

MEASURE APPLICATIONS PARTNERSHIP

Cross-Cutting Challenges Facing Measurement: MAP 2016 Guidance

FINAL REPORT
MARCH 15, 2016



NATIONAL
QUALITY FORUM

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I, Task Order HHSM-500-T0018.

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SUMMARY

- This year, for the first time, more outcome measures were submitted for consideration than process measures.
- The measures under consideration by CMS include an increasing number of measures early in development, demonstrating MAP's role as a key multistakeholder forum in the measure development process.
- Increasing the flow of information between the CDP measure endorsement and MAP measure selection processes and learning more about user experience with measures are needed to ensure MAP has the information it needs to evaluate measures under consideration.
- MAP needs explicitly stated priorities across its workgroups to gauge how well the measures under consideration and the measures currently used in programs address the key areas where MAP would like to drive quality improvement.

The Patient Protection and Affordable Care Act (ACA) of 2010 required that the U.S. Department of Health and Human Services (HHS) implement an annual federal pre-rulemaking process to provide input and gain consensus on the quality and efficiency measures being considered for public reporting and performance-based payment programs. The Measure Applications Partnership (MAP), convened by the National Quality Forum (NQF), was formed in 2011 as a multistakeholder entity to serve in the role of providing recommendations on the measures under consideration by HHS.

MAP provides guidance on the selection and use of performance measures in federal programs on multiple levels. First, MAP considers the impact of an individual measure and the value it might have on improving health and healthcare or reducing healthcare cost or resource use. MAP carefully balances these factors with the concerns that a measure might have potential negative unintended consequences or unfairly burden the provider

being measured. Next, MAP provides guidance at the programmatic level, using its Measure Selection Criteria to determine how measures work together to address key quality issues and improve the whole measure set used in a program by ensuring that it meets the elements described in the criteria. A key element of MAP's work to improve the program measure sets has been to identify and prioritize the need for filling gaps in performance measurement. Finally, MAP seeks to encourage further alignment across programs to promote consistent performance measurement where it can have the most impact and give the most complete view of the quality of care delivered across an episode.

MAP used the five-year mark of its establishment to reflect on the changing landscape of performance measurement and federal quality initiatives to identify areas for continued enhancements to the pre-rulemaking process.

REFLECTIONS AT FIVE YEARS

Changes in the Measures under Consideration

Over the past five years, MAP has made significant strides in strengthening the measures used in federal programs. To date, over 1,543 measures have been submitted for consideration by MAP for use in over 20 federal programs. Of these, nearly 50 percent have been process measures, and just over one-third has been outcome measures. However, guidance from MAP has promoted a change in the type of measures submitted for consideration. In 2015, for the first time in MAP's history, more outcome measures were submitted for consideration than process measures. MAP has continually emphasized the need to measure outcomes that are important to patients, and the shift in the type of measures submitted represents an encouraging direction for the future.

Another important change during the first five years of MAP has been a substantial shift in the stage of development of the measures under consideration. The measures under consideration are increasingly still under development (i.e., measure testing has not been completed) as opposed to being fully developed measures, demonstrating that HHS looks to MAP to provide upfront multistakeholder guidance on measures. This upfront guidance ensures that there is multistakeholder buy-in on the measure concept prior to significant investments in testing the measure. In 2015, more than 60 percent of measures submitted for consideration by MAP were under development and not fully tested. Similarly, less than 30 percent of measures submitted to MAP were NQF-endorsed. MAP has established itself as a key multistakeholder forum that provides guidance on whether measures should be pursued for further development and implemented in federal quality improvement initiatives.

One public commenter noted that this shift to reviewing measures earlier in development points to a need for greater clarity and better communication about the requirements and criteria for measures to be considered for a program. The commenter also recommended additional communication with measure developers to help them improve measures for future submissions.

Changes to the CMS Quality Initiative Programs

In addition to changes in the performance measures that MAP has evaluated in the past five years, strategic shifts have occurred in the quality initiative programs administered by the Centers for Medicare & Medicaid Services (CMS). As noted above, MAP was created by the ACA, landmark legislation that dramatically altered the healthcare landscape. The ACA ushered in the era of value-based purchasing, creating a number of federal pay-for-performance initiatives, particularly for hospitals. MAP plays an important role in considering measures for these initiatives. HHS continues to show its commitment to value-based purchasing, best illustrated by the January 2015 announcement that HHS has set a goal of tying 90 percent of all traditional Medicare payments to quality or value by 2018 through its quality initiative programs.

