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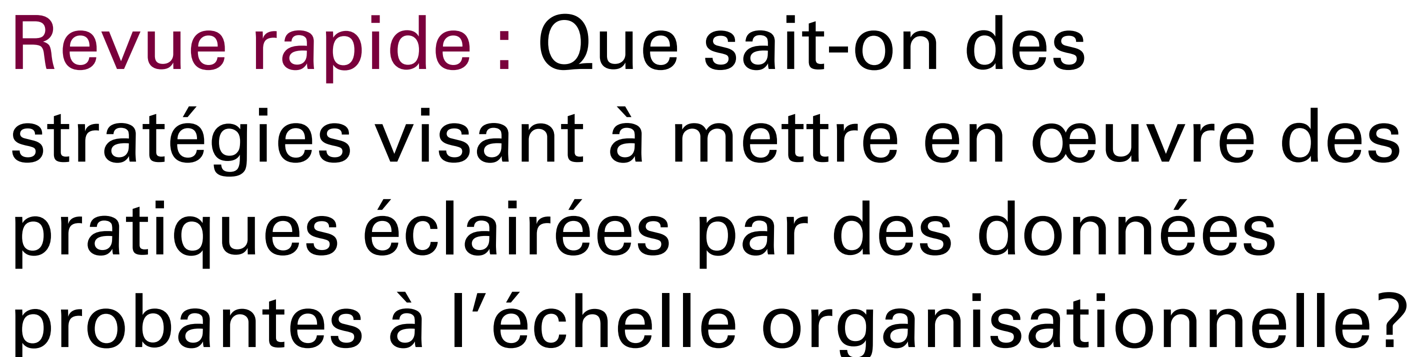

Revue rapide : Que sait-on des stratégies visant à mettre en œuvre des pratiques éclairées par des données probantes à l’échelle organisationnelle?

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Résumé

Contexte

Les élus et le public (les électeurs) s'attendent à ce que les décisions relatives à la santé publique soient éclairées par les meilleures données probantes issues de la recherche dont on dispose, par le contexte local et par une volonté politique. La capacité des organisations de santé publique à concrétiser la prise de décision éclairée par des données probantes (PDÉDP) et à mettre en œuvre des programmes et des services qui sont éclairés par des données probantes varie considérablement d'une organisation à l'autre au Canada.

À l'échelle organisationnelle, la PDÉDP suppose l'intégration des données probantes dans toutes les décisions touchant les pratiques en relevant et en synthétisant les données probantes, puis en élaborant et en exécutant des plans visant à mettre en œuvre et à évaluer des changements aux pratiques. La mise en œuvre à grande échelle de la PDÉDP dans une organisation peut être accomplie au moyen de stratégies qui développent une culture organisationnelle favorable à la PDÉDP et dans lesquelles le personnel de tous les niveaux valorise la PDÉDP et y contribue. Des stratégies peuvent aussi renforcer les capacités du personnel à trouver, à interpréter et à synthétiser les données probantes afin d'élaborer des recommandations relatives aux pratiques et aux programmes.

De son côté, la mise en œuvre de pratiques ou de programmes éclairés par des données probantes (PPÉDP ou « pratiques ou programmes ÉDP ») fait référence à une pratique ou à un programme spécifique dont des données probantes ont prouvé l'efficacité et dont la mise en œuvre a été choisie ou ordonnée. Les organisations sont chargées d'élaborer une stratégie visant à assurer la mise en œuvre réussie des pratiques ou des programmes ÉDP. Cela peut ou non inclure toute l'organisation, selon la nature de la pratique ou du programme ÉDP. Les stratégies de mise en œuvre peuvent inclure l'orientation du personnel relativement à la nouvelle pratique, l'élaboration de processus et de modèles visant à guider le personnel dans la nouvelle pratique, et l'évaluation du changement de pratique au moyen de contrôles ou de sondages.

Au moins deux courants de recherche sont apparus dans ce domaine. L'un est axé sur la compréhension des processus et des mécanismes permettant d'accomplir la PDÉDP dans toute l'organisation; l'autre explore des stratégies visant à mettre en place des pratiques ou des programmes ÉDP précis. Ces deux courants de recherche semblent se rejoindre dans le changement organisationnel. Par exemple, que l'on cherche à accomplir la PDÉDP ou à mettre en œuvre une pratique ou un programme ÉDP, il est évident qu'un changement organisationnel considérable est nécessaire. Cela entraîne généralement des répercussions substantielles sur l'organisation dans son ensemble, ainsi que sur les personnes qui y travaillent. Les initiatives de changement favorisant la mise en œuvre de la PDÉDP ou d'une pratique ou d'un programme ÉDP doivent surmonter des défis comme la résistance ou le manque d'expertise du personnel, en plus de devoir adapter les stratégies aux structures et aux climats spécifiques des organisations.

Plusieurs cadres de référence et modèles existent pour guider les initiatives de changement organisationnel. Ces cadres et ces modèles traduisent des systèmes complexes qui influencent les comportements en représentations visuelles plus simples. Le modèle COM-B en matière de

changement de comportement est un de ces exemples, et il présente la capacité (C), les occasions (O) et la motivation (M) comme étant trois facteurs clés du comportement (*behaviour*, B) (Michie, 2011). Ce modèle offre un aide-mémoire simple permettant d'orienter les initiatives de changement organisationnel, et il a servi à conceptualiser les résultats des études incluses dans cette revue rapide.

Cette revue rapide a été réalisée pour soutenir les organisations de santé publique du Canada dans la mise en œuvre de la PDÉDP. Elle cherche à recenser, à évaluer et à résumer les données probantes issues de la recherche tirées d'études qui cherchent à comprendre le processus de PDÉDP ainsi que d'études qui explorent les meilleures manières de mettre en œuvre les pratiques et les programmes ÉDP, et ce, afin de soutenir les organisations de santé publique dans leurs initiatives de changement dans le but de favoriser les pratiques éclairées par les données probantes.

Cette revue rapide inclut les données probantes disponibles au 18 mars 2022 : **Que sait-on des stratégies visant à mettre en œuvre des pratiques éclairées par des données probantes à l'échelle organisationnelle?**

Points clés

- Étant donné l'hétérogénéité des études incluses, il n'est pas possible de déterminer les stratégies de mise en œuvre de la PDÉDP ou des pratiques et programmes ÉDP qui sont plus efficaces que les autres.
- Des stratégies couramment utilisées dans les approches axées sur la PDÉDP ou sur les pratiques et programmes ÉDP sont notamment la création de rôles spécialisés, l'éducation et la formation du personnel, le développement de processus ou de mécanismes visant à soutenir les nouvelles pratiques, et le soutien de la direction.
- Les facteurs favorables et les obstacles à la PDÉDP et aux pratiques et programmes ÉDP correspondent au modèle COM-B en matière de changement de comportement, lequel présente la capacité, les occasions et la motivation comme étant des facteurs du comportement – voir la figure 1. La capacité reflète la possibilité d'un nouveau comportement. Les facteurs favorables à la capacité incluent le développement des connaissances et des habiletés du personnel, la création de rôles spécialisés, ainsi que le partage de connaissances dans toute l'organisation. Les obstacles à la capacité sont notamment le roulement de personnel et la perte de connaissances qui en découle.
- La notion d'occasions signifie que l'adoption de nouveaux comportements est envisageable. Les facteurs favorables incluent le développement de processus ou de mécanismes au soutien des nouvelles pratiques, des forums encourageant l'apprentissage et l'acquisition de compétences, et des périodes protégées. Les obstacles aux occasions incluent la concurrence des priorités.
- La motivation fait référence à la question de savoir si la motivation est suffisante pour qu'un nouveau comportement apparaisse. Les facteurs favorables sont notamment une culture organisationnelle propice, des attentes envers l'apparition de nouvelles pratiques, la reconnaissance et le renforcement positif, ainsi qu'un fort appui de la part

de la direction. Les obstacles incluent des attitudes négatives envers les nouvelles pratiques, ainsi qu'un manque de compréhension et de soutien des gestionnaires.

- Lorsque vient le temps de consulter des données probantes pour éclairer la PDÉDP et les pratiques et programmes ÉDP, il est important de veiller à ce que les effets des programmes sur les populations en quête d'équité ne creuseront pas les inégalités, mais qu'ils réduiront plutôt les écarts existants. Lorsque les données probantes ne permettent pas de déterminer adéquatement les effets des programmes sur ces groupes, les efforts visant à soutenir la PDÉDP et les pratiques et programmes ÉDP ne devraient probablement pas être déployés avant que des données et des données probantes supplémentaires permettent de confirmer que la mise en œuvre de ces programmes n'accentuera pas les inégalités de santé.

- Étant donné l'importance du contexte en matière de changement organisationnel, l'essai clinique randomisé n'est pas un modèle adapté à l'évaluation d'études portant sur la mise en œuvre de la PDÉDP et des pratiques et programmes ÉDP. Les études de haute qualité qui se penchent sur un seul groupe, comme les études analytiques de cohorte prospectives évaluées au moyen de mesures validées ou les analyses descriptives et qualitatives d'études de cas contenant des descriptions détaillées des interventions et du contexte, sont les plus utiles pour concevoir de nouvelles initiatives dans ce domaine.

Aperçu des données probantes et lacunes dans les connaissances

La mise en œuvre de la PDÉDP dans les organisations

- Sur les 37 études incluses portant sur la mise en œuvre de la PDÉDP, la plupart ont été réalisées dans des milieux de santé publique (n=16) et de soins primaires (n=16). Certaines ont été menées dans des milieux liés aux services sociaux (n=3), à la santé mentale des enfants et des jeunes (n=1) et à la santé au travail (n=1).

- La plupart des études ont été réalisées aux États-Unis (n=17), puis au Canada (n=12), en Australie (n=5) et en Europe (n=4).

- Les modèles d'études sont des rapports de cas (n=17), des études avec essai avant après sur un seul groupe (n=10), des études qualitatives (n=9) et des essais cliniques randomisés (n=2). Un essai clinique randomisé évalue le groupe d'intervention de façon qualitative et ne compare pas les résultats à ceux du groupe témoin. Ainsi, toutes les études quantitatives, sauf une, ne font pas de comparaison avec un groupe témoin (n=30).

- Les études rapportent des résultats quantitatifs (n=11), qualitatifs (n=18) ou quantitatifs et qualitatifs (n=8). En ce qui concerne les études qui rapportent des résultats quantitatifs, les mesures incluent la mise en œuvre de la PDÉDP, les croyances et les comportements liés à la PDÉDP, les priorités organisationnelles relativement à la PDÉDP, et certains indicateurs de qualité des soins aux patients. Les mesures quantitatives sont hétérogènes et ne permettent pas la méta-analyse. Les résultats qualitatifs ont été générés sous forme d'analyses qualitatives formelles (n=31) ou de rapports de cas descriptifs (n=7). La plupart des résultats qualitatifs incluent des facteurs favorables et des obstacles à la mise en œuvre de la PDÉDP (n=22).

- Les stratégies de mise en œuvre de la PDÉDP mentionnées sont notamment les fonctions de courtage des connaissances au soutien de la PDÉDP dans les organisations,

le renforcement général des capacités du personnel de l'organisation, et des partenariats ou des réseaux universitaires ou de recherche en appui à la PDÉDP.

- Les facteurs favorables à la mise en œuvre de la PDÉDP dans les organisations sont entre autres le développement des connaissances et des habiletés relatives à la PDÉDP, un personnel multidisciplinaire exerçant des fonctions de soutien à la PDÉDP, l'accès aux données probantes, le partage de connaissances dans l'organisation, l'intégration de la PDÉDP dans les modèles de processus et de pratique destinés au personnel, des forums consacrés à l'apprentissage et à l'exercice de la PDÉDP (p. ex., des communautés de pratique ou des clubs de lecture), l'intégration de la PDÉDP dans des fonctions nouvelles ou existantes, des périodes protégées pour l'apprentissage et l'exercice de la PDÉDP, une culture organisationnelle propice, des gestionnaires qui s'attendent à ce que la PDÉDP soit utilisée, la reconnaissance et le renforcement positif, ainsi qu'un fort appui de la direction.
- Parmi les obstacles à la mise en œuvre de la PDÉDP dans les organisations, on note le manque de temps, le roulement de personnel et la perte de connaissances, la concurrence des priorités, les attitudes négatives envers la PDÉDP, et le manque de soutien et de compréhension des gestionnaires.
- Le degré de certitude global des données probantes est considéré comme modéré. Bien que la plupart des études soient des études observationnelles non comparatives, le degré de certitude des données probantes a été bonifié pour être considéré comme modéré en raison de la cohérence des résultats et du faible risque de biais dans les études.

