

CAHE: Your international gateway to AH

CAHE talks to allied health clinicians and educators around the world about the future of allied health and where EBP features in the current and future landscape of AH clinical practice and education.

The first article in this series is submitted by Dr Guy Nehrenz, Executive Associate Dean and Professor, College of Allied Health and Nursing, Nova Southeastern University

Evidence based practice in the United States

In the US, we have many allied health professions at the associate degree (two years college) or certificate level. Very little if any time is spent on evidence-based practice from a research standpoint. The purpose of these health professionals is not to do research, but to handle the day to day healthcare duties they are trained to carry out.

Evidence based practice in the United States allied health community has been a slow-to-start process and has become more and more the domain of master's and doctoral programs. As training programs have raised the level of education, the importance of evidence has grown. At the master's level and above, evidence has taken on more meaning as research is more common at these levels. An example of an allied health program at the doctoral level is the Doctor of Physical Therapy (DPT) which includes evidence-based practice principles in the curriculum. Another is the Doctor of Philosophy in Physical Therapy (PhD) which is a research oriented degree with heavy emphasis on outcomes research and evidenced-based practice.

With the increase in technology and advancements in information management, allied health professionals have more access to outcomes information. Outcomes research has been around for quite some time in the US and allied health professionals have become integral members of this community. The Association of School of Allied Health has been deeply involved.

In my own experience, outcomes research and evidence-based practice have been post-professional training. For many of my colleagues, the same is true. Seeking out training in this area is more in the realm of continuing education.

I find that those making policy and setting standards of care tend to be researchers or practitioners trained in an area of expertise. It is their role in the healthcare system to review outcomes, develop standards, and to implement strategies to improve the health of a population. It is the clinicians who provide the care and collect the evidence needed by researchers. I consider this a symbiotic relationship with the goal of improving the way care is provided. The clinician must in fact be the individual who determines whether or not a standard actually works in real life situations. They are the frontline of healthcare and must assure that a "cookbook" approach to treatment is not used without common sense and knowledge.

We invite [submissions](#) from AH clinicians around the world to contribute to the EBP in AH debate.

Evidence in practice: The Arafura Games experience

Last month, CAHE staff members Luke Perraton and Zuzana Machotka took an opportunity to work in clinical roles, as physiotherapists in the sports medicine clinic at the Arafura games in Darwin. Since the first Arafura games in 1991 a group of health professionals (sports physicians, physiotherapists and associated sports trainers) have run a sports medicine clinic, to help athletes participate at their highest level. Under the umbrella of Sports Medicine Australia, the sports medicine clinic is a fun and dynamic working environment for both patients and clinicians, and showcases the application of research evidence into clinical practice.



Working in a clinical role as a physiotherapist as well as working as a CAHE research assistant has provided me with valuable insight into the benefits of applying evidence into clinical practice. I have become more aware of some of the barriers that researchers and clinicians can face when they try to implement research evidence into clinical practice.

Continued on Page 2

[Register online to receive CAHE updates.](#)



An update on the Fellowship

May and June 2009 have been very busy for implementation central! CAHE researcher, Luke Perraton and I have recruited 20 physiotherapy and 20 chiropractic practices spread across Adelaide. A number of physiotherapists and chiropractors from these practices have agreed to participate in the implementation central research project. As part of this phase of the project, Luke and I have been travelling to meet, and collect data, from physiotherapists and chiropractors at the participating practices. This has taken us from Murray Bridge to McLaren Vale and provides us with the unique opportunity to meet with physiotherapists and chiropractors in their clinical working environment. Luke and I will be continuing this process till end of July, by which time this phase of research will be completed. It is anticipated that the next phase of research, during which participating physiotherapists and chiropractors will be invited to attend a one-day workshop in Adelaide, will commence in August/September 2009.

While we have been busy with data collection for the Fellowship, there have also been ongoing updates on the [iCentral website](#). Did you know, since January 2009, there have been more than 400 visits to this website by people from 20 different countries! From end of this month, we plan to upload quick, concise lectures and corresponding podcasts on this website which will outline common issues and topics related to evidence implementation. We have also been creating a bibliography of relevant publications for evidence implementation and this will be available on the [iCentral website](#) soon.

