MEASURE APPLICATIONS PARTNERSHIP

MAP 2015 Considerations for Selection of Measures for Federal Programs: Hospitals

FINAL REPORT

FEBRUARY 2015

NATIONAL QUALITY FORUM

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I Task Order HHSM-500-T0002.

CONTENTS

GUIDANCE ON CROSS-CUTTING ISSUES

Summary

- High value measures help consumers get the information that they need to make informed decisions about their healthcare, and drive significant improvements in the quality and efficiency of care.
- A parsimonious set of high value measures allows providers to focus on high priority aspects of healthcare where performance varies or is less than optimal overall.
- MAP stressed the importance of aligning measures across programs by focusing on comparable performance across settings and data types.

The Measure Applications Partnership (MAP) reviewed measures under consideration for nine hospital and setting-specific programs:

- Hospital Inpatient Quality Reporting (IQR)
- Hospital Value-Based Purchasing (VBP)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital-Acquired Condition Reduction Program (HAC)
- Hospital Outpatient Quality Reporting (OQR)
- Ambulatory Surgical Center Quality Reporting (ASCQR)
- Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs) (Meaningful Use)
- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR)
- Inpatient Psychiatric Facility Quality Reporting (IPFQR)

MAP's pre-rulemaking recommendations for measures in these programs reflect the MAP Measure Selection Criteria, how well the measures address the identified program goals, and NQF's prior work to identify families of measures. Through the discussion of the individual measures across the nine programs, MAP identified several overarching issues. These overarching issues include: (1) the need for high value measures, and (2) the need to increase alignment across programs by focusing on comparable performance across settings and data types. These themes are explored in more detail below.

OVERARCHING THEMES

High Value Measures

In its review of the nine hospital and setting-specific programs, MAP encouraged the use of high value performance measures that are meaningful to consumers and will drive significant improvements in the quality and efficiency of care. The programs should include measures that help consumers get the information that they need to make informed decisions about their healthcare, and help to direct them to facilities with the highest quality care. By working toward a parsimonious set of high value measures, within and across the nine programs, MAP noted that facilities can focus on high priority aspects of healthcare where performance varies or is less than optimal overall. This focus on a parsimonious set of high value measures can also help to reduce measurement burden from data collection and reporting of performance measures.

MAP developed a set of critical objectives for each program in order to guide its deliberation on the measures under consideration and to ensure it is recommending the implementation of high value measures. These objectives, along with the MAP Measure Selection Criteria, were meant to serve as a framework for evaluating potential measures under consideration for use in hospital and setting-specific programs. MAP stressed the need to recommend measures under consideration that meet the critical objectives for each program.

While MAP did not review finalized measures currently used in the program this year, it emphasized that MAP's decisions on measures under consideration must be made in context of measures that currently exist in the program. MAP noted that it should support measures that add value to the current set and work with existing measures to improve crucial quality issues for each setting. MAP also recognized that the value of a measure should be assessed while considering the alignment and burden of the full measure set, further emphasizing the need for parsimony. MAP also underscored the need to consider that a gap may be created when a measure is removed from a program. Thus, measure sets should be consistently reassessed to ensure they include the necessary high value measures that address crucial quality issues and get consumers the information they need.

Public commenters supported MAP's call for the inclusion of high value measures in the program measure sets and agreed with MAP's conclusion that high value measures can help reduce the burden of measurement. Commenters also noted that measures must be informative to consumers and be actionable to providers in order to be effective. However, commenters also cautioned measure implementers within HHS that these measures should include appropriate scientific testing to ensure that they accurately characterize provider performance and do not result in unintended consequences for patients or providers.

Alignment Across Programs

MAP stressed the importance of alignment across programs by focusing on comparable performance across settings, data types, and increased alignment of measure elements. MAP cautioned that the evolution of these programs calls for new areas of increased attention. Specifically, MAP raised a number of alignment challenges, including the unique program objectives of individual programs, updating of existing measure specifications, and balancing shared accountability with appropriate attribution.

Settings

Care for particular conditions can be provided in settings covered by different programs, thus making it difficult to compare providers across settings if measures are not aligned. For example, cancer care can be provided in either a general acute care hospital or a PPS-exempt cancer facility; therefore, it is important to align measures between Hospital Inpatient Quality Reporting program and the Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting program. MAP also noted that healthcare traditionally provided in one particular care setting is now increasingly being provided in multiple care settings. For example, in some communities inpatient care is shifting to outpatient and ambulatory care settings. When possible, MAP encouraged that similar measures should be used across settings and programs to allow quality comparisons between setting types.

MAP encouraged HHS to expand programs, such as Hospital Inpatient Quality Reporting program and Hospital Outpatient Quality Reporting program, to allow small and rural hospitals to report measures and close "reporting gaps" across the healthcare system. Including small and rural hospitals in these programs will help to align measures and provide consumers with comparable data across care settings.

