Barriers to Implementing Recommendations in LMICs

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KDIGO Implementation Conference, Bangkok, June 19-21, 2015

Clinical Practice Guidelines

Systematically developed statements, to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances

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Guidelines do not implement themselves

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Change management

We must remember that there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its outcome than to take the lead in introducing a new order of things.

Because the innovator has for enemies all those who have done well under the old order, and lukewarm defenders among those who may do well out of the new.

Machiavelli, The Prince

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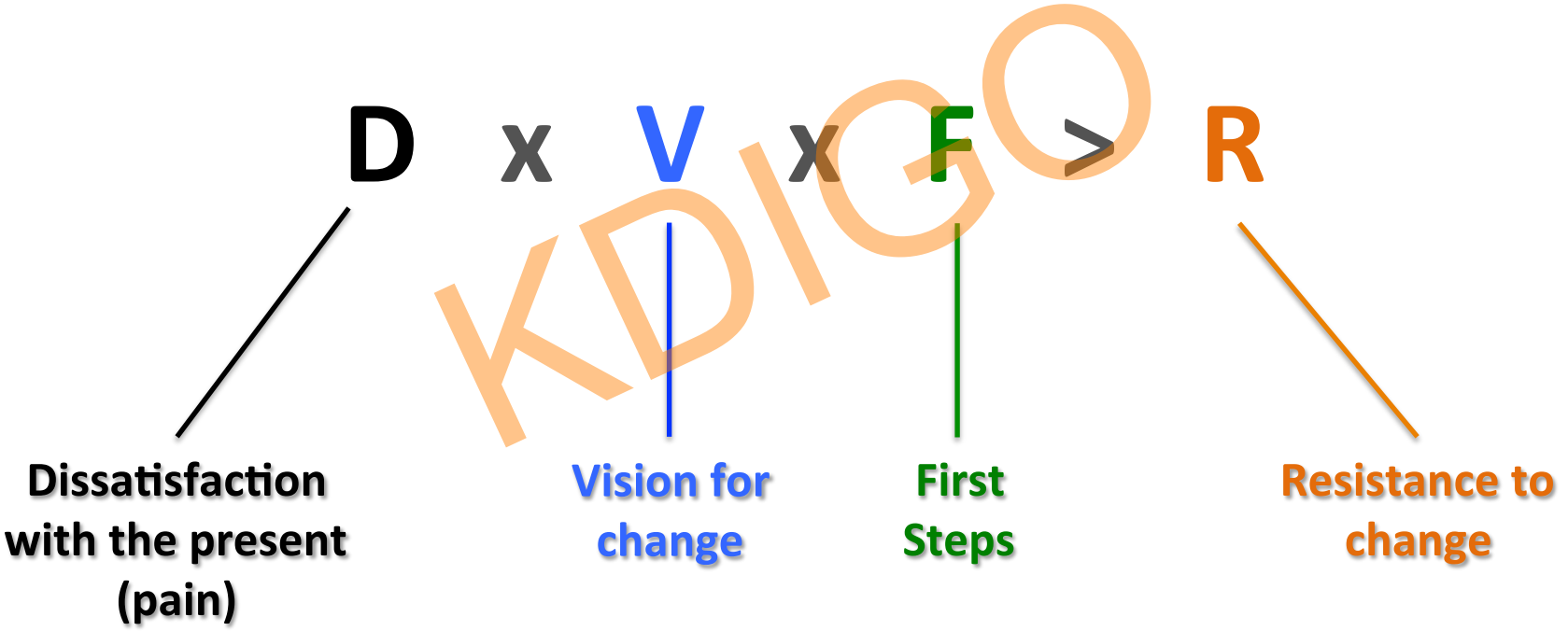
The Beckhard-Harris Change Model

conditions necessary for change to occur



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DVF at two levels

Requirements for System Change

Acceptance of the need for organizational change	Understanding and acceptance of where the organization is headed	Understanding and acceptance of the plan for achieving the vision
Dissatisfaction	**Vision**	**First Steps**
Acceptance of the need for personal change in behaviour	understanding and acceptance of their new role and/or behaviour	understanding and acceptance of specific steps s/he must take to adopt new roles and behaviours

