Table F-4. Key Question 2 intervention descriptions

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Bahrami et al., 20041 | G1: Mailed guideline (increase reach)G2: Guideline + AF (not abstracted)G3: CAL (increase ability)G4: CAL + AF (not abstracted) | Postal mail/emailA copy of the guideline direct from SIGN plus a double sidedlaminated sheet known as the ‘Quick Reference Guide’ which summarizes the findings in an accessible manner.Skills buildingCAL intervention strategy consisted of a laptop computer based support tool, with the potential to assist dental practitioners in deciding on the appropriate treatment of thirdmolars. | Management of impacted and unerupted third molars; treatmentSIGNNoNo | G1: paperG3: electronic-basedG1: postalG2: computerNR | Unclear | G1: Guideline recommendations + quick reference guideG3: The software was based solely on the SIGN guideline |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Banait et al., 20032 | G1: Mailed guidelines (increase reach)G2: Educational outreach (Multicomponent)  | Postal mail/emailCopy of guideline posted to all GPs in July 1997, 3 months prior to interventionMulticomponentPersonal visits by a trained person to health care providers in their own setting. Interactive educational workshops. Seminars held over a period of 6 weeks. Seminars involved 4 to 8 GPs from 2 to 3 practices. Presentation of guideline and then Q&A; info about available services, summaries of local data, copy of the text used during the discussions, contact details, reinforcement visit after 3 months. | Dyspepsia management; treatment Guideline; British Society of Gastroenterology dyspepsia management guidelineNoNo | G1: paper-basedG2: in-personG1: postalG2: in-person (local hospital specialists)Over 6 weeks; 90 minute meetings | NR | Guideline recommendations |

Table F-4. Key question 1 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Beaulieu et al., 20043 | G1: Control (not abstracted)G2: Guideline (increase reach)G3: Guideline + reminder notice and stickers for patients’ charts (multicomponent) | Postal mail/emailOne-page summary of the guidelineAdditional resourcesOne-page summary of the guideline, followed a month later by a reminder notice, which included stickers to post on patients’ charts | Anti-angina therapy; treatment Guideline; College des Medecins du QuebecNoNo | Paper-basedPostalG2: 1 session G2: 2 sessions, 1 month apart | NR | Guideline recommendations. The key recommendations in the summary were: (1) to write a prescription for acetylsalicylic acid for patients with stable angina; (2) to control serum cholesterol, with a target value for low-density lipoprotein cholesterol < 2.6 mmol/l; and (3) to favor b-blockers as the first choice for anti-angina medication. Data on prescribing rates for the three targeted medication classes by physicianspracticing in the same regions as theparticipating physicians were also included in the one-page summary. |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Becker et al., 20084 | G1: Mailed guideline (Increase clinician reach)G2: Guideline implementation (multicomponent, clinicians only)G3: Guideline implementation and motivational counseling directed at patient (multicomponent, clinicians and patients) | Postal mail/emailGuideline delivered via postal mail. Targeting physician.Interpersonal outreach3 interactive seminars with academic detailing and additional resources. Targeting physician.Champions Same as Comparator 2, except this group provided motivational counseling targeting toward the patient. Practice nurses were asked to invite all identified patients for up to 3 counseling sessions (max 10–15 minutes each), the first session within 1 to 3 weeks after inclusion in the study. | G1,G2, G3: Management of acute and chronic LBP—treatmentG3: (For patients) Physical fitness—Prevention DEGAMNoNo | G1: paper-basedG2: in-person + paper-basedG3: in-person + paper-basedG1: postal mailG2: in-person (study nurses)G3: in-person (trained practice nurses)G1: 1 sessionG2: 3 sessions and then 2 more academic detailing sessions after 3 to 6 months. G3: same as G2 + up to 3 counseling sessions, 10-15 minutes max. | Unclear | G1: Informational. A detailed version and a pocket card for physicians, a prescription-like short form information and a more detailed flyer for patients to be handed out during and after consultation. G2: & G3: Session 1 talked about performance of the diagnostic triage and identification of red flags. Session 2 identification of yellow flags, and general principles on management of chronic pain. Session 3 was informing and advising patients. Information about relevant resources for pain patients provided. Plus 2 individual educational visit by study nurses (“academic detailing”). They presented the guideline and at the second session they talked about problems with implementation.  |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Becker et al., 20084 |  |  |  |  |  | G3: Motivate LBP patients for regular physical activity. Nurses wereencouraged to use specifically designed brochures on motivational and behavior change and posters to communicate the key messages. |
| Bekkering et al., 20055,6 | G1: Received guidelines by mail (increase reach)G2: Received guidelines + active training strategy (multicomponent) | Postal mail/emailParticipants received guidelines by mail together with four forms: a self-evaluation form to assess whether their current management was consistent with the recommendations contained in the clinical guidelines, two forms facilitating discussion with other physiotherapists and general practitioners respectively, and a copy of the Quebec Back Pain Disability Scale. A summary of the clinical guidelines was also provided. Physical therapists re instructed “to act as usual,” to read these guidelines if they have read previous guidelines and not read the guidelines if they have not read any other guidelines. | Low back pain; treatment Guidelines; the KNGFNoNo | G1: paper-basedG2: in-personG1: postalG2: in-person (primary investigator and one of two additional trainers with adequate clinical experience in the management of low back pain)2 sessions2.5 hours eachTotal time: 5 hrs2 hrs prep time before each session | Unclear | Guideline recommendations; educational; overcoming barriersG2: Session 1 included a didactic overview of the diagnostic and treatment processes: overview of the evidence and consequences of the evidence for diagnostic and therapeutic management compared with their own current management; interactive Q&A; two examples of role playing with an actor—one on the diagnostic process and one on the treatment process. A 4 week interval in which the physiotherapists were expected to implement the guidelines in practice.  |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Bekkering et al., 20055,6 (continued)  |  | MulticomponentMultifaceted program consisting of education, discussion, role playing, feedback, and reminders. Received guidelines by mail and active training strategy, which consisted of 2 training sessions with groups of 8-12 physical therapists. The aim of the sessions was to improve knowledge and skills regarding evidence-based physical therapy for patients with low back pain. Content of sessions was based on expected barriers to implementation. Sessions were interactive and involved group discussion, role playing, feedback, and reminders. |  |  |  | Session 2 consisted of a discussion of experiences with implementing the guidelines in practice; feedback on current management; two reminders with respect to evidence based patient education |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Bishop and Wing, 200641 | G1: Control (not abstracted)G2: Physician only (increase reach)G3: Physician and patient (multicomponent) | Additional resourcesPatient’s family physician received a copy of the clinical practice guidelines with a letter from a study physician regarding a specific named patient encouraging compliance with the guidelines. In addition each family physician received a ‘‘guideline reminder letter’’ at each of three separate stages of the patient’s clinical course summarizing the different aspects of the guidelines that specifically applied to the 0–4-week, 5–12-week, and greater than 12-week post injury periodsMulticomponentFamily physician received the Group 2 intervention and in addition, the individual patient received lay language versions of a pamphlet outlining the clinical practice guidelines and of the same clinical practice guidelines reminders sent at the same time intervals of the patient’s clinical course | Acute phase of a lower back injury; treatment Guidelines reviewed from 13 countries including the US (AHCPR) which were “remarkably consistent”NoNo | Paper-basedPostal (?)# sessions:4 (baseline, 0-4 week; 5-12 week; > 12 week)Note: Hard to know exactly how clinicians “received” the intervention - was the “letter” handed to them or mailed? | NRPatients received a “lay language” version of the guideline. | Guideline recommendations |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Campbell et al., 20047 | G1: Control (not abstracted)G2: LHA (increase motivation)G3: TPV (multicomponent)G4: TPV and LHA (multicomponent) | Social networksChurch members submitted names of people in the church for whom they turned to for help and advice. Individuals who were named by multiple church members were identified as potential LHAs. These people were then invited to an orientation and were invited to volunteer as an LHA. If they accepted they were then trained.MulticomponentVideo + newsletterMulticomponentVideo + newsletter + lay health advisor | Colorectal cancer; preventionGuideline; USPSTFYesYes | G2: Paper based + videoG3: In-person G4: Paper-based + video + in-personG2: PostalG3: In-person (church members)G4: Postal + in-personBaseline, 2, 4, 6, 9 months. | Mostly qualitative. Text files, graphics and photos in message library for tailoring. | G2: Newsletters were tailored. Newsletter personalized with names and included tailors elements, including feedback on dietary intake, physical activity, screening, CRC risk factors, social support, barriers. Message elements also targeted to cultural, spiritual, and community factors. Videos were targeted. Purpose of the videos was to provide additional motivating messages and modeling and skills demonstration to enhance and complement the information in the newsletters. Videos included testimonial and modeling skills. G3: LHA intervention designed to provide education and promote social support for behavioral change. LHA expected to organize and conduct at least 3 church-wide activities focused on spreading information and enhancing support for  |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Campbell et al., 20047 (continued) |  |  |  |  |  | health eating, physical activity, and CRC screening. All interventions based on the stages of change trans-theoretical framework, the health belief model, and social support models. |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Carney et al., 20058 | G1: Mailed health information (increase reach)G2: Telephone counseling (increase motivation) | Postal mail/emailReceive general health information packets by mail received a variety of brochures.MulticomponentTelephone intervention based on the Trans-theoretical Model and contained both educational and motivational counseling components. Telephone intervention contained four components. First, while talking with study participants, healtheducators independently noted the woman’s barriers to mammography and then, secondly, they assessed the woman’s stage of readiness to change. Third step in intervention involved recording the details of the counseling provided to form the basis of the second counseling call that took place one year later. Final aspect of the intervention was to select the appropriate code(s) on the worksheet indicating barriers to screening and each woman’s stage of change. | Breast cancer and mammography screeningG1: USPSTF mammography screening recommendations, and a brochure describing services provided by the NH State Department of Health and Human Services as part of the NHBCCP.YesNo | G1: print-basedG2: telephoneG1: postalG2: female health educatorsG2: # sessions: 2length: 6 min total time: 12 min | Unclear | G1: Screening recommendations and toll free numbers to find more information. G2: Motivational messages, Tailored information |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Christakis et al., 20069 | G1: Usual care (not abstracted)G2: Parental content Alone (increase reach)G3: Provider notification alone (not abstracted)G4: Parental content and provider notification (multicomponent) | Social networksPatients Alone. Parents in the group that received content alone were able to select topics and to access relevant content. However, their providers received no information regarding their use of the Web site.Social networksPatients + Physicians. Parents in the group that received Web content and notification were able to select and to read about topics in which they were interested. Providers had access to the topics in which the parents were interested and the results of any screening questionnaires they completed. | 13 prevention topics(1) USPSTF Guide to Clinical Preventive Services, (2) Bright Futures guidelines for health supervision, (3) Peer-reviewed systematic reviews of other, preventive care interventions, and (4) High-quality, randomized, controlled trials. NoNo | Web-basedDelivered in clinic or via web at home#: 1length: NRtotal time: NR | Example sentences, it seems like it is both quantitatively and graphically, but that is unclear. | Provide relevant information (based on age-specific recommendations) that will inform and motivate patient to generate conversation with physician. |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Davis et al., 200410 | G1: Control - guidelines by mail (increase reach)G2: Intermediate (multicomponent)G3: High intervention (multicomponent) | Postal mail/emailMailed a copy of the guidelineMulticomponentThe intermediate group received the guideline, invitations to an interactive workshop (e.g., skills training), and structured protocol documents designed to supplement the guideline (e.g., provision of support materials).MulticomponentGuideline + workshop and protocols + clinical nurse specialist | Epilepsy; diagnosis and treatmentNational evidence-based guideline on the Diagnosis and Management of Epilepsy in Adults, publishedby SIGNNoYes | G1: paper-basedG2: paper-based + in-personG1: postal G2: postal + two consultant neurologistsNR | NR | G1: Guideline recommendation G2: workshop was designed to go over case studies and promote discussion. The protocols were designed for use at the first presentation of a new patient and for use by either a practice nurse or a GP at regular review consultations. G3: Role of nurse was to offer adviceand training to practices in establishing epilepsy review programs, to promote the use of the guideline in epilepsy management, and to provide information on epilepsy for both practitioners and patients. |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Eaton et al., 201111 | G1: 1-hour academic detailing (increase clinician ability)G2: Academic detailing plus a patient education toolkit, a computer kiosk with