La mise en œuvre de pratiques éclairées par des données probantes

- La plupart des 21 études incluses portant sur la mise en œuvre de pratiques éclairées par des données probantes ont été réalisées dans des milieux de soins primaires (n=10) et de services sociaux (n=6), ainsi que dans des milieux de santé publique (n=4) et de soins palliatifs (n=1).
- La plupart de ces études ont été réalisées aux États-Unis (n=13), puis au Canada (n=4), en Australie (n=3) et en Europe (n=1).
- Les modèles d'études incluent des rapports de cas (n=13), des études avec essai avant après sur un seul groupe (n=6) et des études qualitatives (n=2). Aucune des études quantitatives ne faisait de comparaison avec un groupe témoin.
- Les études rapportent des résultats quantitatifs (n=8), qualitatifs (n=11), ou quantitatifs et qualitatifs (n=2). En ce qui concerne les études rapportant des résultats quantitatifs, les mesures incluent l'usage des indicateurs relatifs aux pratiques éclairées par des données probantes et à la qualité des soins aux patients. Les mesures quantitatives sont hétérogènes et ne permettent pas la méta-analyse. Les résultats qualitatifs ont été générés sous forme d'analyse qualitative formelle (n=2) ou de rapports de cas descriptifs (n=9). La plupart des résultats qualitatifs incluent des facteurs favorables et des obstacles à la mise en œuvre de la PDÉDP (n=10).
- Les stratégies qui contribuent à la réussite de la mise en œuvre de pratiques ou de programmes éclairés par des données probantes incluent la création d'un rôle ou d'une

équipe dont la fonction est de soutenir la mise en œuvre, l'éducation de la main-d'œuvre, la distribution de documents supplémentaires comme des manuels ou des guides visuels, l'implication du personnel dans l'élaboration du plan de mise en œuvre, l'adaptation du plan de mise en œuvre au contexte local, l'analyse des obstacles, ainsi que l'évaluation et la rétroaction constantes.

- Les obstacles à la mise en œuvre de pratiques ou de programmes éclairés par des données probantes incluent le manque de connaissances du personnel et sa mauvaise compréhension du nouveau programme, une mauvaise communication entre l'équipe de mise en œuvre et les professionnels ou le personnel, le roulement de personnel et la perte de connaissances, le manque de temps et de personnel, et la complexité des programmes.
- Le degré de certitude global des données probantes est considéré comme faible. La plupart des études sont des études observationnelles non comparatives. Bien que les résultats soient cohérents d'une étude à l'autre, la plupart de ces études sont des études de cas non comparatives avec analyses non systématiques.

Perspectives de pairs partenaires travaillant en santé publique au Canada

- Les pairs partenaires travaillant en santé publique au Canada se sont entendus pour dire que les résultats de cette revue reflètent essentiellement leur propre expérience dans leur organisation.
- Leurs commentaires indiquent qu'en pratique, un obstacle particulièrement difficile à surmonter est le fait que le personnel n'a souvent pas les connaissances et la volonté nécessaires pour apprendre ou pour modifier ses comportements.
- Les partenaires ont aussi indiqué que des stratégies clés permettant de soutenir la mise en œuvre de la PDÉDP ou des pratiques ou programmes ÉDP incluent la création d'une unité de soutien centrale consacrée à cette fin dans l'organisation, l'implication du personnel dans l'élaboration et la mise en œuvre des changements, l'offre d'incitatifs et de rétroaction positive au personnel pour récompenser les changements de comportements, et le suivi d'indicateurs de changement à tous les niveaux de l'organisation.
- Une limite des études incluses est de ne pas avoir adéquatement évalué ou examiné les effets de la culture organisationnelle sur le succès des interventions.

Méthodologie

Une description du développement du Service rapide de données probantes du Centre de collaboration nationale des méthodes et outils a été publiée (Neil-Sztramko *et al.*, 2021). L'article présente un aperçu du processus de révision et explique les décisions méthodologiques.

Question de recherche :

Que sait-on des stratégies visant à mettre en œuvre des pratiques éclairées par des données probantes à l'échelle organisationnelle?

Recherche

Les bases de données suivantes ont été fouillées les 18 mars 2022 en utilisant les termes clés : implement*, integrat*, knowledge broker*, transform*, organizational culture, organizational innovation, organizational case studies, change management, capacity building, evidence-based, evidence based, knowledge translation, knowledge exchange:

- MEDLINE database
- Embase
- Ovid Emcare
- Global Health Database
- PsycINFO
- Web of Science

En plus des recherches mentionnées précédemment, des documents produits par des intervenants clés ont été analysés au moyen d'une recherche ciblée interrogeant leurs publications.

Une copie de la stratégie de recherche complète peut être consultée à Appendix 1.

Critères de sélection des études

Les sources de langue anglaise, évaluées par les pairs et les sources publiées avant l'impression et avant l'évaluation par les pairs ont également été incluses.

	Critères d'inclusion	Critères d'exclusion
Population	Organisations de prestation de services liés à la santé du secteur public, comme les directions et les autorités de santé publique, les milieux de soins de santé (hôpitaux, cliniques), les services sociaux Service ou équipe au sein d'une organisation	Secteur privé Milieu universitaire, écoles
Intervention	Interventions dans l'ensemble d'une organisation visant à adopter des pratiques éclairées par des données probantes	Pour les études axées sur la mise en œuvre, interventions mises en œuvre par une organisation externe
Comparisons		
Résultats	Au niveau organisationnel : • Changements de comportements; • Confiance, habiletés; • Données relatives aux patients (p. ex., données portant sur les indicateurs de qualité concernant les erreurs de médication); • Intégration de la prise de décision éclairée par des données probantes (PDÉDP) dans les processus organisationnels (comme le recrutement), le développement professionnel, les processus et les mécanismes de prise de décision; • Changement de culture; • Changements touchant le budget. Quantitatif et qualitatif	Études de mise en œuvre qui mesurent la fidélité
L'Emplacement	Pays membres de l'Organisation de coopération et de développement économiques (OCDE)	Pays à faible et à moyen revenu
L'Étude au cadre	Études primaires	Textes d'opinion, éditoriaux

Extraction et synthèse des données

Pour les synthèses, les données relatives à la conception de l'étude, au cadre, à l'emplacement, aux caractéristiques de la population, aux interventions ou à l'exposition et aux résultats ont été extraites lorsqu'elles étaient déclarées. Nous avons synthétisé les résultats sous forme narrative en raison de la variété des méthodes et des conclusions des études incluses.

Évaluation de la qualité des données probantes

Nous avons évalué la qualité des données probantes incluses en utilisant des outils d'évaluation critique, comme nous le décrivons ci-dessous. L'évaluation de la qualité a été réalisée par un examinateur et vérifiée par un deuxième examinateur. Les conflits ont été résolus par la discussion.

Méthodologie de l'étude	Outils d'évaluation critique
Rapport de cas	Joanna Briggs Institute (JBI) Checklist for Case Reports
Qualitative	Joanna Briggs Institute (JBI) Checklist for Qualitative Research
Études avec essai avant après sur un seul groupe	Joanna Briggs Institute (JBI) Checklist for Quasi-Experimental Studies
Essai clinique randomisé	Joanna Briggs Institute (JBI) Checklist for Randomized Controlled Trials

Les évaluations de la qualité effectuées pour chaque étude incluse sont disponibles sur demande.

Les études avec essai avant après sur un seul groupe ont été évaluées comme des études quasi expérimentales. Les études qui réalisent une analyse qualitative formelle ont été évaluées comme des études qualitatives, y compris celles que les auteurs désignent comme étant des rapports de cas.

En raison de l'hétérogénéité des résultats des études, le cadre de référence Grading of Recommendations Assessment, Development, and Evaluation (GRADE) (Schünemann *et al.*, 2013) n'a pas été utilisé dans le cadre de cette revue. Le degré de certitude global des données probantes a été déterminé en fonction du risque de biais des modèles des études incluses ainsi qu'en fonction de leur qualité.

Résultats

Synthèse des données probantes

Cette revue résume 38 études portant sur la mise en œuvre de la PDÉDP à l'échelle organisationnelle, ainsi que 21 études portant sur la mise en œuvre de certaines pratiques ou de certains programmes éclairés par des données probantes dans les organisations. Bien que ces scénarios de mise en œuvre soient semblables, ils posent des défis distincts aux organisations.

La mise en œuvre de la PDÉDP dans les organisations

La mise en œuvre de la PDÉDP dans les organisations de santé publique, de santé ou de services sociaux exige des changements organisationnels majeurs, parce qu'il faut souvent de nouvelles approches en matière de prise de décision et d'offre de soins. Les changements majeurs dans les organisations sont complexes. Il faut généralement plusieurs années pour les réaliser, et ils requièrent l'investissement constant de ressources désignées. En raison de l'hétérogénéité des modèles d'études, des interventions et des résultats, il n'est pas possible de déterminer quelles stratégies de mise en œuvre de la PDÉDP sont plus efficaces que les autres. L'évaluation des stratégies mises en œuvre par les études incluses dans cette revue est souvent qualitative et décrit des facteurs favorables et des obstacles, au lieu de mesurer l'efficacité de manière quantitative. Cependant, il est possible d'explorer des stratégies de mise en œuvre de la PDÉDP et des facteurs qui semblent contribuer ou nuire à son succès.

La stratégie la plus couramment mise en œuvre dans les études incluses est l'établissement de rôles de courtage de connaissances : c'est la principale stratégie mentionnée dans 22 études. Bien que les études décrivent ces rôles différemment (p. ex., « facilitateur de pratiques éclairées par des données probantes », « facilitateur de connaissances », « mentor en matière de PDÉDP » [traduction libre]), tous ces rôles servent à soutenir la PDÉDP dans les organisations au moyen d'activités de partage de connaissances, de synthèse de données probantes, de mise en œuvre et d'autres activités relatives à la PDÉDP. Dans certaines études, les courtiers de connaissances sont extérieurs à l'organisation. Dans d'autres cas, les courtiers de connaissances ont été choisis au sein du personnel existant. Les stratégies de courtage de connaissances ont principalement été mises en œuvre parallèlement à d'autres stratégies de mise en œuvre de la PDÉDP, comme le renforcement des capacités du personnel, l'intégration de la PDÉDP dans les processus de prise de décision, et le développement du leadership au soutien de la PDÉDP. Lorsque ces stratégies ont été évaluées de façon quantitative en ce qui a trait à la capacité organisationnelle, à la culture et à la mise en œuvre de la PDÉDP, la plupart des études ont observé des augmentations, bien que certaines études n'aient observé aucun changement après la création de rôles de courtage de connaissances. Sur le plan qualitatif, la plupart des études décrivent les facteurs favorables et les obstacles à la PDÉDP, que ce soit sous la forme d'une analyse qualitative formelle ou d'un rapport de cas. Les facteurs favorables sont notamment une culture organisationnelle qui inclut l'appui de la direction et l'adhésion du personnel, des attentes envers l'utilisation de données probantes pour éclairer les décisions, l'accès aux connaissances, et l'intégration de la PDÉDP dans les processus et les modèles. Les obstacles incluent les contraintes de temps et la concurrence des priorités, le roulement de personnel, et le manque de compréhension et de soutien des gestionnaires.

Dix études incluses se concentrent principalement sur le renforcement des capacités en matière de PDÉDP du personnel existant de l'organisation, et ce, souvent à plusieurs niveaux, comme les professionnels de première ligne, les gestionnaires et la direction. Le renforcement des capacités fut principalement réalisé au moyen d'ateliers axés sur la PDÉDP, qui étaient souvent accompagnés d'un suivi continu des animateurs de l'atelier. Ces études portant sur le renforcement des capacités organisationnelles en matière de PDÉDP n'ont généralement pas utilisé d'autres stratégies pour mettre en œuvre la PDÉDP. Bien que les études mesurent souvent les changements sur le plan des connaissances et des habiletés individuelles des participants aux ateliers relativement à la PDÉDP, elles rapportent les changements organisationnels favorables à la PDÉDP de façon qualitative, que ce soit au moyen d'une analyse qualitative formelle ou d'un rapport de cas. Les facteurs favorables à la PDÉDP incluent une culture organisationnelle qui inclut le soutien de la direction et l'adhésion du personnel, des rôles consacrés au soutien de la PDÉDP, des occasions de se rencontrer et d'échanger sur la PDÉDP (comme des communautés de pratique ou des clubs de lecture), le partage de connaissances dans l'organisation, des attentes envers l'utilisation de données probantes pour éclairer les décisions, l'accès aux connaissances, et l'intégration de la PDÉDP dans les processus et les modèles. Les obstacles sont entre autres les contraintes de temps et la concurrence des priorités, le roulement de personnel, et des attitudes négatives à l'égard de la PDÉDP.

