

## Can routine outcome measurements be used to improve supervision of junior clinicians?

Dr Roderick McKay  
Braeside Hospital  
and  
Sydney South West Area Health Service

## Acknowledgments

- ◆ Work presented was developed during a 10 month project conducted by AMHOCN and funded by Australian Government
- ◆ In addition to myself the project team included Tim Coombs, Philip Burgess, Jane Pirkis, Joanne Christo & Angela Delle-Vergini

## Learning objectives

1. To provide understanding of the potential to use routine outcome measurements to improve supervision of junior mental health clinicians
2. To stimulate consideration of how routine outcome measurements may be used to improve clinical care in individuals own services

## Outline

- ◆ The presentation will explore
  - Defining a problem
  - An exploration of available tools
  - A process used
    - ◆ to determine if and how available tools could be used to address the problem
  - A provisional solution
  - Conclusions
- ◆ The overall *process* may be almost as important as the specific problem addressed

## Defining a problem

- ◆ 'How can routine outcome measures be made more clinically useful?' is an important policy or management question
  - But not an important clinical one
- ◆ Effective supervision of junior mental health staff is an important clinical problem
  - Therefore the question became
  - 'Can routine outcome measurements be used to improve supervision of junior clinicians?'

## Orientation to the goals of the DST clinical prompts

- ◆ Assist supervision of clinicians and provide linkages to evidence based practice
- ◆ Improve clinical understanding, and utility, of routine outcome measures
- ◆ Primary target group is junior clinicians
  - But not to forgetting the importance of consumers and carers being able to access such a resource

## What are the challenges?

- ◆ Size of the Evidence based literature
- ◆ Routine outcome measurement items based on symptoms/ functions; most Evidence Based guidelines based upon diagnostic groups
- ◆ The number of Routine outcome measurement items and number of potential combinations of advice to be provided
- ◆ Making advice relevant to clinicians within their existing workflows
- ◆ Clinician scepticism re Routine outcome measurement and Evidence based Medicine
- ◆ Offering simple advice that can be
  - relevant in different settings
  - meaningful, and
  - prompt consideration of the context

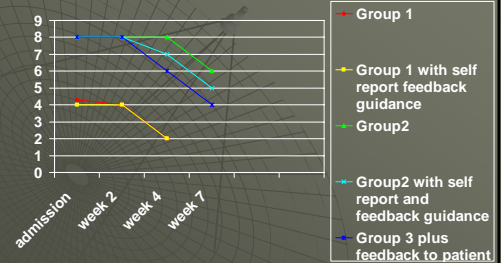
## Why attempt this?

- ◆ Known difficulties linking evidence base to actual practice
- ◆ Known difficulties in staff linking routine outcome measures into their practice
- ◆ Mental health workforce issues
- ◆ Known limitations to access to supervision in some areas of public mental health practice

## Reasons for believing the project could have benefits

- One additional way to disseminate Evidence Based Guidelines
- Has potential to be linked (in future) to electronic systems, and so 'closer' to clinical workflow
- Gives some additional context for junior clinicians to interpret outcome measures within
- Provides a context for carers/consumers to interpret their outcome measures within
- M Lambert work

Michael Lambert workshop on self report measure use



## An exploration of available tools

- ◆ What are aspects of clinical supervision
- ◆ Which aspects may be assisted by tools
- ◆ What tools are potentially available?
  - Routine outcome measures
  - AMHOCN Decision Support Tool
  - Evidence Based Guidelines
  - Literature regarding electronic decision support
  - Expert opinion

Can the routine outcome measures communicate useful information regarding the need for supervision?

Which consumer should a junior clinician discuss first with a senior clinician?

- ◆ Patient A with schizophrenia HoNOS total score 20?
- ◆ Patient B with schizophrenia HoNOS Score 20?

.....and what issues should be discussed?

## HoNOS for communication

What is likely to be the significance of consumers scoring 3 or 4 in only the following items?

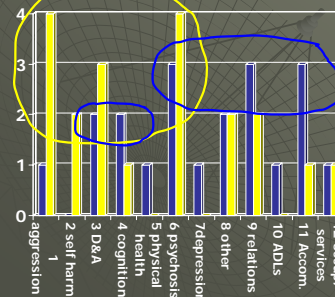
- ◆ 7 (depression),
- ◆ 2 (self harm), 7 (depression)
- ◆ 2 (self harm), 7 (depression), 5 (physical illness)
- ◆ 2 (self harm), 7 (depression), 4 (cognition), 5 (physical illness)
- ◆ 1 (aggression), 4 (cognition), 10 (ADLs)

Please rank the following scenarios in order of clinical risk

The following scenarios list the HoNOS items that have scores of 3 or 4

	HoNOS item	HoNOS score	setting
1	7 (depression)	4	Inpatient admission
2	2 (self harm) 7(depression)	3 4	Inpatient admission
3	2 (self harm) 7(depression)	3 4	Community admission
4	7 (depression)	4	Community admission

Which consumer should a junior clinician discuss first with a senior clinician?



.....and what issues should be discussed?

