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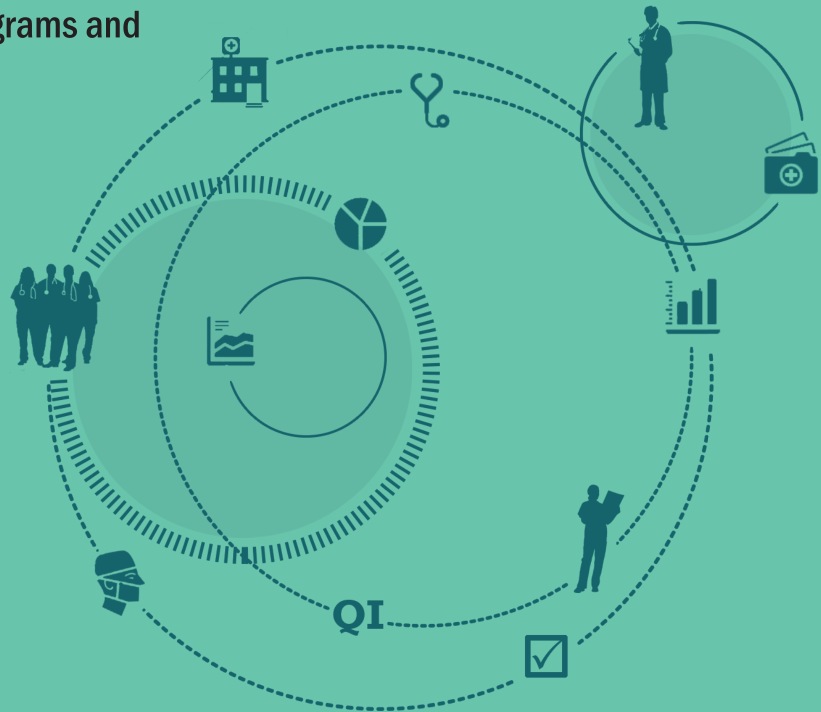
QUALITY IMPROVEMENT IN HEALTHCARE

A guide to acronyms in the quality improvement space — and the organizations, programs and definitions behind them.



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ABMS
American Board of Medical Specialties

ABMS is a nonprofit organization of 24 medical specialty boards (known as the "Member Boards"). It is the largest physician-led specialty certification organization in the US.

ABMS Member Boards maintain a rigorous process for the evaluation and certification of physicians in more than 150 medical specialties and subspecialties. More than 80 percent of practicing physicians in the US have achieved board certification by 1 or more of the Member Boards.

The ABMS Maintenance of Certification (MOC) program supports lifelong learning by physicians [see MOC under "Quality and Incentive Programs", page 14]. ABMS also collaborates with other professional medical organizations and agencies to set standards for graduate medical school education and accreditation of residency programs.

ABMS makes information available to the public about the board certification of physicians, and their participation in the ABMS MOC program.

RESOURCE

American Board of Medical Specialties website. http://www.abms.org/

AHRQ
Agency of Healthcare Research and Quality

AHRQ (formerly known as the Agency for Health Care Policy and Research or AHCPR) is one of several agencies within the US Department of Health and Human Services (HHS) [see HHS, page 5]. The mission of AHRQ is to "improve the quality, safety, efficiency, and effectiveness of healthcare for all Americans." [AHRQ 2013]

AHRQ's priority areas of focus include the following:

Improve healthcare quality by accelerating implementation of patient centered outcomes research (PCOR). AHRQ invests in developing PCOR methods, training, and disseminating PCOR findings. AHRQ will also invest in an initiative to disseminate and support the implementation of PCOR findings in primary care practices.

Make healthcare safer. AHRQ researches the ways patients experience preventable harm during their healthcare, why this harm occurs, and how to prevent it. AHRQ translates the results into practical tools for providers to:

- Make healthcare safer in hospitals, ambulatory and long-term care settings;
- Reduce harm to mothers and babies associated with obstetrical care;
- Improve safety and reduce medical liability by developing a guide for implementing a Communication and Resolution Program; and
- Accelerate patient safety improvements in nursing homes.

Increase accessibility by evaluating the Affordable Care Act (ACA) coverage expansions. AHRQ will lead HHS efforts to evaluate the effects of the ACA-mandated Medicaid and Marketplace coverage expansions. The results will enable HHS and Congress to make better-informed decisions about the implementation of the ACA in terms of access, disparities reduction, use and expenditures, outcomes, financial security, and employer offers and coverage take-up.

Improve healthcare affordability, efficiency, and cost transparency by improving the data, measures, and public reporting strategies for conveying information on healthcare price, cost and quality; and by developing and spreading evidence and tools to measure and enhance the efficiency of health systems—the capacity to produce better quality and outcomes while avoiding overutilization, or to maintain quality and outcomes with lower resource use. AHRQ will analyze variations in quality and resource use, and identify the factors that differentiate higher performing from lower performing systems.

RESOURCE

Agency for Healthcare Research and Quality website. http://www.ahrq.gov/

CMS
Centers for Medicare and Medicaid Services

CMS is the office in HHS [see HHS, page 5] that administers the Medicare program. CMS also works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

CMS has multiple additional responsibilities including: implementing and the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and developing and implementing quality standards and certification for long-term care facilities, along with clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments.

CMS is also responsible for other tasks to advance health information technology, including the implementation of electronic health record (EHR) incentive programs, the creation of standards for the certification of EHR technology [see EHR under "Terminology", page 15], and the updating of privacy and security regulations under HIPAA.

