

MDM logo



The Road to EBM

## 1 How can divisions promote EBM?

### Summary of practical points from this section

This section will help you decide how your division might approach the task of promoting and supporting EBM in general practice. This involves:

- appreciating your division's skill set and resources
- understanding what your GP members need or want in regard to 'evidence'
- knowing which strategies work to change GP behaviour rather than simply impart information, and
- developing a plan to incorporate EBM into existing divisional activities.

### 1.1 Defining objectives

Divisions first need to decide what it is they wish to promote- the 'how' comes later. With this in mind it is important to reconsider the three components of EBM mentioned in the first chapter; namely its philosophy, its skill set and the tools needed to practice it.

#### Philosophy / EBM thinking

An important step for GPs to take is to understand the 'thinking' behind EBM. This means having an understanding of what EBM is and what it isn't. It also means understanding the probabilistic nature of clinical practice and the extent to which interventions impact on risk. Regarding this, a Division might aim simply to explain EBM to its members or investigate the barriers and facilitators to evidence based practice which might be particular to its membership. It might also decide to provide leadership in championing evidence based practice in its region.

There might also be a degree of attitudinal change necessary for GPs to become more acquainted with the principles of EBM. There is both 'self-efficacy'- a belief that one can achieve something – and 'expectancy'- the value that one puts on an outcome – to be achieved before GPs will decide to become more evidence based. Here, local opinion leaders can be used to promote EBM and GPs could be encouraged, perhaps in the workshop setting (refer to section titled, '*Specific Interventions*') to explore the barriers to their own evidence based practice.

#### Skills

The Division could decide to improve GPs skills in EBM. The skills of EBM are those of the 'five steps' as mentioned in 1.4 of 'What is evidence based medicine?' They are, in summary: framing questions, searching electronic databases, critical appraisal, applying the evidence and evaluation. The best way for GPs to learn these skills is in the clinical context. The small group interactive setting of the workshop (refer to '*Specific Interventions*') or the informal atmosphere of the journal club are ideal for skills development. Searching databases on the internet (or CD-ROM) may also involve improving general IT skills and this may or may not be within the scope of the division's resources.

When talking about EBM skills, it is easy to over-emphasise the 'five steps' and get stuck in a discussion about the detail while losing sight of the 'big picture'. For example, it might be less important to learn about the ten sorts of bias in an RCT than to learn to think critically about **all** the new information you come across, be it from your colleagues, a visiting professor or on the internet.

## Resources

Finally, the Division might want to promote EBM resources such as evidence based books and journals, internet sites and clinical practice guidelines. Access to the evidence is an important barrier to practice. Evidence based resources could be integrated into the CME activities of the Division. Presenters should be encouraged to advertise appropriate web-sites or CD-ROMs as future resource material for GPs. Electronic journals and clinical practice guidelines (both paper and internet based) could be advertised in division newsletters while the various EBM resources available on the Monash Division's website could be adapted for local use and distributed to interested GPs.

The best way to find out what a division can do to help GPs move along the road to EBM is to canvas the opinion of the membership regarding their needs. This 'needs assessment' should be formalised and done in a systematic way so as to get the most benefit from the results. A needs assessment of an average division would probably take 3-4 months and cost about \$7,000-\$10,000 in wages and consumables (not counting office space and equipment). It is also important to discuss whether a needs analysis is justifiable without the prior resource commitment to implementation of the inevitable recommendations.

### **1.2 Which strategies are effective in promoting change among clinicians?**

It is important that divisions which are about to preach about EBM should practice in an evidence based way, and accordingly choose strategies which have been shown to be effective. There are many different approaches to changing clinician behaviour, from simple CME events to legally binding government directives. The evidence suggest that these vary in their effectiveness, and GP divisions should examine closely which techniques might be most effective in their particular setting before embarking on an EBM program. On the other hand, not all strategies have yet been trialed or their effectiveness assessed, and so divisions should not be discouraged from being innovative and trying and/or evaluating their own strategies. The following table lists strategies which divisions may use to implement EBM, categorised according to their evidence based effectiveness. By no means should divisions feel restricted to this list, but it is nevertheless important to be aware of what has and has not been shown to be effective.

It is important to understand that the categorisation below is made on a summary of available evidence and that the effectiveness of a particular strategy might depend on other things rather than just the strategy itself. For example, a strategy using educational materials might be effective in a specific setting while academic detailing may be ineffective if the technique is poor.

