Measure Applications Partnership (MAP)

Cardiovascular/Diabetes Task Force In-Person Meeting

NATIONAL QUALITY FORUM

June 21, 2012

Meeting Location:
American College of Surgeons
20 F Street Conference Center, NW
Washington, DC 20001

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MEASURE APPLICATIONS PARTNERSHIP

Cardiovascular/Diabetes Task Force
In-Person Meeting #1

American College of Surgeons Conference Center
20 F St NW # 1000, Washington, DC 20001

WORKGROUP DIAL-IN: (877) 303-9138
PASSCODE: 88651330

WEB ACCESS: HTTP://NQF.COMMPARTNERS.COM
MEETING CODE: 437366

AGENDA: JUNE 21, 2012

Meeting Objectives:

- *Review task force charge, role within the MAP, and plan to complete the tasks;*
- *Identify priority performance measurement areas for diabetes and cardiovascular conditions;*
- *Establish diabetes family of measures; and*
- *Begin defining cardiovascular family of measures.*

8:30 am   **Breakfast**

9:00 am   **Welcome, Introductions, and Disclosures of Interest**
Chris Cassel, Task Force Chair
Ann Hammersmith, General Counsel, NQF

9:30 am   **Families of Measures and Measure Gaps**
- *Review MAP's 2012-2013 scope of work*
- *Discuss charge of the Cardiovascular/Diabetes Task Force*
- *Discuss purpose and approach to families of measures and core measure sets*

10:15 am   **Primary Prevention of Diabetes and Cardiovascular Conditions**
- *Identify high-leverage opportunities for preventing diabetes and cardiovascular conditions*
- *Review available measures*
- *Determine measures to be included in the diabetes and cardiovascular measure families*
- *Identify gaps*
- *Opportunity for public comment*

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11:15   **Break**

11:30   **Diabetes Evaluation and Ongoing Management; Diabetes Complications**
- *Identify high-leverage opportunities for improving diabetes care*
- *Determine measures to be included in the diabetes measure family*
- *Identify gaps*
- *Opportunity for public comment*

12:30 pm   **Lunch**

1:00 pm   **Diabetes Composite Measures**
- *Discuss the inclusion of composites in the diabetes measure family*

1:30 pm   **Measurement Priorities for Cardiovascular Care**
- *Identify high-leverage opportunities for improving treatment of cardiovascular conditions*
- *Discuss the approach for the July Cardiovascular/Diabetes Task Force meeting*
- *Opportunity for public comment*

2:15 pm   **Cardiovascular Secondary Prevention**
- *Determine measures to be included in the cardiovascular family*
- *Identify gaps*

2:45 pm   **Break**

3:00 pm   **Stroke**
- *Determine measures to be included in the cardiovascular family*
- *Identify gaps*
- *Opportunity for public comment*

4:00 pm   **Affordability Measures for Diabetes and Cardiovascular Care**
- *Discuss affordability measures for the diabetes and cardiovascular measure families*
- *Identify gaps*
- *Opportunity for public comment*

4:45 pm   **Summary and Next Steps**

5:00 pm   **Adjourn**

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Cardiovascular/Diabetes Care
Task Force Meeting #1

June 21, 2012

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Welcome, Introductions, and Disclosures of Interest

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Meeting Objectives

- Review task force charge, role within MAP, and plan to complete the tasks;
- Identify priority areas for aligning cardiovascular and diabetes performance measurement;
- Establish diabetes family of measures;
- Begin defining cardiovascular family of measures; and
- Discuss implementation pathways for filling measurement gaps.

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Cardiovascular/Diabetes Task Force Membership

Task Force Chair: Christine Cassel

Organizational Members

American Hospital Association	Rhonda Anderson
Academy of Managed Care Pharmacy	Marissa Schlaiffer
National Committee of Quality Assurance	Peggy O'Kane
American Academy of Family Physicians	Bruce Bagley
American College of Cardiology	Paul Casale
American College of Emergency Physicians	Bruce Auerbach
Consumers' CHECKBOOK	Robert Krughoff
Minnesota Community Measurement	Beth Averbeck
Physician Consortium for Performance Improvement	Mark Metersky
American Medical Directors Association	David Polakoff
American Medical Rehabilitation Providers Association	Suzanne Snyder
AETNA	Randall Krakauer
Premier, Inc.	Richard Bankowitz
Iowa Healthcare Collaborative	Lance Roberts

Subject Matter Experts

James Walker

Eugene Nelson

Federal Government Members

Michael Rapp

Joshua Seidman

Liaisons

Peter Briss – NPP

Mary George – CDP

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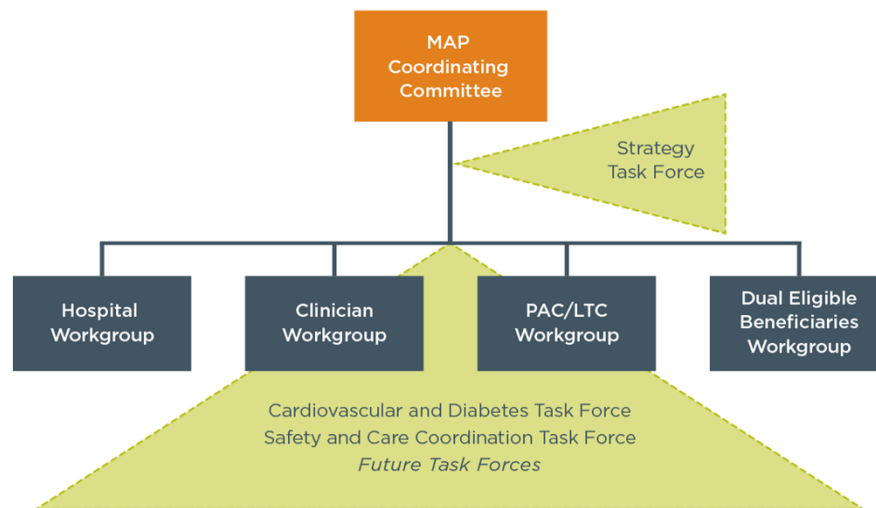# *Families of Measures and Measure Gaps*

Families of Measures and Measure Gaps

- Review MAP's 2012-2013 scope of work
- Discuss charge of the Cardiovascular/Diabetes Care Task Force
- Discuss purpose and approach to families of measures and core measure sets

MAP Structure Year 2

Proposed MAP Work for 2012- 2013

- Develop MAP 3-year strategic plan for achieving aligned performance measurement that enables improvement, transparency, and value

- Identify families of measures for specific topics and core measure sets composed of available measures and gaps
  - Enhance existing two-tiered structure with topic-focused, time-limited task forces

- Provide pre-rulemaking input to HHS on measures under consideration for rulemaking
  - Expand decision making support for activities

- Delve into measurement issues for dual eligible sub-populations

Approach to the MAP Strategic Plan
Submitted to HHS on June 1, 2012

Goal: Apply performance measures to achieve improvement, transparency, and value in pursuit of the aims, priorities, and goals of the National Quality Strategy

- Objectives
  1. Ensure performance measures are high-impact, relevant, actionable, and drive toward realization of the NQS;
  2. Stimulate gap-filling for high-priority measure gaps;
  3. Promote alignment of performance measurement across HHS programs and between public and private initiatives; and
  4. Ensure MAP's recommendations are relevant to public and private stakeholders and MAP's processes are effective.

- Strategies and Tactics
  - Families of Measures and Core Measure Sets
  - Addressing Measure Gaps
  - Measure Implementation Phasing Strategies
  - MAP Analytic Plan
  - MAP Measure Selection Criteria
  - MAP Evaluation Plan
  - MAP Communication Plan

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Proposed Families of Measures

2012 Patient Safety
Care Coordination
Cardiovascular Care
Diabetes Care

2013 Affordability
Population Health
Patient- and Family Engagement
Mental Health

2014 Revisit families as needed
Additional high-impact conditions
Other?

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Proposed MAP Work for 2012:
Key Deliverables

Proposed Deliverables	Proposed Date Due to HHS
Outline of Approach to MAP Strategic Plan	June 1, 2012
• **MAP Strategic Plan for Aligning Performance Measurement** • **Refined MAP Measure Selection Criteria and High-Impact Conditions** • **Families of Measures:** - Cardiovascular Health & Diabetes + cost of care implications - Patient Safety & Care Coordination + cost of care implications	**October 1, 2012**
Measures for High-Need Sub-Populations of Dual Eligible Beneficiaries Interim Report	December 28, 2012
MAP Pre-Rulemaking Input	February 1, 2013
Measures for High-Need Sub-Populations of Dual Eligible Beneficiaries Final Report	July 1, 2013
• Cost of care (e.g., total cost, resource use, appropriateness) • Families of Measures: Population Health, Patient and Family Engagement, and Mental Health	TBD - 2013

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Approach to Developing Families of Measures

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Approach to Families, Gaps, and Phasing

- **Families of Measures and Core Measure Sets**
  - Promote measure alignment through selection of families of measures
  - Encourage best use of available measures in core measure sets for specific HHS and private sector programs
- **Address Measure Gaps**
  - Identify and prioritize gaps; label development vs. implementation gaps
  - Create pathways for gap-filling through engaging public and private measure developers and funders and identifying solutions to barriers
  - Specifically consider eMeasure needs
- **Define Measure Implementation Phasing Strategies**

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Families of Measures

Families of Measures and Core Measure Sets to Align Performance Measurement Across Federal Programs and Public and Private Payers

Family of measures – "related available measures and measure gaps for specific topic areas that span programs, care settings, levels of analysis, and populations" (e.g., care coordination family of measures, diabetes care family of measures)

Core measure set – "available measures and gaps drawn from families of measures that should be applied to specified programs, care settings, levels of analysis, and populations" (e.g., PQRS core measure set, hospital core measure set, dual eligible beneficiaries core measure set)

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MAP Framework for Aligned Performance Measurement: National Quality Strategy

- Working with communities to promote wide use of best practices to enable healthy living
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- Ensuring that each person and family are engaged as partners in their care
- Making care safer by reducing harm caused in the delivery of care
- Promoting effective communication and coordination of care
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models
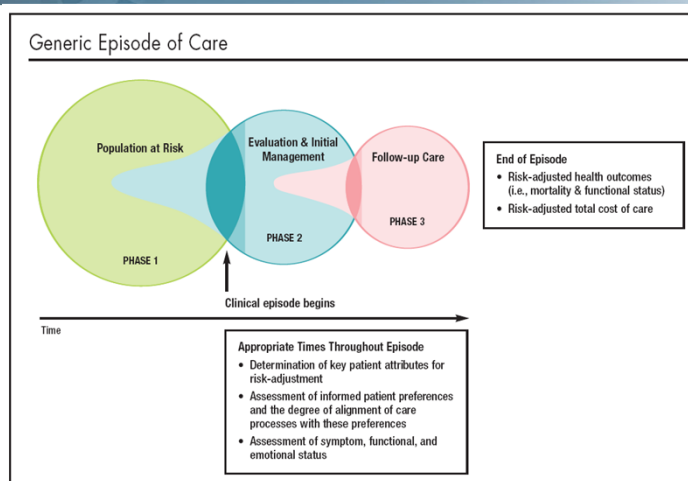
MAP Measure Selection Criteria

1. Measures are NQF-endorsed or meet the requirements for expedited review
2. Adequately addresses each of the National Quality Strategy (NQS) priorities
3. Adequately addresses high-impact conditions relevant to the program's intended population(s)
4. Promotes alignment with specific program attributes, as well as alignment across programs
5. Includes an appropriate mix of measure types
6. Enables measurement across the person-centered episode of care
7. Includes considerations for healthcare disparities
8. Promotes parsimony

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Approach to Developing Measure Families

1. Identify and Prioritize High-Leverage Opportunities for Measurement

- Identification of high-leverage opportunities
  - National Quality Strategy (MSC 2); high-impact conditions (MSC 3)
  - Public-sector efforts: value-based purchasing programs, Partnership for Patients, Million Hearts Campaign
  - Private-sector efforts

- Prioritization of high-leverage opportunities
  - Impact, improvability, inclusiveness
  - Cost- areas of waste, inefficiency, overuse

