The Joanna Briggs Institute

Alan Pearson AM
Professor of Evidence Based Healthcare & Director, NHMRC CREATE (Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange; The University of Adelaide.)
Introduction

• The Joanna Briggs Institute
• What clinicians and other decision makers want
• How JBI translates evidence syntheses into resources and tools designed to meet the needs of users
The Joanna Briggs Institute

- Evidence Based Practice Research Institute since 1996
- Initially, joint venture between Royal Adelaide Hospital and the University of Adelaide
- From 2010, became a second-level academic entity (“School”) within the Faculty of Health Sciences
- Not-for-profit
- 80+ Centres and Groups, >9000 members in over 70 countries
- Global Leader

www.joannabriggs.org
The Joanna Briggs Institute

• International collaboration of health scientists, health professionals and health researchers

• To improve global health through providing point-of-care access to:
  – Evidence databases
  – Decision support systems
  – Implementation, evaluation and continuous improvement tools
JBI Vision

- Evidence-informed Best Practice as a central characteristic of all health services.
JBI Mission

• To be the leader in producing, disseminating and providing a framework for the use of the best available research evidence to inform health decision-making to improve health outcomes globally.
The Joanna Briggs Institute
Programs

Synthesis  Transfer  Utilisation

The Joanna Briggs Institute
Centers
The Joanna Briggs Collaboration
Europe

1. The Scottish Centre for Evidence Based Care of Older People
2. The Scottish Centre for Evidence-based Multi-professional Practice
3. Edinburgh Napier University Evidence Synthesis Group (Scotland)
4. The University of West London Centre for Evidence Based Nursing and Midwifery (England)
5. The University of Nottingham Centre for Evidence Based Nursing and Midwifery (England)
6. The Wales Centre for Evidence Based Care
7. The Spanish Centre for Evidence Based Healthcare
8. Belgian Interuniversity Collaboration for Evidence-Based Practice (BICEP)
9. Finnish Centre for Evidence-Based Health Care
10. The Romanian Centre for Evidence Based Nursing and Midwifery
11. The Romanian Centre for Evidence Based Public Health
12. Centro Studi EBN: An Affiliate Centre of the Joanna Briggs Institute (Italy)
13. Portugal Centre for Evidence Based Practice
14. Danish Centre of Systematic Reviews in Nursing
15. The Swiss Centre for Evidence Based Healthcare

- Pending – Rome, Vienna, Teeside

1,164 health services/universities members in England, Cyprus, France, Ireland, Italy, the Netherlands, Norway, Poland, Portugal, Serbia, Turkey, Scotland (all-of-country), Spain (all-of-country), Switzerland and Wales.
Africa and the Middle East

1. SIDRA Centre for Evidence Based Women’s and Children’s Health, Doa, Qatar
2. The Cameroon Centre for Evidence Based Health Care
3. The Ethiopian Malaria Alert Centre
4. The Kintampo Health Research Centre (Ghana)
5. The Uganda Centre for Evidence Based Practice
6. The South African Centre for Evidence Based Nursing and Midwifery
7. The Witwatersrand Centre for Evidence Based Practice (South Africa)
8. Capetown Centre for Evidence Translation (South Africa)
9. The Kenya Medical Research Institute (KEMRI) Centre for Geographic Medicine Research-Coast, Kilifi
10. The Kintampo Centre for Evidence Based Healthcare, Ghana
11. Malaria Alert Centre (Malawi)
12. Nigeria Joanna Briggs Institute Evidence Synthesis Group
13. University College Hospital (Nigeria)
14. Kigali Health Institute (KHI) (Rwanda)
15. Tanzania Joanna Briggs Institute Evidence Synthesis Group
16. University of Botswana Evidence Synthesis Group

All health services/universities members in Botswana, Burkina Faso, Cameroon, Ethiopia, Ghana, Kenya, Malawi, Rwanda, South Africa, Tanzania, Uganda, Zambia and Zimbabwe

www.joannabriggs.org
The Americas

1. Joanna Briggs Institute of Oklahoma (JBIO)
2. The Indiana Center for Evidence-Based Nursing Practice
3. The Texas Christian University Center for Evidence Based Practice and Research
4. The New Jersey Center for Evidence Based Nursing
5. University of California, San Francisco Centre for Evidence-based Patient Care Quality Improvement
6. The Queen’s Joanna Briggs Collaboration, Canada
7. Saint Elizabeth Health Care Evidence Group, Canada
8. The Brazilian Centre for Evidence-based Healthcare
9. University of Missouri Centre for Evidence Based Healthcare

