HHS 6.2: Measure Development and Endorsement Agenda
Comments Received from NQF Members and the Public

Comment #	Date of Comment	Comment	Comment Submitter Name	Comment Submitter Organization	On Behalf of: Name	On Behalf of: Organization	On Behalf of: Email	On Behalf of: Phone Number
General comments on the Measure Development and Endorsement Agenda Project								
1	Oct 1 2010 4:17PM	I would like to express the concern I have that the issues for patients experiencing end of life and their providers providing hospice or palliative care are not part of this prioritized list of measurement gaps and key issues to be examined. The majority of the medical field still doesn't even understand the difference between the terms Pallaitive care which provides comprehensive, multidisciplinary care for patient's (and their families) with serious or life-threatening illnesses with the emphasize upon the quality of life. Palliative Care is provided throughout the trajectory of a disease process w/out regard to prognosis and can/should be provided in concert with curative care, as well as near EOL. Hospice is a specific form of palliative care that emphasizes comfort care for those patient's no longer seeking curative therapies and in their last months of life. It is very important for persons, both patient and providers from this discipline to be represented in this project. Alison Lauber, MD MCG Augusta, GA	Alison Lauber Shrum	Medical College of Georgia				
4	Oct 2 2010 9:35AM	NQF's National Priority Partnership included palliative and end of life care as one of its six most actionable priorities. Yet, there is no representation from the hospice and palliative care field on NQF's Measure Prioritization Advisory Committee, and among the 20 priorities voted upon. There is no better way to address quality and efficiency of care for these 20 priorities than to incorporate the interdisciplinary palliative care team into the treatment paradigm at the earliest possible time in the course of the illness. Multiple studies have shown highest levels of quality, patient/family satisfaction, and cost savings, particularly in the ED/ICU settings, as well as in the long-term care setting, when costs are continuing to spiral out of control.	Laurence Boggeln	Hospice of the Valleys				
6	Oct 4 2010 3:53PM	I would like to offer my support for the addition of "Palliative Care initiatives" to the MDEA project. In the recent past, NQF and NPP have rightly recognized and supported the powerful role that palliative care services have to play in the augmentation of patient and family care experiences across the continuum of chronic disease. Palliative care is identifiable as health care services that are patient/family-centered, goal-directed, in-line with patient-identified quality of life considerations, coordinated, honest and communicative. It extends across the sea of subspecialist input to meet the patient-identified needs of the most significantly afflicted and extensive health care utilizing segment of our population. As noted in the MDEA report, there are strengths and weaknesses involved in considering the "episode of care" as the centering concept. For patients and families who live lives with chronic disease, the longitudinal perspective of health care and function needs spans well-beyond an artificially limited episode of care. Palliative care services harmonize and blend with the stated aspirations of this project, and function in a manner that takes a patients "long-view" very seriously. Please consider continuing to support and integrate pallitiative care initiatives in the measurement and endorsement goals.	Joseph Halvorson	Essentia Health				

8	Oct 5 2010 1:19PM	I wish to encourage the inclusion of Palliative Care to the MDEA, Consistent with the national goal of focusing care on the patient and family while conserving scarce economic and personnel resources, coordinated interdisciplinary Palliative Care has been proven to improve outcomes for patients with life-threatening disease while saving resources. Improved outcomes include better symptom management, lesser psycho-social-spiritual distress, higher satisfaction with encounters with the medical care system, and lesser family distress following the death of a loved one. All these outcomes are consistently achieved (based on multiple controlled studies) with a net savings of resources. There are precious few areas of medicine where we can achieve better outcomes by spending less. If we are to achieve a better medical care system without further increasing the amount of resources expended, Palliative Care needs to be encouraged, supported, and expanded on a national level. Mark Blum, M.D. FAAHPM Bristol Hospice, Sacramento, CA	Mark Blum	Bristol Hospice, Sacramento					
9	Oct 5 2010 10:34AM	Please support palliative care as part of the MDEA project. The NQF has always recognized and supported palliative care as a quality, efficient, cost-saving, delivery of care system that also includes high patient/family satisfaction. Palliative care embodies "patient centered" health care delivery.	Danette Hanson	Mercy Medical Center					
13	Oct 10 2010 10:14PM	Palliative care was not highly prioritized, but "resource use/overuse, appropriateness and efficiency, shared decision-making, and patient and family engagement were all ranked high. Palliaitve care directly addresses and takes action on these issues, resulting in lower costs. The commitee has therefore approrpiately ranked pallaitvie care highly, without defining it as such. It is the hope of hte palliative care community that paliative care programming will be appropriately implemented so that these highly ranked problems can and will be addressed	Joanne Hilden	Peyton Manning Children's Hospital at St. Vincent					
14	Oct 12 2010 1:39PM	The omission of palliative care as a priority is a major oversight by the Measure Prioritization Advisory Committee. Palliative care has been shown to impact resource use and care coordination- the two major priorities identified by the Committee - as well as patient-family engagement. It has been shown to provide Better Care and more Affordable Care as well as promote Healthy People and Healthy Communities. Thus, it positively impacts both cost of care and satisfaction with care. To ignore this priority hampers the NQF's ability to impact any of the other priorities listed. Further, it is our experience that spiritual and religious values and beliefs are perhaps the major driver behind patient and family care choices, especially at the end of life. Therefore, accounting for them is a key to resource use and patient-family engagement. They represent possibly the most underappreciated and under measured factors in health care. Patients report overwhelmingly that they want these beliefs taken into account in discussion about their care decisions. Yet, this area is not measured and there currently are no quality measures to guide their inclusion. We would urge the NQF to appoint a person from the field of palliative care to its Member Prioritization Advisory Committee and that development of measures within the domain of Palliative Care and the subdomain of Access to Spiritual, Cultural and Psychological Needs be a priority for the NQF.	George Handzo						