- Consider how high-leverage opportunities span the patient-focused episode of care (MSC 6)
  - Do the high-leverage opportunities span settings, levels of analysis?
  - How should measures addressing the high-leverage opportunities vary across settings? (e.g., maintenance of function in outpatient settings, improvement of function in acute settings)

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Patient-focused Episode of Care Model

Generic Episode of Care

Population at Risk — PHASE 1

Evaluation & Initial Management — PHASE 2

Follow-up Care — PHASE 3

End of Episode
- Risk-adjusted health outcomes (i.e., mortality & functional status)
- Risk-adjusted total cost of care

Clinical episode begins

Time

Appropriate Times Throughout Episode
- Determination of key patient attributes for risk-adjustment
- Assessment of informed patient preferences and the degree of alignment of care processes with these preferences
- Assessment of symptom, functional, and emotional status

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MAP Glossary for Categorizing Measures

- **Primary Prevention**: Interventions that reduce the risk of disease occurrence in otherwise healthy individuals (e.g., counseling patients to avoid smoking)
- **Secondary Prevention:** Includes screening to identify risk factors for disease or the early detection of a disease among individuals with diabetes or cardiovascular disease (e.g., evaluating blood pressure in adults with coronary artery disease)
- **Treatment and Management:** Services provided to individuals who clearly have a disease, and the goal is to prevent them from developing further complications (e.g., prescribing ACE-I/ARB to diabetic patients with hypertension or proteinuria)

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The "3 I's"

IOM overarching criteria for choosing clinical priority areas:

- **Impact**—the extent of the burden—disability, mortality, and economic costs—imposed by a condition, including effects on patients, families, communities, and societies
- **Improvability**— the extent of the gap between current practice and evidence-based best practice and the likelihood that the gap can be closed and conditions improved through change in an area; and the opportunity to achieve dramatic improvements in the six national quality aims identified in the Quality Chasm report
- **Inclusiveness**— the relevance of an area to a broad range of individuals with regard to age, gender, socioeconomic status, and ethnicity/ race (equity); the generalizability of associated quality improvement strategies to many types of conditions and illnesses across the spectrum of health care (representativeness); and the breadth of change effected through such strategies across a range of health care settings and providers (reach)

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Topic Areas Reviewed

- Primary prevention of Cardiovascular Disease and Diabetes
  - Tobacco use, Nutrition/Activity/Obesity, Lipid screening, Blood pressure screening, Diabetes screening, Aspirin Use
- Appropriateness/Overuse of Services in Cardiovascular Disease and Diabetes
- Diabetes Evaluation and Ongoing Management
  - Glycemic control, Lipid control, Blood pressure control, Lifestyle management
- Diabetes Exacerbation and Complex Treatments
  - Eye care, Nephropathy, Peripheral neuropathy, Dental care
- Cardiovascular Health – Secondary Prevention
  - Lipid control, Blood pressure control, Lifestyle management
- Cardiovascular Health – Treatment
  - Ischemic Heart Disease
  - Stroke/TIA
  - Heart Failure
  - Atrial Fibrillation
- Cardiovascular Health - Rehabilitation

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Approach to Developing Measure Families

2. Scan of Measures that Address the High-Leverage Opportunities

- NQF-endorsed portfolio of measures (MSC 1)
- Measures in federal programs (current measures, and measures under consideration during first year of pre-rulemaking deliberations)
- Available private sector efforts

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Approach to Developing Measure Families

Public Sector Programs Using Cardiovascular/Diabetes Measures:

- Value-Based Payment Modifier
- Physician Quality Reporting System
- Medicare and Medicaid EHR Incentive Program for Eligible Professionals
- Medicare Shared Savings Program
- Hospital Inpatient Quality Reporting
- Hospital Value-Based Purchasing
- Hospital Outpatient Quality Reporting
- Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs
- Home Health Quality Reporting

Public Sector Programs Not Using Cardiovascular/Diabetes Measures:

- Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting
- Inpatient Psychiatric Facility Quality Reporting
- Ambulatory Surgical Center Quality Reporting
- Nursing Home Quality Initiative and Nursing Home Compare Measures
- Inpatient Rehabilitation Facility Quality Reporting
- Long-Term Care Hospital Quality Reporting
- Hospice Quality Reporting
- End Stage Renal Disease Quality Management

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Approach to Developing Measure Families

Sample of Private Sector Programs Considered:

- Choosing Wisely
- Aligning forces for Quality
- eValue8
- Integrated Healthcare Association (IHA)
- Recognition Programs
- Health Plans

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Approach to Developing Measure Families

3. Define the Family for Each High-Leverage Measurement Opportunity

- Considerations for defining the family (MSC 4, 5, 6, 8)
  - Do available measures address the relevant care settings, populations, level of analysis?
  - When appropriate, are measures harmonized across settings, populations, levels of analysis?
  - What are the types of measures available for each setting, population, level of analysis? (preference for outcome measures, when available, and process measures that are most closely linked to outcomes)
- Considerations for affordability, disparities, vulnerable populations

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Approach to Developing Measure Families

4. Establish Gap-Filling Pathways

- Classification of measure gaps
  - Existing measures
    - » Additional refinements
    - » Testing for application to other settings
    - » Need endorsement
    - » eMeasures not available
    - » Implementation gaps
  - Measure development gap
- Determine opportunities to address measure gaps
  - Development barriers (e.g., funding, data sources)
  - Implementation barriers (e.g., feasibility, burden)

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Primary Prevention (population at risk) of Diabetes and Cardiovascular Conditions
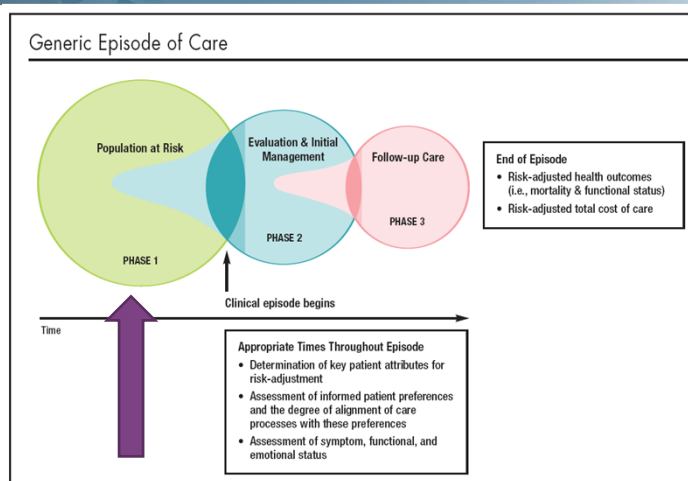
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Patient-focused Episode of Care Model

Primary Prevention

Smoking cessation/tobacco use

- **Impact**
  - 19.3% of adults age 18 and over currently smoke cigarettes (CDC)
  - Cigarette smoking is the leading cause of preventable death in U.S.
  - Cigarette smokers are 2-4 times more likely to develop coronary heart disease, and have about double the risk of stroke
- **Improvability**
  - There are evidence-based guidelines and effective strategies for tobacco use screening and processes/programs to encourage quitting
- **Inclusiveness**
  - Affects a wide range of the population and variety of conditions; higher smoking rates among American Indians/Alaska Natives, adults with lower education levels, and adults below poverty level

Primary Prevention

Nutrition, Exercise, and Weight Management

- **Impact**
  - Healthy diets and regular physical activity are associated with decreased risk of type 2 diabetes, hypertension, obesity, and many other chronic conditions
  - CDC data shows that 36% of adults and 17% of children/adolescents are obese; obesity-related conditions include heart disease, stroke, and type 2 diabetes
- **Improvability**
  - There are a variety of evidence-based interventions recommended to promote physical activity and healthy eating (e.g. CDC Strategy Guides)
  - It is recommended that clinicians screen all adults for obesity and offer intensive counseling and behavioral interventions for obese adults (USPSTF)
- **Inclusiveness**
  - Affects a broad range of individuals, and strategies/capability for change can be applied widely; generally more applicable to outpatient & community settings
  - There are racial and ethnic disparities, as well as geographic variability, in obesity prevalence

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Primary Prevention

Lipid Screening

- **Impact**
  - Individuals with high cholesterol levels have about twice the risk for heart disease
  - There is good evidence that when abnormally high cholesterol levels are identified, lipid-lowering treatment can substantially decrease risk of heart disease
- **Improvability**
  - Lipid disorders are common, but can remain undetected for an extended period due to lack of symptoms
  - Strong evidence-based guidelines exist about screening for lipid disorders in selected sub-populations (e.g. USPSTF)
- **Inclusiveness**
  - Affects a broad range of individuals, and strategies/capability for change can be applied widely; screening most often done in outpatient settings

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Primary Prevention

Blood Pressure Screening

- **Impact**
  - Hypertension is a major risk factor for heart disease and stroke
  - In 2010, hypertension was estimated to cost the U.S. $93 billion (CDC data)
- **Improvability**
  - Per the CDC, around 20% of adults with high blood pressure are not aware that they have it
  - Strong evidence-based guidelines exist about screening for high blood pressure in adults (e.g. USPSTF)
- **Inclusiveness**
  - Affects a broad range of individuals, and strategies/capability for change can be applied widely; screening most often done in outpatient or community settings

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Primary Prevention

Diabetes Screening

- **Impact**
  - Individuals with pre-diabetes have increased risk of type 2 diabetes, heart disease, and stroke
  - Weight loss and increased physical activity can prevent or delay type 2 diabetes
- **Improvability**
  - It is estimated that of the 25.8 million people in the U.S. with diabetes, 7 million are still undiagnosed
  - Evidence-based guidelines exist regarding screening for diabetes in certain at–risk populations, such as individuals with elevated blood pressure (USPSTF)
- **Inclusiveness**
  - Affects a broad range of individuals, but racial and ethnic difference exist in the prevalence of diabetes
  - Strategies/capability for change can be applied widely; screening most often done in outpatient or community settings

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Primary Prevention

Aspirin

- **Impact**
  - Aspirin is an inexpensive intervention that can decrease the incidence of cardiovascular events, including myocardial infarction in men and ischemic strokes in women
- **Improvability**
  - Evidence-based guidelines exist for recommending aspirin use in at–risk populations when the potential benefit outweighs the potential harms (USPSTF)
  - There are significant numbers of individuals who may be at risk of cardiac events despite lack of a previous history of known CHD or stroke
- **Inclusiveness**
  - Affects a broad range of individuals, but age, gender, and racial/ethnic differences exist in the prevalence of risk factors
  - Strategies/capability for change can be applied widely; applies primarily to outpatient or community settings

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Discussion Questions

- Are these the right high-leverage opportunities?
- Are there additional high-leverage opportunities?
- Is this a parsimonious set of high-leverage opportunities?
  - i.e., 2-3 measures addressing each of these opportunities should be incorporated into core sets and program measure sets?

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Available Measures: Primary Prevention

General Considerations

- At what level of analysis are primary prevention measures most actionable?
  - Individual/group, facility, system, population?
  - Screening vs. control?
- Most primary prevention measures assess the pediatric population, adult measures are largely gaps

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Available Measures: Primary Prevention

Lipid Screening/ Blood Pressure Screening (Prevention Tab, Rows 1-7)

- Lipid Screening–1 available measure
  - Not NQF-endorsed
  - Used in the Million Hearts Campaign
  - Screens a subset of the population who have other risk factors

- Blood Pressure Screening—6 available measures
  - Adult Measures to Include
    - » 1 adult measure, used in PQRS and Million Hearts Campaign is not NQF-endorsed
  - Should Child Health Measures be Included?
    - » 2 NQF-endorsed measures that begin at various ages

- Gaps?

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Available Measures: Primary Prevention

Smoking Cessation/Tobacco Use (Prevention Tab, Rows 8-16)

- Adult smoking cessation measures–3 available
  - MAP previously recommended including only one measure (NQF #0028) in federal programs

- Child health smoking measures—2 available
  - The measures include assessment of other risk factors

- Hospital measures—4 available
  - Should the TAM measure recommended for NQF endorsement be included in the family?

- Gaps?

