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.

Competency A: Measuring Performance. The practice measures to understand current performance and to identify opportunities for improvement.

QI 01 (Core) Clinical Quality Measures: Monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type):

A. Immunization measures.
B. Other preventive care measures.
C. Chronic or acute care clinical measures.
D. Behavioral health measures.

GUIDANCE	EVIDENCE
Measuring and reporting clinical quality measures helps practices deliver safe, effective, patient-centered and timely care. The practice shows that it monitors at least five clinical quality measures, including at least: • One immunization measure. • One preventive care measure (not including immunizations). – A measure on oral health counts as a preventive clinical quality measure. • One chronic or acute care clinical measure. • One behavioral health measure. The data must include the measurement period, the number of patients represented by the data, the rate and the measure source (e.g. HEDIS, NQF #, measure guidance).	• **Report**

QI 02 (Core) Resource Stewardship Measures: Monitors at least two measures of resource stewardship (must monitor at least one measure of each type):

A. Measures related to care coordination.
B. Measures affecting health care costs.

GUIDANCE	EVIDENCE
The practice reports at least two measures related to resource stewardship, including a measure related to health care cost and a measure related to care coordination. When pursuing high-quality, cost-effective outcomes, the practice has a responsibility to consider how it uses resources.	• **Report** ***AND*** • **Indicate Measure Category**

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QI 03 (Core) Appointment Availability Assessment: Assesses performance on availability of major appointment types to meet patient needs and preferences for access.	
GUIDANCE	**EVIDENCE**
Patients who cannot get a timely appointment with their primary care provider may seek out-of-network care, facing potentially higher costs and treatment from a provider who does not know their medical history. The practice consistently reviews the availability of major appointment types (e.g., urgent care, new patient, routine exams, follow-up) to ensure that it meets the needs and preferences of its patients, and adjusts appointment availability, if necessary (e.g., seasonal changes, shifts in patient needs, practice resources). A common approach to measuring appointment availability against standards is to determine the third next available appointment for each appointment type.	• **Documented process** ***AND*** • **Report**  ***Documented process only***

QI 04 (Core) Patient Experience Feedback: Monitors patient experience through: **A. Quantitative data. Conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as:** • **Access.** • **Communication.** • **Coordination.** • **Whole-person care, self-management support and comprehensiveness.** **B. Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means.**	
GUIDANCE	**EVIDENCE**
The practice gathers feedback from patients and provides summarized results to inform quality improvement activities. Patient feedback must represent the practice population (including all relevant subpopulations) and may not be limited to patients of one clinician (of several), or to data from one payer (of several). **A.** The practice (directly or through a survey vendor) conducts a patient survey to assess the patient/family/caregiver experience with the practice. The patient survey may be conducted as a written questionnaire (paper or electronic) or by telephone, and includes questions related to at least three of the following categories: • **Access to clinical care** (may include routine, urgent and after-hours; ease of getting to the practice, scheduling an appointment or waiting room amenities would not be considered access questions). • **Communication with the practice, clinicians and staff** (may include "feeling respected and listened to" and "able to get answers to questions").	• **Report**

QI 04 (Core) Patient Experience Feedback: *continued*	
GUIDANCE	**EVIDENCE**
• **Coordination of care** (may include being informed and up to date on referrals to specialists, changes in medications and lab or imaging results). • **Whole-person care/self-management support** (may include provision of comprehensive care and self-management support; emphasizing the spectrum of care needs, such as mental health, routine and urgent care, advice, assistance and support for changing health habits and making health care decisions). **B.** Qualitative methods (e.g., focus groups, individual interviews, patient walkthrough, suggestion box) are another opportunity to obtain feedback from patients. The practice may use a feedback methodology conducive to its patient population, such as "virtual" (e.g., telephone, videoconference) participation. The requirement is not met by: • Comments that were collected on surveys to satisfy QI 04, component A, and/or • Feedback collected by a Patient and Family Advisory Committees (PFAC) that represent more than one practice and/or do not depict the entire patient population.	• **Report**

