MEASURE APPLICATIONS PARTNERSHIP

Coordination Strategy for Healthcare-Acquired Conditions and Readmissions Across Public and Private Payers

FINAL REPORT

OCTOBER 2011

NQF

CONTENTS

EXECUTIVE SUMMARY

At any given time, approximately one in every 20 patients has an infection related to their hospital care, and nearly one in five Medicare patients—nearly 2.6 million seniors—discharged from the hospital is readmitted within 30 days.[1] The financial impact of healthcare-acquired conditions and preventable hospital readmissions runs into the billions; the human impact can be measured in significantly reduced quality of life, lost productivity in the workplace, and the emotional strain of prolonged pain and/or needed care. National focus that spans both public and private sectors on preventing these adverse events can save billions of dollars, help meet the national goal of healthier people and safer care, and redirect current healthcare resources spent on readmissions and healthcare-acquired conditions into further innovations in creating and delivering quality, patient-centered care.

The Measure Applications Partnership (MAP) is a public-private sector partnership convened by the National Quality Forum. MAP is responsible for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment programs, and other purposes. The composition of MAP participants is noteworthy. Its diverse, public-private nature ensures future federal strategies, and rule-making with respect to measure selection is informed upstream by varied, thoughtful organizations that are invested in the outcomes of the measurement decisions made. MAP will issue a series of reports as a result of its work; this report specifically outlines an ideal coordination strategy for HHS and the broader field on alignment of performance measurement and other approaches for addressing healthcare-acquired conditions and readmissions for all patients, regardless of who ultimately pays for their care.

MAP makes three sets of recommendations in this report:

1. We need a national core set of safety measures that are applicable to all patients.

Such a core set could measure all patients regardless of who pays for their care. It would allow for consistency, meaningful comparisons, and greatly streamlined data collection efforts undertaken by providers. Currently, no such set exists or is maintained; its lack of existence results in variable results, partial information—and most important, a failed effort to drive substantial quality improvement.

Providers, patients, purchasers, and communities would all benefit from this advancement. Public comment on this report reinforced the broad support for the creation and maintenance of this core set of safety measures and reinforced the critical nature of ensuring the measurement set must look beyond federal payment and other programs focused on readmissions. MAP also stressed that public reporting of performance on the core set of safety measures include straightforward, understandable information so consumers and purchasers can more effectively gauge safety risks and make informed healthcare choices. Since this core measure set could have broad national impact, a multi-stakeholder group such as MAP should provide input on creating and maintaining the set.

2. We need to collect data elements necessary for calculating the measures in the safety core set on all patients, regardless of care setting, age, or who pays their healthcare bills.

Said plainly, achieving better safety hinges on creating and executing a national safety data strategy. Current data collection frequently involves manual extraction from paper-based clinical and administrative claims; it results in increased data burden (taking precious time away from patient care), inconsistent data, and unnecessary variation in results. Any national data strategy should be anchored on a unified data platform for standardized quality of all types, including safety data,[2] and should consciously seek to reduce, not increase, any reporting burdens on providers. Importantly, a robust, standardized data platform must account for collection of patient-reported information. Patients are an untapped, rich source of information—they are the only constant element across an episode of care that involves multiple providers—and they may hold the keys to valuable insight on problems that arise during care transitions. Patient voice matters and must be thoughtfully incorporated into solving safety issues.

MAP accentuates that the federal government has existing platforms that could be successfully harmonized and leveraged toward creating a unified data strategy that would help reduce healthcare-acquired conditions and readmissions. Public commenters noted the importance of connecting these efforts upstream with electronic health record vendors to allow them to innovate around an aligned vision of data standards and needs.

3. We need to help public- and private-sector entities coordinate their efforts to make care safer; shared "carrots" or incentives are key.

Incentives can serve as a powerful reinforcing motivator in helping move our system to provide more reliable and safer care. However, if incentives—or signals—sent from the public and private sectors are dissimilar, they can cause confusion rather than motivation. To create a more virtuous cycle, public- and private-sector approaches to incentives, such as performance-based payment or tiered networks, should be closely coordinated with one another. Any use of incentives must account for the unique role of safety net providers in serving vulnerable populations to avoid unfairly penalizing either these organizations or the patients they serve.

Coordination extends beyond payers. Consumers, purchasers, and communities play a vital role in developing aligned approaches to making care safer. Purchasers, in particular, are well positioned to influence safer care now by using existing tools to influence decision making. As clearer information emerges, consumers and communities will be better positioned to help push for safer care, although they do have many levers they can pull now to be powerful voices for change.

Use of more uniform material may assist with coordination. These materials could include a standardized discharge plan that would address best practices for care transitions; the current approach to hand-offs from one setting to another are currently a large driver for readmissions. All discharge paperwork similarly could deploy standardized elements.

This report points to a number of immediately actionable items that would make a significant difference in making care safer. Collaboration, innovation, and deliberate coordination across

sectors will be key in achieving those steps. Issues warranting further exploration beyond this report, but may be influential in improving safety, include understanding any potential undesirable consequences, such as incentives that may lead to underreporting of safety events. Such underreporting would hinder a key aspect that underpins all of this work: the importance of transparency in engendering trust and surfacing the kind of data that can truly help providers' performance and assist consumers in making the best decisions possible.

MAP BACKGROUND

Purpose

MAP is a public-private partnership convened by the National Quality Forum (NQF) for providing input to HHS on selecting performance measures for public reporting, performance-based payment programs, and other purposes. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[3]

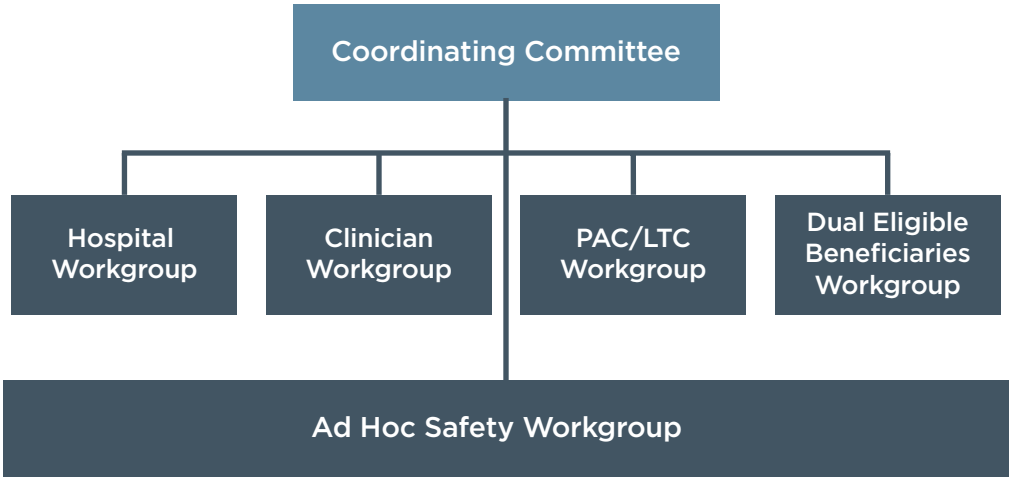
Through MAP activities, a wide variety of stakeholders will provide input into HHS's selection of performance measures. MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures that HHS will receive varied and thoughtful input on performance measure selection.

MAP is designed to facilitate alignment of public- and private-sector uses of performance measures to further the National Quality Strategy's (NQS's) three-part aim of creating better, more affordable care and healthier people.[4] Anticipated outcomes from MAP's work include:

- a more cohesive system of care delivery;
- better and more information for consumer decision making;
- heightened accountability for clinicians and providers;
- higher value for spending by aligning payment with performance;
- reduced data collection burden through harmonizing measurement activities across public and private sectors; and
- improvement in the consistent provision of evidence-based care.

Function

Composed of a two-tiered structure, MAP's overall strategy is set by the Coordinating Committee, which provides final input to HHS. Working directly under the Coordinating Committee are five advisory workgroups responsible for advising the Committee on using measures to encourage performance improvement in specific care settings, providers, and patient populations. More than 60 organizations representing major stakeholder groups, 40 individual experts, and 9 federal agencies (*ex officio* members) are represented in the Coordinating Committee and workgroups.



The NQF Board oversees MAP. The Board will review any procedural questions and periodically evaluate MAP's structure, function, and effectiveness but will not review the Coordinating Committee's input to HHS. The Coordinating Committee and workgroups were selected by the Board, based on Board-adopted selection criteria. Balance among stakeholder groups was paramount. Because MAP's tasks are so complex, including individual subject matter experts in the groups was also imperative.

MAP operates in a transparent manner. The appointment process included open nominations and a public commenting period. MAP meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

MAP decision making is based on a foundation of established guiding frameworks. NQS is the primary basis for the overall MAP strategy. Additional frameworks include the High-Impact Conditions list determined by the NQF Measure Prioritization Advisory Committee, the NQF-endorsed Patient-Focused Episodes of Care framework, the HHS Partnership for Patients safety initiative,[5] the HHS Prevention and Health Promotion Strategy,[6] the HHS Disparities Strategy,[7] and the HHS Multiple Chronic Conditions Framework.[8]

One of MAP's early activities has been the development of measure selection criteria. These criteria are intended to build on, not duplicate, the NQF endorsement criteria. The measure selection criteria characterize the fitness of a measure set for use in a specific program by, among other things, assessing how closely it aligns with the NQS's priority areas and addresses the High-Impact Conditions, and by the extent to which the measure set advances the purpose of the specific program without creating undesirable consequences.

NQF has engaged two subcontractors to support MAP's work. The Stanford Clinical Excellence Research Center has provided input into developing measure selection criteria. Avalere Health has been subcontracted to prepare an analysis of quality issues, strategies for improvement, and measure gaps to support the selection of measures for hospitals, physician offices, and post-acute care/long-term care settings. In addition, Avalere will conduct a similar analysis for dual eligible beneficiaries as a distinct population that crosses all care settings.

Timeline and Deliverables

MAP's initial work includes performance measurement coordination strategies and pre-rulemaking input on the selection of measures for public reporting and payment programs (see Appendix A for schedule of deliverables). Each of the coordination strategies will address:

- measures and measurement issues, including measure gaps;
- data sources and health information technology (health IT) implications, including the need for a common data platform;
- alignment across settings and across public- and private-sector programs;
- special considerations for dual eligible beneficiaries; and
- the path forward for improving measure applications.

MAP began its work in the spring of 2011 (see Appendix B for timeline). The Coordinating Committee set charges for the workgroups in May. Four of the workgroups—Dual Eligible Beneficiaries, Clinician, Safety, and Post-Acute Care/Long-Term Care—met during June and July. The Coordinating Committee has also convened regularly to review progress and provide guidance to the workgroups. These four workgroups provided reports to the Coordinating Committee in August. The Hospital Workgroup will meet in October to consider the measure selection criteria and its approach to the pre-rulemaking task. MAP will provide pre-rulemaking input to HHS on the selection of measures for payment and public reporting programs in February 2012, based on a list of measures under consideration that HHS will post in December. To fulfill its initial tasks, MAP will provide three reports by October 1, 2011: final reports for the clinician and safety coordination strategies and an interim report for the dual eligible beneficiaries quality measurement strategy (with a final report due June 1, 2012).

COORDINATION STRATEGY FOR HEALTHCARE-ACQUIRED CONDITIONS AND READMISSIONS

One of the initial tasks HHS assigned to MAP is to develop a coordination strategy for addressing HACs and readmissions across public and private payers. The charge for the first round of work is not to recommend selection of specific measures but rather to identify opportunities for alignment of performance measurement strategies and other approaches that public and private payers are using to prevent adverse events.

Consistent with all MAP work, the fulfillment of this task was guided by the NQS and, in particular, the HHS Partnership for Patients national safety initiative.[7] The Partnership for Patients is focused on reducing readmissions and healthcare-acquired conditions. At any given time, approximately one in every 20 patients has an infection related to their hospital care, and nearly one in five Medicare patients (approximately 2.6 million seniors) discharged from the hospital is readmitted within 30 days. To pursue these opportunities for improvement, HHS has established two goals for the Partnership for Patients to achieve by the end of 2013: 1) decrease preventable complications during a transition from one care setting to another so that all hospital readmissions would be reduced by 20 percent compared to 2010, and 2) decrease preventable HACs by 40 percent compared to 2010. Achieving these goals will save lives and prevent injuries to millions of Americans and has the potential to save up to $35 billion dollars across the health care system over the next three years.

The Partnership for Patients initiative aims to reduce all-cause harm through specific focus on nine HACs:

- adverse drug events (ADE);
- catheter-associated urinary tract infections (CAUTI);
- central line-associated blood stream infections (CLABSI);
- injuries from falls and immobility;
- obstetrical adverse events;
- pressure ulcers;
- surgical site infections;
- venous thromboembolism (VTE); and
- ventilator-associated pneumonia (VAP).

MAP followed a similar approach, focusing heavily, though not exclusively, on the list of HACs noted above. In addition, MAP considered readmissions broadly, not limiting discussions to just those readmissions potentially related to healthcare-acquired conditions. Beyond the coordination of measurement strategies, MAP emphasized the importance of identifying and disseminating effective strategies for preventing adverse events.

Due to the unique aspects of this work, such as its specific payer focus and cross-setting implications, the MAP Coordinating Committee formed the Ad Hoc Safety Workgroup

(see Appendix C for the workgroup roster) to consider the complexities of the coordination strategy. The Safety Workgroup is composed of members of the MAP Hospital Workgroup at its core as well as additional payers and purchasers from the Coordinating Committee and the three other MAP workgroups: Clinician, Post-Acute Care/Long-Term Care, and Dual Eligible Beneficiaries. The Safety Workgroup received reports on the relevant HAC and readmission issues from each of the other workgroups during the process of developing its input to the Coordinating Committee.

The Safety Workgroup held two, two-day meetings in June and July while developing its report to the MAP Coordinating Committee. The agendas and materials for the Safety Workgroup meetings can be found on the NQF website.[10]

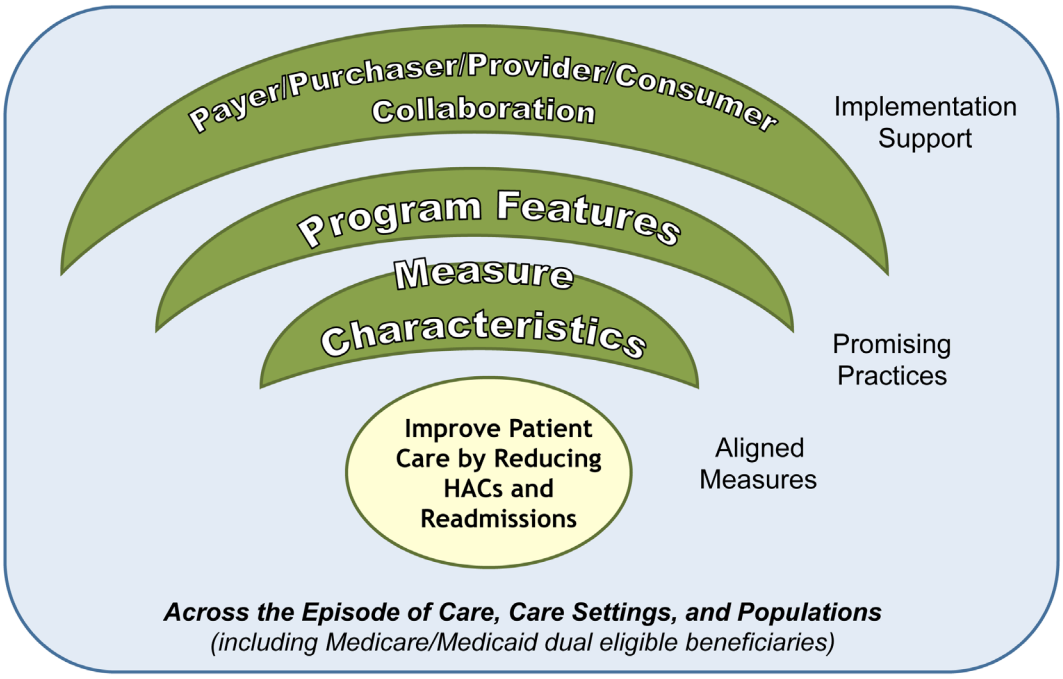
To inform planning for the Safety Workgroup meetings, NQF staff conducted key informant interviews with individuals affiliated with payer and purchaser organizations as well as individuals with expertise in reducing HACs and readmissions (see Appendix D for a list of key informants). The key informants were asked about current best practices for preventing HACs and readmissions as well as what additional information and measures are needed to support improvement in these areas. They also shared potential opportunities for alignment and potential challenges to collaborating on safety strategies.

NQF staff compiled a table that includes the NQF-endorsed® measures that address readmissions and the nine HACs emphasized in the Partnership for Patients safety initiative (see Appendix E for the table). The measures were then mapped to the federal programs in which they are being used: Hospital Compare, Nursing Home Compare, the Physician Quality Reporting System, and the proposed Accountable Care Organization rule.

Finally, NQF staff performed a rapid-turnaround environmental scan of current public- and private-payer and purchaser programs to reduce HACs and readmissions (see Appendix F for the scan results). Examples from a variety of payers and purchasers are included in this scan, but it primarily reflects programs of the payers and purchasers represented in MAP. Programs were reviewed for overall design, collaboration between payers and providers, and characteristics of the measures used. This information was collected from published reports, websites, and interviews. The programs were also mapped to the Partnership for Patients areas of focus.

Based on analysis of the themes that emerged from the key informant interviews and the review of current programs, MAP adopted the conceptual model displayed below, depicting the dimensions of payer alignment, to guide deliberations. Three main aspects to payer alignment are identified in the model: collaboration, program features, and measure characteristics.

Dimensions of Payer Alignment



This model evolved over the course of the work as MAP further defined aspects of both the ultimate aim of improving patient care by reducing HACs and readmissions and the specific means to reach it—aligning measures, finding promising practices in both the public and private sectors, and aligning all of the key stakeholders in collaboration. MAP concluded that each of these means of addressing HACs and readmissions plays a significant role in improving patient care and made recommendations in each area.

RECOMMENDATIONS

Considering HACs and readmissions within one overall coordination strategy for public and private payers is a complex task. These patient safety issues have separate and distinct implications for a coordination strategy. However, MAP also found commonalities in addressing the safety issues through alignment of measures, data sources, and other coordination strategies, such as incentives.

Recommendation #1:

A national core set of safety measures that are applicable to all patients should be created and maintained.

Central to the coordination of public- and private-payer strategies to reduce HACs and readmissions is the need for all-patient measurement to ensure consistency, allow comparisons, and reduce the data collection burden on providers. Current misaligned measurement efforts confuse consumer and purchaser decision making and fail to drive substantial quality improvement because they frequently give variable results and only partial information. Further, inconsistency across public- and private-payer safety programs increases provider reporting efforts, diverts resources from their improvement efforts, and undermines their ability to understand their relative performance. To address this need, a national core set of safety measures applicable to all patients, regardless of public, private, or self-pay status, should be developed. This core measure set should cross the lifespan, include behavioral healthcare, and be applicable to all settings, beyond just the hospital.

Alignment with public-sector initiatives is a key feature of this safety measure set. The set should reflect the NQS and strongly support the national priorities and goals. While aligning the measure set with public programs such as the Partnership for Patients and Medicare and Medicaid HAC and readmission payment programs is important, the set should not be limited to those initiatives. It also is essential to look beyond public-sector initiatives to align with private-sector approaches. The core safety measure set should be identified in partnership with the Centers for Medicare & Medicaid Services (CMS) and needs to be applicable to all patients, not just patients eligible for Medicare, Medicaid, or both.

A priority for the national safety measure set is that the measurement information should be clear, meaningful, and readily available to purchasers and consumers to support decision making. Measurement information also should be evidence-based and clinically relevant to providers to support quality improvement. Public reporting of performance on the core measure set should include straightforward and understandable information that is disseminated broadly and aggressively so purchasers and consumers can understand healthcare safety risks and make informed decisions about their healthcare. Additionally, the measure set needs to include measures with practical information providers can use to improve patient safety.

To meet the goal of a unified safety measure set, the core measures should be consistent across the care continuum, promoting shared accountability among providers across settings. Creating a healthcare system that supports shared accountability is essential to improving patient outcomes and reducing HACs and readmissions. Only when providers are using consistent measures, regardless of setting, will progress be made toward this end.

Establishment of a national core set would allow for the generation of credible, standardized performance measurement information to enable meaningful comparisons. This standardization should not stifle innovation nor hamper successful work currently being performed at the regional or community level. Using measures in addition to those in the core safety set can support ongoing local initiatives as well as advancements in measurement. In instances when additional measures are in use or being tested to support further improvements or address gaps, these initiatives should avoid significantly increasing the data collection and reporting efforts. Generally, these measures would address specific issues not included in the core set to prevent additional data collection burden and confusion.

Since creating a national core safety measure set would have a broad impact, a multi-stakeholder group, such as MAP, should provide input to HHS on creating and maintaining the set. Input from a multi-stakeholder group to HHS on selecting the measure set would ensure the perspectives of all involved parties are considered and would create greater buy-in from all stakeholders. The multi-stakeholder group must be balanced and represent at least payers, consumers, purchasers, and providers. Individuals with specific expertise in measurement and quality improvement also should be included as members of this group. When identifying and maintaining the core safety measure set, the multi-stakeholder group must ensure the measures support adequate access to care and not exacerbate disparities in care.

