



TAC

# 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:

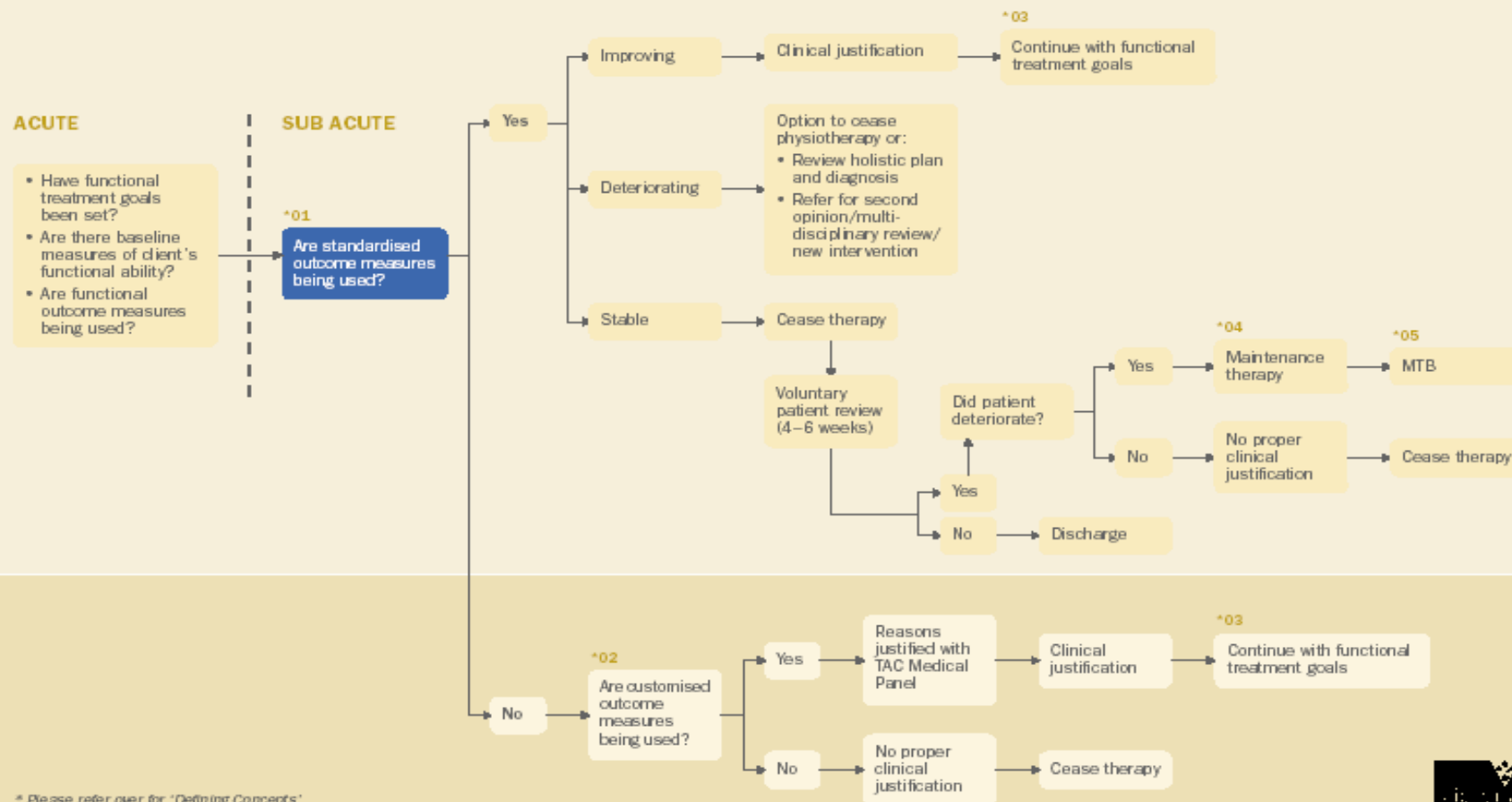
- » **Acute Phase (4-8 weeks)**
  - » assessment \* (subjective and objective)
  - » functional outcome measures
  
