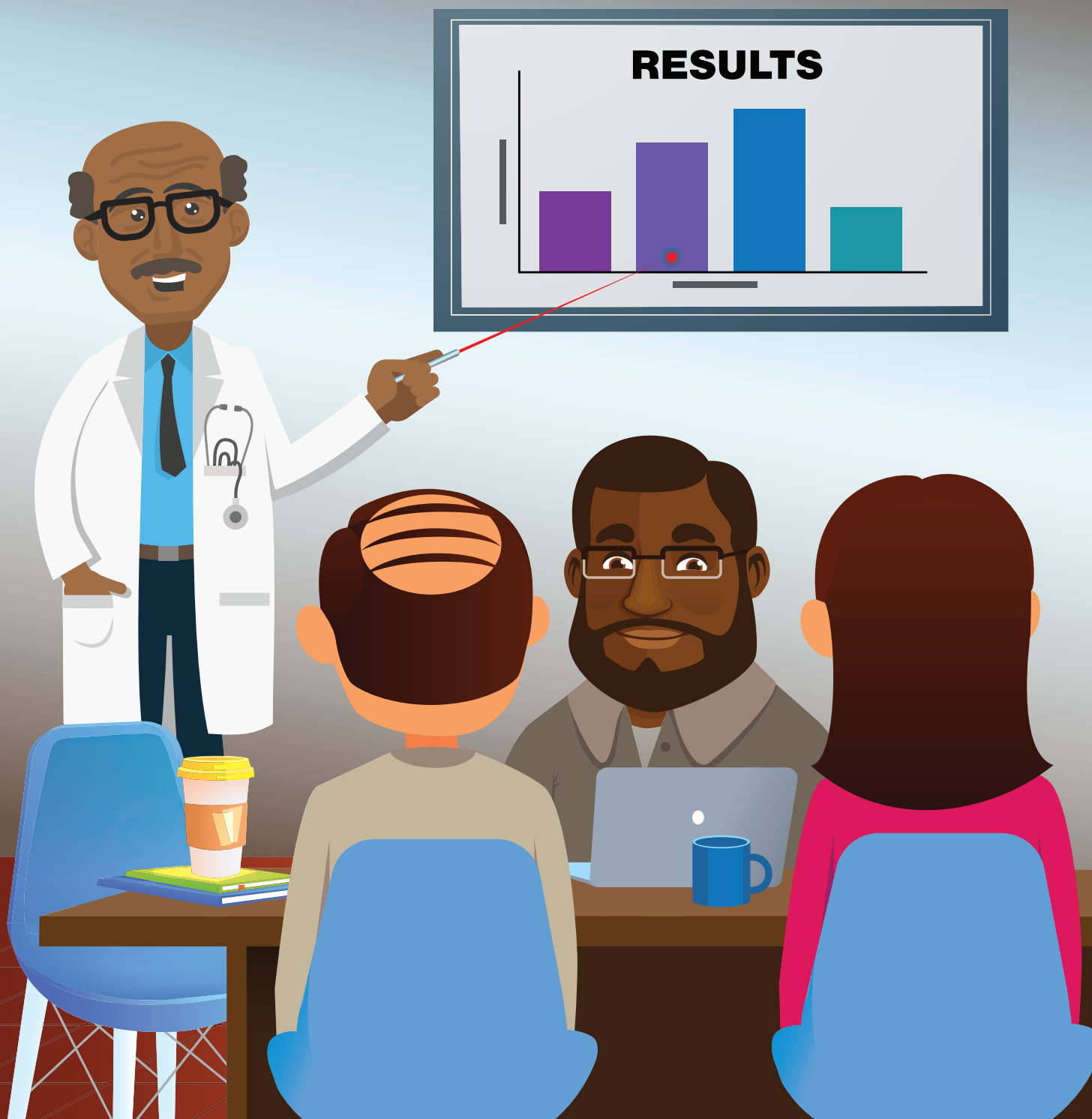


# MEASURING WHAT MATTERS IN PRIMARY CARE: IMPLEMENTING THE PERSON-CENTERED PRIMARY CARE MEASURE

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## What Is the Person-Centered Primary Care Measure?

