

# Measure Applications Partnership (MAP)

## Cardiovascular/Diabetes Task Force In-Person Meeting



NATIONAL  
QUALITY FORUM

**July 17, 2012**

Meeting Location:  
National Quality Forum  
9<sup>th</sup> Floor Conference Center  
1030 15<sup>th</sup> Street, NW  
Washington, DC 20005

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**NATIONAL QUALITY FORUM  
MEASURE APPLICATIONS PARTNERSHIP**

**Cardiovascular/Diabetes Care Task Force  
In-Person Meeting #2**

NQF Conference Center  
1030 15<sup>th</sup> Street NW, Suite 900, Washington, DC 20005

WORKGROUP DIAL-IN: (877) 303-9138  
CONFERENCE ID: 94152232

WEB ACCESS: [HTTP://NQF.COMMPARTNERS.COM](http://NQF.COMMPARTNERS.COM)  
MEETING CODE: 630981

**AGENDA: JULY 17, 2012**

**Meeting Objectives:**

- *Finalize diabetes family of measures;*
- *Establish cardiovascular family of measures; and*
- *Discuss implementation pathways for filling measure gaps.*

**8:00 am      Breakfast**

**8:30 am      Welcome and Introductions**

Chris Cassel, Task Force Chair

- *Review purpose and approach to families of measures and core measure sets*
- *Discuss approach for establishing cardiovascular family of measures*

**8:45 am      Diabetes Family of Measures**

- *Review feedback received from task force exercise*
- *Finalize diabetes family of measures*
- *Prioritize measure gaps*

**9:15 am      Cost Measures for Diabetes and Cardiovascular Care**

- *Discuss cost measures for inclusion in measure family*
- *Identify gaps*
- *Opportunity for public comment*

**9:45 am      Establishing a Cardiovascular Family of Measures**

- *Finalize high-leverage opportunities for preventing cardiovascular conditions*
- *Discuss considerations for disparities*

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## MEASURE APPLICATIONS PARTNERSHIP

- 10:15 am**      **Ischemic Heart Disease**
- *Review available measures*
  - *Determine measures to be included in the cardiovascular measure family*
  - *Identify gaps*
- 11:15 am**      **Break**
- 11:30 am**      **Ischemic Heart Disease, Continued**
- *Opportunity for public comment*
- 12:30 pm**      **Lunch**
- 1:00 pm**      **Stroke**
- *Review available measures*
  - *Determine measures to be included in the cardiovascular measure family*
  - *Identify gaps*
  - *Opportunity for public comment*
- 1:45 pm**      **Atrial Fibrillation**
- 2:15 pm**      **Heart Failure**
- 3:00 pm**      **Mortality**
- *Opportunity for public comment*
- 3:45 pm**      **Gap-Filling Pathways**
- *Review and prioritize cardiovascular gaps identified*
  - *Discuss barriers to filling gaps*
  - *Opportunity for public comment*
- 4:45 pm**      **Summary and Next Steps**
- 5:00 pm**      **Adjourn**

## Pre-Meeting Assignments and Instructions

The agenda for our July Cardiovascular/Diabetes Task Force Meeting is ambitious, it will benefit our discussion if task force members are able to deeply focus on one topic area. During the meeting, we will be asking you to help begin the discussion of your assigned topic area. While we hope you are able to review all of the meeting materials in advance of the meeting, please familiarize yourself with the information in the areas we have assigned you.

Thank you in advance for your time and dedication to this work.

<b>Topic Area</b>	<b>Task Force Member</b>	<b>Task Force Organization</b>
<b>Ischemic Heart Disease – Diagnostic and Procedures (Rows 1-19)</b>	<ul style="list-style-type: none"> <li>• Mary Jo Goolsby</li> <li>• Randy Krakauer</li> <li>• Robert Krughoff</li> <li>• Mark Matersky</li> </ul>	<ul style="list-style-type: none"> <li>• American Academy of Nurse Practitioners</li> <li>• Aetna</li> <li>• Consumers’ Checkbook</li> <li>• Physician Consortium for Performance Improvement</li> </ul>
<b>Ischemic Heart Disease – Medications, Secondary Prevention , Rehab, Complications (Rows 20-61)</b>	<ul style="list-style-type: none"> <li>• Bruce Auerbach</li> <li>• Kathleen Blake</li> <li>• Peter Briss</li> <li>• Peggy O’Kane</li> </ul>	<ul style="list-style-type: none"> <li>• American College of Emergency Physicians</li> <li>• American College of Cardiology</li> <li>• CDC</li> <li>• NCQA</li> </ul>
<b>Stroke</b>	<ul style="list-style-type: none"> <li>• Uri Adler</li> <li>• Joyce Dubow</li> <li>• Mary George</li> <li>• Marissa Schlaifer</li> </ul>	<ul style="list-style-type: none"> <li>• American Medical Rehabilitation Providers Association</li> <li>• AARP</li> <li>• CDC</li> <li>• Academy of Managed Care Pharmacy</li> </ul>
<b>Atrial Fibrillation</b>	<ul style="list-style-type: none"> <li>• Richard Bankowitz</li> <li>• Amy Moyer</li> </ul>	<ul style="list-style-type: none"> <li>• Premier, Inc.</li> <li>• The Alliance</li> </ul>
<b>Heart Failure</b>	<ul style="list-style-type: none"> <li>• Rhonda Anderson</li> <li>• Beth Averbeck</li> <li>• Mike Rapp</li> </ul>	<ul style="list-style-type: none"> <li>• American Hospital Association</li> <li>• Minnesota Community Measurement</li> <li>• CMS</li> </ul>
<b>Mortality</b>	<ul style="list-style-type: none"> <li>• Ahmad Calvo</li> <li>• Gene Nelson</li> <li>• Lance Roberts</li> </ul>	<ul style="list-style-type: none"> <li>• HRSA</li> <li>• Subject Matter Expert: Pop Health</li> <li>• Iowa Healthcare Collaborative</li> </ul>

# Measure Applications Partnership (MAP)

Cardiovascular/Diabetes Care  
Task Force Meeting #2

*July 17, 2012*



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QUALITY FORUM

## *Welcome and Introductions*

## Meeting Objectives

- Finalize diabetes family of measures;
- Establish cardiovascular family of measures; and
- Discuss implementation pathways for filling measurement gaps.