Requirements for Personal Change

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Barriers to implementation

Internal

related to the guideline itself

External

related to the clinical environment and particular local circumstances

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Internal Barriers

- Ethnic and genetic variations
  - HIVAN
  - disease behavior in different races/ethnicities
- Differences in disease characteristics
  - Differences in CKD causes
  - Proteinuric v non-proteinuric diseases

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External barriers

- Structural factors
  - financial disincentives
- Organizational factors
  - inappropriate skill mix
  - lack of facilities or equipment
- Peer group
  - local standards of care not in line with desired practice
- Individual factors
  - knowledge attitudes, skills
- Professional - patient interaction
  - problems with information processing.

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Regional variations in health status

Life expectancy	Asian countries	Chinese province	Indian state
>80	Japan, Korea, Singapore, Australia		
75 – 79.9		Shanghai, Beijing	Kerala
70 – 74.9	Malaysia, Vietnam, Sri Lanka	Zhejiang, 20 others	Punjab
65 – 69.9	Philippines, Thailand, Indonesia, Bangla Desh	Inner Mongolia, 6 others	Maharashtra, 5 others
60 – 64.9	Laos, Myanmar, Pakistan	Tibet	AP, 7 others

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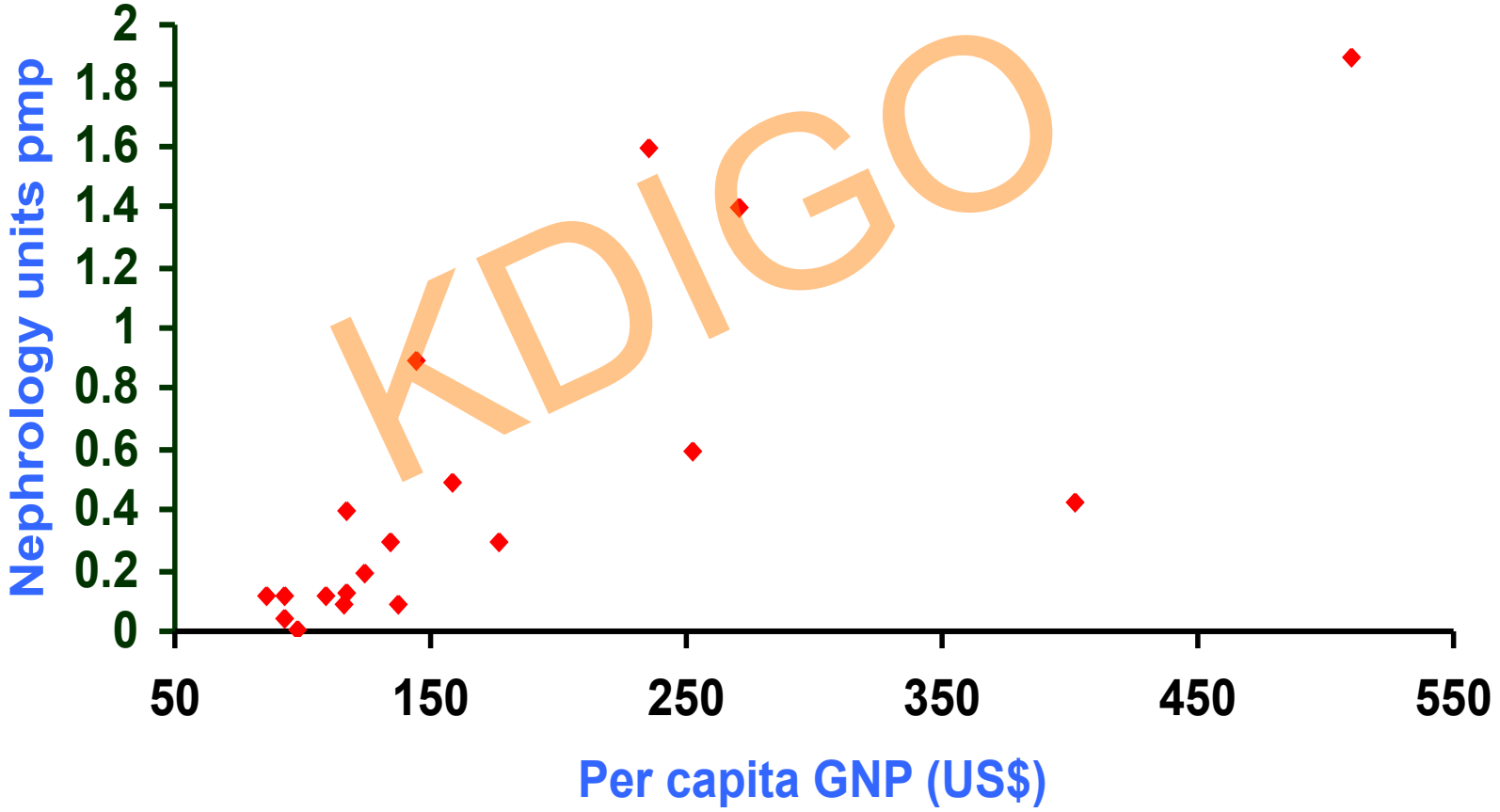
GNP and Nephrology Care Availability in Indian States



