

Barriers in Practicing Outcome Measurement Tools among Health Care Providers

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ABSTRACT

Aim:: To determine the barriers which do not allow the health care providers/therapists to use the beneficial appropriate outcome measurement tools in their daily routine practice.

Methodology: This cross sectional study included 196 health care providers, working clinically in Punjab hospitals either in private or government sectors, to fill the poll to get an entire and legitimate review of applicable hindrances and barriers of standardized outcome measurement tool. Distinctive strategies for information gathering were utilized through writing seek, semi-organized meetings and an online overview. All qualitative variables were presented as frequency distribution tables and interpreted logically to suggest actions, where obtained. As this was a complete descriptive study, no statistical tests of significance were applied.

Results: The results of this study showed that changing routine is difficult in health care settings, use of outcome measurement tools (OMT) is too time consuming for patients, patients preferences are not clear, need of more space to practice OMT, patients overload do not allow to use these standardized OMT, additional financial compensation is needed to practice OMT, lack of training in using OMT, more emphasis is needed to gain more knowledge about OMT, complexity and variability in patient's condition is hurdle in using outcome measurement tool, lack of active strategies for implementation of use of OM tools are some of the barriers in health care setting.

Conclusion: The findings of this study indicate that there is need to overcome the barriers between the health care provider and outcome measurement tools, need to implement active strategies and arrange more seminars and training sessions to emphasize the usefulness of OMT, changes should be done for clinical setups and financial support should be maintained.

Keywords: Outcome measurement tools, Rehabilitation, Performance Evaluation, Health Professional Education

INTRODUCTION

An outcome measurement (OMT) is a tool or results of tests which are used to evaluate the functional status of patient/client, to check the progress and to determine the result of treatment.¹ Outcome measurements tools (OMT) are important in objectively determining the patient functional status, an appropriate measure is one that is upheld by distributed proof showing that it is adequate to patients, solid, legitimate, and responsive (sensitive to change).² With the increasing trend of evidence based practice the use of OM has gain more importance to document the limitation, progress and achieved goals. But it is anabrasivefact that despite the advancement of use of measurement tools more than a decade ago, health care providers are at a distance to the use of such credible, reliable, beneficial and justified OM tools.³

There are multiple factors which affect the use of outcome measurement tools in health care setting among health care providers. Some of these are lack of time, length of time for patients to complete them, length of time to document and analyze the data, no active strategies to implement them, passive implementation and unawareness due to lack of educational degree & evolving knowledge^{3,4}.

There are some additional barriers which interfere with the use of OM tools. The barriers could be symptoms

variability, complex heterogenous and progressive disorder type, difficulty in choosing appropriate OMT, different clinical setting.^{5,6} The aim of the study is to evaluate the barriers among health care providers in practicing the OM tools and knowing the barriers will help to overcome them by reducing the barriers and implementing the strategies to encourage active use of outcome measurement use.

MATERIALS AND METHODS

Design & Setting: This cross sectional survey involved health care providers, working clinically either in private or government sectors in Punjab health facilities/hospitals.

Sample Selection: Using non probability purposive sampling 196 participants (keeping the proportion of 0.5,¹ margin of error to 7% and significance level to 5%) were enrolled with a working experience of at least two years or more from both public and/or private health care setting.

Data Collection: After taking an informed consent from the participants' data was collected from a survey questionnaire comprising items regarding the use and barriers of standardized outcome measures. The questionnaire was developed after literature search^{6, 7,8} and semi-structured interviews. A pilot study was conducted to modify and achieve the final version of questionnaire. The final questionnaire was sent to health care providers randomly selected through mail, telecommunication and by post. Structured interviews were also established and response forms were collected back. A five level Likert scale was used to analyze the data.

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Data Analysis: All qualitative variables were presented as frequency distribution tables and interpreted logically to suggest actions, where obtained. As this was a complete descriptive study, no statistical tests of significance were applied.

Ethical Consideration: All the data were collected after getting an informed consent while maintaining the anonymity and confidentiality of respective participants.

RESULTS

The mean age of study participants was 30.51 ± 4.12 years with a minimum of 25 years and a maximum of 50 years. Out of a total of 196 participants, 90(45.9%) were male and 106(54.1%) were female. Table-1 Shows the frequency table of the responses on each item of questionnaire. Among the 196 health care providers 48.0% were from private sector while 52.0% were from government hospitals.

