WACMHC

Washington Association of Community & Migrant Health Centers

Putting PCMH into Practice: A Transformation Series

Performance Measurement & Quality Improvement (QI)

October 10, 2018

WEBINAR FACILITATOR

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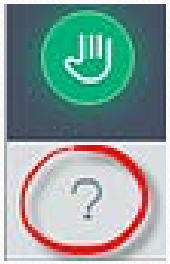
HOUSEKEEPING

- Your lines are currently muted
- We'll address questions at the end of the presentation
- You can ask a question in the following ways:



RAISE YOUR HAND FUNCTION - your line will be unmuted and you can ask the question verbally

QUESTIONS FUNCTION – type your question in the box and the facilitator will read it aloud

- This webinar is being recorded. A recording will be sent to you in a follow-up email.

2017 NCQA PCMH Standard 6: Performance Measurement and Quality Improvement (QI)

Advancing Healthcare
Improving Health

Objectives

1. Name the model for quality improvement used by your organization.
2. Identify the metrics (measures) used to evaluate improvement efforts and outcomes at your organization.
3. Specify how patients, families, providers, and care team members are involved in quality improvement activities.

5

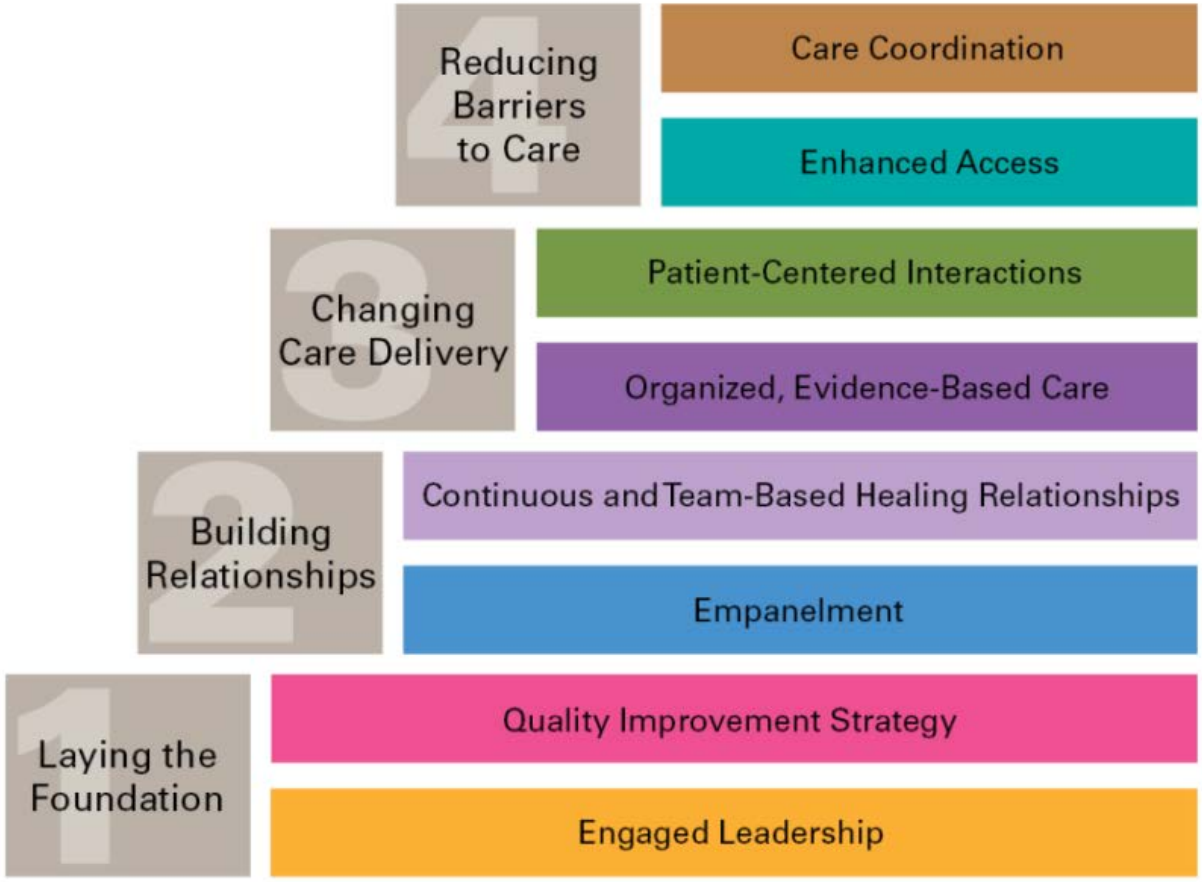
Pre-Work Considerations

- Describe how is data used to drive clinical performance at your practice
- Name a current improvement effort underway at your practice
- How are staff and patients made aware of current clinical performance data at your practice?

Question?

