NATIONAL ASSOCIATION OF
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QM

The Quality Management Plan

A Practical, Patient-Centered Template

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Primary Authors
Dale S. Benson, MD, FACPE
Peyton G. Townes, Jr., MHSA

Special Contributor
Daniel Dobbs

About the Authors

DALE S. BENSON, MD, CPE, FACPE

Dale S. Benson, MD, CPE, FACPE is a family physician and physician executive. He most recently served as Vice President of Innovation, Quality, and Practice Management, as well as Director of the Leadership Development Institute, at AltaMed Health Services in Los Angeles (CA). Prior to that, Dr. Benson was Vice President of Physician Practice Management and Vice President of Ambulatory Care for the Mercy Health System in Chicago. He founded HealthNet Community Health Centers in Indianapolis (IN) in 1969, and for 30 years he served as that network's Executive Director.

Dr. Benson has authored or co-authored many published works, including the Joint Commission book *Quality Assurance in Ambulatory Care*; the Jossey-Bass book *Excellence in Ambulatory Care*; the American Hospital Publishing Company book *Measuring Outcomes in Ambulatory Care*; and numerous articles and monographs. He has lectured extensively on leadership, quality, and efficiency in the ambulatory setting and has taught more than 80 seminars on managing quality.

PEYTON G. TOWNES, JR., MHSA

Peyton G. Townes, Jr., MHSA is a health care manager, programs and resources developer, and consultant / trainer. He is currently President of Ambulatory Innovations, Inc. (Indianapolis, IN), a provider of multiple resources for ambulatory care organizations. For 13 years, Mr. Townes was Assistant Director and Director of Program and Community Development at HealthNet Community Health Centers in Indianapolis. He has served as both Board President and Director of Business Development for the Indiana Primary Health Care Association (IPHCA) and was Assistant Registrar and Marketing Representative for a major group practice in the Washington (DC) area.

Mr. Townes has authored or co-authored several books, including *Quality Assurance in Ambulatory Care* (the Joint Commission), *Excellence in Ambulatory Care* (Jossey-Bass Publishers), and others. In addition, he has developed a number of articles and online newsletters on health care and other topics. On behalf of NACHC, he has authored nationally-distributed monographs; co-developed quality-based webinars and training seminars; and created instructional videos and DVDs. Mr. Townes has also been a featured speaker at conferences and seminars.

DAN DOBBS

Dan Dobbs is President of Overdrive Health Informatics, Inc., a provider of Health Information Technology (HIT) services to ambulatory care organizations. He has more than 25 years of business and administrative experience in the areas of information technology, engineering, and marketing. For 18 years, he had increasing managerial responsibilities at a division of General Motors Corporation in Anderson (IN).

He is a frequent subject matter expert and speaker on performance management and interactive dashboard technology for organizations such as NACHC and the Harvard School of Public Health. He also serves on the Board of Directors of the Indiana Health Information Management Systems Society (IHIMSS).

AMBULATORY INNOVATIONS, INC.

Ambulatory Innovations (AI) is a 16-year-old resources company that provides expert systems (hard copy and online), consultation / training, and outsourced services to the ambulatory care field, including Community Health Centers and related organizations. AI's principals and national network of from-the-field Associates (clinical and managerial) are recognized experts in a wide range of important functional areas related to ambulatory care. Based in Indianapolis (IN), the company has special expertise in Quality Management and related functions, as well as in Telephone Triage.

OVERDRIVE HEALTH INFORMATICS, INC.

Overdrive Health Informatics provides cutting-edge Health Information Technology (HIT) and related performance improvement services that help ambulatory care organizations achieve optimal sustainable performance through actionable Business Intelligence (BI). The company offers a spectrum of high-level tools—primarily real-time, interactive, customizable dashboards—and related improvement expertise to enable Community Health Centers and others to achieve consistently excellent patient care and business operations. The company's mission is to help organizations "overdrive" their total performance.

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  Bethesda MD

About NACHC

The National Association of Community Health Centers (NACHC) is the only national health care organization dedicated exclusively to expanding health care access for the medically underserved through the community health center model. In this role, NACHC represents and supports the collective mission and interests of the nationwide network of more than 1,200 community, migrant, homeless, and public housing health center organizations, which serve 20 million patients via 7,500 sites in all 50 states, Puerto Rico, the District of Columbia, the U.S. Virgin Islands, and Guam.

NACHC's mission is "To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent,and community directed for all medically underserved populations."

In fulfilling its mission, NACHC

- Serves as the major source for information, data, research, and advocacy on key issues affecting community health centers and the delivery of health care for the medically underserved and uninsured in America;
- Provides education, training. technical assistance, and leadership development to health center staff, boards, and others to promote excellence and cost-effectiveness in health delivery practice and community governance; and
- Builds partnerships and linkages that stimulate public and private sector investment in the delivery of quality health care services to medically underserved communities.

NACHC works closely through a shared mission with all 50 states, State/Regional Primary Care Associations, and key strategic partners, including Community HealthVentures and Capital Link.

For more information about NACHC and this Monograph, please contact:
Kathy McNamara
kmcnamara@nachc.com

The Quality Management Plan: A Practical, Patient-Centered Template

Purpose

Two critical and rapidly converging issues lead many health center leaders today to feel very much as though they are, in the words of the old Chinese curse, "living in interesting times." These issues are 1) an expanding number of new initiatives as Community, Migrant, Homeless and Public Housing Health Centers (health centers) play an increasingly important role in the nation's health system, and 2) related calls for ever-greater accountability.

New initiatives bring substantial new challenges. One challenge is simply the smooth integration of additional clinical programs into the already impressive array of health center primary care services. Another is providing services through increasingly sophisticated models of care, such as the Patient Centered Medical Home. Yet another is doing all this within the context of new technologies and expanded reporting mandates.

With this simultaneous onslaught of new initiatives, developing care models, increasing accountability, and advancing technology, health centers often feel overwhelmed. But what if there were an organizing principle that deployed a relatively simple instrument to help health centers effectively redesign their practices (including existing services and new program initiatives), enabling the pieces to fall cleanly into place no matter what the program might be?

It turns out that there is such an organizing principle—for such is the role of "quality." And there is a directly related instrument familiar to all health centers, the Quality Management (QM) Plan, which helps health centers seamlessly integrate new programs, models, and technologies with the primary care services they have long provided. A clear QM Plan that underlies a comprehensive Quality Management program can be a real boon, both in managing new mandates and in ensuring that health centers are truly effective agents in improving individual and community health.

The aim of this monograph is to provide a basic blueprint for the QM Plan of a typical mid-sized health center, which can then easily be modified as needed to accommodate both small and larger, more complex organizations. This monograph models a comprehensive approach to Quality Management that can accommodate a wide range of initiatives, including new programs relating to specialty care and/or broader community-oriented services.

Drivers

The simultaneous twin dynamics of new initiatives and increasing accountability are driven by numerous forces at the national level, including developing HIV/AIDS strategies, new behavioral health initiatives, the emergence of Patient Centered Medical Homes, and national Health Information Technology (HIT) Meaningful Use criteria.

Recent events ensure that these dynamics will continue well into the future. Federal programs bringing significant new opportunities for health centers—notably the American Recovery and Reinvestment Act (PL111-5, commonly known as the "Stimulus Package") and the Patient Protection and Affordable Care Act (PL111-148, generally called "Health Care Reform")—will continue to carry with them increasing visibility, accountability, and scrutiny for health centers of all types and sizes.

Overview

The QM Plan described here provides essentially a "plug and play" model that will work with virtually all health center programs. It fosters a conceptual practice redesign that, while not unduly hard to implement, will help integrate and ensure accountability for new initiatives with a minimum of organizational disturbance.

For each program—primary care to specialty services—health centers can use the same structure, the same approach to quality, and the same "quality categories" template for organizing metric monitoring and quality improvement activity. All of the pieces come together to make up the overall corporate Quality Management program.

This monograph addresses, as examples, both primary care and two clinical initiatives which—while certainly not unfamiliar to health centers—might initially appear to be outside the purview of a normal primary care focus. Both address specific populations, consistent with the national **Triple Aim** initiative (described below.)

The first initiative, HIV-related services, represents a growing opportunity for health centers; while a number of health centers have excellent HIV programs, many others have yet to integrate HIV services into their clinical set. The second, Behavioral Health, presents the challenge of integrating multiple professional disciplines within the optimal setting for broader community-based care.

Our template will address elements of both clinical programs—most critically at the metric level—as examples of how a common quality-based framework can help a health center quickly integrate seemingly disparate programs.