QI 05 (1 Credit) Health Disparities Assessment: Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section): **A. Clinical quality.** **B. Patient experience.**	
GUIDANCE	**EVIDENCE**
The practice stratifies performance data by race and ethnicity or by other indicators of vulnerable groups that reflect the practice's population demographics (e.g., age, gender, language needs, education, income, type of insurance [Medicare, Medicaid, commercial], disability, health status). The intent of this criterion is for the practice to work toward eliminating disparities in health and delivery of health care for its vulnerable patient populations. **Vulnerable populations** are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability" (AHRQ).	• **Report** ***OR*** • **Quality Improvement Worksheet**

QI 06 (1 Credit) Validated Patient Experience Survey Use: The practice uses a standardized, validated patient experience survey tool with benchmarking data available.	
GUIDANCE	**EVIDENCE**
The practice uses the standardized survey tool to collect patient experience data and inform its quality improvement activities. The intent is for the practice to administer a survey that can be benchmarked externally and compared across practices. The practice may use standardized tools such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) PCMH survey, CAHPS-CG or another standardized survey administered through measurement initiatives providing benchmark analysis external to the practice organization. It may not be a proprietary instrument. The practice must administer the entire approved standardized survey (not sections of the survey) to receive credit.	• **Report**
QI 07 (2 Credits) Vulnerable Patient Feedback: Obtains feedback from vulnerable patient groups on the experiences of disparities in care or services.	
GUIDANCE	**EVIDENCE**
The practice identifies a vulnerable population where data (clinical, resource stewardship, quantitative patience experience, access) show evidence of disparities of care or services. The practice obtains qualitative patient feedback from population representatives to acquire better understanding of disparities and to support quality improvement initiatives to close gaps in care.	• **Report**

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Competency B: Setting Goals and Acting to Improve. The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.

QI 08 (Core) Goals and Actions to Improve Clinical Quality Measures: Sets goals and acts to improve upon at least three measures across at least three of the four categories: **A. Immunization measures.** **B. Other preventive care measures.** **C. Chronic or acute care clinical measures.** **D. Behavioral health measures.**	
GUIDANCE	**EVIDENCE**
Review and evaluation offer an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers. The practice has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Measures selected for improvement are chosen from the set of measures identified in QI 01. The goal is for the practice to reach a desired level of achievement based on a self-identified standard of care. The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement. The Institute for Healthcare Improvement is a resource for the PDSA cycle (http://www.ihi.org/IHI/Topics/Improvement/Improvement Methods/HowToImprove/).	• **Report** ***OR*** • **Quality Improvement Worksheet**

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QI 09 (Core) Goals and Actions to Improve Resource Stewardship Measures: Sets goals and acts to improve performance on at least one measure of resource stewardship: A. Measures related to care coordination. B. Measures affecting health care costs.	
GUIDANCE	**EVIDENCE**
The practice has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Review and evaluation offer an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers. Measures selected for improvement may be chosen from the same set of measures identified in QI 02. The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care. The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement. The Institute for Healthcare Improvement is a resource for the PDSA cycle (http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/).	• **Report** ***OR*** • **Quality Improvement Worksheet**
QI 10 (Core) Goals and Actions to Improve Appointment Availability: Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences.	
GUIDANCE	**EVIDENCE**
Knowing that a variety of factors (e.g., season, patient need, practice resource) can affect appointment availability, the practice can adjust to meet patient preferences and needs. After assessing performance on the availability of common appointment types in QI 03, the practice sets goals and acts to improve on availability. The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care. 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.	• **Report** ***OR*** • **Quality Improvement Worksheet**

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QI Competency B: Setting Goals and Acting to Improve.

