MAP Safety and Care Coordination Task Force In-Person Meeting

NATIONAL QUALITY FORUM

June 19-20, 2012

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

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NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

Safety and Care Coordination Task Force
In-Person Meeting #1

20 F Street Conference Center
20 F Street, NW, Washington, DC 20001

Dial-In: 1-877-303-9138 (press *0 for operator assistance)
Passcode for June 19: 85999418
Passcode for June 20: 86009342
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In the "Enter a Meeting" box, type this code: **178953**

DAY 1 AGENDA: JUNE 19, 2012

Meeting Objectives:

- *Review task force charge, role within MAP, and plan to complete the tasks;*
- *Identify priority areas for aligning patient safety performance measurement across public and private programs;*
- *Establish a patient safety family of measures to serve as a national core measure set; and*
- *Create a measure development and implementation pathway to fill patient safety measure gaps.*

8:30 am **Welcome, Introductions, and Disclosures of Interest**
Frank Opelka, Task Force Chair
Ann Hammersmith, General Counsel, NQF

9:15 am **Aligning Patient Safety Measurement**

- MAP's 2012-2013 scope of work
- Role of the Safety and Care Coordination Task Force
- Approach for selecting a family of patient safety measures

9:45 am **Patient Safety Measurement Priorities**

- Current public and private programs using safety measures
- Available patient safety performance measurement results
- High-leverage opportunities for improving patient safety

11:00 am **Break**

11:15 am **Venous Thromboembolism (VTE)**

- Step 1: Assess opportunity for improvement
- Step 2: Review available measures
- Step 3: Determine measures to be included in the safety family
- Step 4: Identify measure gaps

12:15 pm **Public Comment**

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12:30 pm **Lunch**

1:00 pm **Healthcare-Associated Infections (HAIs)**
- Same steps as above

2:30 pm **Break**

2:45 pm **Injuries from Immobility**
- Same steps as above

3:45 pm **Perioperative/Procedural Safety**
- Same steps as above

4:45 pm **Public Comment**

5:00 pm **Summary of Day 1 and Look Forward to Day 2**

5:15 pm **Adjourn**

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Safety and Care Coordination Task Force
In-Person Meeting #1

DAY 2 AGENDA: JUNE 20, 2012

8:30 am **Welcome and Recap of Day 1**

9:00 am **Medication/Infusion Safety**
- Step 1: Assess opportunity for improvement
- Step 2: Review available measures
- Step 3: Determine measures to be included in the safety family
- Step 4: Identify measure gaps

10:30 am **Break**

10:45 am **Obstetrical Adverse Events**
- Same steps as above

11:45 pm **Public Comment**

12:00 pm **Lunch**

12:30 pm **Safety-related Overuse and Appropriateness**
- Same steps as above

1:30 pm **Complications-related Mortality**
- Same steps as above

2:30 pm **Break**

2:45 pm **Safety Measure Gaps and Gap-Filling Pathway**
Mark Antman, Physician Consortium for Performance Improvement (PCPI)
Erin Giovannetti, National Committee for Quality Assurance (NCQA)
- Review patient safety measure gap areas identified by task force
- Discuss barriers to development of measures to fill gaps
- Identify tactics for overcoming barriers
- Lay out pathway for measure development and implementation

4:30 pm **Public Comment**

4:45 pm **Summary of the Meeting and Next Steps**

5:00 pm **Adjourn**

MAP Safety & Care Coordination Task Force

In-Person Meeting

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Welcome, Introductions, and Disclosures of Interest

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Patient Safety/Care Coordination Task Force Membership

Task Force Chair: Frank Opelka

Organizational Members

Aetna	Iowa Healthcare Collaborative
Alliance of Dedicated Cancer Centers	L.A. Care Health Plan
America's Health Insurance Plans	Memphis Business Group on Health
American Hospital Association	Mothers Against Medical Error
American Organization of Nurse Executives	National Association of Children's Hospitals and Related Institutions
American Society of Health-System Pharmacists	National Association of Medicaid Directors
Blue Cross Blue Shield of Massachusetts	National Rural Health Association
Building Services 32BJ Health Fund	Pacific Business Group on Health
Catalyst for Payment Reform	Premier, Inc.
CIGNA	SNP Alliance
Humana, Inc.	The Alliance

Patient Safety/Care Coordination Task Force Membership

Subject Matter Experts

Health IT: Dana Alexander
Patient Safety: Mitchell Levy
State Medicaid: MaryAnne Lindeblad
Mental Health: Anne Marie Sullivan
State Policy: Dolores Mitchell
Palliative Care: R. Sean Morrison
Mental Health: Rhonda Robinson Beale
Patient Experience: Dale Shaller
Safety Net: Bruce Siegel

Federal Government Members

Agency for Healthcare Research and Quality (AHRQ)
Centers for Disease Control and Prevention (CDC)
Centers for Medicare & Medicaid Services (CMS)
Office of the National Coordinator for HIT (ONC)
Veterans Health Administration (VHA)
Health Resources and Services Administration (HRSA)
Office of Personnel Management/FEHBP (OPM)

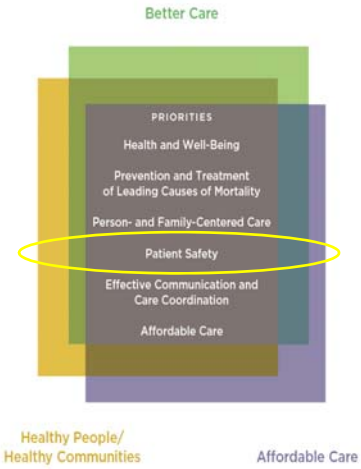
Liaisons

NPP: Laura Cranston
CDP (Safety): Bill Conway
CDP (Care Coordination): Gerri Lamb

Aligning Patient Safety Measurement

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



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MAP Safety Work: Year 1 Recommendations

- **A national core set of safety measures that are applicable to all patients should be created and maintained**
- **Data elements needed to calculate the measures in the safety core set should be collected on all patients**
- **Public- and private-sector entities should coordinate their efforts to make care safer, beginning with incentive structures**

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Approach to MAP Strategic Plan

- **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

MAP Strategies and Tactics

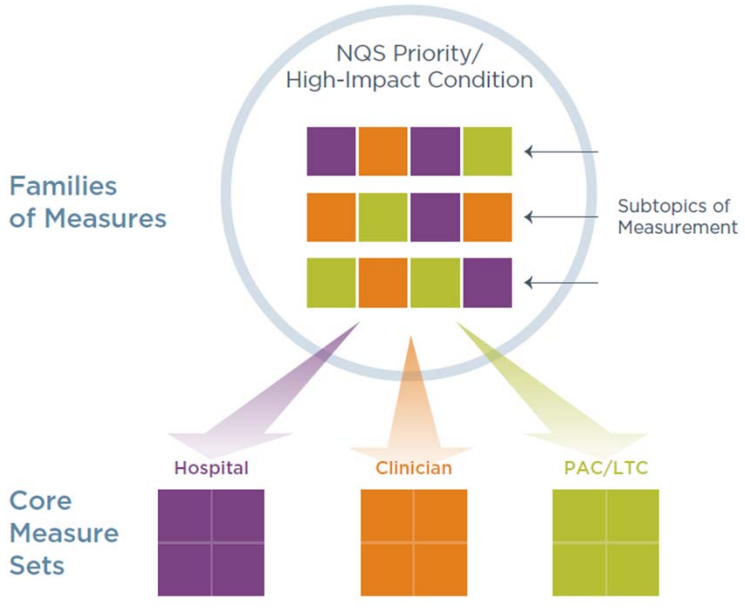
- **Families of Measures and Core Measure Sets**
  - Promote measure alignment through selection of families of measures
  - Encourage best use of available measures in core measure sets for specific HHS and private sector programs
- **Address Measure Gaps**
  - Identify and prioritize gaps; label development 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**

Families of Measures

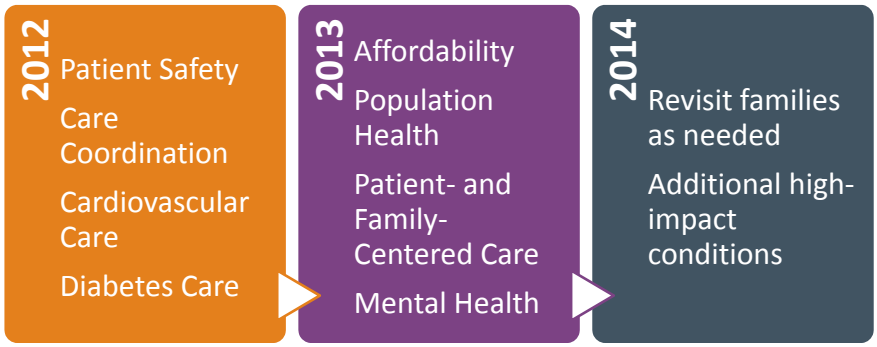
Families of Measures and Core Measure Sets to Align Performance Measurement Across Federal Programs and Public and Private Payers

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)



Proposed Families of Measures



Approach to Developing Measure Families

1. Identify and Prioritize High-Leverage Opportunities for Measurement

- Identification of high-leverage opportunities
  - MAP Measure Selection Criteria (NQS, High-Impact Conditions)
  - Public-sector efforts
  - 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
  - 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)

Approach to Developing Measure Families

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

- NQF-endorsed portfolio of measures
- Measures in or under consideration for federal programs
- Available private sector efforts

Approach to Developing Measure Families

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

- MAP Measure Selection Criteria and related considerations for defining the family
  - 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 and disparities

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)

Patient Safety Measurement Priorities

Programs using Safety Measures

Public Sector Programs:

- Ambulatory Surgical Center Quality Reporting
- End Stage Renal Disease Quality Improvement Program
- Hospital-Acquired Conditions (Present on Admission Indicator)
- Inpatient Psychiatric Hospital Quality Program
- Inpatient Quality Reporting Program (IQR)
- Inpatient Rehabilitation Facility Quality Reporting Program
- Long-Term Care Hospital Quality Reporting Program
- Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs
- National Action Plan to Prevent Healthcare-Acquired Infections: Roadmap to Elimination
- Nursing Home Quality Initiative/Nursing Home Care Measures
- Outpatient Quality Reporting Program
- PPS-Exempt Cancer Hospital Quality Reporting Program
- Value-Based Purchasing Program (VBP)

Programs using Safety Measures

Sample of Private Sector Programs Considered:

- Buying Value
- Catalyst for Payment Reform
- eValue8
- Integrated Healthcare Association (IHA)
- Leapfrog Hospital Survey / Recognition Program
- Health Plans
  - Aetna
  - Blue Cross Blue Shield
  - Cigna
  - Humana
  - UnitedHealth

Patient Safety Measurement Priorities

- High-leverage Opportunity Prioritization Framework
  - Impact
  - Improvability
  - Inclusivity
- Delivery System Culture of Safety
  - Outcome plus process and structure measures
  - Spanning across all settings
    - Prophylaxis, Treatment, Follow-up

Patient Safety Measurement Priorities

Considerations when striving for a parsimonious measure family

- Use of composite measures
- Adverse events that are low incidence
- Overuse threshold for potential harm

Topic	Sub-topic
Healthcare-acquired Infections	Catheter-Associated Urinary Tract Infections (CAUTI)
	Central Line Associated Blood Stream Infections (CLABSI)
	MRSA
	C. Difficile
	Surgical Site Infection
	Ventilator-Associated Pneumonia (VAP)
Medication/Infusion Safety	Adverse Drug Events
	Blood Incompatibility
	Manifestations of Poor Glycemic Control
Venous Thromboembolism	Deep Vein Thrombosis (DVT)
	Pulmonary Embolism (PE)
Perioperative/Procedural Safety	Foreign Object Retained After Surgery
	Trauma (burn, shock, laceration, puncture, iatrogenic pneumothorax, etc.)
	Air Embolism
Injuries from Immobility	Pressure Ulcers
	Falls
Safety-related Overuse & Appropriateness	Imaging
	Antibiotics
Obstetrical Adverse Events	Pre-Delivery, Delivery, Post-Delivery
Complications-related Mortality	Failure to Rescue

Safety Measure Family: Background Analytics

Topic Areas Reviewed

- Venous Thromboembolism (VTE)
- Healthcare-Acquired Infections (HAIs)
  - CAUTI, CLABSI, VAP, SSI, MRSA, C. Diff
- Injuries from Immobility
  - Falls, Pressure Ulcers
- Perioperative/Procedural Safety
  - Air Embolus, Foreign Object Retained After Surgery, Trauma (iatrogenic pneumothorax, burns, shock, laceration)
- Medications/Infusions Safety
  - Adverse Drug Events (ADEs), Manifestations of Poor Glycemic Control, Blood Incompatibility
- Obstetrical Adverse Events
- Safety-related Overuse and Appropriateness
  - Imaging, Medication, and Procedure Overuse
- Complications-related Mortality

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)

Venous Thromboembolism

Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE)

- **Impact**
  - Per the Partnership for Patients, there are >100,000 cases per year of hospital patients having VTE
  - Most common preventable cause of hospital death (AHRQ, 2008)
    - » Estimated 10-30% of patients die within 30 days
  - Estimate of cost per patient in a recent study was $7.6 – 16.6 k/year
- **Improvability**
  - Partnership for Patients estimates that 40% of VTEs are currently preventable
  - Effective evidence-based guidelines for reducing VTEs available
- **Inclusiveness**
  - Affects broad populations , but is more likely with certain risk factors (e.g. older age, limited mobility, genetic history, certain concurrent conditions)
  - Applies across settings, and strategies for improvement may be used broadly

Healthcare-Acquired Infections

Overview

- Among the top 10 leading cause of death in the U.S.
- Particularly an issue in hospitals; four categories account for about 75% of HAIs in the acute hospital setting:

Estimated Annual Hospital Cost of Healthcare-Associated Infections by Site of Infection[6, 7]

Major Site of Infection	Total Infections	Hospital Cost Per Infection	Total Annual Hospital Cost (in Millions)	Deaths Per Year
Surgical Site Infection	290,485	$25,546	$7,421	13,088
Central Line-Associated Bloodstream Infection	248,678	**$36,441**	**$9,062**	30,665
Ventilator-Associated Pneumonia (Lung Infection)	250,205	$9,969	$2,494	**35,967**
Catheter-Associated Urinary Tract Infection	**561,667**	$1,006	$565	8,205

Source: HHS Action Plan to Prevent Healthcare-Associated Infections: Introduction. http://www.hhs.gov/ash/initiatives/hai/introduction.html (Last accessed May, 2012).