- » **Subacute Stage**
  - » standardised outcome measures
  - » customised outcome measures

## 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

## clinical justification flow chart



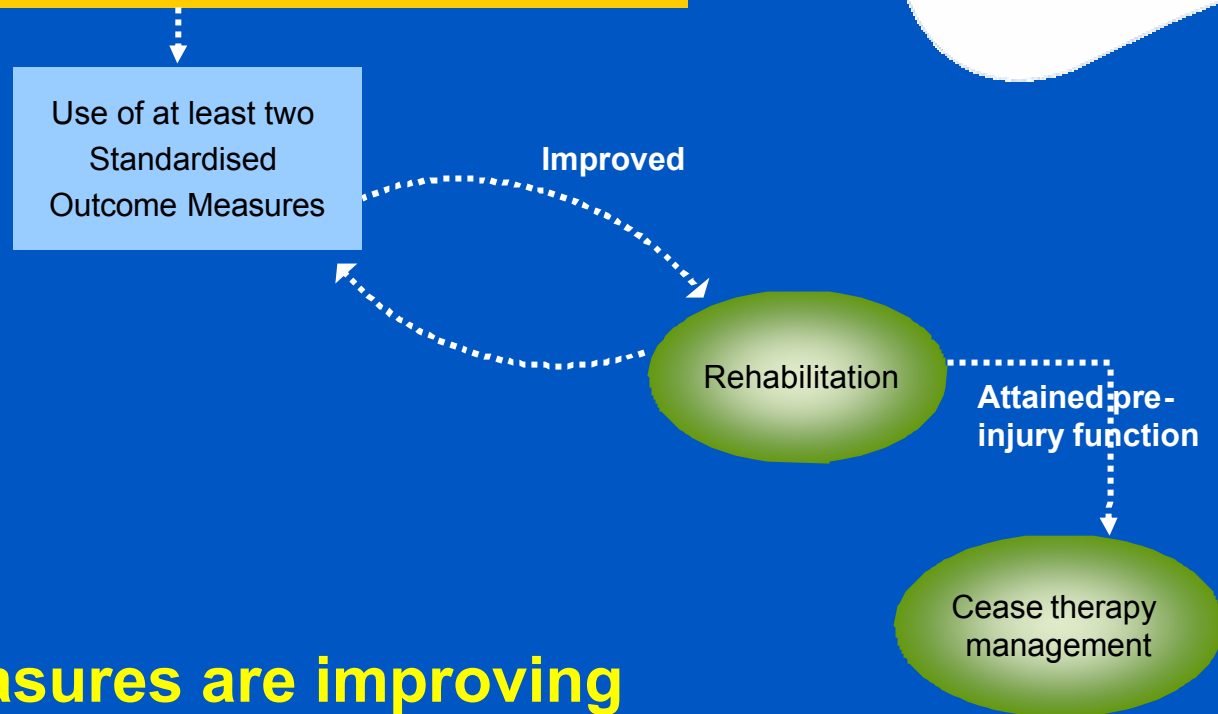
\* Please refer over for 'Defining Concepts'.