RESOURCE

Centers for Medicare & Medicaid Services website. http://www.cms.gov/

HHS
US Department of Health & Human Services

HHS is the US government's principal agency for protecting the health of Americans and delivering essential human services. HHS has 11 separate divisions, including 8 public health agencies and 3 human services agencies, which conduct research and provide a variety of health and human services. The 11 divisions include:

- Administration for Children and Families (ACF);
- Administration for Community Living (ACL);
- Agency for Healthcare Research and Quality (AHRQ);
- Agency for Toxic Substances and Disease Registry (ATSDR);
- Centers for Disease Control and Prevention (CDC);
- Centers for Medicare & Medicaid Services (CMS);
- Food and Drug Administration (FDA);
- Health Resources and Services Administration (HRSA);
- Indian Health Service (IHS);
- National Institutes of Health (NIH); and
- Substance Abuse and Mental Health Services Administration (SAMHSA).

HHS administers more than 300 programs covering a broad spectrum of activities. Some of the agency's chief responsibilities include administration of the Medicare and Medicaid programs; health and social science research; preventing disease; ensuring food and drug safety; substance abuse treatment and prevention; and improving maternal and infant health.

REFERENCE

US Department of Health & Human Services (HHS). About HHS. http://www.hhs.gov/about/index.html Accessed December 5, 2013.

RESOURCE

US Department of Health and Human Services website. http://www.hhs.gov/

IOM
Institute of Medicine

The IOM is an independent, nonprofit organization that works outside the US government to provide unbiased and authoritative health advice to decision makers and the public. IOM is the health arm of the National Academies, which also includes the National Academy of Sciences, the National Academy of Engineering, and the National Research Council.

The purpose of the IOM is to provide independent advice on issues relating to biomedical science, medicine, and health. Its mission is "to help those in government and the private sector make informed health decisions by providing evidence upon which they can rely." [IOM 2013]

The IOM relies on a volunteer workforce of scientists and other experts to provide unbiased information, analysis, and guidance concerning health policy. New IOM members and foreign associates are elected annually by current IOM members, based on candidates' professional achievements in a field relevant to the organization's mission, as well as for their willingness to participate actively in its work. [IOM 2013]

REFERENCE

Institute of Medicine (IOM) website. http://www.iom.edu/ Last Updated November 7, 2013. Accessed December 5, 2013.

The Joint Commission

The Joint Commission is a nonprofit organization that accredits more than 20,000 healthcare organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality reflecting an organization's commitment to meeting certain performance standards.

The mission of the Joint Commission is "to continuously improve healthcare for the public, in collaboration with other stakeholders, by evaluating healthcare organizations and inspiring them to excel in providing safe and effective care of the highest quality and value." [Joint Commission 2013]

REFERENCE

The Joint Commission. About The Joint Commission. http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx http://www.jointcommission.org/ 2013. Accessed December 5, 2013.

MAP
Measure Applications Partnership

MAP is a public-private partnership convened by the National Quality Forum (NQF) [see NQF, page 7] to provide input to the HHS on the selection of quality and efficiency measures for use in public reporting and performance-based payment programs. MAP is the first initiative of its kind, blending the views of diverse groups in order to provide recommendations to the federal government in advance of the regulatory rulemaking process. The MAP collaboration represents a variety of interests, including consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers, in an effort to promote fair and balanced input to HHS on performance measure selection. [NQF 2012]

REFERENCE

National Quality Forum (NQF). The Measure Applications Partnership (MAP) Frequently Asked Questions. http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69492 November 2012. Accessed December 5, 2013.

RESOURCE

National Quality Forum (NQF) website. Measure Applications Partnership. www.qualityforum.org/MAP

NCQA
National Committee for Quality Assurance

The NCQA is a private, nonprofit organization dedicated to improving healthcare quality in the United States. Its governing board includes employers, consumer and labor representatives, health plans, quality experts, regulators, and representatives from organized medicine.

The NCQA's quality improvement efforts are primarily organized around accreditation and performance measurement. The organization manages voluntary accreditation programs for individual physicians, medical groups, and health plans. Health plans seek accreditation through the administration and submission of the Healthcare Effectiveness Data and Information Set (HEDIS) [see HEDIS under "Measures", page 9], which consists of a set of performance measures that compare how well a healthcare plan performs across several domains of care.

Consumers can compare health plans on NCQA's Health Plan Report Card, which rates plans in 5 categories: Access and Service, Qualified Providers, Staying Healthy, Getting Better, and Living with Illness.

RESOURCES

NCQA Health Plan Report Card
http://reportcard.ncqa.org/plan/external/

National Committee for Quality Assurance (NCQA) website.
http://www.ncqa.org/

NCQA Recognized Clinician Directory
http://recognition.ncqa.org/

NPP
National PrioritiesPartnership

The NPP is a partnership of 52 national organizations with a shared goal of achieving "better health, and a safe, equitable, and value-driven healthcare system." The NPP was convened by the NQF [see NQF below, page 7] as part of its overall mission to improve the healthcare system.

The NPP member organizations collaborated to create the National Quality Strategy (NQS) [see NQS under "Quality and Incentive Programs", page 14], which sets clear goals to help the public focus its efforts on improving the quality of health and healthcare. All 52 NPP member organizations worked together to advocate for the creation of the NQS, and continue to shape its direction by offering annual input to the US Secretary of HHS.

Together, the NPP member groups:

- Identify national goals that correspond to the priorities put forth in the NQS;
- Provide input on measures for tracking national progress toward the goals; and
- Offer guidance on strategic opportunities to accelerate improvement. [NQF 2013]

REFERENCE

National Quality Forum (NQF). National Priorities Partnership. http://www.qualityforum.org/npp/ 2013. Accessed December 5, 2013.