Des partenariats et des réseaux universitaires ou de recherche sont la principale stratégie décrite dans trois rapports de cas. Ceux-ci supposent l'établissement de collaborations, que ce soit à travers des universités ou des organisations de santé non gouvernementales, qui offrent du soutien direct en matière de PDÉDP. Ces stratégies n'ont pas été évaluées de façon quantitative, mais elles décrivent des facteurs favorables et des obstacles aux collaborations intersectorielles. Les facteurs favorables à la PDÉDP sont notamment le soutien de la direction et des gestionnaires, des rôles consacrés au soutien de la PDÉDP, le développement de connaissances et d'habiletés du personnel en matière de PDÉDP, et des communications régulières entre les partenaires. Les obstacles incluent les contraintes de temps et la concurrence des priorités, la préférence du personnel pour l'expérience plutôt que pour les données probantes issues de la recherche, et des attitudes négatives à l'égard de la PDÉDP.

Les facteurs favorables et les obstacles couramment relevés dans les études incluses donnent une idée des éléments clés d'une stratégie de PDÉDP. Afin de réussir à changer les comportements, les stratégies doivent agir sur la capacité de changement, ce qui peut être fait en renforçant les capacités du personnel, en créant des rôles consacrés au soutien à la PDÉDP, en améliorant l'accès aux données probantes, et en diffusant les connaissances dans l'organisation. Les stratégies doivent aussi favoriser les occasions de changement, lesquelles peuvent être encouragées au moyen de forums consacrés à l'apprentissage et à l'exercice de la PDÉDP, de périodes protégées consacrées à la PDÉDP, de l'intégration de la PDÉDP dans des rôles nouveaux ou existants, et de l'ajout de la PDÉDP aux processus et aux modèles. Les changements de comportements requièrent également de la motivation, qui peut être suscitée au moyen d'une culture organisationnelle propice, des attentes envers l'utilisation de la PDÉDP, de la reconnaissance et du renforcement positif, ainsi que d'un fort appui de la

direction. Le déploiement de stratégies multiples qui agissent sur la capacité, sur les occasions et sur la motivation augmente la probabilité de changements efficaces et durables.

Mise en œuvre des pratiques et des programmes ÉDP

Les études portant sur la mise en œuvre de pratiques et de programmes ÉDP dans les organisations de santé publique, de santé ou de services sociaux révèlent la complexité des stratégies de mise en œuvre. Plusieurs études portant sur la mise en œuvre décrivent de multiples stratégies concurrentes. La stratégie la plus couramment utilisée dans les études portant sur la mise en œuvre de pratiques ou de programmes ÉDP est la création d'une équipe ou d'un rôle consacré au soutien de la mise en œuvre (n=11). Ces personnes ou ces équipes sont responsables de la planification, de la gestion et de l'évaluation de la mise en œuvre. La deuxième stratégie la plus courante est l'éducation de la main-d'œuvre (n=8), ce qui implique habituellement des ateliers, destinés au personnel de plusieurs paliers de l'organisation, visant à le guider et à le motiver à adopter la nouvelle pratique. Dans plusieurs études (n=5), des ressources supplémentaires, par exemple des manuels et des aides visuelles, ont été mises à la disposition du personnel. Dans de nombreuses études (n=7), une autre stratégie de mise en œuvre est l'implication des professionnels et du personnel des organisations dans l'élaboration de plans de mise en œuvre. Dans certaines études, la planification de la mise en œuvre des pratiques et de programmes ÉDP a été adaptée au contexte organisationnel (n=4) ou éclairée par l'analyse des obstacles (n=2). Plusieurs stratégies de mise en œuvre incluent l'évaluation continue de la mise en œuvre tout en offrant de la rétroaction aux professionnels (n=5).

En ce qui concerne les facteurs qui facilitent la réussite de la mise en œuvre de pratiques éclairées par des données probantes, plusieurs études décrivent les stratégies mentionnées ci-dessus comme étant des facteurs favorables. D'autres facteurs favorables sont le désir de changement du personnel, l'appui de la direction, des communications et des messages cohérents, ainsi qu'une culture d'apprentissage.

Les obstacles à la mise en œuvre sont plutôt cohérents d'une étude à l'autre. Ceux-ci incluent le manque de connaissances du personnel et sa mauvaise compréhension du nouveau programme, une mauvaise communication entre l'équipe de mise en œuvre et les professionnels ou l'équipe, le roulement de personnel et la perte de connaissances, le manque de temps et de personnel, et la complexité des programmes.

Stratégies courantes de mise en œuvre de la PDÉDP et des pratiques et programmes ÉDP

Plusieurs des facteurs favorables et des obstacles à la mise en œuvre de la PDÉDP et des pratiques et programmes ÉDP sont communs aux stratégies explorées dans les études incluses dans cette revue. Pour conceptualiser ces facteurs, la **figure 1** les présente selon le modèle COM-B en matière de changement de comportement (Michie, 2011). Ce modèle présente les facteurs clés qui contribuent à un changement de comportement durable : la capacité, les occasions et la motivation. Le modèle propose que des modifications à l'un ou l'autre de ces trois facteurs influencent le changement de comportement.

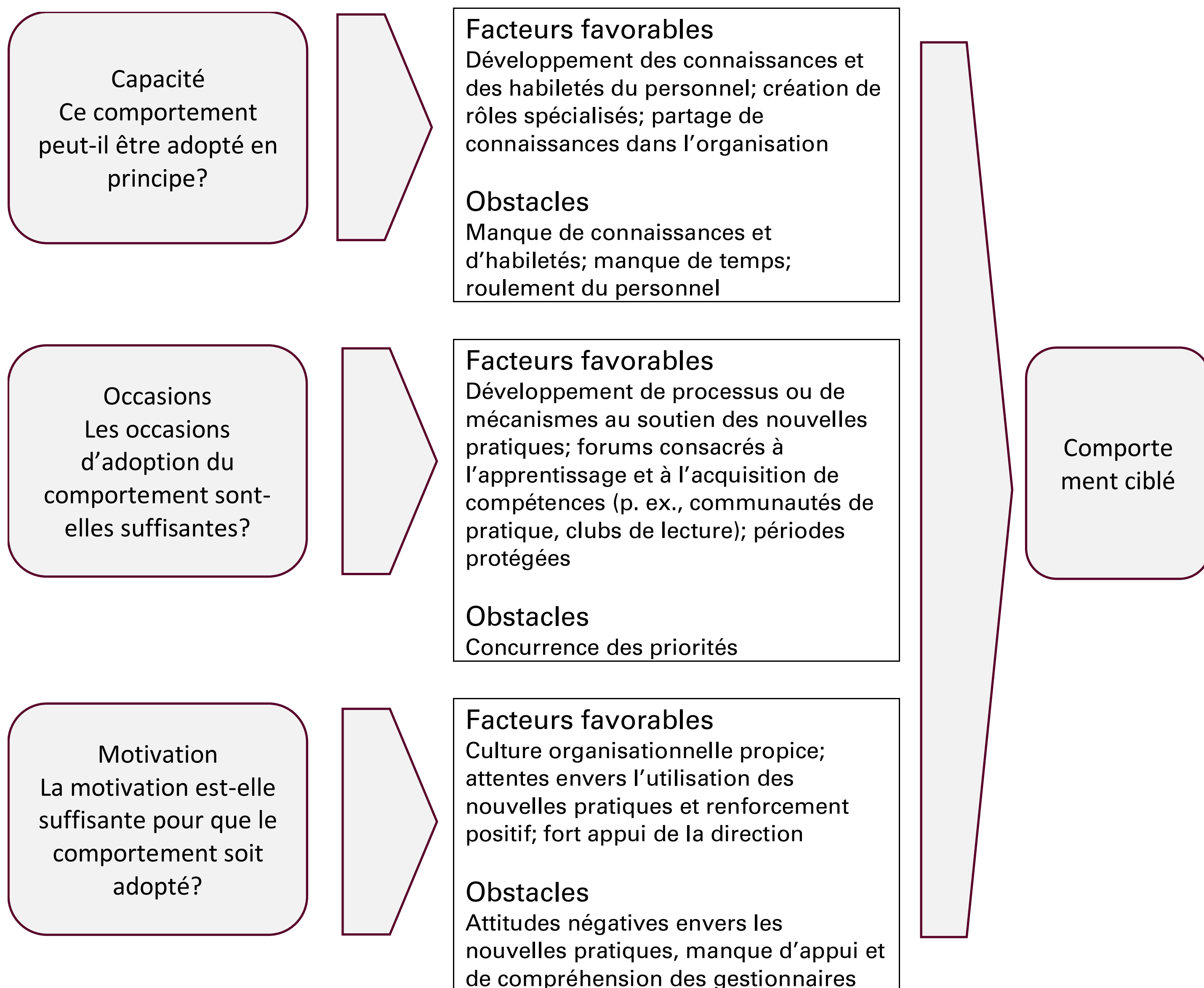

Figure 1 : Cartographie des facteurs favorables et des obstacles à la mise en œuvre organisationnelle de la PDÉDP suivant le modèle COM-B.

Synthèse de la qualité des données probantes

Ce document comprend 38 études uniques sur la mise en œuvre de la PDÉDP dans une organisation et 21 études uniques sur la mise en œuvre des pratiques et programmes ÉDP pour un total de 59 publications.

Dans les études portant sur la mise en œuvre de la PDÉDP dans une organisation, l'absence de groupes témoins entraîne un risque de biais plus élevé. Cependant, étant donné que ces interventions dépendent beaucoup du contexte, le degré de certitude des conclusions de ces études n'aurait pas nécessairement été plus élevé si un groupe témoin avait été inclus. La plupart des études incluses ont été considérées comme de qualité modérée ou élevée selon leurs outils d'évaluation de la qualité respectifs. Ainsi, la certitude globale des données probantes de ces études a été considérée comme modérée.

Dans la même veine, les études portant sur la mise en œuvre des pratiques et programmes ÉDP n’avaient pas non plus de groupe témoin, ce qui entraîne aussi un risque de biais plus élevé. Toutefois, étant donné que ces interventions dépendent beaucoup du contexte, le degré de certitude des conclusions de ces études n’aurait pas nécessairement été plus élevé si un groupe témoin avait été inclus. Les études incluses ont été considérées comme de qualité modérée ou élevée selon leurs outils d’évaluation de la qualité respectifs, mais étant donné que ces recherches sont majoritairement des rapports de cas contenant des évaluations non systématiques des résultats, le degré global de certitude de leurs données probantes a été considéré comme faible.

Question de recherche	Objet d’étude	Données probantes incluses	Cote de qualité	Certitude globale des données probantes
Que sait-on des stratégies visant à mettre en œuvre des pratiques éclairées par des données probantes à l’échelle organisationnelle?	La mise en œuvre de la PDÉDP dans les organisations	Essai clinique randomisé Études avec essai avant après sur un seul groupe Rapport de cas Qualitative	2 Modérée 4 Élevée, 6 Modérée 6 Élevée, 9 Modérée, 2 Failble 5 Élevée, 4 Modérée	Modérée
	la mise en œuvre de pratiques ou de programmes éclairés par des données probantes	Études avec essai avant après sur un seul groupe Rapport de cas Qualitative	1 Élevée, 5 Modérée 8 Élevée, 5 Modérée 2 Élevée	Faible

Conclusion

Cette revue explore la mise en œuvre de la PDÉDP à l’échelle organisationnelle, ainsi que la mise en œuvre de certaines pratiques ou de certains programmes éclairés par des données probantes dans les organisations. Malgré la similitude de ces défis de mise en œuvre, les études emploient des stratégies de mise en œuvre distinctes. Les facteurs favorables et les obstacles décrits dans les études incluses donnent une idée de la manière de planifier et de réaliser une mise en œuvre réussie.