PUBLIC COMMENT

The public comments received were strongly supportive of MAP's recommendation for a national core set of safety measures (see Appendix G for a table of all public comments received). The additional feedback provided through comment fell into two major themes: measure concepts that should be included within the core measure set and considerations for selecting and maintaining the set.

Commenters suggested several concepts for inclusion in the core measure set, including care transitions, medication management, interdisciplinary team-based measures, and measures derived from patient-reported data. Commenters noted a preference for the use of NQF-endorsed measures and the need for measures tied to the evidence base and to clinical guidelines. Commenters raised caution about using HAC rates, lack of appropriate risk adjustment, and issues around the accuracy of attribution to providers.

Public commenters suggested several considerations for selecting and maintaining the core set of safety measures. They supported the idea of a multi-stakeholder group selecting the core measure set and stressed the importance of balance across stakeholder groups, as well as among the different provider groups. Commenters recommended that the selection and maintenance processes be transparent and employ a best-in-class approach to avoid duplication. They also suggested that the maintenance review of the measure set occur at regular intervals, with the allowance for updates as needed based on changes in the evidence.

Recommendation #2:

Data elements needed to calculate the measures in the safety core set should be collected on all patients.

After a national core set of safety measures is defined, the data needed to calculate the measures for all patients should be collected in the most efficient manner possible. Though a daunting undertaking, developing a national safety data strategy, within the context of a broader national data strategy, is essential for coordination of safety measurement and improvement efforts. Differences in data collection mechanisms and processes introduce variation in results unrelated to actual performance (e.g., clinical vs. claims as data sources) and increase data collection burden. Therefore, it is critical that the data strategy be anchored on a unified data platform for collecting standardized quality data of all types, including safety data.[11] To create access to these data, providers and payers should be responsible for collecting and reporting the necessary data elements so measures can be calculated. This process should be simple and consistent, however, and should not require additional administrative effort; rather, the data strategy should ultimately reduce reporting burden.

As a starting place for the data platform, the reporting processes for current databases maintained by federal agencies—for example, the Agency for Healthcare Research and Quality's (AHRQ) Healthcare Cost and Utilization Project,[12] Centers for Disease Control and Prevention's National Healthcare Safety Network,[13] CMS's Hospital Compare,[14] and U.S. Food and Drug Administration's Sentinel Initiative[15]—could be harmonized. This would reduce reporting burden as well as lay the foundation for a robust, standardized data platform. Another key component of the data platform is that it should enable collection of patient-reported information, which can be particularly important for reducing readmissions by understanding problems that arise during care transitions.

It is important that safety information be made available to purchasers and consumers in an easy-to-understand and timely manner to inform decision making for provider selection. Information about healthcare-acquired conditions and readmissions from credible sources supports purchaser contracting decisions and consumers' decisions about where to seek care. Availability of information also can assist in monitoring whether changing payment or delivery models is achieving their goals or exacerbating problems such as cost-shifting.

Transparency of safety information is a key component of a national safety data strategy. While different stakeholders expressed unique needs regarding uses of data—providers need data for quality improvement, purchasers need data to make decisions about value, consumers need data to select providers—all would benefit from a national data strategy, a common data platform, and access to safety performance measurement information across all patients, regardless of payer

PUBLIC COMMENT

Public comments were largely in favor of collecting standardized safety data on all patients. Additional suggestions and a few concerns were raised. A number of commenters expanded on the notion of collecting standardized quality data to include uniform or harmonized definitions, formats, and data collection methodologies and instruments. Commenters called for electronic health record (EHR) vendors to build the capacity to capture key data elements into their systems, noting that lack of harmonization across settings and between federal and state reporting requirements works against vendors. Commenters supported harmonizing existing databases, and one suggested that

the existing AHRQ common formats for safety reporting be used as a starting place. Commenters also showed preference for the use of a distributed data model (DDM) for reporting instead of a centralized database, as a distributed model would allow for timely access to data as well as greater privacy protections for patient information. Commenters strongly supported including patient-reported data, though questions were raised about how to capture this information. Finally, a few commenters raised concern regarding the overall quality of data collected and asked that providers have the opportunity to review data—particularly physician performance data—before its use.

Recommendation #3:

Public- and private-sector entities should coordinate their efforts to make care safer, beginning with incentive structures.

To achieve significant improvement in patient safety, it is clear the public and private sectors must coordinate their safety efforts. As noted above, this includes agreeing on a national core set of safety measures and a standardized approach for capturing and reporting patient safety data. Taking this guidance a step further, patient safety information should be leveraged to support coordinated incentive structures and for other uses aimed at preventing, not just measuring, safety events.

Both public and private payers should implement programs using incentive structures to encourage providers to improve patient safety. A variety of these types of incentive programs, such as performance-based payment and tiered networks, currently are in use across the country (see Appendix F). It is important to establish some level of consistency in the use of incentives while allowing enough space for innovation and new model development. Ideally, organizations can combine incentives and savings from multiple programs to invest further in performance improvement initiatives. The use of incentive structures should account for the unique role of safety net providers in serving vulnerable populations to avoid unfairly penalizing these organizations and the individuals they serve.

Other stakeholder groups, beyond public and private payers, play important roles in coordination efforts for improving patient safety. Consistent and sustained reductions in HACs and readmissions will not occur unless purchasers, consumers, communities, and providers actively support new approaches to healthcare delivery. Purchasers have a strong lever in their purchasing power to encourage implementation and alignment of incentive structures across payers. Using existing tools, such as the National Business Coalition on Health's eValue8[14] survey, can help to inform purchasers' decisions. This also can be accomplished through new toolkits currently in development by purchaser groups that include standardized requests for information[15] and contract language that signals to payers that preventing safety events is imperative.

Additionally, both purchasers and payers should expand their roles to become more active partners in the delivery of care. Though providers and patients remain primary in determining what care is provided and how, payers are well positioned to offer additional quality improvement tools to providers. These include notifications regarding readmissions, as well as preventive mechanisms such as direct enrollee outreach concerning potential medication interactions, prescriptions not being filled, and participation in disease management programs. Payers also can share with providers predictive modeling information that identifies high-risk patients so targeted care plans can be developed upstream to avoid readmissions or HACs. Beyond the traditional role of providers

as the source for all patient education, purchasers, payers, and communities can collaborate with providers to engage employees, members, and patients to build public awareness about patient safety issues and improve health literacy, informed decision making, and adherence to care plans. Providing resources to patients in a coordinated manner from multiple avenues will help ensure patients fully understand the role they should play in maintaining their health and determining their healthcare needs.

Another more specific tactic for improving patient safety, particularly as it relates to reducing readmissions, is to develop and implement standardized discharge plan elements incorporating best practices for care transitions. The discharge plan need not be in a uniform format across the nation but should include a specific set of core elements. This plan would support the consistency desired for transitions between settings, while also allowing for customization to account for unique differences among populations. Some existing programs focusing more broadly on improving care transitions, such as Project BOOST (Better Outcomes for Older adults through Safe Transitions),[18] IHI's STAAR Initiative (State Action on Avoidable Rehospitalizations),[19] Project RED (Re-Engineered Discharge),[20] include some component of standardization of the patient discharge plan within their approach. There is value for patients and providers in having standardized elements on all discharge forms across care settings. In this way, the discharge paperwork also can support continuation of the care plan established in the prior setting of care.

PUBLIC COMMENT

Commenters were in favor of coordinating efforts across public and private payers. While in support of efforts to align incentive structures, commenters indicated that innovation and new model development also should be encouraged. Comments suggested that coordination of incentives should result in system improvements via non-punitive programs. Commenters supported the possibility of special consideration within incentive programs for safety net providers considering their role in serving vulnerable populations. They also encouraged stakeholder groups beyond payers and purchasers to be more active partners in care delivery.

PATH FORWARD

A number of actions can be taken as a result of this report, including identifying and convening a multi-stakeholder group to select a national core safety measure set, as well as promoting a national safety data strategy. Further, payers, purchasers, consumers, communities, and providers should assess their current roles and efforts to prevent HACs and readmissions and determine ways to apply the collaborative approaches captured in this report to drive improvement in safety.

This initial work also has unearthed areas where further examination is needed. Given the complexities that surround readmissions and HACs, the opportunity to continue identifying strategies for addressing readmissions and each of the nine HAC focus areas is warranted. Additionally, attention should be given to potential undesirable consequences. For example, applying measures and incentives can lead to underreporting of safety events, which obscures the causes and possible solutions. Underreporting also can result when infections manifest after the patient leaves the hospital, as there is no mechanism in place in the ambulatory setting to capture these data consistently. Further, when considering readmissions, appropriateness of the readmission should be explored, particularly as it relates to the availability of care supports in the community. All too often, a readmission may be the best care option for a vulnerable patient.

The guidance MAP offers through this report serves as a launching point to better coordinate the efforts of public and private payers in addressing adverse safety events. Beginning with the recommendations put forth here, significant progress can be made toward reducing HACs and readmissions to advance the goals of the Partnership for Patients.

PUBLIC COMMENT

The public commenters strongly supported further exploration of potential undesirable consequences and additional consideration regarding appropriateness of readmissions. Commenters raised concerns about underreporting, citing a number of reasons that underreporting may occur, including oversight related to multiple processes for reporting, conflicting definitions or regional practices, and IT system constraints.

APPENDIX A:
Measure Applications Partnership—Schedule of Deliverables

Task	Task Description	Deliverable	Timeline
15.1: Measures to be implemented through the Federal rulemaking process	Provide input to HHS on measures to be implemented through the Federal rulemaking process, based on an overview of the quality issues in hospital, clinician office, and post-acute/long-term care settings; the manner in which those problems could be improved; and the measures for encouraging improvement.	Final report containing the Coordinating Committee framework for decision making and proposed measures for specific programs	**Draft Report:** January 2012 **Final Report:** February 1, 2012
15.2A: Measures for use in the improvement of clinician performance	Provide input to HHS on a coordination strategy for clinician performance measurement across public programs.	Final report containing Coordinating Committee input	**Draft Report:** September 2011 **Final Report:** October 1, 2011
15.2B: Measures for use in quality reporting for post-acute and long term care programs	Provide input to HHS on a coordination strategy for performance measurement across post-acute care and long-term care programs.	Final report containing Coordinating Committee input	**Draft Report:** January 2012 **Final Report:** February 1, 2012
15.2C: Measures for use in quality reporting for PPS-exempt Cancer Hospitals	Provide input to HHS on the identification of measures for use in performance measurement for PPS-exempt cancer hospitals.	Final report containing Coordinating Committee input	**Draft Report:** May 2012 **Final Report:** June 1, 2012
15.2 D: Measures for use in quality reporting for hospice care	Provide input to HHS on the identification of measures for use in performance measurement for hospice programs and facilities.	Final report containing Coordinating Committee input	**Draft Report:** May 2012 **Final Report:** June 1, 2012

Task	Task Description	Deliverable	Timeline
15.3: Measures that address the quality issues identified for dual eligible beneficiaries	Provide input to HHS on identification of measures that address the quality issues for care provided to Medicare-Medicaid dual eligible beneficiaries.	Interim report from the Coordinating Committee containing a performance measurement framework for dual eligible beneficiaries	**Draft Interim Report:** September 2011 **Final Interim Report:** October 1, 2011
		Final report from the Coordinating Committee containing potential new performance measures to fill gaps in measurement for dual eligible beneficiaries	**Draft Report:** May 2012 **Final Report:** June 1, 2012
15.4: Measures to be used by public and private payers to reduce readmissions and healthcare-acquired conditions	Provide input to HHS on a coordination strategy for readmission and HAC measurement across public and private payers.	Final report containing Coordinating Committee input regarding a strategy for coordinating readmission and HAC measurement across payers	**Draft Report:** September 2011 **Final Report:** October 1, 2011

APPENDIX B: Measure Applications Partnership Timeline

2011				
GROUP	APR	MAY	JUN	JUL
MAP Coordinating Committee Sets charges for all workgroups and centralizes input; provides pre-rulemaking input to CMS (15.1)	Web meeting	In-person meeting: big picture planning, charge for workgroups, framework **May 13** ALL MAP optional attendance at group web meeting	**June 21-22** In-person meeting, clinician coordination strategy, safety input, duals input, framework	**Aug 5** Web meeting
Clinician Workgroup Coordination of measures for physician performance improvement (15.2a), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13** ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 7-8** In-person meeting, framework, strategy for coordination of physician measurement, HACs & readmissions **June 30** Web meeting	**July 13-14** In-person meeting to finalize strategy and themes for report on physician performance measurement
Hospital Workgroup Measures for PPS-exempt cancer hospitals (15.2c), major input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13** ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework		
Ad Hoc Safety Workgroup HACs & readmissions (15.4)		**May 13** ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 9-10** In-person meeting with additional panelists, consider HACs & readmissions, framework	**July 11-12** In-person meeting, review other groups' work on HACs and readmissions to finalize report on HACs & readmissions
Dual Eligible Beneficiaries Workgroup Identify quality issues specific to duals and appropriate measures and measure concepts (15.3); some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13** ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 2-3** In-person meeting to discuss duals' quality issues, HACs & readmissions, framework	**July 6** Web meeting **July 25-26** In-person meeting to continue discussion of quality issues, finalize preliminary themes for report
PAC/LTC Workgroup Measures and coordination for Medicare PAC programs (15.2b), measures for hospice care (15.2d), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13** ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 28** 1 day in-person meeting, consider HACs & readmissions, framework	

Future dates are subject to change

2011					
AUG	SEP	OCT	NOV		DEC
Aug 17-18 In-person meeting, HACs and readmissions, finalize WG input for September reports, begin work on quality issues in 11 settings		**Oct 19** Web mtg	**Nov 1-2** In-person meeting, finalize PAC report, discuss quality issues in 11 settings	MEASURES PUBLISHED BY CMS ON DECEMBER 1	**Dec 8** ALL MAP groups on web meeting to distribute measures with homework
Aug 1 Web meeting **Aug 29-Sept 12** 2 week public comment period for physician strategy and HACs/ readmissions	**Sept 30th** REPORT 15.2a				**Dec 8** ALL MAP groups on web meeting to distribute measures with homework **Dec 12** 1 day in-person meeting to react to proposed measures
			Oct 12-13 In-person meeting to discuss hospital coordination framework and finalize measures for cancer hospitals		**Dec 8** ALL MAP groups on web meeting to distribute measures with homework **Dec 15** In-person meeting to react to proposed measures
Aug 29-Sept 12 2 week public comment period for physician strategy and HACs/ readmissions	**Sept 30th** REPORT 15.4				
	Sept 30th Interim REPORT 15.3	**Oct 3-Oct 24** 30 day public comment period	**Nov 15** 1 day in-person meeting, present public and HHS feedback, begin next phase		**Dec 8** ALL groups on web meeting to distribute measures with homework **Dec 16** Web meeting to react to proposed measures
	Sep 8-9 In-person meeting to discuss measures for PAC and coordination strategy		**Nov 21, Nov 29, or Dec 2** 30 day public comment period on PAC report and public webinar to introduce public comment on PAC report		**Dec 8** ALL MAP groups on web meeting to distribute measures with homework **Dec 14** In-person meeting to react to proposed measures

Future dates are subject to change

2012						
GROUP	JAN	FEB	MAR	APR	MAY	JUNE
MAP Coordinating Committee Sets charges for all workgroups and centralizes input; provides pre-rulemaking input to CMS (15.1)	**Jan 5-6** In-person meeting to finalize pre-rulemaking input 1-2 week public comment period	**Feb 1st** REPORT 15.1 **Early Feb** - informational public webinar **Late Feb** - Web meeting	**Mid March** In-person meeting, finalize input on June reports			
Hospital Workgroup Measures for PPS-exempt cancer hospitals (15.2c), major input on HACs & readmissions (15.4), pre-rulemaking (15.1)				**Early April** Public webinar and 30 day comment period on draft report		**June 1st** REPORT 15.2c
Dual Eligible Beneficiaries Workgroup Identify quality issues specific to duals and appropriate measures and measure concepts (15.3); some input on HACs & readmissions (15.4), pre-rulemaking (15.1)	**Late Jan** Web meeting	**Mid Feb** In-person meeting to finalize measure concepts and themes for report		**Early April** Public webinar and 30 day comment period on draft duals report		**June 1st** REPORT 15.3
PAC/LTC Workgroup Measures and coordination for Medicare PAC programs (15.2b), measures for hospice care (15.2d), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**Feb 1st** REPORT 15.2b **Mid Feb** Web meeting **Late Feb** In-person meeting to finalize measures for hospice		**Early April** Public webinar and 30 day comment period on draft hospice report		**June 1st** REPORT 15.2d

Future dates are subject to change

APPENDIX C:
Roster for the MAP Ad Hoc Safety Workgroup

CHAIR (VOTING)
Frank G. Opelka, MD, FACS

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
Alliance of Dedicated Cancer Centers	Ronald Walters, MD, MBA, MHA, MS
American Hospital Association	Richard Umbdenstock
American Organization of Nurse Executives	Patricia Conway-Morava, RN
American Society of Health-System Pharmacists	Kasey Thompson, Pharm.D
Blue Cross Blue Shield of Massachusetts	Jane Franke, RN, MHA
Building Services 32BJ Health Fund	Barbara Caress
Iowa Healthcare Collaborative	Lance Roberts, PhD
Memphis Business Group on Health	Cristie Upshaw Travis, MHA
Mothers Against Medical Error	Helen Haskell, MA
National Association of Children's Hospitals and Related Institutions	Andrea Benin, MD
National Rural Health Association	Brock Slabach, MPH, FACHE
Premier, Inc.	Richard Bankowitz, MD, MBA, FACP

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Patient Safety	Mitchell Levy, MD, FCCM, FCCP
Palliative Care	R. Sean Morrison, MD
State Policy	Dolores Mitchell
Health IT	Brandon Savage, MD
Patient Experience	Dale Shaller, MPA
Safety Net	Bruce Siegel, MD, MPH
Mental Health	Ann Marie Sullivan, MD

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Agency for Healthcare Research and Quality (AHRQ)	John Bott, MSSW, MBA
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH, FACP
Centers for Medicare & Medicaid Services (CMS)	Shaheen Halim, Ph.D., CPC-A
Office of the National Coordinator for HIT (ONC)	Pamela Cipriano, PhD, RN NEA-BC, FAAN
Veterans Health Administration (VHA)	Michael Kelley, MD
Health Resources and Services Administration (HRSA)	Ian Corbridge, MPH, RN
Office of Personnel Management/FEHBP (OPM)	John O'Brien

PAYERS (VOTING)	REPRESENTATIVES
Aetna	Randall Krakauer, MD
America's Health Insurance Plans	Aparna Higgins, MA
CIGNA	Dick Salmon, MD, PhD
Humana	Thomas James III, MD
LA Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Medicaid Directors	Foster Gesten, MD

PURCHASERS (VOTING)	REPRESENTATIVES
Catalyst for Payment Reform	Suzanne Delbanco, Ph.D.
Hotel and Restaurant Employees Union Welfare Fund	Elizabeth Gilbertson
Pacific Business Group on Health	William Kramer, MBA
The Alliance	Cheryl DeMars

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Payer	Lawrence Gottlieb, MD, MPP, FACP
Payer	Rhonda Robinson Beale, MD
Payer	MaryAnne Lindeblad, BSN, MPH

MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO)
George J. Isham, MD, MS
Elizabeth A. McGlynn, PhD, MPP

Roster for the MAP Coordinating Committee

CO-CHAIRS (VOTING)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Judith Cahill
AdvaMed	Michael Mussallem
AFL-CIO	Gerald Shea
America's Health Insurance Plans	Aparna Higgins, MA
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Consumers Union	Steven Findlay, MPH
Federation of American Hospitals	Chip N. Kahn
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Association of Medicaid Directors	Foster Gesten, MD
National Partnership for Women and Families	Christine Bechtel, MA
Pacific Business Group on Health	William Kramer, MBA

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Joseph Betancourt, MD, MPH
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD
Post-Acute Care/ Home Health/ Hospice	Carol Raphael, MPA

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD MSc
Health Resources and Services Administration (HRSA)	Victor Freeman, MD, MPP
Office of Personnel Management/FEHBP (OPM)	John O'Brien
Office of the National Coordinator for HIT (ONC)	Joshua Seidman

ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING)	REPRESENTATIVES
American Board of Medical Specialties	Christine Cassel, MD
National Committee for Quality Assurance	Peggy O'Kane, MPH
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

APPENDIX D:
Key Informant Interviewees

ORGANIZATIONS	REPRESENTATIVES
Blue Cross Blue Shield Association	Christine Izui
America's Health Insurance Plans	Aparna Higgins
National Business Coalition on Health	Karen Linscott, Dennis White
Catalyst for Payment Reform	Suzanne Delbanco
Readmissions Subject Matter Expert	Steve Jencks, MD, MPH

APPENDIX E:

NQF-endorsed® HAC and Readmission Measures

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0019	Documentation of medication list in the outpatient record	Percentage of patients having a medication list in the medical record.	NCQA	ADE				
0020	Documentation of allergies and adverse reactions in the outpatient record	Percentage of patients 18 years and older who received at least 180-day supply of medication therapy for the selected therapeutic agent and who received annual monitoring for the therapeutic agent. Percentage of patients on ACE inhibitors or ARBs with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Percentage of patients on digoxin with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Percentage of patients on a diuretic with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Percentage of patients on any anticonvulsant for phenytoin, phenobarbital, valproic acid or carbAMA/ zepine with at least one drug serum concentration level monitoring test for the prescribed drug in the measurement year. The sum of the four numerators divided by the sum of the five denominators.	NCQA	ADE				
0021	Therapeutic monitoring: Annual monitoring for patients on persistent medications	Percentage of patients having documentation of allergies and adverse reactions in the medical record.	NCQA	ADE				
0022	Drugs to be avoided in the elderly: a. Patients who receive at least one drug to be avoided, b. Patients who receive at least two different drugs to be avoided.	Percentage of patients ages 65 years and older who received at least one drug to be avoided in the elderly in the measurement year. Percentage of patients 65 years of age and older who received at least two different drugs to be avoided in the elderly in the measurement year.	NCQA	ADE			X	

