Clinical Practice Guideline Evaluation Report

Breast Disease and Cancer

- **Breast Disease and Cancer: Diagnosis**
- **Breast Cancer: Management and Follow-up**

Colorectal Cancer

- **Colorectal Screening for Cancer Prevention in Asymptomatic Patients**
- **Follow-up of Colorectal Polyps or Cancer**

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BC Cancer Agency
CARE + RESEARCH
An agency of the Provincial Health Services Authority

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CANADIAN PARTNERSHIP AGAINST CANCER
PARTENARIAT CANADIEN CONTRE LE CANCER

Acknowledgements

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The Survivorship and Primary Care Program supports and empowers people to live their best lives with cancer and beyond. The Family Practice Oncology Network and their Council's goal is to assist the BC Cancer Agency in its mandate to improve cancer control in the province by providing support and connection to physicians in the community. The BC Cancer Agency is an agency of the Provincial Health Services Authority.

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Acronyms

AGREE – Appraisal of Guidelines for Research & Evaluation
BCCA – BC Cancer Agency
CCOPE – Cancer Care Outreach Program on Education
CME – continuing medical education
CPAC – Canadian Partnership Against Cancer
CPG – clinical practice guideline
EMR – electronic medical records
FIT – fecal immunochemical test
FPON – Family Practice Oncology Network
GPAC – Guidelines and Protocols Advisory Committee
GPOs – general practitioners in oncology
MSP – Medical Services Plan
NICE – National Institute for Health and Care Excellence
PHSA – Provincial Health Services Authority
UBC CPD – University of British Columbia - Continuing Professional Development
WHO – World Health Organization

Executive Summary

The BC Cancer Agency is leading a multi-jurisdictional initiative to explore ways to improve the patient experience during transitions in cancer care. This 3-year initiative is entitled *Primary Care and Cancer Care Integration: Leveraging a suite of existing tools to support patients and health care professionals in the post-treatment transition period*. This clinical practice guideline evaluation serves as a key component of this initiative.

Over the past decade, the Family Practice Oncology Network (FPON) of the BC Cancer Agency has worked with the Guidelines and Protocols Advisory Committee (GPAC), a joint committee between the Doctors of BC and the Ministry of Health, to lead the development of oncology-related clinical practice guidelines for use in the primary care setting. Clinical practice guidelines play an important role in the improvement of quality of care and are a key support for physicians for evidence-based information for specific clinical conditions. They have the potential to improve communication and understanding between specialists and primary care providers, and serve to improve the overall quality of patient care. There is an increasing international focus on evaluation of guidelines for accessing quality of recommendations, and measuring the corresponding effects on health outcomes.

This goal of this evaluation was to investigate to what extent the following GPAC cancer care clinical practice guidelines are utilized in the primary care setting:

Breast Disease and Cancer

Breast Disease and Cancer – Diagnosis – October 2013
Breast Cancer: Management and Follow-up – October 2013

Colorectal Cancer

Colorectal Screening for Cancer Prevention in Asymptomatic Patients – March 1, 2013
Follow-up of Colorectal Polyps or Cancer – January 16, 2013

The objectives of this evaluation included an assessment of practitioner awareness of the guidelines, perceptions of guideline utility, as well as practitioner satisfaction with the guidelines as a clinical tool. This evaluation assessed the effectiveness of the breast and colorectal cancer guidelines in clarifying practitioner roles, and provided insight into the effectiveness of guidelines as a tool to improve the flow of information between the oncology and primary care settings. The evaluation tools included an online questionnaire and practitioner interviews. The evaluation period spanned 8 months from September 2014, to May 2015.

GPAC Breast Cancer Guidelines

The GPAC breast cancer guidelines were published in 2013. Overall most practitioners who participated in the survey indicated that they were aware of them, and most reported following the guideline recommendations when providing care for their patients. The breast cancer guidelines were considered well organized, and most primary care providers felt they could use the guidelines in their practice. Generally, most respondents felt the guidelines reflected current clinical evidence, although some felt that specific evidence was not adequately reflected in the guideline. Inclusion of current relevant evidence in the guidelines was found to be an important

theme for practitioners. Most practitioners felt the guidelines clarified the roles of primary care providers and specialists, however, only about half felt the guideline helped to improve communication of patient information between specialist and primary care providers. Reported barriers to communication included a lack of clearly defined roles in testing, treatment, follow-up and post-treatment surveillance, as well as ongoing communication barriers in shared care. Practitioners were generally satisfied with the guidelines, and most indicated that the GPAC breast cancer guidelines were their first choice in a clinical practice guideline. The majority of practitioners indicated they would be likely to refer the GPAC breast cancer guidelines to a colleague.

GPAC Colorectal Cancer Guidelines

As with the breast cancer guidelines, most practitioners were aware of the GPAC colorectal cancer-care guidelines. The majority of practitioners indicated that they follow the guideline recommendations when providing care for their patients. Roughly half of practitioners considered the colorectal guidelines very well organized, although results were mixed when primary care practitioners reported how easily the guidelines could be incorporated into practice. Although a majority of practitioners felt the guidelines reflected current clinical evidence, a number of practitioners felt that specific evidence was lacking or not adequately reflected in the guidelines. Practitioners felt the guidelines only somewhat clarify the roles of primary care practitioners, but most felt the guidelines completely clarify when to involve specialists in care. Just over a third of practitioners felt that the colorectal guidelines definitely help to improve communication of patient information between specialist and primary care providers, but a significant number felt this was not communicated sufficiently in the guideline. Barriers to communication that were not addressed in the guidelines included clarity of roles in follow-up (i.e. post-testing or post-treatment), clarity and information on when to refer, and information on the provincial colon cancer screening program. Practitioners were generally satisfied with the guidelines reporting that the quality was excellent or very good, and most indicated that the GPAC colorectal guidelines are their first choice in a clinical practice guideline. As with the breast cancer guidelines, most respondents indicated they would likely refer the GPAC colorectal cancer guidelines to a colleague.

Family Practice Oncology Network (FPON) – Continuing Medical Education

FPON's mission is to improve cancer care at the primary care level in communities throughout B.C. The Network delivers cancer care continuing medical education (CME) throughout the province that is structured around evidence-based recommendations provided in clinical practice guidelines. Guidelines and associated tools are made available at the provincial and national level, and are integral in CME training, outreach programs and educational webcasts, as well as general practitioners in oncology (GPO) training. The results of this evaluation showed that almost half of primary care practitioners in the survey had participated in some form of FPON cancer-care CME in the previous two years. It was hoped to evaluate the effect of FPON CME on guideline awareness and utilization; however, the number of participants surveyed was not sufficient to be able to make any general assessments.

Recommendations

One of the key deliverables of this evaluation was this report including actionable recommendations to share with guideline developers and stakeholders.

Recommendation 1 – Include a Statement on the Evidence Reviewed in Individual Guidelines

The results of this evaluation demonstrate that practitioner's confidence increases when they have a summary of the evidence reviewed and evaluated for individual guidelines. While not requiring the inclusion of levels of evidence, documenting the evidence review cycle on each published guideline, and incorporating a regular updates into the development cycle is expected to increase practitioner confidence. The use of the Appraisal of Guidelines for Research & Evaluation (AGREE) Instrument[1] or other standardized tool is recommended as a guideline development and evaluation tool.

Recommendation 2 – Include a Guideline Implementation Strategy for New or Revised Guidelines

Develop, standardize and implement a guideline implementation strategy in order to increase awareness and utilization of guidelines by primary care practitioners. Components of this strategy could include a comprehensive and diverse notification process when guidelines are published, incorporation of guidelines into training and CME, development of guideline point-of-care tools, and cross promotion and collaboration between guideline development organizations.

Recommendation 3 – Improve Access to Clinical Practice Guidelines

Increase accessibility by providing different formats for different audiences including mobile versions (i.e. smartphone, iPad), and incorporate guideline recommendations into coordinated point-of-care tools (e.g. electronic medical records (EMR), guideline summaries, requisitions). Ensure cross-promotion of information between provincial organizations to increase awareness and utilization of information, resources and supports across provincial programs.

Recommendation 4 – Increase Collaboration Between Specialty and Primary Care to Clarify Roles and Develop Tools to Improve Communications Around Transitions in Care

Continue to create opportunities for collaboration between provincial organizations, specialists and primary care practitioners to ensure continuity in guideline recommendations, to clarify physician roles between primary and oncology care, and to develop integrated tools that link guideline recommendations with point-of-care tools (i.e. requisitions, standardized reports, EMR). Establish linkages on partner websites to increase awareness of both primary care and specialist guidelines as well as other provincial programs for related clinical conditions.

Recommendation 5 – Integrate Guideline Development with Other Provincial Programs/Committees to Address Barriers to Implementation of Clinical Recommendations

Establish communication channels to integrate guideline development with the work of other provincial programs/committees (i.e. BC Cancer Agency Screening Programs, Shared Care Committee etc.), as the guideline development process is a key opportunity to communicate and address health care system or other barriers to implementation of clinical recommendations.

[1] AGREE II – www.agreetrust.org

Introduction

The BC Cancer Agency, as part of the Provincial Health Services Authority, provides a comprehensive cancer control program in B.C., in partnership with provincial health authorities. The mandate of the Agency is to reduce the incidence of cancer, to reduce the mortality rate of people with cancer, and to improve the quality of life for people living with cancer.

With advances in cancer care as well as increased prevalence, a growing number of patients are living well and beyond cancer treatment. The prevalence of cancer in B.C. is growing by approximately 3% per year and the survival rate for all cancers continues to increase. Approximately 65% of adults and 80% of children diagnosed with cancer are expected to live at least five years post-diagnosis.[2] There are over 200,000 cancer survivors living in B.C., and the number of survivors is expected to reach 250,000 by 2020.[2] Cancer survivors are now returning to their primary care providers in growing numbers for the management of their care. Managing the diverse and sometimes complex needs of cancer survivors presents new and growing challenges both for patients and for providers, and will require a shift in both culture and current practice for both specialty and primary care.

This project is part of a multi-jurisdictional initiative to explore ways to improve the patient experience during transitions between specialty and primary care. It is funded by the Canadian Partnership Against Cancer (CPAC) and is entitled: *Primary Care and Cancer Care Integration: Leveraging a suite of existing tools to support patients and health care professionals in the post-treatment transition period*. This clinical practice guideline evaluation represents one component of this initiative.

Guidelines serve as tools for patient and practitioner decision-making for care for specific clinical conditions and are often developed or endorsed by authoritative medical or health organizations, with an overarching goal to improve the quality and outcomes of patient clinical care. They are systematic statements that are developed based on review of the current clinical evidence and comprehensive knowledge of best practices. Practitioners have access to a growing number of clinical practice guidelines both from regional health organizations to national or international coalitions.

With the increasing availability of clinical practice guidelines there is an increasing international focus on evaluation of guidelines not only for assessment of the process guideline development and quality, but also for evaluating guideline implementation and patient outcomes. Standardized tools are available including the AGREE Instrument[3] used to evaluate guideline quality and rigour of development, and the Grading of Recommendations Assessment, Development and Evaluation (GRADE) System[4] used to evaluate the quality of evidence and the strength of recommendations. The National Institute for Health and Care Excellence (NICE) has developed a baseline assessment tool that is used to evaluate current practice when measured against

[2] Provincial Survivorship and Primary Care Program Transformational Strategy 2015-2018.
[3] AGREE II – www.agreetrust.org
[4] GRADE - www.gradeworkinggroup.org

recommendations in NICE clinical practice guidelines.[5] This tool can be adapted to include local information, and may be used to help organizations plan activity in order to meet the recommendations in the NICE guidelines.

In Canada, guideline development teams in many provinces, including Newfoundland, Nova Scotia, Ontario, and Alberta have made various efforts to evaluate the implementation of cancer care clinical practice guidelines for primary care providers. This project is an effort to do so in B.C.

The goal of this evaluation was to evaluate to what extent GPAC (BC Guidelines)[6] evidence-based guidelines for breast and colorectal cancer care are utilized in the primary care setting. This evaluation includes measures of physician awareness and use of the guidelines, as well as physician satisfaction with the guidelines as a clinical tool. The GPAC breast and colorectal cancer-care guidelines are new clinical practice guidelines published in 2013. This evaluation was a key opportunity to assess and establish a baseline to assess the effect of the breast and colorectal guidelines on physician practice. This evaluation follows on the recent notification of significant changes to the recommendations for breast screening in the province.[7] The publication of the colon cancer screening guideline was also in alignment with the introduction of the new provincial colon cancer screening program.[7] This evaluation serves as an indicator of the effectiveness of the breast and colorectal cancer screening and follow-up guidelines as a tool for health care providers supporting patients during transitions between screening, treatment and follow-up cancer care.

The strategic outcomes of this project include the evaluation of evidence-based resources and tools, the enhancement of linkages and collaboration between oncologists and primary care physicians, and the improvement of the patient experience in all aspects of survivorship. Additional objectives of this evaluation include assessment of the effectiveness of the breast and colorectal cancer guidelines in clarifying roles of oncologists and primary care physicians in screening and follow-up care, as well as insight into the effectiveness of guidelines as a tool to improve the flow of information between oncology and primary care settings. This evaluation will examine the GPAC guideline dissemination process, assess physician loyalty to the guidelines, and provide insight into the effectiveness of FPON's cancer care CME as a tool for the translating recommendations into practice.

