This is the fourth module of Coach Medical Home—a six-module curriculum designed for practice facilitators who are coaching primary care practices around patient-centered medical home (PCMH) transformation. Based on the Safety Net Medical Home Initiative Framework for Practice Transformation, these modules provide knowledge and tools coaches can use to support practices as they improve quality of care, become medical homes, and achieve PCMH recognition.

Each module has two components: a PDF handbook like this one and a companion PowerPoint® presentation also available on the Coach Medical Home website. The PowerPoint® slides can be saved, modified, and used in your presentations with practice leaders and others. The detailed notes in the handbook will help you learn more and link you to other useful resources. You may also find it helpful to use these notes to guide your talking points during presentations.

Visit www.CoachMedicalHome.org to download this and other modules—and to access dozens of helpful tools and resources.

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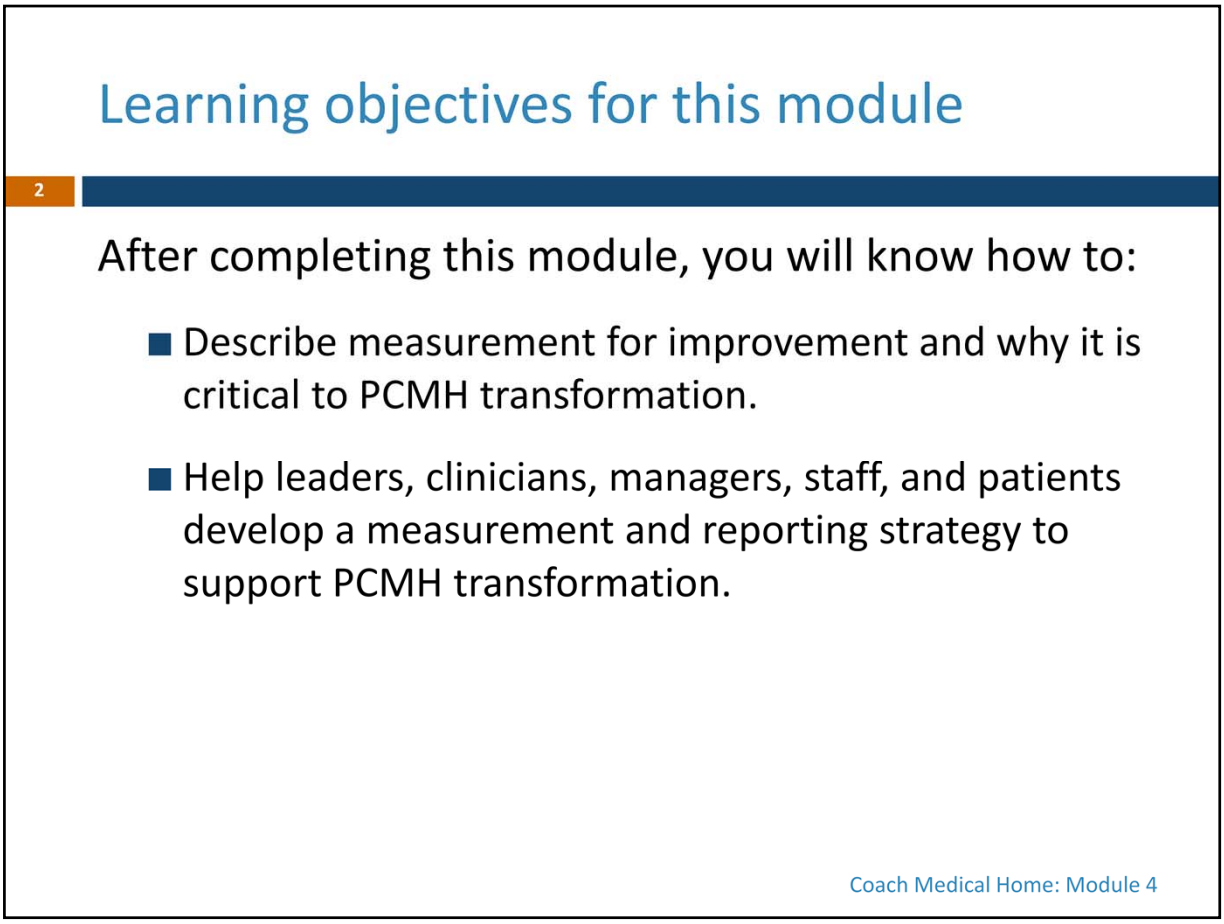
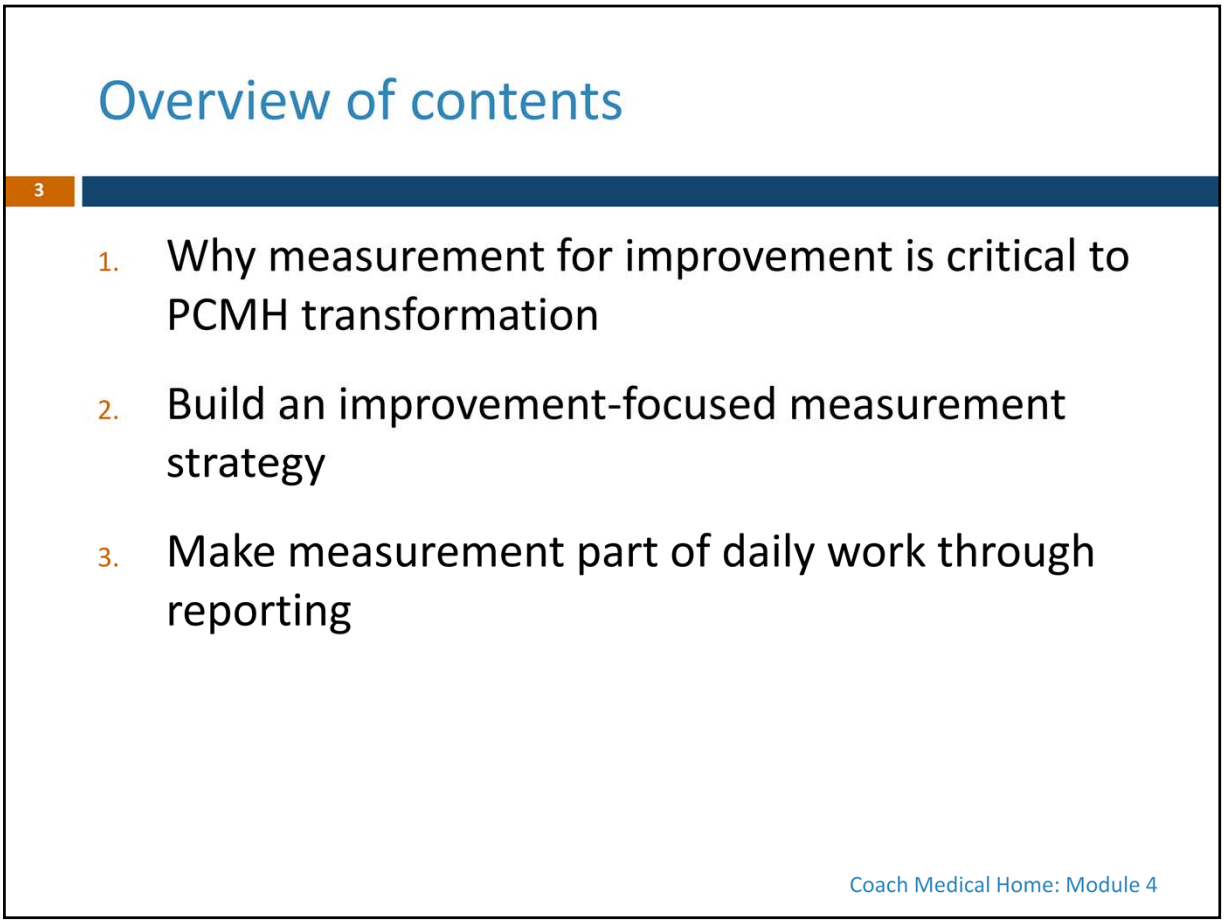


Measurement is an essential part of improvement and patient-centered medical home (PCMH) transformation. It clarifies goals and serves as a mechanism for communicating about them and monitoring progress. But why should practices put resources into this? And how do they set up an approach that balances the needs of leadership, recognition reporting, and day-to-day work?

This module tries equip you with practical examples and tested tools to support practices as they develop, implement, and sustain measurement approaches.

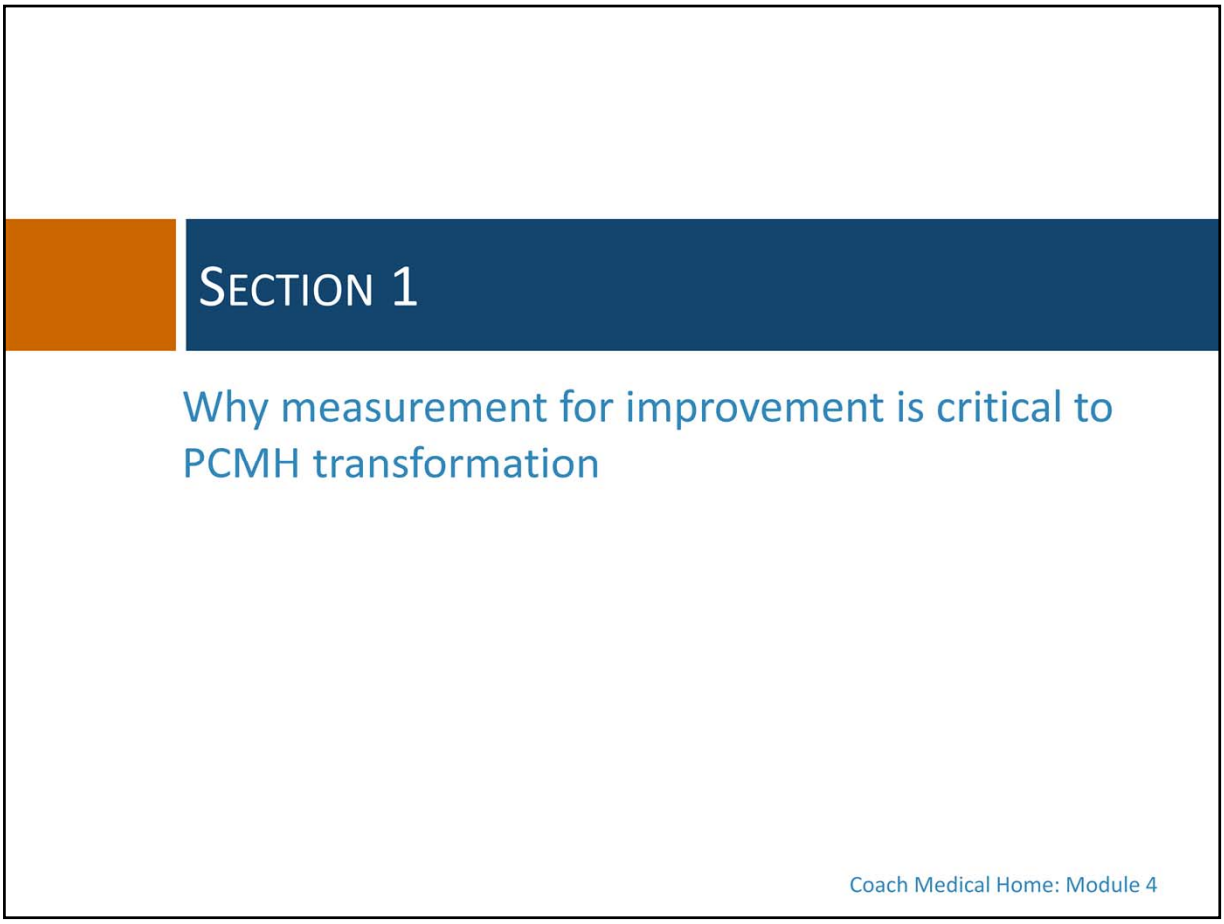


This module is divided into three sections that describe different aspects of the coach's role in helping practices use measurement to support PCMH transformation.

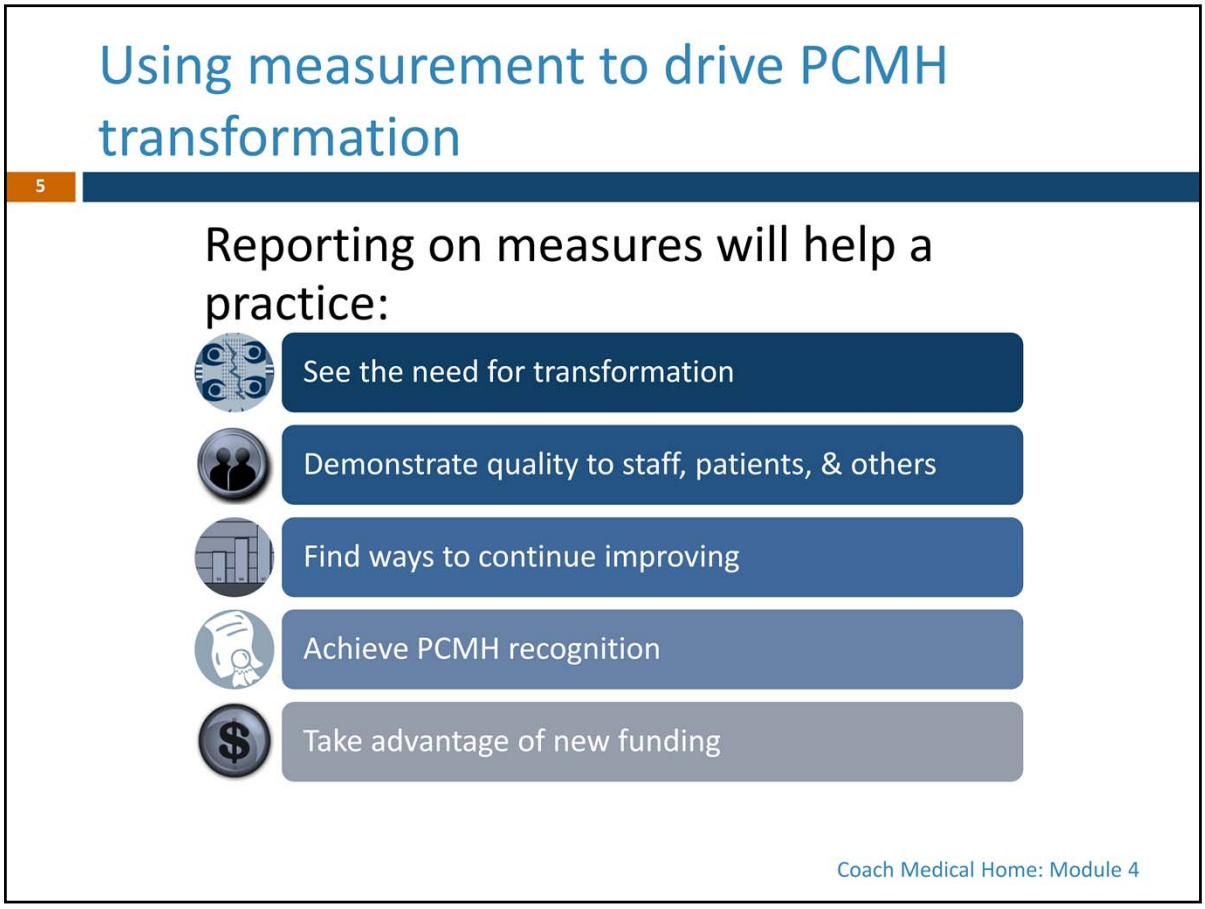
Throughout this module, you will find coaching tips and links to useful tools to help you accomplish the action step(s) listed on that page. Look for the following icons on certain pages:

The light bulb icon points out key tips and insights that will help you in your role as a coach.

