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Implementing Physical Therapy Clinical Practice Guidelines across Allina Health clinical service lines : Successes, Chall+-enges and Pitfalls.

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Disclosure Statement.

- Steven Scherger is a salaried Physical Therapist and Manager and serves in that role for Courage Kenny Sports & Physical Therapy, a part of Allina Health.
- Member of the Allina Health Spine Clinical Service line as Physical Therapy representative.
- Member of the 2018 spine consensus conference planning committee.
- Vice President of the Minnesota Board of Physical Therapy.

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Objectives.

- Participants will be able to understand the historical significance of implementing Clinical Practice Guidelines at Allina Health.
- Participants will have an understanding of current guidelines and applications in patient care.
- Participants will be able to use this understanding to improve patient care through early adaption of changes to Clinical Practice Guidelines in the Future.

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How did we get here. What have clinical guidelines ever done for us?" JOSPT February 2018.

- *J Orthop Sports Phys Ther 2018;48(2):54-57. doi:10.2519/jospt.2018.0602*
- They may not offer simple and guaranteed options for this complex condition, but they do offer us some clear targets for reducing waste and harm, and they promote the delivery of good information to patients, self-management, and a shift toward a less interventionist culture in clinical management..
- Guidelines also highlight the considerable work yet to be done to optimize care.
- The ultimate goal of a CPG is to positively influence health outcomes.
- This requires policy makers and **health systems to invest in their use, and clinicians to ensure that best-practice guidance is used productively, in collaboration with the patient, to inform treatment decision making….**

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Clinical guidelines overview.

- Looking at multiple guidelines:
- National Institute for Health and Care Excellence (NICE), The 2015/2017 "Evidence-Informed Primary Care Management of Low Back Pain" (Canada), CPG from the American College of Physicians and the American Pain Society (United States).
- Synthesis of these guidelines recommend the following
- Ruling out specific spinal pathology.
  - offer high-quality education,
  - encouragement of an early return to activity
- Emphasize the importance of promoting self-management
- Recommend against the routine use of imaging for nonspecific LBP
- Recommend physical exercise for nonspecific LBP
- Advocate a cautious approach to the use of opioids in nonspecific LBP
- LBP management should address psychosocial factors of the patient.

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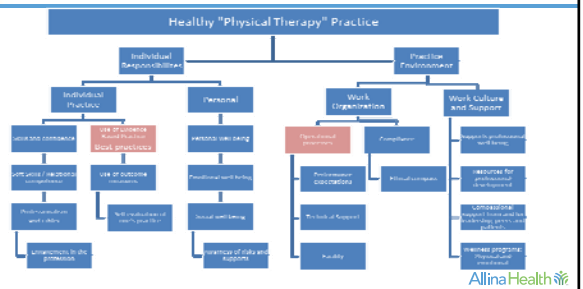
Best Practice as a part of "Healthy Practice".



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Timeline 1990's to 2000's

1990's Allina Health system formation of hospitals and consolidation of outpatient physical therapy clinics to under the name and leadership of Sister Kenny Rehabilitation.

Unification of documentation of forms and processes for diagnosis specific regions.

Early 2000's. Development of standard patient education for diagnosis specific regions.

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Time Line 2000-2010.

Electronic medical record implemented. Duplicates templates of paper forms.

MedX based Spine Centers expanded. Outcome measurements implemented. (ODI/NDI)

Implementation agreement of "Best Practice" for Lumbar and Cervical Spine for evaluation.

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Time Line 2010-2015.

Chart reviews and PDSA project around standard elements of care identifies variance in care across system.

2013 Education and implementation of CPG based on APTA published guidelines. Didactic and Manual therapy competencies.

2013 Sister Kenny and Courage Center Merge forming Courage Kenny Rehabilitation. Implementation of Service lines in rehabilitation and Ortho Spine.

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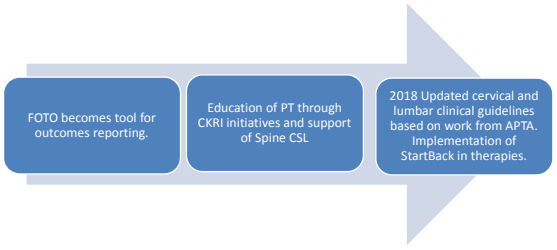
Time Line 2015 to present.



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Learnings of historical implementation.

- Transitions from unformed practices (learned in previous experiences school, previous practice, etc. to unified care based on the CPG.
- This set ground work for further developments in patient care.
  - Leaders, supervisors and peers focus on change management.
- Evidence based care, not trends in care practices, were promoted.
  - Ex. IAOM Mckenzie
- Focus on measured patient outcomes motivated the importance for improving care among practitioners.
- Structured leadership from motivated therapists, managers, Clinical Service Line leaders gave freedom to improve care in measurable ways.