patient activation software, and a PDA-based decision support tool (multicomponent) | Academic detailingA 1-hour academic detailing session during which ATP III cholesterol guidelines were discussed and abbreviated guideline pocket guides were given to each physician; also received a PDA but without the decision support tool and had minimal further contact to mimic usual careMulticomponent1-hour academic detailing session (same as comparator #1); also, a patient education toolkit (and companion Web site), a computer kiosk with patient activation software, and a PDA-based decision support tool for each physician, which included 4 booster academic detailing sessions | Cholesterol treatmentGuidelinesNoNo | G1: In-personG2: In-person, Web-based, electronic-basedNRG1:Academic detailing#: 1length: 1 hourtotal time: 1 hourG2:Academic detailing#: 1length: 1 hourPlus 4 booster sessionsbooster length: NR |  | Guideline recommendations |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Elder et al., 2005;12 200642 | G1: Culturally targeted print-materials + activity inserts (increase reach)G2: Tailored print materials + activity inserts + supporting materials (multicomponent). G3: Tailored print materials + in-person promotora (multicomponent) | Increased reachTargeted newsletters and activities insertsMulticomponentTailored newsletter and activities insertMulticomponentLay health advisor “Promotoras” + tailored newsletter and activities inserts | Reduce dietary fat and increase fiberUnspecified; American Heart AssociationNIH; American Dietetic Association, and the American Cancer SocietyYesUnclear | G1 & G2: Paper-basedG3: Paper-based + in-personG1 & G2: Postal G3: Promotoras (characteristics: Spanish-language dominant; naturally empathetic,able to develop rapport and to be neutral and nonjudgmental; perceived as a role model in the community; and interested in helping women change lifestyle behaviors.)G1: one time mailing (probably)G2: 12 weekly mailingsG3: 12 weekly mailings of print materials + 12 weekly home visit or telephone call | NR | G1: Targeted materials developed for a Latino population and were available in Spanish. Language-appropriate materials that contained information onfood purchasing, food preparation, and food consumption were availablefrom the American Heart Association, American Dietetic Association, andthe American Cancer SocietyG2: Newsletters provided feedback on the assessment process, as well as an opportunity for personalized goal setting and for dealing with identified barriers. Degree of complexity of the activity in the insert varied by the participant’s readiness to change (e.g., acquire information vs. self-monitor). Participants encouraged to complete the activity on the insert and return the self-addressed stamped card to be entered into a raffle and to receive additional  |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Elder et al., 2005;12 200642 (continued) |  |  |  |  |  | chapters of the story (novela) in the newsletter. Also magnetic flower petals containing healthy lifestyle messages and eight recipes.G3: Using the skills acquired in the program, as well as their natural ability to provide support and encouragement and their social networking skills, the promotoras worked with individual participants to negotiate behavioral change goals. The promotoras relied primarily on the participant’s weekly tailored newsletter to guide discussions and suggest opportunities for skill development. |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Feldstein et al., 200613 | G1: Usual care (not abstracted)G2: EMR reminder (increase reach for clinicians)G3: EMR reminder and patient reminder (via letter with educational materials (multicomponent) | MulticomponentG1: Patient-specific EMR in-basket messages for their enrolled patients from the chairman of the osteoporosis quality-improvement committee. Letter-style message informed the provider of the patient’s risk of osteoporosis based upon the patient’s age and prior fracture and state the need for evaluation and treatment; also listed internal and external guideline resources that provided detailed recommendations regarding evaluation, calcium and vitamin D intake, lifestyle and medication. Provider also given the option of contacting the sender for more information.MulticomponentG2: (EMR reminder to clinician) plus patient reminder: a single mailing of an advisory letter with educational materials (addressing menopause, osteoporosis, calcium and  | OsteoporosisNational Osteoporosis Foundation, European Foundation for Osteoporosis and Bone Disease, American Association of Clinical Endocrinologists an d American College of Rheumatology Task Force on Osteoporosis Guidelines. Type of evidence NR.NoUnclear | G1: Usual care G2: Electronic-based (email linked to EMR) G3: Electronic-based - EMR (clinician reminder) + postal mail print letter + provider receipt of patient letterEmail for provider, mail/postal for patientsG2: Baseline and 3 months after the first baseline message for providers.G3: One letter with educational material | Unclear | Options for reducing risk for osteoporosis, need for evaluation and treatment, information on calcium and vitamin D intake, lifestyle and medication |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Feldstein et al., 200613 (continued) |  | vitamin D, physical activity, home safety and fall prevention). Letter identified patient’s risk, discussed clinical practice guideline recommendations, and requested that the patient discuss management options with her provider. |  |  |  |  |
| Gattellari et al., 200514 | G1: Leaflet (increase reach)G2: Video (increase reach)G3: Booklet (increase reach) | Postal mail/emailG1: received a leaflet in the mail called “Testing for prostate cancer”, 856 words in length, with a flesch reading score of 14.6 years It provided brief info on types of PSA screening tests; false-positives. No information on harms.Electronic/digital mediaG2 received a video that met criteria for a decision-aid; “The choice is yours: testing for prostate cancer’; 20 minutes in duration; younger man with family history of prostate cancer and an older man individually weighing up the pros and cons of PSA screening; natural history of cancer, test accuracy, and treatments are described | Prostate cancer screeningCancer Foundation of Western AustraliaYesNo | Two groups, G1 and G3 received paper-based information while G2 receivedPostal#: 1length: 20 minutes v. 2407 wordstotal time: NRNOTE:Treatment, including statistics on treatment-related complications; included a visual aid in the form of a flow-chart outlining the consequences of screening and a  | Quantitative and graphical | Included recommendations, prostate cancer risk, and testing risk and benefit. |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Gattellari et al., 200514 (continued) |  | Postal mail/emailG3: 2407 word evidence-based booklet, entitled “Should I have a PSA test for prostate cancer: information for men who want to know more about screening tests for prostate cancer; Flesch-Kincaid reading age of 11.8 years; included stats on the life-time and age-specifics risks of developing and dying from prostate cancer, family history as risk factor, test accuracy, and potential benefits and harms from treatment, including statistics on treatment-related complications; included a visual aid in the form of a flow-chart outlining the consequences of screening and a values clarification form. |  | values clarification form. |  |  |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Hagmolen et al., 200815 | G1: Guideline dissemination (increase reach)G2: Guideline dissemination + educational