15	Oct 12 2010 5:00PM	Palliative Care should be a crucial consideration in measure development. It overlaps with several of the identified sub-domains including Patient/Family Centered Care; Care Coordination including Transitions; Population Health (e.g. depression screening); Clinical Effectiveness in Acute & Chronic Care Management; Safety; and Overuse. Palliative Care provides a medical specialty that can enhance care delivery to improve quality outcomes based on the patient's goals of care and be cost effective. It meets all the goals of Don Berwick's "Triple Aim". I hope Palliative Care's role will be recognized and elevated in this process.	Lori Bishop	Iowa Health Home Care Hospice/Taylor House				
17	Oct 13 2010 6:30PM	I would like to add my support for representation of Palliative Medicine on the MDEA Project. The new field of Palliative Medicine encompasses many of the goals of the NQF-- better quality family and patient -centered care and cost-effective care in particular. As one of the 6 identified "most actionable priorities" of the NQF National Priority Partnership, strong representation from the field is imperative and funding should reflect the intention of identifying strategies within systems to encourage integration of palliative medicine-- such as pilots and demonstration projects designed to show improved quality of care and cost savings/avoidance when patients have access to full spectrum palliative care cervices. The fundamental principles of Palliative Medicine result in a win-win: higher quality with lower costs.	James Bell	St. Luke's Palliative Care and Hospice	Jim Bell	AAHPM	belljr@crstlukes.com	319-369-8222
18	Oct 15 2010 5:15PM	It is unclear why palliative care received zero votes, especially when it has been shown to accomplish many of the other prioritized domains, such as reducing overuse, improving care coordination, increase patient and family member satisfaction, and perhaps most importantly, decreasing symptom burden and extending life. It also addresses many of the subdomains, such as shared decision making, communication, transitions, patient/family centered care, pain and symptom management. Please reconsider including palliative care as a priority domain.	Corita Grudzen					
19	Oct 18 2010 7:19PM	The Pacific Business Group on Health appreciates the opportunity to comment on the NQF's proposed Measure Development and Endorsement Agenda. We support NQF's and HHS' recognition of the need to develop measures to facilitate much needed changes in the health care delivery system. We provide recommendations below on how the draft agenda can be strengthened. NQF needs to think of a robust communications strategy for the results of this project, beyond providing a report to HHS. While it is obviously important to send the report to HHS this is also an opportunity to align public and private sectors on some common measure development goals. While the first paragraph of the introduction acknowledges the importance of measurement in understanding value, it only makes reference to developing quality measures, We suggest revising the second sentence of the first paragraph to: "There is a strong need for the development of quality and cost measures that will ensure broad transparency on the value . . ."	Christine Chen	Pacific Business Group on Health				

21	Oct 18 2010 7:20PM	There are issues that cut across the three areas covered in this document: Medicare, Child Health, and Population Health. However, they are not always fully recognized. For example, social determinants significantly influence the health of all individuals, regardless of age. Social determinants are explicitly called out as a sub-domain for population health (Table 10), but the same is not done for child health or Medicare. By identifying cross-cutting concerns, the steering committee will help those in Medicare, Medicaid, and the private insurance market to align their efforts and partner to better measure, pay, and improve patient care. We encourage the steering committee to more thoroughly discuss how to address disparities throughout the document, where appropriate.	Christine Chen	Pacific Business Group on Health				
25	Oct 19 2010 2:39PM	The American Medical Association (AMA) appreciates the opportunity to comment on the National Quality Forum's (NQF) Measure Development & Endorsement Agenda Project report. While we support the Project's proposed measure gaps and priorities for quality measurement, we have concerns about the sequencing and coordination the Project's recommendations with other public and private sector measure development, endorsement, and selection activities. Prioritization of a consolidated list of measure gap areas for key issues is an important undertaking to help harmonize the activities of developers, endorsers and implementers of quality measures. However, effective application of the Project's recommendations is challenged by current NQF and other public and private activities also aimed at improving health care provider performance and measurement. These include, among others, development of a National Health Care Quality Strategy and Plan; the NQF Partnership for Applying Measures; the National Priorities Partnership; and efforts by the private sector like Blue Distinction®, a Blue Cross and Blue Shield quality measurement recognition program.	Mark Antman	American Medical Association	Ardis D. Hoven, MD	American Medical Association	mark.antman@ama-assn.org	312-464-5056
24	Oct 19 2010 2:39PM	[comments continued] In this current health reform environment, there is a unique and long desired opportunity to align and synergize what has been a fragmented quality enterprise. We are unsure of the added value of the Project's recommendations if they are not actively aligned with other public and private quality measurement, endorsement, and selection activities. Moreover, if the Project's recommendations are not folded in with current efforts underway by the Department of Health and Human Services (as well as the NQF), we do not believe this important work will create the necessary focus required to improve quality health care at both the local and national levels. The AMA recommends that the Project's efforts and recommendations be harmonized with other quality activities. We appreciate the opportunity to comment.	Mark Antman	American Medical Association	Ardis D. Hoven, MD	American Medical Association	mark.antman@ama-assn.org	312-464-5056
27	Oct 19 2010 3:00PM	Unlike almost any other topic of measurement, palliative care needs are almost universal. Palliative care populations make up nearly a third of patients hospitalized on medical wards. Good-quality care in palliative care domains (good pain and symptom management, psychosocial care, support of caregivers, excellent communication, setting goals, care planning) reaches far beyond these populations. All providers that care for seriously ill patients need to be measured on these domains, and research has only just begun on how to best measure these elements of care that make a difference in patient. Therefore, the Coalition urges the NQF to recognize the urgency of making palliative care measures a high priority on the national measure development agenda.	Dale Lupu	American Academy of Hospice and Palliative Medicine	Dale Lupu	Hospice & Palliative Care Coalton	dlupu@daleviewassociates.com	412.787.9301