The landscape for federal quality initiatives continues to evolve. The Medicare Access and CHIP Reauthorization Act (MACRA) legislation is a prime example of the changing environment as the law repeals the Sustainable Growth Rate in an attempt to continue to tie physician payment to value rather than volume. This legislation will have a significant impact on the clinician quality improvement initiatives, consolidating the Value-based Payment Modifier (VBPM), Physician

Compare (PC), the Physician Quality Reporting System (PQRS), and the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program into a single program: the Merit-Based Incentive Payment System (MIPS). MIPS will evaluate how payments are distributed to providers based on quality of care provided, resource use, meaningful use of EHR technology, and clinical practice improvement.

Similarly, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 shifts the landscape for quality initiatives addressing post-acute and long-term care. The IMPACT Act seeks to improve care for Medicare beneficiaries by implementing and standardizing quality measurement and resource utilization for post-acute care providers. MAP noted that increased attention is needed to ensure consistent performance measurement across the various post-acute care settings, while acknowledging the challenge to consistency that varying data sources may pose.

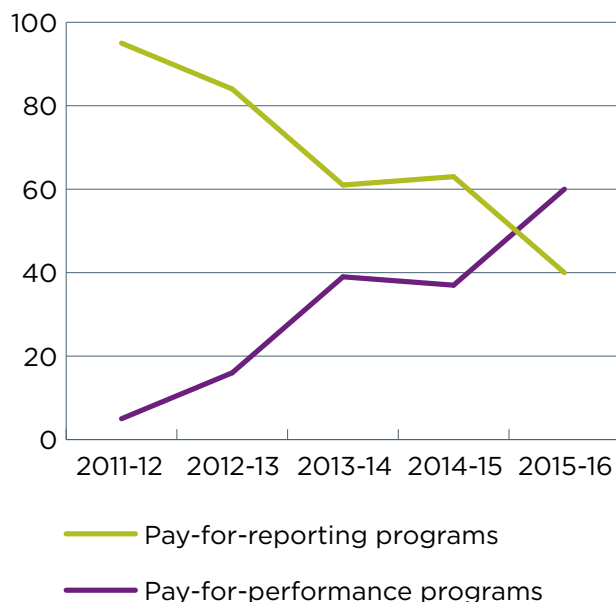
Accordingly, MAP has seen a shift in the uses for the measures it considers. Figure 1 demonstrates the shift in the intended use of the measures MAP reviews from pay-for-reporting programs to pay-for-performance programs.

Impact and Success

Early results show the impact that value-based purchasing can have on healthcare quality and the influence of MAP's recommendations. Since the introduction of the Hospital Readmissions Reduction Program (HRRP), readmission rates have dropped below 18 percent.¹ MAP supported the measures currently used in this program. The Medicare Payment Advisory Commission

(MedPAC) reported that the reduction for conditions subjected to HRRP was greater than the reduction for all causes.² MAP was also instrumental in making recommendations for the measures used in the Hospital Acquired Condition (HAC) Reduction Programs. MAP supported the use of the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network measures and the Agency for Healthcare Research and Quality's Patient Safety for Selected Indicators composite measure. Rates of HACs have declined 17 percent from 2010 to 2014, a change from 145 to 121 HACs per 1,000 discharges. Because of this, patients experienced 2.1 million fewer HACs, and 87,000 lives were saved. Additionally, this reduction in HACs translates into approximately \$20 billion in savings.³

FIGURE 1. PERCENT OF MEASURES REVIEWED FOR PAY-FOR-REPORTING PROGRAMS COMPARED TO PAY-FOR-PERFORMANCE PROGRAMS



GOALS FOR THE FUTURE

MAP continues to reaffirm its mission to recommend measures that address the most important areas for improvement. MAP is committed to continually enhancing its pre-rulemaking process to ensure that it is delivering recommendations that will improve health for all Americans. In the pre-rulemaking cycle for 2015-2016, MAP initiated key processes to strengthen how it makes its recommendations.