Public commenters supported MAP's recommendation to include all hospital providers, including rural and small providers in quality measurement programs. Commenters noted that including these providers would enable consumers and clinicians to compare quality across hospitals.

Data Types

Alignment of measure results across data types is important as well. CMS allows providers to report performance on measures with multiple data types such as measures generated from administrative or claims based data or from the use of electronic clinical data systems. MAP noted that it is important that measures generate reliable and valid results from these multiple data types. MAP noted that increased attention and transparency is needed on the level of specifications standardization for related measures that can be expected across data types.

Measure Elements

In addition to using similar measures across settings, alignment of measurement elements should be considered. MAP noted that alignment of reporting periods and timelines across settings will help to ensure that consumers will have access to data on quality performance across settings when making decisions about where to seek care. Better alignment of the measure elements would also reduce the burden on providers to participate in these programs.

Challenges

Differing Program Objectives

MAP raised a number of challenges around the concept of alignment of measures across programs. First, MAP discussed that there may be different considerations for measures used for specific programs given the unique program objectives. For example, a specific program may be interested in having providers gain experience with public reporting of data such as the Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting program, while other programs may be interested in facilitating information exchange between institutions and increasing the longitudinal tracking of care, such as the Meaningful Use program. These different program objectives may drive the need for unique measures. MAP also noted the need to balance aligning measures and incentives to focus attention on a quality issue while recognizing the potential to penalize a provider multiple times for the same measure result.

MAP also discussed if there is potentially a need for a higher level of reliability and validity for measures used in different types of programs—payment programs, in particular. However, MAP also cautioned that some stakeholders do not

agree that there is a difference in the level of accountability derived from public reporting or payment programs. These stakeholders believe that both applications are equally important and thus require equally valid and reliable measures. MAP members encouraged NQF to consider a potential path forward on how the current NQF endorsement process would consider the issue of use for particular program types, specifically, quality improvement, public reporting, payment, and others. This guidance from the NQF endorsement process would assist MAP in recommendations of specific measures for individual programs and may provide insight on how measures may be applied for different program types.

Updating of Existing Measure Specifications

Given the evolution of the programs as well as the MAP process to evaluate measures under consideration, MAP discussed the challenges to updating an existing measure in any of the HHS programs. MAP encouraged updating measures based on changing evidence and improved data sources, but also cautioned that transparency and education is needed to ensure that users understand the comparability of the new measure to previous versions. MAP discussed whether there is a need to consider a phased approach that would first allow for public reporting of the updated version to allow providers to gain experience before implementing the new measure in payment programs. However, this may cause issues with alignment and potentially cause confusion among measure users while delaying the uptake of potentially improved measures. MAP noted the need for further consideration of this issue through both the CDP and MAP processes to better understand the implications of a change to the specifications of a measure and the application of that updated measure in accountability programs.

Public comments were mixed on the best approach to updating existing measures. Some commenters argued that providers need time to gain experience with a measure before it is used for payment purposes, while others supported a swift approach to addressing measure refinements that supports program alignment and represents the most up-to-date measurement science.

Balancing Shared Accountability with Appropriate Attribution

MAP paid special attention to the issue of balancing the goal of alignment with the need for appropriate attribution. MAP recognized the need to drive improvements in care coordination and to ensure that important topics such as advance directives, smoking cessation, and vaccinations are addressed in multiple care settings but struggled with whether they are appropriate for every care setting and patient/provider interaction. For example, MAP debated if a measure assessing the creation of an advance care plan was appropriate for the Hospital Outpatient Quality Reporting program. While MAP stressed the importance of advance care plans, the group struggled with whether the conversation was appropriate for every outpatient setting or would be better determined between a patient and provider with an ongoing relationship.

MAP also noted that as quality improvement programs evolve and address issues such as readmissions and cost of care there is a need to better understand shared accountability and appropriate attribution across settings. MAP recommended further exploration of the interrelationship between programs for outpatient, acute, and post-acute settings.

Overall, public comments supported MAP's recommendation for alignment in measure sets. Commenters recognized MAP's unique position to look across the healthcare system to identify opportunities for measurement and improvement but noted that specific, actionable national priorities would make it easier to identify and recommend measures that can lead to substantial improvements in patient care. Additionally, some commenters cautioned that overlapping measures in different programs does not necessarily promote the goal of alignment and can lead to hospitals being penalized twice for the same event.

CONSIDERATIONS FOR SPECIFIC PROGRAMS

This section provides an overview of MAP's 2014-2015 pre-rulemaking recommendations for each hospital and setting-specific program. This section outlines each program's critical objectives and provides high level insights into MAP's recommendations on the measures under consideration as well as important measure gaps identified by MAP. MAP used the critical program objectives for each program to develop a vision for how MAP would like to see each program evolve as well as to guide its pre-rulemaking process. Details on specific measures can be found in the **Spreadsheet of 2015 Final Recommendations**.