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Available Measures: Primary Prevention

Lifestyle management (Prevention Tab, Rows 17- 24)

- Adult Measures
  - BMI—1 available measure
  - Physical activity—1 available measure for older adults
  - Diet/nutrition—no available NQF-endorsed measures

- Child Health
  - 3 measures assess BMI, physical activity and nutrition counseling

- Gaps?

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Available Measures: Primary Prevention

Diabetes Screening (Prevention Tab, Row 25)

- No available NQF-endorsed measures
- 1 existing measure previously not recommended by MAP
- Gaps?

Aspirin

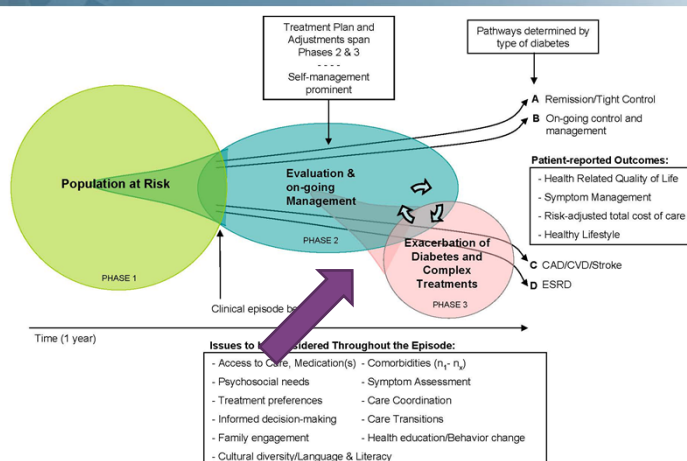- No available NQF-endorsed measures
- Gaps?

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Opportunity for
Public Comment

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Diabetes Evaluation and Ongoing Management; Diabetes Complications

Diabetes Episode of Care

Diabetes Evaluation and Ongoing Management

Glycemic Control

- **Impact**
  - Studies have shown that glycemic control benefits individuals with either type 1 or type 2 diabetes
  - It is estimated that each percentage point drop in A1c blood test levels can reduce the risk of microvascular complications by 40%
- **Improvability**
  - There are effective tests and therapies for glucose control, yet many people with diabetes are not well-controlled
  - Evidence-based guidelines exist regarding assessment and treatment
- **Inclusiveness**
  - Relevant to all individuals with diabetes; chronic management tends to be most applicable to outpatient or LTC settings, with different acute care needs
  - Strategies/capability for change can be applied widely but may be more challenging for some sub-populations (e.g. children and elderly)

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Diabetes Evaluation and Ongoing Management

Lifestyle Management and Vaccination

- **Impact**
  - Healthy eating and physical activity can be effective, relatively low-cost mechanisms to manage diabetes with low risk of adverse effects
  - Smoking cessation decreases risk of cardiovascular events and other complications among individuals with diabetes
  - Influenza, Pneumococcal, and Hep B vaccination can help prevent serious illnesses to which a person with diabetes may be particularly susceptible
- **Improvability**
  - Studies such as the Look AHEAD trial have provided evidence that lifestyle management can achieve weight loss, improve control of diabetes, and decrease cardiovascular risk
  - Influenza and Pneumococcal immunization rates in younger adults with diabetes are suboptimal
- **Inclusiveness**
  - Relevant to all individuals with diabetes; chronic management tends to be most applicable to outpatient or LTC settings

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Diabetes Evaluation and Ongoing Management

Blood Pressure Control

- **Impact**
  - In general, approximately every 10 mmHg reduction in systolic BP results in a 12% decrease in risk of diabetes complications
  - Among individuals with diabetes, improved control of blood pressure can reduce risk of cardiovascular disease by 33-50%
- **Improvability**
  - While approximately 1 in 3 American adults have problems with high blood pressure, the condition is not well-controlled in half of these individuals
  - Evidence-based guidelines exist for blood pressure management among individuals with diabetes
- **Inclusiveness**
  - Relevant to all individuals with diabetes; chronic management tends to be most applicable to outpatient or LTC settings, with different acute care needs
  - Strategies/capability for change apply widely

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Diabetes Evaluation and Ongoing Management

Lipid Control

- **Impact**
  - Individuals with type 2 DM have increased prevalence of abnormal lipid levels, a factor in their higher risk of CVD
  - Improved control of LDL cholesterol may decrease cardiovascular complications by 20-50%
- **Improvability**
  - Almost two-thirds of adults with history of high LDL cholesterol do not have their levels under control
  - Evidence-based guidelines exist for lipid management among individuals with diabetes
- **Inclusiveness**
  - Relevant to all individuals with diabetes; chronic management tends to be most applicable to outpatient or LTC settings, with different acute care needs
  - Strategies/capability for change apply widely

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Diabetes Exacerbation and Complex Treatments

Dental Care

- **Impact**
  - Periodontal disease is more common in people with diabetes. Young adults with diabetes have about twice the risk as those without diabetes
  - Around one-third of people with diabetes have severe periodontal disease, including loss of attachment of gums to the teeth
- **Improvability**
  - Controlling blood glucose levels, consistent dental self-care, and regular visits to a dentist are generally recommended to help prevent serious mouth problems; however, evidence-based guidelines are limited
- **Inclusiveness**
  - Relevant to all individuals with diabetes; chronic management tends to be most applicable to outpatient or LTC settings
  - Strategies may need to be tailored based on the population due to social and environmental factors

Diabetes Exacerbation and Complex Treatments

Peripheral Neuropathy

- **Impact**
  - In 2008, over 70,000 people with diabetes had a leg or foot amputated; people with diabetes are 8x as likely to lose a leg or foot to amputation
- **Improvability**
  - Comprehensive foot care programs can reduce amputation rates by 45-85%
  - Studies indicate that good blood sugar control slows the onset and progression of complications that can lead to lower extremity complications
- **Inclusiveness**
  - Relevant to all individuals with diabetes; chronic management tends to be most applicable to outpatient or LTC settings

Diabetes Exacerbation and Complex Treatments

Eye Care

- **Impact**
  - Diabetes is the leading cause of blindness among adults age 20-74 years old
  - More severe or poorly controlled diabetes over a longer period increases the risk of retinopathy
  - Symptoms of diabetic retinopathy usually do not occur until after severe eye damage
- **Improvability**
  - Detecting and treating diabetic eye disease with laser therapy can decrease severe vision loss by about 50-60%
  - About 65% of adults with diabetes and poor vision can be helped by eyeglasses
- **Inclusiveness**
  - Relevant to all individuals with diabetes; chronic management tends to be most applicable to outpatient or LTC settings
  - Disparities in age, race, and ethnicity exist in obtaining periodic eye exams

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Diabetes Exacerbation and Complex Treatments

Nephropathy

- **Impact**
  - Diabetes is the leading cause of kidney failure (44% of all new cases); in 2008, a total of 202,290 people with ESRD due to diabetes were on chronic dialysis or had previously had a kidney transplant
  - Development of severe kidney disease significantly impairs quality of life and increases costs of care
- **Improvability**
  - Detecting and treating early diabetic kidney disease by lowering BP can reduce decline in kidney function by 30-70%
  - ACEIs and ARBs reduce proteinuria by about 35%
- **Inclusiveness**
  - Relevant to all individuals with diabetes, though disparities exist (e.g. African Americans are more likely than whites to develop ESRD); chronic management tends to be most applicable to outpatient or LTC settings

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Discussion Questions

- Are these the right high-leverage opportunities?
- Are there additional high-leverage opportunities?
- Is this a parsimonious set of high-leverage opportunities?
  - i.e., 2-3 measures addressing each of these opportunities should be incorporated into core sets and program measure sets?

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Available Measures: Diabetes

High Leverage Opportunity	# Available Measures
Glycemic Control	11
Lifestyle Management	1
Blood Pressure Control	7
Lipid Control	9
Dental Care	0
Peripheral Neuropathy	10
Eye Care	7
Nephropathy	3

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Available Measures: Diabetes Treatment and Management

Glycemic Control/HbA1c (Diabetes Tab, Rows 1- 11)

- Should HbA1c testing measures be included in the measure set?
- Should measures of good control and poor control be incorporated in the family?
  - HbA1c <7%, HbA1c <8%, HbA1c >9%,
- Should medication adherence (MPR/PDC) be included in the family?
- Should evidence of self testing be included in the family?
- Gaps?

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Available Measures: Diabetes Treatment and Management

Lifestyle Management (Diet/nutrition, Activity/Exercise, Weight/Obesity) and Smoking Cessation (Diabetes Tab, Row 12)

- 1 available NQF-endorsed measure for tobacco use
- Are disease-specific lifestyle management measures needed?

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Available Measures: Diabetes Treatment and Management

Blood Pressure Control (Diabetes Tab, Rows 13-19)

- Blood Pressure Management (NQF# 0061) crosses all levels of analysis and is used in multiple programs

- Should medication management be included in the family?

- Gaps?

Available Measures: Diabetes Treatment and Management

Lipid Control (Diabetes Tab, Rows 20-26)

- Should lipid testing measures be included in the family?

- Diabetes measure pair (NQF#0064) crosses all levels of analysis and is used in multiple programs

- Should medication management be included in the family?

- Gaps?

Available Measures: Exacerbation of Diabetes and Complex Treatments

Peripheral Neuropathy (Diabetes Tab, Rows 27-36

- Diabetes Mellitus: Foot Exam (NQF# 0056) crosses all levels of analysis and is used in multiple programs

- Should patient education regarding foot care be included in the family?

- Gaps?

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Available Measures: Exacerbation of Diabetes and Complex Treatments

Eye Care (Diabetes Tab, Rows 37-43)

- Eye Exam (NQF#0055) crosses all levels of analysis and is used in multiple programs

- Should diabetic retinopathy management be included in the family?

- Should patient experience regarding eye care be included in the family?

- Gaps?

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Available Measures: Exacerbation of Diabetes and Complex Treatments

Nephropathy (Diabetes Tab, Rows 44-46)

- Urine Protein screening (NF#0062) crosses all levels of analysis and is used in multiple programs
- Gaps?

Dental Care

- No NQF-endorsed measures

Available Measures: Diabetes

Incidence of Complications (Diabetes Tab, Rows 47- 52)

- Should incidence of avoidable complication measures be included in the family?
  - AHRQ PQI's (prevention quality indicators)?
  - Bridges to Excellence avoidable complications measure?

- Gaps?