RESOURCES

2012 Annual Progress Report to Congress. National Strategy for Quality Improvement in Health Care. http://www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.pdf

National Quality Forum (NQF). National Priorities Partners. http://www.qualityforum.org/Setting_Priorities/NPP/NPP_Partner_Organizations.aspx

NQF
National Quality Forum

The NQF is a nonprofit, nonpartisan membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. The NQF reviews, endorses, and recommends the use of standardized healthcare performance measures. These performance measures, also called quality measures, are essential tools used to evaluate how well healthcare services are being delivered. [NQF 2013]

NQF performance measures are intended to:

- Make our healthcare system more information-rich;
- Point to actions physicians, other clinicians, and organizations can take to make healthcare safe and equitable;
- Enhance transparency in healthcare;
- Ensure accountability of healthcare providers; and
- Generate data that helps consumers make informed choices about their care. [NQF 2013]

The NQF operates under a 3-part mission to improve the quality of healthcare by:

- Building consensus on national priorities and goals for performance improvement, and working in partnership to achieve them;
- Endorsing national consensus standards for measuring and publicly reporting on performance; and
- Promoting the attainment of national goals through education and outreach programs. [NQF 2013]

REFERENCE

National Quality Forum (NQF) website. http://www.qualityforum.org/ 2013. Accessed December 5, 2013.

NQMC
National Quality Measures Clearinghouse

The NQMC consists of a database and website that provide information on specific evidence-based healthcare quality measures and measure sets. NQMC is sponsored by AHRQ [see AHRQ, page 4] to promote widespread access to quality measures by the healthcare community and other interested individuals.

The NQMC mission is to "provide practitioners, health care providers, health plans, integrated delivery systems, purchasers, and others an accessible mechanism for obtaining detailed information on quality measures, and to further their dissemination, implementation, and use in order to inform health care decisions." [AHRQ 2013]

NQMC builds on AHRQ's previous initiatives in quality measurement, including the Computerized Needs-Oriented Quality Measurement Evaluation System (CONQUEST), the Expansion of Quality of Care Measures (Q-SPAN) project, the Quality Measurement Network (QMNet) project, and the Performance Measures Inventory (PMI). [AHRQ 2013]

REFERENCE

Agency for Healthcare Research and Quality (AHRQ). National Quality Measures Clearinghouse (NQMC). About NQMC. http://www.qualitymeasures.ahrq.gov/about/index.aspx 2013. Accessed December 5, 2013.

RESOURCE

AHRQ National Quality Measures Clearinghouse (NQMC) website. 2013. http://www.qualitymeasures.ahrq.gov/

PCORI
Patient-Centered Outcomes Research Institute

PCORI is a US-based nongovernmental institute created as part of a modification to the Social Security Act by clauses in the Patient Protection and Affordable Care Act (ACA) [see ACA under "Legislation", page 10].

PCORI is authorized by Congress to conduct research to provide information about the best available evidence to help patients and their healthcare providers make more informed decisions. PCORI's research is intended to give patients a better understanding of the prevention, treatment, and care options available, and the science that supports those options. [PCORI 2013[a]]

PCORI's ultimate purpose is to improve healthcare delivery and outcomes by producing and promoting high integrity, evidence-based information that comes from research guided by patients, caregivers and the broader healthcare community. [PCORI 2013[b]]

REFERENCES

[a]Patient-Centered Outcomes Research Institute (PCORI). About Us. http://www.pcori.org/about-us/landing/ 2013. Accessed December 5, 2013.

[b]Patient-Centered Outcomes Research Institute (PCORI). Mission and Vision. 2013. http://www.pcori.org/about-us/mission-and-vision/ Accessed December 5, 2013.

RESOURCE

Patient-Centered Outcomes Research Institute (PCORI) website. http://www.pcori.org/

PQA
Pharmacy Quality Alliance

The PQA is a 501(c)3 designated nonprofit alliance with more than 100 member organizations. Its mission is to improve the quality of medication management and use across healthcare settings, in order to improve patients' health. PQA undertakes this effort through a collaborative process to develop and implement performance measures, and to recognize examples of exceptional pharmacy quality.

PQA operates as a multi-stakeholder, consensus-based membership organization that collaboratively promotes appropriate medication use, and develops strategies for measuring and reporting performance information related to medications.[PQA 2013]

REFERENCE

Pharmacy Quality Alliance (PQA). PQA Mission and Strategic Objectives. http://pqaalliance.org/about/default.asp Accessed December 5, 2013.

RESOURCES

Pharmacy Quality Alliance website. http://pqaalliance.org/

PQA Strategic Plan. http://www.pqaalliance.org/images/uploads/files/Strategic%20Plan.pdf

URAC
Utilization Review Accreditation Commission

URAC is an independent nonprofit organization that promotes healthcare quality and efficiency through its accreditation, education, and measurement programs.

URAC is independent of any single stakeholder group. The governing board of directors was founded with representatives from all affected constituencies: consumers, providers, employers, regulators, and industry experts. URAC offers a wide range of quality benchmarking programs and services through which organizations can validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards-development process, URAC ensures that all stakeholders are represented in its efforts to establish meaningful quality measures for the entire healthcare industry. [URAC 2013]

REFERENCE

Utilization Review Accreditation Commission (URAC) website. https://www.urac.org/ 2013. Accessed December 5, 2013.