The toolbox icon points out tools you can access via the link provided, or on the "Module 4: Measurement" page of www.CoachMedicalHome.org.



Measurement for improvement is a critical part of PCMH transformation. Nothing builds traction like seeing improvement in measures that can be related to changes made by staff. An improvement-focused measurement and reporting strategy aligns practice goals and external reporting requirements and sets up the practice to build momentum.

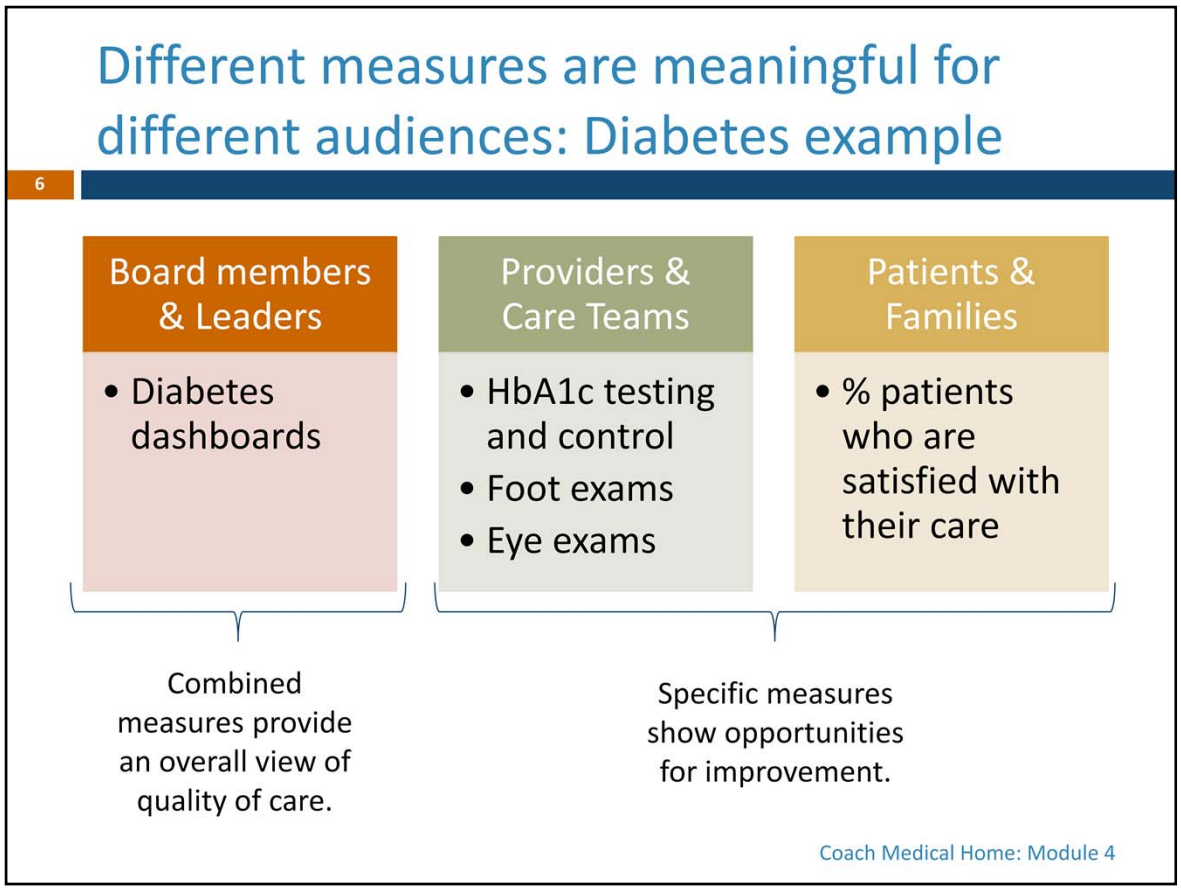


An essential part of PCMH transformation is measurement—tracking and reporting key outcomes related to quality of care and practice redesign. But it's important to remember that measurement alone is not enough—rather, a practice needs to use the results to identify the need for specific areas of improvement and then implement changes that lead to improvement.

Start your measurement discussions with a practice by making the case for why measurement is important. Help them understand the many ways that reporting on a set of measures supports practice goals for improvement and funding. Through measurement reporting, a practice can:

- Demonstrate to the board, leaders, staff, patients, and families that high-quality, evidence-based care is being provided in a timely manner.
- Identify opportunities for further improvement.
- Take steps to become recognized as a PCMH.
- Become eligible for additional funding and resources through Meaningful Use, pay-for performance programs, demonstration projects, grants, etc.

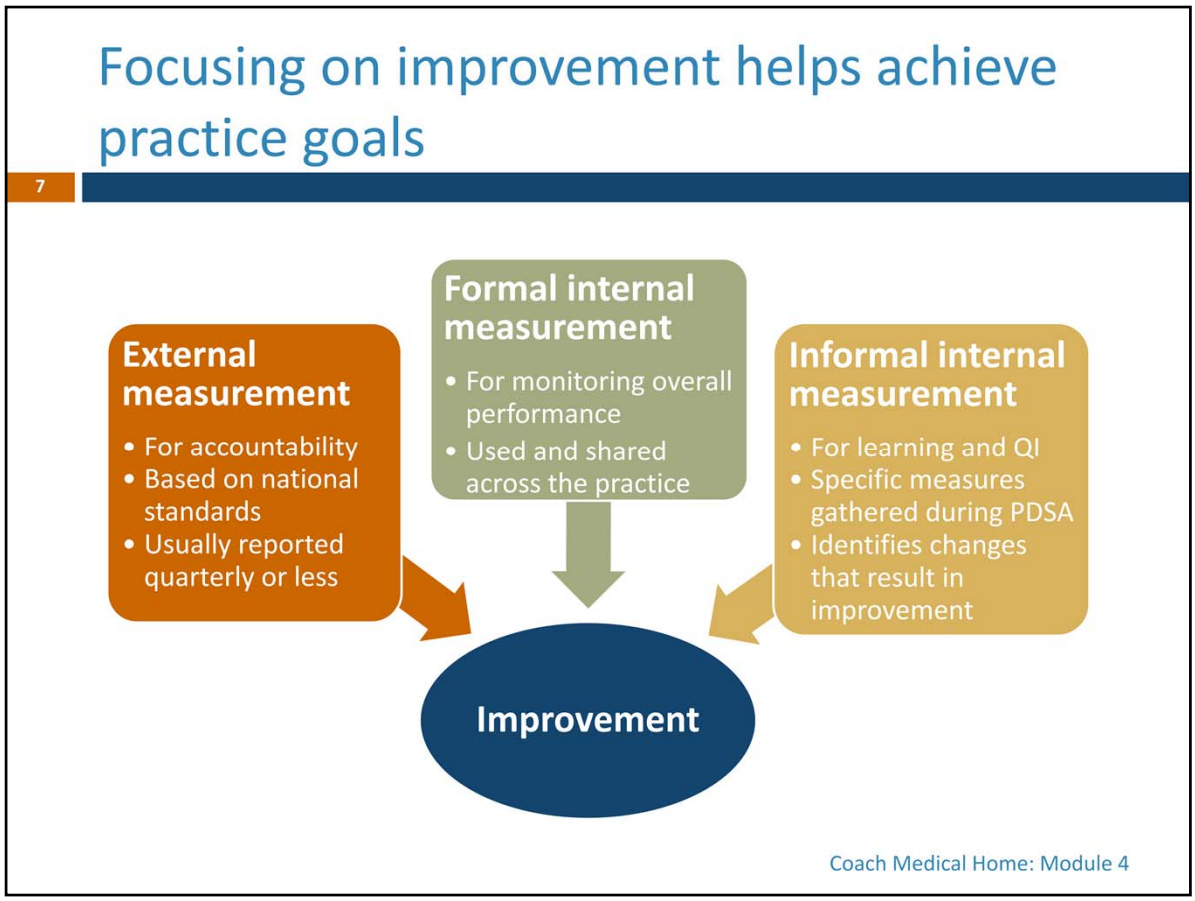
Stage 1 Meaningful Use, NCQA PCMH Standards and PQRS Measures Crosswalk
http://www.coachmedicalhome.org/sites/default/files/coachmedicalhome.org/mu-s2-ncqa-pcmh-2014-crosswalk.pdf



As a coach, it is important to be able to describe how to make required measurement meaningful for various audiences in the practice. Different audiences (board members, leaders, clinicians, and other staff) will want or need to see different measures.

The chart above shows different diabetes measures that may be important to different practice members. Board members and leaders are interested in the overall picture of health for this group of patients, so dashboards and other combined measures provide a quick glimpse of the quality of care. Clinical care teams and support staff are responsible for providing the highest quality of care possible to their panels of patients. The measures they need to understand are more specific and detailed—for example the proportion of patients with annual foot exams—because they need to see where opportunities for improvement exist. Patients and families want to have a satisfying experience with a care team they trust. They want to know they are in good hands—and that their health is likely to improve because of the care they are receiving.

Chart adapted from "Table 1: Examples of Types of Measures of Interest by Board or Staff" in Summer 2012 SNMHI Medical Home Digest.



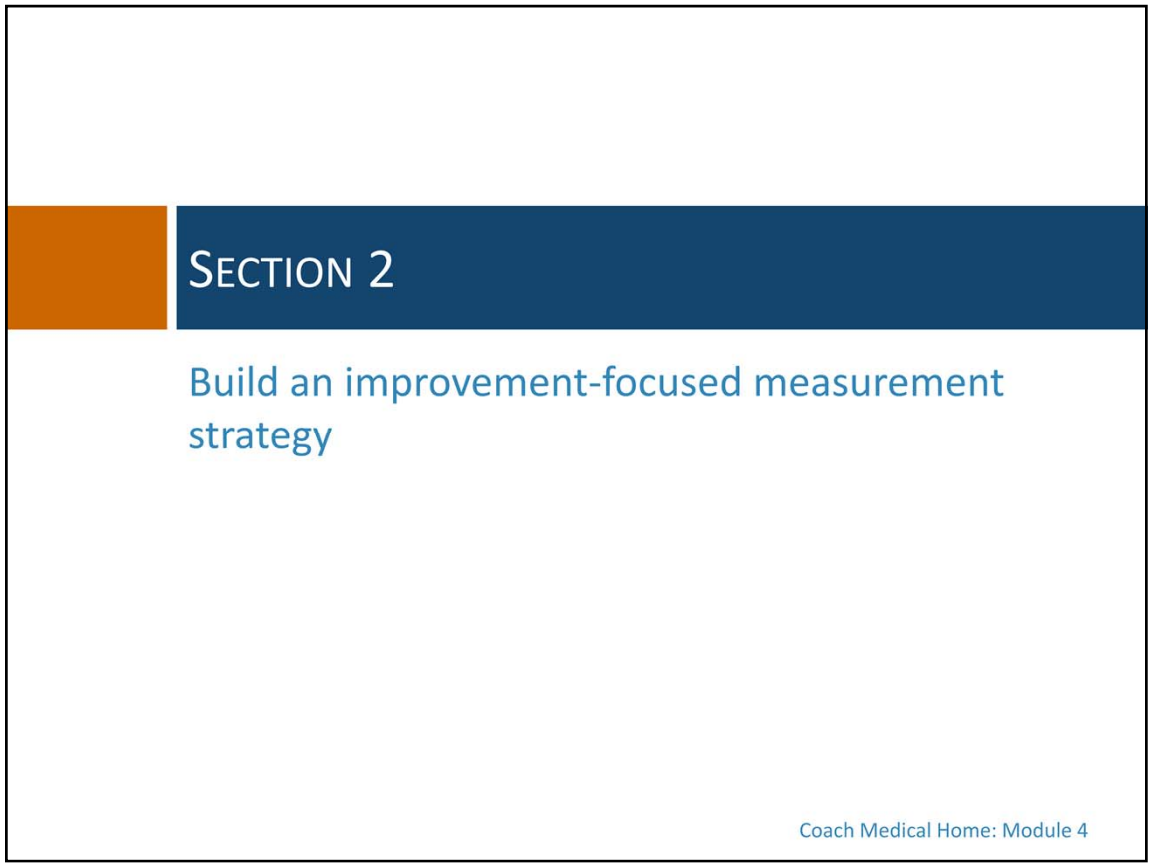
Practices often express frustration with measurement programs that are required for external purposes but not used internally. **A coach can help practices align measurement approaches by focusing on improvement.**

External measurement is for accountability, evaluation, or program monitoring. The measures are based on evidence-based practice guidelines and many have become nationally endorsed standards. Data are usually reported quarterly or less and are often sent to a central location to be combined and shared for comparison. Example: Bureau of Primary Health Care's Universal Data Set (UDS) measures.

