Meaningful clinical outcomes

March 13, 2013

Hello

I work with a team of OT’s in an acute mental health setting and for some time now we’ve been debating what information to collect to meaningfully capture the effectiveness of OT intervention. Previously we’ve collected stats about contacts and stats that capture which community based projects we supported people into but this lacks a more considered view of the impact of our interventions and fails to adequately tie in the use of standardised measures.

We predominantly use the MOHOST and VQ here and have developed excel documents that capture pre and post measurements. We have started to look at recording HoNOS ratings to support the screening of referrals- neighbouring trusts have also looked significantly at this and this has proved useful. We’ve also been looking at the indicative care packages that Mary Morley and others have produced and have found these useful in supporting the thinking about clinical outcomes, as well as added value and impact. We have struggled to pull all of this together in an meaningful way and are keen to do this to better present this to our MDT colleagues, service users and fellow OT professionals.

Would welcome the thoughts of anyone doing this kind of work? Or suggestions for how we may take this forward,

Best wishes

Sarah

March 14, 2013

Dear Sarah and others

I think this is a very important topic of discussion. I look forward to reading the responses. I have worked in mental health for many years. During this time we have used many instruments, some we are still using others we did not find practical to use in day to day clinical practice. For a research project we used the Wisconsin QoL index, I regard it highly as its multi dimensional, takes clients opinion as to what’s important to
them into account and it is very sensitive to change however it’s a relatively long instrument and somewhat complex to fill out. Although it’s not specifically an occupational therapy instrument it contains many items that OT is concerned with and also its very easily understood by MDT colleagues when a person gains increased quality of life overall or in a particular domain. To use in clinical practice it would be best filled at section by section at different sessions. Another instrument I’ve used is the Socially Valuable Roles Classification Scale developed by Geoff Wag horn. In my experience enabling people with mental health problems attain and retain roles is a core aspect of what we are doing clinically and therefore we should measure changes in role functioning. Same goes for the interests – I was at a presentation by Larry Davidson on Recovery and he summed up recovery by stating its helping people to reconnect with the activities that give meaning to their lives and supporting them to stay connected with them. Given this should we be taking a simple approach by doing the interest checklist, pre, post and at some point in the future to establish if our input has enabled reconnection with meaningful activities. This may or may not impress some of our MDT colleagues but I’m not sure whether that’s important. My final thought in this is whether we should use some standardized instruments that are well known and used, for example the SANS (Scale for the Assessment of Negative Symptoms) could easily be completed by an occupational therapist and repeated at intervals during treatment. Remediation negative symptoms is another aspect of mental health care that occupational therapy has long been involved in and I believe our input with clients with such difficulties is crucial yet there is little research evidence showing the efficacy for occupational therapy at addressing negative symptoms. If we were to adopt the use of such instruments and report on a clients score over time we could ensure that the important work that we are doing is recognized by our clinical colleagues and by funders of mental health services.

It was nice to have to opportunity to share these thoughts

Happy St Patrick’s Day!

Niall Turner

March 18, 2013

Hi Sarah & others

This may fall into the category of a non MOHO specific query so may not get circulated to the listserv following Renee’s recent e-mail, but here goes….

Capturing OT outcomes in acute settings is a very real challenge particularly as acute psychiatric wards are getting increasingly acute and lengths of stay are becoming so short.

Much as I’m a MOHO fan I have to say that I simply don’t think it’s feasible to routinely perform pre-post ratings using any of the MOHO tools in acute settings. There is possibly an argument for prioritising a manageable number of patients and doing pre-post
measures with them, and as you mentioned, we have done some work on developing prioritisation protocols.

However, with so many other variables at play (eg medication, relocation from natural environment) it’s a bit dubious how meaningful pre-post data is any way ie how much credit OT could claim for the changes in scores. Dare I say also that it is questionable how much weight changes in MOHOST scores will carry with non OTs (it pains me to say this).

With all this in mind I have come to the conclusion that the most feasible and meaningful data OTs can capture in acute settings is goal attainment data, as arguably one can make a more robust claim for the goal attainment being attributable to the OT intervention if only the OT has been addressing this issue with the service user. It is also a very client centred, recovery friendly form of outcome and very compatible with the move towards more PROMs (Patient reported outcome measures).

It may also be possible to supplement this with some very simple, well recognised measures such as the EQ5D and/or a user satisfaction measure. With this in mind I would commend a very impressive piece of work by the University of Stirling called ‘Framework for measuring impact’ http://www.measuringimpact.org/home which contains a wealth of useful information on outcome evaluation including recommended outcome measures.