28	Oct 19 2010 4:07PM	Humana appreciates the opportunity to comment on the NQF work on Measure Development and Endorsement. Development of measures should be performed with an eye toward what the final vision of the health and medical care system should resemble. Starting with measures first places the priorities wrong. For that reason the acceptance of the National Strategy for Health is the first task. Measures should be adjunctive to help in reaching that goal. The directions outlined on page 2 are in concert with that perspective	Thomas James	Humana Inc.	Tom James	Humana	tjames@humana.com	502-476-8929
32	Oct 19 2010 4:15PM	Pages 6-9 has prioritized lists of measures by various domains. This was from a modified Delphi technique using a relatively small number of people. This means that bias has most likely been introduced through the small sample and the selection of the participants. A corroboration process using another sample drawn with different criteria, or a mathematical model based upon analysis of the factors gauged to have the greater impacts on health outcomes would make this a more valid tool. There could be a lot of futile effort addressing these domains in the absence of a corroborative review of the importance.	Thomas James	Humana Inc.				
35	Oct 19 2010 4:17PM	Thank you for the opportunity to provide comments on the NQF Measure Development and Endorsement Agenda. We have reviewed the report with our member plans and offer the following comments. General Comments AHIP supports the key objectives of the proposed Agenda - to align with the National Health Care Quality Strategy, meet key objectives of the Patient Protection and Affordable Care Act (PPACA), and encourage measure development resources for high leverage areas as identified in the Agenda. While we appreciate NQF's efforts to identify measurement gap areas, it is unclear from the document if a thorough review of NQF-endorsed measures led to the recommended gap domains and subdomains. The gap domains identified are critical areas, but it appears that the document was developed by consensus as opposed to analysis of available measures and the priorities identified in the National Health Care Quality Strategy. NQF should clearly articulate the next steps of this project, including a review of available measures and potential revisions to this document once this review is complete.	Rebecca Zimmermann	America's Health Insurance Plans				
34	Oct 19 2010 4:17PM	part 2 Additionally, we would like to offer the following recommendations to improve the understandability and actionability of the document: The report would be improved with firm definitions and examples for domains and subdomains. As written, the terms could be easily misinterpreted. For example, domains like Social Determinants, Access to Spiritual, Cultural, and Psychological Needs, and Productivity can have different meanings for different users. While the document references the NPP and other inputs, it would be helpful if NQF provided a clear map of the NPP priorities to the recommended domains and subdomains. Acknowledging the limited resources available for measure development, it would be helpful to know how the recommendations included in the report will be prioritized.	Rebecca Zimmermann	America's Health Insurance Plans				

41	Oct 19 2010 4:40PM	The National Association of Children's Hospitals and Related Institutions (NACHRI) is pleased to comment on the draft Measurement Development and Endorsement Agenda. We make these comments on behalf of the more than 200 NACHRI member organizations in the U.S. that serve the needs of neonates, children and adolescents and their families. The health care needs addressed by the diverse members of NACHRI range from preventive care to the care of children with serious and complex conditions, and children's hospitals play an important role in supporting the health of the communities they serve. We find the first sentence of the document revealing in that it does not yet appear that the quality measurement enterprise is fully working with regard to driving sustained improvement. The evaluation of the enterprise is critically needed so that we can reduce the noise to signal ratio and focus on measures that matter. Further, It is unclear to us why there is a disconnect between priorities for measurement and priorities for performance improvement as suggested in the discussion on scope in Table 4. Measures for reporting should be closely aligned with national goals for improvement, and we believe that this effort should be closely coordinated with other efforts, such as the development of the National Quality Strategy and Plan.	Ellen Schwalenstocker	National Association of Children's Hospitals and Related Institutions				
42	Oct 19 2010 4:41PM	NACHri also suggests adding the words "and health risks" after the word "conditions" in the second sentence in the introduction to reflect the later discussion on the limits of a condition-specific approach in children's health care. Finally, other than as a cross-check, the value of prioritizing the sub-domains is not clear. Thinking in terms of bundles or composites, for example, it seems to us that all or most of the sub-domains within each domain will be critical.	Ellen Schwalenstocker	National Association of Children's Hospitals and Related Institutions				
46	Oct 19 2010 5:13PM	The measures address the following important areas: 1) harmonizing metrics and pay practices across types of providers so we're not at cross purposes (e.g., incentivizing hospitals to reduce LOS while paying physicians per diem while they're in the hospital), and 2) looking for unintended consequences of the metrics.	Kim Lopez	Catholic Health Initiatives	Kim Lopez	Catholic Health Initiatives	Kimlopez@catholichealth.net	303-383-2703
47	Oct 19 2010 5:22PM	The National Partnership for Women & Families appreciates the opportunity to comment on the proposed Measure Development and Endorsement Agenda. We fully support the development of an agenda to facilitate the creation of measures that will drive quality and value in the health care system and have several suggestions on how to strengthen the draft agenda provided for comment. We feel that in order to make this document as valuable and productive as possible, it needs a clearer statement of the purpose of the work conducted by the advisory committee, and what the ultimate goal and mission of this effort is.	Debra Ness	National Partnership for Women & Families				
48	Oct 19 2010 5:24PM	In addition to clarifying the framing of the agenda, we strongly suggest that NQF develop a proactive communication/dissemination strategy, beyond submitting the report to HHS. The work that was done by this committee to prioritize conditions and risk areas should also be shared with the private sector, as well as with other areas of the public sector, to achieve full public/private alignment of priorities. We also would suggest that the report make reference to the need for development of not quality measures alone, but cost measures as well, so that we can achieve the goal of being able to measure efficiency and value in the health care system.	Debra Ness	National Partnership for Women & Families				

