Hospital Workgroup Meeting

1030 15th Street NW
Washington, DC

NATIONAL QUALITY FORUM

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

December 15, 2011

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NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

Hospital Workgroup
In-Person Meeting #2

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

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AGENDA: DECEMBER 15, 2011

Meeting Objectives:
- *Review measures under consideration for inclusion in Hospital Inpatient Quality Reporting (IQR), Hospital Value-Based Purchasing (VBP), Inpatient Psychiatric Facility Quality Reporting, Hospital Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (Meaningful Use), and PPS-Exempt Cancer Hospital Quality Reporting;*
- *Provide input on finalized measure sets for Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting;*
- *Discuss cross-cutting considerations for alignment, including input from MAP Dual Eligible Beneficiaries Workgroup and care coordination;*
- *Prioritize identified gaps in measurement for each program measure set;*
- *Finalize input to the MAP Coordinating Committee on measures for use in federal programs.*

8:30 am **Welcome, Review of Meeting Objectives, and Pre-Rulemaking Process**
Frank Opelka, Workgroup Chair
Connie Hwang, Vice President, Measures Application Partnership, NQF
Lindsay Lang, Senior Program Director, Strategic Partnerships, NQF
- Review approach to pre-rulemaking process
- Review cross-program considerations for Dual Eligible Beneficiaries and care coordination

9:00 am **Pre-Rulemaking Input on Inpatient Quality Reporting (IQR) Program Measure Set**
Frank Opelka
- Review measures under consideration for IQR program

10:45 am **Break**

11:00 am **Pre-Rulemaking Input on Hospital Value-based Purchasing (VBP) Program Measure Set**
Frank Opelka
- Review measures under consideration for Hospital VBP program

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11:30 am   **Pre-Rulemaking Input on Inpatient Psychiatric Facility Quality Reporting Program Measure Set**
Frank Opelka
Ann Marie Sullivan, Queens Health Network of the New York City Health and Hospitals Corporation
- Consider measurement priorities for inpatient psychiatric setting
- Review measures under consideration for inpatient psychiatric facility reporting

12:30 pm   **Opportunity for Public Comment**

12:45 pm   **Lunch**

1:15 pm   **Pre-Rulemaking Input on Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs (Meaningful Use) Program Measures**
Frank Opelka
- Review Meaningful Use measures under consideration

2:45 pm   **Pre-Rulemaking Input on Outpatient Quality Reporting (OQR) Program Measure Set**
Frank Opelka
- Review finalized measures in OQR program

3:15 pm   **Break**

3:30 pm   **Pre-Rulemaking Input on Ambulatory Surgical Center (ASC) Quality Reporting Program Measure Set**
Frank Opelka
- Review finalized measures in ASC reporting program

4:00 pm   **Pre-Rulemaking Input on PPS-Exempt Cancer Hospital Quality Reporting Program Measure Set**
Frank Opelka
- Review measures under consideration for Cancer Hospital reporting

4:45 pm   **Opportunity for Public Comment**

5:00 pm   **Summary of Day**
Frank Opelka and Lindsay Lang

5:30 pm   **Adjourn for the Day**

NATIONAL QUALITY FORUM
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Hospital Workgroup
Pre-rulemaking Discussion Guide

Meeting Objectives:
- *Review measures under consideration for inclusion in Hospital Inpatient Quality Reporting (IQR), Hospital Value-Based Purchasing (VBP), Inpatient Psychiatric Facility Quality Reporting, Hospital Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (Meaningful Use), and PPS-Exempt Cancer Hospital Quality Reporting;*
- *Provide input on finalized measure sets for Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting;*
- *Discuss cross-cutting considerations for alignment, including input from MAP Dual Eligible Beneficiaries Workgroup and care coordination;*
- *Prioritize identified gaps in measurement for each program measure set;*
- *Finalize input to the MAP Coordinating Committee on measures for use in federal programs.*

Time	Issue	Considerations
8:00 – 8:30 am	**Breakfast**	
8:30 – 9:00 am	**Welcome, Review of Meeting Objectives, and Pre-Rulemaking Process**	
9:00 – 10:45 am	**Inpatient Quality Reporting (IQR) Program Measure Set**	
9:00	A. Review program summary, final measures and measures under consideration, gaps, relationship to hospital core measure set	- Program set includes 21 new measures under consideration for a total of 93 measures to be included in IQR - Considering all final measures and measures under consideration, 15 of the 34 Hospital core set measures are NOT included in IQR
9:10	B. 4 NQF-endorsed measures under consideration related to care coordination *(Care coordination is cross-program focus area)*	- Effective care coordination is an NQS priority - Fill gaps identified by the Workgroup for additional care transition and patient reported measures - Reporting patients' perspectives on care is a statutory requirement - Noted priority for Dual Eligible Beneficiaries related to care after discharge 0228: 3-Item Care Transition Measure (CTM-3) is part of the Dual Eligible Beneficiaries core set - Condition-specific focus of AMI (0698), Heart Failure (0699) and Pneumonia (0707) measures does not allow for broad applicability

9:25	C. Hospital-wide Readmission measure that is **not** NQF-endorsed, but under consideration in current NQF CDP project *(Care coordination is cross-program focus area)*	• To date, recommended by steering committee with modifications related to harmonization issues with a related measure • Effective care coordination and safer care are NQS priorities • Potentially supports Workgroup recommendation to move toward all-patient, all-payer measures • Key issue for Dual Eligible Beneficiaries – there is a measure with similar intent included within the Duals core set
9:40	D. 2 additional NQF-endorsed measures under consideration for Heart Failure (0699: Heart Failure care transition measure noted above)	• Beta-blocker therapy for Left Ventricular Systolic Dysfunction (0083) and Symptom and Activity Assessment (0077) • Heart Failure is high impact condition • Final IQR measures include 5 existing Heart Failure (0162, 0135, 0136, 0330, 0229) measures to which these would be added to create a condition measure set
9:50	E. 8 measures under consideration that are **not** NQF-endorsed, but under consideration in current NQF CDP project	• Submitted to behavioral health project that launched in November 2011 • Related to tobacco, alcohol, substance screening, treatment and follow up (TAM 1-8) – Fill gap identified by the Workgroup for additional behavioral health measures • Noted high-leverage area of Mental Health/Substance Use for Dual Eligible Beneficiary population
10:05	F. 6 additional measures under consideration that are **not** NQF-endorsed nor specified at this time	• 3 Heart Failure measures: Combination Medical Therapy for LVSD, Counseling Regarding ICD for Patients with LVSD, Symptom Management • 2 Hip/Knee measures – Complication and Readmission: 30-day all-cause readmission measure • Safe Surgery Checklist – there is a Safe Surgery Checklist measure within the current OQR program set
10:20	G. Considerations on the existing program measure set	• Measures that are topped out • Final measures that should be replaced by measures under consideration • Measures not recommended through NQF endorsement maintenance ○ HF-1 Discharge Instructions (0136) is not recommended in current

		NQF Cardiovascular CDP project as it did not pass the importance criteria ○ Catheter Associated Urinary Tract Infection (CAUTI) (0138) is being replaced with a new measure; PSM-003-10 is expected to receive NQF endorsement in Dec. 2011 has this expanded denominator ○ Surgical Site Infections (0299) is being replaced with a new harmonized SSI measure (PSM-002-10) that is more limited measure related to colon surgeries and abdominal hysterectomies; expected to receive NQF endorsement in Dec. 2011
10:40	H. Alignment with other programs	• 30 measures are included with VBP (final and under consideration) • 32 measures are included in Meaningful Use (final and under consideration)
10:45 – 11:00 am	**BREAK**	
11:00 – 11:30 am	**Value-based Purchasing (VBP) Program Measure Set**	
11:00	A. Review program summary, final measures and measures under consideration, gaps, relationship to hospital core measure set	• Program set includes 13 new measures under consideration for a total of 30 measures to be included in Hospital VBP • Considering all final measures and measures under consideration, 23 of the 34 Hospital core set measures are NOT included in Hospital VBP
11:05	B. AMI-10 Statin Prescribed at Discharge (0439)	• Required within statute to measure AMI care • NQF-endorsed • In IQR and under consideration for Meaningful Use • Add to 3 other AMI measures within the program (0163, 0164, 0230)
	C. IQI 91 Mortality for Selected Medical Conditions (Composite) (0530)	• NQF-endorsed • In IQR • Included in Hospital core set

	D. 3 NQF-endorsed measures under consideration related to patient safety	• Safer care is an NQS priority
		• Central Line-Associated Blood Stream Infection (CLABSI) (0139)
		  o In IQR
		  o Required within statute to measure healthcare-associated infections
		  o Specified for ICU patients only
		• PSI 90 Complication/patient safety for selected indicators (Composite) (0531)
		  o In IQR
		  o Included in Hospital core set
		• SCIP-Inf-10 Surgery Patients Preoperative Temperature Management (0452)
		  o In IQR
		  o Add to 7 SCIP measures already included in Hospital VBP

11:15	E. 7 measures under consideration that are **not** NQF-endorsed related to healthcare-acquired conditions (HACs)	• HAC rates have not been submitted to NQF for consideration
		• Safer care is an NQS priority
		• Required within statute to measure healthcare-associated infections
		• Potential alternative measures:
		  o CLABSI (0139) under consideration for Hospital VBP (noted above)
		  o CAUTI (PSM-003-10) expected to receive NQF endorsement in Dec. 2011

11:20	F. Medicare Spending per Beneficiary	• Not NQF-endorsed: this measure is not yet complete or fully tested; NQF expects to receive this measure in Q2 2012 for review. • Making care more affordable is an NQS priority • Specificity to the Medicare patient population does not support application by private payers • Affordability is an important area of focus of the Dual Eligible Beneficiaries Workgroup • Statute states that VBP should include efficiency measures adjusted for factors such as age, sex, race, severity of illness, and other factors

11:25	G. Alignment with other programs	• All measures are also included in IQR (final and under consideration) • 12 measures are included in Meaningful Use (final and under consideration)
	H. Cross-program considerations – Care Coordination	• Includes HF-1 Discharge Instructions (0136), but this measure is not recommended in current NQF CDP project
11:30 am – 12:30 pm	**Inpatient Psychiatric Facility Quality Reporting Program Measure Set**	
11:30	A. Review program summary, final measures and measures under consideration, gaps, relationship to hospital core measure set	• Program set includes 6 new measures under consideration • All measures are NQF-endorsed • 2 measures related to Use of Restraint and Seclusion • 2 measures related to Post Discharge Continuing Care Plan • 2 measures related to Patients Discharged on Multiple Antipsychotic Medications
12:00	B. Alignment with other programs	• Program does not include measures from other programs
12:10	C. Implications for the Dual Eligible Beneficiaries population	• HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge (0558) is part of the Duals core set • Particularly applicable to the Dual Eligible population are the measures related to medication management and post-discharge planning
12:20	D. Cross-program considerations – Care Coordination	• HBIPS-6 Post discharge continuing care plan created (0557) • HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge (0558)
12:30 – 12:45 pm	**Opportunity for Public Comment**	
12:45 – 1:15 pm	**Lunch**	
1:15 – 2:45 pm	**Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (Meaningful Use) Measure Set**	
1:15	A. Review program summary, final measures and measures under	• Program set includes 36 new measures under consideration for a total of 51 measures to be included in Meaningful Use

	consideration, gaps, relationship to hospital core measure set	• Considering all final measures and measures under consideration, 22 of the 34 Hospital core set measures are NOT included in Meaningful Use

1:20	B. 7 NQF-endorsed measures under consideration related to AMI	• AMI is a High Impact Condition
		• Found in Current IQR and Hospital VBP
		   o AMI-8a Primary PCI Received Within 90 Minutes of Hospital Arrival (0163)
		   o AMI-7a Fibronolytic agent received within 30 minutes of hospital arrival (0164)
		• Found in current IQR and under consideration for Hospital VBP
		   o AMI-10 Statin Prescribed at Discharge (0439)
		• Found in current IQR
		   o Aspirin prescribed at discharge for AMI (0142)
		• Not currently used in another program
		   o Aspirin at arrival for acute myocardial infarction (AMI) (0132)
		   o ACEI or ARB for left ventricular systolic dysfunction- Acute Myocardial Infarction (AMI) Patients (0137)
		   o Beta-blocker prescribed at discharge for AMI (0160)

1:30	C. 8 NQF-endorsed measures under consideration related to Maternal Care	Fill gap identified by the Workgroup for maternal care measures • Elective delivery prior to 39 completed weeks gestation (0469) • Exclusive Breastfeeding at Hospital Discharge (0480) • First temperature measured within one hour of admission to the NICU (0481) • First NICU Temperature < 36 degrees C (0482) • Proportion of infants 22 to 29 weeks gestation treated with surfactant who are treated within 2 hours of birth (0484) • Neonatal Immunization (0485) • Healthy Term Newborn (0716) • Hearing screening prior to hospital discharge (EHDI-1a) (1354)

1:40	D. 5 NQF-endorsed measures under consideration related to Child Health	Fill gap identified by the Workgroup for pediatric measures • PICU Pain Assessment on Admission (0341) • PICU Periodic Pain Assessment (0342) • Use of relievers for inpatient asthma (0143) • Use of systemic corticosteroids for inpatient asthma (0144) • Home Management Plan of Care Document Given to Patient/Caregiver (0338)

1:50	E. 8 NQF-endorsed measures under consideration related to the surgical care improvement project (SCIP)	• Safer care is an NQS priority
		• Found in current IQR and Hospital VBP
		  o SCIP-Inf-01 Prophylactic antibiotic received within 1 hour prior to surgical incision (0527)
		  o SCIP-Inf-02 Prophylactic antibiotic selection for surgical patients (0528)
		  o SCIP-Inf-03 Prophylactic antibiotics discontinued with 24 hours after surgery end time (0529)
		  o SCIP-Inf-04 Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose (0300)
		  o SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism
		  o SCIP Card-2 Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period (0284)
		  o Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery (0218)
		• Found in current IQR
		  o SCIP-Inf-09 Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery Being Day Zero (0453)
		• Not found in another hospital program
		  o SCIP-INF-6- Surgery patients with appropriate hair removal (0301)

2:00	F. 2 NQF-endorsed measures under consideration related to pneumonia	• Found in current IQR and Hospital VBP
		   o PN-3b Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital (0148)
		   o PN-6 Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients (0147)

2:05	G. HF-1 Discharge instructions (0136)	• This measure is not recommended for continued endorsement in current NQF CDP project • Heart Failure is a High Impact Condition • Found in current IQR and hospital VBP
2:10	H. STK-1 Venous Thromboembolism (VTE) Prophylaxis (0434)	• Stroke is a High Impact Condition • Found in current IQR
2:15	I. OP–18/ED-3: Median Time from ED Arrival to ED Departure for Discharged ED Patients (0496)	• Found in current OQR • Fill gap identified by the Workgroup for ED measures

2:20	J. 2 measures under consideration that are **not** NQF-endorsed, but under consideration in current NQF CDP project	• Submitted to population health: prevention project that launched in May 2011
		   o IMM-1 Pneumonia Immunization – to date, recommended for endorsement by steering committee
		   o IMM-2 Flu Immunization – to date, recommended for endorsement by steering committee

2:25	K. 1 measure under consideration that is **not** NQF-endorsed nor specified at this time	• CMS wants to create a new measure that will combine two currently NQF-endorsed measures into one measure: HF-2 Evaluation of left ventricular function (0135) and HF-3 Angiotensin converting enzyme inhibitor (ACE–I) or angiotensin II receptor blocker (ARB) for left ventricular systolic dysfunction (0162)

2:30	L. Alignment with other programs	• 17 measures are included with IQR (final and under consideration) • 12 measures are included with VBP (final and under consideration) • 1 measure is included in OQR (final and under consideration)
2:35	M. Implications for the Dual Eligible Beneficiaries population	• Home Management Plan of Care Given to Patient/Caregiver – relates to high leverage area
2:40	N. Cross-program considerations – Care Coordination	• Home Management Plan of Care Document Given to Patient/Caregiver (0338) • Incidence of Potentially Preventable Venous Thromboembolism (0376) • Thirty-day all-cause risk standardized readmission rate following acute myocardial infarction (AMI) hospitalization (0505)
2:45 – 3:15 pm	**Outpatient Quality Reporting (OQR) Program Measure Set**	
2:45	A. Review program summary, final measures and measures under consideration, gaps, relationship to hospital core measure set	• No new measures under consideration for the OQR Program • Considering all final measures and measures under consideration, 33 of the 34 Hospital core set measures are NOT included in OQR
2:50	B. Program set includes 5 measures that are **not** NQF-endorsed	• OP–9: Mammography Follow-up Rates – considered for NQF endorsement in 2010, but not recommended because of concerns that the measure looked at only recall rates, but not at the number of missed cancers as well as concerns with the usability and specifications • OP–10: Abdomen CT—Use of Contrast Material – considered for NQF endorsement in 2010, but not recommended due to concerns with the evidence and measure specifications • OP–14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT) – considered for NQF endorsement in 2010, but not recommended because the measure it did not meet the NQF importance criterion • OP–15: Use of Brain Computed Tomography (CT) in the Emergency

		Department for Atraumatic Headache – considered for NQF endorsement in 2010, but not recommended following public comment due to concerns about potential for unintended consequences as currently specified • OP-25: Safe Surgery Checklist – not previously submitted to NQF for endorsement

3:00	C. Additional considerations on the existing program measure set	• Measures that are topped out
		• Measures not recommended through NQF endorsement maintenance
		   ○ OP–20: Door to Diagnostic Evaluation by a Qualified Medical Professional (0498)
		   ○ OP–22: ED–Patient Left Without Being Seen (0499)

3:05	D. Alignment with other programs	• OP-18: Median time from ED arrival to ED departure for discharged ED patients (0496) is under consideration for Meaningful Use

3:10	E. Implications for the Dual Eligible Beneficiaries population and care coordination	• There are no measures from the Dual Eligible Beneficiaries core set included within the OQR Program Set, but care coordination is a key issue for this population and the following measures are related:
		   ○ Tracking Clinical Results between Visits (0491)
		   ○ Transition Record with Specified Elements Received by Discharged Patients (0649)

3:15 – 3:30 pm	**BREAK**	
3:30 – 4:00 pm	**Ambulatory Surgical Center Quality Reporting (ASC) Program Measure Set**	
3:30	A. Review program summary, final measures and measures under consideration, gaps, relationship to hospital core measure set	• No new measures under consideration for the ASC Program • Program set includes 5 measures, all of which are NQF-endorsed • Measures included in this set are highly related to patient safety
3:40	B. Alignment with other programs	• The measures included in this program are not included in any other programs

		• ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing is related to antibiotic timing measures included in IQR and VBP
3:50	C. Cross-program considerations – Care Coordination	• The program set, including measures that are final and under consideration, does not contain measures related to care coordination
4:00 – 4:45 pm	**PPS Exempt Cancer Hospital Quality Reporting Program Measure Set**	
4:00	A. Review program summary, final measures and measures under consideration, gaps, relationship to hospital core measure set	• Program set includes 5 new measures under consideration • 3 measures are NQF-endorsed • Measures include 2 breast and 1 colon cancer – both are high impact conditions
4:10	B. Program set includes 2 measures that are **not** NQF-endorsed®	• Currently, there are endorsed versions of both the CAUTI (0138) and CLABSI (0139) measures, but they are specified for only the ICU population. The measures under consideration have expanded denominators to include inpatients in ICUs (excluding patients in NICUs), SCAs, and other inpatient locations (excluding Level I and Level II nurseries) • CAUTI (PSM-003-10) expected to receive NQF endorsement in Dec. 2011 has this expanded denominator; expected that 0138 will be retired once this new measure is endorsed
4:20	C. Multiple measure gaps exist	• The program measure set is limited and only includes measures related to breast and colon cancers. The Workgroup previously identified lung, prostate, gynecological, and pediatric cancers as additional priorities for measurement • Survival is not addressed in this measure set. The Workgroup identified survival as the most important outcome of cancer care, particularly for patients

4:35	D. Alignment with other programs	- The measures included in this program are not included in any other programs - The CAUTI and CLABSI measures with expanded denominators are very similar to the existing measures used in IQR currently; CLABSI is also under consideration for Hospital VBP
4:40	E. Cross-program considerations – Care Coordination	The program set, including measures that are final and under consideration, does not contain measures related to care coordination
4:45 – 5:00 pm	**Opportunity for Public Comment**	
5:00 – 5:30 pm	**Summary of Day**	
5:30 pm	**Adjourn for the Day**	

Pre-Rulemaking Considerations from Dual Eligible Beneficiaries Workgroup

In providing input to HHS regarding the selection of measures for Federal payment and public reporting programs, MAP must consider how the programs may impact the quality of care delivered to Medicare-Medicaid dual eligible beneficiaries. The roughly 9 million Americans eligible for both Medicare and Medicaid comprise a heterogeneous group that includes many of the poorest and sickest individuals covered by either program. Despite their particularly intense and complex needs, the healthcare and supportive services accessed by these individuals are often highly fragmented. HHS is pursuing several strategies to improve the quality of care provided to dual eligible beneficiaries, including tasking MAP with considering the implications of existing Federal measurement programs for this vulnerable group.