program (increase ability)G3: Guideline dissemination + educational program + individualized treatment advice based on airway responsiveness and symptoms (multicomponent) | Social networksAll GPs were sent an extract of the latest updated version of the Dutch College of GPs clinical practice guidelinesSkills buildingMailed guideline + invitation for a 2-hr educational session on asthma and inhalation techniquesMulticomponentMailed guideline + educational session + GPs received written individualized treatment advice based on symptoms, the use of medication, lung function, and the severity of AHR. | Treatment of childhood asthmaDutch College of General Practitioner’s clinical practice guidelineNoNo | G1: PrintG2: Print + in-personG3: Print + in-person + printG1: postal G2: Postal + unclearG3: Postal + unclear + postalAll groups: Guideline: 1 session. G2 & G3: Educational session=1 session; total time: 2 hr | Combination of graphical information (e.g., flow chart) quantitative information. | Outlined decision tree for treatment steps |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Jain et al., 200616 | G1: Passive intervention- guidelines by mail (increase reach)G2: Active intervention (multicomponent) | Postal mail/emailMailed a copy of the CPGs to study dietitiansMulticomponentLocal opinion leader + access to website + supporting documents + educational tools +training kits to assist the dietician + posters and pocket cards + audit & feedback + interactive workshop +academic detailing + site reports +reminders + small group session. | Nutrition support; treatmentGuideline, Canadian critical care clinical practice guidelines committeeYesNo | G1: paper G2: every type of formatG1: postalG2: postal + web + in-person + email, etc.NR | NR | G1: GuidelinesG2: The different strategies sought to predispose people through awareness, enable them through agreement and adoption, and then reinforce behaviors through adherence. |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Jousimaa et al., 200217 | G1: Computerized version of guidelines (increase ability)G2: Textbook-based version of guidelines (increase reach) | Electronic/digital mediaPhysicians were given the latest CD-ROM version of the guidelines. Those with access to a computer in the consultation room were given a copy of the CD-ROM to be installed on their consultation room computer. If the physicians did not have access to a computer in the consultation room, they were provided with a laptop computer with preinstalled guidelines during the study period.Postal mail/emailPhysicians were given the latest version of the textbook guidelines. Prior to the study, participating physicians agreed not to use the other version of the guidelines if it was available in thehealth center, but they could use any other source of information, such as medical journals, books, and colleague consultations. | Primary care; treatment and preventionGuidelines; Evidence-Based Medicine Guidelines (EBMG)NoNo | G1: CD-ROM or computer-basedG2: Paper-basedG1: CD-ROM or computer-basedG2: Paper-based#: 1length: used version of guidelines for no less than 4 weeks before data collectiontotal time: NR | NR | Guideline recommendations |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Junghans et al., 200718 | G1: Conventional guideline (increase reach)G2: Ratings about specific patients in vignettes (increase motivation) | Electronic/digital mediaParticipants were provided online guideline paragraphs most relevant to each vignette as well as links to full-text guidelines and detailed information on how the ratings were derived.Opinion leadersPhysicians received an electronic prompt to physicians that said “the expert panels recommend \_\_-” | Angina; treatmentG1: American heart association and European Society of CardiologyG2: 2 expert panels composed of 5 cardiologists, 1 cardiothoracic surgeon, and 5 general practitioners with an interest in cardiologyNoNo | Electronic-basedComputer12 vignettes randomly ordered | NR | Physicians read unique vignettes of patients with suspected orconfirmed angina based on unique combinations of clinical factors(indications). |
| Kennedy et al., 200319 | G1: Control (not abstracted)G2: Information (increase reach)G3: Interview (increase motivation) | Multicomponentvideo and booklet were sent to women at their home 6 weeks before their consultationInterpersonal outreachG2 + in-person structured interview with a researchnurse immediately prior to the initial consultationwith their gynecologist. | Menorrhagia; treatmentSystematic review of treatment efficacy published in the Effective Health Care series + epidemiological and quality of life surveys on the conditionNoNo | G2: Paper + videoG3: Paper + video + in personG2: PostalG3: postal + In person (nurse)G2: 1 sessionG3: interview length was approx. 30 min. 1 session. | Combined  | Booklet emphasized the importance of patient preferences, information about menorrhagia and its causes, treatment options, risks and benefits of surgery, and a personal treatment plan. Video included patient narratives, graphical illustrations, and used color coding to facilitate linkage of the visual material with the information in the booklet. |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| King et al., 200720 | G1: Attention control (not abstracted)G2: Counselor via phone (increase motivation)G3: Automated counselor via phone (increase reach) | Usual CareInterpersonal outreachTelephone assisted physical activity counseling by a trained health educator. Telephone contacts were supplemented by informational mailings and pedometer.Electronic/digital mediaTelephone-assisted physical activity counseling by an automated computer. Telephone contacts were supplemented by informational mailings and pedometer. | Physical activity: Prevention US Department of Health and Human ServicesYesYes | Both: via phone and informational mailingsG2: trained health educatorG3: automated telephone linked computer system that could ‘speak’ to participants over the telephone using computer controlled speech generation.Total # of calls completed (M, SD)G2: 13.1 (2.5)G3: 11.8 (4.8)Average call length in minutesG2: 10.7 (5.0)G3: 6.6 (2.2)10-15 minute sessions | NR: probably qualitative | G2: Health educator offered tailored support and problem solving around physical activity barriers. G2 & G3: The content included physical activity assessment, progress evaluation, individualized problem-solving, goal-setting, feedback, and delivery of positive support and tailored advice. Discussion of cognitive and behavioral strategies, derived from Social Cognitive Theory and the Trans-theoretical Model occurred as appropriate to each person’s stage of motivational readiness for change. Provided with informational mailings, pedometer, and PA self-monitoring log. |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Laprise et al., 200921 | G1: CME (increase ability)G2: CME + practice enablers and reinforcers (multicomponent) | Skills buildingCME that was a small-group interactive workshopChampions CME + PER group. nurses visited GPs’ offices to implement the clinical intervention. A set of clinical tools was developed to support intervention implementation in the practice. | Cardiovascular: preventionClinical practice guidelineNoNo | G1: in-person G2: In-personG1: expert cardiologist and GPG2: Trained nurse2 hrs | NR | CME: included a presentation of the latest CPGs by an expert cardiologist, discussion of 4 cases facilitated by a GP and an interactive response system, and discussion about barriers to guidelines implementation in their practiceG2: The following tools were developed: list of target diagnoses; lists