NCQA PCMH Quality Measurement and Improvement Worksheet

PURPOSE: This worksheet helps practices organize the measures and quality improvement activities related to appointment access (QI 10), clinical quality measures (QI 08), resource stewardship (QI 09), patient experience (QI 11), health disparities in care or experience (QI 13). Refer to PCMH AC and QI in the PCMH Standards and Guidelines and the Distinction for Behavioral Health Integration for additional information.

***NOTE:* Practices are not required to submit the worksheet as evidence; it is provided as an option. Practices may submit their own report 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*
   - Optional (Elective Criteria):
     - *PCMH QI 13 and BH 18**

   The baseline measurement period ***must be*** **within 12 months** before evidence submission for check-in, or **within 24 months**, if there is a remeasurement period. The performance measurement ***must be*** a rate (percentage based on numerator and denominator).

*BH 17 and 18 are part of the optional PCMH Distinction for Behavioral Health Integration.

3. **Establish a performance goal.** Generate at least one performance goal for each identified measure. The specific goal ***must be*** a rate greater than the baseline performance assessment (unless it is an inverse measure). 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 remeasurement period and generate a new performance measurement after action was taken to improve. The remeasurement date ***must occur*** after the date of implementation and ***must be*** within **12 months** before evidence submission for check-in. The performance measurement ***must be*** a rate (percentage based on numerator and denominator).

6. **Assess actions taken and describe improvement.** Briefly describe how your practice site showed improvement on measures. Describe the assessment of the actions; correlate actions and the resulting improvement. **(Applies to QI 12 and 14)**
   - Optional (Elective Criteria): *PCMH QI 12 and QI 14*

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Practice Name: **Cooper Family Medical** ***Date Completed:*** **2/18/2020**

Use ONE Access Measure Identified in QI 010		
Measure 1: QI03/QI10 – Appointment Availability/Access –	**1. Measure selected for improvement; reason for selection**	***Reason:*** Patients who cannot get an appointment when they want will often go elsewhere. This creates care gaps and the opportunity for treatment discrepancies. To minimize this problem we want to decrease the wait time (using the third next available option) for our major appointment types with a focus on new patient access.
	2./3. Baseline performance measurement; numeric goal for improvement *(QI 03)*	***Baseline Start Date*: 9/9/2019** ***Baseline End Date*: 9/13/2019** ***Baseline Performance Measurement (n/d* and %):*** On average it is taking 31 days for a new patient to get an appointment. ***Numeric Goal (%):*** **10 days**
	4. Actions taken to improve and work toward goal; dates of initiation *(QI 10)* ***(Only 1 action required)***	***Action*: To improve access we added a new provider to our team.** ***Date Action Initiated*: October 2019** ***Additional Actions*:**
	5. Remeasure performance ***Note: Continuing QI is encouraged, but is not required for QI 10.***	***Start Date:* 2/17/2020** ***End Date*: 2/21/2020** ***Performance Re-measurement (n/d* and %):*** Our average wait time (based on third next available) dropped from 31 days to 7 days.
	6. Assess actions; describe improvement. ***Note: Continuing QI is encouraged, but is not required for QI 10.***	The addition of the new provider allowed us to get patients in sooner. We went from not meeting our policy goals on three out of four major appointment types to meeting goal on all four.