418 health services/ universities members in Chile, Colombia, Ecuador, Mexico, Peru, Puerto Rico, Canada, USA and Venezuela

www.joannabriggs.org
Asia

1. The Hong Kong Centre for Evidence Based Nursing
2. The Singapore National University Hospital Centre for Evidence-based Nursing
3. The Joanna-Briggs Institute- Institute of Mental Health (Singapore) Centre for Evidence-Based Practices in Mental Health Care
4. The National Healthcare Group HSOR Collaborating Centre for Evidence Based Health
5. National University Cancer Institute Singapore (NCIS) Nursing Evidence Utilisation Group
6. The Taiwan Joanna Briggs Institute Collaborating Centre
7. The Taiwanese Centre for Evidence-based Health Care (Hualien)
8. The Yonsei Evidence Based Nursing Centre of Korea (Seoul)
9. The Thailand Centre for Evidence Based Nursing and Midwifery
10. The Yangon Centre for Evidence Based Health Care
11. (Myanmar)
12. The Fudan Evidence Based Nursing Center (P R China)
13. Peking Medical University Center (P R China)
14. Services Management The Center for Reviews on Health Research and Movement Science (Philippines)
15. The Japan Centre for Evidence Based Practice

44 health services/universities members in Brunei Darussalam, China, Japan, Malaysia, the Philippines, Singapore, South Korea, Taiwan and Thailand
Australasia

1. The New South Wales Centre for Evidence Based Health Care
2. The Centre for Evidence-based Practice South Australia (CEPSA)
3. The Queensland Centre for Evidence Based Nursing and Midwifery
4. The Australian Centre for Evidence Based Community Care
5. The Joanna Briggs Institute Aged Care Unit
6. The Western Australian Centre for Evidence Informed Healthcare Practice (WACEIHP)
7. The Deakin Centre for Quality and Risk Management in Health
8. The Monash Centre for Chronic Disease Management
9. The Australian Centre for Rural and Remote Evidence Based Practice
10. The Australian Capital Regional Centre for Evidence-Based Nursing and Midwifery Practice
11. The Australian Centre for Evidence Based Primary Health Care
12. Dementia Collaborative Research Centre - Consumers, Carers & Social Research
13. Royal Perth Hospital
14. University of Newcastle Evidence Based Health Care Group
15. Royal Adelaide Hospital Fundamentals of Care: JBI Evidence Utilisation Group
17. Sisters of St Joseph Aged Care Services JBI Evidence Utilisation Group
18. Aged Care Quality Association (ACQA): Evidence Utilisation Group
19. SomerCare Rainbow Chimers: JBI Evidence Utilisation Group
20. Rural Health Care Practice: A JBI Evidence Utilisation Group

1,980 health services/universities members Australia, Fiji and New Zealand.
Our Global Scientific Work
Translating science into action for policy, practice and quality improvement

Developing and providing global access to resources:

• Rigorous evidence syntheses;
• Pre-appraised and synthesized summaries of the evidence;
• Clear recommendations for action;
• Clear estimates of benefits/harms;
• Accessible with 30 seconds (!); and
• Tools/system to embed evidence/use evidence/assess the impact of using the evidence.
“Cochrane Systematic Reviews are widely regarded as the highest standard of evidence to inform health decision-making, credibility that is both based in, and reflected by, their format and structure; they are the process record and written culmination of a comprehensive scientific investigation. However, user feedback shows that they are not the most accessible or usable way of presenting evidence to people to inform their health decision-making.”

