The 5 W’s of the CMS Core Quality Process and Outcome Measures

Understanding the process and the expectations

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Performance Improvement Coordinator
Developed: September 2011
Before we start: Core Measure Alphabet Soup

- **AMI** - Acute Myocardial Infarction
- **CHF** - Congested Heart Failure
- **CLABSI** - Central line-associated bloodstream infections
- **CMS** - Centers for Medicare & Medicaid Services
- **FY** - Fiscal year (for this program the year starts October 1)
- **HCAHPS** - Hospital Consumer Assessment of Healthcare Providers and Systems
- **IQR** - Hospital Inpatient Quality Reporting Program
- **LVSD** - Left ventricular systolic dysfunction
- **POA** - Present on admission
- **SCIP** - Surgical Care Improvement Project
- **VBP** - Value Based Purchasing
Learning objectives

- Identify the CMS Core process measures.
- Explain the purpose of measuring performance and public reporting.
- Identify the CMS outcome measures that are used for public reporting.
1. WHAT???
What is a Core Measure?

- A core measure is one that utilizes the results of evidence-based medicine research. These basic core measure principles imply that it is reasonable to expect that every patient with the given diagnosis will receive the baseline (core) care established through such research.
How are Core Measures Reported?

- The reported results represent the percentage of patients admitted with a specific diagnosis who receive the recommended care measure.

<table>
<thead>
<tr>
<th>Number of patients receiving expected care</th>
<th>=</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of patients with given diagnosis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How are Core Measures chosen?

- Following well established quality improvement principles, the Core Measures represent high volume, high cost diagnoses associated with an increased rate of morbidity or mortality.

- The CMS goal is the same as most quality improvement projects; to do the greatest good possible for the most people.
2. WHEN ???
When did the Core Measure process start?

- The first CMS Core measure (then called the National Hospital Quality Measures) collection started in 2003.

- There were:
  - 10 AMI indicators
  - 4 CHF indicators
  - 12 Pneumonia indicators
  - 3 Surgical care improvement indicators
  - 2 Pregnancy related indicators
  - measures

- The only 2 outcome measures were morality for AMI and neonatal. (31 process + 2 outcome measures)
The Changes

- In July 2006, 3 more SCIP measures were added bringing the total to 34 process measures and 2 outcome measures.
- By 2008,
  - 2 more SCIP indicators and mortality for CHF and Pneumonia were added.
  - The pregnancy measures were retired for the CMS program.
  - The HCAHPS survey was added to the requirements for participation in the CMS Hospital Quality Initiative.
  - The program became known as RHQDAPU.
The Changes

- In 2010
  - Another SCIP measure and an AMI measure were added.
  - One pneumonia measure was retired.
    Readmissions for patients with CHF, AMI and pneumonia were added as outcome results.
  - CMS changed the name of the program to the Hospital Inpatient Quality Reporting Program (IQR)
Tomorrow and Beyond.

The timing of the receipt of antibiotics for pneumonia has been evaluated and CMS feels this requirement might encourage the inappropriate use of antibiotics in cases involving delay in diagnosis. It will be discontinued January 1, 2012.
Tomorrow and beyond cont.

- FY 2014 includes the New Claim based measure – Medicare Spending per Beneficiary- This measure will use claims data for hospital discharges occurring between May 15, 2012 and February 14, 2013. Each episode will include all charges from 3 days prior to admission through 30 days post hospital discharge. This would include Medicare A, B and any payments made by the beneficiary.
3. WHY ???
Why are Core Measure results important?

1. The first and most important reason is the **PATIENT**. Everyone in health care wants to provide the best care to each patient every time he/she is admitted to the hospital.
Why are Core Measure results important?

2. Participating in quality measure reporting provides a chance to assure the community that the hospital provides high quality care.

3. With the public reporting of quality measures compliance and cost of care, the patients can now choose the facility they think will best meet their needs.
Why are Core Measure results important?

4. The Board of Directors is charged with assuring quality care and must have a tool to determine how the facility is doing in regard to providing care for the community.
Why are Core Measure results important?

