



## Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

### Brief Measure Information

**NQF #:** 3568

**Corresponding Measures:**

**De.2. Measure Title:** Person-Centered Primary Care Measure PRO-PM

**Co.1.1. Measure Steward:** American Board of Family Medicine

**De.3. Brief Description of Measure:** The Person-Centered Primary Care Measure instrument is an 11-item patient reported assessment of primary care. Patients complete the PCPCM instrument once a year. These instruments are used to calculate a performance score for the participating entity. That entity could be an individual clinician or a practice. The 11 items of the PCPCM assess primary care aspects rarely captured yet thought responsible for primary care effects on population health, equity, quality, and sustainable expenditures. These include: accessibility, comprehensiveness, integration, coordination, relationship, advocacy, family and community context, goal-oriented care, and disease, illness, and prevention management. The target population of the PCPCM Performance Measure (PRO-PM) is all patients, active in a practice.

Patients are defined as active if they have had a documented interaction with the practice within 12 months of the patient's birth month. In the PCPCM PRO, patients are presented with 11 structured items. After each item, patients are asked to state their level of endorsement. The same scale is used for all 11 items: Definitely, Mostly, Somewhat, Not At All. Active patients receive the PCPCM PRO through mail, email, or patient portal, during the month of their birth (e.g., patients born in January will receive a request to complete the PCPCM PRO in January).

The PCPCM PRO-PM is calculated as a continuous variable on a 0 to 100 point scale, in which a higher value equates to better quality.

The time frame used to evaluate quality with the PCPCM PRO-PM is one year.

Receiving patient responses in the month of their birth allows a practice to receive monthly feedback in between quality reporting periods.

Scoring for the PCPCM PRO-PM is completed through a simple 4 step process using the PCPCM PRO to assess the broad scope of primary care from a patient's perspective.

**Step One:** Exclude incomplete patient responses.

Any PCPCM PRO instrument for which a patient failed to answer at least 8 of the 11 items is excluded from calculations.

**Step Two:** Calculate PCPCM PRO item specific mean scores.

Patients choose one of four response options for each item in the PCPCM PRO instrument. In scoring the PCPCM PRO, the first step requires determining an item mean score for each of the 11 items. Since the instrument scale is word based – Definitely, Mostly, Somewhat, Not At All – each response option must be assigned a value. Values are assigned as follows: Definitely = 4, Mostly = 3, Somewhat = 2, Not At All = 1.

Calculating the mean score for each item then requires looking across all PCPCM PRO instruments received for the entity being assessed during the analysis period. For example, if the entity is a clinician, then all completed (see Step One) PCPCM PRO

instruments collected for that clinician are included in the calculation. If the entity is a practice, then all PCPCM PRO instruments collected for that practice are included in the analysis.

An entity's score for each PCPCM PRO item is calculated as a mean, i.e., the summary of all responses across PCPCM PRO instruments received for the entity, divided by the number of instruments received. This process leads to 11 item specific PCPCM PRO scores. Means should be reported to two decimal points.

Step Three: Calculate the PCPCM PRO total score.

The PCPCM PRO total score for the entity is calculated by determining the mean of the 11 scored PRO items. This is done by adding the mean scores of all 11 PRO items and then dividing by 11. PRO means should be reported to two decimal points.

Step Four: Converting PCPCM PRO total scores and to PCPCM PRO-PM performance score.

In order to use the PCPCM PRO as a performance measure for reporting, the 4 point PCPCM PRO scale must be converted to a 0-100 performance scale. To do this, the PCPCM PRO total score for an entity, as calculated in Step Three, is divided by 4 and then multiplied by 100.

Thus, a PCPCM PRO total score of 2.78 (based on a scale of 1-4) becomes a PCPCM PRO-PM performance score of 69.5 (on a scale of 0-100).

The monthly data collection allows for assessed entities to receive regular feedback during the course of the year. However, PCPCM PRO-PM performance scores are calculated based on quality reporting program requirements or a 12-month time frame.

There is no stratification required with the PCPCM.

#### **1b.1. Developer Rationale:** Rationale

The PCPCM PRO-PM fulfills the call from the Institute of Medicine and from CMS to create a stakeholder informed, meaningful measure that is an assessment of quality, low burden for implementation and collection, and provides adequate ability to compare performance across clinicians and practices while providing great face validity, transparency and actionable information.<sup>1,2</sup> The PCPCM PRO-PM does just that. It is unusual in its combination of robust internal consistency together with breadth and brevity. Its combination of parsimony - with a single item for each of 11 diverse primary care components - and conceptual coherence - exemplified by the fact that all 11 items load onto a single factor - is the result of an unusually broad and deep amount of preparatory work grounded in diverse stakeholder engagement.<sup>3</sup> This stakeholder engagement enabled the development of meaningful measure items and is the reason why the PCPCM PRO-PM covers 4 of the 8 "cross cutting connections" in the CMS Meaningful Measures Framework (identified as patient-centered and meaningful to patients; fulfill requirements in programs' statutes; minimize level of burden for providers; significant opportunity for improvement).<sup>2</sup> The PCPCM PRO-PM also addresses a critical quality measure gap as identified by the MACRA Measure Development Plan Technical Expert Panel, of which Dr. Etz – the developer of the PCPCM PRO-PM – was a part.<sup>4</sup>

Benefits and improvements in quality envisioned by use of this measure

The PCPCM PRO-PM is a performance measure that uses the PCPCM PRO instrument. The performance measure is used to assess quality of primary care from patient perspective, comparing an individual clinician's performance to national benchmarks and to other clinicians in their practice, locally, and regionally, as data availability allow.

The performance measure is calculated based on one year of data collection. PCPCM PRO instruments are received monthly by the practice. Active patients (defined as having had contact with the practice in the 12 months preceding their birth month) receive the PCPCM PRO instrument during the month of their birth. Receiving data on a monthly basis allows clinicians to receive feedback on their performance in between annual reporting periods. Such interim feedback enables constant attention and opportunities for correction of performance during any given performance year.

