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AdvaMed
Advanced Medical Technology Association

June 15, 2010

Janet M. Corrigan, PhD, MBA
President and CEO
National Quality Forum
601 Thirteenth St., NW
Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan:

On behalf of the members of The Advanced Medical Technology Association (AdvaMed), we welcome the opportunity to review and provide comments concerning NQF's recent White Paper, "Establishment of a Partnership for Applying Measures to Improve Quality" as it details new opportunities for stakeholders to engage in health care quality provided by the Patient Protection and Affordable Care Act (PPACA).

It is our understanding that this new Partnership will consist of a broad group of stakeholders interested in, or affected by, the use of quality measures. Historically, NQF's membership has consisted of multiple stakeholders from various broad backgrounds, including AdvaMed. AdvaMed's member companies produce medical devices, diagnostic products, and health information systems that are transforming health care through earlier disease detection, less invasive procedures, and more effective treatments. Our member companies produce nearly 90 percent of the health care technology purchased annually in the United States and more than 50 percent of that purchased annually around the world. AdvaMed members range from the largest to the smallest medical technology innovators and companies. For years, our industry has led the way in developing health-related technology that has helped to change and enhance the quality landscape. We recommend that our member companies be represented through AdvaMed in this new and exciting Partnership.

Our industry has played an active role over the years partnering with the existing Quality Alliances. These have included the AQA (formerly the Ambulatory Care Quality Alliance), the Hospital Quality Alliance, and the Quality Alliance Steering Committee, all of which have been comprised of multiple stakeholders. Our industry is engaging in these alliances as participants, members, and leadership, providing clinical expertise, technical knowledge, and methodological and analytical expertise. Thus, it is essential

that our industry continue to be involved in such discussions related to measure selection and be represented in the new Partnership.

We encourage you to consider the value of the contributions of our members across the various provider constituencies that will be addressed in the Partnership.

AdvaMed greatly appreciates the opportunity to provide these comments. We look forward to continuing to work with NQF to further improve the quality of health care in the United States.

Sincerely,

//S//

Steven Brotman, M.D., J.D.
Senior Vice President,
Payment and Health Care Delivery Policy
The Advanced Medical Technology Association
Washington, DC 20004-2654
SBrotman@AdvaMed.org
(202) 434-7207

The following is a comment submitted via email on June 15, 2010:

The document entitled "Establishment of a Partnership for Applying Measures to Improve Quality" is well thought out and presents a reasonable starting point for the multi-stakeholder entity required by the PPACA. I say "starting point" since experience may show that modifications are necessary to achieve the group's goals. This is a point also made in the document itself. In addition, I have the following comments:

- Clear goals should be set for the Partnership. This will likely require discussion with the Secretary but unless such goals are set we have no means by which to judge its success or failure. Is the goal simply to provide measures for public reporting or is it to provide actionable healthcare information to the public? Those 2 goals are not always congruent and success in each is obviously measured differently. I obviously favor the latter goal with implications for the Secretary, NQF, or the Partnership itself to develop tools to assess the impact of Partnership outputs on consumer satisfaction and quality of care.
- The emphasis in the document on evidence and strong analytics is welcome. The danger, of course, with a multi-stakeholder group such as this is that its proceedings would become overly politicized to the detriment of the consumer/patient. Some level of politics is obviously impossible to avoid but it should be minimized to the extent possible and adherence to the evidence and discipline around the fundamentals of performance measurement (validity, feasibility, etc.) will go a long way to accomplishing that goal.
- The transparency called for in the document is also critical in avoiding over-politicization of the document and domination of the process by any one constituency in a manner that is outside of what can be supported by the evidence and good measurement methodology. I would favor more specificity in this area. Specifically the Partnership should be required to put the reasoning for its decisions in writing. I would favor a structured report that would force the Partnership to address specific areas around performance measures that it has either accepted or rejected for public reporting, e.g., strength of evidence supporting the measured process, testing results of the measure, and an assessment of the measure against the NQF's characteristics of a good measure. This sort of process would help avoid the controversies around such approaches as "something is better than nothing" or at least serve to make explicit conclusions based on such reasoning.
- The most likely area where the structure of the Partnership will require some revision over time is the separation of clinicians from hospitals. The current trend is for more and more clinicians including specialist physicians to be employed by hospital systems. This means that hospital will likely be represented on both groups. The Partnership will need to ensure that clinical leadership, which should be focused on the patient, is not "tainted" by administrative concerns so that the appropriate balance between the 2 can be struck as envisioned by this plan.

Thank you for the opportunity to comment. The American College of Cardiology looks forward to continuing to work with NQF as this important aspect of the PPACA is implemented.

Joseph P. Drozda, Jr., M.D., F.A.C.C.
American College of Cardiology

The following is a comment submitted via email on June 10, 2010:

To Whom it May Concern:

I am submitting comments for the NQF Report: Establishment of a Partnership for Applying Measures to Improve Quality on behalf of the American College of Chest Physicians (ACCP) Quality Improvement Committee (QIC). Please find below the ACCP QIC comments:

On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on the report outlining the establishment of a partnership for applying measures to improve quality. The QIC reviewed and agreed with the concepts put forth in the NQF report. The QIC looks forward to seeing how the NQF operationalizes the considerations mentioned.

If you have any questions, please feel free to contact me,

Jeff Maitland
Quality Improvement Project Coordinator
American College of Chest Physicians

The following is a comment submitted via email on June 14, 2010:

Good morning Dr. Corrigan,

The American College of Physicians is submitting the following comments on the NQF Partnership for Applying Measures to Improve Quality document.

The ACP PMTAC recognizes the value of creating this partnership for choosing quality measures for public reporting and payment programs. The description of the Consultative Partnership provides a logical structure and process for choosing quality measures. The functions of the partnership did not address how the Partnership will interface with the NQF Membership and Consensus Development Process. We are specifically interested in the following point, on the last paragraph of page 5 it states that, "the consensus-based entity itself is not charged with making recommendations"… and finishes with the statement that "a mechanism for the NQF Board to address issues raised about the Partnership's processes will need to be established". Will there be a similar mechanism for NQF member organizations to address issues raised about the Partnership's process?

We are pleased to see the document call for the "Partnership for Applying Measures to Improve Quality's multi-stakeholder input should be supported by the best available evidence and analysis". We want to advocate for the Partnership to accompany its evaluation of measures with a transparent assessment of the quality of evidence in support of the measures and a balanced assessment of the potential adverse consequences if poorly supported measures are used prematurely.

We thank you for the opportunity to participate in this important work. Please feel free to contact me if you have any questions.

Sincerely,

Lea Anne

Lea Anne Gardner RN, PhD
Senior Associate
Department of Clinical Programs and Quality of Care
Medical Education and Publishing Division
American College of Physicians

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JENNIE CHIN HANSEN
Chief Executive Officer

National Quality Forum
601 13th Street NW, Suite 500 North
Washington DC 20005

June 15, 2010

Re: Comments on the Establishment of a Partnership for Applying Measures to Improve Quality

Dear NQF Board:

On behalf of the American Geriatrics Society, we appreciate the opportunity to comment on the plan outlined in the document, "Establishment of a Partnership for Applying Measures to Improve Quality."

The American Geriatrics Society believes that quality measurement must do more than measure outcomes of care. It should lead to improvements in the care process that take into account vulnerable elders, who are more likely than other populations to experience adverse outcomes such as falls, line infections, and delirium. By promoting a patient-centered approach that incorporates patient goals of care, quality measurement can address patient safety and protect frail elders. While bad outcomes are not entirely preventable, improving quality of care and care processes may be able to mitigate bad outcomes and decrease morbidity and suffering for vulnerable seniors.

We believe that specific measures are need to assess and address those who are vulnerable and frail. Such measures should:

- account for comorbidities and should assess the aspects of health that are common to these types of patients (e.g., cognitive status, inability to perform activities of daily living, and pain.);
- be constructed so that providers are rewarded for providing treatment that improves the quality of life, particularly where the treatment goal for a given patient is not to prolong life, but to ensure stability and comfort;
- be evidence-based and clinically relevant, and valid for the unique needs of this older population;
- account for patient and family preferences and caregiver and patient burden; and
- address patient safety, particularly regarding overuse or underuse of health care.

To that end, we strongly recommend that the Patient-Focused Coordinating Committee, as well as the Hospital, Clinician, and PAC/LTC workgroups, have geriatrics

representation. It is paramount that geriatrics expertise be included on these panels to ensure that the unique care needs of frail or vulnerable adults are considered.

Improved care processes and better coordination of services can result in cost savings to the Medicare program and to other payers by reducing duplication of services or the provision of unnecessary services or tests, and focusing on effective and efficient interventions. As the science of performance measurement and quality improvement moves forward, the AGS supports efforts to develop new measures or to improve upon current measures for this vulnerable population, particularly given the potential role of quality measurement in a reformed health care system

Thank you for the opportunity to comment.

Sincerely,

Sharon A. Brangman, MD

Sharon A. Brangman, MD
President
American Geriatrics Society

June 15, 2010

Janet Corrigan, MBA, PhD
President and Chief Executive Officer
National Quality Forum
601 13th Street NW, Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan,

The American Medical Association (AMA) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) proposal for the *Establishment of a Partnership for Applying Measures to Improve Quality* (PAMIQ). We support the development of a transparent multi-stakeholder process for providing input to the Secretary of Health and Human Services (HHS) on the selection of quality measures for use in both public and private health programs. As you know, the AMA was a collaborative partner in the Stand for Quality Coalition, which worked to formulate the many important quality provisions included in the Affordable Care Act, including Sec. 3014, requiring multi-stakeholder input to the HHS Secretary.

Background
The AMA has long been and continues to be committed to the development of quality improvement initiatives that increase the quality of care provided to patients. To assist in these efforts, the AMA has been actively involved in discussing and engaging the Administration, Congress, and the medical profession regarding the development and implementation of quality measurement programs and activities.

In order for any quality physician program to be effective, it is vital that certain elements be integral to the program, including such factors as: physician development of quality measures in collaboration with other stakeholders; appropriate use of quality data; effective educational efforts to help ensure that physicians can easily and properly report data under the program; the ability for physicians to verify the data that is used in developing a physician rating under a quality program; physician appeal rights with regard to various aspects of the program; and a stable physician payment structure.

AMA continues to take a leadership role in advancing physician involvement in numerous public and private quality activities. This includes frequent participation in the National Quality Forum (NQF), Quality Alliance Steering Committee (QASC), Stand for Quality Coalition (SFQ), Hospital Quality Alliance (HQA), AQA Alliance (formally the Ambulatory Care Quality Alliance), National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS), Agency for Health Care Research and Quality (AHRQ), and the Institute on Medicine (IOM). Through participation in these organizations, as well as convening the Physician Consortium for Performance Improvement (PCPI), the AMA continues to engage physicians on promoting

quality patient care. It is from this perspective that we offer the following comments on the PAMIQ proposal.

Opportunity to Align Fragmentation in the Quality Enterprise

Efforts to address health care payment and quality have not benefited from a unified strategy focused on improving and refining metrics for measuring the quality of care delivered in a number of settings. In an effort to develop and promote such a strategy, the AMA, NQF and other multi-stakeholders established the SFQ Coalition in March 2009. Many of the quality provisions included in the Affordable Care Act reflect the collaborative efforts of SFQ. These provisions include a renewed focus on developing measures; providing guidance on the selection of performance measures; developing national priorities and goals; identifying gaps in performance measurement; endorsing and maintaining measures for national use; and convening multi-stakeholder groups for various purposes. The PAMIQ proposal addresses this last quality provision.

