# MEASURE APPLICATIONS PARTNERSHIP

*CONVENED BY THE NATIONAL QUALITY FORUM*

MEETING MATERIALS

For

IN-PERSON MEETING OF THE CLINICIAN WORKGROUP

JUNE 13-14, 2011

# NATIONAL QUALITY FORUM
## MEASURE APPLICATIONS PARTNERSHIP

**Clinician Workgroup**
**In-Person Meeting #2**
**July 13-14, 2011**

**Washington Embassy Row Hotel**
**2015 Massachusetts Ave., NW, Washington, DC 20036**
**Web Streaming: http://www.MyEventPartner.com/QualityForum146**
**Public Dial-In: 877-604-9674**
**Passcode: 8727843**

**AGENDA**

**Meeting Objectives:**

- *Review and refine the report outline for the clinician performance measurement coordination strategy deliverable to HHS;*
- *Consider measures for an initial clinician core measure set and alignment with other efforts;*
- *Adopt coordination strategy data platform principles; and*
- *Develop the pathway for improving measure application.*

### Day 1: July 13

**8:30 am** **Breakfast**

**9:00 am** **Welcome, Review of Meeting Objectives, and Opening Remarks**
***Mark McClellan, Workgroup Chair***

**9:15 am** **Clinician Performance Measurement Coordination Strategy Report Outline**
***Mark McClellan***
- *Review and discuss report outline for the deliverable to HHS*

**10:15 am** **Measure Selection Criteria Development**
***Tom Valuck, Senior Vice President, Strategic Partnerships, NQF***
- *Process of measure selection criteria development*

**10:45 am** **Consideration of an Initial Clinician Core Measure Set**
***Connie Hwang, Vice President, Strategic Partnerships, NQF***
- *Purpose of an initial core measure set*
- *Process of using measure selection criteria to develop the draft initial core set*

- *Key issues and limitations*
- *Discussion and questions*

**12:00 pm** **Lunch**

**12:30 pm** **Consideration of an Initial Clinician Core Measure Set (continued)**
***Mark McClellan***

- *Review and discuss the draft initial clinician core measure set*
- *Opportunity for public comment*

**2:30 pm** **Aligning with Other Initiatives**
***Mike Rapp, CMS – PQRS***
***Tom Tsang, ONC – EHR Meaningful Use***
***Mark McClellan, The Brooking Institution – ACOs***
***Karen Adams, NQF – NQS/NPP***

- *Review alignment of the initial clinician core measure set with other initiatives*
- *Discuss extension of the initial core set to ACOs, PQRS, meaningful use, private sector initiatives*
- *Discussion and questions*

**3:45 pm** **Summary of Day 1 and Look-Forward to Day 2**

- *Summation of day 1*
- *Expectations for day 2 activities*

**4:00 pm** **Adjourn for the Day**

# NATIONAL QUALITY FORUM
## MEASURE APPLICATIONS PARTNERSHIP

**Day 2: July 14**

**8:30 am** **Breakfast**

**9:00 am** **Recap of Day 1 and Objectives for Day 2**
***Mark McClellan, Workgroup Chair***

**9:30 am** **Coordination Strategy Data Platform Principles**
***Aisha Pittman, Senior Program Director, Strategic Partnerships, NQF***
- *Recap of federal program alignment issues*
- *Review and adopt coordination strategy data platform principles*
- *Discussion and questions*
- *Opportunity for public comment*

**10:30 am** **Pathway for Improving Measure Applications**
***Gene Nelson, The Dartmouth Institute***
- *Priorities for advancing clinician performance measurement*
- *Discussion and questions*

**11:30 am** **Finalize Coordination Strategy Guidance to HHS**
- *Revisit report outline*
- *Discussion and questions*
- *Opportunity for public comment*
- *Synthesis of day 2*
- *Committee next steps*

**12:00 pm** **Box Lunch / Meeting Adjourns**

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# Measure Applications Partnership Clinician Workgroup

In-Person Meeting #2

July 13-14, 2011



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## *Welcome and Review of Meeting Objectives*

## Meeting Objectives

- Review and refine the report outline for the clinician performance measurement coordination strategy deliverable to HHS;
- Consider measures for an initial clinician core measure set and alignment with other efforts;
- Adopt coordination strategy data platform principles; and
- Develop the pathway for improving measure application.



## Agenda - Day 1

- Clinician Performance Measurement Coordination Strategy Report Outline
- Measure Selection Criteria Development
- Consideration of an Initial Clinician Core Measure Set
- Aligning with Other Initiatives

## Clinician Workgroup Interaction with MAP Coordinating Committee

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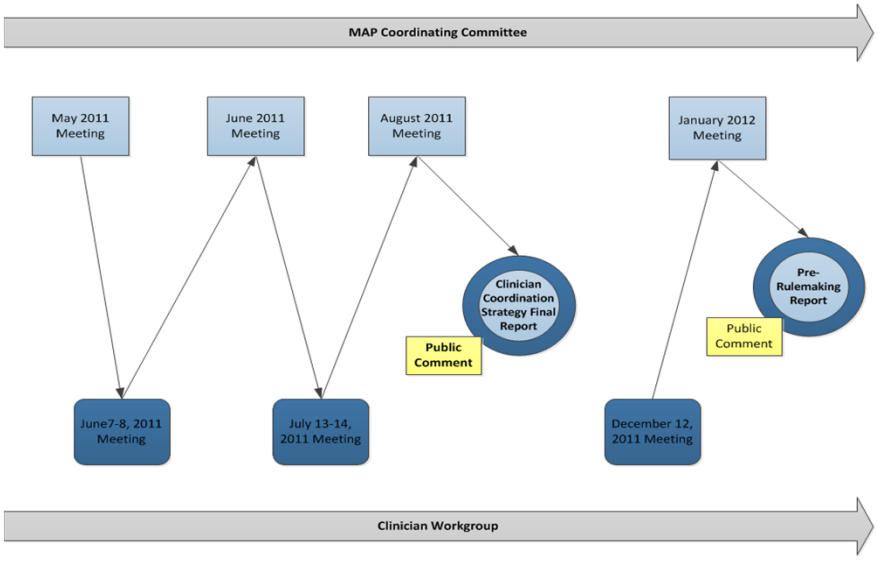


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## Clinician Workgroup Timeline

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*Coordinating Committee Meeting – June 21-22*

**June 30, 2011**
- Convene a web meeting to discuss federal program alignment issues that will be addressed in the coordination strategy

**July 13-14, 2011**
- Conduct second in-person meeting to discuss the coordination strategy for clinician performance measurement

*Coordinating Committee Meeting – August 17-18*

**Late August**
- Two-week public comment period for the physician coordination strategy

**October 1, 2011**
- Final report due to HHS from the MAP Coordinating Committee regarding the clinician coordination strategy

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# *Clinician Performance Measurement Coordination Strategy Report Outline*



## Report Outline

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- Measures and Measurement Issues
  - Measure selection criteria
  - Methodology for selection
  - Initial core clinician measure set
  - Measure gaps identified
  - Special considerations for vulnerable populations
  - Other key considerations

## Report Outline

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- Data Source and HIT Implications
  - Data platform principles
  - Types of data used to collect and report data elements
  - Promotion of the adoption of HIT
  - Other key considerations



## Report Outline

NQF National Quality Forum

- Alignment Issues
  - Across federal Programs
    - Measures
    - Data collection and reporting
  - Beyond federal programs
    - Mapping to other efforts
  - Other key considerations

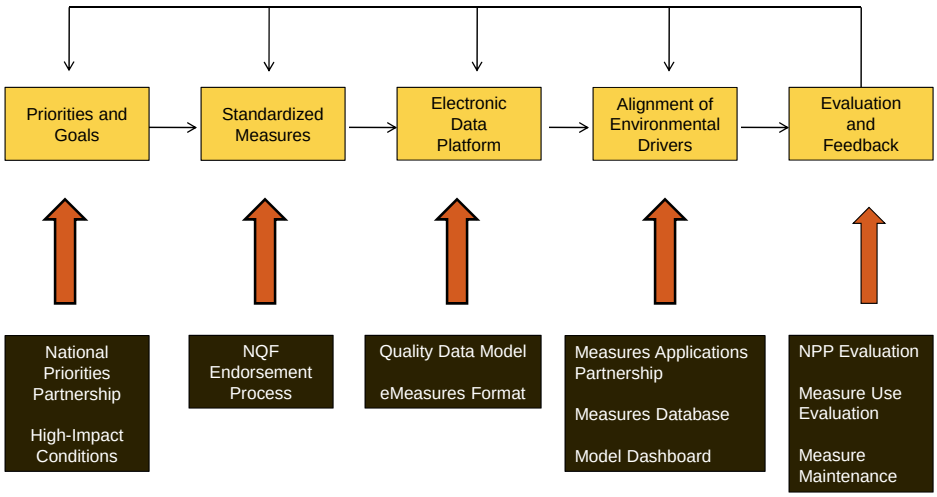
## Report Outline

- Pathway for Improving Measure Application
  - Identification of ideal clinician measure set
  - Further identification of gaps and plan for gap filling
  - Year-end, pre-rulemaking task



## *Measure Selection Criteria Development*

## Quality Measurement Enterprise

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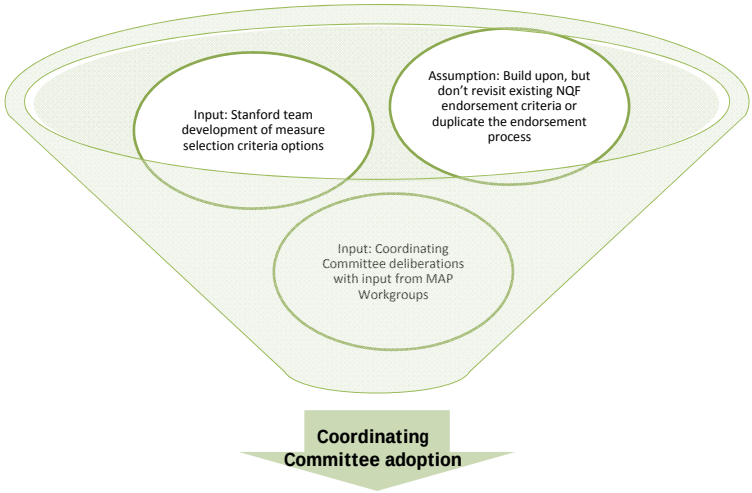
## Measure Selection Criteria Development

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## Measure Selection Principles from May 3-4 MAP Coordinating Committee Meeting

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- Promotes "systemness" and joint accountability
  - Promotes shared decision making and care coordination
  - Addresses various levels of accountability
- Addresses the patient perspective
  - Helps consumers make rational judgments
  - Incorporates patient preference and patient experience
- Actionable by providers
- Enables longitudinal measurement across settings and time
- Contributes to improved outcomes
- Incorporates cost
  - Resource use, efficiency, appropriateness
- Promotes adoption of health IT
- Promotes parsimony
  - Applicability to multiple providers, settings, clinicians



## Measure Selection Principles from Clinician Workgroup to MAP Coordinating Committee

NQF National Quality Forum

- Promote shared accountability and "teamness"
  - Actionable
  - Longitudinal
- Address multiple levels of analysis
  - Individual v. group
  - Cascading measures
- Useful to intended audiences
  - Shared decision making
  - Functional status
  - Quality of life/well-being
- Potential for unintended consequences
- Balance comprehensiveness and parsimony

## Measure Set Selection Criteria Strawperson from June 21-22 MAP Coordinating Committee Meeting

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- Measure Set Criteria
  - Align with NQS and high-impact conditions
  - Address health and health care across the lifespan
  - Include measures of total cost of care, efficiency, appropriateness
  - Understandable, meaningful, useful to intended audiences
  - Parsimonious
  - Safeguards in place to detect/mitigate unintended consequences
  - Address specific program features

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## Measure Set Selection Criteria Strawperson from June 21-22 MAP Coordinating Committee Meeting

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- Individuals Measures within Measure Sets
  - NQF endorsed
  - Build upon measure endorsement thresholds
  - Tested for setting and level of analysis
  - Broad applicability across populations and settings
  - Adequate sample size for stable and meaningful comparison across the intended accountable entities

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# *Consideration of an Initial Clinician Core Measure Set*



## Measure Set Selection "Working" Criteria

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- Individual Measure Criteria
  - Addresses NQS and/or high-impact conditions
  - NQF endorsed
  - Contributes to parsimony
  - Enables longitudinal assessment
  - Ready for implementation
  - Promotes highly reliable system of care
- Measure Set Criteria
  - Comprehensive view of quality (i.e., set addresses NQS priorities and high impact conditions)
  - Measurement of all intended accountable entities
  - Avoids unintended consequences

## Initial Clinician Core Measure Set

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- Purpose of Exercise
  - Initial test of working measure selection criteria
    - Inform Coordinating Committee finalization of measure selection criteria
  - Identify a core set of priority measures for clinician performance
    - Not intended for any particular program
  - Help facilitate selection of measures through pre-rulemaking process



## Initial Clinician Core Measure Set

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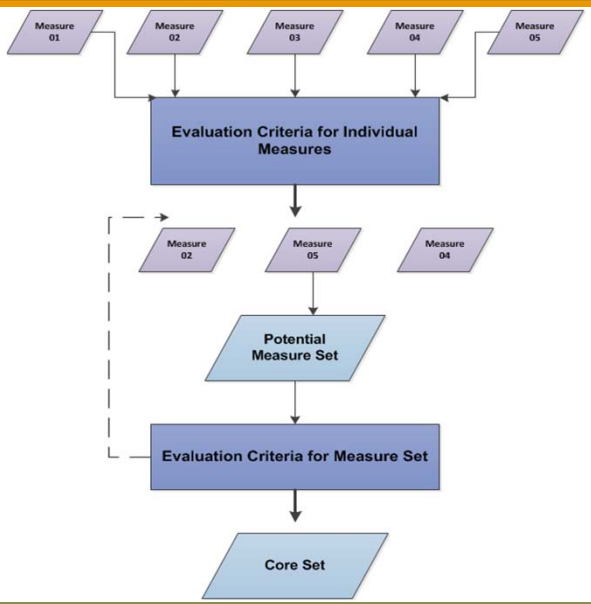

## Initial Clinician Core Measure Set

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- Process for testing the working measure selection criteria:
  - Select measures from the following programs:
    - Physician Quality Review System (PQRS)
    - EHR- Meaningful Use (MU)
    - Generating Medicare Physician Quality Performance Measurement Results (GEM) Project
    - Medicare Advantage/5-Star Rating
    - CHIPRA Initial Core Set Measures
    - Medicaid Core Measure Set
    - ACO Proposed Regulations
    - Integrated Healthcare Association – California Pay for Performance Program (IHA)
    - Blue Cross Blue Shield of Massachusetts Alternative Quality Contract
  - Develop measure sets for evaluation
    - Measures sorted by NQS priorities: person and family-centeredness, care coordination, safer care, prevention, secondary prevention and treatment, healthy living, and affordable care.
    - Secondary prevention and treatment measures sorted by conditions: diabetes, cardiovascular conditions, asthma, and preoperative care.



## Measure Selection Matrix

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| SCORING PARAMETER | | High | 3 |
|---|---|---|---|
| | | Medium | 2 |
| | | Low | 1 |

| | | SELECTION CRITREA | | | | | | Score | RECOMMENDATION |
|---|---|---|---|---|---|---|---|---|---|
| | | Represents a multidimensional view of quality | NQF Endorsed | Promotes Parsimony | Enable Longitudinal Assessment | Ready for specific application | Promote a Highly Reliable System | Total Score | Measure is recommended for selection |
| 0228 Endorsed | Care Transition Measure | High | High | High | Medium | -- | Medium | 13 | Yes |
| 0561 Endorsed | Melanoma: Coordination of Care | Medium | High | Low | Low | -- | Low | 8 | No |

## Initial Clinician Core Measure Set

NQF National Quality Forum

- Limitations of the testing exercise
  - Criteria not yet finalized
  - Not in the context of a specific program
    - Levels of analysis
    - Data sources
    - Specific uses (e.g., public reporting, payment)
  - Short time-frame
  - Selected from measures in use in existing clinician programs



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***Discussion and Questions***

## *Consideration of an Initial Clinician Core Measure Set*

- ***Patient and family engagement (2)***
- ***Care coordination (3)***
- ***Safer care (8)***
- ***Prevention (8)***
- ***Secondary prevention and treatment (10)***
- ***Healthy living (3)***
- ***Affordable care (2)***



## Considerations for Initial Core Clinician Measure Set

- Does the initial clinician core measure set, as a whole:
  - Address the National Quality Strategy priorities and high-impact conditions?
  - Address health and health care across the lifespan?
  - Balance comprehensiveness with parsimony?
  - Link to desired outcomes?
  - Enable longitudinal measurement?
  - Yield information that is useful to consumers, purchasers, payers, providers, and policymakers?
  - Include measures that monitor, deter, or mitigate unintended consequences?
  - Address the needs of dual-eligible Medicare/Medicaid beneficiaries?
- What are the measure gaps in the initial core set?

