Performance Measurement and Quality Improvement

(QI Competencies A, B & C)

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Community Health Solutions

QI 01-04 feed into QI 08-11

QI 01 - 04 **Analyze**	*QI 08 - 11* **Set goals and Act to Improve**	*QI 12* **Achieve Improvement**
5 clinical measures from 4 categories →	3 measures (out of the 5) from 3 categories	Achieve improvement on 2 measures
2 resource stewardship measures from 2 categories →	1 measure (out of the 2)	
Availability of major appointment types →	Same	
Monitor patient experience →	1 measure	

QI – Competency A

The practice measures to understand current performance and to identify opportunities for improvement.

Criteria	Criteria Description	Required Evidence
QI 01 (Core)	**Clinical Quality Measures:** Monitors at least five clinical quality measures across the four categories (Must monitor at least 1 measure of each type). A. Immunization measures B. Other preventive care measures C. Chronic or acute care clinical measures D. Behavioral health measures*	*Report*
QI 02 (Core)	**Resource Stewardship Measures:** Monitors at least two measures of resource stewardship. (Must monitor at least 1 measure of each type). A. Measures related to care coordination B. Measures affecting health care costs	*Report*
QI 03 (Core)	**Appointment Availability**: Assesses performance on availability of major appointment types to meet patient needs and preferences for access.	*Documented process* ***AND*** *Report*

QI – Competency A
(continued)

The practice measures to understand current performance and to identify opportunities for improvement.

Criteria	Criteria Description	Required Evidence
QI 04 (Core)	**Patient Experience Feedback:** Monitors patient experience through **A. Quantitative data**: The practice conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as: • Access, • Communication, • Coordination, • Whole person care, self-management support and comprehensiveness **B. Qualitative data**: The practice obtains feedback from patients/families/caregivers through qualitative means	*Report*

QI – Competency A
(continued)

The practice measures to understand current performance and to identify opportunities for improvement.

Criteria	Criteria Description	Required Evidence
QI 05 **(1 Credit)**	**Health Disparities Assessment:** Assesses health disparities using performance data stratified for vulnerable populations. (Must choose one from each section) A. Clinical Quality B. Patient Experience	*Report **OR** Quality Improvement Worksheet*
QI 06 **(1 Credit)**	**Validated Patient Experience Survey Use**: The practice uses a standardized, validated patient experience survey tool with benchmarking data available	*Report*
QI 07 **(2 Credits)**	**Vulnerable Patient Feedback:** The practice obtains feedback on experiences of vulnerable patient groups.	*Report*

QI – Competency B

The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.

Criteria	Criteria Description	Required Evidence
QI 08 (Core)	**Goals and Actions to Improve Clinical Quality Measures:** Sets goals and acts to improve upon at least three measures across at least three the four categories. A. Immunization measures B. Other preventive care measures C. Chronic or acute care clinical measures D. Behavioral health measures*	*Report **OR** Quality Improvement Worksheet*
QI 09 (Core)	**Goals and Actions to Improve Resource Stewardship Measures:** Sets goals and acts to improve upon at least one measure of resource stewardship. A. Measures related to care coordination B. Measures affecting health care costs	*Report **OR** Quality Improvement Worksheet*
QI 10 (Core)	**Goals and Actions to Improve Appointment Availability:** Sets goals and acts to improve on availability of major appointments types to meet patient needs and preferences.	*Report **OR** Quality Improvement Worksheet*
QI 11 (Core)	**Goals and Actions to Improve Patient Experience:** Sets goals and acts to improve on at least one patient experience measure.	*Report **OR** Quality Improvement Worksheet*

QI – Competency B
(continued)

The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.

Criteria	Criteria Description	Required Evidence
QI 12 (2 Credits)	**Improved Performance:** Achieves improved performance on at least two performance measures.	*Report **OR** Quality Improvement Worksheet*
QI 13 (1 Credit)	**Goals and Actions to Improve Disparities in Care/Services**: Sets goals and acts to improve disparities in care or services on at least one measure.	*Report **OR** Quality Improvement Worksheet*
QI 14 * (2 Credits)	**Improved Performance for Disparities in Care/Services:** Achieves improved performance on at least one measure of disparities in care or service.	*Report **OR** Quality Improvement Worksheet*

QI – Competency C

The practice is accountable for performance. The practice shares performance data with the practice, patients and/or publicly for the measures and patient populations identified in the previous section.

Criteria	Criteria Description	Required Evidence
QI 15 (Core)	**Reporting Performance within the Practice:** Reports practice-level or individual clinician performance results within the practice for measures reported by the practice.	*Documented process **AND** Evidence of implementation*
QI 16 (1 Credit)	**Reporting Performance Publicly or with Patients:** Reports practice-level or individual clinician performance results publicly or with patients for measures reported by the practice.	*Documented process **AND** Evidence of implementation*
QI 17 (2 Credits)	**Patient/Family/Caregiver Involvement in Quality Improvement:** Involves patient/family/caregiver in quality improvement activities.	*Documented process **AND** Evidence of implementation*
QI 18 (2 Credits)	**Reporting Performance Measures to Medicare/Medicaid:** clinical quality measures to Medicare or Medicaid agency	*Evidence of submission*
QI 19 * (Maximum 2 credits)	**Value-Based contract Agreements:** The practice is engaged in Value-Based Contract Agreement. (Maximum 2 credits) A. Practice engages in up-side risk contract (1 credit) B. Practice engages in two-sided risk contract (2 credits)	*Agreement **OR** Evidence of implementation*

https://chcleadership.com/wp-content/uploads/2019/06/QI_PCMH-Standards-and-Guidelines-2017-Edition-Version-4.pdf

Performance Measurement and Quality Improvement (QI)

The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/caregivers in quality improvement activities.

Competency A: Measuring Performance. The practice measures to understand current performance and to identify opportunities for improvement.

QI 01 (Core) Clinical Quality Measures: Monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type):

A. Immunization measures.
B. Other preventive care measures.
C. Chronic or acute care clinical measures.
D. Behavioral health measures.

GUIDANCE	EVIDENCE
Measuring and reporting clinical quality measures helps practices deliver safe, effective, patient-centered and timely care. The practice shows that it monitors at least five clinical quality measures, including at least: • One immunization measure. • One preventive care measure (not including immunizations). – A measure on oral health counts as a preventive clinical quality measure. • One chronic or acute care clinical measure. • One behavioral health measure. The data must include the measurement period, the number of patients represented by the data, the rate and the measure source (e.g. HEDIS, NQF #, measure guidance).	• **Report**

QI 02 (Core) Resource Stewardship Measures: Monitors at least two measures of resource

Selecting Measures

Quality Measures Crosswalk for PCMH 2017

https://www.ncqa.org/portals/0/Programs/Recognition/PCMH/Quality_Measures_Crosswalk.pdf

Quality Measures Crosswalk for PCMH 2017[▲]

KEY TO TABLE SYMBOLS

- ▲ NCQA intends to accept the results of these measures for the 2017 PCMH program. The specifications for these measures are available through CMS eCQM Library at: https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html
- ⚑ Measure included in Quality Payment Program Merit-based Incentive Payment System (MIPS).
- ⌘ HEDIS and Medicare Star measure specifications differ from CMS eCQM specifications.
- ‡ HEDIS Measure included here though HEDIS specification is different than CMS eCQM specification and data collection methodology is via Electronic Clinical Data Systems Reporting (ECDS).
- ★ Medicare Stars measures: A version of this measure is included in the Medicare Stars program though the specifications and method of collection differ from the CMS eCQM version used for the PCMH 2017 program.