Impact on Health and Healthcare

MAP recognized the need to ensure that the measures it recommends will have an impact on improving health and healthcare. MAP established a two-pronged approach for assessing the impact of a measure. First, MAP considers impact with respect to how the measure relates to measures currently included in the program's measure set and how the measure relates to the program goals. Next, MAP assesses the potential improvement in health that could result from the use of the measure. MAP reiterated that the goal of measurement is to assess performance and drive improvement with the overall goal of improving health. This includes considering the relationship to patient outcomes, the opportunity for improvement, and the disease burden in the measured population.

MAP took a broad view of improving health, including considering if a measure could improve population health or could lower cost and resource use by improving quality. MAP recognized that a broad perspective is needed to consider if a performance measure has impact. MAP also noted that assessing impact involves weighing the value of a measure against the burden of implementing and using it, and the potential for negative unintended consequences to patients.

MAP recognized that the impact of a measure can largely depend on how it is used, for example,

quality improvement, public reporting, or pay for performance. A good measure will have little impact if its results do not drive behavior change. A measure should be considered within the context of the program in which it will be used and assessed for how it meets the goals and requirements of the program. MAP also noted the need to consider the intended use of a measure. A measure that might help a provider improve performance may not help a consumer select a provider.

Better information is needed to assess whether a measure has impact. MAP has continually pushed to make its recommendations more evidence based and has reiterated the need for better data to support its decisionmaking. To obtain this information, MAP called for better partnerships with those in the field using measures who can share how implementation of a measure drives improvement, or conversely, if the implementation of a measure has negative unintended consequences. Such partnerships could provide better information about which measures are adding value and which measures are simply adding burden.

To better understand the potential impact of a measure, MAP identified the need for several future multistakeholder measurement science efforts. First, MAP called for guidance on program implementation to render a more meaningful view of how a measure fits within the structure of a program. For example, MAP recommends whether an individual measure should be included in a program, but there is little multistakeholder input into issues such as how a measure is weighted or a program's scoring algorithm, which can significantly alter the score a provider receives. MAP agreed that future work is needed to define key measure attributes and program attributes, examine their interaction,

and give program implementers guidance on which measures may better suit specific programs based on program characteristics. Finally, questions about data sources emerged during this year's pre-rulemaking process. MAP identified several measures under consideration that were submitted using multiple data sources (e.g., eMeasure specifications, and specifications using administrative claims). MAP noted that more knowledge of how these different data sources affect performance measure results is needed.

Improving Information Flow Between Measure Endorsement and Selection

MAP depends on the NQF Consensus Development Process (CDP) for measure endorsement to ensure that sound testing has taken place and that robust evidence supports the measure focus. However, as MAP continues to review measures earlier in their lifecycle, MAP also needs to share its recommendations with the NQF standing committees and Consensus Standards Approval Committee (CSAC) as they make their endorsement decisions.

The interdependency between endorsement and selection requires a seamless flow of information between the two processes. MAP has often conditionally supported measures pending NQF endorsement; the relevant standing committee considers feedback from MAP when the measure is submitted for endorsement. Further, insight gained by MAP on measures under development can help to inform future endorsement projects. Finally, information from the CDP process should flow back to MAP once the NQF endorsement process has completed the measure evaluation. MAP recognized that while funding and timing constraints may exist, the systematic flow of information between the endorsement and selection processes is critical to the future work of MAP.

