



Health Care Quality Performance (HCQP) Program

STEERING COMMITTEE

9/13/10, 3-4:30pm

Department of Health, Beck Conference Room (Basement)

Goals/Objectives

- Obtain Steering Committee approval and input regarding ongoing HCQP Program work

Voting Members (Quorum = 8+ Members)

T	Ted Almon (rep)	T	Neal Galinko, MD, MS, FACP	G	Donna Policastro, NP, RCN
T	Virginia Burke, Esq.	T	David Gifford, MD, MPH	G	Louis Pugliese
T	Cathy Cranston	T	Linda McDonald, RN	T	Sharon Pugsley, BSN (rep)
T	Ron Cotugno, RN	T	Jim Nyberg	T	Gina Rocha, RN, MPH
G	Arthur Frazzano, MD	G	Rhoda E. Perry	T	Corrine Russo, MSW (rep)

Time

Topic/Notes

3:00pm **1. Welcome & Remarks**

David Gifford, MD, MPH, HEALTH

- Dr. Gifford opened the meeting, noting that it had been approximately 10 months since the Committee last met, and participants introduced themselves.

3:10pm **2. Administrative Updates**

Samara Viner-Brown & Rosa Baier

- Sam indicated that funding was reinstated in July and the Committee will now resume its bi-monthly meeting schedule.
- Sam then shared the 11th Annual Report to the General Assembly (handout), asking participants to review off-line and [send any edits to Rosa](#) by 9/27.
- Vote:** The Committee approved the release of the Annual Report, once edits are incorporated and unless anyone comments that its release should be delayed (Yes – 11, No – 0, Abstain – 0).
- Sam shared thoughts that rebranding the Program may help raise awareness and eliminate confusion about what the ‘Health Care Quality Performance’ Program does, and asked for the group’s thoughts about conducting an environmental scan of other states’ program names and websites (format, structure, etc.). The group agreed, so long as the scan did not divert Program resources. Dr. Gifford clarified that the legislative name would remain the same.
- Rosa reviewed a grid that lists all program reports, by setting:

Report (Oldest to Newest, by Setting)	Update Frequency	Last Updated
Home Health		
• Clinical quality measures from Medicare	Quarterly	Nov 2009
• Patient satisfaction	2 years*	May 2008
Hospital		
• Clinical quality measures from Medicare	Quarterly	Oct 2009
• Hand hygiene processes	Annually	Feb 2009
• Surgical Care Infection Program (SCIP) Measures	Quarterly	Sept 2010*
• Central-Line Associated Bloodstream Infections (CLABSI)	Quarterly	Sept 2010
• Pressure ulcer incidence	Quarterly	Sept 2009
• Employee influenza vaccination rates	Annually	Sept 2010*
• MRSA incidence	Quarterly	-
• C. difficile incidence	Quarterly	-
Nursing Home		
• Clinical quality measures from Medicare	Quarterly	Aug 2010
• Resident and family satisfaction	Annually	Jan 2010
• Employee influenza vaccination rates	Annually	-
Physician		
• HIT adoption	Annually	Mar 2010

*Anticipated

- Rosa noted that all reporting ceased during the Program’s funding hiatus, with the exception of the HAI Subcommittee and its reports (listed above under ‘Hospital’). The HAI funding now comes from a separate source, two CDC grants (see below).
- Gina asked if the Committee would consider capping the number of reports per setting, noting that hospitals have more data reports than other settings. Dr. Gifford talked about the Program’s goal of leveraging existing data sources, where available, with Rosa noting that three hospital reports require data collection that is specific to the Program’s mandate: hand hygiene, MRSA, and C. difficile. The first is minimally-burdensome and is a proxy for MRSA that the Subcommittee may eliminate over time. The latter are pending pilots and do require additional staff time and resources.

3:20pm **3. Home Health Measures Subcommittee** (Chair: R. Baier)
Samara Viner-Brown, MS & Rosa Baier, MPH

- Rosa shared updates on the home health patient satisfaction survey process, which is ramping up for October-December 2010 survey administration. Updates are as follows:
 - The timeline was originally scheduled for Fall 2009 (a two-year interval), but was delayed to align with Medicare’s Home Health CAHPS (HH-CAHPS) implementation, which is now scheduled for October. HH-CAHPS is required for all Medicare skilled patients beginning in October 2010 and continuing indefinitely. Medicare will begin reporting these data on Home Health Compare in 2012.

