Attachment to the Annual Progress Report to Congress

National Strategy for Quality Improvement in Health Care:

Agency-Specific Quality Strategic Plans

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

Table of Contents

Agency-Specific Quality Strategic Plans

Agency Leadership

The Department of Health and Human Services (HHS) created a template to guide agencies in the development of agency-specific quality strategic plans, with broad, recommended categories to create consistency across the plans and ensure alignment with the National Quality Strategy (NQS). Using these templates, agencies explained how their own principles, priorities, and aims correspond with those of the NQS; elaborated on their existing and future efforts to implement the NQS; and discussed the methodology for evaluating these efforts.

Some agencies have begun incorporating the NQS into their strategic planning and programmatic activities. The Substance Abuse and Mental Health Services Administration (SAMSHA) developed a draft National Behavioral Health Quality Framework (NBHQF), incorporating two rounds of public comments, and is identifying and finalizing a set of core measures. The NBHQF successfully aligns SAMSHA's mission with the NQS and retains the three aims of NQS as an overarching guideline, while outlining six unique priorities that parallel those in the NQS. In this document, SAMSHA defines its role in fighting national substance abuse, explains how its efforts directly align with the aims of NQS, and illustrates how its own priorities will advance the quality of care in behavioral health. The NBHQF provides a model that HHS will leverage as an example for future agency-specific plans and demonstrates a successful approach for executing the aims of the NQS while achieving measurable improvement across all six priority areas.

Agency for Healthcare Research and Quality (AHRQ) Agency-Specific Quality Strategic Plan

Brief Introduction/Overview

AHRQ's mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. The Agency works to fulfill this mission through one overarching program: Health Services Research. Health services research examines how people get access to health care, how much care costs, and what happens to patients because of the care they receive. The principal goals of health services research are to identify the most effective ways to organize, manage, finance, and deliver high-quality care; reduce medical errors; and improve patient safety. AHRQ conducts and supports health services research within the Agency as well as in leading academic institutions, hospitals, physicians' offices, health care systems, and many other settings across the country.

This mission directly aligns with the priorities of the NQS.

Agency-Specific Quality Strategic Plan Table

1. Title
2. Description
3. Scope of Issue
4. Rationale for Approach
5. Metrics/Goals

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
AIMS	
Better Care *Improve quality by making health care more person-centered, reliable, accessible, and safe.*	1. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) family of surveys. 2. These surveys measure consumer perspectives and experience of care across care settings and among various patient populations. Surveys assess consumer experience of health plans, clinician and group practices, dental care, surgical care, home health care, in-center hemodialysis, and nursing homes. 3. The surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. 4. Over the past 15 years, the CAHPS Consortium has established a set of principles to guide the development of CAHPS surveys and related tools. These principles include identifying and supporting the consumer or patient's information needs, conducting thorough scientific testing, ensuring comparability of data, maintaining an open development process, and keeping products in the public domain. 5. CAHPS results.

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
Healthy People/Healthy Communities *Support proven interventions to address behavioral, social, and environmental determinants of health.*	1. Potentially Preventable Admissions Mapping Tool. 2. Many hospital admissions, such as those for asthma and diabetes, are preventable with adequate primary care, self-care, and community/public services. This tool enables communities, local health departments, and others to identify counties with high levels of potentially preventable admissions for each of these diagnoses, providing both a color-coded map and a cost calculator to estimate savings possible through reduced rates. 3. The tool uses AHRQ's Prevention Quality Indicators, which are National Quality Forum (NQF)-endorsed measures. It is embedded in MONAHRQ, a Web builder that enables localities to create a Web site using their own local data. Public reporting at the facility level can use these data, which can also enable tracking of potentially preventable admissions using AHRQ's Prevention Quality Indicators. The tool also includes links to evidence on ways to reduce rates of potentially preventable admissions for each disease. 4. Five States are now using MONAHRQ to create public reporting Web sites, and others are using the mapping tool to reduce potentially preventable admissions. 5. AHRQ's Healthcare Cost and Utilization Project (HCUP) and National Healthcare Quality Report track State and national rates of potentially preventable admissions.
Affordable Care *Reduce the cost of quality health care for individuals, families, employers, and government.*	1. The Medical Expenditure Panel Survey (MEPS). 2. This survey collects data on health insurance coverage, health care access, and health care costs for a national sample of the U.S. community-dwelling population and is used by policymakers, providers, and consumers to evaluate the current state of the health care system and the effects of proposals for change. 3. The survey includes an employer component, used to examine health insurance offer rates, takeup rates, and enrollment, as well as employer and employee premium costs, for private employers in the United States and in individual States. The computation of the U.S. Gross Domestic Product involves use of these data. 4. The survey results provide the basis for modeling the effects of changes in the financing and provision of care on use of services, the distribution of payments by source—including out-of-pocket, private insurers, and public programs—and financial burdens for individuals and families. 5. The survey results are used to estimate the contribution of chronic illnesses to the concentration and growth in overall medical spending.

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
PRIORITIES	
Making care safer by reducing the harm caused in the delivery of care.	1. Patient Safety Portfolio. 2. The Portfolio's mission is to prevent, mitigate, and decrease the number of medical errors, patient safety risks, and hazards associated with health care and their harmful effect on patients. Specific objectives include to increase the number of U.S. health care organizations using AHRQ-supported tools to improve patient safety; increase the number of evidence-based tools available in AHRQ's inventory to improve patient safety; and reduce costs associated with hospitalizations related to infections resulting from medical care. 3. Since the 1999 publication of "To Err Is Human," the landmark Institute of Medicine report on patient safety, there has been significant progress in identifying and verifying practices that improve safety. However, additional work is needed in demonstrating how practices are implemented and integrated into clinical practices and how to promote a culture that fully supports providing the safest care possible. 4. The initiative relies on grant and contract funding mechanisms, as well as a variety of communication strategies. 5. Quantitative and qualitative measures are used to evaluate the various components of the Patient Safety Portfolio. Outcome data are very important and gathered from a variety of sources, including reporting systems, Web sites, survey data, and interviews with stakeholders.
Ensuring that each person and family are engaged as partners in their care.	1. Questions Are the Answer. 2. This initiative encourages patients to become more engaged in their own health care and aims to improve communication between patients and clinicians—all with the goal of helping to make health care safer. 3. Poor communication among clinicians and patients can lead to a variety of problems, including medication errors, preventable hospital readmissions, and other issues that harm patients and drive up health care costs unnecessarily. 4. The initiative uses a combined patient/clinician education model that includes a public service advertising campaign featuring general market advertisements, a Web site, patient education materials, videos, and clinician-targeted advertisements to reach patients, caregivers, doctors, nurses, and other members of the heath care team. 5. Web metrics and orders placed to AHRQ's Publications Clearinghouse.
Promoting effective communication and coordination of care.	1. Primary Care Medical Home Initiative. 2. Revitalizing the nation's primary care system is foundational to achieving high-quality, accessible, and efficient health care for all Americans. The primary care medical home, also referred to as the patient-centered medical home (PCMH), advanced primary care, and the health care home, is a promising model for transforming the organization and delivery of primary care. 3. As part of this initiative, AHRQ convenes the Federal PCMH Collaborative, which is designed to bring together executive branch employees in agencies or departments that are doing work related to the primary care medical home with nonfederal experts to develop a common base of knowledge about this new health care delivery model. AHRQ also hosts a Web-based PCMH resource center that provides both policymakers and researchers with access to evidence-based resources about the medical home and facilitates the exchange of information (www.pcmh.ahrq.gov). 4. Care coordination is a core pillar of the PCMH. As part of AHRQ's PCMH initiative, in 2011, AHRQ published the "Care Coordination Measures Atlas," which provides a framework and describes existing measures of ambulatory care coordination for potential adoption to monitor the effectiveness of this new delivery model. 5. N/A

