MEASURE APPLICATIONS PARTNERSHIP

CONVENED BY THE NATIONAL QUALITY FORUM

MEETING MATERIALS

For

IN-PERSON MEETING OF THE CLINICIN WORKGROUP

JUNE 7 -8, 2011

NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

In-Person Meeting #1: Clinician Workgroup
June 7-8, 2011

Washington Marriott at Metro Center
775 12th Street NW, Washington, DC

Web Streaming: http://www.MyEventPartner.com/NQForum63
Dial-In: 888.726.2418 Passcode: 3728878

AGENDA

Meeting objectives:

- *Review charge of the MAP Clinician Workgroup, role within the MAP, and a plan to complete the tasks;*
- *Define the elements and discuss guiding principles for a coordination strategy for clinician performance measurement;*
- *Analyze clinician measures currently in use in Federal programs and their alignment to the National Quality Strategy;*
- *Provide input on the coordination of healthcare-acquired condition and hospital readmission measures across public and private payers.*

Day 1: June 7

8:30 am **Breakfast**

9:00 am **Welcome, Review of Meeting Objectives, and Opening Remarks**
Mark McClellan, Workgroup Chair
Janet Corrigan, President and Chief Executive Officer, NQF

9:15 am **Introductions and Disclosures of Interests**
Ann Hammersmith, General Counsel, NQF

9:45 am **MAP Function**
Tom Valuck, Senior Vice President, Strategic Partnerships, NQF

- *Process and purpose of input to Coordinating Committee*
- *Member responsibilities*
- *Communications policies and support*
- *Drawing for terms*
- *Discussion and questions*

10:10 am **Guiding Frameworks and Workgroup Charge**
Mark McClellan and Tom Valuck

- *HHS National Quality Strategy*

- *Integrated Framework for Performance Measurement*
- *Workgroup charge and goals*
- *Discussion and questions*

10:30 am **Break**

10:45 am **Defining the Elements of a Clinician Performance Measurement Coordination Strategy**
Mark McClellan

- *Measure selection principles*
- *Data sources and HIT implications*
- *Special considerations for the Medicare/Medicaid dual eligible beneficiaries*
- *Alignment with other settings*
- *Transition planning*
- *Discussion and questions*
- *Opportunity for public comment*

11:45 am **Measure Selection Principles**
Mark McClellan
Ted vonGlahn, PBGH

- *Discussion and questions*
- *Opportunity for public comment*

12:45 pm **Working Lunch**

1:00 pm **Current Clinician Performance Measurement Programs and Opportunities for Alignment**
Mark McClellan
Karen Milgate, Director, Office of Policy, Center for Strategic Planning, CMS
Mike Rapp, Director, Quality Measurement and Health Assessment Group, Office of Clinical Standards and Quality, CMS
Thomas Tsang, Medical Director, Meaningful Use, ONC

- *Alignment among Federal programs*
- *Public-private alignment*
- *Discussion and questions*
- *Opportunity for public comment*

2:15 pm **Break**

2:30 pm **Clinician Workgroup Input to the Safety Workgroup**
Frank Opelka, MAP Safety Workgroup Chair
Lindsay Lang, Senior Program Director, Strategic Partnerships, NQF

- *Background*

- *Key questions*

4:30 pm **Summary of Day 1 and Look-Forward to Day 2**
- *Summation of day 1*
- *Expectations for day 2 activities*

5:00 pm **Adjourn for the Day**

Day 2: June 8

8:30 am **Breakfast**

9:00 am **Welcome and Recap of Day 1**
Mark McClellan

9:30 am **Defining the Elements of a Clinician Performance Measurement Coordination Strategy: Data Sources and HIT Implications**
Floyd Eisenberg, Senior Vice President, HIT, NQF
- *Discussion and questions*
- *Opportunity for public comment*

10:30 am **Orientation to the Clinician Performance Measures Table**
Taroon Amin, Senior Director, Strategic Partnerships, NQF
Mitra Ghazinour, Project Manager, Strategic Partnerships, NQF

11:00 am **Clinician Performance Measures Currently in Use**
Mark McClellan
Aisha Pittman, Senior Program Director, Strategic Partnerships, NQF
- *Overview of current measures used in Federal and select private programs*
- *Instructions for the break-out sessions*
- *Discussion and questions*

11:30 am **Small group session: Reviewing Current Measures in Use**
- *Affordable Care*
- *Care Coordination*
- *Prevention and Treatment- Diabetes*
- *Prevention and Treatment- Cardiovascular Disease*