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0419	Universal documentation and verification of current medications in the medical record	Percentage of patients aged 18 years and older with a list of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verified with the patient or authorized representative documented by the provider.	CMS	ADE			X	
0553	Care for older adults – medication review (COA)	Percentage of adults 65 years and older who had a medication review	NCQA	ADE				
0554	Medication reconciliation post-discharge (MRP)	Percentage of discharges from January 1 to December 1 of the measurement year for patients 65 years of age and older for whom medications were reconciled on or within 30 days of discharge.	NCQA	ADE				X
0646	Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories	AMA-PCPI	ADE				
0138	Urinary catheter-associated urinary tract infection for intensive care unit (ICU) patients	Percentage of intensive care unit patients with urinary catheter-associated urinary tract infections	CDC	CAUTI				
0453	Urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with day of surgery being day zero	Surgical patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with day of surgery being day zero.	CMS	CAUTI	X			

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0684	Percent of Residents with a Urinary Tract Infection (Long-Stay)	This measure updates CMS' current QM on Urinary Tract Infections in the nursing facility populations. It is based on MDS 3.0 data and measures the percentage of long-stay residents who have a urinary tract infection on the target MDS assessment (which may be an annual, quarterly, or significant change or correction assessment). In order to address seasonal variation, the proposed measure uses a 6-month average for the facility. Long-stay nursing facility residents are those whose stay in the facility is over 100 days. The measure is limited to the long-stay population because short-stay residents (those who are discharged within 100 days of admission) may have developed their urinary tract infections in the hospital rather than the nursing facility.	CMS	CAUTI		X		
0686	Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long-Stay)	This measure updates CMS' current QM on catheter insertions. It is based on data from Minimum Data Set (MDS) 3.0 assessments of long-stay nursing home residents (those whose stay is longer than 100 days). This measure captures the percentage of long-stay residents who have had an indwelling catheter in the last 7 days noted on the most recent MDS 3.0 assessment, which may be annual, quarterly, significant change or significant correction during the selected quarter (3-month period). Long-stay residents are those residents who have been in nursing care at least 100 days. The measure is restricted to this population, which has long-term care needs, rather than the short stay population who are discharged within 100 days of admission.	CMS	CAUTI		X		
	Catheter-Associated Urinary Tract Infection			CAUTI				

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0139	Central line catheter-associated blood stream infection rate for ICU and high-risk nursery (HRN) patients	Percentage of ICU and high-risk nursery patients, who over a certain amount of days acquired a central line catheter-associated blood stream infections over a specified amount of line-days	CDC	CLABSI				
0298	Central Line Bundle Compliance	Percentage of intensive care patients with central lines for whom all elements of the central line bundle are documented and in place. The central line bundle elements include: •Hand hygiene , •Maximal barrier precautions upon insertion •Chlorhexidine skin antisepsis •Optimal catheter site selection, with subclavian vein as the preferred site for non-tunneled catheters in patients 18 years and older •Daily review of line necessity with prompt removal of unnecessary lines	Institute for Healthcare Improvement	CLABSI				X
0464	Anesthesiology and Critical Care: Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter (CVC) Insertion Protocol	Percentage of patients who undergo CVC insertion for whom CVC was inserted with all elements of maximal sterile barrier technique (cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis) followed.	AMA-PCPI	CLABSI			X	
	Central Line Associated Bloodstream Infection (CLABSI)			CLABSI				
	Vascular Catheter-Associated Infections			CLABSI				

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0035	Fall risk management in older adults: (a) Discussing fall risk; (b) Managing fall risk	Percentage of patients aged 75 and older who reported that their doctor or other health provider talked with them about falling or problems with balance or walking. Percentage of patients aged 75 and older who reported that their doctor or other health provider had done anything to help prevent falls or treat problems with balance or walking	NCQA	Injury from Falls and Immobility				
0101	Falls: screening for fall risk	Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months	NCQA	Injury from Falls and Immobility			X	X
0141	Patient Fall Rate	All documented falls, with or without injury, experienced by patients on an eligible unit in a calendar quarter.	ANA	Injury from Falls and Immobility				
0202	Falls with injury	All documented patient falls with an injury level of minor (2) or greater.	ANA	Injury from Falls and Immobility				
0203	Restraint prevalence (vest and limb only)	Total number of patients that have vest and/or limb restraint (upper or lower body or both) on the day of the prevalence study.	The Joint Commission	Injury from Falls and Immobility				
0266	Patient fall	Percentage of ASC admissions experiencing a fall in the ASC.	Ambulatory Surgical Center Quality Collaboration	Injury from Falls and Immobility				
0537	Multifactor fall risk assessment conducted in patients 65 and older	Percent of home health episodes in which the patient was 65 or older and was assessed for risk of falls (using a standardized and validated multi-factor Fall Risk Assessment) at start or resumption of home health care	CMS	Injury from Falls and Immobility				

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	CMS	Injury from Falls and Immobility				
0687	Percent of Residents Who Were Physically Restrained (Long Stay)	The measure is based on data from the MDS 3.0 assessment of long-stay nursing facility residents and reports the percentage of all long-stay residents who were physically restrained. The measure reports the percentage of all long-stay residents in nursing facilities with an annual, quarterly, significant change, or significant correction MDS 3.0 assessment during the selected quarter (3-month period) who were physically restrained daily during the 7 days prior to the MDS assessment (which may be annual, quarterly, significant change, or significant correction MDS 3.0 assessment).	CMS	Injury from Falls and Immobility		X		
0697	Risk Adjusted Case Mix Adjusted Elderly Surgery Outcomes Measure	This is a hospital based, risk adjusted, case mix adjusted elderly surgery aggregate clinical outcomes measure of adults 65 years of age and older.	American College of Surgeons	Multiple: CAUTI, SSI, VTE				
0303	Late sepsis or meningitis in neonates (risk-adjusted)	Percentage of infants born at the hospital, whose birth weight is between 401 and 1500 grams OR whose gestational age is between 22 weeks 0 days and 29 weeks 6 days with late sepsis or meningitis with one or more of the following criteria: Bacterial Pathogen, Coagulase Negative Staphylococcus, Fungal Infection	Vermont Oxford Network	Obstetrical Adverse Events				
0304	Late sepsis or meningitis in very low birth weight (VLBW) neonates (risk-adjusted)	Percentage of infants born at the hospital, whose birth weight is between 401 and 1500 grams OR whose gestational age is between 22 weeks 0 days and 29 weeks 6 days, who have late sepsis or meningitis, with one or more of the following criteria: Bacterial Pathogen, Coagulase Negative Staphylococcus, Fungal Infection	Vermont Oxford Network	Obstetrical Adverse Events				

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0474	Birth Trauma Rate: Injury to Neonates (PSI #17)	Percentage of neonates with specific birth trauma per 1000 births. Exclude infants with injury to skeleton and osteogenesis imperfecta, subdural or cerebral hemorrhage in preterm infant.	AHRQ	Obstetrical Adverse Events				
0477	Under 1500g infant Not Delivered at Appropriate Level of Care	The number per 1,000 livebirths of <1500g infants delivered at hospitals not appropriate for that size infant.	California Maternal Quality Care Collaborative	Obstetrical Adverse Events				
0716	Healthy Term Newborn	Percent of term singleton livebirths (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or the nursery care.	California Maternal Quality Care Collaborative	Obstetrical Adverse Events				
0201	Pressure ulcer prevalence	The total number of patients that have hospital-acquired (nosocomial) stage II or greater pressure ulcers on the day of the prevalence study.	The Joint Commission	Pressure Ulcers				
0337	Decubitus ulcer (PDI 2)	Percent of surgical and medical discharges under 18 years with ICD-9-CM code for decubitus ulcer in secondary diagnosis field.	AHRQ	Pressure Ulcers				
0538	Pressure ulcer prevention included in plan of care	Percent of patients with assessed risk for Pressure Ulcers whose physician-ordered plan of care includes intervention(s) to prevent them	CMS	Pressure Ulcers				
0539	Pressure ulcer prevention plans implemented	Percent of patients with assessed risk for Pressure Ulcers for whom interventions for pressure ulcer prevention were implemented during their episode of care	CMS	Pressure Ulcers				
0540	Pressure Ulcer Risk Assessment Conducted	Percent of patients who were assessed for risk of Pressure Ulcers at start/resumption of home health care	CMS	Pressure Ulcers				

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0678	Percent of Residents with Pressure Ulcers That Are New or Worsened (Short-Stay)	This measure updates Centers for Medicare & Medicaid Services ' current QM pressure ulcer measure which currently includes Stage 1 ulcers. The measure is based on data from the MDS 3.0 assessment of short-stay nursing facility residents and reports the percentage of residents who have Stage 2-4 pressure ulcers that are new or have worsened. The measure is calculated by comparing the Stage 2-4 pressure ulcer items on the discharge assessment and the previous MDS assessment (which may be an OBRA admission or 5-day PPS assessment).The quality measure is restricted to the short-stay population defined as those who are discharged within 100 days of admission. The quality measure does not include the long-stay residents who have been in the nursing facility for longer than 100 days. A separate measure has been submitted for them.	CMS	Pressure Ulcers		X		
0679	Percent of High Risk Residents with Pressure Ulcers (Long Stay)	CMS currently has this measure in their QMs but it is based on data from MDS 2.0 assessments and it includes Stage 1 ulcers. This proposed measure will be based on data from MDS 3.0 assessments of long-stay nursing facility residents and will exclude Stage 1 ulcers from the definition. The measure reports the percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s). High risk populations are those who are comatose, or impaired in bed mobility or transfer, or suffering from malnutrition. Long-stay residents are those who have been in nursing facility care for more than 100 days. This measure is restricted to the population that has long-term needs; a separate pressure ulcer measure is being submitted for short-stay populations. These are defined as having a stay that ends with a discharge within the first 100 days.	CMS	Pressure Ulcers		X		
	Pressure Ulcer Stages III and IV			Pressure Ulcers				

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0171	Acute care hospitalization (risk-adjusted)	Percentage of patients who had to be admitted to the hospital.	CMS	Readmissions				
0212	Proportion with more than one hospitalization in the last 30 days of life	Percentage of patients who died from cancer with more than one hospitalization in the last 30 days of life	NCI	Readmissions				
0329	All-Cause Readmission Index (risk adjusted)	Overall inpatient 30-day hospital readmission rate.	United Health Group	Readmissions				
0330	Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization	The measure estimates a hospital 30-day risk-standardized readmission rate (RSRR), defined as readmission for any cause within 30 days after the date of discharge of the index admission for patients discharged from the hospital with a principal diagnosis of heart failure (HF).	CMS	Readmissions	X			
0335	PICU unplanned readmission rate	The total number of patients requiring unscheduled readmission to the ICU within 24 hours of discharge or transfer.	National Association of Children's Hospitals and Related Institutions	Readmissions				
0336	Review of unplanned PICU readmissions	Periodic clinical review of unplanned readmissions to the PICU that occurred within 24 hours of discharge or transfer from the PICU.	National Association of Children's Hospitals and Related Institutions	Readmissions				
0505	Thirty-day all-cause risk standardized readmission rate following acute myocardial infarction (AMI) hospitalization.	Hospital-specific 30-day all-cause risk standardized readmission rate following hospitalization for AMI among Medicare beneficiaries aged 65 years or older at the time of index hospitalization.	CMS	Readmissions	X			
0506	Thirty-day all-cause risk standardized readmission rate following pneumonia hospitalization.	Hospital-specific 30-day all-cause risk standardized readmission rate following hospitalization for pneumonia among Medicare beneficiaries aged 65 years or older at the time of index hospitalization	CMS	Readmissions	X			

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0695	Hospital 30-Day Risk-Standardized Readmission Rates following Percutaneous Coronary Intervention (PCI)	This measure estimates hospital risk-standardized 30-day readmission rates following PCI in patients at least 65 years of age. As PCI patients may be readmitted electively for staged revascularization procedures, we will exclude such elective readmissions from the measure. The measure uses clinical data available in the National Cardiovascular Disease Registry (NCDR) CathPCI Registry for risk adjustment that has been linked with the administrative claims data used to identify readmissions.	CMS	Readmissions				
0698	30-Day Post-Hospital AMI Discharge Care Transition Composite Measure	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of heart failure for three types of events: readmissions, ED visits and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events that are being submitted concurrently under the Patient Outcomes Measures Phase I project's call for measures (ED and E&M) or is already approved by NQF (readmissions). Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation.	CMS	Readmissions				

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0699	30-Day Post-Hospital HF Discharge Care Transition Composite Measure	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of heart failure for three types of events: readmissions, ED visits and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events that are being submitted concurrently under the Patient Outcomes Measures Phase I project's call for measures (ED and E&M) or is already approved by NQF (readmissions). Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation.	CMS	Readmissions				

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0699	30-Day Post-Hospital HF Discharge Care Transition Composite Measure	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of heart failure for three types of events: readmissions, ED visits and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events that are being submitted concurrently under the Patient Outcomes Measures Phase I project's call for measures (ED and E&M) or is already approved by NQF (readmissions). Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation.	CMS	Readmissions				
	Heart Failure 30 day readmission Rate			Readmissions				
0125	Timing of antibiotic prophylaxis for cardiac surgery patients	Percent of patients aged 18 years and older undergoing cardiac surgery who received prophylactic antibiotics within one hour of surgical incision or start of procedure if no incision was required (two hours if receiving vancomycin or fluoroquinolone)	Society of Thoracic Surgeons	SSI				
0126	Selection of antibiotic prophylaxis for cardiac surgery patients	Percent of patients aged 18 years and older undergoing cardiac surgery who received preoperative prophylactic antibiotics recommended for the operation.	Society of Thoracic Surgeons	SSI				
0128	Duration of prophylaxis for cardiac surgery patients	Percent of patients aged 18 years and older undergoing cardiac surgery whose prophylactic antibiotics were discontinued within 48 hours after surgery end time	Society of Thoracic Surgeons	SSI				

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0130	Deep sternal wound infection rate	Percent of patients aged 18 years and older undergoing isolated CABG who, within 30 days postoperatively, develop deep sternal wound infection involving muscle, bone, and/or mediastinum requiring operative intervention	Society of Thoracic Surgeons	SSI				
0178	Improvement in status of surgical wounds	Percentage of patients whose wounds improved or healed after an operation	CMS	SSI				
200	Death among surgical inpatients with treatable serious complications (failure to rescue)	Percentage of surgical inpatients with complications of care whose status is death	AHRQ	SSI				
0264	Prophylactic intravenous (IV) antibiotic timing	Rate of ASC patients who received IV antibiotics ordered for surgical site infection prophylaxis on time	Ambulatory Surgical Center Quality Collaboration	SSI				
0268	Selection of Prophylactic Antibiotic: First OR Second Generation Cephalosporin	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis	AMA-PCPI	SSI			X	
0269	Timing of prophylactic antibiotics - administering physician	Percentage of surgical patients aged > 18 years with indications for prophylactic parenteral antibiotics for whom administration of the antibiotic has been initiated within one hour (if vancomycin, two hours) prior to the surgical incision or start of procedure when no incision is required.	AMA-PCPI	SSI				
0270	Timing of antibiotic prophylaxis: ordering physician	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours), prior to the surgical incision (or start of procedure when no incision is required)	AMA-PCPI	SSI			X	
0271	Discontinuation of prophylactic antibiotics (non-cardiac procedures)	Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time	AMA-PCPI	SSI			X	

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0299	Surgical Site Infection Rate	Percentage of surgical site infections occurring within thirty days after the operative procedure if no implant is left in place or with one year if an implant is in place in patients who had an NHSN operative procedure performed during a specified time period and the infection appears to be related to the operative procedure.	CDC	SSI	X			
0301	Surgery patients with appropriate hair removal	Percentage of surgery patients with surgical hair site removal with clippers or depilatory or no surgical site hair removal.	CMS	SSI	X			
0452	Surgery Patients with Perioperative Temperature Management	Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer for whom either active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 30 minutes immediately after anesthesia end time	CMS	SSI				
0515	Ambulatory surgery patients with appropriate method of hair removal	Percentage of ASC admissions with appropriate surgical site hair removal.	Ambulatory Surgical Centers Quality Collaborative	SSI				
0527	Prophylactic antibiotic received within 1 hour prior to surgical incision SCIP-Inf-2	Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.	CMS	SSI	X			
0528	Prophylactic antibiotic selection for surgical patients	Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).	CMS	SSI	X			

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0529	Prophylactic antibiotics discontinued within 24 hours after surgery end time	Surgical patients whose prophylactic antibiotics were discontinued within 24 hours after Anesthesia End Time (48 hours for CABG or Other Cardiac Surgery). The Society of Thoracic Surgeons (STS) Practice Guideline for Antibiotic Prophylaxis in Cardiac Surgery (2006) indicates that there is no reason to extend antibiotics beyond 48 hours for cardiac surgery and very explicitly states that antibiotics should not be extended beyond 48 hours even with tubes and drains in place for cardiac surgery.	CMS	SSI	X			
0534	Hospital specific risk-adjusted measure of mortality or one or more major complications within 30 days of a lower extremity bypass.	Hospital specific risk-adjusted measure of mortality or one or more of the following major complications (cardiac arrest, myocardial infarction, CVA/stroke, on ventilator >48 hours, acute renal failure (requiring dialysis), bleeding/transfusions, graft/prosthesis/flap failure, septic shock, sepsis, and organ space surgical site infection), within 30 days of a lower extremity bypass (LEB) in patients age 16 and older.	CMS	SSI				
0637	Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	Percentage of cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 48 hours of surgical end time.	AMA-PCPI	SSI			X	

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0696	The STS CABG Composite Score	This multidimensional performance measure is comprised of four domains consisting of 11 individual NQF-endorsed cardiac surgery metrics: (1) Operative Care--use of the internal mammary artery; (2) Perioperative Medical Care (use of preoperative beta blockade; discharge beta blockade, antiplatelet agents, and lipid-lowering agents--an "all-or-none" measure); (3) Risk-adjusted Operative Mortality; and (4) Risk-Adjusted Postoperative Morbidity (occurrence of postoperative stroke, renal failure, prolonged ventilation, re-exploration, or deep sternal wound infection--an "any-or-none" measure). All measures are based on audited clinical data collected in a prospective registry and are risk-adjusted (with the exception of internal mammary artery use and the four perioperative medications). Based on their percentage scores, a 1 (below average), 2 (average), or 3 (above average) star rating is provided for each STS database participant for each performance domain and overall. Furthermore, the composite score is also deconstructed into its components to facilitate performance improvement activities by providers. This scoring methodology has now been implemented for over two years and has become for many stakeholders the preferred method of evaluating cardiac surgery performance. STS plans to make this report publicly available in the near future. (Additional materials are available upon request)		SSI				
	Foreign Object Retained After Surgery			SSI				
0140	Ventilator-associated pneumonia for ICU and high-risk nursery (HRN) patients	Percentage of ICU and HRN patients who over a certain amount of days have ventilator-associated pneumonia.	CDC	VAP				

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0302	Ventilator Bundle	Percentage of intensive care unit patients on mechanical ventilation at time of survey for whom all four elements of the ventilator bundle are documented and in place. The ventilator bundle elements are: •Head of bed (HOB) elevation 30 degrees or greater (unless medically contraindicated); noted on 2 different shifts within a 24 hour period •Daily “”sedation interruption” and daily assessment of readiness to extubate; process includes interrupting sedation until patient follow commands and patient is assessed for discontinuation of mechanical ventilation; Parameters of discontinuation include: resolution of reason for intubation; inspired oxygen content roughly 40%; assessment of patients ability to defend airway after extubation due to heavy sedation; minute ventilation less than equal to 15 liters/minute; and respiratory rate/tidal volume less than or equal to 105/min/L(RR/TV< 105) •SUD (peptic ulcer disease) prophylaxis •DVT (deep venous thrombosis) prophylaxis	Institute for Healthcare Improvement	VAP				
0217	Surgery Patients with Recommended Venous Thromboembolism (VTE) Prophylaxis Ordered	Percentage of surgery patients with recommended Venous Thromboembolism (VTE) Prophylaxis ordered during admission	CMS	VTE	X			
0218	Surgery Patients Who Received Appropriate Venous Thromboembolism (VTE) Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery End Time	Percentage of surgery patients who received appropriate Venous Thromboembolism (VTE) Prophylaxis within 24 hours prior to surgery to 24 hours after surgery end time	CMS	VTE	X			
0239	Venous Thromboembolism (VTE) Prophylaxis	Percentage of patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.	AMA-PCPI	VTE			X	

