Rehabilitation and Quality Management

Andreas Zieger
www.a-zieger.de

Protestant Hospital Oldenburg
Department of Severely Brain Injured
Early and Postacute Rehabilitation

CvO University of Oldenburg
Department of Special Needs Education and
Rehabilitation Pedagogics

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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
„Health“ - WHO-ICIDH
„QM“ - insurance
- rehab-med
„Patient“

Error control, steering control
Impairment – disability – handicap
deficit-oriented, medial model
Payment of each day of stay in hospital
survival, sequelae, disability
Passive, dependend on doctor’s advice
1980-2000

„QM“
- industry
„Health“
WHO ICIDH-2
„QM“
- insurance
- reha-med

Patient

Quality assurance / management
Customer-oriented

Impairment – activity – participation

Capabilities / resources / integration

Social model

Payment per day of stay, cost saving

Patient-oriented, early rehab

Quality assurance, guidelines

More active, compliant

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Phase Model of Neurological Rehabilitation

**A Acute care**

**B Early rehab**

**C Postacute rehab**

**D Rehabilitation**

**E After care rehabilitation**

**F Long-term care**

Pre-hospital

Reintegration in social areas:
- community
- family, at home
- working place
- school
- residence

Participation

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Holistic, comprehensive
- Individuum-oriented
- Multidisciplinary teamwork
- Flat hierarchy
- Multiperspective
- Integrated, participative

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Reintegration in social areas:
- community
- family, at home
- working place
- school
- residence

Participation
since 2000

<table>
<thead>
<tr>
<th>„QM“</th>
<th>Total Quality Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>- industry</td>
<td>customer- / service-oriented</td>
</tr>
<tr>
<td>- services</td>
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</table>

<table>
<thead>
<tr>
<th>„Health“</th>
<th>Impairment – activity – participation</th>
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<tbody>
<tr>
<td>- WHO ICF</td>
<td>Context factors, barriers / resources</td>
</tr>
<tr>
<td>- „QM“</td>
<td>Quality of life, inclusion / participation</td>
</tr>
<tr>
<td>- insurance</td>
<td>Quality assurance programmes</td>
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<tr>
<td>- reha-med</td>
<td>Patient-oriented, integrative, service-oriented</td>
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<tr>
<td>Patient</td>
<td>Ebm, guidelines</td>
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<td>Active partner for shared decision making</td>
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Convention on the Rights of Persons with Disabilities

UN 2008

Article 26:

„. 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.”

ICF-oriented Rehab Planning

- Team conference
  - Constructing a TOM of understanding of patient
  - Goal-setting
- Person-environment syndrome analysis
- Observations, Findings, Measures
- Operationalization and transfer to practice
- Observations, experiences

Feed-back

- close relatives
- little social network
- Co-workers
- patient
Participation starts from the very beginning!

Social area „community“
- Hospital and environment
- Ward
- Relatives: rooming-in, bed-sharing
- Breakroom
- Therapeutic visits at home
- Garden
- City visits
- Walking

Social area „school / education“

Social area „family / home“
- Patient
- Bedroom
- Cafe
- Plays, Recreation
- Animal visits

Social area „employment“

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

<table>
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<tr>
<th>Level</th>
<th>Description</th>
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<tbody>
<tr>
<td>Ia</td>
<td>Meta analysis of RCT</td>
</tr>
<tr>
<td>Ib</td>
<td>At least 1 randomized controlled trial</td>
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<tr>
<td>IIa</td>
<td>At least 1 controlled study – no randomiz.</td>
</tr>
<tr>
<td>IIb</td>
<td>At least 1 other type of good experimental study (e.g. pre/post)</td>
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<tr>
<td>III</td>
<td>Good descriptive non-experimental studies (comparative/correlation/case)</td>
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<tr>
<td>IV</td>
<td>Experts´ report, authoritative opinions</td>
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</table>
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

- Holistic, comprehensive
- Individuum-oriented
- Multidisciplinary
- Teamwork
- Multiperspective
- Integrated, participative

Reintegration in social areas:
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Participation

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