## A Clinical Justification Approach

Use of at least two  
Standardised  
Outcome Measures

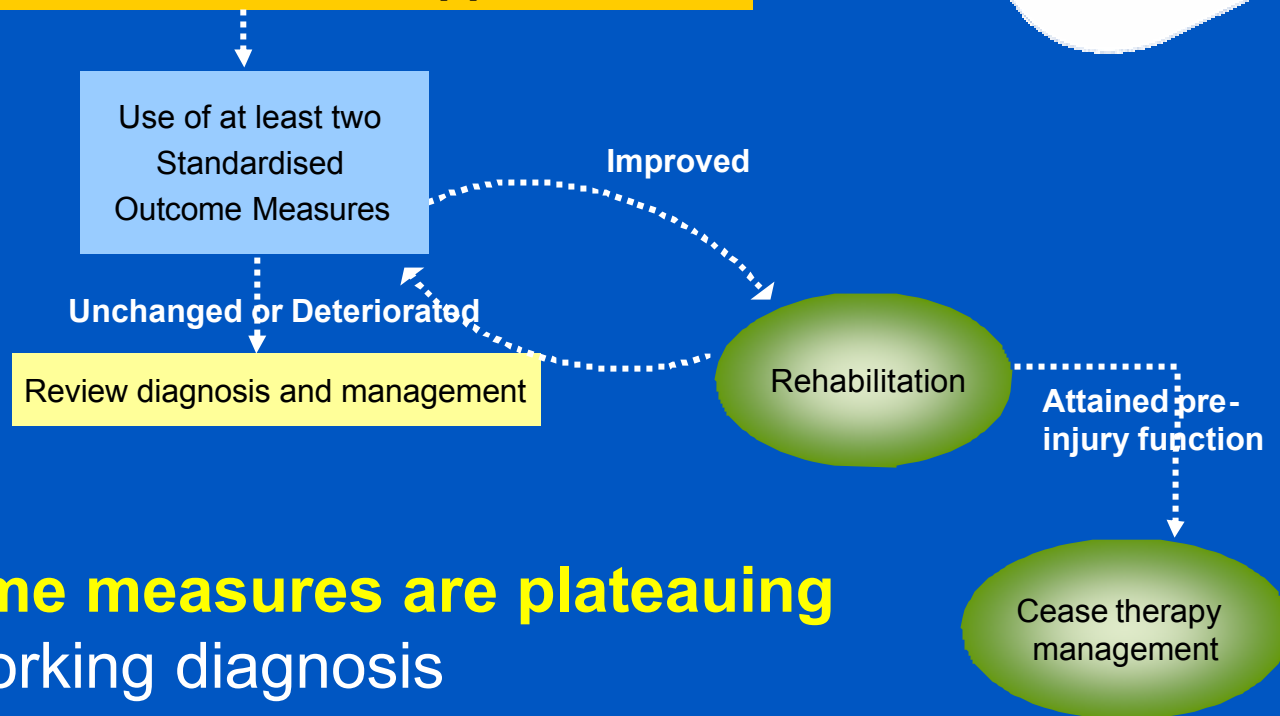
## A Clinical Justification Approach



### When outcome measures are improving

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

## A Clinical Justification Approach

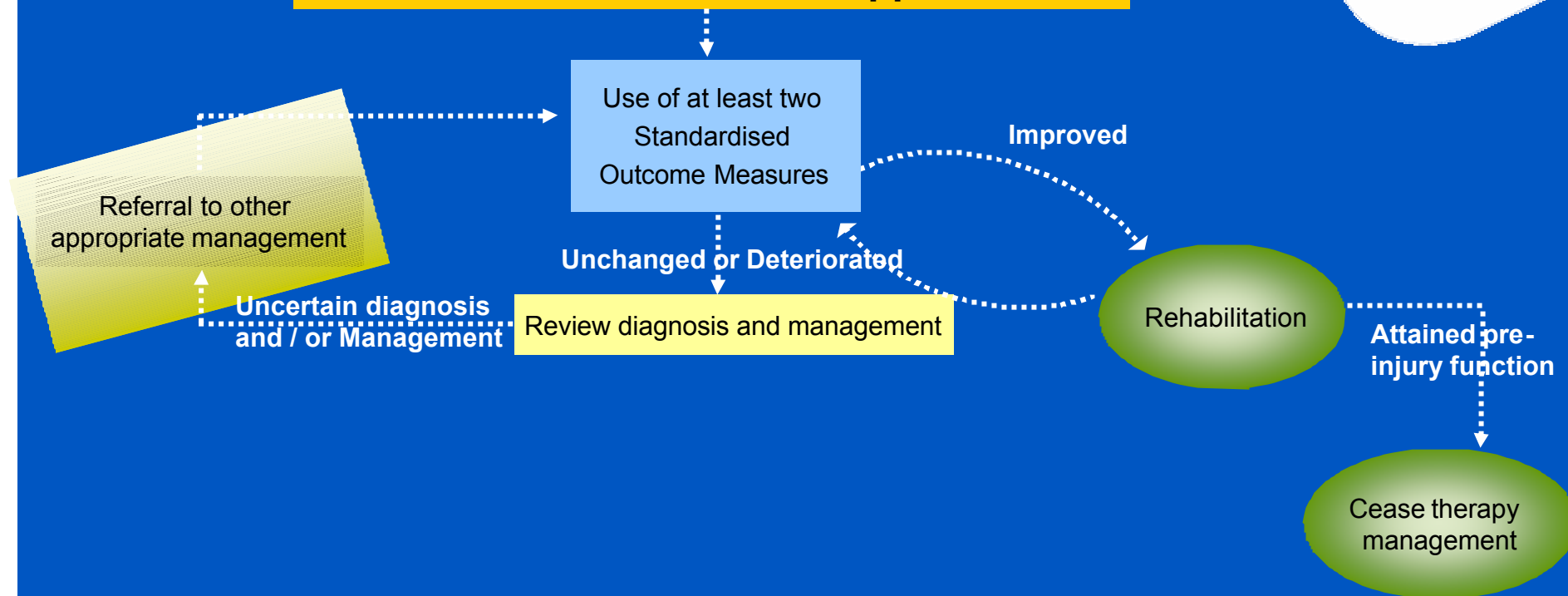


### When outcome measures are plateauing

- » Consider working diagnosis
- » Watch red flags/yellow flags
- » Consider your own knowledge
- » Assess patient compliance/understanding
- » Consider placebo/dependence issues