General Principles for Measure Selection

In reviewing potential measures for individual programs, consider that **the workgroup has identified the areas in which performance measurement can provide the most leverage in improving the quality of care: quality of life, care coordination, screening and assessment, mental health and substance use, as well as structural measures**. A list of measures in these areas which are collectively being considered a draft core set is provided in the last section of this document.

Also consider that the following issues are strongly related to quality of care in the population, regardless of the type of care being provided.

- **Setting goals for care:** Wherever possible, measurement should promote a broad view of health and wellness. Person-centered plans of care should be developed in collaboration with an individual, his/her family, and his/her care team. A plan of care should establish health-related goals and preferences for care that incorporate medical, behavioral, and social needs.
- **Chronicity of care:** More than 60 percent of dual eligible beneficiaries have three or more multiple chronic conditions, with the most common being cardiovascular disease, diabetes, Alzheimer's and related disorders, arthritis, and depression. Many people with disabilities require care and supports, of varying intensity, throughout their lifetimes.
- **Cognitive status**: More than 60 percent of dual eligible beneficiaries are affected by a mental or cognitive impairment. Etiologies of these impairments are diverse and may include intellectual/developmental disability, mental illness, dementia, substance abuse, or stroke.
- **Care transitions and communication:** Many factors, including those listed above, make dual eligible beneficiaries more vulnerable to problems that arise during all types of care transitions. Communication and coordination across all providers is vital. Transactions between the medical system and the community-based services system are particularly important for beneficiaries who use long-term supports.

Considerations for Hospital Programs

The workgroup discussed the overarching factors that are linked to high-quality care in the hospital setting. Of primary importance is the need to manage the risks associated with hospitalizations, whether related to safety, medication management, or symptoms that can affect geriatric patients such as delirium. Facilitating a smooth transition from a hospital stay to another setting of care is vital, as duals

are frequently the patients least able to navigate that change themselves. Coordinated care also helps to reduce readmissions, another important quality factor for this population. Finally, the workgroup encourages consideration of quality and care coordination from the perspective of vulnerable patients accessing the emergency department or other "frequent users" of hospital care.

Measure Gaps in the Hospital Core Set
- Assessment of prior level of function before admission
- Appropriateness of initial hospital admission
- Geriatric measures (i.e., avoidance of delirium)
- Mobilization during inpatient stay
- Restraint-free care
- Informed decision making
- Discharge planning
- Coordination of follow-up care

Measure Exceptions
The workgroup urges caution when recommending clinical process measures. Use of these measures should not negatively impact quality of life decisions made in collaboration with a patient and his/her family. In addition, the workgroup felt that condition-specific measures are marginally important compared to the cross-cutting issues identified. Maternal and pediatric measures do not apply to the dual eligible beneficiary population.

MAP Dual Eligible Beneficiaries Workgroup: Draft Core Set of Measures
The workgroup identified the draft core set presented below from an extensive list of current measures. Potential measures were considered in five areas previously identified by the workgroup as most closely linked to quality of care:

- Quality of Life;
- Care Coordination;
- Screening and Assessment;
- Mental Health and Substance Use; and
- Structural Measures.

Many measure gaps and limitations in current measures were identified during the process of compiling a draft core set. The workgroup is currently considering a range of potential modifications to measures that would make them more appropriate for use with the dual eligible beneficiary population. The following list is presented as a starting place for discussion.

NQF # and Status	Measure Title and Description	Qual of Life	Care Coord	Screening	Mental/SU	Structural	Specified Setting of Care	Finalized, Proposed or Under Consideration by CMS for Federal Program
0329 Endorsed	*All-Cause Readmission Index (risk adjusted)* Overall inpatient 30-day hospital readmission rate, excluding maternity and pediatric discharges		✓				Hospital	
0228 Endorsed	*3-Item Care Transition Measure (CTM-3)* Uni-dimensional self-reported survey that measures the quality of preparation for care transitions. Namely: 1. Understanding one's self-care role in the post-hospital setting 2. Medication management 3. Having one's preferences incorporated into the care plan		✓				Hospital	Under consideration (Category 2) for Hospital Inpatient Quality Reporting
0558 Endorsed	*HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge* Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity		✓		✓		Hospital	Under consideration (Category 1) for Inpatient Psychiatric Facility Quality Reporting
0418 Endorsed	*Screening for Clinical Depression and Follow-up Plan* Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool and follow up plan documented			✓	✓		Ambulatory, Hospital, PAC/LTC Facility	Under consideration (Category 3) for EHR Incentive Program / Meaningful Use; Proposed for Medicaid Adult Core Measures
0647 Endorsed	*Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)* Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements		✓				Hospital, PAC/LTC Facility	Proposed for Medicaid Adult Core Measures
0430 Endorsed	*Change in Daily Activity Function as Measured by the AM-PAC* The Activity Measure for Post-Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post-acute care (PAC) patients. A Daily Activity domain has been identified which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing	✓		✓			Ambulatory, Home Health, Hospital, PAC/LTC Facility	

NQF # and Status	Measure Title and Description	Qual of Life	Care Coord	Screening	Mental/SU	Structural	Specified Setting of Care	Finalized, Proposed or Under Consideration by CMS for Federal Program
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		✓		✓		Ambulatory, Behavioral Health	Proposed for Medicaid Adult Core Measures
0005 Endorsed	*CAHPS Adult Primary Care Survey: Shared Decision Making* 37 core and 64 supplemental question survey of adult outpatient primary care patients		✓				Ambulatory	
0006 Endorsed	*CAHPS Health Plan Survey v 4.0 - Adult questionnaire: Health Status/Functional Status* 30-question core survey of adult health plan members that assesses the quality of care and services they receive	✓					Ambulatory	Proposed for Medicaid Adult Core Measures
0490 Endorsed	*The Ability to use Health Information Technology to Perform Care Management at the Point of Care* Documents the extent to which a provider uses a certified/qualified electronic health record (EHR) system capable of enhancing care management at the point of care. To qualify, the facility must have implemented processes within their EHR for disease management that incorporate the principles of care management at the point of care which include: a. The ability to identify specific patients by diagnosis or medication use, b. The capacity to present alerts to the clinician for disease management, preventive services and wellness, c. The ability to provide support for standard care plans, practice guidelines, and protocol					✓	Ambulatory	
0494 Endorsed	*Medical Home System Survey* Percentage of practices functioning as a patient-centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: a. Improved access and communication b. Care management using evidence-based guidelines c. Patient tracking and registry functions d. Support for patient self-management e. Test and referral tracking f. Practice performance and improvement functions					✓	Ambulatory	
0101 Endorsed	*Falls: Screening for Fall Risk* Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months			✓			Ambulatory	Under consideration (Category 3) for EHR Incentive Program / Meaningful Use

NQF # and Status	Measure Title and Description	Qual of Life	Care Coord	Screening	Mental/SU	Structural	Specified Setting of Care	Finalized, Proposed or Under Consideration by CMS for Federal Program
0729 Endorsed	*Optimal Diabetes Care* Patients ages 18 -75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 14090, Tobacco non-user and for patients with a diagnosis of ischemic vascular disease daily aspirin use unless contraindicated			✓			Ambulatory	Under consideration (Category 2) for Physician Quality Reporting System (PQRS)
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 Normal Parameters: Age 65 and older BMI ≥23 and <30; Age 18 – 64 BMI ≥18.5 and <25			✓			Ambulatory	Proposed for Medicaid Adult Core Measures
0028 Endorsed	*Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention* Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period			✓	✓		Ambulatory	
0004 Endorsed	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement* The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit				✓		Ambulatory	Proposed for Medicaid Adult Core Measures
0523 Endorsed	*Pain Assessment Conducted* Percent of patients who were assessed for pain, using a standardized pain assessment tool, at start/resumption of home health care	✓		✓			Home Health	
0167 Endorsed	*Improvement in Ambulation/locomotion* Percentage of home health episodes where the value recorded for the OASIS item M0702 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care	✓		✓			Home Health	

NQF # and Status	Measure Title and Description	Qual of Life	Care Coord	Screening	Mental/SU	Structural	Specified Setting of Care	Finalized, Proposed or Under Consideration by CMS for Federal Program
0208 Endorsed	*Family Evaluation of Hospice Care* Percentage of family members of all patients enrolled in a hospice program who give satisfactory answers to the survey instrument	✓					Hospice	Under consideration (Category 2) for Hospice Quality Reporting
0260 Endorsed	*Assessment of Health-related Quality of Life (Physical & Mental Functioning)* Percentage of dialysis patients who receive a quality of life assessment using the KDQOL-36 (36-question survey that assesses patients' functioning and well-being) at least once per year	✓		✓	✓		Dialysis Facility	
Not Endorsed	*SNP 6: Coordination of Medicare and Medicaid coverage* Intent: The organization helps members obtain services they are eligible to receive regardless of payer, by coordinating Medicare and Medicaid coverage. This is necessary because the two programs have different rules and benefit structures and can be confusing for both members and providers					✓	[not available]	
Not Endorsed	*Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment* a. Patients screened annually for alcohol misuse with the 3-item AUDIT-C with item-wise recording of item responses, total score and positive or negative result of the AUDIT-C in the medical record. B. Patients who screen for alcohol misuse with AUDIT-C who meet or exceed a threshold score who have brief alcohol counseling documented in the medical record within 14 days of the positive screening.			✓	✓		[not available]	Proposed for Medicaid Adult Core Measures; similar measure under consideration (Category 2) for Hospital Inpatient Quality Reporting
Not Endorsed	*Potentially Harmful Drug-Disease Interactions in the Elderly* Percentage of Medicare members 65 years of age and older who have a diagnosis of chronic renal failure and prescription for non-aspirin NSAIDs or Cox-2 selective NSAIDs; Percentage of Medicare members 65 years of age and older who have a diagnosis of dementia and a prescription for tricyclic antidepressants or anticholinergic agents; percentage of Medicare members 65 years of age and older who have a history of falls and a prescription for tricyclic antidepressants, antipsychotics or sleep agents		✓	✓			Pharmacy	

Cross-Program Considerations - Care Coordination

Measure Number and Title	Federal Programs																
	PQRS	Value-Based Modifier	MU for Eligible Professionals	ACOs	IQR	OQR	VBP	MU for Hospitals and CAHs	Inpatient Psychiatric Quality Reporting	Ambulatory Surgical Center Quality Reporting	PPS- Exempt Cancer Hospital Quality Reporting	ESRD	Home Health Quality Reporting	Hospice Quality Reporting	IRFs	LTCHs	NH Quality Initiative and NH Compare
NQF ID #: 0642 Cardiac rehabilitation patient referral from an inpatient setting																	
NQF ID #: 0643 Cardiac rehabilitation patient referral from an outpatient setting	F					F											
NQF ID #: 0644 Patients with a transient ischemic event ER visit that had a follow-up office visit																	
NQF ID #: 0645 Biopsy follow-up	F																
NQF ID #: 0646 Reconciled medication list received by discharged patients (inpatient discharges to home/self care or any other site of care)																	
NQF ID #: 0647 Transition record with specified elements received by discharged patients (inpatient discharges to home/self care or any other site of care)																	
NQF ID #: 0648 Timely transmission of transition record (inpatient discharges to home/self care or any other site of care)																	
NQF ID #: 0649 Transition record with specified elements received by discharged patients (emergency department discharges to ambulatory care [home/self care])						F											
NQF ID #: 0650 Melanoma continuity of care - recall system	F																
NQF ID #: 0228 3-item care transition measure (CTM-3)					UC												
NQF ID #: 0097 Medication Reconciliation	F	F		F													
NQF ID #: 0171 Acute care hospitalization (risk-adjusted)													F				
NQF ID #: 0173 Emergent care (risk adjusted)																	
NQF ID # 0326 Advance Care Plan	F																
NQF ID # 0494 Medical Home System Survey																	
NQF ID # 0511 Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	F																

Cross-Program Considerations - Care Coordination

Measure Number and Title	Federal Programs																
	PQRS	Value-Based Modifier	MU for Eligible Professionals	ACOs	IQR	OQR	VBP	MU for Hospitals and CAHs	Inpatient Psychiatric Quality Reporting	Ambulatory Surgical Center Quality Reporting	PPS- Exempt Cancer Hospital Quality Reporting	ESRD	Home Health Quality Reporting	Hospice Quality Reporting	IRFs	LTCHs	NH Quality Initiative and NH Compare
NQF ID # 0520 Drug Education on All Medications Provided to Patient/Caregiver During Episode													F				
NQF ID # 0526 Timely Initiation of Care													F				
NQF ID # 0553 Care for Older Adults – Medication Review (COA)																	
NQF ID # 0554 Medication Reconciliation Post-Discharge (MRP)																	
NQF ID # 0542 Adherence to chronic medications																	
NQF ID # 0005, 0006, 0166, 0258, 0517 Consumer Assessment of Healthcare Providers and Systems (CAHPS)				F	F		F					F	F				

F = Finalized Measures
UC = Measures Under Consideration

Program Summary: CMS Hospital Inpatient Reporting

Program Description

Since 2004, CMS has collected quality and patient experience data from acute care hospitals on a voluntary basis under the Hospital Inpatient Quality Reporting (IQR) Program. The program was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This section of the MMA authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. Initially, the MMA provided for a 0.4 percentage point reduction in the annual market basket (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) update for hospitals that did not successfully report. The Deficit Reduction Act of 2005 increased that reduction to 2.0 percentage points. [1] Information gathered through the Hospital IQR program is reported on the Hospital Compare Website.[2]

Statutory Requirements for Measures:

The Secretary shall begin to adopt the baseline set of performance measures set forth in the November 2005 report by the Institute of Medicine of the National Academy of Sciences under section 238 (b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The Secretary shall add other measures that reflect consensus among the affected parties, and to the extent feasible and practicable, shall include measure set forth by one or more national consensus building entities. The Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice. The Secretary shall report quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in inpatient settings on the CMS website. Registry-based measures can be considered for this program. All Cause All Condition readmissions (Section 3025, item #8) to be used for quality improvement, not payment.

Program Measure Set Analysis

Measure Summary:

	Finalized	Under Consideration	Total
Total Measures	72	21	93
NQF-Endorsed®	57	6	63
NQS Priority			
Safer Care	42	3	45
Effective Care Coordination	8	4	12
Prevention and Treatment of Leading Causes of Mortality and Morbidity	29	9	38

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

Person and Family Centered Care	4	1	5
Supporting Better Health in Communities	4	5	9
Making Care More Affordable	4	0	4
Addresses High Impact Conditions	23	1	24
Measure Type			
Process Measures	34	17	51
Outcome Measures	31	0	31
Cost Measures	1	0	1
Structural Measures	4	0	4
Patient Experience	1	1	2

Identified Measure Gaps:

- Child health
- Maternal Care
- Measures are not sensitive to disparities
- Behavioral health beyond substance abuse
- Patient-reported outcomes
- Sepsis measures. The Workgroup had suggested that sepsis be considered separately from infections as a whole.
- Cost and resource use measure

Measure Title	NQF Measure # and Status	Measure Type	Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care	Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Inpatient Quality Reporting
AMI-10 Statin Prescribed at Discharge	0439 Endorsed	Process			X				Yes	Acute Myocardial Infarction	No	No		Yes	Finalized
AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival	0164 Endorsed	Process			X				Yes	Acute Myocardial Infarction	Yes	No	Aligns with core measures	Yes	Finalized
AMI–8a Timing of receipt of primary percutaneous coronary intervention (PCI)	0163 Endorsed	Process			X				Yes	Acute Myocardial Infarction	Yes	No	Aligns with core measures	Yes	Finalized
AMI–2 Aspirin prescribed at discharge	0142 Endorsed	Process			X				Yes	Acute Myocardial Infarction	No	No		Yes	Finalized
Acute myocardial infarction (AMI) 30-day mortality rate	0230 Endorsed	Outcome			X				Yes	Acute Myocardial Infarction	No	No	Aligns with core measures	Yes	Finalized
Acute myocardial infarction 30-day risk standardized readmission measure	0505 Endorsed	Outcome	X	X	X				Yes	Acute Myocardial Infarction	Yes	No	Aligns with core measures	Yes	Finalized
3-Item Care Transition Measure (CTM-3)	0228 Endorsed	Patient Engagement/Experience		X		X			Yes	Care Coordination	Yes	No	MAP Duals Core Measure		Under Consideration-Priority 2
ED–2 Median time from admit decision to time of departure from the emergency department for emergency department patients admitted to the inpatient status	0497 Endorsed	Outcome							Yes	Care Coordination	Yes	No		Yes	Finalized
AMI 30-day Post Discharge Transition Composite Measure	0698 Endorsed	Composite		X					Yes	Care Coordination	Yes	No		No	Under Consideration-Priority 2
HF 30-day Post Discharge Transition Composite Measure	0699 Endorsed	Composite		X	X				Yes	Care Coordination	Yes	No		No	Under Consideration-Priority 2
Hospital-wide Readmission	Not NQF Endorsed	Outcome							Yes	Care Coordination	Yes	No			Under Consideration-Priority 1
ED–1 Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the hospital	0495 Endorsed	Outcome							Yes	Care Coordination	Yes	No			Finalized

