Quality Improvement (QI)/Performance Measurement (PM) is a formal methodology that enables health centers to leverage data collection and analysis, process improvement, and performance benchmarking.

Health centers are using QI and PM as one Population Health Management (PHM) strategy to achieve the “Quadruple Aim” — improved patient experiences, improved clinical outcomes and lowered costs while also improving the work life of health care providers.

Adopting the five core concepts of PHM will lead to better care, improved health outcomes, and cost savings for all.

Population Health Management (PHM) is a “set of interventions that can improve people’s health across the full continuum of care…” (Felt-Lisk, S. & Higgins, T.)

The 5 Core Concepts of PHM are:
1. Patient-Centered Access
2. Team-Based Care
3. Care Management
4. Care Coordination
5. Quality Improvement/Performance Measurement

QI experts must understand data and statistics. It is important to hire a strong person and give them the proper training. To fully engage the health center’s staff in this process, it helps to bring in a QI coach. External coaches can be very helpful. They must be aware of the health center’s operations, finances, and clinical functions, as well as the health landscape of the community. They must also honor HRSA’s 19 Health Center program requirements.

Focusing on QI/PM begins by learning the best ways to track success. Answer these questions:

- How should we define quality care at the health center? Why?
- Do we have a QI committee and a plan in place for tracking appropriate measures for QI/PM?
- Do we have a dedicated QI person?
- What benchmarks should be set in order to reach our “Triple/Quadruple Aim” goals?
- What organizational changes should be made?
- Do we have the software or IT capacity to track QI measures, for example, rates of immunizations, rates of chronic and acute care visits, etc.?
- Are the changes made by the health center effective? Are the changes sustainable?
- Are care teams able to care for our high risk patients more effectively?
- Is the Governing Board engaged in helping the organization move forward with population health management goals?
The NCQA Patient Centered Medical Home Standards and Guidelines (2014) evaluates the health center’s QI and Performance Measurement based on these and other factors:

- The health center measures rates for immunizations, preventive care, chronic and acute clinical care at least once per year
- The health center measures data on care coordination practices, and care costs at least once per year
- The health center collects feedback from patients about their experiences with things like access, communication, and whole person/self-care at least once per year
- Ongoing QI goals are in place and include clinical quality measures as well as patient satisfaction measures
- After goals are set and measured, improvements are made to at least one disparity in care/service for targeted populations. At least once per year, the health center creates performance reports with these measures. Reports include information about individual clinician performance and practice-level performance.
- Results are shared with different stakeholders, and improvement plans are made

Ensure that the health center has analytics software and IT systems in place to track QI/PM data.

- Use PHM software programs such as i2i Tracks/PopIQ, Azara DRVS, and Acuere QOL to create patient registries and plan care

Set goals and use benchmarks (for example: Uniform Data System (UDS) National Roll-up Report, Healthcare Effectiveness Data and Information Set goals, and Patient-Centered Medical Home Recognition Guidelines and Standards)

Create crosschecks (data validation) to ensure that data is accurate. Data out is only as good as data in

Optimize Electronic Health Records or PHM software to provide automated, regular, and accurate dashboards

Use process improvement tools and engage relevant staff in all QI/PM activities

Share data with all staff, not just providers

- Share “patient-centered” data with patients (for example: average wait times, improved avenues for access, and other data that shows the success of value-based care)
- Share data with the health center’s Governing Board

Create improvement plans based on QI reports

Measures of Success*:

All PHM interventions will show QI and performance improvements.

1. Percent of patients demonstrating improved clinical outcomes
2. Percent of patients reporting a better overall experience (average cycle time is 45 minutes or less)
3. Percent of providers reporting a better overall experience
4. Identify high cost/high utilization patients and engage with them on their care to decrease ER visits

*Targets are situational. Please refer to the 2014 PCMH Recognition Standards and Guidelines.