Methods

This evaluation was designed to assess the awareness of, utility of, and satisfaction with GPAC guidelines for breast and colorectal cancer care:

Breast Disease and Cancer

i. Breast Disease and Cancer – Diagnosis – Effective Date October 1, 2013

[5] NICE – www.nice.org.uk

[6] GPAC breast and colorectal cancer clinical practice guidelines are available at BCGuidelines.ca .
[7] Current recommendations for breast and colon screening in B.C. are available at screeningbc.ca .

ii. Breast Cancer: Management and Follow-up – Effective Date October 1, 2013

Colorectal Cancer

i. Colorectal Screening for Cancer Prevention in Asymptomatic Patients – Effective Date: March 1, 2013

ii. Follow-up of Colorectal Polyps or Cancer – Effective Date: January 16, 2013

These guidelines were developed by the Guidelines and Protocols Advisory Committee (GPAC), a joint committee of Doctors of BC (formerly the B.C. Medical Association), and the B.C. Ministry of Health, and are available in electronic form on the BCGuidelines.ca website as well as through FPON on the BC Cancer Agency website.[8] The colorectal cancer guidelines were published in April 2013, and breast disease and cancer guidelines were published in November 2013.

The *World Health Organization Evaluation Practice Handbook*[9] was used to guide the planning and development of the overall evaluation, to develop the evaluation framework, and to guide preparation of the final report. This report was disseminated following an internal peer review process.

Data Collection Methods

The survey tools included an online questionnaire in order to provide primarily quantitative data (i.e. specific and measureable), and semi-structured interviews to provide qualitative data (i.e. providing insight). Additionally, data was collected from the guideline developers in order to review the guideline dissemination process and assess its contributing role in guideline awareness. The evaluation period was 8 months in length spanning from September 18, 2014, to May 26, 2015. The complete methodological approach used is available for review in the *Clinical Practice Guideline Evaluation Framework – October 1, 2014*, available from FPON (refer to Resources).

Health Care Practitioner Questionnaire

Fluid Surveys™ , an online survey software tool, was used to deliver the questionnaire to practitioners, to collect and tabulate the data, and to prepare aggregate data for analysis. The questionnaire was developed through expert consensus in consultation with key stakeholders and an evaluation methodologist in order to ensure a comprehensive, relevant, and sound methodology. Cognitive testing was used to review the design of the questionnaire to ensure that the questions aligned with the clinical or technical intent and that the questions were understood clearly by the respondents. The use of the online questionnaire allowed for delivery to practitioners across the province, facilitated collection and analysis of both quantitative and qualitative data, and allowed for anonymity of participants.

Questionnaire Design

[8] Provincial cancer-care guidelines are available at http://www.bccancer.bc.ca/health-professionals/networks/family-practice-oncology-network/guidelines-protocols .

[9] World Health Organization Evaluation Practice Handbook. World Health Organization; 2013. Available from who.int/iris/handle/10665/96311 .

Four overarching principles were built into the questionnaire design.

1. Participants were asked to provide their practitioner specialty (i.e. general practitioner (GP)/family physician (FP), general practitioner in oncology (GPO), both GP/FP and GPO, oncologist, general surgeon, nurse practitioner with a family practice, and other). An additional category of GP/FP/GPO was added for those respondents who identify with their role as both GP/FP and GPO. The results were then sorted and analyzed by specialty in order to address the specific goals of the evaluation.

2. Participants were asked if they are at least minimally aware of the GPAC guidelines developed for breast cancer or colorectal cancer, ***and*** if they provide care for patients in either of these two clinical groups. If participants were able to answer ***yes*** to both of these questions then they were asked to complete the full survey including the review of guidelines for one of the clinical conditions, as well as general clinical practice guideline questions. If participants answered ***no*** to either of these questions, they were directed to complete only the general guideline questions.

3. Both of the clinical practice guidelines under review were new guidelines published less than two years prior to delivery of the survey. In order to evaluate the influence of ***these*** specific guidelines on clinical practice, practitioners were asked if they have provided care for patients with breast/colorectal cancer (depending on the guideline reviewed) in the last 2 years, in order to address the specific goals of the evaluation.

4. Participants were asked if they have participated in any educational events hosted by FPON (e.g. Cancer Care Outreach Program on Education (CCOPE)[10] oncology webcasts, Family Practice Oncology CME Day, FPON webinars) in order to evaluate the data from the perspective of those who had already engaged in provincial clinical practice guideline-related CME compared to those who had not.

Health Care Practitioner Interviews

Physician interviews were developed as a key component of this evaluation in order to gather in-depth responses to questions. Interviews were conducted as either a follow-up to the online questionnaire or as a stand-alone interview. A BC Cancer Agency research assistant conducted the interviews by telephone or in person. The interviews were administered according to a defined protocol, and were recorded and transcribed with procedures followed to ensure confidentiality of respondents. Responses were retained and stored according to Provincial Health Services Authority (PHSA) data retention policies.

Interview Design

The interview questions were developed following the evaluation of preliminary results of the online questionnaire in order to pursue identified themes. They were developed as open-ended

[10] The CCOPE series are delivered in partnership between FPON and the University of British Columbia's Faculty of Medicine – Continuing Professional Development.

questions and were based on expert consensus. Interview participants could choose to review either the breast cancer or the colorectal cancer guidelines as part of the interview. The predominant themes explored in the interview questions included: an assessment of physician awareness of the GPAC guidelines for breast and colorectal cancer care, as well as feedback on the effectiveness of the GPAC guideline dissemination process; an assessment of the influence of the breast and colorectal guidelines on physician practice, and an assessment of physician confidence in the guidelines as effective and clinically relevant tools for practitioners. Four main questions with additional probing questions were developed by the Guideline Evaluation Working Group, and were modified for each of four categories of practitioner: primary care providers (GPs/FPs), GPOs, oncologists, and general surgeons (refer to Appendix D – Interview Questions by Clinical Specialty).

Interview Protocol

The interviews were semi-structured allowing for flexibility in questioning through the use of additional probing questions. An interview protocol was developed providing a clear guide for the interviewer, and to set the framework for providing reliable and comparable qualitative data. Participants volunteered to participate in a follow-up interview through the online questionnaire. Due to the low response rate for participation, additional physicians were asked by FPON to participate in the interviews.

Survey Implementation

The survey was implemented province-wide and was open to all physicians and nurse practitioners practicing in B.C. The questionnaire was administered to all practitioners in the same way, however, participants were not required to answer every question, but could skip forward in the questionnaire to answer the questions that were pertinent to them. The interview questions were asked based on practitioner specialty.

Participation was solicited through an article and information flyer delivered through the FPON's *Journal of Family Practice Oncology*, through general promotion at conferences,[11] through general communications by the Doctors of BC and some Divisions of Family Practice, as well as targeted communications delivered through the CCOPE oncology CME webcasts series.

Guideline Dissemination Process

GPAC provided information on the guideline review and dissemination process including specific information on the peer review process, and guideline promotion activities for the breast and colorectal cancer guidelines.

Method Limitations

The primary limitation of this evaluation was the use of a convenience sample, or rather inviting participation by an audience that is easy to reach, rather than selecting a random sample of participants. Efforts were made to deliver the survey invitations province-wide through utilization of distribution systems through the Doctors of BC, FPON's *Journal of Family Practice*

[11] BC Cancer Agency Surgical Oncology Network Fall Update (FPON Trade Booth), Family Practice Oncology CME Day, St. Paul's CME Conference for Primary Care Physicians (FPON Trade Booth).

Oncology, and some Divisions of Family Practice in order to reach the broadest audience. Additional communications were delivered through existing CME programs within FPON to investigate questionnaire responses from an audience already engaged in guideline-related CME. Although this aspect of the survey design created a possibility of bias by gathering responses from participants already engaged in cancer care CME, the Guideline Evaluation Committee felt that soliciting feedback from this specific group of practitioners provided a cancer-care perspective and overall added value to the evaluation. For these reasons, survey responses cannot be generalized or applied to the larger practitioner population in B.C.

The semi-structured interviews were developed to gather further insight from practitioners following on the launch of the questionnaire. In order to be completely objective interviews could be conducted by a third-party, however, as this evaluation was developed with the approach of added value as opposed to formalizing a scientific study, the Guideline Evaluation Committee choose to utilize existing resources and infrastructure in a cost-effective way in order to meet the overall objectives of the project.

As with the questionnaire, interview participants could volunteer either at the end of the questionnaire or by contacting the program area. If participants discontinued the questionnaire without completion they would not have an opportunity to volunteer. Much higher numbers of participants would be needed to generate enough interview participants by this method, or very low questionnaire discontinuation rates. The Committee also recognized that due to low participation rates the results couldn't be generalized or representative of any populations.

Evaluation Results

Questionnaire

Of the 179 practitioners who started the questionnaire only about 25% completed. Participants were not required to answer every question and could skip forward in the questionnaire so response numbers vary according to individual questions.

Participants were asked to review *either* the GPAC breast cancer guidelines or the colorectal cancer guidelines. If participants were not familiar with either set of guidelines, they could review general GPAC guideline questions. Most chose to review specific guidelines (137 respondents) rather than only responding to the general guideline questions (20 respondents). When asked to review either the breast cancer or the colorectal cancer guidelines, more respondents indicated they were more familiar with the colorectal cancer guidelines as compared to the breast cancer guidelines (refer to Figure 1).

Figure 1 - Which set of GPAC guidelines are you most familiar with?

Response	Chart	Percentage	Count
Breast Cancer: Diagnosis, and Management and Follow-up		26%	35
Colorectal Cancer: Screening and Follow-up		65%	89
I am not familiar with either set of guidelines		10%	13
	Total Responses		**137**

For each set of guidelines, participants were asked if they have provided care for patients for either breast or colorectal cancer over the last 2 years; 97% (of 33 respondents) confirmed providing care for breast cancer patients, and 95% (of 84 respondents) confirmed providing care for colorectal cancer patients.

Interviews

Of the 12 respondents who agreed to participate in the interviews, 7 were successful in completing the interview portion of the survey. Four participants volunteered for the interview following completion of the online questionnaire, and 3 participants were asked to participate through FPON. The majority of participants were from the Vancouver area (4), with the remainder from Victoria (1), Sooke (1), and Port Alberni (1). Participants included two GPs/FPs, a GPO, an oncologist, a radiation oncologist and two general surgeons.

Evaluation Respondents

Of the 161 respondents who indicated their specialty, most were family physicians or general practitioners (refer to Figure 2).

Figure 2 – Evaluation respondents by specialty.

Response	Chart	Percentage	Count
General Practitioner/Family Physician		67%	108
General Practitioner in Oncology (GPO)		8%	12
Both General Practitioner/Family Physician and GPO		4%	7
Oncologist		5%	8
General Surgeon		9%	15
Nurse Practitioner with a family practice		2%	3
Other, please specify...		5%	8
	Total Responses		**161**

The age range of respondents and number of years of clinical practice are indicated in the figures below (refer to Figures 3 and 4).

Figure 3 – Years of clinical practice.

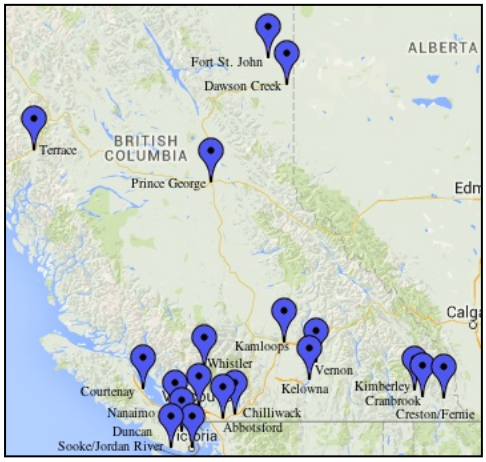
Response	Chart	Percentage	Count
15+		57%	76
5-14		25%	34
Less than 5		18%	24
	Total Responses		**134**

Figure 4 - Age ranges of respondents.

Response	Chart	Percentage	Count
56+		25%	34
46-55		27%	36
36-45		24%	32
25-35		24%	32
	Total Responses		**134**

Of those who indicated the location of their primary practice (133 respondents), the majority had practices located in the Lower Mainland of B.C. (refer to Figure 5).

Figure 5 - Geographical representation of primary practice locations of evaluation respondents.



Breast Disease and Cancer Guidelines

Awareness

Diagnosis

Of the 35 respondents who chose to review the GPAC breast cancer *Diagnosis* guideline, 34% were *extremely* or *very* familiar, 51% were *somewhat* familiar, and 14% were *slightly* or *not at all* familiar with the *Diagnosis* guideline. Of 33 respondents, 61% had read it and 24% had used it in their practice.

Management and Follow-up

Of the 28 respondents who reviewed the GPAC breast cancer *Management and Follow-up* guideline, 39% were *extremely* or *very* familiar, 46% were *somewhat* familiar, and 14% were *slightly* or *not at all* familiar with the guideline. Out of 26 respondents, 65% had read it, and 19% had used it in their practice.

Interview Feedback

Of the GPs/FPs (2 respondents) who answered questions related to awareness of the GPAC breast cancer guidelines *Diagnosis* and *Management and Follow-up*, both were aware of the guidelines and reported reviewing new GPAC guidelines when they are published; however, one respondent indicated they do not use the breast cancer guidelines as a point-of-care tool. One of the respondents had previously participated in a guideline-development working group for GPAC, and receives frequent notifications as part of GPAC's peer review process for guideline development. The other respondent referred to older forms of guideline dissemination methods that are no longer supported by GPAC (i.e. binders, iPhone app). When asked if they believe their colleagues are aware of these guidelines, one felt their colleagues were aware and the other felt that there was mixed awareness of these guidelines, adding that younger physicians (i.e. medical students, residents, those in teaching practice) are more likely to use UpToDate® or phone-based

applications, while older physicians may be more likely to directly source paper or Internet-based information. When asked what the most effective way of providing GPs with the recommendations in the breast cancer guidelines, respondents suggested using multiple electronic formats (e.g. app-based or Internet depending on the audience), sharing the information thorough appropriate organizations (e.g. FPON, B.C. Sections of Medicine), and increasing the role of guideline-based CME.

