2013 Annual Progress Report to Congress

National Strategy for
Quality Improvement in Health Care

Submitted by the U.S. Department of Health and Human Services

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EXECUTIVE SUMMARY

Since the passage of the Affordable Care Act, health care payers, purchasers, providers, and consumers have shown an increased commitment to health and health care quality. The *National Strategy for Quality Improvement in Health Care* (National Quality Strategy) establishes a framework for coordinating and focusing the significant efforts of these diverse stakeholders to improve the quality of health and health care for all Americans. Implementation of the National Quality Strategy involves identifying and prioritizing quality improvement efforts, sharing lessons learned, and measuring the collective success of Federal, State, and private sector health care stakeholders across the country.

The initial National Quality Strategy, published in March 2011, established three aims and six priorities for quality improvement (see Figure 1). The National Quality Strategy's first annual progress report to Congress, published in April 2012, elaborated on these six priorities and established long-term goals and national tracking measures to monitor quality improvement progress. The 2012 report also identified three strategic opportunities for improvement, which cut across all six priority areas. This second annual report provides updates on public and private payers' collaborative efforts to align quality measures, progress against national tracking measures (where possible) and establishment of aspirational targets (as needed), private-sector successes in each of the six priority areas, and progress on each of the three strategic opportunities.

Figure 1: Three Aims and Six Priorities

NATIONAL QUALITY STRATEGY'S THREE AIMS:

1. **BETTER CARE:** Improve the overall quality of care, by making health care more patient-centered, reliable, accessible, and safe.
2. **HEALTHY PEOPLE/HEALTHY COMMUNITIES:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
3. **AFFORDABLE CARE:** Reduce the cost of quality health care for individuals, families, employers, and government.

NATIONAL QUALITY STRATEGY'S SIX PRIORITIES:

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

EFFECTIVE PERFORMANCE MEASURES

The National Quality Strategy encourages efforts to identify and adopt unified measures that meet the reporting requirements of multiple programs and initiatives across the Federal Government, the private sector, States, and even individual health systems and providers. Measure alignment allows stakeholders to gauge performance outcomes, while also creating continuity and consistency for providers and consumers. These alignment efforts include the work of the Measures Application Partnership, composed of over 60 public- and private-sector organizations, and the *Buying Value* initiative, a group of 19 private health care purchasers and purchasers' representatives. These organizations are working together and making progress toward developing common performance measures for value purchasing among public and private payers. Additionally, multiple Federal agencies are making significant strides in reducing the reporting burden for providers by aligning performance measures across programs and reducing the number of measures where possible.

IMPROVING QUALITY ACROSS SIX PRIORITIES

This report includes updates to the national tracking measures that align to each of the National Quality Strategy's six priorities and demonstrate national health and health care quality trends. Health care providers, payers, and communities across the Nation are aligning care delivery, payment incentives, and programming to drive improvement—and they are achieving significant results—although the use of broad, all-payer tracking measures necessary to meaningfully track national progress means that data collection and reporting often lags behind recent progress. This report highlights communities, health systems, and organizations that have shown dramatic improvement in each priority area. Their success demonstrates the potential impact of implementation of the National Quality Strategy.

STRATEGIC OPPORTUNITIES

The 2012 National Quality Strategy progress report identified three strategic opportunities for accelerating system-wide improvement across all of the aims and priorities; this report provides information on progress made against each. The three opportunities are:

1. Develop a national strategy for data collection, measurement, and reporting that supports performance measurement and improvement efforts of public- and private-sector stakeholders at the national and community level.
2. Develop an infrastructure at the community level that assumes responsibility for improvement efforts; resources for communities to benchmark and compare performance; and mechanisms to identify, share, and evaluate progress.
3. Develop payment and delivery system reforms—emphasizing primary care—that reward value over volume; promote patient-centered outcomes, efficiency, and appropriate care; and seek to improve quality while reducing or eliminating waste from the system.

Public- and private-sector efforts to align measures are contributing to the development of a national strategy for collecting data, measuring improvement, and public reporting. Furthermore, the Federal Government is taking unprecedented steps forward in sharing appropriate data with clinicians who are undertaking quality improvement efforts and with consumers making care decisions.

There is also evidence of a growing community-level infrastructure to support quality improvement across the Nation. Communities continue to recognize the role of health and non-health care stakeholders alike in promoting better health and health care quality, and use a variety of tools, such as health information technology, to support better health and health care for their community members.

Finally, private and public payers are embracing a new perspective on health care payment and delivery—one that emphasizes value over volume and rewards providers that deliver high-quality care. The U.S. Department of Health and Human Services (HHS) has launched numerous programs to test approaches to improve quality while also reducing costs. Commercial and state-based programs that also seek to support health care transformation complement these efforts.

LOOKING TO THE FUTURE

The National Quality Strategy serves as a guiding force in the multitude of quality improvement efforts across the Nation, fostering alignment across national, Federal, State, and private sector stakeholders to improve health and health care quality for all Americans. In the few years since the passage of the Affordable Care Act, a growing number of stakeholders are increasing their emphasis on health and health care quality improvement, yielding promising returns and evidence of a health system transformation underway. Future iterations of this report will continue to highlight the expanding depth and breadth of participation in quality reporting and improvement efforts, best practices across the health care sector, and resources for all stakeholders—including payers, providers, communities, and consumers—to guide quality improvement work.

1. INTRODUCTION

The *National Strategy for Quality Improvement in Health Care* (National Quality Strategy) continues to inspire and guide a nationwide effort to coordinate public and private efforts to improve the quality of health and health care for all Americans. The National Quality Strategy serves as a resource for identifying and prioritizing quality improvement efforts, sharing lessons learned, and measuring the collective success of Federal, State, and private-sector health care stakeholders across the country.

Figure 2: National Quality Strategy Aims

The initial National Quality Strategy, required by the Patient Protection and Affordable Care Act (ACA), was published in March 2011. It established three aims, which are being pursued concurrently:

1. BETTER CARE: Improve the overall quality of care, by making health care more patient-centered, reliable, accessible, and safe.
2. HEALTHY PEOPLE/HEALTHY COMMUNITIES: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
3. AFFORDABLE CARE: Reduce the cost of quality health care for individuals, families, employers, and government.

The National Quality Strategy encourages alignment of health and health care quality programs and performance measures across the country. The past year has seen significant advancements in patient safety research and improvement, adoption of new care delivery models rewarding quality improvement, public-private alignment of data collection and measurement, and a decrease in cost growth across the American health care system.

This report provides an update on the Nation's progress improving quality across six priority areas, while also highlighting local examples of excellence that show what is possible. Further, it details the ongoing work by Federal partners, including the U.S. Department of Health and Human Services (HHS), to support the nationwide effort to achieve the National Quality Strategy's three aims: better care, healthy people/healthy communities, and affordable care.