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0371	Venous Thromboembolism (VTE) Prophylaxis	This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.	The Joint Commission	VTE				
0372	Intensive care unit (ICU) VTE prophylaxis	This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).	The Joint Commission	VTE				
0373	VTE Patients with Overlap of Anticoagulation Therapy	This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [sub cu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications. Overlap therapy must be administered for at least five days with an international normalized ratio (INR) = 2 prior to discontinuation of the parenteral anticoagulation therapy or the patient must be discharged on both medications.	The Joint Commission	VTE				
0374	VTE Patients Unfractionated Heparin (UFH) Dosages/Platelet Count Monitoring by Protocol (or Nomogram) Receiving Unfraction-ated Heparin (UFH) with Dosages/ Platelet Count Monitored by Protocol (or Nomogram)	This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.	The Joint Commission	VTE				

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0375	VTE discharge instructions	This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, to home with home health or home hospice on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions.	The Joint Commission	VTE				
0376	Incidence of potentially preventable VTE	This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.	The Joint Commission	VTE				
0434	Deep vein thrombosis (DVT) prophylaxis	Patients with an ischemic stroke or a hemorrhagic stroke and who are non-ambulatory should start receiving DVT prophylaxis by end of hospital day two.	The Joint Commission	VTE				
0450	Postoperative DVT or PE (PSI 12)	Percent of adult surgical discharges with a secondary diagnosis code of deep vein thrombosis or pulmonary embolism	AHRQ	VTE	X			
0503	Anticoagulation for acute pulmonary embolus patients	Anticoagulation ordered for acute pulmonary embolus patients.	American College of Emergency Physicians	VTE				
	STK-2 Discharged on Anti-thromboembolism Therapy			VTE				
	STK-1 Venous Thromboembolism Prophylaxis			VTE				
0353	Failure to Rescue 30-Day Mortality (risk adjusted)	Percentage of patients who died with a complication within 30 days from admission.	The Children´s Hospital of Philadelphia	Multiple: Pressure Ulcers, SSI, VTE				
0531	Patient Safety for Selected Indicator	A composite measure of potentially preventable adverse events for selected indicators	AHRQ	Multiple: Pressure Ulcers, SSI, VTE				
0532	Pediatric Patient Safety for Selected Indicators	Number of potentially preventable adverse events	AHRQ	Multiple: Pressure Ulcers, SSI, VTE				

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0706	Risk Adjusted Colorectal Surgery Outcome Measure	This is a hospital based, risk adjusted, case mix adjusted morbidity and mortality aggregate outcome measure of adults 18+ years undergoing colorectal surgery.	American College of Surgeon	Multiple: ADE, CAUTI, Injury from Falls and Immobility, Pressure Ulcers, Readmissions, VTE				
0704	Proportion of Patients Hospitalized with AMI that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	Percent of adult population aged 18 – 65 years who were admitted to a hospital with acute myocardial infarction (AMI), were followed for one-month after discharge, and had one or more potentially avoidable complications (PACs). PACs may occur during the index stay or during the 30-day post discharge period.	Bridges to Excellence	Multiple: ADE, CAUTI, Injury from Falls and Immobility, Pressure Ulcers, Readmissions, VTE				
0705	Proportion of Patients Hospitalized with Stroke that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	Percent of adult population aged 18 – 65 years who were admitted to a hospital with stroke, were followed for one-month after discharge, and had one or more potentially avoidable complications (PACs). PACs may occur during the index stay or during the 30-day post discharge period.	Bridges to Excellence	Multiple: ADE, CAUTI, Injury from Falls and Immobility, Pressure Ulcers, Readmissions, VTE				
0166	HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems Survey			Multiple: ADE, Readmissions	X			
0555	Monthly INR monitoring for beneficiaries on warfarin	Average percentage of monthly intervals in which Part D beneficiaries with claims for warfarin do not receive an INR test during the measurement period	CMS	Multiple: ADE, VTE				X
0556	INR for beneficiaries taking warfarin and interacting anti-infective medications	Percentage of episodes with an INR test performed 3 to 7 days after a newly-started interacting anti-infective medication for Part D beneficiaries receiving warfarin	CMS	Multiple: ADE, VTE				

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0581	Deep Vein Thrombosis Anticoagulation >= 3 Months	This measure identifies patients with deep vein thrombosis (DVT) on anticoagulation for at least 3 months after the diagnosis	Resolution Health, Inc.	Multiple: ADE, VTE				
0586	Warfarin - PT/ INR Test	This measure identifies the percentage of patients taking warfarin during the measurement year who had at least one PT/ INR test within 30 days after the first warfarin prescription in the measurement year	Resolution Health, Inc.	Multiple: ADE, VTE				
0593	Pulmonary Embolism Anticoagulation >= 3 Months	This measure identifies patients with pulmonary embolism (PE) on anticoagulation for at least 3 months after the diagnosis.	Resolution Health, Inc.	Multiple: ADE, VTE				
0612	Warfarin - INR Monitoring	Percentage of patients taking warfarin with PT/INR monitoring	ActiveHealth Management	Multiple: ADE, VTE				
0708	Proportion of Patients Hospitalized with Pneumonia that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period	Percent of adult population aged 18 – 65 years who were admitted to a hospital with Pneumonia, were followed for one-month after discharge, and had one or more potentially avoidable complications (PACs). PACs may occur during the index stay or during the 30-day post discharge period.	Bridges To Excellence	Multiple: CAUTI, CLABSI, Pressure Ulcer, SSI, VTE				
0709	Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year	Percent of adult population aged 18 – 65 years who were identified as having at least one of the following six chronic conditions: Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD) or Asthma, were followed for one-year, and had one or more potentially avoidable complications (PACs).	Bridges To Excellence	Multiple: CAUTI, CLABSI, Pressure Ulcer, SSI, VTE				
0472	Prophylactic antibiotic received within one hour prior to surgical incision or at the time of delivery – cesarean section	Percentage of patients undergoing cesarean section who receive prophylactic antibiotics within one hour prior to surgical incision or at the time of delivery.	MGH/ Partners Health Care System	Multiple: Obstetrical Adverse Events, SSI				

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0473	Appropriate DVT prophylaxis in women undergoing cesarean delivery	Measure adherence to current ACOG, ACCP recommendations for use of DVT prophylaxis in women undergoing cesarean delivery	Hospital Corporation of America	Multiple: Obstetrical Adverse Events, VTE				
0352	Failure to Rescue In-Hospital Mortality (risk adjusted)	Percentage of patients who died with a complication in the hospital.	The Children´s Hospital of Philadelphia	Multiple: Pressure Ulcers, SSI, VTE				
0351	Death among surgical inpatients with serious, treatable complications (PSI 4)	Percentage of cases having developed specified complications of care with an in-hospital death.	AHRQ	Multiple: VAP, VTE				

APPENDIX F:
Environmental Scan of HAC and Readmission Programs
Healthcare-Acquired Condition Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Medicare	Section 5001(c) of Deficit Reduction Act of 2005 requires the Secretary to identify conditions that are: high cost or high volume or both, result in the assignment of a case to a diagnosis related group (DRG) that has a higher payment when present as a secondary diagnosis, and could reasonably have been prevented through the application of evidencebased guidelines.[21]		The program involves a payment adjustment for healthcare-acquired conditions (HACs). On July 31, 2008, in the inpatient prospective payment system (IPPS) fiscal year (FY) 2009 final rule, CMS included 10 categories of conditions that were selected for the HAC payment provision.	The 10 categories of HACs include: • Foreign object retained after surgery, • Air embolism, • Blood incompatibility, • Stage III and IV pressure ulcers, • Falls and trauma, • Manifestations of poor glycemic control, • Catheter-associated urinary tract infection, • Vascular catheter-associated infection, • Surgical site infection following select procedures, • Deep vein thrombosis/ pulmonary embolism following select procedures	• Pressure ulcers, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Surgical site infections, • Injuries from falls and immobility, • Venous thromboembolism
Medicare	Affordable Care Act (ACA) Section 3008 states that beginning in FY 2015, hospitals scoring in the top quartile for the rate of HACs as compared to the national average will have their Medicare payments reduced by one percent for all DRGs. The applicable period for determination of the rates will be the fiscal year. In calculating the rates, the Secretary will establish and apply an appropriate risk-adjustment methodology. [22]		The program involves a payment adjustment for HACs.	The conditions included in this provision would be those already selected for the current HACs payment policy and any other conditions acquired during a hospital stay that the Secretary deems appropriate.	• Pressure ulcers, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Surgical site infections, • Injuries from falls and immobility, • Venous thromboembolism

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Medicare	The Medicare Modernization Act of 2003 (MMA) under title 42 CFR Part 423, Subpart D, establishes the requirements that Part D sponsors must meet with regard to cost control and quality improvement including requirements for medication therapy management (MTM) programs. Amended by the Medication Therapy Management Empowerment Act of 2011.[23]	Requires a prescription drug plan (PDP) sponsor to offer any willing pharmacy in its network and any other qualified healthcare provider the opportunity to provide MTM services.	Requires the PDP sponsor to reimburse pharmacists and other qualified healthcare providers furnishing MTM services based on the resources used and the time required to provide such services.	Measures evaluate performance of pharmacies and other entities in furnishing MTM services; they do not directly measure impact on adverse drug events.	• Adverse drug events
Medicaid	ACA Section 2702 requires that Medicaid implement payment adjustments for HACs identified by Medicare.[24]		The program involves a payment adjustment for the 10 HACs in the Medicare payment policy.	The 10 categories of HACs include: • Foreign object retained after surgery, • Air embolism, • Blood incompatibility, • Stage III and IV pressure ulcers, • Falls and trauma, • Manifestations of poor glycemic control, • Catheter-associated urinary tract infection, • Vascular catheter-associated infection, • Surgical site infection following select procedures, • Deep vein thrombosis/ pulmonary embolism following select procedures	• Pressure ulcers, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Surgical site infections, • Injuries from falls and immobility, • Venous thromboembolism

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Aetna	Aetna reviews inpatient claims to identify eight HACs and does not pay hospitals for additional inpatient days that directly result from the condition beyond the expected length of stay or that result in a preventable admission. Additionally, charges related to three never events and eight serious reportable events are not paid.[25]	Aetna's Quality Management Department reviews all identified never events and serious reportable events and follows up with individual facilities. If a never event or serious reportable event occurs, hospitals in the network must notify the plan and at least one designated patient safety organization. Facility representatives must identify root causes and identify changes to improve patient care systems and processes. Facility representatives must communicate with patients and their families when these events occur.	The program involves a payment adjustment for HACs. Aetna provides its members with information on its website on protecting themselves from medical error.	**HACs**: • Unintended retention of a foreign object in a patient after surgery or other procedure, • Hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products, • Failure to identify and treat hyperbilirubinemia in neonates, • A burn incurred from any source while being cared for in a healthcare facility, • Intravascular air embolism that occurs while being cared for in a healthcare facility, • Medication error, • A fall while being cared for in a healthcare facility, and • Deep vein thrombosis and/or pulmonary embolism following certain orthopedic procedures **Never Events:** • Surgery or invasive procedure performed on the wrong person, • Surgery or invasive procedure performed on the wrong side or body part, • Performance of the wrong surgical or invasive procedure	• Surgical site infections, • Adverse drug events, • Injuries from falls and immobility, • Venous thromboembolism

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Aetna (con't)				**Serious Reportable Events:** • Unintended retention of a foreign object in a patient after surgery or another procedure, • Patient death or serious disability associated with a hemolytic reaction due to administration of incompatible blood or blood products, • Patient death or serious disability associated with an electric shock while being cared for in a health care facility, • Intraoperative or immediately post-operative death in an ASA Class I patient, • Patient death or serious disability associated with use of contaminated drugs, devices, or biologics provided by a health care facility, • Death or serious disability associated with failure to identify and treat hyperbilrubinemia in neonates, • Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances, • Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility	• Surgical site infections, • Adverse drug events, • Injuries from falls and immobility, • Venous thromboembolism

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Aetna	The Aexcel Specialist Designation is awarded in the areas of: • cardiology, • cardiothoracic surgery, • gastroenterology, • general surgery, • neurology, • neurosurgery, • obstetrics and gynecology, • orthopedics, • otolaryngology/ ENT, • plastic surgery, • urology, and • vascular surgery.[26]	The program originated from discussions with large employer groups and patients who wanted to control rising costs and to have access to information about physicians. Aetna works with affected physicians before implementing the program.	Doctors who have met clinical performance criteria and, are efficient and statistically so, are Aexcel designated. Aetna is considering offering tiered insurance products of a sub-set of Aetna participating doctors, like Aexcel-designated specialists, who are identified based on a combination of clinical performance evaluation, efficiency measures and their utilization of a narrow network of hospitals.	Adverse event rate: Only clinically appropriate events are used in Aexcel measures. Data is obtained from medical, pharmacy, and lab claims as well as member and provider data. Annual monitoring for members on persistent diuretics is endorsed by NQF Annual monitoring for members on persistent anticonvulsants is endorsed by NQF	• Surgical site infections, • Ventilator-associated pneumonia, • Venous thromboembolism, • Adverse drug events

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Aetna	Prospective Reviews and Retrospective Reviews aim to promote drug safety[27]	Aetna developed physician drug information programs to help promote appropriate, cost-effective prescribing and drug therapies. Aetna helps providers identify a systematic plan for members who are at risk for an acute asthma attack and provide the appropriate intervention. Aetna developed a vital plan-specific utilization and financial information for providers through quarterly pharmacy utilization reports.	Prospective Review: Aetna requires precertification of certain drugs to help encourage appropriate prescribing in accordance with generally acceptable guidelines. Drugs requiring precertification have a narrowly defined use and present a greater possibility for inappropriate use. Criteria are based on FDA, manufacturer labeling and peer-reviewed medical information. Retrospective Review: Retrospective review of pharmacy claims: Measure the quality and appropriateness of primary care physician prescribing based on accepted guidelines through formulary compliance reports. Provide physician drug information programs to help promote appropriate, cost-effective prescribing and drug therapies. Help providers identify asthmatic plan members who are at risk for an acute asthma attack and provide the appropriate intervention. Provide vital plan-specific utilization and financial information through quarterly pharmacy utilization reports.		• Adverse drug events

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Aetna	Concurrent drug utilization review helps promote appropriate dispensing and use of drugs that is consistent with established pharmaceutical guidelines. Prescriptions filled at participating pharmacies are automatically screened against the member's available drug history.[28]	Prescriptions filled at participating pharmacies are automatically screened against the member's available drug history. System automatically screens the patient's history for possible adverse reactions.	Concurrent drug utilization review helps promote appropriate dispensing and use of drugs that is consistent with established pharmaceutical guidelines. The review checks for: • Too-early refill, • Exact duplicate, • Step-therapy, • Drug gender • Geriatric and pediatric minimum/ maximum dosing, • Minimum and maximum dosing, • Formulary drug, • Duplicate therapy, • Drug/drug interaction, • Side effects, • Drug-to-disease interaction, • Drug-to-disease by proxy, • Underutilization, • Drug-pregnancy/ lactation, • Drug allergy		• Adverse drug events
Aetna	The Rx Check analyzes members' prescription drug claims to help prevent adverse drug events.[29]	Aetna reaches out to physicians to alert them to a possible drug-to-drug interaction, duplication in drug therapy or other serious issues.	The Rx Check program uses a computer system to analyze members' prescription drug claims.		• Adverse drug events

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Anthem Blue Cross and Blue Shield	Anthem Blue Cross and Blue Shield's New Hampshire launched an e-prescribing program.[30]	Anthem offers physicians free access to e-prescribing software, a free mobile pocket PC, and a discounted wireless telecommunication plan to access real-time patient eligibility, formulary and medication history information.	Anthem Blue Cross and Blue Shield's New Hampshire e-prescribing program gives access to e-prescribing tools, including resources to improve wellness and educate members on healthy living, from nearly any device with an Internet connection.		• Adverse drug events
Blue Cross and Blue Shield of Alabama	Alabama Hospital Quality Initiative (AHQI) is a Blue Cross and Blue Shield of Alabama partnership with CareFusion MedMined Services, the Alabama Hospital Association and Alabama hospitals.[31]	Hospitals are able to share best practices and evaluate interventions. AHQI promotes nursing unit-level goal setting, defines best practices, and encourages transparency and data sharing. Clinicians are provided with real-time, hospital-wide information to provide opportunities for interventions.	The program uses technology that enables hospital-wide use of real-time monitoring of patient conditions to minimize the incidence and effects of HACs, and has reduced HACs among participating hospitals by more than 20 percent.	Hospitals must use the MedMined technology and must have 18 months of data collected to be eligible the infection prevention performance measurement. Eligible hospitals receive a rating based on infection prevention performance. Performance is based on electronically identified signs that indicate potential healthcare associated infections and how well the hospital performed compared to what their predicted performance was for five quarters of data. Performance is based on the Nosocomial Infection Marker (NIM) developed by CareFusion MedMined. A NIM is a statistically proven indicator of a potential hospital infection. NIM rates are predicted and used to categorize hospitals by comparing their observed and predicted NIM rates	• Pressure ulcers, • Surgical site infections, • Catheter-associated urinary tract infections

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Blue Cross and Blue Shield of Kanas City	Blue Cross and Blue Shield of Kansas City (BCBSKC) BagIt! Program encourages patients taking multiple medications, including prescription and over-the-counter drugs and vitamins, to bring them to their next doctor's appointment for a comprehensive medication review.[32]	BCBSKC sends a mailing to members over age 18 listed as taking more than five medications. The letter includes information on the risks of taking multiple prescriptions and a bag to bring their drugs to their next doctor's appointment. A follow up mailing provides safe medication use information and encouraged members to tell their physicians of changes in their drug regimen.	The program aims to improve patient safety by ensuring that members' physicians have a complete medication list, giving them the opportunity to prevent adverse drug events and limit unnecessary prescriptions.		• Adverse drug events
Blue Cross and Blue Shield of North Carolina	The Blue Cross and Blue Shield of North Carolina (BCBSNC) ePrescribe program provides resources to physicians to help prevent adverse drug events.[33]	BCBSN identified 1,000 network physicians with high prescribing volumes and gave them a handheld PDA, wireless network hardware and a software license free of charge. Since the launch of the ePrescribe program, more than 1,000 physicians have enrolled, and generic drugs have accounted for 59 percent of electronic prescriptions. In addition, 29 percent of orders have been flagged for potential ADEs, and 2 percent have been halted and changed based on patient allergy alerts.	Using claims data, BCBSNC uploaded members' medical information into each physician's e-prescribing system. The technology provides point-of-service access to formulary benefits and generic alternatives, as well as alerts regarding potential adverse drug events such as drug interactions and allergic reactions.		• Adverse drug events
Blue Cross and Blue Shield of Rhode Island	Blue Cross & Blue Shield of Rhode Island's (BCBSRI) Polypharmacy Program provided information to physicians to help prevent adverse drug events.[34]	The program targeted physicians of members taking prescription drugs in at least 10 medication classes and having three or more prescribers in a three-month period to reduce duplication and the risk of interactions.	Through the program, 1,419 providers received mailings identifying 3,267 eligible members, and 475 providers requested member profiles covering 2,230 individuals. The program does not apply to HIV, chemotherapy drugs and anti-neoplastics, antibiotics or immunosuppressants.		• Adverse drug events

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Blue Cross Blue Shield Association	All 39 independent Blue Cross and Blue Shield companies established a payment policy that prohibits reimbursement to contracted acute care hospitals for HACs or "never events" – serious events or medical errors that are clearly identifiable and preventable. This is a Blue System-wide policy regarding never events for all commercial and Medicare Advantage business.[35]		Blue Cross and Blue Shield companies will not reimburse for surgery performed on the wrong patient, a wrong body part or for a wrong procedure. Blue companies also will assure that acute care hospitals in Blue networks must hold the member harmless for any charges associated with never events	• The 10 categories of HACs include: • Foreign Object Retained After Surgery • Air Embolism • Blood Incompatibility • Stage III and IV Pressure Ulcers • Falls and Trauma • Manifestations of Poor Glycemic Control • Catheter-Associated Urinary Tract Infection • Vascular Catheter-Associated Infection • Surgical Site Infection Following Select Procedures • Deep Vein Thrombosis/ Pulmonary Embolism following Select Procedures	• Pressure ulcers stages III & IV, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Surgical site infections, • Injuries from falls and immobility, • Venous thromboembolism
Blue Cross Blue Shield Association	The Blue Patient Safety Toolkits are online and printed resources for local network providers.[36]	BCBS developed toolkits for the 39 BCBS companies to share with local network providers.	Toolkit resources include the Blue Surgical Safety Checklist and the CLABSI checklist.		• Surgical site infections, • Central line associated blood stream infections
Blue Cross Blue Shield Association	Blue Distinction is a designation awarded to medical facilities.[37]	Measures are established with expert recommendations. For each specialty area, BCBS reviewed nationally established measures and gathered input from expert physicians and medical organizations.	The designation is awarded in the areas of bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacement, spine surgery and transplants.		• Surgical site infections

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Blue Cross Blue Shield Association	Several plans include a standard drug utilization review program that integrates prospective, concurrent and retrospective analysis to enhance the safety, appropriateness, and cost effective use of pharmaceuticals. Prospective review encourages selection of a cost-effective, therapeutically efficacious medication at the point of prescribing. Retrospective review uses drug utilization data gathered from databases to target patients, physicians, and pharmacists, who are non-compliant with formulary and other clinical programs.[38]	On-line systems provide pharmacists with concurrent review capabilities referencing member pharmacy claims history and indicating potential drug interaction information and formulary therapeutic recommendations.	Drug utilization review program		• Adverse drug events
Blue Cross Blue Shield of MA	The Alternative Quality Contract (AQC) is a global payment model that uses a budget-based methodology, which combines a fixed per-patient payment (adjusted annually for health status and inflation) with substantial performance incentive payments (tied to the latest nationally accepted measures of quality, effectiveness, and patient experience).[39]	BCBSMA worked closely with providers to restructure the traditional fee-for-service payment system. The AQC rewards high-performing providers.	The program involves a global payment, payment for coordination, and physician pay-for-performance.	Performance measures used for the performance incentives are drawn from nationally accepted measure sets, recognized as clinically important, and are shown to be stable and reliable.	• Adverse drug events, • Surgical site infections, • Ventilator associated pneumonia, • Venous thromboembolism, • Obstetrical adverse event