The QM Plan's organizing concept, identified here as broad "quality categories" encompassing specific metrics, is based in the tenets of the Patient Centered Medical Home (PCMH) model. The quality categories described below align well with fundamental PCMH characteristics described by **The Joint Commission**, the **Bureau of Primary Health Care (BPHC)**, the **Agency for Healthcare Research and Quality (AHRQ)**, and the **Joint Principles of the Medical Home** developed by the four primary care medical societies (the American College of Physicians, the American Academy of Family Practice, the American Academy of Pediatrics, and the American Osteopathic Association).

The template described in this monograph is also consistent with the national Triple Aim quality model, first espoused by Dr. Donald Berwick and his colleagues:

- Improving the experience of care
- Improving the health of populations
- Reducing per capita costs of health care

These three aims—often shown as Engagement, Population Health, and Value—clearly integrate the Patient Centered Medical Home concept. While Triple Aim is essentially a macro model (addressing the overall health care system), the QM Plan methodology in this monograph will enable a health center to contribute fully from its micro level to those overarching national goals.

The Quality Management Plan proposed below is straightforward. It actively involves the Governing Board, health center leadership, individual program managers, and ultimately all front-line

staff. It clearly defines roles, responsibilities, and organizational accountabilities. And it provides a comprehensive yet manageable approach to metric monitoring, through improvement methodologies that have stood the test of time.

Throughout this monograph, you will see special notes that explain, clarify, or expand upon a primary point in the text. For ready identification, these essentially parenthetical asides are shown in italics and are preceded by a special "Notes" icon that looks like this: 

THE QUALITY MANAGEMENT PLAN

This monograph describes how an effective Quality Management (QM) Plan underlies a health center's overall Quality Management program. It includes five interrelated sections:

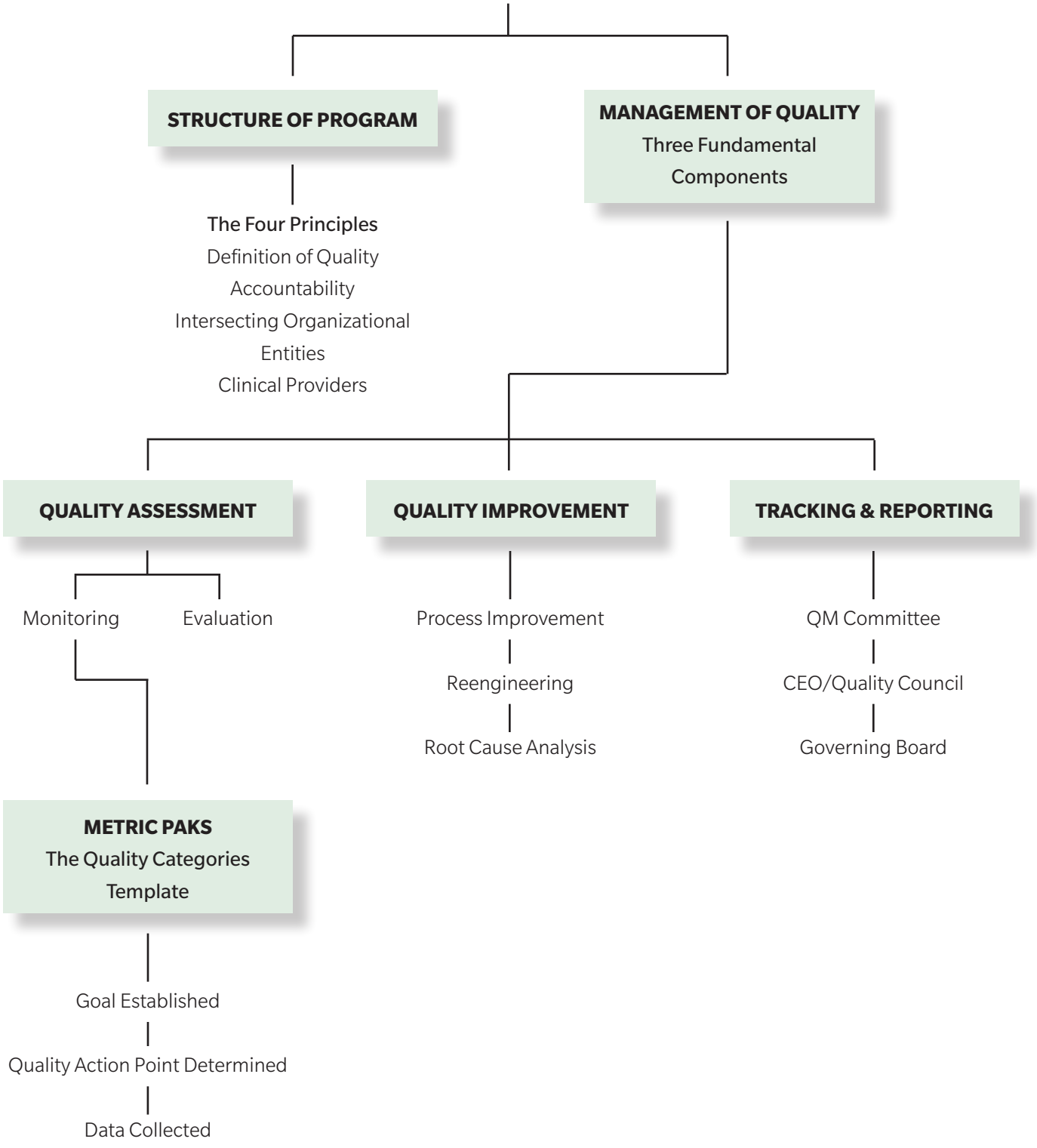
- The *Purpose and Scope* of the QM program
- The organizational *Structure* of the QM program
- Three fundamental components for *managing quality*
- A framework of "*quality categories*" reflecting the basic tenets of the Patient Centered Medical Home. (This framework, also referred to as a template, contributes both to organizing key performance metrics within each health center program and to integrating these into the overall Quality Management effort.)
- APPENDIX: Examples of health center QM Committees; the Nolan Accelerated Improvement Method; the "Five Whys" methodology; internal roles in Quality Management; and a sample electronic quality reporting mechanism.

This monograph also includes four program-specific "Metric Paks," using the quality categories template described in Section IV (below), for Primary Care, HIV, Behavioral Health, and Meaningful Use, as examples of how the categories provide a consistent framework for metrics addressing specific programs.

The term "metric" is used throughout this monograph. In the field, the term "measure" is also used, often to mean virtually the same thing. While a number of organizations have developed highly specific and technical definitions for these terms, the definitions are as yet not entirely consistent across organizations. For our purposes, a metric is simply an important program indicator the organization has chosen to measure.

The diagram that follows is essentially a schematic of this monograph, showing how all of its "moving parts" work together:

The Health Center Quality Management Plan



I. Purpose and Scope of the Quality Management Program

The *purpose* of the health center's Quality Management program is to **assure ongoing excellence in the quality and safety of the care and services the CHC delivers**. Board and staff are committed to improving the health of patients and their community. The health center accomplishes this by continually monitoring (measuring) and improving the excellence of patient care and organizational operations. The ultimate goal is for each program to provide care that is **safe, effective, patient oriented, timely, efficient**, and **equitable**, and in so doing to both provide a true Patient Centered Medical Home and ensure that quality goals are consistent with the national Triple Aim initiative.

The six characteristics shown above in **bold** were noted by the Institute of Medicine in its 2001 report, **"Crossing the Quality Chasm: A New Health System for the 21st Century."**

The *scope* of the QM program is **comprehensive**; quality and safety must extend to all facets of the organization—clinical, managerial, administrative, and facility-related. Accordingly, the Plan addresses each of the health center's clinical programs; the precepts of the Patient Centered Medical Home model; national Meaningful Use criteria; and requirements / guidelines of The Joint Commission, the National Committee for Quality Assurance (NCQA), the Bureau of Primary Health Care (BPHC), the Health Resources and Services Administration (HRSA), and the Federal Tort Claims Act (FTCA). It also addresses external services provided to patients through written agreements; high priority business process issues; and partnership opportunities within the broader community.

The Quality Management program also ensures organizational compliance with appropriate policies concerning *Confidentiality* and *Conflict of Interest*, as well as with all Health Insurance Portability and Accountability Act (*HIPAA*) requirements.

Although not necessarily part of the formal QM Plan, health centers have multiple other systems that contribute to quality and safety, including utilization review, risk management, credentialing / re-credentialing, and so forth. Some state health departments and some managed care plans require formal documentation of these systems; however, the systems themselves need not be specifically included as components of the QM Plan.

