MAP Coordinating Committee Background Materials

NATIONAL QUALITY FORUM

Tuesday, January 8, 2013
Wednesday, January 9, 2013

National Quality Forum
9th Floor Conference Center
1030 15th Street, NW
Washington, DC 20005

BIOS OF THE MAP COORDINATING COMMITTEE

CO-CHAIRS (VOTING)

George J. Isham, MD, MS

George Isham, M.D., M.S. is Senior Advisor to HealthPartners, responsible for working with the board of directors and the senior management team on health and quality of care improvement for patients, members and the community. Dr. Isham is also Senior Policy Fellow, HealthPartners Research Foundation and facilitates forward progress at the intersection of population health research and public policy. Dr. Isham is active nationally and currently co-chairs the National Quality Forum convened Measurement Application Partnership, chairs the National Committee for Quality Assurances' clinical program committee and a is member of NCQA's committee on performance measurement. Dr. Isham is chair of the Institute of Medicine's Roundtable on Health Literacy and has chaired three studies in addition to serving on a number of IOM studies related to health and quality of care. In 2003 Isham was appointed as a lifetime National Associate of the National Academies of Science in recognition of his contributions to the work of the Institute of Medicine. He is a former member of the Center for Disease Control and Prevention's Task Force on Community Preventive Services and the Agency for Health Care Quality's United States Preventive Services Task Force and currently serves on the advisory committee to the director of Centers for Disease Control and Prevention. His practice experience as a general internist was with the United States Navy, at the Freeport Clinic in Freeport, Illinois, and as a clinical assistant professor of medicine at the University of Wisconsin Hospitals and Clinics in Madison, Wisconsin.

Elizabeth A. McGlynn, PhD, MPP

Elizabeth A. McGlynn, PhD, is the director for the Center of Effectiveness and Safety Research (CESR) at Kaiser Permanente. She is responsible for oversight of CESR, a network of investigators, data managers and analysts in Kaiser Permanente's regional research centers experienced in effectiveness and safety research. The Center draws on over 400 Kaiser Permanente researchers and clinicians, along with Kaiser Permanente's 8.6 million members and their electronic health records, to conduct patient-centered effectiveness and safety research on a national scale. Kaiser Permanente conducts more than 3,500 studies and its research led to more than 600 professional publications in 2010. It is one of the largest research institutions in the United States. Dr. McGlynn leads efforts to address the critical research questions posed by Kaiser Permanente clinical and operations leaders and the requirements of the national research community. CESR, founded in 2009, conducts in-depth studies of the safety and comparative effectiveness of drugs, devices, biologics and care delivery strategies. Prior to joining Kaiser Permanente, Dr. McGlynn was the Associate Director of RAND Health and held the RAND Distinguished Chair in Health Care Quality. She was responsible for strategic development and oversight of the research portfolio, and external dissemination and communications of RAND Health research findings. Dr. McGlynn is an internationally known expert on methods for evaluating the appropriateness and technical quality of health care delivery. She has conducted research on the appropriateness with which a variety of surgical and diagnostic procedures are used in the U.S. and in other countries. She led the development of a comprehensive method for evaluating the technical quality of care delivered to adults and children. The method was used in a national study of the quality of care delivered to U.S. adults and children. The article reporting the adult findings received the Article-of-the-Year award from

AcademyHealth in 2004. Dr. McGlynn also led the RAND Health's COMPARE initiative, which developed a comprehensive method for evaluating health policy proposals. COMPARE developed a new microsimulation model to estimate the effect of coverage expansion options on the number of newly insured, the cost to the government, and the effects on premiums in the private sector. She has conducted research on efficiency measures and has recently published results of a study on the methodological and policy issues associated with implementing measures of efficiency and effectiveness of care at the individual physician level for payment and public reporting. Dr. McGlynn is a member of the Institute of Medicine and serves on a variety of national advisory committees. She was a member of the Strategic Framework Board that provided a blueprint for the National Quality Forum on the development of a national quality measurement and reporting system. She chairs the board of AcademyHealth, serves on the board of the American Board of Internal Medicine Foundation, and has served on the Community Ministry Board of Providence-Little Company of Mary Hospital Service Area in Southern California. She serves on the editorial boards for *Health Services Research* and *The Milbank Quarterly* and is a regular reviewer for many leading journals. Dr. McGlynn received her BA in international political economy from Colorado College, her MPP from the University of Michigan's Gerald R. Ford School of Public Policy, and her PhD in public policy from the Pardee RAND Graduate School.

ORGANIZATIONAL MEMBERS (VOTING)

AARP

Joyce Dubow, MUP

Ms. Dubow is Senior Health Care Reform Director in AARP's Office of the Executive Vice- President for Policy and Strategy, where she has responsibility for a broad health portfolio related to AARP's health care reform initiatives with a special focus on health care quality, HIT, and consumer decision making, as well as private health plans in the Medicare program. Dubow serves on several multi-stakeholder groups focusing on quality improvement. She was the first chair (and continues to be a member) of the Consensus Standards Approval Committee (CSAC) of the National Quality Forum. She is a member of the National Committee for Quality Assurance's Committee on Physician Programs and its Measurement Panel on Geriatrics; the National Advisory Committee for Aligning Forces for Quality of the Robert Woods Johnson Foundation; the National Committee on Evidence-based Benefit Design of the National Business Group on Health; the National Heart Lung Blood Institute Cardiovascular Disease Clinical Guideline Expert Panel and the National Advisory Board of the Practice Change Fellows Program. She also participates in the Hospital Quality Alliance, the AQA Steering Committee, the Markle Foundation's Connecting For Health program, as well as other ad hoc groups focusing on health care quality and consumer decision making. In a "former life," Ms. Dubow was the executive vice-president of the Georgetown University Community Health Plan, a university-sponsored prepaid group practice plan. She was also the Director of Policy and Legislation in the federal Office of Health Maintenance Organizations. Ms. Dubow holds a B.A. in Political Science from the University of Michigan and a Masters in Urban Planning from Hunter College of the University of the City of New York.

ACADEMY OF MANAGED CARE PHARMACY

Marissa Schlaifer, RPh, MS

Marissa Schlaifer joined the Academy of Managed Care Pharmacy (AMCP) as Pharmacy Affairs Director in January 2003. The Academy is a professional society with over 6,000 members which is dedicated to

the continuing professional development of health care professionals engaged in the practice of pharmacy in managed care settings. For the Academy, Marissa is involved in all professional and clinical aspects of the organization's activities. She was been involved in the development and implementation of the Medicare prescription drug benefit. Marissa served on various Part D Medication Measures technical expert panels (TEPs), providing input on the development of quality measures, serves on the Department of Defense Uniform Formulary Beneficiary Advisory Panel, and has represented AMCP in many capacities within the Pharmacy Quality Alliance (PQA). Marissa brings experience in both the managed care pharmacy and community pharmacy segments of the profession as well as leadership experience in several pharmacy organizations. Prior to joining AMCP, Marissa was Healthy Outcomes Director at H-E-B Grocery Company, where she was responsible for disease management and health improvement programs, immunization programs and new business opportunities. Previously, Marissa worked for PacifiCare of Texas and Prescription Solutions as a clinical pharmacist, and for Eckerd Drug Company as pharmacy manager and a regional manager for managed care sales. She received her B.S. in Pharmacy and M.S. in Pharmacy Administration from The University of Texas at Austin College of Pharmacy. Marissa has been active in leadership positions within AMCP, the American Pharmacists Association and the Texas Pharmacy Association.

ADVAMED

Steven Brotman, MD, JD

Steven J. Brotman, M.D., J.D. is Senior Vice President, Payment and Policy, for the Advanced Medical Technology Association (AdvaMed). Dr. Brotman leads AdvaMed's health care quality initiatives, working closely with member companies on key policy issues. Dr. Brotman is a Board Certified Pathologist. Dr. Brotman received his M.D. from The Mount Sinai School of Medicine in New York City, where he also completed a residency in Pathology, after performing an internship in General Surgery. He had additional clinical and research fellowship training at the Johns Hopkins Hospital in the field of immuno-pathology, with in-depth training in immuno-dermatology and hematopathology. Additionally, Dr. Brotman earned a J.D. from the University Of Maryland School of Law and was a Federal Judicial Intern working under the Honorable Paul Grimm at the United States Federal Court in Baltimore, MD. Subsequently, he joined Morgan, Lewis, and Bockius, L.L.P. in Washington, D.C. as an associate in the FDA Regulatory/Healthcare group, where he worked with various domestic and international companies on pharmaceutical/device lifecycle, regulatory and healthcare issues. He most recently was a Senior Regulatory and Research Attorney at Wyeth Pharmaceuticals (now Pfizer) specializing in complex safety, drug development, clinical trial and compliance issues. Dr. Brotman has authored several peer-reviewed scientific publications and made numerous presentations to the scientific, pharmaceutical and legal communities. He is on the editorial board of Maryland Medicine, the Maryland Medical Society Journal and developed and taught the Seminar Series on Scientific Evidence at the University Of Maryland School of Law.

AFL-CIO

TBD

AMERICA'S HEALTH INSURANCE PLANS

Aparna Higgins, MA

Ms. Higgins is Vice President, Private Market Innovations at America's Health Insurance Plans (AHIP), where she is focused on a number of key initiatives including performance measurement, innovative payment models and delivery system reform. She led AHIP Foundation's efforts to pilot-test a data

aggregation methodology, a component of the High-Value Health Care project funded by the Robert Wood Johnson Foundation, for individual physician performance measurement across regions and health plans. She is a healthcare economist with expertise and experience in study design and economic modeling and has directed a number of research and analytic projects employing multi-disciplinary teams. She serves on a number of expert panels on performance measurement. Prior to AHIP, she was at Booz Allen Hamilton where she led a team of health services researchers focused on studies related to electronic health record (EHR) adoption, quality measurement, and value-based purchasing. She was the principal investigator for two research studies on physician adoption of EHRs and evaluation design of the business case for Health Information Technology (HIT) in Long-Term Care for the Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation (ASPE). She played a key leadership role in assisting the Centers for Medicare and Medicaid Services (CMS) with the design of a Medicare Hospital Value-based purchasing (VBP) program and was closely involved in developing the hospital VBP report to Congress.

AMERICAN COLLEGE OF PHYSICIANS

David W. Baker, MD, MPH, FACP

David W. Baker, MD, MPH is Michael A. Gertz Professor in Medicine and Chief of the Division of General Internal Medicine, Northwestern University. He received his MD from the UCLA School of Medicine and his MPH from the UCLA School of Public Health. He completed his research training in the UCLA Robert Wood Johnson Clinical Scholars' Program. His research has focused on access to health care, racial and ethnic disparities in care, health communication, and quality of care for chronic diseases. He has led studies examining many aspects of quality, including whether hospital mortality "report cards" lead to changes in market share for hospitals and improvements in outcomes, the effect of disease management programs for patients with heart failure, and an evaluation of the Institute for Healthcare Improvement's Improving Chronic Illness Care Collaborative. His current work is examining quality measurement and quality improvement using electronic health record systems. Dr. Baker has served in many national roles as well. He served as the Associate Project Director for the AHCPR-funded Heart Failure guideline and was lead author for a series of manuscripts in JAMA on quality of care for patients with heart failure. He has served as an advisor to both the Ohio and the Georgia Peer Review Organizations' heart failure quality improvement projects, and he was part of the American Heart Association's first working group for measuring quality of care and outcomes for cardiovascular disease. He served on the American College of Cardiology/American Heart Association Heart Failure Practice Guideline committee and the American Board of Internal Medicine's Committee for their new Heart Failure Practice Improvement Module. He has served as a member of the Health Information Technology Expert Panel's (HITEP) Quality Data Set subcommittee. He currently serves on the Physicians' Consortium for Performance Improvement (PCPI) Measure Implementation and Evaluation subcommittee and the American College of Physicians' Performance Measure Advisory Committee.

AMERICAN COLLEGE OF SURGEONS

Frank G. Opelka, MD, FACS

Frank G. Opelka, MD FACS is the Vice Chancellor for Clinical Affairs and Professor of Surgery at Louisiana State University Health Sciences Center in New Orleans. In LSU, he actively teaches in the 4 health sciences schools developing programs for innovation and delivery system redesign. He also works at the LSU seven hospital system to support efforts for the development of a safety net ACO to address various challenges such as the dual eligible. He also represents the American College of Surgeons, Washington DC Office in the Division of Health Policy and Advocacy. Dr. Opelka founded and serves as the chair of

the Surgical Quality Alliance, with over 20 surgical organizations sitting in the alliance. He serves as one of the original members of the National Priorities Partnership in the National Quality Forum, a member of the NQF's Consensus Standards Advisory Committee, and has served as a chair of an NQF steering committee. Dr. Opelka continues to serve on the Quality Alliance Steering Committee, the AQA, and the AMA's Physician Consortium for Performance Improvement. He has served on several advisory committees to several health plans, including United Health Group, Blue Cross Blue Shield of America, and Humana. Dr. Opelka has developed and assisted the American Board of Medical Specialties in their clinical registry efforts for the Maintenance of Certification Part IV. Prior to serving in the quality arena, Dr. Opelka worked closely with CMS in the Ambulatory APG relative values, AMA's Relative Value Updates Committee, Practice Expense Committee, and an advisory to the CPT Editorial Committee. Dr. Opelka served 12 years on active duty in the US Army where he did his residency in General Surgery at the Walter Reed Army Medical Center and Eisenhower Army Medical Center. His colorectal surgery fellowship was at the Ochsner Clinic New Orleans where he served for 12 years as faculty and attending surgeon. His career then included time at the Beth Israel Deaconess Medical Center in Boston before returning to New Orleans just in time for Hurricane Katrina. Dr. Opelka is a board certified colon and rectal surgery. He is a fellow of the American College of Surgeons and the American Society of Colon and Rectal Surgeons.

AMERICAN HOSPITAL ASSOCIATION

Rhonda Anderson, RN, DNSc, FAAN

Rhonda Anderson, RN, DNSC, FAAN, is Chief Executive Officer of Cardon Children's Medical Center in Mesa, Arizona. She is a Fellow in the American Academy of Nursing and the American College of Healthcare Executives. She also serves on the Institute for Interactive Patient Care (GetWell Network) National Advisory Board, National Guideline Clearinghouse and National Quality Measures Clearinghouse Expert Panel, American Hospital Association Board of Trustees, American Hospital Association Health Research and Educational Trust Board, and a member of the National Association of Children's Hospitals and Related Institutions Quality Council. Rhonda received the Distinguished Achievement Award from Arizona State University College of Nursing and was a selected participant in The First International Institute: Executive Nurse Leadership in the United Kingdom and the United States-Florence Nightingale Trust in London, England. She attended the Wharton School of Business as a selected participant in The Johnson & Johnson Fellowship Program. In November 2005, Rhonda was awarded the Nursing Legends Nurse of the Year Award by the March of Dimes. Rhonda was awarded the American Organization of Nurse Executive's Lifetime Achievement Award in April of 2006, NurseWeek's Lifetime Achievement Award in September of 2006, and is a Phoenix Business Journal 2011 Women in Business Honoree.

AMERICAN MEDICAL ASSOCIATION

Carl A. Sirio, MD

Carl A. Sirio, MD, a board certified internist and critical care physician, was elected to the American Medical Association (AMA) Board of Trustees (BOT) in June 2010. Prior to his election, Dr. Sirio served in the AMA House of Delegates as a delegate from Pennsylvania. Dr. Sirio has a long history of service to the profession. He served eight years on the AMA Council on Medical Education, including serving as chair. He helped establish and chaired the AMA Initiative to Transform Medical Education since inception. In addition, he also represented the AMA to the Liaison Committee on Medical Education where he was in part responsible for the new standards related to building greater diversity in medicine and to understanding the impact the learning environment has on students as they prepare for careers

as physicians. Prior to this he served on the Internal Medicine Residency Review Committee, responsible for policy and accreditation of all graduate medical education programs in internal medicine. Dr. Sirio has broad interests that include the organization and delivery of health care services, medical education, patient safety, quality of care, patient risk assessment, evaluation of clinical performance, process improvement, and health care management and financing. Capitalizing on these interests he serves on the Executive Committee of the Physician Consortium for Performance Improvement, helping to drive the development of evidenced based measures for use by doctors in their efforts to improve care. Dr. Sirio is a co-founder of the Pittsburgh Regional Healthcare Initiative (PRHI), a nationally recognized multistakeholder collaborative designed to improve care over a large geographic area. With PRHI he facilitated the work of 40 competing institutions in an effort to improve care for all patients by reducing infections and improving medication safety. He was the recipient of several large grants from the Agency for Healthcare Research and Quality, equaling more than $6.5 million in total, for work designed to foster meaningful improvement in the care of patients. In addition, he has worked with the National Quality Forum, the National Institute of Medicine, The Joint Commission, and the U.S. Pharmacopoeia, among others, in his efforts related to patient care quality and safety. After spending 17 years at the University of Pittsburgh School Medicine where he was a professor, Dr. Sirio recently moved to the Pittsburgh campus of the Drexel University School Medicine. Completing his undergraduate and medical school training at Columbia University and Rutgers Medical School (now Robert Wood Johnson School of Medicine), Dr. Sirio received post graduate medical training at the Milton S. Hershey Medical Center - Pennsylvania State University, the National Institutes of Health and George Washington University. Dr. Sirio is married to Mary Beth Sirio, RN, MBA, and has four children—Alex, Nicholas, James and Alessandra ranging in age from infancy to 19 years.

AMERICAN MEDICAL GROUP ASSOCIATION

Sam Lin, MD, PhD, MBA

Samuel Lin received his MD and PhD from the Oregon Health Sciences University and is a member of the Alpha Omega Alpha Medical Honor Society. His other degrees include a BS (Seattle Pacific University), MS (Oregon State), MPA (Troy State University) and MBA (Johns Hopkins University). He began his professional career as a US Public Health Service (PHS) Commissioned Officer in the US Department of Health and Human Services (DHHS) and received exceptional capability promotions to the ranks of Captain and to Rear Admiral. From his first assignment as a General Medical Officer and Clinical Director in the US Indian Health Service (IHS), he next headed the IHS Physician Branch. Later, he headed the Office for Europe, DHHS Office of International Health and served as the US Executive Secretary for Joint US Health Commissions with the former USSR, Poland and former Yugoslavia. He was appointed DHHS Deputy Assistant Secretary for Health from 1981 to 1992. During this time, he also served as Acting Director of the National Center for Health Services Research (now Agency for Healthcare Research and Quality), as Acting Director of the Office of Minority Health and as Chair of the Special Committee to Investigate the FDA's Center for Veterinary Medicine. He also served on various policy committees of DHHS UnderSecretaries and FDA Commissioners and as an ex-officio member of a number of NIH Advisory Councils. From 1992 until 1994, he served as Acting DHHS Deputy Assistant Secretary for Minority Health and then as Senior Advisor to the DHHS Deputy Assistant Secretary for International Health focusing on Asian-Pacific Rim and US-Mexico Border health issues. While in Federal service, he co-founded several organizations (the Asian Pacific Islanders American Health Forum, the Association of Asian Pacific Community Health Organizations and the Asian Pacific Nurses Association). He has served, or currently serves, on Boards of VetsFirst, United Spinal Association, Daiichi Sankyo, Inc., Military Officers Association of America, National Capital Area Epilepsy Foundation, China Foundation, Inc.,

Hepatitis Foundation International, Rock-Asia Capital Group, Ltd., Omega Systems Group, Inc., National Military Family Association, as Commissioner and Vice Chair of the Maryland Health Services Cost Review Commission and as Commissioner and Chair of the Maryland Community Health Resources Commission. He serves as the American Medical Group Association's Alternate Delegate to the American Medical Association (AMA). He has been recognized with the Veterans of Foreign Wars' Commander-in-Chief Gold Medal of Merit, institution of the US Public Health Service Samuel Lin Award, Seattle Pacific University's 2008 Alumnus of Year, AMA Foundation's 2008 Excellence in Medicine Leadership Award, Oregon Health & Sciences University 2009 Alumni Award for Medical Leadership. After leaving Federal service, he joined the then-Upjohn Company as Executive Director for Federal Medical Affairs. He established new business relationships and marketing opportunities in diverse arenas including the healthcare of military beneficiaries. He subsequently established The Lin Group, LLC and then Humetrics, Inc., a service disabled, veteran owned small business, and serves as a proprietary consultant or project director for domestic and global healthcare ventures in areas such as health care management and administration, biomedical research and development, biomedical technology and transfer, pharmaceutical and device approvals, health information technology, health management and administration, health facility financing and construction, health systems-medical home and accountable care organizations, alternative and complementary medicine and applied technologies in counter-bioterrorism and homeland security.

AMERICAN NURSES ASSOCIATION

Marla J. Weston, PhD, RN

Marla J. Weston, PhD, RN, a nurse leader with nearly 30 years of diverse management experience in health care operations, is the chief executive officer (CEO) of the American Nurses Association (ANA), and the American Nurses Foundation (ANF). Dr. Weston currently is involved in multiple performance measurement and public reporting initiatives. She is ANA's representative to the National Priorities Partnership, Hospital Quality Alliance, and Nursing Alliance for Quality Care. Prior to assuming the leadership post at ANA, Dr. Weston developed and managed U.S. Department of Veterans Affairs initiatives to improve the quality of health care for veterans in all Veterans Healthcare Administration facilities nationwide, with a focus on improving the VA nursing workforce. She implemented strategies to improve the work environment, created policies and programs to attract and retain a highly qualified nursing workforce, and promoted nursing as a career choice. Dr. Weston served for four years as the Arizona Nurses Association's executive director, where she led efforts to advocate for nurses on the state and national level and promoted the Magnet Recognition concept, an indication of excellent quality of nursing in hospitals. As a principal in her own consulting firm, Dr. Weston has advised hospitals and educational institutions on quality improvements, as well as resource management, recruitment and retention, and regulatory compliance. Earlier in her career, Dr. Weston worked in a variety of hospital nursing roles for 18 years, including direct patient care in intensive care and medical-surgical units, nurse educator, clinical nurse specialist, director of patient care support and nurse executive. As a hospital administrator, Dr. Weston oversaw structural changes in services that resulted in improved patient satisfaction scores and quality measures. Dr. Weston graduated from Indiana University of Pennsylvania with a bachelor's of science degree in nursing. She graduated from Arizona State University, with a master's of science degree in nursing. She earned her doctoral degree at the University of Arizona. Her dissertation topic, "Antecedents to control over nursing practice," addressed ways to increase the decision-making role of the hospital nurse – in short, nurse influence and power.

CATALYST FOR PAYMENT REFORM

Suzanne F. Delbanco, PhD

Suzanne F. Delbanco is the executive director of Catalyst for Payment Reform (www.catalyzepaymentreform.org). Catalyst for Payment Reform (CPR) is an independent, non-profit organization working on behalf of large employers to catalyze improvements to how we pay for health care in the U.S. to signal powerful expectations for better and higher-value care. In addition to her duties at CPR, Suzanne is on the Advisory Committee to the Director of the Centers for Disease Control and Prevention (CDC). She just joined HFMA's Healthcare Leadership Council and serves on the boards of the Health Care Incentives Improvement Institute, the Anvita Health Advisory Council, the executive committee of the California Maternal Quality Care Collaborative, and participates in the Healthcare Executives Leadership Network. Prior to CPR, Suzanne was President, Health Care Division at Arrowsight, Inc., a company using video to help hospitals measure the performance of health care workers and provide them with feedback while they are working to improve adherence to safety and quality protocols. From 2000-2007, Suzanne was the founding CEO of The Leapfrog Group. The Leapfrog Group uses the collective leverage of its large corporate and public members to initiate breakthrough improvements in the safety, quality, and affordability of health care for Americans. Before joining Leapfrog, Suzanne was a senior manager at the Pacific Business Group on Health where she worked on the Quality Team. Prior to PBGH, Suzanne worked on reproductive health policy and the changing healthcare marketplace initiative at the Henry J. Kaiser Family Foundation. Suzanne holds a Ph.D. in Public Policy from the Goldman School of Public Policy and a M.P.H. from the School of Public Health at the University of California, Berkeley.