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## *Opportunity for Public Comment*



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## *Aligning with Other Initiatives*

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## *Summation of Day 1*



## Agenda - Day 2

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- Recap of Day 1 and Objectives for Day 2
- Coordination Strategy Data Platform Principles
- Pathway for Improving Measure Applications
- Finalize Coordination Strategy Guidance to HHS

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## *Recap of Day 1 and Objectives for Day 2*



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## *Coordination Strategy Data Platform Principles*

## Federal Program Alignment Considerations

- Data Collection
  - Different specifications for the same measure
  - Different data collection mechanisms
  - Different sample sizes
- Data Reporting
  - Separate reporting mechanisms for the same measure
  - Individual vs. group reporting
  - Different reporting periods
  - Submission of data vs. rates



## Coordination Strategy Data Platform Principles

- Single, standardized data reporting process
  - Across all federal programs, ultimately all payers
- Single data set to collect all necessary elements
  - Harmonized measure specifications across programs and payers
- Data reporting at individual physician level with aggregation to group level
- Data collection during the course of care
  - Automatic data extraction
  - Ability to collect patient-reported data
- Timeliness of feedback
- Transparency of processes and information

## Rationale Supporting Data Platform Principles

- Decreases clinician reporting burden
- Makes data available for multiple uses
- Encourages electronic data collection; meaningful use of EHRs
- Enables benchmarking performance at multiple levels
  - Meaningful comparative information for consumers and purchasers
  - Timely information for clinician performance improvement
  - Increased ability to link payment and performance



## *Discussion and Questions*

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## *Opportunity for Public Comment*



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## *Pathway for Improving Measure Applications*

## Pathway for Improving Measure Applications


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## Pathway for Improving Measure Applications

- How do we move from the current to the ideal state?
  - Development of ideal core measure set
  - Identification of measure gaps
  - Plan for gap filling
  - Implementation of data platform principles
  - Incorporation of patient-reported data
  - Levers to encourage alignment

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## *Discussion and Questions*



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## *Finalize Coordination Strategy Guidance to HHS*

# Clinician Workgroup Timeline

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*Coordinating Committee Meeting – June 21-22*

**June 30, 2011**
- Convene a web meeting to discuss federal program alignment issues that will be addressed in the coordination strategy

**July 13-14, 2011**
- Conduct second in-person meeting to discuss the coordination strategy for clinician performance measurement

*Coordinating Committee Meeting – August 17-18*

**Late August**
- Two-week public comment period for the physician coordination strategy

**October 1, 2011**
- Final report due to HHS from the MAP Coordinating Committee regarding the clinician coordination strategy

# Measure Applications Partnership
# Clinician Workgroup Charge

Purpose

The charge of the Measure Applications Partnership (MAP) Clinician Workgroup is to advise the Coordinating Committee on a coordination strategy for clinician performance measurement. The initial strategy will address the use of measures for Federal programs, the ability to rely on electronic data sources, priorities articulated in the HHS National Quality Strategy (NQS), and priority conditions defined by NQF's Measure Prioritization Advisory Committee, and the ambulatory/office setting. The Clinician Workgroup will also advise the Coordinating Committee on measures to be implemented through the Federal rulemaking process that are applicable to clinician practice.

Through the two-tiered structure, the MAP Clinician Workgroup will not give input directly to HHS; rather, the Workgroup will advise the Coordinating Committee on the selection of measures and a coordination strategy for clinician performance measurement. The Clinician Workgroup will be guided by the decision making framework and measure selection criteria adopted by the Coordinating Committee, including alignment with the NQS. The Workgroup will give explicit consideration to the performance measures needed for dual eligible beneficiaries, to alignment of measures across all settings of care, and to improving outcomes of care.

The activities and deliverables of the MAP Clinician Workgroup do not fall under NQF's formal consensus development process (CDP).

Tasks

The Clinician Workgroup will review all of the performance measures currently in use for Federal programs and illustrative private sector programs. Attention will be given to where those measures converge and diverge. Convergence will inform the development of a core set of measures, while divergence may be instructive regarding the different purposes of specific programs or emerging measures in the field. The measures currently in use will be mapped to the cross-cutting priorities of the NQS, the high priority conditions identified by the NQF Measure Prioritization Advisory Committee, high impact specialties (e.g., by Part B charges), and the proposed ACO measures.

The Clinician Workgroup will advise the Coordinating Committee on a coordination strategy for clinician measurement and on the selection of measures through the following tasks:

1. Identification of a core set of available clinician performance measures, with focus on:
    a. Clinician measures needed across Federal programs (e.g., PQRS, EHR meaningful use, e-prescribing, resource use reporting, Physician Compare, and the future physician value-based modifier, as well as measures that can better align with hospital and other provider quality measures),
    b. Electronic data sources (e.g., clinically-enriched administrative data, EHRs),
    c. Office setting,

    d. Cross-cutting priorities from the NQS, and
    e. Priority conditions.
2. Identification of critical clinician measure development and endorsement gaps.
3. Development of a coordination strategy for clinician performance measurement, including:
    a. Alignment with other public and private initiatives, (e.g., ACO, PCMH, pay for performance programs, state and regional initiatives),
    b. HIT implications (e.g., coordination of data collection, use of patient-reported data), and
    c. High level transition plan and timeline by month.
4. Input on measures to be implemented through the Federal rulemaking process, based on an overview of the quality problems in the clinician office setting, the manner in which those problems could be improved, and the related measures for encouraging improvement.

Timeframe

Development of the initial clinician measurement coordination strategy will begin in May 2011 and will be completed by October 1, 2011. Input on the clinician measures to be implemented through Federal rulemaking will be completed by February 1, 2012.

Membership

Attachment A contains the MAP Clinician Workgroup roster.

The terms for MAP members are for three years. The initial members will serve staggered terms, determined by random draw at the first in-person meeting. MAP workgroups are convened by the Coordinating Committee as needed, thus a workgroup may be dissolved as the work of the MAP evolves.

Procedures

Attachment B contains the MAP member responsibilities and operating procedures.

**MEASURE APPLICATIONS PARTNERSHIP**
**CLINICIAN WORKGROUP**
*Convened by the National Quality Forum*

## Summary of MAP Clinician In-Person Meeting #1

The Measure Applications Partnership (MAP) Clinician Workgroup held their first in-person meeting on June 7-8, 2011. For those interested in reviewing an online archive of the web meeting, the link will be provided on the MAP Clinician Website.

The next meeting of the Clinician Workgroup will be a web meeting on June 30, followed by an in-person meeting on July 13-14, 2011, in Washington, DC.

**Workgroup Members in Attendance at the June 7-8 meeting:**

**Chair**

| |
|---|
| Mark McClellan, MD, PhD |

**Organizational Members**

| | |
|---|---|
| American Academy of Family Physicians | Bruce Bagley, MD |
| American Academy of Nurse Practitioners | Mary Jo Goolsby, EdD, MSN, NP-C, CAE, FAANP |
| American Academy of Orthopaedic Surgeons | Douglas Burton, MD |
| American College of Cardiology | Paul Casale, MD, FACC |
| American College of Radiology | David Seidenwurm, MD (phone) |
| 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 (phone) |
| Consumers' CHECKBOOK | Robert Krughoff, JD |
| Kaiser Permanente | Amy Compton-Phillips, MD |
| Minnesota Community Measurement | Beth Averbeck, MD |
| Physician Consortium for Performance Improvement | Mark Metersky, MD |
| The Alliance | Cheryl DeMars |
| Unite Here Health | Elizabeth Gilbertson, MS |

| **Expertise** | **Individual Subject Matter Expert Members** |
|---|---|
| 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 (phone) |
| Measure Methodologist | Dolores Yanagihara, MPH |

| Federal Government Members | |
|---|---|
| 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) | Michael Rapp, MD, JD, FACEP |
| Health Resources and Services Administration (HRSA) | Ian Corbridge, MPH, RN |
| Office of the National Coordinator for HIT (ONC) | Thomas Tsang, MD, MPH |
| Veterans Health Administration (VHA) | Joseph Francis, MD, MPH |

The primary objectives of the first in-person meeting were to:

- *Review charge of the MAP Clinician Workgroup, role within the MAP, and a plan to complete the tasks;*
- *Define the elements and discuss guiding principles for a coordination strategy for clinician performance measurement;*
- *Analyze clinician measures currently in use in federal programs and their alignment to the National Quality Strategy;*
- *Provide input on the coordination of healthcare-acquired condition and hospital readmission measures across public and private payers.*

Workgroup Chair, Mark McClellan, as well as Janet Corrigan, President and CEO, NQF, began the meeting with a welcome and introductions. This was followed by disclosures of interest by the Workgroup, led by Ann Hammersmith, General Counsel, NQF.

Tom Valuck, Senior Vice President, Strategic Partnerships, NQF, provided an overview of the MAP function, the specific charge the Coordinating Committee, the interaction between the Coordinating Committee and the Clinician Workgroup, and the MAP's member responsibilities, communications policy, and principles for media and public engagement.

The Workgroup members drew for their terms of membership. The chart below presents the terms for all Workgroup members.

Mark McClellan and Tom Valuck reviewed the Clinician Workgroup charge and described the strategies and models that contribute to the MAP decision making framework. These inputs include the HHS National Quality Strategy, the HHS Partnership for Patients safety initiative, the NQF-endorsed Patient-focused Episode of Care Model, and the high impact conditions as identified by the NQF-convened Measure Prioritization Advisory Committee.

In reviewing the clinician Workgroup charge, there was some discussion among the Workgroup about whether the term "clinician" was too narrow and should be replaced by something broader, such as "healthcare team." Ultimately, the Workgroup agreed that "clinician" was appropriate to use given the charge and its context.

Mark McClellan gave an overview of the elements of the clinician performance measurement strategy, which included:

- Core issues for measures and measurement – set of issues that measures and measurement strategies should seek to address;
- Data source and HIT implications – recognition of limitations of current data systems but potential for measures to promote more integrated and comprehensive data;
- Special considerations for vulnerable populations;

- Alignment with other settings; and
- Pathway for improving measure application.

These elements were discussed in detail throughout the remainder of the meeting.

In considering vulnerable populations Sarah Lash, Senior Program Director, Strategic Partnerships, NQF provided background on the Medicare-Medicaid dual-eligible population and discussed the measurement goals outlined by the MAP Dual-Eligible Workgroup. The complex and heterogeneous dual-eligible population was noted as important to consider throughout all aspects of the coordination strategy; however, the group identified several gap areas that differentially impact the duals:

- Measures that assess care across multiple settings, as well as the adequacy of community supports;
- Measures that support the assessment of multiple comorbidities;
- Measures addressing physical and mental disabilities; and
- Measures addressing cultural competency, language, and health literacy.

Ted vonGlahn, Pacific Business Group on Health, presented the Stanford-PBGH team's work supporting the MAP Coordinating Committee's development of measure selection criteria. Tom Valuck presented the Coordinating Committee's measures selection principles that will serve as the basis of the measure selection criteria. Those principles are:

- Promoting "systemness" and shared accountability,
- Addressing the various levels of accountability in a cascading fashion to contribute to a coherent
- measure set,
- Enabling action by providers,
- Helping consumers make rational judgments,
- Assessing quantifiable impact and contributing to improved outcomes, and
- Considering and assessing the burden of measurement.

In providing input to the Coordinating Committee on the measure selection principles, the Workgroup highlighted the following additional considerations:

- Additional measure selection principles:
  - Measure sets for a specific purpose
  - Impact
  - Evidence-based as indicative of high value
  - Disparities
  - Understandable/usable to intended audiences (e.g., consumers, physicians, policymakers)
  - Actionable to the affected healthcare team member
  - Unintended consequences
  - Balancing parsimony and comprehensiveness
- Key measure types needed in the coordination strategy:
  - Defining what people need – functional status, quality of life, coordinated care
  - Delta measures (change across time)
  - Across settings
  - Patient-reported outcomes

Representatives of ONC and CMS presented their specific needs regarding alignment among federal programs, public-private alignment, and what they wanted the Clinician Workgroup to accomplish. Tom Tsang, Medical Director, Meaningful Use, ONC, gave a brief presentation about HIT implications; and Mike Rapp, Director, Quality Measurement and Health Assessment, CMS, reviewed the federal programs specifically highlighting CMS' goal of working with multiple stakeholders in moving toward value-based purchasing. In reviewing the various federal programs – PQRS, Physician Compare, ePrescribing, EHR/Meaningful Use, and the QRUR/Value Modifier – Dr. Rapp presented the following as key implementation issues for physicians:

- Selection of measures
- Collection of quality data
- Public reporting of measures
- Resource use reports

In discussion, the Workgroup raised issues about patient safety, the current lack of standards around care coordination, harmonization of measure domains, and the proper use of efficiency measures. There was discussion about individual vs. group measures and reporting, and the issue of reporting burden on providers. The Workgroup highlighted the need to incorporate non-clinical data, such as societal factors surrounding patients.

Frank Opelka, MAP Safety Workgroup Chair, presented the current approach and work of the MAP Safety Workgroup to solicit input from the Clinician Workgroup. The Clinician Workgroup provided the following input to the MAP Safety Workgroup:

- Look beyond hospitals
- Importance of real-time feedback of data from payers
- Assessment through risk/predictive modeling
- Significance of payers role in system-wide collaboration
- Significance of clinician role in education/readmission prevention
- Align incentives for performance improvement
- Importance of front-line staff

To begin the second day, Floyd Eisenberg, Senior Vice President, HIT, NQF, provided an overview of NQF's Quality Data Model and how the current and future status of HIT adoption impacts quality measurement. Jim Walker, Chief Health Information Officer of the Geisinger Health System, provided comments highlighting the need for parsimony— finding measures that address care process and management in real time and at multiple levels. There was discussion again about individual/physician-level vs. group reporting, as well as the types of data being collected and reported. The subjects of ACOs and medical homes were raised as examples of a broader approach that HHS seems to be taking for promoting HIT adoption through systems that incorporate data derived from EHRs. The Workgroup also raised the importance of getting both clinicians and the public timely and transparent data to support decision making.

Taroon Amin, Senior Director, Strategic Partnerships, NQF, and Mitra Ghazinour, Project Manager, NQF, provided an orientation to the clinician performance measures table, a tool created to assist the Workgroup in its task of analyzing measures currently in use in federal programs. Mark McClellan and Aisha Pittman, Senior Program Director, Strategic Partnerships, NQF gave an overview of the federal and select private programs, related to clinical performance measures, and explained the Workgroup's afternoon activity of evaluating subsets of the existing clinician measures utilizing the measure selection principles. Through this activity the

Workgroup was asked to consider what should be incorporated into the measure selection criteria and to begin to consider which existing measures would best contribute to a core set of clinician measures.

In reporting back from the small group session, the following essential key themes arose:

- Shared accountability or "teamness"
- The importance of having measures address multiple levels of analysis
- Measures should be useful to their intended audience (e.g., consumers, policy makers, payers, purchasers)
- Predicting, preventing, and mitigating unintended consequences

The group also acknowledged the tension between balancing parsimony and comprehensiveness in a measure selection process, and began noting measure gap areas.