Of the specialists (2) who responded to questions related to awareness of the GPAC breast and colorectal cancer guidelines (radiation oncologist and general surgeon), neither respondent was familiar with GPAC's guidelines for breast cancer and had *limited* or *no knowledge* of GPAC guidelines as a resource of guidelines for primary care physicians. Both respondents indicated that as specialists their reliance for clinical information is with the BC Cancer Agency guidelines.

When asked what other health professionals should be aware of GPAC's breast cancer guidelines, the following suggestions were made: nurses, NPs, physiotherapists, occupational therapists and massage therapists. One specialist physician, however, felt that the most appropriate audience for these guidelines is the GP particularly for continuity of care.

When asked how FPON can support the uptake of the GPAC breast cancer guidelines for primary care providers, 1 respondent (GPO) recommended increasing the profile of FPON in the primary care community as a cancer-care resource for physicians.

Utility

Diagnosis

Participants evaluated the guidelines based on their utility for practitioners, by rating the guideline organization and the overall clarity of the recommendations. When evaluating the *Diagnosis* guideline (of 32 respondents), 63% indicated the guideline is *very* well organized, 68% (of 31 respondents) said it was *very* easy to understand, and 63% (of 30 respondents) indicated it is *very* concise.

Participants were asked to review aspects of clarity in the *Diagnosis* guideline including clarity of roles, and of communication between specialists and primary care providers. Twenty-nine participants responded with the results as follows (refer to Figures 6-8):

Figure 6 - Does the guideline clarify the role of primary care providers?

Response	Chart	Percentage	Count
Completely		52%	15
Somewhat		45%	13
Not very		3%	1
Not at all		0%	0
	Total Responses		**29**

Figure 7 - Does the guideline make it clear when to involve specialists in care?

Response	Chart	Percentage	Count
Completely		55%	16
Somewhat		45%	13
Not very		0%	0
Not at all		0%	0
	Total Responses		**29**

Figure 8 - Does the guideline help to improve communication of patient clinical information between specialists and primary care providers?

Response	Chart	Percentage	Count
Defintely helps		45%	13
Helps a little bit		24%	7
Doesn't help very much		17%	5
Doesn't help at all		3%	1
Don't know		10%	3
	Total Responses		**29**

When participants were asked to elaborate on what barriers to communication were not addressed in the guideline, one respondent reported (refer to Appendix B for a full list of comments):

"Guidelines do not clarify who should be responsible for relaying information to patients regarding results, follow-up, appointment dates, expected long-term follow-up etc. It also does not clarify when a re-referral to a specialist is indicated after the patient has been initially diagnosed and treated."

When primary care providers were asked how easily the *Diagnosis* guideline could be used in their practice, 56% of general practitioners (GPs)/family physicians (FPs) (of 18 respondents), 43% of general practitioners in oncology (GPOs) (of 7 respondents), and 100% of nurse practitioners (NPs) (1 respondent) indicated *very* easily; 44% of GPs/FPs, and 57% of GPOs indicated *somewhat* easily.

When asked if the guideline reflects current clinical evidence (28 respondents), 61% indicated *yes definitely*, 25% said *yes somewhat*, 4% said *not sufficiently*, and 11% answered *don't know*. When respondents were asked to comment on what evidence is not reflected in the guideline. The general themes raised included evidence on screening patients 40-49 years of age, the role of clinical breast examination in screening, and the use of breast cytology. One respondent submitted the following comment:

"More evidence needs to be provided regarding the high false positive rate in screening asymptomatic average risk women 40-49 years of age…. to the high negative procedure rate, and the fact that early detection does not always translate into improvements in mortality."

When GPs/FPs, GPOs, and NPs were asked if they currently follow the recommendations in the *Diagnosis* guideline when providing care for their patients, 94% of GPs (of 18 respondents), 86% of GPOs (of 7 respondents), and 100% of NPs (1 respondent) indicated *yes*; the remaining indicated *not applicable*.

Management and Follow-up

When evaluating the *Management and Follow-up* guideline, 76% (of 25 respondents) indicated the guideline is *very* well organized, 67% (of 24 respondents) said it was *very* easy to understand, and 72% (of 25 respondents) indicated it is *very* concise.

Participants were asked to review aspects of clarity in the *Management and Follow-up* guidelines including clarity of roles, and of communication between specialists and primary care providers. Twenty-five participants responded with the results as follows (refer to Figures 9-11):

Figure 9 - Does the guideline clarify the role of primary care providers?

Response	Chart	Percentage	Count
Completely		52%	13
Somewhat		40%	10
Not very		8%	2
Not at all		0%	0
	Total Responses		**25**

Figure 10 - Does the guideline make it clear when to involve specialists in care?

Response	Chart	Percentage	Count
Completely		64%	16
Somewhat		28%	7
Not very		8%	2
Not at all		0%	0
	Total Responses		**25**

Figure 11 - Does the guideline help to improve communication of patient clinical information between specialists and primary care providers?

Response	Chart	Percentage	Count
Defintely helps		52%	13
Helps a little bit		28%	7
Doesn't help very much		12%	3
Doesn't help at all		0%	0
Don't know		8%	2
	Total Responses		**25**

When asked to elaborate on what barriers to communication are not addressed in the guideline, one respondent indicated (refer to Appendix B):

"*Management is dependent on risk and family doctors should have some idea of risk/benefit of chemo/radiation adjuvants, rather than a "refer to BCAA." This is where patients are lost – the family doctor can't counsel the patient and the oncologists are overwhelmed with volume*."

When primary care practitioners were asked how easily the *Management and Follow-up* guideline could be used in their practice, 60% of GPs/FPs (of 15 respondents), 43% of GPOs (of 7 respondents), and 100% of NPs (1 respondent) indicated *very* easily; 33% of GPs/FPs, and 57% of GPOs indicated *somewhat* easily, and 7% of GPs/FPs indicating they *don't know*. The general themes raised as to why the guideline is not easily used in practice were diverse and included the length and quality of detail in the guideline, as well as the complexity of clinical management (refer to Appendix B).

When asked if the guideline reflects current clinical evidence (of 25 respondents), 64% indicated *yes definitely*, 8% said *yes somewhat,* 4% said *not at all,* and 24% indicated *don't know*.

When GPs/FPs, GPOs, and NPs were asked if they currently follow the recommendations in the *Management and Follow-up* guideline when providing care for their patients, 93% of GPs/FPs (of 15 respondents), 100% of GPOs (of 7 respondents), and 100% of NPs (1 respondent) indicated *yes*; 7% of GPs/FPs indicated *no*.

Interview Feedback

When interview respondents were asked about the influence of GPAC's breast cancer guidelines on their primary care practice, 1 physician (GP) indicated that the guidelines serve as a framework to refer to when there are controversies in care. Another physician (FP) reported using the guidelines with patients to explain the standard of care. When a physician (GPO) was asked if they believe the breast cancer guidelines have influenced the way primary care providers connect with cancer care professionals in their region they indicated *no*.

Interview respondents were asked if they have confidence in GPAC's breast cancer guidelines as high quality useful resources that reflect current evidence. Two primary care providers (GPs/FPs) and one GPO responded that they have confidence in the guidelines as a clinical tool. Clarity in presentation was reported as well done or useful by respondents particularly for recommendations around surveillance, follow-up care, complications and side effects, as well as information on clinical resources available. One GP noted the importance of updating the guidelines when evidence changes, and the necessity of an implementation strategy once the guidelines are published. One physician (GP) recommended review of the guidelines with the AGREE tool, or other standardized tool for assessing relevance, clarity and appropriateness of guidelines.

When respondents were asked for general comments to improve the guidelines, suggestions included increasing the profile of GPAC (BC Guidelines) both in response to search strategies on the Internet, as well as the availability of mobile-friendly versions (i.e. smartphone/iPad) to increase accessibility and usability. Integration of guideline-related CME to increase practical utilization of the guidelines was also recommended by a number of interview respondents.

Satisfaction

Although an indirect measure of satisfaction, participants were asked to rate the quality of the guidelines. They were also asked if the GPAC breast cancer guidelines would be their first choice for a clinical practice guideline.

Diagnosis

When participants were asked to rate the overall quality of the diagnosis guideline (of 27 respondents), 89% indicated that the quality was excellent or very good. When asked if the GPAC *Diagnosis* guideline was their first choice when using a clinical practice guideline (27 respondents), 67% indicated *yes*. When asked for the reasons why the GPAC *Diagnosis* guideline was not their first choice the reasons were varied, however, 1 respondent indicated "outdated advice on women aged 40-50" as a reason. BC Guidelines, the Canadian Task Force on

Preventative Health Care, UpToDate® and other provincial guidelines (i.e. Ontario's guidelines), were cited as sources of guidelines used for the diagnosis of breast cancer.

Management and Follow-up
When asked to rate the overall quality of the *Management and Follow-up* guideline (of 25 respondents), 88% indicated that the quality was *excellent* or *very good*. When asked if the GPAC *Management and Follow-up* guideline was their first choice (of 26 respondents), 73% indicated *yes*. When asked for the reasons why the GPAC *Management* and *Follow-up* guideline was not their first choice, one respondent added that the guideline was not complete enough.

Loyalty
An additional category of loyalty was evaluated to determine the participant's likelihood of referral of the guideline to a colleague.

Diagnosis
When asked how likely they would recommend the GPAC breast cancer *Diagnosis* guideline to a colleague, 74% (of 27 respondents) indicated *extremely or very likely*. Reasons against recommending the *Diagnosis* guideline included reasons around utility (i.e. length, current relevance) or a reliance on primary data as an alternate source of information.

Management and Follow-up
When asked how likely they would recommend the GPAC breast cancer *Management and Follow-up* guideline to a colleague, 89% (of 26 respondents) indicated *extremely or very likely*. One participant indicated they would not recommend the guideline reporting that the guideline is "long and cumbersome".

Colorectal Screening and Follow-up Guidelines

Awareness
Screening
Of the 89 respondents that reviewed the GPAC colorectal cancer *Screening* guideline, 49% were *extremely* or *very* familiar, 44% were somewhat familiar and 7% were slightly or not at all familiar with it. Of 86 respondents, between 60-65% had read it or used it in their practice.

Follow-up
Of the 75 respondents that reviewed the GPAC colorectal cancer *Follow-up* guideline, 41% were *extremely* or *very* familiar, 33% were *somewhat* familiar, and 25% were *slightly* or *not at all* familiar with the guideline. Out of 65 respondents, 59% had read it and 55% had used it in their practice.

Interview Feedback
Two specialist physicians provided feedback on the GPAC colorectal cancer *Screening* and *Follow-up* guidelines. One physician (surgeon) was aware of GPAC's colorectal guidelines, has learned about them through training of family medicine residents at the BC Cancer Agency, and had reviewed them relative to the BC Cancer agency guideline recommendations. Another

specialist physician (oncologist) was not aware of GPAC's colorectal guidelines. When asked if they believe their colleagues are aware of the guidelines, one physician (surgeon) indicated that there is a general awareness of the guidelines in family medicine residents; another physician (oncologist) indicated that their colleagues are not likely aware of these guidelines. When asked what other health professionals that should be aware of GPAC's colorectal cancer guidelines, oncologists, radiation oncologists and gastroenterologists were suggested.

When asked what would be an effective method of providing GPs with the information in the colorectal guidelines, suggestions included incorporating the guidelines into training, ensuring that the guidelines are endorsed by the appropriate organizations, and integrating of the guidelines into CME. Additionally, one physician recommended alignment between guideline recommendations and the information provided in standardized reports delivered through the BC Cancer Agency colon cancer screening program.[12] Inclusion of GPAC colorectal guidelines on the physician resources section of the screening program webpage was also recommended.

When specialist physicians were asked if they believe the GPAC colorectal cancer guidelines have influenced the way primary care providers connect with cancer care professionals in their region, both physicians (1 surgeon, 1 oncologist) responded *no*. One physician indicated that although there may be more fecal immunochemical test (FIT)-positive referrals, possibly due to general awareness in response to the colon cancer screening program, but they felt it would be difficult to determine if it was general knowledge based or guideline influenced. Another physician (oncologist) indicated that differences in clinical recommendations between the BC Cancer Agency colorectal guidelines and GPAC's guidelines create confusion between GPs and cancer care specialists.

Interview respondents were asked if they have confidence in GPAC's colorectal cancer guidelines as high quality useful resources that reflect current evidence. A surgeon felt confident with the guidelines but pointed out the need for guidelines to remain current. Recommendations included suggestions for presentation of guideline recommendations as point of care tools for physicians and patient engagement tools for follow-up care. Another physician stressed the importance of alignment between the BC Cancer Agency guidelines and GPAC's guidelines for the interpretation of the evidence and development of clinical recommendations.

When participants were asked for general comments about how to improve the guidelines, one physician recommended reviewing the evidence and updating the guidelines every 3 years. Another physician suggested the use of a point-of-care summary card of the guidelines. One physician (oncologist) stressed the importance of communicating the evidence around screening as prevention in colorectal cancer and that this evidence should be used to inform patients and physicians about the risks, benefits, and intended outcomes of screening and treatment of pre-cancerous conditions.

[12] BC Cancer Agency colon cancer screening program - www.screeningbc.ca/Colon

Utility

Screening

Participants evaluated the guideline organization and the overall clarity of the recommendations. When evaluating the colorectal cancer *Screening* guideline, 51% (of 81 respondents) indicated the guideline is *very* well organized, 56% (of 81 respondents) said it was *very* easy to understand, and 53% (of 79 respondents) indicated it is *very* concise.

Participants were asked to review aspects of clarity in the *colorectal Screening* guideline including clarity of roles, and of communication between specialists and primary care providers. Participants responded with the results as follows (refer to Figures 12-14).

Figure 12 - Does the guideline clarify the role of primary care providers?

