National Committee for Quality Assurance

Interview with Dr. Erin Giovannetti and Dr. Michael Barr

By Jean Galiana

ACCESS Health International

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Background

The National Committee for Quality Assurance (NCQA) was founded in 1990 to improve the quality of healthcare in the United States. The National Committee for Quality Assurance evaluates and accredits health plans in the United States, the District of Columbia, and Puerto Rico. Health plans accredited by the National Committee for Quality Assurance account for over one hundred million or over seventy percent of all people enrolled in health plans in America.

Patient Centered Medical Homes, often referred to as primary care medical homes, is a primary care model that is team based to coordinate and individualize the care plan of their patients. The American Academy of Pediatrics Council on Pediatrics Practices introduced the Medical Home model in 1967. In 2002, the Future of Family Medicine Project integrated the model within their primary care specialty practice.

Multiple peer reviewed studies and a report by the National Committee for Quality Assurance found that a well functioning Patient Centered Medical Home realizes better self reported health outcomes, better cancer and diabetes screening rates, nearly five percent lower costs per Medicare beneficiary, eleven percent lower growth in emergency department visits, reduced health disparities, and improved access to care for patients. Providers also realized an up to a four and a half to one return on their investment after becoming Patient Centered Medical Homes. A portion of the cost savings is achieved by the efficiency of the team and office and less redundant care due to care coordination. The growth in the number of Patient Centered Medical Home practices is driven by insurers, employers, and health systems that provide incentives to primary care practices to lower costs and improve quality and safety and by implementing quality improvement measures.

The National Committee for Quality Assurance began recognizing practices as Patient Centered or Primary Care Medical Homes in 2008 with 214 providers and twenty eight sites. Today, nearly sixty thousand providers and over eleven thousand sites are recognized. (Figure 1)
Organizations including Federally Qualified Health Centers (FQHC), Community Health Centers (CHCs), Hospitals and Health Systems, Independent Physician Associations (IPAs), physician owned practices, and the military have been recognized as Patient Centered Medical Homes. (Figure 2)
Currently, forty five states use or require the National Committee for Quality Assurance recognition program. (Figure 3)
The Annals of Medicine published a five year cohort study of primary care practices in the Taconic Independent Practice Association, located in the Hudson Valley of New York. The study involved twelve practices and six health plans. The study compared utilization measures of practices that had become Patient Centered Medical Homes to practices that used paper medical records or electronic health records and were not Patient Centered Medical Homes. One of the strong points of this study was that, while there was not a significant change in the quality measures, there was a significant change in utilization measures. Patient Centered Medical Homes showed better outcomes in seven of eight utilization measures. (Figure 4)
Figure 4. Utilization Outcomes From a Patient Centered Medical Home
Five Year Cohort Study

<table>
<thead>
<tr>
<th>Utilization</th>
<th>Outcomes for the Patient Centered Medical Home Compared to the paper group</th>
<th>Outcomes for the Patient Centered Medical Home Compared to the electronic health record group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care visits</td>
<td>7-9% more</td>
<td>9% more</td>
</tr>
<tr>
<td>Specialty visits</td>
<td>10% fewer</td>
<td>10% fewer</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>4-8% fewer</td>
<td>8% fewer</td>
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<td>Radiologic tests</td>
<td>4-8% fewer</td>
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<tr>
<td>Hospitalizations</td>
<td>21-23% fewer</td>
<td>23% fewer</td>
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<tr>
<td>Rehospitalizations</td>
<td>57-60% fewer for every 100 patients</td>
<td>60% fewer for every 100 patients</td>
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<tr>
<td>Emergency visits</td>
<td>Equal to control group</td>
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A report by the Agency for Healthcare Research and Quality (AHRQ) addresses the need for quality improvement infrastructure within the primary care setting. This need is not limited to the United States. Globally, health systems are recognizing the need for higher performing, fully integrated primary care practices. In another report by the Agency for Healthcare Research and Quality, the authors acknowledge the Patient Centered Medical Home as a promising model for achieving the triple aim of lower cost, better health outcomes, and improved patient satisfaction.