HEDIS
Healthcare Effectiveness Data and Information Set

HEDIS is a set of standardized performance measures designed to ensure that consumers have the information they need to reliably compare the performance of healthcare plans. HEDIS is sponsored, supported, and maintained by the NCQA [see NCQA under "Organizations", page 6].

The performance measures in HEDIS are related to several significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes. HEDIS also includes a standardized survey of consumers' experiences, which evaluates the performance of healthcare plans in areas such as customer service, access to care, and claims processing.

Health plans seek NCQA accreditation by administering the HEDIS performance measures across their plans. In general, compliance with conventional reporting practices and HEDIS specifications for the following domains are measured:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care
- Health Plan Stability
- Use of Services
- Cost of Care
- Informed Health Care Choices
- Health Plan Descriptive Information.[NCQA 2013]

REFERENCE

National Committee for Quality Assurance (NCQA). HEDIS 2014 Measures. http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2014/List%20of%20HEDIS%202014%20Measures.pdf Updated 2013. Accessed December 29, 2013.

PCPI®
Physician Consortium for Performance Improvement

The PCPI® is a national, physician-led program convened by the AMA and dedicated to enhancing healthcare quality and patient safety. The organization seeks to accomplish aligning patient-centered care, performance measurement, and quality improvement. [AMA 2013[a]] The PCPI develops, tests, implements and disseminates evidence-based measures that reflect the best practices and best interest of medicine.

PCPI focuses on improving patient health and safety by:

- Promoting the implementation of effective and relevant clinical performance improvement activities; and
- Identifying and developing evidence-based clinical performance measures and measurement resources that enhance the quality of patient care and foster accountability;
- Promoting the implementation of effective and relevant clinical performance improvement activities; and
- Advancing the science of clinical performance measurement and improvement.

The PCPI® is nationally recognized for measure development, specification and testing of measures, and enabling the use of measures in electronic health records (EHRs) [see EHR in "Terminology", page 15]. The PCPI®'s measure development resources include a measure testing protocol, a position statement on the evidence base required for measure development, a composite framework, specification and categorization of measure exceptions and an outcomes measure framework. [AMA 2013[b]]

REFERENCES

[a]American Medical Association (AMA). Physician Consortium for Performance Improvement (PCPI®). http://www.ama-assn.org/ama/pub/physician-resources/physician-consortium-performance-improvement.page 2013. Accessed December 5, 2013.

[b]American Medical Association (AMA). About the PCPI®. http://www.ama-assn.org/ama/pub/physician-resources/physician-consortium-performance-improvement/about-PCPI®.page 2013. Accessed December 5, 2013.

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ACA
Patient Protection and Affordable Care Act

The ACA was signed into law by the President on March 23, 2010. Together with the Health Care and Education Reconciliation Act, the ACA represents the most significant regulatory overhaul of the US healthcare system since the passage of Medicare and Medicaid in 1965.

The HHS consumer information website highlights several provisions of the ACA, [HHS 2013] described below.

Regarding healthcare coverage, the ACA:

- Ends pre-existing condition exclusions for children. Health plans can no longer limit or deny benefits to children under 19 due to a pre-existing condition.
- Keeps young adults covered. If you are under 26, you may be eligible to be covered under your parent's health plan.
- Ends arbitrary withdrawals of insurance coverage. Insurers can no longer cancel your coverage just because you made an honest mistake.
- Guarantees your right to appeal. You now have the right to ask that your plan reconsider its denial of payment.

Regarding costs, the ACA:

- Ends lifetime limits on coverage. Lifetime limits on most benefits are banned for all new health insurance plans.
- Reviews premium increases. Insurance companies must now publicly justify any unreasonable rate hikes.
- Helps plan subscribers get the most from their premium dollars. Premium dollars must be spent primarily on healthcare—not administrative costs.

Regarding care, the ACA:

- Covers preventive care at no cost to plan subscribers. Patients may be eligible for recommended preventive health services with no copayment.
- Protects the choice of doctors. Patients can choose the primary care doctor they want from their plan's network.
- Removes insurance company barriers to emergency services. Patients can seek emergency care at a hospital outside of their health plan's network.

The ACA contains what is known as the "individual mandate," which requires most individuals to obtain health insurance or potentially pay a penalty for noncompliance.

REFERENCE

US Department of Health and Human Services (HHS). About the Law. http://www.hhs.gov/healthcare/rights/index.html 2013. Accessed December 6, 2013.

RESOURCE

HHS. About the Law. http://www.hhs.gov/healthcare/rights/law/index.html 2013. Accessed December 6, 2013.

HITECH
Health Information Technology for Economic and Clinical Health

The HITECH Act seeks to improve American healthcare delivery and patient care through an unprecedented investment in health IT (HIT). HITECH programs provide the necessary assistance and technical support to providers, enable coordination and alignment within and among states, establish connectivity to the public health community in case of emergencies, and assure the workforce is properly trained and equipped to be meaningful users of certified Electronic Health Records (EHRs) [see Meaningful Use under and EHR]. These programs collaboratively build the foundation for every American to benefit from an EHR as part of a modernized, interconnected, and vastly improved system of care delivery. [HealthIT.gov 2013]

Title IV, Division B of the HITECH Act establishes incentive payments under the Medicare and Medicaid programs for eligible professionals (EPs) and eligible hospitals (EHs) that meaningfully use Certified EHR Technology (CEHRT). HITECH also amended several sections of the Social Security Act (SSA) to establish the availability of incentive payments to EPs and EHs to promote the adoption and Meaningful Use of CEHRT. [HealthIT.gov 2013]

REFERENCE

HealthIT.gov. Certification and EHR Incentives. HITECH Act. http://www.healthit.gov/policy-researchers-implementers/hitech-act-0 2013. Accessed December 6, 2013.

