Physiotherapists should ensure their representation in measures of the quality of patient care

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In many developed countries, physiotherapists are one of the few health professional groups to have the privilege of being able to practise independently of their interdiscipli- nary colleagues. This privilege brings with it the responsibility to provide the very best care we can for our patients. Keeping up to date with changes in evidence, acting to overcome barriers to implementation of new and better practices, and cessation of ineffective interventions are considerable challenges for us all. Practice accreditation and departmental or hospital audits of services exist in many centres. These systems of review measure service performance, but whether they also measure the quality of care we provide for our patients is more difficult to determine. In this context, quality means the degree to which a health service increases the likelihood of desired health outcomes for patients, is consistent with current professional knowledge (Lohr and Schroeder 1990), and adheres to existing evidence-based guidelines (Duncan et al 2002). In recent years, increasing attention has been paid to the development of national quality of care audits and registries across a range of disease groups. In this editorial we make a plea for physiotherapists to actively engage in the ongoing development and review of local or national initiatives in their area of practice to ensure that physiotherapists’ contributions to quality patient care are recognised and valued. We use specific national and international examples from the field of stroke to discuss the opportunities for greater physiotherapy engagement and the risks if we do not. However, the issue goes beyond any one disease group or care setting.

Measuring care quality

National audits and disease registries are designed to help set benchmarks across the country, to monitor and ultimately improve the quality of care provided to patients. Each of these tools requires markers or indicators of quality. Indicators need to be clinically relevant, feasible, valid, reliable, and applicable across a range of health care systems (Rubin et al 2001); although they may measure process or outcome, it is the process of care indicators that allow us to measure specific interventions or activity within a system. An indicator is only useful if there is sufficient evidence to support a link between an activity or intervention and positive patient outcomes because this link creates confidence that improvement in a measured process will translate into improvement in outcome. Consensus on defining ‘best practice’ interventions is paramount as it enhances decision making, facilitates development of quality indicators (particularly where evidence alone is insufficient), assists us to synthesise professional norms, and helps us identify and subsequently measure areas where there is uncertainty or incomplete evidence. Preferably, process indicators should be based on evidence-based clinical guidelines; however, when scientific evidence is limited, an extended family of evidence, including expert opinion, may be needed as part of the indicator development process (Campbell et al 2002).

Are indicators related to physiotherapy part of quality audits in stroke?

Examples of process indicators in acute stroke care national audits include: brain CT scan within 24 hours of admission; and secondary prevention medication started by discharge (National Stroke Foundation 2007). What is striking in examining many national audit tools is that, despite the key role physiotherapists play in stroke care, indicators reflecting the practice of physiotherapy are rare. A recent systematic review of process of care indicators used worldwide in acute stroke found that of the 161 indicators in use, only two relate to physiotherapy: assessment by a physiotherapist (varying from 24 to 72 hours of admission), and early mobilisation out of bed (which may or may not involve physiotherapists). No other physiotherapy specific indicators were found (Purvis et al 2009). Post acute care national stroke audits in Australia also measure items related to assessment of impairments, which may involve physiotherapists (National Stroke Foundation 2008). This is despite evidence that many physiotherapy interventions for people with stroke are effective, as shown in the national clinical guidelines for stroke management (National Stroke Foundation 2010). A similar bias is seen in quality of care audits in Sweden in which indicators predominantly reflect medical care. Of the 32 quality indicators recommended in the Swedish Clinical Guidelines, no indicator can be linked specifically to physiotherapy (Board of Health and Welfare 2009). As with the Australian audits, some care indicators will incorporate physiotherapy (eg, satisfaction with rehabilitation received at three months after stroke), but it remains difficult to tease out the impact of the separate team members, particularly if the team practises inter-professional team work. The most specific indicator of quality care related directly to physiotherapy intervention in stroke was found in the Dutch multidisciplinary indicators of quality care in the Netherlands. This indicator captures the number of stroke patients who receive a minimal dose of one hour of physical and/or occupational therapy per working day.

What about registries?

The Australian Stroke Registry is in its infancy (Cadilhoc et al 2010b), but since 1994 a quality registry, RIKS-stroke, has been the vehicle for the collection of data on stroke care in Sweden. RIKS-stroke is one of the most highly developed stroke care registries in the world. Registries, although voluntary, are founded on the idea that key data about every case admitted to hospital is gathered and stored. Patients, rather than consenting to be added to the registry, are able to opt out should they wish. Registries are a powerful tool for benchmarking between hospitals, identifying gaps in care, monitoring changes in care over time and providing the data needed to lobby government about funding for stroke care. They are also a valuable research tool. Initially in RIKS-stroke, only acute medical care was registered from a number of participating hospitals. The registry now...
includes most hospitals in Sweden and data are gathered beyond the acute episode of care. The type of data collected has also broadened to include both processes and outcomes pertaining to rehabilitation and the patient’s experiences. However, in RIKS-stroke there are no quality indicators that can be linked specifically to physiotherapy. The absence of indicators directly related to physiotherapy is not restricted to stroke registries or audits. A scan of international and national audits or registries related to hip fracture management, ICU care, surgical care, mental health, obstetrics, and rehabilitation medicine found few, if any, references to physiotherapy (Australasian Clinical Indicator Report 2008, NHS National Services Scotland 2009, National Hip Fracture Database National Report 2010).

Risks and opportunities

The dearth of indicators related directly to the practice of physiotherapy in major national audits and registries raises important questions. There is little doubt that physiotherapists are accepted as contributing to the delivery of quality interdisciplinary care for patients. It could therefore be argued that as long as the quality of the total interdisciplinary care package is measured, physiotherapists will remain valued as part of that team. This raises the obvious questions of how the quality of interdisciplinary care can be defined and measured. More importantly, it creates a risk that an interdisciplinary care indicator would most likely measure whether a physiotherapist was part of the team and not how much (or how little) physiotherapy might be needed to meet a standard. Let us recall the purpose of national initiatives in quality of care and disease monitoring: benchmarking, identify gaps, monitoring change, and providing data for lobbying about resourcing. If physiotherapy is not specifically noted (in recognition of the important contribution we make to patient outcomes), we lose the opportunities to advance care practices inherent with the use of these tools.

This is not a call for physiotherapists to develop and maintain extensive discipline-specific quality audits of their care. Audits consume time and resources, are hard to maintain, and are only useful if they serve a specific purpose. Instead, we believe that physiotherapists should be active in lobbying for the incorporation of one or more simple indicators of physiotherapy practice within existing registries or national audits. In addition to the obvious advantage of operating within an established and appropriately resourced review system, this approach would have the added benefit of embedding physiotherapy with other important elements of quality care. One challenge is to determine what the indicator(s) may be (eg, dose of therapy, or time from admission to start of training). Another is to convince others that the data needed to support the indicator will be available within medical records, ie, we firmly commit to standardised recording practices. A third challenge would be to convince others that the addition of such an indicator will ultimately improve patient outcome as adherence improves, outcomes improve, ie, the indicator is valid (Cadilhac et al 2010a, Duncan et al 2002).

The dominance of medical indicators in audits and registries reflects both the existing evidence base and the high level of engagement of physicians in the process of developing tools for measuring the quality of care. Physiotherapists must engage in, and advocate for, the establishment and use of indicators that reflect our practice. Reaching consensus about what those indicators should be is the first step in that process.

References


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