BACKGROUND ON THE NATIONAL QUALITY STRATEGY

The Affordable Care Act directs the Secretary of HHS to "establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health." In spring 2011, HHS released the inaugural report to Congress establishing the strategy's three aims (see Figure 2) and six priorities:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.

4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

The 2012 Annual Progress Report to Congress on the National Quality Strategy elaborated on these six priorities, and established long-term goals (see Figure 3) and national tracking measures to monitor quality improvement progress.

Figure 3: Six Priorities and Associated Long-Term Goals

PRIORITIES	LONG-TERM GOALS
Making care safer by reducing harm caused in the delivery of care	Reduce preventable hospital admissions and readmissions. Reduce the incidence of adverse health care-associated conditions. Reduce harm from inappropriate or unnecessary care.
Ensuring that each person and family is engaged as partners in their care	Improve patient, family, and caregiver experience of care related to quality, safety, and access across settings. In partnership with patients, families, and caregivers—and using a shared decisionmaking process—develop culturally sensitive and understandable care plans. Enable patients and their families and caregivers to navigate, coordinate, and manage their care appropriately and effectively.
Promoting effective communication and coordination of care	Improve the quality of care transitions and communications across care settings. Improve the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status. Establish shared accountability and integration of communities and health care systems to improve quality of care and reduce health disparities.
Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease	Promote cardiovascular health through community interventions that result in improvement of social, economic, and environmental factors. Promote cardiovascular health through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan. Promote cardiovascular health through receipt of effective clinical preventive services across the lifespan in clinical and community settings.
Working with communities to promote wide use of best practices to enable healthy living	Promote healthy living and well-being through community interventions that result in improvement of social, economic, and environmental factors. Promote healthy living and well-being through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan. Promote healthy living and well-being through receipt of effective clinical preventive services across the lifespan in clinical and community settings.
Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models	Ensure affordable and accessible high-quality health care for people, families, employers, and governments. Support and enable communities to ensure accessible, high-quality care while reducing waste and fraud.

A broad and robust stakeholder engagement process informed the choice of these priorities, long-term goals, and measures. The 2012 progress report also highlighted three strategic opportunities for improvement, which cut across all six priority areas to support ongoing innovation and improvement.

WHAT'S NEW THIS YEAR

Last year's progress report to Congress on the National Quality Strategy offered an in-depth look at the implementation activities taking place across the Federal Government. This year's progress report focuses on overall quality improvement, while also offering new granularity and focus in some of the priority areas. The following items are new to the report this year:

- A spotlight on unprecedented collaboration between public and private payers, leading to the establishment and adoption of a consensus set of core measures.
- New progress on reducing the burden of data collection for providers engaged in quality improvement.
- Updates to all national tracking measures, where data are available.
- Targets for improvement for each of the remaining national tracking measures.
- Private sector champions achieving excellence and sharing best practices in each of the six priority areas.
- A spotlight on the three strategic opportunities, reflecting the breadth of activity to improve quality infrastructure across the country.

Figure 4: Ongoing National Quality Strategy Implementation Activities

ONGOING NATIONAL QUALITY STRATEGY IMPLEMENTATION ACTIVITIES

The robust implementation activities described in the 2012 National Quality Strategy Annual Progress Report to Congress continue apace within HHS and across the Federal Government, maximizing the impact of the Strategy in Federal programs and across the Nation. These continuing activities include:

- Regular meetings of the Interagency Working Group on Health Care Quality, including senior representatives from 24 Federal agencies
- Continual updates to the Agency-Specific Plans developed by each HHS operating division
- Active engagement of stakeholders in the evolution and dissemination of the National Quality Strategy through the National Priorities Partnership and the Measures Application Partnership
- Publication of toolkits and presentations for use by community partners
- Ongoing alignment between the National Quality Strategy and other Federal quality reports, including the National Healthcare Quality and Disparities Report

For more information on these activities, including the latest versions of the Agency-Specific Plans, visit www.ahrq.gov/workingforquality/.

Though this progress report only touches upon some of the robust quality improvement activities taking place across the Federal Government and the Nation, it is an encouraging survey of progress and engagement.

2. EFFECTIVE PERFORMANCE MEASUREMENT

Performance measures allow us to gauge the quality of care provided, identify best practices for achieving desired outcomes, and identify opportunities for improvement. Since the passage of the Affordable Care Act, performance measurement has become increasingly important. Provider payments are increasingly contingent upon demonstrating progress in meeting established performance thresholds. While this increased focus on performance measurement holds promise, it has unintentionally led to the proliferation of measures—many tailored to specific populations and care settings—and to an increased burden on providers to report on these measures. The National Quality Strategy helps foster alignment of performance measures across the Federal Government, the private sector, States, and even individual health systems and providers. When all payers use the same measures, stakeholders have consistent information to gauge performance and outcomes, and providers have a lower reporting burden.

NEW CONSENSUS AMONG PUBLIC AND PRIVATE PAYERS ON QUALITY MEASUREMENT

The Affordable Care Act required that multi-stakeholder groups provide input on the best performance measures for public reporting and performance-based payment programs. HHS contracted with the National Quality Forum to convene the Measures Application Partnership, a consensus-based entity composed of over 60 public- and private-sector organizations representing consumers, businesses and purchasers, labor, clinicians, hospitals, and Federal partners.

The Measures Application Partnership is helping HHS identify and prioritize the best performance measures. In October 2012, the Measures Application Partnership released a report with recommendations to HHS about the best available measures for specific programs; these measures are related across multiple care settings and are referred to as "families of measures." This first report identified families of measures across four topics, each addressed in the National Quality Strategy: (1) safety, (2) care coordination, (3) cardiovascular conditions, and (4) diabetes. This work immediately inspired action from public and private payers across the health care sector.

In 2012, a group of 19 private health care purchasers and purchasers' representatives—including Fortune 500 corporations, union health funds, and national and regional business coalitions—formed the *Buying Value* initiative to replace the current volume-based purchasing model in health care with one based on quality, patient safety, and increased care coordination and communication. In October 2012, the group began meeting with Federal agencies, including the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and

Quality (AHRQ), to discuss an approach for developing common performance measures for value purchasing among public and private payers, and leveraging work by the Measures Application Partnership. As of February 2013, the *Buying Value* purchasers reached agreement with leading health plans on an initial core set of ambulatory care measures for use by health plans and private purchasers. The *Buying Value* Common Measures list now includes 35 measures; 20 of these measures are part of Stage 2 Meaningful Use in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Examples of these measures include:

- Use of High Risk Medications in the Elderly (NQF# 0022)
- Timely Transmission of Transition Record (NQF# 0648)
- Blood Pressure Control (NQF# 0018)
- Comprehensive Diabetes Care: HbA1C < 8% (NQF# 0575)

The involved parties, including Service Employees International Union (SEIU), American Federation of Labor—Congress of Industrial Organizations (AFL-CIO), IBM, Xerox, Aetna, Cigna, WellPoint, United Healthcare, and the national Blue Cross Blue Shield Association agreed to work together to implement this core set of measures in their programs as soon as possible. In 2013, *Buying Value* seeks increased adoption of the core measure set by local and regional purchasing coalitions, and the increased use of electronic measures, including those that have been selected for the EHR Incentive Programs. Alignment of private- and public-sector quality measures is critical to lowering the burden of reporting on providers and measuring progress toward achieving better health outcomes, quality care, and lower costs. The ongoing, iterative alignment between HHS and initiatives such as *Buying Value* are important steps forward in achieving consensus among private and public payers on quality measurement. For more information about the *Buying Value* initiative, visit www.buyingvalue.org.

