Physiotherapy management of low back pain: Does practice match the Dutch guidelines?

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The purpose of this study is to explore adherence by Dutch physiotherapists to the physiotherapists' guideline for non-specific low back pain. For this study data from the National Information Service for Allied Health Care were used. This is a registration network that continuously collects information about physiotherapy patients and their treatment episodes. Within this network, adherence to the low back pain guideline was assessed by three criteria based on the guideline. These criteria concerned the number of sessions, the treatment goals, and the interventions. Data from patients with 'non-specific low back pain' as the reason for referral and a completed treatment episode were selected (n = 1254); 90 therapists in 40 practices treated these patients. The criterion concerning the number of sessions applied only for patients with acute complaints and was met in 17% of these patients. In about half of the patients the criterion for the treatment goals as well as the criterion relating to the interventions was met. Treatment goals are aimed mainly at improving mobility functions and changing body position. In more than three-quarters of the treatment episodes manual interventions (massage or manual manipulation) and exercise therapy were used frequently. As considerable variation in guideline adherence was shown to exist among therapists, there is clearly room for improvement in the quality of the care. **[Swinkels ICS, Ende van den CHM, van den Bosch W, Dekker J and Wimmers RH (2005): Physiotherapy management of low back pain: Does practice match the Dutch guidelines? *Australian Journal of Physiotherapy* 51: 35–41.]**

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Introduction

Quality of health care is an important element of public health care policy in The Netherlands. Since 1990 Dutch physiotherapists have been responsible for providing insight into the process of care and the quality of care in their practice (Sluijs et al 2003). A number of activities have been undertaken to enhance the quality of care. So far, there have only been a few activities to evaluate the quality of care provided by physiotherapists.

Quality of care can be evaluated on the basis of structure, process, and outcome (Brook et al 1996, Brook et al 2000, Lawrence et al 1997). Structural data refer to the characteristics of therapists and practices (e.g. a therapist's specialty); process data are the components of the encounter between a therapist and a patient (e.g. the interventions); while outcome data refer to the patient's subsequent health status (e.g. an improvement in mobility) (Brook et al 1996). Process data are usually the most sensitive measures of quality, because they provide information about the content of the process, are easy to measure, and vary in accordance with the behaviour of the care provider (Brook et al 1996, Lawrence et al 1997).

The process of care can be evaluated by using explicit criteria (Brook et al 1996). These criteria are used to assess the extent to which actual practice corresponds to recommendations, which may be derived from clinical guidelines (Lawrence et al 1997). In this way, guideline adherence can be used as an indicator for quality of care, on the assumption that the guidelines are scientifically valid and secondly that they are implemented successfully (Lawrence et al 1997).

Process data to assess guideline adherence can be obtained from various sources, such as records maintained by insurance companies to reimburse therapists, clinical records maintained by health care professionals, survey data collected for quality-assessment purposes, and direct observations of the therapist-patient encounter (Brook et al 1996, Brook et al 2000). In The Netherlands a registration network continuously collects information about physiotherapy practice. This network was set up in 2001 to collect healthcare-related information. Data gathered by the network were used for the current study.

The aim of the present study is to investigate to what extent Dutch physiotherapists in private practice adhere to recommendations in clinical guidelines. Because the guideline for the treatment of patients with non-specific low back pain concerns the largest group of patients seen by physiotherapists, the paper will focus on this group of patients. The following aims will be addressed:

1. To give a description of the process of care for patients with non-specific low back pain;
2. To explore to what extent the physiotherapists' treatment of patients with non-specific low back pain adheres to the recommendations in the guideline;
3. To give insight into the variation among therapists regarding guideline adherence.

Method

Registration Since 2001 a registration network of Dutch physiotherapists working in private practices all over the country has been collecting healthcare-related data on a continuous basis. Data from this National Information Service for Allied Health Care (in Dutch called LiPZ) were used for the current study. Dutch therapists in private practice generally use a software program to register their patients and treatments. Besides providing regular information, therapists participating in the network register supplementary information on all their patients by means of special software. The participants submit their data on a monthly basis. After quality control, the data are entered in the database. Collected information includes:

— Patient characteristics (gender, age, health insurance, and education).

— Information about the referral (reason for referral and referrer). The reason for referral as given by letter by the referrer is registered by the physiotherapists. Researchers code these reasons according to the International Classification of Primary Care (ICPC) (WONCA 1998).

