We have the evidence to improve venous leg ulcer outcomes: How do we get this evidence into practice?

Rajna Ogrin  BSc, BPod(Hons), PhD
Senior Research Fellow

Appropriateness of Healthcare delivery in the community

• American adults received “recommended care” only 55% of the time in the years 1999–2000 (McGlynn et al, 2003)

• Similar study in Australia: Adult Australians received appropriate care at 57% (95% CI, 54%–60%) of 35 573 eligible health care encounters (Runciman et al, 2012)
Current information on care of VLU in Australia

• KPMG 2013 study commissioned by AWMA
  – VLU treatment currently involves
    • Variety of treatment provider arrangements
    • Across jurisdictions
  – Variable Compression therapy use:
    • By community nurses range from 17-100%
    • By GP’s range from 0-50%
  – Limited data available on healing times
    • Had to draw on the published literature

Coyer et al 2005 shows more detailed info re: variation from best practice

• And yet we have many clinical practice guidelines and systematic reviews highlighting what is best practice......
  – NHMRC
    • 61 new guidelines and standards issued between 2009 – 2012
  – We have a number of clear, evidence based, clinical practice guidelines in VLU for:
    • Assessment
    • Diagnosis
    • Management
    • Prevention of recurrence
      – Eg. AWMA, SIGN
VLU

- We know that implementing evidence-based care is significantly related to improved healing outcomes ($p < 0.001$) (Edwards et al, 2013)

So why isn’t evidence implemented in practice?

Need to ask....

- How do clinicians translate new knowledge into specific clinical actions that they adopt into practice?
Current thinking

Evidence → Something magic happens → Change in practice

Reality

- Requires active processes of translation
  - Start with clinicians’ awareness that there’s an issue
  - End with patient adherence to the recommended care
- New science developed on this topic:
  - Implementation Science
  - Much research being done in this area
    - Indicate that a raft of processes required
    - Complex
To simplify – 5 key questions

From Grimshaw et al. 2012
What should be transferred?

• Up-to-date systematic reviews or other syntheses of the global evidence
  – BUT must be in a form that is appropriate for those using them

To whom should research knowledge be transferred?

• Varies by the type of research being translated
• Eg
  – clinical research demonstrating harm of treatment
    • National policy makers (including regulatory bodies) and industry.
  – clinical research demonstrating benefits from treatment
    • Patients, healthcare practitioners, local administrators, national policy makers, and industry
By whom should research knowledge be transferred?

• Depends on the target audience and research knowledge being transferred
  – Need to spend effort to identify most appropriate
• May be
  – an individual
    • healthcare provider,
    • researcher, or
    • consumer,
  – group,
  – organization, or
  – healthcare system.

Must have....

• Credibility with the target audience,
• Possess the skills and experience needed to transfer the research knowledge at hand, and
• Have time and resources to do so
How should research knowledge be transferred?

• Process must be planned
  – Systematic sequence including over a dozen steps
    • Most need to be addressed BEFORE implementation begins.
  – Best achieved through combination of multiple activities
    • assessment, negotiation and collaboration, organized planning and structuring, personal reflection and critical analysis.

(Meyer, Durlak and Wandersman, 2012)

• Identify barriers and which are modifiable and non-modifiable
  – Organizational culture
    • lack of leadership commitment
    • lack of middle management engagement
    • lack of ownership
    • lack of equitable resourcing for people, process and technology
Operational barriers

• poor Knowledge Management processes
• lack of appropriate technology and skills
• issues with the scope of the content
  — too large, inadequately representative
• No culture of continually learning and incorporating the needed and accessible knowledge into practice
• the physical layout of the work environment does not match the collaborative intent of the strategy.

Individual barriers

• Eg. Resistance to the sharing of knowledge at the individual level
  — It’s not convenient.
  — They don’t know what they know.
  — They don’t know the value of what they know.
  — They believe knowledge hoarding is job security.
  — They don’t get credit for it.
  — They don’t have the time.

(Taylor Gates, 2006)
Barriers to EBP in wounds:

• Lack of:
  – information and skills (Coyer et al, 2005; Harrison et al, 2005)
  – difficulties with access to evidence based guidelines (Fife et al, 2010)
  – reimbursement associated with specialist wound care and treatments such as compression bandaging
  • high cost of care (Fife et al, 2010; Weller, & Evans, 2012)
  – limited access to specialist multidisciplinary teams (Ndip & Jude, 2009)
  – poor communication (Coyer, et al, 2005)

Taken from Edwards et al, 2013

• Next step....
  – Choose appropriate interventions to address overcoming barriers and supporting enablers:
    • identify potential adopters and practice environments; and
    • prioritise which barriers to target based upon consideration of ‘mission critical’ barriers.
Strategies

– Professional behaviour change strategies
  • Printed educational materials
  • Educational meetings
    — Interactive and participatory
  • Educational outreach
  • Local opinion leaders
  • Reminders
  • Audit and feedback
    — any summary of clinical performance of healthcare over a specified period of time to change health professional behaviour
  • Tailored interventions
  • Multifaceted interventions

– Strategies focusing on consumers
  • Interventions to:
    — facilitate communication and/or decision-making
    — support behaviour change
    — inform and educate

– Strategies focusing on policy makers and senior health service managers
  • Increase interactions between researchers and policy makers; and
  • Research to match beliefs, values, interests, or political goals & strategies of elected officials, social interest groups, & others.
With what effect should research knowledge be transferred?

• Varies across different stakeholder groups
  – Health care professionals
    • Practice that is more evidence-based
    • Observable
      – changes in professional behaviours and quality indicators.
  – Policy Makers
    • ensure that consideration of research evidence is a key component of their decision making, but recognize that there are other legitimate factors
      – Eg. the policy context for policy makers, values and preferences of individual patients – so likely evidence-informed

Continuous Improvement

Should be based on ongoing monitoring of the appropriateness of care (Runciman et al, 2012).

• A Clinical registry is one effective approach.....
  – *It provides a summary of clinical performance of healthcare over a specified period of time*
    • Can be used to change health professional behaviour
References


Thank you

rogrin@rdns.com.au