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MEASURES THAT MATTER

Moving from Measure Madness
to Measures that Matter

TABLE OF CONTENTS

HANYS Quality Institute

HANYS Quality Institute is the Healthcare Association of New York State's (HANYS) center for quality improvement and patient safety, helping New York's hospitals and health systems prioritize, manage, and sustain initiatives that improve patient care.

EXECUTIVE SUMMARY

MOVING FROM MEASURE MADNESS
TO MEASURES THAT MATTER

While the value of measurement is clear, measurement is also clearly out of control and in need of reform.

While providers, patients, consumer groups, payers (government and commercial), and professional societies are united in their commitment to the provision of high-quality, safe, patient-centered care, they are often divided on what and how to measure and report. As noted by the American Hospital Association, opportunities to make meaningful enhancements in quality and patient safety may be lost because there is a lack of focus and agreement on which measures can help improve patient outcomes.[1]

As indicated by recent calls for consensus on measures, the healthcare industry—including providers, government, managed care, and others—has begun to recognize the unintended consequences of divergent measurement demands, but much more needs to be done. This document is intended to contribute to this national dialogue.

HANYS' VISION

As we envision the future state of quality measurement, all stakeholders—healthcare providers, clinicians, commercial payers, government agencies, and patient representatives—will collaborate to achieve a sensible framework that leverages and maximizes use of a common set of valid, reliable, and evidence-based measures. These measures will inspire and improve outcomes across the continuum while contributing to provider-specific innovation and ongoing efforts toward excellence in patient care.

MEASURE MADNESS

The current environment is chaotic. Hospitals and other providers must report on hundreds of measures that are required by government and commercial payers, accreditation agencies, professional societies, and registries. Underlying the collection and reporting of <u>each</u> measure is a complex system of specifications, definitions, data abstraction, analysis, and reporting, consuming significant time and expenses and drawing from limited clinical, information system, and administrative resources. Despite the abundance of existing metrics, new measures are being developed to address the fundamental shifts in how care is paid for (volume to value) and delivered (integrated, preventive care at lower costs).

While many measures evaluate the same focus area or patient population, the measure specifications may be different, requiring providers to understand and implement distinct methodologies and systems. This lack of alignment and coordination, coupled with the sheer

volume of quality measures and the limitations of current electronic health record (EHR) technology, has created an environment of measure madness—displacing and redirecting resources from meaningful improvement efforts.

HANYS' CALL TO ACTION

Measures that Matter is a Call to Action, urging the healthcare field to collaborate on building a parsimonious measurement system that achieves the Triple Aim of better patient care, better health outcomes, and lower costs. HANYS urges the field to:

√ **Streamline**—commit to the minimum number of measures needed to evaluate healthcare quality, outcomes, and value;

√ **Align**—with nationally-endorsed, evidence-based measures;

√ **Focus**—on only those measures that target the most vital aspects of care, are actionable, tailored to the patient population, and that offer opportunities to directly and positively impact patient outcomes; and

√ **Collaborate**—with key healthcare stakeholders, including patients, payers, regulators, and providers, to coordinate efforts.

These basic principles aim to achieve a sensible balance that fulfills the need to measure quality and safety, without distracting limited resources from ongoing improvement, patient care, and innovation.

MEASURE MANAGEMENT STRATEGIES FOR PROVIDERS

In addition to issuing the Call to Action for external entities, HANYS' Statewide Steering Committee on Quality Initiatives encourages healthcare organizations to streamline their internally-driven measurement efforts to focus on the measures that matter. Achieving this goal may require conducting an assessment of the many internal hospital quality improvement efforts and associated data collection, and putting in place coordinated strategies such as:

√ a centralized internal oversight system charged with responsibility for evaluating and determining which measures an organization will use;

√ a method for evaluating and categorizing measures based on their value and utility;

√ established criteria to assess the importance of specific quality measures within the organization; and

√ a weighting system that applies numerical values to the evaluation process.

This document was prepared under the guidance of HANYS' Statewide Steering Committee on Quality Initiatives. HANYS and its members are committed to collaborating with others in the healthcare field to make this vision a reality, knowing that patients across the country depend on healthcare providers to use metrics that drive excellence, innovation, and quality improvement.

PART I

HANYS' VISION FOR THE FUTURE

"As the number and complexity of mandated and expected voluntarily reported measures increase, they may crowd out the resources that would otherwise be devoted to measuring processes and outcomes that have much more meaning to the institution's patients, staff, and leadership." [2]

> As new models of healthcare are created, it is imperative that stakeholders focus quality measurement efforts on what matters most—measures that will have the greatest impact on quality, patient safety, and efficiency throughout the healthcare continuum.

HANYS envisions a future where quality measurement supports providers' efforts to improve quality and patient safety:

✓ Measures will reflect "clinical reality"[3] by accurately measuring the intended target, and be actionable by providers who can use the data to implement evidence-based practices to improve care.

✓ The number of reported measures required of providers by payers (government and commercial) and other entities will be parsimonious, align with one another using standardized definitions, and represent only the most important health priorities.

✓ The data acquisition and reporting process will "no longer [distract] from the process of care nor [require] extra effort"[4] and will be embedded seamlessly in integrated, interoperable electronic health records (EHRs), allowing for more comprehensive measurement.

✓ Providers will focus their quality and patient safety efforts on their most serious safety concerns, and prioritize time and resources to improve care with a goal of zero harm.

HANYS and our members are committed to collaborating with the healthcare field, payers, and government to make this vision a reality, knowing that patients across the country depend on providers to use metrics that drive excellence, innovation, and quality improvement.