Response	Chart	Percentage	Count
Completely		41%	32
Somewhat		58%	46
Not very		1%	1
Not at all		0%	0
	Total Responses		**79**

Figure 13 - Does the guideline make it clear when to involve specialists in care?

Response	Chart	Percentage	Count
Completely		54%	43
Somewhat		44%	35
Not very		1%	1
Not at all		0%	0
	Total Responses		**79**

Figure 14 - Does the guideline help to improve communication of patient clinical information between specialists and primary care providers?

Response	Chart	Percentage	Count
Defintely helps		31%	24
Helps a little bit		45%	35
Doesn't help very much or Doesn't help at all		19%	15
Don't know		5%	4
	Total Responses		**78**

When asked to elaborate on what barriers to communication are not addressed in the guideline, 31 respondents provided feedback (refer to Appendix B for a complete list). General themes included access to specialists for consultation; communication regarding roles in follow-up (patients with personal history, benign results, or abnormal testing); and confusion related to shared care depending on whether practitioners are generally following guideline recommendations or not. One respondent indicated:

"Specialists often will not see patients post-colonoscopy for pathology results for benign polyps. The patients don't generally come in to review the pathology with their GPs. Therefore, they are never told when they need to repeat the next colonoscopy and can easily become lost to follow-up that way."

When primary care practitioners were asked how easily the *Screening* guideline could be used in their practice, 72% of GPs/FPs (of 53 respondents), 33% of GPOs (of 3 respondents), 60% of GPS/FPs/GPOs (of 5 respondents) and 100% of NPs (1 respondent) indicated *very* easily; 28% of GPs/FPs, and 67% of GPOs, and 40% of GPOs/GPs/FPs indicated *somewhat* easily.

When asked to elaborate on why the guideline is not easy to use in practice, respondents referred to the length and complexity of presentation of recommendations, a lack of ready alignment with other tools (i.e. FIT requisition, laboratory requisition), and practical considerations related to time pressures and a lack of quick access to the guidelines (i.e. availability in EMR) (refer to Appendix B for a complete list of comments).

When asked if the guideline reflects current clinical evidence (77 respondents), 66% indicated *yes definitely*, 23% said *yes somewhat,* 1% said *not sufficiently* and 9% indicated *don't know*. Participants were asked to comment on what evidence is not reflected in the guideline. The general themes raised included questions on screening of patients with a positive family history, screening family members of patients, and reported variations on positive FIT test levels. A number of respondents questioned the clinical evidence used to make the recommendations including the following:

"Upon literature search the accuracy of using the DNA tests for detecting precancerous adenomas versus effectiveness of colonoscopies was not well developed in the guidelines. Different perspectives on approach – issue of false negatives using FIT test versus colonoscope citations were selected omitting other relevant papers."

"*Similar to mammography, the issue of lead time bias has not yet been resolved so we won't really know if we are making a difference for about another 10 years."*

When GPs/FPs, GPOs, GP/FP/GPOs and NPs were asked if they currently follow the recommendations in the *Screening* guideline when providing care for their patients, 96% of GPs (of 52 respondents), 67% of GPOs (of 3 respondents), 100% of GP/FP/GPOs (of 5 respondents) and 100% of NPs (1 respondent) indicated *yes*.

Follow-up

When evaluating the colorectal cancer *Follow-up* guideline, 47% (of 66 respondents) indicated the guideline is *very* well organized, 56% (of 66 respondents) said it was *very* easy to understand, and 60% (of 65 respondents) indicated it is *very* concise.

Participants were asked to review aspects of clarity in the *colorectal Follow-up* guidelines. Participants responded with the results as follows (refer to Figures 15-17):

Figure 15 - Does the guideline clarify the role of primary care providers?

Response	Chart	Percentage	Count
Completely		39%	25
Somewhat		60%	39
Not very		2%	1
Not at all		0%	0
	Total Responses		**65**

Figure 16 - Does the guideline make it clear when to involve specialists in care?

Response	Chart	Percentage	Count
Completely		52%	34
Somewhat		42%	28
Not very		6%	4
Not at all		0%	0
	Total Responses		**66**

Figure 17 - Does the guideline help to improve communication of patient clinical information between specialists and primary care providers?

Response	Chart	Percentage	Count
Defintely helps		41%	27
Helps a little bit		42%	28
Doesn't help very much or Doesn't help at all		14%	9
Don't know		3%	2
	Total Responses		**66**

When asked to elaborate on what barriers to communication are not addressed in the guideline, respondents indicated inconsistencies in following guideline recommended care, clear roles in follow-up care, and accessibility of specialists for consultation (refer to Appendix B for full comments). One respondent indicated:

" *Does not fully address the importance of a discharge summary and communication from oncologist at the time the patient is discharged from regular BCCA follow-up and referred back to the community*."

When primary care practitioners were asked how easily the *Follow-up* guideline could be used in their practice, 63% of GPs/FPs (of 43 respondents), 67% of GPOs (of 3 respondents), 80% of GPs/FPs/GPOs (of 5 respondents), and 100% of NPs (1 respondent) indicated *very* easily; 37% of GPs/FPs, 33% of GPOs and 20% of GPs/FPs/GPOs indicated *somewhat* easily. The general themes raised as to why the guideline is not easily used in practice included the length of the guideline and time constraints (refer to Appendix B).

When asked if the guideline reflects current clinical evidence (of 66 respondents), 62% indicated *yes definitely*, 23% said *yes somewhat,* 5% said *not sufficiently* or *not at all* and 11% indicated *don't know*. When asked to elaborate on what evidence is not in the guideline, the general themes included evidence on imaging intervals, FIT tests versus colonoscopy, and evidence on family history of polyps versus family history of colon cancer.

When GPs/FPs, GPOs, GPs/FPs/GPOs, and NPs were asked if they currently follow the recommendations in the *Follow-up* guideline when providing care for their patients, 95% of GPs (of 44 respondents), and 100% of GPOs (of 3 respondents), GP/FP/GPOs (of 4 respondents), and NPs (1 respondent) indicated *yes*; 2% of GPs/FPs indicated *no*, and 2% indicated *not applicable*.

Satisfaction

Screening

When participants were asked to rate the overall quality of the GPAC colorectal *Screening* guideline (of 75 respondents), 91% indicated that the quality was excellent or very good. When asked if the GPAC colorectal *Screening* guideline was their first choice when using a clinical practice guideline (of 74 respondents), 89% of respondents indicated *yes*. When asked for the reasons why the GPAC *Screening* guideline was not their first choice, the reasons included differences on opinion on the evidence for FIT in screening, to a reliance on the BC Cancer Agency guidelines rather than the GPAC guideline. The GPAC colorectal guideline, BC Cancer Agency guidelines and clinical peer reviewed data were the main sources of information respondents used for information on colorectal screening.

Follow-up

When asked to rate the overall quality of the GPAC colorectal *Follow-up* guideline (of 65 respondents), 88% indicated that the quality was *excellent* or *very good*. When asked if the *Follow-up* guideline was their first choice (of 65 respondents), 89% indicated *yes*. When asked for the reasons why the GPAC *Follow-up* guideline was not their first choice, a number of reasons included reliance on the BC Cancer Agency guidelines or on clinical evidence based on peer review (refer to Appendix B) as their first choice.

Loyalty

An additional category of loyalty was added to the evaluation and was determined based on the participant's likelihood of referring the guideline to a colleague.

Diagnosis

When asked how likely they would be to recommend the GPAC colorectal *Screening* guideline to a colleague (75 respondents), 87% indicated *extremely or very likely*. Reasons given for not recommending the *Screening* guideline included concerns about the interpretation of the evidence, an overestimation of the improvements in population health, and lack of access to colonoscopy for asymptomatic high-risk patients. One respondent indicated that the guideline does not refer to the provincial colon cancer screening program (refer Appendix B).

Management and Follow-up

When asked how likely they would recommend the GPAC colorectal *Follow-up* guideline to a colleague, 89% (of 64 respondents) indicated *extremely or very likely*. One respondent indicated they were not likely to recommend the guideline as the scope of considerations were not wide enough.

Family Practice Oncology Network CME

When asked if they have participated in any education events hosted by FPON (e.g. oncology webcasts, FPON CME Day, UBC-FPON Community Cancer Outreach Program on Education (CCOPE)), of 134 respondents 40% indicated *yes*, 58% indicated *no* and 2% indicated *not applicable*. When broken down by specialty 33% of GPs/FPs (of 92 respondents), 100% of GPOs (of 11 respondents), 100% of GPs/FPs/GPOs (of 5 respondents), 50% of oncologists (of 6 respondents), 0% of surgeons (of 11 respondents), and 0% of NPs (of 3 respondents) had participated in FPON CME.

GPAC Guidelines

Participants were asked a number of general questions on GPAC guidelines to assess the level of utilization and to determine practitioner's beliefs about the effect of GPAC's cancer-care guidelines on patient care.

When asked to what extent they use clinical guidelines for any condition in their practice (135 respondents), 53% of GPs/FPs (of 93 respondents), 64% of GPOs (of 11 respondents), 20% of GPs/FPs/GPOs (of 5 respondents), and 100% of NPs (of 3 respondents) indicated they *regularly* use clinical guidelines for specific conditions; 44% of GPs/FPs, 27% of GPOs, and 80% of GPs/FPs/GPOs indicated they *sometimes* use clinical practice guidelines for specific conditions. Those who *do not* use clinical practice guidelines included 3% of GPs/FPs and 9% of GPOs. Reasons for not using guidelines included accessibility, the length and presentation of information, or in some cases a lack of ongoing need after initial review.

When practitioners were asked if they believe implementation of the GPAC cancer-care guidelines will improve overall patient care (135 respondents), 66% indicated *yes significantly,* 33% indicated *yes somewhat,* and 1% indicated *no*; the respondent who indicated *no* added that the reason is because other guidelines are available.

Participants were asked to share their comments for distribution to guideline development organizations and 25 respondents provided comments. The predominant theme was the need and benefit of CME as a means for translating recommendations into clinical practice. Respondents communicated the importance of guidelines that reflect current evidence, of a need for more information on risks and benefits to therapy, and an improvement in specialist to GP knowledge translation. General comments also included recommendations for supplementing the guideline with point-of-care quick reference tools, as well as requests to have additional notifications or reminders when new guidelines are published.

Participants were asked from what sources they learn about new or updated GPAC cancer-care guidelines and they could select all that apply. Respondents cited all of the guideline distribution sources relatively evenly (refer to Figure 18).

Figure 18 - Sources utilized for new or updated GPAC cancer-care guidelines.

Response	Chart	Percentage	Count
Guidelines and Protocols Advisory Committee (GPAC)		36%	49
Family Practice Oncology Network (FPON)		39%	52
Doctors of BC		41%	55
BC Cancer Agency		48%	65
Division of Family Practice		36%	48
BC Guidelines website		36%	49
Not aware of GPAC guidelines		3%	4
	Total Responses		**135**

In order to access the effectiveness of the various communication channels, participants were asked how they learned about the questionnaire; they could check all categories that applied (refer to Figure 19).

Figure 19 - Sources of information about the FPON questionnaire.

Response	Chart	Percentage	Count
FPON *Journal of Family Practice Oncology* article		10%	13
Conference package*		11%	15
FPON webcasts or cancer care workshops (CCOPE)		11%	15
BC Cancer Agency communication		29%	39
Doctors of BC communication		25%	34
Other		26%	35
*(e.g. St. Paul's CME, SON Update, FPON CME Day)	**Total Responses**		**135**

Guideline Dissemination

GPACs guideline peer-review process also serves as a notification to practitioners of guidelines in development. Guidelines in development are distributed to a random selection of physicians in the province including GPs/FPs, specialists and key guideline stakeholders. GPAC solicits feedback through a set template based in part on the AGREE II tool focusing on the AGREE domains of clarity, applicability, and overall presentation. Feedback is reviewed and evaluated, and any changes incorporated into the final published version of the guideline.

Breast Disease and Cancer Guidelines

GPAC distributed 1037 peer review packages in April, 2013, to a random selection of 970 physicians across the province including 572 general practitioners, 292 specialists (e.g. general surgery, plastic surgery, internal medicine, radiology, nuclear medicine, hematology oncology, medical genetics, laboratory medicine, and public health), 60 members of the BC Cancer Agency breast tumour group, 46 nurse practitioners as well as 67 identified stakeholders.

GPAC published *Breast Disease and Cancer – Screening*, and *Breast Cancer – Management and Follow-up* on the BC Guidelines website in November 2013. The breast cancer guidelines were promoted at the Canadian Family Medicine Forum in November 2013, as well as various other CME events. Electronic copies of the guidelines were included in promotional material (i.e. memory sticks) distributed to international medical graduates and graduating nurse practitioners.

Colorectal Screening and Follow-up Guidelines

A total of 1095 peer review packages were mailed in May 2012, to a random selection of 700 general practitioners and 328 specialists (i.e. gastroenterology, general surgery, hematology oncology, internal medicine, laboratory medicine, medical microbiology, and radiology), as well as to 67 identified stakeholders.

GPAC published *Colorectal Screening for Cancer Prevention in Asymptomatic Patients* and *Follow-up of Colorectal Polyps or Cancer* on the BC Guidelines website in April 2013. This was followed by two broadcast messages to all physician offices that bill the B.C. Medical Services Plan (MSP) in April and May 2013. Clarification of lab testing information was published in the June 2013 Physicians' Newsletter.[13] The colorectal cancer guidelines were included in the Canadian Medical Association clinical practice guidelines database and the National Guidelines Clearinghouse in June 2013. The colorectal guidelines were promoted at the Canadian Rural and Remote conference in April 2013 and the Canadian Family Medicine Forum in November 2013. Electronic copies of the guidelines were distributed to international medical graduates and graduating nurse practitioners.

