NQF
National Quality Forum

Measure Applications Partnership Coordinating Committee

In-Person Meeting #3

Background Materials

August 17-18, 2011
9:00 am – 5:00 pm ET

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MAP Measure Selection Criteria Developmental Timeline

Tab 1

MAP Measure Selection Criteria
Developmental Timeline

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

May 2011 | June 2011 | July 2011 | August 2011

May 3-4 Coordinating Committee In-person Meeting

Inputs include:
- Stanford work
- NQF endorsement process – should not duplicate but build on endorsement process

Output- Measure Selection Principles:
- Promoting "systemness"(e.g., joint accountability, care coordination)
- Addresses the patient perspective
- Actionable by providers
- Enables longitudinal measurement across settings and time
- Contributes to improved outcomes
- Incorporates cost
- Promotes adoption of health IT
- Promotes parsimony

June 7-8 Clinician In-person Meeting

Inputs include:
- Stanford work
- Coordinating Committee Input

Output- Measure Selection Principles:
- Promoting "systemness"(e.g., joint accountability, care coordination)
- Addresses the patient perspective
- Actionable by providers
- Enables longitudinal measurement across settings and time
- Contributes to improved outcomes
- Incorporates cost
- Promotes adoption of health IT
- Promotes parsimony
- **Addressing various levels of analysis**
- **Useful to intended audiences, including consumers, clinicians, payers and policymakers**
- **Consideration given to unintended consequences**
- **Balancing comprehensiveness with parsimony**

Bold Above – New items

June 21-22 Coordinating Committee In-person Meeting

Inputs include:
- Stanford work
- Clinician Workgroup priority principles
- NQF Staff synthesis

Output –"Strawperson" Version 2

Suggested Measure Set Level Criteria:
- Align with priorities in the National Quality Strategy
- Address Health and health care costs across the lifespan
- Include measures of total cost of care, efficiency, and appropriateness
- Be understandable, meaningful, and useful to the intended audiences
- Core and advanced measure sets should be parsimonious and foster alignment between public and private payers to achieve a multi-dimensional view of quality
- Have safeguards in place to detect or mitigate unintended consequences
- Address specific program features

Suggested Individual Measure Criteria:
- NQF endorsed
- Build on measure endorsement thresholds
- Measures tested for the setting and level of analysis in which it will be implemented
- Ensures measures have broad applicability across populations and settings
- Ensure adequate sample size

July "Working" Measure Selection Criteria

Individual Measure Criteria:
- Measure addresses National Quality Strategy priorities and high-leverage measurement areas
- Measure meets NQF endorsement criteria
- Measure promotes parsimony through applicability to multiple populations and providers
- Measures enables longitudinal assessment of patient-focused episode of care
- Measure is ready for implementation in the context of a specific program
- Measure is proximal to outcomes

Measure Set Criteria:
- Measure set provides a comprehensive view of quality – NQS
- Measure set provides a comprehensive view of quality – high leverage opportunities
- Measure set is appropriate for all intended accountable entities
- Measure set promotes parsimony
- Measure set avoids undesirable consequences
- Measure set has a balance of measure types
- Measure set includes considerations for health care disparities

August "Working" Measure Selection Criteria

Measure Set Criteria:
- Measures within the set meet NQF endorsement criteria
- Measure set adequately addresses each of the National Quality Strategy Priorities
- Measure set adequately addresses high impact conditions relevant to the programs intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)
- Measure set promotes the goals of the specific program
- Measure set includes an appropriate mix of measure types
- Measure set enables measurement across the patient-focused episode of care
- Measure set includes considerations for health care disparities
- Measure set promotes parsimony
- Measure set avoids adverse unintended consequences