PART II

MEASURE MADNESS

> If the proliferation of required reporting of quality measures continues, "providers will need to invest so much money to report externally imposed measures that there will be scant funds left to support provider-specific internal measurement systems needed for monitoring and improving quality . . ." [5]

PROLIFERATION OF MEASURES

Hospitals and providers are faced with a staggering number of demands for data from a growing number of stakeholders.

- Hundreds of measures are required by government and commercial payers, accreditation agencies, professional societies, registries, and other organizations.

  - According to an analysis by the Measures Application Partnership (MAP), a multi-stakeholder group charged with identifying performance measures for the federal government, "in the second quarter of 2014, 33 different Centers for Medicare and Medicaid Services (CMS) programs used over 850 unique measures, with only one-third used in more than two different CMS programs."[6] (See Appendix for a reference list of measures required for each federal reporting program.)

  - This trend is expected to grow; state and federal government envision that within five years, nearly 90% of all provider payments will be tied to "value."[7]

- Researchers explore changes in practice and their impact on health outcomes.

- Other measures are the focus of consumer report cards, while hospitals and health systems use still other measures to address their distinct quality improvement projects.

- Adding complexity, new measures are being developed to address the fundamental shifts in how care is being paid for (volume to value) and how it is delivered (integrated, preventive care at lower costs).

- The National Quality Forum (NQF), a nonprofit membership-based organization charged with evaluating and endorsing quality measures based on a set of criteria, has endorsed 635 healthcare quality measures.[8]

  - Many more measures are used by state government, insurance companies, specialty societies, registries, oversight and accreditation organizations, consumer groups, and provider groups—and not all are endorsed by NQF.

In short, the measures keep piling up.

Often, measures are intended to evaluate the same focus area or population, but have different specifications. Even what appears to be the smallest of changes requires providers to implement customized approaches for data collection, abstracting, and reporting, consuming significant resources for what is often redundant work.

At the same time, consumers are seeking clarity in the various healthcare measures as they strive to use data to help make healthcare decisions. As pointed out in the *HANYS Report on Report Cards*,[9] quality measures are intended to help consumers make healthcare choices and assist providers in improving care, yet these goals are thwarted by multiple reports that yield conflicting information and dramatically different results.

A recent study that evaluated how 844 hospitals were rated by four prominent report cards found that only 10% were rated as a "high performer" by more than one report card, noting that the divergent ratings and scores from various report cards may cause more confusion than clarity.[10] As multiple stakeholders craft and adopt their own unique measures, the result is a sea of discordant and conflicting data on hospital performance.

LIMITATIONS OF CURRENT EHR TECHNOLOGY

Nationwide, the EHR and health data infrastructure is characterized by a variety of "different systems with limited interoperability, disparate levels of use, and approaches to use based on local factors and needs."[11] Many of these problems stem from vendors' attempts to develop customer-friendly products by allowing significant customization by each facility. However, customization inhibits interoperability and can exacerbate the problem of fragmented and conflicting measures within organizations.

> Gaps in capabilities of current technology pose significant barriers to timely and efficient reporting of measures that matter.

While recent EHR enhancements have begun to support real-time measurement, these systems currently fall woefully short in meeting the needs of providers; and many systems are unable to generate simple, reliable, and actionable reports. Many measures continue to require meticulous reviews of medical records by trained professionals who otherwise would be directing their expertise to providing and improving patient care.[12]

The Institute of Medicine (IOM) report, *Vital Signs*, which aims to target and align measurement efforts in the United States, recognizes that EHRs are a critical part of the solution to reduce the burden on providers and help measurement systems become more effective. The IOM report also states that more changes are needed to move toward complete interoperability among providers.[13] Until then, staff will continue the important but arduous process of manually pulling data from medical charts, consuming and diverting an organization's critical clinical resources. Importantly, "significant opportunity costs are entailed in devoting resources to inefficient, redundant, or poorly specified measurement activities, which can displace other valuable opportunities to improve health and healthcare."[14]

MEASURE MADNESS

LEGEND

ONE BAR REPRESENTS 5 MEASURES

| 33 Accountable Care Organization (ACO) Measures
| 100+ Delivery System Reform Incentive Payment (DSRIP) Measures
| 546 Private Health Plan Measures
| 635 National Quality Forum (NQF) Endorsed Measures
| 850 Centers for Medicare & Medicaid Services (CMS) Measures

IMPACT ON QUALITY AND PATIENT SAFETY

Quality measurement and reporting are critical to improving patient care, outcomes, and experience; however, every measure that is collected requires some investment. As a result of the proliferation of measurement and the limitations of current EHR technology, important opportunities to make meaningful enhancements in quality and patient safety may be lost.[15]

Healthcare providers are simply exhausted from the burden of trying to respond to the volume of mandatory and voluntary requests for quality data, particularly with regard to measures that do not contribute to care improvement in their organizations. Moreover, this work consumes resources and attention that otherwise would be directed to patient care and addressing more meaningful quality priorities.

As an example, a study of physicians' compliance with multiple quality reporting measures estimates a total cost to physician offices of $15.4 billion nationally, plus an average of 785 hours of staff time a year to keep track of metrics.[16]

Organizations of all types and sizes are impacted by measure madness. Just as large hospitals are challenged by many competing demands, smaller health systems face similar difficulties, often with fewer supports and infrastructure to accommodate extensive quality reporting obligations. Clinicians in these health systems often serve in multiple roles, including data collector, reporter, analyzer, information technology specialist, and improvement coordinator, and often have additional administrative or clinical responsibilities.

