A journey continues using outcome measures in mental health services for older people

..or the conversion of a compliant sceptic

15th July 2010

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Acknowledgements

- Routine Outcome Measurement is a team activity and none of the work I will present could have been developed without the support of those I have worked with at Braeside Hospital, in the Sydney South West Area Mental Health Service and from InforMH, NSW Health

Outline

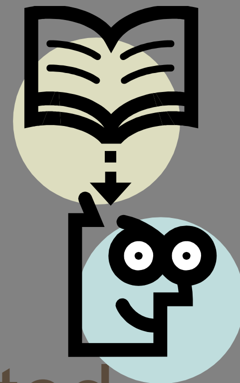
- Towards a consistent framework for using outcome measurement
- A personal and service journey

Goals

- Inform
- Provide a rapid overview of different ways to use outcome measures
- Encourage that believing outcome measurement can be helpful doesn't have to mean hopeless naivety or idealism
- **Inspire action**

A Personal Journey

- How does a (compliant) sceptic become convinced that mental health care would be significantly worse off without routine outcome measurement?



- Can you become a converted compliant sceptic?

A service journey

Braeside challenge

- Outer metropolitan older persons' mental health service
- No academic support
- Collecting ALOT of data
- Using little of it (and nothing from outcomes)
- Expected to collect MORE data
- Finite resources
- A desire to move to more consistent evidence based practice
- Great reluctance to collect more data without a system to use it
  - management support

A service journey…

Braeside currently

- Outcomes never out of site, even if not always focussed upon
- Expecting
  - 100% compliance with inpatient and community outcome measures
  - Elements of outcome measures being available at all case conferences
  - And used in care plan formation and monitoring
  - Outcome measures to be used in analysing and improving service performance
  - ***…further improvement*** ;
    - because we don't always meet out expectations
    - because the environment we work in keeps changing

framework for using routine outcome measurement

From my journey I suggest routine outcome measurement can….

- **Model or represent key aspects of a consumer, or groups of consumers**
  - From different perspectives- no absolute truth
  - At a point in time or changes between time periods
- **Operationalise expert pattern recognition and judgement for different purposes**
  - to guide junior clinicians
  - to standardise practice- eg policy and procedure
  - to model to test and improve expert practice

Suggest routine outcome measurement can..

- **facilitate targeted case finding e.g.**
  - as team leader/ supervisor
  - as a clinician with medical records
- **Improve assessment comprehensiveness and reliability**
  - directly,
  - Indirectly through communication and practice change
- **Improve communication**
  - in person
  - between people not in direct contact (e.g. follow up provider)
  - over time (e.g. between different admissions)

But this requires clear expectations of all participants…

(with acknowledgements to the SSWAMHS Information Reporting Framework)

To fill these responsibilities senior clinicians must know how to….

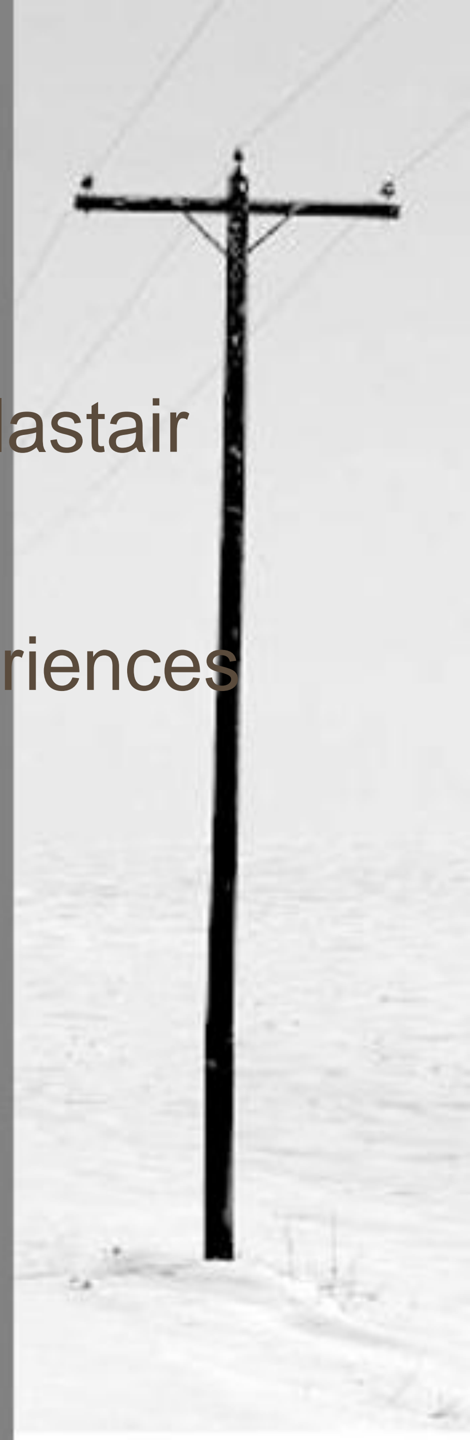
- complete, or assist consumers complete, all relevant measures
- use relevant information systems
- interpret measures
- apply relevant aspects of the measures to practice in their team