49	Oct 19 2010 5:28PM	We would like to comment on the need to address the fact that there are several cross-cutting issues that relate to the three areas of Medicare, Child Health, and Population Health. For example, social determinants significantly influence the health of all individuals, regardless of age, and this factor should not be siloed in the population health category. Given NQF's efforts to improve measure harmonization, it only makes sense that in the measure development and endorsement agenda, we identify cross-cutting concerns, to drive alignment of efforts to better measure, pay, and improve patient care. Finally, we strongly urge the advisory committee to more thoroughly discuss how to address disparities throughout the document, where appropriate.	Debra Ness	National Partnership for Women & Families				
50	Oct 19 2010 5:31PM	The Physician Consortium for Performance Improvement (PCPI) appreciates the opportunity to comment on the National Quality Forum's (NQF) Measure Development & Endorsement Agenda Project report. Prioritization of a consolidated list of measure gap areas for key issues is an important undertaking to help harmonize the activities of developers, endorsers and implementers of quality measures. The PCPI appreciates that NQF has considered other public and private activities also aimed at improving health care provider performance and measurement. These include, among others, the development of a National Health Care Quality Strategy and Plan; the NQF Partnership for Applying Measures; the National Priorities Partnership; and efforts by the private sector like Blue Distinction®, a Blue Cross and Blue Shield quality measurement recognition program. Alignment amongst these many endeavors is critical to engaging physicians in high priority improvement activities. The PCPI appreciates NQF's consideration of these activities and recommends ongoing alignment with other quality activities in the future.	Mark Antman	American Medical Association-Physician Consortium for Performance Improvement	Bernard M. Rosof, MD, MACP	Physician Consortium for Performance Improvement	mark.antman@ama-assn.org	312-464-5056
52	Oct 19 2010 5:33PM	Thanks for the opportunity to comment on the project. The webinar and materials were thorough and helpful. We appreciate the complexity of the project and applaud your effort, process and product. We eagerly await the maternal child health focus which is eminent and look forward to engaging more thoroughly in the process at that time. We are in support of the comments relating to palliative care, including the NQF comments suggesting that palliative care remains a high priority, regardless of the way it reads in the report itself. We urge you to consider combining beginning of life and end of life care issues, as they share many of the same quality challenges: overuse, appropriate levels of care, accountability, communication, care transitions, diversity, disparity, and family centered processes.	Diana Jolles	American College of Nurse-Midwives				
60	Oct 19 2010 10:01AM	It is unclear from the documentation provided by NQF whether the workgroups used expert opinion or analyses of measure gap areas (similar to the one conducted for the Outcomes Measures Gap Analysis) to identify and prioritize gap areas. If a measure gap analysis was performed for this project, it would be very useful, as a commenter, to be able to review the analysis.	Jenna Williams-Bader	WellPoint, Inc.				
61	Oct 19 2010 10:36AM	Approve. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this report. The QIC recognizes and values the direction that the NQF is heading toward with this report and looks forward to seeing its operationalization moving forward.	Jeff Maitland	American College of Chest Physicians	Jeff Maitland	American College of Chest Physicians	jmaitland@chestnet.org	847-498-8369

63	Oct 19 2010 12:43PM	While it is important to send the report to HHS this is also an opportunity to align public and private sectors on some common measure development goals. I suggest revising the second sentence of the first paragraph to: "There is a strong need for the development of quality and cost measures that will ensure broad transparency on the value . . ." There are issues that cut across the three areas covered in this document: Medicare, Child Health, and Population Health. However, they are not always fully recognized. By identifying cross-cutting concerns, the steering committee will help those in Medicare, Medicaid, and the private insurance market to align their efforts and partner to better measure, pay, and improve patient care. I encourage the steering committee to discuss how to address disparities throughout the document, where appropriate.	Gaye Fortner	HealthCare 21 Business Coalition					
Comments on the prioritized, consolidated list of measure gap areas and key issues									
2	Oct 1 2010 8:44PM	A strong Palliative Care program will address the "Triple Aim" of better care/affordable care/healthy people, healthy communities. Once patients and families are educated to their right to self-determination, cost of care goes down and quality of life goes up. Please include Palliative Care in the priorities for Health Care Reform. Becky Sanders	Rebecca Sanders	Lodi Memorial Hospital					
3	Oct 1 2010 12:34PM	I would like to express the concern I have that the issues for patients experiencing end of life are not part of this prioritized list of measurement gaps and key issues to be examined. For the past year I have had the opportunity, as a clinical microsystem coach, to work with an interdisciplinary team dedicated to implementing the NQF Standards of Care for this vulnerable population that probably suffers the most because of our failed health care system. We have worked extremely hard to develop meaningful data sets. We have begun to survey families using the FamCare survey to help us improve our patient and family centered care model. One of the first respondents surveyed replied that end of life care was excellent "but it was the months leading up to death that they had issues with". Health care organizations need to be able to indentify these patients earlier in the dying process and provide the structures of care that deliver what meets patient and family needs. Please consider making this a top priority. Thank you. Susan Curtis, RN ,Center for Performance Improvement, Maine Medical Center, Portland, Maine	Susan Curtis	Marine Medical Center					
5	Oct 2 2010 9:39AM	I have found CAPC and NHPCO to be strong, effective advocates for palliative care and hospice. Collecting and measuring data have been taught from the beginning, and form the basis for significant and important studies being published almost monthly, demonstrating the benefits of palliative care and hospice to individuals, families, providers, and healthcare systems.	Laurence Boggeln	Hospice of the Valleys					