Measures impacting smaller institutions' providers should:

- be actionable by providers;

- be relevant to their patient population and feasible to collect and report with a more limited data infrastructure; and

- address the issue of low case volume, which can impact the validity and reliability of the data.

PART III

CALL TO ACTION:
GETTING TO THE MEASURES THAT MATTER

> As noted in the *Wall Street Journal*, "while the energy around measurement is commendable, fragmentation and disconnected development efforts are creating diminishing returns and even problems for providers and care itself."[17]

To ensure that every patient receives high-quality and safe healthcare, HANYS calls upon the healthcare community, including providers, payers (government and commercial), and professional societies to create a sensible framework for measurement that fulfills the need to monitor and improve quality and patient safety without imposing unreasonable requirements.

Currently, no single organization has central authority over measurement in healthcare. Measures are developed, created, and designed by multiple entities, with varied goals and purposes in mind. Hospitals and health systems are burdened by trying to create an infrastructure, assigning staff, and assessing each measure's methodology to determine whether it has merit for their internal quality improvement efforts.

In order to move forward, the healthcare field must streamline, align, and focus on those measures that are meaningful for improving care. The Institute of Medicine (IOM) provides a strong framework for this concept in its 2015 report, *Vital Signs: Core Metrics for Health and Health Care Progress.* IOM calls for a parsimonious, standardized set of measures collected regularly and consistently across the nation.[18] This consensus will "enhance the ability of healthcare leaders and the public to track progress toward shared goals . . . If the same set were implemented at the national, state, local, and organizational levels, these benefits would be multiplied as a result of the enhanced ability to make comparisons and determine best practices."[19]

CMS has begun to address this issue. In February 2016, CMS and a coalition of key stakeholders, including providers, insurance representatives, and others reached consensus on a core set of seven measure sets that should be used to monitor performance of physicians and other clinicians for the purposes of quality improvement.[20]

Other groups have made similar proposals. In 2015, the Catalyst for Payment Reform (CPR), an independent, nonprofit corporation working on behalf of large employers and other healthcare purchasers identified a list of Employer-Purchaser Priority Measures. The list of 30 measures were selected because they align with other programs, have been successfully implemented in one or more programs, and cut across multiple conditions and topics, when possible.[21]

Again, these are important steps, but the entire healthcare field must work together.

> To help the nation realize the Triple Aim of better patient care, better health outcomes, and lower costs, all stakeholders of quality measurement must collaborate to streamline, align, and focus their measurement systems on the **measures that matter**.

HANYS' CALL TO ACTION URGES ALL STAKEHOLDERS TO:

1. **STREAMLINE—commit to the minimum number of measures needed to evaluate healthcare quality.**

   Stakeholders, including government, should aim toward parsimony among measures to reduce confusion and promote a focus on the most important healthcare priorities. Measures should be able to be reasonably collected given the current tools and measurement infrastructure available to providers. Data collection should not create an undue burden that distracts from the ultimate goal of providing patients with high-quality care.

2. **ALIGN—with national, standardized, evidence-based measures.**

   Measures should be rooted in science, supported by peer-reviewed literature, and be aligned with NQF and MAP. When considering the development or adoption of a new measure, stakeholders must first optimize measures that are currently available and determine if better performance can be achieved. If a government, payer, or other stakeholder seeks to evaluate a particular area of healthcare delivery, it should first look to measures already collected to avoid duplication. Measures should not be developed in isolation.

3. **FOCUS—on those select few representative measures that target the most vital aspects of care, are meaningful and actionable, are tailored to the organization's patient population, and offer opportunities to directly and positively impact patient outcomes.**

   Measures should accurately measure the intended element of care. Providers should be able to use the measures to compare trends over time and implement changes to improve patient care. In addition, measures should be based on the most recent data available. While not always feasible, outcome measures are preferable to process measures as studies have found limited links between clinical outcomes and process of care measures.[22] An outcome measure, for example, is the rate of falls, while a process measure may focus on risk assessment for falls.

   Measures used by regulators and payers should focus on overall performance (outcome measures), and defer the operations and use of process measures for internal quality improvement by healthcare providers. If process measures are used for regulatory or payment purposes, they should be used on a limited basis.

Organizations should have the flexibility to choose the measures that are most relevant for the patient population they serve. We encourage payers and regulators to consider developing a menu of options from which organizations can choose to ensure that they focus on the most critical safety issues impacting their organization.

4. **COLLABORATE—with key healthcare stakeholders to coordinate quality and patient safety efforts.**

Although NQF plays a key role in approving individual quality measures, no single entity has general oversight authority for coordinating and streamlining quality measurement in the United States. HANYS calls on stakeholders in the healthcare community to assert their role as stewards of quality measurement and collaborate to build a parsimonious set of measures that meets the Triple Aim.

EHRs Should Be Part of the Solution

HANYS calls on EHR and health information technology (HIT) vendors to take a more active role in the solution and commit to developing standardized, interoperable e-measures with standard specifications for data collection. Vendors should also produce reliable, actionable reports to support mandatory reporting and hospital-specific quality improvement projects. HIT could be instrumental in significantly reducing the costs of healthcare by addressing this unmet need.

PART IV

RECOMMENDATIONS:
MEASURE MANAGEMENT STRATEGIES FOR PROVIDERS

The U.S. Department of Health and Human Services has indicated that working toward a goal of streamlining and aligning various quality measures and reporting requirements is a long and complex process.[23]

Healthcare providers are simply exhausted from the burden of trying to respond to the sheer volume of mandatory and voluntary requests for quality data—both externally and internally. This work consumes resources and attention that otherwise would be directed to patient care and addressing quality priorities within the individual organization.

