A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity

FINAL REPORT

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NATIONAL
QUALITY FORUM

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EXECUTIVE SUMMARY

Despite overall improvements in public health and medicine, disparities in health and healthcare persist. In 2015, the Centers for Disease Control and Prevention reported significant health and healthcare disparities in leading causes of death. For example, African Americans are more likely to die prematurely from heart disease; the prevalence of heart disease is higher for individuals with lower incomes and lower educational attainment; and individuals with disabilities face disproportionately higher levels of health care need and cost. In addition, the *2016 National Healthcare Quality and Disparities* report highlighted significant disparities in healthcare quality. Racial and ethnic minorities, individuals with disabilities, individuals who have low incomes, and individuals with other social risk factors are more likely to receive lower quality care. Eliminating these disparities has become the priority of the U.S. Department of Health and Human Services (HHS) and many other stakeholder groups.

Performance measurement is an essential yet underused tool for advancing health equity. Measurement allows the monitoring health disparities and assessment of the level to which interventions known to reduce disparities should be employed. Performance measures can also allow stakeholders to assess the impact of interventions known to reduce disparities. Moreover, measures can help to pinpoint where people with social risk factors do not receive the care they need or receive care that is lower quality.

Measurement increasingly serves as a driver for healthcare payment. The growing adoption of global payment systems, alternative payment models (e.g., accountable care organizations [ACOs]), and value-based purchasing offers expanded opportunities for the healthcare system to better address disparities and incentivize the achievement of equity. However, a systematic approach requires use of both measurement and associated policy levers for eliminating disparities and promoting health equity. Stakeholders need a guiding roadmap to help them coordinate and systematically implement strategies for reducing disparities through measurement. Because many quality measures used in alternative payment models, particularly outcome measures, show disparities that may or may not reflect disparities in underlying processes of care, it is essential that these models are not implemented in such a way that safety net providers are unfairly penalized.

The National Quality Forum (NQF) convened a multistakeholder Committee, with funding from the U.S. Department of Health and Human Services (HHS), to provide recommendations on how performance measurement and its associated policy levers can be used to reduce disparities in health and healthcare. The Disparities Standing Committee developed its recommendations by focusing on selected conditions as case studies: cardiovascular disease, cancer, diabetes and chronic kidney disease, infant mortality/low birthweight, and mental illness. Disparities within these conditions were reviewed based on the social risk factors outlined in the 2016 National Academy of Medicine (NAM) report, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*. Three interim reports document each phase of the project:

- report 1: a review of the evidence that describes disparities in health and healthcare outcomes;
- report 2: a review of interventions that have been effective in reducing disparities;

- report 3: an environmental scan of performance measures and assessment of gaps in measures that can be used to assess the extent to which stakeholders are deploying effective interventions to reduce disparities.

This final report presents a roadmap for reducing health and healthcare disparities through performance measurement and associated policy levers. The roadmap primarily focuses on ways in which the U.S. healthcare system (i.e., providers and payers) can use more traditional pathways to eliminate disparities; however, it also identifies areas where collaboration and community partnerships can be used to expand the healthcare system’s role to better address disparities. The roadmap lays out four actions, “Four I’s for Health Equity,” that healthcare stakeholders can employ to reduce disparities:

- **Identify** and prioritize reducing health disparities
- **Implement** evidence-based interventions to reduce disparities
- **Invest** in the development and use of health equity performance measures
- **Incentivize** the reduction of health disparities and achievement of health equity

In the first action, the Committee recommends that measure implementers prioritize the use of measures that are sensitive to disparities in health and healthcare. The Committee noted that stakeholders such as policymakers, payers, and purchasers should leverage existing performance measures, quality improvement, and value-based purchasing programs by implementing disparities-sensitive measures and stratifying them by subgroups to identify disparities. The second action calls for stakeholders to implement evidence-based interventions to reduce disparities at every level of the healthcare system (i.e., government, community, organization, and individual levels). The third action calls for the development and use of health equity performance measures that can be used to assess the use of interventions known to reduce disparities. The Committee developed five domains of measurement that should be used together to advance health equity: collaboration and partnerships, culture of equity, structures for equity, equitable access to care, and equitable high-quality care. The final and fourth action involves incentivizing the reduction of disparities. The use of measurement for reporting and accountability can powerfully promote health equity. However, stakeholders across the U.S. healthcare system must be motivated to act on the results of health equity measures and drive towards improved performance while ensuring that providers have the resources necessary to care for those who are most vulnerable. Although performance measurement is only a tool for advancing health equity, it can have a significant impact on reducing disparities.

To guide implementation of the roadmap, the Committee developed 10 recommendations:

1. Collect social risk factor data.
2. Use and prioritize stratified health equity outcome measures.
3. Prioritize measures in the domains of Equitable Access and Equitable High-Quality Care for accountability purposes.
4. Invest in preventive and primary care for patients with social risk factors.
5. Redesign payment models to support health equity.
6. Link health equity measures to accreditation programs.
7. Support closing disparities by providing additional payments to providers who care for patients with social risk factors.
8. Ensure organizations disproportionately serving individuals with social risk can compete in value-based purchasing programs.
9. Fund care delivery and payment reform demonstration projects to reduce disparities.
10. Assess economic impact of disparities from multiple perspectives.

The roadmap defines a path for systematically reducing disparities in health and healthcare. The Four I’s for Health Equity represent four strategies for healthcare stakeholders to reduce disparities and advance health equity. NQF is committed to collaborating with stakeholders within healthcare and beyond to achieve health equity.

BACKGROUND

The World Health Organization's (WHO) constitution states that the attainment of the highest possible standard of health is a fundamental right of every human being, regardless of race or socioeconomic status. The WHO recognizes the importance of healthcare in achieving health, noting that "the extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health." While there have been significant improvements in medicine and our collective understanding of the impact of social determinants of health on health outcomes, the current reality falls short of this ideal. Many individuals residing throughout the United States continue to face disparities in both health and healthcare. Health equity can only be achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."[1]

The HHS Office of Minority Health describes a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" (based on an individual's gender, age, race, and/or ethnic group, etc.). The Centers for Disease Control and Prevention (CDC) report, *Health Disparities and Inequalities Report-United States, 2013,* found racial and ethnic disparities in mortality due to heart disease and stroke, socioeconomic disparities in the prevalence of diabetes, disparities in suicide rates based on gender, and many others.[2] Healthcare disparities are related to "differences in the quality of care that are not due to access-related factors or clinical needs, preferences, and appropriateness of interventions" (i.e., differences based on discrimination and stereotyping).[3] The *2016 National Healthcare Quality and Disparities Report* found disparities in healthcare related to race, ethnicity, and socioeconomic status (SES) that persist across all National Quality Strategy (NQS) priorities.[4] Poor households received worse care than people in high-income households for about 60 percent of quality measures. African Americans, Hispanics, and American Indians and Alaska Natives received worse care than whites for about 40 percent of quality measures, and Asians and Pacific Islanders received worse care for about 30 percent of the measures.[5]

The reduction of disparities and promotion of health equity have been a goal for the U.S. healthcare system for decades. For instance, the 1983 *President's Commission for the Study of Ethical Problems in Medicine, Biomedicine, and Behavioral Science Research* declared that equitable access to care requires that all citizens have the ability to secure an adequate level of care, as access is a critical driver of health disparities.[6] In the 2001 report, *Crossing the Quality Chasm,* the National Academy of Medicine (NAM) (formally the Institute of Medicine) established equity as an essential aspect of healthcare quality, noting that equitable care does not vary in quality because of social characteristics such as gender, ethnicity, geographic location, and socioeconomic status (SES).[7] Other seminal reports like *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* demonstrated that racial and ethnic minorities often receive lower quality care than their white counterparts, even after controlling for factors such as insurance, SES, comorbidities, and stage of presentation.[8]

Addressing health and healthcare disparities is a priority for both public- and private-sector stakeholders. For instance, the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities and National Partnership for Action to End Health Disparities*, *The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with*

Disabilities, *Healthy People 2020*, the *2013 HHS Language Access Plan*, the *Centers for Medicare and Medicare Services (CMS) Equity Plan for Improving Quality in Medicare*, and provisions in the Affordable Care Act (ACA) have all prioritized the reduction of health and healthcare disparities. The Institute for Healthcare Improvement (IHI) has highlighted the "forgotten" quality aim of health equity, and the Robert Wood Johnson Foundation (RWJF) has donated significant resources towards research and initiatives to improve health equity. In addition, The California Endowment, Aetna Foundation, and the Kresge Foundation have all invested in work to reduce disparities and promote health equity. These are only a few example of commitments that have led to development of guidance and many interventions to reduce disparities, but the implementation of these intervention efforts are rarely systematic and have yet to achieve desired advances in health equity.

Performance measurement can illuminate the healthcare system's progress towards achieving health equity (variation and poor performance) and incentivize both improvement and innovation through accountability. Performance measurement is the regular collection of data to assess whether the correct processes are being performed, structures are in place, and desired results are being achieved.[9] In the same way, performance measures can assess the extent to which stakeholders are employing effective interventions to reduce disparities. Therefore, measures are a critical tool in the effort to promote health equity.

Several organizations have developed guidance on the use of measurement for reducing disparities. For example, the Robert Wood Johnson Foundation (RWJF) has published several reports with recommendations for data collection and performance measurement strategies to reduce disparities. These recommendations include creating a nationwide health information infrastructure to facilitate health disparities research[10] and stratifying quality measures by social risk factors to uncover and respond to disparities.[11] The Commonwealth Fund has also published guidance on data collection to support the detection of disparities and strategies for closing gaps.[12] In addition, the 2016 NAM report, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors,* (released in response to provisions in the IMPACT Act and the first of five reports) defines SES and other social risk factors that could be accounted for in Medicare payment and quality programs.[13] The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) also released guidance in 2016 for accounting for social risk in value-based purchasing programs with recommendations to stratify measures by patient demographic characteristics, adjust performance measure scores, directly adjust payment, and restructure payment incentives.

Performance measurement in healthcare, while critical to monitoring and reducing disparities, is one of many tools needed to eliminate health disparities. Public policy also shapes the environment to promote healthy lifestyles, expand access to care through insurance coverage, eliminate environmental hazards, determine the racial and ethnic distribution of housing, optimize the equitable distribution of food, transportation, vital services, and utilities, and promote many other efforts to advance health equity. The causes of disparities represent complex interactions among institutional, historical, and sociopolitical factors that can only be fully addressed through a variety of mechanisms. Eliminating disparities in health and healthcare will require reengineering the systems that drive disparities and employing interventions that mitigate the impact of social risk on the health of individuals.

PROJECT OVERVIEW

The National Quality Forum (NQF), with funding from the Department of Health and Human Services (HHS), convened a multistakeholder Committee (**Appendix F**), comprising experts in disparities, social risk factors, and healthcare quality improvement, clinical, and measurement expertise to develop a roadmap that demonstrates how performance measurement and its associated policy levers can be used to eliminate disparities. The Disparities Standing Committee focused on the leading causes of morbidity and mortality (i.e., cardiovascular disease, cancer, diabetes, chronic kidney disease, infant mortality, low birthweight, and mental illness) to serve as use cases for the identification of disparities and performance measures that can be used to monitor and reduce disparities. However, the Committee's recommendations apply to all conditions where health and healthcare disparities exist.

Each phase of the Committee's work is documented in a series of three interim reports, which are posted to the **NQF disparities project webpage**. The three interim reports support the primary objectives of the project, which were to:

- review the evidence that describes disparities in health and healthcare outcomes;
- review the evidence of interventions that have been effective in reducing disparities;
- perform an environmental scan of performance measures and assess gaps in measures that can be used to assess the extent to which stakeholders are deploying effective interventions to reduce disparities; and
- provide recommendations to reduce disparities through performance measurement and associated policies.

The Committee used the findings in the three interim reports to create a roadmap for reducing disparities through measurement (roadmap development process included in **Appendix C**). This final report presents the Committee's recommendations.

THE ROADMAP

The growing adoption of global payment systems, alternative payment models (e.g., accountable care organizations [ACOs]), and value-based contracts, has expanded opportunities for the US healthcare system to better address disparities (including through community partnerships). Performance measurement offers an opportunity to assess, support, and incentivize the reduction of disparities. For these reasons, a roadmap is needed to guide stakeholders in coordinating and systematically implementing strategies for reducing disparities through measurement. In developing the roadmap, the Committee recognized that many conceptual models/frameworks/roadmaps have been developed to demonstrate why disparities exist and how they can be reduced. NQF has also engaged in extensive work to better understand the role quality measurement can play in reducing disparities. The Committee built on this work by developing a roadmap with the unique goal of demonstrating how performance measurement can be used to promote health equity and eliminate disparities. The roadmap sets an aspirational goal of eliminating disparities in health and healthcare by describing actions to achieve this goal.

The roadmap builds on the three aims of the National Quality Strategy: better care, healthy people/healthy communities, and affordable care. It integrates existing conceptual models and guidance to form a comprehensive set of strategies for sparking performance measure development and incentivizing the use of measures for reducing disparities. Namely, it draws on the NAM report, *Accounting for Social Risk Factors in Medicare: Identifying Social Risk Factors,* which highlights key social risk factors that include socioeconomic position; race, ethnicity, and cultural context; gender; social relationships; and residential and community context. It also incorporates concepts from the five A's of access to care defined by Penchansky and Thomas: affordability, availability, accessibility, accommodation, and acceptability.[14] The roadmap primarily focuses on ways the U.S. healthcare system (i.e. providers and payers) can use more traditional pathways to eliminate disparities; however, it also identifies areas where collaboration and community partnerships can be used to expand the healthcare system's role to better address disparities.

The roadmap provides guidance for addressing a wide spectrum of disparities based on age, gender, income, race, ethnicity, nativity, language, sexual orientation, gender identity, disability, geographic location, and other social risk factors. It emphasizes the importance of cultural competence, community engagement, and cross-sector partnerships to reduce disparities. In particular, the roadmap includes measurement beyond clinical settings, structures, and processes of care. For example, it includes the assessment of collaboration between healthcare and other sectors (e.g., schools, social services, transportation, housing, etc.) to reduce the impact of social risk factors. Figure 1 illustrates the roadmap's four actions, "Four I's for Health Equity" (i.e., identify, implement, invest, and incentivize)., stakeholders should employ to promote health equity and reduce disparities.

FIGURE 1. A ROADMAP FOR PROMOTING HEALTH EQUITY AND REDUCING DISPARITIES

Although the primary audience for the roadmap is public- and private-sector payers, achieving health equity will require a meaningful commitment and efforts from all stakeholders in the U.S. healthcare system. Consequently, the actions presented in the roadmap allow multiple stakeholders to identify how they can begin to play a part in reducing disparities and promoting health equity. For example, hospitals and/or health plans can identify and prioritize reducing disparities by stratifying performance measures that can detect and monitor known disparities and distinguish which they can address in the near, medium, and long-term. Clinicians can implement evidence-based interventions by connecting patients to community-based services or culturally tailored programs shown to mitigate the drivers of disparities. Healthcare organizations and researchers can test new interventions to add to the current evidence base. Measure developers can work with patients to translate concepts of equity into performance measures that can directly assess health equity. Policy-makers and payers can incentivize the reduction of disparities and the promotion of health equity by building health equity measures into new and existing healthcare payment models. These are only a few of the many ways the roadmap can be implemented and only some of the stakeholders that can act on its recommendations.

Identify and Prioritize Reducing Health Disparities

The use of measurement to identify disparities can help to ensure that all individuals receive quality healthcare regardless of their social risk factors. Measurement can help to pinpoint where people with social risk factors do not receive the care they need or receive care that is lower quality. While national disparities are well documented, individual health and healthcare organizations usually do not systematically assess disparities within the populations they serve. Moreover, the volume of existing measures can make prioritization a challenge, but measures that can help to monitor and reduce disparities should be prioritized. The Disparities Standing Committee built on NQF's 2011 commissioned white paper, developed by researchers at Harvard Medical School and Massachusetts General Hospital, which focused on implications of measurement for health and healthcare disparities.

The white paper provides guidance on criteria for selecting measures that can be used for identifying disparities based on race, ethnicity, and language proficiency. However, many of the recommendations apply to disparities based on all social risk factors. The white paper explains how disparities-sensitive measures can be used to identify and prioritize the reduction of disparities. Disparities-sensitive measures detect differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among population or social groups. The ability of hospitals, health plans, and other healthcare organizations to identify disparities depends on their capacity to collect information on an individual's sociodemographic characteristics. Once these data are collected, healthcare organizations should routinely stratify performance measures to monitor disparities. The authors of the white paper reviewed guiding principles established by an NQF Steering Committee in 2008, included in the report *National Voluntary Consensus Standards for Ambulatory Care-Measuring Healthcare Disparities*, and provided recommendations for refining the criteria.[15]

The Disparities Committee considered these recommendations and revised the criteria to include four key areas of consideration:

1. **Prevalence**—How prevalent is the condition among populations with social risk factors? What is the impact of the condition on the health of populations with social risk factors?
2. **Size of the disparity**—How large is the gap in quality, access, and/or health outcome between the group with social risk factors and the group with the highest quality ratings for the measure?
3. **Strength of the evidence**—How strong is the evidence linking improvement in performance on the measure to improved outcomes in the population with social risk factors?
4. **Ease and feasibility of improvement (actionable)**—Is the measure actionable (e.g. by providers/clinicians/health plans, etc.) among the population with social risk factors?

The authors of the white paper noted that prevalence is important for disparities sensitivity because disparities that are relatively more widespread in populations with social risk factors (e.g. end-stage renal disease, diabetes, and congestive heart failure) may allow for the detection of disparities that have not yet been identified. Further, understanding the quality gap is often even more important if there is evidence that demonstrates differences in quality, access, or health outcomes. If a gap is found, there must be an assessment of whether changes in performance, assessed by the measure, actually leads to improved outcomes in the population with social risk factors. Lastly, some measures assess structures, processes, and outcomes that are more actionable by providers, health plans, communities and other stakeholders. Stakeholders should consider whether there is an entity or group of entities that can take action to improve performance as assessed by the measure. Examples of disparities sensitive measures are included in Table 1 and a more extensive list is included in Appendix D.

TABLE 1. EXAMPLES OF DISPARITIES-SENSITIVE MEASURES

Selected Condition	Measure Title	Measure Steward
Cardiovascular disease	Controlling high blood pressure (diagnosis of hypertension and blood pressure adequately controlled during the measurement period)	CMS/NCQA
Diabetes	Hemoglobin A1c Poor Control (A1c > 9.0% during the measurement period)	NCQA
Cancer	Colorectal cancer screening (appropriate screening for colorectal cancer)	NCQA
Mental health	Initiation and engagement of alcohol and other drug dependence treatment (new episode of alcohol or other drug dependence and received treatment)	NCQA/WC
Low birth weight (PQI9)	Low birth weight (assess the number of low birth weight infants per 100 births)	AHRQ

The Committee acknowledged some of the challenges to identifying disparities-sensitive measures. First, data on social risk factors can be limited, making it hard to explore performance by social group. The Committee also noted the need to ensure patient privacy and that small numbers can make it difficult to stratify while preserving privacy and confidentiality. While small numbers should not be publicly reported, small population sizes should not be used as a justification for not collecting or stratifying data in the first place. When there are concerns that may prevent the reporting of data, oversampling and multiyear pooling techniques should be considered. Stratification should not be used to create an impression that different levels of quality of care are acceptable.

Implement Evidence-Based Interventions to Reduce Disparities

The second action of the roadmap involves the identification of interventions that reduce disparities in health and healthcare. The reduction of disparities will require multilevel, systemic, and sustained interventions. To illustrate the different levels that contribute to the reduction of disparities, the Committee modified the Social-Ecological Model (SEM) to apply to health systems. The SEM illustrates the interactions among various personal and environmental factors that influence health. The Committee extended the SEM to reflect the findings of Chin et al. and others who demonstrated the need for interventions by government, communities, organizations, and providers (with improved patient/individual outcomes as the ultimate target of interventions).[16] By leveraging multiple stakeholders throughout the system, these interventions can lead to improved outcomes for people with social risk factors, helping to demonstrate measurable progress towards achieving health equity.

The Committee built on the work of Cooper et al. that outlined drivers and mediators of disparities. Cooper et al. recognized the impact of individual, financial, structural, social-political, cultural, community, and healthcare system factors on disparities. However, the Cooper et al. framework focuses primarily on disparities based on race and ethnicity. Therefore, the Committee expanded the scope by identifying additional drivers that apply to other social risk factors and including interventions that the healthcare system could use to amplify the effects of the mediators of disparities. The Committee directed a review of the literature to identify effective interventions to reduce disparities based on the modified Cooper et al. framework. The interventions were categorized by the accountable entity as illustrated in the modified SEM in Figure 3.

FIGURE 2. MODIFIED SOCIAL-ECOLOGICAL MODEL

The literature review captured many interventions that have succeeded in reducing disparities in the selected conditions and highlighted gaps in research. The primary findings follow:

- The majority of research focuses on overall improvement of outcomes in populations that are socially at risk (in absolute terms), rather than improving outcomes relative to a socially privileged reference group (e.g., white vs. African American).
- A paucity of health equity-focused implementation science studies is a barrier to the uptake of evidence-based interventions into routine healthcare, clinical, organizational, or policy contexts.
- Existing interventions largely focus on patient education, lifestyle modification, and culturally tailored programs. Far fewer interventions address how to improve health systems for populations with social risk factors.[17]
- Most Interventions target disparities based on race and ethnicity. Few interventions address disparities based on disability status, income, social relationships, health literacy, and residential and community context.
- Many interventions could potentially reduce disparities among multiple conditions (e.g., disparities in the incidence, prevalence, and burden of disease in diabetes and cardiovascular conditions), but are usually implemented and evaluated for addressing disparities in one condition. In addition, many interventions could also address disparities related to more than one social risk factor.

The findings demonstrate the need for further investment in research and demonstration projects to better understand the mediators of disparities, especially in healthcare services. No one intervention can eliminate disparities. There is, however, enough evidence to begin developing, implementing, and adapting programs and policies to reduce disparities and advance health equity. For instance, the RWJF *Finding Answers: Solving Disparities Through Payment and Delivery* Systems *Reform* includes six steps to achieve equity with practical resources for healthcare organizations, a systematic review of articles of disparities interventions, and a searchable database of disparities interventions.[18] The NAM has also published community-based solutions to promote health equity, which provided short- and long-term strategies and solutions that communities may consider to expand opportunities to advance health equity.[19] There are also many other resources for stakeholders seeking to reduce disparities in particular health outcomes. For example, the Patient Centered Outcomes Research Institute (PCORI) published a landscape review of options to reduce disparities in cardiovascular disease.[20] In addition, in 2016 the Institute for Healthcare Improvement published a white paper with five key components for healthcare organizations to improve health equity in the communities they serve.[21]

Addressing disparities in health and healthcare will require interventions that reengineer the systems that lead to and/or perpetuate disparities as well as interventions that target individuals who are at risk. These interventions must be tailored to specific populations, community, and organizational contexts, and address root causes of disparities.[22,23] When these interventions are employed, outcomes must be routinely assessed. Hence, performance measures are needed to monitor the extent to which stakeholders are using interventions known to be effective.

Invest in the Development and Use of Health Equity Performance Measures

The third action of the roadmap involves the selection of health equity performance measures. Health equity measures are quality performance measures that can drive reductions in disparities by incentivizing providers to use interventions known to improve disparities or test new interventions to reduce them, investigate their own practice and community, and try new processes to improve equity. Advancing equity will mean improving both access to and quality of care. The Committee recognized a need for both stratified performance measures that directly measure whether results are equitable between different groups, and other disparity measures that can help guide efforts to improve systems of care such as whether structures are in place that have been demonstrated to reduce disparities. [delete -both disparities-sensitive measures and measures that directly assess equity through the use of interventions known to reduce disparities. To guide the selection and development of health equity measures, the Committee identified domains of health equity measurement. The Committee recognized that achieving equity is a process and requires resources and that stakeholders are at varying stages in that process. The Committee also recognized that no single solution can achieve health equity. Stakeholders must customize interventions to the needs of the populations they serve. The domains of measurement, identified by the Committee, are intended to represent the core processes, structures, and outcomes that must be assessed to achieve equity.

Domains of Health Equity Performance Measurement

The domains of health equity performance measurement represent a prioritized set of goals that must be attained for the healthcare system to achieve equity. They should be considered as a group through which relevant stakeholders can assess how well they are achieving goals outlined within each domain. To develop these domains, the Committee built on current evidence. The Committee adopted a cross-cutting approach (i.e., a method that applies to multiple conditions and social risk factors) rather than a condition-specific or social risk approach. The Committee also recognized that the use of effective interventions is one facet in the achievement of equity. Many structures are needed to support health equity and assess if outcomes are equitable for all. Many of the goals presented in the domains of measurement are rooted in evidence-based interventions known to reduce disparities, and others are based on the Committee's consensus judgment. These goals include several measurable concepts, outlined in the domains below. To achieve equity, the U.S. healthcare system must:

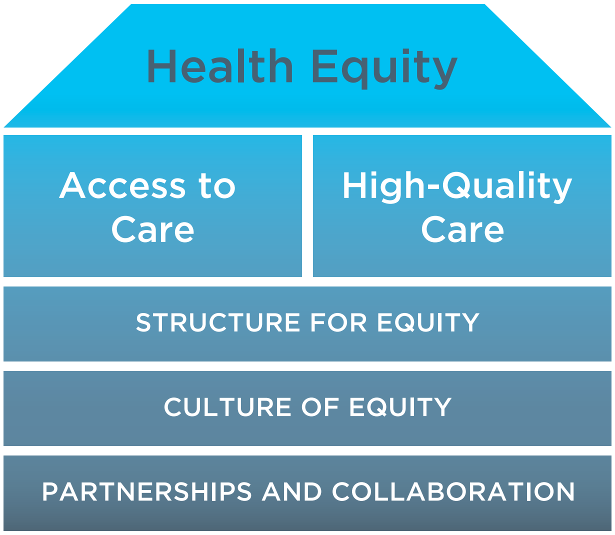
- **Collaborate and partner with** other sectors that influence the health of individuals (e.g., neighborhoods, transportation, housing, education, etc.). Collaboration is necessary to address social determinants of health that are not amenable to what doctors, hospitals, and other healthcare providers alone are trained and licensed to do.
- Adopt and implement a **culture of equity**. A culture of equity recognizes and prioritizes the elimination of disparities through genuine respect, fairness, cultural competency, the creation of environments where all individuals, particularly those from diverse and/or stigmatized backgrounds, feel safe in addressing difficult topics, e.g., racism, and advocating for public and private policies that advance equity.
- Create **structures** that support a culture of equity. These structures include policies and procedures that institutionalize values that

promote health equity, commit adequate resources for the reduction of disparities, and enact systematic collection of data to monitor and provide transparency and accountability about the outcomes of individuals with social risk factors. These structures also include continuous learning systems that routinely assess the needs of individuals with social risk factors, develop culturally tailored interventions to reduce disparities, and evaluate their impact.

- Ensure **equitable access to healthcare.** Equitable access means that individuals with social risk factors are able to easily get care. It also means care is affordable, convenient, and able to meet the needs of individuals with social risk factors.
- Ensure **high-quality care** that continuously reduces disparities within the system. Performance measures should be routinely stratified to identify disparities in care. In addition, performance measures should be used to create accountability for reducing, and ultimately, eliminating disparities through effective interventions.

The Committee recognized the potential challenges to developing performance measures for the domains of *Collaboration and Partnerships*, *Culture of Equity*, and *Structures for Equity*. The Committee recognized a need to minimize the burden of measurement and to ensure that public-reporting and value-based purchasing programs emphasize outcomes that are most valuable for public reporting and supporting consumer decision making. Some domains in the roadmap are more suitable for accountability and others, for quality improvement. The majority of measures that fall within the domains of *Culture for Equity*, *Structure for Equity*, and *Collaboration and Partnerships* should be used primarily for quality improvement initiatives and are less appropriate for accountability. While measures that are aligned with the domains of *Equitable Access to Care* and *Equitable High-Quality Care* may be more suitable for accountability. However, the Committee strongly endorsed reporting progress towards meeting the goals outlined in each domain to ensure transparency. Public reporting, transparency, and accountability are important tools for advancing health equity. Each accountable entity will have various capacities to implement the goals outlined in the *Structure for Equity*, *Culture for Equity*, and *Collaboration and Partnerships* domains and should be allowed the flexibility to customize its approach to meeting these goals based on its unique needs.

FIGURE 3A. DOMAINS OF HEALTH EQUITY MEASUREMENT



Subdomains of Health Equity Performance Measurement

The Committee also identified subdomains to describe the types of concepts and actions to measure within each domain (Figure 4b). These subdomains demonstrate more specific ways to advance the goals of each overarching domain. Many of the concepts reflect traditional means of performance measurement with a health equity lens. Existing performance measures can be modified or adapted to monitor the use of interventions for populations that have social risk factors. Other concepts represent a growing knowledge of the impact of social determinants of health on disparities. Many of these concepts will require the identification of new data sources, data collection tools, and/or the development of new performance measures.

FIGURE 3B. SUBDOMAINS OF HEALTH EQUITY PERFORMANCE MEASUREMENT

Collaboration and Partnerships

SUBDOMAINS	EXAMPLES
Collaboration across health and nonhealth sectors	• Care addresses social determinants of health • Supporting social services needs between clinical visits • Support for high quality child care • Support for early, high-quality education systems within disadvantaged communities through partnerships, research, and advocacy • Support for effective community-based interventions (family nurse partnership, early child intervention) • Leveraging the training and employment role of healthcare organizations (i.e., education, job training, jobs, and career pathways for underserved groups) • Distribution of naloxone to early responders and families of persons with opioid dependence
Community and health system linkages	• Linking medical care with community services to connect patients to resources more effectively • Supporting adequately and equitably resourced public health systems and services • Use of community mapping to link clients to community-based social services • Community engagement and long-term partnerships and investments • Improved integration of medical, behavioral, oral, and other health services • Care coordination between jails/prisons and community care providers • Use of community health workers, navigators, and *promotoras* to address social determinants of health among patients in the health care system.
Build and sustain social capital and social inclusion	• Measure assessing number of completed referrals to family-based programs to encourage family communication, bonding, lifestyle improvements • Measure assessing number of completed referrals to school programs to encourage parent, teacher, student involvement • Measure assessing number of completed referrals to community-based programs in socially disadvantaged communities (e.g., gang rehabilitation, church-based health programs) • Involvement in neighborhood improvement programs (e.g., parks, social space, sidewalk improvements) • Involvement in neighborhood safety, personal safety programs • Community-based self management groups for people with chronic conditions • Involvement in financial literacy, retirement, homeownership programs • Outreach to marginalized communities (e.g., immigrants, undocumented, LGBTQ), communities living in fear of discrimination, deportation
Promotion of public and private policies that advance equity	• Supporting industry standards of care that include and highlight equity and actionable approaches delivering high-value care and services • Supporting and implementing payment systems (at the state, community, institutional, and provider levels) that explicitly prioritize and incentivize identification and reduction of disparities and achievement of equity • Supporting public programs that provide health insurance coverage to the uninsured (e.g., Medicaid, Children's Health Insurance Program, Medicare) and improving healthcare affordability for low-income persons

Culture of Equity

SUBDOMAINS	EXAMPLES
Equity is high priority	• Governance (e.g., membership, policies, mission, vision, etc.) • Leadership • Avoidance of segregated care by status, income, or insurance, e.g. special suites for donors, private office care for those with commercial insurance, and 'clinics' for uninsured patients and those with Medicaid.
Safe and accessible environments for individuals from diverse backgrounds	• Physical safety (especially for disabled, sexual and gender minorities, individuals experiencing trauma and/or domestic violence, etc.) • Emotional safety where people feel safe in speaking up regarding difficult hot topics (e.g., racism, microaggressions, abusive power, stigma, etc.) • Cultural safety (e.g., attire, hair, language, nationality, religion etc.)
Cultural competency	• Workforce diversity at all levels (i.e., among staff and leadership) • Training/continuing education of all providers and staff • Awareness of cumulative structural disadvantage, bias, and stigma and commitment to mitigation – Structural racism and other disadvantages – Intersectionality of multiple structural disadvantages (e.g., limited English proficiency and disability) – Adverse childhood experiences/trauma-informed care • Cumulative allostatic load
Advocacy for public and private policies that advance equity	• Supporting industry standards of care that include and highlight equity and actionable approaches to advancing equity and value, i.e., less costly healthcare • Supporting and implementing payment systems that incentivize identification and reduction of disparities and achievement of equity • Supporting existing public insurance programs that provide health insurance coverage to the uninsured (e.g., Medicaid, Children's Health Insurance Program) and improving healthcare affordability for low-income persons

Structure for Equity

SUBDOMAINS	EXAMPLES
Capacity and resources to promote equity	• Workforce has the knowledge, attitudes, skills, and resources to advance equity • Dedicated budget allocations to promote equity • Information technology (IT) and data analytics capabilities
Collection of data to monitor the outcomes of individuals with social risk factors	• Systematic identification of patients' social risk factors (e.g., implementing "Capturing Social and Behavioral Domains in Electronic Health Records" and/or use of "the Accountable Health Communities Screening Tool") • Systematic reporting and improvement in performance data stratified by social risk factors • Learning systems; doing quality improvement with an equity lens
Population health management	• Integrated information systems and strategies to track key health outcomes and health disparities in communities (e.g., IOM/NAM metrics for health and healthcare progress)
Systematic community needs assessments	• Identifying collective capabilities of communities to enhance assets that promote health and health equity • Public reporting on hospital community health needs assessment including actionable metrics for progress • Targeting interventions toward community-prioritized needs
Policies and procedures that advance equity	• Optimal health literacy as an organizational/system commitment • Comprehensive language assistance and communications services for individuals with limited English proficiency and individuals with disabilities • Comprehensive language assistance and communications services for individuals with limited English proficiency and individuals with disabilities • The health care system takes steps to ensure that all patients have the opportunity (or not) to interact with students and medical trainees. Avoiding policies that create a hidden curriculum in which poor patients are systematically assigned to students and trainees.
Transparency, public reporting, and accountability for efforts to advance equity	• Public reporting of quality performance at increasingly granular levels (e.g., health plan that reports on quality performance of its providers) • Reporting on progress related to other steps the organization has taken (e.g., other domains cited above) • Formalized processes to get comment from the public and other stakeholders in planning and in revising

Equitable Access to Care

SUBDOMAINS	EXAMPLES
Availability	• Assessment of access to quality care in a geographic service area • Availability and access to specialty care including needed treatment, e.g. mental health or drug treatment. • Network adequacy, inclusion of essential community providers • Timely (same day appointments, time to next appointment, timely appointments with specialists, etc.) • "After-hours" access
Accessibility	• Physical accessibility for individuals with disabilities • Geographic (no transportation barriers or transportation support) • Language accessibility including effective communication about the availability of interpreter services including American Sign Language
Affordability	• Fewer delays and less care including visits, tests, prescriptions, and specialty access forgone due to out-of-pocket costs • Ability of a patient to cover the cost of healthcare services without foregoing other necessities (housing, food, transportation, childcare, etc.) • Affordability of standard insurance • Total costs related to health care (premiums + out-of-pocket costs of care including co-insurance, copayments etc.) • Rates of health care related personal bankruptcy
Convenience	• Distance from residence • Flexible appointment schedules • Accessibility to public transportation • Safety of surrounding environment

Equitable High-Quality Care

SUBDOMAINS	EXAMPLES
Person- and family-centeredness	• Measure and improve patient/individual, family, and caregiver experiences of care, including access and satisfaction and experience of discrimination • Communication and comprehension, especially for individuals with low health literacy, limited English proficiency, or with physical and developmental disabilities or cognitive impairments • Informed and shared decision making • Support for self-care including training in patient activation and chronic care self-management • Availability of patient advisors, advisory councils; patients on governing boards • Include patients on quality improvement, patient safety, and ethics teams
Continuous improvements across clinical structure, process, and outcome performance measures stratified by social risk factors	• Including but not limited to measures that assess: – Patient outcomes – Patient-reported outcomes • Clinical process of care measures (e.g., mammography) • Clinical intermediate outcome measures (e.g., blood pressure control in hypertensive patients) • Improvement in key behavioral risk factors (e.g., smoking, diet, physical activity, psychological distress, and substance use) • Promotion of healthy and safe communities with environments that support healthy behavior • Improvement in population health (e.g., fewer avoidable hospitalizations, premature disability/deaths, and unintended pregnancies; improved well-being and health status) • Use disparities-sensitive measures
Use of effective interventions to reduce disparities in healthcare quality	Including but not limited to: • Team-based care • Case managers • Nurse-specific measures • Community health workers/navigators/*promotoras(es)* • Culturally tailored interventions • Self-management support • Telehealth • Patient-centered communication skills and cultural competency training

Current Measurement Landscape

The Committee directed an environmental scan to assess the current landscape of measures that can be used to assess progress towards achieving the goals outlined within the domains of measurement. The scan included disparities-sensitive measures and health equity measures (i.e., measures linked to interventions that are known to reduce disparities in populations with social risk factors and/or aligned with the priority domains of measurement outlined in the Committee's measurement roadmap). NQF conducted the environmental scan by searching for measures that assess structures, processes, and outcomes of care for the selected conditions (i.e., cancer, cardiovascular disease, mental illness, infant mortality, low birth weight, diabetes, and chronic kidney disease) and sorting them by the domains of health equity measurement. The environmental scan retrieved 886 performance measures. The majority of measures aligned with the *Equitable High-Quality Care* and *Equitable Access to Care* domains. Far fewer measures aligned with the *Collaboration and Partnerships* domain. NQF obtained input on the findings of the environmental scan from 19 key informants with clinical expertise and knowledge of disparities within each of the selected conditions. The full compendium of measures is included in **Appendix E**. Given significant gaps (between the ideal state and the current state of measurement), the Committee recommended development of health equity performance measures. The following sections further describe the domains of health equity measurement, example measures, gaps in measurement, and potential measure concepts that can be translated into performance measures.