Tableau 1 : Études individuelles (La mise en œuvre de la PDÉDP dans les organisations)

Reference	Study Design	Setting, Timeline	Sector	Level	Framework	Intervention	Outcomes (Tool)	Findings	Quality Rating (Tool)
Clark, E.C., Dhaliwal, B., Ciliska, D., Neil-Sztramko, S.E., Steinberg, M., & Dobbins, M. (2022). A pragmatic evaluation of a public health knowledge broker mentoring education program: a convergent mixed methods study. *Implementation science communications*, *3*(1), 18.	Mixed methods No comparator	Public Health Units Ontario, Canada 2015-2018	Public Health	4-8 staff members from each of 10 public health units	Not applicable	Organizational goals for EIDM were set by senior leadership during a facilitated focus group using the Is Research Working for you organizational assessment. A Knowledge Broker mentoring program, delivered by knowledge translation specialist mentors, included workshops, webinars, consultations between participants and mentors, and completion of a rapid review.	Quantitative: -Attainment of organizational goals for EIDM (semi-structured interviews) Qualitative: -EIDM facilitators and barriers (semi-structured interviews)	Facilitators for EIDM: -Integration of EIDM into process through structures, processes, or templates -New or re-defined staff positions for EIDM -Leadership support -Culture of expectations that decisions use EIDM -Acceptance of time for learning and doing EIDM Challenges to EIDM: -Lack of EIDM knowledge among management -Lack of protected time -Lack of staff buy-in -Lack of direction or plan for participants	High (Qualitative)
Hooge, N., Allen, D.H., McKenzie, R., & Pandian, V. (2022). Engaging advanced practice nurses in evidence-based practice: An e-mentoring program. *Worldviews on evidence-based nursing*, *19*(3), 235-244.	Single group pre-post study No comparator	Large academic health system Southeast region, United States 12-week program	Primary Care	11 Advanced practice registered nurses	IOWA Model of Evidence-Based Practice	Virtual mentoring program delivered via Microsoft Teams platform included synchronous training sessions, podcasts, blog and video tutorials, and additional research articles and educational material.	Quantitative: -Knowledge and skill for EIDM (evidence-based practice beliefs scale, evidence-based practice implementation scale) -Organizational readiness for EIDM (organizational culture and readiness for system-wide	Compared to baseline, evidence-based practice beliefs scores increased (effect size=0.71, p=0.018). No significant change in evidence-based practice implementation and organizational culture and readiness for system-wide implementation of evidence-based practice scale scores.	High (Quasi-experimental study)

							implementation of evidence-based practice scale) Qualitative -EIDM facilitators and barriers (open-ended Facilitators and Barriers Survey developed by project team)	Facilitators for EIDM: -Flexible timing of program -Convenient online format Challenges to EIDM: -Competing priorities -Time management	
Elliott, M.J., Allu, S., Beaucage, M., McKenzie, S., Kappel, J., Harvey, R., ... Manns, B. (2021). [Defining the Scope of Knowledge Translation Within a National, Patient-Oriented Kidney Research Network]. *Canadian journal of kidney health and disease*, *8*.	Case report No comparator	Canadians Seeking Solutions and Innovations to Overcome Chronic Kidney Disease (Can-SOLVE CKD) Canada Dates not specified	Primary Healthcare	Clinicians, nurses	Can-SOLVE CKD Knowledge Translation Framework	A national integrated KT network (Can-SOLVE CKD) was established, including: -Central knowledge translation committee available for consultation -Support from external partners -KT planning templates -KT champions -KT virtual community of practice -KT online learning module	Findings were described in a narrative case report.	Facilitators for EIDM: -Diverse knowledge base and commitment to knowledge translation of members -Inclusion of patient's perspectives Challenges: -Generalizability of a national research network KT approach to smaller individual project teams -Lack of KT skills among research and patient partners	Moderate (Case report)

Flaherty, H.B., Bornheimer, L.A., Hamovitch, E., Garay, E., Mini de Zitella, M.L., Acri, M.C., & McKay, M. (2021). Examining Organizational Factors Supporting the Adoption and Use of Evidence-Based Interventions. *Community Mental Health Journal, 57*(6), 1187-1194.	Cluster Randomized Controlled Trial Control group	Outpatient child mental health clinics New York, United States Dates not specified	Primary Healthcare	52 child mental health care providers	Not applicable	Providers at child mental health care agencies implemented the 4Rs and 2Ss Multiple Family Group intervention. Providers received training and bimonthly supervision. Clinic Implementation Teams operated at agencies randomized to the intervention arm.	Quantitative: Frequency of use of new techniques (Training Exposure and Utilization Scale), and organizational climate (Texas Christian University's Organizational Readiness for Change Scale)	Increased use of evidence-based interventions was associated with providers' belief that organizational climate supported use of evidence-based interventions ($b=-0.33$, $SE=0.11$, $p<0.01$).	Moderate (Qualitative)
Martin-Fernandez, J., Aromatario, O., Prigent, O., Porcherie, M., Ridde, V., & Cambon, L. (2021). Evaluation of a knowledge translation strategy to improve policymaking and practices in health promotion and disease prevention setting in French regions: TC-REG, a realist study. *BMJ open*, *11*(9), e045936.	Case report No comparator	Regional health agencies France 2017-2019	Public Health	Health professionals and decision-makers across regional health agencies	Not applicable	The Transfert de Connaissances en REGion (TC-REG) knowledge translation plan includes: -Increasing access to scientific evidence -Developing skills for EIDM through training, journal clubs and tutoring -Developing organizational culture for EIDM through collaborative workshops, establishing processes, and incentives	Qualitative: - EIDM facilitators and barriers (unstructured interviews) -Use of EIDM (semi-structured interviews)	Facilitators for EIDM: -Understanding of scientific evidence -Confidence in using scientific evidence -Ability to search and find scientific evidence -Motivation to use scientific evidence -Belief that scientific evidence can help to improve practice, develop new frameworks, advocate for their professional activity, and create new partnerships	Moderate (Case report)
Augustino, L.R., Braun, L., Heyne, R.E., Shinn, A., Lovett-	Case report	Military Treatment	Primary Healthcare	Nursing staff at 4 facilities	Not applicable	An evidence based practice facilitator role supported	Findings were described in a narrative case report.	Facilitators for EIDM: -Incorporating the evidence based practice	High (Case report)

Floom, L., King, H., … Hatzfeld, J. (2020). Implementing Evidence-Based Practice Facilitators: A Case Series. *Military medicine*, *185*(Suppl 2), 7–14.	No comparator	Facilities (MTFs) United States 2018				organization-wide EIDM teams through training, mentoring and encouraging EIDM.		facilitator into existing practice -Involving evidence based practice facilitator in nursing meetings and committees -Aligning the evidence based practice facilitator's work with organizational priorities Challenges to EIDM: -Staff turnover -Lack of standardized evaluation of EIDM use	
Haynes, A., Rowbotham, S., Grunseit, A., Bohn-Goldbaum, E., Slaytor, E., Wilson, A., … Wutzke, S. (2020). Knowledge mobilisation in practice: an evaluation of the Australian Prevention Partnership Centre. *Health research policy and systems*, *18*(1), 13.	Case report No comparator	Australian Prevention Partnership Centre Australia 5-year period; dates not specified	Public Health	Organization-wide, in partnership with research institutions	The Prevention Centre's programme model	Six components for cross-sector collaborative partnerships for EIDM: 1. Involve partners at all stages of projects 2. Foster communication, e.g., forums, narrative reports 3. Develop skills through workshops, webinars with experts, cross-sector projects 4. Build cross-sector project teams 5. Integrate knowledge through high-quality evidence synthesis	Quantitative: -Perceptions of leadership, governance, resource allocation, collaboration and engagement (Partnership survey) Qualitative: -Implementation and impact of projects (Project evaluations) -Experiences and perceptions (semi-structured interviews)	Partners reported: -Translation of research into policy was built into processes -Many projects involved partners from different sectors -Communication across sectors and teams was adequate -Capacity building activities were valuable -Identification of synergies across projects	Moderate (Case report)

						6. Assess and adapt through ongoing surveys and opportunities for feedback			
Roberts, M., Reagan, D. R., & Behringer, B. (2020). A Public Health Performance Excellence Improvement Strategy: Diffusion and Adoption of the Baldrige Framework Within Tennessee Department of Health. *Journal of public health management and practice*, *26*(1), 39–45.	Single group pre-post study No comparator	Tennessee Department of Health (TDH) Tennessee, United States 2012-2018	Public Health	Departments, teams, senior leadership across organization	Malcolm Baldrige Performance Excellence framework	Volunteers were trained as "Baldrige examiners", a role similar to a knowledge broker. These volunteers then supported teams at the local health departments evaluate and improve programming.	Quantitative: -Employee satisfaction (survey) -Adoption of new processes (training records) -Integration of new programs (program process reports)	Authors report diffusion of skills across the local health departments. Department staff reported satisfaction with their jobs at rates higher than national averages.	Moderate (Quasi-experimental study)
van der Zwet, R.J.M., Beneken genaamd Kolmer, D.M., Schalk, R., & Van Regenmortel, T. (2020). Implementing Evidence-Based Practice in a Dutch Social Work Organisation: A Shared Responsibility. *The British Journal of Social Work*, *50*(7), 2212–2232.	Case report No comparator	Social work organization Netherlands 2013-2015	Social work	Research and development team	Organization's model for evidence-based practice implementation, based on Plath, 2013 (see below)	Establishment of a research and development department and long-term collaboration with a university to support EIDM	Qualitative: -EIDM facilitators and barriers (semi-structured interviews)	Facilitators for EIDM: -Strong leadership with commitment to research -Qualified staff in dedicated EIDM support roles -Research partnerships -Training in EIDM -Targeted recruitment of staff with various educational backgrounds Challenges to EIDM: -Lack of qualified staff -Lack of EIDM understanding -Negative attitudes towards EIDM	High (Case report)

								-Preference for experiential vs. research knowledge -Culture of crisis-driven practice -Workload, time management, competing priorities	
Williams, N.J., Wolk, C. B., Becker-Haimes, E. M., & Beidas, R.S. (2020). Testing a theory of strategic implementation leadership, implementation climate, and clinicians' use of evidence-based practice: a 5-year panel analysis. *Implementation science*, *15*(1), 10.	Single group pre-post study	Outpatient children's mental health clinics Philadelphia, United States 2013-2017	Primary Healthcare	Senior leadership across agencies	Policy ecology framework	Development of organizational leadership and climate for EIDM through training, consultation and technical assistance.	Quantitative: -EIDM use (Cognitive-behavioral therapy subscale of the Therapy Procedures Checklist-Family Revised) -Leadership for EIDM (Implementation Leadership Scale) -Organizations' climates for EIDM (Implementation Climate Scale) -Perceptions of leader's transformational leadership (Multifactor Leadership Questionnaire) -Attitudes toward EIDM (Evidence-based Practice Attitudes Scale)	Organizational climates supportive of EIDM were associated with: -Strong leadership for EIDM (d=0.92, p=0.017) -Increased use of EIDM (d=.55, p=0.007) There was no association between clinicians' attitudes towards EIDM and their use of EIDM.	High (Quasi-experimental study)

Dobbins, M., Greco, L., Yost, J., Traynor, R., Decorby-Watson, K., & Yousefi-Nooraie, R. (2019). A description of a tailored knowledge translation intervention delivered by knowledge brokers within public health departments in Canada. *Health Research Policy and Systems*, *17*(1), 63.	Single group pre-post study No comparator	3 Public Health Units Ontario, Canada 2010-2012	Public health	All staff at organization, senior leadership	Not applicable	Knowledge Brokers deployed to public health units supported individual capacity and organizational culture for EIDM. Knowledge brokers held workshops, mentoring, meetings with senior management and developed policies and processes for EIDM.	Quantitative: -knowledge, skills and behavioral assessment (survey) Qualitative: -EIDM facilitators and barriers (analysis of knowledge brokers journals)	Facilitators for EIDM: -Strong leadership support -Systematic integration of research evidence into decision-making processes -Access to librarians -Committed financial and human resources -Interest and enthusiasm from participating staff	Moderate (Quasi-experimental study)
Hitch, D., Lhuede, K., Vernon, L., Pepin, G., & Stagnitti, K. (2019). Longitudinal evaluation of a knowledge translation role in occupational therapy. *BMC health services research*, *19*(1), 154.	Case report No comparator	Public mental health service Major city in Australia 2014-2016	Occupational therapy	Occupational therapists within the organization	Not applicable	Leadership role in KT established to support EIDM, complete research projects, build research capacity and culture, and create a database of research activity.	Quantitative: -Attitudes towards EIDM (Evidence Based Practice Attitude Scale) -EIDM use (Evidence Based Practice Implementation Scale) -Staff perceptions of the Lead Research Occupational therapist role (survey)	After implementation of the KT role, -number of quality assurance and research activities increased (Cliffs Delta=0.44; 95% CI=0.22, 0.62) -no significant change in attitudes towards EIDM -staff viewed KT role positively -staff engaged in KT activities -greater diffusion of evidence across programs	Moderate (Case report)
Mackay, H.J., Campbell, K.L., van der Meij, B.S., & Wilkinson, S.A. (2019). Establishing an evidenced-based dietetic model of care in haemodialysis using implementation	Single group pre-post study No comparator	Haemodialysis unit, hospital Queensland, Australia 2016-2018	Primary healthcare	All staff at organization	Knowledge-to-Action (KTA) Framework, Theoretical Domains Framework (TDF), Behaviour change wheel	A new nutrition service was established to translate nutrition guidelines into practice to support EIDM through: -professional development	Quantitative: EIDM use, malnutrition prevalence (database audit, Patient-Generated Subjective Global Assessment tool) Qualitative: EIDM facilitators and	There was no significant change in malnutrition categories; most patients (72-80%) began the program well-nourished. Facilitators for EIDM: -Establishing processes for best practices	Moderate (Quasi-experimental study)