When validating the PCPCM PRO, we tested its concurrent validity with two existing and validated instruments: the Patient Enablement Instrument (PEI)<sup>5</sup> and the What Matters Index (WMI).<sup>6,7</sup> The PCPCM PRO is well correlated to both the PEI – an assessment of patient self-management – and the WMI – validated to correlate both retrospectively and prospectively with cost and utilization of services. Our comparative analyses used t tests and analysis of variance for continuous variables and c2 for categorical

variables (see Table 1 below). PCPCM PRO-PM scores were strongly and positively associated with the WMI and PEI (both  $p = .0001$ ). It is therefore envisioned that improvements in PCPCM PRO-PM scores, as facilitated by QI activities, will result in both improved patient self-management and reduced cost and utilization of services. See graph in Appendix A.1 (page 3)

The PCPCM PRO-PM is currently being piloted in several settings but is not yet widely implemented. The PCPCM PRO-PM is being piloted by health systems in Colorado, Missouri, Ohio, and Richmond, and within PRIME – a national primary care Qualified Clinical Data Registry (QCDR), hosted by the American Board of Family Medicine. The PCPCM PRO-PM has been endorsed by CMS for use as a QCDR measure in the 2020 MIPS reporting period and is being used by a subset of PRIME members for that purpose. On maintenance review of the PCPCM PRO-PM, we expect to have more information on implementation and scores.

1. Stange KC, Etz RS, Gullett H, et al. Metrics For Assessing Improvements In Primary Health Care. Annual review of public health. 2014;35:423-442.
2. In: Blumenthal D, Malphrus E, McGinnis JM, eds. Vital Signs: Core Metrics for Health and Health Care Progress. Washington (DC) 2015.
3. Etz RS, Zyzanski SJ, Gonzalez MM, Reves SR, O'Neal JP, Stange KC. A New Comprehensive Measure of High-Value Aspects of Primary Care. Ann Fam Med. 2019 May;17(3):221-230.
4. Meaningful Measures Framework of CMS. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy> Accessed June 27, 2020.

**S.4. Numerator Statement:** The PCPCM PRO-PM allows all patients to report their assessment of the quality of primary care received through responses to PCPCM PRO instrument.

The target population is all active patients in a practice during the performance reporting period. A patient is defined as active if the patient has had a documented interaction with the practice within 12 months of the patient's birth month. The PCPCM PRO is the same for all patients, regardless of age. Because the PCPCM PRO applies to all patients and is not particular to a clinical encounter, it is administered once a year to each patient during their birth month.

The target population is defined the same, regardless of unit of analysis (clinician or practice).

The numerator is the sum of all PCPCM PRO scores for active patients.

**S.6. Denominator Statement:** The target population for the denominator is the same as for the numerator.

The denominator is the total number of complete PCPCM PRO instruments received in the reporting period. A completed PRO instrument is defined as a PRO instrument for which the patient has responded to at least 8 of 11 items.

**S.8. Denominator Exclusions:** None.

**De.1. Measure Type:** Outcome: PRO-PM

**S.17. Data Source:** Instrument-Based Data

**S.20. Level of Analysis:** Clinician : Group/Practice, Clinician : Individual

**IF Endorsement Maintenance – Original Endorsement Date: Most Recent Endorsement Date:**

**IF this measure is included in a composite, NQF Composite#/title:**

**IF this measure is paired/grouped, NQF#/title:**

**De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?** N/A

## 1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

**1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form**

NQF\_evidence\_attachment\_11\_7\_2020.docx

**1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?**

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

No

**1b. Performance Gap**

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

**1b.1. Briefly explain the rationale for this measure** (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

*If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.*

**Rationale**

The PCPCM PRO-PM fulfills the call from the Institute of Medicine and from CMS to create a stakeholder informed, meaningful measure that is an assessment of quality, low burden for implementation and collection, and provides adequate ability to compare performance across clinicians and practices while providing great face validity, transparency and actionable information.<sup>1,2</sup> The PCPCM PRO-PM does just that. It is unusual in its combination of robust internal consistency together with breadth and brevity. Its combination of parsimony - with a single item for each of 11 diverse primary care components - and conceptual coherence - exemplified by the fact that all 11 items load onto a single factor - is the result of an unusually broad and deep amount of preparatory work grounded in diverse stakeholder engagement.<sup>3</sup> This stakeholder engagement enabled the development of meaningful measure items and is the reason why the PCPCM PRO-PM covers 4 of the 8 “cross cutting connections” in the CMS Meaningful Measures Framework (identified as patient-centered and meaningful to patients; fulfill requirements in programs’ statutes; minimize level of burden for providers; significant opportunity for improvement).<sup>2</sup> The PCPCM PRO-PM also addresses a critical quality measure gap as identified by the MACRA Measure Development Plan Technical Expert Panel, of which Dr. Etz – the developer of the PCPCM PRO-PM – was a part.<sup>4</sup>

**Benefits and improvements in quality envisioned by use of this measure**

The PCPCM PRO-PM is a performance measure that uses the PCPCM PRO instrument. The performance measure is used to assess quality of primary care from patient perspective, comparing an individual clinician’s performance to national benchmarks and to other clinicians in their practice, locally, and regionally, as data availability allow.

The performance measure is calculated based on one year of data collection. PCPCM PRO instruments are received monthly by the practice. Active patients (defined as having had contact with the practice in the 12 months preceding their birth month) receive the PCPCM PRO instrument during the month of their birth. Receiving data on a monthly basis allows clinicians to receive feedback on their performance in between annual reporting periods. Such interim feedback enables constant attention and opportunities for correction of performance during any given performance year.

When validating the PCPCM PRO, we tested its concurrent validity with two existing and validated instruments: the Patient Enablement Instrument (PEI)<sup>5</sup> and the What Matters Index (WMI).<sup>6,7</sup> The PCPCM PRO is well correlated to both the PEI – an assessment of patient self-management – and the WMI – validated to correlate both retrospectively and prospectively with cost and utilization of services. Our comparative analyses used t tests and analysis of variance for continuous variables and c2 for categorical variables (see Table 1 below). PCPCM PRO-PM scores were strongly and positively associated with the WMI and PEI (both p = .0001). It is therefore envisioned that improvements in PCPCM PRO-PM scores, as facilitated by QI activities, will result in both improved patient self-management and reduced cost and utilization of services. See graph in Appendix A.1 (page 3)

The PCPCM PRO-PM is currently being piloted in several settings but is not yet widely implemented. The PCPCM PRO-PM is being piloted by health systems in Colorado, Missouri, Ohio, and Richmond, and within PRIME – a national primary care Qualified Clinical Data Registry (QCDR), hosted by the American Board of Family Medicine. The PCPCM PRO-PM has been endorsed by CMS for use as a QCDR measure in the 2020 MIPS reporting period and is being used by a subset of PRIME members for that purpose. On maintenance review of the PCPCM PRO-PM, we expect to have more information on implementation and scores.