## A process used

- ◆ Initial over-arching principles developed
- ◆ Iterative process involving
  - Literature review
  - Identification of relevant web accessible, evidence based guidelines
  - Expert clinical panels
  - Development of a logic structure
  - Drafting of prompts

## The over-riding principles

- ◆ The over-riding principles for the development of prompts were that they should consider:
  - Potential clinical risks, both short and long term, but with the former given particular attention
  - Frequency with which such a score is expected to occur in that clinical setting
  - Known clinical context
  - Relevant evidence base for action.
- ◆ These factors should guide actions, particularly:
  - Urgency of seeking supervision from a more senior clinician
  - Key actions or assessments related to short term risk
  - Utilising all available information for appropriate care planning
  - Reviewing relevant evidence based guidelines.
- ◆ Prompts should also take into consideration:
  - Decisions and actions that are under the control of a junior clinician
  - Known high prevalence of co-morbid diagnoses and clinical problems in consumers with mental illness
  - The number of prompts that it is likely that a clinician or consumer can effectively attend to.

## Prompt Sets

- ◆ Links to a broad range of Evidence Based Guidelines that may relate to multiple conditions and NOCC measures
- ◆ Links to **specific Evidence Based Guidelines**, or resources, relevant to specific measures or items on measures
- ◆ An **'alert' prompt** that is related to the potential clinical significance of the item, particularly considering the potential for the item score to be associated with significant, particularly short term, clinical risk.
- ◆ **Other NOCC measures or items** likely to be particularly relevant to understanding the clinical context
- ◆ Advice on the **urgency of seeking supervision** from a senior colleague
- ◆ Brief advice regarding **key clinical issues related to clinical risk management** that are specific to the item being measured and its score
- ◆ Additional advice relevant to the item in most situations
- ◆ **General advice regarding how to link score on the NOCC measures to care planning.**

## Key dividing factors

In decreasing order of importance

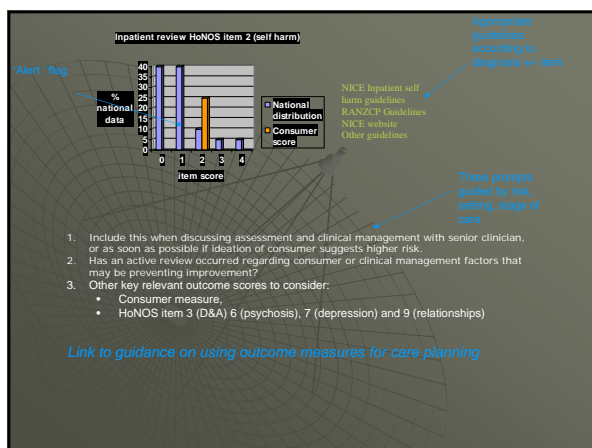
- ◆ age group of the consumer
- ◆ clinical setting,
- ◆ stage of clinical care (NOCC 'Collection occasion')
- ◆ Provisional diagnosis of the consumer
- ◆ Advice was only divided by a factor when considered to be clinically significant

## A provisional solution

- ◆ Prompts could be developed linked to NOCC individual items scores and total scores
- ◆ A logic framework could be developed with key dividing factors
- ◆ General principles for prioritising information from routine outcome measures in care planning could be developed

## 'Alert' flags

- ◆ *General* rule that HoNOS 0/1 low alert, 2/3/4 significant or moderate risk
  - additional category/flag for 're-evaluate score or assessment' for scores that have high likelihood of being incorrect- eg Psychosis item 0/1 on admission to inpatient care with diagnosis of schizophrenia
- ◆ Reviewed by
  - setting
  - collection occasion
  - HoNOS and other rating scale items



## General guidance for using outcome measures at inpatient review

1. If there are significant scores on HoNOS items 1, 2, 4, 5; or Consumer self report self harm items; ensure clinical management includes actions to maximize immediate safety whilst addressing underlying issues
2. Review the changes in ratings on measures and implications for clinical management plans; especially for any rating scale scores that have increased since last scored, and consider if any of these may represent side effects of treatment
3. Review the goals of admission, criteria for discharge, and measures used to monitor these; both within the treating team and with the consumer and/or carer.
4. Ensure the need for changes in clinical management is considered regarding all HoNOS or LSP items scoring 2 or more
5. Ensure the need for specific actions is considered regarding issues reported by consumer self report
6. Consider the implications of agreement and/or conflict between ratings of similar issues on different scales (esp. clinician vs consumer rated).
7. Consider the impact of interactions between items scoring as significant (eg a score of 4 on HoNOS item 3 may increase concerns regarding a score of 3 on item 2)

## Conclusions

- ◆ It is feasible to develop a logic structure and library to link simple clinically relevant advice to total and individual item scores of measures used for routine outcome measurement in Australia.
- ◆ This is the start of a developmental road
- ◆ The processes used are applicable more broadly to 'improving the utility of routine outcome measurement'
  - Define the problem
  - Identify potential tools
  - Explore which aspects of the tools are applicable to the problem, who needs to use them and when, and how the tools must be connected to the problem
    - ◆ Involve both clinicians and 'outcomes' people in this process
  - Develop a provisional solution
  - GIVE IT A GO!
  - Evaluate and refine