Healthcare-Acquired Infections

Catheter-Associated Urinary Tract Infections (CAUTI)

- **Impact**
  - Most common type of Healthcare-Acquired Infection; as many as 560,000 CAUTI episodes occur annually
  - Less cost and mortality relative to other HAIs, but high rate of occurrence still makes a large impact
- **Improvability**
  - The Partnership for Patients estimates that 40% of CAUTI episodes are currently preventable
  - A variety of evidence-based guidelines for prevention are available
- **Inclusiveness**
  - Affects a fairly broad population; tends to be more applicable to inpatient settings

Healthcare-Acquired Infections

Central Line Associated Blood Stream Infections (CLABSI)

- **Impact**
  - Frequent and serious; mortality rate of 12-25% per Partnership for Patients
  - Billions of dollars in excess cost to the U.S. healthcare system
- **Improvability**
  - The Partnership for Patients estimates that 50% of CLABSI episodes are preventable
  - A variety of evidence-based guidelines for prevention are available
- **Inclusiveness**
  - Most applicable to sub-populations with other comorbidities, often within inpatient settings

Healthcare-Acquired Infections

Methicillin-Resistant Streptococcus Aureus (MRSA)

- **Impact**
  - Approximately 94k invasive MRSA infection occur in the U.S. annually, associated with about 19k deaths (CDC MRSA toolkit)
  - Healthcare-related MRSA infections are often more severe and include bloodstream infections, SSIs, or pneumonia
- **Improvability**
  - Specific guidelines available, and basic infection control practices noted to be effective for prevention
  - 2010 CDC study indicated that invasive MRSA infections that began in hospitals declined 28% from 2005-2008
- **Inclusiveness**
  - Affects a fairly broad population; there are condition-specific considerations with different settings

Healthcare-Acquired Infections

Clostridium difficile

- **Impact**
  - Hospital visits due to C. diff infection tripled in the past decade
  - Linked to 14,000 deaths in the U.S. annually
  - >$1 billion in extra health care costs annually
- **Improvability**
  - Infection control measures and more cautious antibiotic use are effective for preventing C. diff infections
- **Inclusiveness**
  - Risk of infection and mortality generally increased in older individuals
  - Involves multiple settings due to risk factors implicated

Healthcare-Acquired Infections

Surgical Site Infection (SSI)

- **Impact**
  - CDC estimated that >110,000 SSIs occurred in 2009; total annual costs in U.S. hospitals estimated to be >$3.2 billion
- **Improvability**
  - The Partnership for Patients estimates that 35% of all SSIs are currently preventable
  - A variety of evidence-based guidelines are available, including several applicable to multiple surgical categories
- **Inclusiveness**
  - Applies to patients that have undergone surgical procedures, and therefore strategies applied to somewhat limited range of settings

Healthcare-Acquired Infections

Ventilator-Associated Pneumonia (VAP)

- **Impact**
  - Relatively frequent and serious, with potential for significant associated costs; Partnership for Patients indicates there are about 40,000 events and 6,000 deaths annually
- **Improvability**
  - The Partnership for Patients estimates that 50% of VAP episodes are preventable
  - A variety of evidence-based guidelines for prevention are available
- **Inclusiveness**
  - Most applicable to sub-populations with other comorbidities within inpatient settings

Injuries from Immobility: Falls

- **Impact**
  - Fall episodes occur frequently within hospitals and other healthcare facilities, but the level of resulting harm varies substantially
  - Estimates vary, but over 29,000 preventable falls may be occurring in hospitals annually
- **Improvability**
  - The Partnership for Patients estimates that 25% of fall injuries are preventable
  - Evidence-based guidelines for fall injury prevention are available, but strategies have been challenging to establish
- **Inclusiveness**
  - Applies somewhat broadly , but certain groups are at much higher risk (e.g. elderly and individuals with disabilities); there are setting-specific considerations

Injuries from Immobility: Pressure Ulcers

- **Impact**
  - Over 2.5 million people get pressure ulcers annually (in health care settings and home); account for between 8-28% of all documented hospital-acquired conditions
  - Higher stage ulcers increase risk for infection and possibly death
- **Improvability**
  - The Partnership for Patients estimates that 50% of the most severe pressure ulcers in acute care settings are preventable
  - Several evidence-based guidelines and an extensive AHRQ toolkit is available
- **Inclusiveness**
  - Certain populations (e.g. elderly and those with limited mobility) at higher risk; capability exists for changes across healthcare settings

Perioperative/Procedural Safety

Air Embolism

- **Impact**
  - Potentially serious but relatively uncommon event
  - Incidence difficult to estimate, but a RTI study of FY 2009 CMS hospital data indicated the rate of discharges with this secondary diagnosis at risk was <0.1 per 1000 at risk
- **Improvability**
  - Limited information available on opportunities for improvement, potentially due to the low incidence rates
  - A 2012 RTI report update for CMS indicated that there are no current guidelines that address prevention of air embolism
- **Inclusiveness**
  - Most likely to affect individuals after select procedures (e.g. neurosurgical and otolaryngological surgery, intravascular catheters, and positive pressure ventilation) that are generally hospital-based

Perioperative/Procedural Safety

Foreign Object Retained After Surgery

- **Impact**
  - Potentially serious but relatively uncommon.
  - 2012 RTI report for CMS indicates there were 241 discharges with this HAC among the >10 million FFS discharges subject to POA coding rules in FY 2009.
- **Improvability**
  - There are several evidence-based guidelines, but the fairly low incidence of the event limits the magnitude of change possible
- **Inclusiveness**
  - Applies to patients that have undergone surgical procedures, and therefore strategies applied to somewhat limited range of settings

Perioperative/Procedural Safety

Iatrogenic Pneumothorax

- **Impact**
  - Potentially serious complication of procedures near the lung
  - An RTI study of FY 2009 Medicare hospital data indicated there were 20,836 discharges with this HAC, and estimated total increase in payments >$10 million
  - With treatment, mortality rate relatively low if otherwise healthy
- **Improvability**
  - A 2012 RTI report update for CMS indicated that there is one current guideline with recommendations addressing prevention of iatrogenic pneumothorax
  - Ultrasound guidance for CVC placement likely underutilized
- **Inclusiveness**
  - Applies most often to patients in a hospital setting with other comorbidities due to the type of initiating procedures

Perioperative/Procedural Safety

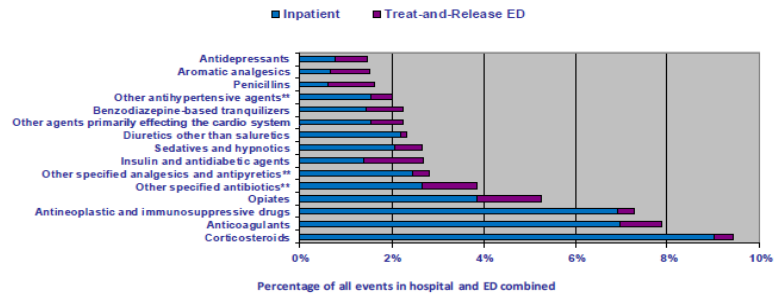
Trauma

- **Impact**
  - Burns, shock, lacerations, punctures, and other such incidents in healthcare settings can lead to serious harms and costs
  - Incidence rates vary depending on grouping and sub-population
- **Improvability**
  - Limited guidelines exist for preventing non-specific healthcare-related trauma, though some exist for specific procedures or topic areas (e.g. preventing Operating Room fires)
- **Inclusiveness**
  - Applies to a broad range of patients, more often in hospital settings

Adverse Drug Events

- **Impact**
  - Hospital patients experience approximately 1.9 million adverse drug events annually (PFP website); mortality estimates vary widely
  - Estimated >700,000 ED visits occur for ADE's in the US annually
  - Studies cited in the 2007 IOM report on Preventing Medication Errors indicate conservative estimates of preventable ADEs in long-term care and ambulatory care number 800,000 and 530,000, respectively.
  - Estimated financial impact >$4 billion annually
- **Improvability**
  - PFP estimates that 50% of ADEs in hospitals are preventable
  - Many efficacious error prevention strategies available per IOM report
- **Inclusiveness**
  - Affects a wide range of individuals, though more in elderly and individuals with multiple comorbidities; applies across conditions, settings, and programs

Figure 2. Most common specific causes of drug-related adverse outcomes* in U.S. hospitals, by setting of care, 2008



*More than one event can be recorded during an inpatient stay or ED visit. This is based on a combined total of 2,147,700 drug-related adverse outcome events in 1,874,800 inpatient stays, and 997,100 events in 838,000 treat and release ED visits with at least one drug-related adverse outcome recorded.
**See appendix for details on these categories. Diagnoses in these categories reflect adverse events of unidentified or unclassified drugs; more specific information is not available in the codes.
Source: AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample and Nationwide Emergency Department Sample, 2008

From: Lucado, J. (Social & Scientific Systems, Inc.), Paez, K. (Social & Scientific Systems, Inc.), and Elixhauser A. (AHRQ). *Medication-Related Adverse Outcomes in U.S. Hospitals and Emergency Departments, 2008*. HCUP Statistical Brief #109. April 2011. Agency for Healthcare Research and Quality, Rockville,MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb109.pdf

Blood Incompatibility

- **Impact**
  - Relatively uncommon. The rate of admission for transfusion reactions, age 18 or over in the U.S. for 2008 was .06 per 100,000
  - 2012 RTI report for CMS indicates there were only 13 discharges with this HAC among the >10 million FFS discharges subject to POA coding rules in FY 2009
- **Improvability**
  - 2012 RTI report indicated there are no U.S. guidelines for prevention, but two international guidelines exist
  - Low incidence limits the potential magnitude of change
- **Inclusiveness**
  - Tends to apply to a more limited subset of the population and settings

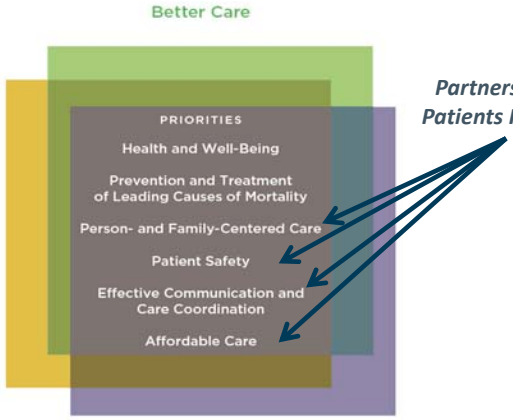
Manifestations of Poor Glycemic Control

- **Impact**
  - Moderate to low incidence; 2012 RTI report for CMS indicates there were 424 discharges with this HAC among the >10 million FFS discharges subject to POA coding rules in FY 2009
  - Moderate cost impact – per RTI report above, approximately $2 million in excess cost estimated for this population
  - May have broader implications if considered beyond HAC criteria
- **Improvability**
  - Several evidence-based guidelines are available
  - Fairly low incidence limits the potential magnitude of change
- **Inclusiveness**
  - Limited in conditions; may apply across settings

Obstetrical Adverse Events

- **Impact**
  - Obstetrical adverse events occur in approximately 9% of all deliveries in the U.S.
  - Wide range of severity, including permanent injuries to the infant and maternal death
- **Improvability**
  - The Partnership for Patients estimates that 30% of obstetrical adverse events are preventable
  - Several evidence-based approaches have been successfully implemented by hospitals and hospital systems
- **Inclusiveness**
  - Women of childbearing age and the fetus or infant are the population at risk; strategies are most applicable to inpatient hospital settings due to the focus on the period of labor and delivery

HHS's National Quality Strategy and the Partnership for Patients

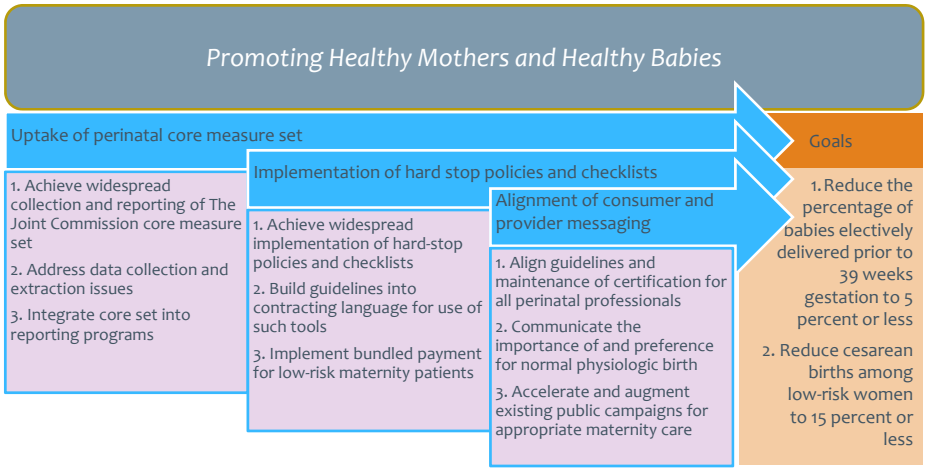


Partnership for Patients Initiative

PfP Areas of Focus

Preventable Hospital Readmissions
Adverse Drug Events
CAUTI
CLABSI
Injuries from Falls and Immobility
Obstetrical Adverse Events
Pressure Ulcers
Surgical Site Infections
Venous Thromboembolism
Ventilator-Associated Pneumonia