RESOURCE

HealthIT.gov website. http://www.healthit.gov/

ACO
Accountable Care Organizations

ACOs are groups of doctors, hospitals, and other healthcare providers who voluntarily come together to give coordinated, high -quality care to their Medicare patients.

The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds in both delivering high-quality care and spending healthcare dollars more wisely, it will share in the savings it achieves for the Medicare program. [CMS 2013]

REFERENCE

Centers for Medicare & Medicaid Services (CMS). Accountable Care Organizations (ACO). http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO/2013. Accessed December 6, 2013.

RESOURCE

Medicare.gov. Accountable care organizations. http://www.medicare.gov/manage-your-health/coordinating-your-care/accountable-care-organizations.html

ACTION
Accelerating Change and Transformation in Organizations and Networks

The ACTION initiative is a model of field-based research designed to promote innovation in healthcare delivery by accelerating the diffusion of research into practice. It is part of AHRQ [see AHRQ under "Organizations"]. The ACTION network includes 15 large partnerships and collaborating organizations that provide healthcare to more than 100 million Americans. [AHRQ 2009]

ACTION promotes innovation in healthcare delivery by accelerating the development, implementation, diffusion, and uptake of demand-driven and evidence-based products, tools, strategies and findings. ACTION develops and diffuses scientific evidence about what does and does not work to improve healthcare delivery systems. It provides an impressive cadre of delivery-affiliated researchers and sites with a means of testing the application and uptake of research knowledge.

ACTION is the successor to the Integrated Delivery System Research Network (IDSRN), a 5-year implementation initiative completed in 2005. [AHRQ 2009]

REFERENCE

Agency for Healthcare Research and Quality (AHRQ). Accelerating Change and Transformation in Organizations and Networks (ACTION). Fact Sheet: Field Partnerships for Applied Research. http://www.ahrq.gov/research/findings/factsheets/translating/action/index.html Updated November 2009. Accessed December 6, 2013.

IDN
Integrated Delivery Network

IDNs are groups of physicians, hospitals, health maintenance organizations (HMOs), and other facilities and providers that work together to offer care to a specific geographic region or market. The make-up of IDNs varies to address a spectrum of issues including capitation, excess capacity, decreased margins, and complaints from patients regarding access. [HCFN 2013]

The IDN concept was developed in the 1980s and has since evolved to the point where IDNs include many types of associations across the continuum of care. For example, one IDN might include a short- and long-term hospital, a health management plan (HMP), a physician-hospital organization (PHO), home health agency, and hospice services. Multi-hospital systems and mergers may be considered limited IDNs, since different entities are joining together to provide care. [HITN 2013]

Some members of an IDN may provide identical or complementary services to patients (horizontal integration), while others may provide various levels of care (vertical integration).

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Healthcare Finance News website. Index. http://www.healthcarefinancenews.com/directory/integrated-delivery-network 2013. Accessed December 28, 2013.

Healthcare IT News website. Index. http://www.healthcareitnews.com/directory/integrated-delivery-network-idn 2013. Accessed December 28, 2013.

RESOURCES

Healthcare Finance News
http://www.healthcarefinancenews.com

Healthcare IT News
http://www.healthcareitnews.com/

IPA
Independent Practice Association

An IPA is a type of health maintenance organization (HMO) in which individual practitioners see patients enrolled in the HMO, but also treat their own patients who are not HMO participants. Compensation to the physician is based on either a per-patient fee or a discounted fee schedule. [IRMI 2013]

REFERENCE

International Risk Management Institute, Inc. (IRMI). Independent practice association (IPA). http://www.irmi.com/online/insurance-glossary/terms/i/independent-practice-association-ipa.aspx 2013. Accessed December 6, 2013.

RESOURCE

Physicians Practice. The Basics of Independent Practice Associations. http://www.physicianspractice.com/blog/basics-independent-practice-associations November 18, 2012.

PCMH
Patient Centered Medical Home

PCMH is not a place: it is a promising model for transforming the organization and delivery of primary care. PCMH offers a way to organize primary care that emphasizes care coordination and communication, in order to transform primary care in fundamental ways that can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.

PCMH is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. [ACPonline.org 2013].

PCMH has become a widely accepted model for how primary care should be organized and delivered throughout the healthcare system, and is intended to ensure that patients are treated with respect, dignity, and compassion, and to enable strong and trusting relationships with providers and staff.

The Patient Centered Primary Care Collaborative (PCPCC) describes PCMH as:

- **Patient-centered:** A partnership among practitioners, patients, and their families that ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.
- **Comprehensive:** Delivered by a team of care providers who are wholly accountable for a patient's physical and mental healthcare needs, including prevention and wellness, acute care, and chronic care.
- **Coordinated:** Care is organized across all elements of the broader healthcare system, including specialty care, hospitals, home healthcare, community services and supports.

AHRQ [see AHRQ under "Organizations", page 4] has an online resource website that provides policymakers and researchers with evidence-based resources about the PCMH approach and its potential to transform primary care and improve the quality, safety, efficiency, and effectiveness of US healthcare. [AHRQ 2013]

REFERENCES

Agency for Healthcare Research and Quality (AHRQ). Patient Centered Medical Home Resource Center. http://pcmh.ahrq.gov/2013 Accessed December 6, 2013.

Patient Centered Primary Care Collaborative website. http://www.pcpcc.org/about/medical-home Accessed December 19, 2013.