The meeting concluded with Mark McClellan providing a synthesis of day 2 conversation and next steps for the Workgroup.

| 1-Year Term | 2-Year Term | 3-Year Term |
|---|---|---|
| Mark McClellan, MD, PhD (*Chair)* | Center for Patient Partnerships, represented by Rachel Grob, PhD | American Academy of Nurse Practitioners, represented by Mary Jo Goolsby, EdD, MSN, NP-C, CAE, FAANP |
| American Academy of Family Physicians, represented by Bruce Bagley, MD | Kaiser Permanente, represented by Amy Compton-Phillips, MD | American College of Radiology, represented by David Seidenwurm, MD |
| American Academy of Orthopaedic Surgeons, represented by Douglas Burton, MD | Minnesota Community Measurement, represented by Beth Averbeck, MD | Association of American Medical Colleges, represented by Joanne Conroy, MD |
| American College of Cardiology, represented by, Paul Casale, MD, FACC | American Speech Language Hearing Association, represented by Janet Brown, MA, CCC-SLP | CIGNA, represented by Richard Salmon, MD, PhD |
| Unite Here Health, represented by Elizabeth Gilbertson, MS | Marshall Chin, MD, MHP, FACP | Consumers' CHECKBOOK, represented by Robert Krughoff, JD |
| Physician Consortium for Performance Improvement, represented by Mark Metersky, MD | Dolores Yanagihara, MPH | Eugene Nelson, MPH, DSc |
| The Alliance, represented by Cheryl DeMars | Centers for Disease Control and Prevention, represented by Peter Briss, MD, MPH | Karen Sepucha, PhD |
| Agency for Healthcare Research and Quality, represented by Darryl Gray, MD, ScD | Health Resources and Services Administration, represented by Ian Corbridge | Ronald Stock, MD, MA |
| Centers for Medicare and Medicaid Services, represented by Michael Rapp, MD, JD, FACEP | Office of the National Coordinator for HIT, represented by Thomas Tsang, MD, MPH | James Walker, MD, FACP |

# Measure Applications Partnership Clinician Workgroup
# Clinician Performance Measurement Coordination Strategy
# June 7-8 Workgroup Meeting Themes

The initial task of the MAP Clinician Workgroup is to develop a coordination strategy for the measurement of clinician performance across Federal programs, including the Physician Quality Reporting System (PQRS), Meaningful Use clinical quality measures, Physician Compare, and emerging programs like the value modifier. At the June 7-8 meeting, the Clinician Workgroup established the elements for the coordination strategy, emphasizing that the focus of the strategy is on the entire health care team. This health care team includes all clinicians and other caregivers, not just physicians. The **elements of the coordination strategy** are:

- Core issues for measures and measurement – set of issues that measures and measurement strategies should seek to address;
- Data source and HIT implications – recognition of limitations of current data systems but potential for measures to promote more integrated and comprehensive data;
- Special considerations for vulnerable populations;
- Alignment with other settings; and
- Pathway for improving measure application.

**Core Issues for Measures and Measurement**

The Clinician Workgroup considered principles for selecting measures for specific purposes as input to the Coordinating Committee and in preparation for identifying core measures for clinician performance measurement. The measure selection process is intended to build on, not duplicate, the NQF measure endorsement process. The endorsement criteria of importance, scientific acceptability, usability, and feasibility were briefly discussed. Measures in the portfolio of NQF endorsed measures are considered to have met these criteria.

The Clinician Workgroup also considered principles that arose from discussion at the May 3-4 MAP Coordinating Committee meeting as an input. Those included:

- Promotes "systemness" (e.g., joint accountability, care coordination);
- Addresses the patient perspective (e.g., patient preferences, useful to consumers);
- Actionable by providers;
- Enables longitudinal measurement;
- Contributes to improved outcomes;
- Incorporates cost;
- Promotes adoption of HIT; and
- Promotes parsimony.

In reviewing the principles and applying them to subsets of measures currently used in clinician performance measurement programs for assessing care coordination, cost, cardiovascular care, and diabetes care, the Clinician Workgroup identified several priority principles:

- Measures should promote **shared accountability and "teamness."** The health care team or an individual clinician should be able to influence the result of the measure (i.e., actionable), and the measure should assess care across settings and time (i.e., longitudinal), promoting care coordination.

- Measures should address multiple **levels of analysis.** Clinician performance measurement programs may permit different levels of data reporting (i.e. individual vs. group) to serve different purposes, though some Federal programs are currently limited to individual level of analysis. Group level analysis promotes shared accountability, while individual level analysis promotes action for specific individuals. The Workgroup discussed that sufficient sample size and designing comparison groups are methodological challenges at the individual clinician level. Using "cascading measures" for harmonization across levels of analysis was raised as a solution.
- Measures should be **useful to the intended audiences, including consumers, clinicians, payers, and policymakers.** Recognizing that measures selected will be used by current and future Medicare programs, measures should serve not only the Medicare's purposes but the results of measures must be understandable and meaningful to patients and clinicians. This should balance patient needs to evaluate providers and clinician needs to improve care. Additional considerations for measuring the patient/consumer perspective include:
    - Shared decision making in determining care pathways and goals.
    - Functional status measures to understand outcomes that matter to patients.
    - Quality of life measures to assess patient preferences, particularly for care at the end of life care.
- Consideration should be given to the potential for **unintended consequences** from measurement. Depending on the type of measure selected, the Workgroup discussed the potential need for risk adjustment or stratification to recognize the complexity of certain subpopulations and the need to avoid incentives for "cherry picking," while not adjusting away disparities that need to be addressed. Giving credit for improvement, as well as attainment, is one approach (i.e., delta measures). Selecting balancing measures is another approach.

With these criteria in mind, the Workgroup discussed the importance of **balancing comprehensiveness with parsimony**, as few measures will address all of the measures selection principles. The consideration of measure selection principles also highlighted the importance of balancing process and outcome measures.

In reviewing subsets of the existing measures, the group began to identify **measure gap areas**, including:

- Measures that address the patient perspective, incorporating patient self-reported data and assessing patient perspective, knowledge, and activation;
- Measures for people with mental illness and multiple chronic conditions; and
- Population-based global risk and functional status measures.

**Data Source and HIT Implications**

The Clinician Workgroup discussed the need for the coordination strategy to promote electronic data sources and HIT adoption to reduce data collection burden and make information more readily available for multiple purposes. Accordingly, consideration needs to be given to:

- The **types of data** used to collect and report measures, since neither claims, EHRs, nor other sources of clinical data are likely to be adequate alone. Consideration was also given to the need to move beyond clinical data sources typically used in measurement (e.g., claims, clinical results, EHR) and incorporate patient self-reported and non-clinical data.
- Data should ideally be **collected during the course of care.**
- **Promoting HIT adoption** and information exchange through the use of measures that increasingly incorporate data derived from EHRs.

- The **timeliness and transparency of data**. Information should be relayed to clinicians and the public so that it can be used by consumers and clinicians in real time as decisions are being made.

**Special Considerations for Vulnerable Populations** Considerations for vulnerable populations, in particular the complex and heterogeneous dual-eligible population, should be considered throughout all aspects of the coordination strategy; however, the group identified several gap areas that differentially impact the duals:

- Measures that assess care across multiple settings, as well as the adequacy of community supports;
- Measures that support the assessment of multiple comorbidities;
- Measures addressing physical and mental disabilities;
- Measures addressing cultural competency, language, and health literacy.

**Alignment with Other Settings** includes aligning the coordination strategy with the goals and principles of the National Quality Strategy. Additional alignment issues will be discussed at future meetings.

**Pathway for Improving Measure Application**

In recognizing that few measures will address all of the measure selection principles and that existing data sources limit measurement, the coordination strategy will contain a pathway for moving from the current state of measurement to an ideal state that incorporates a comprehensive set of measures.

**Next Steps**

This interim report from the Clinician Workgroup will be provided to the Coordinating Committee at its June 21-22 meeting. The Coordinating Committee will provide additional input to inform the July 13-14 Clinician Workgroup meeting. At that workgroup meeting, a draft core set of clinician performance measures will be discussed, as well as alignment with other settings and the pathway for improving measure application.

**MEASURE APPLICATIONS PARTNERSHIP**
**CLINICIAN WORKGROUP**
*Convened by the National Quality Forum*

**Summary of Web Meeting #1**

A web meeting of the Measure Applications Partnership (MAP) Clinician Workgroup was held on Thursday, June 30, 2011. For those interested in reviewing an online archive of the web meeting please click on the link below:

http://www.myeventpartner.com/NQFwebinar/E951D880814D

The next meeting of the Clinician Workgroup will be an in-person meeting on July 13-14, 2011, in Washington, DC.

**Committee Members in Attendance at the June 30 webinar:**

**Chair**

| |
|---|
| Mark McClellan, MD, PhD |

**Organizational Members**

| | |
|---|---|
| American Academy of Family Physicians | Bruce Bagley, MD |
| American Academy of Nurse Practitioners | Mary Jo Goolsby, EdD, MSN, NP-C, CAE, FAANP |
| American Academy of Orthopaedic Surgeons | Douglas Burton, MD |
| American College of Cardiology | Paul Casale, MD, FACC |
| 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 |
| Physician Consortium for Performance Improvement | Mark Metersky, MD |
| The Alliance | Cheryl DeMars |
| Unite Here Health | Elizabeth Gilbertson, MS |

| **Expertise** | **Individual Subject Matter Expert Members** |
|---|---|
| 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**

| | |
|---|---|
| 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) | Michael Rapp, MD, JD, FACEP |
| Health Resources and Services Administration (HRSA) | Ian Corbridge, MPH, RN |
| Office of the National Coordinator for HIT (ONC) | Thomas Tsang, MD, MPH |
| Veterans Health Administration (VHA) | Joseph Francis, MD, MPH |

The primary objectives of the web meeting were to:

- *Review the MAP Clinician Workgroup charge and the plan for accomplishing the charge,*
- *Review alignment challenges with the current federal programs for clinician performance measurement, and*
- *Propose guidance to HHS for better aligning the federal programs.*

The Clinician Workgroup Chair, Mark McClellan, welcomed attendees and reviewed the meeting objectives. Tom Valuck, Senior Vice President, Strategic Partnerships, NQF, reviewed the Workgroup's overall timeline of work and how federal program alignment issues fit into the Clinician Workgroup's scope of work.

Karen Milgate, Director, Office of Policy, Center for Strategic Planning, CMS provided an overview of the federal program alignment challenges for which CMS is looking for input from the Measure Applications Partnership. There are multiple federal programs aimed at measuring and improving clinician quality (e.g. PQRS; EHR/MU; Physician Compare; e-Prescribing Incentive Program; Physician Feedback/Value Modifier). The programs were created for different purposes and have competing characteristics, including varying reporting requirements and measure specifications, and differing timelines for data reporting, providing feedback to physicians, and distributing incentives.

Aucha Prachanronarong, Office of Clinical Standards and Quality, CMS, further explained the detailed differences among the programs. The issues she described were focused on data collection (differences in measure specifications, sample size, and data collection mechanisms) and data reporting (separate reporting mechanisms, individual vs. group reporting, reporting periods, and submission of data vs. rates). This led to discussion among the Workgroup about the level of engagement in these programs by clinicians. The issue was raised that benchmarking is not truly possible at this point as clinicians all report different subsets of measures, leading the Workgroup to note the need for a "core set" of measures. There was discussion about whether each specialty group needs its own unique set of measures, and which measures – such as care coordination or shared decision-marking – are cross-cutting. The group pointed out that cross-cutting measures, which range across specialties and conditions, are of most interest to consumers.

JoAnne Conroy of AAMC led the discussion as Workgroup members addressed the following questions:

- Which areas of misalignment across the federal programs for clinician performance measurement are most concerning?
- Should all programs move toward collecting only electronically-submitted data to encourage adoption of HIT and availability of real time feedback?
- Should all programs allow both individual and group reporting?
- Should all programs require submission of data elements instead of calculated measure results, as data elements can be used for multiple purposes?

The Workgroup's resulting discussion raised the following points:

- The need for a single, standardized data reporting process across all federal programs, and ultimately all payers
- Aligned measure specifications across all federal programs, and ultimately all payers
- A single data set to collect all necessary elements, periodically reported
- Data reporting at the individual physician level with aggregation to group level
- Data collection during the course of care
- Ability to collect patient reported data
- Timeliness of feedback to physicians
- Transparency of processes and information in all of the programs

# Measure Applications Partnership
# Clinician Performance Measurement Coordination Strategy
# Report Outline

1. Executive Summary

2. Introduction
    a. Roadmap to the report
    b. Description of the task and limitations
    c. Guidance to HHS

3. Measures and Measurement Issues
    a. Measure selection criteria
    b. Methodology for selection
    c. Initial core clinician measure set
    d. Measure gaps identified
    e. Special considerations for vulnerable populations
    f. Other key considerations

4. Data Sources and HIT Implications
    a. Data platform principles
    b. Types of data used to collect and report data elements
    c. Promotion of the adoption of HIT
    d. Other key considerations

5. Alignment Issues
    a. Across federal programs
        i. Measures
        ii. Data collection and reporting
    b. Beyond federal programs
        i. Mapping to other efforts
    c. Other key considerations

6. Pathway for Improving Measure Application
    a. Identification of ideal clinician measure set
    b. Further identification of gaps
    c. Year-end, pre-rulemaking

Appendices

- Rosters
- Meeting summaries and materials
- Background materials
- Public comment and response

# MAP Measure Set Selection Criteria
# "Strawperson" for Coordinating Committee Reaction
# (Revised End of Day 1 – June 21, 2011)

## Measure Sets "Fit for a Specific Purpose"

The MAP Coordinating Committee has been charged with identifying selection criteria to be applied to measure sets for public reporting and payment programs. Collectively, these criteria should address if a measure set under consideration is fit for its intended purpose. The measure set should be inclusive enough to achieve the program goals and be applicable to all entities that have an opportunity to contribute to achieving those objectives.

## Inputs to the Strawperson Measure Set Selection Criteria

Several inputs informed the strawperson measure set selection criteria list proposed below. These included:

### *MAP Coordinating Committee and workgroup deliberations*

The MAP Coordinating Committee members weighed in on guiding principles for measure set selection criteria at their first meeting. Subsequent feedback from the Clinician, Dual Eligible Beneficiaries, and Safety Workgroups was instrumental in shaping the strawperson criteria.

### *NQF measure endorsement criteria*

As was agreed at the first MAP Coordinating Committee meeting, the underlying assumption is that the NQF measure endorsement criteria will serve as the baseline. Individual endorsed measures are suitable for a variety of accountability applications, as well as for quality improvement. An NQF-endorsed measure has been determined to address a high impact aspect of healthcare with an opportunity for improvement and sufficient evidence (importance to measure and report); is a reliable and valid indicator of quality (scientific acceptability of measure properties); is understandable and useful for decisions related to accountability and improvement (usable); and is feasible to implement. Therefore, when considering measure set selection criteria, the focus is on sets of measures to achieve specific program goals, rather than on reexamining the integrity of individual measures.

### *Stanford team*

A team assembled by Arnie Milstein, MD, completed a thorough analysis of historical criteria sets, conducted "use cases" across various applications, and reached out to key informants to help elucidate criteria relevant to selecting measures for specific public reporting and payment programs.

**Strawperson Measure Set Selection Criteria (Revised End of Day 1 – June 21, 2011)**

Based on the inputs above, the following measure set selection criteria have emerged for the Committee's consideration and deliberation:

**Measure sets for specific public reporting and payment programs should:**

- Align with the priorities in the National Quality Strategy ---safe care; patient and family engagement; effective prevention and treatment; effective communication and care coordination; working with communities to enable healthy living; and affordable care --and consider high impact conditions with the greatest burden and potential gain to patients and the overall population.

- Address health and health care across the lifespan while promoting:
  - seamless care across transitions;
  - systemness;
  - individual and shared accountability among patients, providers, purchasers, health plans, and settings.

- Include measures of total cost of care, efficiency, and appropriateness.

- Be understandable, meaningful, and useful to the intended audiences:
  - Focus on outcome measures and measures with a clear link to improved outcomes
  - Balance issues of feasibility and evidence with users' needs.
  - Have ability to aggregate measures so that they provide meaningful interpretation of results for the given application.