Discussion

The goal of this evaluation was to investigate how provincial evidence-based guidelines for breast and colorectal cancer care are utilized in the primary care setting. Three primary objectives of the evaluation were to determine physician awareness of the breast and colorectal cancer guidelines, to determine the utility of the guidelines as a tool for practitioners, and to evaluate physician satisfaction with the guidelines. Secondary objectives included evaluation of the guidelines as communication tools for clarifying roles and improving communications between primary care and specialists in cancer care. Finally, participation in FPON CME provided some insight into the use of cancer-care CME as a tool for implementing guidelines into primary care practice.

In the questionnaire, participants were asked if they were at least minimally aware of the breast or colorectal cancer guidelines, in order to ensure that the answers provided reflected a knowledge base that could provide specific insight into the guidelines under evaluation. With the historical awareness and promotion around breast cancer screening in the province there was an expectation that most participants would choose to review the breast cancer guidelines, however, the majority of respondents chose to review colorectal cancer. The new provincial screening program may well be a driver for general awareness of the colorectal cancer care and may have an indirect effect on the guideline awareness. There were also key differences in the guideline dissemination strategies used by GPAC that may have contributed to additional opportunities for guideline promotion with colorectal cancer care having a more comprehensive and targeted strategy.

As the guidelines were published less than 2 years prior to the delivery of this survey, it was important to survey practitioners actively providing care for either of these two patient groups in the last two years. The evaluation results provided confidence that the respondents have provided

[13] B.C. Ministry of Health, MSP Physicians' Newsletter

care after the GPAC guidelines were published, and therefore represent a relevant population to address the key questions of the evaluation.

The semi-structured interviews proved to be a useful tool for providing in-depth information on the breast and colorectal guidelines in particular, on GPAC guidelines in general, as well as insight into guideline- or system-barriers to delivering evidence-based clinical care. The interviews allowed for an assessment of how resources and tools are utilized by the practitioner community, and provided insight into how effective the guidelines are in establishing or enhancing linkages between primary and oncology care. Interpretation and general application of the results of the interviews is limited, however, due to the small number of interviews and a convenience sample selection process for participation. Additionally, a number of the practitioners interviewed were not able to provide information on GPAC's guidelines. Although this limits the application of the data, the qualitative content was felt important to include as it provided insight that would not otherwise be available for this evaluation.

It was hoped to gather responses from a wide selection of physicians in the province through communications generated through the Doctors of BC, the BC Cancer Agency, and FPONs Journal of Family Practice Oncology. Additionally, a number of communication tools available through the FPON program area were also utilized in order to solicit practitioners already engaged in guideline-related CME (e.g. FPON webcasts, CCOPE cancer-care workshops, FPON CME Day). It was recognized that this could potentially generate more respondents who may be biased towards the use of clinical practice guidelines, however, it was felt important to evaluate the responses from this group as it provided insight into responses for those engaged in cancer-care guideline-related CME.

In order to determine if there was any potential for bias against the use of clinical practice guidelines, two additional questions were added to the survey to determine to whether practitioners used guidelines at all, and whether practitioners believe guidelines improve care. None of the responses to the above screening questions revealed general bias against guidelines, however, these results must be interpreted within the limitations of the small number of respondents and of the methods used to solicit participation in the survey.

The strategy for communicating with physicians about the survey was successful and respondents indicated their participation was solicited through the various means. The BC Cancer Agency, and the Doctors of BC seemed to have the largest impact on generating survey respondents. Conference delegate packages and FPON program-related communications were also reasonably effective in soliciting participants. Out of 179 participants only 45 participants completed the entire survey, for a completion rate of 25%. With 32 questions on specific guidelines, in addition to 10 general guideline questions, the completion time was recorded at 45 minutes. Although an incentive was provided the length of the survey was likely a key factor contributing to high dropout rates.

Breast Disease and Cancer Guidelines

Most physicians reported some level of awareness of the GPAC breast cancer guidelines, with most physicians reporting that they have read them. Although a strong majority of practitioners reported following the guideline recommendations when providing care for their patients, only a small number of practitioners reporting using the guidelines in their practice. This may reflect on a stronger level of general awareness of breast clinical care, or may be indicative of the practical usability of these guidelines as point-of-care tools. Interview feedback indicated a strong level of awareness amongst primary care practitioners, however, there was mixed awareness amongst specialists with some confusion between BC Guidelines for primary care practitioners and the BC Cancer Agency guidelines.

The breast cancer guidelines were considered well organized, easy to understand and concise. Most primary care providers (GPs, FPs, GPOs, and NPs) felt that they could use the diagnosis and follow-up guidelines *very* or *somewhat* easily in their practice. Respondents provided general feedback on limitations of the usability of the *Management and Follow-up* guideline including the length and level of detail, the complexity of clinical management, or access/usability issues at the point of care. One participant recommended the use of the AGREE tool or other standardized tool for assessing relevance, clarity, and appropriateness of the breast cancer guidelines.

Although most respondents felt that the guidelines reflected current clinical evidence, some respondents felt evidence on screening patients 40-49 years of age, the role of clinical breast exam in screening, the use of breast cytology, and the risks and benefits to screening, treatment and outcomes were not adequately reflected. Interview respondents felt confident with the guidelines as clinical tools; however, the importance of updates when new evidence is available was also noted as important for gaining practitioner confidence.

The breast cancer guidelines were evaluated as tools for communicating roles, and for facilitating the exchange of patient clinical information between primary care practitioners and specialists. Most respondents felt the guidelines clarified the roles of primary care providers and specialists *completely* or *somewhat*. Although roughly half of respondents felt the guidelines *definitely help* to improve communication of patient information between specialists and primary care providers, up to one-fifth of respondents felt the guidelines do not help very much or at all. Barriers to communication were identified as a lack of clearly defined roles in testing, treatment, follow-up and post-treatment surveillance, as well as associated communication between the BC Cancer Agency, specialists and primary care practitioners.

Participants were generally satisfied with the breast cancer guidelines, with the majority of respondents rating the guidelines as *excellent* or *very good*. More than two-thirds of respondents indicated that the GPAC breast cancer guidelines were their first choice in a clinical practice guideline. An overwhelming majority indicated they would be *extremely* or *very* likely to refer the guideline to a colleague.

Colorectal Screening and Follow-up Guidelines

As with the breast cancer guidelines, the results were similar with most physicians having some level of awareness of the colorectal screening and follow-up guidelines, with roughly two-thirds of respondents reporting having read the guidelines. An overwhelming majority of respondents indicated that they currently follow the guideline recommendations when providing care for their patients. In contrast to the breast cancer guidelines, a majority of respondents reported that they use the colorectal guidelines in their practice. Only specialists interviewed for the evaluation of the colorectal guidelines and feedback indicated mixed awareness, however, the number of interviewers was too small to draw general conclusions.

Just over half of respondents indicated that the colorectal cancer guidelines were considered well organized, easy to understand, and concise. Results varied amongst primary care providers (GPs, FPs, GPOs, and NPs) as to how easily they could use the *Diagnosis* guidelines in their practice, with most GPs/Fps reporting *very* easily, and most GPOs reporting only *somewhat* easily. Most felt the *Follow-up* guidelines were *easily* incorporated into their practice, and only a third reporting *somewhat* easily. General feedback on the limitations of the usability of the colorectal cancer *Screening* guidelines was diverse, including the length and complexity of presentation, inflexible ranges for testing, a lack of ready alignment of the guideline recommendations with other tools (i.e. FIT requisition, laboratory requisition), as well as a lack of quick access to the guidelines (i.e. availability in EMR, guideline summaries, and other point-of-care tools). Limitations on the *Follow-up* guidelines included length, guideline access, and a lack of clarification on testing intervals. Respondents commented on other non-guideline related limitations including time pressures, access to specialists, and patient pressures.

Roughly two-thirds of respondents felt that the guidelines reflected current clinical evidence. A number of respondents, however, felt the evidence and recommendations around screening of family members with a positive family history of polyps, evidence on DNA testing versus colonoscopy, the issue of lead-time bias, and FIT testing levels and false positives/negatives were not adequately reflected in the guideline.

Roughly two-thirds of respondents felt the colorectal guidelines help only *somewhat* to clarify the role of primary care practitioners. More than half of respondents felt the felt the guidelines make it *completely* clear when to involve specialists in care.

When asked if the guidelines help to improve communication of patient clinical information between specialists and primary care, only about one-third felt the colorectal guidelines *definitely help*. Up to one-fifth of respondents felt the guidelines don't *help very much* or *help at all* to improve this communication. Barriers to communication were identified that indicated a need for role clarity for follow-up (post-testing or post-treatment), clarity on when to refer, and information on the provincial colon cancer screening program. Barriers not directly related to the guideline included access to specialists for urgent consults, referral priorities and wait-times for colonoscopy, the lack of a role of primary care physicians in screening and follow-up, as well as the costs of testing and treatment.

Practitioners were overwhelmingly satisfied with the colorectal cancer guidelines reporting that the quality was *excellent* or *very good,* and most indicated that the GPAC colorectal guidelines are their first choice for a clinical practice guideline. For those respondents who did not choose GPAC's colorectal guidelines, there was definitely a reliance on the BC Cancer Agency guidelines as an alternate source of information, as well as peer-reviewed clinical evidence. When asked whether they would refer the GPAC colorectal guidelines to a colleague, most respondents indicated *extremely* or *very likely*. Reasons for not recommending the guideline were related to the evidence used, including overestimations in improvement in public health, and a lack of information on the provincial colon cancer screening program. Additional reasons unrelated to the guideline were related to access to colonoscopy in B.C. for high-risk asymptomatic patients.

GPAC Guidelines

Many respondents offered suggestions on how best to provide practitioners with clinical recommendations or how to generally improve the guidelines. Suggestions included increasing the profile and availability of BC Guidelines both through the development of targeted search strategies, as well as the availability of mobile-friendly versions (i.e. smartphone/iPad). A guideline implementation strategy including promotion, training opportunities, as well as CME when a new guideline is released were identified as facilitators for integration of clinical recommendations into primary care practice. Practitioners recommended including point-of-care tools including guideline summaries, and adding guideline recommendations to the information provided in standardized reports provided by the BC Cancer Agency. Practitioners stressed the importance of including current clinical evidence, regular evidence reviews and updates, as well as including a statement as to how the evidence was gathered and evaluated. Review of the guidelines using a standardized tool such as the AGREE tool was also suggested.

FPON CME

Participation in FPON CME was determined to evaluate if participation in FPON cancer-care CME had any influence on practitioners assessment of the GPAC breast or colorectal cancer-care guidelines, particularly whether it influenced integration of the guidelines into primary care practice. FPON delivers cancer care CME throughout the province that is structured around evidence-based recommendations provided in clinical practice guidelines. Out of 135 respondents, 40% of practitioners had participated in FPON cancer-care CME. More than a third of GPs/FPs indicated participation as well as all of GPOs. Generally there was few differences in responses to the survey questions when responses were evaluated against those who said *yes* versus *no* to FPON CME, however, the small number of respondents as well as the low completion rate across the survey made it not possible to accurately evaluate this aspect of the evaluation.

Recommendations

One of the key deliverables of this evaluation was this report including actionable recommendations to share with guideline developers and stakeholders.

Recommendation 1 – Include a Statement on the Evidence Reviewed in Individual Guidelines

The results of this evaluation demonstrate that practitioner's confidence increases when they have a summary of the evidence reviewed and evaluated for individual guidelines. While not requiring the inclusion of levels of evidence, documenting the evidence review cycle on each published guideline, and incorporating a regular updates into the development cycle is expected to increase practitioner confidence. The use of AGREE II or other standardized tool is recommended as a guideline development and evaluation tool.

Recommendation 2 – Include a Guideline Implementation Strategy for New or Revised Guidelines

Develop, standardize and implement a guideline implementation strategy in order to increase awareness and utilization of guidelines by primary care practitioners. Components of this strategy could include a comprehensive and diverse notification process when guidelines are published, incorporation of guidelines into training and CME, development of guideline point-of-care tools, and cross promotion and collaboration between guideline development organizations.

Recommendation 3 – Improve Access to Clinical Practice Guidelines

Increase accessibility by providing different formats for different audiences including mobile versions (i.e. smartphone, iPad), and incorporate guideline recommendations into coordinated point-of-care tools (e.g. electronic medical records (EMR), guideline summaries, requisitions). Ensure cross-promotion of information between provincial organizations to increase awareness and utilization of information, resources and supports across provincial programs.

Recommendation 4 – Increase Collaboration Between Specialty and Primary Care to Clarify Roles and Develop Tools to Improve Communications Around Transitions in Care

Continue to create opportunities for collaboration between provincial organizations, specialists and primary care practitioners to ensure continuity in guideline recommendations, to clarify physician roles between primary and oncology care, and to develop integrated tools that link guideline recommendations with point-of-care tools (i.e. requisitions, standardized reports, EMR). Establish linkages on partner websites to increase awareness of both primary care and specialist guidelines as well as other provincial programs for related clinical conditions.

Recommendation 5 – Integrate Guideline Development with Other Provincial Programs/Committees to Address Barriers to Implementation of Clinical Recommendations

Establish communication channels to integrate guideline development with the work of other provincial programs/committees (i.e. BC Cancer Agency Screening Programs, Shared Care Committee etc.), as the guideline development process is a key opportunity to communicate and address health care system or other barriers to implementation of clinical recommendations.