12:30 pm **Working Lunch**

1:00 pm **Clinician Performance Measures Currently in Use (continued)**
Mark McClellan
- *Reporting out from each small group*

- *Discussion and questions*
- *Opportunity for public comment*

3:00 pm **Summation and Path Forward**
Mark McClellan
- *Synthesis of day 2*
- *Committee next steps*

3:30 pm **Adjourn**

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Measure Applications Partnership Clinician Workgroup

In-Person Meeting #1

June 7-8, 2011

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Welcome and Review of Meeting Objectives

Meeting Objectives

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- Review charge of the MAP Clinician Workgroup, role within MAP, and a plan to complete the tasks;
- Define the elements and discuss guiding principles for a coordination strategy for clinician performance measurement;
- Analyze clinician measures currently in use in Federal programs and their alignment to the National Quality Strategy;
- Provide input on the coordination of healthcare-acquired condition and hospital readmission measures across public and private payers.

Meeting Agenda: Day 1

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- Welcome, Review of Meeting Objectives, and Opening Remarks
- Introductions and Disclosures of Interests
- MAP Function
- Guiding Frameworks and Workgroup Charge
- Defining the Elements of a Clinician Performance Measurement Coordination Strategy: Measure Selection Principles
- Current Clinician Performance Measurement Programs and Opportunities for Alignment
- Clinician Workgroup Input to the Safety Workgroup
- Summary of Day 1 and Look-Forward to Day 2
- Adjourn for the Day

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Introductions and Disclosures of Interests

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Clinician Workgroup Membership

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Chair	
	Mark McClellan, MD, PhD

Organizational Members	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	Frederick Masoudi, MD, MSPH
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
Unite Here Health	Elizabeth Gilbertson, MD
Kaiser Permanante	Amy Compton-Phillips, MD
Minnesota Community Management	Beth Averbeck, MD
Physician Consortium for Performance Improvement	Mark Metersky, MD
The Alliance	Cheryl DeMars, MD

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Clinician Workgroup Membership

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Subject Matter Experts		
	Disparities	Marshall Chin, MD, MPH, FACP
	Shared Decision Making	Karen Sepucha, PhD
	Population Health	Eugene Nelson, MPH, DSc
	Team-Based Care	Ronald Stock, MD, MA
	Health IT/ Patient Reported Outcome Measures	James Walker, MD, FACP
	Measure Methodologist	Delores Yanagihara, MPH

Federal Government Members	Representatives
Agency for Healthcare Research and Quality	Darryl Gray, MD, ScD
Centers for Disease Control and Prevention	Peter Briss, MD, MPH
CMS Medicare-Medicaid Coordination Office	Michael Rapp, MD, JD, FACEP
Health Resources and Services Administration	Ian Corbridge, RN, MPH
Office of the National Coordinator for HIT	Thomas Tsang, MD, MPH
Veterans Health Administration	Joseph Francis, MD, MPH

Coordinating Committee Co-Chairs	
	George Isham, MD, MS
	Beth McGlynn, PhD, MPP

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MAP Function

Process and Purpose of Input to the Coordinating Committee

Statatory Authority

Health reform legislation, the Affordable Care Act (ACA), requires HHS to contract with the consensus-based entity (NQF) to “convene multi-stakeholder groups to provide input on the selection of quality measures” for public reporting, performance-based payment, and other programs.

HR 3590 § 3014, amending the Social Security Act (PHSA) by adding § 1890(b)(7)

Function

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- Provide input to HHS/CMS on the selection of available measures for public reporting and performance-based payment programs
- Identify gaps for measure development and endorsement
- Encourage alignment of public and private sector programs and across settings

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MAP Two-Tiered Structure

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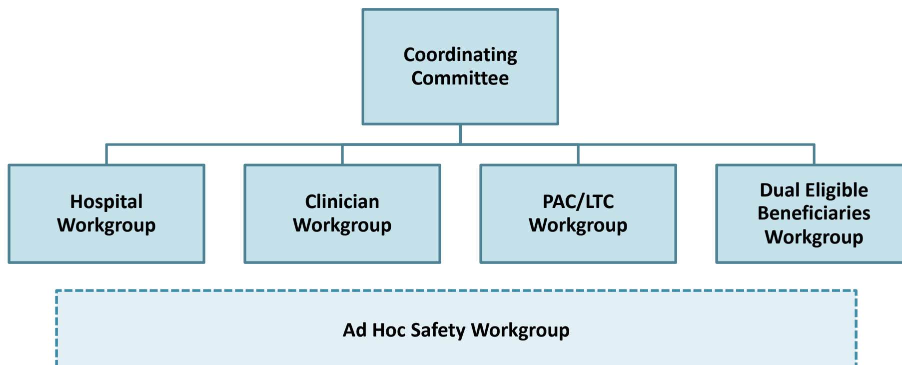