Collaboration and Partnerships

It is common knowledge that a person's health is influenced by factors outside the healthcare system. Collaboration is necessary to address social risk factors that physicians, hospitals, and other healthcare providers are not trained and licensed to address or do not have the resources to address under current payment models. Addressing social risk factors requires partnering with organizations and agencies such as policymakers, communities/neighborhoods, social services, transportation, housing, education, employers, and payers. These collaborations themselves should be grounded in the principles of respect and fairness (e.g., equity in decision making, resources, and information transparency). The Committee noted the role for payers to support greater collaboration and partnerships to advance health equity. Current payment models frequently only reimburse a healthcare provider for clinical services. While some organizations are working to address social risk factors such as housing and food insecurity, this approach may not be feasible over time or scalable to a state or national level.

The environmental scan found very few measures that assess the extent to which healthcare organizations are collaborating with public health programs and other sectors outside of healthcare (e.g., transportation, housing, education, etc.). The subdomain*, community and health system linkages*, focuses on the integration between care settings as a way to reduce disparities. An example of a measure (Table 2) that seeks to improve the integration of medical and behavioral health services is the *Assessment of Integrated Care: Total Score for the "Integrated Services and Patient and Family-Centeredness"* characteristics of the *Site Self Assessments (SSA) Evaluation Tool,* which is maintained in the AHRQ National Quality Measures Clearinghouse. The measure uses survey data collected from health professionals to assess the level of integration between primary care and mental/behavioral healthcare in a variety of care settings.

The subdomain, *collaboration across health and nonhealth sectors,* assesses how the healthcare system interacts with other sectors to improve healthy equity. One example of a potential area of collaboration is between healthcare and transportation systems. Lack of adequate transportation is a significant barrier to accessing care, especially for individuals in rural communities and for those with disabilities. The NQF-endorsed Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey includes items that assess the availability of transportation to medical appointments. Future measurement efforts should assess how the healthcare system engages the transportation system to increase the availability of transportation. For example, the 2017 NCQA Patient-Centered Medical Home (PCMH) standards address a variety of criteria for integration between PCMH and the community. These standards can inform the development of measures that address collaboration and partnerships.

The subdomain, *build and sustain social capital and social inclusion*, includes measures that assess the interaction between the healthcare system and communities. Few measures were found that assess the extent to which healthcare institutions work to build social capital and cohesion in communities. Assessing the level of interactions among these entities can be difficult given the variety of community-level settings. There is also little evidence to suggest which community entities are most important for the healthcare system to engage. The Committee discussed the importance of identifying community anchor institutions for partnerships (i.e., hospitals, universities, major employers, and other enduring institutions that play a role in communities and economies) and creating databases of community resources for providers.

The *Collaboration and Partnerships* domain has the largest gaps in measurement. Table 3 below outlines key gap areas in this domain. Key informants selected from NQF's clinical standing committees noted gaps in measures that address the social determinants of health, including education, employment, income, transportation, and housing, etc. These gaps in measurement may be based on insufficient evidence regarding the use of collaborations to address health and healthcare disparities. As gaps in the integration of physical and mental health are addressed, the Substance Abuse and Mental Health Services Administration's Four Quadrant Model can serve as a framework to promote alignment in the development of integrated measures.[24] The Four Quadrant Model describes subsets of the population based on behavioral health and physical health risk and suggests system elements that could be used to meet the needs of each subset of the population. Committee members recognized the potential challenges to developing measures in this domain, noting that it could be difficult to create benchmarks. The Committee recognized the need for quantification but cautioned that threshold levels may change as measures become standardized.

The environmental scan retrieved only seven measures of collaborations and partnerships. Table 4 shows a breakdown of available measures by subdomain. None of these measures addresses cancer; only one measure relates to each of diabetes/chronic kidney disease (CKD) and cardiovascular disease; and five measures apply to mental illness.

TABLE 2. EXAMPLE OF EXISTING COLLABORATION AND PARTNERSHIP MEASURE

Subdomain	Measure Title	Measure Description	Measure Source
Community and health system linkages	Assessment of Integrated Care: Total Score for the "Integrated Services and Patient and Family-Centeredness" Characteristics on the Site Self Assessment (SSA) Evaluation Tool	This measure is used to assess the total score for the "Integrated Services and Patient and Family-Centeredness" characteristics on the Site Self Assessment (SSA) Evaluation Tool.	AHRQ National Quality Measures Clearinghouse

TABLE 3. EXAMPLE COLLABORATION AND PARTNERSHIP MEASURE CONCEPTS TO FILL GAPS IN MEASUREMENT

Subdomain	Measure Concept Description
Collaboration across health and nonhealth sectors	A measure that assesses the number of partnerships and active projects with nonhealth sector organizations (e.g., schools, transportation, environment, food).
Build and sustain social capital and social cohesion	A measure or measures that assess the following: • Connection to community programs (percent of eligible patients who had a completed referral): – Use of family-based programs to encourage family communication, bonding, lifestyle improvements – Use of school programs to encourage parent, teacher, student involvement – Use of community-based programs in socially disadvantaged communities (e.g., gang rehabilitation, faith-based health programs) • Involvement in neighborhood improvement programs (e.g., parks, social space, sidewalk improvements) • Involvement in neighborhood safety, personal safety programs Involvement in financial literacy, retirement, homeownership programs • Partnerships between healthcare systems and schools • Outreach to marginalized communities (e.g., immigrants, undocumented, LGBTQ), communities living in fear of discrimination, deportation
Community and health system linkages	A measure or measures that assess the following: • Availability of physical/community space at healthcare sites for gatherings of community members to discuss health topics (e.g., support groups) • Financial investment in community organizations, projects • Community outreach gatherings, public health screenings in the community

TABLE 4. PARTNERSHIP AND COLLABORATION SUBDOMAIN MEASURE AVAILABILITY

Subdomains	Number of available measures
Collaboration across health and nonhealth sectors	1
Community and health system linkages	6
Build and sustain social capital and social inclusion	0
Promotion of public and private policies that advance equity	0

Culture of Equity

A culture of equity recognizes and prioritizes the elimination of disparities through genuine respect, fairness, cultural competency, and the creation of environments where all individuals—particularly those from diverse and/or stigmatized backgrounds—feel safe in addressing difficult topics such as racism and advocating for public and private policies that advance equity. The Committee noted that a culture of equity creates emotional safety, such that all persons are respected, all voices are heard, and traditional hierarchies are flattened. This safe environment creates the spaces to discuss difficult topics and creates a foundational atmosphere to address daily behaviors that can undermine policies that promote equity.

Surveys can help in assessing an emotionally safe culture.[25,26] For example, there is a scale to measure moral courage in speaking up which helps create a culture.[27] Emotional safety is a starting point that allows for sharing of experiences of members of disparity groups and uncovering blind spots related to social risk factors. A culture of equity is supported by inclusion of members of disparity groups in key decision making groups (e.g., boards of directors, management, quality improvement teams, etc.). Inclusion in decision making helps ensure that the voices of these groups are heard at all levels. Furthermore, ensuring this type of diversity within decision making groups helps change the conversation. For instance, it is one thing to talk about the importance of wheel chair accessibility and another to discuss this with a person who uses a wheel chair.

The environmental scan identified many measures that assess the concepts within subdomains of the *Culture of Equity* domain, including several NQF-endorsed measures. The majority of measures assess concepts related to *cultural competency*. The Committee adopted a modified definition of cultural competency for this work: the ability to appropriately meet the health and healthcare needs of individuals of diverse backgrounds. The Committee emphasized the importance of measuring bias at both the institutional and provider levels as well as structural racism. Examples include, but are not limited to, cumulative structural disadvantage, bias, and stigma. Improving cultural competency is a key intervention that addresses disparities across all conditions.

There are several NQF-endorsed experience-of-care measures that assess the environment and the manner in which care is received at the provider level. For example, NQF #0008 *Experience of Care and Health Outcomes (ECHO) Survey* (behavioral health, managed care versions) and NQF #0517 *CAHPS® Home Health Care Survey* (experience with care) both assess a patient's experiences with care. These measures can be stratified to ensure that individuals with social risk factors are receiving care in environments that are physically, emotionally, and culturally safe. In addition, the *Communication Climate Assessment Toolkit (C-CAT),* designed for providers, staff, and patients, assesses how well providers help patients cope with stigma.

The Committee also noted the importance of ensuring that equity is a priority at all levels of the healthcare system. For instance, several Committee members agreed that organizations should adopt the national *Culturally and Linguistically Appropriate Services (CLAS) Standards*[28] developed and promulgated by HHS. There are NQF-endorsed measures that can be used to assess the level to which providers are delivering care that complies with CLAS standards. These measures are derived from the *Communication Climate Assessment Toolkit (C-CAT)* and assess the level of patient-centered communication, communication gaps, workforce training, commitment of leadership, and health literacy, among other subdomains relevant to ensure a *culture of equity*. The Committee also discussed the CAHPS Culture Competence Item Set, which covers topics such as patient-provider communication; experiences of discrimination due to race/ethnicity, insurance, or language; experiences leading to trust or distrust; and linguistic competency. The item set is not currently used.

Overall, the scan retrieved 38 *Culture of Equity* measures: 25 specifically for mental illness, one for chronic kidney disease, zero for cardiovascular disease, zero for cancer, four for infant mortality and low birthweight, and eight that apply to multiple conditions. Table 5 includes some key illustrative examples of current measures that address this domain.

Despite the availability of numerous measures and assessment tools, there remain several gaps, highlighted in Table 6. The Committee recommended the development of a measure that assesses the extent to which resources are allocated to activities that advance health equity. In addition, assessments of the culture of organizations should be routinely stratified by respondent demographic characteristics. There were no measures identified that assess the level to which stakeholders are advocating for public and private policies to advance equity, which represents a gap area. Again, the Committee noted challenges to measure development in this area, including developing measures that have meaningful impact and do not become "check-box" measures. Table 7 shows the available measures by subdomain.

TABLE 5. EXAMPLES OF CULTURE OF EQUITY MEASURES

Subdomain	Measure Title	Measure Description	Measure Source
Cultural competency	Language services measure derived from language services domain of the C-CAT	0-100 measure of language services related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit (C-CAT)	NQF Quality Positioning System
Cultural competency	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CAHPS Clinician/Group Survey.	NQF Quality Positioning System

TABLE 6. EXAMPLES OF CULTURE OF EQUITY MEASURE CONCEPTS TO FILL GAPS IN MEASUREMENT

Subdomain	Measure Description
Equity is high priority	A measure that assesses whether health/healthcare equity is explicitly mentioned in institution's mission statement and/or strategic plan
Equity is high priority	A measure that assesses whether an institution has released statements, comment letters, etc. that explicitly discuss the impact of local/state/federal actions on community health and health inequities
Cultural competency	A measure that assesses the extent to which underrepresented groups are present at all levels of the organization (e.g., board, C-suite, support staff)

TABLE 7. CULTURE OF EQUITY SUBDOMAIN MEASURE AVAILABILITY

Subdomains	Number of available measures
Equity is high priority	1
Safe and accessible environments for individuals from diverse backgrounds	22
Cultural competency	15
Advocacy for public and private policies that advance equity	0

Structure for Equity

There are critical structures for supporting a culture of health equity. These structures include laws (including statutes and regulations), policies, and procedures that operationalize the culture of equity. They are necessary to promote health equity, commit adequate resources for the reduction of disparities, and enact systematic collection of data to monitor and provide transparency and accountability for the outcomes of individuals with social risk factors. These structures also include continuous learning systems that routinely assess and objectively measure the needs of individuals with social risk factors, develop culturally tailored interventions to reduce disparities, evaluate their impact, and modify them accordingly. Structures are likely to achieve the greatest impact on equity when leadership and an equitable culture support them. The Committee noted the importance of leading by example and the importance of allocating specific resources to support the work of equity. Structures should create sufficient incentives, financial or otherwise, to move towards equitable health and healthcare. The Committee recognized the need for substantial and systemic funding to enable all of the domains of healthcare equity to be effectively implemented, evaluated, assessed, and monitored.

The environmental scan identified several measures that can assess the concepts within subdomains of the *Structure for Equity* domain. The majority of measures align with the need to assess population health and monitor the outcomes of individuals with social risk factors. The Committee noted the primary importance of collecting data on the health and healthcare of individuals with social risk factors, as the assessment of improvement cannot happen without access to data. There are many known gaps in such data, specifically among health plans. The *NAM Report Accounting for Social Risk Factors in Medicare Payment* found significant gaps in data among public and private health insurers on income, whether beneficiaries lived alone or had social support, sexual orientation, gender identity, and features of the places they live.[29] The Committee highlighted prior recommendations and noted current requirements and incentives for healthcare organizations to build these data collection fields into their electronic health records systems.

Few measures assess data collection efforts to improve health equity. The environmental scan retrieved one measure, NQF #1881 (not endorsed), derived from the C-CAT that captures whether an organization uses standardized qualitative and quantitative collection methods and uniform coding systems to gather valid and reliable information for understanding the demographics and communication needs of the population served. The measure represents an example for measure developers who seek to fill gaps in measurement of data collection. The Office of National Coordinator for Health IT Certification Program requires capture of data regarding race and ethnicity, sexual orientation, gender identity, and social, psychological, and behavioral data that could be used to support measurement in the future.[30]

The Committee also stressed the need for better population health management for individuals with social risk factors. The environmental scan identified many measures that can be used for surveillance to improve strategies for population health management and assess community needs. Examples include measures that assess concepts such as smoking prevalence, cancer screening, infant mortality, and insurance coverage among individuals with social risk factors. NQF #1919 *Cultural Competency Implementation Measure* addresses the ideas of transparency, public reporting, and accountability for efforts to advance equity or the capacity and resources to promote equity. While not a performance measure, the HHS Office of Minority Health CLAS Standard's 15 recommendations specify that institutions "Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public"[31] and could serve as the basis of a future measure.

Overall, the scan identified 46 *Structure of Equity* measures: one for mental health, four for chronic kidney disease, seven for cardiovascular disease, five for cancer, 28 for infant mortality and low birthweight, and one that cuts across condition areas. The majority of the measures found relate to clinical data collection in an effort to reduce disparities, and based on key informant interviews, the most important behaviors to monitor for disparities include tobacco use, alcohol use, opioid abuse, depression, and obesity screening, treatment, and counseling. Table 8 highlights key example measures, while table 9 includes potential gaps in measurement. Table 10 shows available measures by subdomain.

TABLE 8. EXAMPLES OF STRUCTURE OF EQUITY MEASURES

Subdomain	Measure Title	Measure Description	Measure Source
Collection of data to monitor the outcomes of individuals with social risk factors	L1A: Screening for Preferred Spoken Language for Health Care	This measure is used to assess the percent of patient visits and admissions where preferred spoken language for healthcare is screened and recorded. Access to and availability of patient language preference is critical for providers in planning care. This measure provides information on the extent to which patients are asked about the language they prefer to receive care in and the extent to which this information is recorded.	NQF Quality Positioning System
Population health management	Adult Current Smoking Prevalence	Percentage of adult (age 18 and older) U.S. population that currently smokes. The measure is stratified by geography.	NQF Quality Positioning System

TABLE 9. EXAMPLES OF STRUCTURE OF EQUITY MEASURE CONCEPTS TO FILL GAPS IN MEASUREMENT

Subdomain	Measure Description
Collection of data to monitor the outcomes of individuals with social risk factors	A measure that assesses the number of individuals enrolled in a health plan during a measurement year for one or more months that has completed a survey with key questions such as income, home ownership, education, race/ethnicity, household size. A measure assessing use of the ICD-10 Z codes for factors influencing health status.
Population health management	A set of measures that assess hospitalizations and readmissions, emergency room use, frequency and intensity of office visits, medication adherence and persistence, emergence of condition-related adverse events, and existence of co-morbidities and other diagnoses by social risk factors. Outcomes should be stratified by key social and behavioral risk factors, such as mental health conditions, alcohol/drug/substance abuse, and other risk factors.

TABLE 10. STRUCTURE FOR EQUITY SUBDOMAIN MEASURE AVAILABILITY

Subdomains	Number of available measures
Capacity and resources to promote equity	9
Collection of data to monitor the outcomes of individuals with social risk factors	3
Population health management	34
Systematic community needs assessments	0
Policies and procedures that promote equity	0
Transparency, public reporting, and accountability for efforts to advance equity	0

Equitable Access to Care

The Committee emphasized the need to ensure access to care to advance health equity, as access is a central driver of disparities. Equitable access means that individuals with social risk factors can easily get care. It also means care is affordable, convenient, and able to meet the needs of individuals with social risk factors. This requires systematic examination of organizational policies at multiple levels related to patient out-of-pocket costs (at each juncture), and physical and communicational accessibility. Mechanisms should be in place to elicit meaningful input from patients from different groups regarding equitable access.

Further, to ensure equitable access to healthcare, providers should be available, accessible, and acceptable to patients in order to deliver high-quality care to patients and communities. Healthcare workers must be:

1. equitably distributed (available in all communities, including where populations of greater social risk reside);
2. accessible to populations (available to provide care within a reasonable time period that is convenient for the population (i.e., not waiting three months for an appointment and open for evening hours for people who cannot miss work due to economic constraints); and
3. acceptable to the population (possess the required competency—including knowledge of health disparities and social risk—and empowered and motivated to provide quality care that is socio-culturally appropriate and acceptable).[32]

The Committee also recognized the need to address financial access[33] and noted a need to continue to improve access to health insurance and ensure that premiums, deductibles, and co-pays do not create barriers to care.

The environmental scan found many measures that assess access to care and can be stratified to assess equitable access for individuals with social risk factors. Table 11 highlights example measures in this domain. However, there were notable differences in the availability of access measures by condition as well as by subdomain. The environmental scan did not identify any measures of affordability, and very few that specifically focused on assessing accessibility or convenience. However, the Health Professional Shortage Area and Medically Underserved Area designations of the Health Resources and Services Administration (HRSA) and CMS's definition of network adequacy and essential community providers could serve as starting points for future performance measures. The Healthy People 2020 goals also include important targets related to access to care. Measures should be identified or created to assess U.S. progress toward meeting these goals. Additionally, the CAHPS surveys include items of convenience, timeliness, and accessibility, which could be stratified to assess disparities.

Equitable access starts with unconstrained access to primary care. Robust systems of primary care are associated with improved population health and reduced disparities.[34] Primary care plays a unique role in promoting equity through its comprehensive and biopsychosocial focus, longitudinal personal relationships, and its capacity to align intensity of management with patient needs. Primary care capacity to care for people (rather than diseases) across medical, behavioral, and psychosocial dimensions while aligning resources and services to these needs is vital to improving health equity. In addition, the ability to afford healthcare is closely tied to insurance status, so general measures of insurance status may be able to close disparities related to affordability. However, rapid emergence of high deductible health plans risks creating new cost-related disparities related to affordability even among those persons with commercial insurance.

Equitable access is critical for mental health and substance use disorder services. Mental health services are significantly underused by many racial and ethnic minority group members. Despite

Congressional passage of the Mental Health Parity and Addiction Equity Act (MHPAEA), significant access barriers to these services remain, including those related to community availability, costs, and cultural and linguistic appropriateness. Accelerating integration of primary care with behavioral services offers promise for improving access to these services among disparity groups.

Convenience may be less condition-specific, as it can also be influenced by insurance status, the general availability of primary care providers for preventive care, and the geographic availability and insurance coverage for specialists, particularly for rural and low-income populations. General measures of access to primary care or specialist providers, including measures of geographic access and timeliness of care, or measures around innovative solutions such as telehealth, could be used to assess equitable access at the organization level. Language remains an important barrier for many groups with limited English language proficiency, e.g., Latino and Asian Americans, and for the American Sign Language (ASL)/deaf population. While several measures assess whether providers or organizations are culturally competent, fewer measures assess the level to which patients have access to culturally competent care (i.e., accessibility). Convenience also includes physical access issues for people with disabilities.

Continuity of care with the same primary care provider (PCP) is an important undermeasured component of access to care. Having a personal, longitudinal relationship between a PCP and patient is particularly important to marginalized, traumatized groups who are at high risk for healthcare disparities. Unfortunately, many individuals with social risk factors are at higher risk for discontinuity in PCP (or mental health) relationships due to receiving care in facilities where turnover is high (e.g., community health centers, residency clinics, student operated clinics, etc.). Therefore, better measurement of continuity of primary care will be essential to reducing disparities.

The environmental scan identified only three access-to-care measures related to cancer, but 17 access measures that could influence infant mortality and low birthweight. There were six measures of access for mental illness, eight for diabetes and chronic kidney disease, six for cardiovascular disease, and zero cutting across condition areas. The bulk of the access measures focus on availability of providers and/or resources (which can also influence accessibility and convenience). Table 12 shows identified gap areas in this domain. Table 13 includes a breakdown of available measures by subdomain.

TABLE 11. EXAMPLES OF EQUITABLE ACCESS TO CARE MEASURES

Subdomain	Measure Title	Measure Description	Measure Source
Convenience	Patient-Centered Medical Home Patients' Experiences	Percentage of parents or guardians who reported how often they were able to get the care their child needed from their child's provider's office during evenings, weekends, or holidays	Health Information Warehouse
Availability	Medicare Beneficiaries' Ambulatory Care Sensitive Condition (ACSC) Hospitalizations Hospitalization Rate per 1,000 Medicare Beneficiaries	The number of discharges for ACSC in a county divided by the number of Medicare beneficiaries in a county multiplied by 1,000. The primary independent variable of interest is the number of primary care physicians.	Yu-Hsiu Lin, PhD et al.[35]
Accessibility	HCBS CAHPS Measure (5 of 19): Transportation to Medical Appointments	Transportation to medical appointments: Top-box score composed of three survey items	AHRQ National Quality Measures Clearinghouse

TABLE 12. EXAMPLES OF EQUITABLE ACCESS MEASURE CONCEPTS TO FILL GAPS IN MEASUREMENT

Subdomain	Measure Description
Availability	A measure that assesses the number of primary care visit slots held for same-day appointments or drop-in access. A measure that assesses the number of days to get an appointment (could build on items in the California Health Interview Survey)
Accessibility	A measure that assesses the total number of outpatient or clinic practice locations (weighted by visit volume) within one block of a public transportation stop.
Affordability	A measure that assesses the number of services (weighted by dollar value) billed on the basis of a sliding scale linked to patient income. A patient-reported measure that assesses the level of patients' satisfaction with their healthcare costs. CMS cost-related medication nonadherence scale
Convenience	A measure that assesses the number of appointments with wait times of 15 minutes or less, as reported by patients or patient caregivers.

TABLE 13. EQUITABLE ACCESS TO CARE SUBDOMAIN MEASURE AVAILABILITY

Subdomains	Number of available measures
Availability	31
Accessibility	4
Affordability	1
Convenience	4

Equitable High-Quality Care

The Committee emphasized the need to ensure high-quality care within systems that continuously work to reduce disparities. Performance measures should be routinely stratified to identify disparities in care. In addition, performance measures should be used to create accountability for reducing, and ultimately eliminating, disparities through effective interventions. The Committee noted a goal of ensuring that everyone receives the highest quality care by routinely monitoring care and outcomes for groups at greatest risk for suboptimal care. One example of success in this regard is the use of measures stratified by race by the Oregon Medicaid program.

The Committee developed a diagram to show how these domains work together to promote health equity (Figure 4a). The 'means' to achieving health equity require improving collaboration and partnerships which complement fostering a culture of equity and building the structure for equity. Equitable high-quality care and equitable access to care are the primary 'outcomes.' Progress can be made independently within each domain, but achievement of goals in all domains is necessary to reach the ultimate goal of health equity.

Measures that address quality of care made up the overwhelming majority of measures found during the environmental scan; however few are currently used to directly assess disparities for accountability purposes. These measures are predominantly clinical process and outcome measures and relate most closely to the subdomain of *continuous improvements across clinical structure, process, and outcome measures.* Far fewer measures were found that specifically assess the concepts outlined in the *effective interventions to reduce healthcare disparities in quality* subdomain. The majority of measures assess the aspects of shared decision making or patient education. The Committee emphasized the importance of stratifying outcome and process measures currently in use to identify disparities.

Other potential measures could be developed to address self-care, effective patient-provider communication, person-centered care, family engagement, etc. One example of a measure that addresses this subdomain is NQF #0519 *Diabetic Foot Care and Patient Education Implemented*. This process measure uses clinical data to determine the "percentage of home health episodes of care in which diabetic foot care and patient/caregiver education were included in the physician-ordered plan of care and implemented for diabetic patients since the previous OASIS assessment." The Committee also recommended the development of measures that assess the percentage of patients using a patient portal, medication errors (adverse events or other safety concerns), and nonadherence.

Measures and measure concepts that address *Equitable High-Quality Care may* face fewer data collection challenges than the other domains discussed in this report. The clinical nature of quality-of-care measures calls for more traditional data sources including claims data, making data collection more feasible. The current lack of social risk factor data collected, including race, language, disability, etc., poses significant data challenges to the ability of these measures to account for disparities. Further research and measure development are needed for measures that assess whether stakeholders are employing interventions that are known to reduce disparities.

The environmental scan for measures found 755 total measures of high-quality care: 158 measures of high-quality care related to cancer, 214 related to cardiovascular disease, 154 related to diabetes/chronic kidney disease, 129 related to infant mortality and low birthweight, 90 related to mental illness, and 10 cutting across condition areas. The majority of these measures related to the first subdomain, *continuous improvements across clinical structure, process, and outcome performance measures stratified by social risk factors*. However, many of these measures are not currently stratified or used in a stratified manner for accountability purposes.

TABLE 14. EXAMPLES OF EQUITABLE HIGH-QUALITY CARE MEASURES

Subdomain	Measure Title	Measure Description	Measure Source
Evidence-based interventions to reduce disparities	Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care	Percentage of short-term 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	CMS Measure Inventory
Evidence-based interventions to reduce disparities	Depression Care: Percentage of Patients 18 Years of Age or Older with Major Depression or Dysthymia Who Demonstrated a Response to Treatment 12 Months (+/- 30 Days) After an Index Visit	This measure is used to assess the percentage of patients 18 years of age or older with major depression or dysthymia who demonstrated a response to treatment 12 months (+/- 30 days) after an index visit. This measure applies to both patients with newly diagnosed and existing depression.	AHRQ National Quality Measures Clearinghouse

TABLE 15. EXAMPLES OF EQUITABLE HIGH-QUALITY CARE MEASURE CONCEPTS TO FILL GAPS IN MEASUREMENT

Subdomain	Measure Description
Person- and family-centeredness	A measure that assesses the number of adults (>18 years of age) with a documented shared decision making discussion with care provider (useful if had claim encounter code that could be submitted). Questions from the CAHPS survey could potentially be used to fill this gap.
Social risk factors addressed in outcome performance measures	A measure that assesses the number of patients (>18 years of age) with documented social risk factor assessment in medical record Outcome measures (such as complications of surgery) with results stratified by patients with and without social risk factor
Effective healthcare interventions to reduce disparities	A measure that assesses the number of patients with community referral, case management referral, consultation for social work/social services in both the pediatric and adult population

TABLE 16. EQUITABLE HIGH-QUALITY CARE SUBDOMAIN MEASURE AVAILABILITY

Subdomains	Number of available measures
Person- and family-centeredness	44
Continuous improvements across clinical structure, process, and outcome performance measures that could be stratified by social risk factors	684
Use of effective interventions to reduce disparities in healthcare quality	27

This report highlights areas where development of new measures could improve health equity. These include those related to health care affordability; measures assessing value; and prioritization of core behavioral factors. Out-of-pocket costs are growing problem for many disparity groups due to the high costs of new treatments and increase number of high deductible plans. This report found few quality measures that address affordability. Yet, affordability is a major driver for health care disparities. New quality measures could be developed or adapted that assessed percent of a person's weekly income that a particular treatment cost or whether patients reported foregoing paying other bills in order to pay for needed care or simply avoiding the care (or obtaining a prescription) due to costs.

Value and equity represent over-arching goals of the health care system, but there is dearth of measures that capture the cost side of value or that prioritize use of high value interventions. There is a need for new measures that capture whether insurance or health plans are explicitly designed to promote value and in the process improve equity. For example, new measures could be developed that examined the extent to which insurance programs covered high value care, i.e. value-based insurance design. Such measures when stratified by disparity group the extent to which health plans have incorporated value and equity into the design of its coverage. Examples of value-based design include coverage for statins for persons at high risk. Another approach to value is assessing use of low-value care. There is some evidence for example that blacks are more likely to receive low value care. Last, measures could be developed that assess the extent to which health care systems provide patients with transparency in their health care prices. Such transparency in pricing particularly when coupled with meaningful data on experience in outcomes allows patients/families in conjunction with their clinicians to make informed choices. In addition such transparency could help discourage the practice whereby hospitals charge higher prices to patients without insurance while providing discounted prices to entities with market power.

Last, measures of population health highlighted by the IOM/NAM report, "Vital Signs" underscore measures that have the greatest impact on population health and often also have disparate impact on disparity groups. Examples of these measures include improvement in health behavior, e.g. smoking cessation, reduction in BMI, increases in physical activity, reduction in opioid misuse, prevention of teen and/or unwanted pregnancy, depression and psychological distress. Heightened focus on these core measures could not only advance population health and health equity, but also underscore the need for partnerships between health systems and communities to address underlying social determinants that affect these behavioral determinants.

Incentivize the Reduction of Health Disparities and Achievement of Health Equity

The final action of the roadmap emphasizes the need to incentivize and support the reduction of health disparities and the achievement of health equity. The Committee recognized that performance measurement is increasingly used for accountability purposes and this shift to payment and reporting offers opportunities to advance equity in multiple ways. First, reporting the results of performance measures can promote transparency and help identify and address disparities. Second, the shift to value-based purchasing represents a chance to reward providers for reducing disparities or for the use of effective interventions to reduce disparities. Further, the shift to global payment, capitated payment, and bundled payment could support the infrastructure for interventions that reduce disparities. Finally, social and population health measures can be used to ensure resources are allocated to counteract the drivers of disparities.

The increased use of performance measures offers a number of way to incentivize the reduction of disparities. Currently reported measures could be reported by strata to show disparities more transparently. Measures that are sensitive to disparities or could assess the use of interventions to reduce disparities could be prioritized for implementation in public reporting and value-based purchasing. Finally, measures used for accreditation could address health equity.