RESOURCE

National Committee for Quality Assurance (NCQA). Patient-Centered Medical Home. http://www.ncqa.org/tabid/631/default.aspx

QUALITY AND INCENTIVE PROGRAMS

BTE
Bridges to Excellence

BTE is an initiative created by a group of employers, physicians, health plans and patients that has come together to create programs that will help realign medical incentives around 6 key attributes identified by the IOM [see IOM in "Organizations", page 5] in its 2001 report "Crossing the Quality Chasm." The IOM advocated bridging this chasm by redesigning the healthcare system around these 6 attributes to make the system more Safe, Timely, Effective, Efficient, Equitable, and Patient-centered (STEEEP). [NCQA 2013]

BTE has a number of programs that recognize and reward clinicians who deliver superior patient care. These programs measure the quality of care delivered in provider practices, and place a special emphasis on managing patients with chronic conditions, who are most at risk of incurring potentially avoidable complications. The BTE Recognitions cover all major chronic conditions, plus office systems—and also include a real medical home (PCMH) measurement scheme to promote comprehensive care delivery and strong relationships between patients and their care teams.

Physicians, nurse practitioners and physician assistants who meet performance benchmarks for BTE Recognition can earn a range of incentives, sometimes including substantial cash payouts. Insurers and employers fund these payouts from the savings they achieve through lower healthcare costs and increased employee productivity. [HCI3 2012]

REFERENCES

Health Care Incentives Improvement Institute (HCI3). What Is Bridges to Excellence? http://www.hci3.org/node/1/ 2012 Accessed December 6, 2013.

National Committee for Quality Assurance (NCQA). Bridges to Excellence: Rewarding Quality Across the Healthcare System. http://www.ncqa.org/Programs/Recognition/BridgestoExcellence.aspx 2013. Accessed December 6, 2013.

Meaningful Use

"Meaningful use" is the set of standards, defined by the Incentive Programs of the CMS [see CMS under "Organizations"], that governs the use of Electronic Health records (EHR) [see EHR under "Terminology", page 15]. The goal of meaningful use is to improve US healthcare by promoting the spread of EHR. [HealthIT.gov 2013]

The benefits of the meaningful use of EHRs include:

- **Complete and accurate information.** EHRs give providers the information they need to deliver the best possible care. They will know more about their patients and their health history before they enter the examination room.
- **Better access to information.** EHRs facilitate greater access to the information that providers need to diagnose health problems earlier and improve the outcomes of their patients. EHRs also allow information to be shared more easily among doctors' offices, hospitals, and across health systems, leading to better coordination of care.
- **Patient empowerment.** EHRs will help empower patients to take a more active role in their health and in the health of their families. Patients can receive electronic copies of their medical records and share their health information securely over the Internet with their families. [HealthIT.gov 2013]

The HITECH Act [see HITECH under "Legislation", page 10] establishes incentive payments under the Medicare and Medicaid programs that can be earned by eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) that demonstrate that they meaningfully use certified EHR technology. [CMS 2013]

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Medicare Star Rating

CMS [see CMS under "Organizations", page 4] created the Five-Star Quality Rating System (Medicare Star Rating) to help consumers, their families, and caregivers compare nursing homes more easily, and to help identify areas about which consumers may have questions.

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Medicare Star Ratings are found on the CMS Nursing Home Compare website, whose quality rating system that gives each nursing home a rating of between 1 and 5 stars. Those with 5 stars are considered to have quality much above average, and those with 1 star are considered to have quality much below average.

There is one overall 5-star rating for each nursing home, and a separate star rating for each of the following 3 sources of information [CMS 2013]:

- **Health Inspections,** which determine the extent to which a nursing home has met Medicare's minimum quality requirements. More than 200,000 onsite reviews are used in the health inspection scoring nationally.
- **Staffing,** which has information about the average number of hours of care provided to each resident each day by nursing staff. This rating considers differences in the level of need of care of residents in different nursing homes.
- **Quality Measures (QMs)**, which has information on 9 different physical and clinical measures for nursing home residents—for example, the prevalence of pressure sores, or changes to a resident's mobility. This information is collected by the nursing home for all residents. More than 12 million assessments of the conditions of nursing home residents are used in the Five-Star rating system.

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Centers for Medicare & Medicaid Services (CMS). Nursing Home Compare. http://www.medicare.gov/nursinghomecompare/?AspxAutoDetectCookieSupport=1

MOC

Maintenance of Certification

MOC is the process of physicians keeping their certification up to date through one of the 24 medical specialty boards of the ABMS [see ABMS under "Organizations", page 4], as well as some of the medical specialty boards of the American Osteopathic Association (AOA).

In 2000, the Member Boards of ABMS agreed to evolve their recertification programs to one of continuous professional development—the ABMS Maintenance of Certification® (ABMS MOC®). ABMS MOC assures that the physician is committed to lifelong learning and competency in a specialty and/or subspecialty, by requiring ongoing measurement of 6 core competencies adopted by ABMS and the Accreditation Council for Graduate Medical Education (ACGME) in 1999.

The 6 core competencies are measured in a variety of ways, some of which vary according to specialty, using a 4-part process that is designed to keep certification continuous. ABMS MOC program plans were approved in 2006, and the boards are now in the process of implementation. [ABMS 2012]

The CMS [see CMS under "Organizations", page 4] promotes MOC through its Physician Quality Reporting System (PQRS) [see PQRS below]. PQRS is a voluntary reporting program that provides an incentive payments to identified EPs who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries [see FFS].