II. Structure of the Quality Management Program

The structure of the Quality Management program flows from four underlying principles:

- An effective QM program must be based on a **functional definition of quality**.
- The QM program must **ensure accountability** at all levels.
- There must be **clear differentiation of responsibilities** between health center leadership and the QM Committee(s).
- **Clinical providers** must play a key role in quality management, and this role should be made as efficient and effective as possible. (The term "clinical providers" as defined here includes anyone with **independent authority to write prescriptions**.)

In addition, a focus on quality must permeate the entire organization. *All* health center staff must constantly "think" quality and must genuinely feel that quality is an integral component of everyone's job description. This mindset must flow from the organization's leaders. Front-line staff must fully understand that they can at any time make suggestions for metrics, should actively help take advantage of improvement opportunities, and will be constantly kept informed of ongoing quality progress.

A. A Functional Definition of Quality

The quality process begins with the organization's mission, vision, strategic plan, and core values. All quality-related activities are focused on **designing, implementing, monitoring**, and **improving** a total system that actively integrates these constructs and can deliver enhanced outcomes.

A health center must first *define* quality before it can assess and improve quality. The following functional definition of quality is a good example of one that can be specifically adopted by the Board as part of its responsibility for commissioning the Quality Management program. This definition isolates the aspects of quality that can be monitored and constantly improved through the center's Quality Management program, with the ultimate goal of enhancing outcomes of all types.

Quality is the degree of excellence of the center's processes, provider and support—staff performance, decisions, and human interactions.

—Dale Benson MD, CPE, FACPE

Thus, through organization-wide Quality Management activities, the center will focus on monitoring and improving patient care (and related business) **processes**; provider and support staff **performance**; **decisions** having the potential to impact patient (and organizational) health; and ongoing **human interactions**, both with patients and among all center personnel.

B. Accountability

The *Board of Directors* is ultimately accountable for the level of quality and safety at the center. This accountability begins with the Board's initial approval of the definition of quality and the Quality Management Plan, and progresses through re-approval of the QM Plan at least every three years (more often if substantial changes are made in the Quality Management program).

The Board receives and acts upon periodic reports developed through the QM program, and it ensures the availability of resources and systems necessary to support all QM activities.

Many Boards appoint a Board QM Committee charged with monitoring the ongoing effectiveness of the health center's QM program and communicating QM results and issues to the Board. These Committees customarily meet every other month and are staffed by the Director of Quality or the CEO (or both).

The Board holds the health center's *Chief Executive Officer (CEO)* accountable for organizational quality and safety. The CEO regularly reports to the Board on quality; this can be done through the Board QM Committee, if one exists.

The health center's *Director of Quality* has operational responsibility for the QM program and reports to the CEO. Each *Quality Management Committee* reports to the Director of Quality.

A frequent mistake is having the Director of Quality report to the Chief Medical Officer rather than the CEO. Quality involves the entire organization, not just the clinical component; thus, the CEO should supervise the Director of Quality.

The *Chief Medical Officer (CMO)* is accountable to the CEO for the quality and safety of the clinical program, the performance of the provider staff, and the provider performance assessment / improvement component of the QM program.

C. Intersecting Roles: Leadership / Quality Council and QM Committee(s)

In this monograph, "leadership" refers to **those within the organization having true decision making authority**—that is, leaders and managers responsible for program effectiveness within their defined area of responsibility. Thus, the term encompasses the CEO and other top executive staff, division heads, and department managers. The *Quality Council* described below would include staff with leadership or management responsibility and authority.

On the other hand, the *QM Committee* is comprised of **front line employees** who do not have leadership or management responsibility; examples would include (but not be limited to) medical assistants, front desk staff, health educators, providers (not including the CMO), and staff nurses. It is appropriate for supervisors to sit on the QM Committee, since their role is to supervise performance rather than to develop / manage programs.

With that definitional distinction as background, let's consider the roles and responsibilities of the key members of the quality team.

Leadership: Within each center, the effectiveness of the QM program is the direct responsibility of leadership. It is the leaders' responsibility to *develop, support*, and *operate* the Quality Management program. The leaders, with the support and assistance of the Director of Quality, accomplish the following:

1. Select and prioritize metrics to monitor, with a performance goal for each;
2. Determine acceptable performance thresholds (quality action points) for each metric;
3. Ensure that all necessary data are supplied to the appropriate QM Committee(s);
4. Manage ongoing improvement activity; and
5. Assume ultimate responsibility for resolving identified quality and safety problems, as well as taking advantage of any other opportunities to improve. Often these responsibilities are assumed by a Quality Council (as described below).

While staff members at all levels, from supervisors and managers to front-line employees, should always be encouraged to suggest metrics to monitor, it is the organization's leadership that is ultimately responsible for choosing specific metrics that will be measured.

Quality Council: In a typical mid-sized-to-large health center, an overseeing Quality Council might consist of (for instance) six to eight leaders, including members of the Executive Staff and the CMO, appointed by the CEO to serve one or more one-year terms. This Quality Council would assume

leadership responsibilities outlined above for **developing, supporting**, and **operating** the QM program; in doing so, it would oversee all organizational quality activity, including actively addressing any corporate-level issues relating to quality and patient safety. The Quality Council would generally be expected to meet monthly and would normally be chaired by the Director of Quality, who would report Quality Council activity directly to the CEO.

A Quality Council is especially useful in larger programs with multiple site-specific Quality Management Committees. Smaller organizations may not need a Quality Council; in this instance, leaders would fulfill their responsibilities individually and the organization's QM Committee would report directly to the Director of Quality (or whoever is fulfilling that function within the organization).

QM Committee: It is the *QM Committee(s)'s* responsibility to actively monitor QM activity (within the total organization if there is only one Committee, or for a specific program / site if the health center has multiple QM Committees), and to report on this activity. The QM Committee, with the support and assistance of the Director of Quality, ensures that:

1. The chosen metrics are being monitored;
2. Necessary data are being collected;
3. Metrics not meeting pre-established performance thresholds are being moved into the quality improvement phase of activity;
4. Quality improvement is being actively carried out; and
5. Identified quality-related problems are fully resolved.

(See the *Appendix* for a listing of some typical QM Committees within a health center.)

There must be **clear separation of duties and responsibilities** between leadership and the QM Committee(s). A QM Committee is not responsible for overseeing the total Quality Management program, nor is it responsible for actually *solving* quality-related problems. Rather, leadership operates the overall program and is responsible for continual program oversight, as well as for ensuring results of quality improvement activities. The QM Committee's role is to *monitor* the program (or its assigned portion of it) through ongoing metric review. An Internal Roles Chart defining the roles of leadership and the QM Committee(s) within the overall QM program can be found in the *Appendix*.

Each QM Committee should be broadly representative of the staff (either of the overall health center or of the Committee's specific program, depending on the complexity of the organization). It could, for example, consist of five or six front-line staff members appointed by the Director of Quality to one or more one-year terms. The Committee should be cross-functional. Each QM Committee chooses its own Chair; meets monthly to actively monitor the QM program within its assigned area of responsibility; and reports on results, issues, and program effectiveness.

D. The Vital Role of Clinical Providers in Quality Management

Clinical providers are critical to the quality and safety of the total health center program. (Again, as used here, "clinical providers" are those professionals with independent authority to write prescriptions.) Providers not only give excellent care, but they also ensure—by monitoring / measuring / improving processes, performance, decisions, and human interactions—that their care is of the highest possible quality.

Providers participate in specific activities, described below, that are mandated by the FTCA deeming process. These activities generally apply to "licensed independent practitioners" as defined by The Joint Commission.

According to the Joint Commission's 2011 Comprehensive Accreditation Manual, a Licensed Independent Practitioner for Ambulatory Care Programs is defined as follows: An individual permitted by law and by the organization to provide care, treatment, and services without direct supervision. A licensed independent practitioner operates within the scope of his or her license, consistent with individually granted clinical privileges. When standards reference the term licensed independent practitioner, this language is not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified health care personnel (for example, physician assistants and advanced practice registered nurses) to the extent authorized by state law or a state's regulatory mechanism or federal guidelines and organizational policy.

1. Clinical Guidelines. The providers identify and adopt/adapt specific evidence-based clinical guidelines—including, but not limited to, health promotion, disease prevention, and clinical outcome metrics—that are grounded in national standards. The provider staff continually monitors the program for guideline effectiveness.

Multiple sources exist for evidence-based guidelines. As one example, an excellent resource is the Web site for the **National Guideline Clearinghouse**, sponsored by the Agency for Healthcare Research and Quality (AHRQ).

2. Peer Review and Clinical Guidelines Audits. The Chief Medical Officer is responsible for ensuring that Peer Review Audits and Clinical Guidelines Audits are conducted as scheduled, and that these Audits periodically assess the *appropriateness of utilization of services* and the *quality and safety of those services*. Audits are based on systematic collection and evaluation of patient records and are conducted by licensed professionals under the supervision of the CMO.