- Knowledge, Acceptance, Implementation
- Demonstrating ROI of sustaining recognition

Change Concepts for Practice Transformation



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
- 3 Competencies
- 19 Criteria

QI 01 – Clinical Quality Measures

QI 08 – Goals and Actions to Improve CQMs

QI 03 – Appointment Availability Assessment

QI 10 – Goals and Actions to Improve Appointment Availability

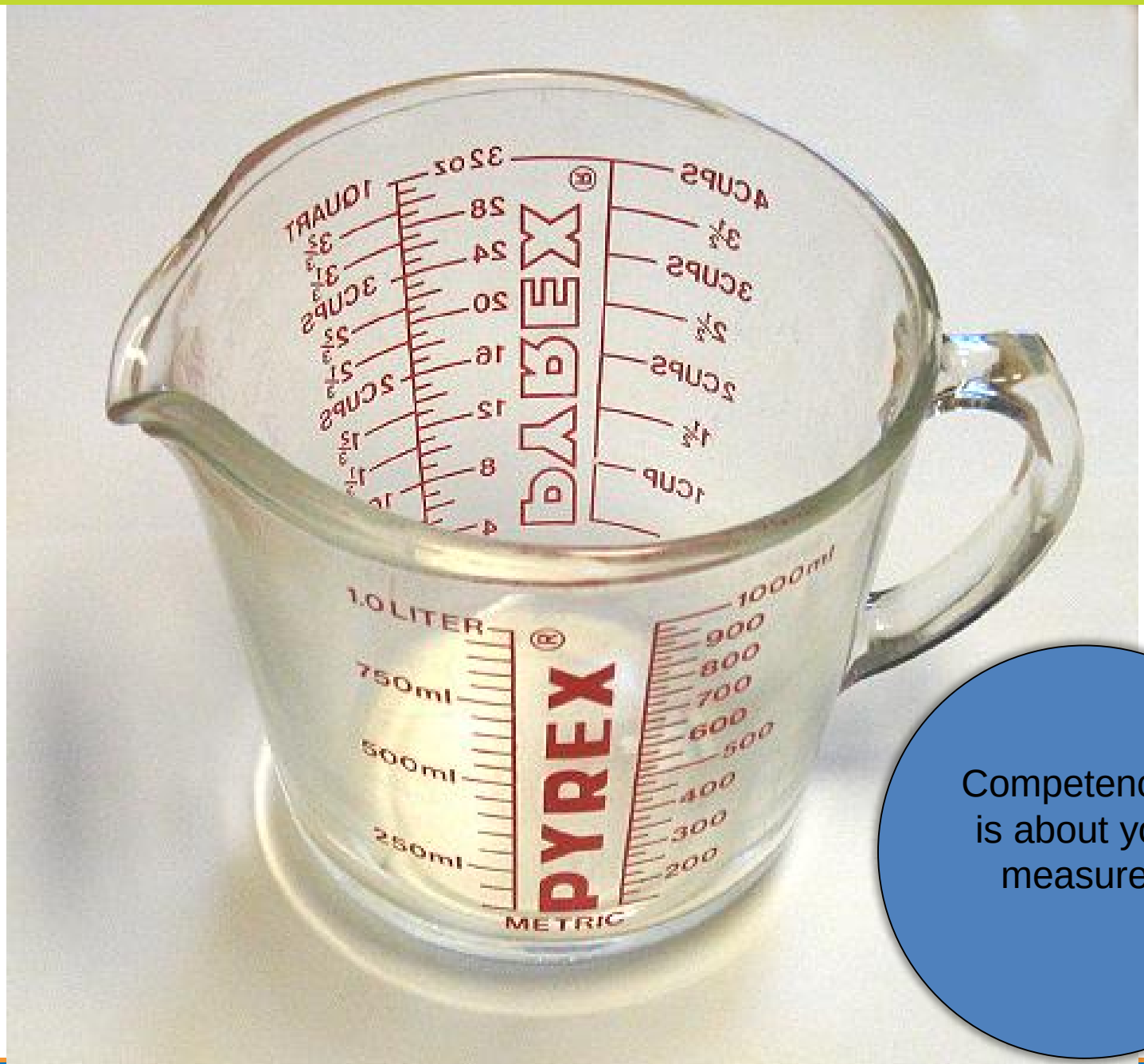
QI 02 – Resource Stewardship Measures

QI 09 – Goals and Actions to Improve RSMs

QI 04 – Patient Experience Feedback

QI 11 – Goals and Actions to Improve Patient Experience

QI 15 – Reports Performance within the Practice



Competency A is about your measures

Competency A Core Criteria

- **QI 01 Clinical Quality Measures – Aligns with PCMH 2014 6A (D is New)**
- QI 02 Resource Stewardship Measures – Aligns with PCMH 2016 6B
- QI 03 Appointment Availability Assessment – Aligns with PCMH 2014 1A4
- QI 04 Patient Experience Feedback – Aligns with PCMH 2014 6C

Competency A Elective Criteria

- QI 05 Health Disparities Assessment – Aligns with PCMH 2014 6A and 6C
- QI 06 Validated Patient Experience Survey Use - Aligns with PCMH 2014 6C
- QI 07 Vulnerable Patient Feedback – Aligns with PCMH 2014 6C

Competency A Required Documented Process = One

QI 03 Core - Assesses performance on availability of major appointment types to meet patient needs and preferences for access

Aligns with PCMH 2014 1A4

Competency A - QI 01 (Core)
Measures 5 Clinical Quality Measures Across Four Categories

One immunization measure
Aligns with PCMH 2014 6A

One preventive care measure (not including immunizations)
Aligns with PCMH 2014 6A

A measure on oral health counts as a preventive clinical quality measure

One chronic or acute care clinical measure

Aligns with PCMH 2014 6A

New

One behavioral health measure

Evidence = Reports

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

Competency A - QI 02 (Core) Resource Stewardship Measures – Aligns with PCMH 2014 6B

