

2012 NQF Report to Congress

# Changing Healthcare by the Numbers

113% INCREASE IN PREMIUMS VS. 27% INCREASE IN WAGES BETWEEN 2001 AND 2011 4 COMMON HEALTHCARE

FACILITY INFECTIONS DECLINED IN 2010 1 IN 5 HOSPITALIZED MEDICARE PATIENTS READMITTED WITHIN 30

DAYS OF DISCHARGE 50% REDUCTION IN DEADLY HEART ATTACKS BETWEEN 1980 AND 2000 50 STATES HAVE

OBESITY RATES HIGHER THAN 20% 1 IN 20 HOSPITALIZED PATIENTS ACQUIRE AN INFECTION RELATED TO CARE



NATIONAL  
QUALITY FORUM

#### ■ 113%

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#### ■ 4

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#### ■ 1 IN 5

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#### ■ 50%

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#### ■ 50

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#### ■ 1 IN 20

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## EXECUTIVE SUMMARY

The U.S. healthcare system is among the most innovative in the world and patients with very serious and/or unusual conditions are particularly appreciative of the range of therapies, interventions, and clinical talent it offers to treat them and restore them to health. That said, it is also one of the most fragmented, unorganized, and uncoordinated systems as compared to its counterparts in the industrialized world—which contributes to less-than-optimal quality outcomes, serious patient safety problems, and very high per-capita costs.<sup>2, 3, 4</sup> Consequently, Members of Congress, business leaders from small and large companies, patients, physicians, nurses, and many others have come to the conclusion that Americans are not deriving enough value for the substantial dollars they spend.

Important strides have been made toward improving this value proposition over the last decade, starting with the *sine qua non* of using standardized performance measures to assess “how we are doing” on an array of healthcare quality and cost dimensions, making the measure results public, and then linking those results to provider payment. And while

### CHANGING HEALTHCARE BY THE NUMBERS

# 85%

of measures used  
in federal programs  
are NQF endorsed

establishing this accountability environment is critical foundational work, it is not sufficient for achieving the kind of substantial improvements that the National Quality Strategy (NQS) envisions. Released by the Department of Health and Human Services (HHS) in March 2011 and supported by public- and private-sector healthcare leaders, the NQS is built around three compelling aims focused on healthy people and communities, better care, and more affordable care. To achieve these ambitious aims also will take fundamental reform of care delivery and payment, which, while underway, will still require time, effort, and perseverance to realize.

That said, the accountability environment’s basic infrastructure is moving into place. A key lesson learned in constructing it is that neither the public nor private sectors, nor any single stakeholder, can meaningfully shape it on their own. Healthcare is too large and complex, with too many interrelated parts, for a go-it-alone strategy to be fully effective. Recent actions of healthcare leaders demonstrate that they understand that sustainable solutions to our nation’s healthcare challenges are ones that all stakeholders embrace. Over the last year, significant progress has been made toward forging a shared sense of priorities for improvement; an agreed-upon way to set, continuously enhance, and implement strategies to achieve these priorities; and standardized methods for measuring progress along the way. Without such agreements, competing strategies and a plethora of near-identical measures run the risk of whipsawing providers and overburdening them

with redundant and sometimes conflicting reporting requirements. In addition, such an environment can confuse consumers who increasingly seek to better inform themselves as they play a more active role in healthcare decision-making.

Congress, wisely understanding this need for a quality infrastructure and more public-private collaboration, passed two statutes that included this notion, and directed HHS to work with a consensus-based entity to act as a key convener and measurement standard setter. These statutes include the 2008 Medicare Improvements for Patients and Providers Act (MIPPA) (PL 110-275) and the 2010 Patient Protection and Affordable Care Act (ACA) (PL 111-148). HHS awarded contracts related to the consensus-based entity to the National Quality Forum (NQF).

NQF has prepared this third Annual Report to Congress which covers highlights of work related to these statutes conducted under federal contract between January 14, 2011 and January 13, 2012. See appendix A for a complete listing of deliverables worked on and completed during the contract year.


 A yellow square containing the number 17 in large white font, with the text 'federal programs received MAP input' in smaller white font below it.
 

17

federal programs  
received MAP input


 A purple square containing the number 450 in large white font, with the text 'organizations are NQF members' in smaller white font below it.
 

450

organizations are NQF  
members

## Building Consensus About What and How to Improve

In the fall of 2010, as HHS was developing the first-ever NQS, the National Priorities Partnership (NPP), convened by NQF, was asked to provide initial input on the overarching aims and priority areas and published a [report](#). Subsequently, in response to a second request from HHS, NPP identified three goals for each of the NQS six priorities in a second [report](#), along with appropriate performance measures, and “strategic opportunities” to accelerate progress. These opportunities require leveraging the reach of the many public and private stakeholder groups participating in NPP, which balances the interests of consumers, purchasers, health plans, clinicians, providers, federal agency leaders, community alliances, states, quality organizations, and suppliers. In 2011, NPP focused further on enhancing patient safety, one of the six NQS priorities and a very important focus for HHS. More specifically, NPP worked collaboratively with HHS on its Partnership for Patients initiative, through hosting quarterly meetings and an interactive webinar series, which brought tools and ideas for reducing patient harm to nearly 10,000 front-line clinicians, hospitals, and other stakeholders across the country. Moving forward in 2012, NPP will draw on the real-world experience of its partners to develop implementation strategies, likely targeting patient safety in maternity care and readmissions.

## Endorsing Measures for Use in Accountability and Performance Improvement

NQF completed 11 endorsement projects during the course of the contract year—using both the NQS priorities that cross conditions and leading health conditions with respect to prevalence and cost as a way to prioritize its efforts. In total, NQF committees evaluated 353 submitted measures and endorsed 170 new measures—or 48 percent of those submitted. While the number of measures endorsed is considerably higher than in previous years, the endorsement rate is lower due to the enhanced rigor of the review criteria. At the same time, NQF placed emphasis on reducing providers' reporting burden by harmonizing specifications related to similar measures.

Currently, the portfolio of NQF-endorsed measures includes more than 700 measures, of which 30 percent assess patient outcomes and experience with care. Considerable progress also has been made in specifying measures for use with electronic health records. NQF worked with 18 measure developers to create eMeasure specifications for 113 existing endorsed measures, and released an initial and updated Measure Authoring

**170**

new measures were  
endorsed by NQF  
in 2011

**65**

different measure  
developers work  
with NQF

**90%**

of NQF's measures  
portfolio is in use

Tool (MAT). The re-tooled measures and MAT are innovations that enable the field to get substantially closer to having electronic health records with the capacity to capture and report performance information during routine care.

## Aligning Payment and Public Reporting Programs that Reward Value

A significant proportion—about 85 percent—of the measures used in federal programs are NQF-endorsed. Further, NQF-endorsed measures are used extensively by private health plans, state governments, and others. Such alignment can simultaneously reduce reporting burdens for providers and accelerate improvement because of the common signals that payers send. The NQF-convened Measure Applications Partnership (MAP), launched in the spring of 2011, fostered further alignment with its series of three performance measurement coordination strategy reports: *Clinician Performance Measurement*, *Dual-Eligible Beneficiaries*, and *Healthcare-Acquired Conditions and Readmissions Across Public and Private Payers*. As a part of these reports, MAP also developed a framework and criteria to guide the selection of the best measures for use in numerous payment and public reporting programs. Building on these reports, MAP then provided **pre-rulemaking guidance** to HHS, including input on measure sets pertaining to 17 HHS programs, as well as strategies for enhancing consistency and minimizing reporting burden across federal

programs and between public- and private-sector efforts. Leaders from nine different HHS agencies are actively participating in MAP.

This advice from MAP—provided many months in advance of relevant rules—represents a true innovation in rulemaking, with the public and private sectors now having forums for substantive back-and-forth dialogue that cuts across program silos, and a unique opportunity to build a shared perspective and consensus about measure selection. Measures related to care coordination—essential to making care more patient centered—are an object lesson for what is possible with pre-rulemaking convening and endorsement. More specifically, MAP recommended that an existing care transitions measure focused on hospitals also be used in other settings, and suggested a broadening of a readmission measure to include all ages and applicability to additional kinds of providers. MAP also advised the Center for Medicare & Medicaid Services (CMS) to require reporting of medication reconciliation measures at the time of transition between settings. As it turns out, NQF has already endorsed measures for medication reconciliation, readmission, and care transitions that apply to additional settings and populations so these measures can

## IMPLEMENTATION OF INNOVATIVE MEASURES NEEDS TO GO HAND-IN-GLOVE WITH FUNDAMENTAL REDESIGN OF DELIVERY AND PAYMENT TO ACHIEVE THE NQS AIMS

move right into other federal programs.

Taken together, the reports are important stepping stones for MAP as the Partnership works on a comprehensive measurement strategy it will recommend to guide HHS measure selection for federal programs in the coming years. This strategy will be informed by the Partnership's in-depth understanding of current measures and their use in relevant programs, opportunities for potential coordination and integration, growing collaboration across the public and private sectors, and a vision for the future.

Numbers are an essential guidepost for gauging healthcare performance, and measures may be a powerful motivator of change when paired with public reporting and payment. But alone, they cannot drive achievement of the value agenda. Rather, implementation of innovative measures needs to go hand-in-glove with fundamental redesign of delivery and payment systems to achieve the NQS' three, interconnected aims. And while local communities are changing the way care is organized and paid for to break down existing silos, facilitate integration and coordination of care, and connect healthcare to other sectors (e.g., employment, education), such innovations have not yet swept the country. When they do, and are coupled with accountability strategies embraced by the public and private sectors, we will be able to achieve our goals of healthier people and communities, and better, less-costly patient care. We will have then changed healthcare by design and by the numbers.

# 1 NATIONAL QUALITY FORUM: BACKGROUND

More than a decade after their publication, the Institute of Medicine's (IOM's) landmark *Quality Chasm* and *To Err is Human* reports still resonate: Our healthcare system continues to fall short on quality, safety, and affordability. That said, recent years have seen a re-energized commitment to improving care and constraining healthcare costs. HHS, NQF, and the increasing number of private-sector organizations that constitute the quality movement are at the center of that resurgence.

Established in 1999 as the standard-setting organization for healthcare performance measures, NQF today has a much-broadened mission to:

- Build consensus on national priorities and goals for performance improvement, and work in partnership with the public and private sectors to achieve them.
- Endorse and maintain best-in-class standards for measuring and publicly reporting on healthcare performance quality.
- Promote the attainment of national goals and the use of standardized measures through education and outreach programs.

NQF is governed by a 27-member Board of Directors (see Appendix B) from a diverse array of public- and private-sector organizations. A majority of seats on the board is held by consumers, employers, and other organizations that purchase healthcare services on consumers' behalf. In 2011, NQF convened hundreds of experts across every stakeholder group on its priority-setting, measure-review, and measure-selection committees—individuals who volunteered their time, talents, experience, and insights (see Appendix F).

## SIDEBAR 1

### Working with NQF Helped Spur Rapid Evolution of Ophthalmology Measures

There are many intangible benefits from the endorsement activities supported under the HHS contract. One of these is that it provides valuable input to measure developers which helps focus measure development resources on important gap areas. The efforts of the American Academy of Ophthalmology (AAO) are a case in point.

As early as the 1980s, and before many other specialty societies, AAO developed "preferred practice patterns" to provide practice guidance for ophthalmologists. These guidelines proved to be a solid foundation to draw from when,

in 2006, AAO began developing related quality measures for quality improvement feedback and public reporting purposes. Over the last five years, AAO has developed ever more sophisticated performance measures—evolving from process, to outcome, to functional status—and credits involvement with the NQF review process as an important catalyst in this evolution.

#### More specifically:

- AAO—in collaboration with the AMA-PCPI—first worked to develop process measures focused on eye-care issues

such as diabetic retinopathy (damage to the eye's retina as a result of long-term diabetes), and performance of optic nerve exams in primary open-angle glaucoma (chronic, progressive optic-nerve damage) patients.

- Recognizing that measures that evaluate actual results of care are more critical to improving quality, NQF encouraged AAO to shift its focus to developing clinical outcome measures. As a result, NQF later endorsed a measure focused on reducing glaucoma patients' eye pressure (which can lead to optic-nerve damage or blindness) by 15 percent.

NQF also directly reached some 10,000 frontline clinicians, hospitals, and others with educational programming via webinars. And its endorsed performance standards touched the care delivered to millions of patients every day.

In recent years, the number and variety of NQF-endorsed measures has greatly expanded. More than 700 NQF-endorsed measures now address most settings of care, conditions, and types of providers. The measures portfolio includes clinical process measures, patient experience of care, the actual outcomes of care, the costs and resources that go into providing care, as well as select structural measures. The portfolio is being enhanced with advanced measures, such as functional outcome and crosscutting care-coordination measures. At the same time, the NQF portfolio is being carefully culled to retire measures that no longer meet the more rigorous criteria. In the last year alone, 353 measures were submitted to NQF and 170, or nearly half, were endorsed. This endorsement rate—or ratio of submitted-to-endorsed measures—reflects NQF’s efforts to systematically raise the bar on performance measurement, even as it seeks to reduce the burden on providers by eliminating duplicative measures.

To be NQF endorsed, a measure must be a process or outcome that is important to measure and report, be scientifically acceptable, be feasible to collect, and provide useful results. NQF conducts an eight-step, consensus-based process that has been continually improved over a decade (see Appendix C). Review committees are comprised of multiple stakeholders; consumer organizations are equal partners with clinicians and other stakeholders throughout the process. There is a strong commitment to transparency and NQF invites public participation at every step, ranging from nominations for committees, to decisions on specific measures. Endorsed measures are re-evaluated every three years to ensure their actual use and usefulness in the field and their continuing relevance with current science, and to determine whether they continue to represent the best in class.

- More outcome measures were later developed and endorsed under the HHS-funded outcomes project, focusing on issues such as complications within 30 days following cataract surgery, as well as 20/40 or better visual acuity within 90 days of cataract surgery.
- Recently, the NQF board has approved measures related to patient functional status, attempting to measure improvement in patients’ visual functional status and their overall satisfaction within 90 days following cataract surgery. These measures are currently under

NQF review, and have been included in the 2012 Physician Quality Reporting System (PQRS) measure set.

Dr. Flora Lum, executive director of AAO’s H. Dunbar Hoskins Jr., MD Center for Quality Eye Care, noted that NQF’s ability to bring patient and consumer perspectives to the Steering Committee responsible for evaluating measures has been invaluable over the years. AAO’s efforts to advance healthcare quality continue, with the organization now striving to develop appropriateness-of-care measures.

The evolution of AAO’s measures over a short time period is noteworthy and the information that results from the measures provides physicians with multi-faceted feedback about the care they deliver. Ideally, such information is available in rapid-response reports, with educational interventions to help facilitate improvements at the practice level, and over time, so that ophthalmologists and patients can gauge progress. As AAO has gone on this journey to develop ever-increasingly sophisticated and meaningful measures, NQF has been pleased to be a part of it.

Measures included in the NQF portfolio are developed and maintained by about 65 different organizations. The following gives a sense of the range of organizations NQF works with: CMS, the National Committee on Quality Assurance (NCQA), the American Medical Association-Physician Consortium for Performance Improvement (AMA PCPI), Ingenix, the Joint Commission, American College of Surgeons (ACS), Bridges to Excellence, Cleveland Clinic, Minnesota Community Measurement, and Pharmacy Quality Alliance.

In recognition of its skill in building consensus across multiple stakeholders in the measure-endorsement realm, NQF has been asked to convene diverse committees to advise the public and private sectors on priorities for improvement, related implementation strategies, and selection of measures to both drive these strategies and gauge results. The NQF-convened NPP and MAP and their published reports are tangible outcomes of this work. An equally important outcome of these partnerships is the ongoing alignment across stakeholder groups and across public- and private-sector leaders about what levers to use to both improve healthcare performance and move the delivery system to be more patient centered.