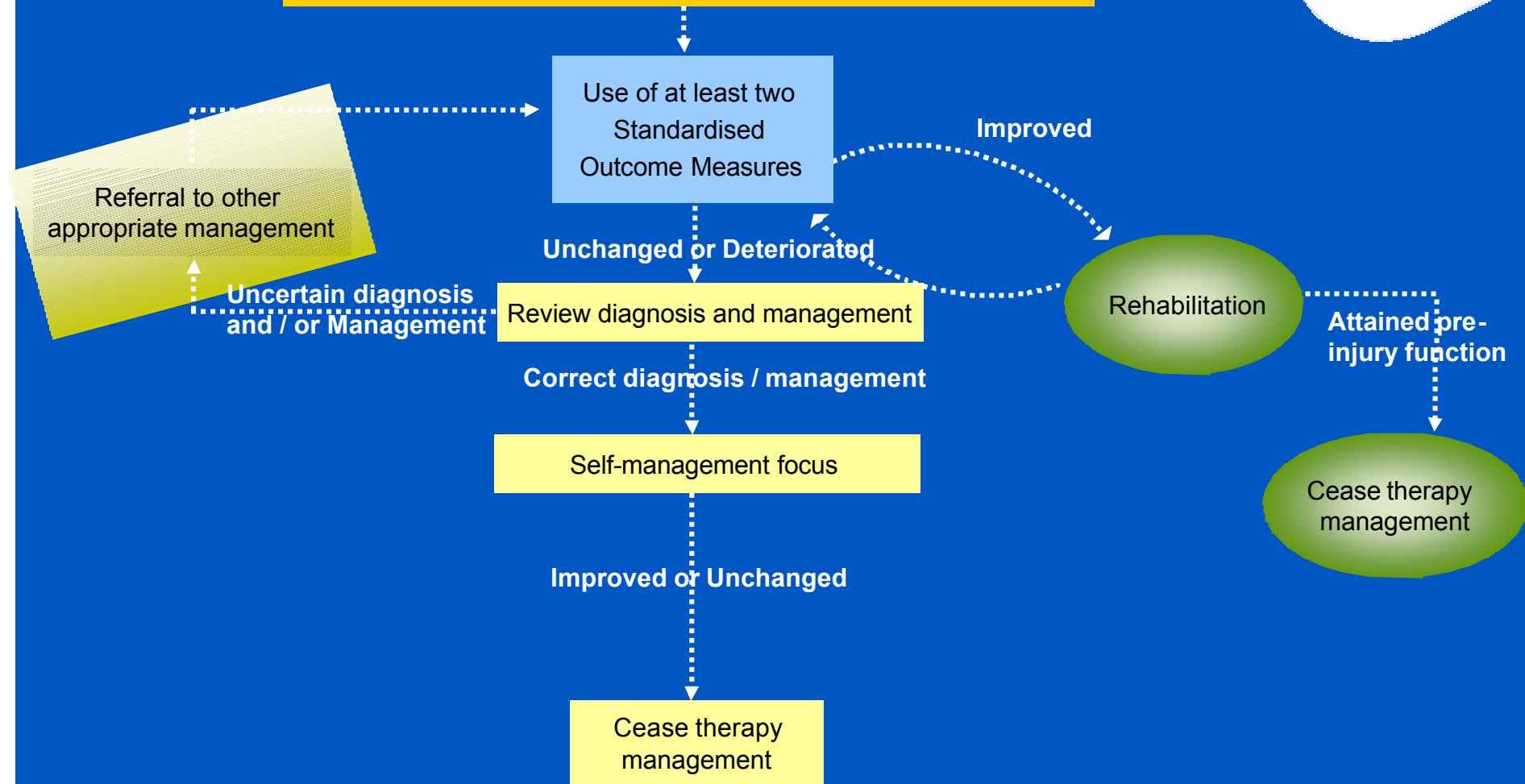
## A Clinical Justification Approach