- Core and advanced measure sets should be parsimonious and foster alignment between public and private payers to achieve a multidimensional view of quality.

- Have safeguards in place to detect or mitigate unintended consequences, such as adverse selection, through the use of "balancing measures" or other mechanisms to detect exclusion of high risk patients.

- Address specific program features including target population, setting, level of analysis, transparency and availability of data from various sources.

**Individual measures within measure sets for specific public reporting and payment programs should be:**

- NQF-endorsed, or if not endorsed, meet conditions for consideration of endorsement (e.g., measures should have been tested).
- Build on measure endorsement thresholds including:
  - Magnitude of the improvability gap;
  - Ability to discriminate to allow for meaningful comparisons; and
  - Proximity to outcomes, including patient-reported outcomes.
- Measures tested for the setting and level of analysis in which it will be implemented.
- Ensure measures have broad applicability across populations and settings.
- Ensure an adequate sample size for stable and meaningful comparison across the intended accountable entities (e.g., ACOs, hospitals, nursing homes, clinicians).

# MAP "Working" Measure Selection Criteria

## Rating Scale for Individual Measure Review – contribution to a comprehensive measure set for accountability

1. **Measures contribute to a multidimensional view of quality focused on the greatest burden**
   *Demonstrated by addressing the priorities in National Quality Strategy (Table 1) or addressing conditions of the greatest burden and potential gain to patients and the population (Table 2)*
   Rating:
   - Low: measure does not address any of the priorities in the NQS nor represent a measure of a high impact condition
   - Medium: measure represents one of the priorities of the NQS or a single high impact condition
   - High: measure represents multiple (more than one) priorities of the NQS and a high impact condition

2. **Measures are Important to measure and report, have Scientifically Acceptable measure properties, Usable, and Feasible (i.e., address a performance gap, evidence-based, reliable, allow valid conclusions about quality, useful for accountability and improvement, and feasible to implement)**
   *Demonstrated by undergoing and receiving NQF endorsement*
   Rating:
   - Low: measure development required or measure under development
   - Medium: measure development completed, but not submitted to NQF
   - High: measure in pipeline for endorsement or endorsed by NQF

3. **Measures have broad applicability to promote parsimony and inclusiveness of intended accountable entities**
   *Demonstrated by applicability across multiple types of providers, levels of analysis, care settings, and conditions*
   Rating:
   - Low: measure is limited to a narrow subset of providers, levels of analysis, care settings, or conditions
   - Medium: measure is applicable to primary (general) care and specialty providers (services) in a limited set of care settings or conditions
   - High: measure is applicable across multiple types of providers, levels of analysis, care settings, and conditions

4. **Measures enable longitudinal assessment of patient-focused episode of care**
   *Demonstrated by assessing care across time or with the patient as the unit of analysis*
   Rating:
   - Low: measure is focused on a narrow phase of an entire episode of care (e.g., point in time, single encounter, acute care stay)
   - Medium: measure provides an assessment of care across some settings of care or time
   - High: measure provides an assessment of care across a broad range of settings of care and time

5. **Measures are ready for implementation in the context of a specific program**
   *Demonstrated by prior operational use in the specific context or specified and tested for the setting and level of analysis needed for the specific program*
   Rating:
   - Low: measure has not been in use, nor is it specified and tested for the setting and level of analysis needed for the program
   - Medium: measure is specified and tested for the setting and level of analysis needed for the program
   - High: measure has been tested and is in operational use in the specific context or specified for the setting and level of analysis needed for the specific program

6. **Measures promote a highly reliable system of care (i.e., delivery of the right care every time)**
   *Demonstrated by focusing on outcomes, composites of all necessary interventions, and processes most proximal to desired outcomes, or with strong evidence chain from distal processes to desired outcomes*
   Rating:
   Low: Measures a distal structure or process that requires additional steps to influence desired outcomes (e.g., the frequency of assessing a lab value)
   Medium: Process proximal to desired outcome (e.g., administering flu vaccine); or strong evidence chain for links to desired outcome (e.g., mammography screening)
   High: Outcome or composite of all required interventions

## Rating Scale for Measure Set Review – final check review of the entire set as a whole

1. **Measure set provides a comprehensive view of quality - NQS**
   *Demonstrated by measures within the set addressing all of the NQS priorities*
   Rating:
   Low: measure set addresses less than 1-2 of the NQS priorities
   Medium: measure set addresses at least 3-4 of the NQF priorities
   High: measure set addresses 5-6 of the NQS priorities

2. **Measure set provides a comprehensive view of quality – high impact conditions**
   *Demonstrated by measures within the set addressing high impact conditions identified for the intended accountable entities*
   Rating:
   Low: measure set addresses a few (or <25%) of the identified high impact conditions
   Medium: measure set addresses some (25-50%) of the identified high impact conditions
   High: measure set addresses most (over half) of the identified high impact conditions

3. **Measure set includes measurement of all intended accountable entities and promotes parsimony to support efficient use of resources for data collection, measurement, and reporting through the smallest number of measures needed to address the National Quality Strategy and high impact conditions**
   *Demonstrated by a measure set which is applicable across multiple types of providers, care settings, and conditions*
   Rating:
   Low: measure set is limited to select set of providers, care settings, and conditions
   Medium: measure set is applicable to at primary care and specialty providers in a limited set of care settings and conditions
   High: measure set is applicable across multiple types of providers, care settings, and conditions

4. **Measure set avoids undesirable consequences**
   *Demonstrated by a measure set in which the measures avoid undesirable consequences or have a method for detecting undesirable consequences*
   Rating:
   Low: concern for unintended undesirable consequences and detection would require additional data collection
   Medium: some concern for unintended undesirable consequences which could be detected with additional analysis of existing data (e.g., analysis of patient case mix); or incentives for potential undesirable consequences are balanced within the set of measures (e.g., incentive to drop caring for certain types of patients balanced with incentives to provide care for that same group of patients)
   High: little concern for unintended undesirable consequences; or the set includes measures to detect potential unintended consequences

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 health care 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 (≥85$^{th}$ 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 |

**Draft Initial Clinician Core Measure Set Summary Table**
**7/11/2011**

| NQF Number and Measure Title | Description | Program |
|---|---|---|
| **Patient and Family Engagement (2 Measures)** | | |
| 0005<br>CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys) | • Getting Timely Care, Appointments, and Information.<br>• How Well Your Doctors Communicate<br>• Helpful, Courteous, Respectful Office Staff<br>• Patients' Rating of Doctor<br>• Health Promotion and Education<br>• Shared Decision Making | ACO |
| 0326<br>Advance Care Plan | Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. | PQRS |
| **Care Coordination (3 Measures)** | | |
| 0228<br>Care Transition Measure | Uni-dimensional self-reported survey that measures the quality of preparation for care transitions. Namely:<br>1. Understanding one's self-care role in the post-hospital setting<br>2. Medication management<br>3. Having one's preferences incorporated into the care plan. | ACO |
| 0576<br>Follow-up after Hospitalization for Mental Illness | Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. | Medicaid, CHIPRA |

**Draft Initial Clinician Core Measure Set Summary Table**
**7/11/2011**

| NQF Number and Measure Title | Description | Program |
|---|---|---|
| 1517<br>Prenatal and Postpartum Care: Timeliness of Prenatal Care | The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization. | CHIPRA |
| **Safer Care (8 Measures)** | | |
| 0021<br>Medication Monitoring (ACE/ARBs, Digoxin, and Diuretics) | The percentage of members 18 years of age and older who received at least a 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the three rates separately and as a total rate.<br>• Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)<br>• Annual monitoring for members on digoxin<br>• Annual monitoring for members on diuretics<br>• Total rate (the sum of the three numerators divided by the sum of the three denominators) | Medicaid, MA 5-Star Rating, IHA, GEM |
| 0298<br>Health Care Acquired Conditions: CLABSI Bundle | Percentage of intensive care patients with central lines for whom all elements of the central line bundle are documented and in place.<br>The central line bundle elements include:<br>•Hand hygiene,<br>•Maximal barrier precautions upon insertion<br>•Chlorhexidine skin antisepsis<br>•Optimal catheter site selection, with subclavian vein as the preferred site for non-tunneled catheters in patients 18 years and older<br>•Daily review of line necessity with prompt | ACO |

| NQF Number and Measure Title | Description | Program |
|---|---|---|
| | removal of unnecessary lines. | |
| 0329<br>Inpatient Readmission Within 30 Days | The percentage of inpatient admissions that resulted in a readmission within 30 days of discharge during the measurement year. This measure is risk adjusted by CMS DRG case mix. | IHA |
| 0640<br>Hours of Physical Restraint Use | The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint per 1000 psychiatric inpatient hours, overall and stratified by age group. | Medicaid |
| 0022<br>Drugs to Be Avoided in the Elderly | Percentage of patients ages 65 years and older who received at least one drug to be avoided in the elderly and/or two different drugs to be avoided in the elderly in the measurement period | PQRS |
| 0101<br>Falls: Screening for Fall Risk | Percentage of patients aged 65 years and older who were screened for fall risk at least once within 12 months | PQRS, ACO |
| 0270<br>Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics | Percentage of surgical patients aged 18 years and older who receive an anesthetic when undergoing procedures with the indications for prophylactic parenteral antibiotics for whom administration of the prophylactic parenteral antibiotic ordered has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) | PQRS |
| 0454<br>Perioperative Temperature Management | Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients | PQRS |

| NQF Number and Measure Title | Description | Program |
|---|---|---|
| | undergoing cardiopulmonary bypass, for whom either active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time | |
| **Prevention (8 Measures)** | | |
| 0031<br>Preventive Care and Screening: Screening Mammography | Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months<br>Measure specification changed and under NQF review:<br>The percentage of women 50–69 years of age who had a mammogram to screen for breast cancer. The<br>eligible population starts at 52 years of age to account for the look-back period. | PQRS, MU, Medicaid, ACO, IHA, BCBS-MA, GEM |
| 0032<br>Cervical Cancer Screening | The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer. | MU, Medicaid, IHA |
| 0033<br>Chlamydia Screening for Women | The percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. | MU,CHIPRA, IHA, BCBS-MA |
| 0034<br>Preventive Care and Screening: Colorectal Cancer Screening | Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening | PQRS, MU, ACO, MA 5-Star Rating, IHA, BCBS-MA, GEM |
| 0038<br>Childhood Immunization Status | The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H | PQRS, MU, CHIPRA, IHA |

| NQF Number and Measure Title | Description | Program |
|---|---|---|
| | influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates. | |
| 1407<br>Immunizations for Adolescents | The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate. | CHIPRA |
| 0046<br>Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older | Percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months | PQRS, MA 5-Star Rating |
| 0418<br>Screening for Clinical Depression and Follow-up Plan | Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented | PQRS, Medicaid, ACO |
| **Secondary Prevention and Treatment (10 Measures)** | | |
| 0541<br>Proportion of Days Covered(PDC): 5 Rates by Therapeutic Category | The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated separately for the following medication categories: Beta-Blockers (BB), Angiotensin-Converting Enzyme Inhibitor/Angiotensin-Receptor Blocker (ACEI/ARB), Calcium-Channel Blockers | Medicaid |

| NQF Number and Measure Title | Description | Program |
|---|---|---|
| | (CCB), Diabetes Medication, Statins. | |
| A composite measure that builds from NQF-endorsed measures:<br>OT1-009 and OT1-029<br>Diabetes Care (CDC)—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), HbA1c Control (<7.0%) for a Selected Population, LDL Screening and Control (<100), Nephropathy Monitoring, Blood Pressure Control (<140/90), Optimal Diabetes Care | The percentage of members 18–75 years of age with type 1 and type 2 diabetes who met the numerator<br>criterion for the rates below.<br>• Hba1c Testing<br>• Hba1c Poor Control (>9.0%)<br>• Hba1c Control (<8.0%)<br>• Hba1c Control (<7.0%) for a Selected Population*<br>• LDL-C Screening<br>• LDL-C Control (<100 mg/dL)<br>• Nephropathy Monitoring<br>• Blood Pressure Control (<140/90 mm Hg)<br>• Optimal Diabetes Care<br>– Combination Rate 1: HbA1c Control (<8.0%), and LDL-C Control (<100 mg/dL), and<br>Nephropathy Monitoring<br>– Combination Rate 2: All criteria in Combination Rate 1 and BP Control (<140/90 mm Hg) | IHA |
| 0018<br>Controlling High Blood Pressure | The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year. | PQRS, MU, Medicaid, ACO, MA 5-Star Rating, BCBS-MA |
| A composite measure that builds from NQF Endorsed measures:<br>0067,0074,0070,0064,0066<br>Coronary Artery Disease (CAD)<br>Composite: All or Nothing Scoring | • Oral Antiplatelet Therapy Prescribed for Patients with CAD<br>• Drug Therapy for Lowering LDL Cholesterol<br>• Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)<br>• LDL Level <100 mg/dl<br>• Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for | ACO |

| NQF Number and Measure Title | Description | Program |
|---|---|---|
| | Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD) | |
| 0079<br>Heart Failure: Left Ventricular Function (LVF) Assessment | Percentage of patients aged 18 years and older with a diagnosis of heart failure who have quantitative or qualitative results of LVF assessment recorded. | PQRS, ACO |
| 0081<br>Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) | Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy | PQRS, MU, ACO |
| 0083<br>Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) | Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy. | PQRS, MU, ACO, |
| 0092<br>Aspirin at Arrival for Acute Myocardial Infarction (AMI) | Percentage of patients, regardless of age, with an emergency department discharge diagnosis of AMI who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay | PQRS |
| 0001<br>Asthma: Asthma Assessment | Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms. | PQRS, MU |
| 0036<br>Use of Appropriate Medications for Asthma | The percentage of patients 5-50 years of age during the measurement year who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total). | MU, Medicaid |

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| NQF Number and Measure Title | Description | Program |
|---|---|---|
| **Healthy Living (3 Measures)** | | |
| 0027<br>Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies | The percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies. | MU, Medicaid |
| 0024<br>Weight Assessment and Counseling for Children and Adolescents | Percentage children, 2 through 18 years of age, whose weight is classified based on BMI percentile for age and gender. | PQRS, MU, CHIPRA |
| 0421<br>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up | Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented Normal Parameters: Age 65 and older BMI ≥23 and <30; Age 18 – 64 BMI ≥18.5 and <25 parameters, a follow-up plan is documented. | PQRS, MU, Medicaid, ACO |
| **Affordable Care (2 Measures)** | | |
| NA49<br>Total Cost of Care (baseline) | The Total Cost of Care measure is based upon actual costs associated with care for membership attributed to<br>a PO, including all covered professional, pharmacy, hospital, and ancillary care, as well as administrative<br>payments and adjustments. | IHA |
| NA48<br>Generic Prescribing (7 therapeutic areas) | The level of generic prescribing will be measured as a simple prescription rate. This will be measured for<br>seven groups of therapeutic classes (SSRIs/SNRIs; Statins; Anti-Ulcer Agents; | IHA |

| NQF Number and Measure Title | Description | Program |
|---|---|---|
| | Cardiac—Hypertension and Cardiovascular; Nasal Steroids; Diabetes—Oral; and Anxiety/Sedation—Sleep Aids) and for all prescriptions, with the exception of self-injectable drugs. | |

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| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| **Patient and Family Engagement** | | | | | | |
| 0005 Endorsed | CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys) | • Getting Timely Care, Appointments, and Information.<br>• How Well Your Doctors Communicate<br>• Helpful, Courteous, Respectful Office Staff<br>• Patients' Rating of Doctor<br>• Health Promotion and Education<br>• Shared Decision Making | AHRQ | | | ACO |
| 0326 Endorsed | Advance Care Plan | Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan | AMA-PCPI/NCQA | Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan | All patients aged 65 years and older | PQRS |