NQF has been fortunate to have received support from the federal government for over 10 years, with more substantial support starting in 2008 when federal leaders strongly committed themselves to designing and implementing a value agenda. More specifically:

- MIPPA has provided NQF with \$10 million annually over a four-year period starting in 2009. These funds—awarded to NQF through a competitive process—are supporting the organization’s efforts to identify priority areas for improvement, endorse and update related performance measures, foster the transition to an electronic environment, and report annually to Congress on the status and progress to date of this effort.

## SIDEBAR 2

### Resource-Use Measures: Critical to the Value Agenda

U.S. healthcare per-capita spending is greater than that in any other country, yet it has not resulted in better health for Americans. With costs increasing beyond annual inflation, spending is largely focused on treating acute and chronic illnesses rather than prevention and health promotion.

Deriving more value from health spending is predicated on having both quality and cost (or resource use) information. To date, limited information about resource use exists. CMS and many measure developers are working to change that, and in 2009, NQF was tasked with further defining resource-use measures and identifying important attributes to consider

when evaluating them. NQF also endorsed its first-ever resource-use measures during the 2011 contract year.

As defined by NQF, resource-use measures are comparable measures of actual dollars or standardized units of resources applied to the care given to a specific population or event—such as a specific diagnosis, procedure, or type of medical encounter. The endorsed measures:

- Relative Resource Use for People with Diabetes
- Relative Resource Use for People with Cardiovascular Conditions
- Total Resource Use Population-Based Per-Member Per-Month (PMPM) Index

- Total Cost of Care Population-Based PMPM Index

“The endorsement of standardized measures of healthcare resource use and cost fills a huge void that has kept the nation from measuring the value of healthcare in a consistent way,” said Steering Committee member Dolores Yanagihara, director, pay for performance, at the Integrated Healthcare Association. “That said, it is a complex process, both technically and from an accountability standpoint. The measures recommended for endorsement give us a broader picture of healthcare—overall and related to specific conditions.”

- ACA has provided NQF with support of about \$10 million, starting in 2011. Under section 3014, Congress directed HHS to contract with “the consensus-based entity under contract” to provide multi-stakeholder input into the NQS, as well as advice to the Secretary of HHS on the selection of measures for use in various quality programs that utilize the federal rulemaking process for measure selection.

With federal leadership and support, as well as the support of foundations and over 450 NQF member organizations, much has been collectively accomplished since NQF’s founding in 1999. With more substantial and predictable support from the federal government over the last three years, and an enhanced commitment on the part of the public and private sectors to work together, the basic infrastructure for performance measurement is moving into place and our ability to shape and further an environment of accountability has grown. NQF’s accomplishments during 2011 will be described against that backdrop.

## 2 BRIDGING CONSENSUS ABOUT IMPROVEMENT PRIORITIES AND APPROACHES

Released by HHS in March 2011, the country’s NQS focuses the public and private sectors on an inspiring set of three, interconnected aims—better care, more affordable care, and healthier people and communities—as well as six related priority areas (see Figure 1). While the field has long targeted improving clinical care, the NQS gives significant, equal heft to the notion of health/wellbeing and affordability.

FIGURE 1:  
NQS AIMS AND PRIORITY AREAS



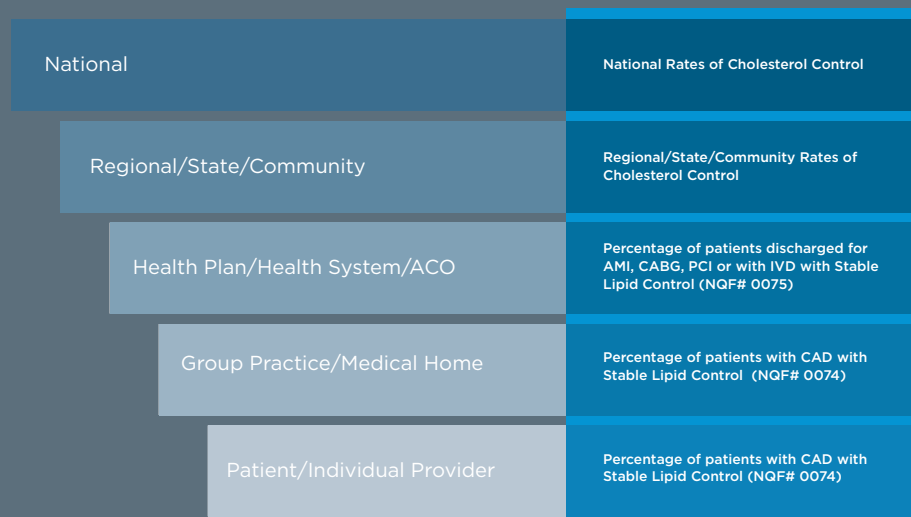
The NQS provides a critical framework for the efforts of the multiple-stakeholder committees convened by NQF. These efforts range from discussions at the highest, most conceptual levels about a three-to-five-year measurement strategy to undergird the evolving value agenda; to committees working in a new measurement area and developing consensus about what and how to measure; to those simultaneously enhancing and culling a set of measures in an established area, while considering their larger context within the NQF-endorsed measurement portfolio.

## National Priorities Partnership

Development of the landmark NQS was informed by the collective input of the NQF-convened National Priorities Partnership (NPP), a collaboration of 51 public- and private-sector organizations uniquely qualified to represent the array of stakeholders needed to improve the nation's healthcare system. As the NQS was being formulated, HHS sought multi-stakeholder **input** from NPP on its aims and priorities. After publication of the NQS in March 2011, HHS again reached out to NQF to convene NPP to provide input on further specifying goals, measures, and implementation pathways to move the national strategy and related priorities forward, drawing upon the real-world experience of its stakeholder participants.

The NPP recommendations are captured in a follow-up report to the HHS Secretary, *Priorities for the National Quality Strategy*, published in September 2011. This second report identifies goals and measure concepts that address the three NQS aims and six priorities simultaneously. For example, there are suggestions for goals and measurement areas related to care coordination that cut across clinical conditions. This would encourage better, more integrated care delivery, enhanced health outcomes, and fewer wasted

**FIGURE 2:**  
**FAMILY OF CHOLESTEROL CONTROL MEASURES**



resources. The NPP report also acknowledges that successful implementation of NQS-related goals and measures are predicated on strategic and technical measure alignment—or agreement—across various levels of accountability in our healthcare system. This starts at the most granular level—the patient and physician—and moves in a linked chain across a family of measures and levels of increasing aggregation. Without agreement about strategic direction and concordance on measure selection, a predictable cacophony results, frustrating clinicians and confusing consumers. The cholesterol-control example (Figure 2) provides an illustration of a family of measures with linkages across levels and illustrates this crucial strategy of alignment. Further, these NQF-endorsed measures are included in HHS’s newly launched and broad-based Million Hearts Campaign—a public-private initiative that aims to prevent one million heart attacks and strokes in five years.

In addition to NPP’s consultative role as it relates to the NQS, NPP has served as a catalyst in developing implementation strategies—working across diverse stakeholder groups to spur collective action—focused on improving patient safety and reducing patient harm. Such a focus also can reduce costs, with the IOM estimating that decreasing healthcare-associated infections (HAIs), complications, and unnecessary readmissions by 10 to 20 percent could result in \$2.4 billion to \$4.9 billion annual savings for the U.S. healthcare system.<sup>5</sup>

## NQF’s Focus on Safety

In 2011, NQF’s work in the safety realm spanned updating of measures and serious reportable events (SREs), a recommended approach for further aligning public- and private-sector patient-safety measurement strategies, and development of implementation strategies in support of HHS’s Partnership for Patients Initiative.

# 10,000

FRONTLINE CLINICIANS, HOSPITALS  
AND OTHERS PARTICIPATED IN THE  
NPP-HHS PARTNERSHIP FOR PATIENTS  
SAFETY WEBINARS

Partnership for Patients is engaging stakeholders from the private and public sectors to reduce all-cause harm (i.e., all forms of harm that can affect patients) and hospital readmissions. More specifically, NPP partnered with the Partnership for Patients to host 11 webinars that attracted about 10,000 frontline clinicians, hospitals, and others across the country and provided education, tools, resources, and insight on key safety issues. *These webinars* ranged from big-picture interventions (e.g., how to get your Board on board when it comes to improving patient safety), to those with a more laser focus on clinical teams (e.g., reducing surgical-site infections [SSIs]). Nearly 90 percent of webinar participants, who came from every region of the country, reported that they would be able to implement something new in their institutions as a result of this novel public-private programming. Moving forward in 2012, NPP is developing two action pathways, which its multiple partners can implement and spread. These pathways are focused on the health of mothers and babies by reducing elective deliveries before 39 weeks, and reducing avoidable admissions and re-admissions across all settings of care. These represent 2 of the 10 areas Partnership for Patients is pursuing to achieve its global safety and harm-reduction goals. Reaching these goals also will substantially reduce costs.

In addition, MAP released a report, *Coordination Strategy for Healthcare-Acquired Conditions and Readmissions Across Public and Private Payers*, in October 2011, detailing the ways in which public and private healthcare providers can align performance measurement to enhance patient safety. Specifically, the report makes three recommendations: 1) There needs to be a national set of core safety measures applicable to all patients; 2) Data need to be collected on all patients to inform these national core safety measures; and 3) Public and private entities need to coordinate their efforts to make care safer. MAP's recent pre-rulemaking report further emphasizes the

### SIDEBAR 3

## NQF and Patient Safety

### Patient-Safety Measures

NQF's inventory of endorsed measures includes more than 100 patient-safety measures, with several focused specifically on healthcare-associated infections or HAIs. Preventing HAIs has become a national priority for public health and patient safety. To date, 27 states are requiring public reporting of certain HAIs. Further, the NQS has identified safer care as one of its primary aims and, in 2013, hospitals' annual Medicare payment updates will be tied to submission of infection data, including central line-associated bloodstream infections and surgical-site infections (SSIs).

In this past year, NQF endorsed four additional patient-safety measures focused on HAIs, including a successfully harmonized measure from the American College of Surgeons and the Centers for Disease Control and Prevention focused on SSIs, and updates of existing HAIs addressing urinary tract infections and bloodstream infections. These efforts were completed under federal contract.

### Serious Reportable Events

Preventing adverse events in healthcare is also central to NQF's patient-safety efforts. To ensure that all patients are protected

from injury while receiving care, NQF has developed and endorsed a set of serious reportable events (SREs). This set is a compilation of serious, harmful, and largely—if not entirely preventable—patient safety events, designed to help the healthcare field assess, measure, and report performance in providing safe care. The SREs focus on the following areas:

- Surgical or invasive-procedure events
- Product or device events
- Patient-protection events
- Care-management events
- Environmental events

importance of safety measures by supporting their inclusion in federal public reporting and performance-based payment programs, and MAP will focus on alignment of core safety measures across programs in 2012. With respect to measure review, NQF endorsed numerous patient-safety measures, including healthcare-associated infections (HAIs), which now address long-term, acute-care and rehabilitation hospitals, and radiation-safety measures, to name a few.

NQF also updated its list of SREs, a compilation of serious, harmful, and largely—if not entirely—preventable patient-safety events, designed to help the healthcare field assess, measure, and report performance in providing safe care. In the 2011 update, the events were broadened in focus to explicitly include hospitals, office-based practices, ambulatory surgery centers, and skilled nursing facilities to reflect the various settings in which patients receive care and could experience harm. Based on input from users, the implementation guidance for each event was expanded, and a glossary was added to facilitate uniformity in reporting of the events. The list includes wrong-site surgery; death or serious injury associated with medication errors or unsafe blood products; and failure to follow up on lab, pathology, or radiology test results. Public and private purchasers have drawn heavily from the SRE list in identifying healthcare-associated conditions for use in payment and reporting programs. (See Sidebar 3.)

Finally, NQF launched a project in 2011 that will leverage health IT data to address patient safety and quality concerns associated with medical devices, such as pumps used to deliver intravenous medications at home. This project, which continues in 2012, will determine what data needs to be collected and shared to improve quality and safety related to devices. It also will focus on ways to identify and report adverse events associated with the use of such devices.

- Radiologic events

- Potential criminal events

Originally envisioned as a set of events that would form the basis for a national state-based reporting system, the SREs continue to serve that purpose. To date, 26 states and the District of Columbia have enacted reporting systems to help stakeholders identify and learn from SREs. The majority of those states incorporate at least some portion of NQF's list to help align reporting efforts and encourage learning across healthcare systems.

**26** STATES AND  
DC HAVE  
IMPLEMENTED  
SERIOUS REPORTABLE  
EVENT (SRE) REPORTING  
SYSTEMS

## 3 ENDORSING MEASURES AND DEVELOPING RELATED TOOLS

With its extensive evaluation (see Sidebar 4) and multi-stakeholder input, NQF is recognized as a voluntary consensus standards-setting organization under the National Technology Transfer and Advancement Act of 1995. In addition, NQF adheres to the Office of Management and Budget's formal definition of consensus.<sup>6</sup> Consequently, NQF-endorsed measures have special legal standing allowing federal agencies to readily adopt them into their programs, which they have done at a striking rate. About 85 percent of measures in federal health programs are currently NQF-endorsed, including those that apply to hospitals, clinicians, nursing homes, patient-centered medical homes, and many other settings.

In 2011, NQF completed 11 endorsement projects—reviewing 353 submitted measures and endorsing 170, or 48 percent. Enhancements to the endorsement process over the last year included strengthening its rigor by requiring testing of measures prior to measure review, initiation of a project to reduce endorsement cycle time, integration of review of existing measures with new measures to ensure harmonization and best-in-class assessment, and creation of an expedited review process to respond to important regulatory or legislative requests. In addition, NQF worked with 18 measure developers to update 113 electronic measures, or eMeasures, so they could be more readily collected through EHRs, and introduced and updated tools to respectively facilitate development and collection of eMeasures.

### NQF Endorsement in 2011

The overall framework used to guide the NQF measures portfolio is multi-dimensional.

#### SIDEBAR 4

#### What Does it Take for a Measure to Get Endorsed?

With the enhanced rigor of NQF's endorsement criteria, only about 50 percent of submitted measures were endorsed this past year.

The leading reason that measures do not pass the grade is failure to meet the "must pass" importance-to-measure-and-report criterion. This includes being able to demonstrate that the proposed measure or related data is focused on a high-impact health goal or priority; there is less-than-optimal performance; and there is strong scientific evidence for the measure, with respect to quality, quantity, and consistency. NQF expert committees rate

the evidence based on specific guidance.

The second "must pass" criterion is scientific acceptability of measure properties. In other words, do the data from testing the measure show that it is reliable and valid and precisely specified? Expert committees look for moderate-to-high ratings so they are confident the measure results are reliably consistent and can be compared across providers and analyzed longitudinally.

Other important criteria include usability and feasibility—assessing whether intended audiences can understand the results and find

them helpful for decision-making and quality improvement. The criteria also consider whether providers can collect data without undue burden. See Appendix C for more detail.