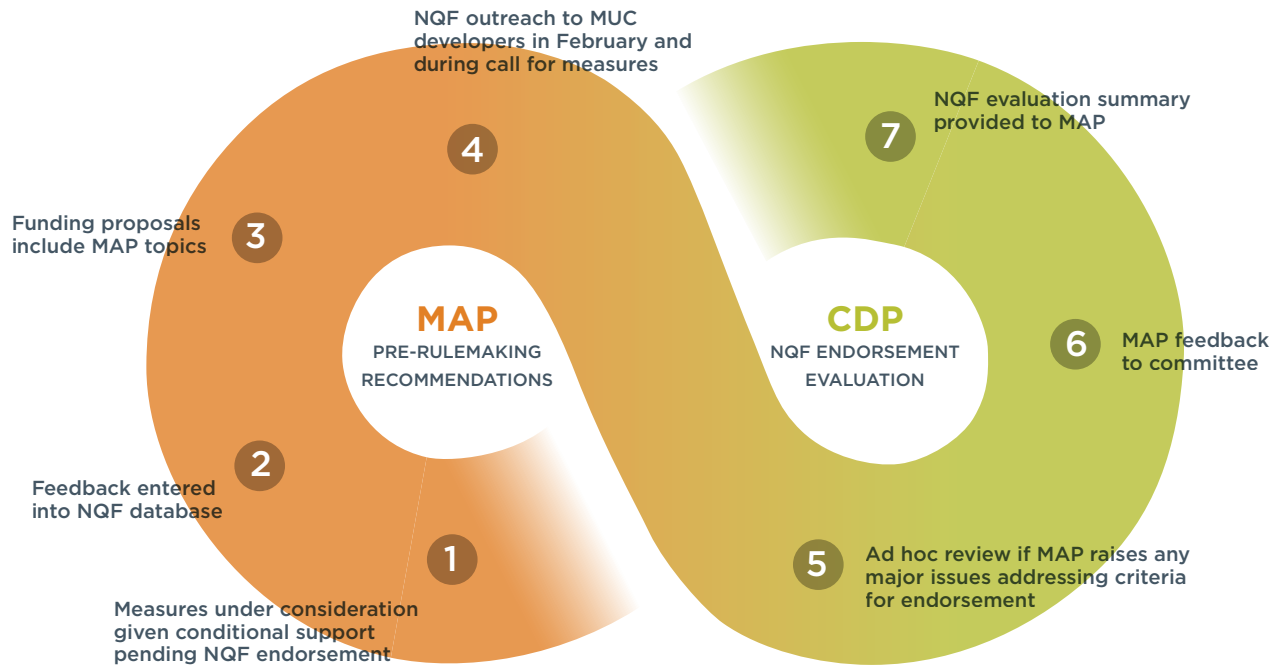
Considering Intended Use: Aligning Program and Measure Attributes

MAP reviewed the input of the **NQF Intended Use Expert Panel** about how NQF's measure endorsement process should consider the intended use of a measure. The Expert Panel did not recommend including the specific use of a measure in the endorsement process, noting that there is limited evidence that a measure needs different levels of evidence or testing to be used for different purposes (i.e., public reporting or pay for performance). However, the Expert Panel did recommend the development of an additional designation for measures that meet the highest levels of evidence and testing to ensure that measure users have this information. The Panel encouraged MAP to consider how this additional designation can be used when selecting individual measures for specific programs. For example, in an effort to align program and measure attributes, MAP may determine that an individual program requires measures with this designation.

MAP discussed the need to apply this additional designation in its future work. MAP noted the recommendation of the Expert Panel to examine key measure and program attributes and their interactions to help inform MAP recommendations. The MAP Coordinating Committee will continue to refine its approach to using this new designation as this change is implemented in future NQF measure endorsement efforts.

One public commenter raised concerns about the implementation of this additional designation and the possibility that MAP may determine that a program could require such measures. The commenter noted that specialty measures already face challenges in meeting the standard endorsement criteria and that requiring additional information about measure testing and provider experience could limit the number of meaningful measures available and greatly increase the time it takes to develop a measure.

FIGURE 2. CDP-MAP INFORMATION FLOW



Clarifying Priorities

MAP noted the need for explicitly stated priorities across its workgroups to understand how well the measures under consideration and the measures currently used in programs address the key areas where MAP would like to drive quality improvement. The MAP core concepts would be a set of priorities that that would cut across the MAP workgroups and the programs they review. This set of priorities would allow MAP to assess progress systematically and ensure that the most important areas of improvement are measured in the CMS quality initiative programs. These priorities would also allow MAP to look more holistically across settings and consider important issues across the continuum of care.