The National Committee for Quality Assurance recognition requirements have continued to evolve over the years to ensure that recognized practices achieve the desired outcomes and sustain the core features of the Patient Centered Medical Home. Some of the earlier changes and the recently released draft 2017 standards are a reaction to what the research has shown and experienced practices have shared. The new recognition process, starting with the 2017 standards in April 2017, will include an initial recognition followed by annual check ins, during which the practice will be expected to attest and or provide evidence that they are sustaining the recognition requirements and improving care. This change is in response to the concern that practices occasionally attain recognition but then regress due to personnel changes or the passage of time.

To learn more about Patient Centered Medical Homes, please refer to the resource page of the Agency of Healthcare Research and Quality, which contains many relevant reports and studies. The book *The Familiar Physician: Saving Your Doctor In the Era of Obamacare*, by Peter B. Anderson details the history of the Patient Centered Medical Home and the efforts of visionaries who supported...
its evolution. The Agency for Healthcare Research and Quality also provides instructional assistance to practices that are planning to achieve the recognition.

In this interview, Dr. Michael Barr and Dr. Erin Giovannetti share the history of the Patient Centered Medical home and the evolution of the National Committee for Quality Assurance recognition program. They also describe the process by which a primary care practice achieves recognition as a Patient Centered Medical Home.
About Erin Giovannetti

Erin R. Giovannetti is a Senior Research Scientist at the National Committee for Quality Assurance. Dr. Giovannetti’s work focuses on developing healthcare performance measures for older adults and vulnerable populations. She leads efforts to develop and evaluate performance measures for the Medicare Advantage Part C Plan Rating program, Medicaid’s Managed Long Term Services and Supports plan, and the Medicare and Medicaid’s Dual Eligible population. Dr. Giovannetti is currently involved in projects focused on developing measures for older adults with functional limitations based on the outcomes individuals identify as most important. Dr. Giovannetti has worked extensively with patient reported outcomes and their use for quality assessment. Her research to date has explored how patient and family reported measures could be used for both care planning and performance measurement. Prior to joining the National Committee for Quality Assurance, Dr. Giovannetti completed a fellowship at Johns Hopkins School of Medicine in the Division of Geriatric Medicine and Gerontology. At Johns Hopkins, she conducted research on best practices to support family caregivers to older adults with multiple chronic conditions. Specific projects she collaborated on include the National Quality Forum Multiple Chronic Conditions Performance Measurement Steering Committee and the Guided Care intervention. She holds a Ph.D. from the Department of Health Policy and Management at Johns Hopkins Bloomberg School of Public Health and a B.A. from Wellesley College.

About Michael Barr
Michael S. Barr is a board certified internist and Executive Vice President of the Quality Measurement & Research Group at the National Committee for Quality Assurance. His portfolio at the National Committee for Quality Assurance includes performance measurement development and testing, contract and grant management, research, and collaboration across the National Committee for Quality Assurance on strategic initiatives, public policy, and program development. Prior to joining the National Committee for Quality Assurance in May 2014, Dr. Barr was the Senior Vice President of the Division of Medical Practice for the American College of Physicians.

From 1999 to 2005, Dr. Barr was the Chief Medical Officer for Baltimore Medical System, Inc., a Joint Commission accredited federally qualified health center. He was on the faculty of the Division of General Internal Medicine at Vanderbilt University from 1993 to 1998. He also held various administrative positions including Physician Director, Medical Management Programs for the Vanderbilt Medical Group. From 1989 to 1993, Dr. Barr served in the United States Air Force.

Dr. Barr has a Bachelor of Science degree in Forest Biology from the State University of New York College of Environmental Science and Forestry (1982). He attended the New York University School of Medicine (1986) through the Air Force Health Professions Scholarship Program. He completed his residency in Internal Medicine at Rush Presbyterian St. Luke’s Medical Center in Chicago, Illinois (1989). Dr. Barr earned a Master of Business Administration degree from the Vanderbilt Owen Graduate School of Management in 1996.