From Strategy to 2020 p13
The JBI Model of Evidence-Based Healthcare
Our Translational Science Program

• Translation Science
  – frequently referred to as the “bench-to-bedside” enterprise of harnessing knowledge from basic sciences to produce new drugs, devices, and treatment options for patients;
  – common understandings relate to two major “gaps” or “translational blocks” in the research-into-action process;
  – these blocks have been well articulated by the Institute of Medicine's Clinical Research Roundtable as "the transfer of new understandings of disease mechanisms gained in the laboratory into the development of new methods for diagnosis, therapy, and prevention and their first testing in humans” and "the translation of results from clinical studies into everyday clinical practice and health decision making” (in Woolfe, 2008).
The need to improve the translation of basic and fundamental research findings into routine clinical practice was one of the main observations of the ‘Review of UK Health Research Funding’ (Cooksey, 2006) and this review identified two contributory problems:

- The first is the gap between the description of a new clinical intervention and initial clinical trials (sometimes referred to as the first translation gap, or T1);
- The second is the gap between evaluation of new interventions in health technology assessment studies and the embedding of the new intervention in clinical practice (referred to as the second translation gap, or T2) (Woolf, 2008).
Unmet need for Knowledge

Discovery → Gap 2 → Clinical Application → Gap 3 → Clinical/Policy Action
Gap 1 – From Knowledge Need to Discovery

– The first gap relates to the gap between “knowledge needs” (as identified by patients, the community, clinicians, governments and organisations) and the work undertaken by scientists and researchers during the “discovery” process. This gap is a vital component of translational research and is addressed by very few research groups, a notable exception being the National Institute for Health Research in the UK, with its associated Clinical Research Networks and its community engagement program “INVOLVE”.
Gap 2 – From Discovery to Clinical Research

- The second gap relates to the gap between what is referred to here as “Discovery Research” (theoretical, epidemiological, or “bench” style research) and “Clinical Research” (experimental trials including but not limited to drug trials). This gap is the most commonly addressed gap on the international stage with significant work being undertaken in many research institutes in Australia and overseas. For most of these Institutes, this is where translational research ends.
Gap 3 – From Clinical Research to Action

• The third translation gap relates to the gap between “Clinical Research” and “Action”;
• Few high status research institutes have strong programs in this regard (although some of them have recently ventured into this realm, notably in cardiology and metabolic/human nutrition centres);
• The focus here is on translating the findings of clinical research (and public health and health services research) into public policy, health provider agency policy, clinical practice and community action. It requires systematic engagement with service users, clinicians, policy makers and health funders. This kind of translational research “delivers” outputs and outcomes to these stakeholders
The need for Knowledge

Discovery Research

Clinical/Public Health Research

Clinical/Public Health Action

**GAP 1**
The gap between "knowledge needs" (as identified by patients, the community, clinicians, governments and organisations) and the work undertaken by scientists and researchers during the “discovery” process.

**JBI Translational Strategies to Address Gap 1:**
Citizen and Stakeholder engagement in:
+ Identifying discovery research opportunities and priorities;
+ At proposal development;
+ During Project;
+ End of Project; and
+ Dissemination
Based on the development and maintenance of a Citizen/Stakeholder Network. (Stakeholders include policy makers, researchers, health service delivery agencies and clinicians)

**GAP 2**
The gap between “Discovery Research” (theoretical epidemiological, or “bench” style research) and “Clinical/Public Health Research”

**JBI Translational Strategies to Address Gap 2:**
Citizen and Stakeholder engagement in:
+ Identifying clinical research opportunities and priorities;
+ At proposal development;
+ During Project; and
+ Dissemination
Based on the development and maintenance of a Citizen/Stakeholder Network and a Clinical Research Network. (Researchers, health service delivery agencies and clinicians)

**GAP 3**
The gap between “Clinical Research and Action”; translating research findings into policy and practice.

**JBI Translational Strategies to Address Gap 3:**
+ The dissemination of evidence and its application;
+ Developing and implementing knowledge transfer via guidance, decision support systems, policy briefs and point-of-care information systems;
+ Designing and implementing education and training strategies to promote knowledge and uptake of the evidence;
+ Designing and implementing knowledge-to-action programs;
+ Evaluating the impact of implementation of health and patient outcomes.

**The Translational Research Trajectory**

The Joanna Briggs Institute
Translation Research Framework

www.joannabriggs.org
The Core Elements of the Joanna Briggs Institute Translation Science Process

**Linking knowledge needs to Discovery Research**
- Forming and Maintaining Citizen and Stakeholder Networks; and
- Conducting Scoping Reviews to Establish the "state of knowledge"

**Linking the Findings of Discovery Research to Clinical/Public Health Research**
- Forming and Maintaining Citizen Networks; and
- Forming and Maintaining Clinical/Public Health Research Networks.