CONSUMERS UNION

Lisa McGiffert

Lisa McGiffert, directs Consumers Union's Safe Patient Project. Consumers Union is the advocacy arm of *Consumer Reports*. The campaign works on state and national levels to make information available to consumers about medical harm, focusing on healthcare-acquired infections, medical errors, physician safety and medical device safety. Beginning in 2003, the campaign initiated state laws to publish hospital infection rates and raise public awareness about the problem; today more than half of the states and Medicare require such reporting. The campaign's collaboration with individuals who have personal experiences with medical harm has developed into a national consumer network to make health care safer. McGiffert routinely lends the consumer voice on these issues at conferences, with the media and when serving on national and state-based patient safety advisory committees. From 1991-2003, McGiffert directed CU advocacy efforts on the full array of health issues in Texas. Prior to joining CU, Lisa was a policy analyst for the Texas Senate Committee on Health and Human Services where, for seven years, she was actively involved in the development and implementation of state policies. She has also worked as a juvenile probation/parole officer. McGiffert has a BA in psychology from Midwestern State University, Texas.

FEDERATION OF AMERICAN HOSPITALS

Charles N. Kahn III

Charles N. ("Chip") Kahn III is President and CEO of the Federation of American Hospitals (FAH), the national advocacy organization for investor-owned hospitals and health systems. Before coming to the FAH, he was President of the former Health Insurance Association of America and a professional staff person on Capitol Hill specializing in health policy issues. Mr. Kahn holds a Masters of Public Health

(M.P.H.) degree from Tulane University School of Public Health and Tropical Medicine, which in 2001 bestowed upon him its prestigious “Champion of Public Health” award. He received a Bachelor of Arts degree from The Johns Hopkins University.

LEADINGAGE (FORMERLY AAHSA)

Cheryl Phillips, MD, AGSF

Cheryl Phillips, M.D. is Senior VP of Advocacy at LeadingAge (formerly the American Association of Homes and Services for the Aging). Prior to joining LeadingAge, she was Chief Medical Officer of On Lok Lifeways, the parent to the PACE (Program of All-inclusive Care for the Elderly) model that serves nursing home eligible seniors in the greater San Francisco bay area. Dr. Phillips is the past president of the American Geriatrics Society, the national organization for geriatric health care professionals, and the past president of the American Medical Directors Association, an organization for physicians in long-term care. Dr. Phillips has served on multiple national boards and advisory groups for chronic care including the CMS Technical Expert Panel on Quality Indicators in Long-Term Care, the NCQA Geriatric Measurement Advisory Panel, and the CMS Technical Advisory Panel for Independence at Home Demonstration. She has twice provided testimony to the U.S. Senate Special Committee on Aging. In 2005, she was appointed by Governor Schwarzenegger as a governor’s delegate to the White House Conference on Aging, and is a Governor’s appointee to the California Commission on Aging and the California Olmstead Committee. In 2002, she served as one of 30 fellows for the Primary Health Care Policy Fellowship under Secretary Tommy Thompson, Department of Health and Human Services. Dr. Phillips completed her family practice residency and geriatric fellowship at the University of California, Davis.

MAINE HEALTH MANAGEMENT COALITION

Elizabeth Mitchell

Elizabeth Mitchell serves as CEO of the Maine Health Management Coalition, an employer-led, multi-stakeholder coalition whose mission is to improve the value of healthcare services. The Coalition is actively engaged in payment reform and health system redesign with its many partners. Elizabeth serves on the Board of the National Business Coalition on Health and as Co-Chair of its Government Affairs Committee and on the Board of the Network for Regional Health Improvement. Elizabeth also serves as chair of Maine’s Chartered Value Exchange, a convener of Maine’s Aligning Forces for Quality project, and on the Advisory Council of the Maine Quality Forum. Prior to being appointed CEO, Elizabeth worked for MaineHealth, Maine’s largest integrated health system. She served in the Maine State Legislature, where she chaired the Health and Human Services Committee and has held posts at the National Academy for State Health Policy, and London’s Nuffield Trust. Elizabeth was selected for an Atlantic Fellowship in Public Policy by the Commonwealth Fund and the British Council. While in the UK, she completed the International Health Leadership Program at Cambridge University’s Judge School of Management, while pursuing graduate studies at the London School of Economics.

NATIONAL ASSOCIATION OF MEDICAID DIRECTORS

Foster Gesten, MD

Foster Gesten is the Medical Director for the Office of Health Insurance Programs in the New York State Department of Health. Dr. Gesten provides clinical direction and leadership for a team of professionals engaged in quality oversight, performance measurement and clinical improvement within health plans and public insurance programs in New York. Major initiatives include the development of statewide public reporting systems for commercial, Medicaid, and Child Health managed care programs on quality,

access, and satisfaction, medical home demonstrations, and provider based quality measurement and improvement. His interests include population health, health service research, and quality improvement projects directed at prevention services and chronic care. Dr. Gesten is a member of the National CAHPS Benchmarking Database (NCBD) Advisory Group, the Committee on Performance Measurement (CPM) at the National Committee for Quality Assurance (NCQA), and an Expert Panel Member for the Agency for Healthcare Quality (AHRQ) Health Care Innovations Exchange. Dr. Gesten was trained in general internal medicine at Brown University.

NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES

Christine A. Bechtel, MA

Christine Bechtel is the Vice President of the National Partnership for Women & Families, a non-profit consumer advocacy organization based in Washington DC. The National Partnership has been the driving force behind some of the country's most important policies and initiatives, including the Family and Medical Leave Act, the Pregnancy Discrimination Act, and the Consumer Partnership for eHealth. As Vice President, Bechtel oversees the day to day operations of the organization, including its work on health care quality, information technology and patient engagement. She also serves on the federal Health IT Policy Committee. Bechtel was previously Vice President of the eHealth Initiative (eHI), where she led the organization's membership, public policy and government relations work. She has a background in health care quality improvement from her work with the American Health Quality Association and Louisiana Health Care Review, now eQHealth Solutions, a Medicare Quality Improvement Organization (QIO). As a Senior Research Advisor at AARP, Bechtel conducted public opinion studies with consumers regarding their views on national political issues. She began her career as a Legislative Associate for United States Senator Barbara A. Mikulski (D-MD), where she focused on legislative issues ranging from women's health and stem cell research to Medicare and Social Security.

PACIFIC BUSINESS GROUP ON HEALTH

William E. Kramer, MBA

Bill Kramer is Executive Director of National Policy for the Pacific Business Group on Health. In this role he leads the organization's policy work at the federal and state level helping to ensure health care reform is implemented in ways that improve health care quality and reduce costs. Kramer also serves as Project Director for the Consumer-Purchaser Disclosure Project, a collaborative led by PBGH and the National Partnership for Women & Families to bring purchasers and consumers together to improve the quality and affordability of health care. Bill has a long and distinguished career in health care. Most recently, he led his own consulting practice where he was actively involved in health reform in Oregon. There he provided policy analysis and guidance to the Oregon Business Council and strategic and technical assistance to the state government. At the national level, Kramer worked with a group of organizations, including the Small Business Majority, on the design and implementation of health insurance exchanges. Prior to developing his consulting practice, Bill was a senior executive with Kaiser Permanente for over 20 years--most recently as Chief Financial Officer for Kaiser Permanente's Northwest Region. Bill also served as general manager for Kaiser Permanente's operations in Connecticut; earlier in his career, he managed marketing, human resources, and medical economics functions. Prior to his career at Kaiser, he was Chief of Budget and Program Analysis Services for the Washington State Department of Social and Health Services. Bill has an MBA from Stanford Graduate School of Business and a BA from Harvard.

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)

CHILD HEALTH

Richard C. Antonelli, MD, MS

Rich is the Medical Director of Integrated Care and of Strategic Partnerships for Children's Hospital Boston. He is on the faculty of Harvard Medical School in the Department of Pediatrics. Between 1987 and 2005, he was in full time, community-based general pediatrics, founding Nashaway Pediatrics in Sterling, MA. Since 1987, his clinical work has focused on providing comprehensive, family-centered care for all children, youth, and young adults, but especially for those with special health care needs. He is a member of the Project Advisory Committee of the National Center for Medical Home Implementation at the American Academy of Pediatrics. He has published data about the outcome efficacy and cost of care coordination services for children and youth with special health care needs and their families in primary care settings. Rich has also published work defining mechanisms for integration and coordination of care across systems including the development of strategies and interventions to improve collaborative efforts between families, primary care providers, and subspecialists. He has served on the Steering Committee for Care Coordination at the National Quality Forum and as an advisor to the Patient-Centered Medical Home measurement tool work group at the National Committee for Quality Assurance (NCQA). In conjunction with researchers and policy representatives from internal medicine and family medicine, he represented the Academic Pediatrics Association in the national initiative *Establishing a Policy Relevant Research Agenda for the Patient-Centered Medical Home: A Multi-Disciplinary Approach.* He co-authored *Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework*, supported by The Commonwealth Fund. Most recently, he was appointed to the Measure Applications Partnership at the National Quality Forum. He has provided consultation on care coordination and integration methodologies and measures to multiple states, to US federal agencies, and to some international stakeholders. Since care coordination is so central to the effective transformation of the American health care system, Antonelli's work has been used for both adult and pediatric health care delivery systems. He has general pediatrics clinical responsibilities in the Primary Care Clinic setting at Children's Hospital Boston where he teaches residents, students, and fellows. In fact, he still is the primary care provider for several patients who have been with him since he first completed his residency!

POPULATION HEALTH

Bobbie Berkowitz, PhD, RN, CNAA, FAAN

Bobbie Berkowitz is currently the Dean and Mary O'Neil Mundinger Professor of Nursing at Columbia University School of Nursing and Senior Vice President of the Columbia University Medical Center. She was previously the Alumni Endowed Professor of Nursing and Chair of the Department of Psychosocial and Community Health at the University Of Washington School Of Nursing and Adjunct Professor in the School of Public Health and Community Medicine. In addition, she served as a Consulting Professor with Duke University and the University of California at Davis. Dr. Berkowitz directed the NIH/NINR funded Center for the Advancement of Health Disparities Research and the National Program Office for the RWJF funded Turning Point Initiative. She joined the faculty at the University of Washington after having served as Deputy Secretary for the Washington State Department of Health and Chief of Nursing Services for the Seattle-King County Department of Public Health. Dr. Berkowitz has been a member of the Washington State Board of Health, the Washington Health Care Commission, the board of the American Academy of Nursing, and chaired the Board of Trustees of Group Health Cooperative. She

serves on a number of editorial boards, including the *Journal of Public Health Management and Practice, American Journal of Public Health, Policy, Politics, and Nursing Practice*, and as Associate Editor of *Nursing Outlook*. Dr. Berkowitz is an elected Fellow in the American Academy of Nursing and elected member of the Institute of Medicine. She holds a Ph.D. in Nursing Science from Case Western Reserve University and Master of Nursing and Bachelor of Science in Nursing from the University of Washington. Her areas of expertise and research include public health systems and health equity.

DISPARITIES

Joseph R. Betancourt, MD, MPH

Dr. Betancourt directs the Disparities Solutions Center, which works with healthcare organizations to improve quality of care, address racial and ethnic disparities, and achieve equity. He is Director of Multicultural Education for Massachusetts General Hospital (MGH), and an expert in cross-cultural care and communication. Dr. Betancourt served on several Institute of Medicine committees, including those that produced *Unequal Treatment: Confronting Racial/Ethnic Disparities in Health Care* and *Guidance for a National Health Care Disparities Report*. He has also advised federal, state and local government, foundations, health plans, hospitals, health centers, professional societies, trade organizations, pharma, and private industry on strategies to improve quality of care and eliminate disparities. He has received grants from foundations and the federal government, and published extensively in these areas. He is a practicing internist, co-chairs the MGH Committee on Racial and Ethnic Disparities, and sits on the Boston Board of Health as well as Health Equity Committee, and the Massachusetts Disparities Council.

RURAL HEALTH

Ira Moscovice, PhD

Dr. Moscovice is the Mayo Professor and Head of the Division of Health Policy and Management at the University of Minnesota School of Public Health. He is director of the Upper Midwest Rural Health Research Center funded by the Federal Office of Rural Health Policy (ORHP). He has written extensively on issues related to rural health care and use of health services research to improve health policy decision making in state government. Dr. Moscovice is one of the leading rural health services researchers in the nation and was the first recipient of the National Rural Health Association's Distinguished Researcher Award in 1992. In 2002, he received a Robert Wood Johnson Foundation Investigator Award in Health Policy Research and in 2004 he served as a member of the Future of Rural Health Care Panel of the Institute of Medicine, National Academies. Dr. Moscovice has served as the principal investigator for numerous rural health studies funded by, among others, ORHP, the Centers for Medicare and Medicaid Studies, AHRQ, the Robert Wood Johnson Foundation, and the U.S. Department of Veterans Affairs. His current research interests include the quality of rural health care, the evaluation of alternative rural health care delivery systems, hospice and end-of-life care for rural Medicare beneficiaries, technology diffusion in rural areas, and the implementation and the assessment of rural health networks.

MENTAL HEALTH

Harold A. Pincus, MD

Harold Alan Pincus, M.D. is Professor and Vice Chair of the Department of Psychiatry at Columbia University's College of Physicians and Surgeons, Director of Quality and Outcomes Research at New York Presbyterian Hospital and Co-Director of Columbia's Irving Institute for Clinical and Translational Research. Dr. Pincus also serves as a Senior Scientist at the RAND Corporation. Previously he was Director of the RAND-University of Pittsburgh Health Institute and Executive Vice Chairman of the

Department of Psychiatry at the University of Pittsburgh. He is the National Director of the Health and Aging Policy Fellows Program (funded by Atlantic Philanthropies), and directed the Robert Wood Johnson Foundation's National Program on Depression in Primary Care and the John A. Hartford Foundation's national program on Building Interdisciplinary Geriatric Research Centers. Dr. Pincus was also the Deputy Medical Director of the American Psychiatric Association and the founding director of APA's Office of Research and Special Assistant to the Director of the NIMH and also served on White House and Congressional staffs. Dr. Pincus was Vice Chair of the Task Force on Diagnostic and Statistical Manual, Fourth Edition (DSM IV) and has been appointed to the editorial boards of ten major scientific journals. He has edited or co-authored 23 books and over 300 scientific publications on health services research, science policy, research career development and the diagnosis and treatment of mental disorders. Among other projects, he is currently leading the national evaluation of mental health services for veterans and the redesign of primary care/ behavioral health relationships in New Orleans. He has also been a consultant to federal agencies and private organizations, including the U.S. Secret Service, Institute of Medicine, John T. and Catherine D. MacArthur Foundation and served on multiple national and international committees. He is a member of the Scientific Council of the National Alliance for the Mentally Ill and chairs the NIH/NCRR Evaluation Key Function Committee for Clinical and Translational Science Awards and the WHO/ICD 11 Technical Advisory Group on Quality and Patient Safety. For over 22 years he worked one night a week treating the severely mentally ill at a community clinic.

POST-ACUTE CARE/ HOME HEALTH/ HOSPICE

Carol Raphael, MPA

Carol Raphael served as the President and Chief Executive Officer of the Visiting Nurse Service of New York (VNSNY), the largest nonprofit home health care organization in the United States from 1989 to 2011. Ms. Raphael expanded the organization's services and launched innovative models of care for complex populations with chronic illness. Prior to joining VNSNY, Ms. Raphael held executive positions at Mt. Sinai Medical Center and in New York City government. Currently, Ms. Raphael is a Visiting Fellow at Harvard University. She chairs the New York eHealth Collaborative, a public-private partnership working to advance the adoption of health information technology. She is the Chair of the Long-Term Quality Alliance, Chair of the National Quality Forum MAP Workgroup on Post Acute and Long Term Care, a strategic adviser to NCQA and was a member of New York State Governor Cuomo's Medicaid Redesign Team. Ms. Raphael is a nationally recognized expert on health care policy and in particular, high-risk, complex populations with chronic illnesses and long term services and supports. She served on numerous commissions including the Medicare Payment Advisory Commission, the New York State Hospital Review and Planning Council and several Institute of Medicine committees. She has served on a number of boards including the Lifetime Blue Cross/Blue Shield Board and the American Foundation for the Blind. She is currently Vice-Chair of the AARP Board and serves on the boards of the Primary Care Development Corporation, Pace University, the Medicare Rights Center and the New York City Citizens Budget Commission. She is a member of several advisory boards including the Harvard School of Public Health's Health Policy Management Executive Council, the New York City Health and Mental Hygiene Advisory Council, The New York City Age-Friendly Commission and the New York University School of Nursing Advisory Board. She co-edited the book *Home Based Care for a New Century.* She was a Visiting Fellow at the Kings Fund in the United Kingdom, and was listed in *Crain's New York Business 50 Most Powerful Women in New York City.*

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

Nancy J. Wilson, MD, MPH

Nancy J. Wilson, MD, MPH is Senior Advisor to the Director of the Agency for Healthcare Research and Quality and leads the Agency's work to develop and implement a national strategy for quality improvement that improves the healthcare delivery system, patient health outcomes, and population health. She also supports the newly established federal-wide Working Group to address healthcare quality. She provides strategic leadership and technical assistance on improvement implementation and data sharing among state Medicaid Medical Directors and is currently working with CMS to identify a core set of quality measures for Medicaid eligible adults. Dr. Wilson has a bachelor's degree in nursing from the University of Pittsburgh, a medical degree from Johns Hopkins, and a master's degree in public health/health care management from the Harvard School of Public Health where she completed a health services research fellowship.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

Gail Janes, PhD, MS

Gail Janes is a Sr. Health Scientist in health policy, with the Office of Prevention Through Healthcare (OPTH) in the Centers for Disease Control and Prevention (CDC), in Atlanta, GA. Her area of concentration is health data policy, and evidence based processes, as they relate to public health practice and policy. Since joining CDC in 1992, she has held various positions including Senior Scientist with the CDC Guide to Community Preventive Services, and Lead Scientist for Guideline Development with the Division of HIV Prevention, where she developed a protocol for applying evidence-based methodologies to the development of programmatic guidelines. She has recently worked closely with the Center for Medicare and Medicaid Services, on the application of value-based purchasing and public reporting to efforts to reduce hospital-associated infections, using CDC's National Healthcare Safety Network. She has also worked on comparative effectiveness methodologies with AHRQ's Center for Outcome Effectiveness, and served as a CDC liaison to the U.S. Preventive Services Task Force. Dr. Janes received her undergraduate degree from the University of Maryland and her doctoral degree in cell biology from Georgetown University. She also received a MS in biostatistics from the University of Illinois. Prior to joining CDC, she served as Senior Statistician with the Department of Veterans Affairs Multicenter Clinical Trial Program, and as Head of the Rotterdam Regional Cancer Registry, in the Netherlands.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

Patrick Conway, MD, MSc

Patrick Conway, MD, MSc, is Chief Medical Officer for the Centers for Medicare & Medicaid Services (CMS) and Director of the Office of Clinical Standards and Quality. This office is responsible for all quality measures for CMS, quality improvement programs in all 50 states, clinical standards, and all coverage decisions for treatments and services for CMS. The office budget exceeds $1.3 billion. Previously, he was Director of Hospital Medicine and an Associate Professor at Cincinnati Children's Hospital. He was also AVP Outcomes Performance, responsible for leading measurement, including the electronic health record measures, and facilitating improvement of health outcomes across the $1.5 billion health care system, including all Divisions and Institutes. Previously, he was Chief Medical Officer at the Department of Health and Human Services (HHS) in the Office of the Assistant Secretary for Planning and Evaluation.

In 2007-08, he was a White House Fellow assigned to the Office of Secretary in HHS and the Director of the Agency for Healthcare Research and Quality. As Chief Medical Officer, he had a portfolio of work focused primarily on quality measurement and links to payment, health information technology, and policy, research, and evaluation across the entire Department. He also served as Executive Director of the Federal Coordinating Council on Comparative Effectiveness Research coordinating the investment of the $1.1 billion for CER in the Recovery Act. He was a Robert Wood Johnson Clinical Scholar and completed a Master's of Science focused on health services research and clinical epidemiology at the University of Pennsylvania and Children's Hospital of Philadelphia. Previously, he was a management consultant at McKinsey & Company, serving senior management of mainly health care clients on strategy projects. He has published articles in journals such as JAMA, New England Journal of Medicine, Health Affairs, and Pediatrics and given national presentations on topics including health care policy, quality of care, comparative effectiveness, hospitalist systems, and nurse staffing. He is a practicing pediatric hospitalist, completed pediatrics residency at Harvard Medical School's Children's Hospital Boston, and graduated with High Honors from Baylor College of Medicine. He is married with two children.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Ahmed Calvo, MD, MPH

Ahmed Calvo, MD, MPH, is Chief Medical Officer and Senior Advisor, Office of Health IT and Quality, Health Resources and Services Administration, US Department of Health and Human Services, Washington DC. HRSA supports over 8000 federally qualified health center (FQHC) sites throughout the nation, which have a long history of collaborating together via the HRSA funded Health Disparities Collaboratives (HDC). The HDC were led by Dr. Calvo as Chief of the Clinical Quality Improvement Branch, in the Bureau of Primary Health Care. Prior to joining HRSA, Dr. Calvo was Director of Medical Education and Medical Director at Scripps Memorial Hospital in Chula Vista; Chief Medical Officer of the San Ysidro Health Center, an FQHC network on the U.S./Mexico border; and on the clinical faculty in the Department of Family and Preventive Medicine at the University of California–San Diego (UCSD) School of Medicine. Dr. Calvo's primary responsibilities at HRSA have been accelerating and disseminating key lessons learned from the multiple quality improvement (QI) Breakthrough Collaboratives. The HRSA agency-wide quality systems strategy work has helped the HHS National Quality Strategy and ongoing work with the HHS Measurement Policy Council. As a Federal liaison representing HRSA, Dr. Calvo is a member of the National Quality Forum (NQF) Measures Application Partnership (MAP). Dr. Calvo's research is focused on evidence-based methods of dissemination science & translational science, applied to clinical and operational QI at a local, regional, and national level. Last year he was asked by HRSA and the NIH to function as Senior Guest Editor for a peer-reviewed issue of the Journal of Health Care for the Poor and Underserved. The special themed issue, titled: "Evidence for Informing the Next Generation of Quality Improvement Initiatives: Models, Methods, Measures, and Outcomes," is due out August 2012. Dr. Calvo currently collaborates in various federal-government dialogues on QI methods, for example, via consultation for the Department of Defense (DoD) and the Veterans Health Administration (VHA) via the Futures Based Agile Thinking (FBAT) initiative with Offices of the Surgeons General of the Air Force, Army, Navy and US Public Health Service (USPHS). This activity was a direct result of interest generated by Dr. Calvo's 2008 paper with Leah Rainsford Calvo and Clement Bezold titled: "Comprehensive Health Homes: Implications of convergence of the chronic care model, planned care model and patient centered medical home model." A graduate from Stanford University and the University of California–San Francisco School of Medicine, Dr. Calvo completed several UCSD/San Diego State University Faculty Development Fellowships on care of underserved communities; a Master's of

Public Health on Public Health Management; and multiple advanced practice fellowships, including the HRSA-funded National Leadership Fellowship at NYU's Wagner School of Public Service, with the National Hispanic Medical Association. He also was Executive Vice-President for Medical Affairs and Principal over the years in a variety of national and international consulting firms; and CEO of multiple medical groups. Dr. Calvo directs an HHS National Health Policy Fellowship in collaboration with the Haas Center for Public Service at Stanford University.