Inpatient Quality Reporting

Measure Title	NQF Measure # and Status	Measure Type	Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care	Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Inpatient Quality Reporting
					NQS Priority										
Medicare Spending per Beneficiary.	Not NQF Endorsed	Cost						X	Yes	Cost	No	No			Finalized
HF–3 Angiotensin converting enzyme inhibitor (ACE–I) or angiotensin II receptor blocker (ARB) for left ventricular systolic dysfunction	0162 Endorsed	Process			X				Yes	Heart Failure	no	No			Finalized
HF–2 Evaluation of left ventricular systolic function	0135 Endorsed	Process			X				Yes	Heart Failure	No	No		Yes	Finalized
Heart Failure : Beta-blocker therapy for Left Ventricular Systolic Dysfunction	0083 Endorsed	Process			X				Yes	Heart Failure	No	No			Under Consideration-Priority 3
Heart Failure: Combination Medical Therapy for LVSD	Not NQF Endorsed	Process							Yes	Heart Failure	No	No			Under Consideration-Priority 2
Heart Failure: Counseling Regarding ICD for Patients with LVSD	Not NQF Endorsed	Process							Yes	Heart Failure	No	No			Under Consideration-Priority 2
Heart failure: Symptom and Activity Assessment	0077 Endorsed	Process			X				Yes	Heart Failure	No	No			Under Consideration-Priority 2
Heart failure: Symptom Management	Not NQF Endorsed								Yes	Heart Failure	Yes	No			Under Consideration-Priority 2
HF-1 Discharge instructions	0136 Endorsed	Process	X	X	X	X	X		Yes	Heart Failure	Yes	No	Not recommended	Yes	Finalized
Heart failure 30-day risk standardized readmission measure	0330 Endorsed	Outcome	X	X	X				Yes	Heart Failure	Yes	No	Aligns with core measures	Yes	Finalized
Heart failure (HF) 30-day mortality rate	0229 Endorsed	Outcome			X				Yes	Heart Failure	No	No	Aligns with core measures	Yes	Finalized
IQI 19: Hip fracture mortality rate	0354 Endorsed	Outcome	X						Yes	Hip/Knee	No	No		Yes	Finalized

Inpatient Quality Reporting

Measure Title	NQF Measure # and Status	Measure Type	Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care	Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Inpatient Quality Reporting
Hip/Knee Complication	Not NQF Endorsed	Outcome							Yes	Hip/Knee	No	No	#1550 currently recommended in NQF CDP project		Under Consideration-Priority 1
Hip/Knee Readmission: 30-day all-cause readmission measure.	Not NQF Endorsed	Outcome							Yes	Hip/Knee	Yes	No	#1551 currently recommended in NQF CDP project		Under Consideration-Priority 1
IMM-1 Pneumonia Immunization	Not NQF Endorsed	Process					X		Yes	Immunizations	No	No	#1653 under consideration in Population Health Prevention project		Finalized
IMM-2 Flu Immunization	Not NQF Endorsed	Process					X		Yes	Immunizations	No	No	#1659 under consideration in Population Health Prevention project		Finalized
Influenza Vaccination for Healthcare Personnel	0431 Endorsed	Process					X		Yes	Immunizations	No	No			Finalized
HCAHPS survey	0166 Endorsed	Patient Engagement/Experience				X			Yes	Patient Experience	Yes	No	Aligns with core measures	Yes	Finalized
Pneumonia (PN) 30-day mortality rate	0468 Endorsed	Outcome			X				Yes	Pneumonia	No	No	Aligns with core measures	Yes	Finalized
PN–3b Blood culture performed in the emergency department prior to first antibiotic received in hospital	0148 Endorsed	Process	X		X				Yes	Pneumonia	Yes	No	Aligns with core measures	Yes	Finalized
PN–6 Appropriate initial antibiotic selection	0147 Endorsed	Process			X				Yes	Pneumonia	No	No		Yes	Finalized
Pneumonia 30-day Post Discharge Transition Composite Measure	0707 Endorsed	Composite		X					Yes	Pneumonia	Yes	No			Under Consideration-Priority 2

Inpatient Quality Reporting

Measure Title	NQF Measure # and Status	Measure Type	Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care	Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Inpatient Quality Reporting
					NQS Priority										
Pneumonia 30-day risk standardized readmission measure	0506 Endorsed	Outcome	X	X				X	Yes	Pneumonia	Yes	No	Aligns with core measures	Yes	Finalized
IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)	0359 Endorsed	Outcome	X						Yes	Safety	no	No		Yes	Finalized
PSI 15: Accidental puncture or laceration	0345 Endorsed	Outcome	X						Yes	Safety	No	No		Yes	Finalized
Air Embolism	Not NQF Endorsed	Outcome	X						Yes	Safety	No	No			Finalized
Blood Incompatibility	Not NQF Endorsed	Outcome	X						Yes	Safety	No	No			Finalized
Catheter-Associated Urinary Tract Infection	Not NQF Endorsed	Outcome	X						Yes	Safety	No	No			Finalized
Central line associated bloodstream infection	0139 Endorsed	Outcome	X						Yes	Safety	No	No		Yes	Finalized
Clostridium Difficile SIR Measure	1717 Submitted	Outcome	X						Yes	Safety	No	No	Under consideration (#1717) in NQF CDP project		Finalized
Falls and Trauma	Not NQF Endorsed	Outcome	X						Yes	Safety	No	No			Finalized
Foreign Body Left During Procedure (PSI 5)	0363 Endorsed	Outcome	X						Yes	Safety	No	No			Finalized
PSI 06: Iatrogenic pneumothorax, adult	0346 Endorsed	Outcome	X						Yes	Safety	no	No			Finalized
VTE-6: Incidence of Potentially-Preventable VTE	0376 Endorsed	Outcome	X	X					Yes	Safety	Yes	No		Yes	Finalized
VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis	0372 Endorsed	Process	X						Yes	Safety	Yes	No		Yes	Finalized

Inpatient Quality Reporting

Measure Title	NQF Measure # and Status	Measure Type	Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care	Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Inpatient Quality Reporting
													NQS Priority spans above		
Mortality for selected medical conditions (composite)	0530 Endorsed	Outcome			X				Yes	Safety	No	No	Aligns with core measures Some mortality rates overlap with existing mortality measures already being reported	No	Finalized
Manifestations of Poor Glycemic Control	Not NQF Endorsed	Outcome	X						Yes	Safety	No	No			Finalized
Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia	1716 Submitted	Outcome	X						Yes	Safety	No	No	Under consideration (#1716) in NQF CDP project		Finalized
NSC (and AHRQ PSI): Death among Surgical Inpatients with Serious Treatable Complications	Not NQF Endorsed	Outcome	X						Yes	Safety	No	No			Finalized
PSI 14: Post-operative wound dehiscence	0368 Endorsed	Outcome	X						Yes	Safety	No	No	Not recommended	Yes	Finalized
Pressure Ulcer Stages III and IV	Not NQF Endorsed	Outcome	X						Yes	Safety	No	No			Finalized
PSI 11: Post-operative respiratory failure	0533 Endorsed	Outcome	X		X				Yes	Safety	No	No		Yes	Finalized
PSI 12: Post-operative PE or DVT	0450 Endorsed	Outcome	X						Yes	Safety	No	No			Finalized

Measure Title	NQF Measure # and Status	Measure Type	Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care	Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Inpatient Quality Reporting
					NQS Priority										
Complication/patient safety for selected indicators (composite)	0531 Endorsed	Composite	X						Yes	Safety	No	No	Aligns with core measures Some components overlap with exsisting HAC policy & AHRQ measures reported on Hospital Compare	No	Finalized
Safe Surgery Checklist	Not NQF Endorsed	Process							Yes	Safety	No	No			Under Consideration-Priority 1
SCIP Cardiovascular-2: Surgery Patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period	0284 Endorsed	Process			X				Yes	Safety	Yes	No		Yes	Finalized
SCIP INF–1 Prophylactic antibiotic received within 1 hour prior to surgical incision	0527 Endorsed	Process	X						Yes	Safety	Yes	No		Yes	Finalized
SCIP INF–2: Prophylactic antibiotic selection for surgical patients	0528 Endorsed	Process	X						Yes	Safety	No	No		Yes	Finalized
SCIP INF–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	0529 Endorsed	Process	X		X			X	Yes	Safety	Yes	No	Aligns with core measures	Yes	Finalized
SCIP INF–4: Cardiac surgery patients with controlled 6AM postoperative serum glucose	0300 Endorsed	Process	X		X				Yes	Safety	No	No		Yes	Finalized
SCIP INF–9: Postoperative urinary catheter removal on post-operative day 1 or 2 with day of surgery being day zero	0453 Endorsed	Process	X						Yes	Safety	Yes	No		Yes	Finalized

Inpatient Quality Reporting

Measure Title	NQF Measure # and Status	Measure Type	Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care	Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Inpatient Quality Reporting
			NQS Priority												
SCIP INF–10: Surgery patients with perioperative temperature management	0452 Endorsed	Process	X						Yes	Safety	No	No		Yes	Finalized
SCIP INF—VTE-1: Surgery patients with recommended venous thromboembolism (VTE) prophylaxis ordered	0217 Endorsed	Process	X						Yes	Safety	No	No	Not recommended		Finalized
SCIP–VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post-surgery	0218 Endorsed	Process	X						Yes	Safety	Yes	No	Aligns with core measures	Yes	Finalized
Surgical site infection	0299 Endorsed	Outcome	X						Yes	Safety	No	No	Aligns with core measures Likely to be replaced by new endorsed measure in Dec. 2011	Yes	Finalized
Catheter-Associated Urinary Tract Infection	0138 Endorsed	Outcome	X						Yes	Safety	No	No	Likely to be replaced by new endorsed measure in Dec. 2011	Yes	Finalized
Vascular-Catheter Associated Infection	Not NQF Endorsed	Outcome	X						Yes	Safety	No	No			Finalized
VTE-5: VTE Discharge Instructions	0375 Endorsed	Process	X						Yes	Safety	No	No		Yes	Finalized
VTE-4 Venous Thromboembolism Patients Recieving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram	0374 Endorsed	Process	X						Yes	Safety	No	No		Yes	Finalized
VTE-3 VTE Patients with Overlap of Anticoagulation Therapy	0373 Endorsed	Process	X						Yes	Safety	Yes	No		Yes	Finalized
VTE-1 Venous Thromboembolism Prophylaxis	0371 Endorsed	Process	X						Yes	Safety	Yes	No			Finalized

Inpatient Quality Reporting

Measure Title	NQF Measure # and Status	Measure Type	NQS Priority						Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Inpatient Quality Reporting
			Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care							
STK-1 Venous Thromboembolism (VTE) Prophylaxis	0434 Endorsed	Process	X		X				Yes	Stroke	Yes	No	Aligns with core measures	Yes	Finalized
STK-10 Assessed for Rehabilitation	0441 Endorsed	Process			X	X			Yes	Stroke	Yes	No	Aligns with core measures	Yes	Finalized
STK-2 Discharged on Antithrombotic Therapy	0435 Endorsed	Process	X		X				Yes	Stroke	No	No	Aligns with core measures	Yes	Finalized
STK-3 Patients with Atrial Fibrillation Receiving Anticoagulation Therapy	0436 Endorsed	Process			X				Yes	Stroke	No	No		Yes	Finalized
STK-4 Thrombolytic Therapy	0437 Endorsed	Process			X				Yes	Stroke	Yes	No		Yes	Finalized
STK-5 Antithrombotic Medication by End of Hospital Day Two	0438 Endorsed	Process			X				Yes	Stroke	Yes	No	Aligns with core measures	Yes	Finalized
STK-6 Discharged on Statin Medication	0439 Endorsed	Process			X				Yes	Stroke	No	No		Yes	Finalized
STK-8 Stroke Education	0440 Endorsed	Process			X	X			Yes	Stroke	Yes	No		Yes	Finalized
Participation in a systematic clinical database for nursing sensitive care	0493 Endorsed	Structure							Yes	Stucture	No	No			Finalized
Participation in a Systematic Clinical Database Registry for General Surgery	0493 Endorsed	Structure		X					Yes	Stucture	No	No			Finalized
Participation in a Systematic Clinical Database Registry for Stroke Care	0493 Endorsed	Structure		X					Yes	Stucture	No	No			Finalized
Participation in a systematic database for cardiac surgery	0113 Endorsed	Structure		X	X				Yes	Stucture	No	No			Finalized

Inpatient Quality Reporting

Measure Title	NQF Measure # and Status	Measure Type	Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care	Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Inpatient Quality Reporting
					NQS Priority										
TAM-1 Tobacco Use Screening	1651 Submiited	Process			X		X		Yes	Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	No	No	#1651 under consideration in Pop Health Prevention project; not yet reviewed		Under Consideration-Priority 2
TAM-2 Tobacco Use Treatment Provided or Offered	1654 Submitted	Process			X				Yes	Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	No	No	#1654 under consideration in Pop Health Prevention project; not yet reviewed		Under Consideration-Priority 2
TAM-3 Tobacco Use Treatment Management at Discharge	1656 Submitted	Process			X				Yes	Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	No	No	#1656 under consideration in Pop Health Prevention project; not yet reviewed		Under Consideration-Priority 2
TAM-4 Tobacco Use: Assessing Status after Discharge	1657 Submitted	Process			X				Yes	Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	Yes	No	#1657 under consideration in Pop Health Prevention project; not yet reviewed		Under Consideration-Priority 2
TAM-5 Alcohol Use Screening	1661 Submitted	Process					X		Yes	Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	No	No	#1661 under consideration in Behavioral Health project; not yet reviewed		Under Consideration-Priority 2
TAM-6 Alcohol Use Brief Intervention Provided or Offered	1663 Submited	Process					X		Yes	Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	No	No	#1663 under consideration in Behavioral Health project; not yet reviewed		Under Consideration-Priority 2
TAM-7 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge	1664 Submitted	Process					X		Yes	Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	No	No	#1664 under consideration in Behavioral Health project; not yet reviewed		Under Consideration-Priority 2

Measure Title	NQF Measure # and Status	Measure Type	NQS Priority							Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Inpatient Quality Reporting
			Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care							
TAM-8 Alcohol and Drug Use: Assessing Status After Discharge	1665 Submitted	Process					X		Yes	Tobacco, Alcohol, Substance Screening, Treatment and Follow Up	Yes	No	#1665 under consideration in Behavioral Health project; not yet reviewed		Under Consideration-Priority 2

Program Summary: CMS Hospital Value-Based Purchasing

Program Description

In FY 2013, Medicare will begin basing a portion of hospital reimbursements on hospital performance on a set of quality measures that have been linked to improved clinical processes of care and patient satisfaction. For FY 2013, the Hospital Value-Based Purchasing Program will distribute an estimated $850 million to hospitals based on their overall performance on the quality measures. These funds will be taken from what Medicare otherwise would have spent for hospital stays, and the size of the fund will gradually increase over time, resulting in a shift from payments based on volume to payments based on performance. Hospitals will continue to receive payments for care provided to Medicare patients based on the Medicare Inpatient Prospective Payment System, but those payments will be reduced by 1 percent starting in fiscal year 2013 to create the funding for the new value-based payments. Hospitals will be scored based on their performance on each measure relative to other hospitals and on how their performance on each measure has improved over time. The higher of these scores on each measure will be used in determining incentive payments. CMS plans to add additional outcomes measures that focus on improved patient outcomes and prevention of hospital-acquired conditions. Measures that have reached very high compliance scores would likely be replaced.[1] The measures included in the Hospital Value-Based Purchasing Program are a subset of those collected through the Hospital IQR program. Information gathered through the Hospital IQR program is reported on the Hospital Compare Website.[2]

Statutory Requirements for Measures:

The Secretary shall select measures for purposes of the Program. Such measures shall be selected from the measures specified the Hospital Inpatient Quality Reporting Program.

Requirements:

- FOR FISCAL YEAR 2013- For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall ensure the following:
  - o Excludes readmission measures
  - o Measures are cover at least the following 5 specific conditions or procedures:
    - Acute myocardial infarction (AMI)
    - Heart failure.
    - Pneumonia.
    - Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as `Surgical Infection Prevention' for discharges occurring before July 2006).

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[1] http://www.healthcare.gov/news/factsheets/valuebasedpurchasing04292011a.html
[2] http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf

- Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.
  - o HCAHPS- Measures selected shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).
- Inclusion of Efficiency Measures – For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected include efficiency measures, including measures of `Medicare spending per beneficiary'. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.
- Limitations –
  - o Time requirement for reporting and notice – The Secretary may not select a measure for use under the Program with respect to a performance period for a fiscal year unless such measure has been specified under the Hospital IQR program and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.
  - o A measure selected shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

Program Measure Set Analysis

	Finalized	Under Consideration	Total
Total Measures	17	13	30
NQF-Endorsed®	16	5	21
NQS Priority			
Safer Care	8	10	18
Effective Care Coordination	2	0	2
Prevention and Treatment of Leading Causes of Mortality and Morbidity	11	2	13
Person and Family Centered Care	2	0	2
Supporting Better Health in Communities	1	0	1
Making Care More Affordable	1	1	2
Addresses High Impact Conditions	7	2	9
Measure Type			
Process Measures	12	2	14
Outcome Measures	4	9	13
Cost Measures	0	1	1
Structural Measures	0	0	0
Patient Experience	1	0	1

Measure Gaps (previously identified by the Hospital Workgroup):

- Maternal care
- Child health
- Behavioral health
- Stroke
- Diabetes
- Disparities–sensitive measures
- Cost and resource use measures

Value Based Purchasing

| Measure Title | NQF Measure # and Status | Measure Type | NQS Priority | | | | | | | Aligned with Program Attributes | Condition/Topic Area | Spans Episode of Care | Addresses Disparities | Contribution to the Program Set (aligment w/ core measures, parsimony, etc.) | HQA approved | CMS Status Value Based Purchasing |
			Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care							
AMI-10 Statin Prescribed at Discharge	0439 Endorsed	Process			X				Yes	Acute Myocardial Infarction	No	No		Yes	Under Consideration-Priority 3
AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival	0164 Endorsed	Process			X				Yes	Acute Myocardial Infarction	Yes	No	Aligns with core measures	Yes	Finalized
AMI–8a Timing of receipt of primary percutaneous coronary intervention (PCI)	0163 Endorsed	Process			X				Yes	Acute Myocardial Infarction	Yes	No	Aligns with core measures	Yes	Finalized
Acute myocardial infarction (AMI) 30-day mortality rate	0230 Endorsed	Outcome			X				Yes	Acute Myocardial Infarction	No	No	Aligns with core measures	Yes	Finalized
Medicare Spending per Beneficiary.	Not NQF Endorsed	Cost						X	Yes	Cost	No	No			Under Consideration-Priority 3
HF-1 Discharge instructions	0136 Endorsed	Process	X	X	X	X	X		Yes	Heart Failure	Yes	No	Not recommended	Yes	Finalized
Heart failure (HF) 30-day mortality rate	0229 Endorsed	Outcome			X				Yes	Heart Failure	No	No	Aligns with core measures	Yes	Finalized
HCAHPS survey	0166 Endorsed	Patient Engagement/Experience				X			Yes	Patient Experience	Yes	No	Aligns with core measures	Yes	Finalized
Pneumonia (PN) 30-day mortality rate	0468 Endorsed	Outcome			X				Yes	Pneumonia	No	No	Aligns with core measures	Yes	Finalized
PN–3b Blood culture performed in the emergency department prior to first antibiotic received in hospital	0148 Endorsed	Process		X	X				Yes	Pneumonia	Yes	No	Aligns with core measures	Yes	Finalized
PN–6 Appropriate initial antibiotic selection	0147 Endorsed	Process			X				Yes	Pneumonia	No	No		Yes	Finalized
Air Embolism	Not NQF Endorsed	Outcome	X						Yes	Safety	No	No			Under Consideration-Priority 3
Blood Incompatibility	Not NQF Endorsed	Outcome	X						Yes	Safety	No	No			Under Consideration-Priority 3