QI 11 (Core) Goals and Actions to Improve Patient Experience: Sets goals and acts to improve performance on at least one patient experience measure.	
GUIDANCE	**EVIDENCE**
After assessing performance on at least one patient experience measure (QI 04), the practice demonstrates that it set a goal for improving patients' experience of care and is working to meet the stated goal. The practice acts to reach a desired level of achievement based on its self-identified standard of care.	• **Report** ***OR*** • **Quality Improvement Worksheet**
QI 12 (2 Credits) Improved Performance: Achieves improved performance on at least two performance measures.	
GUIDANCE	**EVIDENCE**
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**
QI 13 (1 Credit) Goals and Actions to Improve Disparities in Care/Service: Sets goals and acts to improve performance on at least one measure of disparities in care or services.	
GUIDANCE	**EVIDENCE**
After assessing performance in care or services among vulnerable populations (QI 05), the practice identifies disparities, sets goals and acts to improve performance.	• **Report** ***OR*** • **Quality Improvement Worksheet**
QI 14 (2 Credits) Improved Performance for Disparities in Care/Service: Achieves improved performance on at least one measure of disparities in care or service.	
GUIDANCE	**EVIDENCE**
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**

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QI Competency C: Reporting Performance.

Competency C: Reporting Performance. The practice is accountable for performance and shares data within the practice, with patients and/or publicly for the measures and patient populations identified in the previous section.

QI 15 (Core) Reporting Performance within the Practice: Shares clinician-level or practice-level performance results with clinicians and staff for measures it reports.	
GUIDANCE	**EVIDENCE**
The practice provides individual clinician or practice-level reports to clinicians and practice staff that include a minimum of: • One clinical quality measure • One resource stewardship measure • One patient experience measure Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. The practice may use data that it produces, or data provided by affiliated organizations (e.g., larger medical group, individual practice association or health plans).	• **Documented process** ***AND*** • **Evidence of implementation**
QI 16 (1 Credit) Reporting Performance Publicly or with Patients: Shares clinician-level or practice-level performance results publicly or with patients for measures it reports.	
GUIDANCE	**EVIDENCE**
The practice shares individual clinician or practice-level reports with patients and the public that include a minimum of: • One clinical quality measure • One resource stewardship measure • One patient experience measure Reports reflect the care provided by the care team. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. The practice may use data that it produces, or data provided by affiliated organizations (e.g., larger medical group, individual practice association or health plans).	• **Documented process** ***AND*** • **Evidence of implementation**

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QI 17 (2 Credits) Patient/Family/Caregiver Involvement in Quality Improvement: Involves the patient/family/caregiver in quality improvement activities.	
GUIDANCE	**EVIDENCE**
The practice has a process for involving patients and their families in its quality improvement efforts or on the practice's patient advisory council (PFAC). At a minimum, the process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team/PFAC meetings. The ongoing inclusion of patients/families/caregivers in quality improvement activities provides the voice of the patient to patient-centered care.	• **Documented process** ***AND*** • **Evidence of implementation**
QI 18 (2 Credits) Electronic Submission of Measures: Electronically reports clinical quality measures to an external entity such as Medicare, a Medicaid agency or a health plan.	
GUIDANCE	**EVIDENCE**
The practice electronically produces and transmits clinical quality measures related to practice specialties to an external entity such as Medicare, a state Medicaid agency or a health plan. that include a minimum of: • One immunization measure. • One preventive care measure (not including immunizations). • One chronic or acute care clinical measure. • One behavioral health measure. Data submitted are not based on claims and include the entire relevant patient population, not a sample	• **Evidence of submission**

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QI 19 (*Maximum* 2 Credits) Value-Based Payment Arrangements: Engaged in a value-based payment arrangement. **A. Practice engages in upside risk (1 Credit).** **B. Practice engages in two-sided risk (2 Credits).**	
GUIDANCE	**EVIDENCE**
The practice demonstrates it participates in a value-based arrangement by providing information about its participation or a copy of an executed agreement. Value-based arrangements represent a shift from fee-for-service billing to compensating practices and providers for administering quality care to patients. Participation in these programs signals that a practice is willing to be accountable for the value of care it provides, rather than volume of care. **Upside Risk:** The clinician/practice receives an incentive for meeting performance expectations but does not share losses if costs exceed targets. **Two-Sided Risk:** The clinician/practice receives incentives for meeting performance expectations regarding quality and cost but incurs penalties if it does not.	• **Agreement** ***OR*** • **Evidence of implementation** 

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