DEVELOPMENT AND APPLICATION OF IMPLEMENTATION TOOLS FOR REHABILITATION GUIDELINES

Raija SIPILÄ, MD, PhD1, Marja MIKKELSSON, MD, PhD2, Mari HONKANEN, MSocSci3, Antti MALMIVAARA, MD, PhD1,3 and Jorma KOMULAINEN, MD, PhD1

From the 1The Finnish Medical Society Duodecim, Current Care Guidelines, Helsinki, 2Joint Authority for Päijät-Häme Health and Social Care, Lahti and 3Centre for Health and Social Economics, National Institute for Health and Welfare, Helsinki, Finland

Objective: To describe a project to develop guideline implementation tools (GItools) for rehabilitation guidelines, and a collaboration between a guideline producer and a healthcare organization to implement guidelines into care pathways.

Design: Descriptive case study.

Methods: A national guideline organization in Finland launched a 3-year project in 2015 to implement rehabilitation recommendations. Usability of the GItools was evaluated and improved, based on literature, workshops and surveys. An implementation plan guided the production of the GItools. An implementation plan was developed to integrate the shoulder disorders guideline into a care pathway at Päijät-Häme district rehabilitation unit. The implementation plan was produced in 3 facilitated workshops, which included brainstorming, snowballing, prioritizing and short lectures.

Results: Twenty implementation plans and 119 different GItools for 22 guidelines were developed. The GItools, in particular patient material, were perceived as useful for the facilitation of guideline implementation. Four seminars and 14 sessions of continuous medical education were arranged. A plan was developed and executed for the implementation of the shoulder disorders guideline.

Conclusion: It is feasible for a guideline producer to systematically include GItools into rehabilitation guidelines. This implementation project was an example of a successful collaboration between a guideline producer and a healthcare organization.

Key words: rehabilitation; guideline adherence; implementation science.

Accepted Aug 21, 2019; Epub ahead of print XX, 2019

J Rehabil Med 2019; 51: 00–00

Correspondence address: Raija Sipilä, The Finnish Medical Society Duodecim, Current Care Guidelines, PO Box 713, FI-00101 Helsinki, Finland. E-mail: raija.sipila@duodecim.fi

The Institute of Medicine (IOM) defines clinical practice guidelines as “statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options” (1). Clinical guidelines usually include recommendations on diagnosis and treatment. In Finland, it has been acknowledged that national Current Care (CC) Guidelines do not systematically include rehabilitation. Therefore, in 2012 a 3-year project was launched to include rehabilitation into the CC Guidelines (1, 2).

Knowledge transfer is the continuum from evidence development (research) to active implementation of the new evidence in practice (3, 4). Different stakeholders are engaged during the process of knowledge transfer. The guidelines are a bridge between research findings and implementation. However, guideline recommendations do not translate into clinical practice without effort. Diffusion is the first step, during which active recipients search for the information they need. In the second step, dissemination, the message is tailored to meet the needs of the target group. The third step is to use active methods for implementation (Fig. 1).

The actual implementation (4–6) of guidelines ideally happens within healthcare organizations, because success is dependent on the context; there are local barriers and facilitators for change. Guideline developers, however, can facilitate adaptation. One method is to develop guideline implementation tools (GItools). GItools can be categorized into patient support (information and guideline summaries in lay language, self-management support), clinician
support (guideline summaries, algorithms, forms or checklists), implementation support (training material, other resources), and evaluation support (audit tools, other measures) (7). Desirable features for GItools have been surveyed (8).

CC Guidelines have previously included GItools, but the development of these tools has been based more on the resources available than on the needs of healthcare providers or patients. An implementation strategy for CC Guidelines was formulated in order to make implementation activities more structured and target-oriented. Implementation was made more structured by recognizing up to 5 of the most important recommendations to be implemented when there was new evidence or a known evidence-practice gap. Based on these implementation aims, an implementation plan was made for each guideline. The plan included the GItools to be developed, communication activities, and possible educational efforts.

As rehabilitation was embedded into the guidelines, a new 3-year project for the implementation of rehabilitation recommendations was launched at the beginning of 2015. The aims of the project were to develop and publish GItools for rehabilitation guidelines, as well as to implement guidelines for seamless care pathways, and thus improve the health of the population. The current article describes the GItools, how those tools were evaluated by healthcare professionals, and the implementation of a seamless pathway.