Inpatient Quality Reporting Program

The Inpatient Quality Reporting program critical objectives are to support alignment across programs by selecting high value measures that are meaningful to consumers and will drive improvements in the quality and efficiency of care. MAP encouraged a movement toward more comprehensive measures of provider performance, such as all-cause harm measures, to ensure the program is improving care broadly. MAP noted the importance of moving towards measuring patient outcomes rather than healthcare structures or processes. The program should continue to evolve by allowing all relevant providers to participate, including rural and small hospitals. Furthermore, the IQR program should use measurement to engage consumers, patients, and their families as partners in their care. In addition to selecting and aligning high value measures, IQR should work to align reporting requirements with other clinical programs, where appropriate, to reduce the burden on providers and support efficient use of measurement resources.

Previously, MAP recommended filling the following gap list for measures: pediatrics, maternal/child health, cancer, behavioral health, affordability/cost, care transitions, patient education, palliative and end-of-life care, medication reconciliation, safety culture, pressure ulcer prevention, and adverse drug events. A number of measures under consideration could begin to fill some of these gaps, including maternal/child health, affordability/cost, safety culture, and adverse drug events, once they are fully specified and NQF-endorsed. Additionally, MAP suggested that CMS look to existing measures and measures under consideration for the PPS-Exempt Cancer Hospital Quality Reporting Program, the Inpatient Psychiatric Facility Quality Reporting Program, and Hospice Quality Reporting Programs to fill additional gaps in the IQR program measure set and to promote alignment across programs.

MAP recognized a number of challenges in the current measurement environment. MAP noted that several outcome measures, particularly those measuring hospital readmissions, should be reviewed in the upcoming NQF trial period to determine if sociodemographic status (SDS) adjustment is appropriate. If there are conceptual and empirical relationships between SDS factors and these outcomes, these measures should be updated. Given the measures currently included in the set, MAP noted a particular need to emphasize the continued exploration of issues around shared accountability and attribution for the IQR program, particularly for measures addressing the cost of care and care transitions. Additionally, MAP noted for measures that use registries as the data source, CMS should collect data directly from the registries for hospitals that participate. For hospitals that do not participate, CMS should create a pathway to allow them to submit this data directly to CMS without the cost of participation in the registry.

MAP received a number of public comments

supporting its recommendation that outcome measures, particularly readmission measures, be reviewed in the upcoming NQF trial period for adjustment for SDS factors. Commenters noted their support for a robust and transparent trial period for adjustment for sociodemographic factors. Some commenters reiterated the need to consider adjusting measures for SDS factors on an individual basis to ensure that only measures where the provider does not have control over the outcome are adjusted for these factors.

Hospital Value-Based Purchasing Program

For the Hospital Value-Based Purchasing Program, MAP developed critical program objectives that emphasized measuring high impact areas for performance and quality improvement with a strong preference for NQF-endorsed measures as this program seeks to profile the value of healthcare services delivered by providers by linking clinical quality measures and cost measures. MAP noted the importance of keeping the program measure set parsimonious to avoid diluting the payment incentives. Previously, MAP identified a number of measurement gap areas that should be addressed within the Hospital VBP program measure set, including medication errors, mental and behavioral health, emergency department throughput, safety culture, and patient and family engagement.

In its 2014-2015 pre-rulemaking work, MAP welcomed the opportunity to review updated and improved versions of existing measures. As noted in the alignment section of this report, MAP had extensive conversations on the best way to update existing measures in payment programs. MAP noted that measurement is a constantly evolving field; however, the group expressed caution on how these revised measures are phased into the program. MAP iterated the importance of publicly reporting the updated measures prior to use in pay-for-performance applications. MAP also noted that CMS should carefully consider how updated measures are phased into payment and reporting programs to minimize confusion for providers, consumers, and purchasers trying to interpret the results of the measures.

As noted above, public commenters cautioned that overlap between measures in Hospital VBP and the Hospital-Acquired Condition Reduction Program does not promote true alignment and could penalize a hospital twice for the same event.

Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction program critical objectives are to reduce the number of readmissions to an acute care hospital following discharge from the same or another acute care hospital. MAP noted that the program should recognize that not all readmissions are markers of poor quality, and thus planned and unrelated readmissions should be excluded from the measures in the program. The causes of readmissions are complex and multifactorial including environmental, community-level, and patient-level factors, as well as sociodemographic factors. Therefore, multiple entities across the healthcare system, including hospitals, post-acute care facilities, skilled nursing facilities, and others, all have a responsibility to ensure high quality care transitions to reduce unplanned readmissions to the hospital. This program seeks to encourage hospitals to take a leadership role in improving care beyond their walls through care coordination across providers, while recognizing that patient and family engagement is critical to improving these care transitions, and ultimately, patient care and healthcare costs. As noted above, MAP generally agreed that measures assessing hospital readmissions should be considered in the upcoming NQF SDS trial period to review whether there is a conceptual and empirical relationship between the measured outcome and SDS factors. MAP noted this issue is particularly salient for the HRRP program. MAP highlighted that if measures are updated they should be evaluated through the

NQF endorsement process and carefully phased into programs.