The Person-Centered Primary Care Measure (PCPCM) ([www.green-center.org/pcpcm](http://www.green-center.org/pcpcm)) is a patient-reported outcome measure developed by the Larry A. Green Center in conjunction with The Center for Professionalism & Value in Health Care's Measures That Matter initiative (<https://professionalismvalue.org/measures-that-matter>). In the March/April 2022 issue of *FPM* ([www.aafp.org/fpm/2022/0300/p17.html](http://www.aafp.org/fpm/2022/0300/p17.html)), we introduced this new measure and described its unique development pathway. In this supplement, we are sharing how the PCPCM is being used in practice and offering some tips and encouragement to help you get started.

The PCPCM is a survey-based measure that asks patients to assess their personal experience of care using the pillars of primary care—comprehensiveness, first contact access, coordination, and continuity—as guideposts. These pillars have long been associated with improvements in individual and population health, health equity, and cost outcomes. However, existing performance measures are largely focused on specific care or disease processes that are not representative of these important aspects of primary care. Even patient satisfaction measures, which are often tied to a particular care encounter, fall well short of assessing a patient's views on the degree to which their primary care physician and care team meet their needs over time.

The questions asked on the 11-item patient-reported outcome survey instrument are designed to move primary care toward a paradigm focused on what matters to patients and physicians. The PCPCM is endorsed by the National Quality Forum (NQF #3568) and approved for use as a Quality Payment Program (QPP) patient-reported outcome performance measure (PRO-PM) in the Medicare Merit-based Incentive Payment System (MIPS) track of QPP (Q#483) (<https://qpp.cms.gov/mips/explore-measures>).

## Practices Leading the Way With the PCPCM

### Department of Family and Community Medicine, University of Missouri School of Medicine, Columbia, MO

- Academic system with 60,000 patients, nine locations, 60 physicians (not including residents), 11 mid-level clinicians, and a residency program with 42 residents



Several years ago, the fact that the PCPCM is designed to measure what matters to patients and physicians caught the attention of Michael LeFevre, MD, chair of the Department of Family and Community Medicine at the University of Missouri (MU) School of Medicine in Columbia. In his 2017 commentary “It Matters What Is Measured” ([www.jabfm.org/content/30/1/8.full](http://www.jabfm.org/content/30/1/8.full)), LeFevre argues that the existing approach to measuring primary care is “targeted almost exclusively at measuring health care processes and intermediate outcomes, not health.”<sup>1</sup> Noting that the explosion in quality measures is built largely around what can be measured, he states, “Not everything that can be counted counts, and not everything that counts can be counted.”<sup>1</sup> The PCPCM’s potential to measure what counts is the reason he pressed for its implementation at MU. In comments to the American Academy of Family Physicians (AAFP) about his experience, LeFevre said, “The PCPCM gets to what people want and need, which is a personal relationship with a primary care physician, someone who knows you and your story.”

The PCPCM is designed to be implemented relatively easily and with little to no added cost, but successful implementation may require a strong champion like LeFevre. This is especially true if your practice is part of a larger organization. Large health care organizations often have whole divisions accountable for quality measurement or patient experience. Many factors, including requirements set by certifying bodies and existing performance-based contracts, may drive considerations regarding what to measure. Serving as an advocate for the PCPCM within your organization is an important step toward its use. For example, LeFevre's advocacy within his organization resulted in MU's patient experience survey vendor agreeing to distribute the PCPCM at no additional cost.

#### **Westminster Medical Clinic, Westminster, CO**

- Small, independently owned, single location practice with 6,500 patients, three physicians, and four mid-level clinicians
- Self-described as a “family medicine family, taking care of individuals and families”
- Guiding philosophy: “It’s not what’s the matter with you, it’s what’s most important to you.”

