Putting into place evidence-based practice and clinical practice guidelines across a large hospital system can pose substantial challenges. Here’s how one system is approaching the task.

By Sara Schuette, PT
Rehab services in large hospital systems are not immune to the forces shaping health care. Our profession as well as our practices, hospital-based and otherwise, must be ready to respond to the growing demand for increased quality of care at lower costs in an environment of declining reimbursements and growing health care expenses.

ProMedica Total Rehab began its journey toward meeting these conflicting challenges through a series of leadership changes and a restructuring. The position of director of service line development was developed to reflect this structure. The director’s key function is to develop and implement evidence-based practice across our system.

With 9 hospitals, more than 400 employees, more than 30 outpatient clinics, and 350,000+ patient encounters, we knew we needed a focused effort on ensuring that every patient would have a consistent evidence-based clinical experience. This was fundamental to reducing clinical variation and, therefore, unnecessary health care expenses.

**Taking the First Steps**

Our journey began in January 2013. We started by gathering a 6-member subset of our leadership team to develop a focused best-practice team charter. This charter would be the guiding document for implementing best practice through an already established clinical practice guideline (CPG) and creating a structure for developing our own guidelines where none existed. This document helped us focus on the process improvement objectives and key milestones to use to measure our success. The best practices team charter also forced us to consider any assumptions, constraints, obstacles, and risks that could limit our progress.

While 2013 was the year for senior rehab leadership to establish a firm direction before taking the plan to our clinicians, we also wanted to make sure that the clinicians began to grasp the importance of evidence-based practice (EBP).

We started with an internal continuing education presentation, followed by a poster presentation competition among all clinical staff to show how they applied evidence-based practice to real cases. After a winner was selected, the posters traveled to all hospital sites for all employees to view. These 2 activities—the educational presentation and the poster competition—were the only EBP components visible to staff during our planning year.

Once we completed the charter, we needed to know where we stood with our biggest potential obstacle: our clinicians. We began by gauging where our clinicians stood on their beliefs, attitudes, and concerns regarding the use of evidence in their daily practice.

We sent an electronic survey to all clinical staff to help determine our roadblocks.

**Q:** What is your greatest barrier to the use of EBP in your clinical practice?

<table>
<thead>
<tr>
<th>Responses</th>
<th>Percent</th>
<th>Count</th>
</tr>
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<tbody>
<tr>
<td>Insufficient time</td>
<td>76.7%</td>
<td>79</td>
</tr>
<tr>
<td>Lack of information resources</td>
<td>26.2%</td>
<td>27</td>
</tr>
<tr>
<td>Lack of research skills</td>
<td>15.5%</td>
<td>16</td>
</tr>
<tr>
<td>Poor ability to critically appraise the literature</td>
<td>7.8%</td>
<td>8</td>
</tr>
<tr>
<td>Lack of generalizability of the literature findings to my patient population</td>
<td>18.4%</td>
<td>19</td>
</tr>
<tr>
<td>Inability to apply research findings to individual patients with unique characteristics</td>
<td>17.5%</td>
<td>18</td>
</tr>
<tr>
<td>Lack of understanding of statistical analysis</td>
<td>17.5%</td>
<td>18</td>
</tr>
<tr>
<td>Lack of collective support among my colleagues in my facility</td>
<td>23.3%</td>
<td>24</td>
</tr>
<tr>
<td>Lack of interest</td>
<td>3.9%</td>
<td>4</td>
</tr>
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answered question 103
skipped question 12
Out of 350 therapists in the system, 115 responded to the survey. That gave us some solid and statistically significant information. The overall findings did not surprise us. Clinicians did not want EBP to tell them what to do or force them to create a “cookie cutter” approach to therapy. They also felt that, with the current demands of paperwork, productivity, and regulations, there simply was not time for EBP.

Implementing the First CPGs

With a charter in place to direct our efforts, an understanding of our current clinician landscape, and a 2014 goal of implementing 4 CPGs, it was time to get to work.

We created our EBP Implementation Team. It consisted of therapists from all 3 disciplines—physical therapy, occupational therapy, and speech-language pathology—selected based on their aptitude and willingness to use EBP. We engaged direct-care clinicians because we felt that they were the best source for directing the implementation of EBP with the least impact on clinical operations and patient care. Our leadership was encouraged to observe but was not permitted to actively participate on this team. Nevertheless, leadership members played a key role in supporting and encouraging EBP in all settings. They facilitated the attendance of their respective clinical staff in the team meetings. They consciously sacrificed the patient revenue of today for the value and quality of services in the future.

The team’s role was to develop a process to introduce EBP throughout the system. At first, the group was timid due in part to its members’ unfamiliarity with their colleagues from across the system. They also had a healthy skepticism of what EBP really meant. But after the first meeting, the group became engaged and excited—maybe even a bit overzealous at times. For example, they wanted to include far too rudimentary concepts—for instance, basic anatomy—in the presentation content.

