2012 AAOS Orthopaedic Quality Institute: Defining Quality in Musculoskeletal Care

November 8-9, 2012
The Madison Hotel
Washington, DC
November 8, 2012

Dear Colleagues:

Welcome to the 2012 American Academy of Orthopaedic Surgeons (AAOS) Orthopaedic Quality Institute: Defining Quality in Musculoskeletal Care (OQI). The second annual OQI will focus on understanding and informing definitions of quality in value-driven policy and payment reforms, providing a unique opportunity for open dialogue between orthopaedic surgeons and stakeholders representing payors, purchasers, and healthcare policy makers.

Musculoskeletal care is a major driver of healthcare services utilization and spending in the United States. Despite the well-documented benefits of musculoskeletal care in improving quality of life and function in patients who suffer from musculoskeletal ailments, wide variations in utilization rates, quality, and cost of care persist. In an attempt to drive higher value care, payors, purchasers, and healthcare policy makers have modified benefit designs and implemented value-based purchasing plans to incentivize patients to seek and providers to deliver higher value care. These payment and delivery reforms, including bundled payments, provider tiering, centers of excellence designation, reference pricing, and accountable care organizations, incorporate variable definitions of the value of musculoskeletal care.

The objectives of the 2012 Orthopaedic Quality Institute are:

1. To educate AAOS leadership (Board of Directors, Board of Councilors, and Board of Specialty Societies) on payor/purchaser, consumer engagement and other policy initiatives that provide value/quality designations for musculoskeletal providers.
2. To discuss strategies for AAOS engagement in defining quality in musculoskeletal care.
3. To develop a strategic plan and proposed timeline for AAOS input into definitions of quality for use in payment and delivery reforms.

We hope to achieve consensus regarding a plan for AAOS involvement in defining and measuring quality in musculoskeletal care. The meeting participants have been divided and assigned to breakout groups to harvest the diverse intellect and backgrounds of the faculty and attendees. Each group will be tasked with developing concrete deliverables to help define the role of the AAOS in measuring quality musculoskeletal care.

Your insight is valuable and we look forward to a productive collaboration. Thank you for taking time out of your schedule to participate in this important event.

Sincerely,

Kevin J. Bozic, MD, MBA  
Chair, OQI  
Chair, AAOS Council on Research and Quality

Craig A. Butler, MD, MBA  
Co-Chair, OQI  
Chair, AAOS Health Care Systems Committee
OQI Agenda
Orthopaedic Quality Institute: Defining Quality in Musculoskeletal Care

November 8-9, 2012
The Madison Hotel / Washington, DC
Kevin J. Bozic, MD, MBA, Chair
Craig A. Butler, MD, MBA, Co-Chair

Thursday, November 8, 2012

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<td>4:00 – 5:30 PM</td>
<td>OQI Check In</td>
<td>Mt. Vernon Foyer</td>
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<tr>
<td>5:30 – 6:30 PM</td>
<td>Opening Reception</td>
<td>Mt. Vernon</td>
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<tr>
<td>6:30 – 7:00 PM</td>
<td>Keynote Speaker</td>
<td>Montpelier</td>
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| Thomas B. Valuck, MD, JD  
*Senior Vice President, Strategic Partnerships, National Quality Forum* |
| 7:00 – 9:00 PM  | Dinner                                     | Montpelier     |

Friday, November 9, 2012

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<tr>
<td>7:00 – 7:30 AM</td>
<td>Breakfast</td>
<td>Dolley Madison Ballroom</td>
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<tr>
<td>7:30 – 7:35 AM</td>
<td>Overview of OQI</td>
<td>Dolley Madison Ballroom</td>
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| Kevin J. Bozic, MD, MBA  
*Chair, AAOS Orthopaedic Quality Institute* |
| 7:35 – 7:40 AM  | AAOS Commitment to Quality                 | Dolley Madison Ballroom |
| John Tongue, MD  
*President, American Academy of Orthopaedic Surgeons* |
| 7:40 – 7:45 AM  | Session Introductions                      | Dolley Madison Ballroom |
| Kevin J. Bozic, MD, MBA  
*Chair, AAOS Orthopaedic Quality Institute* |
| 7:45 – 8:05 AM  | 1) The Importance of Quality Measurement in Payment and Delivery System Reform | Dolley Madison Ballroom |
| Carolyn Clancy, MD  
*Director, Agency for Healthcare Research and Quality (AHRQ)* |
| 8:05 – 8:20 AM  | 2) The CMS Perspective on Value in Healthcare | Dolley Madison Ballroom |
| Kate Goodrich, MD  
*Acting Director of the Quality Measurement and Health Assessment Group, CMS* |
| 8:20 – 8:35 AM  | 3) Consumer Perspectives on Quality Measurement and Reporting | Dolley Madison Ballroom |
| John Santa, MD, MPH  
*Director, Health Ratings Center, Consumer Reports* |
| 8:35 – 9:05 AM  | Panel Discussion                           | Dolley Madison Ballroom |
| -Kate Goodrich, MD, *Acting Director of the Quality Measurement and Health Assessment Group, CMS*  
-Ralph Brindis, MD, *Past President, American College of Cardiologists*  
-Shep Hurwitz, MD, *Executive Director, American Board of Orthopaedic Surgery*  
-Frank Opelka, MD, *Vice Chancellor of Clinical Affairs, LSU Health Sciences*  
-Donald Casey, MD, MPH, MBA, *Vice President & Medical Director, Clinically Integrated Physician Network, NYU Langone Medical Center* |
### Session II: Review of External Stakeholder Value/Quality Designation Programs

**Moderator:** Joshua Jacobs, MD

<table>
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<tr>
<th>Time</th>
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| 9:05 – 9:10 AM | **Session Introductions**  
Joshua Jacobs, MD  
*First Vice President, American Academy of Orthopaedic Surgeons* | Dolley Madison Ballroom        |
| 9:10 – 9:25 AM | **4) Blue Cross Blue Shield Blue Distinction Program**  
Carole Redding-Flamm, MD, MPH  
*Executive Medical Director, Blue Cross Blue Shield Association* |                                |
| 9:25 – 9:40 AM | **5) United Healthcare Premium Designation Program**  
Steven Stern, MD, MBA  
*Vice President, Cardiac & Orthopaedics/Neuroscience, UnitedHealthcare* |                                |
| 9:40 – 9:55 AM | **6) The Alliance Quality Counts**  
Cheryl DeMars, MSW  
*President and CEO, The Alliance* |                                |
| 9:55 – 10:10 AM | **7) Payment Reform and Quality Measurement**  
William Shrank, MD, MSHS  
*Center for Medicare and Medicaid Innovation* |                                |
| 10:10 – 10:25 AM | **8) National Committee for Quality Assurance Programs**  
Mary Barton, MD, MPP  
*National Committee for Quality Assurance* |                                |
| 10:25 – 10:55 AM | **Panel Discussion**  
-Carole Redding-Flamm, MD, MPH, *Executive Medical Director, BCBSA*  
-Steven Stern, MD, MBA, *Vice President, UnitedHealthcare*  
-Cheryl DeMars, MSW, *President and CEO, The Alliance* | Dolley Madison Ballroom        |
| 10:55 – 11:05 AM | **BREAK** |                                |

### Session III: Update on AAOS Quality Initiatives

**Moderator:** David Jevsevar, MD, MBA

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<th>Time</th>
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| 11:05 – 11:20 AM | **Session Introduction**  
David Jevsevar, MD, MBA  
*Chair, AAOS Evidence Based Practice Committee* | Dolley Madison Ballroom        |
| 11:20 – 11:35 AM | **9) Appropriate Use Criteria (AUC): Distal Radius Fracture**  
David Jevsevar, MD, MBA  
*Chair, AAOS Evidence Based Practice Committee* |                                |
| 11:35 – 11:50 AM | **10) 2013 Topics for AAOS Clinical Practice Guidelines (CPG) and AUCs**  
Michael Goldberg, MD  
*Chair, AAOS Guideline Oversight Committee* |                                |
| 11:50 AM – 12:05 PM | **11) The Role of Registries in Measuring Quality: The American Joint Replacement Registry (AJRR)**  
David Lewallen, MD  
*Chair, AJRR* |                                |
| 12:05 – 12:35 PM | **Panel Discussion**  
-Michael Goldberg, MD, *Chair, AAOS Guideline Oversight Committee*  
-David Lewallen, MD, *Chair, AJRR*  
-John Tongue, MD, *AAOS President*  
-Joshua Jacobs, MD, *AAOS First Vice President*  
-Kevin J. Bozic, MD, MBA, *Chair, AAOS Council on Research & Quality*  
-William R. Martin, III, MD, *AAOS Medical Director*  
-Deborah Cummins, PhD, *AAOS Director, Research and Scientific Affairs* |                                |

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### Session IV: Performance Measure Development

**Moderator: Deborah Cummins, PhD**

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| 1:15 – 1:20 PM | **Session Introductions**  
Deborah Cummins, PhD  
*AAOS Director, Research and Scientific Affairs* | Dolley Madison Ballroom |
| 1:20 – 1:35 PM | **12) The Role of NQF in defining Quality in healthcare**  
Helen Burstin, MD, MPH  
*Senior Vice President for Performance Measures, National Quality Forum* | Dolley Madison Ballroom |
| 1:35 – 1:50 PM | **13) Lessons from the STS National Database**  
David Shahian, MD  
*Chair, Society of Thoracic Surgeons National Database  
Massachusetts General Hospital and Harvard Medical School*  
Panel Discussion  
-Helen Burstin, MD, MPH, *Senior Vice President for Performance Measures, NQF*  
-David Shahian, MD, *MGH Center for Quality and Safety*  
-Frank Opelka, MD, *Vice Chancellor of Clinical Affairs, LSU Health Sciences*  
-Tom Lewandrowski, MD  
-Nancy Davis, PhD, *Executive Director, National Institute for Quality Improvement and Education*  
-Sharon Sprenger, RHIA, CPHQ, MPA, *Director, External Measurement Relations, The Joint Commission* | Dolley Madison Ballroom |
| 1:50 – 2:10 PM | **OQI Breakout Sessions:**  
**Recommendations for AAOS Involvement in Defining/Measuring Quality** |
| 2:10 – 2:15 PM | **Overview of Breakout Session Goals**  
Craig A. Butler, MD, MBA  
*Co-Chair, Orthopaedic Quality Institute* | Dolley Madison Ballroom |
| **Group A Moderators:**  
Frank Opelka, MD, *Vice Chancellor of Clinical Affairs, LSU*  
Kevin J. Bozic, MD, MBA, *Chair, AAOS Orthopaedic Quality Institute* | Adams A |
| **Group A Facilitator:**  
K. William Kumler, MD, MBA | Adams A |
| 2:15 – 4:00 PM | **Group B Moderators:**  
Greg Mencio, MD, *Chair, AAOS Board of Specialty Societies*  
David Shahian, MD, *Chair, Society of Thoracic Surgeons National Database*  
*Group B Facilitator: Brian McCardel, MD* | Ballroom Upper Level |
| **Group C Moderators:**  
David Lansky, PhD, *CEO, Pacific Business Group on Health*  
Tom Friermood, MD, *Panorama Orthopaedics and Spine Center*  
Catherine MacLean, MD, PhD, *WellPoint*  
*Group C Facilitator: Marc Rankin, MD* | Ballroom Upper Level |
| 4:00 – 4:10 PM | **Group A Breakout Report** | Dolley Madison Ballroom |
| 4:10 – 4:20 PM | **Group B Breakout Report** | Dolley Madison Ballroom |
| 4:20 – 4:30 PM | **Group C Breakout Report** | Dolley Madison Ballroom |
| 4:30 – 4:50 PM | **Recommendations and Next Steps**  
Kevin J. Bozic, MD, MBA  
*Chair, AAOS Orthopaedic Quality Institute* | Dolley Madison Ballroom |
| 4:50 – 5:00 PM | **Closing Remarks**  
John Tongue, MD  
*President, American Academy of Orthopaedic Surgeons* | Dolley Madison Ballroom |
OQI Breakout Group A

A Edward Arrington, MD (Surgeon - BOC)
A Kevin Bozic, MD, MBA (Surgeon - Chair)
A Ralph Brindis, MD, MPH, MACC, FSCAI (Stakeholder - Regulatory)
A Helen Burstin, MD, MPH (Stakeholder - Regulatory)
A Donald Casey, Jr., MD, MPH, MBA, FACP, FAHA (Stakeholder - Payor)
A Deborah Cummins, PhD (Staff)
A Frank Federico, RPh (Stakeholder - Regulatory)
A Tom Fenter, MD (Stakeholder - Payor)
A Wilford Gibson, MD (Surgeon - BOC)
A David Halsey, MD (Surgeon - BOS)
A Shepard Hurwitz, MD (Surgeon - Other)
A Joshua Jacobs, MD (Surgeon - BOD)
A K. William Kumier, MD, MBA (Surgeon - Other)
A Tom Lewandrowski, MD (Surgeon - Other)
A John McGraw, MD (Surgeon - BOC)
A Jayson Murray, MA (Staff)
A Frank Opelka, MD, FACS (Surgeon - Other)
A Erin Ransford (Staff)
A Lyle Sorensen, MD (Surgeon - Other)
A Sharon Sprenger, RHIA, CPHQ, MPA (Stakeholder - Regulatory)
A Steven Stern, MD (Stakeholder - Payor)
A David Templeman, MD (Surgeon – BOS)
A Nancy Wilson, MD, MPH (Stakeholder - Regulatory)

3 AAOS Staff
3 Stakeholder – Payor
5 Stakeholder – Regulatory
12 Surgeons (BOC, BOD, BOS, Other)
23 TOTAL

OQI Breakout Group B

B Thomas Barber, MD (Surgeon - BOS)
B Mary Barton, MD, MPP (Stakeholder – Regulatory)
B Joseph Bosco III, MD (Surgeon - BOC)
B Johann Chanin, RN, MSN (Stakeholder - Regulatory)
B Michael Cuffe, MD, MBA (Stakeholder - Payor)
B Carole Flamm, MD, MPH (Stakeholder - Payor)
B Kate Goodrich, MD (Stakeholder - Regulatory)
B Patrick Halpin, MD (Surgeon - BOC)
B Minet Javellana (Stakeholder - Regulatory)
B David Jevsevar, MD (Surgeon - Other)
B Kevin Kwon (Staff)
B Phillip Lerner, MD (Stakeholder - Payor)
B Peter Mandell, MD (Surgeon - Other)
B David Mansfield, MD (Surgeon - BOS)
B Brian McCardel, MD (Surgeon - Other)
B Gregory Mencio, MD (Surgeon - BOS)
B Sharon-Lise Normand, PhD (Guest)
B Fred Redfern, MD (Surgeon - BOC)
B John Santa, MD, MPH (Stakeholder - Regulatory)
B David Shahian, MD (Surgeon - Other)
B John Tongue, MD (Surgeon - BOD)
B Matthew Twetten, MA (Staff)
B William Watters III, MD (Surgeon - Other)

1 Guest
3 AAOS Staff
3 Stakeholder – Payor
4 Stakeholder – Regulatory
11 Surgeons (BOC, BOD, BOS, Other)
22 TOTAL

OQI Breakout Group C

C Frederick Azar, MD (Surgeon - BOD)
C Judi Buckalew, BSN, MPH (Staff)
C Nancy Davis, PhD (Stakeholder - Regulatory)
C Cheryl DeMars, MSSW (Stakeholder - Payor)
C Douglas Dew, MD, MBA (Surgeon - BOC)
C Thomas Friermood, MD (Surgeon - BOC)
C Michael Goldberg, MD (Surgeon - Other)
C Robert Greene, MD, FACP (Stakeholder - Payor)
C Anil Krishnamurthy, MD (Stakeholder - Regulatory)
C David Lansky, PhD (Stakeholder - Payor)
C David Lewallen, MD (Surgeon - Other)
C Catherine MacLean, MD, PhD (Stakeholder - Payor)
C Gregory McDowell, MD (Surgeon - BOC)
C George Muschler, MD (Surgeon - Other)
C Karen Nakano, MD, MS (Stakeholder – Regulatory)
C Simit Pandya (Staff)
C Mark Piasio, MD, MBA (Stakeholder – Payor)
C Marc Rankin, MD (Surgeon - Other)
C William Robb, MD (Surgeon - BOS)
C William Shrank, MD (Stakeholder - Regulatory)
C Sharon Song, PhD (Staff)
C Kristy Weber, MD (Surgeon - Other)
C Charlotte Yeh, MD, FACEP (Stakeholder - Regulatory)

3 AAOS Staff
5 Stakeholder – Payor
5 Stakeholder – Regulatory
10 Surgeons (BOC, BOD, BOS, Other)
23 TOTAL
Mary Barton MD, MPP

Mary Barton, MD, MPP oversees the development, use and maintenance of techniques NCQA uses to evaluate health care quality. She ensures the scientific integrity of NCQA measurement and research. She also leads NCQA in winning and executing health care quality measurement contracts for federal and state governments.

Prior to NCQA, Dr. Barton worked for the Agency for Healthcare Research and Quality (AHRQ), where she was the scientific director of the U.S. Preventive Services Task Force (USPSTF). She supported and provided oversight for the methodological, evidence review and recommendation-making work of the USPSTF. Before joining AHRQ, she was an assistant professor at Harvard Medical School, where she performed clinical epidemiology and health services research related to cancer screening and prevention in terms of access, test performance and outcomes.

Dr. Barton trained in primary care internal medicine at Brigham and Women’s Hospital in Boston and completed a general medicine research fellowship at Harvard. Dr. Barton has a clinical interest in and has presented widely about the performance of the clinical breast examination. She is a member of the American College of Physicians and the Society of General Internal Medicine.

Kevin J. Bozic, MD, MBA

Kevin J. Bozic, MD, MBA is Professor and Vice Chair in the Department of Orthopaedic Surgery and a member of the core faculty of the Philip R. Lee Institute for Health Policy Studies at the University of California, San Francisco (UCSF). Dr. Bozic is a graduate of the UCSF School of Medicine and the Harvard Combined Orthopaedic Residency Program. Additionally, he holds a Bachelor of Science degree in Biomedical Engineering from Duke University and a Masters of Business Administration from Harvard Business School. Dr. Bozic has fellowship training in Adult Reconstructive Surgery from Rush University Medical Center in Chicago.