1. Stange KC, Etz RS, Gullett H, et al. Metrics For Assessing Improvements In Primary Health Care. Annual review of public health. 2014;35:423-442.
2. In: Blumenthal D, Malphrus E, McGinnis JM, eds. Vital Signs: Core Metrics for Health and Health Care Progress. Washington (DC)2015.
3. Etz RS, Zyzanski SJ, Gonzalez MM, Reves SR, O'Neal JP, Stange KC. A New Comprehensive Measure of High-Value Aspects of Primary Care. Ann Fam Med. 2019 May;17(3):221-230.
4. Meaningful Measures Framework of CMS. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy> Accessed June 27, 2020.

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.** *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

During validation reliability testing, variation of PCPCM PRO-PM scores, which illustrate a difference of moderate to large effect size among clinicians in our validation tests, demonstrated a performance gap and opportunities for improvement. Among 6 practices, there were significant differences ( $p=0.004$ ) in PCPCM PRO-PM scores with a moderate effect size (at least .5 standard deviation). See graph in Appendix A.1 (page 3-4)

Among 16 clinicians, there were significant differences ( $p=0.0001$ ) in PCPCM PRO-PM scores with a large effect size ( $>1.0$ ). See graph in Appendix A.1 (page 3-4)

**1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.**

While empirical studies of the PCPCM PRO-PM and its connection to improved outcomes as resulting from quality improvement efforts is limited, its strong concurrent validity with known and validated measures support the benefits likely to result from its use. In addition, existing literature supports both the need for clinician and practice improvement in the areas covered by the PCPCM PRO-PM and the absence of current measures able to support that work.

Current measure sets presume that quality primary care is the sum of quality measures for individual diseases and health screening. Value-based payments to primary care physicians frequently employ measures that are not aligned or recognize the higher-level integrating, personalizing, and prioritizing functions of primary care and the needs of patients, communities or health care systems.<sup>1,2</sup> These measures are then tied to financial incentives which drive behavior to maximize these rudimentary measures. Driving clinicians' behavior toward low-value measures produces burnout and diminishes the value of primary care for people and populations.<sup>3-5</sup> The 2001 Crossing the Quality Chasm report, issued by the Institute of Medicine, revealed a worrying gap in performance between what we know to be good quality care, and care as measured by current forms of assessment.<sup>6</sup> More recent studies of the basic aspects of primary care, such as continuity and comprehensiveness, continue to demonstrate weaknesses in existing attempts both to measure primary care effectively, and to reach measurement targets associated with high quality.<sup>7-9</sup> In addition, measures that focus on single aspects of primary care may inadvertently cause harm to other key aspects of primary care. For instance, studies have shown that quality improvement activities focused on access to care may cause reduced performance in continuity – both of which are critical to overall primary care quality.<sup>10-11</sup>

The PCPCM PRO-PM fulfills the call from the Institute of Medicine and from CMS to create a stakeholder informed, meaningful measure that is an assessment of quality, low burden for implementation and collection, and provides adequate ability to compare performance across clinicians and practices while providing great face validity, transparency and actionable information.<sup>12,13</sup>

1. Etz RS, Gonzalez MM, Brooks EM, Stange KC. Less AND More Are Needed to Assess Primary Care. J Am Board Fam Med. 2017;30(1):13-15.
2. Stange KC, Etz RS, Gullett H, et al. Metrics for assessing improvements in primary health care. Annu Rev Public Health. 2014; 35: 423–442.
3. Berenson RA. If you can't measure performance, can you improve it? Jama. 2016;315(7):645-646.
4. McWilliams J. Michael. Professionalism Revealed: Rethinking Quality Improvement in the Wake of a Pandemic. NEJM Catalyt. 1(5). doi:10.1056/CAT.20.0226
5. Phillips RL. The Built Environment for Professionalism. J Am Board Fam Med. 2020;33(Supplement):S57.
6. Institute of Medicine (U.S.). Committee on Quality of Health Care in America. Crossing the quality chasm : a new health system for the 21st century. Washington, D.C.: National Academy Press; 2001.

7. Bazemore A, Neale AV, Lupo P, Seehusen D. Advancing the Science of Implementation in Primary Health Care. *J Am Board Fam Med*. 2018 May-Jun;31(3):307-311.
8. Gillam SJ, Siriwardena AN, Steel N. Pay-for-performance in the United Kingdom: impact of the quality and outcomes framework: a systematic review. *Ann Fam Med*. 2012 Sep-Oct;5:461-8.
9. Berwick DM. The Moral Determinants of Health. *Jama*. 2020 Jun 12. PMID: 32530455.
10. Casalino LP, Khullar D. Value-Based Purchasing and Physician Professionalism. *JAMA*. 2019;322(17):1647.
11. Campbell SM, Reeves D, Kontopantelis E, Sibbald B, Roland M. Effects of Pay for Performance on the Quality of Primary Care in England. *New England Journal of Medicine*. 2009;361(4):368-378.
12. In: Blumenthal D, Malphrus E, McGinnis JM, eds. *Vital Signs: Core Metrics for Health and Health Care Progress*. Washington (DC)2015.
13. Meaningful Measures Framework of CMS. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy> Accessed June 27, 2020.

**1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability.** (*This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

Evidence to date shows no correlation between self-defined minority status and patient assessment of primary care, using the PCPCM.1 Our findings when validating the PCPCM PRO-PM show neither a positive nor negative association between PCPCM PRO-PM scores and patient self-defined minority status. While unexpected, this does not call into question the validity of patient assessments using the PCPCM PRO-PM.

The existence of health disparities within the US health care system, and in primary care settings, is without question. High quality primary care has previously been shown to mitigate the negative impact associated with negative social drivers of health. 2,3 The PCPCM PRO-PM works to assess the quality of primary care, not the status of population health. The two are associated, but not mutually dependent. For example, Sweden is known to have one of the best population health outcomes, globally, and yet is also known for having a poor primary care system. In a recent study conducted by our team to validate the PCPCM PRO-PM in 28 languages and 34 country settings, including Sweden, the PCPCM PRO-PM was able to detect Sweden’s lower performing primary care.4 It supports the ability of the PCPCM PRO-PM to appropriately assess primary care in spite of social drivers that may disproportionately impact the health of minority populations.

During the maintenance of endorsement period, we intend to focus research efforts to better understand the relationship between the PCPCM PRO-PM and the health outcomes of minority populations so that we may understand how to best use the PCPCM PRO-PM to combat health disparities within the US.

In our validation study, we published findings regarding the PCPCM PRO-PM and known sub-populations1:

“Based on prior research, and clinical and research experience, we hypothesized there would be a positive association between a higher PCPCM score and patients of greater age, patients receiving most of their care from a single physician, the more years a patient knew the physician, a higher What Matters Index score, and a higher Patient Enablement Index score. In contrast, a negative association was hypothesized for patients with minority status and the type of device used to administer the questions was anticipated to be neutral.”

