THE ECOSYSTEM OF EVIDENCE

Lessons learned in the pandemic era and future challenges

10th International Conference for EBHC Teachers and Developers
10th Conference of the International Society for EBHC
Taormina, 25th - 28th October 2023

#EBHC2023

Evidence-based practice and knowledge translation:

In tandem or in tension?

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Transdisciplinary Model of EBP

Sackett et al., 1996; Haynes et al. 2002; Shaneyfelt et al., 2009

Political context

Organizational mandate

Socio/historical context

Community

Client state and circumstance

Professional expertise

Client's preferences and actions

Research evidence

Training/supervision

Professional context

Organizational resources/constraints

Economic context

Aims

1) to identify conceptual and methodological blind spots of EBP, and how KT scholars should consider these for their interventions to succeed;
2) to discuss the possible root causes of these blind spots;
3) to discuss how a contemporary view of EBP can pave the way for KT interventions that will produce sustained behaviour change and improve health outcomes.

Barriers to uptake of EBP

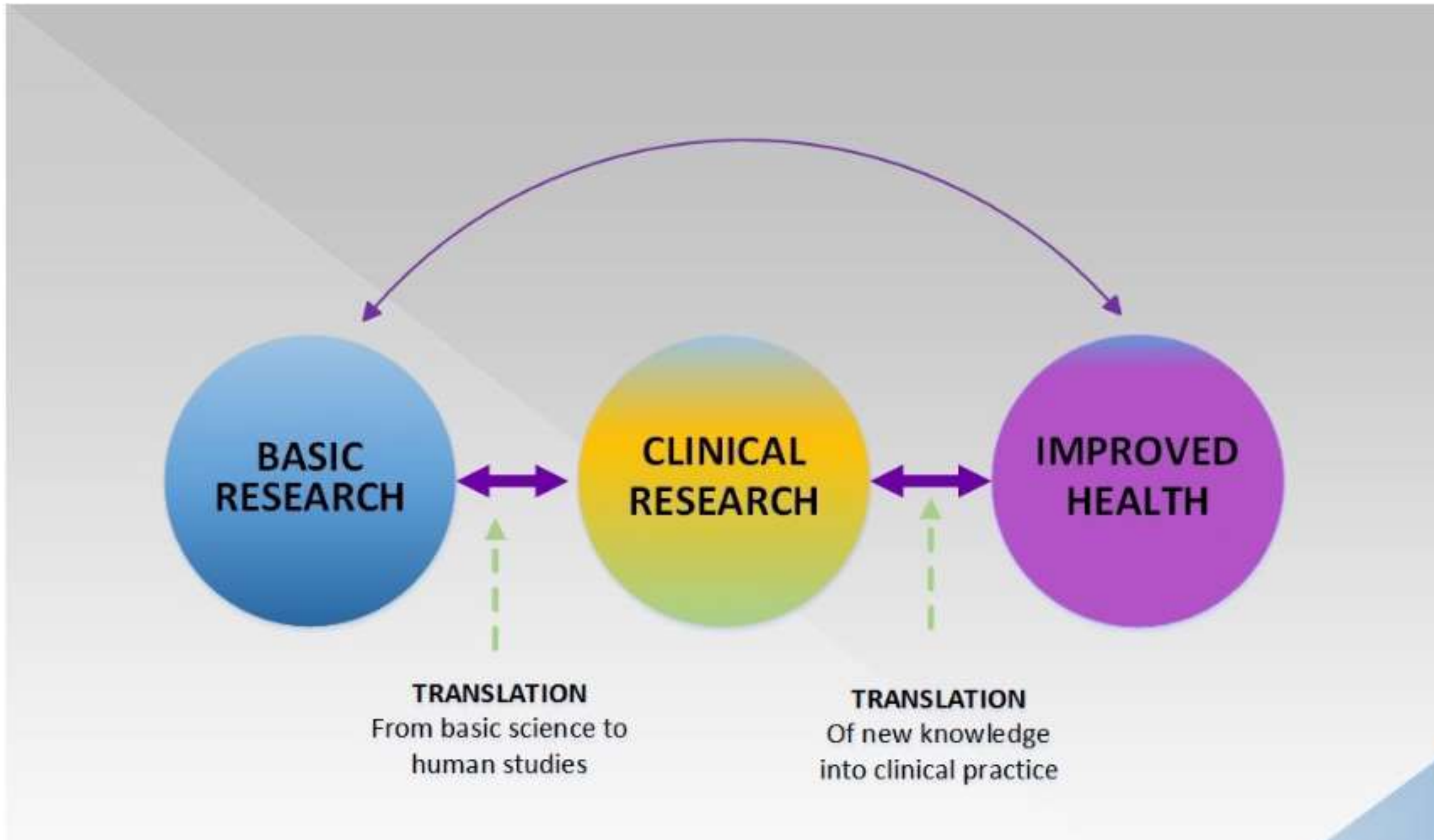
- Confidence
- Knowledge
- Competencies
- Roles
- Attitudes
- Underlying philosophy of care
- Training and CPD