# Draft Initial Clinician Core Measure Set – Details Table
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| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| **Care Coordination** | | | | | | |
| 0228 Endorsed | Care Transition Measure | Uni-dimensional self-reported survey that measures the quality of preparation for care transitions. Namely:<br>1. Understanding one's self-care role in the post-hospital setting<br>2. Medication management<br>3. Having one's preferences incorporated into the care plan | University of Colorado Health Sciences Center | The 15-item and the 3-item CTM share the same set of response patterns: Strongly Disagree; Disagree; Agree; Strongly Agree (there is also a response for Don't Know; Don't Remember; Not Applicable). Based on a subject's response, a score can be assigned to each item as follows:<br>• Strongly Disagree = 1<br>• Disagree = 2 | | ACO |
| 0576 Endorsed | Follow-up after Hospitalization for Mental Illness | Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. | NCQA | Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge.<br>Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge.<br>Time Window: Date of discharge through 30 days after discharge | Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one | Medicaid, CHIPRA |

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| | | | | | discharge on or between January 1 and December 1 of the measurement year. | |
| 1517 Member Voting | Prenatal and Postpartum Care: Timeliness of Prenatal Care | The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization. | NCQA | Deliveries of live births for which women receive the following facets of prenatal and postpartum care:<br>Rate 1: Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.<br>Rate 2: Had a postpartum visit on or between 21 and 56 days after delivery. | Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year | CHIPRA |
| **Safer Care** | | | | | | |
| 0021 Endorsed | Medication Monitoring (ACE/ARBs, Digoxin, and Diuretics) | The percentage of members 18 years of age and older who received at least a 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the | NCQA | a: The number of patients with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.<br>b: The number of patients with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.<br>c: The number of patients with at least one serum potassium and either a | a: The number of patients ages 18 years and older who received at least a 180-days supply of ACE inhibitors or ARBs, including any combination products during the measurement year.<br>b: The number of patients ages 18 years and older who received at least a 180-days supply of digoxin, including any combination products, during the | Medicaid, MA 5-Star Rating, IHA, GEM |

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| | | three rates separately and as a total rate.<br>• Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)<br>• Annual monitoring for members on digoxin<br>• Annual monitoring for members on diuretics<br>• Total rate (the sum of the three numerators divided by the sum of the three denominators) | | serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.<br>Note: The two tests do not need to occur on the same service date, only within the measurement year.<br>d: The number of patients with at least one drug serum concentration level monitoring test for the prescribed drug in the measurement year. If a patient received only one type of anticonvulsant, the drug serum concentration level test must be for the specific drug taken as a persistent medication. If a patient persistently received multiple types of anticonvulsants, each anticonvulsant medication and drug monitoring test combination is counted as a unique event (i.e., a patient on both phenytoin and valproic acid with at least a 180-days supply for each drug in the measurement year must separately show evidence of receiving drug serum concentration tests for each drug to be considered numerator-compliant for each drug). | measurement year.<br>c: The number of patients ages 18 years and older who received at least a 180-days supply of a diuretic, including any combination products, during the measurement year<br>d: The number of patients in the denominator who received at least a 180-days supply for any anticonvulsant for phenytoin, phenobarbital, valproic acid or carbamazepine during the measurement year. Each patient-drug combination is considered a unique event.<br>e: The number of patients in the denominator who received at least a 180-days supply for any statin (HMG CoA Reductase Inhibitors), including any combination product, during the measurement year.<br>F: Sum of the five denominators (a-e) | |

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| | | | | e: The number of patients with both an ALT and an AST liver enzyme test in the measurement year. A hepatic function panel (which includes both a ALT and AST) also counts as numerator compliant.<br>F: Sum of the five numerators (a-e) | | |
| 0298 Endorsed | Health Care Acquired Conditions: CLABSI Bundle | Percentage of intensive care patients with central lines for whom all elements of the central line bundle are documented and in place.<br>The central line bundle elements include:<br>•Hand hygiene ,<br>•Maximal barrier precautions upon insertion<br>•Chlorhexidine skin antisepsis<br>•Optimal catheter site selection, with subclavian vein as the preferred site for non-tunneled catheters in patients 18 years and older<br>•Daily review of line necessity with prompt removal of unnecessary lines | Institute for Healthcare Improvement | Number of intensive care patients with central lines for whom all elements of the central line bundle are documented and in place.<br>The central line bundle elements include:<br>• Hand hygiene ,<br>• Maximal barrier precautions upon insertion<br>• Chlorhexidine skin antisepsis<br>• Optimal catheter site selection, with subclavian vein as the preferred site for non-tunneled catheters in patients 18 years and older<br>• Daily review of line necessity with prompt removal of unnecessary lines | Total number of intensive care patients with central lines on day of week of sample. | ACO |

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| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| 0329 Endorsed | Inpatient Readmission Within 30 Days | The percentage of inpatient admissions that resulted in a readmission within 30 days of discharge during the measurement year. This measure is risk adjusted by CMS DRG case mix. | United Health Group | Total inpatient readmissions within 30 days from non-maternity and non-pediatric discharges to any hospital | Total non-maternity and non-pediatric discharges | IHA |
| 0640 Endorsed | Hours of Physical Restraint Use | The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint per 1000 psychiatric inpatient hours, overall and stratified by age group | TJC | The number of hours that all psychiatric inpatients were maintained in physical restraint per 1000 psychiatric inpatient hours, overall and stratified by age group | Number of psychiatric inpatient hours | Medicaid |
| 0022 Endorsed | Drugs to Be Avoided in the Elderly | Percentage of patients ages 65 years and older who received at least one drug to be avoided in the elderly and/or two different drugs to be avoided in the elderly in the measurement period | NCQA | a: at least one prescription for any drug to be avoided in the elderly in the measurement year.<br>b: At least two different drugs to be avoided in the elderly in the measurement year. | All patients ages 65 years and older as of December 31 of the measurement year. | PQRS |
| 0101 Endorsed | Falls: Screening for Fall Risk | Percentage of patients aged 65 years and older who were screened for fall risk at least once within 12 | AMA-PCPI/NCQA | Patients who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in | All patients aged 65 years and older | PQRS, ACO |

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| | | months | | the past year or any fall with injury in the past year) at least once within 12 months<br><br>Definition: A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force (Tinetti). | | |
| 0270 Endorsed | Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics | Percentage of surgical patients aged 18 years and older who receive an anesthetic when undergoing procedures with the indications for prophylactic parenteral antibiotics for whom administration of the prophylactic parenteral antibiotic ordered has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) | AMA-PCPI/NCQA | Surgical patients who have an order for prophylactic antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required).<br><br>Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that antibiotic is to be given within one hour (if fluoroquinolone or | All surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics | PQRS |

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| | | | | vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) OR documentation that antibiotic has been given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required). | | |
| 0454 Endorsed | Perioperative Temperature Management | Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass, for whom either active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 | AMA-PCPI | Patients for whom either:<br>• active warming was used intraoperatively for the purpose of maintaining normothermia, OR<br>• at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 30 minutes immediately after anesthesia end time<br>Numerator definition:<br>For purposes of this measure, “active warming” is limited to the following modalities only: forced-air warming, warm water garments | All patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer | PQRS |

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| | | minutes immediately before or the 15 minutes immediately after anesthesia end time | | | | |
| **Prevention** | | | | | | |
| 0031 Endorsed | Preventive Care and Screening: Screening Mammography | Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months Measure specification changed and under NQF review: The percentage of women 50–69 years of age who had a mammogram to screen for breast cancer. The eligible population starts at 52 years of age to account for the look-back period. | NCQA | One or more mammograms during the measurement year or the year prior to the measurement year. | Women 52-69 years as of December 31 of the measurement year. Note: Given the measurement look back period, women 50-69 will be captured in this measure. | PQRS, MU, Medicaid, ACO, IHA, BCBS-MA, GEM |
| 0032 Endorsed | Cervical Cancer Screening | The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer. | NCQA | One or more Pap tests during the measurement year or the two years prior to the measurement year. | Women 21–64 years of age during the measurement year. Note: Given the measurement look back period, women 18-64 will be captured in this measure. | MU, Medicaid, IHA |
| 0033 endorsed | Chlamydia Screening for Women | The percentage of women 15-24 years of age who were identified as sexually | NCQA | Documentation in the medical record of at least one Chlamydia test during the measurement year. A | Women 16-25 years of age (reported in stratifications of 16-20, 21-25 and overall) as of | MU,CHIPRA, IHA, BCBS-MA |

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| | | active and who had at least one test for chlamydia during the measurement year. | | woman is considered as having a test if there is documentation of a Chlamydia trachomatis or species test with a service date during the measurement year. | December 31 of the measurement year who are sexually active. Two methods are provided to identify sexually active women: pharmacy data and claims/encounter data. Use both methods to identify the eligible population, although a patient must appear in only one method to be eligible for the measure. | |
| 0034 Endorsed | Preventive Care and Screening: Colorectal Cancer Screening | Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening | NCQA | One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the four criteria below:<br>•fecal occult blood test (FOBT) during the measurement year<br>•flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year<br>•double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year.<br>•colonoscopy during the measurement year or the nine years prior to the measurement year. | Patients 50–80 years of age during the measurement year. Note: Given the measurement look back period, adults 50-80 will be captured in this measure. | PQRS, MU, ACO, MA 5-Star Rating, IHA, BCBS-MA, GEM |

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| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| 0038 Endorsed | Childhood Immunization Status | The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates. | NCQA | For all antigens, count any of the following:<br>•evidence of the antigen or combination vaccine, or<br>•documented history of the illness, or<br>•a seropositive test result.<br>For combination vaccinations that require more than one antigen (i.e., MMR), find evidence of all of the antigens. For immunization information obtained from the medical record, count patients where there is evidence that the antigen was rendered from:<br>•a note indicating the name of the specific antigen and the date of the immunization, or<br>•a certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.<br>For documented history of illness or a seropositive test result, find a note indicating the date of the event. The event must have occurred by the patient's second birthday. Notes in the medical | A systematic sample drawn from children who turn two years of age during the measurement year. | PQRS, MU, CHIPRA, IHA |

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| | | | | record indicating that the patient received the immunization "at delivery" or "in the hospital" may be counted toward the numerator. This applies only to immunizations that do not have minimum age restrictions (e.g., prior to 42 days after birth). A note that the "patient is up-to-date" with all immunizations that does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for this measure. | | |
| 1407 Member Voting | Immunizations for Adolescents | The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate. | NCQA | Children who had documentation in the medical record of recommended immunizations by age 13 years | Children who turned 13 years of age between January 1 of the measurement year and December 31 of the measurement year and who had documentation of a face-to-face visit between the clinician and the child that predates the child's birthday by at least 12 months. | CHIPRA |

# Draft Initial Clinician Core Measure Set – Details Table
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| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| 0046 Endorsed | Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older | Percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months | AMA-PCPI/NCQA | Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months | All female patients aged 65 years and older | PQRS, MA 5-Star Rating |
| 0418 Endorsed | Screening for Clinical Depression and Follow-up Plan | Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented | CMS/QIP | Patient's screening for clinical depression is documented and follow up plan is documented. | Patient 18 years of age and older | PQRS, Medicaid, ACO |
| **Secondary Prevention and Treatment** | | | | | | |
| 0541 endorsed | Proportion of Days Covered(PDC): 5 Rates by Therapeutic Category | The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated separately for the following medication categories: Beta-Blockers (BB), Angiotensin-Converting Enzyme Inhibitor/Angiotensin-Receptor Blocker | PQA | The number of patients who met the PDC threshold during the measurement year for each therapeutic category separately. Follow the steps below for each patient to determine whether the patient meets the PDC threshold.<br>Step 1: Count the total days supply (covered days) within the measurement year for the specific therapeutic medication dispensed during the measurement | Patients who were dispensed at least two prescriptions in a specific therapeutic category on two unique dates of service during the measurement year. | Medicaid |

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| | | (ACEI/ARB), Calcium-Channel Blockers (CCB), Diabetes Medication, Statins. | | year. | | |
| A composite measure that builds from NQF-endorsed measures: OT1-009 and OT1-029 | Diabetes Care (CDC)—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), HbA1c Control (<7.0%) for a Selected Population, LDL Screening and Control (<100), Nephropathy Monitoring, Blood Pressure Control (<140/90), Optimal Diabetes Care | The percentage of members 18–75 years of age with type 1 and type 2 diabetes who met the numerator criterion for the rates below.<br>• Hba1c Testing<br>• Hba1c Poor Control (>9.0%)<br>• Hba1c Control (<8.0%)<br>• Hba1c Control (<7.0%) for a Selected Population*<br>• LDL-C Screening<br>• LDL-C Control (<100 mg/dL)<br>• Nephropathy Monitoring<br>• Blood Pressure Control (<140/90 mm Hg)<br>• Optimal Diabetes Care<br>– Combination Rate 1: HbA1c Control (<8.0%), and LDL-C Control (<100 mg/dL), and Nephropathy Monitoring<br>– Combination Rate 2: | HEDIS, the Minnesota Community Measurement Program | | | IHA |

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| | | All criteria in Combination Rate 1 and BP Control (<140/90 mm Hg) | | | | |
| 0018 Endorsed | Controlling High Blood Pressure | The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year. | NCQA | The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be <140/90mm Hg. | Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year. | PQRS, MU, Medicaid, ACO, MA 5-Star Rating, BCBS-MA |
| A composite measure that builds from NQF Endorsed Measures: 0067,0074,0070,0064,0066 | Coronary Artery Disease (CAD) Composite: All or Nothing Scoring | • Oral Antiplatelet Therapy Prescribed for Patients with CAD<br>• Drug Therapy for Lowering LDL Cholesterol<br>• Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)<br>• LDL Level <100 mg/dl<br>• Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular | (0067, 0074, 0070, 0066: AMA-PCPI ) (0064: NCQA) | | | ACO |

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| | | Systolic Dysfunction (LVSD) | | | | |
| 0079 Endorsed | Heart Failure: Left Ventricular Function (LVF) Assessment | Percentage of patients aged 18 years and older with a diagnosis of heart failure who have quantitative or qualitative results of LVF assessment recorded. | AMA-PCPI | Patients for whom the quantitative or qualitative results of a recent or prior (any time in the past) LVEF assessment is documented* within a 12 month period<br><br>*Documentation must include documentation in a progress note of the results of an LVEF assessment, regardless of when the evaluation of ejection fraction was performed.<br><br>Qualitative results correspond to numeric equivalents as follows:<br>Hyperdynamic: corresponds to LVEF greater than 70%<br>Normal: corresponds to LVEF 50% to 70% (midpoint 60%)<br>Mild dysfunction: corresponds to LVEF 40% to 49% (midpoint 45%)<br>Moderate dysfunction: corresponds to LVEF 30% to 39% (midpoint 35%)<br>Severe dysfunction: corresponds to LVEF less than 30% | All patients aged 18 years and older with a diagnosis of heart failure | PQRS, ACO |

**Draft Initial Clinician Core Measure Set – Details Table**
**7/11/2011**

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| 0081 Endorsed | Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) | Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy | AMA-PCPI | Patients who were prescribed* ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge | All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%<br><br>LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe dysfunction | PQRS, MU, ACO |
| 0083 Endorsed | Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) | Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy. | AMA-PCPI | Patients who were prescribed* beta-blocker therapy** either within a 12 month period when seen in the outpatient setting or at hospital discharge<br><br>*Prescribed may include prescription given to the patient for beta-blocker therapy at one or more visits in the measurement period OR patient already taking beta-blocker therapy as documented in current medication list<br><br>**Beta-blocker therapy should include bisoprolol, carvedilol, or sustained release metoprolol succinate. | All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%<br><br>LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe dysfunction | PQRS, MU, ACO |

## Draft Initial Clinician Core Measure Set – Details Table
## 7/11/2011

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| 0092 Endorsed | Aspirin at Arrival for Acute Myocardial Infarction (AMI) | Percentage of patients, regardless of age, with an emergency department discharge diagnosis of AMI who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay | AMA-PCPI/NCQA | Patients who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay | All patients with an emergency department discharge diagnosis of acute myocardial infarction | PQRS |
| 0001 Endorsed | Asthma: Asthma Assessment | Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms. | AMA-PCPI | Patients who were evaluated during at least one office visit during the reporting year for the frequency (numeric) of daytime and nocturnal asthma symptoms**To be counted in calculations of this measure, symptom frequency must be numerically quantified. Measure may also be met by physician documentation or patient completion of an asthma assessment tool/survey/questionnaire. Assessment tools may include the QualityMetric Asthma Control Test™; NAEPP Asthma Symptoms and Peak Flow Diary. | All patients aged 5-40 years with asthma Patient Selection: ICD-9-CM Codes for asthma: 493.00-493.92And CPT codes for patient visit: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99383-99385, 99393-99395, 99401-99404 And Patient's age is between 5 and 40 years. | PQRS, MU |

