Rehabilitation and Quality Management

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„Medicine is a manner
how people
treat each other.“

Viktor von Weizsäcker 1886-1957

Rehabilitation and Quality Management – terms of contradiction?

1. Can patients in rehabilitation be calculated like object or “things”?
2. Can principles and targets of Total Quality Management be transferred to rehabilitation?

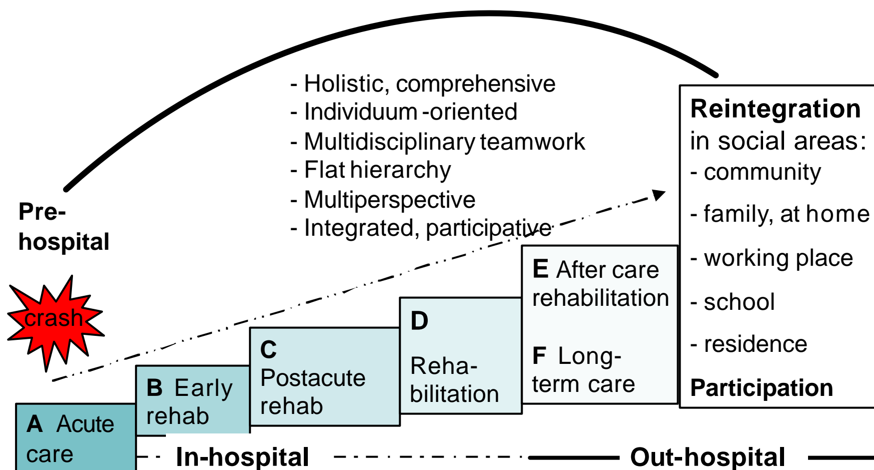
I Paradigm shifts - until 1980

„QM“ - Industry	Error control, steering control
„Health“ WHO-ICIDH	Impairment – disability – handicap deficit-oriented, medial model
„QM“ - insurance	Payment of each day of stay in hospital
- rehab-med	survival, sequelae, disability
„Patient“	Passive, dependend on doctor´s advice

1980-2000

„QM“ - industry	Quality assurance / management Cusom- / customer-oriented
„Health“ WHO ICIDH-2	Impairment – activity – participation Capabilties / resourses / integration Social model
„QM“ - insurance - reha-med	Payment per day of stay, cost saving Patient-oriented, early rehab Quality assurance, guidelines
Patient	More active, compliant

Phase Model of Neurological Rehabilitation



since 2000

„QM“ - industry - services	Total Quality Management customer- / service-oriented
„Health“ - WHO ICF	Impairment – activity – participation Context factors, barriers / resources Quality of life, inclusion / participation
„QM“ - insurance	Quality assurance programmes
- reha-med	Patient-oriented, integrative, service-oriented Ebm, guidelines
Patient	Active partner for shared decision making