Dr. Bozic’s clinical interests are in adult reconstructive surgery of the hip and knee, with an emphasis on primary and revision hip and knee replacement. His research interests are broadly in the fields of health policy and health care services research, and specifically in the areas of healthcare technology assessment, cost-effectiveness analysis, shared medical decision making, and the impact of healthcare reform on cost and quality. In addition to his clinical and research activities, Dr. Bozic is actively involved in numerous regional and national health policy initiatives, including the Agency for Healthcare Research and Quality’s (AHRQ) Effective Healthcare Stakeholder Group, the Integrated Healthcare Association’s Value Assessment of Medical Technologies Program, and the California Health Care Foundation’s California Joint Replacement Registry Project.

Dr. Bozic also holds both regional and national leadership positions, as President of the California Orthopaedic Association, Board of Trustees of the Orthopaedic Research and Education Foundation (OREF) and the Board of Directors of the American Joint Replacement Registry (AJRR), and as Chair of the American Academy of Orthopaedic Surgeons (AAOS) Council on Research and Quality.

Dr. Bozic has been the recipient of numerous awards and honors, including the Orthopaedic Research and Education Foundation’s Clinical Research Award, the American Academy of Orthopaedic Surgeon’s Clinician-Scientist Traveling Fellowship Award, the American Orthopaedic Association’s American-British-Canadian Traveling Fellowship, the
American Association of Hip and Knee Surgeon’s James A. Rand Young Investigator Award, and the Orthopaedic Research Society’s William Harris Award. Since arriving at UCSF, Dr. Bozic has received extramural funding for his research from the OREF, AHRQ, National Institutes of Health (NIH), Robert Wood Johnson Foundation (RWJF), and the California HealthCare Foundation.

Selected current projects include Shared Decision Making in Total Joint Replacement; Identification of Risk Factors for Revision Surgery Following Primary THA and TKA; and Integrated Care Delivery and Episode of Care Payments in Hip and Knee Arthroplasty.

Ralph G. Brindis, MD, MPH, MACC, FSCAI

Ralph G. Brindis, MD, MPH, MACC, FSCAI is a Clinical Professor of Medicine at the University of California, San Francisco and serves on the affiliate faculty of the Phil R. Lee Institute of Health Policy Studies at UCSF. Dr. Brindis was the President of the American College of Cardiology (ACC) from 2010 to 2011 and the Senior Advisor for Cardiovascular Disease for the Northern California Kaiser Permanente Medical Group from 2003 to 2012. He received his undergrad education at MIT and has a Master's Degree in Public Health from UCLA. He graduated Emory Medical School Summa Cum Laude. All of his graduate medical training was performed at UCSF as a Resident and Chief Resident in Internal Medicine and then as a Cardiology Fellow.

Dr. Brindis has served previously as the ACC Governor of Northern California and as Past President of the California Chapter of the ACC. Dr. Brindis is the immediate past Chief Medical Officer and Chair of the ACC National Cardiovascular Registry (ACC-NCDR) Management Board now overseeing seven cardiovascular national registries assessing cardiac catheterization and angioplasty, implantable defibrillators, carotid stenting, percutaneous valve implantation, acute coronary syndromes, ambulatory cardiovascular medical management and congenital heart disease. He is the immediate past Chair of the ACC Appropriateness Use Criteria Task Force developing appropriateness criteria for non-invasive testing and coronary revascularization procedures in cardiovascular disease. He has also served as Chair of the ACC Quality Strategic Directions Committee. Dr. Brindis was the 2007 recipient of the national ACC Distinguished Fellow Award and granted the Master’s designation of the ACC in 2011.

Dr. Brindis is active as a volunteer in the American Heart Association (AHA) having served on the California Affiliate Board and previously as President and member of the Board of the AHA San Francisco Division. Presently he serves on the AHA Western Affiliate STEMI Mission Life Line Task Force and previously served on the Steering Committee of the national AHA Quality of Care and Outcomes Conference. Dr. Brindis sits on the Cardiac Advisory Board of the State of California OSHPD initiative overseeing public reporting of hospital and physician specific CABG mortality along with serving on the Advisory Board of California’s State Pilot program for PCI without surgical on-site capability. Dr. Brindis is a Trustee for the Society of Cardiovascular Angiography and Interventions. Presently he also serves on the NCQA Heart/Stroke Advisory Committee, the Rand-Stanford Comparative Effectiveness Research Advisory Committee, the DAPT –Dual Antiplatelet Platelet Trial Advisory Board and the Data Safety and Monitoring Board of C-PORT Elective. Dr. Brindis presently sits on the FDA medical advisory panel for circulatory devices and also is a panelist for MEDCAC. He previously served on the National Blue Ribbon Advisory Committee for Cardiac Care for the Veteran’s Administration and the VA Hospital National CABG Quality Oversight Committee. Dr. Brindis has over one hundred publications in national peer reviewed cardiovascular journals.
Dr. Brindis is a general adult cardiologist following a career as an interventionalist cardiologist. His major interest in process measures and outcomes assessment in cardiovascular care had led to helping create and implement various Cardiovascular Guidelines for Northern California Kaiser Permanente. Dr. Brindis is married to Dr. Claire Brindis, Director of the Philip R. Lee Institute for Health Policy Studies and the Director of the Center for Reproductive Health Policy Research both at UCSF. Their son Seth is an Emergency Medicine Pediatrician and son Daniel, an environmental lawyer, is employed by Greenpeace. Dr. Brindis swims on the USF Masters Swim Team and enjoys fine wine and golf.

**Helen Burstin, MD, MPH, FACP**

Helen Burstin, MD, MPH, FACP is the Senior Vice President for Performance Measures of the National Quality Forum, a private, not-for-profit membership organization established in 1999 to develop and implement a national strategy for healthcare quality measurement and reporting. Dr. Burstin joined NQF in January 2007 and is responsible for the NQF consensus development process and the endorsement of performance measures, preferred practices, and frameworks. Prior to joining NQF, Dr. Burstin was the Director of the Center for Primary Care, Prevention, and Clinical Partnerships at the Agency for Healthcare Research and Quality (AHRQ). In her role, she oversaw the development of the Health Information Technology (IT) portfolio which invested over $166 million on research at the intersection of health IT and quality of care. Her center also supported the U.S. Preventive Services Task Force and an extensive body of research on primary care and prevention. Prior to joining AHRQ in 2000, Dr. Burstin was an Assistant Professor at Harvard Medical School and the Director of Quality Measurement at Brigham and Women’s Hospital. In her role, she developed a hospital-wide electronic Quality Measurement Reporting System. She also served as the Chair of the Medical Staff Executive Committee on Quality Assurance and Risk Management.

Dr. Burstin is a graduate of the State University of New York at Upstate College of Medicine and the Harvard School of Public Health. She spent a year in Washington, DC as National President of the American Medical Student Association. Dr. Burstin completed a residency in primary care internal medicine at Boston City Hospital. After residency, she completed fellowship training in General Internal Medicine and Health Services Research at Brigham and Women’s Hospital and Harvard Medical School. Dr. Burstin is the author of over 75 articles and book chapters on patient safety, quality, and disparities. She previously served as a deputy editor of the Journal of General Internal Medicine. Dr. Burstin is a member of the Board of Directors of the American Medical Informatics Association (AMIA). She is a Senior Professorial Lecturer in the Department of Health Policy at George Washington University School of Public Health and a Clinical Associate Professor of Medicine at George Washington University School of Medicine. A board certified general internist, Dr. Burstin precepts internal medicine residents at George Washington Medical Faculty Associates.

**Craig A. Butler, MD, MBA, CPE**

Craig A. Butler, MD, MBA, CPE is a board-certified orthopaedic surgeon, fellowship-trained in Sports Medicine with over 25 years of clinical experience. He is managing partner for North Florida Sports Medicine and Orthopaedic Center where his clinical practice focuses on sports medicine and occupational orthopedic medicine with special emphasis on developing cost-effective, evidence-based pathways for treating injuries in these areas.

Dr. Butler serves at state and national levels informing his colleagues and other stakeholders on the details of health care policy and change. His primary interest is in health care business and...
delivery model innovation, emphasizing value by specifically improving quality and lowering costs. He consults in this field as the principal of Veritas Medical Intelligence, LLC.

Dr. Butler is a graduate of the US Air Force Academy, Johns Hopkins University School of Medicine, and the Fuqua School of Business at Duke University. He is also qualified as a Certified Physician Executive with the American College of Physician Executives.

Donald Casey Jr., MD, MBA, MPH, FACP, FAHA

Donald Casey Jr., MD, MBA, MPH, FACP, FAHA recently joined NYU Langone Medical Center as Vice President, and Medical Director of the NYU Physician Clinically Integrated Network in August, 2012. His current role is to develop and implement performance measurement and improvement systems for quality, patient experience, efficiency and patient safety for more than 2,200 physicians currently participating in the NYU Network.

Prior to NYU, he was Chief Medical Officer (CMO) for Atlantic Health System (AHS), a three hospital system in Northern New Jersey from 2005-2012. While at AHS, his responsibilities include leading and overseeing AHS’s initiatives for quality and patient safety, physician leadership development, academic affairs, Computerized Provider Order Management (CPOM) and the Atlantic Center for Research. During his tenure, AHS experienced a more than 40% decline in inpatient mortality with significant improvement in hospital rankings in the University Health System Consortium (UHC) Comparative Database (CDB) and a 25% decline in infection rates.

From 2001-2005, Dr. Casey was CMO for Catholic Healthcare Partners (CHP), a 5 state, 30 hospital non-profit health system based in Cincinnati, Ohio. During his tenure, Dr. Casey’s significant accomplishments included crafting and putting into practice a comprehensive “best practice” driven quality strategic plan to achieve top decile performance that resulted in national recognition for many CHP hospitals. In addition, he successfully designed and implemented CHP’s heart failure GAP initiative, (funded for four years at $1.3 million by the Agency for Healthcare Research and Quality) resulting in a readmissions rate of 5% and a 40% decline in inpatient mortality through improved evidence-based care of patients with chronic heart failure.

Dr. Casey was CMO at the Delmarva Foundation for Medical Care (DFMC), the Medicare Quality Improvement Organization (QIO) for Maryland and Washington, DC between 1997-2001, with responsibility for the oversight of the quality of care provided to all Medicare beneficiaries in these jurisdictions, including hospitals, physicians, home care and long term care. During his tenure at DFMC he revolutionized quality improvement and transparency, resulting in the first statewide reporting of quality measures in Maryland.

Dr. Casey has participated in the development and implementation of numerous clinical practice guidelines and performance measures developed by the American College of Physicians, the American College of Cardiology, the American Heart Association, the Agency for Healthcare Research and Quality (AHRQ), numerous state health agencies, the National Quality Forum (NQF), The Joint Commission and the Centers for Medicare and Medicaid Services (CMS). He is often asked to speak on a number of health policy issues at regional and national forums on the role of evidence-based medicine and effective care coordination in improving the quality of care delivered to patients in the United States. He is co-chair of the NQF Care Coordination Steering Committee since 2006.
Dr. Casey has practiced extensively as a primary care and hospital-based internal medicine specialist for 20 years in a variety of settings and roles, including a Federally Qualified Health Center, urban and suburban office practices, a rural practice patient centered medical home serving a large, fully at-risk captitated Medicaid population, an internal medicine teaching program, and as a consultant and medical director of home care services, long term and post-acute facilities, and home hospice.

Dr. Casey’s academic credentials include an AB degree from Dartmouth College, MD degree from the University of Cincinnati College of Medicine, Masters in Business Administration from the Wharton School at the University of Pennsylvania, and Masters in Public Health from Johns Hopkins School of Hygiene and Public Health. He is a Fellow of the American College of Physicians and the American Heart Association. Dr. Casey has co-authored more than 75 peer reviewed articles for journals and book chapters, including the New England Journal of Medicine, Annals of Internal Medicine, Circulation, Journal of the American College of Cardiology, Journal of Cardiac Failure, the American Journal of Medical Quality, Academic Medicine, Inquiry, Hepatology and Neurology. He is currently an Associate Professor of Medicine at the Mount Sinai School of Medicine in New York and lectures frequently across the United States on new strategies for improving patient care through the effective evidence-based clinical practice guidelines and performance measurements.

**Johann Chanin, RN, MSN**

Johann Chanin, RN, MSN Johann Chanin, Director, Product Development, led the development and implementation of NCQA’s Patient-Centered Medical Home (PCMH) 2011 standards. The PCMH 2011 standards are based on an analysis of data from existing standards, public comment, advisory panel of stakeholders and current evidence. Ms. Chanin is an internal and external resource on NCQA’s medical home standards and other new and revised physician evaluation programs. In addition, she is a member of small team that gives large national workshops on NCQA’s medical home standards. Her current work involves assessing potential programs to support and advance the medical home. She is currently working with a team and an advisory committee with wide health care community representation to build and test evaluation standards for specialty practices.

During her tenure at NCQA, Ms. Chanin has worked on NCQA Recognition Program operations, assisting practices applying for Recognition, reviewing submitted surveys and associated documentation and conducting on-site audits. She managed the development, pilot testing and public comment of other physician program standards leading to the publication of standards and associated policies and procedures. Ms. Chanin’s responsibilities include conducting targeted research on potential new recognition programs.

Her background as a registered nurse, a hospital-based clinical nurse specialist and a health care researcher at the University of Michigan, School of Public Health provide her with a comprehensive understanding of the challenges and measurement and policy issues associated with clinician and practice evaluation. Ms. Chanin earned a Bachelor of Science and a Master of Science in Nursing at the University of Michigan and has worked at a community hospital and a large medical center hospital.
Carolyn Clancy, MD

Carolyn M. Clancy, MD, was appointed Director of the Agency for Healthcare Research and Quality (AHRQ) on February 5, 2003, and reappointed on October 9, 2009. Prior to her appointment, Dr. Clancy was Director of AHRQ’s Center for Outcomes and Effectiveness Research. Dr. Clancy, a general internist and health services researcher, is a graduate of Boston College and the University of Massachusetts Medical School. Following clinical training in internal medicine, Dr. Clancy was a Henry J. Kaiser Family Foundation Fellow at the University of Pennsylvania. Before joining AHRQ in 1990, she was also an assistant professor in the Department of Internal Medicine at the Medical College of Virginia.

Dr. Clancy holds an academic appointment at the George Washington University School of Medicine (Clinical Associate Professor, Department of Medicine) and serves as Senior Associate Editor for the journal Health Services Research. She serves on multiple editorial boards, including Annals of Internal Medicine, Annals of Family Medicine, American Journal of Medical Quality, and Medical Care Research and Review.

Dr. Clancy is a member of the Institute of Medicine and was elected a Master of the American College of Physicians in 2004. In 2009, she was awarded the William B. Graham Prize for Health Services Research. Dr. Clancy's major research interests include improving health care quality and patient safety and reducing disparities in care associated with patients' race, ethnicity, gender, income, and education. As Director of AHRQ, she launched the first annual report to Congress on health care disparities and health care quality.

Dr. Clancy lives in the Maryland suburbs of Washington, DC, with her husband, Bill. She enjoys jogging, movies, and spending time with her extended family, especially her four nieces, who live in Virginia.

Deborah Cummins, PhD

Deborah Cummins, PhD is Director of Research and Scientific Affairs at the American Academy of Orthopaedic Surgeons (AAOS) where she oversees the quality efforts of the Academy, including the evidence based practice initiatives (development of clinical practice guidelines, appropriate use criteria, technology overviews, quality checklists, and shared decision making tools) and patient safety efforts. Additionally, she directs the survey research team and the biomedical research and regulation unit which monitors regulatory issues of interest to orthopaedic surgeons. Previously, Dr. Cummins served as Senior Director of Research at the Academy of Nutrition and Dietetics (2004-2012) where she directed the development of evidence analysis projects to support the development of evidence based nutrition practice guidelines and evidence based position papers. She was part of the American Medical Association Institute for Ethics (1998-2003) where she served as associate director of the Ethical Force Program and Senior Program Manager of Education and Research in the National Patient Safety Foundation. Dr. Cummins has been appointed to serve on several national task forces including the Medicare Evidence Development and Coverage Advisory Committee, Advisory Council to United Network Organ Sharing (UNOS); Advisory Board for the AHA Pathways for Medication Safety program; the ABA-AMA National Health Care Decisions Week Coordinating Council; and the ASBH presidential task force on the ethics of public health and access to health care. Dr. Cummins also holds the position of Adjunct Professor in the School of Health Related Professions (SHRP) at the University of Medicine and Dentistry of New Jersey and has served for many years on hospital ethics committees.
Nancy Davis, PhD

Nancy Davis, PhD serves as Director, Practice-Based Learning and Improvement. Her primary responsibilities include the Aligning and Educating for Quality (ae4Q) and Teaching for Quality (Te4Q) initiatives. Dr. Davis is a founder and serves as CEO and Board Chair of the National Institute for Quality Improvement and Education (NIQIE), dedicated to improving patient care through the integration of quality improvement and continuing professional education.

Previously, Dr. Davis served as Director of CME for the American Academy of Family Physicians, where she championed evidence-based and performance improvement CME. Her work with the AMA contributed to the current CME credit designation for point of care and performance improvement CME activities.

Dr. Davis has served on the Board and as CME Committee Chair for the American College of Medical Quality, on the Board of Directors of the Alliance for CME, is a past president of the Society for Academic CME and has served as Chair of the Council of Medical Specialty Societies CME Directors’ Group. She is a Fellow of the Alliance for Continuing Education in the Health Professions and is credentialed as a Certified CME Professional and a Certified Professional in Healthcare Quality. She is a member of the National Board of Medical Examiners serving on the Public Stakeholders Committee.

Dr. Davis earned a PhD in Adult and Continuing Education at Kansas State University. She has a master’s degree in healthcare administration and a bachelor’s degree as a physician assistant. An experienced clinician, educator and researcher, she has taught graduate students, presented in numerous national forums and published in peer reviewed journals, including the Journal for Continuing Education in the Health Professions, Teaching and Learning in Medicine, Medical Teacher and the American Journal of Managed Care. She co-authored a Guide to CME for the Association of Medical Education in Europe, which is being translated into several languages, and co-authored a book chapter on Teaching Quality Improvement in Medical Education for the American College of Medical Quality.