NPP Maternity Action Team Action Pathway



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Maternity Action Pathway Uptake of Perinatal Core Measure Set

The Joint Commission Perinatal Core Measure Set

- Elective delivery
- Cesarean section

Maternity Action Team Goals

- Antenatal steroids
- Healthcare-associated bloodstream infections in newborns
- Exclusive breast milk feeding

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Safety-related Appropriateness/Overuse

Antibiotic Overuse

- **Impact**
  - Major public health issue due to the potential for antibiotic resistance, which is associated with increased risk of hospitalization and death, as well as higher costs
  - May lead to more side effects, allergic reactions, C. diff infections
  - Per the CDC, current data suggests >10 million courses of antibiotics are prescribed each year unnecessarily
- **Improvability**
  - Guidelines for avoiding inappropriate use of antibiotics are available, particularly for upper respiratory infections
- **Inclusiveness**
  - Broad implications for the general population; applies to both inpatient and outpatient settings

Safety-related Appropriateness/Overuse

Inappropriate Imaging

- **Impact**
  - The U.S. population's total ionizing radiation exposure has nearly doubled in the past 20 years, in large part due to increased use of CT, nuclear medicine, and interventional fluoroscopy
  - Concerns exist over exposure risks, as well as costs
  - Much variability in usage of imaging services across the U.S.
- **Improvability**
  - Up to 30-50% of imaging exams may not be medically necessary
  - Guidelines for avoiding inappropriate imaging are available (e.g. ACR)
- **Inclusiveness**
  - Applies to broad range of individuals and variety of conditions; involves both inpatient and outpatient settings

Complications-related Mortality

- **Impact**
  - Per the Partnership for Patients:

    In 1999, the landmark IOM study, To Err is Human", estimated that as many as 98,000 Americans die every year from preventable medical errors. Despite many successful efforts, this statistic has not improved much in the following decade.
- **Improvability**
  - Many effective evidence-based guidelines and initiatives exist, but implementation varies greatly
- **Inclusiveness**
  - Applies to a broad range of individuals, though the elderly are generally more at risk and disparities exist for certain conditions
  - Tends to be more applicable to inpatient settings

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NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

Safety and Care Coordination Task Force
June 2012 Meeting Discussion Guide

Meeting Objectives:

- Review task force charge, role within MAP, and plan to complete the tasks;
- Identify priority areas for aligning patient safety performance measurement across public and private programs;
- Establish a patient safety family of measures to serve as a national core measure set; and
- Create a measure development and implementation pathway to fill patient safety measure gaps.

DAY 1 – June 19

For each of the eight patient safety topic areas, the task force will follow the steps outlined below:

- Step 1: Assess opportunity for improvement
- Step 2: Review available measures
- Step 3: Determine measures to be included in the safety family
- Step 4: Identify measure gaps

Venous Thromboembolism (VTE) [11:15 am – 12:15 pm]

Available Measures: 27; 16 measures in use or proposed for future use in 8 programs

- Deep Vein Thrombosis
- Pulmonary Embolism

- Overall
    - Should the entire VTE 1-5 bundle be included? 0374, 0375, 0376 are currently not recommended within their NQF endorsement maintenance review.

- Is there any need for DVT and PE to be parsed out separately for the follow-up measures?
- Is there a need for expansion to the pediatric population?
- Are there measurement gaps for VTE?

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Venous Thromboembolism	PSI 12: Post-operative PE or DVT	#0450 Endorsed	AHRQ	Outcome	Percent of discharges among cases meeting the inclusion and exclusion rules for the denominator with ICD-9-CM codes for deep vein thrombosis or pulmonary embolism in any secondary diagnosis field.	Facility	Adult/Elderly Care
Venous Thromboembolism	VTE-6: Incidence of Potentially-Preventable VTE	#0376 Endorsed (Not Recommended by SC, Under CSAC Review)	TJC	Process	This measure assesses the number of patients with confirmed venous thromboembolism (VTE) during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date. This measure is part of a set of six prevention and treatment measures that address VTE (VTE-1: VTE Prophylaxis, VTE-2: ICU VTE Prophylaxis, VTE-3: VTE Patients with Anticoagulation Overlap Therapy, VTE-4: VTE Patients Receiving UFH with Dosages/Platelet Count Monitoring by Protocol, and VTE-5: VTE Warfarin Therapy Discharge Instructions).	Facility, Population: National	Adult/Elderly Care
Venous Thromboembolism	VTE-1 Venous Thromboembolism Prophylaxis	#0371 Endorsed	TJC	Process	This measure assesses the number of patients who received venous thromboembolism (VTE) prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission. This measure is part of a set of six nationally implemented prevention and treatment measures that address VTE (VTE-2: ICU VTE Prophylaxis, VTE-3: VTE Patients with Anticoagulation Overlap Therapy, VTE-4: VTE Patients Receiving UFH with Dosages/Platelet Count Monitoring, VTE-5: VTE Warfarin Therapy Discharge Instructions and VTE-6: Incidence of Potentially-Preventable VTE) that are used in The Joint Commission's accreditation process.	Facility	Adult/Elderly Care

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Venous Thromboembolism	VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis	#0372 Endorsed	TJC	Process	This measure assesses the number of patients who received venous thromboembolism (VTE) prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer). This measure is part of a set of six prevention and treatment measures that address VTE (VTE-1: VTE Prophylaxis, VTE-3: VTE Patients with Anticoagulation Overlap Therapy, VTE-4: VTE Patients Receiving UFH with Dosages/Platelet Count Monitoring by Protocol, VTE-5: VTE Warfarin Therapy Discharge Instructions and VTE-6: VTE Incidence of Potentially-Preventable VTE).	Facility	Adult/Elderly Care
Venous Thromboembolism	VTE-3: Venous Thromboembolism Patients with Anticoagulant Overlap Therapy	#0373 Endorsed	TJC	Process	This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of Parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they should be discharged on both medications and have a Reason for Discontinuation of Overlap Therapy. Overlap therapy should be administered for at least five days with an international normalized ratio (INR) greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy, or INR less than 2 but discharged on both medications or have a Reason for Discontinuation of Overlap Therapy. This measure is part of a set of six prevention and treatment measures that address VTE (VTE-1: VTE Prophylaxis, VTE-2: ICU VTE Prophylaxis, VTE-4: VTE Patients Receiving UFH with Dosages/Platelet Count Monitoring, VTE-5: VTE Warfarin Therapy Discharge Instructions and VTE-6: Incidence of Potentially-Preventable VTE).	Facility	Adult/Elderly Care

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Venous Thromboembolism	VTE-4 Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram	#0374 Endorsed (Not Recommended)	TJC	Process	This measure assesses the number of patients diagnosed with confirmed venous thromboembolism (VTE) who received intravenous (IV) unfractionated heparin (UFH) therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol. This measure is part of a set of six prevention and treatment measures that address VTE (VTE-1: VTE Prophylaxis, VTE-2: ICU VTE Prophylaxis, VTE-3: VTE Patients with Anticoagulation Overlap Therapy, VTE-5: VTE Warfarin Therapy Discharge Instructions and VTE-6: Incidence of Potentially-Preventable VTE).	Facility	Adult/Elderly Care
Venous Thromboembolism	VTE-5: VTE Discharge Instructions	#0375 Endorsed (Not Recommended)	TJC	Process	This measure assesses the number of patients diagnosed with confirmed VTE that are discharged on warfarin to home, home with home health or home hospice with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions. This measure is part of a set of six prevention and treatment measures that address VTE (VTE-1: VTE Prophylaxis, VTE-2: ICU VTE Prophylaxis, VTE-3: VTE Patients with Anticoagulation Overlap Therapy, VTE-4: VTE Patients Receiving UFH with Dosages/Platelet Count Monitoring by Protocol and VTE-6: Incidence of Potentially-Preventable VTE).	Facility	Adult/Elderly Care
Venous Thromboembolism	Venous Thromboembolism (VTE) Prophylaxis	#0239 Endorsed	AMA-PCPI	Process	Percentage of patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.	Clinicians: Individual	Adult

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Deep Vein Thrombosis	Deep Vein Thrombosis Anticoagulation >= 3 Months	#0581 Endorsed	Resolution Health, Inc.	Process	This measure identifies patients with deep vein thrombosis (DVT) on anticoagulation for at least 3 months after the diagnosis	Clinician : Individual, Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population: County or City	
Pulmonary Embolism	Pulmonary Embolism Anticoagulation >= 3 Months	#0593 Endorsed	Resolution Health, Inc.	Process	This measure identifies patients with pulmonary embolism (PE) on anticoagulation for at least 3 months after the diagnosis.	Clinician : Individual, Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population: County or City	

Healthcare-Associated Infections (HAIs) [1:00 – 2:30 pm]

Available measures: 47; 32 measures in use or proposed for future use in 15 programs

- C. Difficile

  - Measure 1717 is currently undergoing NQF-endorsement review – should it be included?
  - Are measures needed for settings aside from inpatient hospitals?
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line Associated Blood Stream Infections (CLABSI)
  - Should there be outpatient process measures related to monitoring or education related to long-term indwelling central catheters?
- MRSA
  - Measure 1716 is currently undergoing NQF-endorsement review – should it be included?
- Surgical Site Infection
  - Is there a place for procedure-specific measures within SSI?
  - There are differences in prophylactic antibiotic selection and timing for cardiac and non-cardiac procedures – is it necessary to distinguish this for the family?
  - Concerns were recently raised related to the strength of the evidence for hair removal – should this be included in the family?
  - Can this list be paired down to create a more parsimonious list?
- Ventilator-Associated Pneumonia (VAP)
  - Could the pediatric VAP outcome measure be expanded to an adult population or is new measure needed?

- Overall
  - Are there measurement gaps for HAIs – other types of infections that have not been included?
  - Where needed, can all of these measures be expanded to the pediatric population or are there special considerations for HAIs with children?

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
C. Difficile	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	#1717 Submitted	CDC	Outcome	Standardized infection ratio (SIR) of hospital-onset CDI Laboratory-identified events (LabID events) among all inpatients in the facility, excluding well-baby nurseries and neonatal intensive care units (NICUs)	Facility, Population : National, Population: State	Adult/Elderly Care, Pediatric
CAUTI	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	#0138 Endorsed	CDC	Outcome	Standardized Infection Ratio (SIR) of healthcare-associated, catheter-associated urinary tract infections (CAUTI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) (excluding patients in neonatal ICUs [NICUs: Level II/III and Level III nurseries]) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • other inpatient locations (excluding Level I and Level II nurseries). Data from these locations are reported from acute care general hospitals (including specialty hospitals), freestanding long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. This scope of coverage includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations.	Facility , Population: National, Population: State	

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
CLABSI	National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	#0139 Endorsed	CDC	Outcome	Standardized Infection Ratio (SIR) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • other inpatient locations. (Data from these locations are reported from acute care general hospitals (including specialty hospitals), freestanding long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. This scope of coverage includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations.	Facility, Population : National, Population: State	
CLABSI	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol	#0464 Endorsed	AMA-PCPI	Process	Percentage of patients who undergo CVC insertion for whom CVC was inserted with all elements of maximal sterile barrier technique (cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis) followed	Clinician: Individual, Clinician: Group/Practice	
CLABSI	Central Line Bundle Compliance	#0298 Endorsed	Institute for Healthcare Improvement	Process	Percentage of intensive care patients with central lines for whom all elements of the central line bundle are documented and in place. The central line bundle elements include: •Hand hygiene , •Maximal barrier precautions upon insertion •Chlorhexidine skin antisepsis •Optimal catheter site selection, with subclavian vein as the preferred site for non-tunneled catheters in patients 18 years and older •Daily review of line necessity with prompt removal of unnecessary lines	Facility	Adult

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
MRSA	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	#1716 Submitted	CDC	Outcome	Standardized infection ratio (SIR) of hospital-onset unique blood source MRSA Laboratory-identified events (LabID events) among all inpatients in the facility	Facility, Population : National, Population: State	
SSI	SCIP INF–1 Prophylactic antibiotic received within 1 hour prior to surgical incision	#0527 Endorsed	CMS	Process	Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.	Facility, Population: Regional, Population: National	Adult
SSI	SCIP INF–2: Prophylactic antibiotic selection for surgical patients	#0528 Endorsed	CMS	Process	Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).	Facility, Population: Regional, Population: National	Adult
SSI	SCIP INF–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	#0529 Endorsed	CMS	Process	Surgical patients whose prophylactic antibiotics were discontinued within 24 hours after Anesthesia End Time (48 hours for CABG or Other Cardiac Surgery). The Society of Thoracic Surgeons (STS) Practice Guideline for Antibiotic Prophylaxis in Cardiac Surgery (2006) indicates that there is no reason to extend antibiotics beyond 48 hours for cardiac surgery and very explicitly states that antibiotics should not be extended beyond 48 hours even with tubes and drains in place for cardiac surgery.	Facility, Population: Regional, Population: National	Adult