Measure Title	NQF Measure # and Status	Measure Type	NQS Priority							Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Value Based Purchasing
			Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care								
Catheter-Associated Urinary Tract Infection	Not NQF Endorsed	Outcome	X							Yes	Safety	No	No			Under Consideration-Priority 3
Central line associated bloodstream infection	0139 Endorsed	Outcome	X							Yes	Safety	No	No		Yes	Under Consideration-Priority 3
Falls and Trauma	Not NQF Endorsed	Outcome	X							Yes	Safety	No	No			Under Consideration-Priority 3
Foreign Body Left During Procedure (PSI 5)	0363 Endorsed	Outcome	X							Yes	Safety	No	No			Finalized
Mortality for selected medical conditions (composite)	0530 Endorsed	Outcome			X					Yes	Safety	No	No	Aligns with core measures Some mortality rates overlap with existing mortality measures already being reported	No	Under Consideration-Priority 3
Manifestations of Poor Glycemic Control	Not NQF Endorsed	Outcome	X							Yes	Safety	No	No			Under Consideration-Priority 3
Pressure Ulcer Stages III and IV	Not NQF Endorsed	Outcome	X							Yes	Safety	No	No			Under Consideration-Priority 3
Complication/patient safety for selected indicators (composite)	0531 Endorsed	Composite	X							Yes	Safety	No	No	Aligns with core measures Some components overlap with exsisting HAC policy & AHRQ measures reported on Hospital Compare	No	Under Consideration-Priority 3

Measure Title	NQF Measure # and Status	Measure Type	Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care	Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Value Based Purchasing
SCIP Cardiovascular-2: Surgery Patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period	0284 Endorsed	Process			X				Yes	Safety	Yes	No		Yes	Finalized
SCIP INF–1 Prophylactic antibiotic received within 1 hour prior to surgical incision	0527 Endorsed	Process	X						Yes	Safety	Yes	No		Yes	Finalized
SCIP INF–2: Prophylactic antibiotic selection for surgical patients	0528 Endorsed	Process	X						Yes	Safety	No	No		Yes	Finalized
SCIP INF–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	0529 Endorsed	Process	X		X			X	Yes	Safety	Yes	No	Aligns with core measures	Yes	Finalized
SCIP INF–4: Cardiac surgery patients with controlled 6AM postoperative serum glucose	0300 Endorsed	Process	X		X				Yes	Safety	No	No		Yes	Finalized
SCIP INF–10: Surgery patients with perioperative temperature management	0452 Endorsed	Process	X						Yes	Safety	No	No		Yes	Under Consideration-Priority 3
SCIP INF—VTE-1: Surgery patients with recommended venous thromboembolism (VTE) prophylaxis ordered	0217 Endorsed	Process	X						Yes	Safety	No	No	Not recommended		Finalized
SCIP–VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post-surgery	0218 Endorsed	Process	X						Yes	Safety	Yes	No	Aligns with core measures	Yes	Finalized
Vascular-Catheter Associated Infection	Not NQF Endorsed	Outcome	X						Yes	Safety	No	No			Under Consideration-Priority 3

Program Summary: Inpatient Psychiatric Hospital Quality Reporting

Program Description

Section 10322 of the Affordable Care Act (ACA) establishes a quality reporting program for psychiatric hospitals and psychiatric units. Beginning in FY 2014, these psychiatric hospitals will be required to submit data to the Secretary of Health and Human Services. Any psychiatric hospital that does not report quality data according to CMS' requirements will receive up to a 2 percent reduction in the annual rate update. [1] Information collected through this program will be reported on the CMS website.

Statutory Requirements for Measures:

Any measure specified by the Secretary must have been endorsed by the entity with a contract under section 1890(a). In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by NQF, the Secretary may specify a measure that is not endorsed as long as due consideration is given to measure that have been endorsed or adopted by a consensus organization identified by the Secretary.

The Secretary shall report quality measures that relate to services furnished in inpatient settings in psychiatric hospitals and psychiatric units on the CMS website.

Program Measure Set Analysis

	Finalized	Under Consideration	Total
Total Measures	0	6	6
NQF endorsed	0	6	6
NQF Priority			
Safer care	0	2	2
Effective care coordination	0	4	4
Prevention and treatment of leading causes of mortality and morbidity	0	0	0
Person and family centered care	0	1	1
Supporting better health in communities	0	0	0
Making care more affordable	0	0	0
Addresses High impact conditions	0	0	0
Measure Type			
Process Measures	0	6	6
Outcome Measures	0	0	0
Cost Measures	0	0	0
Structural Measures	0	0	0
Patient Experience	0	0	0

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[1] https://www.cms.gov/HospitalQualityInits/08_HospitalRHQDAPU.asp#TopOfPage

Identified Measure Gaps:

- Prevention or population health measures
- Outcome measures for after care
- Follow up appointments with outpatient providers, including primary care
- Monitoring of metabolic syndrome for patients on antipsychotic medications
- Cost and resource use
- Structural measures
- Substance abuse
- Readmissions
- Disparities-sensitive measures

Inpatient Psychiatric Quality Reporting

Measure Title	NQF Measure # and Status	Measure Type	NQS Priority							Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Inpatient Psychiatric Quality Reporting
			Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care							
HBIPS-4: Patients discharged on multiple antipsychotic medications.	0552 Endorsed	Process		X					Yes	Patients Discharged on Multiple Antipsychotic Medications	No	No		Yes	Under Consideration-Priority 1
HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	0560 Endorsed	Process	X	X					Yes	Patients Discharged on Multiple Antipsychotic Medications	No	No		Yes	Under Consideration-Priority 1
HBIPS-6 Post discharge continuing care plan created	0557 Endorsed	Process		X					Yes	Post Discharge Continuing Care Plan	Yes	No		Yes	Under Consideration-Priority 1
HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	0558 Endorsed	Process		X					Yes	Post Discharge Continuing Care Plan	Yes	No	MAP Duals Core Measure	Yes	Under Consideration-Priority 1
HBIPS-2 Hours of physical restraint use	0640 Endorsed	Process	X			X			Yes	Use of Restraint and Seclusion	No	No			Under Consideration-Priority 1
HBIPS-3 Hours of seclusion use	0641 Endorsed	Process							Yes	Use of Restraint and Seclusion	No	No			Under Consideration-Priority 1

Program Summary: Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs

Program Description

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs will provide incentive payments to eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The program was created under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009. Incentive payments for eligible hospitals and CAHs may begin as early as 2011 and are based on a number of factors, beginning with a $2 million base payment. For 2015 and later, Medicare eligible hospitals and CAHs that do not successfully demonstrate meaningful use will have a reduction in their Medicare reimbursement. The Medicaid EHR program incentive payments may begin as early as 2011, depending on when an individual state begins its program. The last year a Medicaid eligible hospital may begin the program is 2016. There are no payment adjustments under the Medicaid EHR program.

Statutory Requirements for Measures:

An eligible hospital or CAH must be a meaningful EHR user for the relevant EHR reporting period in order to qualify for the incentive payment for a payment year in the Medicare Fee for Service (FFS) EHR incentive program. An eligible hospital shall be considered a meaningful EHR user for an EHR reporting period for a payment year if they meet the following three requirements: (1) Demonstrates use of certified EHR technology in a meaningful manner; (2) demonstrates to the satisfaction of the Secretary that certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care such as promoting care coordination, in accordance with all laws and standards applicable to the exchange of information; and (3) using its certified EHR technology, submits to the Secretary, in a form and manner specified by the Secretary, information on clinical quality measures and other measures specified by the Secretary. Preference should be given to NQF-endorsed measures when selecting measures for this program.

Program Measure Set Analysis

	Finalized	Under Consideration	Total
Total Measures	15	36	51
NQF-Endorsed®	15	33	48
NQS Priority			
Safer Care	7	10	17
Effective Care Coordination	1	3	4
Prevention and Treatment of Leading Causes of Mortality and Morbidity	7	14	21
Person and Family Centered Care	2	4	6
Supporting Better Health in Communities	0	8	8

Making Care More Affordable	0	2	2
Addresses High Impact Conditions	7	10	17
Measure Type			
Process Measures	12	31	43
Outcome Measures	3	5	8
Cost Measures	0	0	0
Structural Measures	0	0	0

Identified Measure Gaps:

- Cost and resource use
- Structural measures
- Care transitions and communication
- Behavioral health

Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs

Measure Title	NQF Measure # and Status	Measure Type	NQS Priority						Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Meaningful Use
			Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care							
AMI-10 Statin Prescribed at Discharge	0439 Endorsed	Process			X				Yes	Acute Myocardial Infarction	No	No		Yes	Under consideration-priority 3
AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival	0164 Endorsed	Process			X				Yes	Acute Myocardial Infarction	Yes	No	Aligns with core measures	Yes	Under consideration-priority 3
AMI–8a Timing of receipt of primary percutaneous coronary intervention (PCI)	0163 Endorsed	Process			X				Yes	Acute Myocardial Infarction	Yes	No	Aligns with core measures	Yes	Under consideration-priority 3
Aspirin at arrival for acute myocardial infarction (AMI)	0132 Endorsed	Process			X				Yes	Acute Myocardial Infarction	Yes	No		Yes	Under consideration-priority 3
AMI–2 Aspirin prescribed at discharge	0142 Endorsed	Process			X				Yes	Acute Myocardial Infarction	No	No		Yes	Under consideration-priority 3
ACEI or ARB for left ventricular systolic dysfunction- Acute Myocardial Infarction (AMI) Patients	0137 Endorsed	Process			X				Yes	Acute Myocardial Infarction	No	No		Yes	Under consideration-priority 3
ED–2 Median time from admit decision to time of departure from the emergency department for emergency department patients admitted to the inpatient status	0497 Endorsed	Outcome							Yes	Care Coordination	Yes	No		Yes	Finalized
Use of relievers for inpatient asthma	0143 Endorsed	Process							Yes	Child Health	No	No		Yes	Under consideration-priority 2
Use of systemic corticosteroids for inpatient asthma	0144 Endorsed	Process							Yes	Child Health	No	No		Yes	Under consideration-priority 2
Beta-blocker prescribed at discharge for AMI	0160 Endorsed	Process			X		X		Yes	Acute Myocardial Infarction	No	No		Yes	Under consideration-priority 3
ED–1 Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the hospital	0495 Endorsed	Outcome							Yes	Care Coordination	Yes	No			Finalized

Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs

Measure Title	NQF Measure # and Status	Measure Type	NQS Priority						Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Meaningful Use
			Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care							
OP–18/ED-3: Median Time from ED Arrival to ED Departure for Discharged ED Patients.	0496 Endorsed	Outcome				X			Yes	Emergency Department	Yes	No			Under consideration-priority 3
HF-1 Discharge instructions	0136 Endorsed	Process	X	X	X	X	X		Yes	Heart Failure	Yes	No	Not recommended	Yes	Under consideration-priority 3
SCIP-INF-6- Surgery patients with appropriate hair removal	0301 Endorsed	Process	X						Yes	Safety	No	No		Yes	Under consideration-priority 3
Home Management Plan of Care Document Given to Patient/Caregiver	0338 Endorsed	Process		X					Yes	Child Health	Yes	No		Yes	Under consideration-priority 1
PICU Pain Assessment on Admission	0341 Endorsed	Process				X			Yes	Child Health	No	No		Yes	Under consideration-priority 1
PICU Periodic Pain Assessment	0342 Endorsed	Process				X			Yes	Child Health	Yes	No		Yes	Under consideration-priority 1
IMM-1 Pneumonia Immunization	Not NQF Endorsed	Process					X		Yes	Immunizations	No	No	#1653 under consideration in Population Health Prevention project		Under consideration-priority 3
IMM-2 Flu Immunization	Not NQF Endorsed	Process					X		Yes	Immunizations	No	No	#1659 under consideration in Population Health Prevention project		Under consideration-priority 3
PN–3b Blood culture performed in the emergency department prior to first antibiotic received in hospital	0148 Endorsed	Process		X	X				Yes	Pneumonia	Yes	No	Aligns with core measures	Yes	Under consideration-priority 3
PN–6 Appropriate initial antibiotic selection	0147 Endorsed	Process			X				Yes	Pneumonia	No	No		Yes	Under consideration-priority 3

Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs

Measure Title	NQF Measure # and Status	Measure Type	Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care	Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Meaningful Use
					NQS Priority										
VTE-6: Incidence of Potentially-Preventable VTE	0376 Endorsed	Outcome	X	X					Yes	Safety	Yes	No		Yes	Finalized
VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis	0372 Endorsed	Process	X						Yes	Safety	Yes	No		Yes	Finalized
Elective delivery prior to 39 completed weeks gestation	0469 Endorsed	Outcome	X					X	Yes	Maternal Care	No	No	Aligns with core measures	Yes	Under consideration-priority 1
Exclusive Breastfeeding at Hospital Discharge	0480 Endorsed	Outcome					X		Yes	Maternal Care	no	No		Yes	Under consideration-priority 1
First temperature measured within one hour of admission to the NICU.	0481 Endorsed	Process							Yes	Maternal Care	Yes	No			Under consideration-priority 1
First NICU Temperature < 36 degrees C	0482 Endorsed	Outcome							Yes	Maternal Care	Yes	No			Under consideration-priority 1
Proportion of infants 22 to 29 weeks gestation treated with surfactant who are treated within 2 hours of birth.	0484 Endorsed	Process							Yes	Maternal Care	Yes	No			Under consideration-priority 1
Neonatal Immunization	0485 Endorsed	Process					X		Yes	Maternal Care	No	No			Under consideration-priority 2
SCIP Cardiovascular-2: Surgery Patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period	0284 Endorsed	Process			X				Yes	Safety	Yes	No		Yes	Under consideration-priority 3
Healthy Term Newborn	0716 Endorsed	Outcome					X		Yes	Maternal Care	No	No	Aligns with core measures		Under consideration-priority 1
Hearing screening prior to hospital discharge (EHDI-1a)	1354 Endorsed	Process					X		Yes	Maternal Care	No	No			Under consideration-priority 2

Measure Title	NQF Measure # and Status	Measure Type	NQS Priority						Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Meaningful Use
			Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care							
HF-2 & HF-3 to be combined into a single new measure.	Not NQF Endorsed	Process							Yes	Heart Failure	No	No			Under consideration-priority 3
SCIP INF–1 Prophylactic antibiotic received within 1 hour prior to surgical incision	0527 Endorsed	Process	X						Yes	Safety	Yes	No		Yes	Under consideration-priority 3
SCIP INF–2: Prophylactic antibiotic selection for surgical patients	0528 Endorsed	Process	X						Yes	Safety	No	No		Yes	Under consideration-priority 3
SCIP INF–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	0529 Endorsed	Process	X		X			X	Yes	Safety	Yes	No	Aligns with core measures	Yes	Under consideration-priority 3
SCIP INF–4: Cardiac surgery patients with controlled 6AM postoperative serum glucose	0300 Endorsed	Process	X		X				Yes	Safety	No	No		Yes	Under consideration-priority 3
SCIP INF–9: Postoperative urinary catheter removal on post-operative day 1 or 2 with day of surgery being day zero	0453 Endorsed	Process	X						Yes	Safety	Yes	No		Yes	Under consideration-priority 3
SCIP–VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post-surgery	0218 Endorsed	Process	X						Yes	Safety	Yes	No	Aligns with core measures	Yes	Under consideration-priority 3
VTE-5: VTE Discharge Instructions	0375 Endorsed	Process	X						Yes	Safety	No	No		Yes	Finalized
VTE-4 Venous Thromboembolism Patients Recieving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram	0374 Endorsed	Process	X						Yes	Safety	No	No		Yes	Finalized
VTE-3 VTE Patients with Overlap of Anticoagulation Therapy	0373 Endorsed	Process	X						Yes	Safety	Yes	No		Yes	Finalized

Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs

Measure Title	NQF Measure # and Status	Measure Type	NQS Priority — Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care	Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Meaningful Use
VTE-1 Venous Thromboembolism Prophylaxis	0371 Endorsed	Process	X						Yes	Safety	Yes	No			Finalized
STK-1 Venous Thromboembolism (VTE) Prophylaxis	0434 Endorsed	Process	X		X				Yes	Stroke	Yes	No	Aligns with core measures	Yes	Under consideration-priority 3
STK-10 Assessed for Rehabilitation	0441 Endorsed	Process			X	X			Yes	Stroke	Yes	No	Aligns with core measures	Yes	Finalized
STK-2 Discharged on Antithrombotic Therapy	0435 Endorsed	Process	X		X				Yes	Stroke	No	No	Aligns with core measures	Yes	Finalized
STK-3 Patients with Atrial Fibrillation Receiving Anticoagulation Therapy	0436 Endorsed	Process			X				Yes	Stroke	No	No		Yes	Finalized
STK-4 Thrombolytic Therapy	0437 Endorsed	Process			X				Yes	Stroke	Yes	No		Yes	Finalized
STK-5 Antithrombotic Medication by End of Hospital Day Two	0438 Endorsed	Process			X				Yes	Stroke	Yes	No	Aligns with core measures	Yes	Finalized
STK-6 Discharged on Statin Medication	0439 Endorsed	Process			X				Yes	Stroke	No	No		Yes	Finalized
STK-8 Stroke Education	0440 Endorsed	Process			X	X			Yes	Stroke	Yes	No		Yes	Finalized

Program Summary: CMS Hospital Outpatient Reporting

Program Description

The CMS Hospital Outpatient Quality Reporting Program (OQR) is a pay for reporting program for outpatient hospital services. The program was mandated by the Tax Relief and Health Care Act of 2006, which requires hospitals to submit data on measures on the quality of care furnished in hospital outpatient settings. Hospitals that do not meet the program requirements receive a 2 percentage point reduction in their annual payment update under the Outpatient Prospective Payment System (OPPS). Information gathered through the Hospital OQR program is reported on the Hospital Compare Website.[1]

Statutory Requirements for Measures:

The Secretary shall develop measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities. The Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice. The Secretary shall report quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in outpatient settings in hospitals on the CMS website. Measures may be a subset of measures used for other programs. An outpatient setting or outpatient hospital service is deemed a reference to ambulatory surgical center, the setting of such a center or services of such a center.

Program Measure Set Analysis

	Finalized	Under Consideration	Total
Total Measures	26	0	26
NQF-Endorsed®	21	0	21
NQS Priority			
Safer Care	12	0	12
Effective Care Coordination	5	0	5
Prevention and Treatment of Leading Causes of Mortality and Morbidity	6	0	6
Person and Family Centered Care	4	0	4
Supporting Better Health in Communities	1	0	1
Making Care More Affordable	4	0	4
Addresses High Impact Conditions	10	0	10

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[1] https://www.cms.gov/HospitalQualityInits/10_HospitalOutpatientQualityReportingProgram.asp

Measure Type			
Process Measures	15	0	15
Outcome Measures	1	0	0
Cost Measures	6	0	6
Structural Measures	3	0	3
Patient Experience	1	0	1

Identified Measure Gaps:

- Outcome measures. The Workgroup previously indicated the need to move to outcome measures clustered with process and structural measures.
- The program set does not address supporting better health in communities or disparities.
- High impact outpatient issues such as weight management, diabetes management, and readmissions (including admissions following an outpatient surgery).
- Measures that address patient preferences such patient outcomes, patient shared decision making, patient experience of care, and family engagement.
- Efficiency measures. There are measures related to cost of care, but no true measures of efficiency.