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MAP Coordinating Committee Charge

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The charge of the Measure Applications Partnership (MAP) Coordinating Committee is to:

- Provide input to HHS on the selection of performance measures for use in public reporting, performance-based payment, and other programs
- Advise HHS on the coordination of performance measurement strategies across public sector programs, across settings of care, and across public and private payers
- Set the strategy for the two-tiered partnership
- Give direction to and ensure alignment among the MAP advisory workgroups

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MAP Member Responsibilities and Communications Policies and Support

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MAP Policies and Support

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- Member responsibilities
- Communications policies and support
  - Brochure
  - Template press release
  - Frequently asked questions
  - NQF Communications staff

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Workgroup Member Terms

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- While NQF's current scope of work with HHS lasts through June 2012; MAP's work is expected to continue.
  - Specific tasks will change over time
  - The workgroup structure is designed to be flexible and groups may shift to align with evolving priorities
- The terms for MAP members are for three years.
- The initial members will serve staggered 1-, 2-, and 3-year terms, determined by random draw.
- There are equal numbers of 1-, 2-, and 3-year terms.
- Members whose terms expire are eligible to re-nominate themselves during the open Call for Nominations.
- There is no term limit for MAP members at this time.

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Membership Terms

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Chair	Term Length
Mark McClellan, MD, PhD	

Organizational Members	Term Length
American Academy of Family Physicians	
American Academy of Nurse Practitioners	
American Academy of Orthopaedic Surgeons	
American College of Cardiology	
American College of Radiology	
Association of American Medical Colleges	
Center for Patient Partnerships	
CIGNA	
Consumers' CHECKBOOK	
Unite Here Health	
Kaiser Permanente	
Minnesota Community Measurement	
Physician Consortium for Performance Improvement	
The Alliance	

Subject Matter Experts	Term Length
Marshall Chin, MD, MHP, FACP	
Eugene Nelson, MPH, DSc	
Karen Sepucha, PhD	
Ronald Stock, MD, MA	
James Walker, MD, FACP	
Dolores Yanagihara, MPH	

Federal Government Members	Term Length
Agency for Healthcare Research and Quality	
Centers for Disease Control and Prevention	
Centers for Medicare & Medicaid Services	
Health Resources and Services Administration	
Office of the National Coordinator for HIT	
Veterans Health Administration	

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Discussion and Questions

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Guiding Frameworks and Workgroup Charge

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HHS Aims for the National Quality Strategy

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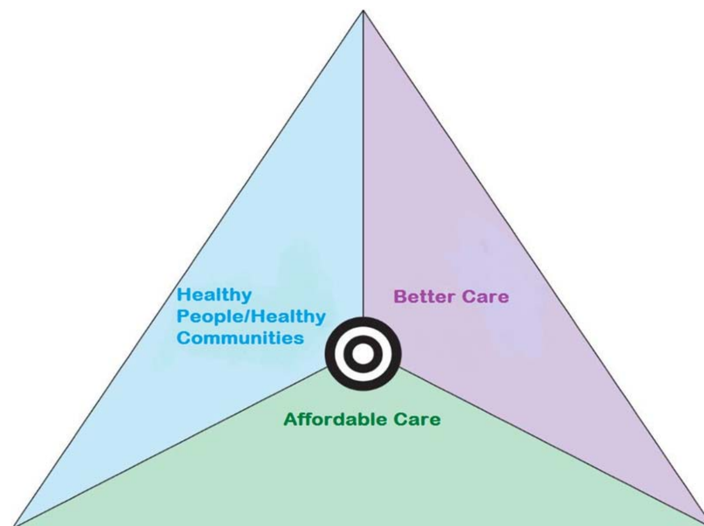

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HHS National Quality Strategy