of generic and commercial names of all antidiabetic and CV drugs available on the market; decision-making algorithm for chart prompting.The goal of the trained PERs was to address important physician-level practice barriers to prevention: time to screen for at-risk patients, time to search for clinical information in support of decisionmaking, and timely access to experts’ recommendations |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Lien et al., 2007,22Svetkey et al., 2003,23Young et al., 200924 | G1: Advice only (increase reach)G2: Advice + behavioral counseling using established intervention (multicomponent)G3: Established intervention + DASH dietary recommendations (multicomponent) | Interpersonal outreachIndividual session with advice. The interventionist reviews the recommended guidelines, gives advice, and provides printed educational materials, but does not provide behavioral counseling.MulticomponentIndividual and group sessions with behavioral counseling. Participants are instructed on ways to identify the sodium content of food, to select and substitute lower sodium choices, and to alter sodium content of recipes.MulticomponentIndividual and group sessions with behavioral counseling + DASH. In addition to the established intervention information in G2, participants in G3 received instruction and counseling regarding DASH dietary recommendations. Participants were asked to monitor intake of fruits,  | Hypertension, diet, physical activity, and weight loss; prevention and treatmentG1: Guideline; National High Blood Pressure Education Program recommendationG2: JNC-V on Detection. Evaluation, and Treatment ofHigh Blood PressureG3: JNC-VI recommendationsG1: # session:1total time: 30 minG2 & G3:# session=18 face-to-face intervention contacts (14 group meetings and 4 individual counseling sessions).UnclearUnclear | G1: In-person + paper-basedG2 & G3: in-personG1: Interventionist (typically a registered dietician)G2 & G3: Nutritionists or health educators | Combined quantitative and qualitative with focus both on social support and understand-ing quantitative guidelines | Review recommended guidelines, give advice, provide counselingG1: Just has advice, no behavioral counselingG2 and G3: include behavioral counseling which sought to increase self-efficacy and outcome expectancies. Message emphasizes the importance of an individual’s ability to regulate behavior by setting goals, monitoring progress towards the goals, and attainingskills necessary to reach the goals. |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Lien et al., 2007,22Svetkey et al., 2003,23Young et al., 200924 (continued) |  | vegetables, and dairy products in addition to recorded physical activity and calorie and sodium intake. |  |  |  |  |
| Marcus et al., 200925 | G1: Contact control treatment delayed group (not abstracted)G2: Telephone-based individualized feedback (increase motivation)G3: Print-based individualized feedback (increase reach) | MulticomponentMailed health education information in the form of tip sheets (stress management, cancer prevention, healthy nutrition and back health) on same schedule as G2 and G3TelephoneTelephone contact with health educator who incorporated feedback generated by the computer expert system and supplemented with stage-based manual and tip sheets but no script.MulticomponentPrinted reports of feedback generated by the computer expert system along with manuals matched to their stage of motivational readiness for physical activity adoption and tip sheets. | Physical activityCDC/ACSM recommendationsYesYes | G1: paper-based/mailed G2:telephone, G3: print (not sure if mailed or in-person)G1: postal, G2: telephone [health educator], G3: NR#:14 contacts for each participant in each intervention group (G2 and G3)length: For G2: 13 minutes mean call time G3: NRtotal time: 182 minutes for G2: NR for G3 | NR - materials available on request from authors | Individually tailored messages generated by a computer expert system, stage-targeted booklets and physical activity-related tip sheets to both groups. Participants in both treatment conditions (G2 and G3) were instructed that their goal was to increase their moderate intensity physical activity to a level that met or exceeded CDC/ACSM recommendations (at least 5 days per week for a total of at least 30 minutes per day) |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Maxwell et al., 201026 | G1: Control (not abstracted)G2: Educational session + letter to provider (multicomponent) G3: Educational session + letter to provider + FOBT kit (multicomponent)  | Multicomponenteducational session facilitated by a trained Filipino American health educatorMulticomponentEducational session facilitated by a trained Filipino American health educator:PLUS free FOBT kit and asked to sign pledge that they would use it | Colorectal cancer screeningAmerican Cancer Society and Task Force on Community Preventive ServicesYesYes | Paper-based and in-personDelivered in community-based networks by a trained nurse#:1length: 60-90 minutestotal time | Combined | Discussed CRC and screening information, demonstrated use of FOBT kit, and addressed barriers to screening as well as peer-to-peer feedback, also received print materials and final RN recommendation to get screened |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Murtaugh et al., 200527 | G1: Usual care (not abstracted)G2: Basic intervention email reminder (increase reach)G3: Augmented intervention of email reminder + package of supporting materials (multicomponent) | Postal mail/email“just-in-time” email reminder on an initial screen listing the 6 key CHF practices in very abbreviated form (spelling acronym “ADHERE”). Subsequent links with more detailed information.Multicomponent“Just-in-time” email reminder like comparator 1 plus package of material stating it was for the care of the CHF pt (including laminated pocket card on med management, prompter card to improve communication with MDs, and self-care guide for patients); also received “expert peer” followup outreach including followup email reminder, inquiries on the usefulness of the card distributed within 10 days of admission to home care. | Heart failure managementNRYesUnclear | Electronic-based and paper-basedEmail and paper-based, but email sent by “expert peer”#: NRlength: within 45 days of pt admissiontotal time: NR | NR | Quick reference sheet and more detailed recommendations on medications, documenting vital signs and symptoms/signs; pt records daily weights, education about low sodium, heart failure symptoms, and education about the “heart failure self-care” guide. |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Paradis et al., 201128 | G1: Paper handouts (increase reach)G2: Educational DVD (increase reach) | Usual CareA packet of written handout materials already available in clinic that covered similar (though not identical) information to that shown in the video (comparator #2). All written handouts were at a fourth-grade readability level. Families could take these materials home with them.Electronic/digital mediaA locally produced DVD that depicted basic aspects of newborn care. Topics covered included normal newborn breathing patterns, bathing and feeding, safe sleeping practices, dealing with crying, and promoting development. A local pediatrician and several ethnically diverse babies appeared in the video. After viewing the video in the clinic, families were given the video to take home with them. | Newborn care; prevention and managementGuidelines; American Academy of PediatricsNoNo | G1: Paper-basedG2: VideoG1 and G2 were delivered in the clinic by a staff member#: 1length: 15 