Outpatient Quality Reporting

Measure Title	NQF Measure # and Status	Measure Type	NQS Priority							Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Outpatient Quality Reporting
			Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care							
OP–1: Median Time to Fibrinolysis.	0287 Endorsed	Process	X						Yes	Acute Myocardial Infarction	Yes	No			Finalized
OP–16: Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) Received Within 60 minutes of Arrival.	0660 Endorsed	Process			X				Yes	Acute Myocardial Infarction	Yes	No			Finalized
OP-2 Fibrinolytic Therapy Received Within 30 Minutes.	0288 Endorsed	Process			X				Yes	Acute Myocardial Infarction	Yes	No	Aligns with core measures		Finalized
OP–4: Aspirin at Arrival.	0286 Endorsed	Process			X				Yes	Acute Myocardial Infarction	Yes	No			Finalized
OP-5 Median Time to ECG.	0289 Endorsed	Process			X				Yes	Acute Myocardial Infarction	Yes	No			Finalized
OP–12: The Ability for Providers with HIT to Receive. Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data.	0489 Endorsed	Structure	X	X					Yes	Care Coordination	No	No			Finalized
OP–17: Tracking Clinical Results between Visits.	0491 Endorsed	Structure	X	X				X	Yes	Care Coordination	Yes	No			Finalized
OP–19: Transition Record with Specified Elements Received by Discharged Patients.	0649 Endorsed	Process	X	X				X	Yes	Care Coordination	Yes	No			Finalized
OP–24: Cardiac Rehabilitation Patient Referral From an Outpatient Setting.	0643 Endorsed	Process		X	X		X		Yes	Care Coordination	Yes	No		No	Finalized
OP-9: Mammography Follow-Up Rates	Not NQF Endorsed	Process							Yes	Care Coordination	Yes	No			Finalized
OP–18/ED-3: Median Time from ED Arrival to ED Departure for Discharged ED Patients.	0496 Endorsed	Outcome				X			Yes	Emergency Department	Yes	No			Finalized

Outpatient Quality Reporting

Measure Title	NQF Measure # and Status	Measure Type	NQS Priority						Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Outpatient Quality Reporting
			Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care							
OP–20: Door to Diagnostic Evaluation by a Qualified Medical Professional.	0498 Endorsed	Process	X			X			Yes	Emergency Department	Yes	No	Not expected to maintain NQF endorsement		Finalized
OP–21: ED–Median Time to Pain Management for Long Bone Fracture.	0662 Endorsed	Process				X			Yes	Emergency Department	Yes	No			Finalized
OP–22: ED–Patient Left Without Being Seen	0499 Endorsed	Patient Engagement/Experience	X			X			Yes	Emergency Department	No	No	Not expected to maintain NQF endorsement	No	Finalized
OP–3: Median Time to Transfer to Another Facility for Acute Coronary Intervention.	0290 Endorsed	Process		X	X				Yes	Emergency Department	Yes	No	Aligns with core measures		Finalized
OP–10: Abdomen CT-Use of contrast material: - for diagnosis of calculi in the kidneys, ureter, and/or urinary tract - excluding calculi of the kidneys, ureter, and/or urinary tract	Not NQF Endorsed	Cost							Yes	Imaging	No	No			Finalized
OP–11: thorax CT—Use of Contrast Material.	0513 Endorsed	Cost	X						Yes	Imaging	No	No			Finalized
OP–13: Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery.	0669 Endorsed	Cost	X					X	Yes	Imaging	No	No		No	Finalized
OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)	Not NQF Endorsed	Cost							Yes	Imaging	No	No			Finalized
OP-15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache	Not NQF Endorsed	Cost							Yes	Imaging	no	No			Finalized
OP–8: MRI Lumbar Spine for Low Back Pain.	0514 Endorsed	Cost	X					X	Yes	Imaging	No	No			Finalized
OP-25: Safe Surgery Checklist	Not NQF Endorsed	Process							Yes	Safety	No	No			Finalized

Outpatient Quality Reporting

Measure Title	NQF Measure # and Status	Measure Type	Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care	Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status Outpatient Quality Reporting
OP–6: Timing of Antibiotic prophylaxis.	0270 Endorsed	Process	X						Yes	Safety	Yes	No			Finalized
OP–7: Prophylactic Antibiotic Selection for Surgical Patients.	0268 Endorsed	Process	X						Yes	Safety	No	No			Finalized
OP–23: ED–Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival.	0661 Endorsed	Process	X						Yes	Stroke	Yes	No		No	Finalized
OP-26:Hospital Outpatient Volume for Selected Outpatient Surgical Procedures	0124, 0165, 0340, 0357, 0361, 0366 Endorsed	Structure							Yes	Surgery	No	No		Yes	Finalized

Program Summary: Ambulatory Surgical Center Quality Reporting

Program Description

This proposed rule (Section 1833(2)(D) of the Affordable Care Act (ACA) would update the revised Medicare ambulatory surgical center (ASC) payment system applicable to services furnished on or after January 1, 2012. Any ASC that does not submit quality measures will incur a 2.0 percentage point reduction to any annual increase provided under the revised ASC payment system for such year. However, due to public comments received, payments adjusted will only begin after October 1, 2012 based on these new reporting requirements. [1]

Statutory Requirements for Measures:

The Act requires the Secretary to develop measures for ASC services in a similar manner in which they apply to hospitals for the Hospital OQR Program, except as the Secretary may otherwise provide. They must be appropriate for the measurement of quality of care (including medication errors) furnished by hospitals in outpatient settings, reflect consensus among affected parties, and to the extent feasible, stem from one or more national consensus building entities. The measures can also be the same as (or a subset of) data submitted under the Hospital IQR program. The Secretary also has the right to replace measures that have been shown to not represent the best clinical practice, or where hospitals are nearly all effectively in compliance. The measures should reflect a good balance of process, outcome, and patient experience measures but ultimately move toward risk-adjusted outcome and patient experience measures that alight with public and private reporting entities, align with the adoption of HIT and Meaningful Use technology, and are endorsed by a national, multi-stakeholder organization. [2] NQF-endorsed measures should be used to the extent feasible and practicable. Additionally, the measure development, selection, modification process established under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A, as added by section 3014 (MAP process), to be used to the extent feasible and practicable.

Program Measure Set Analysis

	Finalized	Under Consideration	Total
Total Measures	5	0	5
NQF endorsed	5	0	5
NQF Priority			
Safer care	5	0	5
Effective care coordination	0	0	0
Prevention and treatment of leading causes of mortality and morbidity	0	0	0

[1] **Federal Register** / Vol. 76, No. 230 / Wednesday, November 30, 2011 / Rules and Regulations (pgs. 74492-74494)
[2] **Federal Register** / Vol. 76, No. 230 / Wednesday, November 30, 2011 / Rules and Regulations (pgs. 74492-74494)

Person and family centered care	0	0	0
Supporting better health in communities	0	0	0
Making care more affordable	0	0	0
Addresses High impact conditions	0	0	0
Measure Type			
Process Measures	1	0	1
Outcome Measures	4	0	4
Cost Measures	0	0	0
Structural Measures	0	0	0

Identified Measure Gaps:

- Risk-adjusted outcomes
- Patient experience
- Cost or resource use
- Structural measures
- Care transitions and follow up

Ambulatory Surgical Center Quality Reporting

Measure Title	NQF Measure # and Status	Measure Type	NQS Priority							Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	CMS Status Ambulatory Surgical Center Quality Reporting
			Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care							
ASC-1: Patient Burn -Percentage of ASC admissions experiencing a burn prior to discharge	0263 Endorsed	Outcome	X						Yes	Safety	No	No		Finalized
ASC-2: Patient Fall	0266 Endorsed	Outcome	X						Yes	Safety	No	No		Finalized
ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	0267 Endorsed	Outcome	X						Yes	Safety	No	No		Finalized
ASC-4: Hospital Transfer/ Admission	0265 Endorsed	Outcome		X					Yes	Safety	Yes	No		Finalized
ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing	0264 Endorsed	Process	X						Yes	Safety	Yes	No		Finalized

Program Summary: PPS-Exempt Cancer Hospital Quality Reporting

Program Description

Section 3005 of the Affordable Care Act (ACA) establishes a quality reporting program for the 11 PPS-exempt cancer hospitals. Beginning in FY 2014, these cancer hospitals will be required to submit data to the Secretary of Health and Human Services. At this time PPS-exempt cancer hospitals must report quality data according to CMS' requirements with no Medicare payment penalty or incentive.[1]   This information will be reported on the CMS website.[2]

Statutory Requirements for Measures:

Any measure specified by the Secretary must have been endorsed by NQF, the entity with a contract under section 1890(a). In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by NQF, the Secretary may specify a measure that is not endorsed as long as due consideration is given to measure that have been endorsed or adopted by a consensus organization identified by the Secretary.

The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care on the CMS website.

Program Measure Set Analysis

	Finalized	Under Consideration	Total
Total Measures	0	5	5
NQF-Endorsed®	0	3	3
NQS Priority			
Safer Care	0	2	2
Effective Care Coordination	0	0	0
Prevention and Treatment of Leading Causes of Mortality and Morbidity	0	3	0
Person and Family Centered Care	0	0	0
Supporting Better Health in Communities	0	0	0
Making Care More Affordable	0	0	0
Addresses High Impact Conditions	0	3	3
Measure Type			
Process Measures	0	3	3
Outcome Measures	0	2	2
Cost Measures	0	0	0
Structural Measures	0	0	0
Patient Experience	0	0	0

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[1] https://www.cms.gov/HospitalQualityInits/05_HospitalHighlights.asp
[2] Spinks, Walters, et al.

Measure Gaps (previously Identified by the Hospital Workgroup):

- Health and well-being:
    - Anti-emetics
    - Dyspnea
    - Emotional well-being
    - Nutritional status/management
- Safety
    - Medication management and documentation
- Person and family centered care
    - Shared-decision making
    - Communication measures
    - Outreach to patients who are not compliant
    - Palliative care
    - Family history and subsequent genetic testing
- Care Coordination
    - Documented consent
    - Documented plan for chemotherapy
- Treatment and prevention
    - Marker/drug combination measures for marker-specific therapies
    - Performance status of patients undergoing oncologic therapy – pre-therapy assessment
    - Measures for specific cancers
        - Gynecological cancers
        - Pediatric cancers and subset of leukemia
        - Staging measures – lung, prostate and gynecological cancers
    - Outcome measures
        - Survival Rates – cancer- and stage- specific
        - Transplants – bone marrow, peripheral stem cells
- Cost and Efficiency
    - Overuse
    - Underuse
- Disparities

PPS-Exempt Cancer Hospital Quality Reporting

Measure Title	NQF Measure # and Status	Measure Type	NQS Priority							Aligned with Program Attributes	Condition/Topic Area	Spans Episode of Care	Addresses Disparities	Contribution to the Program Set (aligment w/ core measures, parsimony, etc.)	HQA approved	CMS Status PPS-Exempt Cancer Hospital Quality Reporting
			Patient Safety	Effective Communcation and Care Coordination	Prevention and Treatment of Leading Causes of Mortality	Person-and Family-Centered Care	Supporting better health in communities	Affordable Care							
Adjuvant hormonal therapy	0220 Endorsed	Process		X					Yes	Breast Cancer	Yes	No	Aligns with core measures		Add-1
Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	0223 Endorsed	Process		X					Yes	Colon Cancer	Yes	No	Aligns with core measures		Add-1
Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer.	0559 Endorsed	Process		X					Yes	Breast Cancer	Yes	No	Aligns with core measures		Add-1
PSM-001-10 - National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	Not NQF Endorsed	Outcome	X						Yes	Safety	No	No			Add-1
PSM-003-10 - National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	Not NQF Endorsed	Outcome	X						Yes	Safety	No	No			Add-1

NATIONAL QUALITY FORUM

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

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

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

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

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

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

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

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

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

NQS priority is adequately addressed in the program measure set

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

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

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

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

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

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

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

Subcriterion 4.1   Program measure set is applicable to the program's intended care setting(s)

Subcriterion 4.2   Program measure set is applicable to the program's intended level(s) of analysis

Subcriterion 4.3   Program measure set is applicable to the program's population(s)

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

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

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

Subcriterion 5.1   Outcome measures are adequately represented in the program measure set

Subcriterion 5.2   Process measures are adequately represented in the program measure set

Subcriterion 5.3   Experience of care measures are adequately represented in the program measure set (e.g. patient, family, caregiver)

Subcriterion 5.4   Cost/resource use/appropriateness measures are adequately represented in the program measure set

Subcriterion 5.5   Structural measures and measures of access are represented in the program measure set when appropriate

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

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

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

Subcriterion 6.1   Measures within the program measure set are applicable across relevant providers

Subcriterion 6.2   Measures within the program measure set are applicable across relevant settings

Subcriterion 6.3   Program measure set adequately measures patient care across time

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

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

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

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

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

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

8. Program measure set promotes parsimony

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

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

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

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

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

Table 1: National Quality Strategy Priorities

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

Table 2: High-Impact Conditions:

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

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

Instructions for applying the measure selection criteria:

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

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

FOR CRITERION 1 – NQF ENDORSEMENT:

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

1. **'Importance to measure and report"**–how well the measure addresses a specific national health goal/ priority, addresses an area where a performance gap exists, and demonstrates evidence to support the measure focus;

2. **'Scientific acceptability of the measurement properties'** – evaluates the extent to which each measure produces consistent (reliable) and credible (valid) results about the quality of care.

3. **'Usability'-** the extent to which intended audiences (e.g., consumers, purchasers, providers, and policy makers) can understand the results of the measure and are likely to find the measure results useful for decision making.

4. **'Feasibility'** – the extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measures.

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

• the extent to which the measure(s) under consideration has been sufficiently tested and/or in widespread use

• whether the scope of the project/measure set is relatively narrow

• time-sensitive legislative/regulatory mandate for the measure(s)

• Measures that are NQF-endorsed are broadly available for quality improvement and public accountability programs. In some instances, there may be evidence that implementation challenges

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

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

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

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

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

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

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

- **Care settings include:** Ambulatory Care, Ambulatory Surgery Center, Clinician Office, Clinic/Urgent Care, Behavioral Health/Psychiatric, Dialysis Facility, Emergency Medical Services - Ambulance, Home Health, Hospice, Hospital- Acute Care Facility, Imaging Facility, Laboratory, Pharmacy, Post-Acute/Long Term Care, Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation.

- **Level of analysis includes:** Clinicians/Individual, Group/Practice, Team, Facility, Health Plan, Integrated Delivery System.

- **Populations include:** Community, County/City, National, Regional, or States. Population includes: Adult/Elderly Care, Children's Health, Disparities Sensitive, Maternal Care, and Special Healthcare Needs.

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

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

1. **Outcome measures** – Clinical outcome measures reflect the actual results of care.[1] Patient reported measures assess outcomes and effectiveness of care as experienced by patients and their families. Patient reported measures include measures of patients' understanding of treatment options and care plans, and their feedback on whether care made a difference.[2]

2. **Process measures –** Process denotes what is actually done in giving and receiving care.[3] NQF-endorsement seeks to ensure that process measures have a systematic assessment of the quantity, quality, and consistency of the body of evidence that the measure focus leads to the desired health outcome.[4] Experience of care measures—Defined as patients' perspective on their care.[5]

3. **Cost/resource use/appropriateness measures** –

    a. Cost measures – Total cost of care.

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

    c. Appropriateness measures – Measures that examine the significant clinical, systems, and care coordination aspects involved in the efficient delivery of high-quality services and thereby effectively improve the care of patients and reduce excessive healthcare costs.[7]

4. **Structure measures** – Reflect the conditions in which providers care for patients.[8] This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FOR CRITERION 8 – PROGRAM MEASURE SET PROMOTES PARSIMONY:

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

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

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

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

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

MAP Hospital Core Measures

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Cardiac	AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival and OP-2: Fibrinolytic therapy received within 30 minutes	164 Endorsed and 288 Endorsed	Process			X			
Cardiac	AMI–8a Timing of receipt of primary percutaneous coronary intervention (PCI)	163 Endorsed	Process			X			
Cardiac	Acute myocardial infarction (AMI) 30-day mortality rate	230 Endorsed	Outcome			X			
Cardiac	Heart failure (HF) 30-day mortality rate	229 Endorsed	Outcome			X			
Cardiac	Acute myocardial infarction 30-day risk standardized readmission measure	505 Endorsed	Outcome	X	X	X			
Cardiac	Heart failure 30-day risk standardized readmission measure	330 Endorsed	Outcome	X	X	X			
Cardiac	OP–3: Median time to transfer to another facility for acute coronary intervention	290 Endorsed	Process		X	X			
Cancer	Family Evaluation of Hospice Care	0208 Endorsed	Composite				X		
Cancer	Comfortable dying: pain brought to a comfortable level within 48 hours of initial assessment	0209 Endorsed	Outcome				X		

MAP Hospital Core Measures

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Cancer	Post breast conserving surgery irradiation	0219 Endorsed	Process			X			
Cancer	Adjuvant hormonal therapy	0220 Endorsed	Process			X			
Cancer	Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection	0221 Endorsed	Process			X			
Cancer	Patients with early stage breast cancer who have evaluation of the axilla	0222 Endorsed	Process			X			
Cancer	Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	0223 Endorsed	Process		X	X			
Cancer	Completeness of pathology reporting	0224 Endorsed	Process			X			
Cancer	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer	0225 Endorsed	Process			X			

MAP Hospital Core Measures

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Cancer	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer	0559 Endorsed	Process		X				
Complications	Complication/patient safety for selected indicators (composite) Includes potentially preventable adverse events for: • Accidental puncture or laceration • Iatrogenic pneumothorax • Postoperative DVT or PE • Postoperative wound dehiscence • Decubitus ulcer • Selected infections due to medical care • Postoperative hip fracture • Postoperative sepsis	531 Endorsed	Other (composite)	X					
Maternal/ child health	Elective delivery prior to 39 completed weeks gestation	0469 Endorsed	Outcome	X					X

MAP Hospital Core Measures

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Maternal/ child health	Cesarean Rate for low-risk first birth women (aka NTSV CS rate)	0471 Endorsed	Outcome	X					X
Maternal/ child health	Healthy Term Newborn	0716 Endorsed	Outcome	X					
Mental Health	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a. Initiation, b. Engagement	0004 Endorsed	Process					X	
Mortality	Mortality for selected medical conditions (composite) Includes in-hospital deaths for: • CHF • Stroke • Hip fracture • Pneumonia • Acute myocardial infarction • GI hemorrhage	530 Endorsed	Other (composite)			X			X
Patient Experience	HCAHPS survey	166 Endorsed	Patient Experience				X		
Respiratory	PN–3b Blood culture performed in the emergency department prior to first antibiotic received in hospital	148 Endorsed	Process			X			
Respiratory	Pneumonia (PN) 30-day mortality rate	468 Endorsed	Outcome			X		X	

MAP Hospital Core Measures

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Respiratory	Pneumonia 30-day risk standardized readmission measure	506 Endorsed	Outcome	X	X				X
Respiratory	Asthma Emergency Department Visits	1381 Endorsed	Outcome	X					
Safety	SCIP INF–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	529 Endorsed	Process	X		X			X
Safety	SCIP–VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post-surgery	218 Endorsed	Process	X					
Safety	Death among surgical inpatients with treatable serious complications (failure to rescue)	200 Withdrawn	Outcome	X					
Safety	Surgical site infection	299 Endorsed	Outcome	X					
Safety	OP-24 surgical site infection	299 Endorsed	Outcome	X					
Safety	Death in Low Mortality DRGs (PSI 2)	0347 Submitted	Outcome	X					
Stroke	STK-4: Venous Thromboembolism (VTE) Prophylaxis for patients with ischemic or hemorrhagic stroke	0434 Endorsed	Process	X		X			

MAP Hospital Core Measures

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Stroke	STK–2: Ischemic stroke patients discharged on antithrombotic therapy	0435 Endorsed	Process	X		X			
Stroke	STK–5: Antithrombotic therapy by the end of hospital day two	0438 Endorsed	Process			X			
Stroke	STK–10: Assessed for rehabilitation services	0441 Endorsed	Process			X	X		

MAP Hospital Core Measures: Identified Measure Gaps

Conditions/Areas for which no NQF-endorsed measures are identified
Alzheimer's disease
Atrial fibrillation
Behavioral health; major depression
Chronic obstructive pulmonary disease (COPD)
Composites containing outcome and process measures
Cost of care
Disparities-sensitive
ED visits
Medication errors/adverse drug events
Mortality rate composite – all-payer with condition-specific rate reporting
Nursing-sensitive
Patient-reported outcomes
Serious reportable events – inclusion for reporting; best methodology needs to be explored
Transitions in care/communication

Measure Applications Partnership

Hospital Workgroup
In-Person Meeting #2

NATIONAL QUALITY FORUM

December 15, 2011

Welcome, Review of Meeting Objectives, and Pre-rulemaking Process

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Workgroup Charge

The Hospital Workgroup will advise the Coordinating Committee on measures to be implemented through the rulemaking process for hospital inpatient and outpatient services, cancer hospitals, the value-based purchasing program, and psychiatric hospitals.