science. Nutrition & Dietetics, *76*(2), 150-157.						-evidence-informed recommendations -multidisciplinary staff involvement -integrated database prompts	barriers (clinic observation, team discussion)	-Buy-in from staff and management-in from staff and management -Regular monitoring and feedback Barriers, mapped to TDF domains, included: -Limited prior knowledge -Limited time	
Williams, C., van der Meij, B.S., Nisbet, J., Mcgill, J., & Wilkinson, S.A. (2019). Nutrition process improvements for adult inpatients with inborn errors of metabolism using the i-PARIHS framework. *Nutrition & Dietetics*, *76*(2), 141-149.	Single group pre-post study No comparator	Metabolic specialist centres Australia, New Zealand 2015-2017	Primary healthcare	Metabolic dietetic service within organization	Integrated-Promoting Action on Research Implementation in Health Services (i-PARIHS) framework	The metabolic dietetic service established: -Electronic referral alert -Metabolic sick day nutrition plans available to all clinical staff -Metabolic diet codes and specialised formula recipes	Quantitative: admissions for patients with inborn errors of metabolism (chart audit)	There was a reduction in total admissions of patients with inborn errors of metabolism (36 vs. 11 across the audit periods; unclear if this was a statistically significant finding.)	Moderate (Quasi-experimental study)
Allen, P., Jacob, R.R., Lakshman, M., Best, L.A., Bass, K., & Brownson, R.C. (2018). Lessons Learned in Promoting Evidence-Based Public Health: Perspectives from Managers in State Public Health Departments. *Journal of Community Health*, *43*(5), 856–863.	Qualitative	State health departments United States 2016	Public Health	Leaders and program managers	State health department evidence-based public health capacity building framework	A larger Randomized Controlled Trial randomized state health departments to an intervention group that received EIDM training and support or a control group that received links to electronic resources. (See Brownson, 2017)	Qualitative: EIDM facilitators and barriers (structured interviews)	Facilitators for EIDM: -Leadership support -Developing structures and culture incorporating evidence based public health -Ongoing training -Building and maintaining partnerships with external partners Challenges to EIDM: -Funding/budget cuts -Lack of time -Lack of political will/support	Moderate (Qualitative)

								-Staff turnover	
Allen, P., O'Connor, J.C., Best, L.A., Lakshman, M., Jacob, R.R., & Brownson, R.C. (2018). Management Practices to Build Evidence-Based Decision-Making Capacity for Chronic Disease Prevention in Georgia: A Case Study. *Preventing Chronic Disease, 15*, E92.	Case report No comparator	State health department Georgia, United States 2013-2016	Public Health	Program staff across organization	Brownson's evidence-based public health framework	Program staff received training for EIDM that included lectures, and small group problem-solving and discussion.	Qualitative: EIDM facilitators and barriers (interviews)	Facilitators for EIDM: -Leadership support -Consistent internal messaging on EIDM -Close partnerships with evaluation teams -Requirement for evidence in proposals Challenges to EIDM: -Competing priorities -Limited budget for staff -Political conflicts in state and local agendas	High (Case report)
Brodowski, M.L., Counts, J.M., Gillam, R.J., Baker, L., Collins, V.S., Winkle, E., ... Redmon, J. (2018). Translating Evidence-Based Policy to Practice: A Multilevel Partnership Using the Interactive Systems Framework. Families in Society. *The Journal of Contemporary Social Services, 94*(3), 141-149.	Case report No comparator	Social service agencies, Kansas and Nebraska, United States 2005-2011	Social work	Social service providing organizations	Interactive Systems Framework for Dissemination and Implementation	A workgroup of state-led agencies and federal partners developed a framework for infrastructure for EIDM, including federal policy for invested in evidence-based programs and quality improvement. Technical assistance was provided to community-based programs through a third party.	Quantitative: Use of EIDM (annual reported funding for evidence-based programs) Qualitative: EIDM facilitators (interviews)	The percentage of funded programs that were evidence-based increased from 29% to 63%. Facilitators for EIDM: -Strong infrastructure (outreach, training, fidelity assessment, supervision, management of the program -Availability of Technical Assistance: -Consideration of context when using EIDM to choose programs -Active engagement and collaboration with key stakeholders at all levels	Moderate (Case report)
Brownson, R.C., Allen, P., Jacob, R.R., deRuyter, A., Lakshman, M., Reis, R.S., & Yan, Y. (2017). Controlling Chronic Diseases	Randomized Controlled Trial	State health departments United States March 2014 and March 2015	Public Health	Program staff across organization	Not applicable	State health departments randomized to: -Intervention group that received EIDM training workshop, and follow-up calls	Quantitative: perceived organizational skills and culture for EIDM (survey)	Following the intervention, -Perceived skills gaps decreased (p=0.02). -Perceived supervisory expectation for use of EIDM increased (p=0.006)	Moderate (Randomized Controlled Trial)

Through Evidence-Based Decision Making: A Group-Randomized Trial. *Preventing chronic disease*, *14*, E121.						for technical assistance and supplemental activity planning and updates support -Control group that received links to electronic resources.		-Use of evidence increased (p=0.008).	
Melnyk, B.M., Fineout-Overholt, E., Giggleman, M., & Choy, K. (2017). A Test of the ARCC© Model Improves Implementation of Evidence-Based Practice, Healthcare Culture, and Patient Outcomes. *Worldviews on evidence-based nursing*, *14*(1), 5–9.	Single group pre-post study No comparator	Washington Hospital Healthcare System, United States 12 months; dates not specified	Primary Healthcare	Service providers, administrators within organizations	Advancing Research and Clinical practice through close Collaboration (ARCC) Model	EIDM mentors were developed within the healthcare system, through intensive EIDM workshops. Teams of participants implemented and evaluated an EIDM change project within their hospital.	Quantitative: Knowledge and skill for EIDM (evidence-based practice beliefs scale, evidence-based practice implementation scale), organizational readiness for EIDM (organizational culture and readiness for system-wide implementation of evidence-based practice scale), patient outcomes (aggregate data from the hospital's medical records)	Following implementation, -Organizational knowledge and skill for EIDM organization increased (effect size=0.62; *p*=0.00) -Organizational implementation of EIDM increased (effect size=2.3; *p*=0.00) -Organizational culture and readiness for EBP increased significantly from baseline (*M*=80.9; *SD*=90.8) to follow-up (*M*=90.8; *SD*=14.7; *t*=3.9; *p* =0.00; effect size=0.70) The following trends were seen in patient outcomes, -Reduction in ventilator days -Decreased pressure ulcer rate -Reduced hospital readmissions for congestive health failure -Increase in patient reported quality of care -Reduced use of formula as a supplement -Decreased wait time for pain medication and	Moderate (Quasi-experimental study)

								decreased length of stay in emergency room	
Williams, N.J., Glisson, C., Hemmelgarn, A., & Green, P. (2017). Mechanisms of Change in the ARC Organizational Strategy: Increasing Mental Health Clinicians' EBP Adoption Through Improved Organizational Culture and Capacity. *Administration and Policy in Mental Health and Mental Health Services, 44*(2), 269-283.	Single group pre-post study No comparator	Children's mental health agencies Large mid-Western urban area, United States 2010-2013	Primary Healthcare	CEOs and administrators, and front-line clinical teams at organizations	Availability, Responsiveness, and Continuity Organizational Strategy	External facilitators supported leadership, staff and an internal liaison. Principles of EIDM were integrated into the organizations' operating procedures. Organizational infrastructure and tools to enable EIDM were developed. Staff and leadership mental models to support EIDM were enabled.	Quantitative: Intentions to adopt EIDM, barriers to EIDM (surveys), Unit-level enactment of Availability, Responsiveness, and Continuity principles and completion of planned activities (ARC principles questionnaire), Organizational proficiency culture for EIDM (Organizational Social Context measure)	Clinicians exhibited: -Higher odds of adopting EIDM (OR=3.19, p=0.003) -Greater use of EIDM with clients (p=0.003) -Fewer EIDM barriers (p=0.026) Intention to use EIDM was the only predictor of EIDM adoption (p=0.032) and EIDM use (p=0.002).	High (Quasi-experimental study)
Bennett, S., Whitehead, M., Eames, S., Fleming, J., Low, S., & Caldwell, E. (2016). Building capacity for knowledge translation in occupational therapy: learning through participatory action research. *BMC medical education, 16*(1), 257.	Case report No comparator	Large urban hospital Australia 18 months, dates not specified	Primary Healthcare	Occupational therapists in hospital	Knowledge to Action Framework, Theoretical Domain Framework	An EIDM capacity building program was implemented. The program included: -Educational outreach across organization -Teams working on clinical case studies -Allocating time for EIDM -Mentorship -Leadership support -Communication regarding EIDM -Development of EIDM processes and resources	Qualitative: EIDM use, perceptions of organizational culture toward EIDM, EIDM facilitators and barriers (focus groups with clinicians and observations by the research team)	Facilitators for EIDM: -EIDM integration into roles -Buy-in to EIDM impact -Developing goals for EIDM -Access to mentors -Supportive leadership -Breaking down EIDM into manageable tasks -Journal club to discuss EIDM processes Challenges to EIDM: -Lack of EIDM knowledge and skill -Perceived lack of capability -Perceived lack of time and training -Competing priorities	Moderate (Case report)

						-Funding for an EIDM champion one day per week -Setting goals and targets for EIDM -EIDM reporting and evaluation		-Challenges with staff rotating between clinical teams	
Awan, S., Samokhvalov, A.V., Aleem, N., Hendershot, C.S., Irving, J.A., Kalvik, A., ... Voore, P. (2015). Development and Implementation of an Ambulatory Integrated Care Pathway for Major Depressive Disorder and Alcohol Dependence. *Psychiatric services, 66*(12), 1265–1267.	Case report No comparator	Centre for Addiction and Mental Health (CAMH) Toronto Ontario, Canada 2013-2014	Primary Healthcare	Service providers, researchers at organization	Not applicable	An integrated care pathway, which relies on EIDM, was implemented for patients with concurrent major depressive disorder and alcohol dependence. Development of the integrated care pathway included evidence reviews, knowledge translation, process reengineering and change management.	Quantitative: -patient symptom assessment and medication titration (Penn Alcohol Craving Scale, Quick Inventory for Depressive Symptoms scores and Beck Depression Inventory) Qualitative: -Facilitators and barriers (focus groups)	Evaluation of patient care found: -Lower program dropout (78% to 46% $p<0.05$) -Reduction in depressive symptom severity (p-value not reported) -Reduction in heavy drinking days (42% to 23%, $p<0.04$) Facilitators: -Inclusion and frontline clinicians -Use of tools/templates (e.g., process maps, medication algorithms) -Team meetings Challenges: -Lack of knowledge and skill for EIDM -Communication with referring providers	Moderate (Case report)
Breckenridge-Sproat, S.T., Throop, M.D., Raju, D., Murphy, D.A., Loan, L.A., & Patrician, P.A. (2015). Building a Unit-Level Mentored	Single group pre-post study No comparator	Military Hospitals Washington, District of Columbia, United States	Primary Healthcare	Nurses across hospitals	Advancing Research and Clinical practice through close Collaboration (ARCC) Model	Unit-level mentors facilitated an educational mentoring program for EIDM. The intervention involved an organizational	Quantitative: -EIDM beliefs (Evidence-Based Practice Beliefs) -Organizational readiness and barriers to EIDM (Organizational	Following the intervention, -Evidence based practice belief scores increased ($p=0.02$) -Organizational readiness for EIDM scores increased ($p<0.01$)	Moderate (Quasi-experimental study)

Program to Sustain a Culture of Inquiry for Evidence-Based Practice. *Clinical Nurse Specialist, 29*(6), 329-337.		18 months; dates not specified				assessment, identification of facilitators and barriers, training EIDM mentors and EIDM implementation. Librarian support, evidence-based practice education material, training modules were provided and supervised study team evidence-based practice projects were completed.	Readiness for System-wide Integration of Evidence-Based Practice) -EIDM implementation (Evidence-Based Practice Implementation Scales)		