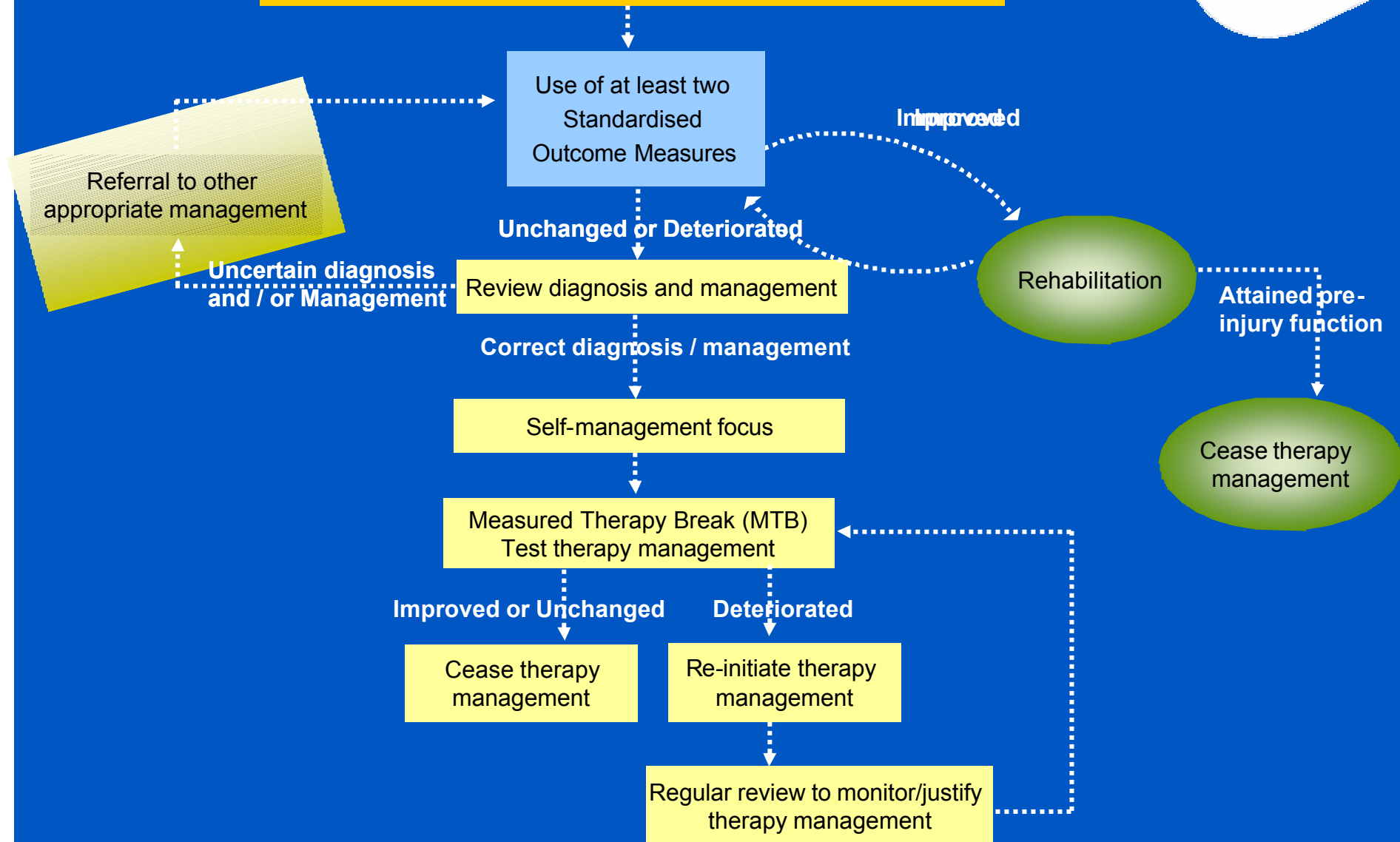
### Outcome measures deteriorating or remaining 'high'

