Implementing patient-reported outcome measures in palliative care clinical practice: a systematic review of facilitators and barriers

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CRD summary
This review identified the facilitators and barriers to the implementation of patient-reported outcome measures in different palliative care settings. The authors made recommendations for managers, health professionals, and patients for three stages of implementation. Their conclusions reflect the evidence presented, but potential limitations from publication bias and study quality should be borne in mind.

Authors' objectives
To identify the facilitators and barriers to the implementation of patient-reported outcome measures, in different palliative care settings, for routine practice, and to generate evidence-based recommendations for clinical practice.

Searching
MEDLINE, PsycINFO, CINAHL, EMBASE and British Nursing Index were searched between August 2011 and March 2012, for studies published between 1985 and 2011. Search terms were reported, and a full strategy for British Nursing Index was presented. Reviews and relevant articles were searched by hand to identify further studies. Sources of grey literature were not searched.

Study selection
Eligible for inclusion were all published primary studies, reported in English, Portuguese, Spanish, Italian, German or French, that used a patient-reported outcome measure during palliative clinical care of adult patients with advanced disease. Studies had to report the barriers or facilitators to the implementation of the measure. Excluded were conference articles, studies of measures completed by proxies, and studies reporting only on the development and feasibility of new measures without reference to users. Studies could be of any quality.

Qualitative and quantitative studies were included. Over half were conducted in the UK; the others were in countries across the world. There were no intervention studies that tested implementation facilitators in clinical practice. None of the quantitative studies considered facilitators and barriers to implementation as a primary outcome. The various included patient-reported measures assessed pain, symptoms, quality of life, and other concepts. Participants (where reported) were patients, carers, families, or health care professionals.

Studies were selected by one reviewer. Indecisions were referred to a second reviewer.

Assessment of study quality
Qualitative studies were assessed for quality according to 16 criteria. Quantitative studies were assessed according to 13 criteria. All these criteria were reported, and they assessed clarity of reporting and whether or not the study methods were robust.

Two reviewers independently assessed the quality of the included studies. Discrepancies were resolved by discussion.

Data extraction
Data were extracted on the barriers, facilitators, and lessons learned. Quotes were used to illustrate the data extraction and emerging synthesis.

The extraction was carried out by one reviewer. The categories developed as part of the subsequent synthesis were appraised and commented upon by a second reviewer.

Methods of synthesis
A narrative synthesis was conducted. This was guided by four stages: the role of theory; the development of a preliminary synthesis by thematic analysis; assessing the robustness of the synthesis; and exploration of relationships.
between studies. The last stage was explored for several categories (reported in the paper), for facilitators, lessons learned, and barriers to the implementation of the outcome measures. The data were also modelled across three time points – preparation, implementation, assessment and improvement.

Results of the review
Twenty-six studies (31 articles) were included. There were nine qualitative studies (stated as eight in the text) and 17 quantitative studies. For qualitative studies, there were six high quality (scoring 13 out of 16); two medium quality (scoring between 10 and 12); and one poor quality (scoring less than 10). For quantitative studies, 10 were classed as high quality (scoring 11 or more out of 13), and seven were classed as poor quality (scoring 9 or less).

Using the three different time points, the recommendations for implementing patient-reported outcome measures were offered at the levels of management, health care professional, and patient. All recommendations were fully reported. The key features were highlighted by the authors, as follows.

It was important to acknowledge interpersonal relationships between clinical team members and the emotional and cognitive processes that occur in individuals. Firm but sensitive leadership was required to provide motivation, and reassurance, as was the provision of feedback to clinicians on the use of the measures for patient benefit and quality of care. Implementation should promote ownership of the measures instead of mandating their use, to avoid conflict. Careful planning was needed, bearing in mind three distinct stages: preparation, implementation, and assessment. The education of clinicians on the benefits, use, and evaluation of the outcome measures might be time consuming, but vital. Acknowledging what could be changed throughout the process was important, so that lessons could be learned for future practice. The education and motivation of patients to promote compliance was recommended.

Authors’ conclusions
Successful implementation of patient-reported outcome measures needed to identify and address any barriers in each setting, and have a coordinator for the process. The cognitive and emotional processes of each individual needed to be considered during changes, and education before implementation was crucial.

CRD commentary
A broad review question was presented, and this was reflected by the wide-reaching inclusion criteria. The search strategy covered a range of relevant sources of published articles. Publication bias and the potential for relevant studies being missed were possible. Reviewer error and bias could not be ruled out during study selection and data extraction.

The quality assessment of the included studies used appropriate criteria for different designs. The results showed a dominance of good-quality qualitative studies over quantitative studies. Most of the included studies did not report the outcomes of interest to this review as their primary outcome. A complicated synthesis was presented; this complication was reflected by the authors having to discuss how to categorise and present the data. There were attempts to explain this process, and some audit trail was apparent from the raw data to the interpretations.

The authors’ conclusion reflects the evidence presented, but potential limitations from publication bias and the quality of the included studies should be borne in mind.

Implications of the review for practice and research
Practice: The authors stated that there was a need for guidance on implementing patient-reported outcome measures in palliative care practice, to improve practice and the quality of care provided, by assisting in clinical decision-making.

Research: The authors stated that research should consider whether the introduction of patient-reported outcome measures was an intervention in itself, and whether an adjustment period for users was needed before data collection and analysis.

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