How did my journey lead to these conclusions?

- Science research honours
- Strong belief in 'evidence based practice'
- 1999
  - New Director of a Aged Care Psychiatry service
    - 'Have a new system starting that will be used to fund us in the future'
  - Initial training in HoNOS
  - Service started collecting inpatient HoNOS data (but never used it)
  - 'State Steering committee'
    - 'See how we can stop this nonsense'

A bumpy ride

- 2000: Opportunistic contact with Prof Alastair Macdonald (UK)
  - An inkling there may be possibilities
- Very negative about my Australian experiences



Learning and inactivity

- 2003 last person to step back for the national Older Persons Mental Health Outcomes Expert Group
  - Not alone
- Aware that they should be able to help 'somehow'
- Staff kept collecting
- Nothing ever retrieved from 'the system'

Slow illumination

- A clinical partner!
- Move from ideas to action with data in general
- Able to try some ideas regarding outcomes

Breakthrough

- ‘Focus’ or ‘Key’ item identified in care plans
- ie started identifying the HoNOS 65+ item that was seen as the main reason a person is receiving care
  - At this time
  - By this service
  - In this setting

  or

  - ‘What is the main clinical issue we need to change?’

One part: Case Conference

Inpatient case conference — Date

Bed Number	Name	Admission HoNOS65	Key item number	Key item score Adm	score key item this week	DRS tool completed	Admission K10	Admission Date	Estimated LOS	Current LOS	Est. date of Discharge	Legal status	Expiry order	MRN	Age	Sex	Sector	Consultant	Care Coordinator	Provisional Diagnosis	Language status (IN THIS ADMISSION)	Physical <48hrs	physical aggression	Fall	Attempted suicide	readmission <28 days	comm. contact<7 days	admitted from	usual residence	SM1 due	SNAP review due
1		30	6	4	3	Y	N/A		60	89		Vol			65	F		CJ	PB	20.01	E	Y	Y	N	N	N	N/A	Wa	N		
2		17	7	4	2	Y	N/A		28	75		Vol			74	F		UB	Nil	05.80	E	Y	N	N	N	N	N	Wa	T		
3		12	7	3	2	Y	N/A		28	50		Vol			67	F		CJ	Nil	32.30	I	Y	N	N	N	N	N	Wa	T		
4																															
5		21	1	1	3	Y	N/A		20	21		Vol			73	F		UB	Nil	01.90	I	Y	N	N	N	N	N/A	Wa	N		
6		12	1	3	2	Y	N/A		60	109		Invol	GT - medical		74	F		UB	Nil	02.00	E	Y	Y	N	N	N	N/A	Z	T		
7		23	1	2	3	Y	N/A		20	27		Vol			57	F		KC	Nil	00.00	E	Y	N	N	N	N	N/A	Wa	H		
8		30	1	3	3	Y	N/A		20	12		Vol			63	M		KC	RT	06.90	E	Y	N	N	N	N	N/A	N	N		
9		25	7	4	2	Y	N/A		60	20		Vol			66	M		KC	Nil	32.20	E	Y	N	N	N	N	N/A	T	T		
10		22	1	3	2	Y	N/A		20	61		Vol			75	M		KC	Nil	02.80	I	Y	Y	N	N	N	N/A	N	N		
11		20	1	3	2	Y	N/A		28	237		Vol			66	M		CJ	Nil.	32.20	E	Y	N	N	N	N	NA	N	T		
12		16	8	3	2	Y	N/A		60	13		Vol			67	F		CJ	Nil	32.20	I	Y	N	N	N	N	N/A	T	T		
13		10	7	3	1	Y	N/A		60	89		Vol			75	M		UB	Nil	32.11	E	Y	N	N	N	N	N/A	Wa	N		
14		20	6	3	2	Y	N/A		60	55		Invol	TPO 26/12/07		71	F		UB	Nil	20.09	E	Y	N	N	N	N	N/A	Wa	T		
15		12	6	3	2	Y	N/A		60	11		Vol			83	F		UB	Nil	01.00	E	Y	N	N	N	N	N/A	Wa	T		
16		12	6	2	2	Y	N/A		20	33		Vol			78	M		CJ	Nil	05.10	E	Y	N	N	N	N	N/A	N	N		
		DRS Completed				100%			Est. LOS	39.8		No. (Invol)				M					I	Y	Y	Y	Y	Y	Y		Home		
TOTAL									Av. LOS	60.1		2				6					4	15	3	0	0	0	0		8		
																											2				

beds occupied	15
Fairfield	6
Liverpool	4
Macarthur	3
Wingecarribee	1

		Av Total HoNOS 65	
Av Age	70	19	

Item 1	6
Item 6	3
item 7	4

Location: (N)ursing Home (H)ostel (T)ownhouse/House/Unit Other Hospital (Wa)rd (G)eriatric Ward (A)dult or older Persons MH Ward (E)mergency Department (Z) Other

Sector (F)airfield, **(L)**iverpool, **(M)**acarthur, **(W)**ingeacrribee, **(E)**astern Zone SSWAHS, (Z) O)ther

Language Status (E)nglish **(I)**nterpreter essential (unable to effectively communicate without) , Interpreter **(P)**referable Interpreter ('conversational' English, limitations apparent) **(D)**esirable (good English but patient's preference)

Other Agencies: (L)MO **(C)**OPMH Community Team (M) Adult MH Community Team (Q)ACAT **(Pa)**tient Carer/**(F)**amily **(P)**rivate psychiatrist **(Z)**Other

A service 'snapshot'

Bed Number	Name	Admission H	Key item nu	Key item sco	score key ite	DRS tool co	Admission K	Admission D	Estimated L	Current LOS	Est. date of I	Legal status	Expiry order	MRN	Age	Sex	Sector	Consultant	Care Coordi	Provisional I	Language st	Physical <48	physical agg	Fall	Attempted s	readmission	comm. conta	admitted fro	usual reside	SM1 due	SNAP review
1																															
2																															
3																															
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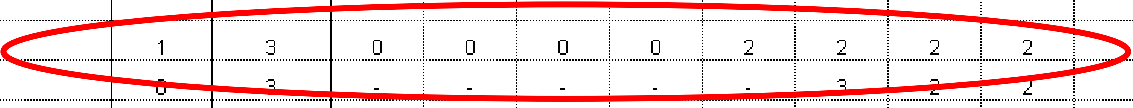
15																															
16																															
		DRS Completed				100%			Est. LOS	39.8		No. (Invol)				M					I	Y	Y	Y	Y	Y	Y		Home		
TOTAL									Av. LOS	60.1		2				6					4	15	3	0	0	0	0		8		
																											2				

beds occupied	15		Av Total HoNOS 65	Item 1	6
Fairfield	6	Av Age 70	19	Item 6	3
Liverpool	4			item 7	4
Macarthur	3				

Highlighting consumers who may benefit from focussed review: Weekly Key Item Score