OFFICE OF PERSONNEL MANAGEMENT/FEHBP (OPM)

John O'Brien

John O'Brien is the Director of Health Care and Insurance at the Office of Personnel Management. In this position he oversees the insurance programs for federal employees including the Federal Employees Health Benefit (FEHB) program, which provides health insurance to over 8 million federal employees, retirees, and their dependents. In addition, he leads the team implementing OPM's responsibilities under the Affordable Care Act (ACA) including the development of multi-state plans for state exchanges. From 2007 to 2009 he helped oversee the State of Maryland's unique all-payer hospital rate setting system as the Deputy Director for Research and Methodology at the Maryland Health Services Cost Review Commission (HSCRC). From 1997 to 2007 he was the Director of Acute Care Policy at the University of Maryland, Baltimore County (UMBC) Hilltop Institute where his work focused on the management and oversight of Medicaid managed care plans. Mr. O'Brien was a 2005 recipient of an Ian Axford Fellowship in Public Policy under which he studied health system performance measurement in New Zealand. He has a Master Degree in Public Administration from Syracuse University.

OFFICE OF THE NATIONAL COORDINATOR FOR HIT (ONC)

Kevin Larsen, MD

Kevin L. Larsen, MD is Medical Director of Meaningful Use at the Office of the National Coordinator for Health IT. In that role he is responsible for coordinating the clinical quality measures for Meaningful Use Certification and overseas the development of the Population Health Tool http://projectpophealth.org. Prior to working for the federal government he was Chief Medical Informatics Officer and Associate Medical Director at Hennepin County Medical Center in Minneapolis, Minnesota. He is also an Associate Professor of Medicine at the University of Minnesota. Dr. Larsen graduated from the University of Minnesota Medical School and was a resident and chief medical resident at Hennepin County Medical Center. He is a general internist and teacher in the medical school and residency programs. His research includes health care financing for people living in poverty, computer systems to support clinical decision making, and health literacy. In Minneapolis he was also the Medical Director for the Center for Urban Health, a hospital, community collaboration to eliminate health disparities. He served on a number of state and national committees in informatics, data standards and health IT.

ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING)

AMERICAN BOARD OF MEDICAL SPECIALTIES

Christine Cassel, MD

Dr. Cassel, a leading expert in geriatric medicine, medical ethics and quality of care, is President and CEO of the American Board of Internal Medicine and the ABIM Foundation. She is board certified in internal medicine and geriatric medicine. Dr. Cassel is past President of the American Federation for Aging Research and the American College of Physicians. She also formerly served as Dean of the School of Medicine and Vice President for Medical Affairs at Oregon Health and Science University, Chair of the Department of Geriatrics and Adult Development at Mount Sinai School of Medicine and Chief of General Internal Medicine at the University of Chicago. Dr. Cassel is one of 20 scientists chosen by United States President Barack Obama to serve on the President's Council of Advisors on Science and Technology (PCAST) and is co-Chair and physician leader of a PCAST report to the President on future directions of health information technology. A member of the Institute of Medicine (IOM) since 1992, she served on the IOM's Comparative Effective Research (CER) Committee and the IOM committees that wrote the influential reports "To Err is Human" and "Crossing the Quality Chasm." She chaired major IOM reports on public heath (2002) and on palliative care (1997). In 2009 and 2010, Modern Healthcare named Dr. Cassel among the 50 most powerful physicians and ranked among the top 100 most powerful people in health care. An active scholar and lecturer, she is the author or co-author of 14 books and more than 200 journal articles on geriatric medicine, aging, bioethics and health policy. A graduate of the University of Chicago, Dr. Cassel received her medical degree from the University of Massachusetts Medical School. She is the recipient of numerous honorary degrees and awards of distinction, including honorary Fellowship in the Royal College of Medicine of England and the Royal College of Physicians and Surgeons of Canada, and Mastership in the American College of Physicians.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Margaret E. O'Kane, MHS

Since 1990, Margaret E. O'Kane has served as President of the National Committee for Quality Assurance (NCQA), an independent, non-profit organization whose mission is to improve the quality of health care everywhere. Under her leadership, NCQA has developed broad support among the consumer, employer and health plan communities. About three-quarters of the nation's largest employers evaluate plans that serve their employees using Healthcare Effectiveness Data and Information Set (HEDIS®) data. In recent years, NCQA has received awards from the National Coalition for Cancer Survivorship, the American Diabetes Association and the American Pharmacists' Association. In addition to her leadership of NCQA, Ms. O'Kane plays a key role in many efforts to improve health care quality. Recently, she was awarded the 2009 Picker Institute Individual Award for Excellence in the Advancement of Patient-Centered Care for her leadership of NCQA and lifetime achievement in improving patient-centered health care. In 1999, Ms. O'Kane was elected as a member of the Institute of Medicine. She also serves as co-chair of the National Priorities Partnership, a broad-based group of high-impact stakeholder organizations, working together to bring transformative improvement to our health care system. Ms. O'Kane began her career in health care as a respiratory therapist and went on to earn a master's degree in health administration and planning from the Johns Hopkins University.

THE JOINT COMMISSION

Mark R. Chassin, MD, FACP, MPP, MPH

Mark R. Chassin, M.D., FACP, M.P.P., M.P.H., is president of The Joint Commission. In this role, he oversees the activities of the nation's leading accrediting body in health care. Joint Commission accreditation and certification is recognized worldwide as a symbol of quality that reflects an organization's commitment to quality improvement and to meeting state-of-the-art performance standards. Dr. Chassin is also president of the Joint Commission Center for Transforming Healthcare. Established in 2009 under Dr. Chassin's leadership, the Center works with the nation's leading hospitals and health systems to address health care's most critical safety and quality problems such as health care-associated infection (HAI), hand-off communications, wrong site surgery, surgical site infections, and preventing avoidable heart failure hospitalizations. The Center is developing solutions through the application of the same Robust Process Improvement™ (RPI) methods and tools that other industries rely on to improve quality, safety and efficiency. In keeping with its objective to transform health care into a high reliability industry, The Joint Commission shares these proven effective solutions with the more than 19,000 health care organizations it accredits and certifies. Previously, Dr. Chassin was the Guggenheim Professor of Health Policy; founding Chairman of the Department of Health Policy at the Mount Sinai School of Medicine, New York; and Executive Vice President for Excellence in Patient Care at The Mount Sinai Medical Center. Dr. Chassin also served as Commissioner of the New York State Department of Health. He is a board-certified internist and practiced emergency medicine for 12 years, and is a member of the Institute of Medicine of the National Academy of Sciences. Dr. Chassin received his undergraduate and medical degrees from Harvard University. He holds a master's degree in public policy from Kennedy School of Government at Harvard, and a master's degree in public health from UCLA.

NATIONAL QUALITY FORUM STAFF

Thomas B. Valuck, MD, JD, MHSA

Senior Vice President

Thomas B. Valuck, MD, JD, is senior vice president, Strategic Partnerships, at the National Quality Forum (NQF), a nonprofit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Dr. Valuck oversees NQF-convened partnerships—the Measure Applications Partnership (MAP) and the National Priorities Partnership (NPP)—as well as NQF's engagement with states and regional community alliances. These NQF initiatives aim to improve health and healthcare through public reporting, payment incentives, accreditation and certification, workforce development, and systems improvement. Dr. Valuck comes to NQF from the Centers for Medicare & Medicaid Services (CMS), where he advised senior agency and Department of Health and Human Services leadership regarding Medicare payment and quality of care, particularly value-based purchasing. While at CMS, Dr. Valuck was recognized for his leadership in advancing Medicare's pay-for-performance initiatives, receiving both the 2009 Administrator's Citation and the 2007 Administrator's Achievement Awards. Before joining CMS, Dr. Valuck was the vice president of medical affairs at the University of Kansas Medical Center, where he managed quality improvement, utilization review, risk management, and physician relations. Before that he served on the Senate Health, Education, Labor, and Pensions Committee as a Robert Wood Johnson Health Policy Fellow; the White House Council of Economic Advisers, where he researched and analyzed public and private healthcare financing issues;

and at the law firm of Latham & Watkins as an associate, where he practiced regulatory health law. Dr. Valuck has degrees in biological science and medicine from the University of Missouri-Kansas City, a master's degree in health services administration from the University of Kansas, and a law degree from the Georgetown University Law School.

Allison Ludwig, RN, MPH, MHA

Project Manager

Allison Ludwig is a Project Manager, Strategic Partnerships, at the National Quality Forum, a nonprofit membership organization with the mission to build consensus on national priorities and goals for performance improvement and endorse national consensus standards for measuring and publicly reporting on performance. Ms. Ludwig supports the work of the NQF-convened Measures Application Partnership Coordinating Committee. Prior to joining NQF, Ms. Ludwig spent two years as an Administrative Fellow at the University of Pittsburgh Medical Center where she worked in various capacities, primarily working to support quality initiatives and further build quality infrastructure at the UPMC Cancer Centers. Before joining UPMC, Ms. Ludwig began her career as a surgical oncology staff nurse at the University of Minnesota Medical Center - Fairview in Minneapolis, MN. Ms. Ludwig received her Bachelor of Science in Nursing from the University of Wisconsin, a Master of Public Health - Health Policy and Master of Health Administration from the University of Iowa.

Amaru J. Sanchez, MPH

Project Analyst

Amaru J. Sanchez, MPH, is a Project Analyst at the National Quality Forum (NQF), a private, nonprofit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Mr. Sanchez is currently supporting the work of the NQF Measure Applications Partnership, established to provide multi-stakeholder input to the Department of Health and Human Services on the selection of performance measures for public reporting and payment reform programs. Prior to joining NQF, Mr. Sanchez served as a Health Policy Research Analyst for the bicameral Public Health Committee at the Massachusetts Legislature. At the legislature, Mr. Sanchez influenced the passage of several novel public health and healthcare related laws as well as drafted legislative proposals relative to medical debt, chronic disease management, health disparities and health care transparency. Mr. Sanchez is a graduate of the Boston University School of Public Health (MPH, Social Behavioral Sciences/Health Policy and Management) and the University of Florida (BS, Integrative Biology).

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	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	TBD
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	Lisa McGiffert
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)	Gail Janes, PhD, MS
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Health Resources and Services Administration (HRSA)	Ahmed Calvo, MD, MPH
Office of Personnel Management/FEHBP (OPM)	John O'Brien
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD

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

ROSTER FOR THE MAP CLINICIAN WORKGROUP

CHAIR (VOTING)
Mark McClellan, MD, PhD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
American Academy of Family Physicians	Bruce Bagley, MD
American Academy of Nurse Practitioners	Mary Jo Goolsby, EdD, MSN, NP-C, CAE, FAANP
American College of Cardiology	Paul Casale, MD, FACC
American College of Emergency Physicians	Bruce Auerbach, MD
American College of Radiology	David Seidenwurm, MD
American Speech-Language-Hearing Association	Janet Brown, MA, CCC-SLP
Association of American Medical Colleges	Joanne Conroy, MD
Center for Patient Partnerships	Rachel Grob, PhD
CIGNA	Richard Salmon, MD, PhD
Consumers' CHECKBOOK	Robert Krughoff, JD
Kaiser Permanente	Amy Compton-Phillips, MD
Minnesota Community Measurement	Beth Averbeck, MD
Pacific Business Group on Health	David Hopkins, PhD
Physician Consortium for Performance Improvement	Mark Metersky, MD
The Alliance	Cheryl DeMars

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Disparities	Marshall Chin, MD, MPH, FACP
Population Health	Eugene Nelson, MPH, DSc
Shared Decision Making	Karen Sepucha, PhD
Team-Based Care	Ronald Stock, MD, MA
Health IT/ Patient Reported Outcome Measures	James Walker, MD, FACP
Measure Methodologist	Dolores Yanagihara, MPH

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Darryl Gray, MD, ScD
Centers for Disease Control and Prevention (CDC)	Peter Briss, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Kate Goodrich, MD
Health Resources and Services Administration (HRSA)	Ian Corbridge, MPH, RN
Office of the National Coordinator for HIT (ONC)	Jesse James, MD, MBA
Veterans Health Administration (VHA)	Joseph Francis, MD, MPH

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

ROSTER FOR THE MAP DUAL ELIGIBLE BENEFICIARIES WORKGROUP

CHAIR (VOTING)
Alice Lind, MPH, BSN

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	David Polakoff, MD, MsC
Center for Medicare Advocacy	Alfred J. Chiplin, JD, M.Div.
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	George Andrews, MD, MBA, CPE
L.A. Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Health Law Program	Leonardo Cuello, JD
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Substance Abuse	Mady Chalk, MSW, PhD
Disability	Anne Cohen, MPH
Emergency Medical Services	James Dunford, MD
Measure Methodologist	Juliana Preston, MPA
Home & Community Based Services	Susan Reinhard, RN, PhD, FAAN
Mental Health	Rhonda Robinson-Beale, MD
Nursing	Gail Stuart, PhD, RN

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Administration for Community Living	Henry Claypool
Substance Abuse and Mental Health Services Administration	Frances Cotter, MA, MPH
Veterans Health Administration	Daniel Kivlahan, PhD

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

ROSTER FOR THE MAP HOSPITAL WORKGROUP

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

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
Alliance of Dedicated Cancer Centers	Ronald Walters, MD, MBA, MHA, MS
American Hospital Association	Richard Umbdenstock
American Organization of Nurse Executives	Patricia Conway-Morana, RN
American Society of Health-System Pharmacists	Shekhar Mehta, PharmD, MS
Blue Cross Blue Shield of Massachusetts	Jane Franke, RN, MHA, CPHQ
Building Services 32BJ Health Fund	Barbara Caress
Connecticut Children's Medical Center	Andrea Benin, MD
Iowa Healthcare Collaborative	Lance Roberts, PhD
Memphis Business Group on Health	Cristie Upshaw Travis, MSHA
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)
Health IT	Dana Alexander, RN, MSN, MBA
Patient Safety	Mitchell Levy, MD, FCCM, FCCP
Palliative Care	R. Sean Morrison, MD
State Policy	Dolores Mitchell
Patient Experience	Dale Shaller, MPA
Safety Net	Bruce Siegel, MD, MPH
Mental Health	Ann Marie Sullivan, MD

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Pamela Owens, PhD
Centers for Disease Control and Prevention (CDC)	Gail Janes, PhD, MS
Centers for Medicare & Medicaid Services (CMS)	Shaheen Halim, PhD, CPC-A
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD
Veterans Health Administration (VHA)	Michael Kelley, MD

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

ROSTER FOR THE MAP POST-ACUTE CARE/LONG-TERM CARE WORKGROUP

CHAIR (VOTING)
Carol Raphael, MPA

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
Aetna	Randall Krakauer, MD
American Medical Rehabilitation Providers Association	Suzanne Snyder, PT
American Physical Therapy Association	Roger Herr, PT, MPA, COS-C
Family Caregiver Alliance	Kathleen Kelly, MPA
HealthInsight	Juliana Preston, MPA
Kindred Healthcare	Sean Muldoon, MD
National Consumer Voice for Quality Long-Term Care	Lisa Tripp, JD
National Hospice and Palliative Care Organization	Carol Spence, PhD
National Transitions of Care Coalition	James Lett II, MD, CMD
Providence Health and Services	Robert Hellrigel
Service Employees International Union	Charissa Raynor
Visiting Nurses Association of America	Margaret Terry, PhD, RN

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Clinician/Nephrology	Louis H. Diamond, MBChB, FCP (SA), FACP, FHIMSS
Clinician/Nursing	Charlene Harrington, PhD, RN, FAAN
Care Coordination	Gerri Lamb, PhD
Clinician/Geriatrics	Bruce Leff, MD
State Medicaid	MaryAnne Lindeblad, MPH
Measure Methodologist	Debra Saliba, MD, MPH
Health IT	Thomas von Sternberg, MD

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	
Agency for Healthcare Research and Quality (AHRQ)	D.E.B. Potter, MS
Centers for Medicare & Medicaid Services (CMS)	Shari Ling
Veterans Health Administration	Scott Shreve, MD

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

MAP "WORKING" MEASURE SELECTION CRITERIA

NATIONAL QUALITY FORUM

1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review

Measures within the program measure set are NQF-endorsed, indicating that they have met the following criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. Measures within the program measure set that are not NQF-endorsed but meet requirements for expedited review, including measures in widespread use and/or tested, may be recommended by MAP, contingent on subsequent endorsement. These measures will be submitted for expedited review.

Response option: Strongly Agree / Agree / Disagree / Strongly Disagree

Measures within the program measure set are NQF-endorsed or meet requirements for expedited review (including measures in widespread use and/or tested)

Additional Implementation Consideration: Individual endorsed measures may require additional discussion and may be excluded from the program measure set if there is evidence that implementing the measure would result in undesirable unintended consequences.

2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities

Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities:

Subcriterion 2.1	Safer care
Subcriterion 2.2	Effective care coordination
Subcriterion 2.3	Preventing and treating leading causes of mortality and morbidity
Subcriterion 2.4	Person- and family-centered care
Subcriterion 2.5	Supporting better health in communities
Subcriterion 2.6	Making care more affordable

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree:

NQS priority is adequately addressed in the program measure set

3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)

Demonstrated by the program measure set addressing Medicare High-Impact Conditions; Child Health Conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program's intended population(s). (Refer to tables 1 and 2 for Medicare High-Impact Conditions and Child Health Conditions determined by the NQF Measure Prioritization Advisory Committee.)

Response option: Strongly Agree / Agree / Disagree / Strongly Disagree:

Program measure set adequately addresses high-impact conditions relevant to the program.

4. Program measure set promotes alignment with specific program attributes, as well as alignment across programs

Demonstrated by a program measure set that is applicable to the intended care setting(s), level(s) of analysis, and population(s) relevant to the program.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 4.1	Program measure set is applicable to the program's intended care setting(s)
Subcriterion 4.2	Program measure set is applicable to the program's intended level(s) of analysis
Subcriterion 4.3	Program measure set is applicable to the program's population(s)

5. Program measure set includes an appropriate mix of measure types

Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, and structural measures necessary for the specific program attributes.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 5.1	Outcome measures are adequately represented in the program measure set
Subcriterion 5.2	Process measures are adequately represented in the program measure set
Subcriterion 5.3	Experience of care measures are adequately represented in the program measure set (e.g. patient, family, caregiver)
Subcriterion 5.4	Cost/resource use/appropriateness measures are adequately represented in the program measure set
Subcriterion 5.5	Structural measures and measures of access are represented in the program measure set when appropriate

6. Program measure set enables measurement across the person-centered episode of care [1]

Demonstrated by assessment of the person's trajectory across providers, settings, and time.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 6.1	Measures within the program measure set are applicable across relevant providers
Subcriterion 6.2	Measures within the program measure set are applicable across relevant settings
Subcriterion 6.3	Program measure set adequately measures patient care across time

1 National Quality Forum (NQF), Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care, Washington, DC: NQF; 2010.

7. Program measure set includes considerations for healthcare disparities[2]

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, age disparities, or geographical considerations considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 7.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Subcriterion 7.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack)

8. Program measure set promotes parsimony

Demonstrated by a program measure set that supports efficient (i.e., minimum number of measures and the least effort) use of resources for data collection and reporting and supports multiple programs and measurement applications. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 8.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome)

Subcriterion 8.2 Program measure set can be used across multiple programs or applications (e.g., Meaningful Use, Physician Quality Reporting System [PQRS])

2 NQF, *Healthcare Disparities Measurement*, Washington, DC: NQF; 2011.

Table 1: National Quality Strategy Priorities

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

Table 2: High-Impact Conditions:

Medicare Conditions
1. Major Depression
2. Congestive Heart Failure
3. Ischemic Heart Disease
4. Diabetes
5. Stroke/Transient Ischemic Attack
6. Alzheimer's Disease
7. Breast Cancer
8. Chronic Obstructive Pulmonary Disease
9. Acute Myocardial Infarction
10. Colorectal Cancer
11. Hip/Pelvic Fracture
12. Chronic Renal Disease
13. Prostate Cancer
14. Rheumatoid Arthritis/Osteoarthritis
15. Atrial Fibrillation
16. Lung Cancer
17. Cataract
18. Osteoporosis
19. Glaucoma
20. Endometrial Cancer

Child Health Conditions and Risks
1. Tobacco Use
2. Overweight/Obese (≥85th percentile BMI for age)
3. Risk of Developmental Delays or Behavioral Problems
4. Oral Health
5. Diabetes
6. Asthma
7. Depression
8. Behavior or Conduct Problems
9. Chronic Ear Infections (3 or more in the past year)
10. Autism, Asperger's, PDD, ASD
11. Developmental Delay (diag.)
12. Environmental Allergies (hay fever, respiratory or skin allergies)
13. Learning Disability
14. Anxiety Problems
15. ADD/ADHD
16. Vision Problems not Corrected by Glasses
17. Bone, Joint, or Muscle Problems
18. Migraine Headaches
19. Food or Digestive Allergy
20. Hearing Problems
21. Stuttering, Stammering, or Other Speech Problems
22. Brain Injury or Concussion
23. Epilepsy or Seizure Disorder
24. Tourette Syndrome

MAP "WORKING" MEASURE SELECTION CRITERIA INTERPRETIVE GUIDE

NATIONAL QUALITY FORUM

Instructions for applying the measure selection criteria:

The measure selection criteria are designed to assist MAP Coordinating Committee and workgroup members in assessing measure sets used in payment and public reporting programs. The criteria have been developed with feedback from the MAP Coordinating Committee, workgroups, and public comment. The criteria are intended to facilitate a structured thought process that results in generating discussion. A rating scale of *Strongly Agree, Agree, Disagree, Strongly Disagree* is offered for each criterion or sub-criterion. An open text box is included in the response tool to capture reflections on the rationale for ratings.

The eight criteria areas are designed to assist in determining whether a measure set is aligned with its intended use and whether the set best reflects 'quality' health and healthcare. The term "measure set" can refer to a collection of measures--for a program, condition, procedure, topic, or population. For the purposes of MAP moving forward, we will qualify all uses of the term measure set to refer to either a "program measure set," a "core measure set" for a setting, or a "condition measure set." The following eight criteria apply to the evaluation of program measure sets; a subset of the criteria apply to condition measure sets.

FOR CRITERION 1 – NQF ENDORSEMENT:

The optimal option is for all measures in the program measure set to be NQF endorsed or ready for NQF expedited review. The endorsement process evaluates individual measures against four main criteria:

1. **'Importance to measure and report"**–how well the measure addresses a specific national health goal/ priority, addresses an area where a performance gap exists, and demonstrates evidence to support the measure focus;
2. **'Scientific acceptability of the measurement properties'** – evaluates the extent to which each measure produces consistent (reliable) and credible (valid) results about the quality of care.
3. **'Usability'-** the extent to which intended audiences (e.g., consumers, purchasers, providers, and policy makers) can understand the results of the measure and are likely to find the measure results useful for decision making.
4. **'Feasibility'** – the extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measures.