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Public Comment

Diabetes Composite Measures

Diabetes Composites

Should a composite be selected to address multiple high leverage opportunities? (Diabetes Tab, Rows 53-55)

- NQF # 0729 Optimal Diabetes Care *(MN Community Measurement)*
  - Each individual component of the measure can be reported separately
  - All-or-none composite
- NQF # 0731 Comprehensive Diabetes Care *(NCQA)*
  - The measure combines several other NQF-endorsed measures
  - The composite is calculated as the sum of all numerators over the sum of all denominators
- ABIM Measure (not NQF-endorsed)

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	NQF #0729	NQF #0731	ABIM Measure (Not Endorsed)
Glycemic Control	• HbA1c (<8%)	• HbA1c poor control (>9%) • HbA1c control (<8%) • HbA1c control (<7%) for selected populations	• HbA1c poor control (>9%) • HbA1c at control
Lifestyle Management	• Tobacco non-user	• Smoking status and cessation advice or treatment	• Smoking status, cessation advice, and treatment
Blood Pressure Control	• BP (<140/90 mmHg)	• BP control (<140/90 mmHg)	• BP poor control (>140/90 mmHg) • BP superior control (<130/80)
Lipid Control	• LDL- C (<100 mg/dL)	• LDL-C screening • LDL- C control (<100 mg/dL)	• LDL- C poor control (>130 mg/dL) • LDL- C superior control (<100 mg/dL)
Dental Care			
Peripheral Neuropathy			• Podiatry exam
Eye Care		• Eye exam (retinal) performed	• Ophthalmologic exam
Nephropathy		• Medical attention for nephropathy	• Nephropathy assessment for eligible patients
Other	• Daily aspirin for patients with IVD		

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Measurement Priorities for Cardiovascular Care

Cardiac Episode of Care

Context for Considering an AMI Episode

Population at Risk

1° Prevention
(no known CAD)

2° Prevention
(CAD with no prior AMI)

2° Prevention
(CAD with prior AMI)
Advanced Care Planning

PHASE 1

Staying Healthy

Acute Phase

Assessment of Preferences

PHASE 2

Getting Better

Post Acute/ Rehabilitation Phase

PHASE 3

2° Prevention

PHASE 4

Living w/ Illness/Disability (T1)
Coping w/ End of Life (T2)

Post-AMI Trajectory 1 (T1)
Relatively healthy adult

Focus on:
• Quality of Life
• Functional Status
• 2° Prevention Strategies
• Rehabilitation
• Advanced Care Planning

Post-AMI Trajectory 2 (T2)
Adult with multiple co-morbidities

Focus on:
• Quality of Life
• Functional Status
• 2° Prevention Strategies
• Advanced Care Planning
• Advanced Directives
• Palliative Care/Symptom Control

EPISODE BEGINS
Onset of Symptoms

EPISODE ENDS
1 Year Post-AMI

Cardiovascular Health – Secondary Prevention

Lipid and Blood Pressure Control
- **Impact**
  - The number of people living with cardiovascular disease has increased as the general population ages, with CHD being the leading cause of death in the U.S.
  - Among individuals with existing cardiovascular disease, maintaining desirable lipid and blood pressure levels can reduce risk of MI and death, as well as the need for heart bypass surgery or angioplasty
- **Improvability**
  - Evidence-based guidelines and effective therapies exist for lipid and blood pressure management for individuals with cardiovascular disease; NHLBI ATP and JNC guideline updates are anticipated to be released this year
  - Studies on the use of recommended therapies indicate that many patients with cardiovascular disease are not receiving optimal therapy
- **Inclusiveness**
  - Applies to a broad population of individuals with CHD or CHD equivalents; chronic management tends to be most applicable for outpatient or LTC settings

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Cardiovascular Health – Secondary Prevention

Lifestyle Management and Vaccines
- **Impact**
  - Healthy eating, exercise, weight management, and avoidance of tobacco and heavy alcohol use can all reduce risk of cardiovascular events among individuals with established cardiovascular disease
  - Influenza and Pneumococcal vaccinations are recommended for individuals with CVD to reduce complications of infection
  - Such interventions have the potential to make substantial impacts at a population level, with relatively small risk of adverse events
- **Improvability**
  - Evidence-based guidelines exist for recommended approaches to promote smoking cessation, increased physical activity, weight management, and immunization
  - Studies indicate that many patients with cardiovascular disease are not receiving appropriate counseling or other interventions
- **Inclusiveness**
  - Applies to a broad population; chronic management tends to be most applicable to outpatient or community settings

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Ischemic Heart Disease - Treatments

Medication therapy

- **Impact**
  - About 935,000 heart attacks occur in the U.S. annually, resulting in approximately 130,000 deaths
  - Antithrombotic therapy can have a major impact in acute settings, as well as for long-term prevention of cardiac events
  - Beta blockers and ACEIs/ARBs are highly effective long-term treatments in appropriate patients
  - Other medications may play a useful role for select populations
- **Improvability**
  - Evidence-based guidelines exist for medication therapy in different settings and sub-populations of patients with ischemic heart disease (e.g. ACC/AHA)
  - Studies on use of recommended therapies show that many patients with cardiovascular disease are not receiving indicated medications or are not consistently adherent to their regimens
- **Inclusiveness**
  - Applies to a broad range of individuals with ischemic heart disease, and includes multiple settings; risk of adverse medication effects is higher in the elderly

Ischemic Heart Disease - Treatments

Procedures

- **Impact**
  - Coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI), and related procedures can be used very effectively in select sub-populations of patients with ischemic heart disease
  - Procedural treatment is more often indicated for severe and/or acute-care issues
  - Some attention has been give to potential overuse of interventional cardiac procedures
- **Improvability**
  - Evidence-based guidelines exist for use of interventional procedures in various sub-populations of patients with ischemic heart disease (e.g. ACC/AHA)
  - A notable amount of variation in use of procedures by region indicates there may be opportunities to improve adherence to guidelines
- **Inclusiveness**
  - Applies to a broad range of individuals with ischemic heart disease, but more applicable to inpatient settings

Stroke/TIA - Treatments

- **Impact**
  - Approximately 795,000 people have a stroke each year in the U.S.; estimated direct and indirect costs of stroke were $53.9 billion in 2010
  - Acute management with thrombolytic therapy and/or other interventions is a critical factor in the disposition of patient outcomes
  - Sub-acute and long-term management include consideration for antithrombotic therapy, control of risk factors/complications, potential need for revascularization, and addressing rehabilitation
- **Improvability**
  - Evidence-based guidelines exist for treatment of stroke (e.g. AHA/ASA)
  - Several large studies have indicated that stroke guideline adherence is lower than desired; efforts such as the Get With The Guidelines® program from the AHA/ASA are striving for improvement
- **Inclusiveness**
  - Applies to a broad range of individuals; acute management issues occur predominately within inpatient settings and longer-term management shifts to outpatient and LTC settings

Heart Failure - Treatments

- **Impact**
  - In the U.S., approximately 5.8 million people have heart failure (HF); estimated costs of HF in 2010 were $39.2 billion
  - Appropriate management includes monitoring signs/symptoms, addressing modifiable risk factors, medication therapy (ACEIs/ARBs, diuretics, beta blockers, and/or aldosterone antagonists) as appropriate, and consideration for ICD and cardiac resynchronization therapy when indicated
- **Improvability**
  - Evidence-based guidelines exist for treatment of HF (e.g. ACC/AHA)
  - Heart failure death rates vary substantially by region; age-adjusted rate (among those 65+) per 100,000 in the U.S. ranged from 41.6 to 344.3 in 2006
- **Inclusiveness**
  - Applies to a broad population, though more in elderly; management issues can apply across settings, with acute exacerbations mainly inpatient

Atrial Fibrillation - Treatments

- **Impact**
  - A-fib is the most common arrhythmia; affected about 2.66 million people in 2010, but estimated to be up to 12 million in 2050
  - Estimated cost for treatment of atrial fibrillation in 2005 was $6.65 billion
  - Treatments include lifestyle changes, medications for heart rate and/or rhythm control, as well as surgery; anti-thrombotic therapy is also an important consideration to decrease stroke risk
- **Improvability**
  - Evidence-based guidelines exist for management (e.g. ACCF/AHA/HRS)
  - Use of recommended therapy, such as antithrombotic therapy in high-risk patients, is suboptimal
- **Inclusiveness**
  - Applies to a fairly broad population, incidence increases with age; many management issues apply across settings, though acute complications are most often handled as an inpatient

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Cardiovascular Rehabilitation

- **Impact**
  - Many cardiovascular conditions/events produce long-term consequences
  - There is evidence that cardiac rehabilitation can improve outcomes in certain patients, particularly post-MI
  - Certain components of rehabilitation may be more efficacious than others
- **Improvability**
  - Consensus recommendations exist for appropriate composition and utilization of cardiac rehabilitation programs (e.g. AACVPR/AHA)
  - Opportunities exist for expanding adoption of successful programs and enhancing standardization of care
- **Inclusiveness**
  - Applies to a broad population of individuals with cardiovascular conditions, but most often to those with more severe disease
  - Issues are relevant across a variety of settings as patients transition through various phases of treatment

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Discussion Questions

- Are these the right high-leverage opportunities?
- Are there additional high-leverage opportunities?
- Is this a parsimonious set of high-leverage opportunities?
  - i.e., 2-3 measures addressing each of these opportunities should be incorporated into core sets and program measure sets?
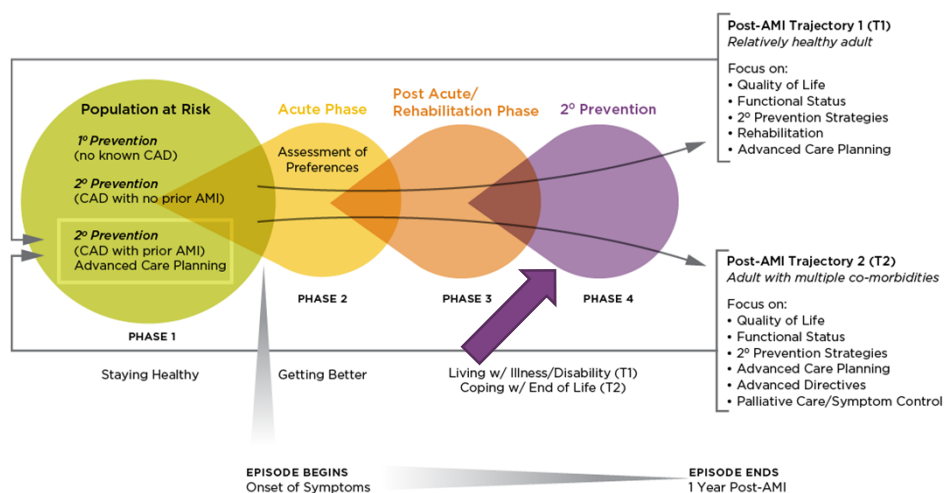
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Cardiovascular:
Secondary Prevention

Cardiac Episode of Care

Context for Considering an AMI Episode

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Available Measures: Cardiovascular, Secondary Prevention

Blood Pressure Control/Lipid Control (CV Secondary Prevention Tab)

- Should testing measures be included in the family?
- Should the family include measures assess blood pressure control for three population subsets?
  - Hypertension
  - Coronary artery disease;
  - Previous diagnosis of cardiovascular conditions?
- Should medication management measures be included in the family?
- Are disease specific lifestyle management measures needed?
- Consideration of composites
  - Optimal vascular care (NQF #0076) address LDL, blood pressure, tobacco use, daily aspirin use for adults with IVD

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Cardiovascular:
Stroke

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Cardiac Episode of Care

Context for Considering an AMI Episode

Post-AMI Trajectory 1 (T1)
Relatively healthy adult

Focus on:
• Quality of Life
• Functional Status
• 2° Prevention Strategies
• Rehabilitation
• Advanced Care Planning

Population at Risk

1° Prevention
(no known CAD)

2° Prevention
(CAD with no prior AMI)

2° Prevention
(CAD with prior AMI)
Advanced Care Planning

Acute Phase

Assessment of Preferences

**Post Acute/
Rehabilitation Phase**

2° Prevention

PHASE 2   PHASE 3   PHASE 4

PHASE 1

Staying Healthy   Getting Better   Living w/ Illness/Disability (T1)
Coping w/ End of Life (T2)

Post-AMI Trajectory 2 (T2)
Adult with multiple co-morbidities

Focus on:
• Quality of Life
• Functional Status
• 2° Prevention Strategies
• Advanced Care Planning
• Advanced Directives
• Palliative Care/Symptom Control

EPISODE BEGINS
Onset of Symptoms

EPISODE ENDS
1 Year Post-AMI

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Stroke sub-topics

Should each of these topics be included in the measure family?

- Acute – Diagnostic
- Acute – Treatment
- Functional status
- Rehabilitation
- Stroke-specific secondary prevention
- Mortality
- Patient-education

Available Measures – Stroke

Acute – Diagnostic (Stroke spreadsheet, rows 1-4)

- CT scan interpretation within 45 minutes (NQF #0661) used in OQR program and at facility level

- *Submitted* CT/MRI reports #2017 adds clinician (individual, group, team) level of analysis, broadens measure scope

- Gaps?

Available Measures – Stroke

Acute – Treatment (Stroke spreadsheet, rows 5-12)

- Should both thrombolytic and antithrombotic measures be included in the family?
  - Thrombolytic Therapy NQF #0437, crosses multiple levels of analysis and is used in multiple programs
  - Antithrombotic Therapy By End of Hospital NQF #0438 cross multiple levels of analysis and is used in multiple programs

- Gaps?

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Available Measures – Stroke

Functional Status (Stroke spreadsheet, rows 13-25)

- Should functional status measures be included in the family?
  - Should functional status measures be condition-specific? OR
  - Should functional status measures address multiple conditions/populations?