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.	1. HHS Million Hearts™ Campaign. 2. This is a national initiative to prevent 1 million heart attacks and strokes over the next 5 years by promoting aspirin for people at risk, blood pressure control, cholesterol management, and smoking cessation (the "ABCS" of cardiovascular disease). 3. Heart disease and stroke are two of the leading causes of death in the United States. 4. AHRQ will support Million Hearts through conferences and communications that will speed the identification and diffusion of innovative strategies along with evidence-based reports to improve the delivery of the Million Hearts ABCS in communities and health care systems. 5. HHS campaign metrics.
Working with communities to promote wide use of best practices to enable healthy living.	1. Extension for Community Healthcare Outcomes (ECHO). 2. AHRQ funded researchers at the University of New Mexico Health Sciences Center to develop and pilot health information technology (IT) to bring state-of-the-art medical knowledge about the effective treatment of persons with hepatitis C virus (HCV) infection to primary care providers and nurses in underserved areas. 3. Approximately 3.2 million Americans are chronically infected with HCV, which causes 12,000 deaths per year. It is the leading cause of liver transplantation. Although treatment is available and effective, it can cause serious side effects and, therefore, must be carefully managed by a medical team. Typically, such care and treatment is not available outside of university medical centers. 4. Project ECHO demonstrates that health IT can help solve the problems of underserved communities by empowering primary care clinicians to provide high-quality specialty care locally. 5. N/A
Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.	1. Value Portfolio. 2. The mission of the Value Portfolio is to reduce unnecessary costs and waste while maintaining or improving quality. The aim is to help the Department fulfill its mission to help Americans receive high-quality, efficient, and affordable care by creating a high-value system, in which providers produce greater value, consumers and payers choose value, and the payment system rewards value. 3. To meet these needs, the Portfolio produces quality and efficiency measures, data, and tools; conducts research on system redesign, public reporting, and payment strategies; and facilitates translation and implementation of evidence-based strategies into policy and practice. 4. Evidence is built through grants and contracts, and strategies are implemented through practice-based or community-based networks. An example of the latter is the 24-community quality collaborative, known as Chartered Value Exchanges, which implements across communities and entire States research findings on public reporting, payment, waste reduction, and quality improvement. The Portfolio also relies heavily on quality and cost data produced through AHRQ efforts such as MEPS, HCUP, and the National Healthcare Quality and Disparities Reports (NHQR/DR). 5. The cumulative number of AHRQ measures, tools, upgrades, and syntheses available on health care value and the cumulative number of AHRQ measures and tools used in national, State, or community public report cards.

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
AREAS OF COORDINATION OR ALIGNMENT	
Demonstration of coordination or alignment with other federal agencies (i.e., involvement of other agencies in program planning or execution, mechanisms for sharing best practices, steps to reduce duplication of effort).	AHRQ participates in and leads various interagency working groups, including the following: • NHQR/DR Interagency Quality Measures Group • HHS Healthcare–Associated Infections Steering Committee • HHS Quality Work Group • Federalwide Interagency Working Group on Health Care Quality • Patient Safety Organization Work Group
Demonstration of coordination or alignment with the private sector or States (i.e., stakeholder meetings, public comment periods, open-door forums, workshops).	AHRQ participates or leads a variety of multistakeholder alliances, including the following: • National Priorities Partnership • Measures Application Partnership • NQF • Ambulatory Care Quality Alliance • Patient-Centered Outcomes Research Institute
Use of measures or benchmarks for performance measures and/or monitoring that align with the NQS.	To be determined by HHS leadership.

Centers for Disease Control and Prevention (CDC) Agency-Specific Quality Strategic Plan

CDC's mission is collaborating to create the expertise, information, and tools that people and communities need to protect their health—through health promotion; prevention of disease, injury, and disability; and preparedness for new health threats.

CDC seeks to accomplish its mission by working with partners throughout the nation and the world to monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training.

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NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
AIMS	
Better Care *Improve quality by making health care more person-centered, reliable, accessible, and safe.*	1. Million Hearts. 2. Million Hearts is a national initiative to prevent 1 million heart attacks and strokes over the next 5 years. Heart disease and stroke are two of the leading causes of death in the United States. 3. Each year, more than 2 million Americans have a heart attack or stroke, and more than 800,000 of them die; cardiovascular disease is the leading cause of death in the United States and the largest cause of lower life expectancy among blacks. Related medical costs and productivity losses approach $450 billion annually, and inflation-adjusted direct medical costs are projected to triple over the next two decades if present trends continue. 4. Multifaceted initiative including public campaign and multiple programmatic and policy actions in clinics and communities. 5. Several, including HCUP, public health surveillance data, and consistent quality metrics from the health care system. 6. Key activities: a. Educational campaigns to increase awareness about heart disease prevention and empower patients to take control of their heart health. b. Use of health IT and quality improvement initiatives to standardize and improve the delivery of care for patients with high blood pressure and high cholesterol. c. Community efforts to promote smoke-free air policies and reduce sodium and artificial transfat in the food supply.

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
Healthy People/Healthy Communities *Support proven interventions to address behavioral, social, and environmental determinants of health.*	1. Million Hearts. 2. Million Hearts is a national initiative to prevent 1 million heart attacks and strokes over the next 5 years. Heart disease and stroke are two of the leading causes of death in the United States. 3. Each year, more than 2 million Americans have a heart attack or stroke, and more than 800,000 of them die; cardiovascular disease is the leading cause of death in the United States and the largest cause of lower life expectancy among blacks. Related medical costs and productivity losses approach $450 billion annually, and inflation-adjusted direct medical costs are projected to triple over the next two decades if present trends continue. 4. Multifaceted initiative including public campaign and multiple programmatic and policy actions in clinics and communities. 5. Several, including HCUP, public health surveillance data, and consistent quality metrics from the health care system. 6. Key activities: a. Educational campaigns to increase awareness about heart disease prevention and empower patients to take control of their heart health. b. Use of health IT and quality improvement initiatives to standardize and improve the delivery of care for patients with high blood pressure and high cholesterol. c. Community efforts to promote smoke-free air policies and reduce sodium and artificial transfat in the food supply.
Affordable Care *Reduce the cost of quality health care for individuals, families, employers, and government.*	1. National Diabetes Prevention Program (NDPP). 2. NDPP is a lifestyle coach led, 16 group session behavior modification program delivered in community settings to reduce the risk of progression from prediabetes to diabetes. 3. CDC estimates that one of every three U.S. adults had prediabetes in 2010. People with prediabetes are five to 15 times more likely to develop type 2 diabetes than people with normal blood glucose (blood sugar) levels. Effective prevention of type 2 diabetes lowers risk for possible complications of diabetes such as heart disease, stroke, kidney disease, blindness, nerve damage, and other health problems. 4. Community-based behavior modification program. 5. Key activities: a. Training—CDC and collaborators train community-based lifestyle coaches and provide the 16 session curriculum for use in community settings. b. Program Recognition—CDC-sponsored recognition program for quality assurance of community sites that will allow CDC to provide a registry that reports program outcomes. c. Intervention site recruitment and technical support. d. Health marketing to increase awareness and referral to NDPP sites.