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Blue Cross Blue Shield of MA	BCBSMA is a member of the eRx Collaborative.[40]	The eRx Collaborative was formed in 2003 between Blue Cross Blue Shield of Massachusetts, Tufts Health Plan and Neighborhood Health Plan with a goal to promote electronic prescribing in Massachusetts as a way to increase safety, affordability and quality in the delivery of health care.	The eRx Collaborative promotes e-prescribing by subsidizing physicians' adoption costs. BCBSMA also has an incentive program to encourage providers to obtain and use the technology.		• Adverse drug events
Blue Cross Blue Shield of MA	Blue Cross and Blue Shield of Massachusetts's (BCBSMA) Hospital Performance Incentive Program (HPIP) is designed to link payment to performance on a set of nationally recognized quality indicators.[41]	BCBSMA worked closely with providers to restructure the traditional fee-for-service payment system. The HPIP rewards high-performing providers.	Hospitals receive payment for performance as well as for improvement. BCBSMA requires hospitals to implement and utilize computerized physician order entry as part of the criteria for participating in quality and incentive programs after 2012.	Quality indicators involve clinical outcomes, clinical processes, patient experience and hospital governance.	• Adverse drug events

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Blue Cross Blue Shield of Michigan	Blue Cross Blue Shield of Michigan has provided two five year $6 million grants to the Michigan Health and Hospital Association (MHA) to support the MHA Keystone Center. From 2004-2009, the rate of CLASBIs in hospitals participating in the Keystone Center fell from 2.5 per 1,000 central line days to 0.86 per 1,000 days. From 2008 to 2010, the rate of VAP has been reduced by 70 percent, to less than 1.5 per 1,000 ventilator days. Among hospitals participating in the CAUTI initiative, the rate of catheter use fell from 19 percent to 14 percent from 2007-2010.[42]	MHA is a collaborative effort among Michigan hospitals, along with state and national patient safety experts, to improve patient safety and reduce healthcare-acquired infections. Approximately 140 Michigan hospitals participate in Keystone Center activities. To date, the MHA Keystone Center has used the following tools to improve patient safety and quality of care: • A standardized checklist and toolkit for installing central lines in intensive care unit (ICU) patients to avoid CLABSI, • An oral care toolkit to reduce VAP, • Daily patient rounds to promote better communication between doctors and nurses about patients' health status, • Pre- and post-surgical briefings to ensure that each surgical team member is aware of all surgical plans and outcomes, in order to avoid errors and surgical site infections; • Empowerment of all surgical team members to encourage individuals to speak out if they see an error about to happen; • Evidence-based procedures to promote timely removal of nonessential catheters and appropriate care of necessary catheters to reduce CAUTIs.	In addition to the funding it provides directly to the MHA Keystone Center, BCBSM provides funding to hospitals, in the form of incentive payments, to participate in selected Keystone initiatives and achieve specific performance targets related to the Keystone activities.	CLABSI rate, VAP rate, Catheter use rate	• Central line associated blood stream infections, • Ventilator associated pneumonia, • Catheter-associated urinary tract infections, • Surgical site infections

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Blue Cross Blue Shield of Michigan	The Southeastern Michigan e-Prescribing Initiative (SEMI) aims to accelerate the adoption of e-prescribing standards and technology. SEMI hopes to reduce medication errors and improve care quality, as well as reduce prescription drug costs.[43] Results to date include: • 3,000+ physicians enrolled, • More than 350,000 prescriptions transmitted monthly, and • Approximately 25,000 prescription changes per month resulting from warnings of potential adverse drug events such as drug-to-drug interactions and patient allergies	SEMI is a partnership between BCBS of Michigan, several large automakers and healthcare providers with support from regional pharmacies and data connectivity from RxHub and SureScripts.	SEMI subsidizes physician groups' implementation costs for e-prescribing and provides incentives for using the system. BCBSM offers a free two-year web solution for e-prescribing through the WebDENIS provider portal.		• Adverse drug events
Blue Cross Blue Shield of Texas	The Educate Before You Medicate program focuses on improving patient education and communication.[44]	Blue Cross Blue Shield of Texas is collaborating with the Dallas–Ft. Worth Hospital Council, the Dallas and Tarrant County Medical Societies, physicians, pharmacies, other insurers and organizations.	The program promotes medication safety to patients. The program emphasizes the importance for health care consumers to: • Know what medications they take and why (educate), • Be prepared to accurately communicate medication information to health care providers (communicate), • Carry a list of the medicine they take (participate).		• Adverse drug events

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Blue Cross of California	The Members-at-Risk Program identifies members whose prescription utilization patterns may put them at risk for adverse drug events. The program targets members who appear to have a high utilization of medications or a lack of coordinated care among providers.[45]	The program aims to help physicians to monitor total drug therapy for members who see multiple providers, utilize the services of multiple pharmacies, or use many medications.	Member information is reviewed to prevent drug-related problems such as drug interactions, duplicate therapies, or drug overutilization.		• Adverse drug events
Blue Cross of California	The Seniors-at-Risk Program promotes the continuity and coordination of care for Blue Cross senior members with chronic diseases.[46]	Feedback is provided to treating physicians for members who may be at risk for adverse drug interactions.	Program objectives include monitoring pharmacy claims for evidence of polypharmacy.		• Adverse drug events
Blue Cross of California	The Primary Care Physician Notification Program works with primary care physicians to prevent adverse drug events and promote patient safety.[47]	Primary care physicians receive a list of their Blue Cross members who have chronic diseases and who are taking psychotropic medications prescribed by a psychiatrist.	The program provides information to primary care physicians.		• Adverse drug events
Blue Shield of California	The California Healthcare-Associated Infection Prevention Initiative was funded by Blue Shield of CA with the aim to use technology to reduce HACs.[48]	CHAIPI provides hospitals with tools and data as well as the opportunity to collaborate with other organizations across the state to implement best practices	CHAIPI uses a comprehensive technology services model to identify and track infection outbreaks. CHAIPI also tracks antibiotic resistance at the local and state levels, mines data to identify opportunities for intervention, and holds quarterly meetings with to share best practices.		• Central line associated blood stream infections, • Catheter-related urinary tract infections, • Ventilator-associated pneumonia, • Surgical site infections

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
CIGNA	CIGNA has both pay-for-performance initiatives and HAC payment limitations to promote better care.[49]	As part of the health plan's pay-for-performance initiative, hospitals can earn percentage increases in reimbursement for following standardized protocols to improve patient safety and reduce surgical site infections. Specific incentive amounts and measures are negotiated on a hospital-by-hospital basis. CIGNA requires hospitals to perform root cause analyses of never events and take action to reduce them in the future.	CIGNA may reduce payments to hospitals for services required to treat HACs that were not present upon admission. CIGNA does not pay facilities or health care practitioners for never events and patients must not be held financially responsible for them. Furthermore, CIGNA does not provide reimbursement to any services related to the never event.	• Catheter-associated urinary tract infections, • Mediastinitis after coronary artery bypass surgery, • Surgical site infections following orthopedic procedures, • Surgical site infections following bariatric surgery	• Surgical site infections, • Pressure ulcers, • Injuries from falls and immobility, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Venous thromboembolism
CIGNA	The Concurrent Drug Utilization Review (CDUR) allows pharmacist to check the patient's history before dispensing medication.[50]	CDUR identifies potential drug utilization issues and sends messages to the dispensing pharmacist to reduce patient risk of adverse drug events.	CDUR a point-of-sale, system based review process that screens incoming prescriptions for safety considerations prior to dispensing by comparing it to the patient's drug history and medical profile (self-reported and medical claims).		• Adverse drug events

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Excellus Blue Cross Blue Shield	Excellus BlueCross BlueShield has provided a total of $7 million to 18 hospitals for initiatives to reduce HACs. From 2008-2011, the number of HACs, including urinary tract infections, CLABSI, and respiratory infections, declined by 17 percent among hospitals receiving funds from Excellus. This reduction translates into $6.3 million in savings for the hospitals.[51]	In 2010, quality improvement incentive payments were provided to 52 upstate NY hospitals. Payments are used to support hospitals' use of data mining technology to track and reduce infections in hospitals and in surrounding communities. The program also provides staff of participating hospitals with monthly web-based educational sessions on how to use the technology, and enables ongoing measurement of outcomes.	The program provides resources to the hospitals and uses a pay-for-performance approach.	The pay-for-performance approach includes benchmarks in the areas of clinical quality, patient safety, patient satisfaction, and hospital efficiency.	• Catheter-associated urinary tract infections, • Central line associated bloodstream infections
Highmark	The QualityBLUE hospital pay- for-performance program is a partnership with hospitals to improve patient care and safety. In 2010, the rate of CLABSI in hospitals participating in Highmark QualityBLUE was 0.96, compared to the national rate of 1.96 as reported by the CDC. From 2008-2010, the rate of MRSA infections in Highmark Quality Blue hospitals declined from 0.33 to 0.17.[52]	Highmark's infection prevention and quality improvement professionals are available for consultation, guidance, and support with patient safety efforts. Additionally, Highmark hosts an annual Best Practices Forum to share best practices and lessons learned.	A portion of hospitals' reimbursement depends on their performance in providing evidence-based services and reducing healthcare-associated infections. At first, Highmark rewarded hospitals for implementing evidence-based guidelines. Now to receive QualityBLUE reimbursements, hospitals must demonstrate progress in improving health outcomes.	The program includes benchmarks to improve surgical safety and indicators to reduce: • Surgical site infections, • Methicillin resistant Staphylococcus aureus (MRSA) infections, • Central line associated bloodstream infections, • Catheter-associated urinary tract infections, • Clostridium difficile infections, • Gram negative rod infections	• Surgical site infections, • Venous thromboembolism, • Central line associated bloodstream infections, • Catheter-associated urinary tract Infections

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Horizon Blue Cross Blue Shield of New Jersey	Horizon Blue Cross Blue Shield aims to improve patient safety through electronic medication history technology.[53]	The program provides physicians access to the SureScripts-RxHub, a third party network that, with patient consent, offers providers secure access to medication histories from retail pharmacies and pharmacy benefits managers.	Horizon Blue Cross Blue Shield has invested in installing electronic medication history technology in select network hospitals with the goal of improving patient safety.		• Adverse drug events
Humana	Humana uses the Centers for Medicare & Medicaid Services (CMS) policy for preventable conditions and the National Quality Forum (NQF) and Leapfrog Group's recommendations of "never event" reporting for commercial and Medicare contracts.[54]		Payment adjustment for HACs	The 10 categories of CMS HACs include: • Foreign object retained after surgery, • Air embolism, • Blood incompatibility, • Stage III and IV pressure ulcers, • Falls and trauma, • Manifestations of poor glycemic control, • Catheter-associated urinary tract infection, • Vascular catheter-associated infection, • Surgical site infection following select procedures, • Deep vein thrombosis/ pulmonary embolism following select procedures • Program also includes NQF serious reportable events	• Surgical site infections, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Pressure ulcers, • Injuries from falls or immobility, • Venous thromboembolism
Humana	Medication Therapy Management programs give information to members.[55]	The MTM program provides guidance to members who need specific medication and health interventions.	All eligible members receive a summary of drug use. Members with a higher risk of drug reactions are offered a personal consultation at no extra cost.		• Adverse drug events

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Humana	The RxMentor program provides resources to members with the aim of reducing adverse drug events.[56]	Eligible members are provided one-on-one telephone consultations with a pharmacist.	Pharmacist consultations advise members of on their medications and help optimize their medication regimen to improve their overall health. RxMentor initial consultations consist of: • comprehensive medication review – including non-prescribed medications, • adherence, • medication safety, • over-the-counter medications, • optimal use of medication, • cost-savings opportunities, and • physician follow up, if applicable • To stay eligible, members must meet these requirements each new plan year: multiple chronic disease conditions, fill a certain number of different Part D medications in a 90-day period, medication costs over $3,000 in a calendar year.		• Adverse Drug Events

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Humana	Concurrent and retrospective drug utilization reviews.[57]	Allows the pharmacist filling the per to review medication history or prescriptions at the point of service to check for potential problems, including: drug interactions, compliance issues, excessive drug use, therapeutic duplications, and overutilization and early refills	Humana conducts concurrent and retroactive reviews of drug utilization.		• Adverse drug events
Independence Blue Cross	Independence Blue Cross is a member of the Partnership for Patient Care.[58]	The partnership grew out of the success of a collaboration called the Regional Medication Safety Program. The program used expertise from the Institute for Safe Medication Practices and ECRI Institute. A set of action goals and best practices were defined and tools to benchmark area hospitals' standing against those goals were developed. Hospitals work to close gaps and improve practices before a reassessment of the institution's progress.	IBC has a pay-for-performance program where hospitals select projects they are working on and those that demonstrate quantitative improvement receive financial support.	Benchmarks were developed to measure performance against goals.	• Adverse drug events

Purchaser	Program Description	Purchaser Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Catalyst for Payment Reform (CPR)	The CPR health plan RFI coordinates purchaser signals and their "ask"—better organizing the private sector agenda for payment reform and providing a consistent set of expectations for the health plans that will be responsible for implementing such reforms. The RFI addresses many aspects of payment reform and contains a special module to assess health plan efforts that align with the Partnership for Patients.[59]	RFI includes value-based methods of payment (i.e., description of value-based component of payment reform program such as fee schedule adjustment, per diem/ case rate/capitation increase or decrease, gain sharing, risk sharing, annual bonus, etc.)	Health plan RFI contract language that allows health care purchasers to query plans about their efforts to link payment to performance and quality improvement, using national standardized measures and goals such as the Partnership for Patients' areas of focus. CPR's RFI will be synched with NBCH's eValue8.	Heart Attack (Acute Myocardial Infarction) Heart Failure (HF) Pneumonia (PNE) Surgical Care Improvement Project (SCIP) Mortality Measures AHRQ PSI and Nursing Sensitive Care Measures Inpatient Quality Indicator Measures Cardiac Surgery Measure Patients' Experience of Care Stroke Care Measure Nursing Sensitive Care Measure Meaningful Use Hospital-Acquired Conditions (HACs)	• Pressure ulcers, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Surgical site infections, • Injuries from falls and immobility, • Venous thromboembolism

Purchaser	Program Description	Purchaser Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
eValue8 (NBCH)	eValue8™, the nation's leading, evidence-based request for information (RFI) tool, is widely used by business health coalitions, their purchaser members, and national employers to assess and manage the quality of their health care vendors. In 2010, eValue8 was used by employers and coalitions to gather health care data from 64 health plans across the nation, representing more than 100 million Americans.[60]	One of the stated, public purposes of eValue8 is to collaborate with purchasers and health care providers to improve community health quality.	eValue8 prepares easy-to-compare performance reports that allow participants to assess health care vendors on a local, regional and national basis. With the resulting information, participating coalitions, purchasers, and plans will all be able to improve their management, administration, and/or delivery of health care services. Reports help: identify results-oriented health plans and networks designate "best in class" vendors determine health care consumer/ employee education opportunities develop targeted strategies for improving results in future years inform rate negotiations and set performance guarantees	The 10 categories of HACs include: • Foreign object retained after surgery, • Air embolism, • Blood incompatibility, • Stage III and IV pressure ulcers, • Falls and trauma, • Manifestations of poor glycemic control, • Catheter-associated urinary tract infection, • Vascular catheter-associated infection, • Surgical site infection following select procedures, • Deep vein thrombosis/ pulmonary embolism following select procedures	• Pressure ulcers, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Surgical site infections, • Injuries from falls and immobility, • Venous thromboembolism

Purchaser	Program Description	Purchaser Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
The Alliance	The Alliance, a not-for-profit cooperative of 160 ERISA employers and insurance trusts, holds managed care contracts with 47 hospitals and over 8.500 licensed practitioners in Wisconsin, Iowa, and Illinois. Collectively their members purchase $450 million worth of health care services annually. The Alliance uses Medicare logic to assign MS-DRG values when purchasing inpatient hospital care, which precludes payment for all of the HACs (as defined by CMS).[61]	The Alliance pays out an incentive "cost of living adjustment" payment to hospitals that perform well on the AHRQ patient safety indicators.	The Alliance contracts directly with hospitals in Wisconsin on behalf of their purchaser members. They pay out value-based methods of reward to hospitals for quality improvement and high achievement.	The 10 categories of HACs include: • Foreign object retained after surgery, • Air embolism, • Blood incompatibility, • Stage III and IV pressure ulcers, • Falls and trauma, • Manifestations of poor glycemic control, • Catheter-associated urinary tract infection, • Vascular catheter-associated infection, • Surgical site infection following select procedures, • Deep vein thrombosis/ pulmonary embolism following select procedures • AHRQ patient safety indicators	• Surgical site infections, • Adverse drug events, • Injuries from falls and immobility, • Venous thromboembolism, • Pressure ulcers, • Catheter-associated urinary tract infections, • Obstetrical adverse events, • Central line associated blood stream infections, • Ventilator associated pneumonia

Readmission Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare	ACA Section 3025 establishes the Hospital Readmissions Reduction Program.[62]		To account for "excess readmissions," effective October 1, 2012, diagnosis related group (DRG) payment rates will be reduced based on a hospital's ratio of actual to expected readmissions. The reduction applies to the base DRG payment only. In fiscal year (FY) 2013, the maximum payment reduction is one percent, two percent in FY 2014, and capped at three percent for FY 2015 and beyond.	The measures included in the policy must represent high volume and high cost conditions and be endorsed by NQF. The measures must have appropriate exclusions for readmissions that are unrelated to the prior discharge (such as planned admissions or transfers to another hospital). For FY 2013 the readmissions policy will apply to: Heart Attack (AMI), Heart Failure and Pneumonia. In FY 2015, the policy expands to include COPD, CABG, PTCA and Other Vascular, as identified by MedPAC in its June 2007 report. In addition, hospitals will be required to submit the appropriate information for CMS to calculate hospital specific all-payer readmission rates, which would be publicly reported on Hospital Compare.

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: Quality Partners of Rhode Island	The Rhode Island Medicare Quality Improvement Organization (QIO) Safe Transitions Project:[63] • focuses on discharge care processes from the hospital to other care settings, • promotes cross-setting communication, • aims to improve patients' transition experiences, self-management skills, and outcomes.	Quality Partners' Safe Transitions Project team works with local providers across all care settings to implement patient and system-level interventions, track progress, measure and share results	Patient Level Care Transitions Interventions: Coaches include nurses, CNAs, and social workers. Coaches work with hospital staff to identify Medicare fee for service patients and follow up with patients after discharge through home visits and phone calls. Coaches focus on the use of a personal health record, assist with medication reconciliation and follow-up appointments, and teach the signs and symptoms of worsening conditions. Systems Level Cross-Setting Communication: An advisory board defined a vision for care transitions and collaborated on strategies to implement system change. The initiative developed two sets of best practices, one for hospitals and one for community physicians.	• 30 day readmission rate (CMS)
Medicare QIO Programs: **Florida Medical Quality Assurance** **Inc. (FMQAI)**	The Care Transition Program aims to address issues in medication management, post discharge follow-up and care plans for patients who move across health care settings.[64]	The program partners with consumers, physicians, hospitals, nursing homes, home health agencies and community organizations to implement system-wide quality improvement interventions in targeted areas of Miami-Dade County, Florida.	FMQAI based the collaborative intervention on the Institute for Healthcare Improvement (IHI) Collaborative Model for Achieving Breakthrough Improvement. The program addresses: • reasons for readmission with a focus on heart failure, myocardial infarction and pneumonia, • medication reconciliation, • communication and coordination of patient services between practitioners in multiple settings, and • patient empowerment to foster increased patient responsibility for the self-management of their disease conditions.	• 30 day readmission rate (CMS)

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: CIMRO of Nebraska	CareTrek, Nebraska's care transitions initiative focuses on improving care transitions across healthcare settings to reduce avoidable readmissions.[65]	The program engages the community of providers, beneficiaries and stakeholders in Douglas and Sarpy counties with a focus on transitions from the hospital to home, skilled nursing facility, home health care or any other care provider to prevent avoidable re-hospitalization.	The program used community mapping to identify gaps in known and standard processes. Community learning groups were formed to develop interventions that result in process improvements. These interventions address issues in medication management, post-discharge follow-up, communication and care coordination. CareTrek promotes increased self-management of chronic disease for patients and their caregivers through education, support and a patient healthcare record.	• 30 day readmission rate (CMS)

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: Colorado Foundation for Medical Care	Connected for Health aimed to make improvements by standardizing transfer processes, increasing patient engagement and caregiver support, promoting culture change around palliative care and end-of-life issues, creating community coalitions, and facilitating the creation of a regional health information exchange.[66]	The program brought together hospital leadership, physicians, employers, state policy leaders, and senior advocates.	The program developed a standardized personal health record (PHR) that is being used in two large hospitals, senior resource centers, physician offices, and nursing facilities; created a post-acute care decision support tool; and conducted training on palliative care; and implemented patient coaching programs.	Hospital Measures % of patients +65 who rate hospital performance as meeting HCAHPS performance standard for medication management (HCAHPS questions 16 & 17). % of patients +65 who rate hospital performance as meeting HCAHPS performance standard for discharge planning (HCAHPS questions 19 & 20) Community Measures % of patients discharged and readmitted within 30 days who are seen by a physician between discharge and readmission. % of patient care transitions (FFS Medicare), in the target community, for which implemented and measured interventions show improvement. Reduction in the % of patients from the target community re-hospitalized within 30 days of discharge from an acute care hospital. Reduction in the 30 day all-cause risk standardized readmission rates following HF, AMI and PNE hospitalizations.