ACP Key HoNOS65+ Item Score

Bed No	Obs	Pt Name	Key Item	Adm Score	4-Sep	11-Sep	18-Sep	25-Sep	2-Oct	9-Oct	16-Oct	23-Oct	30-Oct	6-Nov	13-Nov
1	2(30)		6	4	4	3	3	3	3	3	3	3			
2	2(60)		7	4	2	2	2	2	2	2	2	2			
3	3AR		7	3	3	1	1	2	2	2	2	2			
4	2(30)		1	3	-	-	-	-	-	-	-	3			
5	2(30)		11	3	-	-	-	-	-	3	3	3			
6	2(60)		1	3	2	1	2	2	3	3	2	2			
7	2(15)		1	2	-	-	-	2	2	3	3	3			
8	2(15)		1	3	-	-	-	-	-	3	3	3			
9	2(60)		7	2	-	-	-	-	-	-	-	2			
10															
11	3B		1	3	0	0	0	0	2	2	2	2			
12	2(60)		8	3	-	-	-	-	-	3	2	2			
13	2(30)		7	3	2	1	1	1	1	1	1	1			
14	2(60)		6	3	3	2	2	2	2	2	2	2			
15	2(60)		6	3	-	-	-	-	-	3	2	2			
16	2(60)		6	2	-	-	2	2	2	2	2	2			



HoNOS65+

1. Overactive, aggressive, disruptive or agitated
2. Non-accidental self injury
3. Problem drinking or drug taking
4. Cognitive problems
5. Physical illness or disbaility problems
6. Problems with hallucinations and delusions
7. Problems with Depressed mood
8. Other mental and behavioural problems
9. Problems with relationships
10. Problems with activities of daily living
11. Problems with living conditions
12. Problems with occupation and aactivities

HoNOS65+ 8. Other Mental and behavioural problems

A phobic, **B** anxiety, **C** Obsessive-compulsive, **D** stress, **E** dissociative, **F** somatoform, **G** eating, **H** sleep, **I** sexual, **J** other - specify

Consumer perspective

- Also use K10 up to weekly to monitor progress for selected patients

Conversion

- Made clinical sense to me and others
- Assisted care planning
- Assisted focus at case reviews
  - Are we really getting anywhere?
  - Should we still be involved?
- Assisted communication
  - With time
  - Between staff
  - Between nursing staff and inpatient case conferences