5. Facilities that maintain higher percentages of compliance with the core measures receive higher reimbursement from Medicare and other payers. More income for a facility means the ability to purchase better equipment, enhance services or increase pay or benefits for the employees.
Summary of the benefits of providing quality care

1. Decreased operational costs through improved care processes and shortened lengths of stay.

2. Increased patient satisfaction

3. Meeting accreditation or regulatory requirements.

4. Demonstrating an enhanced reputation in your community by showing your hospital’s commitment to quality health care.
4. WHAT ???
What are the current Core Measure categories

The five focus areas for the process of care are:

- **Heart failure**- CHF accounts for more than 700,000 hospitalizations a year and is associated with high rates of mortality, morbidity and readmission.
What are the current Core Measure categories

- Acute Myocardial Infarction (AMI), cardiovascular disease, is America’s biggest killer. Each year approximately 1.1 million people have a heart attack and almost 2/3 do not make a complete recovery.
What are the current Core Measure categories

- **Pneumonia** accounts for nearly 600,000 Medicare patient hospitalizations with more than 4.5 million inpatient days each year.
- It is also the principle reason for more that 500,000 emergency room visits a year for Medicare patients.
What are the current Core Measure categories

- **SCIP** - Surgical care measures are focused on reducing complications of surgery.
- It is reported that 22% of preventable deaths are related to surgical complications.
- Approximately 500,000 surgical site infections occur annually. If infection occurs the patient is 60% more likely to go to ICU and 5 times more likely to be readmitted for further care.
What are the current Core Measure categories

- Surgical patients also develop venous thrombosis 20 times more often than medical patients. Pulmonary embolism causes 300,000 death a year and is the third leading cause of hospital deaths.
What are the current Core Measure categories

- **Global Immunization Measure Set**
  - Starting January 1, 2012 all patients discharged for acute inpatient care with a length of stay less than 120 days must be assessed for and offered pneumococcal and influenza as appropriate.
Outcome Quality Measures

- CMS has shifted its focus from reporting compliance with the recommended process of providing care sharing the outcomes of care with the public.
- The first two outcome measures that were reported were the readmission and death rates for patients having a heart attack, congestive heart failure and pneumonia.
Outcome Quality Measures

- The data for these reports will be obtained using the POA (present on admission) coding process.
- To assure accurate outcomes are reported is imperative that all the practitioners (physicians, extenders, nurses, therapists etc.) provide the most exact and descriptive admission assessment documentation possible.
Outcome Quality Measures

- Started in the spring of 2011 the public report includes the hospital acquired condition measures which include:
  - Foreign object retained after surgery
  - Air embolism
  - Blood incompatibility
  - Pressure Ulcer stage III or IV
  - Falls and trauma with serious injury
  - Vascular associated infections
  - Catheter associated infections
  - Manifestations of poor glycemic control
5. WHERE???
Some Examples of Available Public Reports

These reports are easily obtained on the intranet and the results are often published in newspapers and magazines for the public to review.
Web page www.phcqa.org

Your statewide report on hospital quality.
Developed by an alliance of health care providers and insurers.
Designed with a uniform, consistent approach to measurement.
### From Penna. Health Care Quality Alliance Public Report January 2010

Appropriate Care Measures Indicates how often patients received all recommended treatments for their clinical condition. Goal is 100%. The column highlighted in yellow is the benchmark to which the hospital is compared.

<table>
<thead>
<tr>
<th></th>
<th>Hospital A</th>
<th>PA Rate *</th>
<th>US Rate *+</th>
<th>Top 10% Nationally +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Appropriate Care</td>
<td>60%</td>
<td>85%</td>
<td>85%</td>
<td>96%</td>
</tr>
<tr>
<td>Heart Attack Care</td>
<td>82%</td>
<td>92%</td>
<td>91%</td>
<td>100%</td>
</tr>
<tr>
<td>Heart Failure Care</td>
<td>49%</td>
<td>85%</td>
<td>85%</td>
<td>99%</td>
</tr>
<tr>
<td>Pneumonia Care</td>
<td>75%</td>
<td>79%</td>
<td>82%</td>
<td>97%</td>
</tr>
<tr>
<td>Surgical Care</td>
<td>56%</td>
<td>86%</td>
<td>84%</td>
<td>97%</td>
</tr>
</tbody>
</table>
Hospital Quality Compare - A quality tool provided by Medicare
Heart Failure

Graph 1 of 4

Percent of Heart Failure Patients Given Discharge Instructions

The rates displayed in this graph are from data reported for discharges April 2008 through March 2009.