Resources

BC Cancer Agency
The Agency provides the full spectrum of cancer care including prevention, screening, diagnosis, treatment and rehabilitation.
www.bccancer.bc.ca

Canadian Partnership Against Cancer
CPAC works with cancer experts, charitable organizations, governments, cancer agencies, national health organizations, patients, survivors and others to implement Canada's cancer control strategy.
www.partnershipagainstcancer.ca

Family Practice Oncology Network
FPON provides comprehensive support, and develops resources and tools for family physicians and nurse practitioners caring for cancer patients.
www.bccancer.bc.ca/health-professionals/networks/family-practice-oncology-network

Guidelines and Protocols Advisory Committee – BC Guidelines
GPAC is a joint committee between the Doctors of BC and the Ministry of Health. BC Guidelines are clinical practice guidelines and protocols that provide recommendations to B.C. practitioners for patients with specific clinical conditions.
BCGuidelines.ca

Appendices

Appendix A – Interview Participants
Appendix B – Interview Questions by Clinical Specialty
Appendix C – Questionnaire Results

Appendix A – Interview Participants

Interview No.	Specialty (GP/FP/Oncologist/Surgeon/GPO)	Location of Primary Practice	Questionnaire Participant? y/n
1	GP	Sooke, BC	y
2	FP (CCFP)	Vancouver, BC	n
3	Radiation Oncologist (CCFP, RCPSC)	Vancouver, BC	y
4	GPO	Vancouver, BC	y
5	Surgeon (RCPSC - General Surgery)	Port Alberni, BC	n
6	Surgeon (RCPSC - General Surgery)	Vancouver, BC	y
7	Oncologist (RCPSC –Internal Medicine, RCPSC – Medical Oncology)	Victoria, BC	n

Appendix B – Interview Questions by Clinical Specialty

Interview Questions	Intended Audience			
	GPs/ FPs	GPOs	Surgeons	Oncologists
Preliminary				
Just so I understand your role, can you tell me if you are fully a GPO at the BC Cancer Agency or Health Authority or whether you also work in primary care practice?		✓		
1.				
We want to make sure that the guidelines are shared widely. Please tell me a bit about your awareness of the guidelines. *or* We want to make sure that the guidelines are shared widely. Given what you know about primary care practices in your region, how do you think these guidelines are used by primary care providers?	✓	✓	✓	✓
Possible Probes:				
• How do you know about them?	✓		✓	✓
• How do you access them?	✓		✓	✓
• When do you access them?	✓		✓	✓
• Do you think your colleagues are aware of the guidelines?	✓		✓	✓
• Can you think of ways that FPON can better support uptake of these guidelines by primary care providers?		✓		
• Our current methods for sharing the guidelines are: posting them on the BC Guidelines website, promoting the guidelines through the Journal of Family Practice Oncology, and including an announcement in the Doctors of BC email blast. We also work with UBC CPD to integrate guidelines into their Cancer Care Community Workshops (CCOPE).	✓	✓	✓	✓
• Given the busy nature of a GP's office what would be an effective method of providing you with this information?	✓			
• Given the busy nature of a GP's office what do you think would be an effective method of providing GPs with this information?		✓	✓	✓
• Are there other health professionals who you think should be aware of these guidelines (e.g. emergency physicians, nutritionists?)	✓	✓	✓	✓
2.				
In what ways have the guidelines influenced your practice? *or* From your point of view, over the past couple of years since their publication, have the guidelines impacted the ways in which primary care providers connect with cancer care professionals in your region? *or*	✓	✓		

From your point of view, over the past couple of years since their publication, have the guidelines impacted the ways in which primary care providers are referring patients to you for cancer related care? *Possible Probes:* • What barriers exist that impede your following the guidelines? • What are some ways FPON could address that/these issues? • Do you see this as a positive change?	 ✓ ✓	 ✓	✓ ✓	✓ ✓
3.				
We want to ensure that GPs have confidence that the cancer-care guidelines are useful, high quality and reflect current evidence. Do you have confidence in the CPGs as a tool for GPs? *Possible Probes:* • What could we do with the guidelines to increase your confidence? • Do you agree with the key messages shared with the primary care providers?	✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
4.				
• Do you have any other comments on how we can improve the guidelines?	✓	✓	✓	✓

Appendix C – Questionnaire Results [1,2]

1. What is your specialty?

Response	Chart	Percentage	Count
General Practitioner/Family Physician		67%	108
General Practitioner in Oncology (GPO)		8%	12
Both General Practitioner/Family Physician and GPO		4%	7
Oncologist		5%	8
General Surgeon		9%	15
Nurse Practitioner with a family practice		2%	3
Other, please specify...		5%	8
	Total Responses		**161**

1. What is your specialty? (Other, please specify)

#	Response
1	GP - geriatrics
2	unspecified
3	*Suppressed**
4	Surgical Oncologist
5	GI
6	palliative
7	Nurse Practitioner working in Oncology
8	Both NP and GPO

** data suppressed to ensure anonymity of respondents*

2. Is this questionnaire for you?

Response	Chart	Percentage	Count
Yes, it is appropriate for me to complete the full questionnaire.		87%	137
No, I should not complete the full questionnaire. I will answer the general questions.		13%	20
	Total Responses		**157**

3. Which set of GPAC guidelines are you most familiar with? You can only choose one.

Response	Chart	Percentage	Count
Breast Cancer: Diagnosis, and Management and Follow-up		26%	35
Colorectal Cancer: Screening and Follow-up		65%	89
I am not familiar with either set of guidelines.		10%	13
	Total Responses		**137**

4. How familiar are you with GPAC's clinical practice guideline for *Breast Disease and Cancer – Diagnosis*?

Response	Chart	Percentage	Count
Extremely or Very		34%	12
Slightly or Not at all		14%	5
Somewhat		51%	18
	Total Responses		**35**

1. Evaluation responses also available by practitioner specialty by contacting FPON.
2. Percentages do not always add to 100% due to rounding.

5. You have indicated that you are familiar with this guideline. How are you familiar with it? (check all that apply)

Response	Chart	Percentage	Count
I heard about it through an announcement		18%	6
I know about it from others who use it		12%	4
I have read it		61%	20
I have used it in my practice		24%	8
Other		15%	5
	Total Responses		**33**

6. In the past two years have you provided care for patients with breast cancer?

Response	Chart	Percentage	Count
Yes		97%	32
No		3%	1
	Total Responses		**33**

7. Is the *Breast Disease and Cancer – Diagnosis* guideline well organized?

Response	Chart	Percentage	Count
Very		63%	20
Somewhat		38%	12
Not very		0%	0
Not at all		0%	0
	Total Responses		**32**

8. Is the guideline easy to understand?

Response	Chart	Percentage	Count
Very		68%	21
Somewhat		29%	9
Not very		3%	1
Not at all		0%	0
	Total Responses		**31**

9. Is the guideline concise?

Response	Chart	Percentage	Count
Very		63%	19
Somewhat		33%	10
Not very		3%	1
Not at all		0%	0
	Total Responses		**30**

10. Does the guideline clarify the role of primary care providers?

Response	Chart	Percentage	Count
Completely		52%	15
Somewhat		45%	13
Not very		3%	1
Not at all		0%	0
	Total Responses		**29**

11. Does the guideline make it clear when to involve specialists in care?

Response	Chart	Percentage	Count
Completely		55%	16
Somewhat		45%	13
Not very		0%	0
Not at all		0%	0
	Total Responses		**29**

12. Does the guideline help to improve communication of patient clinical information between specialists and primary care providers?

Response	Chart	Percentage	Count
Defintely helps		45%	13
Helps a little bit		24%	7
Doesn't help very much		17%	5
Doesn't help at all		3%	1
Don't know		10%	3
	Total Responses		**29**

12b. What barriers to communication are not addressed in this guideline?

There are 4 responses to this question.

12b. What barriers to communication are not addressed in this guideline?

#	Response
1	na
2	Guidelines does not clarify who should be responsible for relaying information to patients regarding results, follow ups, appointment dates, expected long term follow up etc. It also does not clarify when a re-referral to specialist is indicated after the patient has been initially diagnosed and treated.
3	Active treatments and communications between BCCA, surgeon and family doctors - which role is who's for treatment, follow-up and post-treatment surveillance?
4	Emotional/anxiety

13. How easily can you use this guideline in your practice?

Response	Chart	Percentage	Count
Very		50%	14
Somewhat		46%	13
Not very		0%	0
Not at all		4%	1
Don't know		0%	0
	Total Responses		**28**

13b. Why is this guideline not easy to use in your practice?

There are 10 responses to this question.

13b. Why is this guideline not easy to use in your practice?

#	Response
1	I work as a GPO in a cancer clinic. I think the guidline is helpful for community physicians more?
2	Too long and detailed
3	patients often have multiple questions and anxieties that make it difficult to direct and teach them.
4	I have not read the guideline, just heard about from colleaugues
5	too much
6	Already expert in field
7	Not doing primary care at the moment
8	Would have to be loaded onto the computer.
9	It is easy
10	Have to access easily during office visit - would have to create computer link

14. Does the guideline reflect current clinical evidence?

Response	Chart	Percentage	Count
Yes, definitely		61%	17
Yes, somewhat		25%	7
Not sufficiently		4%	1
Not at all		0%	0
Don't know		11%	3
	Total Responses		**28**

14b. What evidence is not reflected in the guideline?

There are 5 responses to this question.

14b. What evidence is not reflected in the guideline?

#	Response
1	More evidence needs to be provided regarding the high false positive rate in screening asymptomatic average risk women 40 to 49yr. of age. In addition, to the high negative procedure rate and the fact that early detection does not always translate into improvements in mortality.
2	Advice not to routinely screen patients 40-50
3	Haven't read it
4	Age for mammography , use of breast cytology
5	No discussion of role of CBE in screening (I am aware the evidence in this area is not spectacular)

15. Do you currently follow the recommendations in this guideline when providing care for your patients?

Response	Chart	Percentage	Count
Yes		86%	24
No		4%	1
Not applicable		11%	3
	Total Responses		**28**

16. Overall, how would you rate the quality of the *Breast Disease and Cancer – Diagnosis* guideline?

Response	Chart	Percentage	Count
Excellent or Very Good		89%	24
Good		7%	2
Fair		4%	1
Poor		0%	0
	Total Responses		**27**

17. When using a clinical practice guideline for the diagnosis of breast cancer, is this GPAC guideline your first choice?

Response	Chart	Percentage	Count
Yes		67%	18
No		15%	4
Not applicable		19%	5
	Total Responses		**27**

17b. Why do you not use the GPAC guideline as your first choice?

There are 4 responses to this question.

17b. Why do you not use the GPAC guideline as your first choice?

#	Response
1	It is one on many resources that I use. I tend to rely more on my analysis of the data in primary research articles and meta analyses rather than someone else's interpretation of the raw data.
2	Outdated advice RE women aged 40-50
3	need quick answers
4	New to me... Changing though

17c. What source do you use for guidelines for the diagnosis of breast cancer?

There are 4 responses to this question.

17c. What source do you use for guidelines for the diagnosis of breast cancer?

#	Response
1	BC guidelines Preventative task force guidelines Other provinces esp. Ontario's guidelines.
2	Canadian task force for preventative screening
3	uptodate
4	Bc guidelines website

18. How likely is it that you would recommend the GPAC Guideline for breast cancer diagnosis to a colleague?

Response	Chart	Percentage	Count
Extremely or Very likely		74%	20
Somewhat likely		19%	5
Not very likely		7%	2
Would not recommend it to a colleague		0%	0
	Total Responses		**27**

18b. What factors make you likely to not recommend this guideline?

There are 3 responses to this question.

18b. What factors make you likely to not recommend this guideline?

#	Response
1	Raw data is best.
2	long, cumbersome, outdated
3	none

19. How familiar are you with GPAC's clinical practice guideline for *Breast Cancer: Management and Follow-up?*

Response	Chart	Percentage	Count
Extremely or Very		39%	11
Slightly or Not at all		14%	4
Somewhat		46%	13
	Total Responses		**28**

20. You have indicated that you are familiar with this guideline. How are you familiar with it? (check all that apply)

Response	Chart	Percentage	Count
I heard about it through an announcement		12%	3
I know about it from others who use it		19%	5
I have read it		65%	17
I have used it in my practice		19%	5
Other		4%	1
	Total Responses		**26**

21. Is the *Breast Cancer: Management and Follow-up* guideline well organized?

Response	Chart	Percentage	Count
Very		76%	19
Somewhat		20%	5
Not very		4%	1
Not at all		0%	0
	Total Responses		**25**

22. Is the guideline easy to understand?

Response	Chart	Percentage	Count
Very		67%	16
Somewhat		29%	7
Not very		4%	1
Not at all		0%	0
	Total Responses		**24**

23. Is the guideline concise?

Response	Chart	Percentage	Count
Very		72%	18
Somewhat		24%	6
Not very		4%	1
Not at all		0%	0
	Total Responses		**25**

24. Does the guideline clarify the role of primary care providers?

Response	Chart	Percentage	Count
Completely		52%	13
Somewhat		40%	10
Not very		8%	2
Not at all		0%	0
	Total Responses		**25**

25. Does the guideline make it clear when to involve specialists in care?

Response	Chart	Percentage	Count
Completely		64%	16
Somewhat		28%	7
Not very		8%	2
Not at all		0%	0
	Total Responses		**25**

26. Does the guideline help to improve communication of patient clinical information between specialists and primary care providers?

Response	Chart	Percentage	Count
Defintely helps		52%	13
Helps a little bit		28%	7
Doesn't help very much		12%	3
Doesn't help at all		0%	0
Don't know		8%	2
	Total Responses		**25**

26b. What barriers to communication are not addressed in this guideline?

There are 3 responses to this question.

26b. What barriers to communication are not addressed in this guideline?

#	Response
1	Management is dependent on risk and the family doctors should have some idea of risk/benefit of chemo/radiation adjuvants rather than a "refer to BCAA". This is where patients are lost - the family doctor can't counsel the patient and the oncologists are overwhelmed with volume
2	Actually contacting the surgeon by phone
3	Compound risk factors for complications and long term side effects and a priority list of possible long term side -effects

27. How easily can you use this guideline in your practice?

Response	Chart	Percentage	Count
Very		52%	13
Somewhat		40%	10
Not very		0%	0
Not at all		4%	1
Don't know		4%	1
	Total Responses		**25**

27b. Why is this guideline not easy to use in your practice?