The establishment of the PAMIQ provides a unique and long desired opportunity to align and synergize what has been a fragmented quality enterprise. Growing development of quality alliances and multiple processes for selection and endorsement result in duplicative meetings, submissions of measures and specifications, conference calls, and requests for nominations and public comments. Rather than allowing the status quo to remain, the proposed PAMIQ structure on page 4 of the Proposal should be "flexible" as noted. Specifically, the multi-stakeholder coordinating groups that feed into the patient-focused coordinating committee should recognize existing quality stakeholders and processes, but not adopt verbatim current structures to serve under this new Partnership.

We urge the new Partnership to eliminate duplication of effort on the selection and use of quality measures in both public and private health programs, and do so by merging new and existing entities within the proposed multi-stakeholder coordinating groups.

Members of the patient-focused coordinating committee will be appointed by the NQF Board. These deliberations must result in appropriate representation of all affected stakeholders, and support inclusion of widely representative organizations with experience in health care delivery and quality improvement.

Many of the quality provisions included in the Affordable Care Act are subjected to federal rulemaking processes. For this reason, it remains unclear what separate or collective input PAMIQ, the National Priorities Partnership, the Agency for Healthcare Research and Quality (AHRQ), or the Centers for Medicare and Medicaid Services (CMS) will have in defining and disseminating a national measure development agenda. **The AMA supports efforts to streamline a measure development agenda. However, collective input into directives for measure developers must be transparent and communicated clearly to avoid confusion or misdirected use of resources.**

Transparency and Oversight

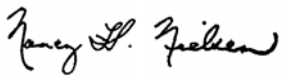
The PAMIQ proposal is the first step among many in building a successful and transparent multi-stakeholder group focused on selecting measures for use in public and private health programs. In moving forward on this continuum, the AMA recommends NQF establish more specific membership

criteria for both the patient-focused coordinating committee and multi-stakeholder coordinating groups, taking into account our aforementioned comments regarding the need to not adopt the status quo but build new collaborations. Along these lines, the Partnership's scope of work must be careful in eliminating duplication of effort with other quality activities. In addition, a strong set of operating procedures, a conflict of interest policy for Partnership members, and an independent evaluation process of PAMIQ must be instituted after its first set of recommendations are made to the Secretary.

Finally, a formal complaint process must be established allowing Partnership members and the public to express concerns with PAMIQ's structure and processes. Consistent monitoring of PAMIQ activities and ensuring complaints receive appropriate attention and action is essential. We strongly urge NQF's relationship to and role within the PAMIQ also be defined.

We appreciate your consideration of our comments and look forward to working with NQF and other stakeholders on streamlining and strengthening our nation's health care quality enterprise.

Sincerely,



Nancy H. Nielsen M.D., PhD

American Medical Rehabilitation Providers Association

Bruce M. Gans, M.D.
Executive Vice President and Chief Medical Officer
Kessler Institute for Rehabilitation
AMRPA Chairman of the Board

June 15, 2010

Janet Corrigan, Ph.D.
Executive Director
National Quality Forum
601 13th Street, NW, S. 500 North
Washington, DC 20005

Delivered Electronically

Re: *Call for Comments: Establishment of a Partnership for Applying Measures to Improve Quality – Its Proposed Structure, Process, Involvement of Stakeholder Groups, and Activities of the Partnership.*

Dear Dr. Corrigan:

This letter is submitted on behalf of the American Medical Rehabilitation Association (AMRPA). AMRPA is the national trade association which represents over 500 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and outpatient rehabilitation service providers. Most, if not all, of our members are Medicare participating providers. Inpatient rehabilitation hospitals and units (IRH/Us) serve approximately 400,000 Medicare beneficiaries per year. Medicare Part A payments represent, on average, over 60% of their revenues. AMRPA members work with patients to maximize health, functional skills, independence, and participation in society so they are able to return to home, work, and/ or an active retirement. The recommendations for new quality measures that the National Quality Forum's (NQF) Partnership for Applying Measures to Improve Quality (the Partnership) provides to the Secretary of Health and Human Services (HHS) will have dramatic implications for our members. We appreciate the opportunity to review and comment on the proposed Partnership and its methods of membership selection.

We commend NQF for taking the steps to prepare for its potential responsibility with the goal of obtaining broad stakeholder involvement to provide input on measure selection for public reporting and payment programs. We have reviewed the above captioned Call for Comments and our comments follow.

I. Activities of the Partnership:

A. Representation with the Partnership

Under the health reform legislation, the Patient Protection and Affordable Care Act (PPACA)[1], new duties are assigned to the consensus-based entity. Among these duties is the responsibility for convening multi-stakeholder groups to provide input to the Secretary of HHS on the selection of measures for public reporting and payment programs. If NQF is tasked with carrying out this consultative process as a neutral convener, this will clearly be an extensive and important role for it in the reporting of quality data.

AMRPA is concerned that the Partnership for Applying Measures to Improve Quality will not adequately represent and examine the needs of medical rehabilitation patients and providers. Created in 1997, AMRPA is the sole organization representing exclusively the concerns of medical rehabilitation providers including Inpatient Rehabilitation Hospitals and Units (IRH/Us) and their patients. Thus, AMRPA considers itself an integral organization to the representation of the interests of IRH/Us, outpatient rehabilitation centers, and other medical rehabilitation providers and their patients. As such, AMRPA wishes to have the opportunity to nominate candidates to the Partnership. These candidates can provide subject matter expertise in measurement, extensive experience in the current inpatient and outpatient rehabilitation patient functional status and measures, public reporting to support informed decision making, and performance-based payment approaches.

B. AMRPA's role

Medical rehabilitation is an integral part of the American health care system. Medicare rehabilitation services include the services of rehabilitation physicians (physiatrists and other rehabilitation trained and experienced physicians), rehabilitation nurses, occupational and physical therapists, speech language pathologists, respiratory therapists, psychologists, social workers, orthotists, prosthetists, audiologists, and other qualified rehabilitation professionals. These services and professionals are provided to people in order to minimize physical and cognitive impairments, maximize functional ability and restore lost functional capacity. Medical rehabilitation is most effective when applied during the acute stage soon after the trauma, be it illness or injury, has occurred or the condition has been detected. Each person is individually assessed, and a comprehensive multidisciplinary treatment plan is tailored to meet his or her goals.

Common conditions requiring rehabilitation are: stroke, brain injury, spinal cord injury, arthritis, cancer, neurological disorders such as Parkinson's and Cerebral Palsy, joint disorders, osteo and rheumatoid arthritis, joint replacements or amputation, sensory deficits, chronic intractable pain, heart attack, other major multiple trauma, Guillain-Barre, chronic pulmonary disease, as well as congenital or developmental disabilities. By minimizing the effects of limitations, medical rehabilitation improves the quality of life for people and their families and eliminates the need for countless hours of care and expense.

[1] P.L. 111-148

Medical rehabilitation services are a standard benefit in most health insurance packages currently offered by both public and private payers.

Medicare **-** Medicare is a primary payer for medical rehabilitation services in an array of settings. It represents over 60% of inpatient rehabilitation hospital and unit revenues.

Medicaid **-** For low income individuals, state Medicaid plans cover an array of rehabilitation services as optional Medicaid benefits. A number of states buy into Medicare to support services, but some states do not cover the deductible and co-insurance. This creates a financial impediment to access.

Private Insurance **-** The private health insurance industry routinely offers coverage of medical rehabilitation services and assistive devices. Inpatient and outpatient rehabilitation services and sites are commonly covered by the Blue Cross/Blue Shield plans. However, some plans have coverage restrictions which undermine the effectiveness of the benefit.

Managed Care **-** Most managed care plans cover some medical rehabilitation services as part of their benefit packages. Benefits are generally case-managed with stringent utilization oversight. Frequently, stroke patients who would achieve better outcomes in a rehabilitation hospital or unit are sent to a nursing home.

Workers' Compensation **–** Medical rehabilitation services are an integral response to workplace injuries to expedite the employee's return to productive employment.

C. Rehabilitation provisions in the Patient Protection and Affordable Care Act (PPACA)

There are a number of provisions in the health reform law with the goal of involving IRH/Us in reporting quality data and potentially, through future Value Based Purchasing (VBP) policies, being paid on their outcome. These provisions include:

i. **§ 3004, "**Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs."

   Starting in FY 2014, if an IRH/U does not report quality data, its payment is decreased by 2% after the reductions taken for the market basket and productivity. The provision also notes that its application may result in an increase factor being less than zero for a fiscal year and the payment rates would be less than the payment rates for the preceding fiscal year.

ii. **§ 3008, "**Payment adjustment for conditions acquired in hospitals."

The Secretary is required to send a report to Congress on whether to expand the HAC policy to IRH/Us. Section 3008 requires the Secretary to conduct a study regarding expanding the HAC policy to payments to IRH/Us, LTCHS, hospital outpatient departments, SNFs and ASCs. The study is to include an analysis of how such policies could impact the quality of patient care, patient safety, and spending under the Medicare program. A report is due to Congress by January 1, 2012 along with recommendations for legislative and administrative changes.

iii. **§ 3013, "**Quality measure development."

In awarding grants, contracts, or agreements under §3013, the Secretary is required to give priority to the development of quality measures that allow the assessment of health outcomes and functional status of patients.

iv. **§ 3023, "**National pilot program on payment bundling" and Continuing Care Hospital Pilot.

By January 1, 2013, the Secretary is to conduct a separate pilot program for integrated care during an episode of care provided around a hospitalization. The purpose of the program is to determine conditions most amenable to bundling across the spectrum of care. The Secretary, in consultation with the Agency for Healthcare Research and Quality and the entity with a contract under section 1890(a) of the Social Security Act, generally NQF, shall develop quality measures for use in the pilot program— (i) for episodes of care; and (ii) for post-acute care which includes IRH/Us.

v. **§10326**

By January 1, 2016, the Secretary is to conduct separate pilot programs for IRH/Us, LTCHs, cancer hospitals, hospice programs and psychiatric hospitals and units to test a value based purchasing program. The pilots are to be budget neutral. The Secretary may, after January 1, 2018, expand the time and scope of the pilot if: a) she determines that doing so will reduce spending without reducing the quality of care or improve the quality of care and reduce spending; b) the Actuary of CMS certifies that the expansion would reduce spending; and c) the Secretary determines such expansion would not limit coverage or benefits to beneficiaries.

D. Rehabilitation measures and field expertise

Starting in 1983, the rehabilitation field, on its own initiative, developed and, since then, has used measures pertaining to health status, functional change and participation in the community. Some of these have also been incorporated into the Medicare Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI). Given this work, the

rehabilitation field has extensive experience in measurement in the areas of function and medical status of these types of patients requiring medical rehabilitation services.

Additionally, AMRPA has considerable data and expertise through its nationwide data base, eRhabData®, which provides considerable insight into trends, changes, case mix, all of which lend themselves to the development of proper measures. This database has been used in discussions with the Centers for Medicaid and Medicare Services (CMS) and has been recognized by Medicare Payment Advisory Commission (MedPAC) in its publications.[2]

Our members are leaders in the rehabilitation field and frequently have testified before various Congressional committees and made presentations before MedPAC. Such expertise and information could be helpful in setting priorities and in recommending measures for endorsement. Our members are quite willing to dedicate the time necessary to assure the success of the Partnership for Applying Measures to Improve Quality.