Payment models designed to promote health equity have the potential to have a large impact on reducing disparities. The Committee recommended multiple payment strategies including upfront payments to fund infrastructure necessary to achieve equity, pay-for-performance that rewards reducing disparities in quality and access to care, and mixed payment models that combine different models. The Committee noted that pay for improvement models have been shown to be particularly promising.

The Committee also recommended that public and private payers adjust payments to providers based on social risk factors and noted that some payers are considering increasing payments for hospital services based on social risk factors. In the same vein, health plans should provide additional payments for outpatient services. In many cases, outpatient care represents an opportunity to address social determinants of health upstream and helps a patient to avoid disruptive and costly inpatient care. This recommendation could shift payment from costly avoidable care to upfront payments that prevent development of downstream conditions e.g. support diabetes prevention programs or intensive case-management to prevent hospital re-admission.

The Committee also recognized the potential risks of using payment and measurement to reduce disparities. For example, current value-based purchasing programs could negatively impact safety-net providers and there is the potential to increase measurement burden. Acknowledging, that payment is only one way of incentivizing and supporting the achievement of health equity, the Committee developed a set of recommendations to further support the implementation of goals outlined in the roadmap.

RECOMMENDATIONS

RECOMMENDATION 1:
Collect social risk factor data.

Data are the bedrock of all measurement activities; however, data on social risk factors is currently limited. These limitations can impede effort to find and reduce disparities. As such, stakeholders must invest in the necessary infrastructure to support data collection. There needs to be standard collection of data related to social risks like housing instability, food insecurity, gender identity, sexual orientation, language, continuity of insurance coverage, etc. Examples include the IOM/NAM Report "Capturing Social and Behavioral Domains and Measures in Electronic Health Records and the CMS Accountable Health Communities Screening tool.[36] The Committee emphasized the need to collect these data through electronic health records, whenever possible. Many performance measures rely on administrative claims data and often do not capture data about individuals who are not continuously enrolled in a health plan. One potential strategy to address this is greater use of the ICD-10 codes for factors addressing health status and contact with health services (Z codes found in chapter 21[37]). These codes capture social risk factors such as education, socioeconomic status, employment, social environment, upbringing, and family circumstances. The Committee also noted that payers could help incentivize the collection of data by either requiring data collection or providing additional payments for the collection of social risk data.

In addition to patient-level data, addressing disparities will require collecting neighborhood-level data on social risk factors to better understand the characteristics of the places in which people live, work, and play. Healthcare organizations must work with public health departments and other institutions in the community to collect these data. In addition to collecting individual patient-level data, organizations that are accountable for populations should collect community-level data that inform health needs. For example, federally qualified health centers (FQHC) conduct regular community health needs assessments, and nonprofit hospitals are required to conduct community health assessments. These data should be publicly reported, shared, and used to inform publicly reported action plans to improve health equity.

RECOMMENDATION 2:
Use and prioritize stratified health equity outcome measures.

Stakeholders should first conduct a needs assessment to identify the extent to which they are meeting the goals outlined in the measurement roadmap. The domains should be considered as a whole rather than aiming to make progress in only one area. Stakeholders may find themselves at varying stages in achieving the goals outlined in the roadmap, but progress in all domains is necessary to achieve equity. The Committee acknowledged that the use of outcome measures often depends on the state of the evidence. In some cases, process and structure measures may be used in place of outcome measures where reliable and valid outcome measures do not yet exist. However, relevant stakeholders should identify and develop outcome measures that can assess the extent to which stakeholders are achieving health equity.

The Committee recommended reducing the number of measures that do not promote equity to address measurement burden. In addition, stakeholders must actively identify and decommission measures that have reached ceiling levels of performance and where there are insignificant gaps in performance. Lastly, health equity performance measures must also be aligned across programs to reduce data collection burden, maximize the influence of the measures, and allow for peer group comparisons. The Committee noted one potential example from the FY 2018 Inpatient Prospective Payment System (IPPS) Proposed Rule. In this rule, CMS sought comments on confidential reporting and future public reporting of two pneumonia measures (NQF #0506 pneumonia readmissions and NQF #0468 pneumonia mortality) currently used in the Hospital Inpatient Quality Reporting (IQR) program stratified by dual eligibility. The goal of this stratification would be to demonstrate differences in outcome rates among patient groups within a hospital and to allow for comparison of potential disparities across hospitals.

RECOMMENDATION 3:
Prioritize measures in the domains of Equitable Access and Equitable High-Quality Care for accountability purposes.

Some domains in the measurement roadmap are more suitable for accountability and others for quality improvement. The majority of measures that fall within the domains of *Culture for Equity*, *Structure for Equity*, and *Collaboration and Partnerships* should be used primarily for quality improvement initiatives and are less appropriate for accountability. However, the Committee strongly endorsed reporting progress towards meeting the goals outlined in each domain to ensure transparency. Each accountable entity will have various capacities to implement the goals outlined in the structure, culture, and collaboration and partnership domains and should be allowed the flexibility to customize its approach to meeting these goals based on their unique needs. Measures that are aligned with the domains of *Equitable Access to Care* and *Equitable High-Quality Care* may be more suitable for accountability. Public reporting, transparency, and accountability are important tools for advancing health equity. Thus, these health equity measures should be implemented in existing public reporting and accountability programs.

RECOMMENDATION 4:
Invest in preventive and primary care for patients with social risk factors.

People with low health literacy, limited eHealth literacy, limited access to social networks for reliable information, or who are challenged with navigating a fragmented healthcare system often rely on continuity with a trusted primary care physician. Equitable access starts with unconstrained access to primary care. Robust systems of primary care are associated with improved population health and reduced disparities.[38] Primary care plays a unique role in advancing equity through its comprehensive and biopsychosocial focus, longitudinal personal relationships, and its capacity to align intensity of management with patient needs. Primary care's capacity to care for people (rather than diseases) across medical, behavioral, and psychosocial dimensions while providing resources and services to align with these needs is vital to improving health equity. This requires minimizing key access barriers to primary care related to cost, location, and physical and linguistic accessibility. It also means ensuring that primary care practices have access to evidence-based programs for tobacco cessation, weight management, diabetes prevention, physical activity promotion and other interventions. Ultimately, provider incentives are needed to prioritize support for traditionally underfunded preventive activities. In addition, reliable and comprehensive measures are needed to assess both potential and realized access to primary care by social disadvantage including disabilities.

RECOMMENDATION 5:
Redesign payment models to support health equity.

Payment models designed to promote health equity have the potential to have a large impact on reducing disparities. The Committee recommended multiple payment strategies. For example, health plans can provide upfront payments to fund infrastructure for achieving equity and addressing the social determinants of health. Upfront payments can include advanced payments for providers with a demonstrated need (i.e., serve patients with social risk factors and need resources to build structures to support equity) and global payments (annual or month-to-month) specifically for pursuing the goals outlined in the domains of *Collaboration and Partnerships*, *Culture for Equity*, and *Structure for Equity*. Health plans can implement pay-for-performance payment models that reward providers for reducing disparities in quality and access to care. These types of rewards can be allocated based on improvement over time, an absolute threshold, progress in reducing disparities, or combinations of these approaches. For example, the Medicare Advanced Payment Initiative provided prospective payments to assist organizations with demonstrated need in establishing accountable care organizations (ACOs). A similar approach could be taken for establishing or incorporating health equity strategies into new or existing programs. The Committee noted that purchasers could use mixed model approaches, combining payment models based on their specific goals (e.g., upfront payments and pay-for-performance to reduce disparities). Payment models can also be phased, using pay-for-reporting, then pay-for-performance incentives.

RECOMMENDATION 6:
Link health equity measures to accreditation programs.

Integrating health equity measures into accreditation programs can increase accountability for promoting health equity and reducing disparities. These measures can be linked to quality improvement-related equity building activities. The Committee noted that organizations like the National Committee for Quality Assurance (NCQA) and URAC have already aligned with this strategy. For example, NCQA has incorporated health equity in its patient-centered medical home recognition program, and URAC promotes compliance with the Mental Health Parity and Addiction Equity Act, by reviewing the mental health or substance abuse disorder benefits provided by the health plans it accredits.

However, the Committee recognized a potential need to expand measurement and accreditation to promote health equity. For example, the Committee noted that healthcare within jails, prisons, and detention centers typically falls outside of mandatory accreditation and incentive programs designed to improve care quality and community coordination. Potential steps to address marginalization of correctional care from the rest of healthcare includes development of new quality measures that assess care within these facilities. Examples might include measures for timely exchange of information on entry and release, pre-release care coordination, and 30-day post-release events (e.g., overdose, ED visits, hospitalizations).

RECOMMENDATION 7:
Support outpatient and inpatient services with additional payment for patients with social risk factors.

The fundamental concept is that social risk factors are like clinical risk factors in the sense that they require more time and effort on the part of providers in specific encounters to achieve the same results. If an office visit is more complex (and billed and paid at a higher level) because of clinical complexity in a patient, the same concept could extend to the incorporation of social risk factors and "social complexity" as a payment concept. This recommendation could shift payment from costly avoidable care to upfront payments that prevent development of downstream conditions e.g. support diabetes prevention programs or intensive case-management to prevent hospital re-admission. As one recent example of this concept being implemented, CMS is going to enhance payments to Medicare Advantage plans for patients who are dual eligible, based on recent data analyses showing that the current model underpays plans for the costs of caring for those patients.

Potential strategies for adjusting payments based on social risk factors may include:

- If placement at the time of hospital discharge for a homeless patient or a patient with no social support at home takes two days longer, on average, than a placement for a patient with a good, supportive home situation, then a diagnosis-related group (DRG) payment could be adjusted upward on the basis of the homelessness or lack of support to account the inherent higher cost (i.e. longer length of stay and more social work and discharge planning time).
- Current procedural terminology codes (CPT) codes for evaluation and management (E&M) visits include five levels of complexity, with criteria for billing at each level linked primarily to the clinical complexity of the patient's presentation and the content of the visit. Social complexity factors could be added to the list of criteria for billing higher-level visits, so that if, for example, it takes 30 minutes longer to explain a new drug regimen to a low-literacy, or low-English-proficiency patient, then the visit can be billed at a higher level to reflect that "social complexity". Again, to keep aggregate program spending budget-neutral, a corresponding payment reduction would have to be found.
- If empirical data show that aggregate episode costs (for example, 90-day episode costs for patients undergoing hip replacement surgery) are higher for patients with defined social risk factors, then payments in bundled episode payment models could be adjusted to take those higher costs into account. For example, if a patient with no stable housing or no social support has to spend time in a residential post-acute care (PAC) facility, unlike a clinically similar patient with good housing and good social support who could be safely discharged home, the added costs of that PAC portion of the episode could be included in an adjusted episode bundle payment. Again, to keep program spending budget-neutral, a corresponding adjustment in the opposite direction would have to be made to reflect the lower episode costs of patients with no social risk factors.

RECOMMENDATION 8:
Ensure organizations disproportionately serving individuals with social risk can compete in value-based purchasing programs.

The Committee recognized that clinicians and providers disproportionately serving individuals with social risk factors can provide high-quality care. However, the growing evidence that social risk can affect a person's health outcomes has raised questions about how to ensure that organizations serving those with social risk are not unfairly penalized. Moreover, safety net organizations with a payer mix with lower reimbursement rates may not have the infrastructure for improving the quality of care. Protecting organizations disproportionately serving individuals with social risk factors could help to ensure that access to care is not reduced. At the same time, the Committee reiterated the need to ensure that at-risk populations have access to high-quality care. The Committee noted a need for ensuring that value-based purchasing promotes improvements, transparency, and fairness.

The Committee proposed ways to improve the fairness of value-based purchasing programs. First, the Committee noted that a need to risk adjust for social risk factors may exist when appropriate as well as stratify the performance score for social risk factors to ensure transparency and drive improvement. Secondly, the Committee suggested using peer-group comparisons to ensure safety net organizations are fairly compared. The Committee added a caveat that it may be necessary to risk adjust within the peer comparison groups to ensure fairness. Thirdly, the Committee noted the need to prospectively monitor the financial impact of value-based purchasing on organizations caring for individuals with social risk factors. Lastly, incentivizing providers for progress made in care processes and outcomes for disadvantaged groups is another way to allow safety net organizations to compete. When incentives are tied to the size of the disparity group, it has the effect of directly linking the size of the incentive to population level impact for that disparity group. The NAM report on *Accounting for Social Risk Factors in Medicare Payment* found using simulations that this approach had greatest potential for reducing disparities. When this "pay for improvement" approach is combined with standard "pay for performance" approach, i.e., meeting a defined benchmark for performance, there is potential for the unintended consequences of each approach to offset each other.

The Committee also recognized that some safety net providers such as rural hospitals and critical access hospitals are often not included in value-based purchasing programs that offer incentive payments. The Committee recommended that ACO programs, such as the Medicare Shared Savings Program (MSSP) ACO, commercial ACOs, and Medicaid ACOs, take social risk into account so that safety net providers are not excluded or unfairly penalized and have the opportunity to share in the potential improvements and savings. The Committee also noted that Federally Quality Health Centers (FQHCs) and Rural Health Clinics are not eligible to apply to participate in the Comprehensive Primary Care Plus (CPC+) program, and this denies these safety net providers the opportunity to receive the incentives within these innovation efforts as well.

The Committee also noted that payers should consider additional payment for organizational factors that fall outside of the control of safety net organizations and other providers serving individuals with social risk factors. The Committee recognized that addressing disparities can require significant resources and infrastructure. For example, addressing disparities can require providing interpreter services, addressing food shortages and deserts, addressing lack of access to specialty care and pharmacies, and helping patients overcome issues like childcare and transportation. These services can help patients achieve better outcomes and improve their access to care, but they are often not reimbursed under traditional payment models.

The Committee also recognized that these organizations may not have the resources to develop this infrastructure. The Committee suggested that additional payments could assist these facilities in developing the infrastructure to provide high-quality care for people with social risk factors. One potential short-term strategy is to allow nonprofit hospitals to formally report expenditures to address these services as a community benefit on their Schedule H, form 990. Other strategies are for communities to collectively pay for language services to minimize the unintended consequence of providers finding ways to avoid serving non-English speaking patients due to uncovered costs.

RECOMMENDATION 9:
Fund care delivery and payment reform demonstration projects to reduce disparities.

The evidence base for many care delivery and payment reform interventions to reduce healthcare disparities is still limited.[39] However, payers and purchasers often want concrete evidence of the effectiveness of an intervention before they will support it financially. The Committee stressed the need to better understand what work is being done to reduce disparities, what interventions are effective, and how these interventions could be replicated and implemented more broadly. For example, policy simulations and health impact assessments could provide guidance on how best to support and implement community interventions that could mediate drivers of disparities. The Committee also emphasized the need to collaborate with researchers to ensure that demonstrations are rigorous and scientifically sound. In addition, there is a need for research specifically focused on dissemination and implementation (D&I) of strategies designed to facilitate uptake of equity-advancing interventions across a range of organizations. Such research offers promise for accelerating the update of best practices. The Committee noted that D&I science could help to translate health equity research from theory into practice. One example is a study that examined update of cultural competency policies in hospitals.[40]

RECOMMENDATION 10:
Assess economic impact of disparities from multiple perspectives.

Reducing healthcare disparities often requires a significant investment. The Committee recognized the need for research to quantify the economic impact of disparities on patients, the healthcare system, and society to support these investments. In the current environment where resources can be limited, demonstrating the current costs of inequity and the potential savings that could be generated could help to motivate and incentivize the reduction of disparities. Multiple economic perspectives are critical to understanding the need to include analysis of the potential long-term benefits to society and the business case perspectives of healthcare organizations, payers, and purchasers.

Currently, there is limited understanding of the economic impact of disparities. One study estimated that racial healthcare disparities cost over $200 billion in direct medical expenditures and over $1 trillion in indirect costs associated with illness and premature death in a three-year period.[41] These costs are borne by patients, employers and purchasers, healthcare providers, and local, state, and federal governments, but it is not easy to appreciate the impact of these costs. Quantifying the costs in terms such as lost productivity, quality adjusted life years, readmission rates, emergency department use, etc. could help organizations understand the imperative to invest in equity.

The Committee noted that understanding the economic impact of disparities is crucial as the system moves to payments based on quality and value. The Committee recognized that reducing disparities will take significant investments by the healthcare system as well as investments in public health to address the many drivers of disparities (e.g. adverse childhood experiences, access to care, and structural racism). However, the Committee reiterated that equity is an essential part of quality and must be part of the value equation for healthcare.

PATH FORWARD

Performance measurement and associated policies offer opportunities to assess, support, and incentivize the reduction of disparities and the achievement of health equity. The Committee's roadmap is intended to lay the foundation for a more comprehensive and systematic approach to measuring and advancing health equity. When developing the roadmap, the Committee sought to build on the work of ASPE[42] and NAM[43] while providing concrete guidance on operationalizing health equity measurement. The roadmap lays out four actions, "Four I's for Health Equity," that healthcare stakeholders can employ to reduce disparities:

- Identify and Prioritize Reducing Health Disparities
- Implement Evidence-Based Interventions to Reduce Disparities
- Invest in the Development and Use of Health Equity Performance Measures
- Incentivize the Reduction of Health Disparities and Achievement of Health Equity

To support measurement efforts, the Committee identified five domains of equity measurement: *Partnerships and Collaboration, Culture of Equity, Structures for Equity, Equitable Access to Care, and Equitable High-Quality Care*. Achieving an equitable healthcare system will require progress across all of the domains of measurement identified by the Committee.

Measurement can be a powerful force for change in healthcare. However, stakeholders (such as policymakers, legislators, hospital administrators, hospital delivery systems, community advocates, patient advocate groups, and providers) across the system must be motivated to act on the results of health equity performance measures and drive towards improved performance while ensuring that providers and clinicians have the resources necessary to care for those who are most vulnerable. Reducing disparities requires addressing them at every level of the healthcare system and engaging stakeholders in other sectors.

Stakeholders across the system must prioritize and invest in health equity. Identifying and developing measures that can reveal disparities as well as provide information on the use of interventions to reduce them is a crucial first step in achieving equity. Measurement must also be leveraged to incentivize and support equity. The current shift to value-based purchasing and alternative payment models can incentivize the reduction of disparities and support providers and clinicians working with vulnerable populations. However, such payment strategies must be implemented in ways that support organizations that disproportionately serve populations with social risk and protect access for individuals with social risk factors. Finally, more work is needed to identify and promote the use of effective interventions to reduce disparities.

The roadmap builds on NQF's 10 years of leadership in promoting health equity. The "Four I's for Health Equity" presented in the roadmap lay out four concrete strategies for healthcare stakeholders to reduce disparities and advance health equity. Reducing disparities and achieving meaningful progress towards health equity will require efforts from all stakeholders. NQF is committed to collaborating with stakeholders within healthcare and beyond to achieve health equity.

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APPENDIX A:
Literature Review and Environmental Scan Methodology

NQF conducted a literature review to provide the Disparities Standing Committee with evidence related to health and healthcare disparities and to provide examples of the types of interventions that have proven effective in reducing disparities in health and healthcare outcomes. To support this goal, NQF conducted a search for information sources relevant to the disparities in the five target conditions associated with the social risk factors identified in the NAM report, *Accounting for Social Risk Factors in Medicare Payment*. The Committee provided key information sources and provided preliminary guidance on where to collect sources. Databases for the literature review included Academic Search Premier, PubMed/Medline, Google Scholar, PsychINFO, PAIS International, Ageline, Cochrane Collaboration, and Campbell Collaboration.

NQF conducted a targeted search within these databases using various combinations of keywords that were derived terms related to the target conditions and social risk factors as well as general terms to capture broader work that may include relevant information. NQF also searched by population types including ethnic and racial minorities according to the Office of Management and Budget definitions. The search was confined to U.S.-based work published between 2010 and 2016. The literature review was not meant to be exhaustive, nor does it include all populations affected by health and healthcare disparities. Rather, it highlights examples of disparities and effective interventions within the selected conditions and illustrates the associations found between social risk factors and health and healthcare outcomes. The information from the literature review informed the development of the roadmap to reduce disparities in health and healthcare . The literature review resulted in over 900 sources. After a review of abstracts, about 370 sources were identified as highly relevant. The literature review documented interventions that have shown effectiveness in reducing disparities within the selected conditions as well as interventions that provide lessons on how to counteract multiple social risk factors across a variety of populations.

NQF also conducted an environmental scan for measures. The purpose of the environmental scan was to identify performance measures and measure concepts that can be used to assess the extent to which stakeholders are employing effective interventions to reduce disparities. These include performance measures that are “disparities-sensitive” (i.e., measures that detect differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among population or social groups) and performance measures that aligned with the priority domains of measurement outlined in the Committee’s roadmap.

The environmental scan consisted of a search for performance measures in several measure repositories, including but not limited to NQF’s portfolio of performance measures (endorsed and not endorsed), the AHRQ National Quality Measures Clearinghouse, the National Guidelines Clearinghouse, the CMS measure inventory, and the Health Indicators Warehouse. NQF conducted a targeted search within these databases using various combinations of keywords that were derived terms related to the selected conditions, interventions known to reduce disparities, and social risk factors, as well as terms associated with the Committee’s priority domains of measurement.

NQF prioritized performance measures based on a set of predetermined criteria. In 2012, NQF’s Disparities Standing Committee created a **protocol for identifying disparities-sensitive measures** based on a commissioned paper by the Disparities Solution Center at Massachusetts General Hospital. The process involves examining how prevalent a condition is among a population with social risk factors, the size of the gap in quality of care, the impact that the measurement area has on the population, and the extent to which the care is sensitive to inadequate communication and sensitive to patient and provider preferences. Lastly, performance measures are classified as disparities-sensitive if the underlying outcome is highly dependent on social determinants of health.

NQF solicited feedback from 19 key informants with in-depth knowledge of each selected condition, disparities, and measurement. These experts were selected from NQF's Cardiovascular, Cancer, Renal, Perinatal, Endocrine, and Behavioral Health Standing Committees. They reviewed the measures identified from the environmental scan for completeness and assessed the extent to which they can be used to reduce disparities based on the criteria for identifying disparities-sensitive measures. The experts also provided feedback on gaps in measurement, as well as data needed to develop new performance measures for disparities measurement.

NQF categorized the performance measures found in the environmental scan based on the domains to which they most closely align. The majority of measures found aligned with the *Equitable Access to Healthcare Quality* domain. Many of the subdomains represent concepts that are not yet well measured by the healthcare system. The full compendium of measures is posted to the NQF disparities project webpage.

Following the collection and categorization of measures, NQF solicited input from the Committee to highlight specific "core measures" that can be used to address disparities now. Committee members called out specific measures and developed exclusionary criteria to identify additional measures from the existing compendium. The following criteria were applied to all outcome measures in the *Equitable High-Quality Care* domain in order to identify additional core measures:

1. Measures for which the denominator includes a large number of patients affected by a social risk factor or set of risk factors
2. Measures for which the denominator is specified for non-inpatient settings (i.e., focus on ambulatory care settings)
3. Outcome measures where there is a clear link between the outcome being measured and a set of actions

NQF posted the draft comprehensive report for a 30-day public commenting period from July 21 to August 21, 2017. Comments were compiled, sorted into themes, and shared with the Committee. The Committee convened on August 30, 2017 to discuss the comments received and finalize report language.

APPENDIX B:
Definitions and Terms

Domain of measurement: A domain of measurement is a categorization/grouping of high-level ideas and measure concepts that further describes the measurement roadmap, and a subdomain is a smaller categorization/grouping within a domain.

Subdomain: A smaller categorization/grouping within a domain.

Measurement roadmap: a conceptual model to provide structure for organizing currently available measures, identifying areas where gaps in measurement exist, and prioritizing areas for future measure development. The roadmap enables stakeholders to organize ideas about what is important to measure for a topic area and how measurement should take place (e.g., whose performance should be measured, care settings where measurement is needed, when measurement should occur, which individuals should be included in measurement, etc.).

Performance measure: A fully developed metric that includes detailed specifications and may have undergone scientific testing.

Measure concept: An idea for a measure that includes a description of the measure, including planned target and population.

Health disparity: The HHS Office of Minority Health describes a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" (based on individuals' gender, age, race, and/or ethnic group, etc.). Healthcare disparities are related to "differences in the quality of care that are not due to access-related factors or clinical needs, preferences, and appropriateness of interventions" (i.e., differences based on discrimination and stereotyping).

Health equity measure: A performance measure that can be linked to an intervention that reduces disparities in health or healthcare.

APPENDIX C:
Disparities Standing Committee Meetings

The Disparities Standing Committee convened four times over the life of the project. NQF hosted an orientation web meeting on October 19, 2016, to discuss the project's objectives and approach. The Committee convened a second time on January 19, 2017, to discuss the findings of the first interim report, **Disparities in Health and Healthcare Outcomes in Selected Conditions**, and how these findings would inform the Committee's roadmap. The Committee also discussed the outline and approach to the second interim report, **Effective Interventions in Reducing Disparities in Healthcare and Health Outcomes in Selected Conditions**.

The Committee met for a two-day, in-person meeting on March 27-28 to identify and prioritize areas of measurement, refine the roadmap for measure development, and provide input on an environmental scan of performance measures that can be used to assess the extent to which stakeholders are employing effective interventions to reduce disparities. During the meeting and in post-meeting follow-up, the Committee finalized the five domains of measurement for use with the Committee's roadmap. The Committee also discussed the findings of the environmental scan for measures documented in the third interim report, **An Environmental Scan of Health Equity Measures and a Conceptual Framework for Measure Development**.

On June 14-15, the Committee convened again to finalize the roadmap as well as make final recommendations for implementation. Prior to the meeting, members of the Committee submitted ideas for potential measures that could be used to address health equity and minimize disparities. The full list of submitted measure concept ideas is posted to the **NQF disparities project webpage**. During the meeting, the Committee discussed the proposed measure concepts and additional gaps in measurement. The final recommendations made by the Committee during the second in-person meeting are detailed in this report.

The Committee convened on August 30, 2017, to discuss and respond to the comments received during the commenting period (July 21-August 21).

APPENDIX D:

Examples of Disparities-Sensitive Measures

The Committee recognized that disparities exist across many conditions. The disparities-sensitive criteria help identify measures that can help detect disparities in care. However, the Committee noted that stakeholders may need a set of examples to assist in the prioritization of disparities measures. The table below contains examples of disparities-sensitive measures. The selection of these core measures focused on high-impact or highly prevalent conditions as well as measures that cut across conditions and populations.

Committee members proposed specific measures as well as the following criteria to apply to all outcome measures in the *Equitable High-Quality Care* domain in order to identify additional core measures:

1. Measures for which the denominator includes a large number of patients affected by a social risk factor or set of risk factors
2. Measures for which the denominator is specified for non-inpatient settings (i.e., focus on ambulatory care settings)
3. Outcome measures where there is a clear link between the outcome being measured and a set of actions

Condition Area	Measure Title	NQF Number
Cross-cutting	Gains in Patient Activation (PAM) Scores at 12 Months	2483
Cross-cutting	LBP: Evaluation of Patient Experience	0308
Cancer	Breast Cancer Screening	0031
Cancer	Breast Cancer Screening	2372
Cancer	Breast Cancer Screening	2372
Cancer	Cervical Cancer Screening	0032
Cancer	Colorectal Cancer Screening	0034
Cardiovascular Disease	30-Day All-Cause Risk-Standardized Mortality Rate Following Percutaneous Coronary Intervention (PCI) for Patients with ST Segment Elevation Myocardial Infarction (STEMI) or Cardiogenic Shock	0536
Cardiovascular Disease	30-Day All-Cause Risk-Standardized Mortality Rate Following Percutaneous Coronary Intervention (PCI) for Patients Without ST Segment Elevation Myocardial Infarction (STEMI) and Without Cardiogenic Shock	0535
Cardiovascular Disease	30-Day Post-Hospital AMI Discharge Care Transition Composite Measure	0698
Cardiovascular Disease	30-Day Post-Hospital HF Discharge Care Transition Composite Measure	0699
Cardiovascular Disease	Acute Myocardial Infarction (AMI) Mortality Rate	0730
Cardiovascular Disease	Adherence to Statin Therapy for Individuals with Cardiovascular Disease	0543
Cardiovascular Disease	Adherence to Statins	0569
Cardiovascular Disease	Adult Smoking Cessation Advice/Counseling	9999
Cardiovascular Disease	Congestive Heart Failure Rate (PQI 08)	0277
Cardiovascular Disease	Controlling High Blood Pressure	0018

Condition Area	Measure Title	NQF Number
Cardiovascular Disease	Controlling High Blood Pressure for People with Serious Mental Illness	2602
Cardiovascular Disease	Gains in Patient Activation (PAM) Scores at 12 Months	2483
Cardiovascular Disease	Heart Failure Mortality Rate (IQI 16)	358
Cardiovascular Disease	Heart Failure Symptoms Assessed and Addressed	0521
Cardiovascular Disease	Heart Failure: Symptom and Activity Assessment	0077
Cardiovascular Disease	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	1789
Cardiovascular Disease	Hypertension Plan of Care	0017
Cardiovascular Disease	Median Time to ECG	0289
Cardiovascular Disease	Median Time to Transfer to Another Facility for Acute Coronary Intervention	0290
Cardiovascular Disease	Optimal Vascular Care	0076
Cardiovascular Disease	Pediatric All-Condition Readmission Measure	2393
Cardiovascular Disease	Shared Decision Making Process	2962
Diabetes/Chronic Kidney Disease	Adherence to ACEIs/ARBs for Individuals with Diabetes Mellitus	2467
Diabetes/Chronic Kidney Disease	Adherence to Oral Diabetes Agents for Individuals with Diabetes Mellitus	2468
Diabetes/Chronic Kidney Disease	CAHPS in-Center Hemodialysis Survey	0258
Diabetes/Chronic Kidney Disease	Comprehensive Diabetes Care	0731
Diabetes/Chronic Kidney Disease	Controlling High Blood Pressure	0018
Diabetes/Chronic Kidney Disease	Diabetes Composite	0729
Diabetes/Chronic Kidney Disease	Diabetes Long-Term Complications Admission Rate (PQI 03)	0274
Diabetes/Chronic Kidney Disease	Diabetes: Hemoglobin A1c Poor Control	0059
Diabetes/Chronic Kidney Disease	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	1789
Diabetes/Chronic Kidney Disease	LBP: Patient Education	0307
Diabetes/Chronic Kidney Disease	Monitoring Hemoglobin Levels Below Target Minimum	0370
Diabetes/Chronic Kidney Disease	Patient Education Awareness—Facility Level	0324
Diabetes/Chronic Kidney Disease	Patient Education Awareness—Physician Level	0320
Diabetes/Chronic Kidney Disease	Uncontrolled Diabetes Admission Rate (PQI 14)	0638
Infant Mortality	Adverse Outcome Index	1769
Infant Mortality	Birth Trauma	0742

Condition Area	Measure Title	NQF Number
Infant Mortality	Birth Trauma – Injury to Neonate (PSI 17)	0474
Infant Mortality	Gastroenteritis Admission Rate (PDI 16)	0727
Infant Mortality	Neonatal Intensive Care All-Condition Readmissions	2893
Infant Mortality	Pediatric All-Condition Readmission Measure	2393
Infant Mortality	PICU Standardized Mortality Ratio	0343
Infant Mortality	PICU Unplanned Readmission Rate	0335
Infant Mortality	Unexpected Complications in Term Newborns	0716
Infant Mortality	Unplanned Maternal Admission to the ICU	0745
Mental Illness	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1879
Mental Illness	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	1880
Mental Illness	Alcohol Screening and Follow-Up for People with Serious Mental Illness	2599
Mental Illness	Alcohol Use Screening	1661
Mental Illness	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	1365
Mental Illness	Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation	1364
Mental Illness	Clinical Depression Screening and Follow-Up Reporting Measure	9999
Mental Illness	Depression Remission at Six Months	0711
Mental Illness	Depression Remission at Twelve Months	0710
Mental Illness	Depression Response at Six Months- Progress Towards Remission	1884
Mental Illness	Depression Response at Twelve Months- Progress Towards Remission	1885
Mental Illness	Gains in Patient Activation (PAM) Scores at 12 Months	2483
Mental Illness	Preventative Care and Screening: Screening for Depression and Follow Up Plan	3132
Mental Illness	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	0418

APPENDIX E:

Compendium of Measures by Domain

The table below contains the results of a search for measures that can be used to assess the extent to which stakeholders are employing effective interventions to reduce disparities as well as measures that can be used to monitor care associated with conditions that are known to have health and healthcare disparities. NQF conducted the environmental scan by searching for measures in the following databases:

- National Quality Forum – Quality Positioning System (NQF QPS)
- Centers for Medicare & Medicaid Services (CMS) Measures Inventory
- Agency for Healthcare Research and Quality (AHRQ)
  - National Quality Measures Clearinghouse
  - National Guidelines Clearinghouse
- Health Indicators Warehouse (HIW)

The compendium is organized by the priority domains of measurement identified by the NQF Disparities Standing Committee. A spreadsheet containing the information in this appendix can be sorted by selected conditions (i.e., cardiovascular disease [CVD], cancer, infant mortality, low birth weight, mental illness, diabetes, and chronic kidney disease [CKD]). The complete compendium, which includes the measures' specifications and subdomain, can be found on the **NQF disparities project webpage**.

