American Hospital Association

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George Isham, M.D.
Elizabeth McGlynn, Ph.D.
Co-Chairs of the Measure Applications Partnership Coordinating Committee
C/O The National Quality Forum
1030 15th Street, NW, Suite 800
Washington, DC 20005

Dear Drs. Isham and McGlynn:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association (AHA) has undertaken an exercise designed to start a conversation about a more deliberate and focused approach to quality measurement and the inclusion of those measures in public reporting and pay-for-performance programs. We undertook this work because our members are overwhelmed by the deluge of quality measures they are asked to report. We believe a more focused approach will lead to even more substantial improvements in care as we have already demonstrated through the success of AHA's work on the targeted areas of the Hospital Engagement Network that saved an estimated 92,000 instances of harm and $988 million.

The National Quality Forum Strategic Framework Board (SFB) is absolutely correct in calling for the establishment of specific national quality goals, with preference then being given to selecting a parsimonious set of quality measures to be used in national efforts linked directly to those goals. Through conversations with the AHA Board of Trustees and representative groups of our membership, we have developed a set of principles for choosing quality metrics and a list of 11 prioritized areas on which hospital measurement should be focused.

To be clear, while our members bring an important perspective and deep knowledge of opportunities for improvement, we know that ours is not the only perspective needed. Instead, we offer the attached document as the starting point for further conversations that will lead to consensus on what is most important to measure and improve across the continuum of care.

We ask that this document be shared with your colleagues on the Measure Applications Partnership Coordinating Committee and would value your feedback. If you have any questions, please do not hesitate to contact me or Nancy Foster, vice president for quality and safety policy, at nfoster@aha.org or (202) 626-2337.

Sincerely,
//s//
Rich Umbdenstock
President and CEO

Attachment

QUALITY MEASURE PRIORITIZATION: AN AHA PROPOSAL

"People think focus means saying yes to the thing you've got to focus on. But that's not what it means at all. It means saying no to the hundred other good ideas that there are. You have to pick carefully. I'm actually as proud of the things we haven't done as the things I have done. Innovation is saying no to 1,000 things." Steve Jobs

The American Hospital Association (AHA) has long called for a more focused, coherent approach to measuring and publicly reporting on quality of care in our nation's hospitals and other healthcare organizations. The need for a more strategic approach has become increasingly urgent in recent years as measures have proliferated in Medicare, Medicaid, state agency and private payer quality reporting and pay-for-performance programs. Important opportunities to make meaningful differences in the quality of care provided to patients are being lost because measurement activities are not focused on critically important areas where improvements will yield significant differences in patient outcomes.

To kick-start a conversation among stakeholders about what should be the focus of national attention and concerted, collaborative action, the AHA worked with its members to identify a list of measurement ideas they thought would lead to the most significant improvements in the care they deliver. During the course of these conversations, a short list of principles about the kinds of measures that should be chosen and how they should be used also emerged. The AHA Board of Trustees encouraged staff to share these ideas with key stakeholders to prompt conversations about whether this is the right starting list of measures and principles, and how we can move toward a more focused and productive way of measuring quality.

Concepts for Focusing Improvement and Measurement

Actin on the members' strong support for a small set of critically important ideas, hospital and health system leaders who are involved in the AHA's policy development process were asked to identify the ideas they believed most important for measurement and improvement activities now. Through a formal decision-making process, eleven measurement concepts received strong support across our elected leadership. Hospital leaders recognized that as improvement is achieved, there will come a time when some measures topics should be retired so that different high priority opportunities can be identified and added. The focused set of measurement and improvement ideas hospital leaders are advancing now are:

Measure Ideas	NQS Category
Harm Rates	Safety
Risk Adjusted Mortality	Clinical Effectiveness
Effective Patient Transitions	Care Coordination
Infection Rates	Safety
End of Life Preferences	Patient and Family Engagement
Cost per Case or Episode	Efficiency
Readmission Rates	Care Coordination
Adherence to Guidelines for Commonly Overused Procedures	Efficiency
Medication Errors	Safety
Diabetes Control	Population/ Public Health
Obesity	Population/ Public Health

The principles AHA members suggested for selecting and using quality measures are:

- Data should be reported in a manner meaningful to consumers so that the public is engaged and understands what the measures signify.
- Outcome measures are most important and preferable to process measures, but must be:
    - crafted carefully to ensure they have appropriate, valid, well-defined numerators and denominators
    - consistent with available science
    - adjusted for those things that are outside the control of the organization being measured (e.g., sociodemographic factors, acuity of illness);
- Measures alone are insufficient and should be coupled with
    - an examination of variation in practice and the reasons for it,
    - tools to improve standardization where important,
    - Information on near misses;
- The focus should be on improvement rather than the actual rates of performance;
- Mental health and access measures are important, and should be considered for the list;
- While population and public health measures are beyond the scope of most current hospital operations, as more coordinated approaches to care become more prevalent and there is broader work under accountable care organizations, population and public health measures will become increasingly of interest to hospitals and health systems.

Requested Action

Others interested in quality measurement are asked to review this list of top ranked measure topics and the associated comments and principles and offer comments and their own ideas about what is most important to measure to support improvements in care and to provide useful information to patients, communities and payers.