## Draft Initial Clinician Core Measure Set – Details Table
## 7/11/2011

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| 0036 Endorsed | Use of Appropriate Medications for Asthma | The percentage of patients 5-50 years of age during the measurement year who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total). | NCQA | Documentation in the medical record must include, at a minimum, a note indicating the patient received a t least one written prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylxanthines during the measurement year. | All patients ages 5-56 years as of December 31 of the measurement year with persistent asthma reported in three age stratifications (5-9, 10-17, 18-56) and as a combined rate. | MU, Medicaid |
| **Healthy Living** | | | | | | |
| 0027 Endorsed | Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies | The percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies. | NCQA | a: Advising Smokers to Quit: The number of patients in the denominator who responded to the survey and indicated that they had received advice to quit smoking from a doctor or other health provider during the measurement year.<br>b: Discussing Smoking Cessation Medications: The number of patients in the denominator who responded to the survey and indicated that their doctor or other health provider recommended or discussed medications to assist with quitting | The number of patients 18 and older who responded to the survey and indicated that they were current smokers and had one or more visits during the measurement year. | MU, Medicaid |

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| | | | | smoking during the measurement year.<br>c: Discussing Smoking Cessation Strategies: The number of patients in the denominator who responded to the survey and indicated that their doctor or health care provider recommended or discussed methods and strategies other than medication to assist with quitting smoking during the measurement year. | | |
| 0024 Endorsed | Weight Assessment and Counseling for Children and Adolescents | Percentage children, 2 through 18 years of age, whose weight is classified based on BMI percentile for age and gender. | NCQA | Number of children 2 through 18 years of age who came in for a well-child visit in the measurement period month and who were classified based on BMI percentile for age and gender. | Number children 2 through 18 years of age, with a well-child visit in the measurement period month. | PQRS, MU, CHIPRA |
| 0421 Endorsed | Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up | Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented | CMS/QIP | Patients with BMI calculated in the past six months and a follow-up plan documented if the BMI is outside of parameters | Patients 18 years and older | PQRS, MU, Medicaid, ACO |

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| | | Normal Parameters: Age 65 and older BMI ≥23 and <30; Age 18 – 64 BMI ≥18.5 and <25 parameters, a follow-up plan is documented. | | | | |
| **Affordable Care** | | | | | | |
| NA49 | Total Cost of Care (baseline) | The Total Cost of Care measure is based upon actual costs associated with care for membership attributed to a PO, including all covered professional, pharmacy, hospital, and ancillary care, as well as administrative payments and adjustments. | Thomson Reuters will run this measure for MY 2012 | | | IHA |
| NA48 | Generic Prescribing (7 therapeutic areas) | The level of generic prescribing will be measured as a simple prescription rate. This will be measured for seven groups of therapeutic classes (SSRIs/SNRIs; Statins; Anti-Ulcer Agents; Cardiac—Hypertension and Cardiovascular; Nasal Steroids; Diabetes—Oral; and Anxiety/Sedation— | Thomson Reuters will run this measure for MY 2011 | | | IHA |

| NQF Number | Measure Name | Measure Description | Measure Steward | Numerator | Denominator | Program |
|---|---|---|---|---|---|---|
| | | Sleep Aids) and for all prescriptions, with the exception of self-injectable drugs. | | | | |

# NATIONAL QUALITY FORUM

## Measure Applications Partnership (MAP)
## Roster for the MAP Clinician Workgroup

### Chair (voting)

Mark McClellan, MD, PhD

### Organizational Members (voting)

| | |
|---|---|
| American Academy of Family Physicians | Bruce Bagley, MD |
| American Academy of Nurse Practitioners | Mary Jo Goolsby, EdD, MSN, NP-C, CAE, FAANP |
| American Academy of Orthopaedic Surgeons | Douglas Burton, MD |
| American College of Cardiology | Paul Casale, MD, FACC |
| 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 |
| Physician Consortium for Performance Improvement | Mark Metersky, MD |
| The Alliance | Cheryl DeMars |
| Unite Here Health | Elizabeth Gilbertson, MS |

| 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)

| | |
|---|---|
| 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) | Michael Rapp, MD, JD, FACEP |
| Health Resources and Services Administration (HRSA) | Ian Corbridge, MPH, RN |
| Office of the National Coordinator for HIT (ONC) | Thomas Tsang, MD, MPH |
| Veterans Health Administration (VHA) | Joseph Francis, MD, MPH |

**MAP Coordinating Committee Co-Chairs (non-voting, ex officio)**

George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

# NATIONAL QUALITY FORUM

## Measure Applications Partnership (MAP)

## Roster for the MAP Clinician Workgroup

## Chair (voting)

**Mark McClellan, MD, PhD**
Mark McClellan is senior fellow, director of the Engelberg Center for Health Care Reform, and Leonard D. Schaeffer Chair in Health Policy Studies at the Brookings Institution. Established in 2007, the Engelberg Center provides practical solutions to achieve high-quality, innovative, affordable health care with particular emphasis on identifying opportunities on the national, state and local levels. A doctor and economist by training, McClellan has a highly distinguished record in public service and academic research. He is a former administrator of the Centers for Medicare & Medicaid Services (CMS) and former commissioner of the Food and Drug Administration (FDA). He also served as a member of the President's Council of Economic Advisers and senior director for health care policy at the White House. Previously, McClellan served in the Clinton administration as deputy assistant secretary of the Treasury for economic policy, where he supervised economic analysis and policy development on a range of domestic policy issues. McClellan also served as an associate professor of economics and associate professor of medicine with tenure at Stanford University, where he directed Stanford's Program on Health Outcomes Research; was associate editor of the Journal of Health Economics; and co-principal investigator of the Health and Retirement Study (HRS), a longitudinal study of the health and economic status of older Americans. He has twice received the Kenneth J. Arrow Award for Outstanding Research in Health Economics. From time to time, McClellan advises U.S. government officials on health care policy issues. In his capacity as a health policy expert, he is the co-director of the Bipartisan Policy Center's Leaders' Project on the State of American Health Care; co-chair of the Robert Wood Johnson Foundation Commission to Build a Healthier America; and chair of the FDA's Reagan-Udall Foundation. McClellan is also co-chair of the Quality Alliance Steering Committee, sits on the National Quality Forum's Board of Directors, is a member of the Institute of Medicine of the National Academy of Sciences, and is a research associate at the National Bureau of Economic Research. McClellan holds an MD from the Harvard University–Massachusetts Institute of Technology (MIT) Division of Health Sciences and Technology, a PhD in economics from MIT, an MPA from Harvard University, and a BA from the University of Texas at Austin. He completed his residency training in internal medicine at Boston's Brigham and Women's Hospital, is board-certified in Internal Medicine, and has been a practicing internist during his career.

## Organizational Members (voting)

**American Academy of Family Physicians**
**Bruce Bagley, MD**
Bruce Bagley, M.D., currently serves as the Medical Director for Quality Improvement for the American Academy of Family Physicians (AAFP). He has served as president and board chair of the AAFP in the past. The AAFP represents more than 98,000 family physicians, family medicine residents and medical students nationwide. During his twenty-eight year practice career, Bagley provided the full range of family medicine services in a single specialty family medicine group practice in Albany, NY. Under his leadership, the 10-physician group was a well-known pioneer in the community in adapting to the challenges of managed care, quality improvement, informatics and patient centered care. Bagley's current responsibilities with the AAFP include liaison work with other national organizations in the quality arena. He actively participates in the development, deployment and implementation of performance measures.

He has been an effective national advocate for the importance of primary care as the foundation of a redesigned US health care system. Bagley has spoken extensively on the topics of performance measurement, patient centered medical home, office redesign, electronic health records and leadership. From 2005 to 2007, he served as a Malcolm Baldrige Quality Award examiner.

**American Academy of Nurse Practitioners**
**Mary Jo Goolsby, EdD, MSN, NP-C, CAE, FAANP**
Dr. Mary Jo Goolsby is the director of research and education for the American Academy of Nurse Practitioners (AANP), a professional society representing the interests of over 140,000 nurse practitioners (NP). Dr. Goolsby oversees all organizational research and data-collection activities, including a national NP practice-based research network (PBRN). Her role includes shared oversight of the only comprehensive database of NPs. Additionally, Dr. Goolsby directs all AANP non-conference accredited and unaccredited educational activities. Initiatives within the research and education components include promotion of practice improvement and outcome measurement by NPs. Dr. Goolsby serves on a variety of expert panels, committees, and workgroups. Professional memberships include AANP, AONE, STTI, NONPF, and ASAE. Dr. Goolsby earned her BSN at Emory University, MSN at the University of Alabama in Huntsville, and EdD in Higher Education at the Florida State University.

**American Academy of Orthopaedic Surgeons**
**Douglas Burton, MD**
Douglas C. Burton, MD is a member of the advisory workgroup for the Measure Application Partnership (MAP). He has a strong interest in developing and implementing a national strategy for healthcare quality measurement and reporting and is honored to serve as the representative for the American Academy of Orthopedic Surgeons. Dr. Burton attended Kansas State University in Manhattan, KS and received his medical degree from the University of Texas Southwestern School of Medicine in Dallas, Texas. He completed his orthopedic residency at The University of Kansas Medical Center, in Kansas City, KS and spine fellowships at Texas Back Institute in Plano, TX and Thomas Jefferson University in Philadelphia, PA. He is the Marc & Elinor Asher Spine Professor at the University of Kansas Medical Center in Kansas City, KS.

**American College of Cardiology**
**Paul Casale, MD, FACC**
Paul N. Casale is a practicing physician, Associate Professor of Medicine at Temple University and Senior Scholar in health policy at Jefferson Medical College. He is a distinguished clinician, teacher, and researcher dedicated to providing high quality care to patients. Throughout his career, he has been involved in efforts to improve quality while controlling costs, contributing to these efforts at both the local and national levels. He has published extensively on cost and disparities in health care, disease management strategies and risk factor identification. He currently serves on the Advisory Group to the Coalition to Reduce Racial & Ethnic Disparities in Cardiovascular Outcomes. In 2004, Dr. Casale was appointed by the Governor of Pennsylvania to the state's Health Care Cost Containment Council. He continues to serve as a member of the Council and is currently the Vice Chair of its Data Systems Committee, as well as a member of its Technical Advisory Group. Dr. Casale has served as Chairman of the Health Care Cost and Quality Committee of the Pennsylvania Medical Society, as well as the Chairman of its Caregivers Task Force. He is also a member of the Pennsylvania Medical Society's Commission on Quality. At the national level, Dr. Casale is a strong proponent of the ACCF's ongoing efforts to improve the quality of cardiovascular patient care. He is a member of the PINNACLE Registry Workgroup, the nation's first registry for ambulatory cardiac care, and has served as the Chair of the ACCF's Medical Director Institute (MDI). The MDI is a forum convened by the ACC to bring together cardiovascular physicians, health plan medical directors,

purchasers, primary care physician representatives and other industry stakeholders to engage in action-oriented discussions that address common challenges in delivering quality cardiovascular care.

**American College of Radiology**
**David Seidenwurm, MD**
David Seidenwurm was raised in New York City. He majored in Philosophy as an undergraduate at Stanford, and concentrated in Neuroscience at the Harvard Medical School, where he earned his M.D. in 1982. After Internship at Kaiser Foundation Hospital in San Francisco and Diagnostic Radiology Residency at Stanford he was a Fellow in Neuroradiology at New York University. Subsequently, he was acting Director of Neuro MRI at NYU and Assistant Professor of Radiology at UCSF. He has been a Neuroradiologist at Radiological Associates of Sacramento since 1991. Currently, he is Chairman of the Diagnostic Radiology Division, comprised of 44 radiologists covering 5 hospital Radiology Departments and 13 independent imaging facilities. Previously, he has served as Chief of Diagnostic Imaging and Radiation Oncology at Sutter Medical Center, Sacramento. He is also a member of the board of directors, and past president of California Managed Imaging, a statewide diagnostic imaging network. Dr. Seidenwurm has been an active contributor to the medical literature. He has been Associate Editor of *Radiology* and a member of the Editorial Board of *Diagnostic Imaging*, among the most influential scientific and professional journals in the field. He has authored numerous peer reviewed scientific papers, consensus statements, and editorial commentaries. His writing has appeared in publications ranging from *JAMA* to *The New Yorker* and *The National Review*. At present, Dr. Seidenwurm holds numerous leadership positions related to medical quality improvement and consensus development at the national level. He is co-chair of the AMA Physicians Consortium committees developing Performance Measures for Stroke, Radiology and Radiation Exposure, previous Chairman of the American College of Radiology Neurological Imaging Appropriateness Criteria Expert Panel and Chairman of the American Society of Neuroradiology Utilization and Appropriateness committee. At present he is the Secretary of the American Society of Neuroradiology.

**American Speech-Language-Hearing Association**
**Janet Brown, MA, CCC-SLP**
Janet Brown, MA CCC-SLP, is director of health care services in speech-language pathology at the American Speech-Language-Hearing Association (ASHA), the professional, credentialing, and scientific organization for speech-language pathologists, audiologists, and speech, language, and hearing scientists. ASHA developed the National Outcomes Measure System (NOMS) consisting of 15 Functional Communication Measures in 1998 to respond to the need for more comprehensive and sensitive outcome measures for speech-language pathology treatment. The eight measures frequently used with stroke patients were endorsed by NQF and accepted into the PQRI registry. Ms. Brown received a Master's degree in speech-language pathology from The Catholic University of America.

**Association of American Medical Colleges**
**Joanne Conroy, MD**
As Chief Health Care Officer, Joanne M. Conroy, M.D., focuses on the interface between the health care delivery system and academic medicine, paying particular attention to how health care in academic settings can address quality-of-care and patient-centered care issues. Dr. Conroy represents the interests of approximately 400 major teaching hospitals and health systems, including 64 Veterans Affairs medical centers, through the AAMC Council of Teaching Hospitals and Health Systems in addition to overseeing the Group on Faculty Practice, Group on Resident Affairs, Chief Medical Officers Group, and the Compliance Officers Forum. Dr. Conroy started her career in Charleston SC as Chair of Anesthesia and Perioperative Medicine, VPMA of the University Hospital and Senior Associate Dean of the College of Medicine at MUSC. From 2001-2008 she served as Executive Vice President of Atlantic Health System, Chief Operating Officer and President of Morristown Memorial Hospital in Morristown, New Jersey. In

those roles, Dr. Conroy gained an understanding of health system operations, hospital-physician relationships, and collaborative partnerships among the various elements of academic health systems. Dr. Conroy earned her B.A. degree in chemistry from Dartmouth College, and was awarded her M.D. degree from the Medical University of South Carolina.

**Center for Patient Partnerships**
**Rachel Grob, PhD**
Rachel Grob, PhD, MA, is currently Director of National Initiatives and Scholar in Residence at the Center for Patient Partnerships (CPP), University of Wisconsin-Madison. Rachel's work at the CPP is focused on enhancing the capacity of patients to influence state and federal health policy, and on understanding and improving responsiveness of the health care system to consumers' experiences. She is also leading an array of research and field-building initiatives. Prior to joining the CPP in 2011, Rachel was Associate Dean of Graduate Studies, Director of the Child Development Institute, and Health Advocacy Program faculty member at Sarah Lawrence College. She is also an investigator in health policy research, Robert Wood Johnson Foundation, 2006-2011. Her publications include articles and book chapters on advocacy and parental/patient perspectives on clinical issues, and her co-edited volume titled Patients as Policy Actors was published in 2011 by Rutgers University Press. She holds degrees from Wesleyan University (B.A.), Sarah Lawrence College (M.A. in Health Advocacy), and City University of New York Graduate Center (Doctorate in sociology).