From August 2013 to March 2015, Dr. Barr was a Commissioner on the Maryland Health Care Commission. He recently completed six years on the Board of Trustees for Baltimore Medical System, Inc., the last two of which as Chairperson. He currently sits on the board of the Horizon Foundation of Howard County.
Interview

Jean Galiana (JG): Please share the history of the Patient Centered Medical Home.

Dr. Michael Barr (MB): The medical home concept is not new. It dates back to the sixties in pediatrics literature. It received new attention initially due to the chronic care model of Ed Wagner and the team at the Macoll Center for Health Care Innovation in Seattle, Washington. The MacColl Center is leading innovation in healthcare delivery, coordinated care, and patient centered care.

Before working at National Committee for Quality Assurance, I was with the American College of Physicians. Our work led us to draft a policy paper entitled *The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care*. This paper examined the application of the chronic care model and the medical home model to a whole practice population, not only the population of patients with chronic and special needs.

IBM is a global company that provides healthcare wherever their employees are in large concentration. They were buying this type of healthcare internationally for their employees. IBM dedicated significant resources to finding better care options for their employees here in the United States. Drs. Paul Grundy and Martin Sepulveda were leading those efforts. The two men approached us at the American College of Physicians and said something to the effect of, “We like what you are writing. We like what the family physicians and pediatricians have written. However, we can find this model of care in other countries, but not in the United States. Would you work with the other medical professional societies to consolidate your ideas into a one to two page statement? If so, then we will bring together the largest employers in the United States for you to present the concept.” This challenge by IBM led to the drafting of the “Joint Principles of the Patient-Centered Medical Home” by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association.

Insurance companies wanted a process through which they could identify practices adhering to the medical home model in order to identify which practices should receive enhanced reimbursement during pilot projects. This led to the collaboration of the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association with the National Committee for Quality Assurance in 2007. The first recognition program launched in 2008, and was updated in 2011 and 2014. We are planning for the release of the 2017 standards soon. That is the abbreviated history of the last ten years of the recognition programs.

JG: What distinguishes a Patient Centered Medical Home from other primary care practices?
**MB:** A Patient Centered Medical home practice is focused on the needs of the individuals and population they are caring for. The practice ensures that their services are well organized and accessible. The clinical team coordinates all care across the care continuum, tracks all of the tests and results, and uses evidence based guidelines so that patients receive care based on their needs, preferences, and choices. Patient Centered Medical Home practices also engage patients in their own care.

**JG:** Are all the Patient Centered Medical Homes successful at maintaining the standards for quality, cost, and access?

**MB:** Occasionally, practices do not sustain the medical home model, which is reflected in some of the literature that is mixed in terms of the ultimate influence of the model on patient outcomes, costs, utilization, and patient experience.

**JG:** Please describe how a practice can be recognized as a Patient Centered Medical Home.

**MB:** The current process dates back to the 2008, 2011, and 2014 standards. A practice that has never been recognized before will visit our website, download the standards, make the necessary changes to the practice, collect the necessary documentation, and then submit their recognition application. Our team at the National Committee for Quality Assurance reviews and scores the submissions. We currently have little interaction with the practice during their transformation process or after the submission other than awarding them recognition or not. Currently, the process has three different levels based on the number of points that the practice has accumulated. A practice may be recognized as a level one initially but can choose to do an add on survey to move up to level two or three. Upon being recognized, the practice enters a three year renewal phase after which they are required to resubmit their application and meet the current standards.

**JG:** Do you educate the practice management?

**MB:** We provide education through a robust set of webinars, seminars, online education tools, and more. The educational components are not customized for the individual practices. There are several hundred National Committee for Quality Assurance certified content experts and consultants who help businesses achieve recognition. Occasionally, we hold regional meetings for specific entities. We also hold an annual congress. The congress last year drew more than eight hundred attendees and is now the largest educational session dedicated to the medical home. The congress in Chicago this year is expected to be even bigger. The congress draws leaders who are committed to creating patient centered medical homes. We will offer expanded education about the Medical Neighborhood model.

