NATIONAL QUALITY FORUM

A Roadmap to Reduce Health and Healthcare Disparities through Measurement

DRAFT REPORT

July 21, 2017

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I Task Order HHSM-500-T0024.

Executive Summary

Despite overall improvements in public health and medicine, disparities in health and healthcare continue to persist. In 2015, the Centers for Disease Control and Prevention reported significant health and healthcare disparities in leading causes of death. For example, African Americans are more likely to die prematurely from heart disease; the prevalence of heart disease is higher for individuals with lower incomes and lower educational attainment; and men have higher suicide rates than women. In the same year, the Agency for Healthcare Research and Quality reported significant disparities in healthcare quality. Racial and ethnic minorities, individuals with disabilities, individuals who have low incomes, and individuals with other social risk factors, are more likely to receive lower quality care. Eliminating these disparities has become the priority of the U.S. Department of Health and Human Services (HHS) and many other stakeholder groups.

Performance measurement is an essential tool for monitoring health disparities and assessing the level to which interventions known to reduce disparities are employed. Performance measures can also be used for public reporting, be tied to accountability programs, and allow stakeholders to assess the impact of interventions. Moreover, measures can help to pinpoint where people with social risk factors do not receive the care they need or receive care that is lower quality. However, there is no systematic approach to use measures for eliminating disparities and promoting health equity.

The National Quality Forum (NQF) convened a multistakeholder Committee, with funding from the Department of Health and Human Services, to provide recommendations on how performance measurement and its associated policy levers can be used to eliminate disparities in health and healthcare. The Disparities Standing Committee developed its recommendations by focusing on selected conditions as case studies: cardiovascular disease, cancer, diabetes and chronic kidney disease, infant mortality/low birthweight, and mental illness. Disparities within these conditions were reviewed based on the social risk factors outlined in the 2016 National Academy of Medicine (NAM) report, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*. Three interim reports document each phase of the project:

- report 1: a review the evidence that describes disparities in health and healthcare outcomes;
- report 2: a review of interventions that have been effective in reducing disparities;
- report 3: an environmental scan of performance measures and assessment of gaps in measures that can be used to assess the extent to which stakeholders are deploying effective interventions to reduce disparities.

This draft report includes the Committee's final roadmap to reduce health and healthcare disparities through performance measurement and associated policy levers. The Committee developed a four-step approach, drawing on the results of the interim reports:

- Step 1: Prioritize disparities-sensitive measures
- Step 2: Identify evidence-based interventions to reduce disparities
- Step 3: Select and use health equity performance measures
- Step 4: Incentivize the reduction of health disparities and achievement of health equity

The roadmap seeks to capitalize on the current care delivery and payment model transformation while recognizing the persistent and pervasive nature of healthcare disparities. In the first step, the Committee recommends that measure implementers prioritize the use of measures that are sensitive to disparities in health and healthcare. The Committee noted that stakeholders such as policymakers, payers, and purchasers can leverage existing quality improvement and value-based purchasing programs by implementing disparities-sensitive measures and stratifying them by subgroups to identify disparities.

The second step emphasizes that stakeholders must take actions to reduce disparities by implementing evidence-based interventions to reduce disparities at every level of the healthcare system.

The next step involves the selection of health equity performance measures. Health equity measures are quality performance measures that can drive reductions in disparities by incentivizing providers to use interventions known to lessen disparities or test new interventions to reduce them, investigate their own practice and community, and try new processes to improve equity. The Committee developed five domains of measurement that should be used together to advance equity: collaboration and partnerships, culture of equity, structures for equity, equitable access to care, and equitable high-quality care.

Finally, the reduction of disparities must be incentivized. The roadmap lays out four strategies for incentivizing health equity through measurement:

1. Implement health equity measures
2. Incentivize health equity through payment reform
3. Support organizations that disproportionately serve individuals with social risk factors
4. Develop and implement demonstration projects with rigorous evaluation partnering with equity researchers

Measurement can be a powerful force for change in healthcare. However, stakeholders (such as policy makers, legislators, hospital administrators, hospital delivery systems, community advocates, patient advocate groups, and providers) across the system must be motivated to act on the results of health equity performance measures and drive towards improved performance while ensuring that providers and clinicians have the resources necessary to care for those who are most vulnerable. Leveraging quality measurement and capitalizing on new delivery and payment models will help to incentivize the elimination of disparities. Performance measurement offers an opportunity to incentivize, support, and assess the reduction of disparities.

Background

The World Health Organization's (WHO) constitution states that the attainment of the highest possible standard of health is a fundamental right of every human being, regardless of race or socioeconomic status. The WHO recognizes the importance of healthcare in achieving health, noting that "the extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health." While there have been significant improvements in medicine and understanding the impact of social determinants of health on health outcomes, the current reality falls short of this ideal. Many individuals residing throughout the United States continue to face disparities in both health and healthcare. Health equity can only be achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."[1]

The HHS Office of Minority Health describes a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" (based on individual's gender, age, race, and/or ethnic group, etc.). The Centers for Disease Control and Prevention (CDC) report, *Health Disparities and Inequalities Report-United States, 2013,* found racial and ethnic disparities in mortality due to heart disease and stroke, socioeconomic disparities in the prevalence of diabetes, disparities in suicide rates based on gender, and many others.[2] Healthcare disparities are related to "differences in the quality of care that are not due to access-related factors or clinical needs, preferences, and appropriateness of interventions" (i.e., differences based on discrimination and stereotyping).[3] The *2015 National Healthcare Quality and Disparities Report* found disparities in healthcare related to race, ethnicity, and socioeconomic status (SES) that continue to persist across all National Quality Strategy (NQS) priorities. Poor households received worse care than people in high-income households for about 60 percent of quality measures. African Americans, Hispanics, and American Indians and Alaska Natives received worse care than whites for about 40 percent of quality measures, and Asians and Pacific Islanders received worse care for about 30 percent of the measures.[4]

Addressing health and healthcare disparities is a priority for both public- and private-sector stakeholders. For instance, the U.S. Department of Health and Human Services (*HHS) Action Plan to Reduce Racial and Ethnic Health Disparities and National Partnership for Action to End Health Disparities*, *Healthy People 2020*, the *2013 HHS Language Access Plan*, the *Centers for Medicare and Medicare Services (CMS) Equity Plan for Improving Quality in Medicare*, and provisions in the Affordable Care Act (ACA) have all prioritized the reduction of health and healthcare disparities. The Institute for Healthcare Improvement has highlighted the "forgotten" quality aim of health equity, and the Robert Wood Johnson Foundation (RWJF) has donated significant resources towards research and initiatives to improving health equity. In addition, The California Endowment, Aetna Foundation, and the Kresge Foundation have all invested in work to reduce disparities and promote health equity. These commitments have led to development of many interventions to reduce disparities, but the implementation efforts are rarely systematic and have yet to achieve significant advances in health equity.

Performance Measurement can illuminate the healthcare system's progress towards achieving health equity (variation, poor performance) and incentivize both improvement and innovation through accountability. Performance measurement is the regular collection of data to assess whether the correct processes are being performed, structures are in place, and desired results are being achieved.[5] In the same way, performance measures can assess the extent to which stakeholders are employing effective interventions to reduce disparities.

Several organizations have begun developing guidance on the use of measurement for monitoring and reducing disparities. For example, the RWJF has published several reports with recommendations for data collection and performance measurement strategies to reduce disparities. These recommendations include creating a nationwide health information infrastructure to facilitate health disparities research[6] and stratifying quality measures by social risk factors to uncover and respond to disparities.[7] The Commonwealth Fund has also published guidance on data collection to support the detection of disparities and strategies for closing gaps.[8] In addition, the 2016 National Academy of Medicine (NAM) report, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors,* (released in response to provisions in the IMPACT Act) provides guidance on whether to account for social factors in Medicare quality measurement and payment programs.[9] The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) also released guidance in 2016 for accounting for social risk in value-based purchasing programs with recommendations to stratify measures by patient characteristics, adjust performance measure scores, directly adjust payment, and restructure payment incentives.

Performance measurement in healthcare, while critical to monitoring and reducing disparities, is one of many tools needed to eliminate health disparities. For example, public policy can also shape the environment to promote healthy lifestyles, expand access to care through insurance coverage, eliminate environmental hazards, determine the racial and ethnic distribution of housing, optimize the equitable distribution of food, transportation, vital services and utilities, and promote many other efforts to advance health equity. The causes of disparities represent complex interactions among institutional, historical, and sociopolitical factors that can only be fully addressed through a variety of mechanisms. Eliminating disparities in health and healthcare will require reengineering the systems that drive disparities and employing interventions that target threats to individuals or populations at risk.

Project Overview

The National Quality Forum (NQF), with funding from HHS, convened a multistakeholder Committee (Appendix D), comprising experts in disparities, social risk factors, and healthcare quality improvement, clinical, and measurement expertise to develop a framework that demonstrates how performance measurement and its associated policy levers can be used to eliminate disparities. The Disparities Standing Committee focused on the leading causes of morbidity and mortality (i.e., cardiovascular disease, cancer, diabetes, chronic kidney disease, infant mortality, low birthweight, and mental illness) to serve as use cases for the identification of disparities and performance measures that can be used to monitor and reduce disparities. However, the Committee's recommendations apply to all conditions where health and healthcare disparities exist.

Each phase of the Committee's work is documented in a series of three interim reports, which are posted to the NQF disparities project webpage. The three interim reports support the primary objectives of the project:

- review the evidence that describes disparities in health and healthcare outcomes;
- review the evidence of interventions that have been effective in reducing disparities;
- perform an environmental scan of performance measures and assess gaps in measures that can be used to assess the extent to which stakeholders are deploying effective interventions to reduce disparities; and
- provide recommendations to reduce disparities through performance measurement.

The Committee used the findings in the three interim reports to create a framework for reducing disparities through measurement (framework development process included in Appendix C). This draft final report presents the Committee's recommendations.

Measurement Framework

The reduction of disparities and promotion of health equity is a primary goal of healthcare quality improvement. In *Crossing the Quality Chasm,* the NAM (formally the Institute of Medicine) established equity as an essential aspect of healthcare quality, noting that equitable care does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status (SES).[10] Other seminal reports like *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* demonstrated that racial and ethnic minorities often receive lower quality care than their white counterparts, even after controlling for factors such as insurance, SES, comorbidities, and stage of presentation.[11]

Performance measurement offers an opportunity to assess, support, and incentivize the reduction of disparities. The NQF Disparities Standing Committee developed a roadmap on how performance measurement can be used to reduce health and healthcare disparities. The Committee recognized that many frameworks have been developed to demonstrate why disparities exist and how they can be reduced. NQF has engaged in extensive work to better understand the role quality measurement can play in reducing disparities. The Committee sought to build on this work by developing a roadmap with the unique goal of demonstrating how quality measurement can be used to identify and eliminate disparities. The roadmap sets an aspirational goal of eliminating disparities in health and healthcare as well as laying out shorter term objectives to achieve this aspirational goal. It describes a path to achieving these objectives and ultimate goal by outlining the actions needed to eliminate disparities and highlighting stakeholders and their responsibilities.

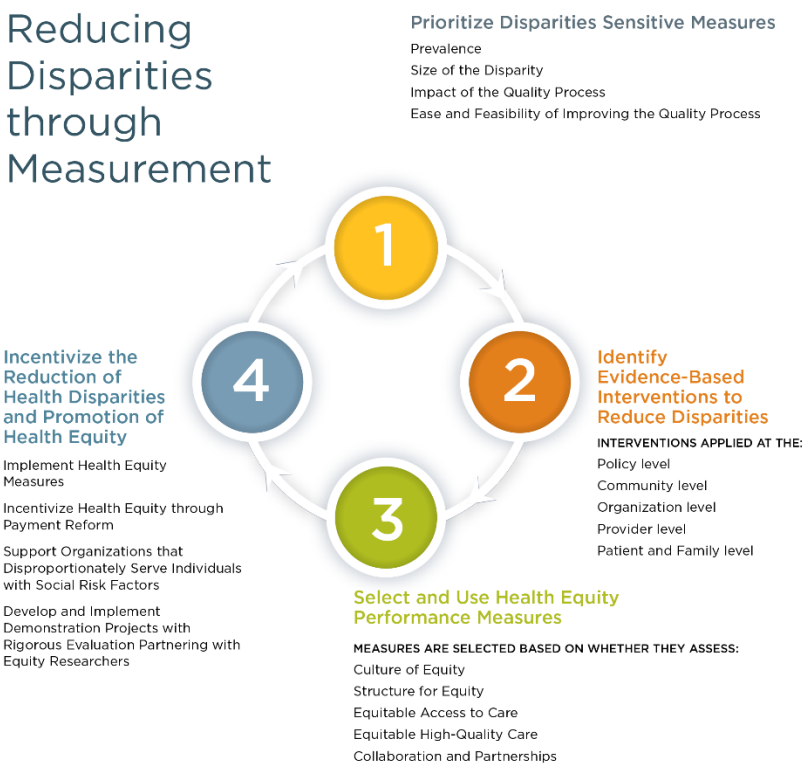
The measurement framework builds on the three aims of the National Quality Strategy: better care, healthy people/healthy communities, and affordable care. The framework applies to a wide spectrum of disparities based on age, gender, income, race, ethnicity, nativity, language, sexual orientation, gender identity, disability, geographic location, and other social risk factors. It incorporates cultural competence, community engagement, and cross-sector partnerships to reduce disparities. In particular, the framework includes measurement beyond clinical settings, structures, and processes of care. For

example, it includes the assessment of collaboration between healthcare and other sectors (e.g., schools, social services, transportation, housing, etc.) to reduce the impact of social risk factors.

The framework builds on existing conceptual models and guidance. Specifically, it draws on the NAM Conceptual Framework of Social Risk Factors and Performance Indicators for Value-Based Payment. It integrates concepts from the five A's of access to care defined by Penchansky and Thomas: affordability, availability, accessibility, accommodation, and acceptability.[12] Similarly, the Committee adopted the updated domains of quality put forth by the NAM in 2010: effectiveness, safety, timeliness, patient/family-centeredness, access, and efficiency. Equity is a cross-cutting dimension embedded in each of these six domains.[13]

The Committee also noted the interconnected yet distinct challenges of eliminating disparities in health and healthcare. Healthcare contributes to a person's health, but health is influenced by factors beyond the control of the traditional healthcare system. However, with increasing use of global payment systems, alternative payment models (e.g., accountable care organizations [ACOs]), and value-based contracts, the scope of the healthcare system is expanding to address population health and some of the underlying social determinants of health, often through community partnerships. Figure 1 illustrates the measurement framework. The following sections describe each step and incorporate the findings of a review of the literature and environmental scan of measures.

Figure 1. A Framework for Reducing Health Disparities through Measurement



Step 1: Prioritize Disparities-Sensitive Measures

The first step in the framework involves prioritizing measures that can help to identify disparities. While national disparities in healthcare are well-documented, individual health and healthcare organizations usually do not systematically assess the health and healthcare disparities of the persons they serve. Moreover, the volume of existing measures can make prioritization a challenge, but measures should be prioritized. Increased use of measurement to identify disparities can help to ensure that all individuals receive quality healthcare regardless of their social risk factors. Measurement can help to pinpoint where people at social risk do not receive the care they need or receive care that is lower quality.

To assist stakeholders in prioritizing measures, the Committee built on prior NQF work to identify measures that can best assess disparities in care. In 2011, NQF commissioned a white paper focused on measurement implications for healthcare disparities and convened the Disparities Standing Committee to develop a set of criteria to identify disparities-sensitive measures. The Committee revised the criteria to a set of four:

1. **Prevalence**—How prevalent is the condition among populations with social risk factors? What is the impact of the condition on the health of populations with social risk factors?
2. **Size of the Disparity**—How large is the gap in quality, access, and/or health outcome between the group with social risk factors and the group with the highest quality ratings for that measure?
3. **Impact of the Quality Process**—How strong is the evidence linking improvement in performance on the measure to improved outcomes in the population with social risk factors?
4. **Ease and Feasibility of Improving the Quality Process (Actionable)**—Is the measure actionable among the population with social risk factors?

The 2011 white paper also identified the following criteria for disparities-sensitive measures in those cases when there is no access to data stratified by race/ethnicity, or when known disparities do not exist: care with a high degree of discretion; communication-sensitive services; social determinant-dependent measures; and outcome and communication-sensitive process measures.

Figure 2. Disparities-Sensitive Measure Selection Criteria

The Committee acknowledged some of the challenges to identifying disparities. First, data on social risk factors can be limited, making it challenging to explore performance. The Committee also noted the need to ensure patient privacy and that small numbers can make it difficult to stratify while preserving privacy and confidentiality. While small numbers should not be publicly reported, small population sizes should not be used as a justification for not collecting or stratifying data in the first place. Stratification should neither be used to hide disparities nor to create an impression that different levels of quality of care are acceptable.

Step 2: Identify Evidence-Based Interventions to Reduce Disparities

The second step of the measurement framework involves the identification of interventions that reduce disparities in health and healthcare. The reduction of disparities will require multilevel, systemic, and sustained interventions. To illustrate the different levels that contribute to the reduction of disparities, the Committee modified the Social-Ecological Model (SEM) to better apply to health systems. The SEM illustrates the interactions among various personal and environmental factors that influence health. The Committee extended the SEM to reflect the findings of Chin et al. and others who demonstrated the need for interventions employed by government, communities, organizations, and providers (with improved patient/individual outcomes as the ultimate target of interventions).[14] By leveraging multiple stakeholders throughout the system, these interventions can lead to improved outcomes for people with social risk factors, helping to demonstrate measurable progress towards achieving health equity.

The Committee built on the work of Cooper et al. who outlined drivers and mediators of disparities. Cooper et al. recognized the impact of individual, financial, structural, social-political, cultural, community, and healthcare system factors on disparities. The Cooper et al. framework focuses primarily on disparities based on race and ethnicity. Therefore, the Committee expanded the scope by identifying additional drivers that apply to other social risk factors and including interventions that the healthcare system could use to amplify the effects of the mediators of disparities. The Committee directed a review of the literature to identify effective interventions to reduce disparities based on the modified Cooper et al. framework. The interventions were categorized by the accountable entity as illustrated in the modified SEM in Figure 3.

Figure 3. Modified Social-Ecological Model

The literature review captured many interventions that have succeeded in reducing disparities in the selected conditions and highlighted gaps in research. The primary findings follow:

- The majority of research focuses on overall improvement of outcomes in populations that are socially at risk (in absolute terms), rather than improving outcomes relative to a socially privileged reference group (e.g., white vs. African American).
- Existing interventions largely focus on patient education, lifestyle modification, and culturally tailored programs. Far fewer interventions address how to improve health systems for populations with social risk factors.[15]
- Most Interventions target disparities based on race and ethnicity. Few interventions address disparities based on disability status, income, social relationships, health literacy, and residential and community context.
- Many interventions could potentially reduce disparities among multiple conditions (e.g., disparities in the incidence, prevalence, and burden of disease in diabetes and cardiovascular conditions), but are usually implemented and evaluated for addressing disparities in one condition. In addition, many interventions could also address disparities related to more than one social risk factor.

The findings demonstrate the need for further investment in research and demonstration projects to better understand the mediators of disparities, especially in healthcare services. No one intervention can eliminate disparities. There is, however, enough evidence to begin developing, implementing, and adapting programs and policies to reduce disparities and advance health equity. Addressing disparities in health and healthcare will require interventions that reengineer the systems that lead to and/or perpetuate disparities as well as interventions that target individuals who are at risk. These interventions must be tailored to specific populations, community, and organizational contexts, and

address root causes of disparities.[16,17] When these interventions are employed, outcomes must be routinely assessed. In addition, performance measures are needed to monitor the extent to which stakeholders are using interventions known to be effective.

Step 3: Select and Use Health Equity Performance Measures

The third step of the measurement framework involves the selection of health equity performance measures. Health equity measures are quality performance measures that can drive reductions in disparities by incentivizing providers to use interventions known to improve disparities or test new interventions to reduce them, investigate their own practice and community, and try new processes to improve equity. Although the scope of the framework primarily focuses on reducing disparities that the healthcare system can influence, the Committee recognized the impact that factors outside the healthcare system can have and the need to partner with others (e.g., community organizations, the education system, the justice system to address them) especially as payment and care delivery models increasingly focus on population and community health.

Advancing equity will mean improving both access to and quality of care. The Committee recognized a need for both disparities-sensitive measures and measures that directly assess equity. To guide the selection and development of health equity measures, the Committee identified domains of health equity measurement. The Committee recognized that achieving equity is a process and that different organizations may be in different places in that process and may have different resources available. The Committee recognized that there is no single solution that a healthcare organization can implement to achieve equity. Organizations must customize to the needs of their community; however, the domains put forth by the Committee are intended to represent the core processes, structures, and outcomes that must be advanced to achieve equity.

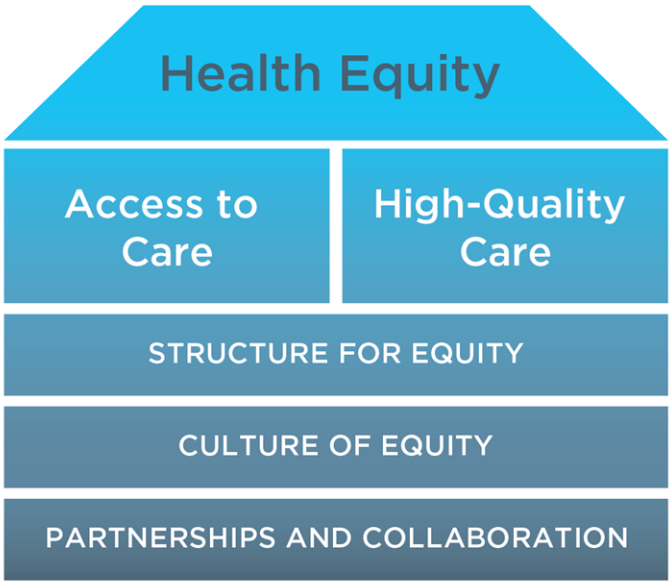
Domains of Health Equity Performance Measurement

The domains of health equity performance measurement represent a prioritized set of goals that must be attained for the healthcare system to achieve equity. They are intended to be considered as a group where relevant stakeholders can assess how well they are achieving goals outlined within each domain. To develop these domains, the Committee built on the results of the literature reviews described above. The Committee reviewed the evidence demonstrating the consistency of the interventions that can be shown to reduce disparities. Due to this consistency, the Committee adopted a cross-cutting approach rather than a condition-specific approach. The Committee also recognized that the use of effective interventions is one facet in the achievement of equity: the necessary structures must also support equity and assessment of equitable outcomes for all. Many of the goals presented in the domains of measurement are rooted in evidence-based interventions known to reduce disparities, and others are based on the Committee's consensus judgment. These goals include several measurable concepts, outlined in the domains below. To achieve equity, the U.S. healthcare system must:

- **Collaborate and partner with** other organizations or agencies that influence the health of individuals
- Adopt and implement a **culture of equity**

- Create **structures** that support a culture of equity.
- Ensure **equitable access to healthcare**
- Ensure **high-quality care** within systems that continuously reduces disparities

Figure 4a. Domains of Health Equity Measurement



The Committee recognized the potential challenges to developing performance measures for the domains of collaboration and partnerships, culture of equity, and structures for equity. The Committee suggested that these domains could be assessed through a survey but also recognized that these domains could be more appropriate for internal quality improvement. The Committee recognized a need to minimize the burden of measurement and to ensure that public-reporting and value-based purchasing programs emphasize outcomes and other measures that are most valuable for public reporting and supporting consumer decision making. The Committee provided additional implementation guidance in step 4.

Subdomains of Health Equity Performance Measurement

The Committee also identified subdomains to describe the types of concepts and actions to measure within each domain (Figure 4b). These subdomains are intended to demonstrate more specific ways to advance the goals of each overarching domain. Many of the concepts reflect traditional means of performance measurement with a health equity lens. As such, existing performance measures can be modified or adapted to monitor the use of interventions for populations that have social risk factors. Other concepts represent a growing knowledge of the impact of social determinants of health on disparities. Many of these concepts will require the identification of new data sources and the development of new performance measures.