- Leadership style
- Culture
- Staff involvement
- Relationships
- Available resources
- Access to literature
- Heavy case loads
- Competing demands

- Policy on care priorities
- Economic & financial incentives
- Regulatory expectations
- Dominant paradigm
- Stakeholder buy-in
- Infrastructure
- Public awareness
- Advances in technology

(Dubouloz 1999; Fortune, 2000; Humphris, et al., 2000; Dysart & Tomlin 2002; Craik & Rappolt 2003; Bennet et al., 2003; Finlayson 2005; Korner-Bitensky 2006; Welch & Dawson 2006; Grol & Wensing 2006; Salbach 2007; Brown 2009; Copley & Allen 2009; Carrier 2010; Dannapfel 2013; Thomas & Law, 2013; Scurlock-Evans 2014; Murray 2015; Bussières 2016; Britton 2016; Yuen et al., 2017; Devery 2018; Bennett 2019; Billings 2018; Summers 2018; Béliveau 2019)

Knowledge translation (KT)



- The links or underlying conceptual, philosophical, and methodological principles of EBP and KT, and how these may align or be in tension remains unclear.

2012)

EBP blind spot - The example of back

Leading cause of disability worldwide since 1990, mostly affects poorer individuals, living in remote regions, women and older people.

Small clinical benefits of nearly all treatment modalities (>3,600 RCTs)

- ***Wrong population*** *(most RCTs in high income countries in young middle-age white people, fail to consider associated multisite pain, comorbidities, and Social Determinants of Health)*
- ***Wrong treatment*** (most therapeutic modalities focus on back pain only)**?**
- ***Wrong outcomes*** (pain, function, disability)**?**

Generalizability of international guidelines based on systematic reviews of RCTs?

KT blind spots – The example of cultu

Equity, Diversity and Inclusion

Phase 2
Solution Building

3. Select, Tailor and Test Implementation Interventions
2. Assess Innovation, Adopters, and Practice Environment for Barriers and Supports
1. Align Knowledge to Local Context (practice and system)