- Reports at least two measures related to resource stewardship
- Must include a measure related to health care cost and a measure related to care coordination
- Evidence = Report

Care Coordination Metrics Examples

Community Resources, Self-Management Support, etc.
Patient satisfaction ratings for community resources
Percent community resources for which loop was closed (i.e., patient received or evaluated the resource)
Patient health confidence pre- and post-provision of self-management support
Referrals
Number of open referrals or percentage of referrals open > 60 days
Percent referral results acknowledged by ordering clinician
Test Orders
Percentage lab orders open > 30 days
Percentage of lab results pushed to portal and accessed by patient
Percent lab results with documentation of patient notification
Percent lab results acknowledged by ordering clinician
Post-Discharge Follow-Up
Percent patients called within 72 hours of discharge from hospital
Percent patients scheduled for follow-up within seven days of discharge from hospital (and/or that showed for appt)
Percent patients with discharge summary in chart by day of follow-up visit
Percent high-risk ED discharges called within one business day
Percent patients discharged from the hospital with med reconciliation performed within five business days

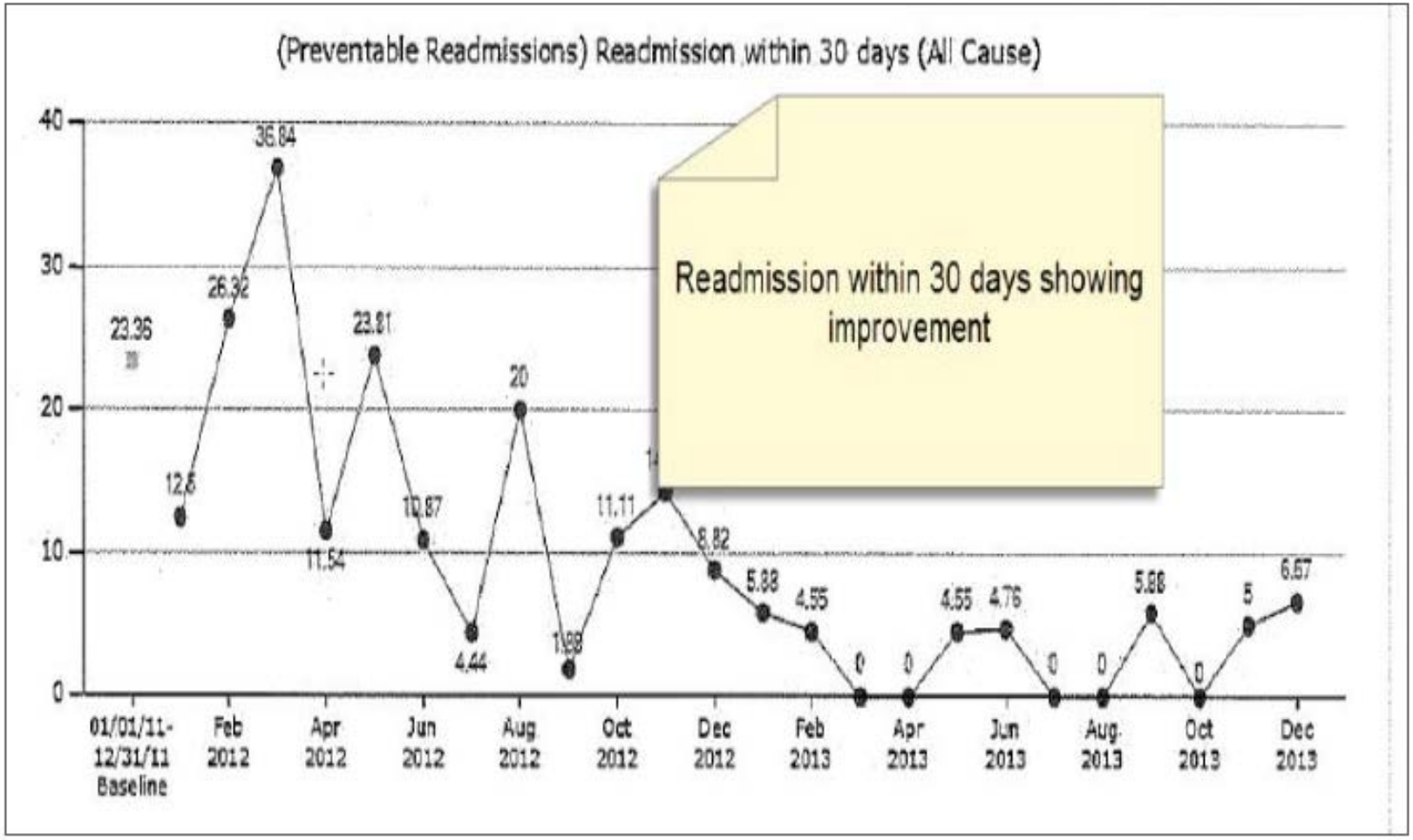
NCQA PCMH QI 02

Resource Measures

- Generic vs. brand name prescriptions
- Number of specialty referrals by provider
- ED usage patterns
- Readmit rates
- Average visits/episode of care