Formal internal measurement is for monitoring the ongoing performance of a practice, site, or team. The measures are "formal" because they are used and shared across the organization. Board members and leaders use combined measures and dashboards reported monthly or less to get an at-a-glance view of care quality. Clinical teams use individual measures to understand where specific opportunities for improvement exist. Examples: quality and outcome measures, access measures, measures from QI initiatives.

Informal internal measurement is for learning and is used by teams and managers to determine which specific changes lead to improvements. Data are typically gathered during PDSA (plan-do-study-act) cycles or other small-scale tests. Measures may be reported as often as weekly and should be displayed visually to engage staff. Example: the number of foot exams on Tuesday for patients with diabetes after MA asked to remove socks and shoes.

Solberg LI, Mosser G, McDonald S. Jt Comm J Qual Improv. 1997 Mar;23(3):135-47. The three faces of performance measurement: improvement, accountability, and research.

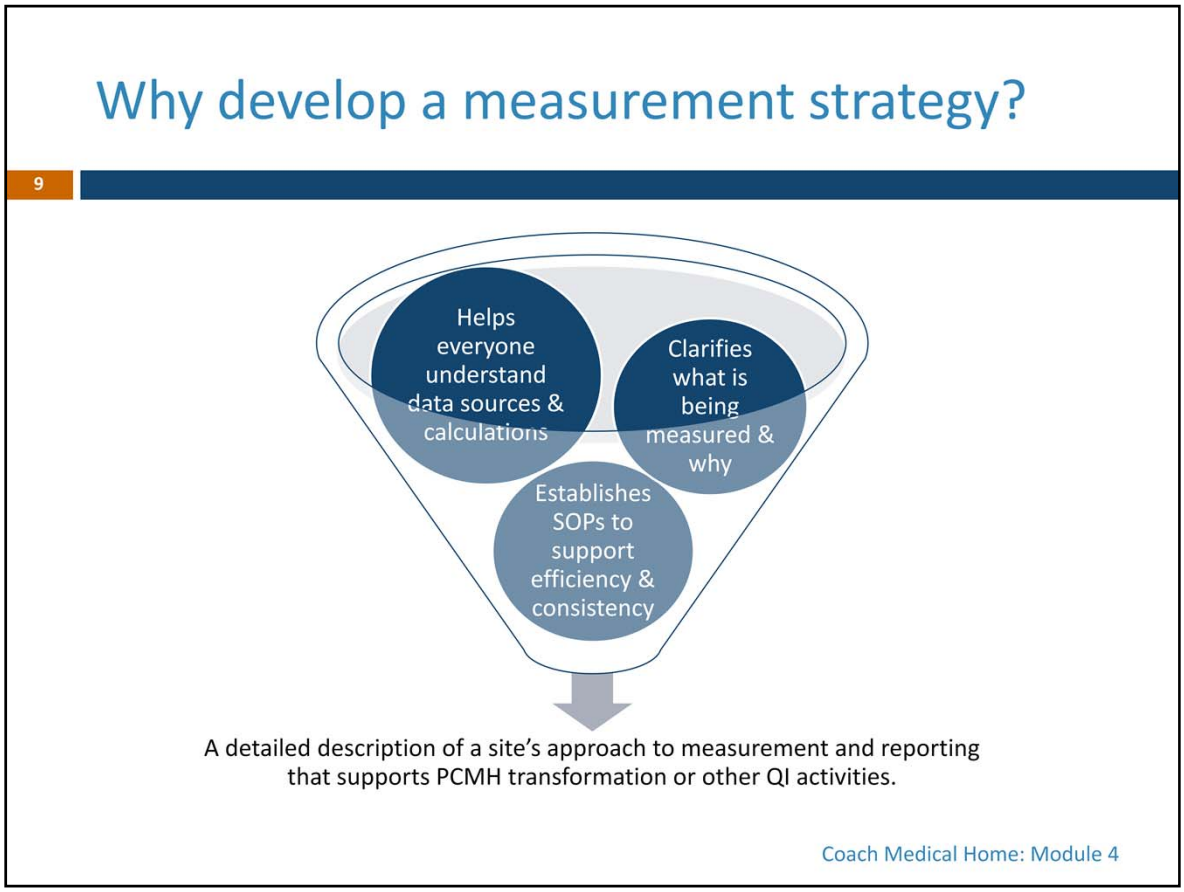


One of the most important things you can do as a coach is to support practices in building an effective and efficient measurement strategy. Ideally, the strategy will engage clinicians, staff, and patients in PCMH transformation and sustain their interest.

This section will help you facilitate a practice's efforts to build a strategy that brings value, fits their needs, and supports transformation efficiently.

Use the presentation slides, tools, and coaching tips provided to:

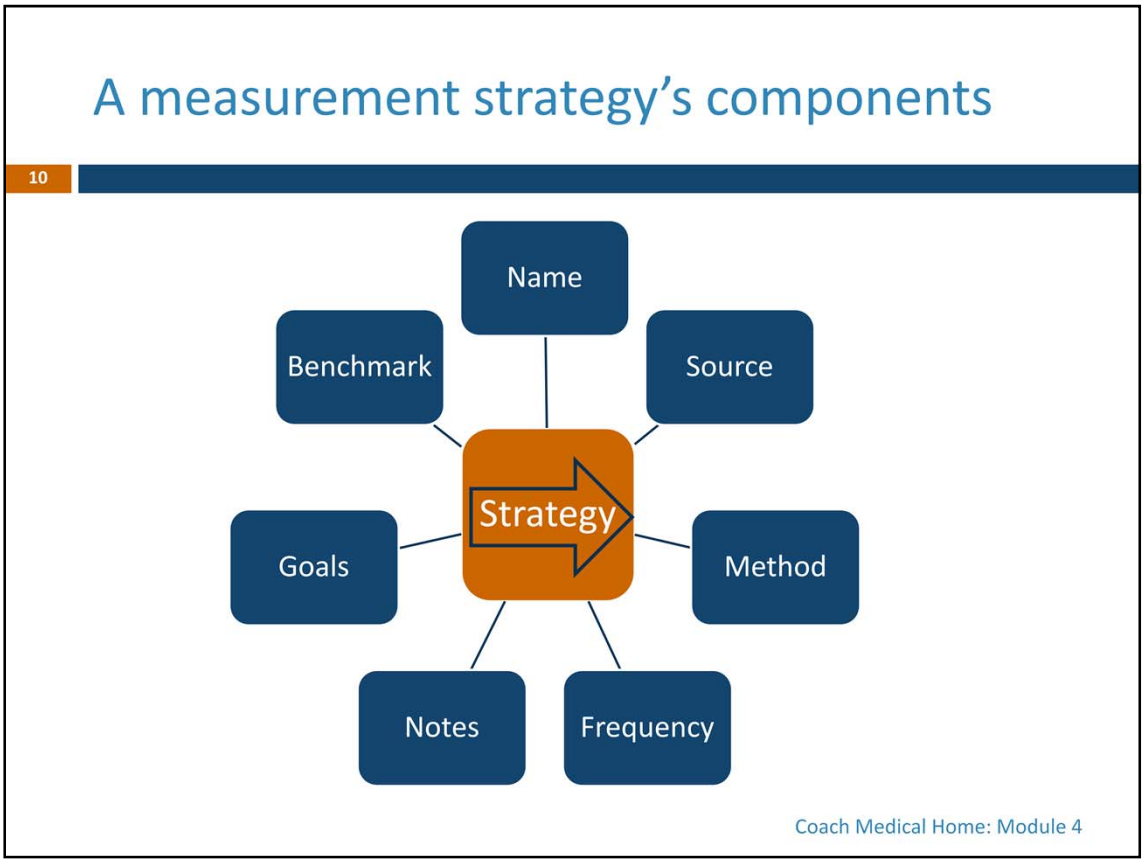
- Recommend tactics that will help the practice select measures that bring the most value
- Show a practice how to tie measurement to strategic goals and daily work
- Engage clinicians and staff in considering what to measure
- Help the practice decide on a balanced set of measures and a strategy they can sustain



Help leaders and staff understand the value of measurement and the importance of a formal measurement strategy. Emphasize benefits such as:

- It clearly outlines the approach to measurement so everyone knows what is being measured and why.
- It provides everyone with an understanding of where the data come from, how the measure is calculated, the frequency of measurement, etc.
- It establishes standard operating procedures (SOPs) so the work can be done efficiently and consistently over time.

It's often helpful to provide examples of what could happen if a formal measurement strategy is not in place. For example, if the person responsible for measurement reporting leaves before definitions of key measures are clearly specified, the practice may not be able to reproduce the data.



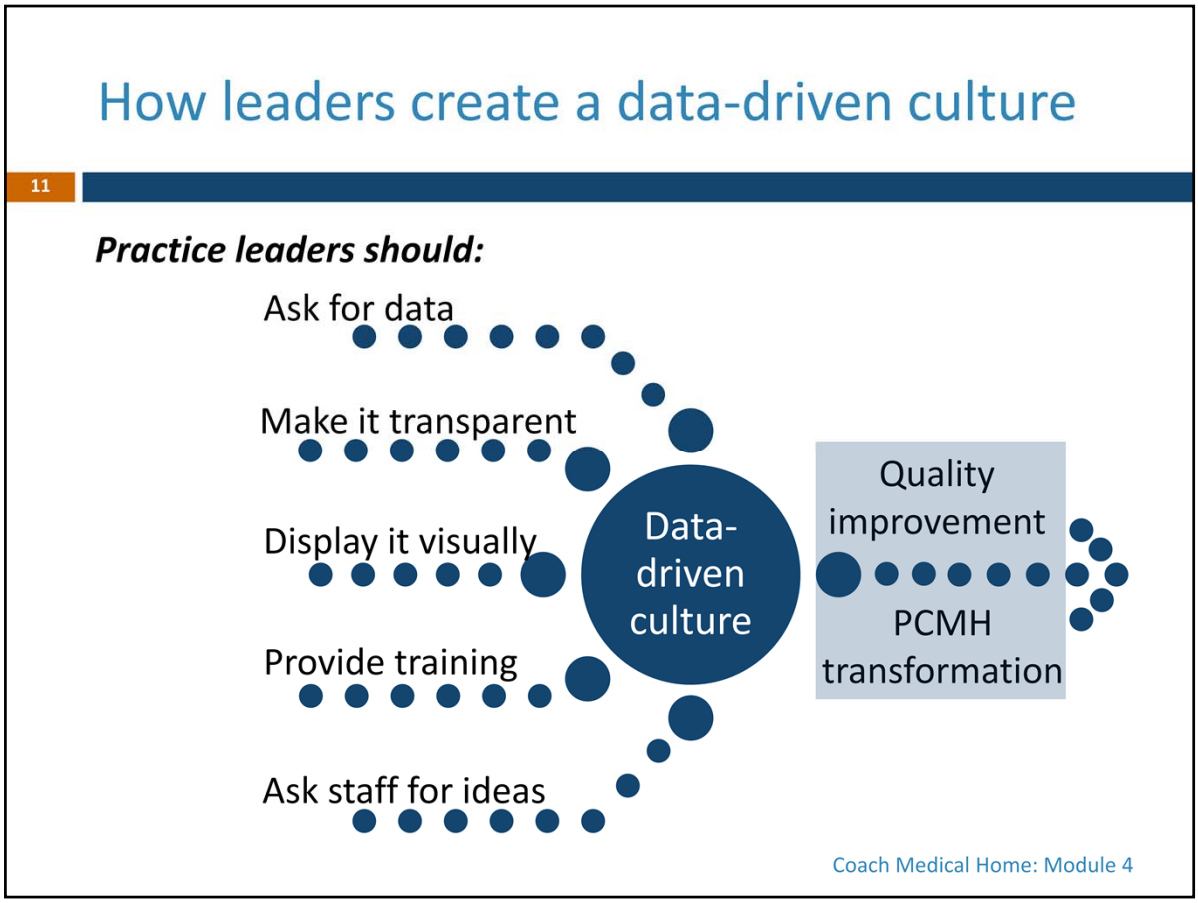
A measurement strategy is far more than a catalog of measures. Instead, it formally documents the practice's approach to measurement for improvement, inspired by overall transformation goals. The strategy's different components include:

- The name of the measure
- The data sources and definitions of the numerator and denominator
- The sampling method used
- The frequency of data collection
- Notes or other key details about the measure
- The goal or target the practice is aiming to achieve
- A national, state, or local benchmark

As a coach, your role is to help leaders and other practice members involved in measurement understand each component and how they fit together to build a formal strategy.

Measurement strategy worksheet: Use this during a coaching session. Ask the practice team to think about each of these items relative to a selected measure.