There are 6 responses to this question.

27b. Why is this guideline not easy to use in your practice?

#	Response
1	Long and cumbersome
2	patients who experience side effects of tamoxifen or other estrogen blocking agents are difficult to help. they overestimate the risks of osteoporosis or endometrial cancer. hot flushes and fatigue and chemo brain and low libido are huge issues post treatment. Very difficult to manage.
3	Don't needit
4	I refer patients back to their FP to for main followup
5	Not complete and detailed enough
6	It is easy

28. Does the guideline reflect current clinical evidence?

Response	Chart	Percentage	Count
Yes, definitely		64%	16
Yes, somewhat		8%	2
Not sufficiently		0%	0
Not at all		4%	1
Don't know		24%	6
	Total Responses		**25**

28b. What evidence is not reflected in the guideline?

There are no responses to this question.

29. Do you currently follow the recommendations in this guideline when providing care for your patients?

Response	Chart	Percentage	Count
Yes		88%	22
No		4%	1
Not applicable		8%	2
	Total Responses		**25**

30. Overall, how would you rate the quality of the *Breast Cancer: Management and Follow-up* guideline?

Response	Chart	Percentage	Count
Excellent or Very Good		88%	22
Good		4%	1
Fair		8%	2
Poor		0%	0
	Total Responses		**25**

31. When using a clinical practice guideline for the management and follow-up of breast cancer, is this GPAC guideline your first choice?

Response	Chart	Percentage	Count
Yes		73%	19
No		8%	2
Not applicable		19%	5
	Total Responses		**26**

31b. Why do you not use the GPAC guideline as your first choice?

There is 1 response to this question.

31b. Why do you not use the GPAC guideline as your first choice?

#	Response
1	Not complete enough

31c. What source do you use for guidelines for the management and follow-up of breast cancer?

There is 1 response to this question.

31c. What source do you use for guidelines for the management and follow-up of breast cancer?

#	Response
1	CS4

32. How likely is it that you would recommend the GPAC Guideline for *Breast Cancer: Management and Follow-up* to a colleague?

Response	Chart	Percentage	Count
Extremely or Very likely		89%	23
Somewhat likely		8%	2
Not very likely		0%	0
Would not recommend it to a colleague		4%	1
	Total Responses		**26**

32b. What factors make you likely to not recommend this guideline?

There is 1 response to this question.

32b. What factors make you likely to not recommend this guideline?

#	Response
1	Long and cumbersome, + oncologist should be trouble-shooting chemo s/e's

33. How familiar are you with GPAC's clinical practice guideline for *Colorectal Screening for Cancer Prevention in Asymptomatic Patients?*

Response	Chart	Percentage	Count
Extremely or Very		49%	44
Slightly or Not at all		7%	6
Somewhat		44%	39
	Total Responses		**89**

34. You have indicated that you are familiar with this guideline. How are you familiar with it? (check all that apply)

Response	Chart	Percentage	Count
I heard about it through an announcement		21%	18
I know about it from others who use it		15%	13
I have read it		61%	52
I have used it in my practice		64%	55
Other		4%	3
	Total Responses		**86**

35. In the past two years have you provided care for patients with colorectal cancer?

Response	Chart	Percentage	Count
Yes		95%	80
No		5%	4
	Total Responses		**84**

36. Is the *Colorectal Screening for Cancer Prevention in Asymptomatic Patients* guideline well organized?

Response	Chart	Percentage	Count
Very		51%	41
Somewhat		47%	38
Not very		3%	2
Not at all		0%	0
	Total Responses		**81**

37. Is the guideline easy to understand?

Response	Chart	Percentage	Count
Very		56%	45
Somewhat		44%	36
Not very		0%	0
Not at all		0%	0
	Total Responses		**81**

38. Is the guideline concise?

Response	Chart	Percentage	Count
Very		53%	42
Somewhat		44%	35
Not very		3%	2
Not at all		0%	0
	Total Responses		**79**

39. Does the guideline clarify the role of primary care providers?

Response	Chart	Percentage	Count
Completely		41%	32
Somewhat		58%	46
Not very		1%	1
Not at all		0%	0
	Total Responses		**79**

40. Does the guideline make it clear when to involve specialists in care?

Response	Chart	Percentage	Count
Completely		54%	43
Somewhat		44%	35
Not very		1%	1
Not at all		0%	0
	Total Responses		**79**

41. Does the guideline help to improve communication of patient clinical information between specialists and primary care providers?

Response	Chart	Percentage	Count
Defintely helps		31%	24
Helps a little bit		45%	35
Doesn't help very much or Doesn't help at all		19%	15
Don't know		5%	4
	Total Responses		**78**

41b. What barriers to communication are not addressed in this guideline?

There are 31 responses to this question.

41b. What barriers to communication are not addressed in this guideline?

#	Response
1	If I need an urgent consult with a specialist, how do I do that?
2	Im not sure if I like that my patients gets assigned to a random surgeon. I like to follow up and refer patients myself.
3	importance of comorbidities and psychosocial factors in deterermining appropriate course of action
4	Specialists often will not see patients post-colonoscopy for pathology results for benign polyps. The patients don't generally come in to review the pathology with their GPs. Therefore, they are never told when they need to repeat the next colonoscopy and can easily become lost to follow-up that way.
5	None
6	no guidance in terms of referal priority.. i.e. urgent vs Routine
7	Relative availability of specialists and responsiveness.
8	Often older healthy asymptomatic patients outside of the current screening guidelines have to wait a long time before getting a colonoscopy for a positive FIT
9	Getting in touch with a specialist on the pnone
10	If specialist not following the guidelines as well sometimes their recommendations cause confusion.

11	I think the barriers I've encountered are trying to expedite the consult appointment for someone with a positive FIT test AND symptoms. The Colon Screening Program currently has long waits, and I find that as a family physician, I'm put in the awkward position where my patient is waiting a long time (16 weeks the last time i phoned!) from the time they hear they have blood in the stool to the time they're triaged. I find that I have to go out of the program to expedite consults on patients i am worried about.
12	responsibility for who is to inform and followup a patient's abnormal tests
13	access to specialists for colonoscopy following abn screening is getting worse: longer wait times
14	Access to specialized care
15	Follow up of pts with personal history - how often and when to refer back to specialist; any further diagnostics while waiting for specialist appointment
16	work flow and accessibility of specialists, but I don't think this is something that can be addressed in a guideline
17	Patients are sometimes referred outside their geographical area for colonoscopy after positive FIT. Makes for somewhat difficult follow-up for an identified cancer as they have to/choose to see a local specialist for surgery.
18	Vagueness on role of flex sig. More detail on BCCA colorectal screening should be in
19	BCCA colon screening program is not mentioned in this.
20	time line from positive FIT to colonoscopy
21	Lack of communications with GPs. Not enough advertisements for GPs about the screening program.
22	long wait if pt. has positive FIT
23	Locally we have tremendous barriers with our specialist colleagues which are not guideline solveable issues but are being approached by the Shared Care Committee
24	Unsure
25	often unclear when one has booked and delay from scope to Surg and Tx post op
26	None
27	It is within the text when to refer, but this should be highlighted or set apart to make it more obvious. Also would be helped by including a flowchart to accompany the text
28	Timing of colonscopy and referral to GI specialists
29	the recent move to bypass primary care physicians from the screening process makes no sense - we have to order the test but do not have a role in following it up - makes no sense
30	a guideline doesn't get back communicators to be better. It does allow a GP to have some "ammunition"in talking with specialists that aren't helpful.
31	Cost of testing and treatment.

42. How easily can you use this guideline in your practice?

Response	Chart	Percentage	Count
Very		69%	53
Somewhat		27%	21
Not very		0%	0
Not at all		3%	2
Don't know		1%	1
	Total Responses		**77**

42b. Why is this guideline not easy to use in your practice?

There are 17 responses to this question.

42b. Why is this guideline not easy to use in your practice?

#	Response
1	the document is too long. Should be much simpler with a more straight-forward algorithm.
2	I think it would be easiest to follow the guideline if the FIT requisition was on the same sheet as the guideline-- that way I would not have to go find the guideline to check how often to screen. Even on the lab req it could say next to the box... do every so many years in asymptomatic patient. A 1 page summary would be useful. A poster for the office would be good- 81/2 by 11- laid out so patients could read it too. My patients would be able to say- hey I was just reading your colon screening poster and I think I should do that, or I had a colonoscopy 5 years ago and it says i should do it again.
3	Busy with the stream of work so do not look that kind of thing up. Just use the knowledge I have.
4	I still do many of my own FOB and refer self.
5	Time constraint
6	practical considerations - would like to be able to access from within emr
7	Less accessible, no quick reference
8	the guidelines for cut off ages are not flexible
9	Patients have a pre-determined idea of what investigation they want to have, no matter what you recommend.
10	My practice is colorectal surgery so I am referred patients with positive screening results. I do not do screening myself (except colonoscopy depending on FIT test and symptoms)
11	I work on a referral basis, so I know the guidelines, but I am dependent on the gatekeepers, that is the family docs to follow the guidelines.
12	Poor access to specialists
13	In a busy general practice many issues crowd the agenda so that discussion of cancer screening may not receive attention
14	it is
15	Have to log off and log in again, this is time consuming
16	as previously stated
17	too long

43. Does the guideline reflect current clinical evidence?

Response	Chart	Percentage	Count
Yes, definitely		66%	51
Yes, somewhat		23%	18
Not sufficiently		1%	1
Not at all		0%	0
Don't know		9%	7
	Total Responses		**77**

43b. What evidence is not reflected in the guideline?

There are 12 responses to this question.

43b. What evidence is not reflected in the guideline?

#	Response
1	What do I do with patients who have a positive family history in a second- or third-degree relative?
2	I'm not familiar enough with the topic to comment.
3	False positives
4	flex sig + barium
5	There is differences between provinces about what a +ve FIT test level is - I guess time will tell in BC.
6	What is evidence for screening family members with colonic polyps?
7	Upon literature search the accuracy of using the DNA tests for detecting precancerous andenomas vs effect9veness of colonoscopies was not well developed in the guidelines. Different perspectives on approach - issue of false negatives using fit test vs colonscope citations were selected omitting other relevant paPERS
8	Adenoma de
9	FIT screening is not appropriate for screening cool-rectal cancer. It is political and economical decision, and has nothing to do with clinical based evidence.
10	similar to mammography, the issue of lead time bias has not yet been resolved, so we won't really know if we are making a difference for about another 10 years
11	family history of polyps not taken into consideration for screening colonoscopies
12	What are the screening guidleines for patients who have a first degree relative with adenomous polyps under the age of 50 but without diagnosis of CRC?

44. Do you currently follow the recommendations in this guideline when providing care for your patients?

Response	Chart	Percentage	Count
Yes		91%	68
No		5%	4
Not applicable		4%	3
	Total Responses		**75**

45. Overall, how would you rate the quality of the *Colorectal Screening for Cancer Prevention in Asymptomatic Patients* guideline?

Response	Chart	Percentage	Count
Excellent or Very good		91%	68
Good		7%	5
Fair		3%	2
Poor		0%	0
	Total Responses		**75**

46. When using a clinical practice guideline for colorectal screening for cancer prevention in asymptomatic patients, is this GPAC guideline your first choice?

Response	Chart	Percentage	Count
Yes		89%	66
No		8%	6
Not applicable		3%	2
	Total Responses		**74**

46b. Why do you not use the GPAC guideline as your first choice?

There are 5 responses to this question.

46b. Why do you not use the GPAC guideline as your first choice?

#	Response
1	I use BCCA colon cancer guidelines
2	I usually go to the BC cancer agency website and look at their screening guidelines for various cancers. I feel that's the source everyone goes to, not just GPs.
3	FIT screening is not appropriate for screening agent for colorectal cancer prevention, based on level one evidence. Screening colonoscopy is a better modality.
4	The BC guidelines are good and they are my first choice. On this particular topic I have not heard of disagreement between different guidelines.
5	Unsure

46c. What source do you use for guidelines for colorectal screening for cancer prevention in asymptomatic patients ?

There are 5 responses to this question.

46c. What source do you use for guidelines for colorectal screening for cancer prevention in asymptomatic patients ?

#	Response
1	I use BCCA colon cancer guidelines
2	the BC cancer agency guidelines http://www.bccancer.bc.ca/HPI/CancerManagementGuidelines/Gastrointestinal/05.Colon/5.1+Screening.htm
3	Clinical and peer reviewed data
4	I've been ordering stool OB on all my asymptomatic low risk patients over the age of 49 every year or two for years. I do rectal exams on the men. In Victoria, the Colon Cancer Screening program is well organized and they have given us lots of information.
5	BC guidelines

47. How likely is it that you would recommend the GPAC Guideline for *Colorectal Screening for Cancer Prevention in Asymptomatic Patients* to a colleague?

Response	Chart	Percentage	Count
Extremely or Very likely		87%	65
Somewhat likely		8%	6
Not very likely		5%	4
Would not recommend it to a colleague		0%	0
	Total Responses		**75**

47b. What factors make you likely to not recommend this guideline?

There are 8 responses to this question.

47b. What factors make you likely to not recommend this guideline?