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
SSI	SCIP INF–10: Surgery patients with perioperative temperature management	#0452 Endorsed	CMS	Process	Surgery patients for whom either active warming was used intraoperatively for the purpose of maintaining normothermia or who had at least one body temperature equal to or greater than 96.8° F/36° C recorded within the 30 minutes immediately prior to or the 15 minutes immediately after Anesthesia End Time.	Facility	All patients, regardless of age
SSI	OP–7: Prophylactic Antibiotic Selection for Surgical Patients.	#0268 Endorsed	AMA-PCPI	Process	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis	Clinician: Individual	Adult
SSI	ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing	#0264 Endorsed	ASC Quality Collaboration	Process	Rate of ambulatory surgery center (ASC) patients who received IV antibiotics ordered for surgical site infection prophylaxis on time	Facility	All ages
SSI	Timing of Prophylactic Antibiotics - Administering Physician	#0269 Endorsed	AMA-PCPI	Process	Percentage of surgical patients aged > 18 years with indications for prophylactic parenteral antibiotics for whom administration of the antibiotic has been initiated within one hour (if vancomycin, two hours) prior to the surgical incision or start of procedure when no incision is required.	Clinician: Individual	Adult
SSI	Perioperative Temperature Management	#0454 Endorsed	AMA-PCPI	Process	Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer for whom either active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 30 minutes immediately after anesthesia end time	Clinician: Individual, Clinician: Group/Practice	All patients, regardless of age

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
SSI	Selection of antibiotic prophylaxis for cardiac surgery patients	#0126 Endorsed	The Society of Thoracic Surgeons	Process	Percent of patients aged 18 years and older undergoing cardiac surgery who received preoperative prophylactic antibiotics recommended for the operation.	Clinician: Group/Practice, Facility, Population: County or City, Population: National, Population: Regional, Population: State	Adult
SSI	Duration of prophylaxis for cardiac surgery patients	#0128 Endorsed	The Society of Thoracic Surgeons	Process	Percent of patients aged 18 years and older undergoing cardiac surgery whose prophylactic antibiotics were discontinued within 48 hours after surgery end time	Clinician: Group/Practice, Facility, Population: County or City, Population: National, Population: Regional, Population: State	Adult
VAP	Ventilator-associated pneumonia for ICU and high-risk nursery (HRN) patients	#0140 Endorsed	CDC	Outcome	Percentage of ICU and HRN patients who over a certain amount of days have ventilator-associated pneumonia	Facility	Pediatric
VAP	Ventilator Bundle	#0302 Endorsed	Institute for	Process	Percentage of intensive care unit patients on mechanical ventilation at time of survey for whom all four elements of the ventilator bundle are	Facility	Adult

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
			Healthcare Improvement		documented and in place. The ventilator bundle elements are: •Head of bed (HOB) elevation 30 degrees or greater (unless medically contraindicated); noted on 2 different shifts within a 24 hour period •Daily “”sedation interruption” and daily assessment of readiness to extubate; process includes interrupting sedation until patient follow commands and patient is assessed for discontinuation of mechanical ventilation; Parameters of discontinuation include: resolution of reason for intubation; inspired oxygen content roughly 40%; assessment of patients ability to defend airway after extubation due to heavy sedation; minute ventilation less than equal to 15 liters/minute; and respiratory rate/tidal volume less than or equal to 105/min/L(RR/TV< 105) •SUD (peptic ulcer disease) prophylaxis •DVT (deep venous thrombosis) prophylaxis		

Injuries from Immobility [2:45 – 3:45 pm]

Available measures: 37; 25 measures in use or proposed for future use in 14 programs

- Falls
  - Should falls without injury be included in the family?
  - Is there a need for expansion to the pediatric population?
  - Measures 1733 and 1730 are currently undergoing NQF-endorsement review – should they be included?
- Pressure Ulcers
  - Should a safety family only address pressure ulcers from stage 2 to 4?

- Overall
  - Are there measurement gaps for Injuries related to Immobility, within or beyond falls and pressure ulcers?

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Falls	Patient Fall Rate	#0141 Endorsed	American Nurses Association	Outcome	All documented falls, with or without injury, experienced by patients on an eligible unit in a calendar quarter.	Clinician: Group/Practice	Adult
Falls	Falls with injury	#0202 Endorsed	American Nurses Association	Outcome	All documented patient falls with an injury level of minor or greater on eligible unit types in a calendar quarter. Reported as Injury falls per 1000 Patient Days. (Total number of injury falls / Patient days) X 1000 Measure focus is safety. Target population is adult acute care inpatient and adult rehabilitation patients.	Clinician: Team	Adult
Falls	ASC-2: Patient Fall	#0266 Endorsed	Ambulatory Surgical Centers Quality Collaborative	Outcome	Percentage of ambulatory surgery center (ASC) admissions experiencing a fall in the ASC.	Clinician: Individual	All ages

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Falls	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	#0674 Endorsed	CMS	Outcome	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	Facility, Population: National	
Falls	Fall risk management in older adults: (a) Discussing fall risk; (b) Managing fall risk	#0035 Endorsed	NCQA	Process	Percentage of patients aged 75 and older who reported that their doctor or other health provider talked with them about falling or problems with balance or walking Percentage of patients aged 75 and older who reported that their doctor or other health provider had done anything to help prevent falls or treat problems with balance or walking	Clinician: Individual	75 years and older
Falls	Falls: Screening for Fall Risk	#0101 Endorsed	NCQA	Process	Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months	Clinician: Individual	65 years or older
Falls	Falls: Plan of Care for Falls	#1733 Submitted	NCQA	Process	Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months	Clinician: Individual, Clinician: Group/Practice, Clinician: Team	65 years or older
Falls	Multifactor Fall Risk Assessment Conducted for Patients 65 and Over	#0537 Endorsed	CMS	Process	Percent of home health episodes in which the patient was 65 or older and was assessed for risk of falls (using a standardized and validated multi-factor Fall Risk Assessment) at start or resumption of home health care	Facility	65 years or older

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Falls	Falls: Risk Assessment	#1730 Submitted	NCQA	Process	Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months	Clinician: Individual, Clinician: Group/Practice, Clinician: Team	65 years or older
Pressure Ulcers	Increase in Number of Pressure Ulcers	#0181 Endorsed	CMS	Outcome	Percentage of patients who had an increase in the number of pressure ulcers	Facility	Adult
Pressure Ulcers	Pressure ulcer prevalence	#201 Endorsed	TJC	Outcome	The total number of patients that have hospital-acquired (nosocomial) category/stage II or greater pressure ulcers on the day of the prevalence measurement episode.	Facility, Clinician: Team	Adult
Pressure Ulcers	Decubitus ulcer (PDI 2)	#337 Endorsed	AHRQ	Outcome	Percent of surgical and medical discharges under 18 years with ICD-9-CM code for decubitus ulcer in secondary diagnosis field.	Facility	Pediatric

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Pressure Ulcers	Percent of High Risk Residents with Pressure Ulcers (Long Stay)	#0679 Endorsed	CMS	Outcome	CMS currently has this measure in their QMs but it is based on data from MDS 2.0 assessments and it includes Stage 1 ulcers. This proposed measure will be based on data from MDS 3.0 assessments of long-stay nursing facility residents and will exclude Stage 1 ulcers from the definition. The measure reports the percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s). High risk populations are those who are comatose, or impaired in bed mobility or transfer, or suffering from malnutrition. Long-stay residents are those who have been in nursing facility care for more than 100 days. This measure is restricted to the population that has long-term needs; a separate pressure ulcer measure is being submitted for short-stay populations. These are defined as having a stay that ends with a discharge within the first 100 days.	Facility, Population: National	

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Pressure Ulcers	Percent of Residents with Pressure Ulcers That Are New or Worsened (Short-Stay)	#0678 Endorsed	CMS	Outcome	This measure updates CMS' current QM pressure ulcer measure which currently includes Stage 1 ulcers. The measure is based on data from the MDS 3.0 assessment of short-stay nursing facility residents and reports the percentage of residents who have Stage 2-4 pressure ulcers that are new or have worsened. The measure is calculated by comparing the Stage 2-4 pressure ulcer items on the discharge assessment and the previous MDS assessment (which may be an OBRA admission or 5-day PPS assessment). The quality measure is restricted to the short-stay population defined as those who are discharged within 100 days of admission. The quality measure does not include the long-stay residents who have been in the nursing facility for longer than 100 days. A separate measure has been submitted for them.	Facility	
Pressure Ulcers	Pressure Ulcer Prevention Plans Implemented	#0539 Endorsed	CMS	Process	Percent of patients with assessed risk for Pressure Ulcers for whom interventions for pressure ulcer prevention were implemented during their episode of care	Facility	Adult
Pressure Ulcers	Pressure Ulcer Risk Assessment Conducted	#0540 Endorsed	CMS	Process	Percent of patients who were assessed for risk of Pressure Ulcers at start/resumption of home health care	Facility	Adult

Perioperative/Procedural Safety [3:45 – 4:45 pm]

Available measures: 19; 10 measures used or proposed for future use in 7 programs

- Trauma (burn, shock, laceration, puncture, iatrogenic pneumothorax, etc.)
- Foreign Object Retained After Surgery
- Air Embolism

- Overall
  - Do these areas rise to the level of impact necessary for inclusion within the family as individual measures? Should these areas be addresses through a composite measure?
  - Are there any appropriate process measures to address prophylaxis in any of these areas?
  - Are there measurement gaps for perioperative/procedural safety?

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Trauma	Accidental puncture or laceration (PDI 1) (risk adjusted)	#0344 Endorsed	AHRQ	Outcome	Percent of medical and surgical discharges under 18 years of age with ICD-9-CM code denoting accidental cut, puncture, perforation or laceration in any secondary diagnosis code.	Facility	Pediatric
Trauma	Iatrogenic pneumothorax in non-neonates (PDI 5) (risk adjusted)	#0348 Endorsed	AHRQ	Outcome	Percent of medical and surgical discharges, age under 18 years, with ICD-9-CM code of iatrogenic pneumothorax in any secondary diagnosis field.	Facility	Pediatric
Trauma	PSI 15: Accidental puncture or laceration	#0345 Endorsed	AHRQ	Outcome	Percent of medical and surgical discharges, 18 years and older, with ICD-9-CM code denoting accidental cut, puncture, perforation, or laceration in any secondary diagnosis field.	Facility	Adult
Trauma	PSI 06: Iatrogenic pneumothorax, adult	#0346 Endorsed	AHRQ	Outcome	Percent of medical and surgical discharges, 18 years and older, with ICD-9-CM code of iatrogenic pneumothorax in any secondary diagnosis field	Facility	Adult
Trauma	PSI 14: Post-operative wound dehiscence	#0368 Endorsed	AHRQ	Outcome	Cases of reclosure of postoperative disruption of abdominal wall per 1,000 cases of abdominopelvic surgery. Excludes obstetric admissions.	Facility	Adult
Trauma	ASC-1: Patient Burn -Percentage of ASC admissions experiencing a burn prior to discharge	#0263 Endorsed	Ambulatory Surgical Centers Quality Collaborative	Outcome	Percentage of ambulatory surgery center (ASC) admissions experiencing a burn prior to discharge	Clinician: Individual	All ages

Trauma	ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	#0267 Endorsed	Ambulatory Surgical Centers Quality Collaborative	Outcome	Percentage of ambulatory surgery center (ASC) admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant.	Clinician: Individual	All ages
Foreign Object Retained After Surgery	Foreign Body Left in During Procedure (PSI 5)	#0363 Endorsed	AHRQ	Outcome	Discharges with foreign body accidentally left in during procedure per 1,000 discharges	Facility	Adult
Foreign Object Retained After Surgery	Foreign Body left after procedure (PDI 3)	#0362 Endorsed	AHRQ	Outcome	Discharges with foreign body accidentally left in during procedure per 1,000 discharges	Facility	Pediatric

DAY 2 – June 20

Medication/Infusion Safety [9:00 – 10:30 am]

Available measures: 57; 36 measures in use or proposed for future use in 13 programs

- Adverse Drug Events
  - Should medication-specific measures for warfarin/Coumadin be included in the family?
  - Are there other medications or types of medications that should be included in a safety family?
- Blood Incompatibility
- Manifestations of Poor Glycemic Control (includes Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Secondary Diabetes w/ Ketoacidosis, Secondary Diabetes w/ Hyperosmolarity)
  - Does this area rise to the level of impact for inclusion within a safety family? There are no available NQF-endorsed measures addressing this area.

- Overall
  - Do blood incompatibility and manifestations of poor glycemic control rise to the level of impact to be included in the family?
  - Are there any appropriate process measures to address prevention of blood incompatibility and manifestations of poor glycemic control?
  - Are there measurement gaps for medication/infusion safety?

