

Chapter 1 : Physical Therapy MIPS Quality Measure Recommendations () | Healthmonix

Outcome measurement tools are specific tests and measures that your physical therapist may use to quantify your overall function. These tools are important, as they provide your therapist with a simple and effective way to measure your mobility.

How to Utilize Self Report, Actual Performance, and Pain Measures by John on October 12, Low scores were given because I wanted the course to include psychometric properties on different performance tests so that the clinician can focus on the ones best suited to their needs. I also wanted videos or pictures of the performance tests being administered. This course did peek my interest to learn more and helped guide me towards Gary Gray for a FMS course. How to Utilize Self Report, Actual Performance, and Pain Measures by Camila on May 9, Even though it is a little complicated topic, the presenter was great with some case studies at the end made easier to understand the concept. Performance Measurement in Painful Musculoskeletal Conditions: How to Utilize Self Report, Actual Performance, and Pain Measures by Member on February 6, It is a difficult topic area and any attempt to improve clinicians ability to deal with subjective vs objective discrimination of test selection is to be commended. The approach was a little awkward and I feel left the learner with some confusion. How to Utilize Self Report, Actual Performance, and Pain Measures by Loretta on January 30, I found the course somewhat confusing, but I feel that physical performance testing is vital for our profession. Not only does it help direct patient care but it offers possible evidence for the need for skilled PT to insurance and referral sources. We tend to look at these measures in silos his own FOTO example and when we do look at them in a coordinated effort - sometimes they do not make sense. We may be quick to think a measure is not valid. However in reality the measures may all be valid; BUT, it is the analysis of various measures as a whole that needs to be considered and will help us determine the credibility which is different then validity of a test. This analysis is individual for each patient and will lead to the establishment of the best plan of care for the patient. Thank you for bringing this into the spot-light. How to Utilize Self Report, Actual Performance, and Pain Measures by Kristy on January 27, Overall this course was applicable to the clinic; however, it was difficult to follow I understand and appreciate the need to understand how to interpret measurement data and how they may affect my POC, but I feel the presentation of the material was a bit tedious. How to Utilize Self Report, Actual Performance, and Pain Measures by Nicole on January 24, It provided me with an intellectual point of view when self analyzing a patients case to determine appropriate treatment plan based on their function and pain. I found it interesting and provided more testing options that I was not aware of. Too technical and difficult to follow. Did not feel engaged. I liked the idea of the flowgrams, but they were hard to follow. How to Utilize Self Report, Actual Performance, and Pain Measures by Michelle on December 31, Test questions and answer choices were confusing, poorly worded and not punctuated correctly, made it hard to answer Performance Measurement in Painful Musculoskeletal Conditions: I look forward to utilizing the revised VAS pain scale with scoring of pain. How to Utilize Self Report, Actual Performance, and Pain Measures by Gary on December 26, understanding why therapist do not recognize when a patient is not telling the truth and steps to either avoid or correct issue by Member on December 24, deceiving test questions. How to Utilize Self Report, Actual Performance, and Pain Measures by Member on December 23, The application at end was good, but overall, the presenter simply read off slides and was a little difficult to follow overall especially with the diagrams not really being that clear and spending little time on them. How to Utilize Self Report, Actual Performance, and Pain Measures by James on December 22, It was interesting because being in the clinic settings we see a lot of cases of these especially with work mans comp Performance Measurement in Painful Musculoskeletal Conditions: How to Utilize Self Report, Actual Performance, and Pain Measures by Kalli on December 11, This was very relevant information with good diagrams that are helpful tools to reference in the future as well. A patients perception of pain is very important to treatment and this helped give me some ideas of how to re-evaluate if I am having difficulty especially when pain and performance are not consistent.

Chapter 2 : PT Outcomes Registry

Registry. Physical Therapy Outcomes Registry. The registry is an organized system for collecting data to evaluate patient function and other clinically relevant measures for the population of patients receiving physical therapist services.