3. Provider Performance Improvement Activity. The CMO appoints provider representatives to the appropriate Quality Management Committee, as well as to process improvement or reengineering teams as needed. The CMO is ultimately responsible for resolving identified clinical problems, as well as for performing ongoing quality improvement in the clinical arena.

4. Integration with the Organization-wide QM Program. Provider-specific assessment and improvement activities are integrated into the overall QM program via the CMO's active leadership (participation on the Quality Council, for instance) and through integration of clinical quality activity reports into the overall reporting structure for all Quality Management Committees.

III. Three Fundamental Components for Managing Quality

The Quality Management Plan should address three fundamental components for ongoing management of quality. The first component is **quality assessment**; the second is **quality improvement**; and the third is **tracking improvement activity and reporting on program effectiveness**.

A. Quality Assessment

Each Quality Management Committee is charged with monitoring predetermined metrics of quality and safety, as selected by the health center's leadership (in conjunction with their program managers, and often with the input of front-line staff).

As noted above, a **metric** is simply a carefully defined program measure—either process or outcome—that is actively and continuously reviewed (i.e., measured and monitored) to determine the level of performance for that particular item.

Leadership, with staff input, provides each Quality Management Committee with externally valid, evidence-based metrics for monitoring. This monograph's template addresses eight broad metric categories (each including one or more metrics) that align with the fundamental tenets of the Patient Centered Medical Home model, as shown in Section IV. These categories apply to both traditional primary care QM activity and to specialty programs such as HIV and Behavioral Health. Through this mechanism, we can generate system-wide continuity.

Sources for metrics include, but are certainly not limited to, UDS process and outcome clinical measures, the **National Quality Forum (NQF)**, **NCQA HEDIS** measures, health and business plan requirements, and metrics developed by various professional societies and/or peer review organizations. **BPHC** recommendations regarding patient satisfaction, access, quality of clinical care, quality of the workforce, work environment, cost, productivity, health status, and outcomes are also excellent potential metric sources. Other resources include the Institute of Medicine's six ***Aims for Improvement*** (care that is safe, effective, patient-centered, timely, efficient, and equitable); Pay for Performance criteria; The Joint Commission's **National Patient Safety Goals**; Meaningful Use criteria; and the Patient Centered Medical Home model.

Although the broad metric categories remain constant, the metrics themselves reflect each program represented by a QM Committee. These metrics relate to processes, performance, outcomes, appropriateness of decisions, and patient satisfaction. Metrics should reflect the uniqueness of the health center (or program) and its specific patient population.

The objective is to initially develop or adopt a minimum of *one metric for each broad category* referenced in this template, then to gradually add others as the organization's QM program matures and the center moves up the "quality progress ladder." For each chosen metric, leadership establishes a goal and a related plan for performance measurement. A Quality Council could be used for these functions.

Leadership also establishes a predetermined performance threshold (the quality action point) at which the QM Committee takes action to refer the metric (in most cases to the program manager most directly involved) for improvement activity.

Data are collected, displayed, and reported routinely, using charts and graphs whenever helpful. Data are analyzed to identify trends, patterns, and performance levels that suggest opportunities for improvement. Analysis is based on predetermined benchmarks, quality action points, and statistical quality control techniques.

This part of the QM Plan describes how measurement data are evaluated and how a decision is made to initiate quality improvement activity. **BPHC-provided trend reports** can be quite useful here.

B. Quality Improvement

In its QM Plan, a health center documents the improvement methodologies it will use. We suggest three that are straightforward, frequently used, and functional: process improvement, re-engineering, and root cause analysis. For each, a team is appointed by the appropriate program leader / manager. The Director of Quality ensures that the teams are appropriately trained and adequately supported.

1. Process Improvement. While a number of process improvement methodologies exist, the **Nolan Accelerated Model for Improvement** is an excellent choice. This relatively straightforward model incorporates the classic PDSA (Plan, Do, Study, Act) cycle for testing and implementing improvement options. When an opportunity for improvement is identified, leadership appoints an improvement team and charges the members with making improvements using the Nolan methodology. (See the Appendix for more detail on this very useful tool.)

There are other acceptable methodologies, as well, such as Six Sigma and the **Lean model**. No matter which method is selected, the key is simply that process improvement is institutionalized and actively addressed on an ongoing basis.

2. Re-engineering. When major process improvement is called for, when certain processes are fundamentally dysfunctional, or when process improvement activity is otherwise unsuccessful, a re-engineering team is appointed and trained to create an all-new process. Each team is assigned a facilitator skilled in reengineering methods and techniques.

3. Root Cause Analysis. Root cause analysis is used primarily for in-depth analysis of an adverse incident (or "sentinel event"). However, it can also help in better understanding a process, as the first step in improvement of that process.

The "Five Whys" methodology can be quite useful in uncovering root causes. See the Appendix to learn how to perform a "Five Why's" analysis.

C. Tracking Improvement Activity and Reporting QM Data

When a QM Committee identifies a quality issue and refers it to leadership to organize an improvement team, the Committee then tracks and reports on progress until improvement has been fully realized. When improvement activity is complete, the Committee periodically re-analyzes related performance and/or outcomes data to ensure that improvement is sustained.

The health center's quality reporting system—for both internal and external tracking and reporting—contributes significantly to ongoing accountability and is thus an important component of quality management.

While tracking and reporting can be done manually, the growing complexity of this effort, the rapidly increasing volume of quality-related data, and ever more urgent calls for sharing / integration of information strongly point to the adoption of electronic reporting mechanisms. An example of how routine internal quality reporting could be accomplished electronically is shown in the *Appendix*.

Reporting of quality activity and its results begins with each QM Committee. Data from each Committee are made available to the Quality Council (or Director of Quality). The data are then collated and presented to the CEO, who periodically shares quality reports with the center's Board.

Included in these internal reports are:

1. Identification of the metrics;
2. Specific metric measurements relative to pre-established goals and quality action points;
3. Improvement activities initiated; and
4. The ongoing results of quality improvement.

QM Committee members generally see the greatest detail, enabling them to constantly analyze and address indicators and related issues. The Quality Council (including the CEO) sees less ground-level detail but is kept informed on current metrics and how performance is improving over time. Finally, the Board generally sees a broad quality overview. For both the Quality Council / CEO and the Board, further drill-down data can be made available if desired.

Finally, it is important that all staff ultimately see the results of quality activity. Since quality is an organization-wide affair, reports of both critical quality issues and related improvements require organization-wide distribution. This can be accomplished electronically via internal email or intranet, through paper-based summaries handed out in staff meetings, by posting quality reports in common areas, and so forth. The precise mechanism is less important than the mandate—simply put, everyone working in a health center should be kept informed of quality issues being addressed, progress on those issues, and improvements generated by the quality process.

An important corollary is the idea of *celebrating successes*. Fixing longstanding problems, generating better processes and outcomes, and generally taking full advantage of opportunities for real improvement are significant achievements, and leaders need to ensure that staff know this and are congratulated for their role in making things better. Celebrations need not be Hollywood productions; simple things like bringing special treats to meetings or sending notes of appreciation to employees will do the job nicely. The important thing is to bring closure to successful improvements while simultaneously creating investment in future quality efforts.

In addition to internal reporting, quality management results are also periodically reported when required to external entities. These include the Bureau of Primary Health Care, State Health Departments, program-specific state and federal agencies (e.g., for HIV programs), and others.

IV. Framework For Organizing Performance Metrics

A health center's QM program should continually monitor both *fundamental primary care metrics* and *program-specific quality metrics* for initiatives addressing specific "populations of focus" (such as HIV patients).

The metric set examples provided in this monograph are called "Metric Paks." Each Metric Pak is organized by eight broad categories that align closely with the philosophy of the Patient Centered Medical Home; these categories thus serve as an appropriate template for both primary care and population-specific programs. This template can help health centers easily integrate both existing programs and new initiatives into the organization's overall QM program in a way that focuses on program-specific metrics while ensuring continuous alignment with Patient Centered Medical Home precepts.

The QM program's objective is to monitor one or more metrics in each of the eight broad categories, for all programs being addressed. The idea is to start with a few metrics in each category, then to add more as the QM program matures.

Program-specific metrics can be developed within these eight broad categories for such clinical services as dental, maternal health, substance abuse, school-based clinics, etc. The resulting Metric Paks, as shown in this monograph for the clinical programs of Primary Care, HIV, and Behavioral Health, can then be plugged into the overall QM program. In a mid-sized health center, these metrics could be monitored by separate Primary Care, HIV, and Behavioral Health QM Committees.

