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**Background** Most existing centres for health technology assessment (HTA) are associated with payers or government agencies, and review and analyse emerging and costly technologies. Yet, such centres can exist within individual medical centres as well, and can use HTA methods locally to synthesise, disseminate and implement best clinical practices to improve the quality, safety and value of patient care.

**Objectives** Describe the structure, processes and outcomes of a model of hospital-based HTA (HB-HTA) in the US, such that it can be applied elsewhere.

**Methods** Our academic medical centre established the centre for Evidence-based Practice (CEP) in 2006. CEP synthesises guidelines and studies for clinical and administrative leaders to inform decision-making, integrates select syntheses into practice through clinical decision support (CDS), and provides education in evidence-based practice. Local utilisation and cost data are incorporated where appropriate.

**Results** Nearly 200 evidence reports have been completed to date, and over 35 reports have been integrated into CDS. The median time from project opening to first draft is 4 weeks. CEP also contracts with external organisations such as the CDC and AHRQ on systematic reviews and guidelines.

**Discussion** To complete reviews rapidly, we work closely with requestors to define the questions up front and limit the scope, use experienced analysts to perform high yield searches with single study reviews and extraction, and use best available evidence and existing guidelines and reviews.

**Implications for Guideline Developers/Users** An HB-HTA centre can develop, adapt and implement guidelines locally to support a culture of evidence-based practice and decision-making.

## 069 FACILITATING IMPLEMENTATION OF GUIDELINES FOR THE PREVENTION OF VASCULAR DISEASE IN GENERAL PRACTICE

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**Background** Although evidence based guidelines have been developed and disseminated, up to a half of patients do not receive guideline based preventive care.

**Objectives** This study aims to evaluate a model for the implementation of preventive care guidelines in general practice.

**Methods** Following a development process for the intervention involving a mixed method study and a pilot carried out in three practices a cluster randomised controlled trial is being conducted in 31 practices across four states. The intervention involves training, preventive care audit, and visits from a facilitator based in

the local primary care support organisation. The facilitator assists practices to review their clinical audit and implement a practice plan structured around the 5As to improve the reach and quality of preventive care. Quantitative and qualitative evaluation methods are being used to assess impact on planned change within the practice, recalled and recorded preventive care, and patient behaviours and risk factors for cardiovascular disease.

**Results** Baseline data collection has been completed from practice staff and patients and the intervention is now complete. The recorded and patient recalled preventive care varied within and between practices resulting in a varied set of priorities for improvement. Early findings suggest that facilitation visits to review and plan improvements to the implementation of preventive guidelines are feasible, acceptable and can support organisational strategies to address gaps in care.

**Discussion** Our results may provide a model for local primary care support organisations to assist practices to improve their quality of preventive care.

## 070 STRATEGIES FOR HEALTH SYSTEM IMPLEMENTATION OF GUIDELINES ON OVERWEIGHT AND OBESITY

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**Background** Evidence-based clinical practice guidelines (CPGs) for adult obesity and overweight provide recommendations to clinicians on interventions for weight loss and maintenance. organisation-wide implementation of these guidelines is critical to achieve changes in practice and patient health outcomes.

**Context** To describe novel guideline implementation strategies used by a large US health care organisation to improve the care of obese and overweight adults.

**Description of Best Practice** An evidence-based CPG was developed to address management strategies for a rapidly increasing number of obese and overweight patients. Interventions aimed at practitioner, patient and systems levels were tailored to facilitate implementation of CPG recommendations. Practitioner interventions included basic knowledge dissemination via electronic distribution of CPGs, presentation of CPGs at clinician champions' meetings; and development of point-of-care job aids, such as in-clinic access to online CPGs and office prompts to refer obese patients to weight management classes. Patient-level interventions included proactive outreach for health education classes and telephone-based coaching; point-of-care educational publications; and after-visit summaries with weight management recommendations. Interventions at the systems level included proactive office encounter recording of patient BMI and exercise regimen; clinical performance goals; reporting of health outcomes of participants in weight management programmes; and, a physician continuing medical education (CME) course. Continued improvements in clinician/patient communication about weight, collection of patient weight information, and patient health outcomes have been observed.

**Lessons for Guideline Developers, Adaptors, Implementers, and/or Users** Novel approaches to integrating guidance on the management of obesity and overweight into practice can achieve significant changes in clinical practice and patient health outcomes.