Moving from evidence to innovations in practice

• OR ....

Why we need to widen our thinking about evidence and evidence based practice
Moving from Evidence to Innovations in Practice

Prof. Gill Harvey, The University of Adelaide

Broadcast live from the Australasian College of Infection Prevention and Control

Moving from Evidence to Innovations in Practice

• A brief look back in time
  – The promise of evidence-based medicine/practice
  – Increasing recognition of translational challenges

• Are we making progress?
  – And if not, why not?

• The knowledge practice gap
  – How we see it
  – How we make sense of it

• Strategies for supporting implementation

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The 1990’s .....
The promise of evidence-based practice

Evidence based medicine: what it is and what it isn’t

Evidence based medicine, whose philosophical origins extend back to mid-19th century Paris andifar, remains a hot topic for clinicians, public health practitioners, purchasers, planners, and the public. There are now frequent workshops in how to practice and teach it (one sponsored by the BMJ will be held in London on 24 April), undergraduate and postgraduate training programmes are incorporating it (or providing how to do wo), British centers for evidence based practice have been established or planned in adult medicine, child health, surgery, pathology, pharmacotherapy, nursing, general practice, and dentistry; the Cochrane Collaboration and Britain’s Centre for Review and Dissemination in York are providing systematic reviews of the effects of health care new evidence based practice journals are being launched, and it has become a common topic in the lay media. But enthusiasm has been mixed with some negative reactions. The concept of evidence based medicine is still far from being a dangerous innovation, perhaps by the

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The early 2010’s

Research

CareTrack: assessing the appropriateness of health care delivery in Australia

Objective: To determine the percentage of health care encounters at which a sample of adult Australians received appropriate care in accordance with evidence-based or consensus-based guidelines.

Design: A retrospective analysis of re-creation and review of medical records from 2005-2007 of a sample of 2005 adults matched to Australian compliance with 132 expert consensus and evidence-based guidelines. The sample was selected from households in the states of South Australia and New South Wales, chosen to represent the socio-economic profile of Australians. Health care was recorded in medical care practices and hospital with oncologists, gastroenterologists, psychiatrists, endocrinologists, urologists, and specialists in general practice. Overall appropriate level of care received 57% of the time.

Variable compliance with indicators of appropriate care, for example:

- Obesity 24%
- Stroke 53%
- Low back pain 72%
- Coronary artery disease 90%

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Are we making progress?

• How we think and talk about evidence, knowledge and knowledge translation

• How we think evidence relates to improvements in practice

• How we plan and support implementation

Some propositions ..... 

1. Good research is not enough to guarantee its uptake in practice

2. The pipeline model of knowledge translation fails to represent the reality of implementing new knowledge in practice

3. We need to embrace more dynamic and iterative conceptualisations of evidence and knowledge translation in healthcare
Proposition 1: Good research does not guarantee people will use it

- Explicit formal knowledge vs knowledge derived from clinical and patient experience
- Population level evidence and patient-level clinical decision making
- Direct (instrumental) use of research vs sense-making and enactment of evidence in practice
- Contested and negotiated nature of evidence
- Effectiveness vs other determinants of quality care, e.g. acceptability, appropriateness, access, equity etc.
Proposition 2: Problems with the pipeline

- Assumption of rational-linear decision making
- Focus on increasing accessibility, awareness, acceptance of and adherence to research
- Limited acknowledgement of the influence of context and the complexities of clinical decision-making
Proposition 3: Viewing evidence and practice change as complex and multi-dimensional

- Understanding processes of individual, team and organisational behavioural change
- Acknowledging contextual influences: local, organisational and health system level
- Importance of forming networks and fostering relationships
- Producer-push models of implementation vs co-production and integrated approaches
- From straight-line to multi-dimensional thinking
Embracing a more dynamic perspective

- **WHAT** is being implemented: characteristics of the innovation or change
- **WHO** is involved: characteristics of the target groups for implementation
- **WHERE**: characteristics of the setting for the intended change
- **HOW**: implications for the process of implementation

Introducing the i-PARIHS framework

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The i-PARIHS framework

\[ SI = \text{Fac}^n(I+R+C) \]

SI = Successful Implementation
- Achievement of agreed implementation/project goals
- The uptake and embedding of the innovation in practice
- Individuals, teams and stakeholders are engaged, motivated and 'own' the innovation
- Variation related to context is minimised across implementation settings
Fac\(^n\) = Facilitation (role and process)
I = Innovation (diverse sources of evidence that drive change)
R = Recipients (individual and collective)
C = Context (inner and outer)
In conclusion ....

• Why do we need to widen our thinking about evidence and evidence-based practice?
• Because .... it’s complex!
• Research evidence, clinical guidelines etc. help to synthesise and codify knowledge of best practice
• But we also need to think about who are the intended users of the new knowledge and how they will respond?
• What behavioural changes will be required at a clinical, team and/or organisational level?
• What contextual factors might act as barriers or enablers?
• And what structures, processes and supports need to be put in place to actively enable and embed implementation?
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Prof. Jerry H. Kavouras, University of Illinois at Chicago

December 15  (FREE Teleclass)
INFECTION CONTROL IN ELDERLY CARE INSTITUTIONS – WHERE SHOULD WE GO?
Prof. Andreas Voss, Radboud University Medical Centre, The Netherlands

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