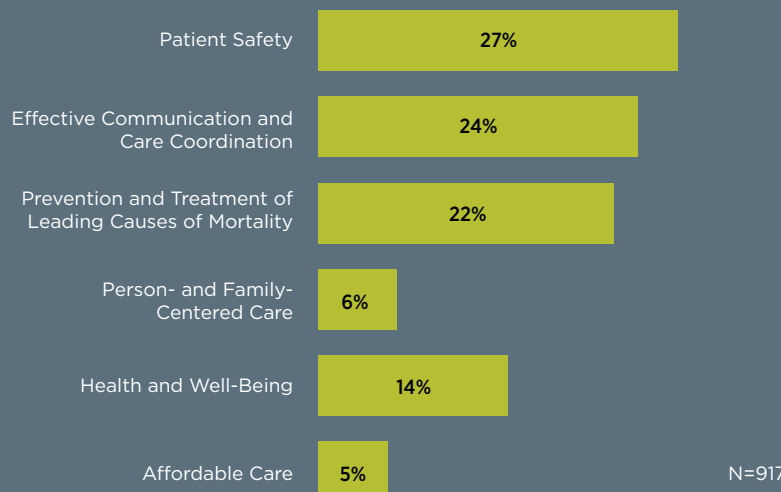
It includes the NQS crosscutting priorities, as well as leading health conditions with respect to prevalence and cost that affect an array of populations. Figure 3 provides a snapshot of how the current NQF-endorsed measures portfolio stacks up against the NQS, with the percentages reflecting the proportion of NQF-endorsed measures against the six priorities. Some measures are counted in multiple priority areas. The chart shows gaps in emerging measurement areas, including patient-family centered care, measures related to community health and wellbeing, and affordability. These gaps require significant foundational work to understand what to focus on for measurement and how to best overcome technical barriers. NQF has undertaken this foundational work over the last year, and has started to bring in measures in all of these areas for endorsement review.

The 170 measures newly endorsed by NQF in 2011 include many outcome measures; measures that focus on populations previously under-represented, including pregnant women and children; a number of patient-safety measures—given the importance of reducing patient harm; measures in new areas that fill important gaps, such as cost (resource use); as well as the updating of measures related to highly prevalent conditions, (e.g., cardiac and surgical care). More specifically:

### Outcome measures

NQF has made great strides over the past year to endorse measures that evaluate results of care, particularly in the patient-safety, nursing-home, and surgical-care areas. Outcome measures are considered most relevant to patients and providers looking for improved quality and patient experience, as opposed to measures that assess process or structure. Examples of outcome measures endorsed in 2011 include potentially avoidable complications for select conditions (i.e., stroke, pneumonia), remission of symptoms in patients with depression, and patient experience in nursing homes and dialysis facilities.

**FIGURE 3**  
**PERCENT OF NQF-ENDORSED MEASURES MAPPED TO ONE OR MORE NQS PRIORITIES**



*Total number of measures is 917; endorsed measures may be reflected in multiple categories*

## Patient-safety measures

Long a focus of NQF, these new patient-safety measures span settings and types of conditions. They include measures focused on HAIs (urinary tract, central-line-associated bloodstream, and SSIs), and measures focused on issues such as standardized data collection and reporting of radiation doses.

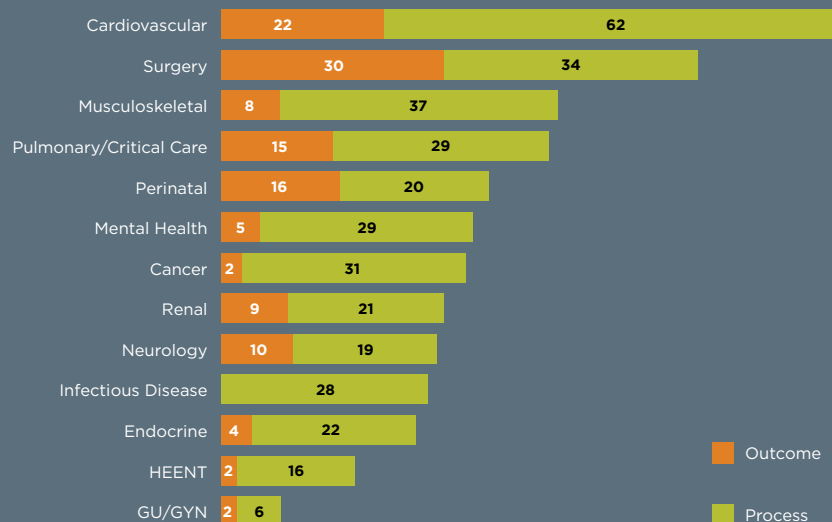
## Maternal and child-health measures

These populations have been underrepresented in performance measurement. NQF has worked to fill these gaps through two endorsement projects over the past year—child health, and perinatal and reproductive health. Child-health measures focus on important screenings and access to care, including immunizations, hearing assessments, and well-child visits. Other measures address population health outcomes, including the number of school days missed due to illness and birth outcomes. Proposed perinatal measures (this project is still underway) address procedures such as cesarean sections and elective delivery prior to 39 weeks.

## New and existing measurement areas

NQF reviewed measures related to resource use, both those related to conditions (e.g., diabetes and cardiovascular disease), and those related more to global resource use. Endorsement projects in 2011 also focused on reviewing existing measurement areas for high-prevalence conditions or areas (palliative care and end-of-life care, cardiovascular disease and kidney disease), adding new measures, and retiring others as the expert committees saw fit. More specifically, NQF endorsed or maintained measures focused on optimal vascular care, complications or death for specific surgical procedures, and assessment of post-dialysis weight by nephrologists for kidney disease patients.

**FIGURE 4:**  
**NQF-ENDORSED MEASURES: PROCESS AND OUTCOME MEASURES BY CLINICAL AREAS**



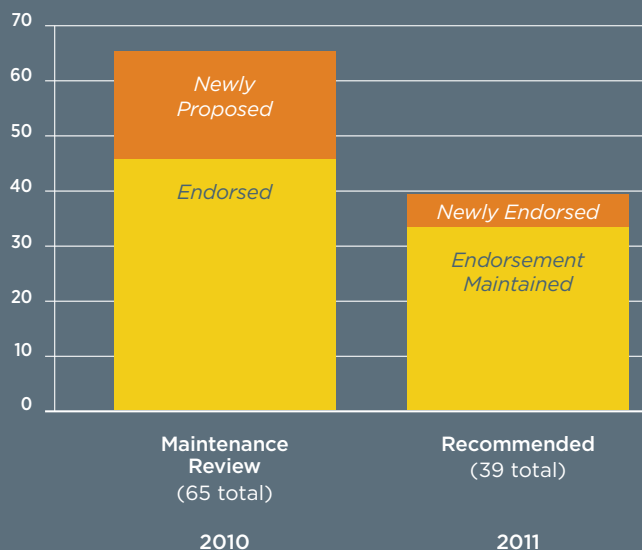
Although NQF has made considerable progress in endorsing outcome measures—which constitute about 30 percent of the portfolio—differences exist with respect to outcome and process measures across conditions, which is illustrated in Figure 4. For example, there are more outcome measures for surgery and perinatal care than for mental health and cancer care. Also, HAIs are reflected under surgery, not infectious disease.

When NQF begins to address a new measurement area, the relevant expert committee will often start by developing a framework report to guide its future measurement review. These reports may include a scan of existing measures, a discussion about where there are key opportunities for improvement, and consideration of potential technical barriers. For example, NQF is developing a population health-measurement framework aimed at aligning delivery system, public health, and community stakeholder efforts to improve health outcomes and the social determinants of health. Historically, there has been little coordination across these sectors. NQF is also developing a patient-centric measurement framework for assessing the efficiency of care provided to individuals with multiple chronic conditions. This report will inform NQF’s future efforts to endorse measures that apply respectively to population health and care for people who have more than one chronic condition.

## Culling the NQF Portfolio

A key part of NQF’s review process is focusing on endorsing best-in-class measures and eliminating similar or even identical measures that create confusion and burden across clinical settings and providers. This alignment of very similar measures—or measure harmonization—can reduce reporting burden for providers and enhance comparability of results for patients and payers, thereby reducing confusion and enabling decision-making. The harmonization of the surgical site infection measures from the Centers for Disease Control and Prevention and the ACS is a case in point (see Sidebar 5). Further, NQF’s

**FIGURE 5:**  
**UPDATE OF CARDIOVASCULAR MEASURES**



maintenance process retires existing measures that no longer meet the higher endorsement bar, thereby further culling the portfolio.

The recent Cardiovascular Project illustrates how NQF expert committees now consider new measures against existing endorsed measures. Using the measure evaluation criteria and guidance on evaluating related and competing measures, the Cardiovascular Committee reviewed proposed new measures and those undergoing maintenance, focusing on measures that address the broadest patient population or settings, while avoiding duplication whenever possible. Based on this rigorous vetting, 39 out of 65 measures (7 new and 32 undergoing maintenance) were endorsed (see Figure 5). When all is said and done, between 2010 and 2011 this represents approximately 13 percent fewer NQF-endorsed cardiovascular measures in this project.

## Enhancing NQF Endorsement

As NQF's measures portfolio evolves, so too does its endorsement process. In 2011, NQF enhanced the rigor of its process by requiring that measures be tested before they are reviewed. This requirement now ensures that expert committees have crucial information about measure reliability and validity as they consider endorsement. In addition, NQF also established an approach that added greater consistency to review of the underlying evidence for measures, and created an expedited endorsement pathway to be responsive to key regulatory or legislative requests. Finally, NQF embarked upon a number of efforts to enhance effectiveness of the review process, including a lean effort to further reduce endorsement cycle time. This effort, which got underway in late 2011, maps each of the steps of the endorsement process to drive out redundancy, waste, and ultimately costs for measure developers, NQF, and HHS.

### SIDEBAR 5

## Harmonizing Surgical-Site Infection Measures

As part of NQF's federally funded Patient-Safety Measures project, similar and competing surgical-site infection (SSI) measures from the Centers for Disease Control and Prevention (CDC) and the American College of Surgeons (ACS) were reviewed. The CDC SSI measure has been in use since 2005; the ACS measure since 2004.

As a result of NQF member and public comments, and requests by the Steering Committee, the developers worked with NQF support to harmonize these two competing approaches to measurement. The result is a newly harmonized SSI measure, which is

currently focused on abdominal hysterectomies and colon surgeries. CDC and ACS will jointly maintain the measure. The two organizations have also committed to developing harmonized measures for other procedures and will incorporate them into the combined SSI measure.

Notably, CMS has selected this harmonized measure for inclusion in the 2012 final rule of the Inpatient Prospective Payment System (IPPS).

Dr. Clifford Ko, director of ACS's National Surgical Quality Improvement Program, was directly involved in this effort. Dr. Ko noted that the resulting

measure—Harmonized Procedure-Specific Surgical-Site Infection Outcome Measure—will now be available to literally thousands of hospitals that want to measure and improve their surgical-site infection rates.

Dr. Daniel Pollock, surveillance branch chief in CDC's Division of Healthcare Quality Promotion, says CMS' decision to include this measure will significantly increase SSI reporting rates in hospitals throughout the country. With increased reporting, providers will have more opportunities to identify areas for improvement. In addition, patients and payers will have SSI rate information

## The Information Technology Accelerant

A future healthcare system that fully embraces health information technology (HIT) will allow for performance data to be collected in real time across settings, integrated, and regularly fed back to providers to inform practice and decision-making. It also will allow performance information to be made accessible in aggregated, de-identified, and timely public reports for payers and patients. Recent federal efforts—to simultaneously wire ambulatory practices and hospitals and assess providers’ “meaningful use” of electronic health records (EHRs)—have been important steps on the path to a future HIT-enabled system.

Such milestones have been augmented by a number of NQF efforts that are helping the field move to a common electronic data platform that allows for the collection of more clinically relevant and actionable performance-measurement data. These HIT-enabled environments hold out the promise of reducing reporting burden for clinicians and other providers, and enhancing the precision and comparability of results.

In the past year, NQF has worked with measure developers to re-specify paper-based measures for EHRs, and developed tools that allow measure developers to marshal the building blocks necessary for their successful implementation. In both cases, these efforts broke new ground. To the best of NQF’s knowledge, they have never been attempted—or accomplished—before. More specifically:

### E-Measures

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In 2010, at the request of HHS, NQF worked with 18 measure developers to re-tool 113 existing, endorsed measures for the electronic environment—that is, to develop electronic specifications that allow an EHR to calculate the measure—so they could be included in the

when they are choosing between hospitals in a community.

While both Drs. Ko and Clifford noted that some characteristics of the original measures may be diminished or lost, they agreed that harmonized measures help eliminate the confusion non-comparable measures create and that, ultimately, providers, payers, and the public benefit.

**THOUSANDS MORE  
HOSPITALS WILL BE  
ABLE TO MEASURE AND  
IMPROVE SURGICAL SITE  
INFECTION RATES**

Meaningful Use program. These eMeasures were further updated and enhanced in 2011. The measure stewards and NQF found that re-tooling measures for a new (electronic) platform was not a simple, straightforward matter; rather it involved the stewards re-conceptualizing each of the measures, with the support of NQF.

### Quality Data Model (QDM)

This information model provides measure developers with a first-ever “grammar,” which defines data elements. These data elements can then be efficiently assembled and re-assembled into performance measures to be read by EHRs. Work on the QDM began in 2007, with funding from the Agency for Healthcare Research and Quality (AHRQ). In 2011, the third version of the QDM was released, which includes data elements to enable development of measures in gap areas, including patient/consumer engagement and disparities, as well as new methods of data capture and use. In summary, this effort makes a substantial contribution toward being able to more readily leverage existing electronic health-record data to produce clinically relevant, advanced measures.

### Measure Authoring Tool (MAT)

This non-proprietary, web-based tool makes it easier and more efficient for measure developers to specify, submit, and maintain electronic measures, or eMeasures. Introduced in 2011, there are now more than 35 organizations using this tool for eMeasure development.

Work that began in 2011 and carries over into 2012 includes a project focused on sharing data across settings, convening a forum for stakeholders to share best practices related to implementation of eMeasures, and a project that will leverage health IT data to address patient safety and quality concerns associated with medical devices, which was described

#### SIDEBAR 6:

### NQF Focuses on Vulnerable Populations

Vulnerable populations—from the disabled, to veterans, to special needs kids, to low-income individuals and racial/ethnic minorities, among others—often require a different and frequently higher level of care. Over the past year, NQF has taken on two major projects with a prime focus on such vulnerable individuals—*The Measure Applications Partnership (MAP) Strategic Report: Performance Measurement for Dual Eligible Beneficiaries Interim Report to HHS*, and measurement work focused on disparities in healthcare.

The interim MAP report provides multi-stakeholder input on performance measures to assess

and improve the quality of care delivered to individuals who are eligible for both Medicare and Medicaid (dual-eligible). An estimated 8.9 million individuals are classified as dual-eligible, a population that includes many of the poorest and sickest individuals in our communities. This particular population frequently experiences fragmented care and accounts for a disproportionate share of total healthcare costs.

In its initial phase of work, MAP has developed a strategic approach to performance measurement and identified opportunities to promote significant improvement in the quality of care provided to these

vulnerable populations. The core of the strategic approach is composed of:

**A vision for high-quality care.** Centered on the needs and preferences of an individual and his or her loved ones, this relies on holistic supports to maximize function and quality of life.

**Guiding principles.** These include desired effects, measurement design, and data.

**A discussion of high-need subgroups.** MAP deliberations suggested that there is not yet an established taxonomy for classifying subgroups of the dual-eligible population. MAP members observed that combinations of particular risk factors lead to high

previously. More specifically, with respect to the first two projects:

### HIT Systems to Support Care Coordination Measurement: Data Sources and Readiness

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This project is analyzing the current process for identifying and sharing data on significant patient factors, planned interventions, and expected outcomes (care goals) to support quality measurement related to transitions of care. It will recommend a critical path forward with specific action steps that the government can take to enable electronic measurement around care plans.

### E-Measure Collaborative

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The eMeasure Collaborative, a public forum convened by NQF, is bringing together stakeholders from across the quality enterprise. The eMeasure Collaborative's goal is to promote shared learning and advance knowledge and best practices related to the development and implementation of eMeasures.

