Follow the Evidence

By Chris Hayhurst

For these outpatient physical therapists, evidence-based practice is the only kind of practice. Here's why, and how they make it work.
But Studer, who has been in practice for 22 years and running his own clinic for 10, won’t stop there. As you gather your objective findings, he’ll tell you, it’s important to share them with your patient or client—not when the patient is leaving and not later in a mailed report, but right then and there.

“We use the evidence, the results of our objective, standardized, validated measurements, to reflect back immediately to the patient,” he explains. “So as soon as we do a progress test, we show them the scores. We’re consuming the information and digesting it right there with them, taking the facts as they are. If we see that their balance has improved, then we know that we’re offering a good level of care for their balance. If we see that their strength has not improved, then we know that we need to adjust our interventions for strength.”

Practicing this way, Studer says, allows patients to “see that it’s important to us that we measure where they are right now, so we prove to them, and to ourselves, that we’ve actually helped them get significantly better.” In addition, he says, “it holds us accountable. It ensures that the care that we’re providing is effecting a change.”

**Seeking Higher Levels Of Evidence**

You’d be hard-pressed to find a physical therapist who wouldn’t want to know that the care he or she provides is effective. And yet many PTs practice every day without such knowledge, or at least with scant proof that it’s their work that’s helping their patients and clients. As 1 PT who owns a successful outpatient clinic in which she’s the sole practitioner put it (she didn’t wish to be named), “I never think about evidence. I just go by feel and by what works for me. If my patients like it and they get better, that’s all I need.”

For PTs such as Studer, that attitude can make steam come out of their ears. “It’s just unprofessional,” Studer says, “to tell a patient or that patient’s spouse, for example, ‘Wow, he looks like he’s walking better today than he was a month ago. Don’t you think so, too?’” Still, notes Studer, when it comes to the “evidence” in evidence-based practice, there’s a hierarchy, and evidence attained through one’s personal clinical experience—“what works for me”—does have a place in that hierarchy.

“We all practice by the evidence at some level,” says Robert Manske, PT, DPT, MEd, SCS, ATC, CSCS, professor and chair of the Wichita State University Department of Physical Therapy in Kansas. “If you read the literature, if you study, if you continue to engage yourself and improve your practice, you have to be practicing at least some degree of evidence-based physical therapy.”

What Manske would like to see, he continues—and what the profession as a whole “is pushing for”—is greater use of those higher levels of evidence—“the evidence you find in the literature.” Things change, he points out, “and sometimes what we [think we] know is entirely different 5 or 10 years later.”

For example, Manske says, he and many others in the world of sports physical therapy for years looked at glenohumeral internal rotation deficit as a “huge problem.” So much so, in fact, that “it became this monster in itself, in that if anyone lost internal shoulder rotation, the PT would stretch the heck out of it.”

Well, says Manske, in October 2013 he and others published an article in *The International Journal of Sports Physical Therapy* that describes current evidence “that it’s only a problem for certain people, and there are certain parameters we need to look at” before reaching any conclusions. “If you’re not following the literature, Manske notes, “you’ll continue to practice behind the times.” And in this case? “You’ll probably continue making your patient’s shoulder a little too loose.”

**The Vision for Evidence**

APTA’s Vision 2020 defines evidence-based practice (EBP) as that which assimilates “evidence to guide clinical decision making to provide best practice for the patient.” EBP includes “the integration of best available research, clinical expertise, and
The role a patient’s personal values can play in evidence-based practice may be easy to overlook. After all, in many cases those values may seem in sync with the PT’s. Still, notes Laura Knapp, PT, DPT, MS, OCS, in her work at the University of Utah Orthopaedic Center in Salt Lake City she’s seen plenty of patients with strong feelings about their conditions or treatments, and with each, she says, she’s balanced their input with the available evidence and found workable middle ground.

“I had a patient the other day with a bursitis. I told her how I thought we should do an iontophoresis.” The patient, Knapp continues, thought otherwise. “She said she wasn’t comfortable with it, and that instead she wanted to try regular electrical stimulation.” Knapp, who says everything about her practice, her teaching, and her mentoring is based on what the literature supports, informed the patient that in this case the evidence didn’t support the use of electrical stimulation alone. But, she added, e-stim could reduce her pain. If the patient wanted to try it, they would. “I knew it couldn’t hurt her, and I realized that she valued it, so after I explained what I was thinking and she said she still wanted to do it, we did.”

