

ROLE OF POLICY IN ADVANCING QUALITY

Learning Objectives

After completing this chapter, you should be able to

- describe the types of oversight organizations that influence healthcare quality;
- recognize how public and private policies encourage quality improvement at the organizational, community, and national levels; and
- identify resources to maintain current knowledge about policy changes, new initiatives, and updates on current initiatives.

The most visible or well-known topics of healthcare policy tend to be those related to funding, payment, and access. Examples include Titles XVIII and XIX, the Social Security Act amendments of 1965 that created Medicare and Medicaid; the Balanced Budget Act of 1997 that created the Children's Health Insurance Program (CHIP); and the Patient Protection and Affordable Care Act of 2010 (ACA). There are many other public and private policies that play an integral role in ensuring the quality of healthcare services.

Licensure is an example of how healthcare quality is affected by public health policies. Physicians, nurses, nurse practitioners, pharmacists, physical therapists, and other care providers must have licenses to practice their professions. These requirements are guided by the statutes and rules outlined in the professional practice acts and occupational licensing bodies of their respective states. There are many other examples of how public and private policies influence healthcare quality. The Americans with Disabilities Act requires health facilities to have ramped sidewalks to the front door and Braille numbers on the elevator buttons. Sprinklers in the ceilings, signs labeled "fire exit," and alarm-activated doors that close automatically are mandated by state building codes and the fire safety requirements of state regulations and private health facility oversight groups. Inappropriate or excessive radiation exposure to patients and healthcare personnel during diagnostic exams is prevented when facilities comply with the requirements of the Occupational Safety and

licensure
status granted by a governmental body and confirming minimum standards

accreditation
“a public recognition by a healthcare accreditation body of the achievement of accreditation standards by a healthcare organization, demonstrated through an independent external peer assessment of that organization’s level of performance in relation to the standards” (Smits, Supachitkul, and Mate 2014, 66)

certification
a form of external quality review for health services professionals and organizations; when applied to individuals, it represents advanced education and competence; when applied to organizations, it represents meeting predetermined standards for a specialized service provided by the organization (Rooney and van Oostenburg 1999).

Health Administration and private oversight entities. The safety and efficacy of medications are investigated by the US Food and Drug Administration before they are released for patient use.

Considering the Donabedian (1980) model for measuring quality (structure, process, outcome), policy initiatives have historically targeted the quality of the structural elements of the healthcare delivery system, such as people, physical facilities, equipment, and drugs. Outcome measures, such as infant mortality rates and life expectancy, and aggregate process measures, such as immunization rates, have been collected for many years by the public health infrastructure at state, national, and international levels. Current health quality policy initiatives target outcomes and processes at the organization, provider, and population levels.

This chapter discusses the increasingly important role of public and private policies on healthcare quality by providing a brief overview of health policy concepts, explaining the role of quality oversight bodies, and introducing several healthcare quality initiatives that demonstrate the use of public and private policies to drive system change and improvement.

External Stakeholders Affecting Quality

A variety of external stakeholders—federal, state, and local government agencies and private organizations—set quality expectations and assess and monitor services delivered by health plans, health facilities, integrated delivery systems, and individual practitioners. Types of quality oversight organizations are summarized in exhibit 2.1.

External stakeholders use three primary approaches to influence healthcare quality: licensure, accreditation, and certification. Licensure is granted by a governmental body and represents *minimum* quality standards, while accreditation and certification are granted by nongovernmental

EXHIBIT 2.1

Types of Healthcare Quality Oversight Organizations in the United States

State licensing bodies. States, typically through their health departments, have long regulated healthcare delivery through the licensure of healthcare institutions such as hospitals, long-term care facilities, and home health agencies, as well as individual healthcare practitioners such as physicians and nurses. States also license, through their insurance and health departments, financial “risk-bearing entities,” including both indemnity insurance products and those managed care products that perform the dual function of bearing risk (like an insurer) and arranging for or delivering healthcare services (like healthcare-providing entities).