## 4 ALIGNING ACCOUNTABILITY PROGRAMS TO ENHANCE VALUE

At the request of HHS, NQF commissioned RAND Health to conduct an *initial evaluation* to better understand who is using NQF-endorsed measures and for what purposes. The RAND studies—coupled with NQF's own internal tracking efforts to understand measure use—have helped to provide some important context for HHS, NQF, and the NQF-convened MAP discussions.

levels of need in an additive or synergistic manner.

**High-leverage opportunities for improvement through measurement.** MAP reached consensus on five areas where measurement could drive significant positive change, including quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures of coordination between Medicare and Medicaid benefits.

In addition to the four primary elements, MAP also considered issues related to data sources and program alignment as inputs to the strategic approach. MAP will next consider gaps in currently

available measures and may propose new measure concepts for development. A final report with MAP's input on improving the quality of care delivered to dual-eligible beneficiaries, including recommendations related to measures, is due to HHS on June 1, 2012.

NQF's healthcare disparities measurement efforts are multi-faceted. For example, measure developers are required to submit measure results stratified by race and ethnicity at the time of measure evaluation. NQF has also worked to endorse measures that address vulnerable populations, including measures used for the Children's Health

Insurance and Reauthorization Act (CHIPRA) and Medicaid, as well as measures that fulfill important needs for vulnerable populations, including frail elders, pregnant women, children, and those who suffer from mental illness. With respect to already endorsed measures, NQF is working to identify measures across all settings that should be routinely stratified by race and ethnicity in order to identify conditions and populations that require targeted improvement efforts to improve quality and eliminate disparities.

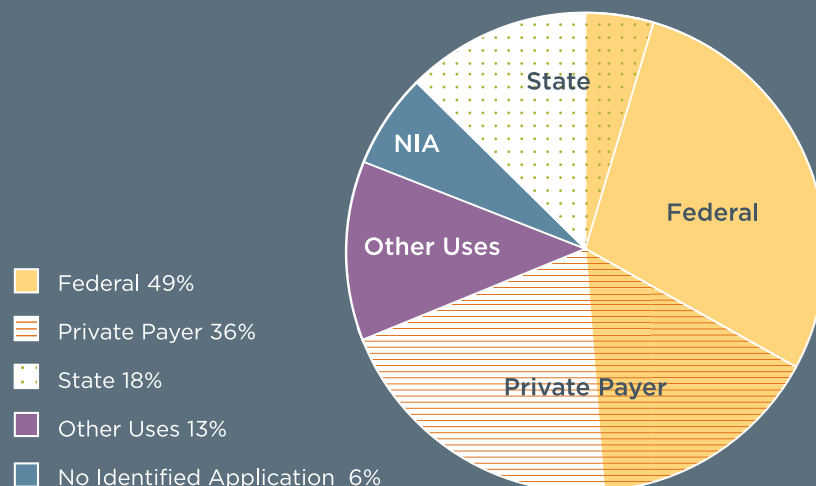
## Growing Use of NQF-Endorsed Measures

RAND interviews of key stakeholders using NQF-endorsed measures and online research across approximately 75 varied organizations found that nearly all used NQF-endorsed measures, although the extent varied as did the particular measures selected for use. Further, the study showed that most organizations used endorsed measures in quality-improvement efforts, followed closely by public reporting, then payment programs. The 2011 study also found that there is a strong preference to use NQF-endorsed measures where they exist because they are vetted, evidence-based, and seen as more credible within the provider community.

NQF's additional research outside of the HHS contract indicates that about 90 percent of the portfolio of NQF-endorsed measures is being used in varied programs across the public and private sectors. Figure 6 is an estimation of the use of NQF-endorsed measures by: federal programs; private payers such as health plans and employers; states; and an amalgamation of other key stakeholders such as national registries, accrediting and specialty board certifying organizations, and community alliances. The gold-colored, hatched, and dotted areas on the chart represent alignment in use of the same measures by key sectors—specifically the overlap between private payers (health plans and employers) and federal programs, and the overlap between state and federal efforts. Alignment holds out the promise of reducing data-collection burden for providers and associated costs, while simultaneously accelerating improvement by sending the same message about where providers should be focusing improvement resources.

Overall use of NQF-endorsed measures by the federal government is high—about 85 percent of measures used in federal programs are NQF-endorsed. Yet the proportion of NQF-endorsed measures in use by various federal programs does differ. Sometimes it is

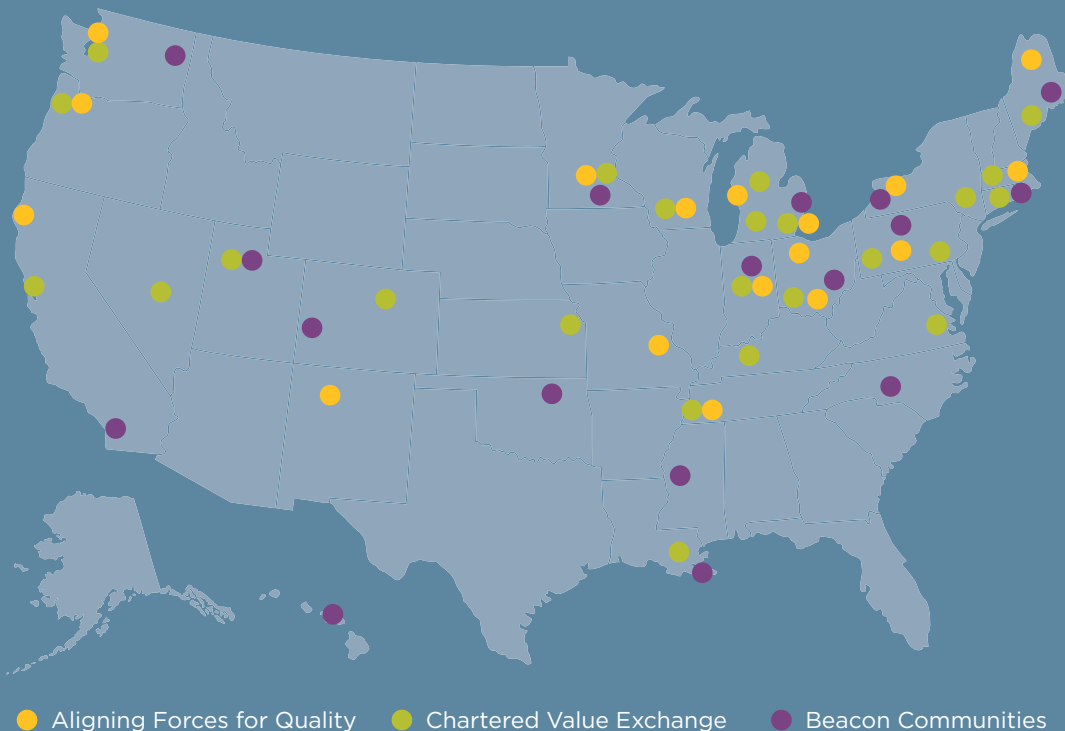
**FIGURE 6:**  
USES OF NQF-ENDORSED MEASURES IN LEADING ACCOUNTABILITY AND QI PROGRAMS



## SIDEBAR 7

## AF4Q: Alignment at the Community Level

At the community level it is more challenging to get a comprehensive picture of use of NQF-endorsed measures. That said, leading multi-stakeholder alliances in communities across the country use NQF-endorsed measures, including the Robert Wood Johnson Foundation's Aligning Forces for Quality (AF4Q) alliances. To support community interest in aligning the measures they are using, a recent analysis conducted by NQF outside of the HHS contract has shown that at least 170 NQF-endorsed measures are being used in one or more of the 16 AF4Q alliances. In addition, NQF endorsed measures are being used by many of the Chartered Value Exchange (CVE) collaboratives, the federally-funded Beacon communities, other communities and a number of states. Given that there is no national requirement to use standardized measures at this level, communities/states have shown leadership in adopting such measures into their local programs.

EXAMPLES OF COMMUNITIES FOCUSED ON QUALITY<sup>1</sup>

The Robert Wood Johnson Foundation's **Aligning Forces for Quality** initiative seeks to increase the quality of healthcare and reduce racial and ethnic disparities in 16 diverse communities – with the involvement and collaborative efforts of physicians, patients, consumer groups, hospitals, health plans, and others.

The U.S. Agency for Healthcare Research and Quality (AHRQ) supports 24 **Learning Network Chartered Value Exchanges**. The CVEs are experimenting with new ways to bring healthcare stakeholders together to collect data and improve the quality of care.

The federal **Beacon Community Cooperative Agreement** program provides 17 communities with funding to improve quality, cost-efficiency, and population health using electronic health records and other health information technology tools to collect and analyze clinical data. The program's goal is to demonstrate the ability of health IT to transform local healthcare systems.

<sup>1</sup> Geographic reach of these efforts varies, e.g., state-wide, county-specific

a matter of timing. For example, the federal government has recently moved some non-endorsed measures into the Physician Quality Reporting System (PQRS) to better address the range of physician specialties. NQF is poised to quickly review such measures.

States also are heavy users of NQF-endorsed measures, in part due to federal programs that encourage or require standardized reporting at the state level, such as AHRQ's Health Care Utilization Project (HCUP), CDC measures and surveys, CHIPRA, and Medicaid. For example, 81 percent of CHIPRA measures and 88 percent of core adult Medicaid measures are NQF-endorsed. In the safety realm, more than half of states and the District of Columbia have implemented reporting systems for SREs, as well as reporting of key patient-safety indicators such as bloodstream and SSI measures.

## Measure Application and Alignment

Convened by NQF in the spring of 2011, the Measure Applications Partnership (MAP) is a public-private partnership made up of 60 organizations representing major stakeholder groups, 9 federal agencies, and 40 subject-matter experts. It was established to provide HHS with thoughtful, pre-rulemaking input about which performance measures to use in public reporting and payment within and across 17 federal programs. Simultaneously, MAP is informing the thinking and decisions of private-sector leaders with respect to their measure-selection strategies.

### FEDERAL AGENCIES PARTICIPATING IN MAP

- Agency for Healthcare Research and Quality
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services

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DIFFERENT  
FEDERAL  
AGENCIES  
PARTICIPATE  
IN MAP

- Health and Human Services' Office on Disability
- Health Resources and Services Administration
- Office of the National Coordinator for Health Information Technology
- Office of Personnel Management
- Substance Abuse and Mental Health Services Administration
- Veterans Health Administration

MAP represents an important innovation in the regulatory process made possible by ACA statute. In contrast to traditional federal rulemaking—where there are limited, unidirectional forums for input before draft rules are issued and no forums that cross programmatic areas—MAP enables public- and private-sector leaders to work together on creating a measurement strategy and implementation plan that is crosscutting and coordinated across settings of care; federal, state, and private programs; levels of measurement analysis; payer type; and points in time. This is not an overnight prospect, but important, unprecedented steps in the direction of strategic alignment were taken.

In 2011, MAP consisted of four programmatic-oriented workgroups—clinician, hospital, LTC/PAC, and dual-eligible beneficiaries—and an ad-hoc safety workgroup, each of which makes recommendations to the MAP Coordinating Committee. This independent committee then integrates and aligns these recommendations across the four programmatic areas—which represent 17 different federal programs—and advises HHS directly. (See Sidebar 8)

In the fall of 2011, and in advance of future measure-selection recommendations, MAP issued reports offering advice to HHS about how the agency might better coordinate its measure strategies as it relates to efforts focused on improving safety and clinician

## SIDEBAR 8

### Measure Applications Partnership Workgroup Leadership

#### MAP Coordinating Committee Co-Chairs

**George Isham, MD, MS**  
Chief Health Officer  
Health Partners

**Elizabeth McGlynn, PhD, MPP**  
Director Center of Effectiveness  
and Safety Research (CESR)  
Kaiser Permanente

#### MAP Advisory Workgroups

##### *Ad-Hoc Safety Workgroup:*

**Frank G. Opelka, MD FACS, Chair**  
Vice Chancellor for Clinical Affairs  
and Professor of Surgery  
Louisiana State University

##### *Clinician Workgroup:*

**Mark McClellan, MD, PhD, Chair**  
Director, Engelberg Center for  
Health Care Reform  
Senior Fellow, Economic Studies,  
Brookings Institution  
Leonard D. Schaeffer Chair in  
Health Policy Studies

##### *Dual-Eligible Beneficiaries Workgroup:*

**Alice R. Lind, MPH, BSN, Chair**  
Senior Clinical Officer  
Center for Health Care Strategies

##### *Hospital Workgroup:*

**Frank G. Opelka, MD FACS, Chair**  
Vice Chancellor for Clinical Affairs  
and Professor of Surgery  
Louisiana State University

##### *Post-Acute/Long-Term Care (PAC/LTC) Workgroup:*

**Carol Raphael, MPA, Chair**  
President and Chief Executive  
Officer  
Visiting Nurse Service of New York

performance. Its reports include *MAP Coordination Strategy for Clinician Performance Measurement* and *MAP Coordination Strategy for Healthcare-Acquired Conditions and Readmissions Across Public and Private Payers*. In 2011, MAP also released the first of two reports focusing on dual-eligible beneficiaries who are enrolled in both Medicare and Medicaid programs: *MAP Strategic Approach to Performance Measurement for Dual-Eligible Beneficiaries*. Despite many of these individuals being the sickest and poorest patients enrolled in any federal program, not to mention among the most expensive, there has been little effort to date to use measurement as a tool to improve their care. For more detail about NQF's efforts to address vulnerable populations, see sidebar 6.

MAP's initial **pre-rulemaking report** published on February 1, 2012, and based on the consensus of 60 organizations:

- **Recommends that 40 percent of the measures CMS was considering move into federal programs** targeting clinicians, hospitals, dual-eligible beneficiaries, and PAC/LTC settings via rules issued in 2012, with another 15 percent targeted for future consideration after further development, testing, and feasibility issues are worked out. MAP did not support inclusion of about 45 percent of other measures proposed by CMS. CMS submitted a large number of measures and measure concepts to get early, detailed feedback about them from key stakeholders. Consequently, many of the measures submitted did not have enough information to guide MAP measure evaluation and selection. See Appendix D for the criteria MAP used to guide measure selection.
- **Expresses clear preference for use of NQF-endorsed measures and feedback loops**  
Nearly 87 percent of measures MAP supported for inclusion are currently endorsed by NQF, and many more are likely eligible for expedited review. That said, assessing the qualitative and quantitative impact of NQF-endorsed measures in the field would provide new and important information for future MAP analyses and decision-making.
- **Considers how to further align measures across programs and with the private sector**  
with the goal of more targeted, interrelated sets of measures that are reported by different kinds of providers, in different settings and sectors, and across time. A good example is care-coordination measures contained within existing programs—care transitions, readmissions, and medication reconciliation—which MAP recommends be applied to additional kinds of providers, types of settings, and, consequently, to span and be integrated across federal programs. See Figure 7 to get a more detailed sense for MAP's crosscutting recommendations for care coordination.
- **Lays out guiding principles for a future three-to-five-year measurement strategy**  
that supports movement towards a healthcare system that enhances value for patients, communities, and those that pay the bills on their behalf. In this future 21st century system, priority is placed on measures that drive the system toward meeting the NQS; measurement is person- rather than clinician- or setting-focused; and measures span settings, time, and types of clinicians. Person-centered measurement provides information about what matters to patients (e.g., “Will I be able to run after I recover from knee surgery?”) and measures that are specific to patient populations or care over time, (e.g., “Did I get the care and support needed to manage my diabetes so

that I did not lose my vision or my mobility?”). This kind of measurement is predicated on a redesigned delivery and payment system, and an HIT-enabled environment that facilitates both coordination and integration of care for a range of patients across the continuum.