Performance Measurement & Quality Improvement

QI 02 B: Example



Competency A – QI 03 (Core)
Appointment Availability Assessment

- Reviews the availability of major appointment types (e.g., urgent care, new patient, routine exams, follow-up) to ensure the needs and preferences patients are met
- Evidence = Documented process ***AND*** report
- A common approach to measuring appointment availability against standards is to determine the **third next available appointment for each appointment type**

Competency A – QI 04 (Core)
Patient Experience Feedback
Aligns with PCMH 2014 6C

A. Conducts a survey (using any instrument) to evaluate customer experiences across at least three dimensions such as:

- Access
- Communication
- Coordination
- Whole-person care, self-management support and comprehensiveness

B. Obtains feedback from through qualitative means - virtual review?

Competency A – QI 04 (Core)
Patient Experience Feedback

- Access (may include routine, urgent, and after-hours care)
- Communication with the practice, clinicians and staff (may include “feeling respected and listened to” and “able to get answers to questions”)
- Coordination of care
- Whole-person care/self-management support, comprehensive care
- Aligns with PCMH 2014 6C

Weak Link

- How do you measure patient feedback through qualitative means?

Competency A – QI 04 (Core)
Patient Experience Feedback

- Qualitative methods (e.g., focus groups, individual interviews, patient walkthrough, suggestion box) are another opportunity to obtain feedback from patients
- May use a feedback methodology conducive to its patient population, such as “virtual” (e.g., telephone, videoconference) participation
- Comments collected on surveys used to satisfy QI 04A do not meet this requirement

Performance Measurement & Quality Improvement

QI 04 B: Example

NEW PATIENT PHONE SURVEY Provider_____

Did your Provider meet and satisfy your needs?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					
ABC Health would like to be your "Patient Centered Medical Home". Overall, how was your experience?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					
Are you aware we have walk-in hours for acute care if you are unable to get in with your provider today?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					
Are you aware that ABC Health offers Pharmacy & Dental services? Able to get your meds today?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					
Do you have any suggestions or comments on how we can increase quality and your satisfaction?	Speaks English	Age	Insured	Race	Co-morbidity
1.					
2.					
3.					
4.					
5.					

caller identifies possible vulnerabilities prior to phone survey.

Providers – You will receive a copy of this survey each time it fills. The Patient Satisfaction Coordinator (PSC) calls all new patients a few days after their first visit to provide immediate feedback as well as recognizing vulnerable subgroups. The PSC will provide care coordination as needed when identified. All findings are kept by the Chief Quality Officer for use in QA/QI activities.

Competency A – QI 05 (1 Credit)
Health Disparities Assessment

- Stratifies performance data by race and ethnicity or other indicators of vulnerable groups
- Age, gender, language needs, education, income, type of insurance, disability, health status

- Evidence = Report OR Quality Improvement Worksheet
- Must choose one clinical and one patient experience measure.
- Aligns with PCMH 2014 6A and 6C

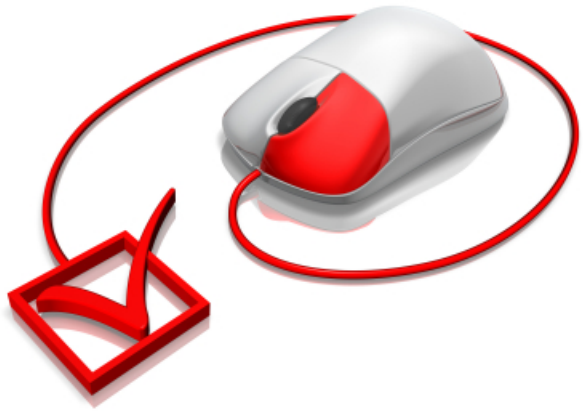
Competency A – QI 06 (1 Credit)
Validated Patient Experience Survey Use

- Uses a standardized survey tool to collect patient experience data and inform its quality improvement activities
- Intent is for practices to administer a survey that can be benchmarked externally and compared across practices
- Aligns with PCMH 2014 6C
- Evidence = Report

QI 06 Examples of Validated Tools

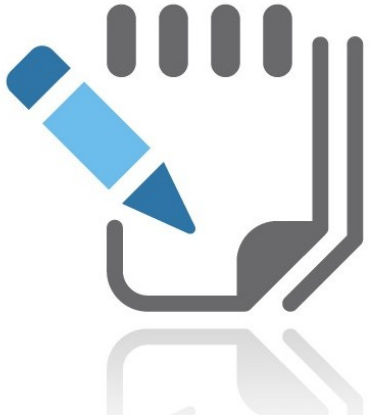
- CAHPS
- CAHPS-CG
- Other standardized survey providing benchmark analysis external to the practice organization

- Proprietary survey instruments are not acceptable



Competency A – QI 07 (2 Credits)
Obtains Feedback from Vulnerable Groups

- Identifies a vulnerable population where data (clinical, resource stewardship, quantitative patience experience, access) show evidence of disparities of care or services.
- Obtains qualitative patient feedback from population representatives to acquire better understanding of disparities and to support quality improvement initiatives.
- Evidence = Report



QI 05 and QI 07 Vulnerable Pops

- QI 05 - Stratifies performance data (any) by race and ethnicity or other indicators of vulnerable groups
- QI 07 - Identifies a vulnerable population where data show evidence of disparities of care or services. Next - obtains qualitative patient feedback to acquire better understanding of disparities and to support quality improvement initiatives


GOAL
Competency B
Sets goals and takes at least ONE action to improve
4 Core criteria
3 Elective criteria