Socioeconomic status and values of key health determinants

Parameter	Poor	Middle class	Affluent
Poor	Did you have enough?	Did you like it?	Was it presented well?
Education	Valued but abstract	Crucial for success and making money	Necessary for making and keeping connections
Destiny	Fate	Choices	*Noblesse oblige*
Worldview	Local	National	International
Language	For survival	For negotiation	About networking
Importance of time	Present	Future	Tradition
Decision	For the moment, survival-based	For future ramifications	On basis of tradition and decorum

Payne, 2003

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Implementation of guidelines is a local responsibility

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Concerns

- ....no one checks your work.....
- ....if a legal problem emerges, they will complain....the board will not accept a guideline.....
- .....most people pay out of pocket.....how can I prescribe the expensive recommendation?
- ....insurance companies are short of scientific manpower.....
- .....physicians have overwhelming workload.....

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Cultural issues…

- .....we do not pay attention to detail....
- .....I know this. there is no need of any guideline.....
- .....Experience is better than guidelines
- ....patient asks you for a specific medication. if you resist, they will go elsewhere....You are swimming against the tide....
- ....our resources are at a level where expert view is more valuable than evidence.....
- .....these guidelines were nor developed for Indian subjects...

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Lack of evidence based stewardship

- ....we do not have a system....for guideline generation ...implementation
- ....this topic has never been a serious concern....
- ....we have never been taught to think in terms of guidelines…
- ....we have lived and worked so far without guidelines, why do we need them now?….
- …..but the rep of xxxx firm told me this is better…

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Professional and political issues

- our physicians.....they don't know.....are not aware of their negligence
- .....do not have skills for finding articles and appraisal...
- ....there are no regulations, the government is not bothered about standardising medical care....
- ....unless those in most important positions believe...nothing will happen....

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Patient issues

- ……The patient cannot come back again and again....
- ……I have seen this over the internet....
- ……If I do not prescribe anything, he will not return to me....

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How can a "central organization" help?

Early and continuous stakeholder engagement

Implementation plan

Audit

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How can a "central organization" help?

Wide dissemination of GL at no cost to practitioner

Awareness raising initiatives

Electronic publishing to improve GL availability

Use of mass media

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Effectiveness of interventions to promote implementation

Variable effectiveness	Largely effective
Audit and feedback	Reminders
Local consensus conferences	Educational outreach (for prescribing)
Opinion leader	Interactive educational workshops
Patient mediated interventions	Multi-faceted interventions