**FIGURE 7**

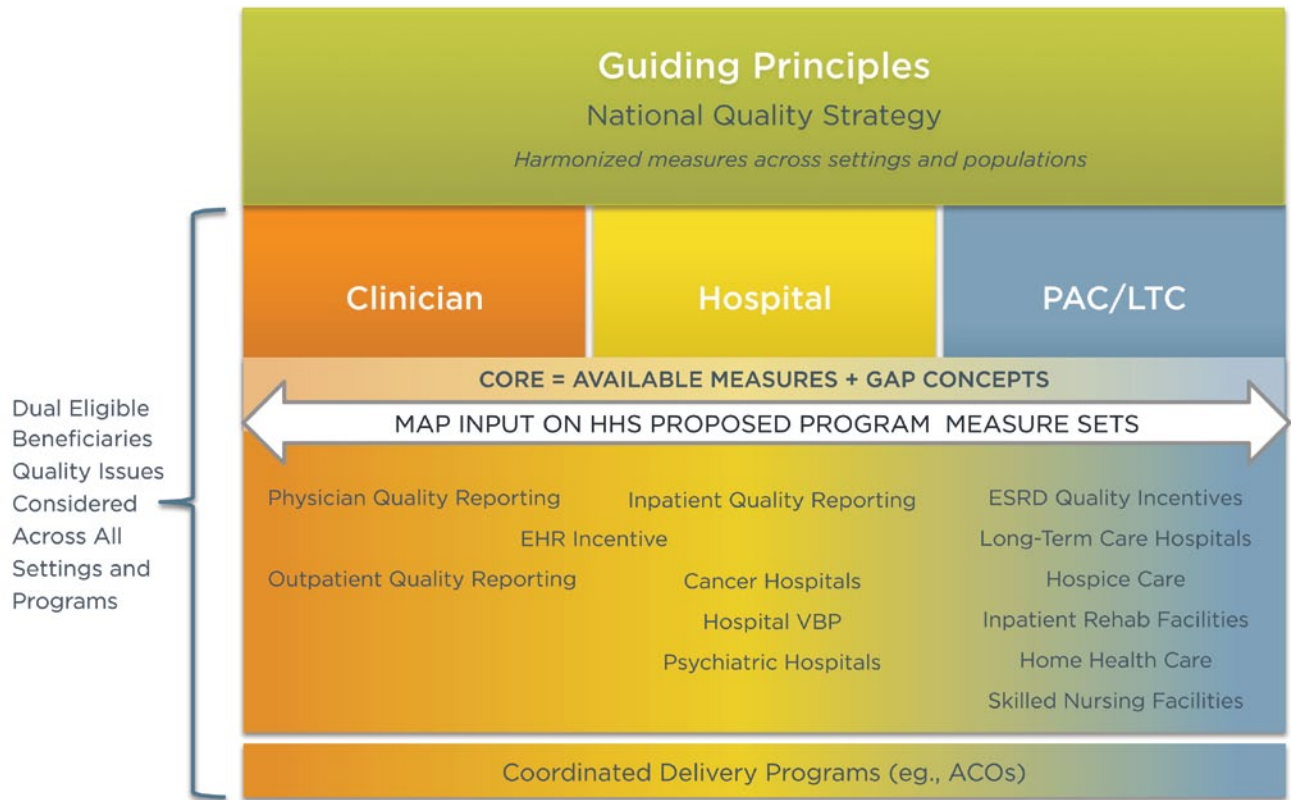
Aligning Care Coordination Measures Across Programs			
	Clinician	Hospital	Post-Acute Care/ Long-Term Care
<b>Care Transitions</b>	Support CTM-3 (NQF #0228) if successfully developed, tested, and endorsed at the clinician level	Support immediate inclusion of CTM-3 measure and urge for it to be included in the existing HCAHPS survey  Support several discharge planning measures (i.e., NQF #0338, 0557, 0558)	Support CTM-3 if successfully developed, tested, and endorsed in PAC-LTC settings  Identify specific measure for further exploration for its use in PAC-LTC settings (i.e., NQF #0326, 0647)
<b>Readmissions</b>	Readmission measures are a priority measure gap and serve as a proxy for care coordination	Support the inclusion of both a readmission measure that crosses conditions and readmission measures that are condition-specific.	Identify avoidable admissions/readmissions (both hospital and ER) as priority measure gaps
<b>Medication Reconciliation</b>	Support inclusion of measures that can be utilized in a health IT environment including medication reconciliation measure (NQF #0097)	Recognize the importance of medication reconciliation upon both admission and discharge, particularly with the dual eligible beneficiaries and psychiatric populations	Identify potential measures for further exploration for its use across all PAC-LTC settings (i.e., NQF #0097)

The MAP proposed guiding principles support the direction of many public- and private-sector leaders who are innovating to move the nation's care delivery system towards more organization and shared accountability for patient welfare, community health, and stewardship of scarce resources. Where appropriate, they are encouraging transitioning from solo-physician practices to actual and virtual patient-centered medical homes, from stand-alone hospitals to those working collaboratively with an array of providers in an integrated delivery system or Accountable Care Organization (ACOs), and from single-specialty to multi-specialty physician groups working more closely with public health oriented organizations. Figure 8 details some key principles to guide measure selection, measurement tactics, the providers the measures are focused on, and the related federal programs.

Implementation of more advanced measures will be possible once care is more organized and integrated, payment crosses settings and providers, and HIT infrastructure is widely in place. Advanced measures could include how well patient care is coordinated between primary and specialty care and across specialists; whether patients are free of pain and can return to work, school, and other daily obligations; the degree to which patient preferences are incorporated into care decisions; and whether recommended care was

appropriate in the first place and delivered cost effectively. Progress is being made as it relates to the development and implementation of such advanced measures, but is predicated on more integrated payment and delivery systems, as well as robust, common electronic data platforms.

**FIGURE 8**



# ACHIEVING RESULTS

Those working to improve performance of the healthcare system are impatient for results, which take time to demonstrate and are influenced by many factors beyond measurement. Nevertheless, there are promising examples, particularly for hospitals and health plans that have been collecting, reporting, and acting on performance measures for a number of years. The case studies included in this section of the report were selected to provide illustrative examples of different kinds of programs and providers using NQF-endorsed measures (although they are efforts conducted outside of the federal contracts.) Taken together, and reflecting upon NQF's accomplishments over the last year, the case studies provide a clear sense that there is forward momentum, as well as a growing commitment on the part of healthcare leaders to enhance healthcare value for patients, communities, and payers.

## Eight Years of Hospital Reporting Show Results

In 2002, three hospital industry associations demonstrated leadership by joining with HHS, The Joint Commission, consumer organizations, and other stakeholders to create a more unified approach to reporting hospital performance information to the public. They launched the Hospital Quality Initiative—later re-named the Hospital Quality Alliance (HQA) —and defined its role as:

- identifying measures for reporting that are meaningful, relevant and understood by consumers;
- rallying hospitals to participate in the initiative and act on the performance results; and
- aligning stakeholders to reduce redundant and wasteful data collection and reporting.

From the beginning, HQA recommended NQF-endorsed measures because of the organization's transparent, rigorous multi-stakeholder consensus process and strong evidence-based approach to endorsement.

In 2003, performance results for over 400 hospitals were reported on the CMS

website for the first time. A year later, CMS began penalizing hospitals financially if they did not report to CMS the same performance information they were required to send to The Joint Commission to maintain hospital accreditation. Between 2003 and 2004, the number of hospitals reporting their results to CMS tripled—from over 400 to more than 1,400 hospitals. In 2005, CMS launched Hospital Compare. Today, over 4,000 hospitals simultaneously report performance data to CMS and The Joint Commission, and the number of measures collected has steadily increased. In 2012, The Joint Commission will incorporate hospital performance into its accreditation determinations for the first time.

Performance results improved steadily over the last eight years. A recent analysis of hospitals shows marked improvement based on NQF-endorsed measures between 2002 and 2009.<sup>7</sup> More specifically, in 2002, about 20 percent of hospitals exceeded 90 percent performance on 22 key measures; by 2009 that percentage had climbed significantly to 86 percent. Key NQF-endorsed measures include measures related to heart attack and heart

failure care, surgical care, children's asthma care, and pneumonia care, among others.

This tight alignment between HQA, CMS and The Joint Commission regarding use and reporting of NQF-endorsed measures is a likely contributor to hospitals improving their performance over time. At the end of 2011, HQA decided to close its doors—noting that it had accomplished

what it had set out to do: establishing a unified approach to collection and public reporting of hospital performance information. HQA also acknowledged that recommendations for measure selection going forward would be best left to the NQF-convened MAP, which is constituted to look across all federal programs to foster alignment and a clear strategic direction for measurement use.

## Linking Quality Measurement to Payment Reform

### BLUE CROSS BLUE SHIELD MASSACHUSETTS' ALTERNATIVE QUALITY CONTRACT

In January 2009, Blue Cross Blue Shield of Massachusetts (BCBS) piloted the Alternative Quality Contract, a pay-for-performance model directly linking payment to meeting quality and cost benchmarks. The private-payer program provides financial bonuses to participating provider organizations such as multispecialty groups, independent practice associations, and physician-hospital organizations that stay within a specified annual budget and meet clinical quality targets. The budget takes into account the entire spectrum of care, ranging from inpatient and outpatient services to long-term care and prescription drug costs.

Performance was evaluated on the quality of care delivered in several clinical settings based on NQF-endorsed measures. More specifically:

Seven participating clinical groups were eligible for bonus payments as high as five percent based on 32 NQF-endorsed ambulatory and office-based quality measures. Measures included and focused on conditions and procedures such as diabetes testing and controlled LDL-C

levels; breast, cervical, and colorectal cancer screenings; and patient experience with accessing and understanding care options.

Providers were eligible for another five percent bonus payment based on 32 NQF-endorsed hospital-based measures. These measures focused on surgical site and wound infections, in-hospital mortality rates, and patient satisfaction communicating with doctors and nurses.

Initial performance evaluations showed that across the board, provider groups delivered care within the scope of their budgets and performed well on clinical quality measures, allowing them to receive financial rewards of up to 10 percent of the total per-member per-month payments.<sup>8</sup>

The results illustrate that programs like the Alternative Quality Contract can offer providers strong incentives to control healthcare spending across the continuum while continuing to provide high-quality care. This idea is in line with recent policy proposals to design payment systems that reward high-quality, efficient, and integrated care.

## National Priorities Focus North Carolina Hospitals

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The North Carolina Center for Hospital Quality and Patient Safety (NCQC) was established by the North Carolina Hospital Association (NCHA) in 2004. The two organizations worked in partnership to conduct quality improvement collaborative projects across the state for about four years, but progress had grown stagnant. With North Carolina ranking as only the 35th healthiest state, NCQC's director embraced the NPP's 2008 *National Priorities and Goals* report recommendations as a way to focus, spur action, and benchmark North Carolina hospitals against national goals. Subsequent NPP reports have built on this first report.

The NCQC targeted much of its initial efforts on patient safety, made sure that frontline staff understood how their actions related to the hospital-wide improvement goals, and focused on both culture change and building up quality improvement skills. The Central Line-Associated Bloodstream Infection (CLABSI) Collaborative, which involved 40 ICUs, was particularly successful.

Using a separate intervention program that sought to learn from mistakes and improve safety, the CLABSI Collaborative achieved a 46 percent reduction in central-line infections over the 18-month time period. These results translated into saving approximately 18 lives (using a 15 percent fatality rate) and saving \$4.5 million (using \$40,000 as the extra cost to a hospital for a CLABSI) across 40 hospitals.<sup>9</sup>

It is important to note that although many individual hospitals had success, not all hospitals in North Carolina participated, and the state rate of CLABSIs did not decrease as much as NCQC had hoped. To address this, NCQC launched a Phase 2 of the initiative to continue its focus on reducing central-line infections, using the NQF-endorsed CLABSIs measure as a way to guide progress and benchmark themselves nationally. The NCQC has stated that it is too early to tell if alignment with the NPP priorities will enable it to meet its own performance goals, but does acknowledge measureable and exciting progress against benchmarks it set.

## Performance of Thoracic Surgeons Published in *Consumer Reports*

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More than two decades ago, The Society of Thoracic Surgeons (STS) launched the Adult Cardiac Surgery Database to track and improve surgical quality. It is the largest cardiothoracic surgery outcomes and quality improvement program in the world, containing more than 4.5 million surgical records and representing approximately 94 percent of all adult cardiac surgery centers throughout the U.S.

Twenty plus years after the launch of its database, STS made the bold decision to offer participating surgical groups the option of voluntarily reporting their performance data in *Consumer Reports*. More specifically, *Consumer Reports* began publicly reporting heart surgery ratings at the surgical group level starting in 2010—including survival rates, complication rates, and other key NQF-endorsed measures.

These ratings are now available on a bi-yearly basis.

A variety of factors influenced STS's decision to begin publicly reporting surgical performance, including the organization's vast experience with collecting and analyzing performance measures; a desire to leverage public reporting to further accelerate improvements in thoracic surgeon performance; and wanting to exhibit leadership in an environment of enhanced accountability.

Doris Peter, manager, *Consumer Reports'* *Health Ratings Center*, notes that reaction to the reports has been very positive from

cardiac surgery groups and consumers alike. Peter noted that the first time STS's data was published in *Consumer Reports*, there were 20 million web impressions on the ratings. *Consumer Reports'* readership is 8 million. Due to this success, the subsequent September 2011 release made the cover of *Consumer Reports* print edition. To date, 36 percent of STS surgery groups are participating in the *Consumer Reports* ratings, a 65 percent increase from the first release.



Looking ahead, NQF and the broader quality movement are at an exciting juncture. A robust measurement infrastructure is moving into place, and increasingly there is a shared commitment about what to improve and what measures to use in the process of doing so. Over the next couple of years, NQF will be:

- **Putting the patient first** by facilitating efforts that move the field toward a focus on patient-oriented as opposed to clinician-oriented measurement. Implementation of patient reported measures—including those that address experience of care, functional status, patient reported outcomes and care coordination—can help put the patient at the center of care.
- **Helping drive waste out of the system** by focusing on bringing more cost/resource use measures through NQF endorsement and understanding in more detail how existing NQF endorsed quality/safety measures—including readmission, medication reconciliation and care coordination measures—can contribute to a more cost-efficient system.
- **Facilitating a future measurement vision** by supporting efforts of the NPP and MAP Partnerships to develop a 3-5 year comprehensive measurement strategy—with broad and strong backing from multiple stakeholders—to recommend to HHS. The intent is that this strategy will cross settings and levels of care, as well as types of clinicians, and will in essence drive a strategic plan for payers that moves the needle with respect to the NQS's six priorities.
- **Bringing the public and private sectors closer together** by further strengthening collaboration and deepening their commitment to the value agenda, further aligning their respective measurement strategies to reduce redundant data collection, and dramatically accelerate improvements in performance of the U.S. healthcare system.

In the coming years, the country should be in the position of realizing many benefits from these efforts to change healthcare by the numbers.

## ENDNOTES

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- 9 National Quality Forum (NQF), *Evaluation of the National Priorities Partnership*, Washington, DC:NQF, 2011. Available at [www.qualityforum.org/Setting\\_Priorities/Evaluation\\_of\\_the\\_National\\_Priorities\\_Partnership.aspx](http://www.qualityforum.org/Setting_Priorities/Evaluation_of_the_National_Priorities_Partnership.aspx). Last accessed February 2012.

