PHMI Measurement Strategy Worksheet Instructions

Note: These instructions support the completion of the Measurement Strategy Worksheet. Reference to the columns in that worksheet are noted in this support document.

First, write down your 2026 clinical outcome SMARTIE goal:

Next, select your family of measures using the table below:

Questions to consider for each measure…

- What is our data source? Where will we draw the data from?
- How will we collect the data? Will we do manual data collection (e.g., chart audit with small sample), or can we generate a data report from an electronic source?
- What is the reporting source (e.g., Power BI, PHM platform, EMR, other)?
- Does a report need to be programmed?
    - If so, who is responsible for programming the report? How can we assure it will be prioritized?
    - If not, can the report be generated by a non-IT person? Does this responsibility easily fit into an existing role?
- Can we report on the data monthly to help inform our testing?

	List measures by category	Notes *(i.e., How easy is it to collect the data for this measure? How feasible is it to regularly report on this measure?)*
Outcome Measure(s): *How is the system performing? How is it impacting patients' health and well-being?* *(Usually 1-2 measures)*		
Process Measures: *Are the parts or steps in the system performing as planned?* *(Usually 2-3 measures)*		
Balancing Measure(s): *How are changes for improvement in one part of the system affecting other parts?* *(Usually 2-3 measures)*		

Once you have some level of confidence that this set of measures will work, start to populate the Measurement Strategy Worksheet.

1. Populate the measures identified above into the *Measure Name* column.
2. Develop an *Operational Definition* for each measure.
3. Populate the *Data Collection Strategy* and *Frequency c*olumns for each measure*,* adding details from your work in the table above.
4. Set a numeric goal in the *Goal* column for each measure.

Measurement Strategy Worksheet

OUTCOME MEASURES - *Reflect how the system impacts the health and wellbeing of patients or community members*				
Measure Name	**Operational Definition**	**Data Collection Strategy**	**Frequency**	**Goal**

PROCESS MEASURES - *Reflect whether the parts or steps in the system are performing as planned*				
Measure Name	**Operational Definition**	**Data Collection Strategy**	**Frequency**	**Goal**

BALANCING MEASURES - *Reflect whether changes designed to improve one part of the system are causing problems in other parts*				
Measure Name	**Operational Definition**	**Data Collection Strategy**	**Frequency**	**Goal**

Example Measurement Strategy

OUTCOME MEASURES - *Reflect how the system impacts the health and wellbeing of patients or community members*				
Measure Name	**Operational Definition**	**Data Collection Strategy**	**Frequency**	**Goal**
Percentage of patients with controlled diabetes (HbA1c <8%)	*Numerator:* Number of patients with diabetes whose most recent HbA1c value in the last 12 months is < 8.0% *Denominator:* All active patients aged 18–75 with a diagnosis of diabetes	*Inclusions:* Active patients (i.e., seen in the last 18-24 months) ages 18–75 with any diabetes diagnosis (type 1 or type 2) within the last 2 years. From each denominator patient, select the most recent HbA1c result within the last 12 months; if that value is < 8.0%, count in numerator. If no HbA1c in last 12 months, count as not controlled (i.e., keep in denominator, not numerator). *Data Sources:* Empanelment or patient roster; EHR problem list or encounter diagnoses (ICD-10 diabetes codes); EHR laboratory results (HbA1c values). Stratify data by race, ethnicity, language, and other key demographics.	Monthly	70%
PROCESS MEASURES - *Reflect whether the parts or steps in the system are performing as planned*				
Measure Name	**Operational Definition**	**Data Collection Strategy**	**Frequency**	**Goal**
Percentage of diabetic patients with a documented HbA1c test in the last 3 months	*Numerator:* Number of diabetic patients with a documented HbA1c test in the last 90 days *Denominator:* All patients aged 18–75 with a diagnosis of diabetes	*Inclusions:* Active patients (i.e., seen in the last 18-24 months) ages 18–75 with any diabetes diagnosis (type 1 or type 2) within the last 2 years. Among denominator patients, count those with at least one HbA1c test dated within the last 90 days from the measurement end date. If a patient has multiple results, use the most recent test date to determine eligibility. If no HbA1c in last 90 days, keep in denominator but not numerator. *Data Sources:* Empanelment or patient roster; EHR problem list or encounter diagnoses (ICD-10 diabetes codes); EHR laboratory results (HbA1c values). Stratify data by race, ethnicity, language, and other key demographics.	Monthly	80%
Percentage of eligible patients referred to Diabetes Self-Management Education and Support (DSMES)	*Numerator:* Number of diabetic patients referred to DSMES during the measurement period *Denominator:* All patients with uncontrolled diabetes (most recent HbA1c ≥ 8.0%)	*Inclusions:* Active patients (i.e., seen in the last 18-24 months) ages 18–75 with any diabetes diagnosis (type 1 or type 2) whose most recent HbA1c in the past 12 months is ≥ 8.0%. Among denominator patients, count those with a DSMES referral order placed within the measurement month. *Data Sources:* Empanelment or patient roster; EHR problem list or encounter diagnoses (ICD-10 diabetes codes); EHR laboratory results (HbA1c values); EHR referrals/orders (DSMES order codes). Stratify data by race, ethnicity, language, and other key demographics.	Monthly	80%
BALANCING MEASURES - *Reflect whether changes designed to improve one part of the system are causing problems in other parts*				
Measure Name	**Operational Definition**	**Data Collection Strategy**	**Frequency**	**Goal**
Number of same-day appointment slots used for diabetes follow-up	*Numerator:* Number of same-day or urgent appointment slots used for diabetes care follow-ups *Denominator:* Total number of same-day or urgent appointment slots available	*Inclusions:* Count all same-day and urgent care appointment slots available in the measurement month. Among those, count appointments used for diabetes-related follow-up (including medication adjustment, abnormal HbA1c follow-up, or care plan review) based on visit reason or diagnosis linked to the encounter. *Data Sources:* EHR scheduling system, visit reason or appointment type fields, provider schedules/appointment templates	Monthly	15%