> Because reform will take time, it is paramount that in the interim, healthcare organizations develop systems to prioritize their limited resources and focus on only the measures that matter.

In addition to addressing the demands from external stakeholders, HANYS' Statewide Steering Committee on Quality Initiatives also encourages healthcare organizations to assess the many internal hospital quality efforts that often drive data collection and development of additional measures.

Targeting measures—both external and internal—that have the greatest impact on improving quality and patient safety will support the delivery of effective and efficient care. Additionally, because financial reimbursement is increasingly tied to better outcomes, improvement on quality metrics will further contribute to organizational stability as these measures are incorporated into value-based payment.[24]

Drawing on their own experiences, members of HANYS' Statewide Steering Committee on Quality Initiatives encourage organizations to prioritize and manage quality measures by employing strategies such as:

- a centralized oversight system within the organization (e.g., Performance/Quality Improvement Council) that analyzes measures and determines which ones the organization will use;

- a method for evaluating and categorizing measures based on their perceived value and utility;

- criteria to assess the importance of specific quality measures within the organization; and

- a weighting system that applies numerical values to the evaluation process.

These strategies provide examples of approaches that can be used to keep healthcare organizations from falling into the measurement madness, but are not intended to be prescriptive or exclusive. Organizations may choose to use these strategies independently to supplement existing internal processes, or integrate the individual strategies into a comprehensive approach.

A New Measure is Submitted to Quality Improvement Oversight Council

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Put Measure Through System/Hospital Decision Matrix

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Discuss if Measure Meets Organization's Criteria

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Rank/Weight Measure Based on Each Criterion

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Council Creates Overall Measure Score

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Council Recommends Tier

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Measure Steward Assigned to Monitor and Identify Changes

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Decision is Communicated

STRATEGY ONE:
DEVELOP DECISION-MAKING AND OVERSIGHT SYSTEM

The board of trustees is ultimately responsible for quality and patient safety provided at the organization. In this role, trustees rely on measurement to help identify and monitor the organization's progress on strategic priorities.

> Board members should be provided with metrics they can use, without being overwhelmed by an array of measures outside the strategic priorities or other key issues.

One approach adopted by hospitals and health systems is development of a centralized oversight system to serve as a clearinghouse and arbiter of measures used within their individual organization. This strategy may be important to consider in a large healthcare system, where there are many individuals, committees, and departments that can generate requests for data collection. Similarly, the concept could also be advantageous in smaller organizations that are seeking to create a formalized forum for measurement discussion and decision-making.

Broad oversight and coordination across the entire organization can reduce redundancy and waste, and ensure measurement aligns with the organization's strategic priorities. Oversight authority for this formal process can be delegated to a multidisciplinary committee or council such as the Performance/Quality Improvement Council, where executives, physicians, and subject matter experts can effectively evaluate and decide which measures to use within the organization.

MEASURE INVENTORY

Organizations that seek to update their understanding of the amount of resources being devoted to measurement demands may find it valuable to conduct a comprehensive assessment of this activity in their organization. One way to begin to quantify the scope of measurement is to undertake an inventory of every measure being collected. While this will likely require some temporary increased resources, an inventory can help capture the full breadth of measurement activities that are occurring and serve to highlight gaps, areas of overlap, and outdated and unnecessary metrics. Using a standardized electronic form with pre-populated measure lists, other data fields, and drop-down menus to conduct the inventory will assist with analysis of the information.

Using results from this inventory, the Performance/Quality Improvement Council or other designated group can analyze the information, develop an overall measurement plan, and make strategic decisions on which measures to modify, add, or discontinue.

MEASURE SELECTION AND REVIEW PROCESS

Organizations may want to establish a formal process for considering requests to establish new metrics or to discontinue current measurement. A formal, annual review process, aligned with the annual quality plan, will enable the oversight authority and hospital's executive team to align measurement across the organization on an ongoing basis. It may also help identify opportunities to share processes or automate measures that are common across the organization to reduce the demand on staff resources; for example, incorporating unifying metrics across common EHR platforms may be helpful. The oversight authority should also establish a system for expedited review of additional measures that may emerge throughout the year.

Applying standardized objective criteria to decision-making about the priority level of measures is central to the oversight system. These criteria could be incorporated into an evaluation system to help gather stakeholder input, score measurement requests, and standardize and support oversight authority decision-making. Examples of criteria for identifying high-priority measures are outlined in later sections.

Having a method to monitor and track measure implementation and performance is also important. When measures are routinely utilized in departmental or medical staff quality reports and included in their monthly, quarterly, and/or annual reports to the Performance/Quality Improvement Council and the hospital's board of trustees, a monitoring system will enable the oversight authority to assess the "real-time" ongoing value of measures.

Healthcare organizations may find it valuable to designate an internal measure steward(s) to act on behalf of the oversight authority to coordinate measurement activity, identify changes and new requirements, and process new requests. Hospital quality and safety departments frequently handle these day-to-day logistics of coordination of measurement activity.

EXTERNAL CONTRACTING AND REPORTING

Quality measures included in managed care contracts have a direct impact on the provider's financial performance. These measures vary, are often not aligned, and can include different and unique performance and attainment metrics. Matching managed care metrics to organizational priorities is a complex process and requires the input of a variety of perspectives.

> Provider organizations are encouraged to include their clinical leaders during discussions about measure selection with managed care organizations and seek their guidance regarding approaches that will enable high performance and optimize value-based arrangements.

The Council may choose to establish an interdisciplinary advisory group that represents financial, quality, and clinical expertise as one way to ensure the organization's efforts to prioritize measures are embedded in agreements with managed care organizations and with physicians and other clinicians working within the healthcare system. Ensuring that measures are aligned throughout the organization, including managed care contracts, will improve efficiency and reduce costs.

Similarly, clinical practices working within healthcare systems also report on measures to external entities. Organizations are encouraged to work with these clinician groups to promote measure alignment with the organization's strategic priorities and existing measurement efforts.

DATA VALIDATION AND OVERSIGHT

An important role of the Council is to ensure that data validation and audits are implemented and reviewed regularly. For measures required by government or commercial entities, audits can ensure that the data are collected accurately (both clinical chart-abstracted measures and measures from billing codes), submitted by the established deadlines, and otherwise meet the required reporting rules and specifications. It is important to recognize that measure specifications are subject to frequent changes, and maintaining compliance requires ongoing vigilance.

A centralized oversight process can monitor the findings of internal data validation, clarify areas of vulnerability, and improve reporting and performance over time. As requirements for pay-for-performance programs become more complex, the development of a formal internal validation process will help improve the organization's overall performance. (See Appendix for a Federal Quality Reporting Reference Guide, which outlines the various programs, measures, means of data submission, and reference materials, and is designed to help guide organizations through the federal pay-for-reporting and pay-for-performance process.)

Clearly identifying an individual who will be accountable for the organization's compliance with each program can help facilitate effective oversight. While there may be one lead person, cross-training with other staff is necessary in order to position the organization to be prepared to accommodate unanticipated absences or other emergencies. To protect data integrity and privacy, some entities such as the National Healthcare Safety Network or Quality Net only allow "authorized" individuals to submit data on behalf of an organization. The process involved in receiving authorization to submit data can take several weeks, so healthcare organizations are encouraged to maintain authorizations for multiple individuals so they are positioned to respond during unexpected transitions and absences.

STRATEGY TWO:
DEVELOP CATEGORIZATION SYSTEM FOR MEASURES

The five-tier system described below is an effective method to categorize measures according to value, utility, frequency, and scope of the measure, while carefully considering the time and costs associated with collection and analysis. Recommended criteria outlined later provide a starting point to enable healthcare systems to further define and operationalize evaluation of measures and assign them to the tiers below.

TIER I: MEASURES FOR BOARD AND EXECUTIVE MANAGEMENT

These are high-priority measures that are aligned with the organization's strategic plan, high-profile requirements from federal/state or accreditation organizations, and closely tied to the goals of achieving improvement in key areas such as clinical and operational success, payment, and customer satisfaction. These high-profile measures are featured in the organization's leadership dashboard, and are routinely analyzed and monitored by the board of trustees and senior management.

> TIER I measures are likely to only include the organization's five to ten key priorities, which may best be addressed as a group of measures within the context of these priorities.

TIER II: MEASURES FOR ORGANIZATIONAL OPERATIONS

This tier includes measures that provide data and information necessary for the medical staff and hospital departments/units to manage operations. The measures are high profile; may be required by regulatory or accreditation organizations; and/or are necessary to manage and analyze the care delivered, including identifying opportunities for improvement.

> This tier includes measures that provide data and information necessary for the medical staff and hospital departments/units to manage operations.

In most organizations, significant time and resources are spent on these measures, as they are closely managed and monitored, reported on at least monthly—if not weekly—at the department level, and analyzed frequently for trends, progress, and risk. Changes in these metrics often invoke action. The measures are included in the department/unit's management plan and assist the department/unit in measuring success of its goals and objectives for the year. The measures may be reviewed by the executive team and board's quality committee quarterly or on a less frequent basis. Measures in this category may include outcome measures such as surgical site infections, falls, or pressure ulcers, and process measures such as risk assessments, appropriate use of prophylactic antibiotics, or frequency of position changes for patients confined to bed.

Tier II measures could target areas that need focused time and attention to meet performance benchmarks. As performance on these measures improves or worsens, they could be moved to either Tier III or Tier I, respectively.

TIER III: MEASURES TO MANAGE, BUT NOT PRIORITIZE

To continuously manage operations and ensure positive sustainable outcomes, some measures will likely be collected, tracked, and trended, but are not the key focus of the department or unit's current improvement activities.

> The important distinction of TIER III measures is that they ensure significant issues do not arise in an otherwise stable process, and they are analyzed for negative trends or special causes.

For example, a hospital may choose to include in this category quality measures that are performing at or better than the benchmark, those that should be tracked as "red flags," or measures that are stabilized and processes that are hard-wired in the daily work of staff. If trends suggest a problem, the organization should consider moving the measure to Tier II and add additional resources to expeditiously address the issue. However, if the measure is stable over time, little action is required. Organizations may want to assess the need for ongoing attention if the data are continually stable.

If possible, the human burden associated with data collection in Tier III should be purposefully limited and ideally automated through use of EHRs and production of run/control charts for quick analysis. Intermittent, prevalence, and sampling can also be beneficial to monitor measures while limiting expended resources.

TIER IV: MEASURES TO TRACK, BUT ONLY BY KEY STAFF

Measures in this category are often the result of time-limited, small pilot studies; clinical quality improvement projects or research; or implementation of a quality improvement Plan-Do-Study-Act (PDSA) cycle at an individual unit. In some cases, these projects are research- or grant-funded.

Tier IV measures enable clinicians and staff to take ownership of improving patient outcomes on a smaller scale. This activity is important for promoting frontline engagement, change, and further establishing a safety culture. Often, measures in this category are piloted at the department or unit level and, if useful, may be incorporated into a quality management plan in future years. If not, these measures sunset after the initial project is completed.

TIER V: MEASURES TO DISREGARD

Tier V includes measures that the organization has chosen not to focus on. Given the quality reporting requirements and associated resource burdens, it is reasonable, and in fact appropriate, for organizations to be prudent in deploying resources for measurement. In cases where specific measures are simply not a priority or a low priority, leadership teams can take a strong stance and simply say "no" to collecting additional data at this time.

STRATEGY THREE:
PRIORITIZE MEASURES BASED ON STANDARDIZED CRITERIA

What criteria should be used to ensure that the measure will contribute to the organization's quality and patient safety priorities and best meet the organization's strategic goals?

The criteria outlined below provide general guidance in assessing the value of measures for quality and patient safety, and are intended to be modified to meet an individual organization's needs and unique environment.

> These criteria provide a framework that can be used to assess the importance of individual measures within an organization.

ALIGNMENT WITH THE ORGANIZATION'S PRIORITIES

How well a measure aligns with the organization's strategic priorities is paramount to prioritization and is generally the first question leadership teams consider. The organization must be clear in its definition of strategic priorities, which may relate to areas such as clinical success, payment, and patient satisfaction and engagement, or other related measures. Ultimately, the question is: does the measure provide information or data that can advance the strategic priorities of the organization?

HOSPITAL PERFORMANCE

Evaluating internal performance on a measure assists organizations in determining actions needed to meet the organization's strategic goals. A hospital's performance on a measure can have a significant impact on the level of priority it is given, and can change over time as the organization's performance on the metric changes. For example, if an organization is performing well (at or near benchmark) on a measure, does its collection require significant resources from the organization? In that case, it may be a low priority. Alternatively, if the hospital is not satisfied in a certain area, that measure may become a high priority.

EVIDENCE-BASED, REPRESENTATIVE, AND ACTIONABLE

Organizations must evaluate whether the measure is valid, reliable, and evidence-based using the information available in the technical specifications and literature. Discussing whether a measure is clinically or statistically meaningful (i.e., valid) will assist organizations in identifying measures that will have the greatest impact on improving patient outcomes. Does the measure accurately evaluate the care delivered (i.e., reliable)? Is the measure actionable at the bedside? Can the organization make an impact on improving the measure at this time?

FINANCIAL IMPACT

Any evaluation of a measure should include a financial impact discussion that assesses the expected resource needs or effort required, balanced by the expected value of the information. As noted previously, many measures require time-intensive data collection and reporting processes, and, in some cases, disproportionate resources are directed to the measure collection instead of patient care.

What are the costs associated with implementation for staff, equipment, and technology, and teams for analysis? What is the cost for collecting and analyzing the measure, compared to the cost of making the measure a low priority? What level of staff is needed to provide the documentation, data abstraction, or analysis?

In short, what tradeoffs does the organization make in other areas to be able to collect data for this measure? Sometimes implementing a new measure is simply not worth the investment.

STRATEGY FOUR:
RANK AND WEIGHT MEASURES

Once healthcare organizations define their criteria for which measures are a priority, it may be helpful to categorize measures in a priority weighting system to further refine and organize their work. The sample below uses three weighting categories, but a variety of weighting scales could be used. An organization must decide how to determine numerical values for prioritizing the measures, although certain criteria or areas may be a strategic imperative.

The weighting system developed by the organization can align with the five-tier system (see page 16) based on its overall numerical value and how the criteria are operationally defined.

SAMPLE TOOL

Below is a sample tool that can guide decision-making based on the aforementioned weighting system.

ORGANIZATION SELECTION CRITERIA	OPERATIONAL DECISION GUIDE	ONE (LOW PRIORITY)	THREE (MEDIUM PRIORITY)	FIVE (HIGH PRIORITY)
Alignment with Organizational Priorities	Does the measure align with the organization's strategic direction and priorities related to: • clinical success • payment • patient and staff satisfaction	Request from a specific unit with low growth or market potential	Expanding program in a particular unit—minor changes anticipated in current benchmark outcomes (will be tracked in dollars saved)	Center for Excellence—new service Recalcitrant outcome in top priority domain High impact on patient safety—(incidence, cost, satisfaction)

ORGANIZATION SELECTION CRITERIA	OPERATIONAL DECISION GUIDE	ONE (LOW PRIORITY)	THREE (MEDIUM PRIORITY)	FIVE (HIGH PRIORITY)
Hospital/System Performance	What is the organization's current performance on the measure? Does it require significant time and attention to improve upon the measure or is it currently sustainable? Does the measure evaluate a condition that has a significant impact on the organization's patient population?	Consistently at 100% or zero for an extended period of time (e.g., one year) Recommend intermittent monitoring only Impacts low volume of patients	Normal variation for an extended period of time (e.g., two years at 75th percentile) Impacts a low volume of patients, but organization is growing that service line	Vital/visible and: - below benchmark; or - strategic goal to maintain high performance (e.g., above 98th percentile) High volume, focused on service line across the continuum
Evidence-Based	Is the measure's relationship to improved outcomes strong; is it clinically and statistically significant?	Little or no research evidence available Some promising case studies	Some reliable evidence available Best practices emerging Consistent promising case studies (intuitive)	Significant evidence available Best practice literature available
Representative/ Actionable	Is the measure actionable?	Limited association with process or outcome Limited impact on outcome Appropriate for focused study only	Proxy measure, but will be able to see change and extrapolate	Accurate representation of process or outcome— sensitive to improvements

