Psychometric validation of the needs assessment tool: progressive disease in interstitial lung disease

INTRODUCTION
People with interstitial lung disease (ILD) are symptomatic, and have limited disease-modifying treatment options, poor prognosis and poor quality of life. Identification and management of patients’ and carers’ palliative care needs are rare despite policy directives promoting palliative care, and availability of palliative interventions.

The validated needs assessment tool in cancer (NAT:PD-C) helps clinicians identify and address palliative needs in daily practice. We adapted, validated and tested the reliability of the NAT:PD-C for patients with ILD (NAT:PD-ILD) and explored implementation implications in practice. This single page guide prompts clinicians to assess holistic needs (priority prompts for specialised palliative care input, patients’ well-being, informal carers’ needs and information needs), triage ongoing care (‘directly managed’, ‘refer to other team member’, ‘refer to specialist palliative care’) and also acts as a referral form.

METHODS
Summary design
The initial adaptation, face and content validation and implementation work are reported elsewhere. This study tested the psychometric properties of (1) inter-rater and test–retest reliability, and (2) construct validity.

Clinicians (doctors, nurses, physiotherapists) and family carers were recruited from four ILD tertiary referral clinics.

Inter-rater and test–retest reliability
Video recordings were made of 10 patient-clinician consultations (range of disease severity and carer present/absent, with clinicians using the NAT:PD-ILD to guide assessment). Clinicians were trained to use the NAT:PD-ILD and rated at least one video consultation (group viewing or individual viewing via secure online service). Clinicians were asked to rereate the same video at least 2 weeks later. Weighted Fleiss’ kappa with quadratic weights was calculated for the ratings on 10 videos (kappa <0=poor agreement, 0–0.20=slight, 0.21–0.40=fair, 0.41–0.60=moderate, 0.61–0.80=substantial, 0.81–1=almost perfect agreement). Data simulations indicated that we required 60 paired assessment ratings to detect at least ‘substantial’ inter-rater agreement (kappa >0.6) for the item 4 (‘Is the patient experiencing unresolved physical symptoms?’) with 80% power.

Construct validation
Trained clinicians conducted a NAT:PD-ILD-guided clinician consultation. Patients completed the St George’s Respiratory Questionnaire (SGRQ-I) and carers completed the Carer Strain Index (CSI) and Carer Support Needs Assessment Tool (CSNAT). Kendall’s tau-b correlation coefficient was calculated to determine the correlation between the NAT:PD-ILD patient well-being items and a subset of SGRQ-I similar constructs identified a priori. The prevalence and bias-adjusted kappa (PABAK), Cohen’s kappa and observed percentage agreement were used to assess agreement between the NAT:PD-ILD carer items and appropriate CSI and CSNAT constructs identified a priori. Data simulations indicated that a sample size of 65 patients would allow estimation of the kappa statistic for agreement such that the CI would not extend beyond the neighbouring category.

All analyses were conducted using Stata V13 (StataCorp, Stata Statistical Software: Release 13. College Station, TX: StataCorp, 2013).

RESULTS
Reliability
Fifty-three clinicians (32 doctors, 18 physiotherapists, 2 clinical physiologists, 1 nurse) participated in 64 first views across 10 videos, with 21 test–retest observations on four videos.

Inter-rater reliability
Eleven (69%) NAT:PD-ILD items reached at least fair agreement (weighted kappa >0.2).

Test–retest reliability
Five items exhibited at least moderate agreement (weighted kappa >0.4) (table 1).

Construct validation
Nine clinicians (six doctors, three nurses) and 68 patients (mean age 66, SD 10.3; 62% men; 45 with a carer (28 participated); 35% oxygen therapy; 56% interstitial pulmonary fibrosis; 80% Medical Research Council breathlessness 3–5) were recruited (online supplementary eTable 1). The SGRQ-I mean summary score was 62.5 (SD 20.9): symptom component 67.4 (26.1); activities component 82.1 (23.2); impact component 51.2 (24.3). Scores for the carer comparator outcome measures are shown in online supplementary eTable 2. Agreement between NAT:PD-ILD concerns and comparator outcomes is shown in table 2. Items 2 (unresolved psychological symptoms/loss quality of life), 3 (problems with daily living activities), 5 (work, financial or legal concerns) and 6 (health beliefs, cultural or social factors) of the NAT:PD-ILD were significantly positively correlated with their comparator SGRQ-I scores (r range 0.24–0.36, P<0.05). PABAK values comparing the NAT:PD-ILD items with CSI/CSNAT items were mostly positive (0.04–0.57, minimum 52% agreement); however, items 11 and 13 have negative PABAK values (interpersonal relationships and grief topics).