(Tool available at www.CoachMedicalHome.org in Module 4: Measurement)

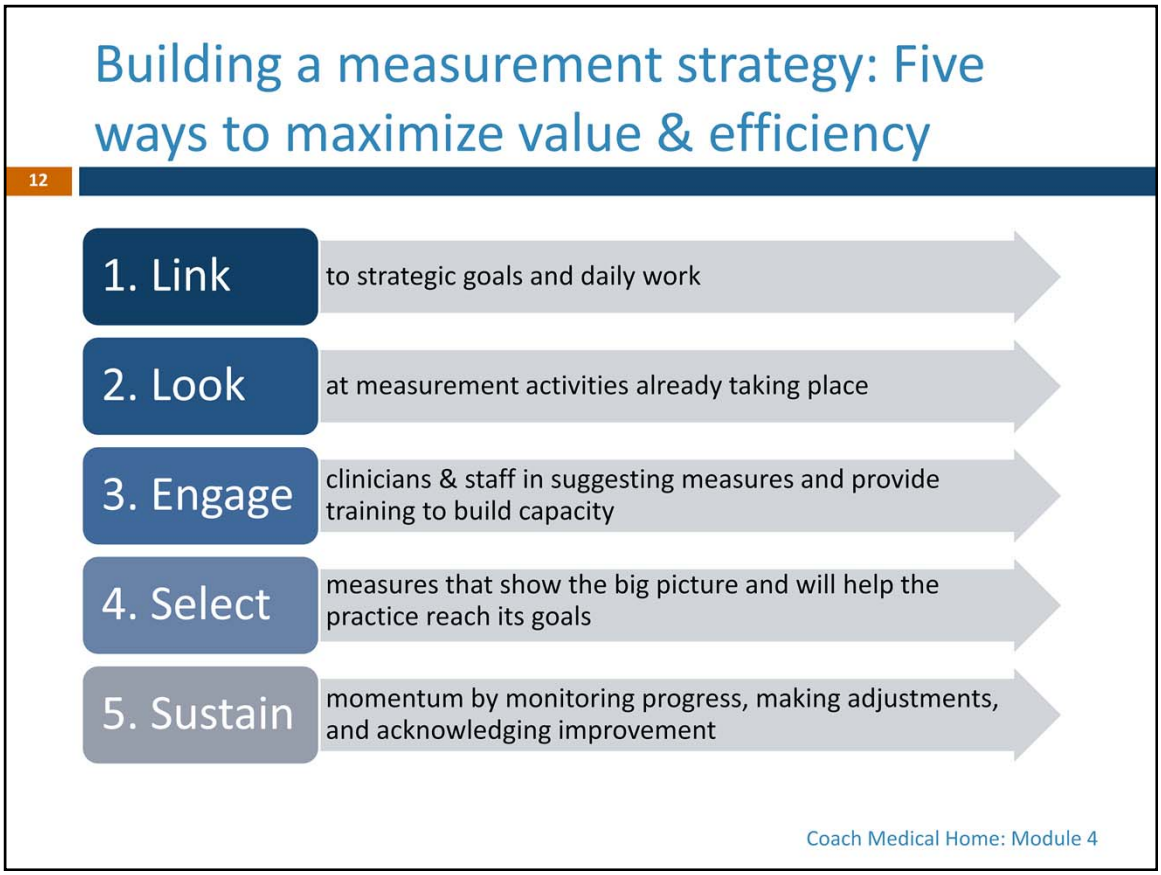


Using measurement to support PCMH transformation requires the sustained engagement and tangible support of a wide range of leaders across the practice. Their job is to continually emphasize that measurement is key to improvement efforts. By sponsoring a measurement strategy, leaders show that they value a data-driven culture that guides quality improvement efforts and PCMH transformation.

You can also point out actions shown above that leaders can take to show their support. By taking these steps, leaders will give the practice a vision for improvement, help identify changes to test, and build and sustain the will to engage in transformation:

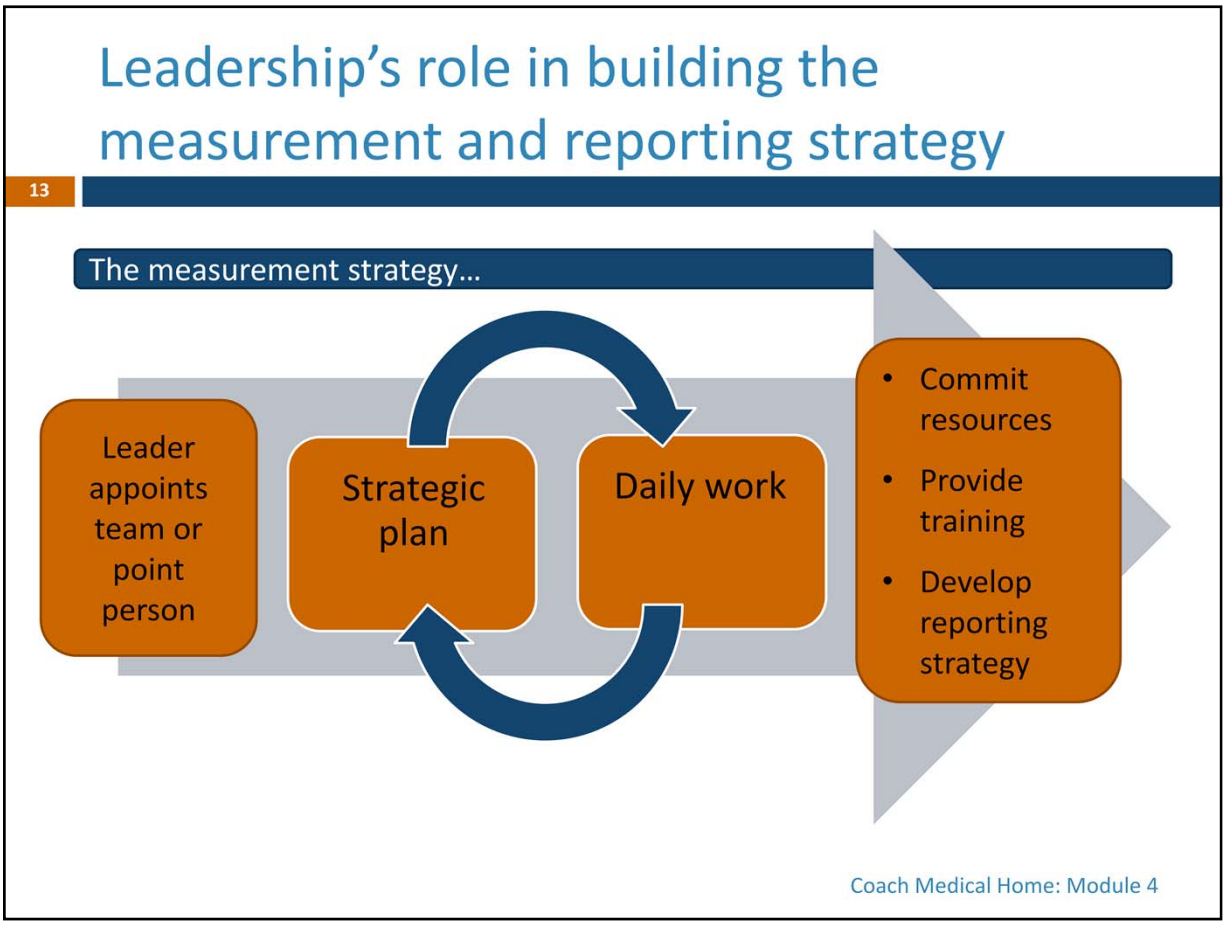
- Ask for data on a regular basis.
- Make QI data transparent across the organization.
- Visually display data and promote it at meetings.
- Provide training to help staff understand data and run charts.
- Ask staff for their ideas on how to improve.

SNMHI Implementation Guide – Engaged Leadership: Strategies for Guiding PCMH Transformation Within
http://www.safetynetmedicalhome.org/change-concepts/engaged-leadership



As a coach, you can guide the practice through specific steps to help them build an efficient strategy based on measures that provide the most value. The steps are summarized here and described in more detail in the following pages.

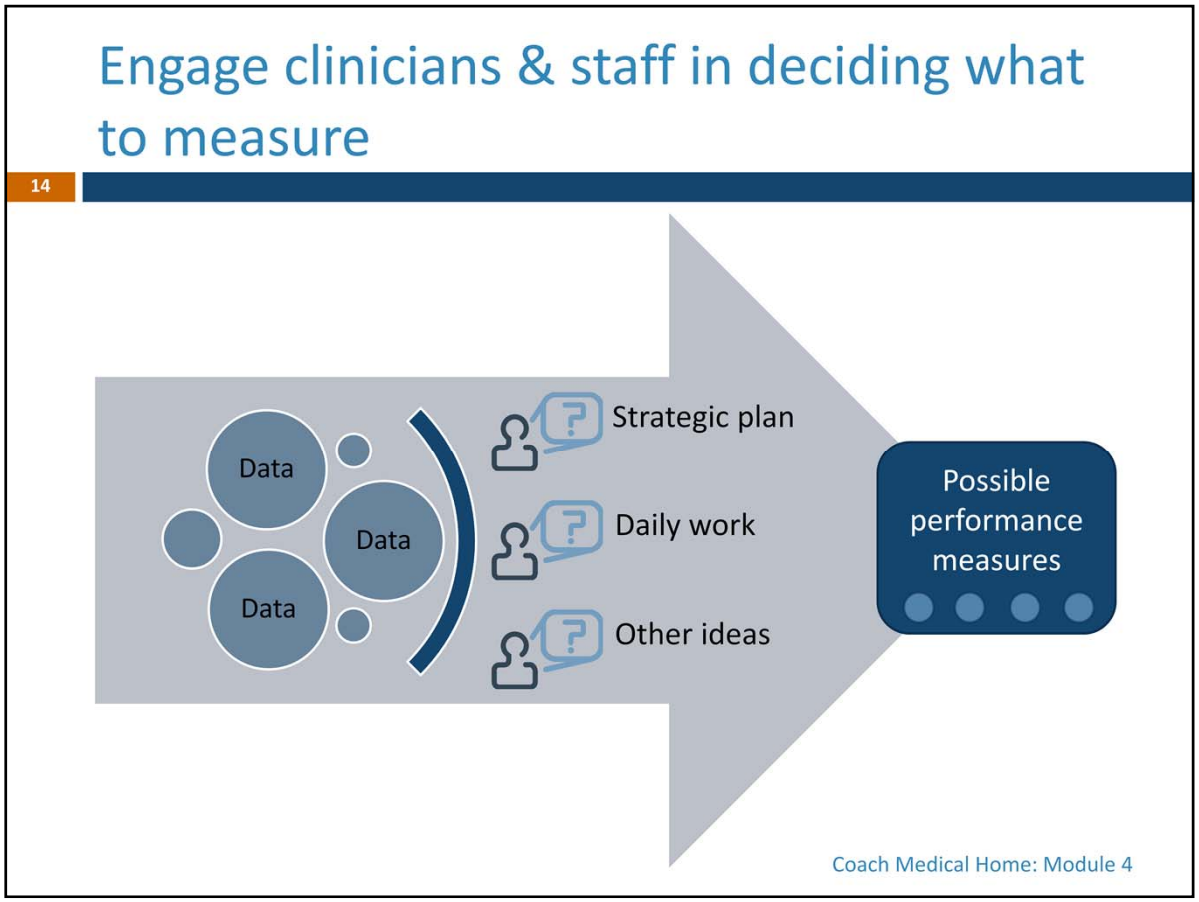
- The more the measurement strategy is tied to the practice's goals and integral to its workflow, the more sustainable it will be.
- Building on measurement activities already taking place at the practice maximizes efficiency by bringing to light valuable data that is already being collected.
- It's essential to engage clinicians and staff. The selected measures need to both reflect the big picture and provide data that are useful to them in everyday practice.
- Acknowledge success. This keeps staff engaged.



To build the measurement strategy, leadership should appoint a person or team to oversee and manage the measurement program and the process for selecting measures.

As a coach you can:

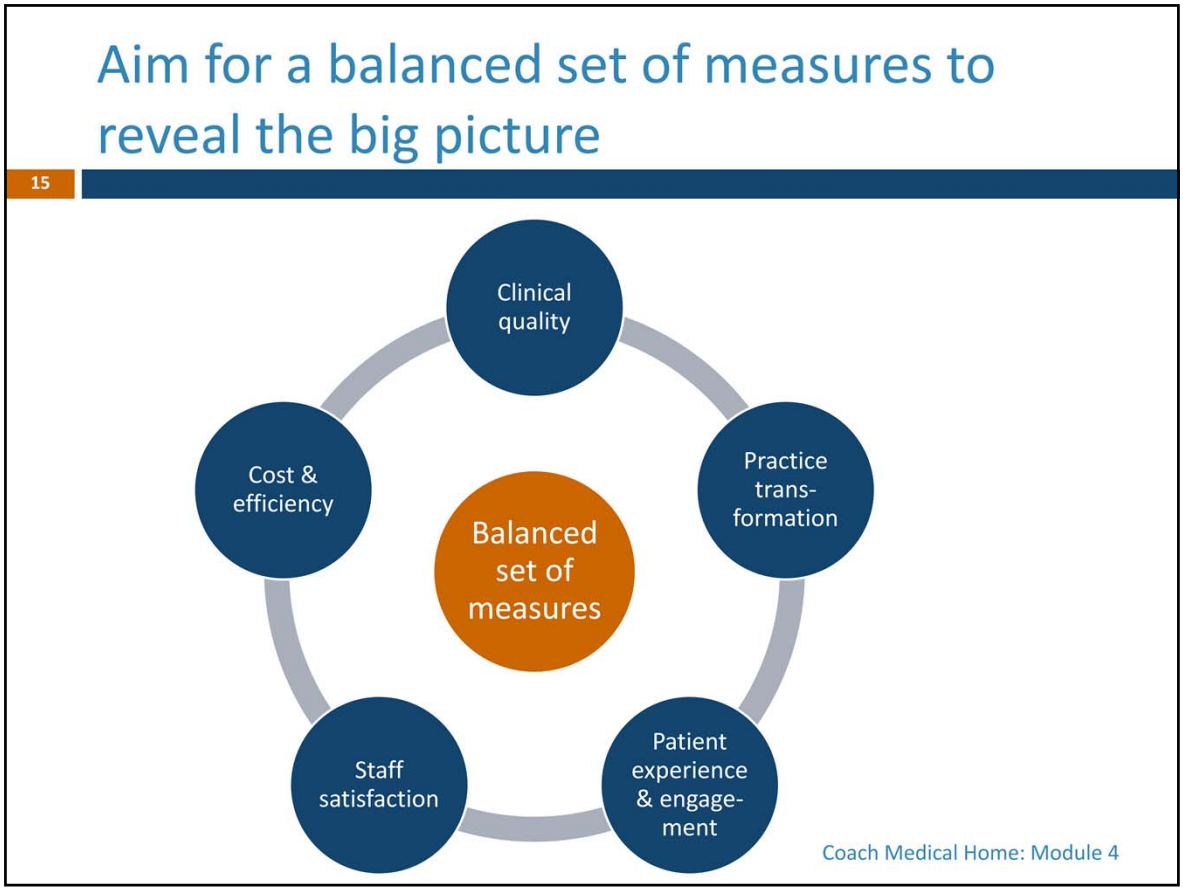
- Emphasize the importance of a point person.
- Recommend that the measurement team include a clinical champion, "data nut," IT staff, panel manager, front desk staff, and medical assistant.
- Help the practice see their strategic plan or other existing goals as a tool to begin shaping the measurement strategy.
- Check in within a week to see how practice is progressing; ask about successes and challenges.
- Check in within a month to see if a reporting strategy is in place.
- Ask leaders and staff about the value and understanding of the measures.