Cheryl DeMars, MSW

Cheryl DeMars, MSW is the President and CEO of The Alliance, a not for profit cooperative of employers whose mission is to move health care forward by controlling costs, improving quality and engaging individuals in their health. The Alliance represents 180 employers who provide health benefits to 80,000 individuals in Wisconsin, Illinois and Iowa.

Prior to assuming the position of CEO in 2006, Ms. DeMars served several roles at The Alliance providing leadership to the organization’s cost and quality measurement activities, consumer engagement strategies and efforts to improve the quality and cost of health care on a community-wide basis. Prior to joining The Alliance in 1992, Ms. DeMars was a program manager at Meriter Hospital in Madison, WI. Ms. DeMars currently serves on the Board and Executive Committee of the National Business Coalition on Health. Ms. DeMars was recently appointed to the Clinician Workgroup of the National Quality Forum’s Measures Application Partnership, which will provide input to the Department of Health and Human Services (HHS) on the selection of measures for use in public reporting and performance-based payment. She also serves on the Technical Advisory Committee for the Catalyst for Payment Reform. In Wisconsin, Ms. DeMars serves on the Advisory Board of the UW Population Health Institute and on the steering committee for the Partnership for Healthcare Payment Reform. Ms. DeMars received a master’s degree in social work from the University of Wisconsin–Madison.
Carole Redding Flamm, MD, MPH

Carole Redding Flamm, MD, MPH is Executive Medical Director for National Programs at the Blue Cross and Blue Shield Association (BCBSA), a national federation of 38 independent, locally operated Blue Cross and Blue Shield companies.

Dr. Flamm provides leadership and strategic direction in developing programs to evaluate and improve the quality, safety, and health outcomes of care experienced by Blue Cross and Blue Shield members, through collaboration with Blue Cross and Blue Shield companies, professional organizations, and other key healthcare stakeholders. She directs the Blue Distinction® program, which is a designation awarded by the Blue Cross and Blue Shield companies to medical facilities that have demonstrated expertise in delivering quality healthcare, under objective selection criteria.

Previously, Dr. Flamm was Associate Director of BCBSA’s Technology Evaluation Center (TEC), which conducts systematic reviews of medical literature and provides leadership in evidence-based decision-making for new medical technologies. Before joining BCBSA, Dr. Flamm completed a fellowship in clinical epidemiology and health services research at the Brigham and Women’s Hospital in Boston. She is board-certified in diagnostic radiology and was an instructor in radiology at Harvard Medical School and an associate in radiology at Beth Israel Hospital in Boston.

Dr. Flamm received her medical degree from the University of Pennsylvania and holds a master’s degree in public health from Harvard. She completed her undergraduate studies summa cum laude at the University of Virginia.

Thomas Friermood, MD

Thomas Friermood, MD is the President of Panorama Orthopedics and Spine Center. Panorama is a 27 physician sub-specialty orthopedic practice with three locations in the Denver metro-area. Panorama Orthopedics & Spine Center was founded as Lakewood Orthopedic Clinic more than 50 years ago. Dr. Friermood has been the managing partner of Panorama Orthopedics & Spine Center since 1984 and has seen the company grow from a 5 doctor practice to a practice of 27 physicians, 3 fellows and 20 physician assistants.

Dr. Friermood received his undergraduate degree from the University of Washington. He graduated with honors from Creighton University Medical School in Omaha, Nebraska in 1974. He completed his internship and orthopedic residency in Sacramento at the University of California at Davis. Dr. Friermood has served as the team doctor for the U.S. Disabled Ski Team for 20 years. He has also done volunteer orthopedics through Orthopedics Overseas. For the past 20 years, Dr. Friermood has devoted most of his energies to the business aspect of medical practice. He no longer does surgery but still has several clinics each week including an indigent care clinic at St. Anthony Hospital. He was integral in the development of Golden Ridge Surgery Center, an out-patient surgery center specializing in orthopedic procedures. He has transformed his company from an orthopedic clinic to an integrated delivery system for musculoskeletal care.

Dr. Friermood was the vision behind the development of OrthoColorado Hospital at the St. Anthony Medical Campus. OrthoColorado is a 48 bed specialty hospital and is a joint venture between Panorama Orthopedics & Spine Center and St. Anthony Hospital. OrthoColorado Hospital opened the summer of 2010, and is now a regional center of excellence with the highest HCHAP scores in the state. On a state and national level, Dr. Friermood is the immediate past president of the Colorado Orthopedic Society and a member of the executive board. He is one of two orthopedic surgeons
representing Colorado on the American Academy of Orthopedic Surgeons Board of Councilors. He is a board member of OrthoColorado Hospital and the Panorama Research and Education Foundation. He is also a member of the Orthopedic Trauma Association, the North American Spine Society and the Western Orthopedic Association. Dr. Friermood has three children and lives in Lakewood, Colorado with his wife, Kay.

**Michael Goldberg, MD**

Michael Goldberg, MD is the Director of the Skeletal Health Program at Seattle Children’s Hospital and Clinical Professor of Orthopaedics at the University of Washington School of Medicine in Seattle. Most of his professional career was spent in Boston where he was the Henry H. Banks Distinguished Professor of Orthopaedics, and now Professor Emeritus at Tufts University School of Medicine, and Chairman of the Department of Orthopaedics at Tufts Medical Center.

Dr. Goldberg’s major clinical interests are in the diagnosis and management of children with syndromes, complex birth defects, and skeletal dysplasias; and measuring the outcomes and functional performance of children undergoing orthopaedic treatments. He is a past president of the Pediatric Orthopaedic Society of North America and an Honorary Member of the Societa Italiana di Orthopedia e Traumatologia Pediatrica; the first American to receive such an honor. He has authored many peer reviewed scientific articles and the textbook: The Dysmorphic Child: An Orthopaedic Perspective. He has participated in the development of outcomes instruments, performance measures, and evidence based guidelines for the American Academy of Orthopaedic Surgeons and the American Academy of Pediatrics. He served as chairman of the AAOS Evidence Based Practice Committee and now sits as chair of the Guideline Oversight Committee. He is a member of the Clinical Effectiveness Team at Seattle Children’s Hospital where he focuses on implementation of clinical standard work through evidence based clinical pathways and patient safety and process checklists.

**Kate Goodrich, MD**

Kate Goodrich joined the Center for Medicare and Medicaid Services in September of 2011 where she serves as Acting Director of the Quality Measurement and Health Assessment Group in the Center for Clinical Standards and Quality (CCSQ). In this role, she oversees The implementation of 8 quality measurement and public reporting programs and partners with other CMS components on 11 other programs. She co-leads a CMS-wide task force to align measures across programs and with the private sector. She also leads an agency wide council to coordinate and implement quality improvement activities and to develop the agency’s strategy for quality improvement.

Previously, Dr. Goodrich served as a Senior Technical Advisor to the Director of CCSQ and the CMS Chief Medical Officer. From 2010-2011 she served as a Medical Officer in the office of the Assistant Secretary for Planning and Evaluation (ASPE) at the Department of Health and Human Services (DHHS) where she managed a portfolio of work on comparative effectiveness research and quality measurement and improvement. Dr. Goodrich is a graduate of the Robert Wood Johnson Clinical Scholars Program at Yale University where she received training in health services research and health policy from 2008-2010. From 1998 to 2008, Dr. Goodrich was on faculty at the George Washington University Medical Center and served as Division Director for Hospital Medicine from 2005-2008. She continues to practice clinical medicine as a hospitalist and associate professor of medicine at George Washington University Hospital.
Shepard Hurwitz, MD

Shepard Hurwitz, MD has been an active member of the ORS since 2000. He serves on the Mentoring Committee and has been an abstract reviewer for the scientific program for 6 years. He was Professor of Orthopaedic Surgery and Mechanical Engineering for 14 years at the University of Virginia and currently at the University of North Carolina. His main areas of investigation have been the effect of diabetes on bone and tendon, the repair/regeneration of tendon and bone, the advanced imaging of cartilage- including blunt trauma effects- and the use of best evidence in the clinical practice of orthopaedics. Much of his research has been funded by the automobile industry through the University of Virginia Center for Applied Biomechanics.

Dr Hurwitz currently serves on the Board of Trustees of the Orthopaedic Research and Education Foundation and is on their Grants Committee. Dr. Hurwitz has been advisor to Masters and PhD candidates in Mechanical Engineering and Biomedical Engineering at the University of Virginia and was an instructor teaching the mechanics of human joint function. Dr. Hurwitz has been a consultant to the National Institutes of Health Clinical Center, the Centers for Disease Control and Prevention and the Department of Defense Non-Lethal Weapons Program.

Joshua J. Jacobs, MD

Joshua J. Jacobs, MD received a Bachelor of Science degree in Materials Science and Engineering from Northwestern University and graduated from the University of Illinois Medical School. In 1987, Dr. Jacobs completed his orthopaedic training at the Combined Harvard Orthopaedic Residency Program in Boston. Dr. Jacobs then completed a one-year fellowship in Adult Reconstructive Orthopaedic Surgery at Rush University Medical Center under the direction of Dr. Jorge Galante.

Dr. Jacobs has remained at Rush since his fellowship training and currently is the William A. Hark, MD/Susanne G. Swift Professor and Chairman of the Department of Orthopaedic Surgery. At Rush University Medical Center he has also served as the Director of the Orthopaedic Surgery Residency Program for 14 years and as the Associate Dean for Research Development for five years. In addition, Dr. Jacobs is an Adjunct Professor of Materials Science and Engineering at Northwestern University. His major research focus is on the biocompatibility of permanent orthopaedic implants, particularly joint replacement devices. Dr. Jacobs has published numerous peer-reviewed manuscripts, most of which focus on the biological consequences of material degradation from joint replacement implants. Dr. Jacobs has received several research awards including a Career Development Award from the Orthopedic Research and Education Foundation, the Otto Aufranc Award from The Hip Society, the Ann Doner Vaughan Kappa Delta Award, American Academy of Orthopaedic Surgeons/Orthopaedic Research Society, the Mark Coventry Award from the Knee Society and the 2011 Ken Ludem Best Paper Award from the International Conference on Wear of Materials.

Dr. Jacobs has served on the Special Grants Review Committee of National Institute of Arthritis, Musculoskeletal and Skin Diseases (NIAMS) and in 2005, he was appointed to the NIAMS Advisory Council recently completing his four-year term. In 2000, he was named Fellow, American Institute for Medical and Biological Engineering and elected to the International Hip Society. Dr. Jacobs is the Past Chairman of the Council on Research, Quality Assessment and Technology of the American Academy of Orthopaedic Surgeons and Past President of the Orthopaedic Research Society and the United States Bone and Joint Decade. He is currently the 1st Vice President of the American Academy of Orthopaedic Surgeons.


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**FACULTY BIOGRAPHIES**

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**David Jevsevar, MD, MBA**

David Jevsevar, MD, MBA is Medical Director of Orthopedic Clinical Program Development for Intermountain Healthcare. He is also the Director of Surgical Services for the Southwest Region for Intermountain. Dr. Jevsevar has had a long involvement with clinical program and care pathway development, quality and performance improvement, supply chain organization pricing initiatives, and cost-effectiveness assessment. Dr. Jevsevar is a graduate of St. Vincent College, received his MD degree from Georgetown University, and completed his residency in Orthopedic Surgery at the Tufts Affiliated and Allegheny General programs. He then served in the United States Air Force, including the Chief of Orthopedics and Chief of Surgery at the Mike O’Callaghan Federal Hospital. Dr. Jevsevar then received his MBA at Auburn University. He is active within the American Academy of Orthopaedic Surgeons, serving as Chair of the Evidence Based Practice Committee, Chair of the Clinical Practice Guideline Workgroup on the Treatment of Knee Osteoarthritis, and a member of the Performance Improvement/CME Committee. Dr. Jevsevar is also part of the AAOS Orthopaedic Quality Institute. Dr. Jevsevar is in clinical practice in St. George, Utah, with a focus on hip and knee arthroplasty.

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**K. William Kumler, MD, MBA**

K. William (Bill) Kumler, MD, MBA completed his orthopaedic residency and later an MBA at George Washington University. Dr. Kumler is a Board Certified Orthopaedic Surgeon with CAQ in Sports Medicine Private Practice and Orthopaedic Teaching Faculty at Mount Carmel Medical Center and Nationwide Children’s Hospital in Columbus, Ohio from 2000-2010. He serves on multiple committees and is a Board Member for Columbus Medical Association as well as a Delegate to the Ohio State Medical Association 2001-2010. He relocated with his family to Maysville, KY in January 2010 as an employed physician for Meadowview Regional Medical Center, a Lifepoint Inc. Hospital. He completed training and continues to practice Art of Hosting Meaningful Conversations. Dr. Kumler worked as a member of the Core Hosting Group for Affordable Sustainable Health Care Project, later named Our Optimal Health from 2005-2010 in Columbus, Ohio. Dr. Kumler completed AAOS Leadership Fellows Program February 2011 under the Mentorship of David Halsey, MD. He is currently serving as a Board Member for Meadowview Regional Medical Center and a member of the AAOS Health Care Systems Committee.

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**David Lansky, PhD**

David Lansky, PhD, is the President and Chief Executive Officer of the Pacific Business Group on Health (PBGH) and directs its efforts to improve the affordability and availability of high quality health care. Since 2008, Dr. Lansky has led the coalition of 50 large employers and health care purchasers representing over three million Californians, including CalPERS, Wells Fargo, Intel, Safeway, Chevron, and the University of California. A nationally-recognized expert in accountability, quality measurement and health IT, Dr. Lansky has served as a board member or advisor to numerous health care programs, including the National Quality Forum, National Priorities Partnership, the Joint Commission, the National Patient Safety Foundation, the Leapfrog Group, the Medicare Beneficiary Education Advisory Panel, Cal eConnect, and the American Health Information Community (AHIC). He is now the purchaser representative on the federal HIT Policy Committee. Dr. Lansky holds a PhD degree from the University of California, Berkeley.
Thomas Lewandowski, MD, FACC, FASE

Thomas Lewandowski, MD, FACC, FASE, is a practicing cardiologist from Appleton, Wisconsin. He joined a private practice group in 1999, which was subsequently purchased by ThedaCare in 2011. He completed his undergraduate studies at Syracuse University in Biomedical Engineering, graduating at the top of his class. He stayed at the University for a year acting as a Research Associate at the Institute for Sensory Research and a teaching assistant for the Department of Biomedical Engineering, before entering medical school at the University of Rochester in Rochester, New York. He then completed his Internship and Residency at the University of Iowa, in Iowa City, Iowa before moving to the University of Michigan in Ann Arbor, Michigan where he completed fellowships in Cardiology, Echocardiography, and Pulmonary Hypertension. He has served as Governor of the Wisconsin Chapter of the American College of Cardiology since 2011. He has held several leadership positions within the WI Chapter since his arrival and presently represents his membership on the ACC Commercial Carrier Advisory Committee, The Wisconsin Healthcare Value Committee, and The Partnership for Healthcare Payment Reform. With the assistance of the Wisconsin State Medical Society and the American College of Cardiology Foundation, he has successfully built a multi-stakeholder coalition within Wisconsin focused on preserving the quality of delivered care, known as SMARTCare (Smarter Management and Resource utilization for Today’s Complex cardiovascular care delivery). While starting in Wisconsin, this project now includes participation from centers in Florida, with inquiries for participation from several other states. Tom is a Fellow of the American College of Cardiology and the American Society of Echocardiography. He is a member of the Society of Cardiovascular Computer Tomography. He is dedicated to patient centered and individualized care as well as to his wife and three very active children.

Catherine MacLean, MD, PhD

Catherine MacLean, MD, PhD is the Staff Vice President of Clinical Quality at WellPoint, Inc., where she leads the Center for Quality Measures and Improvement. Her responsibilities include oversight of the development and execution WellPoint’s quality improvement strategy for commercial, Medicare Advantage and Medicaid members. She also serves as a liaison between national quality organizations and medical specialty societies, and WellPoint.

Prior to joining WellPoint, Dr. MacLean was an Associate Professor of Medicine at UCLA, physician and health services researcher at the Greater Los Angeles VA Healthcare System and a Natural Scientist at RAND. Her research focused the development and evaluation of quality measures and programs. She was the PI of the Arthritis Foundation’s Quality Indicator Project, led an RWJF project that developed the prototype for a ‘consumer quality assessment tool’ and was a core investigator the Assessing Care for Vulnerable Elders (ACOVE) project, which developed a comprehensive set of quality measures for vulnerable elders, including measures for musculoskeletal diseases. She has also been the PI on several AHRQ (Agency for Healthcare Quality and Research)-funded Evidence-based Practice Center Projects. Dr. MacLean has on served quality-related technical expert panels for the NIH, CMS and NCQA including the NIH Consensus Development Panel for total knee replacement. She has chaired NCQA’s Musculoskeletal workgroup, the American College of Rheumatology’s Quality of Care Sub-committee and NQF’s technical advisory committee for bone disease. She currently serves on the Board of Directors for the American Joint Replacement Registry and the American College of Physicians’ Performance Measures Committee. She retains appointments at UCLA, RAND and the Greater Los Angeles VA. Dr. MacLean obtained her MD from Washington University, St. Louis. She completed training in internal medicine at Harbor-UCLA, Torrance, CA and in rheumatology at UCLA’s Center for the Health Sciences. She obtained her PhD in health services from UCLA’s School of Public Health.
Peter Mandell, MD

Peter Mandell, MD was born, raised and has practiced orthopaedic surgery on the San Francisco Peninsula for his entire career. He graduated cum laude with an AB from Yale College and received his MD from the University of California San Francisco where he is an Assistant Clinical Professor of Orthopaedic Surgery. He served for over 20 years as Director of Anatomy Teaching at the San Francisco Orthopaedic Residency Program, his alma mater, and twice was named the SFORP Teacher of the Year.

Dr. Mandell has long had interests in advocacy, health policy, and medical association volunteering. He served over 7 years on the American Academy of Orthopaedic Surgeon’s (AAOS) Board of Councilors, 3 years on the AAOS Board of Directors, 4 years as chair of the AAOS Committee on Professionalism, and currently Chairs the AAOS Council on Advocacy. In addition, Dr. Mandell is a past President of the California Orthopaedic Association and immediate past President of the Western Orthopaedic Association.