- Vendor requirements are as follows:

Possible Patient Populations	Certification	
	Medicare	Non-Medicare
Non-skilled care	Press Ganey	Press Ganey
Skilled care:		
• Medicare/Medicaid	HH-CAHPS; any vendor	n/a
• Commercial/Private Pay	Exempt for 2010	Exempt for 2010

- Because of the introduction of HH-CAHPS into the marketplace, Medicare-certified agencies can now choose any vendor, though all agencies are still required to survey non-skilled patients using Press Ganey. This means that some agencies may have multiple vendors.
- Although the intent was to survey 100% of home health patients, the Subcommittee realized that the new reporting requirements (HH-CAHPS and Press Ganey’s instrument) omitted mention of the commercial/private-pay segment of the patient population. The Subcommittee will research what proportion of agencies’ population falls into this category and revisit inclusion/exclusion based on that information. If it is <15%, it may not be statistically meaningful.
- The agencies are currently in the process of signing contracts with Press Ganey. Rosa shared feedback about Press Ganey’s customer service, focusing primarily on verbal and written communication, and indicated that the Subcommittee is likely to revisit the survey vendor choice before the next survey period.
- Cathy asked if agencies would be penalized because of the problems with Press Ganey. Dr. Gifford and Rosa both indicated that agencies acting in good faith would not be penalized for contractual issues/timing, but Rosa said that she has every indication that Press Ganey will be able to meet the October deadline and is ongoing communication to mitigate any issues.
- Next Subcommittee meeting: 4-6 weeks (to be scheduled)

3:40pm **4. Hospital-Acquired Infections (HAI) Subcommittee** (Chairs: L. Mermel/S. Viner-Brown)
Samara Viner-Brown, MS & Rosa Baier, MPH

- As mentioned previously, the HAI Subcommittee continued meeting during the Program’s hiatus, since HAI funding now comes from CDC grants. This Committee has previously discussed both grants: (1) The CDC ARRA supports the Subcommittee, State HAI Plan, and selection of two HHS priority topics; and (2) the CDC ELC grant allows HEALTH to convene a HAI Collaborative, helping hospitals enroll in NHSN (CDC’s data system) and/or conduct MRSA and C. difficile improvement activities.
- Since the Committee last met, the Subcommittee has recommended reporting two HHS priority topics (MRSA and C. difficile), which are topics of high interest to the local community and legislature. The infection preventionists’ group has met to create common definitions for MRSA data collection and is poised to undertake a pilot, with data shared back with the hospitals but not reported. They have not yet defined C. difficile measures, although they endorsed using NHSN definitions.