Subtopic		Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
ADE	Med Edu	Improvement in Management of Oral Medications	#0176 Endorsed	CMS	Outcome	Percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly, by mouth.	Facility	Adult/Elderly Care
ADE	Med Edu	Drug Education on All Medications Provided to Patient/Caregiver During Episode	#0520 Endorsed	CMS	Process	Percentage of home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems (since the previous OASIS assessment).	Facility	Adult/Elderly Care
ADE	Med Rec	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	#0097 Endorsed	NCQA	Process	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	Clinician: Individual	65 years and older
ADE	Med Rec	Documentation of Current Medications in the Medical Record	#0419 Endorsed	CMS	Process	Percentage of patients aged 18 years and older with a list of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verified with the patient or authorized representative documented by the provider.	Clinician: Individual	Adult

Subtopic		Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
ADE	Med Rec	Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	#0646 Endorsed	AMA-PCPI	Process	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories	Facility, Integrated Delivery System	
ADE	Med Rec	Medication Reconciliation Post-Discharge (MRP)	#0554 Endorsed	NCQA	Process	Percentage of discharges from January 1 to December 1 of the measurement year for patients 65 years of age and older for whom medications were reconciled on or within 30 days of discharge.	Clinician: Individual, Clinician: Group/Practice, Health Plan	
ADE	Med Rec	Adoption of Medication e-Prescribing	#0486 Endorsed	CMS	Structure	Documents whether provider has adopted a qualified e-Prescribing system and the extent of use in the ambulatory setting.	Clinician: Group/Practice, Clinician: Individual	
ADE	Med Rec	Medication Information	#0293 Endorsed	Uni of MN Rural Health Research Center	Process	Percentage of patients transferred to another acute hospitals whose medical record documentation indicated that medication information was communicated to the receiving hospital within 60 minutes of departure	Facility	
ADE	Monitoring	Monthly INR monitoring for beneficiaries on warfarin	#0555 Endorsed	CMS	Process	Average percentage of monthly intervals in which individuals with claims for warfarin do not receive an International Normalized Ratio (INR) test during the measurement period.	Clinician: Group/Practice, Population: State	Adult

Subtopic		Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
ADE	Monitoring	INR for beneficiaries taking warfarin and interacting anti-infective medications	#0556 Endorsed	CMS	Process	Percentage of episodes with an INR test performed 3 to 7 days after a newly-started interacting anti-infective medication for Part D beneficiaries receiving warfarin	Clinician: Individual, Clinician: Group/Practice	Adult
ADE	Monitoring	Warfarin_PT/ INR Test	#0586 Endorsed	Resolution Health, Inc.	Process	This measure identifies the percentage of patients taking warfarin during the measurement year who had at least one PT/INR test within 30 days after the first warfarin prescription in the measurement year	Clinician: Individual, Clinician: Group/Practice, Health Plan, Integrated Delivery System, Population: County or City	Adult
ADE	Monitoring	Warfarin - INR Monitoring	#0612 Endorsed	ActiveHealth Management	Process	The percentage of adult patients taking warfarin who had PT/INR monitoring	Clinician: Individual, Clinician: Group/Practice, Clinician: Team, Facility, Health Plan, Integrated Delivery System, Population: Community, Population: County or City, Population: National, Population:	Adult

Subtopic		Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
							Regional, Population: State	
Blood Incompatibility		Transfusion reaction (PSI 16)	#0349 Endorsed (Recommended for Reserve Status)	AHRQ	Outcome	Percent of medical and surgical discharges, 18 years and older, with ICD-9-CM code for transfusion reaction in any secondary diagnosis field.	Facility	Adult
Blood Incompatibility		Transfusion reaction (PDI 13)	#0350 Endorsed (Recommended for Reserve Status)	AHRQ	Outcome	Percent of medical and surgical discharges, under 18 years of age, with an ICD-9-CM code for transfusion reaction in any secondary diagnosis field. Percent of medical and surgical discharges, under 18 years of age, with an ICD-9-CM code for transfusion reaction in any secondary diagnosis field.	Facility	Pediatric

Obstetrical Adverse Events [10:45 – 11:45 am]

Available measures: 11; 2 measures proposed for future use in 2 programs

- Pre-Delivery

  - What patient safety areas could be addressed in the pre-delivery timeframe?
- Delivery
  - Are elective deliveries prior to 39 weeks and elective Cesarean sections considered patient safety issues?
- Post-Delivery
  - Neonatal bloodstream Infections measures:
    - 1731 – medical record data abstraction; the Joint Commission's version of the AHRQ measure
    - 0478 – claims-based data abstraction, AHRQ
    - 0304 – specific subset of the newborn population: NICU and low birth weight, very high risk; data collected through a registry

- Overall
  - Are there measurement gaps for obstetrical adverse events?

Subtopic		Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Obstetrical Adverse Events	Delivery	Prophylactic antibiotic received within one hour prior to surgical incision or at the time of delivery – cesarean section	#0472 Endorsed	Massachusetts General Hospital/Partners Health Care System	Process	Percentage of patients undergoing cesarean section who receive appropriate prophylactic antibiotics within 60 minutes of the start of the cesarean delivery, unless the patient is already receiving appropriate antibiotics	Facility, Population: State	Maternal Health
Obstetrical Adverse Events	Delivery	Appropriate DVT prophylaxis in women undergoing cesarean delivery	#0473 Endorsed	Hospital Corporation of America	Process	Measure adherence to current ACOG, SMFM recommendations for use of DVT prophylaxis in women undergoing cesarean delivery. Current ACOG and SMFM recommendations call for the use of pneumatic compression devices in all women undergoing cesarean delivery who are not already receiving medical VTE prophylaxis. Numerator: Number of women undergoing cesarean delivery receiving either pneumatic compression device or	Facility	Maternal Health

Subtopic		Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
						medical prophylaxis prior to cesarean delivery. Denominator: All women undergoing cesarean delivery.		
Obstetrical Adverse Events	Delivery	PC-02 Cesarean Section	#0471 Endorsed	TJC	Outcome	This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. This measure is part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	Facility, Population: National	Infant, Maternal Health
Obstetrical Adverse Events	Delivery	Under 1500g infant Not Delivered at Appropriate Level of Care	#0477 Endorsed	California Maternal Quality Care Collaborative	Outcome	The number per 1,000 live births of <1500g infants delivered at hospitals not appropriate for that size infant.	Population: County or City, Facility, Health Plan, Population: National, Population: Regional, Population: State	Infant, Maternal Health
Obstetrical Adverse Events	Delivery	PC-01 Elective delivery prior to 39 completed weeks gestation	#0469 Endorsed	TJC	Process	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)	Facility, Population: National	Infant, Maternal Health

Subtopic		Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Obstetrical Adverse Events	Post-delivery	Late sepsis or meningitis in very low birth weight (VLBW) neonates (risk-adjusted)	#0304 Endorsed	Vermont Oxford Network	Outcome	Standardized rate and standardized morbidity ratio for nosocomial bacterial infection after day 3 of life for very low birth weight infants, including infants with birth weights between 401 and 1500 grams and infants whose gestational age is between 22 and 29 weeks.	Facility	Infant
Obstetrical Adverse Events	Post-delivery	Neonatal Blood Stream Infection Rate (NQI #3)	#0478 Endorsed	AHRQ	Outcome	Percentage of high-risk newborn discharges with an ICD-9-CM diagnosis code of bloodstream infection	Facility	Infant
Obstetrical Adverse Events	Post-delivery	Healthy Term Newborn	#0716 Endorsed	California Maternal Quality Care Collaborative	Outcome	Percent of term singleton live births (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or the nursery care.	Facility, Integrated Delivery System, Population: Regional, Population: State, Clinician: Team	Infant
Obstetrical Adverse Events	Post-delivery	PC-04 Health Care-Associated Bloodstream Infections in Newborns	#1731 Endorsed	TJC	Outcome	This measure assesses the number of staphylococcal and gram negative septicemias or bacteremia in high-risk newborns. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-05: Exclusive Breast Milk Feeding).	Facility, Population: National	Infant

Safety-related Overuse and Appropriateness [12:30 – 1:30 pm]

Available measures: 28; 20 measures in use or proposed for future use in 8 programs

- Imaging
  - What are other critical patient safety issues related to imaging beyond, use of contrast, CT, and radiation?
- Medications
  - When is an inappropriate use of medications considered an immediate safety issue? How does this translate to the measures included within the family?
  - What are other critical patient safety issues related to appropriate use of medications?
- Procedures

- Overall
  - What is the threshold of harm to the patient when considering overuse and appropriateness of care?
  - Are there measurement gaps for safety-related overuse and appropriateness beyond imaging, medications, and procedures?

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Imaging-Contrast Material	OP-11 Use of Contrast: Thorax CT	#0513 Endorsed	CMS	Outcome	Thorax CT – Use of combined studies (with and without contrast) Estimate the ratio of combined (with and without) studies to total studies performed. A high value would indicate a high use of combination studies (71270). Results to be segmented based upon data availability by rendering provider, rendering provider group and facility. This measure calculates the percentage of thorax studies that are performed with and without contrast out of all thorax studies performed (those with contrast, those without contrast, and those with both). Current literature clearly defines indications for the use of combined studies, that is, examinations performed without contrast followed by contrast enhancement. The intent of this measure is to assess questionable utilization of contrast	Facility, Clinician: Group/Practice, Clinician: Individual	

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
					agents that carry an element of risk and significantly increase examination cost. While there may be a direct financial benefit to the service provider for the use of contrast agents due to increased reimbursements for "combined" studies, this proposed measure is directed at the identification of those providers who typically employ interdepartmental/facility protocols that call for its use in nearly all cases. The mistaken concept is that more information is always better than not enough. The focus of this measure is one of the specific body parts where the indications for contrast material are more specifically defined.		
Imaging-CT	Low Back Pain: Use of Imaging Studies	#0052 Endorsed	NCQA	Process	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis	Clinician: Group/Practice, Health Plan, Clinician: Individual, Integrated Delivery System, Population: National, Population: Regional, Population: State	Adult, Excludes over 50
Imaging-CT	LBP: Repeat Imaging Studies	#0312 Endorsed	NCQA	Process	Percentage of patients who received inappropriate repeat imaging studies in the absence of red flags or progressive symptoms (overuse measure, lower performance is better). Includes Plain x-ray, Bone scan, MRI, Myleography, Discography, CT scan.	Clinician: Group/Practice, Clinician: Individual	

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Imaging-CT	LBP: Appropriate Imaging for Acute Back Pain	#0315 Endorsed	NCQA	Process	Percentage of patients with a diagnosis of back pain for whom the physician ordered imaging studies during the six weeks after pain onset, in the absence of "red flags" (overuse measure, lower performance is better). Includes Plain x-ray, Bone scan, MRI, Myleography, Discography, CT scan.	Clinician: Group/Practice, Clinician: Individual	Adult
Imaging-CT	Inappropriate Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism	#0667 Endorsed	Partners HealthCare System, Inc.	Process	Percent of patients undergoing CT pulmonary angiogram for the evaluation of possible PE who are at low-risk for PE consistent with guidelines (1, 2) prior to CT imaging. (1) Torbicki A, Perrier A, Konstantinides S, et al. Guidelines on the diagnosis and management of acute pulmonary embolism: the Task Force for the Diagnosis and Management of Acute Pulmonary Embolism of the European Society of Cardiology (ESC). Eur Heart J. 2008 Sep;29(18):2276-315 2) Fesmire FM, Brown MD, Espinosa JA, Shih RD, Silvers SM, Wolf SJ, Decker WW; American College of Emergency Physicians. Critical issues in the evaluation and management of adult patients presenting to the emergency department with suspected pulmonary embolism. Ann Emerg Med. 2011 Jun; 57(6):628-652.e75. PMID:21621092	Facility, Clinician: Group/Practice	
Imaging-CT	Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury	#0668 Endorsed	Partners HealthCare System, Inc.	Process	Percent of adult patients who presented within 24 hours of a non-penetrating head injury with a Glasgow coma score (GCS) >13 and underwent head CT for trauma in the ED who have a documented indication consistent with guidelines (1) prior to imaging.	Facility, Clinician: Group/Practice	
Imaging-CT	Appropriate Cervical Spine Radiography and CT Imaging in Trauma	#0755 Endorsed	Partners HealthCare System, Inc.	Process	Percent of adult patients undergoing cervical spine radiography or CT imaging for trauma who have a documented evidence-based indication prior to imaging (Canadian C-Spine Rule or the NEXUS Low-Risk Criteria).	Facility, Clinician: Group/Practice, Population: National, Population:	Adult, excludes 65 or older

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
						Regional, Population: State	
Imaging-CT (Also radiation?)	Melanoma: Overutilization of Imaging Studies in Stage 0-IA Melanoma	#0562 Endorsed	AMA-PCPI	Process	Percentage of patients with stage 0 or IA melanoma, without signs or symptoms, for whom no diagnostic imaging studies were ordered. Diagnostic imaging studies include CXR, CT, Ultrasound, MRI, PET, and nuclear medicine scans.	Clinician: Group/Practice, Clinician: Individual	
Imaging-Radiation	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients	#0389 Endorsed	AMA-PCPI	Process	Percentage of patients with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer	Clinician: Group/Practice, Clinician: Individual	
Imaging-Radiation	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	#0511 Endorsed (Not Recommended)	AMA-PCPI	Process	Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT) that were performed	Clinician: Group/Practice, Clinician: Individual	All

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Medication	Appropriate Testing for Children with Pharyngitis	#0002 Endorsed	NCQA	Process	The percentage of children 2–18 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).	Clinician: Group/Practice, Health Plan, Clinician: Individual, Integrated Delivery System, Population: National, Population: Regional, Population: State	Pediatric
Medication	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	#0058 Endorsed	NCQA	Process	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	Clinician: Group/Practice, Health Plan, Clinician: Individual, Integrated Delivery System, Population: National, Population: Regional, Population: State	Adult, excludes 65 and older

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Medication	Appropriate treatment for children with upper respiratory infection (URI)	#0069 Endorsed	NCQA	Process	The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.	Clinician: Group/Practice, Health Plan, Clinician: Individual, Integrated Delivery System, Population: National, Population: Regional, Population: State	Pediatric
Medication	LBP: Appropriate Use of Epidural Steroid Injections	#0309 Endorsed	NCQA	Process	Percentage of patients with back pain who have received an epidural steroid injection in the absence of radicular pain AND those patients with radicular pain who received an epidural steroid injection without image guidance (overuse measure, lower performance is better).	Clinician: Group/Practice, Clinician: Individual	Adult
Medication	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use	#0654 Endorsed	AMA-PCPI	Process	Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy	Clinician: Group/Practice, Clinician: Individual, Clinician: Team	Pediatric
Medication	Otitis Media with Effusion: Systemic corticosteroids – Avoidance of inappropriate use	#0656 Endorsed	AMA-PCPI	Process	Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic corticosteroids	Clinician: Group/Practice, Clinician: Individual, Clinician: Team	Pediatric

Subtopic	Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Medication	Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials	#0657 Endorsed	AMA-PCPI	Process	Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials	Clinician: Group/Practice, Clinician: Individual, Clinician: Team	Pediatric
Procedures	LBP: Surgical Timing	#0305 Endorsed	NCQA	Process	Percentage of patients without documentation of red flags who had surgery within the first six weeks of back pain onset (overuse measure, lower performance is better). Note: This measure is applicable only for physicians who perform surgery.	Clinician: Group/Practice, Clinician: Individual	Adult
Procedures	Endoscopy/Poly Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	#0658 Endorsed	AMA-PCPI	Process	Percentage of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.	Clinician: Group/Practice, Clinician: Individual	50 years or older
Procedures	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	#0659 Endorsed	AMA-PCPI	Process	Endoscopy/Poly Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	Clinician: Group/Practice, Clinician: Individual, Clinician: Team	Adult

Complications-related Mortality [1:30 – 2:30 pm]

Available measures: 42; 5 measures in use in 2 programs

- Overall
  - Should complications-related mortality be addressed in a safety measure family?
  - Are there measurement gaps for complications-related mortality?

Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Death among surgical inpatients with serious, treatable complications (PSI 4)	#0351 Endorsed	AHRQ	Outcome	Percentage of cases having developed specified complications of care with an in-hospital death.	Facility	Adult
Failure to Rescue In-Hospital Mortality (risk adjusted)	#0352 Endorsed	The Children´s Hospital of Philadelphia	Outcome	Percentage of patients who died with a complication in the hospital.	Population: County or City, Facility, Health Plan, Population: National, Population: Regional, Population: State, Integrated Delivery System	Adult
Failure to Rescue 30-Day Mortality (risk adjusted)	#0353 Endorsed	The Children´s Hospital of Philadelphia	Outcome	Percentage of patients who died with a complication within 30 days from admission.	Population: County or City, Facility, Health Plan, Population: National, Population: Regional, Population: State, Integrated Delivery System	Adult

Complications Composites

Measure	NQF Number and Status	Steward	Measure Type	Description	Level of Analysis	Target Population
Patient Safety for Selected Indicators	#0531 Endorsed	AHRQ	Composite	A composite measure of potentially preventable adverse events for selected indicators. Number of potentially preventable adverse events for accidental puncture or laceration, iatrogenic pneumothorax, postoperative DVT or PE, postoperative wound dehiscence, decubitus ulcer, selected infections due to medical care, postoperative hip fracture and postoperative sepsis (separately).	Facility	Adult
Pediatric Patient Safety for Selected Indicators	#0532 Endorsed	AHRQ	Composite	A composite measure of potentially preventable adverse events for selected pediatric indicators. Number of potentially preventable adverse events for accidental puncture or laceration, decubitus ulcer, iatrogenic pneumothorax, postoperative wound dehiscence, postoperative sepsis and selected infection due to medical care (separately).	Facility	Pediatric

Proposed Prioritization for Safety Subtopic Areas

Based on information derived primarily from the Partnership for Patients, CDC, AHRQ, and CMS online resources, the following high-level summary and tiered ranking was developed. Given the limitations of category definitions, uneven availability of data, and lack of distinct universal thresholds, the assignments are somewhat subjective by nature.

Note: Please refer to the meeting Discussion Guide and Master Measures Chart for related measures.

Subtopic	Impact	Improvability	Inclusiveness	Priority
Venous Thromboembolism (VTE)				
VTE* [†]	High incidence & potential for serious harms and $$	PfP: 40% preventable; effective guidelines	Limited conditions & settings	High
Healthcare-acquired Infections (HAI)				
CAUTI* [†‡]	High incidence; moderate to high $$; variable harms	PfP: 40% preventable; effective guidelines	Most common HAI, limited settings	High
CLABSI* [†‡]	High incidence; often serious and high $$	PfP: 50% preventable; effective guidelines	Certain conditions & settings more likely	High
SSIs* [†‡]	High incidence; variable harms and $$	PfP: 35% preventable; effective guidelines	Limited conditions & settings	High
VAP* [‡]	High incidence & potential for serious harms and $$	PfP: 50% preventable; effective guidelines	Limited conditions & settings	High
C. difficile [‡]	High incidence; potential for serious harms and $$	Moderately effective guidelines	High-risk groups; variety of settings	Medium
MRSA [‡]	Moderate incidence	Effective guidelines	Limited conditions; setting-specific issues	Medium
Injuries from Immobility				
Pressure Ulcers* [†]	High incidence; harm and $$ increase with Stage	PfP: 50% preventable; effective guidelines	High-risk groups; multiple settings	High
Falls* [†]	High incidence; variable harms and $$	PfP: 25% preventable; moderately effective guidelines	High-risk groups; setting-specific issues	Medium
Perioperative/Procedural Safety				
Trauma (burns, shock, laceration, iatrogenic pneumothorax, etc.) [†]	Moderate to high incidence	Limited guidelines	Limited conditions & settings	Medium
Foreign Object Retained After Surgery [†]	Low incidence	Effective guidelines	Limited conditions & settings	Low
Air Embolism [†]	Low incidence	No guidelines for prevention	Limited conditions & settings	Low

Subtopic	Impact	Improvability	Inclusiveness	Priority
Medication/Infusion Safety				
Adverse Drug Events*	Very high incidence & $$; variable harms	PfP: 50% preventable; effective guidelines	Variety of conditions, patients & settings	High
Manifestations of Poor Glycemic Control†	Moderate incidence	Effective guidelines	Limited conditions; setting-specific issues	Medium
Blood Incompatibility†	Low incidence	Limited guidelines	Limited conditions & settings	Low
Obstetrical Adverse Events				
Obstetrical Adverse Events*	High incidence; variable harms and $$	PfP: 30% preventable; effective guidelines	Child-bearing age women & infants, limited settings	Medium
Safety-related Overuse and Appropriateness				
Imaging Overuse (CT, Contrast, Radiation)	High incidence and $$; long-term harms	Moderately effective guidelines	Variety of patients, conditions & settings	Medium
Medication Overuse (appropriate use/drug selection, culture /sensitivity testing)	High incidence; population-level harms	Moderately effective guidelines and initiatives	Variety of patients, conditions & settings	Medium

*Partnership for Patients focus area

† Conditions partially or fully included/proposed on the CMS Hospital-Acquired Conditions list

‡ Conditions included in the HHS Healthcare-Associated Infections initiative

Public Sector Programs using Patient Safety Measures

Program	Program Goal / Measurement Focus
Inpatient Quality Reporting Program (IQR)	• Pay for reporting program. • Hospitals that do not successfully report data receive a reduction in the annual updates of their Medicare payment rates. • IQR FY 2015 set will include measures addressing: o VTE o SSI o CLABSI o CAUTI o MRSA o C. difficile o Foreign object retained after surgery o Air embolism o Blood incompatibility o Pressure ulcers o Falls and trauma o Manifestations of poor glycemic control
Value-Based Purchasing Program (VBP)	• In FY 2013, Medicare will begin basing a portion of hospital reimbursement on performance through the Hospital Value-Based Purchasing (VBP) Program. • The FY 2013 set will include measures addressing: o SSI o VTE • Finalized outcome measures for FY 2014 will address: o Foreign object retained after surgery o Air embolism o Blood incompatibility o Pressure ulcers o Falls and trauma o Manifestations of poor glycemic control o CLABSI o CAUTI

Public Sector Programs using Patient Safety Measures

Program	Program Goal / Measurement Focus
Outpatient Quality Reporting Program (OQR)	• Pay for reporting program for outpatient hospital services. • Hospitals that do not meet the program requirements receive a two percentage point reduction in their annual payment update under the Outpatient Prospective Payment System (OPPS). • CY 2014 measure set addresses: o SSI

Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	• Provides incentive payments to adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. For 2015 and later, hospitals that do not successfully demonstrate meaningful use will have a reduction in their Medicare reimbursement.
	• Stage 1 measures addressed:
	  o VTE
	• Proposed Stage 2 measures address:
	  o VTE
	  o Obstetrical adverse events (elective delivery prior to 39 weeks, healthy term newborn)
	  o SSI

Inpatient Psychiatric Hospital Quality Reporting	• ACA established a new pay for reporting program for psychiatric hospitals and psychiatric units. • Beginning in FY 2014, psychiatric hospitals and units that do not report quality data according to CMS' requirements will receive up to a two percent reduction in the annual rate update. • Measures under consideration for the program address: o Adverse drug events (depends how we define)

PPS-Exempt Cancer Hospital Quality Reporting Program	• New program established by the ACA
	• PPS-exempt cancer hospitals must publicly report data with no Medicare payment incentive
	• Proposed measure set addresses:
	  o CLABSI
	  o CAUTI

Ambulatory Surgical Center Quality Reporting	• Pay for reporting program
	• Any ASC that does not submit data will incur a 2 percentage point reduction in annual increase
	• Measure set addresses:
	  o Falls and Trauma
	  o SSI

Program	Program Goal / Measurement Focus
Nursing Home Quality Initiative / Nursing Home Compare Measures	• Measure set addresses: o Falls o Pressure Ulcers o CAUTI o Restraint Use
Inpatient Rehabilitation Quality Reporting Program	• Measure set addresses: o CAUTI o Pressure Ulcers
Long-Term Care Hospital Quality Reporting Program	• Measure set addresses: o CAUTI o CLABSI o Pressure Ulcers
End Stage Renal Disease Quality Improvement Program (QIP)	• Measure set addresses: o ADE
Hospital-Acquired Conditions (Present on Admission Indicator)	Established by section 5001(c) of the Deficit Reduction Act (DRA) of 2005. Requires the Secretary of HHS to identify conditions that are: • High cost or high volume or both • Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis • Could reasonably have been prevented through the application of evidence-based guidelines Hospitals do not receive additional payment for cases in which one of the selected conditions was not present on admission. The selected conditions are: • Foreign Object Retained After Surgery • Air Embolism • Blood Incompatibility

Program	Program Goal / Measurement Focus
	• Falls and Trauma • Manifestations of Poor Glycemic Control • CAUTI • CLABSI • Stage III and IV Pressure Ulcers • Surgical Site Infection following specific procedures • Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Beginning in FY2015, hospitals scoring in the top quartile for the rate of HACs compared to the national average will have their Medicare payments reduced for all DRGs. » The fiscal year will be the applicable period for determination of rates » An appropriate risk-adjustment methodology will be established and applied The included conditions will be the Medicare HACs and any other conditions acquired during a hospital stay that the Secretary deems appropriate. Information on HACs will be made public and posted on Hospital Compare. Hospitals will have an opportunity to review and correct before the information is made public. The Secretary will conduct a study on expanding this policy to IRFs, LTCHs, hospital outpatient departments, PPS-exempt hospitals, SNFs, ASCs, and health clinics. This report was due to be submitted to Congress Jan. 1, 2012.
Partnership for Patients: Better Care, Lower Costs	A public-private partnership launched in December 2011 aimed at improving the quality, safety, and affordability of health care for all Americans. Partners include over 500 hospitals, physicians, nurses, health plans, employers, unions, patients and consumer groups, and state governments. The two goals of the partnership are: - *Keep patients from getting injured or sicker*. By the end of 2013, preventable hospital-acquired conditions would **decrease by 40%** compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients, with more than **60,000 lives saved** over the next three years. - *Help patients heal without complication*. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be **reduced by 20%** compared to 2010. Achieving this goal would mean more than **1.6**

Program	Program Goal / Measurement Focus
	million patients will recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.
National Action Plan to Prevent Healthcare-Acquired Infections: Roadmap to Elimination	Phase 1 focused on HAI prevention in acute care hospitals, and addressed the most common infections. It included the following: • Recommended clinical practices • A prioritized research agenda • An integrated information systems strategy • Policy options for linking payment incentives or disincentives to quality of care and enhancing regulatory oversight of healthcare facilities • A national messaging and communications plan

Sample of Private Sector Value-Based Purchasing Initiatives

Initiatives	Stakeholders Engaged	Program Goal / Measurement Focus	Connects to MAP's work by . . .
NBCH's eValue8 RFI	Purchasers and Health Plans	Created by purchasers, it asks health plans questions about how they handle critical processes that: ➢ Control costs ➢ Reduce/eliminate waste ➢ Ensure patient safety ➢ Close gaps in care ➢ Improve healthcare	➢ Aligning purchasers and payers in an effort to improve healthcare quality, patient safety and cost, and improve the transparency of information for consumers (Partners with **CPR and Leapfrog)**
Catalyst for Payment Reform	Purchasers, Health Plans, and Consumers	Align consumer groups, providers, and payers to reform private sector health care payment (aligned with Medicare). Two major foci: 1) A National Scorecard on Payment Reform will track the status of the private sector's progress from volume- to value-oriented payment both regionally and nationally 2) A National Compendium on Payment Reform will be a web-based, searchable and sortable, detailed database of private-sector payment reform initiatives Both are scheduled to be released at the end of the first quarter of 2013.	➢ Aligning patient groups, providers, and payers in an effort to move private sector healthcare payment from a volume to value-based purchasing model, and to align this effort with Medicare (CPR's health plan RFI is integrated into **NBCH**'s eValue8 and asks specific questions used in the **Leapfrog** Hospital Survey.)
Leapfrog Hospital Survey / Leapfrog Hospital Recognition Program	Purchasers and Hospitals *(health plans and consumers)*	Leapfrog's survey is a nationwide, publicly available survey of over 2,600 acute care facilities that makes information available to purchasers and consumers about patient safety, quality, and cost. 26 measures create a composite safety score of A to F. The Recognition program is a national pay-for-performance program designed to reward hospitals for quality and efficiency, implemented regionally. (usually through an NBCH coalition/Leapfrog Regional Roll-Out market)	➢ Aligning purchasers to improve the quality, safety, and affordability of healthcare in U.S. hospitals and improve the transparency of information for consumers (Recognition Program aligns purchasers/payers/providers by moving from a volume to value-based purchasing model for hospitals) (Leapfrog's survey uses AHRQ, CMS, and Leapfrog measures (26)). It partners with **NBCH** to roll out its survey and rewards program, both of which are included as questions in the eValue8 RFI.)