Figure 4b. Subdomains of Health Equity Performance Measurement

Domain	Subdomains	Example Concepts
Collaboration and Partnerships	Collaboration across health and nonhealth sectors	• Care addresses social determinants of health • Supporting social services needs between clinical visits • Support for early, high-quality education systems within disadvantaged communities through partnerships, research, and advocacy • Support for effective community-based interventions (family nurse partnership, early child intervention) • Leveraging the training and employment role of healthcare organizations (i.e., education, job training, jobs, and career pathways for underserved groups)
	Community and health system linkages	• Linking medical care with community services to connect patients to resources more effectively • Supporting adequately and equitably resourced public health systems and services • Use of community mapping to link clients to community-based social services • Community engagement and long-term partnerships and investments • Improved integration of medical, behavioral, oral, and other health services
	Build and sustain social capital and social inclusion	• Measure assessing number of completed referrals to family-based programs to encourage family communication, bonding, lifestyle improvements • Measure assessing number of completed referrals to school programs to encourage parent, teacher, student involvement • Measure assessing number of completed referrals to community-based programs in socially disadvantaged communities (e.g., gang rehabilitation, church-based health programs) • Involvement in neighborhood improvement programs (e.g., parks, social space, sidewalk improvements) • Involvement in neighborhood safety, personal safety programs • Involvement in financial literacy, retirement, homeownership programs • Outreach to marginalized communities (e.g., immigrants, undocumented, LGBTQ), communities living in fear of discrimination, deportation
	Promotion of public and private policies that advance equity	• Supporting industry standards of care that include and highlight equity and actionable approaches delivering high-value care and services • Supporting and implementing payment systems (at the state, community, institutional, and provider levels)

Domain	Subdomains	Example Concepts
		that explicitly prioritize and incentivize identification and reduction of disparities and achievement of equity • Supporting public programs that provide health insurance coverage to the uninsured (e.g., Medicaid, Children's Health Insurance Program, Medicare) and improve healthcare affordability for low-income persons
Culture of Equity	Equity is high priority	• Governance (e.g., membership, policies, mission, vision, etc.) • Leadership
	Safe and accessible environments for individuals from diverse backgrounds	• Physical safety (especially for disabled, sexual and gender minorities, individuals experiencing trauma and/or domestic violence, etc.) • Emotional safety where people feel safe in speaking up regarding difficult hot topics (e.g., racism microaggressisions, abusive power, stigma, etc.) • Cultural safety (e.g., attire, hair, language, nationality, religion etc.)

	Cultural competency	• Workforce diversity at all levels (i.e., among staff and leadership)
		• Training/continuing education of all providers and staff
		• Awareness of cumulative structural disadvantage, bias, and stigma and commitment to mitigation
		  ○ Structural racism and other disadvantages
		  ○ Intersectionality of multiple structural disadvantages (e.g., limited English proficiency and disability)
		  ○ Adverse childhood experiences/trauma-informed care
		• Cumulative allostatic load

	Advocacy for public and private policies that advance equity	• Supporting industry standards of care that include and highlight equity and actionable approaches to advancing equity and value i.e. less costly health care • Supporting and implementing payment systems that incentivize identification and reduction of disparities and achievement of equity • Supporting existing public insurance programs that provide health insurance coverage to the uninsured (e.g., Medicaid, Children's Health Insurance Program) and improve health care affordability for low-income persons

Domain	Subdomains	Example Concepts
	Systematic community needs assessments	• Identifying collective capabilities of communities to enhance assets that promote health and health equity • Public reporting on hospital community health needs assessment including actionable metrics for progress • Targeting interventions toward community-prioritized needs
	Policies and procedures that advance equity	• Optimal health literacy as an organizational/system commitment • Comprehensive language assistance and communications services for individuals with limited English proficiency and individuals with disabilities
	Transparency, public reporting, and accountability for efforts to advance equity	• Public reporting of quality performance at increasingly granular levels (e.g., health plan that reports on quality performance of its providers) • Reporting on progress related to other steps the organization has taken (e.g., other domains cited above) • Formalized processes to get comment from the public and other stakeholders in planning and in revising
Structure for Equity	Capacity and resources to advance equity	• Workforce has the knowledge, attitudes, skills, and resources to advance equity • Dedicated budget allocations to promote equity • Information Technology (IT) and data analytics capabilities
	Collection of data to monitor the outcomes of individuals with social risk factors	• Systematic identification of patients' social risk factors (e.g., implementing "Capturing Social and Behavioral Domains in Electronic Health Records" and/or use of "the Accountable Health Communities Screening Tool") • Systematic reporting and improvement in performance data stratified by social risk factors • Learning systems; doing quality improvement with an equity lens
	Population health management	• Integrated information systems and strategies to track key health outcomes and health disparities in communities (e.g., IOM/NAM metrics for health and healthcare progress: http://jamanetwork.com/journals/jama/fullarticle/2288464?JamaNetworkReader=True)
	Systematic community needs assessments	• Identifying collective capabilities of communities to enhance assets that promote health and health equity • Public reporting on hospital community health needs assessment including actionable metrics for progress • Targeting interventions toward community-prioritized needs

Domain	Subdomains	Example Concepts
	Policies and procedures that advance equity	• Optimal health literacy as an organizational/system commitment • Comprehensive language assistance and communications services for individuals with limited English proficiency and individuals with disabilities
	Transparency, public reporting, and accountability for efforts to advance equity	• Public reporting of quality performance at increasingly granular levels (e.g., health plan that reports on quality performance of its providers) • Reporting on progress related to other steps the organization has taken (e.g., other domains cited above) • Formalized processes to get comment from the public and other stakeholders in planning and in revising
Equitable Access to Care	Availability	• Assessment of access to quality care in a geographic service area • Availability and access to specialty care • Network adequacy, inclusion of essential community providers • Timely (same day appointments, time to next appointment, timely appointments with specialists, etc.) • "After-hours" access
	Accessibility	• Physical accessibility for individuals with disabilities • Geographic (no transportation barriers or transportation support) • Language accessibility including effective communication about the availability of interpreter services
	Affordability	• Fewer delays and less care including visits, tests, prescriptions, and specialty access forgone due to out-of-pocket costs • Ability of a patient to cover the cost of healthcare services and other necessities (housing, food, transportation, childcare, etc.)
	Convenience	• Distance from residence • Flexible appointment schedules • Accessibility to public transportation • Safety of surrounding environment
Equitable High-Quality Care	Person- and family-centeredness	• Measure and improve patient/individual, family, and caregiver experiences of care, including access and satisfaction and experience of discrimination • Communication and comprehension, especially for individuals with low health literacy, limited English

Domain	Subdomains	Example Concepts
		proficiency, or with physical and developmental disabilities or cognitive impairments • Informed and shared decision making • Support for self-care • Availability of patient advisors, advisory councils; patients on governing boards • Include patients on quality improvement, patient safety, and ethics teams

	Continuous improvements across clinical structure, process, and outcome performance measures stratified by social risk factors	• Including but not limited to measures that assess:
		  ○ Patient outcomes
		  ○ Patient-reported outcomes
		• Clinical process of care measures (e.g., mammography)
		• Clinical intermediate outcome measures (e.g., blood pressure control in hypertensive patients)
		• Improvement in key behavioral risk factors (e.g., smoking, diet, physical activity, psychological distress, and substance use)
		• Promotion of healthy and safe communities with environments that support healthy behavior
		• Improvement in population health (e.g., fewer avoidable hospitalizations, premature disability/deaths, and unintended pregnancies; improved well-being and health status)
		• Disparities-sensitive measures

	Use of effective interventions to reduce disparities in healthcare quality	Including but not limited to: • Team-based care • Case managers • Nurse-specific measures • Community health workers/navigators/*promotoras(es)* • Culturally tailored interventions • Self-management support • Telehealth • Patient-centered communication skills and cultural competency training

Current Measurement Landscape

The Committee used an environmental scan to assess the current landscape of measures that can be used to assess progress towards achieving the goals outlined within the domains of measurement. The scan included disparities-sensitive measures and health equity measures (i.e., linked to interventions that are known to reduce disparities in populations with social risk factors and/or aligned with the priority domains of measurement outlined in the Committee's measurement framework). NQF conducted the environmental scan by searching for measures that assess structures, processes, and

outcomes of care for the selected conditions and sorting them by the domains of health equity measurement. The environmental scan retrieved 886 performance measures. The majority of measures aligned with the *Equitable High-Quality Care* and *Equitable Access to Care* domains. Far fewer measures aligned with the *Collaboration and Partnerships* domain. NQF obtained input on the findings of the environmental scan from 19 key informants with clinical expertise and knowledge of disparities within each of the selected conditions. The full compendium of measures is posted to the NQF disparities project webpage. The Committee noted a need for the development of equity performance measures. Of the available measures, the Committee emphasized a need to focus on measures that are NQF-endorsed outcome measures.

Collaboration and Partnerships

A person's health is influenced by factors outside the healthcare system. Collaboration is necessary to address social determinants of health that physicians, hospitals, and other healthcare providers are not trained and licensed to address or do not have the resources to address under current payment models. Addressing social determinants requires partnering with organizations and agencies such as policymakers, communities/neighborhoods, social services, transportation, housing, education, employers, and payers. These collaborations themselves should be grounded in the principles of respect and fairness (e.g., equity in decision making, resources and information transparency). The Committee noted a particular role for payers and purchasers to support greater collaboration and partnerships to advance equity. Current payment models frequently only reimburse a healthcare provider for clinical services. While some organizations are working to address social determinants such as housing and food insecurity, this approach may not be feasible over time or scalable to a state or national level.

The environmental scan found very few measures that assess the extent to which healthcare organizations are collaborating with public health programs and other sectors outside of healthcare (e.g., transportation, housing, education, etc.). The subdomain*, community and health system linkages*, focuses on the integration between care settings as a way to reduce disparities. An example of a measure (table 1) that seeks to improve the integration of medical and behavioral health services is the *Assessment of Integrated Care: Total Score for the "Integrated Services and Patient and Family-Centeredness"* characteristics of the *Site Self Assessments (SSA) Evaluation Tool,* which is maintained in the AHRQ National Quality Measures Clearinghouse. The measure uses survey data collected from health professionals to assess the level of integration between primary care and mental/behavioral healthcare in a variety of care settings.

The subdomain, *collaboration across health and nonhealth sectors,* assesses how the healthcare system interacts with other sectors to improve healthy equity. One example of a potential area of collaboration is between healthcare and transportation systems. Lack of adequate transportation is a significant barrier to accessing care, especially for individuals in rural communities and for those with disabilities. The NQF-endorsed CAHPS survey includes items that assess the availability of transportation to medical appointments. Future measurement efforts should assess how the healthcare system engages the transportation system to increase the availability of transportation. The 2017 NCQA Patient-Centered Medical Home (PCMH) standards address a variety of criteria for integration between PCMH and the community. These standards can inform the development of measures that address collaboration and partnerships.

The subdomain, *build and sustain social capital and social inclusion*, include measures that assess the interaction between the healthcare system and communities. Few measures were found that assess the extent to which healthcare institutions work to build social capital and cohesion in communities. Assessing the level of interactions among these entities can be difficult given the variety of community-level settings. There is also little evidence to suggest which community entities are most important for the healthcare system to engage. The Committee discussed the importance of identifying community anchor institutions for partnerships (i.e., hospitals, universities, major employers, and other enduring institutions that play a role in communities and economies) and creating databases of community resources for providers.

This *Collaboration and Partnerships* domain has the largest gaps in measurement. Table 2 below outlines key gap areas in this domain. Key informants selected from NQF's clinical standing committees noted gaps in measures that addressed the social determinants of health, including education, employment, income, transportation, and housing, etc. These gaps in measurement may also be preceded by a gap in conclusive evidence regarding the use of collaborations to address health and healthcare disparities. As gaps in the integration of physical and mental health are addressed, SAMSHA's Four Quadrant Model can serve as a framework to promote alignment in the development of integrated measures.[18] The Four Quadrant Model describes subsets of the population based on behavioral health and physical health risk and suggests system elements that could be used to meet the needs of each subset of the population. Committee members recognized the potential challenges to developing measures in this domain, noting that it could be difficult to create benchmarks. The Committee recognized the need for quantification but cautioned that threshold levels may change as measures become standardized.

The environmental scan retrieved only nine measures of collaborations and partnerships. None of these measures addresses cancer; only one measure relates to each of diabetes/chronic kidney disease (CKD) and cardiovascular disease; and five measures apply to mental illness.

Table 1. Examples of Existing Collaboration and Partnership Measures

Subdomain	Measure Title	Measure Description	Measure Source
Community and health system linkages	Assessment of Integrated Care: Total Score for the "Integrated Services and Patient and Family-Centeredness" Characteristics on the Site Self Assessment (SSA) Evaluation Tool	This measure is used to assess the total score for the "Integrated Services and Patient and Family-Centeredness" characteristics on the Site Self Assessment (SSA) Evaluation Tool.	AHRQ National Quality Measures Clearinghouse

Table 2. Example Collaboration and Partnership Measure Concepts to Fill Gaps in Measurement

Subdomain	Measure Concept Description
Collaboration across health and nonhealth sectors	A measure that assesses the number of partnerships and active projects with nonhealth sector organizations (e.g., schools, transportation, environment, food).

Build and sustain social capital and social cohesion	A measure or measures that assess the following:
	• Connection to community programs (percent of eligible patients who had a completed referral):
	  ○ Use of family-based programs to encourage family communication, bonding, lifestyle improvements
	  ○ Use of school programs to encourage parent, teacher, student involvement
	  ○ Use of community-based programs in socially disadvantaged communities (e.g., gang rehabilitation, faith-based health programs)
	• Involvement in neighborhood improvement programs (e.g., parks, social space, sidewalk improvements)
	• Involvement in neighborhood safety, personal safety programs Involvement in financial literacy, retirement, homeownership programs
	• Partnerships between healthcare systems and schools
	• Outreach to marginalized communities (e.g., immigrants, undocumented, LGBTQ), communities living in fear of discrimination, deportation

Community and health system linkages	A measure or measures that assess the following: • Availability of physical/community space at healthcare sites for gatherings of community members to discuss health topics (e.g., support groups) • Financial investment in community organizations, projects • Community outreach gatherings, public health screenings in community

Table 3. Partnership and Collaboration Subdomain Measure Availability

Subdomains	Available measures?
Collaboration across health and nonhealth sectors	Yes
Community and health system linkages	Yes
Build and sustain social capital and social inclusion	No
Promotion of public and private policies that advance equity	No

Culture of Equity

A culture of equity recognizes and prioritizes the elimination of disparities through genuine respect, fairness, cultural competency, and the creation of environments where all individuals—particularly

those from diverse and/or stigmatized backgrounds—feel safe in addressing difficult topics such as racism and advocating for public and private policies that advance equity. The Committee noted that a culture of equity creates emotional safety, such that all persons are respected, all voices are heard, and traditional hierarchies are flattened. This safe environment creates the spaces to discuss difficult and painful topics and creates a foundational culture to address daily behaviors that can undermine policies that promote equity.

Surveys can help in assessing an emotionally safe culture.[19,20] There is a scale to measure moral courage in speaking up which helps create a culture.[21] Emotional safety is a starting point that allows for sharing of experiences of members of disparity groups and uncovering blind spots related to social risk factors. A culture of equity is supported by inclusion of members of disparity groups in key decision making groups (e.g., boards of directors, management, quality improvement teams, etc.). Inclusion in decision making helps ensure that the voices of these groups are heard at all levels. Furthermore, ensuring this type of diversity within decision making groups helps change the conversation. It is one thing to talk about wheel chair accessibility in the abstract, it is another to discuss this with a member who is sitting in a wheel chair.

The environmental scan identified many measures that assess the concepts within subdomains of the *Culture of Equity* domain, including several NQF-endorsed measures. The majority of measures assess concepts related to *cultural competency*. The Committee adopted a modified definition of cultural competency for this work: the ability of clinicians/organizations to appropriately meet the health and healthcare needs of individuals of diverse backgrounds. The Committee emphasized the importance of measuring bias at both the institutional and provider levels. Examples include, but are not limited to, cumulative structural disadvantage, racism, bias, and stigma. Improving cultural competency is a key intervention that addresses disparities across all conditions.

There are several NQF-endorsed experience-of-care measures that assess the environment and the manner in which care is received at the provider level. For example, NQF #0008 *Experience of Care and Health Outcomes (ECHO) Survey* (behavioral health, managed care versions) and NQF #0517 *CAHPS® Home Health Care Survey* (experience with care) both assess a patient's experiences with care. These measures can be stratified to ensure that individuals with social risk factors are receiving care in environments that are physically, emotionally, and culturally safe. In addition, the *Communication Climate Assessment Toolkit (C-CAT),* designed for providers, staff, and patients, assesses how well providers help patients cope with stigma.

The Committee also noted the importance of ensuring that equity is a priority at all levels of the healthcare system. For instance, several Committee members agreed that organizations should adopt the national Culturally and Linguistically Appropriate Services (CLAS) Standards[22] developed and promulgated by HHS. There are NQF-endorsed measures that can be used to assess the level to which organizations are providing care that complies with CLAS standards. These measures derive from the Communication Climate Assessment Toolkit (C-CAT) and assess the level of patient-centered communication, communication gaps, workforce training, commitment of leadership, and health literacy, among other subdomains relevant to ensure a culture of equity. The Committee also discussed the CAHPS Culture Competence Item Set*,* which covers topics such as patient-provider communication;

experiences of discrimination due to race/ethnicity, insurance, or language; experiences leading to trust or distrust; and linguistic competency. The item set is not currently used.

Overall, the scan retrieved 40 *Culture of Equity* measures: 25 specifically for mental health, one for chronic kidney disease, zero for cardiovascular disease, zero for cancer, four for infant mortality and low birthweight, and eight that are cut across conditions. Table 4 includes some key illustrative examples of current measures that address this domain.

Despite the availability of numerous measures and assessment tools, there remain several gaps, highlighted in table 5. The Committee recommended the development of a measure that assesses the extent to which resources are allocated to activities that advance health equity. In addition, assessments of the culture of organizations should be routinely stratified by respondent demographic characteristics. There were no measures identified that assess the level to which stakeholders are advocating for public and private policies to advance equity, which represents a gap area. Again, the Committee noted challenges to measure development in this area, including developing measures that have meaningful impact and do not become "check-box" measures.

Table 4. Examples of Culture of Equity Measures

Subdomain	Measure Title	Measure Description	Measure Source
Cultural competency	Language services measure derived from language services domain of the C-CAT	0-100 measure of language services related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit (C-CAT)	NQF Quality Positioning System
Cultural competency	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CAHPS Clinician/Group Survey.	NQF Quality Positioning System

Table 5. Examples of Culture of Equity Measure Concepts to Fill Gaps in Measurement

Subdomain	Measure Description
Equity is high priority	A measure that assesses whether health/healthcare equity is explicitly mentioned in institution's mission statement and/or strategic plan.

Subdomain	Measure Description
Equity is high priority	A measure that assesses whether an institution has released statements, comment letters, etc. that explicitly discuss the impact of local/state/federal actions on community health and health inequities.
Cultural Competency	A measure that assesses the extent to which underrepresented groups are present at all levels of the organization (e.g., board, C-suite, support staff).

Table 6. Culture of Equity Subdomain Measure Availability

Subdomains	Available measures?
Equity is high priority	Yes
Safe and accessible environments for individuals from diverse backgrounds	Yes
Cultural competency	Yes
Advocacy for public and private policies that advance equity	No
Systematic community needs assessments	No
Policies and procedures that advance equity	No
Transparency, public reporting, and accountability for efforts to advance equity	No

Structure for Equity

The Committee recognized a need to create structures that support a culture of equity. These structures include laws (including statutes and regulations), policies, and procedures that operationalize the culture of equity. These structures are necessary to promote health equity, commit adequate resources for the reduction of disparities, and enact systematic collection of data to monitor and provide transparency and accountability for the outcomes of individuals with social risk factors. These structures also include continuous learning systems that routinely assess and objectively measure the needs of individuals with social risk factors, develop culturally tailored interventions to reduce disparities, evaluate their impact, and modify them accordingly. Structures are likely to achieve the greatest impact on equity when leadership and an equitable culture support them. The Committee noted the importance of leading by example and the importance of allocating specific resources to support the work of equity. Structures should create sufficient incentives, financial or otherwise, to move towards equitable health and healthcare. The Committee recognized the need for substantial and systemic funding to enable all of the domains of healthcare equity to be effectively implemented, evaluated, assessed, and monitored.

The environmental scan identified several measures that can assess the concepts within subdomains of the *Structure for Equity* domain. The majority of measures align with the need to assess population health and monitor the outcomes of individuals with social risk factors. The Committee noted the primary importance of collecting data on the health and healthcare of individuals with social risk factors,

as the assessment of improvement cannot happen without access to data. There are many known gaps in such data, specifically among health plans. The *NAM Report Accounting for Social Risk Factors in Medicare Payment* found significant gaps in data among public and private health insurers on income, whether beneficiaries lived alone or had social support, sexual orientation, gender identity, and features of the places they live.[23] The Committee highlighted prior recommendations and noted current requirements and incentives for healthcare organizations to build these data collection fields into their electronic health records systems.

Few measures assess data collection efforts to improve health equity. The environmental scan retrieved one measure, NQF #1881 (not endorsed), derived from the C-CAT that captures whether an organization uses standardized qualitative and quantitative collection methods and uniform coding systems to gather valid and reliable information for understanding the demographics and communication needs of the population served. The measure represents an example for measure developers who seek to fill gaps in measurement of data collection. The Office of National Coordinator for Health IT Certification Program requires capture of data regarding race and ethnicity, sexual orientation, gender identity, and social, psychological, and behavioral data that could be used to support measurement in the future.[24]

The Committee also stressed the need for better population health management for individuals with social risk factors. The environmental scan identified many measures that can be used for surveillance to improve strategies for population health management and assess community needs. Examples include measures that assess concepts such as smoking prevalence, cancer screening, infant mortality, and insurance coverage among individuals with social risk factors. NQF #1919 *Cultural Competency Implementation Measure* addresses the ideas of transparency, public reporting, and accountability for efforts to advance equity or the capacity and resources to promote equity. While not a performance measure, the HHS Office of Minority Health CLAS Standard's 15 recommendations specify that institutions "Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public"[25] and could serve as the basis of a future measure.

Overall, the scan identified 48 *Structure of Equity* measures: one for mental health, 4 for chronic kidney disease, 7 for cardiovascular disease, five for cancer, 28 for infant mortality and low birthweight, and one that cuts across condition areas. The majority of the measures found relate to clinical data collection in an effort to reduce disparities, and based on key informant interviews, the most important behaviors to monitor for disparities include tobacco use, alcohol use, opioid abuse, depression, and obesity screening, treatment, and counseling. Table 7 highlights key example measures, while table 8 includes potential gaps in measurement.

Table 7. Examples of Structure of Equity Measures

Subdomain	Measure Title	Measure Description	Measure Source
Collection of data to monitor the outcomes of individuals with social risk factors	L1A: Screening for Preferred Spoken Language for Health Care	This measure is used to assess the percent of patient visits and admissions where preferred spoken language	NQF Quality Positioning System

Subdomain	Measure Title	Measure Description	Measure Source
		for healthcare is screened and recorded. Access to and availability of patient language preference is critical for providers in planning care. This measure provides information on the extent to which patients are asked about the language they prefer to receive care in and the extent to which this information is recorded.	
Population health management	Adult Current Smoking Prevalence	Percentage of adult (age 18 and older) U.S. population that currently smokes. The measure is stratified by geography.	NQF Quality Positioning System

Table 8. Examples of Structure of Equity Measure Concepts to Fill Gaps in Measurement

Subdomain	Measure Description
Collection of data to monitor the outcomes of individuals with social risk factors	A measure that assesses the number of individuals enrolled in a health plan during a measurement year for one or more months that has completed a survey with key questions such as income, home ownership, education, race/ethnicity, household size. A measure assessing use of the ICD-10 Z codes for factors influencing health status.
Population health management	A set of measures that assess hospitalizations and readmissions, emergency room use, frequency and intensity of office visits, medication adherence and persistence, emergence of condition-related adverse events, and existence of co-morbidities and other diagnoses by social risk factors. Outcomes should be stratified by key social and behavioral risk factors, such as mental health conditions, alcohol/drug/substance abuse, and other risk factors.