Time	Topic/Notes
	<ul style="list-style-type: none"> In the interim, CMS released its final rule for hospital reimbursement, which mandates hospitals to report Surgical Site Infection (SSI) and Central Line-Associated Bloodstream Infection (CLABSI) data through NHSN beginning in January 2011. SSI and CLABSI reporting will be tied to Medicare reimbursement. As a result, HEALTH has offered increased NHSN support to hospitals participating in the HAI Collaborative and the Subcommittee recommended pushing back the MRSA and C. difficile pilots to Q1 2011 and Q2 2011, respectively. The hospital employee influenza vaccination data report for 2009-2010 is pending final review of the data, which will incorporate the hospital comments received during the 5-day preview period and the Subcommittee's subsequent recommendation to omit the 'Other' category, since some hospitals included non-healthcare workers or healthcare workers without direct patient contact. Next Subcommittee meeting: 9/27, 8-9am, Department of Administration
4:00pm	<p>5. Hospital Measures Subcommittee (Chair: S. Viner-Brown) <i>Samara Viner-Brown, MS & Rosa Baier, MPH</i></p> <ul style="list-style-type: none"> During the Program's hiatus, HARI and HEALTH continued partnering with the hospitals' Hospital Discharge Data Set (HDDS) vendor, Thomson-Reuters, to pilot the present on admission (POA) indicator's inclusion in the data set. The Q1 2010 pilot data was recently shared with both HARI and HEALTH. Gina and Sam shared that their analysts are continuing to work on analyzing the new data. This will be a topic of discussion at next Monday's Subcommittee meeting, which marks the Subcommittee's first meeting since funding was cut. Next Subcommittee meeting: 9/20, 3-4:30pm, HEALTH
4:10pm	<p>6. Nursing Home Measures Subcommittee (Chair: G. Patry) <i>Rosa Baier, MPH</i></p> <ul style="list-style-type: none"> Rosa shared updates on the nursing home resident and family satisfaction survey process, which is ramping up for September-November survey administration. All nursing homes have contracts with My InnerView, the vendor, and are due to submit their mailing lists next week. At the request of the Subcommittee, Rosa and Rachel are working with My InnerView to proactively identify any discrepancies between the expected number of resident and family surveys and the numbers submitted in the mailing lists. Previously, this comparison was done after the survey period and follow-up was conducted by the Division of Facilities Regulations. The Subcommittee also revisited an earlier discussion about publicly reporting nursing home employee vaccination rates, and recommended: <ul style="list-style-type: none"> Analyzing last year's data (2009-2010) and sharing it with individual nursing homes, Conducting a pilot with this year's data (2010-2011), and Publicly reporting next year's data (2011-2012). Rosa and Rachel are in the process of obtaining the data from John Fulton, and may schedule an ad hoc Subcommittee meeting prior to the start of the new flu season, if the data are available. Next Subcommittee meeting: 10/19, 3-4:30pm, RIHCA

Time	Topic/Votes
4:20pm	<p data-bbox="310 191 743 220">7. Physician Measures Workgroup (Chair: R. Gardner)</p> <p data-bbox="358 226 558 256"><i>Rosa Baier, MPH</i></p> <ul style="list-style-type: none"> <li data-bbox="358 281 1414 520">• Since the Committee last met, the Program administered the 2010 Physician HIT Survey. Rosa will include aggregate results with the minutes. Regardless of the measures of EMR adoption and the denominator (survey respondents or all licensed physicians), Rhode Island’s adoption levels are fairly high. Dr. Gifford indicated that Rhode Island ranks 3rd for e-prescribing use. He indicated that both EMR and e-prescribing use are likely to increase with Federal incentives based on the ‘meaningful use’ criteria. <li data-bbox="358 546 1414 646">• In preparation for the 2011 survey (due to be administered in January), Rebekah, Rosa, and Hannah, a Brown MPH student, have begun looking at the free-text fields for any comments that should be incorporated into survey instrument revisions. <li data-bbox="358 672 1414 842">• Rebekah and Rosa will also continue to partner with key stakeholders, including Blue Cross & Blue Shield of Rhode Island, the Rhode Island Quality Institute, UnitedHealthcare of New England, and the Department of Human Services. The goal is to ensure the single survey meets stakeholders’ HIT measurement needs while minimizing the data collection burden for physicians.
4:25pm	<p data-bbox="310 873 448 903">8. Closing</p> <p data-bbox="358 909 646 938"><i>David Gifford, MD, MPH</i></p> <ul style="list-style-type: none"> <li data-bbox="358 963 1435 1329">• Action items: <ul style="list-style-type: none"> <li data-bbox="391 1014 1101 1043">○ Share the Annual Report file with the Committee (Rosa) <li data-bbox="391 1050 1328 1079">○ Review the Annual Report and send any edits to Rosa by 9/27 (Committee) <li data-bbox="391 1085 1179 1115">○ Finalize and submit the Annual Report (Dr. Gifford, Sam, Rosa) <li data-bbox="391 1121 1360 1150">○ Identify a student to conduct an environmental scan of state programs (Rosa) <li data-bbox="391 1157 1373 1186">○ Ensure all agencies with non-skilled patients have Press Ganey contracts (Rosa) <li data-bbox="391 1192 1377 1222">○ Finalize the hospital employee influenza vaccination report (John/Rosa/Rachel) <li data-bbox="391 1228 1370 1257">○ Obtain nursing home employee influenza vaccination data (John/Rosa/Rachel) <li data-bbox="391 1264 1247 1293">○ Review the Physician HIT Survey free-text comments (Rosa/Hannah) <li data-bbox="391 1299 1263 1329">○ Update the Physician HIT Survey instrument for 2011 (Rosa/Rebekah) <li data-bbox="358 1354 1027 1383">• Next Committee meeting: 3-4:30pm, 11/15, HEALTH



