NCQA PCMH 2014 Quality Measurement and Improvement Worksheet

PURPOSE: The purpose of the worksheet is to help practices organize the measures and quality improvement activities that are required in PCMH 6, Elements D and E. Please consult PCMH 6, Elements A, B, C, D and E 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 report detailing their quality improvement strategy.

QUALITY MEASUREMENT & IMPROVEMENT ACTIVITY STEPS:

1. Identify measures for quality improvement – From measures selected in elements **6 A, B, and C** as well as a disparity measure, practice will identify a **total of six (6) measures** comprised of the following: from **6A (3) clinical quality measures**; from **6B (1) resource use and/or care coordination measure**; from **6C (1) patient/family experience measure**; **(1) measure focused on vulnerable populations**, does not need to be same as identified in 6A.

2. Identify a baseline performance assessment – Choose a starting measurement period **(start and end date)** and identify a baseline rate for each measure. You may use rates from the reports provided in PCMH 6 A, B, C. The baseline measurement period **MUST** be **within 24 months** prior to the tool submission if there is a re-measurement period. Otherwise, the measurement period **MUST** be within **12 months** prior to tool submission. The performance rate **MUST** be a percentage or number.

3. Establish a performance goal - Generate at least one performance goal for each identified measure. Specific rate goal **MUST** be a percentage or number. Simply stating that the practice intends to improve does not meet the objective. **(Applies to 6D 1, 3, 5, 7)**

***Note for Multi-sites:* Sites can use organizational goals and actions for each site for factors 1, 3, 5, & 7. However the re-measurement and performance must relate to that specific practice. This means that each practice has its own baseline and its own performance results.**

4. Determine what actions to take to work towards performance goals - List at least one action for each identified measure taken towards meeting the performance goal. Include the **start date** of the activity. The action date **MUST** occur after the date of the baseline performance assessment date. You may list more than one activity but are not required to do so. **(Applies to 6D 2, 4, 6)**

Note: If the action period overlapped with some or all of the baseline measurement period, and the practice does not have earlier measurements to report, the practice should provide an analysis of the impact of the action on the baseline measure (e.g., 'this would tend to increase the baseline measure')

5. Re-measure performance based on actions taken – Choose a re-measurement period and generate a new performance rate after action was taken to improve. The re-measurement date **MUST** occur after the date the action was implemented and **MUST** be within in **12 months** prior to tool submission. If the action was not complete before the re-measurement period, the practice should estimate the completion rate of the action, to evaluate its impact on any re-measurement. It is up to the practice to determine its next follow-up period. **(Applies to 6E 2-4)**

Note: To receive credit for 6E Factors 2-4 the re-measurement rate must show improvement on (2) clinical quality measures; (1) resource use/care coordination measure; (1) patient/family experience measure.

6. Assess actions taken & describe improvement – In a brief description outline how the practice showed improvement on measures. Describe the assessment of the actions implemented and correlate the link between actions taken and the resulting rate improvement. **(Applies to 6E 1)**

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EXAMPLE ON HOW TO COMPLETE A ROW:

Use 3 Measures Identified in 6A		
Measure 1: Colorectal cancer (CRC) screening	**1. Measure Selected for Improvement & Reason for Selection**	**Reason:** We want to increase percentage of patients who receive screening for CRC.
	2. & 3. Baseline Performance Measurement & Numeric Goal for Improvement (6D 1)	**Baseline Start Date:** 1/1/14 **Baseline End Date:** 12/31/14 **Baseline Performance Rate (% or #):** 21.9% **Numeric Goal Rate (% or #):** 32%
	4. What actions were taken to improve and work towards goal? Provide dates actions were initiated. (6D 2) (Only 1 Action Required)	**Action:** Pop up reminders were added to our EMR for patients due/overdue screening **Date Action Initiated:** 1/21/15 **Additional Actions Taken:** Provider quality compensation metric put in place to incentivize providers to ensure appropriate health screening.
	5. Re-measure Performance (6E 2)	**Start Date:** 5/1/15 **End Date:** 5/30/15 **Rate (% or #):** 69.2%
	6. Assess Actions & Describe Improvement (6E 1)	**Since September 2014, there has been an increase of 32.9% 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.**

Identify a Disparity in Care for a Vulnerable Population		
Identify vulnerable population: Uninsured Women **Disparity:** Uninsured women receive fewer mammograms	**1. Identify a disparity in care for a vulnerable population**	**Describe a comparison of a vulnerable population against the general population in which the vulnerable population received care/service at a lower rate.:** Uninsured patients receive fewer mammograms than insured patients
	2. & 3. Baseline Performance Measurement & Numeric Goal for Improvement (6D 7)	**Baseline Start Date:** 07/2014 **Baseline End Date:** 12/2014 **Baseline Performance Rate (% or #):** 25% of uninsured women receive mammograms **Baseline Performance Rate (% or #):** 60% of insured women receive mammograms