Parke, B., Stevenson, L., & Rowe, M. (2015). Scholar-in-Residence: An Organizational Capacity-Building Model to Move Evidence to Action. *Canadian Journal of Nursing Leadership, 28*(2), 10-22.	Case report No comparator	Island Health and the University of Alberta British Columbia, Canada 2012-2014	Primary Healthcare	Whole organization	N/A	Scholar-in-residence roles was established to integrate practice, education, and research through collaboration between a health region and a university. Activities included: -Unit-based research teams that conducted literature reviews, literature appraisal -Workshops on writing for publication, research methods skills -Funded research project proposal writing, ethics applications, data collection and analysis -Publications and presentations -Quality improvement through collaboration with community, hospitals and university	Findings were described in a narrative case report.	Challenges to EIDM: -Cultural differences between the healthcare and university system -Establishing protected time for research in the health organization -Building relationship between the scholar and hospital staff	Moderate (Case report)

Waterman, H., Boaden, R., Burey, L., Howells, B., Harvey, G., Humphreys, J., … Spence, M. (2015). Facilitating large-scale implementation of evidence based health care: insider accounts from a co-operative inquiry. *BMC health services research*, *15*, 60.	Qualitative	The Greater Manchester Collaboration for Leadership in Applied Health Research and Care (GM-CLAHRC) Manchester, United Kingdom Dates not specified	Public Health	Organization	Knowledge Transfer Partnership model	KT Associates facilitated the implementation of EIDM. KT Associates joined teams responsible for implementing EIDM along with the clinical lead, academic lead and program manager.	Qualitative: -Evaluation of KT Associates' role and impact (focus group and interviews)	KT Associates contributed to 4 key stages: -Choosing an evidence-based intervention (collecting information, bringing stakeholders together, identify context, build up network) -Planning the evidence-based intervention (collecting evidence, testing the intervention, sharing info, expanding networks, stakeholder meetings) -Co-ordinating and implementing the evidence-based intervention recruit people and build relationships, individualized support, communication, understanding context) -Evaluating evidence-based intervention (data collection/report, patient and staff experiences, celebratory events, poster/presentations)	High (Case report)
Fernández, M.E., Melvin, C.L., Leeman, J., Ribisl, K.M., Allen, J.D., Kegler, M.C., … Hebert, J.R. (2014). The cancer prevention and control research network: An interactive systems approach to advancing cancer	Case report No comparator	The Cancer Prevention and Control Research Network (CPCRN) United States Dates not specified	Public Health	National network	Interactive Systems Framework for Dissemination and Implementation (ISF)	Workgroups across the network facilitated activities, including: -building the capacity of service providers for EIDM -developing technical assistance for KT	Findings were described in a narrative case report.	Successful EIDM activities were described, including the following. Network members translated and adapted the evidence-based Stanford Chronic Disease Self-Management program which was well attended and highly rated by participants. Cancer screening programs were	High (Case report)

control implementation research and practice. *Cancer Epidemiology, Biomarkers & Prevention*, *23*(11), 2512–2521.						-developing research partnerships -investigating implementation processes from other studies		adapted to the local context, increasing uptake among residents. Several partner universities have implemented workplace health promotion interventions.	
Gallagher-Ford, L. (2014). Implementing and sustaining EBP in real world healthcare settings: transformational evidence-based leadership: redesigning traditional roles to promote and sustain a culture of EBP. *Worldviews on Evidence-Based Nursing 11*(2), 140-142.	Case report No comparator	Large, complex healthcare system USA Dates not specified	Primary Healthcare	Departments across an organization	Not applicable	A nurse administrator promoted and sustained a culture of evidence-based practice through the following activities: -Organizational assessments -Developing clinical nurse specialists as EIDM champions -Mentoring individuals through the change process	Findings were described in a narrative case report.	Clinical nurse specialists have championed EIDM across the organizations. More than 13 projects for EIDM were initiated by clinical nurse specialists.	Low (Case report)
Gifford, W., Lefebre, N., & Davies, B. (2014). An organizational intervention to influence evidence-informed decision making in home health nursing. *The Journal of Nurse Administration*, *44*(7/8), 395-402.	Qualitative	Large community based healthcare organization delivering home and community healthcare Ontario, Canada 20-week intervention,	Public Health	Management and clinical leaders from 4 units	Not applicable	Strategies to promote EIDM to nurse managers and clinical leaders in home healthcare were implemented, including, -Workshop on EIDM -Mentorship support from experienced "evidence facilitators" -Access to university library services	Quantitative: EIDM use (Is Research Working for You? A Self-assessment Tool and Discussion Guide for Health Services Management and Policy Organizations) Qualitative: Usefulness of intervention, EIDM barriers and facilitators (semi	Following the intervention, participants reported: -More resources to conduct research -Relevant staff to contribute to EIDM discussions -More feedback and rationale on decisions -More information about how evidence influenced decision making in the organization (All $p<0.05$)	High (Qualitative)

		dates not specified				-Information-sharing activities -Encouragement and recognition Study Limitations: • Social desirability bias • Survey has not been for internal validity • Response rate 97% pre intervention and 40% post intervention Actual decisions made and patient/staff outcomes not measured	structured interviews)	Facilitators for EIDM: • Ongoing education • Linking staff to EIDM experts • Social networking across organization • Recognition for EIDM work • Audit and feedback Challenges to EIDM: • Lack of time • Lack of knowledge, skills, and confidence • Conflicting priorities within the organization • Nursing shortages	
Kaplan, L., Zeller, E., Damitio, D., Culbert, S., & Bayley, K.B. (2014). Improving the culture of evidence-based practice at a Magnet(R) hospital. *Journal for Nurses in Professional Development, 30*(6), 274-280.	Case report No comparator	Magnet-designated hospital USA, November 1, 2012 to May 10, 2013	Primary Healthcare	Nurses across organization	Not applicable	All nurses received an electronic newsletter on EIDM every 2 weeks. A cohort of direct care nurses participated in a series of EIDM workshop to develop, implement, and disseminate an EIDM project.	Quantitative: Organizational readiness for integration of EIDM (The Organizational Culture and Readiness for System-Wide Integration of Evidence-Based Practice Scale), EIDM knowledge and skill (Evidence-Based Practice Beliefs Scale), EIDM implementation (The Evidence-Based Practice implementation Scale)	Following the intervention, perceptions of organizational increased. Confidence in implementing EIDM was not associated with EIDM use. The education level of nurses was positively associated with EIDM use.	High (Case report)

Miro, A., Perrotta, K., Evans, H., Kishchuk, N. A., Gram, C., Stanwick, R. S., & Swinkels, H. M. (2014). Building the capacity of health authorities to influence land use and transportation planning: Lessons learned from the Healthy Canada by Design CLASP Project in British Columbia. *Canadian journal of public health*, *106*(1 Suppl 1), eS40–eS52.	Single group pre-post study No comparator	Fraser Health, Island Health and Vancouver Coastal Health British Columbia, Canada 2010 - 2012	Public health	Organization	Not applicable	Regional health authorities were provided an expert consultant to foster EIDM in land use and transportation plans and policies. The expert worked with staff to develop and facilitate the implementation of the work plans, by conducting a situation assessment, developing capacity-building plan and implementing the plan.	Quantitative: Knowledge and skill for land use and transportation plans/policies (survey) Qualitative: Activities completed at the health units (interviews)	Following the intervention, staff reported: -Increased knowledge And skills -Increased awareness of other organizations working in the area Facilitators for EIDM -New relationships with colleagues in other health authorities, governments and sectors -Increased opportunities for collaboration -Collaboration between health authorities and local governments -New insights on partnership work Challenges to EIDM -Lack of time and resources -Roles and partnerships not clearly defined -Lack of leadership support and integration of this work across the organization	High (Quasi-experimental study)
Traynor, R., DeCorby, K., & Dobbins, M. (2014). Knowledge brokering in public health: a tale of two studies. *Public health*, *128*(6), 533-544.	Randomised Controlled Trial with control group Case report with no comparator	Public Health Unit, Ontario, Canada, RCT 2003–2007, Case report 2009-2013.	Public Health	Organization	Not applicable	Two studies which implemented Knowledge Brokers who conducted initial and ongoing needs assessments for EIDM, knowledge management and internal network development.	Quantitative: social network data, EIDM skills, knowledge and behavior (survey) Qualitative: Knowledge, attitudes and behaviours for EIDM (interviews, journal analysis)	Knowledge brokering intervention was reported to result in increased use of EIDM. Tailoring knowledge broker approaches to the organizational context was most effective. Knowledge brokers were most effective if they were experts in research	High (Qualitative)

							.	methodology and public health, as well as being approachable and patient.	
Irwin, M.M., Bergman, R.M., & Richards, R. (2013). The experience of implementing evidence-based practice change: a qualitative analysis. *Clinical Journal of Oncology Nursing, 17*(5), 544-549.	Case report No comparator	Various healthcare settings United States 2009-2010	Primary Healthcare	Nursing teams	Not applicable	Institute for Evidence-Based Practice Change program was provided to nurses. This program included a 2.5-day workshop on EIDM, literature searching, and development of an implementation plan, project management, and outcomes measurement. The program also provided an experience mentor for EIDM support for 12-months.	Qualitative: -EIDM facilitators and barriers (verbatim log entries from the team champion)	Facilitators for EIDM: -Adequate time -Organizational support -Engagement and teamwork -Communication and planning -Maintaining focus on EIDM goals Challenges to EIDM -Competing priorities -Data collection and measurement challenges -Staff turnover	Low (Case report)
Humphries, S., Hampe, T., Larsen, D., & Bowen, S. (2013). Building organizational capacity for evidence use: the experience of two Canadian healthcare organizations. *Healthcare management forum*, *26*(1), 26–32.	Case report No comparator	Regina Qu'Appelle Health Region and Northern Health Alberta and British Columbia, Canada 2008-2011	Public health	Management and staff at organizations	Not applicable	The Value Add through Learning and Use of Evidence (VALUE) initiative was implemented, including, -Learning projects (to practice research literacy and skills) -Liaison roles -Research support -Protected time for EIDM activities -Inter-regional collaboration	Findings were described in a narrative case report.	Lessons learned included: -Staff turnover was a challenge –Potential benefit to promoting evidence use in staff orientation -Evidence use implementation needs to be directed at multiple levels within the organization -Strategies with ongoing real-time research expertise and support were valued by participants	High (Case report)

Plath, D. (2013). Organizational processes supporting evidence-based practice. *Administration in social work, 37*(2), 171-188.	Qualitative	Non-governmental social service organization, Australia Dates not specified	Social work	Staff across organization	Not applicable	Strategies to promote EIDM were implemented, including, -leadership commitment to EIDM -staff champions for EIDM -establishment of EIDM "communities of practice" teams	Qualitative: -EIDM facilitators and barriers and facilitators (interviews and focus groups)	Facilitators for EIDM: -Dedicated staff roles for research and KT -Supportive leadership -Sufficient time, training and resources for EIDM -Audit and feedback of practices -Building frontline staff skills in EIDM -EIDM "communities of practice" Challenges to EIDM: -Competing priorities -Lack of knowledge and skills -Culture of responding to crises	Moderate (Qualitative)
Kimber, M., Barwick, M., & Fearing, G. (2012). Becoming an evidence-based service provider: staff perceptions and experiences of organizational change. *The journal of behavioral health services & research, 39*(3), 314–332.	Qualitative	Kinark Child and Family Services Ontario, Canada 2006-2010	Child and youth mental health	Staff across organization	National Implementation Research Network's model	Multiple EIDM interventions were implemented, including: -leadership support -appointing working group leaders -dedicated time for EIDM	Qualitative: -EIDM facilitators and barriers (survey)	Facilitators for EIDM -Staff understanding the clinical transformation project and stages -Effective leadership -Change culture inclusive of staff and management, and various disciplines -Cross-program collaboration -Protected time -Evaluation to demonstrate benefits of change Challenges to EIDM: -Underutilization of internal staff -Lack of preparation for change	Moderate (Qualitative)