Measure Title	NQF # (CMS eCQM #)	Population	NCQA eMeasure Certification	CMS/AHIP Consensus Core Set ACO & PCMH	CPC+	HEDIS Plan Level & Medicare Star Rating System	NCQA PCMH 2017 Recognition Credit	Owner (Developer)
ACUTE CARE								
Appropriate Treatment for Children with Upper Respiratory Infection ⚑	69 (154)	Pediatric	✓			✓	QI 01C	NCQA[i]
BEHAVIORAL HEALTH/CHRONIC CARE								
ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder Medication ⚑	108 (136)	Pediatric	✓			✓	QI 02A	NCQA
Dementia: Cognitive Assessment ⚑	NA (149)	Adult			✓		QI 01D	AMA PCPI[ii]
Depression Remission at 12 Months (Outcome) ⚑	710 (159)	Adult	✓	✓	✓	✓‡	QI 01D	MNCM[iii]
Depression Utilization of the PHQ-9 Tool ⚑	712 (160)	Adult	✓			✓‡	QI 01D	MNCM

Possible Measures for QI 01 – from Meaningful Use

Immunization Measures

- Pneumonia Vaccination Status for older Adults **MU*
- Influenza Immunization **MU*
- Childhood Immunizations

Preventive Care Measures

- Influenza Immunization **MU*
- Tobacco Use: Screening and cessation intervention
- Cervical Cancer Screening
- Colorectal Cancer Screening

Possible Measures for QI 01 – from Meaningful Use *(continued)*

- Chronic/Acute Care Clinical Measures
  - Controlling High Blood Pressure
  - Hemoglobin A1C Poor Control
  - Coronary Artery Disease (CAD): Lipid Therapy
  - Use of Appropriate Medications for Asthma

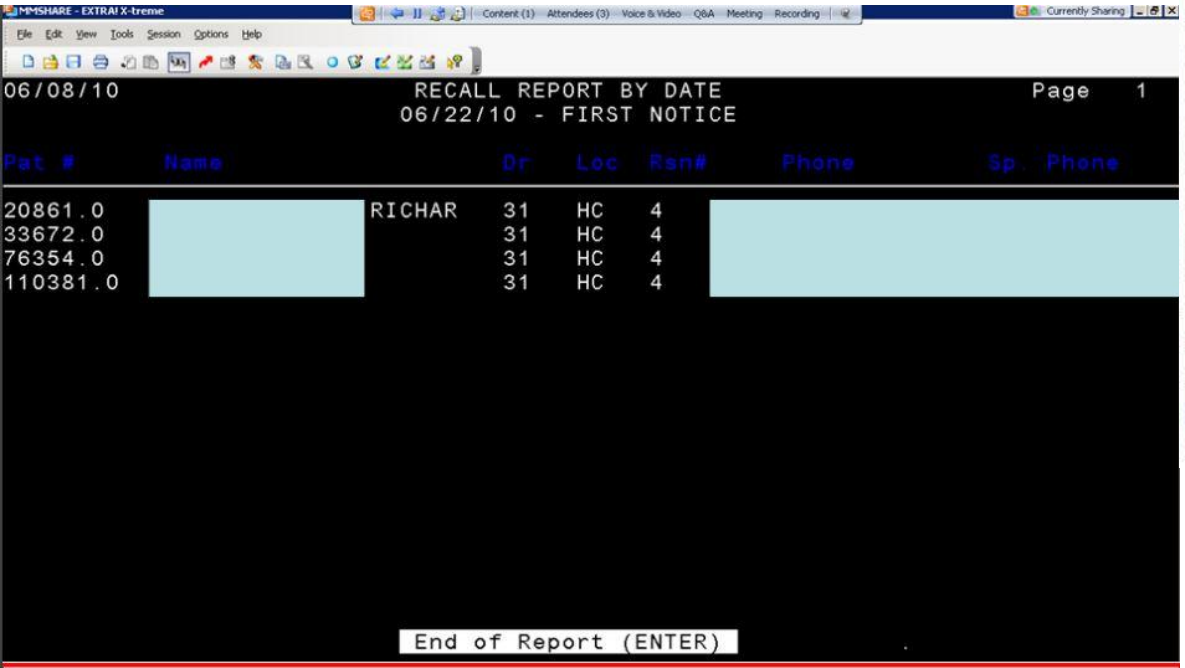
Note: This list is not exhaustive, and is for demonstration purposes only. Clinics may be reporting other measures (other or beyond those above). Clinics should choose the measures that fit their patient population, capacity, and priorities.

Performance Measurement & Quality Improvement

QI 01 A-C: Example

Health Maintenance Topic 1/1/ – 12/31/	In compliance	Overdue	Total
Breast Cancer Screening	51.05% 1,381	48.95% 1,324	100% 2,705
Colon Cancer Colonoscopy	63.35% 1,965	36.65% 1,137	100% 3,102
Pneumococcal Vaccine	83.11% 743	28.36% 350	100% 1,234
Foot Exam	74.84% 992	25.16% 350	100% 1,232
Hemoglobin A1C	71.64% 884	28.36% 350	100% 1,234
Urine Microalbumin/Creatinine Ratio	67.13% 825	32.87% 404	100% 1,229