**JG:** Please describe the standards that you use in the evaluation process.
**MB:** Our recognition program represents the best thinking from a variety of stakeholders around the country, expert consensus, public opinion, and eight years of experience of the National Commission for Quality Assurance. There are six categories of standards in the 2014 standards including patient centered access, team based care, population health management, care management and support, care coordination and care transitions, and performance management and quality improvement. Within those standards, there are six must pass elements that represent the core of a medical home. Those elements are: Patient Centered Appointment Access, The Practice Team, Use Data for Population Management, Care Planning and Self Care Support, Referral Tracking and Follow Up, and Implement Continuous Quality Improvement. Those are very specific elements within the six standards. Every practice must meet at least fifty percent of the points to achieve recognition for those must pass elements. There are one hundred possible points. It takes thirty five points to achieve to level one, sixty to achieve level two, and eighty five to achieve level three.

**JG:** What are the advantages to a practice for becoming recognized as a Patient Centered Medical Home?

**MB:** There are health plans around the country that provide incentives for practices to achieve recognition. There are incentives for recognition, payment models, and demonstration projects. Those are ongoing. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation includes an incentive for practices to become a Patient Centered Medical Home or Patient Centered Specialty Practice (PCSP). Recognition will garner one hundred percent of the points associated with Clinical Practice Improvement Activities (CPIA), one of the four categories of the Merit Based Incentive Payment System (MIPS).

There are other ways the medical homes gain efficiencies that are often overlooked. One is general operational efficiency. The National Committee for Quality Assurance Patient Centered Medical Home standards encourage practices to untangle messy processes and become more streamlined. If the practice improves access and throughput, they could potentially generate increased efficiency and revenue within a fee for services reimbursement arrangement. In a value based reimbursement environment, enhanced and after hours access should help avoid unnecessary emergency department and urgent care utilization.

Legal risk mitigation is another potential advantage of achieving the recognition. We require comprehensive and accessible patient documentation. The patient record must be available after hours for access and phone calls, medications, and the list of medical concerns must be documented. These components make for better care and are useful if litigation arises. The clinician should have clear proof of the care history. Some malpractice carriers offer a discount to providers who are recognized as Patient Centered Medical Homes. This indicates to us that insurers recognize the value of a provider being recognized.
The literature finds that the burnout factor for physicians, medical staff, and the general staff decreases when a practice appropriately implements the medical home. This was also witnessed in the Veterans Health Administration system. Turnover rates and training new staff or hiring new clinicians is likely to improve for a practice that becomes a Patient Centered Medical home. This represents a substantial benefit to the practice organizationally and financially.

Achieving recognition is an opportunity for providers to improve their brand. An organized and efficient practice also receives more referrals.

**JG:** Have providers tracked the outcomes of becoming a Patient Centered Medical Home?

**MB:** Yes. The Patient Centered Medical Homes track their outcomes. Group Health Cooperative, in Seattle Washington, tracked the outcomes of becoming a Patient Centered Medical Home. Group Health Cooperative is an integrated insurer and provider organization. Their year one study and their year two study showed cost savings, higher patient satisfaction, and a lower rate of clinician burnout.

In their 2014-2015 annual review of evidence, the Patient Centered Primary Care Collaborative (PCPCC) evaluated utilization and cost outcomes for the Patient Centered Medical Home model using aggregated data from local and federal governmental programs, federal initiatives, peer reviewed studies, and industry reports. The report supports the need for payment reform, including a more standardized payer buy in. It also stresses the importance of maintaining a focus on value to the patient, the provider, and the payer. The report found that the medical home model reduces health care costs and unnecessary utilization of health services.

**JG:** How many Patient Centered Medical homes have you recognized to date?

**MB:** We have recognized 10,098 primary care centers and over fifty six thousand clinicians. Every time I look, those numbers are bigger.