(continued)

Private sector accrediting bodies. Accrediting bodies set standards for healthcare organizations and assess compliance with those standards. They also focus on the operational areas, state and federal governments rely on or recognize private accreditation for purposes of ensuring compliance with licensure or regulatory requirements.

Medicare and Medicaid compliance. For a healthcare entity to receive Medicare or Medicaid reimbursement, the entity must meet certain federally specified conditions of participation (COPs) or other standards. The Centers for Medicare & Medicaid Services (CMS) promulgates COPs for hospitals, home health agencies, nursing facilities, hospices, ambulatory surgical centers, renal dialysis centers, rural health clinics, outpatient physical therapy and occupational therapy, and rehabilitation facilities. CMS also establishes standards for the participation of managed care organizations contracting under the Medicare program.

US Department of Labor. Oversight of certain aspects of employer-provided health plans is performed by the US Department of Labor. The Employee Retirement Income Security Act of 1974 sets minimum federal standards for group health plans maintained by private-sector employers, by unions, or jointly by employers and unions. The department oversees plan compliance with the following legal requirements of plan administration: reporting and disclosure of plan features and operations, fiduciary obligations for management of the plan and its assets, handling benefit claims, continuation coverage for workers who lose group health coverage, limitations on exclusions for preexisting conditions, prohibitions on discrimination based on health status, renewability of group health coverage for employers, minimum hospital stays for childbirth, and parity of limits on mental health benefits.

Individual certification and credentialing organizations. The American Board of Medical Specialties (an umbrella for 24 specialty boards) and the American Osteopathic Association have certification programs that designate certain medical providers as having completed specific training in a specialty and having passed examinations testing knowledge of that specialty. The Accreditation Council for Graduate Medical Education, sponsored by the American Medical Association and four other organizations, accredits nearly 7,700 residency programs in 1,600 medical institutions across the United States. For nursing, the American Board of Nursing Specialties sets standards for the certification of nursing specialties. The largest numbers of nurses, both in generalist and specialist practice, are certified by the American Nurses Credentialing Center on the basis of practice standards established by the American Nurses Association.

Source: Data from President’s Advisory Committee on Consumer Protection and Quality in the Health Care Industry (1998).

EXHIBIT 2.1

Types of Healthcare Quality Oversight Organizations in the United States
(continued)

organizations. Accreditation and certification represent *optimal* quality standards for organizations or *advanced* education and competence for individuals.

Quality oversight organizations are vital stakeholders of health services organizations. Their standards, regulations, and conditions of participation (COPs) increasingly drive system change and improve quality of care and services. Details on the specific laws, regulations, and impact of healthcare quality may be found in other texts dedicated to health policy and healthcare management. In the next sections, a few key examples of external stakeholders (public and private) and how they influence healthcare quality are provided. Because the priorities and expectations of external stakeholders are constantly changing, students and managers charged with quality responsibilities will need additional resources to learn about the most current requirements of all stakeholder groups affecting their organization. The web resources at the end of this chapter are useful for this purpose.

Federal Health Policies and Oversight

The federal government is a vital stakeholder of health services organizations. Its regulations, COPs, and health policy priorities are increasingly being used to drive system change and improve quality of care and services. Details on specific laws and regulations that affect healthcare quality may be found in other texts dedicated to health policy. This section presents a few key examples that illustrate the role of policy in system improvement. A brief background on the evolution of these initiatives is also provided so readers may appreciate the influence of history on the current healthcare quality landscape.