Principles Informing MAP Measure Selection Criteria

Tab 2

Principles Informing MAP Measure Selection Criteria

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

"STRAWPERSON" VERSION 2 Coordinating Committee June 21-22 Meeting	**MAP "WORKING" MEASURE SELECTION CRITERIA August 5, 2011**
Principles:	**Criteria:**
Align with priorities in the National Quality Strategy	Measure set adequately addresses each of the National Quality Strategy (NQS) priorities • Safer care • Effective care coordination • Prevention and treatment of leading causes of mortality • Person/family centered care • Supporting better health in communities • Making care more affordable
Address health and health care costs across the life span	Measure set adequately addresses high impact conditions relevant to the programs intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)
	Measure set enables measurement across the patient-focused episode of care
Core and advanced measure sets should be parsimonious and foster alignment between public and private payers to achieve a multi-dimensionsal view of quality	Measure set promotes parsimony
Have safeguards in place to detect or mitigate unintended consequences	Measure set avoids adverse unintended consequences
	Measure set includes considerations for health care disparities
Address specific program features	Measure set promotes the goals of the specific program
Include measures of total cost of care, efficiency, and appropriateness	Measure set includes an appropriate mix of measure types • Process • Outcome • Patient Experience • Cost/Efficiency
Be understandable, meaningful, and useful to the intended audiences	Measures within the set meet NQF endorsement usability criterion

Mapping of Stanford Input to MAP Measure Selection Criteria

Tab 3

Mapping of Stanford Input to MAP Measure Selection Criteria

Stanford Input – High Priority Measure Set Selection Criteria	MAP Measure Selection Criteria
Performance classification methods should accompany proposed measure sets to classify performance that is specific to the intended use. The method should demonstrate that performance discrimination is sufficient to yield meaningful results for the user audience	Measures within the set meet NQF endorsement criteria *Measures within the set meet NQF endorsement criteria are determined to be important to measure and report, have scientifically acceptable (i.e., validity and reliability testing) measure properties, usable, and feasible*
Measure sets should capture multiple dimensions of a given quality construct. Use groups of measures that address the same construct, condition, procedure or setting • a. Measure(s) should foster alignment between cost of care and other domains of quality performance. • b. Overuse/appropriateness measures should be included in a balanced measure set.	Measure set adequately addresses each of the National Quality Strategy (NQS) *Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities (Safer care, Effective care coordination, Prevention and treatment of leading causes of mortality, Person and family centered care, Supporting better health in communities, Making care more affordable)*
Outcomes measures are a preferred component of any measure set to ensure that the highest valued performance indicators are deployed – and, in particular, to capture health and cost outcomes across the care system	Measure set includes an appropriate mix of measure types *Demonstrated by a measure set that includes an appropriate mix of process, outcomes, patient experience, and cost/efficiency measures necessary to achieve the goals of the program*
Measure sets for patients whose treatment spans care settings should include continuity of care measures. Measure sets that promote shared accountability by assessing care coordination, team care experiences, and episodes of care that span care settings and integrated care transition processes are preferred	Measure set enables measurement across the patient-focused episode of care *Demonstrated by assessment with the patient as the unit of analysis across providers, settings, and time* Measure set adequately addresses each of the National Quality Strategy (NQS) *Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities (Effective care coordination)*
Measure aggregation methods should accompany proposed measure sets to ensure performance information can be summarized at a level that is meaningful and useful for the user audience	Measure set promotes the goals of the specific program *Demonstrated by a measure set which is applicable to the intended providers, care settings, and levels of analysis, and population(s) relevant to the program* Measures within the set meet NQF endorsement criteria *Measures within the set meet NQF endorsement criteria are determined to be important to measure and report, have scientifically acceptable measure properties, usable, and feasible*
Methods should be incorporated into the measure set to enable provider participation if the provider is unable to supply data for all measures	Not mapped

Steps Table

Tab 4

Measure Applications Partnership (MAP) Dual Eligible Beneficiaries Workgroup

Convened by the National Quality Forum

Goal	**Advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries**
Step 1: Dual Eligible Beneficiaries Workgroup June 2-3, 2011	**Develop Guiding Principles and Strategic Approach to Performance Measurement** • Developed initial vision statement for high-quality care for dual eligible beneficiaries • Developed draft guiding principles for strategic approach to performance measurement
Step 2: Dual Eligible Beneficiaries Workgroup June 2-3, 2011	**Identify High-Leverage Quality Improvement Opportunities for the Population** • Quality of life • Care coordination • Screening and assessment • Mental health and substance use *(added at July 25-26 meeting)*
Step 3: MAP Coordinating Committee June 21-22, 2011	**Guidance from the MAP Coordinating Committee** • Coordinating Committee provided guidance on strategic approach to performance measurement, particularly the guiding principles o Address "affordable care" aspect of NQS o Dysfunction that duals experience in the system is driven by lack of integration o Very small number of duals served in integrated delivery models; need measures that will work in current program parameters • Coordinating Committee provided input related to high-leverage quality improvement opportunities and patient safety issues