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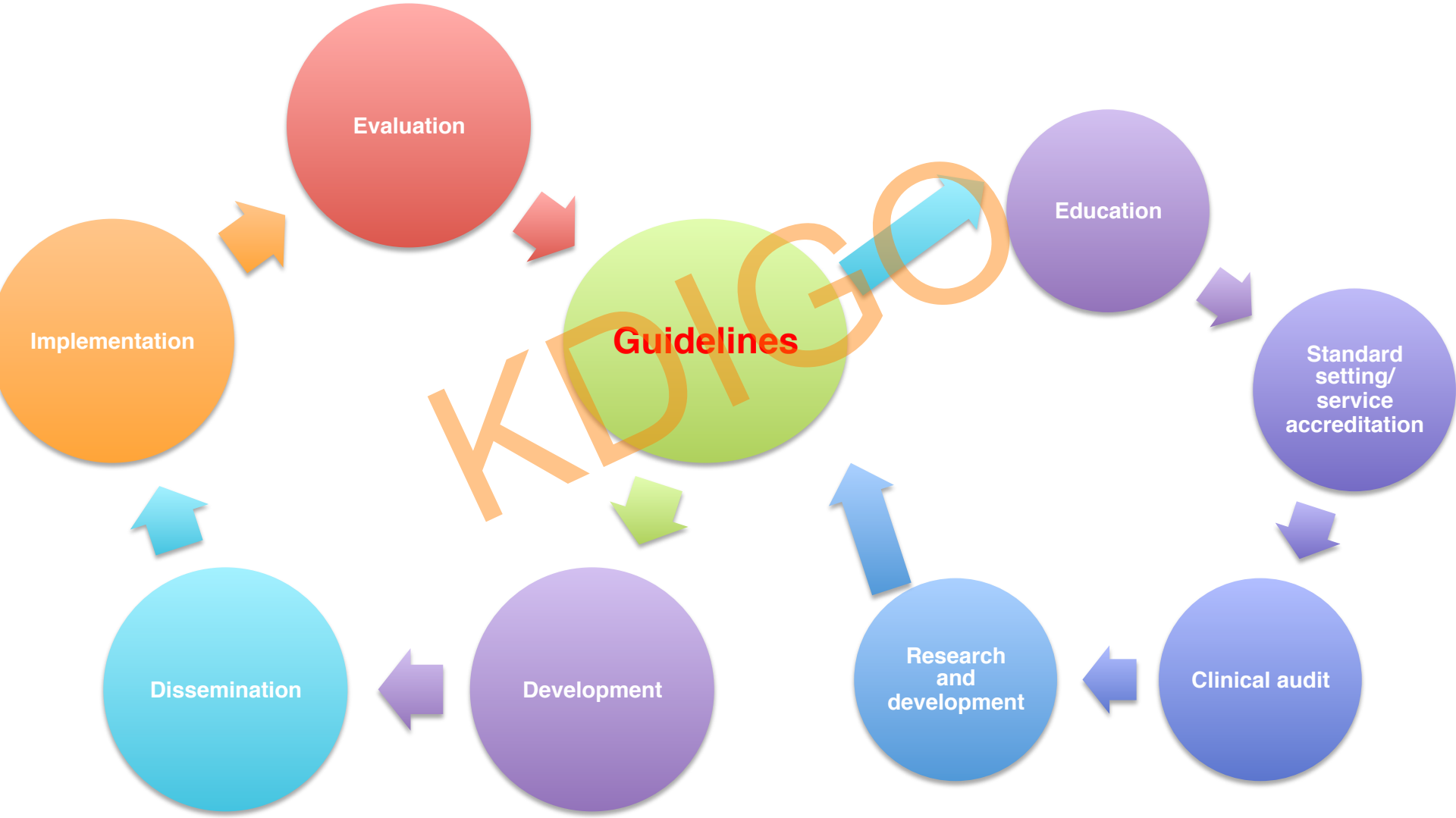
Guideline and audit cycles



Practical steps

- Prioritize topics
  - Clinical teams can only tackle one guideline at a time
- Identify strengths and weaknesses of present provision
- Do not choose areas that are most easily implementable
- Monitor

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Decide leader, stakeholder
Determine current position
• Review local environment
• Audit current practices
• Identify gaps
Prepare people/ environment for GL implementation
• Account for pt preferences/views
Decide on appropriate implementation techniques
• with respect to barriers
Action plan
• putting it together
Evaluate process
• Audit
• Reward
• modify

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Special Feature

Indian commentary on the 2009 KDIGO clinical practice guideline for the diagnosis, evaluation, and treatment of chronic kidney disease-mineral and bone disorders