**Table 1. Strategies to promote behaviour change in physicians.** <sup>1</sup>

Strategy	Explanation	Example
<b>Proven effectiveness</b>		
Academic detailing	This means visiting GPs in their practices on a one-to-one basis like drug reps. It is also known as academic outreach, educational outreach or simply practice visiting.	Quality use of medicines project.
Reminders	Interventions that prompt the health care provider to perform a clinical action. They can be manual or electronic.	'Flags' in clinical notes.
Multifaceted interventions	A combination of interventions.	Division projects which combine workshops, academic detailing, local opinion leaders and audit to effect change.
Interactive educational meetings	Settings where the emphasis is on the dialogue between participants rather than on the presenter or 'expert'.	Workshops (see box in 1.4 of this resource).
<b>Variable effectiveness</b>		
Audit and feedback	A report of clinical performance derived retrospectively or prospectively from records or direct patient encounters.	Quality use of medicines project.
Local opinion leaders	The use of clinicians chosen for their influence on the opinion of their colleagues.	A local specialist with an interest in evidence presenting recent research results (see 1.4).
Local consensus processes	Involving local GPs (ie division members) in selecting the problems to be tackled and the approaches to solving them.	Division business planning or program development.
Patient mediated interventions	Interventions which are directed at patients but which aim to change behaviour in health care providers.	Pharmaceutical companies running 'public health' advertisements in the popular media.
<b>Little or no effect</b>		
Educational materials	Published or printed recommendations for patient care including clinical practice guidelines and audiovisual materials.	Guidelines received in the mail with out accompanying support or implementation strategies.
Didactic educational meetings	Conferences or traditional lectures without input from the participants.	A large proportion of CME!

### **1.3 A framework for developing and implementing an EBM program**

There are several strategies divisions might use to implement an evidence based medicine program. It is important to start with a reasonable assessment of the resources available and a firm understanding about EBM. The subsequent steps have been developed as a framework for changing clinical behaviour and are based on both the theory behind behaviour change and the evidence of effectiveness. <sup>1 2</sup>

#### **Assess resources available**

Some interventions are costly and will be beyond the scope of most divisions unless extra project funding is available. Costs are further discussed below. Other interventions might be able to make use of existing divisional resources such as infrastructure, IT and administration. In addition, some existing divisional projects, such as IT/IM or clinical projects, might be enhanced by an EBM influence and might allow a dovetailing of EBM principles into the project structure.

## Understand the principles of EBM

Those involved in the program should have a thorough understanding of the concepts of evidence based medicine and in particular the attitude and understanding of the local divisional members. It is also important to ensure that the controversies and shortcomings of EBM are understood and explained.

## Canvas the membership to develop a concrete proposal

The proposal for the EBM strategy should be formed by consensus among the division membership with involvement from all important groups. The expected performance of GPs should be detailed and explicit from the start, so that participants can develop a belief that the program is 'do-able'. This goes together with the concept of 'self-efficacy', which is the belief that one can perform a given task, and is a crucial factor in the behaviour change process.<sup>3</sup>

## Identify obstacles to change.

Because divisions form a link between the EBM resource system (research) and the user system (general practice) they are in a unique position to assess potential barriers to the change process.<sup>4</sup> Division members involved in the program will be able to identify the likely and predictable obstacles. These may be related to the individual GP (knowledge, skills, attitudes and habits), the social context (patient expectations, practice culture) or the organisational context (resources, structures, etc).

## Link interventions to obstacles.

Interventions designed to tackle identified obstacles to change will increase the chances of success. Multiple interventions are usually more successful than single ones and these should emphasise interactive and participatory techniques.

## Establish measurable outcomes.

It is essential to measure the success of any intervention but the outcomes should be achievable and measurable. These are also best linked to the identified obstacles. For example, if GP knowledge of EBM is found to be a barrier, an intervention to increase knowledge should be implemented together with a knowledge quiz, or equivalent, as its outcome measure.

## Develop a plan

Well structured, explicitly defined steps which can be evaluated or assessed as an on-going process, will allow a speedy implementation.

## Implement the plan and conduct formative evaluation.

Introduce carefully planned interventions in a sequence, each with short time frames. More limited interventions will make it easier to 'tailor' activities for GPs who can provide immediate feedback on their effect. The evaluation ought to be able to influence the subsequent steps such as determining whether the proposal should be modified, new obstacles considered or the plan adapted to new interventions.