Table 9. Structure for Equity Subdomain Measure Availability

Subdomains	Available measures?
Capacity and resources to promote equity	Yes
Collection of data to monitor the outcomes of individuals with social risk factors	Yes
Population health management	Yes
Systematic community needs assessments	No
Policies and procedures that promote equity	No
Transparency, public reporting, and accountability for efforts to advance equity	No

Equitable Access to Care

Under the current system, access is not equal for all individuals. The Committee emphasized the need to ensure access to care to advance health equity. Equitable access means that individuals with social risk factors can easily get care. It also means care is affordable, convenient, and able to meet the needs of individuals with social risk factors. This requires systematic examination of organizational policies at multiple levels related to patient out-of-pocket costs (at each juncture), and physical and communicational accessibility. Mechanisms should be in place to elicit meaningful input from patients from different groups regarding equitable access.

Further, to ensure equitable access to healthcare, providers should be available, accessible, and acceptable to deliver high-quality care to patients and communities. Healthcare workers must be (1) equitably distributed (available in all communities, including where populations of greater social risk reside), (2) accessible to populations (available to provide care within a reasonable time period that is convenient for the population (i.e., not waiting 3 months for an appointment and open for evening hours for people who cannot miss work due to economic constraints), and (3) acceptable to the population (possess the required competency—including knowledge of health disparities and social risk—and are empowered and motivated to provide quality care that is socio-culturally appropriate and acceptable).[26]

The Committee also recognized the need to address financial access.[27] The Committee noted a need to continue to improve access to health insurance and ensure that premiums, deductibles, and co-pays do not create barriers to care.

The environmental scan found many measures that assess access to care and can be stratified to assess equitable access for individuals with social risk factors. However, there were notable differences in the availability of access measures by condition as well as by subdomain. The environmental scan did not identify any measures of affordability, and very few that specifically focused on assessing accessibility or convenience. However, the Health Professional Shortage Area and Medically Underserved Area designations of the Health Resources and Services Administration (HRSA) and CMS's definition of network adequacy and essential community providers could serve as starting points for future performance measures. The Healthy People 2020 goals also include important targets related to access

to care. Measures should be identified or created to assess U.S. progress toward meeting these goals. Additionally, the CAHPS surveys include items of convenience, timeliness, and accessibility, which could be stratified to assess disparities.

Equitable access starts with unconstrained access to primary care. Robust systems of primary care are associated with improved population health and reduced disparities.[28] Primary care plays a unique role in promoting equity through its comprehensive and biopsychosocial focus, longitudinal personal relationships, and its capacity to align intensity of management with patient needs. Primary care capacity to care for people (rather than diseases) across medical, behavioral, and psychosocial dimensions while aligning resources and services to these needs is vital to improving health equity. In addition, the ability to afford healthcare is closely tied to insurance status, so general measures of insurance status may be able to close disparities related to affordability. However, rapid emergence of high deductible health plans risks creating new cost-related disparities related to affordability even among those persons with commercial insurance.

Equitable access is critical for mental health and substance use disorder services. Mental health services are significantly under-used by many racial and ethnic minority group members. Despite Congressional passage of the Mental Health Parity and Addiction Equity Act (MHPAEA), significant access barriers to these services remain, including those related to community availability, costs, and cultural and linguistic appropriateness. Accelerating integration of primary care with behavioral services offers promise for improving access to these services among disparity groups.

Convenience may be less condition-specific, as it can also be influenced by insurance status, the general availability of primary care providers for preventive care, and the geographic availability and insurance coverage for specialists, particularly for rural and low-income populations. General measures of access to primary care or specialist providers, including measures of geographic access and timeliness of care, or measures around innovative solutions such as telehealth, could be used to assess equitable access at the organization level. Language remains an important barrier for many groups with limited English language proficiency, e.g., Latino and Asian Americans, and for the American Sign Language (ASL)/deaf population. While several measures assess whether providers or organizations are culturally competent, fewer measures assess the level to which patients have access to culturally competent care (i.e., accessibility). Convenience also includes physical access issues for people with disabilities.

Continuity of care with the same primary care provider (PCP) is an important under measured component of access to care. Having a personal, longitudinal relationship between a PCP and patient is particularly important to marginalized, traumatized groups who are at high risk for healthcare disparities. Unfortunately, many individuals with social risk factors are at higher risk for discontinuity in PCP (or mental health) relationships due to receiving care in facilities where turnover is high (e.g., community health centers, residency clinics, student operated clinics, etc.). Therefore, better measurement of continuity of primary care will be essential to reducing disparities.

The environmental scan identified only three access-to-care measures related to cancer, but 17 access measures that could influence infant mortality and low birthweight. There were six measures of access for mental illness, eight for diabetes and chronic kidney disease, six for cardiovascular disease, and zero

cutting across condition areas. The bulk of the access measures focus on availability of providers and/or resources (which can also influence accessibility and convenience).

Table 10. Examples of Equitable Access to Care Measures

Subdomain	Measure Title	Measure Description	Measure Source
Convenience	Patient-Centered Medical Home Patients' Experiences	Percentage of parents or guardians who reported how often they were able to get the care their child needed from their child's provider's office during evenings, weekends, or holidays	Health Information Warehouse
Availability	Medicare Beneficiaries' Ambulatory Care Sensitive Condition (ACSC) Hospitalizations Hospitalization Rate per 1,000 Medicare Beneficiaries	The number of discharges for ACSC in a county divided by the number of Medicare beneficiaries in a county multiplied by 1,000. The primary independent variable of interest is the number of primary care physicians.	Yu-Hsiu Lin, PhD et al.[29]
Accessibility	HCBS CAHPS Measure (5 of 19): Transportation to Medical Appointments	Transportation to medical appointments: Top-box score composed of three survey items	AHRQ National Quality Measures Clearinghouse

Table 11. Examples of Equitable Access Measure Concepts to Fill Gaps in Measurement

Subdomain	Measure Description
Availability	A measure that assesses the number of primary care visit slots held for same-day appointments or drop-in access. A measure that assess the number of days to get an appointment (could build on items in the California Health Interview Survey)
Accessibility	A measure that assesses the total number of outpatient or clinic practice locations (weighted by visit volume) within one block of a public transportation stop.

Subdomain	Measure Description
Affordability	A measure that assesses the number of services (weighted by dollar value) billed on the basis of a sliding scale linked to patient income. A patient-reported measure that assesses the level of patients' satisfaction with their healthcare costs. CMS cost-related medication nonadherence scale
Convenience	A measure that assesses the number of appointments with wait times of 15 minutes or less, as reported by patients or patient caregivers.

Table 12. Equitable Access to Care Subdomain Measure Availability

Subdomains	Available measures?
Availability	Yes
Accessibility	Yes
Affordability	Yes
Convenience	Yes

Equitable High-Quality Care

The Committee emphasized the need to ensure high-quality care within systems that continuously reduce disparities. Performance measures should be routinely stratified to identify disparities in care. In addition, performance measures should be used to create accountability for reducing, and ultimately eliminating, disparities through effective interventions. The Committee noted a goal of ensuring that everyone receives the highest quality care by routinely monitoring care and outcomes for groups at greatest risk for suboptimal care. One example where this has been done successfully is the use of measures stratified by race by the Oregon Medicaid program.

The Committee developed a diagram to show how these domains work together to promote health equity (Figure 4a). The 'means' to achieving health equity require improving collaboration and partnerships which complements fostering a culture of equity and building the structure for equity. Equitable high-quality care and equitable access to care are the primary 'outcomes'. Progress can be made independently within each domain, but achievement of goals in all domains is necessary to reach the ultimate goal of health equity.

Measures that address quality of care made up the overwhelming majority of measures found during the environmental scan. These measures are predominantly clinical process and outcome measures and relate most closely to the subdomain of *continuous improvements across clinical structure, process, and outcome measures.* Far fewer measures were found that specifically assess the concepts outlined in the *effective interventions to reduce healthcare disparities in quality* subdomain. The majority of measures assess the aspects of shared decision making or patient education. The Committee emphasized the importance of stratifying outcome and process measures currently in use to identify disparities.

Other potential measures could be developed to address self-care, effective patient-provider communication, person-centered care, family engagement, etc. One example of a measure that addresses this subdomain is NQF #0519 *Diabetic Foot Care and Patient Education Implemented*. This process measure uses clinical data to determine the "percentage of home health episodes of care in which diabetic foot care and patient/caregiver education were included in the physician-ordered plan of care and implemented for diabetic patients since the previous OASIS assessment." The Committee also recommended the development of measures that assess the percentage of patients using a patient portal, medication errors (adverse events or other safety concerns), and nonadherence.

Measures and measure concepts that address *Equitable High-Quality Care* face fewer data collection challenges than the other domains discussed in this report. The clinical nature of quality-of-care measures calls for more traditional data sources including claims data, making data collection more feasible. The current lack of social risk factor data collected, including race, language, disability, etc., poses significant data challenges to the ability of these measures to account for disparities. Further research and measure development are needed for measures that assess whether stakeholders are employing interventions that are known to reduce disparities.

The environmental scan for measures found 756 total measures of high-quality care: 158 measures of high-quality care related to cancer, 214 related to cardiovascular disease, 154 related to diabetes/CKD, 129 related to infant mortality and low birthweight, 90 related to mental illness, and nine cutting across condition areas. The majority of these measures related to the first subdomain, continuous improvements across clinical structure, process, and outcome performance measures stratified by social risk factors.

Table 13. Examples of Equitable High-Quality Care Measures

Subdomain	Measure Title	Measure Description	Measure Source
Evidence- based interventions to reduce disparities	Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care	Percentage of short-term home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems	CMS Measure Inventory
Evidence- based interventions to reduce disparities	Depression care: percentage of patients 18 years of age or older with major depression or dysthymia who demonstrated a response to treatment	This measure is used to assess the percentage of patients 18 years of age or older with major depression or dysthymia who demonstrated a response to treatment 12	AHRQ National Quality Measures Clearinghouse

Subdomain	Measure Title	Measure Description	Measure Source
	12 months (+/- 30 days) after an index visit.	months (+/- 30 days) after an index visit. This measure applies to both patients with newly diagnosed and existing depression.	

Table 14. Examples of Equitable High-Quality Care Measure Concepts to Fill Gaps in Measurement

Subdomain	Measure Description
Person- and family-centeredness	A measure that assesses the number of adults (>18 years of age) with a documented shared decision making discussion with care provider (useful if had claim encounter code that could be submitted). Questions from the CAHPS survey could potentially be used to fill this gap.
Social risk factors addressed in outcome performance measures	A measure that assesses the number of patients (>18 years of age) with documented social risk factor assessment in medical record
Effective healthcare interventions to reduce disparities	A measure that assesses the number of patients with community referral, case management referral, consultation for social work/social services in both the pediatric and adult population.

Table 15. Equitable High-Quality Care Subdomain Measure Availability

Subdomains	Available measures?
Person- and family-centeredness	Yes
Continuous improvements across clinical structure, process, and outcome performance measures stratified by social risk factors	Yes
Use of effective interventions to reduce disparities in healthcare quality	Yes

Step 4: Incentivize the Reduction of Health Disparities and Achievement of Health Equity

The final step of the measurement framework emphasizes the need to incentivize and support the reduction of health disparities and the achievement of health equity. Leveraging quality measurement

and capitalizing on new delivery and payment models will help to incentivize the elimination of disparities. Performance measurement offers an opportunity to incentivize, support, and assess the reduction of disparities.

The Committee recognized that performance measurement is increasingly used for accountability purposes and this shift to payment and reporting offers opportunities to advance equity in multiple ways. First, the shift to value-based purchasing represents a chance to reward providers for reducing disparities or for the use of effective interventions to reduce disparities. Next, the shift to global payment, capitated payment, and bundled payment could help support the infrastructure for interventions that reduce disparities. Additionally, social and population health measures can be used to ensure appropriate resource allocation to counteract the causes of social risk. Finally, reporting the results of equity measures and stratified results of disparities-sensitive measures can promote transparency and help identify and address disparities.

As part of the roadmap, the Committee developed strategies for using measurement and its associated policy levers to reduce disparities. When making these recommendations, the Committee sought to build on the work of ASPE[30] and NAM[31] while providing concrete guidance on operationalizing health equity measurement. Ultimately, the Committee developed four strategies for creating health equity through measurement:

1. Implement health equity measures
2. Incentivize health equity through payment reform
3. Support organizations that disproportionately serve individuals with social risk factors
4. Develop and implement demonstration projects with rigorous evaluation partnering with equity researchers

Implementation Strategy 1: Implement Health Equity Measures

Recommendation 1: Invest in the collection of social risk factor data.

Data are the bedrock of all measurement activities. As such, stakeholders must invest in the necessary infrastructure to support data collection. There needs to be standard collection of data related to social risks like housing instability, food insecurity, gender identity, sexual orientation, language, continuity of insurance coverage, etc. The Committee emphasized the need to collect these data through electronic health records, whenever possible. Many performance measures rely on administrative claims data and often do not capture data about individuals who are not continuously enrolled in a health plan. One potential strategy to address this is greater use of the ICD-10 codes for factors addressing health status and contact with health services (Z codes found in chapter 21[32]). These codes capture social risk factors such as education, socioeconomic status, employment, social environment, upbringing, and family circumstances.

In addition to patient-level data, addressing disparities will require collecting neighborhood-level data on social risk factors to better understand the characteristics of the places in which people live, work, and play. Healthcare organizations must work with public health departments and other institutions in the community to collect these data. In addition to collecting individual patient-level data, organizations

that are accountable for populations should collect community-level data that inform health needs. For example, FQHCs conduct regular community health needs assessments, and nonprofit hospitals are required to conduct community health assessments. These data should be publicly reported, shared, and used to inform publicly reported action plans to improve health equity.

Recommendation 2: Use and prioritize stratified health equity outcome measures.

Stakeholders should first conduct a needs assessment to identify the extent to which they are meeting the goals outlined in the measurement framework. The domains should be considered as a whole rather than aiming to make progress in only one area. Stakeholders may find themselves at varying stages in achieving the goals outlined in the framework, but progress in all domains is necessary to achieve equity. The Committee acknowledged that the use of outcome measures often depends on the state of the evidence. In some cases, process and structure measures may be used in place of outcome measures where reliable and valid outcome measures do not yet exist. However, relevant stakeholders should identify and develop outcome measures that can assess the extent to which stakeholders are employing effective interventions.

The Committee recommended reducing the number of measures that do not promote equity to address measurement burden. In addition, stakeholders must actively identify and decommission measures that have reached ceiling levels of performance and where there are insignificant gaps in performance. Lastly, health equity performance measures must also be aligned across programs to reduce data collection burden, maximize the influence of the measures, and allow for peer group comparisons. The Committee noted one potential example from the FY 2018 Inpatient Prospective Payment System (IPPS) Proposed Rule. In this rule, CMS sought comments on confidential reporting and future public reporting of two pneumonia measures (NQF #0506 pneumonia readmissions and NQF #0468 pneumonia mortality) currently used in the Hospital Inpatient Quality Reporting (IQR) program stratified by dual eligibility. The goal of this stratification would be to demonstrate differences in outcome rates among patient groups within a hospital and to allow for comparison of potential disparities across hospitals.

Recommendation 3: Some domains of measurement are more appropriate for internal quality improvement and others for accountability.

Some domains in the measurement framework are more suitable for accountability and others for quality improvement. The majority of measures that fall within the domains of *Culture for Equity*, *Structure for Equity*, and *Collaboration and Partnerships* should be used primarily for quality improvement initiatives and are less appropriate for accountability. However, the Committee strongly endorsed reporting progress towards meeting the goals outlined each domain to ensure transparency. Each accountable entity will have various capacities to implement the goals outlined in the structure, culture, and collaboration and partnership domains and should be allowed the flexibility to customize its approach to meeting these goals based on their unique needs. Measures that are aligned with the domains of *Equitable Access to Care* and *Equitable High-Quality Care* may be more suitable for accountability. Public reporting, transparency, and accountability are important tools for advancing health equity. Thus, these health equity measures should be implemented in existing public reporting and accountability programs.

Implementation Strategy 2: Incentivize health equity through payment reform

Recommendation 1: Invest in preventive and primary care for patients with social risk factors.

People with low health literacy, limited eHealth literacy, limited access to social networks for reliable information, or who are challenged with navigating a fragmented healthcare system often rely on a continuity with a trusted primary care physician. Equitable access starts with unconstrained access to primary care. Robust systems of primary care are associated with improved population health and reduced disparities.[33] Primary care plays a unique role in advancing equity through its comprehensive and biopsychosocial focus, longitudinal personal relationships, and its capacity to align intensity of management with patient needs. Primary care's capacity to care for people (rather than diseases) across medical, behavioral, and psychosocial dimensions while providing resources and services to align with these needs is vital to improving health equity. This requires minimizing key access barriers to primary care related to cost, location, and physical and linguistic accessibility.

Recommendation 2: Directly adjust payment for social risk factors.

Public and private payers could take steps to achieve health equity by adjusting payments to providers for social risk factors. The fundamental concept is that social risk factors are like clinical risk factors in the sense that they require more time and effort on the part of providers in specific encounters to achieve the same results. If an office visit is more complex (and billed and paid at a higher level) because of clinical complexity in a patient, the same concept could extend to the incorporation of social risk factors and "social complexity" as a payment concept.

As one recent example of this concept being implemented, CMS is going to enhance payments to Medicare Advantage plans for patients who are dual eligible, based on recent data analyses showing that the current model underpays plans for the costs of caring for those patients.

Potential strategies for implementing this recommendation might include:

- If placement at the time of hospital discharge for a homeless patient or a patient with no social support at home takes two days longer, on average, then placement for a patient with a good, supportive home situation, then a diagnosis-related group (DRG) payment could be adjusted upward on the basis of the homelessness or lack of support factor to take into account the inherent higher cost (longer length of stay and more social work and discharge planning time). To be budget-neutral, a corresponding adjustment in the other direction would be required for patients without social risk factors whose lengths of stay are shorter than average and who require less staff time during that stay.
- Current procedural terminology codes (CPT) codes for evaluation and management (E&M) visits currently include five levels of complexity, with criteria for billing at each level linked primarily to the clinical complexity of the patient's presentation and the content of the visit. Social complexity factors could be added to the list of criteria for billing higher-level visits, so that if, for example, it takes 30 minutes longer to explain a new drug regimen to a low-literacy, or low-English-proficiency patient, then the visit can be billed at a higher level to reflect that "social complexity". Again, to keep aggregate program spending budget-neutral, some corresponding payment reduction would have to be found.

- If empirical data show that aggregate episode costs (for example, 90-day episode costs for patients undergoing hip replacement surgery) are higher for patients with defined social risk factors, then payments in bundled episode payment models could be adjusted to take those higher costs into account. For example, if a patient with no stable housing or no social support has to spend time in a residential post-acute care (PAC) facility unlike a clinically similar patient with good housing and good social support who could be safely discharged home, the added costs of that PAC part of the episode could be included in an adjusted episode bundle payment. And again, to keep program spending budget-neutral, a corresponding adjustment in the opposite direction would have to be made to reflect the lower episode costs of patients with no social risk factors.

Recommendation 3: Link health equity measures to accreditation programs.

Integrating health equity measures into accreditation programs can increase accountability for promoting health equity and reducing disparities. These measures can be linked to quality improvement-related equity building activities. The Committee noted that organizations like the National Committee for Quality Assurance (NCQA) and URAC have already aligned with this strategy. For example, NCQA has incorporated health equity in its patient-centered medical home recognition program, and URAC promotes compliance with the Mental Health Parity and Addiction Equity Act, by reviewing the mental health or substance abuse disorder benefits provided by the health plans it accredits.

Recommendation 4: Support outpatient services with additional payment for patients with social risk factors.

Some purchasers are considering increasing payments for hospital services based on social risk factors. For example, CMS is considering adjusting payments for patients who are dually eligible for the Hospital IQR and Hospital-Acquired Condition Reduction Program (HACRP) and the Hospital Hospital-Value-Based Purchasing Program (VBP).[34] In the same vein, health plans should provide additional payments for outpatient services. In many cases, outpatient care represents an opportunity to address social determinants of health upstream and helps a patient to avoid disruptive and costly inpatient care.

Recommendation 5: *Redesign payment models to support health equity.*

Payment models designed to promote health equity have the potential to have a large impact on reducing disparities. The Committee recommended multiple payment strategies. For example, health plans can provide upfront payments to fund infrastructure for achieving equity and addressing the social determinants of health. Upfront payments can include advanced payments for providers with a demonstrated need (i.e., serve patients with social risk factors and need resources to build structures to support equity) and global payments (annual or month-to-month) specifically for pursuing the goals outlined in the domains of *Collaboration and Partnerships*, *Culture for Equity*, and *Structure for Equity*. Health plans can implement pay-for-performance payment models that reward providers for reducing disparities in quality and access to care. These types of rewards can be allocated based on improvement over time, an absolute threshold, progress in reducing disparities, or combinations of these approaches. For example, the Medicare Advanced Payment Initiative provided prospective payments to assist organizations with demonstrated need in establishing accountable care organizations (ACOs). A similar

approach could be taken for establishing or incorporating health equity strategies into new or existing programs. The Committee noted that purchasers could use mixed model approaches, combining payment models based on their specific goals (e.g., upfront payments and pay-for-performance to reduce disparities). Payment models can also be phased, using pay-for-reporting, then pay-for-performance incentives.

Implementation Strategy 3: Support organizations that disproportionately serve individuals with social risk factors

Recommendation 1: Ensure organizations disproportionately serving individuals with social risk can compete in value-based purchasing programs.

Recent legislation such as the Patient Protection and Affordable Care Act, the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act), and the Medicare Access and CHIP Reauthorization Act (MACRA) has mandated the increased use of value-based purchasing. HHS has set a goal of tying 90 percent of Medicare fee-for-service payments to value-based purchasing by 2018.[35] Value-based purchasing offers an opportunity to incentivize improvements in quality by tying a provider's payment to results on performance measures.

The Committee recognized that clinicians and providers disproportionately serving individuals with social risk factors can provide high-quality care. However, the growing evidence that social risk can affect a person's health outcomes has raised questions about how to ensure that organizations serving those with social risk are not unfairly penalized. Moreover, safety net organizations with a payer mix with lower reimbursement rates may have less infrastructure for improving the quality of care. Protecting safety net and other organizations disproportionately serving individuals with social risk factors could help to ensure that access to care is not reduced. At the same time, the Committee reiterated the need to ensure that at-risk populations have access to high-quality care. The Committee noted a need for ensuring that value-based purchasing promotes improvements, transparency, and fairness.

The Committee proposed ways to improve the fairness of value-based purchasing programs. First, the Committee noted that a need to risk adjust for social risk factors may exist when appropriate as well as stratify the performance score for social risk factors to ensure transparency and drive improvement. Secondly, the Committee suggested using peer-group comparisons to ensure safety net organizations are fairly compared. The Committee added a caveat that it may be necessary to risk adjust within the peer comparison groups to ensure fairness. Thirdly, the Committee noted the need to prospectively monitor the financial impact of value-based purchasing on organizations caring for individuals with social risk factors. Finally, the Committee recognized that some safety net providers such as rural hospitals and critical access hospitals are often not included in value-based purchasing programs that offer incentive payments. The Committee suggested ensuring that rural and safety net providers have the opportunity to participate in accountable care organizations and earn shared savings by ensuring there are no incentives to avoid adding them to the ACO. The Committee recommended that ACO programs, such as the Medicare Shared Savings Program (MSSP) ACO, commercial ACOs, and Medicaid ACOs, take social risk into account so that safety net providers are not excluded or unfairly penalized and have the opportunity to share in the potential improvements and savings. The Committee also

noted that FQHCs and Rural Health Clinics currently are not eligible to apply to participate in the Comprehensive Primary Care Plus (CPC+) program, and this denies these safety net providers the opportunity to receive the incentives within these innovation efforts. Finally, the Committee noted that healthcare within jails, prisons, and detention centers typically falls outside of mandatory accreditation and incentive programs designed to improve care quality and community coordination. Potential steps to address marginalization of the correctional care from the rest of healthcare includes development of new quality measures that assess care within these facilities.