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Learnings....

- Supportive training and implementation is needed before implementation can be effective.
  - Peer team implementation allows more rapids engagement of evidence based care.
  - Time for therapist to learn evidence based care.
  - Variation of education and clinical exposures of CPG leads variation in care performance as well as confidence in delivery.
  - Appeal to clinician knowledge, behaviors and enabling environment.

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Learnings.....

- As implementation improves, care delivery becomes more efficient, less cost per episode.
  - Mitigated through current trends in insurance limitation in number of visits, flat fee for visits.
- Imbedding best practices into technology/documentation or focus on knowledge of therapist.

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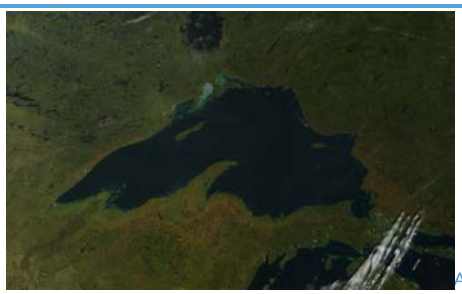
Brief overview



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Definitional changes with acuity.

- Acute, subacute, and chronic **stages** have been defined as time-based stages in classifying patient conditions.
- **Acute phase**, the condition is usually highly irritable (pain experienced at rest or with initial to mid-range spinal movements: before tissue resistance);
- **Subacute phase**, the condition often exhibits moderate irritability (pain experienced with mid-range motions that worsen with end-range spinal movements: with tissue resistance);
- **Chronic phase conditions** often have a low degree of irritability (pain that worsens with sustained end-range spinal movements or positions: overpressure into tissue resistance).

➢ **There are cases where the alignment of irritability and the duration of symptoms does not match accordingly, requiring clinicians to make judgments when applying time-based research results on a patient-by-patient basis.**

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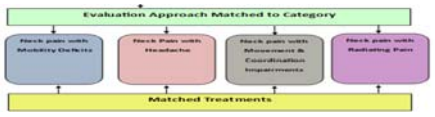
Classification of neck pain.

- Mobility Deficits
- Headache
- Whiplash (WAD)
- Neck pain with Radiating Pain.



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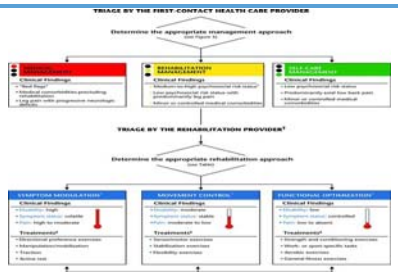
Lumbar Algorithm



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Triage Process: Multivariable

Pain Rating

Evaluation

Table 1.
Triage Process and Matching Criteria for the Rehabilitation Provider*

Rehabilitation Approach		Symptom Modulation	Movement Control	Functional Optimization
Triaging Variables†	Pain rating	High to moderate	Moderate to low	Low to absent
	Disability rating‡	High	Medium	Low
	Clinical status§	Volatile: symptoms predominate	Stable: movement impairments predominate	Well-controlled: performance deficits predominate
Treatment Modifying Variables	Psychosocial status‖	+/-	+/-	+/-
	Comorbidities¶	+/-	+/-	+/-

FOTO

Medical co-management needed.

STarT Back,

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Lumbar Categories.

- **Symptom modulation**: (Volatile: Symptoms predominate.)
  - Patients whose spinal movements are hindered by significant pain and symptomatic features. The goal of treatment is to control the noxious pain generator(s) that interfere with spinal movement.
- **Movement control**: (Stable: Movement impairments predominate)
  - Patients whose spinal movement is hindered by dysfunctional joint mobility, soft tissue compliance or neuromuscular control. The goal of treatment is to improve joint and soft tissue mobility and integrate new gains in movement with appropriate neuro muscular control.
- **Functional Optimization**: Symptoms well controlled: Performance deficits predominate)
  - Patients whose spinal movement is hindered by muscular deconditioning and fatigue. The goal of this treatment is to improve lumbar spine muscular capacity to withstand physical performance, functional or work demands.

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Psychological Informed Physical Therapy practice

- The biopsychosocial approach is currently the model that Physical therapists are expected to manage patients with musculoskeletal conditions.
- Physical therapists are now expected to recognize pain associated psychosocial distress (i.e. yellow flags) and to modify their treatment approach accordingly.
- However, a gap exists between learning how to identify pain associated psychosocial distress in patients as well as being competent to apply treatment required to effectively manage these patients.

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What is the STarT Back Screening Tool?