Perspective

Public Release of Clinical Outcomes Data — Online CABG Report Cards

Timothy G. Ferris, M.D., M.P.H., and David F. Torchiana, M.D.

On September 7, 2010, Consumers Union (publisher of *Consumer Reports*) reported the results of coronary-artery bypass grafting (CABG) procedures at 221 U.S. cardiac surgery programs.¹

The voluntary reporting of risk-adjusted outcomes in approximately 20% of U.S. cardiac surgery programs is a watershed event in health care accountability.

The reported ratings derive from a registry developed by the Society of Thoracic Surgeons (STS) in 1989. More than 90% of the approximately 1100 U.S. cardiac surgery programs participate in the registry. Registry data are collected from patients' charts and include key outcomes such as complications and death, the severity of preoperative illness, co-existing conditions, surgical technique, and medications. These data are maintained by the Duke Clinical Research Institute and are analyzed with the use of

well-tested statistical methods. The data-collection and auditing methods, specifications of the measures, and statistical approaches have evolved over the course of two decades and reflect a substantial commitment by cardiac surgeons and their leadership.^{2,3}

For years, participants in the STS registry have been examining these data and using them to make improvements. What does the public now get to see? Each surgical program that has chosen to make its data public is assigned a rating of one, two, or three stars. Stars are assigned on the basis of results on 11 performance measures (see table) that have been endorsed by the National Quality Forum. The rat-

ing depends on whether the risk-adjusted outcomes in a program fall below, are equal to, or exceed the average performance range. The performance thresholds are designed to ensure a 99% probability that outlier programs — those rated significantly below or above the mean and therefore given one and three stars, respectively — are truly below or above average. With the use of this method, 23 to 27% of the programs have been identified as outliers over the past 3 years. In addition to the star rating for overall performance, consumers see the star rating and actual performance scores (on a scale from 0 to 100) in four subcategories: 30-day survival (“patients have a 98% chance of surviving at least 30 days after the procedure and of being discharged from the hospital”), complications (“patients have an 89% chance of avoiding all five of the major complica-

Measures of Quality Used by the Society of Thoracic Surgeons in the Ratings of Coronary-Artery Bypass Grafting (CABG) Programs.	
Measure	Description
Postoperative renal failure	Percentage of patients (without preexisting renal failure) undergoing isolated CABG in whom postoperative renal failure developed or dialysis was required
Surgical reexploration	Percentage of patients undergoing isolated CABG who required a return to the operating room because of bleeding, tamponade, graft occlusion, or other cardiac reason
Antiplatelet medication at discharge	Percentage of patients undergoing isolated CABG who were receiving aspirin, safety-coated aspirin, or clopidogrel at discharge
Beta-blockade at discharge	Percentage of patients undergoing isolated CABG who were receiving beta-blockers at discharge
Antilipid treatment at discharge	Percentage of patients undergoing isolated CABG who were receiving a statin or other pharmacologic lipid-lowering regimen at discharge
Risk-adjusted operative mortality after CABG	Percentage of patients undergoing isolated CABG who died during the hospitalization in which the CABG was performed or within 30 days after the procedure
Preoperative beta-blockade	Percentage of patients undergoing isolated CABG who received beta-blockers within 24 hours before surgery
Prolonged intubation (ventilation)	Percentage of patients undergoing isolated CABG (without preexisting intubation or tracheostomy) who required intubation for more than 24 hours
Rate of deep sternal-wound infection	Percentage of patients undergoing isolated CABG in whom a deep sternal-wound infection developed within 30 days after the procedure
Stroke or cerebrovascular accident	Percentage of patients (without preexisting neurologic deficit) undergoing isolated CABG in whom a postoperative neurologic deficit developed that persisted for more than 24 hours
CABG using of an internal thoracic artery	Percentage of CABG performed using an internal thoracic artery

tions”), use of appropriate medications (“patients have a 90% chance of receiving all four of the recommended medications”), and surgical technique (“patients have a 98% chance of receiving at least one optimal surgical graft”).