**CIGNA**
**Richard Salmon, MD, PhD**
Dr. Dick Salmon, Vice President and National Medical Executive for Network Performance Improvement and Quality, CIGNA HealthCare, is responsible for the company's clinical network performance improvement initiatives and health plan quality programs. The network performance improvement initiatives include assessment of physician and hospital quality and cost efficiency, responsible communication of that information to plan members, sharing that information with physicians and hospitals and enabling and rewarding improvement through pay for performance programs. The plan quality programs include accreditation, population health improvement and credentialing. Prior to this position, Dr. Salmon developed new care facilitation programs in case management and disease management. He previously was the New England Regional Medical Director, and President and General Manager of CIGNA New Hampshire. Before joining CIGNA HealthCare, Dr. Salmon was the Senior Vice President and Chief Medical Officer for HealthSource, a three million member HMO acquired by CIGNA in 1997. Dr. Salmon has worked extensively with managed care since 1984. His career began in academic medicine at Case Western Reserve University and the affiliated University Hospital, where he was an Assistant Professor of Family Medicine and Chief Resident in Family Practice. Dr. Salmon is Board Certified in Family Practice. He earned his medical degree and a Ph.D. in Biomedical Engineering from Case Western Reserve University.

**Consumers' CHECKBOOK**
**Robert Krughoff, JD**
Robert M. Krughoff is founder and president of Center for the Study of Services/Consumers' CHECKBOOK (CSS/CHECKBOOK), an independent, nonprofit consumer organization founded in 1974. The organization publishes local versions of Consumers' CHECKBOOK magazine in seven major metropolitan areas (Seattle/Tacoma, Boston, Chicago, Minneapolis/St. Paul, Philadelphia, San Francisco/Oakland/San Jose, and Washington, DC). The magazine evaluates local service providers ranging from auto repair shops to plumbers to various types of health care providers. CHECKBOOK also has nationally distributed publications and websites to help consumers find quality and save money, including: *Guide to Top Doctors, Consumers' Guide to Hospitals, Guide to Health Plans for Federal Employees,* and *checkbook.org/patientcentral* (which has patient experience ratings of individual

physicians). Krughoff also has a role in the work CSS/CHECKBOOK does in survey design, implementation, analysis, and reporting for large-scale surveys in the health care field, including CAHPS surveys of members about health plans and of patients about physicians. Before founding CSS/CHECKBOOK, Krughoff served in the U. S. Department of Health, Education, and Welfare as Director of the Office of Research and Evaluation Planning and as Special Assistant to the Assistant Secretary for Planning and Evaluation. Krughoff is a graduate of Amherst College and the University of Chicago Law School, where he was an associate editor of the *Law Review*.

**Kaiser Permanente**
**Amy Compton-Phillips, MD**

Amy Compton-Phillips, MD is the Associate Executive Director for Quality for The Permanente Federation. Amy joined The Permanente Federation in January 2010 but has been with Mid-Atlantic Permanente Medical Group (MAPMG) since 1993. Amy is an internal medicine physician that served MAPMG in a variety of roles through years including Internal Medicine Service Chief, Physician Director for the Columbia Gateway Medical Center, Physician Director for Population Care, and Guideline Director. Amy has extensive experience in directing patient care programs, including disease management of high risk members and transitions in care for patients newly discharged from a hospital. She has also been active in developing provider and patient education programs using both print and Web-based materials, and has been a frequent presenter at public and Kaiser Permanente national seminars. Amy received her medical degree from the University of Maryland Medical School, where she also completed her residency program, and completed her undergraduate degree at Johns Hopkins University. In addition, she is a graduate of the Advanced Leadership Program at the University Of North Carolina Kenan-Flagler School Of Business. In her spare time, she enjoys skiing, biking, sailing, and carting her children around to a never ending set of after school activities.

**Minnesota Community Measurement**
**Beth Averbeck, MD**

Beth Averbeck, MD, is the Associate Medical Director, Primary Care for HealthPartners Medical Group, with expertise in health disparities, diabetes care, internal medicine, primary care redesign, and quality improvement. She has over 15 years of leadership experience in process improvement and clinical operations and plays a key role in HealthPartners Medical Group's efforts to improve quality of care for patients. Through her work and leadership in redesigning ambulatory care, the gap in mammography screening rates between white patients and patients of color in HealthPartners clinics decreased by 46 percent between 2007 and 2009. In 2010, her team was named an American Medical Group Association Acclaim Award honoree, and in 2006, her team received the Acclaim Award for implementation of reliable workflows and processes in ambulatory care. These achievements reflect her desire to improve care for patients of all communities and backgrounds. Under her leadership, HealthPartners received NCQA Medical Home recognition for all primary care clinics in 2009, and in 2010 received Minnesota Health Care Home Certification for all primary care clinics. Beth Averbeck has presented at conferences sponsored by the American Medical Group Association, the Institute for Clinical Systems Improvement, and the Institute for Healthcare Improvement in the areas of transparency, pay for performance, physician culture, electronic medical record decision support, reliability in ambulatory care and reducing disparities in health care. She also serves on the boards for Minnesota Community Measurement and the Institute for Clinical Systems Improvement. She has been with HealthPartners since 1993. She holds an academic appointment as a Clinical Assistant Professor at the University of Minnesota Medical School, where she received her medical degree. In 2010, she was honored by the *Minneapolis/St. Paul Business Journal* with a Women in Business award.

**Physician Consortium for Performance Improvement**
**Mark Metersky, MD**

Dr. Mark Metersky is a pulmonary and critical care physician and is Professor of Medicine and Director of the Center for Bronchiectasis Care at the University of Connecticut School of Medicine. He has published extensively on the subjects of pulmonary infections, performance measurement and quality improvement and is a frequent lecturer at national and international meetings on these areas. He was elected to be a member of the Executive Committee of the AMA Physician Consortium for Performance Improvement in 2009. He serves on the Technical Expert Panel for the Centers for Medicare and Medicaid Services National Pneumonia Project and is the clinical lead for the Medicare/AHRQ Patient Safety Monitoring System that is managed by Qualidigm (Connecticut's Medicare QIO). Dr. Metersky has had extensive experience in implementing quality improvement efforts, both at his own hospital and at a statewide level, through his work with Qualidigm. He has also served on the Quality Improvement Committee and is the Vice Chair of the Health and Science Policy Committee (the committee that oversees Clinical Practice Guideline production) for the American College of Chest Physicians.

**The Alliance**
**Cheryl DeMars**

Cheryl DeMars is the President and CEO of The Alliance, a not for profit cooperative of employers whose mission is to move health care forward by controlling costs, improving quality and engaging individuals in their health. The Alliance represents 165 employers who provide health benefits to 83,000 citizens in Wisconsin, Illinois and Iowa. Prior to assuming the position of CEO in 2006, Ms. DeMars served several roles at The Alliance providing leadership to the organization's cost and quality measurement activities, consumer engagement strategies and efforts to improve the quality and cost of health care on a community-wide basis. Prior to joining The Alliance in 1992, Ms. DeMars was a program manager at Meriter Hospital in Madison, WI. Ms. DeMars currently serves on the Board and Executive Committee of the National Business Coalition on Health. Ms. DeMars was recently appointed to the Clinician Workgroup of the National Quality Forum's Measures Application Partnership, which will provide input to the Department of Health and Human Services (HHS) on the selection of measures for use in public reporting and performance-based payment. She also serves on the Technical Advisory Committee for the Catalyst for Payment Reform. In Wisconsin, Ms. DeMars serves on the Advisory Board of the UW Population Health Institute. Ms. DeMars received a master's degree in social work from the University of Wisconsin–Madison.

**Unite Here Health**
**Elizabeth B. Gilbertson, MS**

Elizabeth B. Gilbertson is currently Chief of Strategy for UNITE HERE HEALTH *(formerly the Hotel Employees and Restaurant Employees International Union Welfare Fund)*, a national Taft-Hartley health trust that covers 246,000 lives. She was a founder and Chair/Co-Chair (1999-2010) of the Health Services Coalition, a large labor-management organization that contracts with hospitals and advocates for public policy to improve health care quality, affordability, and access in Nevada. Prior to assuming her current role, Ms. Gilbertson has held a variety of leadership roles for UNITE HERE HEALTH with a focus on the health plan operated by the Fund itself for approximately 120,000 covered lives in Las Vegas. Currently, a major focus of her work is supporting the development of intensive primary care and medical management programs that target the complex chronically ill. Her background includes experience representing nurses in collective bargaining for the Connecticut Nurses Association and District 1199, New England, SEIU. She has served on National Quality Forum task forces on ambulatory care measures, and is a Board member of the National Committee for Quality Assurance (NCQA). She holds a Bachelor's Degree in History from Smith College and Master's Degree in Health Advocacy from Sarah Lawrence College. In addition, she attended the Yale University School of Public Health and has an Associate Degree in Nursing.

## Individual Subject Matter Expert Members (voting)

### Disparities
**Marshall Chin, MD, MPH, FACP**
Marshall H. Chin, MD, MPH, FACP, Professor of Medicine at the University of Chicago, is a general internist and health services researcher with extensive experience improving the care of vulnerable patients with chronic disease. He is Director of the Robert Wood Johnson Foundation (RWJF) Finding Answers: Disparities Research for Change National Program Office, a major effort to reduce racial and ethnic disparities in health care. He was a member of the Institute of Medicine Committee on Future Directions for the National Healthcare Quality and Disparities Reports. Dr. Chin is a graduate of the University of California at San Francisco School of Medicine and completed residency and fellowship training in general internal medicine at Brigham and Women's Hospital, Harvard Medical School.

### Population Health
**Eugene Nelson, MPH, DSc**
Dr. Nelson is Professor of Community and Family Medicine at The Dartmouth Institute for Health Policy and Clinical Practice, Dartmouth Medical School**;** Director, Population Health Measurement Program, The Dartmouth Institute**;** Director, Population Health and Measurement, Dartmouth-Hitchcock Medical Center. Dr. Nelson is a national leader in health care improvement and the development and application of measures of quality, system performance, health outcomes, value, and patient and customer perceptions. In the early 1990s, Dr. Nelson and his colleagues at Dartmouth began developing clinical microsystem thinking. His work to develop the "clinical value compass" and "whole system measures" to assess health care system performance has made him a well-recognized quality and value measurement expert. He is the recipient of The Joint Commission's Ernest A. Codman award for his work on outcomes measurement in health care. Dr. Nelson, who has been a pioneer in bringing modern quality improvement thinking into the mainstream of health care, helped launch the Institute for Healthcare Improvement and served as a founding Board Member. He has authored over 150 publications and is the first author of three recent books: (a) Quality by Design: A Clinical Microsystems Approach, (b) Practice-Based Learning and Improvement: A Clinical Improvement Action Guide: Second Edition, and (c) Value by Design: Developing Clinical Microsystems to Achieve Organizational Excellence. He received an AB from Dartmouth College, a MPH from Yale University and a DSc from Harvard University.

### Shared Decision Making
**Karen Sepucha, PhD**
Dr. Sepucha is the director of the Health Decision Sciences Center in the General Medicine Division at Massachusetts General Hospital and an assistant professor in Medicine at Harvard Medical School. Her research and clinical interests involve developing and implementing tools and methods to improve the quality of significant medical decisions made by patients and clinicians. Dr. Sepucha was the medical editor for a series of five breast cancer patient decision aids (PtDAs) developed by the not-for-profit Foundation for Informed Medical Decision Making. The PtDAs have won seven media awards and Dr. Sepucha has led the dissemination of these programs to more than 80 academic and community cancer centers across the country. She is also responsible for efforts to integrate decision support tools into primary and specialty care at MGH. Her recent research has focused on the development of instruments to measure the quality of decisions. The decision quality instruments have been used in a national survey of medical decisions, and a subset of the items is being evaluated for use in CAHPS as part of the primary care medical home certification. Dr. Sepucha has been active in local, national and international efforts to improve decision quality, including the International Patient Decision Aids Standards collaboration. She got her Ph.D. in Engineering-Economic Systems and Operations Research at Stanford University with a focus in decision sciences.

**Team-Based Care**
**Ronald Stock, MD, MA**
Ronald Stock, is a geriatrician, clinical health services researcher and current Medical Director of the Center for Medical Education & Research with PeaceHealth Oregon Region and Sacred Heart Medical Center in Eugene, OR. His roles include physician oversight of the development of a collaborative project with the Oregon Health & Sciences University (OHSU) School of Medicine to expand medical student training in Oregon and executive leadership in a collaborative project with the University of Oregon to create a clinical translational research center. He is former Executive Medical Director for PeaceHealth's Gerontology Institute. For the past 20 years, Dr. Stock has dedicated his professional career to improving the quality of healthcare for older adults, with a focus on redesigning the primary care delivery system in a community for vulnerable and frail elders using the chronic care model and an inter-professional team approach. A graduate of the University of Nebraska College Of Medicine, Dr. Stock completed his residency and faculty development fellowship in Family Medicine at the Medical University of South Carolina and University of North Carolina-Chapel Hill and has a Certificate of Added Qualifications in Geriatric Medicine. He currently holds academic appointments as a Clinical Associate Professor of Family Medicine at OHSU and Courtesy Professor in the Department of Human Physiology at the University of Oregon.

**Health IT/ Patient Reported Outcome Measures**
**James M. Walker, MD, FACP**
James M. "Jim" Walker, MD FACP, designs and studies health IT systems that support safe and effective care. He is the Chief Health Information Officer of the Geisinger Health System, where he leads Geisinger's development of a fully integrated inpatient and outpatient EHR; a networked patient health record (PHR) used by 145,000 patients; and a health information exchange that serves 2.5 million patients in 31 Pennsylvania counties. He is the program director of the Keystone Beacon Community. Dr. Walker serves as the chair of the Medical Informatics Committee of the American College of Physicians, as a member of the HIT Standards Committee of HHS, on the faculty of the CMIO Boot Camp of the American Medical Informatics Association, and as a member of the National Committee on Vital and Health Statistics. He leads AHRQ-funded research and development projects in health-information exchange and HIT safety and is Project Director of the Keystone Beacon Community. He has published numerous peer-reviewed articles and a widely used book, Implementing an Electronic Health Record System (2005). Dr. Walker earned his MD degree at the University of Pennsylvania before completing a residency in internal medicine at the Penn State Hershey Medical Center and a National Library of Medicine fellowship in medical informatics.

**Measure Methodologist**
**Dolores Yanagihara, MPH**
Dolores Yanagihara is director of the California Pay for Performance Program with the Integrated Healthcare Association. Her work includes overall administration of the program, guiding the governance committees, negotiating contracts to meet the program's technical needs, spearheading data exchange and data quality improvement efforts, and promoting quality and efficiency measurement and improvement nationally by sharing expertise through committee membership, publications, and speaking engagements. Ms. Yanagihara has over fifteen years experience developing, managing, and evaluating cutting edge public health programs. Her interest in public health was sparked by her tour of duty in the Peace Corps in Sierra Leone, West Africa. She earned a Masters in Public Health in Health Education and International Health from the University of Hawaii at Manoa, and a Bachelor of Science in Biology from the University of Notre Dame.

## Federal Government Members (non-voting, ex officio)

**Agency for Healthcare Research and Quality (AHRQ)**
**Darryl Gray, MD, ScD**

Darryl T Gray, MD, ScD, FAHA is a Medical Officer in the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality (AHRQ). Dr Gray is a Contracting Officer's Technical Representative and Program Official for several AHRQ grants and contracts in patient safety areas and he co-chairs the Child Health sub-group for AHRQ's National Healthcare Quality and Disparities reports. He serves as AHRQ's representative to the American Medical Association's Performance Measurement Advisory Group and has also reviewed NQF performance measures in pediatric cardiac surgery, adult cardiac care and other areas. He also serves as AHRQ's liaison to the Steering Committee of the American Heart Association's Quality of Care and Outcomes Research Council and is a Fellow of the American Heart Association. Dr Gray's major research interests include analyses of care patterns, clinical outcomes and costs of diagnostic and therapeutic procedures. His studies of pediatric cardiac procedures and other interventions have been published in the *New England Journal of Medicine, Lancet, JAMA, Circulation, Spine* and elsewhere. Dr Gray graduated magna cum laude from Harvard, where he also earned a Doctor of Science Degree in Epidemiology. He also holds an MD degree from Case Western Reserve University and a Masters in Public Health from the University of Washington (Seattle). He received internal medicine and pediatrics training respectively at St Luke's Hospital in Cleveland and at BC Children's Hospital in Vancouver, British Columbia. After serving as a Visiting Researcher at Sweden's Center for Medical Technology Assessment and at Karolinska Institute, Dr Gray joined the medical staff and faculty at Mayo Clinic. He then moved to the University of Washington Schools of Public Health and Medicine, where he attained the rank of Research Associate Professor and Adjunct Research Associate Professor before coming to AHRQ in 2004.