To be recommended by MAP, a measure that is not NQF-endorsed must meet the following requirements, so that it can be submitted for expedited review:

- the extent to which the measure(s) under consideration has been sufficiently tested and/or in widespread use
- whether the scope of the project/measure set is relatively narrow
- time-sensitive legislative/regulatory mandate for the measure(s)
- Measures that are NQF-endorsed are broadly available for quality improvement and public accountability programs. In some instances, there may be evidence that implementation challenges

and/or unintended negative consequences of measurement to individuals or populations may outweigh benefits associated with the use of the performance measure. Additional consideration and discussion by the MAP workgroup or Coordinating Committee may be appropriate prior to selection. To raise concerns on particular measures, please make a note in the included text box under this criterion.

FOR CRITERION 2 – PROGRAM MEASURE SET ADDRESSES THE NATIONAL QUALITY STRATEGY PRIORITIES:

The program's set of measures is expected to adequately address each of the NQS priorities as described in criterion 2.1-2.6. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. This assessment should consider the current landscape of NQF-endorsed measures available for selection within each of the priority areas.

FOR CRITERION 3 – PROGRAM MEASURE SET ADDRESSES HIGH-IMPACT CONDITIONS:

When evaluating the program measure set, measures that adequately capture information on high-impact conditions should be included based on their relevance to the program's intended population. High-priority Medicare and child health conditions have been determined by NQF's Measure Prioritization Advisory Committee and are included to provide guidance. For programs intended to address high-impact conditions for populations other than Medicare beneficiaries and children (e.g., adult non-Medicare and dual eligible beneficiaries), high-impact conditions can be demonstrated by their high prevalence, high disease burden, and high costs relevant to the program. Examples of other on-going efforts may include research or literature on the adult Medicaid population or other common populations. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria.

FOR CRITERION 4 – PROGRAM MEASURE SET PROMOTES ALIGNMENT WITH SPECIFIC PROGRAM ATTRIBUTES, AS WELL AS ALIGNMENT ACROSS PROGRAMS:

The program measure sets should align with the attributes of the specific program for which they intend to be used. Background material on the program being evaluated and its intended purpose are provided to help with applying the criteria. This should assist with making discernments about the intended care setting(s), level(s) of analysis, and population(s). While the program measure set should address the unique aims of a given program, the overall goal is to harmonize measurement across programs, settings, and between the public and private sectors.

- **Care settings include:** Ambulatory Care, Ambulatory Surgery Center, Clinician Office, Clinic/Urgent Care, Behavioral Health/Psychiatric, Dialysis Facility, Emergency Medical Services - Ambulance, Home Health, Hospice, Hospital- Acute Care Facility, Imaging Facility, Laboratory, Pharmacy, Post-Acute/Long Term Care, Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation.
- **Level of analysis includes:** Clinicians/Individual, Group/Practice, Team, Facility, Health Plan, Integrated Delivery System.
- **Populations include:** Community, County/City, National, Regional, or States. Population includes: Adult/Elderly Care, Children's Health, Disparities Sensitive, Maternal Care, and Special Healthcare Needs.

FOR CRITERION 5 – PROGRAM MEASURE SET INCLUDES AN APPROPRIATE MIX OF MEASURE TYPES:

The program measure set should be evaluated for an appropriate mix of measure types. The definition of "appropriate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. The evaluated measure types include:

1. **Outcome measures** – Clinical outcome measures reflect the actual results of care.[1] Patient reported measures assess outcomes and effectiveness of care as experienced by patients and their families. Patient reported measures include measures of patients' understanding of treatment options and care plans, and their feedback on whether care made a difference.[2]
2. **Process measures –** Process denotes what is actually done in giving and receiving care. [3] NQF-endorsement seeks to ensure that process measures have a systematic assessment of the quantity, quality, and consistency of the body of evidence that the measure focus leads to the desired health outcome.[4] Experience of care measures—Defined as patients' perspective on their care.[5]
3. **Cost/resource use/appropriateness measures** –

   a. Cost measures – Total cost of care.

   b. Resource use measures – Resource use measures are defined as broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (broadly defined to include diagnoses, procedures, or encounters).[6]

   c. Appropriateness measures – Measures that examine the significant clinical, systems, and care coordination aspects involved in the efficient delivery of high-quality services and thereby effectively improve the care of patients and reduce excessive healthcare costs.[7]
4. **Structure measures** – Reflect the conditions in which providers care for patients.[8] This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure

1 National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

2 Consumer-Purchases Disclosure Project. (2011). Ten Criteria for Meaningful and Usable Measures of Performance

3 Donabedian, A. (1988) The quality of care. *JAMA*, 260, 1743-1748.

4 National Quality Forum. (2011). Consensus development process. Retrieved from http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx

5 National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

6 National Quality Forum (2009). National voluntary consensus standards for outpatient imaging efficiency. Retrieved from http://www.qualityforum.org/Publications/2009/08/National_Voluntary_Consensus_Standards_for_Outpatient_Imaging_Efficiency__A_Consensus_Report.aspx

7 National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

8 National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

(such as medical staff organizations, methods of peer review, and methods of reimbursement).[9] In this case, structural measures should be used only when appropriate for the program attributes and the intended population.

FOR CRITERION 6 – PROGRAM MEASURE SET ENABLES MEASUREMENT ACROSS THE PERSON-CENTERED EPISODE OF CARE:

The optimal option is for the program measure set to approach measurement in such a way as to capture a person's natural trajectory through the health and healthcare system over a period of time. Additionally, driving to longitudinal measures that address patients throughout their lifespan, from health, to chronic conditions, and when acutely ill should be emphasized. Evaluating performance in this way can provide insight into how effectively services are coordinated across multiple settings and during critical transition points.

When evaluating subcriteria 6.1-6.3, it is important to note whether the program measure set captures this trajectory (across providers, settings or time). This can be done through the inclusion of individual measures (e.g., 30-day readmission post-hospitalization measure) or multiple measures in concert (e.g., aspirin at arrival for AMI, statins at discharge, AMI 30-day mortality, referral for cardiac rehabilitation).

FOR CRITERION 7 – PROGRAM MEASURE SET INCLUDES CONSIDERATIONS FOR HEALTHCARE DISPARITIES:

Measures sets should be able to detect differences in quality among populations or social groupings. Measures should be stratified by demographic information (e.g., race, ethnicity, language, gender, disability, and socioeconomic status, rural vs. urban), which will provide important information to help identify and address disparities.[10]

Subcriterion 7.1 seeks to include measures that are known to assess healthcare disparities (e.g., use of interpreter services to prevent disparities for non-English speaking patients).

Subcriterion 7.2 seeks to include disparities-sensitive measures; these are measures that serve to detect not only differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among populations or social groupings (e.g., race/ethnicity, language).

FOR CRITERION 8 – PROGRAM MEASURE SET PROMOTES PARSIMONY:

The optimal option is for the program measure set to support an efficient use of resources in regard to data collection and reporting for accountable entitles, while also measuring the patient's health and healthcare comprehensively.

Subcriterion 8.1 can be evaluated by examining whether the program measure set includes the least number of measures required to capture the program's objectives and data submission that requires the least burden on the part of the accountable entitles.

Subcriterion 8.2 can be evaluated by examining whether the program measure set includes measures that are used across multiple programs (e.g., PQRS, MU, CHIPRA, etc.) and applications (e.g., payment, public reporting, and quality improvement).

9 Donabedian, A. (1988) The quality of care. *JAMA*, 260, 1743-1748.

10 Consumer-Purchases Disclosure Project. (2011). Ten Criteria for Meaningful and Usable Measures of Performance.

MAP Decision Categories and Rationale

MAP Decision (Standardized Options)	MAP Rationale (Standardized Options)	MAP Findings (Open Text)
Support	• NQF-endorsed measure • Addresses a NQS priority not adequately addressed in the program measure set • Addresses a high-impact condition not adequately addressed in the program measure set (*Note: for PAC/LTC high-impact condition will be replaced with PAC/LTC core concept)* • Promotes alignment across programs, settings, and public and private sector efforts • Addresses specific program attributes • Addresses a measure type not adequately represented in the program measure set • Enables measurement across the person-centered episode of care • Addresses healthcare disparities • Promotes parsimony • Addresses a high-leverage opportunity for dual eligible beneficiaries • Core measure not currently included in the program measure set • Addresses a high-volume diagnosis or procedure • New specifications are improvement over the existing finalized measure	*MAP findings will highlight additional considerations raised by the group.*
Support Direction	• Not ready for implementation; measure concept is promising but requires modification or further development • Not ready for implementation; should be submitted for and receive NQF endorsement • Not ready for implementation; data sources do not align with program's data sources • Not ready for implementation; more experience with the measure is needed • Not ready for implementation; concerns regarding feasibility of data collection	*MAP findings will include suggestions for modifications to measures/measure concept, or indicate that the measure is not currently endorsed for the program's setting.*
Phased Removal	• NQF endorsement removed (the measure no longer meets the NQF endorsement criteria) • NQF endorsement retired (the measure is no longer maintained by the steward) • NQF endorsement placed in reserve status (performance on this measure is topped out) • A 'Supported' measure under consideration addresses a similar topic and better addresses the needs of the program promotes alignment • Measure requires modification or further development	*MAP findings will indicate the timing of removal.*

	• Performance on this measure is likely topped out	
Do Not Support	• Measure does not adequately address any current needs of the program • A finalized measure addresses a similar topic and better addresses the needs of the program • A 'Supported' measure under consideration addresses as similar topic and better addresses the needs of the program • NQF endorsement removed (the measure no longer meets the NQF endorsement criteria) • NQF endorsement retired (the measure is no longer maintained by the steward) • NQF endorsement placed in reserve status (performance on this measure is topped out) • Measure previously submitted for endorsement and was not endorsed • Measure has not been submitted for NQF endorsement • More experience with the measure is needed	*MAP findings will refer to the finalized or 'Supported' measure under consideration that is preferred.*
Insufficient Information	• MAP has insufficient information (e.g., specifications, measure testing, measure use) to evaluate the measure	

Descriptions from Strategic Plan:

- **Support** indicates measures for immediate inclusion in the program measure set, or for continued inclusion in the program measure set in the case of measures that have previously been finalized for the program.
- **Support Direction** indicates measures, measure concepts, or measure ideas that should be phased into the program measure set over time.
- **Phased Removal** indicates measures that should remain in the program measure set for now, yet be phased out as better measures become available.
- **Do Not Support** indicates measures or measure concepts that are not recommended for inclusion in the program measure set. These include measures or measure concepts under consideration that do not address measure gaps or programmatic goals as well as previously finalized measures for immediate removal from the program measure set.
- **Insufficient Information** indicates measures, measure concepts, or measure ideas for which MAP does not have sufficient information (e.g., measure description, numerator or denominator specifications, exclusions) to determine what recommendation to make.

MAP GUIDANCE FOR THE SELECTION OF AVOIDABLE ADMISSION AND READMISSION MEASURES

MAP's Role

Recognizing the complexity inherent in measuring and safely reducing hospital readmissions, the NQF Board of Directors asked MAP to develop guidance for implementing readmission measures for public reporting and performance-based payment programs, in the context of care coordination and shared accountability. This document is intended to provide guidance to program implementers (e.g., CMS, health plans) and to MAP members during pre-rulemaking deliberations about the use of avoidable admission and readmission measures.

The guidance document defines implementation principles for reducing avoidable admissions and readmissions and the implementation issues that should be taken into account when selecting avoidable admission and readmission measures for programs. This guidance is intended to be used in tandem with the MAP Measure Selection Criteria. The identification of measures for specific programs, which is the focus of the MAP pre-rulemaking process, is beyond the scope of this document.

Background

Safely reducing avoidable admissions and readmissions represents a substantial opportunity for improvement in health care quality and affordability. The National Quality Strategy promotes effective communication and care coordination through improving the quality of care transitions and communications across settings. The HHS Partnership for Patients initiative has identified readmissions as a priority, setting an ambitious goal of reducing readmissions by 20% by the end of 2013. To this end, payers and purchasers in the public and private sectors, in collaboration with providers and health professionals, are working to better coordinate care and reduce avoidable admissions and readmissions.

The gap between current performance and what is achievable is enormous. About one in five Medicare beneficiaries who have been hospitalized are readmitted within 30 days, increasing costs of the Medicare program by billions of dollars.[6] Although Medicare beneficiaries are more likely to be readmitted, private sector purchasers also spend billions of dollars each year on rehospitalizations.[7,8] Patients and their families bear multiple burdens associated with avoidable admissions and readmissions, in terms of prolonged illness and pain, potential unnecessary exposure to harm, emotional distress, loss of productivity, inconvenience, and added cost.

Addressing avoidable admissions and readmissions is complex and will require a fundamental transformation of our approaches to healthcare delivery and financing. Many readmissions, particularly those that are planned, are likely necessary for good care. However, a variety of factors contribute to avoidable admissions and readmissions, including coordination of care delivery related to the quality of inpatient or post-acute treatment, poor communication, inadequate care planning, lack of patient involvement with and understanding of the treatment plan, and inadequate community supports.[9]

Just as the causes of avoidable admissions and readmissions are multi-factorial, so are the solutions.[10] Effective coordination of care requires all of those involved in care delivery to look beyond their walls and identify partners in improving care. Hospitals play a central role in reducing readmissions, but health professionals

(particularly primary care providers) and other post-acute providers (such as nursing homes and home health providers) also have equally important roles. In addition, health plans can contribute data and incentives. Perhaps most importantly, patients and their support systems in the community, are essential but often untapped partners in reducing avoidable admissions and readmissions and must be fully integrated into any improvement strategy.

Performance measurement also plays an important role in motivating efforts to safely reduce avoidable admissions and readmissions. Measurement provides readily available information to focus improvement efforts and drives change and accountability for improvement. However, measurement is not a perfect science, and attention to what is measured and how it is measured is important to understand and mitigate potential undesired effects of measurement.

Implementation Principles for Safely Reducing Avoidable Admissions and Readmissions

To guide the selection of measures that will encourage care coordination and safely reduce avoidable admissions and readmissions, MAP Safety/Care Coordination Task Force and Coordinating Committee members identified the following implementation principles:

- **Promote shared accountability**. Reducing avoidable admissions and readmissions requires the coordinated efforts of everyone involved in patient care across the continuum, and performance measures are needed to assess readmissions across every site of care. New multi-disciplinary teams and creative partnerships are needed to build coordinated approaches to care centered on the patient, and new payment and delivery models are needed to incentivize integration across the system. Two examples that could provide the right incentives are accountable care organizations and patient-centered medical homes, financed by shared savings, bundled payments, or global payments. MAP identified the importance of identifying a single point of contact for care coordination, most often a primary care provider. MAP also noted the need for development of health professionals' care coordination skills and capacity to work within patient-centered, team-based models of care to promote shared accountability. Performance measures are needed across every site of care to assess the effectiveness of these shared accountability approaches for safely reducing readmissions.
- **Engage patients as partners**. Patients and their caregivers have the best information about their needs, and patients themselves are a common thread across their care. As such, their active engagement as partners in care is essential for safely reducing avoidable admissions and readmissions. Patients should serve in leadership roles, such as governance boards, and provide input into the design and implementation of policies and programs. Individuals should be partners in their care planning to ensure they help shape their goals for care, fully understand their care plans, and receive the support they need to effectively engage in their care processes. Providers must account for differing levels of health literacy and activation among patients and for various life circumstances. MAP identified focusing on the needs of complex patients, such as persons with mental illness or children with poorly-controlled asthma, to be an effective starting place for engaging patients.
- **Ensure effective transitions**. One of the greatest contributing factors to reducing readmissions is safe and effective transitions from one care setting to the next, including to home. All of the other principles and interventions discussed here contribute to smooth, patient-centered transitions, including effective communication with patients and among providers, and engaging patients and community resources throughout the process. MAP identified additional factors that support effective transitions, including systems that ensure follow-up appointments are made and

kept, follow-up phone calls are made, and prescriptions are filled and medications are taken properly.

- **Communicate across transitions**. Timely exchange of information, so that the right person has the right information at the right time, is key to reducing avoidable admissions and readmissions. Two-way communication with patients and patient education are important so that everyone involved understands the care plan. Communication among providers is important to ensure all are following the same care plan and handoffs are completed. MAP noted that because health plans have relationships with a variety of providers and related organizations, health plans can be pivotal in ensuring that important information is shared with providers to track patient progress across settings. MAP also noted the important role for health IT in supporting communication across transitions.
- **Engage communities as partners**. Patient and caregiver readiness for discharge from inpatient or post-acute care depends on the supports that will be available to them once they return home or to community-based care. Numerous community-based resources are available, but providers and patients may be unaware of or unable to access the programs. For patients with long-term care needs, local agencies can assist individuals in navigating support options, such as home-delivered meals, transportation, and personal care attendant services.

Implementation Issues for Avoidable Admission and Readmission Measures

MAP Safety/Care Coordination Task Force and Coordinating Committee members reviewed the available measures to determine which should be included in the care coordination family of measures[11] and identified gaps for which current measures do not exist or may need refinement. In addition, MAP members raised potential implementation issues associated with the use of avoidable admission and readmission measures.

In deliberations about which avoidable admission and readmission measures should be included in the care coordination family, MAP identified a number of issues to inform the use of these measures in programs:

- **Readmission measures should be part of a suite of measures to promote a system of patient-centered care coordination**. The suite should assess performance of all entities and individuals who are jointly accountable for safely reducing readmissions (e.g., hospital, post-acute, and ambulatory providers), should include measures of both avoidable admissions and readmissions, and should address important care coordination processes as well as readmissions. Process measures and patient-reported measures of experience with care can help guide basic actions that are fundamental to improving outcomes.
- **All-cause and condition-specific measures of avoidable admissions and readmissions are both important**. All-cause measures provide aggregate information across conditions that is less likely to suffer from small sample size issues, and may be more meaningful for public reporting. In addition, all-cause measures promote systems thinking and give providers flexibility to determine the most effective interventions for the highest-priority improvement opportunities across their systems. Condition-specific measures provide actionable information for those working to improve care coordination in condition-specific domains, and are meaningful to patients with specific conditions.
- **Monitoring by program implementers is necessary to understand and mitigate potential unintended consequences** of measuring avoidable admissions and readmissions. Potential undesirable effects of measurement include providers delaying necessary readmissions to improve measurement results and lower scores disadvantaging those caring for higher-risk populations. Monitoring options, or potential balancing measures, include mortality rates, average length of stay, observation

days, emergency department visits, patient experience, post-discharge follow-up rates, proportion of discharges to post-acute care settings versus home, and financial impact on safety net providers.

- **Risk adjustment** for patient-level severity of illness alone may not address all of the nuances inherent in the complexity of reporting avoidable admissions and readmissions. Institutional providers, health professionals, and health plans have very different resources available to serve very different patient populations. Similar entities should be compared to each other. Program implementers should consider stratifying measures by factors such as race, gender, and socioeconomic status to enable fair comparisons. Stratification has the advantage of not obscuring disparities in care for populations with inequities in health outcomes. In addition, program implementers should consider adjustments to payments, rather than adjustments to measures, to address equity issues.
- Readmission measures should **exclude planned readmissions**, to avoid penalizing providers for readmissions that are necessary for high quality care. The National Uniform Billing Committee has identified new billing codes that can be used to identify planned and unrelated readmissions on claims.

6 Jencks SF, Williams MV, Coleman EA, Rehospitalizations among patients in the Medicare fee-for-service program, *New Engl J Med*, 2009;360(14):1418-1428.

7 Goldfield NI, McCullough EC, Hughes JS, et al., Identifying potentially preventable readmissions, *Health Care Financ Rev*, 2008;30(1):75-91.

8 Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Promoting Greater Efficiency in Medicare*, Washington, DC:MedPAC, 2007.

9 We have limited definitive evidence about the causes of avoidable admissions and readmissions. MAP members raised these patient-level, provider-level, and community-level factors as likely contributing causes.

10 As for the causes of avoidable admissions and readmissions, we have limited definitive evidence about the most effective solutions. MAP members raised these care coordination-related efforts as promising approaches.

11 See MAP Families of Measures Public Comment Draft report, available at: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=71737.

Hospital Readmission Reduction Program

Program Type:

Pay for Performance – Hospitals' readmissions information, including their risk-adjusted readmission rates, will be made available on the Hospital Compare website.

Incentive Structure:

CMS has defined a "readmission" as an admission to an acute care hospital within thirty days of a discharge from the same or another acute care hospital. CMS will calculate an excess readmission ratio for each of the applicable conditions selected for the program. These ratios will be measured by the hospital's readmission performance in the previous three years as compared to the national average and adjusted for factors that CMS deems clinically relevant, including patient demographic characteristics, comorbidities, and patient frailty. These ratios will be re-calculated each year using the most recent three years of discharge data and no less than 25 cases. DRG payment rates will be reduced based on a hospital's ratio of actual to expected admissions. In FY 2013, the maximum payment reduction is 1 percent, 2 percent in FY 2014, and capped at 3 percent for FY 2015 and beyond.

Care Settings Included:

Hospitals paid under the Inpatient Prospective Payment System (IPPS).

Statutory Mandate:

The Hospital Readmission Reduction Program was mandated by section 3025 of the Affordable Care Act.

Statutory Requirements for Measures:

The Affordable Care Act requires that each condition selected by the Secretary of HHS for the Hospital Readmission Reduction Program have measures of readmissions that have been NQF-endorsed and that the endorsed measures have exclusions for readmissions unrelated to the prior discharge.[1] Measures should address conditions and procedures for which readmissions are high volume or high expenditure.[2]

On August 18, 2011, CMS issued the FY2012 IPPS final rule which established the use of the NQF-endorsed readmission measures for acute myocardial infarction (#0505), heart failure (#0330), and pneumonia (#0506) as required by the ACA. Beginning in FY 2015, the Secretary of HHS can expand the program to include other applicable conditions.[3]

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP did not review the Hospital Readmission Reduction Program during the 2012 pre-rulemaking activities.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	All of the measures in the program set are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	Three NQS priorities are addressed: Safety, Communication/Care Coordination, and Prevention/Treatment.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	The measure set addresses two high-impact conditions: acute myocardial infarction (AMI) and heart failure.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	The program measure set addresses conditions with high volumes of readmissions. The measures in the program set are included in the IQR program and in private sector programs as well.
5. Program measure set includes an appropriate mix of measure types	The program set includes outcomes measures.
6. Program measure set enables measurement across the person-centered episode of care	While the set does not enable measurement across the person-centered episode, readmissions relate to the transition from one setting to the next.
7. Program measure set includes considerations for healthcare disparities	The measures in the program set are not disparities sensitive.
8. Program measure set promotes parsimony	The measure set consists of three measures that are also included in the IQR set.

[1] http://www.gpo.gov/fdsys/pkg/FR-2011-05-05/pdf/2011-9644.pdf
[2] https://www.federalregister.gov/articles/2012/08/31/2012-19079/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the
[3] http://www.gpo.gov/fdsys/pkg/FR-2011-08-18/pdf/2011-19719.pdf

Hospital-Acquired Condition Payment Reduction Program (ACA 3008)

Program Type:

Pay for Performance – Information will be reported on the Hospital Compare website beginning FY 2015.[1]

Incentive Structure:

Hospitals scoring in the top quartile for rates of hospital acquired conditions (HACs) as compared to the national average will have their Medicare payments reduced by 1 percent for all DRGs.[2] Calculated rates will include an appropriate risk adjustment methodology. The applicable period for determination of the rates will be the fiscal year. Prior to FY 2015 and each subsequent fiscal year, hospitals will receive confidential reports on their HAC rates to give them the opportunity to review and submit corrections before their information is made public.

