MEASURE APPLICATIONS PARTNERSHIP

Coordination Strategy for Clinician Performance Measurement

FINAL REPORT

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NQF

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EXECUTIVE SUMMARY

There has been a proliferation of federal programs that focus on measuring clinician performance as a gauge of whether resources spent on healthcare are achieving appropriate value and results. While each program has important and targeted aims, the siloed and disconnected nature of their underlying measurement requirements create undue burden for clinicians, wasteful and duplicative data collection for clinicians and government, and send conflicting signals. Ultimately and most important, this misalignment hampers acceleration toward delivery of safer, appropriate, and higher-quality care for all patients.

The federal government at present has an unrivaled opportunity to step back and better connect the dots among its various programs designed to assess clinician performance and drive positive change. As financial stakes get higher with these programs, in that their results will be publicly reported and tied to clinician payment, there is a strategic imperative to address misalignment that may negatively impact efforts to improve healthcare. These challenges must be solved by all healthcare stakeholders in a constructive manner that allows for varied perspectives to be considered.

The Measure Applications Partnership (MAP) is a public-private sector partnership convened by the National Quality Forum. MAP is responsible for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment programs, and other purposes. The composition of MAP participants is noteworthy. Its diverse, public-private nature ensures federal strategies with respect to measure selection are informed upstream by varied, thoughtful organizations that all have a vested stake in the selection of measures used in various government programs. Adding private-sector voice to these deliberations before measures are selected is a significant enhancement to the traditional federal rulemaking process. It holds great potential to streamline the rulemaking process because HHS will receive distilled, targeted, and vetted recommendations in advance of issuing proposed regulations, ultimately helping to ensure that both the public and private sectors are rowing in the same direction.

MAP will issue a series of reports as a result of its work. This report specifically outlines a coordination strategy for HHS on federal clinician performance measurement. The recommendations presented would simultaneously accelerate improvement and a more cohesive system of care delivery because clinicians and the largest payer in the country will be focused on a select, targeted set of performance measures linked to achieving overall national aims for improved health and healthcare.

To facilitate progress toward more connectivity across federal programs, MAP first identified characteristics of an ideal performance measure set, recognizing that attributes within that set may be more or less emphasized given a proposed application, e.g., reporting versus payment. The characteristics of an ideal set include promotion of shared accountability, use of “cascading” measures across all levels (e.g., health system, clinician group, individual clinician) and settings, and appropriate mix of measure types. In addition, the set should be useful to its intended audiences, balance comprehensiveness with data collection burden, take into account undesirable consequences from measurement, and consider healthcare disparities.

Next MAP began developing measure selection criteria as a tool to evaluate and recommend measure sets for specific public reporting and performance-based payment programs. These criteria are needed to help guide specific measure choices—the next assignment of MAP—that demonstrate the characteristics of an ideal measure set, as described above. These draft criteria include:

- Measures within the set meet NQF endorsement criteria
- Measure set adequately addresses each of the National Quality Strategy priorities
- Measure set adequately addresses high-impact conditions relevant to the program's intended population
- Measure set promotes alignment with specific program attributes
- Measure set includes an appropriate mix of measure types
- Measure set enables measurement across the patient-focused episode of care
- Measure set includes considerations for disparities
- Measure set promotes parsimony

The Clinician Workgroup, a subset of the overall MAP, then evaluated a set of measures—specifically, the proposed Physician Value-Based Payment Modifier (Value-Modifier) measure set published in the July 1, 2011, proposed Physician Fee Schedule rule—against these ideal characteristics and criteria. The Value-Modifier measure set was chosen because it applies to both individual clinicians and group practices and because of its significance as the initial set for HHS's first performance-based program to be applied to all clinicians participating in Medicare.

Clinician Workgroup members thought that while the majority of criteria were addressed in the Value-Modifier set, there was a notable absence of patient experience measures and a need for greater emphasis on healthy living, care coordination, affordability, safety, and attention to disparities. There was a lack of parsimony—meaning opportunities abound to reduce the number of proposed measures without sacrificing comprehensiveness. The workgroup also agreed that the Value-Modifier could potentially be further streamlined to reduce duplication and data collection efforts.

Comprehensive measure alignment is ultimately not possible until a common data platform exists, instead of the current parallel platforms that support administrative, registry, and electronic health record data collection. A future, unified health IT platform would eliminate disjointed data formats that result in confusing results and also would reduce duplication of measurement activities that are burdensome to clinicians. Ideally, data will be collected once during the process of care and subsequently used for multiple quality measurement and improvement purposes. Health IT adoption and standardized data platforms would also reduce administrative costs borne by CMS and other payers. Finally, future data platforms should also enable the collection of patient-reported data (both quantitative and qualitative) and the tracking of patient-reported data across settings and over time. Patients are a rich source of important information that can heavily influence the trajectory of better care over time.

As a result of its current work, MAP identified four major measure gaps for future development, including measures that capture the patient's perspective, appropriateness of care measures,

measures most relevant to vulnerable populations, and care coordination measures. Filling these gaps will require federal and private-sector support for measure development, testing, and endorsement. Future MAP reports driven by the Clinician Workgroup will build off of this coordination strategy input, going the next step to recommend specific core measure sets for public and private programs.

As the federal government moves toward paying clinicians on the basis of performance, crucial work must to be done to harmonize existing duplicate measures across various federal programs; to identify a core set of metrics that will relate to all programs; and to work with the private sector to identify shared priorities for improvement going forward. MAP is pleased to have the opportunity to help facilitate the federal government's challenging and critical transition from volume to performance-based pay, an approach policymakers hope will deliver benefits for patients and communities in terms of higher-quality, more affordable care.

MAP BACKGROUND

Purpose

MAP is a public-private partnership convened by the National Quality Forum (NQF) for providing input to HHS on selecting performance measures for public reporting, performance-based payment programs, and other purposes. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[1]

Through MAP activities, a wide variety of stakeholders will provide input into HHS's selection of performance measures. MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures that HHS will receive varied and thoughtful input on performance measure selection.

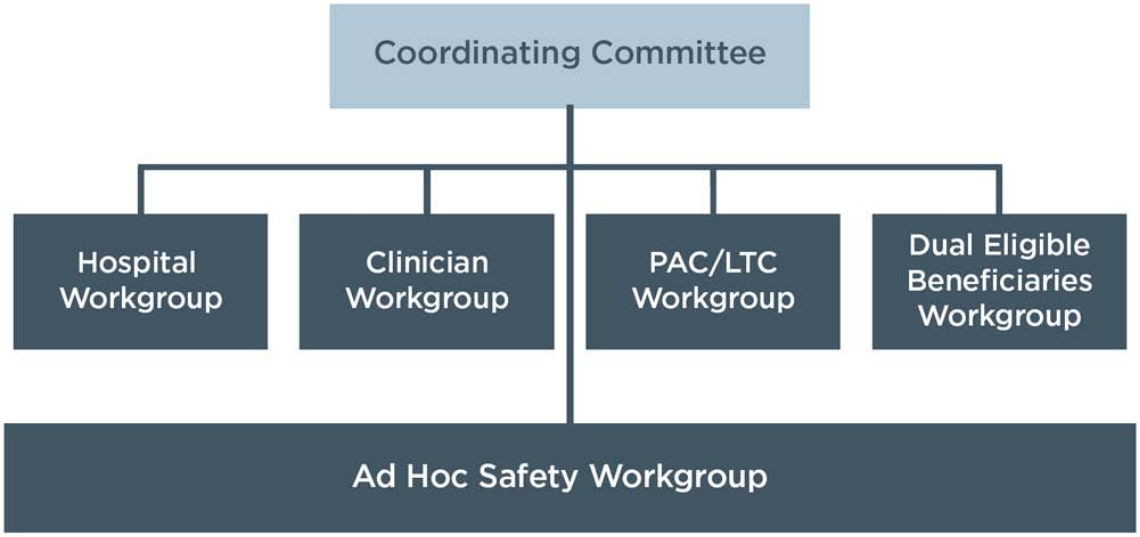
MAP is designed to facilitate alignment of public- and private-sector uses of performance measures to further the NQS's three-part aim of creating better, more affordable care and healthier people.[2] Anticipated outcomes from MAP's work include:

- a more cohesive system of care delivery;
- better and more information for consumer decision making;
- heightened accountability for clinicians and providers;
- higher value for spending by aligning payment with performance;
- reduced data collection burden through harmonizing measurement activities across public and private sectors; and
- improvement in the consistent provision of evidence-based care.

Function

Composed of a two-tiered structure, MAP's overall strategy is set by the Coordinating Committee, which provides final input to HHS. Working directly under the Coordinating Committee are five advisory workgroups responsible for advising the Committee on using measures to encourage performance improvement in specific care settings, providers, and patient populations. More than 60 organizations representing major stakeholder groups, 40 individual experts, and 9 federal agencies (ex officio members) are represented in the Coordinating Committee and workgroups.

The NQF Board oversees MAP. The Board will review any procedural questions and periodically evaluate MAP's structure, function, and effectiveness but will not review the Coordinating Committee's input to HHS. The Coordinating Committee and workgroups were selected by the Board, based on Board-adopted selection criteria. Balance among stakeholder groups was paramount. Because MAP's tasks are so complex, including individual subject matter experts in the groups was also imperative.



MAP operates in a transparent manner. The appointment process included open nominations and a public commenting period. MAP meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

MAP decision making is based on a foundation of established guiding frameworks. NQS is the primary basis for the overall MAP strategy. Additional frameworks include the High-Impact Conditions lists determined by the NQF Measure Prioritization Advisory Committee, the NQF-endorsed Patient-Focused Episodes of Care framework, the HHS Partnerships for Patients safety initiative,[3] the HHS Prevention and Health Promotion Strategy,[4] the HHS Disparities Strategy,[5] and the HHS Multiple Chronic Conditions Framework.[6]

One of MAP's early activities has been the development of measure selection criteria. The selection criteria are intended to build on, not duplicate, the NQF endorsement criteria. The measure selection criteria characterize the fitness of a measure set for use in a specific program by, among other things, how closely they align with the NQS's priority areas and address the High-Impact Conditions, and by the extent to which the measure set advances the purpose of the specific program without creating undesirable consequences.

NQF has engaged two subcontractors to support MAP's work. The Stanford Clinical Excellence Research Center has provided input into developing measure selection criteria. Avalere Health has been subcontracted to prepare an analysis of quality issues, strategies for improvement, and measure gaps to support the selection of measures for hospitals, physician offices, and post-acute care/long-term care settings. In addition, Avalere will conduct a similar analysis for dual eligible beneficiaries as a distinct population that crosses all care settings.

Timeline and Deliverables

MAP's initial work includes performance measurement coordination strategies and pre-rulemaking input on the selection of measures for public reporting and payment programs (see Appendix 1 for schedule of deliverables). Each of the coordination strategies will address:

- measures and measurement issues, including measure gaps;
- data sources and health information technology (health IT) implications, including the need for a common data platform;
- alignment across settings and across public- and privatesector programs;
- special considerations for dual eligible beneficiaries; and
- the path forward for improving measure applications.

MAP began its work in the spring of 2011 (see Appendix 2 for timeline). The Coordinating Committee set charges for the workgroups in May. Four of the workgroups—Dual Eligible Beneficiaries, Clinician, Safety, and Post-Acute Care/Long-Term Care—met during June and July. The Coordinating Committee has also convened regularly to review progress and provide guidance to the workgroups. These four workgroups provided reports to the Coordinating Committee in August. The Hospital Workgroup will meet in October to consider the measure selection criteria and its approach to the pre-rulemaking task. MAP will provide pre-rulemaking input to HHS on the selection of measures for payment and public reporting programs in February 2012, based on a list of measures under consideration that HHS will post in December. To fulfill its initial tasks, MAP will provide three reports by October 1, 2011: final reports for the clinician and safety coordination strategies and an interim report for the dual eligible beneficiaries quality measurement strategy (with a final report due June 1, 2012).

COORDINATION STRATEGY FOR CLINICIAN PERFORMANCE MEASUREMENT

MAP has been charged with developing a coordination strategy that addresses alignment issues across federal clinician performance measurement programs. Throughout this strategy clinician refers to the entire team of healthcare professionals. MAP recognizes the importance of teamwork in providing care that is centered on the patient, rather than on individual clinicians. New delivery models, such as patient-centered medical homes and accountable care organizations (ACOs), are pushing toward further integration of patient-centered care. These new models call for new ways of measuring performance that promote high-performing teams and improvement in the outcomes that matter to patients.

As clinicians face increasing measure reporting requirements, stakeholders widely agree alignment is critical for reducing data collection burden, maximizing meaningfulness of the information, and accelerating improvement. To support measure alignment, MAP has identified characteristics of an ideal measure set and tested a set of measures, the proposed Physician Value-Based Payment Modifier (Value-Modifier) measure set, against those characteristics. In addition to providing an evaluation of the proposed measure set, this exercise highlighted important measure gaps and provided input into the measure selection criteria MAP is developing to select measures for specific purposes (e.g., public reporting and performance-based payment programs). MAP also has adopted data platform principles that will further address data collection burden. Finally, MAP presents a path forward, indicating critical next steps toward achieving alignment and making available the performance measures needed to support integrated delivery.

Approach

The MAP Clinician Workgroup advised the Coordinating Committee on developing the clinician performance measurement coordination strategy. The Clinician Workgroup is a 27-member, multi-stakeholder group (see Appendix 3A for the workgroup roster). The workgroup had two, two-day in-person meetings and two web meetings to consider aspects of the coordination strategy. The agendas and materials for the Clinician Workgroup meetings can be found on the NQF website.[7]

To inform planning for the Clinician Workgroup meetings, NQF staff compiled a table of performance measures currently in use in federal programs and select private programs (see NQF website[8] for the table). Measure attributes included in the table are endorsement status, retooled eMeasure specification availability, description, steward, numerator, denominator, data sources, and type, as well as the corresponding settings and programs in which the measure is used. Further, each measure is mapped to targeted conditions and the NQS priorities.

The Clinician Workgroup reviewed the performance measures currently in use in federal programs—specifically, Physician Quality Reporting System, Medicare and Medicaid EHR Meaningful Use Incentive Program, and illustrative private-sector programs—and identified qualities that make measures suitable for broad application across performance measurement programs. The workgroup gave explicit attention to measurement challenges within the dual eligible beneficiary population, although there is a separate MAP workgroup devoted specifically to dual eligible

coordination strategies. An initial attempt to define a core measure set for all clinician measurement led to a strong consensus among the group that measure sets need to be evaluated in the context of a specific purpose (e.g., public reporting vs. payment; individual vs. group accountability). Accordingly, the workgroup defined characteristics of ideal measure sets that are applicable to multiple purposes. The group examined how a measure set proposed for a specific program, the physician Value-Modifier, aligns with the ideal characteristics, using draft measure selection criteria as an evaluation tool (see Appendix 4A for the evolution of the measure selection criteria).

Considering data collection and reporting challenges across federal programs led to developing data platform principles. Discussing other ongoing efforts, specifically the work of the National Priorities Partnership (NPP) to define goals and measures for the NQS priorities and efforts to develop measures for ACOs, raised additional alignment imperatives.

Alignment

Multiple federal programs involve clinician performance measurement (see Appendix 5 for an overview of federal programs). The differing goals and structures of these programs create issues that can cause undue burden for clinicians and groups participating in multiple programs and confusion for consumers and purchasers who use performance improvement information for decision making. Consumers face challenges choosing providers and finding affordable care, while purchasers are faced with out-of-control costs and want to promote better care by rewarding higher-performing clinicians.

The federal programs for clinician performance measurement are briefly described below:

- *The Physician Quality Reporting System* (PQRS) provides incentive payments to eligible professionals who satisfactorily report data on quality measures (selected from among 240 measures) for covered services furnished to Medicare beneficiaries.[9]
- *The Medicare and Medicaid EHR Meaningful Use Incentive Program* (EHR-MU) provides incentive payments to eligible professionals (as well as eligible hospitals) for the "meaningful use" of certified electronic health record (EHR) technology to enhance quality, safety, and effectiveness of care.[10]
- *The E-Prescribing Incentive Program* (ERx) provides incentive payments to eligible professionals who are successful electronic prescribers.[11]
- *The Physician Resource Use Measurement and Reporting (RUR) Program,* which will be incorporated into the Physician Feedback/Physician Value-Based Payment Modifier Program (Value-Modifier), currently provides confidential feedback reports to physicians and other medical professionals. These reports gauge the resource use and quality of care provided to patients in comparison to the peer groups practicing in the same specialty.[12]
- *The Physician Compare website* currently serves as a healthcare professional directory but will be enhanced to provide performance information.

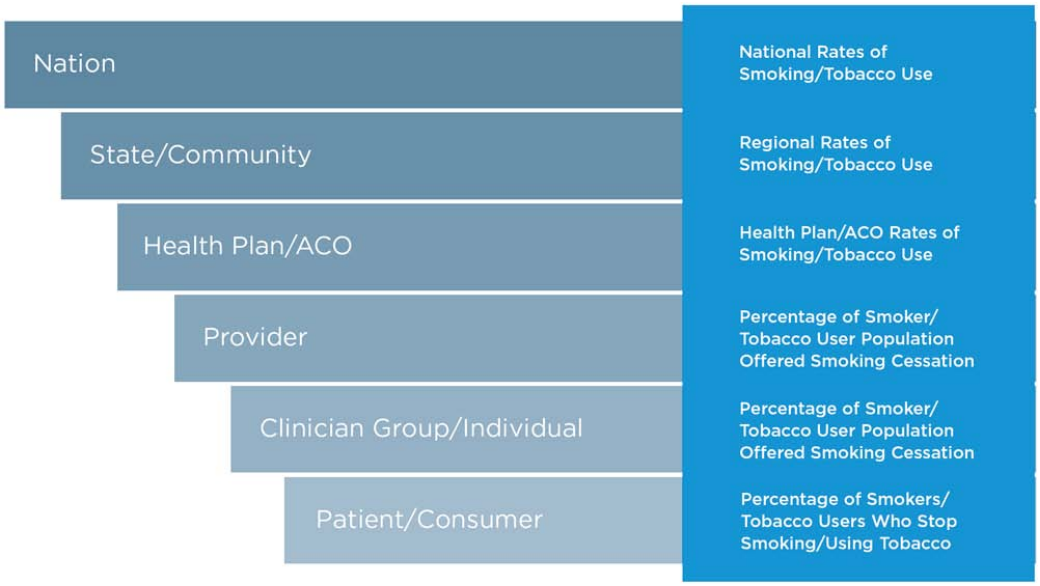
Clinicians who participate in the PQRS, EHR-MU, and ERx incentive programs face measure and data alignment issues that make participation burdensome and confusing. The misalignment of programs induces duplication of efforts, which increasingly taxes clinicians' limited resources and time available for quality improvement. For example, a recent Government Accountability Office report on electronic prescribing notes that the misalignment of technology certification requirements between ERx and EHR-MU programs creates the possibility clinicians will invest in

technology that may not be suitable for both programs.[13] With the ERx program scheduled to introduce penalties in 2012 when the EHR-MU program will be providing incentives, clinicians could invest in technology to avoid a penalty from the ERx program that may not be suitable to receive incentives from the EHR-MU program.[14] Additionally, a clinician currently participating in both programs must report the same electronic prescribing information to each program separately due to the varying reporting requirements.[15] The Centers for Medicare & Medicaid Services (CMS) has since indicated their intent to better align these two programs, the details of which are captured in the 2012 Medicare Physician Fee Schedule proposed rule.[16]

The importance of alignment is only growing as Physician Compare and Value-Modifier programs will depend on data generated from clinician participation in the PQRS and EHR-MU programs. Issues include different data sources (e.g., claims, EHRs) and reporting periods for the same measure resulting in different specifications across programs; separate reporting mechanisms for the same measure (e.g., submission of data for PQRS and submission of rates for EHR-MU); and inconsistency in allowing group reporting. Given these differences, a measure concept that overlaps programs may have up to seven different reporting options that vary by data sources, specifications, and reporting periods. Measure results generated from these seven different reporting options may not be comparable and may cause confusion in interpreting performance results.

There is broad recognition that the need for alignment of clinician performance measurement programs extends beyond federal programs to private-sector initiatives. Addressing federal program alignment issues creates opportunities to align broadly with private-sector initiatives. As an example of successful public/private alignment, PQRS now gives credit for Medical Specialty Board Maintenance of Certification (MOC), and several certification boards have incorporated a PQRS reporting option into their MOC programs. It will be increasingly important to continue these alignment efforts, since each well-intentioned public and private performance measurement initiative imposes data collection requirements on clinicians that could potentially conflict with the requirements for other programs. Medical home initiatives typically include health IT structural and process requirements (e.g. EHRs, e-prescribing); CMS has proposed 65 process and outcome measures across 5 domains for ACOs;[17] and many health plans have created clinician performance measurement programs (e.g., BCBS-MA Alternative Quality Contract,[18] IHA Pay for Performance[19]). Clinicians may become linked to several of these programs that occur at multiple levels of the system (e.g., clinician, group, health plan, or system).

Measurement approaches targeted to one program or setting create duplicity of measurement and further perpetuate "silos" in the healthcare system. Ideally, an aligned measurement approach would use "cascading measures," harmonized measures applied at each level of the system, to provide a comprehensive picture of quality and identify targeted interventions at each level of the system. The diagram below illustrates the cascading measures approach for smoking. Using standardized data elements to calculate measures across levels of analysis would further reduce data collection burden. The NQS priorities and goals serve as a guide for aligning public and private efforts. NPP has identified measures for tracking progress on the national priorities and goals of NQS, while MAP identifies specific measures that can help to move the needle at the provider and clinician levels.



PUBLIC COMMENT

Comments received reiterated the need to align measures used in performance measurement programs to reduce measurement burden. Commenters also highlighted the need to define and align program goals and strategies clearly, as misaligned program goals cause confusion and may result in misaligned measures among programs.

Characteristics of an Ideal Measure Set

MAP has identified seven characteristics of an ideal measure set to encourage alignment across federal programs and between public- and private-sector programs. The ideal measure set represents measurement areas that should be incorporated into any measurement program. The ideal set bridges federal programs and the private sector's quality initiatives by denoting measure characteristics that are comprehensive, yet flexible enough to address multiple applications.

Measure sets should promote shared accountability and "systemness."

Patients should receive care in a seamless delivery system in which there is communication and coordination across the healthcare providers and settings that are jointly held accountable for the patient's care. The healthcare team and/or an individual clinician should be able to influence the result of the measure (i.e., actionable), and the measure should target an improvement gap (i.e., not "topped-out"). To promote system coordination and improvement, measures should assess care across settings and time (i.e., longitudinal).

Measure sets should address multiple levels of analysis, using "cascading" measures for harmonization across levels.