REDUCING THE BURDEN OF DATA REPORTING BY ALIGNING MEASURES

As more public and private payers tie payment to health care quality, programs requiring data collection have proliferated. While these initiatives appropriately focus the attention of health care providers on quality outcomes and improvement, they also require effort and infrastructure to provide clinically relevant evidence-based guidelines at the point of care, standardized multipurpose data collection, and interoperable data transmission. The Office of the National Coordinator for Health Information Technology (ONC) has launched the Health eDecisions Standards and Interoperability Initiative, with significant private-sector participation, to standardize and enable the sharing of clinical decision support interventions and tools. Meanwhile, in the past year, CMS has achieved unprecedented alignment across its data-reporting programs, as described below, leading to tangible reductions in burden on providers, while still fostering accountability for quality outcomes.

Many CMS programs, such as the Physician Quality Reporting System (PQRS), Physician Value-

based Payment Modifier, the Shared Savings Program for Accountable Care Organizations (ACOs), and the Electronic Health Record (EHR) Incentive Programs require reporting of quality measures by physicians and other eligible professionals. Established in various statutes at different times, these programs often have different quality reporting requirements. CMS is pursuing opportunities to align reporting requirements in 2013 for eligible professionals practicing in groups. For example, eligible professionals participating in the Shared Savings Program will receive credit for the PQRS program for certain measures that are satisfactorily reported by their ACO on their behalf. Another reporting option reduces the reporting burden and allows individual providers to report once to receive credit for both PQRS and the EHR Incentive Programs. Alignment of measures and reporting mechanisms across these programs reduces the burden on health care providers and allows them to focus on the measures that matter.

Alignment across quality reporting programs also reduces the burden on hospitals. The same measures that hospitals report for the Hospital Inpatient Quality Reporting (IQR) program are posted on Hospital Compare, and the Hospital Value-Based Purchasing program uses a subset of these IQR measures. As a result, hospital IQR measure data can also be used to determine if the hospital has met its Hospital Value-Based Purchasing measure data reporting requirements. In 2012, CMS launched the process for using electronic health records to directly report the quality data required by other hospital programs, and allow hospitals using certified EHR technology to use the same data (and often in the same format) to report on quality measurement and deliver clinical care. Furthermore, many hospital programs are aligning to focus on smaller sets of measures that maximize improvement and better outcomes for patients.

Other Federal agencies have taken similar steps to align measures and reduce the burden of reporting. In 2012, the Health Resources and Services Administration (HRSA) established the Measures Management Review Board to harmonize and align measures across HRSA to promote the use of nationally recognized measures, such as those endorsed by the National Quality Forum and used in the CMS EHR Incentive Programs and PQRS. The goal is to reduce the reporting burden for HRSA grantees, including community health centers and health services organizations, by developing a common reporting platform to more easily report quality measures data.

These are not isolated examples of measure alignment and burden reduction. In 2012, HHS established a Measurement Policy Council (MPC) to ensure ongoing harmonization of measures across agencies and programs. Guided by the six priority areas of the National Quality Strategy, the Measurement Policy Council began by reaching consensus on measures for hypertension control, smoking cessation, hospital-acquired conditions (HAC), care coordination, patient experience of care, and depression screening and remission (see Appendix B). The council, composed of 11 HHS operating divisions, also agreed on processes for adoption of consensus measures across programs. Current work focuses on aligning measures for HIV/AIDS, obesity,

and diabetes. While this work resides within HHS, the MPC used criteria established by the Measures Application Partnership, a public-private partnership convened by the National Quality Forum.

3. IMPROVING QUALITY ACROSS SIX PRIORITY AREAS

Central to the National Quality Strategy are six priorities that focus national quality improvement efforts. Established in 2011 after significant stakeholder input, the six priorities now guide public and private investments in quality improvement. The 2012 progress report on the National Quality Strategy added national tracking measures in each of the six priority areas to provide a national, all-payer lens through which to understand our national progress. The 2012 report also included baseline rates for these measures. The section below includes updates to these baselines where new national data are available. The data sources for the key measures provide nationally representative snapshots, but there is a lag between when the data snapshot is taken and when the information is available to report; accordingly, the data collection and reporting is slow to show progress. We expect to show progress on the national quantitative data over time, but for this report, we're highlighting select programs across the Nation that demonstrate progress in each of the priority areas.

Across the country, health care providers, payers, and communities have accepted the invitation of the National Quality Strategy to align care delivery, payment incentives, and local infrastructure to drive improvement—and they are achieving significant results. This section highlights select communities and health systems that have shown dramatic improvement in each priority area and, in some cases, insights from those leaders about how to replicate their success. These examples of rapid improvement and achievement of excellence present a preview of the future.

Finally, this section includes aspirational targets for improvement for each of the national tracking measures. Aspirational targets for patient safety (priority area #1) and cardiovascular health (priority area #4) were established last year to align with the goals of the Partnership for Patients and the Million Hearts® Initiative. The additional targets, appearing for the first time this year, were developed through a consensus process with public- and private-sector content experts using predictive modeling based on past performance of major data sources. These targets were established with the recognition of the slow rate in which progress can be shown across nationally representative data in combination with the need for the targets to have face validity with the general public. Over time, we do expect to see progress in National Quality Strategy implementation reflected in improved results in these tracking measures. The full listing of measures and targets is available in Appendix A.

PRIORITY 1: MAKING CARE SAFER BY REDUCING HARM CAUSED IN THE DELIVERY OF CARE

Everyone agrees that no patients should be harmed by the health care they receive and all clinicians should be empowered with the best tools and information to deliver safe, effective, quality care. Eliminating infections, falls, and other harms in health care settings is fundamental to improving quality. High-quality care means appropriate care transitions, so that patients who leave the hospital do not have to be readmitted. A growing body of safety-improvement research, new payment incentives to reward quality, and the HHS-sponsored national hospital learning initiative known as the Partnership for Patients are working in concert to reduce hospital-acquired conditions and 30-day hospital readmissions.