Using the MAP core concepts as a framework can help provide a more comprehensive view of measurement gaps, track their evolution over time, and illuminate where gaps exist across high-leverage areas, disease states, and programs. This framework would also help to show the impact of a measure and support alignment. Working with a shared organizing framework would give MAP a

better understanding of how a measure could help address a problem and how to target gaps and fill them.

To ensure collaboration with CMS based on a shared strategy and framework, MAP will build its core concepts around the CMS Quality Strategy. The CMS Quality Strategy aligns with the three broad aims of the National Quality Strategy (NQS) and its six priorities. The NQS has served as the foundation for MAP’s work; however, there is a need to operationalize the NQS in the MAP pre-rulemaking process. The MAP core concepts build on the goals of the CMS Quality Strategy. These goals include the following:

- Making care safer
- Strengthening person and family engagement
- Promoting effective communication and coordination of care
- Promoting effective prevention and treatment
- Working with communities to promote best practices of healthy living
- Making care affordable

MAP will also adopt the objectives CMS has established in its Quality Strategy to achieve these goals. However, the MAP core concepts would seek to operationalize these goals by adding areas of focus to each CMS objective. The objectives would show what MAP is trying to achieve; the areas of focus would show how MAP will do so. The areas of focus will represent the measurement topics MAP will seek to promote across programs. The core concepts and areas of focus will serve as a tool to evaluate measures under consideration and identify gaps going forward. A measure under consideration will be more likely to gain MAP's support if it addresses an area of focus.

MAP will continue to develop its core concepts for the 2016-2017 pre-rulemaking cycle.

Filling Measurement Gaps

The identification of measurement gaps in each program that MAP reviews has been a fundamental part of the MAP pre-rulemaking process. However, the current process makes it difficult to interpret and prioritize gaps. MAP recognized the need to refine its process to

develop clearer priorities that apply across both public and private programs. MAP needs to look across programs and make recommendations that can improve health and healthcare nationally and across populations. In the future, the MAP core concepts will serve as a set of shared priorities to better identify gaps, sending stronger signals about where measure development is needed, and allowing MAP to track progress in gap filling.

MAP noted a key gap of cross-cutting measures that assess care across settings, providers, and time. MAP stated the need to hold clinicians, hospitals, and post-acute care settings all responsible for the quality of a patient's care as a person moves through an episode of care. The core concepts will help to ensure that all parts of the care continuum work to improve care in key areas.

MAP recommended exploring ways in which current measures could be expanded to fill gaps. As noted above, the core concepts will ease comparisons of where measures currently exist to assess priority areas and how these measures could be updated to fill gaps in other settings.

TABLE 1. EXAMPLE OF THE MAP CORE CONCEPT FRAMEWORK

NQS Priority	MAP Core Concept/CMS Objective	Example Areas of Focus
Strengthen Person and Family Engagement	Ensure care delivery incorporates patient and caregiver preferences	Shared decisionmaking Experience of care
	Improve experience of care for patients, caregivers, and families	Physical functioning Mental/behavioral health Patient reported pain and symptom management
	Promote patient self-management	Care matched with patient goals Establishment of patient/family/caregiver goals Advanced care planning and treatment/palliative and end-life care Patient-centered care planning

Promoting Alignment

The MAP core concepts will allow high-value measure concepts to be identified across programs, thus serving as a tool to promote alignment. Alignment refers to using the same measures across programs. Although MAP encourages alignment, MAP recognizes that this is not always feasible. Differences in measure specifications based on available data sources and levels of analysis can make implementing the same measure impossible in different settings. The core concepts will provide consistent guidance on where performance measurement could have the most impact and give a more complete view of the quality of care delivered across an episode. Using its core concepts to promote alignment will allow MAP to send a clear message about the priorities and expectations shared by multiple stakeholders across public and private programs. Increased comparability across settings and levels of analysis will also make quality information more valuable for consumers, purchasers, and payers.