Furthermore, our members use multidisciplinary teams of rehabilitation physicians, rehabilitation nurses, occupational and physical therapists, speech language pathologists, respiratory therapists, psychologists, social workers, orthotists, prosthetists, audiologists, and other qualified rehabilitation professionals. Such expansive expertise, we believe, could prove useful in the Partnership.

Therefore, AMRPA strongly wishes to bring that expertise to the table as CMS seeks to expand quality reporting. AMRPA would be able to make valuable contributions to the selection of quality measures for public reporting and payment purposes through the nomination of candidates to the Partnership and its various committees.

II. Partnership Structure

AMRPA's understanding is that there will be a central or umbrella, multi-stakeholder coordinating group, named the "Patient-Focused Coordinating Committee." This committee will focus on measures needed for public reporting and payment approaches that cut across individual clinicians and provider sites of care. Underneath the Coordinating Committee, there will be multi-stakeholder working groups which will be provider focused. NQF has proposed establishing work groups for hospitals, clinicians, and PAC/LTC. Their focus will be on providing recommendations on the selection of measures for current public reporting and payment programs like RHQDAPU and PQRI. The input and recommendations from these working groups would flow through the Coordinating Committee to HHS for the purpose of avoiding conflicts and diffusion of Partnership input.

This two-tiered approach with functional work groups under a central committee is a well structured and efficient method of organizing the Partnership. NQF proposes that the Coordinating Committee would need members with subject matter expertise in measurement, public reporting to support informed decision making, and performance-based payment

[2] MedPAC Report to Congress: *Medicare Payment Policy*, 228-9, 237 (March 2010), a*vailable at: http://www.medpac.gov/documents/Mar10_EntireReport.pdf.*

approaches. In the medical rehabilitation arena, there are a number of experts in measurement and public reporting who would be excellent nominees for the Coordinating Committee. Given the opportunity, such nominations could be provided by AMRPA. Therefore, AMRPA would greatly appreciate the opportunity to nominate and have representation on the various committees and groups in the Partnership, and additionally recommends NQF seek nominees from the clinicians that comprise the multidisciplinary teams referenced above.

III. Partnership Involvement of "Multi-Stakeholder" Groups

A. Clarification on methods and functions of stakeholder input

AMRPA applauds NQF's recognition of "the importance of broad stakeholder input."[3] However, it is not clear whether there are two different methods of functional involvement in the Partnership. There appears to be a process whereby NQF alliances nominate members to the Partnership to comment on measures and recommendations to HHS. There also appears to be a separate process whereby the public will nominate people for the multi-stakeholder groups.

The NQF paper on the Partnership states that the "*alliance*s will be solicited for nominations of members to serve on the *Partnership* and for comment on the selected measures and comment on recommendations to HHS."[4] (Emphasis added). On the other hand, the NQF paper also states that "*public* nominations must be sought for members of the *multi-stakeholder groups*."[5] (Emphasis added).

The PPACA defines a "multi-stakeholder group" as a "voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of quality measures."[6] However, by only soliciting alliances for nominations of members to serve on the Partnership and provide input to the Secretary, the Partnership could be losing input from IRH/Us in the quality measure development, selection, discussion and endorsement.[7] While we commend NQF for building upon the work of the AQA Alliance (AQA), the Hospital Quality Alliance (HQA), and the Pharmacy Quality Alliance (PQA), inpatient rehabilitation hospitals and units and their Medicare beneficiaries do not have representation on these alliances. AMRPA's concern is that by only accepting nominations and feedback for the Partnership from the aforementioned alliances, to the exclusion of others, the field of advice and expertise will be narrow.

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[3] NQF, *Establishment of a Partnership for Applying Measures to Improve Quality: to Provide Input on Measure Selection for Public Reporting and Payment Programs*, May 10, 2010, at 3, *available at* http://www.cpehn.org/pdfs/Establishment%20of%20a%20Partnership%20-%20NQF.pdf.

[4] *Id.*

[5] *Id.*

[6] HR 3590 §3014(a)(1), amending SSA §1890(b) by adding (7)(D).

[7] NQF, *Establishment of a Partnership for Applying Measures to Improve Quality: to Provide Input on Measure Selection for Public Reporting and Payment Programs*, May 10, 2010, at 3, *available at* http://www.cpehn.org/pdfs/Establishment%20of%20a%20Partnership%20-%20NQF.pdf.

There should be a clear voice on behalf of IRH/Us and their patients on this Partnership and in the multi-stakeholder groups. AMRPA would greatly appreciate the opportunity to fill this gap and nominate representatives from the field.

B. AMRPA involvement in the multi-stakeholder groups

i. Patient-Focused Coordinating Committee

In the medical rehabilitation arena, there are a number of experts in measurement and public reporting who would be excellent nominees for the Patient-Focused Coordinating Committee. Given that AMRPA is the sole organization representing exclusively the concerns of rehabilitation providers including Inpatient Rehabilitation Hospitals and Units (IRH/Us) and their patients, AMRPA's inclusion in the nominations and comment processes would be a clear voice on behalf of IRH/Us, their Medicare beneficiaries, and their other patients.

ii. Hospital Group

AMRPA members include rehabilitation hospitals that are licensed in each state as hospitals and are further certified by Medicare as hospitals. The major focus of the health reform law is the enhancement of care coordination and transitions of care. Approximately 85% of referrals to our hospitals come from acute care hospitals. Such a process begs for clarity and coordination between measures used and information exchanged. Given AMRPA and its members' expertise in this area, opening the table beyond NQF alliances to AMRPA would be a step toward promoting care coordination and improving the transitions of care.

iii. PAC/LTC Group

AMRPA would also be able to play a valuable role in the PAC/LTC Group. Such involvement would be appropriate if the definition of post acute care for this group includes rehabilitation hospitals, long term care hospitals, and other downstream post acute care providers who receive referrals from acute care hospitals, long term care hospitals, or inpatient rehabilitation hospitals. Given such a definition for the PAC/LTC Group, AMRPA would greatly appreciate the opportunity to nominate representatives from the field to this group.

IV. Summary

For the reasons enumerated above, AMRPA would like to be included in the nominations of members to serve on the Partnership and for comment on the selected measures and comment on recommendations to HHS. In addition, AMRPA seeks the opportunity to have representation on the Patient-Focused Coordinating Committee, the Hospital Group, and the PAC/LTC Group.

AMRPA appreciates the opportunity to review these documents. AMRPA asks that the nomination process be clarified and that it be invited to nominate and have representation on the

various committees/groups in the Partnership. If you have any questions, please feel free to contact me or Carolyn Zollar at AMRPA.

Sincerely,

Bruce M. Gans, M.D.
Executive Vice President and Chief Medical Officer
Kessler Institute for Rehabilitation
AMRPA, Chairman of the Board

cc Carolyn Zollar
AMRPA Board of Directors
Martha Kendrick

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Marla J. Weston, PhD, RN
Chief Executive Officer

June 10, 2010

Janet M. Corrigan, PhD, MBA
President and CEO
The National Quality Forum
Re: Call for Comments on PAMIQ / Electronically via: MeasureApplications@QualityForum.org
601 Thirteenth Street, NW, Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan:

Thank you for allowing the American Nurses Association (ANA), the full-service professional organization representing the interests of the nation's 3.1 million Registered Nurses through its constituent member associations and organizational affiliates, to provide comments on the establishment of the Partnership for Applying Measures to Improve Quality (PAMIQ).

ANA supports the establishment of the Partnership and appreciates the efforts necessary to ensuring its success. ANA, as the largest and most diverse nursing organization, has worked to convene the nursing community to provide input throughout the priority setting process and understands the level of detail inherent in the activity. ANA offers the following input for consideration by the NQF Board of Directors as it moves forward to establish PAMIQ:

- Care must be exercised to ensure that the multi-stakeholder group is composed of organizations representing the broadest level of expertise
- The role and responsibilities of Partners and of NQF must be fully and clearly explicated
- PAMIQ must be of a size that allows for accomplishment of its goals while ensuring a manageable process
- Explicit criteria for measure development must be detailed to ensure a full and robust portfolio.
- Finally, ANA supports ongoing evaluation of the efforts of PAMIQ in improving the health of the population as a marker of success.

ANA looks forward to continuing activities with NQF related to improving the quality of care provided to all in America. If you have questions, or if the American Nurses Association can be of additional assistance, please contact Mary Jean Schumann, MSN, MBA, RN, CPNP, Chief Programs Officer, by phone (301-628-5059), fax (301-628-5012) or e-mail **(**MaryJean.Schumann@ANA.org).

Sincerely,

Marla J Weston

Marla J. Weston, PhD, RN
Chief Executive Officer

The following is a comment submitted via email on June 14, 2010:

Here are the comments from the American Osteopathic Association:

The American Osteopathic Association (AOA) believes that the partnership as outlined in the document entitled "Establishment of a Partnership for Applying Measures to Improve Quality to Provide Input on Measure Selection for Public Reporting and Payment Programs" can only work if physicians have representation on the Patient-Focused Coordinating Committee and the multi-stakeholder workgroups. Physician input into measure selection for public reporting and payment programs will be important to ensure that the measures are accurate for these types of programs.

Any measures that are under consideration should go to the NQF membership for review and comment. AOA agrees that transparency in all aspects of this process is important.

As a member of the Ambulatory Care Quality Alliance (AQA) steering committee, the AOA believes that the AQA could serve as the Clinician Group identified in the diagram on p. 4 of the proposal as one of the four partners envisioned by the NQF. Given the encompassing number of physician (AOA, AMA, ACP, AAFP, ABMS, etc.) and non-physician groups represented on the AQA, this entity can provide the multi-stakeholder approach as outlined in the proposal.

The AOA looks forward to working with the NQF as this proposed partnership becomes a reality. If you have any questions, please contact me. Thank you.

Sharon L. McGill, MPH
Director, Department of Quality and Research
AMERICAN OSTEOPATHIC ASSOCIATION

American Society of
Health-System Pharmacists
7272 Wisconsin Avenue
Bethesda, Maryland 20814
(301) 657-3000
Fax: (301) 664-8877
www.ashp.org

June 30, 2010

Janet M. Corrigan, Ph.D.
President and Chief Executive Officer
The National Quality Forum
601 Thirteenth Street, N.W.
Suite 500 North
Washington, D.C. 20005

Dear Dr. Corrigan:

On behalf of the American Society of Health-System Pharmacists (ASHP), thank you for the opportunity to comment on the Establishment of a Partnership for Applying Measures to Improve Quality, an effort to prepare for a potential new responsibility of convening a multi-stakeholder groups to provide input on the selection of quality measures for public reporting and payment programs.

We commend NQF for leading efforts to develop this partnership and the associated activities and considerations as described. ASHP believes that NQF is the logical consensus-based entity to be tasked with carrying out this consultative process in its role as neutral convener based on its successful work in quality measure endorsement and other consensus-building activities such as the National Priorities Partnership. As CMS selects the quality measures that must be reported in order to demonstrate meaningful use of certified EHR technology under the American Recovery and Reinvestment Act of 2009, CMS will give preference to those endorsed by the NQF. This further demonstrates NQF's success in quality measure endorsement.