For this project, guideline topics were specifically selected to include diseases that significantly decrease patients’ ability to function and work (musculoskeletal system, depression, and neurological diseases). The project was divided into 2 sections. The first section, targeted at healthcare professionals, was composed mainly of the development of GItools and arrangement of educational seminars. The second section targeted healthcare organizations. Thus, organizational partners were sought to plan actual implementation activities.

**GItools and educational activities**

A clinician summary and a plain language summary for patients were compiled for each CC Guideline. Optional GItools included press releases, slide presentations, clinical algorithms, performance measures, resources for patients and caregivers (information, self-management resources), as well as resource-planning guides. During the project GItools were selected for each guideline based on the implementation aims. Rehabilitation was emphasized, if relevant for the guideline topic, and described in an implementation plan. In addition, podcasts on clinician summaries and videos were added to the GItools repertoire. Videos consisted of short lectures, interviews or demonstrations of rehabilitation methods.

One national and 4 regional continuous medical education (CME) events are arranged annually in Finland. For these events, CC Guideline working groups offered CME sessions on guideline topics relevant to rehabilitation according to the implementation plan. In addition, separate yearly rehabilitation seminars were planned.

In order to facilitate shared decision-making, the content of guideline patient summaries was revised. Literature and other guideline organizations’ patient summaries were reviewed, and opinions of the CC website (https://www.kaypahoito.fi/) users...
In the second phase, the target groups for each aim, barriers to and objectives for change were identified, prioritized and categorized. Snowballing, prioritizing and short lectures were used. First, the facilitated by RS. Methods such as brainstorming, discussion, CC (RS) was set up to plan the implementation project. Of 6 professionals from the health district and a facilitator from the administration of Päijät-Häme primary healthcare, and specialized healthcare. Implementation of the Current Care pathway according to the recently published CC Guideline. Inhabitants. The rehabilitation unit operates in both primary care and specialized healthcare, and the rehabilitation unit. One follow-up meeting was organized (November 2016). A group consisting of 6 professionals from the health district and a facilitator from CC (RS) was set up to plan the implementation project.

The implementation plan was developed during 3 workshops facilitated by RS. Methods such as brainstorming, discussion, snowballing, prioritizing and short lectures were used. First, the objectives for change were identified, prioritized and categorized. In the second phase, the target groups for each aim, barriers to and facilitators of change, as well as possible means (interventions) to drive change, were identified. In the third phase, interventions were selected, areas of responsibility and roles were designated, and schedule was decided. If you prefer finalized, it is suitable for us.

RESULTS

GItools and educational activities

During the project, 22 rehabilitation-related new or updated guidelines were published. For 20 of these, an implementation plan was recorded. Various web materials, as well as patient summaries, slide presentations and videos including rehabilitation-related materials, were developed and published (Table I).

The GItools comprised evaluation of rehabilitation needs and methods, including medical as well as vocational rehabilitation. Many of them included information on the ability to function and ability to work, psychosocial treatment and psychotherapies, non-pharmacological treatment, patient self-care guidance, as well as lifestyle changes. Some GItools included information on rehabilitation plans, therapeutic exercises, the different roles of healthcare professionals, group coaching on coping with disability and rehabilitation organizers.

Among the 50 responses to the questionnaire, these GItools were perceived to be quite good for facilitating guideline implementation (mean 3.6–4.1 on a scale from 1 to 5 for various GItools). Furthermore, it was perceived that the GItools should be included in the future (Likert scale from 1 (negative) to 5 (positive)). Number of answers 50

Table I. Guideline implementation tools (GItools) developed during the project. All included rehabilitation-related themes

<table>
<thead>
<tr>
<th>GItool</th>
<th>Description of the tool</th>
<th>Number of tools developed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient summary</td>
<td>A plain language short version of the guideline</td>
<td>15</td>
</tr>
<tr>
<td>Slide presentation</td>
<td>A set of slides that can be used by healthcare professionals to learn and to educate others</td>
<td>15</td>
</tr>
<tr>
<td>Video</td>
<td>Short lectures or demonstration of rehabilitation methods</td>
<td>9</td>
</tr>
<tr>
<td>Diagram</td>
<td>Interactive or plain flow charts on diagnostics, treatment or rehabilitation</td>
<td>6</td>
</tr>
<tr>
<td>Clinical pathway</td>
<td>Flow charts on treatment and rehabilitation pathways. Does not include work tasks of different professionals</td>
<td>5</td>
</tr>
<tr>
<td>Podcasts</td>
<td>Podcasts on clinician or patient summaries</td>
<td>3</td>
</tr>
<tr>
<td>Other web materials</td>
<td>Information for patients and their carers, self-management support, influence of the disease according to ICF framework</td>
<td>44</td>
</tr>
<tr>
<td>Performance measures</td>
<td>Descriptions of recommended performance measures</td>
<td>22</td>
</tr>
</tbody>
</table>

ICF: International Classification of Functioning, Disability and Health.
guidelines (mean 3.8–4.4) (Table II). Patient material was rated as the most useful tool.