DOMAIN:
Partnerships and Collaboration

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Functional Change: Change in Mobility Score for Skilled Nursing Facilities	Outcome	2774	NQF QPS
Diabetes/CKD	Assessment of Iron Stores	Process	0252	NQF QPS
Mental Illness	Assessment of Integrated Care: Overall Score on the Site Self Assessment (SSA) Evaluation Tool	Process		AHRQ
Mental Illness	Assessment of Integrated Care: Total Score for the "Integrated Services and Patient and Family-Centeredness" Characteristics on the Site Self Assessment (SSA) Evaluation Tool.	Process		AHRQ
Mental Illness	Closing the Referral Loop: Receipt of Specialist Report	Process		CMS
Mental Illness	Health Education, Suicide Prevention: Schools	Not available		HIW

DOMAIN:
Culture of Equity

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	New Cancer Patient– Intervention Urgency	Outcome	1752	NQF QPS
Cross-cutting	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	Outcome	1904	NQF QPS
Cross-cutting	Cross-Cultural Communication Measure Derived from the Cross-Cultural Communication Domain of the C-CAT	Outcome	1894	NQF QPS
Cross-cutting	Health Literacy Measure Derived from the Health Literacy Domain of the C-CAT	Outcome	1898	NQF QPS
Cross-cutting	Individual Engagement Measure Derived from the Individual Engagement Domain of the C-CAT	Outcome	1892	NQF QPS
Cross-cutting	Language Services Measure Derived from Language Services Domain of the C-CAT	Outcome	1896	NQF QPS
Cross-cutting	Leadership Commitment Measure Derived from the Leadership Commitment Domain of the C-CAT	Outcome	1905	NQF QPS
Cross-cutting	Performance Evaluation Measure Derived from Performance Evaluation Domain of the C-CAT	Outcome	1901	NQF QPS
Cross-cutting	Workforce Development Measure Derived from Workforce Development Domain of the C-CAT	Outcome	1888	NQF QPS
CVD	Adult Depression in Primary Care: Percentage of Patients with Cardiovascular Disease with Documentation of Screening for Major Depression or Persistent Depressive Disorder Using Either PHQ-2 or PHQ-9.	Process		AHRQ
CVD	Hypertension Plan of Care	Outcome	0017	NQF QPS
Diabetes/CKD	Anemia of Chronic Kidney Disease: Patient Informed Consent for ESA Treatment	Process		CMS
Diabetes/CKD	Assessment of Health-Related Quality of Life in Dialysis Patients	Process	0260	NQF QPS
Diabetes/CKD	Bipolar Disorder: Assessment for Diabetes	Process	0003	NQF QPS
Diabetes/CKD	CAHPS in-Center Hemodialysis Survey	Outcome: PRO	0258	NQF QPS
Diabetes/CKD	Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)	Outcome	2606	NQF QPS
Diabetes/CKD	Diabetes Care for People with Serious Mental Illness: Eye Exam	Process	2609	NQF QPS
Diabetes/CKD	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)	Outcome	2608	NQF QPS
Diabetes/CKD	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Outcome	2607	NQF QPS
Diabetes/CKD	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing	Process	2603	NQF QPS
Diabetes/CKD	Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy	Process	2604	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Diabetes/CKD	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	Process	1934	NQF QPS
Diabetes/CKD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Process	1932	NQF QPS
Infant Mortality	Hospital Inpatients' Experiences: Percentage of Parents Who Reported How Often Providers Prevented Mistakes and Helped Them to Report Concerns.	Consumer Experience		AHRQ
Infant Mortality	Maternal Depression Screening	Process	1401	NQF QPS
Infant Mortality	Preterm Births, <32 Weeks of Gestation (Percent)	Outcome		HIW
Infant Mortality	Preterm Births, 32-33 Weeks of Gestation (Percent)	Outcome		HIW
Infant Mortality	Preterm Births, 32-36 Weeks of Gestation (Percent)	Outcome		HIW
Infant Mortality	Preterm Births, 34-36 Weeks of Gestation (Percent)	Outcome		HIW
Infant Mortality	Preterm Births, Total (Percent)	Outcome		HIW
Mental Illness	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF	Outcome		CMS
Mental Illness	Advanced Care Planning for Patients with Parkinson's Disease	Process		CMS
Mental Illness	Competency Assessment Instrument (CAI): Provider's Mean Score on the "Client Preferences" Scale.	Structure		AHRQ
Mental Illness	Competency Assessment Instrument (CAI): Provider's Mean Score on the "Community Resources" Scale.	Structure		AHRQ
Mental Illness	Competency Assessment Instrument (CAI): Provider's Mean Score on the "Evidence-Based Practice" Scale.	Structure		AHRQ
Mental Illness	Competency Assessment Instrument (CAI): Provider's Mean Score on the "Family Education" Scale.	Structure		AHRQ
Mental Illness	Competency Assessment Instrument (CAI): Provider's Mean Score on the "Family Involvement" Scale.	Structure		AHRQ
Mental Illness	Competency Assessment Instrument (CAI): Provider's Mean Score on the "Stigma" Scale.	Structure		AHRQ
Mental Illness	Competency Assessment Instrument (CAI): Provider's Mean Score on the "Team Value" Scale.	Structure		AHRQ
Mental Illness	HCBS CAHPS Measure (1 of 19): Staff Are Reliable and Helpful	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (10 of 19): Global Rating of Case Manager	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (11 of 19): Would Recommend Personal Assistance/Behavioral Health Staff to Family and Friends	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (12 of 19): Would Recommend Homemaker to Family and Friends	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (13 of 19): Would Recommend Case Manager to Family and Friends	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (14 of 19): Unmet Need in Dressing/Bathing Due to Lack of Help	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (15 of 19): Unmet Need in Meal Preparation/Eating Due to Lack of Help	Outcome	2267	CMS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Mental Illness	HCBS CAHPS Measure (16 of 19): Unmet Need in Medication Administration Due to Lack of Help	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (17 of 19): Unmet Need in Toileting Due to Lack of Help	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (18 of 19): Unmet Need with Household Tasks Due to Lack of Help	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (19 of 19): Hit or Hurt by Staff	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (2 of 19): Staff Listen and Communicate Well.	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (3 of 19): Case Manager is Helpful	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (4 of 19): Choosing the Services That Matter to You.	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (6 of 19): Personal Safety and Respect	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (7 of 19): Planning Your Time and Activities	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (8 of 19): Global Rating of Personal Assistance and Behavioral Health Staff	Outcome	2267	CMS
Mental Illness	Hospital-Based Inpatient Psychiatric Services: The Total Number of Hours That All Patients Admitted to a Hospital-Based Inpatient Psychiatric Setting Were Maintained in Physical Restraint.	Process	0640	AHRQ

DOMAIN:
Structure for Equity

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Cervical Cancer Screening: Percentage of Pap Tests for Which the Time Between the Date the Pap Test is Performed and the Date That Pap Test is Processed by the Laboratory is Less Than or Equal to 14 Days.	Process		AHRQ
Cancer	Melanoma: Continuity of Care – Recall System	Structure	0650	NQF QPS
Cancer	Radical Prostatectomy Pathology Reporting	Process	1853	NQF QPS
Cancer	Radiology: Reminder System for Screening Mammograms	Structure	0509	CMS
Cancer	Statewide Cancer Registries	Process		HIW
Cross-cutting	L1A: Screening for Preferred Spoken Language for Health Care	Process	1824	NQF QPS
CVD	Adult Current Smoking Prevalence	Structure	2020	QPS
CVD	Annual Monitoring for Patients on Persistent Medications (MPM)	Process	2371	QPS
CVD	Atherosclerotic Disease - Lipid Panel Monitoring	Process	0616	QPS
CVD	Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	Process	1927	QPS
CVD	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	Process	1933	QPS
CVD	Carotid Artery Stenting: Evaluation of Vital Status and NIH Stroke Scale at Follow Up	Process	2396	QPS
CVD	Coronary Heart Disease Deaths	Outcome		HIW
CVD	Dyslipidemia New Med 12-Week Lipid Test	Process	0583	QPS
CVD	Functional Change: Change in Self Care Score for Skilled Nursing Facilities	Outcome	2769	QPS
CVD	In-Person Evaluation Following Implantation of a Cardiovascular Implantable Electronic Device (CIED)	Process	2461	CMS
CVD	In-Person Evaluation Following Implantation of a Cardiovascular Implantable Electronic Device (CIED)	Process	2461	QPS
CVD	New Atrial Fibrillation: Thyroid Function Test	Process	0600	QPS
CVD	Participation in a Systematic National Database for General Thoracic Surgery	Structure	0456	QPS
CVD	Patient(s) with Hypertension That Had a Serum Creatinine in Last 12 Reported Months.	Process	0605	QPS
CVD	Prevention and Management of Obesity for Adults: Percentage of Patients with BMI Greater Than or Equal to 25 Who Have 30 Minutes of Any Type of Physical Activity Five Times Per Week Documented.	Process		AHRQ - 008874
CVD	Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	Process	0541	QPS
Diabetes/CKD	Anemia Management Reporting Measure	Process		CMS
Diabetes/CKD	Chronic Kidney Disease (CKD): Monitoring Calcium	Process	0574	QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Diabetes/CKD	Chronic Kidney Disease (CKD): Monitoring Parathyroid Hormone (PTH)	Process	0571	QPS
Diabetes/CKD	Chronic Kidney Disease (CKD): Monitoring Phosphorus	Process	0570	QPS
Diabetes/CKD	Comorbidity Reporting Measure			CMS
Diabetes/CKD	Diabetes and Elevated HbA1C – Use of Diabetes Medications	Process	0630	QPS
Diabetes/CKD	Diabetes: The Relative Resource Use by Members with Diabetes During the Measurement Year.	Cost/ Resource Use		AHRQ
Diabetes/CKD	Frequency of Adequacy Measurement for Pediatric Hemodialysis Patients	Process	1418	QPS
Diabetes/CKD	Gains in Patient Activation (PAM) Scores at 12 Months	Outcome: PRO	2483	QPS
Diabetes/CKD	Lower-Extremity Amputation Among Patients with Diabetes Rate (PQI 16)	Outcome	0285	QPS
Diabetes/CKD	Per Capita Cost for Beneficiaries with Diabetes	Cost/ Resource Use		CMS
Diabetes/CKD	Relative Resource Use for People with Diabetes (Inpatient Facility Index)	Process	1557	CMS
Diabetes/CKD	Standardized Hospitalization Ratio for Dialysis Facilities	Outcome	1463	QPS
Infant Mortality	Adult Current Smoking Prevalence	Structure	2015	NQF QPS
Infant Mortality	Alcohol Abstinence, Prenatal	Outcome		HIW
Infant Mortality	Anencephaly	Outcome		HIW
Infant Mortality	Breastfeeding at 1 Year	Outcome		HIW
Infant Mortality	Breastfeeding at 6 Months	Outcome		HIW
Infant Mortality	Breastfeeding, Ever	Outcome		HIW
Infant Mortality	Breastfeeding, Exclusively Through 3 Months	Outcome		HIW
Infant Mortality	Breastfeeding, Exclusively Through 6 Months	Outcome		HIW
Infant Mortality	Cigarette Abstinence, Prenatal	Outcome		HIW
Infant Mortality	Deaths: Infants with Down Syndrome	Outcome		HIW
Infant Mortality	Five Minute APGAR Less Than 7	Outcome	0741	NQF QPS
Infant Mortality	Formula Supplementation: Breastfed Newborns	Outcome		HIW
Infant Mortality	Illicit Drug Abstinence, Prenatal	Outcome		HIW
Infant Mortality	Infant Deaths Between 28 Days-1 Year	Outcome		HIW
Infant Mortality	Infant Deaths Within First 28 Days of Life	Outcome		HIW
Infant Mortality	Infant Deaths, All	Outcome		HIW
Infant Mortality	Infant Deaths: Congenital Heart Defects	Outcome		HIW
Infant Mortality	Infant Deaths: Sudden Unexpected/Unexplained Causes	Outcome		HIW
Infant Mortality	Low Birth Weight Rate (PQI 9)	Outcome	0278	NQF QPS
Infant Mortality	PC-05 Exclusive Breast Milk Feeding	Process	0480	NQF QPS
Infant Mortality	Percent of Live Births That Are Low Birth Weight (LBW)	Outcome		HIW

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Infant Mortality	Percentage of Low Birthweight Births	Outcome	1382	NQF QPS
Infant Mortality	Perinatal Deaths	Outcome		HIW
Infant Mortality	Pregnancies Conceived Within 18 Months of Previous Birth	Outcome		HIW
Infant Mortality	Smoking Abstinence, Preconception	Outcome		HIW
Infant Mortality	Smoking Cessation During Pregnancy	Outcome		HIW
Infant Mortality	Very Low Birth Weight Deliveries (Percent)	Outcome		HIW
Infant Mortality	Worksite Lactation Support Programs	Structure		HIW
Mental Illness	Depression Assessment Conducted	Process	0518	QPS

DOMAIN:
Equitable Access to Care

Condition Area	Measure Title	Measure Type	NQF #	Source
Cancer	Cervical Cancer Screening: Percentage of Women Age 21 Years and Older Screened in Accordance with Evidence-Based Standards.	Process		AHRQ
Cancer	New Cancer Patient– Intervention Urgency	Outcome	1752	NQF QPS
Cancer	Preventive Services: Percentage of Adult Enrolled Members Age 19 Years and Older Who Are Up-to-Date for All Appropriate Preventive Services (Combination 6).	Process		AHRQ
CVD	Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)	Process	0070	NQF QPS
CVD	Duration of Antibiotic Prophylaxis for Cardiac Surgery Patients	Process	0128	NQF QPS
CVD	ED- Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival	Process	0661	CMS
CVD	Heart Failure in Adults: Percentage of Heart Failure Patients Who Are Current Smokers or Tobacco Users Who Received Smoking Cessation Advice or Counseling in Primary Care.	Process		AHRQ
CVD	Heart Failure: Post-Discharge Appointment for Heart Failure Patients	Process	2455	NQF QPS
CVD	Relative Resource Use for People with Cardiovascular Conditions (RCA)	Cost/ Resource Use	1558	NQF QPS
Diabetes/CKD	Adult Kidney Disease: Referral to Nephrologist	Process		CMS
Diabetes/CKD	Kidney Transplant Referral Rate for Prevalent Dialysis Patients	Process		CMS
Diabetes/CKD	Kidney Transplant Waitlist Decision Rate for Prevalent Dialysis Patients	Process		CMS
Diabetes/CKD	Per Capita Cost for Beneficiaries with Diabetes	Cost/ Resource Use		CMS
Diabetes/CKD	Percentage of Prevalent Patients Waitlisted (PPPW)	Process		CMS
Diabetes/CKD	Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	Process	0541	NQF QPS
Diabetes/CKD	Standardized First Kidney Transplant Waitlist Ratio for Incident Dialysis Patients (SWR)	Process		CMS
Diabetes/CKD	Standardized Kidney Transplant Referral Ratio for Incident Dialysis Patients	Process		CMS
Infant Mortality	Birth Dose of Hepatitis B Vaccine and Hepatitis B Immune Globulin for Newborns of Hepatitis B Surface Antigen (HBsAg) Positive Mothers	Process	0479	NQF QPS
Infant Mortality	Chlamydia Screening and Follow Up	Process	1395	NQF QPS
Infant Mortality	Contraceptive Care - Access to LARC	Structure	2904	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Source
Infant Mortality	Contraceptive Care – Most & Moderately Effective Methods	Outcome	2903	NQF QPS
Infant Mortality	Contraceptive Care - Postpartum	Outcome	2902	NQF QPS
Infant Mortality	Frequency of Ongoing Prenatal Care (FPC)	Process	1391	NQF QPS
Infant Mortality	Lactation Care in Birthing Facilities	Structure		HIW
Infant Mortality	Patient-Centered Medical Home Patients' Experiences: Percentage of Parents or Guardians Who Reported How Often They Were Able to Get the Care Their Child Needed from Their Child's Provider's Office During Evenings, Weekends, or Holidays.	Consumer Experience		AHRQ
Infant Mortality	Prenatal & Postpartum Care (PPC)	Process	1517	NQF QPS
Infant Mortality	Prenatal Care, Early and Adequate	Process		HIW
Infant Mortality	Prenatal Care, First Trimester	Process		HIW
Infant Mortality	Preventive Services for Children and Adolescents: Percentage of Newborns Who Have Had Neonatal Screening for Hemoglobinopathies, Phenylketonuria and Hypothyroidism in the First Week of Life.	Process		AHRQ
Infant Mortality	Proportion of Infants 22 to 29 Weeks Gestation Screened for Retinopathy of Prematurity.	Process	0483	NQF QPS
Infant Mortality	Reproductive Health Services Receipt: Sexually Active Females	Process		HIW
Infant Mortality	Structural Attributes of Facility in Which High Risk Women Deliver Newborns: A PQMP Measure	Structure	2896	NQF QPS
Infant Mortality	Under 1500g Infant Not Delivered at Appropriate Level of Care	Outcome	0477	NQF QPS
Infant Mortality	Very Low Birth Weight Infants Born at Level III Hospitals			HIW
Mental Illness	Behavioral Health Care Patients' Experiences: Percentage of Adult Patients Who Reported How Often They Were Seen Within 15 Minutes of Their Appointment.	Patient Experience		AHRQ
Mental Illness	Follow-Up After Hospitalization for Mental Illness	Process	0576	NQF QPS
Mental Illness	Follow-Up After Hospitalization for Schizophrenia (7- and 30-Day)	Process	1937	NQF QPS
Mental Illness	HCBS CAHPS Measure (5 of 19): Transportation to Medical Appointments	Outcome	2267	CMS
Mental Illness	Mental Illness Services Receipt: Homeless Adults			HIW
Mental Illness	Mental Illness Utilization: Number and Percentage of Members Receiving the Following Mental Illness Services During the Measurement Year: Any Service, Inpatient, Intensive Outpatient or Partial Hospitalization, and Outpatient or ED.			CMS

DOMAIN:
Equitable High-Quality Care

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Adjuvant Chemotherapy is Recommended or Administered Within 4 Months (120 Days) of Diagnosis to Patients Under the Age of 80 with AJCC III (Lymph Node Positive) Colon Cancer	Process	0223	NQF QPS
Cancer	Adjuvant Hormonal Therapy	Process	0220	NQF QPS
Cancer	Age Appropriate Screening Colonoscopy	Efficiency		CMS
Cancer	Appropriate Age for Colorectal Cancer Screening Colonoscopy	Outcome		CMS
Cancer	Appropriate Follow-Up Imaging for Incidental Simple Ovarian Cysts	Process		CMS
Cancer	At Least 12 Regional Lymph Nodes Are Removed and Pathologically Examined for Resected Colon Cancer.	Process	0225	NQF QPS
Cancer	Barrett's Esophagus	Outcome	1854	NQF QPS
Cancer	Biopsy Follow-Up	Process	0645	CMS
Cancer	Breast Cancer Deaths	Outcome		HIW
Cancer	Breast Cancer Resection Pathology Reporting- pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	Outcome	0391	NQF QPS
Cancer	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	Process	0391	CMS
Cancer	Breast Cancer Screening	Process	2372	CMS
Cancer	Breast Cancer Screening	Process	2372	CMS
Cancer	Breast Cancer Screening	Process		CMS
Cancer	Breast Cancer Screening	Process	0031	NQF QPS
Cancer	Breast Cancer: Hormonal Therapy for Stage I (T1b)-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	Process	0387	NQF QPS
Cancer	Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer	Process	0387	CMS
Cancer	Cancer - Anorexia and Weight Loss: Percentage of Patients Treated with Enteral or Parenteral Nutrition Who Had an Assessment Prior to Starting Nutrition That There Was Difficulty Maintaining Nutrition Due to Significant Gastrointestinal Issues and That Expected Life Expectancy Was at Least One Month.			AHRQ
Cancer	Cancer - Anorexia and Weight Loss: Percentage of Patients Who Presented for an Initial Visit for Cancer Affecting the Oropharynx or Gastrointestinal Tract or Advanced Cancer at a Cancer-Related Outpatient Site for Whom There Was an Assessment for the Presence or Absence of Anorexia or Dysphagia.			AHRQ

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Cancer - Delirium: Percentage of Hospitalized Patients with Cancer Over the Age of 65 or with Advanced Cancer with Delirium for Whom There Was an Assessment for the Presence or Absence of at Least One of the Following Potential Causes and Their Association with Delirium: Medication Effects, Central Nervous System Disease, Infection, or Metabolic Processes.			AHRQ
Cancer	Cancer - Dyspnea: Percentage of Inpatients with Primary Lung Cancer or Advanced Cancer with Dyspnea on Admission Who Were Offered Symptomatic Management or Treatment Directed at an Underlying Cause Within 24 Hours.			AHRQ
Cancer	Cancer - Dyspnea: Percentage of Outpatients with Primary Lung Cancer or Advanced Cancer Who Reported New or Worsening Dyspnea Who Were Offered Symptomatic Management or Treatment Directed at an Underlying Cause Within One Month.			AHRQ
Cancer	Cancer - Dyspnea: Percentage of Patients in the Hospital Treated for Dyspnea Who Had an Assessment Within 24 Hours That the Treatment Was Effective in Relieving Dyspnea or That a Change in Treatment for Dyspnea Was Made.			AHRQ
Cancer	Cancer - Fatigue/Anemia: Percentage of Known Cancer Patients Who Are Newly Diagnosed with Cancer Who Had an Assessment of the Presence or Absence of Fatigue.			AHRQ
Cancer	Cancer - Fatigue/Anemia: Percentage of Patients Seen for an Initial Visit or Any Visit While Undergoing Chemotherapy at a Cancer-Related Outpatient Site for Whom There Was an Assessment of the Presence or Absence of Fatigue.			AHRQ
Cancer	Cancer - Information and Care Planning: Percentage of Patients with Advanced Cancer Who Are Admitted to the ICU and Survive 48 Hours for Whom the Patient's Preferences for Care or an Attempt to Identify Them Was Documented in the Medical Record Within 48 Hours of ICU Admission.			AHRQ
Cancer	Cancer - Information and Care Planning: Percentage of Patients with Advanced Cancer Who Are Mechanically Ventilated in the ICU for Whom the Patient's Preference for Mechanical Ventilation or Why This Information Was Unavailable Was Documented in the Medical Record Within 48 Hours of Admission to the ICU.			AHRQ
Cancer	Cancer - Information and Care Planning: Percentage of Patients with Advanced Cancer Who Died an Expected Death for Whom There Was Documentation of an Advanced Directive or a Surrogate Decision Maker in the Medical Record.			AHRQ
Cancer	Cancer - Information and Care Planning: Percentage of Patients with Advanced Cancer Who Died an Expected Death Who Were Referred for Palliative Care Prior to Death (Hospital-Based or Community Hospice) or There Was Documentation Why There Was No Referral.			AHRQ

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Cancer - Nausea and Vomiting: Percentage of Patients Undergoing Moderately or Highly Emetic Chemotherapy or with Cancer Affecting the Gastrointestinal Tract or Abdomen Seen for a Visit in a Cancer-Related Outpatient Setting for Whom the Presence or Absence of Nausea or Vomiting Was Assessed at Every Visit.			AHRQ
Cancer	Cancer - Nausea and Vomiting: Percentage of Patients with Advanced Cancer Affecting the Gastrointestinal Tract or Abdomen Admitted to a Hospital for Whom the Presence or Absence of Nausea or Vomiting Was Assessed Within 24 Hours.			AHRQ
Cancer	Cancer - Pain: Percentage of Patients Who Had a Cancer-Related Outpatient Visit Who Were Screened for the Presence or Absence and Intensity of Pain Using a Numeric Pain Score.			AHRQ
Cancer	Cancer - Pain: Percentage of Patients Whose Outpatient Cancer Pain Regimen Changed for Whom There Was an Assessment of the Effectiveness of the Treatment at or Before the Next Outpatient Visit with That Provider or at Another Cancer-Related Outpatient Visit.			AHRQ
Cancer	Cancer - Pain: Percentage of Patients with Advanced Cancer Who Received Radiation Treatment for Painful Bone Metastases for Whom Single-Fraction Radiation Was Offered OR There Was Documentation of a Contraindication to Single-Fraction Treatment.			AHRQ
Cancer	Cancer - Pain: Percentage of Patients with Cancer Pain Started on Chronic Opioid Treatment Who Were Offered Either a Prescription or Nonprescription Bowel Regimen Within 24 Hours or Had Documented Contraindication to a Bowel Regimen.			AHRQ
Cancer	Cancer - Skin Rash: Percentage of Patients Treated with Agents That Block Epidermal Growth Factor Receptors (EGFRs) for Whom the Presence and Severity of Skin Rash Was Evaluated Within One Month After Starting the Treatments and at Each Visit.			AHRQ
Cancer	Cancer Deaths, Total	Outcome		HIW
Cancer	Cancer Prevalence: Adults (Percent)	Outcome		HIW
Cancer	Cancer Survival	Outcome		HIW
Cancer	Cervical Cancer Screening	Process	0032	CMS
Cancer	Cervical Cancer Screening	Process	0032	CMS
Cancer	Cervical Cancer Screening	Process		CMS
Cancer	Cervical Cancer Screening: Age Standardized Incidence Rate Per 100,000 Women of Invasive Cervical Cancer—Non-Squamous Cell Carcinoma Diagnosed in a Year.			AHRQ

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Cervical Cancer Screening: Age Standardized Incidence Rate Per 100,000 Women of Invasive Cervical Cancer—Squamous Cell Carcinoma Diagnosed in a Year.			AHRQ
Cancer	Cervical Cancer Screening: Age Standardized Incidence Rate Per 100,000 Women of Invasive Cervical Cancer—Non-Squamous Cell Carcinoma Diagnosed in a Year	Process		AHRQ
Cancer	Cervical Cancer Screening: Age Standardized Incidence Rate Per 100,000 Women of Invasive Cervical Cancer—Squamous Cell Carcinoma Diagnosed in a Year.	Process		AHRQ
Cancer	Cervical Cancer Screening: Number of Days at Which 90% of Pap Tests Are Processed by the Lab.			AHRQ
Cancer	Cervical Cancer Screening: Number of Days at Which 90% of Women with a High-Grade Pap Test Result Who Had a Follow-Up Colposcopy.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Eligible Women Who Have a Subsequent Pap Test Within 3 Years (36 Months) of the Index Test with a Negative Result.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Eligible Women Who Have a Subsequent Pap Test Within 42 Months of the Index Test with a Negative Result.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Eligible Women with at Least One Pap Test in a 3-Year Frame.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Eligible Women with at Least One Pap Test in a 42-Month Time Frame.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Invasive Carcinoma of the Cervix Diagnosed at Stage 1 in a 12-Month Period.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Invasive Carcinoma of the Cervix Diagnosed at Stage 1 in a 12-Month Period.	Process		AHRQ
Cancer	Cervical Cancer Screening: Percentage of Pap Test Results That Are Reported as Unsatisfactory in a 12-Month Frame.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Pap Tests with an HSIL+ Result That Have a Histological Confirmation of HSIL, Carcinoma in Situ, or Invasive Carcinoma Within 12 Months of the HSIL+ Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Pap Tests with ASC-H Results That Have a Histological Confirmation of HSIL, Carcinoma in Situ, or Invasive Carcinoma Within 12 Months of the ASC-H Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women Who Had a Colposcopy Within 12 Months of a Pap Test with an ASC-H/HSIL+ Result Who Had a Histologic Investigation Within 12 Months of the ASC-H/HSIL+ Cytological Finding.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with a Cytological Finding of ASC-H/HSIL+ Who Had a Histologic Investigation Within 12 Months of the ASC-H/HSIL+ Cytological Finding.			AHRQ

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Cervical Cancer Screening: Percentage of Women with a High-Grade Pap Test Result Who Had a Follow-Up Colposcopy Within 6 Weeks of the Index Pap Test Report Date.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with a Negative ASCUS, LSIL, AGC, ASC-H, HSIL or More Severe Pap Test Result.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Histology of HSIL Per 1000 Women Who Had a Pap Test in the Previous 12 Months.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Invasive Cervical Cancer—Non-Squamous Cell Carcinomas Who Are Diagnosed Greater Than 5 Years Since Previous Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Invasive Cervical Cancer—Non-Squamous Cell Carcinomas Who Are Diagnosed Within 0.5 to 3 Years Since Previous Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Invasive Cervical Cancer—Non-Squamous Cell Carcinomas Who Are Diagnosed Within Greater Than 3 to 5 Years Since Previous Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Invasive Cervical Cancer—Squamous Cell Carcinoma Who Are Diagnosed Greater Than 5 Years Since Previous Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Invasive Cervical Cancer—Squamous Cell Carcinoma Who Are Diagnosed Within 0.5 to 3 Years Since Previous Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Invasive Cervical Cancer—Squamous Cell Carcinoma Who Are Diagnosed Within Greater Than 3 to 5 Years Since Previous Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Invasive Cervical Cancer—Non-Squamous Cell Carcinomas Who Are Diagnosed Within Greater Than 3 to 5 Years Since Previous Pap Test.	Process		AHRQ
Cancer	Cervical Cancer Screening: Women 21-65 Years	Process		HIW
Cancer	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	Process	0385	CMS
Cancer	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	Process	0385	NQF QPS
Cancer	Colonoscopy Use: Adults 50-75 (Percent) (Source: NHIS)	Process		HIW
Cancer	Colonoscopy/Sigmoidoscopy: Adults 50+ (Percent)	Process		HIW
Cancer	Colorectal Cancer Deaths (Per 100,000)	Outcome		HIW
Cancer	Colorectal Cancer Deaths, Including Unspecified Sites	Outcome		HIW