minutestotal time: 15 minutes | NR | Basic aspects of Newborn care as depicted by guidelines. Topics included normal newborn breathing patterns, bathing and feeding, safe sleeping practices, dealing with crying, and promoting development. |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Partin et al., 200429 | G1: Usual care (not abstracted)G2: Pamphlet (increase reach)G3: Video (increase reach) | Usual CareNote: Usual care never described so it was not abstracted. Postal mail/emailPamphlet that provided a balanced representation of the potential risks and benefits of screening.Electronic/digital mediaVideo designed to provide a balanced representation of the risks and benefitsof screening | Prostate cancer screeningG2: unclearG3: Foundation for Informed Medical Decision MakingYesNo | G2: Paper-basedG3: VideoG2: Postal G3: Postal. (In the video two physicians (an internist and urologist) and patient delivered information)G2: 1 time exposure, 8 page pamphletG3: 23 min video, 1 time exposure | G2: QualitativeG3: Qualitative and graphical  | G2: Written at 6th grade level. It starts with a definition of the PSA and why not all doctors are recommending it. It defines the prostate and CaP and how CaP is different from the common but less serious condition, BPH, which causes similar symptoms. It then summarizes the accuracy of the PSA and the unknown efficacy of CaP treatments. Space is provided on the back to write down questions to discuss with a health care provider. The point that there is a decision to make and that the patient should play an active role in it is emphasized throughout.G3: Designed to enable 100% comprehension at the 10th grade level. Video developed by the Foundation for Informed Medical Decision Making. It uses physician actors who articulate the advantages and disadvantages of testing,  |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Partin et al., 200429 (continued) |  |  |  |  |  | presents testimonials from patients, and shows graphic illustrations to promote an informed decision. Viewers are asked to consider 3 questions in making a decision about screening and are encouraged to discuss screening with their doctors. |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Rahme et al., 200530 | G1: No treatment control (not abstracted)G2: Decision tree (increase ability)G3: Workshop (increase ability)G4: Workshop + decision tree (multicomponent) | Additional resourcesA laminated sheet representing the decision tree was distributed to physicians in the decision tree group, followed by a letter of explanation from the Continuing Medical Education Department regarding the content and use of the decision tree, without any further justification or discussion of the medical content.Skills buildingSmall-group 90 minute workshops modeled after the Script Concordance test. The decision tree was presented during the workshops for the workshop group but the laminated sheet was not distributedMulticomponentWorkshop + laminated decision tree | Osteoarthritis treatmentEvidence-based clinical practice guidelines - American College of RheumatologyNoNo | G2: Paper-basedG3: In-personG4: Paper-based +in-personG2: In-person by sales representativesG3/G4: In-person (peer-facilitated by a general practitioner and a rheumatologist who served as a resource person)G3/G4: 90 minute workshop | G2: QualitativeG3/G4: Unclear | The decision tree discussed treatment choices for osteoarthritis patients, suggesting nonpharmacological treatment including physical exercise as first-line therapy, and pharmacological choices starting with acetaminophen and moving to NSAIDs or COX-2 inhibitors with or without a gastroprotective agent, depending on the patient response to treatment and the presence of risk factors for NSAID gastropathy.The workshop discussedevidence-based management of patients with osteoarthritis. |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Rebbeck et al., 200631 | G1: Dissemination of guidelines by mail (increase reach)G2: Implementation group (multicomponent) | Postal mail/emailDissemination of guidelines by mailSkills buildingA one-day (8 hour) workshop, which included interactive sessions outlining the content of the guidelines, practical sessions covering the treatments endorsed in the guidelines (i.e., ‘reassure patient’ and ‘advise to act as usual’), and the use of functional outcome measures. Physiotherapists also given a laminated copy of the algorithms outlining the process of care, appointment cards, and marketing material to be used for general practitioners who usually refer to the practice. A followup educational outreach visit (2 hrs) approximately 6 months later, involving problemsolving regarding use of the guidelines in clinical practice and an update of the evidence given. | Whiplash treatment/managementClinical practice guidelines, developed by the MAANoNo | G1: paper-basedG2: in-personG1: postal mailG2: in-person, delivered in part by opinion leaderG2: Educational intervention#: 2 length: 8 hours and 2 hourstotal time: 10 hrs. | NR | G1: guideline recommendationsG2: guideline recommendations + information and help with problem solving |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Rimer et al., 200132 | G1: No treatment control/usual care (not abstracted) G2: TP (increase reach)G3: TC (multicomponent) | Postal mail/emailTP: “(PRISM; 7x9 in, full-color booklet with graphic images included tailored colored pie charts to illustrate risk-related information; Addressed personally to recipient with tailoring “especially for you”, based on prior interview’s info- pt’s stage of readiness; also had personal risk of breast cancer in next 10 years using Gail model; overall women’s risks by age group, etc. Tailored on 20 itemsMulticomponentTP +TC- same as TP + a call by trained advisors asking open-ended questions about the booklet to elicit discussion about breast cancer and mammography; discussed Gail scores, addressed barrier to screening and other concerns; communicated guidelines | Breast cancer screeningNIH Consensus Conference on Breast Cancer Screening YesYes | Paper-based and telephonePostal or telephone (telephone was by research staff)TP#: 1length: 20-25 pagestotal time: NRTP + TC#: 1length: nonetotal time: NR | Combined | Guidelines, tailored statistics, risk factors, barriers |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Rycroft-Malone201233 | G1: Standard dissemination via postal mail (increase reach)G2: Standard dissemination + a Web-based education package championed by an opinion leader (Multicomponent)G3: Standard dissemination + plan-do-study-act (Multicomponent) | Dissemination - postal mail/email:A guideline package was mailed out to senior levels of the Trust (including medical directors, nursing directors, clinical governance leads, and audit leads) and to the English Strategic Health Authorities and the Health Boards of Northern Ireland, Wales, and Scotland. The guideline package contained: a copy of the RCN/RCA guidelines; a patient version of the guideline; and a PowerPoint presentation outlining some principles of guideline implementation.Dissemination—multicomponent:Mailed guideline package (comparator 1) + had identified opinion leaders working in participating surgical areas champion a Web-based resource developed from the content of the guideline package that was interactive, and incorporated educational tools and a patient digital storyMailed + opinion leaders=Multicomponent | Peri-operative fastingJoint Royal College of Nursing (RCN)/Royal College of Anaesthetists (RCA) Clinical GuidelineBased on a theoretical framework developed for this study called the Promoting Action on Research Implementation