Appendices

January 11, 2012

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MAP Background

Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment programs, and other purposes. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses (see Appendix 9 for ACA Section 3014).[1]

MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures HHS will receive varied and thoughtful input on performance measure selection. In particular, the ACA-mandated annual publication of measures under consideration for future federal rulemaking allows MAP to evaluate and provide upstream input to HHS in a more global and strategic way.

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

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

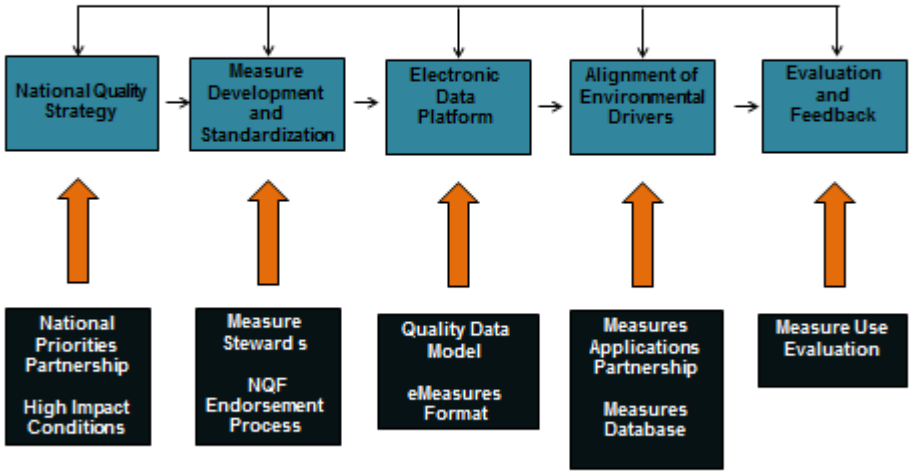
Coordination with Other Quality Efforts

MAPs activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency; aligning payment with value; rewarding providers and professionals for using health information technology (health IT) to improve patient care; and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers, measure developers, groups convened by the National Quality Forum (NQF), accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare.

Foundational to the success of all of these efforts is a robust "quality measurement enterprise" (Figure 4) that includes:

- setting priorities and goals for improvement;
- standardizing performance measures;
- constructing a common data platform that supports measurement and improvement;
- applying measures to public reporting, performance-based payment, health IT meaningful use programs, and other areas; and
- promoting performance improvement in all healthcare settings.

Figure 4. Functions of the Quality Measurement Enterprise



The National Priorities Partnership (NPP), a multi-stakeholder group convened by NQF to provide input to HHS on the National Quality Strategy (NQS), by identifying priorities, goals, and global measures of progress.[3] Another NQF-convened group, the Measure Prioritization Advisory Committee, has defined high-impact conditions for the Medicare and child health populations.[4] Cross-cutting priorities and high-impact conditions provide the foundation for all of the subsequent work within the quality measurement enterprise.

Measure development and standardization of measures are necessary to assess the baseline relative to the NQS priorities and goals, determine the current state and opportunities for improvement, and monitor progress. The NQF endorsement process meets certain statutory requirements for setting consensus standards and also provides the resources and expertise necessary to accomplish the task. A platform of data sources, with increasing emphasis on electronic collection and transmission, provides the data needed to calculate measures for use in accountability programs and to provide immediate feedback and clinical decision-support to providers for performance improvement.

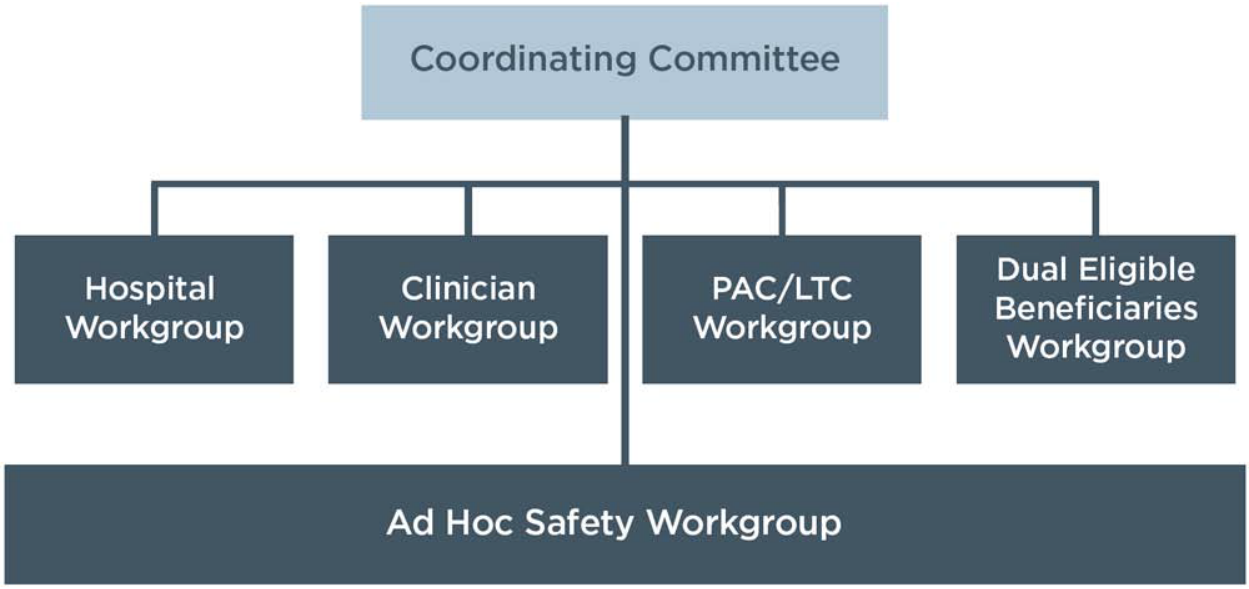
Alignment around environmental drivers, such as public reporting and performance-based payment, is MAP's role in the quality measurement enterprise. By considering and recommending measures for use in specific applications, MAP will facilitate the alignment of public- and private-sector programs and harmonization of measurement efforts under the NQS.

Finally, evaluation and feedback loops for each of the functions of the quality measurement enterprise ensure that each of the various activities is driving desired improvements.[5,6] Further, the evaluation function monitors for potential unintended consequences that may result.

Function

Composed of a two-tiered structure, MAP's overall strategy is set by the Coordinating Committee, which provides final input to HHS. Working directly under the Coordinating Committee are five advisory workgroups responsible for advising the Committee on using measures to encourage performance improvement in specific care settings, providers, and patient populations (Figure 5). More than 60 organizations representing major stakeholder groups, 40 individual experts, and 9 federal agencies (*ex officio* members) are represented on the Coordinating Committee and workgroups (see Appendix 10 for Coordinating Committee and workgroup rosters).

Figure 5. MAP Structure



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

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

MAP decision making is based on a foundation of established guiding frameworks. The NQS is the primary basis for the overall MAP strategy. Additional frameworks include the high-impact conditions determined by the NQF-convened Measure Prioritization Advisory Committee, the NQF-endorsed Patient-Focused Episodes of Care framework,[7] the HHS Partnership for Patients safety initiative,[8] the HHS Prevention and Health Promotion Strategy,[9] the HHS Disparities Strategy,[10] and the HHS Multiple Chronic Conditions framework.[11]

Timeline and Deliverables

MAP's initial work included performance measurement coordination strategies on the selection of measures for public reporting and performance-based payment programs (see Appendix 11 for a schedule of deliverables). Each of the coordination strategies addresses:

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

On October 1, 2011, three coordination strategies were issued. The report on coordinating readmissions and healthcare-acquired conditions focuses on alignment of measurement, data collection, and other efforts to address these safety issues across public and private payers.[12] The report on coordinating clinician performance measurement identifies the characteristics of an ideal measure set for assessing clinician performance, advances measure selection criteria as a tool, and provides input on a recommended measure set and priority gaps for clinician public reporting and performance-based payment programs.[13] An interim report on performance measurement for dual eligible beneficiaries offers a strategic approach that includes a vision, guiding principles, characteristics of high-need subgroups, and high-leverage opportunities for improvement, all of which will inform the next phase of work to identify specific measures most relevant to improving the quality of care for dual eligible beneficiaries.[14]

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

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

[3] National Quality Forum (NQF), National Priorities Partnership (NPP), *Input to the Secretary of Health and Human Services on Priorities for the National Quality Strategy*, Washington, DC:NQF, 2011. Available at www.qualityforum.org/Setting_Priorities/NPP/National_Priorities_Partnership.aspx. Last accessed December 2011.

[4] National Quality Forum (NQF), *Measurement Prioritization Advisory Committee Report, Measure Development and Endorsement Agenda*, Washington, DC:NQF, 2011. Available at www.qualityforum.org/News_And_Resources/Press_Releases/2011/National_Quality_Forum_Releases_Measure_Development_and_Endorsement_Agenda__Prioritized_List_of_Measure_Gaps.aspx. Last accessed December 2011.

[5] RAND Health, *An Evaluation of the Use of Performance Measures in Health Care.* Washington, DC:NQF, 2011. Available at www.qualityforum.org/Setting_Priorities/Measure_Use_Evaluation.aspx. Last accessed December 2011.

[6] National Quality Forum (NQF), *Evaluation of the National Priorities Partnership Phase 1: Cross-Case Analysis Report*, Washington, DC: 2011.

[7] National Quality Forum (NQF), *Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care*, Washington, DC:NQF, 2010. Available at www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx. Last accessed December 2011.

[8] HHS, *Partnership for Patients:Better Care, Lower Costs*, Washington, DC: HHS; 2011. Available at http://www.healthcare.gov/center/programs/partnership. Last accessed August 2011.

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

[10] HHS, *National Partnership for Action to End Health Disparities*, Washington, DC: HHS; 2011. Available at http://minorityhealth.hhs.gov/npa/. Last accessed August 2011.

[11] HHS, *HHS Initiative on Multiple Chronic Conditions*, Washington, DC: HHS: 2011. Available at www.hhs.gov/ash/initiatives/mcc/. Last accessed August 2011.

[12] National Quality Forum (NQF), Measure Application Partnership (MAP), *Coordination Strategy for Healthcare-Acquired Conditions and Readmissions Across Public and Private Payers*, Washington, DC:NQF, 2011. Available at www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx. Last accessed December 2011.

[13] National Quality Forum (NQF), Measure Application Partnership (MAP), *Coordination Strategy for Clinician Performance Measurement*, Washington, DC:NQF, 2011. Available at www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx. Last accessed December 2011.

[14] National Quality Forum (NQF), Measure Application Partnership (MAP), *Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries*, Washington, DC:NQF, 2011. Available at www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx. Last accessed December 2011.

MAP Pre-Rulemaking Process

Statutory Requirements

Under ACA, HHS now follows a federal "pre-rulemaking process" for obtaining input from MAP on the selection of performance measures for specific federal programs. Each year, HHS will complete the following pre-rulemaking processes:

- make a list of measures currently under consideration by HHS for qualifying programs publicly available annually by December 1;
- provide the opportunity for MAP to review the list of measures under consideration and give input to HHS annually by February 1 on the measures under consideration; and
- consider MAP input and publishing the rationale for selecting any performance measures not endorsed by NQF.