Table 1: Frequency of the Responses on Each Item of Questionnaire

Sr. No.	Question(s)	Completely Disagree	Disagree	Disagree Nor agree	Agree	Completely agree
1.	I have been utilizing estimation instruments before this venture	55 (28.1)	22 (11.2)	22 (11.2)	62 (31.6)	35 (17.9)
2.	I have adequate learning to utilize estimation instruments	42 (21.4)	50 (25.5)	46 (23.5)	35 (17.9)	23 (11.7)
3.	I have a positive attitude towards the use of measurement instruments	13 (6.6)	23 (11.7)	19 (9.7)	101 (51.5)	40 (20.4)
4.	I miss the routine of using measurement instruments in daily clinical practice	10 (5.1)	39 (19.9)	74 (37.8)	49 (25.0)	24 (12.2)
5.	Changing my routine is troublesome for me	18 (9.2)	51 (26.0)	48 (24.5)	61 (31.1)	18 (9.2)
6.	Use of measurement instruments time consuming for patients	41 (20.9)	10 (5.1)	12 (6.1)	97 (49.5)	36 (18.4)
7.	I find using measurement instruments a problem because I do not have (physical) space in my practice	24 (12.2)	42 (21.4)	23 (11.7)	79 (40.3)	28 (14.3)
8.	Using measurement instruments requires additional financial compensation	07 (3.6)	37 (18.9)	39 (19.9)	67 (34.2)	46 (23.5)
9.	I find using measurement instruments a problem because I have had no training in using them	23 (11.7)	28 (14.3)	58 (29.6)	43 (21.9)	44 (22.0)
10.	I am convinced of the usefulness of measurement instruments	14 (7.1)	8 (4.1)	38 (19.4)	89 (45.4)	47 (24.0)
11.	Patient's symptoms variability and complex heterogeneous and progressive condition do not allow me to use outcome measurement tools.	11 (5.6)	35 (17.9)	33 (16.8)	98 (50.0)	19 (9.7)
12.	Patient burden do not allow me to use OMT	11 (5.6)	44 (22.4)	54 (27.6)	48 (24.5)	39 (19.9)
13.	There are no active strategies to implement the use of OMT	20 (10.2)	39 (19.9)	36 (18.4)	66 (33.7)	35 (17.9)

DISCUSSION

The point of this effort was to locate the present utilization of outcome measurement tools, and related boundaries in the utilization of estimation apparatuses in clinical treatment practice. Contrasting the consequences of this investigation and different examinations in the writing, similar issues demonstrate to exist in various regions with respect to the utilization of estimation apparatuses. The outcomes from these diverse investigations don't uncover the contentions; there is just here and there modification in the accentuation.

An approach to group estimation instruments is the Universal Order of Capacity, Incapacity and Medical issues (ICF). Utilizing this system gives a clearer comprehension of the sort of estimation instruments utilized in clinical work on: concentrating on hindrances in capacity, on incapacities, on close to home elements or on outer elements. There were two main factors causing problems in the application of outcome measurement tools. One was on the behalf of participants (lack of knowledge, not considering the measurement instruments to use) and

second was on the level of management (lack of time, support and availability). Same is explained in the study of Swinkles et al⁹.

In this study 17.9% of the health care providers/therapists were using the OM tools and 31% find it difficult to change their routine for using these tools. 28% do not use these measurement instruments. In the same way Jette and Diane et al concluded that 48% of their subjects using the standardized measures in their routine clinical practice and 90% among these believed that they enhanced the quality of treatment. Other 52% do not use these measures. 17% of the participants have sufficient knowledge and 25.5% have skills for the use of measurement tools. 25% have not sufficient knowledge and 39.8% of participants think that they have some skills for OM use. In general practice out of total participants 58 resists OM use although 51.1% have positive attitude towards the use of measurement tools.

Copeland and Janet et al^{3, 4} found that less than the half percentage is concerned with the use of OM tools. In their study, they mentioned that master's degree and high level of knowledge supports the use of OM tools.

The research is limited in difference of reporting and perceiving behaviors of individual. Further researches are needed to convey the benefits of OM use to the practitioners. In this study 49% of the participants find it too time consuming at both levels patients and providers at the same time, 50% believe that OM use give them enough room to include patients' preferences. Despite of positive attitude study participants do not routinely use OM. Setting facilitation, financial involvement and time issues are the factors reported. Same issues were reported by Van Peppen¹⁰.

The semi organized meetings affirmed the supposition that there is a hole between announced use and saw conduct on one hand and reality then again. This is the finish of a few examinations appearing detailed use is presumably an overestimation of reality in clinical practice.

Most of the study participants showed having an inspirational demeanor to the utilization of institutionalized measures and to be persuaded of the advantages of the utilization of estimation instruments. Be that as it may, the two gatherings of advisors showed experiencing issues changing their day by day schedule.

The most vital boundaries could be recognized at the dimension of the health care provider/specialists (absence of information and inadequate mix in day by day practice). In both the meetings and the study, advisors showed a requirement for little scale training, input on the utilization of estimation apparatuses and direction on which estimation instruments to pick. This is predictable with the tantamount investigation for American physical specialists just as with prior overviews, in which the dominant part of members showed that the most imperative hindrances are absence of commonality with, absence of preparing in and absence of access to (result) measures. Moreover, the meetings in our investigation showed that in the dominant part of clinical settings there is no sufficient arrangement on institutionalized measures.

One constraint of this investigation is the way that the writing study was not a precise audit of the writing. Another restricting point is the moderately little reaction rate to the electronic review, which could imperil the legitimacy of the detailed discoveries

CONCLUSION

The study concluded that changing routine is difficult in health care setting, use of OM tools is too time consuming, patients preferences are not clear, need of more space to practice these measurement tools, additional financial compensation is needed to practice OMT, lack of training in

using OMT, patients overload do not allow to use these standardized OM tools,

More emphasis is needed to gain more knowledge about OMT, insufficient availability of measurement instrument, complexity and variability in patient's condition is hurdle in using OMT, lack of active strategies for implementation of use of OMT are the barriers in health care setting

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