



Équipe Multidisciplinaire  
de Recherche sur les Urgences

Emergency Multidisciplinary  
Research Unit

# Identifying and traversing gaps in Evidence Based care through Knowledge Translation

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# Objectives





- Sensitize you to the gap between research and practice
- Consider an approach to understanding barriers
- Look at how KT can help you implement change



# Question 1

Based on your observation of clinical practice in the settings you have worked in over the past 4 years, what proportion of comatose survivors of cardiac arrest have undergone active cooling to achieve therapeutic hypothermia?

# Choices





-  0 – 20% of them
-  20 – 50% of them
-  50 – 90% of them
-  > 90% of them



## Question 2

Based on your observations, how often do patients with OA receive treatment with potentially risky anti-inflammatories when effective alternatives exist?

# Choices





-  0 – 20% of the time
-  20 – 50% of the time
-  50 – 90% of the time
-  > 90% of the time



# Question 3

What percentage of low-risk head trauma patients undergo evaluation with a validated Level II decision rule to determine the need for CT head?

# Choices

-  0 – 20% of the time
-  20 – 50% of the time
-  50 – 90% of the time
-  > 90% of the time









# Question 4

Based on your observations, what proportion of current smokers admitted for cardio-respiratory conditions for which smoking is a risk factor receive brief cessation counselling?

PEDS: Smoking parents of asthmatic children

# Choices

-  0 – 20% of the time
-  20 – 50% of the time
-  50 – 90% of the time
-  > 90% of the time

SPECIAL ARTICLE

## The Quality of Health Care Delivered to Adults in the United States

Elizabeth A. McGlynn, Ph.D., Steven M. Asch, M.D., M.P.H., John Adams, Ph.D.,  
Joan Keesey, B.A., Jennifer Hicks, M.P.H., Ph.D., Alison DeCristofaro, M.P.H.,  
and Eve A. Kerr, M.D., M.P.H.

### ABSTRACT

#### BACKGROUND

We have little systematic information about the extent to which standard processes involved in health care — a key element of quality — are delivered in the United States.

#### METHODS

We telephoned a random sample of adults living in 12 metropolitan areas in the United States and asked them about selected health care experiences. We also received written consent to copy their medical records for the most recent two-year period and used this information to evaluate performance on 439 indicators of quality of care for 30 acute and chronic conditions as well as preventive care. We then constructed aggregate scores.

#### RESULTS

Participants received 54.9 percent (95 percent confidence interval, 54.3 to 55.5) of recommended care. We found little difference among the proportion of recommended preventive care provided (54.9 percent), the proportion of recommended acute care provided (52.5 percent), and the proportion of recommended chronic care provided (54.3 percent).

From RAND, Santa Monica, Calif. (E.A.M., S.M.A., J.A., J.K., J.H., A.D.); the Veterans Affairs (VA) Greater Los Angeles Health Care System, Los Angeles (S.M.A.); the Department of Medicine, University of California Los Angeles, Los Angeles (S.M.A.); the VA Center for Practice Management and Outcomes Research, VA Ann Arbor Health Care System, Ann Arbor, Mich. (E.A.K.); and the Department of Medicine, University of Michigan, Ann Arbor (E.A.K.). Address reprint requests to Dr. McGlynn at RAND, 1700 Main St., P.O. Box 2138, Santa Monica, CA 90407, or at [beth\\_mcglynn@rand.org](mailto:beth_mcglynn@rand.org).

**Table 3.** Adherence to Quality Indicators, Overall and According to Type of Care and Function.

Variable	No. of Indicators	No. of Participants Eligible	Total No. of Times Indicator Eligibility Was Met	Percentage of Recommended Care Received (95% CI)*
Overall care	439	6712	98,649	54.9 (54.3–55.5)
Type of care				
Preventive	38	6711	55,268	54.9 (54.2–55.6)
Acute	153	2318	19,815	53.5 (52.0–55.0)
Chronic	248	3387	23,566	56.1 (55.0–57.3)
Function				
Screening	41	6711	39,486	52.2 (51.3–53.2)
Diagnosis	178	6217	29,679	55.7 (54.5–56.8)
Treatment	173	6707	23,019	57.5 (56.5–58.4)
Follow-up	47	2413	6,465	58.5 (56.6–60.4)

\* CI denotes confidence interval.

