# UCSF Health

Care Support

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Patient Driven Outcomes

Background

- A substantial proportion of the older adult population faces complex medical care and has long-term service and support needs.

- The complexity and diversity of needs in this population makes it difficult to measure the quality of care using current objective measures which may not reflect patients' individualized goals, preferences and values.

- Person-reported outcome measures can be a powerful tool for evaluating quality if patients are integrated into the care process and are simultaneously used to inform individual self-management, care planning, quality improvement and system-level accountability.

- Measurement strategies that build on and guide care planning and care delivery would address this current gap in outcome measurement.

- Because UCSF Care Support's core value of providing patient-centered care with patients setting active goals aligned well with the NCQA pilot objectives, the team was chosen to test two tools designed to assess patient driven outcomes.
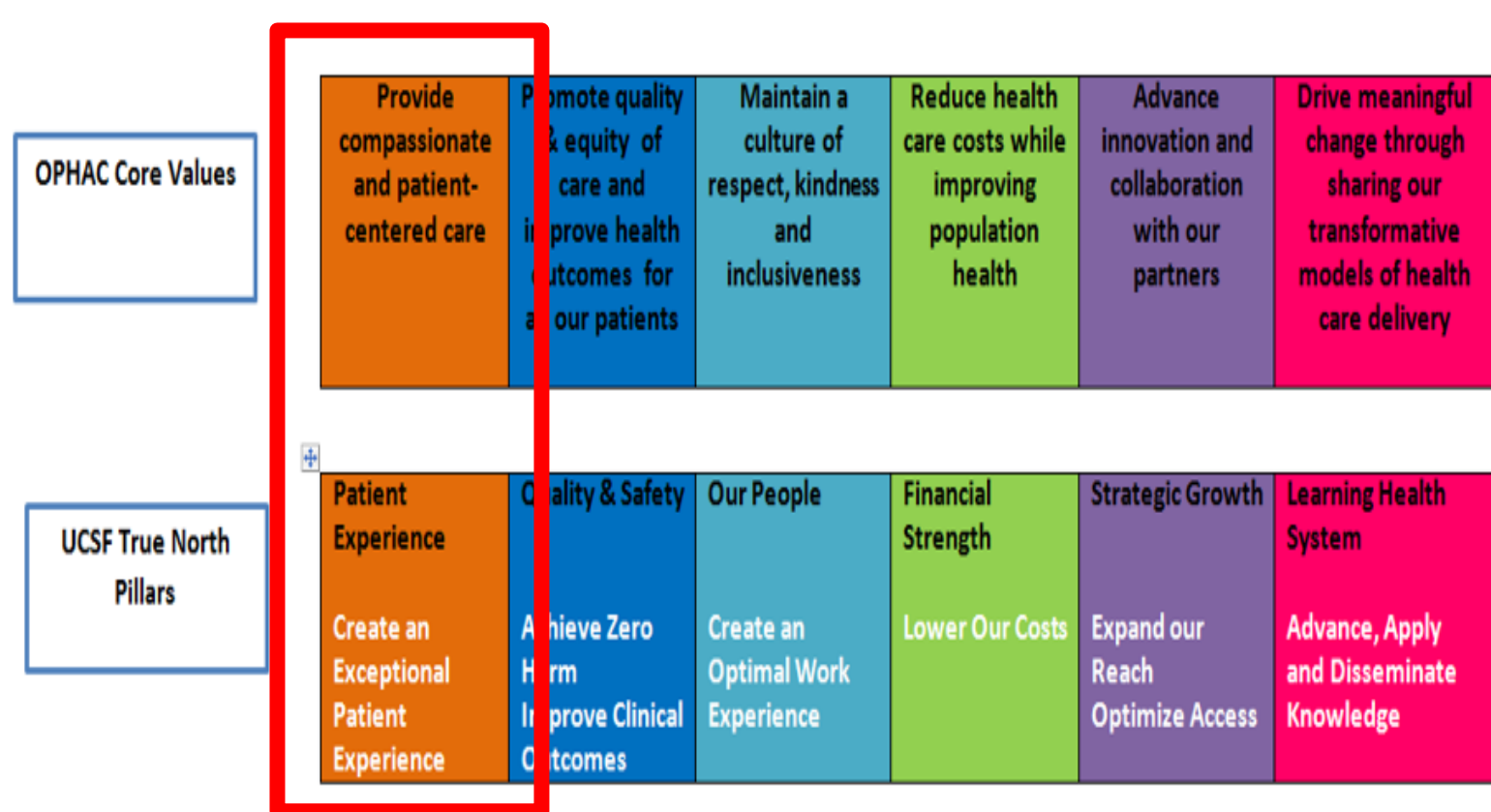
Project Goals

- The Care Support team in collaboration with The National Committee for Quality Assurance (NCQA) explored how to best develop person-driven outcomes measures - measures based on what is important to older adults.

- In this project, we explored two measurement approaches:
  1. **Goal Attainment Scaling (GAS)** and
  2. **Prioritized Person-Reported Outcome Measurement (P-PROM)**

➤ **GAS** measures a patient's progress towards goal attainment using a qualitative scale. Providers and patients identify a specific measureable short-term goals, and specify +2 to the -2 rated outcomes for the other goal areas in observable terms. Over time the provider assesses whether the patients' outcomes are better or worse than expected on the identified goal.