MAP established a set of goals for alignment. MAP stated that alignment should do the following:

- Reduce redundancy (i.e., duplication of measures) and strive towards a comprehensive core measurement approach
- Send a clear and consistent message regarding the expectations of payers, purchasers, and consumers
- Reduce the costs of collecting and reporting data
- Enable comparison of providers

- Transform care in priority areas with notable potential for improvement
- Avoid confusion on the part of all stakeholders

MAP raised some cautions about alignment of measures. First, MAP cautioned that it is important to balance the needs and goals of an individual program with the goal of alignment. MAP noted that not all measures will be right for all programs; rather, a measure may address a critically important issue for one program or setting. Alignment should also not be a reason to limit innovation. MAP recognized the need to weigh the benefit of alignment against the benefit of a new measure.

Finally, MAP noted barriers to alignment that should be addressed. These barriers include concerns about unnecessary variation in definitions, limited interoperability of electronic health records, and discrepancies in how measures are being used—in particular, concerns about differing specifications of NQF-endorsed measures.

One public commenter recommended that MAP align measure selection for federal programs with the core measure sets developed by the Core Quality Measure Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers. One commenter agreed with MAP that aligning measures across the system is important. This commenter also noted the challenge of aligning populations, noting that many disorders can start at less than 65 years of age and are excluded from many currently available measures.

2015-2016 PRE-RULEMAKING INPUT

MAP built upon the lessons of its past and its vision for the future when developing its 2015-2016 pre-rulemaking recommendations. As MAP reviewed 141 measures for 16 federal programs, key issues arose across the settings. Noting the increasingly high stakes of performance measurement, MAP cautioned that measure results should be properly attributed, and measures should be appropriately risk-adjusted.

Attribution/Shared Accountability

As the U.S. healthcare system increasingly shifts to a performance-based payment system, MAP noted the importance of identifying the appropriate accountable entity that can be held responsible for patients' care and of encouraging shared accountability for patient outcomes. MAP continues to encourage programs to shift from assessing process of care to measuring care outcomes that are important to patients and their families. However, MAP noted that measuring care outcomes raises an important measurement challenge—appropriate attribution of these outcomes to providers. MAP continues to encourage shared accountability across providers for important patient outcomes; however, MAP found it challenging to define how to appropriately assign patients and their outcomes to multiple organizations and providers who often have a role in influencing these outcomes.

Three examples help illustrate the importance of attribution. The use of 30-day readmission measures, mortality measures, or episode-based payment measures places a significant responsibility for the patient's unplanned post-discharge care on acute-care hospitals. This highlights the need to develop guidance on appropriate approaches to attribution. Another example of the attribution issue relates to clinician-level measurement for public reporting

and pay-for-performance programs. With an increasing emphasis on team-based care that includes primary care physicians, specialists, nurse practitioners, and other clinicians, it may be problematic to hold an individual clinician responsible for a patient's health outcome. Finally, MAP noted that important population health goals, such as smoking cessation, should be advanced through the various federal programs. However, improvement of population-level smoking rates cannot be the sole responsibility of one provider. MAP noted the need for balance: measurement should encourage providers to take a greater role in achieving population health goals while recognizing the limits of an accountable entity's ability to drive improvement in population health outcomes.

MAP cautioned that measures and programs need to recognize that multiple entities are involved in delivering care, and there is both individual and joint responsibility to improve quality and cost performance across the patient episode of care. MAP encouraged a multistakeholder evaluation of these attribution issues to provide the field with guidance on theoretical and empirical approaches to attribution that can be used to guide the selection of measures for federal programs. The development of this guidance should raise the issue above an individual measure and provide guidance across measure development, endorsement, selection, and use.

Disparities and Sociodemographic Status (SDS) Adjustment

MAP strives to reduce disparities in healthcare through the selection of measures that identify inadequate resources, poor patient-provider communication, a lack of culturally competent care, and inadequate linguistic access, among other factors contributing to healthcare disparities.

MAP noted that all members of the healthcare community have a role in promoting appropriate treatment of all patients by identifying and addressing the factors that lead to disparities in health outcomes.

MAP continues to support the two-year SDS trial period undertaken by NQF. This trial period will allow a measure undergoing review for endorsement to be examined to determine whether the measure has a conceptual and empirical basis to include SDS factors in the risk adjustment model. MAP continues to recommend that individual measures that are proposed for selection in programs be reviewed by the relevant standing committees to determine if SDS adjustment is appropriate. MAP reinforces the principle that the decision to include SDS factors in an outcome measure's risk adjustment model should be made on a measure-by-measure basis, and should be supported by strong conceptual and empirical evidence.