Table 1: Priority 1 Measures

MEASURE FOCUS	MEASURE NAME/DESCRIPTION	BASELINE RATE	MOST RECENT RATE	ASPIRATIONAL TARGET
Hospital-Acquired Conditions	Incidence of measurable hospital-acquired conditions	145 HACs per 1,000 admissions[1]	142 HACs per 1,000 admissions in 2011[2]	Reduce preventable HACs by 40% by the end of 2014[3]
Hospital Readmissions	All-payer 30-day readmission rate	14.4%, based on 32.9 million admissions[4]	14.4% based upon 32.7 million admissions in 2011[5]	Reduce all readmissions by 20% by the end of 2014

Nationwide data from 2011 indicates the HAC rate is declining, and although the all-payer 30-day readmission rate isn't declining yet, recent data from the Medicare program is promising. Among Medicare patients, who represent approximately 58 percent of all hospital readmissions, the hospital readmission rate decreased in 2012. After holding steady at 19 percent for years—meaning that nearly 1 in 5 Medicare hospital discharges resulted in a return trip to the hospital—that proportion declined to 18 percent for one data point in 2012, representing nearly 70,000 fewer Medicare Fee-for-Service readmissions.

[1] Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), and Centers for Medicare & Medicaid Services (CMS), 2010.
[2] AHRQ, CDC, and CMS, 2011.
[3] The target date for the Priority 1 measures was adjusted from 2013 to 2014, because the 3-year Hospital Engagement Network program, a key driver for improvement in these measures, did not begin until December 2011.
[4] AHRQ, CDC, and CMS, 2010.
[5] AHRQ, CDC, and CMS, 2011.

New data from large hospital networks also reflect promising trends across all payers. The Irving, Texas-based VHA cooperative of nonprofit hospitals reduced all-payer, all-cause readmissions by 17.6 percent in just 12 months across 192 hospitals. VHA's success is built upon its collaboration with hospitals, which view VHA as a trusted advisor, and upon championing the use of qualitative tools and approaches to help hospitals improve safety and quality. For example, VHA shares "Practice Blueprints" with its hospitals to demonstrate how other institutions have successfully addressed readmissions (currently VHA has 16 Blueprints related to readmissions). VHA then works with hospitals over a 10- to 14-week period to redesign and test new clinical practices that more closely align with the leading institutions. Since 2011, Dignity Health has dramatically reduced rates of hospital-acquired infections across its 36 hospitals in 3 states, achieving a 70 percent decline in central-line associated bloodstream infections (CLABSI), a 53 percent decline in ventilator-associated pneumonia (VAP), a 52 percent decline in surgical site infections (SSI), and a 24 percent reduction in catheter-associated urinary tract infections (CAUTI). Together these four harms represent over 80 percent of all health care-associated infections nationwide. Through engagement with the Partnership for Patients, these systems and other high performers now share their best practices, such as the use of clinical decision support and quality measure alignment, with 3,700 hospitals nationwide.

PRIORITY 2: ENSURING THAT EACH PERSON AND FAMILY IS ENGAGED IN THEIR CARE

High-quality care is not only safe; it is also timely, accessible, and consistent with individual and family preferences and values. Individuals stay healthier when they and their families are actively engaged in their care, understand their options, and make choices that work for their lifestyles. Improving health care quality includes improving the experience of care, from ease of getting appointments to clear communication about care plan options.

Table 2: Priority 2 Measures

MEASURE FOCUS	MEASURE NAME/DESCRIPTION	BASELINE RATE	MOST RECENT RATE	ASPIRATIONAL TARGET
Timely Care	Adults who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted	14.4%*[6]	Update available in Fall 2013	Reduce to <10% by 2017
Decisionmaking	People with a usual source of care whose health care providers sometimes or never discuss decisions with them	13.2%*[7]	Update available in Fall 2013	Reduce to <10% by 2017

*Corrected May 2014

Though updated nationwide data is not yet available on these two measures, local communities, private payers, and individual practices are improving the person and family experience of care in significant and innovative ways. At Mount Sinai Hospital in New York City, Dr. Kevin Baumlin noticed that visits to crowded, noisy emergency rooms—overwhelming for anyone—were particularly traumatic and disorienting for seniors. To improve this experience for patients and their caregivers, Mount Sinai opened a geriatric Emergency Department (ED) that is quieter, has more space, and allows family members and caregivers to be with patients. Understanding the importance of a simple person-to-person conversation, trained volunteers armed with reading glasses, hearing aids, crossword puzzles, and magazines sit with seniors to help them get their bearings and feel comfortable. The care team, including nurses, social workers, and pharmacists, works with each patient and their caregiver—often a family member, but sometimes a neighbor or a home aide—to develop a care plan that meets their needs and will prevent future ED visits.

In January 2011, Kaiser Permanente in Southern California implemented a shared decision-making pilot in three of its medical centers. Patients diagnosed with osteoarthritis of the hip or knee were offered video-based decision aids to help them identify their treatment goals and navigate the various care options based on their values and preferences. Over 80 percent of patients who used the tools thought they were very helpful, and the tools also had a significant impact on care choices, including a 50 percent reduction in the number of elective hip replacement surgeries over the 9-month pilot compared with a matched case control group from a previous year. Based on these and similar favorable results from other pilots, Kaiser

[6] AHRQ, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey, 2010.
[7] AHRQ, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey, 2010.

Permanente is expanding the use of these decision aids to all of its medical centers in Southern California, Colorado, and the Northwest. Now thousands of patients will be supported in making the decisions that are consistent with their lifestyles and values.

PRIORITY 3: PROMOTING EFFECTIVE COMMUNICATION AND COORDINATION OF CARE

Conscious, patient-centered coordination of care not only improves the patient's experience, it also leads to better long-term health outcomes, as demonstrated by fewer unnecessary trips to the hospital, fewer repeated tests, fewer conflicting prescriptions, and clearer advice about the best course of treatment. Quality language assistance services and the adoption of electronic health records make it easier for clinicians to effectively communicate with patients across settings, and new models of care delivery and payment, such as patient-centered medical homes and ACOs, are giving providers shared incentives to work together to keep patients healthy. While the rate for patient-centered medical homes (below) fell slightly, we believe that with the burgeoning number of public- and private-sector-sponsored patient-centered medical homes across the Nation, the measure will show improvement over time as the data reflects current reality.

Table 3: Priority 3 Measures

MEASURE FOCUS	MEASURE NAME/DESCRIPTION	BASELINE RATE	MOST RECENT RATE	ASPIRATIONAL TARGET
Patient-Centered Medical Home	Percentage of children needing care coordination who receive effective care coordination	69%[8]	66.1%[9]	Increase to 90% by 2017
3-Item Care Transition Measure®	• During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left • When I left the hospital, I had a good understanding of the things I was responsible for in managing my health • When I left the hospital, I clearly understood the purpose for taking each of my medications	45%[10]	Update available in Fall 2013	Increase to 50% by 2017

[8] Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau; CDC, National Center for Health Statistics, National Survey of Children's Health, 2007.
[9] HRSA, Maternal and Child Health Bureau; CDC, National Center for Health Statistics, National Survey of Children's Health, 2011/12.
[10] CMS, 50 Hospital Mode Experiment, October 2012.