Clinician performance measurement programs may permit different levels of data reporting (i.e., individual vs. group) to serve different purposes. Group-, team-, or system-level analysis promotes shared accountability, while individual-level analysis promotes action for specific individuals.

Using cascading measures that are harmonized across multiple levels of the system would align interventions. For example, while the percentage of smokers/tobacco users referred to community-based smoking cessation resources can be assessed at the individual level, smoker/tobacco user population rates also can be evaluated at the group, team, or system level.

Measure sets should be useful to the intended audiences, including consumers, clinicians, payers, and policymakers.

Recognizing that measures are used by current and future Medicare programs, they should not only serve Medicare's purposes, but also their results must be understandable and meaningful to patients and clinicians. The information garnered from the measure set should inform patients' healthcare decisions and provide feedback to providers on how to improve care. In addition, payers and policymakers should be able to use this information to evaluate and improve programs.

Measure sets should include appropriate representation among types of measures: outcome, process, structure, experience, and cost measures.

Each type of measure plays an important role in improving quality and promoting accountability. While outcome measures are needed to assess the impact of a given intervention, including process measures with a strong link to outcomes is vital to documenting and adopting best practices. Structural measures may be important where access to healthcare services is a particular concern (e.g., the dual eligible beneficiary population). Additionally, evaluating patient experience is a first step toward patient-centeredness and consideration of the patient's goals and preferences. Incorporating cost measures is imperative to address the affordability of healthcare.

Measure sets should balance comprehensiveness with parsimony, recognizing that few measures will address all of the measure selection principles.

Efforts devoted to data collection steal resources from efforts devoted to quality improvement. To achieve the goal of being as efficient as possible to reduce undue data collection burden and duplicative measurement efforts, measure sets should use the best measures to adequately address the purpose of the program. This can be accomplished by including measures that not only gauge quality and performance, but also lead to the most effective interventions.

Consideration should be given to the potential for undesirable consequences from measurement.

Depending on the type of measure selected, risk adjustment or stratification may be needed to recognize the complexity of certain subpopulations and the need to avoid incentives for "cherry picking," while not adjusting away disparities that need to be addressed. Measurement approaches that can mitigate undesirable consequences include giving credit for improvement (i.e., delta measures) and incorporating programmatic features to monitor the potential for undesirable consequences.

Measure sets should include considerations for healthcare disparities.

Incorporating considerations for healthcare disparities in a measure set will assist in understanding and addressing the unique needs of vulnerable populations, including the Medicare-Medicaid dual

eligible population. Healthcare disparities can be addressed by including direct measures (e.g., availability of translation services) or by stratifying measures on factors such as race, ethnicity, gender, rural location, or socioeconomic status to elicit potential opportunities to improve healthcare disparities.

PUBLIC COMMENT

Overall, commenters supported the characteristics of an ideal measure set and suggested some measure concepts that would support these characteristics. For example, one commenter recommended function and cognition measures to address vulnerable populations, while another highlighted the principles proposed in the NQF-commissioned paper Healthcare Disparities Measurement. Commenters also noted various applications (e.g., payment reform, public reporting) may use different measures to achieve the characteristics of the ideal measure set.

MAP "Working" Measure Selection Criteria

MAP is developing measure selection criteria as a tool to evaluate and recommend measure sets for specific public reporting and performance-based payment programs. Using measure selection criteria helps determine if a set of measures demonstrates the characteristics of an ideal measure set, as described by MAP's measure selection principles. More information on the development of the measure selection criteria can be found in Appendix 4.

1. Measures within the set meet NQF endorsement criteria

Measures within the set meet NQF endorsement criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. (Measures within the set that are not NQF endorsed but meet requirements for submission, including measures in widespread use and/or tested, may be submitted for expedited consideration).

Response option:

Yes/No: Measures within the measure set are NQF endorsed or meet requirements for NQF submission (including measures in widespread use and/or tested)*

2. Measure set adequately addresses each of the National Quality Strategy (NQS) priorities

Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities (Appendix 4B: Table 1):

Subcriterion 2.1	Safer care
Subcriterion 2.2	Effective care coordination
Subcriterion 2.3	Preventing and treating leading causes of mortality and morbidity
Subcriterion 2.4	Person- and family-centered care

* Individual endorsed measures may require additional discussion and may not be included in the set if there is evidence that implementing the measure results in undesirable unintended consequences.

Subcriterion 2.5 Supporting better health in communities

Subcriterion 2.6 Making care more affordable

Response option for each subcriterion:

Yes/No: NQS priority is adequately addressed in the measure set

3. Measure set adequately addresses high-impact conditions relevant to the program's intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)

Demonstrated by the measure set addressing Medicare high-impact conditions; child health conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program's intended population(s). (Appendix 4B: Table 2 for Medicare High-Impact Conditions and Child Health Conditions determined by NQF's Measure Prioritization Advisory Committee.)

Response option:

Yes/No: Measure set adequately addresses high-impact conditions relevant to the program's intended population(s)

4. Measure set promotes alignment with specific program attributes

Demonstrated by a measure set that is applicable to the intended provider(s), care setting(s), level(s) of analysis, and population(s) relevant to the program.

Response option:

Subcriterion 4.1 **Yes/No:** Measure set is applicable to the program's intended provider(s)

Subcriterion 4.2 **Yes/No:** Measure set is applicable to the program's intended care setting(s)

Subcriterion 4.3 **Yes/No:** Measure set is applicable to the program's intended level(s) of analysis

Subcriterion 4.4 **Yes/No:** Measure set is applicable to the program's population(s)

5. Measure set includes an appropriate mix of measure types

Demonstrated by a measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, and structural measures necessary for the specific program attributes.

Response option:

Subcriterion 5.1 **Yes/No:** Outcome measures are adequately represented in the set

Subcriterion 5.2 **Yes/No:** Process measures with a strong link to outcomes are adequately represented in the set

Subcriterion 5.3	**Yes/No:** Experience of care measures are adequately represented in the set (e.g. patient, family, caregiver)
Subcriterion 5.4	**Yes/No:** Cost/resource use/appropriateness measures are adequately represented in the set
Subcriterion 5.5	**Yes/No:** Structural measures and measures of access are represented in the set when appropriate

6. Measure set enables measurement across the patient-focused episode of care[20]

Demonstrated by assessment of the patient's trajectory across providers, settings, and time.

Response option:

Subcriterion 6.1	**Yes/No:** Measures within the set are applicable across relevant providers
Subcriterion 6.2	**Yes/No:** Measures within the set are applicable across relevant settings
Subcriterion 6.3	**Yes/No:** Measure set adequately measures patient care across time

7. Measure set includes considerations for healthcare disparities[21]

Demonstrated by a measure set that promotes equitable access and treatment by addressing race, ethnicity, socioeconomic status, language, gender, or age disparities. Measure set also can address populations at risk for healthcare disparities (e.g., patients with behavioral/mental illness).

Response option:

Subcriterion 7.1	**Yes/No:** Measure set includes measures that directly address healthcare disparities (e.g., interpreter services)
Subcriterion 7.2	**Yes/No:** Measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack)

8. Measure set promotes parsimony

Demonstrated by a measure set that supports efficient (i.e., minimum number of measures and the least burdensome) use of resources for data collection and reporting and supports multiple programs and measurement applications.

Response option:

Subcriterion 8.1	**Yes/No:** Measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome)
Subcriterion 8.2	**Yes/No:** Measure set can be used across multiple programs or applications (e.g., Meaningful Use, Physician Quality Reporting System [PQRS])

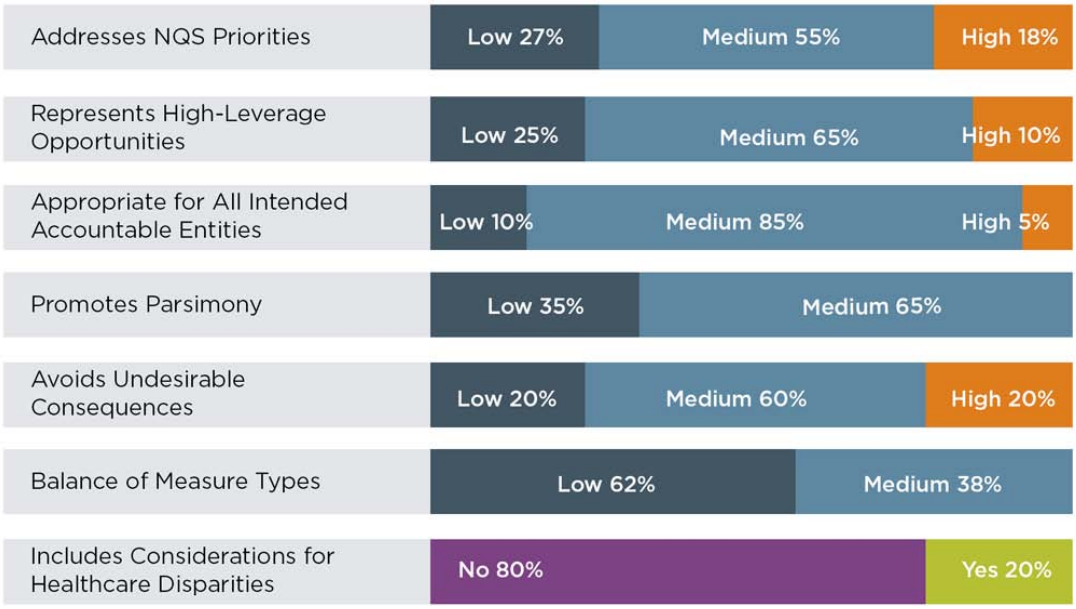
PUBLIC COMMENT

Commenters generally agreed with the elements of the measure selection criteria, though several commenters raised concerns that the binary ratings were too limiting and did not allow for a more nuanced assessment. Accordingly, some commenters suggested using a scaled rating system. MAP workgroups had initially piloted a version of the measure selection criteria that included a scaled rating system; however, based on these experiences, MAP adopted a binary rating system to potentially heighten contrast in responses. Commenters highlighted that the high-impact condition list only addresses two distinct populations, Medicare and child health, and recommended that consideration be given to priority conditions for non-Medicare adults. Finally, commenters questioned how MAP will address specific program attributes (criterion 4) while simultaneously promoting alignment.

Evaluating the CMS Value-Based Payment Modifier Proposed Quality Measure Set

The Clinician Workgroup evaluated the Physician Value-Based Payment Modifier[22] (Value-Modifier) quality measure set that was published in the 2012 Medicare Physician Fee Schedule proposed rule, using a version of the MAP measure selection criteria (see Appendix 4B for the draft criteria used by the Clinician Workgroup, which included a high/medium/low rating scale). The MAP Hospital and Post-Acute Care/Long-Term Care workgroups will be engaging in a similar exercise of applying measure selection criteria to relevant measure sets, which will inform the next iterations of the measure selection criteria. The Value-Modifier quality measure set was selected for review because it applies to both individual and group or team levels of analysis and because of its significance as the initial set of measures for the Value-Modifier program, which will be the first performance-based payment program to be applied to all clinicians participating in Medicare. With implementation of the Value-Modifier program set for 2015, CMS is required to establish an initial core set of quality measures by January 1, 2012. The core set will be augmented by incorporating additional quality and cost measures over time. The initial Value-Modifier proposed set includes measures from the PQRS and EHR-MU programs for 2012. A list of the proposed quality measures for the Value-Modifier can be found in Appendix 6.

The graph below reflects the extent to which the Clinician Workgroup found the proposed Value-Modifier measure set met each criterion in the draft measure selection criteria:



The workgroup members provided the following rationale in support of their responses:

Addresses NQS priorities

The Value-Modifier proposed measure set addresses most NQS priorities but does not necessarily cover the true intent of the priority. Whereas treatment and secondary prevention (i.e., clinical effectiveness) measures dominate the set, measures representing patient-centeredness are notably absent. Other NQS priorities—healthy living, care coordination, affordability, and safety—also are inadequately represented in the measure set.

Represents high-leverage opportunities

The measure set heavily addresses conditions that have been a focus for years, such as cardiovascular conditions and diabetes. Less consideration is given to other high-leverage opportunities for improvement, such as care coordination measures that cut across conditions and measures of patient experience.

Appropriate for all intended accountable entities

The measure set is appropriate for individual clinicians and groups or teams of clinicians, though focused on primary care. Team-based care, pediatrics (by design for this Medicare program), and most specialties are not addressed. The lack of measures related to specialties and team-based care may hinder shared accountability and understanding the performance of the entire system. Moreover, some measures may not have sufficient sample size to calculate rates for individual clinicians.

Promotes parsimony

The lack of measures that cross conditions and specialties works against parsimony for the set. Focus on systems of care beyond specific conditions would help achieve parsimony. The alignment with EHR-MU measures should be stronger to reduce duplication and data collection burden. Removing duplicative hypertension and lipid control measures from the set would further reduce burden.

Avoids undesirable consequences and healthcare disparities

Attention to downstream consequences is important, as all measures have the potential for undesirable consequences (e.g., adverse selection). However, the group found it difficult to assess the measure set for potential undesirable consequences and disparities, given the information in the proposed rule. Program implementation could include processes to monitor and detect undesirable consequences and disparities.

Balance of measure types

The measure set is dominated by process measures. Outcomes, experience, and cost have minimal or no representation. While not yet fully specified, cost information ultimately will be a part of the Value-Modifier. The addition of clinician-group CAHPS, which assesses patient experience, would greatly enhance the measure set.

Gaps in the Value-Modifier Proposed Quality Measure Set

MAP identified gaps in the measure set in the areas of patient preferences, patient experience, functional status, quality of life, care coordination, mental and behavioral health, cost, overuse, and appropriateness.

Data Platform Principles

Promoting standardized electronic data sources and health IT adoption has the potential to reduce data collection burden so clinicians can eventually collect data once and use it for multiple quality measurement purposes and programs. The following data platform principles recommend processes that will reduce quality measurement burden and facilitate health IT adoption. These principles are in concert with current efforts to define standardized data elements and distributed data models (e.g., NQF developed Quality Data Model,[23] PCAST Report,[24] ONC HITPC,[25] QASC[26]).

Principle #1:

A standardized measurement data collection and transmission process should be implemented across all federal programs, and ultimately all payers.

A unified process across all public and private payers would significantly reduce provider burden. Current technology uses multiple data formats that primarily enable point-to-point exchange of administrative information and limited clinical data.[27] Current performance measurement suffers from these disjointed data formats, which create an incomprehensive view of quality and duplicity of measurement activities. Health information exchanges are an example of a mechanism that promotes standardization.

Principle #2:

A library of all data elements needed for all measures (i.e., an inventory of all standardized data elements) should be defined and maintained. The data element library should be broad and deep enough to allow for innovation and flexibility in measurement.

Data elements should include all information needed to calculate measures, including data elements that could support risk adjustment and stratification. As no individual source of data is sufficient for quality measurement, the data elements may be generated from multiple sources of data including, but not limited to, claims, pharmacy data, lab or other clinical results, registries, or EHRs. Cost elements should be included in the library to better collect data on affordability of care. Ideally, EHR certification requirements would include capturing all of the data elements to calculate the measures in core sets.

Principle #3:

The data platform should support patient-centered measurement by enabling the collection of patient-reported data (both quantitative and qualitative) and the tracking of care across settings and over time.

Availability of patient-level data facilitates care coordination when every specialist or setting has access to accurate and up-to-date information.[28] Additionally, use of patient identifiers, along with mechanisms to ensure patient confidentiality, would enable patient-centered measurement across providers, payers, and time.

Principle #4:

Data collection should occur at the individual clinician level when analysis is appropriate at that level; data also should enable group-team-level analysis.

Patient-level data can be used for analysis at any level (e.g., individual clinician, group or team, system). Individual clinician level analysis can help consumers and clinicians make decisions in selecting clinicians, while group- or team-level analysis promotes team accountability. Further, consideration needs to be given to a variety of statistical and advanced analytical techniques that may enhance the methodological approaches to address the inherent difficulty in individual clinician level reporting, such as the small numbers issue.

Principle #5:

Data collection should occur during the course of care, when possible.

Data collection burden should be minimized by capturing data as a part of workflow, including clinical interactions that are outside of typical in-person clinical encounters (e.g., clinician phone conversations with patients). Data should be available for use in clinical decision making.

Principle #6:

Processes such as clinician review of data and feedback loops should be implemented.

Clinician review and feedback can help ensure data integrity, inform continuous improvement of data validity and measure specifications, and enhance clinician engagement and support for performance measurement efforts.

Principle #7:

Timely feedback of measurement results is imperative to support improvement of care by clinicians and more informed decisions by consumers.

Timeliness standards that minimize the lag time from data collection to analysis, and then to reporting, should be adopted. Ideally, feedback would be at the point of care to provide clinical decision support and enable real-time quality improvement.

In operationalizing these principles, multiple considerations will need to be taken into account. Clinicians are at various stages of readiness. Data collection will need to happen through existing and new sources while the infrastructure is developing. Difficult issues related to privacy, confidentiality, ownership, and access to data will need to be resolved, as will distribution of implementation costs.

PUBLIC COMMENT

Comments received expressed strong agreement with the data principles' emphasis on efficiency and standardization to reduce data collection burden and facilitate health IT adoption. Commenters emphasized the need for a data element library to standardize data elements for use within and across settings. Additionally, commenters suggested consideration be given to including structural data elements (e.g., team composition, staffing levels) within the data element library. A few commenters provided additional considerations for operationalizing the data platform principles, such as expressing concern for how the principles will translate into policy and debating the relative strengths and weaknesses of centralized and distributed data models.

Pathway for Improving Measure Applications

Core Sets

Currently, public and private programs may have similar aims (e.g., public reporting, encouraging health IT adoption, performance-based payment) yet use varying measure sets, introducing unnecessary burden, complexity, and costs for clinicians and others who are using performance information for various purposes. In addition to using cascading measures across multiple levels of analysis, identification of core sets or subsets for specific purposes is needed to enhance alignment across public and private sector programs. Core sets also can support community-based efforts to implement performance measurement programs by providing vetted measures as a starting point and creating opportunities to benchmark outside of their communities.

Priority Measure Gaps

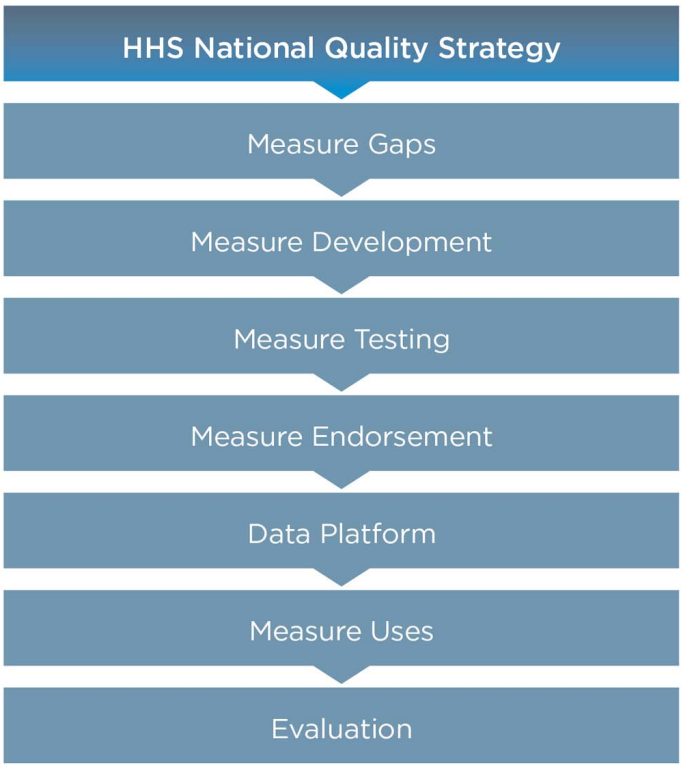
Considering the ideal measure set highlights gaps in the currently available quality measures. One priority gap area is measures that capture the patient's perspective by incorporating patient-reported data. Patient-reported measures include measures of experience, shared decision making about care goals, functional status and quality of life, and assessment of health risk. A second priority gap area is appropriateness of care measures, as misuse and overuse of interventions can significantly increase harm to patients and unnecessary cost. Appropriateness measures also can help to understand defensive medicine.

A third priority gap area is measures that are most relevant to vulnerable populations, such as Medicare-Medicaid dual eligible beneficiaries. These measures include the assessment of multiple comorbidities; physical and mental disabilities; and cultural competency, language, and health literacy. A fourth priority gap area is care coordination measures, specifically the coordination of care across multiple settings and providers and the adequacy of community supports. A fifth priority gap area is measures recognizing the team-based nature of quality care. Indices of high-performing teams include leadership, training, clinicians' capabilities, information sharing, and culture.

Coordinated Strategy for Gap Filling

It is imperative to address the measure gaps through concerted federal and private support for developing, testing, and endorsing measures. While the NQS should guide gap-filling priorities, a coordinated strategy is needed to ensure the most efficient path for addressing gaps. In the absence of a coordinated strategy, resources will be wasted and there will continue to be a proliferation of program-specific measures. Various federal and private sector entities have begun to coordinate measure development. For example, the Children's Health Insurance Program Reauthorization Act (CHIPRA) established the Pediatric Quality Measurement Program[29] to enhance and improve initial core measure sets through coordinated measure development conducted by grantees and contractors. Both de novo measure development and harvesting of innovative quality measures already tested and used within that private sector, but not yet NQF endorsed, should be pursued. The strategy for gap filling also must consider the funding needed to develop, test, endorse, and maintain measures. In recognition of the need to fund the quality measurement infrastructure, section 3013 of the Affordable Care Act authorized $75 million per year for measure development; however, no funding has been appropriated.

The steps below capture the critical pathway for improving measure applications:



Innovative approaches to care should be identified for possible broader application. For example, findings from the Patient-Centered Outcomes Research Institute (PCORI[30]) should be readily incorporated into measures. Additionally, the impact of measure application should be evaluated for continuous improvement.

Recognizing that individual clinicians and groups of clinicians are at various stages of infrastructure development, interim "ramping up" solutions are needed for public- and private-sector performance measurement programs. A practical approach would be to include measures that can be collected and reported with current data infrastructure capabilities now, while encouraging and supporting a progression toward collecting and reporting advanced measures. Measures that are easily calculable with administrative data or by survey data can be used now; measures that require clinical data and data from EHRs are becoming feasible; and measures of longitudinal, patient-centered care are on the horizon.