Examples might include measures for timely exchange of information on entry and release, pre-release care coordination, and 30-day post-release events (e.g., overdose, ED visits, hospitalizations).

Recommendation 2: Consider additional payment for organizational factors that fall outside of the control of safety net organizations and other providers serving individuals with social risk factors.

The Committee recognized that addressing disparities can require significant resources and infrastructure. As noted in the second interim report, addressing disparities can require providing interpreter services, addressing food shortages and deserts, addressing lack of access to specialty care and pharmacies, and helping patients overcome issues like childcare and transportation. These services can help patients achieve better outcomes and improve their access to care, but they are often not reimbursed under traditional payment models. The Committee also recognized that these organizations may not have the resources to develop this infrastructure. The Committee suggested that additional payments could assist these facilities in developing the infrastructure to provide high-quality care for people with social risk factors. One potential short-term strategy would be to allow nonprofit hospitals to formally report expenditures to address these services as a community benefit on their Schedule H, form 990.

Recommendation 3: Provide coaching and technical assistance in quality improvement and disparity reduction.

The Committee noted that some providers have been very successful in improving quality and reducing disparities. The Committee suggested developing a way to share best practices, provide coaching, and offer technical assistance to support organizations serving those with social risk factors to assist them in their quality improvement efforts.

Implementation Strategy 4: Develop and implement demonstration projects with rigorous evaluation partnering with equity researchers.

Recommendation 1: Fund care delivery and payment reform demonstration projects to reduce disparities.

The Committee's second interim report found that the evidence base for many care delivery and payment reform interventions to reduce healthcare disparities is still limited.[36] However, payers and purchasers often want concrete evidence of the effectiveness of an intervention before they will support it financially. The Committee stressed the need to better understand what work is being done to reduce disparities, what interventions are effective, and how these interventions could be replicated and implemented more broadly. The Committee also emphasized the need to collaborate with

researchers to ensure demonstrations that are rigorous and scientifically sound. Last, members suggested the need for research specifically focused on dissemination and implementation (D&I) of strategies designed to facilitate uptake of equity-advancing interventions across a range of organizations. Such research offers promise for accelerating the update of "best practices and processes." The Committee noted that dissemination and implementation science could help to translate health equity research from theory into everyday practice. One example is a study that examined update of cultural competency policies in hospitals.[37]

Recommendation 2: Conduct policy simulations to demonstrate how community interventions mediate drivers of disparities.

The second interim report highlighted the role of community partnerships and interventions to reduce disparities. However, there is a need to better understand the effects of community and patient partnerships that are not well-studied. Policy simulations and health impact assessments could provide guidance on how best to support and implement community interventions that could mediate drivers of disparities.

Recommendation 3: Assess economic impact of disparities from multiple perspectives.

Reducing healthcare disparities often requires a significant investment. The Committee recognized the need for research to quantify the economic impact of disparities on patients, the healthcare system, and society to support these investments. In the current environment where resources can be limited, demonstrating the current costs of inequity and the potential savings that could be generated could help to motivate and incentivize the reduction of disparities. Multiple economic perspectives are critical to understanding the need to include analysis of the potential long-term benefits to society and the business case perspectives of healthcare organizations, payers, and purchasers.

Currently, there is limited understanding of the economic impact of disparities. One study estimated that racial healthcare disparities cost over $200 billion in direct medical expenditures and over $1 trillion in indirect costs associated with illness and premature death in a three-year period.[38] These costs are borne by patients, employers and purchasers, healthcare providers, and local, state, and federal governments, but it is not easy to appreciate the impact of these costs. Quantifying the costs in terms such as lost productivity, quality adjusted life years, readmission rates, emergency department use, etc. could help organizations understand the imperative to invest in equity.

The Committee noted that understanding the economic impact of disparities is crucial as the system moves to payments based on quality and value. The Committee recognized that reducing disparities will take investments in and by the healthcare system as well as upstream investments to address social determinants of health. However, the Committee reiterated that equity is an essential part of quality and must be part of the value equation for healthcare.

Path Forward

Performance measurement offers an opportunity to assess, support, and incentivize the reduction of disparities and the achievement of health equity. The Committee's framework is intended to lay the

foundation for a more comprehensive and systematic approach to measuring and advancing health equity. To support measurement efforts, the Committee identified five domains of equity measurement: *Partnerships and Collaboration, Culture of Equity, Structures for Equity, Equitable Access to Care, and Equitable High-Quality Care*. Achieving an equitable healthcare system will require progress across all of the domains of measurement identified by the Committee.

The Committee specified four recommendations for implementation of the measurement framework: implementing health equity measures, incentivizing health equity through payment reform, supporting organizations that disproportionately serve individuals with social risk factors, and developing and implementing demonstration projects with rigorous evaluation that partner with equity researchers, and supporting D&I research to determine optimal strategies for spreading best practices and processes that advance health equity.

Measurement can be a powerful force for change in healthcare. However, stakeholders (such as policymakers, legislators, hospital administrators, hospital delivery systems, community advocates, patient advocate groups, and providers) across the system must be motivated to act on the results of health equity performance measures and drive towards improved performance while ensuring that providers and clinicians have the resources necessary to care for those who are most vulnerable. Reducing disparities requires addressing them at every level of the healthcare system and engaging stakeholders in other sectors. Stakeholders across the system must prioritize and invest in equity financially as well as through technology and other aspects. Identifying and developing measures that can reveal disparities as well as provide information on the use of interventions to reduce them is a crucial first step in achieving equity. Measurement must also be leveraged to incentivize and support equity. The current shift to value-based purchasing and alternative payment models can incentivize the reduction of disparities and support providers and clinicians working with vulnerable populations. However, such payment strategies must be implemented in ways that support safety net organizations and protect access for individuals with social risk factors. Finally, more work is needed to identify and promote the use of effective interventions to reduce disparities.

This draft final report will be disseminated for a 30-day comment period starting July 21 through August 21. The Committee will consider public comments and finalize the report for publication in September.

References

[1] Centers for Disease Control and Prevention (CDC). Chronic disease prevention and health promotion website. https://www.cdc.gov/chronicdisease/healthequity/index.htm. Last accessed July 2017.

[2] Agency for Healthcare Research and Quality (AHRQ). *2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy.* Rockville, MD: AHRQ; 2016. Available at http://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/index.html. Last accessed October 2016.

[3] HHS, Office of Minority Health. *National Stakeholder Strategy for Achieving Health Equity*. Washington, DC: HHS; 2016. Available at http://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf. Last accessed December 2016.

[4] Agency for Healthcare Research and Quality (AHRQ). *2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy.* Rockville, MD: AHRQ; 2016. Available at http://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/index.html. Last accessed October 2016.

[5] HHS. *Performance Management and Measurement.* Washington, DC: Health Resources and Services Administration; 2011. Available at https://www.hrsa.gov/quality/toolbox/methodology/performancemanagement/. Last accessed March 2017.

[6] Bilheimer LT, Klein RJ. Data and measurement issues in the analysis of health disparities website. http://www.rwjf.org/en/library/research/2010/10/health-services-research-in-2020-/data-and-measurement-issues-in-the-analysis-of-health-disparitie.html. Last accessed June 2017.

[7] Robert Wood Johnson Foundation. Collecting data to identify disparities and measure heart care quality website. http://www.rwjf.org/en/library/articles-and-news/2010/03/collecting-data-to-identify-disparities-and-measure-heart-care-q.html. Last accessed June 2017.

[8] Mead H, Cartwright-Smith L, Jones K, et al. *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook.* Washington, DC: The Commonwealth Fund; 2008. Available at http://www.commonwealthfund.org/publications/chartbooks/2008/mar/racial-and-ethnic-disparities-in-u-s--health-care--a-chartbook. Last accessed July 2017.

[9] National Academies of Sciences, Engineering, and Medicine. *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*. Washington, DC: National Academies Press; 2016.

[10] Institute of Medicine (IOM). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press; 2001.

[11] Institute of Medicine (IOM). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press; 2003.

[12] Penchansky R, Thomas JW. The concept of access: definition and relationship to consumer satisfaction. *Med Care*. 1981;19(2):127-140.

[13] Ulmer C, Bruno M, Burke S, eds. *Future Directions for the National Healthcare Quality and Disparities Reports*. Washington, DC: National Academies Press; 2010.

[14] Chin MH, Walters AE, Cook SC, Huang ES. Interventions to reduce racial and ethnic disparities in health care. *Med Care Res Rev*. 2007;64(5 Suppl):7S-28S.

[15] Clarke AR, Goddu AP, Nocon RS, et al. Thirty years of disparities intervention research: what are we doing to close racial and ethnic gaps in health care? *Med Care*. 2013;51:1020-1026.

[16] Cooper LA, Hill MN, Powe NR. Designing and evaluating interventions to eliminate racial and ethnic disparities in health care. *J Gen Intern Med*. 2002;17(6):477-486.

[17] Chin MH, Clarke AR, Nocon RS, et al. A roadmap and best practices for organizations to reduce racial and ethnic disparities in health care. *J Gen Intern Med*. 2012;27(8):992-1000.

[18] Mauer BJ. *Behavioral Health/Primary Care Integration and the Person Centered Healthcare Home*. Washington, DC: National Council for Behavioral Health Care; 2009.

[19] Martinez W, Lehmann LS, Thomas EJ, et al. Speaking up about traditional and professionalism-related patient safety threats: a national survey of interns and residents. *BMJ Qual Saf*. 25 April 2017.

[20] Webb LE, Dmochowski RR, Moore IN, et al. Using coworker observations to promote accountability for disrespectful and unsafe behaviors by physicians and advanced practice professionals. *Jt Comm J Qual Patient Saf*. 2016;42(4):149-164.

[21] Martinez W, Bell SK, Etchegaray JM, et al. Measuring moral courage for interns and residents: scale development and initial psychometrics. *Acad Med.* 2016;91(10):1431-1438.

[22] HHS. National CLAS Standards website. https://www.thinkculturalhealth.hhs.gov/clas. Last accessed July 2017.

[23] National Academies of Sciences, Engineering, and Medicine. *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*. Washington, DC: National Academies Press; 2016.

[24] HHS, Office of the National Coordinator for Health Information Technology, 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications; Final Rule. 80 *Fed. Reg.* 62602-62759 (October 16, 2015), 45 *CFR* 170. Available at https://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25597.pdf. Last accessed May 2017.

[25] HHS Office of Minority Health. The National CLAS Standards website. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53. Last accessed May 2017.

[26] World Health Organization (WHO). *Global Strategy on Human Resources for Health: Workforce 2030.* Geneva, Switzerland: WHO; 2016. Available at http://apps.who.int/iris/bitstream/10665/250368/1/9789241511131-eng.pdf?ua=1. Last accessed July 2017.

[27] Carrillo JE, Carrillo VA, Perez HR, et al. Defining and targeting health care access barriers. *J Health Care Poor Underserved.* 2011 May;22(2):562-575.

[28] Leiyu S, Starfield B, Politzer R, et al. Primary care, self-rated health, and reductions in social disparities in health. *Health Serv Res*. 2002;37(3):529-550.

[29] Lin Y, Ebert JM, Probst JC. Ambulatory care – sensitive condition hospitalizations among Medicare Beneficiaries. *Am J Prev Med*. 2016;51(4):493-501.

[30] HHS, Office of the Assistant Secretary for Planning and Evaluation (ASPE). *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs*. Available at https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs. Last accessed July 2017.

[31] National Academies of Sciences, Engineering, and Medicine. *Accounting for Social Risk Factors in Medicare Payment: Criteria, Factors, and Methods.* Washington, DC: National Academies Press; 2016.

[32] Centers for Disease Control and Prevention (CDC). *ICD-10-CM Official Guidelines for Coding and Reporting: FY 2016*. Atlanta, GA: CDC; 2016. Available at https://www.cdc.gov/nchs/data/icd/10cmguidelines_2016_final.pdf. Last accessed July 2017.

[33] Shi L, Starfield B, Politzer R, et al. Primary care, self-rated health, and reductions in social disparities in health. *Health Serv Res*. 2002;37(3):529-550.

[34] Centers for Medicare & Medicaid Services (CMS). Fiscal Year (FY) 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information CMS-1677-P [Factsheet]. Available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-04-14.html. Last accessed June 2017

[35] Centers for Medicare & Medicaid Services (CMS). Better care, smarter spending. Healthier people: paying providers for value, not volume [Factsheet]. Available at https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2015-fact-sheets-items/2015-01-26-3.html. Last accessed June 2017.

[36] DeMeester RH, Xu LJ, Nocon RS, Cook SC, et al. Solving disparities through payment and delivery system reform: A program to achieve health equity. *Health Aff (Millwood)*. 2017;36(6):1133-1139.

[37] Ogbolu Y, Fitzpatrick GA.. Advancing organizational cultural competency with dissemination and implementation frameworks: towards translating standards into clinical practice. *ANS Adv Nurs Sci.* 2015 Jul-Sep;38(3):203-214.

[38] LaVeist TA, Gaskin D, Richard P. Estimating the economic burden of racial health inequalities in the United States. *Int J Health Serv*. 2011;41(2):231-238.

Appendix A: Literature Review and Environmental Scan Methodology

NQF conducted a literature review to provide the Disparities Standing Committee with evidence related to health and healthcare disparities and to provide examples of the types of interventions that have proven effective in reducing disparities in health and healthcare outcomes. To support this goal, NQF conducted a search for information sources relevant to the disparities in the five target conditions associated with the social risk factors identified in the NAM report. The Committee provided key information sources and provided preliminary guidance on where to collect sources. Databases for the literature review included Academic Search Premier, PubMed/Medline, Google Scholar, PsychINFO, PAIS International, Ageline, Cochrane Collaboration, and Campbell Collaboration.

NQF conducted a targeted search within these databases using various combinations of keywords that were derived terms related to the target conditions and social risk factors as well as general terms to capture broader work that may include relevant information. NQF also searched by population types including ethnic and racial minorities according to the Office of Management and Budget definitions. The search was confined to U.S.-based work published between 2010 and 2016. The literature review was not meant to be exhaustive, nor does it include all populations affected by health and healthcare disparities. Rather, it highlights examples of disparities and effective interventions within the selected conditions and illustrates the associations found between social risk factors and health and healthcare outcomes. The information from the literature review informed the development of the roadmap to reduce disparities in health and healthcare . The literature review resulted in over 900 sources. After a review of abstracts, about 370 sources were identified as highly relevant. The literature review documented interventions that have shown effectiveness in reducing disparities within the selected conditions as well as interventions that provide lessons on how to counteract multiple social risk factors across a variety of populations.

NQF also conducted an environmental scan for measures. The purpose of the environmental scan was to identify both performance measures and measure concepts that can be used to assess the extent to which stakeholders are employing effective interventions to reduce disparities. These include performance measures that are “disparities-sensitive” (i.e., linked to interventions that are known to reduce disparities in populations that have social risk factors) and performance measures that aligned with the priority domains of measurement outlined in the Committee’s conceptual framework. The scan included measures that are currently stratified by social risk factors as well as measures that should be prioritized for stratification if they are not currently specified in that way.

The environmental scan consisted of a search for performance measures in several measure repositories, including but not limited to NQF’s portfolio of performance measures (endorsed and not endorsed), the AHRQ National Quality Measures Clearinghouse, the National Guidelines Clearinghouse, the CMS measure inventory, and the Health Indicators Warehouse. NQF conducted a targeted search within these databases using various combinations of keywords that were derived terms related to the selected conditions, interventions known to reduce disparities, and social risk factors, as well as terms associated with the Committee’s priority domains of measurement.

NQF prioritized performance measures based on a set of predetermined criteria. In 2012, NQF's Disparities Standing Committee created a protocol for identifying disparities-sensitive measures based on a commissioned paper by the Disparities Solution Center at Massachusetts General Hospital. The process involves examining how prevalent a condition is among a population with social risk factors, the size of the gap in quality of care, the impact the measurement area has on the population, and the extent to which the care is sensitive to inadequate communication and sensitive to patient and provider preferences. Lastly, performance measures are classified as disparities-sensitive if the underlying outcome is highly dependent on social determinants of health.

NQF solicited feedback from 19 key informants with in-depth knowledge of each selected condition, disparities, and measurement. These experts were selected from NQF's Cardiovascular, Cancer, Renal, Perinatal, Endocrine, and Behavioral Health Standing Committees. They reviewed the measures identified from the environmental scan for completeness and assessed the extent to which they can be used to reduce disparities based on the criteria for identifying disparities-sensitive measures. The experts also provided feedback on gaps in measurement, as well as data needed to develop new performance measures for disparities measurement.

NQF categorized the performance measures found in the environmental scan based on the domains to which they most closely align. The majority of measures found aligned with the *Equitable Access to Healthcare Quality* domain. Many of the subdomains represent concepts that are not yet well measured by the healthcare system. The full compendium of measures is posted to the NQF disparities project webpage.

Appendix B: Definitions and Terms

Domain of measurement: A domain of measurement is a categorization/grouping of high-level ideas and measure concepts that further describes the measurement framework, and a subdomain is a smaller categorization/grouping within a domain.

Subdomain: A smaller categorization/grouping within a domain.

Measurement framework: a conceptual model for organizing ideas about what is important to measure for a topic area and how measurement should take place (e.g., whose performance should be measured, care settings where measurement is needed, when measurement should occur, which individuals should be included in measurement, etc.). Frameworks provide a structure for organizing currently available measures, areas where gaps in measurement exist, and prioritization for future measure development.

Performance measure: A fully developed metric that includes detailed specifications and may have undergone scientific testing.

Measure concept: An idea for a measure that includes a description of the measure, including planned target and population.

Health disparity: The HHS Office of Minority Health describes a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" (based on individuals' gender, age, race, and/or ethnic group, etc.). Healthcare disparities are related to "differences in the quality of care that are not due to access-related factors or clinical needs, preferences, and appropriateness of interventions" (i.e., differences based on discrimination and stereotyping).

Health equity measure: A performance measure that can be linked to an intervention that reduces disparities in health or healthcare

Appendix C: Disparities Standing Committee Meetings

The Disparities Standing Committee convened four times over the life of the project. NQF hosted an orientation web meeting on October 19, 2016, to discuss the project's objectives and approach. The Committee convened a second time on January 19, 2017, to discuss the findings of the first interim report, Disparities in Health and Healthcare Outcomes in Selected Conditions, and how these findings inform the Committee's conceptual framework. The Committee also discussed the outline and approach to the second interim report, Effective Interventions in Reducing Disparities in Healthcare and Health Outcomes in Selected Conditions.

The Committee met for a two-day, in-person meeting on March 27-28 to identify and prioritize areas of measurement, refine the conceptual framework for measure development, and provide input on an environmental scan of performance measures that can be used to assess the extent to which stakeholders are employing effective interventions to reduce disparities. During the meeting and in post-meeting follow-up, the Committee finalized the five domains of measurement for use with the Committee's conceptual framework and roadmap. The Committee also discussed the findings of the environmental scan for measures documented in the third interim report, An Environmental Scan of Health Equity Measures and a Conceptual Framework for Measure Development.

On June 14-15, the Committee convened again to finalize the conceptual framework and roadmap as well as make final recommendations for implementation. Prior to the meeting, members of the Committee submitted ideas for potential measures that could be used to address health equity and minimize disparities. The full list of submitted measure concept ideas is posted to the NQF disparities project webpage. During the meeting, the Committee discussed the proposed measure concepts and additional gaps in measurement. The final recommendations made by the Committee during the second in-person meeting are detailed in this report.

The Committee will convene on August 30, 2017, to discuss and respond to the comments received during the commenting period (July 21-August 21).

Appendix D: Compendium of Measures by Domain

The table below contains the results of a search for measures that can be used to assess the extent to which stakeholders are employing effective interventions to reduce disparities as well as measures that can be used to monitor care associated with conditions that are known to have health and healthcare disparities. The compendium is organized by the priority domains of measurement identified by the NQF Disparities Standing Committee. A spreadsheet containing the information in this appendix can be sorted by selected conditions (i.e., cardiovascular disease, cancer, infant mortality, low birth weight, mental illness, diabetes, and chronic kidney disease). The full compendium, which includes the measures' specifications and subdomain, can be found on the NQF disparities project webpage.

Domain: Partnerships and Collaboration

NQF #	Condition Area	Measure Title	Measure Type	Source
2774	CVD	Functional Change: Change in Mobility Score for Skilled Nursing Facilities	Outcome	QPS
N/A	Mental Illness	Assessment of integrated care: overall score on the Site Self Assessment (SSA) Evaluation Tool	N/A	AHRQ
N/A	Mental Illness	Assessment of integrated care: total score for the "Integrated Services and Patient and Family-Centeredness" characteristics on the Site Self Assessment (SSA) Evaluation Tool.	N/A	AHRQ
0252	Diabetes/ CKD	Assessment of Iron Stores	Process	QPS
N/A	Mental Illness	Closing the Referral Loop: Receipt of Specialist Report	Process	CMS
N/A	Mental Illness	Health education, suicide prevention: schools	N/A	HIW

Domain: Culture of Equity

NQF #	Condition Area	Measure Title	Measure Type	Source
N/A	Diabetes/ CKD	Anemia of chronic kidney disease: Patient informed consent for ESA treatment	Process	CMS
1904	Cross-cutting	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	Outcome	NQF QPS
N/A	Mental Illness	Competency Assessment Instrument (CAI): provider's mean score on the "Client Preferences" scale.	Structure	AHRQ
N/A	Mental Illness	Competency Assessment Instrument (CAI): provider's mean score on the "Community Resources" scale.	Structure	AHRQ
N/A	Mental Illness	Competency Assessment Instrument (CAI): provider's mean score on the "Evidence-based Practice" scale.	Structure	AHRQ

N/A	Mental Illness	Competency Assessment Instrument (CAI): provider's mean score on the "Family Education" scale.	Structure	AHRQ
N/A	Mental Illness	Competency Assessment Instrument (CAI): provider's mean score on the "Family Involvement" scale.	Structure	AHRQ
N/A	Mental Illness	Competency Assessment Instrument (CAI): provider's mean score on the "Stigma" scale.	Structure	AHRQ
N/A	Mental Illness	Competency Assessment Instrument (CAI): provider's mean score on the "Team Value" scale.	Structure	AHRQ
1894	Cross-cutting	Cross-cultural communication measure derived from the cross-cultural communication domain of the C-CAT	Outcome	NQF QPS
2267	Mental Illness	HCBS CAHPS Measure (1 of 19): Staff are reliable and helpful	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (10 of 19): Global rating of case manager	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (11 of 19): Would recommend personal assistance/behavioral health staff to family and friends	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (12 of 19): Would recommend homemaker to family and friends	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (13 of 19): Would recommend case manager to family and friends	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (14 of 19): Unmet need in dressing/bathing due to lack of help	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (15 of 19): Unmet need in meal preparation/eating due to lack of help	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (16 of 19): Unmet n need in medication administration due to lack of help	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (17 of 19): Unmet need in toileting due to lack of help	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (18 of 19): Unmet need with household tasks due to lack of help	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (19 of 19): Hit or hurt by staff	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (2 of 19): Staff listen and communicate well.	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (3 of 19): Case manager is helpful	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (4 of 19): Choosing the services that matter to you.	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (6 of 19): Personal safety and respect	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (7 of 19): Planning your time and activities	Outcome	CMS
2267	Mental Illness	HCBS CAHPS Measure (8 of 19): Global rating of personal assistance and behavioral health staff	Outcome	CMS
1898	Cross-cutting	Health literacy measure derived from the health literacy domain of the C-CAT	Outcome	NQF QPS