The Southcentral Foundation in Anchorage, Alaska, provides primary outpatient care to approximately 55,000 Alaska natives and American Indians using a team-based approach, recognized by the National Committee for Quality Assurance as a Level 3 Patient-Centered Medical Home™, the highest level achievable. The Foundation's small, integrated, primary care teams include a physician, one or two medical assistants, a full-time nurse focused on care coordination, an administrative assistant to provide case management support, and often a behaviorist. The team is collectively responsible and accountable for a group of patients' care. The team members are physically co-located to encourage communication and, when patients call, nurses decide whether to schedule a same-day appointment with a physician or health care provider or offer counseling by phone. As a result of its team-based care coordination, the Foundation has seen a decrease in emergency room visits by 5 percent, hospital admissions by 53 percent, specialty care visits by 65 percent, and visits to primary care doctors by 20 percent.[11] The Foundation also uses its EHR system to facilitate care coordination and keep medical records safe and private, ensure prescription safety, and provide alerts and reminders about health screenings and immunizations.

PRIORITY 4: PROMOTING THE MOST EFFECTIVE PREVENTION AND TREATMENT PRACTICES FOR THE LEADING CAUSES OF MORTALITY, STARTING WITH CARDIOVASCULAR DISEASE

Cardiovascular disease—including heart disease and stroke—is the leading cause of death in the United States. Every day, 2,200 people die from cardiovascular disease—that translates to 815,000 Americans each year, or 1 in every 3 deaths.[12] Heart disease and stroke can also result in serious illness, disability, and decreased quality of life. And yet cardiovascular disease is preventable. Improving the quality of American health care demands an intense focus on preventing and treating cardiovascular disease. The Million Hearts Initiative is a public-private partnership between HHS and 65 partners, led by the Centers for Disease Control and Prevention, with the goal of preventing 1 million heart attacks and strokes over the next 5 years. The initiative is focusing on aspirin use, blood pressure and cholesterol screenings, clinical decision and caregiver support, and smoking cessation to achieve this goal.

[11] Available at Malcolm Baldrige National Quality Award. http://www.nist.gov/baldrige/award_recipients/southcentral_profile.cfm. Accessed April 30, 2013.
[12] Available at Million Hearts, About Heart Disease and Stroke: Consequences and Costs. http://millionhearts.hhs.gov/abouthds/cost-consequences.html.

Table 4: Priority 4 Measures

MEASURE FOCUS	MEASURE NAME/DESCRIPTION	BASELINE RATE	MOST RECENT RATE	ASPIRATIONAL TARGET
Aspirin Use	Outpatient visits at which adults with cardiovascular disease are prescribed/maintained on aspirin	47%[13]	53%[14]	Increase to 65% by 2017
Blood Pressure Control	Adults with hypertension who have adequately controlled blood pressure	46%[15]	53%[16]	Increase to 65% by 2017
Cholesterol Management	Adults with high cholesterol who have adequate control	33%[17]	32%[18]	Increase to 65% by 2017
Smoking Cessation	Outpatient visits at which current tobacco users received tobacco cessation counseling or cessation medications	23%[19]	22%[20]	Increase to 65% by 2017

While there are slight declines in the rates for cholesterol management and smoking cessation in the table above, these changes are not statistically significant. The successful efforts of the Million Hearts Initiative, as well as numerous other public- and private-sector efforts, suggest that the rates will show improvement over time. Ellsworth Medical Clinic in rural Wisconsin is a leading example of how a small practice can help its patients control their blood pressure and achieve excellence in cardiovascular care. In 2009, Dr. Christopher Tashjian focused his entire team on blood pressure control. He says, "It doesn't matter who our patients call, whether it's the nurse, or the receptionist, or lab tech, or the Care Coordinator, they are going to hear the exact same message: we care about your blood pressure and we are going to work with you to get it under control." Ellsworth Medical Clinic uses its EHR system's analytics and decision support to carefully monitor which patients have uncontrolled blood pressure. A care coordinator closely works with those patients to create patient-centered care plans. From 2007 to 2011, Ellsworth Medical Clinic improved the blood pressure control rate among its patients with cardiovascular disease from 68 percent to 97 percent, including a 90 percent control rate among those patients with hypertension.

[13] CDC, National Ambulatory Medical Care Survey (NAMCS) and National Hospital Ambulatory Medical Care Survey (NHAMCS), 2007–2008.
[14] CDC, NAMCS and NHAMCS, 2009–2010.
[15] CDC, National Health and Nutrition Examination Survey (NHANES), 2005–2008.
[16] CDC, NHANES, 2009–2010.
[17] CDC, NHANES, 2005–2008.
[18] CDC, NHANES, 2009–2010.
[19] NAMCS, 2005–2008.
[20] CDC, NAMCS and NHAMCS, 2009–2010.

PRIORITY 5: WORKING WITH COMMUNITIES TO PROMOTE BEST PRACTICES FOR HEALTHY LIVING

High-quality health care extends beyond the walls of medical facilities. Access to healthy food, preventive services, and physical exercise are all vital to maintaining overall health and preventing painful and costly medical complications. The Prevention and Public Health Fund, created by the Affordable Care Act, helps States and communities expand and sustain the necessary infrastructure to prevent disease, detect it early, and manage conditions before they become severe. To date, the CDC has used the fund to invest in a broad range of evidence-based activities, including community and clinical prevention initiatives, research, surveillance and tracking; public health infrastructure; immunizations and screenings; tobacco prevention; and public health workforce and training. The Affordable Care Act also makes it easier for patients with private insurance or Medicare to afford necessary preventive services, like mammograms and wellness exams, by prohibiting insurers from charging co-pays for these important services. But even as these changes go into effect nationally, local communities remain leaders in public health promotion and achievement.

