**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 but before submission for evaluation. 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* |

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

|  |  |  |
| --- | --- | --- |
| *Example:* Clinical Measure | | |
| *Measure 1:* Colorectal cancer (CRC) screening  (CMS # (if applicable): 130 | **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:* 5/1/20 Baseline End Date: 5/30/20**  ***Baseline Performance Measurement (n/d\* and %):* 175/547 = 32.0%**  ***Numeric Goal (%):* 333/547 = 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*: 7/1/20**  ***Additional Actions:* Provider quality compensation metric put in place to incentivize providers to ensure appropriate health screening.** |
| **5. Remeasure performance *(QI 12)*** | ***Start Date:* 5/1/21 *End Date:* 5/30/21**  ***Performance Remeasurement (n/d\* and %):* 380/550 = 69.1%** |
| **6. Assess actions; describe improvement. *(QI 12)*** | **Since July 2020, 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.** |

\*n/d = numerator/denominator

|  |  |  |
| --- | --- | --- |
| *Example:* Identify a Disparity in Care for a Vulnerable Population | | |
| *Vulnerable population:* Uninsured women  *Disparity:*  Uninsured women receive fewer mammograms | **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 clinical care/patient experience at a lower performance:*** **Uninsured patients receive fewer mammograms than insured patients** |
| **2./3. Baseline performance measurement and numeric goal for improvement *(QI 05)*** | ***Baseline Start Date:* 07/2020 *Baseline End Date:* 12/2020**  ***Baseline Performance Measurement for Vulnerable Population (n/d\* and %):* 23/102 = 23% of uninsured women receive mammograms**  ***Baseline Performance Measurement for General Population (# and %):* 675/1026= 66% of insured women receive mammograms**  ***Numeric Goal (%):* 50% of uninsured women receive mammograms** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(QI 13)* *(Only 1 action required)*** | ***Action:* Identified community resources for free or low-cost mammograms and shared with uninsured patients**  ***Date Action Initiated:* 01/2021**  ***Additional Actions:*** |
| **5. Remeasure Performance (QI 14)** | ***Start Date*: 01/2021 *End Date:* 07/2021**  ***Performance Remeasurement (n/d\* and %):* 43/111 = 39%** |
| **6. Assess actions; describe improvement. (QI 14)** | **During a measurement period from July–Dec 2020, there was a 43-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 16-percentage point increase in the number of uninsured women receiving mammograms during the remeasurement period of Jan–July 2021.** |

\*n/d = numerator/denominator

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

|  |  |  |
| --- | --- | --- |
| Use ONE Access Measure Identified in QI 10 | | |
| *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 (n/d\* and %):***  ***Numeric Goal (%):*** |
| **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 (n/d\* and %):*** |
| **6. Assess actions; describe improvement.**  ***Note: Continuing QI is encouraged, but is not required for QI 10.*** |  |

\*n/d = numerator/denominator

|  |  |  |
| --- | --- | --- |
| Use FIVE Measures Identified in QI 08, QI 09 and QI 11 | | |
| *Measure 1:*  (CMS # (if applicable): | **1. Measure selected for improvement; reason for selection** | ***Reason:*** |
| **2./3. Baseline performance measurement; numeric goal for improvement  *(From QI 01, QI 02 or QI 04)*** | ***Baseline Start Date:*       *Baseline End Date:***  ***Baseline Performance Measurement (n/d\* and %):***  ***Numeric Goal (%):*** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(QI 08, QI 09, or QI 11)* *(Only 1 action required)*** | ***Action*:**  ***Date Action Initiated*:**  ***Additional Actions:*** |
| **5. Remeasure performance *(QI 12)*** | ***Start Date:*       *End Date:***  ***Performance Re-Measurement (n/d\* and %):*** |
| **6. Assess actions; describe improvement. (QI 12)** |  |

\*n/d = numerator/denominator

|  |  |  |
| --- | --- | --- |
| *Measure 2:*  (CMS # (if applicable): | 1. Measure selected for improvement; reason for selection | *Reason:* |
| **2./3. Baseline performance measurement; numeric goal for improvement  *(From QI 01, QI 02 or QI 04)*** | ***Baseline Start Date:***       ***Baseline End Date:***        ***Baseline Performance Measurement (n/d\* and %):***  ***Numeric Goal (%):*** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(QI 08, QI 09 or QI 11)* *(Only 1 action required)*** | ***Action:***  ***Date Action Initiated:***  ***Additional Actions:*** |
| **5. Remeasure performance *(QI 12)*** | ***Start Date:***       ***End Date:***        ***Performance Remeasurement (n/d\* and %):*** |
| **6. Assess actions; describe improvement. (QI 12)** |  |

\*n/d = numerator/denominator

|  |  |  |
| --- | --- | --- |
| *Measure 3:*  (CMS # (if applicable): | 1. Measure selected for improvement; reason for selection | *Reason:* |
| **2./3. Baseline performance measurement; numeric goal for improvement  *(From QI 01, QI 02 or QI 04)*** | ***Baseline Start Date:***       ***Baseline End Date:***        ***Baseline Performance Measurement (n/d\* and %):***  ***Numeric Goal (%):*** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(QI 08, QI 09 or QI 11)* *(Only 1 action required)*** | ***Action:***  ***Date Action Initiated:***  ***Additional Actions:*** |
| **5. Remeasure performance *(QI 12)*** | ***Start Date:***       ***End Date:***        ***Performance Remeasurement (n/d\* and %):*** |
| **6. Assess actions; describe improvement. (QI 12)** |  |