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
PRIORITIES	
Making care safer by reducing the harm caused in the delivery of care.	1. National Healthcare Safety Network (NHSN). 2. NHSN is the nation's public health surveillance system on healthcare–associated infections and related health care quality issues; it supports the goals of the HHS Action Plan to Prevent Healthcare–Associated Infections. 3. Each year, more than 2 million people develop healthcare–associated infections, with direct medical costs as high as $30 billion. 4. System providing data that are used for public reporting, quality measurement, and improvement. 5. NHSN data. 6. Key activities: a. Data system with analytic tools for acute care hospitals; long-term, acute care hospitals; psychiatric hospitals; rehabilitation hospitals; outpatient dialysis centers; ambulatory surgery centers; and long-term care facilities. b. Capacity for health care facilities to share data in a timely manner between health care facilities (e.g., a multihospital system) or with other entities (e.g., public health agencies or quality improvement organizations). c. In aggregate, CDC analyzes and publishes surveillance data to estimate and characterize the national burden of healthcare–associated infections. At the local level, the data analysis features of NHSN available to participating facilities range from rate tables and graphs to statistical analysis that compares the health care facility's rates with national aggregate metrics.
Ensuring that each person and family are engaged as partners in their care.	1. Million Hearts. 2. Million Hearts is a national initiative to prevent 1 million heart attacks and strokes over the next 5 years. Heart disease and stroke are two of the leading causes of death in the United States. 3. Each year, more than 2 million Americans have a heart attack or stroke, and more than 800,000 of them die; cardiovascular disease is the leading cause of death in the United States and the largest cause of lower life expectancy among blacks. Related medical costs and productivity losses approach $450 billion annually, and inflation-adjusted direct medical costs are projected to triple over the next two decades if present trends continue. 4. Multifaceted initiative including public campaign and multiple programmatic and policy actions in clinics and communities. 5. Several, including HCUP, public health surveillance data, and consistent quality metrics from the health care system. 6. Key activities: a. Educational campaigns to increase awareness about heart disease prevention and empower patients to take control of their heart health. b. Use of health IT and quality improvement initiatives to standardize and improve the delivery of care for patients with high blood pressure and high cholesterol. c. Community efforts to promote smoke-free air policies and reduce sodium and artificial transfat in the food supply.

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
Promoting effective communication and coordination of care.	1. Million Hearts. 2. Million Hearts is a national initiative to prevent 1 million heart attacks and strokes over the next 5 years. Heart disease and stroke are two of the leading causes of death in the United States. 3. Each year, more than 2 million Americans have a heart attack or stroke, and more than 800,000 of them die; cardiovascular disease is the leading cause of death in the United States and the largest cause of lower life expectancy among blacks. Related medical costs and productivity losses approach $450 billion annually, and inflation-adjusted direct medical costs are projected to triple over the next two decades if present trends continue. 4. Multifaceted initiative including public campaign and multiple programmatic and policy actions in clinics and communities. 5. Several, including HCUP, public health surveillance data, and consistent quality metrics from the health care system. 6. Key activities: a. Educational campaigns to increase awareness about heart disease prevention and empower patients to take control of their heart health. b. Use of health IT and quality improvement initiatives to standardize and improve the delivery of care for patients with high blood pressure and high cholesterol. c. Community efforts to promote smoke-free air policies and reduce sodium and artificial transfat in the food supply.
Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.	1. Million Hearts. 2. Million Hearts is a national initiative to prevent 1 million heart attacks and strokes over the next 5 years. Heart disease and stroke are two of the leading causes of death in the United States. 3. Each year, more than 2 million Americans have a heart attack or stroke, and more than 800,000 of them die; cardiovascular disease is the leading cause of death in the United States and the largest cause of lower life expectancy among blacks. Related medical costs and productivity losses approach $450 billion annually, and inflation-adjusted direct medical costs are projected to triple over the next two decades if present trends continue. 4. Multifaceted initiative including public campaign and multiple programmatic and policy actions in clinics and communities. 5. Several, including HCUP, public health surveillance data, and consistent quality metrics from the health care system. 6. Key activities: a. Educational campaigns to increase awareness about heart disease prevention and empower patients to take control of their heart health. b. Use of health IT and quality improvement initiatives to standardize and improve the delivery of care for patients with high blood pressure and high cholesterol. c. Community efforts to promote smoke-free air policies and reduce sodium and artificial transfat in the food supply.

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
Working with communities to promote wide use of best practices to enable healthy living.	1. Community Transformation Grants. 2. Community Transformation Grants support community-level efforts to reduce chronic diseases such as heart disease, cancer, stroke, and diabetes. By promoting healthy lifestyles, especially among population groups experiencing the greatest burden of chronic disease, these grants will help improve health, reduce health disparities, and control health care spending. 3. Chronic diseases account for the leading causes of death and disability in the United States and the majority of health care spending. 4. Capacity building and community-based intervention implementation. 5. Healthy People 2020 focus areas and achieving demonstrated progress in the following five performance measures outlined in the Affordable Care Act: 1) changes in weight, 2) changes in proper nutrition, 3) changes in physical activity, 4) changes in tobacco use prevalence, and 5) changes in emotional wellbeing and overall mental health, as well as other program-specific measures. 6. Key activities: a. Approximately $103 million in prevention funding has been awarded to 61 States and communities serving approximately 120 million Americans. b. These awards are distributed among State and local government agencies, Tribes and Territories, and State and local nonprofit organizations within 36 States, including seven Tribes and one Territory. c. At least 20 percent of grant funds will be directed to rural and frontier areas. d. The purpose of this program is to create healthier communities by 1) building capacity to implement broad evidence- and practice-based policy, environmental, programmatic, and infrastructure changes, as appropriate, in large counties, States, and Tribes and Territories, including in rural and frontier areas and 2) supporting implementation of such interventions in five strategic areas (Strategic Directions).
Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.	1. National Diabetes Prevention Program (NDPP). 2. NDPP is a lifestyle coach led, 16 group session behavior modification program delivered in community settings to reduce the risk of progression from prediabetes to diabetes. 3. CDC estimates that one of every three U.S. adults had prediabetes in 2010. People with prediabetes are five to 15 times more likely to develop type 2 diabetes than people with normal blood glucose (blood sugar) levels. Effective prevention of type 2 diabetes lowers risk for possible complications of diabetes such as heart disease, stroke, kidney disease, blindness, nerve damage, and other health problems. 4. Community-based behavior modification program. 5. Key activities: a. Training—CDC and collaborators train community-based lifestyle coaches and provide the 16 session curriculum for use in community settings. b. Program Recognition—CDC-sponsored recognition program for quality assurance of community sites that will allow CDC to provide a registry that reports program outcomes. c. Intervention site recruitment and technical support. d. Health marketing to increase awareness and referral to NDPP sites.
AREAS OF COORDINATION OR ALIGNMENT	
Demonstration of coordination or alignment with other federal agencies (i.e., involvement of other agencies in program planning or execution, mechanisms for sharing best practices, steps to reduce duplication of effort).	Million Hearts.