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		Numeric Goal Rate (% or #): 50% of uninsured women receive mammograms
	4. What actions were taken to improve and work towards goal? Provide dates actions were initiated. (6D 7) (Only 1 Action Required)	Action: Identified community resources for free or low-cost mammograms and shared with uninsured patients Date Action Initiated: 1/2015 Additional Actions Taken:
	5. Re-measure Performance	N/A
	6. Assess Actions (6E 1)	During a one year measurement period from July 2014 to Dec 2014, 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 2015 to July 2015.

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Practice Name: Sumter Pediatrics **Date Completed:**

Use 3 Measures Identified in 6A		
Measure 1: HPV Vaccination	**1. Measure Selected for Improvement & Reason for Selection**	Reason: We want to increase the number of patients receiving the HPV vaccine.
	2. & 3. Baseline Performance Measurement & Numeric Goal for Improvement (6D 1)	Baseline Start Date: 1/1/15 Baseline End Date: 12/31/15 Baseline Performance Rate (% or #): 48% Numeric Goal Rate (% or #): 55%
	4. What actions were taken to improve and work towards goal? Provide dates actions were initiated. (6D 2) (Only 1 Action Required)	Action: Postcard reminders are sent to all patients eligible for HPV vaccination. Date Action Initiated: 1/21/16 Additional Actions Taken: During any visit to the practice (e.g., sick visits), the attending nurse will conduct an Immunization Review and remind patients of any immunizations they are due to receive. As needed, the nurse will provide counseling and materials relevant to the HPV vaccine with the goal of the patient scheduling an appointment to receive the vaccination before leaving.
	5. Re-measure Performance (6E 2)	Start Date: 3/31/15 End Date: 3/31/16 Rate (% or #): 20%
	6. Assess Actions & Describe Improvement (6E 1)	Although our performance did not improve, this is likely due to the rolling year nature of the reporting and some data integrity issues, with more of our children having received this immunization toward the end of the previous year, making them fall off of the numerator in March. We will continue to implement this effort, as we believe this will help with our performance on this measure.
Measure 2: Meningitis Vaccination	**1. Measure Selected for Improvement & Reason for Selection**	Reason: We want to increase the number of patients receiving the Meningitis vaccine.
	2. & 3. Baseline Performance Measurement & Numeric Goal for Improvement (6D 1)	Baseline Start Date: 1/1/15 Baseline End Date: 12/31/15 Baseline Performance Rate (% or #): 24.46% Numeric Goal Rate (% or #): 30%
	4. What actions were taken to improve and work	Action: Postcard reminders are sent to all patients eligible for HPV vaccination. Date Action Initiated: 1/21/16

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	towards goal? Provide dates actions were initiated. (6D 2) (Only 1 Action Required)	Additional Actions Taken: During any visit to the practice (e.g., sick visits), the attending nurse will conduct an Immunization Review and remind patients of any immunizations they are due to receive. As needed, the nurse will provide counseling and materials relevant to the Meningitis vaccine with the goal of the patient scheduling an appointment to receive the vaccination before leaving.
	5. Re-measure Performance (6E 2)	Start Date: 3/31/15 End Date: 3/31/16 Rate (% or #): 19.67%
	6. Assess Actions & Describe Improvement (6E 1)	We believe that our project has solid footing, and will continue to work on increasing this immunization rate. We think that we are better able to address this important vaccine continuing the changes we made, and think the dip in the rate was due to the rolling year percentage and time of year that the vaccines are mostly given.
Measure 3: ADHD 12 month follow up	1. Measure Selected for Improvement & Reason for Selection	Reason: We want to increase the number of patients seen for their 12 month ADHD follow up.
	2. & 3. Baseline Performance Measurement & Numeric Goal for Improvement (6D 1)	Baseline Start Date: 1/1/15 Baseline End Date: 12/31/15 Baseline Performance Rate (% or #): 57.1% Numeric Goal Rate (% or #): 67%
	4. What actions were taken to improve and work towards goal? Provide dates actions were initiated. (6D 2) (Only 1 Action Required)	Action : Postcard reminders are sent to all patients who have missed their 12 month ADHD follow up. Date Action Initiated: 1/21/16 Additional Actions Taken: When patients (or parents) call for a prescription refill, the staff will note if the patient is overdue on a 12 month ADHD follow up. If the patient is overdue, the staff will attach a note to the EMR saying they will not be able to refill the prescription again until the patient is seen for follow up so that staff will work to reschedule the patient instead for a necessary follow-up..
	5. Re-measure Performance (6E 2)	Start Date: 3/31/15 End Date: 3/31/16 Rate (% or #): 56.11%
	6. Assess Actions & Describe Improvement (6E 1)	We had minimal decline in our numbers, and we think that as time goes by this will improve. As we continue to reach out to patients, and particularly address the refill without being seen issue, we believe that more patients will come in for their follow-ups annually.