**JG:** Approximately how many patients would that represent?

**MB:** We do not have that exact data. I would estimate that Patient Centered Medical Homes serve approximately forty to sixty million individuals based on a conservative estimate of patients per full time practicing clinician.

**JG:** Can you describe how the Patient Centered Medical Homes improves elder care?

**MB:** At some point everyone is going to need care coordination and self management support. A medical home that is well organized can handle multiple comorbidities and complex patients. Older people are often forced to go to the emergency department if a practice does not leave open appointments for same day visits. Patient Centered Medical Homes must provide same day access.
Patient Centered Medical Homes are better prepared to handle the complex care of patients with multiple chronic conditions, who are primarily older people. This is due to the care coordination and integration along with the patient involvement in care management.

**Erin Giovannetti (EG):** There was a poll conducted by the Hartford Foundation that asked older adults about their experiences and opinions of their doctors and what they wanted from their doctors. Their goals matched very closely with the medical home model. The results were overwhelming. Seventy three percent of seniors reported that they wanted the Patient Centered Medical Home type of coordinated care. The medical home is a perfect fit for older adults who spend much more time interacting with the healthcare system. They want a medical **home**.

I have just finished joining several focus groups with older adults. The questions we posed were about what they wanted from their healthcare provider. The number of people who simply wanted to be heard by their doctor and to have their different doctors communicate with each other was striking. The participants also did not want to wait for six months for an appointment with their doctor. The medical home model embraces and encourages the characteristics that the senior participants wanted.

**JG:** Dr. Giovannetti, please describe your elder care research activities.

**EG:** We are in the process of developing innovative quality measurements to be used in patient centered medical homes, home health programs, and any program that focuses on older adults who have some functional limitation. We are developing person driven outcome measures. These measures are individualized to the outcomes that are the most important to older adults. In traditional quality measurement, we often measure the same health issue of a population such as their hemoglobin A1C or their blood pressure. As people age and experience functional limitations or have multiple comorbidities, the heterogeneity of the population becomes a challenge. This makes it difficult to determine what the most important outcomes are for the patients. We are designing these measures to facilitate better patient centered care. We are in the process of conducting focus groups across the country. We are asking older adults what they wish to achieve with the care they are receiving. One older adult might tell us, “I took a lot of pride in being able to take care of my yard. I need my doctors to work together to enable me to tend to my yard.” In our research, we define excellent quality care as care that enables people to reach their goals even if their hemoglobin A1C is not precisely where clinicians want it to be. We are designing individualized quality measures that capture the patient’s goals.

**JG:** Have you noticed that the goals and priorities of the patients vary significantly?

**EG:** Definitely. One individual’s priority may be their functional ability. Someone else might not have functional ability on the top of the list. They may want an
intervention for insomnia, because lack of sleep keeps them from doing what they want to do. We want to measure slightly different outcomes in different individuals. Those outcomes will change over time based on what is important to each person. We want a Patient Centered Medical Home provider to be able to measure how well they are helping to deliver outcomes that are individualized for the patient.

**JG:** Would that type of measurement require a concept change on the part of the clinician, such as a shift in focus away from the standard cure the ailment protocol?

**EG:** There will be many challenges that will require a different interaction between providers and individuals. There was a publication a few years ago by Mary Tinetti and David Rubin about the need for providers to understand and honor the goals of their patients with multiple comorbidities. This requires a shift from care directed by the provider’s goals to care directed by the patient’s goals.

**JG:** Who do you envision will determine the patient’s goals and priorities when you complete the measurement research and tool?

**EG:** We are exploring whether community health workers, peer counselors, social workers, or nurses could make this inquiry. We are examining how the health team can work together, not necessarily only what the primary care provider can do.