QI 01-B – Documentation and Provider Reminder Tool for Preventative Visits



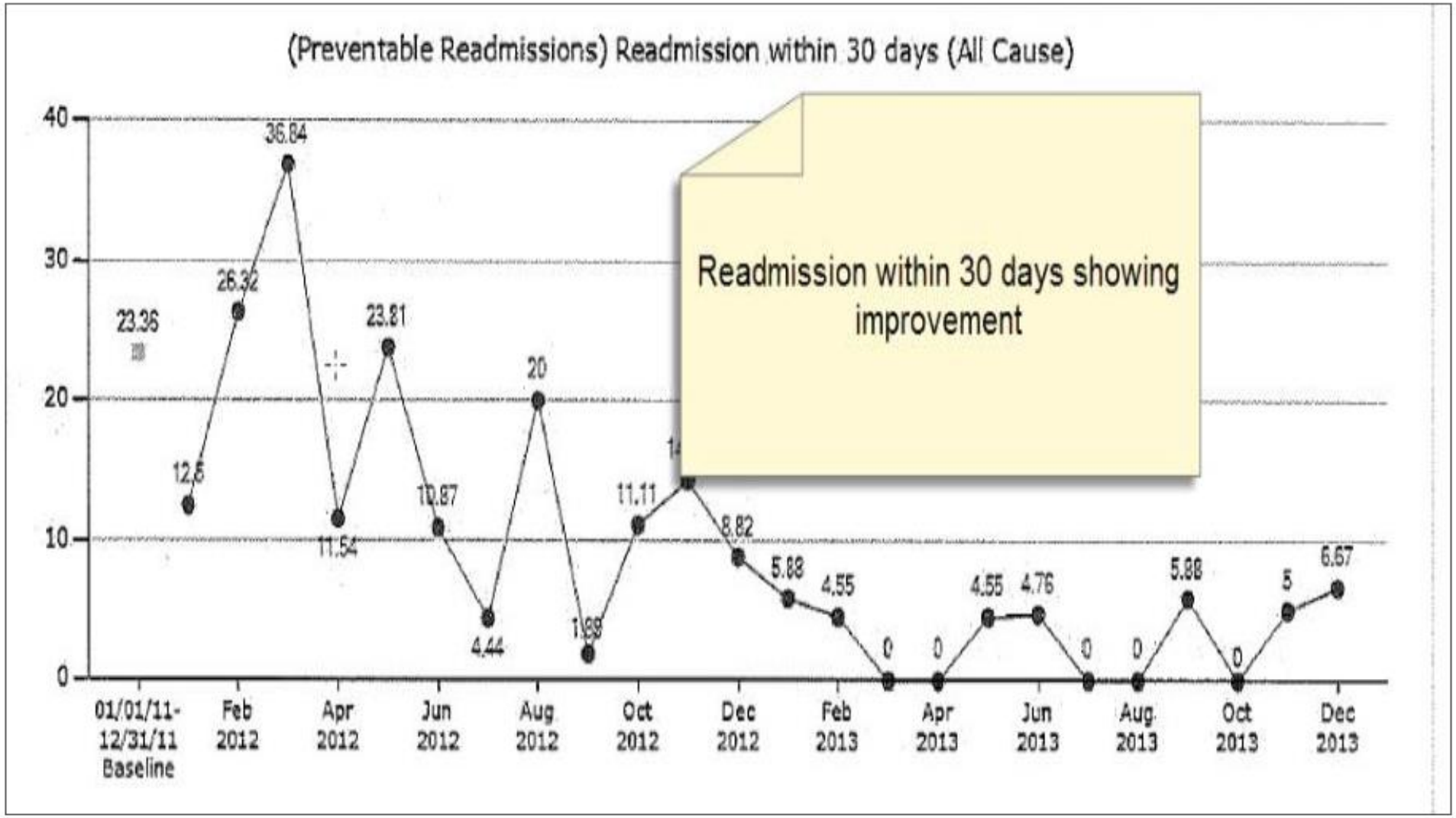
PPC2F-4,5: The Recall Report function is a part of the practice management system which allows designated members of the healthcare team to enter reminders for future appointments. For example, if a patient comes in for a preventive visit today and does not schedule an appointment for next year upon checking out, team members can enter into the recall system a reminder that prompts them in a year to proactively contact the patient. It is used for primary preventive care, including complete physical exams, lab tests and imaging studies. In this case, the list of patients are due for their Annual Male Physical Exam (Rsn# 4 as seen above). Healthcare team members in each location reconcile this report weekly.

Physician Name	CPT code	Cpt code desc	Diag code	Diag code desc	Date of service	Pat Date of Birth	Patient Name	Phone Number	Pat Sex
BAKER, MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/03/2009	09/06/1966	[redacted]		M
JENIKE, MD	99395	PREVENTIVE EST. PATIENT AGE 18-39	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/03/2009	12/19/1970			M
PHILLIPS MD	99395	PREVENTIVE EST. PATIENT AGE 18-39	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/03/2009	01/27/1976			M
PHILLIPS MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/03/2009	11/01/1957			M
SHERRILL MD	99395	PREVENTIVE EST. PATIENT AGE 18-39	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/03/2009	04/25/1976			M
JENIKE, MD	99395	PREVENTIVE EST. PATIENT AGE 18-39	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/03/2009	12/30/1969			M
SHERRILL MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/03/2009	12/16/1948			M
BERGER	99395	PREVENTIVE EST. PATIENT AGE 18-39	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/03/2009	05/23/1974			M
BERGER	99395	PREVENTIVE EST. PATIENT AGE 18-39	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/03/2009	10/14/1971			M
JENIKE, MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/03/2009	07/16/1963			M
BERGER	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/04/2009	06/23/1954			M
SHERRILL MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/04/2009	06/24/1962			M
BAKER, MD	99385	PREVENTIVE NEW PATIENT AGE 18-39	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/04/2009	12/02/1970			M
BERGER	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/04/2009	03/26/1960			M
SHERRILL MD	99395	PREVENTIVE EST. PATIENT AGE 18-39	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/04/2009	01/10/1985			M
SHERRILL MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/05/2009	12/19/1968			M
BERGER	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/05/2009	09/23/1953			M
BAKER, MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/05/2009	09/18/1964			M
JENIKE, MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/05/2009	08/10/1956			M
JENIKE, MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/05/2009	07/02/1956			M
BERGER	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/05/2009	10/25/1959			M
BERGER	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/05/2009	12/24/1952			M
PHILLIPS MD	99385	PREVENTIVE NEW PATIENT AGE 18-39	v70.0	WELL EXAM OVER AGE 17 & OLDER	08/05/2009	10/12/1978			M
BAKER, MD	99395	PREVENTIVE EST. PATIENT AGE 18-39	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/06/2009	06/24/1970			M
JENIKE, MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/06/2009	09/06/1952			M
JENIKE, MD	99395	PREVENTIVE EST. PATIENT AGE 18-39	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/06/2009	12/10/1983			M
PHILLIPS MD	99385	PREVENTIVE NEW PATIENT AGE 18-39	v70.0	WELL EXAM OVER AGE 17 & OLDER	08/06/2009	07/01/1980			M
BERGER	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/06/2009	04/01/1951			M
SHERRILL MD	99395	PREVENTIVE EST. PATIENT AGE 18-39	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/06/2009	11/04/1972			M
JENIKE, MD	99395	PREVENTIVE EST. PATIENT AGE 18-39	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/06/2009	07/07/1970			M
SHERRILL MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/07/2009	04/18/1962			M
SHERRILL MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/07/2009	10/02/1954			M
SHERRILL MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	v70.0	WELL EXAM OVER AGE 17 & OLDER	08/10/2009	04/24/1964			M
SHERRILL MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	v70.0	WELL EXAM OVER AGE 17 & OLDER	08/10/2009	01/26/1965			M
SHERRILL MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	v70.0	WELL EXAM OVER AGE 17 & OLDER	08/10/2009	01/28/1968			M
SHERRILL MD	99395	PREVENTIVE EST. PATIENT AGE 18-39	v70.0	WELL EXAM OVER AGE 17 & OLDER	08/11/2009	02/14/1990			M
BERGER				ER AGE 17 & OLDER	08/11/2009	11/10/1952			M
BERGER				ER AGE 17 & OLDER	08/11/2009	04/24/1945			M
BERGER				ER AGE 17 & OLDER	08/11/2009	05/01/1972			M
BERGER				ER AGE 17 & OLDER	08/11/2009	04/16/1976			M
SHERRILL MD				ER AGE 17 & OLDER	08/11/2009	02/15/1953			M
JENIKE, MD				ER AGE 17 & OLDER	08/12/2009	07/23/1980			M
JENIKE, MD				ER AGE 17 & OLDER	08/12/2009	08/12/1990			M
JENIKE, MD				ER AGE 17 & OLDER	08/12/2009	02/27/1947			M
SHERRILL MD				ER AGE 17 & OLDER	08/12/2009	12/20/1947			M
BERGER				ER AGE 17 & OLDER	08/12/2009	10/08/1968			M
BAKER, MD				ER AGE 17 & OLDER	08/13/2009	04/24/1981			M
BAKER, MD				ER AGE 17 & OLDER	08/13/2009	05/25/1971			M
SHERRILL MD				ER AGE 17 & OLDER	08/13/2009	05/09/1964			M
BERGER				ER AGE 17 & OLDER	08/13/2009	04/12/1970			M
SHERRILL MD	99395	PREVENTIVE EST. PATIENT AGE 18-39	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/13/2009	11/09/1981			M
JENIKE, MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/14/2009	04/18/1958			M
JENIKE, MD	99395	PREVENTIVE EST. PATIENT AGE 18-39	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/14/2009	02/14/1977			M
SHERRILL MD	99396	PREVENTIVE EST. PATIENT AGE 40-64	V70.0	WELL EXAM OVER AGE 17 & OLDER	08/14/2009	07/09/1961			M