APPENDIX 1:
Measure Applications Partnership—Schedule of Deliverables

Task	Task Description	Deliverable	Timeline
15.1: Measures to be implemented through the Federal rulemaking process	Provide input to HHS on measures to be implemented through the Federal rulemaking process, based on an overview of the quality issues in hospital, clinician office, and post-acute/long-term care settings; the manner in which those problems could be improved; and the measures for encouraging improvement.	Final report containing the Coordinating Committee framework for decision making and proposed measures for specific programs	**Draft Report:** January 2012 **Final Report:** February 1, 2012
15.2A: Measures for use in the improvement of clinician performance	Provide input to HHS on a coordination strategy for clinician performance measurement across public programs.	Final report containing Coordinating Committee input	**Draft Report:** September 2011 **Final Report:** October 1, 2011
15.2B: Measures for use in quality reporting for post-acute and long term care programs	Provide input to HHS on a coordination strategy for performance measurement across post-acute care and long-term care programs.	Final report containing Coordinating Committee input	**Draft Report:** January 2012 **Final Report:** February 1, 2012
15.2C: Measures for use in quality reporting for PPS-exempt Cancer Hospitals	Provide input to HHS on the identification of measures for use in performance measurement for PPS-exempt cancer hospitals.	Final report containing Coordinating Committee input	**Draft Report:** May 2012 **Final Report:** June 1, 2012
15.2 D: Measures for use in quality reporting for hospice care	Provide input to HHS on the identification of measures for use in performance measurement for hospice programs and facilities.	Final report containing Coordinating Committee input	**Draft Report:** May 2012 **Final Report:** June 1, 2012

Task	Task Description	Deliverable	Timeline
15.3: Measures that address the quality issues identified for dual eligible beneficiaries	Provide input to HHS on identification of measures that address the quality issues for care provided to Medicare-Medicaid dual eligible beneficiaries.	Interim report from the Coordinating Committee containing a performance measurement framework for dual eligible beneficiaries	**Draft Interim Report:** September 2011 **Final Interim Report:** October 1, 2011
		Final report from the Coordinating Committee containing potential new performance measures to fill gaps in measurement for dual eligible beneficiaries	**Draft Report:** May 2012 **Final Report:** June 1, 2012
15.4: Measures to be used by public and private payers to reduce readmissions and healthcare-acquired conditions	Provide input to HHS on a coordination strategy for readmission and HAC measurement across public and private payers.	Final report containing Coordinating Committee input regarding a strategy for coordinating readmission and HAC measurement across payers	**Draft Report:** September 2011 **Final Report:** October 1, 2011

APPENDIX 2: Measure Applications Partnership Timeline

2011				
GROUP	**APR**	**MAY**	**JUN**	**JUL**
MAP Coordinating Committee Sets charges for all workgroups and centralizes input; provides pre-rulemaking input to CMS (15.1)	Web meeting	In-person meeting: big picture planning, charge for workgroups, framework **May 13** ALL MAP optional attendance at group web meeting	**June 21-22** In-person meeting, clinician coordination strategy, safety input, duals input, framework	**Aug 5** Web meeting
Clinician Workgroup Coordination of measures for physician performance improvement (15.2a), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13** ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 7-8** In-person meeting, framework, strategy for coordination of physician measurement, HACs & readmissions **June 30** Web meeting	**July 13-14** In-person meeting to finalize strategy and themes for report on physician performance measurement
Hospital Workgroup Measures for PPS-exempt cancer hospitals (15.2c), major input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13** ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework		
Ad Hoc Safety Workgroup HACs & readmissions (15.4)		**May 13** ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 9-10** In-person meeting with additional panelists, consider HACs & readmissions, framework	**July 11-12** In-person meeting, review other groups' work on HACs and readmissions to finalize report on HACs & readmissions
Dual Eligible Beneficiaries Workgroup Identify quality issues specific to duals and appropriate measures and measure concepts (15.3); some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13** ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 2-3** In-person meeting to discuss duals' quality issues, HACs & readmissions, framework	**July 6** Web meeting **July 25-26** In-person meeting to continue discussion of quality issues, finalize preliminary themes for report
PAC/LTC Workgroup Measures and coordination for Medicare PAC programs (15.2b), measures for hospice care (15.2d), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13** ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 28** 1 day in-person meeting, consider HACs & readmissions, framework	

Future dates are subject to change

2011					
AUG	SEP	OCT	NOV	MEASURES PUBLISHED BY CMS ON DECEMBER 1	DEC
Aug 17-18 In-person meeting, HACs and readmissions, finalize WG input for September reports, begin work on quality issues in 11 settings		**Oct 19** Web mtg	**Nov 1-2** In-person meeting, finalize PAC report, discuss quality issues in 11 settings		**Dec 8** ALL MAP groups on web meeting to distribute measures with homework
Aug 1 Web meeting **Aug 29-Sept 12** 2 week public comment period for physician strategy and HACs/ readmissions	**Sept 30th** REPORT 15.2a				**Dec 8** ALL MAP groups on web meeting to distribute measures with homework **Dec 12** 1 day in-person meeting to react to proposed measures
			Oct 12-13 In-person meeting to discuss hospital coordination framework and finalize measures for cancer hospitals		**Dec 8** ALL MAP groups on web meeting to distribute measures with homework **Dec 15** In-person meeting to react to proposed measures
Aug 29-Sept 12 2 week public comment period for physician strategy and HACs/ readmissions	**Sept 30th** REPORT 15.4				
	Sept 30th Interim REPORT 15.3	**Oct 3-Oct 24** 30 day public comment period	**Nov 15** 1 day in-person meeting, present public and HHS feedback, begin next phase		**Dec 8** ALL groups on 2 hr web meeting to distribute measures with homework **Dec 16** Web meeting to react to proposed measures
	Sep 8-9 In-person meeting to discuss measures for PAC and coordination strategy		**Nov 21, Nov 29, or Dec 2** 30 day public comment period on PAC report and public webinar to introduce public comment on PAC report		**Dec 8** ALL MAP groups on web meeting to distribute measures with homework **Dec 14** In-person meeting to react to proposed measures

Future dates are subject to change

2012						
GROUP	JAN	FEB	MAR	APR	MAY	JUNE
MAP Coordinating Committee Sets charges for all workgroups and centralizes input; provides pre-rulemaking input to CMS (15.1)	**Jan 5-6** In-person meeting to finalize pre-rulemaking input 1-2 week public comment period	**Feb 1st** REPORT 15.1 **Early Feb** - informational public webinar **Late Feb** - Web meeting	**Mid March** In-person meeting, finalize input on June reports			
Hospital Workgroup Measures for PPS-exempt cancer hospitals (15.2c), major input on HACs & readmissions (15.4), pre-rulemaking (15.1)				**Early April** Public webinar and 30 day comment period on draft report		**June 1st** REPORT 15.2c
Dual Eligible Beneficiaries Workgroup Identify quality issues specific to duals and appropriate measures and measure concepts (15.3); some input on HACs & readmissions (15.4), pre-rulemaking (15.1)	**Late Jan** Web meeting	**Mid Feb** In-person meeting to finalize measure concepts and themes for report		**Early April** Public webinar and 30 day comment period on draft duals report		**June 1st** REPORT 15.3
PAC/LTC Workgroup Measures and coordination for Medicare PAC programs (15.2b), measures for hospice care (15.2d), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**Feb 1st** REPORT 15.2b **Mid Feb** Web meeting **Late Feb** In-person meeting to finalize measures for hospice		**Early April** Public webinar and 30 day comment period on draft hospice report		**June 1st** REPORT 15.2d

Future dates are subject to change

APPENDIX 3A: Roster for the MAP Clinician Workgroup

CHAIR (VOTING)
Mark McClellan, MD, PhD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
American Academy of Family Physicians	Bruce Bagley, MD
American Academy of Nurse Practitioners	Mary Jo Goolsby, EdD, MSN, NP-C, CAE, FAANP
American Academy of Orthopaedic Surgeons	Douglas Burton, MD
American College of Cardiology	Paul Casale, MD, FACC
American College of Radiology	David Seidenwurm, MD
American Speech-Language-Hearing Association	Janet Brown, MA, CCC-SLP
Association of American Medical Colleges	Joanne Conroy, MD
Center for Patient Partnerships	Rachel Grob, PhD
CIGNA	Richard Salmon MD, PhD
Consumers' CHECKBOOK	Robert Krughoff, JD
Kaiser Permanente	Amy Compton-Phillips, MD
Minnesota Community Measurement	Beth Averbeck, MD
Physician Consortium for Performance Improvement	Mark Metersky, MD
The Alliance	Cheryl DeMars
Unite Here Health	Elizabeth Gilbertson, MS

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Disparities	Marshall Chin, MD, MPH, FACP
Population Health	Eugene Nelson, MPH, DSc
Shared Decision Making	Karen Sepucha, PhD
Team-Based Care	Ronald Stock, MD, MA
Health IT/ Patient Reported Outcome Measures	James Walker, MD, FACP
Measure Methodologist	Dolores Yanagihara, MPH

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Agency for Healthcare Research and Quality (AHRQ)	Darryl Gray, MD, ScD
Centers for Disease Control and Prevention (CDC)	Peter Briss, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Michael Rapp, MD, JD, FACEP
Health Resources and Services Administration (HRSA)	Ian Corbridge, MPH, RN
Office of the National Coordinator for HIT (ONC)	Thomas Tsang, MD, MPH
Veterans Health Administration (VHA)	Joseph Francis, MD, MPH

MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

APPENDIX 3B: Roster for the MAP Coordinating Committee

CO-CHAIRS (VOTING)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Judith Cahill
AdvaMed	Michael Mussallem
AFL-CIO	Gerald Shea
America's Health Insurance Plans	Aparna Higgins, MA
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Consumers Union	Steven Findlay, MPH
Federation of American Hospitals	Chip N. Kahn
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Association of Medicaid Directors	Foster Gesten, MD
National Partnership for Women and Families	Christine Bechtel, MA
Pacific Business Group on Health	William Kramer, MBA

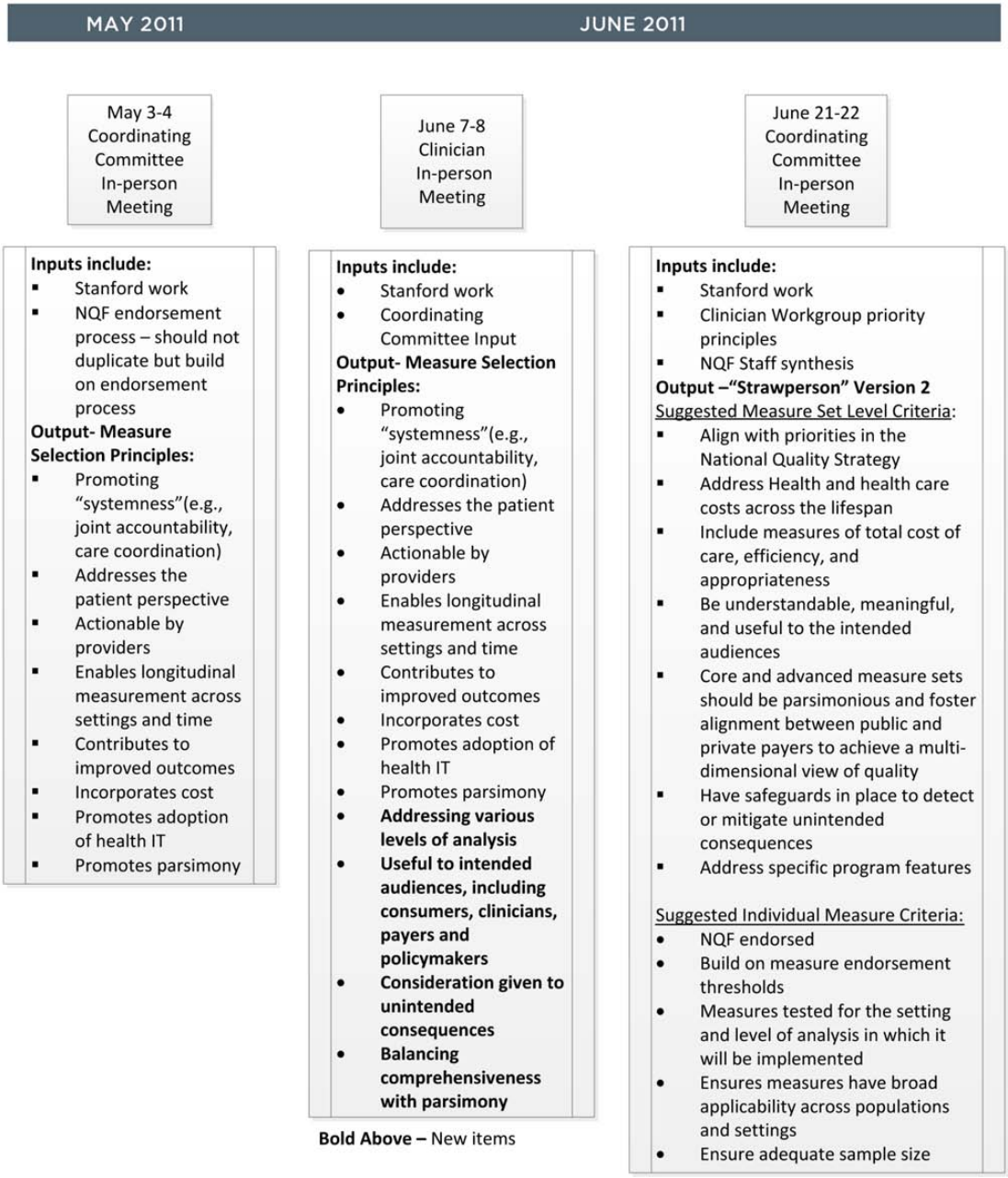
EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Joseph Betancourt, MD, MPH
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD
Post-Acute Care/ Home Health/ Hospice	Carol Raphael, MPA

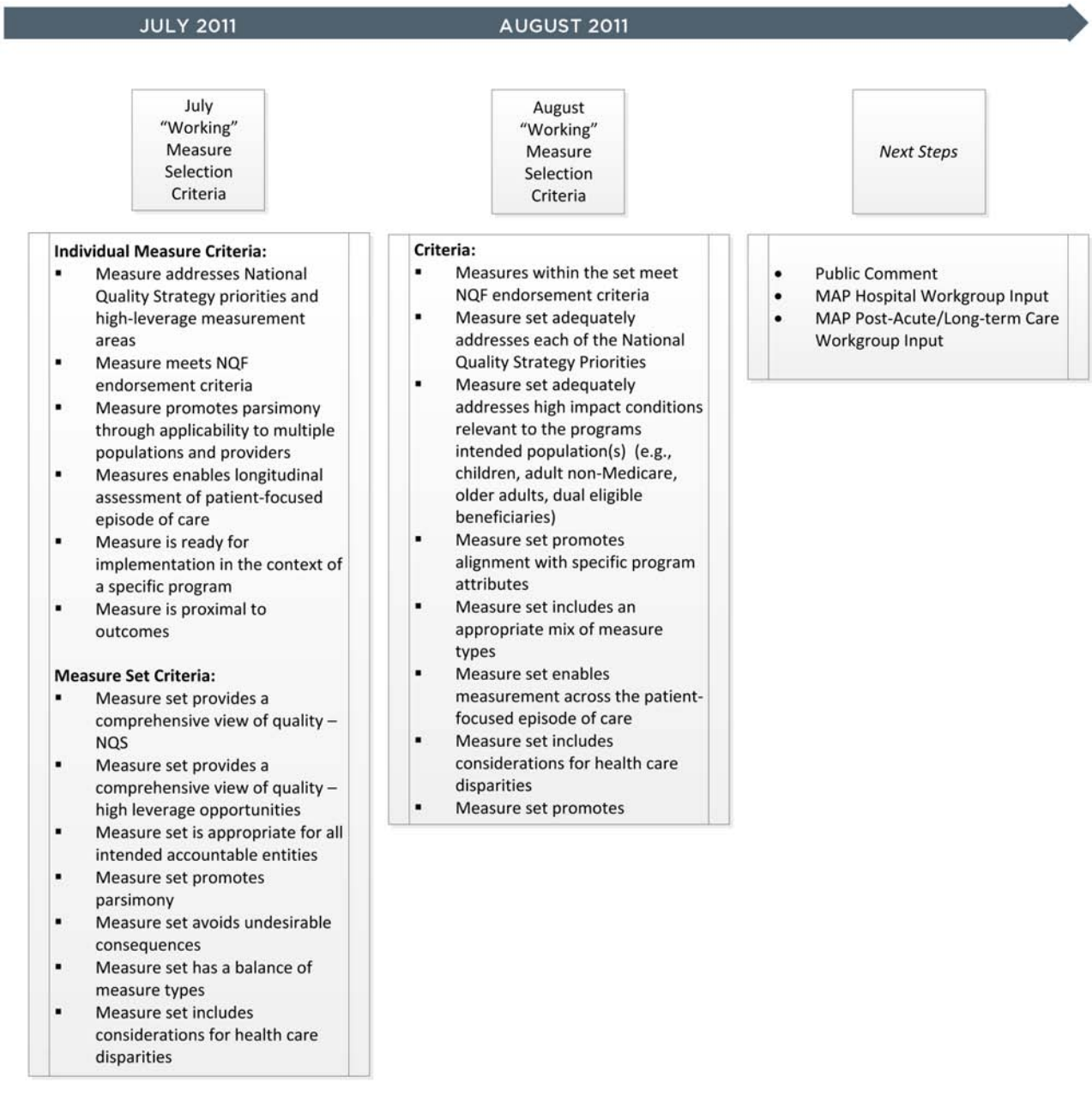
FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD MSc
Health Resources and Services Administration (HRSA)	Victor Freeman, MD, MPP
Office of Personnel Management/FEHBP (OPM)	John O'Brien
Office of the National Coordinator for HIT (ONC)	Joshua Seidman

ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING)	REPRESENTATIVES
American Board of Medical Specialties	Christine Cassel, MD
National Committee for Quality Assurance	Peggy O'Kane, MPH
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

APPENDIX 4A:
MAP Measure Selection Criteria Development Timeline

Purpose: To develop measure selection criteria for public reporting, payment programs, and program monitoring and evaluation




JULY 2011
AUGUST 2011
July "Working" Measure Selection Criteria
August "Working" Measure Selection Criteria
Next Steps
Individual Measure Criteria:
Measure addresses National Quality Strategy priorities and high-leverage measurement areas
Measure meets NQF endorsement criteria
Measure promotes parsimony through applicability to multiple populations and providers
Measures enables longitudinal assessment of patient-focused episode of care
Measure is ready for implementation in the context of a specific program
Measure is proximal to outcomes
Measure Set Criteria:
Measure set provides a comprehensive view of quality – NQS
Measure set provides a comprehensive view of quality – high leverage opportunities
Measure set is appropriate for all intended accountable entities
Measure set promotes parsimony
Measure set avoids undesirable consequences
Measure set has a balance of measure types
Measure set includes considerations for health care disparities
Criteria:
Measures within the set meet NQF endorsement criteria
Measure set adequately addresses each of the National Quality Strategy Priorities
Measure set adequately addresses high impact conditions relevant to the programs intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)
Measure set promotes alignment with specific program attributes
Measure set includes an appropriate mix of measure types
Measure set enables measurement across the patient-focused episode of care
Measure set includes considerations for health care disparities
Measure set promotes
Public Comment
MAP Hospital Workgroup Input
MAP Post-Acute/Long-term Care Workgroup Input

APPENDIX 4B:
MAP "Working" Measure Selection Criteria

Rating Scale for Individual Measure Review—contribution to a comprehensive measure set for accountability

1. Measure addresses National Quality Strategy priorities and high-leverage measurement areas

Demonstrated by addressing the priorities in National Quality Strategy (Table 1) and high-leverage measurement areas which address conditions of the greatest cost, prevalence, burden and potential improvement for patients and the population (Table 2: High Impact Conditions represents high-leverage measurement areas for Medicare and children as determined by NQF's Measure Prioritization Advisory Committee)

Rating:

Low: measure does not address any of the priorities in the NQS nor represent a high-leverage measurement opportunity

Medium: measure represents one of the priorities of the NQS or a high-leverage measurement opportunity

High: measure represents multiple (more than one) priorities of the NQS and a high-leverage measurement opportunity

2. Measure meets NQF endorsement criteria

Measures meeting NQF endorsement criteria are determined to be important to measure and report, have scientifically acceptable measure properties, usable, and feasible.