DISCUSSION
Items within the NAT:PD-ILD demonstrated acceptable inter-rater reliability and construct validation given the broad constructs assessed and the breadth of clinical experience. The constructs of patient-reported quality of life (SGRQ-I) and assessment of need are related but different, therefore the relatively small number of items rated as moderate or strong is unsurprising. Similarly, many carer-related items both on NAT:PD-ILD and within CSI and CSNAT capture areas of concern that overlap, but are not directly comparable. The NAT:PD-C, with similar psychometric properties, resulted in reduced patient and carer needs when
### Table 1: Inter-rater reliability test and test–retest results, weighted kappa

<table>
<thead>
<tr>
<th>NATPD-ILD item</th>
<th>Number of observations</th>
<th>Distribution of categories†</th>
<th>Weighted kappa (SE)</th>
<th>% Agreement</th>
<th>Weighted kappa (SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the patient have a carer?</td>
<td>77</td>
<td>NA</td>
<td>14%</td>
<td>86%</td>
<td>0.69 (0.24)</td>
</tr>
<tr>
<td>2. Has the patient or carer requested a referral to a Specialist Palliative Care Service (SPCS)?</td>
<td>70</td>
<td>NA</td>
<td>9%</td>
<td>91%</td>
<td>0.82 (0.44)</td>
</tr>
<tr>
<td>3. Do you require the assistance of the SPCS?</td>
<td>65</td>
<td>NA</td>
<td>20%</td>
<td>80%</td>
<td>0.13 (0.30)</td>
</tr>
<tr>
<td>4. Is the patient experiencing unresolved physical symptoms?</td>
<td>89</td>
<td>6%</td>
<td>38%</td>
<td>56%</td>
<td>0.49 (0.21)</td>
</tr>
<tr>
<td>5. Is the patient experiencing unresolved psychological symptoms?</td>
<td>76</td>
<td>36%</td>
<td>57%</td>
<td>8%</td>
<td>0.32 (0.16)</td>
</tr>
<tr>
<td>6. Does the patient have problems with daily living activities?</td>
<td>85</td>
<td>8%</td>
<td>54%</td>
<td>38%</td>
<td>−0.07 (0.41)</td>
</tr>
<tr>
<td>7. Does the patient have concerns about spiritual or existential issues?</td>
<td>57</td>
<td>79%</td>
<td>18%</td>
<td>4%</td>
<td>0.44 (0.30)</td>
</tr>
<tr>
<td>8. Does the patient have work, financial or legal concerns?</td>
<td>75</td>
<td>83%</td>
<td>13%</td>
<td>4%</td>
<td>0.15 (0.58)</td>
</tr>
<tr>
<td>9. From the health delivery point of view, are there health beliefs, cultural or social factors involving the patient or family that are making care more complex?</td>
<td>57</td>
<td>77%</td>
<td>21%</td>
<td>2%</td>
<td>−0.55 (0.73)</td>
</tr>
<tr>
<td>10. Is the carer or family distressed about the patient’s physical symptoms?</td>
<td>85</td>
<td>32%</td>
<td>47%</td>
<td>21%</td>
<td>−0.17 (0.39)</td>
</tr>
<tr>
<td>11. Is the carer or family having difficulty providing physical care?</td>
<td>79</td>
<td>61%</td>
<td>34%</td>
<td>5%</td>
<td>0.59 (0.23)</td>
</tr>
<tr>
<td>12. Is the carer or family having difficulty coping with the patient’s psychological symptoms?</td>
<td>71</td>
<td>69%</td>
<td>30%</td>
<td>1%</td>
<td>0.36 (0.21)</td>
</tr>
<tr>
<td>13. Is the carer or family concerned about financial or legal concerns?</td>
<td>69</td>
<td>93%</td>
<td>7%</td>
<td>0%</td>
<td>0.77 (0.24)</td>
</tr>
<tr>
<td>14. Is the carer or family experiencing problems that are interfering with their functioning or interpersonal relationships, or is there a history of such problems?</td>
<td>67</td>
<td>61%</td>
<td>37%</td>
<td>1%</td>
<td>0.21 (0.38)</td>
</tr>
<tr>
<td>15. Is the carer or family experiencing unresolved psychosocial problems or feelings that are interfering with their well-being or functioning?</td>
<td>70</td>
<td>47%</td>
<td>43%</td>
<td>10%</td>
<td>0.75 (0.12)</td>
</tr>
<tr>
<td>16. Is the carer or family experiencing grief over the future death of the patient?</td>
<td>45</td>
<td>69%</td>
<td>27%</td>
<td>4%</td>
<td>0.57 (0.27)</td>
</tr>
</tbody>
</table>

*39/53 (74%) saw only one video consultation, 13 (25%) saw two video consultations and 1 (2%) saw four video consultations, though they may have watched each video up to two times (mean (SD) 1.3 (0.6), median 1).