Because we wanted our first run out of the gates with CPGs to be successful among all staff, we frequently reminded team members that they were going to be speaking to competent, practicing clinicians. A separate group was created for each CPG.

The team established 2 guiding criteria that they felt were critical: (1) Each CPG group must assume that as professionally licensed clinicians, the staff possessed a general level of clinical competence; and (2) The method of delivery must be multi-modal.

The EBP Implementation Team created a plan to use when introducing either formal CPGs or EBP that we established. The team’s secondary role has been to monitor the progress of the separate CPG groups, ensuring that the process continues smoothly.

In summary, the plan consisted of 6 elements:

1. Identify what we are doing currently.
2. Assume a level of competency among staff.

Clockwise from top: Sara Schuette, PT, David Vernier, PT, Andrew Parsons, PT, Wendi Sargent, OT, Amy Thorpe-Wiley, SLP, Michael Studnicka, PT.
helped develop a template within our electronic medical records (EMR) system that would help to integrate use of this clinical practice into the daily clinical management of patients.

The team was asked to have face-to-face conversations with key physicians prior to implementation. They did, and no concerns were voiced. The actual roll-out of the education and mechanics of integrating Wells into clinical practice went smoothly. We did, however, face some unexpected resistance. Despite Wells becoming a standard of care, several therapists expressed concern that its use could expose them to additional liability. We addressed this concern through our implementation education.

Testing the Plan

With a plan in place, it then was necessary to test its execution. The team selected the Wells clinical decision rule to test the process. That rule deals with evidence-based approaches to the clinical examination of outpatients who are at risk for deep vein thrombosis. The team made this selection because Wells:

- Is short and to the point,
- Is becoming the new standard of care for DVT screening, thus reducing therapist liability,
- Applies across all disciplines including clinicians from home care and acute care,
- Is much more reliable than current techniques, and
- Has the potential to save the physician time with more accurate classification of a patient’s DVT risk.

In general, when we implement a best practice, it usually will be a CPG. However, we don’t want to limit best practices to guidelines, and decided to test the process with a decision rule.

We created a formal education document that we distributed to all PTs, occupational therapists (OTs), speech-language pathologists (SLPs), and staff throughout the system including acute care, outpatient, and home health via our online education tool, Health Stream. The team took this implementation a step further and

3. Determine how to reach 350 clinicians.
4. Develop a multi-faceted education and competency program.
5. Create a technical review.
6. Ensure that the information is accessible to new and current staff once implemented.

We also encountered some physician resistance. Despite the evidence, they wanted to continue to either order a Doppler study or require a formal office/emergency department visit regardless of the probability of DVT as determined by using the rule. We discovered, despite having met with physicians prior to implementation, that many were not as ready for evidence-based implementation as we had expected.

NOTICE OF CLASS ACTION AND PROPOSED SETTLEMENT IN ZIDEK v. ANALGESIC HEALTHCARE INC., (N.D. III. 13-C-7742)

TO: All persons and entities with facsimile numbers that during the Class Period (October 29, 2009, through and including December 15, 2014), were sent one or more facsimile communications by, from or at the direction of Analgesic Healthcare Inc. (“AHCI”) and/or John Does 1-10: (i) that did not contain Personal Health Information of any person, and (ii) regardless of whether they contained an opt-out notice as described in 47 U.S.C. § 227 and/or regulations promulgated to implement the TCPA (the “Settlement Class”).

Personal Health Information means information that (i) is created, maintained or received by any health care provider, health care plan, employer, medical device manufacturer or supplier, or health clearinghouse, and (ii) relates to the past, present, or future physical or mental health or condition of any individual, the provision of health care (including without limitation any medical device), or the past, present or future payment for the provision of healthcare (including without limitation any medical device) to any individual.

This notice relates to the settlement of a class action lawsuit that stems from allegations by the named Plaintiffs that Analgesic Healthcare Inc. (“AHCI”) and John Does 1-10 sent unsolicited advertisements by fax in violation of the Telephone Consumer Protection Act, Illinois Consumer Fraud Act and Illinois common law (conversion, private nuisance, and trespass to chattels). Such claims have been expressly denied by Defendants; however, a settlement has been reached between the Parties to this Litigation.