Table 5: Priority 5 Measures

MEASURE FOCUS	MEASURE NAME/DESCRIPTION	BASELINE RATE	MOST RECENT RATE	ASPIRATIONAL TARGET
Depression	Percentage of adults who reported symptoms of a major depressive episode in the last 12 months who received treatment for depression in the last 12 months	68.2%[21]	68.1% for 2011	Increase to 78.2% by 2020
Obesity	Proportion of adults who are obese	35.7%[22]	Update available in 2014	Reduce to 30.5% by 2020

The national tracking measure for depression appears to be declining, but the change between the baseline rate and most recent rate is not statistically significant. Due to the increased coverage of mental health services under the essential health benefits provisions of the Affordable Care Act, we expect this measure to show improvement over time. Additionally, local communities are proving that progress is possible through concerted effort, even on seemingly intractable problems. Childhood obesity is one such challenge. Nationally, childhood obesity rates have leveled off over the past several years but remain very high. Some communities, however, are successfully encouraging their kids to be more active and to eat more healthfully,

[21] Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, 2010.
[22] CDC, NHANES, 2009–2010.

leading to sustained declines in childhood obesity. From 2005 to 2011, the State of Mississippi saw a 13.3 percent decline in childhood obesity rates and, since 2007, New York City has achieved a 5.5 percent decline. This progress is the result of robust and sustained interventions, such as offering healthier foods in schools and requiring schools to offer more physical activity.[23]

PRIORITY 6: MAKING QUALITY CARE MORE AFFORDABLE BY DEVELOPING AND SPREADING NEW HEALTH CARE DELIVERY MODELS

High-quality health care is useful only when patients find it affordable. Moreover, quality improvement often goes hand in hand with cost savings for both payers and consumers. Hospital-acquired infections, avoidable readmissions, and uncoordinated, duplicative care endanger patient safety and increase health care costs. The National Quality Strategy focuses attention on keeping care affordable as efforts to innovate and improve health and health care delivery continue. The strategy provides a national call to align clinical best practices and outcomes with financial incentives through new health care delivery models, such as ACOs, patient-centered medical homes, and bundled payment arrangements.

Table 6: Priority 6 Measures

MEASURE FOCUS	MEASURE NAME/DESCRIPTION	BASELINE RATE	MOST RECENT RATE	ASPIRATIONAL TARGET
Out-of-Pocket Expenses	Percentage of people under 65 with out-of-pocket medical and premium expenses greater than 10% of income	17.6%*[24]	Update available in Fall 2013	See footnote[25]
Health Spending Per Capita	Annual all-payer health care spending per person	$8,402[26]	$8,680 per person in 2011[27]	See footnote[28]

*Corrected May 2014

[23] Available at Robert Wood Johnson Foundation Health Policy Snapshot: Childhood Obesity Issue Brief, September 2012. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401163. Accessed March 13, 2013.
[24] Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey, 2010.
[25] See the HHS Budget in Brief for a discussion of investments and proposals to reduce health care spending. U.S. Department of Health and Human Services. Fiscal Year 2014: Budget in Brief. April 2013. http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf.
[26] CMS, Health Expenditure Data, Health Expenditures by State of Residence; 2010.
[27] Available at CMS Office of the Actuary Web site. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Accessed March 13, 2013.
[28] See the HHS Budget in Brief for a discussion of investments and proposals to reduce health care spending. U.S. Department of Health and Human Services. Fiscal Year 2014: Budget in Brief. April 2013. http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf.

Recent trends in national indicators of cost growth and individual affordability are very encouraging. According to the 2011 *National Health Expenditures Highlights,*[29] total U.S. health spending grew 3.9 percent in 2011; this is the same rate of growth as in 2009 and 2010, and in all 3 years, spending grew more slowly than in any other year in the report's 51-year history. Medicare spending per beneficiary grew just 0.4 percent per capita in fiscal year 2012, continuing the pattern of very low growth in 2010 and 2011. Medicaid spending per beneficiary also decreased 0.9 percent in 2011, compared with 0.6 percent growth in 2010. Family premiums for employer-sponsored insurance increased at an annual average rate of 6.2 percent from 2004–2008, 5.6 percent from 2009–2012, and 4.5 percent in 2012 alone.[30] In 2011, the Affordable Care Act's 80/20 rule (medical loss ratio policy), coupled with stronger rate review programs, resulted in an estimated $2.1 billion in savings to consumers of private health insurance.[31]

Innovative new models of paying for health care are spreading rapidly nationwide and are beginning to yield results that will further drive down future costs. Private payers are increasingly implementing payment models similar to the Medicare ACOs, which hold providers accountable for improving quality and lowering the rate of growth in expenditures for an assigned patient population. CareFirst BlueCross BlueShield established a "Patient-Centered Medical Home" Program in January 2011. It serves about one-third of all 3.4 million CareFirst members in Maryland, Washington, DC, and northern Virginia. The medical home program links insurance payments to primary care providers to the quality of care they deliver. In June 2013, CareFirst reported that the program reduced costs and improved the quality of care even more in its second year than in its first, citing cost savings of $98 million for the medical home program in 2012, compared with $38 million the year before. Most of the savings came from reduced hospital admissions, less use of emergency rooms, and lower spending on drugs. The program ensures high-quality care by tying physician and nurse practitioners' reimbursements to a combination of cost savings and quality measures; in 2012, two-thirds of the providers participating in the medical home program qualified for these increased reimbursements.[32]

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[29] Available at National Health Expenditure Data Web site. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html. Accessed March 13, 2013.
[30] Available at The Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits: 2012 Annual Survey, September 2012. http://kff.org/private-insurance/report/employer-health-benefits-2012-annual-survey.
[31] CMS Fact Sheet: Lower Costs, Better Care: Reforming Our Health Care Delivery System. February 28, 2013. <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-02-28.html>, Accessed June 11, 2013.
[32] Begley, Sharon. "New Healthcare Model Cut Even More Costs in Year Two: Insurer." Reuters, June 6, 2013. Accessed June 7, 2013.

4. STRATEGIC OPPORTUNITIES

The 2012 National Quality Strategy progress report illuminated three specific approaches for accelerating system-wide improvement across all of the aims and priorities of the National Quality Strategy. These three strategic opportunities are based on input provided by the National Priorities Partnership, a group of national health care stakeholders. The three strategic opportunities are:

1. Develop a national strategy for data collection, measurement, and reporting that supports performance measurement and improvement efforts of public- and private-sector stakeholders at the national and community level.
2. Develop an infrastructure at the community level that assumes responsibility for improvement efforts, resources for communities to benchmark and compare performance, and mechanisms to identify, share, and evaluate progress.
3. Develop payment and delivery system reforms—emphasizing primary care—that reward value over volume; promote patient-centered outcomes, efficiency, and appropriate care; and seek to improve quality while reducing or eliminating waste from the system.

To successfully drive quality improvement, these strategic opportunities will require engagement by both public- and private-sector partners, adoption of common goals across stakeholders, and the engenderment of shared accountability throughout the health care system. Though this level of coordination and collaboration is rare in health care, remarkable progress to date on these three strategic opportunities are cause for hope and further inspiration. Examples of the breadth and depth of activity within each of the strategic opportunities are highlighted below.

NATIONAL STRATEGY FOR DATA COLLECTION, MEASUREMENT, AND REPORTING

All payers, public and private, benefit from consensus on a national strategy for data collection, measurement, and reporting while ensuring the privacy and security of personally identifiable information. The ongoing work and significant progress in that effort is described in Section 2 of this report.

The ultimate goal is to allow providers to make health care decisions based on real-time data analysis using patient data reports and clinical decision support tools, such as computerized alerts and reminders. To that end, the HHS Office of National Coordinator for Health IT will release a health IT-focused quality improvement strategy that aims to coordinate evidence-based guidelines, clinical decision support tools, and electronic clinical quality measures. The strategy will define specific actions for payers, providers, and vendors, to improve quality using health IT.