Dr. Mandell has given numerous lectures at scientific meetings and been interviewed by the New York Times, CNN, National Public Radio, and several medical trade publications such as AM News. He has testified before the US Congress and the California State Assembly.

William R. Martin, III, MD

William R. Martin III, MD currently serves as the Medical Director of the American Academy of Orthopaedic Surgeons (AAOS). As medical director, Dr. Martin supervises the Office of Government Relations and the Department of Research and Scientific Affairs. He is also a staff liaison to the Quality Project Team, the AAOS committee that oversees the Orthopaedic Quality Institute.

Prior to joining the Academy, Dr. Martin served the AAOS as a member of the Council on Advocacy and the Diversity Advisory Board. He was a member of the Leadership Fellows Class of 2004, and has served on the Healthcare Delivery Committee, the Existing Government Program Workgroup, and the Board Advocacy Workshop Project Team.

Dr. Martin is a graduate of Tufts University, and received his medical degree from the Stritch School of Medicine at Loyola University. He completed a general surgery internship and orthopaedic residency at Maricopa Medical Center in Phoenix, AZ. He also finished an adult foot and ankle reconstruction fellowship and postgraduate work in public health at the University of North Carolina.

Dr. Martin was professionally active as a member of the Western Orthopaedic Association, the J. Robert Gladden Orthopaedic Society, the American Orthopaedic Foot & Ankle Society, the Arizona Orthopaedic Association, the Arizona and American Medical Associations, the Arizona Medical Board, and the Board of Directors for the National Board of Medical Examiners. He has received numerous awards for his research, humanitarian, and leadership efforts.
Brian McCordel, MD

Brian McCordel, MD was born and raised in Lansing, Michigan. He attended the University of Michigan, getting his B.S. and M.D. He did his residency at UNC-Chapel Hill, and then moved home to start a solo private practice, and is currently in a group of seven orthopedic surgeons, with an interest in trauma and adult reconstructive surgery. He has practiced at Sparrow Health System for 22 years, having served as Chairman of Surgery at SHS among many other posts, and is currently in his 15th year as Chief of Orthopedics. He is a founding Board member of MARCQI, the BCBSM statewide total joint registry, and is the founding Chairman of GLHIE, the state’s only functioning public health information exchange (HIE). He is a member of the Health Care Systems Committee of the AAOS, and was one of the invited guests in 2011 to the first AAOS Orthopedic Quality Initiative in Washington, DC. He is married to a wonderful woman, and has 3 great sons.

Gregory Mencio, MD

Gregory Mencio, MD is a graduate of Duke University School of Medicine. He completed a two-year residency in general surgery at the University of Pittsburgh Medical Center and did his orthopaedic training at Duke University Medical Center followed by a fellowship in pediatric orthopaedics at Newington Children's Hospital (currently Connecticut Children's Medical Center).

Dr. Mencio is board-certified in orthopaedic surgery and is a specialist in pediatric orthopaedics with clinical interests in scoliosis and surgery of the spine, pediatric musculoskeletal trauma, limb lengthening, and management of gait and orthopaedic aspects of neuromuscular disorders. He has served on the faculty of the Department of Orthopaedics and Rehabilitation at Vanderbilt University Medical Center since 1991, where he is currently Professor and Vice Chair of Orthopaedics and Chief of Pediatric Orthopaedics at Monroe Carell Jr. Children's Hospital at Vanderbilt. He is the director of the Pediatric Orthopaedic Fellowship at Vanderbilt. He has been the medical Director of the Spina Bifida Clinic at Vanderbilt since 1991.

Dr. Mencio has been actively involved in teaching orthopaedics to fellows, residents and medical students throughout his career. He has been the recipient of the Chief Residents’ Teaching award four times during his tenure at Vanderbilt (1996, 2002, 2003, 2011). He has been an author/co-author on numerous peer review articles, a contributor to several reference orthopaedic texts, and is co-editing the 4th edition of Skeletal Trauma in Children.

At Vanderbilt, he is chair of the Credentials Committee at Monroe Carell Jr. Children’s Hospital, and he is co-chair of the VUMC Medical Economic Opportunity (MEOC) Committee (Surgical/Procedural). He is a past member of the AAOS CME courses Committee, BOS Education Committee, and advisory board of the Annual POSNA /AAOS International Pediatric Orthopaedic Symposium. He is a past chairman of the Education Council of the Pediatric Orthopaedic Society of North America (POSNA). He is currently Chair of the AAOS Board of Specialty Societies (BOS) and a member of the AAOS Board of Directors.

Dr. Mencio has been actively involved in medical mission work for over 20 years, leading medical teams to countries in Central and South American, the Dominican Republic and Mexico to perform surgery on children with orthopaedic problems.
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Frank Opelka, MD, FACS
Frank Opelka, MD, FACS is the Executive Vice President of HealthCare and Medical Education Redesign for the Louisiana State University Systems Office. The LSU Health Care System is a 10 hospital safety net health system providing care to the underinsured of Louisiana. He joined LSU in the spring of 2005. Dr. Opelka is the LSU Health Sciences Center's advocate for improving patients' health through quality improvement programs, the e-health record, LSU healthcare performance metrics, and e-prescription program.

Dr. Opelka is a physician executive and a recognized national leader in surgical quality, patient safety, public reporting, and care & delivery system redesign for the surgical patient. He serves as an associate medical director in Washington DC for the American College of Surgeons in quality related matters.

Dr. Opelka serves on numerous national alliances, initiatives and national committees for patient safety, quality improvement and in areas of health policy. Dr. Opelka serves within the National Quality Forum’s National Priority Partnership and the Measures Application Partnership. He works closely with the Brookings Institute as a member of the Quality Alliance Steering Committee, and the National Committee for Quality Assurance, the Agency for Health Research and Quality. Dr. Opelka founded the American College of Surgeon’s Surgical Quality Alliance which pulls together over 22 surgical specialties to improve surgical quality, optimize the surgical patients’ voice and experience, provide efficient care, and increase access to care. Dr. Opelka is a national recognized and published expert in colon and rectal surgeon.

Marc Rankin, MD
Marc Rankin, MD is a board-certified orthopaedic surgeon, fellowship-trained in Sports Medicine. Dr. Rankin earned his BA in Biology from Hampton University and his MD form Howard University College of Medicine. He is the team physician for the University of District of Columbia and St. Johns High School. Dr. Rankin is an Assistant Clinical Professor, Department of Orthopaedic Surgery at Howard University Hospital in Washington, DC. He also serves as a consulting physician for the Veterans Administration and an Institutional Review Board Member at Providence Hospital. Dr. Rankin serves on the AAOS Healthcare Systems Committee as part of the Leadership Fellows Program.

John Santa, MD, MPH
John Santa, MD, MPH is the Director of the Consumer Reports Health Ratings Center. He comes to Consumer Reports with a diverse background in clinical, administrative, business and education activities. He has been interested in explicit approaches evaluating and comparing health services, products and practitioners throughout his career and been involved in many successful efforts to do so. Since coming to Consumer Reports he has focused on comparisons of hospitals, drugs, treatments and physicians. The Health Ratings Center has provided comparative information for multiple print publications and web releases.

Prior to coming to Consumer Reports in 2008, Dr. Santa worked in multiple sectors in the health care industry, most recently as an associate professor in public administration at Portland State University and in Family Medicine at Oregon
Health & Science University. His research interests focused on comparative effectiveness, the integration of medical care and public health, preventive medicine and benefit design.

Dr. Santa was the administrator of the Office of Oregon Health Policy and Research from 2000 to 2003 during the administration of Governor John Kitzhaber MD. During that time Oregon implemented an evidence-based approach to prescription drug purchasing that eventually came to be known as the Drug Effectiveness Review Project. Dr. Santa provided administrative and medical direction to the Project. Dr. Santa also served on the board of the Public Employees Benefit Board, Oregon’s largest private health benefits purchaser, serving as the chair of the Benefit Design Committee and chair of the Board. In the 1990s he was the Medical Director of a large multispecialty medical group in Portland, Oregon.

He has served on multiple boards including the Oregon Medical Insurance Pool, Oregon’s high risk insurance pool, and the Cascade AIDS Project, Oregon’s largest nonprofit AIDS services provider. He has worked in leadership positions for hospitals, physician groups and health insurers.

Dr. Santa has taught in multiple environments including medical school, internal medicine residencies and preventive medicine residencies. His recent teaching responsibilities focused on Masters of Public Health students. Dr. Santa received his bachelor’s degree from Stanford University in 1972, his MD from Tufts University in 1976 and MPH from Portland State University in 2005. He has practiced primary care internal medicine in solo, group and institutional settings, most recently at the VA.

David Shahian, MD

David Shahian, MD is a graduate of Harvard College and Harvard Medical School. He trained in general surgery at the Massachusetts General Hospital and was a fellow in cardiothoracic surgery at Rush-Presbyterian-St. Luke’s Medical Center. He served for over two decades as Division Chief of Cardiothoracic Surgery at the Lahey Clinic, and he currently holds dual appointments in the Center for Quality and Safety and the Department of Surgery at the Massachusetts General Hospital. Dr. Shahian is Professor of Surgery at Harvard Medical School.

In addition to his clinical career in CT surgery, Dr. Shahian has been involved with health policy issues for nearly two decades, particularly in the area of performance measurement. As Chair of the Society of Thoracic Surgeons (STS) National Database Workforce and its Quality Measurement Task Force, he led development of the STS composite CABG performance measure, the composite AVR performance metric, and 27 cardiac surgery risk models. He has also been a leader in implementation of the mandatory cardiac surgery public reporting initiative in Massachusetts and the voluntary, nationwide public reporting program established by the Society of Thoracic Surgeons in conjunction with Consumer Reports.

Dr. Shahian is the author or co-author of over 150 peer-reviewed journal articles and book chapters. His research has focused on performance measurement and related health policy issues. Dr. Shahian served as Chair of the NQF Task Force on Evidence and he is Vice-Chair of the NQF Health Professionals Council. He is a member of the AMA-PCPI Executive Committee and Co-Chair of the National Quality Registry Network. Dr. Shahian is a member of the American College of Cardiology/American Heart Association Performance Measurement Task Force.
William Shrank, MD, MSHS

William Shrank, MD, MSHS, is serving as part-time faculty in the Division of Pharmacoepidemiology and Pharmacoeconomics at Brigham and Women's Hospital (BWH). Dr. Shrank lives in Washington D.C. where he is the Director of Rapid-Cycle Evaluation at the Center for Medicare and Medicaid Innovation at CMS. He leads the evaluation of all payment and health-system delivery reform programs supported by the Innovation Center as well as all Congressionally mandated demonstration programs. He developed the rapid-cycle strategy to promote continuous quality improvement and rapid spread of effective programs while maintaining scientific rigor. He also oversees the intramural research enterprise for CMS.

At BWH, Dr. Shrank’s research is focused on evaluating quality in pharmacologic care, enhancing adherence to chronic medications, and improving prescription drug labels. He was the founder and principal investigator of the CVS Caremark Harvard Partnership for Improving Medication Adherence, a multi-disciplinary research initiative to improve how patients take medication, as well as the Pharmacy Care Research Institute, also funded by CVS Caremark. He received a career development award from the National Heart, Lung, Blood Institute of the National Institutes of Health to evaluate interventions to improve rational prescribing in cardiovascular disease, and a Pioneer Award from the Robert Wood Johnson Foundation to study the effect of labeling on medication use. He has published over 100 articles in the peer-reviewed literature focusing on prescription drug use.

Dr. Shrank serves or has served on national advisory committees for the FDA, CMS, DHHS, AHRQ, the Society of General Internal Medicine, the American College of Physicians Foundation, and the U.S. Pharmacopeia. He attended Brown University, received his M.D. from Cornell University, and did his residency training in Internal Medicine at Georgetown University. He served on the clinical faculty in General Internal Medicine at University of Colorado Health Sciences Center before finishing a health services research fellowship at UCLA, Rand, and the West Los Angeles VA Hospital where he earned an M.S. in Health Services from UCLA. Until 2011, he practiced general internal medicine at the Brigham and Women’s Hospital.

Sharon Sprenger, MPA, RHIA, CPHQ

Sharon Sprenger, MPA, RHIA, CPHQ is the Director, External Measurement Relations, Division of Healthcare Quality Evaluation. She serves as the primary Joint Commission representative in external efforts to make credible, evidence-based performance measurement data readily available and useful to the public, providers, purchasers, oversight organizations and other interested parties. In her tenure at The Joint Commission, she has been responsible for performance measure identification, evaluation, pilot testing, and implementation activities for core measures, disease-specific care certification, and international initiatives as applicable to all Joint Commission accreditation programs and settings. In her current position, she is a primary interface with the Centers for Medicare and Medicaid Services (CMS) and the respective Quality Improvement Organizations to create the common measure specifications for shared measure sets. Ms. Sprenger has participated on numerous national groups and currently serves as the co-lead for the Adult Immunization Measures Workgroup - National Adult Immunization Summit, Technical Expert Panel CMS Long Term Care Hospitals Program Quality Measures, Technical Expert Panel CMS Inpatient Rehabilitation Hospitals Program Quality Measures, and liaison for the American Medical Association (AMA) Physician Consortium for Performance Improvement. Previously, she has participated on groups such as the Agency for Healthcare Research and Quality Subcommittee of the National Advisory Committee (SNAC) on Medicaid Adult Health Quality Measures, Technical Expert Panel CMS Hospice Program Quality Measures, CMS Nursing Home Quality Measure Development Technical Expert Panel, liaison for the National Quality Forum (NQF) National Consensus Standards for the Prevention and Care of Venous

Ms. Sprenger’s diverse professional experience includes positions with Blue Cross and Blue Shield of Michigan, The HMO of Delaware, Condell Memorial Hospital, Area IV Professional Standards Review Organization, and Central Michigan Community Hospital. She has provided numerous presentations to health care organizations and professional organizations around the country. Ms. Sprenger has participated in numerous national workgroups regarding performance measurement, addressing areas such as hospital care, long-term care, behavioral health care, and hospice/end of life care.

Ms. Sprenger has a Master’s in Public Administration with a concentration in Health Services Administration from Roosevelt University, a Bachelor’s of Science in Medical Records Administration and an Associate’s Applied Science in Medical Records Technology from Ferris State University. Ms. Sprenger is a Registered Health Information Administrator (RHIA) and is a Certified Professional in Healthcare Quality (CPHQ).

Steven Stern, MD

Steven Stern, MD is the Vice President, Cardiology and Orthopaedic/Neuroscience Line of Service at UnitedHealthcare. As Vice President, Dr. Stern works to improve the quality and affordability of cardiology and orthopaedic/neurological care. His team engages with physicians and their specialty societies, hospitals, and other care providers to improve outcomes and promote cost-effective treatment. Dr. Stern was in clinical practice at Northwestern Memorial Hospital for 17 years prior to coming to UnitedHealthcare. He has authored or co-authored more than 25 published peer-reviewed articles and edited a textbook published in 2000: Key Techniques in Orthopedics. He is board-certified by the American Board of Orthopaedic Surgery, and is a fellow in the American Academy of Orthopaedic Surgeons. He is a graduate of the Massachusetts Institute of Technology with a B.S. in Mechanical Engineering and an M.D. from Harvard Medical School. He did his residency and fellowship (Knee Surgery) at The Hospital for Special Surgery in New York City and was a North American Travelling Fellow in 1992.

John Tongue, MD

John Tongue, MD is the President of the American Academy of Orthopaedic Surgeons. Dr. Tongue is in private practice in Tualatin, Oregon and is also a clinical associate professor at Oregon Health Sciences University in Portland.

A graduate of Northwestern University in Evanston, Illinois, and the St. Louis University School of Medicine in Missouri, Dr. Tongue served as an intern and general surgery resident at the University of Oregon Medical School in Portland, Ore. He then completed his orthopaedic surgery residency at the San Francisco Orthopaedic Residency Training Program. He completed a sports medicine fellowship at the Orthopaedic Fracture Clinic in Eugene, Ore., and a hand surgery fellowship at the University of California in San Francisco. Active in several professional societies, Dr. Tongue is a member of the American
Orthopaedic Association, the Western Orthopaedic Association, and the Oregon Medical Association. He also has authored more than 80 publications, book chapters and presentations. Dr. Tongue has served as the Academy’s Chair of the Board of Councilors and has previously volunteered on numerous committees and task forces, including the Council on Education, the Committee on Public Education and the Council on Research. Dr. Tongue is the recipient of numerous awards and honors, including the AAOS Humanitarian Award, the National Highway Traffic Safety Association Public Service Award for his work in passing the Oregon Safety Belt Law, and the Oregon Medical Association’s Doctor-Citizen of the Year Award.

When not volunteering or seeing patients, Dr. Tongue enjoys fly fishing, skiing and spending time with his wife Nancy and their three children.

**Thomas Valuck, MD, JD**

Thomas Valuck, MD, JD, is Senior Vice President, Strategic Partnerships, at the National Quality Forum (NQF). Dr. Valuck oversees NQF-convened partnerships—the Measure Applications Partnership (MAP) and the National Priorities Partnership (NPP)—as well as NQF’s engagement with states and regional community alliances. These NQF initiatives aim to improve health and healthcare through use of performance information for public reporting, payment incentives, accreditation and certification, and systems improvement.

Dr. Valuck comes to NQF from the Centers for Medicare & Medicaid Services (CMS), where he advised senior agency and Department of Health and Human Services leadership regarding Medicare payment and quality of care, particularly value-based purchasing. While at CMS, Dr. Valuck was recognized for his leadership in advancing Medicare’s pay-for-performance initiatives, receiving both the 2009 Administrator’s Citation and the 2007 Administrator’s Achievement Awards.

Before joining CMS, Dr. Valuck was the vice president of medical affairs at the University of Kansas Medical Center, where he managed quality improvement, utilization review, risk management, and physician relations. Before that he served on the Senate Health, Education, Labor, and Pensions Committee as a Robert Wood Johnson Health Policy Fellow; the White House Council of Economic Advisers, where he researched and analyzed public and private healthcare financing issues; and at the law firm of Latham & Watkins as an associate, where he practiced regulatory health law. Dr. Valuck has degrees in biological science and medicine from the University of Missouri-Kansas City, a master’s degree in health services administration from the University of Kansas, and a law degree from Georgetown University Law School.