Rating:

Low: measure development required or measure under development

Medium: measure development completed, measure not submitted to NQF or in pipeline for endorsement

High: measure is endorsed by NQF

3. Measure promotes parsimony through applicability to multiple populations and providers

Demonstrated by applicability to multiple types of providers, levels of analysis, care settings, and conditions

Rating:

Low: measure is limited to one subset of providers, levels of analysis, care settings, or conditions

Medium: measure is applicable to a narrow subset of providers, levels of analysis, care settings or conditions

High: measure is applicable to multiple types of providers, levels of analysis, care settings, or conditions

4. Measure enables longitudinal assessment of patient-focused episode of care

Demonstrated by assessing care across time or with the patient as the unit of analysis (across settings and time)

Rating:

Low: measure is focused on a narrow phase of an entire episode of care (e.g., point in time, single encounter, acute care stay)

Medium: measure provides an assessment of care across some settings of care or time

High: measure provides an assessment of care across a broad range of settings of care and time

5. Measure is ready for implementation in the context of a specific program

Demonstrated by prior operational use in the specific context or specified and tested for the setting and level of analysis needed for the specific program

Rating:

Low: measure has not been in use, nor is it specified and tested for the setting and level of analysis needed for the program

Medium: measure is specified and tested for the setting and level of analysis needed for the program

High: measure has been tested and is in operational use in the specific context or specified for the setting and level of analysis needed for the specific program

6. Measures is proximal to outcomes

Demonstrated by focusing on outcomes, composites of all necessary interventions, and processes most proximal to desired outcomes, or with strong evidence chain from distal processes to desired outcomes

Rating:

Low: Measures a distal structure or process that requires additional steps to influence desired outcomes (e.g., the frequency of assessing a lab value)

Medium: Process proximal to desired outcome (e.g., administering flu vaccine); or strong evidence chain for links to desired outcome (e.g., mammography screening)

High: Outcome or composite of all required interventions

Rating Scale for Measure Set Review—final check review of the entire set as a whole

1. Measure set provides a comprehensive view of quality—NQS

Demonstrated by measures as a set addressing all of the NQS priorities

Rating:

Low: measure set addresses less than 1-2 of the NQS priorities

Medium: measure set addresses at least 3-4 of the NQF priorities

High: measure set addresses 5-6 of the NQS priorities

2. Measure set provides a comprehensive view of quality—high-leverage opportunities

Demonstrated by measures as set addressing high-leverage opportunities identified for the intended accountable entities

Rating:

Low: measure set addresses a few of the identified high-leverage opportunities

Medium: measure set addresses some of the identified high-leverage opportunities

High: measure set addresses most of the identified high-leverage opportunities

3. Measure set is appropriate for all intended accountable entities

Demonstrated by a measure set that is applicable to the intended providers, care settings, and levels of analysis relevant to the program

Rating:

Low: measure set is limited to a few of the intended providers, care settings, and levels of analysis

Medium: measure set is applicable to some of the intended providers, care settings, and levels of analysis

High: measure set is applicable to all of the intended providers, care settings, and levels of analysis

4. Measure set promotes parsimony

Demonstrated by a measure set that supports efficient use of resources for data collection, measurement, and reporting through the smallest number of measures needed to address the National Quality Strategy, high-leverage opportunities, and all intended accountable entities

Rating:

Low: measure set contains an excessive number of measures to cover the relevant NQS, high-leverage opportunities, or intended accountable entities

Medium: measure set demonstrates moderately efficient use of measures in covering the relevant NQS, high-leverage opportunities, or intended accountable entities

High: measure set demonstrates highly efficient use of measures in covering the relevant NQS, high-leverage opportunities, or intended accountable entities

Measure set avoids undesirable consequences

Demonstrated by a measure set in which the measures avoid undesirable consequences or have a method for detecting undesirable consequences

Rating:

Low: significant concern for unintended undesirable consequences and detection would require additional data collection

Medium: some concern for unintended undesirable consequences which could be detected with additional analysis of existing data (e.g., analysis of patient case mix); or incentives for potential undesirable consequences are balanced within the set of measures (e.g., incentive to drop caring for certain types of patients balanced with incentives to provide care for that same group of patients)

High: little concern for unintended undesirable consequences; or the set includes measures to detect potential unintended consequences

Measure set has a balance of measure types

Demonstrated by a measure set that has a balance of clinical process, outcomes, patient experience, and cost measures

Rating:

Low: measure set has predominately one type of measure

Medium: measure set includes two or three types of measures

High: measure set address all four types of measures

Measure set includes considerations for health care disparities

A measure set can address this category by doing one of the following:

Including measures that directly address health care disparities (e.g. health literacy)

Including measures that have been tested for stratification (by race, ethnicity, SES)at the level of analysis appropriate for the program

Table 1: National Quality Strategy Priorities

• Making care safer by reducing harm caused in the delivery of care.
• Ensuring that each person and family is engaged as partners in their care.
• Promoting effective communication and coordination of care.
• Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
• Working with communities to promote wide use of best practices to enable healthy living.
• Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

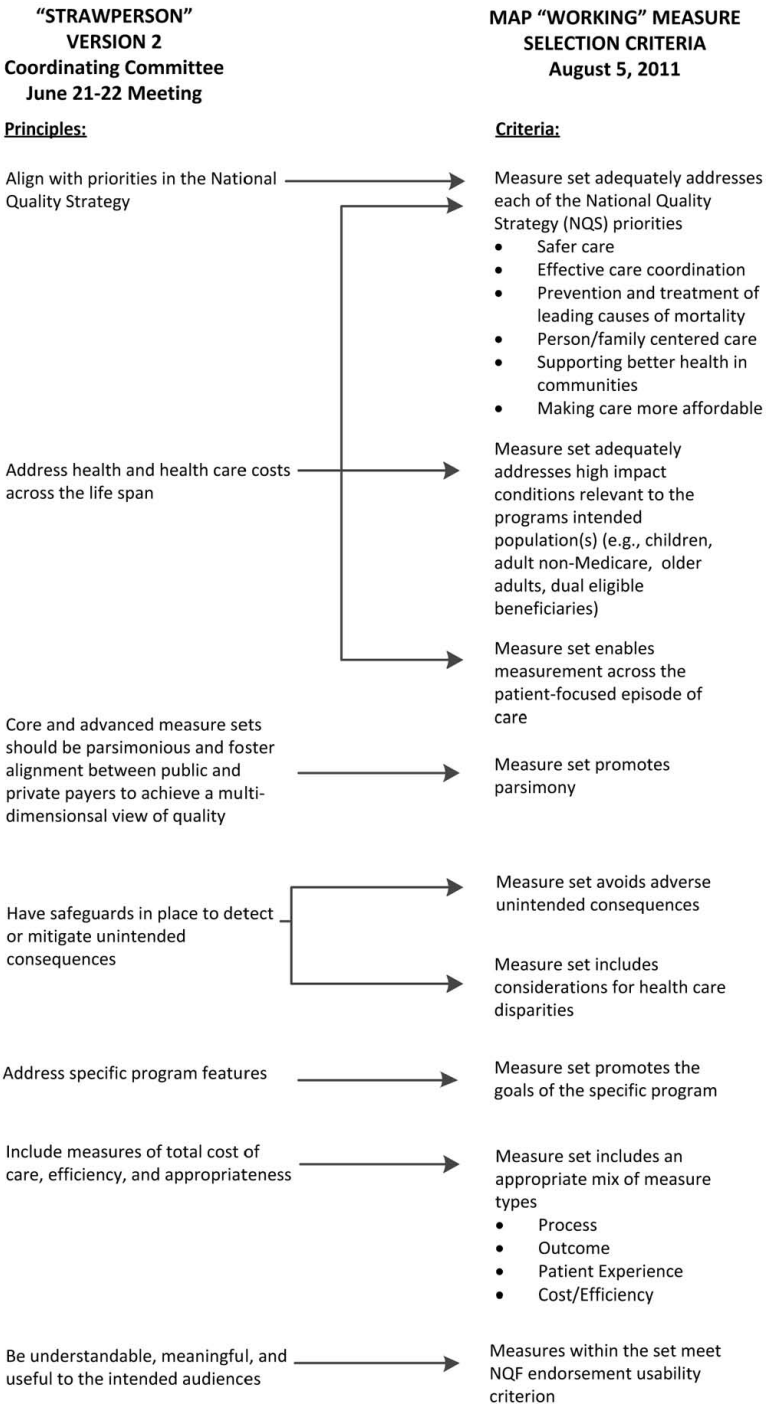
Table 2: High-Impact Conditions

Medicare Conditions
1. Major Depression
2. Congestive Heart Failure
3. Ischemic Heart Disease
4. Diabetes
5. Stroke/Transient Ischemic Attack
6. Alzheimer's Disease
7. Breast Cancer
8. Chronic Obstructive Pulmonary Disease
9. Acute Myocardial Infarction
10. Colorectal Cancer
11. Hip/Pelvic Fracture
12. Chronic Renal Disease
13. Prostate Cancer
14. Rheumatoid Arthritis/Osteoarthritis
15. Atrial Fibrillation
16. Lung Cancer
17. Cataract
18. Osteoporosis
19. Glaucoma
20. Endometrial Cancer

Child Health Conditions and Risks
Tobacco Use
Overweight/Obese (≥85th percentile BMI for age)
Risk of Developmental Delays or Behavioral Problems
Oral Health
Diabetes
Asthma
Depression
Behavior or Conduct Problems
Chronic Ear Infections (3 or more in the past year)
Autism, Asperger's, PDD, ASD
Developmental Delay (diag.)
Environmental Allergies (hay fever, respiratory or skin allergies)
Learning Disability
Anxiety Problems
ADD/ADHD
Vision Problems not Corrected by Glasses
Bone, Joint, or Muscle Problems
Migraine Headaches
Food or Digestive Allergy
Hearing Problems
Stuttering, Stammering, or Other Speech Problems
Brain Injury or Concussion
Epilepsy or Seizure Disorder
Tourette Syndrome

APPENDIX 4C:
Principles Informing MAP Measure Selection Criteria

Purpose: To develop measure selection criteria for public reporting; payment programs; and program monitoring and evaluation



APPENDIX 4D:
Clinician Workgroup Experience Using the Measure Selection Criteria

The Clinician Workgroup evaluated the proposed measure set for the Physician Value-Based Payment Modifier (Value-Modifier), which was published in the 2012 Medicare Physician Fee Schedule Proposed Rule[1]. The Value-Modifier program was selected for review because it applies to both individual and group levels of analysis and because of its significance as the initial set of measures for the value-modifier program, which will be the first performance-based payment program to be applied to all physicians participating in Medicare.

For this exercise, the Clinician Workgroup used the draft set-level measure selection criteria below that were derived from the Coordinating Committee measure selection criteria principles and the Workgroup's characteristics of an ideal measure set:

1. **Measure set provides a comprehensive view of quality**—assesses the extent to which a measure set **addresses all of the National Quality Strategy (NQS) priorities** (effective communication and care coordination, person- and family-centered care, making quality care more affordable, enable healthy living, make care safer, prevention and treatment of leading causes of mortality)
2. **Measure set provides a comprehensive view of quality**—assesses the extent to which a measure set **addresses high-leverage opportunities identified for the intended accountable entities**
3. Measure set is appropriate for all intended accountable entities—assesses the extent to which a measure set is **applicable to the intended providers, care settings, and levels of analysis relevant to the program**
4. **Measure set promotes parsimony**—assesses the extent to which a measure set supports efficient use of resources for data collection, measurement, and reporting through the **smallest number of measures needed** to address the NQS, high-leverage opportunities, and all intended accountable entities
5. **Measure set avoids undesirable consequences**—assesses the extent to which a measure set **avoids undesirable consequences or has a method for detecting** undesirable consequences
6. **Measure set has an appropriate representation of measure types**—assesses the extent to which a measure set **includes clinical process, outcomes, patient experience, and cost measures**
7. **Measure set includes considerations for healthcare disparities**—assesses if a measure set **either includes measures that directly address healthcare disparities or includes measures that have been tested for stratification** (by race, ethnicity, socioeconomic status) at the level of analysis appropriate for the program

The Clinician Workgroup members found the set-level measure selection criteria to be a useful qualitative tool to iteratively assess the adequacy of a measure set for a specific purpose, though the criteria would ideally better ascertain if a set contains the best or right measures to address a

given criterion. The Clinician Workgroup provided feedback on their experience using each individual criterion:

- Nearly all measures can loosely address some aspect of the NQS priorities, but it is difficult to determine if a measure set addresses the true goals and intent of the NQS priorities.
- High-leverage should be defined beyond high-impact conditions to capture opportunities for improvement that cross conditions.
- Evaluating if a measure set is appropriate for all intended accountable entities was viewed as important by the group. However, simply including measures that are applicable to all intended accountable entities does not necessarily encourage collaboration and coordination across the system.
- Determining if a measure set meets all of the other criteria in a parsimonious manner was challenging for the group to assess. Evaluation of whether the measure set contains the minimum number of measures necessary requires an understanding of the universe of available measures.
- While it is important to consider if a measure set avoids undesirable consequences, it is difficult to predict as all measures have some potential for unintended consequences. Undesirable consequences may best be addressed through programmatic features, such as monitoring and mitigation strategies.
- Representation of process, outcomes, experience, and cost measures is important. However, appropriate use for the specific program, rather than equal representation of measure types, is the goal. For example, a single experience of care measure may be adequate for a measure set.
- Addressing healthcare disparities should be a priority. This criterion is difficult to assess as it depends on adequacy of risk adjustment or use of stratification, which may not be feasible at the individual clinician level due to sample size.

1 Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS). *Physician Fee Schedule.* Baltimore, MD: CMS, 2011. Available at: https://www.cms.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=descending&itemID=CMS1249142. Last accessed August 2011.

APPENDIX 5: Overview of Federal Clinician Programs

Federal Programs	Physician Quality Reporting System (PQRS)	Electronic Health Records (EHR)—Meaningful Use	Physician Feedback/ Value Modifier	Physician Compare	E-Prescribing Incentive Program
Description/Purpose of Program	PQRS provides an incentive payment to eligible professionals who select among 240 measures to report.	The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals for the "meaningful use" of certified EHR technology. To qualify for an incentive payment under the Medicaid EHR Incentive Program, an eligible professional must meet one of the following criteria: • Have a minimum 30% Medicaid patient volume* • Have a minimum 20% Medicaid patient volume, and is a pediatrician* • Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals	The Physician Resource Use Measurement and Reporting (RUR) Program, or the Physician Feedback/ Value Modifier Program, uses claims data to create confidential reports measuring the resource use and quality of care involved in furnishing care. These feedback reports are provided to medical professionals and medical practice groups.	The Physician Compare Web site serves as a healthcare professional directory on Medicare.gov. The website is updated on a monthly basis. Physician compare can begin incorporating quality reporting in 2013, based on performance starting 2012.	The E-Prescribing Incentive Program provides incentive payments to eligible professionals who are successful electronic prescribers. Eligible professionals report on an electronic prescribing quality measure.

Federal Programs	Physician Quality Reporting System (PQRS)	Electronic Health Records (EHR)—Meaningful Use	Physician Feedback/ Value Modifier	Physician Compare	E-Prescribing Incentive Program
Types of Clinicians Participating	Physicians (medicine, osteopathy, podiatric med, optometry, surgery, oral surgery, dental med, chiropractic) – same categories as Medicare EHR/MU and E-Prescribe **Practitioners including:** Physician Assistant Nurse Practitioner Clinical Nurse Specialist Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant) Certified Nurse Midwife Clinical Social Worker Clinical Psychologist Registered Dietician Nutrition Professional Audiologists Same categories as e-Prescribe but not HER/MU Therapists (Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist) – same categories as e-Prescribe but not EHR/MU	**FOR MEDICARE** Physicians (medicine, osteopathy, podiatric med, optometry, dental surgery/ medicine, chiropractor) – same as PQRS and e-Prescribe **FOR MEDICAID** • Physicians (primarily doctors of medicine and doctors of osteopathy • Nurse practitioner • Dentist • Certified nurse-midwife • Physician assistant practicing in a Federally qualified health center (FQHC) led by a physician assistant or a rural health clinic (RHC), that is so led by a physician assistant.	The 2010 pilot included physicians and medical professional groups.	Clinicians participating in PQRS	Medicare physicians (same categories as PQRS and Medicare EHR/MU) Practitioners (same categories as PQRS but not EHR/MU) Therapists (same categories as PQRS but not EHR/MU) Participation is further limited by whether or not the professional has prescribing authority.

Federal Programs	Physician Quality Reporting System (PQRS)	Electronic Health Records (EHR)—Meaningful Use	Physician Feedback/ Value Modifier	Physician Compare	E-Prescribing Incentive Program
Data Reporting/Data Submission (and timing)	Physicians are considered to have "satisfactorily reported" if they meet requirements for number and type of measures, sufficient number/percent of patients, and timeliness of submission. **Individual physicians:** Claims based reporting of individual measures (Select 3 measures from 240 possible, but note that some measures are restricted to certain reporting mechanisms) Registry based reporting of individual measures (Select 3 measures from 240 possible, but see above note – not all 240 available for all reporting mechanisms) Claims based reporting of one measure group Registry based reporting of one measure group 6-month and 12-month reporting period option EHR-based reporting for a 12-month period (Select 3 measures) **Group practice:** For groups with 200 or more eligible professionals, report 26 measures. For groups with 2-199 eligible professionals, report 1-4 measure groups and 3-6 individual measures (# of measures/measure groups depends on size of group) Measure rates are calculated by CMS or registries based upon data submitted by the eligible professional or group practice	Using CMS' web-based Registration and Attestation System, providers complete numerators and denominators for the meaningful use objectives and clinical quality measures, exclusions to specific objectives, and legally attest to the successful demonstration of meaningful use. To qualify for incentive payments, meaningful use requirements must be met in the following ways: Medicare EHR Incentive Program—demonstrate meaningful use of certified EHR technology every year of participation. Medicaid EHR Incentive Program—Eligible professionals may qualify for incentive payments if they adopt, implement, upgrade OR demonstrate meaningful use in their first year of participation. They must successfully demonstrate meaningful use for subsequent participation years. For eligible professionals, there are a total of 25 meaningful use objectives. To qualify for an incentive payment, 20 of these 25 objectives must be met, including: 15 required core objectives & 5 menu set objectives that may be chosen from a list of 10. Reporting Period: The reporting period for the EHR Incentive program using a certified EHR is any continuous 90 day period during the first payment year. EPs must report on 6 total measures from the table of 44 clinical quality measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures. A maximum of 9 measures would be reported if the EP needed to attest to the 3 required core, the three alternate core, and the 3 additional measures. Dates/Timelines: April 18, 2011 - Medicare EHR Incentive Program began February 29, 2012 - last day for EPs to register and attest to receive an Incentive Payment for CY 2011 2016 – last year to receive a Medicare EHR Incentive Payment 2021 – last year to receive a Medicaid EHR Incentive Payment	CMS uses claims data to create confidential reports gauging the resources and quality of care utilized in furnishing care to Medicare beneficiaries.	CMS is populating Physician Compare with information from eligible professionals who satisfactorily reported PQRS measures and for successful e-prescribers.	The program ends in 2014, but physicians will receive a penalty for not e-prescribing beginning in 2012. (see incentive structure below for more information) 2011eRX Incentive Program For incentive payment purposes, eligible professionals may submit information: To CMS on their Medicare Part B claims, To a qualified registry, To CMS via a qualified electronic health record (EHR) product. For purposes of the 2012 payment adjustment, eligible professionals must submit information on their Medicare Part B claims.

Federal Programs	Physician Quality Reporting System (PQRS)	Electronic Health Records (EHR)—Meaningful Use	Physician Feedback/ Value Modifier	Physician Compare	E-Prescribing Incentive Program
Data Sources	• Claims • Registry • EHR • GPRO tool	EHR	Claims data	N/A	Claims data (2009); Registry (2010); EHR (2010)
Performance Reports to Clinicians (and timing)	Feedback reports are provided to physicians by CMS the summer after the reporting period option which they chose. CMS provides a PQRS feedback report to every eligible professional that attempted to report a PQRS measures at least once during the reporting period regardless of whether an incentive payment was earned.	N/A Once providers complete a successful online attestation submission by entering their data into the Medicare EHR Incentive Program Registration and Attestation System, they will see an immediate summary of their attestation and whether or not it was successful. For the Medicaid EHR Incentive Program, providers will follow a similar process using their state's Attestation System.	Feedback reports include data such as the following: • beneficiary characteristics • practice site • performance measurement results for physician quality • patient chronic conditions • PQRS participation • medical practice group • non-risk adjusted cost measures • risk adjustment model • cost of service categories • utilization statistics • peer groups • benchmarks	N/A	The eRx incentive payments and the eRx feedback reports are issued through separate processes. eRx Incentive Program feedback report availability is not based on whether or not an incentive payment was earned. Feedback reports will be provided to every eligible professional submitting Medicare Part B PFS claims who reported the eRx measure a minimum of once during the reporting period.

Federal Programs	Physician Quality Reporting System (PQRS)	Electronic Health Records (EHR)—Meaningful Use	Physician Feedback/ Value Modifier	Physician Compare	E-Prescribing Incentive Program
Public Reporting (and timing)	None at this time. CMS is required to establish a plan for making information available through the Physician Compare Web site by January 1, 2013.	N/A	N/A	The Physician Compare Web site contains information about medical professionals who satisfactorily participated in the PQRS; however, it does not yet include physician and eligible professional performance information. CMS is required to establish a plan for making information available on physician performance through the Physician Compare by January 1, 2013. The reporting period can begin on or after January 1, 2012.	N/A

Federal Programs	Physician Quality Reporting System (PQRS)	Electronic Health Records (EHR)—Meaningful Use	Physician Feedback/ Value Modifier	Physician Compare	E-Prescribing Incentive Program
Incentive Structure	Incentives are in place through 2014 for reporting; penalties for not reporting begin in 2015. According to the ACA, the incentive payment amount for the 2011 reporting period will be 1.0 percent of the total estimated allowed charges. For the periods from 2012 through 2014, the incentive payment will be 0.5 percent. Starting in 2015, eligible professionals who do not satisfactorily report for the reporting period will be subject to a payment adjustment or penalty, by which the PFS amount will decrease by 1.5 percent for 2015 and 2.0 percent for 2016 and every year thereafter.	Medicare EHR Incentive Program: Participation started January 2011. Attestation opened in April, 2011 and Payments began in May 2011. Eligible professionals must begin participation by 2012 in order to receive the maximum incentive payment. Medicare eligible professionals that do not successfully demonstrate meaningful use will have a payment adjustment in their Medicare reimbursement, beginning 2015 and beyond. Incentive payments for the Medicare EHR Incentive Program will be issued within four to six weeks of providers successfully submitting their attestation. Medicaid EHR Incentive Program: States and territories will offer the incentive program on a voluntary basis, which may begin as early as 2011. Payments will be paid by the states and are expected to begin in 2011. There are no payment adjustments to Medicaid reimbursement if a provider does meet meaningful use beginning 2015. Incentives for the Medicaid EHR Incentive Program will be issued within six weeks of providers successfully submitting their attestation. NOTE: PARTICIPATION MANDATORY UNDER MEDICARE BUT VOLUNTARY UNDER MEDICAID	CMS is required to include cost and quality data when calculating payments for physicians by applying a value-based payment modifier under the Medicare Physician Fee Schedule (MPFS), which will begin in 2015. By 2017, the value-based payment modifier will be applied to the majority of medical professionals, and ultimately it will be employed for the value-based payment modifier.	N/A	2011 and 2012 eRX Incentive Program The incentive will amount to 1.0% of the total estimated allowed charges submitted not later than 2 months after the end of the reporting period. (aligns with PQRS for 2011 but not for 2012) 2013 eRX Incentive Program The incentive amount will be reduced to 0.5%, and starting in 2012, eligible professionals who are not successful electronic prescribers may be subject to a payment adjustment or penalty. The PFS amount shall be reduced by 1.0% for 2012, 1.5% for 2013, and 2.0% for 2014. (note: penalties are incurred 3 years sooner than with PQRS)

APPENDIX 6:
Value-Based Payment Modifier Proposed Quality Measures

NQF Measure Number and Status	Measure Name
0028 Endorsed	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
0001 Endorsed	Asthma: Asthma Assessment
0002 Endorsed	Appropriate Testing for Children with Pharyngitis
0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement
0012 Endorsed	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
0013 Endorsed	Hypertension: Blood Pressure Measurement
0014 Endorsed	Prenatal Care: Anti-D Immune Globulin
0017 Endorsed	Hypertension (HTN): Plan of Care
0018 Endorsed	Controlling High Blood Pressure
0024 Endorsed	Weight Assessment and Counseling for Children and Adolescents
0031 Endorsed	Preventive Care and Screening: Screening Mammography
0032 Endorsed	Cervical Cancer Screening
0033 Endorsed	Chlamydia Screening for Women
0034 Endorsed	Preventive Care and Screening: Colorectal Cancer Screening
0036 Endorsed	Use of Appropriate Medications for Asthma
0038 Endorsed	Childhood Immunization Status
0041 Endorsed	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
0043 Endorsed	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older
0045 Endorsed	Osteoporosis:Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older
0047 Endorsed	Asthma: Pharmacologic Therapy
0052 Endorsed	Low Back Pain: Use of Imaging Studies
0055 Endorsed	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
0056 Endorsed	Diabetes Mellitus: Foot Exam
0059 Endorsed	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
0061 Endorsed	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus

0062 Endorsed	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
0064 Endorsed	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
0066 Endorsed	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)
0067 Endorsed	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
0068 Endorsed	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
0070 Endorsed	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
0073 Endorsed	Ischemic Vascular Disease (IVD): Blood Pressure Management Control
0074 Endorsed	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
0075 Endorsed	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control < 100 mg/dl
0079 Endorsed	Heart Failure: Left Ventricular Function (LVF) Assessment
0081 Endorsed	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
0082 Endorsed(to be retired)	Heart Failure: Patient Education
0083 Endorsed	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
0084 Endorsed (to be retired)	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
0085 Endorsed (to be retired)	Heart Failure: Weight Measurement
0086 Endorsed	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
0088 Endorsed	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
0089 Endorsed	Diabetic Retionpathy: Communication with the Physician Managing On-going Diabetes Care
0091 Endorsed	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation
0097 Endorsed	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility
0101 Endorsed	Falls: Screening for Fall Risk
0102 Endorsed	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy
0105 Endorsed	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD
0385 Endorsed	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

0387 Endorsed	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer
0389 Endorsed	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients
0421 Endorsed	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up
0555 Endorsed	Monthly INR for Beneficiaries on Warfarin
0575 Endorsed	Diabetes: HbA1c Control < 8%
0729 Endorsed	Diabetes Mellitus: Tobacoo Non-Use
0729 Endorsed	Diabetes: Aspirin Use
NA1	Heart Failure: Left Ventricular Function (LVF) Testing
NA2	30 Day Post Discharge Physician Visit
NA5	Coronary Artery Disease (CAD): LDL level < 100 mg/dl
NA88	Chronic obstructive pulmonary Disease (COPD): smoking cessation counseling received
NA89	Proportion of adults 18 years and older who have had their BP measured within the preceding 2 years
NA90	Preventive Care: Cholesterol-LDL test performed
Note: NA denotes measures that have not been submitted to NQF.	

