobacco or alcohol use, had increased. The survey also indicated that nurses had increased the extent to which they addressed all four lifestyle habits. The progress of the implementation of CPGs on lifestyle interventions in PHC was somewhat limited, and important differences in physicians and nurses' attitudes, as well as their use of the guidelines, were found (IV).

Conclusions: Health orientation differs in many ways from more traditional fields in medicine. To strengthen the implementation of this very important (but not “urgent”) field in health care, it needs, first of all, to be prioritized at all levels! The results of the studies demonstrate relatively slow adoption of lifestyle intervention CPGs in clinical practice, and indicate room for improvement. The findings of this thesis can inform healthcare policy and research on further development of the health orientation perspective, as well as on the challenges of implementing CPGs in primary care. In summary, this thesis presents important lessons learned regarding health orientation - from the development of CPGs in the field, via assessing healthcare organizations' readiness to change and health professionals' attitudes to methods to assist patients with lifestyle changes.

Key words: Health orientation, health promotion, prevention, primary health care, readiness for change, lifestyles, clinical practice guidelines, implementation, guideline development, tobacco use, alcohol use, unhealthy eating habits, physical activity, organizational support