# Is this a problem?

## ■ IOM: Crossing the Quality Chasm

“ between the health care that we now have and the health care that we could have lies not just a gap, but a chasm”



**Table 5. Adherence to Quality Indicators, According to Clinical Area.\***

Indication	No. of Indicators	No. of Eligible Children	Total No. of Times Indicator Eligibility Was Met	Weighted Adherence Rate (95% CI) <i>percent</i>
Upper respiratory tract infection	5	654	914	92.0 (89.9–94.1)
Allergic rhinitis	2	156	159	85.3 (79.6–90.9)
Acne	8	72	85	56.8 (45.4–68.2)
Fever	15	148	328	51.4 (43.2–59.6)
Childhood immunizations	15	769	2498	49.8 (45.6–54.0)
Urinary tract infection	6	84	144	47.8 (36.7–59.0)
Vaginitis and sexually transmitted diseases	15	59	169	44.4 (33.5–55.3)
Asthma	17	165	676	45.5 (42.3–48.7)
Well-child care	33	1022	4406	38.3 (34.2–42.5)
Acute diarrhea	12	76	419	37.8 (33.3–42.3)
Adolescent preventive services	8	532	1852	34.5 (31.0–37.9)

\* Data are not reported for the management of prenatal care, otitis media with effusion, depression, or attention deficit-hyperactivity disorder, because fewer than 50 children were eligible for care processes related to these clinical areas.

Rita-Mangione et al. The Quality of Ambulatory Care  
Delivered to Children in the United States. Oct. 2007



The NEW ENGLAND  
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**So many gaps**

**How to prioritize?**



# Considerations

- Prevalence
- Harmful effects of the gap
- Beneficial impact of closing the gap
- Low lying fruit