Care Settings Included:

Hospitals paid under the Inpatient Prospective Payment System (IPPS).

Statutory Mandate:

Section 3008 of the Affordable Care Act established this new payment adjustment for HACs.

Statutory Requirements for Measures:

The conditions addressed by this program are the same as those already selected for the current HAC payment policy and any other conditions acquired during a hospital stay that the Secretary deems appropriate. The conditions included at this time are[3]:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
    - Fractures
    - Dislocations
    - Intracranial Injuries
    - Crushing Injuries
    - Burn
    - Other Injuries
- Manifestations of Poor Glycemic Control
    - Diabetic Ketoacidosis
    - Nonketotic Hyperosmolar Coma
    - Hypoglycemic Coma
    - Secondary Diabetes with Ketoacidosis
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG):
- Surgical Site Infection Following Bariatric Surgery for Obesity

    - Laparoscopic Gastric Bypass
    - Gastroenterostomy
    - Laparoscopic Gastric Restrictive Surgery
- Surgical Site Infection Following Certain Orthopedic Procedures:
    - Spine
    - Neck
    - Shoulder
    - Elbow
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
    - Total Knee Replacement
    - Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization

Additional Program Considerations:

- The Hospital-Acquired Conditions (HAC) program should include measures that address conditions that are high cost, high volume, or both; are assigned to a higher-paying MS-DRG when present as a secondary diagnosis; and could reasonably have been prevented through the application of evidence-based guidelines.[4]

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP did not review the CMS Hospital-Acquired Condition Payment Reduction Program during the 2012 pre-rulemaking activities.
- In its review of the Value-Based Purchasing Program during 2012 Pre-Rulemaking, MAP did not support the inclusion of the eight HAC rates under consideration and advised that these rates be replaced with NQF-endorsed measures addressing the same safety events. The CMS HAC rates have not been submitted to NQF for endorsement, and MAP raised concerns about the scientific acceptability of those measures.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	None of the measures are NQF endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	The measure set addresses the NQS priority of Safety.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	There are no high-impact conditions directly addressed by this measure set.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	The measures included in this set align with the attributes of the program; however, they are not used in other Federal programs.
5. Program measure set includes an appropriate mix of measure types	The measure set includes rates of hospital-acquired conditions.
6. Program measure set enables measurement across the person-centered episode of care	The measure set addresses occurrence of conditions acquired within the hospital setting.
7. Program measure set includes considerations for healthcare disparities	The measure set does not include any disparities-sensitive measures.
8. Program measure set promotes parsimony	The program includes eight measures total.

[1] http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf
[2] http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm
[3] http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html
[4] http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html

Hospital Inpatient Quality Reporting

Program Type:

Pay for Reporting – Information is reported on the Hospital Compare website.[1]

Incentive Structure:

Hospitals receive a reduction of 2.0 percentage points of their annual market basket (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) payment update for non-participation.[2]

Care Settings Included:

Hospitals paid under the Inpatient Prospective Payment System (IPPS).

Statutory Mandate:

The Hospital Inpatient Quality Reporting Program (IQR) was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and subsequently updated in the Deficit Reduction Act of 2005.

Statutory Requirements for Measures:

The program was required to begin with the baseline set of performance measures set forth in the November 2005 report by the Institute of Medicine of the National Academy of Sciences under section 238 (b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

The program measure set should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures.

The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

Additional Program Considerations:

- Measures should align with the National Quality Strategy[3] and promote the health and well-being of Medicare beneficiaries[4,5]
- Measures should align with the Meaningful Use program when possible[6,7]

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP supported the inclusion of the CTM-3, Hospital-Wide Readmission measure, the Hip and Knee Complication and Readmission Rate measures, and the Elective-Delivery Prior to 39 Weeks measure.
- MAP suggested the removal of the HAC rate measures and supported replacing these with NQF-endorsed measures.

Program Measure Set Evaluation Using MAP Measure Selection Criteria

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	The majority (47) of measures in the set are NQF-endorsed. Six measures in the set have lost endorsement.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	All NQS priorities are addressed by the program measure set.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	The measure set addresses three high-impact conditions.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	Measures in the program align with VBP, Meaningful Use, Hospital Readmissions Reduction Program, HAC Payment Reduction Program, and the PPS-Exempt Cancer Hospital Quality Reporting Program. Additionally, 29 measures are used in private sector programs.
5. Program measure set includes an appropriate mix of measure types	The program includes process, structure, outcome, patient experience of care, and cost measures.
6. Program measure set enables measurement across the person-centered episode of care	The measure set addresses care within the hospital setting. Two measures are patient reported outcome measures (PRO).
7. Program measure set includes considerations for healthcare disparities	Four measures are disparities sensitive.
8. Program measure set promotes parsimony	While the set was reduced in the 2012 rule-making cycle, 59 measures remain in the program measure set for FY 2015.*

*The IQR program includes 59 finalized measures for FY 2015 and 60 finalized measures for FY 2016; however, 61 measures are listed in the table of Current Finalized Measures. The HCAHPS and the CTM-3 are considered as separate measures in the table. These are listed as one measure in the 2013 IPPS final rule.

---

[1] http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf
[2] https://www.cms.gov/HospitalQualityInits/08_HospitalRHQDAPU.asp
[3] https://www.federalregister.gov/articles/2012/08/31/2012-19079/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the#h-345
[4] Institute of Medicine, "Performance Measurement: Accelerating Improvement," December 1, 2005, available at: http://www.iom.edu/CMS/3809/19805/31310.aspx.

[5] http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/html/PLAW-108publ173.htm
[6] https://www.federalregister.gov/articles/2010/08/16/2010-19092/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the#h-181
[7] http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf

Hospital Value-Based Purchasing

Program Type:

Pay for Performance – Information is reported on the Hospital Compare website.[1]

Incentive Structure:

Starting on October 1, 2012, Medicare began basing a portion of hospital reimbursement on performance through the Hospital Value-Based Purchasing Program (VBP). Medicare began withholding 1 percent of its regular hospital reimbursements from all hospitals paid under its inpatient prospective payment system (IPPS) to fund a pool of VBP incentive payments. The amount withheld from reimbursements increases over time:

- FY 2014: 1.25%
- FY 2015: 1.5%
- FY 2016: 1.75%
- FY 2017 and succeeding fiscal years: 2%.

Hospitals are scored based on their performance on each measure within the program relative to other hospitals as well as on how their performance on each measure has improved over time. The higher of these scores on each measure is used in determining incentive payments.

Care Settings Included:

Hospitals paid under the Inpatient Prospective Payment System (IPPS).

Statutory Mandate:

Hospital VBP was mandated by section 3001 of the Patient Protection and Affordable Care Act.

Statutory Requirements for Measures:

Measures selected for the VBP program must be included in IQR and reported on the Hospital Compare website for at least 1 year prior to use in the VBP program.

The program was required to begin with a baseline set of performance measures for FY 2013 that included measures addressing AMI, heart failure, pneumonia, surgeries as measured by the Surgical Care Improvement Project, healthcare-associated infections as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan), and HCAHPS. For FY 2014 or a subsequent fiscal year, the program set should include efficiency measures including measures of "Medicare Spending per Beneficiary."

The Secretary of HHS can replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice). Measures of readmissions are statutorily excluded and cannot be included in the Hospital VBP program[2].

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP supported the inclusion of the NHSN CLABSI measure (NQF#0139) and SCIP-Inf-10 Preoperative Temperature Management (NQF #0452).
- MAP supported the direction of the Medicare Spending per Beneficiary measure pending further specification and testing and also recommended harmonizing with a similar measure in the Physician Value-Based Modifier Program.

Program Measure Set Evaluation Using MAP Measure Selection Criteria

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	The majority (16) of measures in the program set are NQF-endorsed. Three measures in the set have lost endorsement: NQF # 0136, 0148, and 0217.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	The program set does not address the NQS priorities of healthy living or affordability.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	Two high-impact conditions are addressed by the program measure set.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	The measure set addresses the statutory requirements set forth by the ACA. All measures in VBP are included in IQR and six are included in Meaningful Use as well. The majority (14) of measures are used in private programs.
5. Program measure set includes an appropriate mix of measure types	The set includes process, outcome, patient experience of care, and cost measures.
6. Program measure set enables measurement across the person-centered episode of care	One patient-reported outcome (PRO) measure is included.
7. Program measure set includes considerations for healthcare disparities	Two measures are disparities sensitive.
8. Program measure set promotes parsimony	The measure set addresses many of the MAP Measure Selection Criteria with 19 measures. Measures are included in the IQR program.

[1] http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf
[2] http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/html/2011-10568.htm

Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs

Program Type:

Pay for Reporting – Information not publicly reported at this time.

Incentive Structure:

The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. For the Medicare Incentive program (hospitals), incentive payments began in 2011 and are comprised of an Initial Amount, Medicare Share, and Transition Factor.[1] The CAH EHR Incentive payment is based on a formula for Allowable Costs and the Medicare Share.[2] The Medicaid Incentive program includes an Overall EHR Amount and Medicaid Share.[3] Medicare payment penalties will take effect in 2015 for providers who are eligible but do not participate. Payment penalties do not apply to Medicaid.[4]

Care Settings Included:

Hospitals paid under IPPS, Medicare Advantage, and critical access hospitals.[5]

Statutory Mandate:

The program was created under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

Statutory Requirements for Measures:

Measures of processes, experience, and/or outcomes of patient care, observations or treatment that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable and timely care should be included. Measures must be reported for all patients, not just Medicare and Medicaid beneficiaries.[6] Preference should be given to quality measures endorsed by NQF.[7]

Additional Program Considerations:

- For Stage 1:[8]
    - Eligible Hospitals and CAHs must report on all 15 total clinical quality measures.

- For Stage 2 (2014 and beyond):[9]
    - Eligible Hospitals and CAHs must report on 16 clinical quality measures that cover 3 of the National Quality Strategy Domains. Measures are selected from a set of 29 clinical quality measures that includes the 15 measures from Stage 1.

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP suggested measures should ideally demonstrate how EHRs facilitate information exchange between institutions and longitudinal tracking of care.
- MAP also supported the alignment of the Hospital Meaningful Use measures with those in other hospital performance measurement programs.
- MAP supported the addition of measures relating to high-impact conditions and measures that address previously identified gap areas.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	All finalized measures in this program are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	All of the NQS priority areas are addressed by the measure set with the exception of Patient and Family Engagement.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	Nearly half (12) of the measures address high-impact conditions.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	Over half (16) of the measures are used in private programs. The majority (25) of measures are used in other Federal programs (i.e., IQR, OQR, and VBP).
5. Program measure set includes an appropriate mix of measure types	The majority (26) of the measures are process measures, while the remaining three measures are outcome measures. There are no structural, cost, or patient experience measures in this set.
6. Program measure set enables measurement across the person-centered episode of care	No patient-reported outcome (PRO) measures are included.
7. Program measure set includes considerations for healthcare disparities	One measure is disparities sensitive.
8. Program measure set promotes parsimony	The measure set addresses many of the measure selection criteria with 29 measures.

[1] http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/EHR_TipSheet_Medicare_Hosp.pdf
[2] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CAH-Payment-Tip-Sheet.pdf
[3] http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicaid_Hosp_Incentive_Payments_Tip_Sheets.pdf
[4] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Getting_Started.html
[5] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Eligible_Hospital_Information.html
[6] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/html/2010-17207.htm

[7] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf
[8] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/html/2010-17207.htm
[9] http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf

PPS-Exempt Cancer Hospital Quality Reporting Program

Program Type:

Required Public Reporting – Information will be reported on the CMS website.[1]

Incentive Structure:

The Prospective Payment System-Exempt Cancer Hospital (PCH) Quality Reporting Program does not currently include an incentive or a penalty for failing to report quality measures as specified. CMS plans to address incentives for the PCH Quality Reporting Program in future rulemaking.[2]

Care Settings Included:

PPS-exempt hospitals which primarily provide care for persons with cancer (as described in Section 1866(k)(1) of the Social Security Act).

Statutory Mandate: Sec. 3005 of the Affordable Care Act (ACA) requires CMS to establish a quality reporting program for PCHs beginning FY 2014.

Statutory Requirements for Measures:

The program measure set should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures. The measure set should also include measures that reflect the level of care and most important aspects of care furnished by PCHs, in addition to the gaps in the quality of cancer care.

The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

Additional Program Considerations:

Future rule-making will consider measures of clinical quality of care, care coordination, patient safety and experience, population health, and efficiency. PPS-Exempt Cancer hospitals will also be measured in the future on informed decision-making and quality improvement programs.[3]

MAP 2012 Pre-Rulemaking Program-Specific Input:

- The current finalized five measures were under consideration and supported by MAP during the 2012 pre-rulemaking activities. MAP noted this was a limited starter set and encouraged program expansion.
- MAP reinforced the importance of alignment and advised that cancer care measures be included in IQR, and IQR measures should be applied to PPS-exempt cancer hospitals.
- Previously identified gaps within the program set include:
    - Outcome measures, particularly measures of survival (with appropriate risk adjustment)
    - Health and well-being

- Patient safety
- Prevention and screening
- Treatment of lung, prostate, gynecological, hematological, and pediatric cancers
- Palliative care

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	All (5) of the finalized measures are NQF Endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	Two NQS priorities addressed: safer care and treatment/prevention of leading causes of morbidity and mortality.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	Two high-impact conditions addressed: breast cancer and colon cancer.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	All of the measures in this set are used in private programs. The CAUTI and CLABSI measures are included in other Federal quality reporting programs: Hospital Inpatient, Inpatient Rehab Facility, and Long-term Care Hospital. CLABSI is also in Hospital VBP.
5. Program measure set includes an appropriate mix of measure types	The measure set contains process and outcome measures; however, it lacks structural, cost, and patient experience measures.
6. Program measure set enables measurement across the person-centered episode of care	The measure set includes three evaluation and initial management measures for the outpatient setting and two hospital-acquired conditions measures.
7. Program measure set includes considerations for healthcare disparities	There are no disparities sensitive-measures included in the measure set.
8. Program measure set promotes parsimony	The program currently includes five measures total.

[1] http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf
[2] https://www.cms.gov/HospitalQualityInits/08_HospitalRHQDAPU.asp

[3] http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf

Inpatient Psychiatric Facilities Quality Reporting Program

Program Type:

Pay for Reporting – Information will be reported on the Hospital Compare website.[1]

Incentive Structure:

Inpatient psychiatric hospitals or psychiatric units will receive a reduction of 2.0 percentage points of their annual market basket (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) Prospective Payment System (PPS) update for non-participation.[2]

Care Settings Included:

Inpatient Psychiatric Facilities (IPFs) required to report in the program include inpatient psychiatric hospitals or psychiatric units paid under the IPF PPS. The IPF Quality Reporting Program applies to freestanding psychiatric hospitals, government-operated psychiatric hospitals and distinct psychiatric units of acute care hospitals and critical access hospitals. The IPF Quality Reporting Program does not apply to children's hospitals, which are paid under a different system.

Statutory Mandate:

Section 1886(s)(4) of the Social Security Act as amended by sections 3401(f) and 10322(a) of the Affordable Care Act (ACA) requires CMS to establish quality measures required for the IPF Quality Reporting Program.

Statutory Requirements for Measures:

The IPF Quality Reporting Program was required to begin with performance measures established by CMS by October 1, 2012 for FY 2014.

The program measure set should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures.

The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP reviewed six measures under consideration and supported all six measures for inclusion during the 2012 pre-rulemaking activities.
- Previously identified gaps within the program set include:
    - Coordination between inpatient psychiatric care and alcohol/substance abuse treatment centers;
    - Outcome measures for after care – patients keeping follow up appointments;

- Monitoring of metabolic syndrome for patients on antipsychotic medications; and
- Primary care follow-up after discharges for psychiatric episodes.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	All six finalized measures in the program set are endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	Three NQS priorities are addressed (Safety, Communication/Care Coordination, and Patient/Family Engagement).
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	There are no high-impact conditions directly addressed by this measure set.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	One measure aligns with the Long-term Care Hospital Quality Reporting Program.
5. Program measure set includes an appropriate mix of measure types	Only process measures were included within the measure set.
6. Program measure set enables measurement across the person-centered episode of care	Measures within the program address care within and discharge from the inpatient setting.
7. Program measure set includes considerations for healthcare disparities	The measure set does not include any disparities-sensitive measures.
8. Program measure set promotes parsimony	The program includes six measures total.

[1] http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf
[2] http://www.cms.gov/Medicare/medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

Hospital Outpatient Quality Reporting

Program Type:

Pay for Reporting – Information is reported on the Hospital Compare website.[1]

Incentive Structure:

Hospitals receive a reduction of 2.0 percentage points of their annual market basket (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) payment update for non-participation.[2] Hospitals providing outpatient services such as clinic visits, emergency department visits, critical care services (including trauma team activation) that do not meet the minimum Outpatient Quality Reporting Program (OQR) requirements will not receive the Outpatient Prospective Payment System (OPPS) payment updates for CY 2012, which may result in a reduction in the OPPS payments.

Care Settings Included:

Hospitals providing outpatient services such as clinic visits, emergency department visits, and critical care services (including trauma team activation) paid under the OPPS.

Statutory Mandate:

The OQR Program was first established in the Balanced Budget Act of 2007. The program was mandated by Congress to replace Title XVIII of the Social Security Act reasonable cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act of 2007 established PPS for outpatient services rendered on or after August 2010.[3] The Affordable Care Act of 2010 established the role of the OQR Program as a pay for reporting program for hospitals.

Statutory Requirements for Measures:

The OQR Program measure set should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures.

The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

Additional Program Considerations:

- Future rule-making will consider measures of clinical quality of care, care coordination, patient safety and experience, population health, and efficiency.[4]

MAP 2012 Pre-Rulemaking Program-Specific Input:

- There were no measures under consideration for OQR during MAP's 2012 pre-rulemaking activities.
- Of the 26 finalized measures, MAP determined seven measures should be removed from the program until they are further developed; however, these measures remain in OQR at this time. Measures OP-9, OP-10, OP-14, and OP-15 were previously submitted for NQF endorsement, but

did not receive it. Endorsement was being removed from measures OP-20 and OP-22, and measure OP-25 has not been submitted for endorsement.

- Previously identified gaps within the program set include:
  - 3-Item Care Transition Measure (CTM-3)
  - Patient safety
  - Risk-adjusted outcomes
  - Weight and diabetes management

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	The majority (17) measures are NQF endorsed; three with time-limited endorsement.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	The measure set addresses all of the NQS priorities.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	The program measure set includes eight measures addressing high-impact conditions.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	Within the measure set, three measures align with PQRS and one measure aligns with Meaningful Use – Hospitals and Critical Access Hospitals. Three measures are also used in private programs.
5. Program measure set includes an appropriate mix of measure types	The measure set includes a variety of measure types, the majority being process measures; however, the set lacks measures of patient experience and cost.
6. Program measure set enables measurement across the person-centered episode of care	The measure set includes throughput measures related to urgent/emergent care.
7. Program measure set includes considerations for healthcare disparities	One measure is disparities sensitive.
8. Program measure set promotes parsimony	The measure set addresses many of the MAP Measure Selection Criteria with 24 measures total.

[1] http://www.gpo.gov/fdsys/pkg/FR-2012-07-30/pdf/2012-16813.pdf
[2] https://www.cms.gov/HospitalQualityInits/08_HospitalRHQDAPU.asp
[3] http://healthreformgps.org/wp-content/uploads/opps-rule.pdf

[4] http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-28612.pdf

Ambulatory Surgical Centers Quality Reporting Program

Program Type:

Pay for Reporting – Information is reported to the Centers for Medicare and Medicaid Services (CMS).[1]

Incentive Structure:

Medicare ambulatory surgical centers (ACSs) will receive a reduction of 2.0 percentage points of their annual market basket (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) ASC payment system update for non-participation beginning CY 2014.[2] The ASC Quality Reporting program data collection begins CY 2012 with most measures to be used for payment determination beginning CY 2014.

Care Settings Included:

An ASC operating exclusively to provide surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission to the ASC facility.[3]

Statutory Mandate:

CMS is authorized but not required to implement a reduction in annual payment updates for failing to report on quality measures (ASC Quality Reporting) under the Medicare Improvements and Extension Act of the Tax Relief and Health Care Act (MIEA-TRHCA) of 2006.

Statutory Requirements for Measures:

The ASC Quality Reporting Program may include the same or similar measures reported in the Hospital Outpatient Quality Reporting or Inpatient Quality Reporting Programs.

The program measure set should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures. To the extent feasible, outcome and patient experience measures should be risk-adjusted. In order to reduce burden of measurement on smaller ASCs, CMS finalized only claims based measures for the first year of the program and only structural measures in the second year of the program.

The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP did not consider any new measures for this program during the 2012 pre-rulemaking activities

- MAP recommended that ASCs be held to the same standard as acute care hospital outpatient procedural areas and encouraged greater alignment among surgical programs.
- MAP noted the program measure set should be expanded to include care transitions, patient experience of care (i.e., Surgical CAHPS), Surgical Care Improvement Project (SCIP), appropriateness of procedure, and risk-adjusted outcome measures.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	The majority (6) of measures are NQF endorsed; one with time-limited endorsement.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	The measure set addresses the NQS priority of Safety.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	There are no high-impact conditions directly addressed by this measure set.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	One measure is aligned with other Federal quality reporting programs, including Hospital Inpatient and Long-Term Care Hospital. Five measures are used in private sector programs.
5. Program measure set includes an appropriate mix of measure types	The measure set contains process, outcome, and structural measures; however, it lacks cost and patient experience measures.
6. Program measure set enables measurement across the person-centered episode of care	Measures address the specific point in time of care at the ASC, not across care settings or providers.
7. Program measure set includes considerations for healthcare disparities	The measure set does not include any disparities-sensitive measures.
8. Program measure set promotes parsimony	The program includes eight measures total.

[1]https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772497737
[2] http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-28612.pdf
[3] http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/ASCs.html#

Medicare Shared Savings Program

Program Type:

Pay for Reporting and Pay for Performance.[1]

Incentive Structure:

Option for one-sided risk model (sharing of savings only for the first two years, and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three years).[2]

Care Settings Included:

Providers, hospitals, and suppliers of services

Statutory Mandate:

Sec. 3022 of the Affordable Care Act (ACA) requires the Centers for Medicare & Medicaid Services (CMS) to establish a Medicare Shared Savings Program (MSSP) that promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.[3]

Statutory Requirements for Measures:

Appropriate measures of clinical processes and outcomes; patient, and, wherever practicable, caregiver experience of care; and utilization (such as rates of hospital admission for ambulatory sensitive conditions).[4]

MAP 2012 Pre-Rulemaking Program-Specific Input:

- In comparison to the other federal clinician performance measurement programs, MAP determined that the MSSP measure set approximates an ideal measure set as it addresses patient experience, multiple cross-cutting priorities and high-impact conditions, as well as key quality outcomes.
- MAP suggested that the program measure set be further aligned with the Medicare Advantage 5-star quality rating system measure set and private-sector measurement efforts for health plans and accountable care organizations.
- MAP recognized that the MSSP program is designed to generate cost savings; however, the measure set should incorporate cost measures to encourage transparency.
- MAP noted that the MSSP measure set could be improved by addressing community supports and patient-reported measures of health and functional status.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	Most (30) of the finalized measures are NQF endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	The measures address all of the NQS priorities except making care more affordable.