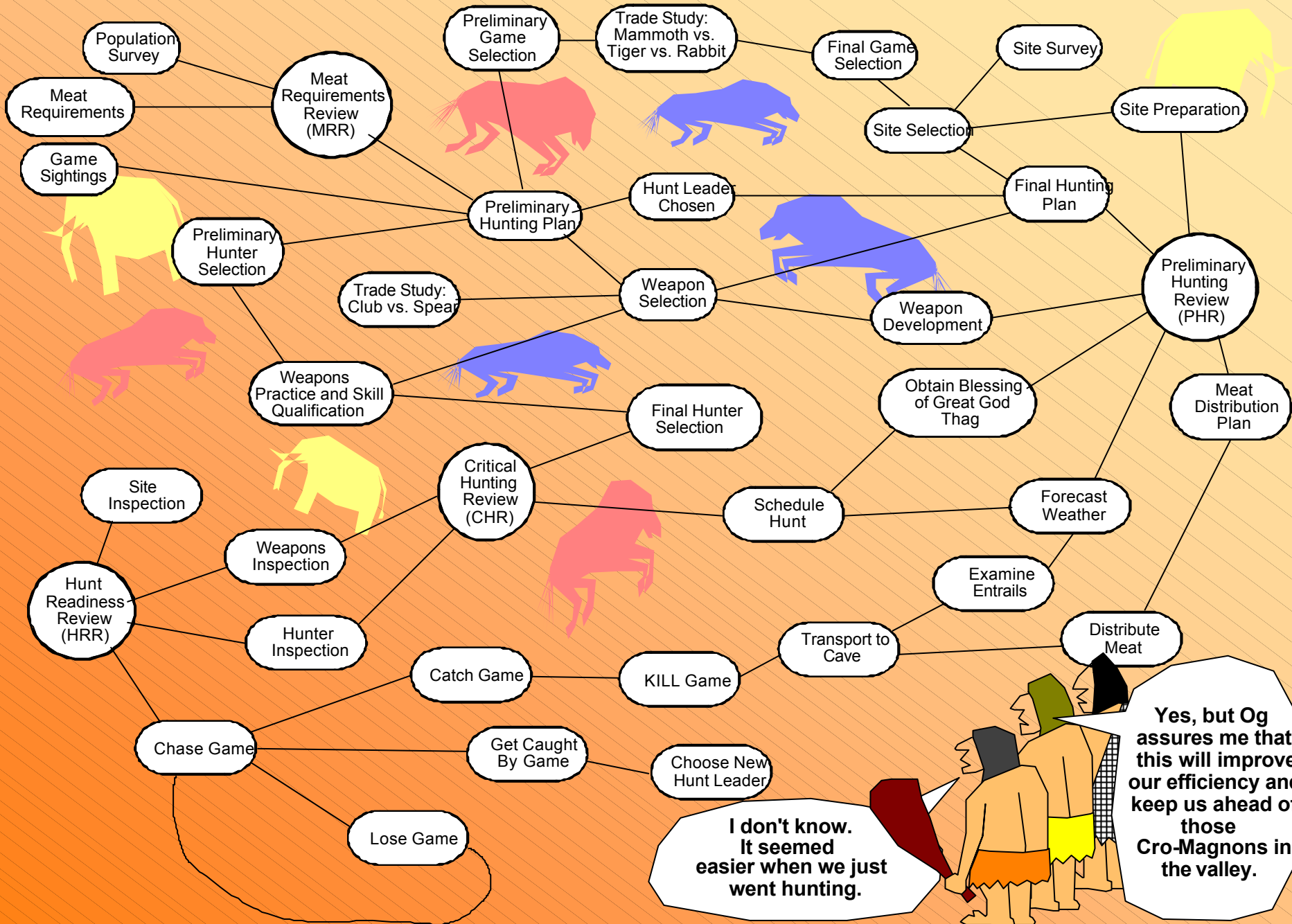
- » Need for external review by other Health Professional
- » Consider yellow flags
- » Appropriateness of current treatment
- » Suggestions for future management of condition
- » Consider extent of TAC's ongoing liability for treatment