**Charlotte Yeh, MD**

Charlotte Yeh, MD is the Chief Medical Officer for AARP Services, Inc., the wholly-owned taxable subsidiary of AARP. AARP Services, Inc. manages the carrier relationships for and performs quality control oversight of the wide range of products and services that carry the AARP name and are made available by independent carriers as benefits to AARP’s almost 40 million members. Dr. Yeh is specifically responsible for working with AARP’s major health carriers, UnitedHealth Group, Aetna and Genworth, to identify programs and initiatives that will lead to enhanced care for older adults. She directs AARP Services’ efforts to meet expanding member expectations in healthcare, and leads new process improvement programs focused transforming health care delivery in the areas of quality, safety and efficiency.
Dr. Yeh has more than 30 years experience in healthcare. She is a board-certified emergency physician, trained in emergency medicine at UCLA. She practiced emergency medicine for thirteen years at Newton-Wellesley Hospital in Massachusetts, where she also served as the chief of the department for seven years. Dr. Yeh also worked for eight years as Physician-in-Chief for the Department of Emergency Medicine at Tufts Medical Center in Boston, before being named Carrier Medical Director for the National Heritage Insurance Company, a contractor for Medicare Part B claims for Northern New England.

From 2003 to 2008, Dr. Yeh served as Regional Administrator at the Centers for Medicare and Medicaid Services in Boston. In her position there, she was responsible the Medicare, Medicaid and SCHIP programs across the six New England states. During her tenure, Dr. Yeh directed the implementation of the Medicare Modernization Act, the single biggest expansion of the Medicare program since its inception more than forty years ago.

Dr. Yeh is a former member of the Boards of the American Hospital Association, the Massachusetts Hospital Association, Health Research and Education Trust and the American College of Emergency Medicine. She is the former chair of the Massachusetts Trauma Committee and former medical director of the Metropolitan Boston Emergency Medical Services Council. She has lectured frequently on blending clinical practice with the legal requirements of the Emergency Medical Treatment and Labor Act, which guarantees access to emergency care.

Passionate about connecting underserved communities to better health care while addressing the cultural values of the many diverse members AARP serves, Dr. Yeh is pleased to represent AARP Services, Inc. on a number of important councils, committees and boards, including the Blue Cross Blue Shield of Massachusetts Foundation and the Center for Health Design.
Disclosees Listed in Last Name Alphabetical Order

Today's Date: Oct 22, 2012

- **Kevin John Bozic, MD, MBA** (San Francisco, CA): 9 (AAOS; Agency for Healthcare Research and Quality (AHRQ); American Association of Hip and Knee Surgeons; American Joint Replacement Registry; American Orthopaedic Association; California Joint Replacement Registry Project; California Orthopaedic Association; Harvard Business School; Orthopaedic Research and Education Foundation); Submitted on: 09/20/2012. *

- **Craig Alan Butler, MD, MBA** (Tallahassee, FL): 3B (Stryker, Advisory Board - Stryker Performance Solutions); 9 (Chair, Health Care Systems Committee Member, Council on Advocacy; AAOS); Submitted on: 04/03/2012. *

- **Deborah Cummins, PhD** (Rosemont, IL): (n) Submitted on: 04/05/2012. *

- **Thomas G Friermood, MD** (Golden, CO): 9 (Colorado Orthopedic Society); Submitted on: 10/11/2012. *

- **Michael J Goldberg, MD** (Seattle, WA): 8 (Journal Children's Orthopaedics; Journal of Pediatric Orthopedics); 9 (AAOS); Submitted on: 10/12/2012. *

- **Shepard R Hurwitz, MD** (Chapel Hill, NC): 7 (Saunders/Mosby-Elsevier; SLACK Incorporated); 9 (Orthopaedic Research and Education Foundation; American Board of Orthopaedic Surgery, Inc.; Orthopaedic Trauma Association); Submitted on: 06/13/2012. *

- **Joshua J Jacobs, MD** (Chicago, IL): 4 (Implant Protection); 5 (Medtronic Sofamor Danek; Nuvasive; Zimmer); Submitted on: 05/01/2012. *

- **David Jevsevar, MD, MBA** (Saint George, UT): 2 (Medacta USA); 4 (Omni Life Sciences); 5 (Medacta USA); Submitted on: 07/05/2012. *

- **K William Kumler, III MD** (Maysville, KY): 9 (AAOS Health Care Systems Committee); Submitted on: 11/16/2011. *

- **Peter J Mandell, MD** (Burlingame, CA): 8 (AAOS Now); 9 (Western Orthopaedic Association); Submitted on: 08/20/2012. *

- **William Martin III, MD** (Washington, DC): 9 (National Board of Medical Examiners); Submitted on: 04/18/2012. *

- **Brian R McCardel, MD** (Lansing, MI): There is no current disclosure data available.

- **Gregory A Mencio, MD** (Nashville, TN): 6 (3M; Covidien/Kendall; Ethicon Medical Mission Assistance Program); 9 (AAOS; Board of Specialty Societies; Pediatric Orthopaedic Society of North America; Tennessee Orthopaedic Society); Submitted on: 09/09/2012. *

- **Marc E Rankin, MD** (Washington, DC): 8 (Orthopedics ); 9 (Eastern Orthopedic Association); Submitted on: 10/25/2011. *

- **John R Tongue, MD** (Tualatin, OR): (n) Submitted on: 10/01/2012. *

* Disclosure Items Answered: (n) = Respondent answered 'No' to all items indicating no
conflicts.
1= Royalties from a company or supplier; 2= Speakers bureau/paid presentations for a company or supplier; 3A= Paid employee for a company or supplier; 3B= Paid consultant for a company or supplier; 3C= Unpaid consultant for a company or supplier; 4= Stock or stock options in a company or supplier; 5= Research support from a company or supplier as a PI; 6= Other financial or material support from a company or supplier; 7= Royalties, financial or material support from publishers; 8= Medical/Orthopaedic publications editorial/governing board; 9= Board member/committee appointments for a society.
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2012 Orthopaedic Quality Institute: Defining Quality in Musculoskeletal Care

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The Current State of Orthopaedic Quality Reporting

A Preliminary Report by the Washington Health Policy Fellows

AAOS Orthopaedic Quality Institute
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ABBREVIATIONS USED

AAOS – American Academy of Orthopaedic Surgeons
ACS – American College of Surgeons
AHRQ – Agency for Healthcare Research and Quality
BTE – Bridges to Excellence
CCHRI – California Cooperative Healthcare Reporting Initiative
CDC – Centers for Disease Control
CMS – Centers for Medicare & Medicaid Services
CJRR – California Joint Replacement Registry
CPPI – California Physician Performance Initiative
CR – Consumer Reports
FDA – Food & Drug Administration
HCl3 – Health Care Incentives Improvement Institute
HHS – Dept. of Health & Human Services
HSS – Hospital Safety Score
MAP – Measure Applications Partnership
NIH – National Institutes of Health
NPP – National Priorities Partnership
NQF – National Quality Forum
NSQIP – National Surgical Quality Improvement Project
PBGH – Pacific Business Group on Health
PROMIS – Patient Reported Outcome Measurement System
SCIP – Surgical Care Improvement Project
PURPOSE

1. Define the current quality landscape for health care in general terms, identifying the key public and private players.

2. Describe how orthopaedic surgeons are currently being evaluated for quality, and identify imminent changes.

3. Identify potential problem areas for orthopaedic quality reporting, including irrelevant or misaligned quality initiatives.

4. Recommend key quality partnerships for the AAOS to engage in and develop, with the goal of being at the forefront of quality improvement among medical specialty organizations.
INTRODUCTION

There has been a heightened public concern for patient safety, such that medical providers are under increased scrutiny to demonstrate adequate knowledge, diagnostic capabilities, expertise in decision-making ability, first-rate outcomes, and overall excellent quality care.

The Institute of Medicine identifies six aims for improvement of healthcare quality, including care that is safe, effective, patient-centered, timely, and equitable. Concerns over hospital-associated complications and iatrogenic injury has led to the development of an assortment of clinical guidelines and the implementation of various process measures with the goal of creating a safe healthcare environment with excellent quality care.

Outlined in this document are the key public and private stakeholders and their current efforts to define, improve, and measure quality healthcare. In particular, issues relating to orthopaedic surgery are highlighted.
The Physician Quality Reporting System (PQRS; formerly known as the Physician Quality Reporting Initiative, or PQRI) is a voluntary reporting system with the aim to improve patient care by providing eligible practitioners an incentive payment for successful participation. It is a program mandated by federal legislation which uses a combination of incentive payments and payment adjustments to increase reporting of quality metrics and promote healthcare quality. Eligible professionals report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries. CMS implements PQRS through regulations published in the Federal Register.

To participate in the 2012 PQRS, individual eligible professionals may choose to report information on individual PQRS measures or measures groups: (1) to CMS on their Medicare Part B claims, (2) to a qualified PRQS registry, (3) to CMS via a qualified electronic health record product, or 4) to a qualified PQRS data submission vendor. Individual eligible professionals who meet the criteria for satisfactory submission will qualify to earn a Physician Quality Reporting incentive payment equal to 0.5% of their total estimated Medicare Part B PFS allowed charges for covered professional services furnished during that same reporting period. Starting in 2015, the bonus changes to a penalty.

Interestingly, in a national survey of 4934 U.S. physicians conducted June through October 2009, half of PQRI participants believed it had no impact on quality (Federman and Keyhani, 2011). Medical specialists (57.0%) and surgeons (55.1%) were more likely than primary care (40.4%) and other physicians (45.7%) to say that PQRI has no impact on quality (p=0.004).
Concerns over hospital-associated complications led to the development of clinical guidelines and implementation of process measures such as the Surgical Care Improvement Project (SCIP) (Bratzler and Hunt, 2006). SCIP is a national quality partnership of organizations committed to improving the safety of surgical care through the reduction of postoperative complications.

Initiated in 2003 by CMS and the CDC, the SCIP partnership is coordinated through a steering committee of 10 national organizations, including the Agency for Healthcare Research and Quality (AHRQ), American College of Surgeons, American Hospital Association, American Society of Anesthesiologists, Association of periOperative Registered Nurses, Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, Department of Veterans Affairs, Institute for Healthcare Improvement, and the Joint Commission on Accreditation of Healthcare Organizations.

The Surgical Infection Prevention (SIP) measures, created as a core measure set in 2003, transitioned to the Surgical Care Improvement Project (SCIP) measures July of 2006. The measures are as follows: Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision, Prophylactic Antibiotic Selection for Surgical Patients, Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time, Cardiac Surgery Patients With Controlled A.M. Postoperative Blood Glucose, Surgery Patients with Appropriate Hair Removal, Urinary catheter removed on Postoperative Day 1 or 2, Surgery Patients with Perioperative Temperature Management, Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period, Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered, and Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours of Surgery.

SCIP measures against infections have been evaluated recently in a multi-institutional setting with minimal reduction in infections identified (Stulberg et al, 2010; Hawn et al, 2008; Ingraham et al, 2010). Actually, in a recent article in JBJS, Wang et al (2012) reviewed 17,714 total hip arthroplasties at 128 New York state hospitals during 2008, when hospitals were first at risk of losing payments from CMS if there were reasonably preventable events (such as VTE and surgical site infection) after arthroplasty. The authors found that hospital compliance with SCIP guidelines increased from 93 to 96% for infection prevention measure and 91 to 97% for the VTE prevention measure. Increased compliance with SCIP infection prevention guidelines did not lead to reductions in infection outcomes following hip replacement. However, increased compliance with VTE prophylaxis was associated with a higher risk of surgical site infections.
The inpatient prospective payment system (IPPS) is a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates, as set forth by the Social Security Act (Section 1886d). Under the IPPS, each case is categorized into a diagnosis-related group (DRG), each of which has a payment weight assigned to it based on the average resources used to treat Medicare patients in that DRG.

The Deficit Reduction Act (DRA) of 2005 required a quality adjustment in Medicare Severity Diagnosis Related Group (MS-DRG) payments for certain hospital-acquired conditions (HAC). Section 5001(c) of DRA required the Secretary to identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. CMS titled the provision “Hospital-Acquired Conditions and Present on Admission Indicator Reporting” (HAC & POA). In August 2010, CMS published the IPPS Fiscal Year 2011 Final Rule. The HAC payment provision applies only to IPPS hospitals (does not include Critical Access Hospitals, Long-Term Care Hospitals, Maryland Waiver Hospitals, Cancer Hospitals, Children’s Inpatient Facilities, Rural Health Clinics, Federally Qualified Health Centers, Religious Non-Medical Health Care Institutions, Inpatient Psychiatric Hospitals, Inpatient Rehabilitation Facilities, and Veterans Administration/Department of Defense Hospitals). For discharges after October 1, 2008, IPPS hospitals do not receive the higher payment for cases when one of the selected conditions is acquired during hospitalization. The case is paid as though the secondary diagnosis is not present.

On July 31, 2008, in the IPPS Fiscal Year 2009 Final Rule, CMS included 10 categories of conditions that were selected for the HAC payment provision.

The 10 categories of HACs include: Foreign Object Retained After Surgery, Air Embolism, Blood Incompatibility, Stage III and IV Pressure Ulcers, Falls and Trauma (Fractures, Dislocations, Intracranial Injuries, Crushing Injuries, Burn, Other Injuries), Manifestations of Poor Glycemic Control (Diabetic Ketoacidosis, Non-ketotic Hyperosmolar Coma, Hypoglycemic Coma, Secondary Diabetes with Ketoacidosis, Secondary Diabetes with Hyperosmolarity), Catheter-Associated Urinary Tract Infection, Vascular Catheter-Associated Infection, Surgical Site Infection (Mediastinitis Following Coronary Artery Bypass Graft, Surgical Site Infection Following Bariatric Surgery for Obesity, Laparoscopic Gastric Bypass, Gastroenterostomy, Laparoscopic Gastric Restrictive Surgery, Surgical Site Infection Following Certain Orthopedic Procedures, including Spine, Neck, Shoulder, Elbow), Deep Vein Thrombosis/Pulmonary Embolism Following Certain Orthopedic Procedures (Total Knee Replacement, Hip Replacement).

Payment implications began October 1, 2008, for these 10 categories of HACs.
Patient Reported Outcome Measurement System (PROMIS)

www.nihpromis.org

In 2004, the National Institutes of Health initiated a multi-center cooperative group referred to as the Patient-Reported Outcomes Measurement Information System (PROMIS), as part of a ‘roadmap’ for medical research in the 21st century charted by the director of the NIH. PROMIS aims to “build and validate common, accessible item banks to measure key symptoms and health concepts applicable to a range of chronic conditions, enabling efficient and interpretable clinical trial and clinical practice applications of patient-reported outcomes (PROs)” (www.nihpromis.org).

The NIH PROMIS Roadmap initiative is a 5-year cooperative group program of research designed to develop, validate, and standardize item banks focusing on several important symptoms and health status domains that have relevance across chronic diseases and assists individual clinical practitioners in assessing patients’ responses to interventions and in modifying treatment plans on the basis of these (Cella et al, 2007).

The PROMIS network of clinicians, clinical researchers, and measurement experts is organized around 6 primary research sites (PRSs) and a statistical coordinating center (SCC), all of whom work closely with NIH project scientists representing several institutes of the NIH. The 6 PRSs include investigators from Duke University, Stanford University, Stony Brook University, University of North Carolina, University of Pittsburgh, and University of Washington, along with several collaborating institutions. The SCC is based at the Center on Outcomes, Research, and Education (CORE) at Evanston Northwestern Healthcare and includes collaborators from UCLA, Rehabilitation Institute of Chicago, United BioSource Corporation and Westat, Inc.

The PROMIS® questionnaires measure what patients are able to do and how they feel by asking questions, focusing on mental health topics such as fatigue and anxiety, or physical health topics such as pain and sleep impairment, or topics related to social health such as ability to participate in roles and activities. A patient’s answers to a set of questions are calculated into scores that can be used to improve communication, manage health conditions and design treatment plans.
Patient Safety Indicators (AHRQ)
http://www.qualityindicators.ahrq.gov/Modules/psi_overview.aspx

The Agency for Healthcare Research and Quality (AHRQ) develops Quality Indicators to provide health care decision makers with tools to assess their data. The AHRQ is within the Department of Health and Human Services, and is the lead federal agency for healthcare quality monitoring and improvement. Currently, the AHRQ Quality Indicators are only for use with administrative data in acute care hospitals, and are not available for other types of settings (e.g., long-term care, outpatient, ambulatory, hospice, individual practice, emergency department, or diagnostic centers) or populations (e.g., mental health or substance abuse, emergency preparedness, patient falls, rehabilitation, readmission, surgery, heparin therapy, c. difficile, or nursing quality).

The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth. The PSIs were developed after a comprehensive literature review, analysis of ICD-9-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.

The PSIs can be used to help hospitals identify potential adverse events that might need further study; provide the opportunity to assess the incidence of adverse events and in hospital complications using administrative data found in the typical discharge record; include indicators for complications occurring in hospital that may represent patient safety events; and, indicators also have area level analogs designed to detect patient safety events on a regional level.
The National Healthcare Safety Network (NHSN) is a secure, internet-based surveillance system that integrates and expands patient and healthcare personnel safety surveillance systems managed by the Division of Healthcare Quality Promotion (DHQP) at CDC. NHSN also enables hospitals to monitor adverse reactions and incidents associated with receipt of blood and blood products. Enrollment is open to all types of healthcare facilities in the United States.

While maintaining data security, integrity, and confidentiality, NHSN has the capacity for healthcare facilities to share data in a timely manner with other healthcare facilities or entities.

The purposes of NHSN are to collect data from a sample of healthcare facilities to permit valid estimation of the magnitude of adverse events among patients and healthcare personnel, analyze and report the data to determine trends, provide facilities with risk-adjusted metrics for inter-facility comparisons and QI activities, assist with surveillance, evaluate and determine prevention strategies, and ultimately to improve patient safety at the local and national level.
**Bundled Payment Program**


Bundled payment, also known as episode-based payment, episode payment, episode-of-care payment, case rate, evidence-based case rate, global bundled payment, global payment, package pricing, or packaged pricing, is defined as the reimbursement of health care providers on the basis of expected costs for clinically-defined episodes of care. (Cromwell et al, 1997; Miller, 2009)

Under the Bundled Payments initiative, CMS would link payments for multiple services patients receive during an episode of care, so as to provide incentives to deliver health care services more efficiently while maintaining or improving quality of care. Basically, if actual spending by health care providers is under budget, the providers receive a bonus, whereas if actual spending is over budget, payment to the providers is partially withheld.