APPENDIX 7:
Table of Public Comments

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	**Academy of Managed Care Pharmacy**	**Judith Cahill**	There is substantial constructive guidance in the Coordination Strategy for Clinician Performance Measures. However, it is unclear how this information will be useful to the Department of Health and Human Services which is looking to identify specific measures to incorporate across the board in a national measure set. The missing piece seems to be MAP identifying specific measures that meet the MAP recommended criteria agreed upon, or, singling out gaps if no specific measures are available.'
General Comments	**American Board of Internal Medicine**	**Christine K Cassel**	On behalf of the American Board of Internal Medicine, I appreciate the opportunity to comment on the Measures Application Partnership (MAP) report, "Coordination Strategy for Clinician Performance Measures". As a member of the Coordinating Committee, I am aware and appreciative of the extraordinary level of effort involved in the organizing, preparation, and synthesis of expertise from such a diverse group of knowledgeable stakeholders on such a remarkable truncated timeline. I believe that on the whole, the report admirably reflects the conversations at the coordinating committee meetings. It also does a nice job of highlighting the reason for this report, i.e, the burden on physicians, patients and other stakeholders of misaligned reporting requirements and metrics across federal and private sector program. While this report clearly aims at addressing the alignment issue in the public sphere, I look forward to Phase II, where we can begin to think together strategically about how to cross-leverage the professional assessment and public accountability scopes of work. They are different, but in this highly interdependent environment each should perform with reference to the other.
General Comments	**American Board of Internal Medicine**	**Christine K Cassel**	One particular theme from the Coordinating Committee discussions that I was pleased to see highlighted in this report is the importance of considering the fitness of a measure for its particular "application." That is, that the function and attributes of a specific measure intended to inform consumers via a public reporting application may be very different from the properties of a measure that is intended to support movement across an improvement delta. These are crucial considerations in building a measurement portfolio that advances programmatic objectives and does not result in unintended consequences, and the MAP would be performing an important service in underscoring this point to CMS and the other federal agencies. Along those lines, I would point to the last paragraph of page 8 and the top of page 9 as needing some clarification, with the text for the first criterion for an ideal measure. On the one hand, the text refers to actionability and that the measure should "target an improvement gap (i.e., not "topped out")." However, if the measure is intended for public reporting, then who are the outstanding physicians in that area or procedure is precisely the type of information that patients are looking for. So again, there is probably the need to focus on measures that advance both informed decision-making and clinical improvement, and to be explicit about which goal we are addressing as we assess their fitness for inclusion.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	**American Board of Internal Medicine**	**Christine K Cassel**	Another theme that emerged from the conversation was the need for more flexibility and bandwidth in the measure development, selection and endorsement process to accommodate more multi-faceted, complex, and clinically meaningful and actionable measures than currently is afforded by a constellation of one-off, individual metrics. This would include more work with measure sets, with multi-dimensional measures and with composites that are able to provide meaningful and relevant summary statistics. To that end, we were pleased to see that the first criteria for measure collection would require that the measures meet NQF "readiness" criteria, but not that they necessarily are already NQF endorsed. This openness will offer some much needed room for measures to be implemented and evaluated on a larger national test-bed than any single measure-developer would be able to accomplish on its own. One could imagine a process in which some percentage of reported measures are actually in a beta-test position, much as test developers trial new questions, formats and presentations with different properties.
General Comments	**American Board of Internal Medicine**	**Christine K Cassel**	Finally, this is perhaps a parochial concern but I hope you will indulge this comment: Page 8, paragraph 1: The report highlights the PQRS/MOC program as a good example of a public-private sector alignment initiative. However, the sentence that immediately follows could be read to suggest that this program actually is another example of the problem: "Each well-intentioned public and private performance measurement initiative imposes data collection requirements on clinicians that could potentially conflict with the requirements for other programs." Clearly, this is precisely what the MOC-PQRS program is intended to avoid and I hope that can be clarified. Thank you again for the rich opportunity to participate in and contribute to the MAP process. I very much look forward to continuing our work together.
General Comments	**American Board of Medical Specialties**		On behalf of the American Board of Medical Specialties and its Member Boards, I am pleased to submit comments on the Draft Strategy for Clinician Performance Measurement. We need to begin by expressing our admiration for what has been accomplished over so short a time with so many different workgroups, deliverables, and decision paths. NQF has managed the process well, providing for ample public comment, and has done a good job of accounting for a wide range of inputs while still keeping the recommendations concrete and practical. The report captures well the conversations of the Subcommittee and the Coordinating Committee when it reviewed the draft recommendations, and honestly highlights the alignment and burden issues associated with reporting, especially the misalignment across Federal programs over which the MAP should have much influence. The Clinician Work group occupied itself with two different conversations, each of which is reflected in the report. The first was a conversation about measure selection criteria and the test of these proposed criteria against the extant set of available measures. The second was a conversation about data collection to support measure development. There are at least three other conversations that the Workgroup might yet have.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	American Board of Medical Specialties		First, while there was lots of discussion about the dimensions of care that need to be measured, there was little or no discussion of the qualities of clinicians that need to be measured, despite a clear recommendation from the Clinician Workgroup that physician level data are needed and that the physician needs to be the unit of analysis. We suggest a framework for thinking about the qualities or capabilities of clinicians below. Second, there was virtually no discussion of the "applications" themselves. Many assumptions have been made about how payment policy and performance transparency will yield better care for patients, but the mechanism by which they would do so has not been examined. We think this has lots of implications for measurement, as we suggest below. And finally, there was no discussion of methods of analysis. The limitations of conventional inferential statistical approaches for the assessment of individual physician performance are well known and were clearly highlighted in the test of the proposed criteria. We think these cautions need to be heeded and that a full discussion of methodological alternatives needs to take place.
General Comments	American Board of Medical Specialties		There has been virtually no discussion of the methods by which physician performance should be assessed. The "performance measurement" framework underlying the measure sets discussion assumed the use of inferential statistical methods like multivariate regression analysis, that have limitations that have been alluded to in the Workgroup discussions. The workgroup has worried about issues of cell size, sampling, risk adjustment, and other challenges that are well known but were not addressed directly during the Workgroup's deliberations. We think the MAP offers an opportunity for an open discussion of methods. What are the best ways to assess the various dimensions of performance that are important to patients? What are the best ways to analyze the data we collect to account for the dynamism and complexity of the health system, especially when the determinants of care and outcomes are many and data are often sparse or infrequent? Would an entirely different set of methods be appropriate to monitoring applications than to payment and reporting applications? We suspect that different applications might not only need different measures but they might be better served by different methods, too. A tremendous variety of statistical and advanced analytical techniques in use in other industries are just being brought to the health sector. Much of this methodological experimentation is being done in the private sector.
General Comments	American Board of Medical Specialties		Data mining and advanced analytics like signal processing, methods might offer more flexibility, more explanatory power, and more effective targeting than current methods. Decision tree and rule induction, "nearest neighbor" and other clustering analysis, data segmentation and feature extraction, and neural network analysis, all offer pathways to more sensitive identification of patterns when conventional assumptions of linearity, independence, and normal distributions are unlikely to hold. It's time to take a hard look at our methodological resources and not lock ourselves into formal measurement structures and specific statistical methods when more flexible and sensitive methods might become available.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	**American Board of Medical Specialties**		The MAP has opened the door to a very fruitful discussion about how best to measure performance in the health system and we are pleased to have an opportunity to participate. The criteria have been discussed as if they are all "selection" criteria. Our sense is that the criteria themselves may have different applications, some of which can be determined in measures selection, some may be determined through measure application, and some through measure evaluation. For example, the criterion that the measure should "avoid undesirable consequences" will be difficult to apply at the stage of measure selection, but will be very useful at the stage of evaluation. Similarly, the appropriateness of the mix of "structure, process, and outcome" measures may be best determined in thinking through the measure applications –different mixes might be appropriate to different uses. The report suggests the need for a lot of rigorous thinking ahead to makes sure that the effort invested in the building of our data and measurement infrastructure will yield commensurate benefits. We look forward to being a part of that ongoing dialog.
General Comments	**American College of Cardiology Foundation**	**Eric D. Peterson**	Thank you for the opportunity to comment on the Measure Applications Partnership Coordination Strategies for Clinician Performance Measurement and for Healthcare-Acquired Conditions and Readmissions across Public and Private Payers. We recognize the importance of the MAP work and support its mission to advance the National Quality Strategy and improve healthcare for all Americans. We also appreciate the tremendous amount of work that went into creation of these thoughtful recommendations. On behalf of the American College of Cardiology Foundation (ACCF)/American Heart Association (AHA) Task Force on performance Measures, I respectfully ask that you consider the comments.
General Comments	**American College of Cardiology Foundation**	**Eric D. Peterson**	In general, we would urge the committee to acknowledge the significant role played by professional societies in performance measurement, at both the clinician and hospital level and as stewards of the standardized data elements that are key to the data platform principles proposed. Finally, one small editorial comment related to use of the word "duplicity" on p. 8, paragraph 2: It appears that what is intended here is "duplication". As above, we appreciate the consideration given to unintended consequences. We would also strongly suggest that the MAP involve professional societies in the ongoing evaluation of the appropriateness of these strategies. Changes in the evidence base need to be acknowledged and translated into practice measures and partnership strategies including public and private payers in a timely way. For example, there are emerging divergent trends in mortality and readmission (or length of stay) rates in heart failure, i.e., rather than readmission rates, total bed days of care may be a better measure. The ACCF and the AHA are uniquely positioned to assist with identifying and responding to these emerging trends. We have jointly engaged in the production of clinical practice guidelines for over 25 years.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	**American College of Cardiology Foundation**	**Eric D. Peterson**	In addition, ACCF and AHA, in partnership and separately, have established a number of highly respected national inpatient registries, which provide a rich data source that allows participating facilities and medical professionals to reduce care variations and implement continuous quality improvement processes, including the reduction of readmissions. In addition, we have collaborated for a number of years to develop standardized cardiovascular data standards. We would welcome the opportunity to contribute our expertise to the MAP effort. Recommendation 2: Overall our comments on the data strategy mirror those regarding the data platform principles in the Clinician Coordination Strategy. A single, centralized regulatory authority is essential if we are to make progress towards a national safety data strategy. One notable omission is the absence of a call for a universal patient identifier concept, so that data can be aggregated across contexts. A universal patient identifier is essential to longitudinal care assessment and the approach to reducing readmissions. We recognize that this is also an issue that must first be addressed from a statutory perspective, however, we would strongly urge the committee to consider making a recommendation in this regard.
General Comments	**American College of Chest Physicians**	**Jeff Maitland**	On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on these principles. While the QIC approves this document based on the core principles it is based around, they note that the principles mentioned would be impossible to enact without a national mandate.'
General Comments	**American College of Physicians**	**Michael Barr**	ACP appreciates the opportunity to review and comment on this document. The limited number of comments offered are predominantly due to this documents consistency with ACPs approach to performance measurement. However, another factor is the short time period allowed for comment. We recommend that NQF provide more time in the future.'
General Comments	**American Hospital Association**	**Nancy Foster**	The American Hospital Association welcomes the opportunity to comment on the report of the Clinician Workgroup of the Measure Applications Partnership (MAP). Overall, we found this report to be very helpful. It provides a thorough overview of the many of the most critical questions that need to be resolved to advance clinician level quality reporting, including the need to create greater alignment across measures, to identify a core set of clinical data elements that need to be captured to create quality measures, and the need to integrate the clinician level measures across programs and with the measures for health care provider organizations so that all providers are working toward the same goals for patients. We are absolutely in agreement with the Workgroup's observation that it is necessary to know the purpose for which the measures are being assessed to be able to judge the measure's usefulness, including whether the measure will work at an individual clinician level or only at a larger group practice level or whether the measure will be used for quality improvement, public reporting or payment.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	American Hospital Association	Nancy Foster	While we are supportive of the points that are made in the work group's report, we are concerned about something that the report fails to address. The report contains several references to the draft criteria developed for the Coordinating Committee to help choose measure sets, but there is nothing in the report that helps us understand how the Workgroup proposes to undertake the challenging task of assessing and choosing individual measures to make up the measure sets. In our experience with hospital measurement, it is much more challenging to choose measures that are themselves worthy of inclusion in a set than it is to decide that a set of measures is acceptable. Surely, in reviewing what HHS send over to the MAP, choices will have to be made about the worthiness of individual measures, and yet we see no criteria, no process articulated, and no discussion of what it will take to choose individual measures --- only the articulation of criteria for assessing a set as a whole. We urge the Workgroup to consider the characteristics of what it will look for in individual measures to determine which would be right for inclusion in a public reporting or payment program for clinicians.
General Comments	American Hospital Association	Nancy Foster	In so doing, we urge the Workgroup to think about the different ways in which clinicians can be categorized for assessment. Clearly, clinicians are often categorized by specialty, and that is certainly an option. Other options might include categorizing clinicians by their primary site of care delivery. For example, it may be more meaningful to assess the care of intensivists as a group, regardless of their specialty, and not try to assess a pulmonologist who works primarily in the intensive care unit in the same way one would assess a pulmonologist who works primarily in a clinical office. We realize that any classification of clinicians is likely to be challenging, and it is likely that no classification scheme will work perfectly, but it would be helpful to know how the clinician work group is thinking about this issue as they approach the task of selecting groups of measures that will be used to assess the care of different categories of clinicians. Please contact me if we can be of further assistance to the Clinician Workgroup in carrying out this work. Thank you for this opportunity to comment.
General Comments	American Medical Directors Association	Jacqueline Vance	On behalf of the American Medical Directors Association (AMDA) Board of Directors, I would like to submit AMDAs overall support of the MAP Clinician Coordinating Strategy. AMDA represents more than 5,600 medical directors, attending physicians, and others who practice in the long term care continuum. According to results from AMDA's biennial survey, generally, AMDA physician members perform more than thirty nursing facility visits per month. AMDA physicians also care for patients in other venues in the long-term care continuum, which includes hospitals, home health care, assisted living settings, hospice, and nurses and allied healthcare professionals who provide interdisciplinary team care in the nursing home setting to provide the highest quality of care to their residents. While AMDA does support the basic tenets of the MAP Clinician Coordinating Strategy, the current cost of data collection and the time that the reporting of measures takes does not justify the means. It is critical to implement a more user-friendly reporting system, as well as one that is supported by a system of payment reform that serves all health providers and systems.'

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	**American Nurses Association**	**Maureen Dailey**	Thank you for a comprehensive and thoughtful report. It is not clear from the report that the focus of the clinician setting is the office settings, primary care and specialty practices Clarity on the focus of the setting is needed early in the report. On page 4, it is noted that Avalere Health provided an analysis related to "physician" offices. The naming of the MAP workgroups on page 4 does not specify the reader to the clinician office setting. On page 4, the definition of clinician speaks to the"entire team of healthcare professionals". In the other MAP workgroups interdisciplinary clinician teams are addressed in the coordination strategy. In the Alignment section on page 6, identification of the office setting would provide clarity prior to the description of federal programs. Consistency of use and provision of definitions of terms such as provider, clinician, interdisciplinary team, group, program, and systemness would also provide clarity across the MAP reports.
General Comments	**American Optometric Association**	**Dori Carlson**	The AOA has specific concerns with one item on the list of high impact "Child Health Conditions and Risks." Unlike the other items on the list, the NQF draft would limit children's vision and eye health conditions and risks to "vision problems not corrected by glasses." The category should be changed to "vision and eye health" to be consistent with all of the other categories. Narrowing eye and vision health care to "problems not corrected by glasses" is shortsighted because it improperly downplays both the seriousness of conditions correctable by glasses and the role of glasses themselves. As written, the category suggests that vision problems we can correct with glasses are not a public health concern, and that quality health care does not include vision problems correctable by glasses. This is in direct opposition to recent large scale studies that highlight refractive error and other conditions treated by glasses in children as major public health problems facing our nation today, including: the population-based cross sectional Multi-Ethnic Pediatric Eye Disease and Baltimore Pediatric Eye Disease Studies[1](2011), the Randomized Clinical Trial of Treatments for Symptomatic Convergence Insufficiency in Children [2](2008), and the multi-phased, multi-center, interdisciplinary, clinical, Vision in Pre-Schoolers Study[3]
General Comments	**America's Health Insurance Plans**	**Carmella Bocchino**	We applaud the Clinician Workgroup for its excellent work in identifying the various federal provider incentive programs and emphasizing the need for alignment of these various programs. We offer the following comments on the report: Need for public-private sector alignment of measures and incentives and building upon existing private sector efforts. In many areas of the country the private sector has implemented innovative payment and delivery models and the federal government needs to build upon these programs and lessons learned. Need to consider additional areas of priority beyond those referenced in the report. The priority conditions referenced in the report are applicable to Medicare populations but there are other clinical conditions that remain priorities for both Medicare Advantage and commercial populations. Alignment of measures in the Value-based modifier measure set with the National Prevention Strategy.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	**America's Health Insurance Plans**	**Carmella Bocchino**	In addition to alignment across federal programs, public-private sector of alignment measures and incentives is also critical. Such alignment can help reduce confusion for providers and consumers and help drive quality improvement and achievement of the goals laid out by the National Quality Strategy. In many areas of the country the private sector has implemented innovative payment and delivery models and the federal government needs to build upon these programs and lessons learned. Such an approach was taken by the Center for Medicare and Medicaid Innovation in launching its Patient Centered Medical Home (PCMH) demonstrations across the country. Finally we would like to suggest the inclusion of care provided in other care settings, such as community health centers, in order to better reflect and capture alignment of measurement across a broader range of settings beyond private proactive clinicians and group capabilities. The report identifies prior work conducted by CMS and NQF that identified the high priority conditions for Medicare. AHIP had previously commented on this project and shared with NQF a list of conditions that were identified as high priority based on Medicare Advantage (MA) and commercial data. While there was overlap between CMS/NQF identified conditions and MA and commercial populations, additional areas remain a priority for MA and commercial populations that are listed below. We underscore the importance of including framework and for consideration by MAP the following list of conditions: Arrhythmias including both atrial fibrillation and others, colonoscopy, low back pain, pneumonia, sepsis, and trauma. In addition, within the commercial population, the following were the list of priorities: Child Health, Maternity Care including pregnancy and delivery, asthma, uterine disorders including hysterectomy, hypertension, hyperlipidemia, skin disorders, respiratory disorders including bronchitis and sinusitis, and inflammation of the esophagus
General Comments	**Association for Professionals in Infection Control and Epidemiology**	**Russell Olmsted**	The Association for Professionals in Infection Control and Epidemiology (APIC) appreciates the opportunity to provide input to the proposed draft of the National Quality Forum Measure Applications Partnership Coordination Strategy for Clinician Performance Measurement. APIC is a nonprofit, multi-disciplinary, international organization representing over 14,000 infection preventionists (IPs), whose mission is to improve health and promote safety by reducing the risks of infection and adverse outcomes in patients and healthcare personnel. APIC believes that measurement is central to determining the success of clinician performance measurement. However, measurement should be purposeful, meaningful and avoid undue burden on providers. APIC supports the concept of aligning clinical quality measures with those already being monitored and reported to other agencies in order to avoid duplication of reporting requirements. We encourage emphasis on assessing performance and value of care using measures that can be automated as readily as possible. At this time, there are few core, population-level measures across the continuum are available that have been tested and validated. Many of the existing measures focus on process of care and rely on the labor-intensive process of manually-abstracting data from medical charts.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	**Association for Professionals in Infection Control and Epidemiology**	**Russell Olmsted**	APIC has communicated its concern to CMS regarding the reference (page 8 of the NQF draft) 65 Proposed ACO measures. Proposed measure #24 is a composite that mixes singular events with rate-based measures as well as an AHRQ PSI composite. To our knowledge this new composite has not been thoroughly tested and we draw attention to this issue, particularly for the group reviewing and aligning such measures. Proposed ACO measure #25 captures CLABSI bundle data. Because the information is so detailed, the measure is labor intensive, and it would seem to be impossible to retrieve from claims data. In addition, APIC offers the following comments regarding the measures selected for Clinician Performance Measurement: 0038 – Childhood Immunization Status – This measure may be difficult for physician offices to collect and report given the difficulty in capturing immunizations provided by numerous providers or facilities (physician's office, school, etc.). 0039 – Flu shots – This measure should not be limited to those older than 50 years. 0041 – Flu shots – Consider extending the collection and reporting period to March or April because the influenza season has become longer.
General Comments	**Association for Professionals in Infection Control and Epidemiology**	**Russell Olmsted**	0043 – Pneumonia vaccine – Change the name to pneumococcal vaccine. 0279 – Bacterial pneumonia – APIC wonders why this measure is limited to metropolitan areas. 0281 – Urinary Tract Infections – This measure mixes device and non-device UTIs together. 0298 – HAC CLABSI Bundle - The CLABSI Bundle is the NHSN process measure "adherence to central line insertion practices (CLIP)." We do not understand how it is possible that these process elements could be retrieved from claims data. Again, thank you for this opportunity to comment on this important issue.
General Comments	**Atlantic Health**	**Donald Casey**	We believe that an all cause readmission rate for all index hospitalizations needs further study and improved correlation with improved clinical outcomes, especially mortality and quality of life. CMS would be wise to first explain the discrepancies noted by the Yale researchers in the Circulation figures noted above and also cross validate any analysis solely based upon Medicare administrative datasets containing only the first nine to twelve ICD-9 codes listed in complete claims that may contain as many as 30-40 other diagnostic codes. Additionally, there are many conditions that are "Present on Admission" that should be evaluated and included in the detailed analytics, with cross validation using information from the entire episode of care occurring between hospitalizations (e.g. Hospital-Acquired Infections, etc.). Finally, in the most recently released Hospital Compare data, no significant changes were noted in the publicly reported 30-day all cause readmission rates for Acute Myocardial Infarction, Heart Failure and Pneumonia using methods similar to that proposed in this new readmission rate. This suggests that public reporting of these rates by CMS has had no demonstrable effect in improving outcomes.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	**Atlantic Health**	**Donald Casey**	Because of these unresolved issues, we do not believe it is appropriate for MAP to unilaterally label Readmission Measures as "Patient Safety" measures without further clarity. We hope that the MAP can provide more clarity about these discrepancies and others in its current deliberations. We are also concerned that payment policies similar to those described in the Final Rule for the IPPS in 2012 are poorly constructed and likely to result in significant misspecification bias leading to financial penalties for those hospitals with better clinical outcomes, especially 30-day mortality results.
General Comments	**BCBSA**	**Matt Schuller**	The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comment on the Measure Applications Partnership (MAP) Coordination Strategy for Clinician Performance Measurement. BCBSA is a national federation of 39 independent, community-based, and locally operated Blue Cross and Blue Shield companies ("Plans") that collectively provide healthcare coverage for nearly 98 million-one in three-Americans. BCBSA and the Blue Plans have a system-wide commitment to support the HHS Partnership for Patients national safety initiative which complements The Blues® ongoing leadership in efforts to improve patient safety. We support and commend the MAP efforts as outlined in the public comment documents to further the National Quality Strategy's three-part aim of creating better, more affordable care and healthier people.'®
General Comments	**BCBSA**	**Matt Schuller**	Distributed models have been successfully applied in areas closely aligned with the MAP's mission of improving quality and safety and, in particular, reducing readmissions. One example that the MAP should highlight for HHS is a Michigan-based voluntary partnership among all governmental and several local payers that used a distributed approach to producing multi-payer re-hospitalization data reflecting more than 90 percent of covered lives in Michigan. This was a critical component of guiding and evaluating a statewide readmissions reduction initiative.[1] [1]Boutwell et al., "An Early Look At A Four-State Initiative To Reduce Avoidable Hospital Readmissions," Health Affairs, July 2011, available at http://content.healthaffairs.org/content/30/7/1272.full'