“These associations are in the hypothesized direction ... except for minority status which was nonsignificant. Moreover, rank-ordered associations were observed for income, whether the survey was hard to complete, and whether respondents felt that clinician awareness of their PCPCM responses would positively inform their care. No associations were observed for region, mode of administration, or sex.” See graph in Appendix A.1 (page 4-5)

1. Etz RS, Zyzanski SJ, Gonzalez MM, Reves SR, O’Neal JP, Stange KC. A New Comprehensive Measure of High-Value Aspects of Primary Care. *Ann Fam Med*. 2019 May;17(3):221-230.
2. Starfield B. Primary care and equity in health: the importance to effectiveness and equity of responsiveness to people’s needs. *Humanity and Society*. 2009;33(1/2):56-73.
3. Starfield B. Equity in health. *J Epidemiol Community Health*. 2002;56(7):483-484.
4. Zyzanski SJ, Gonzalez MM, O’Neal JP, Etz RS, Reves SR, Stange KC. Person-Centered Primary Care in 35 OECD Countries. *Ann*



Fam Med. 2020;(in press).

**1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4**

Equity-oriented health care is associated with better patient outcomes,<sup>2</sup> and primary care is associated with health and health care equity.<sup>3-13</sup> The PCPCM measures the mechanisms by which primary care results in greater health and health care equity, and thus will be very useful in efforts to improve equity.

1. Ford-Gilboe M, Wathen CN, Varcoe C, et al. How Equity-Oriented Health Care Affects Health: Key Mechanisms and Implications for Primary Health Care Practice and Policy. *Milbank Q.* 2018;96(4):635-671.
2. Homa L, Rose J, Hovmand PS, et al. A participatory model of the paradox of primary care. *Ann Fam Med.* 2015;13(5):456-465.
3. Kringos DS, Boerma WG, Hutchinson A, van der Zee J, Groenewegen PP. The breadth of primary care: a systematic literature review of its core dimensions. *BMC Health Serv Res.* 2010;10:65.
4. Starfield B. Primary care and equity in health: the importance to effectiveness and equity of responsiveness to people's needs. *Humanity and Society.* 2009;33(1/2):56-73.
5. Starfield B. Equity in health. *J Epidemiol Community Health.* 2002;56(7):483-484.
6. Macinko JA, Starfield B. Annotated bibliography on equity in health, 1980-2001. *Int J Equity Health.* 2002;1(1):1.
7. Starfield B, Shi L, Grover A, Macinko J. The effects of specialist supply on populations' health: assessing the evidence. *Health Aff (Millwood).* 2005;Suppl Web Exclusives:W5-97-W95-107.
8. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *The Milbank Quarterly.* 2005;83(3):457-502.
9. Williams RL, Flocke SA, Stange KC. Race and preventive services delivery among black patients and white patients seen in primary care. *Med Care.* 2001;39(11):1260-1267.
10. Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: a multidisciplinary review. *Vol 3272003.*
11. Starfield B. *Primary Care: Balancing Health Needs, Services, and Technology.* Rev. ed. ed. New York, NY: Oxford University Press; 1998.
12. Starfield B. *Primary Care: Concept, Evaluation, and Policy.* New York, NY: Oxford University Press; 1992.

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. ***Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.***

**2a.1. Specifications** The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

**De.5. Subject/Topic Area** (check all the areas that apply):

**De.6. Non-Condition Specific**(check all the areas that apply):

**De.7. Target Population Category** (Check all the populations for which the measure is specified and tested if any):

**S.1. Measure-specific Web Page** (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

This measure does not yet have a measure-specific web page yet.

**S.2a. If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

[This is not an eMeasure Attachment:](#)

**S.2b. Data Dictionary, Code Table, or Value Sets** (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

[No data dictionary Attachment:](#)

**S.2c.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

[Attachment Attachment: PCPCM\\_Instrument.docx](#)

**S.2d.** Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

[Patient](#)

**S.3.1. For maintenance of endorsement:** Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

[No](#)

**S.3.2. For maintenance of endorsement,** please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

[N/A](#)

**S.4. Numerator Statement** (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

*IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).*

[The PCPCM PRO-PM allows all patients to report their assessment of the quality of primary care received through responses to PCPCM PRO instrument.](#)

[The target population is all active patients in a practice during the performance reporting period. A patient is defined as active if the patient has had a documented interaction with the practice within 12 months of the patient's birth month. The PCPCM PRO is the same for all patients, regardless of age. Because the PCPCM PRO applies to all patients and is not particular to a clinical encounter, it is administered once a year to each patient during their birth month.](#)

[The target population is defined the same, regardless of unit of analysis \(clinician or practice\).](#)

[The numerator is the sum of all PCPCM PRO scores for active patients.](#)

**S.5. Numerator Details** (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

*IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).*

[All patients receive the PCPCM PRO instrument once a year during their birth month. In any given reporting period, any returned PCPCM PRO instruments that do not have at least 8 of the 11 PCPCM PRO items completed are not included in calculations.](#)

[Before calculating the PCPCM PRO total scores, it is necessary to calculate the PCPCM PRO item scores. For PCPCM PRO item scores, the numerator is the sum of all received patient responses eligible for calculation. The value for patient responses is based on the scale of 4 \(Definitely\) to 1 \(Not At All\), as described above.](#)

[The time frame for PCPCM PRO-PM scores is 12 months.](#)



This process is same, regardless of unit of analysis (clinician or practice).

**S.6. Denominator Statement** (Brief, narrative description of the target population being measured)

The target population for the denominator is the same as for the numerator.

The denominator is the total number of complete PCPCM PRO instruments received in the reporting period. A completed PRO instrument is defined as a PRO instrument for which the patient has responded to at least 8 of 11 items.

**S.7. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The target population is all active patients in a practice during the performance reporting period. A patient is defined as active if the patient has had a documented interaction with the practice within 12 months of their birth month. The PCPCM PRO is the same for all patients, regardless of age. Because the PCPCM PRO applies to all patients and is not particular to a clinical encounter, it is administered once a year to each patient during their birth month.

The target population is defined the same, regardless of unit of analysis (clinician or practice).

**S.8. Denominator Exclusions** (Brief narrative description of exclusions from the target population)

None.

**S.9. Denominator Exclusion Details** (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

N/A

**S.10. Stratification Information** (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

No stratification of measure results is required.