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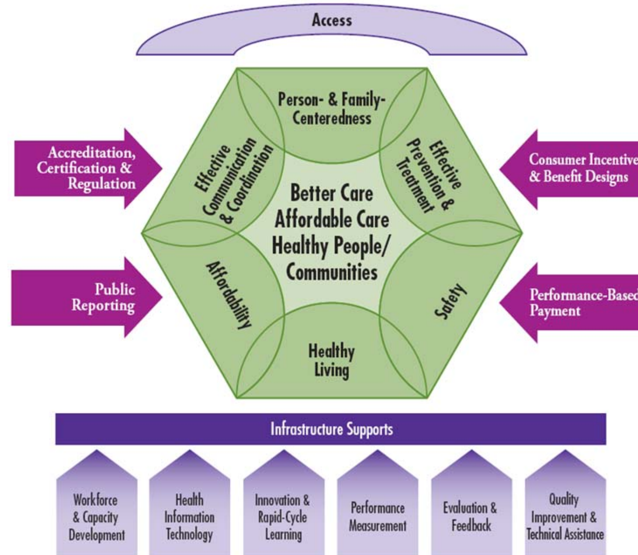

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Principles for the National Quality Strategy

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1. Person-centeredness and family engagement

2. Specific health considerations will be addressed for patients of all ages, backgrounds, health needs, care locations, and sources of coverage.

3. Eliminating disparities in care

4. Aligning the efforts of public and private sectors

5. Quality improvement

6. Consistent national standards

7. Primary care will become a bigger focus

8. Coordination will be enhanced

9. Integration of care delivery

10. Providing patients, providers, and payers with the clear information they need to make choices that are right for them will be encouraged.

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High-Impact Conditions

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Medicare Conditions

Condition		Votes
1.	Major Depression	30
2.	Congestive Heart Failure	25
3.	Ischemic Heart Disease	24
4.	Diabetes	24
5.	Stroke/Transient Ischemic Attack	24
6.	Alzheimer's Disease	22
7.	Breast Cancer	20
8.	Chronic Obstructive Pulmonary Disease	15
9.	Acute Myocardial Infarction	14
10.	Colorectal Cancer	14
11.	Hip/Pelvic Fracture	8
12.	Chronic Renal Disease	7
13.	Prostate Cancer	6
14.	Rheumatoid Arthritis/Osteoarthritis	6
15.	Atrial Fibrillation	5
16.	Lung Cancer	2
17.	Cataract	1
18.	Osteoporosis	1
19.	Glaucoma	0
20.	Endometrial Cancer	0

Child Health Conditions and Risks

Condition and Risk	Votes
Tobacco Use	29
Overweight/Obese (≥85th percentile BMI for age)	27
Risk of developmental delays or behavioral problems	20
Oral Health	19
Diabetes	17
Asthma	14
Depression	13
Behavior or conduct problems	13
Chronic Ear Infections (3 or more in the past year)	9
Autism, Asperger's, PDD, ASD	8
Developmental delay (diag.)	6
Environmental allergies (hay fever, respiratory or skin allergies)	4
Learning Disability	4
Anxiety problems	3
ADD/ADHD	1
Vision problems not corrected by glasses	1
Bone, joint or muscle problems	1
Migraine headaches	0
Food or digestive allergy	0
Hearing problems	0
Stuttering, stammering or other speech problems	0
Brain injury or concussion	0
Epilepsy or seizure disorder	0
Tourette Syndrome	0

Patient-Focused Episodes of Care Model

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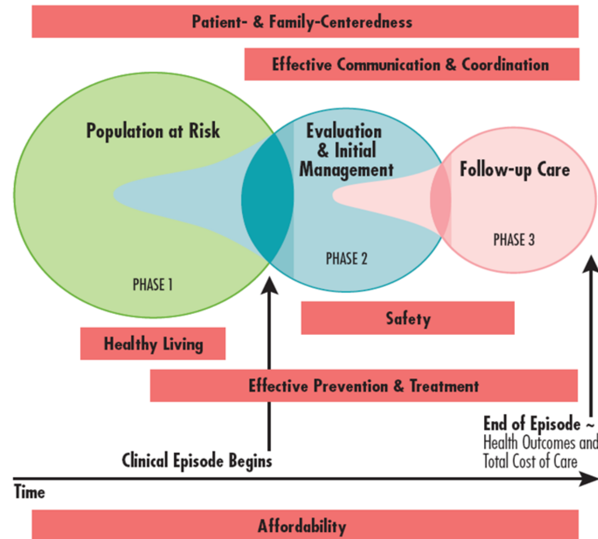

MAP Decision-Making Framework

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- Overarching principle:
  - The aims and priorities of the National Quality Strategy (NQS) will provide the foundation for MAP decision making.
- Additional factors for consideration:
  - The two dimensional framework for performance measurement—NQS priorities and high-impact conditions—will provide focus.
  - The patient-focused episodes of care model will reinforce patient-centered measurement across settings and time.
  - HHS Multiple Chronic Conditions Framework.
  - Attention to equity across the NQS priorities.
  - Connection to financing and delivery models and broader context (e.g., ACOs).