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Colorectal Cancer Resection Pathology Reporting- pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	Outcome	0392	NQF QPS
Cancer	Colorectal Cancer Screening	Process	0034	CMS
Cancer	Colorectal Cancer Screening: Persons 50-75 Years	Outcome		HIW
Cancer	Combination Chemotherapy is Recommended or Administered Within 4 Months (120 Days) of Diagnosis for Women Under 70 with AJCC T1cN0M0, or Stage IB - III Hormone Receptor Negative Breast Cancer.	Process	0559	NQF QPS
Cancer	Communication and Shared Decision-Making with Patients and Families for Interventional Oncology Procedures	Process		CMS
Cancer	Completeness of Pathology Reporting	Process	0224	NQF QPS
Cancer	Diagnostic Imaging: Percentage of Patients Undergoing a Screening Mammogram Whose Information is Entered into a Reminder System with a Target Due Date for the Next Mammogram.	Process	0509	AHRQ
Cancer	Draft: Breast Cancer Condition Episode for CMS Episode Grouper	Cost/ Resource Use		CMS
Cancer	Draft: Colon Cancer Condition Episode for CMS Episode Grouper	Cost/ Resource Use		CMS
Cancer	Draft: Lung Cancer Condition Episode for CMS Episode Grouper	Cost/ Resource Use		CMS
Cancer	Draft: Prostate Cancer Condition Episode for CMS Episode Grouper	Cost/ Resource Use		CMS
Cancer	External Beam Radiotherapy for Bone Metastases	Process	1822	NQF QPS
Cancer	Follow-Up After Initial Diagnosis and Treatment of Colorectal Cancer: Colonoscopy	Process	0572	NQF QPS
Cancer	Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	Process	0379	NQF QPS
Cancer	Hematology: Multiple Myeloma: Treatment with Bisphosphonates	Process	0380	NQF QPS
Cancer	Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemia's: Baseline Cytogenetic Testing Performed on Bone Marrow	Process	0377	NQF QPS
Cancer	Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	Process	0378	NQF QPS
Cancer	HER2 Negative or Undocumented Breast Cancer Patients Spared Treatment with HER2-Targeted Therapies	Process	1857	NQF QPS
Cancer	HER2 Testing for Overexpression or Gene Amplification in Patients with Breast Cancer	Process	1878	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	History of Breast Cancer - Cancer Surveillance	Process	0623	NQF QPS
Cancer	History of Prostate Cancer - Cancer Surveillance	Process	0625	NQF QPS
Cancer	Invasive Colorectal Cancer	Process		HIW
Cancer	Invasive Uterine Cervical Cancer: Females	Process		HIW
Cancer	KRAS Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer Who Receive Anti-Epidermal Growth Factor Receptor Monoclonal Antibody Therapy	Process	1859	NQF QPS
Cancer	Late-Stage Breast Cancer: Females	Process		HIW
Cancer	Lung Cancer Deaths	Outcome		HIW
Cancer	Lung Cancer Reporting (Biopsy/Cytology Specimens)	Outcome		CMS
Cancer	Lung, Trachea, and Bronchus Cancer Deaths (Per 100,000)	Outcome		HIW
Cancer	Mammogram: Women 50+ (Percent) (Source: BRFSS)	Process		HIW
Cancer	Mammography Counseling: Women 50-74 Years	Process		HIW
Cancer	Mammography: Women 40+ (Percent) (Source: NHIS)	Process		HIW
Cancer	Mammography: Women 50-74 Years	Process		HIW
Cancer	Melanoma Coordination of Care	Process	0561	NQF QPS
Cancer	Melanoma: Percentage of Patients Who Undergo a Cervical Lymph Node Dissection (LND) or Completion Lymph Node Dissection (CLND) for Melanoma for Whom at Least 15 Regional Lymph Nodes Are Resected and Pathologically Examined.			AHRQ
Cancer	Minimally Invasive Surgery Performed for Patients with Endometrial Cancer	Process		CMS
Cancer	Needle Biopsy to Establish Diagnosis of Cancer Precedes Surgical Excision/Resection	Process		CMS
Cancer	Needle Biopsy to Establish Diagnosis of Cancer Precedes Surgical Excision/Resection	Process	0221	NQF QPS
Cancer	Non-Recommended Cervical Cancer Screening in Adolescent Females: Percentage of Adolescent Females 16 to 20 Years of Age Who Were Screened Unnecessarily for Cervical Cancer.			AHRQ
Cancer	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (Paired with 0384)	Process	0383	NQF QPS
Cancer	Oncology: Radiation Dose Limits to Normal Tissues	Process	0382	NQF QPS
Cancer	Oncology: Treatment Summary Communication – Radiation Oncology	Process	0381	NQF QPS
Cancer	Oncology: Cancer Stage Documented	Process	0386	CMS
Cancer	Oncology: Cancer Stage Documented	Process	0386	NQF QPS
Cancer	Oncology: Medical and Radiation - Pain Intensity Quantified	Process	0384	NQF QPS
Cancer	Overuse of Imaging for Staging Breast Cancer at Low Risk of Metastasis	Process		CMS
Cancer	Overutilization of Imaging Studies in Melanoma	Process	0562	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Pap Smears: Women 18+ (Percent) (Source: NHIS)	Process		HIW
Cancer	Pap Smears: Women 18+ Without Hysterectomy (Percent)	Process		HIW
Cancer	Pap Test Counseling: Women 21-65 Years	Process		HIW
Cancer	Pap Test: Women 18+ (Percent)	Process		HIW
Cancer	Patients with Advanced Cancer Screened for Pain at Outpatient Visits	Process		CMS
Cancer	Patients with Early Stage Breast Cancer Who Have Evaluation of the Axilla	Process	0222	NQF QPS
Cancer	Patients with Metastatic Colorectal Cancer and KRAS Gene Mutation Spared Treatment with Anti-Epidermal Growth Factor Receptor Monoclonal Antibodies	Process	1860	NQF QPS
Cancer	Post Breast Conservation Surgery Irradiation	Process	0219	NQF QPS
Cancer	Preoperative Diagnosis of Breast Cancer	Process		CMS
Cancer	Preventive Services for Adults: Percentage of Adolescent Girls and Women Age 21 and Younger Who Undergo Cervical Cancer Screening.	Process		AHRQ
Cancer	Preventive Services for Adults: Percentage of Women Ages 21 to 64 Years Who Have Screening for Cervical Cancer (Pap Test) Every Three Years.	Process		AHRQ
Cancer	Preventive Services for Adults: Percentage of Women Ages 65 to 70 Who Are Screened for Cervical Cancer and Have Undergone Appropriate Screening 10 Years Prior.	Process		AHRQ
Cancer	Preventive Services for Children and Adolescents: Percentage of Sexually Active Women Age 25 Years and Younger Who Have Had Screening for Chlamydia.			AHRQ
Cancer	Preventive Services: Percentage of Adult Enrolled Members Age 19 Years and Older Who Are Up-to-Date for All Appropriate Preventive Services (Combination 3).	Process		AHRQ
Cancer	Proportion Dying from Cancer in an Acute Care Setting	Process	0214	NQF QPS
Cancer	Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than 3 Days	Intermediate Clinical Outcome	0216	NQF QPS
Cancer	Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life	Intermediate Clinical Outcome	0213	NQF QPS
Cancer	Proportion of Patients Who Died from Cancer Not Admitted to Hospice	Process	0215	NQF QPS
Cancer	Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life	Process	0210	NQF QPS
Cancer	Proportion of Patients Who Died from Cancer with More Than One Emergency Department Visit in the Last 30 Days of Life	Intermediate Clinical Outcome	0211	NQF QPS
Cancer	Proportion with More Than One Hospitalization in the Last 30 Days of Life	Process	0212	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Prostate Cancer: Adjuvant Hormonal Therapy for High or Very High Risk Prostate Cancer Patients	Process	0390	NQF QPS
Cancer	Prostate Cancer: Adjuvant Hormonal Therapy for High Risk or Very High Risk Prostate Cancer	Process	0390	CMS
Cancer	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Process	0389	NQF QPS
Cancer	Prostate Cancer: Three-Dimensional Radiotherapy	Process	0388	NQF QPS
Cancer	Pulmonary Resection: Percentage of Patients with Lung Cancer Undergoing Pulmonary Resection Who Have Documentation of at Least One of the Specified Mediastinal Staging Procedures.			AHRQ
Cancer	Quantitative HER2 Evaluation by IHC Uses the System Recommended by the ASCO/CAP Guidelines	Process	1855	NQF QPS
Cancer	Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer	Outcome	1790	NQF QPS
Cancer	Screening Colonoscopy Adenoma Detection Rate	Outcome		CMS
Cancer	Sentinel Lymph Node Biopsy for Invasive Breast Cancer	Process		CMS
Cancer	Thyroid Nodules: Percentage of Patients with a Diagnosis of Thyroid Nodule(s) Who Had a Fine Needle Aspiration Biopsy Performed.			AHRQ
Cancer	Thyroid Nodules: Percentage of Patients with Thyroid Nodule(s) Who Had a Documented Physical Examination Description of the Nodule That Included All of the Following: Measurement, Texture, Mobility, Location and Presence or Absence of Palpable Cervical Lymph Node.			AHRQ
Cancer	Trastuzumab Administered to Patients with AJCC Stage I (T1c) – III and Human Epidermal Growth Factor Receptor 2 (HER2) Positive Breast Cancer Who Receive Adjuvant Chemotherapy	Process	1858	NQF QPS
Cancer	Unnecessary Screening Colonoscopy in Older Adults	Efficiency		CMS
Cancer	Uterine Cervix Cancer Deaths	Process		HIW
Cross-cutting	Care Coordination	Process		CMS
Cross-cutting	Care Coordination	Patient Engagement/ Experience		CMS
Cross-cutting	Cultural Competence	Process		CMS
Cross-cutting	Cultural Competency Implementation Measure	Process		CMS
Cross-cutting	Family Experiences with Coordination of Care (FECC)-1 Has Care Coordinator	Process	2842	NQF QPS
Cross-cutting	Family Experiences with Coordination of Care (FECC)-15: Caregiver Has Access to Medical Interpreter When Needed	Process	2849	NQF QPS
Cross-cutting	Follow-Up After ED Visit for Complex Populations	Process		CMS
Cross-cutting	Gains in Patient Activation (PAM) Scores at 12 Months	Outcome: PRO	2483	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cross-cutting	LBP: Evaluation of Patient Experience	Process	0308	NQF QPS
CVD	30-Day All-Cause Risk-Standardized Mortality Rate Following Percutaneous Coronary Intervention (PCI) for Patients with ST Segment Elevation Myocardial Infarction (STEMI) or Cardiogenic Shock	Outcome	0536	NQF QPS
CVD	30-Day All-Cause Risk-Standardized Mortality Rate Following Percutaneous Coronary Intervention (PCI) for Patients Without ST Segment Elevation Myocardial Infarction (STEMI) and Without Cardiogenic Shock	Outcome	0535	NQF QPS
CVD	Abdominal Aortic Aneurysm (AAA) Repair Mortality Rate (IQI 11)	Outcome	0359	NQF QPS
CVD	Ace Inhibitor / Angiotensin Receptor Blocker Use and Persistence Among Members with Coronary Artery Disease at High Risk for Coronary Events	Process	0551	NQF QPS
CVD	ACE/ARB Therapy at Discharge for ICD Implant Patients with Left Ventricular Systolic Dysfunction	Process	1522	NQF QPS
CVD	ACEI or ARB for Left Ventricular Systolic Dysfunction- Acute Myocardial Infarction (AMI) Patients	Process	0137	NQF QPS
CVD	Acute Myocardial Infarction (AMI) Mortality Rate	Outcome	0730	NQF QPS
CVD	Acute Myocardial Infarction (AMI): the Risk-Adjusted Rate of All-Cause in-Hospital Death Occurring Within 30 Days of First Admission to an Acute Care Hospital with a Diagnosis of AMI.	Outcome		AHRQ
CVD	Adult Smoking Cessation Advice/Counseling	Process	9999	CMS
CVD	Ambulatory Initiated Amiodarone Therapy: TSH Test	Process	0578	NQF QPS
CVD	Anti-Lipid Treatment Discharge	Process	0118	NQF QPS
CVD	Anti-Platelet Medication at Discharge	Process	0116	NQF QPS
CVD	Anti-Platelet Medication on Discharge	Process	0237	NQF QPS
CVD	Aspirin at Arrival	Process	0286	NQF QPS
CVD	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	Process	0132	NQF QPS
CVD	Aspirin Prescribed at Discharge for AMI	Process	0142	NQF QPS
CVD	Aspirin Use and Discussion: Percentage of Members Who Are Currently Taking Aspirin, Including Women 56 to 79 Years of Age with at Least Two Risk Factors for Cardiovascular Disease (CVD); Men 46 to 65 Years of Age with at Least One Risk Factor for CVD; and Men 66 to 79 Years of Age, Regardless of Risk Factors	Process		AHRQ
CVD	Aspirin Use and Discussion: Percentage of Women 56 to 79 Years of Age and Men 46 to 79 Years of Age Who Discussed the Risks and Benefits of Using Aspirin with a Doctor or Other Health Provider.	Process		AHRQ
CVD	Aspirin Use for the Primary Prevention of Cardiovascular Disease and Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement.			AHRQ

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Atherosclerotic Disease and LDL Greater Than 100 - Use of Lipid Lowering Agent	Process	0636	NQF QPS
CVD	Atrial Fibrillation - Anticoagulation Therapy	Process	0624	NQF QPS
CVD	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	Process	1525	NQF QPS
CVD	Atrial Fibrillation Medicare Beneficiaries (Number)			HIW
CVD	Atrial Fibrillation Medicare Beneficiaries (Percent)			HIW
CVD	Behavioral Counseling Interventions to Promote a Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults: U.S. Preventive Services Task Force Recommendation Statement.			AHRQ
CVD	Behavioral Counseling to Promote a Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: U.S. Preventive Services Task Force Recommendation Statement.			AHRQ
CVD	Beta Blockade at Discharge	Process	0117	NQF QPS
CVD	Beta Blocker at Discharge for ICD Implant Patients with Left Ventricular Systolic Dysfunction	Process	1529	NQF QPS
CVD	Beta Blocker at Discharge for ICD Implant Patients with a Previous MI	Process	1528	NQF QPS
CVD	Beta Blocker on Discharge	Process	0238	NQF QPS
CVD	Beta-Blocker Prescribed at Discharge for AMI	Process	0160	NQF QPS
CVD	Beta-Blocker Therapy (I.E., Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate) for LVSD Prescribed at Discharge	Process	2438	NQF QPS
CVD	Bilateral Cardiac Catheterization Rate (IQI 25)	Outcome	0355	NQF QPS
CVD	CAD: Beta-Blocker Treatment After a Heart Attack	Process	0072	NQF QPS
CVD	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low Risk Surgery	Efficiency	0669	NQF QPS
CVD	Cardiac Rehabilitation Patient Referral from an Inpatient Setting	Process	0642	NQF QPS
CVD	Cardiac Rehabilitation Patient Referral from an Outpatient Setting	Process	0643	NQF QPS
CVD	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients	Efficiency	0670	NQF QPS
CVD	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)	Efficiency	0671	NQF QPS
CVD	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low Risk Patients	Efficiency	0672	NQF QPS
CVD	Cardiac Surgery Patients with Controlled Postoperative Blood Glucose	Process	0300	CMS
CVD	Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	Outcome	2474	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Chronic Stable Coronary Artery Disease: Antiplatelet Therapy	Process	0067	NQF QPS
CVD	Chronic Stable Coronary Artery Disease: Lipid Control	Process	0074	NQF QPS
CVD	Chronic Stable Coronary Artery Disease: Symptom and Activity Assessment	Process	0065	NQF QPS
CVD	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	Outcome: PRO	0209	NQF QPS
CVD	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 Mm Hg)	Outcome	0061	NQF QPS
CVD	Congestive Heart Failure Admission Rate (Per 100,000 Beneficiaries)			HIW
CVD	Congestive Heart Failure Rate (PQI 08)	Process	0277	NQF QPS
CVD	Controlling High Blood Pressure	Outcome	0018	NQF QPS
CVD	Controlling High Blood Pressure for People with Serious Mental Illness	Outcome	2602	NQF QPS
CVD	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	Process	0236	CMS
CVD	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Process	0066	NQF QPS
CVD	Defect Free Care for AMI	Composite	2377	NQF QPS
CVD	Discharge Medications (ACE/ARB and Beta Blockers) in Eligible ICD Implant Patients	Composite	0965	NQF QPS
CVD	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	Process	0090	CMS
CVD	Emergency Medicine: Aspirin at Arrival for Acute Myocardial Infarction (AMI)	Process	0092	NQF QPS
CVD	Evaluation of Left Ventricular Systolic Function (LVS)	Process	0135	CMS
CVD	Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)	Outcome	2881	NQF QPS
CVD	Excess Days in Acute Care (EDAC) After Hospitalization for Heart Failure	Outcome	2880	NQF QPS
CVD	Family Evaluation of Hospice Care	Outcome: PRO	0208	NQF QPS
CVD	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	Process	0288	NQF QPS
CVD	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	Process	0164	NQF QPS
CVD	Frailty Assessment	Process	9999	CMS
CVD	Gains in Patient Activation (PAM) Scores at 12 Months	Outcome: PRO	2483	NQF QPS
CVD	Guidelines for the Management of Absolute Cardiovascular Disease Risk.			AHRQ
CVD	Heart Attack Medicare Beneficiaries (Number)			HIW

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Heart Attack Medicare Beneficiaries (Percent)			HIW
CVD	Heart Disease Death (Per 100,000)			HIW
CVD	Heart Disease Death (Percent)			HIW
CVD	Heart Failure - Use of ACE Inhibitor (ACEI) or Angiotensin Receptor Blocker (ARB) Therapy	Process	0610	NQF QPS
CVD	Heart Failure - Use of Beta Blocker Therapy	Process	0615	NQF QPS
CVD	Heart Failure (HF) : Assessment of Clinical Symptoms of Volume Overload (Excess)	Process	0078	NQF QPS
CVD	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Process	0081	NQF QPS
CVD	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Process	0083	NQF QPS
CVD	Heart Failure (HF): Detailed Discharge Instructions	Process	0136	CMS
CVD	Heart Failure Mortality Rate (IQI 16)	Outcome	0358	NQF QPS
CVD	Heart Failure Symptoms Assessed and Addressed	Process	0521	NQF QPS
CVD	Heart Failure: Left Ventricular Ejection Fraction Assessment (Outpatient Setting)	Process	0079	NQF QPS
CVD	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization.	Outcome	0505	NQF QPS
CVD	Hospital 30-Day Risk-Standardized Readmission Rates Following Percutaneous Coronary Intervention (PCI)	Outcome	0695	NQF QPS
CVD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization for Patients 18 and Older	Outcome	0230	NQF QPS
CVD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery	Outcome	2558	NQF QPS
CVD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization for Patients 18 and Older	Outcome	0229	NQF QPS
CVD	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization	Outcome	0330	NQF QPS
CVD	Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery	Outcome	2515	NQF QPS
CVD	Hospital Risk-Standardized Complication Rate Following Implantation of Implantable Cardioverter-Defibrillator (ICD)	Composite	0694	NQF QPS
CVD	Hospital Specific Risk-Adjusted Measure of Mortality or One or More Major Complications Within 30 Days of a Lower Extremity Bypass (LEB).	Outcome	0534	NQF QPS
CVD	Hospitalized Patients Who Die an Expected Death with an ICD That Has Been Deactivated	Process	1625	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	Cost/ Resource Use	2431	NQF QPS
CVD	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Outcome	1789	NQF QPS
CVD	Hybrid Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI)	Outcome	2473	NQF QPS
CVD	Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data	Outcome	2879	NQF QPS
CVD	Hyperlipidemia (Primary Prevention) - Lifestyle Changes and/or Lipid Lowering Therapy	Process	0611	NQF QPS
CVD	Infection Within 180 Days of Cardiac Implantable Electronic Device (CIED)	Outcome	9999	CMS
CVD	In-Hospital Risk Adjusted Rate of Bleeding Events for Patients Undergoing PCI	Outcome	2459	NQF QPS
CVD	In-Hospital Risk Adjusted Rate of Mortality for Patients Undergoing PCI	Outcome	0133	NQF QPS
CVD	INR for Individuals Taking Warfarin and Interacting Anti-Infective Medications	Process	0556	NQF QPS
CVD	INR Monitoring for Individuals on Warfarin	Process	0555	NQF QPS
CVD	INR Monitoring for Individuals on Warfarin After Hospital Discharge	Process	2732	NQF QPS
CVD	Ischemic Heart Disease Medicare Beneficiaries (Number)			HIW
CVD	Ischemic Heart Disease Medicare Beneficiaries (Percent)			HIW
CVD	Ischemic Vascular Disease (IVD): Blood Pressure Control	Outcome	0073	NQF QPS
CVD	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control <100 Mg/dL	Outcome	0075	NQF QPS
CVD	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Process	0068	NQF QPS
CVD	Lipid Management in Adults: Percentage of Patients with Established Atherosclerotic Cardiovascular Disease (ASCVD), or 10-Year CHD Risk Greater Than or Equal to 10%, or Diabetes and on Lipid-Lowering Medication Who Have a Fasting Lipid Panel Within 24 Months of Medication Prescription.	Process		AHRQ
CVD	Lipid Management in Adults: Percentage of Patients with Established Atherosclerotic Cardiovascular Disease (ASCVD), or a 10-Year Risk for CHD Greater Than or Equal to 10%, or Diabetes, Who Are on a Statin or Have LDL Less Than 100 Ml/dL Within a 12-Month Period.	Process		AHRQ
CVD	Lipid Modification: Cardiovascular Risk Assessment and the Modification of Blood Lipids for the Primary and Secondary Prevention of Cardiovascular Disease.	N/A	N/A	N/A

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Long-Term Care Hospital (LTCH) Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support	Outcome	2632	NQF QPS
CVD	Median Time to ECG	Efficiency	0289	NQF QPS
CVD	Median Time to Fibrinolysis	Process	0287	NQF QPS
CVD	Median Time to Transfer to Another Facility for Acute Coronary Intervention	Process	0290	NQF QPS
CVD	MI - Use of Beta Blocker Therapy	Process	0613	NQF QPS
CVD	Operative Mortality Stratified by the 5 STAT Mortality Categories	Outcome	0733	NQF QPS
CVD	Optimal Vascular Care	Composite	0076	NQF QPS
CVD	Overuse of Percutaneous Coronary Intervention (PCI) in Asymptomatic Patients	Process	9999	CMS
CVD	Patient(s) with an Emergency Medicine Visit for Non-Traumatic Chest Pain That Had an ECG.	Process	0665	NQF QPS
CVD	Patient(s) with an Emergency Medicine Visit for Syncope That Had an ECG.	Process	0664	NQF QPS
CVD	PCI Mortality (Risk-Adjusted) ©	Outcome	9999	CMS
CVD	Pediatric All-Condition Readmission Measure	Outcome	2393	NQF QPS
CVD	Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Process	2631	NQF QPS
CVD	Percutaneous Coronary Intervention (PCI): Comprehensive Documentation of Indications for PCI	Process	2411	NQF QPS
CVD	Percutaneous Coronary Intervention (PCI): Post-Procedural Optimal Medical Therapy	Composite	2452	NQF QPS
CVD	Perioperative Anti-Platelet Therapy for Patients Undergoing Carotid Endarterectomy	Process	0465	CMS
CVD	Perioperative Temperature Management	Process	0454	NQF QPS
CVD	Persistence of Beta-Blocker Treatment After a Heart Attack	Intermediate Clinical Outcome	0071	NQF QPS
CVD	Pharmacologic Treatment of Hypertension in Adults Aged 60 Years or Older to Higher Versus Lower Blood Pressure Targets: A Clinical Practice Guideline from the American College of Physicians and the American Academy of Family Physicians.			AHRQ
CVD	Post MI: ACE Inhibitor or ARB Therapy	Process	0594	NQF QPS
CVD	Post-Discharge Appointment for Heart Failure Patients	Process	2439	NQF QPS
CVD	Post-Discharge Evaluation for Heart Failure Patients	Process	2443	NQF QPS
CVD	Preoperative Beta Blockade	Process	0127	NQF QPS
CVD	Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter (CVC)	Process	0464	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections	Process	2726	NQF QPS
CVD	Primary and Secondary Prevention of Cardiovascular Disease: Antithrombotic Therapy and Prevention of Thrombosis, 9th Ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines.			AHRQ
CVD	Primary PCI Received Within 90 Minutes of Hospital Arrival	Process	0163	NQF QPS
CVD	Primary Prevention of Cardiovascular Events in Diabetics – Use of Aspirin or Antiplatelet Therapy	Process	0632	NQF QPS
CVD	Proportion of Patients Hospitalized with AMI That Have a Potentially Avoidable Complication (During the Index Stay or in the 30-Day Post-Discharge Period)	Composite	0704	NQF QPS
CVD	Proportion of Patients Hospitalized with Stroke That Have a Potentially Avoidable Complication (During the Index Stay or in the 30-Day Post-Discharge Period)	Outcome		NQF QPS
CVD	Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year.	Outcome	0709	NQF QPS
CVD	RACHS-1 Pediatric Heart Surgery Mortality Rate (PDI 06)	Outcome	0339	NQF QPS
CVD	RACHS-1 Pediatric Heart Surgery Volume (PDI 7)	Structure	0340	NQF QPS
CVD	Radiology: Stenosis Measurement in Carotid Imaging Reports	Process	0507	CMS
CVD	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) Who Die While in Hospital	Outcome	1534	CMS
CVD	Rate of Open Repair of Small or Moderate Abdominal Aortic Aneurysms (AAA) Where Patients Are Discharged Alive	Outcome	1523	CMS
CVD	Risk Adjusted Colon Surgery Outcome Measure	Outcome		NQF QPS
CVD	Risk-Adjusted Average Length of Inpatient Hospital Stay	Outcome	0327	NQF QPS
CVD	Risk-Adjusted Coronary Artery Bypass Graft (CABG) Readmission Rate	Outcome	2514	NQF QPS
CVD	Risk-Adjusted Deep Sternal Wound Infection	Outcome	0130	NQF QPS
CVD	Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR)	Outcome	0120	NQF QPS
CVD	Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR) + CABG Surgery	Outcome	0123	NQF QPS
CVD	Risk-Adjusted Operative Mortality for CABG	Outcome	0119	NQF QPS
CVD	Risk-Adjusted Operative Mortality for Mitral Valve (MV) Repair	Outcome	1501	NQF QPS
CVD	Risk-Adjusted Operative Mortality for Mitral Valve (MV) Repair + CABG Surgery	Outcome	1502	NQF QPS
CVD	Risk-Adjusted Operative Mortality for Mitral Valve (MV) Replacement	Outcome	0121	NQF QPS
CVD	Risk-Adjusted Operative Mortality for Mitral Valve (MV) Replacement + CABG Surgery	Outcome	0122	NQF QPS
CVD	Risk-Adjusted Operative Mortality for Pediatric and Congenital Heart Surgery	Outcome	2683	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Risk-Adjusted Postoperative Prolonged Intubation (Ventilation)	Outcome	0129	NQF QPS
CVD	Risk-Adjusted Stroke/Cerebrovascular Accident	Outcome	0131	NQF QPS
CVD	Risk-Adjusted Surgical Re-Exploration	Outcome	0115	NQF QPS
CVD	Risk-Standardized Acute Admission Rates for Patients with Heart Failure	Outcome	2886	NQF QPS
CVD	Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions	Outcome	2888	NQF QPS
CVD	Screening for Peripheral Artery Disease and Cardiovascular Disease Risk Assessment with the Ankle–Brachial Index in Adults: U.S. Preventive Services Task Force Recommendation Statement.			AHRQ
CVD	Secondary Prevention of Cardiovascular Events - Use of Aspirin or Antiplatelet Therapy	Process	0631	NQF QPS
CVD	Selection of Antibiotic Prophylaxis for Cardiac Surgery Patients	Process	0126	NQF QPS
CVD	Shared Decision Making Process	Outcome: PRO	2962	NQF QPS
CVD	Stable Coronary Artery Disease: Percentage of Patients with Cardiovascular Disease Who Received an Annual Influenza Vaccination.	Process		AHRQ
CVD	Stable Coronary Artery Disease: Percentage of Patients with Documentation in the Medical Record of Prognostic Assessment Preceding or Following a Course of Pharmacologic Therapy.	Process		AHRQ
CVD	Stable Coronary Artery Disease: Percentage of Patients with Documentation in the Medical Record of Receiving a Pneumonia Vaccination According to the CDC Recommendations.	Process		AHRQ
CVD	Stable Coronary Artery Disease: Percentage of Patients with Documentation in the Medical Record That an LDL Was Obtained Within the Last 12 Months with an LDL Less Than 100 Mg/dL. Consider Less Than 70 Mg/dL for High-Risk Patient.	Process		AHRQ
CVD	Stable Coronary Artery Disease: Percentage of Patients with Stable Coronary Artery Disease Who Have Demonstrated an Understanding of How to Respond in an Acute Cardiac Event by "Teaching Back" as to How They Would Respond in the Case of Acute Cardiac Event.	Process		AHRQ
CVD	Standardized Adverse Event Ratio for Children < 18 Years of Age Undergoing Cardiac Catheterization	Outcome	0715	NQF QPS
CVD	Statin Prescribed at Discharge	Process	0639	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Statin Therapy for Patients with Cardiovascular Disease: Percentage of Males 21 to 75 Years of Age and Females 40 to 75 Years of Age During the Measurement Year Who Were Identified as Having Clinical ASCVD Who Remained on a High- or Moderate-Intensity Statin Medication for at Least 80% of the Treatment Period.	Process		AHRQ
CVD	Statin Therapy for Patients with Cardiovascular Disease: Percentage of Males 21 to 75 Years of Age and Females 40 to 75 Years of Age During the Measurement Year Who Were Identified as Having Clinical ASCVD Who Were Dispensed at Least One High- or Moderate-Intensity Statin Medication.	Process		AHRQ
CVD	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease		9999	CMS
CVD	Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes	Process	9999	CMS
CVD	Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: U.S. Preventive Services Task Force Recommendation Statement.			AHRQ
CVD	Statin Use in Persons with Diabetes	Process	2712	NQF QPS
CVD	Stent Drug-Eluting Clopidogrel	Process	0588	NQF QPS
CVD	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge	Process	0241	CMS
CVD	Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy	Process	0325	CMS
CVD	Stroke Education	Process	0440	CMS
CVD	STS Aortic Valve Replacement (AVR) + Coronary Artery Bypass Graft (CABG) Composite Score	Composite	2563	NQF QPS
CVD	STS Aortic Valve Replacement (AVR) Composite Score	Composite	2561	NQF QPS
CVD	STS CABG Composite Score	Composite	0696	NQF QPS
CVD	STS Individual Surgeon Composite Measure for Adult Cardiac Surgery	Composite	3030	NQF QPS
CVD	STS Mitral Valve Repair/Replacement (MVRR) + Coronary Artery Bypass Graft (CABG) Composite Score	Composite	3032	NQF QPS
CVD	STS Mitral Valve Repair/Replacement (MVRR) Composite Score	Composite	3031	NQF QPS
CVD	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period	Process	0284	CMS
CVD	Surgical Volume for Pediatric and Congenital Heart Surgery: Total Programmatic Volume and Programmatic Volume Stratified by the 5 STAT Mortality Categories	Structure	0732	NQF QPS
CVD	Therapy with Aspirin, P2Y12 Inhibitor, and Statin at Discharge Following PCI in Eligible Patients	Composite	0964	NQF QPS
CVD	Thorax CT—Use of Contrast Material	Process	0513	NQF QPS
CVD	Thrombolytic Therapy	Process	0437	CMS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Time to Intravenous Thrombolytic Therapy	Process	1952	NQF QPS
CVD	Troponin Results for Emergency Department Acute Myocardial Infarction (AMI) Patients or Chest Pain Patients (with Probable Cardiac Chest Pain) Received Within 60 Minutes of Arrival.	Process	0660	NQF QPS
CVD	Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft (CABG)	Process	0134	NQF QPS
CVD	Ventilator-Associated Pneumonia for ICU and High-Risk Nursery (HRN) Patients	Outcome	0140	NQF QPS
Diabetes/CKD	Ace Inhibitor / Angiotensin Receptor Blocker Use and Persistence Among Members with Coronary Artery Disease at High Risk for Coronary Events	Process	0551	NQF QPS
Diabetes/CKD	Adherence to ACEIs/ARBs for Individuals with Diabetes Mellitus	Process	2467	NQF QPS
Diabetes/CKD	Adherence to Oral Diabetes Agents for Individuals with Diabetes Mellitus	Process	2468	NQF QPS
Diabetes/CKD	Adherence to Statins for Individuals with Diabetes Mellitus	Process	0545	NQF QPS
Diabetes/CKD	Adult Kidney Disease : Patients on Erythropoiesis Stimulating Agent (ESA)—Hemoglobin Level > 12.0 G/dL	Outcome	1666	NQF QPS
Diabetes/CKD	Adult Kidney Disease: Hemodialysis Adequacy: Solute	Outcome	0323	NQF QPS
Diabetes/CKD	Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute	Outcome	0321	NQF QPS
Diabetes/CKD	Adult Kidney Disease: Advance Directives Completed	Outcome	9999	CMS
Diabetes/CKD	Adult Kidney Disease: Blood Pressure Management	Intermediate Outcome		CMS
Diabetes/CKD	Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis	Outcome		CMS
Diabetes/CKD	Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days	Outcome		CMS
Diabetes/CKD	Adult Kidney Disease: Discussion of Advance Care Planning	Process	9999	CMS
Diabetes/CKD	Adult Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level <10g/dL	Outcome	9999	CMS
Diabetes/CKD	Adult Kidney Disease: Hemodialysis Adequacy: Solute	Outcome	0323	CMS
Diabetes/CKD	Adult Kidney Disease: Laboratory Testing (Lipid Profile)	Process	1668	NQF QPS
Diabetes/CKD	Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute	Outcome	0321	CMS
Diabetes/CKD	Adult Kidney Disease: Transplant Referral	Process	9999	CMS
Diabetes/CKD	Advanced Chronic Kidney Disease (CKD): Percent of Patients with Documentation That Education Was Provided.			AHRQ
Diabetes/CKD	Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	Process	1662	NQF QPS
Diabetes/CKD	Assessment of Iron Stores	Process	0252	NQF QPS
Diabetes/CKD	Avoidance of Utilization of High Ultrafiltration Rate (>/= 13 Ml/Kg/Hour)	Process	2701	NQF QPS
Diabetes/CKD	Bloodstream Infection in Hemodialysis Outpatients	Outcome	1460	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Diabetes/CKD	CKD - Lipid Profile Monitoring	Process	0626	NQF QPS
Diabetes/CKD	CKD with LDL Greater Than or Equal to 130 – Use of Lipid Lowering Agent	Process	0627	NQF QPS
Diabetes/CKD	CKD, Diabetes Mellitus, Hypertension and Medication Possession Ratio for ACEI/ARB Therapy	Process	0550	NQF QPS
Diabetes/CKD	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	Outcome: PRO	0209	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care	Composite	0731	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 Mm Hg)	Outcome	0061	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Eye Exam	Process	0055	CMS
Diabetes/CKD	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	Process	0055	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Foot Exam	Process	0056	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	Outcome	0575	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Outcome	0059	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Process	0057	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C)	Process	0057	CMS
Diabetes/CKD	Comprehensive Diabetes Care: Medical Attention for Nephropathy	Process	0062	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Percentage of Members 18 to 64 Years of Age with Diabetes (Type 1 and Type 2) Whose Most Recent Hemoglobin A1c (HbA1c) Level is Less Than 7.0% (Controlled).			AHRQ
Diabetes/CKD	Controlling High Blood Pressure	Outcome	0018	NQF QPS
Diabetes/CKD	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Process	0066	NQF QPS
Diabetes/CKD	Dehydration Admission Rate (PQI 10)	Outcome	0280	NQF QPS
Diabetes/CKD	Delivered Dose of Hemodialysis Above Minimum	Outcome	0249	NQF QPS
Diabetes/CKD	Delivered Dose of Pediatric Peritoneal Dialysis (PD) Above Minimum	Outcome		CMS
Diabetes/CKD	Delivered Dose of Peritoneal Dialysis Above Minimum	Outcome	0318	NQF QPS
Diabetes/CKD	Diabetes Composite	Composite	0729	CMS
Diabetes/CKD	Diabetes Long-Term Complications Admission Rate (PQI 03)	Outcome	0274	NQF QPS
Diabetes/CKD	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation	Process	0417	CMS
Diabetes/CKD	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention - Evaluation of Footwear	Process	0416	CMS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Diabetes/CKD	Diabetes Mellitus: High Blood Pressure Control		0729	CMS
Diabetes/CKD	Diabetes Short-Term Complications Admission Rate (PQI 01)	Outcome	0272	NQF QPS
Diabetes/CKD	Diabetes with Hypertension or Proteinuria - Use of an ACE Inhibitor or ARB	Process	0619	NQF QPS
Diabetes/CKD	Diabetes with LDL-C Greater Than 100 – Use of a Lipid Lowering Agent	Process	0618	NQF QPS
Diabetes/CKD	Diabetes: Foot Exam	Process	0056	CMS
Diabetes/CKD	Diabetes: Hemoglobin A1c Poor Control	Intermediate Outcome	0059	CMS
Diabetes/CKD	Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation	Process	0417	NQF QPS
Diabetes/CKD	Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear	Process	0416	NQF QPS
Diabetes/CKD	Diabetic Foot Care and Patient/Caregiver Education Implemented During All Episodes of Care	Process	0519	CMS
Diabetes/CKD	Diabetic Foot Care and Patient Education Implemented	Process	0519	NQF QPS
Diabetes/CKD	Diabetic Foot Care and Patient Education Implemented During Short Term Episodes of Care	Process		CMS
Diabetes/CKD	Diabetic Foot Care and Patient Education in Plan of Care	Process		CMS
Diabetes/CKD	Diabetic Foot Care and Patient/Caregiver Education Implemented During Long Term Episodes of Care	Process		CMS
Diabetes/CKD	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Process	0089	NQF QPS
Diabetes/CKD	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Process	0088	NQF QPS
Diabetes/CKD	Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care	Process	0520	NQF QPS
Diabetes/CKD	End Stage Renal Disease (ESRD): Percentage of a Facility's ESRD Patients Aged 18 Years and Older with Medical Record Documentation of a Discussion of Renal Replacement Therapy Modalities at Least Once During the 12-Month Reporting Period.			AHRQ
Diabetes/CKD	End Stage Renal Disease (ESRD): Percentage of a Physician's ESRD Patients Aged 18 Years and Older with Medical Record Documentation of a Discussion of Renal Replacement Therapy Modalities at Least Once During the 12-Month Reporting Period.	Process		AHRQ
Diabetes/CKD	End Stage Renal Disease (ESRD): Percentage of Medicare Patients with a Mean Hemoglobin Value Greater Than 12 G/dL.			AHRQ
Diabetes/CKD	End Stage Renal Disease (ESRD): Risk-Adjusted Standardized Transfusion Ration (STrR) for Dialysis Facility Patients			AHRQ
Diabetes/CKD	End-Stage Kidney Failure Due to Diabetes			HIW
Diabetes/CKD	End-Stage Kidney Failure: Diabetics			HIW