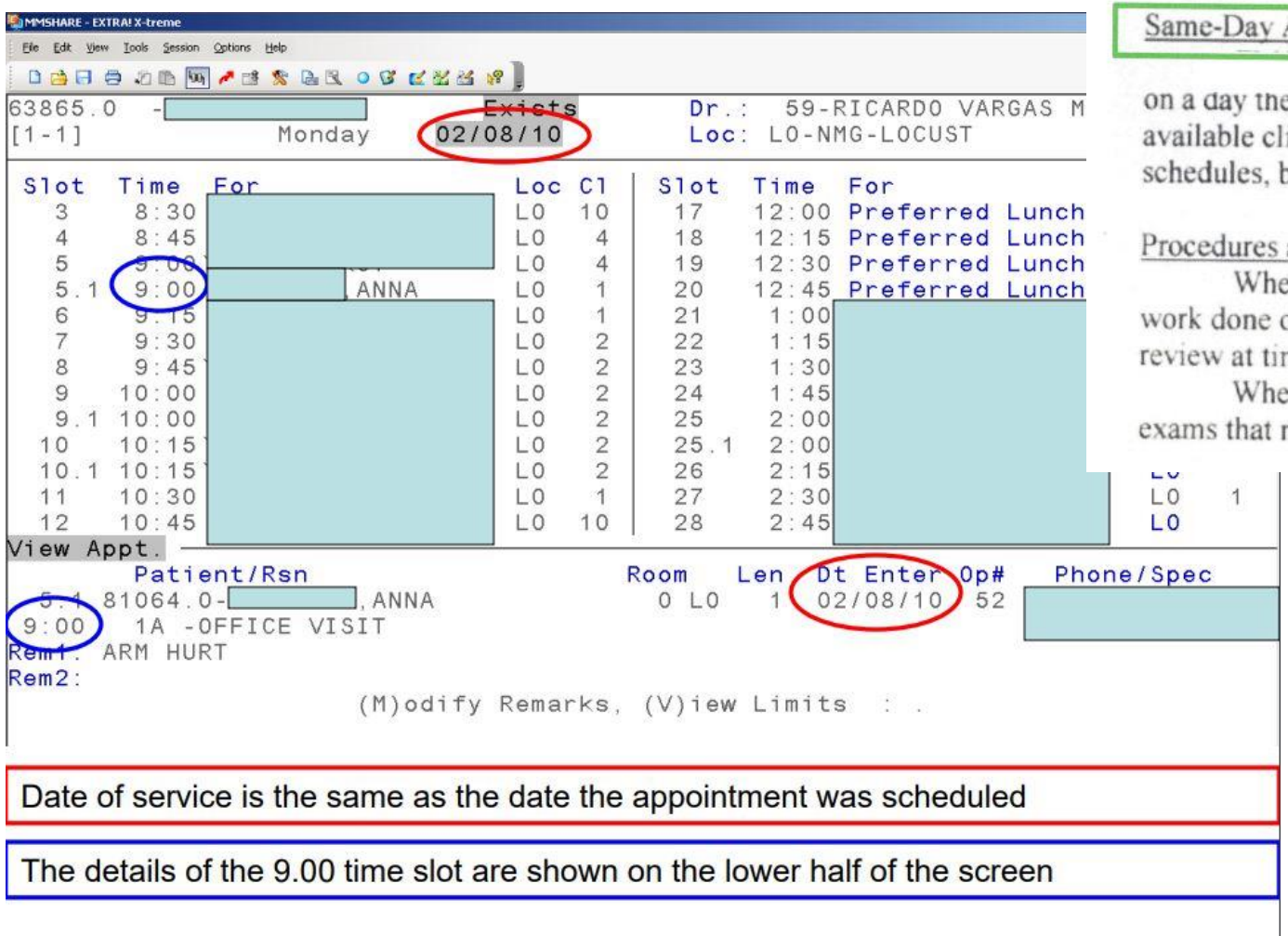
PPC2F-4: This is a location specific report that identifies all male patients between the ages of 17 and 64 who are due for a preventive visit in August of 2010. This report is ran monthly and forwarded to Health care team members who use this report to check if appointments are already scheduled. If appointments are not yet scheduled, team members will contact the patients to schedule their annual preventive visit.

Performance Measurement & Quality Improvement

QI 02 B: Example



QI 03 – Documentation of Same Day Access



Date of service is the same as the date the appointment was scheduled

The details of the 9.00 time slot are shown on the lower half of the screen

PCMH 1A: Example Scheduling Policy

Office Scheduling Policy

Personal Clinicians:

For all routine office visits (check-ups, follow-ups) and physicals, patients are to be scheduled with their personal clinician (which-ever provider they see on a regular basis) to keep continuity of care.

