



Moroccan Society of Physical  
and Rehabilitation Medicine

تحت الرعاية السامية لصاحب الجلالة الملك محمد السادس  
under the high patronage of His Majesty King Mohammed VI



Mediterranean Forum of Physical  
and Rehabilitation Medicine

13<sup>th</sup>

# MEDITERRANEAN CONGRESS OF PHYSICAL & REHABILITATION MEDICINE

November 2019, 7<sup>th</sup> to 10<sup>th</sup>, Marrakech, Morocco

20<sup>th</sup> National Moroccan  
PRM Congress



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**Evidence based medicine versus evidence based  
health practice – same or different approach**



**Assist. Prof. Frane Grubišić, MD, PhD**

Department of Rheumatology, Physical Medicine and Rehabilitation  
University Hospital Center Sestre Milosrdnice Zagreb  
School of Medicine, University of Zagreb  
Croatia

Chair of Special Interest Scientific Committee on the Evidence Based Medicine  
European Society of Physical and Rehabilitation Medicine

Cochrane Rehabilitation, Co-chair of the Publication Committee



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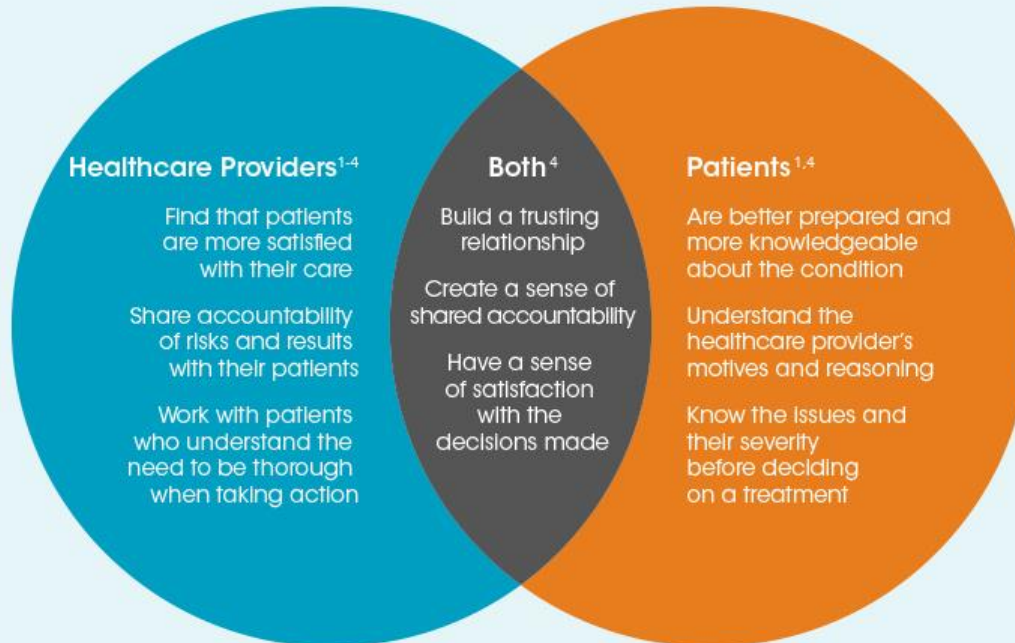
# EVIDENCE BASED MEDICINE – REMINDER

- The basic tenet of evidence-based medicine is to place greater emphasis on evidence from clinical research, especially randomized controlled trials
- This approach requires new skills - efficient literature searching and understanding of types and quality of evidence in evaluating the clinical literature
- ...”the conscientious and judicious use of current best evidence from clinical care research in the management of individual patients”

- Evidence based material “producers” – e.g. Cochrane Collaboration, and the Campbell Collaboration → they offer successful and influential systematic reviews and practice guidelines
- Evidence based material “consumers” – e.g. frontline practitioners or policymakers engaged in clinical decision making who might benefit from translational and transdisciplinary dissemination and training

# Transdisciplinary Model of Evidence-Based Practice (EBP)

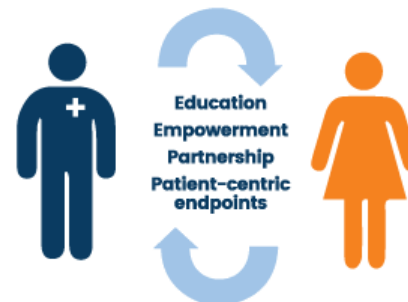
- evidence may involve quantitative data (e.g., numerical results of program or policy evaluations) and/or qualitative data (e.g., nonnumerical observations collected by focus groups)
- evidence may be narrowly defined (i.e., pyramid of evidence) or it may draw more broadly from sources (i.e. quality improvement or patient satisfaction data) and consequently weight those categories more equally
- both psychology and social work have emphasized **the importance of clients' characteristics as potential moderators of outcome**
- **importance of patients' characteristics and preferences to final decisions regarding clinical care**