To evaluate measurement properties of a set of public quality indicators on physical therapy. Design An observational study with web-based collected survey data and Setting Dutch primary care physical therapy practices. Participants In physical therapy practices, 11 physical therapists reporting on 30 patients each. Main Outcome Measure s Eight quality indicators were constructed: Measurement properties on content and construct validity, reproducibility, floor and ceiling effects and interpretability of the indicators were assessed using comparative statistics and multilevel modeling. Results Content validity was acceptable. Construct validity using known group techniques of two outcome indicators was acceptable; hypotheses on age, gender and chronic vs. Conclusion Weaknesses in data collection should be dealt with to reduce bias and to reduce ceiling effects by randomly extracting data from electronic medical records. More specificity of the indicators seems to be needed, and can be reached by focusing on most prevalent conditions, thus increasing usability of the indicators to improve quality of care. Health-care professionals, such as physical therapists constantly strive to improve the quality and professionalism of their care and there is a growing awareness of the importance of evidence-based physical therapy [1]. Simultaneously, declining trust in health-care institutions has led to a call for audits and inspections as well as more transparency of quality of care [2 , 3]. To promote transparency and accountability in health systems, a need exists for performance indicators [4]. Moreover, benchmarks are seen as a powerful incentive to improve the quality of care [5]. On behalf of the Dutch Healthcare Authority 23 indicators capturing the quality of physical therapy in primary care [6] were developed during a systematic iterative consensus procedure with all stakeholders, who agreed that the measurement aim was evaluative [7], meaning that quality of care was measured to detect longitudinal changes. The indicators described 3 domains: In this study, the eight indicators that capture the physical therapy care process will be the focal point. This set was based on the guideline which described the report of clinical reasoning in patient records [8]. To our knowledge this is the first time that such a set of indicators is evaluated systematically on criteria for good measurement properties as defined by Terwee et al. The purpose of this study was to assess the quality indicators on these measurement properties. In , this invitation was repeated. Practices that did not participate in were urged to do so in by the health insurance companies with financial incentives. Measures and data collection The set of eight indicators is intended to capture the quality of the physical therapy care process. The indicators are based on a guideline that addressed the clinical reasoning process [8 , 10 – 14]. Each indicator is composed of one or more items questions , see Appendix. Data for these indicators were collected by the physical therapists themselves for 2 months during each year using questionnaires to report retrospectively on 30 medical records. Therapists were asked to select patients who completed their treatment and to stratify on acute vs. For each patient record, therapists reported information on the questionnaires and patient characteristics including age, gender, direct access or referral, number of treatment sessions and treatment goal. The study was conducted in accordance with the Declaration of Helsinki. Testing framework and statistical analyses Content validity Content validity was more or less guaranteed in the development procedure. However, as new ground is being broken, it is important to reflect on other aspects of content validity too, such as item selection and reduction, and the interpretability or understandability of the questions. Construct validity As construct validity relates scores on this instrument to that of other measures of the same underlying concept, it can be assessed by testing predefined hypothesis using known group techniques, i. Gijsbers van Wijk et al. It is hypothesized that the different view on men and women will also be present in physical therapy. Hypothesis 1 Male patients will receive higher scores than female patients on outcome indicators 6 and 7. Furthermore, Mayer et al. Hypothesis 2 Younger patients will receive higher scores than older patients on outcome indicators 6 and 7. Hypothesis 3 Acute patients will receive higher scores than chronic patients on outcome indicators 6 and 7. Hypotheses for the process indicators indicators 1 through 5 and indicator 8 could not be formulated due to a lack of scientific evidence.

Age, gender and chronicity were also dichotomized with the following reference categories, younger than 65 years, female and acute patients code 0. The use of multilevel analysis was necessary due to nested data i. The data set collected in and with different patients was not appropriate to proper testâ€”retest procedures. Floor and ceiling effects Floor and ceiling effects describe the percentage of respondents who received the highest or the lowest possible score. If these effects are present, differentiation is not possible and changes cannot be measured, which threatens both reliability and responsiveness of the indicators. This property was assessed by examining the percentage of therapists and practices that received the highest or lowest possible score. Interpretability As interpretability refers to the ability to assign qualitative meaning to quantitative scores [9], subgroups were compared with assign meaning to the scores of the whole group of patients. Furthermore, in , it became clear that health insurance companies shifted the measurement aim from evaluative to discriminative to help decide which practices would receive pay for performance. It is therefore conceivable that indicator scores in were higher than in Taking the mean score over the 2 years would then lead to overestimation of the indicator scores. To test this, the group of therapists that provided data only in was compared with those that only provided data in Within the practices 11 therapists assessed a total of patients. Data showed representativeness compared with a national representative sample [19 â€” 21], although solo practices were underrepresented, larger practices were overrepresented and patients younger than 24 were also underrepresented.

