Chapter 1 - Introduction

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Outcome Measures
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The use of outcome measurement tools is a widely accepted means by which to grade patient response to care. They are an important adjunct to other reasonable forms of assessment such as standardized functional measurement (i.e., ROM, strength testing, sensory system evaluation) and subjective information gained from patient interviews. However, the compulsory use of outcome measurement tools may also serve a number of other valuable purposes, particularly in the clinical educational setting:

1. Acceptance of the role outcome measures play in the third-party pay environment, and repeated exposure to correct use of these tools as required by various insurance providers;

2. Use as a valid research instrument. Patient data may be collected (through retrospective or prospective study design) on any number of subjects with virtually any variety of clinical presentation. The research and clinical implications possible through our multiple-site clinical system are, in a word, vast;

3. Use as a viable (and extremely important) means of separating biological, psychological, and social influences on a patient’s clinical presentation. This serves two very valuable purposes: A) To aid us in the management of our patients, particularly as it may relate to the referral and/or potential co-management with an allied healthcare professional, and B) To facilitate understanding of the biopsychosocial model, which will likely encourage a greater degree of “whole patient” care – and the thorough understanding of this care – in our clinics;

4. As initially indicated, outcome tools aid as an important determinant of patient progress, allowing us as practitioners to not only monitor the success or failure of our treatment plan, but to also recognize when additional care – including that which may lie outside our scope of practice – is warranted.

While there are literally hundreds, if not thousands of outcome tools available for use in a chiropractic setting, the most commonly used include the SF12 and SF36, the Oswestry Disability Indices, the Roland-Morris Low Back, the Headache Disability Inventory, the Vermont Disability Predictor, and the Fear Avoidance Beliefs Questionnaire. Less commonly used although valid measures include the McGill Pain Questionnaire, Quadruple Visual Analog Scale, Dizziness Handicap Inventory, and the Beck or Zung’s Depression Scales.

SF12/SF36: Well-researched tool which defines patient responses into ten separate classifications, including physical, emotional, and social categories. Grading is through a numeric system. Pros: Widely accepted by researchers and third-party pay. Cons: Lengthy, gains validity with larger groups (as such, is better suited to large clinical trials).
Oswestry Disability Indices: Used in specific low back and cervical versions, determines level of disability through a numeric scale. Pros: Short, easy to complete, widely used. Cons: Determines level of disability, but does little to differentiate organic from non-organic causes.

Roland-Morris Low Back: Excellent tool for following patient response to low back specific care delivery. Pros: Widely used, easy to complete. Cons: As with Oswestry indices, measures patient response to care but lacks in ability to tease out underlying reasons (for poor care responses).

Headache Disability Inventory: Created by a chiropractor, works as a valuable tool in treating headache, helping to break down physical and emotional presentations of head pain. Pros: Widely used (among chiropractors), easy to use. Cons: Possibly considered by some to be “chirocentric”, not as well researched as other tools.

Vermont Disability Predictor: Developed for and used by the state of Vermont to predict disability in workers compensation patients. Pros: Very easy to administer and understand. Aids in predicting which patients will potentially fail (at least partially) in care. Cons: Validity may be questionable, may not be viable as a third-party pay tool.

Fear Avoidance Beliefs Questionnaire: Quality tool for determining psychosocial influences on potential patient outcomes. Recent research suggests use as a tool for predicting chiropractic success. Pros: Strong aid in the identification of patients prone to passive care dependence, allows practitioner to alter treatment plan to more aggressive active-based care if results are indicative. Cons: None.

These outcome tools are often designed to be administered approximately every four weeks (beginning at the initiation of care), or as deemed necessary by the clinician overseeing the patient’s care. Reasons for greater or lesser degree of use include: Unexpected changes in patient presentation, chronicity of condition(s), measurement of the effects of recent changes to treatment plan, patient compliance issues, third-party pay inquiries, and dismissal from care (most applicable to PI, Auto, W/C cases).

As an educational tool, it is suggested that the student intern primarily involved in a case be integral in the process of actually scoring the outcomes used. The results should be reviewed and discussed with the clinician in charge, both for accuracy and as the results of the outcome tools relate to current and future care. Of course, the discussion must include not only what may have been discovered from the specific outcome tool(s), but how these findings might or might not coincide with additional subjective and objective data available. Second, to facilitate appropriate and timely use of these tools, identification stickers may be placed on the outside of patient files to indicate which outcome(s) are being used, and the date in which they were last administered.

Additional reading:


