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.
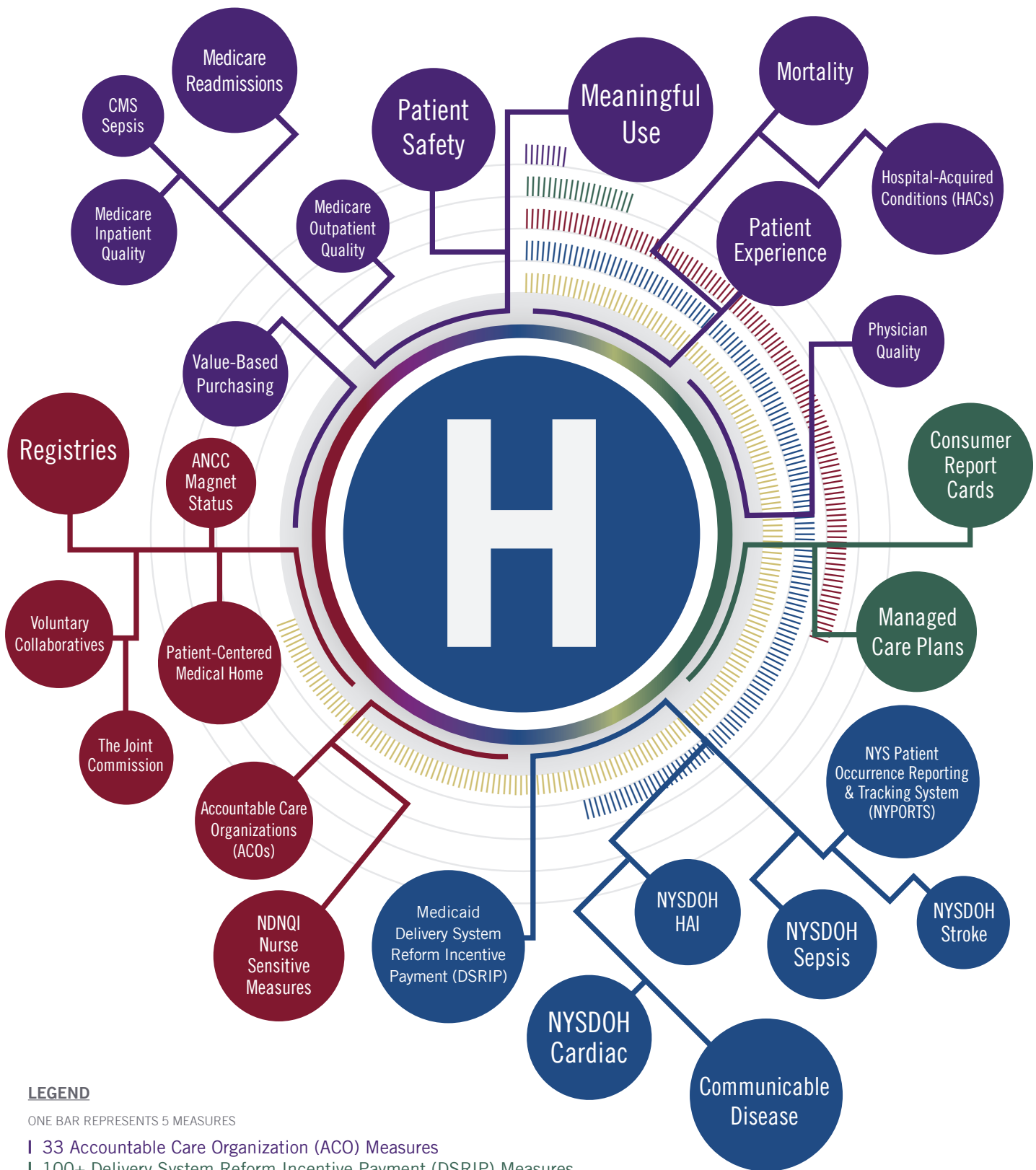
LIMITATIONS OF CURRENT EHR TECHNOLOGY

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]

Medicare Readmissions

CMS Sepsis

Medicare Inpatient Quality

Medicare Outpatient Quality

Patient Safety

Meaningful Use

Mortality

Hospital-Acquired Conditions (HACs)

Patient Experience

Physician Quality

Value-Based Purchasing

Registries

ANCC Magnet Status

Consumer Report Cards

Voluntary Collaboratives

Patient-Centered Medical Home

Managed Care Plans

The Joint Commission

Accountable Care Organizations (ACOs)

NDNQI Nurse Sensitive Measures

Medicaid Delivery System Reform Incentive Payment (DSRIP)

NYS Patient Occurrence Reporting & Tracking System (NYPORTS)

NYSDOH HAI

NYSDOH Sepsis

NYSDOH Stroke

NYSDOH Cardiac

Communicable Disease

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.