- Gaps?

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Available Measures – Stroke

Rehabilitation (Stroke spreadsheet, rows 26-27)

- Should stroke-specific rehab measures be included in the family?
  - Assessment for rehab?
  - Ordering rehab services?
  - Outcomes resulting from rehab?

- Gaps?

Available Measures – Stroke

Secondary Prevention (Stroke spreadsheet, rows 28-32)

- Should stroke-specific secondary prevention measures be included in the family? OR
- Should stroke be incorporated into broader cardiovascular-secondary prevention measures?

Education (Stroke spreadsheet, row 33)

- Should stroke-specific patient education measures be included in the family?

Available Measures – Stroke

Mortality (Stroke spreadsheet, rows 34-36)

- Should mortality measures be included in the family?

- Gaps?

Affordability Measures for Diabetes and Cardiovascular Care

Appropriateness/Overuse of Services

- **Impact**
  - Unnecessary tests and procedures waste health care resources and have the potential to do harm
  - Costs may be significant – e.g. for Cardiovascular disease: Kale et al estimated excess direct costs of using expensive brand-name statins for initiating lipid-lowering therapy at around $5.8 billion per year, and of annual ECGs by adults presenting for general medical exams to be $6-$38 million
- **Improvability**
  - It is estimated that as much as 30% of care is duplicative or unnecessary; recommendations for avoiding certain tests or treatments based on evidence (or lack thereof) have begun to emerge, such as the Choosing Wisely® campaign
- **Inclusiveness**
  - Affects a broad range of individuals; strategies/capability for change can be applied widely, though is more applicable in certain regions

Sources: Kale et al 2011. *"Top 5" Lists Top $5 Billion*. Arch Intern Med 171(20):1856-58.
Choosing Wisely. ABIM Foundation. http://choosingwisely.org/wp-content/uploads/2012/04/032912_Choosing-Wisely-One-Pager.pdf (last accessed June, 2012)

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Discussion Questions

Affordability Tab

- Should any of the available overuse measures be included in the family? (Rows 1-4)

- Should any of the available resource use measures be included in the family? (Rows 5-9)

- Gaps?

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**Consensus
Standards for Cost
and Resource Use**

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Taroon Amin, MA, MPH
Senior Director, Performance Measures

Ashlie Wilbon, RN, MPH
Senior Project Manager, Performance Measures

June 25, 2012

Defining Resource Use Measures

- Broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (may include diagnoses, procedures, or encounters).

  - A resource use measure counts the frequency of defined health system resources; some further apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit of resource.

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Resource Use: A Building Block

Value

Stakeholder Preference

Efficiency

Quality

Time

Costs/resources used to provide care

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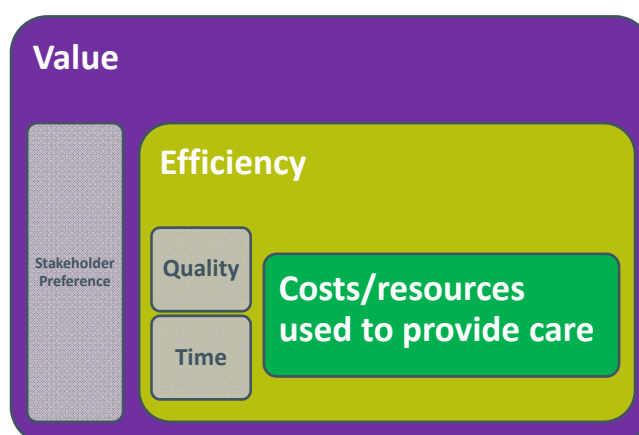
Endorsed Resource Use Measures

- Endorsed January 30, 2012:
  - 1598: Total Resource Use Population-based PMPM Index (HealthPartners)
  - 1604: Total Cost of Care Population-Based PMPM Index (HealthPartners)
  - 1558: Relative Resource Use for People with Cardiovascular Conditions (NCQA)
  - 1557: Relative Resource Use for People with Diabetes (NCQA)
- Endorsed March 30, 2012:
  - 1560: Relative resource use for people with asthma (*NCQA*)
  - 1561: Relative resource use for people with COPD (*NCQA*)
  - 1609: ETG-based hip/knee replacement cost-of-care (*Ingenix*)
  - 1611: ETG-based pneumonia cost-of-care (*Ingenix*)

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Comparing Approaches

	HealthPartners	NCQA	Ingenix
Measure Type	Per-capita	Condition-specific Per-capita	Episode-based
Data Sources	Administrative Claims	Administrative Claims, EHR, Imaging/Diagnostic Study, Laboratory, Pharmacy, Registry, Paper Records	Administrative Claims
Lowest Level of Analysis	Physician group	Physician Group	Physician
Tested Population	Commercial	Commercial, Medicaid, Medicare	Commercial
Risk adjustment	Johns Hopkins ACG's	HCC's	ETG-based
Costing Approach	Actual prices paid & Standardized prices	Standardized Prices	Actual prices paid
Proprietary components (Y/N)	Yes	No	Yes
Endorsed Measures	Total cost of care, Total resource use	Asthma, COPD, **Cardiovascular, Diabetes**	Pneumonia, hip and knee replacement

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Overarching Issues

- Reliability and validity testing at the individual physician level
- Appropriateness of actual/standardized costing in various applications
- Evaluating single measures that are part of a grouper system
- Proprietary components within measures
- Implications of carve out arrangements (e.g., mental health, pharmacy)
- Linking quality and cost measures to determine efficiency

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Challenges in implementing cost/resource use measures as national consensus standards

- Intended use matters –Align with appropriate:
  - Level of analysis
  - Costing approach
  - Sample size
  - Attribution approach

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Measurement Gaps

- All populations
- Expanded condition-specific measures
- Measures using actual prices
- Linking cost/resource use measures and quality
- Future work should address and prioritize gaps

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Next Steps & Future Work in Cost and Resource Use Measurement

- Final report (April 2012)
- Proposed resource use work for 2012
  - Guidance Report on Measurement Considerations and Recommendations for Updates to the NQF Resource Use Measure Submission Form
    - To address methodological challenges encountered in the first project; consider approaches to measuring efficiency
  - Resource Use Endorsement Project: Expanded Populations
    - Evaluation of cost per beneficiary measures for Medicare

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Questions?

Taroon Amin, MA, MPH

- Senior Director
- tamin@qualityforum.org
- 202-559-9470

Ashlie Wilbon, RN, MPH

- Senior Project Manager
- awilbon@qualityforum.org
- 202-559-9478

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Summary of Day and Next Steps

Adjourn

Next Meeting:
Tuesday, July 17, 2012

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Approach to the Strategic Plan

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MAP GOAL AND OBJECTIVES

In pursuit of the aims, priorities, and goals of the National Quality Strategy (NQS), the Measure Applications Partnership (MAP) informs the selection of performance measures to achieve the goal of improvement for clinicians and providers, transparency for consumers and purchasers, and value for all. MAP's objectives are to:
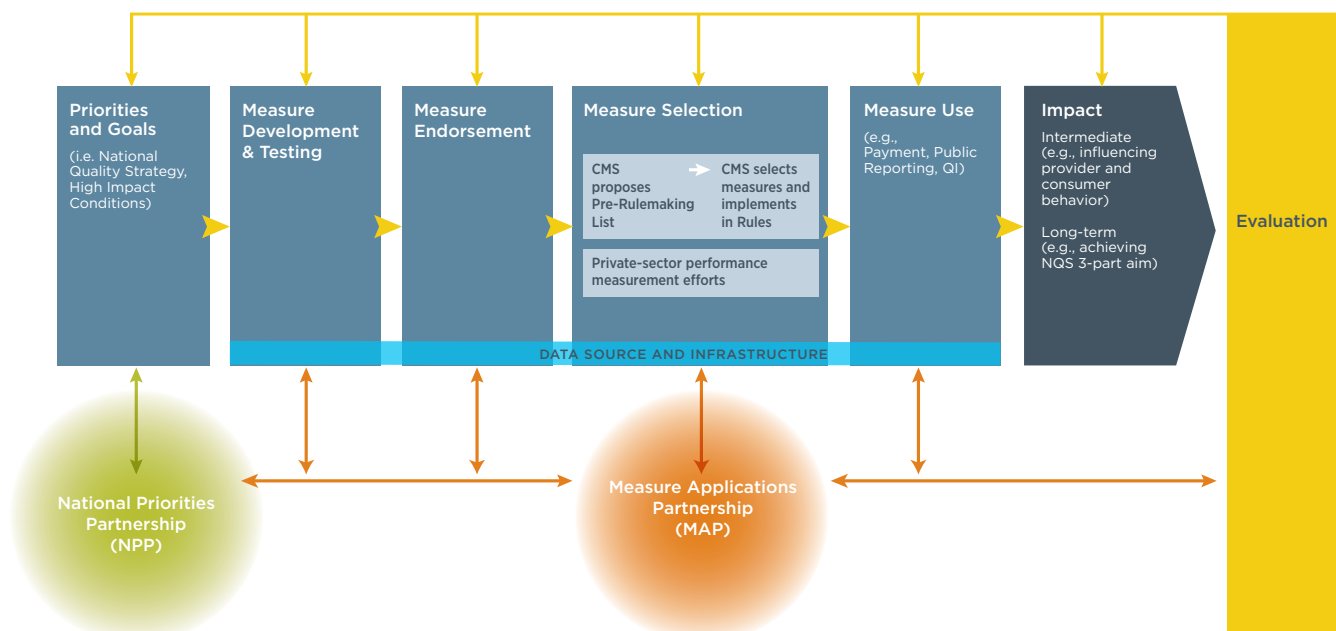
1. Ensure performance measures are high-impact, relevant, actionable, and drive toward realization of the NQS;

2. Stimulate gap-filling for high-priority measure gaps;

3. Promote alignment of performance measurement across Department of Health and Human

Services (HHS) programs and between public and private initiatives; and

4. Ensure MAP's recommendations are relevant to public and private stakeholders and its processes are effective.

Many stakeholders are engaged in performance measurement efforts to achieve the goals of the NQS. These efforts comprise the Quality Measurement Enterprise (Figure 1) and include priority and goal setting, measure development and testing, measure endorsement, measure selection and use for various purposes, and determining impact.

FIGURE 1. QUALITY MEASUREMENT ENTERPRISE

MAP, a public-private partnership, works collaboratively with the stakeholders across the Quality Measurement Enterprise to ensure that the application of performance measures achieves improvement, transparency, and value. Each objective relates to various functions of the Quality Measurement Enterprise.

Objective 1

Ensure performance measures are high-impact, relevant, actionable, and drive toward realization of the NQS. MAP's primary purpose, as specified in the Affordable Care Act (ACA), is to provide input to HHS on selecting performance measures for numerous accountability applications, such as public reporting, performance-based payment, and health information technology incentives tied to "meaningful use." This input to HHS includes recommendations for applying the best available measures and prioritization of measure gaps to guide policymakers' decision-making. NQF-endorsement is a threshold criterion for selecting measures that are important, scientifically acceptable, feasible, and useful for accountability purposes and quality improvement.

Objective 2

Stimulate gap-filling for high-priority measure gaps. MAP, through collaboration with HHS and private entities, will develop pathways to provide solutions for filling gaps, including but not limited to, defining measure ideas to address gap areas; identifying needed funding for measure development, testing, and endorsement; engaging measure developers; facilitating the construction of test beds for measure testing; and identifying opportunities to build mechanisms for efficient collection and reporting of data.

Objective 3

Promote alignment of performance measurement across HHS programs and between public and private-sector initiatives. Aligned performance measurement is important to send clear direction and provide strong incentives to providers and clinicians regarding desired health system change. Performance measures should align across settings, programs, populations, and payers in order to provide a comprehensive picture of quality. Strategically aligning public and private payment and public reporting programs will encourage delivery of patient-centered care and reduce providers' data collection burden.

Objective 4

Ensure MAP's recommendations are relevant to public and private stakeholders and its processes are effective. MAP's careful balance of interests is designed to provide HHS and the field with thoughtful input on performance measure selection. MAP must leverage its relationships with various healthcare stakeholders to promote MAP's recommendations and ensure that MAP's input is considered across the Quality Measurement Enterprise.