**Translating Knowledge into Action:**
**Evidence Synthesis/Integrative Studies**
Using the science of synthesis to identify "best practices":
- Using the external evidence; evidence synthesis
**Fundamentals of Evidence Transfer**
Investigating mechanisms for action:
- Synthesis theory and methods;
- Meaning of evidence;
- Types of evidence; and
- How implementation occurs

**Evidence Transfer:**
Investigating gaps in knowledge and implementing strategies to address them:
- Development of systems, tools and resources for policy and practice;
- Designing and implementing education and training;
- Evaluation of impact

**Evidence Implementation:**
Designing effectiveness and implementation studies through:
- Collaboration (local, national, international);
- Testing implementation strategies;
- Multi-centre implementation trials

www.joannabriggs.org
JBI COnNECT+ @Ovid

(Clinical Online Network for Care and Therapeutics)

• Over 9000 organizational subscribers (governments [i.e. all-of-country], health systems, universities, corporates etc) in 120 countries.
Includes:

- The JBI Library
  - The JBI Database of Systematic Reviews and Implementation Reports;
  - The JBI Database of Best Practice Information Sheets and Technical Reports; and
  - The JBI Database of Rapid Appraisals of Published Papers.
**JBISRIR (Dec 21 2012 – Nov 13 2013)**

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<th>Number</th>
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<tr>
<td>Number of protocols submitted</td>
<td>276 (191 sent for peer review, 85 archived)</td>
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<tr>
<td>Number of systematic reviews submitted</td>
<td>103 (78 sent for peer review, 25 archived)</td>
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<td>Protocols approved</td>
<td>102</td>
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<td>Reviews approved</td>
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...and the COnNECT+ online services via Ovid

- Summaries of systematic reviews/guidance (BPIS);
- Evidence Summaries;
- Recommended practices;
- E B Clinical/system audit criteria;
- Consumer Information; and
- Online tools and expert systems.
Best Practice Information Sheets

- 4 page summary of a (usually single) systematic review;

- Includes a decision making algorithm.
Database of Evidence Summaries, recommended practices, E B Audit Criteria and consumer information sheets
Organised by “node” filters

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Evidence Summary

Chemotherapy: Constipation Management

29/01/2009

Author

Sheena Saunders RV CN

Summary

QUESTION:

What is the best available evidence regarding constipation resulting from chemotherapy?

CLINICAL BOTTOM LINE:

In order to have a diagnosis of constipation a patient must have two or more of the following symptoms for at least 12 weeks (not necessarily consecutive): straining during bowel movements, lumpy or hard stools, sensation of incomplete evacuation, sensation of anorectal blockage or manual manoeuvres to facilitate bowel movements, less than three bowel movements a week; loose stools.