The Workgroup will:

- **Provide input on measures to be implemented through the Federal rulemaking process, the manner in which quality problems could be improved, and the related measures for encouraging improvement.**
- Identify critical hospital measure development and endorsement gaps.
- Identify performance measures for PPS-exempt cancer hospital quality reporting by:
  - Reviewing available performance measures for cancer hospitals, including clinical quality measures and patient-centered cross-cutting measures;
  - Identification of a core set of performance measures for cancer hospital quality reporting; and
  - Identification of measure development and endorsement gaps for cancer hospitals.

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Meeting Objectives

- Review measures under consideration for inclusion in Hospital Inpatient Quality Reporting (IQR), Hospital Value-Based Purchasing (VBP), Inpatient Psychiatric Facility Quality Reporting, Hospital Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (Meaningful Use), and PPS-Exempt Cancer Hospital Quality Reporting;

- Provide input on finalized measure sets for Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting;

- Discuss cross-cutting considerations for alignment, including input from MAP Dual Eligible Beneficiaries Workgroup and care coordination;

- Prioritize identified gaps in measurement for each program measure set;

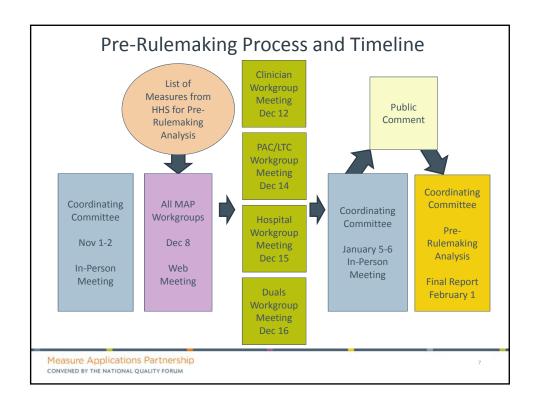- Finalize input to the MAP Coordinating Committee on measures for use in federal programs.

Measure Applications Partnership
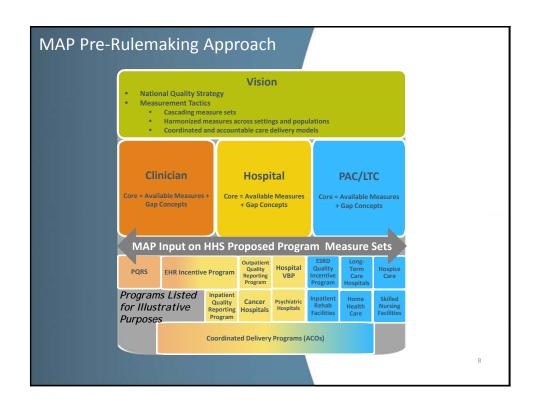CONVENED BY THE NATIONAL QUALITY FORUM

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Agenda

Provide Pre-Rulemaking Input on Program Measure Sets:

- Inpatient Quality Reporting (IQR)
- Hospital Value-based Purchasing (VBP)
- Inpatient Psychiatric Facility Quality Reporting
- Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs (Meaningful Use)
- Outpatient Quality Reporting (OQR)
- Ambulatory Surgical Center (ASC) Quality Reporting
- PPS-Exempt Cancer Hospital Quality Reporting
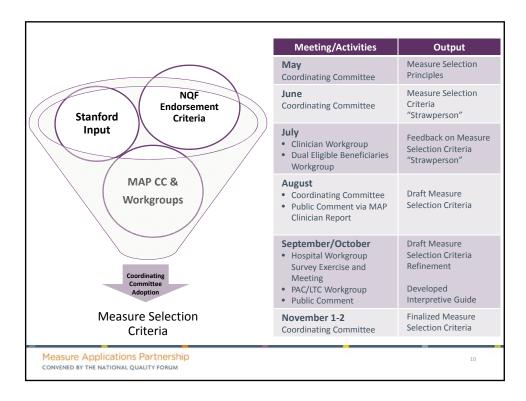
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MAP Pre-Rulemaking Approach

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Pre-Rulemaking Process and Timeline

MAP Pre-Rulemaking Approach

Review of Finalized MAP Measure Selection Criteria

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Meeting/Activities	Output
May Coordinating Committee	Measure Selection Principles
June Coordinating Committee	Measure Selection Criteria "Strawperson"
July • Clinician Workgroup • Dual Eligible Beneficiaries Workgroup	Feedback on Measure Selection Criteria "Strawperson"
August • Coordinating Committee • Public Comment via MAP Clinician Report	Draft Measure Selection Criteria
September/October • Hospital Workgroup Survey Exercise and Meeting • PAC/LTC Workgroup • Public Comment	Draft Measure Selection Criteria Refinement Developed Interpretive Guide
November 1-2 Coordinating Committee	Finalized Measure Selection Criteria

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MAP Measure Selection Criteria

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

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

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

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

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MAP Measure Selection Criteria

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

6. **Program measure set enables measurement across the person-centered episode of care**

7. **Program measure set includes considerations for healthcare disparities**

8. **Program measure set promotes parsimony**

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Providing Input on Program Measure Sets: Stepwise Approach and Supporting Materials

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Pre-Rulemaking Task

▫ Workgroup members have the following documents for each program:
  » Discussion guide
  » Reference materials:
    • *Program summary sheet*
    • *Program measure chart*
    • *Individual measure information*
    • *Considerations from the Dual Eligible Beneficiaries Workgroup*

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Pre-Rulemaking Task Discussion Guide (DRAFT Example)

Provides stepwise approach for the workgroup meeting

NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

PAC/LTC Workgroup
Pre-Rulemaking Discussion Guide

Meeting Objectives:
- Review measures proposed by Centers for Medicare & Medicaid Services (CMS) for inclusion in the following federal programs: Nursing Home Quality Initiative, Home Health Quality Reporting, Inpatient Rehabilitation Facility Quality Reporting, Long-Term Care Hospital Quality Reporting End Stage Renal Disease Quality Improvement, and Hospice Quality Reporting;
- Consider MAP Dual Eligible Beneficiaries Workgroup cross cutting input.
- Identify gaps in measurement for each program measure set;
- Finalize input to the MAP Coordinating Committee on measures for use in federal programs.

Time	Issue/Question	Considerations
10:15- 11:00 am	**Rulemaking Input for Inpatient Rehabilitation Facility Quality Reporting Program** • Staff review program summary, gaps, relationship to core measure concepts	
10:20	1. Additional considerations for evaluation of the program set?	• Nine of the PAC/LTC Workgroup core concepts are not addressed. Are there additional gaps to highlight?
10:30	2. One measure considered for addition is endorsed and aligns with core set. Do you recommend adding this measure to the set?	NQF # 0675 Pain Management- • The measure addresses the core measure concepts
10:33	3. Four measures considered for addition are endorsed but do not align with core set. Do these measures address priority quality issues specific to IRFs?	NQF #0376 Incidence of VTE potentially preventable and NQF #0431 Staff Immunization • NQF #0682 Pneumococcal Vaccination and NQF# 0680 Influenza Immunization • Promotes parsimony- used in nursing home quality reporting, proposed for[5] use in LTCH's

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Pre-Rulemaking Task Program Summary Sheet (DRAFT Example)

Program Summary: Inpatient Rehabilitation Facilities (IRFs)

Provides description of program, statutory requirements, and analysis of program measure set

Program Description

As indicated in Section 3004 of the Affordable Care Act, CM requirements for inpatient rehabilitation facilities (IRFs). S failure to report quality data will result in a 2% reduction i the data must be made available to public, with IRFs provi prior to its release. [1] Two measures are required for FY 201 future years. Program Priorities and Goals:
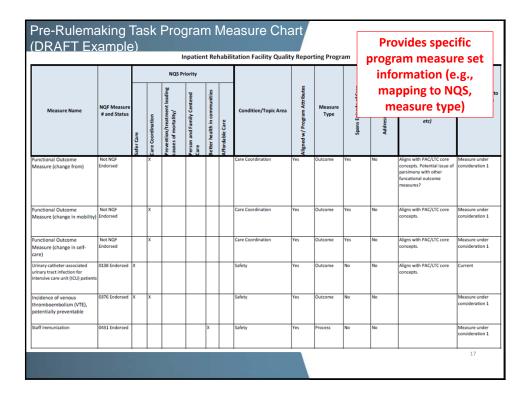
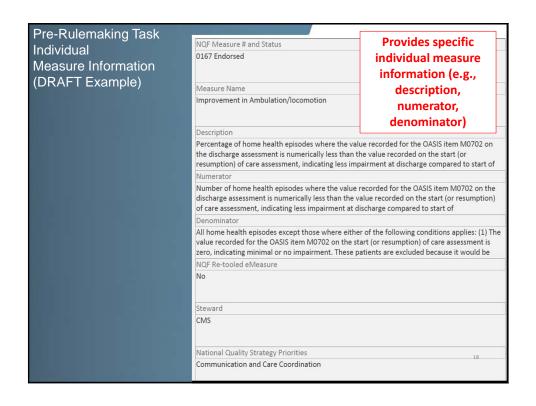Statutory Requirements for Measures[6]:

- Measures should align with the NQS three-part aim including better care for the individual, better population health, and lower cost through better quality
- Measures should be relevant to the priorities in IRFs setting, such as improving patient safety (e.g., avoiding healthcare associated infections and adverse events), reducing adverse events, and encouraging better coordination of care and person- and family-centered care
- Measures should serve the primary role of IRFs, addressing the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge

Program Measure Set Analysis

Measure Summary:

	Current	Proposed Addition	Proposed Deletion	Total
Total Measures	2	8	0	10
NQF-Endorsed®	2	5	0	7
NQS Priority				
Safer Care	2	1	0	3
Effective Care Coordination	0	5	0	5
Prevention and Treatment of Leading Causes of Mortality and Morbidity	0	0	0	0
Person and Family Centered Care	0	0	0	0
Supporting Better Health in Communities	0	3	0	3
Making Care More Affordable	0	0	0	0
Addresses High Impact Conditions	0	0	0	0
Measure Type				
Process Measures	0	3	0	3

Slide 1

Pre-Rulemaking Task Program Measure Chart (DRAFT Example)

Provides specific program measure set information (e.g., mapping to NQS, measure type)

Inpatient Rehabilitation Facility Quality Reporting Program

Measure Name	NQF Measure # and Status	NQS Priority						Condition/Topic Area	Aligned w/ Program Attributes	Measure Type	Spans Episode of Care	Address	etc)	to
		Safer Care	Care Coordination	Prevention/treatment leading causes of mortality/	Person and Family Centered Care	Better health in communities	Affordable Care							
Functional Outcome Measure (change from)	Not NQF Endorsed		X					Care Coordination	Yes	Outcome	Yes	No	Aligns with PAC/LTC core concepts. Potential issue of parsimony with other funcational outcome measures?	Measure under consideration 1
Functional Outcome Measure (change in mobility)	Not NQF Endorsed		X					Care Coordination	Yes	Outcome	Yes	No	Aligns with PAC/LTC core concepts.	Measure under consideration 1
Functional Outcome Measure (change in self-care)	Not NQF Endorsed		X					Care Coordination	Yes	Outcome	Yes	No	Aligns with PAC/LTC core concepts.	Measure under consideration 1
Urinary catheter-associated urinary tract infection for intensive care unit (ICU) patients	0138 Endorsed	X						Safety	Yes	Outcome	No	No	Aligns with PAC/LTC core concepts.	Current
Incidence of venous thromboembolism (VTE), potentially preventable	0376 Endorsed	X	X					Safety	Yes	Outcome	No	No		Measure under consideration 1
Staff immunization	0431 Endorsed					X		Safety	Yes	Process	No	No		Measure under consideration 1

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Slide 2

Pre-Rulemaking Task Individual Measure Information (DRAFT Example)

Provides specific individual measure information (e.g., description, numerator, denominator)

NQF Measure # and Status
0167 Endorsed

Measure Name
Improvement in Ambulation/locomotion

Description
Percentage of home health episodes where the value recorded for the OASIS item M0702 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of

Numerator
Number of home health episodes where the value recorded for the OASIS item M0702 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of

Denominator
All home health episodes except those where either of the following conditions applies: (1) The value recorded for the OASIS item M0702 on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be

NQF Re-tooled eMeasure
No

Steward
CMS

National Quality Strategy Priorities
Communication and Care Coordination

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Slide 1:

Pre-Rulemaking Task Considerations from Dual Eligible Beneficiaries Workgroup (DRAFT Example)

Pre-Rulemaking Considerations from MAP Dual Eligible Beneficiaries Workgroup

In providing input to HHS regarding the selection of measures for Federal payment and public reporting programs, MAP must consider how the programs may impact the quality of care delivered to Medicare-Medicaid dual eligible beneficiaries. The roughly 9 million Americans eligible for both Medicare and Medicaid comprise a heterogeneous population with complex needs and care that is often uncoordinated by either program. Despite their particularly intense and complex needs, the care of these individuals are often highly fragmented. HHS is pursuing several strategies to improve the quality of care for these beneficiaries, including tasking MAP with considering the implications for this population.

Provides specific considerations from the Dual Eligible Beneficiaries Workgroup

General Principles for Measure Selection

In reviewing potential measures for individual programs, consider the measurement can provide the most leverage in improving the overall coordination, screening and assessment, mental health and substance which are collectively being considered a draft core set is provided

Also consider that the following issues are strongly related to quality

- **Health-related goals:** Wherever possible, measurement should promote a broad view of health and wellness, encouraging development of person-centered plans of care to manage medical, behavioral, and social needs. Developed in concert with a beneficiary's team of providers, a plan of care should establish health-related goals and preferences for care. Because of the chronic needs of the beneficiary population, plans are more likely to be long-term than episode-based.
- **Chronicity of care:** More than 60 percent of dual eligible beneficiaries have three or more multiple chronic conditions, with the most common being cardiovascular disease, diabetes, Alzheimer's and related disorders, arthritis, and depression.
- **Cognitive status:** More than 60 percent of dual eligible beneficiaries are affected by a mental or cognitive impairment. Etiologies of these impairments vary and may be the result of intellectual/developmental disability, serious mental illness, dementia, substance abuse, stroke, or other cause.
- **Care transitions and communication:** Many factors, including those listed above, make dual eligible beneficiaries more vulnerable to problems that arise during all types of care transitions. Communication and coordination across all providers is vital. Transactions between the medical system and the community-based services system are particularly important for beneficiaries who use long-term supports.

Input for the Hospital/Clinician/PAC/LTC Workgroup

The MAP Dual Eligible Beneficiaries Workgroup considered the core set of measures developed by the Hospital/Clinician/PAC/LTC Workgroup and the MAP Coordinating Committee. In response, they suggest:

Measure Gaps in the Hospital/Clinician/PAC/LTC Core Set

Measures Suggested for Removal

Other Considerations for Hospital/Clinician/PAC/LTC Programs

MAP Dual Eligible Beneficiaries Workgroup: Draft Core Set of Measures

The workgroup identified the draft core set presented below from an extensive list of current measures. Potential measures were considered in five areas previously identified by the workgroup as most closely linked to quality of care:

- Quality of Life;
- Care Coordination;
- Screening and Assessment;
- Mental Health and Substance Use; and
- Structural Measures.

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Slide 2:

Hospital Workgroup
Pre-Rulemaking Input

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Workgroup Input

The Hospital Workgroup will consider the following program measure sets:

Program	Finalized measures	Measures under consideration
Ambulatory Surgical Center Quality Reporting	5	0
Hospital Inpatient Quality Reporting	72	21
Hospital Outpatient Quality Reporting	26	0
Hospital Value-Based Purchasing	17	13
Inpatient Psychiatric Facility Quality Reporting	0	6
Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs (Meaningful Use)	15	36
Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	0	5

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Workgroup Input

For each discussion guide item, the workgroup must decide:

- Support
- Do Not Support
- Support Direction (e.g., promising measure concept, premature to recommend)

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Cross-Program Considerations for Dual Eligible Beneficiaries

Who Are Dual Eligible Beneficiaries?
A **Heterogeneous** Group

- Only factor that all dual eligible beneficiaries share is low income
- Approximately a third of duals are younger adults with disabilities and the remaining two thirds are older than 65. Almost no children.
- More than 40% of duals have a mental or cognitive condition
- One in three duals have limitations in 3 or more ADLs
- Conditions like HIV/AIDS, Alzheimer's, cerebral palsy, ESRD, and schizophrenia disproportionately impact dual eligible beneficiaries

Income $10,000 or Less: 55% / 6%
Cognitive / Mental Impairment: 54% / 24%
Less than HS Education: 52% / 19%
Fair/Poor Health: 50% / 22%
Minority Race / Ethnicity: 46% / 17%
Non-elderly Disabled: 41% / 11%
Reside in LTC Facility: 15% / 2%

Dual Eligible Beneficiaries

Other Medicare Beneficiaries

High-Leverage Areas and Construction of the Draft Core Set

High-Leverage Areas for Quality Improvement Through Measurement

- Quality of Life
- Care Coordination
- Screening and Assessment
- Mental Health and Substance Use
- Structural Measures

The Workgroup identified the draft core set from an extensive list of current measures that applied to the five areas listed above. Many measure gaps and limitations of current measures also surfaced during the process. The draft core set is presented as a starting point for discussion, as it highlights measure concepts that were identified as important.