QI 01 – Clinical Quality Measures

QI 08 – Goals and Actions to Improve CQMs

QI 03 – Appointment Availability Assessment

QI 10 – Goals and Actions to Improve Appointment Availability

QI 02 – Resource Stewardship Measures

QI 09 – Goals and Actions to Improve RSMs

QI 04 – Patient Experience Feedback

QI 11 – Goals and Actions to Improve Patient Experience

QI 15 – Reports Performance within the Practice

Competency B Core Criteria Aligns with PCMH 2014 1A6 and 6D

- **QI 08 Goals and Actions to Improve Clinical Quality Measures (behavioral health is new)**
- QI 09 Goals and Actions to Improve Resource Stewardship Measures
- QI 10 Goals and Actions to Improve Appointment Availability
- QI 11 Goals and Actions to Improve Patient Experience

Competency B Elective Criteria

- QI 12 Improved Performance – Aligns with PCMH 2014 6E
- QI 13 Goals and Actions to Improve Disparities in Care/Service – Aligns with PCMH 2014 6D
- **QI 14 Improved Performance for Disparities in Care/Service- New**

- QI 01 – Clinical Quality Measures
- QI 08 – Goals and Actions to Improve CQMs
- QI 03 – Appointment Availability Assessment
- QI 10 – Goals and Actions to Improve Appointment Availability
- QI 02 – Resource Stewardship Measures
- QI 09 – Goals and Actions to Improve RSMs
- QI 04 – Patient Experience Feedback
- QI 11 – Goals and Actions to Improve Patient Experience
- QI 15 – Reports Performance within the Practice

Competency B – QI 08 (Core)
Goals and Actions to Improve on 3 Clinical Measures Across 3 of 4 Categories

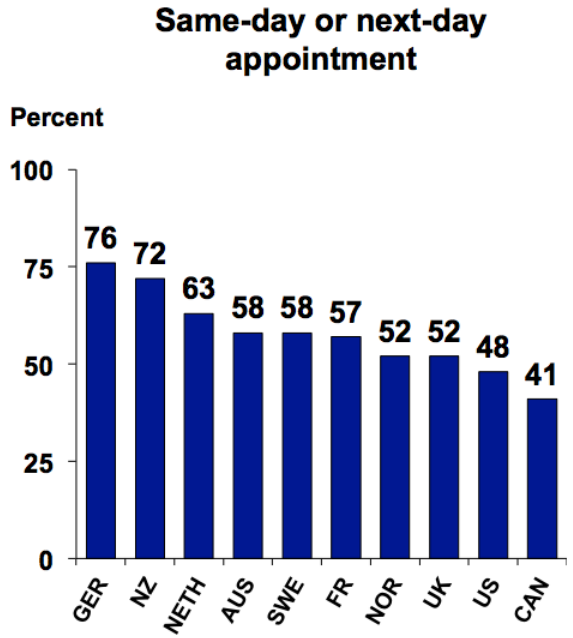
- **A. Immunization measures – Aligns with PCMH 2014 6A**
- **B. Other preventive care measures – Aligns with PCMH 6A**
- **C. Chronic or acute care clinical measures – Aligns with PCMH 2014 6A**
- **D. Behavioral health measures – New Category**
- **Evidence = Report OR Quality Improvement Worksheet**
- **Measures may be chosen from QI 01**

Competency B – QI 09 (Core) Goals and Actions to Improve Resource Stewardship

- Measures related to care coordination
- Measures affecting health care costs
- Measures selected for improvement may be chosen from the same set of measures identified in QI 02
- Aligns with PCMH 2014 6D
- Report ***OR*** Quality Improvement Worksheet

Competency B – QI 10 (Core)
Goals and Actions to Improve Appointment Availability – Aligns with PCMH 2014 1A6

- After assessing performance on the availability of common appointment types in QI 03, the practice sets goals and acts to improve on availability
- Report ***OR*** Quality Improvement Worksheet



If You Have Met Your Goals Then What…

- Practices that have met their appointment-availability access goals in QI 03 and cannot reasonably adjust their goals or identify room for improvement (practices with open-access scheduling) may select another patient-access area (e.g., time spent in the waiting room, no show rates, extended hours, alternative visit types) as their focus.

Competency B – QI 11 (Core)
Goals and Actions to Improve Patient Experience

- After assessing performance on at least one patient experience measure (QI 04), the practice demonstrates that it set a goal and took action to improve patients' experience of care
- Aligns with PCMH 2014 6D
- Report ***OR***

  Quality Improvement Worksheet

Competency B – QI 12 (2 Credits) Improved Performance - Aligns with PCMH 2014 6E

- The practice demonstrates that it has improved performance on at least two measures. Demonstration of improvement is determined by the goals set in QI 08, QI 09 or QI 11
- Report ***OR*** Quality Improvement Worksheet

Competency B – QI 13 (1 Credit)
Goals and Actions to Improve Disparities in Care or Service

- Identifies health disparities in care or services among vulnerable populations. The practice sets goals and acts to improve performance. After assessing performance on the disparities in care (QI 05), the practice sets goals and acts to improve on care or service
- Aligns with PCMH 2014 6D
- Report ***OR***

  Quality Improvement Worksheet

Competency B – QI 14 (2 Credits) Improved Performance for Disparities in Care or Service - ***New***