MAP STRATEGIES AND TACTICS

To date, MAP has generated program- and measure-specific recommendations to HHS, developed coordination strategies for performance measurement across public- and private-sector programs, and identified and prioritized measure gaps. Over the next three years, MAP plans to engage in several strategies and tactics to operationalize the MAP objectives. While each strategy and tactic can address multiple MAP objectives, the table below indicates the primary objectives each strategy and tactic addresses. For each objective, MAP will identify indicators of success.

TABLE 1. MAP STRATEGIES AND TACTICS

GOAL	OBJECTIVES	STRATEGIES/TACTICS	BY 2015, MAP WILL…
Apply performance measures to achieve improvement, transparency, and value, in pursuit of the aims, priorities, and goals of the National Quality Strategy	**1.** Ensure performance measures are high-impact, relevant, actionable, and drive toward realization of the NQS	• Families of Measures and Core Measure Sets • MAP Measure Selection Criteria • MAP Analytics Plan • Measure Implementation Phasing Strategies	*TBD—Indicators of success to be developed as part of the Strategic Plan*
	2. Stimulate gap-filling for high-priority measure gaps	• Families of Measures and Core Measure Sets • Addressing Measure Gaps	
	3. Promote alignment of performance measurement across HHS programs and between public and private initiatives	• Families of Measures and Core Measure Sets • MAP Communication Plan	
	4. Ensure MAP's recommendations are relevant to public and private implementers and its processes are effective	• MAP Evaluation Plan • MAP Communication Plan	

Families of Measures and Core Measure Sets

In accordance with MAP's objectives to identify best measures and align performance measurement, MAP will identify families of measures—sets of related available measures and measure gaps that span programs, care settings, and levels of analysis—for each of the NQS priority areas. The measure families will inform the development and revision of core measure sets for specific programs or settings. For example, a care coordination measure family might identify aligned care transitions measures across settings and levels of analysis. Core sets, pulled from the care coordination family, would contain the care transitions measures that address the highest-leverage opportunities for improvement in a particular program or setting. Figure 2 illustrates the concept of families of measures and core measure sets.

FIGURE 2. FAMILIES OF MEASURES AND CORE MEASURE SETS
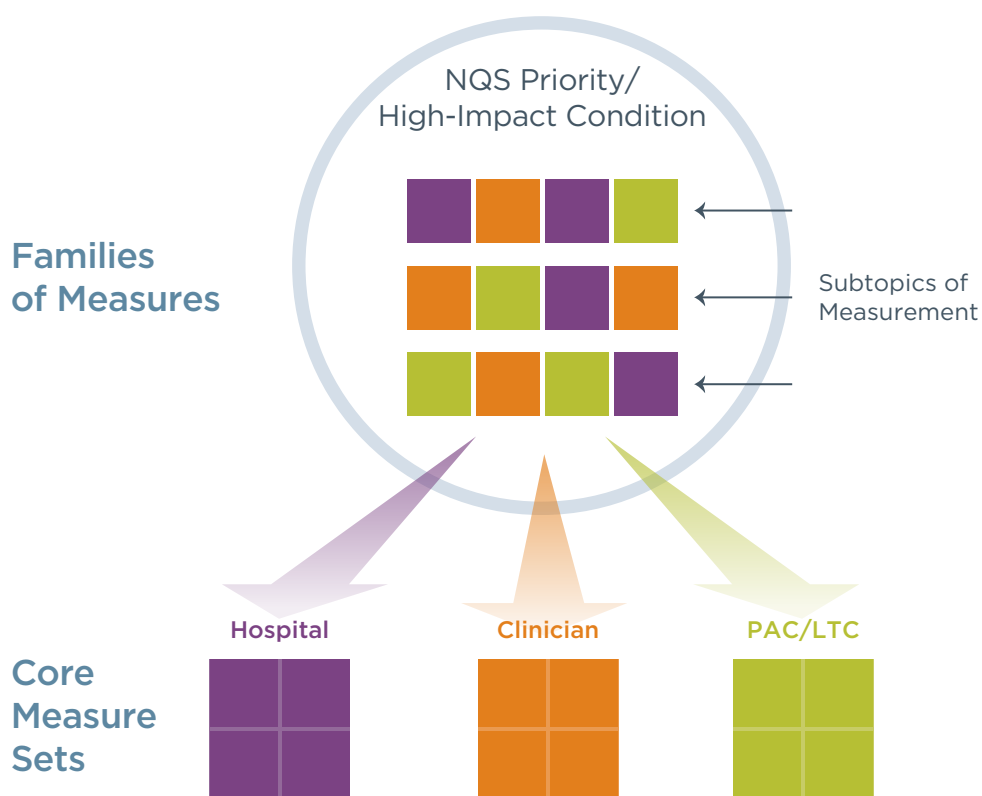
Identification of measure families and core measure sets will build on the high-leverage strategic opportunities and national-level measures in the NQS 2012 Annual Progress Report and reports from the National Quality Forum's (NQF's) measure endorsement process. National Priorities Partnership (NPP) and endorsement project Steering Committee liaisons will serve on the MAP task forces devoted to developing measure families to provide insight on the input to the NQS and endorsement recommendations. Additionally, MAP will build on private- and public-sector efforts to select measures; for example, the HHS Interagency Working Group on Healthcare Quality is engaging in efforts to align and coordinate performance measurement efforts across federal programs. Each task force includes MAP members who are federal liaisons.

Addressing Measure Gaps

Critical measure gaps—such as patient-reported functional status, cost, care coordination, patient engagement, and shared decision making—persist across settings and programs despite being previously identified as high-priority gaps. MAP will help facilitate a coordinated strategy for gap filling among public and private entities by engaging measure developers and those who fund measure development, and by identifying solutions to implementation barriers. For measure development gaps, where measures currently do not exist, MAP will propose strategies to engage measure developers. Such strategies may include identifying where existing measures may need additional testing for application to other settings, bringing tested measures in for NQF endorsement, and prioritizing gaps to signal to funders where measure development is most needed. As part of the gap-filling approach, MAP will identify opportunities to promote the development of eMeasures. For implementation gaps, where measures exist but are not included in a particular program, MAP will proactively identify and propose solutions to the implementation barriers that perpetuate the implementation gaps.

Define Measure Implementation Phasing Strategies

MAP recognizes that its recommendations must consider strategies to quickly and deliberately transition from the current measure sets to ideal measure sets. Phasing strategies will address how a program's purpose transitions over time; for example, some federal programs transition to pay for performance after several initial years as a public reporting program. Phasing strategies must also consider the evolving mechanisms for data collection, including systems capability and capacity, best practices for collecting data needed for robust measurement, and interim strategies for data collection. For example, MAP would identify which measures in a program should be phased out as more person-centered, cross-cutting, and health information technology (HIT)-enabled measures become available. MAP will engage stakeholders to provide input on the feasibility of MAP's phasing strategies. For example, the NPP affinity groups will provide input on how MAP's phasing strategies will address the real-world implementation challenges of measurement.

MAP Analytics Plan

In its first year, MAP emphasized the need for MAP's decision making to be more analysis-driven, informed by measure data and experience in the field. MAP has identified several types of information needed to inform MAP's decisions. Information on current performance gaps highlights the high-leverage opportunities for performance measurement. Qualitative and quantitative information on measure use provides insight into public- and private-sector implementation experiences. Finally, assessing the impact of measures in the field could elicit potential undesirable consequences and help to understand if performance measures are truly driving improvement. To provide thorough recommendations on the best performance measures for specific purposes, MAP will establish an analytics plan that:

• Builds on the NQS and the goals, measures, and strategic opportunities identified by NPP and other initiatives to identify high-leverage opportunities for improvement; and

• Utilizes information on measure use and impact by establishing feedback loops.

Build on NQS/NPP and other initiatives to identify high-leverage opportunities for improvement. The foundation for MAP's decision making is the NQS. Accordingly, MAP's analytics plan will incorporate NPP's input to HHS regarding strategic opportunities and national-level measures to achieve the aims, priorities, and specific goals of the NQS. MAP and NPP will promote bi-directional collaboration to ensure MAP's decisions align with the true intent of the NQS aims and priorities. For example, NPP co-chairs serve on the Strategy Task Force and select NPP members will serve as liaisons to the MAP families of measures task forces. In addition, MAP will leverage findings from other initiatives focused on advancing healthcare quality. Specifically, MAP will actively seek information that describes impact and improvability, with a focus on incidence, prevalence, cost, improvement gaps, and regional variation. For example, *The Healthcare Imperative: Lowering Costs and Improving Outcomes,* published by the Institute of Medicines (IOM), will provide MAP with valuable information regarding opportunities to address healthcare waste and resource use. Similarly, MAP will incorporate information gleaned from NQF's endorsement process and other NQF convening activities. Broader healthcare quality research and measure endorsement information will facilitate MAP's articulation of the highest-leverage opportunities for performance measurement.

Utilize information on measure use and impact by establishing feedback loops. MAP will need information on the use and impact of existing measures to make informed decisions about the best available measures. MAP will leverage its relationships with stakeholders to obtain such information, as well as look to prior work

and several ongoing efforts, including the NQF endorsement/maintenance process, CMS *National Impact Assessment of Medicare Quality Measures Report*, which provides trended data for eight CMS programs, the Quality Alliance Steering Committee (QASC) Environmental Scan, and the Agency for Healthcare Research and Quality's (AHRQ) National Healthcare Quality & Disparities Reports.

As illustrated in Figure 1, MAP seeks to establish feedback loops with multiple stakeholders across the Quality Measurement Enterprise to strengthen MAP's recommendations over time. MAP will leverage NQF's relationships with communities, such as the Aligning Forces for Quality community alliances, to understand how they are approaching performance measurement.

MAP Measure Selection Criteria

The MAP Measure Selection Criteria (MSC) were developed and adopted to guide MAP's input on the selection of measures and to identify measure gaps. MAP envisions that the MSC will continue to evolve as MAP gains experience using the criteria. MAP will revisit the selection criteria to ensure the aforementioned goals and objectives are clearly articulated within the criteria and address issues raised during the first-year experience. For example, MAP highlighted the need to explore whether the differing purposes of performance measurement programs (e.g., public reporting, performance-based payment, quality improvement) call for different selection criteria. MAP will consider how the selection criteria should address removal of low-value measures (e.g., measures that are low impact or have implementation issues), along with other minor refinements (e.g., identifying high-impact conditions for other age groups). Finally, MAP recognizes that some issues may be better suited for exploration by other stakeholders within the Quality Measurement Enterprise. For example, although the selection criteria address disparities, MAP notes there is a need for a national strategy on addressing healthcare disparities, which

may be better suited for the membership and implementation role of the NPP and informed by the NQF Healthcare Disparities and Cultural Competency project.

MAP Evaluation Plan

MAP seeks to establish feedback loops with various stakeholders to gauge the effectiveness and impact of its recommendations and to enhance its subsequent decision making. MAP must determine whether its recommendations are meeting stakeholders' needs and are aligned with stakeholders' goals. As a first step in developing an evaluation plan, MAP will identify its key audiences and determine what those audiences deem most important to assess. Next, MAP will engage in a systematic evaluation to understand if its processes were transparent and effective and to determine uptake and impact of MAP's recommendations on driving improvement, transparency, and value. Uptake of MAP's recommendations will be informed by finalized federal rules and outreach to private-sector stakeholders implementing performance measurement initiatives. Determining MAP's impact on the broader Quality Measurement Enterprise and understanding if MAP is truly driving improvement, transparency, and value will be informed by stakeholder outreach.

MAP Communication Plan

MAP will develop a plan for disseminating its recommendations in a clear and effective manner to both public- and private-sector audiences. For example, stakeholder feedback from MAP's first year of pre-rulemaking input requested that MAP clarify its response categories, which included "support," "support direction," and "do not support." MAP will explore options to determine the most discerning response categories for its recommendations. The communication plan will also design strategies for targeted outreach to key stakeholders in the public and private sectors—including measure developers, entities selecting

measures for various programs, and healthcare entities that collect and report measurement data. As part of its collaboration with NPP, MAP will identify opportunities to synchronize and activate stakeholders within the Quality Measurement Enterprise to facilitate achieving the partnerships shared objectives.