Bundled payments can align incentives for all providers to partner closely across all specialties and settings that a patient may encounter to improve the patient’s experience of care during a hospital stay in an acute care hospital, and during post-discharge recovery.

The Bundled Payments for Care Improvement initiative is seeking applications for four broadly defined models of care, three of which would involve a retrospective bundled payment arrangement, with a target payment amount for a defined episode of care and one of which would be paid prospectively.

**Retrospective Bundled Payments**
In these models, CMS and providers would set a target payment amount for a defined episode of care. Applicants would propose the target price, which would be set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants in these models would be paid for their services under the Original Medicare fee-for-service system, but at a negotiated discount. At the end of the episode, the total payments would be compared with the target price. Participating providers may share the gains resulting from the more efficient redesigned care model.

**Prospective Bundled Payments**
CMS would make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians and other practitioners. Physicians and other practitioners would submit “no-pay” claims to Medicare and would be paid by the hospital out of the bundled payment.

Provisions for bundled payments are included in both the Patient Protection and Affordable Care Act and the Affordable Health Care for America Act.

Bundled payment has the potential to discourage unnecessary care, encourage coordination across providers, and potentially improve quality whilst not imposing penalties for providers for caring for sicker patients (Miller, 2009). However, increased quality and efficiency of care have yet not been demonstrated with this model.
**Value-Based Purchasing**


The concept of value-based purchasing (VBP) is that buyers should hold providers of health care accountable for both cost and quality of care. VBP utilizes information on the quality of health care, including patient outcomes and health status and compares these data to the financial burden. VBP focuses on identifying and rewarding the best-performing providers while reducing inappropriate care.

On May 5, 2012, CMS published a Notice of Proposed Rulemaking for the IPPS, which included a number of proposed policies related to the Hospital VBP Program. FY 2013 is the first year in which value-based incentives are available under the Program. The rule also proposed new provisions for the FY 2016 payment year, which aligns the HVBP Program with the National Quality Strategy and its priorities of better patient outcomes, quality, safety, and lower cost with Medicare payment.

Value-based purchasing involves employers and other purchasers gathering and analyzing information on the costs and quality of various competing providers and health plans, and providing incentives to encourage and reward desired practices by providers and consumers.

HEDIS (the Health Plan-Employer Data and Information Set) is a set of standardized measures developed by the National Committee for Quality Assurance (NCQA) to facilitate employer efforts to assess health plan performance. HEDIS measures have been criticized for emphasizing preventive and process measures, such as mammography screening rates, rather than outcomes of care. Furthermore, they have also focused primarily on the health issues relevant to the employed population. Nonetheless, employers do rely on the HEDIS measures to designate preferred providers for their employees.
PRIVATE SECTOR

National Quality Forum
http://www.qualityforum.org/Home.aspx

The National Quality Forum (NQF) is a private, non-profit consortium. Member organizations include physician organizations (including the AAOS), nursing organizations, allied health organizations, and hospital systems. The NQF is governed via eight councils:

- Consumer Council
- Health Care Council
- Health Professionals Council
- Provider Organizations Council
- Public/Community Health Agency Council
- Purchasers Council
- Quality Measurement, Research, and Improvement Council
- Supplier and Industry Council

The NQF promotes quality in medicine by evaluating and endorsing standardized performance measurements. They provide a “stamp of approval” for quality measures developed by health providers and hospital systems across the United States. Endorsements are re-evaluated every 3 years. The endorsement process integrates the input of the NQF’s diverse membership. There is a 9-step Consensus Development Process used for endorsing each quality initiative, integrating the input of member organizations as well as the general public. Four primary criteria are utilized in the endorsement process:

- Does a quality measure report high-impact, priority issues with strong evidence that improvement will provide a distinct benefit to patients?
- Is a quality measure scientifically acceptable – will measurements be reliable and valid?
- Is a quality measure useable and relevant, able to be interpreted by all involved parties?
- Is a quality measure feasible, able to be tracked using available resources?

Currently, the NQF website lists 727 endorsed quality standards. In addition to these existing standards, the NQF has a 3-year plan to endorse quality measures in 22 specialty areas of healthcare, including cardiology, infectious disease, neurology, and perinatal care.

The NQF has been central to several major developments in the health care quality arena in recent years. One accomplishment has been to publish the report Safe Practices for Better Healthcare, last updated in 2010. This is a collection of 34 measures that provide a broad framework for improving outcomes and patient safety, applicable in nearly any hospital. These measures have been viewed as a benchmark, and are often integrated into industry quality-measuring algorithms. The full report is attached in the Appendix.
Also, efforts by the NQF to develop a list of Serious Reportable Events (SRE) (often known colloquially as the “never events”) have formed the basis for reporting hospital performance to the public in more than half of states to date. Moreover, this list is now used by CMS to determine payment for services stemming from adverse events. This complete report is also available in the Appendix.

The NQF is a core member of the National Priorities Partnership (NPP), a collaboration of 51 major national organizations whose shared objective is the creation and implementation of a unified National Quality Strategy. The NPP provides regular consensus input to the Dept. of HHS regarding the National Quality Strategy. Other members of the NPP include the American Medical Association, American Nurses Association, the Leapfrog Group, the Pacific Business Group on Health, and the Joint Commission. Ex-officio governmental members include the AHRQ, CDC, CMS, NIH, FDA, and the Veterans’ Administration. The NPP’s latest report on the status of the National Quality Strategy is included in the Appendix.

The NQF is also the primary mover behind the Measure Applications Partnership (MAP), a large-scale public-private effort to advise the U.S. government on what performance measures are most suitable for pay-for-performance programs and public health care quality reporting. The goal is to create more alignment in quality measurement and reporting between the public and private sectors. MAP strives to bring all major stakeholders to the same table to discuss and implement quality measures. Within MAP there are both hospital and physician workgroups that advise the MAP coordinating committee, which in turn reports to the Dept. of HHS. The 3-year plan for MAP is included in the Appendix.

In 2009, the NQF was contracted by the U.S. Department of Health & Human Services to establish a systematic program to develop and monitor quality measures across a wide spectrum of health services, utilizing the broad membership of the NQF. This relationship was created as part of the Medicare Improvements for Patients and Providers Act of 2008. One of the first steps of this project was to identify the 20 medical conditions with the greatest impact on the U.S. health system, in order to appropriately focus quality initiatives. Together these 20 conditions account for approximately 95% of Medicare costs. Of interest to orthopaedic surgeons, hip/pelvic fractures ranked #11 and osteoarthritis/rheumatoid arthritis ranked #14. This contract is ongoing, and the goal is to create usable quality metrics that will target the highest-impact areas of the American health care system. The full report is included in the Appendix.
The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) is a nationally validated, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care in the private sector. Preoperative through 30-day postoperative ACS NSQIP® data is collected by a trained Surgical Clinical Reviewer on randomly assigned patients and entered online in a HIPAA-compliant, secure, web-based platform. ACS NSQIP monitors accrual rates and data sampling methodologies and conducts Inter-Rater Reliability Audits on a random basis.

A comprehensive report is prepared twice yearly, which includes risk-adjusted 30-day morbidity and mortality outcomes for each participating hospital. The outcomes are reported as odds ratio, which represents the estimated odds of a complication or event happening in a specific hospital compared to the estimated odds of that event happening in all hospitals in ACS NSQIP. An expected OR is 1.0. Numbers greater than 1.0 indicate the hospital is doing worse than expected, and numbers less than 1.0 signify that the hospital is doing better than expected.

“The reports help hospitals identify areas where they may be underperforming. Hospital quality committees use the report findings as the basis for quality improvement action plans to re-engineer workflows, foster and improve internal education, and develop clinical performance improvement initiatives.”

A recent study in the Annals of Surgery involving 118 ACS NSQIP hospitals concluded that the program helped each hospital prevent between 250 to 500 complications per year (Hall et al, 2009). In addition, 82 percent of those hospitals saw improvement in morbidity levels and 66 percent saw improvement in mortality levels.
Founded in 1989, the Pacific Business Group on Health (PBGH) consists of 50 large health care payers who have at least 2,000 beneficiaries in California. However, these are businesses with a national presence, including Boeing, Chevron, and General Electric. The mission of the PBGH is “to improve the quality and availability of health care while moderating costs.” The organization has 4 key strategies to achieve their mission:

1. Engaging consumers
2. Paying for value
3. Redesigning care delivery
4. Advancing value-based policy

PBGH has several different quality-measurement programs. In 1993, it established the California Cooperative Healthcare Reporting Initiative (CCHRI), bringing together health care purchasers, insurers, and providers. Nine health insurers, covering 90% of California’s insured workers, are members, along with various physician and other provider groups. PBGH funds the CCHRI, which in turn serves as the data collection and quality monitoring entity.

The CCHRI created the California Physician Performance Initiative (CPPI) in 2006, in order to “measure and report the quality of patient care that is provided by individual physicians.” Currently, the CPPI uses 16 measures (see Appendix for complete list). The only measure presently applying to orthopaedic surgeons is to place adult patients with rheumatoid arthritis on disease-modifying anti-rheumatic drugs. The results are publicly available, and Blue Shield uses the CPPI ratings in determining their “Blue Ribbon” physicians.

The CCHRI also administers the Patient Assessment Survey, which measures patient-reported experiences for individual physician groups. Participating health plans are using this survey program as part of their pay-for-performance calculations. The 4-page questionnaire for patients seeing specialists (see Appendix) focuses on ease of access to care, communication, care coordination, attention to patient emotional health, satisfaction with office staff, and a grade of the physician on a scale of 0-10.

PBGH has been a supporter of the California Joint Replacement Registry (CJRR), recognizing the huge cost burden that total joint replacement places on health care purchasers. The CJRR seeks to be a model for tracking the performance of arthroplasty devices and surgeons for the rest of the nation.

Finally, as a major partner in the development of California’s health insurance exchange under PPACA, PBGH is advocating for and developing methodologies to measure and reward quality through the insurance exchange. Value-driven health care will likely be a
major force shaping the California exchange, and likely will influence other states as well.
In 2000, the Leapfrog Group was formed as a consortium of large employers seeking to use their combined purchasing power to improve health care quality and value. One key impetus for formation was the 1999 Institute of Medicine report, *To Err Is Human*. Today, Leapfrog members provide health insurance to 37 million Americans.

Leapfrog advocates for 4 key quality improvements in hospitals:
1. Computerized physician order entry
2. Evidence-based hospital referral for consumers
3. Intensive care unit staffing by intensivist physicians
4. Scoring of hospitals based on adherence to the National Quality Foundation’s Safe Practices

Similarly, member companies in Leapfrog agree to 4 purchasing principles for health insurance:
1. Educating employees about safety, quality, and affordability in health care, encouraging comparison of health care providers.
2. Recognizing and rewarding health care providers for improvements in safety, quality, and affordability.
3. Holding health plans accountable for implementing Leapfrog purchasing principles.
4. Building support with benefits consultants/brokers to adhere to Leapfrog purchasing principles.

**Leapfrog Hospital Survey**
The core initiative of the Leapfrog Group has been the Leapfrog Hospital Survey, a voluntary survey that hospitals can choose to complete in order to receive a designation of quality improvement from Leapfrog. The survey evaluates each hospital’s performance in regards to the key improvements listed above, using 8 of the 34 NQF Safe Practices. The survey results are readily available to the public on the Leapfrog website. The survey addresses 7 high-risk surgical procedures, none of which are orthopaedic.

**Leapfrog Hospital Safety Score**
Leapfrog also generates the Hospital Safety Score (HSS). This score utilizes 26 publicly-available measurements of hospital safety and performance to grade more than 2600 hospitals in the United States. Hospitals are scored whether or not they have completed the Leapfrog Hospital Survey. Metrics are derived from Leapfrog’s criteria, NQF Safe Practices, the AHRQ, CDC, and CMS guidelines (including hospital-acquired conditions). These measures are placed into one of two domains within the HSS, each worth 50% of the score: process & structural measures and outcome measures. Examples include giving antibiotics within 1 hour of surgical incision (process), computerized order entry (structural), and retained foreign bodies (outcome). Data is weighted based on
opportunity for improvement, impact, and evidence. Scores are readily available to the public on the HSS website.

Within the HSS, there are several metrics that apply to orthopaedic surgeons:
1. Appropriate preoperative antibiotics
2. Antibiotic discontinuation after 24 hrs
3. Timely urinary catheter removal
4. Appropriate VTE prophylaxis
5. Falls and trauma
6. Death among surgical inpatients
7. Postoperative DVT/PE
8. Postoperative wound dehiscence

Leapfrog Hospital Recognition Program
Leapfrog also operates a proprietary pay-for-performance system that health insurance plans can license to help purchase high-value health care. The program gives members the ability to generate comparative reports based on local, regional, and national hospital performance data.
Health Care Incentives Improvement Institute
http://www.hci3.org

The Health Care Incentives Improvement Institute (HCI3) is a private, non-profit organization whose mission is to improve health care through evidence-based incentives and payment reforms. They offer two primary services to health care providers and purchasers: the Bridges to Excellence (BTE) pay-for-performance model, and the Prometheus bundled payment pilot model. Current major partners are numerous, and include Aetna, Blue Cross Blue Shield, Cigna, 3M, IBM Intel, Wellpoint, and the states of Colorado and Georgia.

Bridges to Excellence
The BTE program relies on voluntary reporting of clinical data by providers via an electronic medical record. The data is then scored by independent Performance Assessment Organizations (PAOs), who issue performance reports to providers and insurers. These PAOs include the National Committee for Quality Assurance and IRPO. In addition, providers who achieve recognition from the HCI3 are designated on the publicly-available website.

Currently, there are 12 clinical Recognition Programs within the BTE – providers can seek to obtain recognition for any of these programs by participating in the BTE. The programs are: asthma, cardiac, congestive heart failure, cardiology practice (a comprehensive recognition developed by the American College of Cardiology), COPD, coronary artery disease, depression, diabetes, hypertension, medical home, physician office systems, and spine.

Notably, most of these programs focus on cardiovascular care. The spine recognition does apply to orthopaedic surgeons. In order to achieve recognition, providers must:
1. Make appropriate recommendations for physical therapy.
2. Avoid unnecessary imaging.
3. Appropriately use epidural injections and surgery.
4. Educate patients.
5. Share decision-making for non-operative vs. operative treatment with patient.

Of note, the HCI3 plans to introduce a joint replacement recognition program in the near future.

Prometheus
Prometheus is an acronym for “Provider Payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle-Reduction, Excellence, Understandability, and Sustainability.” Clearly this is an ambitious project. In short, Prometheus seeks to create a fair, widely-applicable method to determine evidence-based bundled payments for episodes of care. While this paper does not focus on payment reform, the model is detailed and intriguing. From the standpoint of quality, scorecards using the clinical measures from the BTE Recognition Programs are used to measure and incentivize performance within the Prometheus model.
UnitedHealth Premium Designation

UnitedHealth is the largest health insurer in the United States. Their network includes 595,000 physicians and other health providers, as well as nearly 5,000 hospitals. In order to encourage improvements in care, UnitedHealth grants a premium designation to certain physicians within their network. A physician can earn up to two “stars,” one for quality of care and another for cost-effective care. The quality star must be earned before the cost star is awarded.

The Premium program evaluates physicians in 21 specialties. UnitedHealth uses its internal claims data to compare each physician to a national standard comprised of all member physicians in that specialty. NQF-endorsed standards are used as benchmarks to evaluate the claims-based data. The 75th percentile is the benchmark for achieving exceptional quality, in relation to the outcomes of the other physicians in the statistical pool. In addition, board certification is a prerequisite to obtaining the quality star. If physicians do not have sufficient volumes of UnitedHealth patients to be evaluated by this methodology (there are thresholds), they can still achieve the quality star by participating in quality-improvement programs operated by Bridges to Excellence and the NCQA.

The cost-effective care designation takes into account not only a physician’s direct fee for providing a service, but also the facility and ancillary costs associated with the treatment they provide for a patient episode. In order to achieve the cost star, a physician must meet or exceed the median cost-effectiveness compared to other same-specialty doctors in the same geographic area.

There are a number of orthopaedic procedures that are tracked in the Premium program. These are: Achilles tendon repair, ankle ligament repair, ankle arthroscopy, midfoot arthrodesis, arthroscopic shoulder decompression/debridement, arthroscopic rotator cuff repair, arthroscopic shoulder SLAP repair, arthroscopic clavicle resection/tendodesis, arthroscopic carpal tunnel release, open carpal tunnel release, cervical spine fusion/instrumentation, cervical spine laminectomy, lumbar spine decompression, lumbar spine fusion/instrumentation, revision lumbar spine surgery, vertebral corpectomy, hip arthroscopy, hip arthroplasty, revision hip arthroplasty, arthroscopic knee ligament reconstruction, arthroscopic meniscectomy, knee arthroplasty, and revision knee arthroplasty. (For full details of the outcomes criteria measured for each of these procedures, see the comprehensive methodology in the Appendix.)
Healthgrades

Healthgrades is a web-based service that creates performance reports on individual physicians and hospitals. In order to achieve the Recognized Doctor designation, a physician must:

1. Never have had a revocation of a medical license.
2. Have no malpractice judgments or legal settlements in the past 5 years.
3. Be free of state or federal disciplinary actions for the past 5 years.
4. Be board-certified.

In order to collect this information, Healthgrades uses several publicly-available data sources. These include state medical boards, CMS, the American Board of Medical Specialties, and the American Osteopathic Association.

Healthgrades also calculates and publishes a number of different designations for hospitals. Several of these awards are calculated by evaluating outcomes of 26-28 patient cohorts (America’s Best Hospitals Award, Distinguished Hospital Award for Clinical Excellence, Hospital Report Card for Mortality and Complication Outcomes). The primary data source on these cohorts came from the Medicare Provider Analysis and Review (purchased from CMS). Cohorts relevant to orthopaedic surgery include mortality statistics for pulmonary emboli, complications after neck/back surgery (with or without fusion), complications after hip fracture care, and complications after total hip/total knee replacement.
Consumer Reports (CR), long known for publishing information on manufactured product quality, has now begun rating hospitals. They currently provide scores for more than 1100 hospitals in 44 states. CR calculates their ratings by tracking 6 categories of outcomes:

1. Infections
   a. Central line infections –
      i. Data from public reporting in 18 states, as well as from the Leapfrog Hospital Survey.
   b. Surgical site infections –
      i. Data from public reporting in 11 states.
      ii. Pertinent to orthopaedics, surgical procedures tracked include hip/knee surgeries and spinal fusions.