N/A	Infant Mortality	Hospital inpatients' experiences: percentage of parents who reported how often providers prevented mistakes and helped them to report concerns.	Consumer Experience	
0640	Mental Illness	Hospital-based inpatient psychiatric services: the total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.	Process	AHRQ
1892	Cross-cutting	Individual engagement measure derived from the individual engagement domain of the C-CAT	Outcome	NQF QPS
1896	Cross-cutting	Language services measure derived from language services domain of the C-CAT	Outcome	NQF QPS
1905	Cross-cutting	Leadership commitment measure derived from the leadership commitment domain of the C-CAT	Outcome	NQF QPS
N/A	Infant Mortality	Number of States and the District of Columbia that verify through linkage with vital records that all newborns are screened shortly after birth for conditions mandated by their State-sponsored screening program	N/A	N/A
N/A	Infant Mortality	Percent of infants who are put down to sleep on their backs	N/A	N/A
1901	Cross-cutting	Performance evaluation measure derived from performance evaluation domain of the C-CAT	Outcome	NQF QPS
N/A	Infant Mortality	Rate of infant deaths from sudden infant death syndrome (SIDS)	N/A	N/A
1888	Cross-cutting	Workforce development measure derived from workforce development domain of the C-CAT	Outcome	NQF QPS

Domain: Structure for Equity

NQF #	Condition Area	Measure Title	Measure Type	Source
2020	CVD	Adult Current Smoking Prevalence	Structure	QPS
2015	Infant Mortality	Adult Current Smoking Prevalence	Structure	OPUS
N/A	Infant Mortality	Alcohol abstinence, prenatal	N/A	HIW
N/A	Infant Mortality	Anencephaly	N/A	HIW
2371	CVD	Annual Monitoring for Patients on Persistent Medications (MPM)	Process	QPS
0616	CVD	Atherosclerotic Disease - Lipid Panel Monitoring	Process	QPS
N/A	Infant Mortality	Breastfeeding at 1 year	N/A	HIW
N/A	Infant Mortality	Breastfeeding at 6 months	N/A	HIW
N/A	Infant Mortality	Breastfeeding, ever	N/A	HIW

N/A	Infant Mortality	Breastfeeding, exclusively through 3 months	N/A	HIW
N/A	Infant Mortality	Breastfeeding, exclusively through 6 months	N/A	HIW
1927	CVD	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	Process	QPS
N/A	Cancer	Cervical cancer screening: percentage of Pap tests for which the time between the date the Pap test is performed and the date that Pap test is processed by the laboratory is less than or equal to 14 days.	N/A	AHRQ Clearinghouse
N/A	Infant Mortality	Cigarette abstinence, prenatal	N/A	HIW
N/A	Infant Mortality	Deaths: infants with Down syndrome	N/A	HIW
0518	Mental Illness	Depression Assessment Conducted	Process	QPS
10627	Diabetes/ CKD	Diabetes: the relative resource use by members with diabetes during the measurement year.	N/A	NQMC
0741	Infant Mortality	Five minute APGAR less than 7	Outcome	OPUS
N/A	Infant Mortality	Formula supplementation: breastfed newborns	N/A	HIW
1418	Diabetes/ CKD	Frequency of Adequacy Measurement for Pediatric Hemodialysis Patients	Process	QPS
2483	Diabetes/ CKD	Gains in Patient Activation (PAM) Scores at 12 Months	Outcome: PRO	QPS
N/A	Infant Mortality	Illicit drug abstinence, prenatal	N/A	HIW
N/A	Infant Mortality	Infant deaths between 28 days-1 year	N/A	HIW
N/A	Infant Mortality	Infant deaths within first 28 days of life	N/A	HIW
N/A	Infant Mortality	Infant deaths, all	N/A	HIW
N/A	Infant Mortality	Infant deaths: congenital heart defects	N/A	HIW
N/A	Infant Mortality	Infant deaths: sudden unexpected/unexplained causes	N/A	HIW
1824	Cross-cutting	L1A: Screening for preferred spoken language for health care	Process	NQF QPS
0278	Infant Mortality	Low Birth Weight Rate (PQI 9)	Outcome	OPUS
0650	Cancer	Melanoma: Continuity of Care – Recall System	Structure	NQF Cancer Project

0456	CVD	Participation in a Systematic National Database for General Thoracic Surgery	Structure	QPS
0480	Infant Mortality	PC-05 Exclusive Breast Milk Feeding	Process	OPUS
N/A	Infant Mortality	Percent of live births that are low birth weight (LBW)	N/A	HIW
1382	Infant Mortality	Percentage of low birthweight births	Outcome	OPUS
N/A	Infant Mortality	Perinatal Deaths	N/A	HIW
N/A	Infant Mortality	Pregnancies conceived within 18 months of previous birth	N/A	HIW
N/A	CVD	Prevention and management of obesity for adults: percentage of patients with BMI greater than or equal to 25 who have 30 minutes of any type of physical activity five times per week documented.	Process	NQMC - 008874
0541	CVD	Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	Process	QPS
1853	Cancer	Radical Prostatectomy Pathology Reporting	Process	NQF Cancer Project
0509	Cancer	Radiology: Reminder System for Screening Mammograms	Structure	CMS Measure Inventory
1557	Diabetes/ CKD	Relative Resource Use for People with Diabetes (Inpatient Facility Index)	Process	CMS
N/A	Infant Mortality	Smoking abstinence, preconception	N/A	HIW
N/A	Infant Mortality	Smoking cessation during pregnancy	N/A	HIW
N/A	Cancer	Statewide cancer registries	Process	HIW
N/A	Infant Mortality	Very low birth weight deliveries (percent)	N/A	HIW
N/A	Infant Mortality	Worksite lactation support programs	N/A	HIW

Domain: Equitable Access to Care

NQF #	Condition Area	Measure Title	Measure Type	Source
N/A	Diabetes/ CKD	Adult Kidney Disease: Referral to Nephrologist	Process	CMS

N/A	Mental Illness	Behavioral health care patients' experiences: percentage of adult patients who reported how often they were seen within 15 minutes of their appointment.	Patient Experience	AHRQ
0479	Infant Mortality	Birth dose of hepatitis B vaccine and hepatitis B immune globulin for newborns of hepatitis B surface antigen (HBsAg) positive mothers	Process	QPS
N/A	Cancer	Cervical cancer screening: percentage of women age 21 years and older screened in accordance with evidence-based standards.	Process	AHRQ Clearinghouse
1395	Infant Mortality	Chlamydia Screening and Follow Up	Process	QPS
2904	Infant Mortality	Contraceptive Care - Access to LARC	Structure	QPS
2903	Infant Mortality	Contraceptive Care – Most & Moderately Effective Methods	Outcome	QPS
2902	Infant Mortality	Contraceptive Care - Postpartum	N/A	QPS
0070	CVD	Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)	Process	QPS
0128	CVD	Duration of Antibiotic Prophylaxis for Cardiac Surgery Patients	Process	QPS
0661	CVD	ED- Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival	Process	CMS
0576	Mental Illness	Follow-Up After Hospitalization for Mental Illness	Process	QPS
1937	Mental Illness	Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)	Process	QPS
1391	Infant Mortality	Frequency of Ongoing Prenatal Care (FPC)	Process	QPS
2267	Mental Illness	HCBS CAHPS Measure (5 of 19): Transportation to medical appointments	Outcome	CMS
	CVD	Heart failure in adults: percentage of heart failure patients who are current smokers or tobacco users who received smoking cessation advice or counseling in primary care.	Process	NQMC - 008936
2455	CVD	Heart Failure: Post-Discharge Appointment for Heart Failure Patients	Process	QPS
N/A	Diabetes/ CKD	Kidney Transplant Referral Rate for Prevalent Dialysis Patients	N/A	CMS
N/A	Diabetes/ CKD	Kidney Transplant Waitlist Decision Rate for Prevalent Dialysis Patients	N/A	CMS
N/A	Infant Mortality	Lactation care in birthing facilities	N/A	HIW
N/A	Mental Illness	Mental Illness services receipt: homeless adults	N/A	HIW

N/A	Mental Illness	Mental Illness utilization: number and percentage of members receiving the following Mental Illness services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED.	N/A	CMS
1752	Cancer	New Cancer Patient– Intervention Urgency	Outcome	QPS
N/A	Infant Mortality	Patient-centered medical home patients' experiences: percentage of parents or guardians who reported how often they were able to get the care their child needed from their child's provider's office during evenings, weekends, or holidays.	Consumer Experience	NQMC
N/A	Diabetes/ CKD	Per Capita Cost for Beneficiaries with Diabetes	Cost/Resource Use	CMS - 2720
N/A	Diabetes/ CKD	Percentage of Prevalent Patients Waitlisted (PPPW)	N/A	CMS
1517	Infant Mortality	Prenatal & Postpartum Care (PPC)	Process	QPS
N/A	Infant Mortality	Prenatal care, early and adequate	N/A	HIW
N/A	Infant Mortality	Prenatal care, first trimester	N/A	HIW
N/A	Infant Mortality	Preventive services for children and adolescents: percentage of newborns who have had neonatal screening for hemoglobinopathies, phenylketonuria and hypothyroidism in the first week of life.	Process	NQMC
N/A	Cancer	Preventive services: percentage of adult enrolled members age 19 years and older who are up-to-date for all appropriate preventive services (combination 6).	Process	AHRQ Clearinghouse
0541	Diabetes/ CKD	Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	Process	QPS
0483	Infant Mortality	Proportion of infants 22 to 29 weeks gestation screened for retinopathy of prematurity.	Process	QPS
1558	CVD	Relative Resource Use for People with Cardiovascular Conditions (RCA)	Cost/Resource Use	QPS
N/A	Infant Mortality	Reproductive health services receipt: sexually active females	N/A	HIW
N/A	Diabetes/ CKD	Standardized First Kidney Transplant Waitlist Ratio for Incident Dialysis Patients (SWR)	N/A	CMS
N/A	Diabetes/ CKD	Standardized Kidney Transplant Referral Ratio for Incident Dialysis Patients	N/A	CMS
2896	Infant Mortality	Structural Attributes of Facility in which High Risk Women Deliver Newborns: A PQMP Measure	N/A	QPS
0477	Infant Mortality	Under 1500g infant Not Delivered at Appropriate Level of Care	Outcome	QPS
N/A	Infant Mortality	Very low birth weight infants born at level III hospitals	N/A	HIW

Domain: Equitable High Quality Care

NQF #	Condition Area	Measure Title	Measure Type	Source
0536	CVD	30-day all-cause risk-standardized mortality rate following Percutaneous Coronary Intervention (PCI) for patients with ST segment elevation myocardial infarction (STEMI) or cardiogenic shock	Outcome	QPS
0535	CVD	30-day all-cause risk-standardized mortality rate following percutaneous coronary intervention (PCI) for patients without ST segment elevation myocardial infarction (STEMI) and without cardiogenic shock	Outcome	QPS
N/A	Mental Illness	30-Day all-cause unplanned readmission following psychiatric hospitalization in an IPF	Outcome	CMS
0698	CVD	30-Day Post-Hospital AMI Discharge Care Transition Composite Measure	Composite	QPS
0699	CVD	30-Day Post-Hospital HF Discharge Care Transition Composite Measure	Composite	QPS
0359	CVD	Abdominal Aortic Aneurysm (AAA) Repair Mortality Rate (IQI 11)	Outcome	QPS
0344	Infant Mortality	Accidental Puncture or Laceration Rate (PDI #1)	Outcome	OPUS
0551	CVD	Ace Inhibitor / Angiotensin Receptor Blocker Use and Persistence Among Members with Coronary Artery Disease at High Risk for Coronary Events	Process	QPS
0551	Diabetes/ CKD	Ace Inhibitor / Angiotensin Receptor Blocker Use and Persistence Among Members with Coronary Artery Disease at High Risk for Coronary Events	Process	QPS
1522	CVD	ACE/ARB Therapy at Discharge for ICD implant patients with Left Ventricular Systolic Dysfunction	Process	QPS
0137	CVD	ACEI or ARB for left ventricular systolic dysfunction-Acute Myocardial Infarction (AMI) Patients	Process	QPS
0730	CVD	Acute Myocardial Infarction (AMI) Mortality Rate	Outcome	QPS
N/A	CVD	Acute myocardial infarction (AMI): the risk-adjusted rate of all-cause in-hospital death occurring within 30 days of first admission to an acute care hospital with a diagnosis of AMI.	Outcome	NQMC - 010029
2467	Diabetes/ CKD	Adherence to ACEIs/ARBs for Individuals with Diabetes Mellitus	Process	QPS
2379	CVD	Adherence to Antiplatelet Therapy after Stent Implantation	Process	QPS
1879	Mental Illness	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Intermediate Outcome	QPS
1880	Mental Illness	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Process	QPS

2468	Diabetes/ CKD	Adherence to Oral Diabetes Agents for Individuals with Diabetes Mellitus	Process	QPS
0543	CVD	Adherence to Statin Therapy for Individuals with Cardiovascular Disease	Process	QPS
0569	CVD	ADHERENCE TO STATINS	Process	QPS
0545	Diabetes/ CKD	Adherence to Statins for Individuals with Diabetes Mellitus	Process	QPS
0223	Cancer	Adjuvant chemotherapy is recommended or administered within 4 months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	Process	NQF Cancer Project
0220	Cancer	Adjuvant hormonal therapy	Process	NQF Cancer Project
0747	Infant Mortality	Admission to neonatal intensive care unit at term.	Outcome	OPUS
N/A	CVD	Adult depression in primary care: percentage of patients with cardiovascular disease with documentation of screening for major depression or persistent depressive disorder using either PHQ-2 or PHQ-9.	Process	NQMC - 010778
1666	Diabetes/ CKD	Adult Kidney Disease : Patients on Erythropoiesis Stimulating Agent (ESA)--Hemoglobin Level > 12.0 g/dL	Outcome	QPS
0323	Diabetes/ CKD	Adult Kidney Disease: Hemodialysis Adequacy: Solute	Outcome	QPS
0321	Diabetes/ CKD	Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute	Outcome	QPS
N/A	Diabetes/ CKD	Adult Kidney Disease: Advance Directives Completed	Outcome	CMS
N/A	Diabetes/ CKD	Adult Kidney Disease: Blood Pressure Management	Intermediate Outcome	CMS - 0474
N/A	Diabetes/ CKD	Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis	Outcome	CMS
N/A	Diabetes/ CKD	Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days	Outcome	CMS
N/A	Diabetes/ CKD	Adult Kidney Disease: Discussion of Advance Care Planning	Process	CMS
N/A	Diabetes/ CKD	Adult Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level <10g/dL	Outcome	CMS
0323	Diabetes/ CKD	Adult Kidney Disease: Hemodialysis Adequacy: Solute	Outcome	CMS
1668	Diabetes/ CKD	Adult Kidney Disease: Laboratory Testing (Lipid Profile)	Process	QPS
0321	Diabetes/ CKD	Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute	Outcome	CMS

N/A	Diabetes/ CKD	Adult Kidney Disease: Referral to Hospice	Process	CMS - 2726
N/A	Diabetes/ CKD	Adult Kidney Disease: Transplant Referral	Process	CMS
N/A	Mental Illness	Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions	Process	CMS
N/A	CVD	Adult smoking cessation advice/counseling	Process	CMS
N/A	Mental Illness	Advanced Care Planning for Patients with Parkinson's Disease	Process	CMS
N/A	Diabetes/ CKD	Advanced chronic kidney disease (CKD): percent of patients with documentation that education was provided.	N/A	NQMC - 360
1769	Infant Mortality	Adverse Outcome Index	Composite	OPUS
N/A	Cancer	Age Appropriate Screening Colonoscopy	Efficiency	CMS
N/A	Mental Illness	Alcohol & Other Drug Use Disorder Treatment at Discharge	Process	CMS
N/A	Mental Illness	Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge	Process	CMS
N/A	Mental Illness	Alcohol Drug Use: Assessing Status After Discharge	N/A	CMS
2599	Mental Illness	Alcohol Screening and Follow-up for People with Serious Mental Illness	Process	QPS
1663	Mental Illness	Alcohol Use Brief Intervention	Process	CMS
1661	Mental Illness	Alcohol Use Screening	Process	CMS
0578	CVD	Ambulatory initiated Amiodarone Therapy: TSH Test	Process	QPS
N/A	Diabetes/ CKD	Anemia Management Reporting Measure	Process	CMS
1662	Diabetes/ CKD	Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	Process	QPS
N/A	Mental Illness	Annual Parkinson's Disease Diagnosis Review	Process	CMS
0105	Mental Illness	Antidepressant Medication Management (AMM)	Process	QPS
0118	CVD	Anti-Lipid Treatment Discharge	Process	QPS
0116	CVD	Anti-Platelet Medication at Discharge	Process	QPS
0237	CVD	Anti-platelet medication on discharge	Process	QPS
2337	Mental Illness	Antipsychotic Use in Children Under 5 Years Old	Process	QPS
2111	Mental Illness	Antipsychotic Use in Persons with Dementia	Process	QPS
0473	Infant Mortality	Appropriate DVT prophylaxis in women undergoing cesarean delivery	Process	OPUS

N/A	Cancer	Appropriate age for colorectal cancer screening colonoscopy	Outcome	CMS
N/A	Cancer	Appropriate follow-up imaging for incidental simple ovarian cysts	Process	CMS
0472	Infant Mortality	Appropriate Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision – Cesarean section.	Process	OPUS
0069	Infant Mortality	Appropriate Treatment for Children With Upper Respiratory Infection (URI)	Process	OPUS
0286	CVD	Aspirin at Arrival	Process	QPS
0132	CVD	Aspirin at arrival for acute myocardial infarction (AMI)	Process	QPS
0142	CVD	Aspirin prescribed at discharge for AMI	Process	QPS
N/A	CVD	Aspirin use and discussion: percentage of members who are currently taking aspirin, including women 56 to 79 years of age with at least two risk factors for cardiovascular disease (CVD); men 46 to 65 years of age with at least one risk factor for CVD; and men 66 to 79 years of age, regardless of risk factors	Process	NQMC - 010563
N/A	CVD	Aspirin use and discussion: percentage of women 56 to 79 years of age and men 46 to 79 years of age who discussed the risks and benefits of using aspirin with a doctor or other health provider.	Process	NQMC - 010564
N/A	CVD	Aspirin use for the primary prevention of cardiovascular disease and colorectal cancer: U.S. Preventive Services Task Force recommendation statement.		NGC
0260	Diabetes/ CKD	Assessment of Health-related Quality of Life in Dialysis Patients	Process	QPS
0225	Cancer	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.	Process	NQF Cancer Project
0636	CVD	Atherosclerotic Disease and LDL Greater than 100 - Use of Lipid Lowering Agent	Process	QPS
0624	CVD	Atrial Fibrillation - Anticoagulation Therapy	Process	QPS
1525	CVD	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	Process	QPS
N/A	CVD	Atrial fibrillation Medicare beneficiaries (number)	N/A	HIW
N/A	CVD	Atrial fibrillation Medicare beneficiaries (percent)	N/A	HIW
N/A	Mental Illness	Avoidance of Dopamine-Blocking Medications in Patients with Parkinson's Disease	Process	CMS
2701	Diabetes/ CKD	Avoidance of Utilization of High Ultrafiltration Rate (>/= 13 ml/kg/hour)	Process	QPS
1854	Cancer	Barrett's Esophagus	Outcome	NQF Cancer Project
N/A	CVD	Behavioral counseling interventions to promote a healthful diet and physical activity for cardiovascular disease prevention in adults: U.S. Preventive Services Task Force recommendation statement.		NGC

N/A	CVD	Behavioral counseling to promote a healthful diet and physical activity for cardiovascular disease prevention in adults with cardiovascular risk factors: U.S. Preventive Services Task Force recommendation statement.		NGC
0117	CVD	Beta Blockade at Discharge	Process	QPS
1529	CVD	Beta Blocker at Discharge for ICD implant patients with Left Ventricular Systolic Dysfunction	Process	QPS
1528	CVD	Beta Blocker at Discharge for ICD implant patients with a previous MI	Process	QPS
0238	CVD	Beta blocker on discharge	Process	QPS
0160	CVD	Beta-blocker prescribed at discharge for AMI	Process	QPS
2438	CVD	Beta-Blocker Therapy (i.e., Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate) for LVSD Prescribed at Discharge	Process	QPS
0355	CVD	Bilateral Cardiac Catheterization Rate (IQI 25)	Outcome	QPS
0645	Cancer	Biopsy Follow-Up	Process	CMS
0003	Mental Illness	Bipolar Disorder: Assessment for diabetes	Process	QPS
2892	Infant Mortality	Birth risk Cesarean Birth Measure	Outcome	OPUS
0742	Infant Mortality	Birth Trauma	Outcome	OPUS
0474	Infant Mortality	Birth Trauma – Injury to Neonate (PSI 17)	Outcome	OPUS
N/A	Infant Mortality	Blood folate concentration: reproductive-aged women	N/A	HIW
1460	Diabetes/ CKD	Bloodstream Infection in Hemodialysis Outpatients	Outcome	QPS
2601	Mental Illness	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness	Process	QPS
N/A	Cancer	Breast cancer deaths	Outcome	HIW
0391	Cancer	Breast Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	Outcome	NQF Cancer Project
0391	Cancer	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	Process	CMS
0031	Cancer	Breast Cancer Screening	Process	NQF Cancer Project
2372	Cancer	Breast Cancer Screening	Process	CMS
2372	Cancer	Breast Cancer Screening	Process	CMS
	Cancer	Breast Cancer Screening	Process	CMS
0387	Cancer	Breast Cancer: Hormonal Therapy for Stage I (T1b)-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	Process	NQF Cancer Project

0387	Cancer	Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer	Process	CMS
0072	CVD	CAD: Beta-Blocker Treatment after a Heart Attack	Process	QPS
0258	Diabetes/ CKD	CAHPS In-Center Hemodialysis Survey	Outcome: PRO	QPS
N/A	Cancer	Cancer - anorexia and weight loss: percentage of patients treated with enteral or parenteral nutrition who had an assessment prior to starting nutrition that there was difficulty maintaining nutrition due to significant gastrointestinal issues and that expected life expectancy was at least one month.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - anorexia and weight loss: percentage of patients who presented for an initial visit for cancer affecting the oropharynx or gastrointestinal tract or advanced cancer at a cancer-related outpatient site for whom there was an assessment for the presence or absence of anorexia or dysphagia.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - delirium: percentage of hospitalized patients with cancer over the age of 65 or with advanced cancer with delirium for whom there was an assessment for the presence or absence of at least one of the following potential causes and their association with delirium: medication effects, central nervous system disease, infection, or metabolic processes.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - dyspnea: percentage of inpatients with primary lung cancer or advanced cancer with dyspnea on admission who were offered symptomatic management or treatment directed at an underlying cause within 24 hours.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - dyspnea: percentage of outpatients with primary lung cancer or advanced cancer who reported new or worsening dyspnea who were offered symptomatic management or treatment directed at an underlying cause within one month.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - dyspnea: percentage of patients in the hospital treated for dyspnea who had an assessment within 24 hours that the treatment was effective in relieving dyspnea or that a change in treatment for dyspnea was made.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - fatigue/anemia: percentage of known cancer patients who are newly diagnosed with cancer who had an assessment of the presence or absence of fatigue.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - fatigue/anemia: percentage of patients seen for an initial visit or any visit while undergoing chemotherapy at a cancer-related outpatient site for		AHRQ Clearinghouse

		whom there was an assessment of the presence or absence of fatigue.	N/A	
N/A	Cancer	Cancer - information and care planning: percentage of patients with advanced cancer who are admitted to the ICU and survive 48 hours for whom the patient's preferences for care or an attempt to identify them was documented in the medical record within 48 hours of ICU admission.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - information and care planning: percentage of patients with advanced cancer who are mechanically ventilated in the ICU for whom the patient's preference for mechanical ventilation or why this information was unavailable was documented in the medical record within 48 hours of admission to the ICU.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - information and care planning: percentage of patients with advanced cancer who died an expected death for whom there was documentation of an advanced directive or a surrogate decision maker in the medical record.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - information and care planning: percentage of patients with advanced cancer who died an expected death who were referred for palliative care prior to death (hospital-based or community hospice) or there was documentation why there was no referral.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - nausea and vomiting: percentage of patients undergoing moderately or highly emetic chemotherapy or with cancer affecting the gastrointestinal tract or abdomen seen for a visit in a cancer-related outpatient setting for whom the presence or absence of nausea or vomiting was assessed at every visit.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - nausea and vomiting: percentage of patients with advanced cancer affecting the gastrointestinal tract or abdomen admitted to a hospital for whom the presence or absence of nausea or vomiting was assessed within 24 hours.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - pain: percentage of patients who had a cancer-related outpatient visit who were screened for the presence or absence and intensity of pain using a numeric pain score.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - pain: percentage of patients whose outpatient cancer pain regimen changed for whom there was an assessment of the effectiveness of the treatment at or before the next outpatient visit with that provider or at another cancer-related outpatient visit.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - pain: percentage of patients with advanced cancer who received radiation treatment for painful bone metastases for whom single-fraction radiation		AHRQ Clearinghouse

		was offered OR there was documentation of a contraindication to single-fraction treatment.	N/A	
N/A	Cancer	Cancer - pain: percentage of patients with cancer pain started on chronic opioid treatment who were offered either a prescription or nonprescription bowel regimen within 24 hours or had documented contraindication to a bowel regimen.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer - skin rash: percentage of patients treated with agents that block epidermal growth factor receptors (EGFRs) for whom the presence and severity of skin rash was evaluated within one month after starting the treatments and at each visit.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cancer deaths, total	Outcome	HIW
N/A	Cancer	Cancer prevalence: adults (percent)	Outcome	HIW
N/A	Cancer	Cancer survival	Outcome	HIW
0669	CVD	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low Risk Surgery	Efficiency	QPS
0642	CVD	Cardiac Rehabilitation Patient Referral From an Inpatient Setting	Process	QPS
0643	CVD	Cardiac Rehabilitation Patient Referral From an Outpatient Setting	Process	QPS
0670	CVD	Cardiac stress imaging not meeting appropriate use criteria: Preoperative evaluation in low risk surgery patients	Efficiency	QPS
0671	CVD	Cardiac stress imaging not meeting appropriate use criteria: Routine testing after percutaneous coronary intervention (PCI)	Efficiency	QPS
0672	CVD	Cardiac stress imaging not meeting appropriate use criteria: Testing in asymptomatic, low risk patients	Efficiency	QPS
0300	CVD	Cardiac Surgery Patients With Controlled Postoperative Blood Glucose	Process	CMS
2474	CVD	Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	Outcome	QPS
1933	Mental Illness	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	Process	QPS
N/A	Cross-cutting	Care Coordination	Process	CMS
N/A	Cross-cutting	Care Coordination	Patient Engagement/Experience	CMS
2396	CVD	Carotid Artery Stenting: Evaluation of Vital Status and NIH Stroke Scale at Follow Up	Process	QPS
1773	Infant Mortality	CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI) Event	Outcome	OPUS
0032	Cancer	Cervical Cancer Screening	Process	CMS
0032	Cancer	Cervical Cancer Screening	Process	CMS