†Items 1–3: 1=yes, 2=no; Items 4–16: 0=none, 1=some/potential, 2=significant.

‡Same category assigned by rater on both occasions; too few categories to calculate kappa statistic.

NA, not applicable; NATPD-ILD, needs assessment tool: progressive disease in interstitial lung disease.
## Table 2  
Relationship between NAT:PD-ILD items and SGRQ-ILD comparator items, and between the NAT:PD-ILD items relating to the carer and appropriate CSI and CSNAT items

<table>
<thead>
<tr>
<th>Agreement between NAT:PD-ILD items and SGRQ-ILD comparator items</th>
<th>The prevalence and bias-adjusted kappa (PABAK), Cohen's kappa and percentage of agreement between NAT:PD-ILD items relating to the ability and well-being of the carer and appropriate CSI and CSNAT items</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAT:PD-ILD</td>
<td>Patient well-being 'Does the patient have…'</td>
</tr>
<tr>
<td>4. Unresolved physical symptoms</td>
<td>Part 2 section 3 Q1–6, and part 2 section 4 Q6</td>
</tr>
<tr>
<td>5. Unresolved psychological symptoms/loss of quality of life?</td>
<td>Part 1 Q6; part 2 section 4 Q1–6; and part 2 section 7</td>
</tr>
<tr>
<td>6. Problems with daily living activities?</td>
<td>Part 2 section 2 Q1–5; part 2 section 4 Q1–5; part 2 section 5 Q1–5; part 2 section 6 Q1–4; and part 2 section 7</td>
</tr>
<tr>
<td>7. Spiritual or existential concerns?</td>
<td>Part 2 section 1</td>
</tr>
<tr>
<td>8. Work, financial or legal concerns?</td>
<td>Part 2 section 4 Q1–6</td>
</tr>
<tr>
<td>9. Health beliefs, cultural or social factors making care delivery complex?</td>
<td>Part 2 section 4 Q1–6</td>
</tr>
</tbody>
</table>

*This is more of a practical question, but was the nearest construct within the CSNAT.

Levels of concern in the NAT:PD-ILD were grouped into 0=‘None’ vs 1=‘Some/great deal’ = ‘Significant’, the CSI responses were coded 0 for ‘No’ and 1 for ‘Yes’, and the four CSNAT items responses were categorised into two groups: 0=‘No’ vs 1=‘A little more’ + ‘Quite a lot more’ + ‘Very much more’. For each NAT:PD-ILD item, the agreement between whether or not the carer indicated at least some problems and whether or not they had a ‘1’ in any of the recoded CSI or CSNAT items, they were being compared with was calculated.

applied in practice; the key factor in any clinical tool.5

The NAT:PD-ILD is best seen as a communication and decision tool where action is thereby triggered if more in-depth exploration is needed, rather than an outcome measurement. The challenges of a clinical assessment and diagnosis are recognised as an inexact science with variation between clinicians.9 10 Study clinicians had a wide range of clinical experience to increase generalisability. Some NAT:PD-ILD items with poor agreement (inter-rater and construct) are consistent with the clinician participants’ expressed lack of confidence, for example, spiritual and existential concerns and may rather reflect an educational need.7

The clinician participants rated the videos after 10–15 min of training, inter-rater reliability is likely to improve with practice. Clinicians using the tool in daily practice will gain more experience as they use the tool.

Although we reached our target sample size for the construct validity analysis, we have insufficient sample for the carer comparisons. Also, our sample was convenience, not consecutive, potentially affecting representativeness.

The tool is yet to be tested in a clinical trial to evaluate its use by clinicians in terms of impact on patient and carer experience.

CONCLUSIONS
The adapted NAT:PD-ILD has adequate reliability and construct validation. Effectiveness in clinical practice, and optimum implementation are yet to be evaluated and identified.

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Contributors MJJ and DC conceived the study and design. MJJ, DCC, MB, JMB, JR, JY, GG and TP. MJJ, DCC and JY wrote the protocol. JR, AJ and JA led on reliability testing. JY led on construct. GG provided carer assessment expertise. JMB and CF conducted the analysis. All authors contributed to interpretation. MJJ wrote the first draft and all authors contributed to revisions and the final draft.

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