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Workgroup Interaction with Coordinating Committee

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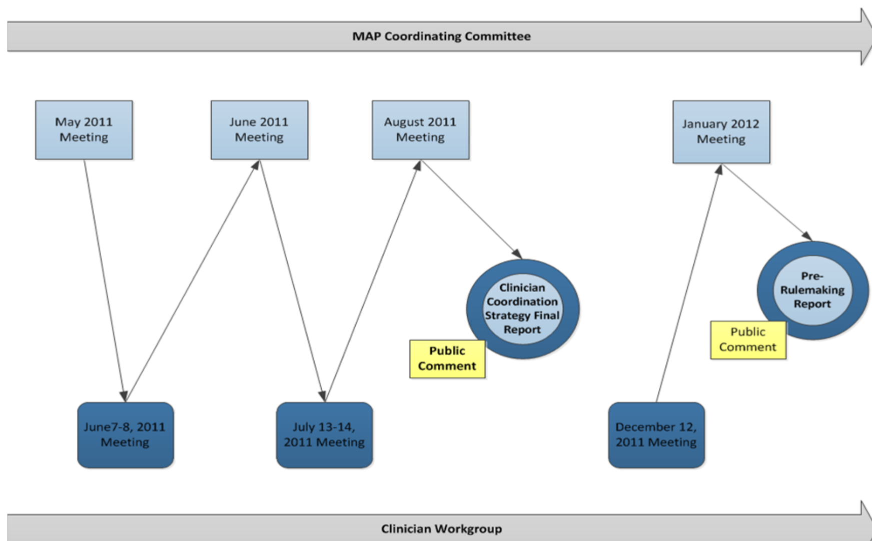

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Upcoming Work & Timeline

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Coordinating Committee Meeting – June 21-22

June 30, 2011
- Convene a web meeting to discuss the decision-making criteria and framework developed by the Coordinating Committee

July 13-14, 2011
- Conduct second in-person meeting to discuss the coordination strategy for clinician performance measurement

Coordinating Committee Meeting – August 17-18

Late August
- Two-week public comment period for the physician coordination strategy

October 1, 2011
- Final report due to HHS from the MAP Coordinating Committee regarding the clinician coordination strategy

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Discussion and Questions

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Defining the Elements of a Clinician Performance Measurement Coordination Strategy

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Elements of a Coordination Strategy

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- Measure selection principles
  - Selecting measures for specific uses (i.e., public reporting and payment reform)
  - Identifying gaps
  - Addressing value (i.e., quality and cost)
- Data source and health IT implications
  - Burden of measurement/data collection mechanisms
  - Levels of analysis (i.e., group practice vs. individual)
  - Progression toward e-Measures and interoperable data platform
- Special considerations for Medicare/Medicaid dual eligible beneficiaries

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Elements of a Coordination Strategy

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- Alignment with other settings and other public/private initiatives including new payment and delivery models
  - Capture key concepts from Workgroup deliberations
  - Coordinating Committee will discuss alignment themes across all workgroups
- Transition Planning
  - Consider how to move from current to ideal in each element of coordination strategy

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Overview of the Medicare/Medicaid Dual Eligible Population

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Background

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- Dual eligible beneficiaries receive healthcare coverage through both Medicare and Medicaid
- ~9.2 million people are dually enrolled (2008 data)
- While most duals are vulnerable in one or more ways, the population is not homogenous: range of physical and cognitive impairments, number of chronic conditions, settings in which care is delivered
- Population is low income by definition/design; more than half of duals have incomes less than $10,000/year
- Considerable healthcare needs and in the population lead to patient complexity, high utilization, and spending

Beneficiary Overlap, 2007

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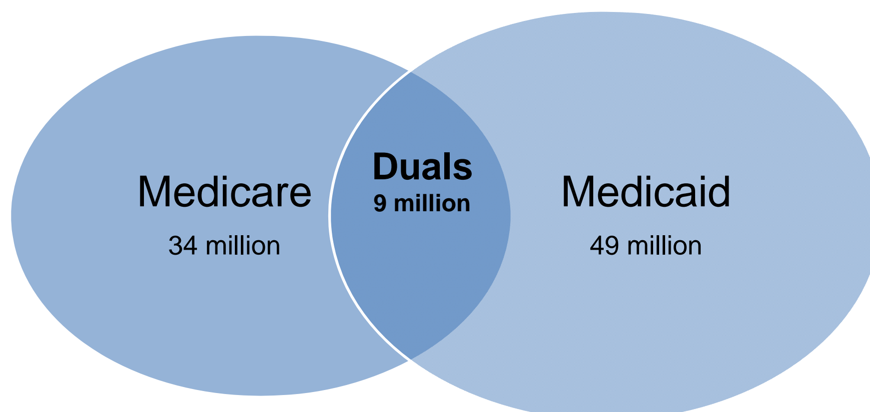
Duals comprise 21% of the Medicare population and 15% of the Medicaid population.