PART IV: RECOMMENDATIONS

ORGANIZATION SELECTION CRITERIA	OPERATIONAL DECISION GUIDE	ONE (LOW PRIORITY)	THREE (MEDIUM PRIORITY)	FIVE (HIGH PRIORITY)
Financial Impact	What are the costs associated with the data collection and reporting infrastructure, including staff time, equipment, and technology? What is the opportunity cost for performing poorly?	No data currently available Substantial time required for chart abstraction Small volume of patients	Some economies of scale available with numerous areas utilizing information—approved with plan to coordinate and limit all waste Data distribution can be automated	Data collection can be automated Analytic reports can be automated Significant financial consequences (penalties) for non-reporting or poor performance
Voluntary	Is there a financial, quality, or reputation impact for performing poorly or not reporting on the measures?	Voluntary; not part of any current oversight, registry, or governmental system	Growing reliance on registry information in outpatient clinics	Anticipated to be mandatory within three years with baseline in current fiscal year Significant part of a particular payer's incentives tied to this

P. 22   HANYS | MEASURES THAT MATTER

CONCLUSION

> HANYS calls upon the healthcare field to collaborate to achieve a sensible balance of quality measurement reporting that fulfills the need to measure quality and safety, without draining limited resources from patient care and quality improvement.

While the value of measurement is clear, measurement is also clearly out of control and in need of reform.

In this document, HANYS has highlighted some of the adverse consequences associated with the chaotic state of healthcare reporting and measurement. The lack of alignment and coordination, an overwhelming volume of quality measures, and limitations of current EHR technology have created an environment of measure madness—consuming precious resources that could be directed toward meaningful efforts to continuously enhance quality and patient safety.

HANYS and our members are working toward a vision for the future where quality measurement supports providers' efforts to improve quality and patient safety—where measures accurately evaluate the intended aim, provide actionable information, are consistent with nationally-recognized standards, are relevant and critical to the organization's patient population and safety priorities, and are embedded in interoperable electronic health records.

We stand ready to collaborate with the healthcare field to make this vision a reality. Our efforts will be measured by the most important metrics of all—safer patients, better care, and healthier communities.

This document neither endorses, nor should be taken to endorse, any particular healthcare quality measure or measurement entity. Each organization is encouraged to make independent conclusions about the various measures, including whether to use this information to drive quality improvement, and whether to respond to an organization's request for data.

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HANYS' STATEWIDE STEERING COMMITTEE ON QUALITY INITIATIVES

HANYS extends our sincere appreciation to the members of the Statewide Steering Committee on Quality Initiatives for their input and guidance during the development of this document. We thank them for their leadership and participation in the national dialogue focused on improving quality and patient safety through reasonable healthcare measurement.

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APPENDIX

FEDERAL QUALITY REPORTING PROGRAMS

The Centers for Medicare and Medicaid Services administers many federal quality pay-for-reporting and pay-for-performance programs, which (as of January 2016) include:

- Hospital Inpatient Quality Reporting Program;

- Hospital Value-Based Purchasing Program;

- Hospital Readmission Reduction Program;

- Hospital-Acquired Condition Reduction Program;

- Hospital Outpatient Quality Reporting Program;

- Ambulatory Surgery Center Quality Reporting Program;

- Long-Term Care Hospital Quality Reporting Program;

- Inpatient Psychiatric Facility Quality Reporting Program;

- Inpatient Rehabilitation Facility Quality Reporting Program;

- End-Stage Renal Disease Facility Quality Reporting Program;

- PPS-Exempt Cancer Hospital Quality Reporting Program;

- Home Health Quality Reporting Program; and

- Physician Quality Reporting Program.

In addition, CMS is expected to soon finalize a quality reporting program for skilled nursing facilities.

FEDERAL RULEMAKING PROCESS

Changes to the federal quality pay-for-reporting and pay-for-performance programs are made through the annual federal rulemaking process, which includes the following steps:

1. **PUBLICATION OF PROPOSED RULE:** A Notice of Proposed Rule Making (NPRM) is published in the *Federal Register* at www.federalregister.gov. The proposed rule often contains specific program proposals, as well as future topics and issues for consideration for which CMS is seeking comments.

2. **COMMENT PERIOD:** Each NPRM is followed by a period set aside for public comment. Comments are accepted via email and by postal mail for 60 days following publication. The purpose of the comment period is to provide an opportunity for the public and interested and affected parties to influence the outcome by raising issues and questions that can be addressed before the regulation is finalized.

3. **PUBLIC INSPECTION OF COMMENTS:** Comments received are made available for public inspection. Traditionally, comments submitted by mail are available for public viewing in a room at U.S. Department of Health and Human Services (HHS) headquarters in Washington, D.C. Comments will be available for public viewing on the CMS website after the comment period has ended.

4. **ANALYSIS OF COMMENTS:** Comments are analyzed and summarized by CMS, and responses are prepared by the implementation teams responsible for the content.

5. **PUBLICATION OF FINAL RULE:** The final rule is published in the *Federal Register*. It includes a summary of the comments and responses to the comments, including any changes that were made to the proposed regulation as a result of the comments.

MEASURES

Each of the federal programs has a distinct set of measures outlined in each program's specification manual; however, in an effort to achieve program alignment, some measures cross programs. This trend will increase in the coming years with the adoption of the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act). The Act requires the submission of standardized data by long-term care hospitals (LTCHs), skilled nursing facilities (SNFs), home health agencies (HHAs), and inpatient rehabilitation facilities (IRFs).

While HANYS supports alignment of measures across settings, we have serious concerns that providers could be subject to multiple payment penalties for their performance on a single measure. For example, hospitals are subject to payment penalties for hospital-acquired conditions (HACs) in both the HAC Reduction Program and the Hospital Value-Based Purchasing Program.