Traditional **uni-directional**  
research-centered view



New **bi-directional**  
patient-centered view



# Shared decision making (SDM)

- Measurements for SDM can be categorised by decision antecedents (e.g., role preference), the decision process (e.g., observed or perceived behaviour of the clinician) or decision outcomes (e.g., decisional conflict, decisional regret, satisfaction)
- The SDM process can be assessed by an external observer, the patient or the physician
- The OPTION ("observing patient involvement") scale is the most prominent instrument for assessing the extent to which clinicians actively involve patients in decision-making → recently revised to a short form that assesses the SDM process from an observer's perspective in just five items

# Shared decision making - measures

Several measures exist to assess the patient's perspective

- Perceived Involvement in Care (PICS)
- ColloboRATE measure

Assessment SDM from both the patient's and the physician's points of view

- OPTION scale
- MAPPIN'SDM measure
- the 9-item Shared Decision Making Questionnaire (SDM-Q-9)

# Shared decision making (SDM)

- Systematic reviews suggest that SDM and SDM tools (e.g, decision aids) support patient-centred care:
  1. by improving patient-professional communication and patients' knowledge of their options
  2. their levels of trust and satisfaction with providers
  3. their sense of control over medical decisions and problems

# Shared decision making

Systematic review of health professionals' perceived barriers and facilitators to SDM implementation

- time pressures, characteristics of patients and clinical situations,
- professionals' familiarity with patients
- patients' preferences and preferred role in decision making as
- most frequently cited factors influencing patient involvement in SDM

Légaré F, Ratte S, Gravel K, et al. Barriers and facilitators to implementing shared decision-making in clinical practice: update of a systematic review of health professionals' perceptions. *Patient Educ Couns*. 2008;73:526-35.

# Transdisciplinary Model of Evidence-Based Practice (EBP)

- it provides a useful framework for guiding health services research with an interdisciplinary and real-world perspective
- EBP model may guide evidence-based policy considerations focused on the population's health but also may influence EBP at the individual level
- important implications for both academia and practice

Satterfield JM, Spring B et al. Toward a Transdisciplinary Model of Evidence-Based Practice. *Milbank Q* 2009; 87(2): 368–390.

# Transdisciplinary Model of Evidence-Based Practice (EBP)

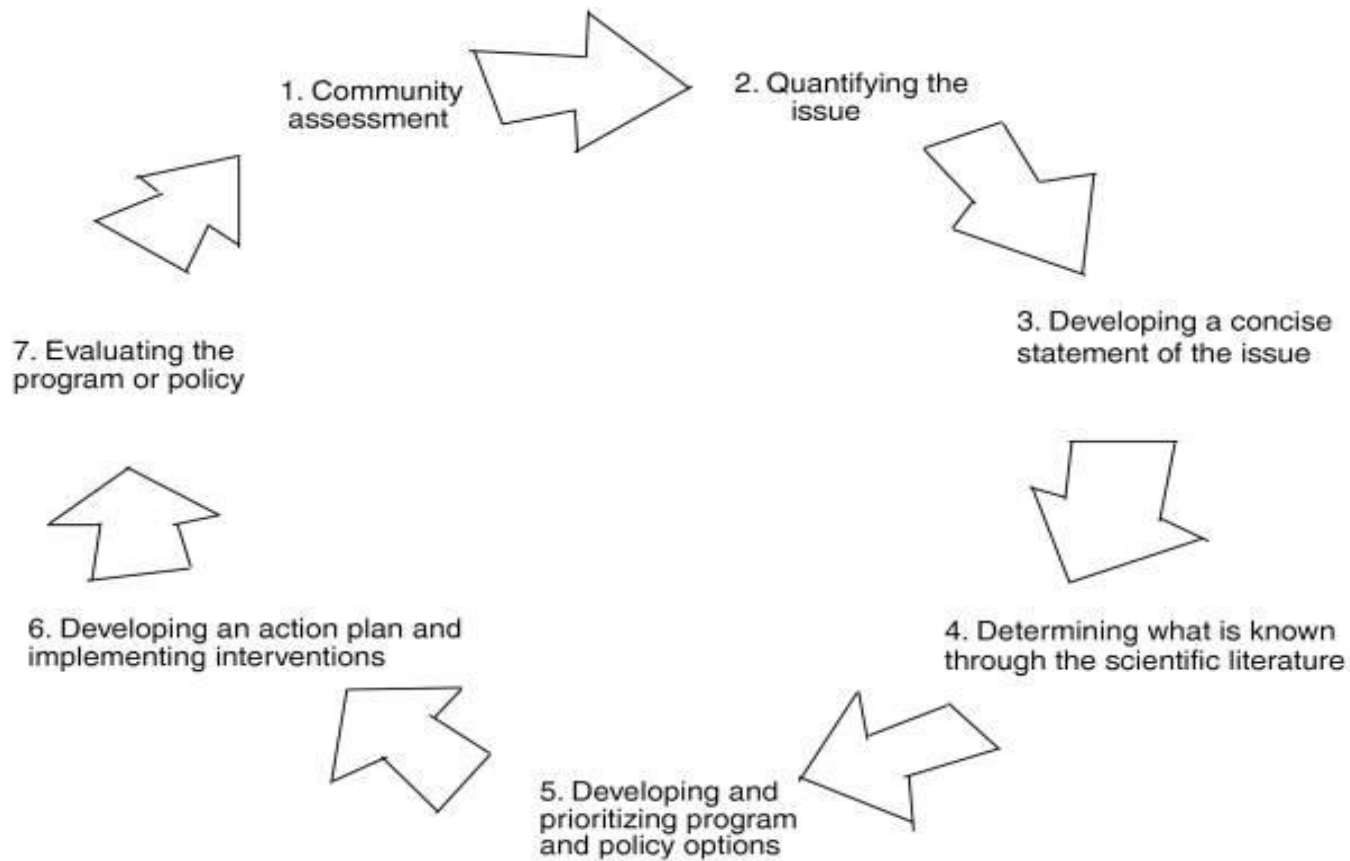
- By taking into account contextual factors, patients' preferences, evidence, and expertise, EBP is intended to provide realistic, high-quality, acceptable and effective care as broadly as possible
- As the evidence base deepens and expands across disciplines, the health professions may be pressured to implement those evidence-based practices shown to be most effective