3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	Over half (19) of the measures address high-impact conditions.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	Over half (19) of the measures are used in private programs; most (24) of the measures are used in other Federal programs.
5. Program measure set includes an appropriate mix of measure types	The measure set is comprised of process, outcome, and patient experience measures, but lacks cost measures.
6. Program measure set enables measurement across the person-centered episode of care	The measure set crosses the episode of care as the set includes primary prevention measures, evaluation and initial management, and follow-up care. Additionally, two measures are patient-reported outcome measures (PRO).
7. Program measure set includes considerations for healthcare disparities	A small number (5) of measures are disparities sensitive.
8. Program measure set promotes parsimony	The measure set addresses many of the MAP Measure Selection Criteria with 33 measures; however, the measure set could be enhanced with additional measures of cost, functional status, and patient-reported outcomes.

Note: The MSSP program includes 33 finalized measures; however, only 24 measures are listed in the Table of Current Finalized measures. MSSP counts 6 of the *CAHPS Clinician/Group Survey* (NQF#005) rates as separate measures. Additionally *Optimal Diabetes Care* (NQF#0729) is considered 5 separate measures in MSSP.

---

[1] http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-Guide-Quality-Performance-2012.PDF
[2] http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html
[3] http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf
[4] http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf

Physician Quality Reporting System

Program Type:

Pay for Reporting

Incentive Structure:

In 2012-2014, eligible professionals can receive an incentive payment equal to a percentage (2% in 2010, gradually decreasing to 0.5% in 2014) of the eligible professional's estimated total allowed charges for covered Medicare Part B services under the Medicare Physician Fee Schedule.[1] Beginning in 2015, eligible professionals and group practices that do not satisfactorily report data on quality measures will receive a reduction (1.5% in 2015, and 2% in subsequent years) in payment.[2].[3]

Care Settings Included:

Multiple. Eligible professionals include:

- Physicians—medicine, osteopathy, podiatric med, optometry, oral surgery, dental med, chiropractic
- Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologists
- Therapists—physical therapist, occupational therapist, qualified speech-language therapist[4]

Statutory Mandate:

The 2006 Tax Relief and Healthcare Act (TRHCA) required the establishment of a physician quality reporting system. The PQRS was initially implemented in 2007 and was extended as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2008 (MMSEA), the Medicare Improvements for Patients and Providers Act of 2009 (MIPPA), and the Affordable Care Act.[5]

Statutory Requirements for Measures:

No specific types of measures required. Individual clinicians participating in the PQRS may select three measures (out of more than 200 measures) to report or may choose to report a specified measure group.

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP considered how to incorporate measures that would increase clinician participation, while selecting measures that drive quality, are meaningful to consumers, and support parsimony.
- MAP aimed to avoid non-discriminating, "low-bar" measures that would be difficult to remove from clinician performance measurement programs in the future.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are	Slightly more than half (179) of finalized measures

	NQF-endorsed or meet the requirements for expedited review	are NQF-endorsed.
2.	**Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities**	All NQS priorities are addressed with fewer measures for the affordability and patient- and family-engagement priorities.
3.	**Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)**	Half (165) of measures address high-impact conditions.
4.	**Program measure set promotes alignment with specific program attributes as well as alignment across programs**	Two-thirds (205) of measures are used in other Federal programs; over one-quater (86) of measures are used in private programs .
5.	**Program measure set includes an appropriate mix of measure types**	The measure set is mostly comprised of process and outcome measures with a few cost measures and no patient experience measures.
6.	**Program measure set enables measurement across the person-centered episode of care**	The measure set crosses the episode of care as the set includes primary prevention measures, evaluation and initial management, and follow-up care. Additionally, 14 measures are patient-reported outcome measures (PRO).
7.	**Program measure set includes considerations for healthcare disparities**	A small number (15) have considerations of disparities.
8.	**Program measure set promotes parsimony**	The PQRS measures address nearly all of the MAP Measure Selection Critieria; however, any three measures a clinician chooses to report may not address the criteria.

[1] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html
[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html
[3] CY 2013 PFS final rule. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1
[4] CMS.gov. Downloads Eligible professionals 03-08-2011. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html
[5] CY 2013 PFS final rule. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

Physician Compare

Program Type:

Public Reporting[1]

Incentive Structure:

None.

Care Settings Included:

Multiple. Eligible professionals include[2]:

- Physicians—medicine, osteopathy, podiatric med, optometry, oral surgery, dental med, chiropractic
- Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologists
- Therapists—physical therapist, occupational therapist, qualified speech-language therapist

Statutory Mandate:

Section 10331 of the Patient Protection and Affordable Care Act of 2010. The web site was launched on December 30, 2010. Performance information will be reported on the website beginning on January 1, 2013.

Statutory Requirements for Measures:

Data reported under the existing Physician Quality Reporting System will be used as an initial step for making physician measure performance information public on Physician Compare. The following types of measures are required to be included for public reporting on Physician Compare[3]:

- Patient health outcomes and functional status of patients
- Continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use
- Efficiency
- Patient experience and patient, caregiver, and family engagement
- Safety, effectiveness, and timeliness of care

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

There are no measures currently finalized for Physician Compare. Accordingly, a table of finalized measures is not included.

---

[1] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/index.html

[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html

[3] PFS Final Rule 2013

Physician Feedback Program/Value-Based Payment Modifier

Program Type:

Pay for Performance

Incentive Structure:

Physician Feedback Program

CMS is statutorily required to provide confidential feedback reports to physicians that measure the quality and resources involved in furnishing care to Medicare Fee-for-Service (FFS) beneficiaries. Physician feedback reports also serve currently as the preview vehicle to inform physicians of the types of measures that will comprise the value modifier. Starting in the fall of 2013, all groups of physicians with 25 or more eligible professionals will begin receiving Physician Feedback reports. [1]

Value-Based Payment Modifier

The modifier begins in 2015 for groups of 100 or more eligible professionals, and is applicable to all physicians and groups of physicians on or after January 1, 2017. The modifier payment adjustment varies over time and must be implemented in a budget neutral manner. Payment adjustment amount is built on satisfactory reporting through PQRS.[2]

- Successfully reporting through PQRS:
    - Option for no quality-tiering: 0% adjustment
    - Option for quality-tiering: up to -1% for poor performance; reward for high performance to be determined
- Not successfully reporting through PQRS: -1% adjustment

In 2015 and 2016, the value-based payment modifier will not be applied to groups of physicians that are participating in the Medicare Shared Savings Program, testing of the Pioneer ACO model, or other Innovation Center or CMS initiatives.[3] Additionally, future rulemaking cycles will determine a value-based payment modifier for individuals, smaller groups, and hospital-based physicians. [4]

Care Settings Included:

Multiple. Eligible professionals include:

- Physicians—medicine, osteopathy, podiatric med, optometry, oral surgery, dental med, chiropractic

---

[1] U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Medicare Program; Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME
Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013 (Final Rule)
[2] Ibid
[3] Ibid
[4] Ibid

- Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologists
- Therapists—physical therapist, occupational therapist, qualified speech-language therapist

Statutory Mandate:

Section 1848(p) of the Social Security Act (the Act) as established by Section 3003 and 3007 of the Affordable Care Act of 2010 (ACA). [5]

Statutory Requirements for Measures:

The program must include a composite of appropriate, risk-based quality measures and a composite of appropriate cost measures.[6] The Secretary is also required to use NQF-endorsed measures, whenever possible. Final rule indicated, for 2013 and beyond, the use of all measures included in PQRS.

MAP 2012 Pre-Rulemaking Program-Specific Input:

MAP noted that the majority of the measures under consideration have not yet been tested for individual clinician-level measurement, and therefore may have feasibility issues with regard to attribution and risk adjustment.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	Most (13) of the finalized measures are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	The measures address all of the NQS priorities except Patient and Family Engagement.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	Majority (13) of the measures address high-impact conditions.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	Majority of the measures (13) are used in private programs; all of the measures are currently used in Federal programs.
5. Program measure set includes an appropriate	The measure set is comprised of process, outcome,

[5] Ibid

[6] U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Medicare Program; Payment Policies under the Physician Fee Schedule, Five-Year Review of Work Related Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition, and other Revisions to Part B for CY 2012, *Fed Reg,* 2011, 76 (228): 73026-73474.

mix of measure types	and cost/resource use measures, but lacks patient experience/patient-reported measures.
6. Program measure set enables measurement across the person-centered episode of care	The measures address two portions of the episode of care—primary prevention and evaluation and management—but the set lacks follow-up care measures. Additionally, the measure set does not include patient-reported outcome measures (PRO).
7. Program measure set includes considerations for healthcare disparities	A small number of measures (2) are disparities-sensitive measures.
8. Program measure set promotes parsimony	The measure set addresses many of the MAP Measure Selection Criteria with 19 measures; however, the measure set could be enhanced with additional measures of patient-reported outcomes to address the gap in the NQS priority of Patient and Family Engagement and measures to enable measurement across the person-centered episode of care.

Medicare and Medicaid EHR Incentive Program for Eligible Professionals

Program Type:

Payment incentive program for using EHRs.

Incentive Structure:

Eligible professionals who demonstrate meaningful use of certified EHR technology, which includes reporting clinical quality measures, can receive incentive payments. The incentives vary by program.[1]

- Medicare. Up to $44,000 over 5 continuous years. The program started in 2011 and will continue through 2014. The last year to begin participation is 2014. Penalties will take effect in 2015 and in each subsequent year for providers who are eligible but do not participate. The penalty is a payment adjustment to Medicare reimbursements that starts at 1% per year, up to a maximum 5% annual adjustment.
- Medicaid. Up to $63,750 over 6 years. The program started in 2011 and will continue through 2021. The last year to begin participation is 2016. Penalty payment adjustments do not apply to Medicaid.[2]

Care Settings Included:

Multiple. Under the Medicare EHR incentive program, eligible professionals include doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, and optometry as well as chiropractors. Under the Medicaid EHR incentive program, eligible professionals include doctors of medicine and osteopathy, nurse practitioners, certified nurse-midwives, dentists, and physicians assistances furnishing services in a federally qualified health center or rural health clinic.[3]

Statutory Mandate:

The program was created under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

Statutory Requirements for Measures:

Measures are of processes, experience, and outcomes of patient care that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable, and timely care. Measures must be reported for all patients, not just Medicare and Medicaid beneficiaries.[4] Preference should be given to quality measures endorsed by NQF.[5]

Anticipated Future Rules:

It is anticipated that the Meaningful Use Stage 3 proposed rule will be published in early 2014.

Additional Program Considerations:

The goal of the Medicare and Medicaid Electronic Health Record (EHR) Incentive program is to provide measures for eligible professionals under three main components of Meaningful Use:

- The use of a certified EHR in a meaningful manner, such as e-prescribing;
- The use of certified EHR technology for electronic exchange of health information to improve quality of healthcare; and

- The use of certified EHR technology to submit clinical quality and other measures.

For Stage 1:[6]

- Eligible Professionals must report on six total clinical quality measures: three required core measures (substituting alternate core measures where necessary), and three additional measures (selected from a set of 38 clinical quality measures).

For Stage 2 (2014 and beyond):[7]

- Eligible Professionals must report on 9 total clinical quality measures that cover 3 of the National Quality Strategy priorities (selected from a set of 64 clinical quality measures).

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP concluded that it supports the use of disease-specific eMeasures and patient-centered, cross-cutting measures that enhance interoperability and coordination to encourage a more robust health IT infrastructure. Initially, the meaningful use measures should be broad enough to generally encourage eMeasurement. Over time, as health IT becomes more effective and interoperable, the Meaningful Use program should have a greater focus on two types of measures:
    - health IT-sensitive measures (i.e., measures that provide information on whether electronic health records are changing care processes)
    - health IT-enabled measures (i.e., measures that require data from multiple settings/providers or are longitudinal and would require an health IT-enabled collection platform to be fully operational).
- MAP recommended measures without e-specifications to be re-tooled as eMeasures prior to inclusion in the program.
- To reduce clinician burden, MAP suggests that HHS consider establishing a process in the Meaningful Use program that will allow clinicians to receive credit for electronically reporting measures through PQRS, provided the measures are in the Meaningful Use program.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	Three-quarters (56) of finalized measures are NQF endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	All NQS priorities are addressed.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	Two-thirds (50) of measures address high-impact conditions.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	Over two-thirds (60) of measures are used in other Federal programs; over half (43) are used in private programs.
5. Program measure set includes an appropriate mix of measure types	Over two-thirds (60) of measures are process measures; outcome measures are included, but the

	set does not include cost or experience measures.
6. Program measure set enables measurement across the person-centered episode of care	The measure set crosses the episode of care as the set includes primary prevention measures, evaluation and initial management, and follow-up care. Additionally, five measures are patient-reported outcome measures.
7. Program measure set includes considerations for healthcare disparities	A small number (8) of measures are disparities sensitive.
8. Program measure set promotes parsimony	The measure set addresses many of the MAP Measure Selection Criteria with 76 measures; however, the measure set could be enhanced with additional outcomes and cost measures.

FYI: Note the MU-EP program includes 76 finalized measures covering both Stage 1 and Stage 2. The table of Current Finalized measures notes the stage(s) to which each measure applies.

---

[1] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html
[2] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Getting_Started.html
[3] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/
[4] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/html/2010-17207.htm
[5] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf
[6] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/html/2010-17207.htm
[7] http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf

Long-Term Care Hospital Quality Reporting

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

For fiscal year 2014, and each year thereafter, Long-Term Care Hospital providers (LTCHs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive full annual payment updates; failure to report quality data will result in a 2 percent reduction in the annual payment update.[1] The data must be made publicly available, with LTCH providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.[2]

Care Settings Included:

Long-Term Care Hospitals

Statutory Mandate:

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for LTCHs.

Statutory Requirements for Measures:

Measures should align with the National Quality Strategy (NQS), promote enhanced quality with regard to the priorities most relevant to LTCHs (such as patient safety, better coordination of care, and person- and family-centered care), and address the primary role of LTCHs—furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days).[3]

MAP 2012 Pre-Rulemaking Program-Specific Input:

- Measures should address delirium and the percentage of patients returning to the community.
- Measures should address the PAC/LTC core measures not currently addressed in the measure set:
    - Establishment of patient/ family/caregiver goals
    - Shared decision-making
    - Falls
    - Adverse drug events
    - Transition planning

---

[1] CMS.gov. LTCH Quality Reporting.http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html?redirect=/LTCH-Quality-Reporting/
[2] CMS.gov. LTCH Quality Reporting.http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html?redirect=/LTCH-Quality-Reporting/
[3] FY 2012 IPPS/LTCH PPS final rule. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

- Advance care planning and treatment
- Inappropriate medication use
- Avoidable admissions

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	Five measures are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	This measure set lacks measures representing prevention and treatment, care coordination, making care affordable, and patient/family engagement.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	None of the measures in the set addresses high-impact conditions. Measures in the set address the MAP PAC/LTC core measure concepts of infection rates and pressure ulcers.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	All measures are used in other federal programs; two measures are used in private programs.
5. Program measure set includes an appropriate mix of measure types	The measure set is comprised of outcome and process measures.
6. Program measure set enables measurement across the person-centered episode of care	The measure set does not include follow-up care. Primary prevention measures and evaluation and initial management measures do not apply to the LTCH setting.
7. Program measure set includes considerations for healthcare disparities	None of the measures is disparities-sensitive.
8. Program measure set promotes parsimony	This measure set addresses some of the MAP Measure Selection Criteria; however, LTCH is a post-acute care setting so some criteria may not apply to this setting.

Inpatient Rehabilitation Facility Quality Reporting

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

For fiscal year of 2014, and each year thereafter, Inpatient Rehabilitation Facility providers (IRFs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive annual payment updates. Failure to report quality data will result in a 2 percent reduction in the annual increase factor for discharges occurring during that fiscal year.[1] The data must be made publicly available, with IRF providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.[2]

Care Settings Included:

Inpatient Rehabilitation Facilities

Statutory Mandate:

Section 3004(b) of the Affordable Care Act (ACA) directs the Secretary to establish quality reporting requirements for IRFs.

Statutory Requirements for Measures:

Measures should align with the National Quality Strategy (NQS), be relevant to the priorities of IRFs (such as patient safety, reducing adverse events, better coordination of care, and person- and family-centered care), and address the primary role of IRFs—rehabilitation needs of the individual, including improved functional status and achievement of successful return to the community post-discharge. [1]

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP supported the direction of measures under consideration that address the PAC-LTC core measure concepts. MAP could not support immediate inclusion of the measures as they had not been specified and tested for IRFs.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	Both measures are NQF-endorsed: NQF #0138 National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection

[1] FY 2012 IRF PPS final rule The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1.

	(CAUTI) NQF #0678 Percent of Residents With Pressure Ulcers That Are New or Worsened (short-stay)
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	Only the NQS priority of safer care is addressed.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	None of the measures in the set addresses high-impact conditions. Two MAP PAC/LTC core measure concepts are addressed—infection rates and pressure ulcers.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	Both measures are used in other federal programs; one measure NQF #0138 is also used in private program.
5. Program measure set includes an appropriate mix of measure types	The measure set only includes outcome measures.
6. Program measure set enables measurement across the person-centered episode of care	The measure set is limited to two evaluation and initial management measures and does not include follow-up care.
7. Program measure set includes considerations for healthcare disparities	None of the measures is disparities-sensitive.
8. Program measure set promotes parsimony	The measure set is limited to two measures; many of the MAP Measure Selection Criteria are not met.

[1] CMS.gov. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

[2] CMS.gov. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

End Stage Renal Disease Quality Improvement

Program Type:

Pay for Performance, Public Reporting

Incentive Structure:

Starting in 2012, payments to dialysis facilities will be reduced if facilities do not meet or exceed the required total performance score, which is the sum of the scores for established individual measures during a defined performance period. Payment reductions will be on a sliding scale, which could amount to a maximum of two percent per year.[1] Performance is reported on the Dialysis Facility Compare website.

Care Settings Included:

Dialysis Providers/Facilities

Statutory Mandate:

The ESRD Quality Incentive Program (QIP), required by section 1881 (h) of the Social Security Act and added by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153(c), was developed by CMS to be the first pay-for-performance (also known as "value-based purchasing") model quality incentive program.[2]

Statutory Requirements for Measures:

Measures of anemia management that reflect labeling approved by the Food and Drug Administration (FDA), dialysis adequacy, patient satisfaction, iron management, bone mineral metabolism, and vascular access. [3]

MAP 2012 Pre-Rulemaking Program-Specific Input:

- The measure set should address aspects of care beyond clinical care for dialysis patients and include measures of care coordination, physical and mental comorbidities, shared decision-making, patient experience, and cost.
- Currently available depression screening measures should be explored for application in ESRD facilities.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment)

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	Less than half (5) of measures in the set are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	The measure set addresses the NQS priorities of prevention and treatment, safety, and patient and family engagement.

MAP Measure Selection Criteria	Evaluation
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	All measures in the set address a high-impact condition as renal disease is a high-impact condition. The majority of the PAC/LTC core measure concepts do not apply to the ESRD program. One measure addresses experience of care.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	None of the measures in the set are used in other federal programs. One measure is used in private programs: NQF #1423 Minimum spKt/V for Pediatric Hemodialysis Patients
5. Program measure set includes an appropriate mix of measure types	The measure set includes outcome, process, and structure measures, but lacks cost measures.
6. Program measure set enables measurement across the person-centered episode of care	The measure set is focused on evaluation and initial management. The primary prevention and follow-up care portions of the episode are not addressed. None of the measures are patient-reported outcome measures.
7. Program measure set includes considerations for healthcare disparities	None of the measures in the set are disparities-sensitive.
8. Program measure set promotes parsimony	This measure set addresses few of the MAP Measure Selection Criteria.

[1] Federal Register. Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Bad Debt Reductions for All Medicare Providers. https://www.federalregister.gov/articles/2012/07/11/2012-16566/medicare-program-end-stage-renal-disease-prospective-payment-system-quality-incentive-program-and

[2] Final rule ESRD PY 2012-2013-2014. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

[3] Final rule ESRD PY 2012-2013-2014. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

Hospice Quality Reporting Program

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

Failure to submit required quality data, beginning in FY 2014 and for each year thereafter, shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year.[1] The data must be made publicly available, with Hospice Programs having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of hospice quality data. [2]

Care Settings Included:

Multiple; hospice care can be provided in inpatient and outpatient settings.

Statutory Mandate:

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for Hospice Programs.[3]

Statutory Requirements for Measures:

None.

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP previously noted the need to move beyond the Medicare hospice benefit and identify patient-centered measures that broadly assess end-of life preferences and care.
- The MAP performance measurement coordination strategy for hospice and palliative care identified measures that can assess hospice and palliative care across settings.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	One of two measures in this set is NQF-endorsed – NQF #0209, Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment. There is only one other measure currently in this set and it is not endorsed – Participation in a Quality Assessment Performance Improvement Program That Includes at Least Three Indicators Related to Patient Care.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	Measure NQF # 0209 addresses communication and care coordination; the second measure addresses prevention and treatment as well as

	safety.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	This measure set does not address any high-impact conditions; however, the set does address the MAP PAC-LTC core measure concept of functional and cognitive status assessment.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	None of the measures are used in other federal or private programs.
5. Program measure set includes an appropriate mix of measure types	The measure set includes one outcome measure (NQF #0209) and one structural measure.
6. Program measure set enables measurement across the person-centered episode of care	One measure is a patient-reported outcome measure (NQF #0209).
7. Program measure set includes considerations for healthcare disparities	None of the measures are disparities-sensitive.
8. Program measure set promotes parsimony	The measure set is limited to two measures; many of the MAP Measure Selection Criteria are not met.

[1] Ibid
[2] CMS. Hospice Quality Reporting. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html
[3] Ibid

Nursing Home Quality Initiative and Nursing Home Compare

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with the requirements in 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs. Part of this requirement includes completing the Minimum Data Set (MDS), a clinical assessment of all residents in Medicare- or Medicaid-certified nursing facilities. Quality measures are reported on the Nursing Home Compare website using a Five-Star Quality Rating System, which assigns each nursing home a rating of 1 to 5 stars, with 5 representing highest standard of quality, and 1 representing the lowest.[1]

Care Settings Included:

Medicare- or Medicaid-certified nursing facilities

Statutory Mandate:

The 1987 Omnibus Budget Reconciliation Act mandated the development of a nursing home resident assessment instrument.

Statutory Requirements for Measures:

OBRA mandated the inclusion of domains of resident health and quality of life in the resident assessment instrument.

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP suggested that the measure set incorporate additional measures for short-stay residents to reflect the increase of this type of nursing home care. These short-stay measures should align with measures selected for use in IRFs.
- MAP suggested including Nursing Home-CAHPS measures in the program measure set.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	More than half of measures (16) in the set are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities	The measure set addresses all of the NQS priorities except making care affordable and patient and family engagement.

3. **Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)**	Two measures in the set address high-impact conditions. Additionally, the measure set addresses several MAP PAC/LTC core measure concepts—falls, functional and cognitive status assessment, inappropriate medication use, infection rates, mental health, and pressure ulcers.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	Two measures in the set are used in other federal programs. None of the measures are used in private programs.
5. Program measure set includes an appropriate mix of measure types	The set includes process, outcome, and structure measures. The set does not include patient experience of care or cost measures.
6. Program measure set enables measurement across the person-centered episode of care	The measure set addresses primary prevention and evaluation and management; follow-up care is not addressed in the measure set. Two measures in the set are patient-reported outcomes.
7. Program measure set includes considerations for healthcare disparities	One measure in the set is disparities-sensitive.
8. Program measure set promotes parsimony	The measure set addresses many of the MAP Measure Selection Criteria. Additionally, all measures are collected through MDS, a required assessment for home health patients, which reduces reporting burden.