## Cardiovascular/Diabetes Task Force Membership

Task Force Chair: Christine Cassel

### Organizational Members

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

### Subject Matter Experts

James Walker  
Eugene Nelson

### Federal Government Members

Michael Rapp  
Joshua Seidman

### Liaisons

Peter Briss – NPP  
Mary George – CDP

## *Families of Measures and Measure Gaps*

### 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



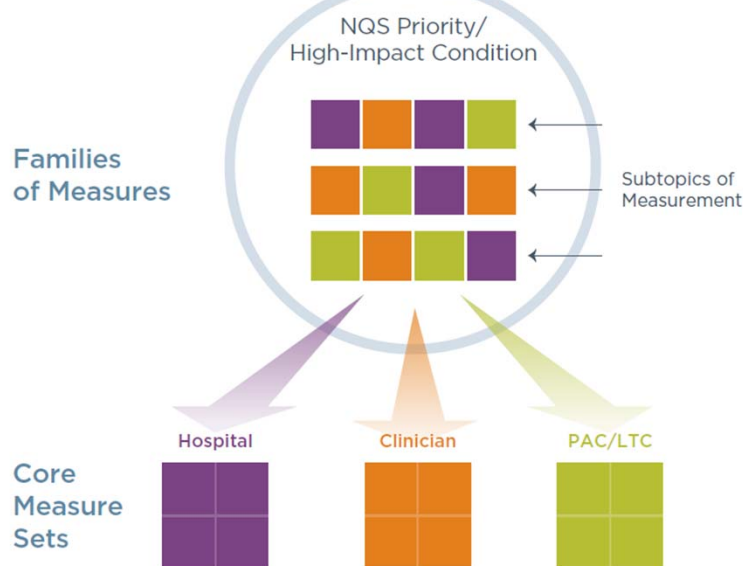


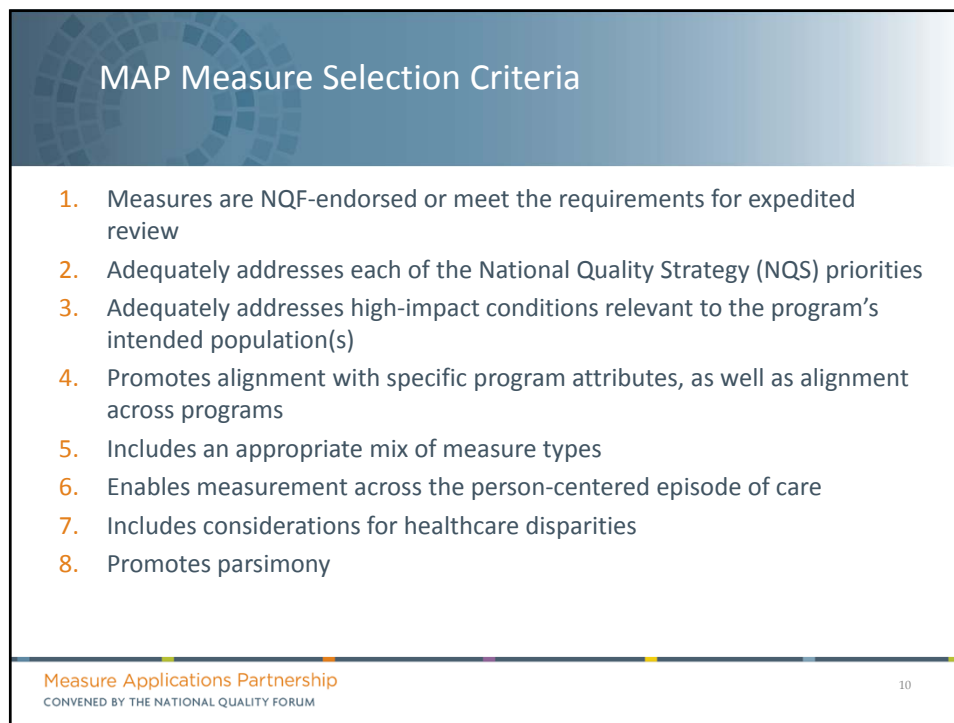
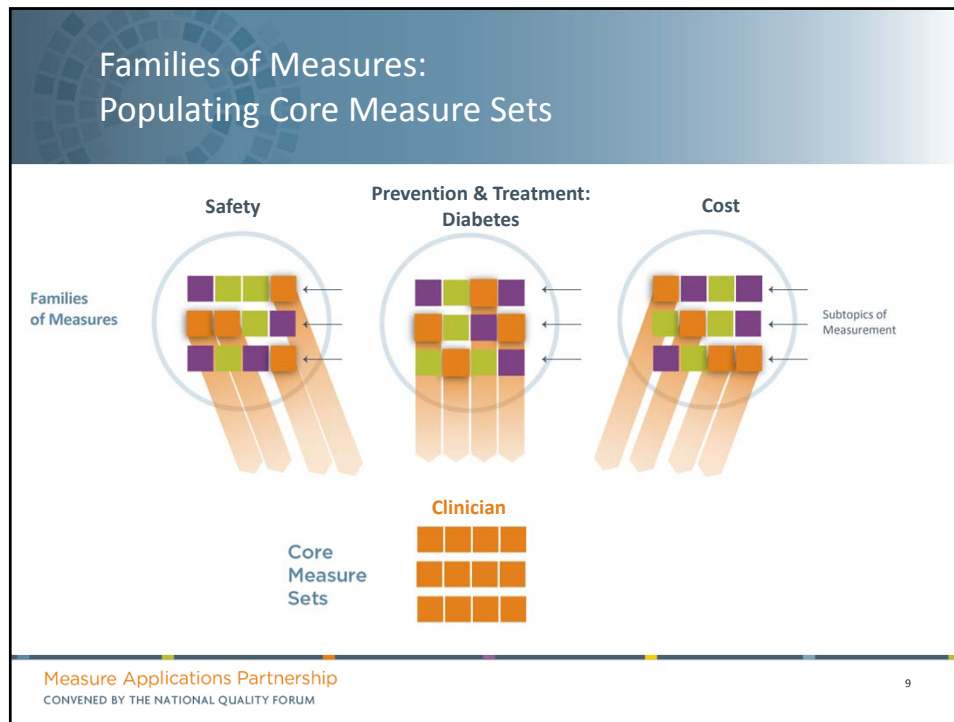
## Families of Measures

### 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)



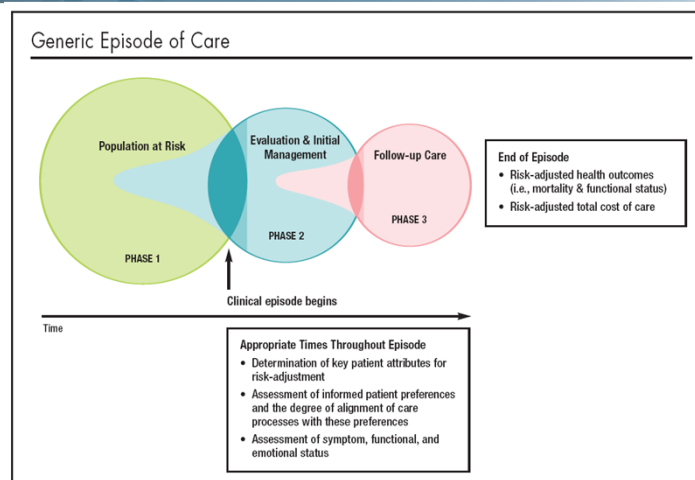


## Approach to Developing Measure Families

### 1. Identify and Prioritize High-Leverage Opportunities for Measurement

- Identification of high-leverage opportunities
  - National Quality Strategy (MSC 2); high-impact conditions (MSC 3)
  - Public-sector efforts: value-based purchasing programs, Partnership for Patients, Million Hearts Campaign
  - Private-sector efforts
- Prioritization of high-leverage opportunities
  - Impact, improvability, inclusiveness
  - Cost- areas of waste, inefficiency, overuse
- Consider how high-leverage opportunities span the patient-focused episode of care (MSC 6)
  - Do the high-leverage opportunities span settings, levels of analysis?
  - How should measures addressing the high-leverage opportunities vary across settings? (e.g., maintenance of function in outpatient settings, improvement of function in acute settings)

## Patient-Focused Episode of Care Model



## Approach to Developing Measure Families

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

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

## Approach to Developing Measure Families

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

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

## 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)

## Approach to Developing Measure Families

### Public Sector Programs Using Cardiovascular/Diabetes Measures:

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

### Public Sector Programs Not Using Cardiovascular/Diabetes Measures:

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

## ***Diabetes Family of Measures\****

***\*includes primary prevention of cardiovascular disease and diabetes***

## **Diabetes Family of Measures\***

- The task force reviewed:
  - Primary prevention measures for cardiovascular disease and diabetes
  - Measures for diabetes management and exacerbation, in the context of the patient-focused episode of care
- The task force identified:
  - 4 primary prevention measures that apply to both the cardiovascular and diabetes families of measures
  - 6 additional diabetes management measures that apply to the diabetes family of measures only

## Diabetes Family of Measures\*

### June 21<sup>st</sup> Key Themes

- The episode of care model is a useful framework
- Outcome measures focused on control are preferred to process measures focused on screening/testing
- Measures should have broad denominator populations to help achieve a parsimonious set of measures
  - Measures with broad denominator populations can be stratified by condition for quality improvement purposes.
- Assessing management of diabetes is the highest-leverage opportunity
  - Assessing exacerbations is important, but is best suited for quality improvement.