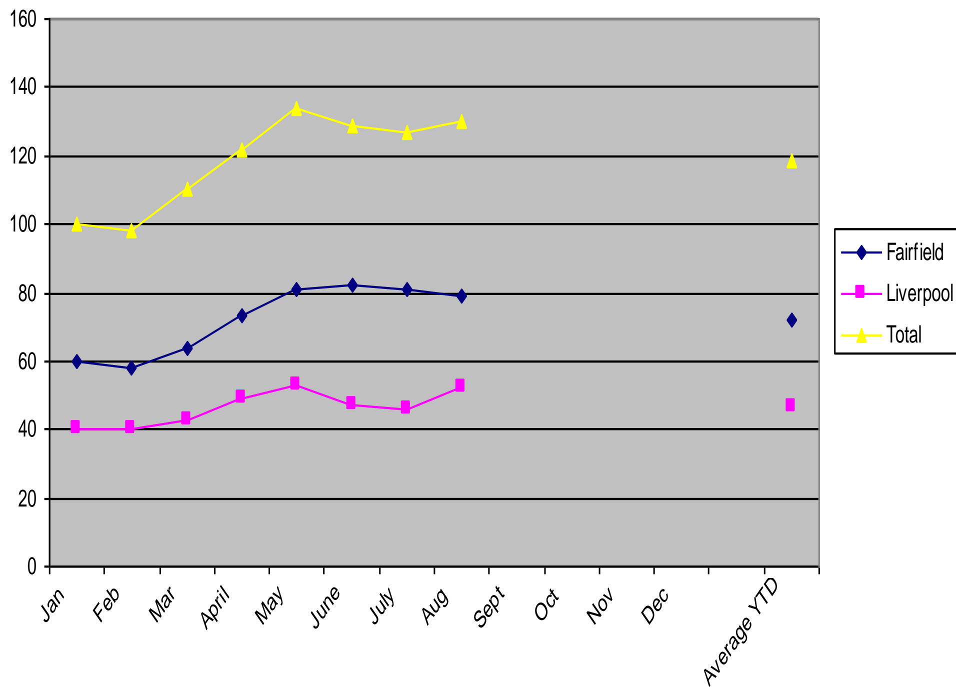
Conversion

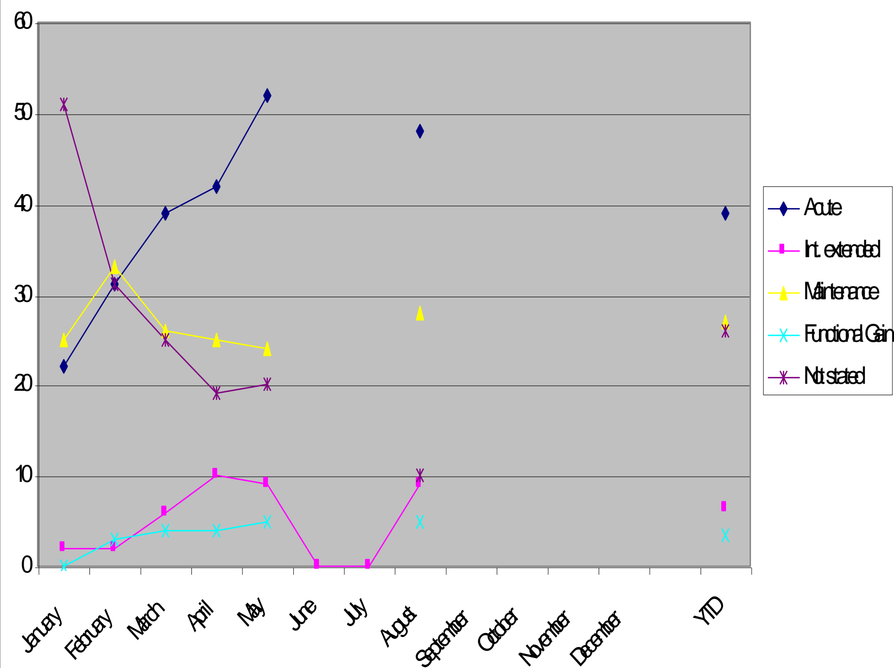
- Looked at Collated data with other data
  - Really told me things about the service I didn't know
  - Could relate numbers to 'real patients'
- Improved understanding of patients seen by the service and how this influences our care

Learning how to use outcome measurement to improve service functioning

- Exploring length of stay
  - A journey from
    - Challenge, to
    - Understanding, to
    - Action

Challenge: major increase in inpatient length of stay with community team under increased pressure





Initial understanding: Changing inpatient clinical problems

Distribution admission HoNOS 65 key item at case conference

%

50
45
40
35
30
25
20
15
10
5
0

Jan
Feb
Mar
April
May
June
July
Aug
Sept
Oct
Nov
Dec
Average % Year to da

Aggression/overactivity
Series4
Psychosis
Depression

Initial understanding: Changing inpatient consumer supports

HoNOS profile current inpatients

Percentage scoring 2 or mo

100
90
80
70
60
50
40
30
20
10
0

Jan Feb March April May June July Aug Sept Oct Nov Dec YTD

Psychosis
Depression
Accommodation
Occupation/activities

Action: Impact on response

- Increasing management support for aggression training
- Security staff roles revised and clarified
- Duress system installed
- Reviewed social worker resources and sought funds to increase these
  - And received them (eventually)

Improving understanding

- National and state benchmarking highlighted how changed length of stay compared with other services
  - But also identified differences in consumer populations and service characteristics that may contribute
- Participating helped to understand how to interpret outcomes and related data

Are teams seeing consumers with similar problems?

- Using HoNOS 65+ (Routine Outcome Measure) to understand clinical profiles of consumers within teams

48

Average HoNOS65 scores by Item - Group vs National Avg.
2006-07 data

2.0
1.5
1.0
0.5
0.0

Group Avg.
Nat. Avg.