Empowered by new authority granted through the Affordable Care Act, CMS is providing unprecedented access to timely health care data in an effort to support performance measurement, quality improvement, and patient and family engagement. Qualifying entities that participate in the Medicare Data Sharing for Performance Measurement program are now eligible to receive previously restricted Medicare data to measure provider performance. The first seven organizations from across the country have already been selected, and they include primarily regional nonprofit organizations interested in working with their local health care community to improve quality.[33] Participating entities are required to combine these Medicare data with claims data from other sources to produce reports on provider performance that will be available to the general public.

Additionally, CMS has created an ACO data sharing program in which participating Medicare ACOs receive monthly beneficiary-level claim feeds, currently helping approximately 250 ACOs better coordinate care for more than 4 million Medicare beneficiaries. The Blue Button capability—developed by the U.S. Department of Veterans Affairs in collaboration with CMS, the Department of Defense, and the Markle Foundation's Consumer Engagement Workgroup—helps inform and empower patients and their families in their health care decisionmaking. The Blue Button capability allows Veterans to securely download their personal health information from their My HealtheVet account, and self-enter their personal health indicators, emergency contact information, test results, and family health history. Medicare beneficiaries can use Blue Button to download copies of their personal health information from their MyMedicare.gov account. In addition to Federal agencies, private-sector partners like UnitedHealth Group, Aetna, and Kaiser Permanente are adopting Blue Button.

ORGANIZATIONAL INFRASTRUCTURE AT THE COMMUNITY LEVEL

Many health care organizations view the adoption of an EHR system with evidence-based clinical decision support capabilities as the first step to transforming their practices to provide consistently high-quality care across their communities. However, providers across the Nation face similar hurdles to successfully implementing EHRs. The Health Information Technology (IT) Regional Extension Center (REC) program, composed of 62 organizations that serve local communities across the Nation, is working with more than 31,000 medical practices and 140,000 providers—nearly 45 percent of the Nation's primary care providers—to adopt and meaningfully use EHRs to improve patient health and care delivery. More than half of eligible providers have qualified for and received incentive payments for demonstrating meaningful use of EHRs, and nearly 80 percent of eligible hospitals have done so. RECs have been successful at getting medical practices to change the way they use health IT to improve quality. They are

[33] Oregon Health Care Quality Corporation, Health Improvement Collaborative of Greater Cincinnati, Kansas City Quality Improvement Consortium, Maine Health Management Coalition Foundation, HealthInsight, California Healthcare Performance Information System.

helping providers meet challenges to achieve meaningful use and are leveraging those accomplishments to support quality improvement and other health care transformation goals.

PAYMENT AND DELIVERY SYSTEM REFORMS

The Affordable Care Act directed HHS to support the transformation of health care financing and delivery away from reimbursement for volume of services and toward payment for the value of care delivered to beneficiaries. To that end, HHS offers more than three dozen opportunities for providers across the care spectrum to participate in pilot programs to improve quality and reduce the cost of care.[34] Examples of these programs include Bundled Payments for Care Improvement, Strong Start for Mothers and Newborns, and Health Care Innovation Awards. The breadth and depth of participation in these programs is impressive. To date, 500 hospitals, 30,000 physicians, and 2,500 other clinicians from all 50 States and Washington, DC, are participating in at least one payment reform model sponsored by the Center for Medicare & Medicaid Innovation.

Most importantly, commercial and State-based programs that also support health care transformation are complementing these Federal payment and delivery system reforms. For example, Horizon Blue Cross Blue Shield of New Jersey has shown improved quality and reduced costs through its patient-centered medical home initiatives. These outcomes include a 26 percent reduction in emergency department use, a 25 percent reduction in hospital readmissions, an 8 percent increase in improved diabetes control, and a 6 percent increase in breast and cervical cancer screenings for medical home patients compared with patients in practices that are not participating in the medical home program.[35] Cigna Medical Group, an Arizona-based multispecialty group participating in Cigna's Collaborative Accountable Care Initiative, reduced medical costs by $27.04 per patient per month in its first year of the program. The initiative focuses on improving the quality and efficiency of care through the use of a shared-savings accountable care model with embedded care coordinators.[36] These efforts are just two examples among many; there are an estimated 428 ACOs, thousands of patient-centered medical homes, and many other payment and delivery reform efforts taking place nationwide.[37]

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[34] Available at Centers for Medicare and Medicaid Services. Center for Medicare and Medicaid Innovation: Report to Congress, December 2012. http://innovation.cms.gov/Files/reports/RTC-12-2012.pdf. Accessed March 13, 2013.
[35] Available at Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost and Quality Results, Patient-Centered Primary Care Collaborative, 2012. http://www.pcpcc.net/guide/benefits-implementing-primary-care-medical-home. Accessed March 12, 2013.
[36] Salmon R, Sanderson M, Walters B, et al. A Collaborative Accountable Care Model In Three Practices Showed Promising Early Results On Costs And Quality Of Care. Health Affairs 2012 Nov;31 (11):2379-2387.
[37] Available at Muhlstein D. Continued Growth Of Public And Private Accountable Care Organizations. Health Affairs Blog Online, February 19, 2013. http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations/. Accessed March 12, 2013.

The recent surge of activity across the three strategic opportunities represents a strong foundation upon which further multi-stakeholder engagement—and ultimately, measurable improvement toward the goals and aims of this strategy—can rest. Sustained progress, however, will require participating actors—and the community-level infrastructure that supports them—to relentlessly monitor, evaluate, and redesign initiatives as necessary. The Federal Government intends to take a leadership role in developing best practices for monitoring and evaluation, which will be examined in subsequent iterations of this report.

5. LOOKING TO THE FUTURE

The National Quality Strategy is an adaptable and evolving resource to improve health, improve quality of care, and lower costs for all Americans. Focused on its six priorities, stakeholders from across the health care community are making significant national and local progress toward the three aims of better care, healthy people/healthy communities, and affordable care.

There are many indicators of national progress on quality improvement, with each measure offering a different lens through which to view and understand progress. The national tracking measures for each of the six National Quality Strategy priority areas were chosen to give the broadest possible view of national quality improvement.

The effort to focus on measures that are the most relevant to clinicians, payers, and consumers can reduce the administrative burden of data collection and reporting. HHS will continue to pare down and consolidate the measures that providers are required to collect and report. The Department's enthusiastic engagement with private payers, through the Measures Application Partnership and the *Buying Value* initiative, will continue to drive this work. Future iterations of this report will describe these ongoing efforts and will also reflect the breadth of participation in quality reporting and improvement efforts.