	Primary Prevention of Cardiovascular Disease and Diabetes		Evaluation and Ongoing Management of Diabetes		Exacerbation of Diabetes and Complex Treatments	
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
Clinician Group/ Individual	<ul style="list-style-type: none"> <li>• <b>Smoking Cessation/ Tobacco Use (0028, 1406);</b></li> <li>• <b>Lifestyle Management – Weight/Obesity (0024, 0421)</b></li> <li>• Lipid Control</li> <li>• Blood pressure Control</li> <li>• Lifestyle Management – Diet/nutrition</li> <li>• Lifestyle Management – Activity/Exercise</li> </ul>	<ul style="list-style-type: none"> <li>• Smoking Cessation/ Tobacco Use</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Glycemic control/ HbA1c (0060, 0575);</b></li> <li>• <b>Lipid Control (0064)</b></li> <li>• Glycemic control for complex patients</li> <li>• Lifestyle Management – Diet/nutrition</li> <li>• Lifestyle Management – Activity/Exercise</li> <li>• Blood Pressure Control</li> </ul>		<ul style="list-style-type: none"> <li>• Sequelae of diabetes exacerbations</li> </ul>	
Provider/ Facility	<ul style="list-style-type: none"> <li>• <b>Lifestyle Management – Weight/Obesity (0421)</b></li> <li>• Smoking Cessation/ Tobacco Use</li> <li>• Lipid Control</li> <li>• Blood pressure Control</li> <li>• Lifestyle Management – Diet/nutrition</li> <li>• Lifestyle Management – Activity/Exercise</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Smoking Cessation/ Tobacco Use (1651, 1654)</b></li> </ul>	<ul style="list-style-type: none"> <li>• Glycemic control/ HbA1c</li> <li>• Glycemic control for complex patients</li> <li>• Lipid Control</li> <li>• Lifestyle Management – Diet/nutrition</li> <li>• Lifestyle Management – Activity/Exercise</li> <li>• Blood Pressure Control</li> </ul>		<ul style="list-style-type: none"> <li>• Sequelae of diabetes exacerbations</li> </ul>	

	Primary Prevention of Cardiovascular Disease and Diabetes		Evaluation and Ongoing Management of Diabetes		Exacerbation of Diabetes and Complex Treatments	
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
System	<ul style="list-style-type: none"> <li>• <b>Lifestyle Management-Weight/Obesity (0024)</b></li> <li>• Smoking Cessation/ Tobacco Use</li> <li>• Lipid Control</li> <li>• Blood pressure Control</li> <li>• screening</li> <li>• Lifestyle Management – Diet/nutrition</li> <li>• Lifestyle Management – Activity/Exercise</li> <li>• Cardiometabolic risk</li> </ul>	<ul style="list-style-type: none"> <li>• Smoking Cessation/ Tobacco Use</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Glycemic control/ HbA1c (0575)</b></li> <li>• <b>Lipid Control (0064)</b></li> <li>• Glycemic control for complex patients</li> <li>• Lipid Control</li> <li>• Lifestyle Management – Diet/nutrition</li> <li>• Lifestyle Management – Activity/Exercise</li> <li>• Blood Pressure Control</li> </ul>		<ul style="list-style-type: none"> <li>• Sequelae of diabetes exacerbations</li> </ul>	
Community	<ul style="list-style-type: none"> <li>• <b>Smoking Cessation/Tobacco Use (1406, 1651, 1654); Lifestyle Management – Weight/Obesity (0024, 0421)</b></li> <li>• Cardiometabolic risk</li> <li>• Lipid Control</li> <li>• Blood pressure Control</li> <li>• Lifestyle Management –Diet/nutrition</li> <li>• Lifestyle Management – Activity/Exercise</li> </ul>		<ul style="list-style-type: none"> <li>• <b>Glycemic control/ HbA1c (0575); Lipid Control (0064)</b></li> <li>• Lifestyle Management –Diet/nutrition</li> <li>• Lifestyle Management – Activity/Exercise</li> <li>• Blood Pressure Control</li> </ul>		<ul style="list-style-type: none"> <li>• Sequelae of diabetes exacerbations</li> </ul>	

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## Diabetes Family of Measures\*

**Identified Gaps**

- Gaps identified fall outside of the scope of the task force and will be addressed by other MAP task forces. These gaps include:
  - Patient experience
  - Patient engagement, self-management
  - Informed decision making
  - Care coordination

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## Diabetes Family of Measures

### Outstanding Issues for Specific Measures

- Pediatric A1c
  - NQF #0060 Pediatric A1c Testing was initially selected for family; however the group also indicated a preference for glycemic control rather than glycemic testing
  - General agreement to remove pediatric glycemic testing measure and highlight pediatric glycemic control as a gap
- Diabetes Composites
  - Conflicting measures selected for family
    - » NQF #0729 (diabetes composite which includes glycemic control and lipid control, MN Community Measurement)
    - » NQF #0575 (glycemic control, NCQA) and NQF #0064 (lipid control, NCQA) selected for family
  - Equally split on Minnesota Community Measurement and NCQA measures
    - » Differing opinions on value of “all or none” scoring

## Diabetes Family of Measures- Composites

Diabetes Tab, Row 10 and 12	NQF #0729 MN Community	NQF #0731 NCQA
<b>SCORING</b>	• All-or-none	• Sum of all numerators over the sum of all denominators
<b>Risk Adjustment</b>	• Case-mix	• None
<b>Glycemic Control</b>	• HbA1c (<8%)	• HbA1c poor control (>9%) • HbA1c control (<8%) • HbA1c control (<7%) for selected populations
<b>Lifestyle Management</b>	• Tobacco non-user	• Smoking status and cessation advice or treatment
<b>Blood Pressure Control</b>	• BP (<140/90 mmHg)	• BP control (<140/90 mmHg)
<b>Lipid Control</b>	• LDL- C (<100 mg/dL)	• LDL-C screening • LDL- C control (<100 mg/dL)
<b>Eye Care</b>		• Eye exam (retinal) performed
<b>Nephropathy</b>		• Medical attention for nephropathy
<b>Other</b>	• Daily aspirin for patients with IVD	

## Diabetes Family of Measures- Gaps

### General agreement with gaps highlighted

- Post-acute care/long-term care are not considered gaps, most high-leverage opportunities do not apply to these settings
  - Consider lipid control and BP control
- Concerns that family has numerous gaps and is not yet a “robust” measure family, places additional burden on measure developers as there are few resources for measure development
- Need to contextualize recommendations- how we anticipate measure to be applied

## Diabetes Family of Measures- Gaps

### Additional gaps noted:

- Functional status
- Measures that account for clinical complexity and patient preference
- Smoking cessation outcome measure (e.g., quit rates)
- Inpatient lifestyle management measures (assessment, advice, coordination of follow-up care)
- Patient Behavior and compliance Care coordination related to glycemic control
- Appropriate medication use
- Mortality

## Gap Prioritization

### Following concepts highlighted as priorities:

- Lifestyle management (Weight/obesity, Activity/exercise, Diet/nutrition)
- Lipid control (across settings, levels)
- Blood pressure control
  - Recommendation to consider including NQF #0018 Controlling High Blood Pressure (Diabetes Tab, Row 11) to address Lipid control
- Smoking cessation/tobacco use
- Glycemic control across settings
- Cardiometabolic risk (across settings, levels)

## *Cost Measures for Diabetes and Cardiovascular Care*

## Defining Resource Use Measures

- Broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (may include diagnoses, procedures, or encounters).
- A resource use measure counts the frequency of defined health system resources; some further apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit of resource.

