<table>
<thead>
<tr>
<th>Aim: improved care</th>
<th></th>
</tr>
</thead>
</table>
| Patient and caregiver experience | • Getting timely care, appointments, and information  
• How well your doctors communicate  
• Helpful, courteous, respectful office staff  
• Patients’ ratings of doctor  
• Health promotion and education  
• Shared decision making  
• Health status or functional status |
| Care coordination — transitions | • Risk-standardized, all-condition readmission  
• 30-Day post-discharge physician visit  
• Medication reconciliation  
• Care transitions measure  
• Management of ambulatory-sensitive conditions: diabetes; chronic obstructive pulmonary disease (COPD); congestive heart failure (CHF); dehydration; bacterial pneumonia; urinary tract infections (UTIs)  
• % of all physicians meeting HITECH meaningful use requirements |
| Care coordination — information systems | • % of PCPs meeting HITECH meaningful use requirements  
• % of PCPs using clinical decision support  
• % of PCPs meeting eRx incentive program requirements  
• Patient registry use |
| Patient safety | • Health care–acquired conditions composite (includes foreign object retained after surgery, central-line–associated bloodstream infections [CLABSI], falls and trauma, catheter associated UTI, and others)  
• CLABSI bundle use |
| Aim: improved health |  |
| Preventive health | • Influenza immunization  
• Pneumococcal vaccination  
• Mammography screening  
• Colorectal cancer screening  
• Cholesterol management for patients with cardiovascular conditions  
• Adult weight screening and follow-up  
• Blood-pressure measurement  
• Tobacco-use assessment and intervention  
• Depression screening |
| At-risk population — diabetes | • Composite and individual measures (glycated hemoglobin, LDL cholesterol <100 mg/dl, blood pressure <140/90 mm Hg, tobacco nonuse, aspirin use)  
• Poor glycemic control (glycated hemoglobin >9%)  
• Blood pressure control in diabetes  
• Screening rates for microalbuminuria  
• Dilated eye exam; foot exam |
| At-risk population — heart failure | • Left ventricular function assessment  
• Left ventricular function testing  
• Weight measurement  
• Patient education  
• Heart failure prescription rates for left ventricular systolic dysfunction (LVSD)  
• Angiotensin-converting–enzyme inhibitor or angiotensin-receptor blocker (ACE/ARB) rates for LVSD  
• Warfarin therapy for patients with atrial fibrillation |
| At-risk population — coronary artery disease | • Coronary artery disease (CAD) composite and individual measures (oral antiplatelet therapy for patients with CAD; drug therapy for lowering LDL cholesterol; beta-blocker for patients with CAD with prior myocardial infarction; LDL cholesterol <100 mg/dl; ACE/ARB therapy for patients with CAD and diabetes, LVSD, or all of the above) |
| At-risk population — hypertension | • Blood-pressure control rates (<140/90 mm Hg)  
• Hypertension plan of care |
| At-risk population — COPD | • Spirometry evaluation  
• Smoking-cessation counseling  
• Bronchodilator therapy based on FEV<sub>1</sub> |
| At-risk population — frail elderly | • Screening for fall risk  
• Osteoporosis management in women who had a prior fracture  
• Monthly INR for beneficiaries on warfarin |

* Most measures and standards would be based on rates within the total eligible population. HITECH denotes the Health Information Technology for Economic and Clinical Health Act. LDL low-density lipoprotein, FEV<sub>1</sub> forced expiratory volume in 1 second, INR international normalized ratio, and PCPs primary care physicians.