ASHP represents pharmacists and pharmacy technicians who practice in a variety of health-systems, including inpatient, outpatient, home care, and long-term-care settings. Pharmacists in health-systems are experts in medication use who serve on interdisciplinary teams to ensure that medicines are used safely, effectively, and in a cost-conscious manner. As the national professional association representing health-system pharmacists, ASHP can offer unique and vital assistance in providing input on the selection of quality measures, especially pertaining to appropriate medication use to optimize patient outcomes. ASHP supports the value of pharmacists' expertise in medication management in quality measures pertaining to the safe and effective use of medications and patient outcomes. The selection and use of quality measures is critical in ensuring optimal drug therapy management, and health-system pharmacists are positioned to best inform this process.

As a member of the National Quality Forum (NQF), ASHP supports the proposed Partnership for Applying Measures to Improve Quality. ASHP strongly believes that ensuring multi-stakeholder involvement in the Partnership for Applying Measures to Improve Quality will serve to align efforts of those involved in healthcare delivery and vastly accelerate improvements in the quality of patient care through payment reform recommendations.

ASHP is pleased to be part of the transformational change in healthcare delivery and payment as a result of the enactment of the Patient Protection and Affordable Care Act. We look forward to ongoing participation in activities that support NQF and the Partnership for Applying Measures to Improve Quality by being actively engaged through the submission of nominations to multi-stakeholder groups, provision of comments, and other activities as needed to support this critical initiative. If you have any questions concerning the Society's support, please contact me by phone at (301) 664-8815 or via e-mail at mandrawis@ashp.org.

Regards,

Mary Andrawis, Pharm.D., M.P.H.
Director, Clinical Guidelines and Quality Improvement

June 15, 2010

Janet Corrigan, PhD, MBA
President & CEO
National Quality Forum
601 Thirteenth Street, NW Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan,

On behalf of the AQA Steering Group, we appreciate the opportunity to provide comments on the National Quality Forum's Establishment of a Partnership for Applying Measures to Improve Quality (PAMIQ) proposal. The AQA is a voluntary multi-stakeholder collaborative of physicians and other clinicians, consumers, purchasers, health plans, and others whose mission is to improve patient safety, health care quality and value in all settings.

The PAMIQ will be established to provide the Secretary of Health and Human Services input on the selection of measures to be used in public reporting and payment programs. We appreciate the NQF's efforts to develop a practical and functional structure to meet the requirements outlined in the Patient Protection and Affordable Health Care Act.

The AQA Steering Group supports the two-tiered model that the NQF has outlined in the PAMIQ document. We believe that this two-tiered structure - with an overall coordinating group and provider-focused workgroups - will facilitate participation by stakeholders and ensure that the various perspectives on measures are communicated to the Secretary.

AQA Role

In September 2004, the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), America's Health Insurance Plans (AHIP) and the Agency for Healthcare Research and Quality (AHRQ) joined together to create a collaborative effort to determine how to most effectively and efficiently improve physician-level performance measurement, data aggregation, and reporting. Since that time, the AQA has transitioned to a multi-stakeholder collaborative of over 100 organizations representing consumer organizations; public and private purchasers/payers; health insurance plans; physician organizations; other clinician organizations; government; organizations representing hospitals; certification, accreditation and other quality measurement and quality improvement organizations; and health care manufacturers. The AQA also expanded its scope to include ambulatory and surgical care settings, as well as other clinician organizations.

The AQA has demonstrated the ability to reach multi-stakeholder consensus on clinician level measures recommended for implementation into public and private programs. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) included language that identified the AQA as a consensus organization that the Secretary could utilize for input on measures proposed for inclusion in the CMS Physicians Quality Reporting Initiative (PQRI)[1]. The AQA worked quickly and effectively to implement voting procedures in accordance with approved operating guidelines as outlined in the AQA governance

[1] Public Law 110–275 Subtitle C: Provisions Relating to Part B, Sec. 131. Physician payment, efficiency and quality improvements http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_public_laws&docid=f:publ275.110.pdf .

document. AQA was able to meet crucial deadlines for reviewing and approving measures by a consensus organization which resulted in additional measures being available for use in PQRI.

The AQA continues to offer guidance on the implementation of measures by providing a forum to discuss lessons-learned from measure implementers, data aggregation projects, and public and private reporting initiatives. AQA meetings allow for stakeholders to exchange information and experiences on best practices and implementation challenges.

In addition to the successful track record of identifying where consensus exists with adoption of measures, the AQA has produced a number of foundational documents that guide and lead use of measures for quality improvement and reporting. These include the *Data Sharing and Aggregation Principles for Performance Measurement and Reporting, Principles for Public Reports* and *Reporting to Clinicians and Hospitals, Parameters for Selecting Measures for Physician and Other Clinician Performance,* and *Principles of Efficiency Measures.* The AQA was also instrumental in calling for a data sharing and aggregation pilot. The AQA proposed project was later implemented as the CMS Better Quality Information to Improve Quality for Medicare Beneficiaries (BQI) special project.

Given the AQA's past role in reviewing measures and advising the Secretary on measures for use in public reporting programs, the AQA Steering Group believes that the AQA should participate as a leader by convening, collecting, and providing summaries of the physician and other clinician perspective within the proposed structure. We further propose that the AQA be designated as a member of the PAMIQ coordinating committee with the ability to name their representative to serve on this committee. We would anticipate that PAMIQ operating procedures would recognize the expertise of existing stakeholder groups to determine who would best represent the organization perspective as a member of the coordinating committee.

Areas for Additional Discussion
The AQA Steering Group identified several areas needing additional detail as the NQF further develops the PAMIQ, including the size and scope of PAMIQ membership, organizational structure and processes, and the timeline for implementation. The AQA Steering Group would be happy to assist the NQF as they progress in developing these areas.

The AQA Steering Group appreciates the opportunity to provide these comments and welcomes the opportunity to discuss them further.

Sincerely,

The AQA Steering Group

Representing the following organizations:
AARP
America's Health Insurance Plans
American Academy of Family Physicians
American Board of Medical Specialties
American College of Cardiology
American College of Physicians
American College of Surgeons
American Osteopathic Association
American Physical Therapy Association
American Psychological Association
Consumers Union
HealthPartners
National Partnership for Women and Families
Society of Thoracic Surgeons
Wisconsin Collaborative for Health Care Quality

Federal Liaison: Agency for Healthcare Research and Quality

Association of
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June 15, 2010

Janet Corrigan, PhD
President and Chief Executive Officer
National Quality Forum
601 13th Street NW
Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan,

On behalf of The Association of American Medical Colleges which represents all 130 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies, we appreciate the opportunity to provide comments on the establishment of the Partnership for Applying Measures to Improve Quality (PAMIQ).

The AAMC has been a strong supporter of providing accurate and valid performance data to the public and spurring quality improvement efforts amongst our members. As a founding member of the Hospital Quality Alliance (HQA), the AAMC has been intimately involved in the HQA's collaborative efforts regarding the Hospital Compare website. This collaborative ensured hospital performance data is reported in a consistent, unified manner, which increased the credibility of the data. The AAMC has also been actively involved in physician measurement and public reporting through the AQA. The AAMC appreciates the opportunity to provide input and direction for public reporting through these alliances.

The AAMC supports the development of the PAMIQ partnership. Through our experiences with HQA and other alliances, the AAMC believes that well-organized multi-stakeholder groups can be an effective way to improve the quality of measures and performance reporting. Given our experiences with these organizations, we would like to provide the following comments on the draft report and offer a few recommendations to ensure a smooth transition to this new structure.

Membership

It is critical that the membership of PAMIQ includes representation from a variety of stakeholders as well as individuals with specific expertise. Because PAMIQ will be tasked with evaluating measures and making recommendations for implementation in public reporting and payment programs, the committee will need individuals with measurement expertise as well as those with actual experience in implementing measures.

A clear set of criteria for the selection of members to PAMIQ should be developed. The criteria should be shared with the public prior to a call for nominations. Once the criteria have been finalized, a set of roles and responsibilities for individuals serving on PAMIQ should be developed and be included in the nomination materials.

Clarification
The Patient Protection and Affordable Care Act (PPACA) legislation requires the Secretary to seek input from a multi-stakeholder group on the selection of measures to be included in public reporting and payment programs. PPACA further defines multi-stakeholder as a voluntary collaborative of organizations representing a broad group of stakeholders. We would like to clarify that the proposed Patient Coordinating Committee as well as the individual provider groups would be multi-stakeholder. We also encourage NQF to identify the proper stakeholders by looking beyond organization affiliation and instead considering both organizational affiliations as well as individual expertise required.

Clear Priorities and Explicit Evaluation Criteria

The HQA has distinguished itself from the NQF in evaluating measures for nationwide implementation by setting priorities for measure implementation and articulating specific evaluation criteria that address issues not covered by the NQF endorsement process. Specifically, the HQA requires the ability to collect the required measure data in a valid, reliable and systematic way that can be replicated on a nationwide basis as a consideration for approval. Once PAMIQ has been formed, the partnership should follow a similar format: 1) agree to clear priority areas that align with the priorities put forth by the Secretary and 2) develop explicit criteria for measure adoption.

To this end, during the past decade considerable experience has been gained in developing and implementing sound, evidence-based performance measures that have significantly improved health care quality. At the same time, much has been learned about the attributes of performance measures that should be factored into both short- and long-term strategic planning by CMS. Specifically, while some measures have proven to be excellent tools in supporting evidence-based quality improvement (i.e., aspirin at arrival, beta blockers at discharge), others do not accurately capture the adequacy of a given process (i.e., smoking cessation counseling), are far removed from a desired outcome (i.e., evaluation of LVS function) or have been reported to have unintended consequences (i.e., timing of antibiotic from hospital arrival in pneumonia). PAMIQ should utilize these criteria and make sure only those measures that support accountability are recommended for use. In doing so, only strong measures, which meet these more rigorous criteria, will be incorporated into public reporting and payment programs. It is essential that the decisions by PAMIQ be informed by experience with measure use.

Clarification
The list of measures provided by the Secretary for PAMIQ review may include measures that have challenges associated with their implementation and therefore would prohibit their inclusion in public reporting until those challenges were resolved. The AAMC recommends PAMIQ have the flexibility to make conditional recommendations contingent on the resolution of those challenges.

Operating procedures

The current draft does not speak to the operating procedures for PAMIQ. We assume, since PAMIQ has not been established, those procedures have yet to be developed. The AAMC supports and encourages the development of PAMIQ operational procedures as well as governance guidelines for consideration by the appropriate parties (e.g. NQF Board of Directors) and make the proposed procedures available for public comment. The development of PAMIQ procedures will be critical in ensuring a successful process moving forward.

Clarification

As stated in the draft report, the Patient-Focused Coordinating Committee will be addressing those measures that cut across individual clinicians and provider sites of care. In addition, the graphical representation of the PAMIQ structure includes a notation stating that the Patient-Focused Committee could handle measures addressing bundled payments or an additional group could be formed for that purpose. The document does not address how the individual provider groups would be a part of these discussions. We believe it is critically important that the PAMIQ structure require the participation and input from the provider groups for decisions regarding measures crossing silos or provider groups.

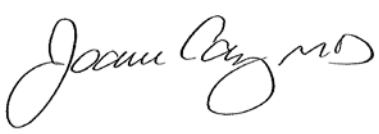
The legislation requires the Secretary to seek input on a list of measures that are being considered for use in current public reporting and payment programs within the next year. The consensus-entity may also provide input on future programs (i.e. demonstration projects). The AAMC would like to clarify whether the measures for the new programs would be included in the annual review of measures or whether the PAMIQ structure would address the measures for these programs on an ad-hoc basis.

Evaluation

The AAMC supports an independent evaluation of PAMIQ following its first set of recommendations made to the Secretary. Continued review and ongoing modifications to the process will ensure a successful outcome.