- The pathophysiology underlying chemotherapy induced constipation remains unclear and poorly defined with few studies undertaken. Chemotherapy related constipation is a manifestation of alimentary mucositis which affects the entire gastrointestinal tract. (Level IV)
- Chemotherapy induced constipation is recognised as being a mixture of reduced frequency of bowel action and increased stool consistency. (Level IV)
- Constipation may be secondary to other drug regimes associated with chemotherapy agents such as, anti-emetics, opioids. (Level IV)
- Chemotherapy agents that are known to cause constipation are the vinca alkaloids, platinum, thalidomide and hormonal agents. (Level IV)
- Chemotherapy induced constipation occurs as a result of an altered balance of normal gut function due to, (Level IV)
  - Decreased oral intake (dehydration),
  - Decreased motility (increased time for reabsorption to occur),
  - Automatic neuropathy,
  - Increased reabsorption,
  - Blackage,
  - Over-treated diarrhoea,
  - Anti-nausea agents,
  - Analgesics
  - Decreased exercise.
- Treatment options for chemotherapy induced constipation firstly require a detailed patient history outlining the patient's normal bowel habits such as, frequency, consistency and colour of the stool. Current changes in bowel function should also be noted such as, frequency of motions including nocturnal motions, consistency, colour and the presence of blood or mucus. (Level IV)
- Review of the patient's treatment plan including medication regime including chemotherapy, analgesics, antibiotics anti-emetics and complimentary and natural medicines should be obtained. (Level IV)
- A physical examination of the patient including, abdominal examination, presence or absence of bowel sounds, temperature and blood pressure. An abdominal x-ray is also recommended. (Level IV)
- Implementation of a treatment plan should follow the physical examination, including, maintaining adequate hydration, optimise gut motility, decrease secretions or diarrhea or if an infection is identified, treat. (Level IV)
- Expert opinion recommends that a gradual increase in fibre supplements is the first line measure with a goal of 20-30 grams per day, this can be achieved by increasing the daily amount by 5 grams a day. (Level IV)
- Gastrointestinal laxatives can be added to the fibre supplement if symptoms do not improve. (Level IV)
- A Cochrane review found that there was insufficient data available comparing differences between classes of laxatives and between different combinations of laxatives to make a recommend about the 'best' management of constipation for patients receiving palliative care. (Level I)
- Evidence suggests that increased fluid intake and exercises may improve chronic constipation, therefore, can be recommended. (Level IV)
- Expert opinion recommends that where the constipation treatment regime includes medications, they should be titrated down to the least expensive/most effective maintenance dose. (Level IV)
- "Rasaca" medications such as, enemas, suppositories and stimulant laxatives should only be used when needed. (Level IV)
Recommended Practice

Constipation Management

06/06/2007

Equipment

- Resident/client’s care plan with bowel chart
- Gloves
- Laxatives
- Stool softener

Recommended Practice

1. Assess the resident/client’s:
   a) patterns of elimination: frequency, amount, consistency, colour, and presence of blood;
   b) diet, focusing on fluid and fibre intake;
   c) mobility, activity level, and functional status. (Level IV)
2. Assess any abdominal pain/cramping or other symptoms of constipation in cognitively impaired resident/clients including frowning, increased symptoms of restlessness, behaviour change and irritability.
3. Assess current medications the resident/client is receiving.
4. Thoroughly wash and dry hands, don gloves and perform abdominal palpation.
5. Perform digital rectal examination if permitted by organisation policy. (Level IV)
6. Administer laxatives as ordered by General Practitioner and document time of effect.
7. Suppositories or enemas (as prescribed) may be required for moderate to severe acute constipation. Please refer to separate care bundles regarding administration of suppositories or enemas.
8. Encourage the resident/client to increase their physical activity or passive exercise as appropriate. (Level IV)
9. Encourage the resident/client to increase fluids (approx. 2 litres per day) and soluble fibre. (Level IV)
10. Maintain toileting regime and ensure privacy where safely possible. (Level IV)
Use of Restraint

08/04/2010

Author
Lea-Ellen Schneller B Pharm FACPP

Who is this for?
The purpose of this information is to summarise previous research and present the best available evidence on the use of restraint for people in acute and aged care. A restraint is any device that prevents a person from being able to move freely. Restraints can be physical or chemical using medication.

Physical restraints may involve the use of leather or cloth wrist and ankle restraints, full-sheet restraints, soft belts or vests, hand mitts, crotch/pelvis ties, suit/harnesses, wheelchair safety bars, genchairs (special tilted chairs) or over-chair tables. Restraint remains a controversial topic. It should only be used to avoid or prevent harm or to enable medical treatment that could not be provided through other methods.

What We Know
The use of restraint is common in acute care and even more common in residential care. Physical restraint may be performed for a variety of reasons. Many people may therefore experience some form of physical restraint during their stay in hospital or residential care. People more likely to be restrained include the elderly being transferred from residential care, people with a psychiatric illness, people with mental difficulties or with disruptive behaviour, and people assessed as being at risk of falling. Chemical restraint may also be used and involves the use of calming medications.

Indications for restraint vary, but include: the safety of the person restrained; to manage aggression and agitation; to control behaviour; due to lack of staff; to allow treatment; to prevent wandering.
Online Tools and Systems

Implementing Evidence-Based Practice with Tools You Can Use!