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
Demonstration of coordination or alignment with the private sector or States (i.e., stakeholder meetings, public comment periods, open-door forums, workshops).	Million Hearts.
Use of measures or benchmarks for performance measures and/or monitoring that align with the NQS.	To be determined by HHS leadership.

Centers for Medicare and Medicaid Services (CMS) Agency-Specific Quality Strategic Plan

Agency-Specific Quality Strategic Plan Table

1. Title
2. Description
3. Scope of Issue
4. Rationale for Approach
5. Metrics/Goals

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
AIMS	
Better Care *Improve quality by making health care more person-centered, reliable, accessible, and safe.*	Complete if there is an overarching initiative that aligns to the aim, but does not easily align to any priority.
Healthy People/Healthy Communities *Support proven interventions to address behavioral, social, and environmental determinants of health.*	Complete if there is an overarching initiative that aligns to the aim, but does not easily align to any priority.
Affordable Care *Reduce the cost of quality health care for individuals, families, employers, and government.*	Complete if there is an overarching initiative that aligns to the aim, but does not easily align to any priority.
PRIORITIES	
Making care safer by reducing the harm caused in the delivery of care.	1. Partnership for Patients—Care Transitions Objective. 2. A Partnership for Patients goal is to reduce 30-day rehospitalizations by 20 percent over 3 years. 3. Medication errors and poor communication and coordination between providers from the inpatient setting and home or other postacute care settings have resulted in a 20 percent 30-day readmission rate for the nation. 4. The Partnership for Patients was created as a national campaign to support public/private partnerships to achieve the overall aims. 5. 30-day readmission rates for all patients nationally.
Ensuring that each person and family are engaged as partners in their care.	1. Everyone With Diabetes Counts. 2. To decrease health disparities and promote health equity by improving health literacy for Medicare beneficiaries with diabetes in vulnerable underserved populations. 3. Diabetes outcomes are worse in vulnerable populations, including those with low literacy and minority populations. 4. Quality Improvement Organizations (QIOs) are contracted to recruit Medicare beneficiaries with diabetes in underserved, vulnerable populations and encourage them to complete diabetes self-management education classes. These classes are taught by community health workers in the communities where the beneficiaries reside; therefore, partnering with State, local, and community groups is critical to success. 5. Clinical data results of the diabetes measures (Hemoglobin A1c, Lipids, and Eye Exams), as well as Medicare claims data to evaluate both utilization of these measures and potential cost savings.

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
Promoting effective communication and coordination of care.	1. Community-Based Care Transitions Program (CCTP) (Section 3026 of the Affordable Care Act). 2. CCTP provides funding to test models for improving care transitions for high-risk Medicare beneficiaries through a comprehensive community effort. This program supports the Partnership for Patients goal of reducing 30-day hospital readmissions for Medicare fee-for-service (FFS) beneficiaries by 20 percent. 3. Medication errors and poor communication and coordination between providers from the inpatient setting and home or other postacute care settings have resulted in a 20 percent 30-day readmission rate for the nation. 4. CCTP allows applicants to propose a plan to implement care transitions interventions, including a per eligible discharge rate that needs to result in measureable savings to the Medicare program. 5. CCTP measures include 30-day readmission rates for hospitals and communities, admission rates, and intervention level measures (process and outcome specific to the intervention implemented).
Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.	1. Million Hearts/Physician Quality Reporting System (PQRS). 2. PQRS is a program providing payments to Medicare physicians and other eligible professionals who report quality measures data to CMS. CMS worked with CDC to select measures for use in the Million Hearts initiative that are currently in use in PQRS. 3. Cardiovascular disease is the leading cause of morbidity and mortality in the United States. Several preventive strategies have been shown to reduce the risk of development of cardiovascular disease. 4. By including measures related to the ABCS in the PQRS measure set and designating them as core measures, this will hopefully encourage reporting on the measures and provide information on the extent to which care related to the ABCS is being provided by physicians and other eligible professionals. 5. Measures for screening for and treatment of high blood pressure, high cholesterol, smoking cessation, and aspirin use for individuals with ischemic heart disease.
Working with communities to promote wide use of best practices to enable healthy living.	1. Medicaid Incentives for Prevention of Chronic Diseases (MIPCD). 2. MIPCD is an Affordable Care Act-mandated program of grants to 10 States to provide incentives to Medicaid beneficiaries to participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. Each State program addresses one or more of the following issues: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, avoiding onset of diabetes, or improving management of diabetes in those who already have it. Each State proposes a structure of incentives designed for their populations. 3. Tobacco use is the largest cause of preventable morbidity and mortality in the United States, accounting for more than 430,000 deaths per year. It has been estimated that 300,000 deaths per year may be attributable to obesity, and in 2008 the estimated health care cost of obesity was $147 billion. More than one-third of U.S. adults have two or more major risk factors for heart disease, a leading cause of morbidity, mortality, and health care costs. Diabetes is the seventh leading cause of death in the United States, with almost 24 million Americans having diabetes, at an estimated cost in 2007 of $116 billion. 4. Improving participation in preventive activities requires finding methods to encourage Medicaid consumers to engage in and remain in such efforts. A review of the effects of financial incentives on consumer health behaviors, primarily in commercial insurance programs, showed them to be effective about 73 percent of the time. Few data are available for Medicaid populations. 5. Each State uses a somewhat different set of interventions and incentive

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
	structures, so specific metrics will differ. Overall, CMS will evaluate use of health services, quality improvements and clinical outcomes under the programs, ability of special populations (such as adults with disabilities and children with special health care needs) to participate in the programs, level of satisfaction of Medicaid beneficiaries with accessibility and quality of the health care services provided, costs incurred by the States to administer the programs, and cost savings resulting from the programs.
Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.	1. Pioneer Accountable Care Organization (ACO) Model and Medicare Shared Savings Program. 2. These ACO models share the goal of reducing expenditures for Medicare FFS beneficiaries while maintaining or improving quality through outcomes-based payment arrangements that link incentives to quality measures and total costs of care in Medicare Part A and B. 3. Poor coordination of care and communication leads to duplication of medical services, rehospitalizations, and increased costs. 4. These models incentivize providers and institutions to work together to coordinate patient care through payment arrangements that are linked to performance outcomes. 5. Metrics include several outcome, process, and patient experience metrics that are aligned with other CMS programs, such as PQRS.
AREAS OF COORDINATION OR ALIGNMENT	
Demonstration of coordination or alignment with other federal agencies (i.e., involvement of other agencies in program planning or execution, mechanisms for sharing best practices, steps to reduce duplication of effort).	N/A
Demonstration of coordination or alignment with the private sector or States (i.e., stakeholder meetings, public comment periods, open-door forums, workshops).	N/A
Use of measures or benchmarks for performance measures and/or monitoring that align with the NQS.	To be determined by HHS leadership.