Step 4: Dual Eligible Beneficiaries Workgroup July 6, 2011	**Refine Strategic Approach and High-Leverage Opportunities** • Incorporated Coordinating Committee guidance • Reviewed vision statement and guiding principles • Began to define high-need population subgroups • Considered opportunities to improve affordability of care
Step 5: Dual Eligible Beneficiaries Workgroup July 25-26, 2011	**Finalize Strategic Approach and High-Leverage Opportunities** • Refined vision statement and elaborated on guiding principles • Discussed high-need population subgroups and relationship to high-leverage opportunities for improvement • Considered data source/HIT implications and alignment issues • Aligned with other ongoing initiatives (e.g. framework for measuring multiple chronic conditions)
Step 6: Dual Eligible Beneficiaries Workgroup July 25-26, 2011	**Match Current Measures to Identified Opportunities** • Discussed current measurement activities in the Medicare and Medicaid programs • Gathered existing endorsed measures that apply to high-leverage opportunities • Assessed selected measures for appropriateness as indicators of quality in the dual eligible population
Step 7: MAP Coordinating Committee August 17-18, 2011	**MAP Coordinating Committee Review and Approval** • Coordinating Committee reviews themes for interim report on proposed performance measurement strategy for dual eligible beneficiaries • Coordinating Committee provides further input and guidance

Step 8 and beyond: Dual Eligible Beneficiaries Workgroup Ongoing through June 1, 2012	**Continued Refinement of Strategy and Recommendations** • Incorporate HHS and public comment on interim report • Continue mapping measures currently in use to identified high-leverage opportunities for quality improvement • Refine illustrative measures, identify gaps in available measures, and propose modifications and/or new measure concepts to fill gaps • Discuss transition plans and path forward

Measures Application Partnership (MAP) Clinician Workgroup
Convened by the National Quality Forum

<table>
<tr><th>Goal</th><th colspan="2">Provide input to HHS on a coordination strategy for clinician performance measurement across Federal programs</th></tr>
<tr><td>Step 1:
Clinician Workgroup
June 7-8, 2011</td><td colspan="2"><u>Core Elements of a Coordination Strategy</u>
Measure selection principles
Data source and HIT Implications
Alignment with other settings and public/private initiatives including new payment and delivery models
Special considerations for vulnerable populations
Transition planning</td></tr>
<tr><td>Step 2:
Clinician Workgroup
June 7-8, 2011</td><td colspan="2">Identify Clinician Performance Measures Currently In Use
(Measures Used In Federal and Select Private Programs)</td></tr>
<tr><td>Step 3:
Clinician Workgroup
June 7-8, 2011</td><td colspan="2">Identify Current Clinician Performance Measurement Programs and Opportunities for Alignment</td></tr>
<tr><td></td><td><u>Federal Programs Included in Coordination Strategy</u>
Physician Quality Reporting System (PQRS)
E-Prescribing Incentive Program
Electronic Health Records – Meaningful Use
Physician Feedback/Value Modifier [Previously called The Physician Resource Use Measurement and Reporting (RUR) Program]
Physician Compare</td><td><u>Programs For Additional Consideration</u>
Medicare Advantage/5-star rating
CHIPRA Initial Core Set Measures
Medicaid Core Measure Set
ACO Proposed Regulations
IHA (Integrated Healthcare Association – California Pay for Performance Program)
Blue Cross Blue Shield of Massachusetts Alternative Quality Contract</td></tr>
</table>