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	**BCBSA**	**Matt Schuller**	Blue Plans have numerous innovative programs underway that focus on improving patient safety and quality. We have provided a few additional examples of Blue Plan programs that focus on reducing hospital acquired infections and preventable hospital readmissions that are not included in Appendix F. The additional programs provided are not an exhaustive list of Blue Plan programs. Anthem Blue Cross and Blue Shield The Unique Role of the Health Plan in Care Management to Prevent Hospital Readmissions WellPoint's 2010 Readmission Prevention Program uses focused utilization management and skilled nursing facility (SNF) initiatives to reduce acute inpatient admissions/thousand and SNF days/thousand using a range of new tactics that requires a strong partnership between the medical directors, nursing and non-clinical staff. WellPoint implemented the multidisciplinary Geographic Care Support Team model that identifies and manages high-risk members while they are in the hospital with the help of community-based care managers; implements the care transitions model, negotiates alternatives to continued stay; and prevents complications that can result in SNF admissions, readmissions after 30 days, etc.
General Comments	**BCBSA**	**Matt Schuller**	Independence Blue Cross Partnership for Patient Care The Partnership for Patient Care (PPC) is a regional patient safety collaborative that includes Independence Blue Cross, The Health Care Improvement Foundation and more than 70 of the region's hospitals and health care institutions. The goal of the collaborative is to make the Delaware Valley the safest place in the world to receive healthcare. The PPC has a successful portfolio of patient safety projects across a broad range of topics including reducing hospital acquired infections and reducing hospital readmissions – the PAVE Project.
General Comments	**BCBSA**	**Matt Schuller**	Blue Cross Blue Shield of Michigan Michigan Transitions of Care Collaborative (M-TC) The Michigan Transitions of Care Collaborative (www.mtc2.org) is a statewide initiative that BCBSM includes as a component in their Physician Group Incentive Program (PGIP). The goal of M-TC2 is to improve transitions between inpatient and outpatient settings with a primary focus on the transition from hospital to home. The collaborative utilizes The Society of Hospital Medicine's (SHM) Project BOOST (Better Outcomes for Older Adults through Safe Transitions). The long term goal of M-TC2 is to decrease the occurrence of potentially avoidable re-hospitalizations within 30 days of discharge. We appreciate your consideration of our comments and commend MAP and HHS for including a wide variety of stakeholders input on performance measure selection. We look forward to continuing to work with MAP and HHS on the Partnership for Patients national safety initiative.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	**Center for Patient Partnerships**	**Rachel Grob**	MAP Should Acknowledge Even More Emphatically the Current Lack of Strong Patient Experience Measures, and Should Advocate Including a Qualitative Approach to Measure Development in This Area. The report notes a lack of adequate measures of patient experience and shared decision-making about care goals (p. 17). This gap merits more emphatic attention, and I want to emphasize a point made repeatedly by consumer representatives on the Workgroup-i.e., that addressing it with concerted effort and resources devoted to new measure development is a key priority from the point of view of consumers. Further, research shows that consumers learn most and most easily from qualitative data about the experience and perspective of other patients. We must develop measures that convey the richness of patient experience in a way that is representative. This will mean actively soliciting feedback from patients instead of relying on the accounts of those who have had either very good or very bad experiences with care. It will also mean committing resources for methodologically sound qualitative measurement, and learning to cull a balanced synthesis from these data.
General Comments	**Center for Patient Partnerships**	**Rachel Grob**	This draft report reflects hard work, under tight time constraints, by the MAP Clinician Work Group's leadership, MAP Coordinating Committee, and NQF staff. I recognize their efforts and thank them for all their hard work. The comments I have made under various categories on this web site reflect issues discussed during the Clinician Workgroup meetings but not highlighted or emphasized as they might have been in the report. Some comments also reflect ideas for next steps in MAP strategy that may have been raised at Clinician Workgroup meetings but bear reiterating here. I also offer a suggestion for clarifying the report.
General Comments	**Center for Patient Partnerships**	**Rachel Grob**	MAP Must Address the Question of How to Build Towards an Ideal Measure Set from the Application of Measure Set Criteria to Specific Programs. The second paragraph on page 4 of the report notes that "one of MAP's early activities has been the development of measure selection criteria" and that "the measure selection criteria characterize the fitness of a measure set for use in a specific program." This is true, as is the statement on page five (second paragraph) noting that "an initial attempt to define a core measure set for all clinician measurement led to a... consensus among the group that measure sets need to be evaluated in the context of a specific purpose." However, it bears noting that this conclusion was reached in part because of the extreme time constraint imposed on the work group by the mandated due dates for MAP deliverables. Many members of the group voiced repeated concern about what an overall measure set would look like, and a strong desire to pursue this question in a way not permissible within the structure of, charge to, and time constraints pertaining to the MAP.
General Comments	**Cleveland Clinic**	**Barbara Ackerman**	The public comment period on the proposed rule for Medicare Programs: Payment Policies und the Physician Fee Schedule and Other Revisions to Part B for Calendar Year (CY) 2012 closed on August 30, 2011. This proposed rule addressed the establishment of the Value-Based Payment Modifier Program, and CMS clearly outlined the associated measures. Cleveland Clinic requests clarification on why the MAP is requesting comment on the same measures outlined in the proposed PFS rule. The duplicate request for comments on the same measures is confusing and could potentially diminish the important work of the MAP.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	Nursing Alliance for Quality Care	Mary Jean Schumann	Overall recommendation is that the committee considers evaluating implementation of the major measure sets from the point of use. What would be the reality of a hospital, clinic, payer, or other entity making a good faith effort to collect the data required for the applicable measure sets? The committee may need to be even more bold in their efforts to assure a realistic burden of data collection to enhance the quality of the information and its value to all.
General Comments	Pacific Business Group on Health	Jennifer Eames Huff	Ensuring programs are designed to deliver better quality and more affordable care to consumers needs to be a higher priority in the report. Thus, greater attention is needed on the value of the measures for accountability purposes. Whenever feasible, we need to focus on individual clinicians, particularly where variation in performance is most evident, and not just higher levels of aggregation. We will generate the greatest improvements in care if we promote individual accountability, together with shared accountability. Shared accountability means holding all components of a system (or all members of a team) accountable, not just the system or team itself. Focusing on individual accountability reinforces professional motivation for quality improvement, provides information for patients to use in choosing physicians, and identifies improvement opportunities that are masked by higher levels of aggregation. Individual clinicians have tremendous influence over how health care is delivered. For example, physicians serve as key advisors to patients and make decisions that control 87% of personal health spending. Shared accountability and "systemness" are important elements of a patient-centered system, but should not overshadow or replace individual accountability.
General Comments	Pacific Business Group on Health	Jennifer Eames Huff	We are extremely supportive of alignment both within federal programs and across private initiatives. Alignment creates synergies across programs, reduces the amount of effort providers expend on data collection, and ensures that we are all "rowing in the same direction." However, the discussion on alignment narrowly focuses on effort of data collection, and while important, it is not the only component to consider. Absent in this discussion is the need to achieve programmatic goals and the needs of end-users. Patients, purchasers and other stakeholders have a tremendous need for information on cost and quality. Patients face challenges every day when trying to navigate the health care system, including choosing a provider, trying to find affordable care, and determining what treatment will be best for them. Purchasers must deal with the increasingly out-of-control cost of care and the need to reward higher-performing providers to spur better care. These issues are currently not reflected in the discussion of alignment. We are also extremely supportive of creating a core set of high value measures that can be used in a variety of HHS initiatives. To facilitate rapid improvements in care and judicious use of public funds, it is extremely important these measures are high value. Including "low value" measures for the sake of alignment will not drive us toward our goal.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	Society of Hospital Medicine	Wendy Nickel	**The Importance of a Coordination Strategy:** We strongly agree that a coordination strategy is critical to streamlining the various quality reporting processes that are being created by various groups. This report is an excellent first step in defining a direction for improving integration of these processes. **Obtaining Balanced Reporting:** SHM supports a balanced reporting of measure types (process, outcome, structure). We would also like to recommend that the Clinical Performance Measurement Coordinating Strategy include a focus on the IHI Triple aim in creating measures. **Real-time Feedback of Measures:** The issue of timeliness of feedback to providers relies heavily on the reporting mechanism. A properly-designed reporting mechanism (for most measures) could provide real-time feedback to providers, in which they would have access to a running report of performance.
General Comments	Society of Hospital Medicine	Wendy Nickel	**Priority Gaps in Current Measures:** We strongly agree that measures related to inappropriate use of resources are sorely needed, and mostly absent from the current lists. We strongly agree that measures of vulnerable populations are critical, as listed. We also agree that measures which assess coordination of care across episodes of care are critical to improving overall health outcomes and minimizing duplication of testing (i.e. cost). Thank you again for the opportunity to provide comment.
General Comments	Southeast Texas Medical Associates, LLP	James Holly	**Methods of Tracking Quality Metrics a the Point of Service** To make it possible for a provider to track over 200 quality metrics, the tracking has to be an intuitive part of the provider's workflow. The following is SETMA's deployment of NQF quality metrics. Incidental to the provider seeing a patient and incidental to the evaluation of that patient, the data to document the provider's fulfillment of these quality metrics is aggregated without the provider doing anything. The color coding makes the process quick and easy. The legend on the template explains how it is used. If a metric appears in "red," i.e., it applies to this patient and has not been done, the provider can click the "view" button to find out precisely what is missing in the patient's care. Because the object is to treat the patient excellently and the by-product is the review of the quality metrics, the healthcare process is strengthened. If a "cluster" or a "galaxy" of metrics is met on a particular patient the outcome will improve and quality of care will increase.
General Comments	Southeast Texas Medical Associates, LLP	James Holly	The following is a list of the quality metrics which SETMA has been tracking, auditing, analyzing, public reporting and using in order to design and implement quality improvement initiatives. These five steps define the SETMA Model of Care which is explained in detail in the fourth attachment above entitled, "The Future of Healthcare, Innovation and Change: SETMA Model of Care: Patient-Centered Medical Home, The Future of Healthcare Innovation and Change," One of the principles with which we have designed our Electronic Health Record (including our Intranet, secure web portal and Health Information Exchange) is that "we want to make it easier to do it right than not to do it at all." All ten principles are defined in the last document above which is entitled, "Spanning the Specialties to Bring You the Best Standards."

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	**Southeast Texas Medical Associates, LLP**	**James Holly**	On page six of that document, the principles which have guided SETMA's development of our EHR appear; they are: 1. Pursue Electronic Patient Management rather than Electronic Patient Records 2. Bring to bear upon every patient encounter what is known rather than what a particular provider knows. 3. Make it easier to do it right than not to do it at all. 4. Continually challenge providers to improve their performance. 5. Infuse new knowledge and decision-making tools throughout an organization instantly. 6. Establish and promote continuity of care with patient education, information and plans of care. 7. Enlist patients as partners and collaborators in their own health improvement. 8. Evaluate the care of patients and populations of patients longitudinally. 9. Audit provider performance based on the Consortium for Physician Performance Improvement Data Sets. 10. Create multiple disease-management tools which are integrated in an intuitive and interchangeable fashion giving patients the benefit of expert knowledge about specific conditions while they get the benefit of a global approach to their total health.
General Comments	**The American Geriatrics Society**	**Susie Sherman**	The American Geriatrics Society (AGS) is the nation's largest membership association of geriatrics healthcare professionals, with nearly 6,000 members. We, and our members, are dedicated to improving the health, independence and quality of life of older people through initiatives in clinical practice, professional and public education, research, and public policy advocacy. AGS appreciates this opportunity for comment, and have provided our feedback. **Care Coordination Strategy for Clinician Performance Measurement Set** "Characteristics of an Ideal Measure Set: Measure Sets Should Include Appropriate Representation Among Different Types of Measures: Outcome, Process, Structure, Experience and Cost Measures" (Page 9) In regards to the seven "Characteristics of an Ideal Measure Set," which NQF has identified to encourage alignment across federal programs and between public and private-sector programs, we believe it would be helpful to insert language about function and cognition. For example, Principle 4 states, Measure Sets Should Include Appropriate Representation Among Different Types of Measures: Outcome, Process, Structure, Experience and Cost Measures.
General Comments	**The American Geriatrics Society**	**Susie Sherman**	AGS recommends that function and cognition be considered as additional types of measures, as they are critical outcomes that would likely benefit older populations, especially those that are vulnerable and suffer from multiple chronic conditions. While we recognize that these measures are not routinely collected, and therefore may not be necessary, we ask that NQF take into account our nation's ever-growing older adult population and consider functional and cognition measures as important additions.

Comment Category	Commenter Organization	Commenter Name	Comment
Characteristics of an Ideal Measure Set	**American Board of Medical Specialties**	**Kevin B. Weiss**	We were pleased to see the concept of "fitness" of the measure set find its way into the report, but we are not sure that this concept was sufficiently discussed or dealt with in its recommendations. Despite the fact that the Workgroup showed a "strong consensus" that "measure sets need to be evaluated in the context of a specific purpose," those purposes were never discussed and the fitness of the measures never evaluated. The headline for Criterion 4 is "the measure set promotes alignment with specific program attributes." But the substance of the criterion has to do with providers, care settings, units of analysis, and populations relevant to the program, and not to the needs of the applications themselves. The report suggests that the measures should be multi-purposed, with an underlying assumption that this is possible for all measures, but we think this assumption should be examined. Are some measures more suitable to payment incentives and others to public transparency initiatives? These applications might have different goals (is the goal of value-based payment policy to stimulate improvement or to reward excellence?) or might be designed to activate different people (is the goal of performance transparency initiatives to activate doctors or to improve consumer choice?)
Characteristics of an Ideal Measure Set	**American Board of Medical Specialties**	**Kevin B. Weiss**	These are not trivial differences, and they might have large implications for measurement. For example, Criterion 1 suggests that measures "should target an improvement gap (i.e., not "topped-out"). Is this true? Is it equally true for both payment applications and for reporting programs? Criterion 3 suggests that measure sets should "inform patients' healthcare decisions" and "provide feedback to providers on how to improve care." Do we want to focus only on measures where there is wide variation in performance? Do we want to focus on measures where there are clear guidelines and standards and thresholds of acceptable performance? Is a particular measure suitable for one use over another? A measure with a distribution highly skewed to the right might be more differentiating for the few physicians residing on the tail to the left. Is this less useful or more useful to patients? Do we want to focus payment penalties on the few stragglers? What about a measure with a distribution skewed to the left? Do we want to focus rewards on the few good performers? Questions about the use of the measures are not secondary to the measure selection process. They are primary. We think it will be a mistake to consider measure criteria without some discussion of the way that measure will be deployed.
Characteristics of an Ideal Measure Set	**American Board of Medical Specialties**	**Kevin B. Weiss**	Our sense is that all of the workgroups have focused on criteria for measure selection without considering the fitness of the measures for their specific applications, which we believe was a primary intention for the Measures Application Partnership. We strongly recommend that this issue be addressed in future meetings.

Comment Category	Commenter Organization	Commenter Name	Comment
Characteristics of an Ideal Measure Set	**American College of Cardiology Foundation**	**Eric D. Peterson**	While all the elements included are important, the list of desirable characteristics may be incomplete. In particular, we appreciate the explicit focus on consideration of unintended consequences. This section, however, would benefit from a better description of the ultimate goal of measurement, that is, improving quality of care (timely, effective, safe, equitable, patient centered, and efficient/ providing value) and outcomes (helping to advance the National Quality Strategy). We would also suggest that it be made clearer that measures for a given disease state, condition, procedure, or population should be considered only if measurement and improvement will produce meaningful gains. Including each type of measure just so every measure type can be represented, even if no achievable patient-centered health benefits will result will be counterproductive. This section would also be enhanced if it conveyed that the ideal measure set is one that is tested and proven to achieve its stated goals. We would also recommend that the committee add statistical validity to the list of characteristics, especially if the "cascading" measures approach is used. In applying measures at the individual physician level, the number of events may be too small to provide statistically valid information on individual performance.
Characteristics of an Ideal Measure Set	**American College of Chest Physicians**	**Jeff Maitland**	Approve with comment. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on these principle. The QIC feels that the minimum level of measure acceptability should be discussed as well as what is ideal. The QIC also notes that the operationalization of this principle may prove to be problematic.
Characteristics of an Ideal Measure Set	**American College of Physicians**	**Michael Barr**	ACP is very supportive of the MAP document outlining the coordination strategy for clinician performance measurement. The document is consistent with ACP policy and aligns with our advocacy efforts for EHR-based performance measurement and reporting as articulated in this policy paper: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/ehrs.pdf.
Characteristics of an Ideal Measure Set	**American Nurses Association**	**Maureen Dailey**	The characteristics described were developed with flexibility to evaluate measure sets across settings, teams, and programs across the MAP workgroups. Promoting systemness (e.g., joint accountability, care coordination) is important across care setting and programs. Registered Nurses (RN) provide care coordination and patient-centered care as a core professional nursing standard of practice. In the office setting, advanced practice registered nurses (APRNs) , nurse practitioners, clinical nurse specialists, and certified nurse midwives, are essential primary care clinician providers. The ANA supports multiple levels of analysis (i.e., individual clinician, teams, systems etc.). Individual RNs are clinician team members who provide essential care coordination within the office setting, transitional care and other across settings. Moreover, RNs are integral to quality of care improvement and their contributions should be recognized across settings and programs. The ANA strongly supports use of multiple measure types described including structural, process, outcome, patient experience, and cost measures. Structural measures are the backbone of patient safety.

Comment Category	Commenter Organization	Commenter Name	Comment
Characteristics of an Ideal Measure Set	**American Optometric Association**	**Dori Carlson**	An important characteristic of the ideal measure set is a specific category of Vision and Eye Health. This is critical not only to comprehensively assure measurement of vision and eye health but also to fully account for other listed Child Health Conditions and Risks, including, Risk of Developmental Delays or Behavioral Problems, Behavior or Conduct Problems, Learning Disability, ADD/ADHD cannot be fully accommodated within the parameters of National Quality Strategy Priorities since they all share a vision and eye health element. Undetected and untreated eye disorders, such as amblyopia, strabismus, binocular problems and uncorrected refractive errors, are major child health problems that are associated with poor reading and other poor school outcomes, Risk of Developmental Delays or Behavioral Problems, and Behavior or Conduct Problems. It is also most important to note the similarities of symptoms between ADD/ADHD and Learning Disability, and uncorrected vision disorders such as uncorrected hyperopia and uncorrected convergence insufficiency all too often lead to miss-diagnosis of -ADD/ADHD and Learning Disability. It is estimated that as many as 20 percent of children treated for ADD/ADHD only have an uncorrected vision and eye health problem that was never diagnosed or treated.
Characteristics of an Ideal Measure Set	**Atlantic Health**	**Donald Casey**	We agree with the general tenor of the need for proper vigilance regarding undesirable consequences. For example, the Centers for Medicare & Medicaid Services (CMS) has contracted with Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE) to develop a hospital-wide (all-condition) 30-day readmission measure. This measure is being developed using Medicare Part A (inpatient only) administrative claims data and is designed for potential use in public reporting. While we believe that reducing unplanned hospitalizations and re-hospitalizations is an important goal of quality improvement, there are serious reasons to question whether such reductions are associated with improved healthcare outcomes. We have submitted comments directly to Yale through CMS recently and also submitted diagrams obtained from a previous publication from these authors at the August MAP meeting for Acute Myocardial Infarction and Heart Failure Readmissions, which paradoxically suggest that in two thirds of the regions in the US with the highest 30-day readmission rates are associated with lowest 30-day mortality rates.
Characteristics of an Ideal Measure Set	**BCBSA**	**Matt Schuller**	Blue Plans support a core set of measures that could be used for multiple purposes and programs. Without common population goals that thread across all federal programs with varying attribution methodologies (e.g., ACO proposed rule and PQRS), it will be challenging to determine that core set of measures. Measures used in quality improvement programs for primary care physicians may vary widely, e.g. Blue Plans have aimed to address gaps in care across all conditions and settings in their particular communities. In addition, measures available to specialist physicians for improvement are minimal and when available, have small patient denominators. Therefore, as an initial step in identifying a core set of measures for reporting, we recommend that the NQF MAP Clinician Workgroup recommends the development of a core set of measures that can be implemented across all disciplines and care settings such as within the areas identified in the document as priority measure gaps.