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Diabetes/CKD	ESRD- HD Adequacy CPM III: Minimum Delivered Hemodialysis Dose for ESRD Hemodialysis Patients Undergoing Dialytic Treatment for a Period of 90 Days or Greater.	Outcome	0250	NQF QPS
Diabetes/CKD	Family Evaluation of Hospice Care	Outcome: PRO	0208	NQF QPS
Diabetes/CKD	Glycemic Control - Hyperglycemia	Outcome	2362	NQF QPS
Diabetes/CKD	Glycemic Control - Hypoglycemia	Outcome	2363	NQF QPS
Diabetes/CKD	Hemodialysis (HD) Adequacy: Delivered Dose of Hemodialysis Above Minimum	Outcome	0249	CMS
Diabetes/CKD	Hemodialysis Adequacy Clinical Performance Measure I: Hemodialysis Adequacy- Monthly Measurement of Delivered Dose	Process	0247	NQF QPS
Diabetes/CKD	Hemodialysis Adequacy Clinical Performance Measure II: Method of Measurement of Delivered Hemodialysis Dose	Process	0248	NQF QPS
Diabetes/CKD	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous Fistula	Process	0259	NQF QPS
Diabetes/CKD	Hemodialysis Vascular Access: Long-Term Catheter Rate	Intermediate Clinical Outcome	2978	NQF QPS
Diabetes/CKD	Hemodialysis Vascular Access: Standardized Fistula Rate	Intermediate Clinical Outcome	2977	NQF QPS
Diabetes/CKD	Hemoglobin A1c (HbA1c) Testing for Pediatric Patients	Process	0060	NQF QPS
Diabetes/CKD	Hemoglobin Greater Than 12 G/dL	Process		CMS
Diabetes/CKD	High Risk for Pneumococcal Disease - Pneumococcal Vaccination	Process	0617	NQF QPS
Diabetes/CKD	Hospital Specific Risk-Adjusted Measure of Mortality or One or More Major Complications Within 30 Days of a Lower Extremity Bypass (LEB).	Outcome	0534	NQF QPS
Diabetes/CKD	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Outcome	1789	NQF QPS
Diabetes/CKD	Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data	Outcome	2879	NQF QPS
Diabetes/CKD	Hypercalcemia Clinical Measure	Outcome	1454	CMS
Diabetes/CKD	Hypertension Diagnosis and Treatment: Percentage of Adult Patients Age Greater Than or Equal to 18 Years Diagnosed with Chronic Kidney Disease Whose Blood Pressure is at SBP Less Than 140 mmHg and DBP Less Than 90 mmHg.			AHRQ
Diabetes/CKD	Influenza Immunization in the ESRD Population (Facility Level)	Process	0226	NQF QPS
Diabetes/CKD	Kt/V Dialysis Adequacy Comprehensive Clinical Measure	Outcome		CMS
Diabetes/CKD	LBP: Patient Education	Process	0307	NQF QPS
Diabetes/CKD	Maximizing Placement of Arterial Venous Fistula (AVF)	Outcome	0257	NQF QPS
Diabetes/CKD	Measurement of nPCR for Pediatric Hemodialysis Patients	Process	1425	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Diabetes/CKD	Measurement of Phosphorus Concentration	Process	0255	NQF QPS
Diabetes/CKD	Measurement of Serum Calcium Concentration	Process	0261	NQF QPS
Diabetes/CKD	Medical Evaluation: Chronic Kidney Disease & Diabetes Older Adults			HIW
Diabetes/CKD	Medication Reconciliation for Patients Receiving Care at Dialysis Facilities	Process	2988	NQF QPS
Diabetes/CKD	Method of Adequacy Measurement for Pediatric Hemodialysis Patients	Process	1421	NQF QPS
Diabetes/CKD	Mineral Metabolism Reporting Measure	Process		CMS
Diabetes/CKD	Minimizing Use of Catheters as Chronic Dialysis Access	Outcome	0256	NQF QPS
Diabetes/CKD	Minimum Delivered Peritoneal Dialysis Dose	Outcome	2704	NQF QPS
Diabetes/CKD	Minimum spKt/V for Pediatric Hemodialysis Patients	Outcome	1423	NQF QPS
Diabetes/CKD	Monitoring Hemoglobin Levels Below Target Minimum	Outcome	0370	NQF QPS
Diabetes/CKD	Monthly Hemoglobin Measurement for Pediatric Patients	Process	1424	NQF QPS
Diabetes/CKD	National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Patients Clinical Measure	Outcome		CMS
Diabetes/CKD	Non-Diabetic Nephropathy - Use of ACE Inhibitor or ARB Therapy	Process	0621	NQF QPS
Diabetes/CKD	Optimal End Stage Renal Disease (ESRD) Starts	Process	2594	NQF QPS
Diabetes/CKD	Patient Education Awareness—Facility Level	Process	0324	NQF QPS
Diabetes/CKD	Patient Education Awareness—Physician Level	Process	0320	NQF QPS
Diabetes/CKD	Pediatric Kidney Disease : ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL	Outcome	1667	NQF QPS
Diabetes/CKD	Pediatric Kidney Disease: Adequacy of Volume Management	Process		CMS
Diabetes/CKD	Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/V	Outcome	2706	NQF QPS
Diabetes/CKD	Percent of Residents with a Urinary Tract Infection (Long-Stay)	Outcome	0684	NQF QPS
Diabetes/CKD	Percentage of Medicare Patients at a Provider/Facility Who Have an Average Hemoglobin Value Less Than 10.0 G/dL	Outcome		CMS
Diabetes/CKD	Periodic Assessment of Post-Dialysis Weight by Nephrologists	Process	1438	NQF QPS
Diabetes/CKD	Peritoneal Dialysis Adequacy Clinical Performance Measure I - Measurement of Total Solute Clearance at Regular Intervals	Process	0253	NQF QPS
Diabetes/CKD	Peritoneal Dialysis Adequacy Clinical Performance Measure II - Calculate Weekly KT/Vurea in the Standard Way	Process	0254	NQF QPS
Diabetes/CKD	Peritoneal Dialysis Adequacy: Delivered Dose of Peritoneal Dialysis (PD) Above Minimum	Outcome	0318	CMS
Diabetes/CKD	Potentially Harmful Drug-Disease Interactions in the Elderly	Process	2993	NQF QPS
Diabetes/CKD	Primary Prevention of Cardiovascular Events in Diabetics – Use of Aspirin or Antiplatelet Therapy	Process	0632	NQF QPS
Diabetes/CKD	Proportion of Patients Hospitalized with Pneumonia That Have a Potentially Avoidable Complication (During the Index Stay or in the 30-Day Post-Discharge Period)	Outcome	0708	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Diabetes/CKD	Proportion of Patients Hospitalized with Stroke That Have a Potentially Avoidable Complication (During the Index Stay or in the 30-Day Post-Discharge Period)	Outcome	0705	NQF QPS
Diabetes/CKD	Proportion of Patients with Hypercalcemia	Outcome	1454	NQF QPS
Diabetes/CKD	Risk-Adjusted Average Length of Inpatient Hospital Stay	Outcome	0327	NQF QPS
Diabetes/CKD	Risk-Adjusted Postoperative Renal Failure	Outcome	0114	NQF QPS
Diabetes/CKD	Risk-Adjusted Standardized Mortality Ratio for Dialysis Facility Patients	Outcome	0369	CMS
Diabetes/CKD	Risk-Standardized Acute Admission Rates for Patients with Diabetes	Outcome	2887	NQF QPS
Diabetes/CKD	Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions	Outcome	2888	NQF QPS
Diabetes/CKD	Standardized Hospitalization Ratio for Admissions	Outcome	1463	CMS
Diabetes/CKD	Standardized Mortality Ratio for Dialysis Facilities	Outcome	0369	NQF QPS
Diabetes/CKD	Standardized Readmission Ratio (SRR) Clinical Measure	Outcome	2496	CMS
Diabetes/CKD	Standardized Readmission Ratio (SRR) for Dialysis Facilities	Outcome	2496	NQF QPS
Diabetes/CKD	Standardized Transfusion Ratio (STrR) Clinical Measure	Outcome		CMS
Diabetes/CKD	Standardized Transfusion Ratio for Dialysis Facilities	Outcome	2979	NQF QPS
Diabetes/CKD	Statin Use in Persons with Diabetes	Process	2712	NQF QPS
Diabetes/CKD	Ultrafiltration Rate > 13 Ml/Kg/Hr.	Process		CMS
Diabetes/CKD	Uncontrolled Diabetes Admission Rate (PQI 14)	Outcome	0638	NQF QPS
Diabetes/CKD	Urinary Tract Infection Admission Rate (PQI 12)	Outcome	0281	NQF QPS
Diabetes/CKD	Use of Iron Therapy for Pediatric Patients	Process	1433	NQF QPS
Diabetes/CKD	Vascular Access Type - AV Fistula Clinical Measure	Process	0257	CMS
Diabetes/CKD	Vascular Access Type Â€“ Catheter >= 90 Days Clinical Measure	Outcome	0256	CMS
Diabetes/CKD	Vascular Access—Catheter Vascular Access and Evaluation by Vascular Surgeon for Permanent Access.	Process	0262	NQF QPS
Diabetes/CKD	Vascular Access—Functional Arteriovenous Fistula (AVF) or AV Graft or Evaluation for Placement	Process	0251	NQF QPS
Infant Mortality	Accidental Puncture or Laceration Rate (PDI #1)	Outcome	0344	NQF QPS
Infant Mortality	Admission to Neonatal Intensive Care Unit at Term.	Outcome	0747	NQF QPS
Infant Mortality	Adverse Outcome Index	Composite	1769	NQF QPS
Infant Mortality	Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery	Process	0473	NQF QPS
Infant Mortality	Appropriate Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision – Cesarean Section.	Process	0472	NQF QPS
Infant Mortality	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Process	0069	NQF QPS
Infant Mortality	Birth Risk Cesarean Birth Measure	Outcome	2892	NQF QPS
Infant Mortality	Birth Trauma	Outcome	0742	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Infant Mortality	Birth Trauma – Injury to Neonate (PSI 17)	Outcome	0474	NQF QPS
Infant Mortality	Blood Folate Concentration: Reproductive-Aged Women			HIW
Infant Mortality	CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI) Event	Outcome	1773	NQF QPS
Infant Mortality	Children with MSI Who Underwent Surgery Under Continued Anesthesia Immediately Following Sedated		2823	NQF QPS
Infant Mortality	Counseling for Women of Childbearing Potential with Epilepsy	Process	1814	NQF QPS
Infant Mortality	Diabetes and Pregnancy: Avoidance of Oral Hypoglycemic Agents	Process	0582	NQF QPS
Infant Mortality	Duration of Sedated MRI for Children with Suspected Deep Musculoskeletal Infection		2825	NQF QPS
Infant Mortality	End Stage Renal Disease (ESRD): Percentage of Patient Months for All Pediatric (< 18 Years Old) in-Center Hemodialysis Patients in Which the Delivered Dose of Hemodialysis (Calculated from the Last Measurement of the Month Using the UKM or Daugirdas II Formula) Was spKt/V ≥ 1.2.	Outcome		AHRQ
Infant Mortality	Fetal Deaths			HIW
Infant Mortality	First NICU Temperature < 36 Degrees Centigrade	Outcome	0482	NQF QPS
Infant Mortality	First Temperature Measured Within One Hour of Admission to the NICU.	Process	0481	NQF QPS
Infant Mortality	Folic Acid Intake: Reproductive-Aged Women			HIW
Infant Mortality	Frequency of Adequacy Measurement for Pediatric Hemodialysis Patients	Process	1418	NQF QPS
Infant Mortality	Gastroenteritis Admission Rate (PDI 16)	Outcome	0727	NQF QPS
Infant Mortality	Group B Streptococcal Disease: Newborns			HIW
Infant Mortality	Healthy Weight Prior to Pregnancy			HIW
Infant Mortality	Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge	Process	0475	NQF QPS
Infant Mortality	HIV/AIDS: CD4 Cell Count or Percentage Performed	Process	0404	NQF QPS
Infant Mortality	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	Process	0405	NQF QPS
Infant Mortality	HIV/AIDS: Tuberculosis (TB) Screening	Process	0408	NQF QPS
Infant Mortality	Hospital Inpatients’ Experiences: Percentage of Parents Who Reported How Often They Got Prompt Help When They Pressed the Call Button.	Consumer Experience		AHRQ
Infant Mortality	Hospital Standardized Mortality Ratio (HSMR): the Ratio of the Actual Number of Acute in-Hospital Deaths to the Expected Number of in-Hospital Deaths, for Conditions Accounting for About 80% of Inpatient Mortality.	Outcome		AHRQ
Infant Mortality	Iatrogenic Pneumothorax Rate (PDI 5)	Outcome	0348	NQF QPS
Infant Mortality	Incidence of Episiotomy	Process	0470	NQF QPS
Infant Mortality	Infant Deaths Due to Birth Defects			HIW
Infant Mortality	Influenza Immunization in the ESRD Population (Facility Level)	Process	0226	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Infant Mortality	In-Hospital Neonatal Death	Outcome	0746	NQF QPS
Infant Mortality	In-Hospital Maternal Deaths	Outcome	0743	NQF QPS
Infant Mortality	Initial Risk Assessment for Immobility-Related Pressure Ulcer Within 24 Hours of PICU Admission		3005	NQF QPS
Infant Mortality	Inpatient Perinatal Care: Percent of Live-Born Neonates Less Than 2,500 Grams That Have a Temperature Documented Within 15 Minutes After Their Arrival to a Level 2 or Higher Nursery.	Process		AHRQ
Infant Mortality	Inpatient Perinatal Care: Percent of Live-Born Neonates Less Than 2,500 Grams That Have a Temperature Documented Within the Golden Hour from Birth to 60 Minutes of Age.	Process		AHRQ
Infant Mortality	Inpatient Perinatal Care: The Number of Live-Born Neonates Less Than 2,500 Grams That Arrive to a Level 2 or Higher Nursery Whose Qualifying Temperature Falls Within the Criteria for That Stratum: Cold, Very Cool, Cool, Euthermic, and Overly Warm.			AHRQ
Infant Mortality	Intrapartum Antibiotic Prophylaxis for Group B Streptococcus (GBS)	Process	1746	NQF QPS
Infant Mortality	Late Sepsis or Meningitis in Neonates (Risk-Adjusted)	Outcome	0303	NQF QPS
Infant Mortality	Late Sepsis or Meningitis in Very Low Birth Weight (VLBW) Neonates (Risk-Adjusted)	Outcome	0304	NQF QPS
Infant Mortality	Maternal and Newborn Care: Proportion of Newborn Screening Samples That Were Unsatisfactory for Testing, by Submitting Hospital and Comparator Groups.	Process		AHRQ
Infant Mortality	Maternal and Newborn Care: Rate of Formula Supplementation from Birth to Discharge in Term Infants Whose Mothers Intended to Exclusively Breastfeed.	Process		AHRQ
Infant Mortality	Maternal Blood Transfusion	Outcome	0750	NQF QPS
Infant Mortality	Measurement of nPCR for Pediatric Hemodialysis Patients	Process	1425	NQF QPS
Infant Mortality	Method of Adequacy Measurement for Pediatric Hemodialysis Patients	Process	1421	NQF QPS
Infant Mortality	Minimum spKt/V for Pediatric Hemodialysis Patients	Outcome	1423	NQF QPS
Infant Mortality	Monthly Hemoglobin Measurement for Pediatric Patients	Process	1424	NQF QPS
Infant Mortality	Multivitamins/Folic Acid Use, Preconception			HIW
Infant Mortality	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Outcome	0138	NQF QPS
Infant Mortality	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	Outcome	0139	NQF QPS
Infant Mortality	Neonatal Blood Stream Infection Rate (NQI 03)	Outcome	0478	NQF QPS
Infant Mortality	Neonatal Immunization	Process	0485	NQF QPS
Infant Mortality	Neonatal Intensive Care All-Condition Readmissions	Outcome	2893	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Infant Mortality	Neonatal Zidovudine (ZDV) Prophylaxis: Percentage of Infants Born to HIV-Infected Women Who Were Prescribed ZDV Prophylaxis for HIV Within 12 Hours of Birth During the Measurement Year.	Process		AHRQ
Infant Mortality	Neonate Immunization Administration	Process	0145	NQF QPS
Infant Mortality	Operative Mortality Stratified by the 5 STAT Mortality Categories		0733	NQF QPS
Infant Mortality	Participation in a National Database for Pediatric and Congenital Heart Surgery	Structure	0734	NQF QPS
Infant Mortality	PC-01 Elective Delivery	Process	0469	NQF QPS
Infant Mortality	PC-02 Cesarean Birth	Outcome	0471	NQF QPS
Infant Mortality	PC-03 Antenatal Steroids	Process	0476	NQF QPS
Infant Mortality	PC-04 Health Care-Associated Bloodstream Infections in Newborns	Outcome	1731	NQF QPS
Infant Mortality	Pediatric All-Condition Readmission Measure	Outcome	2393	NQF QPS
Infant Mortality	Pediatric Computed Tomography (CT) Radiation Dose		2820	NQF QPS
Infant Mortality	Pediatric Kidney Disease : ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL		1667	NQF QPS
Infant Mortality	Pediatric Lower Respiratory Infection Readmission Measure		2414	NQF QPS
Infant Mortality	Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/V		2706	NQF QPS
Infant Mortality	Perinatal Care: Proportion of Infants Receiving Enteral Feedings Who Receive Any Human Milk, with or Without Fortifier or Formula, Within 24 Hours Before Discharge, Transfer, or Death.	Process		AHRQ
Infant Mortality	Perioperative Care: Percentage of Patients, Regardless of Age, Who Undergo a Procedure Under Anesthesia and Are Admitted to an ICU Directly from the Anesthetizing Location, Who Have a Documented Use of a Checklist or Protocol for the Transfer of Care from the Responsible Anesthesia Practitioner to the Responsible ICU Team or Team Member.	Process		AHRQ
Infant Mortality	Perioperative Care: Percentage of Patients, Regardless of Age, Who Undergo a Surgical Procedure Under Anesthesia Who Have Documentation That All Applicable Safety Checks from the World Health Organization (WHO) Surgical Safety Checklist Were Performed Before Induction of Anesthesia.	Process		AHRQ
Infant Mortality	Perioperative Care: Percentage of Patients, Regardless of Age, Who Undergo Central Venous Catheter (CVC) Insertion for Whom CVC Was Inserted with All Elements of Maximal Sterile Barrier Technique, Hand Hygiene, Skin Preparation and, If Ultrasound is Used, Sterile Ultrasound Techniques Followed.	Process		AHRQ
Infant Mortality	Perioperative Temperature Management	Process	0454	NQF QPS
Infant Mortality	Perioperative Temperature Management		2681	NQF QPS
Infant Mortality	PICU Severity-Adjusted Length of Stay	Outcome	0334	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Infant Mortality	PICU Standardized Mortality Ratio	Outcome	0343	NQF QPS
Infant Mortality	PICU Unplanned Readmission Rate	Outcome	0335	NQF QPS
Infant Mortality	Pneumocystis Carinii Pneumonia (PCP) Prophylaxis: Percentage of Eligible Infants with HIV-Exposure Who Were Prescribed PCP Prophylaxis in the Measurement Year.	Process		AHRQ
Infant Mortality	Pregnancy Test for Female Abdominal Pain Patients.	Process	0502	NQF QPS
Infant Mortality	Pregnant Women That Had HBsAg Testing.	Process	0608	NQF QPS
Infant Mortality	Pregnant Women That Had HIV Testing.	Structure	0606	NQF QPS
Infant Mortality	Pregnant Women That Had Syphilis Screening.	Process	0607	NQF QPS
Infant Mortality	Prenatal Anti-D Immune Globulin	Process	0014	NQF QPS
Infant Mortality	Prenatal Blood Group Antibody Testing	Process	0016	NQF QPS
Infant Mortality	Prenatal Blood Groups (ABO), D (Rh) Type	Process	0015	NQF QPS
Infant Mortality	Pressure Ulcer Rate (PDI 2)	Outcome	0337	NQF QPS
Infant Mortality	Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter (CVC)	Process	0464	NQF QPS
Infant Mortality	Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections		2726	NQF QPS
Infant Mortality	Proportion of Infants 22 to 29 Weeks Gestation Treated with Surfactant Who Are Treated Within 2 Hours of Birth.	Process	0484	NQF QPS
Infant Mortality	Pulmonary Resection: Percentage of Patients Undergoing Pulmonary Resection for Whom Forced Expiratory Volume in One Second (FEV_1) and Diffusing Capacity of Carbon Monoxide (DL_{CO}) Was Obtained Within 365 Days Before Lung Resection.	Process		AHRQ
Infant Mortality	RACHS-1 Pediatric Heart Surgery Mortality Rate (PDI 06)	Outcome	0339	NQF QPS
Infant Mortality	RACHS-1 Pediatric Heart Surgery Volume (PDI 7)	Structure	0340	NQF QPS
Infant Mortality	Retained Surgical Item or Unretrieved Device Fragment Count (PDI 03)	Outcome	0362	NQF QPS
Infant Mortality	Review of Unplanned PICU Readmissions	Process	0336	NQF QPS
Infant Mortality	Rh Immunoglobulin (Rhogam) for Rh Negative Pregnant Women at Risk of Fetal Blood Exposure.	Process	0652	NQF QPS
Infant Mortality	Risk-Adjusted Average Length of Inpatient Hospital Stay	Outcome	0327	NQF QPS
Infant Mortality	Risk-Adjusted Operative Mortality for Pediatric and Congenital Heart Surgery		2683	NQF QPS
Infant Mortality	Spinal Bifida			HIW
Infant Mortality	Standardized Adverse Event Ratio for Children < 18 Years of Age Undergoing Cardiac Catheterization	Outcome	0715	NQF QPS
Infant Mortality	Standardized Mortality Ratio for Neonates Undergoing Non-Cardiac Surgery	Outcome	0714	NQF QPS
Infant Mortality	Surgical Volume for Pediatric and Congenital Heart Surgery: Total Programmatic Volume and Programmatic Volume Stratified by the 5 STAT Mortality Categories	Structure	0732	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Infant Mortality	Thermal Condition of Low Birthweight Neonates Admitted to Level 2 or Higher Nurseries in the First 24 Hours of Life: A PQMP Measure	Outcome	2895	NQF QPS
Infant Mortality	Third or Fourth Degree Perineal Laceration	Outcome	0748	NQF QPS
Infant Mortality	Time from Triage to MRI for Children with Suspected Deep Musculoskeletal Infection		2824	NQF QPS
Infant Mortality	Transfusion Reaction Count (PDI 13)	Outcome	0350	NQF QPS
Infant Mortality	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain	process	0651	NQF QPS
Infant Mortality	Unanticipated Operative Procedure	Outcome	0749	NQF QPS
Infant Mortality	Unexpected Complications in Term Newborns	Outcome	0716	NQF QPS
Infant Mortality	Unplanned Maternal Admission to the ICU	Outcome	0745	NQF QPS
Infant Mortality	Use of Iron Therapy for Pediatric Patients	Process	1433	NQF QPS
Infant Mortality	Uterine Rupture During Labor	Outcome	0744	NQF QPS
Infant Mortality	Ventilator-Associated Pneumonia for ICU and High-Risk Nursery (HRN) Patients	Outcome	0140	NQF QPS
Infant Mortality	Ventriculoperitoneal (VP) Shunt Malfunction Rate in Children	Outcome	0713	NQF QPS
Infant Mortality	Ventriculoperitoneal (VP) Shunt Malfunction: Percentage of Initial VP Shunt Placement Procedures Performed on Children Between 0 and 18 Years of Age That Malfunction and Result in Shunt Revision Within 30 Days of Initial Placement.	Outcome		AHRQ
Mental Illness	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Intermediate Outcome	1879	NQF QPS
Mental Illness	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Process	1880	NQF QPS
Mental Illness	Alcohol & Other Drug Use Disorder Treatment at Discharge	Process		CMS
Mental Illness	Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge	Process		CMS
Mental Illness	Alcohol Drug Use: Assessing Status After Discharge			CMS
Mental Illness	Alcohol Screening and Follow-Up for People with Serious Mental Illness	Process	2599	NQF QPS
Mental Illness	Alcohol Use Brief Intervention	Process	1663	CMS
Mental Illness	Alcohol Use Screening	Process	1661	CMS
Mental Illness	Annual Parkinson's Disease Diagnosis Review	Process	9999	CMS
Mental Illness	Antidepressant Medication Management (AMM)	Process	0105	NQF QPS
Mental Illness	Antipsychotic Use in Children Under 5 Years Old	Process	2337	NQF QPS
Mental Illness	Antipsychotic Use in Persons with Dementia	Process	2111	NQF QPS
Mental Illness	Assessment of Integrated Care: Overall Score on the Site Self Assessment (SSA) Evaluation Tool			AHRQ
Mental Illness	Assessment of Integrated Care: Total Score for the "Integrated Services and Patient and Family-Centeredness" Characteristics on the Site Self Assessment (SSA) Evaluation Tool.			AHRQ
Mental Illness	Avoidance of Dopamine-Blocking Medications in Patients with Parkinson's Disease	Process	9999	CMS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Mental Illness	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness	Process	2601	NQF QPS
Mental Illness	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	1365	CMS
Mental Illness	Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation	Process	1364	NQF QPS
Mental Illness	Clinical Depression Screening and Follow-Up Reporting Measure	Process	9999	CMS
Mental Illness	Closing the Referral Loop: Receipt of Specialist Report			Wyoming's PCMH Program
Mental Illness	Cognitive Impairment Assessment Among Older Adults (75 Years and Older)	Process	9999	CMS
Mental Illness	Cognitive Impairment or Dysfunction Assessment for Patients with Parkinson's Disease	Process	9999	CMS
Mental Illness	Continuity of Pharmacotherapy for Alcohol Use Disorder	Process	3172	NQF QPS
Mental Illness	Continuity of Pharmacotherapy for Opioid Use Disorder	Process	3175	NQF QPS
Mental Illness	Counseling Patients with Parkinson's Disease About Regular Exercise Regimen	Process	9999	CMS
Mental Illness	Depression Care: Percentage of Patients 18 Years of Age or Older with Major Depression or Dysthymia Who Demonstrated a Response to Treatment 12 Months (+/- 30 Days) After an Index Visit.	Outcome	1885	AHRQ
Mental Illness	Depression Interventions Implemented During All Episodes of Care	Process		CMS
Mental Illness	Depression Interventions Implemented During Long Term Episodes of Care	Process		CMS
Mental Illness	Depression Interventions Implemented During Short Term Episodes of Care	Process		CMS
Mental Illness	Depression Interventions in Plan of Care	Process		CMS
Mental Illness	Depression Remission at Six Months	Outcome	0711	NQF QPS
Mental Illness	Depression Remission at Twelve Months	Outcome	0710	NQF QPS
Mental Illness	Depression Response at Six Months- Progress Towards Remission	Outcome	1884	NQF QPS
Mental Illness	Depression Response at Twelve Months- Progress Towards Remission	Outcome	1885	NQF QPS
Mental Illness	Depression Screening by Primary Care Providers: Adults			HIW
Mental Illness	Depression Utilization of the PHQ-9 Tool	Process	0712	NQF QPS
Mental Illness	Discharged to the Community with Behavioral Problems	Outcome		CMS
Mental Illness	Evaluation or Interview for Risk of Opioid Misuse	Process		CMS
Mental Illness	Follow-Up After Discharge from the Emergency Department for Mental Illness or Alcohol or Other Drug Dependence.	Process		CMS
Mental Illness	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence	Process	2605	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Mental Illness	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	Process		CMS
Mental Illness	Follow-Up After Hospitalization for Mental Illness: Percentage of Discharges for Patients 6 Years of Age and Older Who Were Hospitalized for Treatment of Selected Mental Illness Disorders and Who Had an Outpatient Visit, an Intensive Outpatient Service, or Partial Hospitalization with a Mental Illness Provider Within 30 Days of Discharge.	Process	0576	AHRQ
Mental Illness	Follow-Up After Hospitalization for Mental Illness: Percentage of Discharges for Patients 6 Years of Age and Older Who Were Hospitalized for Treatment of Selected Mental Illness Disorders and Who Had an Outpatient Visit, an Intensive Outpatient Service, or Partial Hospitalization with a Mental Illness Provider Within 7 Days of Discharge.	Process	0576	AHRQ
Mental Illness	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	Process	0108	CMS
Mental Illness	Gains in Patient Activation (PAM) Scores at 12 Months	Outcome	2483	NQF QPS
Mental Illness	HBIPS-1 Admission Screening	Process	1922	NQF QPS
Mental Illness	HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	Process	0560	NQF QPS
Mental Illness	HBIPS-6 Post Discharge Continuing Care Plan Created	Process	0557	NQF QPS
Mental Illness	HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge	Process	0558	NQF QPS
Mental Illness	Improvement in Anxiety Level	Outcome		CMS
Mental Illness	Improvement in Behavior Problem Frequency	Outcome		CMS
Mental Illness	Improvement in Confusion Frequency	Outcome		CMS
Mental Illness	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: A. Initiation, B. Engagement	Process	0004	NQF QPS
Mental Illness	Major Depressive Disorder (MDD): Percentage of Patients Aged 18 Years and Older with a Diagnosis of MDD Who Have a Depression Severity Classification and Who Receive, at a Minimum, Treatment Appropriate to Their Depression Severity Classification at the Most Recent Visit During the Measurement Period.			N/A
Mental Illness	Major Depressive Disorder: Suicide Risk Assessment	Process	0104	NQF QPS
Mental Illness	Medication Continuation Following Inpatient Psychiatric Discharge	Process	3205	NQF QPS
Mental Illness	Medication Reconciliation on Admission	Composite	3207	NQF QPS
Mental Illness	Mental Illness: Risk-Adjusted Rate of Readmission Following Discharge for a Mental Illness.	Cost/ Resource Use		AHRQ
Mental Illness	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Process	2800	NQF QPS
Mental Illness	Parkinson’s Disease Rehabilitative Therapy Options	Process	9999	CMS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Mental Illness	Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)		0726	AHRQ
Mental Illness	Patient Experiences of Psychiatric Care: Percent of Patients Who Responded Positively to the "Dignity" Domain on the Inpatient Consumer Survey (ICS).			AHRQ
Mental Illness	Patient Experiences of Psychiatric Care: Percent of Patients Who Responded Positively to the "Outcome of Care" Domain on the Inpatient Consumer Survey (ICS).			AHRQ
Mental Illness	Patient Experiences of Psychiatric Care: Percent of Patients Who Responded Positively to the "Participation in Treatment" Domain on the Inpatient Consumer Survey (ICS).			AHRQ
Mental Illness	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	Process		CMS
Mental Illness	Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department	Process	2806	NQF QPS
Mental Illness	Preventative Care and Screening: Screening for Depression and Follow Up Plan	Process	3132	NQF QPS
Mental Illness	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Process	0418	NQF QPS
Mental Illness	Preventive Care and Screening: Unhealthy Alcohol Use - Screening	Process	9999	CMS
Mental Illness	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Process	2152	CMS
Mental Illness	Preventive Care and Screening-Tobacco Use-Screening and Cessation Intervention (eMeasure)	Process	3185	NQF QPS
Mental Illness	Psychiatric Symptoms Assessment for Patients with Parkinson's Disease	Process	9999	CMS
Mental Illness	Querying About Parkinson's Disease Medication-Related Motor Complications	Process	9999	CMS
Mental Illness	Querying About Sleep Disturbances for Patients with Parkinson's Disease	Process	9999	CMS
Mental Illness	Querying About Symptoms of Autonomic Dysfunction for Patients with Parkinson's Disease	Process	9999	CMS
Mental Illness	Social-Emotional Support Lacking: Adults (Percent)			HIW
Mental Illness	Stabilization in Anxiety Level	Outcome		CMS
Mental Illness	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	Process	1664	NQF QPS
Mental Illness	Tobacco Use Screening and Follow-Up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	Process	2600	NQF QPS
Mental Illness	Treatment: Adults with Major Depressive Episode			HIW
Mental Illness	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	Process		CMS
Mental Illness	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Process	2801	NQF QPS

APPENDIX F:

Disparities Standing Committee and NQF Staff Roster

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APPENDIX G:

Public Comments

NQF received 64 comments from 17 organizations representing a variety of stakeholders. The table below includes the 64 public comments that were submitted on the draft report between July 21st and August 21st 2017. The Disparities Standing Committee discussed the public comments during the post-comment web meeting on August 30th and worked to address the comments and questions in the initial components of the roadmap. The comments submitted on the draft report were generally positive and represent seven themes: general comments, social risk factors, data and reporting, measure recommendations, effective interventions, measurement gaps, and specificity of recommendations.

Social Risk Factors

Several commenters expressed a desire to consider additional social risk factors, including health literacy and language as well as the intersectionality of these factors with the existing risk factors. Many comments specifically noted the desire for a greater focus on disability as a social risk factor. Others requested greater specificity when defining certain groups, especially Asian and Pacific Islander populations.

Data and Reporting

Comments that addressed data and reporting were supportive overall and generally addressed the first action, Identify and Prioritize Reducing Health Disparities. Comments highlighted issues that the Committee had previously addressed including small sample size and lack of data for addressing disparities and populations with social risk. Several methods of measurement were recommended including oversampling and multi-pooling across years to address small sample sizes. Commenters also expressed support for the Committee's recommendation for accountability and transparency. The Committee agreed that these methods could alleviate some of the data challenges. The report has been updated to reflect these suggestions.

Measure Recommendations

Several comments recommended additional measures to include in the report. One comment, which the Committee discussed specifically, noted that the measures were overly adult-focused and that the report included too few pediatric measures. The Committee agreed that the compendium of measures focuses on adults and mentioned that during earlier deliberations the Committee discussed and considered the effects of adverse childhood experiences and their impact on disparities.

Effective Interventions

Commenters provide suggestions for effective interventions to reduce disparities. One comment focused on dual eligible financial alignment demonstrations as an effective intervention. The Committee specifically addressed comments that called for the engagement of community-based organizations to link individuals to social services, supporting their inclusion in the report. The report has been updated to further highlight this intervention.

