**PURPOSE: This worksheet helps practices organize the measures and QI activities that are required by PCMH 1, Element A and PCMH 6, Elements D and E. Refer to PCMH 1, Element A and PCMH 6, Elements A–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 QI strategy but should consult the QI Worksheet Instructions for guidance.***

**QUALITY MEASUREMENT & IMPROVEMENT ACTIVITY STEPS**

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| 1. **Identify measures for QI.** From PCMH Element **1A, factors 1–5**, select **one aspect of access** to improve. From PCMH 6:  * *From Element A:* At least **three clinical quality measures**. * *From Element B:* At least **one resource use and/or care coordination measure.** * *From Element C****:*** At least **one patient/family experience measure.** * At least **one measure focused on vulnerable populations** with an identified health disparity (the measure may be one identified in Elements A or C, but is not required to be).   **2. Identify a baseline performance assessment.** Choose a starting measurement period **(start and end date)** and identify a baseline performance measurement for each measure.   * *For PCMH 1 A,* factor 6, use data from factors 1–5. * *For PCMH 6 D,* use performance measurements from the reports provided in PCMH 6 A–C.   The baseline measurement period ***must be*** **within 12 months** before tool submission,or **within 24 months**, if there is a remeasurement period. The performance measurement ***must be*** a rate (percentage based on numerator and denominator) or number (with number of patients represented by the data).  **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 1A 6; 6D 1, 3, 5, 7) *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 assessment date. You may list more than one activity, but are not required to do so. **(Applies to 1A 6; 6D 2, 4, 6)**  **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 tool submission. The performance measurement ***must be*** a rate (percentage based on numerator and denominator) or number (with number of patients represented by the data). **(Applies to 6E 2–4) *Note: To receive credit for 6E, factors 2–4, the remeasurement must show improvement on two clinical quality measures; one resource use/care coordination measure; one patient/family experience measure.***  **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 6E 1)** |

***EXAMPLE:* HOW TO COMPLETE A ROW**

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| *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 *(6D 1)*** | ***Baseline Start Date:* 5/1/15 Baseline End Date: 5/30/15**  ***Baseline Performance Measurement (% or #):* 56/547 = 32.0%**  ***Numeric Goal (% or #):* 58%** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(6D 2)*  *(Only 1 action required)*** | ***Action:* Pop-up reminders were added to our EMR for patients due/overdue screening**  ***Date Action Initiated*: 7/1/15**  ***Additional Actions:* Provider quality compensation metric put in place to incentivize providers to ensure appropriate health screening.** |
| **5. Remeasure performance *(6E 1,2)*** | ***Start Date:* 5/1/16 *End Date:* 5/30/16**  ***Performance Re-Measurement (% or #):* 380/550 = 69.1%** |
| **6. Assess actions; describe improvement *(6E 1)*** | **Since July 2015, there has been an increase of 37.1% 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.** |

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| *Example:* Identify a Disparity in Care for a Vulnerable Population | | |
| *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 performance:*** **Uninsured patients receive fewer mammograms than insured patients** |
| **2./3. Baseline performance measurement and numeric goal for improvement *(6D 7)*** | ***Baseline Start Date:* 07/2015 *Baseline End Date:* 12/2015**  ***Baseline Performance Measurement for Vulnerable Population (% or #):* 25/100 = 25% of uninsured women receive mammograms**  ***Baseline Performance Measurement for General Population (% or #):* 600/1000 = 60% of insured women receive mammograms**  ***Numeric Goal (% or #):* 50% of uninsured women receive mammograms** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(6D 7)* *(Only 1 action required)*** | ***Action:* Identified community resources for free or low-cost mammograms and shared with uninsured patients**  ***Date Action Initiated:* 1/2016**  ***Additional Actions:*** |
| **5. Remeasure Performance**  ***Note: Continuing QI is encouraged, but is not required for 6D 7.*** | ***Start Date*:       *End Date:***  ***Performance Re-Measurement (% or #):*** |
| **6. Assess actions; describe improvement**  ***Note: Continuing QI is encouraged, but is not required for 6D 7.*** | **During a 1-year measurement period from July–Dec 2015, 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 remeasurement period of Jan–July 2016.** |