- The STarT Back Screening Tool (SBST) developed by Keele university in the UK, is a simple prognostic questionnaire that helps clinicians identify modifiable risk factors: (biomedical, psychological and social) for back pain disability.
- The tools score stratifies or categorizes the patients into low, medium or high risk categories.
- For each category there is a recommended treatment approach.

- This approach has been shown to reduce back pain related disability and be cost-effective.

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Psychological Informed Physical Therapy practice

- Physical therapists will need to embrace this psychosocial component by:
  - 1) training and understanding the principles of psychologically informed physical therapy or cognitive behavioral therapy (CBT)/ Pain neuroscience education (PNE)
    - These approaches have been shown to be an effective treatment for many chronic musculoskeletal conditions.
  - 2) psychological informed treatment approaches to decrease the likelihood patients will experience continued disability due to musculoskeletal pain.

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Psychological Informed Physical Therapy practice

- **Standard Physical Therapy practice**: Address physical impairments based on biomedical model. Primary goal of reducing symptoms.
- **Psychological Informed Physical Therapy practice**: incorporate patient's beliefs, attitudes, and emotional responses into patient management techniques of the biopsychosocial model. Primary goal of reducing disability.
- **Mental health practice: (psychologists)** Identify and treat mental illness. Primary goal to minimize the impact of the psychological disorder on function and well being.

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Three categories: Matched Evaluation.

Core Evaluation: Neurological testing, Lumbar ROM and Functional mobility assessment, Red Flag screening, Psychological status,

Tests related to tissue irritability	Tests related to local mobility and global stability	Tests related to optimized function
Directional preference, Neural mobility, local mobility, joint and soft tissue mobility. Examples: SLR, ASLR, repeated movements, slump testing, segmental stability.		Global stability, motor control, strength and endurance training, aerobic conditioning. Examples: Prone stability test, Abdominal testing, MedX testing.

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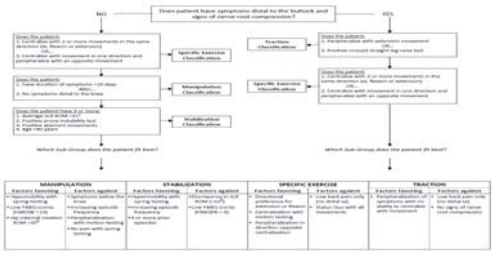
Symptom Modulation Algorithm



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What have clinical guidelines ever done for us?"

- What is the point of the guideline nobody follows?
- Multiple barriers at play:
  - Clinicians' knowledge and understanding of the guideline,
  - Issues related to the ease of "implementing the recommendations within local clinical structures" i.e. EMR/Excellian.
  - Individuals "willingness to accept its recommendations"(often in the face of deeply held beliefs, clinical experience, and vested interests)

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Change mindset: Who are you?

"It is supposed to be hard. If it wasn't hard, everyone would do it. It is the Hard that makes it great!"---*a league of their own.*

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Change of Clinical Guidelines: Drama or Empowerment.

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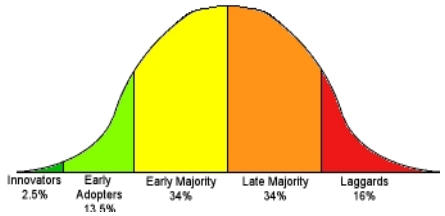
Change implementation curve



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Evidence based care or patient focused care.

EBC: Skills and knowledge. Improving Continuing Competency is the work we do.

Focus on the patient; is the how we do our work. Improving relational competence "engagement"

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Focus on the future: Where will we be in 5-10 years.

- Future recommendations to CPG ? Changes in language?------yes
- Changes to practice/scope and technologies.
- New treatment techniques.
- Reduction of barriers?
- Maximizing PT practice through PT Primary Spine Practitioners.
- Pitting treatment and clinical decisions against each another.
- Limitations in reimbursement.
  - Limitations in CPT codes.
  - Length of care
- Access to care.
- Value of PT still not known.
  - Medical community
  - Peers
  - Public.

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Next steps and Recommendations.

- Shift change implementation mindset to become an early adaptor.
- Clinical guidelines are adjuncts to continued competency.
  - Increase safe patient care through improved quality, effectiveness, and efficiency
    - Better Value.
  - Use Outcome: measurements not anecdotal evidence or case studies.
- Use The Guidelines!!!!
  - Learn, read understand more. Get involved in clinical or professional associations.
- Discuss use guidelines with peers.
- Mentor and Assist peers with use of Guidelines.
  - Don't pit one treatment or clinician against another.
    - This is better, that is not. Different =/= better.
    - Adjuncts to standard care is a luxury!

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Questions.

Two African proverbs.

- If you think you are too small to make a difference you haven't spent the night with a mosquito.
- If you want to go fast, go alone. If you want to go far go together.
- I look forward to working with you!!!!

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