Finally, as this Fellowship aims to implement a guideline, thanks to Motor Accident Commission, **iCentral** will soon host the full WAD guideline developed by the Motor Accident Commission. All supporting materials for these guidelines (such as the consumer resource) will also be available

on the website. An accompanying audio file will also be included which will provide an overview of this guideline, and how it will play an integral role in this Fellowship. Visit the [iCentral website](#).

Implementation Central

Evidence in practice: The Arafura Games experience

Continued from Page 1

But is evidence-based practice even possible? Or is it an ideal? Working in the sports medicine clinic at the Arafura games showed me that evidence-based practice is not only possible, but it can be practical and effective. The sports medicine clinic at the Arafura games provides a perfect working example of evidence-based practice.

Evidence-based practice can be thought of as consisting of three elements; research evidence, clinical experience and patient values. Many clinicians possess a wealth of clinical experience. Good clinicians also understand the importance of patient values. But many lack the time to search for and critically appraise research evidence.

The Arafura games experience highlighted to me how busy clinicians can overcome this barrier and integrate research evidence into their clinical practice more effectively. The answer is through teamwork.

Consistently throughout my time at the games I was exposed to current research evidence that was shared between clinicians. The findings of research studies were routinely discussed and the strength and relevance of this evidence was debated between clinicians. Research was then applied by clinicians directly into clinical practice. The team approach allowed busy clinicians to pool their knowledge on current research evidence, integrate this knowledge into clinical practice, and monitor the outcomes.

Increasingly, as our health care system evolves clinicians will be expected to integrate research evidence into their clinical practice. My experience in Darwin at the Arafura games showed me that although there are barriers to integrating research into practice, many of these barriers can be addressed by using a team approach.

Submitted by CAHE staff member [Luke Perraton](#)

CONTACTS

www.unisa.edu.au/cahe

karen.grimmer-somers@unisa.edu.au

[@unisa.edu.au](https://twitter.com/unisa.edu.au)

Telephone (08) 8302 2769

Facsimile (08) 8302 2766

University of South Australia

GPO Box 2471

Adelaide SA 5001

Australia

CRICOS Provider Number

001218



Action in Allied Health



What's happening in the world of AH – share your news with CAHE

This is the first of a regular column aimed at sharing news of current events, news and contacts which may be of interest to allied health (AH) professionals. I would like to encourage all allied health practitioners, clinicians, administrators and educators to let me know what is happening out there so that I can share it with readers.

Planning and work which is directly relevant to many in AH, is currently being generated through the State Department of Health's Clinical Senate and its eight Statewide Clinical Networks. The Networks provide multi-disciplinary clinical consultation and advice up to the Department to assist the planning and improvement of health services. Some achievements to date:

- The SA Stroke Services Plan 2009-2016 to improve the care of this patient group has been written and has moved onto a costing phase.
- The Orthopaedic and Rehabilitation Networks are working together on improved rehabilitation models of care and pathways for patients undergoing arthroplasty, experiencing orthopaedic trauma and fragility fractures.
- A Rehabilitation Research Workgroup has been established, to foster collaborative multiD research in SA

The eight individual Networks produce regular newsletters and they can be found on the Statewide Clinical Network website www.health.sa.gov.au/clinicalnetworks along with other information and contact details.

Canberra will host the **8th National Allied Health Conference**, 25 - 27 October 2009, which is titled "Allied Health Leading Change". More information at www.ahpa.com.au/events.

This year's **Smart Strokes conference**, which has an emphasis on allied health & nursing practices, will be in Sydney, 6-7 August. They have a scholarship fund to assist people to attend the conference. The 6th Asia Pacific Conference, **Against Stroke** will incorporate the annual SSA conference and will be held in Cairns, 6 – 10 Sept. This conference usually has heavily reduced registration for AH. Early details for both events at www.conferenceaction.com.au.

There is great work being undertaken on falls prevention under the auspices of the Health Departments' Quality & Safety unit. A particularly active regional group is the CNAHS Falls Network which provides regular multi-D education sessions. The last one on vestibular rehabilitation was a sell out and the next, on "Risk Takers" is on 23 June 2009. Contact Gillian.Bartley@Health.sa.gov.au for details or to get onto their mailing list for their excellent newsletter.