Sample of Private Sector Value-Based Purchasing Initiatives

Initiatives	Stakeholders Engaged	Program Goal / Measurement Focus	Connects to MAP's work by . . .
Integrated Healthcare Association (IHA)	Providers and Health Plans	IHA promotes accountability and transparency through health care standards, measurement, rewards, and providing information to third parties for public reporting. IHA supports numerous pay-for-performance programs, a multi-payer, multi-hospital "bundled" payment program in CA, and the development and implementation of efficiency measures to lower health care costs.	➢ Supporting collaboration among providers and payers in rewarding value-based purchasing programs on the regional, national, and international level
Buying Value – "A Health Care Purchasers' Initiative"	Purchasers and Consumers	Large employer and consumer groups, including all of the above, linking private purchasing efforts to national, public value-based purchasing efforts, such as Medicare's Value-Based Purchasing Program, the Partnership for Patients, and State Insurance Exchanges. Focused on alerting purchasers to: ➢ The opportunity to move to value purchasing ➢ The danger of additional cost-shifting	➢ Supporting alignment in public and private efforts to use value-based purchasing (Informal partners of this initiative include **NBCH**, **The Leapfrog Group**, **Catalyst for Payment Reform**, the Consumer-Purchaser Disclosure Project, the National Partnership for Women and Families, and others.)
America's Health Insurance Plans (AHIP)	Health Plans	AHIP is the national trade association representing the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. As the national trade association, AHIP collects information about payer initiatives that promote quality, patient safety, and affordability.	➢ Promoting the adoption and use of health information technology ➢ Emphasizing care coordination to target chronic illnesses ➢ Reducing preventable admissions/readmissions/ER visits ➢ Recognizing and rewarding quality care and appropriate resource use **through partnerships with providers, the government,*

Initiatives	Stakeholders Engaged	Program Goal / Measurement Focus	Connects to MAP's work by . . .
		Examples include: • Aetna Physician Incentive Program • Blue Cross and Blue Shield of Florida, Recognizing Physician Excellence Program • Blue Cross Blue Shield of Massachusetts, Group Performance-Based Incentive Program • CIGNA and Dartmouth-Hitchcock Healthcare System, Medical Home Collaboration • Geisinger Health Plan, ProvenHealth Navigator • HealthPartners, Partners in Quality • Horizon Blue Cross Blue Shield of New Jersey – Physician Recognition Program (expanding to surgical and medical specialties) • UnitedHealthcare/PacifiCare – Quality Incentive Program	*and employers**

National Priorities Partnership

convened by the NATIONAL QUALITY FORUM

To: Frank Opelka, Measure Applications Partnership Safety and Care Coordination Task Force Chair

From: Maureen Corry and Bernie Rosof, National Priorities Partnership Maternity Action Team Co-Chairs

Re: MAP Safety and Care Coordination Task Force Consideration of Maternity Measures

Date: June 14, 2012

On behalf of the National Priorities Partnership (NPP) Maternity Action Team, allow us to provide an update on the evolving work of the Action Team to ensure that our mutual desire to coordinate efforts between NPP and MAP is met. Building upon MAP's support of an elective delivery measure for inclusion in its hospital core measure set, the Action Team would like to alert the MAP task force to our two primary goals of reducing elective deliveries and cesarean section in low-risk women, and request consideration for the inclusion of these high-priority areas in its family of measures.

Background

In March 2011, the Department of Health and Human Services (HHS) released the National Quality Strategy (NQS) and identified six priorities to achieve the overarching national aims of healthy people and communities, better care, and affordable care. In support of the NQS, HHS launched the Partnership for Patients initiative to advance the priority areas of safety, care coordination, and affordability and to achieve two goals by the end of 2013:

1. Decrease preventable hospital-acquired conditions by 40 percent compared to 2010.
2. Decrease preventable hospital readmissions by 20 percent compared to 2010.

To achieve broad stakeholder engagement and action toward these goals, HHS requested the National Quality Forum (NQF) convene NPP in a leadership role to bring together critical thought leaders and organizations to identify high-leverage strategies to accelerate system-level change. In support of this work and as part of its action catalyst role, NPP identified maternity care—specifically inappropriate elective deliveries and cesarean section in low-risk women—as a major opportunity to improve care, and reduce harm and costs, particularly for Medicaid and private payer populations. While NPP has long supported improving the delivery of appropriate maternity care—which accounts for nearly one-third of U.S. hospital admissions—efforts to prevent perinatal harm to mothers and babies have been less intensive until recently. Now, however, increased attention from both the public and private sectors has created a ripe environment for bold, concerted action.

NPP convened a multistakeholder Action Team—the Maternity Action Team—comprised of nearly two-dozen public and private stakeholders—to develop an action pathway to address inappropriate maternity care, focusing specifically on reducing elective deliveries by general induction and reducing cesarean section in low-risk women. The Action Team has established two aspirational goals to improve maternity care for mothers and babies, and to achieve the National Quality Strategy aims of better health, better care, and lower costs and the Partnership for Patients goal to reduce harm.

NPP Maternity Action Team Goals to Promote Healthy Mothers and Healthy Babies

1. Reduce the percentage of babies electively delivered prior to 39 weeks gestation to 5 percent or less
2. Reduce cesarean births among low-risk women to 15 percent or less

The Action Team identified three high-leverage strategies to reach these aspirational goals, with a major focus on measurement, use of evidence-based tools and practices, and consistent provider and consumer messaging. These three strategies are interrelated and together offer a cohesive pathway to facilitate action and achieve safe reductions in inappropriate elective deliveries and cesarean sections.

Maternity Action Pathway – Uptake of Perinatal Core Measure Set

The Action Team agreed that in order to accelerate progress, there must be a strategy to drive standardized measurement in hospitals across the country to increase transparency and create a culture for improvement. Currently, The Joint Commission (TJC) estimates that only about 4 percent of its accredited hospitals report on a set of perinatal measures developed to improve maternity care for mothers and babies[1]. TJC is taking action to increase reporting of this set, and its leadership has been open to recommendations from the Action Team about how to increase uptake. Other Action Team members also are working to advance this. ACOG, for example, advocated for a phased approach to measurement to minimize hospitals' data collection burden. The Action Team has voiced support for this tactic and some members, including Pacific Business Group on Health, have written TJC supplemental letters of support for this approach.

[1] The Joint Commission Perinatal Core Measure Set: PC-01 Elective delivery; PC-02 Cesarean section; PC-03 Antenatal steroids; PC-04 Health care-associated bloodstream infections in newborns; PC-05 Exclusive breast milk feeding

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Safety and Care Coordination Task Force

Chair (voting)
Frank G. Opelka, MD, FACS

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

Expertise	Individual Subject Matter Expert Members (voting)
Patient Safety	Mitchell Levy, MD, FCCM, FCCP
Palliative Care	R. Sean Morrison, MD
State Policy	Dolores Mitchell
GE Healthcare	Dana Alexander
Patient Experience	Dale Shaller, MPA
Safety Net	Bruce Siegel, MD, MPH
Mental Health	Ann Marie Sullivan, MD
Payer	Rhonda Robinson Beale, MD
Payer	MaryAnne Lindeblad, BSN, MPH

Payers (voting)	Representatives
Aetna	Randall Krakauer, MD
America's Health Insurance Plans	Aparna Higgins, MA
CIGNA	Dick Salmon, MD, PhD
Humana	Thomas James III, MD
LA Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Medicaid Directors	Foster Gesten, MD
National Health Policy Group	Rich Bringewatt

Purchasers (voting)	Representatives
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Pacific Business Group on Health	William Kramer, MBA
The Alliance	Cheryl DeMars, MSSW

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	John Bott, MSSW, MBA
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH, FACP
Centers for Medicare & Medicaid Services (CMS)	Shaheen Halim, PhD, CPC-A
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD
Veterans Health Administration (VHA)	Michael Kelley, MD
Health Resources and Services Administration (HRSA)	Ian Corbridge, MPH, RN
Office of Personnel Management/FEHBP (OPM)	John O'Brien

Liaisons	
NPP	Laura Cranston
CDP (Safety)	Bill Conway
CDP (Care Coordination)	Gerri Lamb

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)

Bios of the MAP Safety and Care Coordination Task Force

Chair (voting)

Frank G. Opelka, MD FACS

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

Organizational Members (voting)

Alliance of Dedicated Cancer Centers
Ronald Walters, MD, MBA, MHA, MS

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

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

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

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

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

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

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

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

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

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

Memphis Business Group on Health
Cristie Upshaw Travis, MSHA

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

Mothers Against Medical Error
Helen Haskell, MA

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

National Association of Children's Hospitals and Related Institutions
Andrea Benin, MD
Andrea L. Benin, MD is Senior Vice-President, Quality and Patient-Safety for the Connecticut Children's Medical Center as well as Assistant Professor of Pediatrics, University of Connecticut School of Medicine. In this role, Dr Benin drives the agenda and activities to provide the highest quality, safest care for children in Connecticut. Dr. Benin is a pediatrician with background and training in informatics, public health, epidemiology, and infectious diseases. Dr. Benin has particular expertise in developing, validating, and measuring metrics of quality of care – in both paper and electronic formats. Her previous position was as System Executive Director, Performance Management for the Yale New Haven Health System and Quality and Safety Officer, Yale-New Haven Children's Hospital as well as Assistant Clinical Professor, Pediatrics, Yale School of Medicine in New Haven, Connecticut. In that role, she oversaw the quality and safety activities for the three-hospital Yale New Haven Health System as well as the Children's Hospital. Dr. Benin has served on and continues to serve on multiple peer-review groups and study sections as well as several national steering committees.

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

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

University. Dr. Bankowitz is a graduate of the University of Chicago Pritzker School of Medicine and the University of Chicago Graduate School of Business.

Individual Subject Matter Expert Members (voting)

Patient Safety
Mitchell Levy, MD, FCCM, FCCP

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

Palliative Care
R. Sean Morrison, MD

Dr. R. Sean Morrison is Director of the National Palliative Care Research Center, a national organization devoted to increasing the evidence base of palliative care in the United States. He is also the Vice-Chair of Research; Professor of Geriatrics and Medicine; and Hermann Merkin Professor of Palliative Medicine in the Brookdale Department of Geriatrics and Palliative Medicine at the Mount Sinai School of Medicine in New York City. During 2009-2010, he served as President of the American Academy of Hospice and Palliative Medicine. Dr. Morrison is the recipient of numerous awards, including a PDIA American Academy of Hospice and Palliative Medicine National Leadership Award, the American Geriatrics Society's Outstanding Achievement for Clinical Investigation Award, the Open Society Institute Faculty Scholar's Award of the Project on Death in America, a Paul Beeson Faculty Scholars Award, a Brookdale National Fellowship, and a Faculty Council Award from the Mount Sinai School of Medicine. He is currently Principal Investigator of an NIA funded five-year multisite study on improving the management of pain in older adults. Dr. Morrison has published extensively in all major peer-reviewed medical journals, including the New England Journal of Medicine, Annals of Internal Medicine, and the Journal of the American Medical Association. He edited the first textbook on geriatric palliative care and has contributed to more than 10 books on the subject of geriatrics and palliative care. As one of the leading figures in the field of palliative medicine, Dr. Morrison has appeared numerous times on television and in

print, including ABC World News Tonight, The Factor with Bill O'Reilly, the New York Times, the Los Angeles Times, USA Today, the Philadelphia Enquirer, the New York Daily News, Newsday, AARP, and Newsweek. He figured prominently in the Bill Moyers series On Our Own Terms, a four-part documentary aired on PBS and in Gail Sheehy's new book, Passages in Caregiving.
R. Sean Morrison received his BA from Brown University and his MD from the University of Chicago Pritzker School Of Medicine. He completed his residency training at the New York Hospital-Cornell Medical Center followed by fellowship training at the Mount Sinai School of Medicine in New York City. He has been on the faculty of the Department of Geriatrics and Palliative Medicine and Department of Medicine at Mount Sinai since 1995.

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

Health IT
Dana Alexander, RN MSN MBA FHIMSS FAAN
Dana Alexander brings more than 25 years of clinical practice (RN and Nurse Practitioner), healthcare system experience to include academic, IDN, and community hospitals with responsibilities that spanned the care continuum (long-term care, post-acute care, home health, hospice, behavioral health and other specialty services). She leverages both professional nursing practice knowledge and health system operational experience to develop strategic planning initiatives and redesign of clinical business processes that result in improved quality, patient safety and reduced costs. Ms. Alexander is actively involved with analysis of standardizing and harmonizing quality data needs from an eMeasure perspective to include implementation challenges.