REPORTING

Each of the programs requires a specific process for reporting quality data, which can also vary by each individual measure with the quality reporting program. For some measures, the data are automatically conveyed to CMS via Medicare claims. In other programs, providers must submit data through MyQualityNet.org or another specific data portal. Still other measures require submission of chart abstracted data through the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). The table beginning on page 31 summarizes the various mechanisms for federal quality data reporting.

UNDERSTAND FINAL RULE, REQUIRED MEASURES, & TIMEFRAME

IMPLEMENT DATA COLLECTION & REPORTING INFRASTRUCTURE

ABSORB PAYMENT ADJUSTMENTS

REVIEW DATA BEFORE SUBMISSION

PREPARE TO RESPOND TO PUBLIC INQUIRIES

CORRECT DATA

PREVIEW DATA

SUBMIT DATA

MEDICARE OUTPATIENT

MEDICARE INPATIENT PSYCHIATRIC

MEDICARE INPATIENT

MEDICARE INPATIENT REHABILITATION

MEDICARE PHYSICIAN

MEDICARE AMBULATORY SURGERY CENTER

MEDICARE END-STAGE RENAL DISEASE

MEDICARE LONG-TERM CARE HOSPITAL

PROPOSED RULE · COMMENT PERIOD · FINAL RULE

PROGRAM	NUMBER OF REQUIRED MEASURES	DATA SUBMISSION MECHANISM(S)	REFERENCE MATERIAL
Hospital Inpatient Quality Reporting Program	44 plus 4 out of 28 electronic clinical quality measures (eCQMs)	• QualityNet Secure Portal • NHSN • Medicare Claims	www.qualitynet.org https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalrhqdapu.html http://www.qualityreportingcenter.com/inpatient/iqr/tools/
Hospital Outpatient Quality Reporting Program	25	• QualityNet Secure Portal • NHSN • Medicare Claims	www.qualitynet.org https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/hospitalOutpatientQualityReportingProgram.html
Ambulatory Surgery Center Quality Reporting Program	6	• QualityNet Secure Portal • NHSN • Medicare Claims	www.qualitynet.org https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ASC-Quality-Reporting/
Long-Term Care Hospital Quality Reporting Program	12	• Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System • NHSN • Medicare Claims	www.qualitynet.org https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/
Inpatient Psychiatric Facilities Quality Reporting Program	13	• QualityNet Secure Portal • NHSN • Medicare Claims	www.qualitynet.org http://www.qualityreportingcenter.com/inpatient/ipf/tools/

Current as of January 2016

PROGRAM	NUMBER OF REQUIRED MEASURES	DATA SUBMISSION MECHANISM(S)	REFERENCE MATERIAL
Inpatient Rehabilitation Facility	7	• IRF Patient Assessment Instrument (IRF PAI) submitted via QIES ASAP system • NHSN • Medicare Claims	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/
End-Stage Renal Disease Facility Quality Incentive Program	16	• NHSN • Consolidated Renal Operations in a Web-Enabled Network (CROWNWeb) • Medicare Claims	www.qualitynet.org https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/esrdqip/index.html http://esrdny.ipro.org/
PPS Exempt Cancer Hospitals	22	• QualityNet Secure Portal • NHSN	www.qualitynet.org http://www.qualityreportingcenter.com/inpatient/pch/tools/

RECONSIDERATION PROCESS

CMS pay-for-reporting and pay-for-performance programs include a reconsideration process, during which providers can request that CMS reconsider whether the provider met the program requirements for a particular calendar year (CY). The request must identify the hospital's specific reason(s) for believing it has met the Annual Payment Update (APU) requirements and should receive the full payment update.

CMS will officially respond to the reconsideration request submitted by each facility. If a facility is dissatisfied with the result of reconsideration, the facility may file a claim under 42 Code of Federal Regulations (CFR) Part 405, Subpart R (a Provider Reimbursement Review Board appeal). Some programs—Inpatient Quality Reporting (IQR), Outpatient Quality Reporting (OQR), LTCH Quality Reporting Program (QRP), IPF QRP—allow an additional judicial review or appeal of the reconsideration determination, while other programs do not (Ambulatory Surgical Center Quality Reporting).

PREVIEW PERIODS

Data collected through the IQR program are displayed for public viewing on Hospital Compare at www.medicare.gov/hospitalcompare. Prior to the release of data on Hospital Compare, hospitals are given the opportunity to review data during a 30-day preview period via the QualityNet Secure Portal. During this time, hospitals have the opportunity to work with CMS to resolve errors in CMS calculations, but are not able to make changes to their data.

The End-Stage Renal Disease Quality Incentive Program also includes a preview period—a 30-day timeframe (normally occurring in late summer each year) during which a facility has the opportunity to review the preliminary performance scores calculated by CMS. During that time, a facility may submit one or more clarification questions and/or a single formal inquiry in the event that it believes an error in calculating its scores has been made. Only one formal inquiry will be permitted per facility, but that inquiry may include as many questions as necessary.

EXTRAORDINARY CIRCUMSTANCES WAIVER

In the event that a hospital is unable to submit data or access medical records due to an extraordinary circumstance, such as a natural disaster, the hospital may request an extension or waiver. Hospitals need to complete the Extraordinary Circumstances Extension or Waiver form and submit the form and any supporting documentation within 45 days of the date of the extraordinary circumstance.

Hospitals that are included under a blanket waiver by CMS (due to widespread natural disasters such as hurricanes, tornadoes, etc.) will not be required to submit the Extraordinary Circumstances Extension or Waiver form.

HANYS Quality Institute