At least every three years, HHS will assess the impact of performance measures at least every three years (the first report due to the public by March 1, 2012).[1]

With respect to the second bullet, MAP is charged with providing pre-rulemaking input to HHS on the list of measures under consideration. This process provides MAP's many stakeholders with an unprecedented opportunity to evaluate the measures under consideration and provide upstream input to HHS in a more coordinated and strategic manner. Unlike previous years when HHS only received feedback during the program-by-program rulemaking process, private-sector stakeholders are now asked before the actual rulemaking process begins to provide input on how measures might be used across federal public reporting and performance-based payment programs.

Approach to Measure Analysis

HHS provided MAP with its list of measures under consideration in early December 2011, and MAP began its evaluation. The list included 368 measures across 23 federal programs (Table 1).[2]

Table 1. HHS Measures Under Consideration

CMS PROGRAM	NO. OF MEASURES UNDER CONSIDERATION
Ambulatory Surgical Center Quality Reporting	0
CMS Nursing Home Quality Initiative and Nursing Home Compare Measures	0
End Stage Renal Disease Quality Improvement	5
e-Rx Incentive Program	0
Home Health Quality Reporting	0
Hospice Quality Reporting	6
Hospital Inpatient Quality Reporting	22
Hospital Outpatient Quality Reporting	0
Hospital Value-Based Purchasing	13
Inpatient Psychiatric Facility Quality Reporting	6
Inpatient Rehabilitation Facility Quality Reporting	8
Long-Term Care Hospital Quality Reporting	8
Medicare and Medicaid EHR Incentive Program for Eligible Professionals	92
Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	39
Medicare Shared Savings Program	0
Physician Quality Reporting System	153
Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	5
Children's Health Insurance Program Reauthorization Act Quality Reporting	0
Health Insurance Exchange Quality Reporting	0
Initial Core Set of Health Care Quality Measures For Medicaid-Eligible Adults	0
Medicare Part C Plan Rating - Quality and Performance Measures	0
Medicare Part D Plan Rating - Quality and Performance Measures	0
Physician Feedback/Value-Based Modifier Program	
a. Physician Quality and Resource Use Report[2]	see footnote
b. Value-Based Payment Modifier	10
Total	**367 ***

Physician Quality and Resource Use Report includes quality measures reported from the Physician Quality Reporting System, and the Value-Based Payment Modifier which includes 4 Prevention Quality Indicators (PQI) and 1 cost measure. Therefore, measures in this component are listed only in the Physician Quality Reporting System and Value-Based Payment Modifier and are not duplicated in the ACA 3014 Measures list.

*After Measures Under Consideration list was posted, an additional measure was added to the Medicare and Medicaid EHR Incentive Program for Eligible Professionals to total 368.

HHS designated some of the programs as required for MAP review and some as optional. The optional programs provide context for the others. The measures under consideration for the required programs were divided among the MAP Clinician, Hospital, and PAC/LTC workgroups, depending on which setting the program primarily covers (e.g., the Hospital Workgroup reviewed the measures under consideration for the Hospital Inpatient Quality Reporting program). MAP's pre-rulemaking analysis offers input on the following federal programs (Table 2):

Table 2. Federal Programs Reviewed

Federal Program	MAP Workgroup
Value-Based Payment Modifier	**Clinician Workgroup**
Physician Quality Reporting System	
Medicare and Medicaid EHR Incentive Program for Eligible Professionals	
Medicare Shared Savings Program	
Hospital Inpatient Quality Reporting	**Hospital Workgroup**
Hospital Value-Based Purchasing	
Hospital Outpatient Quality Reporting	
Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	
Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	
Inpatient Psychiatric Facility Quality Reporting	
Ambulatory Surgical Center Quality Reporting	
Home Health Quality Reporting	**PAC/LTC Workgroup**
CMS Nursing Home Quality Initiative and Nursing Home Compare Measures	
Inpatient Rehabilitation Facility Quality Reporting	
Long-Term Care Hospital Quality Reporting	
Hospice Quality Reporting	
End Stage Renal Disease Quality Management	

*e-Rx Incentive Program was discussed in context of Meaningful use

*Five optional CMS programs not addressed in MAP Pre-rulemaking input

Each MAP workgroup met for one day during December 2011 to evaluate the measures under consideration for each program in light of the measure sets that had previously been finalized for that program through federal rulemaking. Each workgroup developed its findings and conclusions for transmission to the Coordinating Committee. The agenda and materials for each workgroup meeting can be found on the NQF website.

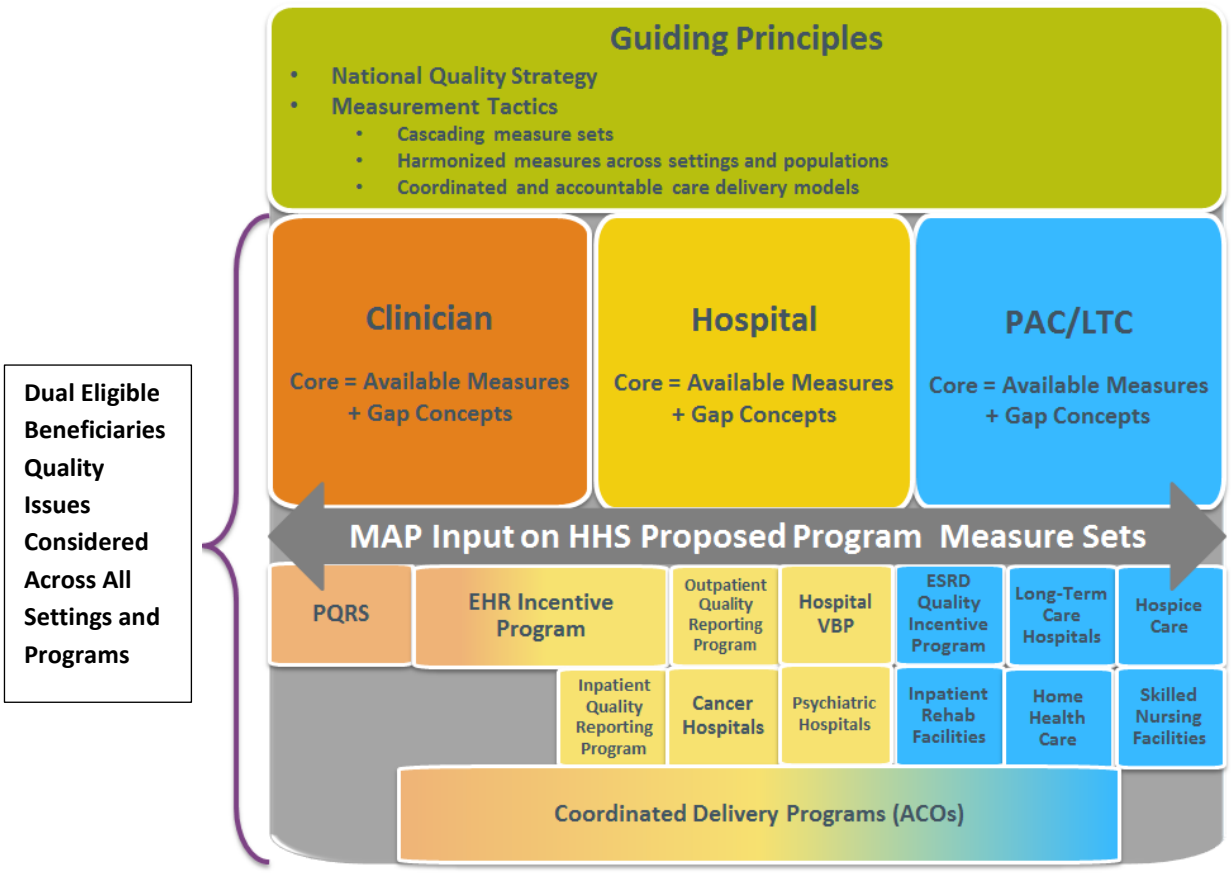
To accomplish the workgroup reviews of the measures under consideration and program measure sets, a structured discussion guide was used to provide a stepwise approach to program-by-program analysis, as well as to raise cross-cutting issues of alignment across programs. The setting-specific MAP workgroups assessed each measure under consideration according to whether it addressed an identified measure gap area for a particular setting or whether it represented an important priority area for a particular program within the setting (e.g., Meaningful Use within the clinician office setting). Additionally, MAP conversations with CMS led to an approach which lays out a "framework" for performance measurement based on the NQS and the notion of integrated care models. To help move from the siloed nature of federal programs, MAP generated core measure sets to identify areas of highest importance within the Clinician, Hospital, PAC/LTC settings as a way to get closer to the ideal

framework (see Figure 6). Also, the MAP Measure Selection Criteria tool served as a guide for discussion of which measures to include in particular programs based on what those measures would add to the program measure set. In addition to evaluating new measures for programs, the MAP workgroups assessed the need to remove measures that had previously been finalized for use in programs.

The Dual Eligible Beneficiaries Workgroup provided input to each of the other MAP workgroups on specific measures applicable to the dual eligible beneficiaries' population. The Dual Eligible Beneficiaries Workgroup then had a web meeting to review the findings and conclusions from the setting-specific workgroups to provide additional input before the Coordinating Committee's review.

The MAP Coordinating Committee met on January 5-6, 2012, to review of the MAP workgroups' findings and conclusions (Coordinating Committee Meeting Materials). At that time, the Committee finalized the input to HHS contained within this report, including the disposition of each measure under consideration; the overall composition of each program measure set; priority measure gaps that need to be addressed through development, testing, and endorsement; and the MAP framework for aligned performance measurement.

Figure 6. MAP Approach to Aligned Performance Measurement



[1] GPO, *Patient Protection and Affordable Care Act (ACA), PL 111-148 Sec. 3014*.

[2] National Quality Forum, (NQF),Measure Application Partnership (MAP), *Pre-Rulemaking Advisory Work: List of Measures Under Consideration for 2012*. Washington, DC:NQF, 2011. Available at www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx. Last accessed December 2011.

MAP "WORKING" MEASURE SELECTION CRITERIA

NATIONAL QUALITY FORUM

1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review

Measures within the program measure set are NQF-endorsed, indicating that they have met the following criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. Measures within the program measure set that are not NQF-endorsed but meet requirements for expedited review, including measures in widespread use and/or tested, may be recommended by MAP, contingent on subsequent endorsement. These measures will be submitted for expedited review.

Response option: Strongly Agree / Agree / Disagree / Strongly Disagree

Measures within the program measure set are NQF-endorsed or meet requirements for expedited review (including measures in widespread use and/or tested)

Additional Implementation Consideration: Individual endorsed measures may require additional discussion and may be excluded from the program measure set if there is evidence that implementing the measure would result in undesirable unintended consequences.

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

Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities:

Subcriterion 2.1	Safer care
Subcriterion 2.2	Effective care coordination
Subcriterion 2.3	Preventing and treating leading causes of mortality and morbidity
Subcriterion 2.4	Person- and family-centered care
Subcriterion 2.5	Supporting better health in communities
Subcriterion 2.6	Making care more affordable

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree:

NQS priority is adequately addressed in the program measure set

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

Demonstrated by the program measure set addressing Medicare High-Impact Conditions; Child Health Conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program's intended population(s). (Refer to tables 1 and 2 for Medicare High-Impact Conditions and Child Health Conditions determined by the NQF Measure Prioritization Advisory Committee.)

Response option: Strongly Agree / Agree / Disagree / Strongly Disagree:

Program measure set adequately addresses high-impact conditions relevant to the program.