**S.11. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

**S.12. Type of score:**

Continuous variable, e.g. average

If other:

**S.13. Interpretation of Score** (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

**S.14. Calculation Algorithm/Measure Logic** (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

Scoring for the PCPCM PRO-PM is completed through a simple 4 step process using the PCPCM PRO to assess the broad scope of primary care from a patient's perspective.

Step One: Exclude incomplete patient responses.

Any PCPCM PRO instrument for which a patient failed to answer at least 8 of the 11 items is excluded from calculations.

Step Two: Calculate PCPCM PRO item specific mean scores.

Patients choose one of four response options for each item in the PCPCM PRO instrument. In scoring the PCPCM PRO, the first step requires determining an item mean score for each of the 11 items. Since the instrument scale is word based – Definitely, Mostly, Somewhat, Not At All – each response option must be assigned a value. Values are assigned as follows: Definitely = 4, Mostly = 3, Somewhat = 2, Not At All = 1.

Calculating the mean score for each item then requires looking across all PCPCM PRO instruments received for the entity being assessed during the analysis period. For example, if the entity is a clinician, then all completed (see Step One) PCPCM PRO instruments collected for that clinician are included in the calculation. If the entity is a practice, then all PCPCM PRO instruments collected for that practice are included in the analysis.

An entity's score for each PCPCM PRO item is calculated as a mean, i.e., the summary of all responses across PCPCM PRO instruments received for the entity, divided by the number of instruments received. This process leads to 11 item specific PCPCM PRO scores. Means should be reported to two decimal points.

Step Three: Calculate the PCPCM PRO total score.

The PCPCM PRO total score for the entity is calculated by determining the mean of the 11 scored PRO items. This is done by adding the mean scores of all 11 PRO items and then dividing by 11. PRO means should be reported to two decimal points.

Step Four: Converting PCPCM PRO total scores and to PCPCM PRO-PM performance score.

In order to use the PCPCM PRO as a performance measure for reporting, the 4 point PCPCM PRO scale must be converted to a 0-100 performance scale. To do this, the PCPCM PRO total score for an entity, as calculated in Step Three, is divided by 4 and then multiplied by 100.

Thus, a PCPCM PRO total score of 2.78 (based on a scale of 1-4) becomes a PCPCM PRO-PM performance score of 69.5 (on a scale of 0-100).

The monthly data collection allows for assessed entities to receive regular feedback during the course of the year. However, PCPCM PRO-PM performance scores are calculated based on quality reporting program requirements or a 12-month time frame.

There is no stratification required with the PCPCM.

**S.15. Sampling** *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed. The PCPCM PRO-PM is calculated on all PCPCM PRO responses received.

Patients unable to respond to the PCPCM PRO because of cognitive impairment may have their responses turned in by proxy. Such proxy would be a non-practice-based caregiver with knowledge of the patient's interaction with the practice.

Patients under the age of 13 should have their PCPCM PRO responses turned in by proxy. Such proxy would be their parent, guardian, or other adult responsible for their care and with knowledge of the patient's interaction with the practice.

Patients 13 years of age through 17 years of age may be given the option to respond to the PCPCM PRO on their own, or to have their responses filled by proxy by the adult responsible for their care.

**S.16. Survey/Patient-reported data** *(If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)*

Specify calculation of response rates to be reported with performance measure results.

To inform quality improvement activities, a minimum of 10 completed PCPCM PRO instruments must be received (8 of 11 items

must have a response).

To provide a PCPCM PRO-PM score, a minimum of 30 completed PCPCM PRO instruments must be received (8 of 11 items must have a response).

If a practice or system has more four or more full time clinicians for whom PCPCM PROs are being collected, quality or performance scores for the practice or system will require a minimum of 120 completed responses.

**S.17. Data Source** (Check *ONLY* the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Instrument-Based Data

**S.18. Data Source or Collection Instrument** (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

The PCPCM PRO-PM performance data are collected using the PCPCM PRO instrument. The PCPCM PRO is an 11-item patient reported instrument. The measure has been tested and validated using the following methods for administration:

- Paper-based delivery, point of care. The paper instrument can be mailed to active patients (defined as having a documented encounter with the practices within 12 months prior to the patient's birth month). Data entry will then be required. Data may be entered into a simple Excel-type document for data management and scoring. Point of care instrument use should not be used for performance measure purposes as these responses will skew positive.
- Asynchronous delivery, electronic administration and submission. Patients active in a practice (defined as having a documented encounter with the practices within 12 months prior to the patient's birth month) can receive the PCPCM PRO via email, patient portal, or email invitation with a unique link, during the month of their birth. Triggering an invitation to complete the PCPCM PRO immediately following a clinical encounter should not be used for performance measure purposes as these responses will skew positive.

The PCPCM PRO instrument is available and validated in the following languages: simple Chinese, Czech, Danish, Dutch, English (British), English (American), Estonian, Finnish, French (European), German, German (Swiss), Greek, Hebrew, Hungarian, Icelandic, Italian, Japanese, Korean, Latvian, Lithuanian, Luxembourgian, Norwegian, Polish, Portuguese (European), Slovakian, Slovenian, Spanish (European), Spanish (Latin American), Swedish, and Turkish. The manuscript supporting the validation of the PCPCM PRO in these languages has been accepted by the Annals of Family Medicine but is not yet been published.

Table 1: The Person-Centered Primary Care Measure (PCPCM) Patient Reported Outcome (PRO) Instrument

**HOW WOULD YOU ASSESS YOUR PRIMARY CARE EXPERIENCE?**

The practice makes it easy for me to get care.

Definitely Mostly Somewhat Not at all

This practice is able to provide most of my care.

Definitely Mostly Somewhat Not at all

In caring for me, my doctor considers all of the factors that affect my health. Definitely Mostly Somewhat Not at all

My practice coordinates the care I get from multiple places.

Definitely Mostly Somewhat Not at all

My doctor or practice knows me as a person.

Definitely Mostly Somewhat Not at all

My doctor and I have been through a lot together.

Definitely Mostly Somewhat Not at all

My doctor or practice stands up for me.

Definitely Mostly Somewhat Not at all

The care I get takes into account knowledge of my family.

Definitely Mostly Somewhat Not at all

The care I get in this practice is informed by knowledge of my community. Definitely Mostly Somewhat Not at all

Over time, this practice helps me to meet my goals.