***Practice Name:* Wake Forest Pediatric Associates, PLLC *Date Completed:* 02-28-17**

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| Use ONE Access Measure Identified in 1A | | |
| *Measure 1:* Same-day appointment access | **1. Measure selected for improvement; reason for selection** | ***Reason:* Increase same-day appointment usage to improve patient access.** |
| **2./3. Baseline performance measurement; numeric goal for improvement *(1A 6)*** | ***Baseline Start Date*: 05-22-16 *Baseline End Date*: 06-22-16**  ***Baseline Performance Measurement (% or #):* 1051/2592 = 40.5%**  ***Numeric Goal (% or #):* 50%** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(1A 6)* *(Only 1 action required)*** | ***Action*: In order to increase our same-day appointment usage, I brainstormed with the schedulers, and we decided to offer same-day physicals. I ran the “Same-Day Appointments” report for the previous month and decided on a goal. I met with the schedulers and discussed this measure and also sent out an electronic message to take advantage of same-day appointments/open slots/cancelations and offer these to parents/patients first when they are calling in to schedule a physical that is needed now. Began offering same-day physicals to parents when appropriate.**  ***Date Action Initiated*: 06-23-16**  ***Additional Actions*: Continued to offer same-day appointments for physicals past the PDSA cycle of 30 days.** |
| **5. Remeasure performance**  ***Note: Continuing QI is encouraged, but is not required for 1A 6.*** | ***Start Date:* 06-25-16 *End Date*: 07-25-16**  ***Performance Re-Measurement (% or #):* 749/2171 = 34.5%** |
| **6. Assess actions; describe improvement**  ***Note: Continuing QI is encouraged, but is not required for 1A 6.*** | **Our Same-Day Appointment percentage did not increase during the initial re-measurement period. We attribute this to the fact that it was summer time and we had providers on vacation most days. We were unable to use as many same-day slots for physicals because there were less providers in the office to see patients; therefore, less same-day appointment slots were available. We did run the Same-Day Appointment report again on 02-27-17 for the previous month (01-26-17 – 02-26-17), and our percentage did increase to 52.9% which surpassed our goal of 50%.** |

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| Use THREE Measures Identified in 6A | | |
| *Measure 1:* Asthma patients on a controller medication who have NOT had a PFT in the last 6 months | **1. Measure selected for improvement; reason for selection** | |  | | --- | | Reason: We want to decrease the number of asthma patients on a controller medication who have not received a PFT within the last 6 months. It is important to monitor lung function regularly to ensure appropriate treatment of asthma. It is recommended that all asthma patients on a controller medication have a PFT done at least every 6 months.  https://www.nhlbi.nih.gov/health-pro/resources/lung#asthma | |  | |
| **2./3. Baseline performance measurement; numeric goal for improvement  *(6D 1)*** | ***Baseline Start Date:* 02-22-16 *Baseline End Date:* 02-22-16 (\*please note that our system does not have the capability to run this report as a date *range*, but instead as the number of all active patients for our practice *at the time* of the report)**  ***Baseline Performance Measurement (% or #):* 166/1732 = 10%**  ***Numeric Goal (% or #):* 5% (please note that this an inverse measure-decrease in percentage demonstrates improvement)** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(6D 2)* *(Only 1 action required)*** | ***Action*: Reports were run monthly in EHR to identify patients who were on a controller medication that had not had a PFT in the last 6 months. The list of patients was reviewed each month by the Asthma Educator. She would call the parent/patient to schedule an appointment. If unable to reach the patient, she would mail a letter.**  ***Date Action Initiated*: 02-23-16**  ***Additional Actions:* Pop-up reminders were put in our EHR for patients that were due/overdue for a PFT, so if they came into the office for a different type of appointment the care team would be alerted.** |
| **5. Remeasure performance *(6E 1,2)*** | ***Start Date:* 02-21-17 *End Date:* 02-21-17 (\*please note that our system does not have the capability to run this report as a date *range*, but instead as the number of all active patients for our practice *at the time* of the report)**  ***Performance Re-Measurement (% or #):* 71/2069 = 3%** |
| **6. Assess actions; describe improvement  *(6E 1)*** | ***During a one year measurement period, we did show a decrease in the number of patients who were on a controller medication that had NOT had a PFT in the last 6 months. Our percentage decreased from 10% to 3%-surpassing our goal of 5%. By running monthly reports and contacting patients to come in for a PFT appointment, along with putting reminders on the charts, we did in fact improve our percentage.*** |