7	Oct 4 2010 4:53PM	The Infectious Diseases Society of America believes that priority should be given to the development of performance measures for hospital-based physicians. Such physicians often play a pivotal role in the treatment of highly complex hospitalized patients or, in the case of infectious diseases physicians, in implementing system-wide practices that retard the development of antimicrobial resistance, reduce the prevalence of hospital-acquired infections and prevent new disease outbreaks. To date, virtually all of the physician-level measure development efforts have been focused on the outpatient setting--little thought and few resources have been given to developing accountability measures for predominantly hospital-based physicians. This measure gap must be addressed before Medicare can confidentially report cost and quality data to hospital-based physicians, publicly release their performance results, and establish innovative payment models that focus on incentiving physicians and other providers across multiple settings of care.	Jason Scull	Infectious Diseases Society of America					
10	Oct 6 2010 4:29PM	It is curious to me that there is not a priority for measuring palliative care yet under most of the domains that received a high priority the highest component is what an interdisciplinary palliative care team manages with people with chronic diseases: -communication; medication management; transitions; patient/family centered systems of care; function symptoms and QOL; shared decision making; self-management; appropriateness/efficiency. It seems that you are boxed in by a concept of palliative care that means it is only appropriate for people who are near the end of their lives. The Palliative Care model is one that can be used from the time of diagnosis for any chronic disease to accomplish many of the goals you want to measure.	Rita Layson	Hospice and Palliative Care of Greensboro					
11	Oct 7 2010 9:17PM	I have practiced as an infectious disease specialist for the last 25 years and in this role have participated in the treatment of thousands of patients at the end of life, often in the typical American setting for this rite of passage, the intensive care unit. This perspective has allowed me to become all too familiar with how disjointed and inefficient this process often is. Poorly addressed suffering of patients and families is paired with allocation of precious resources toward ends with no defined goals until a prolonged painful death ultimately occurs. In the last year, dissatisfaction with my role had lead to a career change to Palliative Care. My training has revealed to me how many opportunities we have to improve the quality of care of patients with advanced illness and at the same time reduce the wasted resources that occur in hospitals across our country every day. We as a society must learn a more healthy way to view the natural and potentially very meaningful process of dying. I truly cannot think of a single issue that could have a greater impact on redefining our health care system. John Weems, M.D. Greenville, South Carolina	John Weems						

12	Oct 8 2010 11:39AM	Unfortunately, there is no representation from the hospice and palliative care field on NQF's Measure Prioritization Advisory Committee, and among the priorities voted upon (20). It is essential that this oversight be addressed, as well as its implications for our nation's ability to improve quality for patients and populations and to get a handle on health care spending (Don Berwick's "Triple Aim"- better care/affordable care/healthy people, healthy communities). Palliative care addresses all three goals, and is especially important for improving the experience of care received by patients and families. As an inpatient Palliative Care Coordinator, I have the opportunity every day to see the difference our programs make-not only in patient's (and their families) lives, but also in reduction of hospital expenses. As our population ages, Palliative Care-with Hospice being at the end of the PC continuum-must be included in any initiatives. Thank you. Lynn Crawford, BSN, CHPN	Sarah Lash		Lynn Crawford	Southwest Washington Medical Center	lecrawfo@swmedicalcenter.org	360-696-5103
16	Oct 12 2010 5:16PM	How can Palliative Care/Medicine not be considered a top priority? We experience the need for this specialty to be pushed to the forefront in our practice on a daily basis as we witness futility of care; disregard or lack of inclusion of patient/family goals; poorly managed pain and other symptoms. How can we have the availability of the best health care in the world and yet have some of the worst outcomes? Could it be that we are missing "what really matters most" when it comes to advanced chronic, serious, and life threatening illnesses? The holistic approach in the Palliative Care model provided by an interdisciplinary team helps put the focus back where it belongs - with the patient and family at the center. My new mantra is "just because we can, doesn't mean we should". I think your list of priorities is appropriate as long as Palliative Care is included. It truly overlaps the other measures.	Lori Bishop	Iowa Health Home Care Hospice/Taylor House				
20	Oct 18 2010 7:20PM	We support of the next phase of the project focusing on adults (non-Medicare) and maternal health/neonatal priority conditions. The ranking for palliative care should be moved up in Table 1. All too often patients receive unwanted aggressive treatment at the end of life, diminishing their quality of life and resulting in unnecessary health care services. Palliative care is a patient-centered approach that allows individuals to receive respectful and compassionate care at the end of life.	Christine Chen	Pacific Business Group on Health				