Measures Application Partnership (MAP) Clinician Workgroup

Convened by the National Quality Forum

Goal	**Provide input to HHS on a coordination strategy for clinician performance measurement across Federal programs**
Step 4: MAP Coordinating Committee June 21-22, 2011	**Guidance from MAP Coordinating Committee** • The scope of the clinician coordination strategy should focus on federal programs, while considering the broader context, as a detailed alignment strategy with the private sector is beyond scope. As part of efforts going forward, a phase 2 proposal could include addressing public and private alignment in-depth. • Patients should be considered part of the team. The Clinician Workgroup should consider the importance of patient reported data in gathering specific types of information (e.g., care coordination, patient experience). • The audience should be noted when considering use (e.g., patients to select providers, clinicians to use data to improve practice). • Information on quality and cost should be obtained at the population and clinician levels; clinician data should include both individual clinician and group levels of analysis. • The efforts should avoid getting locked into current limitations regarding the flow of information and practice patterns. Consider the infrastructure that needs to be in place to meet the long term goals and objectives of the clinician group. • Consider a core set and an aspirational set of measures; define domains in the missing areas of measures (i.e., measurement gaps).
Step 5: Clinician Workgroup July 13-14, 2011 and August 1, 2011	**Key Elements of the Clinician Coordination Strategy** <u>Characteristics of an Ideal Measure Set</u> • Promote shared accountability and "systemness" • Address multiple levels of analysis • Useful to the intended audiences, including consumers, clinicians, payers, and policymakers • Mitigates potential for unintended consequences • Considers health care disparities • Balances comprehensiveness and parsimony • Appropriate representation among types of measures <u>Data Platform Principles</u> • A standardized measurement data collection and transmission process should be implemented across all Federal programs, and ultimately all payers (e.g., HIE). • A library of all data elements needed for all measures (i.e., an inventory of all standardized data elements) should be defined and maintained. The data element library should be broad and deep enough to allow for innovation and flexibility in measurement. • The data platform should support patient-centered measurement, by enabling the collection of patient-reported data (both quantitative and qualitative) and the tracking of care across settings and over time. • Data collection should occur at the individual clinician level,

	Priority Measure Gap Areas • Patient-reported measures of experience, engagement, risk, functionality • Outcomes • Coordination of care across multiple settings and providers, including the adequacy of community supports • Assessment of multiple comorbidities • Physical and mental disabilities Cultural competency, language, health literacy • Cost, overuse	when analysis is appropriate at that level; data should also enable group level analysis. • Data collection should occur during the course of care, when possible, to minimize burden and maximize use in clinical decision making. • Processes such as clinician review of data and feedback loops should be implemented to ensure data integrity and to inform continuous improvement of data validity and measure specifications. • Timely feedback of measurement results is imperative to support improvement of care by clinicians and more informed decisions by consumers. In operationalizing these principles, certain considerations will need to be taken into account: • Timeline for progressing from the current state to ideal state. • Incorporating cost data elements into the data element library. • Privacy, confidentiality, ownership, and access to data. • Distribution of implementation costs.
Step 6: MAP Coordinating Committee August 17-18, 2011	**MAP Coordinating Committee to Review, Approve, and Finalize Report on Coordination Strategy for Clinician Performance Measurement**	

Measures Application Partnership (MAP) Ad Hoc Safety Workgroup

Convened by the National Quality Forum

<table>
<tr><td>Goal</td><td colspan="3">Provide input to HHS on a coordination strategy for healthcare-acquired conditions (HACs) and readmissions across public and private payers</td></tr>
<tr><td>Step 1:
Ad Hoc Safety Workgroup
June 9-10, 2011</td><td colspan="3">Establish the Dimensions of Public-Private Payer Alignment
Payer/Purchaser/Provider/Consumer Collaboration
Program Features
Measure Characteristics</td></tr>
<tr><td>Step 2:
Ad Hoc Safety Workgroup
June 9-10, 2011</td><td colspan="3">Define the Key Elements of a Public-Private Payer Coordination Strategy</td></tr>
<tr><td></td><td><u>Measure Characteristics</u>
Measure alignment across public programs and public/private payers is essential
Consider statutory requirements for public programs (CMS, AHRQ, CDC, states)
Public/private payer measure alignment complicated by different populations
Anticipate and monitor for consequences
Beyond unintended consequences, such as cost</td><td><u>Program Features</u>
Create incentive structures that support better care
Alignment of efforts across continuum to send consistent signals
Comprehensive care transition business model costs more than the cost of the readmissions penalty
Bridge transition from hospital to community
Discharge planning and follow up both essential
Patient education to facilitate self-management
Medication reconciliation</td><td><u>Payer/Purchaser/Provider/ Consumer Collaboration</u>
Ensure that collaboration extends beyond payers and providers to include purchasers, communities, and patients/families/caregivers
Support improvement on the frontlines
Establish organizational cultures that encourage reporting safety issues
Reinforce teamwork and shared accountability
Engage patients in reduction of events (e.g., education using plain language, pharmacist education to prevent adverse drug events)
Create joint accountability between</td></tr>
</table>