➤ **P-PROM** measures a patient's progress on standardized outcomes associated with their goals. Providers and patients identify one or more goals and select a standardized questionnaire addressing a domain that aligns with the patient situation. Over time the provider assesses whether the patients are maintaining or improving on the identified PROM.

- Quantitative and qualitative methods were used to assess the meaning and value that patients and clinical care teams derived from using these two measurement approaches.

Project Plan and Intervention

Care Support aimed to 1) engage 20 patients or caregivers of those ≥60 yrs old, with one or more ADL limitations, who were English-speaking in goal setting by July 2017; 2) test the use of GAS and PPROM goal setting tools along with SMART goals with at least one initial scaling and one follow-up.

GAS (Goal Attainment Scaling): Measures progress toward goal attainment using defined range of expected outcomes (expected, better than expected, worse than expected).

PPROM (Person-Reported Outcome Measures): Assesses progress on an individualized outcome using a validated set of questions in a variety of domains.

Example goal made
SMART Goal: Walk inside my apartment without a walker for 2 minutes a day, 5 days a week for the next 3 months. (Patient goal)

Much less than expected -2	Somewhat less than expected -1	Expected level 0	Somewhat better than expected +1	Much better than expected +2
Cannot walk at all	Can walk for 1 min/ day, 5 days/wk	Can walk for 2 mins/ day, 5 days/wk	Can walk for 5 mins/ day outside of the house	Can walk for 10 mins/ day outside of the house with the dog

Results of Testing GAS and PPROM

Number of patients/caregivers	GAS	PPROM
Patients Enrolled	13	9
Follow-Ups Completed	13	7
Patients Lost to Follow-up	0	2
Goals Met	10	6

Example goal made
SMART Goal: Make time to go out to lunch with a friend at least once every 2 weeks. (Caregiver goal using the Caregiver Burden domain)

Caregiver Burden

Here is a list of things that other caregivers have found to be difficult. Please put a checkmark in the columns that apply to you. We have included some examples that are common caregiver experiences to help you think about each item. Your situation may be slightly different, but the item could still apply.

	Yes, on a regular basis	Yes, sometimes	No
My sleep is disturbed (for example: the person I care for is in and out of bed or wanders around at night)	☐	☐	☐
Caregiving is inconvenient (for example: helping takes so much time or it's a long drive over to help).	☐	☐	☐
Caregiving is a physical strain (for example: lifting in and out of a chair; effort or concentration is required).	☐	☐	☐
Caregiving is confining (for example: helping restricts free time or I cannot go visiting).	☐	☐	☐

PPROM Domains: Companionship, Depression, Physical Activity, Anxiety, Social Function, Sleep, Caregiver Burden, Pain, Social Function, Cognition, Health Care Task Difficulty, Access to Services and Support, Choice and Control in Daily Function, Community Inclusion.

Project Evaluation & Impact

The Care Support Team tracked Outcome and Balance measures through the duration of the project. Results represent assessment after 12 months of testing GAS and PPROM measures.

	Measures	Results
Outcome	% of patients with improvement in key clinical measures- (Among all patients that completed an outcome scaling who have diagnoses associated with reported key clinical measures)	• Lower BP (HTN)- 60% (3/5) • HgbA1C (Diabetes)- 0% (2/7) people had pre and post data and HgbA1C values are same as baseline • Depression (PhQ9)- 33.3% (1/3) • Hyperlipidemia (LDL or Triglycerides)- no data to report (no pre-post data)
	% of patients that have self-reported improvement	• 46% (6/13)*
	% of patients that have reduction in healthcare utilization	• ED- 42.8% (3/7) • IP- 28.8% (2/7) • NS- 28.6% (2/7)
Balance	Minutes required to complete a GAS	• Baseline: 21 minutes • Follow up: 12 minutes
	Minutes required to complete PROMs	• Baseline:15 minutes • Follow up: 10 minutes
	# of patients spontaneously asked about either measure	• 2

* Excluded patients that were disenrolled from program before self-report comparison could be assessed and those who didn't reach time of 3 month post initial scaling.

Next Steps, Dissemination & Lessons Learned

Next Steps:
Test and operationalize the GAS in a more condensed format (3 outcome options). This is a national multi-site learning collaborative and is still in the tool evaluation phase; test and evaluate in other populations.

Dissemination:
NCQA will be conducting a earning collaborative and disseminating results learned from 6 participating sites. Once value in patient reported outcomes is identified in various care settings, nest steps will be roll out in Palliative Care and Primary Care. Results of this project will inform how goals and PROMs can be effectively incorporated into patient care and provide a basis for development of performance measures for evaluating health care delivery.

Lessons Learned:
- **Expand the potential patient pool to all adults**
  - We lowered age to 60 to be able to include more patients/caregivers.
  - A larger patient pool would allow for greater refinement of these tools.
- **Include non-English speaking patients**
  - Many Care Support patients have ESL, making the use of PROMS that have not been tested in other languages problematic.
- **Explore better delivery of general confidence question**
  - The question "In general, how confident are you that you can control and manage most of your health problems?" is confusing with all participants but especially when used as a tool with caregivers.

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