Hospital-Acquired Condition Reduction Program

The Hospital-Acquired Condition Reduction Program (HAC) critical objectives are focused on minimizing the major drivers of patient harm. The measures in this program overlap with those in the Hospital VBP program, helping to support alignment and focus attention on these critical safety issues. MAP noted that gaps for this program include adverse drug events and sepsis beyond post-operative infections. MAP also highlighted the need for greater antibiotic stewardship as programs such as the HAC Reduction Program increase attention on infection rates.

In its 2014-2015 pre-rulemaking activities, MAP supported updates to the National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) and Central Line-associated Blood Stream Infection (CLABSI) outcome measures currently in the program. These updates were recently reviewed and recommended by the NQF Patient Safety Standing Committee. Implementing these updated measures would extend them to hospital settings outside the intensive care unit (ICU) and add another risk adjustment methodology to account for this expansion. As with other updated measures, MAP applauded improvements to the measures but cautioned that they should be implemented carefully to minimize confusion and burden.

Comments received on the HAC Reduction Program echoed the themes that CMS should pay careful attention to the best approach to update measures in payment programs; overlap between the HAC Reduction and VBP programs may penalize hospitals twice for the same event.

Hospital Outpatient Quality Reporting Program

The critical program objectives of the Hospital Outpatient Quality Reporting (OQR) program are to align the program with ambulatory care measures in programs such as the Physician Quality Reporting System and Physician Compare. Specific gap areas for the OQR program measure set include measures of emergency department (ED) overcrowding, wait times, and disparities in care—specifically, disproportionate use of EDs by vulnerable populations. Other gaps include measures of cost, patient-reported outcomes, patient and family engagement, follow-up after procedures, care coordination, and an outpatient CAHPS module.

Many of the measures under consideration for the 2014-2015 pre-rulemaking cycle attempted to fill these gaps, especially an outpatient CAHPS module, patient-reported outcomes, patient and family engagement measures, care coordination measures, and measures of ED care. While MAP was generally supportive of these measures, they did express caution that survey measures should be aligned to reduce undue burden on providers and patients. As noted above, MAP had an in-depth discussion about the use of NQF #0326 Advance Care Plan in the OQR program. While MAP was overwhelmingly supportive of the importance of advance care planning, the group ultimately decided this measure was not appropriate for the OQR program. MAP noted this measure might be more appropriate in primary care settings and other settings where the patient has an established and ongoing relationship with a provider. MAP cautioned that the goal of alignment must be balanced with the need to include measures that can meaningfully improve the care delivered in a setting.

Public commenters noted that survey measures must respond to the needs of the patient, including what information the patient has identified as the most important. Surveys should not be overgeneralized to ease administrative burden.

Ambulatory Surgery Center Quality Reporting Program

The Ambulatory Surgery Center Quality Reporting (ASCQR) program critical objectives are to include measures that are highly impactful and meaningful to patients. This program also aims to align measures with CMS's various quality reporting programs, particularly OQR, to ensure that quality is measured consistently across care settings to allow consumers, purchasers, and payers to compare providers who may be performing the same procedure. MAP identified priority measure gap areas for the ASCQR program including measures of surgical quality, infections, complications including anesthesia-related complications, post-procedure follow-up, in addition to measures of patient and family engagement including an ASC-specific CAHPS module, patient-reported outcomes, and cost/resource use. In the 2014-2015 pre-rulemaking cycle, MAP supported a number of measures that could begin to fill the gap around complications. MAP encouraged continuing the development of the Outpatient/Ambulatory Surgery Patient Experience of Care Survey to begin to fill the gap around patient and family engagement.

Public comments received on MAP's recommendation for the ASCQR program highlighted the need to select measures that are specified and tested for the facility setting. As noted above, public commenters stated that survey measures must respond to the needs of the patient, including what information the patient has identified as the most important. Similar to OQR, surveys in ASCQR should not be overgeneralized to ease administrative burden.

Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs)

The Meaningful Use critical program objectives are to select measures that represent the future of measurement (e.g. facilitating information exchange between institutions and longitudinal tracking of care, such as measures that monitor incremental changes in a patient's condition over time). The eMeasures in the program should be reliable and valid with a preference to measures endorsed by NQF. The eMeasures selected for the Meaningful Use program should be assessed for comparability with measures derived from alterative data sources used in programs such as IQR, and the comparability between data types should be transparent. Furthermore, this program seeks to align with other hospital performance measurement programs to reduce measurement burden on providers and the most appropriate use of measurement resources. MAP encouraged the development of a number of promising measure concepts during its 2014-2015 pre-rulemaking work. Several of these concepts were electronic versions of existing measures. MAP was hopeful that the collection of reliable clinical data could enhance the existing measures to better capture patient severity as well as improve the measure reliability.

Public comments cautioned that a number of the measures under consideration for this program may require extensive additional work, including measure testing and field testing.

