



Job Aid: Standardized Quality Measures

Familiarity with the standardized quality measures that payers and regulatory groups use is an important part of a practice facilitator's core knowledge.

Standardized quality measures

Standardized measures allow "apples-to-apples" comparisons across providers and organizations. Practices may receive payments tied to performance on particular quality measures.

Places to find standardized quality measures and specifications

- [National Quality Forum \(NQF\) Quality Positioning System](#)
- [CMS Measure Inventory](#)
- [CMS' Clinical Quality Measure \(eCQM\) Resource Center](#)
- [NCQA's Healthcare Effectiveness Data and Information Set \(HEDIS®\)](#)
- [CAHPS® Clinician and Group Survey Database](#)

Measure specifications

Measure specifications provide detailed instructions on how to calculate the measure. Specification sheets include: Measure ID name and number, Denominator, Numerator, Exclusions and Exceptions, Time period, and Data sources. They also include the rationale and evidence base for the measure and the measure sponsor.

ICD-10 and CPT codes

[ICD-10 codes](#) are diagnostic codes and often used to define the population being examined.

[CPT codes](#) are procedure codes that represent the services provided to a patient.

Methods for tracking performance

- Manually extract data and use analytic programs
- Contract with group or vendor
- Use electronic health record (EHR) or registry pre-built reports
- Use reports generated by health plan or other payers



Improving performance on standardized measures

Improving performance on standardized measures involves the same work as improving performance on any quality measure the practice has selected.

Study the specifications carefully and review them frequently. Look out for documentation and mapping errors, double-barreled requirements, and time periods.

Benchmarking

Benchmarks are a powerful tool to spur improvement through friendly competition. They also indicate what level of improvement is possible.

Practice-level benchmarks: get these from your facilitation program, local quality collaboratives, or health plan contracting groups if available.

Provider-level benchmarks: identify the top 10% of performers in the practice for the standardized measure. Average their scores. The mean is the practice's internal benchmark for that measure.

Fall-out analysis

A fall-out analysis looks for reasons a patient who is in the denominator of a measure didn't make it into the numerator.

Step 1. Extract data from the EHR or registry at the individual patient level in a report that includes all patients eligible for the service or outcome. These are the denominator.

Step 2. Identify patients who didn't receive the indicated care or attain the desired outcome. These are the fall-outs. Randomly select 100 from the list, or use the entire list if there are fewer than 100 fall-outs.

Step 3. Review the record of each patient on the list for possible reasons for fall-out. Be a detective and look for clues. Document possible reasons for fall-out for each patient on the spreadsheet.

- Did the patient receive the service, but it was incorrectly documented?
- Did the patient receive the service and it was correctly documented? Or did the patient not have a visit during the measurement period? Both of these indicate a mapping error.
- Was the service simply not provided during the specific visit type?



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- Was the service offered and the patient refused?
- Did the patient fail to complete an activity or action required by the measure?
- Were there other reasons for fall-out?

Step 4. Tally how many times each cause of fall-out occurs on a tally sheet.

Reason for now well child visit	
No longer patient of clinic	
No contact in the past year	
Scheduled but no show	
Completed outside measurement period	
Parent declined to schedule	

Creating a Pareto chart

The Pareto Principle, also known as the 80-20 rule, posits that 80% of consequences come from 20% of causes. A Pareto chart is a bar graph that shows frequencies from "most frequent" to "least frequent."

1. Place the frequency information from the tally sheets of your fall-out analysis into a spreadsheet.
2. Sort the list in descending order, so that the reason that appeared most frequently is on top and calculate the percentage for each reason. If you've analyzed exactly 100 patients, the raw numbers and the percentages will be the same.
3. Create a bar chart where each bar shows the frequency of each reason for fall-out, from most frequent to the least frequent.
4. Draw a line above the bar graph that shows the cumulative total.



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