

HRSA / PCMH

Audit Binder

[Your Health Center Name]

Reporting Period: January 1, 2026 – March 31, 2026

Document Type: HRSA / PCMH Audit Binder

Prepared By: Quality Improvement Team

HRSA Chapter 10 Aligned	NCQA PCMH Q-PASS Ready	UDS-Friendly Reporting
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This binder demonstrates the type of documentation package a health center can generate and maintain for HRSA operational site visit preparation, quality improvement documentation, and PCMH evidence organization. All names, data, and examples are fictional.

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SECTION 01 — EXECUTIVE OVERVIEW

Executive Overview

This health center operates a structured quality improvement program designed to support regulatory readiness, clinical measure performance, and team accountability across care operations. The organization uses standardized PDSA documentation, assigned task ownership, recurring review cadences, and centralized evidence storage.

During the reporting period, the quality team focused on preventive screening performance, hypertension control workflow consistency, and documentation reliability for PCMH evidence collection. Three active projects were tracked through defined aim statements, predictions, intervention testing, data review, and next-step decisions.

<p>3</p> <p>Active PDSA Projects</p>	<p>4</p> <p>Measures Monitored</p>	<p>6</p> <p>Evidence Items Tracked</p>
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SECTION 02 — QUALITY INFRASTRUCTURE

Quality Infrastructure Summary

Leadership and Oversight

Area	Owner	Review Frequency	Documentation Location
Quality program oversight	Director of Quality Improvement	Monthly	QI Committee folder
PDSA cycle coordination	PCMH Coordinator	Biweekly	QI project workspace
Measure review	Clinical Operations Manager	Monthly	UDS dashboard export
Evidence collection	Compliance and Accreditation Lead	Ongoing	Q-PASS evidence library

Standard Workflow

- 1 Identify priority gap or audit risk.

- 2 Open or update a PDSA project.

- 3 Assign interventions and owners.

- 4 Review data trend and implementation status.

- 5 Document decision to adopt, adapt, or abandon.

- 6 Export binder-ready evidence packet for leadership or survey review.

SECTION 03 — MEASURE MONITORING

Measure Monitoring Snapshot

Quarterly Performance Summary — Q1 2026

Measure	Baseline	Current Quarter	Target	Status
Colorectal Cancer Screening	38%	46%	50%	Improving
Cervical Cancer Screening	49%	54%	58%	Improving
Hypertension Control	57%	61%	65%	Improving
Diabetes: HbA1c Poor Control	34%	29%	25%	Improving

Observations

Performance review identified positive movement in screening and chronic disease workflows after implementation of standing-order reminders, outreach task standardization, and pre-visit planning prompts. Remaining gaps were tied primarily to documentation variation, overdue follow-up, and inconsistent staff handoff practices.

SECTION 04 — ACTIVE PROJECTS

Active PDSA Cycle Summaries

Project	Aim	Owner	Start	Stage	Decision
CRC Outreach Reliability	Increase CRC screening 38%→50%	PCMH Coordinator	2026-01-08	Study	Adapt
BP Recheck Workflow	Improve BP recheck documentation 52%→92%	Manager	2026-02-01	Act	Adopt with revisions
Diabetes Lab Follow-Up	Reduce overdue HbA1c follow-up calls 40%	Analyst	2026-02-12	Study	Continue

SECTION 05 — DETAILED DOCUMENTATION

Detailed PDSA Documentation

Project 1

CRC Outreach Reliability

<p>Aim</p> <p>Increase colorectal cancer screening completion from 38% to 50% among eligible adults within 90 days.</p>	<p>Problem Statement</p> <p>Eligible patients were being identified inconsistently, and outreach completion was not tracked in one shared workflow.</p>
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Plan

Element	Documentation
Change idea	Create one outreach queue with MA ownership and weekly status review
Prediction	A standardized queue will improve outreach completion and raise screening completion by at least 8 percentage
Population	Adults aged 45–75 due for colorectal cancer screening
Data source	EHR preventive screening list and outreach log
Review cadence	Weekly

Do	The team launched a standing outreach queue, added a script for patient communication, and assigned a daily review owner. Front-desk staff documented kit acceptance or refusal in a common workflow note.
Study	After six weeks, outreach completion increased, but kit return rates varied by site and by patient contact method. Text reminders performed better than voicemail-only outreach.
Act	The team chose to adapt the process by adding a second text reminder at day 10 and by escalating nonresponsive patients to care coordinators after two failed outreach attempts.