\*n/d = numerator/denominator

|  |  |  |
| --- | --- | --- |
| *Measure 4:*  (CMS # (if applicable): | 1. Measure selected for improvement; reason for selection | *Reason:* |
| **2./3. Baseline performance measurement; numeric goal for improvement  *(From QI 01, QI 02 or QI 04)*** | ***Baseline Start Date:***       ***Baseline End Date:***        ***Baseline Performance Measurement (n/d\* and %):***  ***Numeric Goal (%):*** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(QI 08, QI 09 or QI 11)* *(Only 1 action required)*** | ***Action:***  ***Date Action Initiated:***  ***Additional Actions:*** |
| **5. Remeasure performance *(QI 12)*** | ***Start Date:***       ***End Date:***        ***Performance Remeasurement (n/d\* and %):*** |
| **6. Assess actions; describe improvement. (QI 12)** |  |

\*n/d = numerator/denominator

|  |  |  |
| --- | --- | --- |
| *Measure 5:*  (CMS # (if applicable): | 1. Measure selected for improvement; reason for selection | *Reason:* |
| **2./3. Baseline performance measurement; numeric goal for improvement  *(From QI 01, QI 02 or QI 04)*** | ***Baseline Start Date:***       ***Baseline End Date:***        ***Baseline Performance Measurement (n/d\* and %):***  ***Numeric Goal (%):*** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(QI 08, QI 09 or QI 11)* *(Only 1 action required)*** | ***Action:***  ***Date Action Initiated:***  ***Additional Actions:*** |
| **5. Remeasure performance *(QI 12)*** | ***Start Date:***       ***End Date:***        ***Performance Remeasurement (n/d\* and %):*** |
| **6. Assess actions; describe improvement. (QI 12)** |  |

\*n/d = numerator/denominator

|  |  |  |
| --- | --- | --- |
| Use ONE Measure Identifying a Disparity in Patient Experience | | |
| *Vulnerable population:*  *Disparity:* | **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 patient experience at a lower performance:*** |
| **2./3. Baseline performance measurement, numeric goal for improvement. (*QI 05)*** | ***Baseline Start Date:*       *Baseline End Date:***  ***Baseline Performance Measurement for Vulnerable Population (n/d\* and %):***  ***Baseline Performance Measurement for General Population (n/d\* and %):***  ***Numeric Goal (%):*** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(QI 13)* *(Only 1 action required)*** | ***Action:***  ***Date Action Initiated:***  ***Additional Actions:*** |
| **5. Remeasure performance. (QI 14)** | ***Start Date:*       *End Date:***  ***Performance Re-Measurement (n/d\* and %):*** |
| **6. Assess actions and describe improvement. (QI 14)** |  |

\*n/d = numerator/denominator

|  |  |  |
| --- | --- | --- |
| Use ONE Measure Identifying a Disparity in Clinical Quality | | |
| *Vulnerable population:*  *Disparity:* | **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 clinical care at a lower performance:*** |
| **2./3. Baseline performance measurement, numeric goal for improvement. (*QI 05)*** | ***Baseline Start Date:*       *Baseline End Date:***  ***Baseline Performance Measurement for Vulnerable Population (n/d\* and %):***  ***Baseline Performance Measurement for General Population (n/d\* and %):***  ***Numeric Goal (%):*** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(QI 13)* *(Only 1 action required)*** | ***Action:***  ***Date Action Initiated:***  ***Additional Actions:*** |
| **5. Remeasure performance. (QI 14)** | ***Start Date:*       *End Date:***  ***Performance Re-Measurement (n/d\* and %):*** |
| **6. Assess actions and describe improvement. (QI 14)** |  |

\*n/d = numerator/denominator

|  |  |  |
| --- | --- | --- |
| Use TWO Behavioral Health Measures Identified in BH 17 | | |
| *BH Measure 1:*  (CMS # (if applicable): | **1. Measure selected for improvement; reason for selection** | ***Reason:*** |
| **2./3. Baseline performance measurement; numeric goal for improvement  *(From BH 17)*** | ***Baseline Start Date:*       *Baseline End Date:***  ***Baseline Performance Measurement (n/d\* and %):***  ***Numeric Goal (%):*** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(BH 18)* *(Only 1 action required)*** | ***Action*:**  ***Date Action Initiated*:**  ***Additional Actions:*** |
| **5. Remeasure performance**  ***Note: Continuing QI is encouraged, but is not required for BH 18.*** | ***Start Date:*       *End Date*:**  ***Performance Remeasurement (n/d\* and %):*** |
| **6. Assess actions; describe improvement.**  ***Note: Continuing QI is encouraged, but is not required for BH 18.*** |  |

\*n/d = numerator/denominator

|  |  |  |
| --- | --- | --- |
| *BH Measure 2:*  (CMS # (if applicable): | 1. Measure selected for improvement; reason for selection | *Reason:* |
| **2./3. Baseline performance measurement; numeric goal for improvement  *(From BH 17)*** | ***Baseline Start Date:*       *Baseline End Date:***  ***Baseline Performance Measurement (n/d\* and %):***  ***Numeric Goal (%):*** |
| **4. Actions taken to improve and work toward goal; dates of initiation *(BH 18)* *(Only 1 action required)*** | ***Action*:**  ***Date Action Initiated*:**  ***Additional Actions:*** |
| **5. Remeasure performance**  ***Note: Continuing QI is encouraged, but is not required for BH 18.*** | ***Start Date:*       *End Date*:**  ***Performance Remeasurement (n/d\* and %):*** |
| **6. Assess actions; describe improvement.**  ***Note: Continuing QI is encouraged, but is not required for BH 18.*** |  |

\*n/d = numerator/denominator