V. Jha, V. Kher[1], R. Pisharody[2], R. K. Sharma[3], G. Abraham[4], Gokulnath[5], A. Almeida[6], A. Gupta[3]

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Provide perspective

The purpose of this commentary is not to critique the recommendations given by KDIGO but to understand and arrive at a consensus about its application in India. The members of the panel have used their clinical experience and expertise in the subject to examine the KDIGO recommendations that have been derived after a rigorously performed evidence review. The panel recognized that by and large, the biological and clinical behavior of patients is likely to be similar around the world and hence the derived guidelines and the science behind it would apply for the management of abnormalities in CKD-MBD in Indian patients as well. There was no additional

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Develop consensus

By consensus, the following were considered to be reasonable monitoring intervals:

- CKD Stage 3: Serum calcium and phosphorous every 3 months; PTH optional.
- CKD Stage 4: Serum calcium and phosphorous every 3 months; PTH once in 12 months unless clinical indications for more frequent estimation arise.
- CKD Stage 5: Serum calcium and phosphorous every month; PTH every 3-6 months.
- CKD Stages 4-5D: Total alkaline phosphatase every 3-6 months in Stage 4 and every 3 months in Stage 5.

With respect to vitamin D, the consensus was that a baseline value can be obtained and repeated once in 12 months in all stages of CKD.

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Gaps identified, solutions suggested

There is widespread ignorance about the impact of the methodological issues on PTH assays. Proper collection, storage and transport conditions must be ensured. Samples need to be collected properly (in prechilled tubes), and transported on ice (especially important during summer and monsoon months). This is often not im
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Although bone biopsy is the best test to confirm bone disorders in CKD-MBD, it is currently not feasible, since there is an extreme paucity of centers that can perform this test and interpret it appropriately according to the guidelines. Incidentally, the use of bone biopsy is limited in the industrially advanced nations also and is mostly done for research purposes. Indian clinicians and researchers need to develop this capability. Finally, there are no

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Be practical

amongst Indian CKD patients. The A lateral abdominal radiograph can be easily obtained at most places and is cheap, but an echocardiogram is not as widely available and is relatively expensive. The former can therefore be routinely performed and the latter whenever possible. It is unclear, however, as to how this will change patient management. One suggestion is to not use calcium-containing phosphate binders in those with calcification.

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It is important to follow proper methodology, which includes proper patient preparation, use of optimized exposure settings and an experienced reader. These tests could be repeated once every year to detect progression.

Emphasize the less well understood points

Given the low awareness of the significance of dialysate calcium, it is important to emphasize the KDIGO guideline that ca
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There is a tendency of starting activated vitamin D therapy in incompletely worked up CKD subjects, and this practice needs to be resisted. However, if serum PTH is progressively rising and remains persistently above the u
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b

Recommendation 5.3 is important because vitamin D levels are low in our patient population and early detection would help in early initiation of treatment.[11] Recommendation 5.5 is especially relevant in postmenopausal women or patients with diabetes mellitus. Caution should be exercised while prescribing bisphosphonates to avoid low turnover bone disease. The pretransplant bone