4. Program measure set promotes alignment with specific program attributes, as well as alignment across programs

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

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 4.1	Program measure set is applicable to the program's intended care setting(s)
Subcriterion 4.2	Program measure set is applicable to the program's intended level(s) of analysis
Subcriterion 4.3	Program measure set is applicable to the program's population(s)

5. Program measure set includes an appropriate mix of measure types

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

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 5.1	Outcome measures are adequately represented in the program measure set
Subcriterion 5.2	Process measures are adequately represented in the program measure set
Subcriterion 5.3	Experience of care measures are adequately represented in the program measure set (e.g. patient, family, caregiver)
Subcriterion 5.4	Cost/resource use/appropriateness measures are adequately represented in the program measure set
Subcriterion 5.5	Structural measures and measures of access are represented in the program measure set when appropriate

6. Program measure set enables measurement across the person-centered episode of care [1]

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

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 6.1	Measures within the program measure set are applicable across relevant providers
Subcriterion 6.2	Measures within the program measure set are applicable across relevant settings
Subcriterion 6.3	Program measure set adequately measures patient care across time

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

7. Program measure set includes considerations for healthcare disparities[2]

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, age disparities, or geographical considerations considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 7.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Subcriterion 7.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack)

8. Program measure set promotes parsimony

Demonstrated by a program measure set that supports efficient (i.e., minimum number of measures and the least effort) use of resources for data collection and reporting and supports multiple programs and measurement applications. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 8.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome)

Subcriterion 8.2 Program measure set can be used across multiple programs or applications (e.g., Meaningful Use, Physician Quality Reporting System [PQRS])

2 NQF, *Healthcare Disparities Measurement*, Washington, DC: NQF; 2011.

Table 1: National Quality Strategy Priorities

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

Table 2: High-Impact Conditions:

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

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

MAP "WORKING" MEASURE SELECTION CRITERIA INTERPRETIVE GUIDE

NATIONAL QUALITY FORUM

Instructions for applying the measure selection criteria:

The measure selection criteria are designed to assist MAP Coordinating Committee and workgroup members in assessing measure sets used in payment and public reporting programs. The criteria have been developed with feedback from the MAP Coordinating Committee, workgroups, and public comment. The criteria are intended to facilitate a structured thought process that results in generating discussion. A rating scale of *Strongly Agree, Agree, Disagree, Strongly Disagree* is offered for each criterion or sub-criterion. An open text box is included in the response tool to capture reflections on the rationale for ratings.

The eight criteria areas are designed to assist in determining whether a measure set is aligned with its intended use and whether the set best reflects 'quality' health and healthcare. The term "measure set" can refer to a collection of measures--for a program, condition, procedure, topic, or population. For the purposes of MAP moving forward, we will qualify all uses of the term measure set to refer to either a "program measure set," a "core measure set" for a setting, or a "condition measure set." The following eight criteria apply to the evaluation of program measure sets; a subset of the criteria apply to condition measure sets.

FOR CRITERION 1 – NQF ENDORSEMENT:

The optimal option is for all measures in the program measure set to be NQF endorsed or ready for NQF expedited review. The endorsement process evaluates individual measures against four main criteria:

1. **'Importance to measure and report"**–how well the measure addresses a specific national health goal/ priority, addresses an area where a performance gap exists, and demonstrates evidence to support the measure focus;
2. **'Scientific acceptability of the measurement properties'** – evaluates the extent to which each measure produces consistent (reliable) and credible (valid) results about the quality of care.
3. **'Usability'-** the extent to which intended audiences (e.g., consumers, purchasers, providers, and policy makers) can understand the results of the measure and are likely to find the measure results useful for decision making.
4. **'Feasibility'** – the extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measures.

To be recommended by MAP, a measure that is not NQF-endorsed must meet the following requirements, so that it can be submitted for expedited review:

- the extent to which the measure(s) under consideration has been sufficiently tested and/or in widespread use
- whether the scope of the project/measure set is relatively narrow
- time-sensitive legislative/regulatory mandate for the measure(s)
- Measures that are NQF-endorsed are broadly available for quality improvement and public accountability programs. In some instances, there may be evidence that implementation challenges

and/or unintended negative consequences of measurement to individuals or populations may outweigh benefits associated with the use of the performance measure. Additional consideration and discussion by the MAP workgroup or Coordinating Committee may be appropriate prior to selection. To raise concerns on particular measures, please make a note in the included text box under this criterion.

FOR CRITERION 2 – PROGRAM MEASURE SET ADDRESSES THE NATIONAL QUALITY STRATEGY PRIORITIES:

The program's set of measures is expected to adequately address each of the NQS priorities as described in criterion 2.1-2.6. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. This assessment should consider the current landscape of NQF-endorsed measures available for selection within each of the priority areas.

FOR CRITERION 3 – PROGRAM MEASURE SET ADDRESSES HIGH-IMPACT CONDITIONS:

When evaluating the program measure set, measures that adequately capture information on high-impact conditions should be included based on their relevance to the program's intended population. High-priority Medicare and child health conditions have been determined by NQF's Measure Prioritization Advisory Committee and are included to provide guidance. For programs intended to address high-impact conditions for populations other than Medicare beneficiaries and children (e.g., adult non-Medicare and dual eligible beneficiaries), high-impact conditions can be demonstrated by their high prevalence, high disease burden, and high costs relevant to the program. Examples of other on-going efforts may include research or literature on the adult Medicaid population or other common populations. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria.

FOR CRITERION 4 – PROGRAM MEASURE SET PROMOTES ALIGNMENT WITH SPECIFIC PROGRAM ATTRIBUTES, AS WELL AS ALIGNMENT ACROSS PROGRAMS:

The program measure sets should align with the attributes of the specific program for which they intend to be used. Background material on the program being evaluated and its intended purpose are provided to help with applying the criteria. This should assist with making discernments about the intended care setting(s), level(s) of analysis, and population(s). While the program measure set should address the unique aims of a given program, the overall goal is to harmonize measurement across programs, settings, and between the public and private sectors.

- **Care settings include:** Ambulatory Care, Ambulatory Surgery Center, Clinician Office, Clinic/Urgent Care, Behavioral Health/Psychiatric, Dialysis Facility, Emergency Medical Services - Ambulance, Home Health, Hospice, Hospital- Acute Care Facility, Imaging Facility, Laboratory, Pharmacy, Post-Acute/Long Term Care, Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation.
- **Level of analysis includes:** Clinicians/Individual, Group/Practice, Team, Facility, Health Plan, Integrated Delivery System.
- **Populations include:** Community, County/City, National, Regional, or States. Population includes: Adult/Elderly Care, Children's Health, Disparities Sensitive, Maternal Care, and Special Healthcare Needs.

FOR CRITERION 5 – PROGRAM MEASURE SET INCLUDES AN APPROPRIATE MIX OF MEASURE TYPES:

The program measure set should be evaluated for an appropriate mix of measure types. The definition of "appropriate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. The evaluated measure types include:

1. **Outcome measures** – Clinical outcome measures reflect the actual results of care.[1] Patient reported measures assess outcomes and effectiveness of care as experienced by patients and their families. Patient reported measures include measures of patients' understanding of treatment options and care plans, and their feedback on whether care made a difference.[2]
2. **Process measures –** Process denotes what is actually done in giving and receiving care. [3] NQF-endorsement seeks to ensure that process measures have a systematic assessment of the quantity, quality, and consistency of the body of evidence that the measure focus leads to the desired health outcome.[4] Experience of care measures—Defined as patients' perspective on their care.[5]
3. **Cost/resource use/appropriateness measures** –

   a. Cost measures – Total cost of care.

   b. Resource use measures – Resource use measures are defined as broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (broadly defined to include diagnoses, procedures, or encounters).[6]

   c. Appropriateness measures – Measures that examine the significant clinical, systems, and care coordination aspects involved in the efficient delivery of high-quality services and thereby effectively improve the care of patients and reduce excessive healthcare costs.[7]
4. **Structure measures** – Reflect the conditions in which providers care for patients.[8] This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure

1 National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

2 Consumer-Purchases Disclosure Project. (2011). Ten Criteria for Meaningful and Usable Measures of Performance

3 Donabedian, A. (1988) The quality of care. *JAMA*, 260, 1743-1748.

4 National Quality Forum. (2011). Consensus development process. Retrieved from http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx

5 National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

6 National Quality Forum (2009). National voluntary consensus standards for outpatient imaging efficiency. Retrieved from http://www.qualityforum.org/Publications/2009/08/National_Voluntary_Consensus_Standards_for_Outpatient_Imaging_Efficiency__A_Consensus_Report.aspx

7 National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

8 National Quality Forum. (2011). The right tools for the job. Retrieved from http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx

(such as medical staff organizations, methods of peer review, and methods of reimbursement).[9] In this case, structural measures should be used only when appropriate for the program attributes and the intended population.

FOR CRITERION 6 – PROGRAM MEASURE SET ENABLES MEASUREMENT ACROSS THE PERSON-CENTERED EPISODE OF CARE:

The optimal option is for the program measure set to approach measurement in such a way as to capture a person's natural trajectory through the health and healthcare system over a period of time. Additionally, driving to longitudinal measures that address patients throughout their lifespan, from health, to chronic conditions, and when acutely ill should be emphasized. Evaluating performance in this way can provide insight into how effectively services are coordinated across multiple settings and during critical transition points.

When evaluating subcriteria 6.1-6.3, it is important to note whether the program measure set captures this trajectory (across providers, settings or time). This can be done through the inclusion of individual measures (e.g., 30-day readmission post-hospitalization measure) or multiple measures in concert (e.g., aspirin at arrival for AMI, statins at discharge, AMI 30-day mortality, referral for cardiac rehabilitation).

FOR CRITERION 7 – PROGRAM MEASURE SET INCLUDES CONSIDERATIONS FOR HEALTHCARE DISPARITIES:

Measures sets should be able to detect differences in quality among populations or social groupings. Measures should be stratified by demographic information (e.g., race, ethnicity, language, gender, disability, and socioeconomic status, rural vs. urban), which will provide important information to help identify and address disparities.[10]

Subcriterion 7.1 seeks to include measures that are known to assess healthcare disparities (e.g., use of interpreter services to prevent disparities for non-English speaking patients).

Subcriterion 7.2 seeks to include disparities-sensitive measures; these are measures that serve to detect not only differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among populations or social groupings (e.g., race/ethnicity, language).

FOR CRITERION 8 – PROGRAM MEASURE SET PROMOTES PARSIMONY:

The optimal option is for the program measure set to support an efficient use of resources in regard to data collection and reporting for accountable entitles, while also measuring the patient's health and healthcare comprehensively.

Subcriterion 8.1 can be evaluated by examining whether the program measure set includes the least number of measures required to capture the program's objectives and data submission that requires the least burden on the part of the accountable entitles.

Subcriterion 8.2 can be evaluated by examining whether the program measure set includes measures that are used across multiple programs (e.g., PQRS, MU, CHIPRA, etc.) and applications (e.g., payment, public reporting, and quality improvement).