If you were sent one or more facsimile communications by, from or at the direction of AHCI and/or John Does 1-10 that did not contain Personal Health Information of any person, and regardless of whether they contained an opt-out notice as described in 47 U.S.C. § 227, your rights may be affected by the proposed settlement of this class action lawsuit. You may be entitled to money. Settlement shares will be based on the number of faxes AHCI’s records indicate were sent to each Settlement Class Member. If AHCI’s records do not indicate how many faxes were sent to a Settlement Class Member, then the Settlement Class Member will be entitled to a single Settlement Share per unique fax number. Settlement Class Members may submit proof or other information to show the number of faxes they were sent if AHCI’s records do not indicate the number of faxes they were sent. This notice is intended only as a summary of the lawsuit and proposed settlement. It is not a complete statement of the lawsuit or the proposed settlement. The Settlement Agreement is available on www.class-settlement.com/analgesic, from Settlement Class Counsel at www.edeliman.com, or at the Clerk’s Office, U.S. District Court for the Northern District of Illinois, 219 S. Dearborn St., Chicago, IL 60604. To submit a claim, go to www.class-settlement.com/analgesic and complete a claim form by June 15, 2015. The deadline to opt out of or object to the settlement is June 15, 2015. The hearing to approve the settlement will be held on July 28, 2015 at 5:00 p.m. before Judge Linerrose, Courthouse 1911 of the U.S. District Court for the Northern District of Illinois. If you have questions about this notice or the proposed settlement, you may contact Settlement Class Counsel at EDELMAN, COMBS, LATTurner & GOODWIN, LLC, 20 S. Clark St., Suite 1500, Chicago, IL 60606 (312) 739-4260.
Implementing the First CPG

We had scheduled 4 CPGs to be implemented. The first sizable CPG that was formally undertaken at the system level was Hip Pain and Mobility Deficits—Hip Osteoarthritis, developed by APTA’s Orthopaedic Section.

Why the hip?

We are not unlike many other outpatient therapy clinics. Thirty-five percent of our patient population is experiencing low back pain. However, we needed a CPG that could be applied easily throughout the system with our currently available resources. We needed a “win” with the staff, one that would convince them that EBP is very manageable to apply within their daily practice.

We gathered a team of 4 physical therapists and a clinician from our EBP team to lead the integration of this CPG into clinical practice. The team decided to use live presentations with each of the 4, structuring the education around specific sections, such as evaluation and interventions, of the CPG.

The group presented at 9 locations across the system over a 3-month period. It shared the CPG information using both a didactic PowerPoint and a lab portion to demonstrate the respective manual therapy techniques associated with the CPG. The subjective feedback from the staff regarding the content, format, and roll-out of the first formal CPG has been overwhelmingly positive.

Assessing the Results

Now that we have rolled out several CPGs, we need to determine if the clinicians have integrated these CPGs into practice. Our staff responded well to a group of their peers presenting the information. Though having the presenters travel to each site was costly, we are reaping the rewards of that personal networking across the system. Further, we have seen the lines of communication open up significantly among clinicians who did not necessarily know each other.

Monitoring actual practice for the successful integration of evidence-based care is 1 of our greatest challenges—not only at ProMedica but as a profession. Though we have an EMR, it is not yet able to help us aggregate the data we need to determine compliance with the CPGs or determine the impact of their integration from an outcomes perspective.

For now, the hip pain and OA team members complete manual chart reviews of the patients who have hip pain or osteoarthritis diagnoses to assess whether therapists integrated the guidelines into practice. In cases where they did not, was there documentation supporting this lack of integration? In addition, our leadership team is working directly with our EMR vendor to request reports that help us aggregate therapist- and clinic-specific...
outcomes reports based on the respective recommended evidence-based outcomes tool associated with the CPG.

**Shifting the Focus to Cost of Care**

Though we are pleased with the success of the process and the openness of our staff to the integration of the CPGs into clinical practice, we would like to shift our focus. We began by prioritizing CPG implementation based on perceived ease. In our next phase, data regarding costs of care (including the cost of clinical variation on specific patient populations) will drive our CPG priorities.

Data transparency speaks to the scientific minds of clinicians and provides an indisputable method for demonstrating the financial impact of treatment variability. More important, the data will be instrumental in telling our story and providing a baseline from which we can measure the effect of clinical integration of CPGs.

The use of EBP also is key from a quality perspective. Implementing evidence-based outcomes tools directed by the respective CPG can tell the quality story by initiating use of the outcome tool before any effort to affect clinical practice. It is the most objective way to demonstrate the effect on the quality of care after formal implementation of the CPG. Additionally, the outcomes data ensure that anyone who walks through our doors will receive the same high-quality, evidence-based care at each of our sites.

Implementation of clinical practice guidelines within a large hospital-based system is daunting. Failure to plan for clinical integration of these guidelines can result in weak adoption by clinicians. Lack of planning also minimizes the impact on the future of health care. We owe it to our patients and clients and our profession to provide the best value. That can only come through adoption of evidence-based care. It makes good business sense, and it is quite simply the right thing to do.

Sara Schuette is director of rehab, ProMedica Total Rehab, service line development.

**REFERENCES**