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: eQHealth Solutions	Louisiana Care Transitions Project had a primary objective to reduce unnecessary all-cause readmissions. The program focused on intervention plans and patient coaching.[67]	The program engaged hospital leadership by emphasizing how reducing avoidable readmissions reduces cost, reduces the risk of HACs, and improves patient satisfaction. All five acute care hospitals in the Baton Rouge area participated as well as home health agencies, nursing homes, hospice agencies, and physician practices.	The program used coaches who made hospital visits followed by telephone sessions on day two, seven, 15, 21 and 30 post-charge. Coaches also assisted with medication reconciliation. The selection criteria for inclusion in the program were: • fee-for-service Medicare beneficiaries who lived in a designated ZIP code area, and were able to participate in self-care or had a caregiver, • discharged to home with no addition support services, • diagnosed with CHF, pneumonia, AMI or COPD, and • consented to participate in the program	• 30 day all-cause readmissions • HCAHPS composite 5 score
Medicare QIO Programs: GMCF	The Care Transitions Initiative aims to improve post-acute care coordination and reduce readmission rate through community care transition interventions.[68]	The program focuses on improving provider communication at transfer and including community providers in planning.	The program focuses on: enhanced assessment on admission of post-discharge needs (including caregivers and community providers in discharge planning, reconciling medications, initiating a standard care plan), enhanced teaching and learning (improving patient understanding of self-care, assessing understanding of discharge instructions), handoff communications (including reconciling medications and providing real-time information to the next care provider), post-acute follow up (scheduling a visit within 48 hours for high-risk patients, and 5 days for moderate risk patients)	• 30 day readmission rate (CMS)

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: Healthcare Quality Strategies, Inc	The New Jersey Care Transitions Project (NJCTP) is a pilot project designed to improve care coordination and reduce unnecessary hospital admissions and readmissions.[69]	The program includes 10 hospitals, including the Virtua health system, 11 nursing and rehabilitation facilities, 6 home health agencies, 7 hospices, and 4 dialysis centers, as well as a number of physician practices, to implement strategies that will improve care transitions.	The program focuses on improving coordination as patients move between care settings, as well as educating and activating patients to facilitate self-management. The program emphasizes communication at the point of patient transfer, the transitional care model, and working with community agencies to raise awareness among Medicare beneficiaries.	• 30 day readmission rate (CMS)
Medicare QIO Programs: IPRO	IPRO included five New York counties (Rensselaer, Saratoga, Schenectady, Warren and Washington) in its Care Transitions Initiative.[70]	The provider community consists of 5 acute care hospitals, 6 home health agencies, 28 nursing homes, 5 dialysis centers, 5 hospice organizations, several physician health networks and primary care practices, 3 major payers and 2 Regional Health Information Organizations (RHIOs). A kick-off event was held with learning sessions featuring Eric Coleman and Mary Naylor.	The program: • trained participants in the Care Transitions Intervention Model, • focused on cross-setting medication reconciliation and medication discrepancy monitoring and communication, • created systems in the acute care setting to ensure a seven day post discharge physician visit in the discharge instructions, • ensured compliance with medications and discharge plan through follow-up calls, • educated patients and caregivers, • developed cross-setting partnerships, • encouraged self-management, • facilitated assessment for palliative care management, • utilized telehealth for high-risk patients, • developed standardized transfer of patient information .	• Overall all-cause 30 day readmission rate; • 30 day all-cause readmission rates for AMI, heart failure, and pneumonia; • Patient satisfaction (HCAHPS)

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: MPRO	MPRO is conducting a Care Transitions project in the mid-Michigan area to measurably improve the quality of care for Medicare beneficiaries who transition between care settings. The project focuses on improving care coordination between providers and across settings by improving transitions from the hospital to home, skilled nursing care, home health care or other providers to prevent avoidable hospital readmission.[71]	MPRO is working with providers to implement interventions that result in process improvements and address issues in medication management, post-discharge follow-up, communication and coordination of care.	The Care Transitions project promotes increased self-management of chronic disease for patients and their caregivers through education, support and a patient health care record.	• 30 day readmission rate
Medicare QIO Programs: Qualis Health	The Stepping Stones: Bridging Healthcare Gaps is the care transitions project of Whatcom County aims to eliminate unnecessary readmissions to St. Joseph Hospital in Whatcom County, Washington.[72]	The project connects providers throughout the healthcare system to enable safe and effective transition of patients, eliminate unnecessary hospital readmissions, and enable patients and their families to participate fully in their health and healthcare, particularly when discharged from the hospital.	• The program strategies are: • engaging providers to ensure coordination, communication and information exchange around the needs of each patient, particularly when patients are discharged. Activities include identifying patients at highest risk, using the CMS CARE tool, and implementing the teach-back technique. • implementing use of care transition coaches and coaching protocols to help patients self-manage their care. • expanding use of shared care plan personal health record • engaging key healthcare, business, nonprofit, and government entities	• 30 day readmission rate (CMS)

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: Quality Insights of Pennsylvania	Quality Insights is working on a community-based, cross-setting project called the Care Transitions Cross-Setting Interventions to help hospitals, skilled nursing facilities, home health agencies and physician offices improve coordination across the care continuum. The program aims to promote efficient transitions from hospital to home, skilled nursing care or home health care. Collaborators work to reduce unnecessary hospitalizations and readmissions.[73]	The program works with providers in Allegheny, Fayette, Washington and Westmoreland Counties. 5 hospitals, 2 in-patient rehabilitation facilities, 1 in-patient psychiatric unit, 6 home health agencies, 12 skilled nursing facilities participate in the project. The project also includes community resources, such as Area Agencies on Aging.	The project focuses on: • care transitions interventions, • care transitions coaching, • implementation of the continuity assessment record & evaluation tool, • the four pillars of care transitions: • medication self-management • red flags (knowledge of worsening condition and how to respond) • follow-up • personal health record • discharge process improvement • post-discharge follow-up • handover management communication • care plans for patients moving across health care settings	• 30 day readmission rate (CMS)
Medicare QIO Programs: TMF Health Quality Institute	TMF Health Quality Institute is conducting a Care Transitions project in the Lower Rio Grande Valley of Texas to improve the quality of care transitions between settings.[74]	The Care Transitions project aims to improve care coordination among providers and across settings by promoting transitions from the hospital to home, skilled nursing care, home health care or other providers to prevent avoidable readmission.	The program works with providers to implement interventions that result in process improvements and address issues in medication management, post-discharge follow-up, communication and care coordination. The project promotes increased self-management of chronic disease for patients and their caregivers through education, support and a patient health care record as patients transfer across care settings.	• 30 day readmission rate (CMS)

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: AQAF	The Alabama QIO project is Post-Acute Transitions in Healthcare (PATH) Alabama. The program is based in the Tuscaloosa Hospital Referral Region (HRR) that includes Tuscaloosa, Bibb, Greene, Hale, Fayette, Lamar and Pickens counties. PATH Alabama promotes improved transitions from the hospital to home, skilled nursing care, or home health care.[75]	Program partners are: AQAF, Tuscaloosa health care providers, Alabama Hospital Association, Alabama Nursing Home Association, Alabama Association of Home Health Agencies, Alabama Department of Public Health, American Heart Association-Birmingham chapter, and academic centers including University of Alabama Tuscaloosa - School of Medicine College of Community Health Services, University of Alabama Capstone Graduate Nursing Program, University of Alabama at Birmingham , Division of Geriatrics and Palliative Care, Auburn University Motivational Interviewing Training Institute, and Medicare beneficiary advocacy organizations such as Alabama Department of Senior Services, West Alabama Area Agency on Aging, and Tuscaloosa AARP.	The PATH Alabama project provides a framework for integrating and coordinating care with participating health care providers, and encourages Medicare patients to advocate for their care needs and self-manage their chronic conditions. The aims of PATH Alabama are: Establishing a multidisciplinary, multi provider work group that will lead to effective partnerships between the community at large, providers, academic institutions, and patients; Promoting capacity building in the targeted communities through increased knowledge and empowerment of community constituents; and Engaging community providers in the development, application and dissemination of data driven strategies for reducing hospital readmissions	• 30 day readmission rate (CMS)

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: Health Care Excel	The Care Transitions Program focuses on improving care coordination, particularly promoting improved care transitions for Medicare beneficiaries from the hospital to home, skilled nursing facilities or home health care. This project is based in the Evansville Hospital Service Area, which includes Vincennes, Indiana.[76]	The program brings together healthcare providers, patients, caregivers, families, and the community to improve care coordination.	The goals of the program are: • eliminating unnecessary hospital readmissions, • improving communication and information exchange when a Medicare patient is discharged from the hospital, • forming partnerships in the community that include senior service organizations, community and business leaders and families to enable effective transitions for Medicare patients, and • engaging patients, caregivers and their families to actively participate in their healthcare • The strategies of the program are: • coaching to help Medicare patients to self-manage their healthcare, • coaching and systems interventions for Medicare patients at the highest risk for hospital readmission, • individualized care plans for Medicare patients, • medication reconciliation, and • education about the importance of personal health records.	• 30 day readmission rate (CMS)

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Aetna	The Transitional Care Model program was created by a research team at the University of Pennsylvania to improve the health care and outcomes of Medicare beneficiaries with chronic illnesses who are making the transition from hospital to home. The 2006- 2007 Aetna pilot program showed a drop in readmissions in the intervention group (N=45 compared to N=60 in the control group) and savings of $439 per member. Aetna is implementing the Transitional Care Model in Philadelphia, New York, Northern New Jersey, Florida, and Arizona. The program will expand to additional parts of the country where there are large populations of Medicare members.[77]	Aetna partnered with the University of Pennsylvania to implement the program.	The program arranges for a home visit by an advanced-practice nurse within seven days of hospital discharge. The nurse evaluates: patients' clinical and psychosocial needs; the safety of the home environment; and the ability of the patient and caregiver to follow the care plan recommended at hospital discharge. Following the initial home visit, the program provides for additional in-person visits and phone calls by the nurse to coordinate patient care, communicate with physicians as needed, and help patients access all of the resources necessary to follow the care plan successfully (e.g., physical therapy, social workers, financial assistance, and Meals on Wheels). The home visit nurses coordinate and communicate with the patient's physicians.	Avoidable admissions and readmissions are defined as those which most likely would not have occurred if care plans had been followed.

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Aetna	The Aexcel Specialist Designation is awarded in the areas of: • cardiology, • cardiothoracic surgery, • gastroenterology, • general surgery, • neurology, • neurosurgery, • obstetrics and gynecology, • orthopedics, • otolaryngology/ ENT, • plastic surgery, • urology, and • vascular surgery.[78]	The program originated from discussions with large employer groups and patients who wanted to control rising costs and to have access to information about physicians. Aetna works with affected physicians before implementing the program.	Doctors who have met clinical performance criteria and, are efficient and statistically so, are Aexcel designated. Aetna is considering offering tiered insurance products of a sub-set of Aetna participating doctors, like Aexcel-designated specialists, who are identified based on a combination of clinical performance evaluation, efficiency measures and their utilization of a narrow network of hospitals.	• 30-day hospital readmission rate: Excludes expected readmissions.
Anthem Blue Cross Blue Shield	The Readmissions Prevention Program attempts to engage members in the hospital via telephone prior to discharge to assist in identifying any care situations where assistance with discharge and follow-up care could prevent a gap in care, and a subsequent further unplanned readmission.[79]	WellPoint teams help identify high-risk patients while they are still in the hospital and meet regularly with patients and nursing staff.	The initial phone call assesses home support, offers case management services on discharge and verifies a contact number for post discharge follow-up calls. Case managers may be able to help with navigating the health system, identifying and engaging community resources, benefit maximization or transitions to other levels of care.	• 30 day readmission rate (CMS)

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Blue Cross and Blue Shield of Illinois	Preventing Readmissions through Effective Partnerships (PREP) is collaboration between BCBS Illinois and the Illinois Hospital Association to reduce rates of readmissions by 2014.[80]	The program is collaboration between the Illinois Hospital Association (IHA) and BCBS of Illinois. BCBSIL provides financial support to IHA, which through its Quality Care Institute will provide hospitals with extensive technical assistance, strategic approaches, tools, and other resources. A standardized approach to discharge planning will be an integral part of the program.	The initiatives of the program are: • redesigning hospital discharge processes; • Improving transitions of care, • developing and improving palliative care programs, • reducing readmissions from infections, and • measuring reductions in readmissions using standardized metrics A focus of PREP will be educating the patient, assessing the patient's unique needs before discharge, and then making sure the patient has the information needed to ensure a smooth transition. This includes standardized discharge pathways that highlight medications, follow up, pending tests, self-management instructions, and goal setting.	• 3 day readmissions for heart failure, AMI, and pneumonia; • 10 day readmissions heart failure, AMI, and pneumonia; • 30 day readmissions heart failure, AMI, and pneumonia
Blue Cross Blue Shield of MA	The Blue Care Connection Aftercare Program facilitates patients' transition from the hospital to home. Preliminary results show a 25 percent reduction in readmission rates at targeted hospitals, generating an initial cost savings of $4.4 million. Member satisfaction surveys also indicate that 95 percent of respondents were satisfied with the support that they received through the program.[81]		Case managers initiate calls to identified members within two days of hospital discharge and assess the patient's condition, reinforce discharge instructions and address self-management strategies.	• Cost savings • Member satisfaction
Blue Cross Blue Shield of Texas	Through the Pre-Admission/ Post Discharge Outreach Program advisors reach out to members before and after surgery.[82]		Advisors review medications and if appropriate refer the member to BCBSTX case, condition, or lifestyle management programs.	

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Blue Shield of California	The CalPERs Accountable Care Organization (ACO) pilot showed a 4% reduction in hospital admissions, a 9% decrease in average length of stay, and a 22% drop in readmissions, resulting in $15.5 million in annual savings. The pilot program involved approximately 40,000 CalPERs members.[83]	ACO with Catholic Healthcare West and Hill Physicians Medical Group.	The ACO was a joint effort between Blue Shield of California, Hill Physicians Medical Group, and Catholic Healthcare West, which operates local hospitals in a three-county area in the Sacramento, CA area. CalPERS members in the Sacramento area, for a reduced premium, could use the integrated network in which each of the three entities shared patient data and coordinated patient care. All three organizations agreed with CalPERS to maintain healthcare costs for the ACO at rates at or below 2009 levels in the Sacramento area. If they delivered care for rates less than those levels, they could keep the difference and share the savings. However, if costs went above the 2009 level, they would be responsible for paying the difference.	• Average patient length of stay; • Total patient length of stay; • Number of patients with a 20-day or longer length of stay
BlueCross Blue Shield of Florida	The BCBS of Florida Physician Home Visiting Program uses predictive modeling software and claims analysis to determine which patients are most at risk of being readmitted to hospitals in the upcoming year and contacts these patients to conduct monthly home visits.[84]	Physicians and case managers can refer patients to the program.	Nurse case managers contact patients by phone to offer the program. The program's physicians (including family practitioners, internists, and geriatricians) conduct at least monthly home visits and evaluate patients' medications to identify duplicative or conflicting prescriptions; assess the safety of patients' homes; evaluate patients' diets; and examine the adequacy of patients' social support systems. Based on their assessments, physicians treat patients' medical needs and fill gaps in care. The visiting physicians coordinate care plans with patients' primary care physicians.	
CIGNA	The Care Transitions Program provides education and guidance from nurses who monitor and support the patient's hospital discharge, transition and recovery.[85]	Program nurses facilitate follow-up appointments and support the patient's hospital discharge.	The program provides support with identifying a caregiver, educates the patient and their caregivers about the hospital discharge plan, builds awareness of the patient's condition, signs and symptoms of the condition and what to do if the individual's condition worsens, helps patients manage prescriptions and other medications and facilitates follow-up medical appointments.	

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
CIGNA	The Chronic Health Improvement Program is for patients who have congestive heart failure with diabetes and/ or chronic obstructive pulmonary disease (COPD). More than 80 percent of program participants are Medicare Advantage beneficiaries.[86]	Cigna staff contact primary care physicians whose patients have the targeted conditions, and discuss the impact the program can have on patients' health. The program receives referrals from physicians, nurse care coordinators, and other Cigna staff. The program works with patient's to help them follow their physician's recommendations.	The program's clinical team includes a hospitalist who also provides outpatient care, a board-certified cardiologist who practices internal medicine, nurses, a diabetes educator, and social workers. Patients receive detailed health risk assessments to identify medical and behavioral health care needs, psychosocial challenges (e.g., depression, inability to travel to medical appointments), lack of effective medications, and financial issues that may make it difficult to access care and follow physicians' recommendations. The care team develops comprehensive care plans and links patients with case management and community-based services. Nurses call patients regularly so that nurses can monitor the patients' health conditions and help them access needed care.	• Preventable hospital and SNF admissions
CIGNA	The Home-Based Care Program aims to improve health-care for patients with complex medical needs and patients who have difficulty reaching doctors' offices.[87]	Primary care physicians are updated on the health status of their homebound patients and on the care they are receiving.	Clinicians and social workers visit patients' homes to develop care plans, monitor safety of home environments, check vital signs, help patients take medications correctly, and arrange to access community services such as transportation and Meals on Wheels.	• Preventable hospital and SNF admissions

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
CIGNA	The Transition of Care Nurse Program helps patients after hospital discharge and aims to promote timely recovery and prevent worsening of health problems. The program initially was created for CIGNA HealthCare of Arizona's Medicare Advantage individual customers, and it has been expanded to include all Cigna Medical Group patients hospitalized in the facilities where the program exists.[88]	CIGNA nurses work with hospitalists to develop discharge plans and consult with hospitalists in the emergency room. The nurses also give all primary care physicians regular updates on their patients admitted to hospitals including information on who was admitted, why they were admitted, how their health status has changed in the hospital and immediately following discharge.	Transition of Care nurses: • Meet with patients in hospitals, answer their questions, review medications, and prepare for discharge • Relay critical clinical information from outpatient settings to emergency room physicians and hospitalists • Share up-to-date information about the health status of hospitalized patients with their primary care physicians • Coordinate with hospitalists to develop discharge plans • Contact patients by phone within 24 hours of discharge to check on their health status, review medications, and help with unmet needs • Consult with social workers to help patients access needed care and community services such as transportation and pharmacy assistance programs. Social workers coordinate with other behavioral health specialists to provide support to patients with depression, particularly those with multiple chronic medical conditions CIGNA is in the process of adding clinical pharmacists to the program. Clinical pharmacists will check new and previously prescribed medications for potential duplication, medication interactions, and gaps in medication that may have led to the hospitalization in the first place.	• Patient satisfaction • Preventable hospital readmissions

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Humana	In the Post-Hospital Transition Program, Humana nurses contact patients within 72 hours of discharge from hospitals or skilled nursing facilities. Preliminary research suggests that 30 day readmission rates were lower among patients receiving post-discharge assessments than among those that did not.[89]		The program connects patients who have ongoing, complex needs with Humana's case management nurses, who help them access medical, social, and/or behavioral health services. The program nurses ask patients if they understand their health conditions and medications, have follow-up visits scheduled with their primary care physician, need durable medical equipment and/or home care, and know whom to call for help and when. The program arranges for patients to receive any of the items or services they need following hospital or SNF discharge. Nurses wok with patients to follow up with the primary care physician.	• 30 day readmission rates

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Independence Blue Cross	Independence Blue Cross conducted the Transitional Case Management Pilot Program to help members dually eligible for Medicare and Medicaid transition safely from hospital to home.[90]		Based on the success of the pilot, Independence Blue Cross expanded and re-launched the program in 2009 and 2010 to include all members with Medicare Advantage and some with commercial coverage who had CHF, diabetes, pneumonia, COPD, atrial fibrillation; syncope and collapse, dehydration, cellulitis of extremities, or gastrointestinal bleeding. The pilot program was associated with a 10.7 percent effective reduction in readmissions.Nurses or social workers visit members in hospitals to: • describe the case management services, • ensure that they schedule follow-up visits with primary care physicians and take prescribed medications, • develop personal rapport with patients so that they feel comfortable with subsequent interactions. • Following hospital discharge: • nurse case managers contact members to assess their functional capacity and needs, • provide case management services to arrange for medical care and help members access community resources (e.g., support groups, transportation), disease management programs, home health services, and durable medical equipment, and • nurses or social workers ensure patients schedule follow up visits with primary care physicians.	