Behav/Dist
Self-injury
Alc/Drug
Cognitive
Physical
Hallucinations
Depressed
Other psych
Relationships
ADLS
Living Condn
Occupation

Extract from national older persons mental health benchmarking Workbook prepared by AMHOCN

Learning from benchmarking:
What practice is the norm and are there an ‘outliers’?

Are there have differences in practice in **different services**?

Depression HoNOS65 Scores at Discharge for 06/07 Patients Admitted with Significant Scores

	Bar 1	Bar 2	Bar 3	Bar 4	Bar 5	Bar 6	Bar 7	Bar 8
Not Significant	27	33	5	35	28	52	8	188
Still Significant	9	45	8	12	11	9	11	105

0% 20% 40% 60% 80% 100%

paired HoNOS Records
N.B.All admissions & discharges in FY06/07

N=424

Data extracted, analysed and presented by InforMH as part of NSW SMHSOP benchmarking forums

Learning from benchmarking:

How does any one team address different problems ?

(Remembering care occurs across different settings)

Braeside OPMH Unit - still significant scores at discharge for patients rated significant at admission (FY06/07; n=118)

	Still significant 3,4	Still significant =2	Not significant
Agressions	15	16	45
Self Harm	0		11
Drug/Alcohol	0		7
Cognition	42	22	16
Physical Health	35	26	14
Hallucinate/ Delusions	17	14	38
Depression	30	15	33
Other	37	22	43
Relations	14	15	26
ADL	47	13	18
Living Conditions	11	5	30
Occupation	20	17	26

Y-axis: 0%, 20%, 40%, 60%, 80%, 100%

Data extracted, analysed and presented by InforMH as part of NSW SMHSOP benchmarking forums

Impact on response

- Increasing awareness of the importance of the problem
- But limited changes in clinical practice
  - Concern that did not disadvantage consumers through discharge ‘too early’ or inappropriate residential care placement
  - And only slow changes in length of stay

Learnt of other work

- British RCT of providing feedback on outcome measurements to clinicians
  - No change in clinical status at end of trial
  - Marked reduction in inpatient bed utilisation

Slade et al Br J Psych 2006 *Use of Standardised Outcome Measures in adult Mental health Services*

Michael Lambert workshop on self report measure use showing improved consumer outcomes with feedback

9
8
7
6
5
4
3
2
1
0

admission
week 2
week 4
week 7

Group 1
Group 1 with self report feedback guidance
Group2
Group2 with self report and feedback guidance
Group 3 plus feedback to patient

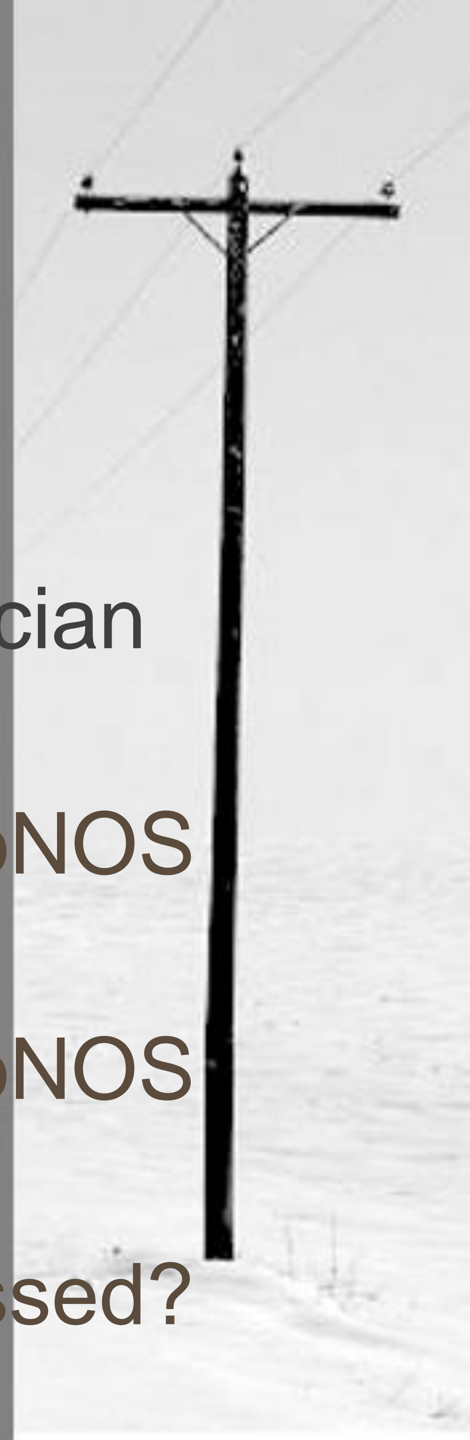
National Clinical Prompts Project: can the outcome measures communicate meaningful information?