**JG:** Where are you in the process of this research?

**EG:** We are beginning a pilot project with this approach. We will conduct the pilot program over the course of twelve months. By the fall of 2017, we will be finished and have some preliminary results sometime around December. I am also happy to provide you with our project summaries. (Appendix A)

**JG:** Do the Patient Centered Medical Homes provide after hour care?

**MB:** Patient Centered Medical Homes provide same day appointments for routine and urgent care. That is a critical factor. The literature indicates that emergency department visits are often non urgent and driven by lack of access to primary care. When a practice cannot take a patient who needs care that day, the patient may go to the emergency department. Many of their conditions are not acute and could be treated by the primary care physician. These emergency department visits are referred to as avoidable. Some studies have reported that up to fifty six percent of emergency department visits are avoidable. This represents millions of dollars in unnecessary or wasteful care. A practice that does not offer same day appointments cannot be recognized as a Patient Centered Medical Home. Another standard for the Primary Care Medical Home that could prevent a patient from visiting the emergency department is that the clinician must provide timely clinical advice by phone or a secure interactive electronic system.
The patient’s records also need to be accessible after hours. Patient records must be updated in real time.

**EG:** I have often heard the Patient Centered Medical Home standards described as a road map. The National Committee for Quality Assurance provides the optimal standards. The provider can assess where their current situation and move into the direction of improvement.

**JG:** Do you also recognize long term care or home healthcare providers?

**MB:** At this time, we do not have programs for long term care or home health providers. The focus of the Patient Centered Medical Home is primary care.

**JG:** Why is the National Committee for Quality Assurance Patient Centered Medical Home recognition program undergoing a redesign at this time?

**MB:** Feedback from our providers, patients, and consumers indicated that our program is: too hard or to easy, too onerous, that practices sometimes become recognized but do not stay at that level of performance, that we are too focused on structure and process, and we are not focused enough on clinical outcomes. We took the feedback to heart and reviewed the literature. Then we began a redesign process at the end of 2014 and have been working on it since.

Beginning in 2017, practices that are interested in being recognized will go to our new online portal, identify that they are interested, and will be given a pre assessment. We added the pre assessment because we have learned that practices that are not prepared when they attempt to be recognized have a difficult experience. We will use our educational activities to help them prepare. When a provider is prepared to begin the recognition process, we will assign them a facilitator. The facilitator will engage with their practice through three or four check ins over the course of their transformation. The check ins are specific to the needs of the individual practice. If the managers of a practice think they need to work on patient access to care, which happens to be the first standard, their first check in will deal with access. If they think that they need to work on care coordination that will be the subject of the check in. We will then require specific tests and evidence for the provider to assemble for the next check in.

We plan to reduce the documentation burden by introducing the concept of virtual desktop sharing at the time of the check in. For example, we may request to see the appointment calendar of the practice to determine how many slots have been left open for patients who need to be seen that day. At the following check in, we will conduct an official review during which the provider will be told how many points they have received toward recognition and how many are left to achieve. At a later date, the provider will have their second check in followed by a third. This will amount to three or four check ins over the course of twelve to eighteen months. At some point, the practice will reach the threshold necessary for recognition. (Figure 5)
Our 2017 standards remove the levels of recognition. A provider will either be a recognized medical home or they will not. We made this change because the literature shows that some of our earlier lower level recognition practices have not differentiated themselves from a non recognized practice.

We will have annual sustaining recognition requirements. Practices will check in with us on a limited set of options within each standard. They should have maintained all of the standards, but they are not required to show us everything. For example, there will be a variety of ways to prove that they are improving access and care coordination. We will be introducing an option to submit clinical quality measure data through the use of their health information technology in lieu of doing some of the documentation requirements.

We ran a pilot project of the new recognition process and it was well received. I share some details of the pilot program in a Google Hangout video. Some of the practices that participated in the pilot program give their feedback in the same video. We are very encouraged by the initial feedback. We plan to further improve the recognition process based upon the feedback. We improved the program just as we ask practices to improve their processes.

JG: Thank you both for this interesting discussion.

EG: Thank you for your interest in National Committee for Quality Assurance.