Patient Experience
Dale Shaller, MPA
Dale Shaller is Principal of Shaller Consulting Group, a health policy analysis and management consulting practice based in Stillwater, Minnesota. He has devoted nearly three decades to the design, implementation, and evaluation of health care quality measurement and improvement programs, with a special focus on listening to the voice of the patient and promoting methods for engaging consumers in managing their health and health care. His work on measuring and improving the experience of patients and families has been based in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program funded by the U.S. Agency for Healthcare Research and Quality. He has served as a

member of the Harvard and Yale CAHPS research teams for 10 years, working on patient experience survey design, measurement, and reporting issues. He has directed the National CAHPS Benchmarking Database since its inception in 1998 and is a co-author of The CAHPS Improvement Guide and other articles related to strategies for improving the patient experience. Mr. Shaller currently serves as the Chair of the Patient Experience Committee for the Aligning Forces for Quality program funded by the Robert Wood Johnson Foundation. He has been a principal investigator on several projects funded by the Picker Institute, including a series of case studies documenting factors contributing to high-performing patient- and family-centered medical centers. He also has written a series of reports on consumer decision-making in health care, and was a founding developer of the TalkingQuality website that provides practical guidance to developers of health care quality reporting tools for consumers. He has served on many national health care advisory panels and is a frequent writer and presenter on health care quality and patient engagement strategies. He received his B.A. from Kalamazoo College and holds a Master's degree in public affairs from the Humphrey Institute of Public Affairs at the University of Minnesota.

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

Mental Health
Ann Marie Sullivan, MD
Ann Marie Sullivan, M.D. is the Senior Vice President for the Queens Health Network of the New York City Health and Hospitals Corporation. As Senior Vice President, she is responsible for Elmhurst and Queens Hospital Centers, two public hospitals which have been serving the Queens Community of over 2 million New York City residents. The Network, a teaching affiliate of the Mount Sinai School of Medicine currently comprises 806 acute care beds, a trauma and stroke center, a large comprehensive Women's Health Services, and centers for excellence in Cancer, Cardiology, Diabetes and Mental Health. In addition, the Network serves the ethnically diverse Queens Community with large Primary Care and Mental Health Ambulatory services. Dr. Sullivan attended NYU Medical School and completed her Psychiatric Residency at New York University/ Bellevue Hospital in1978. She has served as the Associate Director of Psychiatry and Medical Director of Ambulatory Care at the Gouverneur Diagnostic and Treatment Center and joined the Queens Health Network as the Regional Director of Psychiatry in 1990. Dr. Sullivan is a Clinical Professor of Psychiatry at the Mount Sinai School of Medicine, and has lectured and written on community based psychiatric services. She is currently on the Board of Trustees for the American Psychiatric Association and the Board of Directors of the NYC Mental Health Association. She is also a fellow for the New York Academy of Medicine and the American College of Psychiatrist.

Payer
Rhonda Robinson Beale, MD
Rhonda Robinson Beale, MD, has more than 30 years' experience in the fields of managed behavioral healthcare and quality management. She is the chief medical officer of OptumHealth Behavioral Solutions (formerly United Behavioral Health). Before joining United, she served as the senior vice president and chief medical officer of two prominent organizations, PacifiCare Behavioral Health (PBH) and CIGNA Behavioral Health. As a highly respected member of the behavioral health community, Dr. Robinson Beale has been involved extensively with the National Committee for Quality Assurance (NCQA), National Quality Forum, and the Institute of Medicine. Dr. Robinson Beale was a member of the committee that produced To Err is Human: Building a Safer Health System and Crossing the Quality Chasm: A New Health System for the 21st Century. Dr. Beale served over 8 years on Institute of Medicine's (IOM) Neuroscience and Behavioral Health and Health Care Services Boards. She serves as a committee member and consultant to various national organizations such as NQF, NCQA, NBGH, NIMH, SAMHSA, and is a past Board Chair of the Association for Behavioral Health and Wellness.

Payer
MaryAnne Lindeblad, BSN, MPH
MaryAnne Lindeblad is currently the Assistant Secretary, Aging and Disability Services Administration, Department of Social and Health Services. She served as Director, Division of Healthcare Services, Medicaid Purchasing Administration; Assistant Administrator Public Employees Program, Washington State Health Care Authority; and Director of Operations, Unified Physicians of Washington. In 2009, she was selected to the inaugural class of the Medicaid Leadership Institute, sponsored by the Robert Wood Johnson Foundation. Ms. Lindeblad currently serves as chair of the Medicaid Managed Care Technical Advisory Group and is a member of the Executive Committee for the National Academy for State Health Policy, and chairs their Long Term and Chronic Care subcommittee. She serves as board President of the Olympia Free Medical Clinic and board Vice Chair of the Family Support Center. She holds a B.S. in Nursing from Eastern Washington University's Intercollegiate Nursing Program and a Master's in Public Health from the University of Washington.

Federal Government Members (non-voting, ex officio)

Agency for Healthcare Research and Quality (AHRQ)
John Bott, MSSW, MBA
John Bott is working under contract on site with the Agency for Healthcare Research and Quality (AHRQ). His work focuses on the continual maintenance and improvement of the AHRQ Quality Indicators (QIs) measure sets. Present work on the AHRQ QIs also includes examining enhancements to the measures with additional data (e.g. lab values) and the addition of readmission measures. Prior to joining AHRQ in early 2009 John worked in both the public and private sector at the State of Wisconsin and The Alliance (Madison, Wisconsin) respectively. In the private sector John worked on quality and cost measurement for the primary purposes of comparative quality and cost reporting and value based purchasing.

Centers for Disease Control and Prevention (CDC)
Chesley Richards, MD, MPH, FACP
Chesley Richards MD, MPH, FACP, is the Director, in the Office of Prevention through Healthcare (OPTH) in the Office of the Director, Centers for Disease Control and Prevention. OPTH, a new office at CDC, works to build and enhance strategic collaboration between public health and healthcare sector

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

Centers for Medicare & Medicaid Services (CMS)
Shaheen Halim, PhD, CPC-A

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

Office of the National Coordinator for HIT (ONC)
Kevin L. Larsen, MD

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

Veterans Health Administration (VHA)
Michael Kelley, MD

Since 2007, Dr. Michael Kelley has been the National Program Director for Oncology for the Department of Veterans Affairs. He develops policy and programs in oncology for the national Veterans Health Administration where a primary focus has been on electronic data systems to collect cancer patient data for quality improvement and other purposes. Dr. Kelley is a board certified Medical Oncologist. He completed Internal Medicine training at Duke University followed by fellowship and post-doctoral work at the National Cancer Institute. He is Chief of Hematology and Oncology at the Durham Veterans Affairs Medical Center where he oversees the clinical service, clinical research, and fellowship training. He is also Associate Professor of Medicine at Duke University Medical Center with research interests that include treatment and prevention of lung cancer, the genetics and molecular biology of chordoma, and

clinical trials. Dr. Kelley has published over 50 peer-reviewed publications as well as reviews and book chapters. He is an active member of the American Society of Clinical Oncologist and is Fellow of the American College of Physicians.

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

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

Payers (voting)

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.

NATIONAL QUALITY FORUM

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

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

Humana
Thomas James III, MD
Dr. Tom James is Corporate Medical Director for Humana. In this capacity he is responsible for providing the clinical input into the quality and efficiency measurements and display of health care providers within the Humana network. Dr. James works closely with national and local professional organizations and societies to explain Humana's goals on transparency and other clinical issues, and to receive feedback that allows for greater alignment between Humana and the national professional groups. He is also involved with Humana's group Medicare clinical program development. He is providing consulting services to Humana's major and national accounts. Dr. James was previously Humana's chief medical officer for Kentucky, Indiana and Tennessee and the Medical Advisor to the Strategic Advisory Group of Humana Sales. He has nearly thirty years of experience in health benefits having served as

medical director for such health companies as HealthAmerica, Maxicare, Sentara, Traveler's Health Network, and Anthem, in the Mid-Atlantic, Midwest and South. Dr. James is board certified in Internal Medicine and in Pediatrics. He received his undergraduate degree from Duke University and his medical degree from the University of Kentucky. Dr. James served his residencies at Temple University Hospital, Pennsylvania Hospital, and Children's Hospital of Philadelphia. He is currently the chairman of the Patient Safety Task Force for the Greater Louisville Medical Society. He is on the Board of such organizations as Kentucky Opera, Hospice of Louisville Foundation, and Kentucky Pediatrics Foundation. He chairs the Health Plan Council for the National Quality Forum (NQF), and is on work groups for both the AQA Alliance and the AMA PCPI. Dr. James remains in part-time clinical practice of internal medicine-pediatrics.

LA Care Health Plan
Laura Linebach, RN, BSN, MBA
Laura Linebach, RN, MBA is the Quality Improvement Director for L.A. Care Health Plan, the largest public entity health plan in the country with over 800,000 members. She directs the company-wide quality improvement programs as well as the disease management program for several product lines including Medicaid and Medicare HMO Special Needs Plan. Before L.A. Care, she was the Quality improvement Director in the commercial HMO area. She has more than 30 years of experience as a healthcare quality professional and leader and has taught numerous classes on nursing history and Quality Improvement throughout her career. Ms. Linebach has had extensive experience in quality management in the military, managed care organizations, community mental health centers and the state mental health hospital setting. She has led organizations through multiple successful NCQA accreditation reviews as well as several of The Joint Committee visits. She founded the Nursing Heritage Foundation in Kansas City Missouri to collect and preserve nursing history and has written several articles related to nursing history. Ms Linebach also served as a flight nurse in the Air Force Reserves and later as Officer-in-Charge of the Immunization Clinic for the 442nd Medical Squadron. She is a member of the National Association for Healthcare Quality and the California Association for Healthcare Quality.
Ms. Linebach has a Bachelor of Science degree in nursing from Avila College, Kansas City, Missouri and a master's in history as well as business administration from the University of Missouri-Kansas City.

National Association of Medicaid Directors
Foster Gesten, MD
Foster Gesten is the Medical Director for the Office of Health Insurance Programs in the New York State Department of Health. Dr. Gesten provides clinical direction and leadership for a team of professionals engaged in quality oversight, performance measurement and clinical improvement within health plans and public insurance programs in New York. Major initiatives include the development of statewide public reporting systems for commercial, Medicaid, and Child Health managed care programs on quality, access, and satisfaction, medical home demonstrations, and provider based quality measurement and improvement. His interests include population health, health service research, and quality improvement projects directed at prevention services and chronic care. Dr. Gesten is a member of the National CAHPS Benchmarking Database (NCBD) Advisory Group, the Committee on Performance Measurement (CPM) at the National Committee for Quality Assurance (NCQA), and an Expert Panel Member for the Agency for Healthcare Quality (AHRQ) Health Care Innovations Exchange. Dr. Gesten was trained in general internal medicine at Brown University.

SNP Alliance
Richard Bringewatt
Richard Bringewatt is President of the National Health Policy Group and Chair of the Special Needs Plan (SNP) Alliance, two organizations that he co-founded in 2003. Bringewatt has primarily focused his

career on initiatives to fundamentally improve care for high-risk/high-need persons through the integration of primary, acute and long-term care, and the integration of policy, payment, and performance evaluation for Medicare and Medicaid. Prior to forming the National Health Policy Group, Bringewatt co-founded the National Chronic Care Consortium in 1991, a leadership organization established to design and implement new integration methods. Early in his career, Bringewatt assumed overall leadership in establishing integrated financing, policy and program operations for Area Agencies on Aging in Pennsylvania. He also evaluated OnLok, ACCESS, Triage, and Nursing Home Without Walls waiver programs for HCFA and developed and managed an integrated network services for older adults.

Purchasers (voting)

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

Pacific Business Group on Health
David Hopkins, PhD
David S. P. Hopkins is Director of Quality Measurement at the Pacific Business Group on Health (PBGH). PBGH is a business coalition of 50 large purchasers dedicated to improving the quality and availability of health care while moderating cost. Hopkins is also affiliated with the Center for Primary Care and Outcomes Research and the Center for Health Policy at Stanford University Medical School. Prior to joining PBGH in 1995, he was Vice President with International Severity Information Systems, Inc., a medical severity indexing software and consulting firm. From 1978 to 1993, Hopkins held a number of senior management positions at Stanford University and Stanford University Medical Center. Hopkins earned his A.B. in Biology from Harvard, and his M.S. in Statistics and Ph.D. in Operations Research from Stanford. He is a 1993 graduate of the Advanced Training Program in Health Delivery Improvement at Intermountain Health Care. He is co-author (with Susan D. Horn) of Clinical Practice Improvement: A New Technology for Developing Cost-Effective Quality Health Care (Faulkner & Gray, 1994) and of Planning Models for Colleges and Universities (Stanford University Press, 1981), which

was awarded the 1981 Frederick W. Lanchester Prize for best publication in operations research by the Operations Research Society of America. Hopkins is author or co-author of articles in The New England Journal of Medicine, Medical Care, Management Science, and Operations Research.Hopkins chairs the California Cooperative Healthcare Reporting Initiative (CCHRI) Executive Committee and the Integrated Healthcare Association Pay-for-Performance Technical Efficiency Committee. He is a director and member of the Executive Committee of the California Hospital Assessment and Reporting Taskforce (CHART). On the national front, he is Vice Chair of the National Quality Forum (NQF) Purchaser Council and serves on the NQF Consensus Standards Approval Committee, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Business Advisory Group, America's Health Insurance Plans (AHIP) Data Oversight Work Group, and the Network for Regional Healthcare Improvement (NRHI) Board of Directors. From 1994 until 2006, he served as a Director of Fair Isaac Corporation, a publicly-traded company that provides statistically-based decision systems and services to the financial services, direct marketing, insurance, and retail industries.

Pacific Business Group on Health
William E. Kramer, MBA

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

The Alliance
Cheryl DeMars, MSSW

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

Board of the UW Population Health Institute. Ms. DeMars received a masters degree in social work from the University of Wisconsin–Madison.

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

George J. Isham, MD, MS

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

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.