Example of the core challenge

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

- Consumer A with schizophrenia HoNOS total score 20?
- Consumer B with schizophrenia HoNOS Score 20?

…..and what issues should be discussed?



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

4
3
2
1
0

1 aggression
2 self harm
3 D&A
4 cognition
5 physical health
6 psychosis
7depression
8 other
9 relations
10 ADLs
11 Accom.
12 occup/ services

Consumer A
Consumer B

……and what issues should be discussed?

Further service understanding

- Used case conference tables to analyse 2 years of admissions to determine influences upon length of stay and guide further action

- Conclusions
  - …..
  - **A relatively few ‘outliers’ were impacting on the mean LOS**
    - Could we identify factors contributing to this?

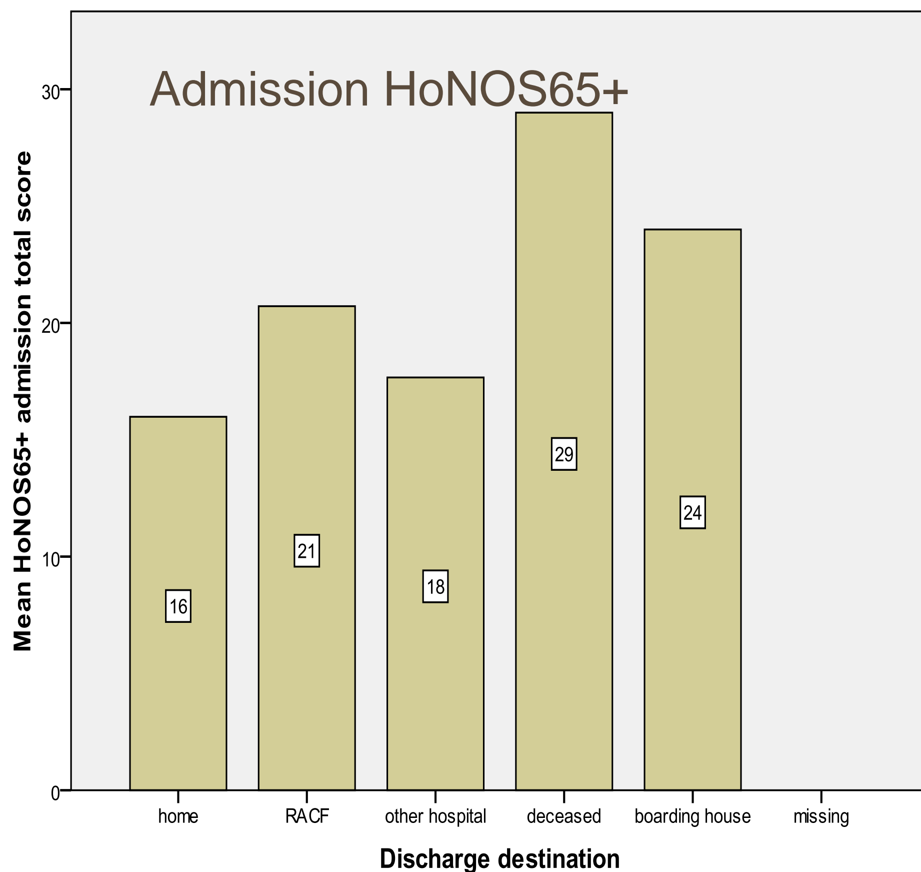
Further understanding (continued)