## Measurement Gaps

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

## Available Measures: Cost

### Cost Tab, Rows 1-5

- Which measures are preferred for inclusion in the CV/DM family?
  - Broader-population measures:
    - » NQF #1598: Total Resource Use Population-based PMPM Index (HealthPartners)
    - » NQF #1604: Total Cost of Care Population-Based PMPM Index (HealthPartners)
  - Condition-specific measures:
    - » NQF #1558: Relative Resource Use for People with Cardiovascular Conditions (NCQA)
    - » NQF #1557: Relative Resource Use for People with Diabetes (NCQA)
  - Other approaches to highlight as gaps?

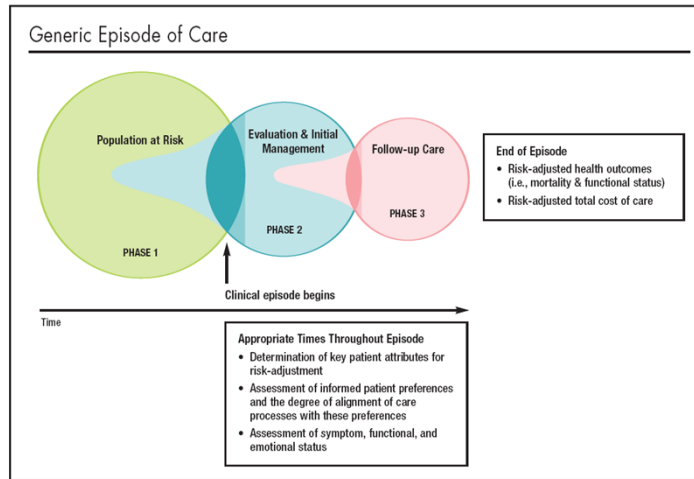
## Comparing Approaches

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

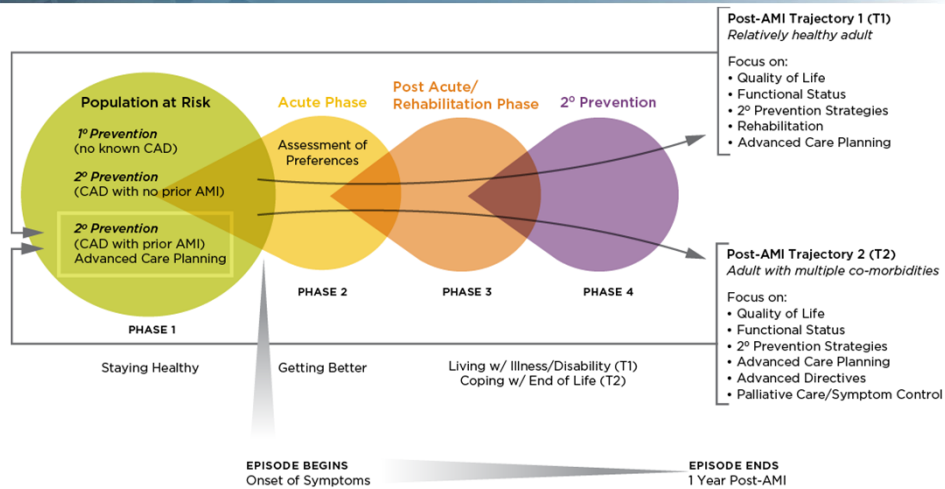
## ***Opportunity for Public Comment***

## ***Establishing a Cardiovascular Family of Measures***

## Patient-focused Episode of Care Model: Chronic Conditions



## Patient-focused Episode of Care Model: Acute Conditions



## High Leverage Opportunities

- High-impact cardiovascular conditions
  - Ischemic Heart Disease
  - Stroke/TIA
  - Atrial Fibrillation
  - Heart Failure
- High-leverage opportunities within each condition
  - Acute Diagnosis and Treatment
  - Secondary Prevention and Treatment
  - Rehabilitation
  - Mortality

## Available Measures: Cardiovascular Conditions

High Leverage Opportunity	# of Available Measures
Stroke	35
Ischemic Heart Disease	61
Atrial Fibrillation	4
Heart Failure	13
Mortality	13



# *Disparities*

# *Ischemic Heart Disease*

## Ischemic Heart Disease: Treatments

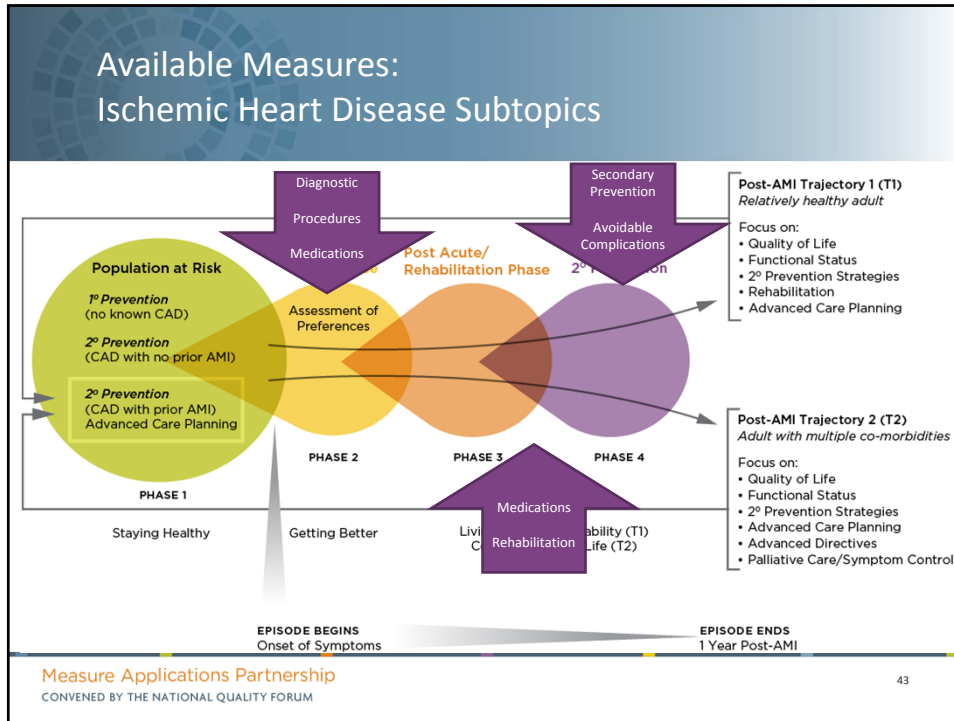
### Procedures

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

## Ischemic Heart Disease: Treatments

### Medication therapy

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



- ### Available Measures: Ischemic Heart Disease
- #### Diagnostic (IHD Tab, Rows 1-8)
- 4 measures of ED response to chest pain
    - NQF #0289 Median time to ECG, broad population, multiple levels of analysis and used in a federal program
    - NQF #0660 Troponin results broad population, multiple levels of analysis and used in a federal program
  - 4 measures of overuse of cardiac imaging
    - NQF #0669 Low risk non- cardiac surgeries with imaging test
    - NQF #0670 Imaging test in low-risk surgery patients
    - NQF #0671 Imaging test after PCI
    - NQF #0672 Testing in asymptomatic, low risk patients
  - Gaps?
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## Available Measures: Ischemic Heart Disease

### Procedures (IHD Tab, Rows 9-19)

- 3 measures for PCI
  - NQF #0163 used across multiple hospital programs
  - Gaps?
- 8 measures for CABG
  - NQF #0696 CABG composite covers 11 components of CABG care

## Available Measures: Ischemic Heart Disease

### Medication (IHD Tab, Rows 20-48)

- Measures assess provisions of medication during at one of three time periods:
  - During the acute episode
  - Upon discharge (ordered or prescribed)
  - Secondary prevention (in the outpatient setting)
- Medications with available measures:
  - Fibrinolytic Therapy
  - Aspirin/Anti-platelets
  - ACE/ARB
  - Beta Blockers
  - Statins