Input from clinicians and staff in what to measure is vital.

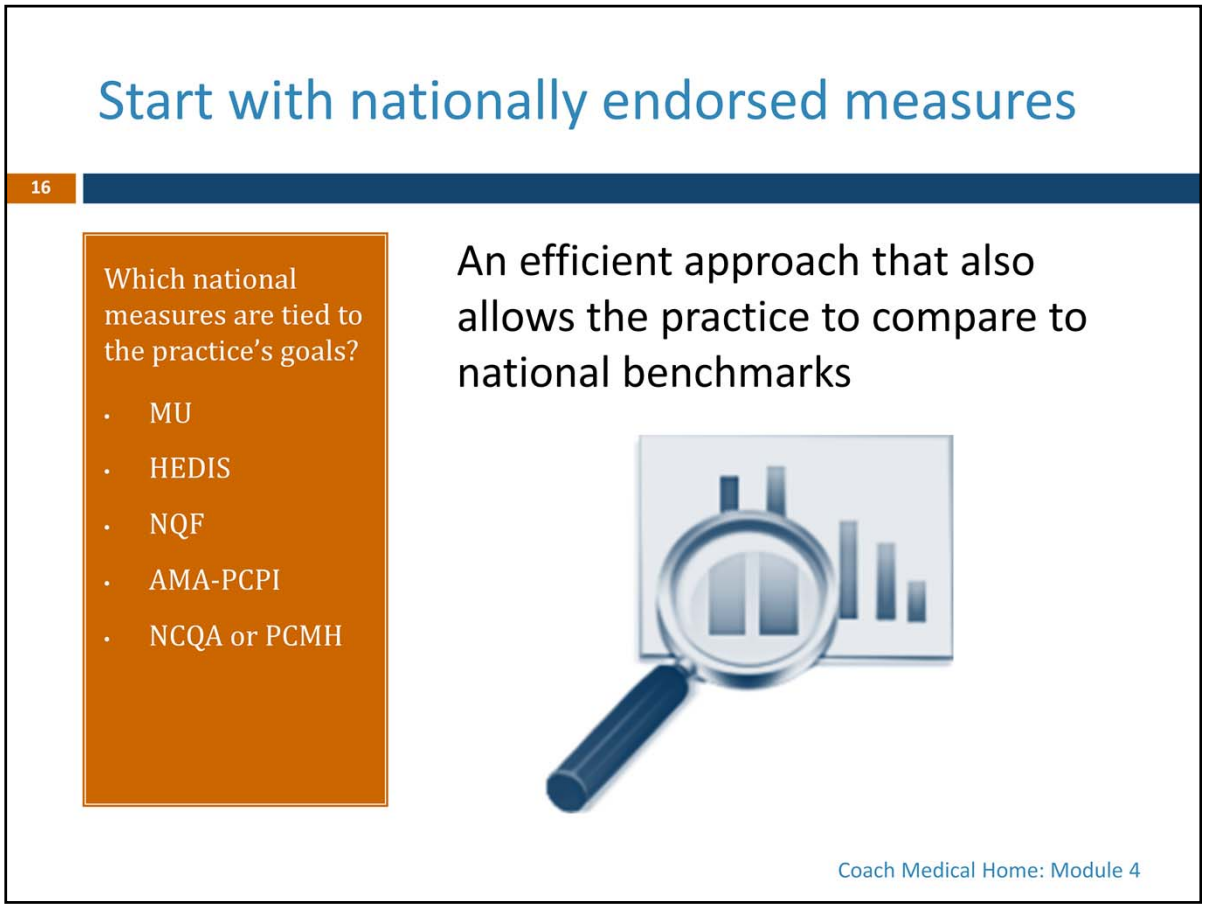
Coach the measurement team to try the following ideas as they engage with clinicians and staff. In addition, you can recommend to leaders and managers that they let teams measure something they think is important—even if it's not directly linked to the strategic plan or important to leadership. This will give them ownership around the measures.

- Ask them to think about measures that tie to the practice's mission and strategic plan. Examples: UDS, Meaningful Use, Pay for Performance.
- Encourage them to consider how the measure relates to or is built into their daily work.
- Identify the team members who are "data nuts" or who seem especially engaged in working with the data. They may already have ideas to share.



A balanced set of measures refers to a mix of measures from a variety of domains (clinical quality, practice transformation, patient experience, etc.). Having a balanced set of measures allows an organization to ensure that while improvements are being seen in one area or domain, unintended declines are not occurring in others. For example, if you improve the clinical quality measures or patient outcomes, but the new approach is viewed as unpleasant for patients and/or high cost, then the new approach will not be sustainable.

Have practices read: Putting Measurement Into Practice With a Clinical Instrument Panel
http://www.aafp.org/fpm/2003/0200/p43.pdf



Selecting specific measures to include in the measurement strategy is not always an easy task. Some practices may assume that their situation is so unique that everything must be customized, including performance measures.

Recommend that the practice start with a core set of nationally recognized and endorsed clinical performance measures—and then add other practice-level measures specific to their needs. Not only is this an efficient approach, it allows the practice to compare its performance to national benchmarks. Examples of national measures that serve as a good starting point include:

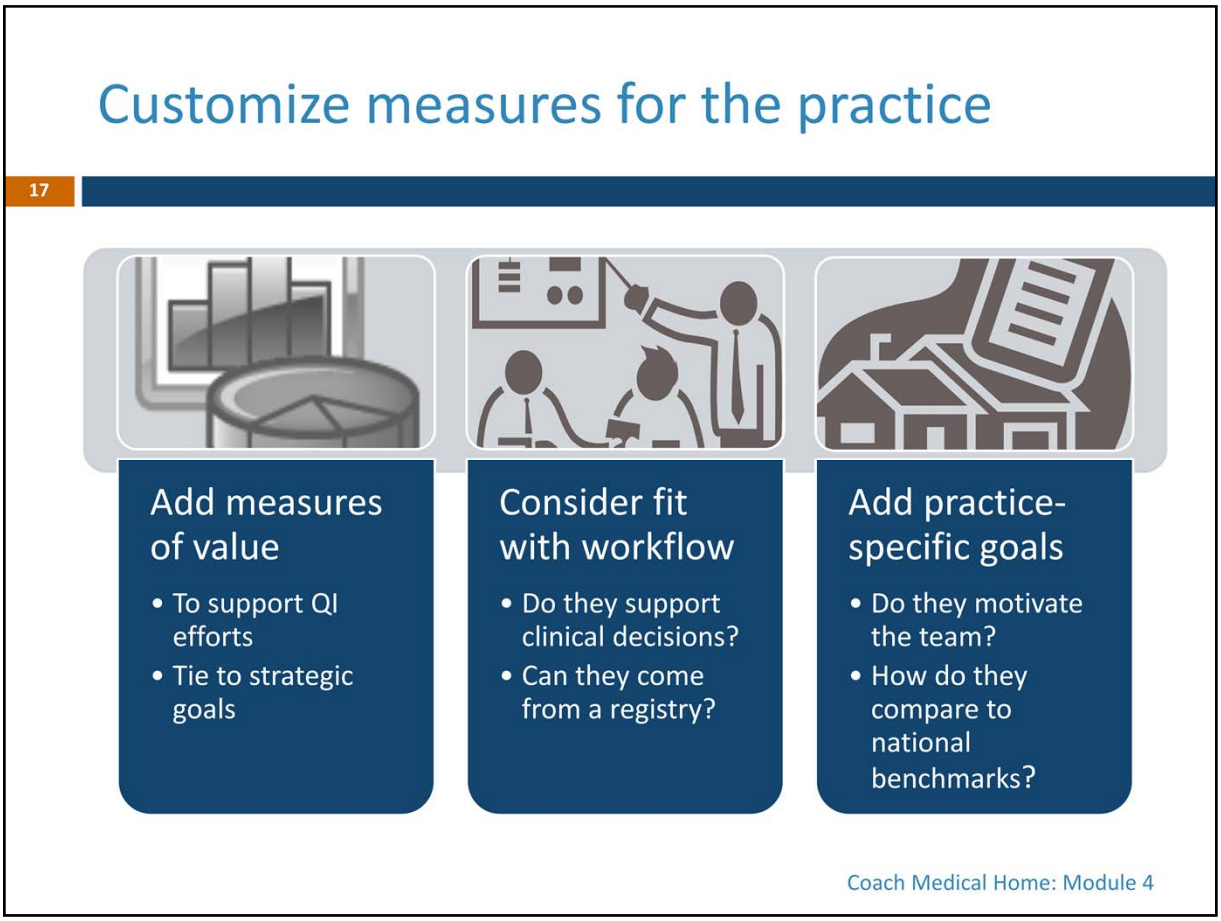
- Meaningful Use (MU) Clinical Quality Measures
- HEDIS® measurement set
- National Quality Forum (NQF) measures
- AMA Physicians Consortium for Performance Improvement measurement set

If NCQA PCMH™ Recognition or other PCMH recognition is among the practice's strategic goals, they should review the list of standards and measures that the recognition program requires. This can lead to a solid set of meaningful measures. Examples: measures of continuity or identification of the three most common and important conditions that would benefit from measurement and monitoring.

Menu of measures

SNMHI Threshold Reference Table

(Tools available at www.CoachMedicalHome.org in Module 4: Measurement)



Encourage practices to think about how they might incorporate measurement into the regular workflow. Remember to ask whether or not the data collection and reporting under consideration will help the clinical team make clinical decisions. For example, does the way that the practice proposes to measure diabetes care for reporting purposes also provide clinicians with the most recent HbA1C score for their patients? Also emphasize that accurate documentation is a critical part of making measurement useful.

Next, help the practice identify additional practice-specific goals that will motivate and stretch practice team members. It's also helpful to review how the goals selected compare to national benchmarks.

Finding value in measures that overlap

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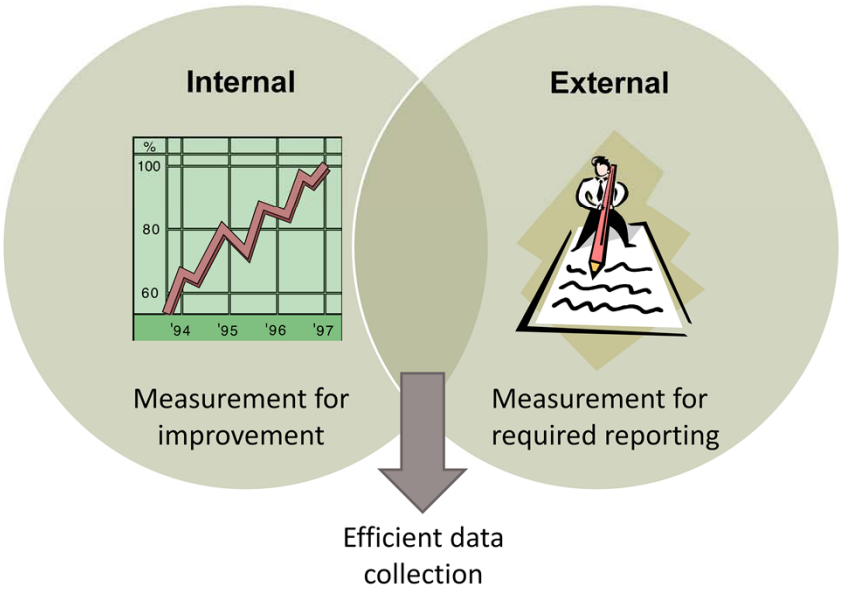
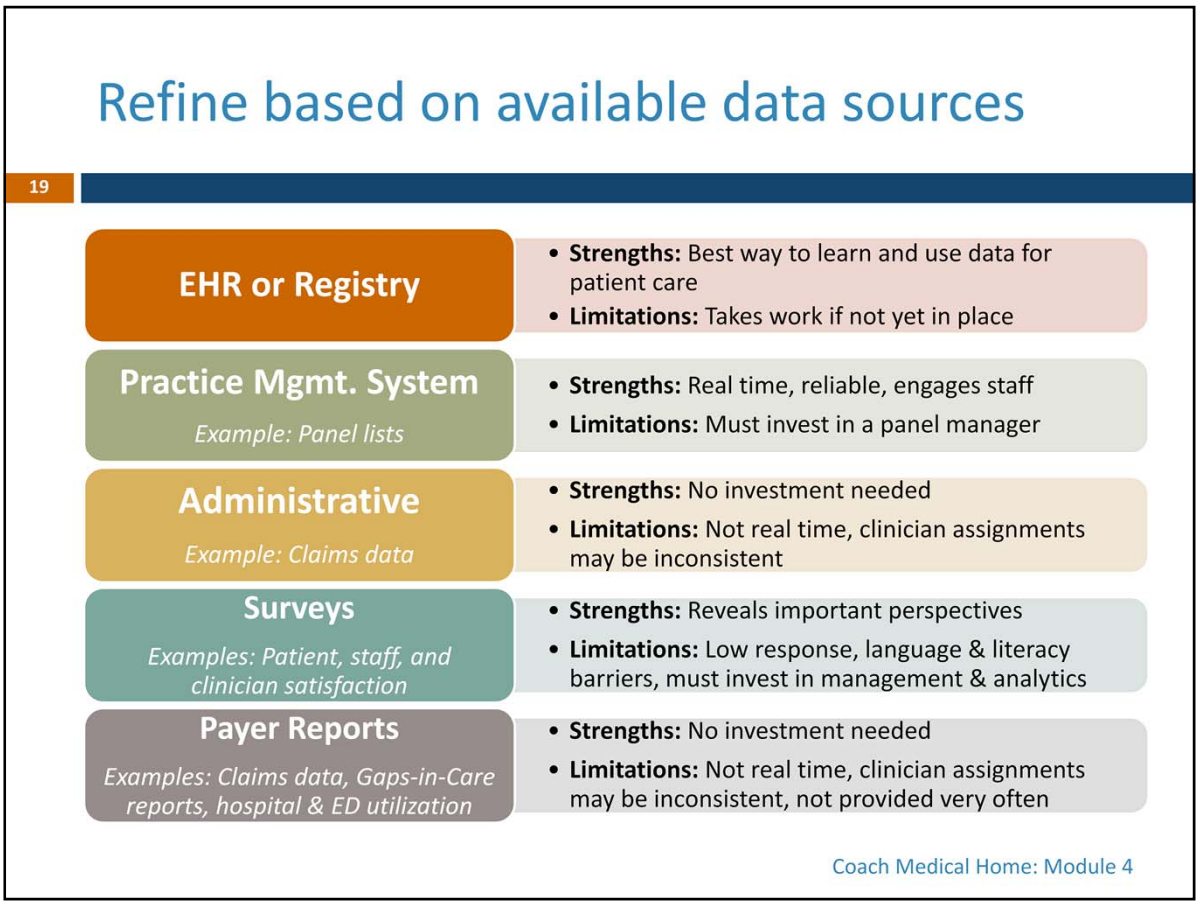


Coach Medical Home: Module 4

Remember that PCMH transformation usually involves both measurement for internal improvement efforts and measurement for external reporting.