	shifting/cherry picking • Length of stay and observation status as balancing measures • Optimum rate of readmissions may not be zero Attention to disparities • Risk adjustment vs. stratification • Improvement, as well as achievement; delta measures Measures should promote shared accountability (e.g., hospitals, other providers, community entities) Measures must be meaningful to all stakeholders and actionable Consider pros and cons of different approaches to readmission measurement • 30 vs. 90 days • All payer vs. segmented • All cause readmissions vs. exclusions • All condition admissions vs. specific conditions Account for burden of data collection on providers • Volume, reliability, validity	• Communication/collaboration between provider and community entities • Home visits Transparency is essential to drive improvement	hospitals, other providers, and community entities • Open communication lines between healthcare facilities and community supports • Consider impact of patient's home environment and social determinants on health Share data and information across providers and settings • Provide real-time data to improve the care process (e.g., track admissions to different facilities, detect HAC post-discharge, notify whether prescriptions are filled, avoid drug-drug interactions and drug allergies) • Identify high risk patients through predictive modeling and share information with providers • Utilize the resources and toolkits of payers to advance improvement on the frontlines • Create a learning community to share promising practices • Provide safety information to purchasers and consumers to inform decision making

	Measures would ideally be suitable for multiple purposes • Driving improvement vs. public reporting vs. payment		
Step 3: MAP Coordinating Committee June 21-22, 2011	**Guidance from the MAP Coordinating Committee** • Explore how patients can be activated to further engage in their care plans and to improve safety outcomes • Encourage purchasers to use their leverage to promote payer alignment of measures and incentives • Consider mechanisms to obtain multi-stakeholder engagement and commitment to coordination, particularly at the local/community level • Learn from community and regional efforts to achieve alignment across multi-stakeholder efforts to improve quality and reduce cost • Look beyond current models of care to drive improvement • Ensure overall approach spans the continuum of care, not just hospitals • Harmonize measures in use by private and public payers • Use measures that are actionable by providers but also provide meaningful comparisons to patients, purchasers, and payers • Consider preventable admissions while developing the strategy for readmissions • Prioritize efficiency and resource use measures, as well as quality measures		
Step 4: Ad Hoc Safety Workgroup July 11-12, 2011	**Develop a Coordination Strategy for Addressing Readmissions and HACs Across Public and Private Payers** **A national core set of safety measures that are applicable to all patients should be created and maintained.** • A multi-stakeholder group, such as the MAP, should provide input to HHS on the creation and maintenance of the set • Core measure set should align with the HHS Partnership for Patients and other federal initiatives		

	• Regional use of safety measures beyond the national core set could support local initiatives and innovation in measurement • Core measures should be meaningful to purchasers and consumers to support decision making and meaningful to providers to support quality improvement • Core measures should be consistent across the care continuum, promoting shared accountability among providers across settings **Data elements needed to calculate the measures in the safety core set should be collected on all patients.** • A multi-stakeholder group should develop a national safety data strategy, in the context of a broader national data strategy • Providers and payers should be required to report the necessary data elements to calculate measures • The data platform should enable collection of patient-reported data • Data should be made available in a timely manner to inform purchaser and consumer decision making and monitor cost shifting • Current databases maintained by federal agencies (e.g., AHRQ's HCUP, CDC's NHSN, CMS's Hospital Compare) could be harmonized as a starting place for building the data platform **Public and private sector entities should coordinate their efforts to make care safer, beginning with incentive structures.** • Payers should implement incentive structures (e.g., tiered networks, performance-based payment) that encourage providers to enhance safety • Purchasers should use their leverage (e.g., RFIs, model contract language) to encourage implementation and alignment of incentive structures across payers • Purchasers and payers should act as partners in the delivery of care by providing tools to providers, such as decision support (e.g., medication interactions, prescriptions not filled, notification of readmissions) and predictive modeling for high risk patients • Purchasers, payers, and providers should collaborate to engage employees/members/patients in their care (e.g., improve health literacy, informed decision making, adherence to care plans) • Providers should develop and implement a standardized discharge plan that incorporates best

	practices for care transitions
Step 5: MAP Coordinating Committee August 17-18, 2011	**Review and Finalization of the Coordination Strategy by the Coordinating Committee** • Are these three recommendations the right focus areas for addressing HACs and readmissions across public and private payers? • Should any of the recommendations be reworded? • What additional guidance should be provided to HHS? To private payers? • What entities should be responsible for following up on these recommendations? • What future work, beyond identification of a national core set of safety measures, should the MAP undertake to pursue the safety recommendations?