N/A	Cancer	Cervical Cancer Screening	Process	CMS
N/A	Cancer	Cervical cancer screening: age standardized incidence rate per 100,000 women of invasive cervical cancer—non-squamous cell carcinoma diagnosed in a year.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: age standardized incidence rate per 100,000 women of invasive cervical cancer—squamous cell carcinoma diagnosed in a year.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: age standardized incidence rate per 100,000 women of invasive cervical cancer—non-squamous cell carcinoma diagnosed in a year	Process	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: age standardized incidence rate per 100,000 women of invasive cervical cancer—squamous cell carcinoma diagnosed in a year.	Process	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: number of days at which 90% of Pap tests are processed by the lab.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: number of days at which 90% of women with a high-grade Pap test result who had a follow-up colposcopy.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of eligible women who have a subsequent Pap test within 3 years (36 months) of the index test with a negative result.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of eligible women who have a subsequent Pap test within 42 months of the index test with a negative result.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of eligible women with at least one Pap test in a 3-year frame.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of eligible women with at least one Pap test in a 3-year frame.	N/A	N/A
N/A	Cancer	Cervical cancer screening: percentage of eligible women with at least one Pap test in a 42-month time frame.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of invasive carcinoma of the cervix diagnosed at stage 1 in a 12-month period.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of invasive carcinoma of the cervix diagnosed at stage 1 in a 12-month period.	Process	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of Pap test results that are reported as unsatisfactory in a 12-month frame.	N/A	AHRQ Clearinghouse

N/A	Cancer	Cervical cancer screening: percentage of Pap tests with an HSIL+ result that have a histological confirmation of HSIL, carcinoma in situ, or invasive carcinoma within 12 months of the HSIL+ Pap test.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of Pap tests with ASC-H results that have a histological confirmation of HSIL, carcinoma in situ, or invasive carcinoma within 12 months of the ASC-H Pap test.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of women who had a colposcopy within 12 months of a Pap test with an ASC-H/HSIL+ result who had a histologic investigation within 12 months of the ASC-H/HSIL+ cytological finding.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of women with a cytological finding of ASC-H/HSIL+ who had a histologic investigation within 12 months of the ASC-H/HSIL+ cytological finding.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of women with a high-grade Pap test result who had a follow-up colposcopy within 6 weeks of the index Pap test report date.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of women with a negative ASCUS, LSIL, AGC, ASC-H, HSIL or more severe Pap test result.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of women with histology of HSIL per 1000 women who had a Pap test in the previous 12 months.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of women with invasive cervical cancer and non-squamous cell carcinomas who are diagnosed greater than 5 years since previous Pap test.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of women with invasive cervical cancer and non-squamous cell carcinomas who are diagnosed within 0.5 to 3 years since previous Pap test.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of women with invasive cervical cancer and non-squamous cell carcinomas who are diagnosed within greater than 3 to 5 years since previous Pap test.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of women with invasive cervical cancer and squamous cell carcinoma who are diagnosed greater than 5 years since previous Pap test.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of women with invasive cervical cancer and squamous cell carcinoma who are diagnosed within 0.5 to 3 years since previous Pap test.	N/A	AHRQ Clearinghouse

N/A	Cancer	Cervical cancer screening: percentage of women with invasive cervical cancer and squamous cell carcinoma who are diagnosed within greater than 3 to 5 years since previous Pap test.	N/A	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: percentage of women with invasive cervical cancer—non-squamous cell carcinomas who are diagnosed within greater than 3 to 5 years since previous Pap test.	Process	AHRQ Clearinghouse
N/A	Cancer	Cervical cancer screening: women 21-65 years	Process	HIW
1365	Mental Illness	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	CMS
1364	Mental Illness	Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation	Process	QPS
2823	Infant Mortality	Children with MSI who underwent surgery under continued anesthesia immediately following sedated	N/A	OPUS
0626	Diabetes/ CKD	Chronic Kidney Disease - Lipid Profile Monitoring	Process	QPS
0574	Diabetes/ CKD	Chronic Kidney Disease (CKD): Monitoring Calcium	Process	QPS
0571	Diabetes/ CKD	Chronic Kidney Disease (CKD): Monitoring Parathyroid Hormone (PTH)	Process	QPS
0570	Diabetes/ CKD	Chronic Kidney Disease (CKD): Monitoring Phosphorus	Process	QPS
0627	Diabetes/ CKD	Chronic Kidney Disease with LDL Greater than or equal to 130 – Use of Lipid Lowering Agent	Process	QPS
0550	Diabetes/ CKD	Chronic Kidney Disease, Diabetes Mellitus, Hypertension and Medication Possession Ratio for ACEI/ARB Therapy	Process	QPS
0067	CVD	Chronic Stable Coronary Artery Disease: Antiplatelet Therapy	Process	QPS
0074	CVD	Chronic Stable Coronary Artery Disease: Lipid Control	Process	QPS
0065	CVD	Chronic Stable Coronary Artery Disease: Symptom and Activity Assessment	Process	QPS
N/A	Mental Illness	Clinical Depression Screening and Follow-Up Reporting Measure	Process	CMS
N/A	Mental Illness	Closing the Referral Loop: Receipt of Specialist Report	N/A	Wyoming's PCMH Program
N/A	Mental Illness	Cognitive Impairment Assessment Among Older Adults (75 Years and Older)	Process	CMS
N/A	Mental Illness	Cognitive Impairment or Dysfunction Assessment for Patients with Parkinson's Disease	Process	CMS
0385	Cancer	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	Process	NQF Cancer Project

0385	Cancer	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	Process	CMS
N/A	Cancer	Colonoscopy use: adults 50-75 (percent) (Source: NHIS)	Process	HIW
N/A	Cancer	Colonoscopy/sigmoidoscopy: adults 50+ (percent)	Process	HIW
N/A	Cancer	Colorectal cancer deaths (per 100,000)	Outcome	HIW
N/A	Cancer	Colorectal cancer deaths, including unspecified sites	Outcome	HIW
0392	Cancer	Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	Outcome	NQF Cancer Project
0034	Cancer	Colorectal Cancer Screening	Process	CMS
N/A	Cancer	Colorectal cancer screening: persons 50-75 years	Outcome	HIW
0559	Cancer	Combination chemotherapy is recommended or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or Stage IB - III hormone receptor negative breast cancer.	Process	NQF Cancer Project
0209	CVD	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	Outcome: PRO	QPS
0209	Diabetes/ CKD	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	Outcome: PRO	QPS
N/A	Cancer	Communication and shared decision-□making with patients and families for interventional oncology procedures	Process	CMS
N/A	Diabetes/ CKD	Comorbidity Reporting Measure		CMS - 2282
0224	Cancer	Completeness of pathology reporting	Process	NQF Cancer Project
0731	Diabetes/ CKD	Comprehensive Diabetes Care	Composite	QPS
0061	CVD	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	Outcome	QPS
0061	Diabetes/ CKD	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	Outcome	QPS
0055	Diabetes/ CKD	Comprehensive Diabetes Care: Eye Exam	Process	CMS
0055	Diabetes/ CKD	Comprehensive Diabetes Care: Eye Exam (retinal) performed	Process	QPS
0056	Diabetes/ CKD	Comprehensive Diabetes Care: Foot Exam	Process	QPS
0575	Diabetes/ CKD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	Outcome	QPS
0059	Diabetes/ CKD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Outcome	QPS
0057	Diabetes/ CKD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Process	QPS

0057	Diabetes/ CKD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C)	Process	CMS
0062	Diabetes/ CKD	Comprehensive Diabetes Care: Medical Attention for Nephropathy	Process	QPS
N/A	Diabetes/ CKD	Comprehensive diabetes care: percentage of members 18 to 64 years of age with diabetes (type 1 and type 2) whose most recent hemoglobin A1c (HbA1c) level is less than 7.0% (controlled).	N/A	NQMC - 10523
N/A	CVD	Congestive heart failure admission rate (per 100,000 beneficiaries)		HIW
0277	CVD	Congestive Heart Failure Rate (PQI 08)	Process	QPS
3172	Mental Illness	Continuity of Pharmacotherapy for Alcohol Use Disorder	Process	QPS
3175	Mental Illness	Continuity of Pharmacotherapy for Opioid Use Disorder	Process	QPS
0018	CVD	Controlling High Blood Pressure	Outcome	QPS
0018	Diabetes/ CKD	Controlling High Blood Pressure	Outcome	QPS
2602	CVD	Controlling High Blood Pressure for People with Serious Mental Illness	Outcome	QPS
0236	CVD	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	Process	CMS
0066	CVD	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Process	QPS
0066	Diabetes/ CKD	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Process	QPS
N/A	CVD	Coronary heart disease deaths		HIW
1814	Infant Mortality	Counseling for Women of Childbearing Potential with Epilepsy	Process	OPUS
N/A	Mental Illness	Counseling Patients with Parkinson's Disease About Regular Exercise Regimen	Process	CMS
N/A	Cross-cutting	Cultural Competence	Process	CMS
N/A	Cross-cutting	Cultural Competency Implementation Measure	Process	CMS
2377	CVD	Defect Free Care for AMI	Composite	QPS
0280	Diabetes/ CKD	Dehydration Admission Rate (PQI 10)	Outcome	QPS
0249	Diabetes/ CKD	Delivered Dose of Hemodialysis Above Minimum	Outcome	QPS
N/A	Diabetes/ CKD	Delivered Dose of Pediatric Peritoneal Dialysis (PD) Above Minimum	Outcome	CMS

0318	Diabetes/ CKD	Delivered Dose of Peritoneal Dialysis Above Minimum	Outcome	QPS
1885	Mental Illness	Depression care: percentage of patients 18 years of age or older with major depression or dysthymia who demonstrated a response to treatment 12 months (+/- 30 days) after an index visit.	Outcome	AHRQ
N/A	Mental Illness	Depression Interventions Implemented During All Episodes of Care	Process	CMS
N/A	Mental Illness	Depression Interventions Implemented During Long Term Episodes of Care	Process	CMS
N/A	Mental Illness	Depression Interventions Implemented During Short Term Episodes of Care	Process	CMS
N/A	Mental Illness	Depression Interventions in Plan of Care	Process	CMS
0711	Mental Illness	Depression Remission at Six Months	Outcome	QPS
0710	Mental Illness	Depression Remission at Twelve Months	Outcome	QPS
1884	Mental Illness	Depression Response at Six Months- Progress Towards Remission	Outcome	QPS
1885	Mental Illness	Depression Response at Twelve Months- Progress Towards Remission	Outcome	QPS
N/A	Mental Illness	Depression screening by primary care providers: adults	N/A	HIW
0712	Mental Illness	Depression Utilization of the PHQ-9 Tool	Process	QPS
0630	Diabetes/ CKD	Diabetes and Elevated HbA1C – Use of Diabetes Medications	Process	QPS
0582	Infant Mortality	Diabetes and Pregnancy: Avoidance of Oral Hypoglycemic Agents	Process	OPUS
2606	Mental Illness	Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)	Outcome	QPS
2609	Mental Illness	Diabetes Care for People with Serious Mental Illness: Eye Exam	Process	QPS
2608	Mental Illness	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)	Outcome	QPS
2607	Mental Illness	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Outcome	QPS
2603	Mental Illness	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing	Process	QPS
2604	Mental Illness	Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy	Process	QPS
0729	Diabetes/ CKD	Diabetes Composite	Composite	CMS
0274	Diabetes/ CKD	Diabetes Long-Term Complications Admission Rate (PQI 03)	Outcome	QPS

0417	Diabetes/ CKD	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation	Process	CMS
0416	Diabetes/ CKD	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention - Evaluation of Footwear	Process	CMS
0729	Diabetes/ CKD	Diabetes Mellitus: High Blood Pressure Control	N/A	CMS
1934	Diabetes/ CKD	Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	Process	QPS
1932	Diabetes/ CKD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Process	QPS
0272	Diabetes/ CKD	Diabetes Short-Term Complications Admission Rate (PQI 01)	Outcome	QPS
0619	Diabetes/ CKD	Diabetes with Hypertension or Proteinuria - Use of an ACE Inhibitor or ARB	Process	QPS
0618	Diabetes/ CKD	Diabetes with LDL-C greater than 100 – Use of a Lipid Lowering Agent	Process	QPS
0056	Diabetes/ CKD	Diabetes: Foot Exam	Process	CMS
0059	Diabetes/ CKD	Diabetes: Hemoglobin A1c Poor Control	Intermediate Outcome	CMS
0417	Diabetes/ CKD	Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation	Process	QPS
0416	Diabetes/ CKD	Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear	Process	QPS
0519	Diabetes/ CKD	Diabetic Foot Care and Paitent/Caregiver Education Implemented during All Episodes of Care	Process	CMS
0519	Diabetes/ CKD	Diabetic Foot Care and Patient Education Implemented	Process	QPS
N/A	Diabetes/ CKD	Diabetic foot care and patient education implemented during short term episodes of care	Process	CMS - 2685
N/A	Diabetes/ CKD	Diabetic Foot Care and Patient Education in Plan of Care	Process	CMS - 0984
N/A	Diabetes/ CKD	Diabetic Foot Care And Patient/Caregiver Education Implemented During Long Term Episodes Of Care	Process	CMS - 0960
0089	Diabetes/ CKD	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Process	QPS
0088	Diabetes/ CKD	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Process	QPS
0509	Cancer	Diagnostic imaging: percentage of patients undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram.	Process	AHRQ Clearinghouse
0965	CVD	Discharge Medications (ACE/ARB and beta blockers) in Eligible ICD Implant Patients	Composite	QPS

N/A	Mental Illness	Discharged to the Community with Behavioral Problems	Outcome	CMS
N/A	Cancer	Draft: Breast Cancer Condition Episode for CMS Episode Grouper	Cost/Resource Use	CMS
N/A	Cancer	Draft: Colon Cancer Condition Episode for CMS Episode Grouper	Cost/Resource Use	CMS
N/A	Cancer	Draft: Lung Cancer Condition Episode for CMS Episode Grouper	Cost/Resource Use	CMS
N/A	Cancer	Draft: Prostate Cancer Condition Episode for CMS Episode Grouper	Cost/Resource Use	CMS
0520	Diabetes/ CKD	Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care	Process	QPS
2825	Infant Mortality	Duration of Sedated MRI for Children with Suspected Deep Musculoskeletal Infection	N/A	OPUS
0583	CVD	Dyslipidemia new med 12-week lipid test	Process	QPS
0090	CVD	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	Process	CMS
0092	CVD	Emergency Medicine: Aspirin at Arrival for Acute Myocardial Infarction (AMI)	Process	QPS
N/A	Diabetes/ CKD	End stage renal disease (ESRD): percentage of a facility's ESRD patients aged 18 years and older with medical record documentation of a discussion of renal replacement therapy modalities at least once during the 12-month reporting period.	N/A	NQMC - 9910
N/A	Diabetes/ CKD	End stage renal disease (ESRD): percentage of a physician's ESRD patients aged 18 years and older with medical record documentation of a discussion of renal replacement therapy modalities at least once during the 12-month reporting period.	Process	NQMC, NQMC - 9910
N/A	Diabetes/ CKD	End stage renal disease (ESRD): percentage of Medicare patients with a mean hemoglobin value greater than 12 g/dL.	N/A	NQMC, NQMC - 9489
N/A	Infant Mortality	End stage renal disease (ESRD): percentage of patient months for all pediatric (< 18 years old) in-center hemodialysis patients in which the delivered dose of hemodialysis (calculated from the last measurement of the month using the UKM or Daugirdas II formula) was spKt/V ≥ 1.2.	Outcome	NQMC
N/A	Diabetes/ CKD	End stage renal disease (ESRD): risk-adjusted standardized transfusion ration (STrR) for dialysis facility patients	N/A	NQMC - 9490
N/A	Diabetes/ CKD	End-stage kidney failure due to diabetes	N/A	HIW
N/A	Diabetes/ CKD	End-stage kidney failure: diabetics	N/A	HIW
0250	Diabetes/ CKD	ESRD- HD Adequacy CPM III: Minimum Delivered Hemodialysis Dose for ESRD hemodialysis patients	Outcome	QPS

		undergoing dialytic treatment for a period of 90 days or greater.		
0135	CVD	Evaluation of Left ventricular systolic function (LVS)	Process	CMS
N/A	Mental Illness	Evaluation or Interview for Risk of Opioid Misuse	Process	CMS
2881	CVD	Excess days in acute care (EDAC) after hospitalization for acute myocardial infarction (AMI)	Outcome	QPS
2880	CVD	Excess days in acute care (EDAC) after hospitalization for heart failure	Outcome	QPS
1822	Cancer	External Beam Radiotherapy for Bone Metastases	Process	NQF Cancer Project
0208	CVD	Family Evaluation of Hospice Care	Outcome: PRO	QPS
0208	Diabetes/ CKD	Family Evaluation of Hospice Care	Outcome: PRO	QPS
2842	Cross-cutting	Family Experiences with Coordination of Care (FECC)-1 Has Care Coordinator	Process	NQF QPS
2849	Cross-cutting	Family Experiences with Coordination of Care (FECC)-15: Caregiver has access to medical interpreter when needed	Process	NQF QPS
N/A	Infant Mortality	Fetal deaths	N/A	HIW
0288	CVD	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	Process	QPS
0164	CVD	Fibrinolytic Therapy received within 30 minutes of hospital arrival	Process	QPS
0482	Infant Mortality	First NICU Temperature < 36 degrees Centigrade	Outcome	OPUS
0481	Infant Mortality	First temperature measured within one hour of admission to the NICU.	Process	OPUS
N/A	Infant Mortality	Folic acid intake: reproductive-aged women	N/A	HIW
N/A	Mental Illness	Follow-up after Discharge from the Emergency Department for Mental Illness or Alcohol or Other Drug Dependence.	Process	CMS
N/A	Cross-cutting	Follow-Up after ED visit for complex populations	Process	CMS MUD
2605	Mental Illness	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence	Process	QPS
N/A	Mental Illness	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	Process	CMS
0576	Mental Illness	Follow-up after hospitalization for mental illness: percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected Mental Illness disorders and who had an outpatient visit, an intensive outpatient service, or partial	Process	AHRQ

		hospitalization with a Mental Illness provider within 30 days of discharge.		
0576	Mental Illness	Follow-up after hospitalization for mental illness: percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected Mental Illness disorders and who had an outpatient visit, an intensive outpatient service, or partial hospitalization with a Mental Illness provider within 7 days of discharge.	Process	AHRQ
0572	Cancer	Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy	Process	NQF Cancer Project
0108	Mental Illness	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	Process	CMS
N/A	CVD	Frailty Assessment	Process	CMS
1418	Infant Mortality	Frequency of Adequacy Measurement for Pediatric Hemodialysis Patients	Process	OPUS
1401	Infant Mortality	Maternal Depression Screening	Process	QPS
2483	CVD	Gains in Patient Activation (PAM) Scores at 12 Months	Outcome: PRO	QPS
2483	Mental Illness	Gains in Patient Activation (PAM) Scores at 12 Months	Outcome	QPS
2483	Cross-cutting	Gains in Patient Activation (PAM) Scores at 12 Months	Outcome: PRO	NQF QPS
0727	Infant Mortality	Gastroenteritis Admission Rate (PDI 16)	Outcome	OPUS
2362	Diabetes/ CKD	Glycemic Control - Hyperglycemia	Outcome	QPS
2363	Diabetes/ CKD	Glycemic Control - Hypoglycemia	Outcome	QPS
N/A	Infant Mortality	Group B streptococcal disease: newborns	N/A	HIW
N/A	CVD	Guidelines for the management of absolute cardiovascular disease risk.		NGC
1922	Mental Illness	HBIPS-1 Admission Screening	Process	QPS
0560	Mental Illness	HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	Process	QPS
0557	Mental Illness	HBIPS-6 Post discharge continuing care plan created	Process	QPS
0558	Mental Illness	HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	Process	QPS
N/A	Infant Mortality	Healthy weight prior to pregnancy	N/A	HIW
N/A	CVD	Heart attack Medicare beneficiaries (number)		HIW

			N/A	
N/A	CVD	Heart attack Medicare beneficiaries (percent)	N/A	HIW
N/A	CVD	Heart disease death (per 100,000)	N/A	HIW
N/A	CVD	Heart disease death (percent)	N/A	HIW
0610	CVD	Heart Failure - Use of ACE Inhibitor (ACEI) or Angiotensin Receptor Blocker (ARB) Therapy	Process	QPS
0615	CVD	Heart Failure - Use of Beta Blocker Therapy	Process	QPS
0078	CVD	Heart Failure (HF) : Assessment of Clinical Symptoms of Volume Overload (Excess)	Process	QPS
0081	CVD	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Process	QPS
0083	CVD	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Process	QPS
0136	CVD	Heart Failure (HF): Detailed discharge instructions	Process	CMS
N/A	CVD	Heart failure in adults: percentage of patients with heart failure diagnosis who were educated on the management of their condition.	Process	NQMC - 008934
0358	CVD	Heart Failure Mortality Rate (IQI 16)	Outcome	QPS
0521	CVD	Heart Failure Symptoms Assessed and Addressed	Process	QPS
0079	CVD	Heart Failure: Left Ventricular Ejection Fraction Assessment (Outpatient Setting)	Process	QPS
0077	CVD	Heart Failure: Symptom and Activity Assessment	Process	QPS
0379	Cancer	Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	Process	NQF Cancer Project
0380	Cancer	Hematology: Multiple Myeloma: Treatment with Bisphosphonates	Process	NQF Cancer Project
0377	Cancer	Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemia's: Baseline Cytogenetic Testing Performed on Bone Marrow	Process	NQF Cancer Project
0378	Cancer	Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	Process	NQF Cancer Project
0249	Diabetes/ CKD	Hemodialysis (HD) Adequacy: Delivered Dose of Hemodialysis Above Minimum	Outcome	CMS
0247	Diabetes/ CKD	Hemodialysis Adequacy Clinical Performance Measure I: Hemodialysis Adequacy- Monthly measurement of delivered dose	Process	QPS
0248	Diabetes/ CKD	Hemodialysis Adequacy Clinical Performance Measure II: Method of Measurement of Delivered Hemodialysis Dose	Process	QPS
0259	Diabetes/ CKD	Hemodialysis Vascular Access Decision-making by surgeon to Maximize Placement of Autogenous Arterial Venous Fistula	Process	QPS