Background: Further Information on How These Ideas Were Chosen

For more than a decade, hospitals have measured and publicly reported on aspects of the quality of the care they provide. The number of measures has rapidly grown, with the Medicare program alone contributing a significant portion of reporting requirements. As noted in the Medicare Payment Advisory Commission's June 2014 report, there will be 58 measures in the fiscal year (FY) 2016 inpatient quality reporting (IQR) program, nearly *six times more* measures than the 10 measures the program started with in FY 2005. Similarly, the number of outpatient quality reporting (OQR) program measures has more than doubled, going from 11 in 2009 to 28 in 2016. Hospitals offering post-acute care or inpatient psychiatric services may have to report even more measures under quality reporting programs established under the Affordable Care Act (ACA). Other payers and state departments of health or public health have also adopted their own measures, with each organization requiring hospitals and other providers to submit data that will support that organization's measurement agenda. In many cases, the different payers and state agencies seem to be interested in measuring similar concepts, but they are using measures that are not the same. The result is an overwhelming set of discordant and conflicting data on how well each hospital is performing.

Hospitals agree that well-conceived public quality reporting and pay-for-performance programs can promote improvement and provide the public with meaningful information on quality. Unfortunately, measurement requirements have been added without strong alignment to specific national quality improvement priorities or goals. As a result, the number of quality measures requested of hospitals, the number of variations in measure specifications all purporting to assess the same aspect of care, and the number of organizations reporting quality data has instead grown so rapidly that it has created confusion about what is being measured, how it should be measured, and what the results of the measurement effort show, as described in a Kaiser Health news article last year[i]. At a time when health care resources are under intense scrutiny, an aligned, focused and rigorous approach to quality measurement and pay-for-performance programs would ensure that such programs are targeted at areas that will truly drive the most meaningful improvements for patients and promote coordination of quality improvement efforts across the health care delivery system.

On behalf of its members, the AHA has urged a more strategic and rational approach to quality reporting and pay for performance. The AHA has encouraged the Department of Health and Human Services (HHS), private payers and others to focus their measurement efforts on a small set of issues of great significance to patients and with a high probability of care improvement. Further, the AHA has urged that the measures selected for use in hospital quality reporting

programs be aligned with the measures used in similar programs for other parts of the health care delivery system to stimulate coordinated improvement.

The AHA has been participating in multi-stakeholder efforts to identify measures that should be used in public reporting, quality improvement and pay-for-performance programs, including the Hospital Quality Alliance, the National Quality Form (NQF) and the Measure Applications Partnership (MAP). These efforts bring together committed individuals and organizations who believe that the sharing of performance data can help both prompt substantial improvement in the quality of care provided and better inform the public so that patients can choose providers based on an understanding of the value of the care provided.

Originally, the AHA and other hospital associations participating in these efforts believed that these multi-stakeholder discussions would lead to greater consensus on a small, critically important set of metrics. We believed this would lead to coordinated efforts to improve the care for patients. However, since the measures included in various programs have been numerous and scattered, such coordination has not materialized.

While the AHA and its members believe this focus is essential to improvement, others have heard the call as an attempt to limit the amount of available information on hospital quality. At the same time, these stakeholders often find the measures currently in use confusing and too granular. Any truly successful national quality measurement approach must address these diverse needs. The measures used in these efforts must be scientifically sound to be credible to all who should act on them. They also must provide useful information that is important to patients, their families and the public, and to those who pay for the services patients receive. They must provide useful information to clinicians and hospitals so that they understand where their performance excels and where it falls short. Because change requires effort and imposes new risks for patients and care givers, the measures also must provide insights about areas where the value of improvement is judged to be greater than the cost of creating the change and the potential risks associated with the change

HHS espouses a desire to create a more aligned and effective quality measurement system, and took a step in that direction in 2012 when it promulgated the National Quality Strategy (NQS). The NQS identified six areas of focus for federal efforts -- clinical effectiveness, efficiency, public and population health, patient safety, care coordination, and patient and family-centered care. The NQS has provided an organizing framework for measures, but it has not led to the kind of strategic focus for which the AHA has advocated. Purchasers and consumers also are struggling to make sense of multiple report cards and data displays, and the MAP has criticized the Centers for Medicare and Medicaid Services (CMS) for advancing too many measures for review.

The Path to Greater Focus

Since the AHA's member hospitals continue to be overwhelmed by quality reporting demands that are impeding rather than supporting efforts to improve quality, the AHA sought to change the national conversation by identifying the short list of quality measures that hospital leaders would prefer, with the intention of using it as a discussion starter with HHS, the Measure Applications Partnership, and others. We do not believe that other stakeholders will simply

accept the list we have created; however, we hope it may help them envision how a shorter list of key measures might better meet their needs and ours, and provide a basis for further conversation.

A two part process was used to work with AHA's policy bodies (Regional Policy Boards and Governing Councils) to develop the list of preferred quality measures. In the late 2013, members of the boards and councils prioritized the six categories of the National Quality Strategy (NQS) and, working with their quality teams, each member identified a small set of important metrics that they would recommend for public reporting and to improve performance. About 450 hospital leaders ranked the importance of the six NQS categories on a scale of 1 to 5. The results of this ranking exercise were, in order of most important to least important:

1. Patient Safety
2. Clinical Effectiveness
3. Care Coordination
4. Patient and Family Engagement
5. Efficiency
6. Population and Public Health

AHA staff reviewed all of the submitted suggestions for measures and selected the ideas that were mentioned by more than eight individuals. This list of measures was taken back to members at the spring 2014 meetings where hospital leaders were asked to vote on which of those ideas they thought were best and discuss what they thought of the choices made by their group and the balance of those choices among the six NQS categories. The result was the list of 11 measures shown in the table above and the principles articulated just below the table.

Further, members urged the AHA to recognize that hospitals are not the only organizations that have an opportunity to improve outcomes. They suggested that the AHA form new strategic partnerships and work with other stakeholders to address community factors affecting outcomes.

[i] Jordan Rau, *Hospital Ratings are in the Eye of the Beholder*. Kaiser Health News, March 18, 2013