Measurement Gaps

Comments that highlighted measurement gaps focused on the dearth of measures from clinic-community linkages projects, specifically in the community and health system linkages sub-domain. The Committee agreed that more measures are needed to address these important areas of health equity measurement.

Specificity of Recommendations

One comment called for clearer language on certain pieces of the report including the sub-domains. These changes have been incorporated into the report. Another comment called for more specificity on the accountably entities to which the implementations strategies and recommendations would most apply. The comment requested additional recommendations or guidance on how providers at every level can work to reduce disparities. The comment also questioned how current methods used by CMS and others fairly report and pay for those health care systems and providers who care for at-risk populations. The Committee agreed that such clarifications are necessary and could be included in any future work of the Disparities Standing Committee.

Prioritize Disparities-Sensitive Measures

America's Health Insurance Plans

Richard Bankowitz

We support this provision.

Asian & Pacific Islander American Health Forum

Kathy Ko Chin

Overall, the Asian & Pacific Islander American Health Forum appreciates the intersectional framework the Committee took that is expansive and acknowledges disparities across race, ethnicity, health literacy, language and many other social factors that influence health. We agree that measurement burden is a valid concern and must be balanced against the obligation and necessity to have measures that identify and ultimately eliminate health and healthcare disparities. While there are valid and important considerations about patient privacy in the context of small populations, we encourage the Committee to consider adding that where such concerns may prevent the public reporting of data, that methodologies such as oversampling and multi-year pooling techniques be considered. Overall, we agree that even if such data cannot be reported publicly, that should not be an excuse for failing to collect and stratify data internally. This distinction is critical for small but growing populations, such as Asian Americans, Native Hawaiians and Pacific Islanders who face different disparities compared to other groups and experience different disparities within specific subgroups (e.g. Native Hawaiians compared to aggregated Asian Americans).

California Pan-Ethnic Health Network

Caroline Sanders

CPEHN appreciates the broad, intersectional framework the Committee provides which is expansive and acknowledges disparities across race, ethnicity, health literacy, language and many other social factors that influence health.

CPEHN appreciates the work of the Committee in demonstrating that it is possible to address health disparities while also alleviating measurement burden. We understand this is a very real barrier for health plans, hospitals and practitioners in engaging in this work. This was part of the challenge California's health benefit exchange faced when deciding how it would prioritize the elimination of health disparities as part of its quality improvement strategy. NQF's revised set of Disparities-Sensitive Measure Selection criteria (below) which we strongly support will help practitioners reduce measurement burden while identifying where to begin in addressing health disparities as part of quality improvement efforts:

The prevalence is great

Disparities are large and well-documented

There is strong evidence linking quality improvement to better health outcomes

The measures selected are actionable

The Criteria is intuitive, but also carefully laid out to assist those interested in achieving health equity in an evidence-based prioritization process that will result in measurable, demonstrable results.

We agree with the authors that even data for smaller subpopulations should be collected and stratified internally, even if data is too small to be publically reported for privacy reasons or lack of statistical significance. This is especially true for smaller subpopulations such as American Indian and Alaska Native (AIAN) and Asian and Pacific Islander

(API) where specific measures may yield very small numbers. This qualitative information is important and can still be used to inform interventions and improve the quality of care.

Community Catalyst

Ann Hwang, MD

The number of measures that currently exist can be challenging to navigate, we agree that measures should be prioritized in order to help facilitate quality data from providers and healthcare systems. However, while we agree that there is a proliferation of measures, there is also a serious lack of the “right” measures – measures that would more broadly capture system performance in a way that is meaningful to consumers. We note that the Institute of Medicine’s Vital Signs report (Vital Signs: Core Metrics for Health and Health Care Progress, 2015) suggested a slate of measures that are broad in their scope yet parsimonious in number. And we would emphasize the need to look beyond the health care sector in assessing quality and disparities.

Hassanah

Janice Tufte

I was involved with the federal mandated “Ten Year Plan to End Homelessness” specifically related to efforts in Washington State. I want to say that our initial successes were because of effective leadership and collaborative development of system implementation changes. I agree with Chin et al; “interventions employed by government, communities, organizations, and providers (with improved patient/individual outcomes as the ultimate target of interventions).14 By leveraging multiple stakeholders throughout the system, these interventions can lead to improved outcomes for people with social risk factors, helping to demonstrate measurable progress towards achieving health equity”

Justice in Aging

Georgia Burke

Justice in Aging endorses the Committee’s decision to prioritize measures that help to identify disparities and believes that the Committee’s approach to tackling these issues is a sound one. We support the Committee’s view that collecting stratifying data is critical to identifying disparities in ways that allow for targeted interventions. When small population sizes are involved, there are challenges, but it is important to find solutions and work-arounds. Otherwise health disparities can be masked.

SNP Alliance

Deborah Paone

We agree that it is important to prioritize disparities-sensitive measures. We appreciate the four criteria outlined to select such measures, however we note several challenges to using these criteria. First, populations with social risk factors are very diverse--in age, language, culture, medical, behavioral, functional conditions, community-level characteristics, and other conditions. Given this diversity of populations, we are concerned that there is not enough research to guide the answers to the four criteria/questions posed on prevalence, size, impact, and feasibility. For example, a condition may be prevalent among a subgroup of persons dually eligible—e.g., those under age 65 with a physical disability--where this condition is central to health outcomes and drives behavioral health management, social support, and medical care. However the same condition may not be prevalent among another subgroup of persons who are dually eligible—e.g., age 80+ with significant medical comorbidities or functional limitations. This leads to a key question: How will stratification of “at risk” groups be defined--to allow for meaningful application of the other criteria? Paucity of data and evidence comparing quality improvement efforts of meaningful “at-risk” subgroups to the group with “the highest quality ratings” will be the limiting factor in applying all of these criteria. This is a significant limitation. We would suggest three steps to begin: (1) greater attention to defining and stratifying population subgroups using clinical, functional AND social risk characteristics, (2) quality reporting for current measures applied to those subgroups (e.g., under current payment programs) done at the population subgroup level (i.e., compare ratings for similar population groups and to overall population). This could help illuminate measures that are sensitive to specific social risk factors (as well as highlight measure specification anomalies), or at least provide insight into current measures—are they indeed meaningful measures of quality for these population subgroups (stratified according to similar clinical, functional, and social risk characteristics)? After population stratification, (3) report the stratification mix by provider and plan. This will increase the utility of reporting—allowing for comparison of measurement results among organizations with similar population distributions. Such stratification would also help identify opportunities or promising practices for more tailored care or effective approaches to addressing unique subgroup issues that impact health status.

SPAN/Family Voices NJ

Lauren Agoratus

We support the set of criteria including prevalence, size of disparity, impact of quality process, and ease/feasibility of improving. We are concerned that some common measures such as disparities for those with developmental disabilities and even developmental screening inequities aren't listed, even though early intervention is the key to best outcomes. (Source: CDC https://www.cdc.gov/ncbddd/disabilityandhealth/features/unrecognizedpopulation.html.)

Summit Health Institute for Research and Education, Inc. (SHIRE)

Ruth Perot

SHIRE applauds the use of the intersectional framework the Committee created that is expansive and acknowledges disparities across race, ethnicity, health literacy, language and many other social factors that influence health. We agree that measurement burden is a valid concern and must be balanced against the obligation and necessity to have measures that identify and ultimately eliminate health and health care disparities. While there are valid and important considerations about patient privacy in the context of small populations, we encourage the NQF to consider adding language to the effect that such concerns can be ameliorated by using such methodologies as oversampling and multi-year pooling techniques. We agree that even if such data cannot be reported publicly, that should not be a rationale for failing to collect and stratify data internally. This distinction is critical for small but growing populations, such as Asian Americans, Native Hawaiians and Pacific Islanders, as well as subgroups of African descent, such as Ethiopians, who may face different disparities compared to other groups and experience different disparities within the racial/ethnic categories to which they belong.

Identify Evidence-Based Interventions to Reduce Disparities

America's Health Insurance Plans

Richard Bankowitz

We support this provision.

Asian & Pacific Islander American Health Forum

Kathy Ko Chin

Overall, the Asian & Pacific Islander American Health Forum agrees that reducing disparities requires multi-level and sectorial interventions that address both resources, knowledge and institutional systems. As discussed throughout the Report, we note the critical nature and voice that persons who are directly impacted (patients and their caregivers/families) must have at different levels in disparity reduction programs to ensure such programs are responsive to their needs and ultimately address the various factors that influence health. Further, we welcome the need for interventions that address both racial and ethnic disparities, but also the intersections with health literacy, language, disability, income, education, etc. as a recognition that patients are whole people who experience multiple factors that influence their health in different ways.

California Pan-Ethnic Health Network

Caroline Sanders

CPEHN appreciates the Committee's decision to modify the Social-Ecological Model (SEM) to better apply to health systems. The need for interventions employed by government, communities, organizations and providers has been clearly demonstrated by Chin et al. We agree with the Committee that leveraging multiple stakeholders throughout the system can improve outcomes for people with social risk factors.

We also agree with the Committee that intersectionality is important. As individuals and communities, we each hold different identities, relating to such factors as our race and ethnicity, language, gender, age, sexual orientation, national origin and ability. As multi-identity, multi-cultural individuals and communities, we encounter systems differently, in ways that either support or hinder our health. We appreciate the expansive nature of the Committee's spectrum which focuses on disparities beyond race and ethnicity to include age, gender, income, nativity, language, sexual orientation, gender identity, disability and geographic location amongst other social risk factors. Because of these multiple and at times overlapping identities, we strongly support the idea espoused by the Committee of addressing disparities for more than one social risk factor.

Community Catalyst

Ann Hwang, MD

As stated in the report, findings from the literature review on evidence based interventions to reduce disparities demonstrate need for further investment in research and pilot projects to better understand the mediators of disparities. We believe that this is a critical step to create a validated evidence base to develop meaningful measures.

Hassanah

Janice Tufte

I think it is very important to develop measures that address improving our health systems to effectively tackle disparities in populations with social risk factors. It is true most measures are written focusiing on individual patients' engagement, lifestyle and activation. I am of the belief that changing the culture of the health system with "buy in from the top",support of clinic and insttution change champions, should move equitable research and cultue change along faster.

I appreciate the mention of encoraging future research specifically looking at individuals with differing abilities (disabiities), income levels, social networks, comunity context and health literacy. These are very important areas to develop as comparators within the individuals who live in the same area (zip code), and or from the same population to derive some significant findings that might be utilized for common good, better health and health care outcomes

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Justice in Aging

Georgia Burke

Justice in Aging particularly appreciates the recognition in this section of the report on the importance of tailored interventions, many of which are not purely medical. For low-income older adults, issues of economic security, access to stable affordable housing, and reliable transportation to medical appointments are critical to positive health outcomes. In the dual eligible financial alignment demonstrations that CMS currently is undertaking, there has been an emphasis on care coordination that includes help for beneficiaries to access housing, food service, transportation, pest control and other services. See CMS, Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative (March 2017) at 16-17, available at cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CareCoordinationIssueBrief508032017.pdf Person-centered approaches that are culturally competent and language concordant are key and must be tested and evaluated.

SNP Alliance

Deborah Paone

We wholeheartedly agree with the Committee's findings that there needs to be significantly more resources focusing on developing and testing integrated approaches and interventions at the system level—across settings, disciplines, and services—that are tailored to meaningful population subgroups and take into account community and organizational context. These interventions need to take into account the multiple chronic conditions, functional limitations, and social risk factors that characterize the population subgroups. We have noted that these population subgroups need to be defined with as much specificity as possible to be meaningful and to guide efforts to address the multiple factors that impact health outcomes. Implementation and quality evaluation of such interventions or approaches would need to attend to the interaction between person, conditions, characteristics, and context. While challenging, this is work that is desperately needed to guide efforts to tailor care, increase positive health outcomes, and reduce health disparities.

Population stratification—using information to more effectively group individuals with similar medical, behavioral, long-term care, AND social risk factors—offers the opportunity for tailoring care and support. Care approaches being developed and best practices already tested need to take into account functional and social risk factors in addition to medical/clinical diagnoses. Those developing "best practice" programs or models need guidance to ensure robust examination and reporting of their testing results among various population subgroups (consistently defined) in order to highlight similarities or differences arising from population characteristics—independent of the program model. There may need to be customized tailoring of "best practices" to accommodate differences within the population—in order to achieve intended results. Guidance on program translation and customization of program approaches will help ensure fidelity, while also recognizing the diversity of intended population groups.

SPAN/Family Voices NJ

Lauren Agoratus

We are concerned that the literature review focuses on outcomes "in populations socially at risk" but "existing interventions…focus on patient education, lifestyle modification, and culturally tailored programs. Far fewer…address…social risk factors." We acknowledge that targets are "based on race and ethnicity" but are concerned that "few…are based on disability status…health literacy." As previously mentioned, we know that there are health disparities for individuals with disabilities. In addition, health literacy is the single largest factor affecting health care access. We appreciate the acknowledgement that multiple conditions increases risk.

Summit Health Institute for Research and Education, Inc. (SHIRE)

Ruth Perot

SHIRE agrees that reducing disparities requires multi-level interventions that address resources, knowledge and institutional systems. As discussed throughout the Report, we note the critical nature and voice that persons who are directly impacted (patients and their caregivers/families) must have at different levels in disparity reduction programs to ensure such programs are responsive to their needs and ultimately address the various factors that influence health. Further, we welcome interventions that address both racial and ethnic disparities, but also the intersections with health literacy, language, disability, income, education, etc. as a recognition that health care consumers patients have many experiences that influence their health in different ways.

Select and Use Health Equity Performance Measures

America's Health Insurance Plans

Richard Bankowitz

We support this provision and the domains of health equity performance measurement described in the report. We feel it would be helpful to develop standardized performance measures in these areas to facilitate collaboration between health plans, providers, and other stakeholders. The committee should also provide guidance on how to demonstrate that measurement goals are being met, how to distinguish between good and poor performance, and how to determine the impact of measurement. Measures that address structure for equity, culture of equity and partnerships and collaboration are much harder to identify compared to measures that address high-quality care and access to care.

Asian & Pacific Islander American Health Forum

Kathy Ko Chin

We at the Asian & Pacific Islander American Health Forum welcome the scanning of existing performance measures that can be used in quality improvement programs. Such measures aim to minimize measurement burden on covered entities, while leveraging existing measurement infrastructure. In addition, we appreciate the identification and consideration given to gaps in measures that must be developed. We encourage NQF to consider, as done with this Report, broad stakeholder input in the development of such measures to address these gaps. Similarly, we welcome the explicit emphasis and inclusion of community, educational and other entities, who while not traditionally part of the healthcare delivery system, play a role in achieving health equity and provide critical supports to patients.

We strongly support the finalization of four domains of health equity. In particular, we emphasize the "Collaborate with other organizations or entities that influence the health of individuals" and inclusion of measures that address the social determinants of health in concrete and actionable ways. One such area is the community and services linkage, which has the potential to improve quality for persons who are limited English proficient. As outlined in our "Connecting Limited English Proficient Indviudals to Healthcare Systems Report," (available at www.apiahf.org), there is a recognition amongst various sectors of the need to include community-based organizations (CBOs) within the healthcare system, yet operational challenges to doing so.

CBOs and other trusted community partners play a vital role in supporting a person's "whole health" as they relate to language access, faith, mental and social support, education, financial security, etc. As noted in the Report, it is critical that there be collaboration and linkage amongst health providers of different types and amongst those who are in non-health/non-clinical areas. Such non-health/non-clinical entities provide essential services that are often not reimbursed by many payers (public or private), including patient navigation at the onset of enrollment, selection of appropriate primary care provider, resolution of and filing of appeals and other benefits claims. In addition, CBOs, for example, help patients understand what services are covered by their plans, provide assistance with scheduling appointments and help them obtain prescription drugs. These services are often provided with little to no reimbursement or resources to the CBO and are relied upon by racial and ethnic minorities and those with limited literacy, health literacy and English proficiency.

Although more LEP individuals have coverage, language continues to present a significant barrier when accessing health care services. Spoken language differences between patient and provider, the lack of appropriate interpretation services, and inadequate translated materials for patients all contribute to communication barriers that adversely affect health outcomes and contribute to the existence of health disparities. Patients who are LEP are less likely to seek care, even when insured, and experience lower quality of care and more adverse health outcomes, such as longer hospital stays and a greater chance of hospital readmission for certain chronic conditions, compared to those who speak English well. Many of those who need interpretation services are not aware of their rights to receive language assistance at a hospital or clinic.

CBOs serving Asian American, Native Hawaiian and Pacific Islander (AA and NHPI) communities often focus on providing services to specific AA and NHPI ethnic subgroups that are most represented in the community. Others provide services for segments in a community, such as immigrants and refugees, that often have a large proportion of individuals who came to the U.S. from an Asian or Pacific Island nation. Many of these individuals are LEP, and therefore CBOs frequently have multilingual staff and volunteers who come from the community with the necessary cultural understand to competently provide in-language assistance to the individuals they serve.

CBOs can function as a hub for LEP individuals who want to access care, but who need culturally and linguistically appropriate assistance to navigate the health care system. Although CBO staff may not be certified community health workers (CHWs), they still provide culturally competent in-language enrollment assistance and assistance in helping people access care and navigate the health care system. CBOs can serve as important members of a care coordination system designed to improve health care access and quality for LEP individuals and receive compensation for services provided by staff, just as CHWs are compensated for helping individuals navigate the health care system. This compensation could come in the form of contracts between CBOs and hospitals, insurers, and provider networks in which CBO staff provide interpretation and health system navigation for LEP individuals. Health plans could contract with CBOs to help their LEP members find providers, describe services covered under their plan, make appointments with providers, and provide interpretation assistance during clinic visits.

With respect to the "Culture of Equity" subdomain, we support protecting access to care though critical public programs, including Medicaid and the Children's Health Insurance Program (CHIP). Similarly, with respect to "Equitable Access to Care," we welcome the addition of language accessibility as a measurement and strongly agree with equity in access to care as being a core tenant in achieving health equity.

With respect to the "Structures of Equity" subdomain, we agree with the integrated nature of data, both in terms of collection, reporting and analysis and having the systems and infrastructure in place to support robust, timely and accurate data collection.

Overall, the equity measures provide concrete ways to operationalize a drive to improve health equity and should be leveraged so that payers have an incentive to integrate them into their quality improvement programs. These measures are critical to assessing progress and eventually, as the report notes, creating incentives for adoption.

California Pan-Ethnic Health Network

Caroline Sanders

CPEHN agrees with the need for disparities sensitive measures and measures that directly assess equity. We support including measures of Collaboration and Partnerships including collaboration across health and non-health sectors, community and health system linkages, building and sustaining social capital and social inclusion. We support the Committee's framework of measurement beyond clinical settings, structures, and processes of care to include for example, an assessment of collaboration between healthcare and other sectors (e.g., schools, social services, transportation, housing, etc.) to reduce the impact of social risk factors. A hospital may discharge a patient in "good condition." However without the social supports needed to recuperate such as adequate housing and access to healthy foods, that patient has a much higher likelihood of being readmitted.

As the Committee notes, "achieving equity is a process and that different organizations may be in different places in that process and have different resources available" (p. 11). The Committee's Domains of Health Equity Performance Measurement is a helpful tool as it takes into account these differences in organizational progress and capacity towards meeting these ambitious goals.

Community Catalyst

Ann Hwang, MD

We are pleased to see the following domains in the report as a way to achieve equity: collaboration and partnership, culture of equity, structure for equity, equitable access to care and equitable high-quality care. We note that there are critical gaps in the available measures in these domains, particularly for consumer-centered measures that capture overall system performance, and we urge NQF to create or identify measures that will more fully assess performance in these domains.

We are encouraged to see importance placed on stratifying outcome and process measures to identify disparities. We urge stratification by the spectrum of disparities identified on page 6 of the report.

Family HealthCare Center

Paul Nelson

Of the performance measures listed, there is a recurring emphasis on measures related to infant mortality. I found none related to maternal mortality. State by state, the last data set available is 2001-2006, maternal mortality rates are highly related to a state's poverty level. Given the UN/WHO/IMF report for 2015, our nation ranks 41st out of the 51 advanced/developed nation's. Given the best 10 of these nations, we would need to reduce our nation's maternal mortality incidence by 70% to rank among these nations. We are the ONLY developed nation with a worsening maternal mortality incidence for 25 years.

* Its possible that I missed a Lead Poisoning indicator. But if not, it is highly correlated with poverty.

Hassanah

Janice Tufte

Ensuring equitable access to care and actual equitable delivery of care are going to prove challenging from EHR patient portals to system non-interoperability. Patients involved with measurement subject matter prioritization, the development of equitable and balancing measures, will assist in ensuring that more relevant and effective measures will be utilized. Rural, Urban, Suburban health care providers and patients from diverse demographic, socio economic and nativity backgrounds should be involved.

RE Figure 4B Sub Domains: Community and Health System Linkages. I was a Patient Co-Investigator on the PCORI funded GHRI/ KPWHRI "Learning to Integrate Neighborhoods with Clinical Care-LINCC" project. I have noticed as missing measures from clinic-community linkages projects are the actual outcomes, documentation of useage, or utilization of community resorces once provided. If a CBO refers a client to a health system there is a record of some sort to gather data on, it is a bigger challenge to have a patient report back on if they have utilzed a community resource, and or access data from that CBO.

"Linking medical care with community services to connect patients to resources more effectively" how to measure this? A community liaison or community resource specialist might refer to local resources though that resource has perhaps dried up, or takes months or even years to access. One way to address this accessibility gap is to build and nurture valuable community partnerships that might come from unlikely corners sometimes.

Justice in Aging

Georgia Burke

In this section, Justice in Aging particularly appreciates the work of the Committee on the Culture of Equity domain and subdomains, the Equitable Access to Care domain and subdomains and the Equitable High Quality Care domain and subdomains. For dual eligible beneficiaries, who rely on both Medicare and Medicaid, improvements in these areas, and measures that track progress, are critically important. We strongly encourage continued measures development in these areas.

SNP Alliance

Deborah Paone

We support the Committee's recognition that to reduce disparities, factors outside of the healthcare system must be included. A growing body of evidence shows that community resources, education, employment, and the justice system can signficantly affect health status. These influences may persist over a lifetime or even over generations. Achieving health equity requires collaboration. Healthcare providers and plans in resource-poor communities, disproportionately serving low-income and social risk populations especially need help.

We appreciate the subdomains and the environmental scan to find relevant measures. The collaboration and partnership domain is an area of particular interest, specifically, the integration between care settings. Special needs plan members (consumers) frequently require home services, medical care, and behavioral health support. These "systems" of care are still largely separate (not integrated) and this fragmentation adversely affects these individuals. To integrate effectively, policy, regulatory, and payment changes are needed—for example allowing for streamlined information transfer across settings, paying for services outside of current benefit definitions, and identifying consumer decisions on goals that impact the ability to follow standard condition-based guidelines. States currently drive Medicaid benefit definitions for low-income individual and the federal government sets Medicare benefit criteria. When a person is in both these programs, there are overlapping and conflicting policies--this can impact what, how, and when the individual receives care. Quality measures also do not align.

We agree with Avedis Donabedian's framework for quality, attending to availability, accessibility, accommodation, amenability, and affordability—however many of the current "quality" measures, even when they focus on these issues, do not take into account the diversity of social risk populations and their ability to participate in quality surveys. For example, HOS or CAHPS self-report survey data has known limitations arising from: survey instrument and survey design elements that do not match the diverse dual population (e.g., 2-year look-back longitudinal survey), lack of robust language accommodation, inadequate methods of administration (assumes communication device, stability in residence, health or other literacy), and sampling (lack of oversampling of ethnic/language diverse populations)—all limitations which may bias results. We urge attention to refining these tools and methods to accommodate diverse and social risk populations. Then stratifying the results by social risk groups will be the second step to ensuring meaningful interpretation of results that could help drive health equity improvement.

SPAN/Famiy Voices NJ

Lauren Agoratus

We agree that equity can be achieved by "collaborating and partnering with other organizations." We would suggest partnering with federally funded Family-to-Family Health Information Centers which are family-staffed organizations that assist families of children with specialhealth care needs and the professionals who serve them. We also strongly support a "culture of equity." We agree this will be enhanced by creating "structures that support…equity, equitable access to healthcare, and high-quality care." We are concerned that "few measures assess data collection efforts to improve health equity."

Summit Health Institute for Research and Education, Inc. (SHIRE)

Ruth Perot

SHIRE welcomes the explicit emphasis and inclusion of community, educational and other entities, who while not traditionally part of the health care delivery system, play a role in achieving health equity and provide critical support to health care consumers.

Community based organizations and other trusted community partners play a vital role in supporting a person's "whole health" as they relate to language access, wellness promotion and disease prevention, mental and social support, education, financial security, etc. It is critical that there be collaboration and linkage among health providers of different types and among those who are in non-medical/non-clinical areas. Such entities provide essential services now that are often not reimbursed by many payers (public or private), including patient navigation at the onset of enrollment in coverage, selection of appropriate primary care provider, resolution of and filing of appeals and other benefits claims. In addition, CBOs, for example, help patients understand what services are covered by their plans, provide assistance with scheduling appointments and help them obtain prescription drugs, as well as such wellness promotion services as nutrition education, stress management, etc. These services are often provided with little to no reimbursement or resources to the CBO and yet are relied upon by racial and ethnic minorities and those with limited literacy and health literacy and English proficiency.

Language continues to present a significant barrier when accessing health care services. Spoken language differences between patient and provider, the lack of appropriate interpretation services, and inadequate translated materials for patients all contribute to communication barriers that adversely affect health outcomes and contribute to the existence of health disparities. Patients who are LEP are less likely to seek care, even when insured, and experience lower quality of care and more adverse health outcomes, such as longer hospital stays and a greater chance of hospital readmission for certain chronic conditions, compared to those who speak English well. Many of those who need interpretation services are not aware of their rights to receive language assistance at a hospital or clinic.

CBOs can serve as important members of a care coordination system designed to improve health care access and quality for LEP, Medicaid and other individuals with special needs. They should therefore be able to receive compensation for services provided by staff, just as community health workers and other outreach personnel are compensated for helping individuals navigate and fully benefit from the health care system. This compensation could come in the form of contracts between CBOs and hospitals, insurers, health plans, clinics and provider networks.

Incentivize the Reduction of Health Disparities and Achievement of Health Equity

America's Health Insurance Plans

Richard Bankowitz

We support this provision. We support the recommendation that health equity measures be incorporated into accountability programs and aligned across payers to facilitate adoption. We also support the recommendation that social determinants of health be an integral part of any efforts to address health disparities.

Asian & Pacific Islander American Health Forum

Kathy Ko Chin

The Asian & Pacific Islander American Health Forum agrees that data are the bedrock of all measures and ability to understand, access, monitor and eliminate disparities and that such data should be stratified to the greatest extent possible, using systems that create ease in operation as much as possible (e.g. social risk factors in electronic health records). We welcome the strong emphasis on the levels of stratification and levels from which data is collected: clinical (Claims or administrative; patient-reported data; community and systems level). Moreover, we underscore the Committee's recommendation on accountability and transparency. Public reporting of measures and activities is relevant not only to hold systems and providers accountable, but also empowers patients by providing them with information to take an active role in quality improvement and their care. It is difficult to imagine patients being able to play active, empowered roles in quality improvement without access to data most useful for the patient and provided in a form and manner that is responsive to patients (e.g. health literacy and linguistic competency).

APIAHF underscores performance measures can be used to continuously identify disparities in health and healthcare, used to hold various stakeholders accountable (providers, payers, policymakers) and to create incentives to reduce disparities and provide assistance to providers who are striving to improve quality and have a patient population that experiences a multitude of risk factors.

As such, we recognize the importance of adjusting for social risk factors in payment programs and share concern about both the burden on clinicians who disproportionately serve those with more social risk factors, while at the same time not creating lower standards for improving health outcomes in disadvantaged populations. We agree that one method of doing so is to directly adjust payment for social risk factors, stratify data across social risk factor groups to provide transparency and link health equity measures to accreditation programs.

Lastly, we strongly endorse the recommendation to conduct policy simulations and demonstration projects to test how interventions can mitigate disparities. For example, community-based organizations (CBO) represent a trusted and reliable connection to patients who come from diverse backgrounds, including those who are limited English proficient. We agree that there is a need to conduct such demonstration projects to determine how to effectively integrate CBOs into the healthcare delivery system, how to create sustainable funding models and ensure partnerships with payers and providers.

California Pan-Ethnic Health Network

Caroline Sanders

We agree with the Committee that financial incentives are an important policy lever to hold health plans, hospitals and providers accountable for reducing disparities and achieving health equity. Large payers like Medicaid and Medicare are increasingly turning to payment incentives as a strategy for improving quality by holding health plans, providers, and hospitals accountable for measurable results. We agree with the Committee that value-based purchasing represents a chance to reward providers for reducing disparities or for the use of effective interventions to reduce disparities as does the shift to global payment, capitated payment, and bundled payment.

Additionally we support the use of social and population health measures to ensure appropriate resource allocation to counteract the causes of social risk. We agree with the Committee that stratification of disparities-sensitive measures can promote transparency and help identify and address disparities.

Lastly, we strongly endorse the recommendation to conduct policy simulations and demonstration projects to test how interventions can mitigate disparities. Researchers for example with RWJ's Finding Answers: Disparities Research for Change project conducted an exhaustive review and evaluation of promising practices for reducing racial and ethnic disparities in care. These models should be encouraged and supported and the results widely shared.

California Pan-Ethnic Health Network

Caroline Sanders

We agree with the Committee that financial incentives are an important policy lever to hold health plans, hospitals and providers accountable for reducing disparities and achieving health equity. Large payers like Medicaid and Medicare are increasingly turning to payment incentives as a strategy for improving quality by holding health plans, providers, and hospitals accountable for measurable results. We agree with the Committee that value-based purchasing represents a chance to reward providers for reducing disparities or for the use of effective interventions to reduce disparities as does the shift to global payment, capitated payment, and bundled payment.

Additionally we support the use of social and population health measures to ensure appropriate resource allocation to counteract the causes of social risk. We agree with the Committee that stratification of disparities-sensitive measures can promote transparency and help identify and address disparities.

Lastly, we strongly endorse the recommendation to conduct policy simulations and demonstration projects to test how interventions can mitigate disparities.

Community Catalyst

Ann Hwang, MD

We are encouraged to see in the report detailed recommendations on incentivizing the reduction of disparities and achieving health equity. Promoting payment models that will address disparities with a goal to achieve health equity is a step in the direction of an equitable healthcare system for vulnerable populations.

Hassanah

Janice Tufte

This section is well thought out with very effective strategies and recomendations. Thank you I will read a couple times to digest the full report

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Justice in Aging

Georgia Burke

The Committee accurately notes that performance measurement is increasingly used for accountability including for determining payments under Medicare and Medicaid. Justice in Aging believes that this trend increases the importance of the work of the Committee, particularly the implementation strategies in this section. Looking at the policy recommendations in this section, we particularly support the recommendation of supporting organizations that disproportionately serve individuals with social risk factors. It is our experience that many safety net providers, though making do with inadequate funding, have developed innovative culturally competent programs and effective interventions to address disparities. Providing these programs with stable support at reasonable levels is important. It is important that payment models do not unfairly penalize them because they disproportionately serve the very populations that are most in need of culturally competent, qualify care.

SNP Alliance

Deborah Paone

We applaud the Committee for attending to the ASPE and NAM reports and recognizing the danger that current value based payment methods add to inequities in resource distribution. The safety net providers and plans that disproportionately serve low-income and social risk populations may be negatively impacted, as these independent research committees and experts have concluded. The Disparities Committee rightly points out that low reimbursement rates or lack of bonus payments can end up restricting resources to the providers and plans that are serving the most at-risk populations.

We particularly note the opportunities to add social complexity factors to risk adjustment and payment models and the need to support organizations that disproportionately serve these individuals with social risk factors (Strategies 2 and 3). The recommendations offer practical approaches that could be implemented under current statutory authority by the Secretary.

We agree that there needs to be standardization in data elements and definitions related to social risk factors. We note the existing challenges with accessing electronic health record information—additional technical support and capacity will be needed to effectively add and collect uniform social risk data. In addition, we note that individuals (consumers/patients) may resist the collection of some of these data elements—as they may not understand why or agree with the need for healthcare providers to have information about their employment, marital, education, or housing status. As others have pointed out, the need for person-level data to identify risk areas and address underlying issues that impact health status will have to be balanced with individual rights to privacy.

Plans and providers serving unique special needs populations may have small tailored programs that are customized to these unique groups. We hope that any collection or reporting of quality measurement data recognizes and respects the uniqueness of specialty populations and allows for accommodation in care. Small sample sizes within any one organization are a limitation, but pooling information may assist in quality improvement strategies. With a better understanding of the subgroups within populations--needs, characteristics, preferences, and what works--we will be able to more effectively target resources and tailor care.

SPAN/Famiy Voices NJ

Lauren Agoratus

We understand that “performance measurement is increasingly used for accountability.” However, what appears to be missing is that by reducing health disparities, the result is cost savings and more importantly, better health outcomes for underserved populations. We support the strategies developed to address equity through implementation of health equity measures, incentivized payment, support of organizations that disproportionately serve individuals with social risk factors, and demonstration projects.

Summit Health Institute for Research and Education, Inc. (SHIRE)

Ruth Perot

SHIRE agrees that data are the bedrock of all measures and are essential to understand, access, monitor and eliminate disparities. We concur that such data should be stratified to the greatest extent possible, using systems that create ease in operation as much as possible (e.g. social risk factors in electronic health records). We welcome the strong emphasis on the levels of stratification and levels from which data are collected: clinical claims or administrative data; patient-reported data; community and systems level data. Moreover, we underscore the Report’s recommendation on accountability and transparency. Public reporting of measures and activities is relevant not only to hold systems and providers accountable, but also empowers patients by providing them with information to take an active role in quality improvement and their care at the patient-level. It is difficult to imagine how patients might play active, empowered roles in quality improvement without access to data provided in a form (e.g. linguistically and culturally appropriate) that meets their needs.