MB: Thank you.
END
Appendix A: Developing Person-Driven Outcome Measures for Older Adults with Long Term Services and Supports Needs

Project Summary

Introduction
There is broad agreement that individuals’ priorities and health goals should guide their care and that outcome measures are needed to evaluate it. However, existing quality measures do not effectively evaluate what is most important to individuals, particularly older adults with functional limitations (i.e., difficulty with at least one activity of daily living). This population frequently needs services and supports beyond traditional medical care, such as assistance in the home to support independence, transportation to support social and community engagement, and other services to help them live longer in the community. Our previous research demonstrates that for these individuals, goals documented in care plans are often unstructured and heterogeneous; focus on short-term issues, service provision, and/or disease-specific objectives; and may relate to but do not specify more long-term, holistic outcomes important to the individual. This suggests that the documentation of goals as currently implemented is unlikely to yield meaningful information about the extent to which older adults with functional limitations attain the outcomes that are important to them or how well organizations assist them to achieve their goals.

The next step in our research is to test a more structured approach to measuring outcomes identified by the individual as important. We will balance the need for individualized and meaningful goals and outcomes to guide care with the need for structured valid and reliable data for quality measurement. The ultimate goal of this project is to improve the lives of older adults with functional limitations by developing performance measures that can assess how well organizations are helping people to maintain or improve their well-being.

Methods for Measurement
This project will pair a targeted goal setting approach with two methods for measuring and monitoring person-driven outcomes related to an individual’s goal: Goal Attainment Scaling (GAS) and Prioritized Person Reported Outcome Measurement (PROM).

- GAS will measure individuals’ progress toward goal attainment using a qualitative scale. Providers and individuals will identify specific measurable short term goals, define expected outcomes (expected outcome, better than expected outcome, and worse than expected outcome), and assign numerical weights to these outcomes. Over time they will assess whether the individual’s outcomes are better or worse than expected on the identified goal.

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• Prioritized PROM will measure individuals’ progress on standardized outcomes associated with their goals. Providers and individuals will identify one or more goals and select a standardized PROM questionnaire addressing a domain that best aligns with the outcome the individual identified as important from a bank of PROM questionnaires representing many domains. Over time they will assess whether individuals are maintaining or improving on the PROM domain that they have identified as most important.²

Approach
We have formed a learning collaborative with five organizations providing care to older adults with functional limitations. With these organizations we will:

1) Conduct focus groups with individuals, family and friend caregivers, and providers to understand the scope of individual goals and gain input on how to implement the two methods for measurement (PROM/GAS);
2) Develop the clinical workflow and data collection tools necessary to implement these methods in specific settings;
3) Pilot these methods in a small sample of patients at each setting over 12 months; and
4) Use data from the pilot to calculate system-level performance measures based on the selected methods.

Organizations in the learning collaborative comprise a mix of clinical practices and complex case management programs that focus on goal-oriented care planning. This variety of organizations will help us to identify the settings where each method for measurement is most feasible (i.e., one approach may be more feasible in the health plan setting than the provider office setting).

The learning collaborative sites will be active partners in helping to develop and implement the methods (GAS/PROM) in their sites. Core teams from each learning collaborative site will join together through in-person and web-based meetings to share successes and problem-solve challenges. Each site will develop a workflow and data collection tools for PROM and GAS measurement that best fit their structure while also collecting the necessary data elements for quality measurement. The sites will then use rapid-cycle testing to refine and improve each method. Finally the sites will qualitatively evaluate the approaches and make recommendations for widespread dissemination.

At the end of this exploratory phase of research each site will have developed the training materials, workflow, and data collection tools necessary to demonstrate one or both approaches in a larger sample of patients to evaluate the

effectiveness. We will have also collected the preliminary data elements necessary to draft quality measure specifications for person-driven outcome metrics. In the next phase of research, the demonstration phase, we will formally evaluate one or both of the selected approaches on a larger scale and evaluate the reliability and validity of system-level performance measures derived from person-driven outcome measures.

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