## APPENDIX A:

### 2011 Accomplishments: January 14, 2011 to January 13, 2012

Description	Output	Status (as of 1/13/12)	Notes/Scheduled or Actual Completion Date
<b>I. Priorities, Principles, and Coordination Strategies</b>			
Provision of input on priorities for the NQS	<i>Input to the Secretary of Health and Human Services on Priorities for the National Quality Strategy</i> ; final written report of Partnership and Subcommittee meeting deliberations and recommendations	Completed	September 1, 2011
MAP report recommending measures for use in the improvement of physician performance	<i>Measure Applications Partnership Coordination Strategy for Clinician Performance Measurement</i> ; final report including MAP Coordinating Committee recommendations	Completed	October 1, 2011
MAP report recommending measures that address the quality issues identified for dual-eligible beneficiaries	<i>Measure Applications Partnership Strategic Approach to Performance Measurement for Dual-Eligible Beneficiaries</i> ; interim report including MAP Coordinating Committee recommendations	Completed	October 1, 2011
MAP report recommending measures to be used by private and public payers to reduce readmissions and healthcare-acquired conditions (HACs)	<i>Measure Applications Partnership Coordination Strategy for Healthcare-Acquired Conditions and Readmissions Across Public and Private Payers</i> ; final report including recommendations regarding the optimal approach for coordinating readmission and HAC measures	Completed	October 1, 2011
Measures for use in quality reporting programs under Medicare	<i>Measure Applications Partnership Pre-Rulemaking Report: Input on Measures Under Consideration by HHS for 2012 Rulemaking</i>	In progress	Completed February 2012 after close of reporting year
MAP report recommending measures that address the quality issues identified for dual-eligible beneficiaries	Final report including potential new performance measures to fill gaps in measurement for dual-eligible beneficiaries	In progress	June 1, 2012
<b>II. Measure Endorsement</b>			
Cardiovascular measures and maintenance review	Two-phase project to endorse new cardiovascular measures and conduct maintenance on existing NQF-endorsed measures	Completed	39 measures endorsed in January 2012
Emergency regionalization medical care measurement framework	Environmental scan and white paper comparing how regions coordinate and perform on delivering emergency services	Completed	Framework endorsed in January 2012
Patient safety: SREs	Reviewed existing list of NQF SREs for hospitals to identify ones appropriate for other settings; considered potential new SREs for all settings	Completed	Updated list of 29 SREs endorsed in May 2011

Description	Output	Status (as of 1/13/12)	Notes/Scheduled or Actual Completion Date
Patient outcomes measures	Three-phase project endorsing measures specific to outcomes on Medicare high-impact conditions, child health, and mental health	Completed	38 measures endorsed: - 30 measures endorsed in January and March 2011 - 8 measures endorsed during previous contract year (September 2010)
Patient-safety measures	Two-phase project endorsed new measures of patient safety (e.g., healthcare-associated infections, medication safety) and maintaining currently endorsed measures	Completed	Phase 1: 4 measures endorsed in January 2012 Phase 2: 2 measures endorsed in August and September 2011
Nursing-home measures	Endorsed measures of nursing-home care quality	Completed	5 measures endorsed in February 2011
Child-health measures	Endorsed measures specific to the care of children	Completed	44 measures endorsed in September 2011
Surgery measures and maintenance review	Two-phase project to endorse new surgery measures and conduct maintenance on existing NQF-endorsed measures	Phase 1 complete; Phase 2 in progress	Phase 1: 18 measures endorsed in December 2011 NQF Board endorsed Phase 2 measures after the close of the contract year Phase 2 addendum report issued for public comment just after contract year closed
Efficiency and resource-use measures	Endorsed measures of imaging efficiency; white paper drafted; endorsed measures of healthcare efficiency	Completed          In progress; completed just after contract year	<b>Imaging Efficiency (Complete)</b> - 6 imaging efficiency measures endorsed in February 2011 - 1 imaging efficiency measure was recommended to be combined with an existing NQF measure and was endorsed in April 2011 <b>Efficiency - Resource Use (In Progress)</b> Cycle 1: 4 measures ratified by Board January 2012 Cycle 2: 4 measures posted for public comment in December 2011; voting closed in February 2012
Cancer measures and maintenance review	Project to endorse new cancer measures and conduct maintenance on existing NQF-endorsed measures	In progress	Call for nominations completed in November 2011; call-for-measures deadline was January 2012
Perinatal measures and maintenance review	Project to endorse new perinatal measures and conduct maintenance on existing NQF-endorsed measures	In progress	Steering Committee reviewed 23 measures in December 2011

Description	Output	Status (as of 1/13/12)	Notes/Scheduled or Actual Completion Date
Renal measures and maintenance review	Project to endorse new renal measures and conduct maintenance on existing NQF-endorsed measures	In progress	Steering Committee reviewed 33 measures by December 2011; member and public commenting to conclude after close of reporting year
Pulmonary/critical-care measures and maintenance review	Project to endorse new pulmonary/critical-care measures, and conduct maintenance on existing NQF-endorsed measures	In progress	Call for nominations closed in December 2011 Call-for-measures deadline was January 2012
Palliative and end-of-life care	Project to endorse new palliative and end-of-life care measures and conduct maintenance on existing NQF-endorsed measures	In progress	NQF Board endorsed measures after close of reporting year
Care-coordination measures and maintenance review	Set of endorsed care- coordination measures	In progress	Call for measures closed January 9, 2012
Population Health Phase 1: Prevention measures and maintenance measures review	Set of endorsed measures for preventative services	In progress	Member and public commenting period concluded February 2012
Population health Phase 2: Population health measures	Commissioned paper addressing population health measurement issues and set of endorsed population health measures	In progress	Draft paper completed January 2012 after close of reporting year
Behavioral health measures and maintenance review	Set of endorsed measures for behavioral health	In progress	Call for nominations closed December 13, 2011 Call for measures closed February 14, 2012
All-cause readmissions (expedited Consensus Development Process [CDP] review)	Set of endorsed all-cause readmission measures	In progress	Member and public commenting concluded January 2012
<i>Multiple Chronic Conditions Measurement Framework</i> report analyzing measures being used to gauge quality of care for people with multiple chronic conditions	Work plan completed; interim report available for public comment	In progress	May 30, 2012
Patient-reported outcomes (PROs) workshops addressing prerequisites for endorsed PRO measures	Two workshops discussing commissioned papers addressing methodological prerequisites for NQF consideration of PRO measures for endorsement (The Veterans Administration may fund the papers; proposal is pending their approval)	In progress	June 30, 2012
Oral health	Report that catalogs oral health measures, measure concepts, priorities and gaps in measurement	In progress	July 6, 2012
Rapid-cycle CDP improvement (measure-endorsement process)	Summary of process improvement approach, events, and metrics used to enhance the quality and efficiency of CDP process	In progress	Four rapid-cycle improvement events completed in November and December 2012; additional events planned during first quarter of 2012

Description	Output	Status (as of 1/13/12)	Notes/Scheduled or Actual Completion Date
<b>III. Health Information Technology</b>			
Retooled eMeasures, eMeasures Format Review Panel, and eMeasure Updates	Published 113 measures for an electronic environment  eMeasure Format Review Panel reviewed retooled measures to ensure the electronic specifications or requirements of these measures are consistent with the original focus and intent of the measure  Held 10 webinars/conference calls to solicit comments and proposed resolutions	Completed	All updates and related activities completed by December 22, 2011  Completed first cycle of review in Fall 2010, following public comment period
MAT	Non-proprietary, web-based tool that allows performance-measure developers to specify, submit, and maintain electronic measures in a more streamlined, efficient, and highly structured way	Completed  Contractor training; release of the MAT Basic Version on 9/29/11; enhanced version on target for release	Total number of unique organizations using MAT: 32
QDM maintenance	Updated the QDM (Version 3, released in April 2011) to reflect additional types of data needed to support emerging measures (e.g., measures that include social determinants of health, patient/consumer engagement)	Review and updates to QDM are ongoing based on annual cycle	Each new version of the QDM will be published annually; NQF will post a draft of modifications for the next version; annual QDM updates and versions will be integrated into MAT and, moreover, enable incorporation of required data elements in electronic measures as new types and sources of data are recognized over time
eMeasures process and technical assistance	Provided education, training, and ad-hoc support to HHS, HHS contractors, MAT users, QDM users, eMeasure developers, EHR vendors, providers implementing measures, and other relevant quality and health IT stakeholders	Ongoing	Developed and posted <i>MAT User Guide</i> to provide manual for MAT and eMeasure development  Completed 5 technical-assistance trainings to CMS' eMeasure contractors, focusing on topics such as QDM and in-depth MAT training  Completed 7 public webinars (with as many as 740 attendees per webinar), focusing on topics such as eMeasures training for measure developers and IT vendors
Patient-safety-complications measures and maintenance review (Phase 1)	Set of endorsed measures on complications-related areas	In progress	Steering Committee reviewed 27 measures in December 2011
Commissioned paper on data sources and readiness of HIT systems to support care coordination	Final report and commissioned paper	In progress	Draft paper available for public comment in February 2012

Description	Output	Status (as of 1/13/12)	Notes/Scheduled or Actual Completion Date
Critical path	Examine new measurement areas (e.g. care plans) to understand the feasibility of measuring such areas in an electronic environment	Ongoing	End of September 2012
eMeasure Learning Collaborative	Examining issues related to implementation of eMeasures with a multi-stakeholder group in order to define best practices and recommendations to the Office of the National Coordinator's Federal Advisory Committees	Ongoing	End of September 2012
<b>IV. Measure Use and Application</b>			
Patient safety: state-based reporting agencies initiative	Convened 27 state-based patient-safety reporting agencies to discuss safety reporting efforts and share "best practices"	Completed	Majority of work completed during previous contract year; final HHS-funded call completed January 24, 2011
RAND report analyzing uses of NQF-endorsed measures	<i>An Evaluation of the Use of Performance Measures in Health Care</i> ; work plan and list of research questions completed; report by independent researcher completed	Completed	
Recommendations for measures to be implemented through the federal rulemaking process for public reporting and payment	<i>Measure Applications Partnership Pre-Rulemaking Report: Input on Measures Under Consideration by HHS for 2012 Rulemaking</i>	In progress	Completed in February 2012 after close of reporting year
MAP report recommending measures for use in quality reporting for Prospective Payment System-exempt cancer hospitals	Final report including MAP Coordinating Committee recommendations	In progress	June 1, 2012
MAP report recommending measures for use in quality reporting for hospice care	Final report including MAP Coordinating Committee recommendations	In progress	June 1, 2012
NPP support for Partnership for Patients' HHS initiative focused on patient safety	First round of work included 2 quarterly convenings and 8 webinars Content of meetings and webinars were captured in individual summaries Next round of work includes creating affinity groups to implement specific patient-safety strategies and webinars	In progress	

## APPENDIX B: NQF Board and Leadership Staff

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Medical Director, Bluegrass Care Clinic,  
Affiliated with the University of Kentucky School of Medicine

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Senior Fellow and Director, Engelberg Center for Health Care Reform and Leonard D. Schaeffer Chair in Health Policy Studies  
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**Sheri S. McCoy**

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Network for Regional Healthcare Improvement

**Dolores L. Mitchell**

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National Partnership for Women & Families

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**Richard J. Umbdenstock**

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American Hospital Association

### CMS

**Don Berwick, MD**

Administrator (until 12/2/11)

**Marilyn Tavenner, BSN, MPA**

Acting Administrator and Chief Operating Officer (12/5/11 – present)  
Centers for Medicare & Medicaid Services  
Designee: Patrick Conway, MD  
Chief Medical Officer

## AHRQ

[Carolyn M. Clancy, MD](#)

Director, Agency for Healthcare Research and Quality  
Designee: Nancy Wilson, MD, MPH  
Senior Advisor to the Director

## HRSA

[Mary Wakefield, PhD, RN](#)

Administrator, Health Resources and Services  
Administration  
Designee: Terry Adirim, MD  
Director, Office of Special Health Affairs

## CDC

[Thomas R. Frieden, MD, MPH](#)

Director, Centers for Disease Control and Prevention  
Designee: Peter A. Briss, MD, MPH  
Captain, U.S. Public Health Service  
Medical Director

## EX OFFICIO (NON-VOTING):

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(Chair, Consensus Standards Approval Committee)  
Associate Professor of Medicine  
Massachusetts General Hospital

[Paul C. Tang, MD, MS](#)

(Chair, Health Information Technology Advisory  
Committee)  
Vice President and Chief Medical Information Officer  
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Chief Information Officer

## APPENDIX C:

### Overview of Consensus Development Process

For each Consensus Development Project (CDP), NQF follows a careful eight-step process that ensures transparency, public input, and discussion among representatives across the healthcare enterprise.

1. **Call for Nominations** allows anyone to suggest a candidate for the committee that will oversee the project. Committees are diverse, often encompassing experts in a particular field, providers, scientists, and consumers. After selection, NQF posts committee rosters on its website to solicit public comments on the composition of the panel and makes adjustments as needed to ensure balanced representation.
2. **Call for Measures** starts a 30-day period for developers to submit a measure or practice through NQF's online submission forms.
3. **Steering Committee Review** puts submitted measures to a four-part test to ensure they reflect sound science, will be useful to providers and patients, and will make a difference in improving quality. The expert steering committee conducts this detailed review in open sessions, each of which starts a limited period for public comment.
4. **Public Comment** solicits input from anyone who wishes to respond to a draft report that outlines the steering committee's assessment of measures for possible endorsement. The steering committee may request a revision to the proposed measures.
5. **Member Vote** asks NQF members to review the draft report and cast their votes on the endorsement of measures.
6. **CSAC Review** marks the point at which the NQF Consensus Standards Approval Committee (CSAC) deliberates on the merits of the measure and the issues raised during the review process, and makes a recommendation on endorsement to the Board of Directors. The CSAC includes consumers, purchasers, healthcare professionals, and others. It provides the big picture to ensure that standards are being consistently assessed from project to project.
7. **Board Ratification** asks for review and ratification by the NQF Board of Directors of measures recommended for endorsement.
8. **Appeal** opens a period when anyone can appeal the Board's decision.

## APPENDIX D:

### MAP Measure-Selection Criteria

The Measure Applications Partnership (MAP) has developed measure-selection criteria to guide its evaluations of program measure sets. The term “measure set” can refer to a collection of measures—for a program, condition, procedure, topic, or population. For the purposes of MAP’s pre-rulemaking analysis, we qualify the term measure set as a “program measure set” to indicate the collection of measures used in a given federal public reporting or performance-based payment program.

The measure-selection criteria are intended to facilitate structured discussion and decision-making processes. The iterative approach employed in developing the criteria allowed MAP in its entirety, as well as the public, to provide input on the criteria. Each MAP workgroup deliberated on draft criteria and advised the Coordinating Committee. Comments were received on the draft criteria through the public comment period for the *Coordination Strategy for Clinician Performance Measurement* report. A *Measure-Selection Criteria Interpretive Guide* also was developed to provide additional descriptions and direction on the meaning and use of the measure-selection criteria.