Help the practice identify measures that serve multiple purposes because this will support efficient data collection. For example, many of the Meaningful Use measures can be constructed using data that also let care teams see who is in need of preventive services or follow-up care associated with chronic conditions. Again, good measurement hinges on good documentation.

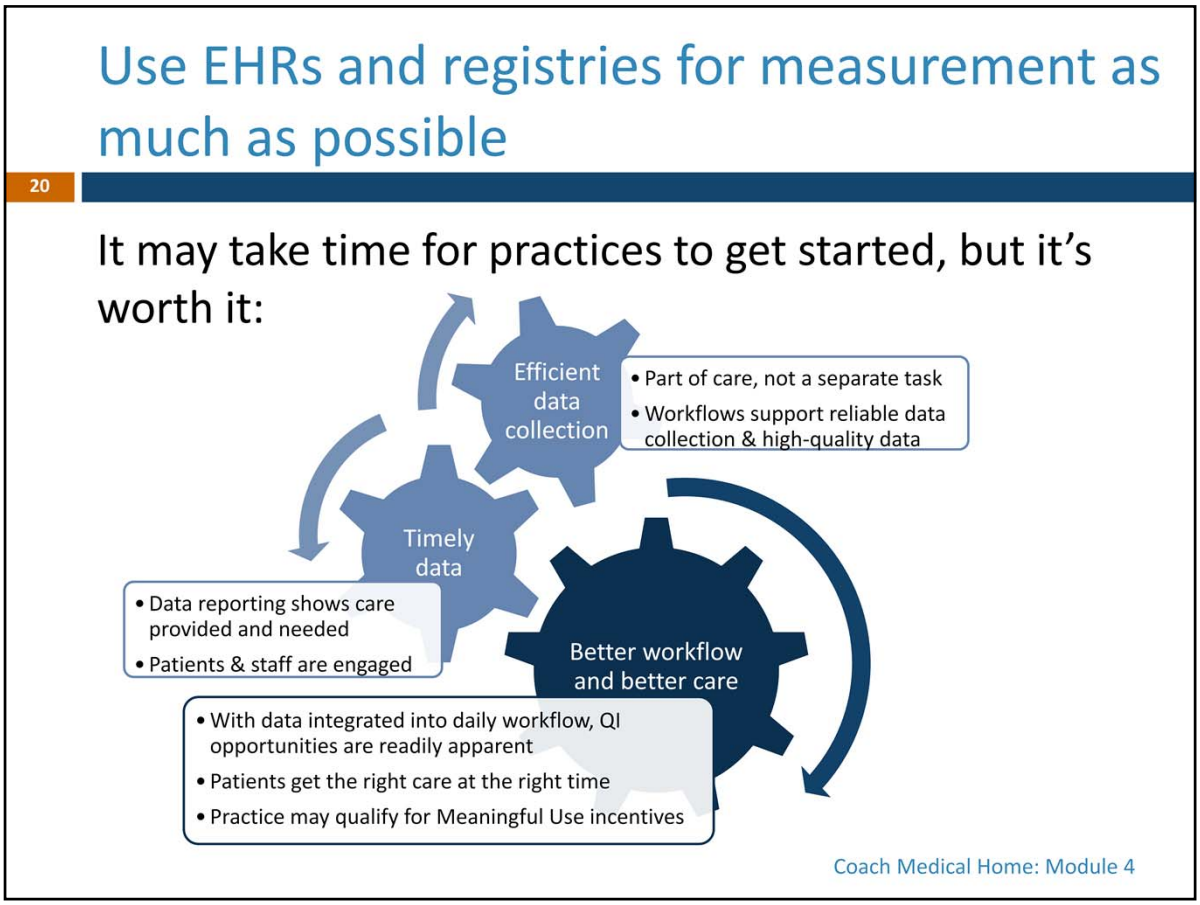


EHRs or registries are the best source of data for improvement because they allow measures to be integrated into the daily workflow. They contain up-to-date and clinically relevant information (unlike claims data). This is explained further on the next page.

That said, all organizations are in different places with EHR implementation or registry use and may need to continue to rely on manual/paper-based systems. **Help the practice select measures accordingly.** For example, if a stand-alone diabetes registry is in place, then consider focusing on diabetes measures.

Accurate measurement requires accurate documentation. The team designing the reporting strategy needs to work closely with providers. Providers need to agree on the data definition and fields.

Note: We intentionally use the term electronic health record (EHR) instead of electronic medical record (EMR). For more information on the distinction, please read: http://www.healthit.gov/buzz-blog/electronic-health-and-medical-records/emr-vs-ehr-difference/



EHRs and registries are critical for developing a measurement strategy because they:

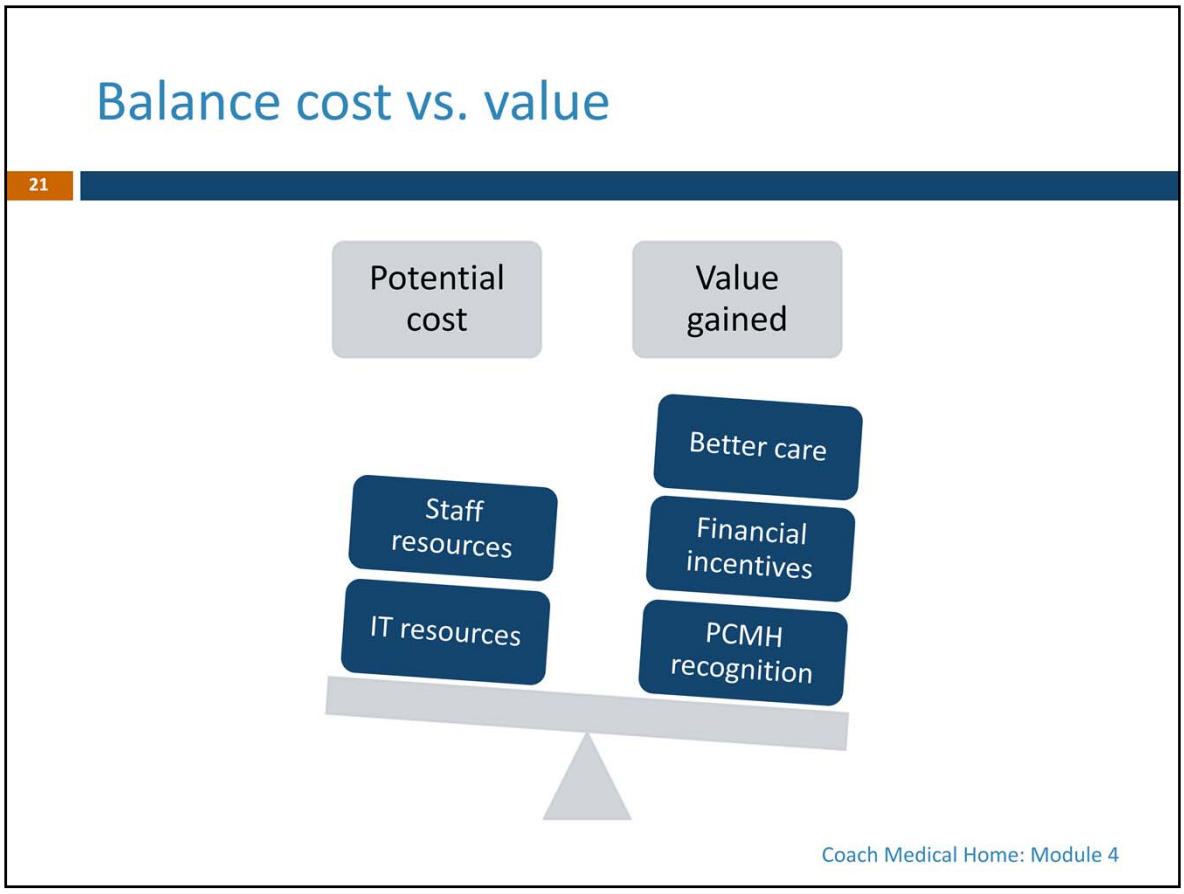
- Facilitate the complete and accurate documentation of key data elements.
- Allow for timely use of data to ensure patients get the right care at the right time.
- Support the care team in managing preventive and chronic care needs efficiently. They help the care team prepare for the day, conduct outreach with patients, and manage panels effectively.

The coach's role is not to provide or implement HIT, but rather to:

- Make the case for investing in HIT and training. For example, you can explain how Meaningful Use and PCMH overlap.
- Help staff and leaders frame questions to HIT vendors or enlist support from vendor user groups or Regional Extension Center (REC).
- Connect practice sites that have similar registries so they can learn from each other and share templates and workflows.
- Make sure that data capture is as complete and accurate as possible.

Registries Made Simple
http://www.aafp.org/fpm/2011/0500/p11.html?aafpvlogin=0230552&aafpvpw=&URL_success=http%3A%2F%2Fwww.aafp.org%2Ffpm%2F2011%2F0500%2Fp11.html

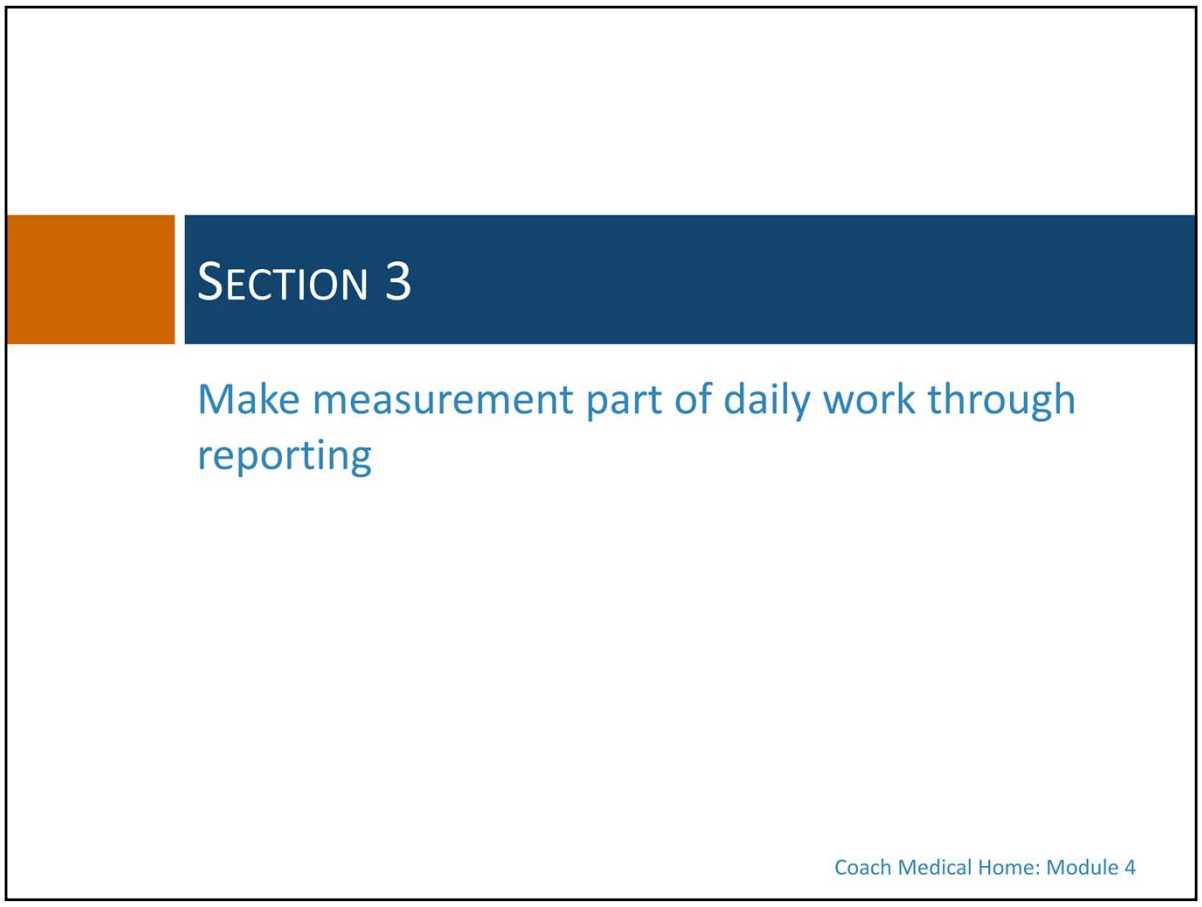
AAFP Video on Registries: Consider viewing this 13-minute video at a staff meeting during your next site visit, then discuss how these concepts translate for the practice.
http://www.aafp.org/online/en/home/membership/initiatives/pcmh/aafpleads/aafppcmh/pcmhvideos.html



Measures that focus on improvement are what will best support PCMH transformation—but don't forget the practical aspects.

