Clinical Justification: tools for the practitioner

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Clinical justification

The application of valid, reliable and objective tools at regular intervals to:

» assess change in functional status
» measure progress towards, and achievement of functional goals
» guide clinical decision making
» justify efficacy of continuing treatment
Functional outcome measures

Tools to assess the change in patient characteristics over time:

» **Acute Phase (4-8 weeks)**
  » assessment *(subjective and objective)*
  » functional outcome measures

» **Subacute Stage**
  » standardised outcome measures
  » customised outcome measures
Advantages of using Standardised Outcome Measures

» Assists shift of central focus of management from health professional to the patient

» Time efficient – assessment, report writing

» All stakeholders can observe and understand progress of a condition

» Provides valid and reliable data for measure of effectiveness
Clinical justification flow chart

ACUTE
- Have functional treatment goals been set?
- Are there baseline measures of client’s functional ability?
- Are functional outcome measures being used?

SUB ACUTE
- Are standardised outcome measures being used?

Yes
- Improving
  - Clinical justification
  - Continue with functional treatment goals

Deteriorating
- Option to cease physiotherapy or:
  - Review holistic plan and diagnosis
  - Refer for second opinion/multi-disciplinary review/new intervention

Stable
- Cease therapy
  - Voluntary patient review (4-6 weeks)
    - Did patient deteriorate?
      - Yes
        - MTB
        - Maintenance therapy
      - No
        - No proper clinical justification
        - Cease therapy
    - No
      - Discharge

No
- Are customised outcome measures being used?
  - Yes
    - Reasons justified with TAC Medical Panel
    - Clinical justification
    - Continue with functional treatment goals
  - No
    - No proper clinical justification
    - Cease therapy

* Please refer over for “Defining Concepts”.
A Clinical Justification Approach

- Use of at least two Standardised Outcome Measures
When outcome measures are improving

» Rehabilitation Phase of recovery
» Demonstrates a return to pre-injury status
» Plateauing of measures marks end of rehabilitation phase
When outcome measures are plateauing

» Consider working diagnosis
» Watch red flags/yellow flags
» Consider your own knowledge
» Assess patient compliance/understanding
» Consider placebo/dependence issues
Outcome measures deteriorating or remaining ‘high’
» Need for external review by other Health Professional
» Consider yellow flags
» Appropriateness of current treatment
» Suggestions for future management of condition
» Consider extent of TAC’s ongoing liability for treatment
A Clinical Justification Approach

Use of at least two Standardised Outcome Measures

Uncertain diagnosis and/or management

Review diagnosis and management

Correct diagnosis/management

Self-management focus

Improved or Unchanged

Rehabilitation

Attained pre-injury function

Cease therapy management

Improved

Unchanged or Deteriorated

Referral to other appropriate management
A Clinical Justification Approach

- Use of at least two Standardised Outcome Measures
  - Uncertain diagnosis and/or management
    - Review diagnosis and management
      - Correct diagnosis/management
        - Self-management focus
          - Measured Therapy Break (MTB)
            - Test therapy management
              - Improved or Unchanged
                - Cease therapy management
              - Deteriorated
                - Re-initiate therapy management
          - Regular review to monitor/justify therapy management
    - Unchanged or Deteriorated
      - Rehabilitation
        - Attained pre-injury function
  - Rehabilitated
    - Cease therapy management

Referral to other appropriate management
Why the Neanderthals Became Extinct

I don't know. It seemed easier when we just went hunting.

Yes, but Og assures me that this will improve our efficiency and keep us ahead of those Cro-Magnons in the valley.
Guide to selection and interpretation of Standardised Outcome Measures

» Designed as a quick guide to some commonly-used tests

Guide to selecting and interpreting standardised outcome measures: Orthopaedic conditions

<table>
<thead>
<tr>
<th>Scale</th>
<th>Also known as</th>
<th>What it measures</th>
<th>What it asks about</th>
<th>How it is scored</th>
<th>What a score means</th>
<th>What a change in score means (MDC)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Specific Functional Scale (Stratford et al)</td>
<td>PSFS</td>
<td>Disability in people with back, neck or knee problems</td>
<td>Difficulty with activities specified by each patient. Note: This questionnaire is administered by interview</td>
<td>Patient is asked to identify 3-5 activities and then to rate each on a 0-10 difficulty scale. Item scores can be averaged.</td>
<td>Possible score 0-10 Lower score means worse disability</td>
<td>MDC90 = 2 for averaged scores, 2.6 - 3 for single item scores (Chalmers et al. 1997; Stratford et al. 1999; Worrall et al. 1999)</td>
<td>May be useful for all patients, but only been tested in people with back, neck and knee problems.</td>
</tr>
<tr>
<td>Oswestry Disability Questionnaire (Fairbank et al. 1980)</td>
<td>ODI, ODQ</td>
<td>Disability in people with low back pain</td>
<td>Pain intensity, personal care (washing, dressing, etc.), lifting, walking, sitting, standing, sleeping, sex life (if applicable), social life, travelling. Modified versions: 1. Replaces &quot;full&quot; section with &quot;changing degree of pain&quot; (this version is not recommended). 2. Replaces &quot;full&quot; section with &quot;day-to-day living at home and homemaker&quot; (Fritz and Ingrams 2001)</td>
<td>Each section has 6 statements, which are scored 0,1,2,3,4,5. The section scores are summed, then divided by the total possible score (50 if all sections are scored by 100 and expressed as a percentage score.</td>
<td>Possible score 0-100 A higher score means worse function. 0-20% minimal disability 20-40% moderate disability 40-60% severe disability 60-100% housebound or bedbound (Fairbank et al. 1980) It is rare for an ambulatory, non-admitted patient to have a score exceeding 80%. Unexpected high scores may indicate the need for further assessment.</td>
<td>MDC90: 10% points (Davidson and Keating 2002)</td>
<td>The frequent references to pain may be undesirable in chronic pain patients when the aim is to help patients use QOL scores to determine indications for treatment.</td>
</tr>
<tr>
<td>Neck Disability Index (Vernon and Mor 1991)</td>
<td>NDIM</td>
<td>Disability in people with neck pain</td>
<td>Pain intensity. Personal care (washing, dressing, etc.), Lifting, Reading, Headaches, Concentration, Work, Driving, Sleeping, Recreation</td>
<td>Each section has 6 statements, which are scored 0,1,2,3,4,5. The section scores are summed. A percentage can be calculated as for the Oswestry.</td>
<td>Possible score 0-50 or 0-100 if transformed to a percentage A higher score means worse function.</td>
<td>MDC90: 5 points or 10% points (Stratford et al. 1999)</td>
<td>Has limited content relating to headaches.</td>
</tr>
</tbody>
</table>

1 Original classification by Fairbank et al (1980) was "crippled"
Application of outcome measures in clinical practice

» Select reliable and valid tools relevant to clinical diagnosis and functional goals

» Use more than one standardised outcome measure (where possible)

» Collect serial outcome measure scores at regular intervals and look for patterns over time

» Use results to educate and inform patients of functional status as part of regular reviews