The Westminster Medical Clinic in Westminster, CO, is an example of an independent family medicine practice that implemented the PCPCM with relative ease. Practice administrator Caitlin Barba told the AAFP that the practice is using the PCPCM because the assessment supports their objective “to move care and practice into a framework of what matters to patients.” To put these words into action, the clinic not only implemented the PCPCM survey in 2021, but they also shared the results with their patient advisory council. Council members expressed appreciation that the PCPCM was developed with input from patients, for patients. The council's feedback helped practice leadership better understand steps they could take to strengthen their strong baseline scores at both the physician and practice levels.

Barba noted that Westminster's leadership embraces a “heal thyself to heal others” philosophy for the practice and works hard to ensure all physicians, other clinicians, and staff members find joy and satisfaction in their work. Reviewing survey responses helped physicians and care teams feel better connected with their patients on a more personal level, which contributed to improving their job satisfaction. This was an unexpected and important outcome of administering the PCPCM.

Westminster Medical Clinic took the PCPCM to another level when they invited care teams that included physicians, physician assistants (PAs), and nurse practitioners (NPs) to complete the survey as a form of self-assessment. Comparing the care teams' responses with patients' responses helped the practice identify differences between how they thought they were doing and how their patients thought they were doing. As part of the clinic's efforts to incorporate what they learned from the survey, they added the question “What's most important to you?” to their patient intake paperwork.

#### **Moving Toward Measuring What Matters**

Champions of the PCPCM like LeFevre and Barba strongly believe that the survey is an important step toward measuring what matters with the goal of replacing the existing approach to performance measurement, which is burdensome and relies on many narrow process- and system-based measures. In order to improve individual and population health outcomes in a cost-efficient manner, the AAFP strongly advocates for a more rational, aligned measurement approach that reflects aspects of primary care that matter to patients and physicians. The AAFP also advocates for adoption of the PCPCM in performance-based contracts, including value-based payment. Family physicians and family medicine practices can be instrumental in this effort by implementing the PCPCM and asking for it to be included in all of their performance-based contracts.

## Tips to Get Started With PCPCM Implementation

The following are a few things to think about before you start using the PCPCM:

1. Determine whose buy-in you need to move forward with implementation. Can you make this decision independently or do you need to work with others within your organization? Are any of your payers willing to adopt the PCPCM as a performance measure?
2. Decide how you want the survey to be delivered to patients (e.g., patient portal, email, paper) during their birth month and whether you want to “go it alone” (as Westminster Medical Clinic did) or enlist the services of a vendor or registry.
  - a. A vendor typically acts outside the context of the practice’s electronic health record (EHR) to support patient surveys.
  - b. The American Board of Family Medicine (ABFM) PRIME Registry (<https://primeregistry.org/>) is an example of a registry that supports use of the PCPCM. It can connect to the practice’s EHR, pull patient contact information, and send an email to patients during their birth month inviting them to participate in the PCPCM survey. The email provides a link that opens a patient portal in which patients respond to the survey. Their answers are then fed back to a quality dashboard that physicians and practices can use to inform quality improvement.
  - c. Some registries and third-party vendors can also report PCPCM data to MIPS.
3. Decide how to engage your patients.
  - a. This involves shaping the message that accompanies the survey. According to LeFevre, informing patients about the importance and intended use of the PCPCM results may help increase survey response.
  - b. Consider sharing the PCPCM results with your patient advisory council. If you don’t have a patient advisory council, this is an opportunity to form one. The AAFP provides information and resources to support patient engagement at <https://www.aafp.org/engagement>.

To learn more about the PCPCM, visit the Green Center’s website ([www.green-center.org/pcpcm](http://www.green-center.org/pcpcm)), where you can find useful resources and download the survey in multiple languages.

## References

1. LeFevre M. It matters what is measured. *J Am Board Fam Med*. 2017;30(1):8-9.