— Characteristics of the health problem (duration of the complaint and a prior episode of low back pain [appearing after a complaint-free episode of at least four weeks and at most two years]).

— Aspects of the treatment plan (treatment goals and interventions) and the extent of care (number of sessions and duration of episode); per patient, one treatment goal at the level of activities and one treatment goal at the level of functions can be registered. The definitions of the treatment goals are based on the International Classification of Functioning, Disability and Health (WHO 2001). At the end of a treatment episode physiotherapists register a maximum of three interventions that have been applied in at least 50% of the sessions.

Therapists and practices In early 2001 randomly selected physiotherapists were invited to participate in the registration network. Those physiotherapists were a sample of all private physiotherapy practices as listed in a national database (Hingstman et al 2002). We aimed at a registration network of 40 practices. On the basis of a power calculation it was estimated that 40 practices supply sufficient data to detect a difference of two treatment sessions between two different clusters of patients with a proportion of at least 3.5% of the total patient population with 90% statistical power and a 5% significance level. Therapists could participate only if they used one out of two specified software programs in their practice. Physiotherapists with a homogeneous patient population (> 50% of the treatment episodes belonging to one patient category, for instance children) were not eligible. Twenty per cent of the invited therapists were willing and eligible for participation. Frequently mentioned reasons for not participating were ‘not enough time’ and ‘personal reasons’. In case of dropouts new physiotherapists were invited in a non-selective way. Since 2001 over 140 physiotherapists working in more than 60 practices have participated. Participants are offered a financial incentive. Furthermore on a yearly base they receive benchmark data.

For the current study, data of therapists who treated patients referred with non-specific low back pain during the period July 2002 to September 2003 were selected. This resulted in a group of 90 therapists in 40 practices; 23% of the 40 participating were solo practices, 59% of the 90 physiotherapists were male, 35% were aged 36 to 45 years and 39% were aged 46 to 55 years. Almost half the therapists had been in practice for 15 to 24 years. In the selected period an average of 31.4 patients with low back pain were treated per practice (range = 1 to 171). From comparisons with other available data, the participating practices, therapists, and collected data appear to be representative of The Netherlands (Dekker et al 1998, Hingstman et al 2001, Verheij et al 2002).

Patient population All patients aged 18 years or older referred with low back pain without X-ray diagnosis (ICPC-code L03.00; ICD10-code M54.5) between July 2002 and September 2003 were selected from the database (n = 1613). Data from these patients were collected until April 2004. Of a total of 1613 patients, 1486 had completed a treatment episode (92.1%). For 15% of the patients with a completed treatment episode the interventions were unknown and consequently the data of these patients were omitted; 1254 patients remained. Data from these patients have been used for the current study.

According to the Dutch Act ‘Regulations on medical research involving human subjects’ ethical approval is necessary for medical research in which persons are subjected to treatment or are required to behave in a certain manner. As this was not the case for the current study, ethical approval was not required. Nevertheless, the Dutch Data Protection Authority was notified of the research. In addition, pursuant to the Personal Data Protection Act data were collected anonymously, patients were informed about the research by posters and leaflets in practice waiting rooms, and patients had the opportunity to refuse participation.

Dutch physiotherapy guideline for the assessment and treatment of patients with low back pain In 2001 the physiotherapy guideline for the assessment and treatment of patients with non-specific low back pain was published in The Netherlands. The recommendations in this guideline were based on scientific evidence where available; otherwise they were based on consensus. The guideline recommends that the diagnostic process should focus on disability and participation problems resulting from back pain. The treatment should consist of an active approach, in which patients learn to take control of their back pain. The main treatment interventions are systematic patient education and exercise therapy aimed at improvement of functioning (Bekkering et al 2003). For patients with a normal course (in whom activities and participation gradually increase) reassurance, adequate information, and advice to stay active are the most important recommendations. One treatment session should be sufficient; if necessary a second appointment may be made. For patients with an abnormal course, in whom activities and participation do not improve, exercise therapy should be provided, with a behavioural approach if necessary. The guideline does not include a recommendation about the number of sessions in patients with an abnormal course (Bekkering et al 2003).

The implementation of the guideline consisted of dissemination to all members of the Royal Dutch Society for Physiotherapy, publication in Dutch journals, presentations at congresses and symposia, and education (Bekkering 2004).

Process criteria In a study aimed at evaluating the effects of

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