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Characteristics of an Ideal Measure Set	**Center for Patient Partnerships**	**Rachel Grob**	I understand the value of MAPs work to articulate "characteristics of an ideal measure set". I also appreciate the utility of the workgroup 'exercise applying measure set criteria' to a specific program. However, a critical next step will be to return to the question of how an ideal overall measure set might best be developed. Questions I would like to see addressed and/or raised in this report and in future MAP meetings include: Presuming that measure set criteria will be applied to a number of existing programs (even if measure development proceeds apace), who will have the authority to review the emerging "set of data sets" that will result, and assess this set of sets to see how it measures up to the ideals articulated by the MAP? When and how might this work be accomplished? How will deficiencies in any given data set, as measured by the "measure selection criteria" be fed back, in granular form, to the overarching data set development process? For example, if several measure sets all lack adequate measures of patient experience, who will be tracking this repetitive deficit, and how?
Characteristics of an Ideal Measure Set	**GlaxoSmith Kline**	**Deborah Fritz**	GlaxoSmithKline supports the characteristics of an ideal measure set as described in the report and recommends noting the importance of measuring adherence to treatment regimens, evidence- based prevention and the management of chronic and co-morbid conditions. In addition, GSK recommends the report note that simple utilization and expenditure numbers are not adequate measures of cost. Cost should be considered in terms of total cost over time (e.g. episode based) as is noted for quality measures in the proposed measures selection criteria.
Characteristics of an Ideal Measure Set	**HealthInsight**	**Kimberly Mueller**	The importance of using 'cascading measures for harmonization across levels' cannot be understated. Several national strategies for calculating performance measures are focused at the individual provider level (PQRS, MU, etc.). ACO- and other EOC-type payment policy strategies support team-based care, as does public reporting. Our experience is that there is a disconnect between these strategies which inhibits using EHR-generated performance measures (for example) for calculating and evaluating clinic based performance. The large investment of time and resources represented by these programs should be able to accommodate varying levels of reporting, but that doesn't seem to be the case at present.
Characteristics of an Ideal Measure Set	**Nursing Alliance for Quality Care**	**Mary Jean Schumann**	Concept of cascading measures is strong and allows variable depth of focus in a given area. Excellent appreciation of the opportunity costs of duplicative or un-needed data collection and analysis. Acknowledgement of potential for undesirable consequences addresses a significant potential barrier with providers. Recommendation: Within the final paragraph in this section, assure that the "considerations for healthcare disparities in a measure set" follows principles set forth in the NQF Commissioned Paper: Healthcare Disparities Measurement

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Characteristics of an Ideal Measure Set	**Pacific Business Group on Health**	**Jennifer Eames Huff**	Measure sets should promote shared accountability: The last sentence on page 8 should be revised to: "health care team and/or individual clinician." Shared and individual accountability are not exclusive of each other. Measure sets should include appropriate representation: For these purposes, the primary goal of the measure set is accountability (public reporting and payment). Sometimes measures of accountability do not give direct feedback for improvement or intervention (e.g., outcomes tell you good/bad but not what to do) but provide important information for consumers (e.g., provider explains things is way that is easy to understand). "Including process measures is vital to documenting and adopting best practices" should be revised to "including process measures linked to outcomes is vital to encouraging high value care." Measure sets should balance comprehensiveness: Replace first sentence with: "Reducing the amount of effort providers expend on data collection will allow them to devote more resources to their patients and delivering better, more affordable care." Alignment within federal programs and across the private sector is not specifically called out as a characteristic of an ideal measure set, yet the focus of this report is a "coordination strategy".
Characteristics of an Ideal Measure Set	**Southeast Texas Medical Associates, LLP**	**James Holly**	1. Measure sets should promote shared accountability and "system-ness." With the deployment of both a secure web portal and an HIE, this is possible. It is particularly possible with structured data fields which can be audited without provider action and which data fields are populated incidental to the patient's care and not intentional, as the latter will distort the experience similarly that described in the Hawthorne effect. Accountability implies that the behavior of an individual is causative to an outcome. Thus, the only metrics which will have value are those where providers' performance differ from the performance of others. 2. Measure sets should address multiple levels of analysis, using "cascading" measures for harmonization across levels. SETMA's Model of Care is built upon both "tracking" of quality metrics one patient at a time by one provider at a time, and "auditing" of a single provider's performance, or a group of providers' performance over a population or panel of patients. Statistical analysis is critical as a third step in this process so as to focus attention on quality improvement over a population which will most often be measured by standard deviations in outcomes metrics as opposed to a mean analysis.

Comment Category	Commenter Organization	Commenter Name	Comment
Characteristics of an Ideal Measure Set	**Southeast Texas Medical Associates, LLP**	**James Holly**	3. Measure sets should be useful to the intended audiences, including consumers, clinicians, payers, and policymakers. Making it possible for a provider to see his/her performance in real-time will have more impact on behavior than telling them 18 months after-the-fact about their HEDIS Scores. This is the power of SETMA's Model of Care wherein the provider can know how he/she is performing on every patient which is being seen. Giving providers real-time population or panel auditing will have more impact on process and outcome metrics than virtually any other effort. Making "tracking," "auditing," and "statistical analysis" available to consumer, payers and policy makers has a significant impact on quality. In SETMA's Model of Care, the Treatment Plan and Plan of Care includes a report to the consumer as to what the standards of care are for a condition and whether or not the care they are receiving meets those standards. 4. Measure sets should include appropriate representation among types of measures – outcomes, process, structure, experience, and cost measures. The types of measures actually express a continuum and cannot be measured in isolation. Equality important is the recognition that as one goes from outcomes to cost measures, the difficulty of doing real-time reporting increases. "Outcomes" are conditional upon "process," which depend upon "structure" for success. All of three of these contribute to and ultimately find their value in the patient "experience" of care and as a pubic policy issue in the "cost" of that care. "Excellent" and "expensive" are not synonyms. Efficiency does not sacrifice excellence. More, in healthcare, is not necessary better and quality of care is not conditional upon healthcare being treated by the provider or patient as a delicatessen, i.e., "I want one of those and one of those…" 5. Measure sets should balance comprehensiveness with parsimony, recognizing that few measures will address all of the measure-selection principles. This is a balancing act as outcomes really only improved as an effect of quality metrics with multiple metrics (7 or 8 at least) for each condition and ultimately with multiple conditions in the same patient being treated at the same time resulting in multiple metric sets. 6. Consideration should be given to the potential for undesirable consequences from measurement. The most undesirable consequence is where the fulfilling of the quality metric becomes an end in itself rather than a by-product of excellence of care. 7. Measure sets should include considerations for healthcare disparities. Data analytics are more likely to expose disparities in care than are metric sets designed specifically for a disparity. And, once a disparity is identified, further analysis is required to explain the reason and to design a solution.
Measure Selection Criteria	**Academy of Managed Care Pharmacy**	**Judith Cahill**	Measure Selection Criteria #4 indicates that the "measure set promotes alignment with specific program attributes." Those attributes are identified as applicable to intended providers, applicable to the program's intended level of analysis, applicable to the program's population. The attributes identified in selection criteria #4 are important however, the Academy of Managed Care Pharmacy (AMCP) is concerned that this measure selection criteria seems to be in conflict with the characteristic of harmonization across levels and the criterion of parsimony. These qualities indicate that the measures should be more general. AMCP encourages the MAP to resolve the apparent discrepancy or to explain how the various criteria can co-exist.

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Measure Selection Criteria	**American Board of Medical Specialties**	**Kevin B. Weiss**	We are surprised that the "Competencies Framework" adopted a dozen years ago by ABMS and the ACGME was never discussed by the Clinician Workgroup. This framework was adopted in the late 1990s in recognition of evolving thinking about what excellent clinician performance actually means, informed by fifteen years of quality theory and practice. These competencies are being introduced in the curricula in physician training programs and they form the basis of the assessment processes now embraced by all of the ABMS member boards in their Maintenance of Certification programs. This framework has also been adopted by The Joint Commission. The ACGME and ABMS have recognized six competencies: • Professionalism – a commitment to professional responsibility, adherence to ethical principles, and sensitivity to diverse populations; • Patient care and procedural skills – compassionate, appropriate, and effective care for treating health problems and promoting health • Medical knowledge – knowledge about established and evolving biomedical, clinical, and related sciences and their application in patient care • Interpersonal and communication skills – including both team-based care and good communication with patients and their families • Systems-based practice – awareness of and responsibility to the larger context and systems of care, and management of resources to optimize care (e.g., coordinating care or managing care across disciplines).
Measure Selection Criteria	**American Board of Medical Specialties**	**Kevin B. Weiss**	Practice-based learning and improvement – Investigation and evaluation of patient care practices, appraisal and assimilation of scientific evidence, and improvement in the practice of medicine. This strikes us as a useful framework for thinking about clinician performance, and might provide some guidance for the identification of gaps that have not yet been contemplated by the committee – gaps in valued skills rather than just gaps in areas of medical treatment, and gaps in methods of assessment for skills and attributes that are not well assessed through statistical analysis of performance measures, as we discuss briefly below. The report captures well the criteria identified by the Workgroup. It's hard to quibble with them. But it seems needlessly narrow in its view of clinical performance – a focus on clinical and procedural measures to the exclusion of the other competencies. To be sure, there is a strong emphasis throughout the National Quality Strategy and the Partnership for Patients on care coordination, and we need measures of coordination of care from the patient's perspective. But these measures are likelier to be reflective of the management of care systems than they are of the performance of specific individuals. Indeed, most of our measures today are oriented to groups, organizations, or systems of care.
Measure Selection Criteria	**American Board of Medical Specialties**	**Kevin B. Weiss**	This may well be appropriate, since we all probably agree that patient outcomes emerge from systems. But of course systems are made up of people, and if there is an interest in understanding the performance of individual physicians – and the clinician Workgroup was unequivocal that the unit of analysis was to be individual clinicians – then some means of capturing individual skill and individual performance should be a priority.

Comment Category	Commenter Organization	Commenter Name	Comment
Measure Selection Criteria	**American College of Cardiology Foundation**	**Eric D. Peterson**	The individual criteria proposed are reasonable and we fully support them. There is no discussion in the report of the decision to switch from the rating scale (low-medium-high) used by the workgroup in evaluating the proposed VBP measure set to the binary (yes/no) scoring model proposed in the draft report. The elements of the scoring criteria are appropriate and sufficiently complete. However, binary scoring risks spurious results. Evaluating measures on the degree to which they meet the criteria provides more guidance on what is ready for use and what needs further work. Interpreted strictly, "no" is likely to be the dominant answer for most measure sets. This will not help to identify those measures that are close enough for use. At worst, it could create pressure to approve measure sets that do not measure up. The mixed results from the workgroup exercise more accurately reflects the challenges in measure selection. We believe that binary scoring limits the precision of the measure evaluation tool and we would encourage the committee to reconsider this approach. In addition, we believe that the scoring section is overly focused on whether all of the bases are covered rather than whether the measure set will achieve meaningful health gains.
Measure Selection Criteria	**American College of Cardiology Foundation**	**Eric D. Peterson**	An incomplete measure set that has a few measure domains but has a very strong process outcome link that addresses large treatment gaps, disparities, and variation that would result in many lives saved if implemented could be rejected, whereas a measure set that covers all of these areas, but has little link to any meaningful outcome, would be supported. Finally, prospectively tested measures with a proven link to outcomes and outcome measures with excellent risk discrimination (where events/deaths that are preventable are occurring) should be given substantial priority even if they do not score as highly in other domains. Again, we are concerned that the proposed binary scoring methodology will fail to capture this. If this scoring approach is retained, we would recommend adding a question to allow reviewers to indicate that, despite deficiencies in some domains, the measure set advances the National Quality Strategy to a sufficient degree that approval should occur.
Measure Selection Criteria	**American College of Chest Physicians**	**Jeff Maitland**	Approve with comment. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on these principle. The QIC notes that a measure set should only be formed if there is more value in looking at the measures as a set, rather than individually.
Measure Selection Criteria	**American College of Physicians**	**Michael Barr**	ACP has reviewed the working measure criteria and supports the NQF selection criteria. These are well-described and consistent with ACP policy.
Measure Selection Criteria	**American Nurses Association**	**Maureen Dailey**	The measure selection set criteria developed by NQF for use as a tool are limited by the binary response criteria. Increased flexibility (i.e., a rating scale) is needed for use across settings, programs, and clinician teams. RNs' innovations in care delivery models (e.g., transitional care) offer principles and experience to guide successful care coordination and quality improvement, particularly with high risk and vulnerable populations to reduce disparities. Financial and systemic incentives should be required for care coordination to assure that it is properly designed and implemented by qualified healthcare professionals with experience, knowledge, and skill in care coordination.

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Measure Selection Criteria	**American Optometric Association President**	**Dori Carlson**	According to the CDC, vision disorders are the fourth most common disability in the United States and the most prevalent handicapping condition during childhood. The current recommendations are not appropriate performance measures for public reporting (e.g. Narrowing eye and vision health care to "problems not corrected by glasses"). This will adversely impact performance based programs that are intended to assure early detection, diagnosis and treatment (e.g. corrected by glasses and other means) of vision and eye health conditions. This current language ultimately lets children, families and society down through misdiagnosis and increased disability and loss of economic opportunity that may otherwise have been prevented. And because the burden of undiagnosed problems will randomly and unjustly target 83 percent of children in families under the federal poverty level, the impact of this current language seems especially harsh and disproportionate and should be modified to read 'Vision and Eye Health'..
Measure Selection Criteria	**Association for Professionals in Infection Control and Epidemiology**	**Denise Graham**	APIC believes that measurement is central to determining the success of clinician performance measurement. However, measurement should be purposeful, meaningful and avoid undue burden on providers. APIC supports the concept of aligning clinical quality measures with those already being monitored and reported to other agencies in order to avoid duplication of reporting requirements. We encourage emphasis on assessing performance and value of care using measures that can be automated as readily as possible. At this time, there are few core, population-level measures across the continuum are available that have been tested and validated. Many of the existing measures focus on process of care and rely on the labor-intensive process of manually-abstracting data from medical charts. APIC has communicated its concern to CMS regarding the reference (page 8 of the NQF draft) 65 Proposed ACO measures. Proposed measure #24 is a composite that mixes singular events with rate-based measures as well as an AHRQ PSI composite. To our knowledge this new composite has not been thoroughly tested and we draw attention to this issue, particularly for the group reviewing and aligning such measures. Proposed ACO measure #25 captures CLABSI bundle data. Because the information is so detailed, the measure is labor intensive, and it would seem to be impossible to retrieve from claims data.
Measure Selection Criteria	**Center for Patient Partnerships**	**Rachel Grob**	Articulate a Role for the MAP in Measure Development, as Well As in Measure Selection. If the MAP is to make substantial progress towards the very worthwhile outcomes it articulates on page 2 of the report, it will be essential to concentrate on measure development as well as on measure selection. Workgroup members have repeatedly articulated a desire to be part of such a process and our hope that a next phase in MAP's work will involve measure development. From the consumer perspective, it is certain that without substantial work on measure development the goal of "better and more information for consumer decision-making" (p. 2) cannot be met.

Comment Category	Commenter Organization	Commenter Name	Comment
Measure Selection Criteria	**GlaxoSmith Kline**	**Deborah Fritz**	GlaxoSmithKline agrees that measures within the measure set should meet NQF endorsement criteria: important to measure, scientifically sound, usable and feasible and should be in widespread use and/or tested. While NQF endorsement may be preferred, endorsement by other bodies should be considered if those groups use the same endorsement criteria, use a transparent endorsement processes, consider other external expert input and consider public comments.
Measure Selection Criteria	**Nursing Alliance for Quality Care**	**Mary Jean Schumann**	Recommendation: Within the 'Working Measure Selection Criteria' # 8, consider inclusion of a Sub criterion 8.3: Measure set does not replicate other existing measures (including those known to be evaluated by other entities).
Measure Selection Criteria	**Pacific Business Group on Health**	**Jennifer Eames Huff**	Criterion #1: We strongly support this criterion. Criterion #2: May be helpful to clarify if "making care more affordable" covers efficiency (a key IOM domain that does not appear to be addressed). Criterion #4: This criterion states that a measure set must be applicable to the intended "provider(s), care setting(s), level(s) of analysis . . ." It leaves a lot of opportunity for avoiding promoting accountability at the individual physician level. This is a good opportunity to advocate that performance to be measured at all levels, including the individual physician level. Criterion #5: Given that the goal is identify measures for public reporting and accountability programs, we strongly encourage the criteria to communicate an emphasis on measures that are meaningful and useful to consumers and purchasers. Criterion #6: Agree with the need to have measures that cut across settings and are longitudinal, a more patient-centered approach. Criterion #8: While agree with the overall concept of parsimony, would encourage the criterion to balance the desire for measure sets to use the minimum number of measures and be the least burdensome with the value of information obtained.
Measure Selection Criteria	**TeenScreen National Center at Columbia University**	**Laurie Flynn**	The evaluation of whether a measure set adequately addresses high-impact conditions relevant to the program's intended populations is especially important, and we agree that measures of conditions of high prevalence, high disease burden, and high cost relevant to the program's population(s) should be prioritized. This measure selection criterion might be strengthened by adding language stating that an ideal measure set will be composed of measures addressing all of the high-impact conditions in the population(s) assessed or by providing a more detailed description of what is required to meet the definition of "adequately" in this context.

Comment Category	Commenter Organization	Commenter Name	Comment
Measure Selection Criteria	**The Advanced Medical Technology Association (AdvaMed)**	**Steven Brotman**	1.Measures within the set meet NQF endorsement criteria Measures within the set meet NQF endorsement criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. (Measures within the set that are not NQF endorsed but meet requirements for submission, including measure in widespread use and/or tested, may (emphasis added) be submitted for expedited consideration). Response option: Yes/No: Measures within the measure set are NQF endorsed or meet requirements for NQF submission (including measures in widespread use and/or tested AdvaMed strongly believes that all measures chosen for quality reporting programs should have NQF approval prior to implementation. Accordingly, AdvaMed strongly suggests the following three recommendations concerning NQF Endorsement as it applies to the Measure Selection Criteria: 1.CORRECT THE TITLE IN THE CRITERIA TO PREVENT THE MISCONCEPTION THAT THE MEASURE FULLY MEETS AND PASSES THE COMPREHENSIVE NQF-ENDORSEMENT PROCESS.
Measure Selection Criteria	**The Advanced Medical Technology Association (AdvaMed)**	**Steven Brotman**	The title statement that "Measures within the set meet NQF endorsement criteria" (emphasis added) is misleading. This statement would lead to a misconception that: (a) these proposed measures have previously been endorsed by NQF or (b) would indeed pass the NQF comprehensive endorsement process, if subjected to it. Both of these concepts would be factually incorrect. The measure criteria mentioned in Criteria #1 "important to measure and report, scientifically acceptable measure properties, usable, and feasible" is just the criteria to submit an individual measure -- or a measure set -- to NQF for comprehensive review of the measure. The actual measure examination and endorsement process by NQF is highly robust, detailed and much more comprehensive. To be factually correct, the title should read: "Measures within the set meet the criteria for submission to NQF for evaluation and endorsement."
Measure Selection Criteria	**The Advanced Medical Technology Association (AdvaMed)**	**Steven Brotman**	2. Requiring Expedited NQF Review for non-NQF Endorsed Measures. Although the parenthetical in Criteria #1 states that "Measures within the set that are not NQF endorsed but meet requirements for submission... may (emphasis added) be submitted for expedited consideration" this is insufficient. This leaves open the option of not submitting any measure(s)/measure set(s) for NQF endorsement-whether by traditional or expedited processes -- by the measure developer/submitter. It is important that timelines and requirements for the measure selection process do not appear open-ended.

Comment Category	Commenter Organization	Commenter Name	Comment
Measure Selection Criteria	**The Advanced Medical Technology Association (AdvaMed)**	**Steven Brotman**	The NQF Consensus Development Process option for an "expedited review" was established by the NQF Board of Directors to allow for accelerated endorsement for projects with associated time-sensitive legislative or regulatory requirements. It is our understanding that this expedited process usually takes considerably less time (i.e., several months) to complete and avoids the sometimes lengthier wait times for traditional NQF review, as well as avoiding the unnecessary waiting for the cycle of 1-3 years for the subject matter to appear in the queue for review/additions/edits to the included measures/measure sets. Therefore, AdvaMed strongly believes that the consideration of using a non-NQF endorsed measure/measure set should simultaneously trigger an expedited review for endorsement by NQF, even for those measures that have submitted previously to NQF and are in the "pipeline" for review.
Measure Selection Criteria	**The Advanced Medical Technology Association (AdvaMed)**	**Steven Brotman**	3.THE COMMITTEE SHOULD RECOMMEND THAT A MEASURE WHICH DOES NOT PASS THE NQF REVIEW PROCESS (TRADITIONAL OR EXPEDITED), SHOULD BE TERMINATED OR PLACED ON HOLD, UNTIL SUCH TIME WHEN IT BECOMES ENDORSED BY NQF. No mention is provided in Criteria #1 of what would happen if a non-NQF-endorsed measure was recommended /supported by the Measure Application Partnership, then sent for NQF review (traditional or expedited) and was subsequently not endorsed by NQF. Unfortunately, the measure could conceivably continue to be implemented, regardless of failing to meet NQF's rigorous endorsement standards. AdvaMed believes that it should be clearly stated in the criteria (or a footnote to the criteria) that a measure which fails to be endorsed by NQF, would be removed (or placed on hold) and not be recommended for implementation until endorsement by NQF. AdvaMed appreciates the opportunity to submit comments regarding the Coordination Strategy for Clinician Performance Measurement draft report and look forward to working with NQF to address our concerns.
Evaluation of the Value-Modifier Measure Set	**American Board of Medical Specialties**	**Kevin B. Weiss**	CMS has acknowledged that the currently available measures inadequately represent the range of physician practices paid for by Medicare, tipping to general internal medicine and family practice and under-representing other specialties. There is clearly a gap in terms of the areas of clinical medicine captured by extant measure sets. This particular gap was acknowledged by the Clinician Workgroup. The ABMS Boards might be able to provide some directional guidance to the MAP on the clinical priorities within each of the specialties where measure development should be a priority. The Boards have a process by which they identify areas of knowledge and skill that are most important to the specialty – the clinical areas most important to be assessed – and would be pleased to work with the MAP and with HHS to identify these clinical priorities. The MAP identified a wide set of measure gaps not specific to the areas of clinical practice, notably in areas of patient preference, patient experience, functional status, care coordination, mental and behavioral health, cost, overuse, and appropriateness. We support the three areas selected and highlighted among the measurement gaps: patient-reported measures of function, mental health, quality of life, experience, and health risk; appropriateness measures; and measures specific to discrete populations.