Below is the PCMH-based template that assigns metrics to eight broad categories, together with the underlying PCMH concepts for each category. In the specific Metric Paks (collections of program-specific metrics placed into the "eight broad categories" template) that follow, we suggest metrics that could be addressed within each category for both traditional Primary Care and—as examples of integration of new initiatives—HIV and Behavioral Health.

Because it is a critical initiative cutting across multiple programs, we have also created a Meaningful Use Metric Pak. These metrics are also consistent with the PCMH model and thus fit well into the template. They can be supplemented or replaced as Meaningful Use progresses through its planned future Levels.

Health center leadership can add, delete, or modify metrics in each Metric Pak. To maintain the underlying PCMH foundation, however, the continual focus should be on creating metrics within the broad categories of the template. Again, the key is that this template provides a relatively simple PCMH-centered framework into which a health center can easily drop new metrics relating to both existing programs and new initiatives.

The Quality Categories Template for Assessment and Improvement

Below are the eight broad categories for organizing metrics within the context of a Patient Centered Medical Home care model. A definition is provided for each category, together with important concepts underlying that category.

Although the QM program focuses primarily on the quality of clinical patient care, we have also included one template category focusing on the quality of business processes. There are two reasons for this. First, business processes represent a significant potential source of both savings and untapped revenues. Second, while patient care is clearly "the point of the sword," it is undeniably true that any important health center process ultimately has the potential to impact that care; a sword's effectiveness, after all, depends nearly as much on its hilt as on its point.

Following the category descriptions below are the program-specific "Metric Paks" containing sample metrics for each chosen program, as example of how to use the QM Plan to help integrate both existing services and new initiatives.

Here are the eight broad categories and their underlying concepts:

1. Access and Cycle Time

Definition: Ease and timeliness with which health care services can be obtained, including the efficiency of the patient visit.

Concepts: Enhanced access; open scheduling; expanded hours, including evenings and weekends; access to specialty care and other resources needed to provide care; more efficient cycle times.

2. Comprehensive, Coordinated, and Integrated Care

Definition: A comprehensive, coordinated, continuous, and whole person plan of care for a particular patient, progressing without interruption; includes referrals, test results, and record transfer. Services are well integrated with other health care and community resources.

Concepts: Care planning and management; continuous care; comprehensive and whole person (physical, mental and social) care; continuity of care, with referral and test tracking; coordination of care with other providers, including coordinated information flow; enhanced communication with providers, patients, families, and the community; strong community linkages.

3. Clinical Quality and Safety

Definition: Treatment is consistent with predetermined performance and safety guidelines or generally accepted evidence-based standards. Health outcomes meet predetermined safety and effectiveness goals.

Concepts: Evidence-based clinical processes; clinical decision support tools; appropriate diagnostic tests and therapeutic procedures; chronic disease management; clinical outcomes; medication management; patient safety.

4. Prevention and Health Promotion

Definition: Compliance with predetermined guidelines for prevention, early detection, and health / lifestyle / self management education.

Concepts: Health promotion; disease prevention; health and disease management education; lifestyle behaviors; self management training and support; preventive services.

5. Patient and Community Relationships

Definition: Care is patient centered, with a designated personal provider leading an interdisciplinary team. Care is given within the context of strong community linkages and partnerships.

Concepts: Patient centered care; trained interdisciplinary care teams with defined roles and responsibilities; an on-going healing relationship with a personal physician and care team; a physician and team collectively take responsibility for ongoing care; relationships with patient's family, as appropriate; culturally and linguistically appropriate care; strong community linkages and partnerships.

6. Health Information Technology

Definition: Health information technology contributes to the quality, safety, and efficiency of care.

Concepts: New options for enhanced communication (patients, physicians, staff); a systems- based approach; electronic patient, test, and referral tracking; utilization metrics; electronic prescribing; health information exchange; patient education; non-clinical systems.

7. Patient Satisfaction and Loyalty

Definition: The degree to which healthcare services and resulting health status meet patient expectations and create loyalty.

Concepts: Patient satisfaction surveys; the patient experience; patient centered care; feedback regarding expectations met; patient participation in decision making; compassionate and culturally effective care; patient loyalty surveys.

8. Business Process Quality

Definition: Effectiveness, efficiency, and results of the processes contributing to the successful business of the health center.

Concepts: Maximized revenue; operational efficiency; aligned and supportive payment systems; recognized added value of Patient Centered Medical Home care model.

Sample Health Center Metric Paks

Collections of Program-Specific Metrics, Using the PCMH-Based Quality Categories Template for a Quality Management Program

Specific Health Center Programs (Used as Examples):

- Primary Care
- HIV
- Behavioral Health Care
- Meaningful Use – Level 1

The Metric Pak for each example program (on the following pages) includes sample metrics for quality assessment and improvement activity. The underlying broad categories provide an opportunity to organize quality around the fundamental precepts of the PCMH care model—enabling consistency across all of an organization's programs.

The organization should establish its ultimate goal for each metric. The goal should include considerable stretch; in fact, it is frequently "100% compliance."

Although not specifically shown in the Metric Paks, leadership should also establish a *quality action point* for each metric. This serves as the center's current acceptability threshold for that metric; it is generally less than the ultimate goal and reflects what the organization can live with at the current time. It is the point above which the center may not need to expend major resources for an all-out improvement project.

For instance, if the ultimate goal of the metric is "100% compliance," the target for the current year may be 85%. Failure to reach the quality action point should virtually always result in quality improvement activity.

In the spirit of continuous improvement, current performance (unless it's 100%) won't be the final stopping point. At least once per year, leadership should reevaluate the quality action point and adjust it as appropriate—presumably upward. The ultimate goal will remain 100% compliance.

In addition to assigning metric goals and related quality action points, leadership should also clarify the mechanics of data gathering for each selected metric. This includes specifying the appropriate data source, who compiles the data, and how relevant data are generated. Only through rigorous analysis of hard data can the QM Committee adequately monitor and evaluate metric performance.

As noted, the Metric Paks contain examples of one or two metrics for each category in the template. There is certainly no requirement to use these samples; you may already have (or wish to create) others more relevant to what you are trying to accomplish in your own program(s). The key is to start with one or two metrics in each broad category, then add others as your QM program matures.

As you review the Metric Paks below, refer as needed to the category Definitions and underlying Concepts provided on pages 17-19. For an alternative perspective, a listing of the metrics for each of the eight PCMH-based quality categories immediately follows the four program-based Metric Paks.

Metric Pak: PRIMARY CARE

METRIC	GOAL
Access & Cycle Time	
Access to primary care when needed	100% of patients report that they are able to access care when needed.
Cycle time	The average visit cycle time is 45 minutes or less.
Comprehensive, Coordinated & Integrated Care	
Congestive Heart Failure (CHF) medication follow-up	100% of CHF patients on diuretics or digoxin have follow-up lab tests performed per guidelines.
Referral follow-up	100% of referrals made by a referral nurse are tracked for patient follow-through.
Clinical Quality & Safety	
Hypertension – lab assessment	100% of hypertension patients have serum creatinine and cholesterol documented within the past 12 months.
Medication reconciliation	100% compliance is achieved with **National Patient Safety Goals** of accurately and completely reconciling medications across the continuum of care on all patients.
Prevention & Health Promotion	
Asthma self-management goals	Self-management goals are established and documented on 100% of asthma patients.
BMIs in children	100% of children with elevated BMIs are offered specific obesity intervention.
Patient & Community Relationships	
Easy access to patient's designated provider and team	100% of patients report success in seeing their desired provider or team member on the preferred day.
Community partnerships	At least one new formal community linkage is developed each year.
Health Information Technology	
Readily accessible medication-specific information	100% of primary care patients have a readily accessible drug profile that is current and complete.
Health maintenance forms	Electronic health maintenance forms are current and complete for 100% of patients.
Patient Satisfaction & Loyalty	
Results of care	100% of patients report satisfaction with results of visit(s) to the health center.
Patient willingness to return	100% of patients report that they would always return to the health center even if a particular visit does not go well.
Business Process Quality	
Days in accounts receivable (A/R)	Organization meets monthly target for days in A/R.
Cost per medical visit	Organization meets monthly targets and is within BPHC guidelines.