Physicians who are incentive-eligible for 2014 PQRS can receive an additional 0.5% incentive payment when MOC Program Incentive requirements have been met. Physicians cannot receive more than one additional 0.5% Maintenance of Certification Program Incentive, even if they complete an MOC Program in more than one specialty. [CMS 2014]

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NQS

National Quality Strategy

The NQS, or National Quality Strategy, is shorthand for the National Strategy for Quality Improvement in Health Care, a nationwide effort to align public and private interests to improve the quality of health and healthcare. Part of the ACA [see ACA under "Legislation", page 10]. The NQS is guided by 3 aims: to provide better care, to facilitate healthy people/healthy communities, and to provide affordable care.

To achieve these aims, the NQS applies 6 priorities that address the range of quality concerns that affect most Americans. These aims and priorities have the potential to rapidly improve health outcomes and increase the effectiveness of care for all populations. [AHRQ 2013[a]]

The 6 NQS priorities are:

- Making care safer by reducing harm caused in the delivery of care;
- Ensuring that each person and family are engaged as partners in their care;
- Promoting effective communication and coordination of care;
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease;
- Working with communities to promote wide use of best practices to enable healthy living; and
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models. [AHRQ 2013[b]]

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[a]Agency for Healthcare Research and Quality (AHRQ). The National Quality Strategy (NQS). http://www.ahrq.gov/workingforquality/index.html Accessed December 6, 2013.

[b]Agency for Healthcare Research and Quality (AHRQ). National Quality Strategy: Overview. http://www.ahrq.gov/workingforquality/nqs/overview.htm 2013. Accessed December 6, 2013.

PQRS

Physician Quality Reporting System

PQRS is a reporting program run by the CMS [see CMS under "Organizations", page 4] which uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

PQRS provides an incentive payment to practices with EPs identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN). EPs qualify for the payments by satisfactorily reporting data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer) [see FFS].

Beginning in 2015, the PQRS also applies a payment adjustment to EPs who do not satisfactorily report data on quality measures for covered professional services. [CMS 2013]

The PQRS reporting set pulls data from the PCPI®, HEDIS, and other measures, but is primarily vetted by the NQF [see PCPI, HEDIS, and NQF, pages 9 and 7].

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American Medical Association (AMA). Physician Quality Measure Reporting. http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-quality-reporting-system.page

EHR

Electronic Health Record

An EHR is an electronic version of a patient's medical history that is maintained by care providers over time. An EHR may include all of the key administrative clinical data relevant to that person's care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports.

The EHR automates access to information and can streamline the clinician's workflow. The EHR also has the ability to support

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other care-related activities directly or indirectly through various IT interfaces, including evidence-based decision support, quality management, and outcomes reporting. [CMS 2012]

The use of EHRs is intended to strengthen the relationship between patients and clinicians. The data, and the timeliness and availability of it, will enable providers to make better decisions and provide better care. For example, the EHR can improve patient care by [CMS 2012]:

- Reducing the incidence of medical error by improving the accuracy and clarity of medical records;
- Making the health information available, reducing duplication of tests, reducing delays in treatment, and patients well informed to take better decisions; and
- Reducing medical error by improving the accuracy and clarity of medical records.

An EHR is different from an Electronic Medical Record (EMR). An EMR contains the standard medical and clinical data gathered in only one provider's office. EHRs go beyond the data collected in the individual provider's office and include a more comprehensive patient history. For example, EHRs can contain and share information from all providers involved in a patient's care. EHR data can be created, managed, and consulted by authorized providers and staff from across more than one healthcare organization.

Unlike EMRs, EHRs also allow patients' health records to move with them—to other healthcare providers, specialists, hospitals, nursing homes, and across states. [HealthIT.gov 2013]

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HealthIT.gov. What Is an Electronic Medical Record (EMR)? http://www.healthit.gov/providers-professionals/electronic-medical-records-emr 2013 Accessed December 6, 2013.

FFS

Fee for Service

FFS or fee-for-service, describes a healthcare delivery system through which some Medicaid enrollees are served. In an FFS system, healthcare providers are paid for each medical service (such as an office visit, test, or procedure).

Individual states select payment methodologies such as FFS for Medicaid services in their Medicaid State plan. The CMS [see CMS in "Organizations", page 4] reviews all state plans to make sure reimbursement methodologies are consistent with federal statutes and regulations.

States may develop their FFS provider payment rates based on: the costs of providing the service; a review of what commercial payers pay in the private market; or a percentage of what Medicare pays for equivalent services.

FFS payment rates are often updated based on specific trending factors, such as the Medicare Economic Index or a Medicaid-specific trend factor that uses a state-determined inflation adjustment rate. The methodologies for service rates are described in the individual Medicaid state plan.

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ICD-9

International Classification of Diseases, Ninth Revision

ICD-9 is the ninth revision of the International Classification of Diseases (ICD), which is designed to promote international comparability in the collection, processing, classification, and presentation of mortality statistics. This includes the analysis of the general health situation of population groups. It is used to monitor the incidence and prevalence of diseases and other health problems.

ICD-9 provides a format for reporting causes of death on the death certificate. The reported conditions are then translated into medical codes through use of the classification structure, and the selection and modification rules contained in the applicable revision of the ICD, published by the World Health Organization. These coding rules improve the usefulness of mortality statistics by giving preference to certain categories, by consolidating conditions, and by systematically selecting a single cause of death from a reported sequence of conditions. [CDC 2009]

The ICD has been revised periodically. ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as of 1994. ICD-10 is currently being phased in to replace ICD-9 in various segments of the US healthcare system. [CMS 2013] On October 1, 2014, the ICD-10 code sets will replace current ICD-9 code sets. The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA) Act. The change to ICD-10 does not affect CPT coding for outpatient procedures and physician services.