CAHE would like to help disseminate information on a broad range of areas so please forward AH news to [Julie Luker](mailto:Julie.Luker@unisa.edu.au) and we will include it in our bi-monthly newsletter for inclusion in CAHE's new **Allied Health in Action** column! [CAHE newsletter deadlines for 2009](#).

CONTACTS

www.unisa.edu.au/cahe
karen.grimmer-somers@unisa.edu.au
 Telephone (08) 8302 2769
 Facsimile (08) 8302 2766

University of South Australia
 GPO Box 2471
 Adelaide SA 5001
 Australia

CRICOS Provider Number
 001218



Outcome Measure Corner: Oswestry Disability Index

Scale: Oswestry Disability Index

- Condition-specific outcome measure
- Self-administered
- Acceptable face validity & construct validity
- High levels of test-retest reliability

What it measures

The Oswestry Disability Index was developed to systematically record limitations of activities of daily living due to low back pain (Roland and Fairbank 2000). It consists of 10 sections: pain intensity, personal care, lifting, walking, sitting,

standing, sleeping, sex life, social life and travelling.

How it is administered?

Six possible response options are provided for each of the 10 sections. The responses for each section are measured by a 0 to 5 degree of difficulty scale, 0 equating to no disability and 5 equating to the extreme disability. For each section, individuals place a tick next to the response option that best describes their status on the day of assessment.

Outcome Measure Corner

Continued from Page 3

How it is scored?

The scores for each section are tallied to produce a total raw score. The total score is derived by: (total raw score / (5 x number of sections answered)) x 100 and is expressed as a percentage (Fairbank and Pynsent 2000).

What the score means?

The minimum score is 0, which equates to no disability due to low back pain, whereas the maximum score is 100 and equates to extreme disability due to low back pain.

Important Points

- A decrease in disability due to low back pain is interpreted as a decrease in the total raw score or a decrease in the raw domain scores (score per section), on repeated measurements.

- It is recommended that a change of four points is required to indicate a clinically significant change in status (Meade et al 1990).

References:

Fairbank J and Pynsent P (2000): The Oswestry disability index. *Spine* 25: 2940-2953.

Meade T, Dwyer S, Browne W, Townsend J and Frank A (1990): Low-back-pain of mechanical origin: randomised comparison of chiropractic and hospital outpatient treatment. *British Medical Journal* 300: 1431-1437.

Roland M and Fairbank J (2000): The Roland-Morris disability questionnaire and the Oswestry disability questionnaire. *Spine* 25: 3115-3124.

For further details about Oswestry Disability Index please refer to page 94 of the **CAHE Musculoskeletal Outcomes Calculator Manual Version 6**.



June 2009 Bulletin from the Chief Allied & Scientific Health Advisor, SA Health, Catherine Turnbull

WHO Global Community of Practice, Rehab

You are invited to join the first ever Global Community of Practice for Rehabilitation - an online forum open to all who are working in the field of rehabilitation. Our first discussions took place on "Community Based Rehabilitation - development and challenges" from 1 to 5 June 2009.

It only takes a few moments to register by following the links on the [Global Community of Practice for Rehabilitation](#) webpage.

The Community of Practice is for practitioners, support workers, researchers, policy makers and experts. Health and rehabilitation professionals from all related healthcare disciplines are invited to participate, network, learn and develop best practice with colleagues from across the world.

A summary of the first week of discussion will be presented in a report to the WHO's Global Forum for International Health Professional Bodies on 'Multi-professional working to strengthen primary health care' in late June 2009, an event which will be the launch pad for a new Virtual Network entitled 'The Global Network for Health Professionals'.

Join the [Global Community of Practice for Rehabilitation](#) forum today, and get involved in this unique and exciting initiative.



The first online discussion week in June is very much an exemplar activity to both launch the Global Community of Practice for Rehabilitation, and to pave the way for a further six week discussion period later in 2009. Each of the weeks will focus on a specific aspect of rehabilitation and in particular the challenges and issues faced by the multi-professionals involved.

[Register online to receive CAHE updates.](#)

CONTACTS

www.unisa.edu.au/cahe

[karen.grimmer-somers](mailto:karen.grimmer-somers@unisa.edu.au)

@unisa.edu.au

Telephone (08) 8302 2769

Facsimile (08) 8302 2766

University of South Australia

GPO Box 2471

Adelaide SA 5001

Australia

CRICOS Provider Number

001218