Metric Pak: HIV

METRIC	GOAL
Access & Cycle Time	
Easy access to Case Manager	100% of HIV patients report success in seeing desired Case Manager on preferred day.
Rapid HIV testing	Rapid HIV tests are provided and results are reported during the same visit to 100% of health center patients.
Comprehensive, Coordinated & Integrated Care	
Dental referrals	100% of HIV patients have a dental referral annually.
Retention in care	100% of HIV patients are seen at least twice annually, with visits at least 60 days apart.
Clinical Quality & Safety	
Viral load or CD4 count	Viral load / CD4 count measured at least twice annually on 100% of HIV patients.
Maximum viral control	100% of HIV patients achieve maximal viral control at least six months post-antiretroviral therapy (ART) initiation.
Prevention & Health Promotion	
Risk counseling	100% of health center patients determined to be at risk for HIV infection based on a sexual history receive risk counseling.
TB screening	100% of HIV patients have an annual PPD screen.
Patient & Community Relationships	
Case Management referrals	100% of HIV patients report that their Case Managers assist them in obtaining services not provided at their clinic/program.
Designated personal provider	100% of HIV patients report that they are always able to see their designated provider or team member when needed.
Health Information Technology	
CD4 count and viral load documentation	CD4 count and viral load are documented in the most recent four progress notes in 100% of HIV patients' electronic charts.
Drug profile documentation	100% of HIV patients have a documented drug profile in their electronic chart based upon patient-specific information.
Patient Satisfaction & Loyalty	
Reception area	100% of HIV patients report that the reception area is clean, safe, comfortable and respectful of privacy concerns.
Satisfaction with Case Manager	100% of HIV patients report that they are comfortable and satisfied with their Case Manager.
Business Process Quality	
Collection rate	80% of charges billed for HIV services are collected.
Required certificates and consents	100% of HIV program-required eligibility and informed consents are completed.

Metric Pak: BEHAVIORAL HEALTH

METRIC	GOAL
Access & Cycle Time	
Session time	Session time for 90% of Behavioral Health Care (BHC) patient visits should be no more than thirty minutes (+/- five minutes).
Total patient visit cycle time	90% of BHC patients will leave the health center no more than one hour from entry time.
Comprehensive, Coordinated & Integrated Care	
Duration of treatment	For 80% of BHC patients, duration of treatment should be 8-12 weeks.
Outpatient follow-up	100% of BHC patients discharged from in-patient care receive at least one follow-up outpatient visit with a BH provider within 30 days of discharge.
Clinical Quality & Safety	
PHQ-9 (Patient Health Questionnaire) scores	90% of depressed patients show a 50% decrease in PHQ-9 scores within six months after treatment is initiated.
Use of integrated clinical pathways	Integrated clinical pathways are established and utilized in 80% of BHC patients.
Prevention & Health Promotion	
Prevention focused referrals	80% of BHC patients are offered prevention focused education or referrals per guidelines.
Substance abuse	100% of patients are screened for substance abuse at general intake.
Patient & Community Relationships	
Same-day service - primary care and behavioral health care	90% of applicable patients are provided same-day primary care and BHC services.
Community-based social services	Needed social services for 100% of BHC patients are arranged in the community within two weeks of Behavioral Health intake.
Health Information Technology	
Patient information in Electronic Health Record (EHR)	BHC information is fully integrated into the patient's EHR for all BHC patients.
External reports	100% of BHC reports to external entities are generated through electronic reporting systems.
Patient Satisfaction & Loyalty	
Patient recommendation	100% of BHC patients report that they would recommend the health center's BHC services to family and friends.
Communication with patients	100% of BHC patients report that practitioners and staff listen intently, understand fully, and explain clearly.
Business Process Quality	
Collection rate	80% of charges billed for BHC services are collected.
Reimbursement of BHC services	100% of available reimbursements are received through case management fee structures and capitation contracts.

Metric Pak: MEANINGFUL USE—LEVEL 1

METRIC	GOAL
Access & Cycle Time	
Patient electronic access	At least 10% of all unique patients are provided timely electronic access to their health information within four business days of Electronic Health Record (EHR) update.
Comprehensive, Coordinated & Integrated Care	
Patient reminders	Reminders are sent to at least 20% of patients 65 and over or 5 years and younger.
Transition of care summary	Provide summary of care record for at least 50% of transitions of care and referrals.
Clinical Quality & Safety	
Computerized Physician Order Entry (CPOE)	CPOE used for at least one medication order RE: at least 30% of all unique patients having one or more medications in their medication list.
Maintenance of problem list	At least 80% of unique patients have at least one problem list entry (or "none") recorded as structured data.
Prevention & Health Promotion	
Recording of smoking status	Smoking status is recorded for at least 50% of all patients age 13 and older using structured data.
Immunization registries data submission	Perform at least one test of certified EHR technology's capacity to submit electronic data to immunization registries.
Patient & Community Relationships	
Electronic copy of health information	At least 50% of all patients who request an electronic copy of their health information are provided it within three business days.
Syndromic surveillance data transmission	Perform at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies.
Health Information Technology	
Recording of demographics	At least 50% of all patients have required demographics recorded as structured data.
Patient lists (by condition)	Generate at least one report listing patients with a specific condition.
Patient Satisfaction & Loyalty	
(No specific Meaningful Use—Level 1 metrics.)	
Business Process Quality	
(No specific Meaningful Use—Level 1 metrics.)	

ACCESS & CYCLE TIME

Definition: Ease and timeliness with which health care services can be obtained, including the efficiency of the patient visit.

Concepts: Enhanced access; open scheduling; expanded hours, including evenings and weekends; access to specialty care and other resources needed to provide care; more efficient cycle times.

METRIC	GOAL
Primary Care	
Access to primary care when needed	100% of patients report that they are able to access care when needed.
Cycle time	The average visit cycle time is 45 minutes or less.
HIV	
Easy access to Case Manager	100% of HIV patients report success in seeing desired Case Manager on preferred day.
Rapid HIV testing	Rapid HIV tests are provided and results are reported during the same visit to 100% of health center patients.
Behavioral Health	
Session Time	Session time for 90% of Behavioral Health Care (BHC) patient visits should be no more than 30 minute (+/- five minutes).
Total patient visit cycle time	90% of BHC patients will leave the health center no more than one hour from entry time.
Meaningful Use—Level 1	
Patient Electronic Access	At least 10% of all unique patients are provided timely electronic access to their health information within four business days of Electronic Health Record (EHR) update.

COMPREHENSIVE, COORDINATED, & INTEGRATED CARE

Definition: A comprehensive, coordinated, continuous, and whole person plan of care for a particular patient, progressing without interruption; includes referrals, test results, and record transfer. Services are well integrated with other health care and community resources.

Concepts: Care planning and management; continuous care; comprehensive and whole person (physical, mental and social) care; continuity of care, with referral and test tracking; coordination of care with other providers, including coordinated information flow; enhanced communication with providers, patients, families, and the community; strong community linkages.

METRIC	GOAL
Primary Care	
Congestive heart failure (CHF) medication follow-up	100% of CHF patients on diuretics or digoxin have follow-up lab tests performed per guidelines.
Referral follow-up	100% of referrals made by a referral nurse are tracked for patient follow-through.
HIV	
Dental referrals	100% of HIV patients have a dental referral annually.
Retention in care	100% of HIV patients are seen at least twice annually, with visits at least 60 days apart.
Behavioral Health	
Duration of treatment	For 80% of BHC patients, duration of treatment should be 8-12 weeks.
Outpatient follow-up	100% of BHC patients discharged from in-patient care receive at least one follow-up outpatient visit with a BH provider within 30 days of discharge.
Meaningful Use—Level 1	
Patient reminders	Reminders are sent to at least 20% of patients 65 and over or 5 years and younger.
Transition of care summary	Provide summary of care record for at least 50% of transitions of care and referrals.

CLINICAL QUALITY & SAFETY

Definition: Treatment is consistent with predetermined performance and safety guidelines or generally accepted evidence-based standards. Health outcomes meet predetermined safety and effectiveness goals.

Concepts: Evidence-based clinical processes; clinical decision support tools; appropriate diagnostic tests and therapeutic procedures; chronic disease management; clinical outcomes; medication management; patient safety.

METRIC	GOAL
Primary Care	
Hypertension - lab assessment	100% of hypertension patients have serum creatinine and cholesterol documented within the past 12 months.
Medication reconciliation	100% compliance is achieved with **National Patient Safety Goals** of accurately and completely reconciling medications across the continuum of care on all patients.
HIV	
Viral load or CD4 count	Viral load / CD4 count measured at least twice annually on 100% of HIV patients.
Maximum viral control	100% of HIV patients achieve maximal viral control at least six months post-antiretroviral therapy (ART) initiation.
Behavioral Health	
PHQ-9 (Patient Health Questionnaire) scores	90% of depressed patients show a 50% decrease in PHQ-9 scores within six months after treatment is initiated.
Use of integrated clinical pathways	Integrated clinical pathways are established and utilized in 80% of BHC patients.
Meaningful Use—Level 1	
Computerized Physician Order Entry (CPOE) for medication orders	CPOE used for at least one medication order RE: at least 30% of all unique patients having one or more medications in their medication list.
Maintenance of problem list	At least 80% of unique patients have at least one problem list entry (or "none") recorded as structured data.