Same-Day Appointments:

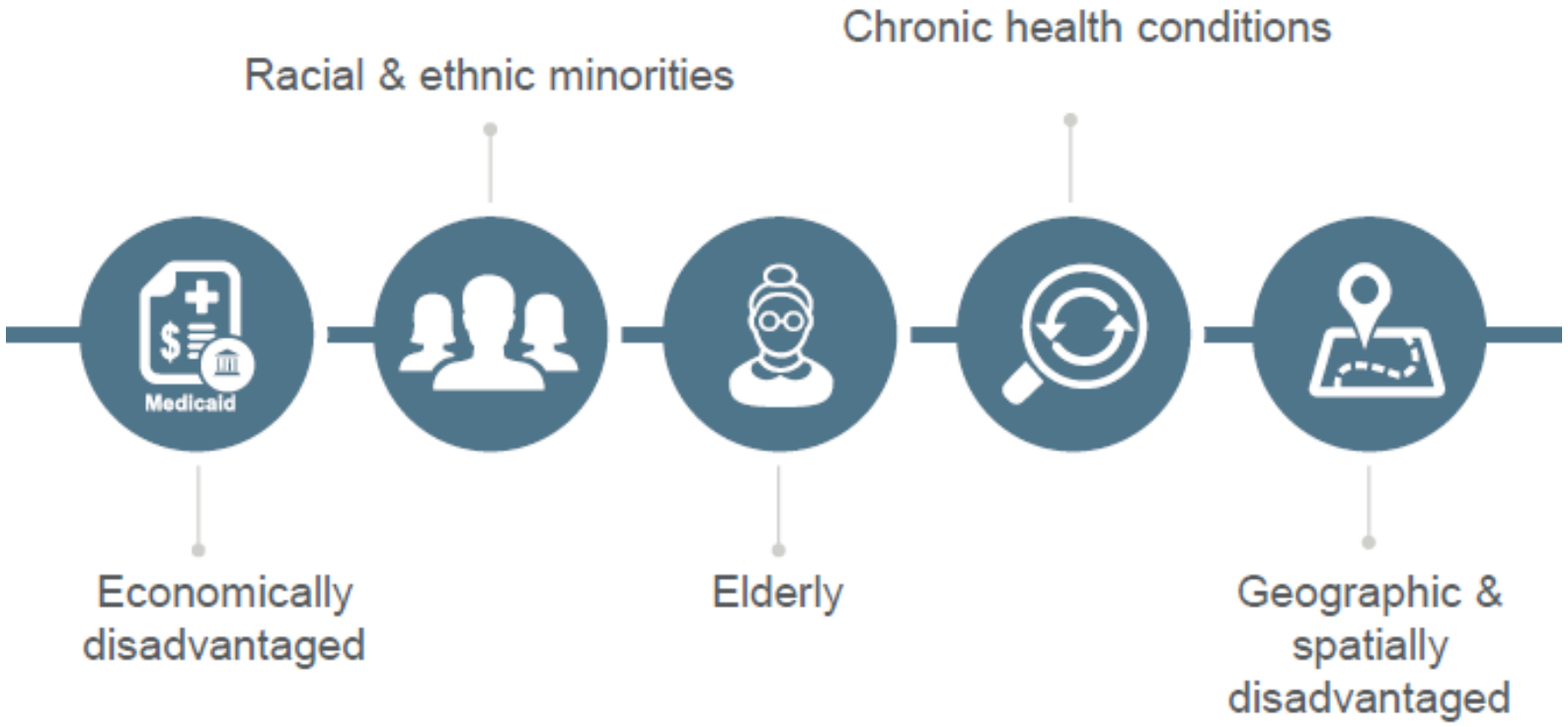
practices as an "Advanced Access" practice. Any patient that needs to be seen on a day the office is open (Monday – Saturday) will be able to be seen that day with the available clinician. Not all clinicians will have opening everyday due to their community schedules, but there will a clinician available to see a patient when they call.

Procedures and Exams:

When scheduling a patient for an annual physical, please make sure that they have the lab work done one week prior to visit. This will ensure that the results are in-house for the doctor to review at time of service.

When a patient is scheduling an office visit, please make sure to note and procedures or exams that need to be done (i.e. hearing test, EKG, skin tag removal…).

Types of Vulnerable Populations



Source: AJMC – Vulnerable Populations: Who Are They?
http://www.ajmc.com/journals/supplement/2006/2006-11-vol12-n13suppl/nov06-2390ps348-s352

QI 04, 05, 06, 07 – Documentation of Patient Survey

TODAY'S OFFICE VISIT Survey Card

1. Did you see the clinician, or team member, that you wanted to see today?

o Yes o No o Did not matter who I saw today

2. How would you rate the length of time you waited to get this appointment?

o Excellent o Very Good o Good o Fair o Poor

aiting during today's visit?

o Good o Fair o Poor

getting through to this office by phone?

o Good o Fair o Poor

PCMH 6C: Example Patient Experience Survey Results

Survey Results : 1/1/13 -12/31/13	Strongly disagree 1	2	3	4	Strongly Agree 5	n/a	Average
I usually see my primary care provider for my appointments			7	34	77		4.6
I am able to schedule an appointment on the day I want it			10	50	54	4	4.4
If I am sick, I can get an appointment the same day for care			17	43	47	11	4.3
If I leave a message during office hours, I get a return call the same day		3	18	47	36	14	4.1
I know how to get care during evenings or on weekends	4	11	19	40	35	9	3.8
My questions are answered in a way that I can understand				31	87		4.7
I feel comfortable asking questions during my visit		1		30	87		4.7
I have a say in decisions about my care			2	36	79	1	4.7
The practice helps me make appointments for tests or specialists			5	46	63	4	4.5
The practice informs me about the results of blood tests or x-rays		2	3	40	67	6	4.5
My doctor or a nurse reviews my medications at each visit			4	44	64	6	4.5
When I come for a visit, my doctor has my test results in my chart			5	40	67	6	4.6
The practice reminds me when I need follow up appointments or screening tests			8	48	60	2	4.4
Overall I am satisfied with the care I receive at the practice		1		35	81	1	4.7

Novant Health - CG-CAHPS (through Sep'09)

Snapshot Questions:

13 - In the last 12 months, when you phoned [+hospname+] to get an appointment for CARE (YOU/YOUR CHILD) NEEDED RIGHT AWAY, how often did you get an appointment as soon as you thought (you/your child) needed? Would you say:

15 - (If Q8 is Patient, READ:) In the last 12 months, when you made an appointment for a CHECK-UP or ROUTINE CARE with this doctor, how often did you get an appointment as soon as you thought you needed? Would you say: (If Q8 is Non-Patient, READ:) In the last 12 months, when you made an appointment for a CHECK-UP or ROUTINE CARE for your child with this doctor, how often did you get an appointment as soon as you thought your child needed? Would you say:

17 - In the last 12 months, when you phoned [+hospname+] DURING regular office hours, how often did you get an answer to your medical question that same day? Would you say:

20 - Wait time includes time spent in the waiting room and exam room. In the last 12 months, how often did (you/your child) see this doctor WITHIN 15 MINUTES of (your/his or her) appointment time? Would you say:

24 - In the last 12 months, how often did this doctor give you easy to understand instructions about taking care of these health problems or concerns? Would you say:

25 - In the last 12 months, how often did this doctor seem to know the important information about (your/your child's) medical history? Would you say:

29 - In the last 12 months, when this doctor ordered a blood test, x-ray or other test for (you/your child), how often did someone from [+hospname+] follow up to give you those results? Would you say:

30 - Using any number from 0 to 10, where 0" is the "Worst Doctor Possible" and "10" is the "Best Doctor Possible what number would you use to rate this doctor?0 = Worst Doctor Possible10 = Best Doctor Possible

31 - In the last 12 months, how often were clerks and receptionists at [+hospname+] as helpful as you thought they should be? Would you say:

32 - In the last 12 months, how often did clerks and receptionists at [+hospname+] treat you with courtesy and respect? Would you say:

Group By Question: 2 - Calendar Year.