Measures Application Partnership (MAP) Post-Acute Care/Long-Term Care (PAC-LTC) Workgroup
Convened by the National Quality Forum

<table>
<tr><td>Goal</td><td colspan="2">Provide input to HHS on a coordination strategy for performance measurement across post-acute care and long-term care programs.</td></tr>
<tr><td>Step 1:
PAC-LTC
June 28, 2011</td><td colspan="2"><u>Core Elements of a Coordination Strategy</u>
Measures and measurement issues
Measure selection principles
Priority areas for measurement
Special considerations for dual eligible beneficiaries
Identification of measure gaps
Alignment
Data source and HIT implications
Pathway for improving measure application</td></tr>
<tr><td>Step 2:
PAC-LTC
Workgroup
June 28, 2011</td><td colspan="2">Identify PAC-LTC Settings and Quality Performance Programs</td></tr>
<tr><td></td><td><u>Settings</u>
Post-Acute Care
Skilled Nursing Facilities (SNF)
Inpatient Rehabilitation Facilities (IRF)
Long-term Care Hospitals (LTCHs)
Home Health Care
Hospice
End Stage Renal Disease (ESRD) Facilities</td><td><u>Examples of Quality Performance Programs</u>
Post-Acute Care Payment Reform Initiative
Minimum Data Set (MDS)
CAHPS Nursing Home Survey
Nursing Home Compare
Quality Measurement Reporting Program
Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI)
Outcome and Assessment Information Set (OASIS)
Home Health Compare
Dialysis Facility Compare (DFC)</td></tr>
</table>

Measures Application Partnership (MAP) Post-Acute Care/Long-Term Care (PAC-LTC) Workgroup

Convened by the National Quality Forum

<table>
<tr><td>Step 3:
PAC-LTC Workgroup
June 28, 2011</td><td colspan="2">Identify Key Considerations and Priority Areas for Measurement</td></tr>
<tr><td></td><td><u>Priority Areas for Measurement</u>
Function
Goal Attainment
Care Coordination
Cost/Access</td><td><u>Key Considerations for Measurement</u>
Balancing standardization and customization
Multi-level measurement
Reducing data burden</td></tr>
<tr><td>Step 4:
MAP Coordinating Committee
August 17-18 , 2011</td><td colspan="2">Provide an overview of the June 28 PAC-LTC meeting discussion and receive feedback from MAP Coordinating Committee</td></tr>
<tr><td>Step 5:
PAC-LTC Workgroup
September 8-9 2011</td><td colspan="2">Develop a coordination strategy for PAC-LTC performance measurement</td></tr>
<tr><td>Step 6:
MAP Coordinating Committee
November 1-2, 2011</td><td colspan="2">Guidance from MAP Coordinating Committee</td></tr>
</table>

Step 7: PAC-LTC Workgroup December 14, 2011	**React to proposed measures and develop the report outline regarding the coordination strategy for PAC-LTC performance measurement**
Step 8: MAP Coordinating Committee January, 2012	**MAP Coordinating Committee to review, approve, and finalize report on coordination strategy for PAC-LTC performance measurement**
Step 9: MAP Coordinating Committee Feb 1, 2012	**MAP Coordinating Committee to submit the final report regarding the coordination strategy for PAC-LTC performance measurement to HHS**

MAP Coordinating Committee August 5, 2011 Web Meeting Summary

Tab 5

MEASURE APPLICATIONS PARTNERSHIP
COORDINATING COMMITTEE
Convened by the National Quality Forum

Summary of Web Meeting #2

A web meeting of the Measure Applications Partnership (MAP) Coordinating Committee was held on Friday, August 5, 2011. For those interested in viewing an online archive of the web meeting, please click on the link below:

http://www.myeventpartner.com/NQFwebinar/E952DD85854A

The next meeting of the Coordinating Committee will take place on August 17-18, 2011, in Washington, DC.