Comment Category	Commenter Organization	Commenter Name	Comment
Evaluation of the Value-Modifier Measure Set	**American Board of Medical Specialties**	**Kevin B. Weiss**	However, we did not see any reference to composite measures – multi-dimensional measures that summarize performance in an area of clinical practice. These might be especially useful to patients who might be better guided by summary measures that capture more globally the ability of clinicians to manage clinical problems than by discrete clinical process measures or even outcome measures that might not be proximate to individual clinician performance. We would welcome a consideration of composite measures in future discussions.
Evaluation of the Value-Modifier Measure Set	**American College of Cardiology Foundation**	**Eric D. Peterson**	
Evaluation of the Value-Modifier Measure Set	**American Nurses Association**	**Maureen Dailey**	The measure set gaps (e.g., care coordination patient preferences experience, team-based measures, quality of life, and mental health) should be addressed. ANA agrees that additional cross cutting measures across multiple chronic illnesses and conditions and patient-centered measures (e.g., functional status) would promote parsimony.
Evaluation of the Value-Modifier Measure Set	**Association for Professionals in Infection Control and Epidemiology**	**Denise Graham**	APIC offers the following regarding the measures selected for Clinician Performance Measurement: 0038-Childhood Immunization Status-This measure may be difficult for physician offices to collect and report given the difficulty in capturing immunizations provided by numerous providers or facilities (physician's office, school, etc.) 0039-Flu shots-This measure should not be limited to those older than 50 years. 0041-Flu shots-Consider extending the collection and reporting period to March or April because of a longer influenza season. 0043-Pneumonia vaccine-Change the name to pneumococcal vaccine. 0279-Bacterial pneumonia-APIC wonders why this measure is limited to metropolitan areas. 0281-Urinary Tract Infections-This measure mixes device and non-device UTIs together.
Evaluation of the Value-Modifier Measure Set	**Center for Patient Partnerships**	**Rachel Grob**	Parsimony Must be Balanced with Comprehensiveness. The desire for measure sets to use the minimum number of measures and be the least burdensome (page 12) must be balanced carefully with the need to collect information valuable to all parties including consumers, who arguably constitute one of the stakeholder groups with worst access to meaningful measures. Clarify Difference Between Process Used by Clinician Work Group and Description of Measure Selection Criteria in the Report. The report should note explicitly that the methodology for measure set assessment presented on pp. 10-12 is not precisely the same as that used by the Clinician Workgroup during its exercise evaluating the CMS Value-Based Payment Modifier Proposed Quality Measure Set. For example, the granular-level yes/no questions described on pages 10-12 were not used rather, a "high, medium, low" scale was applied for most questions. This is evident in the table presented on p. 13 and from materials in the appendix, but should be made clearer in the text.

Comment Category	Commenter Organization	Commenter Name	Comment
Evaluation of the Value-Modifier Measure Set	**Pacific Business Group on Health**	**Jennifer Eames Huff**	Addresses NQS Priorities: Seems like it really should be set inadequately addresses most priorities. Replace first sentence with "... proposed measure set inadequately addresses most NQS priorities..." The measure set for the value-modifier is problematic and includes lots of process measures that are burdensome to collect. Achieving 0% for a high score for both parsimony and balance reflect this deficiency. This is disconcerting, especially in light of the recurring "measurement effort" theme in the report and the need to provide meaningful information to consumers and purchasers.
Data Platform Principles	**American Board of Medical Specialties**	**Kevin B. Weiss**	The Clinician Workgroup turned its attention to data collection and made recommendations for collecting data at the element level in order to create more "data liquidity" and enable the creation of multiple measures out of that same data sets. The language used to discuss these recommendations was not always clear. For example, the report expresses a preference for data collected at the physician level, when the Workgroup was really reflecting its preference for collecting data at the patient level and making the individual physician the unit of analysis rather than a group or organization. That aside, the general thrust of the recommendations – to collect information at the element level rather than collected structured measure data, is a good one. The report does capture the intent of the Workgroup that data collection should be at the elemental level so that measures can be aggregated to different levels or units of analysis.
Data Platform Principles	**American Board of Medical Specialties**	**Kevin B. Weiss**	We mentioned to the Coordinating Committee the previous recommendations of the President's Council on Science and Technology on health information data which more extensively treated this issue and its implications. We recommend the report of the PCAST from December 2010 and welcome further dialog about how to transition from the current, highly structured and inflexible approach to a more flexible and "liquid" data collection strategy. In addition to providing more flexibility around measurement development, this may also increase methodological opportunities along the lines suggested above.
Data Platform Principles	**American College of Cardiology Foundation**	**Eric D. Peterson**	Overall, the proposed data platform principles are reasonable. Definitions of the data elements and standards should involve input from the respective professional societies. Again, we highlight the acknowledgement of the potential for unintended consequences, but would encourage further discussion of is issue, including consequences like the disruption of workflow or communication between team members. We would recommend that in addition to data elements to calculate performance measures and confounders to allow risk adjustment and stratification, the report should acknowledge the need for data elements to define reasons for inability to implement performance measures, such as contraindications, health system or other barriers, complications, comorbidities, competing diagnoses and patient preferences. Principle 1: We agree that a standardized measurement data collection and transmission process is necessary, however, it is unlikely that this will occur absent the regulatory authority to enforce this. We would suggest that the committee consider recommending that there be one legislated statutory/ regulatory authority that subsumes all programs in order to achieve this.

Comment Category	Commenter Organization	Commenter Name	Comment
Data Platform Principles	**American College of Cardiology Foundation**	**Eric D. Peterson**	Principle 2: We believe that Principle 2 should call for greater informatics rigor. Specifically: 1) the data elements need to be instantiated using a vocabulary standards based approach, 2) the relevant professional societies should be the stewards of those data elements and 3) the data elements need to be atomic and parsimonious. Principles 4 and 5: We would suggest that these principles recommend moving away from administrative/claims data in favor of clinical data captured through the process of care. The report as currently written could increase rather than reduce the burden of collecting data for administrative purposes. We would strongly advocate for replacing additional administrative data collection with a more sensible set of clinically relevant data that improves efficiency, quality of care and outcomes, and /or reduces expenditures.
Data Platform Principles	**American College of Chest Physicians**	**Jeff Maitland**	Approve with comment. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on these principle. The QIC is concerned that there is not a practical way to implement the data platform principles. The QIC notes that all electronic health record companies would have to have all of the same data elements and a similar platform, which would be a very difficult task.
Data Platform Principles	**American Nurses Association**	**Maureen Dailey**	Standardized electronic data sources should build on useful elements in existing minimum data sets (MDS), whenever possible for consistent and efficient measurement and evaluation across programs and settings. However needed changes should be made to reflect the current evidence-base. For example, the MDS across settings should reflect current evidence-based guidelines for pressure ulcers (e.g., staging definitions). The current MDS have rich clinical data elements for use in program, setting, and team-based evaluation. A standardized, unified process is needed, including a data dictionary and library with common definitions and data elements for use within and across settings It is important to capture structural data elements (e.g., team clinician composition, staffing levels and specific skill mix) to evaluate the functioning of interprofessional teams within settings, groups, and across settings. Specifically, the clinician type and other key characteristics of the team members performing the work, relative to key cross cutting functions (e.g., care coordination), is essential to evaluate quality, efficiency and cost.
Data Platform Principles	**American Optometric Association**	**Michael Duenas**	the MAP can take decisive steps toward making healthy eyes and vision a reality for all children and adolescents by making this necessary change in MAP Measure Selection for high impact Child Health Conditions and Risks from “Vision problems not corrected by glasses” to “Vision and Eye Health.” This necessary action would additionally serve to assist the creation of important conduits to best practices that enable healthy living, increase access to the essential delivery of evidenced-based care, improve communication and coordination of care, assist consumer decision making and further serve to increase alignment of public and private sector efforts. Furthermore, this would better assure that “Vision and Eye Health” is fully included and integrated into common data platforms through closure of ongoing gaps in children and adolescent “Vision and Eye Health” data.

Comment Category	Commenter Organization	Commenter Name	Comment
Data Platform Principles	**BCBSA**	**Matt Schuller**	The MAP does not specify the characteristics of the data platform. We recommend relying on a distributed data network approach rather than a more risky and costly centralized data approach. When recommending that HHS harmonize reporting processes within existing federal databases as a "starting place," the MAP should urge the agency to seek all available opportunities to adopt a distributed model for current and future data collection and aggregation efforts. Recommending that a national data strategy use a distributed approach would best align with the MAP's objective of assuring data collection mechanisms and processes are "simple and consistent," as well as efficient. Under a decentralized, distributed approach, entities store specified data at their own site, follow standardized data and program protocols to derive the necessary results, and submit aggregated summary information. This minimizes administrative burden and costs, enables data holders to assure the validity and integrity of the data, and mitigates the privacy risks inherent in a centralized data approach.
Data Platform Principles	**GlaxoSmith Kline**	**Deborah Fritz**	GlaxoSmithKline supports the proposed data principles.
Data Platform Principles	**Nursing Alliance for Quality Care**	**Mary Jean Schumann**	Very appropriate emphasis on the critical role of technology, and the need for accepted principles to prevent a multitude of standards with variable data collection requirements. Recommendation: Within Principle # 1, consider change from "all federal programs and ultimately all payers" to language inclusive of private sector entities. The development of a library of information needed to calculate measures is an excellent idea, allowing work to carry forward seamlessly. Recommendation: Within Principle #4, assure that data collection allows stratification by level or licensure of clinician (i.e. physician, nurse, clinical social worker, etc.). This is critical to comparison of outcomes across groups and evaluating effectiveness in conjunction with costs. Intent to capture data as a part of workflow is commendable. Consider an explicit criteria that data collection and recording does not intrude on efficiency of patient care. Recommendation: Assure that data collection platforms are congruent with use by researchers (i.e. allow access to needed data without patient identifiers, etc.)
Data Platform Principles	**Pacific Business Group on Health**	**Jennifer Eames Huff**	Principle #4: Data collection should always occur at individual clinician level, but only reported when appropriate (e.g., adequate reliability). Data can always be "rolled up" to higher levels of analysis. Rephrase to: "Data collection should always occur at the most granular level to support reporting at all levels (e.g., individual clinician, team, practice site, etc.), whenever feasible."'

Comment Category	Commenter Organization	Commenter Name	Comment
Path Forward	**American College of Cardiology Foundation**	**Eric D. Peterson**	Overall the pathway appears sound, however, we would note that it is presented in too little detail to be fully evaluable. The discussion would be enhanced if the final two steps, measure uses and evaluation, emphasized that measures should be continuously assessed to ensure they are meeting the stated goals. For example, many payers and health systems use performance measures based on Hemoglobin A1c goals that recent trials suggest may not be beneficial, and may in fact be harmful. In addition, we have only begun to explore the implications of multiple comorbidities. Over the next decade, we will likely learn that doing all the right things, for some patients, will provide inferior outcomes compared to doing only a limited number of high-value things. Ongoing evaluation of the evidence for improved outcomes, value, efficiency and equity resulting from the use of measures will therefore be essential for improving measure applications. The risk is that performance measures can set practices in stone. When doubt arises about a therapy or procedure addressed by a performance measure, how can it be challenged and tested? The pathway as currently conceptualized contains no mechanism for suspending measurement during a trial, and hence the only evaluation of measures in use is of implementation.
Path Forward	**American College of Cardiology Foundation**	**Eric D. Peterson**	There is the potential for conflicts to arise between valuable patient-oriented outcomes research, large scale comparative effectiveness studies and performance measures being used in community practice. Finally, in several places shared decision-making is specifically mentioned as desirable to measure and encourage. While we agree with this in principle, some caution is warranted given that the evidence that patients prefer shared decision-making is mixed. There appear to be subsets of patients with very different views on this. It is also a costly process in terms of time and effort, so the scope of decisions for which its cost-benefit ratio is appropriate must be carefully considered. These matters deserve further deliberation before shared decision-making is prioritized as a gap that needs urgent filling.
Path Forward	**American College of Chest Physicians**	**Jeff Maitland**	Approve, as written. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on these principle.

Comment Category	Commenter Organization	Commenter Name	Comment
Path Forward	**American Nurses Association**	**Maureen Dailey**	The ANA strongly supports the use of data registries as a bridge to the gap in patient enriched data. Patient and team (or unit-level) data is crucial to performance measurement to reduce avoidable adverse events and improve patient-centered care coordination within/across settings. The measures gaps identified in the report are important. The ANA strongly agrees that care coordination and team-based accountability measures are key gaps areas needing cross cutting measure development funding and expedited endorsement. Improved care coordination within settings and across settings is needed to meet the Partnership for Patient goals of reduced focused adverse events (i.e., hospital acquired conditions and unplanned or avoidable rehospitalization). Patient engagement is another key measure gaps area to reduce adverse events, including avoidable disease progression and loss of function. In particular, team-based performance in evaluating a patient's readiness for change and activating the patient/care giver in self care activation is a gap area. An additional gap area is caregiver experience given the complex care needs of growing chronically ill and frail elderly populations, and shift to community-based care. Caregiver support and burden is an important area for evaluation. It is important to empower patients in decisions, including expressing unwanted futile care at end of life.
Path Forward	**American Optometric Association**	**Michael Duenas**	The AOA believes that the Child Health Condition and Risk as described as "Vision problems not corrected by glasses" in the MAP Measure Selection Criteria, Table 2, contradicts the National Quality Strategy Priorities set as described in Table 1 and again throughout the document. Importantly the AOA believes that the "path forward" in improving measure applications for children, must, 1) improve alignment of "Vision and Eye Health" across settings and across public-and private sector programs, 2) assure that "Vision and Eye Health" is fully included and integrated into common data platforms, 3) be designed to close ongoing gaps in children and adolescent "Vision and Eye Health" data, and 4) fulfill the need for early diagnosis and prompt and appropriate "Vision and Eye Health" treatment (e.g. corrected by glasses and other means).

Comment Category	Commenter Organization	Commenter Name	Comment
Path Forward	Center for Patient Partnerships	Rachel Grob	**HHS Must Commit to Ongoing Multi-stakeholder Group** Measure Selection and Development in Our Continuously Evolving Health Care Landscape. Health care is extremely dynamic: technology development, emerging health threats, and ever-changing determinants of health are just some of the factors that assure constant flux. Every reform effort plants the seeds of its own malleability, since the reform itself induces further changes that could never have been fully anticipated. Given this inherent imperfectability, sound measurement will depend on built-in mechanisms that encourage ongoing learning and adaptation. If learning and adaptation are repeatedly curtailed by short timelines and narrowly constructed agendas (as has been the case with the Clinician Workgroup to date), and if stakeholders are brought together with substantial time for discussion only under pressure to produce particular pre-specified products (as has also been the case for the Clinician Workgroup to date), then the benefits of a more openly deliberative process will never accrue. Since the quality of measurement "products" in a dynamic environment depend heavily on process, I encourage HHS to invest heavily in process. This means making time for collaborative development of meeting agendas, soliciting ideas and experience from members by allotting time for brainstorming, and idea sharing encouraging small group work, etc..
Path Forward	GlaxoSmith Kline	Deborah Fritz	GlaxoSmithKline agrees that the priority measure gap areas (patient reported data, appropriateness and vulnerable populations) identified in the report are important and should be addressed.
Path Forward	Nursing Alliance for Quality Care	Mary Jean Schumann	The proposed "core set" of vetted measures to enhance accessibility to multiple users is ideal. To whatever extent these can be established as plug-and-play, utilization is likely to be enhanced. The demonstrated emphasis on coordination of efforts across federal and private entities is critical to success. Identification of priority gaps in current measures is appropriate
Path Forward	Pacific Business Group on Health	Jennifer Eames Huff	Core Sets: This paragraph oversimplifies the complexity of aligning public and private programs and again, narrowly focuses on the "measurement effort" issue. For example, different populations and payment systems in Medicare, Medicaid, and the private sector cause challenges to aligning measure sets. More context is needed to better describe the issue.

NOTES

1 U.S. Government Printing Office (GPO), *Patient Protection and Affordable Care Act (ACA), PL 111-148 Sec. 3014*, Washington, DC: GPO; 2010, p.260. Available at www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Last accessed August 2011.

2 Department of Health and Human Services (HHS), *Report to Congress: National Strategy for Quality Improvement in Health Care,* Washington, DC: DHHS; 2011. Available at www.healthcare.gov/center/reports/nationalqualitystrategy032011.pdf. Last accessed August 2011..

3 HHS, *Partnership for Patients:Better Care, Lower Costs.* Available at http://www.healthcare.gov/center/programs/partnership. Last accessed August 2011.

4 HHS, *National Prevention, Health Promotion and Public Health Council (National Prevention Council)*. Available at http://www.healthcare.gov/center/councils/nphpphc/index.html. Last accessed August 2011.

5 HHS, *National Partnership for Action to End Health Disparities*. Available at http://minorityhealth.hhs.gov/npa/. Last accessed August 2011.

6 HHS, *HHS Initiative on Multiple Chronic Conditions.* Available at www.hhs.gov/ash/initiatives/mcc/. Last accessed August 2011.

7 National Quality Forum (NQF), Measuring Performance Clinician Workgroup, Washington, DC:NQF, 2011. Available at www.qualityforum.org/Setting_Priorities/Partnership/Clinician_Workgroup.aspx. Last accessed August 2011.

8 National Quality Forum (NQF), Clinician Measures Chart, Washington, DC:NQF, 2011. Available at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=68150. Last accessed August 2011.

9 Centers for Medicare & Medicaid Services (CMS), *Physician Quality Reporting System (PQRS)*, Baltimore, MD: CMS; 2011. Available at www.cms.gov/pqrs/01_overview.asp?. Last accessed August 2011.

10 CMS, *EHR Meaningful Use Incentive Program*, Baltimore, MD: CMS; 2011. Available at https://www.cms.gov/EHRIncentivePrograms/01_Overview.asp#TopOfPage. Last accessed August 2011.

11 CMS, *E-Prescribing Incentive Program (ERx)*, Baltimore, MD: CMS; 2011. Available at http://www.cms.gov/ERXincentive/. Last accessed August 2011.

12 CMS, *Physician Feedback Value-Based Modifier Program*, Baltimore, MD: CMS; 2011. Available at http://www.cms.gov/PhysicianFeedbackProgram/. Last accessed August 2011.

13 Government Accountability Office (GAO), *Electronic Prescribing: CMS Should Address Inconsistencies In Its Two Incentive Programs that Encourage the Use of Health Information Technology,* Washington, DC: GAO; 2011.Available at www.gao.gov/new.items/d11159.pdf. Last accessed August 2011.

14 American Medical Association (AMA), *Statement of the American Medical Association to the Centers for Medicare and Medicaid Services of the Department of Health and Human Services Re: Public Town Hall Meeting 2012 Physician Quality Reporting System,* Washington DC: AMA; 2011.

15 Government Accountability Office (GAO), *Electronic Prescribing: CMS Should Address Inconsistencies In Its Two Incentive Programs that Encourage the Use of Health Information Technology,* Washington, DC: GAO; 2011.Available at www.gao.gov/new.items/d11159.pdf. Last accessed August 2011.

16 CMS, *Physician Fee Schedule,* Baltimore, MD: CMS; 2011. Available at https://www.cms.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=descending&itemID=CMS1249142. Last accessed August 2011.

17 CMS, *Improving Quality of Care for Medicare Patients: Accountable Care Organizations,* Baltimore, MD: CMS; 2011. Available at http://docs.google.com/viewer?a=v&q=cache:LNhVixXO7iUJ:https://www.cms.gov/MLNProducts/downloads/ACO_Quality_Factsheet_ICN906104.pdf+cms+65+proposed+process+and+outcome+measures+ACOs&hl=en&gl=us&pid=bl&srcid=ADGEESjv649_dgTQfJg2ta_UMmgtRzepJcIB87VUVGn3KhRn3-0JLkUiYEGRjqLegm63g_Jwh9bsW-GQR80Klv988TYuu0fC1w0KIQ4fUktaA1mVMpyKp0azdoWnE4nH3HxYStB_Af0_&sig=AHIEtbTThIeu2A0qFq84En29exTME-85rQ&pli=1. Last accessed August 2011.

18 Blue Cross Blue Shield of Massachusetts (BCBS MA), May 2010. Available at http://www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf. Last accessed August 2011.

19 Integrated Health Association (IHA). Available at http://www.iha.org/pay_performance.html. Last accessed August 2011.

20 National Quality Forum (NQF), *Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care*, Washington, DC: NQF; 2010.

21 NQF, *Healthcare Disparities Measurement, (commissioned paper under public comment)*, Washington, DC: NQF; 2011.

22 CMS, *Physician Fee Schedule.*

23 National Quality Forum (NQF). http://www.qualityforum.org/QualityDataModel.aspx. Last accessed August 2011.

24 December 2010 Executive Office of the President: President's Council of Advisors on Science and Technology. *Report to the President: Realizing the Full Potential of Health Information Technology to Improve Healthcare for Americans: The Path Forward.* http://www.whitehouse.gov/sites/default/files/microsites/ostp/pcast-health-it-report.pdf. Last accessed August 2011.

25 The Office of the National Coordinator for Health Information Technology (ONC, HHS). 18 October 2010. HIT *Policy Committee: Governance Workgroup. Nationwide Health Information Network (NW-HIN). Preliminary Report and Recommendations on the Scope of Governance.* Available at http://healthit.hhs.gov/blog/faca/index.php/2010/11/30/hitpc-governance-wg-seeks-additional-input-on-roles-and-responsibilities/. Last accessed August 2011.

26 Quality Alliance Steering Committee. Washington, DC. Available at http://www.healthqualityalliance.org/. Last accessed August 2011.

27 December 2010 Executive Office of the President: President's Council of Advisors on Science and Technology.

28 December 2010 Executive Office of the President: President's Council of Advisors on Science and Technology.

29 HHS, Agency for Healthcare Research & Quality (ARHQ), Pediatric Quality Measures Program (PQMP). Available at http://www.ahrq.gov/chipra/pqmpfact.htm. Last accessed August 2011.

30 Patient-Centered Outcomes Research Institute (PCORI). Washington, DC. Available at http://www.pcori.org/. Last accessed August 2011.

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