MAP measure-selection criteria and the interpretive guide were finalized at the November 1, 2011, Coordinating Committee

in-person meeting. The following criteria were then used as a tool during the pre-rulemaking task:

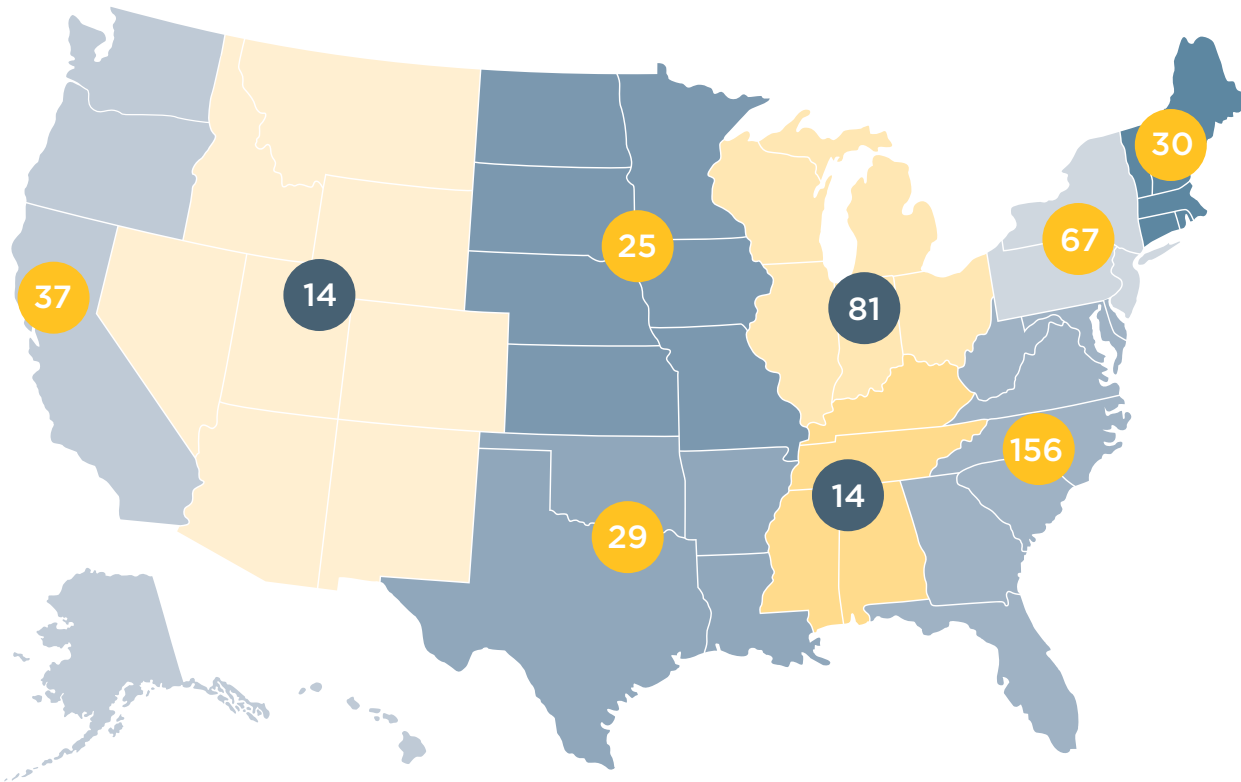
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review.
2. The program measure set adequately addresses each of the NQS priorities.
3. The program measure set adequately addresses high-impact conditions relevant to the program’s intended populations (e.g., children, adult non-Medicare, older adults, or dual-eligible beneficiaries).
4. The program measure set promotes alignment with specific program attributes, as well as alignment across programs.
5. The program measure set includes an appropriate mix of measure types (e.g., process, outcome, structure, patient experience, and cost).
6. The program measure set enables measurement across the person-centered episode of care.
7. The program measure set includes considerations for healthcare disparities.
8. The program measure set promotes parsimony.

Public commenters supported the MAP measure-selection criteria and noted that the tool served MAP well in its pre-rulemaking activities.

## APPENDIX E: NQF Membership

NQF members represent more than 450 organizations from across the country committed to advancing healthcare quality. Members of NQF participate in one of eight Member Councils organized by stakeholder group—consumers; health plans; health professionals; provider organizations; public-community

health agencies; purchasers; quality measurement, research, and improvement; and supplier-industry—and are afforded a strong voice in crafting national solutions to quality concerns. Member organizations are from every region of the country as the map below indicates.



## NQF Member Organizations

3M Health Care  
 AARP  
 Abbott Laboratories  
 ABIM Foundation  
 Academy of Managed Care Pharmacy  
 Academy of Medical-Surgical Nurses  
 Accreditation Association for Ambulatory Health Care  
 Institute for Quality Improvement  
 ACS-MIDAS+  
 Ada County Paramedics  
 Adventist Health System  
 Advocate Physician Partners  
 Aetna  
 Affinity Health System  
 AFL-CIO  
 Agency for Healthcare Research and Quality  
 Albuquerque Coalition for Healthcare Quality  
 Aligning Forces for Quality-South Central  
 Pennsylvania  
 Alliance for Health  
 Alliance of Community Health Plans  
 Ambulatory Surgery Foundation  
 Amedisys  
 American Academy of Allergy, Asthma and  
 Immunology  
 American Academy of Dermatology  
 American Academy of Family Physicians  
 American Academy of Hospice and Palliative  
 Medicine  
 American Academy of Neurology  
 American Academy of Nurse Practitioners  
 American Academy of Nursing  
 American Academy of Ophthalmology  
 American Academy of Orthopaedic Surgeons  
 American Academy of Otolaryngology-Head and  
 Neck Surgery  
 American Academy of Pediatrics  
 American Academy of Physical Medicine and  
 Rehabilitation  
 American Association of Birth Centers  
 American Association of Cardiovascular and  
 Pulmonary Rehabilitation  
 American Association of Clinical Endocrinologists  
 American Association of Colleges of Nursing  
 American Association of Diabetes Educators  
 American Association of Neurological Surgeons  
 American Association of Nurse Anesthetists  
 American Association of Nurse Assessment  
 Coordination  
 American Board of Medical Specialties  
 American Board of Optometry  
 American Case Management Association  
 American Chiropractic Association  
 American College of Cardiology  
 American College of Cardiology/American Heart  
 Association Task Force on Performance Measures  
 American College of Emergency Physicians  
 American College of Gastroenterology  
 American College of Medical Quality  
 American College of Nurse-Midwives  
 American College of Obstetricians and Gynecologists  
 American College of Physician Executives  
 American College of Physicians  
 American College of Radiology  
 American College of Rheumatology  
 American College of Surgeons  
 American Data Network  
 American Dietetic Association  
 American Federation of Teachers Healthcare  
 American Gastroenterological Association Institute  
 American Geriatrics Society  
 American Health Care Association  
 American Health Information Management  
 Association  
 American Health Quality Association  
 American Heart Association  
 American Hospice Foundation  
 American Hospital Association  
 American Medical Association  
 American Medical Association-Physician Consortium  
 for Performance Improvement  
 American Medical Directors Association  
 American Medical Informatics Association  
 American Nurses Association  
 American Occupational Therapy Association  
 American Optometric Association  
 American Organization of Nurse Executives  
 American Osteopathic Association  
 American Pharmacists Association Foundation  
 American Physical Therapy Association  
 American Psychiatric Association for Research and  
 Education  
 American Psychiatric Nurses Association  
 American Sleep Apnea Association  
 American Society for Gastrointestinal Endoscopy  
 American Society for Radiation Oncology  
 American Society of Anesthesiologists  
 American Society of Breast Surgeons  
 American Society of Clinical Oncology  
 American Society of Colon and Rectal Surgeons  
 American Society of Health-System Pharmacists  
 American Society of Hematology  
 American Society of Nuclear Cardiology  
 American Society of Pediatric Nephrology  
 American Society of Plastic Surgeons  
 American Urological Association  
 America's Health Insurance Plans  
 AmeriHealth Mercy Family of Companies  
 AMGEN Inc.  
 AmSurg Corp.  
 Anesthesia Quality Institute  
 Arkansas Medicaid  
 Ascension Health  
 Association for Professionals in Infection Control and  
 Epidemiology  
 Association for the Advancement of Wound Care  
 Association of American Medical Colleges  
 Association of periOperative Registered Nurses  
 Association of Rehabilitation Nurses  
 Association of Women's Health, Obstetric and  
 Neonatal Nurses  
 AstraZeneca  
 Atlantic Health  
 Aultman Health Foundation  
 Aurora Health Care  
 Avalere Health LLC  
 Baptist Health South Florida  
 Baptist Memorial Health Care Corporation  
 Baxter Healthcare  
 BayCare Health System

Baylor Health Care System	eHealth Initiative
Betsy Lehman Center for Patient Safety and Medical Error Reduction	Eisai, Inc.
Better Health Greater Cleveland	Eli Lilly and Company
BJC HealthCare	Elsevier Clinical Decision Support
BlueCross BlueShield Association	Emergency Nurses Association
Boehringer Ingelheim	Employers' Coalition on Health
Bon Secours St. Francis Health System	Englewood Hospital and Medical Center
Booz Allen Hamilton	Epstein Becker & Green, P.C.
Bristol-Myers Squibb Company	Exeter Health Resources
Bronson Healthcare Group, Inc.	Federation of American Hospitals
Buyers Health Care Action Group	FirstWatch Solutions, Inc.
California HealthCare Foundation	Florida Health Care Coalition
California Hospital Association	Florida Hospital
California Hospital Patient Safety Organization	Florida State University, Center for Medicine and Public Health
California Maternal Quality Care Collaborative	Forest Laboratories, Inc.
California Office of Statewide Health Planning and Development	Foundation for Informed Medical Decision Making
CareFirst BlueCross BlueShield	Fox Chase Cancer Center
CareFusion	Franciscan Alliance
CaroMont Health	GE Healthcare
Case Management Society of America	Genentech
Caterpillar Inc.	Genesis HealthCare System
Catholic Health Association of the United States	Gentiva Health Services
Catholic Health Initiatives	GlaxoSmithKline
Catholic Healthcare Partners	Good Samaritan Hospital
Cedars-Sinai Medical Center	Greater Detroit Area Health Council
Center for Health Care Quality, Department of Health Policy, George Washington University	Greenway Medical Technologies
Center to Advance Palliative Care	Group Health Cooperative
Centers for Disease Control and Prevention	H. Lee Moffitt Cancer Center and Research Institute Hospital, Inc.
Centers for Medicare & Medicaid Services	Hackensack University Medical Center
Childbirth Connection	Harborview Medical Center
Children's Hospital Boston	Health Action Council Ohio
Children's Hospitals and Clinics of Minnesota	Health Level Seven, Inc.
CHRISTUS Health	Health Management Associates, Inc.
CIGNA HealthCare	Health Resources and Services Administration
Citizens for Patient Safety	Health Services Advisory Group
City of Hope	Health Services Coalition
Cleveland Clinic	Health Watch USA
Colorado Business Group on Health	HealthCare 21 Business Coalition
Commission for Case Manager Certification	Healthcare Information and Management Systems Society
Community Health Accreditation Program	Healthcare Leadership Council
Community Health Alliance- Humboldt County Del-Norte	HealthGrades
Community Health Foundation of Western and Central New York	HealthPartners
Connecticut Center for Patient Safety	HealthSouth Corporation
Connecticut Hospital Association	Healthy Memphis Common Table
Consumer Coalition for Quality Health Care	Heart Rhythm Society
Consumers Advancing Patient Safety	Henry Ford Health System
Consumers' Checkbook	Highmark, Inc.
Consumers Union	Hoag Hospital
Coral Initiative, LLC	Horizon Blue Cross Blue Shield of New Jersey
Core Consulting, Inc.	Hospice and Palliative Nurses Association
Council of Medical Specialty Societies	Hospira
Crozer-Keystone Health System	Hospital Corporation of America
Dallas-Fort Worth Hospital Council Education and Research Foundation	Hospital for Special Surgery
Dana-Farber Cancer Institute	Hudson Health Plan
Deloitte Consulting LLP, Health Sciences and Government	Humana Inc.
Dental Quality Alliance	Huntington Memorial Hospital
Detroit Medical Center	Illinois Hospital Association
Dialog Medical	Infectious Diseases Society of America
Edwards Lifesciences	Infusion Nurses Society
	Inland Northwest Health Services
	Institute for Clinical Systems Improvement
	Institute for Safe Medication Practices
	Integrated Healthcare Association

*Intelligent Healthcare*  
*Interim HealthCare, Inc.*  
*Intermountain Healthcare*  
*Iowa Healthcare Collaborative*  
*IPRO*  
*Jefferson School of Population Health*  
*Johns Hopkins Health System*  
*Kaiser Permanente*  
*Kansas City Quality Improvement Consortium*  
*Kidney Care Partners*  
*Lamaze International*  
*Lehigh Valley Business Coalition on Health Care*  
*LHC Group, Inc.*  
*Long-Term Quality Alliance*  
*Louisiana Health Care Quality Forum*  
*Maine Health Management Coalition*  
*Maine Quality Counts*  
*Maine Quality Forum*  
*Maryland Health Care Commission*  
*Maryland Patient Safety Center*  
*Massachusetts Health Quality Partners*  
*Mayo Clinic*  
*McKesson Corporation*  
*MedAssets*  
*MedeAnalytics, Inc.*  
*Medisolv, Inc.*  
*MedStar Health*  
*Memorial Hermann Healthcare System*  
*Memorial Sloan-Kettering Cancer Center*  
*Merck & Co., Inc.*  
*Mercy Medical Center*  
*Meridian Health System*  
*MHA Keystone Center for Patient Safety & Quality*  
*Middlesex Hospital*  
*Midwest Care Alliance*  
*Milliman Care Guidelines*  
*Minnesota Community Measurement*  
*Mothers Against Medical Error*  
*Mount Auburn Hospital*  
*National Academy for State Health Policy*  
*National Academy of Clinical Biochemistry*  
*National Alliance of Wound Care*  
*National Association for Behavioral Health*  
*National Association for Healthcare Quality*  
*National Association of Certified Professional Midwives*  
*National Association of Children's Hospitals and Related Institutions*  
*National Association of Dental Plans*  
*National Association of EMS Physicians*  
*National Association of Health Data Organizations*  
*National Association of Pediatric Nurse Practitioners*  
*National Association of Psychiatric Health Systems*  
*National Association of Public Hospitals and Health Systems*  
*National Association of State Medicaid Directors*  
*National Breast Cancer Coalition*  
*National Business Coalition on Health*  
*National Business Group on Health*  
*National Center for Healthcare Leadership*  
*National Coalition for Cancer Survivorship*  
*National Committee for Quality Assurance*  
*National Consensus Project for Quality Palliative Care*  
*National Consortium of Breast Centers*  
*National Consumers League*  
*National Council of State Boards of Nursing*  
*National Council on Aging*  
*National Forum for Heart Disease and Stroke Prevention*  
*National Health Law Program*  
*National Hospice and Palliative Care Organization*  
*National Institute for Quality Improvement and Education*  
*National Nursing Staff Development Organization*  
*National Partnership for Women & Families*  
*National Patient Safety Foundation*  
*National Pressure Ulcer Advisory Panel*  
*National Rural Health Association*  
*National Sleep Foundation*  
*NCH Healthcare System*  
*Nemours Foundation*  
*Neocure Group*  
*New Jersey Health Care Quality Institute*  
*New Jersey Hospital Association*  
*New York Presbyterian Healthcare System*  
*New York University College of Nursing*  
*Next Wave*  
*Niagara Health Quality Coalition*  
*North Carolina Center for Hospital Quality and Patient Safety*  
*North Mississippi Medical Center*  
*North Shore-Long Island Jewish Health System*  
*North Texas Specialty Physicians*  
*Northeast Health Care Quality Foundation*  
*Northwestern Memorial HealthCare*  
*Norton Healthcare, Inc.*  
*Novartis*  
*Nursing Alliance for Quality Care*  
*Oakstone Medical Publishing*  
*Oncology Nursing Society*  
*Oregon Health Care Quality Corporation*  
*Ortho-McNeill-Janssen Pharmaceutical, Inc.*  
*OSUCCC-James Cancer Hospital*  
*P2 Collaborative of Western New York*  
*Pacific Business Group on Health*  
*Park Nicollet Health Services*  
*Partners HealthCare System, Inc.*  
*Partnership for Prevention*  
*Patient Centered Primary Care Collaborative*  
*Pennsylvania Health Care Association*  
*Pfizer*  
*Pharmacy Quality Alliance*  
*PhRMA*  
*Phytel, Inc.*  
*Planetree*  
*Premier, Inc.*  
*Press Ganey Associates*  
*Professional Research Consultants, Inc.*  
*Providence Health & Services*  
*Puget Sound Health Alliance*  
*PULSE of New York*  
*Quality Outcomes, LLC*  
*Quantros, Inc.*  
*Renal Physicians Association*  
*Resolution Health, Inc.*  
*Rhode Island Department of Health*  
*Robert Wood Johnson University Hospital-Hamilton*  
*Rockford Health System*  
*Roswell Park Cancer Institute*  
*Saint Barnabas Health Care System*  
*Saint Francis Hospital and Medical Center*  
*Sanofi Pasteur*