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| *Measure 2:* Active 2 year olds who have *not* had 4 doses of DTaP | 1. Measure selected for improvement; reason for selection | *Reason: We want to decrease the percentage of our 2 year olds that are not up-to-date on their DTaP vaccine. The CDC (Centers for Disease Control and Prevention) and ACIP (Advisory Committee on Immunization Practices) recommend that children have 4 doses of DTaP by age 2 years. Diphtheria, tetanus, and pertussis are serious diseases caused by bacteria. Diphtheria, tetanus, and pertussis vaccine (DTaP) can help prevent these diseases.*  *(https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.*html) |
| **2./3. Baseline performance measurement; numeric goal for improvement  *(6D 1)*** | ***Baseline Start Date:*** 08-23-16 ***Baseline End Date:*** 08-23-16 **(\*please note that our system does not have the capability to run this report as a date *range*, but instead as the number of all active patients for our practice *at the time* of the report)**  ***Baseline Performance Measurement (% or #):*** 62/563 = 11%  ***Numeric Goal (% or #):*** 10% (please note that this is an inverse measure- decrease in percentage demonstrates improvement) |
| **4. Actions taken to improve and work toward goal; dates of initiation *(6D 2)* *(Only 1 action required)*** | ***Action:*** Created a schedule and ran/reviewed monthly reports in EHR and NCIR (results here provided from EHR, but NCIR is consistent with these results). Called the parent(s) of patients who were not up to date on the DTaP vaccine and scheduled appointments to come in for the vaccine. If unable to reach parent(s) by phone, a letter was mailed to the parent  ***Date Action Initiated:*** 09-01-16  ***Additional Actions:*** If unable to reach the patient by phone/mail or if the patient never came to the appointment for the vaccine, the provider was notified and a pop-up reminder was placed in the chart in EHR. |
| **5. Remeasure performance  *(6E 1,2)*** | ***Start Date:*** 02-21-17 ***End Date:*** 02-21-17 **(\*please note that our system does not have the capability to run this report as a date *range*, but instead as the number of all active patients for our practice *at the time* of the report)**  ***Performance Re-Measurement (% or #):*** 51/565 = 9% |
| **6. Assess actions; describe improvement  *(6E 1)*** | NCIR and EHR reports for 2 year old DTaP vaccine administration were reviewed monthly. Patients who were not up-to-date on this vaccine were reminded via phone or mail to comply with CDC guidelines. Parents were advised of the importance and need for this vaccine. Our reports demonstrate that our actions did improve compliance with DTaP vaccination recommendations. Our percentage of patients that were not up-to-date decreased from 11% to 9%, surpassing our goal of 10%. |