Why is this important?

Heart failure is a chronic condition. It results in symptoms such as shortness of breath, dizziness, and fatigue. Before you leave the hospital, the staff at the hospital should provide you with information to help you manage the symptoms after you get home. The information should include your:

- activity level (what you can and can't do)
- diet (what you should, and shouldn't eat or drink)
- medications
- follow-up appointment
- watching your daily weight
- what to do if your symptoms get worse

Higher percentages are better.

http://www.hospitalcompare.hhs.gov/Hospital/Search/ResultsMF.asp

1/19/2010
Quality Report

**Quality Report**

**Hospital**

**National Quality Improvement Goals: Pneumonia Care**

**Reporting Period: July 2008 - June 2009**

<table>
<thead>
<tr>
<th>Measure Area</th>
<th>Nationwide</th>
<th>Statewide</th>
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<tr>
<td>Pneumonia Care</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Read More</td>
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</table>

<table>
<thead>
<tr>
<th>Measure</th>
<th>Hospital Results</th>
<th>Top 10% Scored at Least</th>
<th>Average Rate</th>
<th>Top 10% Scored at Least</th>
<th>Average Rate</th>
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</thead>
<tbody>
<tr>
<td>Adult smoking cessation advice/counseling*</td>
<td>90%</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>97%</td>
</tr>
<tr>
<td>(See Quarterly Results)</td>
<td>[ ]</td>
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<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>Blood cultures for pneumonia patients admitted through the Emergency Department*</td>
<td>80%</td>
<td>99%</td>
<td>94%</td>
<td>100%</td>
<td>95%</td>
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<tr>
<td>(See Quarterly Results)</td>
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<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>Blood cultures for pneumonia patients in intensive care units</td>
<td>85%</td>
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<td>95%</td>
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<td>(See Quarterly Results)</td>
<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>Initial antibiotic selection for CAP in immunocompetent - ICU patients*</td>
<td>63%</td>
<td>99%</td>
<td>94%</td>
<td>98%</td>
<td>65%</td>
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<tr>
<td>(See Quarterly Results)</td>
<td>[ ]</td>
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<tr>
<td>Initial antibiotic selection for CAP in immunocompetent - non-ICU patients*</td>
<td>96%</td>
<td>100%</td>
<td>64%</td>
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<td>66%</td>
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<td>(See Quarterly Results)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Pneumococcal vaccination*</td>
<td>99%</td>
<td>99%</td>
<td>94%</td>
<td>100%</td>
<td>65%</td>
</tr>
<tr>
<td>(See Quarterly Results)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Symbol Key:
- [ ] This organization achieved the best possible result.
- [ ] This organization's performance is above the target range/value.
- [ ] This organization's performance is similar to the target range/value.
- [ ] This organization's performance is below the target range/value.
- [ ] New displayers

http://www.qualitycheck.org/QualityReport.aspx?hcoiid=3695&q=enqig&program=Critical ...

1/19/2010

HOSPITAL COUNCIL of WESTERN PENNSYLVANIA
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<th>Hospital</th>
<th>Cases</th>
<th>Mortality Rating</th>
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<th>Short Length of Stay</th>
<th>Long Length of Stay</th>
<th>Readmission Rating</th>
<th>Average Charge</th>
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<td>Magee-Womens</td>
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<td>Miners</td>
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<td>3.0</td>
<td>3.0</td>
<td>○</td>
<td>$10,950</td>
</tr>
</tbody>
</table>

- ○ Significantly higher than expected.
- ● Not significantly different than expected.
- ●● Significantly lower than expected.
- NR Not reported. Had fewer than five cases evaluated.

The mortality, length of stay and readmission figures account for varying illness levels among patients. See page 4.

*While lower-than-expected and higher-than-expected ratings for mortality or readmissions may suggest good performance or opportunities for improvement, respectively, similar ratings for the short or long length of stay outlier measures are meant to be a tool to help hospitals identify variation in utilization patterns.*
Other sites. Some charge a fee for reports.