PPS-Exempt Cancer Hospital Quality Reporting Program

The PPS-Exempt Cancer Hospital Quality Reporting program (PCHQR) critical objectives are to include measures appropriate to cancer hospitals that reflect the highest priority services provided by these hospitals and should align with measures in the IQR and OQR programs, where appropriate and relevant.

The program aims to include measures that address gaps in the quality of cancer care. MAP has previously identified pain screening and management, patient and family/caregiver experience, patient-reported symptoms and outcomes, survival, shared decision-making, cost/resource use, care coordination and psychosocial/

supportive services as gap areas for this program. During the 2014-2015 pre-rulemaking cycle, MAP conditionally supported a number of measures where the dedicated cancer centers have uniformly high rates of performance. MAP recognized the role these centers could play as benchmarks for general acute care hospitals providing cancer care and recommended CMS consider the adoption of these measures in the IQR program as well. Additionally, MAP noted that the PCHQR measures set should move beyond measurement of cancer care to include cross-cutting measures facilitating alignment across care settings and programs.

MAP did not receive any public comments on its programmatic input on this program. Measure specific comments were included in MAP's Spreadsheet of 2015 Final Recommendations.

Inpatient Psychiatric Facility Quality Reporting Program

The Inpatient Psychiatric Facility Quality Reporting (IPFQR) program critical objectives are to ensure that measures in the program are meaningful to patients. This program aims to improve person-centered psychiatric care by addressing priority measure topics, such as assessing patient and family/caregiver experience and engagement, and establishing relationships with community resources.

MAP previously identified measure gaps in the IPFQR program, including step down care, behavioral health assessments and care in the ED, readmissions, identification and management of general medical conditions, partial hospitalization or day programs, and a psychiatric care module for CAHPS. In its 2014-2015 review of measures under consideration, MAP strongly supported the need to move beyond the measurement of psychiatric care in inpatient psychiatric facilities (IPFs) into measurement of other important general medical conditions that affect patients with psychiatric conditions. Furthermore, MAP noted that the measurement of psychiatric treatment quality should not be limited to IPFs or psychiatric units within hospitals, but rather be expanded to general medical facilities that are treating these patients as well. MAP noted that this would allow for alignment across settings and providers.

MAP did not receive any public comments on its programmatic input on this program. Measure specific comments were included in MAP's Spreadsheet of 2015 Final Recommendations.

APPENDIX A:
Program Summaries

Inpatient Quality Reporting Program (IQR)

Program Type
Pay-for-Reporting and Public Reporting. A subset of the measures in the program are publicly reported on the Hospital Compare web site.

Incentive Structure
Hospitals that do not report data on the required measures will receive a 2 percent reduction in their annual Medicare payment update.

Program Goals
- Provide an incentive for hospitals to publicly report quality information about their services
- Provide consumers information about hospital quality so they can make informed choices about their care.

Program Update
- For FY 2017, CMS has finalized a total of 63 measures for the program measure set.
  - 11 new measures were added for FY 2017.
    - » These measures address coronary artery bypass graft (CABG) surgery readmissions and mortality, pneumonia and heart failure episode of care payments, severe sepsis and septic shock management, newborn screening for hearing, exclusive breast feeding, child asthma home management plan of care, and healthy term newborns.
    - » Two measures were readopted as voluntary electronic clinical quality measures to support alignment with the Medicare EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals. These measures are NQF #0142 AMI-2 Aspirin Prescribed at Discharge and NQF #0639 AMI-10 Statin Prescribed at Discharge.
  - 19 measures were removed for FY 2017. These measures were removed because they were topped out. However, to continue aligning the IQR and Medicare EHR Incentive Program, 10 measures will be retained on a voluntary basis to allow hospitals an opportunity to test the accuracy of the electronic health record reporting systems.

MAP's Suggested Critical Program Objectives
- Choose high impact measures that will improve both quality and efficiency of care and are meaningful to consumers.
- Move towards more outcome measures rather than structure or process measures.
- Align reporting requirements with other clinical programs where appropriate to reduce the burden on providers and support efficient use of measurement resources.
- Engage patients and families as partners in their care.
- Expand the program to include measures that allow rural and other small hospitals to participate.
- In the 2013-14 pre-rulemaking process, MAP recommended the rapid filling of the following fairly extensive gap list for this program: pediatrics, maternal/child health, cancer, behavioral health, affordability/cost, care transitions, patient education, palliative and end of life care, medication reconciliation, a culture of safety, pressure ulcer prevention, and adverse drug events. MAP suggested that HHS could look to existing measures in the PPS-Exempt Cancer Hospital Quality Reporting Program, the Inpatient Psychiatric Facility Quality Reporting Program, and Hospice

Quality Reporting Programs to begin to fill these gaps.

Hospital Value-Based Purchasing Program

Program Type

Pay for Performance

Incentive Structure

Medicare bases a portion of hospital reimbursement on performance through the Hospital Value-Based Purchasing Program (VBP). Medicare withholds 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 2015: 1.5%
- FY 2016: 1.75%
- FY 2017 and future 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.