Hope this helps

David

March 18, 2013

David and Members:

Certainly you may feel free to think and talk critically about MOHO on the listserv. My only request was that MOHO be incorporated (which it was, here). Otherwise, we will have a non-specific OT listserv, and I do not believe that was ever the intention behind the creation of this list.

Best to you,

Renee

March 18, 2013

Hi David
I don't usually respond to this but I thought I would for this time. I have been reading closely on this subject as I work in an acute psychiatric unit and was going through similar challenge myself.

I am pleased and somewhat relieved to hear that Goal Attainment data is mentioned as I was thinking along the same line and looking at using Goal Attainment Scale. I wonder if you could tell me a bit more about how you have been gathering Goal Attainment data in your service and how this has been received by MDT and management.

Regards,

Shoko Matsusaka

March 18, 2013

We have been working with Goal Attainment Scaling (GAS) on a limited basis and plan to try and implement at least 1 GAS goal/pt in their tx plan after administering a modified MOHOST. This is on a 35 bed acute care psych unit.

Sarah Skinner

March 18, 2013

We had this very same problem, so switched to OSA - however the problem we found here, was that our "veteran" were so highly anxious in their first week of the programme that when we caught up with them they couldn't even remember what or how they answered and therefore had to resort back to MOHOST. I am sure you won't have the same amount of clients as I do - 16 new every 6 weeks - and therefore you may want to try OSA as this is very personal goal orientated and has the ability to also be converted to a graph to impress your commissioners!

Karen Miles (specialist occupational therapist)

March 19, 2013

Hi David and all,

I have some data about goal attainment using a MOHO framework (currently struggling to get this published but will keep on trying).

As you know, outcomes can be measured by repeat assessments, goal attainment or satisfaction surveys and all three have their uses. My experience is that adult acute mental health services benefit from all three, as not only is it hard to prioritise repeat assessments but it can also be difficult for service users to attain their goals within an admission .... however skilled the OTs may be in negotiating graded, occupation-focused goals with their clients.
My colleagues were well-trained in negotiating measurable goals using the key dimensions of occupational engagement (chapter 13 in MOHO textbook) to grade goals, and they used the East Kent Outcomes System to capture goal attainment (Murphy and Logan 2009). This summarises therapy outcomes using a rating scale that records the degree to which goals have been achieved or not (Johnson and Elias 2010). When 70% or more goals have been met, this is regarded as a ‘good outcome’ (Commissioning Support Programme 2011).

In our survey, across all our mental health and learning disability services, 66.5% of treatment plans had goals that were deemed to have been ‘all met’ or ‘almost all met’-rising to 84% in older adult community settings, but reducing to just 43% in adult acute settings due largely to service users being discharged before their occupational goals had been met. (The total was 73% when adult acute settings were not included).

I’m not so pessimistic as to whether MOHOST scores impress other disciplines, – just yesterday I met two OTs who told me that they had measured their effectiveness using MOHOST and their posts had been continued on the basis of this! As to whether OTs can claim the credit for any improvement, other disciplines would be hard-pressed to claim any credit for changes that they have not assessed or treated and the very fact that OTs can measure the changes means that their role is valuable to the whole team.

There’s no doubt in my mind that it’s harder to prove the effectiveness of OT in some acute services, but by combining repeat assessments, goal attainment and patient satisfaction, we can strengthen the evidence.

Best wishes to all,
Sue Parkinson


March 19, 2013

Hi Sue et al

Your e-mail was a very helpful upbeat counterbalance to mine!

Great to hear your account of how OTs have used MOHOST data to secure their posts, and you are right to point out that other professions would be equally hard pressed to claim the credit for changes taking place in acute settings.
Finally, it’s good to hear that others are exploring goal attainment data

David

March 19, 2013

Hi Shoko

Sue has explained how her trust captured goal attainment data. The way we capture it is through our electronic case record (ECR) care plan. This allows us to enter one of 3 outcomes following an intervention

- Need (ie goal) Met
- Need partially met
- Need unmet

We can extract this data pretty quickly and easily from the data warehouse (IT database)

Hope this helps

David

April 12, 2013

Hello,

I work in an acute psychiatric hospital with older adults, functional and organic. I am interested in hearing from anyone who is using the MOHOST (or the new adjusted MOHOST) with people with dementia AND the goal attainment scale (GAS). I am very interested in the GAS, and have found a number of (mostly non-OT) articles, but nothing so far regarding dementia, and no articles connecting GAS and MOHOST. Any specific examples of working with people where goals would be more maintenance rather than development would be very welcome!

thanks

Sue Scott