A total of 4 educational seminars were arranged during the project, with 610 professionals attending. The first, entitled “From patient to a rehabilitee – from rehabilitee to coping with the illness” explored prevention of youth marginalization, rehabilitation of musculoskeletal disorders and the organization of rehabilitation. The topics of the other seminar were cardiac rehabilitation, treatment of musculoskeletal problems and the organization of rehabilitation. The topics of the other seminar were cardiac rehabilitation, treatment of musculoskeletal problems and the organization of rehabilitation. The topics of the other seminar were cardiac rehabilitation, treatment of musculoskeletal problems and the organization of rehabilitation. The topics of the other seminar were cardiac rehabilitation, treatment of musculoskeletal problems and the organization of rehabilitation.

Feedback from participants was mainly positive regarding the usefulness of topics and the content of the 4 seminars arranged during the project. On a scale from 1 (disagree) to 5 (agree), the mean value for the majority of lectures was greater than 4.

### Table III. Example of the description of the implementation objectives

<table>
<thead>
<tr>
<th>Principal objectives</th>
<th>Who has to change practice?</th>
<th>Expected change in practice</th>
<th>Barriers to change</th>
<th>How to put the change into practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rehabilitation</strong></td>
<td>Patient</td>
<td>Engage to self-care and rehabilitation</td>
<td>Lack of motivation</td>
<td>Leaflet to patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Laziness</td>
<td>Active follow-up of response to exercise</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pain</td>
<td>Good pain treatment</td>
</tr>
<tr>
<td></td>
<td>Physicians</td>
<td>Guide self-care methods to patient</td>
<td>Lack of knowledge</td>
<td>Possibility to contact professionals easily</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Organize follow-up of self-care</td>
<td>Lack of knowledge</td>
<td>Group interventions (group exercise for patients with musculoskeletal problems, individualized exercise in small groups)</td>
</tr>
<tr>
<td></td>
<td>Physicians</td>
<td>Understand the meaning of rehabilitation</td>
<td>Lack of knowledge of local care pathway</td>
<td>Multifaceted education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Refer to physiotherapist timely</td>
<td>Attitudes</td>
<td>To make an agreement on work distribution between physicians and physiotherapists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guide patients to self-care methods</td>
<td>Lack of knowledge</td>
<td>Multifaceted education</td>
</tr>
<tr>
<td></td>
<td>Professional or physiotherapists</td>
<td>Guide patients to self-care methods and make an agreement with patient how to carry the programme out</td>
<td>Lack of co-operation</td>
<td>To make an agreement about work distribution between physicians and physiotherapists, and about procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Organize follow-up of self-care</td>
<td>Abilities to motivate</td>
<td>Multifaceted education</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hurry</td>
<td>Multifaceted education</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Structures and procedures</td>
<td>Multifaceted education</td>
</tr>
</tbody>
</table>

### Implementation of seamless care pathways

The group that prepared the implementation of the CC guideline on shoulder tendon disorders held 5 meetings between June 2016 and March 2017. The group identified important objectives of change and how these aims could be put into practice. They divided the aims into 4 categories: diagnostics, pain treatment, rehabilitation, and the care pathway. In addition, the aims were prioritized.