Health Resources and Services Administration (HRSA) Agency-Specific Quality Strategic Plan

Brief Introduction/Overview

HRSA, an agency of HHS, is the primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. HRSA provides leadership and financial support to health care providers in every State and U.S. Territory. HRSA grantees provide health care to uninsured people, people living with HIV/AIDS, and pregnant women, mothers, and children. They train health professionals and improve systems of care in rural communities. HRSA oversees organ, bone marrow, and cord blood donation. It supports programs that prepare against bioterrorism, compensates individuals harmed by vaccination, and maintains databases that protect against health care malpractice and health care waste, fraud, and abuse.

Vision
Healthy Communities, Healthy People

Mission
To improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs.

Goals
Goal I: Improve Access to Quality Care and Services

Goal II: Strengthen the Health Workforce

Goal III: Build Healthy Communities

Goal IV: Improve Health Equity

Agency-Specific Quality Strategic Plan Table

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NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
AIMS	
Better Care *Improve quality by making health care more person-centered, reliable, accessible, and safe.*	1. Health Center Person-Centered Medical Home (PCMH). 2. The goal is to improve the quality and coordination of care in health centers by supporting all health centers to achieve recognition as a PCMH by The Joint Commission, National Committee for Quality Assurance, or other national recognition body. 3. Health centers provide care to nearly 20 million medically underserved people through more than 8,100 service delivery sites in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. 4. Development of a PCMH requires the organization's commitment to systematically change the ways it delivers care to better meet the needs of the patients and community it serves. 5. By September 30, 2013, 25 percent of Federally Qualified Health Centers will be nationally recognized as a PCMH.
Healthy People/Healthy Communities *Support proven interventions to address behavioral, social, and environmental determinants of health.*	1. Maternal, Infant, and Early Childhood Home Visiting Program. 2. The Home Visiting Program aims to identify and provide evidence-based comprehensive health and social services to improve outcomes for families who reside in at-risk communities. 3. In at-risk communities, the maternal and child health outcomes are significantly worse than those in other communities with more resources. 4. The program, established under the Affordable Care Act, aims to reduce risk factors and enhance protective factors to improve maternal and child outcomes. 5. States will select/define performance measures for each of 35 constructs (e.g., maternal depression, employment status of enrolled adults) identified for tracking and improvement.
Affordable Care *Reduce the cost of quality health care for individuals, families, employers, and government.*	1. Medicare Beneficiary Quality Improvement Project (MBQIP). 2. The primary goal is to help Critical Access Hospitals (CAH) implement quality improvement initiatives to improve their patient care and operations through participation in Hospital Compare. 3. There are more than 1,300 certified CAHs located throughout the United States providing hospital services to rural patients. Literature has suggested that the clinical quality received in rural hospitals is not commensurate with that of nonrural hospitals. 4. MBQIP assists CAHs in supporting public reporting for core clinical quality measures to Hospital Compare to allow better tracking of their performance and to provide assistance in how to improve these rates. 5. By 2012, participating CAHs will report pneumonia and congestive heart failure measures to Hospital Compare. By 2013, participating CAHs will report all outpatient measures to Hospital Compare and Hospital Consumer Assessment of Healthcare Providers and Systems. By 2014, participating CAHs will report the following non-Hospital Compare measures: pharmacy review of orders within 24 hours and outpatient emergency department transfer communication of 100%. In addition, CAHs will achieve a participation rate in quality improvement initiatives reported to their respective States of 75 percent by fiscal year (FY) 2013 and 100 percent by FY 2014.

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
PRIORITIES	
Making care safer by reducing the harm caused in the delivery of care.	1. Partnership for Patients Community-Based Care Transition Program. 2. The goal is to prevent complications during a transition from one care setting to another in an effort to decrease hospital readmissions. 3. Hospital readmissions are a national problem that has been identified by the National Priorities Partnership. Many of these readmissions result from complications because of transition from one care setting to another. 4. To date, HRSA has engaged 954 rural hospitals, including 448 CAHs, in supporting safe care transitions. 5. By 2013, preventable complications during a transition from one care setting to another will have decreased so that all hospital readmissions will be reduced by 20 percent.
Ensuring that each person and family are engaged as partners in their care.	1. Partners in Care (within the National HIV/AIDS Strategy). 2. The program focuses on engaging patients in their care delivery. The goal is to train patients on self-management practices and engage patients and providers in quality improvement activities. 3. HIV is a major public health problem in America and abroad. More than 1.2 million people are living with HIV in the United States and more than 50,000 are exposed each year. 4. The program focuses on patient and provider engagement to help reduce the spread of HIV and improve health care outcomes. 5. The program tracks patients enrolling in the Partners in Care program. The broader National HIV/AIDS Strategy has measurable targets for each of three primary goals (http://www.whitehouse.gov/administration/eop/onap/nhas).
Promoting effective communication and coordination of care.	1. HRSA Patient Safety and Pharmacy Collaborative (PSPC). 2. PSPC is a national quality improvement effort driven by community-based organizations and supported by partnerships to help improve care coordination regarding medications and integrate medication management. 3. Adverse drug events are the leading cause of death and injury in the United States. For patients with chronic disease, the lack of coordination across health care providers increases these patients' risk of adverse drug events such as polypharmacy, duplication of therapy, or incorrect drugs or dosages. 4. PSPC has new federal partnerships with CMS and QIOs that will actively engage new teams for PSPC 4.0. In PSPC 3.0, there were 128 teams in 43 States (including the District of Columbia and Puerto Rico). 5. Increase care coordination for people with chronic disease to reduce adverse drug events.
Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.	1. Quality Measures Alignment. 2. Quality Measures Alignment works to align the use of quality measures across HRSA and HHS, starting with cardiovascular disease. 3. Cardiovascular disease causes one in three deaths reported each year in the United States, with annual direct costs estimated at $273 billion. 4. By aligning the quality measures for cardiovascular disease, all of HHS can help support and track improvements resulting from the Million Hearts campaign. 5. The goal is to prevent 1 million heart attacks and strokes in the next 5 years.