Phase 3
Implementation, Evaluation and Sustainability

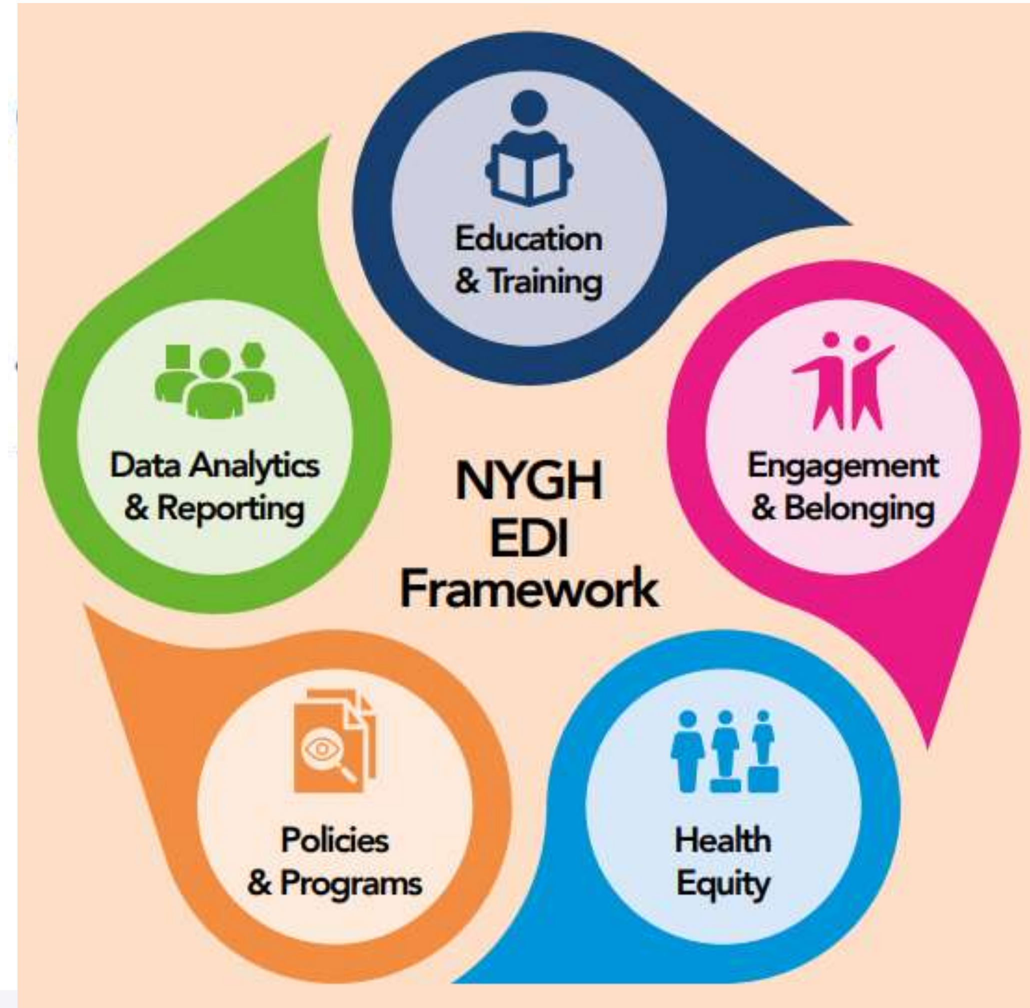
1. Monitor Knowledge Use and Evaluate Implementation Processes
2. Evaluate Outcomes
3. Nurture Change and Sustain Knowledge Use

Knowledge Creation
Inquiry
Synthesis
Tools/ Products

Tailoring Knowledge
Tailoring Knowledge

Phase 1
Identification and Clarification of the Practice Issue/Problem

1. Call to Action
2. Guideline Development Plan
3. Search & Screen
4. Assess & Select
5. Draft, Revise and Endorse



KT blind spots – culture & context

Reducing barriers to conservative spine care to minimize opioid exposure in the Northern Indigenous community of Pimicikamak, MB, Canada: A Global Spine Care Initiative (GSCI) and World Spine Care Canada (WSCC) implementation project

Bussières A., Passmore S., Tavares P., Kopansky-Giles D., Ward J., Ladwig J.C., Haldeman S., Glazebrook C., Atkinson-Graham M., Nordin M., Mior S., Hurwitz E.L., Woolf A.D., Johnson M., Fowler-Woods M., Moss J., Scott M., Robak N., Broeckelmann E., Smolinski R., Hogg-Johnson S., Hamilton H., Mckay D., Monias D.