- **Why Not the Best**  
  [www.whynotthebest.org](http://www.whynotthebest.org)

- **Health Grades**  
  [www.healthgrades.com](http://www.healthgrades.com)

- **Free Online Hospital Quality Report**  
  [www.Hospital-Quality.com](http://www.Hospital-Quality.com)

- **The Leap Frog Group for patient safety**  
  [www.leapfroggroup.org](http://www.leapfroggroup.org)

- **Consumer Health Ratings**  
  [www.consumerhealtratings.com](http://www.consumerhealtratings.com)

- **Wrong Diagnosis**  
  [www.wrongdiagnosis.com](http://www.wrongdiagnosis.com)
Another way the measures are reported

All or nothing scoring
Appropriateness of Care measure calculations

- While there are many indicators in each of the core measure sets, many reports use only the appropriateness of care score, which is obtained by counting all the patients who met every indicator in the measure set and dividing that number by the total number of patients with the diagnosis.
Appropriateness of Care Core measure calculations

- For example: In one month the facility has 10 patients admitted with pneumonia. Of these 10, 2 receive all of the core measures recommended by CMS.
- Even though each indicator had a compliance rate higher than 67% the public would only see this facility’s overall appropriateness of care score for pneumonia patients which is only 20% for that month.
## Appropriateness of Care Scoring Sample

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
<th>Patient 4</th>
<th>Patient 5</th>
<th>Patient 6</th>
<th>Patient 7</th>
<th>Patient 8</th>
<th>Patient 9</th>
<th>Patient 10</th>
<th>Indicator score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial antibiotic received within 6 hours after arrival</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>n</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>90%</td>
</tr>
<tr>
<td>Assessed and Given Pneumococcal vaccination</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>n</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>90%</td>
</tr>
<tr>
<td>Blood culture before first Antibiotic received</td>
<td>n</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>n</td>
<td>y</td>
<td>y</td>
<td>80%</td>
</tr>
<tr>
<td>Given Adult smoking cessation advice/counseling</td>
<td>y</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>n</td>
<td>na</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>83%</td>
</tr>
<tr>
<td>Appropriate Initial Antibiotic selection (ICU)</td>
<td>y</td>
<td>na</td>
<td>na</td>
<td>y</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>n</td>
<td>na</td>
<td>na</td>
<td>67%</td>
</tr>
<tr>
<td>Appropriate Initial Antibiotic selection (Non-ICU)</td>
<td>na</td>
<td>y</td>
<td>y</td>
<td>na</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>na</td>
<td>y</td>
<td>y</td>
<td>100%</td>
</tr>
<tr>
<td>Assessed and Given Influenza Vaccine</td>
<td>y</td>
<td>n</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>n</td>
<td>80%</td>
</tr>
<tr>
<td>total</td>
<td>5 of 6</td>
<td>4 of 5</td>
<td>5 of 5</td>
<td>4 of 5</td>
<td>5 of 6</td>
<td>4 of 5</td>
<td>5 of 6</td>
<td>5 of 6</td>
<td>5 of 6</td>
<td>6 of 6</td>
<td></td>
</tr>
<tr>
<td>Appropriateness of care score</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2 of 10 or 20%</td>
</tr>
</tbody>
</table>
It is important that everyone understands and supports the indicators included in each core measure bundle. Some of the indicators are physician driven but many are nursing measures. In today’s modules, we will go through each measure in detail.
Test your knowledge

1. Which is not a current CMS core Quality measure?
   a. CHF
   b. AMI
   c. COPD
   d. Pneumonia
Test your knowledge

2. We measure quality to:
   a. To be sure we are providing the baseline care to each patient admitted with a specific diagnosis
   b. Provide a tool for the Board of Directors so they can assure good care.
   c. To meet regulatory requirements
   d. All of the above
Test your knowledge

3. Individual quality reports for each hospital are available to the public.

a. True
b. False
Test your knowledge

4. The new core measure set starting January 1, 2012 is called the __________ immunization set.
   a. Universal
   b. Global
   c. Mandatory