The US government serves the following generic purposes: “to provide for those who cannot provide for themselves, to supply social and public goods, to regulate the market, and to instill trust and accountability” (Tang, Eisenberg, and Meyer 2004, 48). To accomplish these purposes, the government uses public policy or “authoritative decisions made in the legislative, executive, or judicial branches of government that are intended to direct or influence the actions, behaviors, or decisions of others” (Longest 2010, 5). Some of these public policies are considered health policies because they “pertain to health or influence the pursuit of health” (Longest 2010, 6). Health policies are crafted to influence health determinants, which in turn influence health. The ACA (US Department of Health and Human Services [HHS] 2015) was the most significant legislation resulting from public health policy since enactment of the Medicare and Medicaid programs in 1965.

However, the federal government’s influence extends beyond the ACA. In 2011, the HHS published *National Strategy for Quality Improvement in Health Care*. This document outlined the National Quality Strategy, a road map

for achieving affordability, better care, and healthy people and communities. The recommendations in this document affect all healthcare stakeholders—patients; providers; employers; health insurance companies; academic researchers; and local, state, and federal governments (HHS 2011). Each year, the road map is reviewed and revised as needed to reflect current priorities and performance results (Agency for Healthcare Research and Quality [AHRQ] 2016b).

The three broad aims of *National Strategy for Quality Improvement in Health Care* guide the local, state, and national efforts to improve health and the quality of healthcare. These aims include the following (AHRQ 2014):

- *Better care.* Improve overall quality by making healthcare more patient-centered, reliable, accessible, and safe.
- *Healthy people/healthy communities.* Improve the health of the US population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
- *Affordable care.* Reduce the cost of quality healthcare for individuals, families, employers, and the government.

The many legislative, regulatory, and reimbursement changes necessary to support the National Quality Strategy are affecting quality management at the provider level. Two notable changes came from federal legislation passed before the National Quality Strategy: The Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, promoted the adoption and meaningful use of health information technology (Jha 2012). This legislation has influenced the transition to electronic health records to improve the quality and safety of the healthcare system. The large federal subsidies for adopting this technology and financial disincentives have made the conversion from paper to electronic records possible in many organizations.

The ACA may also support the National Quality Strategy by encouraging healthcare organizations to form **accountable care organizations (ACOs)** to bring about efficiencies in consumption of services while lowering overall costs. An ACO is a network of providers (primarily doctors and hospitals) that share financial and medical responsibilities for providing coordinated care to patients in hopes of limiting unnecessary spending (Gold 2015).

Knowledge Acquisition

Public policy at the federal level creates formal structures and mechanisms for acquiring new knowledge so that public and private policymakers may make informed, evidence-based decisions about health quality practices. For example,

accountable care organization (ACO) a network of providers (primarily doctors and hospitals) that share financial and medical responsibilities for providing coordinated care to patients in hopes of limiting unnecessary spending (Gold 2015)

public policy “authoritative decisions made in the legislative, executive, or judicial branches of government that are intended to direct or influence the actions, behaviors, or decisions of others” (Longest 2010, 5)

health policies policies that “pertain to health or influence the pursuit of health” (Longest 2010, 6)

the AHRQ sponsors and conducts research and disseminates information to advance healthcare quality (see exhibit 2.2).

Another example is the Innovation Center at CMS (2016a), which the ACA created “for the purpose of testing innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care for those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits.” Best practices and lessons learned from these tests are made available to all healthcare organizations to support quality improvement throughout the healthcare system at large. Several of the innovation models being tested have the potential to greatly affect quality and safety improvement activities at the provider level (see exhibit 2.3).

One initiative of the CMS Innovation Center is a nationwide public-private collaboration called Hospital Engagement Networks (HEN). These networks work at the regional, state, national, or hospital-system level to help identify solutions already working and disseminate them to other hospitals and providers. Initially, the CMS Innovation Center formed 26 HENs in 2012 as part of a campaign to reduce harm and improve the quality and safety of healthcare. Many of these networks were successful at achieving this goal. For instance, the 127 hospitals participating in the Iowa-based HEN prevented potential harm to more than 4,300 patients in 2013 and reduced healthcare costs by more than \$51 million according to data released by the Iowa Healthcare Collaborative (Iowa Hospital Association 2014), which administers

EXHIBIT 2.2

Agency for Healthcare Research and Quality

Mission. To support research designed to improve the quality, safety, efficiency, and effectiveness of healthcare for all Americans. The research sponsored, conducted, and disseminated by AHRQ provides information that helps people make better decisions about healthcare.