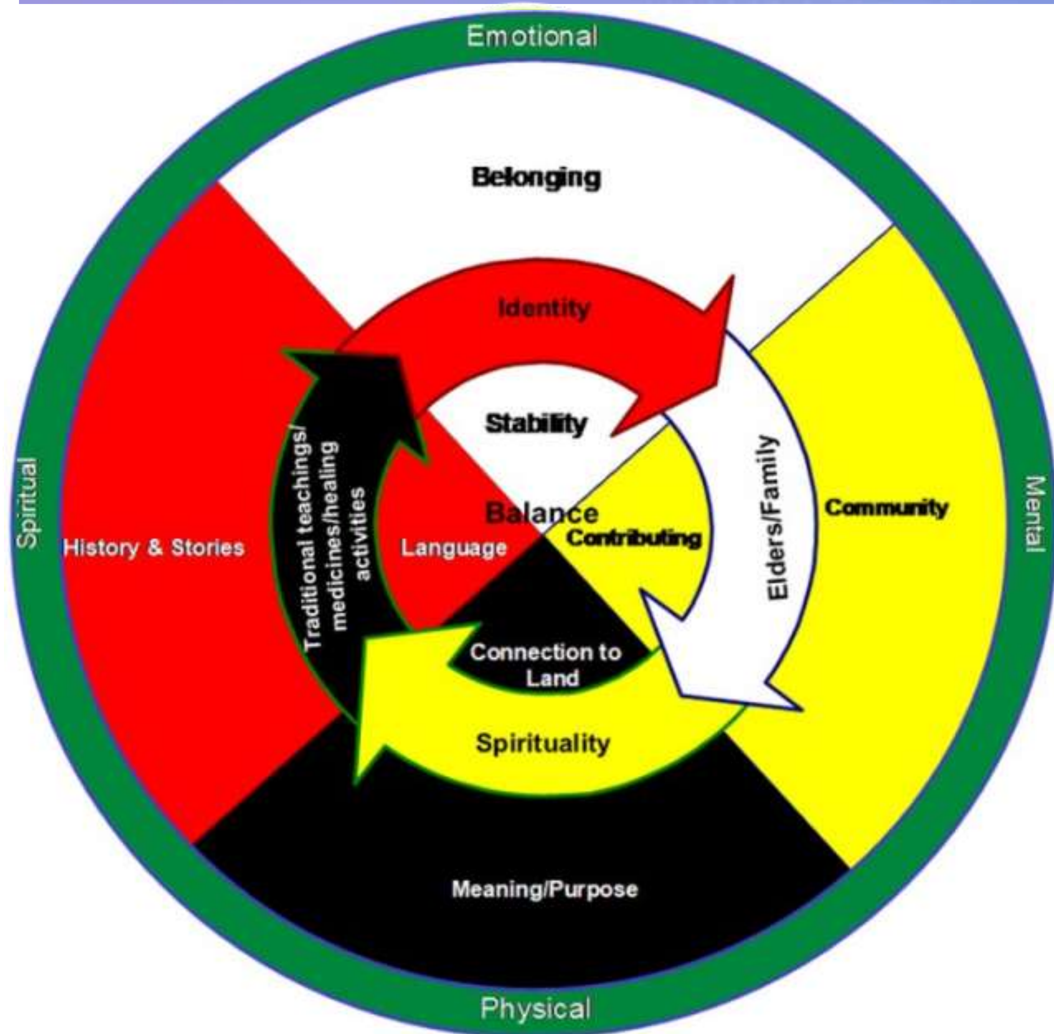
Remote Northern Indigenous populations have a **GREATER** burden of injury and diseases. In part, these disparities are due to the **LIMITED** access to health care. **Serious injury and illness require patients to fly out**

This project takes place in a First Nations community located **520 km** north of Winnipeg, Manitoba's capital city.

Aim: to assess the readiness and feasibility to implement a model of spine care in a northern Canada First Nation community **using mixed-methods participatory approach.**

Methods

First Nations Medicine Wheel



Thematic content analysis to identify theoretical opportunities & challenges

Cultural Safety
Strengths
Resiliencies

Quantitative analysis: Prevalence, burden, self-care

Analysis, Reflection, Ongoing Consultation

Spiritual Health

Emotional Health

Physical Health

Mental Health

Researcher Positionality

Causality
Access to Equipment & Services

Capacities
Mobility
Comorbidity Awareness and Prevention

Quantitative (Community health survey, Chart review, Adoption survey)

Housing
Family
Community
Ceremony

Qualitative interviews: First Nations persons and their caregivers

Adapted from Juutilainen et al., 2019

Results

Quantitative studies

Community Health Survey (n=130)