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| *Measure 3:* Active patients who are 2 years old *without* a Well-Child Check (WCC) | 1. Measure selected for improvement; reason for selection | *Reason:* According to guidelines from Bright Futures/American Academy of Pediatrics, 2 year olds should have a Well-Child Check (WCC). The Bright Futures/AAP 2016 “Recommendations for Preventive Pediatric Healthcare” states “The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.”  https://brightfutures.aap.org/ |
| **2./3. Baseline performance measurement, numeric goal for improvement. *(6D 1)*** | ***Baseline Start Date:*** 08-23-16 ***Baseline End Date:*** 08-23-16 **(\*please note that our system does not have the capability to run this report as a date *range*, but instead as the number of all active patients for our practice *at the time* of the report)**  ***Baseline Performance Measurement (% or #):* 15/563 = 2.7%**  ***Numeric Goal (% or #):*** 1.7% (please note that this is an inverse measure- decrease in percentage demonstrates improvement) |
| **4. Actions taken to improve and work toward goal; dates of initiation *(6D 2)* *(Only 1 action required)*** | ***Action:*** Ran reports monthly to identify 2 year olds that needed a WCC. Called parents to schedule an appointment. If unable to reach parents by phone, letters were mailed to parents.  ***Date Action Initiated:*** 09-01-16  ***Additional Actions:*** Also ran monthly reports in NCIR (North Carolina Immunization Registry) to identify 2 year olds who were not up-to-date on vaccines, which also sometimes correlated with being behind on well-child checks. |
| **5. Remeasure performance.  *(6E 1,2)*** | ***Start Date:*** 02-01-17 ***End Date:*** 02-01-17 **(\*please note that our system does not have the capability to run this report as a date *range*, but instead as the number of all active patients for our practice *at the time* of the report)**  ***Performance Re-Measurement (% or #):* 8/550 = 1.5**% |
| **6. Assess actions and describe improvement. *(6E 1)*** | By running reports and contacting patients that needed 2 year well-child checks, our goal was to decrease the percentage by 1%. During the period of 08-23-16 to 02-01-17, we did demonstrate improvement in 2 year olds *without* a WCC by decreasing from 2.7% to 1.5% which surpassed our goal of 1.7%. |

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| Use ONE Measure Identified in 6B | | |
| *Measure 1:* Medication Reconciliation | **1. Measure selected for improvement; reason for selection** | ***Reason:*** Medication reconciliation, especially during a transition of care, creates the most accurate list possible of the patient’s medications. We chose this measure because this is very important for patient health and safety.  <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP_7MedicationReconciliationObjective.pdf>  <http://www.ihi.org/topics/adesmedicationreconciliation/Pages/default.aspx> |
| **2./3. Baseline performance measurement; numeric goal for improvement  *(6D 3)*** | ***Baseline Start Date:* 10-06-15 *Baseline End Date:* 01-05-16**  ***Baseline Performance Measurement (% or #):* 239/295 = 81%**  ***Numeric Goal (% or #):* 90%** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(6D 4)* *(Only 1 action required)*** | ***Action*: Educated the clinical staff about the importance of reconciling the medication list by sending message through EHR and by discussing one-on-one and in group meetings. Explained the importance of getting an accurate list of medications along with how the patient is taking the medications (dosage, frequency, route). Reviewed reports at least monthly and discussed results with the providers and clinical staff.**  ***Date Action Initiated*: 01-06-16**  ***Additional Actions:* Re-educated and gave reminders to the clinical staff one-on-one or by EHR message as needed based on monthly EHR report results if their percentages were not increasing.** |
| **5. Remeasure performance *(6E 1, 3)*** | ***Start Date:* 01-08-16 *End Date:* 12-31-16**  ***Performance Re-Measurement (% or #):* 1217/1325 = 91.8%** |
| **6. Assess actions; describe improvement  *(6E 1)*** | **By continuing to run reports and communicating the importance of medication reconciliation to the staff and sending reminders as needed, our percentage did increase by 10.8% from 01/2016 to 12/2016, surpassing our goal of 90%.** |