Created. The agency was founded in December 1999 as the Agency for Health Care Policy and Research, a public health service agency in the HHS. Reporting to the HHS secretary, the agency was reauthorized on December 6, 1999, as the Agency for Healthcare Research and Quality. Sister agencies include the National Institutes of Health, the Centers for Disease Control and Prevention, the Food and Drug Administration, the Centers for Medicare & Medicaid Services, and the Health Resources and Services Administration.

Main functions. AHRQ sponsors and conducts research that provides evidence-based information on healthcare outcomes; quality; and cost, use, and access. The information helps healthcare decision makers—patients and clinicians, health system leaders, purchasers, and policymakers—make more informed decisions and improve the quality of healthcare services.

Source: Adapted from AHRQ (2016a).

Accountable care. Accountable care organizations and similar care models are designed to incentivize healthcare providers to become accountable for a patient population and to invest in infrastructure and redesigned care processes that provide for coordinated care, high quality, and efficient service delivery.

Episode-based payment initiatives. Under these models, healthcare providers are held accountable for the cost and quality of care that beneficiaries receive during an episode of care, which usually begins with a triggering healthcare event (such as a hospitalization or chemotherapy administration) and extends for a limited time thereafter.

Primary care transformation. Primary care providers are a key point of contact for patients’ healthcare needs. Strengthening and increasing access to primary care is critical to promoting health and reducing overall healthcare costs. Advanced primary care practices—also called *medical homes*—use a team-based approach while emphasizing prevention, health information technology, care coordination, and shared decision making among patients and their providers.

Initiatives focused on Medicaid and CHIP populations. Medicaid and CHIP are administered by the states but are jointly funded by the federal government and the states. Initiatives in this category are administered by the participating states.

Initiatives focused on Medicare and Medicaid enrollees. The Medicare and Medicaid programs were designed with distinct purposes. Individuals enrolled in both Medicare and Medicaid (called *dual eligibles*) account for a disproportionate share of the programs’ expenditures. A fully integrated, person-centered system of care that ensures all enrollees’ needs are met could better serve this population in a high-quality, cost-effective manner.

Initiatives to accelerate the development and testing of new models. Many innovations necessary to improving the healthcare system will come from local communities and healthcare leaders from across the country. By partnering with these local and regional stakeholders, CMS can help accelerate the testing of models today that may be the next breakthrough tomorrow.

Initiatives to speed the adoption of best practices. Recent studies indicate that it takes nearly 17 years, on average, before best practices (practices backed by research) are incorporated into widespread clinical practice—and even then the application of the knowledge is very uneven. The CMS Innovation Center is partnering with a broad range of healthcare providers, federal agencies, professional societies, and other experts and stakeholders to test new models for disseminating evidence-based best practices and significantly increasing the speed of adoption.

Source: Data from CMS (2016b).

EXHIBIT 2.3

Categories of New Payment and Service Delivery Models Being Tested by the CMS Innovation Center

the network. To sustain this national progress and momentum, in 2015 CMS awarded a second round of contracts to 17 HENs, which include more than 3,200 hospitals (CMS 2015a).

CMS also promotes local implementation of quality practices through its network of Quality Improvement Organizations (QIOs). The Medicare QIO Program (formerly referred to as the Medicare Utilization and Quality Control Peer Review Program) was created by statute in 1982 to improve quality and efficiency of services delivered to Medicare beneficiaries (Leavitt 2006, 2). Today, the QIO Program comprises 14 regional Quality Innovation Networks designed to “bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality” (Quality Improvement Organizations 2016).