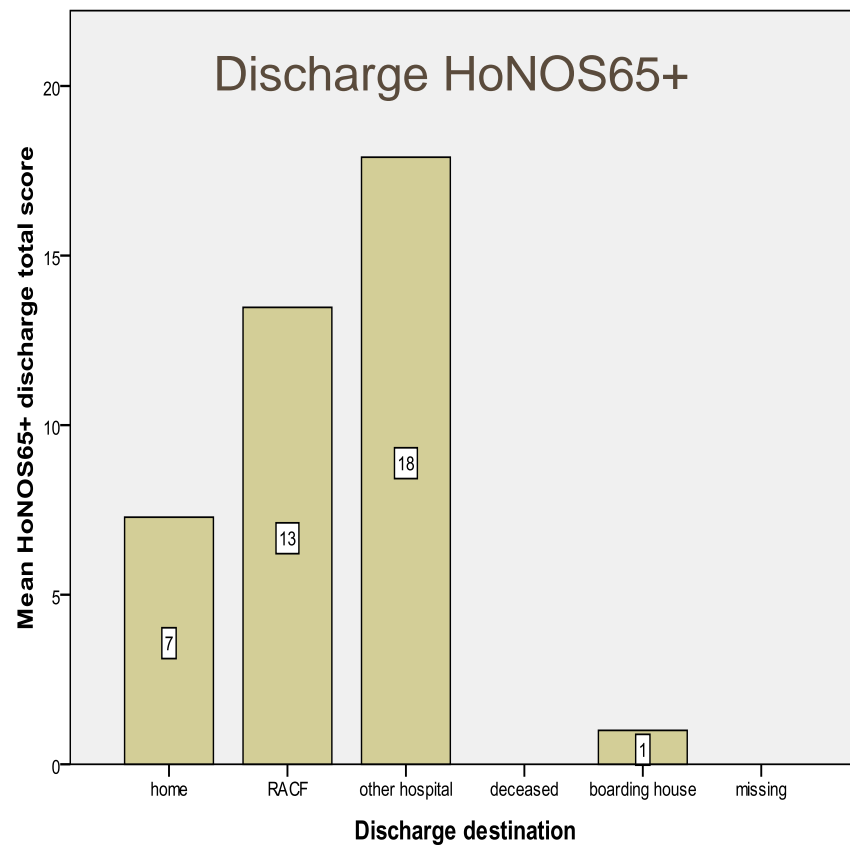
- Diagnosis not significantly associated with LOS
- change in accommodation during admission associated with >100% increase in LOS
- only 18% of patients from home with a *combination of a diagnosis of dementia and Focus of Care HoNOS 65+item 1 (aggression/ overactivity)* returned home.
  - Led to specific practice recommendations not possible without outcome measurements

Further understanding

- Influences upon length of stay identifiable at admission were
  - treating consultant
  - Gender (male) and
  - younger age
- *The effect of treating consultant was cancelled out* if adjusted for the degree of improvement in focus item,
  - **but not by change in total HoNOS 65+ score,**
- Led to discussions about practice that would not have had occurred without utilising routine outcome measurement

Total HoNOS 65+ score and discharge destination





The future? (The journey continues)

'Rewards' to date

- have been mostly (not only) in
  - assisting team functioning,
  - Improving care planning
  - Improving service understanding
  - Encouraging 'service improvement'
- Less in
  - directing the practice of individual clinicians
  - Directly affecting the consumer – clinician interaction

Yet these are the most important uses for those collecting the measures

- **Probable focus of future development**
- **The future is also tied to (exciting) developments in the use of outcomes and information in SSWAMHS**

What is required to use outcome measurement to improve clinical care?

MOST IMPORTANT IS LEADERSHIP

- Reinforce compliance
- A willingness to review clinical / team processes
- Prioritising linkage of outcome measurement to clinical processes
  - Stop treating outcome measurement as ‘administrative’
- **Start asking ‘what clinical practices do**

  I most want to improve, and how can outcome measurement help?
  - Stop asking ‘how can routine outcome improve practice’
- Identify local priorities

Thank you…may *your* journey continue