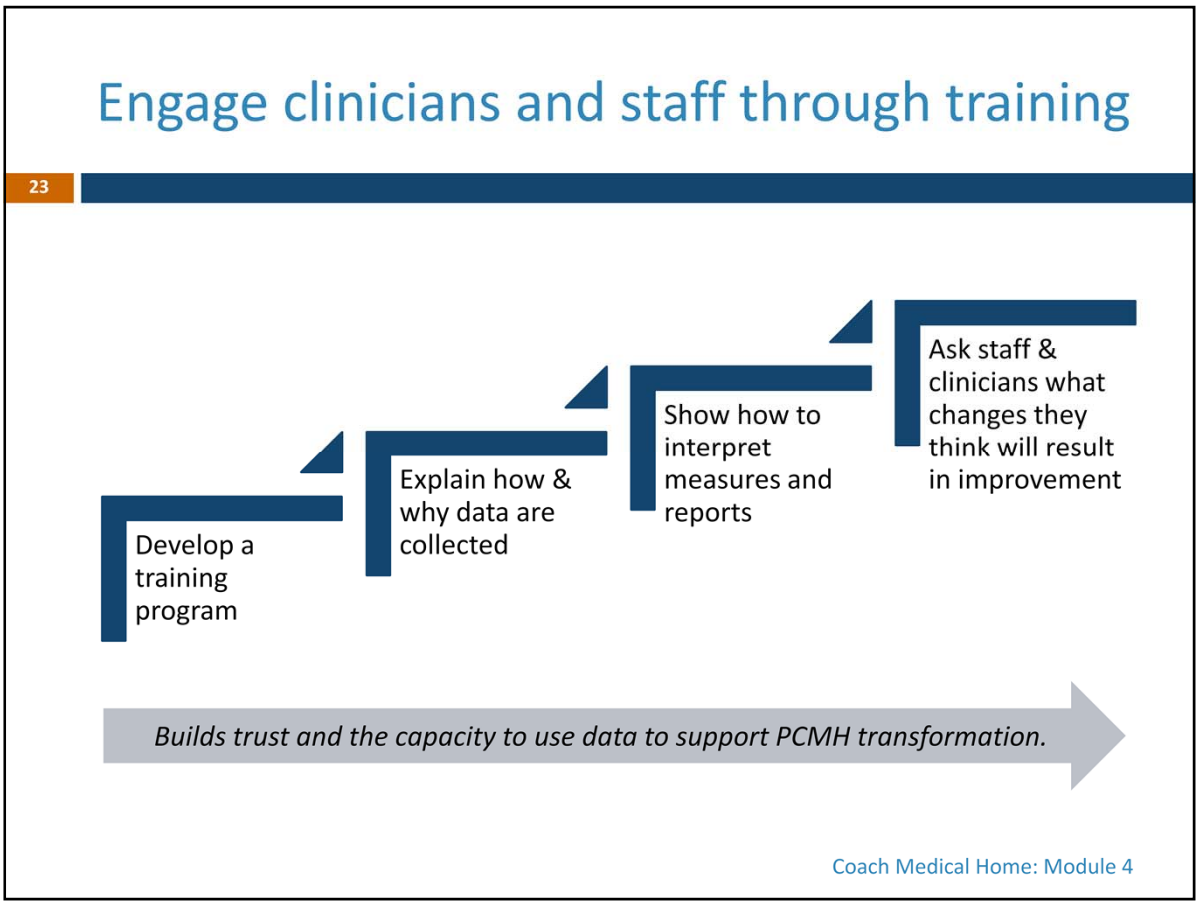
Some measures, particularly those that are part of external pay-for-reporting programs, can **bring funds into the organization or prevent decreases in reimbursement** if not reported. The potential gains/losses tied to measures is an important consideration. Meaningful Use measures are a good example of measures that can work for both QI and accountability with financial compensation currently tied to reporting.

Finally, consider the resources that the staff and practice will need to devote to specific measures. Select measures that minimize the cost of maintaining them. This should be balanced with the investment to have measures of value available to drive improvements in care.



Once the measurement strategy has been developed, the practice needs to use reports in daily work to support improvement. This section includes tools and resources for coaches on how to engage the practice in effective reporting.

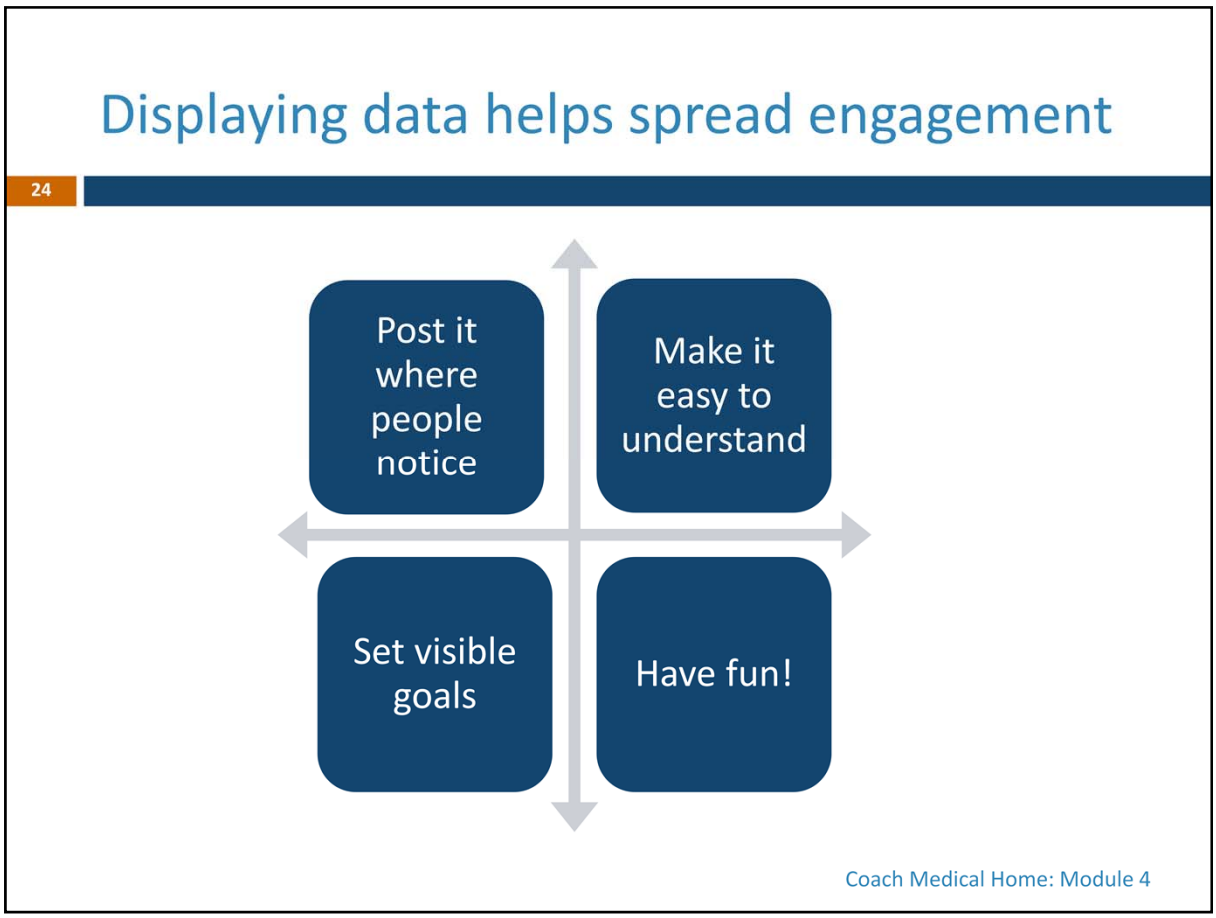
- Designing strategies to engage staff and patients
- Best practices for making data transparent
- Run charts and dashboards
- Sustaining momentum



All clinicians and staff need to be comfortable with the data in order for it to actually support improvement. Providing staff training around measurement not only ensures that everyone knows how to interpret measures, it also helps ensure that each team member understands their role in helping to improve the practice's performance on these measures. This can build their trust and pique their interest in measurement. Training should thoroughly explain why and how the data are collected and should demonstrate how to interpret measures, graphs, and other reports.

Encourage leaders to plan for a training program to build the practice's capacity to use and report the data effectively.

Encourage the transformation team to include a patient and to engage patients and families in ideas for improving measures.



The best way for the practice to engage staff is to display and discuss data in a way that engages all:

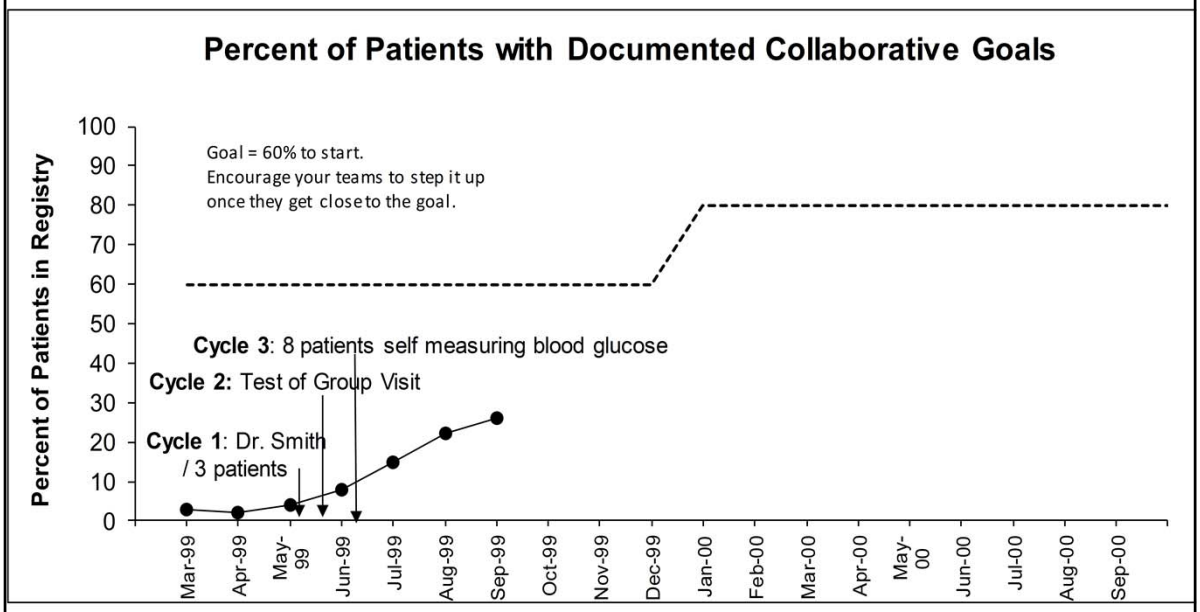
- Place data everywhere and post it visually (see examples on the next page).
- Make sure it's easy to understand.
- Set visible goals based on national performance targets.
- Report data regularly (monthly to start, then weekly).
- Report at the team level whenever possible.
- Celebrate success.
- Make it fun!

As a coach, you can support the practice by:

- Providing examples.
- Checking back with leaders. Encourage them to put data into email messages and presentations that are routinely shared with all staff.
- Encourage the transformation team to set attainable goals that challenge staff without causing people to feel discouraged.

Access several sample presentations and worksheets on the "Module 4: Measurement" page of www.CoachMedicalHome.org.

Minimum standard for monthly reporting: Annotated run chart



One of the best ways to visually display data over time is on run charts. Ideally these run charts are available for each of the care teams. Initially, however, run charts for all patients in the practice may be more readily available. Care team performance on specific measures may vary and the processes/workflows that are used may vary. It is best to look at the performance over time by care team, discuss the differences, and steal shamelessly what is working!

Ask the practice to show you their current process for developing and displaying reports. If they are not using run charts with data over time, then share the samples available on coachmedicalhome.org

Coach the staff member with dedicated time for measurement reporting on how to use these tools. Remember to check back in a week to see how it is going. Also, consider placing a call to the leader to ask how they liked the run charts.

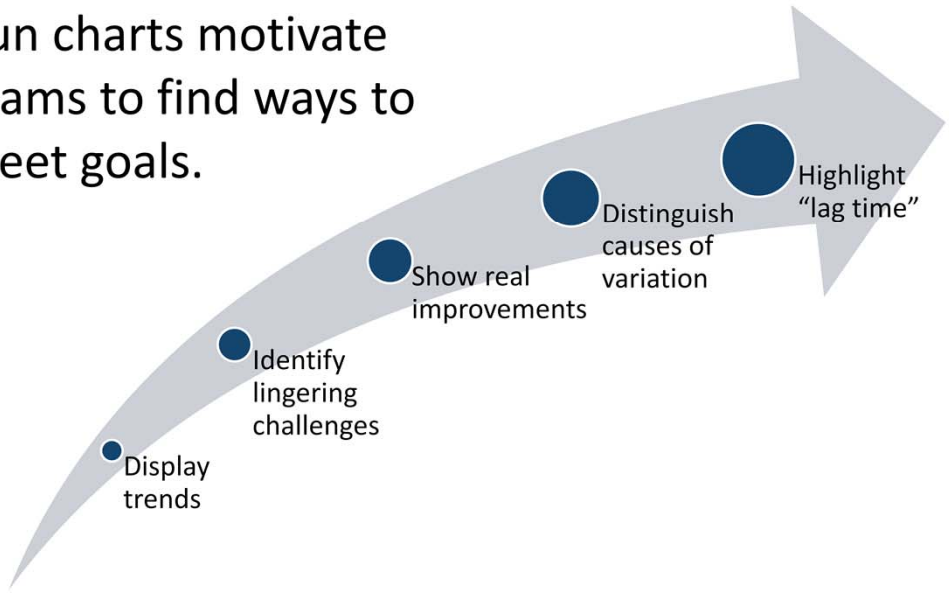
When you review these with the team**, emphasize the importance of the annotations or changes that were made** so that changes that result in improvements can be shared across the organization.

Do-It-Yourself run chart tool (Tool available at www.CoachMedicalHome.org in Module 4: Measurement)

Why run charts work so well

26

Run charts motivate teams to find ways to meet goals.