MAP looks to the work of the Disparities Standing Committee (DSC) to ensure that MAP's recommendations will help to reduce healthcare disparities. The DSC is charged with developing a roadmap for using quality measurement and associated policy levers to reduce disparities proactively. The DSC will be able to provide MAP with strategic direction and guidance, while supporting measure development activity and growth of the NQF portfolio of measures addressing disparities and cultural competency.

Maintaining MAP Recommendations

MAP discussed the need to develop processes to maintain the integrity of its recommendations. First, MAP stated the need to learn about the experiences of those implementing the measures that MAP is reviewing. MAP members noted that users with experience with measures in the field can help identify trends in measures' overall performance or variation in performance. Further, those with measure use experience can provide

guidance on the specific interventions that lead to performance improvement, share information on whether the measure is having the intended effect, and help MAP understand the extent to which the measure is being used. As a starting place to gaining this insight, MAP encouraged feedback to MAP's enhanced public commenting process so users can share their experiences with the measures under consideration. Additionally, MAP noted the need to gather information about the measures after they are implemented within programs to ensure that the measures are feasible (i.e., can be implemented without undue burden) and to determine whether the measures result in any unintended consequences.

In addition to enhanced connections with measure users to understand their implementation experiences, MAP noted the importance of the multistakeholder review of measures as they are refined and implemented. First, MAP noted that recommendations for measures under development should be revisited once the measure is fully developed, specified, and tested. MAP appreciates the opportunity to provide upfront guidance to CMS on measures as they are being developed but emphasized that downstream multistakeholder review of measures is critical. Once a measure is fully developed, a multistakeholder review will ensure that measures are achieving their intended purpose and are improving health and healthcare. Secondly, MAP noted the need to review measures after they are implemented. MAP emphasized a need to review its decisions in light of guidance from the CDP process and insights from measure users as noted above. MAP and CMS agreed that future efforts should examine how best to implement such a process.

CONCLUSION

MAP's 2015-2016 pre-rulemaking recommendations provide guidance to HHS on the use of 141 measures in 16 federal programs. In this cycle, MAP focused on ways to improve its decisionmaking abilities. MAP clarified its guidance on key issues, impact, gaps, and alignment to confirm that it is making recommendations consistently. MAP also identified several key cross-cutting issues across the various workgroups, including attention to disparities and sociodemographic adjustment, the need for guidance on appropriate attribution, and the need for information on measure implementation experience. These enhancements to the pre-rulemaking process will help ensure that MAP's recommendations drive progress on the most important quality issues while preventing undue measurement burden on the healthcare system.

MAP will continue to work to improve the pre-rulemaking process. MAP noted the need to establish its priorities through the development of its core concepts. MAP will use these core concepts in the future to develop recommendations on measures under consideration and identify outstanding gaps in the programs. MAP will continue to develop ways to learn about implementation experience concerning the measures under consideration from those currently using the measures. Additionally, MAP will continue to align its work more closely with that of the CDP to ensure that information flows seamlessly between the processes.

ENDNOTES

- 1 HHS. *New HHS Data Shows Major Strides in Patient Safety, Leading to Improved Care and Savings*. Washington, DC: HHS; 2014. Available at <http://innovation.cms.gov/Files/reports/patient-safety-results.pdf>. Last accessed February 2016.
- 2 Medicare Payment Advisory Commission (MedPAC). *Report to the Congress Medicare and the Health Care Delivery System*. Washington, DC: MedPAC; 2013. Available at http://www.medpac.gov/documents/reports/jun13_entirereport.pdf. Last accessed February 2016.
- 3 Agency for Healthcare Research & Quality (AHRQ). *Saving Lives and Saving Money: Hospital-Acquired Conditions Update Interim Data From National Efforts To Make Care Safer, 2010-2014*. Bethesda, MD: AHRQ; 2014. Available at http://www.ahrq.gov/sites/default/files/publications/files/interimhacrate2014_2.pdf. Last accessed February 2016.

APPENDIX A: MAP Coordinating Committee Roster and NQF Staff

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