MAP Action Plan

MAP has identified multiple strategies and tactics to drive toward performance measures that promote improvement, transparency, and value. The MAP Strategic Plan will include an action plan and deliverables for accomplishing each tactic over the next three years. Below is a brief timeline for each of the MAP Strategies and Tactics:

- Development of **families of measures** will begin in May 2012. By October 2012 MAP will develop measure families for safety, care coordination, cardiovascular prevention and treatment, and diabetes prevention and treatment. Additional measure families addressing the remaining NQS priorities (population health, patient- and family-centered care, affordability) will be developed in 2013. MAP will also identify other topic areas requiring the development of a measure family (e.g., mental health) and define a timeline for development. Finally, MAP will establish a process for revisiting the families of measures and related **core measure sets** over time.

- **Addressing measure gaps** and **implementation phasing strategies** will occur through the development of measure families and core sets and MAP's annual pre-rulemaking input.

- Initial development of a **MAP Analytics Plan** will occur in June of 2012 and will continue to evolve throughout the course of MAP's work.

- The MAP **Measure Selection Criteria** will be refined in 2012 to ensure they address the MAP goals and objectives. The criteria will be refined annually, as needed, to address any issues raised as MAP applies the criteria.

- MAP will begin developing a protocol for an **evaluation plan** in 2012 and refine according to stakeholder feedback. In 2014 MAP will engage in a systematic evaluation of its impact to date.

- Initial development of a MAP **communication plan** will begin in early 2012 and be executed throughout the course of MAP's work, with refinements, as necessary, to ensure maximum effectiveness and outreach.

Priority 4. Promoting the Most Effective Prevention and Treatment Practices for the Leading Causes of Mortality, Starting with Cardiovascular Disease

Providing high-value care to patients that improves the length and quality of their lives is the goal of health care. Focusing national quality improvement efforts on diseases that kill the most Americans places cardiovascular disease at the top of the list. Moreover, effective strategies for preventing and treating heart disease and strokes are well documented. The National Quality Strategy identifies increasing blood pressure control in adults, reducing high cholesterol levels in adults, increasing the use of aspirin to prevent cardiovascular disease for appropriate populations, and decreasing smoking among adults as important opportunities to prevent and treat cardiovascular disease.

Nationwide Initiative—The Million Hearts Campaign is a public-private sector initiative led by HHS to prevent 1 million heart attacks and strokes over the next 5 years. Cardiovascular disease is the leading cause of morbidity and mortality in the United States. Several preventive strategies can reduce the risk of developing cardiovascular disease: appropriate aspirin therapy for those who need it, blood pressure control, cholesterol management, and smoking cessation (the ABCS of cardiovascular disease). Among the many Millions Hearts activities are:

- *Educational efforts to increase awareness about heart disease and prevention and to demonstrate how individuals can take control of their heart health;*

- *Discovery and dissemination of care practices that use interdisciplinary teams, health information technology, and incentives to optimize outcomes;*

- *Improving adherence to appropriate medications for the ABCS.*

Already, Million Hearts is partnering with many organizations around the country, including professional societies, consumer groups, employers, and insurers. The Georgetown University School of Medicine, for example, has intensified its emphasis on the powerful preventive benefits of the ABCS and on the role of teams in effective care delivery. (millionhearts.hhs.gov)

Long-Term Goals for Promoting the Best Prevention and Treatment Practices for the Leading Causes of Mortality:

1. Promote cardiovascular health through community interventions that result in improvement of social, economic, and environmental factors.
2. Promote cardiovascular health through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan.
3. Promote cardiovascular health through receipt of effective clinical preventive services across the lifespan in clinical and community settings.

Exhibit 5. Key Measures for National Quality Strategy Priority 4—Promoting the Most Effective Prevention and Treatment Practices for the Leading Causes of Mortality, Starting with Cardiovascular Disease

MEASURE FOCUS	KEY MEASURE NAME/DESCRIPTION	CURRENT RATE	ASPIRATIONAL TARGET
Aspirin Use	People at increased risk of cardiovascular disease who are taking aspirin	47%*	65% by 2017
Blood Pressure Control	People with hypertension who have adequately controlled blood pressure	46%**	65% by 2017
Cholesterol Management	People with high cholesterol who have adequately managed hyperlipidemia	33%**	65% by 2017
Smoking Cessation	People trying to quit smoking who get help	23%***	65% by 2017

* Source: Centers for Disease Control and Prevention, National Ambulatory Medical Care Survey (NAMCS) and National Hospital Ambulatory Medical Care Survey (NHAMCS), 2007-2008
** Source: Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey (NHANES), 2005-2008
*** Source: NAMCS, 2005-2008

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

MAP "WORKING" MEASURE SELECTION CRITERIA INTERPRETIVE GUIDE

Instructions for applying the measure selection criteria:

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

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

FOR CRITERION 1 – NQF ENDORSEMENT:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    a. Cost measures – Total cost of care.

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

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

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

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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.

National Quality Forum

Measure Applications Partnership (MAP)
Roster for the MAP Cardiovascular and Diabetes Care Task Force

Chair (voting)

Chris Cassel, MD

Organizational Members (voting)	Representatives
Academy of Managed Care Pharmacy	Marissa Schlaifer
Aetna	Randall Krakauer, MD
American Academy of Family Physicians	Bruce Bagley, MD
American College of Cardiology	Paul Casale, MD, FACC
American College of Emergency Physicians	Bruce Auerbach, MD, FACC
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Directors Association	David Polakoff, MD, MsC
American Medical Rehabilitation Providers Association	Suzanne Snyder, PT
Consumers' CHECKBOOK	Robert Krughoff, JD
Iowa Healthcare Collaborative	Lance Roberts, PhD
Minnesota Community Measurement	Beth Averbeck, MD
National Committee for Quality Assurance	Peggy O'Kane, MPH
Physician Consortium for Performance Improvement	Mark Metersky, MD
Premier, Inc.	Richard Bankowitz, MD, MBA, FACP

Expertise	Individual Subject Matter Expert Members (voting)
Population Health	Eugene Nelson, MPH, DSc
Health IT/ Patient Reported Outcome Measures	James Walker, MD, FACP

Federal Government Members (non-voting, ex officio)	Representatives
Centers for Medicare & Medicaid Services (CMS)	Michael Rapp, MD, JD, FACEP
Office of the National Coordinator for HIT (ONC)	Joshua Seidman, MD, PhD

Liaisons (non-voting, ex officio)	Representatives
Centers for Disease Control and Prevention (CDC)	Peter Briss, MD, MPH *(NPP)*
Centers for Disease Control and Prevention (CDC)	Mary George, MD, MSPH *(CDP)*

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

George J. Isham, MD, MS

Elizabeth A. McGlynn, PhD, MPP

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Cardiovascular/Diabetes Task Force

Chair (voting)

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

Organizational Members (voting)

Academy of Managed Care Pharmacy
Marissa Schlaifer, RPh, MS
Marissa Schlaifer joined the Academy of Managed Care Pharmacy (AMCP) as Pharmacy Affairs Director in January 2003. The Academy is a professional society with over 6,000 members which is dedicated to the continuing professional development of health care professionals engaged in the practice of pharmacy in managed care settings. For the Academy, Marissa is involved in all professional and clinical aspects of the organization's activities. She was been involved in the development and implementation of the Medicare prescription drug benefit. Marissa served on various Part D Medication Measures technical expert panels (TEPs), providing input on the development of quality measures, serves on the Department of Defense Uniform Formulary Beneficiary Advisory Panel, and has represented AMCP in many capacities within the Pharmacy Quality Alliance (PQA). Marissa brings experience in both the managed care pharmacy and community pharmacy segments of the profession as well as leadership experience in several pharmacy organizations. Prior to joining AMCP, Marissa was Healthy Outcomes Director at H-E-B Grocery Company, where she was responsible for disease management and health improvement programs, immunization programs and new business opportunities. Previously, Marissa worked for PacifiCare of Texas and Prescription Solutions as a clinical pharmacist, and for Eckerd Drug Company as pharmacy manager and a regional manager for managed care sales. She received her B.S. in Pharmacy and M.S. in Pharmacy Administration from The University of Texas at Austin College of Pharmacy.

Marissa has been active in leadership positions within AMCP, the American Pharmacists Association and the Texas Pharmacy Association.

Aetna
Randall Krakauer, MD

Dr. Randall Krakauer graduated from Albany Medical College in 1972 and is Board Certified in Internal Medicine and Rheumatology. He received training in Internal Medicine at the University of Minnesota Hospitals and in Rheumatology at the National Institutes of Health and Massachusetts General Hospital/Harvard Medical School, and received an MBA from Rutgers. He is a fellow of the American College of Physicians and the American College of Rheumatology and Professor of Medicine at Seton Hall University Graduate School of Medicine. He is past chairman of the American College of Managed Care Medicine. Dr. Krakauer has more than 30 years of experience in medicine and medical management, has held senior medical management positions in several major organizations. He is author of many publications on Medical Management, Advanced Care Management and Collaborative Medical Management. He is responsible for medical management planning and implementation nationally for Aetna Medicare members, including program development and administration.

American Academy of Family Physicians
Bruce Bagley, MD

Bruce Bagley, M.D., currently serves as the Medical Director for Quality Improvement for the American Academy of Family Physicians (AAFP). He has served as president and board chair of the AAFP in the past. The AAFP represents more than 98,000 family physicians, family medicine residents and medical students nationwide. During his twenty-eight year practice career, Bagley provided the full range of family medicine services in a single specialty family medicine group practice in Albany, NY. Under his leadership, the 10-physician group was a well-known pioneer in the community in adapting to the challenges of managed care, quality improvement, informatics and patient centered care. Bagley's current responsibilities with the AAFP include liaison work with other national organizations in the quality arena. He actively participates in the development, deployment and implementation of performance measures. He has been an effective national advocate for the importance of primary care as the foundation of a redesigned US health care system. Bagley has spoken extensively on the topics of performance measurement, patient centered medical home, office redesign, electronic health records and leadership. From 2005 to 2007, he served as a Malcolm Baldrige Quality Award examiner.

American College of Cardiology
Paul Casale, MD, FACC

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

ACCF's Medical Director Institute (MDI). The MDI is a forum convened by the ACC to bring together cardiovascular physicians, health plan medical directors, purchasers, primary care physician representatives and other industry stakeholders to engage in action-oriented discussions that address common challenges in delivering quality cardiovascular care.

American College of Emergency Physicians
Bruce Auerbach, MD, FACC

Dr. Auerbach is Vice President and Chief of Emergency and Ambulatory Services and Associate Medical Director at Sturdy Memorial Hospital in Attleboro, Massachusetts. He is Board-certified in emergency medicine and a Fellow of the American College of Emergency Physicians (ACEP). He is Past President of the Massachusetts Medical Society and Massachusetts College of Emergency Physicians and is past Chair of ACEP's Quality and Performance Committee. He currently serves on the AMA PCPI Executive Committee, is co-Chair of ACEP's Delivery System Reform Task Force, Chairs the Massachusetts Hospital Association's Clinical Issues Advisory Council and serves on its Board. He is State Lead for the State Action on Avoidable Rehospitalizations (STAAR) and a member of the State's Care Transition Steering Committee. He is on the Board of the Coverys Malpractice Insurance company and Chair of the Board of the Albert Schweitzer Fellowship Program, an organization dedicated to reducing health disparities and underserved communities. He has appointments at the Harvard School of Public Health, the Department of Community Medicine at Tufts University School of Medicine and the Division of Emergency Medicine at the University of Massachusetts Medical School. A native of Philadelphia, Dr. Auerbach received his medical degree from Temple University where he met his wife Robin Richman, MD.