Definitely Mostly Somewhat Not at all  
Over time, my practice helps me to stay healthy.  
Definitely Mostly Somewhat Not at all

**S.19. Data Source or Collection Instrument** (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

Available in attached appendix at A.1

**S.20. Level of Analysis** (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual

**S.21. Care Setting** (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Outpatient Services

If other:

**S.22. COMPOSITE Performance Measure** - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

N/A

## 2. Validity – See attached Measure Testing Submission Form

PCPCM\_testing\_nqf\_revised\_\_11\_7\_2020.docx

### 2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

No

### 2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

No

### 2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

## 3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

### 3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

#### 3a.1. Data Elements Generated as Byproduct of Care Processes.

Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

### 3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

**3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)** Update this field for **maintenance of endorsement**.

Patient/family reported information (may be electronic or paper)

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.** For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

Data elements used are collected directly from patients. Patients are invited to fill out the PCPCM PRO instrument electronically. In almost all cases, patients are sent an email with an embedded link either to an electronic survey platform, or to an electronic Patient Reported Outcomes (PRO) module as part of the PRIME registry. The most likely format will be electronic sources, however paper-based instruments can be used. In all implementation of the PCPCM PRO-PM to date, performance scores and feedback are provided electronically to practices and clinicians. PCPCM PRO-PM scores are calculated at the point of data collection and then shared with the measured entity.

**3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.**

Attachment:

### 3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

**3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.**

**IF instrument-based**, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

Collecting patient reported information has known challenges. Some practices are able to collect patient reported data using a patient portal in their EHR, however many practices use third party vendors to assist with this process. Based on electronically collected PCPCM PRO instruments from over 4,000 patients, the average time to complete the PCPCM is 60-90 seconds.

We have previously implemented the PCPCM PRO-PM in the PRIME qualified clinical data registry, consisting of a potential pool of over 2400 clinicians, nationally. In this case, PRIME has a Patient Reported Outcomes (PRO) module through which patient data is collected. The QCDR takes on the responsibility of contacting patients as specified by the measure and calculating performance scores, as specified. The PRIME registry includes a clinician dashboard for its members. On the dashboard, PRIME members are able to receive information on their PCPCM PRO-PM score. In this case, practices and clinicians are able to see their data as collected, comparing it to local and national benchmarks. They are also able to see the individual item scores within the PCPCM PRO instrument, thereby enabling targeted quality improvement work. All practices and clinicians involved in this implementation have indicated very low burden related to the PCPCM PRO-PM.

Additionally, we have piloted the PCPCM PRO-PM among 10 practices that do not share an EHR, patient portal, or registry. In this case, our research team created a HIPAA compliant electronic platform that we then made freely available to participating practices. Onboarding for PCPCM PRO-PM use with the help of our platform required that practices fill out basic demographic information for the practice and for participating clinicians. They were then able to securely upload known patient email addresses, patient birth month, and clinician to which the patient is attributed within the practice.

We were able to onboard practices within 1 week and were able to collect PCPCM PRO-PM scores for 16 clinicians and 6 practices within the following 2 weeks. All of this was done in the Spring 2020, during the height of the COVID-19 pandemic in the US. That

practices and clinicians were willing to participate, onboarded quickly, and met the threshold of responses required to compute a PCPCM PRO-PM score during the pandemic is evidence of the low practice/clinician burden associated with use of the PCPCM PRO-PM, and successful strategies to mitigate difficulty with patient generated data collection.

**3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).**

There are no fees or other requirements to use any aspect of the measure as specified.

## 4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

### 4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

#### 4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
Public Reporting	Payment Program <a href="https://qpp.cms.gov/mips/explore-measures?tab=qualityMeasures&amp;py=2020#measures">https://qpp.cms.gov/mips/explore-measures?tab=qualityMeasures&amp;py=2020#measures</a>
Quality Improvement (Internal to the specific organization)	CMS QPP MIPS

#### 4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

Name of program and sponsor: CMS Quality Payment Program – Merit-based Incentive Payment System

Purpose: As stated on the CMS website, “To improve the care received by Medicare beneficiaries. To lower costs to the Medicare program through improvement of care and health. To advance the use of healthcare information between allied providers and patients. To educate, engage and empower patients as members of their care team.”

Geographic area and number and percentage of accountable entities and patients included: This is a national program for CMS applying to all clinicians and practices who receive CMS payments.

Level of measurement and setting: Primary care Clinician – Individual and Clinician – group/practice; the PCPCM PRO-PM has been endorsed for use as a PRIME QCDR measure in the CMS QPP MIPS program as QPP# ABFM10

#### 4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

As described above, the PCPCM PRO-PM has been endorsed for use as a PRIME QCDR measure in the CMS QPP MIPS program as QPP# ABFM10. The PCPCM PRO-PM is on the draft 2020 CMS MUC list as MUC20-0042. At least one insurer is experimenting with the measure, as are two other health systems. The PCPCM PRO-PM is a new measure and is newly being piloted. There are no policies or actions that restrict access or impede implementation. We expect to be able to report current use in our maintenance for endorsement application.

#### 4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6



**years of initial endorsement.** *(Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)*

As described above, the PCPCM PRO-PM has been adopted and implemented by the PRIME registry. Beta testing was conducted in 2019 and full use of the PCPCM PRO-PM began in 2020. As PRIME members are able to report PCPCM PRO-PM for the 2020 CMS QPP cycle, we expect to have data reporting this implementation and adoption within 12 months.

The University of Colorado, in conjunction with Anthem, did their first pilot testing of the PCPCM PRO-PM in July and August of 2020. Approximately 1,550 PCPCM PRO instruments were collected and analysis is ongoing. UC/Anthem intend a second fielding of the PCPCM PRO-PM in January 2021. If the measure continues to perform well, the intention is for it to be used as part of a new primary care payment program.

The University of Missouri, in partnership with their patient survey vendor NRC, is programming the PCPCM PRO-PM to be used among all of their primary care clinicians and locations (family medicine, internal medicine, and pediatrics). Work on this has proceeded according to schedule during the pandemic. Pilot testing of the PCPCM PRO-PM in this setting will take place within the next 12 months. If successful, the intention is for use as part of the payment system.

Virginia Commonwealth University practices were able to use our research-based platform to field the PCPCM PRO-PM among their 6 primary care settings. This work is expected to expand during the next 12 months.

**4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.**

**How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.**

Virginia practices that fielded the PCPCM PRO-PM using our research based electronic platform were provided with their performance scores in relation to other Virginia practices and in relation to national benchmarks as established through validation testing. Clinicians and practices were provided with summary performance scores, as well as PCPCM PRO item level scores (as compared with benchmarks) to enable easy identification of areas in need of improvement. No practices reported negative experience or consequences. Some practices did not have many email addresses for their patients. Among those that did, response rates varied from 14-31%. Future implementation will need to include ways to help practices collect patient email addresses and to help practices know how best to engage patients. In addition, the low maintenance platform created by our research team does not yet have a clinician dashboard. We are in the process of applying for funding to create that functionality. Some tools are available on our website (<https://www.green-center.org/pcpcm>) to assist with quality improvement suggestions however more resources could, and will, be made available.

