PCMH6: Measure and Improve Performance

The most effective patient-centered medical homes are those that commit to continuous quality improvement. A well-functioning PCMH practice uses performance data to identify opportunities for improvement and consistently works toward improvements in clinical quality, efficiency and patient experience.

In Standard 6A, 6B and 6C, NCQA requires practices to demonstrate how data is used to monitor practice performance and how practice uses the data to improve patient outcomes. Data may be internal or external sources. If an external source (such as a health plan) provides the data, it must represent at least 75 percent of your patient population. 6A, 6B and 6C are time consuming elements so many practices focus on these measures early in the transformation process.

**Element A: Measure Performance**

<table>
<thead>
<tr>
<th>What will the practice measure and how will the practice obtain necessary data?</th>
<th>To obtain the minimum 50% score required for must-pass elements, practice must be able to measure or receive data on at least 2 of the following factors:</th>
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<tr>
<td>Factor 1: At least three preventive care measures</td>
<td>For example: mammograms, colonoscopies, vaccines, bone density exams, smoking, depression screenings, alcohol use, etc.</td>
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<tr>
<td>Factor 2: At least three chronic or acute care clinical measures</td>
<td>For example: Hemoglobin A1C, LDL, blood pressure, diabetic foot and eye exams, etc.</td>
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<td>Factor 3: At least two utilization measures affecting health care costs</td>
<td>For example: ER visits, hospital admissions, use of brand-name drugs when generics are available, etc.</td>
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<tr>
<td>Factor 4: Performance data stratified for vulnerable populations (to assess disparities in care)</td>
<td>For example: diabetic smokers, elderly, language barriers, low-income, disability, co-morbid conditions, frailty, etc.</td>
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</tbody>
</table>

**Documentation:**

Practice must be able to provide reports showing your performance on the measures selected above. Sample documentation attached.

**Element B: Measure Patient/Family Experience**

Obtain feedback from patients/families on their experiences with practice and their care by conducting at least one of the following factors:

Factor 1: Survey (any instrument) to evaluate patient/family experience on at least three of the following categories:
- Access: routine, urgent and after-hours
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- Communication: with your practice, clinicians and staff (may include feeling respected, listened to and able to get answers to questions)
- 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 the provision of comprehensive care and self-management support and emphasizing the spectrum of care needs such as mental health; routine and urgent care; advice, assistance and support for making changes in health habits and making health care decisions.

Note: Practice can mail surveys or give them to patients at the time of their visit. Also, practice is not required to survey every patient in your practice. For example – choose a subset of patients to survey, or survey patients on a particular day, week or month when they come to the office.

Factor 2: CAHPS Patient-Centered Medical Home (PCMH) survey tool

Factor 3: A request for feedback on the experiences of vulnerable patients
You may ask patients to self-identify on the survey in order to identify vulnerable sub-groups.

Factor 4: A request for feedback through qualitative means
For example: patient walk-throughs, focus groups, individual interviews, suggestion boxes, etc.

Documentation:

Provide a sample survey and a report showing summarized results of patient feedback. (A blank survey tool does by itself does not meet the requirement of this element – provide the results too).

Element C: Implement Continuous Quality Improvement—MUST PASS
Implement a quality improvement process on at least two of the following factors:

| Factor 1: Set goals and act to improve performance on at least three measures from Element A |
| Factor 2: Set goals and act to improve performance on at least one measure from Element B |
| Factor 3: Set goals and address at least one identified disparity in care or service for vulnerable populations |
| Factor 4: Involve patients/families in quality improvement teams or the practice’s advisory council |
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Documentation:

NCQA has created a PCMH Quality Measurement and Improvement Worksheet (located in NCQA survey tool) that can be used to document Element C, Factors 1-3.

Document factor 4 by describing practice process and providing examples of how requirement was met (e.g., meeting notes, agenda).

Recommended Links/Resources:


- Webinars on all standards
- Tools/practice examples for all measures/NCQA standards
- Practical tools/resources for practice transformation
- Specific tools to consider: (https://www.communitycarenc.org/media/files/web-based pcmh-2011-workbook-1-xl.xls)
  - 6C1 – Diabetes Management – DM Stoplight Tool
  - 6C1-Tracking Log for Depression

http://www.safetynetmedicalhome.org/

- Safety Net Medical Home Initiative