Purchaser	Program Description	Purchaser Provider Collaboration	Program Design	Measure Characteristics
Catalyst for Payment Reform (CPR)	The CPR health plan RFI coordinates purchaser signals and their "ask"—better organizing the private sector agenda for payment reform and providing a consistent set of expectations for the health plans that will be responsible for implementing such reforms. The RFI addresses many aspects of payment reform and contains a special module to assess health plan efforts that align with the Partnership for Patients.[91]	RFI includes value-based methods of payment (i.e., description of value-based component of payment reform program such as fee schedule adjustment, per diem/case rate/capitation increase or decrease, gain sharing, risk sharing, annual bonus, etc.)	Health plan RFI contract language that allows health care purchasers to query plans about their efforts to link payment to performance and quality improvement, using national standardized measures and goals such as the Partnership for Patients' areas of focus. CPR's RFI will be synched with NBCH's eValue8.	Readmissions for the following areas: • Acute Myocardial Infarction (AMI) • Pneumonia (PNE) • Heart Failure (HF) • Chronic obstructive pulmonary disease • Coronary artery bypass graft • Percutaneous transluminal coronary angioplasty • Other vascular
eValue8 (NBCH)	eValue8™, the nation's leading, evidence-based request for information (RFI) tool, is widely used by business health coalitions, their purchaser members, and national employers to assess and manage the quality of their health care vendors. In 2010, eValue8 was used by employers and coalitions to gather health care data from 64 health plans across the nation, representing more than 100 million Americans.[92]	One of the stated, public purposes of eValue8 is to collaborate with purchasers and health care providers to improve community health quality.	eValue8 prepares easy-to-compare performance reports that allow participants to assess health care vendors on a local, regional and national basis. With the resulting information, participating coalitions, purchasers, and plans will all be able to improve their management, administration, and/or delivery of health care services. Reports help: • Identify results-oriented health plans and networks • Designate "best in class" vendors • Determine health care consumer/employee education opportunities • Develop targeted strategies for improving results in future years • Inform rate negotiations and set performance guarantees	

Purchaser	Program Description	Purchaser Provider Collaboration	Program Design	Measure Characteristics
The Alliance	The Alliance, a not-for-profit cooperative of 160 ERISA employers and insurance trusts, holds managed care contracts with 47 hospitals and over 8.500 licensed practitioners in WI, IA, and IL. Collectively their members purchase $450 million worth of health care services annually.[93]	The Alliance has a gain sharing program with its contracted hospital that allows it to track readmissions and provide reward payments based on improved performance.	The Alliance contracts directly with hospitals in Wisconsin on behalf of their purchaser members. They pay out value-based methods of reward to hospitals for quality improvement and high achievement.	
The Alliance	The Alliance is a founding member and active participant of WHIO – the Wisconsin Health Information Organization. WHIO is a public-private, voluntary, nonprofit organization whose primary purpose is to aggregate, analyze, and disseminate health care data in a manner that supports the ongoing transition toward value-based health care purchase and delivery decisions. These data are used to inform patient and employer health care decision making, as well as assist in provider quality improvement efforts. Although The Alliance produces QualityCounts® reports on both in-patient and outpatient care, its members wanted information to compare the cost and quality of clinics and physicians. In order to measure care at this level, it needed a much larger pool of data to work with. That's why The Alliance, along with many other organizations, founded WHIO.[94]	The WHIO is a public-private collaboration between insurance companies, health care providers, major employers and public agencies. The data gathered through it is given back to the providers for quality improvement purposes.	With an unprecedented volume of data covering more than 233.5 million claims for care provided to 3.7 million Wisconsin residents, the WHIO Health Analytics Exchange is unique. It represents over 60% of the commercially insured Wisconsin market. The Exchange holds a rolling 27 months of claims data and a total of 21.5 million episodes of care are now found in the database. An episode of care is defined as the series of treatments and follow-up related to a single medical event such as a broken leg or heart surgery, or the year-long treatment of a diabetic patient. The Wisconsin Health Information Organization is composed of insurance companies, health care providers, major employers and public agencies.	Readmissions data is available through WHIO.

APPENDIX G:
Table of Public Comments

Comment Category	Commenter Organization	Commenter Name	Comment
General	**AAOS**	**Daniel J. Berry**	Comments imported from letter received on 9/12/2011: The AAOS supports quality measures that are actionable and help align and coordinate care in all settings by all providers. We support the measurement and reduction of complications and readmissions. We have concerns, however, with the ability of an overall performance rate on a measure or set of measures to inform a hospital/provider of its specific needs for quality and patient safety improvement.
General	**Academy of Managed Care Pharmacy**	**Judith Cahill**	The Academy of Managed Care Pharmacy (AMCP) congratulates the Measures Application Partnership (MAP) on the significant work accomplished during a short time frame on the Coordination Strategy for Healthcare-Acquired Conditions and Readmissions Across Public and Private Payers. AMCP recommends that MAP specifically draw attention to the issue of adverse drug events and medication errors as a cause for readmissions. Medication errors harm an estimated 1.5 million people each year in the United States, costing the nation at least $3.5 billion annually. An estimated 60 percent of medication errors occur during times of transition: upon admission, transfer, or discharge of a patient. Medication errors result in readmissions to the hospital, greater use of emergency, post-acute, and ambulatory services, and duplication of services that needlessly increase the cost of care. Such errors can involve underuse, overuse, or misuse of medication. In other words, an important therapy can be missed or a prescribed therapy can contribute directly to patient harm. Contributing factors may include patient misunderstanding of instructions, drug-drug interactions, drug-food interactions, and duplicative therapy. AMCP strongly encourages the MAP to include information on adverse drug events in the final draft of the report.
General	**American College of Chest Physicians**	**Jeff Maitland**	On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on these recommendations. While the QIC approves this document based on the core principles it is based around, they note that the recommendations mentioned would be impossible to enact without a national mandate.
General	**American Nurses Association**	**Maureen Dailey**	Thank you for a comprehensive and insightful report. Consistency of use and definition of terms and acronyms used across the national quality landscape will reduce confusion by stakeholders. Hospital acquired conditions (HACs) is addressed by the CMS's Partnership for Patients safety goals. Healthcare-acquired conditions (HCAC) has been used in Federal proposed rulings when discussing healthcare acquired conditions across settings. Nine HACs and readmissions were discussed in the report. It would also provide clarity to identify both the HACs and readmissions (avoidable) as adverse safety events. Additionally, the use of the terms providers and clinicians was not consistent. It is important to note that reduction of healthcare acquired conditions in community-based settings (e.g., home care) involves patient-centered care, including engaging patients in effective self-care. Patient engagement and adherence is critical to prevention of these adverse events in settings where patient choice and decision making impact their care outcomes more directly.

Comment Category	Commenter Organization	Commenter Name	Comment
General	America's Health Insurance Plans	Carmella Bocchino	We applaud the Ad Hoc Safety Workgroup in its efforts to develop strategies for public-private sector alignment. The report focuses on a number of key areas that require alignment including measures and incentives. While we agree that reporting on patient safety measures should include all appropriate patients we also want to emphasize that reporting on all patients should not translate into the establishment of an all payer claims database. Instead we recommend the use of a distributed data model (DDM) for collecting and reporting data on patient safety. DDMs are currently being used by the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA) for surveillance and other purposes. The DDM has many benefits including timely access to needed data and fewer risks relating to patient privacy since data remain with its owners and does not involve transmission of personal health information. Finally the report includes an excellent summary of private sector programs. We have included a link to the monograph that AHIP published on private sector safety programs and encourage you to cross walk your report to our monograph to ensure inclusion of one additional private sector program that is currently not included in your report. http://www.ahipresearch.org/pdfs/innovations2011.pdf
General	Association for Professionals in Infection Control and Epidemiology	Denise Graham	The Association for Professionals in Infection Control and Epidemiology (APIC) supports the National Quality Strategy and the development of a coordination strategy on alignment of performance measurement for healthcare-acquired conditions (HACs) and readmissions. APIC is pleased to have this opportunity to comment. APIC believes that HACs are not true quality or safety measures. The HACs are a mix of singular events and rate-based measures. In the case of the HAI-HACs, they are rate-based measures. These include vascular catheter-associated infections, CAUTI and Surgical Site Infection (SSI), and they are epidemiologically sound as defined by the CDC's NHSN. However, the definitions of the HAIs in the HACs are based on claims algorithms that are unable to measure true change in HAI reductions. In addition, the current VAP measure is not yet recommended as a quality measure by the HAI National Action Plan supported by HHS. Three NHSN measures (CLABSI, CAUTI, and SSI) are already required by CMS for submission in 2011, or beginning January 2012. The focus on reducing HACs & HAIs is better addressed using NHSN measures. Reductions in HAC-HAIs are already being measured using the current AHRQ supported Comprehensive Unit-based Safety Program (CUSP) initiative being implemented across most states with American Hospital Association/Trust for America's Health support, Keystone and others.

Comment Category	Commenter Organization	Commenter Name	Comment
General	BCBSA	Matt Schuller	The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comment on the Measure Applications Partnership (MAP) Coordination Strategy for Healthcare-Acquired Conditions and Readmissions Across Public and Private Payers. BCBSA is a national federation of 39 independent, community-based, and locally operated Blue Cross and Blue Shield companies (BCBS) that collectively provide healthcare coverage for nearly 98 million - one in three Americans. BCBSA and the Blue Plans have a system-wide commitment to support the HHS Partnership for Patients national safety initiative which complements The Blues' ongoing leadership in efforts to improve patient safety. We support and commend the MAP efforts as outlined in the public comment documents to further the National Quality Strategy's three-part aim of creating better, more affordable care and healthier people.'
General	Consumer-Purchaser Disclosure Project	Tanya Alteras	The Consumer-Purchaser Disclosure Project appreciates the intense work that has gone into the development of these recommendations regarding patient safety and healthcare-acquired conditions, and also appreciate the opportunity to submit comments. Overall, we support the framework that the MAP has developed for addressing the goal of improving patient care by reducing HACs and readmissions, and feel that the three recommendations provide a progressive way for all stakeholders to think about the concrete steps needed to achieve improved outcomes. On page 5, the report notes that one of the results of the key informant interviews was the gathering of information on potential opportunities for alignment and potential challenges to collaborating on safety strategies. It would be extremely useful to have some details from those conversation described in the body of the report to give readers real life examples of what is being accomplished in this area.
General	Consumer-Purchaser Disclosure Project	Tanya Alteras	Finally, on page 6, the sentence in the first paragraph that says "in addition, MAP considered readmissions broadly, not limiting discussions to just those readmissions potentially related to healthcare-acquired conditions" could cause some confusion and we suggest deleting it. There is nothing in the Partnership for Patients that would lead a reader to think that it is only addressing readmissions related to the HACs that it is trying to reduce, so there is no need to make that connection in this report.
General	Federation of American Hospitals	Jayne Chambers	The FAH is concerned by the description of the purpose of MAP on page three of the report, paragraph three. This paragraph describes MAP as not duplicating NQF endorsement criteria, but rather, developing selection criteria that help to evaluate a measure set for use in specific programs and alignment with the National Quality Strategy (NQS) priority list. The FAH agrees that MAP is an additive process that goes to the implementation of NQF-endorsed measures in payment and reporting programs. However, FAH suggests that the purpose of MAP is broader than what is described as the fitness of a measure set for use in a specific program. The FAH members believe MAP must look at individual measures within a group of measures. MAP must understand the appropriateness and consequences of individual measures and then determine which measures should be grouped as a set. We envision the recommendation to HHS in the final MAP reports to the Secretary to address both topics.

Comment Category	Commenter Organization	Commenter Name	Comment
General	Federation of American Hospitals	Jayne Chambers	The Federation of American Hospitals (FAH) is pleased to have the opportunity to comment on Measure Applications Partnership (MAP) Coordinating Strategy for Healthcare-acquired Conditions (HAC) and Readmissions Across Public and Private Payers Public Comment Draft. While the FAH has a seat on the MAP Coordinating Committee, our members have a keen interest in the recommendations in this patient safety report and wish to express their support for the thoughtful and cogent articulation of the challenges facing hospitals and other providers in tackling the problems of HACs and readmissions. The report highlights the very tough challenges of the need for a common data platform, alignment of measures and reporting programs across public and private-sector programs, the need for the development of a path for improving the application of measures and the challenged of dealing with dual eligibles. Nevertheless, the FAH has several recommendations for refining the report.
General	Harborview Medical Center	Jeanne Lowe	Harborview Medical Center is the sole regional Level I adult & pediatric trauma and burn center serving approximately 25% of the land mass of the United States. As part of the only academic health system (UW Medicine) and the major safety net provider for a 5 state region-Washington, Wyoming, Alaska, Montana and Idaho (WWAMI), we serve unique and essential roles to the Northwest region. We appreciate the opportunity to comment on the MAP Safety Coordination Strategy. In general we support the efforts of NQF and MAP in aligning quality measures across public and private payers for all patients. By standardizing definitions and data collection, we foresee decreases in provider burden, and in patient confusion around quality reporting. The development of a robust, standardized common data platform will also lead to the ability to develop more targeted interventions for quality improvement.
General	Johns Hopkins Health System Readmissions Taskforce	Daniel J. Brotman	**Comments imported from email received on 9/12/2011:** Calls into question the notion that readmissions is a sign of bad quality care; notes that unintended consequences could come from reimbursing for a low readmission rate without taking into account specific patient populations where they are occurring; thinks the MAP report does not call out these nuances clearly enough. States that there needs to be more work done on risk adjustment, qualitative and quantitative analysis of readmissions to understand the quality and utilization components of readmissions. Comments that the MAP report does not mention patient/family accountability for health maintenance and preventive behaviors.
General	National Association of Healthcare Quality	Jan Orton	While we understand that NQF has deadlines imposed by CMS, NAHQ believes that NQF should have a policy that ALWAYS allows for a 30 day commenting period by the members. Large, multi-stake organizations need that time to coordinate the efforts and thoughtfully review the large documents produced by NQF to provide appropriate feedback.

Comment Category	Commenter Organization	Commenter Name	Comment
General	Society of Hospital Medicine	Wendy Nickel	Thank you for the opportunity to provide comment. The Society of Hospital Medicine (SHM) commends the National Quality Forum on developing a strategy to create a national set of safety measures for all patients, as well as minimizing the burden of quality reporting to multiple organizations. SHM would like to offer our overall endorsement of the report. Additionally, we would like to recommend that EHR/HIT vendors be directed to build the capacity to capture key data elements into the system as they are being produced, and select measures that can drive improvement more rapidly. This would allow for quality improvement to occur in real-time, as opposed to retrospectively.
Core Set	AAOS	Daniel J. Berry	**Comments imported from a letter received on 9/12/2011:** The AAOS asks that NQF/MAP take a cautious approach and start by focusing on the HACs and readmissions that can be adequately measured, have evidence-based guidelines and are able to be accurately risk-adjusted. The AAOS would like to highlight that there is shared accountability in delivering preventive services and in a patient's treatment and diagnosis. Typically, a team of providers care for the patient. In our fragmented system, however, a shared team approach to healthcare is not well established. We would encourage caution in developing policy that may hurt the team approach to care through inequitable attribution. Accurate attribution should be an element of performance assessment and quality improvement initiatives. The AAOS urges that safety information be made available to purchasers and consumers only after the providers have had an opportunity to review reports related to their performance and have had an opportunity to correct any misinformation or incorrect information in the report.
Core Set	American College of Cardiology Foundation (ACCF)/American Heart Association (AHA) Task Force on Performance Measures	Eric D. Peterson	**Comments imported from a letter dated 9/12/2011:** We appreciate the consideration given to unintended consequences. We would also strongly suggest that the MAP involve professional societies in the ongoing evaluation of the appropriateness of these strategies. Changes in the evidence base need to be acknowledged and translated into practice measures and partnership strategies including public and private payers in a timely way.
Core Set	American College of Chest Physicians	Jeff Maitland	Approve with comment. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this recommendation. The QIC notes that operationalization of this recommendation would be very difficult. The QIC would recommend a core set of measures that apply to all payers and patients.
Core Set	American Medical Rehabilitation Providers Association	Bruce M. Gans	**Comments imported from letter received on 9/12/2011:** Recommendation #1: Recommends selecting measures that are patient-centered, promote safety and prevent illness or injury, and assure access. Regarding readmissions, measure selection should be focused on avoidance of adverse events, achievement of positive outcomes, and demonstration of effectiveness/efficiency. Readmission measures should be risk-adjusted. Also emphasizes low collection burden for providers, comprehensiveness for patients, and significant to both patients and providers.

Comment Category	Commenter Organization	Commenter Name	Comment
Core Set	**American Nurses Association**	**Maureen Dailey**	The representation of stakeholders on the body identified to identify and maintain the core safety measures set should be balanced. Given the interprofessional focus of NQF, ANA respectfully requests adequate representation of nurses on this body across settings. As the largest group of healthcare providers, nurses provide direct care and care coordination to prevent HACs, healthcare acquired conditions across settings, and readmissions (e.g., transitional care). Additionally, advanced practice nurses provide increased access to primary care. Ongoing adequate representation of nursing is critical for adequate evaluation of safety measures across all settings and populations, including the chronically ill, frail elderly, children, and other vulnerable and high cost populations.
Core Set	**Association for Professionals in Infection Control and Epidemiology**	**Denise Graham**	Recommendation #1 states, "since creating a national core safety measure set would have a broad impact, a multi-stakeholder group, such as MAP, should provide input to HHS on creating and maintaining the set." In pursuing alignment, NQF focuses heavily on the current list of nine HACs, yet CMS has indicated its intent to remove vascular catheter-associated infections, CAUTI, etc., from the HACs once the NHSN CLABSI, CAUTI data are posted and eligible for reimbursement, likely beginning in 2015. APIC would therefore strongly urge that NQF reconsider the HAC list "core set", evaluate the current elements, and decide whether HACs can truly be called "quality/safety measures." Regarding specific measures listed, APIC does not support the numbered item or the recommendation that follows: 0464 - replace with CDC/NHSN measure 0125 through 0128 (STS) - replace with 0527 - 0529 (CMS) 0130 - APIC submitted comments of non-support via the NQF Cardiac Surgery Endorsement Project 0264, 0268-270, 0515 - duplicative of CMS SCIP 0271, 0637, 0472 - duplicative of CMS SCIP 0140 - support AFTER CDC revision
Core Set	**BCBSA**	**Matt Schuller**	We support the recommendation for developing a national core set of safety measures that are applicable to all patients. The development of a national core set of safety measures will help focus quality improvement efforts and align multiple federal and state efforts with those in the private sector.

Comment Category	Commenter Organization	Commenter Name	Comment
Core Set	Consumer-Purchaser Disclosure Project	Tanya Alteras	On page 7, in the first paragraph under "Recommendation #1," it says "inconsistency across public-and private-payer safety programs increases provider reporting efforts, diverts resources from their improvement efforts, and undermines their ability to understand their relative performance." While those who are deeply involved in MAP's work may understand this language, we feel that many others outside MAP, and outside the beltway, will not. We suggest simplifying this concept in the following way: "Further, inconsistency of quality measures across public and private sector programs requires providers to spend more time and resources collecting quality data, and less time actually identifying and addressing ways to improve patient safety and overall health care outcomes." We support the statement regarding the continued use of innovative measurement work being conducted at the regional or community level, and suggest that language be added to this paragraph to emphasize the goal of having data collected across public and private sector payers in those regions and communities. Finally, while the need for collection of patient-reported data is referenced in Recommendation #2, it should also be explicitly noted in Recommendation #1 that this core measure set should include measures based on patient-reported data wherever possible.
Core Set	Federation of American Hospitals	Jayne Chambers	Specifically with regard to Recommendation number one, the HAC and readmission coordinating strategy on Page 7 of the report, the recommendation describes a process for developing a core safety measure set. FAH agrees with this recommendation and would encourage it to explicitly state that the measures to be used in the set would be NQF-endorsed. It seems to be implied, but we believe the report would be stronger if it directly stated that NQF-endorsed measures would be utilized.
Core Set	GlaxoSmith Kline	Deborah Fritz	GlaxoSmithKline supports the concept of a national core set of credible, standardized performance measurers of patient safety. This will allow meaningful comparisons and reduce the burden of collecting and reporting data. GSK strongly recommends: (1) Maintenance of measure sets and measure specifications is essential and should employ an updating process on a regular and as needed basis; (2) Regular updates should occur at a set time, such as a staggered 3-year cycle and include consideration of public comments; (3) Updates should be evidence based and ensure that measures are current with practice guidelines. The maintenance process should also allow for as needed updates when there is new information, such as new practice guidelines, new peer reviewed articles, new approved indications, or new medication approvals; (3) The updating process should involve a broad range of stakeholders and be transparent so that anyone wishing to provide comments or supply data to measure developers regarding new scientific evidence or new technologies knows how to do so; (4) Because care transitions have a significant impact on readmissions, care transition measures should be part of the core set of safety measures; (5) These should include measures of Comprehensive Medication Management (assuring medications are coordinated, appropriate, understood by the patient and move patients toward clinical goals).

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Core Set	**Harborview Medical Center**	**Jeanne Lowe**	In general we support the efforts of NQF and MAP in aligning quality measures across public and private payers for all patients. By standardizing definitions and data collection, we foresee decreases in provider burden, and in patient confusion around quality reporting. The development of a robust, standardized common data platform will also lead to the ability to develop more targeted interventions for quality improvement. Two of the limitations of the report we see are: 1) discrepancies in reporting of the HACs via both claims-based data and the CDCs surveillance system (NHSN); and 2) inclusion of VAP as a quality safety measure. CAUTI, CLABSI, and SSI criteria are well-defined by the CDC, whereas coded data for these measures are inherently flawed and dependent on the quality of documentation and coding. Discrepancies between the two reporting systems will only cause confusion. Additionally, the VAP measure is not well-defined, nor is it an endorsed quality/safety measure.
Core Set	**Medisolv, Inc.**	**Zahid Butt**	Medisolv supports the concept of a national core set of safety measures that are applicable to all patients. In addition to the creation and maintenance of the core measure set we would support the "best in class" concept for any given safety objective in this core set. This would avoid the type of conflicting duplication of specification as is currently present in the CAUTI and CLABSI specifications from CMS HACs and CDC/NHSN.
Core Set	**Nursing Alliance for Quality Care**	**Mary Jean Schumann**	It is stated that a national core safety measure set would have a broad impact, therefore a multi-stakeholder group should provide input to HHS on creating and maintaining the set. While the recommendation is made for what groups should be included, NAQC would respectfully urge that stakeholder discussions include those who are responsible for the 24 hour care of the patient and who ultimately keep these patients safe at the point of care, ie nurses. Absence of the nursing safety net input, measure definitions remain theoretical constructs and lack likelihood of successful quality improvement.