Peirson, L., Ciliska, D., Dobbins, M., & Mowat, D. (2012). [Building capacity for evidence informed decision making in public health: a case study of organizational change]. *BMC public health, 12*, 137.	Qualitative	Peel Public Health, Ontario, Canada September 2008 to February 2010	Public Health	All staff at organization, including leadership	LEADS in a Caring Environment Framework	Multiple EIDM interventions were implemented, including: -hiring of new leadership supportive of EIDM -development of strategic organizational plan for EIDM -Development of staff knowledge and skills	Qualitative: EIDM facilitators (semi-structured interviews and focus groups, review of documents)	Facilitators for EIDM: -Leadership at the highest level driving EIDM initiatives -Organizational structures (e.g., journal clubs, workshops, library services) -Establishing EIDM specialist roles, training staff in EIDM and encouraging knowledge sharing with co-workers - Supportive organizational culture -Accessible knowledge and sharing knowledge across the organization -Communication around EIDM and its priority to the organization	High (Qualitative)
Ward, M., & Mowat, D. (2012). [Creating an organizational culture for evidence-informed decision making]. *Healthcare management forum, 25*(3), 146-150.	Case report No comparator	Peel Public Health, Ontario, Canada 2010-11 (4th year of a 10-year initiative)	Public Health	All staff at organization, including leadership	LEADS in a Caring Environment Framework	Key elements of the EIDM strategic approach included: -Structured process for research review -Library reference service -Staff development in EIDM knowledge and skills -Dedicated staff time for EIDM -Active engagement with the research community -Accountability for EIDM at all levels of the organization	Findings were described in a narrative case report.	After 4 years of implementation, there was systematic and transparent application of research to more than 15 program decisions. EIDM was embedded as a cultural norm within the organization. Key lessons identified included: -Identify a senior, influential leader -Commit to a multiyear strategy -Be realistic about the infrastructure needed -Staff support for skill development	Moderate (Case report)

								-Make senior staff accountable for progress -Partner with leading researchers -Invest resources in change management. -Measure progress to communicate successes to staff	

Tableau 2 : Études individuelles (Mise en œuvre des pratiques et des programmes ÉDP)

Reference	Study Design	Setting, Timeline	Sector	Level	Framework	Intervention	Outcomes (Tool)	Findings	Quality Rating (Tool)
Pullyblank, K., Brunner, W., Wyckoff, L., Krupa, N., Scribani, M., & Strogatz, D. (2022). Implementation of Evidence-Based Disease Self-Management Programs in a Rural Region: Leveraging and Linking Community and Health Care System Assets. *Health Education & Behavior.* Epub ahead of print.	Single group pre-post study No comparator	Clinical health departments and community-based organizations Rural, central New York, United States March 2017-Nov 2019	Primary healthcare	Organization	Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework, Wagner's Chronic Care model and Plan-Do-Study-Act (PDSA) framework	The evidence-based was implemented through a multi-sector collaboration between a rural health care system and a network of community-based organizations. The program established a central recruitment, referral and coordinating office for the region.	Quantitative: Number of referrals (electronic health records), implementation, training, workshop schedules, quality assurance (Living Well internal documents), Workshop attendance and completion (program records)	The number of program workshops offered increased from 4-6/year to 23 by 2019. The number of community-based organizations grew from 4 to 6 counties. The number of non-referring clinics fell from 27 to 9. Health care providers and community-based organizations integrated the Living Well program into their culture of care. The authors concluded that a multi-sector approach using a central coordinating, referral, and recruitment hub can be an effective strategy to implement evidence-based programs in rural locations.	High (Quasi-experimental)
Rodriguez-Quintana, N., Lewis, C.C., Scott, K., Marriot, B., Wahlen, S., & Hindman, R. (2022). Implementation of the Wolverine Mental Health Program, Part 2: Implementation	Single group pre-post study No comparator	Wolverine Human Services Michigan, United States 2013-2018	Social work	Organization	Framework for Dissemination	A cognitive behavioural therapy program was implemented. The program was adapted fit the needs of the population and the multidisciplinary health team. Strategies used	Qualitative: -Implementation facilitators (site visits by the cognitive behavioral therapy intermediary and implementation research team for an	Six key blended strategies: 1)Dedicated implementation teams 2)Progress monitoring 3)Adapting the program to fit the needs of the	Moderate (Quasi-experimental)

Phase. *Cognitive and Behavioral Practice 29*(1), 227-243.						to support the programs integrated all team members	intensive immersion)	population/organization 4)Training/supervision 5)Consultation calls to support implementation 6)Train the trainers approach (identifying early adopters, capturing and sharing local knowledge, incentives)	
Scott, K., Lewis, C.C., Rodriguez-Quintana, N., Marriott, B.R., & Hindman, R.K. (2022). Implementation of the Wolverine Mental Health Program, Part 1: Adoption Phase. *Cognitive and Behavioral Practice, 29*(1), 214-226.	Case report No comparator	Wolverine Human Services juvenile residential facilities Michigan, United States 2013-2018	Social work	Organization	Framework for Dissemination	Cognitive behavioral therapy was implemented across facilities. Adaptation involved an implementation team, needs assessment, development of an implementation template, site training and ongoing reassessment.	Quantitative: -EIDM needs assessment (Evidence-Based Practice Attitude Scale, Attitudes Toward Standardized Assessment Scale, Organizational Culture Survey, Survey of Organizational Functioning and Infrastructure Survey and Sociometric Opinion Leader Survey) Qualitative: -Perceived effectiveness of implementation Strategies, organizational culture and readiness for change, and impact of infrastructure on new practice	The needs assessment identified 76 barriers; 23 were prioritized and addressed. Barriers included: -Lack of training in evidence-based practice -Poor communication -Low morale among staff -Lack of teamwork -Lack of incentive -High staff turnover At the reassessment 24 of the barriers showed statistically significant improvement.	Moderate (Quasi-experimental)

							implementation (Focus group interviews with clinicians and operations staff)		
Darling, E.K., Easterbrook, R., Grenier, L.N., Malott, A., Murray-Davis, B., & Mattison, C.A. (2021). [Lessons learned from the implementation of Canada's first alongside midwifery unit: A qualitative explanatory study](). *Midwifery, 103*, 103146.	Case report No comparator	Alongside Midwifery Unit (AMU) Markham Stouffville Hospital (MSH) Markham, Ontario, Canada Nov 2018 – May 2020	Primary healthcare	Unit within a large community hospital	Consolidated Framework for Implementation Research	This report explored the implementation of the first Alongside Midwifery Unit (AMU) in Canada. Implementation included frequent and open communication, dedicated project management, leadership engagement, ongoing evaluation and adaptation.	Qualitative -Facilitators (document analysis and key informant interviews)	Facilitators for implementation: -sociopolitical climate, desire for change, effective project support, dedicated time and resources, ongoing program evaluation and feedback, communication with leadership, involving all staff in planning and decision making.	Moderate (Case report)
McCarthy, S. & Griffiths, L.J. (2021). [The Journey to Evidence: Adopting Evidence-Based Programs in an Australian Child Welfare Organization](). *Human Service Organizations: Management, Leadership & Governance*, *45*(3), 273-280.	Case report No comparator	Child welfare system, Victoria, Australia Dates not specified	Social work	Organization	Not applicable	This case report explores the adoption and implementation of evidence-based practice within the child welfare system. Implementation was initiated by a new CEO. Readiness for change was assessed. A new role dedicated to implementation was established. Staff recruitment focused on hiring individuals with experience implementing evidence-based practices.	Qualitative: -Facilitators for implementation (interviews)	Facilitators for implementation: -Consistent communication and messaging -Adaptive management -Building a shared understanding of evidence -Development of a learning culture -Investment in staff skilled in evidence-based practice -Building relationships -Transformational leadership approach	Moderate (Case report)

Poehler, A.R., Parks, R.G., Tabak, R.G., Baker, E.A., & Brownson, R.C. (2020). Factors Facilitating or Hindering Use of Evidence-Based Diabetes Interventions Among Local Health Departments. *Journal of Public Health Management and Practice, 26*(5), 443-450.	Case report No comparator	Local health departments Missouri, United States Jan – April 2017	Public health	Organization	Not applicable	Twenty diabetes-related evidence-based programs and policies were implemented in local health departments. Staff capacity to implement these programs was developed through training and provision of resources.	Qualitative: -Facilitators, barriers and capacities to use evidence-based programs and policies (interviews with directors and diabetes/chronic disease practitioners)	Facilitators: -Knowledge of evidence-based programs and policies -Leadership support -Targeted messaging -Staff capacity building for EIDM evidence-based decision making -Access to professional development/training -Regular staff communications/ meetings -Meetings with internal and community decision makers -Obtaining and providing evidence relevant to the community Barriers: -Community perception/buy-in -Limited resources (funding and staff)	Moderate (Case report)
Connell, C.M., Lang, J.M., Zorba, B., Stevens, K. (2019). Enhancing Capacity for Trauma-informed Care in Child Welfare: Impact of a Statewide Systems Change Initiative. *American Journal of Community Psychology, 64*(3-4), 467-480.	Case report No comparator	Department of Children and Families Connecticut, United States 2011-2016	Social work	All staff at organization	Not applicable	Implementation of trauma-informed care, through workforce development, trauma screening procedures, policy changes, improved access to evidence-based trauma-focused treatments, and focused evaluation of changes.	Quantitative: - Staff perceptions of individual and organizational use of trauma-informed practices (Trauma System Readiness Tool) -Staff perception of contributions of each intervention component to success of program (survey)	Staff and organizational use of trauma-informed practices increased. Staff rated the availability of trauma-focused treatments in the community, integration of trauma-informed care into practice guides as the strongest contributors to organizational change.	High (Case report)

Wilkinson, S.A., O'Brien, M., McCray, S., & Harvey, D. (2019). Implementing a best-practice model of gestational diabetes mellitus care in dietetics: a qualitative study. *BMC health services research*, *19*(1), 122.	Qualitative	Two regional sites Queensland, Australia Dates not specified	Primary healthcare	Team	Theoretical Domains Framework, Behaviour Change Wheel	A medical nutrition therapy model of care for gestational diabetes mellitus was implemented at local regional sites. The implementation strategy included developing local consensus processes, self-monitoring clinician behaviour, prompts and cues, adjusting and reorganising clinic environment	Qualitative: stakeholder experiences and learnings (semi-structured interviews)	The project itself was described as a "catalyst for positive change". Facilitators for change included: -Engagement with an external project team -Robust project methodology and guided process to overcome local barriers -Wide, ongoing site stakeholder engagement and local networking -Multi-disciplinary higher-level management support and engagement -Positive attitude -Building confidence and capacity of local implementers through regular contact	High (Qualitative)
McAllen, E.R., Stephens, K., Swanson-Biearman, B., Kerr, K., & Whiteman, K. (2018). Moving Shift Report to the Bedside: An Evidence-Based Quality Improvement Project. *The Online Journal of Issues in Nursing*, *23*(2).	Single group pre-post study No comparator	532-bed, acute care, tertiary, teaching hospital Midwest United States Dates not specified	Primary healthcare	3 units within the hospital	Iowa Model of Evidence-Based Practice to Promote Quality Care and Kotter's Eight Stage Process for Major Change	A bedside report was implemented in standard nursing care. Staff were involved in implementation planning and provided education.	Quantitative: -Compliance (audits) -Number of patient falls (hospital incident reporting system) -Patient satisfaction (a combination of questions from the Press Ganey® and Hospital Consumer Assessment of Healthcare Providers and Systems surveys) -Nurse satisfaction (survey)	Compliance: -Combined compliance rate of 94% Falls: -Patient falls decreased by 24% in the four months after BSR implementation Patient Satisfaction: - Only the general surgery unit had a significant improvement in patient satisfaction based on the Ganey score (p=0.03)	Moderate (Quasi-experimental)