The move on the part of the STS to make results available to the public will certainly trigger a cascade of responses. Advocates of transparency will point to the shortcomings of the ratings — the voluntary and therefore selective participation of programs (50 of the programs that have chosen to report their data have received three stars, whereas only 5 have received one star), the lack of long-term outcomes (e.g., 10-year survival, graft patency, and functional improvement), and the lack of physician-specific ratings. Expect such advocates to

push for more. Nonparticipating cardiac surgery programs will come under pressure to allow the outcomes in their programs to be reported. Physicians in other surgical specialties that are amenable to this type of approach, such as orthopedics or vascular surgery, may be expected to follow suit. And this event will fuel the debate regarding the risks and benefits of public reporting, including the question of whether it assists patients in discriminating among sites of care. While these issues play out, several aspects of this release of ratings deserve attention.

First, years of pressure from policymakers, health care purchasers, and patient-advocacy groups to provide greater accountability played a major role in bringing this publication to fruition. Public reporting of outcomes has

widespread support, and cardiac surgeons have been among the principal targets of these efforts. The first statewide report card on cardiac surgical performance was mandated in New York in 1989. Early experiences with public reporting of the outcomes of cardiac surgery spurred efforts by the STS and others to improve cardiac surgery.⁴ Although some consumer advocates pushing for transparency may view this release as a glass four-fifths empty — given the selectivity and number of programs reporting — the external pressure has been critical in stimulating improvement efforts within the medical profession.

Second, the publication of definitive analyses derived from clinical data can be a double-edged sword for providers. When performance reports are based on

administrative data, physicians often justifiably argue that the data are flawed and the conclusions suspect. In contrast, with these new ratings, not only have the participants endorsed the methods, but they have volunteered to display performance results that carry the imprimatur of the physicians' specialty society. Experience with performance reporting in Massachusetts has shown that when the data and analyses are as good as possible, a public report of suboptimal performance requires a substantive public response: state Department of Public Health officials suspended a Massachusetts cardiac surgery program to conduct an external review, amidst substantial media attention, when the program was identified as a high-mortality outlier.

Third, the process of moving clinical data from the STS registry into the public domain has been long, complex, and expensive. As a member-supported organization, the STS navigated treacherous waters to bring its members to the point of permitting the publication of their data. Some key decisions facilitated this process: the STS reported group-level rather than physician-level data, rigorously validated its data-collection and risk-adjustment models, and selected a performance-classification system that maximized specificity. Such choices helped to mitigate physicians' biggest fear: the risk of misclassification. Moreover, cardiac surgery programs have been looking at these data for years, so there shouldn't be any sur-

prises. The success that the STS has had in leading a nontrivial fraction of its members to agree to participate suggests that public reporting can be done in a way that doesn't alienate the profession.

There is no question about the need for accountability on the part of health care providers or the central role of measurement in the improvement of health care. Nonetheless, questions remain about the role of public reporting in improving health care. Performance measurements audited by regulators are one alternative, especially in situations in which the information is too complex for patients to use in discriminating among care sites. Insofar as public reporting drives improvement of all outcomes, it benefits everyone; insofar as risk aversion leads to changes in the population receiving an indicated service, the net effect can be nil or even negative.⁵ Given the heterogeneity in the delivery of medical services, it should come as no surprise that we have developed multiple methods for assessing performance and encouraging accountability. Regardless of which approach proves most beneficial to patients, public reporting will increasingly be a fact of life for physicians.