Transparency

Transparency is a vital component of an efficient and effective healthcare system, as it fosters improved management of the cost and quality of health services (Wetzel 2014). In 1987, an unprecedented effort at nationwide healthcare performance transparency occurred when the Health Care Financing Agency (HCFA), now known as CMS, produced its first annual report of “observed hospital-specific mortality rates for Medicare acute care hospitals” (Cleves and Golden 1996, 40). The goal of this HCFA transparency initiative was to produce “better information to guide the decisions of physicians, patients, and the agency, thus improving outcomes and the quality of care” (Roper et al. 1988, 1198).

This initial transparency strategy set the stage for using federal policy to systematically develop and implement expectations, requirements, methodology, and infrastructure to collect, publish, and disseminate performance data measuring beneficiaries’ quality of care. The mortality data reports were discontinued in 1994 and the focus turned to gathering and reporting performance data for high-volume, high-cost clinical conditions and patient experiences.

The specific performance data that healthcare organizations are required to report to CMS change each year. Many of the organization-specific quality performance data currently being reported can be found on the Medicare website (www.medicare.gov). In addition to quality measures for hospitals, the public has access to performance data for nursing homes, home health providers, and dialysis facilities. Making performance results more transparent—enabling stakeholders to assess healthcare quality and compare providers—is intended to encourage healthcare organizations to take steps toward improving health services. Refer to the web resources box for more information about these measurement and reporting initiatives.

Financial Incentives

The inpatient prospective payment system (IPPS) implemented by CMS in the 1980s focused on containing the increasing costs of hospital care. The next phase of financial incentives is focusing on improving the value of health services. Value is the ratio of quality to cost (value = quality/cost). Section 5001(c) of Deficit Reduction Act of 2005 required CMS to identify conditions that “could reasonably have been prevented through the application of evidence-based guidelines” (CMS 2015b). As of October 1, 2008, CMS denied additional payment for these hospital-acquired conditions (HACs), also known as never events, when patients developed one during a hospital stay (CMS 2015b). For example, when a patient got a HAC, such as a surgical-site infection following coronary artery bypass graft, the hospital would be paid as though this infection were not present.

To understand how CMS has refocused the IPPS on value, consider the historical role of clinical complications and hospital payment. If a surgical sponge was accidentally left inside the patient after surgery and the patient required another surgery to remove it, both surgeries were billed to the payer. The HAC financial incentive in the IPPS was designed to ensure that CMS would not pay for complications that should not have occurred in the first place. In addition, it was intended to encourage hospitals to adopt evidence-based practices to prevent never events from occurring.

To date, the success of this approach to financially incentivizing hospital quality improvements has been mixed. Waters and colleagues (2015) studied the association between Medicare’s nonpayment policy and four of the more common HACs: central line-associated bloodstream infections (CLABSIs), catheter-associated urinary tract infections (CAUTIs), hospital-acquired pressure ulcers (HAPUs), and injurious inpatient falls. “Medicare’s nonpayment policy was associated with an 11% reduction in the rate of change in CLABSIs . . . and a 10% reduction in the rate of change in CAUTIs, but was not associated with a significant change in injurious falls . . . or HAPUs” (Waters et al. 2015, 347). The authors concluded that reductions in the rates of CLABSI and CAUTI resulted from implementation of better hospital processes, whereas little evidence exists that changing hospital processes can lead to reductions in HAPUs or injurious inpatient falls (Waters et al. 2015).

A continued focus on value is the theme of contemporary healthcare quality policy at the federal level. The Medicare Access and CHIP Reauthorization Act of 2015 introduced two value-based payment models for physicians that have an impact on quality management: a Merit-Based Incentive Payment System and alternative payment models. These value-based payment models are intended to strengthen the relationship between physician payment and quality practices such as efficient use of healthcare resources and clinical improvements. These changes to the Medicare payment system for physicians

value
the ratio of quality
to cost (value =
quality/cost)

hospital-acquired
conditions (or
never events)
medical conditions
that “could reason-
ably have been
prevented through
the application of
evidence-based
guidelines” (CMS
2015b)

are not expected to be implemented for several years. It will be essential for physicians and healthcare facilities to understand how these payment models work so they can determine how and where to focus a systems approach to improving performance (Bassett 2016).