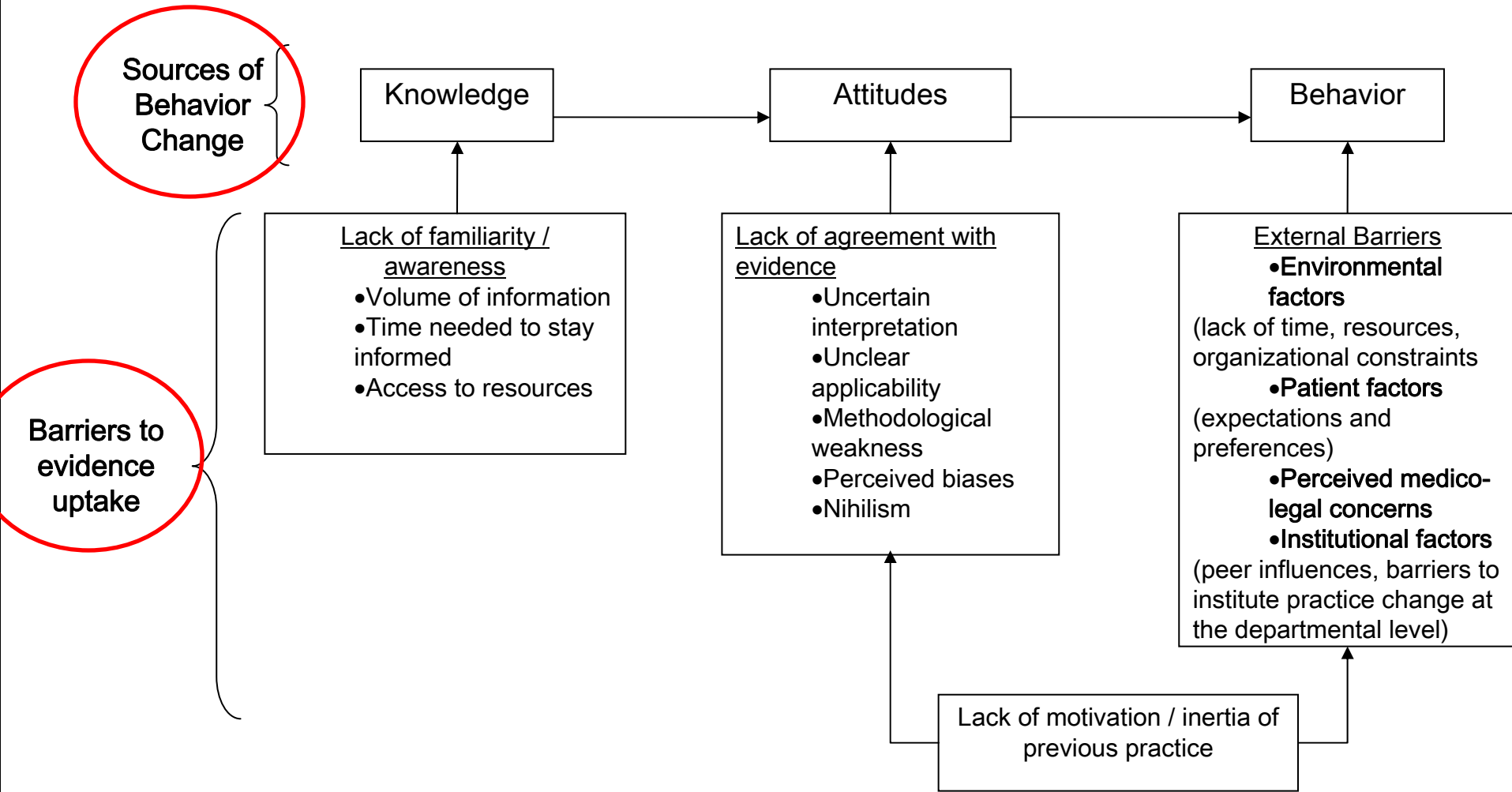
# Choices

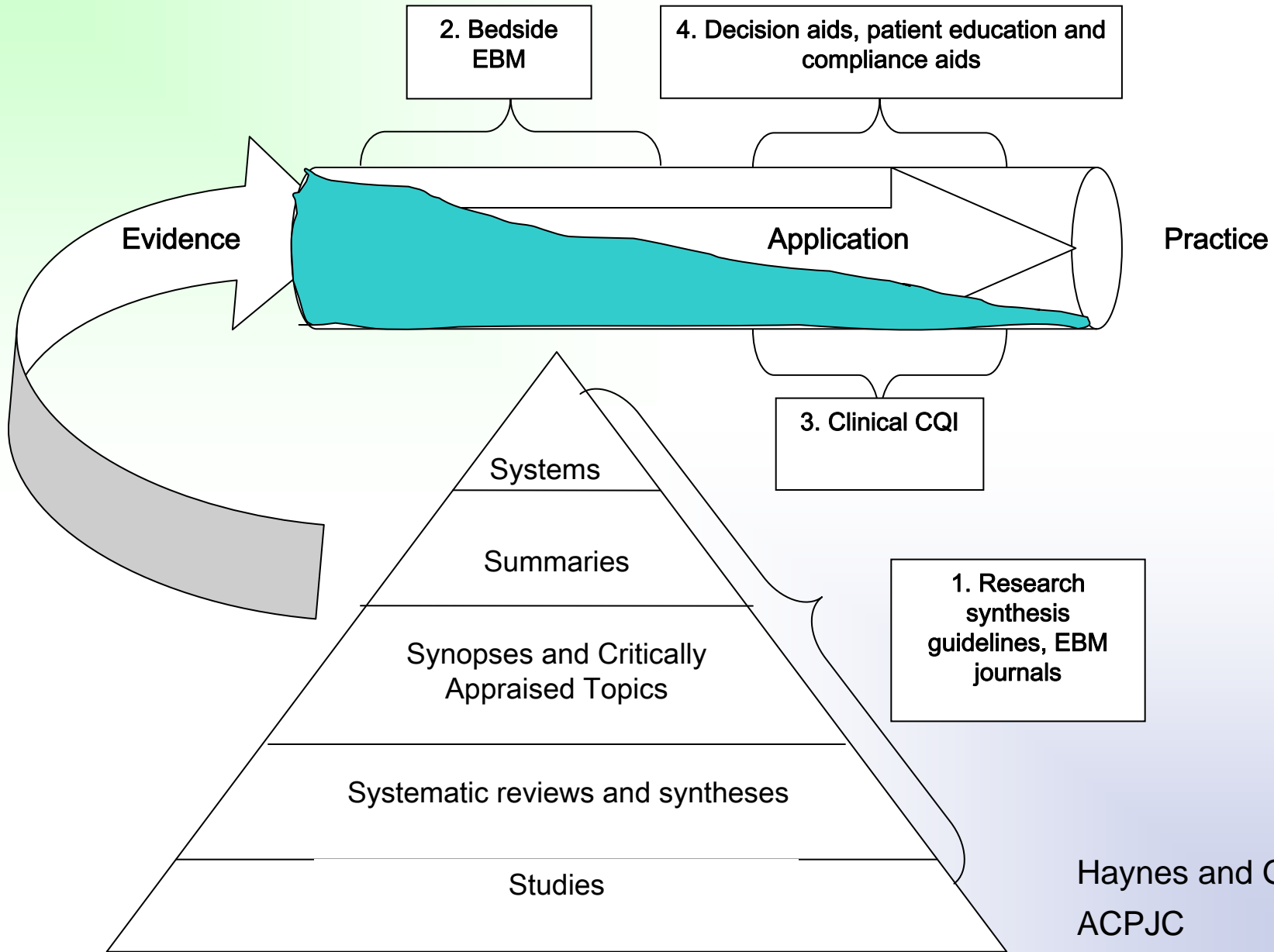
- Therapeutic hypothermia
- NSAIDS for OA
- Unnecessary CT heads
- Smoking cessation



# The gap between research and practice

Why does it exist?