### **Example – Promoting evidence based guidelines.**

*A division may decide to promote the use of evidence based guidelines in general practice. Staff members would need to start by ensuring they had an understanding of the principles of EBM and making an assessment of available resources. Following this, it would be necessary to review the evidence on current accepted guidelines for 'guideline implementation' and discuss with division members the particular methods. The GP planners would decide what can be realistically achieved and would need to be explicit about the expectations of each GP. Would a series of guidelines be implemented? Who would do the implementation? How would success be verified?*

*Obstacles to change would need to be addressed. These could be GP related, such as beliefs about the benefits of guideline usage, or logistical, such as having reminder systems in place and ensuring easy and quick access to each guideline. They would most likely also relate to a lack of time. Interventions would then be linked to the obstacles. For example, an interactive CME session could be planned to present the evidence of benefit from evidence based guidelines to division members and to explore their opinions and their own personal barriers. Advertising and supporting the implementation of reminder systems could be achieved through existing IT programs, or by the use of targeted academic detailing.*

*Following this, a staged plan would be drawn up. The first stage might involve the interactive CME and awareness promotion. Later each practice might need to be assessed according to its potential to change. Some may already be using all the latest guidelines while others may have never used them. Some clinics may be hostile to the concept and require more information. Measuring instruments such as audits would need to be discussed and planned.*

*Evaluation and implementation of the plan would go hand in hand. For example, if evaluation of the interactive CME activities revealed either that GPs didn't trust guidelines or were hostile to the idea, then further implementation would need to be delayed or done in stages. If practice feedback revealed a large number of practices without clinical IT then paper-based guidelines might need more exposure.*

### **1.4 Incorporating EBM into divisional activity**

An easy and relatively cheap way of embracing EBM is to incorporate it into the other activities of the division. This not only includes having evidence based CME but also ensuring that other divisional programs are based on current, best evidence. Sackett's mantra of 'explicit, judicious and conscientious' use of evidence comes to mind, and the effectiveness of the division as a whole may be enhanced by encouraging each program to develop an evidence based framework (see 'Specific Interventions').

Most divisions have a role in providing CME for their membership and this can be a useful conduit through which to teach and promote EBM. An obvious way of doing this would be by organising specific CME activities to teach GPs the skills of EBM such as those applied to the five steps (ie searching, critical appraisal etc (see 1.1 of this resource)). This may not be as popular, however, as demonstrating the principles and teaching the skills of EBM within a CME activity on a clinical topic (see 'Specific Interventions'). For example, new advances in the treatment or prevention of a specific disease could be taught by presenting the new evidence and getting GPs to critically appraise it with the help of facilitators (see box). Likewise both the resources and skills of EBM can be promoted through other divisional activities such as IT/IM projects or the division's clinical programs (see 'Specific Interventions').

### **Evidence based medicine and cardiovascular CME**

*In the Monash Division we decided to run a workshop to promote EBM using cardiovascular disease as a theme. A brief chat to a local cardiologist revealed that the results of the recent heart outcomes prevention and evaluation (HOPE) study might be of significance to general practice. The cardiologist also mentioned that the results of an earlier study on anti-platelet drugs may have been misleading to some clinicians and he thought that it would be interesting to compare both trials in the workshop setting. In addition, he pointed out that the recent promotion of the 'New Zealand cardiovascular risk tables' via journals, the internet and government programs provided a new challenge for GPs regarding the assessment of cardiovascular risk and this could also be covered in the workshop.*

*Two planning meetings were held to establish the content and structure of the workshop and organise the reading material. The original article of the HOPE study was sent to enrolled GPs prior to the workshop and a list of important points given to the three facilitators of the interactive working groups. In the first part of the workshop the presenter critically appraised the anti-platelet drug study and then the participants (n=18) broke up into three groups to do the same to the HOPE study. The groups then reported back to the whole workshop with their conclusions. In the second half the 'New Zealand risk tables' were explained with examples and then applied to various scenarios within the interactive working groups. The workshop was two hours long (see 'Specific Interventions').*

*This format demonstrates the application of EBM skills (critical appraisal) and philosophy (the concept of risk) in the GP setting using useful and interesting topics. It also uses an effective method of CME (interactive educational meetings).*

### **References**

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