# Quality Reporting
## Understanding National Priorities, Identifying Local Applicability

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**KEYWORDS**

• Anesthesia • Registry • Quality • Measurement • Feasibility • NACOR • CMS • NQF

**KEY POINTS**

- When considering quality measures to collect and report, practices should understand the larger framework and priorities of payers and the healthcare community.
- Practices may develop and use local quality improvement measures based on local needs but measures used for quality reporting by national entities and payers must undergo a more rigorous and well-defined process.
- Anesthesia practices face a significant amount of challenges when reporting data to a registry, most significantly when merging data files from multiple data sources.
- Practice champions and practice leadership should explore how registry reporting can be used for meeting federal reporting requirements and improving patient care locally.

Since the 1990s, the use of quality measures among a variety of healthcare stakeholders has grown at an exponential rate. Practices must not only maintain current knowledge of the measures that affect individual physicians and other clinicians locally but also understand how the assessment of these medical professionals by such quality measures may affect the priorities and quality activities of facility administration staff. Moreover, because quality measures are increasingly used by hospital administrators, health plans, and payers, practices must contemplate whether the

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measures they choose to report are common among their peers and are objective. They must also have the ability to differentiate their care from other practices and clinicians. Although it may seem like a dog-eat-dog world, competitiveness and quantifying differences is unfortunately the framework that practices encounter today.

Practices are often compelled to report quality measures based on external factors. For measures incorporated in federal payment programs, for instance, those measures used in the Physician Quality Reporting System (PQRS) (2007–2016) and its successor, the Merit-Based Incentive Payment System (MIPS) Quality Component, public and private payers will require that the quality measures undergo a rigorous development process that follows standard measure development processes.[1] Accreditation organizations may also require practices to collect and report quality measures as part of an accreditation requirement or quality assurance and performance improvement activity.[2]

In other cases, practices may include their reporting of quality measures and performance improvement activities within contracts they hold with the hospital or facilities where they work. When practices are responsible for federal quality reporting themselves (outside of the hospital quality administration), hospital administrators may include certain reporting requirements for the practice to meet. In other cases, contracts may require that the practice identify measures or metrics to collect and report to the administration. Performance on these measures is often tied to payment bonuses or incentives.

Regardless of whether a practice chooses to voluntarily report or feels compelled to report a measure, the process of quality measure development, quality reporting, and gathering quality feedback reports relies significantly on transparency. Transparency in the quality reporting process also works to improve buy-in from clinicians and the processes used for identifying when and where process improvements should take place. Yet, at the same time, transparency does not suggest that every practice will understand measure algorithms, reliability, validity, or a measure's significance to clinical care. Transparency likewise does not mean that patients or caregivers will be able to use that data to make rational choices when choosing a physician or practice.

## UNDERSTANDING MEASURE INFLUENCERS

When considering quality measures to collect and report, practices should understand the larger framework and priorities of payers and the healthcare community. Federal legislation requires the Centers for Medicare & Medicaid Services (CMS) to annually publish and update its Measure Development Plan (MDP). The MDP "provides a foundation for building a measure portfolio for the Quality Payment Program and identifies initial priorities among clinical specialties, quality domains, and measurement gaps."[3] After more than 2 decades of quality measure development, often without a united or coherent strategy, the CMS has been given considerable influence over measure development and direction.

The most recent MDP deemphasized measures that practices and clinicians often consider as process, attestation, or check-box measures. Although these measures are expected to be available for reporting in the short term, the trend away from measures such as the administration of prophylactic antibiotic or use of an interoperative warming device has already begun.[4] Replacement of these measures has become most urgent among measure developers as the CMS and payers emphasize other measures considered as high-priority. High priority measures include those process measures that have a direct impact to patient outcomes, care coordination, and patient satisfaction.

Additional attention from payers, developers, and other healthcare stakeholders has focused on the use of electronic resources. Electronic data can be used to verify that