American Hospital Association
Rhonda Anderson, RN, DNSc, FAAN

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

American Medical Directors Association
David Polakoff, MS, MsC

Dr. David Polakoff is the Chief Medical Officer of MassHealth, and Director of the Office of Clinical Affairs of the Commonwealth Medicine Division of the University of Massachusetts Medical School. Dr. Polakoff is a noted Geriatrician, with over a decade of experience as a senior health care executive. Dr. Polakoff served as Chief Medical Officer of Mariner Health Care, and Genesis Health Care, and is the founder of Senior Health Advisors, a consulting firm. Dr. Polakoff has a longstanding interest in health policy, with a particular eye toward quality of services for the aging population, research on related topics, and has delivered hundreds of invited presentations.

American Medical Rehabilitation Providers Association
Suzanne Snyder, PT
Suzanne Snyder is the Director of Rehabilitation Utilization and Compliance at Carolinas Rehabilitation. Carolinas Rehabilitation owns or manages over a 180 inpatient rehabilitation beds in Charlotte, North Carolina as well as over 14 outpatient therapy and physician clinics. Suzanne is a Fellow in the American College of Healthcare Executives and holds a Master's degree in Business Administration, a Bachelors in Physical Therapy and a Certification in Utilization Management. In 2009 Suzanne expanded her ability to impact the lives of patients and the rehab community by becoming a member of the AMRPA Board of Directors. In her role at Carolinas Rehabilitation Suzanne is responsible for oversight of IRF PAI data collection/transmission, utilization management, utilization review, Medicare appeals, insurance authorizations, medical necessity documentation and quality outcomes reporting. She has appealed Medicare denials from multiple Fiscal Intermediaries and through the Medicare Appeals Council level and Medicaid Program Integrity Denials in the state of North Carolina. Suzanne was instrumental in the creation and continuation of the EQUADRSM (Exchanged Quality Data for Rehabilitation) Network a Patient Safety Organization, established to share quality outcomes amongst rehabilitation providers and define the most appropriate quality indicators for the inpatient rehabilitation setting. She has helped to shape quality measures for the inpatient rehabilitation field through her work as co-chair of the American Medical Rehabilitation Providers Association's (AMRPA) Quality Committee and participation on technical expert panels for MedPAC and CMS. Suzanne is a Commission on Accreditation of Rehabilitation Facilities (CARF) surveyor and coordinates the CARF readiness of Carolinas Rehabilitation.

Consumers' CHECKBOOK
Robert Krughoff, JD
Robert M. Krughoff is founder and president of Center for the Study of Services/Consumers' CHECKBOOK (CSS/CHECKBOOK), an independent, nonprofit consumer organization founded in 1974. The organization publishes local versions of Consumers' CHECKBOOK magazine in seven major metropolitan areas (Seattle/Tacoma, Boston, Chicago, Minneapolis/St. Paul, Philadelphia, San Francisco/Oakland/San Jose, and Washington, DC). The magazine evaluates local service providers ranging from auto repair shops to plumbers to various types of health care providers. CHECKBOOK also has nationally distributed publications and websites to help consumers find quality and save money, including: *Guide to Top Doctors, Consumers' Guide to Hospitals, Guide to Health Plans for Federal Employees,* and *checkbook.org/patientcentral* (which has patient experience ratings of individual physicians). Krughoff also has a role in the work CSS/CHECKBOOK does in survey design, implementation, analysis, and reporting for large-scale surveys in the health care field, including CAHPS surveys of members about health plans and of patients about physicians.
Before founding CSS/CHECKBOOK, Krughoff served in the U. S. Department of Health, Education, and Welfare as Director of the Office of Research and Evaluation Planning and as Special Assistant to the Assistant Secretary for Planning and Evaluation. Krughoff is a graduate of Amherst College and the University of Chicago Law School, where he was an associate editor of the *Law Review.*

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.

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

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

Physician Consortium for Performance Improvement

Mark Metersky, MD

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

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.

Individual Subject Matter Expert Members (voting)

Population Health
Eugene Nelson, MPH, DSc

Dr. Nelson is Professor of Community and Family Medicine at The Dartmouth Institute for Health Policy and Clinical Practice, Dartmouth Medical School; Director, Population Health Measurement Program, The Dartmouth Institute; Director, Population Health and Measurement, Dartmouth-Hitchcock Medical Center. Dr. Nelson is a national leader in health care improvement and the development and application of measures of quality, system performance, health outcomes, value, and patient and customer perceptions. In the early 1990s, Dr. Nelson and his colleagues at Dartmouth began developing clinical microsystem thinking. His work to develop the "clinical value compass" and "whole system measures" to assess health care system performance has made him a well-recognized quality and value measurement expert. He is the recipient of The Joint Commission's Ernest A. Codman award for his work on outcomes

measurement in health care. Dr. Nelson, who has been a pioneer in bringing modern quality improvement thinking into the mainstream of health care, helped launch the Institute for Healthcare Improvement and served as a founding Board Member. He has authored over 150 publications and is the first author of three recent books: (a) Quality by Design: A Clinical Microsystems Approach, (b) Practice-Based Learning and Improvement: A Clinical Improvement Action Guide: Second Edition, and (c) Value by Design: Developing Clinical Microsystems to Achieve Organizational Excellence. He received an AB from Dartmouth College, a MPH from Yale University and a DSc from Harvard University.

Health IT/ Patient Reported Outcome Measures
James M. Walker, MD, FACP

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

Federal Government Members (non-voting, ex officio)

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

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

Office of the National Coordinator for HIT (ONC)
Joshua Seidman, MD, PhD

Dr. Seidman leads the Meaningful Use Division at ONC, overseing three areas: helping to evolve meaningful use practice and policy; supporting providers through ONC's regional extension program to become meaningful users of health IT; and oversight of ONC's e-Quality Measurement agenda. During two decades in health care, Seidman has focused on: quality measurement and improvement; the intersection of e-health and health services research; and structuring consumer e-health interventions to support improved health behaviors and informed decision making. Previously, Seidman was the founding President of the Center for Information Therapy, which advanced the practice and science of using health IT to deliver tailored information to consumers to help them make better health decisions. At the

IxCenter, Seidman focused on stimulating innovation, diffusing best practices, and evangelizing for a patient-centered orientation to implementation of health IT applications. Seidman has also served as Director of Measure Development at NCQA and has done research and analysis related to providers at the American College of Cardiology and The Advisory Board Company. Seidman earned a PhD in health services research and an MHS in health policy & management from Johns Hopkins School of Public Health, and a BA in political science from Brown University.

Liasons (non-voting, ex officio)

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

Centers for Disease Control and Prevention (CDC)
Mary George, MD, MSPH *(CDP)*
Mary George, MD, MSPH is the senior Medical Officer for the Division for Heart Disease and Stroke Prevention at the CDC in Atlanta. She has been at CDC since 2006 and currently oversees the Paul Coverdell National Acute Stroke Registry. She is the Division's lead for quality improvement, emergency preparedness, and represents the Division with several clinically related projects and national organizations. Her interests are in stroke systems of care, quality improvement, and health services research and clinical preventive services for stroke and cardiovascular disease. She has had experience is developing National Quality Forum (NQF)-endorsed clinical quality measures, has served on several quality measure technical expert and advisory panels, and was co-chair of the NQF Steering Committee for Cardiovascular performance measures. Dr. George obtained her medical degree from Oregon Health & Science University and completed residencies in general and vascular surgery and plastic and reconstructive surgery at the University of Rochester. She is a board certified surgeon, Fellow of the American College of Surgeons, and Fellow of the American Heart Association. She obtained a master of science in public health informatics at Emory University.

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

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

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

Elizabeth A. McGlynn, PhD, MPP
Elizabeth A. McGlynn, PhD, is the director for the Center of Effectiveness and Safety Research (CESR) at Kaiser Permanente. She is responsible for oversight of CESR, a network of investigators, data managers and analysts in Kaiser Permanente's regional research centers experienced in effectiveness and safety research. The Center draws on over 400 Kaiser Permanente researchers and clinicians, along with Kaiser Permanente's 8.6 million members and their electronic health records, to conduct patient-centered effectiveness and safety research on a national scale. Kaiser Permanente conducts more than 3,500 studies and its research led to more than 600 professional publications in 2010. It is one of the largest research institutions in the United States. Dr. McGlynn leads efforts to address the critical research questions posed by Kaiser Permanente clinical and operations leaders and the requirements of the national research community. CESR, founded in 2009, conducts in-depth studies of the safety and comparative effectiveness of drugs, devices, biologics and care delivery strategies. Prior to joining Kaiser Permanente, Dr. McGlynn was the Associate Director of RAND Health and held the RAND Distinguished Chair in Health Care Quality. She was responsible for strategic development and oversight of the research portfolio, and external dissemination and communications of RAND Health research findings. Dr. McGlynn is an internationally known expert on methods for evaluating the appropriateness and technical quality of health care delivery. She has conducted research on the appropriateness with which a variety of surgical and diagnostic procedures are used in the U.S. and in other countries. She led the development of a comprehensive method for evaluating the technical quality of care delivered to adults and children. The method was used in a national study of the quality of care delivered to U.S. adults and children. The article reporting the adult findings received the Article-of-the-Year award from AcademyHealth in 2004. Dr. McGlynn also led the RAND Health's COMPARE initiative, which developed a comprehensive method for evaluating health policy proposals. COMPARE developed a new microsimulation model to estimate the effect of coverage expansion options on the number of newly insured, the cost to the government, and the effects on premiums in the private sector. She has conducted research on efficiency measures and has recently published results of a study on the methodological and policy issues associated with implementing measures of efficiency and effectiveness of care at the individual physician level for payment and public reporting. Dr. McGlynn is a member of the Institute of Medicine and serves on a variety of national advisory committees. She was a member of the Strategic Framework Board that provided a blueprint for the National Quality Forum on the development of a national quality measurement and reporting system. She chairs the board of AcademyHealth, serves on the board of the American Board of Internal Medicine Foundation, and has served on the Community Ministry Board of Providence-Little Company of Mary Hospital Service Area in Southern California. She serves on the editorial boards for Health Services Research and The Milbank Quarterly and is a regular reviewer for many leading journals. Dr. McGlynn received her BA in international political economy from Colorado College, her MPP from the University of Michigan's Gerald R. Ford School of Public Policy, and her PhD in public policy from the Pardee RAND Graduate School.

NATIONAL QUALITY FORUM

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.

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

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

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

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Allen Leavens, MD

Allen Leavens, MD, MPH is a Senior Director in the Strategic Partnerships Department at the National Quality Forum. He will be coordinating the Measures Applications Partnership (MAP) data analytics initiative, intended to provide MAP members with more comprehensive information to guide decision-making. Board Certified in Public Health and General Preventive Medicine, he comes to NQF from Resolution Health Inc (RHI) where he served as the Director of Healthcare Quality Improvement.

Megan Duevel Anderson, MS

Megan Duevel Anderson, MS, is a Project Analyst, Strategic Partnerships, at the National Quality Forum (NQF). Ms. Duevel Anderson contributes to the Dual Eligible Workgroup, Cardiovascular and Diabetes Task Force, and Data Analytics Team of the Measure Applications Partnership (MAP). Most recently, Ms. Duevel Anderson comes from The US Army Bavaria Medical Department Command where she was the Joint Commission and Performance Improvement Officer; responsible for accreditation and quality management of US Army outpatient clinics. Her post-graduate fellowship was completed at the Veteran's Administration National Center for Patient Safety Field Office; with research in Patient Safety in Women Veterans and Measuring Patient Safety in Developing Countries. Ms. Duevel Anderson has a Bachelor of Arts from Gustavus Adolphus College in Minnesota and a Master's of Science from The Dartmouth Institute for Health Policy and Clinical Practice Research.

Yetunde Alexandra Ogungbemi

Alexandra Ogungbemi, BS, is an Administrative Assistant in Strategic Partnerships, at the National Quality Forum (NQF). Ms. Ogungbemi contributes to the Clinician, Dual Eligible Beneficiaries, and Post-Acute Care/Long-Term Care Workgroups, as well as the Cardiovascular and Diabetes Task Force of the Measure Applications Partnership (MAP). Post-graduation, she spent 2 years managing the Administrative side of Cignet Healthcare a multi-specialty physician's practice in Southern Maryland before joining NQF. Ms. Ogungbemi has a bachelor of science in Health Services Administration.