in Health Services (PARIHS) frameworkNo | G1: paper + electronic-based (CD)G2: paper + electronic-based (CD) + web-based + in-personG3: paper + electronic-based (CD) + in-personG1: postal mailG2: postal mail + local opinion leaderG3: postal mail + PDSA facilitatorG1:1 session,total time: 6 monthsG2:#: Multiple sessions but # not specified;total time: 6 monthsG3: 6 meetings + local audit activity; total time: 6 months | G1: Combined, qualitative and graphical (print guidelines, including the guideline development process, recommendations, algorithm poster, and audit criteria; also, patient version of guidelines; and a PowerPoint presentation)G2: Combined (guidelines described in G1 + an interactive Web-based resource)G3: Combined (guidelines described in G1) | Guideline recommendationsG1, G2, and G3: Copy of guidelines, patient version of guidelines, powerpoint presentation outlining some principles of guideline implementation. G2: Web-based resource that was interactive, incorporating educational tools such as self-check tests, working through clinical scenarios, and a patient digital story. Championed by a local opinion leader. G3: Plan-do-study-act group had a dedicated facilitator with relevant clinical and/or managerial experience that held a one-day training session. |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Rycroft-Malone201233 (continued) |  | Dissemination – multiple componentMailed guideline package (comparator 1) + used a plan-do-study-act quality improvement approach, which included training a facilitator at each Trust and involved making small changes and test cycles to see whether an improvement occurred in the system or processMailed + additional resources=multicomponent |  |  |  |  |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Simon et al., 200534 | G1: Mailed educational materials (increase reach)G2: Individual academic detailing (increase ability)G3: Group academic detailing (increase ability)  | Postal mail/emailMailing that contained printed material describing the currentguidelines for prescribing antihypertensive medicationsand a laminated wallet card that summarized the guidelinesSkills buildingMailing (same as comparator 1) + one-on-one educational outreach meetings which consisted of a single visit (15-30 minutes) from the trained detailer, incorporating the core principles and methods of academic detailingSkills buildingMailing (same as comparator 1) + 45-minute small-group academic detailing sessions; also employed supportive group processes, such as encouraging clinicians to share success stories in overcoming barriers to adhering to guideline recommendations and providing clinicians with an opportunity for mutual reinforcement of desired practice behaviors. | Hypertension; treatmentGuidelinesNoNo | G1: Paper-basedG2: In-personG3: In-personG1: Postal mailG2: In-person, delivered by respected physician idea championG3: in-person via group, delivered by respected physician idea championG2:#: 1length: 15-30 minutestotal time: 15-30 min.G3:#: 1length: 45 minutestotal time: 45 min. | G1: UnclearG2: CombinedG3: Combined | Academic detailing; guideline recommendations |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Soler et al., 201035 | G1: Control (not abstracted)G2: Training session on the SEPAR guidelines (increase ability)G3: G2 + portable-device for spirometry (multicomponent) | Skills buildingG2: GPs dealing with COPD received training session based on the literal transcription of the SEPAR-SEMYC guidelines for the diagnosis, severity stratification and management of COPD. Training was performed by pulmonologists from Spanish hospital institutions who had previous information about the SEPAR guidelinesMulticomponentG3: G2 intervention plus the GPS in G3 attended a spirometry training session on the KoKo Peak Pro devices immediately after the SEPAR guidelines presentation. | COPDChartUnclearNo | Paper-based, in-personIn person#: 1 training session for participants in G2 and G3 length: NRtotal time: NR | Unclear | NR |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Sullivan et al., 201036 | G1: VA guidelines (increase reach)G2: COPE: web-based education program (increase ability) | Postal mail/emailResidents accessed online through links in email and completed training individually, deciding how much time to spend on it. VA guidelines are a text document that uses a modular approach ‘‘to provide a scientific evidence base for practice interventions and evaluations, specifically in the use of opioids to treat CNCP.’’ It contains clinical algorithms clinicians can use to ‘‘determine the best interventions and timing of care for their patients, reduce the incidence of adverse-effects and other undesirable outcomes, and optimize healthcare utilization.’’ Key points and a treatment algorithm flow chart provide a distillation of the recommendationsSkills buildingResidents accessed online through links in email and completed training individually. The COPE training focuses on communication challenges  | Chronic non-cancer pain; treatmentGuidelines; Veterans Affairs/Dept. of DefenseNoNo | G1 and G2 were both web-basedEmail with links to intervention for G1 and G2G1:#: 1length: 26 chapterstotal time: up to individualG2:#: 1length: 6 chapterstotal time: up to individual | UnclearNOTE:Over 100 web pages depict clinical interactions between simulated physicians and patients with supporting scientific, policy, and clinical material. Basic factual material about opioid pharmacology, opioid effectiveness for CNCP, and the risks of chronic opioid therapy are presented in the first chapter. Depicts interactions with one patient at low-risk for poor outcome from opioid therapy and one patient at high risk for poor outcome. A summary chapter provides take home points and  | G1: Guideline recommendationsG2: Skill-building and help with problem solving in shared decisionmaking for cancer treatment |

Table F-4. Key question 1 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Sullivan et al., 201036 (continued) |  | between physicians and patients with CNCP who are using long-term prescription opioids. Presents a shared decisionmaking procedure. Over 100 web pages depict clinical interactions between simulated physicians and patients with supporting scientific, policy, and clinical material. Basic factual material about opioid pharmacology, opioid effectiveness for CNCP, and the risks of chronic opioid therapy are presented in the first chapter. Depicts interactions with one patient at low-risk for poor outcome from opioid therapy and one patient at high risk for poor outcome. A summary chapter provides take home points and printable F-Patient Treatment Agreements, Survival Tips, and key Helpful Phrases to use with patients. Interactive quizzes engage the viewer in clinical problem solving. |  |  | Printable Patient Treatment Agreements, Survival Tips, and key Helpful Phrases to use with patients. Interactive quizzes engage the viewer in clinical problem solving. |  |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Watson et al., 200237 | G1: Guideline materials by postal mail (increase reach)G2: EO session and guidelines (increase ability)G3: CPE session and guidelines (increase ability)G4: Guidelines + EO and CPE (multicomponent) | Postal mail/emailGuideline materials mailed to all pharmacies in the Grampian region of ScotlandInterpersonal outreachOne outreach visit by a trained pharmacist and a followup phone call 4-6 weeks later to determine whether the guidelines were being used and whether there had been any problems or queries with their useSkills buildingInvitations to attend one of three CPE sessions arranged at different