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
Working with communities to promote wide use of best practices to enable healthy living.	1. Healthy Weight Collaborative. 2. This is a cooperative agreement with the National Initiative for Children's Healthcare Quality to support national teams to prevent and treat obesity among children. 3. In 2008, more than one-third of children and adolescents were overweight or obese. Obese youth are likely to have risk factors for cardiovascular disease and prediabetes, and are at greater risk for bone and joint problems, sleep apnea, and social and psychological problems. 4. The collaborative will support at least 50 multisector, place-based teams from all over the country that will provide community-based interventions using quality improvement techniques to prevent and treat obesity among children. 5. The goal is to establish innovative partnerships between public health, primary care, and community organizations, and support sustainable change and foster collaboration through technology.
Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.	1. PCMH Recognition for HIV/AIDS Grantees. 2. This program provides opportunities for HIV/AIDS grantees to receive technical assistance in applying for PCMH recognition. 3. HIV/AIDS grantees provide comprehensive services for people with HIV/AIDS who need care but cannot afford it. Since 1981, HIV has infected 1.7 million people in the United States. 4. The aim of this new model of care delivery is the provision of comprehensive care, patient-centered care, care coordination, accessible services, and quality and safety. When these aims are realized, costs may be contained for all parties involved. 5. The goal is for more HIV/AIDS grantees qualifying as a PCMH to be accredited or recognized.
AREAS OF COORDINATION OR ALIGNMENT	
Demonstration of coordination or alignment with other federal agencies (i.e., involvement of other agencies in program planning or execution, mechanisms for sharing best practices, steps to reduce duplication of effort).	1. Advanced Primary Care Practice Demonstration. 2. This demonstration assesses the quality and cost-effectiveness of health centers in providing care to Medicare beneficiaries through a medical home model. 3. Health centers provide care to at least 200 Medicare beneficiaries in a 12-month period. All beneficiaries are eligible to enroll, including dually eligible beneficiaries, as long as they are not in hospice care, under treatment for end-stage renal disease, or enrolled in Medicare Advantage. 4. CMS and HRSA will work together to develop a national technical assistance and training strategy to assist health centers in the transformation to medical homes, enhancing patient-centered comprehensive and coordinated care. 5. The goal is to realize cost savings and improved clinical outcomes by September 2014.
Demonstration of coordination or alignment with the private sector or States (i.e., stakeholder meetings, public comment periods, open-door forums, workshops).	1. National Health Service Corps Scholarship and Loan Repayment. 2. These programs address a nationwide shortage of health care professionals by providing recruitment and retention services in the form of scholarship and loan repayment programs. They include the National Health Service Corp (NHSC), Nursing Education Loan Repayment, Nursing Scholarship, Faculty Loan Repayment, Native Hawaiian Health Scholarship, and State Loan Repayment programs. 3. The NHSC uses mass media to support efforts to increase visibility among prospective Corps members using media stories, Twitter, Webinars, and advertisements in trade and professional publications. 4. As of December 2011, there are over 17,000 scholars across the United States.
Use of measures or benchmarks for performance measures and/or monitoring that align with the NQS.	To be determined by HHS leadership.

Food and Drug Administration (FDA) Agency-Specific Quality Strategic Plan

Agency-Specific Quality Strategic Plan Table

1. Title
2. Description
3. Scope of Issue
4. Rationale for Approach
5. Metrics/Goals

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
AIMS	
Better Care *Improve quality by making health care more person-centered, reliable, accessible, and safe.*	N/A
Healthy People/Healthy Communities *Support proven interventions to address behavioral, social, and environmental determinants of health.*	N/A
Affordable Care *Reduce the cost of quality health care for individuals, families, employers, and government.*	N/A
PRIORITIES	
Making care safer by reducing the harm caused in the delivery of care.	1. Safe Use Initiative. 2. The Safe Use Initiative is an FDA Center for Drug Evaluation and Research nonregulatory program through which collaborative cross-health sector projects are created to better manage specific preventable drug risks and reduce preventable harm from FDA-regulated drugs. 3. Adverse events from drug use are estimated to result in more than 4 million visits to emergency departments, doctors' offices, or other outpatient settings annually. 4. Innovation and improvement of risk management approaches through collaborations between federal agencies and the broader health care community can reduce preventable drug harm through increased communication, engagement, and action across all sectors of public health and health care. 5. The metrics will be based on the specific project's objectives and outcomes. FDA and interested collaborators will develop appropriate evaluation metrics to measure an approach's success.
Ensuring that each person and family are engaged as partners in their care.	N/A
Promoting effective communication and coordination of care.	N/A
Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.	N/A
Working with communities to promote wide use of best practices to enable healthy living.	N/A
Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.	N/A

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
AREAS OF COORDINATION OR ALIGNMENT	
Demonstration of coordination or alignment with other federal agencies (i.e., involvement of other agencies in program planning or execution, mechanisms for sharing best practices, steps to reduce duplication of effort).	N/A
Demonstration of coordination or alignment with the private sector or States (i.e., stakeholder meetings, public comment periods, open-door forums, workshops).	N/A
Use of measures or benchmarks for performance measures and/or monitoring that align with the NQS.	To be determined by HHS leadership.

Indian Health Service (IHS) Agency-Specific Quality Strategic Plan

Brief Introduction/Overview

Agency-Specific Quality Strategic Plan Table

1. Title
2. Description
3. Scope of Issue
4. Rationale for Approach
5. Metrics/Goals

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
AIMS	
Better Care *Improve quality by making health care more person-centered, reliable, accessible, and safe.*	N/A
Healthy People/Healthy Communities *Support proven interventions to address behavioral, social, and environmental determinants of health.*	N/A
Affordable Care *Reduce the cost of quality health care for individuals, families, employers, and government.*	N/A
PRIORITIES	
Making care safer by reducing the harm caused in the delivery of care.	1. Meaningful Use. 2. Meaningful use of electronic health records (EHRs) can improve health care processes through the use of software applications that provide secure access, clinical decision support, performance reporting, and exchange of information with other providers of care. 3. The vision driving the achievement of meaningful use of EHR is one in which all patients are fully engaged in their health care and providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided, while also affording improved access and elimination of health care disparities. 4. Under the provisions of the American Recovery and Reinvestment Act of 2009, CMS is authorized to make incentive payments for Medicare and Medicaid eligible professionals and hospitals that demonstrate meaningful use of certified EHR technology. 5. All 59 meaningful use measures have been programmed into reports on the IHS EHR, Resource and Patient Management System, for use at the local level to demonstrate meaningful use of a certified EHR technology.
Ensuring that each person and family are engaged as partners in their care.	N/A