By publishing ratings using the best available data, the STS has responded to the public in a way that attempts to both inform patients and mitigate physicians' fears. We hope that the experience of the STS can be applied to other initiatives that are aimed at bringing performance data de-

rived from clinical sources to the public, thereby reducing the time and expense of this process. For example, this experience may contain lessons for the Centers for Medicare and Medicaid Services as it prepares to handle the wave of clinical data it will receive through the Physician Quality Reporting Initiative and the "meaningful use" program for electronic health records. At least some of these data will almost certainly be publicly reported. The STS's success suggests that reporting can be done in a way that physicians will support. Whether the STS approach is an anomaly or a precedent that other specialty groups will emulate remains to be seen.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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This article (10.1056/NEJMp1009423) was published on September 7, 2010, at NEJM.org.

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Health Care Quality Performance (HCQP) Program

2010 PHYSICIAN HIT SURVEY SUMMARY REPORT

In early 2010, the Rhode Island Department of Health (HEALTH) administered the Physician HIT Survey to 3,224 physicians licensed in Rhode Island, in active practice, and located in Rhode Island, Connecticut, or Massachusetts. The response rate was 57.8% (n=1,862).

Table 1 presents electronic medical record (EMR) and e-prescribing results for these 1,862 respondents and all 3,224 physicians (including 1,362 non-respondents). **Table 2** compares this year’s results with last year’s. HEALTH also reports the following benchmarks:¹

- Among the 1,380 physicians who report using EMR components:
 - 811 (58.8%) are using all basic functionalities at least 60% of the time, and
 - 658 (47.7%) are using all advanced functionalities at least 60% of the time.
- Among all 1,862 respondents, 522 (28.03%) are e-prescribing at least 60% of the time and through an EMR.

For more information, visit the public reporting program’s Web site at www.health.ri.gov/chic/performance.

Table 1: 2010 Physician HIT Survey Summary Results

Measure ¹	Survey Respondents (N=1,862)		All Physicians (N=3,224)	
	Population	Score	Population	Score
1. Physicians with EMRs, n (%) ²	1,862	1,380 (74.1%)	3,224	1,380 (42.8%)
2. Physicians with ‘qualified’ EMRs, n (%) ³	1,862	345 (18.5%)	3,224	345 (10.7%)
3. Basic EMR functionality use, mean ⁴	1,380	65.4	--	--
4. Advanced EMR functionality use, mean ⁵	1,380	46.6	--	--
5. Physicians who are e-prescribing, n (%)	1,862	918 (49.3%)	3,224	918 (28.5%)

Table 2: Trends for the Physician HIT Survey Results, 2009-2010⁶

Measure ¹	Survey Respondents			All Physicians		
	2009	2010	Change %	2009	2010	Change
1. Physicians with EMRs, % ²	67.6%	74.1%	6.5%	39.3%	42.8%	3.5%
2. Physicians with ‘qualified’ EMRs, % ³	12.5%	18.5%	6.0%	7.3%	10.7%	3.4%
3. Basic EMR functionality use, mean ⁴	63.6	65.4	1.8	--	--	--
4. Advanced EMR functionality use, mean ⁵	44.1	46.6	2.5	--	--	--
5. Physicians who are e-prescribing, %	41.2%	49.3%	8.1%	23.9%	28.5%	4.6%

CCHIT: Certification Commission on Health Information Technology certification

-- Same as survey respondents’ population and scores, since non-respondents are not applicable for this measure.

¹ See the Measure Specifications for definitions of these measures and their benchmarks.

² EMR: Integrated electronic clinical information systems that tracks patient health data, and may include such functions as visit notes, prescriptions, lab orders, etc.

³ **Qualified EMRs:** EMRs with specific clinical documentation, reporting, results management, decision support, and e-prescribing functions AND Certification Commission on HIT (CCHIT) certification. Excluding CCHIT certification, 545 physicians qualify (29.3% of respondents; 16.9% of all physicians).

⁴ **Basic EMR functionality:** Clinical documentation and results management. Scores range from 0-100 based on use.

⁵ **Advanced EMR functionality:** Decision support, external communication, order management, and reporting. Scores range from 0-100 based on use.

⁶ For 2009, the response rate was 58.1% (n=1,888). Denominators for Measures 1, 2, and 5 were 1,888 (respondents) and 3,248 (all physicians); for Measures 3 and 4, 1,277 respondents. 2010 denominators are included in Table 1.