Patient values are a recognized part of evidence-based practice. Knapp explains, “If a patient really values something—and it’s within the realm of good practice—it could work. You know, there are people on both ends of the bell curve. Even if the research doesn’t support it in every case, it doesn’t mean it never works.”

Jan Reynolds, APTA’s director of evidence-based resources, notes that physical therapists are expected to use their own judgment. “There is a misunderstanding among many PTs that evidence-based means using only the published literature,” she says. “But from the very beginnings, the pioneers of evidence-based practice emphasized that clinicians integrate the best available evidence with their own clinical expertise and their patients’ values.”

patient values and circumstances.” Its purpose, the statement concludes, is to enhance “patient management” and “reduce unwarranted variation in the provision of physical therapy services.” Most physical therapists have no trouble with the latter 2 components of the definition—finding clinical expertise and respect for patient values to be naturally evolving aspects of their day-to-day work. But integrating the best available research?

APTA’s new vision statement, adopted in 2013, is for PTs to be “transforming society by optimizing movement to improve the human experience.” One of the vision’s guiding principles, quality, states in part: “As independent practitioners, doctors of physical therapy in clinical practice will embrace best practice standards in examination, diagnosis/classification, intervention, and outcome measurement.”

Clinicians in all professions struggle with this, says Dianne Jewell, PT, DPT, PhD, CCS, author of Guide to Evidence Based Physical Therapist Practice, 2nd edition, “in part because the process can be cumbersome.” So much about gathering evidence depends on the clinician’s ability to access information quickly and efficiently, says Jewell. Depending on the technology available to them in their clinical setting, and the time they have allotted in their day, that may be out of their control.

In addition, notes Jewell, some PTs lack confidence in their ability to evaluate the literature and so tend to avoid it. Services that preappraise evidence, such as high-quality clinical practice guidelines, can help reduce barriers to the integration of evidence in clinical decision making. Some PTs, however, find it tempting to “discount that evidence out of hand if it doesn’t agree with what they typically do,” she says.

Tara Jo Manal, PT, DPT, OCS, SCS, director of clinical services and residency training and associate professor in the University of Delaware’s Physical Therapy Department, finds this last challenge especially troubling. “Many PTs perceive that they have to give something up to follow evidence-based practice. They believe it’s taking away their autonomy.”
Nothing could be further from the truth, Manal says. “It’s exactly the opposite. If I could say to you, ‘If you do this, your patient will get better faster and have a better outcome,’ that’s not taking away your autonomy. That’s making your practice easier and more effective. It’s giving you a gift.”

PTs, Manal says, shouldn’t fear the changes that evidence ultimately may compel them to make. “When a patient doesn’t respond to what the literature predicts,” she notes, “you’re free to try something else.” In fact, she welcomes those changes. “If we’re going to reduce variability in practice, we have to be ready to abandon the things that aren’t as effective and adopt the things that are.”

So how do outpatient clinicians gather, digest, and integrate evidence into practice? How do they find the time? And how do they ensure that the evidence they gather is good evidence—the kind that either justifies a change in practice or reaffirms what is already being done?

**Leveraging Electronic Records**

Studer, for one, says he and his team are “constantly collaborating, talking among ourselves, and questioning each other.” They take the approach that the best way to stay current on the evidence is by “putting ourselves out there as much as possible.” In his case, that means each year he teaches up to 25 webinars, delivers half a dozen or more in-person lectures, and presents at APTA’s Combined Sections Meeting.

When you’re the one doing the teaching, he notes, “you’d better be ready with the latest information.” In his practice, Studer continues, he relies on his clinic’s electronic medical record (EMR) system to simplify the use and interpretation of objective tests. “I highly recommend first finding and learning 1 or 2 objective tests that you don’t already know that would be appropriate to use, given your patient population, at least several times a day. And then incorporate those tests into your EMRs.”

Once you do, Studer notes, it takes just moments to input the data for any 1 patient or client. Then the program will automatically populate with normative scores to indicate where on the spectrum the individual falls. “It makes it really easy, economical, and efficient,” he says. “And so you’re much more likely to use that test.”

Sheila Reid, PT, MS, agrees. Reid is a physical therapist with Fletcher Allen Health Care in Burlington, Vermont, where she also serves as a clinical research educator in the outpatient rehabilitation department. She says she and her colleagues “have learned to use our electronic health record system to help us support the evidence we use.”