## Available Measures: Ischemic Heart Disease

### Medication (IHD Tab, Rows 20-48):

- Fibrinolytic Therapy (Rows 20-21)
  - NQF #0288/0287 Median time to Fibrinolysis, multiple levels of analysis
- Aspirin/Anti-platelets (Rows 23-31)
  - Aspirin at arrival – low opportunity for improvement (rows 23-25)
  - Aspirin at discharge – low opportunity for improvement (rows 26-28)
  - Secondary prevention– NQF #0068 IVD use of aspirin or other anti-thrombotic , covers multiple levels of analysis, used in multiple programs (row 29)
- ACE/ARB (Rows 32-35)
  - ACE/ARB at discharge – low opportunity for improvement (rows 26-28)
  - ACE Inhibitor or ARB Therapy – NQF #0066 Diabetes or Left Ventricular Systolic Dysfunction , covers multiple levels of analysis, used in multiple programs (row 34)

## Available Measures: Ischemic Heart Disease

### Medication (IHD Tab, Rows 20-48):

- Beta Blockers (Rows 36-45)
  - Beta blocker at discharge – low opportunity for improvement
  - Beta blockers with procedures – too narrow of a population? (rows 37-42)
  - Secondary prevention measures –
    - » NQF #0070 Beta Blocker prior MI or LVSD , covers multiple levels of analysis, used in two programs
    - » NQF #0071 Persistence of Beta Blocker after AMI , covers multiple levels of analysis

Note: These measures are aligned and vary by data source
- Statins (rows 46-48)
  - Available measure focus on possession ratios and statins at discharge or with procedures– do any of these areas represent a high leverage opportunity?
  - Secondary prevention- Should assessment of persistent statin use be considered a gap?

## Available Measures: Ischemic Heart Disease

### Secondary Prevention (IHD Tab, Rows 49-55)

- The CV/DM task force concluded separate primary prevention and secondary prevention measures are not needed in the following areas:
  - Blood pressure control
  - Lifestyle management (smoking, weight/obesity, diet/nutrition, physical activity/exercise)
  - Cardiometabolic risk
  - *The primary prevention measures should be broad and stratified by condition for QI*
- Patient factors should contribute to goals for lipid and glycemic control, measures should be reported by condition or other patient factors
  - NQF #0074 Lipid Control, clinician level of analysis, used in multiple federal programs
  - NQF #0075 Lipid profile and lipid control, clinician and health plan level of analysis, not used in federal programs
  - Note: These measures are aligned and vary by data source

## Available Measures: Ischemic Heart Disease

### Rehabilitation (IHD Tab, Rows 57-59)

- Available measures assess only referral to rehabilitation program
- Preference to look at outcomes related to rehabilitation

### Complications (IHD Tab, Rows 60-61)

- Previous discussion of complications for diabetes highlighted need for community-level indicators, and not at the clinician level

Note: Measures assessing surgical avoidable complications were reviewed in MAP Safety Task Force, therefore they have not been included

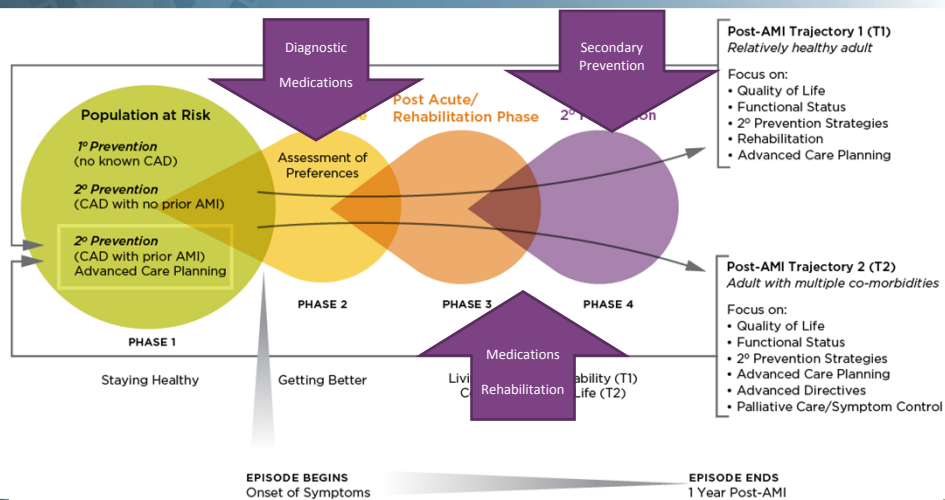
# *Opportunity for Public Comment*

# *Stroke*

## Stroke/TIA: Treatments

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

## Available Measures- Ischemic Heart Disease Subtopics





## Available Measures: Stroke

### Diagnostic (Stroke Tab, Rows 1-4)

- NQF #0661 CT scan interpretation within 45 minutes, level of analysis at the facility level, used in a federal program
- Gaps?

## Available Measures: Stroke

### Acute/Post Acute - Medications (Stroke Tab, Rows 5-20)

- Should measures covering the following be included in the family?
  - VTE Prophylaxis (row 5)
    - » Stroke specific process measures reviewed by MAP Safety Task Force, not selected for family
    - » MAP Safety Task Force selected NQF #0376 Incidence of Potentially Preventable VTE, this is outcome measure indicating poor care; stroke patients who develop VTE would be included in this measure
  - DVT Prophylaxis (row 6)
    - » Stroke specific process measures reviewed by MAP Safety Task Force, not selected for family
    - » MAP Safety Task Force selected NQF # 0450 Postoperative DVT or PE , this is outcome measure indicating poor care for surgeries; stroke patients may not be included in this measure

## Available Measures: Stroke

### Acute/Post Acute Medications (Stroke Tab, Rows 5-20)

- Should measures covering the following be included in the family?
  - t-PA (rows 7-12)
  - Antithrombotics (rows 13-15)
    - » NQF #0435 Discharge on Antithrombotics, facility measure used in federal programs
    - » NQF #0325 Discharges on Antiplatelet Therapy, clinician measures used in federal programs
  - Anticoagulants (rows 16-17)
  - Statins (rows 18-19)
  - Anti-hypertensives (row 20)

## Available Measures: Stroke

### Rehabilitation (Stroke Tab, Rows 21-35)

- Should any of the following stroke-specific rehab measures be included in the family?
  - Assessment for rehab
  - Ordering rehab services
  - Outcomes resulting from rehab, including function (rows 25-31)

## Available Measures: Stroke

### Gaps identified by NQF-CDP Stroke Project

- Stroke severity information
- If services ordered were received
- Specific measures for TIA
- Screening and diagnosis of Afib
- Imaging
- Pre-hospital care, transfers, and post-hospital care
- Functional status outcome measures
- Health disparities
- Palliative/End of Life Care