Project 2

BP Recheck Workflow

<p>Aim</p> <p>Improve same-day blood pressure recheck documentation from 62% to 90% within 60 days.</p>	<p>Problem Statement</p> <p>Initial elevated blood pressure values were often documented, but recheck timing and final result entries were inconsistent across nursing workflows.</p>
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Plan

Element	Documentation
Change idea	Standardize rooming script and require recheck field completion before visit close
Prediction	Documentation compliance will increase when the step is embedded into staff workflow
Population	Adult visits with initial BP above threshold
Data source	EHR visit audit and nursing workflow review
Review cadence	Biweekly

Do	Team leads piloted a revised rooming checklist and retrained staff on recheck timing, documentation placement, and escalation steps when repeat blood pressure remained elevated.
Study	Documentation compliance improved in the first month, but some missed cases remained tied to float staff and late-rooming workflows.
Act	The intervention was adopted with revisions, including onboarding tip sheets for float staff and a supervisor audit of missed recheck documentation twice monthly.

Project 3

Diabetes Lab Follow-Up

<p>Aim</p> <p>Reduce overdue HbA1c follow-up calls older than 14 days by 40% within one quarter.</p>	<p>Problem Statement</p> <p>Patients with abnormal results were not always contacted within the expected timeframe, and follow-up attempts were spread across multiple staff inboxes.</p>
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Plan

Element	Documentation
Change idea	Route all overdue follow-up tasks into one team queue with aging rules
Prediction	Shared ownership and aging visibility will reduce backlog
Population	Adult diabetes patients with overdue follow-up contact
Data source	Lab result work queue and outreach tracker
Review cadence	Weekly

Do	The organization consolidated follow-up tasks into a shared tracker and color-coded items older than 7 and 14 days.
Study	The backlog fell steadily, though variability remained on Mondays after weekend result volume.
Act	The cycle remained active with a next test focused on redistributing Monday backlog tasks by 10:00 AM daily.

SECTION 06 — EVIDENCE & TASKS

Evidence and Task Tracking

Evidence Register

Evidence Item	Related Standard / Use	Owner	Status
QI Committee charter	Quality oversight documentation	Director of QI	Complete
Q1 committee minutes	Leadership review evidence	Executive Assistant	Complete
PDSA project logs	Improvement methodology evidence	PCMH Coordinator	Complete
Measure trend export	Performance review evidence	QI Analyst	Complete
Training sign-in sheets	Staff education evidence	Nurse Manager	In progress
Outreach workflow SOP	Standardized process evidence	Clinical Ops Manager	Complete

Open Tasks

Task	Owner	Due Date	Priority	Status
Upload BP recheck retraining sign-in sheet	Nurse Manager	2026-04-05	High	Open
Finalize Q2 outreach script revision	PCMH Coordinator	2026-04-08	Medium	Open
Validate denominator logic for CRC list	QI Analyst	2026-04-10	High	In progress
Add committee approval note to SOP	Director of QI	2026-04-12	Low	Open

SECTION 07 — MEETING DOCUMENTATION

QI Committee Meeting Snapshot

<p>Meeting Date March 18, 2026</p>	<p>Chair Director of Quality Improvement</p>	<p>Attendees Medical Director, PCMH Coordinator, Nurse Manager, QI Analyst, Clinical Operations Manager</p>
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Agenda Summary

- Reviewed quarterly preventive screening trends
- Assessed progress of active PDSA cycles
- Confirmed documentation gaps needing follow-up before leadership review
- Approved revised outreach workflow for next test cycle

Key Decisions

- Continue CRC outreach project with revised text reminder cadence
- Adopt BP recheck workflow with additional float staff training
- Maintain weekly evidence review until all Q1 artifacts are complete

SECTION 08 — AUDIT READINESS

Audit Readiness Checklist

Requirement Area	Evidence Present	Notes
Written QI activities documented	Yes	PDSA logs included
Measure trends reviewed	Yes	Quarterly snapshot included
Committee oversight documented	Yes	Minutes and decisions summarized
Assigned accountability visible	Yes	Owners listed on tasks and projects
Improvement actions tracked to closure	Partial	Two open items remain
Supporting artifacts centrally organized	Yes	Evidence register maintained

How This Binder Is Generated

A complete export can include date-filtered project logs, attached supporting files, full task histories, SPC or trend visuals, site-specific comparisons, and print-ready appendix sections. This format works best when paired with a short explanation of how the binder is generated: select date range, choose site or project, export structured documentation, and walk into the review with one organized packet.

APPENDIX A

Sample Folder Structure

Audit Binder

- ■ ■ ■ **01** Executive Overview
- ■ ■ ■ **02** Quality Infrastructure
- ■ ■ ■ **03** Measure Trends
- ■ ■ ■ **04** PDSA Cycle Summaries
- ■ ■ ■ **05** Detailed PDSA Logs
- ■ ■ ■ **06** Evidence Register
- ■ ■ ■ **07** Committee Minutes
- ■ ■ ■ **08** Supporting Documents

APPENDIX B

Suggested Disclaimer for Website Use

"This binder is prepared for HRSA site visit and PCMH evidence review purposes. All data reflects the reporting period indicated on the cover. Content should be verified against source systems prior to submission."