PPC8B: The scores in this report reflect performance on measures in element 8B by individual provider.

Filters:

7 - Provider.
826 - WOLFF, Christian G.

Quality Measurement and Improvement Worksheet

NCQA PCMH Quality Measurement and Improvement Worksheet

Worksheet is included with e-copy of 2017 PCMH Standards and Guidelines http://store.ncqa.org

NCQA PCMH Quality Measurement and Improvement Worksheet

PURPOSE: This worksheet helps practices organize the measures and quality improvement activities that are outlined in PCM AC 06, QI 08-14 and BH 17-18. Refer to PCMH AC and QI in the PCMH 2017 Standards and Guidelines and the Distinction for B Health Integration for additional information.

***NOTE:** Practices are not required to submit the worksheet as documentation; it is provided as an option. Practices may submit their own r detailing their quality improvement strategy but should consult the QI Worksheet Instructions for guidance.*

QUALITY MEASUREMENT & IMPROVEMENT ACTIVITY STEPS

1. **Identify measures for QI.** Select **aspects of performance** to improve:
   - Must Demonstrate: (Core Criteria)
     - *PCMH QI 01-QI 04*
     - *BH 17* (not required unless pursing the Behavioral Health Integration Distinction)*
   - Optional (Elective Criteria):
     - *PCMH QI 05*
2. **Identify a baseline performance assessment.** Choose a starting measurement period **(start and end date)** and identify a baseline performance measurement for each measure. Use performance measurements from the reports provided in PCMH QI 01-05 and BH 17*.
   - Must Demonstrate: (Core Criteria)
     - *PCMH QI 08-QI 11*
3. **Establish a performance goal.** Generate at least one performance goal for each identified measure. The specific goal ***must be*** a rate or number greater than the baseline performance assessment. Simply stating that the practice intends to improve does not meet the objective. **(Applies to QI 08-11,13 and BH 18*)**
   ***For multi-sites:** Organizational goals and actions for each site may be used if remeasurement and performance relate to the practice. Each practice must have its own baseline and performance results.*
4. **Determine actions to work toward performance goals.** List at least one action for each identified measure and the **activity start date**. The action date ***must occur*** after the date of the baseline performance measurement date. You may list more than one activity, but are not required to do so. **(Applies to QI 08-11,13 and BH 18*)**
5. **Remeasure performance based on actions taken.** Choose a

Example from the Quality Measurement and Improvement Worksheet

Example: Clinical Measure		
Measure 1: **Colorectal cancer (CRC) screening**	**1. Measure selected for improvement; reason for selection**	***Reason:*** **The USPSTF has recommended screening for colorectal cancer as a preventive test for adults. We want to increase percentage of patients who receive screening for CRC.**
	2./3. Baseline performance measurement; numeric goal for improvement (QI 01)	***Baseline Start Date:*** **5/1/17** **Baseline End Date: 5/30/17** ***Baseline Performance Measurement (% or #):*** **175/547 = 32.0%** ***Numeric Goal (% or #):*** **58%**
	4. Actions taken to improve and work toward goal; dates of initiation (QI 08) ***(Only 1 action required)***	***Action:*** **Pop-up reminders were added to our EMR for patients due/overdue screening** ***Date Action Initiated*****: 7/1/17** ***Additional Actions:*** **Provider quality compensation metric put in place to incentivize providers to ensure appropriate health screening.**
	5. Remeasure performance (QI 12)	***Start Date:*** **5/1/18** ***End Date:*** **5/30/18** ***Performance Remeasurement (% or #):*** **380/550 = 69.1%**
	6. Assess actions; describe improvement. (QI 12)	**Since July 2017, there has been an increase of 37.1 percentage points in patients receiving CRC screening due to incentivizing providers and use of clinical decision support of EMR to indicate when patients are due for screening.**

QI 08, 09, 10, 13 – Example from 2011 Quality Measurement and Improvement Worksheet - Documented Measure(s) Improvement Plan

Quality Measurement and Improvement Worksheet with an Example

NCQA provided a breast cancer screening measure as a guide. Your practice information (to be entered below the example) does not have to exactly match the example. You may delete the example prior to submitting your worksheet.

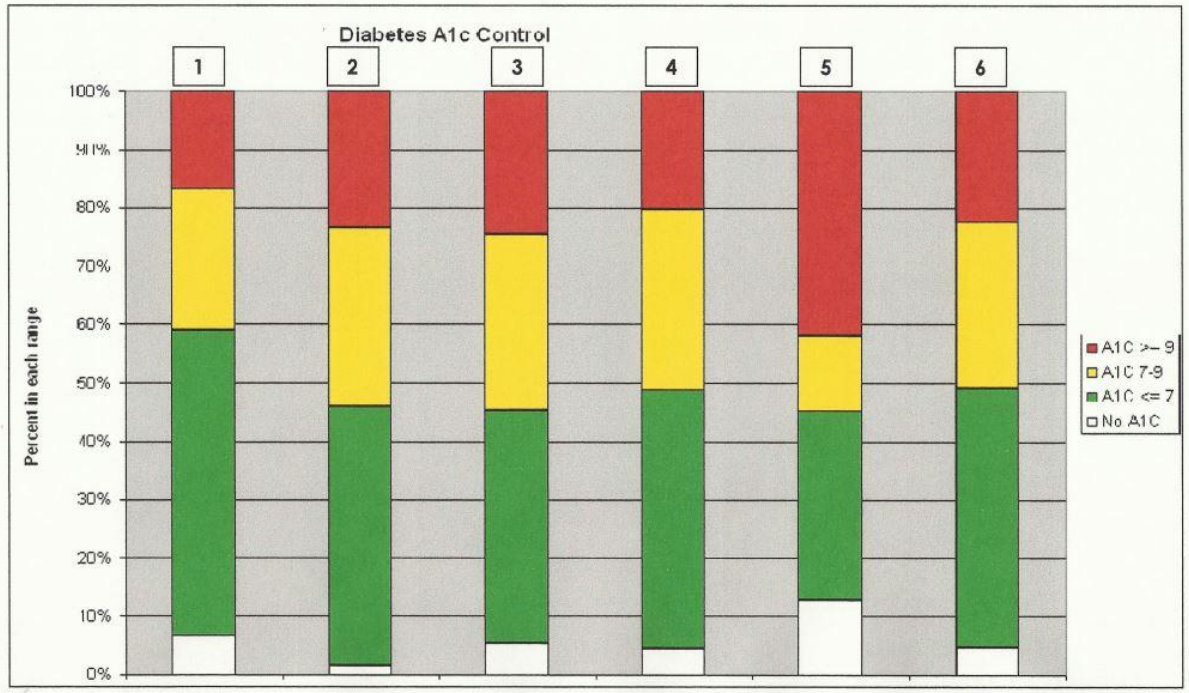
A. Measure	B. Opportunity Identified	C. Initial Performance/ Measurement Period *PCMH 6 Elements A/ B*	D. Performance Goal *PCMH 6 Element C*	E. Action Taken/Date of Implementation *PCMH 6 Element C*	F. Performance at Remeasurement *PCMH 6 Element D*	G. Demonstrated Improvement *PCMH 6 Element D*
1. Breast Cancer Screening	*Uninsured patients receive fewer mammograms than insured patients*	*01/09-01/10: 25% of uninsured women receive mammograms*	*50% of uninsured women receive mammograms*	*2/10: Identified community resources for free or low-cost mammograms and shared with uninsured patients*	*01/10-01/11: 40% of uninsured women receive mammograms*	*During a one year measurement period from Jan 2009 to Jan 2010, there was a 30 percentage point difference in screening rates between insured and uninsured women. After compiling a list of community resources and sharing the information with our uninsured population, we saw a 15 percentage point increase in the number of uninsured women receiving mammograms during the re-measurement period of Jan 2010 to Jan 2011.*
Performance Measures (Identified in 6A)						
1. Diabetes	Patients in our service area have uncontrolled diabetes with elevated A1C's	7/11-7/12 – 307/746 41% of patients with an A1C less than 9	50% of patients with an A1C less than 9	**8/12: Instituted Chronic disease visit days to develop all inclusive treatment plans for diabetic management**	**1st Quarter 2013: 551/757 – 73% of our patients with an A1C less than 9**	**During a one year measurement period from July 2011 to July 2012 only 41% of our diabetic patients had an A1C less than 9. After instituting Chronic disease days with extended visits and patient centered treatment plan development we saw a 32% increase in the number of diabetic patients with and A1C less than 9 during the re-**