PREVENTION & HEALTH PROMOTION

Definition: Compliance with predetermined guidelines for prevention, early detection, and health /lifestyle / self-management education.

Concepts: Health promotion; disease prevention; health and disease management education; lifestyle behaviors; self-management training and support; preventive services.

METRIC	GOAL
Primary Care	
Asthma self-management goals	Self-management goals are established and documented on 100% of asthma patients.
BMIs (body mass index) in children	100% of children with elevated BMIs are offered specific obesity intervention.
HIV	
Risk counseling	100% of health center patients determined to be at risk for HIV infection based on a sexual history receive risk counseling.
TB screening	100% of HIV patients have an annual PPD screen.
Behavioral Health	
Prevention focused referrals	80% of BHC patients are offered prevention focused education or referrals per guidelines.
Substance abuse	100% of patients are screened for substance abuse at general intake.
Meaningful Use—Level 1	
Recording of smoking status	Smoking status is recorded for at least 50% of all patients age 13 and older using structured data.
Immunization registries data submission	Perform at least one test of certified EHR technology's capacity to submit electronic data to immunization registries.

PATIENT & COMMUNITY RELATIONSHIPS

Definition: Care is patient centered, with a designated personal provider leading an interdisciplinary team. Care is given within the context of strong community linkages and partnerships.

Concepts: Patient centered care; trained interdisciplinary care teams with defined roles and responsibilities; an on-going healing relationship with a personal physician and care team; a physician and team collectively take responsibility for ongoing care; relationships with patient's family, as appropriate; culturally and linguistically appropriate care; strong community linkages and partnerships.

METRIC	GOAL
Primary Care	
Easy access to patient's designated provider and team	100% of patients report success in seeing their desired provider or team member on the preferred day.
Community partnerships	At least one new formal community linkage is developed each year.
HIV	
Case Management referrals	HIV patients report that their Case Managers assist them in obtaining services not provided at their clinic/program.
Designated personal provider	HIV patients report that they are always able to see their designated provider or team member when needed.
Behavioral Health	
Same-day service - primary care and behavioral health care	90% of applicable patients are provided same-day primary care and BHC services.
Community-based social services	Needed social services for 100% of BHC patients are arranged in the community within two weeks of Behavioral Health intake.
Meaningful Use—Level 1	
Electronic copy of health information	At least 50% of all patients who request an electronic copy of their health information are provided it within three business days.
Syndromic surveillance data transmission	Perform at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies.

HEALTH INFORMATION TECHNOLOGY

Definition: Health information technology contributes to the quality, safety, and efficiency of care.

Concepts: New options for enhanced communication (patients, physicians, staff); a systems- based approach; electronic patient, test, and referral tracking; utilization metrics; electronic prescribing; health information exchange; patient education; non-clinical systems.

METRIC	GOAL
Primary Care	
Readily accessible medication-specific information	100% of primary care patients have a readily accessible drug profile that is current and complete.
Health maintenance forms	Electronic health maintenance forms are current and complete for 100% of patients.
HIV	
CD4 count and viral load documentation	CD4 count and viral load are documented in the most recent four progress notes in 100% of HIV patients' electronic charts.
Drug profile documentation	100% of HIV patients have a documented drug profile in their electronic chart based upon patient-specific information.
Behavioral Health	
Patient information in electronic health record (EHR)	BHC information is fully integrated into the patient's Electronic Health Record for all BHC patients.
External reports	100% of BHC reports to external entities are generated through electronic reporting systems.
Meaningful Use—Level 1	
Recording of demographics	At least 50% of all patients have required demographics recorded as structured data.
Patient lists (by condition)	Generate at least one report listing patients with a specific condition.

PATIENT SATISFACTION & LOYALTY

Definition: The degree to which healthcare services and resulting health status meet patient expectations and create loyalty.

Concepts: Patient satisfaction surveys; the patient experience; patient centered care; feedback regarding expectations met; patient participation in decision making; compassionate and culturally effective care; patient loyalty surveys.

METRIC	GOAL
Primary Care	
Results of care	100% of patients report satisfaction with results of visit(s) to the health center.
Patient willingness to return	100% of patients report that they would always return to the health center even if a particular visit does not go well.
HIV	
Reception area	100% of HIV patients report that the reception area is clean, safe, comfortable and respectful of privacy concerns.
Satisfaction with Case Manager	100% of HIV patients report that they are comfortable and satisfied with their Case Manager.
Behavioral Health	
Patient recommendation	100% of patients report that they would recommend the health center's BHC services to family and friends.
Communication with patients	100% of BHC patients report that practitioners and staff listen intently, understand fully, and explain clearly.
Meaningful Use—Level 1	
No specific metrics.	

BUSINESS PROCESS QUALITY

Definition: Effectiveness, efficiency, and results of the processes contributing to the successful business of the health center.

Concepts: Maximized revenue; operational efficiency; aligned and supportive payment systems; recognized added value of Patient Centered Medical Home care model.

METRIC	GOAL
Primary Care	
Days in accounts receivable (A/R)	Organization meets monthly target for days in A/R.
Cost per medical visit	Organization meets monthly targets and is within BPHC guidelines.
HIV	
Collection rate	80% of charges billed for HIV services are collected.
Required certificates and consents	100% of HIV program-required eligibility and informed consents are completed.
Behavioral Health	
Collection rate	80% of charges billed for BHC services are collected.
Reimbursement of BHC services	100% of available reimbursements are received through case management fee structures and capitation contracts.
Meaningful Use—Level 1	
No specific metrics.	

APPENDIX

A. Examples of Organizational QM Committees

Primary Care QM Committee
Maternal Health QM Committee
School-Based Clinics QM Committee
HIV QM Committee
Dental QM Committee
Meaningful Use QM Committee
Behavioral Health QM Committee

B. Nolan Accelerated Model for Improvement

With the **Nolan Accelerated Model for Improvement**, developed by Thomas W. Nolan, PhD, Senior Fellow at the Institute for Health Care Improvement, process improvement teams are appointed by management. The teams are charged with improving a process by developing responses to three fundamental questions:

a. What are we trying to accomplish? (*Setting Aims*)

b. How will we know that a change is actually an improvement? (*Establishing Metrics*)

c. What changes can we make that will result in improvement? (*Selecting Changes*)

The team then designs and implements (with the support of management) the Plan-Do-Study-Act (PDSA) cycle to test improvement ideas.

The improvement plan must include both a baseline measurement and a built-in mechanism to determine the effectiveness (and, when appropriate, the replicability) of the improvement. The QM Committee and the Quality Council monitor progress of the improvement activity. If the PDSA cycle is successful, the resulting change is then implemented.

C. The "Five Whys" Method for Assessment

With the **Five Whys method**, the team considers why the issue being explored occurred. They then take that initial answer and ask "Why?" again. With each successive step, the team asks "Why?" again, until it has been asked five times. This approach enables the team to dig deeply into the source of the issue, generally resulting in a better understanding and, thus, a more functional solution.