The PRIME registry has a clinician dashboard and has successfully implemented the PCPCM PRO-PM. No practices have reported burden or difficulty related to PCPCM PRO-PM implementation. Ten practices were involved in the beta testing of the PCPCM and over 34 have currently signed up to use the PCPCM PRO-PM for the 2020 QPP reporting. The PCPCM PRO-PM results are displayed in a variety of ways on the clinician dashboard (see Appendix A.1 pages 6-9). Patient response rate to the PCPCM PRO within PRIME was low. The email address used to distribute the PCPCM PRO-PM may not have been well identified by patients or email providers and may have been screened out as spam. A new address for PCPCM PRO delivery to patients is now being considered. Practices and clinicians are also being provided with more information regarding how best to engage patients in the use of the PCPCM PRO.

In both cases – in Virginia and among the PRIME members, all active patients were eligible to receive the PCPCM PRO. Among the Virginian practices, the all patients with known email addresses were targeted in order to establish practice baselines for use of this new measure. In PRIME, all active patients receive the PCPCM PRO instrument in the month of their birth.

**4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.**

As mentioned above, clinicians have access to their data on their PRIME dashboard on an on-going basis and dashboards are updated as new data becomes available. Educational and explanatory efforts include the following:

1) The lead PCPCM PROM developer and researcher, Dr. Rebecca Etz with the Larry A Green Center, held a live webinar for all PRIME practices. Dr. Etz presented the measure, discussed each step of measure use, measure benefits, and measure results leading to practice improvement activities. Dr. Etz ended with time for questions and dialogue. The webinar was recorded and is available on the PRIME website: <https://primeregistry.org/measures-that-matter/>.

- 2) The PRIME Registry team distributes patient education materials to the practices to encourage patient participation. These materials can be found here: <https://www.green-center.org/pcpcm>.
- 2) Our QCDR vendor presents the measure to each practice in which they are working for measure review.
- 3) PRIME sends email announcements to PRIME practices and promotes the measure during conversations with practices during PRIME webinars and during individual demonstrations.

**4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.**

**Describe how feedback was obtained.**

While implementing and testing this measure, we did not receive any comments regarding burden or unexpected negative consequences related to adoption. A more thorough analysis of use experience by clinicians and patients is planned over the next 12 months.

**4a2.2.2. Summarize the feedback obtained from those being measured.**

This step has not yet been conducted but will be conducted within the next 12 months.

**4a2.2.3. Summarize the feedback obtained from other users**

This step has not yet been conducted but will be conducted within the next 12 months.

**4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.**

This step has not yet been conducted but will be conducted within the next 12 months.

**Improvement**

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

**4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)**

**If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.**

Each item of the PCPCM is actionable. For example, if a clinician scores poorly on the item “Over time, this practice helps me to meet my goals”, clinicians can use that feedback to make sure discussion of patient goals is part of the clinical encounter. The PCPCM is freely available online, as is some advice regarding quality improvement activities and action reflection items to assist with quality improvement efforts.<sup>12</sup> Examples related to each of the PCPCM items include:

PCPCM Item: The practice makes it easy for me to get care

Example Actions: Altering scheduling options, availability, or who does the scheduling; Providing options for asynchronous communication or telehealth visits

PCPCM Item: This practice is able to provide most of my care

Example Actions: Schedule longer visits for more complicated problems or patients so that you provide more of the care rather than referring out; Refer in-house to staff or clinicians with specialized expertise or interests

PCPCM Item: In caring for me, my doctor considers all of the factors that affect my health

Example Actions: Consider starting visits by asking patients what matters to them for this visit; Ask patients, “What one thing would you like someone taking care of you to know?” and add this to the medical record in a consistent and easy-to-see place

PCPCM Item: My practice coordinates the care I get from multiple places

Example Actions: The medical assistant asks and documents any care received elsewhere since my last visit; When doing medication reconciliation, ask about care received elsewhere.

PCPCM Item: My doctor or practice knows me as a person.

Example Actions: Try to talk about at least one non-medical item during each visit; Ask the patients what matters to them; Link recommended treatments to what gives meaning in the patient’s life

PCPCM Item: My doctor and I have been through a lot together.

Example Actions: Do phone follow up after hospital discharges; Consider other ways you might connect with patients’ important

health and life events.

PCPCM Item: My doctor or practice stands up for me.

Example Actions: Let patients know when you spend time doing prior authorizations; Discuss options regarding medications with patients to show them you are aware of patient costs and taking that into account.

PCPCM Item: The care I get takes into account knowledge of my family.

Example Actions: Do a quick and dirty family tree and update it periodically – try to find a consistent place in the EHR to keep this information; More routinely ask about the family as a resource or the impact of the patient's illness on the family.

PCPCM Item: The care I get in this practice is informed by knowledge of my community.

Example Actions: Participate in community events and include that in posters or on the practice website; Ask about the patient's neighborhood.

PCPCM Item: Over time, this practice helps me to meet my goals.

Example Actions: Frame care plans around patients' goals or what matters to them; Do HOPE notes: [https://drwaynejonas.com/wp-content/uploads/2018/01/HOPENoteQuestions\\_WEB.pdf](https://drwaynejonas.com/wp-content/uploads/2018/01/HOPENoteQuestions_WEB.pdf).

PCPCM Item: Over time, my practice helps me to stay healthy.

Example Actions: Look for teachable moments when the patient is open to a health behavior change; Standing orders for immunizations.

Each clinician or practice can create quality improvement activities best suited to their context.

There is a clear and large body of evidence that demonstrates the strong connection between patient experience of care and traditional health care outcomes, such as improved intermediate outcomes, greater adherence to recommended treatment, and reduced use of health care services. Two systematic reviews – one in the US and one in the UK – provide clear evidence to that effect.<sup>1-3</sup>

The items within the PCPCM PRO instrument used to calculate the PCPCM PRO-PM performance measure are also each individually supported by empirical resource as having a strong effect on desirable health outcomes. For instance, continuity of care is associated with improved intermediate outcomes and reductions in cost of care.<sup>4,5</sup> Comprehensiveness has been shown to be associated with lower hospitalization rates, greater use of preventive services, greater adherence to recommended treatment and reduction of burnout among clinicians.<sup>3,6-10</sup>

The ability to assess those aspects of primary care that uniquely contribute to primary care's proven ability to improve patient health outcomes and experience while reducing health burden and costs warrants a national measure. A 2014 review of measures used to assess primary care shows many aspects of care remain unassessed by current measures. The PCPCM allows for patient reported assessment of those aspects of primary care identified by patients and clinicians as most important.<sup>11</sup>

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5 Institute of Medicine (U.S.). Division of Health Care Services. Committee on the Future of Primary Care., Donaldson MS. Primary care : America's health in a new era. Washington, D.C.: National Academy Press; 1996.