Haynes and Glasziou  
ACPJC

# What is KT?



# How do you do KT?



# Chapter 22.7 Users Guides

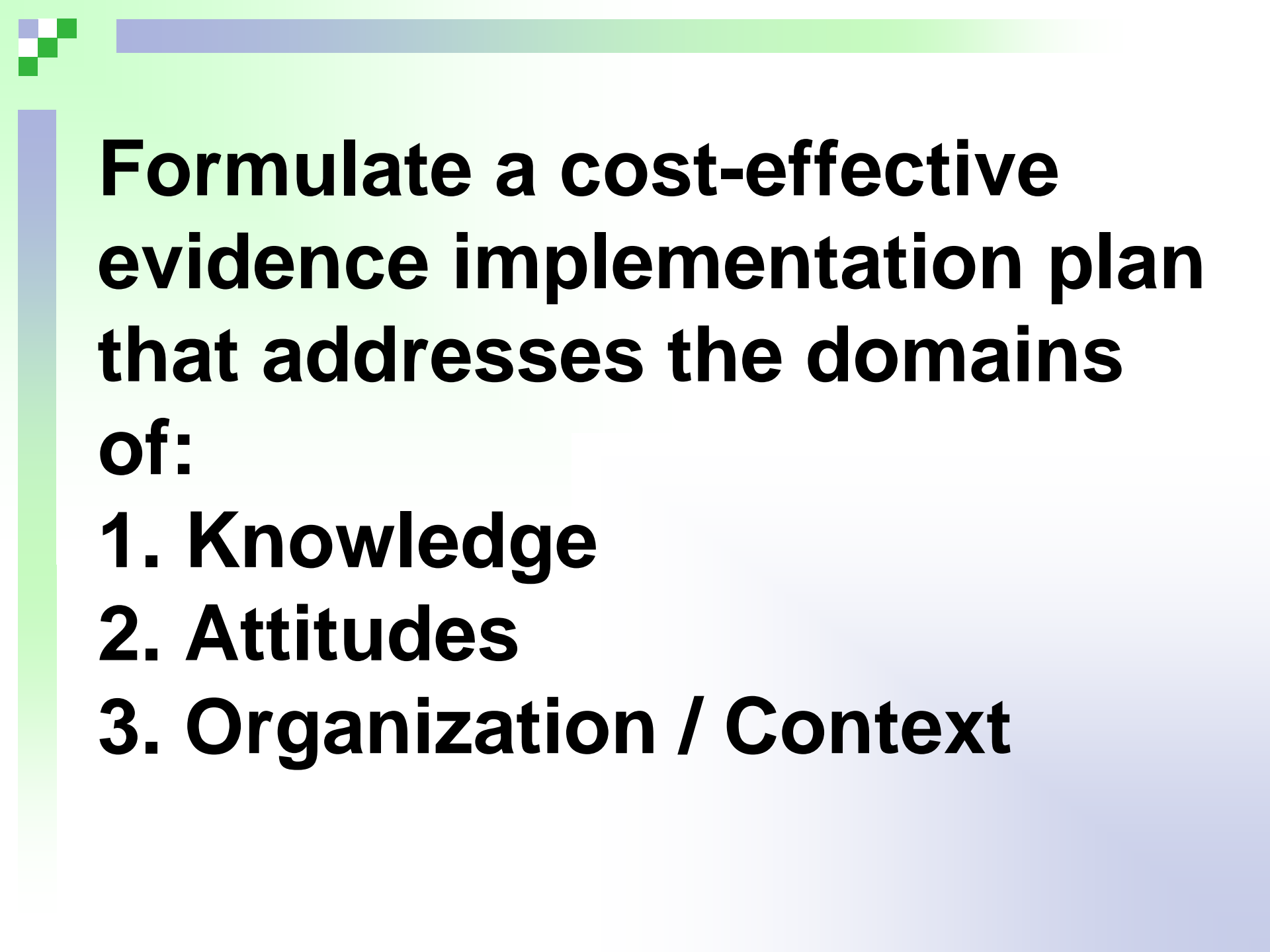
- 10 steps to changing behavior
- Pragmatic
- Barrier identification
- Implementation strategies
- Passive / Active
- Organizational
- Multifaceted and targeted interventions



# Other KT modalities

- Innovative CME
- Clinical pathways
- Local opinion leaders
- Communities of practice
- Clinical Decision Support Systems
- Academic detailing
- Pay for performance
- Regulatory





**Formulate a cost-effective evidence implementation plan that addresses the domains of:**


**1. Knowledge**

**2. Attitudes**

**3. Organization / Context**


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# Conclusions

- Many gaps and obstacles to EB care
- Getting there depends on Evidence-Based Implementation
- KT science can get us there
- Chapter 22.7 – superb guide ? Small group session



Thanks!

Questions?

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