And they’ve learned to do it efficiently, she adds. “If a PT reads an article that shows, for instance, manual therapy added to the treatment of osteoarthritis of the knee is more effective than standard exercises alone, instead of writing that out every time” she follows that protocol, she can instead create a “smart phrase” so that all she has to do is “plug in a word, and the entire phrase will come up and populate the note.”

And just like that, Reid says, “the evidence that we’re using is included right there in our documentation.” Anyone who reads it—therapists, referring physicians, insurers—“can see our justification for doing what we did.”

For Jennifer Gamboa, PT, DPT, OCS, MTC, president and director of clinical services at Body Dynamics Inc, an outpatient physical therapy and wellness center in Falls Church, Virginia, accessing evidence is “part of the culture—we’re constantly reviewing the literature.”

And while it’s been that way since she opened her clinic 17 years ago, says Gamboa, only relatively recently did her multidisciplinary team find a way to turn individual research into practice-wide gains. “We’ve definitely evolved. We’ve moved from scattershot to something far more structured and standardized.”

That structure, explains Gamboa, comes in the form of monthly journal club meetings. Six of those meetings are “clinician’s choice, where every clinician in the practice brings literature to the table and discusses it.” The other 6 meetings use a template-style problem-solving strategy. Clinician’s-choice meetings are held roundtable-style, says Gamboa, “where we get a broad scan of the literature on a variety of topics.”

Each reporting clinician uses Physical Therapy’s “Bottom Line” format to

Only relatively recently did Gamboa’s multidisciplinary team find a way to turn individual research into practice-wide gains. “We’ve definitely evolved. We’ve moved from scattershot to something far more structured and standardized.”
quickly and concisely summarize the literature. “So it’s a standardized format. Everybody has about 5 minutes to present. Then we ask questions and move around the group.”

The meetings use a specific review technique. For that, Gamboa says, “we identify a specific problem as a group—say, low back pain. Then 1 person pulls the literature for the best interventions. We grade the level of evidence behind each intervention, and then we determine when we would refer out and when we would expect people to refer to us.”

The goal, says Gamboa, is to get a “big cross-section of the literature to find the predominant trend. Then each participant is assigned 1 or more articles, depending on the total. Each person annotates a bibliography for those articles.” In the end, she says, each review wraps up in a 1-page written summary that can serve not only as a reference piece, but also for use for patient education or even marketing, “We use it for clients, we use it for physicians, and we use it ourselves as well. If I’m wondering what I’m supposed to be doing for a particular condition such as TMJ, it’s all right there,” she says.

Finally, says Gamboa, her clinic uses the software program FOTO (for Focus on Therapeutic Outcomes) to track and measure outcomes and efficiency. “It lets us keep track of things such as how quickly our patients are getting better compared to others nationwide with the same condition and comorbidities. It helps us make sure we are where we’re supposed to be.”

“Show Me the Numbers!”

To gain that kind of confidence is exactly the reason Mike Studer, in his practice in Oregon, works with his patients and clients the way that he does. He describes a patient he’s seeing now—a patient with Parkinson disease (PD). When the patient first was diagnosed, his spirit was crushed, Studer recalls. He saw himself “destined for a regression in quality of life,” Studer thought otherwise, and with his patient’s cooperation began his first day in therapy with a series of objective tests. “We did a 2-minute walk test, a Berg balance test, an isokinetic strength test, and a 60-second sit-to-stand test. Then we finished with a CTSIB”—the Clinical Test of Sensory Integration and Balance.

The idea, Studer says, was to show the patient where he was now, not only so that Studer could determine the best course of action, but also to establish a baseline to which they both could refer. And 1 month later, they did. “After seeing him 1 or 2 times a week for a month,” says Studer, “we came together again for a reevaluation and did all those tests again. He had improved on each of them.” But Studer didn’t just tell his patient he had improved; he showed him the numbers. “And so this gentleman—and I’ve been seeing him for almost 3 months now—can see that he’s improving already, and he can continue to improve from here.”

For a patient with PD, for which the evidence shows that quality of interventions can vastly improve quality of life, that attitude change alone can make a huge difference, notes Studer, “It makes him further reinvested in 2 of the most important aspects of his treatment: his intensity in therapy, where he knows he needs to give me his best effort, and following through with his home exercise program. And it’s just because he saw the measurement improvements.” That, says Studer, is evidence at its best.

Chris Hayhurst is a freelance writer.

REFERENCES