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.

Program Goals

- Improve healthcare quality by realigning hospitals' financial incentives.
- Provide incentive payments to hospitals that meet or exceed performance standards.

Program Update

- For the FY 2017 Measure Set:
  - Six measures were removed from the FY 2017 program measure set because they were topped out.
  - Three additional measures were added to the program measure set: NQF#0469 PC-01 Elective Delivery Prior to 39 Weeks Gestation, NQF #1716 Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia, and NQF #1717 Clostridium difficile (C. difficile) Infection
- For the FY 2019 Measure Set:
  - NQF #1550 Hospital-level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) was added to the program measure set.

MAP's Suggested Critical Program Objectives

- Include measures where there is a need and opportunity for improvement.
- Emphasize areas of critical importance for high performance and quality improvement, and ideally, link clinical quality and cost measures to capture value.
- NQF-endorsed measures are strongly preferred.
- Keep the program measure set parsimonious to avoid diluting the payment incentives.
- MAP identified a number of gap areas that should be addressed within the VBP program measure set, including medication errors, mental and behavioral health, emergency department throughput, a hospital's culture of safety, and patient and family engagement.

Hospital Readmissions Reduction Program

Program Type

Pay for Performance and Public Reporting – Payments are based on information publicly reported on the Hospital Compare website.

Incentive Structure

Diagnosis-related group (DRG) payment rates will be reduced based on a hospital's ratio of actual to expected readmissions. The maximum payment

reduction is 3 percent beginning October 2014 and for subsequent payment years.

Program Goals

- Reduce readmissions in acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), which is approximately 4000 hospitals in the U.S.
- Provide consumers with quality of care information that will help them make informed decisions about their health care. Hospitals' readmissions information, including their risk-adjusted readmission rates, is available on the Hospital Compare website.

Program Update

- The Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary Artery Bypass Graft (CABG) Surgery was added to the program measure set for implementation in FY 2017.
- The planned readmission algorithm for the acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, and total hip arthroplasty/ total knee arthroplasty measures was updated.

MAP's Suggested Critical Program Objectives

- Reduce the number of admissions to an acute care hospital following discharge from the same or another acute care hospital.
- Engage patients and their families as partners in care.
- Improve patient care and reduce overall healthcare costs.
- Exclude planned readmissions from the measures in the program.
- Encourage hospitals to take a leadership role in improving care beyond their walls through care coordination across providers since the causes of readmissions are complex and multifactorial.
- Improve care transitions by decreasing readmission rates through optimizing processes under the hospital's control. For example, improving communication of important inpatient information to those who will be taking care of the patient post-discharge.
- Acknowledge that factors affecting readmissions are complex, and may include environmental, community-level, and patient-level factors, including socio-demographic factors.
- Recognize that multiple entities across the health care system, including hospitals, post-acute care facilities, skilled nursing facilities, and others, all have a responsibility to ensure high quality care transitions to reduce unplanned readmissions to acute care hospitals.

Hospital-Acquired Condition (HAC) Reduction Program

Program Type

Pay-for-Performance and Public Reporting. HAC scores will be reported on the Hospital Compare website beginning December 2014.

Incentive Structure

- The 25% of hospitals that have the highest rates of HACs (as determined by the measures in the program) will have their Medicare payments reduced by 1%.
- The measures in the program are classified into two domains: Domain 1 includes the Patient Safety Indicator (PSI) 90 measure, a composite of eight administrative claims based measures and Domain 2 includes infection measures developed by the Centers for Disease Control and Prevention's (CDC) National Health Safety Network (CDC NHSN). Each domain will be weighted to determine the total score.
- In the FY 2014 IPPS/LTCH PPS rule, measures for FY 2015, FY 2016 and FY 2017 HAC Reduction Program were finalized.

  - FY 2015: PSI 90 (domain 1) and CDC NHSN's Central-line Association Bloodstream Infection (CLABSI) and Catheter-Associated Urinary Tract Infection (CAUTI) measures (domain 2).FY 2015: PSI 90 (domain 1) and CDC NHSN's Central-line Association Bloodstream Infection (CLABSI and CAUTI measures (domain 2). FY 2016: CDC NHSN surgical site infection measure (infections following abdominal hysterectomy and colon procedures) will be added to domain 2
  - FY 2017: CDC NHSN MRSA and C. difficile measures will be added to domain 2.
- The weight that each domain contributes to the total HAC score has been finalized for FY 2015 and FY 2016.
  - FY 2015: Domain 1 is 35% and Domain 2 is 65% of the Total HAC Score.
  - FY 2016: Domain 1 will be 25% and Domain 2 will be 75% of the Total HAC score.