This bar-code number lets you verify that you're getting exactly the right version or edition of a book. The digit and digit formats both work.

Advanced Search Abstract Background and Purpose. The use of information obtained from HR and BP measures in decision making for patient care and the effects of practice setting and academic preparation on the measurement and use of HR and BP also were examined. A sample of subjects was selected from a list of 2, clinical instructors at the clinical education sites of the 2 participating universities. Clinical instructors from a variety of practice settings were surveyed. A item survey questionnaire was mailed to the clinical instructors. Usable survey questionnaires were received from respondents The majority of the respondents strongly agreed or agreed More than one third A slightly larger percentage Relationships were found between practice setting and frequency of HR and BP measurement in new patients. Practices related to HR and BP measurement reported by this sample of clinical instructors do not meet the recommendations for physical therapy care described in the Guide. We believe the need for physical therapists to measure heart rate HR and blood pressure BP has increased for several reasons. First, high BP is a serious health concern in the United States. One in 4 adults has high BP, almost one third The Department of Veterans Affairs, in its high BP treatment and screening algorithms, recommends that BP be measured in any patient aged 18 years or older in primary care settings. The APTA Board of Directors, in response to a call from legislative bodies for descriptions of practice parameters of health care professions, appointed a task force to develop a document describing physical therapist practice. Development of Volume II began by using an expert consensus method, and this volume included preferred practice patterns in 4 categories: Revisions to the first edition, based on input from the general membership of APTA and changes in House of Delegates policies, were made in and The second edition of the Guide, which includes templates of forms for inpatient and outpatient settings, was published in According to Harris 7 and Duncan, 8 such clinical decision making should be based on the best available evidence in the literature. Winslow et al 14 recommended measuring HR and BP when first getting a patient out of bed due to the increased incidence of orthostatic hypotension. Many older patients referred for physical therapy have secondary cardiovascular comorbidities and are taking cardiovascular medications. These medications often alter HR and BP responses to activity. Balogun et al 21 found small drops in systolic and diastolic BP during continuous cervical traction in young subjects. They recommended that physical therapists monitor the BP response of patients at high risk for cardiovascular disease before, during, and after cervical traction. Patients at high risk for cardiovascular disease were described as elderly patients, those with increased sensitivity of baroreceptors, and those with carotid artery plaques or a history of hypotension or hypertension. Several authors 22 â€” 24 recommended that HR and BP should be monitored in patients undergoing isokinetic orthopedic rehabilitation protocols. This is especially true for patients with risk factors for cardiovascular disease, patients with coronary artery disease, and older individuals. Currently, there is no information about the extent to which physical therapists routinely measure HR and BP or the way in which they use this information in clinical practice. We also examined the use of information obtained from HR and BP measurement in decision making for patient care and the effects of practice setting and academic preparation on the measurement of HR and BP and use of these measurements in physical therapy practice. Method Subjects The subjects for this study were selected from a list of 2, clinical instructors at the clinical education sites of the Department of Physical Therapy, Saint Louis University, and the Program in Physical Therapy, Washington University. We chose to survey clinical instructors because we had access to an existing list. We decided not to send packets of survey questionnaires to the institutions for individual clinicians to complete for 2 reasons. First, we believed that this would make following up on nonrespondents more difficult. Second, the clinicians may have perceived this approach as less personal, leading to a decrease in the return rate. Although both programs are located in St Louis, Mo, their clinical education sites are located throughout the continental United States. We used 2 decision rules when selecting our sample. First, to avoid a preponderance of clinical instructors working in the Midwest, at least one clinical instructor was selected from

each of the states where clinical education sites are located. Using this method, we selected clinical instructors roughly half from each university working in 35 states and the District of Columbia. Second, we included clinical instructors from sites representing major practice areas such as rehabilitation, acute care, pediatrics, skilled nursing, outpatient care, and home health. Because we surveyed only clinical instructors, there may have been a systematic bias in our respondents. We do not know whether clinical instructors are similar to other therapists in the way they practice. In an effort to reduce the risk of bias in subject selection, the investigator EMF who chose names from the list was not a member of the clinical education team at either university.