2. Hospital readmissions
   a. Data from 30-day readmission rates publicly reported by CMS.

3. Complications
   a. Data from composite complications score created by AHRQ for CMS, publicly reported.
   b. Pertinent to orthopaedics, the composite score incorporates post-operative hip fracture, post-operative DVT/PE, post-operative sepsis, and post-operative wound dehiscence as 4 of the 8 complications metrics tracked.

4. Mortality
   a. Data from composite mortality score created by AHRQ for CMS, publicly reported.
   b. Pertinent to orthopaedics, the composite score incorporates hip fracture mortality as one of the 6 mortality metrics tracked.

5. Patient experience
   a. Data from CMS’s Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, administered to samples of former hospital inpatients and publicly reported.
   b. CMS publishes results for 9 categories within HCAHPS to evaluate individual hospitals: communication about medications, communication about discharge, doctor-patient communication, nurse-patient communication, getting help, controlling pain, keeping the room clean, and overall patient experience.

6. Hospital practices
   a. Electronic health records (EHR)
      i. Data from American Hospital Association information technology survey, which reports 28 different measures of EHR implementation
   b. Appropriate use of imaging
      i. Data publicly reported by CMS.
      ii. 4 components
1. Performing MRI of lumbar spine without prior conservative management of low back pain.
2. Performing additional screening mammogram or breast ultrasound on patients who have had a screening mammogram in the past 45 days.
3. Percentage of chest CT scans performed twice, once without contrast and once with contrast.
4. Percentage of abdominal CT scans performed twice, once without contrast and once with contrast.

CR also calculates an overall safety score, combining central line infection rates, readmission rates, complications/mortality rates, medication/discharge communication, and appropriate CT scanning use.
U.S. News & World Report
http://health.usnews.com/health-news/best-hospitals/articles/2012/07/16/best-hospitals-2012-13-how-they-were-ranked

U.S. News & World Report annually issues rankings of the top hospitals for 16 medical specialties, orthopaedic surgery being one of these. While nearly 4800 hospitals were assessed, only 148 hospitals ranked in even one specialty. Seventeen hospitals made an Honor Roll by ranking in 6 or more specialties.

In order to be ranked, a hospital had to meet at least one of the following criteria:
1. Be a teaching hospital.
2. Be a hospital affiliated with a medical school.
3. Have at least 200 beds.
4. Have at least 100 beds and have at least 4 of 8 specific medical technologies (for example, radiation oncology or PET/CT scanning).

Hospitals that met one of these qualifications then had to meet volume thresholds, which vary by specialty. To be ranked for orthopaedics, a hospital had to have 303 Medicare admissions, 275 of which were surgical.

If the volume threshold for a specialty was met, hospitals then received a 4-part score:
1. Reputation (32.5% of score)
   a. Based on rankings of 200 randomly-selected physicians in each specialty
2. Survival score (32.5% of score)
   a. Calculated based on mortality of Medicare inpatients, adjusted for patient condition, over the past 3 years.
3. Care-related indicators (30% of score)
   a. Primarily based on the American Hospital Association’s 2010 survey; assesses factors such as nursing staffing, technology implementation, etc.
4. Patient safety score (5% of score)

One important thing to note in the U.S. News rankings is the relative weight of hospital reputation compared to patient safety. Most of the other private-sector quality measurement systems discussed in this report put a much greater emphasis on patient safety.
CONCLUSION

There are many stakeholders including federal and state governments, as well as public and private entities who are actively striving to improve quality in healthcare. There are a plethora of avenues and measures being utilized to craft a safe healthcare environment. However, not all of these efforts provide accurate and equitable assessments of quality, particularly in regards to individual physicians.

The time is now for the American Academy of Orthopaedic Surgeons to participate in the creation of a new culture of safety in healthcare. It would be in the best interest for patients across the country for their surgeons to design a comprehensive measurement system that evaluates the appropriate metrics, to develop a method that can accurately gauge whether or not their care is safe, efficient, and valuable, and for their surgeons to have not only a presence, but a voice at the table when administrative policies are being created in the area of healthcare quality.
References


Guidelines for Reporting Physician Data

Background and Rationale for Creating the Reporting Guidelines

Nearly every major health care payer sponsors a physician profiling program that provides physicians with data that can be used to influence physician behavior and decision-making and facilitate practice improvements. The adequacy and effectiveness of the information contained within the reports can be diminished when physicians are unable to understand the data or know how to use them.

The American Medical Association (AMA) recognizes the importance of providing uniform and intelligible reports to physicians so that they can evaluate and corroborate the accuracy of profiling results, especially when they are used as the basis for pay-for-performance, tiered networks, narrow networks, and/or public reporting systems. More importantly, the data, if consistently and coherently presented, can provide an additional source of information in order to support data-driven decision-making.

Multiple barriers prevent physicians from effectively using the data in these reports. Physicians may have difficulty understanding complex performance data and analytic methodologies used in creating these reports. The utility of existing data reports is also limited by the lack of aggregated claims data from all sources, including Medicare and Medicaid. There are three reporting strategies that payers can adopt however, to assist physicians in being able to better understand and use their performance data.

1. Greater industry-wide standardization of the reporting format
2. Greater transparency of the processes used to create the report
3. Adequate depth of data available to physicians including patient-specific data

The implementation of these strategies would enhance the effectiveness of the reports and increase physician understanding and use of the data. Each payer is currently using its own unique reporting format, making it challenging for physicians to decipher the information that is presented in these multiple formats. Physician data reports also often contain insufficient physician data (e.g., patient-specific data) and systems information to allow the reports to be verifiable and actionable by physicians and suitable to drive practice improvement activities.

The AMA has a multitude of policies that address all aspects of physician profiling, including its associated activities and the appropriate release, use and storage of physician data. We encourage all parties involved in health care to access these policies, which can be found under Section 406 Physician-Specific Health Care Data and Section 410 Practice Parameters on the AMA Web site’s policy finder at www.ama-assn.org. See also www.ama-assn.org/go/profiling for additional information.

However, this document is dedicated solely to the process of reporting physician profiling results and how this process can become more uniform and understandable to the physician community. It does not address AMA policies regarding how physician data are used and if profiling should or should not be performed and should not to be construed to do so. In the
spirit of collaboration, the AMA presents this effort to assist payers and other reporting bodies in improving the utility and transparency of the data contained in these reports.

The AMA, in consultation with many physicians, Federation of Medicine staff, national health insurers, accreditation bodies, and others, has created the following Guidelines for Reporting Physician Data (Reporting Guidelines). The AMA recognizes that other organizations, such as the Consumer-Purchaser Disclosure Project (CPDP) and AQA, have published criteria for physician performance measurement. The AMA strongly backs the CPDP’s provision that performance reporting should include both quality and cost of care information, with cost of care information never being reported without accompanying quality data. The AMA supports these other data reporting criteria and will continue to collaborate with other groups working in this area.

However, existing reporting principles and criteria do not specifically address standardization of the reporting format and inclusion of sufficient data detail, which are the main areas of focus for these Reporting Guidelines. Health plan support for the Reporting Guidelines will increase uniformity between insurers’ reports and boost the value and utility of the data to physicians. This, in turn, will increase the impact on physician decision-making and behavior. Developing data reports in accordance with these Reporting Guidelines will mutually support physicians and payers.

The individual guidelines within the Reporting Guidelines fall under five general categories: Overarching Physician Data Reporting Guidelines, Quality Reporting Guidelines, Cost of Care Reporting Guidelines, Transparency Reporting Guidelines, and Reconsideration Reporting Guidelines. A ranking system (primary and secondary individual guidelines) indicates the recommended priority for instituting each individual guideline. The AMA urges health plans and other payers and reporting bodies to formally affirm their support for the Reporting Guidelines and many of the concepts embodied within them. While it may not be feasible for all health plans and other reporting entities to immediately follow all of the individual guidelines within this document, a group’s support for the Reporting Guidelines indicates an acknowledgement that these are aspirational goals for physician data reporting and that their organization will seek ways to implement these concepts into their reporting systems.

Adoption of these Reporting Guidelines may also require changes in the reporting of physician data to consumers, as physician and public reporting systems may have common links. Although consumer reporting is outside the scope of this document, the AMA recognizes that payers may provide physician performance data to their members and urges plans that provide these data to do so in a manner that facilitates consumer understanding of both the health plan information and the limitations of that data.

Please note: These Reporting Guidelines only address the format of physician data reports. The content of these reports, as well as various other issues related to physician profiling (attribution, risk adjustment, etc.), is outside the scope of these Reporting Guidelines. Processes associated with activities or evaluations related to profiling are not implicitly or explicitly supported or opposed by the AMA based on their inclusion or exclusion in the Reporting Guidelines. Additionally, these Reporting Guidelines may not apply to new types of data sets being developed by payers. The Reporting Guidelines address the reporting of administrative claims data, as this is the type of information being used most widely for physician performance measurement. As health plans and other reporting bodies become increasingly engaged in using other data sources, such as electronic health records (EHRs) and clinical registries, the AMA will update the Reporting Guidelines to address reporting issues unique to these particular data...
sources. The AMA will periodically review and modify the Reporting Guidelines to address these new types of information being analyzed and reported by health plans and other reporting bodies.

**Overarching Physician Data Reporting Guidelines**

*Note: Primary Reporting Guidelines are numbered; Secondary Reporting Guidelines are bulleted and follow the Primary Reporting Guidelines.*

The Overarching Physician Data Reporting Guidelines deal with topics that apply to the physician reporting system as a whole and/or pertain to all sections of physician data reports. The Overarching Reporting Guidelines also address the reporting of a physician’s overall quality and cost scores and suggest a drill-down structure for data reports.

1.) If reports are available for individual physicians, physician group practices, or subgroups of physician group practices, physicians can access and download these data reports on demand, such as via a secure web-based portal. The reporting system allows for 24/7 access to reports.

**Secondary Reporting Guidelines**

- The web-based system should allow for the exportation of reports to other formats that are more user-friendly and enable the physician’s office to sort the data (e.g., Microsoft Access, Excel, etc.).
- Users should be able to convert each report page to a printer-friendly version (e.g., pdf). Before printing patient-specific information, the reporting system should display a warning indicating the possibility of confidentiality breaches if the data are printed.

2.) Physicians can always access their own data and can grant report access to other individuals (other physicians, nurses, office staff, etc.). Group practices can authorize individuals within a practice to access individual physician, group practice, or practice subgroup data reports.

3.) A highlighting system (color-coding, symbols, etc.) should be used throughout the physician data report to clearly identify areas with meaningful and actionable differences in performance. If color-coding is used, reports should also employ letters or some other means to indicate color so that the system can be understood by colorblind individuals.

4.) The first report page should include a statement listing all of the ways that the reporting body uses the physician data (i.e., public reporting, physician payment, network inclusion, benefit design, etc.), as well as an indication of how the reporting entity envisions that the physician can use the provided data.

5.) Reports include a practitioner characteristics and designations section that is pre-populated by the plan and allows physicians to submit requests to the reporting body to update and correct their information. This section includes any designations, practice improvement activities, etc., that are used in determining a physician’s rating. Physicians should be encouraged to review and update their data, particularly
when changes occur, to ensure that the information in report sponsors’ databases is correct.

6.) Each section of the report displays the date range for the specific data being presented in that report section.

7.) The data report clearly identifies the benchmarking group (specialty, locale, etc.) being used in the report.

8.) The reporting entity should clearly indicate the patient population(s) (commercial, Medicare Advantage, etc.) being evaluated in the report.

9.) The report lists contact information for obtaining assistance from the health plan with questions or concerns.

10.) A glossary with definitions for key terms and fields used in the physician data report is provided.

Secondary Guideline

- Users can access definitions for report terms and fields from any page in the report, either through a hyperlink to a glossary page or a “pop-up” function that displays term or field definitions as they appear throughout the report.

11.) The report includes an individual/group top-level quality and cost of care summary report. When possible, this report contains graphical representations of the distribution of overall quality and cost of care scores among all plan providers. These graphs should indicate the plan’s average scores, where the physician falls in relation to plan peers, and an indication of cutoffs for meeting any plan targets. The particular universe of providers in the physician’s comparator peer group for quality and cost evaluation is described in detail (e.g., plan participation; specialty; subspecialty [if applicable]; local, regional, or national market; and any other criteria used by the plan to determine the physician’s peer group). The physician’s summary report indicates the physician’s tier or network assignment (if applicable), the designation criteria used by the plan to place physicians in networks or tiers (performance cutoffs, percentiles, etc.), and the impact on benefit design for the patient (e.g., differential co-pays or co-insurance).

Secondary Guideline

- The physician’s top-level summary report should show the calculation for any pay-for-performance bonus and how the physician’s tier/network assignment was determined.

Figure 1 below provides an example from the AMA’s Standardized Physician Data Report of one possible way to implement the Reporting Guidelines for the top-level quality and cost of care summary report.
12.) Reports feature a layered/drill-down format. Reports begin with summary information, progress to reports with increasing levels of detail, and conclude with patient-specific data. Users can directly access the report at all levels by either starting with the summary reports and drilling down to reports displaying increasing levels of detail by clicking hyperlinked text, or by immediately selecting and navigating to a particular report section.

Secondary Guideline

- It is recommended that an illustration of the report’s structure be provided to help users understand and navigate the report’s hierarchical structure.

13.) If the physician’s summary data will be publicly reported or used by the insurer to confer a status or benefit to the physician, the report indicates the time period (subject to local regulations and requirements) that physicians have to appeal and receive the results of the appeal prior to the public posting or insurer’s use of the information.

Quality Reporting Guidelines

Note: Primary guidelines are numbered; secondary guidelines are bulleted and follow the primary guidelines for each report section.

The Quality Reporting Guidelines present physician performance data relative to established quality measures. The Reporting Guidelines ensure that physicians have complete information regarding their quality performance as compared with their peers and any plan targets, as well as access to quality measure specifications. The Reporting Guidelines provide physicians with the patient-level quality data needed to verify the accuracy of the report and/or to implement practice improvement activities.

1. Quality Summary Report: The highest level quality report provides aggregated data for a physician by condition. It includes the sample size, how often the physician

Figure 1.
met the applicable quality measures (measure set) for each condition (including any applicable appropriate use measures), how often his/her peers met the measure set, and any existing plan quality targets. If appropriate and when possible, the report also includes the physician’s met-measure-set performance for the prior reporting period and the percent change from the previous reporting period so that the physician can track improvements and declines in performance over time. If a reporting entity stratifies quality data by severity of illness, the performance data for each stratified disease severity group should be reported separately.

**Secondary guidelines**
- Where appropriate, the Quality Summary Report may divide quality results into separate sections such as those applicable to chronic, acute, and preventive care or use other criteria that are particularly pertinent to the program.
- To enhance the utility of the report, the user should also be able to re-sort the results in multiple ways, including by level of performance (e.g., from best scores to worst scores).

**Figure 2** below provides an example from the AMA’s Standardized Physician Data Report of one possible way to implement the Reporting Guidelines for the Quality Summary Report.

### Figure 2.

<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
<th>Number of Patients</th>
<th>Your Current Measure Compliance Rate</th>
<th>Plan/Insurer Average Measure Compliance Rate</th>
<th>Plan Target Measure Compliance Rate</th>
<th>Prior Report Measure Compliance Rate</th>
<th>% Change</th>
<th>Met Goal</th>
<th>Compliance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>C402</td>
<td>Chronic Stable Coronary Artery Disease</td>
<td>12</td>
<td>0.58</td>
<td>0.60</td>
<td>0.80</td>
<td>0.40</td>
<td>29%</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>I501</td>
<td>Heart Failure</td>
<td>10</td>
<td>0.70</td>
<td>0.74</td>
<td>0.85</td>
<td>0.86</td>
<td>6%</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>J451</td>
<td>Asthma</td>
<td>12</td>
<td>0.60</td>
<td>0.79</td>
<td>0.80</td>
<td>0.80</td>
<td>2%</td>
<td>G</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Underlined, blue text in the figure represents hyperlinked report fields that, when clicked, provide additional information about that term or direct the user to the next report level to obtain more detailed data.

### 2. Quality Detail Report by Condition/Indicator: The intermediate-level quality report provides physician performance data related to the individual measures that comprise a condition’s measure set and provides measure-met-level detail. It clearly states the sample size for each measure, how often the physician met each specific quality measure, how often his/her peers met each measure, any existing plan quality targets, and the number of measure opportunities removed from the denominator by the reporting body in determining the measure performance rate. The report specifies the source for the quality measures used.
**Secondary Guideline**

- Physicians should be able to access full information about the measure specifications from the measure developer and a list of all codes used to determine inclusion in the numerator and denominator of the measure’s performance calculations.

**Figure 3** below provides an example from the AMA’s Standardized Physician Data Report of one possible way to implement the Reporting Guidelines for the Quality Detail Report by Condition/Indicator.

**Figure 3.**

`Chronic Stable Coronary Artery Disease Care Pathway`

<table>
<thead>
<tr>
<th>Measure</th>
<th>Number of Patients</th>
<th>Number of Patients with Criteria Met</th>
<th>Number of Exclusions</th>
<th>Your Current Measure Compliance Rate</th>
<th>Plan/Insurer Average Measure Compliance Rate</th>
<th>Plan Target Measure Compliance Rate</th>
<th>Met Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amplitude Therapy</td>
<td>12</td>
<td>11</td>
<td>0</td>
<td>0.92</td>
<td>0.95</td>
<td>0.85</td>
<td><img src="Green.png" alt="Green" /></td>
</tr>
<tr>
<td>Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF &lt; 40%)</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0.08</td>
<td>0.98</td>
<td>0.85</td>
<td><img src="Red.png" alt="Red" /></td>
</tr>
<tr>
<td>ACE Inhibitor or AEB Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF &lt; 40%)</td>
<td>11</td>
<td>8</td>
<td>1</td>
<td>0.73</td>
<td>0.75</td>
<td>0.85</td>
<td><img src="Yellow.png" alt="Yellow" /></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>0.55</strong></td>
<td><strong>0.36</strong></td>
<td><strong>0.55</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Underlined, blue text in the figure represents hyperlinked report fields that, when clicked, provide additional information about that term or direct the user to the next report level to obtain more detailed data.