**Centers for Disease Control and Prevention (CDC)**
**Peter Briss, MD, MPH**

Dr. Peter Briss currently serves as the Medical Director of CDC's National Center for Chronic Disease Prevention and Health Promotion. He has been with CDC and the Commissioned Corps of the US Public Health Service for more than 20 years. He has participated in a broad range of cross-disciplinary research and service particularly involving systematic reviews, evidence-informed practice, program evaluation, policy analysis, and research translation. He has applied these interests across a broad range of health and behavioral topics ranging from health care to community prevention. He has participated in public health teaching, practice, and research at state and federal levels in the U.S. and internationally. Dr. Briss received his medical degree and training in internal medicine and pediatrics at the Ohio State University and his MPH in Health Management and Policy from the University of Michigan. He completed training in epidemiology and preventive medicine at CDC, is board certified in internal medicine and preventive medicine, and continues to serve as an active clinician at Grady Memorial Hospital in Atlanta. He has authored or coauthored approximately 80 professional publications and coedited the Guide to Community Preventive Services.

**Centers for Medicare & Medicaid Services (CMS)**
**Michael Rapp, MD, JD, FACEP**

Dr. Rapp is director of the Quality Measurement and Health Assessment Group of the Centers for Medicare and Medicaid Services. The group is responsible for evaluating measurement systems to assess healthcare quality in a broad range of settings. The group actively works with many stakeholders to promote widespread participation in the quality measurement development process. Dr. Rapp is an emergency physician and was in active clinical practice until taking his position at CMS. His public service activities include approximately four years as Chairman of the Department of HHS Practicing Physicians Advisory Council. Dr. Rapp is a fellow of the American College of Emergency Physicians, and a member of the Medical Society of Virginia, the American Medical Association, and the American Health Lawyers Association.

**Health Resources and Services Administration (HRSA)**
**Ian Corbridge, MPH, RN**
Ian Corbridge, MPH, RN, is a Public Health Policy Analyst in the Office for Health Information Technology & Quality within the Health Resources & Services Administration (HRSA). HRSA is the primary Federal agency for improving access to healthcare services for people who are uninsured, isolated or medically needy. Ian helps to oversee and align HRSA's quality improvement and performance measurement work. These efforts help to impact the quality of care and well-being for approximately 20 million Americans who benefit directly from HRSA's services. Ian has degrees in nursing and global studies from Pacific Lutheran University and a master's degree in public health from the George Washington University.

**Office of the National Coordinator for HIT (ONC)**
**Thomas Tsang, MD, MPH**

**Veterans Health Administration (VHA)**
**Joseph Francis, MD, MPH**
Dr. Francis was appointed the Chief Quality and Performance Officer for the Veterans Health Administration (VHA) in December, 2009. In this role, he leads a multi-disciplinary staff responsible for coordinating major national quality management programs, including performance measurement, utilization management, clinical practice guideline development, risk management, peer review, the credentialing and privileging of health professions, and health system accreditation. Prior to that position, he had been VHA's Deputy Chief Quality and Performance Officer. Dr. Francis received his MD degree in 1984 from Washington University in St. Louis and completed a residency and fellowship in General Internal Medicine and a Masters in Public Health at the University of Pittsburgh. Dr Francis joined the VA in 1991, and was appointed Chief Medical Officer of the VA Mid South Healthcare Network (VISN) 9 in 1996. From 2000 until 2004, Dr Francis served as Vice President for Data Management and Quality at St Vincent Hospital in Indianapolis, a 750-bed tertiary care hospital that is part of Ascension Health, the largest Catholic health system in the U.S. In that role, he implemented organizational safety, patient satisfaction, and performance improvement initiatives, and led the Corporate Compliance and Research Compliance programs. He also led city-wide efforts to prepare for bioterrorism and to establish a smallpox response program for Indianapolis. Dr. Francis returned to VA in June, 2004 to direct its Quality Enhancement Research Initiative (QUERI), a Health Services Research and Development program to accelerate the introduction of evidence-based practices in conditions of high importance to veterans, including polytrauma, mental health, post-traumatic stress disorder, substance use disorder, chronic heart failure, ischemic heart disease, diabetes, spinal cord injury, HIV care, and stroke. From October 2006 to May, 2008, Dr. Francis served the Deputy Chief Research and Development Officer, with responsibility over administration and policy development for VA's $1.7 billion research operations. Board-certified in internal medicine, geriatrics, and medical management, Dr. Francis has been on the medical faculty of the University of Pittsburgh, University of Tennessee, and Vanderbilt University. He has conducted NIH-funded research on acute delirium among older patients, and also served as President of the Alzheimer's Association of Middle Tennessee.

## MAP Coordinating Committee Co-Chairs (non-voting, ex officio)

**George J. Isham, MD, MS**
George Isham, M.D., M.S. is the chief health officer for HealthPartners. He is responsible for the improvement of health and quality of care as well as HealthPartners' research and education programs. Dr. Isham currently chairs the Institute of Medicine (IOM) Roundtable on Health Literacy. He also

chaired the IOM Committees on *Identifying Priority Areas for Quality Improvement* and *The State of the USA Health Indicators*. He has served as a member of the IOM committee on *The Future of the Public's Health* and the subcommittees on the Environment for Committee on Quality in Health Care which authored the reports *To Err is Human* and *Crossing the Quality Chasm.* He has served on the subcommittee on performance measures for the committee charged with redesigning health insurance benefits, payment and performance improvement programs for Medicare and was a member of the IOM Board on Population Health and Public Health Policy. Dr. Isham was founding co-chair of and is currently a member of the National Committee on Quality Assurance's committee on performance measurement which oversees the Health Employer Data Information Set (HEDIS) and currently co-chairs the National Quality Forum's advisory committee on prioritization of quality measures for Medicare. Before his current position, he was medical director of MedCenters health Plan in Minneapolis and In the late 1980s he was executive director of University Health Care, an organization affiliated with the University of Wisconsin-Madison.

**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.

## National Quality Forum Staff

### Janet M. Corrigan, PhD, MBA

Janet M. Corrigan, PhD, MBA, is president and CEO of the National Quality Forum (NQF), a private, not-for-profit standard-setting organization established in 1999. The NQF mission includes: building consensus on national priorities and goals for performance improvement and working in partnership to achieve them; endorsing national consensus standards for measuring and publicly reporting on performance; and promoting the attainment of national goals through education and outreach programs. From 1998 to 2005, Dr. Corrigan was senior board director at the Institute of Medicine (IOM). She provided leadership for IOM's Quality Chasm Series, which produced 10 reports during her tenure, including: To Err is Human: Building a Safer Health System, and Crossing the Quality Chasm: A New Health System for the 21st Century. Before joining IOM, Dr. Corrigan was executive director of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Among Dr. Corrigan's numerous awards are: IOM Cecil Award for Distinguished Service (2002), American College of Medical Informatics Fellow (2006), American College of Medical Quality Founders' Award (2007), Health Research and Educational TRUST Award (2007), and American Society of Health System Pharmacists' Award of Honor (2008). Dr. Corrigan serves on various boards and committees, including: Quality Alliance Steering Committee (2006–present), Hospital Quality Alliance (2006–present), the National eHealth Collaborative (NeHC) Board of Directors (2008–present), the eHealth Initiative Board of Directors (2010–present), the Robert Wood Johnson Foundation's Aligning Forces for Healthcare Quality (AF4Q) National Advisory Committee (2007–present), the Health Information Technology (HIT) Standards Committee of the U.S. Department of Health and Human Services (2009–present), the Informed Patient Institute (2009 – present), and the Center for Healthcare Effectiveness Advisory Board (2011 – present). Dr. Corrigan received her doctorate in health services research and master of industrial engineering degrees from the University of Michigan, and master's degrees in business administration and community health from the University of Rochester.

### Thomas B. Valuck, MD, JD, MHSA

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.

# NATIONAL QUALITY FORUM

**Constance W. Hwang, MD, MPH**
Dr. Hwang is vice president of the Measure Applications Partnership (MAP), which is responsible for providing input to the Department of Health and Human Services on the selection of performance measures for public reporting and performance-based payment programs. Dr. Hwang is a board-certified general internist, and prior to joining NQF, was the Director of Clinical Affairs and Analytics at Resolution Health, Inc (RHI). RHI is a wholly-owned subsidiary of WellPoint Inc., providing data-driven disease management interventions aimed at both patients and providers to improve quality of care and cost efficiency. At RHI, Dr. Hwang managed an analytics team that developed and implemented clinical algorithms and predictive models describing individual health plan members, their overall health status, and potential areas for quality and safety improvement. Dr. Hwang has served as clinical lead for physician quality measurement initiatives, including provider recognition and pay-for-performance programs. She has experience designing and programming technical specifications for quality measures, and represented RHI as a measure developer during NQF's clinically-enriched claims-based ambulatory care measure submission process. Nominated to two different NQF committees, Dr. Hwang has participated in both NQF's measure harmonization steering committee, which addressed challenges of unintended variation in technical specifications across NQF-endorsed quality measures, and the NQF technical advisory panel for resource use measures regarding cardiovascular and diabetes care. Dr. Hwang is a former Robert Wood Johnson Clinical Scholar at Johns Hopkins and received her Master of Public Health as a Sommer Scholar from the Johns Hopkins Bloomberg School of Public Health. She completed her internal medicine residency at Thomas Jefferson University Hospital in Philadelphia, and received her medical degree from Mount Sinai School of Medicine in New York.

**Aisha Pittman, MPH**
Aisha T. Pittman, MPH, is a Senior Program Director, Strategic Partnerships, at the National Quality Forum (NQF). Miss Pittman leads the Clinician Workgroup and the Post-Acute Cae/Long-Term Care Workgroup of the Measure Applications Partnership (MAP). Additionally, Ms. Pittman leads an effort devoted to achieving consensus on a measurement framework for assessing the efficiency of care provided to individuals with multiple chronic conditions. Ms. Pittman comes to NQF from the Maryland Health Care Commission (MHCC) where she was Chief of Health Plan Quality and Performance; responsible for state efforts to monitor commercial health plan quality and address racial and ethnic disparities in health care. Prior to MHCC, Ms. Pittman spent five years at the National Committee for Quality Assurance (NCQA) where she was responsible for developing performance measures and evaluation approaches, with a focus on the geriatric population and Medicare Special Needs Plans. Ms. Pittman has a bachelor of science in Biology, a bachelor of Arts in Psychology, and a Masters in Public Health all from The George Washington University. Ms. Pittman was recognized with GWU's School of Public Health and Health Services Excellence in Health Policy Award.

**Taroon Amin, MPH, MA**
Taroon Amin, MPH, MA, is Senior Director in Strategic Partnerships and Performance Measures, at the National Quality Form (NQF), a nonprofit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Mr. Amin provides leadership support to multiple workgroups within the Measures Applications Partnership (MAP) and resource measures under NQF-review in the Consensus Development Process (CDP). Mr. Amin comes to NQF from the Schneider Institutes for Health Policy at Brandeis University, where he was an Agency for Health Care Research and Quality (AHRQ T-32) fellow. During his time there, Taroon worked with Health Care Incentives Improvement Institute (HCI3), American Board of Medical Specialties Research and Education Foundation (ABMS-REF), and American Medical Association-convened Physicians Consortium for Performance Improvement (AMI-PCPI) to develop the Patient-Centered Episode Grouper

System (PACES), a public sector episode grouper system for the Medicare Program. Also at Schneider, Taroon worked with the American Association of Medical Colleges and Teaching Hospitals (AAMC) on the development of Health Innovation Zones (HIZs) in response to Section XVIII of the Patient Protection and Affordable Care Act and also worked with the Government of India on the evaluation of public sector insurance schemes. Before joining Schneider, Taroon led Six Sigma/ Lean quality improvement projects at New York-Presbyterian Hospital, the University Hospitals of Cornell and Columbia and the Morgan Stanley Children's Hospital. Taroon holds a degree in international health systems management from Case Western Reserve University with his international training from Tsinghua University (Beijing), École des Sciences Politiques (Paris) and the Indian Institute of Management (Ahmedabad). Taroon also holds a master's degree in public health from Columbia University and a master's degree in social policy from Brandeis University, where he is currently a PhD candidate. Philanthropically, Mr. Amin serves as founding member of International Health Care Leadership (IHL), an independent non-profit organization developed to train Chinese healthcare professionals how to incorporate healthcare public policy into healthcare reform and hospital management.

**Mitra Ghazinour, MPP**

Mitra Ghazinour, MPP, is project manager, Strategic Partnerships, at the National Quality Forum (NQF), 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. Ghazinour is currently supporting the work of the NQF Measure Applications Partnership (MAP) Clinician and Post-Acute/Long-Term Care (PAC/LTC) workgroups. Prior to working at NQF, she was a research analyst III at Optimal Solutions Group, LLC, serving as the audit team leader for the Evaluation & Oversight (E&O) of Qualified Independent Contractors (QIC) project. Her responsibilities as audit team leader included serving as a point of contact for QIC and CMS, conducting interviews with QIC staff, reviewing case files, facilitating debriefings and meetings, and writing evaluation reports. Ms. Ghazinour also served as the project manager for the Website Monitoring of Part D Benefits project, providing project management as well as technical support. Additionally, she provided research expertise for several key projects during her employment at IMPAQ International, LLC. In the project, Development of Medicare Part C and Part D Monitoring Methods for CMS, Ms. Ghazinour assisted with the collaboration between CMS and IMPAQ on a broad effort to review, analyze, and develop methods and measures to enhance the current tools CMS uses to monitor Medicare Advantage (Part C) and Prescription Drug (Part D) programs. In another effort to support CMS, Ms. Ghazinour coordinated the tasks within the National Balancing Contractor (NBIC) project which entailed developing a set of national indicators to assess states' efforts to balance their long-term support system between institutional and community-based supports, including the characteristics associated with improved quality of life for individuals. She also provided analytic support for the development of the report on the Medicare advantage value-based purchasing programs as part of her work on the Quality Improvement Program for Medicare Advantage Plans project at IMPAQ. Ms. Ghazinour has a Master's degree in Public Policy and a bachelor's degree in Health Administration and Policy Program (Magna Cum Laude) from the University of Maryland, Baltimore County (UMBC).

**Rachel Weissburg**

Rachel Weissburg is currently employed at the National Quality Forum, a non-profit, multi-stakeholder organization, as part of its Strategic Partnerships department. Specifically, she supports the Measure Applications Partnership, which provides the Dept. of Health and Human Services input on public reporting and payment-based reporting programs. Before coming to NQF Ms. Weissburg worked at The Endocrine Society, the world's oldest and largest association of endocrinologists. She created and managed programs for the Society's public education affiliate, The Hormone Foundation, and collaborated with clinicians – endocrinologists and family practice doctors – to understand their needs and priorities. Under her supervision, the Foundation's award-winning patient materials reached nearly 2

million patients with information about conditions such as diabetes, osteoporosis, growth hormone use, and infertility. Before working with The Hormone Foundation, Ms. Weissburg spent over four years with The Leapfrog Group, a health care membership organization representing purchasers of health care. While at Leapfrog, Ms. Weissburg was responsible for writing the first national policy that asked hospitals to openly acknowledge serious reportable events – or "never events" – and take remedial action if these events occurred in their facilities. She also worked closely with the Centers for Medicare and Medicaid Services, health plans, and other stakeholders to implement similar policies and shift reimbursement models from a fee-for-service to a fee-for-outcome model. She also managed Leapfrog's membership of Fortune 500 companies and coordinated regional implementation of its transparency and quality initiatives in over twenty-seven communities nationwide.