Private Health Policies and Oversight

Accreditation bodies are private, nongovernmental groups with policies and standards that encourage healthcare quality and safety improvement. Accreditation is voluntary, which means that, unlike public policies and oversight, healthcare organizations can choose whether to comply with an accreditation group's private policies and be subject to its oversight.

The Joint Commission is a nongovernmental accreditation organization for several types of health services organizations: ambulatory care, behavioral health care, critical access, home care, hospitals, laboratory services, nursing care, and office-based surgery. The Joint Commission also offers certification for disease-specific services for conditions such as chronic kidney disease and stroke and for programs such as palliative and perinatal care and primary care medical homes. For more information, see its website at www.jointcommission.org.

The National Committee for Quality Assurance (NCQA) offers accreditation programs for health plans and related organizations and programs such as wellness and health promotion and disease management. The NCQA also offers a variety of certifications; for a fuller description, see www.ncqa.org. The national Public Health Voluntary Accreditation Board was established to "improve and protect the health of the public by advancing the quality and performance of Tribal, state, local, and territorial public health departments" (Public Health Accreditation Board 2016). Additional accreditation organizations are listed in the web resources box.

Organizations seeking CMS approval to participate in federally funded insurance programs such as Medicare and Medicaid may undergo state surveys on behalf of CMS or be surveyed by an accrediting body approved by CMS. Some private accreditation groups such as The Joint Commission, DNV GL, the Healthcare Facilities Accreditation Program, and the Institute for Medical Quality have been granted *deemed authority* by CMS. An organization accredited by one of these groups "would have 'deemed status' and would not be subject to the Medicare survey and certification process because it has already been surveyed by the accrediting organization" (American Society for Healthcare Engineering 2016). Because of this private-public relationship, the policies and standards of accreditation organizations with deemed authority necessarily support and, in many instances, parallel the federal regulations governing the healthcare organizations they accredit.

Knowledge Acquisition

Accreditation bodies, like public agencies, work to identify and disseminate best practices that support healthcare quality and safety improvements. For example, since 1996, accredited facilities have been encouraged to report sentinel events to The Joint Commission. A **sentinel event** is a patient safety event that affects a patient and results in death, permanent harm, or severe temporary harm and intervention required to sustain life (Joint Commission 2016). "Reporting of the event enables 'lessons learned' from the event to be added to The Joint Commission's Sentinel Event Database, thereby contributing to the general knowledge about sentinel events and to the reduction of risk for such events" (Joint Commission 2016). As of June 2016, The Joint Commission had published 56 sentinel event alerts describing process changes healthcare organizations can make to improve prevention.

Knowledge sharing is common practice in other accreditation and certification bodies. For example, more than 1,500 cancer care programs accredited by the Commission on Cancer report data to the National Cancer Database (NCDB). Data in the NCDB, jointly sponsored by the American College of Surgeons and the American Cancer Society, are used to analyze and track patients with malignant neoplastic diseases, their treatments, and their outcomes (American College of Surgeons 2016). This information is available to healthcare organizations to encourage the spread of cancer care best practices.

Laboratories accredited by the College of American Pathologists offer complimentary online access to resource guides that present new and evolving technologies in pathology and assist pathologists with ways to better understand, evaluate, and implement these technologies into their practices. For more information, see the group's website at www.cap.org.

Transparency

Since 2002, healthcare organizations accredited by The Joint Commission have been required to gather and report data for various performance measures. In 2002, hospitals reported data for eight measures of care provided for patients with heart failure, pneumonia, and myocardial infarction. By 2014, hospitals reported data for up to 49 different measures of disease-specific care as well as surgical care, venous thrombosis, and immunization care (Baker and Chassin 2016).