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Use 1 Measure Identified in 6B		
Measure 1: Summary of Care Record on Care Transitions	**1. Measure Selected for Improvement & Reason for Selection**	**Reason: Our practice wants to increase the delivery of summary of care record on care transitions to provide better care coordination for our patients referred to specialists or facilities.**
	2. & 3. Baseline Performance Measurement & Numeric Goal for Improvement (6D 3)	**Baseline Start Date: 1/1/16 Baseline End Date: 3/31/16** **Baseline Performance Rate (% or #): 13.71%** **Numeric Goal Rate (% or #): 51.00%**
	4. What actions were taken to improve and work towards goal? Provide dates actions were initiated. (6D 4) (Only 1 Action Required)	**Action : Our practice developed a new protocol that included using a previously unused functionality in our EMR that allows us to develop care transition summary of records for our patients. In addition to using this new functionality, we developed a new process whereby our physicians and referral coordinators would include the summary of care information and utilize the EMR functionality as part of our new referral process.** **Date Action Initiated: April 1, 2016** **Additional Actions Taken: Our nurse coordinators continued to remind the physicians and referral coordinators of this new process throughout the second quarter of 2016.**
	5. Re-measure Performance (6E 3)	**Start Date: 4/1/16 End Date: 6/30/16 Rate (% or #): 66.17%**
	6. Assess Actions & Describe Improvement (6E 1)	**We saw significant improvement in this measure by focusing our practice efforts on ensuring that our physicians and referral coordinators understood the new process, while also making sure that each provider was held accountable. The improvement was a true team effort, showing what can happen when various employees and departments of our practice can accomplish when working collaboratively.**

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Use 1 Measure Identified in 6C		
Measure 1: **How satisfied are you with how easily you were able to talk with a doctor or nurse when you called or sent an email?**	**1. Measure Selected for Improvement & Reason for Selection**	**Reason: Our practice wanted to improve on the speed with which our physicians returned calls to patients who called with clinical questions.**
	2. & 3. Baseline Performance Measurement & Numeric Goal for Improvement (6D 5)	**Baseline Start Date: 11/1/15 Baseline End Date: 11/30/15** **Baseline Performance Rate (% or #): 84%** **Numeric Goal Rate (% or #): 90%**
	4. What actions were taken to improve and work towards goal? Provide dates actions were initiated. (6D 6) (Only 1 Action Required)	**Action : Our office instituted a new clinical practice protocol that involved the following steps to improve physician call return time: Physicians who did not respond to phone calls in a timely fashion were identified in the Medical Message tab in our EMR by our Clinical Practice Management Team, and any deficient physicians were approached during the business day by our Clinical Practice Management Team with a verbal warning and a type-written letter requiring a response to the awaiting patients by the end of the business day. The protocol required immediate physician response with the consequence of the physician having to receive direct messages in a printed format or have a nurse waiting for them when they leave the room to remind them, both of which the physicians desired to avoid.** **Date Action Initiated: 12/1/15** **Additional Actions Taken:**
	5. Re-measure Performance (6E 4)	**Start Date: 3/1/16 End Date: 5/15/16 Rate (% or #): 86%**
	6. Assess Actions & Describe Improvement (6E 1)	**We saw a slight improvement in this category, and attribute it to our efforts to holding our physicians accountable to returning calls in a timely manner. We will continue to keep this new process in our office, and monitor continued surveys in the future to determine if more work needs to be done on this issue.**

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Identify a Disparity in Care for a Vulnerable Population		
Identify vulnerable population: _____ **Disparity:** _____	**1. Identify a disparity in care for a vulnerable population**	**Describe a comparison of a vulnerable population against the general population in which the vulnerable population received care/service at a lower rate:** _____
	2. & 3. Baseline Performance Measurement & Numeric Goal for Improvement (6D 7)	**Baseline Start Date:** _____ **Baseline End Date:** _____ **Baseline Performance Rate (% or #):** _____ **Numeric Goal Rate (% or #):** _____
	4. What actions were taken to improve and work towards goal? Provide dates actions were initiated. (6D 7) (Only 1 Action Required)	**Action :** _____ **Date Action Initiated:** _____ **Additional Actions Taken:**
	5. Re-measure Performance	**N/A**
	6. Assess Actions (6E 1)	