Program Goals

- Heighten awareness of HACs and eliminate the incidence of HACs that could be reasonably prevented by applying evidence-based clinical guidelines.
- Provide motivation to reduce the incidence of HACs, improve patient outcomes, and reduce the cost of care.
- Support a broader public health imperative by helping to raise awareness and action by prompting a national discussion on this important quality problem.
- Drive improvement for the care of Medicare beneficiaries, but also privately insured and Medicaid patients, through spill over benefits of improved care processes within hospitals.

Program Update

- No new measures were added in the FY 2015 IPPS/LTCH PPS rule to allow hospitals time to gain experience with the measures that were finalized in the FY 2014 IPPS/LTCH PPS rule.
- PSI-90 is currently undergoing review by NQF. AHRQ is considering the addition of three additional measures for the composite, PSI #9 Perioperative Hemorrhage or Hematoma Rate, PSI #10 Postoperative Physiologic and Metabolic Derangement Rate, and PSI #11 Postoperative Respiratory Failure Rate. CMS believes this change to be significant and will propose the change in the rulemaking process prior to requiring reporting of the revised measure.
- The CDC NHSN CLABSI and CAUTI measures also recently underwent NQF review. These measures were recommended for continued endorsement.

MAP's Suggested Critical Program Objectives

- Focus on reducing the major drivers of patient harm.
- Overlap in measures between the HAC Reduction Program and the Hospital Value-Based Purchasing Program can help to focus attention on critical safety issues.
- In its 2013-14 round of pre-rulemaking, MAP noted a number of gaps for this program: PSI-5 to address foreign bodies retained after surgery, and development of measures to address wrong site/wrong side surgery and sepsis beyond post-operative infections.

Hospital Outpatient Quality Reporting Program

Program Type

Pay for Reporting – Information on measures is reported on the Hospital Compare website.

Incentive Structure

Hospitals that do not report data on the required measures will receive a 2 percent reduction in their annual Medicare payment update.

Program Goals

- Establish a system for collecting and providing

quality data to hospitals providing outpatient services such as clinic visits, emergency department visits, and critical care services.

- Provide consumers with quality of care information that will help them make informed decisions about their health care.

Program Update

- For calendar year (CY) 2018, CMS finalized the following measure: OP-32 Facility Seven-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy
- CMS proposed criteria for determining when a measure is "topped-out." Two criteria were proposed: 1) statistically indistinguishable performance at the 75th and 90th percentiles and 2) a truncated coefficient of variation less than or equal to 0.10.
- CMS finalized removal of the following measures for CY2017:
  - OP-6 Timing to Prophylactic Antibiotics
  - OP-7 Prophylactic Antibiotic Selection for Surgical Patients

MAP's Suggested Critical Program Objectives

- Focus on measures that have high impact and support national priorities
- Align the OQR measures with ambulatory care measures
- Specific gap areas for the OQR program measure set include measures of emergency department (ED) overcrowding, wait times, and disparities in care—specifically, disproportionate use of EDs by vulnerable populations. Other gaps include measures of cost, patient-reported outcomes, patient and family engagement, follow-up after procedures, fostering important ties to community resources to enhance care coordination efforts, and an outpatient CAHPS module.

Ambulatory Surgical Centers Quality Reporting Program

Program Type

Pay for Reporting – Performance information is currently reported to the Centers for Medicare & Medicaid Services (CMS) but it is expected to be publicly available in the future.

Incentive Structure

Ambulatory surgical centers (ACSs) that treat Medicare beneficiaries and fail to report data will receive a 2.0 percent reduction in their annual payment update. The program includes ASCs operating exclusively to provide surgical services to patients not requiring hospitalization.

Program Goals

- Promote higher quality, more efficient care for Medicare beneficiaries.
- Establish a system for collecting and providing quality data to ASCs.
- Provide consumers with quality of care information that will help them make informed decisions about their health care.

Program Update

- For calendar year (CY) 2018, CMS finalized the following measure: OP-32 Facility Seven-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy
- CMS finalized criteria for determining when a measure is "topped-out". Two criteria were proposed: 1) statistically indistinguishable performance at the 75th and 90th percentiles, and 2) a truncated coefficient of variation less than or equal to 0.10.

MAP's Suggested Critical Program Objectives

- Include measures that have high impact and are meaningful to patients.
- Align measures with CMS' various quality reporting programs, particularly the Hospital Outpatient Quality Reporting program, to facilitate comparisons across care settings, and

to reduce burden for facilities that participate in these programs.

- Priority measure gap areas for the ASCQR program include surgical care quality, infection rates, follow-up after procedures, complications including anesthesia related complications, cost, and patient and family engagement measures including an ASC-specific CAHPS module and patient-reported outcome measures.

Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs)

Program Type

Pay for Reporting. The Medicare and Medicaid EHR Incentive Programs provide incentives to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

Incentive Structure

For the Medicare Incentive Program (hospitals), incentive payments began in 2011 and are comprised of an Initial Amount, Medicare Share, and Transition Factor. The CAH EHR Incentive payment is based on a formula for Allowable Costs and the Medicare Share. The Medicaid Incentive program includes an Overall EHR Amount and Medicaid Share. Medicare payment penalties will take effect in 2015 for providers who are eligible but do not participate. Payment penalties do not apply to Medicaid.