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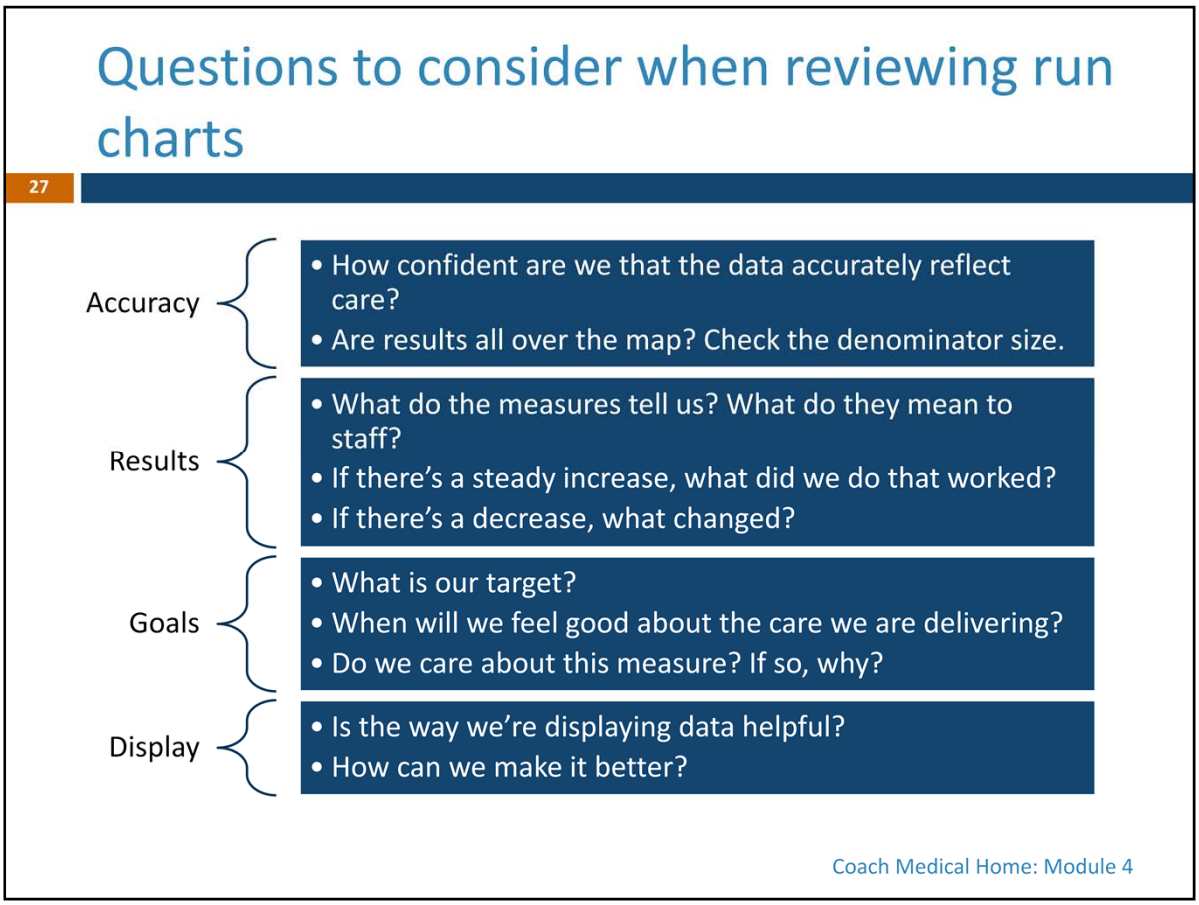
If the practice is hesitant about trying out a run chart, you can make the case by emphasizing the points in the slide and showing examples. Try it out on something that the practice thinks it can improve quickly. And then celebrate results. Also, consider showing an example such as the expected rise of influenza cases in the winter to help the team understand the difference between common cause variation and special cause variation.

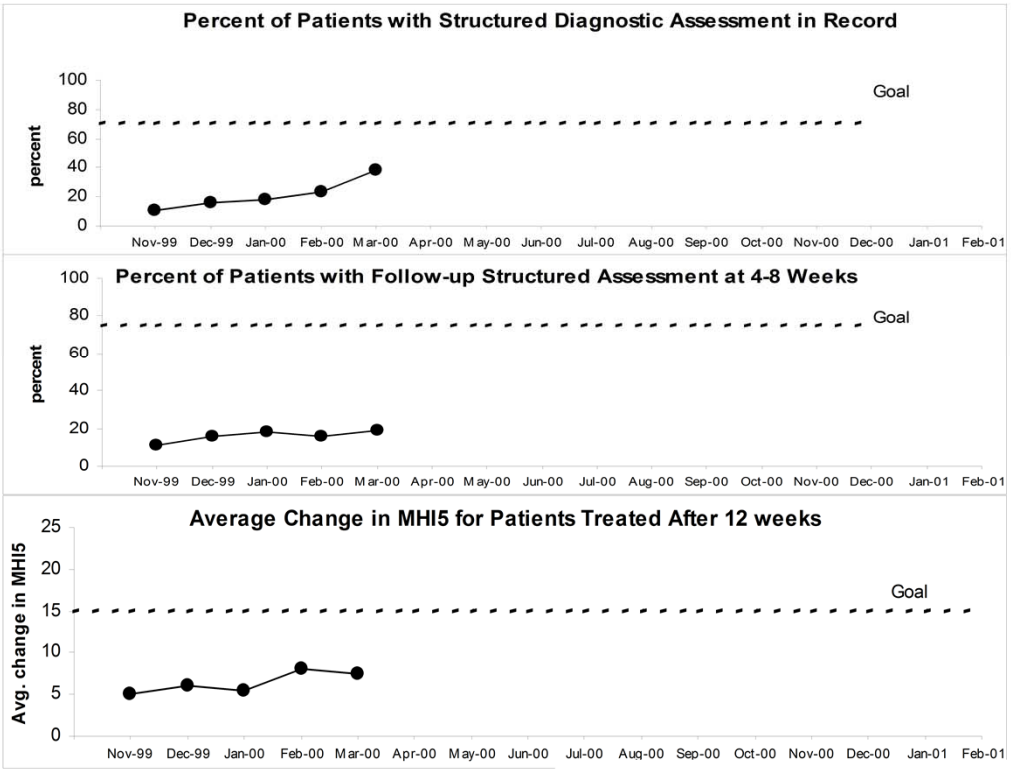


Asking specific questions about measures displayed in a run chart will help the practice make the most of the data by ensuring a clear link to transformation goals. It also facilitates discussion of the results and can improve data accuracy and display.

When measures don't move:

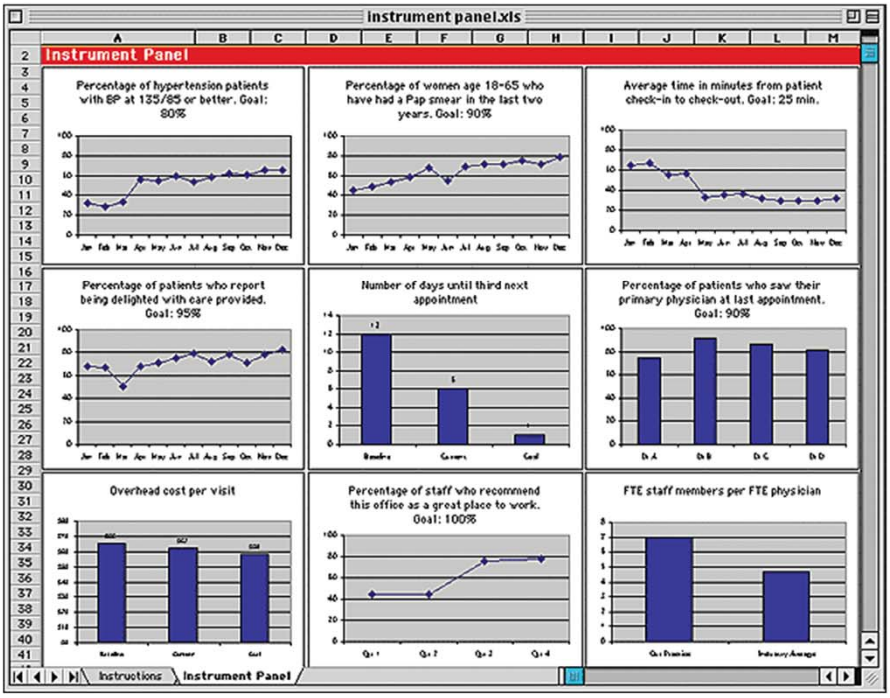
- Take time with the team to re-energize and hold a learning session.
- Drill down on patient care to help identify solutions. Prompt with questions like: How do you follow up? How do you reach out?

A family of measures refines understanding



This slide provides an example of different measures of mental health symptoms. It visually demonstrates an approach you can take to look at a family of measures or balanced set of measures. It is possible that as improvements are seen in one area (e.g., clinical quality) another measure is impacted negatively (e.g., decreased patient satisfaction or increased costs). **Looking at these measures together makes these connections evident.**

A dashboard provides a broader view



This example shows a balanced set of clinical quality, practice transformation, patient satisfaction, staff satisfaction, and operational measures. Depending on the sophistication of the HIT and support by IT staff, the practice may already be able to produce a similar report.

Clinical Quality measures:

- Controlled hypertension
- Cervical cancer screening

Practice Transformation/Efficiency

- Cycle Time or average time (in minutes) from check-in to check-out
- Number of days to 3rd next available appointment
- Continuity: % of patients who saw their PCP

Satisfaction

- Patient satisfaction: % delighted with care provided
- Staff satisfaction: % of staff who recommend the office as a great place to work

Operational

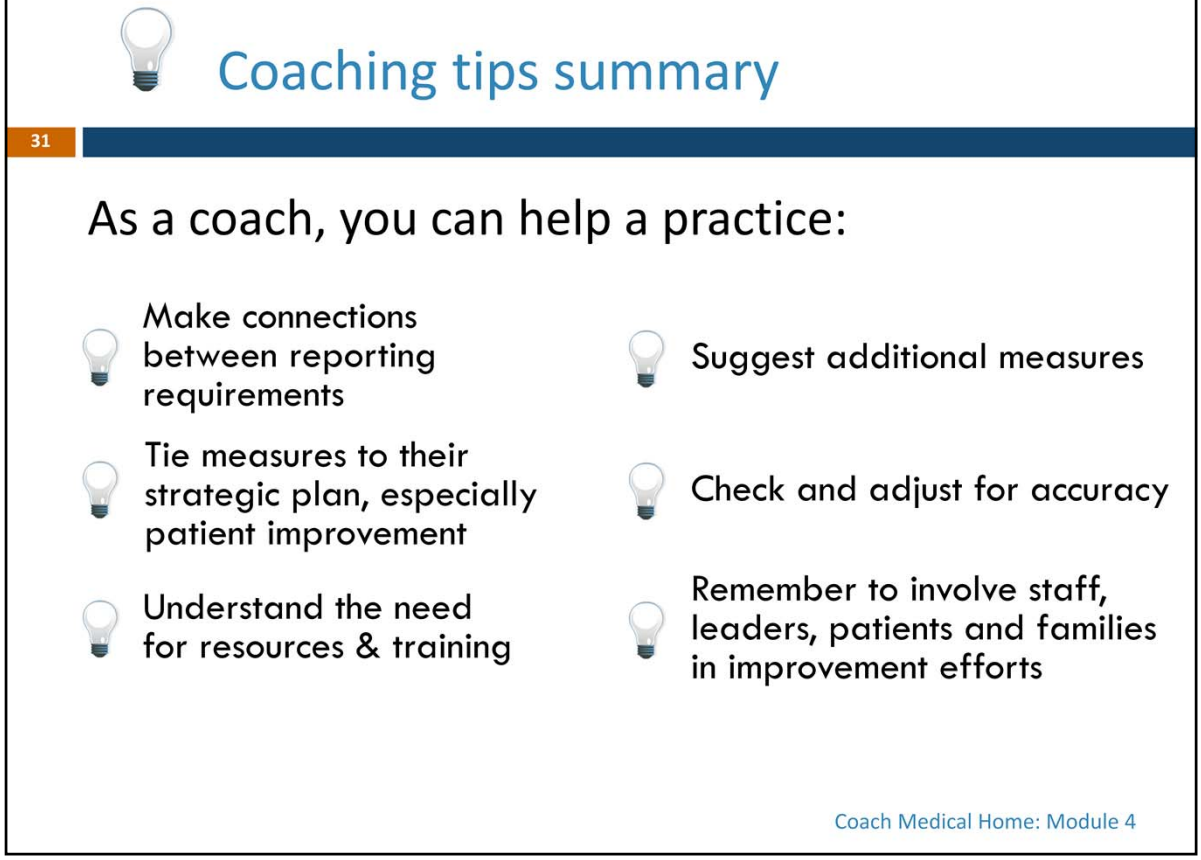
- Overhead cost per visit
- FTE staff to FTE physician

These charts were created in an Excel tool available as part of Putting Measurement into Practice with a Clinical Instrument Panel. http://www.aafp.org/fpm/2003/0200/p43.pdf

Example data wall for staff and patients

Measurement Wall at Community Health Partners, Inc., Livingston, Montana

This slide provides a visual example of a data wall. **Encourage practices to be transparent and display team level data on a wall where staff (and patients) can view it.** This will stimulate conversations and friendly competition resulting in improvements for patients!



In addition to the tips above, **be patient and persistent**. This work takes time outside of visit hours. Set due dates, send reminders, and then check on progress. Encourage leaders to make this a priority and gently hold them accountable.

Here are some helpful questions and talking points:

- "My understanding is that we agreed to complete the measurement strategy worksheet for the balanced set of seven measures by Tuesday. Do you have questions about the worksheet?"
- "What makes this a difficult step to accomplish? How can your manager better support you in getting this completed?"
- "Once this step is completed your practice will be closer to having a report on measures that show how well your community is receiving preventive services and the right care for their chronic conditions. You will be able to reach out to patients who are overdue and invite them to come in for care. This is all about making sure the your community is as healthy as it can be."