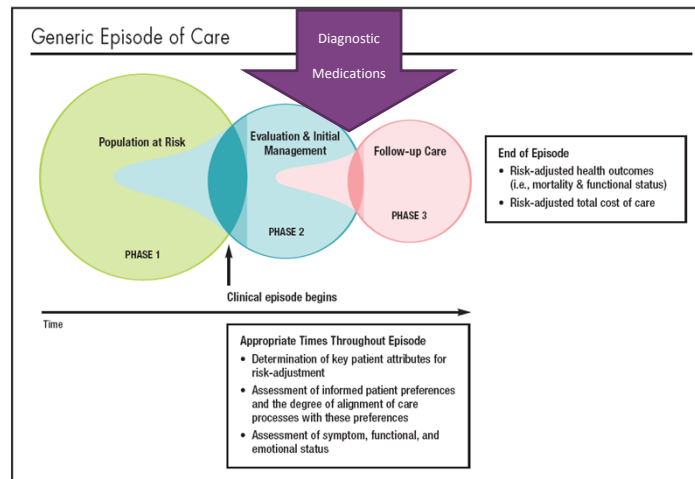
## *Opportunity for Public Comment*

## *Atrial Fibrillation*

### Atrial Fibrillation: Treatments

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

## Patient-focused Episode of Care Model: Chronic Conditions



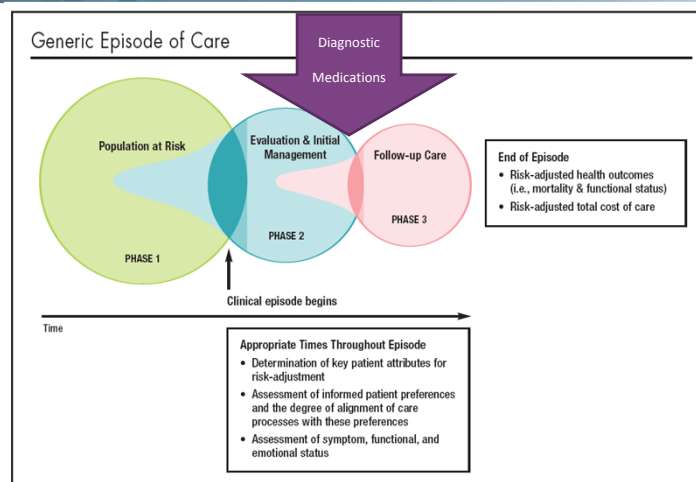
## Available Measures: Atrial Fibrillation

### Atrial Fibrillation (Afib Tab, Rows 1-4)

- Diagnostic (rows 1-2)
  - Assessment thromboembolic risk and thyroid function– are these high-leverage opportunities?
  - Gaps?
- Medications (rows 3-4)
  - NQF #1525- Chronic anticoagulation therapy

# Heart Failure

## Patient-focused Episode of Care Model: Chronic Conditions



## Heart Failure: Treatments

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

## Available Measures: Heart Failure

### HF Tab, Rows 1-13

- **Diagnostic**
  - NQF #0135 Evaluation of LVS function
- **Medications**
  - ACE/ARBs
    - » Available measures assess ACE/ARB prescribed/ordered, not ongoing
  - Beta-Blockers
    - » NQF #0083 Beta blocker therapy for LVSD, multiple levels of analysis and used in multiple programs

# *Mortality*

## Available Measures: Mortality

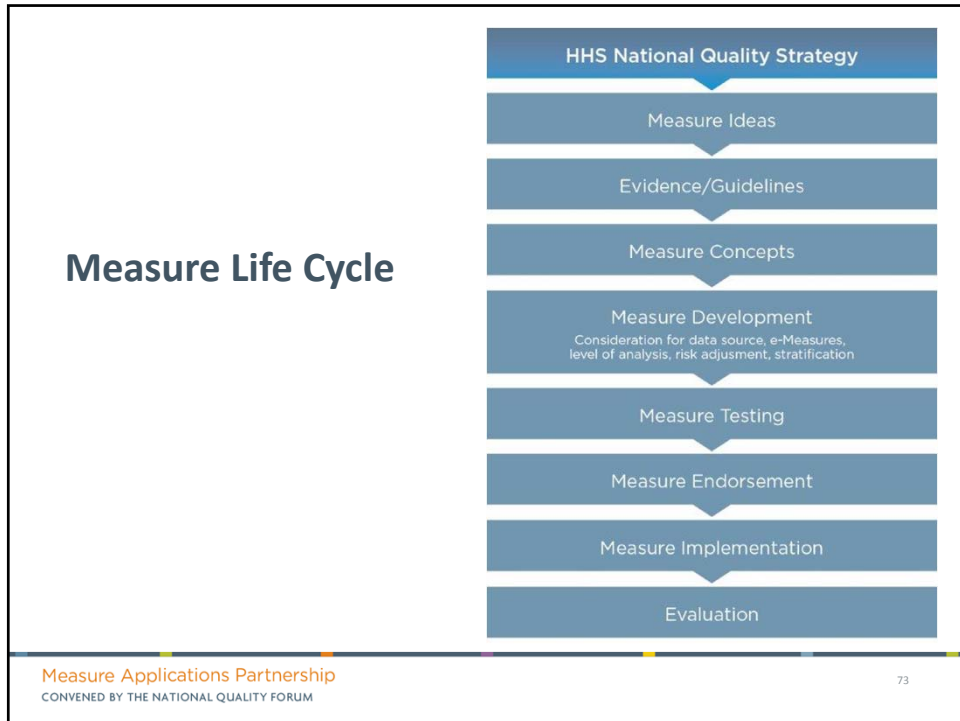
### Mortality Tab, Rows 1- 13

- Should mortality measures be included in the family?
  - All-cause vs. condition-specific?
  - 30-day vs. in-hospital discharge deaths



## *Opportunity for Public Comment*

## *Gap Filling Pathways*



## *Opportunity for Public Comment*

Measure Applications Partnership  
CONVENED BY THE NATIONAL QUALITY FORUM

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## *Summary of Day and Next Steps*

## *Adjourn*

Background Information  
Reviewed During June  
In-Person Meeting



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*July 12, 2012*

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## MAP Glossary for Categorizing Measures

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

## 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)

## Cardiovascular Health – Secondary Prevention

### Lipid and Blood Pressure Control

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

## Cardiovascular Health – Secondary Prevention

### Lifestyle Management and Vaccines

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

## Cardiovascular Rehabilitation

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

## Appropriateness/Overuse of Services

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

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

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## MAP Cardiovascular/Diabetes Task Force June 21<sup>st</sup> Meeting Summary

At the June 21<sup>st</sup> Cardiovascular/Diabetes Task Force meeting, we reviewed primary prevention measures for cardiovascular disease and diabetes, as well as measures for diabetes management and exacerbation, in the context of the patient-focused episode of care (see Figure 1 at the end of the document for the episode of care model). The task force identified 4 primary prevention measures that apply to both the cardiovascular and diabetes families of measures, and 6 additional diabetes management measures that apply to the diabetes family of measures only. In developing the diabetes family of measures and beginning to develop the cardiovascular family of measures, the task force concluded:

- The episode of care model is a useful framework for determining a comprehensive family of measures.
- Outcome measures focused on control (e.g., measures of blood pressure or lipid control) are preferred to process measures focused on screening/testing.
- Rather than including multiple condition-specific measures, measures should have broad denominator populations to help achieve a parsimonious set of measures (e.g., one lipid control measure for both diabetes and cardiovascular conditions, rather than a lipid control measure for diabetes and a lipid control measure for cardiovascular conditions). Measures with broad denominator populations can be stratified by condition for quality improvement purposes.
- Improving evaluation and ongoing management of diabetes will prevent downstream exacerbations and complications. Accordingly, the group identified management of diabetes as the highest-leverage opportunity. Assessing exacerbations is important, but is best suited for quality improvement.
- Several gaps identified fall outside of the scope of the Cardiovascular/Diabetes Task Force and will be addressed by other MAP task forces. These gaps include:
  - Patient experience
  - Patient engagement; self-management
  - Informed decision making
  - Care coordination



The table below summarizes the task force's decisions, characterizing the high-leverage opportunities along the episode of care and by level of analysis. The bolded high-leverage opportunities represent areas where the task force has identified measures to populate the family; non-bolded entries are considered gaps. Shading indicates that the group did not identify high-leverage opportunities for measurement in that area.