The 11th revision of the ICD classification has already started and will continue until 2015. [WHO 2013]

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World Health Organization (WHO). International Classification of Diseases (ICD). http://www.who.int/classifications/icd/en/ 2013. Accessed December 6, 2013.

P4P

Pay-for-Performance

P4P is an emerging movement in health insurance, [Fenter 2008] in which providers are compensated by payers for meeting certain pre-established measures for quality and efficiency. P4P programs have been implemented by both Medicare and private insurers. The CMS [see CMS under "Organizations", page 4] has numerous demonstration projects underway to pilot P4P programs in a range of care settings, from primary care clinics to hospitals. The goal of P4P is to improve the transparency and accountability of the quality improvement process as a complement to other incentives. [HHS 2013]

P4P attaches financial incentives to clinical care objectives. Using quantitative metrics, a percentage of physician compensation can be tied to achieving specific clinical benchmarks in the care they provide. The key difficulty in establishing a P4P program is in choosing appropriate benchmarks. In general, stressing adherence to evidence-based guidelines for care (eg, ordering of pneumonia vaccines for all patients over the age of 65) should be preferred over patient outcomes (eg, number of diabetic patients with a HbA1c less than 7.0%), because patient outcomes often depend on factors outside the provider's control. [HHS 2013]

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PMPM

Per Member Per Month

PMPM is one type of capitation payment model for healthcare, in which a provider organization is given a set amount of money each month to provide an agreed upon range of services for the patients enrolled in the program for the period of time covered by the agreement. Depending on the contract, the types of services provided to patients enrolled in the program may vary. PMPM payments are meant to incentivize providers to implement wellness strategies that keep their patients healthier and reduce the need for expensive acute care services.

Managed care organizations use capitation payments to control healthcare costs, through controlling the use of healthcare resources by putting the physician at financial risk for services provided to patients. In order to ensure that patients do not receive suboptimal care through underutilization of healthcare services, managed care organizations measure (and report on) rates of resource utilization in physician practices. These reports are made available to the public as a measure of healthcare quality, and can be linked to financial rewards, such as bonuses.

Capitation is a fixed amount of money per patient per unit of time (per year in the case of PMPM), paid in advance to the physician for the delivery of healthcare services. The amount of money paid is determined by the services provided, the number of patients involved, and the period of time during which the services are provided. Capitation rates are developed using local costs and average utilization of services and so can vary from one region to another. When the primary care provider signs a capitation agreement, a list of specific services that must be provided to patients is included in the contract. [ACP 2013]

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http://www.acponline.org

Capitation (healthcare). In Wikipedia. http://en.wikipedia.org/wiki/PMPM

VBP
Value Based Payment

VPB is an approach to paying for healthcare that financially rewards physicians who provide healthcare that is high value—that is, high in quality while also low in cost.

CMS [see CMS under "Organizations"] will implement VBP for Medicare and Medicaid providers by 2015, as mandated by the Affordable Care Act (ACA) [see ACA under "Legislation"]. To accomplish this, CMS will begin applying a value modifier under the Medicare Physician Fee Schedule (MPFS) that will factor cost and quality data into the calculations for payments for physicians.

The reward formula is a simple system: performance is assessed in 2 dimensions (quality and cost), and payments go to physicians who have above-average performance in both dimensions. Physicians who perform worse than average or choose not to be involved are paid less, and there will be no change for physicians with average performance. The maximum bonus is about 2% of Medicare fees, and the maximum penalty is approximately 1%. Scoring physicians relative to one another achieves budget neutrality for CMS. For physicians, it eliminates the effects of common shocks to performance, such as an influenza epidemic or vaccine shortage. The disadvantage of this incentive structure is the uncertainty for physicians about the amount of improvement that will be necessary to receive a bonus or avoid a penalty. [NEJM 2013]

The CMS will implement VBP in 2 stages. Groups of 100 or more physicians who submit claims to Medicare under a single tax identification number will be subject to the value modifier in 2015. All physicians who participate in FFS [see FFS] Medicare will be affected by the value modifier by January 1, 2017. [CMS 2013]

The ACA directs the CMS to provide information to physicians and medical practice groups about their resource use and the quality of care provided to their Medicare patients, including patterns of resource use/cost among different healthcare providers, as part of Medicare's efforts to improve the quality and efficiency of clinical care. [ACP 2013] This actionable information is intended to help physicians improve the care they furnish, as the CMS moves toward physician reimbursement that rewards value rather than volume.

The program's two primary components for accomplishing this are Quality and Resource Use Reports (QRURs, also known as Physician Feedback Reports); and development and implementation of the value-based payment modifier.

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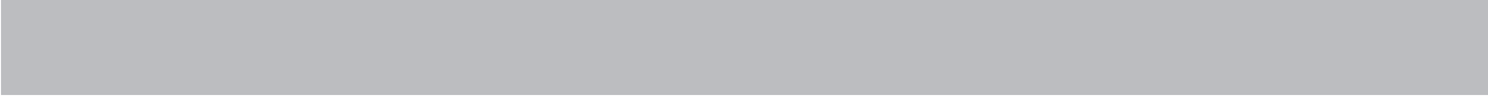
ADDITIONAL RESOURCES

Glossaries of Terms

Agency for Healthcare Research and Quality (AHRQ). National Quality Measures Clearinghouse (NQMC) Glossary.
http://www.qualitymeasures.ahrq.gov/about/index.aspx

Agency for Healthcare Research and Quality (AHRQ). Effective Health Care Program. Glossary of Terms.
http://effectivehealthcare.ahrq.gov/index.cfm/glossary-of-terms/



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