2978	Diabetes/ CKD	Hemodialysis Vascular Access: Long-term Catheter Rate	Intermediate Clinical Outcome	
2977	Diabetes/ CKD	Hemodialysis Vascular Access: Standardized Fistula Rate	Intermediate Clinical Outcome	
0060	Diabetes/ CKD	Hemoglobin A1c (HbA1c) Testing for Pediatric Patients	Process	QPS
N/A	Diabetes/ CKD	Hemoglobin Greater than 12 g/dL	Process	CMS - 1694
0475	Infant Mortality	Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge	Process	OPUS
1857	Cancer	HER2 negative or undocumented breast cancer patients spared treatment with HER2-targeted therapies	Process	NQF Cancer Project
1878	Cancer	HER2 testing for overexpression or gene amplification in patients with breast cancer	Process	NQF Cancer Project
0617	Diabetes/ CKD	High Risk for Pneumococcal Disease - Pneumococcal Vaccination	Process	QPS
0617	CVD	High Risk for Pneumococcal Disease - Pneumococcal Vaccination	Process	QPS
0623	Cancer	History of Breast Cancer - Cancer Surveillance	Process	NQF Cancer Project
0625	Cancer	History of Prostate Cancer - Cancer Surveillance	Process	NQF Cancer Project
N/A	Infant Mortality	HIV, prenatally acquired	N/A	HIW
0404	Infant Mortality	HIV/AIDS: CD4 Cell Count or Percentage Performed	Process	OPUS
0405	Infant Mortality	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Process	OPUS
0408	Infant Mortality	HIV/AIDS: Tuberculosis (TB) Screening	Process	OPUS
0505	CVD	Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization.	Outcome	QPS
0695	CVD	Hospital 30-Day Risk-Standardized Readmission Rates following Percutaneous Coronary Intervention (PCI)	Outcome	QPS
0230	CVD	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older	Outcome	QPS
2558	CVD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery	Outcome	QPS

0229	CVD	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older	Outcome	QPS
0330	CVD	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure (HF) hospitalization	Outcome	QPS
2515	CVD	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery	Outcome	QPS
N/A	Infant Mortality	Hospital inpatients' experiences: percentage of parents who reported how often they got prompt help when they pressed the call button.	Consumer Experience	
0694	CVD	Hospital Risk-Standardized Complication Rate following Implantation of Implantable Cardioverter-Defibrillator (ICD)	Composite	QPS
0534	CVD	Hospital specific risk-adjusted measure of mortality or one or more major complications within 30 days of a lower extremity bypass (LEB).	Outcome	QPS
0534	Diabetes/ CKD	Hospital specific risk-adjusted measure of mortality or one or more major complications within 30 days of a lower extremity bypass (LEB).	Outcome	QPS
N/A	Infant Mortality	Hospital standardized mortality ratio (HSMR): the ratio of the actual number of acute in-hospital deaths to the expected number of in-hospital deaths, for conditions accounting for about 80% of inpatient mortality.	Outcome	NQMC
1625	CVD	Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated	Process	QPS
2431	CVD	Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Acute Myocardial Infarction (AMI)	Cost/Resou rce Use	QPS
1789	CVD	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Outcome	QPS
1789	Diabetes/ CKD	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Outcome	QPS
2473	CVD	Hybrid hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI)	Outcome	QPS
2879	CVD	Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data	Outcome	QPS
2879	Diabetes/ CKD	Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data	Outcome	QPS
1454	Diabetes/ CKD	Hypercalcemia Clinical Measure	Outcome	CMS
0611	CVD	Hyperlipidemia (Primary Prevention) - Lifestyle Changes and/or Lipid Lowering Therapy	Process	QPS
N/A	Diabetes/ CKD	Hypertension diagnosis and treatment: percentage of adult patients age greater than or equal to 18 years		NQMC - 10057

		diagnosed with chronic kidney disease whose blood pressure is at SBP less than 140 mmHg and DBP less than 90 mmHg.	N/A	
0017	CVD	Hypertension Plan of Care	Outcome	QPS
0348	Infant Mortality	Iatrogenic Pneumothorax Rate (PDI 5)	Outcome	OPUS
N/A	Mental Illness	Improvement in Anxiety Level	Outcome	CMS
N/A	Mental Illness	Improvement in Behavior Problem Frequency	Outcome	CMS
N/A	Mental Illness	Improvement in Confusion Frequency	Outcome	CMS
0470	Infant Mortality	Incidence of Episiotomy	Process	OPUS
N/A	Infant Mortality	Infant deaths due to birth defects	N/A	HIW
N/A	CVD	Infection within 180 Days of Cardiac Implantable Electronic Device (CIED)	Outcome	CMS
0226	Diabetes/ CKD	Influenza Immunization in the ESRD Population (Facility Level)	Process	QPS
0226	Infant Mortality	Influenza Immunization in the ESRD Population (Facility Level)	Process	OPUS
0746	Infant Mortality	In-hospital Neonatal Death	Outcome	OPUS
0743	Infant Mortality	In-hospital Maternal Deaths	Outcome	OPUS
2459	CVD	In-hospital Risk Adjusted Rate of Bleeding Events for patients undergoing PCI	Outcome	QPS
0133	CVD	In-Hospital Risk Adjusted Rate of Mortality for Patients Undergoing PCI	Outcome	QPS
3005	Infant Mortality	Initial Risk Assessment for Immobility-Related Pressure Ulcer within 24 Hours of PICU Admission		OPUS
0004	Mental Illness	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a. Initiation, b. Engagement	Process	QPS
N/A	Infant Mortality	Inpatient perinatal care: percent of live-born neonates less than 2,500 grams that have a temperature documented within 15 minutes after their arrival to a Level 2 or higher nursery.	Process	NQMC
N/A	Infant Mortality	Inpatient perinatal care: percent of live-born neonates less than 2,500 grams that have a temperature documented within the Golden Hour from birth to 60 minutes of age.	Process	NQMC
N/A	Infant Mortality	Inpatient perinatal care: the number of live-born neonates less than 2,500 grams that arrive to a Level 2 or higher nursery whose qualifying temperature falls within the criteria for that stratum: cold, very cool, cool, euthermic, and overly warm.	N/A	NQMC

2461	CVD	In-person Evaluation Following Implantation of a Cardiovascular Implantable Elec	Process	CMS
2461	CVD	In-Person Evaluation Following Implantation of a Cardiovascular Implantable Electronic Device (CIED)	Process	QPS
0556	CVD	INR for Individuals Taking Warfarin and Interacting Anti-Infective Medications	Process	QPS
0555	CVD	INR Monitoring for Individuals on Warfarin	Process	QPS
2732	CVD	INR Monitoring for Individuals on Warfarin after Hospital Discharge	Process	QPS
1746	Infant Mortality	Intrapartum Antibiotic Prophylaxis for Group B Streptococcus (GBS)	Process	OPUS
N/A	Cancer	Invasive colorectal cancer	Process	HIW
N/A	Cancer	Invasive uterine cervical cancer: females	Process	HIW
N/A	CVD	Ischemic heart disease Medicare beneficiaries (number)		HIW
N/A	CVD	Ischemic heart disease Medicare beneficiaries (percent)		HIW
0073	CVD	Ischemic Vascular Disease (IVD): Blood Pressure Control	Outcome	QPS
0075	CVD	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control <100 mg/dL	Outcome	QPS
0068	CVD	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Process	QPS
1859	Cancer	KRAS gene mutation testing performed for patients with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy	Process	NQF Cancer Project
N/A	Diabetes/ CKD	Kt/V Dialysis Adequacy Comprehensive Clinical Measure	Outcome	CMS
0303	Infant Mortality	Late sepsis or meningitis in neonates (risk-adjusted)	Outcome	OPUS
0304	Infant Mortality	Late sepsis or meningitis in Very Low Birth Weight (VLBW) neonates (risk-adjusted)	Outcome	OPUS
N/A	Cancer	Late-stage breast cancer: females	Process	HIW
0308	Cross-cutting	LBP: Evaluation of Patient Experience	Process	NQF QPS
0307	Diabetes/ CKD	LBP: Patient Education	Process	QPS
N/A	CVD	Lipid management in adults: percentage of patients with established atherosclerotic cardiovascular disease (ASCVD), or 10-year CHD risk greater than or equal to 10%, or diabetes and on lipid-lowering medication who have a fasting lipid panel within 24 months of medication prescription.	Process	NQMC - 009379
N/A	CVD	Lipid management in adults: percentage of patients with established atherosclerotic cardiovascular disease (ASCVD), or a 10-year risk for CHD greater than or equal to 10%, or diabetes, who are on a statin or have LDL less than 100 ml/dL within a 12-month period.	Process	NQMC - 009378

2632	CVD	Long-Term Care Hospital (LTCH) Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support	Outcome	QPS
0285	Diabetes/ CKD	Lower-Extremity Amputation among Patients with Diabetes Rate (PQI 16)	Outcome	QPS
N/A	Cancer	Lung cancer deaths	Outcome	HIW
N/A	Cancer	Lung Cancer Reporting (Biopsy/Cytology Specimens)	Outcome	CMS
N/A	Cancer	Lung, trachea, and bronchus cancer deaths (per 100,000)	Outcome	HIW
0104	Mental Illness	Major Depressive Disorder: Suicide Risk Assessment	Process	QPS
N/A	Cancer	Mammogram: women 50+ (percent) (Source: BRFSS)	Process	HIW
N/A	Cancer	Mammography counseling: women 50-74 years	Process	HIW
N/A	Cancer	Mammography: women 40+ (percent) (Source: NHIS)	Process	HIW
N/A	Cancer	Mammography: women 50-74 years	Process	HIW
N/A	Infant Mortality	Maternal and newborn care: proportion of newborn screening samples that were unsatisfactory for testing, by submitting hospital and comparator groups.	Process	NQMC
N/A	Infant Mortality	Maternal and newborn care: rate of formula supplementation from birth to discharge in term infants whose mothers intended to exclusively breastfeed.	Process	NQMC
0750	Infant Mortality	Maternal blood transfusion	Outcome	OPUS
2769	Cross-cutting	Functional Change: Change in Self Care Score for Skilled Nursing Facilities	Outcome	QPS
0257	Diabetes/ CKD	Maximizing Placement of Arterial Venous Fistula (AVF)	Outcome	QPS
1425	Diabetes/ CKD	Measurement of nPCR for Pediatric Hemodialysis Patients	Process	QPS
1425	Infant Mortality	Measurement of nPCR for Pediatric Hemodialysis Patients	Process	OPUS
0255	Diabetes/ CKD	Measurement of Phosphorus Concentration	Process	QPS
0261	Diabetes/ CKD	Measurement of Serum Calcium Concentration	Process	QPS
0289	CVD	Median Time to ECG	Efficiency	QPS
0287	CVD	Median Time to Fibrinolysis	Process	QPS
0290	CVD	Median Time to Transfer to Another Facility for Acute Coronary Intervention	Process	QPS
N/A	Diabetes/ CKD	Medical evaluation: chronic kidney disease & diabetes older adults	N/A	HIW
3205	Mental Illness	Medication Continuation Following Inpatient Psychiatric Discharge	Process	QPS
2988	Diabetes/ CKD	Medication Reconciliation for Patients Receiving Care at Dialysis Facilities	Process	QPS

3207	Mental Illness	Medication Reconciliation on Admission	Composite	QPS
0561	Cancer	Melanoma Coordination of Care	Process	NQF Cancer Project
N/A	Cancer	Melanoma: percentage of patients who undergo a cervical lymph node dissection (LND) or completion lymph node dissection (CLND) for melanoma for whom at least 15 regional lymph nodes are resected and pathologically examined.	N/A	AHRQ Clearinghouse
N/A	Mental Illness	Mental illness: risk-adjusted rate of readmission following discharge for a mental illness.	Cost/Resource Use	AHRQ
2800	Mental Illness	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Process	QPS
1421	Diabetes/ CKD	Method of Adequacy Measurement for Pediatric Hemodialysis Patients	Process	QPS
1421	Infant Mortality	Method of Adequacy Measurement for Pediatric Hemodialysis Patients	Process	OPUS
0613	CVD	MI - Use of Beta Blocker Therapy	Process	QPS
N/A	Diabetes/ CKD	Mineral Metabolism Reporting Measure	Process	CMS
N/A	Cancer	Minimally invasive surgery performed for patients with endometrial cancer	Process	CMS
0256	Diabetes/ CKD	Minimizing Use of Catheters as Chronic Dialysis Access	Outcome	QPS
2704	Diabetes/ CKD	Minimum Delivered Peritoneal Dialysis Dose	Outcome	QPS
1423	Diabetes/ CKD	Minimum spKt/V for Pediatric Hemodialysis Patients	Outcome	QPS
1423	Infant Mortality	Minimum spKt/V for Pediatric Hemodialysis Patients	Outcome	OPUS
0370	Diabetes/ CKD	Monitoring hemoglobin levels below target minimum	Outcome	QPS
1424	Diabetes/ CKD	Monthly Hemoglobin Measurement for Pediatric Patients	Process	QPS
1424	Infant Mortality	Monthly Hemoglobin Measurement for Pediatric Patients	Process	OPUS
N/A	Infant Mortality	Multivitamins/folic acid use, preconception	N/A	HIW
N/A	Diabetes/ CKD	National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Patients Clinical Measure	Outcome	CMS
0138	Infant Mortality	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	Outcome	OPUS

0139	Infant Mortality	National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	Outcome	OPUS
0221	Cancer	Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection	Process	NQF Cancer Project
	Cancer	Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection	Process	CMS
0478	Infant Mortality	Neonatal Blood Stream Infection Rate (NQI 03)	Outcome	OPUS
0485	Infant Mortality	Neonatal Immunization	Process	OPUS
2893	Infant Mortality	Neonatal Intensive Care All-Condition Readmissions	Outcome	OPUS
N/A	Infant Mortality	Neonatal zidovudine (ZDV) prophylaxis: percentage of infants born to HIV-infected women who were prescribed ZDV prophylaxis for HIV within 12 hours of birth during the measurement year.	Process	NQMC
0145	Infant Mortality	Neonate immunization administration	Process	OPUS
0600	CVD	New Atrial Fibrillation: Thyroid Function Test	Process	QPS
0621	Diabetes/ CKD	Non-Diabetic Nephropathy - Use of ACE Inhibitor or ARB Therapy	Process	QPS
N/A	Cancer	Non-recommended cervical cancer screening in adolescent females: percentage of adolescent females 16 to 20 years of age who were screened unnecessarily for cervical cancer.	N/A	AHRQ Clearinghouse
0383	Cancer	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	Process	NQF Cancer Project
0382	Cancer	Oncology: Radiation Dose Limits to Normal Tissues	Process	NQF Cancer Project
0381	Cancer	Oncology: Treatment Summary Communication – Radiation Oncology	Process	NQF Cancer Project
0386	Cancer	Oncology: Cancer Stage Documented	Process	CMS
0386	Cancer	Oncology: Cancer Stage Documented	Process	NQF Cancer Project
0384	Cancer	Oncology: Medical and Radiation - Pain Intensity Quantified	Process	NQF Cancer Project
0733	CVD	Operative Mortality Stratified by the 5 STAT Mortality Categories	Outcome	QPS
0733	Infant Mortality	Operative Mortality Stratified by the 5 STAT Mortality Categories	N/A	OPUS

2594	Diabetes/ CKD	Optimal End Stage Renal Disease (ESRD) Starts	Process	QPS
0076	CVD	Optimal Vascular Care	Composite	QPS
N/A	Cancer	Overuse of Imaging for Staging Breast Cancer at Low Risk of Metastasis	Process	CMS
N/A	CVD	Overuse of Percutaneous Coronary Intervention (PCI) in Asymptomatic Patients	Process	CMS
0562	Cancer	Overutilization of Imaging Studies in Melanoma	Process	NQF Cancer Project
N/A	Cancer	Pap smears: women 18+ (percent) (Source: NHIS)	Process	HIW
N/A	Cancer	Pap smears: women 18+ without hysterectomy (percent)	Process	HIW
N/A	Cancer	Pap test counseling: women 21-65 years	Process	HIW
N/A	Cancer	Pap test: women 18+ (percent)	Process	HIW
N/A	Mental Illness	Parkinson's Disease Rehabilitative Therapy Options	Process	CMS
0734	Infant Mortality	Participation in a National Database for Pediatric and Congenital Heart Surgery	Structure	OPUS
0324	Diabetes/ CKD	Patient Education Awareness—Facility Level	Process	QPS
0320	Diabetes/ CKD	Patient Education Awareness—Physician Level	Process	QPS
0726	Mental Illness	Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)	N/A	ARHQ Measure Clearinghouse
N/A	Mental Illness	Patient experiences of psychiatric care: percent of patients who responded positively to the "Dignity" domain on the Inpatient Consumer Survey (ICS).		AHRQ
N/A	Mental Illness	Patient experiences of psychiatric care: percent of patients who responded positively to the "Outcome of Care" domain on the Inpatient Consumer Survey (ICS).		AHRQ
N/A	Mental Illness	Patient experiences of psychiatric care: percent of patients who responded positively to the "Participation in Treatment" domain on the Inpatient Consumer Survey (ICS).		AHRQ
0665	CVD	Patient(s) with an emergency medicine visit for non-traumatic chest pain that had an ECG.	Process	QPS
0664	CVD	Patient(s) with an emergency medicine visit for syncope that had an ECG.	Process	QPS
0605	CVD	Patient(s) with hypertension that had a serum creatinine in last 12 reported months.	Process	QPS
N/A	Mental Illness	Patients discharged on multiple antipsychotic medications with appropriate justification	Process	CMS
N/A	Cancer	Patients with Advanced Cancer Screened for Pain at Outpatient Visits	Process	CMS

0222	Cancer	Patients with early stage breast cancer who have evaluation of the axilla	Process	NQF Cancer Project
1860	Cancer	Patients with metastatic colorectal cancer and KRAS gene mutation spared treatment with anti-epidermal growth factor receptor monoclonal antibodies	Process	NQF Cancer Project
0469	Infant Mortality	PC-01 Elective Delivery	Process	OPUS
0471	Infant Mortality	PC-02 Cesarean Birth	Outcome	OPUS
0476	Infant Mortality	PC-03 Antenatal Steroids	Process	OPUS
1731	Infant Mortality	PC-04 Health Care-Associated Bloodstream Infections in Newborns	Outcome	OPUS
N/A	CVD	PCI mortality (risk-adjusted) Â©	Outcome	CMS
2393	CVD	Pediatric All-Condition Readmission Measure	Outcome	QPS
2393	Infant Mortality	Pediatric All-Condition Readmission Measure	Outcome	OPUS
2820	Infant Mortality	Pediatric Computed Tomography (CT) Radiation Dose		OPUS
1667	Diabetes/ CKD	Pediatric Kidney Disease : ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL	Outcome	QPS
1667	Infant Mortality	Pediatric Kidney Disease : ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL	N/A	OPUS
N/A	Diabetes/ CKD	Pediatric Kidney Disease: Adequacy of Volume Management	Process	CMS
2414	Infant Mortality	Pediatric Lower Respiratory Infection Readmission Measure		OPUS
2706	Diabetes/ CKD	Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/V	Outcome	QPS
2706	Infant Mortality	Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/V		OPUS
2806	Mental Illness	Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department	Process	QPS
2631	CVD	Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Process	QPS
0684	Diabetes/ CKD	Percent of Residents with a Urinary Tract Infection (Long-Stay)	Outcome	QPS
N/A	Diabetes/ CKD	Percentage of Medicare Patients at a provider/facility who have an average hemoglobin value less than 10.0 g/dL	Outcome	CMS - 1446
2411	CVD	Percutaneous Coronary Intervention (PCI): Comprehensive Documentation of Indications for PCI	Process	QPS
2452	CVD	Percutaneous Coronary Intervention (PCI): Post-procedural Optimal Medical Therapy	Composite	QPS

N/A	Infant Mortality	Perinatal care: proportion of infants receiving enteral feedings who receive any human milk, with or without fortifier or formula, within 24 hours before discharge, transfer, or death.	Process	NQMC
1438	Diabetes/ CKD	Periodic Assessment of Post-Dialysis Weight by Nephrologists	Process	QPS
0465	CVD	Perioperative Anti-platelet Therapy for Patients Undergoing Carotid Endarterectomy	Process	CMS
N/A	Infant Mortality	Perioperative care: percentage of patients, regardless of age, who undergo a procedure under anesthesia and are admitted to an ICU directly from the anesthetizing location, who have a documented use of a checklist or protocol for the transfer of care from the responsible anesthesia practitioner to the responsible ICU team or team member.	Process	NQMC
N/A	Infant Mortality	Perioperative care: percentage of patients, regardless of age, who undergo a surgical procedure under anesthesia who have documentation that all applicable safety checks from the World Health Organization (WHO) Surgical Safety Checklist were performed before induction of anesthesia.	Process	NQMC
N/A	Infant Mortality	Perioperative care: percentage of patients, regardless of age, who undergo central venous catheter (CVC) insertion for whom CVC was inserted with all elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques followed.	Process	NQMC
0454	CVD	Perioperative Temperature Management	Process	QPS
0454	Infant Mortality	Perioperative Temperature Management	Process	OPUS
2681	Infant Mortality	Perioperative Temperature Management		OPUS
0253	Diabetes/ CKD	Peritoneal Dialysis Adequacy Clinical Performance Measure I - Measurement of Total Solute Clearance at Regular Intervals	Process	QPS
0254	Diabetes/ CKD	Peritoneal Dialysis Adequacy Clinical Performance Measure II - Calculate Weekly KT/Vurea in the Standard Way	Process	QPS
0318	Diabetes/ CKD	Peritoneal Dialysis Adequacy: Delivered Dose of Peritoneal Dialysis (PD) Above Minimum	Outcome	CMS
0071	CVD	Persistence of Beta-Blocker Treatment After a Heart Attack	Intermediate Clinical Outcome	
N/A	CVD	Pharmacologic treatment of hypertension in adults aged 60 years or older to higher versus lower blood pressure targets: a clinical practice guideline from the American College of Physicians and the American Academy of Family Physicians.		NGC

0334	Infant Mortality	PICU Severity-adjusted Length of Stay	Outcome	OPUS
0343	Infant Mortality	PICU Standardized Mortality Ratio	Outcome	OPUS
0335	Infant Mortality	PICU Unplanned Readmission Rate	Outcome	OPUS
N/A	Infant Mortality	Pneumocystis carinii pneumonia (PCP) prophylaxis: percentage of eligible infants with HIV-exposure who were prescribed PCP prophylaxis in the measurement year.	Process	NQMC
0219	Cancer	Post breast conservation surgery irradiation	Process	NQF Cancer Project
0594	CVD	Post MI: ACE inhibitor or ARB therapy	Process	QPS
2439	CVD	Post-Discharge Appointment for Heart Failure Patients	Process	QPS
2443	CVD	Post-Discharge Evaluation for Heart Failure Patients	Process	QPS
2993	Diabetes/ CKD	Potentially Harmful Drug-Disease Interactions in the Elderly	Process	QPS
0502	Infant Mortality	Pregnancy test for female abdominal pain patients.	Process	OPUS
0608	Infant Mortality	Pregnant women that had HBsAg testing.	Process	OPUS
0606	Infant Mortality	Pregnant women that had HIV testing.	Structure	OPUS
0607	Infant Mortality	Pregnant women that had syphilis screening.	Process	OPUS
0014	Infant Mortality	Prenatal Anti-D Immune Globulin	Process	OPUS
0016	Infant Mortality	Prenatal Blood Group Antibody Testing	Process	OPUS
0015	Infant Mortality	Prenatal Blood Groups (ABO), D (Rh) Type	Process	OPUS
0012	Infant Mortality	Prenatal Screening for Human Immunodeficiency Virus (HIV)	Process	QPS
0127	CVD	Preoperative Beta Blockade	Process	QPS
N/A	Cancer	Preoperative Diagnosis of Breast Cancer	Process	CMS
0337	Infant Mortality	Pressure Ulcer Rate (PDI 2)	Outcome	OPUS
N/A	Infant Mortality	Preterm births, <32 weeks of gestation (percent)	N/A	HIW
N/A	Infant Mortality	Preterm births, 32-33 weeks of gestation (percent)	N/A	HIW
N/A	Infant Mortality	Preterm births, 32-36 weeks of gestation (percent)	N/A	HIW
N/A	Infant Mortality	Preterm births, 34-36 weeks of gestation (percent)	N/A	HIW

