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Adherence to *Measuring What Matters* Measures Using Point-of-Care Data Collection Across Diverse Clinical Settings

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Abstract

Context. *Measuring What Matters* (MWM) for palliative care has prioritized data collection efforts for evaluating quality in clinical practice. How these measures can be implemented across diverse clinical settings using point-of-care data collection on quality is unknown.

Objectives. To evaluate the implementation of MWM measures by exploring documentation of quality measure adherence across six diverse clinical settings inherent to palliative care practice.

Methods. We deployed a point-of-care quality data collection system, the Quality Data Collection Tool, across five organizations within the Palliative Care Research Cooperative Group. Quality measures were recorded by clinicians or assistants near care delivery.

Results. During the study period, 1989 first visits were included for analysis. Our population was mostly white, female, and with moderate performance status. About half of consultations were seen on hospital general floors. We observed a wide range of adherence. The lowest adherence involved comprehensive assessments during the first visit in hospitalized patients in the intensive care unit (2.71%); the highest adherence across all settings, with an implementation of >95%, involved documentation of management of moderate/severe pain. We observed differences in adherence across clinical settings especially with MWM Measure #2 (Screening for Physical Symptoms, range 45.7%−81.8%); MWM Measure #5 (Discussion of Emotional Needs, range 46.1%−96.1%); and MWM Measure #6 (Documentation of Spiritual/Religious Concerns, range 0−69.6%).

Conclusion. Variations in clinician documentation of adherence to MWM quality measures are seen across clinical settings. Additional studies are needed to better understand benchmarks and acceptable ranges for adherence tailored to various clinical settings.   J Pain Symptom Manage 2016;51:497−503. © 2016 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.

Key Words
Quality, quality measures, Measuring What Matters, *implementation, alliance, collaboratives*

Introduction

There is limited understanding of how to implement palliative care quality measures into routine quality initiatives across patient populations and clinical settings.[1–3] The American Academy of Hospice and Palliative Medicine and Hospice and Palliative Care Nurses Association recently convened panels of

technical and clinical experts to produce a set of prioritized measures for the field. The goal of *Measuring What Matters* (MWM)[4] was to provide the field of hospice and palliative medicine with a select set of valid and implementable quality indicators to measure quality of care. Such a select set is expected to support regular quality assessment and measurement within individual palliative care organizations. Data from these efforts have the potential to inform establishment of benchmarks and collaborative quality improvement efforts.

As the MWM initiative proposed a list of 10 quality measures, significant unanswered questions remain. First, how do these measures perform in the diverse settings and patient populations for whom palliative care is appropriate? Second, how does adherence to these measures compare across these settings? These remain unanswered questions for a few key reasons. One reason is that the MWM measures were only recently defined; experiences with integrating these measures are relatively recent. Additionally, each component measure of MWM was tested and validated in a patient population defined by a specific diagnosis or setting using retrospective chart abstraction. For example, MWM Measure #9 (Care Consistency with Documented Care Preferences) was developed for and tested within a hospitalized patient population.[5] We do not yet know how clinicians will use these measures in other settings, like outpatient clinics. Another example is MWM Measure #1, which recommends a "comprehensive assessment" for all patients evaluated by the team. This measure was included from the set of "Prepare, Embrace, Attend, Communicate, Empower" (PEACE) measures,[6] which was developed to evaluate quality of care of patients with acute care or end-of-life needs admitted to services (e.g., hospice or hospital admission). It remains unknown how clinicians may adhere to this measure in outpatient settings, where needs may be more focused and clinical interactions may be spread over time. As clinical palliative care continues to grow in noninpatient settings such as community-based delivery[7] and outpatient clinics,[8] the field is beginning to appreciate the differences in palliative care delivery among varied settings and the implications for quality measurement.

To better understand the performance of quality measures across different clinical settings, we examined MWM measure adherence using a point-of-care data collection method in a large and diverse patient population from five Palliative Care Research Cooperative Group (PCRC) member sites.

Methods

We conducted a cross-sectional descriptive study of quality measure implementation across patients consulted for specialty palliative care. We included data entered prospectively into the Quality Data Collection Tool (QDACT) electronic system by palliative care clinicians from January 2, 2014, to September 16, 2015. This study was performed within an overall series of investigations to assess the usability and feasibility of a new QDACT platform for the PCRC. This investigation was approved by Duke University (Pro00035703, Pro00055212) and, when applicable, participating organizations' institutional review boards.

Settings

This study was conducted within the PCRC, a multisite research infrastructure to support and coordinate clinical research in palliative care.[9] Data collected from five PCRC organizations were analyzed. Organizations included four academic sites and one community-based site. Organizations each a priori devised a sampling technique to identify and collect data on patients. Investigators worked with their clinical teams to develop a sampling recruitment strategy to collect data generalizable to the entire practice.[10] Data were collected across six common clinical settings of palliative care.

Study Design

We designed this cross-sectional multisite study to generate descriptive data on adherence to the MWM measures.[4] We compared adherence to quality measures across six types of palliative care clinical settings: hospital general floor, hospital intensive care unit (ICU), emergency department, outpatient, long-term care, and home. In an additional analysis, all hospital-based palliative care consultations, including those from the general floor, ICU, and emergency department, were aggregated into one category: "acute care." All others, including outpatient palliative care clinics, home-based palliative care consultations, and long-term care facility palliative care visits were aggregated into "nonacute care." Palliative care visits that were coded as "other" were treated as nonacute care.

Instrument

Clinicians used the QDACT tool to collect near real-time clinical data across the eight domains of quality palliative care proposed by the National Consensus Project for Quality Palliative Care.[11] By using the QDACT, clinicians can report data on up to 82% of all quality measures in the field, including nine of the MWM measures.[1] The QDACT is a clinician-entered, point-of-care quality assessment tool that includes commonly used validated clinical instruments (e.g., Edmonton Symptom Assessment