Note: The Nursing Home Quality Initiative and Nursing Home Compare program includes 38 finalized measures; however, only 26 measures are listed in the Table of Current Finalized Measures. Several measures include short-stay and long-stay rates, and for the purposes of reporting, these are considered separate measures.

[1] Centers for Medicare and Medicaid Services. Five-Star Quality Rating System. Available at https://www.cms.gov/CertificationandComplianc/13_FSQRS.asp#TopOfPage. Last accessed October 2011.

Home Health Quality Reporting

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

Medicare-certified[1] home health agencies (HHAs) are required to collect and submit the Outcome Assessment Information Set (OASIS). The OASIS is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.[2] Home health agencies meet their quality data reporting requirements through the submission of OASIS assessments and Home Health CAHPS. HHAs that do not submit data will receive a 2 percentage point reduction in their annual HH market basket percentage increase.

Subsets of the quality measures generated from OASIS are reported on the Home Health Compare website, which provides information about the quality of care provided by HHAs throughout the country.[3] Currently, 23 of the 97 OASIS measures are finalized for public reporting on Home Health Compare.

Care Settings Included:

Medicare-certified home health agencies

Statutory Mandate:

Section 1895(b)(3)(B)(v)(I) of the Social Security Act, as amended by section 5201 of the Deficit Reduction Act, established the requirement that HHAs that do not report quality data would not receive the full market basket payment increase.

Statutory Requirements for Measures:

None.

MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP supported recent attempts to include shared decision-making in Home Health CAHPS and suggested continuing to explore opportunities to assess shared decision-making.

Program Measure Set Evaluation Using MAP Measure Selection Criteria (Initial Staff Assessment):

MAP Measure Selection Criteria	Evaluation
1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review	The majority of measures (80) in the set are not NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy (NQS)	The set addresses all NQS priorities except for

priorities	making care affordable.
3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s)	Seventeen measures in the set address high-impact conditions. Additionally, the measure set addresses all MAP PAC/LTC core concepts except advanced care planning and treatment, shared decision-making, and inappropriate medication use.
4. **Program measure set promotes alignment with specific program attributes as well as alignment across programs**	None of the measures are used in other federal programs. Seven measures are used in private programs.
5. Program measure set includes an appropriate mix of measure types	The set includes process, outcome, and patient experience of care measures. The set does not include structure or cost measures.
6. Program measure set enables measurement across the person-centered episode of care	The measure set addresses all parts of the episode of care: primary prevention, evaluation and initial management, and follow-up care. Additionally, five measures in the set are patient-reported outcome measures.
7. Program measure set includes considerations for healthcare disparities	Two measures in the set are disparities-sensitive.
8. Program measure set promotes parsimony	The measure set address many of the MAP Measure Selection Criteria. Additionally, all measures are collected through OASIS, a required assessment for home health patients, which reduces reporting burden.

[1] "Medicare-certified" means the home health agency is approved by Medicare and meets certain Federal health and safety requirements.
[2] Centers for Medicare and Medicaid Services. Background. June 2011. Available at http://www.cms.gov/OASIS/02_Background.asp#TopOfPage. Last accessed October 2011.

[3] The Official U.S. Government Site for Medicare. Introduction. Available at http://www.medicare.gov/HomeHealthCompare/About/overview.aspx. Last accessed October 2011.

NATIONAL QUALITY FORUM

Core Measure Set: System Level of Analysis

Setting- and level-of analysis-specific core measure sets are drawn from the MAP Families of Measures. These core measure sets may assist in identifying measures that could be added to program measure sets or measures that could replace previously finalized measures in program measure sets. MAP's core measure sets serve as guidance for pre-rulemaking decisions; however, MAP is not restricted to considering only these measures.

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Appropriate testing for children with pharyngitis	0002	Safety	Clinician Office/Clinic, Urgent Care	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004	Duals	Clinician Office/Clinic, Hospital/Acute Care Facility	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
CAHPS Health Plan Survey v 4.0 - Adult questionnaire	0006	Care Coordination, Duals	Clinician Office/Clinic	Health Plan
NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)	0007	Care Coordination, Duals	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)	0008	Care Coordination, Duals	Clinician Office/Clinic	Health Plan
CAHPS Health Plan Survey v 3.0 children with chronic conditions supplement	0009	Care Coordination	Clinician Office/Clinic	Health Plan
Young Adult Health Care Survey (YAHCS)	0010	Care Coordination	Clinician Office/Clinic	County or City, Health Plan, National, Regional, State
Use of High Risk Medications in the Elderly	0022	Safety, Duals	Clinician Office/Clinic, Pharmacy	Health Plan, Integrated Delivery System

Note: The System Core Measure Set includes all measures within the various MAP Families of Measures that are specified for the health plan, integrated delivery system, community, county/city, regional, state, and national levels of analysis.

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Use of Imaging Studies for Low Back Pain	0052	Safety	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058	Safety	Urgent Care, Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Diabetes Measure Pair: A Lipid management: low density lipoprotein cholesterol (LDL-C) <130, B Lipid management: LDL-C <100	0064	Diabetes	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Appropriate treatment for children with upper respiratory infection (URI)	0069	Safety	Urgent Care, Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Medication Reconciliation	0097	Hospice, Duals	Urgent Care, Clinician Office/Clinic	County or City, Group/Practice, Individual, Integrated Delivery System
Risk-Adjusted Operative Mortality for CABG	0119	Cardiovascular	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, National, Regional, State
Risk-Adjusted Operative Mortality MV Replacement + CABG Surgery	0122	Cardiovascular	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, National, Regional, State, Team
National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138	Safety, Cancer	Hospice, Hospital/Acute Care Facility, Inpatient, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	Facility, National, State
National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	0139	Safety, Cancer	Hospice, Hospital/Acute Care Facility, Inpatient, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	Facility, National, State

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Primary PCI received within 90 minutes of Hospital Arrival	0163	Cardiovascular, Care Coordination	Hospital/Acute Care Facility	Facility, National, Regional
Fibrinolytic Therapy received within 30 minutes of hospital arrival	0164	Care Coordination	Hospital/Acute Care Facility	Facility, National, Regional
Increase in number of pressure ulcers	0181	Safety	Home Health	Facility, Other
Family Evaluation of Hospice Care	0208	Care Coordination, Hospice, Cancer	Hospice	Facility, National
Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	0209	Safety, Hospice, Cancer, Duals	Hospice	Facility, National
Proportion receiving chemotherapy in the last 14 days of life	0210	Hospice	Clinician Office/Clinic, Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion with more than one emergency room visit in the last days of life	0211	Care Coordination, Hospice	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion admitted to the ICU in the last 30 days of life	0213	Care Coordination, Hospice	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion not admitted to hospice	0215	Care Coordination	Hospice	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion admitted to hospice for less than 3 days	0216	Care Coordination, Hospice	Hospice	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	0288	Cardiovascular, Care Coordination	Hospital/Acute Care Facility, Urgent Care	Facility, National

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Median Time to ECG	0289	Cardiovascular	Hospital/Acute Care Facility, Urgent Care	Facility, National
Median Time to ECG	0289	Care Coordination	Hospital/Acute Care Facility, Urgent Care	Facility, National
Median Time to Transfer to Another Facility for Acute Coronary Intervention	0290	Care Coordination	Hospital/Acute Care Facility, Urgent Care	Can be measured at all levels, Facility, National
HIV/AIDS: Medical Visit	0403	Care Coordination	Urgent Care, Clinician Office/Clinic	Integrated Delivery System
Documentation of Current Medications in the Medical Record	0419	Safety	Clinician Office/Clinic, Dialysis Facility, Home Health, Nursing Home/Skilled Nursing Facility, Other, Outpatient, Inpatient Rehabilitation Facility	Individual, National
Adult Weight Screening and Follow-Up	0421	Cardiovascular, Diabetes, Duals	All settings	Can be measured at all levels
Thrombolytic Therapy	0437	Cardiovascular	Hospital/Acute Care Facility	Facility, Integrated Delivery System, National
Assessed for Rehabilitation	0441	Cardiovascular	Hospital/Acute Care Facility	Facility, Integrated Delivery System, National
PC-01 Elective Delivery	0469	Safety	Hospital/Acute Care Facility	Facility, National
PC-02 Cesarean Section	0471	Safety	Hospital/Acute Care Facility	Facility, National
Under 1500g infant Not Delivered at Appropriate Level of Care	0477	Safety	Hospital/Acute Care Facility	County or City, Facility, Health Plan, National, Regional, State
Severe Sepsis and Septic Shock: Management Bundle	0500	Safety	Hospital/Acute Care Facility	Facility, Integrated Delivery System
Prophylactic antibiotics discontinued within 24 hours after surgery end time	0529	Safety	Hospital/Acute Care Facility	Can be measured at all levels, Facility, National, Regional
Medication Reconciliation Post-Discharge	0554	Safety	Clinician Office/Clinic	County or City, Health Plan, Integrated Delivery System, National, Regional

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy	0572	Cancer	Clinician Office/Clinic, Other	County or City, Group/Practice, Health Plan, Individual
Comprehensive Diabetes Care: HbA1c control (<8.0%)	0575	Diabetes	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Follow-Up After Hospitalization for Mental Illness	0576	Care Coordination, Duals	Clinician Office/Clinic, Inpatient, Outpatient	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Deep Vein Thrombosis Anticoagulation >= 3 Months	0581	Safety	Clinician Office/Clinic	County or City, Group/Practice, Health Plan, Individual, Integrated Delivery System
Pulmonary Embolism Anticoagulation >= 3 Months	0593	Safety	Clinician Office/Clinic	County or City, Group/Practice, Health Plan, Individual, Integrated Delivery System
Cardiac Rehabilitation Patient Referral From an Inpatient Setting	0642	Cardiovascular	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility	Facility, Group/Practice, Health Plan, Individual, Integrated Delivery System
Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0646	Safety	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System
Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0647	Care Coordination, Duals	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0648	Care Coordination, Hospice, Duals	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System
Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	0649	Care Coordination	Urgent Care, Hospital/Acute Care Facility	Facility, Integrated Delivery System
Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	0669	Cardiovascular	Urgent Care	Facility, National
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	0674	Safety	Nursing Home/Skilled Nursing Facility	Facility, National
Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Discharged Resident Instrument	0691	Care Coordination, Duals	Nursing Home/Skilled Nursing Facility	Facility, National
Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument	0692	Care Coordination, Duals	Nursing Home/Skilled Nursing Facility	Facility, National
The STS CABG Composite Score	0696	Cardiovascular	Hospital/Acute Care Facility	Community, County or City, Facility, Group/Practice, National, Regional, State, Team
30-Day Post-Hospital AMI Discharge Care Transition Composite Measure	0698	Care Coordination	Hospital/Acute Care Facility	National
30-Day Post-Hospital HF Discharge Care Transition Composite Measure	0699	Care Coordination	Hospital/Acute Care Facility	National

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Proportion of Patients Hospitalized with AMI that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	0704	Care Coordination	Hospital/Acute Care Facility	County or City, Facility, Health Plan, National, Regional, State
Proportion of Patients Hospitalized with Stroke that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	0705	Care Coordination	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, National, Regional, State
30-day Post-Hospital PNA (Pneumonia) Discharge Care Transition Composite Measure	0707	Care Coordination	Hospital/Acute Care Facility	National
Proportion of Patients Hospitalized with Pneumonia that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	0708	Care Coordination	Hospital/Acute Care Facility	County or City, Facility, Health Plan, National, Regional, State
Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year.	0709	Cardiovascular, Care Coordination	Clinician Office/Clinic, Other	County or City, Group/Practice, Health Plan, National, Regional, State
Healthy Term Newborn	0716	Safety	Hospital/Acute Care Facility	Facility, Integrated Delivery System, Regional, State, Team
Inpatient Consumer Survey (ICS) consumer evaluation of inpatient behavioral healthcare services	0726	Care Coordination		
Optimal Diabetes Care	0729	Diabetes, Duals	Clinician Office/Clinic	Group/Practice, Integrated Delivery System
Comprehensive Diabetes Care	0731	Diabetes	Clinician Office/Clinic	Group/Practice, Health Plan, Individual
American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753	Safety	Hospital/Acute Care Facility	Facility, National, State
Appropriate Cervical Spine Radiography and CT Imaging in Trauma	0755	Safety	Hospital/Acute Care Facility, Other	Facility, Group/Practice, National, Regional, State

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Asthma Emergency Department Visits	1381	Care Coordination	Hospital/Acute Care Facility	County or City, Health Plan
Risky Behavior Assessment or Counseling by Age 13 Years	1406	Cardiovascular, Diabetes	Clinician Office/Clinic, Outpatient	Group/Practice, Individual, National, Regional, Team
Total Resource Use Population-based PMPM Index	1598	Cardiovascular, Diabetes	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Dialysis Facility, Emergency Medical Services/Ambulance, Home Health, Hospice, Hospital/Acute Care Facility, Imaging Facility, Inpatient, Laboratory, Nursing Home/Skilled Nursing Facility, Outpatient, Pharmacy, Rehabilitation (renamed to "Inpatient Rehabilitation Facility"), Urgent Care	Community, Group/Practice
Total Cost of Care Population-based PMPM Index	1604	Cardiovascular, Diabetes	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Dialysis Facility, Emergency Medical Services/Ambulance, Home Health, Hospice, Hospital/Acute Care Facility, Imaging Facility, Inpatient, Laboratory, Nursing Home/Skilled Nursing Facility, Outpatient, Pharmacy, Rehabilitation (renamed to "Inpatient Rehabilitation Facility"), Urgent Care	Community, Group/Practice
Patients Treated with an Opioid who are Given a Bowel Regimen	1617	Safety, Hospice	Clinician Office/Clinic, Hospital/Acute Care Facility	Community, Group/Practice

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Bereaved Family Survey	1623	Hospice	Hospice, Nursing Home/Skilled Nursing Facility	Facility, National, Regional
Patients Admitted to ICU who Have Care Preferences Documented	1626	Care Coordination, Hospice, Duals	Hospital/Acute Care Facility	Facility, Health Plan, Integrated Delivery System
CARE - Consumer Assessments and Reports of End of Life	1632	Care Coordination, Hospice, Duals	Home Health, Hospice, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Community, Facility, National, Regional
TOB-1 Tobacco Use Screening	1651	Cardiovascular, Diabetes	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient	Facility, National
TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	1654	Cardiovascular, Diabetes	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient	Facility, National
National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	1716	Safety	Behavioral Health/Psychiatric : Inpatient, Dialysis Facility, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, National, State
National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	1717	Safety	Behavioral Health/Psychiatric : Inpatient, Dialysis Facility, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, National, State
Plan All-Cause Readmissions	1768	Care Coordination, Duals	Hospital/Acute Care Facility, Inpatient	Health Plan

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
COPD - Management of Poorly Controlled COPD	1825	Duals	Urgent Care, Clinician Office/Clinic, Home Health, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	County or City, Facility, Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Cultural Competency Implementation Measure	1919	Duals	Urgent Care, Clinician Office/Clinic, Dialysis Facility, Hospice, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Health Plan, Integrated Delivery System
SNP6: coordination of Medicare and Medicaid Coverage	N/A	Duals		Health Plan
Unhealthy Alcohol Use: Screening and Brief Counseling		Duals	Clinician Office/Clinic	

NATIONAL QUALITY FORUM

Core Measure Set: Individual Clinician and Group Levels of Analysis

Setting- and level-of analysis-specific core measure sets are drawn from the MAP Families of Measures. These core measure sets may assist in identifying measures that could be added to program measure sets or measures that could replace previously finalized measures in program measure sets. MAP's core measure sets serve as guidance for pre-rulemaking decisions; however, MAP is not restricted to considering only these measures.

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey	1741	Care Coordination, Duals	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Hospital/Acute Care Facility	Individual, Group/Practice
Appropriate testing for children with pharyngitis	0002	Safety	Clinician Office/Clinic, Urgent Care	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004	Duals	Clinician Office/Clinic, Hospital/Acute Care Facility	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)	0005	Care Coordination, Duals	Clinician Office/Clinic	Individual
NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)	0007	Care Coordination, Duals	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Controlling High Blood Pressure	0018	Cardiovascular, Diabetes	All settings, Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Hospital/Acute Care Facility, Urgent Care, Clinician Office/Clinic	Group/Practice, Individual
Body Mass Index (BMI) 2 through 18 years of age	0024	Cardiovascular, Diabetes	Clinician Office/Clinic	Individual

Note: The Individual Clinician and Group Core Measure Set includes all measures within the various MAP Families of Measures that are specified for the individual and group-practice levels of analysis.

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention	0028	Cardiovascular, Diabetes, Duals	Clinician Office/Clinic	Individual
Use of Imaging Studies for Low Back Pain	0052	Safety	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058	Safety	Urgent Care, Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Diabetes Measure Pair: A Lipid management: low density lipoprotein cholesterol (LDL-C) <130, B Lipid management: LDL-C <100	0064	Diabetes	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy--Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)	0066	Cardiovascular	Assisted Living, Clinician Office/Clinic, Outpatient, Home Health, Urgent Care, Nursing Home/Skilled Nursing Facility, Clinician Office/Clinic	Group/Practice, Individual
Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic	0068	Cardiovascular	All settings, Clinician Office/Clinic	Group/Practice, Individual
Appropriate treatment for children with upper respiratory infection (URI)	0069	Safety	Urgent Care, Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Chronic Stable Coronary Artery Disease: Beta-Blocker Therapy--Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)	0070	Cardiovascular	Assisted Living, Clinician Office/Clinic, Outpatient, Home Health, Urgent Care, Nursing Home/Skilled Nursing Facility, Clinician Office/Clinic	Group/Practice, Individual
IVD: Complete Lipid Profile and LDL Control <100	0075	Cardiovascular	All settings, Clinician Office/Clinic	Group/Practice, Individual

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	0081	Cardiovascular	Assisted Living, Clinician Office/Clinic, Outpatient, Home Health, Hospital/Acute Care Facility, Urgent Care, Nursing Home/Skilled Nursing Facility, Clinician Office/Clinic	Group/Practice, Individual
Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction	0083	Cardiovascular	Urgent Care, Clinician Office/Clinic, Home Health, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Facility, Group/Practice, Individual
Medication Reconciliation	0097	Hospice, Duals	Urgent Care, Clinician Office/Clinic	County or City, Group/Practice, Individual, Integrated Delivery System
Falls: Screening for Fall Risk	0101	Duals	Clinician Office/Clinic	Individual
Risk-Adjusted Operative Mortality for CABG	0119	Cardiovascular	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, National, Regional, State
Risk-Adjusted Operative Mortality MV Replacement + CABG Surgery	0122	Cardiovascular	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, National, Regional, State, Team
Patient Fall Rate	0141	Safety	Hospital/Acute Care Facility	Group/Practice
Pressure ulcer prevalence (hospital acquired)	0201	Safety	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	Facility, Team
Falls with injury	0202	Safety	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility	Team

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Proportion receiving chemotherapy in the last 14 days of life	0210	Hospice	Clinician Office/Clinic, Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion with more than one emergency room visit in the last days of life	0211	Care Coordination, Hospice	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion admitted to the ICU in the last 30 days of life	0213	Care Coordination, Hospice	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion not admitted to hospice	0215	Care Coordination	Hospice	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion admitted to hospice for less than 3 days	0216	Care Coordination, Hospice	Hospice	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge	0241	Cardiovascular	Hospital/Acute Care Facility	Individual
Patient Fall	0266	Safety	Ambulatory Surgery Center, Hospital/Acute Care Facility	Individual
Median Time to Transfer to Another Facility for Acute Coronary Intervention	0290	Care Coordination	Hospital/Acute Care Facility, Urgent Care	Can be measured at all levels, Facility, National
LBP: Surgical Timing	0305	Safety	Clinician Office/Clinic	Group/Practice, Individual
LBP: Appropriate Use of Epidural Steroid Injections	0309	Safety	Clinician Office/Clinic	Group/Practice, Individual
LBP: Shared Decision Making	0310	Care Coordination	Clinician Office/Clinic	Group/Practice, Individual

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Advance Care Plan	0326	Care Coordination, Hospice, Duals	Ambulatory Surgery Center (ASC), Clinic/Urgent Care (renamed to "Urgent Care"), Clinician Office (renamed to "Clinician Office/Clinic"), Home Health, Hospice, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation (renamed to "Inpatient Rehabilitation Facility")	Individual
Multiple Myeloma – Treatment with Bisphosphonates	0380	Cancer	Urgent Care, Clinician Office/Clinic	Group/Practice, Individual, Team
Oncology: Radiation Dose Limits to Normal Tissues	0382	Cancer	Clinician Office/Clinic, Other	Group/Practice, Individual, Team
Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0383	Hospice, Cancer	Clinician Office/Clinic, Other	Group/Practice, Individual, Team
Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)	0384	Hospice, Cancer	Clinician Office/Clinic, Other	Group/Practice, Individual, Team
Oncology: Cancer Stage Documented	0386	Cancer	Clinician Office/Clinic, Other	Group/Practice, Individual, Team
Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients	0389	Cancer	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Other	Group/Practice, Individual, Team
Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients	0390	Cancer	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Other	Group/Practice, Individual, Team
Screening for Clinical Depression	0418	Duals	Clinician Office/Clinic, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Individual

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Documentation of Current Medications in the Medical Record	0419	Safety	Clinician Office/Clinic, Dialysis Facility, Home Health, Nursing Home/Skilled Nursing Facility, Other, Outpatient, Inpatient Rehabilitation Facility	Individual, National
Adult Weight Screening and Follow-Up	0421	Cardiovascular, Diabetes, Duals	All settings	Can be measured at all levels
Change in Daily Activity Function as Measured by the AM-PAC:	0430	Duals	Clinician Office/Clinic, Home Health, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Facility, Individual
Adoption of Medication e-Prescribing	0486	Safety	Clinician Office/Clinic, Other	Group/Practice, Individual
Prophylactic antibiotics discontinued within 24 hours after surgery end time	0529	Safety	Hospital/Acute Care Facility	Can be measured at all levels, Facility, National, Regional
Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy	0572	Cancer	Clinician Office/Clinic, Other	County or City, Group/Practice, Health Plan, Individual
Comprehensive Diabetes Care: HbA1c control (<8.0%)	0575	Diabetes	Clinician Office/Clinic	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Follow-Up After Hospitalization for Mental Illness	0576	Care Coordination, Duals	Clinician Office/Clinic, Inpatient, Outpatient	Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Deep Vein Thrombosis Anticoagulation >= 3 Months	0581	Safety	Clinician Office/Clinic	County or City, Group/Practice, Health Plan, Individual, Integrated Delivery System

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Pulmonary Embolism Anticoagulation >= 3 Months	0593	Safety	Clinician Office/Clinic	County or City, Group/Practice, Health Plan, Individual, Integrated Delivery System
Cardiac Rehabilitation Patient Referral From an Inpatient Setting	0642	Cardiovascular	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility	Facility, Group/Practice, Health Plan, Individual, Integrated Delivery System
Otitis Media with Effusion: Systemic corticosteroids – Avoidance of inappropriate use	0656	Safety	Urgent Care, Clinician Office/Clinic	Group/Practice, Individual, Team
Otitis Media with Effusion: Systemic antimicrobials – Avoidance of inappropriate use	0657	Safety	Ambulatory Surgery Center (ASC), Urgent Care, Clinician Office/Clinic	Group/Practice, Individual, Team
Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	0659	Safety	Ambulatory Surgery Center (ASC), Urgent Care, Clinician Office/Clinic, Hospital/Acute Care Facility	Group/Practice, Individual, Team
Inappropriate Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism	0667	Safety	Hospital/Acute Care Facility, Other	Facility, Group/Practice
Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury	0668	Safety	Hospital/Acute Care Facility, Other	Facility, Group/Practice
The STS CABG Composite Score	0696	Cardiovascular	Hospital/Acute Care Facility	Community, County or City, Facility, Group/Practice, National, Regional, State, Team
Proportion of Patients Hospitalized with Stroke that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	0705	Care Coordination	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, National, Regional, State
Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year.	0709	Cardiovascular, Care Coordination	Clinician Office/Clinic, Other	County or City, Group/Practice, Health Plan, National, Regional, State