Survey Questionnaire The item survey questionnaire was in 2 parts. The first part had questions about HR and BP measurement in clinical practice, and the second part asked for demographic data. Questions in part 1 asked about access to equipment needed to measure HR and BP, the frequency with which HR and BP measurements were taken, and the effects of vital sign measurements on the choice of interventions. We also asked respondents about the importance of measuring vital signs, their potential use as screening measures, and reasons why they did not measure HR and BP. The final questions in the first part of the survey instrument asked about educational preparation for measuring HR and BP. Part 2 of the survey questionnaire asked respondents about the types of patients seen, the type of facility where the clinical instructors worked, the type of cardiopulmonary comorbidities reported as present in patients seen by the clinical instructors, the number of years the clinical instructors had been engaged in practice, and their sex. To give respondents a frame of reference, we asked them to limit their responses on the frequency of HR and BP measurement, use of these measures, and the presence of comorbidities to patients they had seen within the week before the survey. Five physical therapy faculty members, 2 of whom were involved in clinical practice, reviewed the survey questionnaire. After the reviewers critiqued the survey questionnaire, their suggestions were incorporated into the final version of the survey instrument. We did not evaluate the reliability or validity of data obtained by use of the survey.

Procedure In July , survey instruments were mailed to the individuals selected from the list of 2, clinical instructors. We followed several of the procedures recommended by Dillman 25 in designing and implementing the survey. In an accompanying letter, we explained the purposes of the study and defined vital signs as HR and BP. We also explained that return of the survey questionnaire implied informed consent. A business reply envelope was included with the questionnaire. We requested that the questionnaires be returned within 3 weeks. A postcard reminder was mailed to nonrespondents 2 weeks following the initial mailing, and a second mailing was sent to nonrespondents in mid August with a letter requesting participation and another copy of the survey instrument. We used a code on the return envelope to track the survey instrument. Return envelopes were separated from the survey questionnaires when they were received. The median was used to better describe the data when an extreme datum may have influenced the mean. To compare the responses of subgroups within the sample, we used contingency tables, the Fisher exact test, and chi-square analysis. Eighteen questionnaires were returned as undeliverable, and 1 questionnaire was eliminated from the analysis because the clinical instructor had based her responses on experiences prior to her maternity leave. Therefore, our final response rate was . The number of respondents by state ranged from 15 states to 1 state , with a mean of 3. When we compared subsamples, the smallest sample size was 10. The majority of the respondents were female . Although respondents worked in a variety of settings, most were in outpatient settings. A complete description of the respondent demographics is presented in Table 1. Although our respondents were clinical instructors who worked at facilities that were affiliated with our universities, the demographic information from our respondents regarding sex and type of facility was similar, in our view, to the membership profile of APTA. More of our respondents reported practicing as a physical therapist from 1 to 10 years.

Chapter 4 : Outcome Measures - Physiopedia

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Chapter 5 : Geriatric Assessment Tool Kit

Edema Definition: A local or generalized condition in which the body tissues contain an excessive amount of tissue fluid. (Taber's Medical Dictionary).

Chapter 6 : 3 Types of Outcome Measures: Performance-Based, Self-Reported, and Hybrids | WebPT

Step 1: Select At Least 1 Outcome Measure. For the MIPS Quality Performance Category, you must report at least one outcome measure. If no outcome measures are applicable to your patient population, then you must select at least one high-priority measure (see Step 2).

Chapter 7 : Which Outcome Measurement Tool Should I Use and When? | WebPT

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Chapter 8 : Outcome Measures in Patient Care

Access tests and measures that have been identified for use in functional limitation reporting, as well as tests that have been cited in Clinical Summaries and APTA section-generated clinical practice guidelines.