#	Response
1	I think in BC there is still a lack of access for asymptomatic patients that want to be screened by colonoscopy. Many patients that are not "high risk" would be found early if they had access to this. In the USA it is the standard to have a colonoscopy. I find it very frustrating to explain to people that the FIT test is the best I can provide if they're low risk, even though they could very well have polyps or cancer and not know it. The wealthy people (not many in my practice) I can send preferentially for private screening and it i am really inspired I can phone and beg a favor from a surgeon but I can't do that every day.
2	It wouldn't come up in conversation. We already know how to deal with these patients and are more likely to discuss topics that are a challenge.
3	DOes not make reference to BCCA colon screening program
4	Not a good guideline, based on current level one clinical evidence.
5	My colleagues should already know this
6	It's easier to Google "BC Guidelines."
7	Other options
8	Overestimates the improvement in population health

48. How familiar are you with GPAC's clinical practice guideline for *Follow-up of Colorectal Polyps or Cancer.*

Response	Chart	Percentage	Count
Extremely or Very		41%	31
Slightly or Not at all		25%	19
Somewhat		33%	25
	Total Responses		**75**

49. You have indicated that you are familiar with this guideline. How are you familiar with it? (check all that apply)

Response	Chart	Percentage	Count
I heard about it through an announcement		20%	13
I know about it from others who use it		23%	15
I have read it		59%	38
I have used it in my practice		55%	36
Other		3%	2
	Total Responses		**65**

50. Is the *Follow-up of Colorectal Polyps or Cancer* guideline well organized?

Response	Chart	Percentage	Count
Very		47%	31
Somewhat		52%	34
Not very		2%	1
Not at all		0%	0
	Total Responses		**66**

51. Is the guideline easy to understand?

Response	Chart	Percentage	Count
Very		56%	37
Somewhat		44%	29
Not very		0%	0
Not at all		0%	0
	Total Responses		**66**

52. Is the guideline concise?

Response	Chart	Percentage	Count
Very		60%	39
Somewhat		40%	26
Not very		0%	0
Not at all		0%	0
	Total Responses		**65**

53. Does the guideline clarify the role of primary care providers?

Response	Chart	Percentage	Count
Completely		39%	25
Somewhat		60%	39
Not very		2%	1
Not at all		0%	0
	Total Responses		**65**

54. Does the guideline make it clear when to involve specialists in care?

Response	Chart	Percentage	Count
Completely		52%	34
Somewhat		42%	28
Not very		6%	4
Not at all		0%	0
	Total Responses		**66**

55. Does the guideline help to improve communication of patient clinical information between specialists and primary care providers?

Response	Chart	Percentage	Count
Doesn't help very much or Doesn't help at all		14%	9
Defintely helps		41%	27
Helps a little bit		42%	28
Don't know		3%	2
	Total Responses		**66**

55b. What barriers to communication are not addressed in this guideline?

There are 17 responses to this question.

55b. What barriers to communication are not addressed in this guideline?

#	Response
1	Does not fully address the importance of a discharge summary and communication from Oncologist at the time the patient is discharged from regular BCCA followup, and referred back to the community.
2	need a way of being able to ask specialists questions over the phone more easily
3	We don't refer our own patients.
4	None
5	not sure
6	Communication with specialists is not addressed in this document.
7	Usually I look for guidance from the Gastroenterologist after a colonoscopy is done. Usually, the GI specialist will state when he/she wants the patient to repeat a colonoscopy depending on the results of the scope. It is usually not my call as a GP
8	who is responsible for the followup any abnormal tests
9	The guidelines suggest follow-up CT abdomen and Chest every 6-12 months, but which one is it 6 or 12 months? Who organizes this test? The oncologist is recommending 12 months for CT abdomen but didn't order a CT chest....now what?
10	variation in quality of colonoscopies and information provided back hinder veffectivev use of the guideline
11	n/a
12	long wait times for colonoscopy
13	Same issues as previously mentioned-our colleagues were not open to communication and are barely accessible now.
14	difficult to ensure steps are followed by others
15	again the role of the primary care physician for rereferral is not clear
16	the specialists don't all follow the guidelines e.g. to return patients to GP for follow up
17	When BCCA will hand over follow-up to community physicians. Reporting tools and statistical collection in not outlined.

56. How easily can you use this guideline in your practice?

Response	Chart	Percentage	Count
Very		65%	42
Somewhat		34%	22
Not very		0%	0
Not at all		2%	1
Don't know		0%	0
	Total Responses		**65**

56b. Why is this guideline not easy to use in your practice?

There are 11 responses to this question.

56b. Why is this guideline not easy to use in your practice?

#	Response
1	somewhat long to remember
2	I'm sure I have answered this question.
3	Time constrainrs
4	access

5	usually the follow up falls within the GI specialist's role, and I, as a GP, make sure that followup is done, but it is usually the specialist that is dictating how and when followup should occur.
6	needs clarification on interval between follow-up scans.
7	it is fine.
8	n/a
9	As before
10	accessing it
11	Not defining handover from BCCA to community

57. Does the guideline reflect current clinical evidence?

Response	Chart	Percentage	Count
Not sufficiently or Not at all		5%	3
Yes, definitely		62%	41
Yes, somewhat		23%	15
Don't know		11%	7
	Total Responses		**66**

57b. What evidence is not reflected in the guideline?

There are 7 responses to this question.

57b. What evidence is not reflected in the guideline?

#	Response
1	False positives
2	don't know
3	Effectiveness of the various fit tests compared to colonoscopy in detecting precancerous polyps and false negs and pos of detection can confound issues; guideline supports the system and
4	interval of imaging increased to annually for 5 years rather than q6 months x3 years - this is per Cancer Care Ontario & ASCO guidelines, adapted to BCCA guidelines
5	figure 1 on natural history should be updated to reflect outcome by cancer stage
6	FIT is not a good screening agent for cool-rectal cancer prevention. Screening colonoscopy is the best agent for asymptomatic patient over 50.
7	family history of polyps not taken into account (only FHx of colon cancer)

58. Do you currently follow the recommendations in this guideline when providing care for your patients?

Response	Chart	Percentage	Count
Yes		92%	60
No		5%	3
Not applicable		3%	2
	Total Responses		**65**

59. Overall, how would you rate the quality of the *Follow-up of Colorectal Polyps or Cancer* guideline?

Response	Chart	Percentage	Count
Excellent or Very good		88%	57
Good		11%	7
Fair		2%	1
Poor		0%	0
	Total Responses		**65**

60. When using a clinical practice guideline for the follow-up of colorectal polyps or cancer, is this GPAC guideline your first choice?

Response	Chart	Percentage	Count
Yes		89%	58
No		9%	6
Not applicable		2%	1
	Total Responses		**65**

60b. Why do you not use the GPAC guideline as your first choice?

There are 5 responses to this question.

60b. Why do you not use the GPAC guideline as your first choice?

#	Response
1	I use BCCA guideline
2	again, usually the GI specialist is directing followup care.
3	Is not in line with most current BCCA guidelines
4	i am not a family practice physician
5	Not a very good screening program.

60c. What source do you use for guidelines for the follow-up of colorectal polyps or cancer?

There are 5 responses to this question.

60c. What source do you use for guidelines for the follow-up of colorectal polyps or cancer?

#	Response
1	I use BCCA guideline
2	BCCA guidelines, or rely on the GI specialist to inform me of what followup is required
3	BCCA guidelines, adapted from Cancer Care Ontario & ASCO
4	i use the colorectal surgery guideline which is essentially the same
5	Clinical evidence based on peer reviewed published data.

61. How likely is it that you would recommend the GPAC Guideline for *Follow-up of Colorectal Polyps or Cancer* to a colleague?

Response	Chart	Percentage	Count
Extremely or Very likely		89%	57
Somewhat likely		6%	4
Not very likely		5%	3
Would not recommend it to a colleague		0%	0
	Total Responses		**64**

61b. What factors make you likely to not recommend this guideline?

There are 3 responses to this question.

61b. What factors make you likely to not recommend this guideline?

#	Response
1	See previous answer
2	n/a
3	Scope of considerations not wide enough

[General Guideline Questions] 62. To what extent do you use clinical practice guidelines for any condition in your practice?

Response	Chart	Percentage	Count
Regularly or Sometimes		96%	130
I do not use clinical practice guidelines		4%	5
	Total Responses		**135**

62b. Why don't you use clinical practice guidelines?

There are 4 responses to this question.

62b. Why don't you use clinical practice guidelines?

#	Response
1	I reference them to learn about conditions but do not access them in any ongoing way. I don't know if reading them once counts as "using" them or not.
2	Not easily accessible until today. I didn't know they existed.
3	Too long and wordy. Hard to get at. App is fair
4	I keep up to date on the particular diseases I treat and don't find guidelines helpf

63. Do you believe that the implementation of the GPAC guidelines for cancer care in the primary care practice setting will improve overall patient care?

Response	Chart	Percentage	Count
Yes, significantly		66%	89
Yes, somewhat		33%	45
No		1%	1
	Total Responses		**135**

63b. You answered that you do not believe that the implementation of the GPAC guidelines for cancer care in the primary care practice setting will improve overall patient care. Please explain:

There is 1 response to this question.

63b. You answered that you do not believe that the implementation of the GPAC guidelines for cancer care in the primary care practice setting will improve overall patient care. Please explain:

#	Response
1	Because there are other guidelines available

64. In the last two years, have you participated in any education events hosted by the Family Practice Oncology Network (FPON) (e.g. Oncology Webcasts, FPON CME Day, UBC-FPON Community Cancer Outreach Program on Education (CCOPE))?

Response	Chart	Percentage	Count
Yes		40%	54
No		58%	78
Not applicable		2%	2
	Total Responses		**134**

65. From what source do you learn about new or updated GPAC guidelines for cancer care? (Check all that apply)

Response	Chart	Percentage	Count
Guidelines and Protocols Advisory Committee (GPAC)		36%	49
Family Practice Oncology Network (FPON)		39%	52
Doctors of BC		41%	55
BC Cancer Agency		48%	65
Division of Family Practice		36%	48
BC Guidelines website		36%	49
Not aware of GPAC guidelines		3%	4
	Total Responses		**135**

66. How many years have you been practicing?

Response	Chart	Percentage	Count
15+		57%	76
5-14		25%	34
Less than 5		18%	24
	Total Responses		**134**

67. What are the first three digits of the postal code where your main practice is located?

*Suppressed**

** data suppressed to ensure anonymity of respondents*

68. What is your age?

Response	Chart	Percentage	Count
56+		25%	34
46-55		27%	36
36-45		24%	32
25-35		24%	32
	Total Responses		**134**

69. How did you learn about this questionnaire? (check all that apply)

Response	Chart	Percentage	Count
FPON *Journal of Family Practice Oncology* article		10%	13
Conference package (e.g. St. Paul's CME, SON Update, FPON CME Day)		11%	15
FPON webcasts or cancer care workshops (CCOPE)		11%	15
BC Cancer Agency communication		29%	39
Doctors of BC communication		25%	34
Other		26%	35
	Total Responses		**135**

70. Please write in any additional comments you would like to share with the guidelines development organizations.

There are 25 responses to this question.

70. Please write in any additional comments you would like to share with the guidelines development organizations.

#	Response
1	Keep up the good work!
2	a one page summary chart that can be posted on the wall for easy reference
3	Guidelines are a useful resource, but they are not something I use on a day to day basis. Sometimes if BC guidelines are behind the times (e.g. - breast cancer screening, Pap smear starting age), I may step outside the guidelines.
4	Having a cme thru divisions of fp would be helpful
5	To be most effective guidelines must be kept simple and embedded in our brains with the actual guideline for reference. Behavioral change in our daily habits is more important but harder to implement than the writing of the guideline. I suggest 5% effort on development and 95% on facilitating physician behavioral change (eg CCOPE nights). I appreciate the effort and production of this well made guideline
6	The Yearly Oncology Day conference is excellent and I would highly recommend it to all family doctors!
7	I need to review the guidelines periodically - difficult to remember the specifics.
8	My main issue is having access to these guidelines "at my fingertips"
9	These guidelines are useful as it gives a FP a map and allows the patient to understand why we are doing things in a certain way
10	Guidelines need to be very short, bullets are good. Otherwise i dont read them esp in the office.
11	I wish I knew about the colon cancer follow up guideline earlier! They are very valuable to my practice -- it would be great to have these advertised more overtly (and then to have a reminder they are there in case one misses the first email/mail out). I have been mostly relying on specialists' advise post-colonoscopy on when to repeat the colonoscopy, but this helps me to be more well-informed.
12	For the patient to be able to make informed consent; for pt to follow the guideline, the pt should be aware of the risks, benefits and alternatives to screening: fit, follow-ups, timing, vs colonoscopy vs doing nothing ie the benefits of early or late detection to the pt
13	The key thing missing as a specialist is knowlege translation to GPs. Referrals for colonoscopy that do nkt follow guidelines. GPs make pts have expectation they needa scope. Very time consuming explaining guidelines plus waste of referral.
14	Division of Family Practice
15	Learned via Divisions Victoria
16	*Suppressed**
17	advice on the nuts and bolts of using guidelines in busy office setting might help. It is not so much the quality of the guideline as it is the ability of the physician to make one's practice guideline based that matters.
18	I believe the family doctors should have more access to risks and benefits to adjuvant therapy in breast cancer. Patient's find chemotherapy difficult and don't understand often the side effects or that they can make their own choices about therapy following mastectomy/lumpectomy. A one-visit with oncologist isn't really enough and the family doctor should have enough info to counsel the patients
19	Years of practice last option should be >30years?

20	I hope med students and residents are explicitly taught about these guidelines.
21	Excellent work and wonderful initiative. This will form a foundation and support for ancillary work for the future. Well done!
22	came from UBC family medicine
23	I mostly get confused about the guidelines for use of tamoxifen and AI's - this is individualized per pt
24	Guidelines are just that guidelines and should not be a substitute to good clinical medicine. Some of the rectal cancers present earlier then the guidelines get implemented which can lead to delayed diagnosis and management.
25	Please review the options for years in practice - one is 15-29 years and one is >20 years

** data suppressed to ensure anonymity of respondents*