26	Oct 19 2010 2:58PM	The Hospice and Palliative Care Coalition wishes to voice its concern that the measure prioritization committee ranked palliative care as the last measure gap priority (with 0 votes). Palliative care is one of the top national priority areas defined by the National Priority Partners. Substantial progress has been made in developing measures of palliative care quality; yet substantial work remains to develop measures with robust reliability, actionability, and usability for public reporting and value based purchasing. If a substantial further investment in the development of palliative care measures is not made a priority, progress in achieving better palliative and hospice care will be thwarted. Additional supporting information on these comments is being submitted via email.	Dale Lupu	American Academy of Hospice and Palliative Medicine	Dale Lupu	Hospice & Palliative Care Coalition	dalelupu@daleviewassociates.com	412.787.9301
29	Oct 19 2010 4:13PM	The National Hospice and Palliative Care Organization appreciates the systematic approach taken by the Committee and its notation of the importance of palliative care despite a low overall ranking. However, we feel strongly that palliative care should be recommended as a priority area for measure development. Palliative care is one of the top national priority areas defined by the National Priority Partners and is also a measure developer priority. The impact of palliative care is extensive and improvability and feasibility in palliative care are certainly equal to that in other domains. As healthcare is faced with an aging population and increasingly complex patient populations, palliative care will continue to be an important priority, particularly as evidence grows that palliative care improves quality of life and is associated with cost savings by avoiding overly aggressive care that offers minimal benefit. In accordance with the NPP palliative and end-of-life care goals, patients need access to high-quality care that addresses pain and suffering along with the psychosocial needs of patients and their families, and that is concordant with patient preferences. Yet only 9 palliative and end of life care measures currently have NQF endorsement. NHPCO urges the Committee to recognize the necessity of making development and implementation of palliative care measures a high priority on the national measure development agenda.	Carol Spence	National Hospice and Palliative Care Organization	Jonathan Keyserling	National Hospice and Palliative Care Organization	jkeyserling@nhpco.org	703-837-3153
30	Oct 19 2010 4:14PM	Humana appreciates the opportunity to comment. Related to some specific elements of the report: a.) Ambulatory care,was given a lower priority based upon lack of evidence-based measures. Yet the impact on health outcomes is primarily from patient behavior, genetics and environment and coupled with ambulatory care and guidance. The evidence-based measures in this space represent common acute care conditions (URI, Strep, UTI) and preventive services. NQF needs to consider other measurement systems from the social sciences rather than rely on "hard" evidence-based criteria b.) on page 12--Disparities/Access does not receive a separate domain, but is considered by the CMS Administrator to be a significant concern., as addressed earlier in the document	Thomas James	Humana Inc.				

31	Oct 19 2010 4:15PM	The National Hospice and Palliative Care Organization appreciates the systematic approach taken by the Committee and its notation of the importance of palliative care despite a low overall ranking. However, we feel strongly that palliative care should be recommended as a priority area for measure development. Palliative care is one of the top national priority areas defined by the National Priority Partners and is also a measure developer priority. The impact of palliative care is extensive and improvability and feasibility in palliative care are certainly equal to that in other domains. As healthcare is faced with an aging population and increasingly complex patient populations, palliative care will continue to be an important priority, particularly as evidence grows that palliative care improves quality of life and is associated with cost savings by avoiding overly aggressive care that offers minimal benefit. In accordance with the NPP palliative and end-of-life care goals, patients need access to high-quality care that addresses pain and suffering along with the psychosocial needs of patients and their families, and that is concordant with patient preferences. Yet only 9 palliative and end of life care measures currently have NQF endorsement. NHPCO urges the Committee to recognize the necessity of making development and implementation of palliative care measures a high priority on the national measure development agenda.	Carol Spence	National Hospice and Palliative Care Organization	Jonathan Keyserling	National Hospice and Palliative Care Organization	jkeyserling@nhpco.org	703-837-3153
33	Oct 19 2010 4:17PM	In building a portfolio of quality performance measures, a high priority should be given to measures that focus on the care provided to patients with multiple serious chronic and life-threatening conditions, due to their vulnerability, progressive illness, age and the demonstrated lack of continuity in their care. Approximately 68% of Medicare costs are related to people with four or more chronic conditions - the typical patient who can benefit from hospice and palliative care. The Committee has noted the importance of palliative care despite a low ranking among the measure gap domains. However, the critical importance of both spiritual/cultural/psychological needs and family caregiver needs was not recognized in the ranking of sub-domains. There is sufficient evidence in healthcare practice to demonstrate the deleterious effects of distress and suffering due to spiritual and psychological pain and the benefits of supportive care provided to patients and families. Because of its focus on the patient and family as the unit of care, palliative care interventions can reduce psychological morbidity of both patients and family members and may have a positive influence on physical wellbeing as well. The Committee should recognize the significance of the sub-domains of spiritual/psychological needs and the importance of addressing those needs through creation of quality measures for palliative care.	Carol Spence	National Hospice and Palliative Care Organization				
39	Oct 19 2010 4:18PM	Medicare Measure Gap Domains & Subdomains In Table 3, it is unclear how "Performance Measurement" could be a subdomain of measure gap sub-domains. NQF should clarify the intent of this subdomain. In Table 3, the term "Social Determinants" should be clarified. "Access to Spiritual, Cultural, and Psychological Needs" in Table 2 & 3 is not easily understood. Healthcare acquired conditions is not explicitly included in any of the domains and subdomains and should be added.	Rebecca Zimmermann	America's Health Insurance Plans				