# A Clinical Justification Approach



# A Clinical Justification Approach





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.

# Why the Neanderthals Became Extinct

# 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

Scale	Also known as	What it measures	What it asks about	How it is scored	What a score means	What a change in score means (MDC90)*	Comments
Patient-Specific Functional Scale (Stratford et al)	PSFS	Disability in people with back, neck or knee problems	Difficulty with activities specified by each patient  Note: This questionnaire is administered by interview	Patient is asked to identify 3-5 activities and then to rate each on a 0-10 difficulty scale. Item scores can be averaged.	Possible score 0-10 Lower score means worse disability	MDC90 1 – 2 for averaged scores, 2.5 – 3 for single item scores (Chatman et al. 1997; Stratford et al. 1995; Westaway et al. 1998)	May be useful for all patients, but has only been tested in people with back, neck and knee problems.
Oswestry Disability Questionnaire (Fairbank et al. 1980)	ODI, ODQ	Disability in people with low back pain	Pain intensity, personal care (washing, dressing, etc.), lifting, walking, sitting, standing, sleeping, sex life (if applicable), social life, travelling.  Modified versions: 1. Replaces "sex life" section with "changing degree of pain" (this version is not recommended) 2. Replaces "sex life" section with "employment/homemaking" (Fritz and Irgang 2001)	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 completed), then multiplied by 100 and expressed as a percentage score.	Possible score 0-100 A higher score means worse function. 0-20% minimal disability 20-40% moderate disability 40-60% severe disability 60-80% housebound <sup>1</sup> 80-100% bedbound or exaggerating (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.	MDC90 10% points (Davidson and Keating 2002)	The frequent references to pain may be undesirable in chronic pain patients when treatment programs aim to reduce the patient's focus on pain.  Does not measure ability to move between postures (eg get out of a chair), work or housework.
Neck Disability Index (Vernon and Mior 1991)	NDI, Mior Index	Disability in people with neck pain	Pain intensity, Personal care (washing, dressing, etc.), Lifting, Reading, Headaches, Concentration, Work, Driving, Sleeping, Recreation	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.	Possible score 0-50 or 0-100 if transformed to a percentage A higher score means worse function.	MDC <sub>90</sub> 5 points or 10% points (Stratford et al. 1999)	Has limited content relating to headaches.

<sup>1</sup> 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

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Victoria  
The Place To Be