

Evidence Based Medicine Sub-committee
 Medical Care Advisory Committee
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Evidence Based Medicine

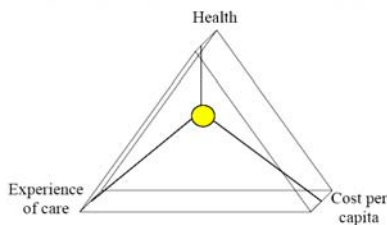
- **DEFINITION:** “The conscientious, explicit and judicious use of current evidence in making decisions about the care of individual patients.” (Sackett D, 1996, Center for Evidence based Medicine)
- **PURPOSE:** To integrate clinical expertise with best relevant external clinical evidence from systematic scientific clinical research.
- **PROCESS:** Clinical evidence is ranked according to “robustness” or medical certainty of research, resulting in varying strengths of subsequent clinical recommendations

Evidence Based Medicine is the integration of *clinical expertise, patient values, and the best evidence* into the decision making process for patient care.

- Clinical expertise refers to the clinician's cumulated experience, education and clinical skills.
- The patient brings to the encounter his or her own personal and unique concerns, expectations, and values.
- The best evidence is usually found in clinically relevant research that has been conducted using sound methodology. (Sackett D, 2002)

Institute for Healthcare Improvement’s TRIPLE AIM

1. The health of a defined population;
2. The experience of care by the people in this population; and
3. The cost per capita of providing care for this population.



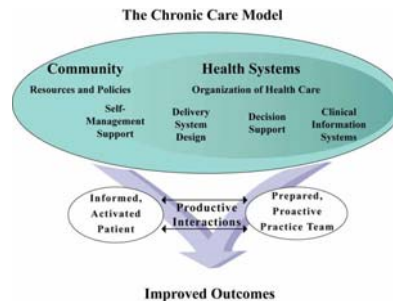
To achieve the Triple Aim, some entity must act as an integrator.

- An integrator is an entity whose purpose is to achieve high levels of performance in all three components.
- That assembles a system to improve and maintain health (in addition to treating illness).
- Has an organization structure and management process which ensures care and services can be delivered.

It is assumed that the proper implementation of the Chronic Care Model as stressed by the Governor’s Quality Care Summit will lead to a strict adherence to evidence based care, as well as the other components seen in the diagram. Our job will be to develop a reasonable approach to apply it to the Medicaid beneficiaries.

Including defining the:

- scope of implementation
- focus of its use
- missing links of implementation



Evidence-based medicine issues:

Developed by Connie Schardt, Duke University Medical Center Library and Jill Mayer, University of North Carolina at Chapel Hill Health Science Library

Opponents	Proponents
EBM is "old hat". Clinicians have been using the literature to guide their decisions for a long time. The label is new.	The new focus on EBM "formalizes" that "old hat" process and filters the literature so that decisions are made based on "strong" evidence.
EBM is "cook book medicine". It suggests that decisions are based solely on the evidence, down playing sound clinical judgment.	EBM should be one part of the process. Decisions must be blended with individual clinical expertise, patient preferences and when available good evidence.
EBM is the mindless application of population studies to the treatment of the individual. It takes the results of studies of large groups of people and tries to apply them to individuals who may have unique circumstances or characteristics, not found in the study groups.	The last step in the EBM process is to decide whether or not the information and results are applicable to your patient and to discuss the results with the patient.
Often there is no randomized controlled trial or "gold standard" in the literature to address the clinical question.	Clinicians might consider the "evidence pyramid" and look for the next best level of evidence. Clinicians need to understand that there may be no good evidence to support clinical judgment.
There is often great difficulty in getting access to the evidence and in conducting effective searches to identify the best evidence.	Librarians can help identify the best resources and teach clinicians effective searching skills.

(USPSTF) LEVELS OF RESEARCH EVIDENCE

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small.	Offer or provide this service only if other considerations support the offering or providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

Proposal:

Based on USPSTF guidelines for Preventative Medicine, mandate reimbursement for one well care visit for every Medicaid enrollee per year. Enrollees would be personally responsible to see their primary care physician for a preventative care visit, and would not be re-enrolled without evidence of that annual visit. The outcome should be a positive impact on chronic diseases including:

- Earlier diagnosis & treatment of chronic diseases such as Hypertension, Hyperlipidemia, Diabetes, and Depression.
- Earlier intervention with alcohol, tobacco and other addictions
- Screening for communicable diseases (and their containment)
- Decrease in ED visits for diagnoses addressable in primary care office

Examples of recommended screenings proved beneficial by evidenced medicine:

- **The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.**
Grade: [B Recommendation](#).
- **The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.**
Grade: [B Recommendation](#).
- **The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.**
Grade: [B Recommendation](#).
- **The U.S. Preventive Services Task Force (USPSTF) recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and followup.**
Grade: [B Recommendation](#).
- **The USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products.**
Grade: [A Recommendation](#).
- **The U.S. Preventive Services Task Force (USPSTF) recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.**
Grade: [A Recommendation](#).
- **The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection (go to [Clinical Considerations](#) for discussion of risk factors).**
Grade: [A Recommendation](#).
- **The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians discuss aspirin chemoprevention with adults who are at increased risk for coronary heart disease (CHD). Discussions with patients should address both the potential benefits and harms of aspirin therapy.**
Grade: [A Recommendation](#).
- **The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening men aged 35 and older for lipid disorders.**
Grade: [A Recommendation](#).
- **The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.**
Grade: [B Recommendation](#).
- **The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.**
Grade: [A Recommendation](#).
- **The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.**
Grade: [B Recommendation](#).