51	Oct 19 2010 5:32PM	The National Partnership encourages NQF to use the next phase of this project to focus on non-Medicare adults, and in particular, to maternity and perinatal health care and conditions. We also recommend that in Table 1, the ranking for palliative care be moved up in priority. One of the biggest failures of our system is the fact that too often, patients receive unwanted, aggressive treatment at the end of live. Palliative care reflects a patient-centered approach, that provides individuals with respect and compassion, while meeting their health care needs and preferences. Palliative care enhances joint decision-making, improves quality, and reduces unnecessary hospitalizations and emergency department visits. Related to this, we suggest changing the language from "PC and EOLC" to "palliative and hospice care" in an effort to raise awareness and educate consumers about what hospice care really is. It is fully covered by Medicare, but most consumers are not aware of what it means, let alone that it is considered the gold standard for patient-centered end of life care.	Debra Ness	National Partnership for Women & Families				
56	Oct 19 2010 5:50PM	We are concerned that palliative care is ranked last and scores far behind the other domains. This is a crucial matter for quality of life, for family engagement, for appropriate use/overuse and waste, for care coordination, and safety. There are major concerns about dignity and choice during a vulnerable time.	Carol Sakala	Childbirth Connection				
58	Oct 19 2010 6:02PM	Continuing with Childbirth Connection rationale for an upcoming maternal/newborn focus, childbirth care has become excessively procedure-intensive (6 of 10 most common hospital procedures are maternity-related), despite the largely healthy population. C-section is the most common hospital operating room procedure, and the rate rose from 4.5% in 1965 to 31.8% in 2007, setting a new national record each consecutive year of this century. Another common procedure of concern is labor induction, for example when used electively to bring about preterm or early term birth, when used for spurious indications (e.g., fetus seems large), or when used casually and before the cervix is soft and ready to open. Conversely, many safe and beneficial practices are underused (e.g., smoking cessation help for pregnant women, prenatal and postpartum breastfeeding support). There is large unwarranted practice variation. High-performing benchmark providers suggest much scope for improvement. Resource use is also highly variable. For example, in 2007, the average facility charge in freestanding birth centers was $1,872, in contrast to the average national hospital charge for a vaginal birth without complications, $8,316. Average charges for complicated cesarean sections soared to $20,074. The nation can realize great health gains and cost efficiencies by appropriate care that reduces surgical birth and iatrogenic complications, and makes good use of high-performing caregivers and settings.	Carol Sakala	Childbirth Connection				
59	Oct 19 2010 6:04PM	Continuing with Childbirth Connection rationale for an upcoming maternal/newborn focus, we also appreciate the proposal to consider maternal and newborn well-being and care together. The child health framework does not address the considerable scope of influence on newborn health of prenatal, intrapartum, and postpartum factors. The well-being of mothers and newborns is intertwined, and it is appropriate to develop a framework that includes both. Often the same care benefits both, and in other cases, trade-offs need to be considered. We would also like to point out that maternal and newborn health and maternity care directly involve all six focal NPP areas (although palliative care fortunately impacts just a fraction of this population, primarily newborns with life-threatening conditions).	Carol Sakala	Childbirth Connection				

62	Oct 19 2010 11:55AM	It is very surprising to see that palliative care received zero votes, especially since some of the highly prioritized subdomains (eg, appropriateness, shared decision making, quality of life) are so closely aligned with palliative care. Looking at the subdomains listed under palliative care, it seems that the domain may have been low on the priority list due to its limited scope. WellPoint believes that palliative care measures should be higher on the priority list.	Jenna Williams-Bader	WellPoint, Inc.				
64	Oct 19 2010 12:44PM	I support the next phase of the project focusing on adults (non-Medicare) and maternal health/neonatal priority conditions. The ranking for palliative care should be moved up in Table 1. Palliative care is a patient-centered approach that allows individuals to receive respectful and compassionate care at the end of life.	Gaye Fortner	HealthCare 21 Business Coalition				
Comments on the prioritization of child health conditions, child health measure gap areas, and key issues								
22	Oct 18 2010 7:21PM	We are concerned about the ranking of Child Health Conditions and Risks in Table 5. We believe that "Overweight/Obese" should be ranked first given its tremendous impact on our nation's youth. An increasing number of children are overweight or obese, making them at risk for health problems during their youth and as adults that will likely translate into increased use in health care services. For example, they are more likely to have risk factors associated with cardiovascular disease than are other children and adolescents. We recommend adding social determinants as a sub-domain in child health, as the steering committee has importantly done for the population health section.	Christine Chen	Pacific Business Group on Health				
23	Oct 19 2010 2:03PM	We are surprised by the prioritization list for child health measures, especially since tobacco use is at the top whereas other topics that have a high impact on quality, health and cost (eg, brain injury & concussion [safety] - seat belt use and helmet use) are at the very bottom of the list. Also, if the child health topic is meant to capture priorities for adolescents, it is surprising not to see substance or alcohol use/abuse on the list. Lastly, it also appears that there is a heavier emphasis on measuring chronic condition care rather than preventive care, especially since physical activity and nutrition are not mentioned.	Jenna Williams-Bader	WellPoint, Inc.				
36	Oct 19 2010 4:17PM	For Child Health, the focus was on medically identifiable conditions. The Committee paid limited attention to healthy social integration, child-friendly communities, developmental issues (including bullying, internet or other external influences on emotional health) or childhood education. Were non-medical child advocates included on this Committee? The issues were only partially identified in this group	Thomas James	Humana Inc.				