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Workgroup-Specific Considerations: Hospital

- For hospitals, quality is tightly linked to person-centeredness, patient safety, medication management, care coordination/transitions, and readmissions
- Considering the heterogeneity of the population, think broadly about measures of care coordination, integration of care needs and care teams across specialty areas, patient experience, and outcomes
- Ensure that clinical process measures do not negatively impact quality of life decisions
- Measure gaps:
  - Composites of the quality of overall care delivery, appropriateness of index hospital admission, discharge planning and coordination of follow-up care
- Exceptions:
  - Most condition-specific measures are marginally important compared to the cross-cutting issues identified above

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Using the Duals Workgroup Guidance

Across program measures sets:

- Is there representation of the issues presented in the five high-leverage opportunity areas and the list of draft core measures?
- If not, is it appropriate to add any measures to fill that gap?
- Does a measure set include measures which are inappropriate or counterproductive to use with vulnerable populations?

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Cross-Program Considerations for Care Coordination

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Cross-Program Considerations of Care Coordination

- A priority of the MAP is to support alignment across all federal programs
- Care coordination is a priority gap area across all care settings
- Across program measure sets:
  - Review existing care coordination measures in the program measure set
  - Consider if available endorsed measures will fill a care coordination gap

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Pre-Rulemaking Input on Inpatient Quality Reporting (IQR) Program Measure Set

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Pre-Rulemaking Input on Hospital Value-based Purchasing (VBP) Program Measure Set

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Pre-Rulemaking Input on Inpatient Psychiatric Facility Quality Reporting Program Measure Set

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Psychiatric Inpatient Hospital Quality Measures

CONTEXT AND ISSUES
Dr. Ann Sullivan
Sr. VP Queens Health Network

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Inpatient Psychiatric Care

- Largely treat highly acute patients who are acutely dangerous to self or others, or who are acutely suffering serious functional impairment; there is still variation in acuity in different settings across the country.
- Treatment must include highly skilled use of patient engagement, staff teamwork, and clinical interventions that are effective and the least restrictive
- Restraint and seclusion should only be utilized as a last resort and considered a treatment failure. Nevertheless, there may be times that for acute patient and staff safety it is necessary

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Inpatient Use of Restraint and Seclusion

- Use of restraint and seclusion always carries a risk of harm and requires training and careful monitoring
- It is known that restraint and seclusion can be drastically reduced in appropriate clinical environments
- CMS and JCAHO require hospitals to work towards restraint free environments.
  - JCAHO has benchmarked some participating hospitals in their rates of restraints/seclusion.

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Inpatient Use of Restraint and Seclusion

Measures under consideration:

HBIPS-2 Hours of physical restraint use (NQF #640)

- Numerator: The total number of hours that all psychiatric inpatients were maintained in physical restraint
- Denominator: Number of psychiatric inpatient days

HBIPS-3 Hours of seclusion use (NQF #641)

- Numerator: The total number of hours that all psychiatric inpatients were held in seclusion
- Denominator: Number of psychiatric inpatient days

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After Care from Inpatient Psychiatric Hospitalization

- Up to 30 days post discharge is a critical time for psychiatric patients just as it is for medical patients
- Readmissions are high
  - NY state 20% readmitted in 30 days
- National QARR only 43% on average keep their first follow up appointment
- Higher incidence of attempted suicide, completed suicide. and violent episodes in the 30 days post discharge

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After Care from Inpatient Psychiatric Hospitalization

Measure under consideration:

HBIPS-6 Post discharge continuing care plan created (NQF #557)

- Numerator: Psychiatric inpatients for whom the post discharge continuing care plan is created and contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications, and next level of care recommendation
- Denominator: Psychiatric inpatient discharges including patients referred for next level of care with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders

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After Care from Inpatient Psychiatric Hospitalization

Measure under consideration:

HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge (NQF #558)

- Numerator: Psychiatric inpatients for whom the post discharge continuing care plan was transmitted to the next level of care

- Denominator: Patients referred for next level of care with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders

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After Care from Inpatient Psychiatric Hospitalization

Issues to consider:

- Proposed measures are process measures that address key components of care planning that need to occur and are important to measure
- However, these measures do not address outcomes directly
- The QARR measures that require that appointments post discharge occur within 7 days and measures whether the appointment was actually kept could be seen as a more potent influence on outcome.
  - The issue is whether hospitals are responsible for this care transition measure.

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Prescription of 2 or More Antipsychotic Medications

- Best practice in prescription of antipsychotic medications for psychotic disorders or symptoms is use of only one antipsychotic medication at a time.
- The "theory " is that different mechanisms of action of antipsychotics may improve outcome, and the practice has become more common in recent years. However, there is no evidence base for combining use of more than one antipsychotic at a time.
  - If prescribed at regular doses this can increase side effects with no clinical evidence for improved outcomes.
  - The measure attempts to severely limit this practice.
- One time this would be indicated is when changing meds and titrating from one antipsychotic to another. It is often appropriate and necessary to decrease one while increasing the other.
  - All other reports of efficacy of the practice are anecdotal.

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Prescription of 2 or More Antipsychotic Medications

Measure under consideration:

HBIPS-4: Patients discharged on multiple antipsychotic medications (NQF #552)

- Numerator: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications
- Denominator: Psychiatric inpatient discharges with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders discharged on one or more routinely scheduled antipsychotic medications

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Prescription of 2 or More Antipsychotic Medications

Measure under consideration:

HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification (NQF #560)

- Numerator: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification
- Denominator: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications

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Future Concepts for Measurement

- Outcome measures for after care
  - Patient keeping follow up appointments
- Monitoring of metabolic syndrome for patients on antipsychotic medications
- Primary care follow up after discharge

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Opportunity for Public Comment

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Pre-Rulemaking Input on Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (Meaningful Use) Program Measures

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Pre-Rulemaking Input on Outpatient Quality Reporting (OQR) Program Measures

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Pre-Rulemaking Input on Ambulatory Surgical Center (ASC) Quality Reporting Program Measures

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Pre-Rulemaking Input on PPS-Exempt Cancer Hospital Quality Reporting Program Measures

Opportunity for Public Comment

Summary of Day

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)
Roster for the MAP Hospital Workgroup

Chair (voting

Frank G. Opelka, MD, FACS

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

Expertise	Individual Subject Matter Expert Members (voting)
Patient Safety	Mitchell Levy, MD, FCCM, FCCP
Palliative Care	R. Sean Morrison, MD
State Policy	Dolores Mitchell
Health IT	Brandon Savage, MD
Patient Experience	Dale Shaller, MPA
Safety Net	Bruce Siegel, MD, MPH
Mental Health	Ann Marie Sullivan, MD

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	Mamatha Pancholi, MS
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH, FACP
Centers for Medicare & Medicaid Services (CMS)	Shaheen Halim, PhD, CPC-A
Office of the National Coordinator for HIT (ONC)	Leah Marcotte
Veterans Health Administration (VHA)	Michael Kelley, MD

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

George J. Isham, MD, MS

Elizabeth A. McGlynn, PhD, MPP

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Measure Applications Partnership (MAP)
Bios of the MAP Hospital Workgroup

Chair (voting)

Frank G. Opelka, MD FACS
Frank G. Opelka, MD FACS is the Vice Chancellor for Clinical Affairs and Professor of Surgery at Louisiana State University Health Sciences Center in New Orleans. At LSU, he actively teaches in the 4 health sciences schools, developing programs for innovation and delivery system redesign. He also works at the LSU seven hospital system to support efforts for the development of a safety net ACO to address various challenges, such as the dual eligibles. He also represents the American College of Surgeons, Washington DC Office in the Division of Health Policy and Advocacy. Dr. Opelka founded and serves as the chair of the Surgical Quality Alliance, with over 20 surgical organizations sitting in the alliance. He serves as one of the original members of the National Priorities Partnership in the National Quality Forum, a member of the NQF's Consensus Standards Advisory Committee, and has served as a chair of an NQF steering committee. Dr. Opelka continues to serve on the Quality Alliance Steering Committee, the AQA, and the AMA's Physician Consortium for Performance Improvement. He has served on several advisory committees to several health plans, including United Health Group, Blue Cross Blue Shield of America, and Humana. Dr. Opelka has developed and assisted the American Board of Medical Specialties in their clinical registry efforts for the Maintenance of Certification Part IV. Prior to serving in the quality arena, Dr. Opelka worked closely with CMS in the Ambulatory APG relative values, AMA's Relative Value Updates Committee, Practice Expense Committee, and an advisory to the CPT Editorial Committee. Dr. Opelka served 12 years on active duty in the US Army where he did his residency in General Surgery at the Walter Reed Army Medical Center and Eisenhower Army Medical Center. His colorectal surgery fellowship was at the Ochsner Clinic New Orleans where he served for 12 years as faculty and attending surgeon. His career then included time at the Beth Israel Deaconess Medical Center in Boston before returning to New Orleans just in time for Hurricane Katrina. Dr. Opelka is a board certified colon and rectal surgery. He is a fellow of the American College of Surgeons and the American Society of Colon and Rectal Surgeons.

Organizational Members (voting)

Alliance of Dedicated Cancer Centers
Ronald Walters, MD, MBA, MHA, MS
Ron Walters is an associate vice president of medical operations and informatics at The University of Texas MD Anderson Cancer Center in The Texas Medical Center, applying more than 30 years of experience and knowledge at MD Anderson. Dr. Walters is a breast medical oncologist and is responsible for the professional aspects of Clinical Operations including Medical Informatics, the Tumor Registry, the Transfer Center, Managed Care Programs, Uncompensated Charity Care, Clinical Safety and Effectiveness and the Physicians Network. He serves on multiple institutional committees striving for improvements in patient care, research and our support systems. Dr. Walters pursued his MBA at the University of Houston. When he realized it didn't cover enough of the health care administration aspects, he went for a Masters degree too. It was in business school where he really learned to appreciate that a different perspective was obtained if you had some hands-on experience in the profession. He completed

a Masters program in the management of computing and information systems at Houston Baptist University. Dr. Walters considers himself a productive member of a great team with great leadership at MD Anderson Cancer Center.

American Hospital Association
Richard Umbdenstock

Richard J. Umbdenstock became president and chief executive officer of the American Hospital Association (AHA) on January 1, 2007. He was the elected AHA Board Chair in 2006. The AHA leads, represents and serves more than 5,000 member hospitals, health systems and other health care organizations, and 40,000 individual members. Mr. Umbdenstock's career includes experience in hospital administration, health system leadership, association governance and management, HMO governance and health care governance consulting. He has written several books and articles for the hospital board audience and authored national survey reports for the AHA and its Health Research and Educational Trust, and for the American College of Healthcare Executives. He received a B.A. degree in Politics in 1972 from Fairfield University, Fairfield, CT, and a Master of Science degree in 1974 in Health Services Administration from the State University of New York at Stony Brook. He is a Fellow of the American College of Healthcare Executives. Mr. Umbdenstock serves on the National Quality Forum Board of Directors and the National Priorities Partnership, and chairs the Hospital Quality Alliance.

American Organization of Nurse Executives
Patricia Conway-Morana, RN

Pat Conway-Morana received her basic nursing education as a diploma graduate from Riverside Hospital School of Nursing; her BSN from Jefferson College of Health Sciences: her BS in Business Administration from Christopher Newport University; a Master of Administration from Lynchburg College and is currently a Nursing Doctoral Candidate at George Mason University. She has worked as a Labor and Delivery Staff Nurse and in several leadership roles including Labor and Delivery Nurse Manager; Risk Management Consultant; Director of Accreditation and Licensure; and Chief Nurse Executive at Carilion Health System; Columbus Regional Medical Center and Inova Fairfax Hospital. Pat is certified in Inpatient Obstetrics; as a Professional in Healthcare Quality; Board Certified as a Nurse Executive, Advanced: Certified Nurse in Executive Practice and is a Fellow in the American College of Healthcare Executives. Pat is on the Board of Directors of the American Organization of Nurse Executives and is the Board Chairperson for the AONE Foundation. She is also a member of the American Nurses Association, Sigma Theta Tau International Honor Society, and the American College of Healthcare Executives. Pat is currently working full time on her doctoral dissertation, "Predicting Structurational Divergence in Nursing."

American Society of Health-System Pharmacists
Shekhar Mehta, PharmD, MS

Shekhar Mehta, Pharm.D., M.S., is Director of Clinical Guidelines and Quality Improvement at the American Society of Health-System Pharmacists (ASHP), in Bethesda, Maryland. He earned his Master of Science in Biostatistics from the University of Pittsburgh School of Public Health in August of 2006, and Pharm.D. from the University of Maryland School of Pharmacy in 2010. While attending the University of Maryland he concurrently interned in the Biometrics and Data Management Department at Boehringer-Ingelheim Pharmaceuticals for 3 years helping develop clinical trial reports for submission to the FDA. Following the completion of his Pharm.D., Dr. Mehta mastered clinical skills and served the leadership role of being one of the first residents of an emerging PGY1 Pharmacy Practice Residency Program at Frederick Memorial Hospital, a small but diverse community hospital in Frederick, Maryland. Dr. Mehta joined the team at ASHP in the summer of 2011, where he coordinates and manages the development of ASHP therapeutic guidance documents in the compendium of Best Practices for Hospital

and Health-System Pharmacy. He serves as an advocate on clinical quality improvement initiatives with various public and private sector organizations on behalf of ASHP.

Blue Cross Blue Shield of Massachusetts
Jane Franke, RN, MHA, CPHQ

Jane Franke, RN, MHA, CPHQ is the Director of Hospital Performance Measurement & Improvement for Blue Cross Blue Shield of Massachusetts. Ms. Franke has been involved in the strategic development and evolution of hospital performance measurement since 2002 and currently oversees the Hospital Performance Incentive Program (HPIP); HPIP provides hospitals across the state with the opportunity to earn increased payment by meeting absolute thresholds for good performance on a set of clinical outcome, clinical process, and patient experience measures. Ms. Franke also works with hospitals and medical group practices participating in the Alternative Quality Contract (AQC), BCBSMA's innovative global payment model that uses a budget based methodology and substantial performance incentive payments to improve quality and efficiency. Ms. Franke serves on the Steering Committee for the State Action on Avoidable Rehospitalizations (STAAR) and the Massachusetts Coalition for Prevention of Medical Errors. Ms. Franke has more than 20 years of hospital-based clinical experience and, prior to her role at BCBSMA, was the Executive Director of a successful physician hospital organization operating under global risk in central Massachusetts.

Building Services 32BJ Health Fund
Barbara Caress

Barbara Caress has over 25 years of experience as a non-profit and public agency manager, consultant and administrator. She is currently Director of Strategic Policy and Planning for the SEIU Local 32BJ Health, Pension, Legal and Training Funds, which provide benefits to 250,000 people living in seven states. She directs the Funds' research and planning efforts and staffs the Trustees' committees on health insurance, benefits and reform. Under her direction the 32BJ Health Funds have undertaken a substantial re-design effort dedicated to developing incentives for members to use, and providers to offer, patient centered medical homes and other certified quality providers. Ms Caress spent many years as a health care consultant working for such clients as the New York City and State Health Departments, the Community Service Society, Local 1199 and the United Hospital Fund. She is currently a member of NCQA's Standards Committee and the NYC Primary Care Improvement Project Advisory Board. Author of a wide range of health policy reports and reviews, Ms Caress received her undergraduate and graduate education at the University of Chicago and is currently an adjunct faculty member at the School of Public Affair, Baruch College, CUNY.

Iowa Healthcare Collaborative
Lance Roberts, PhD

Lance L. Roberts, PhD is the Health Services Analyst for the Iowa Healthcare Collaborative. He is primarily responsible for collaborating with state healthcare stakeholders and national quality/safety measurement and reporting organizations in order to promote and carry out responsible public reporting efforts in Iowa. These efforts culminate in the release of Iowa hospital quality/safety performance information in the online Iowa Report. He also utilizes his health services research background to produce actionable knowledge for use in various continuous improvement, policy, and research activities conducted by the Iowa Healthcare Collaborative. His educational and professional background include both technology and health services research science. His 14 years of manufacturing experiences included work in production and inventory control, purchasing, master scheduling, capacity management, supervision, and an array of manufacturing/process engineering activities including several years of experience with TPS/Lean methods and philosophy implementation. His healthcare experiences include

Six Sigma, Lean, and computer simulation implementation projects within hospitals; teaching undergraduate statistics; public reporting of delivery system performance; and health services research.

Memphis Business Group on Health
Cristie Upshaw Travis, MSHA

Cristie Upshaw Travis is Chief Executive Officer of the Memphis Business Group on Health, a business coalition with 15 employer members and affiliates providing health care benefits to approximately 350,000+ residents of the Mid-South and Tennessee, which focuses on sharing solutions and providing tools to manage health benefits in an ever-changing environment. Ms. Travis is Immediate Past Chair of the Board of Governors of the National Business Coalition on Health, and continues to serve on the Board; she is former Chair of the Board of Directors for The Leapfrog Group; and she serves on the Purchaser Advisory Committee for NCQA. She is Immediate Past Chair of the Healthy Memphis Common Table, a community health collaborative in Memphis, TN, and continues to serve on the Board. Ms. Travis is a member of the Board of Trustees for the Southern College of Optometry; President of the Community Advisory Board for the University of Memphis Graduate Program in Health Administration; a member of the Dean's Advisory Council for the University of Memphis School of Public Health; and a member of the Community Advisory Board for the Christian Brothers University Physician's Assistant program. She also serves on the National Commission on Prevention Priorities and the National Transitions of Care Coalition. She has her Master of Science in Hospital and Health Administration from the University of Alabama at Birmingham. Ms. Travis is a frequent national speaker on value-based benefit design, community health improvement collaboratives, employer-sponsored quality improvement initiatives, health plan performance measurement and worksite initiatives. She has recently presented for the National Quality Forum, the World Congress, Integrated Benefits Institute, National Business Coalition on Health, The Leapfrog Group, America's Health Insurance Plans (AHIP), America's Health Information Management Association (AHIMA), and Agency for Healthcare Research & Quality (AHRQ).

Mothers Against Medical Error
Helen Haskell, MA

Helen Haskell is founder and president of Mothers Against Medical Error, a consumer-led organization dedicated to improving patient safety and providing support for patients who have experienced medical injury. For Helen, patient safety is a calling to which she was brought by the medical error death of her fifteen-year-old son Lewis in a South Carolina hospital in November, 2000. In 2005, Helen helped put together a coalition of patients, policymakers, and healthcare providers to pass the Lewis Blackman Patient Safety Act, the first of several South Carolina legislative initiatives addressing healthcare safety and transparency. In 2007, the state of South Carolina created the Lewis Blackman Chair of Patient Safety and Clinical Effectiveness, an endowed professorship named in honor of her deceased son. Helen is actively involved in patient safety and quality improvement efforts in South Carolina, the United States, and internationally, on topics including medical education reform, patient-activated rapid response, infection prevention, medical error disclosure, and patient empowerment and education. She is a director of the patient safety organizations Consumers Advancing Patient Safety and The Empowered Patient Coalition; a member of the AHRQ National Advisory Council; and a founding member of the Nursing Alliance for Quality Care. Helen is co-author, with Julia Hallisy, of numerous patient educational materials including *The Empowered Patient Guide to Hospital Care for Patients and Families.*

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National Association of Children's Hospitals and Related Institutions
Andrea Benin, MD
Andrea L. Benin, MD is System Executive Director, Performance Management for the Yale New Haven Health System and the Quality and Safety Officer, Yale-New Haven Children's Hospital as well as Assistant Clinical Professor, Pediatrics, Yale School of Medicine in New Haven, Connecticut. Dr. Benin is a Pediatrician with background and training in informatics, public health, epidemiology, and infectious diseases. Since 2005, she has overseen the quality and safety activities for the three-hospital Yale New Haven Health System. As part of that work, Dr. Benin provides her expertise in developing, validating, and measuring metrics of quality of care – in both paper and electronic formats. Dr. Benin recently completed a grant from the National Library of Medicine targeting this interest. Dr. Benin has served on multiple peer-review groups and study sections as well as several national steering committees.