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
Promoting effective communication and coordination of care.	1. Improving Patient Care (IPC). 2. IPC goals are to improve access and continuity, decrease utilization of emergent and urgent care, improve staff satisfaction, and improve health and health care outcomes. 3. The IPC program strives to stimulate the desire and optimism for improvement and intolerance of the status quo; promote widespread adoption of best practices that will lead to improvement; test and adapt ideas and knowledge for the Indian health system; help grow a vibrant health care workforce; and ensure that quality is a way of life for future generations. 4. Partner with IHS, Tribal, and Urban Indian health programs to improve health and promote wellness of American Indian and Alaska Native people through improved quality of and access to care. The work supports fundamental changes in the system of care to build effective relationships for health and for health care that is Tribe, community, family, and patient centered. 5. Use of iCare and IPC reports in the IHS Resource and Patient Management System.
Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.	1. Meaningful Use. 2. Meaningful use of EHRs can improve health care processes through the use of software applications that provide secure access, clinical decision support, performance reporting, and exchange of information with other providers of care. 3. The vision driving the achievement of meaningful use of EHR is one in which all patients are fully engaged in their health care and providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided, while also affording improved access and elimination of health care disparities. 4. Under the provisions of the American Recovery and Reinvestment Act of 2009, CMS is authorized to make incentive payments for Medicare and Medicaid eligible professionals and hospitals that demonstrate meaningful use of certified EHR technology. 5. All 59 meaningful use measures have been programmed into reports on the IHS Resource and Patient Management System for use at the local level to demonstrate meaningful use of a certified EHR technology.
Working with communities to promote wide use of best practices to enable healthy living.	N/A
Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.	N/A
AREAS OF COORDINATION OR ALIGNMENT	
Demonstration of coordination or alignment with other federal agencies (i.e., involvement of other agencies in program planning or execution, mechanisms for sharing best practices, steps to reduce duplication of effort).	N/A
Demonstration of coordination or alignment with the private sector or States (i.e., stakeholder meetings, public comment periods, open-door forums, workshops).	N/A
Use of measures or benchmarks for performance measures and/or monitoring that align with the NQS.	To be determined by HHS leadership.

National Institutes of Health (NIH) Agency-Specific Quality Strategic Plan

Agency-Specific Quality Strategic Plan Table

1. Title
2. Description
3. Scope of Issue
4. Rationale for Approach
5. Metrics/Goals

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
AIMS	
Better Care *Improve quality by making health care more person-centered, reliable, accessible, and safe.*	N/A
Healthy People/Healthy Communities *Support proven interventions to address behavioral, social, and environmental determinants of health.*	N/A
Affordable Care *Reduce the cost of quality health care for individuals, families, employers, and government.*	N/A
PRIORITIES	
Making care safer by reducing the harm caused in the delivery of care.	N/A
Ensuring that each person and family are engaged as partners in their care.	1. Shared Medical Decision Making. 2. The Shared Medical Decision Making initiative will support research on methods to optimize shared medical decisionmaking by health care providers and patients. While early results are promising, the study of patient decision aids is in its infancy, and aids are available for relatively few medical conditions. There are only a few examples of implementation of shared decisionmaking in clinical practice. Providing guidance on deliberation and assessing patient preference are outside the scope of usual clinical care. In FY 2013, the Office of Behavioral and Social Sciences Research (OBSSR) will partner with NIH Institutes and Centers to launch the initiative. This funding opportunity announcement will support research on the effects of shared decisionmaking on health care costs, patient satisfaction, and patient outcomes, as well as investigation of the feasibility of implementing shared decisionmaking in clinical practice. This program contributes to the NIH Director's Theme 3: Advancing Translational Science. The shared decisionmaking paradigm helps assure that patients receive the best evidence-based treatment. 3. Decisions about what medical treatments patients should receive are often very complex. Often, the clinical trials literature does not clearly identify a dominant treatment alternative, and treatment choice therefore requires weighing the risks and benefits of alternative treatments, as well as consideration of patient preferences, willingness to assume risk, and degree of support. Many patients are no longer willing to let their treatments be selected for them. A growing societal cry is reflected in the phrase "no decision about me, without me," yet informed consent processes rarely address patient preferences. Moreover, evidence suggests that patients are usually not told about the full range of clinical options, their risks, and benefits. 4. Shared decisionmaking has been widely advocated as an effective means for reaching agreement on the best strategy for treatment. Through this process, a health care provider and a patient consider personalized

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
	information about the options, outcomes, probabilities, and scientific uncertainties of available treatment options, as well as assessing the values patients assign to risks and outcomes. Patient decision support interventions and shared decision aids help patients make decisions by providing information on options. Some of these tools elicit patient values and preferences and help communicate the utility associated with different treatment options. 5. N/A
Promoting effective communication and coordination of care.	1. Shared Medical Decision Making. 2. The Shared Medical Decision Making initiative will support research on methods to optimize shared medical decisionmaking by health care providers and patients. While early results are promising, the study of patient decision aids is in its infancy, and aids are available for relatively few medical conditions. There are only a few examples of implementation of shared decisionmaking in clinical practice. Providing guidance on deliberation and assessing patient preference are outside the scope of usual clinical care. In FY 2013, OBSSR will partner with NIH Institutes and Centers to launch the initiative. This funding opportunity announcement will support research on the effects of shared decisionmaking on health care costs, patient satisfaction, and patient outcomes, as well as investigation of the feasibility of implementing shared decisionmaking in clinical practice. This program contributes to the NIH Director's Theme 3: Advancing Translational Science. The shared decisionmaking paradigm helps assure that patients receive the best evidence-based treatment. 3. Decisions about what medical treatments patients should receive are often very complex. Often, the clinical trials literature does not clearly identify a dominant treatment alternative, and treatment choice therefore requires weighing the risks and benefits of alternative treatments, as well as consideration of patient preferences, willingness to assume risk, and degree of support. Many patients are no longer willing to let their treatments be selected for them. A growing societal cry is reflected in the phrase "no decision about me, without me," yet informed consent processes rarely address patient preferences. Moreover, evidence suggests that patients are usually not told about the full range of clinical options, their risks, and benefits. 4. Shared decisionmaking has been widely advocated as an effective means for reaching agreement on the best strategy for treatment. Through this process, a health care provider and a patient consider personalized information about the options, outcomes, probabilities, and scientific uncertainties of available treatment options, as well as assessing the values patients assign to risks and outcomes. Patient decision support interventions and shared decision aids help patients make decisions by providing information on options. Some of these tools elicit patient values and preferences and help communicate the utility associated with different treatment options. 5. N/A
Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.	N/A

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
Working with communities to promote wide use of best practices to enable healthy living.	1. Annual Dissemination and Implementation Science Meeting and Training Institute on Dissemination and Implementation Science. 2. The goal of the annual NIH Conference on the Science of Dissemination and Implementation is to facilitate growth in the research base by providing a forum for communicating and networking about the science of dissemination and implementation. 3. There is a recognized need to close the gap between research evidence and clinical and public health practice and policy. Dissemination and implementation research in health seeks to find how this is best accomplished, and is gaining momentum as a field of scientific inquiry. 4. Researchers, evaluators, and implementers who are interested in identifying opportunities and strategies for overcoming obstacles for dissemination and implementation research and evaluation are encouraged to attend this meeting. The goal is to engage in dialogue, exchange ideas, explore contemporary topics, and challenge one another to identify and test research approaches that will advance dissemination and implementation science. 5. N/A
Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.	N/A
AREAS OF COORDINATION OR ALIGNMENT	
Demonstration of coordination or alignment with other federal agencies (i.e., involvement of other agencies in program planning or execution, mechanisms for sharing best practices, steps to reduce duplication of effort).	N/A
Demonstration of coordination or alignment with the private sector or States (i.e., stakeholder meetings, public comment periods, open-door forums, workshops).	N/A
Use of measures or benchmarks for performance measures and/or monitoring that align with the NQS.	To be determined by HHS leadership.