**Table 1. High-Leverage Opportunities and Gaps\***

	Primary Prevention of Cardiovascular Disease and Diabetes		Evaluation and Ongoing Management of Diabetes		Exacerbation of Diabetes and Complex Treatments	
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
Clinician Group/ Individual	<ul style="list-style-type: none"> <li>• <b>Smoking Cessation/ Tobacco Use (0028, 1406);</b></li> <li>• <b>Lifestyle Management – Weight/Obesity (0024, 0421)</b></li> <li>• Lipid Control</li> <li>• Blood pressure Control</li> <li>• Lifestyle Management – Diet/nutrition</li> <li>• Lifestyle Management – Activity/Exercise</li> </ul>	<ul style="list-style-type: none"> <li>• Smoking Cessation/ Tobacco Use</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Glycemic control/ HbA1c (0060, 0575);</b></li> <li>• <b>Lipid Control (0064)</b></li> <li>• Glycemic control for complex patients</li> <li>• Lifestyle Management –Diet/nutrition</li> <li>• Lifestyle Management – Activity/Exercise</li> <li>• Blood Pressure Control</li> </ul>		<ul style="list-style-type: none"> <li>• Sequelae of diabetes exacerbations</li> </ul>	
Provider/ Facility	<ul style="list-style-type: none"> <li>• <b>Lifestyle Management – Weight/Obesity (0421)</b></li> <li>• Smoking Cessation/ Tobacco Use</li> <li>• Lipid Control</li> <li>• Blood pressure Control</li> <li>• Lifestyle Management –</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Smoking Cessation/ Tobacco Use (1651, 1654)</b></li> </ul>	<ul style="list-style-type: none"> <li>• Glycemic control/ HbA1c</li> <li>• Glycemic control for complex patients</li> <li>• Lipid Control</li> <li>• Lifestyle Management –Diet/nutrition</li> <li>• Lifestyle Management – Activity/Exercise</li> <li>• Blood Pressure Control</li> </ul>		<ul style="list-style-type: none"> <li>• Sequelae of diabetes exacerbations</li> </ul>	

	Primary Prevention of Cardiovascular Disease and Diabetes		Evaluation and Ongoing Management of Diabetes		Exacerbation of Diabetes and Complex Treatments	
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
	<ul style="list-style-type: none"> <li>Diet/nutrition</li> <li>Lifestyle Management – Activity/Exercise</li> </ul>					
System	<ul style="list-style-type: none"> <li><b>Lifestyle Management-Weight/Obesity (0024)</b></li> <li>Smoking Cessation/ Tobacco Use</li> <li>Lipid Control</li> <li>Blood pressure Control</li> <li>screening</li> <li>Lifestyle Management – Diet/nutrition</li> <li>Lifestyle Management – Activity/Exercise</li> <li>Cardiometabolic risk</li> </ul>	<ul style="list-style-type: none"> <li>Smoking Cessation/ Tobacco Use</li> </ul>	<ul style="list-style-type: none"> <li><b>Glycemic control/ HbA1c (0575)</b></li> <li><b>Lipid Control (0064)</b></li> <li>Glycemic control for complex patients</li> <li>Lipid Control</li> <li>Lifestyle Management –Diet/nutrition</li> <li>Lifestyle Management – Activity/Exercise</li> <li>Blood Pressure Control</li> </ul>		<ul style="list-style-type: none"> <li>Sequelae of diabetes exacerbations</li> </ul>	
Community	<ul style="list-style-type: none"> <li><b>Smoking Cessation/Tobacco Use (1406, 1651, 1654);</b></li> <li><b>Lifestyle Management – Weight/Obesity (0024, 0421)</b></li> <li>Cardiometabolic risk</li> <li>Lipid Control</li> <li>Blood pressure Control</li> <li>Lifestyle Management –Diet/nutrition</li> <li>Lifestyle Management – Activity/Exercise</li> </ul>		<ul style="list-style-type: none"> <li><b>Glycemic control/ HbA1c (0575);</b></li> <li><b>Lipid Control (0064)</b></li> <li>Lifestyle Management –Diet/nutrition</li> <li>Lifestyle Management – Activity/Exercise</li> <li>Blood Pressure Control</li> </ul>		<ul style="list-style-type: none"> <li>Sequelae of diabetes exacerbations</li> </ul>	

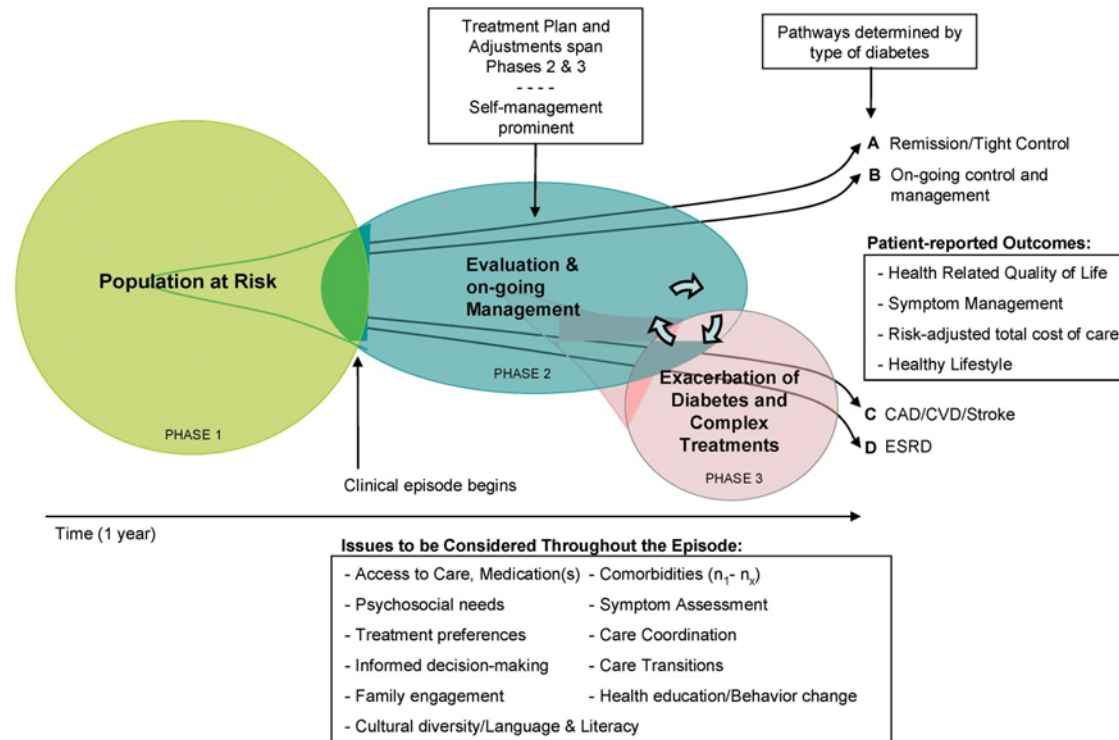
\*Detailed information on the measures selected for inclusion can be found in the accompanying Excel spreadsheet.

### Composite Considerations

The task force selected measures for glycemic control (Tab 'Measure Specifications', Row 9, NQF #0575, developed by NCQA) and lipid control (Tab 'Measure Specifications', Row 10, NQF #0064, developed by NCQA) to be included in the family. The task force also selected a composite measure (Tab 'Measure Specifications', Row 11, NQF #0729, developed by MN Comm. Measurement) to be included in the family, which includes measures of glycemic control and lipid control that are different than the two selected for the family. This creates a duplication of measurement within the diabetes family. To resolve the duplication, the task force can choose to: (1) select the individual measures and composite developed by NCQA or (2) select the individual measures and composite developed by MN Community Measurement.