Thank you again for the opportunity to comment,

Sincerely,



Joanne Conroy, MD
Chief Health Care Officer
Association of American Medical Colleges

Boehringer Ingelheim

Thomas Valuck
Senior Vice President for Strategic Partnerships
National Quality Forum
601 13th Street NW, Suite 500 North
Washington DC 20005

June 15, 2010

RE: Partnership for Applying Measures to Improve Quality

Dear Mr. Valuck,

Hemal Shah, PharmD
Executive Director
Health Economics & Outcomes Research
Boehringer Ingelheim Pharmaceuticals, Inc.
900 Ridgebury Rd/P.O. Box 368
Ridgefield, CT 06877-0368
Telephone (203) 798-9988

On behalf of Boehringer Ingelheim Pharmaceuticals, Inc. (BIPI), I am pleased to submit comments in response to the NQF paper entitled, "Establishment of a Partnership for Applying Measures to Improve Quality to Provide Input on Measure Selection for Public Reporting and Payment Programs."

Boehringer Ingelheim (BI) is committed to ensuring that federal quality improvement initiatives, including public reporting and payment programs, accurately incorporate relevant stakeholder perspectives to improve health care quality. We support NQF's proposal for convening stakeholders to inform CMS programs but ask for further clarification and transparency on several elements of the proposal. In this letter, we provide comments on the following areas:

- Clarity Needed around Stakeholder Involvement
- Additional Transparency Needed around Member Selection and Measure Evaluation
- Defining Evaluation Criteria
- Additional Programs for Evaluation
- Additional Specificity Needed on Evaluating the Partnership
- Maintaining Independence from NQF Board

Clarity Needed around Stakeholder Involvement

BI supports the Partnership's effort to maintain formal relationships with relevant federal agencies, in particular the Centers for Medicare & Medicaid Services (CMS), CMS' contracted Quality Improvement Organizations (QIOs), and the Agency for Healthcare Research and Quality (AHRQ). These agencies have valuable perspectives and extensive experience in developing, housing, maintaining, and using measures for federal public reporting and quality improvement initiatives. We recommend that NQF clarify the nature of relationships anticipated with these agencies, such as the channels that will be made available for them to provide data, input, and/or respond to the Partnerships recommendations. We also suggest that NQF provide detail on the experience, expertise, and position of federal officials who will serve as liaisons to the Partnership. Additional information on the frequency and nature of communications between these liaisons and the Partnership is also needed. Transparency about the Partnership's relationship with CMS is especially important since the Partnership is

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primarily intended to provide recommendations that will ultimately support CMS' current and future programs.

Further, with the establishment of the CMS Innovation Center under the Affordable Care Act (ACA), BI supports the Partnership's proposed role to provide input on measures included in CMS pilots and demonstrations. This role would help ensure that the new payment and delivery models are tested to determine the impact on quality of care. However, we recommend that the Partnership clarify how its relationship with CMS and its recommendations on measures will impact subsequent CMS activities such as rulemaking.

Additionally, NQF should clarify how the Partnership will coordinate with quality alliances not selected to participate in the membership. As indicated in the paper, coordination with quality alliances will help avoid duplication of effort by the volunteer members of the alliances and the Partnership. However, this coordination appears to be limited to alliances that are selected to participate in the Partnership. Communication with other alliances, through formal comment opportunities or other relationship-building, is also important. We recognize that it may not be possible or necessary to comprehensively involve all alliances equally, but communication and coordination among key stakeholders should be maintained.

Additional Transparency Needed around Member Selection and Measure Evaluation

BI supports NQF's effort to ensure a transparent and iterative process for selecting members of multi-stakeholder groups and the effort to incorporate diverse perspectives on the proposed central Patient-Focused Coordinating Committee. However, we recommend that NQF clarify the anticipated composition of the Patient-Focused Coordinating Committee, criteria for selecting members, and subsequent comment opportunities on the selections. NQF should make the expected composition of Committee representatives and member selection criteria publicly available prior to soliciting membership nominations and provide a formal opportunity for stakeholders to submit input on each. BI supports the opportunity to subsequently comment on the proposed Partnership roster before it is finalized (as indicated in the paper) and proposes that additional time (30 days total) be added to the typical NQF comment period on steering committee rosters (currently 14 days). To ensure the Partnership incorporates balanced perspectives on measures, we recommend that additional "tier 2" workgroups be included to gather input from payers and healthcare product suppliers, rather than only care setting-focused workgroups as currently outlined in the paper.

We also suggest that NQF clarify the process for gathering public input on the Partnership's recommendations. For consistency, BI recommends that NQF maintain its policy of a 30-day comment period on measures. For ease of submitting and comparability across comments, the Partnership should develop a clear format for submitting written comments. Further, in order to maintain full transparency, the Partnership should also align with the NQF by ensuring that all of the stakeholder comments are made available to the public via a web-based platform or some other avenue.

Finally, we recommend that NQF clarify the "research entities" that might receive contracts for analysis to support decision making, including both type of institute (e.g. academic center) and specific organizations if they have already been identified (e.g. IOM, NIH, AHRQ). NQF should also provide additional transparency and clarification on the criteria that will be used to select these research entities.

Defining Evaluation Criteria

We ask that NQF provide clarification on the "stronger analysis" that the Partnership will provide for decision-making described in the paper and how this analysis will differ from NQF's current endorsement processes and criteria. For example, if nominees to the Partnership will have different or more extensive expertise than current NQF members, this should be indicated, as well as what new type of expertise will be required and where the Partnership will seek experts for membership during the nomination process. Similarly, if the Partnership's criteria for evaluating and recommending measures differ from NQF's current criteria used to

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endorse measures, it should be clearly defined and made available for comment by the public and NQF members.

Additional Programs for Evaluation

In addition to providing input on measures in the Reporting Hospital Quality Data for the Annual Payment Update (RHQDAPU) program and the Physician Quality Reporting Initiative (PQRI), BI recommends that the Partnership evaluate other public reporting programs not indicated in the paper, particularly the Hospital Outpatient Data Reporting Program (HOP QDRP). HOP QDRP measures to date have been largely aligned with RHQDAPU program metrics, but to make the program more effective, measures must be differentiated to target outpatient services. Providing guidance on measure selection for the HOP QDRP, PQRI, and RHQDAPU will help ensure appropriate measure alignment between these programs.

Additional Specificity Needed on Evaluating the Partnership

BI agrees that periodic evaluation of the Partnership is necessary to assess the group's structure, processes, and impact. However, we ask that NQF clarify the metrics that will be used to evaluate success in these areas. We propose that the Partnership's structure and processes be quantitatively evaluated for several specific areas:

- Success in appointing a diverse body of stakeholders to the Partnership,
- Optimized resource utilization in the Partnership's interactions with CMS and other federal agencies, and
- Minimal duplication of effort with existing stakeholder input-gathering exercises.

Further, this evaluation should include careful review of the Partnership's ability to provide an accurate and representative picture of stakeholder interests to the Secretary. One option to evaluate impact would be a qualitative analysis of whether stakeholder comments were incorporated in final decisions.

Maintaining Independence from NQF Board

Finally, we support NQF's decision to keep the Partnership independent of the NQF Board and its governance processes. NQF endorses measures for use by a wider range of stakeholders while the Partnership is intended to focus on measures for CMS programs.

In conclusion, we look forward to working together to maximize the value of this Partnership for all relevant stakeholders.

Sincerely,

Hemal Shah, PharmD
Executive Director, Health Economics and Outcomes Research
Boehringer Ingelheim Pharmaceuticals, Inc.
900 Ridgebury Road / PO Box 368
Ridgefield, CT 06877-0368

The following is a comment submitted via email on May 18, 2010:

Thank you. I appreciate this important effort and submit the following comments for your consideration.

Physicians and hospitals are unsure of how to proceed moving forward because of the lack of comprehensive safety/quality systems available currently for broad reporting.

Additional partners:
1. Payers- Kaiser Permanente has a lot of interests that overlap with this.
2. Agree with need for Federal input in process/ define expectations etc
3. Continued patient input.
4. Software vendors for input on what is reasonably possible versus costs of reporting.

Consider partnerships using existing sources of data:
1. NCDR/ACC data bases. Large data cardiovascular data bases with co morbidities which also could enable assessment of co morbidities as well as the cardiac conditions.

Many of current measures are process based. Consider developing measures that are combinations of process and outcome. This is important. For example, as one of the areas of focus is hospital acquired infection. However, if one considers only the infection (outcome), then hospitals which serve populations with high incidence of HIV could unintentionally end up being shut down as they will have higher frequencies of HAIs despite the best processes. They need to be judged on how well they attempt to deal with a bad situation, and not just penalized because that the hospital is serving an outlier population.

Another example is that of infections in implantable defibrillator patients. Hospitals that serve direct emergencies will have more patients with fresh out-of-hospital cardiac arrests. Those patients commonly aspirate in the field, and are intubated in the field and have IVs started in ambulances all of which contribute to subsequent detection of infection 48 hours later when the patients are in the hospital. Those infections will largely not be preventable by the hospital actions.

As you consider quality measures how do you apportion the contributions of hospital based physicians, hospitals, patient factors, and out patient based physicians in the endpoint outcome?

The recent concern about industry/physician relationships and conflicts of interest, probably precludes industry from being involved directly in the quality assurance program. However, industry can certainly contribute in a consultative manner.

Thank you for your consideration.

Arjun D. Sharma, M.D., FACC,
Vice President, Patient Safety,
Boston Scientific Corporation CRM

Edwards Lifesciences
Global Reimbursement and Health Economics

June 15, 2010

Janet M. Corrigan, PhD, MBA
President and CEO
National Quality Forum
601 Thirteenth St., NW
Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan:

As a new member to NQF, Edwards Lifesciences appreciates the opportunity to submit comments with regard to the "Establishment of a Partnership for Applying Measures to Improve Quality".

Edwards strongly supports NQF's potential selection as the "consensus-based entity" with the new duties as defined by the Patient Protection and Affordable Care Act (PPACA). NQF has made considerable strides since its inception and currently plays, arguably, the preeminent role in quality measure development and implementation in the United States. The existing process NQF utilizes in its formal "Consensus Development Process" (CDP) to evaluate and endorse quality measures, in fact, already incorporates multi-stakeholder groups via its philosophy and model of involving NQF's broad membership of healthcare organizations throughout the process, whether it be the initial "Intent to Call for Candidate Standards" stage to the selection of each project's Steering Committee and Technical Advisory Panel. Thus, NQF is a natural section for this newly defined role being that the primary goal is to work effectively with multi-stakeholder groups to provide agreed upon input to the Secretary of Health and Human Services.

Furthermore, Edwards believes the proactive steps that NQF is taking in order to "hit the ground running" is very forward-thinking and will undoubtedly prove to be impactful from the start. Specifically, Edwards agrees with the idea of a "two-tiered" structure and hopes the final process includes a true tiered process, rather than simply 4 different work groups handling 4 different types of measures. Edwards believes it is vital for the Patient-Focused Coordinating Committee to have more than just the "strategic" role indicated. In addition to getting the much needed input from the more specialized work groups (i.e., Hospital Group, Clinician Group, PAC/LTC Group), Edwards believes the Patient-Focused Coordinating Committee should consist of other stakeholders involved in the patient's care, including members across all NQF Councils that could review the recommendations and balance them with a more comprehensive perspective. This would facilitate critical, yet difficult, discussions, and would also allow for genuine multi-stakeholder, agreed-upon recommendations. We strongly encourage consideration of the value of contributions from stakeholders across the various provider constituencies in the Partnership. This includes representatives from the medical technology industry that partner with clinicians to develop medical devices, diagnostic products, and health information systems that save lives and enhance patient quality of care through earlier disease detection and minimally invasive procedures.

