

# Outcome Measures to Support Professional Judgement



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# Introduction

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- BC  $\Rightarrow$  Assisted Living is a service/housing option to offer clients who are case managed
- In an attempt for consistency Case Managers (CM) independently developed their own tool to guide their decision making, Assisted Living Access Tool (ALAT)
- The ALAT has 56 elements & 51 are directly from the RAI-HC tool + the Zarit screener + subjective comments area (7 pages)

# The issue

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- The ALAT is not a researched or evidence based tool (demonstrated what the CM wanted to examine)
- CM were completing a RAI-HC assessment on clients and completing the ALAT (7 pages)
- Time management
- Duplication existed

# Purpose

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- To make the RAI-HC clinically relevant to the front line clinician (trust)
- Remove duplication of work
- To document a process to critically determine outcome measures to support professional judgement (using AL as case study)

# Literature Review

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- Research
  - Supported the validity and reliability of the MDS
  - Quality indicators
  - Health outcomes measures post MDS use
  - Changes in mortality/morbidity/hospitalization post MDS
  - Most in US nursing homes
  - No published literature found on the use of MDS-HC outcome scores to determine eligibility for AL

# Research Questions Phase 1

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- Are we able to determine who is a good candidate (eligible) for assisted living by using outcome measures from the RAI-HC?
- Are the extra elements chosen by the CM to help make the eligibility decision “value added”?

# Method

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- Sample N=108 (Northern Health) Individuals deemed eligible by CM, either in AL or on waitlist for AL
- Removed individuals who were eligible d/t well spouse only (subgroup)
- Used the Assisted Living definition (operational) to chose variables to describe clients
- Developed a decision guide using 2 RAI-HC outcome measures  $\Rightarrow$  CPS & MAPLe
- Vancouver Coastal Health & Fraser Health\* agreed to sample their population using the decision guide

# Method

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- Northern Health: some CMs piloting it to determine its usefulness at the front line
- Follow up with these CM as a focus group (preliminary findings)
- Phase 2 on going

# Decision Table

## Decision Table for Assisted Living Candidate

CPS Score	MAPLe	ACTION
0	1	What else can be done to keep this person in the community? If NO Document discrepancy in service/care plan note pad and w/l
	2	What else can be done to keep this person in the community? If NO Document discrepancy in service/care plan note pad and w/l
	3	Appropriate candidate
	4	Not appropriate if due to behaviour or worsening decision making otherwise appropriate candidate
	5	Not appropriate due to behaviour
1	1	What else can be done to keep this person in the community? If NO Document discrepancy in service/care plan note pad and w/l
	2	Appropriate candidate
	3	Appropriate candidate
	4	Not appropriate if due to behaviour or worsening decision making otherwise appropriate candidate
	5	Not appropriate due to behaviour
2	3	Appropriate candidate (will need monitoring)
	4	Use Caution- need support plan in place e.g. risk waiver
	5	Not appropriate
3	4	Only with well spouse
	5	Not appropriate

### Decision Table for Assisted Living Candidate

CPS Score	MAPLe	Fraser Health N=126	VCHA N=386	NH N=108	ACTION
0	1	2%	11%	8%	What else can be done?
	2	24%	10%	7%	What else can be done?
	3	19%	18%	23%	Appropriate candidate
	4	2%	0.2%	3%	Not appropriate if due to behaviour or worsening decision making otherwise appropriate candidate
	5	0%	0%	0%	Not appropriate due to behaviour
1	1	0.8%	4%	5%	What else can be done?
	2	11%	6%	4%	Appropriate candidate
	3	12%	14%	14%	Appropriate candidate
	4	2%	0.8%	3%	Not appropriate if due to behaviour or worsening decision making otherwise appropriate candidate
	5	0.8%	0.2%	0%	Not appropriate due to behaviour
2	3	4%	3%	0%	Appropriate candidate (will need monitoring)
	4	13%	15%	15%	Use Caution- need support plan in place e.g. risk waiver
	5	3%	1%	0.9%	Not appropriate
3	4	5%	9%	10%	Only with well spouse
	5	3%	7%	6%	Not appropriate

# Results ⇒ Themes

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## Validation of professional judgement

- “It’s kinda nice to have your assessment & your outcomes support what you in a sense all ready know”

## Validates a purpose of completing the RAI-HC

...if they had only let us know & think differently from the start why we needed [RAI] ...take these scores & [help us] decide & back us up [decision-wise]

“I think that it is finally showing a purpose for using the MDS tool”

# Results ⇒ Themes

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## Freedom to make that judgement call

“I think it’s important for CM’s still have some flexibility to use their clinical judgement”

## Time saving

- “...good to know that the full hour assessment is going to in itself be an end to what you need to do & the outcome scores gives you that feedback right now”
- [saving] 15-20 minutes

# Conclusion

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- The decision table has face validity (help prioritize when have W/L)
- Continue to monitor & evaluate (rigor & scrutiny) – second phase document how CM make decisions
- Will obtain feedback from remaining CMs
- There does not seem to be any value added using the extra information from the ALAT
- The model process has potential –continue to test
- NH – will move to HCC Council to make a regional direction

# The Process

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1. Identify a population
2. Examine legislation/provincial policy that can help define the population
3. Can information from step 2 make a tight enough operational definition?
4. Are there outcome measures either singularly or in combination that describes this population?

Do the outcome measures describe the variables you want?

5. Develop a working model

6. Use working model to examine sample populations

Caution: the existing population may not be correct

7. Adapt working model as needed
8. Use working model for larger samples by engaging other Health Authorities.
9. Ask for critical review from peers.
10. Use qualitative techniques to examine clinicians' anecdotal evaluation
11. Revise as necessary
12. Send model through proper channels for provincial approval.

# Thank you

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Any comments or questions

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