37	Oct 19 2010 4:18PM	Child Health AHIP supports prioritizing the development of child health measures. The conditions recommended (pg.14) for measure development appear appropriate but are lacking an important emphasis on developmental issues. NQF should define the age range for "child"; For young children, tobacco use may not be the top priority domain. NQF should consider adding the following domains - substance abuse, safety (such as helmet and seat belt use) and physical activity/ nutrition.	Rebecca Zimmermann	America's Health Insurance Plans				
43	Oct 19 2010 4:48PM	Condition-specific approaches are limiting in children's health care. NAcHRI believes the report overlooks an important sub-population of children - children with multiple and complex chronic conditions. Children and youth with special health care needs (CYSHCN) account for approximately 16.2 percent of children (Chevarley, 2006), but a disproportionate amount of health care expenditures. The group of children with SHCN is a diverse one, ranging from children with single chronic conditions to children with multiple chronic conditions and diseases or syndromes involving multiple organs and requiring assistive technology. Children with disabilities had more than four times the number of hospitalizations, eight times the number of hospital days, twice the number of ED, more than twice as many physician and more than five times the number of nonphysician visits, three times the number of prescribed medications and substantially more home health provider days as compared to other children (Newacheck et al., 2006). Newacheck, et al. found variation in expenditures geographically, by racial/ethnic category and by income. Moreover, the prevalence of "medically complex children" is increasing (Cohen, et al., 2006). We believe that the development of a balanced set of cross-cutting measures for these children is an important priority. We also agree with putting a high priority on measures of prevention.	Ellen Schwalenstocker	National Association of Children's Hospitals and Related Institutions				
44	Oct 19 2010 4:49PM	NACHRI also notes that, although safety received relatively few votes as a measure gap domain, adverse events received several votes as a sub-domain. We believe that the votes for medication safety do not recognize the unique needs and risks of children with regard to medication, and also suggest pain management is an important area. Finally, we agree that this report should be aligned with the findings of the Subcommittee of the AHRQ National Advisory Committee with regard to measure gaps, especially measures of inpatient and specialty services, health outcomes measures, behavioral health and measures of 'most integrated health care systems.	Ellen Schwalenstocker	National Association of Children's Hospitals and Related Institutions				
45	Oct 19 2010 4:57PM	NACHRI appreciates the increasing inclusion of child health representation on NQF committees. However, it appears that there was only one person on the Measure Prioritization Advisory Committee with child health expertise and experience. Going forward, we respectfully request that projects with a significant focus on children's health and healthcare, such as this one, include a broad range of children's healthcare expertise.	Ellen Schwalenstocker	National Association of Children's Hospitals and Related Institutions				

53	Oct 19 2010 5:34PM	The National Partnership believes that in the ranking of child health conditions in Table 5, "overweight/obese" should be moved up given its impact on our nation's youth, and the ripple effects that this condition has as children grow up and become adults in our health care system. We understand that much attention is being paid to this condition via other avenues, most notably First Lady Michelle Obama's campaign to lower obesity rates. However, rather than that being a reason to rank this condition below tobacco, we believe that the measurement agenda should align with these other efforts, and rank overweight/obese as number one.	Debra Ness	National Partnership for Women & Families					
54	Oct 19 2010 5:35PM	Finally, on the matter of child health, we suggest adding "social determinants" as a sub-domain, as we noted in our general comments.	Debra Ness	National Partnership for Women & Families					
55	Oct 19 2010 5:40PM	We feel that "overweight/obese" should occupy the topmost position in the list of priority child health conditions and risks. Threats of this condition to child (and future adult) well being and to health care costs are considerable. Further, this overlaps with several other concerning conditions, such as diabetes.	Carol Sakala	Childbirth Connection					
57	Oct 19 2010 5:52PM	Childbirth Connection appreciates the opportunity to comment on the proposed focus of the next phase of the Measure Development and Endorsement Agenda project in 2011. We support the proposed focus on community needs and are enthusiastic about payment reform and public reporting as possible domains. We also support the focus on non-Medicare adults, and strongly support identifying domain and sub-domain gaps relevant to childbearing women and newborns. Our experience with the latter clarifies that this population and the full episode of maternity care provide high-leverage opportunities. Notably, the entire population experiences maternity care during the earliest vulnerable period of rapid development, and over 80% of women in the nation give birth to one or more children. Fully 25% of those discharged from hospitals are childbearing women and newborns (more than any other hospital condition), and costs of their care far exceed costs of any other hospital condition.	Carol Sakala	Childbirth Connection					
65	Oct 19 2010 12:45PM	I share concerns about the ranking of Child Health Conditions and Risks in Table 5. I recommend adding social determinants as a sub-domain in child health, as the steering committee has importantly done for the population health section.	Gaye Fortner	HealthCare 21 Business Coalition					
Comments on the prioritization of population health measure gap areas and key issues									
38	Oct 19 2010 4:18PM	Population Health AHIP supports the domains and subdomains included in the report for population health. Under Domain 2, Lifestyle Behaviors, we recommend adding obesity or weight management.	Rebecca Zimmermann	America's Health Insurance Plans					
40	Oct 19 2010 4:19PM	My comment my get to the focus of NQF and whether it primarily looks to evidence-based measues of clinical science. For population health, the Committee did not address many of the determinants of health such as access to jobs, education, housing, density, social infrastructure. As Don Berwick has pointed out the medical care system is only responsible for 10% of the determinations of health. The rest are environmental, genetic, and behavioral Those are the conditions that also need to be addressed	Thomas James	Humana Inc.					