Additionally, it will be important that the Partnership plan be updated with the conclusions obtained from the two NQF task forces currently working on evaluating the evidence that supports the quality

measure endorsement process ("Guidance for Evaluating the Evidence Related to the Focus of Quality Measurement"). This will allow for greater consistency in the evidentiary requirements and analytical activities needed to support these measure recommendations.

Edwards appreciates the opportunity for comment. Understanding that this is a high-level plan, we look forward to the opportunity to work with NQF in refining the details of the plan as NQF progresses further towards implementation as the "consensus-based entity".

Sincerely,

Dirksen Lehman
Vice President, Government Affairs and Reimbursement

Edwards Lifesciences

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Statewide Parent Advocacy Network, Inc.

Empowered Families: Educated, Engaged, Effective!

Family Voices-NJ Comments to the National Quality Forum:
Partnership for Applying Measures to Improve Quality
To Provide Input on Measure Selection for Public Reporting and Payment Programs

6/14/10

Thank you for the opportunity to comment on the proposed document "Establishment of a Partnership for Applying Measures to Improve Quality: To Provide Input on Measure Selection for Public Reporting and Payment Programs." Family Voices is a national network that advocates to "keep families at the center of children's health care," with a special focus on behalf of children with special healthcare needs and their families. Our NJ Chapter is housed at the Statewide Parent Advocacy Network (SPAN), NJ's federally funded Parent Training and Information Center which is also NJ's Family-to-Family Health Information Center and a chapter of the Federation of Families for Children's Mental Health. The Family Voices Coordinator also serves as the NJ Caregiver Community Action Network representative for National Family Caregivers Association in a volunteer capacity. Our comments are as follows:

In general we understand that the Patient Protection and Affordable Care Act (PPACA) has new requirements for multi-stakeholder input assigning new duties to the consensus-based entity, and that the National Quality Forum (NQF) is a consensus-based entity under Health/Human Services (HHS) and may additionally be asked to act in a consultative capacity "as a neutral convener." We appreciate that the "consensus-based entity...is not charged with making recommendations to the Secretary, so that Partnership…substantive recommendations will not flow through the NQF Board…" We agree that "a mechanism for the NQF Board to address issues raised about the Partnership's processes will need to be established."

Activities of a Partnership for Applying Measures to Improve Quality

We agree that "public reporting and payment programs are construed expansively" and should cover "Medicare payment…HHS public reporting, etc." We agree that the definition of "multi-stakeholder group" is a "collaborative of organizations representing a broad group of stakeholders" and would suggest this must include consumers and consumer groups, and particularly organizations that represent the interests of those at greatest risk of poor quality healthcare and disparate health outcomes, i.e., patients with

disabilities and/or special healthcare (including mental health) needs, immigrants, speaking languages other than English, with low and moderate incomes, etc.
We strongly support that starting with 2011, HHS will "make available to the public a list of measures…being considered." We also agree that, starting in 2012, "the entity must transmit the pre-rulemaking input of the multi-stakeholder groups to HHS," including input to the Reporting Hospital Quality Data for the Annual Payment Update program (RHQDAPU) and the Physician Quality Reporting Initiative (PQRI).

The document states "in the longer term" it would include input on "hospital readmissions reduction" and "payment adjustment for conditions acquired in hospitals." We would suggest however, that these should be done initially in keeping with best practices for health outcomes, including the Medicaid discontinuance of reimbursement for medical errors. The plan also relegates in the long term key issues such as the medical home (Medicare), accountable care organizations, and bundled payment approaches. We strongly urge the Partnership to begin work as soon as possible on the Medicare pilot demonstrations for the medical home, as the medical home has the potential to both reduce unnecessary expenditures and more importantly result in better health outcomes, particularly for children and youth with special healthcare needs and their families. We feel that bundled payment approaches will enhance the medical home and can be utilized under PPACA funding for Health Information Technology (HIT). Indeed, at our recent NJ Statewide Health Care Reform Implementation Conference 6/8-9, ACOs (Accountable Care Organizations) were seen as a key ingredient for both cost quality and health equity.

We were pleased to see that the new statute requires HHS "to publicly report performance information though standardized websites". We were pleased to see that this information will meet the needs not only of hospitals, health care providers, researchers, and policymakers but most importantly patients and other consumers. As an organization that works extensively with families who speak languages other than English, it is critical that the "standardized websites" provide access to those with limited English proficiency as well as limited literacy. Further, consideration must be given to ensuring availability of performance information for those with limited or no access to the web at home, through partnerships with libraries, community-based organizations, schools and community colleges, as well as through availability of hard copies.

Key Considerations in Establishment of a Partnership for Applying Measures to Improve Quality

Involvement of stakeholder groups: We agree that there must be coordination between current activities of "quality alliances and the new activities of the Partnership…to avoid duplication of efforts." We support the notion that the alliances will be asked for "nominations of members to serve on the Partnership and for comment on the selected members and comment on recommendations to HHS." We would hope that the alliances would solicit prospective members on a widespread basis from a variety of external consumer advocacy groups, including in particular those representing communities who face the greatest health disparities. In addition, it would be important to include representatives who work at all levels – national, regional, state, and local –

because the application of quality measures impacts each of these levels differently. These diverse perspectives would strengthen the final recommendations.
Transparency and due process: Again, we support that "public nominations must be sought for members of the multi-stakeholder groups, and public comment must be sought on member selections." We strongly support the notion that meetings "will be publicly announced and convened in open session…Summaries of deliberations will be publicly available in a timely manner…Public comment will be sought on recommendations." We would urge the continued availability of comments online and recommend that meetings also be broadcast as webinars or telephone conference calls to maximize accessibility to the larger public.

Analytic support for evidence-based decision making: We agree that both in-depth and quick turnaround analyses must be available. We support but are not limited to the examples of 1)an in-depth RAND project that is currently in use which includes ACOs, medical home, bundling, etc. (also support others like Mathematica, Kaiser, RWJ studies etc.); 2) the ECRI Technology and Planning Assessment due to their evidence based experience in researching medical procedures/devices/drugs and patient outcomes; as well as the 3) CHBRP (Californian Health Benefits Review Program "to provide an independent analysis of the medical, financial, and public health impacts of proposed health insurance benefits, mandates, and repeals."

Flexible structure: We strongly support the 2 tier approach which includes the Patient-Focused Coordinating Committee as well as the "multi-stakeholder work groups addressing measures for specific care providers." We agree that the Patient-Centered Coordinating Committee would focus on "measures needed for public reporting and payment approaches…" We would suggest collaboration with the Patient Centered Primary Care Collaborative found at www.pcpcc.net as well as the national center for medical home housed at the American Academy of Pediatrics. We strongly support the Patient-Centered Coordinating Committee addressing "shared accountability and care coordination" and highly recommend approaches like "Take Charge of Your Health" (see http://patienteducation.stanford.edu/programs/cdsmp.html) and Health Dialog (see www.healthdialog.com/Main/PersonalHealthCoaching/SharedDecisionMaking).

Thank you again for the opportunity to comment on the NQF proposed guidelines on Establishment of a Partnership for Applying Measure to Improve Quality.

Sincerely,

Lauren Agoratus, M.A.-parent
NJ Coordinator- Family Voices at the Statewide Parent Advocacy Network
NJ Caregiver Community Action Network-Nat'l Family Caregivers (volunteer)
35 Halsey St., 4th Fl., Newark, N.J. 07102
(800) 654-SPAN ext. 110
Email familyvoices@spannj.org
Website www.spannj.org

Our Mission: To empower families and inform and involve professionals and other individuals interested in the healthy development and educational rights of children, to enable all children to become fully participating and contributing members of our communities and society.

HOSPITAL QUALITY ALLIANCE Improving Care Through Information

June 15, 2010

Janet Corrigan, MBA, PhD
President and Chief Executive Officer
National Quality Forum
601 13th Street NW, Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan,

The Hospital Quality Alliance (HQA) is pleased to provide the following comments for NQF Board consideration in establishing the Partnership for Applying Measures to Improve Quality (referred to in this letter as the Measures Partnership). Please do not hesitate to contact Alyssa Keefe, HQA Managing Director by phone at 202-478-9927 or by email akeefe@aamc.org if you have any questions.

Background
Established in December 2002, the HQA is a national public-private collaboration that is committed to making meaningful, relevant, and easily understood information about hospital performance accessible to the public, and to informing and encouraging efforts to improve quality.

The HQA believes that the availability and use of clinical quality, patient experience, equity, efficiency, and pricing information will spur positive changes in health care delivery. A cornerstone of our collaboration is *Hospital Compare* (www.HospitalCompare.hhs.gov) which publicly reports hospital performance in a consistent, unified manner to ensure the availability of credible information about the care delivered in the nation's hospitals. Among other important activities, the HQA has a long history of prioritizing and advocating for the nationwide implementation of quality measures, many of which are currently used in CMS public reporting programs for hospitals. Since the inception of CMS's hospital inpatient public reporting program, the HQA has been a leader in recommending and implementing measures and providing feedback on the feasibility and usability of the measures in the hospital setting.

The HQA supports the establishment of the Measures Partnership, and appreciates the chance to provide our thoughts on both the opportunities and challenges ahead, and to reflect on many of the lessons learned that will serve to strengthen the Measures Partnership going forward. Our experience has demonstrated that a broad-based, multi-stakeholder consensus-based coalition can be effective in producing high quality, useable information for consumers and providers alike.

The members of the HQA have the ability to speed implementation and effective use of quality data. Equally important, members identify and address the barriers to implementation and work to overcome those barriers. Balancing the need for clinically meaningful and patient actionable measures with the burden of data collection is one of the challenges we face. Despite the fact that the HQA has advanced measures it believes to be clinically important and that would inform consumer decision making, it remains an ongoing challenge to ensure that published reports are meaningful and useful to consumers. **A strategic focus for the Measures Partnership will be to address how to advance the use of quality information by patients and providers.**

HQA's experience in advancing quality measures for nationwide implementation makes us uniquely positioned to share perspective and expertise as this new Partnership is launched. We offer the following recommendations for NQF Board consideration and look forward to ongoing dialogue with NQF and other interested stakeholders to ensure that the consultative process envisioned in the Affordable Care Act is successfully implemented.

Membership and Support Structure

Each HQA member brings expertise related to quality measurement, as well as representation of the perspective of important stakeholder groups. Many members play a significant role in the development and/or implementation of hospital quality measures.

"Multi-stakeholder group" is defined in the Affordable Care Act statute as a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of quality measures. **The HQA recommends that the NQF consider developing more specific membership criteria for use within the framework of the law. These criteria would focus on membership to the Patient Coordinating Committee, as well as the subgroups.**

The HQA developed membership criteria in 2007 and offers the following for consideration.

- The mission, membership, and capabilities of the organization are of critical importance. Organizations with a narrow or singular interest bring a more limited perspective to the deliberations;
- The organization's ability to bring a unique constituency or membership not already represented by other nominees (or future members);
- The individual or organizations involvement in key measurement and reporting activities, forums or initiatives (e.g., prior experience with measure development, endorsement, implementation, validation, etc.);
- The individual or organizations particular expertise or perspective and how it can help advance national transparency efforts, and
- Whether the individual or the organization has the ability to meet the responsibilities outlined by the Measures Partnership (see note below).