Progressive, systematic, timely, and sufficiently long-lasting therapeutic exercise period for patients with shoulder tendon problems was identified as the most important implementation theme. Engagement of patients with self-care was perceived as another important rehabilitation-related implementation aim. The group defined the aims in a table, including target group, barriers and facilitators, and possible means (interventions) to drive change. As an example, Table III

### Table IV. Agreed actions to implement the Current Care Guideline on shoulder tendon problems

<table>
<thead>
<tr>
<th>What to be done</th>
<th>Who is responsible?</th>
<th>Schedule</th>
<th>Present state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model of care for working aged patients with musculoskeletal diseases</td>
<td>Chief of physiotherapy and physician from the primary healthcare named by the group responsible for implementation</td>
<td>Starting in Spring 2017, ready in 2018</td>
<td>Underway</td>
</tr>
<tr>
<td>Agreement and documentation of work distribution between physicians and physiotherapists, and of procedures</td>
<td>Chief of physiotherapy and physician from the primary healthcare named by the group responsible for implementation</td>
<td>Spring 2017</td>
<td>Done</td>
</tr>
<tr>
<td>Planning and starting the group physiotherapy</td>
<td>Chief of physiotherapy and physician from the primary healthcare named by the group responsible for implementation</td>
<td>Spring 2017</td>
<td>Done</td>
</tr>
<tr>
<td>Education in multiprofessional small groups addressed to primary care physicians and physiotherapists</td>
<td>Chief of physiotherapy and physician from the primary healthcare named by the group responsible for implementation</td>
<td>Autumn 2017 to Spring 2018</td>
<td>Underway</td>
</tr>
<tr>
<td>Agreement and documentation of how to consult</td>
<td>Chief of physiotherapy and physician from the primary healthcare named by the group responsible for implementation</td>
<td>Spring 2017</td>
<td>Underway</td>
</tr>
<tr>
<td>Leaflet for patients about self-care</td>
<td>Chief of physiotherapy and physician from the primary healthcare named by the group responsible for implementation</td>
<td>Spring and Autumn 2017</td>
<td>Underway</td>
</tr>
</tbody>
</table>
shows the rehabilitation-related objectives for change. The implementation plan template is shown in Appendix SI. The group decided on the steps, responsibilities, and timetable for implementation, and how to follow and measure change. Table IV shows the agreed actions.

The new generic model of care for patients with musculoskeletal diseases was developed and published on the CC website (https://www.kaypahoito.fi/). Materials for patients and the education were produced. Four different multidisciplinary education sessions were organized between October 2017 and February 2018, with an orthopaedic surgeon, a physiatrist, 2 physiotherapists and a facilitator acting as instructors. Each session included lectures, as well as hands-on education on diagnostic tests and therapeutic exercises in which a physician and a physiotherapist worked as a pair. The generic model of care for patients with musculoskeletal diseases was introduced. In addition, self-care instructions were gathered and tips for motivating the patients were shared. There were 74 participants, 40 of whom were physicians and 34 were physiotherapists. An electronic feedback questionnaire was sent to the participants after the sessions; however, only 27% responded. The majority of respondents found the sessions useful. Respondents also stated that they were committed to changing their behaviour concerning shoulder tendon disorders. Respondents expressed gratitude specifically for the hands-on sessions on diagnostics and exercises.

An important part of implementation is to follow how change occurs. The group described the objectives of change and possible measures for change. For example, to measure the objective “timely given, systematically and progressively executed and long enough therapeutic exercises in degenerative tendon problems”, the following measures were identified: exercise groups established (yes/no), number of participants, time on "waiting list", Western Ontario rotator cuff-index in use, number of sick-leave days due to shoulder problems, and electronic training diary in use (yes/no). However, the group recognized several barriers to the use of these measures. For example, problems in obtaining reports from electronic health records were found to be an important barrier.

**DISCUSSION**

Based on our experience, it is feasible for a guideline producer to achieve systematic inclusion of rehabilitation into guidelines and thereafter into GItools. We successfully forged co-operation between a guideline producer and a healthcare organization in a local implementation project, although some difficulties occurred in following the scheduled timetable.

This project lacks data on the effectiveness of our GItools. Based on the questionnaire, however, the GItools, particularly the patient versions and information for patients, were well received and considered useful. According to a Cochrane Review, a GItool developed by the guideline producers may moderately increase adherence to the guidelines (9). However, there was a limited number of randomized controlled trials (RCTs), and there was variation in the clinical conditions, types of healthcare professionals included in the studies, types of behaviour targeted, and the GItools. Due to this heterogeneity, it was not possible for the Cochrane Review to draw conclusions about the comparative effectiveness of GItools.

Implementation interventions are often complex. Theory-based careful planning is therefore crucial, particularly with complex interventions, such as implementation of seamless care pathways (5). To plan the implementation project we used a similar theory-based structured approach as that used by French et al. (10). This process began with asking the question “Who needs to do what differently?”, followed by barrier identification, selection of intervention components and planning of evaluation. The last additional step was the planning of responsibilities and drafting a schedule. Implementation at the local level facilitates the identification of aims and barriers, and offers expertise on facilities and resources (4, 6, 11, 12).