								-The Hospital Consumer Assessment of Healthcare Providers and Systems surveys showed improvement, but the changes were not statistically significant Nurse Satisfaction: -Significant reduction in the proportion of nurses who reported having enough time for report (80% to 59.6%; Mann Whitney U standardized test statistic=-2.668; p=0.008)	
Wilkinson, S.A., Hughes, E., Moir, J., Jobber, C. & Ackerie, A. (2018). Process of knowledge translation within routine clinical care: Implementing best practice in weight management. *Nutrition & Dietetics, 75*(4), 363-371.	Single group pre-post study No comparator	South-East Queensland Hospital Queensland, Australia 2016-2017	Primary healthcare	Organization	Theoretical Domains Framework (TDF), behaviour change wheel	A medical nutrition therapy model of care for gestational diabetes mellitus was adapted at local regional sites. The adaptation strategy included a needs assessment, barrier analysis and adaptation to local context.	Quantitative: service attendance metrics, anthropometry, diet quality, interventions delivered (hospital records)	Guideline adherence increased over time (4.4% - 50%, p<0.001); no significant differences observed between other outcomes.	High (Qualitative)
Williams, N.J., Ehrhart, M.G., Aarons, G.A., Marcus, S.C., & Beidas, R.S. (2018). Linking molar organizational climate and strategic implementation climate to clinicians'	Case report No comparator	Department of Behavioral Health and Intellectual DisAbility Services	Primary Healthcare	Network of clinics	Not applicable	Policy initiative for 4 psychotherapy protocols was initials. A dedicated role for implementation was established. Clinicians were trained in the new	Quantitative: impact of work environment on personal well-being and strategic implementation climate, perceptions of organizational for EIDM (survey)	In organizations with more supportive work environments, organizational support for EIDM predicted implementation. In organizations with less positive work environments, there	High (Case report)

use of evidence-based psychotherapy techniques: cross-sectional and lagged analyses from a 2-year observational study. *Implementation Science, 13*(1), 85.		Philadelphia, Pennsylvania, USA 2 years, dates not specified				psychotherapy protocols.		was no association between implementation and organizational support.	
Kane, H., Hinnant, L., Day, K., Council, M., Tzeng, J., Soler, R., Chambard, M., Roussel, A., & Heirendt, W. (2017). Pathways to Program Success: A Qualitative Comparative Analysis (QCA) of Communities Putting Prevention to Work Case Study Programs. *Journal of Public Health Management and Practice*, *23*(2), 104-111.	Case report No comparator	Public Health Departments United States 2010-2012	Public health	Organization	Communities Putting Prevention to Work Case Study Evaluation Conceptual Model	The Communities Putting Prevention to Work (CPPW) Initiatives program was implemented to increase high-impact, evidence-based, population-wide environmental improvement strategies. The program implemented strategies through partnerships with local, community and state organizations.	Quantitative: Completion of work plan objectives, leadership support, collaboration, staff turnover (site visits and interviews)	Two highly consistent combinations of conditions were found to lead to successful completion of objectives 88.2% of the time: 1)Having public health improvement and topical experience and having a history of collaboration with partners 2)Not having public health improvement and topical experience and having leadership support	Moderate (Case report)
Fabbruzzo-Cota, C., Frecea, M., Kozell, K., Pere, K., Thompson, T., Tjan Thomas, J., & Wong, A. (2016). A Clinical Nurse Specialist-Led Interprofessional Quality Improvement Project to Reduce Hospital-Acquired Pressure Ulcers. *Clinical Nurse*	Single group pre-post study No comparator	Mount Sinai Hospital (MSH) Toronto, Ontario, Canada 2012-2014	Primary Healthcare	Organization	Donabedian healthcare quality model	An advanced practice nurse-led interprofessional initiative to reduce hospital-acquired pressure ulcers using evidence-based practice. Key components of the initiative included: -Clinical experience integrated with theory,	Quantitative: -Incidence of pressure ulcers (Quarterly pressure ulcer prevalence and incidence audits) -Uptake of change in clinical practice (audits)	Evidence of successful implementation and outcomes: -80% decrease in hospital acquired pressure ulcers since the implementation. -63% of at-risk patients had a turning click posted at the bedside -All units had the Positioning Decision Tree for Patients at Risk available	Moderate (Quasi-experimental)

Specialist, 30(2), 110-116.						research and expert opinion -Synthesizing, critiquing and applying research - Involvement of interprofessional teams and senior leadership -Funding -Education		Evidence of staff engagement and commitment to initiatives: -28 nurses became skin and wound nurse champions -Provided feedback -Attended lectures -2 nurses joined Skin and Wound Care Steering Committee	
Nelson, G., Kiyang, L.N., Crumley, E.T., Chuck, A., Nguyen, T., Faris, P., ... & Gramlich, L.M. (2016). Implementation of Enhanced Recovery After Surgery (ERAS) Across a Provincial Healthcare System: The ERAS Alberta Colorectal Surgery Experience. *World Journal of Surgery, 40*, 1092-1103.	Case report No comparator	Alberta Health Services Alberta, Canada Feb 2013 – Dec 2014	Primary healthcare	Within a single health care system for colorectal surgery	Not applicable	A guideline for enhanced recovery after colorectal surgery was implemented. Implementation included an multidisciplinary implementation team and ongoing audit and feedback.	Quantitative: -Length of stay, complications, and 30-day post-discharge 30-day post-discharge readmissions (Interactive Audit System) -Guideline compliance (interview audit)	Patient Outcomes: -Median length of stay reduced from 6 days to 4.5 days after 15-months of implementation ($p<0.0001$) -Significant reduction in the risk of readmission (adjusted RR=1.73; 95% CI=1.09, 2.73; p=0.018) -Significant reduction in the proportion of patients who developed at least one complication (difference in proportions = 11.7 %, 95 % CI 2.5, 21; p=0.0139) -Net cost savings between $2806 and $5898 USD/patient Compliance: -Median overall guideline compliance	High (Case report)

								increased from 39 % to 60 %	
Kegeles, S.M., Rebchook, G., Tebbetts, S., Arnold, E., & Trip Team. (2015). Facilitators and barriers to effective scale-up of an evidence-based multilevel HIV prevention intervention. *Implementation Science, 10*, 50.	Single group pre-post study No comparator	Community-based organizations United States Two-year data collection period	Public health	Two to four individuals (coordinators, supervisors / directors, core group member volunteers) from 72 community-based organizations	Principles of Framework Analysis	The Mpowerment Project, a multi-level HIV prevention intervention, was implemented. Implementation included education for providers, resources for providers, e.g., manuals and videos. The community-based organizations implementing the program were involved in planning the implementation.	Qualitative: barriers and facilitators to implementation (semi-structured interviews, notes and commentaries from technical assistance providers)	Factors that influenced implementation success included: -Buy-in from service providers -Desire to change existing prevention approach -Planning for intervention before implementation -Evaluation of intervention -Organizational stability Barriers included: -complexity of program -adaptability of program	Moderate (Quasi-experimental)
McConnell, T., O'Halloran, P., Donnelly, M., & Porter, S. (2015). Factors affecting the successful implementation and sustainability of the Liverpool Care Pathway for dying patients: a realist evaluation. *BMJ Support Palliative Care 5*(1), 70-77.	Case report No comparator	One health and social care trust Northern Ireland 2011-2012	Palliative care	Two policymakers from the Department of Health, Social Services and Public Safety, and 22 participants from two service groups (Cancer and Specialist Services, and Acute Services)	Diffusion of innovations in health service organisations	The Liverpool Care Pathway was implemented to improve best practice in end-of-life care. Implementation involved a dedicated program facilitator, education for staff, regular evaluation and feedback.	Qualitative: facilitators and barriers for implementation (realist evaluation, semi-structured interviews)	Facilitators for implementation included: -Visibility and availability of program facilitator as a reminder to use pathway and support staff -Sharing positive feedback -Supportive senior management Barriers to implementation included: -Lack of resources -Differing needs and expectations	Moderate (Case report)

								-Ambivalence toward pathway approach from medical providers -Lack of ongoing senior management support and withdrawal of program facilitators -Social barriers (i.e., negative public perceptions in response to negative media)	
Schreiber, J., Marchetti, G.F., Racicot, B., & Kaminski, E. (2015). The use of a knowledge translation program to increase use of standardized outcome measures in an outpatient pediatric physical therapy clinic: administrative case report. *Physical Therapy, 95*(4), 613-629.	Case report No comparator	Pediatric outpatient facility with one primary and three satellite clinics United States Six-month duration	Primary healthcare	17 physical therapists	Knowledge-to-action framework	A multicomponent knowledge translation (KT) program was implemented to increase the use of standardized outcome measures and address inconsistency of frequency and duration of physical therapist services. The KT program included: barrier identification, use of a knowledge broker, workshops / practice sessions, online and hard-copy resources, and an ongoing program evaluation with communication of results.	Quantitative: knowledge assessment (baseline, 8-month follow-up), self-report surveys, chart review data on use of outcome measures	Knowledge assessment scores significantly increased (54.1 ± 13.5 to 81.8 ± 12.7, $p<0.001$). Self-reported *knowledge* of testing and measurement significantly improved, specifically with respect to test selection ($p=0.003$), administration ($p=0.001$), interpretation ($p=0.001$), and sharing of results ($p=0.022$). Self-reported *performance* of testing and measurement significantly improved, specifically with respect to test selection ($p=0.001$), administration ($p<0.001$), and interpretation ($p=0.006$).	High (Case report)

								Documented frequency of administration increased for all outcome measures at the beginning of the program and was sustained at 8-months.	
Stevans, J.M., Bise, C.G., McGee, J.C., Miller, D.L., Rockar, P., Jr, & Delitto, A. (2015). Evidence-based practice implementation: case report of the evolution of a quality improvement program in a multicenter physical therapy organization. *Physical therapy*, *95*(4), 588–599.	Case report No comparator	The University of Pittsburgh Medical Center, Centers for Rehab Services Pennsylvania, USA 2005	Primary Healthcare	Organization	Not applicable	The Low Back Pain Quality Improvement Initiative project was implemented. A local consensus process engaged providers in planning. Implementation champions supported the program. Providers were provided with education for the project. Implementation was evaluated regularly and feedback applied to adjust strategies.	Qualitative: Facilitators for implementation (interviews)	Facilitators for implementation included -Understanding the complex nature of the clinical setting from a systems perspective to identify implementation barriers. -Multicomponent intervention strategy -Vision, leadership, and commitment from all the members of the organization -Iterative measurement, reassessment, and refinement of strategies.	High (Case report)
Fearing, G., Barwick, M., & Kimber, M. (2014). Clinical transformation: Manager's perspectives on implementation of evidence-based practice. *Administration and Policy in Mental Health and Mental Health Services*	Case report No comparator	Kinark Child and Family Services Ontario, Canada 2006-2009	Social work	Organization	National Implementation Research Network implementation model	This report explores the process of an evidence-based practice implementation effort in all clinical services. Implementation was driven by multidisciplinary implementation teams.	Qualitative: -Managers perceptions (audio recording of management meetings)	8 overarching themes: 1)Staff workload (workload is too large to take on changes) 2)Operational shifts (increased staff recognition of how the organization was changing to accommodate new processes) 3)Clearer understanding of the	High (Case report)

Research, 41(4), 455-468.								organization's clinical supervision model 4)Development of sustainability plans -5)Practice Lead and Peer Coach 6)Evidence-based practice selection based on the benefits and limitations to implementing a particular practice 7)Culture Change (transitioning from implementation to practice as usual) 8)Limited organizational resources (e.g. staff resource) can inhibit the clinical transformation process	
Hurlburt, M., Aarons, G.A., Fettes, D., Willging, C., Gunderson, L., & Chaffin, M.J. (2014). Interagency Collaborative Team Model for Capacity Building to Scale-Up Evidence-Based Practice. *Children and Youth Services Review, 39*, 160-168.	Case report No comparator	Large children's service system California, United States 2008-2009	Social work	27 stakeholders involved in the early implementation process (county representatives, directors, supervisors, trainers, coaches, front line providers)	Exploration, Preparation, Implementation, and Sustainment (EPIS) implementation framework	The Interagency Collaborative Team (ICT) model was used to implement an evidence-based child neglect intervention (SafeCare). Implementation included initial education, stakeholder development and alignment, practice fit assessment, resource support solidification, fidelity focus, skill development, and progress monitoring / feedback. Additional,	Qualitative: personal-, organizational- and system-level factors affecting implementation (semi-structured interviews)	Facilitators for implementation included: -Initial commitment and collaboration among stakeholders -Cross-level leadership -Practice fit to the local context -Ongoing negotiation of rights, roles, responsibilities and interests among stakeholder organizations -Importance of early successes	High (Case report)

						the model focuses on distributed local leadership, systemic and cross-agency trust, and program adaptation.		A challenge was insufficient communication and information exchange.	
Damschroder, L.J., & Lowery, J.C. (2013). Evaluation of a large-scale weight management program using the consolidated framework for implementation research (CFIR). *Implementation Science, 8*, 51.	Case report No comparator	Five Veteran Affairs facilities United States July and October 2007	Public health	Organization	Consolidated Framework for Implementation Research	This report explores the variation in the implementation of the MOVE! weight management program, s a multi-tiered set of tools and treatment options based on published guidelines for obesity management.	Qualitative: -Facilitators for implementation (semi-structured interviews with 24 key stakeholders)	Facilitators for implementation, according to the Consolidated Framework for Implementation Research: 1. Inner setting: -Strong working relationships -Tension for change (seeking and welcoming new programming and improvements) -Priority of the change or program -Goals and feedback (-Learning climate -Leadership engagement to support the program 2. Process: -Planning a formal implementation plan 3. External change agents: -Audit and feedback 4. Intervention characteristics: -Relative advantage over alternatives 5. Outer setting: -Staff who are aware of patient needs	High (Case report)

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