Committee Members in Attendance at the August 5, 2011 Web Meeting:

George Isham (Co-Chair)	Foster Gesten, National Association of Medicaid Directors
Elizabeth McGlynn (Co-Chair)	Aparna Higgins, America's Health Insurance Plans
Rhonda Anderson, American Hospital Association	Chip Kahn, Federation of American Hospitals
David Baker, American College of Physicians	Ira Moscovice [subject matter expert: rural health]
Christine Bechtel, National Partnership for Women and Families	Michael Mussallem, AdvaMed
Bobbie Berkowitz, [subject matter expert: population health]	Peggy O'Kane, National Committee for Quality Assurance
Christine Cassel, American Board of Medical Specialties	Cheryl Phillips, LeadingAge
Mark Chassin, The Joint Commission	Harold Pincus [subject matter expert: mental health]
Maureen Dailey, American Nurses Association (substitute for Marla Weston)	Carol Raphael [subject matter expert: health IT]
Suzanne Delbanco, Catalyst for Payment Reform	Chesley Richards, Centers for Disease Control and Prevention
Joyce Dubow, AARP	Gerald Shea, AFL-CIO
Steven Findlay, Consumers Union	Carl Sirio, American Medical Association
Victor Freeman, Health Resources and Services Administration	Nancy Wilson, Agency for Healthcare Research and Quality

The primary objectives of the web meeting were to:

- Review the evolution and current draft of the measure selection criteria and
- Prepare for the August 17-18 in-person Coordinating Committee meeting.

Coordinating Committee Co-Chairs, George Isham and Beth McGlynn, began the meeting with a welcome and review of the meeting objectives. Beth introduced Connie Hwang as the new Vice President of the Measure Applications Partnership and NQF staff-lead for the Coordinating Committee.

Tom Valuck, Senior Vice President, Strategic Partnerships, NQF, provided an overview of the timelines for the MAP workgroups and Coordinating Committee and gave an update on the progress of the MAP workgroups' activities to date. Tom also introduced Avalere Health, LLC, as the subcontractor to the MAP that will provide background analytic support for the pre-rulemaking task. Following Tom's presentation, two Committee members inquired about the possibility of the Hospital Workgroup providing additional input into the measure selection criteria. NQF staff acknowledged this request and will follow up with the Committee on further engagement of the Hospital Workgroup.

Beth McGlynn began the section on the measure selection criteria. Beth stated that Coordinating Committee will further refine the measure selection criteria at the August in-person meeting. Following Beth's initial presentation, Connie Hwang reviewed the draft measure selection criteria development process. The draft criteria was shaped by the Coordinating Committee's May 3-4 meeting, the MAP workgroups' June and July meetings, and the "strawperson" measure principles document that resulted from the June 21-22 Coordinating Committee meeting. Connie presented NQF staff's work to operationalize the "strawperson" measure principles document into a draft rating system.

Patrick Romano, Professor of General Medicine and Pediatrics, University of California, discussed the input the Stanford Clinical Excellence team had to the measurement selection criteria. Patrick highlighted that a key aspect of the work was to ensure that the measure selection criteria will build on, and not duplicate, the NQF measure endorsement criteria. Patrick's presentation focused on the takeaways and prioritizations from the key informants' feedback:

- performance discrimination,
- measure aggregation,
- preference for outcomes measures,
- accountability for transitions,
- multiple dimensions in domain, and
- broad provider participation.

Following Patrick's presentation, Connie Hwang presented how the Clinician Workgroup applied the draft of the measure selection criteria to evaluate the CMS proposed Physician Value-Based Payment Modifier Measure Set and discussed that experience. Connie highlighted that the majority of the respondents agreed that the MAP measure selection criteria are a good starting point for assessing the adequacy of a measure set for a specific purpose. However, the Clinician Workgroup respondents felt that more work is needed to further refine the criteria to identify the best measures that fit a given criterion.

Committee members raised a number of points regarding the measure selection criteria. Discussion included the following points:

- Importance of aligning measures to alleviate measurement burden and fragmented measurement;
- Operationalizing the measure selection criteria for specific applications;
- Alternative criteria rating systems to avoid regression to the mean;
- Identification of measure gaps (e.g., measures for working-age population) and process for gap-filling;
- Mapping the input from the Stanford team to the measure selection criteria draft; and
- Clarifying the meaning of parsimony.

During the public question period, the issue of weighing the criteria differently for different applications and the associated trade-offs was raised. NQF staff and Patrick Romano commented that further discussion among the Coordinating Committee and MAP workgroups on the issue of weighting is warranted..

The next meeting of the Coordinating Committee is August 17-18, 2011, in Washington D.C.