EXAMPLE

Other Reporting Examples

QI 12, 14, 15 – Documented Practice and Provider Level Measure(s) Monitoring and Reporting

PCMH 6E: Example Reporting by Clinician



PCMH 6E: Example Tracking Data Over Time

	Jan 2014	Dec 2013	Nov 2013	Oct 2013	Sept 2013
Immunizations					
Pneumovax	61.31	61.21	52.25	61.39	60.95
Diabetes					
HgA1C	73.39	73.48	74.12	74.11	71.54
CHF					
Ace Inhibitors	99.18	99.58	99.69	99.13	99.56
CAD					
Antihyperlipidemic	99.07	99.05	99.65	98.67	98.87

QI 16, 18 – Documented Reporting of Measure Publicly and to Medicare and/or Medicaid

Reporting Period 07/01/09 - 06/30/10

Codes used to report performance measures to external entities	Units reported
3078F, MEDICARE BP < 80 MM	2096
3048f, MEDICARE LDL-C <100 MG	1979
3074F, MEDICARE BP <130 MM	1771
3044f, MEDICARE A1C <7.0%	1724
4011F, MEDICARE ORAL ANTIPLATELET THERAPY	1096
4006F, MEDICARE BETA-BLOCKER THERAPY	837
3045F, MEDICARE A1C LEVEL 7-9%	652
3077f, MEDICARE-SYSTOLIC BP > 140 MM	585
3079f, MEDICARE BP 80-89 MM	522
3075f, MEDICARE BP 130 TO 139 MM	452
3049F, MEDICARE LDL-C 100-129 MG	418
4009F, MEDICARE ACE OR ARB THERARY	260
3050F, MEDCIARE LDL-C >130 MG	169
3046f, MEDICARE A1C > 9.0%	164
3080f, MEDICARE BP . 90 MM	132
G0402, WELCOME TO MEDICARE	74
G0375, SMOKING CESSATION COUNSELING 4-10MN	44
3022f, MEDICARE LVEF > 40%	33
3021F, MEDICARE LVEF , 40%	32
99406, SMOKING CESSATION COUNSELING	19
G0372, MEDICARE MOBILITY DEVICE CERTIFICAT	19
99420, HEALTH RISK ASSESSMENT	4
99374, CARE PLAN OVRSGHT-HOME HLT <30 MIN	3
2000F, MEDICARE PT NOT PERFORMED	1
	13086

PPC8F: The practice electronically reports the PQRI measures listed above to CMS.

QI 17 – Documented Invitation for Patient Input for Practice QI Activities

An Invitation From Your Doctor

You are invited to join your doctor and other patients in our practice for a "group visit." It's an idea that other doctors around the country have found helps them care for their patients in ways that cannot be accomplished during the usual 15- to 20-minute office visit.

Here's how it works: Your doctor and one of our nurses will visit with you and approximately 15 to 20 other patients for about an hour and a half in a conference room here at our office. During the visit, there will be time for talking with other patients as well as education about specific health problems. Then, your doctor will spend time talking with each patient individually about health problems and concerns. If you have additional health concerns that need to be addressed, there will also be time to meet alone with your doctor after the group visit. Of course, the visits are completely voluntary.

The group visit program was set up to provide an additional opportunity for patients to meet with their doctor on a regular basis and to learn how to deal with common health problems. Group visits also give patients the opportunity to learn from other patients who are dealing with similar health problems and to get their health needs met and their questions answered. From time to time other health professionals, such as pharmacists or health educators, may join your doctor and nurse at the visits.

The date and time of the next group visit is listed at the bottom of this letter. If you are interested in attending, please let your physician or nurse know. You are welcome to bring a family member or friend with you.

When you come in for the group visit, simply check in as usual with the front desk and pay your usual co-pay. The receptionist will direct you to our meeting place.

We welcome your possible interest in this new opportunity for you to participate with your physician in your health care. Of course, if you decide not to participate, your doctor will continue to see you at the office as in the past.

Tips and FAQs

Tips and Tricks

- Select goals with a large margin for improvement.
- Goals should be above the baseline performance for that measure
- Consider existing quality initiatives ongoing at your Clinic. Talk to people and see if there are quality improvement activities already underway which could help to improve your measure performance.
- Interventions (how you act to improve the measure) should be current and rapid-cycle (e.g. PDSA cycle, small tests of change).

Frequently Asked Questions

Would a QI and outreach program around advance directives fit anywhere in the quality measures for QI 01? As part of our 'Honoring Choices', our clinic team proactively reaches out to patients and attempts to document their wishes.