- The practice demonstrates that it has improved performance on at least one measure related to disparities in care or service. Demonstration of improvement is determined by the goals set in QI 13
- Report ***OR*** Quality Improvement Worksheet

Recap - QI Elective Criteria

QI 05 – Health Disparities Assessment

QI 13 – Goals and Actions to Improve Disparities in Care

QI 07 – Vulnerable Patient Experience Feedback

QI 11 – Goals and Actions to Improve Vulnerable Patient Experience

Performance Measurement & Quality Improvement

QI Worksheet: Example

NCQA PCMH Quality Measurement and Improvement Worksheet

PURPOSE: This worksheet helps practices organize the measures and quality improvement activities that are outlined in PCMH AC 01-03, AC 06 and QI 08-14. Refer to PCMH AC and QI in the PCMH 2017 Standards and Guidelines 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 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:* At least five clinical quality measures
     - *PCMH QI 02:* At least two resource stewardship measures
     - *PCMH QI 03:* Assess availability of major appointment types
     - *PCMH QI 04:* Monitors patient experience
   - Optional (Elective Criteria):
     - *PCMH QI 05:* At least two measures for vulnerable populations (one clinical quality, one patient experience)

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 QI 08-11 and 13,* use performance measurements from the reports provided in PCMH QI 01-05.

   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) 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 QI 08-11 and 13)**
   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 and 13)**

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) or number (with number of patients represented by the data).

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)**

EXAMPLE: HOW TO COMPLETE A ROW

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:*** 5/1/16 **Baseline End Date:** 5/30/16 ***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:*** 7/1/16 ***Additional Actions:*** Provider quality compensation metric put in place to incentivize providers to ensure appropriate health screening.
	5. Remeasure performance *(QI 12)*	***Start Date:*** 5/1/17 ***End Date:*** 5/30/17 ***Performance Remeasurement (% or #):*** 380/550 = 69.1%
	6. Assess actions; describe improvement. *(QI 12)*	Since July 2016, 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.

NCQA PCMH Quality Measurement and Improvement Worksheet

Practice Name: ***Date Completed:***

Use ONE Access Measure Identified in QI 010		
Measure 1:	**1. Measure selected for improvement; reason for selection**	***Reason:***
	2./3. Baseline performance measurement; numeric goal for improvement *(QI 03)*	***Baseline Start Date:*** ***Baseline End Date:*** ***Baseline Performance Measurement (% or #):*** ***Numeric Goal (% or #):***
	4. Actions taken to improve and work toward goal; dates of initiation *(QI 10)* ***(Only 1 action required)***	***Action:*** ***Date Action Initiated:*** ***Additional Actions:***
	5. Remeasure performance ***Note: Continuing QI is encouraged, but is not required for QI 10.***	***Start Date:*** ***End Date:*** ***Performance Remeasurement (% or #):***
	6. Assess actions; describe improvement. ***Note: Continuing QI is encouraged, but is not required for QI 10.***	

QI 01 – Clinical Quality Measures

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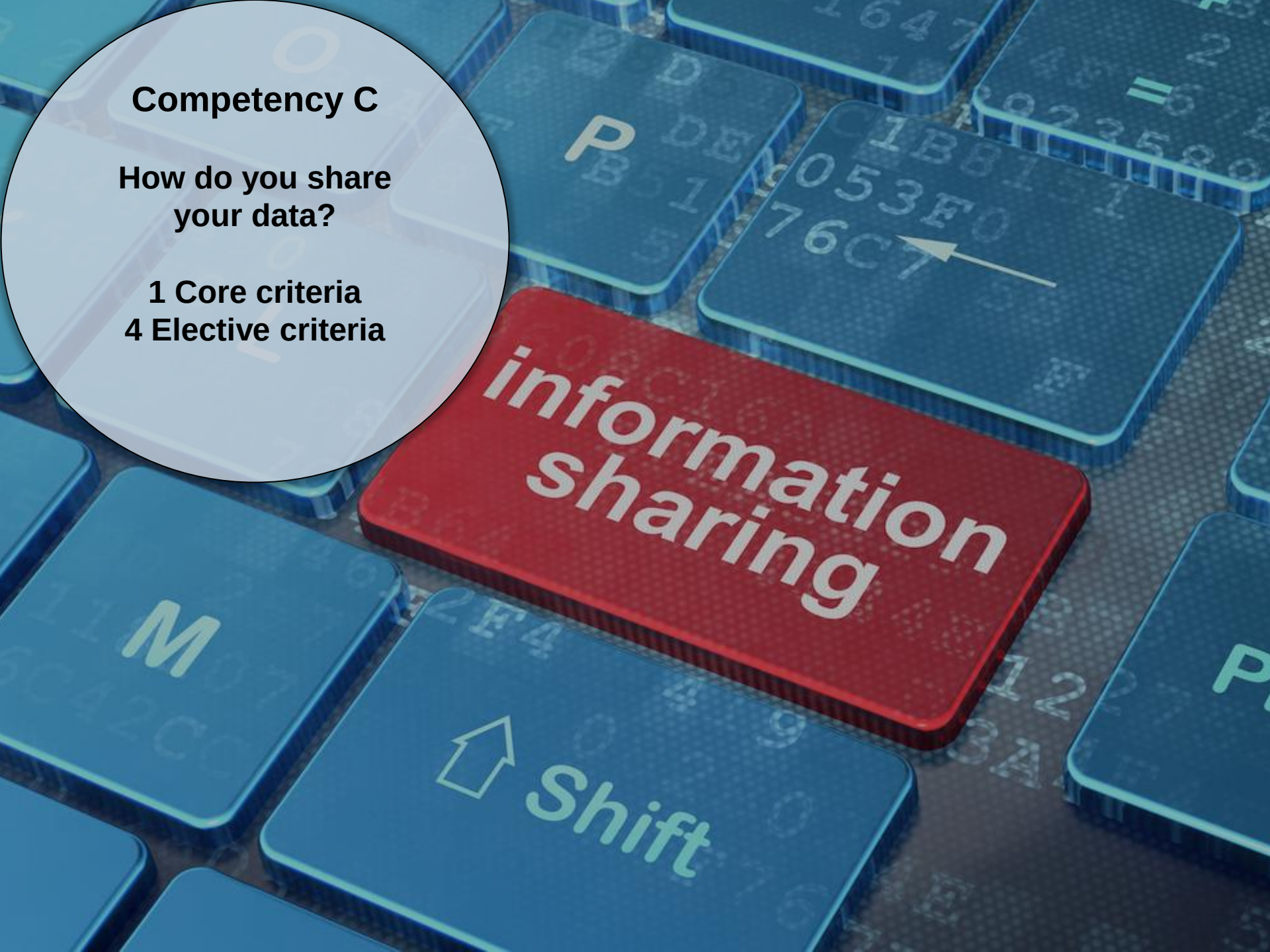
QI 15 – Reports Performance within the Practice