For Stage 1, eligible facilities must report on all 15 total clinical quality measures. For Stage 2 (2014 and beyond) eligible facilities 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.

Program Goals

- Promote widespread adoption of certified EHR technology by providers.
- Incentivize "meaningful use" of EHRs by hospitals to:
  - Improve quality, safety, efficiency, and reduce health disparities
  - Engage patients and family
  - Improve care coordination, and population and public health
  - Maintain privacy and security of patient health information

Program Update

- The 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 (2014):
  - Removal of clinical quality measures (CQMs) as a separate core objective for Stage 1 for eligible professionals, eligible hospitals, and CAHs. Reporting CQMs will still be required in order to achieve meaningful use.
  - For Stage 2 (2014):
  - The earliest Hospitals and Critical Access Hospitals will demonstrate Stage 2 of meaningful use is October 2014.
- For Stage 2 (2014 and beyond):
  - Eligible hospitals and CAHs must meet 16 core objectives and 3 menu objectives that they select from a total list of 6, or a total of 19 core objectives.
  - New Core Objective: Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR)

MAP's Suggested Critical Program Objectives

- Preference should be given to NQF-endorsed quality measures.
- Select measures that represent the future of measurement (facilitating information exchange between institutions and longitudinal tracking of care, such as measures that monitor incremental changes in a patient's condition over time).
- Align the measure set with other hospital performance measurement programs.
- Ensure e-measures in the program are reliable and provide comparable results to paper-based measures.

PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)

Program Type

Reporting: Information will be publicly reported beginning in 2014.

Incentive Structure

There is currently no financial incentive for the 11 hospitals in this program to report quality measures. CMS plans to create an incentive structure in the future.

Program Goals

- Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the Inpatient Prospective Payment System and the Inpatient Quality Reporting Program.
- Encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices

Program Update

- NQF #1822 External Beam Radiotherapy for Bone Metastases was added to the program beginning in October 2017. MAP supported this measure for the PCHQR program, noting that it helps to fill a gap in palliative care.
- CMS noted that future measure topics may include patient-centered care planning and care coordination, shared decision making, measures of quality of life outcomes, and measures of admissions for complications of cancer and treatment for cancer.
- CMS will make the results of NQF #220 Adjuvant Hormonal Therapy publicly available in 2015. The results of NQF #138 NHSN Catheter-Associated Urinary Tract Infections (CAUTI) Outcome Measure and NQF #139 NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome measure will be made available by 2017.

MAP's Suggested Critical Program Objectives

- Include measures appropriate to cancer hospitals that reflect the highest priority services provided by these hospitals.
- Align measures with the Inpatient Quality Reporting Program and Outpatient Quality Reporting Program where appropriate and relevant.
- The measures should address gaps in cancer care quality. MAP has previously identified pain screening and management, patient and family/caregiver experience, patient-reported symptoms and outcomes, survival, shared decision making, cost, care coordination and psychosocial/supportive services as gap areas for this program

Inpatient Psychiatric Facilities Quality Reporting Program

Program Type

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

Incentive Structure

- Inpatient psychiatric hospitals or psychiatric units that do not report data on the required measures will receive a 2 percent reduction in their annual federal payment update.
- The IPFQR Program applies to freestanding

psychiatric hospitals, government-operated psychiatric hospitals, and distinct psychiatric units of acute care hospitals and critical access hospitals. This program does not apply to children's hospitals, which are paid under a different system.

Program Goals

- Provide consumers with quality information to help inform their decisions about their healthcare options.
- Improve the quality of inpatient psychiatric care by ensuring providers are aware of and reporting on best practices.
- Establish a system for collecting and providing quality data for inpatient psychiatric hospitals or psychiatric units.

Program Update

- For FY 2016:
  - Two structural measures regarding routine assessment of patient experience of care and use of an electronic health records were added to the program measure set for FY 2016.
- For FY 2017:
  - NQF #1654 Tobacco Use Treatment Provided or Offered (TOB-2) and Tobacco Use Treatment (TOB-2a) was added to the program measure set for FY 2017.
  - Two influenza measures, NQF #0431 Influenza Vaccination Coverage Among Healthcare Personnel and #1659 Influenza Immunization) were added to the program measure set.

MAP's Suggested Critical Program Objectives

- Ensure measures in the program are meaningful to patients.
- Improve person-centered psychiatric care, such as assessing patient and family/caregiver experience and engagement and establishing relationships with community resources, are priority measure gap areas.
- Measure gaps in the IPFQR program include step down care, behavioral health assessments and care in the ED, readmissions, identification and management of general medical conditions, partial hospitalization or day programs, and a psychiatric care module for CAHPS.

APPENDIX B:
Measure Applications Partnership (MAP) Rosters

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ISBN 978-1-933875-87-3

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