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Healthy Term Newborn	0716	Safety	Hospital/Acute Care Facility	Facility, Integrated Delivery System, Regional, State, Team
Inpatient Consumer Survey (ICS) consumer evaluation of inpatient behavioral healthcare services	0726	Care Coordination		
Optimal Diabetes Care	0729	Diabetes, Duals	Clinician Office/Clinic	Group/Practice, Integrated Delivery System
Comprehensive Diabetes Care	0731	Diabetes	Clinician Office/Clinic	Group/Practice, Health Plan, Individual
Appropriate Cervical Spine Radiography and CT Imaging in Trauma	0755	Safety	Hospital/Acute Care Facility, Other	Facility, Group/Practice, National,Regional, State
Risky Behavior Assessment or Counseling by Age 13 Years	1406	Cardiovascular, Diabetes	Clinician Office/Clinic, Outpatient	Group/Practice, Individual, National, Regional, Team
Chronic Anticoagulation Therapy	1525	Cardiovascular	Clinician Office/Clinic	Individual
Total Resource Use Population-based PMPM Index	1598	Cardiovascular, Diabetes	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Dialysis Facility, Emergency Medical Services/Ambulance, Home Health, Hospice, Hospital/Acute Care Facility, Imaging Facility, Inpatient, Laboratory, Nursing Home/Skilled Nursing Facility, Outpatient, Pharmacy, Rehabilitation (renamed to "Inpatient Rehabilitation Facility"), Urgent Care	Community, Group/Practice

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Total Cost of Care Population-based PMPM Index	1604	Cardiovascular, Diabetes	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Dialysis Facility, Emergency Medical Services/Ambulance, Home Health, Hospice, Hospital/Acute Care Facility, Imaging Facility, Inpatient, Laboratory, Nursing Home/Skilled Nursing Facility, Outpatient, Pharmacy, Rehabilitation (renamed to "Inpatient Rehabilitation Facility"), Urgent Care	Community, Group/Practice
Patients Treated with an Opioid who are Given a Bowel Regimen	1617	Safety, Hospice	Clinician Office/Clinic, Hospital/Acute Care Facility	Community, Group/Practice
Hospice and Palliative Care -- Pain Screening	1634	Safety, Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care -- Pain Assessment	1637	Safety, Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care -- Dyspnea Treatment	1638	Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care -- Dyspnea Screening	1639	Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care – Treatment Preferences	1641	Hospice, Duals	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
COPD - Management of Poorly Controlled COPD	1825	Duals	Urgent Care, Clinician Office/Clinic, Home Health, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	County or City, Facility, Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	1902	Duals	Clinician Office/Clinic, Urgent Care	Group/Practice, Individual
Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	1904	Duals	Clinician Office/Clinic, Urgent Care	Group/Practice, Individual
Medical Home System Survey (MHSS)	1909	Care Coordination, Duals	Clinician Office/Clinic	Group/Practice, Individual, Team
OP-25 Safe Surgery Checklist	N/A	Safety	Hospital/Acute Care Facility	
Unhealthy Alcohol Use: Screening and Brief Counseling		Duals	Clinician Office/Clinic	

NATIONAL QUALITY FORUM

Core Measure Set: Hospital Care Setting and Facility Level of Analysis

Setting- and level-of analysis-specific core measure sets are drawn from the MAP Families of Measures. These core measure sets may assist in identifying measures that could be added to program measure sets or measures that could replace previously finalized measures in program measure sets. MAP's core measure sets serve as guidance for pre-rulemaking decisions; however, MAP is not restricted to considering only these measures.

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
TOB-1 Tobacco Use Screening	1651	Cardiovascular, Diabetes	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient	Facility, National
TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	1654	Cardiovascular, Diabetes	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient	Facility, National
Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction	0083	Cardiovascular	Urgent Care, Clinician Office/Clinic, Home Health, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Facility, Group/Practice, Individual
Risk-Adjusted Operative Mortality for CABG	0119	Cardiovascular	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, National, Regional, State
Risk-Adjusted Operative Mortality MV Replacement + CABG Surgery	0122	Cardiovascular	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, National, Regional, State, Team
National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138	Safety, Cancer	Hospice, Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	Facility, National, State
National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	0139	Safety, Cancer	Hospice, Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	Facility, National, State

Note: The Hospital Core Measure Set includes all measures within the various MAP Families of Measures that are specified for the hospital or ambulatory surgery setting and facility or team levels of analysis.

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Primary PCI received within 90 minutes of Hospital Arrival	0163	Cardiovascular, Care Coordination	Hospital/Acute Care Facility	Facility, National, Regional
Fibrinolytic Therapy received within 30 minutes of hospital arrival	0164	Care Coordination	Hospital/Acute Care Facility	Facility, National, Regional
HCAHPS	0166	Care Coordination	Hospital/Acute Care Facility	Facility
Pressure ulcer prevalence (hospital acquired)	0201	Safety	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	Facility, Team
Falls with injury	0202	Safety	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility	Team
Proportion receiving chemotherapy in the last 14 days of life	0210	Hospice	Clinician Office/Clinic, Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion with more than one emergency room visit in the last days of life	0211	Care Coordination, Hospice	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion admitted to the ICU in the last 30 days of life	0213	Care Coordination, Hospice	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Post breast conserving surgery irradiation	0219	Cancer	Hospital/Acute Care Facility	Facility
Adjuvant hormonal therapy	0220	Cancer	Hospital/Acute Care Facility	Facility

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection	0221	Cancer	Hospital/Acute Care Facility	Facility
Patients with early stage breast cancer who have evaluation of the axilla	0222	Cancer	Hospital/Acute Care Facility	Facility
Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	0223	Cancer	Hospital/Acute Care Facility	Facility
Completeness of pathology reporting	0224	Cancer	Hospital/Acute Care Facility	Facility
At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer	0225	Cancer	Hospital/Acute Care Facility	Facility
3-Item Care Transition Measure (CTM-3)	0228	Care Coordination, Duals	Hospital/Acute Care Facility	Facility
Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older	0229	Cardiovascular	Hospital/Acute Care Facility	Facility
Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older	0230	Cardiovascular	Hospital/Acute Care Facility	Facility
Patient Burn	0263	Safety	Ambulatory Surgery Center (ASC)	Facility
Hospital Transfer/Admission	0265	Care Coordination	Ambulatory Surgery Center (ASC)	Facility
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	0267	Safety	Ambulatory Surgery Center (ASC)	Facility

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Median to Fibrinolysis	0287	Cardiovascular, Care Coordination	Hospital/Acute Care Facility	Facility
Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	0288	Cardiovascular, Care Coordination	Hospital/Acute Care Facility, Urgent Care	Facility, National
Median Time to ECG	0289	Cardiovascular	Hospital/Acute Care Facility, Urgent Care	Facility, National
Median Time to ECG	0289	Care Coordination	Hospital/Acute Care Facility, Urgent Care	Facility, National
Median Time to Transfer to Another Facility for Acute Coronary Intervention	0290	Care Coordination	Hospital/Acute Care Facility, Urgent Care	Can be measured at all levels, Facility, National
Administrative Communication	0291	Care Coordination	Hospital/Acute Care Facility	Facility
Medication Information	0293	Safety	Hospital/Acute Care Facility	Facility
Patient Information	0294	Care Coordination	Hospital/Acute Care Facility	Facility
Physician Information	0295	Care Coordination	Hospital/Acute Care Facility	Facility
Nursing Information	0296	Care Coordination	Hospital/Acute Care Facility	Facility
Procedures and Tests	0297	Care Coordination	Hospital/Acute Care Facility	Facility
Late sepsis or meningitis in Very Low Birth Weight (VLBW) neonates (risk-adjusted)	0304	Safety	Hospital/Acute Care Facility	Facility
PICU Unplanned Readmission Rate	0335	Care Coordination	Hospital/Acute Care Facility	Facility
Accidental Puncture or Laceration Rate (PDI 1)	0344	Safety	Hospital/Acute Care Facility	Facility
Accidental Puncture or Laceration Rate (PSI 15)	0345	Safety	Hospital/Acute Care Facility	Facility
Death among surgical inpatients with serious, treatable complications (PSI 4)	0351	Safety	Hospital/Acute Care Facility	Facility

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Bilateral Cardiac Catheterization Rate (IQI 25)	0355	Cardiovascular	Hospital/Acute Care Facility	Facility
Foreign Body left after procedure (PDI 3)	0362	Safety	Hospital/Acute Care Facility	Facility
Foreign Body Left During Procedure (PSI 5)	0363	Safety	Hospital/Acute Care Facility	Facility
Incidence of Potentially Preventable VTE	0376	Safety	Hospital/Acute Care Facility	Facility
Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients	0389	Cancer	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Other	Group/Practice, Individual, Team
Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients	0390	Cancer	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Other	Group/Practice, Individual, Team
Adult Weight Screening and Follow-Up	0421	Cardiovascular, Diabetes, Duals	All settings	Can be measured at all levels
Change in Daily Activity Function as Measured by the AM-PAC:	0430	Duals	Clinician Office/Clinic, Home Health, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Facility, Individual
INFLUENZA VACCINATION COVERAGE AMONG HEALTHCARE PERSONNEL	0431	Safety	Ambulatory Surgery Center (ASC), Urgent Care, Clinician Office/Clinic, Dialysis Facility, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Facility
Thrombolytic Therapy	0437	Cardiovascular	Hospital/Acute Care Facility	Facility, Integrated Delivery System, National
Assessed for Rehabilitation	0441	Cardiovascular	Hospital/Acute Care Facility	Facility, Integrated Delivery System, National
Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate (PSI 12)	0450	Safety	Hospital/Acute Care Facility	Facility
Risk-Adjusted Morbidity: Length of Stay >14 Days After Elective Lobectomy for Lung Cancer	0459	Cancer	Hospital/Acute Care Facility	Facility
PC-01 Elective Delivery	0469	Safety	Hospital/Acute Care Facility	Facility, National

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
PC-02 Cesarean Section	0471	Safety	Hospital/Acute Care Facility	Facility, National
Under 1500g infant Not Delivered at Appropriate Level of Care	0477	Safety	Hospital/Acute Care Facility	County or City, Facility, Health Plan, National, Regional, State
Severe Sepsis and Septic Shock: Management Bundle	0500	Safety	Hospital/Acute Care Facility	Facility, Integrated Delivery System
Prophylactic antibiotics discontinued within 24 hours after surgery end time	0529	Safety	Hospital/Acute Care Facility	Can be measured at all levels, Facility, National, Regional
30-day all-cause risk-standardized mortality rate following percutaneous coronary intervention (PCI) for patients without ST segment elevation myocardial infarction (STEMI) and without cardiogenic shock	0535	Cardiovascular	Hospital/Acute Care Facility	Facility
30-day all-cause risk-standardized mortality rate following Percutaneous Coronary Intervention (PCI) for patients with ST segment elevation myocardial infarction (STEMI) or cardiogenic shock	0536	Cardiovascular	Hospital/Acute Care Facility	Facility
HBIPS-6 Post discharge continuing care plan created	0557	Care Coordination, Duals	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient	Facility
HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	0558	Care Coordination, Duals	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient	Facility

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer.	0559	Cancer	Hospital/Acute Care Facility	Facility
Cardiac Rehabilitation Patient Referral From an Inpatient Setting	0642	Cardiovascular	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility	Facility, Group/Practice, Health Plan, Individual, Integrated Delivery System
Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0646	Safety	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System
Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0647	Care Coordination, Duals	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System
Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0648	Care Coordination, Hospice, Duals	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System
Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	0649	Care Coordination	Urgent Care, Hospital/Acute Care Facility	Facility, Integrated Delivery System
Otitis Media with Effusion: Systemic antimicrobials – Avoidance of inappropriate use	0657	Safety	Ambulatory Surgery Center (ASC), Urgent Care, Clinician Office/Clinic	Group/Practice, Individual, Team

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	0659	Safety	Ambulatory Surgery Center (ASC), Urgent Care, Clinician Office/Clinic, Hospital/Acute Care Facility	Group/Practice, Individual, Team
Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival.	0661	Cardiovascular, Care Coordination	Clinician Office/Clinic, Hospital/Acute Care Facility	Facility
Inappropriate Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism	0667	Safety	Hospital/Acute Care Facility, Other	Facility, Group/Practice
Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury	0668	Safety	Hospital/Acute Care Facility, Other	Facility, Group/Practice
The STS CABG Composite Score	0696	Cardiovascular	Hospital/Acute Care Facility	Community, County or City, Facility, Group/Practice, National, Regional, State, Team
Proportion of Patients Hospitalized with AMI that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	0704	Care Coordination	Hospital/Acute Care Facility	County or City, Facility, Health Plan, National, Regional, State
Proportion of Patients Hospitalized with Stroke that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	0705	Care Coordination	Hospital/Acute Care Facility	County or City, Facility, Group/Practice, Health Plan, National, Regional, State
Proportion of Patients Hospitalized with Pneumonia that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	0708	Care Coordination	Hospital/Acute Care Facility	County or City, Facility, Health Plan, National, Regional, State

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Healthy Term Newborn	0716	Safety	Hospital/Acute Care Facility	Facility, Integrated Delivery System, Regional, State, Team
Validated family-centered survey questionnaire for parents' and patients' experiences during inpatient pediatric hospital stay	0725	Care Coordination	Hospital/Acute Care Facility	Facility
Inpatient Consumer Survey (ICS) consumer evaluation of inpatient behavioral healthcare services	0726	Care Coordination		
American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753	Safety	Hospital/Acute Care Facility	Facility, National, State
Appropriate Cervical Spine Radiography and CT Imaging in Trauma	0755	Safety	Hospital/Acute Care Facility, Other	Facility, Group/Practice, National, Regional, State
Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated	1625	Hospice	Hospital/Acute Care Facility	Facility
Patients Admitted to ICU who Have Care Preferences Documented	1626	Care Coordination, Hospice, Duals	Hospital/Acute Care Facility	Facility, Health Plan, Integrated Delivery System
CARE - Consumer Assessments and Reports of End of Life	1632	Care Coordination, Hospice, Duals	Home Health, Hospice, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Community, Facility, National, Regional
Hospice and Palliative Care -- Pain Screening	1634	Safety, Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care -- Pain Assessment	1637	Safety, Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care -- Dyspnea Treatment	1638	Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice

Measure Title	NQF#	MAP Family	Care Setting	Level of Analysis
Hospice and Palliative Care -- Dyspnea Screening	1639	Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care – Treatment Preferences	1641	Hospice, Duals	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	1716	Safety	Behavioral Health/Psychiatric : Inpatient, Dialysis Facility, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, National, State
National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	1717	Safety	Behavioral Health/Psychiatric : Inpatient, Dialysis Facility, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, National, State
Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	1789	Care Coordination, Duals	Hospital/Acute Care Facility	Facility
Cross-cultural communication domain of the Communication Climate Assessment Toolkit	1894	Hospice	Urgent Care, Clinician Office/Clinic, Hospital/Acute Care Facility	Facility
Health Literacy domain of Communication Climate Assessment Toolkit	1898	Hospice	Urgent Care, Clinician Office/Clinic, Hospital/Acute Care Facility	Facility
Cultural Competency Implementation Measure	1919	Duals	Urgent Care, Clinician Office/Clinic, Dialysis Facility, Hospice, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Health Plan, Integrated Delivery System
OP-25 Safe Surgery Checklist	N/A	Safety	Hospital/Acute Care Facility	

NATIONAL QUALITY FORUM

PAC/LTC Core Concepts

MAP developed a set of 13 core measure concepts that should be used to assess care across all PAC/LTC programs, particularly inpatient rehabilitation facilities, long-term care hospitals, nursing homes, and home health agencies. In reviewing existing measures utilized across post-acute and long-term care programs, MAP employed the NQS priorities as a roadmap to identify the six highest-leverage areas for measurement: function, goal attainment, patient and family engagement, care coordination, safety and cost/access. Within these areas, priority measure concepts identified are specific, yet flexible to allow for customization to address the unique care needs within each PAC/LTC program.

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts
Function	• Functional and cognitive status assessment • Mental Health
Goal Attainment	• Establishment of patient/family/caregiver goals • Advanced care planning and treatment
Patient Engagement	• Experience of care • Shared decision making
Care Coordination	• Transition planning
Safety	• Falls • Pressure ulcers • Adverse drug events
Cost/Access	• Inappropriate medicine use • Infection rates • Avoidable admissions

Core Measure Set: PAC/LTC Care Settings and Facility Level of Analysis

Setting- and level-of analysis-specific core measure sets are drawn from the MAP Families of Measures. These core measure sets may assist in identifying measures that could be added to program measure sets or measures that could replace previously finalized measures in program measure sets. MAP's core measure sets serve as guidance for pre-rulemaking decisions; however, MAP is not restricted to considering only these measures.

Measure Title	NQF #	MAP Family	Care Setting	Level of Analysis
Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction	083	Cardiovascular	Urgent Care, Clinician Office/Clinic, Home Health, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Facility, Group/Practice, Individual

Note: The PAC/LTC Core Measure set includes all measures within the various MAP Families of Measures that are specified for PAC/LTC care settings and the facility level of analysis. PAC/LTC care settings include: assisted living, home health, behavioral health outpatient, nursing home/skilled nursing facility, hospice, behavioral health inpatient, long term acute care hospital, inpatient rehabilitation facility, and dialysis facility.

Measure Title	NQF #	MAP Family	Care Setting	Level of Analysis
National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138	Safety, Cancer	Hospice, Hospital/Acute Care Facility,Behavioral Health/Psychiatric : Inpatient, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	Facility, National, State
National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	0139	Safety, Cancer	Hospice, Hospital/Acute Care Facility, Behavioral Health/Psychiatric: Inpatient, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	Facility, National, State
Acute care hospitalization (risk-adjusted)	0171	Care Coordination, Hospice	Home Health	Facility
Emergency Department Use without Hospitalization	0173	Care Coordination, Hospice	Home Health	Facility
Improvement in management of oral medications	0176	Safety	Home Health	Facility
Improvement in pain interfering with activity	0177	Safety	Home Health	Facility
Improvement in dyspnea	0179	Hospice	Home Health	Facility
Increase in number of pressure ulcers	0181	Safety	Home Health	Facility, Other
Pressure ulcer prevalence (hospital acquired)	0201	Safety	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility	Facility, Team
Family Evaluation of Hospice Care	0208	Care Coordination, Hospice, Cancer	Hospice	Facility, National
Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	0209	Safety, Cancer, Duals, Hospice	Hospice	Facility, National

Measure Title	NQF #	MAP Family	Care Setting	Level of Analysis
Proportion not admitted to hospice	0215	Care Coordination	Hospice	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
Proportion admitted to hospice for less than 3 days	0216	Hospice	Hospice	County or City, Facility, Group/Practice, Health Plan, Integrated Delivery System, National, Regional, State
3-Item Care Transition Measure (CTM-3)	0228	Care Coordination, Duals	Hospital/Acute Care Facility	Facility
CAHPS In-Center Hemodialysis Survey	0258	Care Coordination, Duals	Dialysis Facility	Facility
Assessment of Health-related Quality of Life (Physical & Mental Functioning)	0260	Duals	Dialysis Facility	Facility
Adult Weight Screening and Follow-Up	0421	Cardiovascular, Diabetes, Duals	All settings	Can be measured at all levels
Change in Daily Activity Function as Measured by the AM-PAC:	0430	Duals	Clinician Office/Clinic, Home Health, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Facility, Individual
Influenza Vaccination Coverage Among Healthcare Personnel	0431	Safety	Ambulatory Surgery Center (ASC), Urgent Care, Clinician Office/Clinic, Dialysis Facility, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Facility
CAHPS® Home Health Care Survey	0517	Care Coordination, Duals	Home Health	Facility
Depression Assessment Conducted	0518	Hospice	Home Health	Facility

Measure Title	NQF #	MAP Family	Care Setting	Level of Analysis
Timely Initiation of Care	0526	Care Coordination	Home Health	Facility
HBIPS-6 Post discharge continuing care plan created	0557	Duals, Care Coordination	Hospital/Acute Care Facility, Inpatient	Facility
HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	0558	Duals, Care Coordination	Hospital/Acute Care Facility, Inpatient	Facility
Cardiac Rehabilitation Patient Referral From an Inpatient Setting	0642	Cardiovascular	Hospital/Acute Care Facility, Inpatient Rehabilitation Facility	Facility, Group/Practice, Health Plan, Individual, Integrated Delivery System
Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0646	Safety	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System
Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0647	Care Coordination, Duals	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System
Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0648	Care Coordination, Duals, Hospice	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Integrated Delivery System
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	0674	Safety	Nursing Home/Skilled Nursing Facility	Facility, National

Measure Title	NQF #	MAP Family	Care Setting	Level of Analysis
Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Discharged Resident Instrument	0691	Care Coordination	Nursing Home/Skilled Nursing Facility	Facility
Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument	0692	Care Coordination	Nursing Home/Skilled Nursing Facility	Facility
Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Family Member Instrument	0693	Care Coordination	Nursing Home/Skilled Nursing Facility	Facility
Bereaved Family Survey	1623	Hospice	Hospice, Nursing Home/Skilled Nursing Facility	Facility, National, Regional
Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated	1625	Hospice	Hospital/Acute Care Facility	Facility
CARE - Consumer Assessments and Reports of End of Life	1632	Care Coordination, Hospice	Home Health, Hospice, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility	Community, Facility, National, Regional
Hospice and Palliative Care -- Pain Screening	1634	Safety, Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care -- Pain Screening	1634	Safety	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care -- Pain Assessment	1637	Hospice, Safety	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care -- Dyspnea Treatment	1638	Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care -- Dyspnea Screening	1639	Hospice	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice
Hospice and Palliative Care – Treatment Preferences	1641	Hospice, Duals	Hospice, Hospital/Acute Care Facility	Facility, Group/Practice

Measure Title	NQF #	MAP Family	Care Setting	Level of Analysis
Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.	1647	Hospice	Hospice	Facility
TOB-1 Tobacco Use Screening	1651	Cardiovascular, Diabetes	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient	Facility, National
TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	1654	Cardiovascular, Diabetes	Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Inpatient	Facility, National
National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	1716	Safety	Behavioral Health/Psychiatric : Inpatient, Dialysis Facility, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, National, State
National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	1717	Safety	Behavioral Health/Psychiatric : Inpatient, Dialysis Facility, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, National, State
COPD - Management of Poorly Controlled COPD	1825	Duals	Urgent Care, Clinician Office/Clinic, Home Health, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	County or City, Facility, Group/Practice, Health Plan, Individual, Integrated Delivery System, National, Regional, State
Cultural Competency Implementation Measure	1919	Duals	Urgent Care, Clinician Office/Clinic, Dialysis Facility, Hospice, Hospital/Acute Care Facility, Nursing Home/Skilled Nursing Facility, Inpatient Rehabilitation Facility	Facility, Health Plan, Integrated Delivery System