Before finalizing criteria for membership, **HQA encourages NQF to articulate the expectations, roles and responsibilities of Measures Partnership nominees (noted above) and, to the extent possible, delineate the operational structure anticipated to be put into place to support the work of Measures Partnership.** This additional information will be critical to informing the nomination and selection process. For example, the HQA has relied heavily on the volunteer time of our Principals and a small group of staff volunteers from our member organizations to accomplish its work. Often, additional resources are needed.

Finally, right-sizing the Measures Partnership is vital to its flexibility and ability to fulfill its charge in a timely fashion. HQA's experience with a relatively small and constant membership has been successful in advancing hospital quality measures for nationwide implementation. Currently, HQA has 19 members. Mutual respect and a familiar dialogue have been established over time, and created a climate that facilitates difficult conversations with the objective of reaching consensus. **We encourage NQF to keep membership in Measures Partnership to a manageable size. The work that needs to get done is significant and resources are limited. A select number of key stakeholders will make the process more manageable**. Finally, the Measures Partnership should be informed by a broad set of

perspectives, so it will be critically important for it to have a strategy for soliciting input from all interested stakeholders.

Clear Priorities and Explicit Evaluation Criteria

The HQA has distinguished itself from the NQF in evaluating measures for nationwide implementation by setting priorities for measure implementation, and articulating measurement evaluation criteria that are distinct from the NQF endorsement criteria (See Attachment A). Specifically, the ability of required data for the measure calculation to be collected systematically and replicated on a nationwide basis is a key consideration in HQA approval. **The Measures Partnership, once formed, should consider and agree upon clear priorities that align with the national priorities set forth by the Secretary, and consider explicit criteria for measure adoption.** In addition, more explicit criteria beyond those currently available related to the use of measures in payment programs, may need to be developed. For example, the relationship between process and outcome measures and the utility of measures in driving performance should be evaluated and considered. Finally, the information regarding a patient's ability to use the measures in a way that is meaningful for health care discussions and for engagement with their physicians and providers is of great importance as we endeavor to create a public reporting program that is patient centric.

The number of endorsed measures greatly outweighs the infrastructure's ability to publicly report them all at this time. Well defined and agreed upon criteria and priorities are of critical importance moving forward. In addition, reflecting on the appropriate use of the current measures in future pay for reporting programs will also be important.

The HQA strongly supports NQF's plan to provide strong evidence based analytical support to the Measures Partnership. This support will be necessary when trying to evaluate one measure against another or in appropriately applying measurement criteria for the use of measures in payment and public reporting programs. The HQA's recommendations have relied on the experience of our members, and on occasion limited data analysis. Additional resources are essential to ensure that the Measures Partnership is successful.

Finally, one of the limitations of the work at the HQA has been its ability to influence the measurement development process. The HQA is often evaluating measures that are available, rather than calling for the development of measures that are rooted in a shared vision for public reporting or part of a broader strategic plan for measurement use in payment programs. **The HQA supports the efforts of NQF and the leadership of HHS to bring alignment to these processes and encourages participation by the Measures Partnership in these efforts.**

Defining Scope

While the charge of Measures Partnership is statutorily clear, the HQA encourages the NQF to consider a defined scope of work for the Measures Partnership as a way to limit duplication of effort or unnecessary overlap as we embark simultaneously on many new initiatives. We acknowledge that this scope will likely evolve over time, but an agreed upon set of expectations developed through consensus will ensure that resources are not wasted.

Strategic Coordination and Communication

Recently, the Alliances have had discussions about how to coordinate efforts across care settings in the areas of quality measurement. Once established, the Measures Partnership will bring many

stakeholders together, and we are heartened about the opportunities for additional collaboration. Each NQF convening activity (e.g. National Priorities Partnership (NPP), the Measures Partnership, and the Measure Endorsement Process) has a different focus and purpose, but all are interrelated. **The HQA encourages the development of a strategic communications plan that will facilitate coordination, where appropriate, among each of these activities. This plan should assess the strengths, weaknesses, opportunities and threats for further consideration and discussion.**

Rules of the Road

The current draft does not speak to the "rules of the road" for the Measures Partnership. **The HQA supports and encourages the Measures Partnership, once formed, to develop a proposed set of operational procedures and governance guidelines for consideration by the appropriate parties (e.g. NQF Board of Directors) and make the proposed procedures available for public comment.** We anticipate that this will grow and evolve over time but should be of highest priority once the Measures Partnership members are named.

The Role of NQF in the Measures Partnership

The NQF is a member of the HQA steering committee and fully participates in HQA activities. The HQA appreciates and values the contributions of NQF to this process. **Given NQF's role as an HHS contractor, convener of the NPP, and member of several Alliances, it will be important to clearly define NQF's roles and responsibilities as the Measures Partnership is established and formed.**

Transparency, Due Process, and Disclosure of Conflicts of Interest

The HQA strongly supports the transparency and due process that is outlined in the draft paper. **In addition, the HQA urges NQF to examine its conflict of interest policies and determine what changes, if any, need to be made to strengthen the Measures Partnership process. The NQF should consider a public reporting of conflicts of interest for all Measures Partnership members.**

As noted in the relevant sections of the Affordable Care Act below, the timeline for measures to be proposed and for feedback to be provided for inclusion in payment programs is short. **To ensure due process and increased transparency, we encourage NQF to consider the timeline for actions of the Measures Partnership and post it publicly as soon as possible.** The Measures Partnership will benefit from the expertise of the public and other stakeholders who will likely comment during the public comment phases of this process. Having an understanding of that process and timing as early as possible will be critical to ensure active participation.

Section 3014 of Affordable Care Act notes:

- *Beginning in 2011, by December 1 the Secretary shall make public the list of quality measures being considered for use in public reporting or payment;*
- *Beginning in 2012, by February 1, the Secretary must implement a facilitated process through which she receives multi-stakeholder feedback. To develop this feedback, an independent entity must convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures and national priorities for quality improvement for use in public reporting and public health care programs. The Secretary must take into consideration the input from these multi-stakeholder groups. Where the Secretary proposes to use measures that have not received national endorsement, the Secretary shall publish in the Federal Register the rationale for such use.*

Evaluation

The HQA strongly supports an independent evaluation of Measures Partnership and NPP following its first set of recommendations made to the Secretary. In addition, monitoring our ongoing progress in improving the health of the country will be an important indicator of the success of our coordinated activities.

We appreciate your consideration of our comments and look forward to continuing to work with you.

Sincerely,

AARP
AFL-CIO
American Hospital Association
American Medical Association
American Nurses Association
Association of American Medical Colleges
Federation of American Hospitals
National Association of Children's Hospitals and Related Institutions
National Association of Public Hospitals and Health Systems
National Business Coalition on Health
Society of Critical Care Medicine
The Joint Commission
Wisconsin Collaborative for Healthcare Quality

Attachment A: HQA Measurement Evaluation Criteria

ATTACHMENT A

HQA CRITERIA FOR ASSESSING NQF-ENDORSED MEASURES FOR ADOPTION AND PRIORITIZATION
Updated 9/10/09

HQA relies on the National Quality Forum (NQF) to endorse performance measures that are important, scientifically acceptable, usable, and feasible. One of the HQA's key activities is to review NQF-endorsed measures to determine which ones enjoy broad, multi-stakeholder support and can be implemented on a national basis in the near-term. The HQA assesses measures for their relative importance and their ability to be implemented on a national basis using the following criteria.

HQA Evaluation Criteria for HQA Approval
IMPORTANCE
The measure is endorsed by the NQF. (This includes NQF Time-limited measures. This policy is expected to be revisited in September 2010)
The measure(s) address one or more of the areas set forth in the National Priority Partnership as well as the HQA priorities. • Patient and Family Engagement • Population Health (HQA Conditions: delivery/newborn, diabetes, hypertension, cancer, behavioral health, stroke, cardiac, bone/joint) • Care Coordination (Current HQA Priority) • Palliative and End-of-Life Care (Current HQA Priority) • Safety (Current HQA Priority) (HQA: Patient safety and medication management) • Overuse (HQA: inappropriate treatment, resource utilization) • Cost/Price (Current HQA Priority)
The measure(s) address a critical area where there is opportunity for improvement and the measures(s) themselves will drive system change or and/or quality improvement
The measure addresses performance in multiple care settings and the continuum of care (Clarification: Where appropriate, the HQA has called for measures that can be consistently applied to multiple care settings. For example, the AMI measures that are currently reported or will be reported in the inpatient and outpatient setting are one example. In addition measures that cut across the hospital outpatient department to the ASC setting are also of interest. The HQA has also stated its interest in episode of care measures for the future.)
The measure is specified in a way that will allow for identification of disparities in care (Clarification: The measure results can be stratified according to race, gender and ethnicity, to allow for analysis of how the process or outcome being measured affects different patients.)
USABILITY
The measure(s) show variation among providers' performance
The measure(s) are part of a group that address the same construct, condition, procedure or setting, and taken together provide a picture of care to both providers and consumers
The measure(s) addresses outcomes
The measure(s) addresses efficiency
The intent of the measure and the measure(s) themselves are understood by consumers
The measure(s) are actionable by providers, health plans, and purchasers

The measure(s) are applicable in a variety of settings or to a range of hospitals, e.g., small and large, urban, rural, and children's
The measure(s) has the potential to be applied to an episode-of-care framework or composite in the future (Note: This statement is a first step in indicating the HQA interest in measures that move us in this direction for the future.)
FEASIBILITY
The measure has been fully tested and validated in the care setting in which it's been intended to measure. (Note: This is somewhat repetitive of the first importance criteria but worth a second mention. For example a measure specified for the physician office and tested for that care setting may also be deemed applicable for the hospital outpatient setting. However, before implementation it must also be field tested in the outpatient setting to ensure the feasibility and integrity of data collection as well as appropriate validation mechanisms are in place.)
The measure(s) are sufficiently specified for national, standardized implementation into the RHQDAPU or HOP QDRP program.
There is an existing data source or mechanism to collect data. More specifically, there is an identified data repository (or a planned data repository), i.e., CMS and or TJC are able to accept data from hospitals.
The data source is readily available and can be used to publicly report the measure

The following is a comment submitted via email on May 18, 2010:

While it is good to use (1) a central, multi-stakeholder coordinating group, named here the "Patient-Focused Coordinating Committee," and (2) multi-stakeholder work groups addressing measures for specific care providers like hospitals and clinicians, a significant blind spot exists with this approach. It is the lack of employer/small business feedback.

Yisrael M. Safeek, MD, MBA, CPE
CEO, Integrity Physician Solutions
Board Of Examiners, The Malcolm Baldrige Program

KIDNEY CARE PARTNERS

June 15, 2010

Janet M. Corrigan, PhD, MBA
President and CEO
National Quality Forum
601 13th Street, NW, Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan:

Kidney Care Partners (KCP), a coalition of patient advocates, dialysis professionals, care providers, and manufacturers working together to improve the quality of care for individuals with Chronic Kidney Disease (CKD), appreciates the opportunity to review and provide comments on the National Quality Forum's (NQF) Establishment of a Partnership for Applying Measures to Improve Quality paper. As an NQF Member, we commend you for thoughtfully and proactively planning for the new responsibilities that will presumably be conveyed to NQF under the Patient Protection and Affordable Care Act.

