OBJECTIVES

- Understand why APTA is supporting efforts to create Clinical Practice Guidelines (CPG)
- Learn who is generating the guidelines and how are they developed
- Gain insight into CPG as different from protocols for patient care
- Understand how the guidelines are implemented and their intended impact on practice
- Learn how to access guidelines and the CPG+ appraisals of the guidelines.

WHY CREATE CLINICAL PRACTICE GUIDELINES (CPG)

History of the evolution of CPG

The evolution of practice guidelines...

Early 1980s:
- Shifted away from “cookbook”/prescriptive approach
- Evolved into a “do anything” approach.
- Treatment based on anecdotal experience of each practitioner.
- Lots of $$ available for treatment

Late 1980s - early 1990s:
- Began to create a critical mass of research to support our interventions. (Reliability, validity; basic science)
- Difficult for some PTs to make the shift from “belief” to evidence. Little change in practice despite emerging evidence.
- HMOs, $$ for rx became tighter
Late 1990s – mid 2000’s:
- Increased sophistication of intervention/outcome research & began randomized, multicenter clinical trials.
- Increased grant awards; PTs at NIH
- Introduction of “evidence based practice” into clinical practice – Hooked on Evidence created

Mid 2000’s - present:
- Continued high quality research in PT
- Began implementation of treatment based on findings of randomized, multicenter clinical trials.
- PTs shifting to EB treatment as standard of care
- 3rd party $$ for treatment increasingly dependent on EB Guidelines -- all disciplines

The California experience with legislated practice guidelines
2004 Division of Workers Compensation:
- Treatment intervention legislated to follow EB Guidelines (ACOEM)
- PT not well represented in ACOEM Guidelines.
- In 2004, there were no published evidence based treatment guidelines for PT other than APTA’s Guide to PT Practice.

2005 –
- CPTA created a “Guidelines Task Force”
- Task force discussions led to a presentation of the California experience with regulated treatment guidelines to the APTA Orthopedic Section.

APTA ORTHO SECTION
2006 – began the process of developing EB practice guidelines --
“Clinical Practice Guidelines”

“IT is believed that the publication of these clinical guidelines will help advance orthopaedic PT practice and could be used to guide professional and postprofessional education, and to establish an agenda for future clinical research.”

As part of APTA’s strategic objective to reduce unwarranted variation in care, APTA supports the development of clinical practice evidence-based documents.

- 2008 – APTA work group proposed a process for developing CPGs;
- 2008 – APTA recognized the importance of dedicating financial support to the sections for the purpose of creating CPG

2012 --- CPG development is part of APTA’s evidence-based documents initiative. The initiative aims to provide structure, process, and resources for the development of evidence-based documents that facilitate the translation of research findings into physical therapist practice.

2015 –
- APTA is offering financial and training support to sections
- 9 sections have CPG in development
- Orthopedic section has published 10 guidelines + 1 updated after 5 years

2015 APTA Calls for proposals for CPG development
- 2 cycles for submissions.
- March 16, 2015 Deadline
- September 15, 2015
- Expected completion is in 4 years. Finalized documents will be published and available for open access.

Why are Clinical Practice Guidelines important for the profession of PT?

With a finite resource of healthcare $$, public policy is demanding guidelines as to how to best spend those $$ …

Goal: efficient, effective treatment ("biggest bang for the buck")

Shall we as a profession be Proactive? Or Reactive?
If we as a profession publish Clinical Practice Guidelines based on evidence…

it is then much more likely that policy makers will adopt these guidelines for PT than develop their own.

Non-PT providers may create PT guidelines if we don’t do it first.

Who benefits?
- Patients / Consumers / Public
- Policy makers
- 3rd Party Payers
- Physical Therapists

Patient / consumer / public:
- Should expect “best” practice from any PT at any location
- Published guidelines educate the consumer as to what treatment to expect.
- Establishes a standard of care that the public should expect when receiving PT.
- Direct the public to the “best” provider of PT – i.e. physical therapists.

(remember non-PTs sometimes provide physical medicine treatment)

Policy Makers:
- Benefit from established standards of care that follow Clinical Practice Guidelines.
- Direct how health care $$ are spent.
- Want to avoid paying for treatment that is unnecessary, costly, not effective.
- Should be able to expect similar PT treatments from state to state, rural or city, small or large facility.

3rd Party Payers (UR):
- Should be able to avoid paying for treatment that is unnecessary, costly, not effective.
- Should be able to expect similar PT treatments from state to state, rural or city, small or large facility.
- Guidelines are important for providing quick access to synthesis of evidence to assist with UR (including expectation of frequency and duration of PT)
- CPG may assist with establishing policies regarding treatment coverage.

