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 collaborated with the National Committee for Quality Assurance (NCQA) explored how to best develop person-driven outcomes 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 outcome using a validated set of questions in a variety of domains.
- P-PROM measures a patient’s progress towards goal attainment using defined ranges of expected outcomes (expected, better than expected, worse than expected).

Results of Testing GAS and P-PROM

<table>
<thead>
<tr>
<th>Number of patients/caregivers</th>
<th>GAS</th>
<th>PPROM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Enrolled</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Follow-Ups Completed</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Patients Lost to Follow-up</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Goals Met</td>
<td>10</td>
<td>6</td>
</tr>
</tbody>
</table>

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

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)

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

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)

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.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>% 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)</td>
<td>46% (6/13)</td>
<td></td>
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<tr>
<td>% of patients that have self-reported improvement</td>
<td>46% (6/13)</td>
<td></td>
</tr>
<tr>
<td>% of patients that have reduction in healthcare utilization</td>
<td>4-2.8% (4/7)</td>
<td></td>
</tr>
<tr>
<td>Balance</td>
<td>Minutes required to complete a GAS</td>
<td>Baseline: 21 minutes</td>
</tr>
<tr>
<td>Minutes required to complete PROMs</td>
<td>Baseline: 15 minutes</td>
<td></td>
</tr>
<tr>
<td># if patients spontaneously asked about either outcome</td>
<td>Baseline: 10 minutes</td>
<td></td>
</tr>
</tbody>
</table>

Patient Driven Outcomes

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 ranges of expected outcomes (expected, better than expected, worse than expected).

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)

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

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 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 effective 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 especially when used as a tool with caregivers.