9 Donabedian, A. (1988) The quality of care. *JAMA*, 260, 1743-1748.

10 Consumer-Purchases Disclosure Project. (2011). Ten Criteria for Meaningful and Usable Measures of Performance.

Dual Eligible Beneficiaries Core Measure Set (DRAFT)

NQF # and Status	Measure Title and Description	Quality of Life	Care Coord	Screening	Mental/Subst	Structural	Specified Setting of Care	Use in Federal Programs
0329 Endorsed	*All-Cause Readmission Index (risk adjusted)* Overall inpatient 30-day hospital readmission rate, excluding maternity and pediatric discharges		✓				Hospital	
0228 Endorsed	*3-Item Care Transition Measure (CTM-3)* Uni-dimensional self-reported survey that measures the quality of preparation for care transitions. Namely: 1. Understanding one's self-care role in the post-hospital setting 2. Medication management 3. Having one's preferences incorporated into the care plan		✓				Hospital	Under consideration for Hospital Inpatient Quality Reporting **(Supported)**
0558 Endorsed	*HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge* Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity		✓		✓		Hospital	Under consideration for Inpatient Psychiatric Facility Quality Reporting **(Supported)**
0418 Endorsed	*Screening for Clinical Depression and Follow-up Plan* Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool and follow up plan documented			✓	✓		Ambulatory, Hospital, PAC/LTC Facility	Finalized for use in PQRS and Medicare Shared Savings, Medicaid Adult Core Measures Under consideration for Meaningful Use **(Supported)**
0647 Endorsed	*Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)* Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements		✓				Hospital, PAC/LTC Facility	

NQF # and Status	Measure Title and Description	Quality of Life	Care Coord	Screening	Mental/Subst	Structural	Specified Setting of Care	Use in Federal Programs
0430 Endorsed	*Change in Daily Activity Function as Measured by the AM-PAC* The Activity Measure for Post-Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post-acute care (PAC) patients. A Daily Activity domain has been identified which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing	✓		✓			Ambulatory, Home Health, Hospital, PAC/LTC Facility	
0576 Endorsed	*Follow-up after hospitalization for mental illness* Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner		✓		✓		Ambulatory, Behavioral Health	Finalized for use in Medicaid Adult Core Measures, CHIPRA Core Measures
0005 Endorsed	*CAHPS Adult Primary Care Survey: Shared Decision Making* 37 core and 64 supplemental question survey of adult outpatient primary care patients		✓				Ambulatory	Finalized for use in Medicare Shared Savings
0006 Endorsed	*CAHPS Health Plan Survey v 4.0 - Adult questionnaire: Health Status/Functional Status* 30-question core survey of adult health plan members that assesses the quality of care and services they receive	✓					Ambulatory	Finalized for use in Medicare Shared Savings and Medicaid Adult Core Measures
0490 Endorsed	*The Ability to use Health Information Technology to Perform Care Management at the Point of Care* Documents the extent to which a provider uses a certified/qualified electronic health record (EHR) system capable of enhancing care management at the point of care. To qualify, the facility must have implemented processes within their EHR for disease management that incorporate the principles of care management at the point of care which include: a. The ability to identify specific patients by diagnosis or medication use, b. The capacity to present alerts to the clinician for disease management, preventive services and wellness, c. The ability to provide support for standard care plans, practice guidelines, and protocol					✓	Ambulatory	

NQF # and Status	Measure Title and Description	Quality of Life	Care Coord	Screening	Mental/Subst	Structural	Specified Setting of Care	Use in Federal Programs
0494 Endorsed	*Medical Home System Survey* Percentage of practices functioning as a patient-centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: a. Improved access and communication b. Care management using evidence-based guidelines c. Patient tracking and registry functions d. Support for patient self-management e. Test and referral tracking f. Practice performance and improvement functions					✓	Ambulatory	
0101 Endorsed	*Falls: Screening for Fall Risk* Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months			✓			Ambulatory	Finalized for use in PQRS, Medicare Shared Savings, and Value Modifier Under consideration for Meaningful Use **(Supported)**
0729 Endorsed	*Optimal Diabetes Care* Patients ages 18 -75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 14090, Tobacco non-user and for patients with a diagnosis of ischemic vascular disease daily aspirin use unless contraindicated			✓			Ambulatory	Components of this composite are finalized for use in Medicare Shared Savings and Value Modifier, Under consideration for PQRS **(Supported)**
0421 Endorsed	*Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up* Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented Normal Parameters: Age 65 and older BMI ≥23 and <30; Age 18 – 64 BMI ≥18.5 and <25			✓			Ambulatory	Finalized for use in PQRS, Meaningful Use, Medicare Shared Savings Program, and Value Modifier
0028 Endorsed	*Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention* Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period			✓	✓		Ambulatory	Finalized for use in PQRS, Meaningful Use, Medicare Shared Savings Program, and Value Modifier

NQF # and Status	Measure Title and Description	Quality of Life	Care Coord	Screening	Mental/Subst	Structural	Specified Setting of Care	Use in Federal Programs
0004 Endorsed	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement* The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit				✓		Ambulatory	Finalized for use in PQRS, Meaningful Use, Value Modifier, and Medicaid Adult Core Measures
0523 Endorsed	*Pain Assessment Conducted* Percent of patients who were assessed for pain, using a standardized pain assessment tool, at start/resumption of home health care	✓		✓			Home Health	Finalized for use in Home Health
0167 Endorsed	*Improvement in Ambulation/locomotion* Percentage of home health episodes where the value recorded for the OASIS item M0702 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care	✓		✓			Home Health	Finalized for use in Home Health
0208 Endorsed	*Family Evaluation of Hospice Care* Percentage of family members of all patients enrolled in a hospice program who give satisfactory answers to the survey instrument	✓					Hospice	Under consideration for Hospice Quality Reporting **(Supported)**
0260 Endorsed	*Assessment of Health-related Quality of Life (Physical & Mental Functioning)* Percentage of dialysis patients who receive a quality of life assessment using the KDQOL-36 (36-question survey that assesses patients' functioning and well-being) at least once per year	✓		✓	✓		Dialysis Facility	**Supported** for ESRD Quality Reporting
Not Endorsed	*SNP 6: Coordination of Medicare and Medicaid coverage* Intent: The organization helps members obtain services they are eligible to receive regardless of payer, by coordinating Medicare and Medicaid coverage. This is necessary because the two programs have different rules and benefit structures and can be confusing for both members and providers					✓	[not available]	

NQF # and Status	Measure Title and Description	Quality of Life	Care Coord	Screening	Mental/Subst	Structural	Specified Setting of Care	Use in Federal Programs
Not Endorsed	*Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment* a. Patients screened annually for alcohol misuse with the 3-item AUDIT-C with item-wise recording of item responses, total score and positive or negative result of the AUDIT-C in the medical record. B. Patients who screen for alcohol misuse with AUDIT-C who meet or exceed a threshold score who have brief alcohol counseling documented in the medical record within 14 days of the positive screening.			✓	✓		[not available]	
Not Endorsed	*Potentially Harmful Drug-Disease Interactions in the Elderly* Percentage of Medicare members 65 years of age and older who have a diagnosis of chronic renal failure and prescription for non-aspirin NSAIDs or Cox-2 selective NSAIDs; Percentage of Medicare members 65 years of age and older who have a diagnosis of dementia and a prescription for tricyclic antidepressants or anticholinergic agents; percentage of Medicare members 65 years of age and older who have a history of falls and a prescription for tricyclic antidepressants, antipsychotics or sleep agents		✓	✓			Pharmacy	

Clinician Core Measures (Drawn from Value Modifier Measures)

NQF Measure Number and Status	Measure Name
0028 Endorsed	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
0001 Endorsed	Asthma: Asthma Assessment
0002 Endorsed	Appropriate Testing for Children with Pharyngitis
0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement
0012 Endorsed	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
0014 Endorsed	Prenatal Care: Anti-D Immune Globulin
0018 Endorsed	Controlling High Blood Pressure
0024 Endorsed	Weight Assessment and Counseling for Children and Adolescents
0031 Endorsed	Preventive Care and Screening: Screening Mammography
0032 Endorsed	Cervical Cancer Screening
0033 Endorsed	Chlamydia Screening for Women
0034 Endorsed	Preventive Care and Screening: Colorectal Cancer Screening
0038 Endorsed	Childhood Immunization Status
0041 Endorsed	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
0043 Endorsed	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older
0047 Endorsed	Asthma: Pharmacologic Therapy
0052 Endorsed	Low Back Pain: Use of Imaging Studies
0055 Endorsed	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
0056 Endorsed	Diabetes Mellitus: Foot Exam
0061 Endorsed	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
0062 Endorsed	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
0066 Endorsed	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)
0067 Endorsed	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
0068 Endorsed	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
0070 Endorsed	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
0073 Endorsed	Ischemic Vascular Disease (IVD): Blood Pressure Management Control
0074 Endorsed	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
0075 Endorsed	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control < 100 mg/dl
0079 Endorsed	Heart Failure: Left Ventricular Function (LVF) Assessment
0081 Endorsed	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
0083 Endorsed	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
0086 Endorsed	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
0088 Endorsed	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
0089 Endorsed	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care
0097 Endorsed	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility
0101 Endorsed	Falls: Screening for Fall Risk
0102 Endorsed	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy

0105 Endorsed	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD
0385 Endorsed	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
0387 Endorsed	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
0389 Endorsed	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients
0421 Endorsed	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up
0575 Endorsed	Diabetes: HbA1c Control < 8%
0729 Endorsed	Diabetes Mellitus: Tobacco Non-Use
0729 Endorsed	Diabetes: Aspirin Use
NA	Proportion of adults 18 years and older who have had their BP measured within the preceding 2 years
NA	Preventive Care: Cholesterol-LDL test performed
Note: NA denotes measures that have not been submitted to NQF.	

Gaps – (bolded= prioritized)

- **Patient and family experience**
- **Resource use**
- **Physician (specialty groups) and conditions**
- Outcome measures – included patient reported outcomes
- Care coordination – team approach to care
- Multi-morbidity chronic diseases and functional status
- Child health
- Patient Safety
- Disparities

Post- Acute Care / Long Term Care

CMS Nursing Home Quality Initiative and Nursing Home Compare Measures
Program description

The Nursing Home Compare website assists consumers, their families, and caregivers in informing their decisions regarding choosing a nursing home. The Nursing Home Compare includes the Five-Star Quality Rating System, which assigns each nursing home a rating of 1 to 5 stars, with 5 representing highest standard of quality, and 1 representing the lowest.[1] Nursing Home Compare data are collected through different mechanisms, such as annual inspection surveys and complaint investigations findings, the CMS Online Survey and Certification Reporting (OSCAR) system, and Minimum Data Set (MDS) quality measures.[2] Currently, all eighteen of the MDS quality measures are reported on Nursing Home Compare.

End Stage Renal Disease Quality Improvement
Program description and statutory requirements

The End Stage Renal Disease (ESRD) Quality Initiative promotes improving the quality of care provided to ESRD patients through the End Stage Renal Disease Quality Incentive Program (ESRD QIP) and by providing information to consumers on the Dialysis Facility Compare website. ESRD QIP was established by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153(c).[3] Starting in 2012, payments to dialysis facilities will be reduced if facilities do not meet the required total performance score, which is the sum of the scores for established individual measures during a defined performance period.[4] Payment reductions will be on a sliding scale, which could amount to a maximum of 2 percent per year. CMS will report performance scores in two places, the Dialysis Facility Compare website and certificates posted at each participating facility.[5] A subset of the measures used in the quality improvement program are utilized in ESRD QIP and publicly reported on dialysis compare.