National Rural Health Association
Brock Slabach, MPH, FACHE
Brock Slabach currently serves as the Senior Vice-President of Member Services for the National Rural Health Association (NRHA), a membership organization with over 20,000 members nationwide. Mr. Slabach has over 23 years of experience in the administration of rural hospitals. From 1987 through 2007, he was the administrator of the Field Memorial Community Hospital, in Centreville, Mississippi. His experiences have led him to be a member of the NRHA Board of Trustees (2004-2007), Member of AHA's Regional Policy Board (RPB) for Region 4 (2004-2007), Chair of the NRHA Hospital and Health Systems Constituency Group (2004-2007), Chair, National Rural Health Policy Issues Group for HHS's Office of Rural Health Policy (ORHP) (2006-2007) and the President of the Delta Rural Health Network (2004). He earned his Bachelor of Science from Oklahoma Baptist University and his Master of Public Health in Health Administration from the University of Oklahoma.

Premier, Inc.
Richard Bankowitz, MD, MBA, FACP
In his role as chief medical officer, Richard Bankowitz, MD, MBA, FACP, works at an enterprise level to engage physicians, provide thought leadership, and ensure that Premier continues to deliver value to its clinician constituency. Dr. Bankowitz previously served as vice president and medical director for Premier Healthcare Informatics. A board-certified internist and a medical informaticist, Dr. Bankowitz has devoted his career to improving healthcare quality at the national level by promoting rigorous, data-driven approaches to quality improvement and by engaging senior clinicians and healthcare leaders. In 2011, Dr. Bankowitz was named by Modern Healthcare magazine as one of the top 25 clinical informaticists in the United States. He began his career at the University of Pittsburgh, School of Medicine as an assistant professor of medicine and medical informatics. Prior to joining Premier, Dr. Bankowitz was medical director at CareScience, where he was responsible for strategy, product delivery, consulting, sales and advocacy efforts. He also has previously served as the corporate information architect of the University HealthSystem Consortium (UHC), where he was responsible for the strategic direction of the organization's executive reporting tools and comparative data. In his 12-year tenure with UHC, Dr. Bankowitz also held positions as senior director of clinical informatics, director of clinical information management and director of clinical evaluative sciences. Dr. Bankowitz is a fellow of the American College of Physicians and was a National Library of Medicine graduate trainee in medical informatics. He also is senior scholar with the Center for Healthcare Policy at Thomas Jefferson University. Dr. Bankowitz is a graduate of the University of Chicago Pritzker School of Medicine and the University of Chicago Graduate School of Business.

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Individual Subject Matter Expert Members (voting)

Patient Safety
Mitchell Levy, MD, FCCM, FCCP
Mitchell M. Levy MD is Chief, Division of Critical Care, Pulmonary, and Sleep Medicine, Department of Medicine, The Warren Alpert Medical School of Brown University, where he is Professor of Medicine. He is also Medical Director of the Medical Intensive Care Unit at Rhode Island Hospital, Providence, Rhode Island. Dr. Levy is a founding member (2002) and a member of the Executive Committee of the Surviving Sepsis Campaign, a global initiative to improve the care of patients with severe sepsis. He is the lead investigator for Phase III of the campaign, the goal of which is to facilitate adoption of evidence-based guidelines for sepsis management into clinical practice and reduce mortality in severe sepsis by 25% by 2009. Dr. Levy is Past-President of the Society of Critical Care Medicine (2009). Dr. Levy's current research interests include biomarkers in sepsis, end-of-life care in the ICU, and knowledge translation. He has authored over 100 peer-reviewed articles and book chapters. He is the co-director of the Ocean State Clinical Coordinating Center, which manages large, international, multi-center clinical trials in sepsis. Dr. Levy is very active in the field of quality and safety. He continues to serve as the representative to the National Quality Forum for SCCM and also serves on the advisory committees on Quality for the Blue Distinction program of Blue Cross Blue Shield of America. Dr. Levy has worked on several state-wide initiatives on quality, including Rhode Island and New Jersey, and has served on the steering committee for their efforts in sepsis and palliative care. He led a similar initiative for the New York City Health and Hospital Corporation in their quality initiative in catheter-related bloodstream infection and sepsis. He was recently appointed a content expert and voting member of the Hospital Workgroup of the Measure Applications Partnership (MAP) of the National Quality Forum and serves as a technical expert for the project Closing the Quality Gap: Prevention of Healthcare-associated Infections, which is part of the Evidence-Based Practice Center (EPC) program of the Agency for Healthcare Research and Quality (AHRQ).

Palliative Care
R. Sean Morrison, MD
Dr. R. Sean Morrison is Director of the National Palliative Care Research Center, a national organization devoted to increasing the evidence base of palliative care in the United States. He is also the Vice-Chair of Research; Professor of Geriatrics and Medicine; and Hermann Merkin Professor of Palliative Medicine in the Brookdale Department of Geriatrics and Palliative Medicine at the Mount Sinai School of Medicine in New York City. During 2009-2010, he served as President of the American Academy of Hospice and Palliative Medicine. Dr. Morrison is the recipient of numerous awards, including a PDIA American Academy of Hospice and Palliative Medicine National Leadership Award, the American Geriatrics Society's Outstanding Achievement for Clinical Investigation Award, the Open Society Institute Faculty Scholar's Award of the Project on Death in America, a Paul Beeson Faculty Scholars Award, a Brookdale National Fellowship, and a Faculty Council Award from the Mount Sinai School of Medicine. He is currently Principal Investigator of an NIA funded five-year multisite study on improving the management of pain in older adults. Dr. Morrison has published extensively in all major peer-reviewed medical journals, including the New England Journal of Medicine, Annals of Internal Medicine, and the Journal of the American Medical Association. He edited the first textbook on geriatric palliative care and has contributed to more than 10 books on the subject of geriatrics and palliative care. As one of the leading figures in the field of palliative medicine, Dr. Morrison has appeared numerous times on television and in print, including ABC World News Tonight, The Factor with Bill O'Reilly, the New York Times, the Los Angeles Times, USA Today, the Philadelphia Enquirer, the New York Daily News, Newsday, AARP, and Newsweek. He figured prominently in the Bill Moyers series On Our Own Terms, a four-part documentary aired on PBS and in Gail Sheehy's new book, Passages in Caregiving.

R. Sean Morrison received his BA from Brown University and his MD from the University of Chicago Pritzker School Of Medicine. He completed his residency training at the New York Hospital-Cornell Medical Center followed by fellowship training at the Mount Sinai School of Medicine in New York City. He has been on the faculty of the Department of Geriatrics and Palliative Medicine and Department of Medicine at Mount Sinai since 1995.

State Policy
Dolores Mitchell
Dolores L. Mitchell is the Executive Director of the Group Insurance Commission, the agency that provides life, health, disability, dental and vision services to the Commonwealth's employees, retirees and their dependents; many of these benefits are also provided to a number of authorities, municipalities, and other entities. More than 350,000 people are covered by the GIC. Mrs. Mitchell has been in this position since 1987, serving in the administrations of Governors Dukakis, Weld, Cellucci, Swift, Romney, and now Governor Patrick. Mrs. Mitchell is a member of a number of professional and community organizations, including the Massachusetts Health Data Consortium, of which she is a Director, the Greater Boston Big Sister Association, of which she is a Board member, the Massachusetts Health Council, and the Mass E-Health Collaborative of which she is a Director. More recently, she is a member of the governing board of the Massachusetts Health Care Connector Authority, and its companion organization, the Quality and Cost Council. She is an elected member of the board of the National Committee for Quality Assurance (NCQA), the Hospital Quality Alliance (HQA), the Consumer/Purchaser Disclosure, and has recently been elected a member of the Board of Directors of the National Quality Forum (NQF), and is one of the founding members of Catalyst for Health Payment Reform. She is also an Advisory Board member of the Milbank Foundation. Mrs. Mitchell is a frequent speaker on health care, politics, women's career issues, and related subjects.

Health IT
Brandon Savage, MD
Brandon Savage, MD, is the Chief Medical Officer for GE Healthcare's Integrated IT Solutions (IITS) business. Dr. Savage's passion is empowering healthcare systems with powerful tools to help optimize the cost and quality of the care they deliver. As CMO, Dr. Savage is responsible for building GE's clinical IT vision, driving this vision into current and future IT products, and facilitating integrated product solutions that enable digital communities and early health. Dr. Savage's primary focus is to leverage strategic customer-driven development, with organizations such as Intermountain healthcare, to evolve GE's Enterprise Electronic Health Record, marketed as Centricity® Enterprise, into a knowledge-driven, evidence-based medical system that supports clinicians in providing the highest levels of care. Additionally Dr. Savage works with the regulatory teams to ensure GE's products promote the quality standards that protect the safety of the patients we serve. Previous to his CMO role, Dr. Savage served as the General Manager of Global Marketing for GE Healthcare IITS with responsibilities for developing an integrated product strategy and brand promise to unite the business. Specifically, Dr. Savage and his team led efforts focused on growth strategies, market analysis, interoperability, platforming, brand strategy and marketing excellence. During his tenure at GE, Dr. Savage also led the development of products, such as computerized provider order entry (CPOE), and worked with customers to select and implement software solutions. Prior to GE, Dr. Savage practiced internal medicine and served as an assistant professor of medicine at the University of California, San Diego, with a focus on clinical trials, patient safety, and residency training. During this time, he also co-founded Intensive Solutions International, which developed software for managing patients in intensive care units. Dr. Savage has a Bachelor of Arts from the University of California, Berkeley, in molecular cellular biology and a Medical Doctor degree from the University of California, San Diego. He has been published in

numerous journals and magazines, including *Physician Executive*, *American Journal of Kidney Diseases*, and *Current Opinion in Critical Care*.

Patient Experience
Dale Shaller, MPA

Dale Shaller is Principal of Shaller Consulting Group, a health policy analysis and management consulting practice based in Stillwater, Minnesota. He has devoted nearly three decades to the design, implementation, and evaluation of health care quality measurement and improvement programs, with a special focus on listening to the voice of the patient and promoting methods for engaging consumers in managing their health and health care. His work on measuring and improving the experience of patients and families has been based in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program funded by the U.S. Agency for Healthcare Research and Quality. He has served as a member of the Harvard and Yale CAHPS research teams for 10 years, working on patient experience survey design, measurement, and reporting issues. He has directed the National CAHPS Benchmarking Database since its inception in 1998 and is a co-author of The CAHPS Improvement Guide and other articles related to strategies for improving the patient experience. Mr. Shaller currently serves as the Chair of the Patient Experience Committee for the Aligning Forces for Quality program funded by the Robert Wood Johnson Foundation. He has been a principal investigator on several projects funded by the Picker Institute, including a series of case studies documenting factors contributing to high-performing patient- and family-centered medical centers. He also has written a series of reports on consumer decision-making in health care, and was a founding developer of the TalkingQuality website that provides practical guidance to developers of health care quality reporting tools for consumers. He has served on many national health care advisory panels and is a frequent writer and presenter on health care quality and patient engagement strategies. He received his B.A. from Kalamazoo College and holds a Master's degree in public affairs from the Humphrey Institute of Public Affairs at the University of Minnesota.

Safety Net
Bruce Siegel, MD, MPH

Dr. Siegel has an extensive background in healthcare management, policy and public health. Before joining NAPH as Chief Executive Officer, he served as Director of the Center for Health Care Quality and Professor of Health Policy at the George Washington University School of Public Health and Health Services. He also previously served as President and CEO of two NAPH members: Tampa General Healthcare and the New York City Health and Hospitals Corporation. In addition, Dr. Siegel has served as Commissioner of Health of the State of New Jersey. Among many accomplishments, Dr. Siegel has led groundbreaking work on quality and equity for the Robert Wood Johnson Foundation, as well as projects for the Commonwealth Fund, the California Endowment, and the Agency for Healthcare Research and Quality. He currently is a member of the National Advisory Council for Healthcare Research and Quality. Dr. Siegel earned an A.B. from Princeton University, a Doctor of Medicine from Cornell University Medical College, and a Master of Public Health from Johns Hopkins University School of Hygiene and Public Health.

Mental Health
Ann Marie Sullivan, MD

Ann Marie Sullivan, M.D. is the Senior Vice President for the Queens Health Network of the New York City Health and Hospitals Corporation. As Senior Vice President, she is responsible for Elmhurst and Queens Hospital Centers, two public hospitals which have been serving the Queens Community of over 2 million New York City residents. The Network, a teaching affiliate of the Mount Sinai School of Medicine currently comprises 806 acute care beds, a trauma and stroke center, a large comprehensive Women's Health Services, and centers for excellence in Cancer, Cardiology, Diabetes and Mental Health.

In addition, the Network serves the ethnically diverse Queens Community with large Primary Care and Mental Health Ambulatory services. Dr. Sullivan attended NYU Medical School and completed her Psychiatric Residency at New York University/ Bellevue Hospital in1978. She has served as the Associate Director of Psychiatry and Medical Director of Ambulatory Care at the Gouverneur Diagnostic and Treatment Center and joined the Queens Health Network as the Regional Director of Psychiatry in 1990. Dr. Sullivan is a Clinical Professor of Psychiatry at the Mount Sinai School of Medicine, and has lectured and written on community based psychiatric services. She is currently on the Board of Trustees for the American Psychiatric Association and the Board of Directors of the NYC Mental Health Association. She is also a fellow for the New York Academy of Medicine and the American College of Psychiatrist.

Federal Government Members (non-voting, ex officio)

Agency for Healthcare Research and Quality (AHRQ)
Mamatha Pancholi, MS

Centers for Disease Control and Prevention (CDC)
Chesley Richards, MD, MPH, FACP
Chesley Richards MD, MPH, FACP, is the Director, in the Office of Prevention through Healthcare (OPTH) in the Office of the Director, Centers for Disease Control and Prevention. OPTH, a new office at CDC, works to build and enhance strategic collaboration between public health and healthcare sector stakeholders to improve the use of preventive services, and to enhance the quality and safety of healthcare. Previously, Dr. Richards served as the Deputy Director, Division of Healthcare Quality Promotion in the National Center for Infectious Diseases at CDC. Dr. Richards is a board-certified internist and geriatrician and holds an appointment as Clinical Associate Professor of Medicine in the Division of Geriatric Medicine and Gerontology at Emory University. Dr. Richards earned his MD from the Medical University of South Carolina, an MPH in Health Policy and Administration from University of North Carolina at Chapel Hill and is a graduate of the Epidemic Intelligence Service (EIS) at CDC and the Program on Clinical Effectiveness at Harvard School of Public Health. Dr. Richards's interests include patient safety, healthcare quality, and preventive services, especially among older adults.

Centers for Medicare & Medicaid Services (CMS)
Shaheen Halim, PhD, CPC-A
Dr. Shaheen Halim is the current Director of the Division of Hospital and Medication Measures of the Quality Measures and Health Assessment Group in the Centers for Medicare and Medicaid Services' Office of Clinical Standards and Quality. Her Division is responsible for the development, maintenance, and implementation of quality measures in CMS' pay for reporting, and value based purchasing programs such as the Hospital Inpatient Quality Reporting Program, Hospital Outpatient Quality Reporting Program, Hospital Value Based Purchasing, Cancer Hospital Reporting Program, Inpatient Psychiatric Facility Reporting Program, and Ambulatory Surgical Center Reporting Program. Shaheen's Division is also responsible for the coordination and development of content on the Hospital Compare website, which provides hospital quality information to consumers.   She received her Ph.D. in Sociology from Texas A&M University in 2005, and has been with the Centers for Medicare and Medicaid Services for 6 years.

Office of the National Coordinator for HIT (ONC)
Leah Marcotte
Leah Marcotte is the Partnership for Patients liaison and works in the Meaningful Use Division in the Office of the National Coordinator for Health Information Technology (ONC). At ONC, she helps to: support the policy-making process for the second stage of meaningful use in the CMS EHR Incentive Program; develop resources for primary care physicians transitioning to and optimizing the use of electronic health records; and encourage further integration of health informatics training in medical education. She also works to strategically align ONC initiatives with the goals of the Partnership for Patients. Leah is currently attending the University of Pennsylvania School of Medicine and is working at ONC through a fellowship. During medical school, she developed a focus in quality and patient safety through involvement in curriculum development and quality improvement research. She received her BA in Neurobiology from the University of Pennsylvania.

Veterans Health Administration (VHA)
Michael Kelley, MD
Since 2007, Dr. Michael Kelley has been the National Program Director for Oncology for the Department of Veterans Affairs. He develops policy and programs in oncology for the national Veterans Health Administration where a primary focus has been on electronic data systems to collect cancer patient data for quality improvement and other purposes. Dr. Kelley is a board certified Medical Oncologist. He completed Internal Medicine training at Duke University followed by fellowship and post-doctoral work at the National Cancer Institute. He is Chief of Hematology and Oncology at the Durham Veterans Affairs Medical Center where he oversees the clinical service, clinical research, and fellowship training. He is also Associate Professor of Medicine at Duke University Medical Center with research interests that include treatment and prevention of lung cancer, the genetics and molecular biology of chordoma, and clinical trials. Dr. Kelley has published over 50 peer-reviewed publications as well as reviews and book chapters. He is an active member of the American Society of Clinical Oncologist and is a Fellow of the American College of Physicians.

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

George J. Isham, MD, MS
George J. 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.

NATIONAL QUALITY FORUM

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.

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.

Lindsay Lang, MHSA, RN
Lindsay currently serves as a Senior Project Manager with the National Quality Forum (NQF). In her time at NQF, she has been responsible for developing a process for the maintenance of all NQF-endorsed performance measures and supported multiple convening activities. She currently leads a team creating the Quality Positioning System (QPS), a web-based search engine for finding NQF-endorsed measures, and supports the Hospital and Ad Hoc Safety Workgroups of the Measure Applications Partnership (MAP). Ms. Lang joined the National Quality Forum with 10 years of experience in the healthcare industry. She received her Bachelor of Science in Nursing from the University of Iowa and practiced as an RN in oncology, hematology and dialysis care settings. She went on to earn a Master's of Health Services Administration (MHSA) from the University of Kansas. During this time, she first developed an interest in working in healthcare quality serving as a Hospital Liaison for the National Database of Nursing Quality Indicators. Upon completion of her MHSA, she was awarded an Administrative Fellowship with Trinity Health system in Michigan. Prior to relocating to Washington, DC, Ms. Lang worked as a Nurse Manager of an inpatient neurosciences unit at Froedtert Hospital in Wisconsin. She came to NQF from the Advisory Board Company, where she worked as a Dedicated Advisor in the Business Intelligence.