Based on our analysis of aims and barriers, we chose a multifaceted intervention. Although there is no solid evidence that multifaceted interventions are more effective than single ones, multifaceted interventions allow targeting several barriers and persons at different stage of change at the same time (11). Intervention components consisted of using the services of opinion leaders, interprofessional mixed educational sessions, and dissemination of guideline-based materials. These intervention components have proven to have a small-to-moderate effect on guideline implementation.

Educational meetings alone, or combined with other interventions, can improve professional practice and healthcare outcomes for patients. However, educational meetings should not be used alone when the aim is to change complex behaviour. When using educational interventions, mixed interactive and didactic education meetings are the most effective educational interventions, although the effect is small-to-moderate (13). Studies have shown variable effects for interprofessional education interventions. It may be beneficial to include attendees from a single organization. According to our feedback the attendees felt that the presence of both physicians and physiotherapists was
an advantage, and provided the opportunity to get to know each other. In addition, the interactive part of sessions was acknowledged. Interventions may have a different effect on different professionals. There is a lack of evidence on whether any single active knowledge transfer intervention improves the knowledge of physiotherapists, but there is strong evidence to suggest that an active multi-component knowledge transfer intervention leads physiotherapists to change their practice behaviour, compared with passive dissemination (14).

The use of opinion leaders alone or in combination with other interventions may successfully promote evidence-based practice, but effectiveness varies between studies (15). These results are based on heterogeneous studies that differ in terms of the type of intervention included, the setting and outcomes measured. In most of the studies the role of the opinion leader was not clearly described, and it is therefore not possible to determine the best way to optimize the effectiveness of opinion leaders.

Commitment from management is essential for successful implementation (16, 17). One of the reasons for piloting this project in Päijät-Häme was, that primary and specialized healthcare, including rehabilitation, were parts of the same organization, so it was easy to obtain commitment to the project from administration and management. However, the fusion of 3 different primary healthcare organizations and specialized healthcare into a single large organization was carried out in 2017. This resulted in difficulties in keeping to the planned timetable. In addition, a new electronic health record system caused several problems in clinical work. Professionals (both physiotherapists and physicians) had multiple new factors to adapt to. This may have disadvantaged the implementation of the CC Guideline on shoulder tendon disorders. On the other hand, the new organization enhanced the possibilities of uniting care pathways, as all physiotherapists were under the same management. Bekkering et al. found, in 2003 in a study of physiotherapy guidelines on low back pain, that the most important discrepancies between current practice and recommendations of guidelines were problems in co-operation between referring physician and physiotherapists, and knowledge or skills of the physiotherapists. In order to create permanent change in how shoulder tendon disorders are rehabilitated, more extensive education of physiotherapists on musculoskeletal diseases may be needed. This was started in 2018 and continued up to the Spring of 2019. In addition to good co-operation with physicians, who should refer patients to physiotherapy when needed, a seamless shoulder tendon disorder care pathway requires knowledge and commitment from other professionals, such as nurses who conduct the triage of patients when patients contact healthcare.

The current study has several limitations. It is a case study, a description of our project. The implementation of rehabilitation of shoulder tendon problems in Päijät-Häme district is continuing and the final results are not yet available.

Implementation of rehabilitation has distinctive features. A multidisciplinary team includes several professionals and the process may take place at one or multiple levels, as well as in different organizations. Rehabilitation is often a long process, but it is dependent on the right timing, good collaboration, continuing assessment and evaluation, clear goals and commitment from the rehabilitation. It is essential to understand that implementation of rehabilitation is not easy, and requires enough time. There is limited evidence to recommend one knowledge translation strategy over another among allied health professions (19), working together for a common goal. However, it is evident that RCTs will never be able to produce evidence of effectiveness of implementation for different rehabilitation contexts. Therefore observational effectiveness data from clinical registers, including electronic health records, will also be needed (20, 21). High competence of staff and the use of the best available scientific evidence will probably lead to the best implementation results in a particular clinical and organizational context.

**ACKNOWLEDGEMENT**

This study was funded by the Social Insurance Institute of Finland.

The authors have no conflicts of interest to declare.

**REFERENCES**