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| Use ONE Measure Identified in 6C | | |
| *Measure 1:* Patient Satisfaction Survey: Coordination of Care- Instructions the care provider gave the patient about referrals | **1. Measure selected for improvement; reason for selection** | ***Reason:*** According to results from our Patient Satisfaction Surveys, 75% of patients that reported a referral indicated that the instructions they were given about the referral were “good” or “very good”. 25% of patients reported the instructions they received as “poor” or “very poor”. As a medical home, our practice chose this measure so that we could improve the patient’s experience during the referral process by giving more clear instructions and expectations. Our goal was that 100% of patients who indicated on our survey that they had a referral entered the response of “good” or “very good”. |
| **2./3. Baseline performance measurement; numeric goal for improvement  *(6D 5)*** | ***Baseline Start Date:* 05-01-15 *Baseline End Date:* 12-31-15**  ***Baseline Performance Measurement (% or #):* 75%**  ***Numeric Goal (% or #):* 100%** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(6D 6)* *(Only 1 action required)*** | ***Action*: Our Referral Coordinator made changes to our referral process and sent out a message to the staff explaining these changes. She created a handout for the patients explaining the referral process which includes: type of specialist, what to expect through the referral process, and what is expected of the patient. This handout also contained her contact information with instructions to contact her if they had not been contacted within the recommended time interval (depending on type of referral).**  ***Date Action Initiated*: 02-01-16**  ***Additional Actions:* The Referral Coordinator also advised the providers when making a referral to send an electronic patient message to the “Referral folder” with the patient’s *best* contact phone number.** |
| **5. Remeasure performance *(6E 4)*** | ***Start Date:* 07-01-16 *End Date:* 12-31-16**  ***Performance Re-Measurement (% or #):* 100%** |
| **6. Assess actions; describe improvement  *(6E 1)*** | **After making changes to our referral process by advising the providers to get the best phone number for the patient and by providing patients with handouts explaining the process, our percentage of patients who answered “good” or “very good” on the Patient Satisfaction Survey did increase and met our goal of 100%. We had no responses of “poor” or “very poor” during this re-measurement period.** |

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| Identify a Disparity in Care for a Vulnerable Population | | |
| *Vulnerable population:* Asthma patients on a controller medication with Medicaid insurance  *Disparity:* Asthma patients on a controller medication with Medicaid receive fewer Pulmonary Function Tests (PFTs) | **1. Measure selected for improvement; reason for selection** | ***Describe a comparison of a vulnerable population against the general population in which the vulnerable population received care/service at a lower performance:* After reviewing a report of Asthma patients on a controller medication who have not had a PFT within the last 6 months who have Medicaid insurance, we realized that they have a higher percentage rate than our general population.** |
| **2./3. Baseline performance measurement, numeric goal for improvement. *(6D 7)*** | ***Baseline Start Date:* 10-01-16 *Baseline End Date:* 10-01-16 (\*please note that our system does not have the capability to run this report as a date *range*, but instead as the number of all active patients for our practice *at the time* of the report)**  ***Baseline Performance Measurement for Vulnerable Population (% or #):* 45/591 = 7.6%**  ***Baseline Performance Measurement for General Population (% or #):* 60/1933 = 3.1%**  ***Numeric Goal (% or #):* 5%** (please note that this is an inverse measure- decrease in percentage demonstrates improvement) |
| **4. Actions taken to improve and work toward goal; dates of initiation *(6D 7)* *(Only 1 action required)*** | ***Action:* Ran reports monthly of patients that needed a PFT and called to schedule appointments or mailed letters if unable to contact by phone. Explained to parents the importance of regular asthma checks and PFTs in the maintenance of asthma.**  ***Date Action Initiated:* 10-03-16**  ***Additional Actions:* Offered to schedule appointments outside of the normal times that we usually do this type of appointment to accommodate schedules or transportation issues. Referred patients, as needed, to CCWJC (Community Care of Wake and Johnston counties) which is our community resource for patients with Medicaid insurance. CCWJC can make home visits, do home assessments, provide education and assistance with asthma issues.** |
| **5. Remeasure performance.**  ***Note: Continuing QI is encouraged, but is not required to meet 6D 7.*** | ***Start Date:* 01-01-17 *End Date:* 01-01-17 (\*please note that our system does not have the capability to run this report as a date *range*, but instead as the number of all active patients for our practice *at the time* of the report)**  ***Performance Re-Measurement (% or #):* 53/635 = 8.3%** |
| **6. Assess actions and describe improvement.**  ***Note: Continuing QI is encouraged, but is not required to meet 6D 7.*** | **On 10/01/16 we ran a report of Asthma patients on a controller medication without PFT in the last 6 months (one report for our general population and one report for patients with Medicaid). The patients with Medicaid had a 4.5% higher rate of not getting PFTs compared to our general population. After calling patients, mailing letters, offering more convenient appointment times, and referring patients to Community Care we did *not* see a decrease in the percentage of patients with Medicaid who needed a PFT. Our percentage rate actually increased from 7.6% to 8.3% indicating that we need to continue and increase our efforts to assist this population in their health maintenance.** |