*n/d = numerator/denominator

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Use FIVE Measures Identified in QI 08, QI 09 and QI 11		
Measure 1: QI01C/QI08 – DM HbA1c Poor Control	**1. Measure selected for improvement; reason for selection**	***Reason:*** Sugar control is imperative in managing a diabetic patients' health. However we find that many patients long range sugar is often out of range and the patient needs assistance to make changes to their habits to improve. We are looking to improve (decrease) the number of patients whose HbA1c is greater than 9.
	2./3. Baseline performance measurement; numeric goal for improvement ***(From QI 01, QI 02 or QI 04)***	***Baseline Start Date:*** **1/1/2019** ***Baseline End Date:*** **12/31/2019** ***Baseline Performance Measurement (n/d* and %):*** **365/1159 = 31.49%** ***Numeric Goal (%):*** **20%**
	4. Actions taken to improve and work toward goal; dates of initiation ***(QI 08, QI 09, or QI 11) (Only 1 action required)***	***Action*****:** Enrolled patients in "Living with Diabetes" - a counseling program headed by our local hospital. Patients were referred by our providers based on lab results. We also started reviewing nutritional counseling, with recipes and tips on exercise for all levels of fitness tailored to the individual patient. (This is in conjunction with the patient educational materials available in our office.) ***Date Action Initiated*****: 1/1/2020** *Additional Actions:* Pop-up reminders in our EHR to check A1c for patients over 9 more frequently were created. Our staff will reach out to patients' insurance to confirm coverage.
	5. Remeasure performance ***(QI 12)***	***Start Date:*** **01/02/2020** ***End Date:*** **07/29/2020** ***Performance Re-Measurement (n/d* and %):*** 390/985 = 39.59%
	6. Assess actions; describe improvement. (QI 12)	Unfortunately we did not see improvement on this measure during this time despite our efforts. However with the PHE occurring during this same period there were additional barriers to meeting this goal. Therefore we will continue to focus on this measure.

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Measure 2: QI01B/QI08 – Screening BMI and Follow up Plan	**1. Measure selected for improvement; reason for selection**	***Reason:*** Patients who have a high BMI are at risk of further help complications. We would like to improve (increase) on the amount of patients who have had a screening BMI.
	2./3. Baseline performance measurement; numeric goal for improvement ***(From QI 01, QI 02 or QI 04)***	***Baseline Start Date:*** 1/1/2019 ***Baseline End Date:*** 12/31/2019 ***Baseline Performance Measurement (n/d* and %):*** 7985/10272=78.28% ***Numeric Goal (%):*** 90%
	4. Actions taken to improve and work toward goal; dates of initiation ***(QI 08, QI 09 or QI 11) (Only 1 action required)***	***Action:*** To make improvement in this area we changed our workflow processes so that it is now mandatory to capture a BMI at every visit unless there is a medical/clinical reason that would prevent us from doing so. ***Date Action Initiated:*** 1/1/2020 ***Additional Actions:***
	5. Remeasure performance ***(QI 12)***	***Start Date:*** 1/1/2020 ***End Date:*** 4/20/2020 ***Performance Remeasurement (n/d* and %):*** 5300/5622 = 94.91%
	6. Assess actions; describe improvement. (QI 12)	Goal met. However we will continue with improvement efforts.

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Measure 3: QI01A/QI08 – Pneumococcal Vaccine	**1. Measure selected for improvement; reason for selection**	***Reason:*** Prevention is an important part of patient health. As this immunization is important and can be life saving for specific vulnerable patient populations we would like to improve in this area by increasing the number of patients who receive this immunization.
	2./3. Baseline performance measurement; numeric goal for improvement ***(From QI 01, QI 02 or QI 04)***	***Baseline Start Date:*** 1/1/2019 ***Baseline End Date:*** 12/31/2019 ***Baseline Performance Measurement (n/d* and %):*** 1966/3748=52.45% ***Numeric Goal (%):*** 65%
	4. Actions taken to improve and work toward goal; dates of initiation ***(QI 08, QI 09 or QI 11) (Only 1 action required)***	***Action:*** Email and text blasts to all patients who fall within the appropriate demographic for pneumovax and/or Prevnar 13 were sent. Every 3 months, patients will receive a reminder to call the office to schedule their "pneumonia shot" for the year. Once patient schedules they will not get another reminder until 365 days after receiving their immunization. ***Date Action Initiated:*** 5/11/2020 ***Additional Actions:*** Pop-up reminder in our EHR Health Maintenance section of patient record is added if patient is due to alert the team of patient need.
	5. Remeasure performance ***(QI 12)***	***Start Date:*** 05/11/2020 ***End Date:*** 07/29/2020 ***Performance Remeasurement (n/d* and %):*** 1720/3284 = 52.38%
	6. Assess actions; describe improvement. (QI 12)	Unfortunately we did not meet our goal or improve on this measure. During this PHE immunizations have been a challenge. However we realize the importance and will continue to make it a focus of improvement.