D. Delineation of Roles: Quality Council / Quality Management Committee

QUALITY MANAGEMENT ROLES

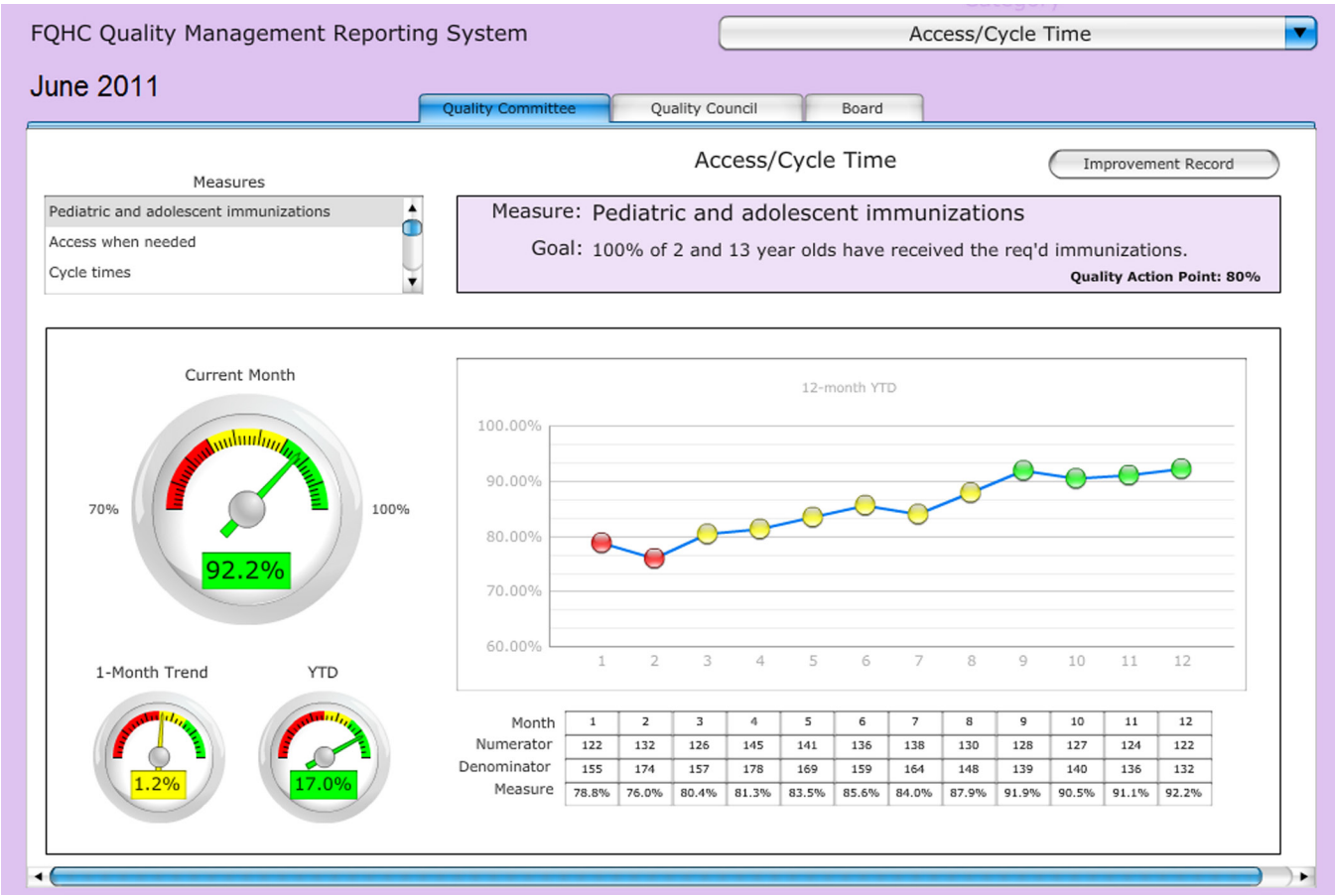
QUALITY COUNCIL (Health Center Leaders and Director of Quality)	QM COMMITTEE(S) (Front-line staff representatives)
1. Delineate organizational scope of care; identify key processes and related metrics (structure, process, outcome).	**1.** Assist leadership in identification of key processes and related metrics (structure, process, outcome).
2. Identify goal, quality action point, and data source for each metric.	**2.** Quality Assessment phase: ■ Ensure that appropriate metrics are being actively monitored. ■ Assess metric measurement data. ■ Refer identified quality deficiencies to leadership for Quality Improvement action.
3. Assign metrics to appropriate categories in the specific Metric Pak.	**3.** Quality Improvement phase: ■ Support and monitor all Quality Improvement activities, including Process Improvement, Re-engineering, and Root Cause Analysis. ■ Evaluate effectiveness of QI activities, and document improvements.
4. Appoint appropriate committees, in conjunction with the Director of Quality.	**4.** Report up through Quality Management channels.
5. Manage data collection and provide data to QM Committee(s) as needed.	
6. Manage Quality Improvement activities: ■ Assign responsibility for improvements. ■ Manage Process Improvement, Re-engineering, and Root Cause Analysis projects. ■ Solve problems. ■ Institutionalize improvements. Develop policies and procedures as needed.	
7. Report to CEO and Board through Corporate Quality Committee or Director of Quality.	
8. Periodically evaluate overall QM Program.	

E. A Sample Electronic Reporting System

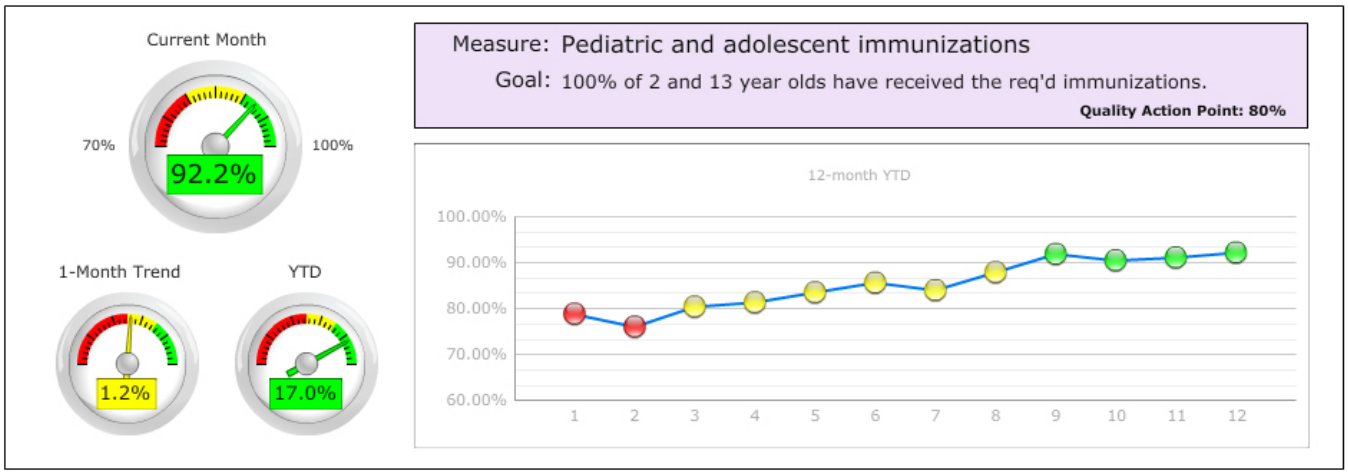
Below is an example of an electronic QM reporting system that could be attached to (or become part of) a Practice Management system or Electronic Health Record. In order of decreasing detail, it shows QM Committee, Quality Council / CEO, and Board-level views of tracked quality metrics, related Goals, and quality action points.

In this sample system, the level of reporting is selected by clicking the appropriate tab (in the view immediately below, the "Quality Committee" tab has been selected); the category of metric is then chosen from the drop-down menu at the top right of the screen; and specific associated metrics (mapped to the selected categories) appear in the drop-down menu at the upper left of the screen. Once all selections have been made, the underlying data populates the gauges, graph, and table. Performance is highlighted by color, with green indicating acceptable performance, yellow indicating caution, and red indicating a quality problem (opportunity to improve).

- The **QM Committee** sees the most detail, enabling members to continuously analyze, understand, and address the ongoing dynamics and issues related to each specific metric. As shown below, the Committee sees current metric performance (compared to goal), monthly and year-to-date trends, calendar year trending, and the detailed data underlying these results and trends.



■ The **Quality Council** (leadership) view, shown below, provides less detail—specifically eliminating the data table underlying the visuals—but still informs on current performance metrics and how each is trending over time.



■ The **Board** view (below) gives Board members a general quality overview in "basic dashboard" format, showing results for multiple metrics simultaneously. It also uses a green-yellow-red schema, depending on whether metric performance is acceptable (green), marginal (yellow), or unacceptable (red).

Clinical Quality and Safety Dashboard											
Diabetes: Foot Exam			Diabetes: HBA1c			Hypertension: Lab Assessment			Substance abuse screening		
96%			7.6			100%			100%		
Current	3-month	YTD	Current	3-month	YTD	Current	3-month	YTD	Current	3-month	YTD
96.3%	98.7%	97.0%	7.60	8.16	8.45	100.0%	94.5%	89.0%	100.0%	98.9%	97.0%

Finally, while there is no sample view specifically for front-line employees, all staff should be kept continually apprised regarding quality issues, the status of metrics over time, and the results of quality improvement activities. This can be accomplished by sharing any or all of the above reports, at leadership's discretion, with staff groups either in hard copy or electronically. Reports can also be distributed in all-staff meetings, and hard copies can be posted in common staff areas such as break rooms.

NATIONAL ASSOCIATION OF
Community Health Centers

National Association of Community Health Centers, Inc.® 7200 Wisconsin Ave., Suite 210, Bethesda, MD 20814

(301) 347-0400 ▪ Fax: (301) 347-0459 ▪ www.NACHC.com