Satterfield JM, Spring B et al. Toward a Transdisciplinary Model of Evidence-Based Practice. *Milbank Q* 2009; 87(2): 368–390.

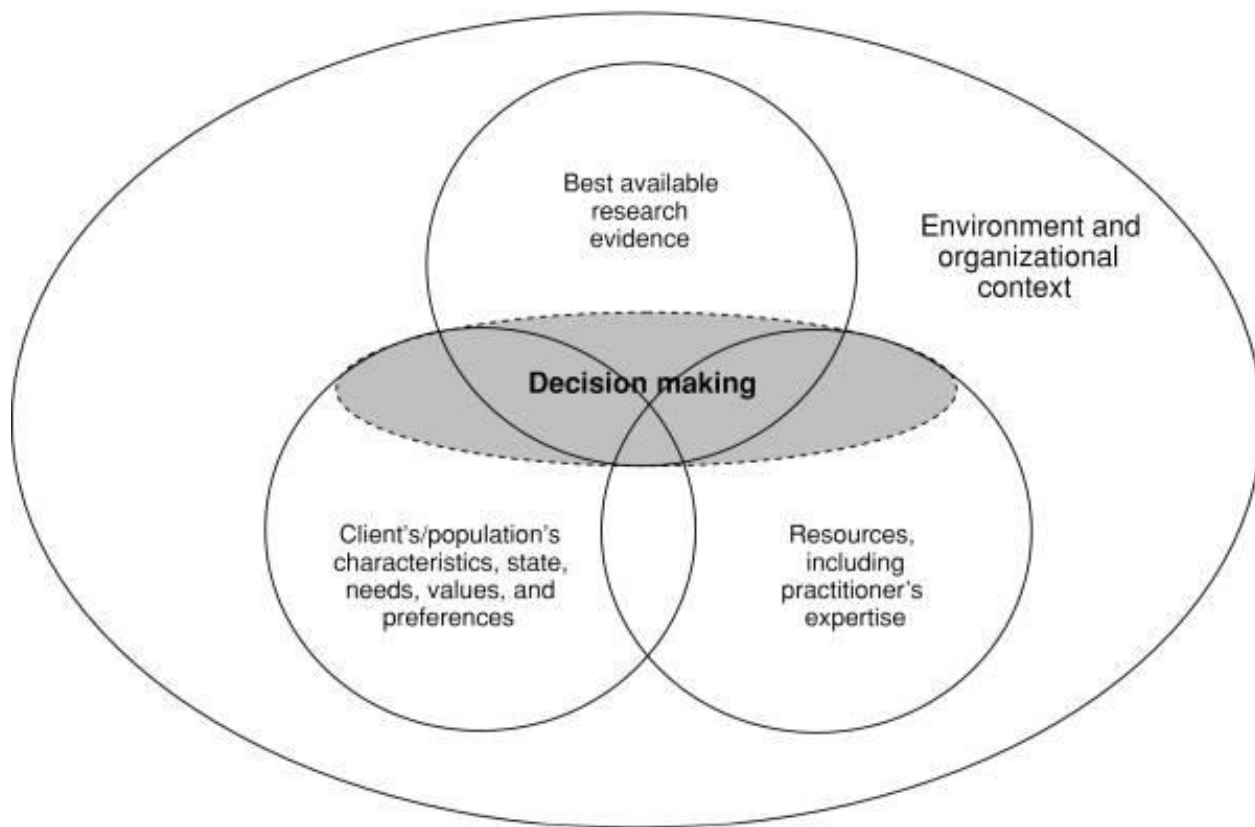
## Three-Circle Model of Evidence-Based Clinical Decisions