Statutory Requirements for Measures:
To the extent possible, the program must include measures pertaining to anemia management that reflect the labeling approved by the FDA for such management, dialysis adequacy, patient satisfaction, iron management, bone mineral metabolism, and vascular access.[6]

Home Health Quality Reporting and Home Health Compare
Program description

As indicated in the conditions of participation, Medicare-certified[1] home health agencies (HHAs) are required to collect and submit the Outcome Assessment Information Set (OASIS). The OASIS is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.[7] Subsets of the quality measures generated from OASIS are reported on the Home Health Compare website, which provides information about the quality of care provided by HHAs throughout the country.[8] Currently, 23 of the 97 OASIS measures are finalized for public reporting on Home Health Compare.

[1] "Medicare-certified" means the home health agency is approved by Medicare and meets certain Federal health and safety requirements.

Hospice Quality Reporting

Program description and statutory requirements

Section 3004 of the Affordable Care Act requires the establishment of a quality reporting program for hospice. Quality measures will be reported beginning in fiscal year (FY) 2014. Failure to submit required quality data shall result in a 2% reduction in the annual payment update.[9] All data submitted will be made available to the public; however, hospice providers must have an opportunity to review the data that is to be made public before its release.[10] Two measures are required for FY2104; six measures are under consideration for future years.

Statutory Requirements for Measures:

- Measures should align with the NQS three-part aim including better care for the individual, better population health, and lower cost through better quality.
- Measures should align with other Medicare and Medicaid quality reporting programs as well as other private sector initiatives. [11]

Inpatient Rehabilitation Facilities (IRFs) Quality Reporting

Program description and statutory requirements

As indicated in Section 3004 of the Affordable Care Act, CMS is directed to establish quality reporting requirements for inpatient rehabilitation facilities (IRFs). Starting in Fiscal Year (FY) 2014, and each subsequent year, failure to report quality data will result in a 2% reduction in the annual payment update. Additionally, the data must be made available to the public, with IRF providers having an opportunity to review the data prior to its release. [12] Two measures are finalized for FY 2014; eight measures are under consideration for future years.

Statutory Requirements for Measures: [13]

- Measures should align with the NQS three-part aim including better care for the individual, better population health, and lower cost through better quality
- Measures should be relevant to the priorities in the IRF setting, such as improving patient safety (e.g., avoiding healthcare associated infections and adverse events), reducing adverse events, and encouraging better coordination of care and person- and family-centered care
- Measures should serve the primary role of IRFs, addressing the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge

Long-Term Care Hospital Quality Reporting

Program description and statutory requirements

As indicated in Section 3004 of the Affordable Care Act, CMS is required to establish quality reporting requirements for long-term care hospitals (LTCHs). Providers must submit data on quality measures to receive annual payment updates; failure to report quality data will result in a 2% reduction in the annual payment update.[14] The data must be made publicly available, with LTCH providers having an opportunity to review the data prior to its release.[15] The CMS final FY 2012 Medicare Long Term Acute Care Hospital PPS Rule, published in August 2011, finalized three measures for LTCH reporting in 2014. Eight measures are proposed for addition to the program.

Statutory Requirements for Measures:[16]

- Measures should align with the NQS three-part aim including better care for the individual, better population health, and lower cost through better quality
- Measures should promote enhanced quality with regard to the priorities most relevant to LTCHS, such as patient safety (e.g., avoiding healthcare associated infections and adverse events), better coordination of care, and person-centered and family-centered care
- Measures should address the primary role of LTCHs, furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days)

Hospital Setting

Ambulatory Surgical Center Quality Reporting

Program description and statutory requirements

This proposed rule (Section 1833(2)(D) of the Affordable Care Act (ACA) would update the revised Medicare ambulatory surgical center (ASC) payment system applicable to services furnished on or after January 1, 2012. Any ASC that does not submit quality measures will incur a 2.0 percentage point reduction to any annual increase provided under the revised ASC payment system for such year. However, due to public comments received, payments adjusted will only begin after October 1, 2012 based on these new reporting requirements. [17]

Statutory Requirements for Measures:
The Act requires the Secretary to develop measures for ASC services in a similar manner in which they apply to hospitals for the Hospital OQR Program, except as the Secretary may otherwise provide. They must be appropriate for the measurement of quality of care (including medication errors) furnished by hospitals in outpatient settings, reflect consensus among affected parties, and to the extent feasible, stem from one or more national consensus building entities. The measures can also be the same as (or a subset of) data submitted under the Hospital IQR program. The Secretary also has the right to replace measures that have been shown to not represent the best clinical practice, or where hospitals are nearly all effectively in compliance. The measures should reflect a good balance of process, outcome, and patient experience measures but ultimately move toward risk-adjusted outcome and patient experience measures that alight with public and private reporting entities, align with the adoption of HIT and Meaningful Use technology, and are endorsed by a national, multi-stakeholder organization. [18]NQF-endorsed measures should be used to the extent feasible and practicable. Additionally, the measure development, selection, modification process established under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A, as added by section 3014 (MAP process), to be used to the extent feasible and practicable.

Hospital Inpatient Quality Reporting

Program description and statutory requirements

Since 2004, CMS has collected quality and patient experience data from acute care hospitals on a voluntary basis under the Hospital Inpatient Quality Reporting (IQR) Program. The program was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This section of the MMA authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. Initially, the MMA provided for a 0.4 percentage point reduction in the annual market basket (the measure of

inflation in costs of goods and services used by hospitals in treating Medicare patients) update for hospitals that did not successfully report. The Deficit Reduction Act of 2005 increased that reduction to 2.0 percentage points. [19]Information gathered through the Hospital IQR program is reported on the Hospital Compare Website.[20]

Statutory Requirements for Measures:
The Secretary shall begin to adopt the baseline set of performance measures set forth in the November 2005 report by the Institute of Medicine of the National Academy of Sciences under section 238 (b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The Secretary shall add other measures that reflect consensus among the affected parties, and to the extent feasible and practicable, shall include measure set forth by one or more national consensus building entities. The Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice. The Secretary shall report quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in inpatient settings on the CMS website. Registry-based measures can be considered for this program. All Cause All Condition readmissions (Section 3025, item #8) to be used for quality improvement, not payment.

Hospital Outpatient Quality Reporting

Program description and statutory requirements

The CMS Hospital Outpatient Quality Reporting Program (OQR) is a pay for reporting program for outpatient hospital services. The program was mandated by the Tax Relief and Health Care Act of 2006, which requires hospitals to submit data on measures on the quality of care furnished in hospital outpatient settings. Hospitals that do not meet the program requirements receive a 2 percentage point reduction in their annual payment update under the Outpatient Prospective Payment System (OPPS). Information gathered through the Hospital OQR program is reported on the Hospital Compare Website.[21]

Statutory Requirements for Measures:
The Secretary shall develop measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities. The Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice. The Secretary shall report quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in outpatient settings in hospitals on the CMS website. Measures may be a subset of measures used for other programs. An outpatient setting or outpatient hospital service is deemed a reference to ambulatory surgical center, the setting of such a center or services of such a center.

Hospital Value-Based Purchasing

Program description and statutory requirements

In FY 2013, Medicare will begin basing a portion of hospital reimbursements on hospital performance on a set of quality measures that have been linked to improved clinical processes of care and patient satisfaction. For FY 2013, the Hospital Value-Based Purchasing Program will distribute an estimated $850 million to hospitals based on their overall performance on the quality measures. These funds will be

taken from what Medicare otherwise would have spent for hospital stays, and the size of the fund will gradually increase over time, resulting in a shift from payments based on volume to payments based on performance. Hospitals will continue to receive payments for care provided to Medicare patients based on the Medicare Inpatient Prospective Payment System, but those payments will be reduced by 1 percent starting in fiscal year 2013 to create the funding for the new value-based payments. Hospitals will be scored based on their performance on each measure relative to other hospitals and on how their performance on each measure has improved over time. The higher of these scores on each measure will be used in determining incentive payments. CMS plans to add additional outcomes measures that focus on improved patient outcomes and prevention of hospital-acquired conditions. Measures that have reached very high compliance scores would likely be replaced.[22] The measures included in the Hospital Value-Based Purchasing Program are a subset of those collected through the Hospital IQR program. Information gathered through the Hospital IQR program is reported on the Hospital Compare Website.[23]

Statutory Requirements for Measures:

The Secretary shall select measures for purposes of the Program. Such measures shall be selected from the measures specified the Hospital Inpatient Quality Reporting Program.

Requirements:

- FOR FISCAL YEAR 2013- For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall ensure the following:
  - Excludes readmission measures
  - Measures are cover at least the following 5 specific conditions or procedures:
    - Acute myocardial infarction (AMI)
    - Heart failure.
    - Pneumonia.
    - Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as `Surgical Infection Prevention' for discharges occurring before July 2006).
    - Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.
  - HCAHPS- Measures selected shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).
- Inclusion of Efficiency Measures – For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected include efficiency measures, including measures of `Medicare spending per beneficiary'. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.
- Limitations –
  - Time requirement for reporting and notice – The Secretary may not select a measure for use under the Program with respect to a performance period for a fiscal year unless such measure has been specified under the Hospital IQR program and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.
  - A measure selected shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

Inpatient Psychiatric Facility Quality Reporting

Program description and statutory requirements

Section 10322 of the Affordable Care Act (ACA) establishes a quality reporting program for psychiatric hospitals and psychiatric units. Beginning in FY 2014, these psychiatric hospitals will be required to

submit data to the Secretary of Health and Human Services. Any psychiatric hospital that does not report quality data according to CMS' requirements will receive up to a 2 percent reduction in the annual rate update.[24] Information collected through this program will be reported on the CMS website.
Statutory Requirements for Measures:
Any measure specified by the Secretary must have been endorsed by the entity with a contract under section 1890(a). In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by NQF, the Secretary may specify a measure that is not endorsed as long as due consideration is given to measure that have been endorsed or adopted by a consensus organization identified by the Secretary.
The Secretary shall report quality measures that relate to services furnished in inpatient settings in psychiatric hospitals and psychiatric units on the CMS website.

Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs

Program description and statutory requirements

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs will provide incentive payments to eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The program was created under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009. Incentive payments for eligible hospitals and CAHs may begin as early as 2011 and are based on a number of factors, beginning with a $2 million base payment. For 2015 and later, Medicare eligible hospitals and CAHs that do not successfully demonstrate meaningful use will have a reduction in their Medicare reimbursement. The Medicaid EHR program incentive payments may begin as early as 2011, depending on when an individual state begins its program. The last year a Medicaid eligible hospital may begin the program is 2016. There are no payment adjustments under the Medicaid EHR program.

Statutory Requirements for Measures:
An eligible hospital or CAH must be a meaningful EHR user for the relevant EHR reporting period in order to qualify for the incentive payment for a payment year in the Medicare Fee for Service (FFS) EHR incentive program. An eligible hospital shall be considered a meaningful EHR user for an EHR reporting period for a payment year if they meet the following three requirements: (1) Demonstrates use of certified EHR technology in a meaningful manner; (2) demonstrates to the satisfaction of the Secretary that certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care such as promoting care coordination, in accordance with all laws and standards applicable to the exchange of information; and (3) using its certified EHR technology, submits to the Secretary, in a form and manner specified by the Secretary, information on clinical quality measures and other measures specified by the Secretary. Preference should be given to NQF-endorsed measures when selecting measures for this program.

Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting

Program description and statutory requirements

Section 3005 of the Affordable Care Act (ACA) establishes a quality reporting program for the 11 PPS-exempt cancer hospitals. Beginning in FY 2014, these cancer hospitals will be required to submit data to the Secretary of Health and Human Services. At this time PPS-exempt cancer hospitals must report quality data according to CMS' requirements with no Medicare payment penalty or incentive.[25] This information will be reported on the CMS website.[26]

Statutory Requirements for Measures:
Any measure specified by the Secretary must have been endorsed by NQF, the entity with a contract under section 1890(a). In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by NQF, the Secretary may specify a measure that is not endorsed as long as due consideration is given to measure that have been endorsed or adopted by a consensus organization identified by the Secretary.
The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care on the CMS website.

Clinician Setting

Medicare and Medicaid EHR Incentive Program for Eligible Professionals

Program description and statutory requirements

The American Recovery and Reinvestment Act of 2009 specified three main components of Meaningful Use:

1. The use of a certified EHR in a meaningful manner, such as e-prescribing.
2. The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
3. The use of certified EHR technology to submit clinical quality and other measures.

Eligible professionals must report on 6 total clinical quality measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures (selected from a set of 38 clinical quality measures).[27]

Statutory Requirements for Measures:
Measures are of processes, experience and/or outcomes of patient care, observations or treatment that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable and timely care. Measures must be reported for all patients, not just Medicare and Medicaid beneficiaries.[28]

Medicare Shared Savings Program

Program description and statutory requirements

Section 3022 of the Affordable Care Act requires the Centers for Medicare & Medicaid Services (CMS) to establish a shared savings program in order to facilitate cooperation among providers, improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries, and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization, also called an ACO. The measure set contains 33 finalized measures.

Statutory Requirements for Measures:
The Secretary of HHS is required to determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of clinical processes and outcomes; patient and, where practicable, caregiver experience of care; and utilization (such as rates of hospital admissions for ambulatory care sensitive conditions). [29,30]

Physician Quality Reporting System

Program description and statutory requirements

The 2006 Tax Relief and Health Care Act (TRHCA) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries.
Individual clinicians participating in the PQRS may select 3 measures (out of more than 200 measures) to report or may choose to report a disease group. Clinicians have three options for submitting data: (1) Medicare Part B claims submission, (2) submission via a qualified Physician Quality Reporting registry, or (3) submit using a qualified electronic health record (EHR) product. Individual eligible professionals who meet the criteria for satisfactory submission qualify to earn an incentive payment equal to 1% of their total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges. Group practices may also submit and are qualified to receive an incentive payment of 1% if the practice similarly meets criteria for participation. Groups with 200 or more eligible professionals must report a set of measures.
Beginning in 2011, physicians have the opportunity to earn an additional incentive of 0.5% by working with a Maintenance of Certification entity to satisfactorily submit data. [31]

Statutory Requirements for Measures:
This program must include measures pertaining to physicians (medicine, osteopathy, podiatric med, optometry, surgery, oral surgery, dental med, chiropractic) and therapists (Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist).

Value-Based Payment Modifier

Program description and statutory requirements

Section 3007 of the ACA requires CMS to pay physicians differentially based on a modifier derived from composites of quality and cost measures. The program's goal is to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. This system will be phased in over a 2-year period beginning in 2015. By 2017, the value-based payment modifier will be applied to the majority of clinicians. The program must include a composite of appropriate, risk-based quality measures and a composite of appropriate cost measures.

Statutory Requirements for Measures:
This program must include measures pertaining to quality of care, care coordination, cost, efficiency (focus on preventable readmissions), safety/functional status, and outcomes. They should address systems of care, use composite measures where possible, and pull from the core set of PQRS for 2012. [32]

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MAP Hospital Core Measures

In order to develop the hospital core measure set, MAP began by evaluating the CMS Hospital Inpatient Quality Reporting (IQR) Program using the draft measure selection criteria. This long-standing quality reporting program is the most extensive of the seven programs under consideration within the workgroup's scope. Subsequently, two additional hospital program measure sets, the CMS Hospital Outpatient Quality Reporting (OQR) Program and Hospital Value-Based Purchasing (VBP) Program, were evaluated to provide additional context to the current landscape of measures required by hospitals for reporting.

Using these evaluations as the groundwork for identifying a core measure set, MAP then identified additional individual measures available within existing programs to be included in the core measures list. Where no existing measures were available, they looked to other NQF-endorsed measures to fill gaps. This approach allowed members to develop a core measure set while discussing in detail the value any given measure added to the set. It also facilitated the identification of a number of measure gap areas for future endorsement and development.

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Cardiac	AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival and OP-2: Fibrinolytic therapy received within 30 minutes	164 Endorsed and 288 Endorsed	Process			X			
Cardiac	AMI–8a Timing of receipt of primary percutaneous coronary intervention (PCI)	163 Endorsed	Process			X			
Cardiac	Acute myocardial infarction (AMI) 30-day mortality rate	230 Endorsed	Outcome			X			
Cardiac	Heart failure (HF) 30-day mortality rate	229 Endorsed	Outcome			X			
Cardiac	Acute myocardial infarction 30-day risk standardized readmission measure	505 Endorsed	Outcome	X	X	X			
Cardiac	Heart failure 30-day risk standardized readmission measure	330 Endorsed	Outcome	X	X	X			

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Cardiac	OP–3: Median time to transfer to another facility for acute coronary intervention	290 Endorsed	Process		X	X			
Cancer	Family Evaluation of Hospice Care	0208 Endorsed	Composite				X		
Cancer	Comfortable dying: pain brought to a comfortable level within 48 hours of initial assessment	0209 Endorsed	Outcome				X		
Cancer	Post breast conserving surgery irradiation	0219 Endorsed	Process			X			
Cancer	Adjuvant hormonal therapy	0220 Endorsed	Process			X			
Cancer	Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection	0221 Endorsed	Process			X			
Cancer	Patients with early stage breast cancer who have evaluation of the axilla	0222 Endorsed	Process			X			
Cancer	Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to	0223 Endorsed	Process		X	X			
Cancer	Completeness of pathology reporting	0224 Endorsed	Process			X			
Cancer	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer	0225 Endorsed	Process			X			

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Cancer	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer	0559 Endorsed	Process		X				
Complications	Complication/patient safety for selected indicators (composite) Includes potentially preventable adverse events for: • Accidental puncture or laceration • Iatrogenic pneumothorax • Postoperative DVT or PE • Postoperative wound dehiscence • Decubitus ulcer • Selected infections due to medical care • Postoperative hip fracture • Postoperative sepsis	531 Endorsed	Other (composite)	X					
Maternal/ child health	Elective delivery prior to 39 completed weeks gestation	0469 Endorsed	Outcome	X					X
Maternal/ child health	Cesarean Rate for low-risk first birth women (aka NTSV CS rate)	0471 Endorsed	Outcome	X					X
Maternal/ child health	Healthy Term Newborn	0716 Endorsed	Outcome	X					

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Mental Health	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a. Initiation, b. Engagement	0004 Endorsed	Process					X	
Mortality	Mortality for selected medical conditions (composite) Includes in-hospital deaths for: • CHF • Stroke • Hip fracture • Pneumonia • Acute myocardial infarction • GI hemorrhage	530 Endorsed	Other (composite)			X			X
Patient Experience	HCAHPS survey	166 Endorsed	Patient Experience				X		
Respiratory	PN–3b Blood culture performed in the emergency department prior to first antibiotic received in hospital	148 Endorsed	Process			X			
Respiratory	Pneumonia (PN) 30-day mortality rate	468 Endorsed	Outcome			X		X	
Respiratory	Pneumonia 30-day risk standardized readmission measure	506 Endorsed	Outcome	X	X				X
Respiratory	Asthma Emergency Department Visits	1381 Endorsed	Outcome	X					

Subject/Topic Area	Measure Title	NQF Measure Number and Status	Measure Type	NQS Priority					
				Safer care	Effective care coordination	Prevention and treatment of leading causes of mortality and morbidity	Person and family centered care	Supporting better health in communities	Making care more affordable
Safety	SCIP INF–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac surgery)	529 Endorsed	Process	X		X			X
Safety	SCIP–VTE-2: Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post-surgery	218 Endorsed	Process	X					
Safety	Death among surgical inpatients with treatable serious complications (failure to rescue)	200 Withdrawn	Outcome	X					
Safety	Surgical site infection	299 Endorsed	Outcome	X					
Safety	OP-24 surgical site infection	299 Endorsed	Outcome	X					
Safety	Death in Low Mortality DRGs (PSI 2)	0347 Submitted	Outcome	X					
Stroke	STK-4: Venous Thromboembolism (VTE) Prophylaxis for patients with ischemic or hemorrhagic stroke	0434 Endorsed	Process	X		X			
Stroke	STK–2: Ischemic stroke patients discharged on antithrombotic therapy	0435 Endorsed	Process	X		X			
Stroke	STK–5: Antithrombotic therapy by the end of hospital day two	0438 Endorsed	Process			X			
Stroke	STK–10: Assessed for rehabilitation services	0441 Endorsed	Process			X	X		

MAP Hospital Core Measures: Identified Measure Gaps:

- Transitions in care/communication
- Cost of care and efficiency
- Disparities-sensitive
- Patient-reported outcomes
- Composites – containing outcome and process measures, all-payer mortality rates
- Serious reportable events, particularly medication errors/adverse drug events
- Nursing-sensitive
- Emergency Department visits –trauma, access
- Behavioral health, specifically major depression
- Condition – specific measures: Alzheimer's disease, Atrial fibrillation, Chronic obstructive pulmonary disease (COPD)

PAC/LTC Core Measure Concepts

*Measures in in italics are under consideration

Core Measure Concepts	Nursing Home Compare Measures	Home Health Compare Measures	Quality Reporting Inpatient Rehabilitation Facility	Quality Reporting Program LTCH
Functional and cognitive status assessment	• The Percentage of Residents on a Scheduled Pain Medication Regimen on Admission Who Self-Report a Decrease in Pain Intensity or Frequency (Short-stay) • Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay) • Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay) • Percent of Low Risk Residents Who Lose Control of Their Bowel or Bladder (Long-Stay) • Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long-Stay) • Percent of Residents Who Lose Too Much Weight (Long-Stay) • Percent of Residents Who Have Depressive Symptoms (Long-Stay)	• Improvement in ambulation/locomotion • Improvement in bathing • Improvement in bed transferring • Improvement in status of surgical wounds • Improvement in dyspnea • Depression assessment conducted • Pain assessment conducted • Pain interventions implemented during short term episodes of care • Improvement in pain interfering with activity • Diabetic foot care and patient/caregiver education implemented during short term episodes of care	• *Functional Outcome Measure (change from)* • *Functional Outcome Measure (change in mobility)* • *Functional Outcome Measure (change in self-care)* • *The Percentage of Residents on a Scheduled Pain Medication Regimen on Admission Who Self-Report a Decrease in Pain Intensity or Frequency (Short-stay)*	• *Functional Outcome Measure (change in mobility)* • *The Percentage of Residents on a Scheduled Pain Medication Regimen on Admission Who Self-Report a Decrease in Pain Intensity or Frequency (Short-stay)* • *Functional Outcome Measure (change in self-care)*
Mental Health				
Establishment and Attainment of Patient/Family/ Caregiver Goals				
Advanced care planning and treatment				