Substance Abuse and Mental Health Services Administration (SAMHSA) Agency-Specific Quality Strategic Plan

Brief Introduction/Overview

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. To achieve this mission, SAMHSA has identified eight strategic initiatives to focus the Agency's work on improving lives and capitalizing on emerging opportunities. Each initiative has at least two measures: one population based and one SAMHSA specific. The population-based measures are aspirational and will require broad change in partnership with other systems, levels of government, private organizations, and the American people. The SAMHSA-specific measures are closely tied to SAMHSA-funded programs and provide more immediate targets for the work described in these initiatives.

SAMHSA is also developing a National Behavioral Health Quality Strategy with six priorities that focus on behavioral health while aligning with the NQS. These priorities include 1) promote the most effective prevention, treatment, and recovery practices for behavioral health disorders; 2) ensure that behavioral health care is consumer and family centered; 3) encourage effective coordination within behavioral health care systems and between the behavioral health care system and primary care and social service systems; 4) assist communities in the use of best practices to support healthy living; 5) make behavioral health care safer by reducing harm caused in the delivery of services; and 6) foster affordable, quality behavioral health care for individuals, families, employers, and governments by developing and advancing new delivery models.

Agency-Specific Quality Strategic Plan Table

1. Title
2. Description
3. Scope of Issue
4. Rationale for Approach
5. Metrics/Goals

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
AIMS	
Better Care *Improve quality by making health care more person-centered, reliable, accessible, and safe.*	N/A
Healthy People/Healthy Communities *Support proven interventions to address behavioral, social, and environmental determinants of health.*	N/A
Affordable Care *Reduce the cost of quality health care for individuals, families, employers, and government.*	N/A

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
	PRIORITIES
Making care safer by reducing the harm caused in the delivery of care.	1. Strategic Initiative 7 (SI-7): Data, Outcomes, and Quality. 2. This initiative realizes an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes. 3. Discrete service systems can limit access to appropriate care, lead to uneven quality in service delivery and coordination, and increase information silos. 4. Better use and availability of data will enable providers to more fully understand individual needs and provide person-centered care that works for consumers. Using a range of data effectively will drive accountability, leading to higher-quality, safer, more accessible, and more reliable care. 5. The goal is to increase the number of States adopting the Behavioral Health Barometer for planning and reporting purposes.
Ensuring that each person and family are engaged as partners in their care.	1. Strategic Initiative 1 (SI-1): Prevention of Substance Abuse and Mental Illness. 2. This initiative creates communities where everyone takes action to promote emotional health and reduce the likelihood of mental illness, substance abuse (including tobacco), and suicide. 3. By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide. 4. If communities and families can intervene earlier—before mental and substance use disorders are typically diagnosed—future disorders can be prevented or the symptoms can be mitigated. 5. The goal is to reduce the percentage of children and youth aged 12 to 20 years who report past 30-day substance use (including improper use of prescription drugs) and decrease the percentage of children and youth aged 12 to 17 years who report a major depressive episode in the past year.
Promoting effective communication and coordination of care.	1. Strategic Initiative 5 (SI-5): Health Reform. 2. This initiative increases access to high-quality prevention, treatment, and recovery services; reduces disparities regarding the availability of services for mental and substance use disorders; and supports integrated, coordinated care. 3. In 2014, 32 million more Americans will be covered by health insurance because of changes under the Affordable Care Act. Between 20 to 30 percent of these people (6 to 10 million) will have a mental or substance use disorder. 4. The bidirectional integration of primary and behavioral health care will better meet the needs of individuals with mental and/or substance use disorders who seek care in primary care settings to address their health needs. 5. The goal is to increase rates of insurance coverage among people with mental and substance use disorders.

NQS AIMS, PRIORITIES, AND ALIGNMENT	PROGRAM / INITIATIVE
Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.	1. Strategic Initiative 4 (SI-4): Recovery Support. 2. This initiative partners with people in recovery from mental and substance use disorders and family members to guide the behavioral health system and promote individual-, program-, and system-level approaches. 3. Thirty three percent of people who report dropping out of treatment indicate they might have stayed longer in substance abuse treatment if they had received practical assistance, help with areas of life functioning, and better individualized services. 4. An individual's ability to have a successful, satisfying, and healthy life integrated in a community is fostered through the availability of and appropriate use of prevention, health, clinical treatment, and recovery support services. 5. The goal is to improve the health status of individuals with co-occurring physical and behavioral health conditions.
Working with communities to promote wide use of best practices to enable healthy living.	1. Strategic Initiative 1 (SI-1): Prevention of Substance Abuse and Mental Illness. 2. This initiative creates communities where everyone takes action to promote emotional health and reduce the likelihood of mental illness, substance abuse (including tobacco), and suicide. 3. The annual total estimated societal cost of substance abuse in the Unites States is $510.8 billion. 4. Future disorders can be prevented or the symptoms can be mitigated through multiple and consistent interventions by all systems touching children and youth (e.g., schools, health systems, faith-based organizations, families, and community programs). 5. The goal is to reduce the percentage of children and youth aged 12 to 20 years who report past 30-day substance use (including improper use of prescription drugs) and decrease the percentage of children and youth aged 12 to 17 years who report a major depressive episode in the past year.
Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.	1. Strategic Initiative 5 (SI-5): Health Reform. 2. This initiative increases access to high-quality prevention, treatment, and recovery services; reduces disparities regarding the availability of services for mental and substance use disorders; and supports integrated, coordinated care. 3. Individuals with a mental disorder are twice as likely to be uninsured as those without a mental disorder. 4. This initiative focuses on enhancing access to services and effective referral arrangements for people living with mental and/or substance use disorders across all health care settings, through a "whole person approach." 5. The goal is to increase rates of insurance coverage among people with mental and substance use disorders.
AREAS OF COORDINATION OR ALIGNMENT	
Demonstration of coordination or alignment with other federal agencies (i.e., involvement of other agencies in program planning or execution, mechanisms for sharing best practices, steps to reduce duplication of effort).	HHS Tobacco Prevention and Control Working Group (a collaboration with CDC, FDA, NIH [including the National Cancer Institute], CMS, IHS, Administration for Children and Families, Administration on Aging, HRSA, and offices within HHS).
Demonstration of coordination or alignment with the private sector or States (i.e., stakeholder meetings, public comment periods, open-door forums, workshops).	SAMHSA's Strategic Initiative on Public Awareness and Support articulates a clear strategy to engage the public through multiple communications channels and satisfy current customer needs, in the format information is desired.
Use of measures or benchmarks for performance measures and/or monitoring that align with the NQS.	To be determined by HHS leadership.