In the 3 years since the passage of the Affordable Care Act, the Nation has seen increasing interest and activity in health care quality improvement and delivery system reform. There is a growing body of evidence on how to keep patients safer, how to best coordinate care to improve outcomes, and how to lower costs through improvement. This work includes publicly supported research, such as AHRQ's recent report, *Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices,* increasing numbers of CMS- and private sector-sponsored care coordination programs and pilots, and consensus recommendations from the clinician community, such as the *Choosing Wisely*® initiative by the American Board of Internal Medicine. This body of wisdom will grow as we evaluate the new models of care being tested across the Nation. Future iterations of this report will highlight specific best practices and point stakeholders from across the health care sector—payers, clinicians, communities, and consumers—to resources that guide quality improvement work for all populations.

Appendix A. National Tracking Measures and Aspirational Targets

National Quality Strategy Priority	Measure Focus	Measure Name/Description	Baseline Rate	Most Recent Rate	Aspirational Target
Making Care Safer	Hospital-Acquired Conditions	Incidence of measurable hospital-acquired conditions	145 HACs per 1,000 admissions	142 HACs per 1,000 admissions in 2011	Reduce preventable HACs by 40% by the end of 2014
	Hospital Readmissions	All-payer 30-day readmission rate	14.4%, based on 32.9 million admissionss	14.4%, based on 32.7 million admissions in 2011	Reduce all readmissions by 20% by the end of 2014
Person- and Family-Centered Care	Timely Care	Adults who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted	14.4*%	Update available in Fall 2013	Reduce to <10% by 2017
	Decisionmaking	People with a usual source of care whose health care providers sometimes or never discuss decisions with them	13.2*%	Update available in Fall 2013	Reduce to <10% by 2017
Effective Communication and Care Coordination	Patient-Centered Medical Home	Percentage of children needing care coordination who receive effective care coordination	69%	66.1%	Increase to 90% by 2017
	3-item Care Transition Measure	• During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left • When I left the hospital, I had a good understanding of the things I was responsible for in managing my health • When I left the hospital, I clearly understood the purpose for taking each of my medications	45%	Update available in Fall 2013	Increase to 50% by 2017
Prevention and Treatment of Leading Causes of Mortality	Aspirin Use	Outpatient visits at which adults with cardiovascular disease are prescribed/ maintained on aspirin	47%	53%	Increase to 65% by 2017
	Blood Pressure Control	Adults with hypertension who have adequately controlled blood pressure	46%	53%	Increase to 65% by 2017
	Cholesterol Management	Adults with high cholesterol who have adequate control	33%	32%	Increase to 65% by 2017
	Smoking Cessation	Outpatient visits at which current tobacco users received tobacco cessation counseling or cessation medications	23%	22%	Increase to 65% by 2017
Health and Well-Being of Communities	Depression	Percentage of adults who reported symptoms of a major depressive episode (MDE) in the last 12 months who received treatment for depression in the last 12 months	68.2%	68.1% for 2011	Increase to 78.2% by 2020
	Obesity	Proportion of adults who are obese	35.7%	Update available in 2014	Reduce to 30.5% by 2020
Making Quality Care More Affordable	Out-of-Pocket Expenses	Percentage of people under 65 with out-of-pocket medical and premium expenses greater than 10 percent of income	17.6*%	Update available in Fall 2013	See footnote[1]
	Health Spending per Capita	Annual all payer health-care spending per person	$8,402	$8,680 per person in 2011	See footnote[1]

* Corrected May 2014

1 See the HHS Budget in Brief for a discussion of investments and proposals to reduce health care spending. U.S. Department of Health and Human Services. Fiscal Year 2014: Budget in Brief. April 2013. http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf.

Appendix B. Measurement Policy Council

The Measurement Policy Council reviewed the U.S. Department of Health and Human Services (HHS) Measures Inventory throughout 2012 and reached a consensus on the following measures in the areas of hospital-acquired conditions (HAC), hypertension control, care coordination, patient experience, smoking cessation, and depression screening. These measures have been selected in concert with the Measures Application Partnership, and the majority will be used in relevant programs across HHS agencies.

Hospital Acquired Conditions

1. Nine Partnership for Patients topics and associated measures (see Table B.1)
2. Additional work is ongoing to further refine HAC measures and topics

Table B.1 – Partnership for Patients Topics and Measures

Hospital-Acquired Condition	Measure
Adverse Drug Event (ADE)	ADE Associated with Digoxin
	ADE Associated with Hypoglycemic Agents
	ADE Associated with IV Heparin
	ADE Associated with LMWH and Factor Xa Inhibitor
	ADE Associated with Warfarin
	Total ADE (sum of 5 above)
CAUTI	Catheter-Associated Urinary Tract Infections
CLABSI	Bloodstream Infections Associated with Central Venous Catheters
Falls	In-Hospital Patient Falls
Obstetric Adverse Events	Obstetric Trauma in Vaginal Delivery with (PSI 18) and without Instrument (PSI 19)
Pressure Ulcer	Hospital-Acquired Pressure Ulcers
Surgical Site Infection (SSI)	SSIs for 17 procedures in 2010 with CDC data
VAP	Ventilator-Associated Pneumonia
VTE	Postoperative Venous Thromboembolic Events
All Other HACs	Femoral Artery Puncture for Catheter Angiographic Procedures
	AE Associated with Hip Joint Replacements
	AE Associated with Knee Joint Replacements
	Contrast Nephropathy Associated with Catheter Angiography
	Hospital-Acquired MRSA
	Hospital-Acquired Vancomycin Resistant Enterococcus
	Hospital-Acquired Antibiotic Associated *C. diff*
	Mechanical Complications Associated with Central Venous Catheters
	Postoperative Cardiac Events for Cardiac and Non-Cardiac Surgeries
	Postoperative Pneumonia
	Latrogenic Pneumothorax
	Postoperative Hemorrhage or Hematoma
	Postoperative Respiratory Failure
	Accidental Puncture or Laceration

Hypertension Control

1. **NQF #0018**: Controlling High Blood Pressure
2. **Meaningful Use Under Development:** Percentage of patients aged 18–85 years with a diagnosis of hypertension whose blood pressure improved during the measurement period

Smoking Cessation

1. **NQF #0028**: Preventive Care and Screening Measure Pair: (a.) Tobacco Use Assessment, (b.) Tobacco Cessation Intervention
2. **Meaningful Use Core Measure 9**: Record smoking status for patients 13 years or older
3. ***Children's Health Insurance Program Reauthorization Act*** **(CHIPRA) composite in development**
    a. The Council will monitor a currently under development adolescent smoking cessation measures for CHIPRA (age range 12–21)

Depression Screening

1. **NQF #0418**: Screening for Clinical Depression (percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow up plan documented)
2. **NQF #0710**: Depression Remission at Twelve Months (defined by PHQ-9 score)
3. **NQF #1401**: Maternal Depression Screening (percentage of children 6 months of age who had documentation of a maternal depression screening for the mother)