PAC/LTC Core Measure Concepts

*Measures in in italics are under consideration

Core Measure Concepts	Nursing Home Compare Measures	Home Health Compare Measures	Quality Reporting Inpatient Rehabilitation Facility	Quality Reporting Program LTCH
Experience of care		• Home Health Consumer Assessment of Healthcare Providers and Systems (CAHPS)		
Shared decision making				
Transition planning		• Timely initiation of care		
Falls	• Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	• Multifactor fall risk assessment conducted for patients 65 and over		
Pressure ulcers	• Percent of residents with pressure ulcers that are new or worsened (short-stay) • Percent of high risk residents with pressure ulcers (long-stay)	• Pressure ulcer prevention in plan of care • Pressure ulcer risk assessment conducted • Pressure ulcer prevention implemented	• Percent of Residents with Pressure Ulcers That Are New or Worsened (Short-Stay)	• Percent of Residents with Pressure Ulcers That Are New or Worsened (Short-Stay)
Adverse drug events		• Drug education on all medications provided to patient/caregiver during short term episodes of care • Improvement in management of oral medications		
Inappropriate medication use				
Infection rates	• Percent of residents who have/had a		• Urinary catheter-associated urinary	• Urinary catheter-associated urinary

PAC/LTC Core Measure Concepts

*Measures in in italics are under consideration

Core Measure Concepts	Nursing Home Compare Measures	Home Health Compare Measures	Quality Reporting Inpatient Rehabilitation Facility	Quality Reporting Program LTCH
	catheter inserted and left in their bladder (long-stay) • Percent of residents with a urinary tract infection (long-stay)		tract infection	tract infection • Central Line Catheter-Associated Blood Stream Infection (CLABSI) • *Ventilator bundle*
Avoidable admissions		• Acute care hospitalization • Emergency Department Use without Hospitalization		
Measures not mapped to a core set concept	• Percent of residents who were assessed and appropriately given the seasonal influenza vaccine (short-stay) • Percent of residents assessed and appropriately given the seasonal influenza vaccine (long-stay) • Percent of residents assessed and appropriately given the pneumococcal vaccine (short-stay) • Percent of residents who were assessed and appropriately given the pneumococcal vaccine (long-stay) • Nurse staffing hours - 4 parts • Percent of Residents Who Were Physically Restrained (Long Stay)	• Influenza immunization received for current flu season • Pneumococcal polysaccharide vaccine (PPV) ever received • Heart failure symptoms addressed during short -term episodes of care	• *Incidence of venous thromboembolism (VTE), potentially preventable* • *Staff immunization* • *Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)* • *Patient Immunization for Influenza*	• *Staff immunization* • *Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)* • *Patient Immunization for Influenza* • *Percent of Residents Who Were Physically Restrained (Long Stay)*

the Administrator) for use under this Act. In developing such measures, the Administrator shall consult with the Director of the Agency for Healthcare Research and Quality.".

(c) FUNDING.—There are authorized to be appropriated to the Secretary of Health and Human Services to carry out this section, $75,000,000 for each of fiscal years 2010 through 2014. Of the amounts appropriated under the preceding sentence in a fiscal year, not less than 50 percent of such amounts shall be used pursuant to subsection (e) of section 1890A of the Social Security Act, as added by subsection (b), with respect to programs under such Act. Amounts appropriated under this subsection for a fiscal year shall remain available until expended.

SEC. 3014. QUALITY MEASUREMENT.

(a) NEW DUTIES FOR CONSENSUS-BASED ENTITY.—

(1) MULTI-STAKEHOLDER GROUP INPUT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)), as amended by section 3003, is amended by adding at the end the following new paragraphs:

"(7) CONVENING MULTI-STAKEHOLDER GROUPS.—

"(A) IN GENERAL.—The entity shall convene multi-stakeholder groups to provide input on—

"(i) the selection of quality measures described in subparagraph (B), from among—

"(I) such measures that have been endorsed by the entity; and

"(II) such measures that have not been considered for endorsement by such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality measures; and

"(ii) national priorities (as identified under section 399HH of the Public Health Service Act) for improvement in population health and in the delivery of health care services for consideration under the national strategy established under section 399HH of the Public Health Service Act.

"(B) QUALITY MEASURES.—

"(i) IN GENERAL.—Subject to clause (ii), the quality measures described in this subparagraph are quality measures—

"(I) for use pursuant to sections 1814(i)(5)(D), 1833(i)(7), 1833(t)(17), 1848(k)(2)(C), 1866(k)(3), 1881(h)(2)(A)(iii), 1886(b)(3)(B)(viii), 1886(j)(7)(D), 1886(m)(5)(D), 1886(o)(2), and 1895(b)(3)(B)(v);

"(II) for use in reporting performance information to the public; and

"(III) for use in health care programs other than for use under this Act.

"(ii) EXCLUSION.—Data sets (such as the outcome and assessment information set for home health services and the minimum data set for skilled nursing facility services) that are used for purposes of classification systems used in establishing payment rates under this title shall not be quality measures described in this subparagraph.

"(C) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—

"(i) IN GENERAL.—In convening multi-stakeholder groups under subparagraph (A) with respect to the selection of quality measures, the entity shall provide for an open and transparent process for the activities conducted pursuant to such convening.

"(ii) SELECTION OF ORGANIZATIONS PARTICIPATING IN MULTI-STAKEHOLDER GROUPS.—The process described in clause (i) shall ensure that the selection of representatives comprising such groups provides for public nominations for, and the opportunity for public comment on, such selection.

"(D) MULTI-STAKEHOLDER GROUP DEFINED.—In this paragraph, the term 'multi-stakeholder group' means, with respect to a quality measure, a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of such quality measure.

"(8) TRANSMISSION OF MULTI-STAKEHOLDER INPUT.—Not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups provided under paragraph (7).". Deadline.

(2) ANNUAL REPORT.—Section 1890(b)(5)(A) of the Social Security Act (42 U.S.C. 1395aaa(b)(5)(A)) is amended—

(A) in clause (ii), by striking "and" at the end;

(B) in clause (iii), by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following new clauses:

"(iv) gaps in endorsed quality measures, which shall include measures that are within priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act, and where quality measures are unavailable or inadequate to identify or address such gaps;

"(v) areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act and where targeted research may address such gaps; and

"(vi) the matters described in clauses (i) and (ii) of paragraph (7)(A).".

(b) MULTI-STAKEHOLDER GROUP INPUT INTO SELECTION OF QUALITY MEASURES.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1890 the following:

"QUALITY MEASUREMENT

"SEC. 1890A. (a) MULTI-STAKEHOLDER GROUP INPUT INTO SELECTION OF QUALITY MEASURES.—The Secretary shall establish a pre-rulemaking process under which the following steps occur with respect to the selection of quality measures described in section 1890(b)(7)(B): Deadlines. 42 USC 1395aaa–1. Regulations.

"(1) INPUT.—Pursuant to section 1890(b)(7), the entity with a contract under section 1890 shall convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures described in subparagraph (B) of such paragraph.

"(2) PUBLIC AVAILABILITY OF MEASURES CONSIDERED FOR SELECTION.—Not later than December 1 of each year (beginning with 2011), the Secretary shall make available to the public a list of quality measures described in section 1890(b)(7)(B) that the Secretary is considering under this title.

"(3) TRANSMISSION OF MULTI-STAKEHOLDER INPUT.—Pursuant to section 1890(b)(8), not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups described in paragraph (1).

"(4) CONSIDERATION OF MULTI-STAKEHOLDER INPUT.—The Secretary shall take into consideration the input from multi-stakeholder groups described in paragraph (1) in selecting quality measures described in section 1890(b)(7)(B) that have been endorsed by the entity with a contract under section 1890 and measures that have not been endorsed by such entity.

Federal Register, publication.

"(5) RATIONALE FOR USE OF QUALITY MEASURES.—The Secretary shall publish in the Federal Register the rationale for the use of any quality measure described in section 1890(b)(7)(B) that has not been endorsed by the entity with a contract under section 1890.

"(6) ASSESSMENT OF IMPACT.—Not later than March 1, 2012, and at least once every three years thereafter, the Secretary shall—

"(A) conduct an assessment of the quality impact of the use of endorsed measures described in section 1890(b)(7)(B); and

Public information.

"(B) make such assessment available to the public.

"(b) PROCESS FOR DISSEMINATION OF MEASURES USED BY THE SECRETARY.—

"(1) IN GENERAL.—The Secretary shall establish a process for disseminating quality measures used by the Secretary. Such process shall include the following:

"(A) The incorporation of such measures, where applicable, in workforce programs, training curricula, and any other means of dissemination determined appropriate by the Secretary.

"(B) The dissemination of such quality measures through the national strategy developed under section 399HH of the Public Health Service Act.

"(2) EXISTING METHODS.—To the extent practicable, the Secretary shall utilize and expand existing dissemination methods in disseminating quality measures under the process established under paragraph (1).

"(c) REVIEW OF QUALITY MEASURES USED BY THE SECRETARY.—

"(1) IN GENERAL.—The Secretary shall—

"(A) periodically (but in no case less often than once every 3 years) review quality measures described in section 1890(b)(7)(B); and

"(B) with respect to each such measure, determine whether to—

"(i) maintain the use of such measure; or

"(ii) phase out such measure.

"(2) CONSIDERATIONS.—In conducting the review under paragraph (1), the Secretary shall take steps to—

"(A) seek to avoid duplication of measures used; and

"(B) take into consideration current innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices for such quality improvement and measures endorsed by the entity with a contract under section 1890 since the previous review by the Secretary.

"(d) RULE OF CONSTRUCTION.—Nothing in this section shall preclude a State from using the quality measures identified under sections 1139A and 1139B.".

(c) FUNDING.—For purposes of carrying out the amendments made by this section, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $20,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2010 through 2014. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3015. DATA COLLECTION; PUBLIC REPORTING.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 3011, is further amended by adding at the end the following:

"SEC. 399II. COLLECTION AND ANALYSIS OF DATA FOR QUALITY AND RESOURCE USE MEASURES. 42 USC 280j–1.

"(a) IN GENERAL.—The Secretary shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information, as described in section 399JJ, and may award grants or contracts for this purpose. The Secretary shall ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time.

"(b) GRANTS OR CONTRACTS FOR DATA COLLECTION.—

"(1) IN GENERAL.—The Secretary may award grants or contracts to eligible entities to support new, or improve existing, efforts to collect and aggregate quality and resource use measures described under subsection (c).