Comment Category	Commenter Organization	Commenter Name	Comment
Core Set	**Washington State Department of Health**	**David Birnbaum**	Thank you for a comprehensive & thoughtful report. Three metrics identified could be reconsidered & improved: 0138 Urinary catheter associated urinary tract infection for intensive care unit (ICU) patients expressed as percentage infected. Incidence, (not prevalence, a distinction lacking as defined), is meaningful as a measure of prevention success, but only if expressed per 1,000 device-days (instead of percentage) to compensate for differences in length of exposure to risk. Might also consider widening scope to all in-patient areas (not just ICU). 0139 Central line catheter associated blood stream infection rate for ICU & high-risk nursery (HRN). Confusing as defined (percentage over a certain amount of days over a specified amount of line-days) - should be defined as incidence per 1,000 device-days, and include all in-patient areas (not just ICU). 0140 Ventilator-associated pneumonia. Research shows current surveillance definitions to be unworkable, unreliable & accuracy of reporting for inter-hospital comparisons can't be validated. Better case criteria definitions are needed, then scope of surveillance could extend to all in-patient areas. You also will need to consider merits of reporting stratified rates rather than the Standardized Infection Ratio metric (see "SIR, you've led me astray!"; INFECT CONTROL HOSP EPIDEMIOL 2011;32(3):276-282.). David Birnbaum, PhD, MPH
Data Elements	**AAOS**	**Daniel J. Berry**	**Comments imported from a letter received on 9/12/2011:** The AAOS agrees that developing a national safety data strategy within the context of a broader national data strategy is essential for coordination of safety measurement and improvement efforts. The AAOS, however, is concerned about the overall quality of data collection. Differences in data collection mechanisms and processes introduce variation in results unrelated to actual performance. In addition, the AAOS encourages NQF/MAP to be cognizant of the fact that administrative claims may not give the information that is needed to fully and accurately assess providers' performance or properly characterize readmissions. The AAOS supports harmonization of the reporting processes for current databases maintained by federal agencies . . . however, [it] questions whether a goal of 100 percent reporting is realistic, or even feasible, given the nascency of electronic health record technology. The AAOS suggests that patient-reported information could also require patients to document their compliance with discharge plans/instructions.
Data Elements	**AHRQ**	**William B. Munier**	**Comments imported from a letter dated 9/12/2011:** Support harmonizing definitions and formats with the goals of reducing reporting burden and creating a standardized data platform. Specifically, recommends using AHRQ's Common Formats (as a comprehensive way to collect data on all patients and all types of patient safety events) to collect data and "leverage the Common Formats and the established development process and expertise for the national core set of patient safety measures."
Data Elements	**American College of Chest Physicians**	**Jeff Maitland**	Approve with comment. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this recommendation. The QIC notes, that in order to successfully implement this recommendation, a national IT strategy would need to be developed and implemented to standardize the electronic health record platforms.

Comment Category	Commenter Organization	Commenter Name	Comment
Data Elements	American Medical Rehabilitation Providers Association	Bruce M. Gans	**Comments imported from letter received on 9/12/2011:** Recommendation #2: Supports concept of a common data collection instrument. Lists nine criteria that the data collection tool should meet and eight further elements that it should have "at a minimum", such as "functional info including motor, self-care and mobility, and cognitive function; environmental factors, social factors, resource consumption, etc."
Data Elements	American Nurses Association	Maureen Dailey	Collecting patient safety data elements efficiently and reliably across settings and payers can only be accomplished if meaningful use incentives are aligned across settings and Federal and State reporting requirements are harmonized. Creation of a minimum data set of safety elements should minimize burden.
Data Elements	America's Health Insurance Plans	Aparna Higgins	**Comments imported from email received on 9/12/2011:** While we agree that reporting on patient safety measures should include all appropriate patients we also want to emphasize that reporting on all patients should not translate into the establishment of an all payer claims database. Instead we recommend the use of a distributed data model (DDM) for collecting and reporting data on patient safety.
Data Elements	Association for Professionals in Infection Control and Epidemiology	Denise Graham	APIC fully supports Recommendation #2: "As a starting place for the data platform, the reporting processes for current databases maintained by federal agencies - for example, the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project,10 Centers for Disease Control and Prevention's National Healthcare Safety Network,11 CMS's Hospital Compare,12 and U.S. Food and Drug Administration's Sentinel Initiative,13 - could be harmonized. This would reduce reporting burden as well as lay the foundation for a robust, standardized data platform." APIC believes harmonization of measures would greatly reduce reporting burden as well as the confusion that results from multiple definitions of the same thing.
Data Elements	BCBSA	Matt Schuller	We believe this is an opportunity to recommend relying on a distributed data network approach rather than a more risky and costly centralized data approach. When recommending that HHS harmonize reporting processes within existing federal databases as a "starting place," MAP should urge the agency to seek all available opportunities to adopt a distributed model for current and future data collection and aggregation efforts. Recommending that a national data strategy use a distributed approach would best align with MAP's objective of assuring data collection mechanisms and processes are "simple and consistent," as well as efficient. Under a decentralized, distributed approach, entities store specified data at their own site, follow standardized data and program protocols to derive the necessary results, and submit aggregated summary information. This minimizes administrative burden and costs, enables data holders to assure the validity and integrity of the data, and mitigates the privacy risks inherent in a centralized data approach.

Comment Category	Commenter Organization	Commenter Name	Comment
Data Elements	BCBSA	Matt Schuller	**Patient-reported Information** The collection of patient-reported information is laudable. While we support this effort, it is often challenging for insurers to collect this information in a complete manner. We encourage patient-reported information to be collected from providers at the point of care and suggest incentivizing providers to collect this information. We suggest MAP provide recommendations on practicable means of data collection for patient-reported information. For example, in England providers collect patient-reported information (such as key symptoms via patient reports) pre and post procedures.
Data Elements	BCBSA	Matt Schuller	Distributed data models have been proven effective for quality measurement, comparative effectiveness research, and medical product safety evaluation where data from multiple organizations are required. This includes a large-scale Mini-Sentinel pilot that lays the groundwork for the Food and Drug Administration's (FDA) Sentinel System. MAP recognizes several additional examples of federated models in its accompanying report, Coordination Strategy for Clinician Performance Measurement. Additionally, published literature[reinforces that distributed approaches can perform essentially all of the functions of a centralized database, while avoiding many disadvantages. Distributed models have been successfully applied in areas closely aligned with MAP's mission of improving quality and safety and, in particular, reducing readmissions. One example that MAP should highlight for HHS is a Michigan-based voluntary partnership among all governmental and several local payers that used a distributed approach to producing multi-payer re-hospitalization data reflecting more than 90 percent of covered lives in Michigan. This was a critical component of guiding and evaluating a statewide readmissions reduction initiative.
Data Elements	Consumer-Purchaser Disclosure Project	Tanya Alteras	In the section on public reporting, we suggest adding some language to the third paragraph that discusses the fact that many patient safety measures are specified in a way that is more conducive to internal quality improvement than to consumer decision-making. For example, there are a number of patient safety measures related to infections that are currently in the NQF endorsement pipeline, and they use "standardized infection rate" (SIR), which compare a facility to averages based on past poor practices, rather than reporting the rate of infections. While the SIR methodology may be more effective for hospital quality improvement purposes, information on actual infection rates is more useful to consumers. We understand that this is a recommendations paper and does not delve into these technical issues, but at the same time, we think this is something that can be reflected in the recommendations without getting too detailed. For example, we suggest adding language that urges data collection approaches and reporting methods that will produce salient and meaningful measures for all users, including consumers and purchasers.

Comment Category	Commenter Organization	Commenter Name	Comment
Data Elements	**Georgetown University Law Center**	**Rachel Nelson**	Beginning with a core set of measures, an extremely helpful second step would be to define data collection and encoding standards in a manner consistent with the Standards and Interoperability Framework supported by HHS/ONC. This would facilitate harmonization of reporting around the same platform that is being built for and through the HITECH Act's incentives for Meaningful Use of Certified EHR Technology. It may be helpful to conceptualize (and describe) the "platform" as allowing for a primary pathway that is EHR compatible but implemented in parallel to minimally burdensome alternative pathway(s) for providers subject to measurement/reporting requirements but not yet enjoying the benefits of EHR technology. This might help to catalyze focus in the harmonization of current reporting processes around a strategy that is leaning forward toward where we think the data will be, and how we think it will most likely move for the majority of purposes, a few years from now rather than risking a harmonization around the existing features of projects that may currently be optimized for legacy data management technology.
Data Elements	**GlaxoSmith Kline**	**Deborah Fritz**	GSK agrees that the data strategy should be anchored on a unified data platform for collecting standardized quality data of all types, including safety data. Data collection should be simple and consistent and should not require additional administrative effort. For example, tracking and reporting adult immunizations is difficult because of the lack of a common data platform and reporting. This can compromise patient safety particularly for patients being admitted to the hospital or nursing home (e.g., hepatitis and flu immunization status prior to admission). Because states do not generally require reporting on adult immunizations and because adult immunizations may occur in various settings (work, pharmacy, doctor's office) and at different life stages (e.g., once every 10 years, annually), it is difficult to track or measure adult immunizations at the physician or at the community level.
Data Elements	**Harborview Medical Center**	**Jeanne Lowe**	We believe that additional data from all payers would provide valuable quality improvement tools. By aligning patient data across different providers and across the care continuum, providers and payers alike will have more reliable access to all patient care information. However, adequate protections must be guaranteed that sharing of this information will not in any way promote punitive actions, but rather systems improvements.

Comment Category	Commenter Organization	Commenter Name	Comment
Public-Private Coordination	**AAOS**	**Daniel J. Berry**	Comments imported from letter received on 9/12/2011: The AAOS generally supports MAP's third recommendation, which supports coordination of public-and private-sector entities . . [but] the AAOS is concerned about programs that may penalize providers who are not actually responsible for the safety event. The AAOS believes the report falls short on acknowledging the critical role patients play in determining their own healthcare outcomes. Patients are not merely consumers making decisions about healthcare purchases. They must be seen as sharing the responsibility for their own outcomes. The AAOS recognizes, however, that there are many factors beyond the providers'/hospitals' control that may impact rates of readmission, including the patient's own behavior. The AAOS is concerned with the presumption that all of the HACs cited in the report could be "reasonably prevented" through the use of evidence-based guidelines. The AAOS believes there is an important distinction between reduction and preventability. The AAOS agrees that surgical site infection is a serious patient safety concern. Infection, however, is a multidimensional condition with many contributing factors. Patients have varying degrees of susceptibility to infection. Therefore, it is important to recognize this level of unavoidability and apply a method of risk adjustment that can adequately encompass the relevant risk factors. We believe that without risk adjustment the system creates a disincentive to treat patients with the co-morbidities listed above. We would strongly recommend that prevalence measures include a risk adjustment component. The AAOS suggests that NQF take a cautious, measured approach toward development of venous thromboembolism measures. Even with best practice recommendations from the AAOS or the American College of Clinical Pharmacy (ACCP), the incidence of Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) following total knee and hip replacement can at best be "reduced" but not eliminated. The AAOS supports movement toward developing clinically relevant quality measures which recognize the importance of measuring both process and outcome. We cannot stress enough the importance of risk adjustment when outcome measures are publicly reported and/or used in future value-based purchasing programs. The AAOS urges NQF/MAP to further develop a means for risk adjusting for the wide range variation in patient characteristics prior to fully implementing the policy. The AAOS believes that risk adjustment is necessary to differentiate and account for patient demographics, co-morbidities, severity of illness, and procedure.
Public-Private Coordination	**American College of Chest Physicians**	**Jeff Maitland**	Approve with comment. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this recommendation. The QIC notes that if performance measures were linked to a CEO of a hospital/medical center (instead of institution or provider) rates may improve at a much higher rate.

Comment Category	Commenter Organization	Commenter Name	Comment
Public-Private Coordination	**American Nurses Association**	**Maureen Dailey**	The role of improved communication and collaboration between interdisciplinary team members harnessing technology (e.g., telehealth, electronic health records, predictive risk modeling data), utilizing effective evidence-based tools (e.g., checklists), and employing advanced patient engagement and self-care activation was not highlighted. Partnership between public and private sectors is important. However, moving towards shared accountability for interdisciplinary teams for patient safety supported by structural supports (e.g., safety culture and appropriate skill mix, staffing, and technology integration) is also important. The work of improving safety outcomes occurs within healthcare teams, with the patient at the center. Patient safety is the floor for quality healthcare, for self-directing and non self-directing vulnerable patient populations. Discharge and transitional care safety measures must adequately capture interdisciplinary team care coordination, in addition to capturing core elements. The timeliness of medication reconciliation is critical (30 days is not adequate to prevent readmissions). Additionally, patients require a triple check medication reconciliation upon hospital discharge (medication list, prescriptions, and community-based transfer summary/orders must reconcile).
Public-Private Coordination	**Association for Professionals in Infection Control and Epidemiology**	**Denise Graham**	APIC fully supports the development of a single national core set of safety measures and a standardized approach for capturing and reporting patient safety data that is used by both the public and private sectors. APIC also supports the NQF approach for readmissions, considering them broadly, not limiting discussions to just those readmissions potentially related to healthcare-acquired conditions. Further, when considering readmissions, appropriateness of the readmission should be explored, particularly as it relates to the availability of care supports in the community. All too often, a readmission may be the best care option for a vulnerable patient. APIC does have concerns for how readmissions are defined. APIC urges NQF to ensure that final definitions, or specification of the definitions, consider and define exclusions such as planned readmission or transfer to another hospital. Planned readmissions should include staged surgeries, rehabilitation or a series of chemotherapy treatments. NQF should also consider some readmissions that are not "preventable" such as trauma, psychoses, substance abuse, maternity and neonatal, and end stage renal disease and consider the unintended consequences if not included.
Public-Private Coordination	**Consumer-Purchaser Disclosure Project**	**Tanya Alteras**	The last paragraph on page 10 discusses the responsibilities of payers and purchasers to provide information to patients and consumers, which we agree is an important role. We suggest the last sentence of that paragraph be edited to note that providing resources to patients from multiple avenues can help patients fully understand their role as long as that information is coordinated! Finally, we fully support the language on the need for a core set of discharge plan elements, built on best practices from existing programs that have shown to result in improved care transitions and patient outcomes.

Comment Category	Commenter Organization	Commenter Name	Comment
Public-Private Coordination	Consumer-Purchaser Disclosure Project	Tanya Alteras	We fully support the recommendation that public and private sector payers work together, using aligned measure sets (as per recommendation #1), and aligned incentive programs that promote value-based decision-making. The first full paragraph on page 10 states "With this kind of alignment, organizations will have the opportunity to combine incentives and savings from multiple programs for much greater investment in expanding their ability to improve performance - and to measure more effectively at the same time." We think that this point could use some clarification. Is the point that if the quality measurement efforts were coordinated and aligned across sectors, providers could spend less time trying to respond to data requests and requirements? If so, this should be clarified, and expanded upon in a way that does not make this point redundant with the way it is made in recommendation #1, and also, expands on this point to make sure to include the effect on alignment on patients.
Public-Private Coordination	Federation of American Hospitals	Jayne Chambers	Recommendation number three focuses on the public- and private-sector entities coordinating efforts to make care safer and the use of incentive structures to carry out this goal. Page 10 of the report, first full paragraph at the top of the page is confusing and appears to recommend specific methodologies without providing evidence that these methodologies are the most appropriate or effective. We also found the fourth sentence in that paragraph to be confusing.
Public-Private Coordination	GlaxoSmith Kline	Deborah Fritz	GSK agrees that public- and private-sector entities should coordinate their efforts to make care safer (e.g., standardized elements on all discharge forms across care settings). However, explicit efforts should be made to encourage innovation and new model development. The use of incentives and savings is an effective way to change behavior and encourage care delivery innovation. The report states that purchasers and payers should expand their roles to become more active partners in the delivery of care. GSK strongly recommends that the report encourage all stakeholders be active partners in care delivery to increase use of mechanisms such as comprehensive medication management and disease management programs. Similarly, broad collaboration is needed to build public awareness about patient safety issues, improve health literacy and adherence to care plans.
Public-Private Coordination	Harborview Medical Center	Jeanne Lowe	As previously noted, coordination of patient quality and safety measures across private and public sectors should result in systems improvements via a non-punitive program.

Comment Category	Commenter Organization	Commenter Name	Comment
Public-Private Coordination	**Next Wave**	**John Shaw**	Vulnerable populations tend to have characteristics such as a higher proportion of language or communication difficulties, higher proportions of behavioral health issues (mental illness, substance abuse, and/or developmental disabilities), and/or less effective social support structures available in the community. While programs exist to overcome these challenges to providing quality care, these programs require additional effort and funding to achieve comparable outcomes. MAP appropriately advocates (p. 10) that the use of incentive structures should contribute to this funding of the "safety net" to providers who serve these vulnerable populations to avoid unfairly penalizing them. We strongly recommend that measures used for such incentive structures (e.g. Value Base Purchasing) be transparently evaluated to identify and differentiate the magnitude of this "population served" effect between providers versus any performance effect, and make appropriate adjustments to prevent incentivizing providers to avoid these populations.
Public-Private Coordination	**Washington State Department of Health**	**David Birnbaum**	The Council of State & Territorial Epidemiologists is establishing a coordinating committee with CDC to define a nationally-recommended set of healthcare-associated infection (HAI) metrics for public reporting. CSTE members in state HAI programs, in turn, work with advisory committees to ensure needs of their hospital and public members are addressed in a manner consistent with current knowledge and research priorities identified in the scientific literature. Your project report inventory is comprehensive and its recommendations are commendable. Three metrics listed in that report (0138, 0139, 0140) should be reconsidered and improved to smooth the way toward better coordination between all entities concerned. David Birnbaum, PhD, MPH
Path Forward	**American Nurses Association**	**Maureen Dailey**	The current Partnership for Patients focus on HACs and readmissions should be expanded to include healthcare acquired conditions, when feasible. Structural safety measures are lacking for nursing homes and home care. Structural measures for interdisciplinary care coordination teams are also needed. Structural measures are the essential to patient safety and should be included in value-based purchasing programs. Additionally, a growing problem is premature and avoidable institutionalization related to uncoordinated care, unmanaged chronic conditions, and lack of community supports. This is a patient safety issue. Similar to avoidable rehospitalization, avoidable institutionalization carries risk for healthcare acquired conditions, loss of function, depression etc. Given the growing vulnerable populations with multiple chronic illnesses and frail elderly, prevention of avoidable healthcare acquired conditions, readmissions, emergency department use, and institutionalization is important for safety, quality of life, and excessive cost is crucial to meet the broad aims of the National Quality Strategy. Given state budget issues, hospitals admission for "observation" to facilitate nursing home coverage also needs to be addressed. These admissions carry safety risk and are uncomfortable for vulnerable elders.
Path Forward	**GlaxoSmith Kline**	**Deborah Fritz**	GlacoSmithKline strongly agrees that the full range of stakeholders be involved through a transparent and open process in the selection of a national core safety measure set, as well as strategies to promote a national safety data strategy.

Comment Category	Commenter Organization	Commenter Name	Comment
Path Forward	**Next Wave**	**John Shaw**	We strongly support further examination of underreporting of safety events in the MAP report (p. 11). Prior work has demonstrated significant under-reporting of certain safety events due to a combination of oversight (e.g., different numbers of deaths for a single provider reported in different data systems), conflicting definitions and/or regional practices (e.g. is a dural tear and repair during complex spine surgery a complication or an expected part of the procedure), IT system constraints (e.g. no way to consistently capture post-operative infections in the ambulatory setting), etc. In a number of cases, we have seen that the variability due to underreporting is a significant proportion if not the majority of overall outcome variation. To prevent inappropriate/perverse incentives in measure use - particularly for payment, we strongly recommend that whenever underreporting is suspected, an evaluation be performed to measure or at least estimate "Signal to Noise Ratio" of variation due to actionable practice variation vs. variation due to underreporting. This should be reported transparently prior to use decisions for that measure.
Path Forward	**Next Wave**	**John Shaw**	We strongly support further examination of the appropriateness of readmissions in the MAP report (p. 11). Readmission rates are strongly influenced by the availability of care supports in the community and the patient's own self care knowledge, abilities, and activation. We agree with the MAP that a readmission may be the best care option for a vulnerable patient. Tools to evaluate both the patient's own self care abilities and the availability of community supports are needed to identify program supports and/or to risk adjust incentive measures to prevent incentivizing providers to avoid caring for vulnerable populations.

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NATIONAL QUALITY FORUM
601 13TH STREET, NW
SUITE 500 NORTH
WASHINGTON, DC 20005

www.qualityforum.org