

# REDESIGN AND FINANCE MEASURES

Last revised 10/8/2005

## CORE MEASURES

	MEASURE	DEFINITION	MEASUREMENT APPROACH	GOAL
	<b>Clinical Processes and Outcomes</b>	National outcomes measures per chronic condition	Teams will specify the condition(s) for which they are tracking national measures and will report on all core measures for that condition	As defined by HDC 2005
<b>1</b>	<b>Office visit cycle time</b>	N: Total elapsed minutes from patient arrival at the health center to patient departure for patient visits sampled in the reporting period D: Number of visits sampled	Sample a minimum of 10-15 patients per week using a patient visit cycle tool to capture the various components of total time the patient spent in the office. Sample at various times and on various days to allow for segmentation of analysis.  Include all time from patient arrival until patient departure.	45 minutes
<b>1a</b>	<b>Value-added time as percent of total cycle time</b>	N: Total value-added time D: Visit cycle time  Multiply by 100 to obtain a percent.	The patient visit cycle tool should include a breakdown of time intervals in order to be able to identify value-added time components as well as non-value-added time.  Examples of Non-value-added time include: Time waiting before going to an exam room Time waiting in exam room Time filling out paperwork  Examples of Value-added time include: Time spent with provider Educational time spent with any member of the care team  Office visit cycle time begins at the time of arrival and ends when patient leaves office.  It is the sum of non-value-added time plus value-added time.	75%

<p><b>2a</b></p> <p><b>Time to 3<sup>rd</sup> Next Available Appointment</b></p> <p><b>OR</b></p> <p><i>(When Advanced Access is implemented and Time to 3<sup>rd</sup> Next Available Appointment is less than 1 day, use...)</i></p> <p><b>2b</b></p> <p><b>Future Appointment Capacity</b></p>	<p>N: Sum of number of days between the day a patient makes a request for an appointment with a provider and the third available appointment for a non-urgent/emergent visit with that provider, for each of the providers sampled during the reporting period D: Number of providers sampled during the reporting period</p> <p>N: Number of open appointment slots during the week after next D: Total number of scheduled appointment slots during that week</p> <p>Multiply by 100 to obtain a percent.</p>	<p>Sample each provider(s) the same day of the week, once a week.</p> <p>Count number of days between a request for an appointment (e.g. enter dummy patient) with a provider and the third next available appointment for a physical or return exam for that provider.</p> <p>Count all calendar days, including weekends, holidays, and days off.</p> <p>Do not count any saved appointments for urgent visits.</p> <p>On Friday, count the number of open appointment slots during the next week for the providers at the site. Divide this by these providers' number of scheduled appointments slots during that next week.</p>	<p>0 days</p> <p>20% increase</p>
<p><b>3</b></p> <p><b>No show rate</b></p>	<p>N: Number of patients who miss a scheduled appointment D: Number of scheduled appointment slots, whether scheduled in advance or not</p> <p>Multiply by 100 to obtain a percent.</p>	<p>Count all of the patient appointments that are missed during the month.</p> <p>Count the total number of scheduled appointment slots during the same period.</p> <p>If a full month's data cannot be captured, use a one week sample.</p>	<p>50 % reduction</p>
<p><b>4</b></p> <p><b>Number of Patient Care Encounters per FTE Provider</b></p>	<p>N: Number of patient encounters during the reporting period D: Sum of the number of FTE MD's plus FTE advanced practice providers</p>	<p>Record each patient care visit regardless of type. Do not include encounters for enabling services.</p> <p>Use the UDS definition for counting full-time equivalents. Count the FTE's dedicated to clinical care. This includes administrative time, such as charting, that is associated with patient care.</p>	<p>365</p>

5	<b>Panel Size per FTE Provider (weighting is not defined)</b>	N: Number of unique patients seen in the 12 months ending with the reporting period D: Sum of number of FTE MD's plus FTE advanced practice providers	Count all unique users during the 12 months prior to the reporting period in accordance with the UDS definition.  FTE's as in #4	1700
6	<b>Net Revenue per Patient Encounter</b>	N: Total charges in the reporting period for the provider(s) at the site, minus (contractual adjustments plus bad debt plus write-offs plus sliding fee adjustments) D: Total patient encounters	Add all the charges for services rendered during the reporting month by all provider(s) at the site and subtract (contractual adjustments plus bad debt plus write-offs plus sliding fee adjustments)	\$110
7	<b>Total Operating Expenses per Patient Encounter</b>	N: Sum of all operating expenses incurred by the site during the reporting period D: Total patient encounters	If the practice operates on a cash basis, calculate total direct and indirect expenses paid by the site during the reporting period. If the practice operates on an accrual basis, use the expenses accrued for the site during the reporting period. Expenses should include the salaries, benefits, and taxes for all employees, including the providers. They should also include direct cost of supplies, contracted services, insurance, etc., as well as any allocated expenses for shared services such as billing and collection, administrative overhead, facilities, shared support staff, etc. If any costs cannot be attributed directly to the site, allocate these costs on a per visit basis, based on total practice costs per visit and the number of visits at the site.	\$100
8	<b>Percent Self-pay Collections</b>	N: Sum of all monies collected at the time of patient visits during the reporting period D: Total dollars of potential collections at the time of patient visits during the reporting period	Add all the monies collected at the time of the patient visits during the reporting period.  Add all of the self-pay amounts, along with co-pay, deductible, and sliding fee amounts for all of the visits in the month.	85%
9	<b>Voluntary Staff Turnover Rate</b>	N: Number of voluntary terminations, layoffs) in the reporting period D: total number of employees in the microsystem at the beginning of the reporting period.	Count all voluntary terminations within the microsystem team. Voluntary terminations exclude terminations for cause, reductions in force and layoffs. Count all employees, whether full or part time	<10%

10	<b>Percent of Patients Who Would Recommend the Health Center</b>	<p>N: Number of patients who respond positively to the survey question "I would recommend this health center to my family and friends"</p> <p>D: Number of patients who complete the survey</p> <p>Multiply by 100 to get a percent.</p>	<p>Sample 15 patients per week using the PEERS survey, another internal survey instrument, or a unique survey that includes the statement "I would recommend this health center to my family and friends" or question "Would you recommend this health center to your family and friends?". Add the number of positive responses. A positive response on a scale of Strongly agree, Agree, Neither Agree nor Disagree, Disagree, Strongly Disagree includes Strongly Agree or Agree. If the health center survey includes only a yes or no response, count the number of Yes responses.</p>	95%
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