- *If your practice identifies advance directives as an area that is appropriate to focus your quality improvement efforts and applies to your patient population (i.e., adult primary care), it would be acceptable as a measure for B (preventive care measures). We would accept this as a primary care measure because the information helps patients to establish preferences and avert issues that may arise when such directives are needed.*
- *Please note that you will need to provide a dated report with a numerator, denominator, and percentage for this measure to meet the requirement of the criteria*

Frequently Asked Questions

What are some examples that would qualify as resource stewardship, care coordination? (QI 02-A)

For care coordination, the intent of **QI 02A** is to evaluate the communication/coordination that occurs between providers or providers and patients, so it's generally looking at closing the loop on care coordination tasks/processes. Some examples for care coordination may include but are not limited to:

- Reduced % of patients seeing multiple providers (3 or more)
- Medication reconciliation after care transition (MU)
- Follow up with patients or providers to ensure ordered lab or imaging tests were completed
- Follow up with patients following receipt of abnormal test results
- Outreach to patients not recently seen that result in an appointment
- Follow-up phone calls to check on the patient after an ER visit (or hospitalization)
- # patient calls received after hours by the call center were reconciled in the patient record and addressed by the care team the next business day
- Following up on pediatric visits to after-hours care
- Number of referrals sent
- % of patients who had a positive TB screen who had a FU Chest x-ray
- % of patients who had a positive GC/Chlamydia who were treated with antibiotics

Frequently Asked Questions

What are some examples that would qualify as resource stewardship, measures affecting health care costs? (QI 02-B)

The intent of **QI 02B** is for practices to use measures to help them understand how efficiently they're providing care and judiciously using resources. Examples of measures affecting health care costs may include but are not limited to:

- Total cost per patient
- Medical cost per medical visit
- # of medications prescribed
- Use of high cost medications
- Use of imaging for low back pain
- Redundant imaging or lab tests
- Emergency department utilization
- Hospital readmission rates
- Use of generic versus brand name medication
- # of Specialist referrals
- # of patients who went to urgent care during open office hours
- # of referrals/ED visits for needs that could be addressed in the office
- Appropriate testing for children with pharyngitis
- Appropriate treatment for children with URI

Frequently Asked Questions

Would a report with results on the CG CAHPS Survey over time satisfy both QI 04 and QI 06?

- It is not necessary to highlight the categories of questions in the CAHPS Clinician and Group Survey Tool to satisfy **QI 04/06**. As of July 2015, NCQA is accepting CAHPS Clinician and Group surveys to meet the requirement.

Frequently Asked Questions

For QI 04B, may practices use the "comments" section in the patient experience survey to meet this requirement?

No. Comment sections or "free text" questions on a patient experience survey do not meet the requirement as a method of collecting qualitative feedback from patients and their families.

Frequently Asked Questions

What type of qualitative data and feedback meet this requirement for QI 04-B?

- Practices may collect qualitative feedback through a suggestion box in the waiting room, by hosting focus groups or by conducting individual patient interviews. Practices can also meet the requirements of QI 04B if they have a patient advisory council and encourage feedback on patient satisfaction issues on the council agenda.

Frequently Asked Questions

Can my practice use comments received in a social media format (i.e., Yelp, Facebook, etc.) as qualitative feedback for QI 04B?

Yes, collection of qualitative data through reviews on Google, Yelp, Facebook, Health Grades, etc. may be used as data for QI 04B if the practice actively notifies patients of the availability of those sites to submit patient experience information. If the sites are not actively advertised and not all patients are aware and represented, it would not meet the intent of the criteria.

Frequently Asked Questions

- **Are practices required to use the CAHPS PCMH survey to meet this requirement? QI 04**

  No. Practices may use any patient experience survey that includes questions related to three of the four categories specified in the standards (access; communication; coordination; whole-person care, self-management support and comprehensiveness).

Frequently Asked Questions

For QI 07, is this asking for practices to separately (other than a question in the patient experience survey on race/ethnicity) obtain feedback of vulnerable patient groups? In other words, if a practice includes a question on race/ethnicity in the patient experience survey and stratifies their data by that question, then it is our understanding that it would meet the intent of QI 05-B. Would it also meet the intent of QI 07? Or is this asking for an additional method of feedback?

- **QI 05 and QI 07** evaluate different things (assessing vs. obtaining feedback), so stratifying data to identify a disparity in care would not meet both criteria. **QI 05** focuses on ASSESSING for a disparity in care. The practice should identify a vulnerable population at their practice (which could be based on race, ethnicity, socioeconomic status, health insurance status, etc.) and stratify the performance data between the general population and the vulnerable population to identify a potential health disparity for at least one clinical quality measure and one patient experience measure.
- Please note that for **QI 05**, the practice needs to identify a true health disparity to meet the intent, but must provide evidence showing that data was stratified and reviewed for the presence of a health disparity. For **QI 07**, if the practice has found there are disparities of care or service for a vulnerable patient population at their practice, the practice OBTAINS FEEDBACK from the identified vulnerable patient population. This may be done either through some feedback mechanism (i.e., survey) or representatives of that identified vulnerable group (i.e., focus groups, interviews, etc.). The intent behind the feedback is to use that information to better develop/support quality improvement activities to address the disparities in care or service.

Frequently Asked Questions

May "improve performance" be a stated performance goal? **QI 08-10**

- No. The performance goal must be quantified (e.g., a number or percentage signifying a specific performance level).

Frequently Asked Questions

How do practices assess the effectiveness of improvement actions? QI 12

Assessing effectiveness of improvement actions includes remeasurement to compare results over time and evaluation of what is driving change. Results may be quantitative (numerical data that demonstrate performance and can be compared to benchmarks) or qualitative (conceptual data that describe why performance is high or low), but practices must look at the goals set, actions taken to improve and previous or baseline results.

Frequently Asked Questions

When remeasuring to show improvement, what is an acceptable period of time between the initial measurement and the follow-up measurement period? QI 12

NCQA does not specify a time period required for remeasurement, but it must be long enough for the practice to implement a performance improvement plan and to assess results.

Frequently Asked Questions

We have Board members who are patients at our clinic(s) and we also have a Board QI Committee. Would the Board Bylaws be sufficient for showing how a community health center involves patients in QI teams or on an advisory council? QI 17

- The intent is for the practice to include patients in QI discussions to ensure their input and ideas are incorporated in the process beyond just responding to patient experience surveys.
- If the board bylaws include the process for including patients on the Board QI committee and describes how they participate in QI discussions at that committee, then it could meet the intent of the requirement.
- It's okay if the document is not a "documented process" in a strict sense; rather, NCQA is looking for practices to have the process for staff documented somewhere to reference and use in the future as a practice policy/process.

Frequently Asked Questions

Pediatric Practices:

Can a practice use the CHIPRA Initial Core Set of Children's Health Care Quality Measures? QI 01

- **Yes.** Measures from the CHIPRA Initial Core Set meet the requirements.

Frequently Asked Questions

Pediatric Practices:

What are some examples of utilization measures appropriate for pediatric practices? QI 02B

- Emergency department visits for ambulatory-care sensitive conditions.
- Re-admissions within 30 days.
- Urgent care visits while the practice is open.

Questions?

http://store.ncqa.org/index.php/catalog/product/view/id/2776/s/2017-pcmh-standards-and-guidelines-epub/