The Joint Commission's performance measure project is intended to assist facilities in identifying important quality gaps and help them improve their care (Baker and Chassin 2016). This aim is achieved, in part, by making facility-specific data and comparative state and national data for various measures publicly available on The Joint Commission's Quality Check website (www.qualitycheck.org). Several performance improvements have resulted from The Joint Commission's transparent quality measurement

sentinel event
a patient safety event that affects a patient and results in death, permanent harm, or severe temporary harm and intervention required to sustain life (Joint Commission 2016)

efforts, including reduction of medically unnecessary early elective deliveries from 13.6 percent in 2011 to 3.3 percent in 2014 (Joint Commission 2015).

Financial Incentives

Private accrediting bodies lack the authority to impose financial incentives on healthcare organizations to influence quality improvements. However, private sector health plans and business groups are encouraging payment strategies similar to those being advanced by CMS in order to improve the value of healthcare services.

Summary

This chapter discusses the role of quality oversight organizations and introduces public and private groups whose policies and initiatives target system change. These initiatives fall into three areas: knowledge acquisition, transparency, and financial incentives. Because of the dynamic and rapidly changing nature of healthcare quality policy, both public and private, readers are encouraged to review the accompanying Internet resources as a means to keep current on changes, new initiatives, and plans for the future.

Exercise 2.1

Objective: To become familiar with the current CMS quality initiatives and how they support the National Quality Strategy and organizational performance improvement.

Instructions:

- Based on your work setting or an area of interest, select and explore one of the CMS quality initiatives (e.g., hospitals, home health, nursing home, end-stage renal disease) at www.cms.gov/center/quality.asp and review the current National Quality Strategy report (www.ahrq.gov/workingforquality/).
- In two or three paragraphs, answer the following questions in reference to the quality initiative you selected:
 - a. What does the CMS quality initiative include? Describe the initiative and its relationship to the National Quality Strategy.
 - b. How can the data publicly available on the compare site for the quality initiative benefit a healthcare organization? Describe how the measurement data can be used in the setting you are interested in to improve performance.

Exercise 2.2

Objective: To become familiar with the current quality measurement initiatives of The Joint Commission.

Instructions: Explore the current ORYX performance measures of The Joint Commission (www.jointcommission.org/performance_measurement.aspx). For each measure, describe which system or systems in your chosen setting will be improved by the use of the measure.

Companion Readings

- Callender, A. N., D. A. Hastings, M. C. Hensley, L. Morris, and M. W. Peregine. 2007. *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors*. US Department of Health and Human Services Office of Inspector General and American Health Lawyers Association. Published September 13. <http://oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibility/Final%209-4-07.pdf>.
- Chassin, M. A., J. M. Loeb, S. P. Schmalz, and R. M. Wachter. 2010. "Accountability Measures—Using Measurement to Promote Quality Improvement." *New England Journal of Medicine* 363 (7): 683–88.
- Commonwealth Fund. 2013. "Better Care at Lower Cost: Is It Possible?" Published November 21. www.commonwealthfund.org/publications/health-reform-and-you/better-care-at-lower-cost.
- Partnership for Sustainable Health. 2013. *Strengthening Affordability and Quality in America's Health Care System*. Robert Wood Johnson Foundation. Published April. www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf405432.
- Skywe, P. M. 2009. *Leadership in Healthcare Organizations: A Guide to Joint Commission Leadership Standards*. Governance Institute. Published Winter. www.jointcommission.org/leadership_in_healthcare_organizations.

Web Resources

Accreditation

- Accreditation Association for Ambulatory Health Care (AAAHHC):
www.aaahc.org
- Accreditation Commission for Education in Nursing (ACEN):
www.acenursing.org

(continued)