"(2) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

"(A) be—

"(i) a multi-stakeholder entity that coordinates the development of methods and implementation plans for the consistent reporting of summary quality and cost information;

"(ii) an entity capable of submitting such summary data for a particular population and providers, such as a disease registry, regional collaboration, health plan collaboration, or other population-wide source; or

"(iii) a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act);

"(B) promote the use of the systems that provide data to improve and coordinate patient care;

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Coordinating Committee

Co-Chairs (voting)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

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

NATIONAL QUALITY FORUM

Expertise	Individual Subject Matter Expert Members (voting)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Joseph Betancourt, MD, MPH
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD
Post-Acute Care/ Home Health/ Hospice	Carol Raphael, MPA

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD MSc
Health Resources and Services Administration (HRSA)	Ahmed Calvo, MD, MPH
Office of Personnel Management/FEHBP (OPM)	John O'Brien
Office of the National Coordinator for HIT (ONC)	Joshua Seidman, MD, PhD

Accreditation/Certification Liaisons (non-voting)	Representatives
American Board of Medical Specialties	Christine Cassel, MD
National Committee for Quality Assurance	Peggy O'Kane, MPH
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)
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Mark McClellan, MD, PhD

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

Expertise	Individual Subject Matter Expert Members (voting)
Disparities	Marshall Chin, MD, MPH, FACP
Population Health	Eugene Nelson, MPH, DSc
Shared Decision Making	Karen Sepucha, PhD
Team-Based Care	Ronald Stock, MD, MA
Health IT/ Patient Reported Outcome Measures	James Walker, MD, FACP
Measure Methodologist	Dolores Yanagihara, MPH

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	Darryl Gray, MD, ScD
Centers for Disease Control and Prevention (CDC)	Peter Briss, MD, MPH

Centers for Medicare & Medicaid Services (CMS)	Michael Rapp, MD, JD, FACEP
Health Resources and Services Administration (HRSA)	Ian Corbridge, MPH, RN
Office of the National Coordinator for HIT (ONC)	Joshua Seidman, MD, PhD
Veterans Health Administration (VHA)	Joseph Francis, MD, MPH

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)
George J. Isham, MD, MS
Elizabeth A. McGlynn, PhD, MPP

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Measure Applications Partnership (MAP)

Roster for the MAP Ad Hoc Safety Workgroup

Chair (voting)
Frank G. Opelka, MD, FACS

Organizational Members (voting)	Representatives
Alliance of Dedicated Cancer Centers	Ronald Walters, MD, MBA, MHA, MS
American Hospital Association	Richard Umbdenstock
American Organization of Nurse Executives	Patricia Conway-Morana, RN
American Society of Health-System Pharmacists	Kasey Thompson, PharmD
Blue Cross Blue Shield of Massachusetts	Jane Franke, RN, MHA, CPHQ
Building Services 32BJ Health Fund	Barbara Caress
Iowa Healthcare Collaborative	Lance Roberts, PhD
Memphis Business Group on Health	Cristie Upshaw Travis, MSHA
Mothers Against Medical Error	Helen Haskell, MA
National Association of Children's Hospitals and Related Institutions	Andrea Benin, MD
National Rural Health Association	Brock Slabach, MPH, FACHE
Premier, Inc.	Richard Bankowitz, MD, MBA, FACP

Expertise	Individual Subject Matter Expert Members (voting)
Patient Safety	Mitchell Levy, MD, FCCM, FCCP
Palliative Care	R. Sean Morrison, MD
State Policy	Dolores Mitchell
Health IT	Brandon Savage, MD
Patient Experience	Dale Shaller, MPA
Safety Net	Bruce Siegel, MD, MPH
Mental Health	Ann Marie Sullivan, MD

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	John Bott, MSSW, MBA
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH, FACP
Centers for Medicare & Medicaid Services (CMS)	Shaheen Halim, PhD, CPC-A
Office of the National Coordinator for HIT (ONC)	Leah Marcotte

Veterans Health Administration (VHA)	Michael Kelley, MD
Health Resources and Services Administration (HRSA)	Ian Corbridge, MPH, RN
Office of Personnel Management/FEHBP (OPM)	John O'Brien

Payers (voting)	**Representatives**
Aetna	Randall Krakauer, MD
America's Health Insurance Plans	Aparna Higgins, MA
CIGNA	Dick Salmon, MD, PhD
Humana	Thomas James III, MD
LA Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Medicaid Directors	Foster Gesten, MD

Purchasers (voting)	**Representatives**
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Unite Here Health	Elizabeth Gilbertson, MS
Pacific Business Group on Health	William Kramer, MBA
The Alliance	Cheryl DeMars, MSSW

Expertise	**Individual Subject Matter Expert Members (voting)**
Payer	Lawrence Gottlieb, MD, MPP, FACP
Payer	Rhonda Robinson Beale, MD
Payer	MaryAnne Lindeblad, BSN, MPH

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)
George J. Isham, MD, MS
Elizabeth A. McGlynn, PhD, MPP

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Measure Applications Partnership (MAP)

Roster for the MAP Dual Eligible Beneficiaries Workgroup

Chair (voting)
Alice Lind, MPH, BSN

Organizational Members (voting)	Representative
American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	David Polakoff, MD, MsC
Better Health Greater Cleveland	Patrick Murray, MD, MS
Center for Medicare Advocacy	Patricia Nemore, JD
National Health Law Program	Leonardo Cuello, JD
Humana, Inc.	Thomas James, III, MD
L.A. Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National PACE Association	Adam Burrows, MD

Expertise	Individual Subject Matter Expert Members (voting)
Substance Abuse	Mady Chalk, MSW, PhD
Emergency Medical Services	James Dunford, MD
Disability	Lawrence Gottlieb, MD, MPP
Measure Methodologist	Juliana Preston, MPA
Home & Community Based Services	Susan Reinhard, RN, PhD, FAAN
Mental Health	Rhonda Robinson-Beale, MD
Nursing	Gail Stuart, PhD, RN

Federal Government Members (non-voting, ex officio)	Representative
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Medicare-Medicaid Coordination Office	Cheryl Powell
Health Resources and Services Administration	Samantha Wallack Meklir, MPP
HHS Office on Disability	Henry Claypool
Substance Abuse and Mental Health Services Administration	Rita Vandivort-Warren, MSW
Veterans Health Administration	Daniel Kivlahan, PhD

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)

George Isham, MD, MS

Elizabeth McGlynn, PhD, MPP

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Measure Applications Partnership (MAP)

Roster for the MAP Hospital Workgroup

Chair (voting)
Frank G. Opelka, MD, FACS

Organizational Members (voting)	Representatives
Alliance of Dedicated Cancer Centers	Ronald Walters, MD, MBA, MHA, MS
American Hospital Association	Richard Umbdenstock
American Organization of Nurse Executives	Patricia Conway-Morana, RN
American Society of Health-System Pharmacists	Shekhar Mehta, PharmD, MS
Blue Cross Blue Shield of Massachusetts	Jane Franke, RN, MHA, CPHQ
Building Services 32BJ Health Fund	Barbara Caress
Iowa Healthcare Collaborative	Lance Roberts, PhD
Memphis Business Group on Health	Cristie Upshaw Travis, MSHA
Mothers Against Medical Error	Helen Haskell, MA
National Association of Children's Hospitals and Related Institutions	Andrea Benin, MD
National Rural Health Association	Brock Slabach, MPH, FACHE
Premier, Inc.	Richard Bankowitz, MD, MBA, FACP

Expertise	Individual Subject Matter Expert Members (voting)
Patient Safety	Mitchell Levy, MD, FCCM, FCCP
Palliative Care	R. Sean Morrison, MD
State Policy	Dolores Mitchell
Health IT	Brandon Savage, MD
Patient Experience	Dale Shaller, MPA
Safety Net	Bruce Siegel, MD, MPH
Mental Health	Ann Marie Sullivan, MD

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	Mamatha Pancholi, MS
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH, FACP
Centers for Medicare & Medicaid Services (CMS)	Shaheen Halim, PhD, CPC-A

Office of the National Coordinator for HIT (ONC)	Leah Marcotte
Veterans Health Administration (VHA)	Michael Kelley, MD

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Elizabeth A. McGlynn, PhD, MPP

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Post-Acute Care/Long-Term Care Workgroup

Chair (voting)
Carol Raphael, MPA

Organizational Members (voting)	Representative
Aetna	Randall Krakauer, MD
American Medical Rehabilitation Providers Association	Suzanne Snyder, PT
American Physical Therapy Association	Roger Herr, PT, MPA, COS-C
Family Caregiver Alliance	Kathleen Kelly, MPA
HealthInsight	Juliana Preston, MPA
Kindred Healthcare	Sean Muldoon, MD
National Consumer Voice for Quality Long-Term Care	Lisa Tripp, JD
National Hospice and Palliative Care Organization	Carol Spence, PhD
National Transitions of Care Coalition	James Lett II, MD, CMD
Providence Health and Services	Robert Hellrigel
Service Employees International Union	Charissa Raynor
Visiting Nurses Association of America	Margaret Terry, PhD, RN

Expertise	Individual Subject Matter Expert Members (voting)
Clinician/Nursing	Charlene Harrington, PhD, RN, FAAN
Care Coordination	Gerri Lamb, PhD
Clinician/Geriatrics	Bruce Leff, MD
State Medicaid	MaryAnne Lindeblad, MPH
Measure Methodologist	Debra Saliba, MD, MPH
Health IT	Thomas von Sternberg, MD

Federal Government Members (non-voting, ex officio)	
Agency for Healthcare Research and Quality (AHRQ)	Judy Sangl, ScD
Centers for Medicare & Medicaid Services (CMS)	Shari Ling
Veterans Health Administration	Scott Shreve, MD

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

Measure Applications Partnership - Schedule of Deliverables

Task	Task Description	Deliverable	Timeline
15.1: Measures to be implemented through the Federal rulemaking process	Provide input to HHS on measures to be implemented through the Federal rulemaking process, based on an overview of the quality issues in hospital, clinician office, and post-acute/long-term care settings; the manner in which those problems could be improved; and the measures for encouraging improvement.	Final report containing the Coordinating Committee framework for decision making and proposed measures for specific programs	Draft Report: January 2012 Final Report: February 1, 2012
15.2a: Measures for use in the improvement of clinician performance	Provide input to HHS on a coordination strategy for clinician performance measurement across public programs.	Final report containing Coordinating Committee input	Draft Report: September 2011 Final Report: October 1, 2011
15.2b: Measures for use in quality reporting for post-acute and long term care programs	Provide input to HHS on a coordination strategy for performance measurement across post-acute care and long-term care programs.	Final report containing Coordinating Committee input	Draft Report: January 2012 Final Report: February 1, 2012
15.2c: Measures for use in quality reporting for PPS-exempt Cancer Hospitals	Provide input to HHS on the identification of measures for use in performance measurement for PPS-exempt cancer hospitals.	Final report containing Coordinating Committee input	Draft Report: May 2012 Final Report: June 1, 2012
15.2d: Measures for use in quality reporting for hospice care	Provide input to HHS on the identification of measures for use in performance measurement for hospice programs and facilities.	Final report containing Coordinating Committee input	Draft Report: May 2012 Final Report: June 1, 2012
15.3: Measures that address the quality issues identified for dual eligible beneficiaries	Provide input to HHS on identification of measures that address the quality issues for care provided to Medicare-Medicaid dual eligible beneficiaries.	Interim report from the Coordinating Committee containing a performance measurement framework for dual eligible beneficiaries	Draft Interim Report: September 2011 Final Interim Report: October 1, 2011
		Final report from the Coordinating Committee containing potential new performance measures to fill gaps in measurement for dual eligible beneficiaries	Draft Report: May 2012 Final Report: June 1, 2012
15.4: Measures to be used by public and private payers to reduce readmissions and healthcare-acquired conditions	Provide input to HHS on a coordination strategy for readmission and HAC measurement across public and private payers.	Final report containing Coordinating Committee input regarding a strategy for coordinating readmission and HAC measurement across payers	Draft Report: September 2011 Final Report: October 1, 2011