Benchmarking Implementation of the 4th Joint Societies’ Task Force Guidelines across 13 European Countries

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Conflict of interest: nothing to declare

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“In practice, the majority of physicians [...] revert to a *subjective assessment* of combined cardiovascular risk, rather than using the more objective risk assessment systems recommended by guidelines such as those of the Joint European Task Force.”

*(Graham et al, 2006)*
4th Joint Societies’ Task Force Guidelines: Implementation Strategy

4th JTF recommended implementation strategy at national level:

1. If not already in place, form a multidisciplinary implementation group that has the support of national health authorities.

2. Adapt the guidelines to local needs.

3. Develop partnerships between politicians, health professionals, educators and business.

4. Define a communication strategy.

5. Develop an evaluation strategy.

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Assessing Implementation

EACPR Prevention Implementation Committee – Study

Study aims:

• to benchmark implementation of the 4th JTF Guidelines across a range of European countries

• to identify enablers and barriers to implementation

• to inform implementation plans of the 5th JTF

• to inform EACPR and ESC about perspectives on their roles across Europe
Methodology

• Selection of countries (13) to represent differing regions and likely states of development in Europe

• Interviews with key stakeholders in each country

• Interviews structured to address key elements of 4th JTF
  – Multidisciplinary implementation group
  – Adaptation for local needs
  – Partnerships – professionals, educators, business, politicians
  – Communication strategy
  – Evaluation strategy

• Interviews informed by key national documents relevant to prevention implementation.
Selected Countries
Planned Participants

• In each country: aim to interview
  – national coordinator(s)
  – 1 representative each from cardiac society, heart foundation, health ministry, and health service agency/health inspectorate

• In total, 55 key informants interviewed:

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*No identified heart foundation in Poland.
Participation: Voluntary Organisations & National Coordinators

Interviews secured with national coordinators, cardiac societies & heart foundations:

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### Cardiac societies (n=9)

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## Participation: Health Ministries

### Health ministries (n=7)

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*Self-completed questionnaire*

### Challenges

- Difficult to identify those with responsibility for cardiovascular health.
- Administrative decentralisation in many countries => no central individual responsible for cardiovascular health on a national level.
- When potential informants identified, very difficult to make contact.
Participation: Health Service Agencies/Health Inspectorates

Health service agencies/inspectorates (n=3)

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Challenges
- Health systems vary considerably across countries; difficult to identify the appropriate agencies.
- Many countries do not have an agency that fits this category.
Results: Implementation Strategies

Variable implementation of 4th JTF:

1. Multidisciplinary implementation group to inform & shape policy:
   = 8/13 countries

1. Guidelines adapted to local needs = 8/13 countries, e.g.:
   • Revised cut-off values in the Netherlands
   • Prevention in children covered by Russia & Estonia

2. Defined communication strategy:
   • Published in main cardiology journal and cardiac society website
     = 13/13 countries
   • Different approaches to wider distribution, e.g.:
     • User-friendly version for GP training in Italy
     • Version for general public in Poland
4. Developing an **evaluation plan** is a challenge for most countries.
   - No systematic audit at national level = **0/13 countries**
   - Smaller-scale evaluations in Estonia, Italy and the Netherlands

5. **Partnerships** between politicians, health professionals, educators and business - very complex area = ??/13.
   - Health professionals supportive
   - Political reluctance, business opposition
Results: Support for the Guidelines

- Participants satisfied with scope, credibility and evidence base.
- Strong support for concept of single European guideline.
- Recognition of guidelines’ role in improving physician performance and patient care.
- Differing approaches to implementation:
  1. **Adoption** as the national guidelines, with local adaptation – mainly the adjustment of risk charts to national data
  2. **Incorporation** into national guidelines
  3. **Co-existence** with other guidelines

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Results: Common Challenges

- Lack of government support
  - Tackling population risk
  - Economic considerations
  - Bureaucracy

- Motivating doctors to engage in prevention
  - Prioritising prevention
  - Counselling patients
  - Slow process
  - Financial incentives

- Lifestyle risk factors on the rise in children and young people
Results: Common Challenges

• Guidelines:
  – Too long and too dense for practitioners
  – Don’t equip doctors to advise the general public
  – Fatigue from multiple guidelines, frequently updated
  – Conflicts between different guidelines

• SCORE
  – Identification of risk in different groups
  – Mortality versus morbidity risk

• Auditing implementation

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Results: Issues to Consider

- Simpler guidelines
- Standardised guidelines across scientific societies
- Audit of implementation
- Treatment versus prevention
- Level of focus: population or high-risk patients?
- Develop other guidelines?
- Role of the ESC – broaden focus to the general public or confine its message to physicians?
Acknowledgements

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- **Thanks:** Sophie Squarta for project assistance
- **Thanks:** All who have participated as interviewees