Competency C

How do you share your data?

1 Core criteria
4 Elective criteria

Competency C Criteria

- QI 15 Reporting Performance within the Practice (Core)
- QI 16 Reporting Performance Publicly or with Patients (Elective)
- QI 17 Patients/Family Caregiver Involvement in Quality Improvement (Elective)
- **QI 18 Reporting Performance Measures to Medicare/Medicaid (Elective) - New**
- **QI 19 Value-Based Contract Agreements (Elective) - New**

Competency C Required Documented Processes

QI 15 Core - Reports practice-level or clinician-level performance results within the practice for measures reported by the practice

Aligns with PCMH 2014 6F

QI 16 Credit - Reports practice-level or clinician-level performance results publicly or with patients for measures reported by the practice

Aligns with PCMH 2014 6F

QI 17 Credit - Involves patient/family/caregiver in quality improvement activities

Aligns with PCMH 2014 2D

Competency C - QI 15 (Core) Reports Performance Within the Practice

- Provides clinician-level or practice-level reports to clinicians and practice staff
- The practice may use data that it produces or data provided by affiliated organizations, such as a larger medical group, individual practice association or health plan
- Aligns with PCMH 2014 6F
- Evidence = Documented process ***AND*** evidence of implementation

Competency C - QI 16 (1 Credit) Reports Performance Publicly or with Patients

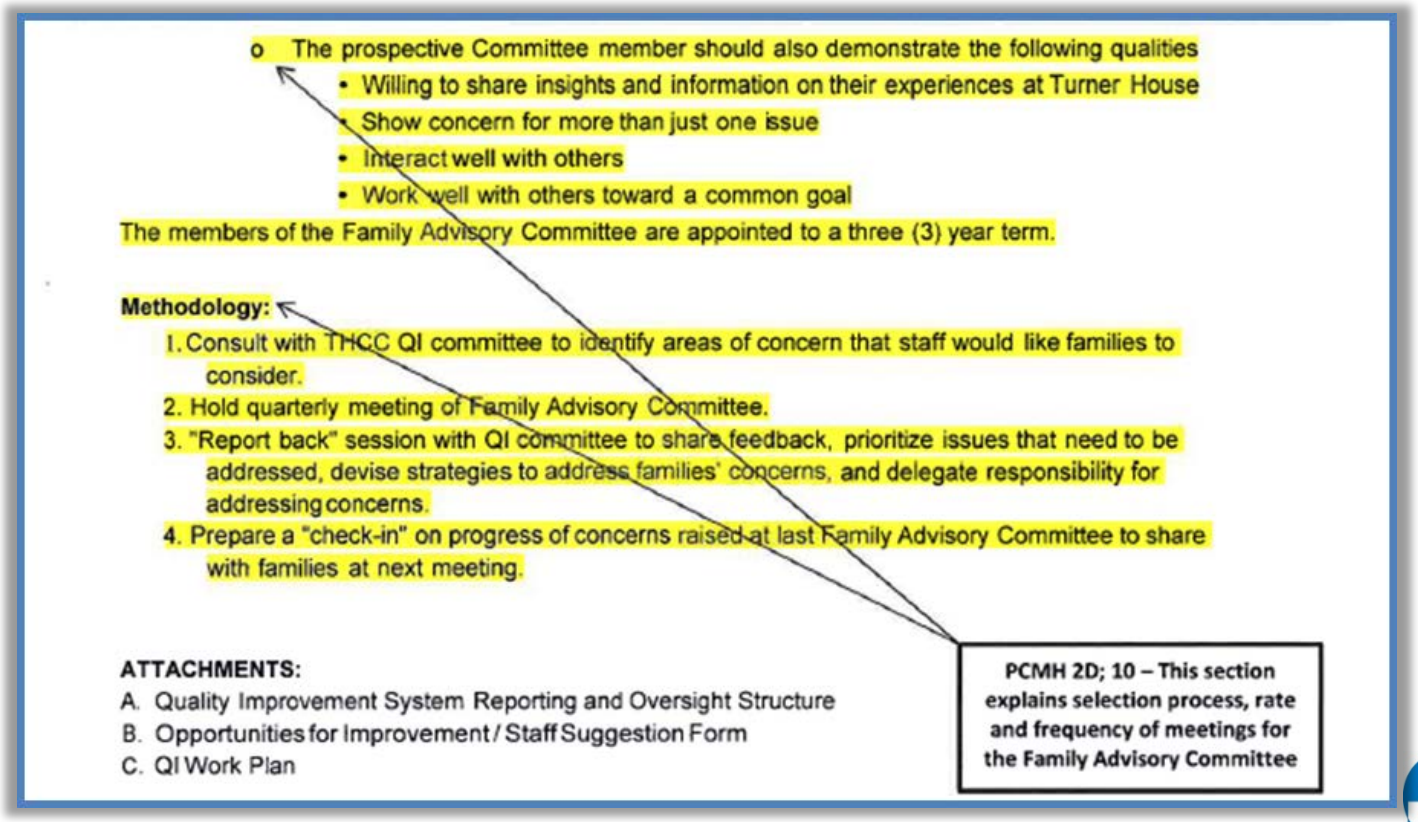
- Shares clinician-level or practice-level reports with patients and the public
- The practice may use data that it produces or data provided by affiliated organizations, such as a larger medical group, individual practice association or health plan
- Aligns with PCMH 2014 6F
- Evidence = Documented process ***AND*** evidence of implementation