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Measure 4: QI02 B/QI09 – Measure Affecting Healthcare Cost	**1. Measure selected for improvement; reason for selection**	***Reason:*** Cardiovascular disease is a leading cause of morbidity in this country. Uncontrolled cardiovascular disease can cause additional co-morbidities which leads to higher medical costs. However with the proper treatment the risk can be reduced. For this reason we would like to increase the number of patients who are on statin therapy for the prevention and treatment of cardiovascular disease.
	2./3. Baseline performance measurement; numeric goal for improvement ***(From QI 01, QI 02 or QI 04)***	***Baseline Start Date:*** 1/1/2020 ***Baseline End Date:*** 4/22/2020 ***Baseline Performance Measurement (n/d* and %):*** 340/723 = 31.54% ***Numeric Goal (%):*** 40%
	4. Actions taken to improve and work toward goal; dates of initiation ***(QI 08, QI 09 or QI 11) (Only 1 action required)***	***Action:*** all providers were asked to prescribe statins for all appropriate patients with cardiovascular disease, and ONLY those who had failed statins previously, or those with other chronic diseases that precluded them from participation, (i.e., kidney failure, etc.) would be exempt. ***Date Action Initiated:*** 05/01/2020 ***Additional Actions:***
	5. Remeasure performance ***(QI 12)***	***Start Date:*** 05/01/2020 ***End Date:*** 07/29/2020 ***Performance Remeasurement (n/d* and %):*** 1278/598 = 46.82%
	6. Assess actions; describe improvement. (QI 12)	Not only did we meet but we exceeded our goal which is a big accomplishment with the barriers that we had to overcome on this measure. However we will continue to focus on this important topic.

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Measure 5: QI04/QI11 – Patient Experience – Length of Wait	**1. Measure selected for improvement; reason for selection**	***Reason:*** The patients' impression of their wait time can play a big role in their satisfaction in their experience which in turn can impact their healthcare. To improve their healthcare we need to improve their experience and improve their impression by decreasing their wait time. We are going to focus on all three areas but only list the time in the waiting room on this study.
	2./3. Baseline performance measurement; numeric goal for improvement ***(From QI 01, QI 02 or QI 04)***	***Baseline Start Date:*** 3/3/20 ***Baseline End Date:*** 3/13/20 ***Baseline Performance Measurement (n/d* and %):*** *35/*95=37% rated less than excellent on wait time in exam room ***Numeric Goal (%):*** We would like to decrease this to less than 20%
	4. Actions taken to improve and work toward goal; dates of initiation ***(QI 08, QI 09 or QI 11) (Only 1 action required)***	***Action:*** 4/1/2020 ***Date Action Initiated:*** We have requested all patients to arrive at the office 15 minutes in advance of their scheduled appointment. This will allow patients to be in the exam room, chart information updated by nurse and ready for the provider at their designated time. We have also started encouraging patients to fill out all necessary paperwork (available on our website) prior to their visit, which will speed up processing upon their arrival. All patients will be encouraged to call the office 5-7 days after any outside testing has been completed to ensure their results are not overlooked or delayed. All nurses will maintain their tickler files for daily check of outstanding results as part of the morning huddles ***Additional Actions:***
	5. Remeasure performance ***(QI 12)***	***Start Date:*** 7/14/2020 ***End Date:*** 7/24/2020 ***Performance Remeasurement (n/d* and %):*** 62/175 = 35% rated less than excellent on wait time in exam room
	6. Assess actions; describe improvement. (QI 12)	Although we did not reach out goal we did see a 2% improvement during a busier time period. However we will continue our efforts to improve on this important patient experience metric.

*n/d = numerator/denominator