NCQA PCMH 2014 Quality Measurement and Improvement Worksheet

Alcohol Use Screening is a preventive care measure that determines the number of patients who have been screened for an alcohol use problem anytime in the reporting period.

Alcohol Use Screening	**1. Measure selected for improvement; reason for selection**	***Reason:*** Alcohol Use Screening is a preventive care measure that determines the number of patients who have been screened for an alcohol use problem anytime in the reporting period. Morbidity and mortality from uncontrolled and/or excessive alcohol use can be mitigated by screening for alcohol overuse, addressing/counseling with the patient and implementing a treatment program.
	2./3. Baseline performance measurement, numeric goal for improvement. *(6D 1)*	***Baseline Start Date:*** October 1, 2016 ***Baseline End Date:*** December 31, 2016 ***Baseline Performance Measurement(% or #):*** 47% ***Numeric Goal (% or #):*** 62% (15% improvement)
	4. Actions taken to improve and work toward goal; dates of initiation *(6D 2)(Only 1 action required)*	***Action:*** A structured template was implemented on January 2, 2017 with an alcohol screening questionnaire to be asked of every patient on every office encounter. ***Date Action Initiated:*** January 2, 2017 ***Additional Actions:*** NA
	5. Remeasure performance. *(6E 1,2)*	***Start Date:*** March 30, 2017 ***End Date:*** June 30, 2017 ***Performance Re-Measurement(% or #):*** 91%
	6. Assess actions and describe improvement. *(6E 1)*	Assessing every patient at every office encounter dramatically improves the screening for an alcohol use problem thereby providing the PCP with the ability to address the problem in more patients.

NCQA PCMH 2014 Quality Measurement and Improvement Worksheet

San Diego Medical Group (SDMG) sets as a goal and acts to improve the rate of electronic laboratory tests results received into its electronic medical record.

Monitoring Lab Orders, Lab Results and Methods by Which the Labs Were Received **The practice sets as a goal and acts to improve the rate of electronic laboratory test results received into its electronic medical record**	**1. Measure selected for improvement; reason for selection**	***Reason:*** The practice uses resources judiciously to help patients receive appropriate care. Lab results have had a high rate of non-transmission from the laboratory hub into the practice's electronic database. The practice has been proactively working with the its EMR and lab vendors to rectify the problem. The measured data included how often labs were received electronically versus non-electronically or not received at all.
	2./3. Baseline performance measurement; numeric goal for improvement *(6D 3)*	***Baseline Start Date:*** September 5, 2015 ***Baseline End Date:*** September 6, 2016 ***Baseline Performance Measurement(% or #):*** 23% electronic lab results were not received on average among the three Providers ***Numeric Goal (% or #):*** 13% (a 10% reduction in lab error transmission)
	4. Actions taken to improve and work toward goal; dates of initiation*(6D 4)(Only 1 action required)*	***Action*:** The practice analyzed the data in conjunction with its EMR vendor to authenticate veracity of the electronic lab data not being received. It was verified. The practice analyzed the data in conjunction with its laboratory vendor to authenticate veracity of the electronic lab data not being received. It was verified. The laboratory vendor identified an error in transmission of the data from its electronic hub into the practice's electronic EMR database. The practice facilitated a working relationship between the EMR and laboratory vendors to address the problem and mitigate the transmission error. The practice was informed on September 7, 2016 the transmission error had been rectified. ***Date Action Initiated*:** September 7, 2016 ***Additional Actions:*** **NA**
	5. Remeasureperformance *(6E 1, 3)*	***Start Date:*** September 7, 2016 ***End Date:*** September 7, 2017 ***Performance Re-Measurement (% or #):*** 20% electronic lab results were not received on average among the three Providers
	6. Assess actions; describe improvement *(6E 1)*	20% electronic lab results were not received on average among the three Providers. The practice improved its electronic transmission rate of lab results by a mere 3%. This still represents 5,186 actual lab tests which were not received. Despite the practice routinely obtaining the results manually, this represents an ongoing problem the practice intends to ttake up with the EMR and laboratory vendors.

NCQA PCMH 2014 Quality Measurement and Improvement Worksheet

San Diego Medical Group sets the goal to seek improvement of phone wait times on hold and ease of use of its voicemail system for patients

Practice sets the goal to seek improvement of phone wait times on hold and ease of use of its voicemail system for patients	**1. Measure selected for improvement; reason for selection**	***Reason:*** Handwritten notes provided in the office suggestion box a patient stated more staff was needed to handle the phones and long wait times on hold. Handwritten suggestions from committee members of the Practice Advisory Council when responding to "What would you suggest to this office in general" and "In what ways can we improve" SDMG's included letting patients know when there will be a long wait time on hold, have 'soft, soothing" music playing when placed on hold and less waiting time for patients when placed on hold. Both methods of feedback have been recently implemented, therefore, only a small amount of raw data is currently available.
	2./3. Baseline performance measurement; numeric goal for improvement *(6D 5)*	***Baseline Start Date:*** **March 21, 2017** ***Baseline End Date:*** **June 21, 2017** ***Baseline Performance Measurement(% or #):*** **2 documented notations of patient feedback** ***Numeric Goal (% or #):*** **10 documented notations of patient feedback**
	4. Actions taken to improve and work toward goal; dates of initiation*(6D 6)(Only 1 action required)*	***Action*:** Based on the suggestions from June 21, 2017 Practice Advisory Council, on June 26, SDMG reviewed and modified its automated voicemail system which answers all incoming calls. The goals for the change included enhanced simplicity for patient use, easier instructions and prompts for patient navigation and improved patient access to a live staff member. The entire programming structure was updated (see below) and launched on July 6, 2017. Also, a new staff work station in the front office was implemented and staffed on July 6, 2017 to assist with answering phones. ***Date Action Initiated*: July 5, 2017** ***Additional Actions:*** **NA**
	5. Remeasureperformance *(6E 4)*	***Start Date:*** **July 6, 2017** ***End Date:*** **September 6,2017** ***Performance Re-Measurement (% or #):*** **6 documented notations of patient feedback**
	6. Assess actions; describe improvement *(6E 1)*	During the re-measurement period the practice collected more raw data through suggestion box patient participation. SDMG received 22% less complaints regarding the voicemail and phone wait times. The practice will continue to obtain and quantify feedback through the suggestion box, Practice Advisory Council and directly from patients with the goal of continuous quality improvement.