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10 Soler JK, Okkes I, Wood M, et al. The coming of age of ICPC: celebrating the 21st birthday of the International Classification of Primary Care. *Fam Pract*. 2008 Aug;4:312-7.

11 Etz RS, Zyzanski SJ, Gonzalez MM, Reves SR, O'Neal JP, Stange KC. A New Comprehensive Measure of High-Value Aspects of Primary Care. *Ann Fam Med*. 2019 May;17(3):221-230.

#### 4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

**4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.**

We have not had any unexpected findings to date. We will be looking for these as implementation of the measure increases.

**4b2.2. Please explain any unexpected benefits from implementation of this measure.**

We have not had any unexpected benefits to date. We will be looking for these as implementation of the measure increases.

## 5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

### 5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

No

#### 5.1a. List of related or competing measures (selected from NQF-endorsed measures)

#### 5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

### 5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

#### 5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

Yes

#### 5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

Conceptually, the PCPCM PRO PM and CAHPS Clinician & Group Surveys (CG-CAHPS) Version 3.0 -Adult, Child (NQF #0005) are different measures, though we have heard some people wonder if there was some overlap. The PCPCM PRO PM has some overlap with population targeted by CG CAHPS: The PCPCM PRO PM targets all patients who have been to a primary care practice, and the CG CAHPS targets all patients who have been seen in ambulatory care settings. Other than this overlap in potential population, this measure is not conceptually similar to CG CAHPS. The CG CAHPS measure is a consumer-based measure that focuses on patient experience of care delivery and is limited to domains such as communication and access. The PCPCM PRO PM is a patient assessment of primary care (not a reporting of patient satisfaction or experience) that covers the full scope of primary care as identified by both clinicians and patients. The PCPCM PRO PM is not encounter specific and the CG CAHPS is based on clinical encounters. For these reasons, there is no need to harmonize these two measures. See Appendix A.1 (pages 10-11) for comparison chart.

### 5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

#### 5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide

**a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)**

## Appendix

**A.1 Supplemental materials may be provided in an appendix.** All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

**Attachment** Attachment: [Appendix\\_A.1-637413747614416086.docx](#)

## Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** American Board of Family Medicine

**Co.2 Point of Contact:** Jill, Shuemaker, [jshuemaker@theabfm.org](mailto:jshuemaker@theabfm.org), 202-524-8313-

**Co.3 Measure Developer if different from Measure Steward:** Virginia Commonwealth University, The Larry A. Green Center

**Co.4 Point of Contact:** Rebecca, Etz, [rebecca.etz@vcuhealth.org](mailto:rebecca.etz@vcuhealth.org), 804-827-4995-

## Additional Information

### Ad.1 Workgroup/Expert Panel involved in measure development

**Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.**

Here is the list of panel members involved in the measure development:

Rebecca S. Etz PhD

- Developer of the Person-Centered Primary Care Measure
- Co-Director, The Larry A. Green Center for the Advancement of Primary Health Care for the Public Good
- Associate Professor, Department of Family Medicine and Population Health, Virginia Commonwealth University, Richmond, Virginia
- Adjunct Associate Professor, Center for Community Health Integration, Case Western Reserve University, Cleveland, Ohio
- Adjunct Associate Professor, University of Colorado, Department of Family Medicine
- Visiting Visionary, The Institute for Integrative Health

Kurt C. Stange MD, PhD

- Developer and Subject Matter Expert, Person-Centered Primary Care Measure
- Co-Director, The Larry A. Green Center for the Advancement of Primary Health Care for the Public Good
- Director, Center for Community Health Integration, Case Western Reserve University, Cleveland, Ohio
- Professor, Departments of Family Medicine & Community Health, Population & Quantitative Health Sciences, General Medical Sciences and Sociology, and Case Comprehensive Cancer Center, Case Western Reserve University, Cleveland, Ohio
- Practicing Family Physician

Stephen J. Zyzanski PhD

- Analyst and Psychometrician, Person-Centered Primary Care Measure
- Center for Community Health Integration
- Professor Emeritus, Departments of Family Medicine & Community Health, Population & Quantitative Health Sciences, Case Comprehensive Cancer Center, Case Western Reserve University, Cleveland, Ohio

Martha M. Gonzalez BA

- Data Manager and Analyst, Person-Centered Primary Care Measure
- Data Manager, The Larry A. Green Center for the Advancement of Primary Health Care for the Public Good
- Data Analyst, Department of Family Medicine and Population Health, Virginia Commonwealth University, Richmond, Virginia

Sarah R. Reves MSN, FNP-C, MBA

- Data Analyst and Subject Matter Expert, Person-Centered Primary Care Measure
- Deputy Director, The Larry A. Green Center for the Advancement of Primary Health Care for the Public Good
- Nurse Researcher, Department of Family Medicine and Population Health, Virginia Commonwealth University, Richmond, Virginia
- Assistant Clinical Faculty, Virginia Commonwealth University Department of Family Medicine

- [Practicing Family Nurse Practitioner](#)  
[Jonathan P. O'Neal BA](#)
- [Data Analyst, Person-Centered Primary Care Measure](#)
- [Program Director, The Larry A. Green Center for the Advancement of Primary Health Care for the Public Good](#)
- [Department of Family Medicine and Population Health, Virginia Commonwealth University, Richmond, Virginia](#)

[We cross-checked this list with the roster of Primary Care and Chronic Illness committee members and none of them participated in the development of this measure.](#)

**Measure Developer/Steward Updates and Ongoing Maintenance**

**Ad.2 Year the measure was first released:**

**Ad.3 Month and Year of most recent revision:**

**Ad.4 What is your frequency for review/update of this measure?** [Current plans are to review/update annually, however this will be adjusted as we learn more](#)

**Ad.5 When is the next scheduled review/update for this measure?**

**Ad.6 Copyright statement:** [This measure has been copyrighted through the Creative Commons and is freely available for use with no fee.](#)

**Ad.7 Disclaimers:**

**Ad.8 Additional Information/Comments:**