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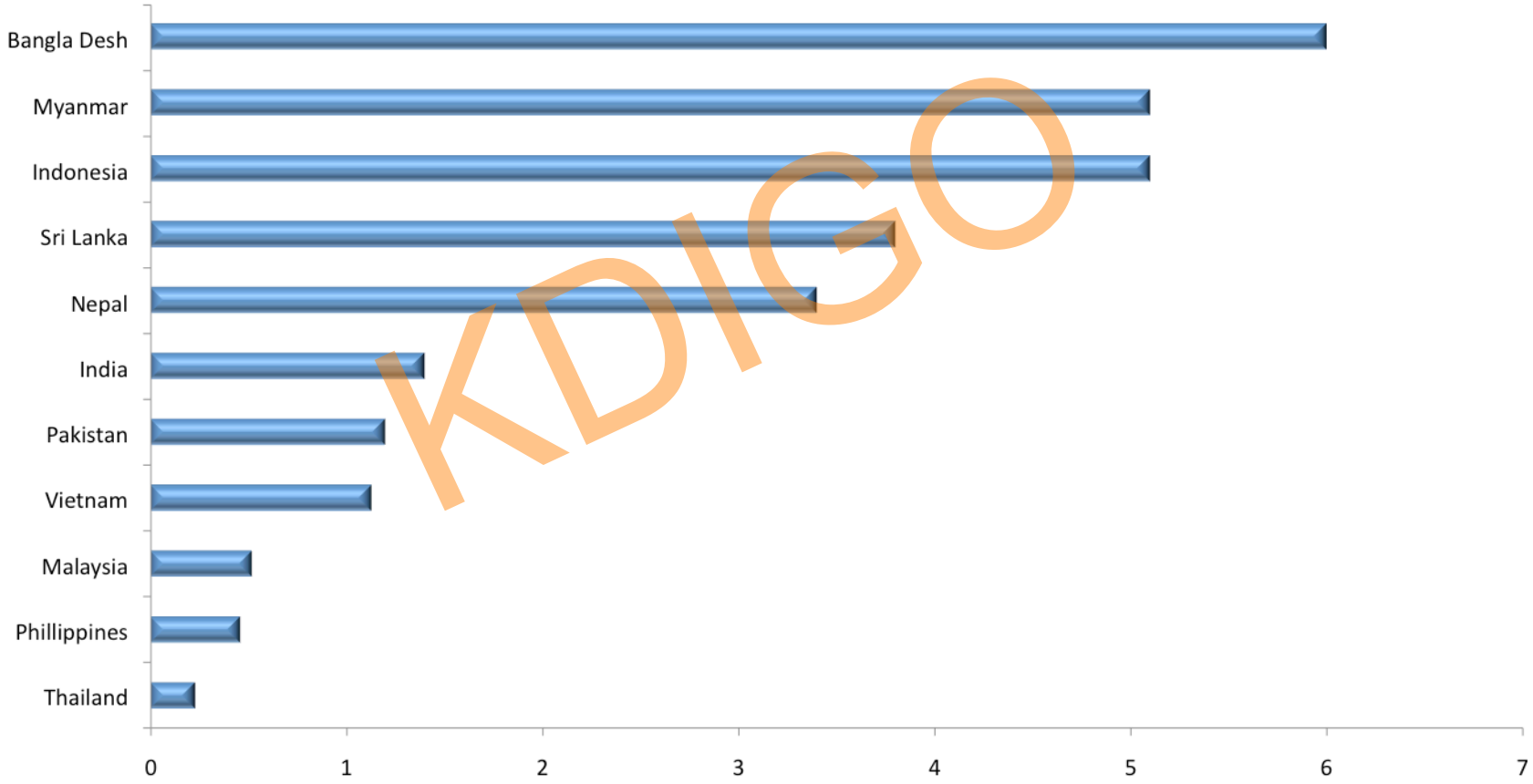
Upcoming challenges : manpower shortage



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Jha, Semin Nephrol 2009

Labor Productivity

Overall, labour productivity and employment growth in US economy by sector

Source:
Kocher and Sahni, NEJM, 2011

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If developing world uses current models, there will never be enough trained personnel for rising demand

ISSN 0971-4065

Vol 22, Supplement, December 2012

INDIAN JOURNAL OF NEPHROLOGY

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Indian Society of Nephrology Guidelines for Hemodialysis Units

Official Publication of the Indian Society of Nephrology
Free full text at
www.indianjnephrol.org

PubMed
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IL PRINCIPE
DI NICOLO MACHIAVELLI
AL MAGNIFICO LORENZO
DI PIERO DE MEDICI
LA VITA
DI CASTRVCCIO CASTRACANI
DA LVCCA
IL MODO CHE TENNE
IL DVCA VALENTINO
PER AMMAZZARE VITELLOZZO VITELLI,
OLIVEROTTO DA FERMO, IL SIGNOR PAOLO,
ET IL DVCA DI GRAVINA.
I RITRATTI
DELLE COSE DELLA FRANCIA
ET DELL'ALAMAGNA.
M. D. L.

He who neglects what is done for what ought to be done, sooner effects his ruin than his preservation.

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