## The Most Commonly Applied Framework in EBPH



## Our Revised EBP Model



Evidence based practice →  
Evidence based public health

# Key components of EBPH

- making decisions based on the latest scientific evidence on intervention effectiveness
- using data and information systems systematically
- engaging the community and a range of stakeholders in assessment and decision making;
- conducting quantitative and qualitative evaluation
- disseminating what is learned to decision makers
- These skills are critical to effective practice and to meeting Public Health Competencies, Public Health Accreditation Board Standards for EBPH, and workforce development goals

# Evidence based public health (EBPH)

- EBPH - process of integrating evidence from scientific research and practice to improve the health of the target population
- numerous direct and indirect benefits - access to high quality information on best practice, a higher likelihood of successful prevention programs and policies, greater workforce productivity, and more efficient use of public and private resources
- ...yet gaps between discovery of new research findings and their application in public health and policy settings is extensive in time lapse, completeness, and fidelity

# Potential drawbacks of this approach...

- the absence of evidence and the lack of a conceptual framework regarding how much evidence is sufficient to judge and evaluate our policy decisions
- there is evidence that something should be done (e.g., needs of assessment, measures of prevalence, and preventability of risks and conditions) but....
- we lack evidence regarding what should be done (e.g., the effectiveness of health intervention) or how to do it (e.g. evaluation of the health process)

*Carter SM, Rychetnik L, Lloyd B et al. Am J Public Health. 2011; 101(3):465-72.*

# Investigating these gaps leads to several key findings...

- 1) practitioners underuse EBIs (evidence based interventions)
- 2) passive approaches for disseminating EBIs are largely ineffective, because dissemination does not happen spontaneously
- 3) stakeholder involvement in the research or evaluation process is likely to enhance dissemination
- 4) theory and planning frameworks are useful to guide the uptake of EBIs
- 5) capacity-building approaches in health-related settings (public health, medical care, policy) should be time-efficient, consistent with organizational climate, culture and resources, and aligned with the needs and skills of staff members

# Capacity/ies –magic word in EBPH

- Capacity - determinant of performance → greater capacity is linked with higher public health impact
- capacity is the ability for a public health agency to provide or perform essential public health services → it requires skills in evaluating the quality (“strength”), quantity (“weight”) and applicability of evidence (national or international standards to agency-level practices)
- Many of the principles of EBPH have their historical precedents in the seminal work of Archie Cochrane, who noted in the early 1970s that many medical treatments lacked scientific effectiveness

- a shift towards devolution of decision-making or a re-organisation of decision-making structures.
- Many countries have increasingly devolved or partially devolved healthcare systems (for example Spain, Netherlands, Denmark → high levels of devolved decision-making)
- Scandinavian countries - devolution of healthcare has long been an integral part of healthcare strategy → some of these countries are well equipped to provide (quantitative) evidence at local levels through central government-funded registers which encompass aspects of clinical healthcare, public health and social care

Costa-Font J, Perdikis L. Varieties of health care devolution: 'systems or federacies'? In: LSE 'Europe in Question' Discussion Paper Series. London: London School of Economics and Political Science; 2018.

Karanikolos M, Mladovsky P, Cylus J, Thomson S, Basu S, Stuckler D, Mackenbach JP, McKee M. Financial crisis, austerity, and health in Europe. Lancet. 2013;381(9874):1323–31.

# EVIDENCE BASED PUBLIC HEALTH – to remember

- importance to maintain both a practitioner and a stakeholder - oriented focus in concepts of EBPH
- definition proposed by Kohatsu puts a stronger focus on participatory decision making: “evidence-based public health is the process of integrating science-based interventions with community preferences to improve the health of populations

# Five A's...

- Assess, Ask, Acquire, Appraise, Apply
- assess the patient and clinical situation
- ask relevant clinical or treatment question
- acquire evidence or other data
- appraise the collected data
- apply the indicated treatment

“Thank you for your attention”