3. **Quality Detail Report by Patient:** The report includes a section that provides patient-specific data for all of the measures listed in the intermediate-level quality report. The Quality Detail Report by Patient displays the patient’s name, date of birth, insurer identification number, the applicable quality measures for the patient’s condition, whether or not each quality measure was met for each patient, and the dates that services related to the measures were provided. The report indicates any measures that the insurer has excluded from consideration in measure calculation and the reason for exclusion (either an exclusion code or explanatory text; see Figure 4-a below). Health plans and reporting bodies should have a process in place that allows physicians to submit requests for reconsideration of a patient’s inclusion in the denominator of a quality performance measure calculation (see Figure 4-b) and to supply a reason (medical, patient, or system) for the exception request (see Figure 4-c). Physicians can request that patients not in their care be removed from the report. Physicians can also indicate the date of service for any services provided but not captured by claims data and submit this information to the insurer so that the patient may be added to the numerator of a quality measure calculation. When possible, the reconsideration process should be electronic and allow physicians to submit requests directly through the web-based reporting system.
Secondary guidelines

- To enhance the utility of the report, the user should be able to re-sort the results by the “measure met” field in order to create a list of missed quality opportunities.
- It is desirable for reporting systems to be capable of connecting to a physician’s EHR system to facilitate the reporting of quality measures, particularly those that cannot be captured with administrative claims data.

Figure 4 below provides an example from the AMA’s Standardized Physician Data Report of one possible way to implement the Reporting Guidelines for the Quality Detail Report by Patient.

Cost of Care Reporting Guidelines

Note: Primary Reporting Guidelines are numbered; Secondary Reporting Guidelines are bulleted and follow the Primary Reporting Guidelines for each report section.

The Cost of Care Reporting Guidelines address the reporting of physician performance data relative to the cost of health care resources used. The data reports should provide physician or group average episode costs and break down these costs into service categories, as well as compare a physician or group’s cost relative to their peers and any plan targets. Physicians should be provided with the patient-level cost data needed to verify the accuracy of the report and/or to make changes in their practice to increase their efficiency of care. Throughout this section, cost of care is quantified in terms of episode costs, as this is currently the most common methodology used by payers in measuring the cost of resource utilization. Reporting bodies may use other methods to quantify resource use, including total per capita costs or utilization of certain types of services (e.g., emergency room visits, imaging, etc.). The general principles outlined in this document—providing physicians with
verifiable, patient-specific data in a transparent manner—will apply to all reports, regardless of how resource use or cost is measured.

1. **Cost Summary Report:** The highest level report for physician cost of care groups patient episodes of care into diagnostic groups and displays the number of cases that are attributed to that physician within each diagnostic group. (The methodology behind determining a diagnostic group varies, but it bundles episodes with similar ICD-9 codes into groups [e.g., ETGs, MEGs, or Caves Groupers].) This report also lists that physician’s average cost for each diagnostic group, the peer average cost, any existing plan target episode cost, and the physician’s cost variation from the plan target (if applicable). If appropriate and when possible, the report also details the physician’s average diagnostic group cost for the prior reporting period and the percent change from the previous period so that the physician can track improvements and declines in performance over time. If a health plan stratifies some diagnostic groups by severity of illness, the physician data for each stratified diagnostic group should be reported separately. The report should clearly indicate whether actual or standardized costs are being used.

**Secondary Guideline**
- If possible, payers should stratify and separately report cost information depending on the availability of pharmacy data.

**Figure 5** below provides an example from the AMA’s Standardized Physician Data Report of one possible way to implement the Reporting Guidelines for the Cost Summary Report.

**Figure 5.**

![Figure 5](image)

Note: Underlined, blue text in the figure represents hyperlinked report fields that, when clicked, provide additional information about that term or direct the user to the next report level to obtain more detailed data.

2. **Cost Detail Report by Diagnostic Group:** The intermediate-level cost report contains the same basic data elements as the Cost Summary Report but also breaks down the individual diagnostic group costs into the types of services provided to patients, such as professional services, inpatient facility, surgical and other procedures, pharmacy, lab work and pathology, radiology, outpatient surgery, ancillary services, physical therapy, and any other service categories cited in the payer’s physician assessment. The numerical values represent the average episode of
care costs associated with each service. The report should clearly indicate whether actual or standardized costs are being used.

Secondary Guideline

- When possible, a graphical representation of the intermediate-level cost report should be provided.

**Figure 6** below provides an example from the AMA’s Standardized Physician Data Report of one possible way to implement the Reporting Guidelines for the Cost Detail Report by Diagnostic Group.

### Figure 6.

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnosis</th>
<th>Pharmacy Data Available</th>
<th>Episode Count</th>
<th>Service</th>
<th>Your Average Episode Cost by Service</th>
<th>Peer Average Episode Cost by Service</th>
<th>Target Episode Cost</th>
<th>Variance Ratio</th>
<th>Met Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endoscopy</td>
<td>Hypertension</td>
<td>Y</td>
<td>10</td>
<td>Professional Services</td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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</tr>
</tbody>
</table>

**Note:** Underlined, blue text in the figure represents hyperlinked report fields that, when clicked, provide additional information about that term or direct the user to the next report level to obtain more detailed data.

3. **Cost Detail Report by Patient:** The report includes a section with patient-specific cost data for each service category within a diagnostic group. The report indicates the patient’s name, date of birth, co-morbidities, insurer identification number, episode cost, and benchmark information. This report allows the physician to compare the data with his/her own records for accuracy and may also be used to identify patterns of individual treatment regimens that vary from peers. The report should clearly indicate whether actual or standardized costs are being used.

Secondary guidelines

- Data systems should include a functionality (e.g., pop-up window) that displays the co-morbidity codes of record for a patient and indicates which co-morbidities/codes were used for risk adjustment purposes.
- For services included in the physician’s average episode cost that were provided by other physicians/providers, the report should indicate, if not in violation of existing contracts, the name of the other physician/provider.

**Figure 7** below provides an example from the AMA’s Standardized Physician Data Report of one possible way to implement the Reporting Guidelines for the Cost Detail Report by Patient.
Figure 7.

Note: Underlined, blue text in the figure represents hyperlinked report fields that, when clicked, provide additional information about that term or direct the user to the next report level to obtain more detailed data.

Report Transparency Reporting Guidelines

Note: Primary guidelines are numbered; secondary guidelines are bulleted and follow the primary guidelines.

All physician data reports include a transparency section that provides complete information regarding the payer’s use and analysis of physician data, and any determinations about the physician as a result of that analysis. This section should provide concise, high-level summaries of the payer’s methodologies, with hyperlinks to any more detailed methodology documents or manuals created by the insurer or reporting body. The transparency section should include the following information:

1.) An explanation of which physicians are eligible for evaluation under the program, including the specialties and subspecialties evaluated in the reporting system.

2.) A description of the methodology used to calculate the physician quality score based on the payer’s quality measures and an indication of the total number of quality measures used by the payer, with a hyperlink that provides access to a full list of the payer’s quality measures and specifications.

3.) A description of the methodology used to calculate the physician cost of care score, to include the episode grouper software (with version) used by the payer in those calculations.

4.) An indication of the level at which the payer measures and reports performance data (physician group, practice, and/or the individual physician).
5.) A detailed explanation of the methodology used to attribute a particular patient’s service to a specific provider.

6.) The minimal sample size (patients, opportunities, or episodes) required for inclusion in the quality and cost evaluations and an explanation of the extent to which the minimum sample size ensures statistical validity.

7.) The algorithms and methodology used to calculate the physician’s rolled-up quality and cost scores in the top-level quality and cost of care summary report.

8.) A detailed description of all statistical tests used, to include the confidence intervals or other statistical tools (e.g., R-squared) used for quality and cost of care measurements and the reliability testing used for physician data results.

9.) The methodologies used to determine any existing target quality measure compliance rates and target episode costs.

10.) The methodology used for risk adjustment to account for variation in both case mix and disease severity, to include the factors being considered in risk adjustment and how these factors are applied to adjust physicians’ scores in both the quality and cost evaluations.

11.) The methodology the payer uses to handle cost outliers, to include any caps or percentage cutoffs.

12.) A listing of all the ways that the payer uses the physician data (i.e., public reporting, physician payment, network inclusion, benefit design, etc.).

13.) Detailed instructions on how a physician can request reconsideration of his/her evaluation and provide additional information to support a change in rating, to include an explanation of the electronic reconsideration process, if applicable.

The AMA and/or its delegates will assist physicians in using the information provided by health plans and other reporting entities in efforts to improve the quality, efficiency, and patient-centeredness of care.

**Reconsideration Reporting Guidelines**

*Note: Primary guidelines are numbered; secondary guidelines are bulleted and follow the primary guidelines.*

The Reconsideration Reporting Guidelines ensure that physicians have the ability to request reconsideration of their performance scores and submit supporting documentation to the health plan or reporting body. The Reporting Guidelines recommend that any electronic reconsideration process generate a report that documents all of a physician or group’s requests that are being submitted to the payer for reconsideration, including a timeline of how and when the reconsideration process should be completed.

1.) The reporting system includes a process through which physicians can request reconsideration of specific items listed in their performance report.
2.) When a reconsideration request results in a change to a physician’s score, the health plan corrects the physician’s score and notifies the physician of the change. If possible, the health plan generates a corrected data report.

3.) If the health plan or reporting body utilizes an electronic reconsideration process, the system automatically generates a report that lists all of the physician/group’s reconsideration requests (e.g., quality measure exceptions, patients not in his/her care, missing services for quality measures). This report serves as the physician/group’s record of the items that have been transmitted back to the health plan for further review and possible adjustment of the physician’s quality score. The report includes the reason for the reconsideration request and the date of service for any missing services.

Secondary guidelines

- A subsequent report is sent to the physician noting the payer’s actions, with justification, on the physician’s submissions for review.
- The report also includes a functionality (e.g., electronic signature) that allows a physician to attest that the changes being submitted are accurate to the best of his/her knowledge.
MEETING ROOMS
AT THE MADISON

AAOS Orthopaedic Quality Institute

Opening Reception
Mt. Vernon

Keynote Presentation / Dinner
Montpelier

Breakfast / General Session
Dolley Madison Ballroom - Lower Level

Luncheon
Dolley Madison Ballroom - Upper Level

Breakout Groups
A: Adams A
B: Adams B
C: Dolley Madison Ballroom - Upper Level

WWW.MADISONHOTELDC.COM
202.862.1600
AAOS Travel Policy
Travel Policy

Volunteers and AAOS Staff

The Academy/Association (AAOS) policy for AAOS-related travel for volunteers and staff is outlined below. This policy is effective January 1, 2012. Travel guidelines for members of the Board of Directors and for Council and Cabinet Chairs are outlined in a separate policy.

Please note that no member is eligible for reimbursement for travel to the Annual Meeting. This is the case even if a member is scheduled to attend a Council or Committee meeting during the course of the Annual Meeting.

Introduction

The AAOS recognizes that volunteers give generously of their time and spend time away from their practices to participate in AAOS events. When this dedication on the part of members is added to the fact that more than 3,000 trips are made by AAOS volunteers in the course of a year, it becomes paramount that the AAOS travel policy be fair, consistent, and easily understandable. In addition, it must provide for prompt and accurate reimbursement of expenses incurred. Finally, it must fulfill certain obligations required by the Internal Revenue Service and also adhere to principles of prudent management.

Domestic Air travel

Travelers are strongly encouraged to use CorpTrav, AAOS' official travel agent, to make their travel arrangements for AAOS business. In so doing the airfare and agent fees are charged directly to AAOS but travelers retain any reward miles that may apply. In addition, AAOS receives complimentary air travel certificates in proportion to the amount of airfare AAOS books through United Airlines. These certificates are then used for special, unbudgeted events or tickets that cost more than $750.

Round-trip travel should be booked on one airline whenever possible (the same airline going and returning). If different airlines are needed, please make arrangements by contacting CorpTrav with the details. If the ticket exceeds $600, CorpTrav will contact the AAOS Travel Specialist to authorize issuing the ticket.

Discounted non-refundable and non-transferable coach class tickets for scheduled meetings should be purchased at least 21 days prior to travel, as this will generally yield the lowest fare available. The fee to book the ticket is $20 if the ticket is purchased online and $30 if acquired over the phone – i.e., agent-assisted booking.

Reimbursement for discounted coach class will be limited to the 21-day rate. If your departure date is less than three weeks away and the price of discounted coach class airfare exceeds $750, CorpTrav may offer you the use of an AAOS earned certificate from United Airlines. However, no reward miles are earned when traveling on an earned certificate.

AAOS will reimburse for the additional fees charged by the airlines for checked bags up to a two bag maximum. Overweight baggage fees will not be reimbursed. Flight changes will be reimbursed up to $150
per round trip.

Use of a private airplane is strongly discouraged due to liability issues as the Academy's insurance will neither cover the volunteer traveling aboard a private airplane on AAOS business nor the AAOS.

**Upgrades**

Upgrade purchases are not reimbursable, including upgrades to Economy Plus.

**International flights**

Volunteers traveling on behalf of the AAOS can travel Business Class on all international trips. Staff members whose flight time is at least seven hours may also travel Business Class. (For purposes of this policy, flights to/from Canada, Hawaii and Alaska are considered domestic.)

**West Coast travel**

Staff returning to Chicago from the Pacific time zone may, at their option, stay overnight if they cannot arrange a return flight departing before 5pm Central time (3 pm Pacific Time).

**RELATED TOPICS**

**E-tickets vs. paper tickets**

Please avoid requesting paper tickets when making travel arrangements. The airlines have created interlining agreements (to facilitate flight changes that occur because of aircraft delays or weather problems) that have diminished the usefulness of paper tickets. In addition to the $50 fee for issuing paper tickets, there is also a charge to send the ticket via Federal Express. If a ticket is lost, there is an additional fee to replace it. If the ticket is unused, it must be returned to CorpTrav, who will charge a fee to refund the unused ticket.

**Hotel/lodging**

Lodging accommodations should be made at mid-price hotels, such as Starwood, Hilton, Marriott, or Hyatt properties. AAOS will reimburse lodging expenses up to $250 per day including all taxes, with the exception of hotel stays in New York, Washington D.C., and San Francisco, which are reimbursable at a maximum of $400 per day including all taxes.

Travelers to Rosemont should stay at the Hyatt Rosemont, where AAOS has preferential room rates. Stays at other Chicago area hotels will be reimbursed at the Hyatt Rosemont preferred rate and transportation costs are not reimbursable.

**Meals**

AAOS will reimburse individuals for meals in conjunction with official AAOS business at a rate of $125 per day, excluding those meals provided by AAOS. The entire $125 may be applied toward dinner. AAOS does not reimburse for meals taken in lieu of AAOS-provided or sponsored meals, or for meals after travel has concluded (i.e., after return flight).
**Other travel expenses**

AAOS will reimburse individuals for usual and customary miscellaneous expenses related to travel in conjunction with AAOS business. Allowable expenses in this category include:

- Telephone up to $25 per day
- Internet usage based on hotel’s access charge and reasonable cost (See Exhibit A)
- Hotel in-room movie or use of hotel fitness center
- Customary gratuities for baggage handling, etc.
- Ground transportation to and from airports
- Valet laundry service up to $50 when travel covers seven consecutive days.

Master accounts at hotels will only cover the room and tax. Any other incidental expenses are to be paid by the traveler and claimed on the expense voucher, if appropriate.

Personal expenses are not reimbursable. Examples include, but are not limited to, child care, pet care, entertainment, and toiletry purchases.

**Automobile travel**

AAOS will reimburse individuals traveling in conjunction with AAOS business via personal automobile at the published US Government Internal Revenue Service rate per mile ($0.555 per mile effective 01/01/12). If a personal vehicle is used in lieu of airline travel, mileage reimbursement may not exceed the cost of the commercial 21-day discounted Coach airfare. Automobile rental for travel in conjunction with AAOS business is discouraged. Hotel shuttle vans and taxis are the preferred mode of ground travel. Small groups who find that car rental is the most cost-effective option should contact AAOS’ Travel Specialist Anita Cooper at 847-384-4182, or by email at cooper@aaos.org for complimentary or discounted rental coupons.

**SPECIAL RULES REGARDING TRAVEL**

**Add-on personal travel**

Add-on or personal travel is defined as travel either before or after AAOS meetings that is scheduled at the sole discretion of the traveler. All expenses incurred with add-on travel are the responsibility of the traveler.

**Expense Reporting/Receipts**

Original receipts are required for each travel expense item that is $25 or more, including taxi fares, however, the traveler is encouraged to obtain receipts for all expenses. As required under IRS guidelines receipts for meals should be detailed showing individual food or beverage items. Hotel receipts should include detailed room folios.

Expense reports (with attached receipts documenting all costs of $25 or more) are due to the Accounts Payable Department within 30 days of the completed travel. This ensures timely reimbursement and
accurate record keeping. Reimbursement checks are typically issued within two weeks of receipt of vouchers.

**Exhibit A**

**Internet Access Procedures when Traveling**

The traveling employee, member, or faculty will be reimbursed for Internet use for AAOS business or AAOS-related research. Some computer systems do not support all methods of Internet connection.

**Internet access**

In order to be reimbursed for Internet connectivity, the traveler must utilize one of the following:

- The hotel's local Internet service provider to access the Internet at the hotel's stated per diem rate. It is the responsibility of the hotel guest to obtain this information and specifics regarding log-on and/or passwords upon check-in, or

- His/her own Internet service provider if that provider has a local access number or toll-free access for the area where the employee, member or faculty is traveling. *It is the responsibility of the employee, member or faculty to ensure that this option is a viable alternative prior to traveling.*

Most national Internet service providers (ISPs) have areas on their websites where local access or toll-free access numbers can be found. Please note that when using the service provider's toll-free access number in lieu of a local access number, a surcharge or per-minute charge is typically added to the subscriber's monthly bill. This will be the subscriber's responsibility to pay and is not reimbursable.

Many national ISPs also have a customer service number to call for the local access number for a given travel destination. Small providers may not have a national access network. The traveler should contact his/her individual service provider for more details.