Physical Therapists:
- Clinical Practice Guidelines:
  - Provide quick access to synthesis of evidence.
  - Give the PT direct access to the knowledge-base of the experts.
  - Allow one to self-assess current practice
  - Assist with developing direction of future clinical research.
CPG do present challenges:
- Pressure to conform vs individual discretion in choosing treatments
- Is there a place for “fringe” treatments in a world of CPG?
- What role will Guidelines play in healthcare litigation?

CPGs vs. Clinical Protocols | Comparison

<table>
<thead>
<tr>
<th>CPGs</th>
<th>Clinical Protocols</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific to pathology</td>
<td>Specific to a pathology or procedure</td>
</tr>
<tr>
<td>‘Families’ of diagnostics and interventions</td>
<td>Step-by-step instructions</td>
</tr>
<tr>
<td>Recommendations for practice</td>
<td>Prescriptive list</td>
</tr>
<tr>
<td>Most often derived from review of scientific research</td>
<td>Often come from another healthcare provider</td>
</tr>
<tr>
<td></td>
<td>Most often derived from clinical experience</td>
</tr>
</tbody>
</table>

CPGs vs. Clinical Protocols | Analogy

How do we use CPGs in patient/client care?
- Risk Factors
- Differential Diagnosis
- Intervention
  - Clinically effective interventions
  - Patient subgrouping
- Prognosis

Application of CPG | Case Study
- 27 year old female
- Swelling, pain, and limited ability to bear weight
- Onset 4 days ago
- Inversion mechanism injury
- Chief concern: Unable to run without play basketball
Application of a CPG | Risk Factors

**Risk Factors - Acute Lateral Ankle Sprain**
Clinicians should recognize the increased risk of acute lateral ankle sprain in individuals who (1) have a history of a previous ankle sprain, (2) do not use an external support, (3) do not properly warm up with static stretching and dynamic movement before activity, (4) do not have normal ankle dorsiflexion range of motion, and (5) do not participate in a balance proprioceptive prevention program when there is a history of a previous injury.

**Risk Factors - Ankle Instability**
Clinicians should recognize the increased risk for developing ankle instability in patients who (1) have an increased talar coronal, (2) are not using an external support, or (3) did not perform balance or proprioceptive exercises following an acute lateral ankle sprain.

Application of a CPG | Patient Classification

- Acute lateral ankle sprain
  - Acute phase management
  - “Pain and swelling”
- Chronic ankle instability
  - Acute on chronic pattern
  - “Instability”

Application of a CPG | Examination

**Examination - Outcome Measures**
- Pain
- Swelling
- Range of motion
- Strength
- Coordination

Application of a CPG | Examination, Continued...

**Examination - Activity Limitation and Participation Restriction Measures**
- When evaluating a patient in the postacute period following a recent or recurring lateral ankle sprain, assessment of activity limitation, participation restriction, and symptom reproduction should include objective and reproducible measures, such as single-leg hop tests that assess performance with lateral movements, diagonal movements, and directional changes.

Application of a CPG | Physical Agents

**Physical Therapy**
- Cryotherapy: cold should be used immediately after the injury to reduce pain and swelling.
- Electrophoresis: electrical current may be used for pain relief.
- Ultrasound therapy: may be used for pain relief.

Application of a CPG | Other Interventions

**Physical Therapy**
- Progressive resistance exercises: weights are gradually increased to strengthen muscles.
- Proprioceptive neuromuscular facilitation techniques: used to improve balance and coordination.
- Ankle braces: may be used for stabilization and support.
PTNow.org | CPG+: AGREE II for CPG Appraisal

- Domain 1. Scope and Purpose
- Domain 2. Stakeholder Involvement
- Domain 3. Rigour of Development
- Domain 4. Clarity of Presentation
- Domain 5. Applicability
- Domain 6. Editorial Independence
- Overall Assessment
- Notes

Federal Guidelines Clearinghouse | An AHRQ Initiative

- Systematically developed statements
- Produced under the auspices of a medical specialty association; relevant professional society; public or private organization; government agency at the Federal, State, or local level; or health care organization or plan
- Based on a systematic review of evidence
- Explicit statement that the clinical practice guideline was based on a systematic review
- Description of the search strategy
- Description of study selection
- Summary of the evidence synthesis
- Assessment of the benefits and harms of recommended care and alternative care options
- Full text guideline is available in English to the public upon request
- Guideline is the most recent version published

Discussion