	Individual Measures	Composite	Composite Scoring
<b>OPTION 1:</b> NCQA measures	<ul style="list-style-type: none"> <li>NQF# 0575 Comprehensive Diabetes Care: HbA1c control (&lt;8.0%) NCQA</li> <li>NQF# 0064 Diabetes Measure Pair: A Lipid management: low density lipoprotein cholesterol (LDL-C) &lt;130, B Lipid management: LDL-C &lt;100 NCQA *Note the group only selected LDL-C&lt;100 for inclusion in the family. Only LDL-C&lt;100 is included in the composite</li> </ul>	NQF #0731 Comprehensive Diabetes Care	Percentage: sum of subcomponents denominators over sum of subcomponents numerator
<b>OPTION 2:</b> MN Community Measurement measures	<p>The subcomponents are not individually endorsed; however, they can be collected and reported separately:</p> <ul style="list-style-type: none"> <li>A1c&lt;8</li> <li>LDL&lt;100</li> </ul>	NQF #0729 Optimal Diabetes Care	All-or-nothing: must meet threshold for each subcomponent to be considered numerator compliant

**Figure 1: Context for Considering a Diabetes Episode of Care**



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

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

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

- *Educational efforts to increase awareness about heart disease and prevention and to demonstrate how individuals can take control of their heart health;*
- *Discovery and dissemination of care practices that use interdisciplinary teams, health information technology, and incentives to optimize outcomes;*
- *Improving adherence to appropriate medications for the ABCS.*

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

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

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

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

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

\* Source: Centers for Disease Control and Prevention, National Ambulatory Medical Care Survey (NAMCS) and National Hospital Ambulatory Medical Care Survey (NHAMCS), 2007-2008

\*\* Source: Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey (NHANES), 2005-2008

\*\*\* Source: NAMCS, 2005-2008

# MAP “WORKING” MEASURE SELECTION CRITERIA



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

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

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

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

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

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

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

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

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

NQS priority is adequately addressed in the program measure set

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### **6. Program measure set enables measurement across the person-centered episode of care <sup>1</sup>**

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

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

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

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

**Subcriterion 6.3** Program measure set adequately measures patient care across time

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

## 7. Program measure set includes considerations for healthcare disparities<sup>2</sup>

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

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

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

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

## 8. Program measure set promotes parsimony

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

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

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

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

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<sup>2</sup> NQF, *Healthcare Disparities Measurement*, Washington, DC: NQF; 2011.



**Table 1: National Quality Strategy Priorities**

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

**Table 2: High-Impact Conditions:**

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

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

# MAP “WORKING” MEASURE SELECTION CRITERIA INTERPRETIVE GUIDE



NATIONAL  
QUALITY FORUM

## Instructions for applying the measure selection criteria:

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

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

### FOR CRITERION 1 - NQF ENDORSEMENT:

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

1. **‘Importance to measure and report’**—how well the measure addresses a specific national health goal/ priority, addresses an area where a performance gap exists, and demonstrates evidence to support the measure focus;
2. **‘Scientific acceptability of the measurement properties’** – evaluates the extent to which each measure produces consistent (reliable) and credible (valid) results about the quality of care.
3. **‘Usability’**- the extent to which intended audiences (e.g., consumers, purchasers, providers, and policy makers) can understand the results of the measure and are likely to find the measure results useful for decision making.
4. **‘Feasibility’** – the extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measures.

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

- the extent to which the measure(s) under consideration has been sufficiently tested and/or in widespread use
- whether the scope of the project/measure set is relatively narrow
- time-sensitive legislative/regulatory mandate for the measure(s)
- Measures that are NQF-endorsed are broadly available for quality improvement and public accountability programs. In some instances, there may be evidence that implementation challenges

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

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

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

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

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

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

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

- **Care settings include:** Ambulatory Care, Ambulatory Surgery Center, Clinician Office, Clinic/Urgent Care, Behavioral Health/Psychiatric, Dialysis Facility, Emergency Medical Services - Ambulance, Home Health, Hospice, Hospital- Acute Care Facility, Imaging Facility, Laboratory, Pharmacy, Post-Acute/Long Term Care, Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation.
- **Level of analysis includes:** Clinicians/Individual, Group/Practice, Team, Facility, Health Plan, Integrated Delivery System.
- **Populations include:** Community, County/City, National, Regional, or States. Population includes: Adult/Elderly Care, Children's Health, Disparities Sensitive, Maternal Care, and Special Healthcare Needs.

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

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

1. **Outcome measures** – Clinical outcome measures reflect the actual results of care.<sup>1</sup> Patient reported measures assess outcomes and effectiveness of care as experienced by patients and their families. Patient reported measures include measures of patients’ understanding of treatment options and care plans, and their feedback on whether care made a difference.<sup>2</sup>
2. **Process measures** – Process denotes what is actually done in giving and receiving care.<sup>3</sup> NQF-endorsement seeks to ensure that process measures have a systematic assessment of the quantity, quality, and consistency of the body of evidence that the measure focus leads to the desired health outcome.<sup>4</sup> Experience of care measures—Defined as patients’ perspective on their care.<sup>5</sup>
3. **Cost/resource use/appropriateness measures** –
  - a. *Cost measures* – Total cost of care.
  - b. *Resource use measures* – Resource use measures are defined as broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (broadly defined to include diagnoses, procedures, or encounters).<sup>6</sup>
  - c. *Appropriateness measures* – Measures that examine the significant clinical, systems, and care coordination aspects involved in the efficient delivery of high-quality services and thereby effectively improve the care of patients and reduce excessive healthcare costs.<sup>7</sup>
4. **Structure measures** – Reflect the conditions in which providers care for patients.<sup>8</sup> This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure

1 National Quality Forum. (2011). The right tools for the job. Retrieved from [http://www.qualityforum.org/Measuring\\_Performance/ABCs/The\\_Right\\_Tools\\_for\\_the\\_Job.aspx](http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx)

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

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

4 National Quality Forum. (2011). Consensus development process. Retrieved from [http://www.qualityforum.org/Measuring\\_Performance/Consensus\\_Development\\_Process.aspx](http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx)

5 National Quality Forum. (2011). The right tools for the job. Retrieved from [http://www.qualityforum.org/Measuring\\_Performance/ABCs/The\\_Right\\_Tools\\_for\\_the\\_Job.aspx](http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx)

6 National Quality Forum (2009). National voluntary consensus standards for outpatient imaging efficiency. Retrieved from [http://www.qualityforum.org/Publications/2009/08/National\\_Voluntary\\_Consensus\\_Standards\\_for\\_Outpatient\\_Imaging\\_Efficiency\\_\\_A\\_Consensus\\_Report.aspx](http://www.qualityforum.org/Publications/2009/08/National_Voluntary_Consensus_Standards_for_Outpatient_Imaging_Efficiency__A_Consensus_Report.aspx)

7 National Quality Forum. (2011). The right tools for the job. Retrieved from [http://www.qualityforum.org/Measuring\\_Performance/ABCs/The\\_Right\\_Tools\\_for\\_the\\_Job.aspx](http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx)

8 National Quality Forum. (2011). The right tools for the job. Retrieved from [http://www.qualityforum.org/Measuring\\_Performance/ABCs/The\\_Right\\_Tools\\_for\\_the\\_Job.aspx](http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx)

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

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

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

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

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

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

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

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

#### **FOR CRITERION 8 – PROGRAM MEASURE SET PROMOTES PARSIMONY:**

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

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

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

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

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



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

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**Chair (voting)**

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Chris Cassel, MD

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**Organizational Members (voting)**

**Representatives**

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

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**Expertise**

**Individual Subject Matter Expert Members (voting)**

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Population Health	Eugene Nelson, MPH, DSc
Health IT/ Patient Reported Outcome Measures	James Walker, MD, FACP

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

**Representatives**

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Centers for Medicare & Medicaid Services (CMS)	Michael Rapp, MD, JD, FACEP
Office of the National Coordinator for HIT (ONC)	Joshua Seidman, MD, PhD

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**Liaisons (non-voting, ex officio)**

**Representatives**

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Centers for Disease Control and Prevention (CDC)

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Peter Briss, MD, MPH (*NPP*)

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Centers for Disease Control and Prevention (CDC)

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Mary George, MD, MSPH (*CDP*)

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

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George J. Isham, MD, MS

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Elizabeth A. McGlynn, PhD, MPP

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