Competency C - QI 17 (2 Credits) Involves Patient/Family/Caregiver in QI Activities

- Has a process for involving patients and families in quality improvement efforts or on the practice's patient advisory council (PFAC)
- Aligns with PCMH 2014 2D
- Evidence = Documented process ***AND*** evidence of implementation

QI 17 Example

Clarifies role, selection criteria, frequency of meetings



- The prospective Committee member should also demonstrate the following qualities
  - Willing to share insights and information on their experiences at Turner House
  - Show concern for more than just one issue
  - Interact well with others
  - Work well with others toward a common goal

The members of the Family Advisory Committee are appointed to a three (3) year term.

Methodology:

1. Consult with THCC QI committee to identify areas of concern that staff would like families to consider.
2. Hold quarterly meeting of Family Advisory Committee.
3. "Report back" session with QI committee to share feedback, prioritize issues that need to be addressed, devise strategies to address families' concerns, and delegate responsibility for addressing concerns.
4. Prepare a "check-in" on progress of concerns raised at last Family Advisory Committee to share with families at next meeting.

ATTACHMENTS:

A. Quality Improvement System Reporting and Oversight Structure
B. Opportunities for Improvement / Staff Suggestion Form
C. QI Work Plan

PCMH 2D; 10 – This section explains selection process, rate and frequency of meetings for the Family Advisory Committee

Source: Turner House Children's Clinic, 2015, used with permission.

Competency C - QI 18 (2 Credits) Reports Clinical Quality Measures to Medicare or Medicaid - ***New***

The practice demonstrates it reports a minimum number of clinical quality measures to Medicare or to a state Medicaid agency

- At least one immunization measure
- One preventive care measure (not including immunizations)
- One chronic or acute care clinical measure
- One behavioral health measure
- Evidence = Evidence of submission

Competency C – QI 19 (2 Credits Maximum) Engaged in Value-Based Agreements - ***New***

Upside Risk Contract

A value-based program where the clinician/practice receives an incentive for meeting performance expectations but do not share losses if costs exceed targets

Two-Sided Risk Contract

A value-based program where the clinician/practice incur penalties for not meeting performance expectations but receive incentives when the care requirements of the agreement are met. Expectations relate to quality and cost.

The practice demonstrates it participates in a value-based program (such as ACOs) by providing information about their participation or a copy of agreement.

QI 01 – Clinical Quality Measures

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QI 04 – Patient Experience Feedback

QI 11 – Goals and Actions to Improve Patient Experience

QI 15 – Reports Performance within the Practice

Questions?

Upcoming WACMHC Learning Events

Leading People through Transition: A 4D Approach to Transformation

November 5, 9 am – 4 pm | Yakima, WA

REGISTER

Learn how to design and implement lasting change in your health center! This in-person, interactive workshop will allow you to practice the skills that support effective change. Bring your transformation ideas and issues and leave with an action plan - begin with the end in mind. Leaders of change including QI and Medical Directors, Operations Officers, and Clinic Supervisors are encouraged to attend.

SOGI Data: Improving Your Process for HRSA Reporting and QI

November 6, 12:30 pm – 1:30 pm

REGISTER

Join us for this educational webinar about collecting, using and reporting SOGI data. Presenters will discuss how to build reports into workflows, how to assess your LGBTQ population vis-à-vis QI measures, and EHR capabilities for data collection. Health centers will discuss their experiences, goals and challenges in their organization's recent focus on collecting SOGI data in both medical and dental clinics.

Thank you for joining the series!

Please submit feedback in the evaluation after the end of the session.

Questions? Contact the WACMHC Practice Transformation Team at QualityImprove@wacmhc.org