Sanofi-Aventis	University of Michigan Hospitals & Health Centers
Scott & White Healthcare	University of North Carolina-Program on Health Outcomes
Seattle Cancer Care Alliance	University of Pennsylvania Health System
Sharp HealthCare	University of Texas Southwestern Medical Center
Siemens Healthcare, USA	University of Texas-MD Anderson Cancer Center
Sisters of Charity of Leavenworth Health System	University of Virginia Health System
SNP Alliance	URAC
Society for Academic Emergency Medicine	Urgent Care Association of America
Society for Cardiovascular Angiography and Interventions	US Department of Defense-Health Affairs
Society for Healthcare Epidemiology of America	UW Health
Society for Maternal-Fetal Medicine	Vanderbilt University Medical Center
Society for the Advancement of Blood Management	Vanguard Health Management
Society for Vascular Surgery	Verilogue, Inc
Society of Behavioral Medicine	Veterans Health Administration
Society of Critical Care Medicine	VHA, Inc.
Society of Gynecologic Oncology	Virginia Business Coalition on Health
Society of Hospital Medicine	Virginia Cardiac Surgery Quality Initiative
Society of Thoracic Surgeons	Virginia Mason Medical Center
Southeast Texas Medical Associates, LLP	Virtua Health
St. Joseph Health System	WellPoint
St. Louis Area Business Health Coalition	WellSpan Health
Stamford Health System	WellStar Health System
State Associations of Addiction Services	West Virginia Medical Institute
Substance Abuse and Mental Health Services Administration	Wisconsin Collaborative for Healthcare Quality
Summa Health System	Wisconsin Medical Society
Surgical Care Affiliates	Wound, Ostomy and Continence Nurses Society
Sylvester Comprehensive Cancer Center, University of Miami Hospitals and Clinics	Yale New Haven Health System
Taconic IPA, Inc.	Zynx Health
Takeda Pharmaceuticals North America, Inc.	
Tampa General Hospital	
Telligen	
Tenet Healthcare Corporation	
Texas Health Resources	
Texas Medical Institute of Technology	
The Advanced Medical Technology Association	
The Alliance	
The Alliance for Home Health Quality and Innovation	
The Commonwealth Fund	
The Coordinating Center	
The Empowered Patient Coalition	
The Federation of State Medical Boards of the U.S., Inc.	
The Health Alliance of Mid-America, LLC	
The Health Collaborative	
The Joint Commission	
The Leapfrog Group	
The National Consumer Voice for Quality Long-Term Care	
The National Forum of ESRD Networks	
The Partnership for Healthcare Excellence	
Thomas Jefferson University Hospital	
Thomson Reuters	
Trauma Support Network	
Trinity Health	
Trust for America's Health	
UCB, Inc.	
UMass Memorial Medical Group, Inc.	
United Surgical Partners International	
UnitedHealth Group	
Universal American Corp.	
University HealthSystem Consortium	
University of California-Davis Medical Group	
University of Kansas School of Nursing	

## APPENDIX F: 2011 NQF Volunteer Leaders

Stancel M. Riley

*Chair*  
*Ambulatory and Office-Based Surgery Technical Advisory Panel*  
*Serious Reportable Events in Healthcare Project*  
*Chair*  
*Patient Safety Serious Reportable Events Technical Advisory Panel*  
Massachusetts Board of Registration in Medicine

Mary George

*Co-chair*  
*Cardiovascular Endorsement Maintenance Steering Committee*  
Centers for Disease Control and Prevention

Raymond Gibbons

*Co-chair*  
*Cardiovascular Endorsement Maintenance Steering Committee*  
Mayo Clinic

Donald Casey

*Co-chair*  
*Care Coordination Endorsement Maintenance Steering Committee*  
Atlantic Health

Gerri Lamb

*Co-chair*  
*Care Coordination Endorsement Maintenance Steering Committee*  
Arizona State University

Thomas McInerney

*Co-chair*  
*Child Health Quality Measures Steering Committee*  
University of Rochester

Marina L. Weiss

*Co-chair*  
*Child Health Quality Measures Steering Committee*  
*Co-chair*  
*National Voluntary Standards for Patient Outcomes Child Health Steering Committee*  
March of Dimes

David Classen

*Co-chair*  
*Common Formats Expert Panel*  
University of Utah

Henry Johnson

*Co-chair*  
*Common Formats Expert Panel*  
ACS-MIDAS+

Timothy Ferris

*Chair*  
*Consensus Standards Approval Committee*  
Massachusetts General Hospital/  
Institute for Health Policy

Ann Monroe

*Vice-chair*  
*Consensus Standards Approval Committee*  
Community Health Foundation of Western and Central New York

Doris Lotz

*Co-chair*  
*Efficiency Resource Use Steering Committee*  
New Hampshire Department of Health and Human Services

Sally Tyler

*Co-chair*  
*Patient Safety SRE Steering Committee*  
AFSCME

Gregg S. Meyer

*Co-chair*  
*Patient Safety SRE Steering Committee*  
Massachusetts General Hospital

Paul C. Tang

*Chair*  
*Health Information Technology Advisory Committee*  
Palo Alto Medical Foundation and Stanford University

Dennis Andrusis

*Co-chair*  
*Healthcare Disparities and Cultural Competency Consensus Standards Committee*  
Texas Health Institute

Denice Cora-Bramble

*Co-chair*  
*Healthcare Disparities and Cultural Competency Consensus Standards Committee*  
Children's National Medical Center

Michael Doering

*Co-chair*  
*Improving Patient Safety through State-Based Reporting in Healthcare Workgroup*  
Pennsylvania Patient Safety Authority

Diane Rydrych

*Co-chair*  
*Improving Patient Safety through State-Based Reporting in Healthcare Workgroup*  
Minnesota Department of Health

Iona Thraen

*Co-chair*  
*Improving Patient Safety through State-Based Reporting in Healthcare Workgroup*  
Utah Department of Health

William Corley

*Chair*  
*Leadership Network*  
Community Health Network

George J. Isham

*Co-chair*  
*Measure Applications Partnership Coordinating Committee*  
HealthPartners, Inc.

Elizabeth A. McGlynn

*Co-chair*  
*Measure Applications Partnership Coordinating Committee*  
Kaiser Permanente Center for Effectiveness and Safety Research

Frank G. Opelka

*Chair*  
*Measure Applications Partnership Ad Hoc Safety Workgroup*  
*Chair*  
*Measure Application Partnership Hospital Workgroup*  
Louisiana State University Health Sciences Center

Mark McClellan

*Chair*  
*Measure Applications Partnership Clinician Workgroup*  
The Brookings Institution,  
Engelberg Center for Health Care Reform

Alice Lind

*Chair*  
*Measure Applications Partnership Dual Eligible Beneficiaries Workgroup*  
Center for Health Care Strategies

Carol Raphael

*Chair*  
*Measure Applications Partnership Post-Acute Care/Long-Term Care Workgroup*  
Visiting Nurse Service of New York

Michael Lieberman

*Chair*  
*Measure Authoring Tool Oversight and Testing Workgroup*  
Oregon Health and Science University

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Caroline S. Blaum

*Co-chair*

*Multiple Chronic Conditions  
Measurement Framework Steering  
Committee*

University of Michigan Health  
System - Institute of Gerontology

Barbara McCann

*Co-chair*

*Multiple Chronic Conditions  
Measurement Framework Steering  
Committee*

Interim HealthCare

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Helen Darling

*Co-chair*

*National Priorities Partnership  
National Business Group on Health*

Margaret O'Kane

*Co-chair*

*National Priorities Partnership  
National Committee for Quality  
Assurance*

Bernard Rosof

*Co-chair*

*National Priorities Partnership  
Physician Consortium for  
Performance Improvement  
convened by the American Medical  
Association*

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*Co-chair*

*National Voluntary Consensus  
Standards for End Stage Renal  
Disease*

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*Renal Endorsement Maintenance  
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Southern California Permanente  
Medical Group*

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*Co-chair*

*National Voluntary Consensus  
Standards for End Stage Renal  
Disease*

*Co-chair*

*Renal Endorsement Maintenance  
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Pharmacy*

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Tom Rosenthal

*Co-chair*

*National Voluntary Consensus  
Standards for Endorsing  
Performance Measures for  
Resource Use: Phase II  
UCLA School of Medicine*

Bruce Steinwald

*Co-chair*

*National Voluntary Consensus  
Standards for Endorsing  
Performance Measures for  
Resource Use: Phase II*

*Co-chair*

*Efficiency Resource Use Steering  
Committee  
Independent Consultant*

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*Co-chair*

*National Voluntary Consensus  
Standards for Imaging Efficiency  
Massachusetts General Hospital*

Eric D. Peterson

*Co-chair*

*National Voluntary Consensus  
Standards for Imaging Efficiency  
Duke University Medical Center*

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David A. Johnson

*Chair*

*National Voluntary Consensus  
Standards for Patient Outcomes  
Biliary and Gastrointestinal  
Technical Advisory Panel  
American College of  
Gastroenterology*

Dianne Jewell

*Chair*

*National Voluntary Consensus  
Standards for Patient Outcomes  
Bone/Joint Technical Advisory  
Panel  
Virginia Commonwealth University*

Lee Newcomer

*Chair*

*National Voluntary Consensus  
Standards for Patient Outcomes  
Cancer Technical Advisory  
Committee  
United HealthCare*

Edward Gibbons

*Chair*

*National Voluntary Consensus  
Standards for Patient Outcomes  
Cardiovascular Technical Advisory  
Panel  
University of Washington School of  
Medicine*

David Herman

*Chair*

*National Voluntary Consensus  
Standards for Patient Outcomes  
Eye Care Technical Advisory Panel  
Mayo Clinic*

E. Patchen Dellinger

*Chair*

*National Voluntary Consensus  
Standards for Patient Outcomes  
Infectious Disease Technical  
Advisory Panel  
University of Washington School of  
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Sheldon Greenfield

*Chair*

*National Voluntary Consensus  
Standards for Patient Outcomes  
Metabolic Technical Advisory Panel  
University of California, Irvine*

Barbara Yawn

*Chair*

*National Voluntary Consensus  
Standards for Patient Outcomes  
Pulmonary Technical Advisory  
Panel  
Olmstead Medical Center*

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*Co-chair*

*National Voluntary Consensus  
Standards for Patient Outcomes  
Mental Health Steering Committee  
Rhode Island Department of Health*

Jeffrey Sussman

*Co-chair*

*National Voluntary Consensus  
Standards for Patient Outcomes  
Mental Health Steering Committee  
University of Cincinnati*

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Charles Homer

*Co-chair*

*National Voluntary Standards for  
Patient Outcomes Child Health  
Steering Committee  
NICHQ*

---

David Gifford

*Co-chair*

*National Voluntary Standards for  
Nursing Homes  
American Health Care Association  
and National Center for Assisted  
Living*

Christine Mueller

*Co-chair*

*National Voluntary Standards for  
Nursing Homes  
University of Minnesota School of  
Nursing*

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June Lunney

*Co-chair*

*Palliative Care and End-of-Life Care  
Endorsement Maintenance Steering  
Committee  
Hospice and Palliative Nurses  
Association*

Sean Morrison

*Co-chair*

*Palliative Care and End-of-Life Care  
Endorsement Maintenance Steering  
Committee  
Mount Sinai School of Medicine*

---

Sherrie Kaplan

*Co-chair*

*Patient Outcomes: All-Cause  
Readmissions Expedited Review  
Steering Committee  
UC Irvine School of Medicine*

Eliot Lazar

*Co-chair*

*Patient Outcomes: All-Cause  
Readmissions Expedited Review  
Steering Committee  
New York Presbyterian Healthcare  
System*

---

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*Co-chair*

*Patient Safety Measures Steering  
Committee  
Surgical Care Affiliates*

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*Co-chair*  
*Patient Safety Measures Steering Committee*  
*Co-chair*  
*Patient Safety Measures: Complications Endorsement Maintenance Steering Committee*  
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*Chair*  
*Patient Safety Measures HAI Technical Advisory Panel*  
 University of Michigan Hospitals & Health Centers

**David Nau**

*Chair*  
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 Pharmacy Quality Alliance

**Steven Clark**

*Chair*  
*Patient Safety Measures Perinatal Technical Advisory Panel*  
 Hospital Corporation of America

**Pamela Cipriano**

*Co-chair*  
*Patient Safety Measures: Complications Endorsement Maintenance Steering Committee*  
 University of Virginia Health System

**Tejal Gandhi**

*Chair*  
*Patient Safety Serious Reportable Events Technical Advisory Panel*  
*Chair*  
*Physician Office Technical Advisory Panel Serious Reportable Events in Healthcare*  
 Partners Healthcare

**Eric Tangalos**

*Chair*  
*Patient Safety Serious Reportable Events Technical Advisory Panel*  
*Chair*  
*Skilled Nursing Facility Technical Advisory Panel Serious Reportable Events In Healthcare Project*  
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*Co-chair*  
*Perinatal and Reproductive Health Endorsement Maintenance Steering Committee*  
 Massachusetts General Hospital

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*Co-chair*  
*Perinatal and Reproductive Health Endorsement Maintenance Steering Committee*  
 Childbirth Connection

**Paul Jarris**

*Co-chair*  
*Population Health: Prevention Endorsement Maintenance Steering Committee*  
 Association of State and Territorial Health Officers

**Kurt Stange**

*Co-chair*  
*Population Health: Prevention Endorsement Maintenance Steering Committee*  
 Case Western Reserve University

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*Co-chair*  
*Quality Data Model Sub-committee*  
 Partners Healthcare

**Caterina Lasome**

*Co-chair*  
*Quality Data Model Sub-committee*  
 Ion Informatics

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*Co-chair*  
*Regionalized Emergency Medical Care Services Steering Committee*  
 The RAND Corporation

**Andrew Roszak**

*Co-chair*  
*Regionalized Emergency Medical Care Services Steering Committee*  
 Department of Health and Human Services

**James Weinstein**

*Chair*  
*Resource Use Project: Phase II Bone/Joint Technical Advisory Panel*  
 The Dartmouth Institute for Health Policy; Dartmouth-Hitchcock Clinic

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*Chair*  
*Resource Use Project: Phase II Cancer Technical Advisory Panel*  
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**Jeptha Curtis**

*Co-chair*  
*Resource Use Project: Phase II Cardiovascular/Diabetes Technical Advisory Panel*  
 Yale University School of Medicine

**James Rosenzweig**

*Co-chair*  
*Resource Use Project: Phase II Cardiovascular/Diabetes Technical Advisory Panel*  
 Boston Medical Center and Boston University School of Medicine

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 Family Medicine of Albermarle

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 Ann Arbor Veterans Affairs Medical Center

**David Torchiana**

*Co-chair*  
*Surgery Endorsement Maintenance Steering Committee*  
 Massachusetts General Physicians Organization







Report to the Congress and the Secretary of the U.S. Department of Health and Human Services,  
Covering the Period of January 14, 2011, to January 13, 2012  
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