Convention on the Rights of Persons with Disabilities

UN 2008

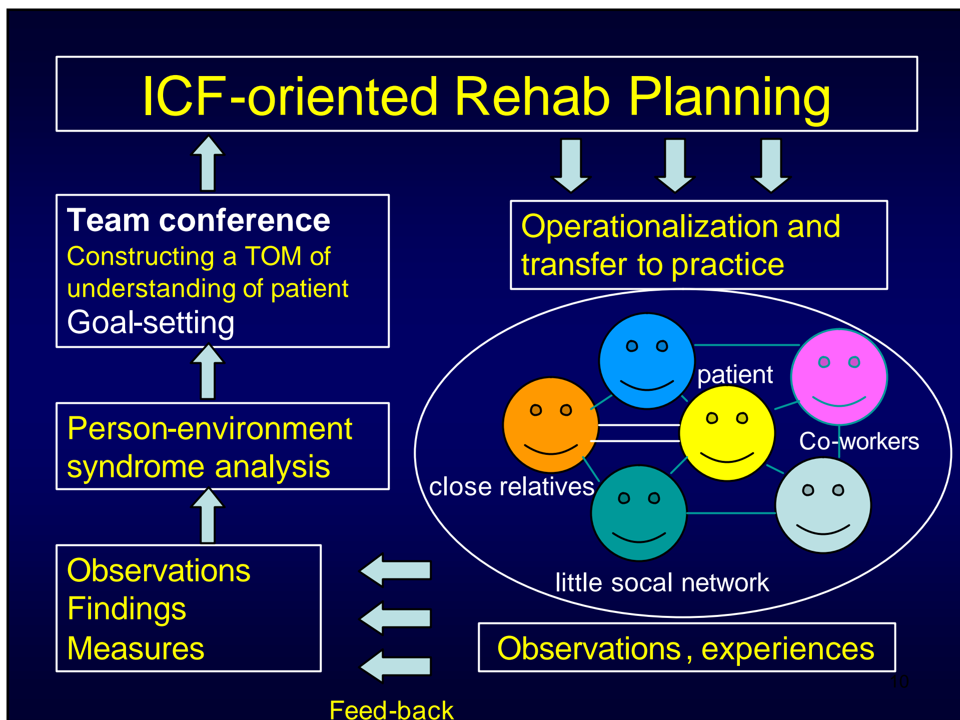
<u>Article 26:</u>

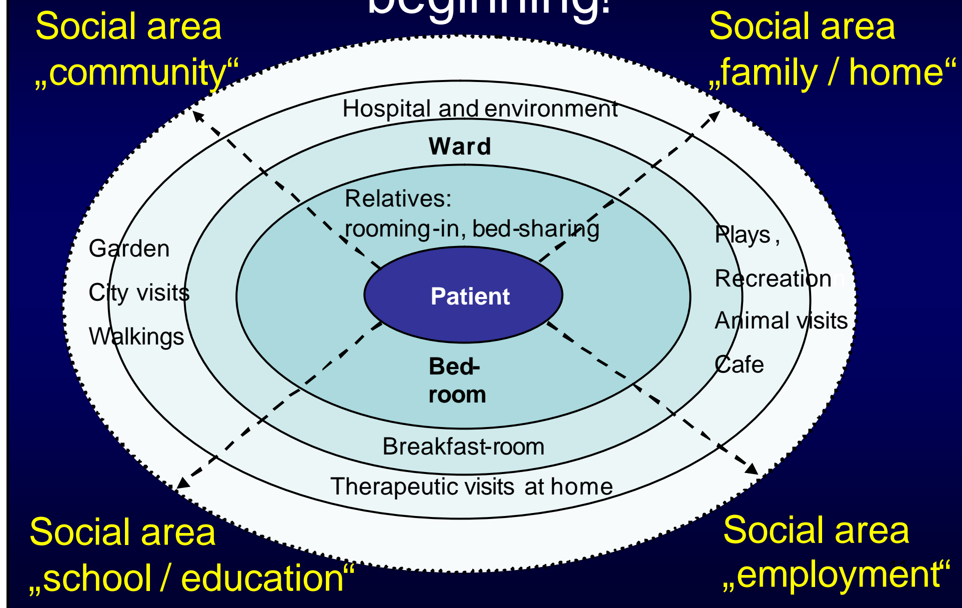
„.. to enable persons with disabilities
full inclusion and participation
in all aspects of life…“

II Teamwork – core process in rehabilitation

Crosby (1979)

“Quality starts with human beings, not with ´things´. Who wants to change quality at first has to target at *the inner attitudes* of the employees.”





III Quality Management in Rehabilitation

Assessments for social integration and participation

- QOLIBRI (Steinbüchel, Truelle et al 2005)
- Quality of Community Integration (Truelle et al 2010)
- Quality of Life Satisfaction (Oswald et al 2010)
- Q-SOC (Schmitz 2009)

Evidenced based medicine in neurological rehabilitation

Sackett (1996)

"Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of *individual* patients. The practice … means *integrating individual clinical expertise with the best available external clinical evidence from systematic research.*" (p. 71)

Level of Evidence

Ia	Meta analysis of RCT
Ib	At least 1 randomized controlled trail
IIa	At least 1 controlled study – no randomiz.
IIb	At least 1 other type of good experimental study (e.g. pre/post)
III	Good descriptive non-experimental studies (comporative/correlation/case)
IV	Experts´ report, authoritative opinions

Reasons for a critical debate

- Complexity of life of human beings
- Patients cannot be reduced to objects or customs.
- Case reports / patients´ narratives always have been a vital part of medicine
- Severest brain injured patients cannot be applied to regular testing
- Research design must be adapted to capacities of low-level patients
- Low-level quality is an integral part of evidence based thinking (Sackett)!

Integration of *narrative* and *empirical* quality in rehab research

- Holistic
- Qualitative and quantitative oriented
- Complementary
- Comprehends all levels of evidence
- Multiperspective
- Translational research effects
- Participative

Patient´s expertise to rehabilitation research

- Cognitive concepts of good quality in health care
- Ideas about indicators and preconditions of good quality in rehabilitation
- Different from health-care professionals
- Deeper understanding of patients´ needs
- Experts of their own life
- Participation in evaluation research

NIH Consensus Report

„The customer perspective on existing models of rehabilitation for TBI“

- Clubhouse project
- Learning in Natural Community LINCS
- Life after Brain-injury: Special Education & Rehab Services OSERS

(Rankin 2006)

IV Conclusion

1. Assessment of patients´ wishes / needs
2. Integration of patient´s experiences and visions into research design
3. Discussion about results in public meetings
4. Translation in clinical practice and QM programmes
5. Extension to disability studies and participative evaluation
6. Decision making on regional and federal level

QM in neurorehabilitation - an overall integrating and developing process