N/A	Infant Mortality	Preterm births, total (percent)	N/A	HIW
3132	Mental Illness	Preventative care and screening: screening for depression and follow up plan	Process	QPS
0464	CVD	Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter (CVC)	Process	QPS
0464	Infant Mortality	Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter (CVC)	Process	OPUS
2726	CVD	Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections	Process	QPS
2726	Infant Mortality	Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections	N/A	OPUS
0418	Mental Illness	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Process	QPS
N/A	Mental Illness	Preventive Care and Screening: Unhealthy Alcohol Use - Screening	Process	CMS
2152	Mental Illness	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Process	CMS
3185	Mental Illness	Preventive Care and Screening-Tobacco Use-Screening and Cessation Intervention (eMeasure)	Process	QPS
N/A	Cancer	Preventive services for adults: percentage of adolescent girls and women age 21 and younger who undergo cervical cancer screening.	Process	AHRQ Clearinghouse
N/A	Cancer	Preventive services for adults: percentage of women ages 21 to 64 years who have screening for cervical cancer (Pap test) every three years.	Process	AHRQ Clearinghouse
N/A	Cancer	Preventive services for adults: percentage of women ages 65 to 70 who are screened for cervical cancer and have undergone appropriate screening 10 years prior.	Process	AHRQ Clearinghouse
N/A	Cancer	Preventive services for children and adolescents: percentage of sexually active women age 25 years and younger who have had screening for chlamydia.	N/A	AHRQ Clearinghouse
N/A	Cancer	Preventive services: percentage of adult enrolled members age 19 years and older who are up-to-date for all appropriate preventive services (combination 3).	Process	AHRQ Clearinghouse
N/A	CVD	Primary and secondary prevention of cardiovascular disease: antithrombotic therapy and prevention of thrombosis, 9th ed: American College of Chest Physicians evidence-based clinical practice guidelines.		NGC
0163	CVD	Primary PCI received within 90 minutes of hospital arrival	Process	QPS
0632	CVD	Primary Prevention of Cardiovascular Events in Diabetics – Use of Aspirin or Antiplatelet Therapy	Process	QPS
0632	Diabetes/ CKD	Primary Prevention of Cardiovascular Events in Diabetics – Use of Aspirin or Antiplatelet Therapy	Process	QPS

0214	Cancer	Proportion dying from Cancer in an acute care setting	Process	NQF Cancer Project
0484	Infant Mortality	Proportion of infants 22 to 29 weeks gestation treated with surfactant who are treated within 2 hours of birth.	Process	OPUS
1351	Infant Mortality	Proportion of infants covered by Newborn Bloodspot Screening (NBS)	Process	QPS
0704	CVD	Proportion of Patients Hospitalized with AMI that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	Composite	QPS
0708	Diabetes/ CKD	Proportion of Patients Hospitalized with Pneumonia that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	Outcome	QPS
N/A	CVD	Proportion of Patients Hospitalized with Stroke that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	Outcome	QPS
0705	Diabetes/ CKD	Proportion of Patients Hospitalized with Stroke that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	Outcome	QPS
0216	Cancer	Proportion of patients who died from cancer admitted to hospice for less than 3 days	Intermediate Clinical Outcome	
0213	Cancer	Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life	Intermediate Clinical Outcome	
0215	Cancer	Proportion of patients who died from cancer not admitted to hospice	Process	NQF Cancer Project
0210	Cancer	Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life	Process	NQF Cancer Project
0211	Cancer	Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life	Intermediate Clinical Outcome	
0709	CVD	Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year.	Outcome	QPS
1454	Diabetes/ CKD	Proportion of patients with hypercalcemia	Outcome	QPS
0212	Cancer	Proportion with more than one hospitalization in the last 30 days of life	Process	NQF Cancer Project
0390	Cancer	Prostate Cancer: Adjuvant Hormonal Therapy for High or Very High Risk Prostate Cancer Patients	Process	NQF Cancer Project
0390	Cancer	Prostate Cancer: Adjuvant Hormonal Therapy for High Risk or Very High Risk Prostate Cancer	Process	CMS

0389	Cancer	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Process	NQF Cancer Project
0388	Cancer	Prostate Cancer: Three-Dimensional Radiotherapy	Process	NQF Cancer Project
N/A	Mental Illness	Psychiatric Symptoms Assessment for Patients with Parkinson's Disease	Process	CMS
N/A	Infant Mortality	Pulmonary resection: percentage of patients undergoing pulmonary resection for whom forced expiratory volume in one second (FEV₁) and diffusing capacity of carbon monoxide (DL_{CO}) was obtained within 365 days before lung resection.	Process	NQMC
N/A	Cancer	Pulmonary resection: percentage of patients with lung cancer undergoing pulmonary resection who have documentation of at least one of the specified mediastinal staging procedures.	N/A	AHRQ Clearinghouse
1855	Cancer	Quantitative HER2 evaluation by IHC uses the system recommended by the ASCO/CAP guidelines	Process	NQF Cancer Project
N/A	Mental Illness	Querying About Parkinson's Disease Medication-Related Motor Complications	Process	CMS
N/A	Mental Illness	Querying About Sleep Disturbances for Patients with Parkinson's Disease	Process	CMS
N/A	Mental Illness	Querying About Symptoms of Autonomic Dysfunction for Patients with Parkinson's Disease	Process	CMS
0339	CVD	RACHS-1 Pediatric Heart Surgery Mortality Rate (PDI 06)	Outcome	QPS
0339	Infant Mortality	RACHS-1 Pediatric Heart Surgery Mortality Rate (PDI 06)	Outcome	OPUS
0340	CVD	RACHS-1 Pediatric Heart Surgery Volume (PDI 7)	Structure	QPS
0340	Infant Mortality	RACHS-1 Pediatric Heart Surgery Volume (PDI 7)	Structure	OPUS
0507	CVD	Radiology: Stenosis Measurement in Carotid Imaging Reports	Process	CMS
1534	CVD	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) Who Die While in Hospital	Outcome	CMS
1523	CVD	Rate of Open Repair of Small or Moderate Abdominal Aortic Aneurysms (AAA) Where Patients Are Discharged Alive	Outcome	CMS
0362	Infant Mortality	Retained Surgical Item or Unretrieved Device Fragment Count (PDI 03)	Outcome	OPUS
0336	Infant Mortality	Review of Unplanned PICU Readmissions	Process	OPUS

0652	Infant Mortality	Rh immunoglobulin (Rhogam) for Rh negative pregnant women at risk of fetal blood exposure.	Process	OPUS
N/A	CVD	Risk Adjusted Colon Surgery Outcome Measure	Outcome	QPS
0327	CVD	Risk-Adjusted Average Length of Inpatient Hospital Stay	Outcome	QPS
0327	Diabetes/ CKD	Risk-Adjusted Average Length of Inpatient Hospital Stay	Outcome	QPS
0327	Infant Mortality	Risk-Adjusted Average Length of Inpatient Hospital Stay	Outcome	OPUS
2514	CVD	Risk-Adjusted Coronary Artery Bypass Graft (CABG) Readmission Rate	Outcome	QPS
0130	CVD	Risk-Adjusted Deep Sternal Wound Infection	Outcome	QPS
1790	Cancer	Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer	Outcome	NQF Cancer Project
0120	CVD	Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR)	Outcome	QPS
0123	CVD	Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR) + CABG Surgery	Outcome	QPS
0119	CVD	Risk-Adjusted Operative Mortality for CABG	Outcome	QPS
1501	CVD	Risk-Adjusted Operative Mortality for Mitral Valve (MV) Repair	Outcome	QPS
1502	CVD	Risk-Adjusted Operative Mortality for Mitral Valve (MV) Repair + CABG Surgery	Outcome	QPS
0121	CVD	Risk-Adjusted Operative Mortality for Mitral Valve (MV) Replacement	Outcome	QPS
0122	CVD	Risk-Adjusted Operative Mortality for Mitral Valve (MV) Replacement + CABG Surgery	Outcome	QPS
2683	CVD	Risk-Adjusted Operative Mortality for Pediatric and Congenital Heart Surgery	Outcome	QPS
2683	Infant Mortality	Risk-Adjusted Operative Mortality for Pediatric and Congenital Heart Surgery	N/A	OPUS
0129	CVD	Risk-Adjusted Postoperative Prolonged Intubation (Ventilation)	Outcome	QPS
0114	Diabetes/ CKD	Risk-Adjusted Postoperative Renal Failure	Outcome	QPS
0369	Diabetes/ CKD	Risk-adjusted standardized mortality ratio for dialysis facility patients	Outcome	CMS
0131	CVD	Risk-Adjusted Stroke/Cerebrovascular Accident	Outcome	QPS
0115	CVD	Risk-Adjusted Surgical Re-exploration	Outcome	QPS
2887	Diabetes/ CKD	Risk-Standardized Acute Admission Rates for Patients with Diabetes	Outcome	QPS
2886	CVD	Risk-Standardized Acute Admission Rates for Patients with Heart Failure	Outcome	QPS
2888	CVD	Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions	Outcome	QPS

2888	Diabetes/ CKD	Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions	Outcome	QPS
N/A	Cancer	Screening Colonoscopy Adenoma Detection Rate	Outcome	CMS
N/A	CVD	Screening for peripheral artery disease and cardiovascular disease risk assessment with the ankle–brachial index in adults: U.S. Preventive Services Task Force recommendation statement.		NGC
0631	CVD	Secondary Prevention of Cardiovascular Events - Use of Aspirin or Antiplatelet Therapy	Process	QPS
0126	CVD	Selection of Antibiotic Prophylaxis for Cardiac Surgery Patients	Process	QPS
N/A	Cancer	Sentinel Lymph Node Biopsy for Invasive Breast Cancer	Process	CMS
0333	Infant Mortality	Severity-Standardized ALOS - Deliveries	Outcome	QPS
2962	CVD	Shared Decision Making Process	Outcome: PRO	QPS
N/A	Infant Mortality	Sickle cell disease (SCD): percentage of children who, having initially tested positive for SCD through newborn screening, received confirmatory testing by 3 months of age.	Process	NQMC
N/A	Infant Mortality	Sickle cell disease (SCD): percentage of children whose confirmatory testing results were communicated to their families by 4 months of age.	Process	NQMC
N/A	Infant Mortality	Sickle cell disease (SCD): percentage of children with a newborn screen positive for SCD who receive appropriate preventive antibiotics by 3 months of age.	Process	NQMC
N/A	Mental Illness	Social-emotional support lacking: Adults (percent)	N/A	HIW
N/A	Infant Mortality	Spinal bifida	N/A	HIW
N/A	Mental Illness	Stabilization in Anxiety Level	Outcome	CMS
N/A	CVD	Stable coronary artery disease: percentage of patients with cardiovascular disease who received an annual influenza vaccination.	Process	NQMC - 008860
N/A	CVD	Stable coronary artery disease: percentage of patients with documentation in the medical record of prognostic assessment preceding or following a course of pharmacologic therapy.	Process	NQMC - 008870
N/A	CVD	Stable coronary artery disease: percentage of patients with documentation in the medical record of receiving a pneumonia vaccination according to the CDC recommendations.	Process	NQMC - 008861
N/A	CVD	Stable coronary artery disease: percentage of patients with documentation in the medical record that an LDL was obtained within the last 12 months with an LDL less than 100 mg/dL. Consider less than 70 mg/dL for high-risk patient.	Process	NQMC - 008864

N/A	CVD	Stable coronary artery disease: percentage of patients with stable coronary artery disease who have demonstrated an understanding of how to respond in an acute cardiac event by "teaching back" as to how they would respond in the case of acute cardiac event.	Process	NQMC - 008858
0715	CVD	Standardized adverse event ratio for children < 18 years of age undergoing cardiac catheterization	Outcome	QPS
0715	Infant Mortality	Standardized adverse event ratio for children < 18 years of age undergoing cardiac catheterization	Outcome	OPUS
1463	Diabetes/ CKD	Standardized Hospitalization Ratio for Admissions	Outcome	CMS
1463	Diabetes/ CKD	Standardized Hospitalization Ratio for Dialysis Facilities	Outcome	QPS
0369	Diabetes/ CKD	Standardized Mortality Ratio for Dialysis Facilities	Outcome	QPS
0714	Infant Mortality	Standardized mortality ratio for neonates undergoing non-cardiac surgery	Outcome	OPUS
2496	Diabetes/ CKD	Standardized Readmission Ratio (SRR) Clinical Measure	Outcome	CMS
2496	Diabetes/ CKD	Standardized Readmission Ratio (SRR) for dialysis facilities	Outcome	QPS
N/A	Diabetes/ CKD	Standardized Transfusion Ratio (STrR) Clinical Measure	Outcome	CMS - 1937
2979	Diabetes/ CKD	Standardized Transfusion Ratio for Dialysis Facilities	Outcome	QPS
0639	CVD	Statin Prescribed at Discharge	Process	QPS
N/A	CVD	Statin therapy for patients with cardiovascular disease: percentage of males 21 to 75 years of age and females 40 to 75 years of age during the measurement year who were identified as having clinical ASCVD who remained on a high- or moderate-intensity statin medication for at least 80% of the treatment period.	Process	NQMC - 010519
N/A	CVD	Statin therapy for patients with cardiovascular disease: percentage of males 21 to 75 years of age and females 40 to 75 years of age during the measurement year who were identified as having clinical ASCVD who were dispensed at least one high- or moderate-intensity statin medication.	Process	NQMC - 010518
N/A	CVD	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease		CMS
N/A	CVD	Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes	Process	CMS
N/A	CVD	Statin use for the primary prevention of cardiovascular disease in adults: U.S. Preventive Services Task Force recommendation statement.		NGC
2712	CVD	Statin Use in Persons with Diabetes	Process	QPS

2712	Diabetes/ CKD	Statin Use in Persons with Diabetes	Process	QPS
0588	CVD	Stent drug-eluting clopidogrel	Process	QPS
0241	CVD	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge	Process	CMS
0325	CVD	Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy	Process	CMS
0440	CVD	Stroke Education	Process	CMS
2563	CVD	STS Aortic Valve Replacement (AVR) + Coronary Artery Bypass Graft (CABG) Composite Score	Composite	QPS
2561	CVD	STS Aortic Valve Replacement (AVR) Composite Score	Composite	QPS
0696	CVD	STS CABG Composite Score	Composite	QPS
3030	CVD	STS Individual Surgeon Composite Measure for Adult Cardiac Surgery	Composite	QPS
3032	CVD	STS Mitral Valve Repair/Replacement (MVRR) + Coronary Artery Bypass Graft (CABG) Composite Score	Composite	QPS
3031	CVD	STS Mitral Valve Repair/Replacement (MVRR) Composite Score	Composite	QPS
1664	Mental Illness	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	Process	QPS
0284	CVD	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period	Process	CMS
0732	CVD	Surgical Volume for Pediatric and Congenital Heart Surgery: Total Programmatic Volume and Programmatic Volume Stratified by the 5 STAT Mortality Categories	Structure	QPS
0732	Infant Mortality	Surgical Volume for Pediatric and Congenital Heart Surgery: Total Programmatic Volume and Programmatic Volume Stratified by the 5 STAT Mortality Categories	Structure	OPUS
N/A	Infant Mortality	Syphilis, congenital	N/A	HIW
0964	CVD	Therapy with aspirin, P2Y12 inhibitor, and statin at discharge following PCI in eligible patients	Composite	QPS
2895	Infant Mortality	Thermal Condition of Low Birthweight Neonates Admitted to Level 2 or Higher Nurseries in the First 24 Hours of Life: A PQMP Measure	Outcome	OPUS
0748	Infant Mortality	Third or fourth degree perineal laceration	Outcome	OPUS
0513	CVD	Thorax CT—Use of Contrast Material	Process	QPS
0437	CVD	Thrombolytic Therapy	Process	CMS
N/A	Cancer	Thyroid nodules: percentage of patients with a diagnosis of thyroid nodule(s) who had a fine needle aspiration biopsy performed.	N/A	AHRQ Clearinghouse

N/A	Cancer	Thyroid nodules: percentage of patients with thyroid nodule(s) who had a documented physical examination description of the nodule that included all of the following: measurement, texture, mobility, location and presence or absence of palpable cervical lymph node.	N/A	AHRQ Clearinghouse
2824	Infant Mortality	Time from Triage to MRI for Children with Suspected Deep Musculoskeletal Infection		OPUS
1952	CVD	Time to Intravenous Thrombolytic Therapy	Process	QPS
2600	Mental Illness	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	Process	QPS
0350	Infant Mortality	Transfusion Reaction Count (PDI 13)	Outcome	OPUS
1858	Cancer	Trastuzumab administered to patients with AJCC stage I (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy	Process	NQF Cancer Project
N/A	Mental Illness	Treatment: adults with major depressive episode		HIW
0660	CVD	Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) Received within 60 minutes of arrival.	Process	QPS
N/A	Diabetes/ CKD	Ultrafiltration Rate > 13 ml/kg/hr.	Process	CMS
0651	Infant Mortality	Ultrasound determination of pregnancy location for pregnant patients with abdominal pain	process	OPUS
0749	Infant Mortality	Unanticipated Operative Procedure	Outcome	OPUS
0638	Diabetes/ CKD	Uncontrolled Diabetes Admission Rate (PQI 14)	Outcome	QPS
0716	Infant Mortality	Unexpected Complications in Term Newborns	Outcome	OPUS
N/A	Cancer	Unnecessary Screening Colonoscopy in Older Adults	Efficiency	CMS
0745	Infant Mortality	Unplanned maternal admission to the ICU	Outcome	OPUS
0281	Diabetes/ CKD	Urinary Tract Infection Admission Rate (PQI 12)	Outcome	QPS
N/A	Mental Illness	Use of first line psychosocial care for children and adolescents on antipsychotics	Process	CMS
2801	Mental Illness	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Process	QPS
0134	CVD	Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft (CABG)	Process	QPS
1433	Diabetes/ CKD	Use of Iron Therapy for Pediatric Patients	Process	QPS

1433	Infant Mortality	Use of Iron Therapy for Pediatric Patients	Process	OPUS
N/A	Cancer	Uterine cervix cancer deaths	Process	HIW
0744	Infant Mortality	Uterine Rupture During Labor	Outcome	OPUS
0257	Diabetes/ CKD	Vascular Access Type - AV Fistula Clinical Measure	Process	CMS
0256	Diabetes/ CKD	Vascular Access Type â€“ Catheter >= 90 Days Clinical Measure	Outcome	CMS
0262	Diabetes/ CKD	Vascular Access—Catheter Vascular Access and Evaluation by Vascular Surgeon for Permanent Access.	Process	QPS
0251	Diabetes/ CKD	Vascular Access—Functional Arteriovenous Fistula (AVF) or AV Graft or Evaluation for Placement	Process	QPS
0140	CVD	Ventilator-associated pneumonia for ICU and high-risk nursery (HRN) patients	Outcome	QPS
0140	Infant Mortality	Ventilator-associated pneumonia for ICU and high-risk nursery (HRN) patients	Outcome	OPUS
0713	Infant Mortality	Ventriculoperitoneal (VP) shunt malfunction rate in children	Outcome	OPUS
N/A	Infant Mortality	Ventriculoperitoneal (VP) shunt malfunction: percentage of initial VP shunt placement procedures performed on children between 0 and 18 years of age that malfunction and result in shunt revision within 30 days of initial placement.	Outcome	NQMC

Appendix E: Disparities Standing Committee and NQF Staff Roster

Marshall Chin, MD, MPH, FACP (co-chair)
Richard Parrillo Family Professor of Healthcare Ethics, University of Chicago
Chicago, Illinois

Ninez Ponce, MPP, PhD (co-chair)
Professor, UCLA Fielding School of Public Health, UCLA Center for Health Policy Research
Los Angeles, California

Philip Alberti, PhD
Senior Director, Health Equity Research and Policy, Association of American Medical Colleges
Washington, District of Columbia

Susannah Bernheim, MD, MHS
Director of Quality Measurement, Yale New Haven Health System Center for Outcomes Research and Evaluation (CORE)
New Haven, Connecticut

Michelle Cabrera
Director, Health Policy and Research, SEIU California
Washington, District of Columbia

Juan Emilio Carrillo, MD, MPH
Senior Faculty, Disparities Solutions Center, Massachusetts General Hospital
Clinical Associate Professor of Medicine, Weill Cornell Medicine
New York, New York

Lisa Cooper, MD, MPH, FACP
James F. Fries Professor of Medicine and Director of the Johns Hopkins Center to Eliminate Cardiovascular Disparities, Johns Hopkins University School of Medicine
Baltimore, Maryland

Ronald Copeland, MD, FACS
Senior Vice President and Chief Diversity & Inclusion Officer, Kaiser Permanente
Oakland, California

José Escarce, MD, PhD
Professor of Medicine, David Geffen School of Medicine, University of California at Los Angeles;
Professor of Health Policy and Management, UCLA Fielding School of Public Health
Los Angeles, California

Traci Ferguson, MD, MBA, CPE
Vice President, Clinical Services Management, WellCare Health Plans, Inc.
Tampa, Florida

Kevin Fiscella, MD

Tenured Professor Family Medicine, Public Health Science, Community Health and Oncology, University of Rochester
Rochester, New York

Nancy Garrett, PhD
Chief Analytics Officer, Hennepin County Medical Center
Minneapolis, Minnesota

Romana Hasnain-Wynia, PhD
Chief Research Officer, Denver Health
Denver, Colorado

Lisa Iezzoni, MD, MSc
Director, Mongan Institute for Health Policy; Professor of Medicine, Harvard Medical School
Massachusetts General Hospital
Boston, Massachusetts

David Nerenz, PhD
Director, Center for Health Policy & Health Services Research, Henry Ford Health System
Detroit, Michigan

Yolanda Ogbolu, PhD, CRNP-Neonatal
Director, Office of Global Health and Assistant Professor, University of Maryland Baltimore, School of Nursing
Baltimore, Maryland

Robert Rauner, MD, MPH, FAAFP
Director, Partnership for a Healthy Lincoln
Lincoln, Nebraska

Eduardo Sanchez, MD, MPH, FAAFP
Chief Medical Officer for Prevention, American Heart Association
Dallas, Texas

Sarah Hudson Scholle, MPH, DrPH
Vice President, Research & Analysis, National Committee for Quality Assurance
Washington, District of Columbia

Thomas Sequist, MD, MPH
Chief Quality and Safety Officer, Partners Healthcare System
Boston, Massachusetts

Christie Teigland, PhD
Vice President, Advanced Analytics, Avalere Health | An Inovalon Company
Arnold, Maryland

Mara Youdelman, JD, LLM
Managing Attorney (DC Office), National Health Law Program

Washington, District of Columbia

NQF Staff

Helen Burstin
Chief Scientific Officer

Erin O'Rourke
Senior Director

Andrew Anderson
Senior Project Manager

Suzanne Theberge
Senior Project Manager

Tara Rose Murphy
Project Manager

Mauricio Menendez
Project Analyst

Madison Jung
Project Analyst

Ignatius Bau
Consultant