Research
- JBI TAP
  A simple online tool designed to assist researchers to analyze small qualitative data sets following a three-step thematic analysis process.
- JBI CAN-IMPLEMENT
  A practical guide to assist individuals and groups in adopting existing guidelines for Cochrane use.

Appraisal & Implementation
- JBI JOURNAL CLUB
  Create your own journal club and keep up to date with the latest research in a social and relaxed environment.
- JBI RAPID
  Learn how to critically appraise individual research papers using a standardized checklist.
- JBI SUMARI
  Develop, conduct and report on systematic reviews of multiple research papers.

Point of Care
- JBI MANUAL BUILDER
  Build an evidence-based clinical manual tailored to the information needs of your organization.
- JBI PAMPHLET BUILDER
  Build evidence-based information pamphlets for your patients/clients on a range of health topics.

Quality Improvement
- JBI PACES
  User-friendly tool that makes it easy for health professionals to conduct efficient, time-saving, evidence-based clinical audits and change practice.
- JBI POOL
  Easy to use tool for the collection and storage of patient related prevalence data.
- JBI COOL
  Easy to use tool for the collection and storage of client related prevalence data.

www.joannabriggs.org
Manual Builder

- Using database of evidence summaries and recommended practices, can build a customized practice manual “on the fly”
Clinical Policy Manual

THE JOANNA BRIGGS INSTITUTE

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Consumer Pamphlet Builder

- Using database of consumer information sheets, can build a customized pamphlet “on the fly”
What is Evidence Based Health Information?

Just as a detective searches for evidence to solve a crime, so too do health professionals look for evidence to guide their practice. The detective must have evidence to support their case. In a similar fashion, the health care professional must have evidence to support their proposed course of treatment. They search for information that will help them to provide the most effective or beneficial form of care to their patients. Due to the wealth of information available to them, the process of discovering which information is the best can be difficult and time consuming. It would take an enormous amount of time for your doctor to sift through the large amounts of research and information available to them on a particular topic. This is where the Joanna Briggs Institute comes into play. We conduct the 'detective' work, providing them (and you) with the best available evidence.

Evidence Reliability

The evidence related to the topic of each consumer publication produced by the Joanna Briggs Institute is assessed for reliability and quality. We do not rate a procedure or treatment, but the evidence (or research) that is available to support it. Evidence can play a critical role in any investigation and it is important for detectives to recognize evidence that will provide 'reliable' information to aid in the investigation.

This is also the case when assessing health information, as some types of evidence are more reliable than others. For Joanna Briggs Institute evidence based information for consumers, you can be assured that the best available evidence is utilized. If you would like more information about research and levels of evidence, please contact the Joanna Briggs Institute or visit the research page of our consumer website.

What does this mean for consumers?

As consumers of health care it is important to know that your treatment is being based on the best available evidence. It is also important that you are provided with all of the information in order to have greater independence in relation to your own health care decisions and to be involved in the decision making process.

Further Information

The Joanna Briggs Institute Consumer Information Program provides up to date literature reviews to ensure your information is based on the best available evidence. The Institute also produces systematic reviews and Best Practice Information sheets aimed at clinicians and health professionals. This means you are provided with the same high standard of publications based on the same information as those working directly in the field.

Contact Details

If symptoms persist, please contact Dr Read to book an appointment.

Smithville General Practice and Surgery
45 Kittel St
Smithville SA 5860
Ph: 088563483

Please remember to bring medicare card and results/images of previous tests to all appointments. At General Practice and Surgery we now bulk bill.

The Best Available Evidence for older adults with constipation
• User friendly on-line tool to make audit, feedback and practice improvement easier to implement and report

• 2 options
  – Clinician
  – Organizational or quality improvement

• GRIP: assists in the development of a plan for practice improvement
Criteria Legend

1. Disease modifying anti-rheumatic drugs are initiated immediately after rheumatoid arthritis diagnosis. (10 of 10 samples taken)
2. Gastro-protection in RA patients over 65 years of age with a history of peptic ulcer is performed when NSAIDs are used. (10 of 10 samples taken)
3. Occupational therapy advice is available for RA patients experiencing functional limitations. (10 of 10 samples taken)
4. The patient has been educated about rheumatoid arthritis. (10 of 10 samples taken)
• Prevalence database that can be used to track outcomes in real time.
Other Tools