While the near term activities of the NQF Partnership will focus on the Reporting Hospital Quality Data for the Annual Payment Update program and the Physician Quality Reporting Initiative, KCP recognizes that the influence of the Partnership in the long term will likely be far-reaching, affecting such systems as the End-Stage Renal Disease Quality Incentive Payment program. We support the creation of a Consultative Partnership, in particular the eventual expansion of its roles and responsibilities, as outlined in the NQF brief. The Department of Health and Human Services and the Centers for Medicare and Medicaid Services should not make decisions about measures for the government's quality programs without systematic, broad-based, and transparent stakeholder participation.

Specifically, KCP welcomes and encourages the multi-stakeholder input that would be provided by the Partnership in the selection of quality measures for ESRD public reporting and payment programs. We view the Partnership's prioritization of this prevalent and devastating disease as an accurate and appropriate reflection of its staggering personal, fiscal, and societal burden and strongly encourage the final document to make this a clear priority in light of CKD's impact on U.S. health, in particular its disproportionate impact on minorities.

> Approximately 26 million Americans—1 in 9 adults—are stricken with CKD and in 2007, the adjusted rate of prevalent and incident end-stage renal disease (ESRD) cases reached 1,665 and 354 per million population, respectively.[1]
>
> The disease burden of CKD and ESRD disproportionately affects minority populations, in particular African American and Latino populations: The rate of

[1] U.S. Renal Dialysis System, USRDS 2009 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States. 2009.

ESRD in minority patients ranges from 1.5 to 4 times those of age-adjusted Caucasian patients.[2]

Risk of hospitalization is 1.25 times greater in patients with CKD than in patients without, and adjusted hospital admission rates for dialysis patients have fallen only 1.5% since 1993.[3]

Risk of death is 1.72 times greater for patients with CKD and adjusted all-cause mortality rates are 6.7 to 8.5 times higher for dialysis patients than for their counterparts in the general population. Nearly 85,000 Americans die with kidney failure each year.[4]

The long-term effects of ESRD diagnosed in childhood include increased risk of death from cardiovascular disease, making this population many times more likely to die from cardiovascular causes compared to age-matched controls.[5]

In 2007, costs for Medicare patients with CKD reached $57.5 billion and costs for ESRD rose 6.1 percent, to $23.9 billion—5.8% of the Medicare budget. Expenditures for patients with CKD with Medicare as primary payer now account for nearly 28% of Medicare spending.[6]

Additionally, as a coalition that has both developed and campaigned for the use of endorsed national consensus standards and as the only provider group facing the implementation of a true pay-for-performance program under the Medicare Improvements for Patients and Providers Act of 2008, KCP fully comprehends the importance of convening a broad and diverse set of stakeholders when developing and selecting measures for public reporting and payment programs. We recommend that the final document more strongly emphasize the importance of broad participation of knowledgeable individuals with an understanding of the practical applications of measures and data elements to ensure that those that are selected are feasible. Toward that end, while the reference to engaging the Quality Alliances is a start, we suggest also including the Kidney Care Quality Alliance among those who should be consulted.

Again, thank you for this opportunity to respond to the NQF's Establishment of a Partnership for Applying Measures to Improve Quality paper, and we look forward to joining you in this important work as the Partnership's roles and responsibilities expand.

Sincerely,

Linda Keegan
Executive Director
Kidney Care Partners

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[2] Norris K and Nissenson A. Racial Disparities in Chronic Kidney Disease: Tragedy, Opportunity, or Both? Clin J Am Soc Nephrol. 3:316-316, 2008.

[3] U.S. Renal Dialysis System, USRDS 2009 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States. 2009.

[4] Id.

[5] Lilien MRand Groothoff JW. Cardiovascular Disease in Children with CKD or ESRD. Nat. Rev. Nephrol. 5:229–235, 2009.

[6] U.S. Renal Dialysis System, USRDS 2009 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States. 2009.

June 15, 2010

Thomas Valuck, MD, JD
Senior Vice President, Strategic Partnerships
National Quality Forum
601 Thirteenth St., NW
Suite 500 North
Washington, DC 20005

Dear Dr. Valuck:

On behalf of the members of the Supplier and Industry Council, we appreciate the opportunity to review and provide comments about NQF's recent paper, "*Establishment of a Partnership for Applying Measures to Improve Quality*" as it detailed new opportunities for stakeholders to engage in health care quality established through the Patient Protection and Affordable Care Act (PPACA).

This new Partnership is to be comprised of a broad group of stakeholders interested in or affected by the use of quality measures. In staying true to NQF's recognition of including appropriate and necessary stakeholders as evidenced by your membership, we recommend that members across all NQF Councils be represented in the Partnership. This inclusiveness would also parallel the existing National Priorities Partnership (NPP), which consists of representation across multiple stakeholders.

The existing Quality Alliances, including the AQA (formerly the Ambulatory care Quality Alliance), the Pharmacy Quality Alliance, the Hospital Quality Alliance, and the Quality Alliance Steering Committee, include multiple stakeholders in their members, leadership, and participants. Industry is engaging in these alliances as participants, members, and leadership, providing clinical expertise, technical knowledge, and methodological and analytical expertise. It would naturally flow from this current engagement that industry would continue to be involved in such discussions related to measure selection.

Based on this precedent set by NQF's Council structure, NPP, and the Quality Alliances, we suggest that industry be represented in the new Partnership. It is important, however, to note that our Council represents many different types of industry, including biopharmaceutical, diagnostic, medical device, and health information technology. Each of the member organizations provides broad expertise, but it is not necessarily interchangeable knowledge. We encourage you to consider the value of the contributions of our council members across the various provider constituencies that will be addressed in the Partnership.

Additionally, in reference to the "flexible structure" illustration of the Partnership's governance, we recommend including pharmacy as a provider constituency since pharmacists are often the clinical providers that patients most frequently encounter on a regular basis. Coupled with that, pharmacy should be included as another venue of care along with hospitals, post-acute care/

long-term care, and clinicians to recognize both pharmacists as care providers as well as a care setting. As the Partnership seeks to identify measures for use in reporting and payment programs, we think it is important to include measures related to pharmacy care as a means to evaluate the full continuum of care.

Again, we appreciate the opportunity to offer these comments. We look forward to continuing to work with NQF to improve the quality of health care in the U.S.

Sincerely,

Dave Domann, Chair, Supplier & Industry Council

Kathleen Shoemaker, Vice-Chair, Supplier & Industry Council

Richard I. Smith
SENIOR VICE PRESIDENT
POLICY, RESEARCH AND STRATEGIC PLANNING

PhRMA

June 15, 2010

Janet M. Corrigan, PhD, MBA
President and CEO
National Quality Forum
601 Thirteenth St., NW
Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan:

Thank you for your continued leadership at the National Quality Forum (NQF) and your dedication to improving healthcare quality in the U.S. As members of NQF, the Pharmaceutical Research and Manufacturers of America (PhRMA) and its member companies appreciate the opportunity to review and provide comments about the recent NQF paper, "*Establishment of a Partnership for Applying Measures to Improve Quality.*" As detailed in the paper, the Patient Protection and Affordable Care Act (PPACA) established new opportunities for stakeholders to engage with government to improve healthcare quality. Specifically, PPACA assigns new duties to a consensus-based entity to convene multi-stakeholder groups to provide input to the Secretary of Health and Human Services (HHS) on the selection of measures for public reporting and payment programs. We appreciate NQF's current work as a consensus-based entity under contract with HHS, and appreciate the opportunity to provide comment on its thoughtful proposal for a new Consultative Partnership, the "Partnership for Applying Measures to Improve Quality."

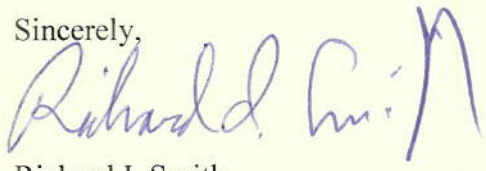
Biopharmaceutical innovators contribute to higher quality care, improved health outcomes, and the quality enterprise. We are committed to collaborating with others to build upon the quality improvement work that has taken place to date. Therefore, we support NQF in ensuring that if it is selected by HHS as the consensus-based entity as described in PPACA, the selection process described in the NQF paper for convening multi-stakeholder groups is one that is open, transparent and inclusive.

The biopharmaceutical research sector brings substantial expertise into any discussion of quality and healthcare data; in fact, it likely generates more data (including a large volume of data governed by rigorous FDA standards) about healthcare outcomes than any other health sector. As such, we believe it is important the research-and-development-based biopharmaceutical industry be represented as part of the multi-stakeholder group, *Partnership for Applying Measures to Improve Quality*. Joined with the contributions of many other stakeholders, the biopharmaceutical industry can make an important

contribution to the input given to the Secretary about the selection of quality measures for public reporting and payment programs because pharmaceuticals transverse all patient populations, all provider groups, and all health states, making pharmaceuticals a common denominator in the delivery of quality healthcare.

PhRMA and its member companies are active participants in the quality arena as members of NQF as well as members, participants, and leadership of the Quality Alliances, including the AQA (formerly the Ambulatory care Quality Alliance), the Pharmacy Quality Alliance, the Hospital Quality Alliance, and the Quality Alliance Steering Committee. We participate in the Quality Alliances and NQF because we value the work and believe in the overarching mission of improving healthcare quality for Americans. We believe that NQF's proposal to establish a new Consultative Partnership provides an important new opportunity to partner with you and others in the healthcare sector to improve quality and provide thoughtful input to the Secretary of HHS on her selection of measures for public reporting and payment programs. The biopharmaceutical research sector is committed to the utilization of evidence-based decision-making to improve healthcare quality and believe we can play an important and collaborative role in the new Consultative Partnership.

Sincerely,



Richard I. Smith

The Physician Consortium for Performance Improvement®
Convened by the American Medical Association

June 15, 2010

Janet Corriganv, PhD, MBA
CEO and President
The National Quality Forum
601 Thirteenth Street, NW
Washington, DC 20005

Re: Establishment of a Partnership for Applying Measures to Improve Quality

Dear Dr. Corrigan:

The Physician Consortium for Performance Improvement® (PCPI) appreciates the opportunity to comment on the National Quality Forum's (NQF) draft document titled *Establishment of a Partnership for Applying Measures to Improve Quality (PAMIQ)*. We believe a transparent, focused, multi-stakeholder process for recommending measures to the Department of Health and Human Services for its various programs is important. We have two recommendations intended to strengthen the approach outlined.

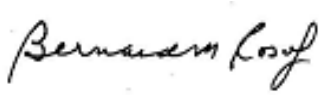
First, we suggest that it is important for this new Partnership to consider in its deliberations the national strategy for quality, to which the National Priorities Partnership contributes. We suggest the document include language to reference the national strategy. Otherwise, we risk diluting efforts or worse, promoting opposing efforts, even if unintentional.

Our second recommendation is to consider the explicit roles of major measure developers (ie, those who are stewards of measures and commit to maintenance and testing) in the three proposed work groups. The draft document suggests that the provider-focused work groups would provide immediate input on the selection of measures. In these conversations, it would be helpful, for example, for the PCPI to contribute its learnings to the clinician group directly, for timely exchange of information that can improve decision-making. Moreover, the PCPI may in some cases provide the analytic support for Partnership decision making.

We look forward to continuing to work with NQF as this activity progresses.

We appreciate the opportunity to comment.

Sincerely,



Bernard M. Rosof, MD, MACP

CC: Karen Kmetik, PhD
Mark Antman, DDS, MBA