venues; each session followed a standard SCPPE format and comprised a 1 hour presentation on vulvovaginal candidiasis by ta consultant or genito-urinary medicine; a 90 minute case study workshop and practice applying guidelines. CPE occurred prior to outreach visit | OTC management of vulvovaginal candidiasisCochrane Review (2001) by the same authors of this study. Title: Oral versus intra-vaginal imidazole and trazole anti-fungal treatment of acute, uncomplicated vulvovaginal candidiasisYesUnclear | Paper-based, in-personPostal, pharmacy-based, in-person by pharmacistG2: One visit and 1 followup phone call at 4–6 weeks G3: CPE session=1 hour presentation, 90 minute case study workshop, total time: 2.5 hoursG4: G2+G3 | Combined | Guideline recommendations |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Wetter et al., 200638 | G1: Single standard telephone-counseling session (increase reach)G2: Multiple enhanced telephone counseling sessions (multicomponent) | Skills buildingSC Consisted of the single CIS counseling session that had been delivered during the initial call to the CIS, plus an offer of Spanish language self-help materials that would be mailed to the participant.Skills buildingEnhanced Counseling was Standard counseling plus 3 additional proactive counseling calls; involved practical counseling (the identification of triggers to smoke and high risk situations, as well as coping strategies); social support from counselor and assisting participant in strategies for obtaining social support in their environment; motivational enhancement techniques; culturally tailored | Smoking cessation; preventionGuidelineYesNo | Phone-based supplemented by printed materialsCounselors from CIS and research teamG1:#: 1 calllength: NRtotal time: NRG2:#: 4 callslength: Call 2: M=16 min; Call 3: M=15 min; Call 4: M=14 mintotal time: Approx. 45 min + initial call | Qualitative | Motivational, coping, social support |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Wolters et al., 200539 | G1: Control mailed guidelines (increase reach)G2: Intervention involving package for learning, supporting materials, decision tree, and information leaflets for patients (multicomponent) | Postal mail/emailSent existing national guidelines on LUTSMulticomponentPackage for learning + supporting materials + decision trees + information leaflets for patients | LUTSDutch College of General Practitioner’s clinical practice guidelineNoUnclear | Paper-basedPostal1 time | NR | G2: Items designed to enhance knowledge. PIL contained background information, package of questions reflecting on a recent male patient attending surgery with LUTS, the clinical management of hypothetical four cases, clinical management of LUTS, statements about (fear of) prostate cancer, and possible barriers around bladder catheterization in care of acute urinary retention. The consultation supporting materials included Dutch College of General Practitioners guidelines on Lower urinary Tract Symptoms summarized on a A5 format card, The guideline summarized in two decision trees, IPSS, BS, Voiding dairy. The patient information leaflet talked about the causes of LUTS and treatment options and prostate carcinoma in relation to LUTS and the limitations of PSA-testing |

Table F-4. Key question 2 intervention descriptions (continued)

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| --- | --- | --- | --- | --- | --- | --- |
| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Wright et al., 200840 | G1: Standardized lecture by expert opinion leader (increase motivation)G2: Standardized lecture by expert opinion leader + academic detailing and a toolkit (multicomponent) | Opinion leadersStandardized formal lecture led by expert opinion leader in colon cancer. The lecture emphasized the importance of adequate lymph node assessment in colon cancer management to the local surgeons and pathologists.MulticomponentStandardized formal lecture led by expert opinion leader in colon cancer (as in comparator 1); also, the expert opinion leader met with locally identified opinion leaders in colon cancer to discuss the importance ofadequate lymph node assessment, local barriers to improving lymph node assessment, and possible solutions (academic detailing) and provided the local opinion leader with a toolkit containing a pathology template and a poster and pocket cards that emphasized that 12 lymph nodes should be assessed. A followup reminder package was sent 6 months after the presentation to the treatment  | Colon cancer; treatmentGuidelinesNoNo | in-personExpert and local opinion leaders in colon cancerG1: Expert opinion leader in colon cancerG2: Expert and local opinion leaders in colon cancerG1:#: 1 lecturelength: NRtotal time: NRG2:#: 1 lecture + one academic detailing session length: 15–30 minutestotal time: NR | NR | Guideline recommendations |

Table F-4. Key question 2 intervention descriptions (continued)

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| **Author,****Year** | **Groups**  | **Comparators**  | **Clinical Focus of the Evidence,****Source** **of Information,****Theory-Based,****Prior Testing** | **Intervention Format,****Delivery Agent,** **Intensity** | **Evidence Presentation**  | **Message of Intervention** |
| Wright et al., 200840 (continued) |  | group only, which included a cover letter from the expert opinion leader, a peer-reviewed article regarding optimization of lymph node assessment by using lymph node clearing solutions, and more of the same pocket cards. |  |  |  |  |

Abbreviations: ADHERE = acronym for six key heart failure clinical practices for improved patient health outcomes; AF = audit and feedback; AHCPR = Agency for Health Care Policy and Research; AHR = airway hyper-responsiveness; ATP III = Adult Treatment Panel III; BPH = benign prostatic hypertrophy; BS=Bother score; CAL = computer-assisted learning; CaP = Cancer of the Prostate; CDC/ACSM=Centers for Disease Control and American College of Sports Medicine (joint study); CD-ROM=prepressed compact disc that contains data accessible to, but not wriTable F-by, a computer for data storage and music playback; CHF = congestive heart failure; CIS=Computer Information Service; CME = continuing medical education; CNCP = Chronic non-cancer pain; COPD = chronic obstructive pulmonary disease; COPE = Compassionate Options for Progressive Eldercare; COX-2 = Cyclooxygenase-2; CPG = Clinical Practice Guideline; CRC = colorectal cancer; CV = cardiovascular; DASH = Dietary Approaches to Stop Hypertension; DEGAM=German College of General Practitioners and Family Physicians; DVD = optical disc storage format; EMR = electronic medical record; FOBT = fecal occult blood test; G = group; GP = general practitioner; hr = hour; IPSS=International Prostate Symptom Score; JNC-V = Joint National Committee; KNGF = Royal Dutch Society for Physical Therapy; LBP = lower back pain; LHA = lay health advisor; LUTS=lower urinary tract symptoms; MAA = Motor Accidents Authority; NIH = National Institutes of Health; NR = not reported; NSAID = nonsteroidal anti-inflammatory drug; OTC = Over the counter; PA = physician’s assistant; PDA = personal digital assistant; PER = practice enablers and reinforcers; PIL = packaged for individual learning; PRISM=Personally Relevant Information about Screening mammography; PSA = prostate-specific antigen; pt = patient; Q&A = Questions and Answers; SC = Standard Counseling; SCPPE = \_; SIGN=Scottish intercollegiate guideline network; TP = Tailored print; TC = Tailored print and telephone counseling; TPV = tailored and targeted print and video; US=United States; USPTF = US Preventive Services Task Force; VA = Veterans Administration.