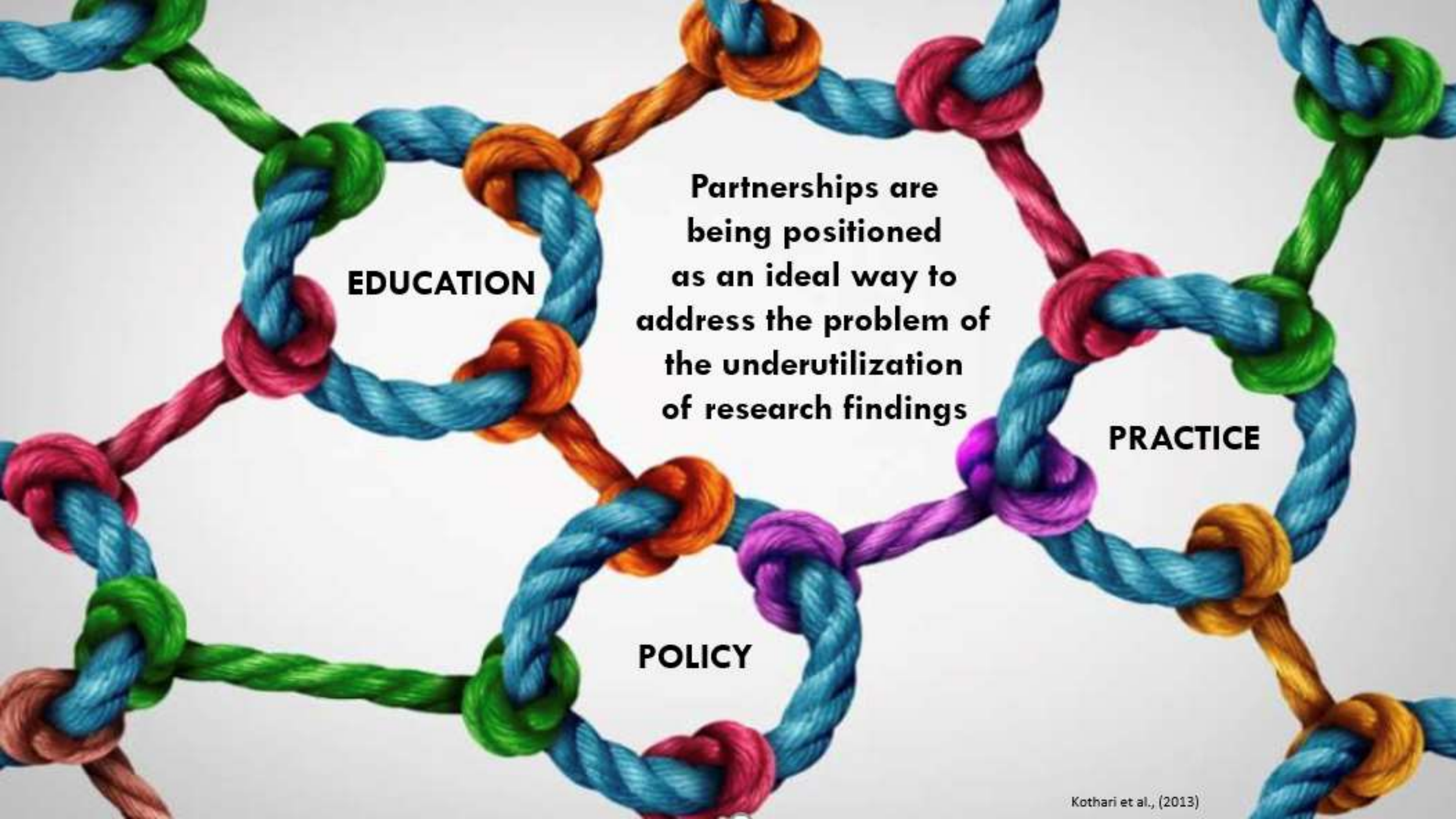
Chart review in Nursing Station (n=41)

1) Prevalence & burden of spine pain, and related comorbidities are very high
2) Access to high-value spine care is limited
3) Potential to reduce diagnostic imaging and opioids prescribing/use

Qualitative interviews of Clinician (n=10) and Community

5) Chiropractic care, manual therapy, massage therapy, and acupuncture align with Indigenous ways of healing

6) Strongly engaged leaders & local clinicians are helping culturally adapt an implementable model of spine care.


Partnerships are
being positioned
as an ideal way to
address the problem of
the underutilization
of research findings
EDUCATION
PRACTICE
POLICY
Kothari et al., (2013)