SHIRE underscores the recommendation that performance measures can be used to continuously identify disparities in health and health care, used to hold various stakeholders accountable (providers, payers, policymakers) and to create incentives to reduce disparities and provide assistance to providers who are striving to improve quality and have a patient population that experiences a multitude of risk factors.

Lastly, we strongly endorse the recommendation to conduct policy simulations and demonstration projects to test how interventions can mitigate disparities. For example, community-based organizations (CBO) represent a trusted and reliable connection to patients who come from diverse backgrounds, including those who are limited

English proficient. We agree that there is a need to conduct such demonstration projects to determine how to effectively integrate CBOs into the health care delivery system, how to create sustainable funding models and ensure partnerships with payers and providers. For maximum effectiveness, these programs should be funded adequately and over a sufficient period of time to be able to document results.

Thank you for the opportunity to comment on this Report. If you have questions, please contact Ruth Perot, Executive Director/CEO at rperot@shireinc.org.

General Comments

ACL/NIDILRR

Amanda Reichard

Congratulations! You have made great strides in addressing the difficult task of reducing health and health care access disparities. The document is well-organized, easy to read, and comprehensive.

Please consistently include people with disabilities as a health disparity group of interest. Although this group is named in some places throughout the document, the document does not regularly use examples of the unique needs of individuals with disabilities and discussion of what solutions are necessary to eliminate disparities. As a result, people with disabilities are underemphasized, and as it is written now, the reader could easily forget this population as an important one for which to address health disparities.

The literature clearly documents the disparities experienced by this group (Krahn & Fox 2014; Reichard, Stolzle & Fox, 2011; Horner-Johson, et al., 2014), their disproportionately higher levels of health care need and cost (Reichard, Gulley, Rasch & Chan, 2015), and frequently provides evidence and suggested solutions to the group's unique needs (e.g. Krahn & Fox, 2014). However, this group typically does not receive a consummate level of attention in policy and practice as a health disparity group with substantial and frequently unique needs (Krahn, Walker, Correa-de-Araujo, 2016). Thus, it is crucial that we continue to work toward addressing health and health care disparities experienced by people with disabilities.

Below are some examples of where you could highlight the disability population more consistently throughout the document:

(p. 4). At the bottom of the second paragraph: add in a similar disability example. The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities (2005) is a great resource for such examples.

(p. 5). In the last paragraph before Project Overview, add into the sentence that begins "For example": implement universal design to improve physical access.

(p. 6). In the first paragraph under Measurement Framework, add in a sentence about disability with supporting documentation, (similar to what is written about race/ethnicity). The Surgeon General's Report (referenced above) and the Surgeon General's Report, Closing the Gap (2001), also provide great examples for use here.

(p. 9). Bottom of the last paragraph, it is important to specify the disparity groups here rather than listing them as "social risk".

(p. 13). Collaboration and Partnership: The subdomain "Build and sustain social capital and social inclusion" could benefit from some example concepts that highlight topics relevant to people with disabilities, specifically. Some ideas for inclusion:

Improvement of physical accessibility of housing, to improve ability of people with disabilities' to enter/exit their home, and to make houses in the community more visitable by people with physical limitations

Improvement of transportation (e.g., physical accessibility of public transit, greater affordable and reliable paratransit systems), to improve ability of people with disabilities ability participate in necessary health care activities (e.g., health promotion, health care visits, health education).

(p. 14). Safe and accessible environments for individuals from diverse backgrounds.

1. Recommend separating out accessibility from safety, and rename this subdomain to: "Safe environments for all."

2. Add new Subdomain could/should for accessibility; including it with safety minimizes its importance in establishing equity. However, this Subdomain should

be included under the Domain: Structure for Equity, as accessibility environments are critical to ensuring that people with disabilities can use all components of the environment (e.g., transportation, housing) necessary for managing, improving, and maintaining their health.

The title could be: Accessible environments. Example Concepts could include:

Systematic identification of physical access barriers related to receiving necessary care (e.g. transportation, health care buildings, examination tables)

Systematic identification of physical access barriers to health promotion activities (e.g. inaccessible exercise facilities, reliable/accessible transportation, inaccessible sidewalks)

(p. 14). Culture of Equity/Cultural Competency. This subdomain could benefit from a bullet addressing the need for Disability Etiquette competency.

(P. 14). Policies and procedures that advance equity. This subdomain could benefit from a bullet such as:
* Require cultural competency training, including disability etiquette

(p. 15). Structure for Equity/Collection of data to monitor the outcomes of individuals with social risk factors.

1. Recommend changing the name of this subdomain: Collection of data to monitor the outcomes of groups with known health disparities.

2. This subdomain's example concepts would benefit from a disability-related bullet, such as "Ensuring that metrics include means for accurately identifying the groups (especially disability identifiers) experiencing health disparities." Disability identifiers in surveys continue to presents barriers to monitoring outcomes for this population. (see Altman, 2014; Burkhauser et al., 2014; McDermott & Turk, 2011).

(p. 15). Systematic community needs assessments. I recommend adding a phrase such as "as well as additional equity priorities" to the end of the third bullet. Although it is very important to target interventions to the community-prioritized needs, the community may have blind spots for additional areas that must be addressed to create equity.

(p. 17). Use of effective interventions to reduce disparities in healthcare quality. Add a reference to expanding/changing programs designed to address the needs of people without disabilities to be able to accommodate people with disabilities (e.g. Rimmer et al).

(p. 20). I recommend adding in the highlighted words to the last bullet in the table:

Community outreach gatherings, public health screenings in accessible community settings

In addition, we strongly suggest that the report summarize the findings of the NQF HCBS Quality Group in the background section with an emphasis on the HCBS quality framework, quality domains, gaps analysis http://www.qualityforum.org/Measuring_HCBS_Quality.aspx

Finally, the section on cultural competency should include a broader discussion on the disparities cross-culturally. An emerging literature that refines cultural variation across an number of disciplines (e.g. cognitive psychology, sociology, anthropology, etc.) suggests that some of the things that are taken as human universals may not resonate well outside the relatively narrow cultural grouping of large scale industrialized, western societies. For instance, there is significant variation across the individual/collectivist continuum which may have implications for many aspects of health care conceptualization, delivery, and measurement.

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American Association on Health and Disability

E. Clarke Ross

Recognition of Disability

We appreciate the acknowledgement of persons with disabilities - Pages 2, 6, 10, 16. However, completely missing from the report is a discussion of disability as a disparity factor/consideration. We encourage the addition of a discussion of this topic. Such as discussion could include a summary of the following peer reviewed professional journal literature and related materials:

1. NQF disparities committee member, Lisa Iezzoni, M.D.. Among her many articles are April 2017 Disability and Health Journal on "Do prominent quality measurement surveys capture the concerns of persons with disabilities;" 2016 Disability and Health Journal on "Trends in Colorectal Cancer Screening Over Time for Persons with Chronic Disability;" and similar journal articles on breast cancer and disability, physical access barriers, and treatment disparities facing Medicare beneficiaries.

2. Former CDC NCBDDD division director Gloria Krahn, Ph.D. Among her many publications are February 2015 American Journal of Public Health on "Persons with Disabilities As An Unrecognized Health Disparity Population;" and September 8, 2015 CMS OMH health equity symposium presentation and resources on health inequity and persons with disabilities.

3. Froehlich-Grobe et al, October 2016 Disability and Health Journal on "Impact of Disability and Chronic Conditions on Health."

4. Henan Li, et al, March 2017 Disability and Health Journal on "Health of U.S. Parents with and without Disabilities."

5. Havercamp, et al, 2015 Disability and Health Journal on "National Health Surveillance of Adults with Disabilities, Adults with Intellectual and Development Disability, and Adults with No Disabilities."

6. Ohio Disability and Health Program 2015 free-standing publication with references, "The Double Burden: Health Disparities Among People of Color Living with Disabilities."

7. Network for Public Health Law-CDC 2017 webinar materials including April 20 on "The Built Environment as a Social Determinant of Health" and May 18 on "Housing as a Social Determinant of Health."

Further, an analysis of disparities should examine the NQF MAP December 2012 identified "high need" subgroups of persons dually eligible for Medicare and Medicaid: (1) persons with physical or sensory disabilities; (2) persons with serious mental illness and/or substance use disorder; (3) persons with cognitive impairment (e.g., dementia; intellectual disability and/or developmental disability); and (4) "medically complex adults age 65 or older with functional limitations and co-occurring chronic conditions."

Person and Family Centeredness and Experience of Care

We appreciate the pages 16-17 importance of person and family centeredness; page 21 recognition of NQF endorsed experience of care, including ECHO and CAHPS HCBS Experience of Care Survey; page 27 – the potential of CAHPS surveys on convenience, timeliness, and accessibility; and page 28 – the importance of Patient-Centered Medical Homes Patients' Experience and CAHPS HCBS Experience of Care Survey

When examining persons with disabilities, two disability quality measurement programs have each operated for over 20 years - the National Core Indicators and Personal Outcome Measures. These programs were initially designed for persons with intellectual and other developmental disabilities, but have evolved for other populations of persons with disabilities over recent years. Other NQF committees and workgroups have examined the NCI & POM and should be referenced in the disparities report.

Recognition of Mental Illness/Mental Health

Thank you for the pages 5, 24, 27, and 30 recognition of mental illness. We particularly applaud the page 19 focus – Gaps in the integration of physical and mental health and recognition of the SAMHSA 4 Quadrant Model.

Recognition of Low-Birth Rate

Thank you for the page 5 and 24-28 recognition of low-birth rate.

Importance of Collaboration Between Health Care and Community/Social Sectors

Particularly important are the page 7 importance of Collaboration Between Health Care and Community/Social Sectors; page 11 – Influence of Community Organizations; page 11 – health care sectors must collaborate and partner with other organizations and agencies that influence the health or individuals; page 13 – Collaboration Across Health and Health Care Sectors, Community and Health Systems Linkages, Social Inclusion; pages 18-20 discussion of Collaborations and Partnerships; and pages 36 & 37 – a step to incentivize the reduction of health disparities and achievement of health equity includes: (1) ensure that organizations that disproportionately serve individuals with social risk factors can compete in value-based purchasing, and (2) consider additional payment for organizations that fall outside the control of safety net organizations and providers.

Pivotal Role of Continuity of Care

Thank you for the page 27 identification of the pivotal role of continuity of care

Pivotal Role of Primary Care

We agree with the page 27 – pivotal role of primary care and page 34 – a step to incentivize the reduction of health disparities and achievement of health equity includes direct investment in preventive and primary care for patients with social risk factors

Population Health Management

We agree with the page 15 observation – importance of population health management – and pages 24-26 – need for better population health for individuals with social risk factors as an important measure gap.

American Association on Health and Disability and Lakeshore Foundation, part 3, Clarke Ross

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American Optometric Association

Christopher Quinn, O.D.

The American Optometric Association (AOA) appreciates the opportunity to comment on the draft report, “A Roadmap to Reduce Health and Healthcare Disparities through Measurement” from the National Quality Forum (NQF).

The AOA represents approximately 33,000 doctors of optometry and optometry students. Doctors of optometry are eye and vision care professionals who diagnose, treat and manage diseases, injuries and disorders of the eye, surrounding tissues and visual system and play a major role in a patient's overall health and well-being by detecting and helping to prevent complications of systemic diseases such as hypertension, cardiovascular disease, neurologic disease, and diabetes - the leading cause of acquired blindness. Doctors of optometry serve patients in nearly 6,500 communities across the country, and in 3,500 of those communities we are the only eye doctors available. Providing more than two-thirds of all primary eye and vision health care in the United States, doctors of optometry deliver up to 80 percent of all primary vision and eye health care provided through Medicaid. Recognized as Medicare physicians for more than 25 years, doctors of optometry provide medical eye care to nearly six million Medicare beneficiaries annually.

The AOA generally supports NQF's efforts to reduce disparities in health and health care. Eye and vision health is no different from the rest of health – disparities in both health and healthcare exist for a variety of reasons. Furthermore, a number of systemic diseases with disparate health outcomes and experiences for different groups manifest with ocular symptoms and doctors of optometry play a key role in the management of those diseases. Diabetes is a particular concern for our doctors - diabetic retinopathy, the most common microvascular complication of diabetes, is the leading cause of new cases of blindness and low vision for Americans ages 20 to 74 and accounts for about twelve percent of all new cases of blindness each year. [1] As the draft report identified, there are significant socioeconomic disparities in the prevalence of diabetes that must be addressed.

[1] Klein R, Klein B. Vision disorders in diabetes. In: National Diabetes Data Group, ed. Diabetes in America, 2nd ed. Bethesda, MD: National Institutes of Health, National Institutes of Diabetes and Digestive and Kidney Disease; 1995: 293-337

However, we are concerned that the eye exam measures for patients with diabetes that NQF identifies as part of the compendium of measures remain flawed, as we have expressed to NQF previously. NQF measure #0055, Comprehensive Diabetes Care: Eye Exam, measures the number of individuals who have had an eye exam in the measure year OR who had an eye exam that was negative for retinopathy in the previous measure year. This effectively endorses a schedule of an eye exam every two years for patients with diabetes, which is counter to current best practices for these patients. The evidence-based clinical practice guideline for Eye Care of the Patient with Diabetes Mellitus indicates that patients with diagnosed diabetes should receive a dilated, comprehensive eye exam at least annually and this frequency should be reflected in the NQF's quality measures. More frequent examination may be needed depending on changes in vision and the severity and progression of diabetic retinopathy. [2]

Relying on a flawed measure to improve disparities in care does a disservice to those the NQF is trying to help. The best way to improve the health outcomes of disadvantaged populations is to ensure that they're receiving the accepted standard of care – and the only way to know that is if the measures accurately reflect that standard. The AOA supports NQF's efforts to reduce disparities, but urges a critical review of the relied-upon measures.

[2] http://aoa.uberflip.com/i/374890-evidence-based-clinical-practice-guideline-diabetes-mellitus

America's Health Insurance Plans

Richard Bankowitz

We appreciate the compendium of measures by domain in Appendix D, and feel that providing a link to the measure specifications would be useful.

Asian & Pacific Islander American Health Forum

Kathy Ko Chin

The Asian & Pacific Islander American Health Forum (APIAHF) is the nation's leading health policy group working to advance the health and well-being of over 20 million Asian Americans, Native Hawaiians and Pacific Islanders (AAs and NHPIs) across the U.S. and territories. As such, APIAHF works to improve access to and the quality of care for communities who are predominately immigrant, many of whom are limited English proficient, and may be new to the U.S. health care system or unfamiliar with private or public coverage. APIAHF appreciates the opportunity to review and comment on the draft report "A Roadmap to Reduce Healthcare Disparities Through Measurement," (Report).

Overall, we wish to express our strong support for and adoption of the Report and the National Quality Forum's (NQF) work to develop an integrated roadmap to identifying and eventually eliminating health and healthcare disparities. The Report contains an extensive framework for identifying performance measures that address social risk factors for chronic diseases as a way to eliminate disparities and achieve health equity. Such work is critical at a time of rapid change in the healthcare delivery system and underscores, as outlined in the Report, the need for integration and emphasis of achieving health equity as an explicit goal in the process. Having performance measures that are evidence-based, broad in their scope so as to address various social risk factors for chronic conditions that disproportionately impact racial and ethnic minorities and others who are limited English proficient and/or experience other barriers to good health and quality health care, is critical to monitoring, assessing, evaluating and eventually eliminating disparities. Performance measures are a critical lever in achieving health equity and APIAHF welcomes NQF's Report on the issue.

We agree with the four-part model as a way of recognizing the value and accountability that all sectors, including payers, policymakers, providers and patients have in eliminating disparities. The Report and emphasis on sector-specific analysis recognizes the unique roles, assets and obligations each have in eliminating disparities. In particular, we welcome the inclusion of policymakers as well as community organizations that serve diverse groups and can serve as aggregators of information and resources and trusted messengers.

California Pan-Ethnic Health Network

Caroline Sanders

The California Pan-Ethnic Health Network (CPEHN) strongly supports the National Quality Forum's (NQF) "A Roadmap to Reduce Health and Healthcare Disparities through Measurement," Draft Report, July 21, 2017. CPEHN is a statewide multicultural health advocacy organization dedicated to improving access to health care and eliminating health disparities by advocating for public policies and sufficient resources to address the health needs of communities of color in California.

Health disparities are pervasive, particularly among communities of color and limited English proficient communities. Recent data from the Agency on Quality Health Care Research shows that despite consistent calls to end health disparities they continue to worsen among certain populations. Rather than continuing to see quality improvement and disparities reduction as separate objectives, health equity and quality improvement must be linked. Even the Centers for Medicare and Medicaid Services (CMS) now recommend that agencies evaluate the impact of disparities and integrate equity solutions across all programs. Without an explicit focus on disparities reduction, quality interventions run the risk of leaving disparities constant or could have the unintended consequence of worsening them.

While a consensus is forming that eliminating disparities must be prioritized, figuring out how to do so requires knowledge of the appropriate measures, interventions and incentives. This draft Report provides a critical roadmap for health care purchasers, plans and practitioners who desire to prioritize health equity as part of their quality improvement strategies. The Report lays out a clear four-step process that includes:

Prioritizing disparities-sensitive measures

Identifying evidence-based interventions to reduce disparities

Selecting and using health equity performance measures

Incentivizing the reduction of health disparities and achievement of health equity

If followed carefully and thoughtfully, this process will lead towards achievement of the Triple Aim of the National Quality Strategy: better quality of care, healthy people and communities, and affordable care.

Community Catalyst

Ann Hwang, MD

Community Catalyst appreciates the opportunity to comment on the 2017 draft report: A Roadmap to Reduce Health and Healthcare Disparities through Measurement.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the U.S. health system. The Center for Consumer Engagement in Health Innovation (the Center) is a hub devoted to teaching, learning, and sharing knowledge to bring the consumer experience to the forefront of health. The Center works directly with consumer advocates to enhance their skills and power to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals, and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers.

The Center has placed high priority on addressing disparities and achieving health equity, as evidenced by our policy priorities (https://www.communitycatalyst.org/resources/publications/document/Consumer-Policy-Platform-for-HST-web.pdf?1473712433). We appreciate NQF's continued focus and investment in addressing health and healthcare disparities. Overall, we believe the framework outlined in the draft report is a step in the right direction. We agree that health is influenced beyond the factors in control by traditional healthcare system. The social and economic determinants are a major player in determining health outcomes. The role of structural racism is also key to understanding the impacts on health disparities, as noted in the report. We encourage continued research and application of measures that can unearth the systemic causes of health disparities. The compendium of measures shows that we have a long way to go—while there are numerous highly granular measures that measure narrow aspects of quality, we note the serious deficit in "big-dot" consumer-centered measures that would allow consumers, providers, policymakers, and payers alike to understand the overall performance of the health system. We urge NQF to actively engage diverse consumers, consumer advocates and the community when developing measures. We believe that the strong participation of patients, families, caregivers, and communities will be critical to ensuring that we create measures that are meaningful to consumers and help achieve equity.

Family HealthCare Center

Paul Nelson

In 1960, health spending as a portaion of our nation's economy (GDP) was 5.0%. By 2016, it was 16.2%. All of the other OECD nation's cluster around 12.0% of their GDP for their health spending. The difference for our nation was @$ 1 Trillion in 2016. Furthermore, we have largely solved the scientific mandate for the health care of Complex Healthcare Needs to the detriment of our nation's humanitarian mandate for the health care of each citizen's Basic Healthcare Needs. The current Paradigm Paralysys of our nation's healthcare industry also means that there is unlikely to be any benefit from an effort to reverse the current level of health inequity.

Prominent for any paradigm shif to improved the cost and quality problems of our nation's healthcare, I recommend a need to clarify for Quality purposes a clear definition for CARING RELATIONSHIPS, COLLECTIVE ACTION, COMMON GOOD, HEALTH, INSTITUTION and SOCIAL CAPITAL. As a prelude to improved capitalization of Primary Healthcare, I would recommend that a set of qualifying criteria be proposed to recognize its capability to participate in a community's equitably available, ecologically accessible, justly efficient and reliably effective healthcare for their citizen's Basic Healthcare Needs. Ultimately, the success of improved Primary Healthcare will be related to their community's effort to support the Social Capital required for improving the level of its Common Good.

Any definition of Social Capital must recognize the long-term character of its impact, basically very poorly measurable given current research strategies. I offer the following as a definition for Social Capital: The prevalence of caring relationships occurring throughout the generational networks of a community's citizens that promotes a spontaneous expression of collaboration, reciprocity and trust for resolving the social dilemmas encountered daily by each citizen within their community's civil life.

In effect, this definition for Social Capital implies that the cost and quality problems of our nation's health spending will not be solved without a community by community driven strategy. The Cooperative Extension Service intiated in 1914 by Congress for agriculture would be a relavent model. The Design Principles for managing a common pool resource should be applied. Defined originally by Nobel Prize (2009) winner Professor Elinor Ostrom, they have been tested and validated by many of her colleagues.

Federation of American Hospitals

Jayne Chambers

The Federation of American Hospitals ("FAH") appreciates the opportunity to comment on the National Quality Forum report: A Roadmap to Reduce Health and Healthcare Disparities through Measurement. FAH and our members continue to work toward reducing health and healthcare disparities. To that end, FAH hoped that the report would provide practical guidance on current issues in addition to the conceptual model and measures proposed. We urge the Committee to provide recommendations on how to improve the current methods used by the Centers for Medicare & Medicaid Services (CMS) and others to fairly report and pay for those healthcare systems and providers who care for these at risk populations. Many of the current and future activities can lead to negative unintended consequences, particularly the current practices around accounting for social risk in performance measures and payment programs. FAH encourages the Committee to address steps that can be taken to mitigate and minimize this potential harm to our healthcare system and patients.

FAH also notes that the report is not specific on which healthcare entities can drive the greatest improvements through the proposed measure concepts and recommendations. Currently, it appears that the report focuses on what larger systems such as health plans and accountable care organizations can do since many of the measures and measure concepts identified under the subdomains of the health equity section would only be applicable at the system level. Additional recommendations or guidance on how providers at every level can work to reduce disparities would be beneficial and help all of us move toward the collective goal.

FAH supports that many of the measure concepts are considered appropriate for quality improvement (QI) only and not accountability. In addition, several of the concepts are focused on structures and processes and at times it is difficult to know how each proposed concept can positively impact patient outcomes. For example, it is not clear how the concept calling for equity to be explicitly stated in the mission statement and/or strategic plan can drive improvements and reduce disparities. Many of the measure concepts seem to be more suited as best practices rather than measures for QI.

FAH thanks the Disparities Standing Committee for their thoughtful report. The comments we provide are intended to further improve and refine this work.

Institute for Healthcare Improvement

Amy Reid

Thank you for your incredible work to advance equtiy. We're grateful for the time you took and the opportunity to dialogue through this open comment period.

1. Domains to advance equity: In the report, the committee proposes five domains of measurement that should be used together to advance equity: collaboration and partnerships, culture of equity, structures for equity, equitable access to care, and equitable high-quality care. The Institute for Healthcare Improvement has outlined the following 5 pillars for health care to advance equity: 1) make equity a strategic priority, 2) infrastructure that supports equity, 3) impacting multiple determinants of health over which healthcare can have an impact (eg improving clinical processes, improving SES of employees), 4) address institutional racism, and 5) community partnerships.

There is overlap in our frameworks in the following areas: equity culture/priority, supportive equity structures, partnerships, and equitable care. You may consider two additional areas: 1) other determinants of health that healthcare can impact to advance equity such as SES and educational attainment of employees, and 2) addressing institutional racism – equitable access to care is one part of that. We suggest explicitly naming racism, socializing an institution to these discussions, and reviewing policies, practices, decisions, and regulations with a racial equity lens to understand differential impact of institutional policies.

2. Simplifying measures: Currently, equity is not regarded as strategically important by the majority of policy-makers, payers or health system leaders. One or two measures tied to reimbursement and accreditation would have an important impact and promote a pragmatic approach. We suggest a clear emphasis on stratification. REAL data may not be granular enough to fuel true community partnerships. It will be key to move towards collection and understanding the self-identified race and ethnicity of individuals served by the system as a standard – e.g., Chinese, Japanese, etc instead of 'Asian', Hmong, Somali, Mexican American, etc.

In addition, we want to move beyond cultural competency to cultural sensitivity or humility.

3. Simplifying implementation guidance: Pairing suggested measures with comments on implementation is incredibly helpful. We suggest that a simplification would aid utilization. Perhaps 'pay for reporting of stratified data' and 'adjust payment for social risk factors' and 'link health equity measures

to accreditation programs' all under the rubric of 'redesign payment models to support equity'. The main issues do not relate to defining a reasonable measure set, but rather how to deploy and collect them without unduly burdening health systems, and your work in this area will be of great value.

James P. Scanlan, Attorney at Law

James Scanlan

In its current form, the July 21, 2017 Draft Report (DR) titled "A Roadmap to Reduce Health and Healthcare Disparities through Measurement" will do a great disserve to health and healthcare (HHD) disparities research, as the NQF's Commissioned Paper: Healthcare Disparities Measurement (CP) also did.

Standard measures of differences between health and healthcare (HHC) outcome rates tend to be systematically affected by the prevalence of an outcome. As HHC generally improves, relative differences in favorable outcomes (e.g., survival, receipt of appropriate care) tend to decrease, while relative differences in the corresponding adverse outcomes (e.g., mortality, non-receipt of appropriate care) tend to increase. Thus, as the NCHS recognized more than a decade ago, whether HHC disparities are deemed to be increasing or decreasing commonly turns on whether one examines relative differences in the favorable outcome or relative differences in the adverse outcome.

Absolute differences tend also to be affected by the prevalence of an outcome, though in a more complicated way than the two relative differences. Roughly, as uncommon outcomes become more common, absolute differences tend to increase; as common outcomes become even more common, absolute differences tend to decrease.

All measures may change in the same direction as prevalence changes. But anytime a relative difference and the absolute difference change in opposite directions, the other relative difference will necessarily change in the opposite direction of the first relative difference and the same direction of the absolute difference. See references below.

See ref. 2 (at 337-339) and 5 (slides 113-118) regarding Massachusetts's inclusion of a disparities element in its Medicaid P4P program that would tend to increase healthcare disparities.

See ref. 2 (at 343-344) regarding that fact that, while CP recognized that different measures might yield different conclusions about directions of changes in disparities, it failed to recognize patterns by which the measures tend to be affected by the prevalence of an outcome and the need to consider those patterns when determining what observed patterns indicate about underlying processes. See ref. 6 urging withdrawal of the CP.

The DR, however, fails even to indicate that choice of measure might make a difference in determining whether HHC disparities are increasing or decreasing.

1. http://www.jpscanlan.com/images/The_Mismeasure_of_Health_Disparities_JPHMP_2016_.pdf
2. http://jpscanlan.com/images/Race_and_Mortality_Revisited.pdf
3. https://www.regulations.gov/document?D=USBC-2016-0003-0135
4. http://jpscanlan.com/images/2013_Fed_Comm_on_Stat_Meth_paper.pdf
5. http://jpscanlan.com/images/Univ_Mass_Medical_School_Seminar_Nov._18,_2015_.pdf
6. http://jpscanlan.com/images/Harvard_et_al._Commissioned_Paper_Letter.pdf

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Justice in Aging

Georgia Burke

Justice in Aging appreciates the opportunity to comment. Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources.

We are most appreciative of the thorough and thoughtful analysis that went into the report. We encourage the Committee to continue to focus on developing and implementing measurements to address health disparities and prioritizing those measures. As the Committee report demonstrates, measures are not an end in themselves. They exist to promote the development and implementation of effective person-centered interventions that improve lives and reduce disparities. We support continued efforts to develop and refine disparities-related measures and to incorporate those measures into program evaluations.

Men’s Health Network

Colin Stephenson

Thank you for the opportunity to comment. At Men’s Health Network we believed that disparities in health care have been correlated with the prevalence of many chronic diseases. Furthermore, inadequate health care could affect individual’s overall health and quality of life. We appreciate that the Report focuses on disparities-sensitive measures and other research to design evidence-based interventions. One of the solutions suggested, incentivizing providers to use interventions for health equity through payment reform, is beneficial because numerous healthcare programs in the past have shown successful outcomes by using incentives to motivate healthy behaviors. In order to successfully implement the program, it would be very important to promote the intervention to the providers and health care institutes before the implementation. The Report summary states that some of the health equity measurement would be obtained from surveys and it would be helpful to see a sample of survey(s) for the patients and providers along with the measurement description of the draft report.

There are many factors that are linked to disparities in health and health care and MHN would like to emphasize gender barriers including gender minorities and sexual orientation.”Modern American males are conditioned from a young age to view health care as falling under the purview of women. Part of this is due to men’s anthropologically ingrained predisposition to ignore pain and discomfort, to ‘play through it,’ and to be providers of their family unit”(Giorgianni et al., pg. 2, 2013). It is often underestimated how difficult it is to correctly diagnose the opposite sex. Poor patient-provider communication could be caused by a gender barrier as much as lack of cultural or linguistic competence in health care setting. Health care providers, both male and female, claim that they do not feel comfortable communicating health issues with men. The poor patient-provider communication is linked to healthcare disparities and there needs to a specialized health care practitioner for males.

Again, thank you for this opportunity to provide comments on the Report.

SNP Alliance

Deborah Paone

As the Committee points out, health disparities arise as a symptom of deeper issues, and need to be addressed in collective action. The medical, behavioral health, long-term care, and social services systems will need to join with public health and other community efforts. Policy, legislative and regulatory changes, advocacy, and local action will be needed to make progress in connecting efforts to improve health equity outcomes--across settings and services, government and private agencies, and with individuals and the communities affected.

While these efforts are underway, we need to be judicious about how we measure and who we determine is accountable for measurement results. A core set of meaningful structure, process, and outcome measures should be used across settings and over time. To be useful for quality improvement, this core set of measures must be amenable to action/change from one reporting period to the next. Focusing across services on one set of core measures for key vulnerable population groups that require care and support across settings/disciplines--will combine and enhance rather than splinter efforts around quality improvement. Reducing the number of measures to focus on what is meaningful for at-risk populations will help target action.

We underscore the importance of taking action to recognize that organizations serving a high proportion of individuals with social risk factor issues on top of medical, long-term care, and behavioral health needs—are currently being penalized in quality measurement and value-based payment systems.

The Committee’s examination and recommendations are well thought out and provide a blueprint for addressing vital issues in addressing health disparities through increased attention to social risk factors in vulnerable populations.

Thank you for the opportunity to comment. We are pleased to assist you in any way in the future.

SPAN/Family Voices NJ

Lauren Agoratus

In general, we appreciated the framework based on the National Academy of Medicine (NAM) Conceptual Framework of Social Risk Factors and Performance Indicators for Value-Based Payment regarding access to care including affordability, availability, accessibility, and accommodation. We agree with using the NAM domains of quality including effectiveness, safety, timeliness, patient/family-centeredness, access, and efficiency. However, we are deeply concerned with the current climate regarding cutting healthcare protections and Medicaid both under the ACA repeal and budget. We were unable to locate any measures on insurance status. The NJ Hospital Association conference on the uninsured indicated that individuals without coverage could be diagnosed on average 2-4 years after their insured peers, when disease is less treatable and most costly, resulting in increased morbidity and mortality.

Looking through the appendices, we are deeply concerned that the focus is mostly on adults as illness affect the pediatric population differently (e.g. renal disease can cause cognitive and growth adverse effects.) In addition, there was no focus on children with special health care needs, yet 1 in 5 children have special needs (Source: CAHMI http://childhealthdata.org/) other than some condition-specific information on sickle cell, cardiac, and renal disease. We did appreciate inclusion of mental health. We were also unable to locate measures regarding screening other than adult screenings for cancer, obesity, etc.; besides developmental screenings, other screenings of importance for children are newborn screenings, immunizations, and lead particularly with the recent findings of lead in water, even in schools.

Overall, we strongly support addressing health disparities but unless some of the key factors previously mentioned are addressed, there will continue to be underserved populations resulting in poorer health outcomes.

Summit Health Institute for Research and Education, Inc. (SHIRE)

Ruth Perot

Summit Health Institute for Research and Education, Inc. (SHIRE) has been involved in combating disparities in health and health care for twenty years with focus directed toward improving the health status of communities of color. Since 2013, SHIRE has worked in concert with AmeriHealth Caritas District of Columbia to implement data collection/reporting strategies at the community level. SHIRE has conducted Wellness Circles for AmeriHealth members who have diabetes and hypertension. The collection and analysis of health outcomes data, including weight loss, blood pressure indicators, and HbAic levels, plays an essential role in determining to what extent gaps in chronic disease rates between Medicaid beneficiaries of color and the total District of Columbia population are narrowing. Thus, our organization has first-hand knowledge of the importance of measuring and monitoring health disparities and progress toward their elimination. Accordingly, we appreciate the opportunity to review and comment on the draft report "A Roadmap to Reduce Healthcare Disparities Through Measurement" (the Report).

We are pleased to express our strong support for the Report and for the work of the National Quality Forum (NQF) to develop an integrated roadmap to identifying and eventually eliminating health and health care disparities. The Report contains an extensive framework for identifying performance measures that address social risk factors for chronic diseases as a way to eliminate disparities and achieve health equity. Such work is critical at a time of rapid change in the health care delivery system and underscores, as outlined in the Report, the need for integration and emphasis on achieving health equity as an explicit goal in the process. It is essential to have performance measures that are evidence-based and broad in their scope. These measures can address various social risk factors for chronic conditions that disproportionately impact racial and ethnic minorities and others who are limited English proficient and/or experience other barriers to good health and quality health care. Such measures are critical to monitoring, assessing, evaluating and eventually eliminating disparities. We believe that performance measures are a critical lever in achieving health equity. SHIRE welcomes NQF's Report on these critically important issues.

We agree with the four-part model as a way of recognizing the value and accountability that all sectors, including payers, policymakers, providers and patients have in eliminating disparities. The Report and emphasis on sector-specific analysis recognizes the unique roles, assets and obligations each have in eliminating disparities. In particular, we welcome the inclusion of policymakers as well as community organizations that serve diverse groups and can play an important role in identifying and even aggregating information and resources in their role as trusted messengers and community partners.

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