Total Medicare beneficiaries = 43 million **Total Medicaid beneficiaries = 58 million**

Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2007 and Urban Institute estimates based on data from the 2007 MSIS and CMS-Form 64.

Medicaid Enrollment, FFY 2007

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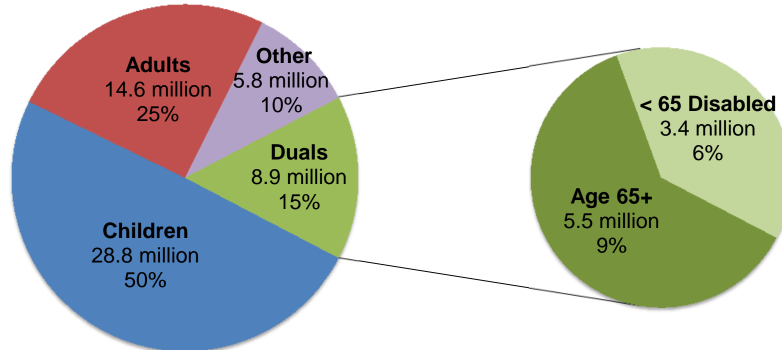

Total Medicaid Enrollment = 58.1 million

Duals' share of Medicaid enrollment varies significantly across states (10%-25%)
Duals account for 39% of all Medicaid expenditures, despite comprising only 15% of the beneficiary population.

SOURCE: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

Ethnicity and Geography

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Ethnicity

- Dual eligible population is more diverse than the overall Medicare population
- 40% minority population vs. 20% minority in overall Medicare
  - 59% White non-Hispanic
  - 21% Black non-Hispanic
  - 12% Hispanic
  - 9% Other

Geography

- 79% of duals live in urban areas
- 21% of duals live in rural areas

SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of MSIS-MCBS 2003 linked file.

Type and Level of Impairment Among Duals

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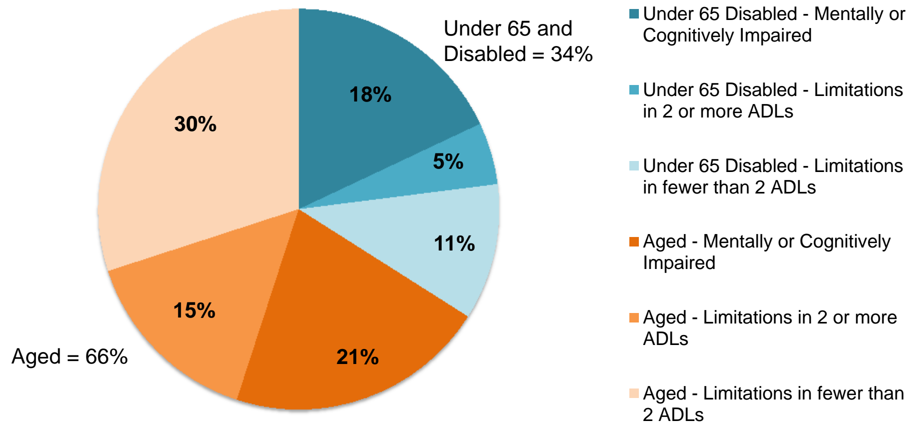
About a third of dual eligible beneficiaries have limitations in three or more ADLs, but 45% of duals did not report any impairments.



NOTES: ADL = activity of daily living. Analysis excludes beneficiaries with ESRD
SOURCE: MedPAC analysis of Cost and Use file 1999-2001 MCBS

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Prevalence of Mental/Cognitive Conditions

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	Dual Eligibles				All Other Medicare Beneficiaries
	18-64	**65-79**	**80+**	**All**	
Alzheimer's/ dementia	5.8	12.9	39.0	16.1*	7.3
Depression	27.6	17.4	25.3	22.9*	8.4
Intellectual/ developmental disability	6.7	--	--	3.1*	--
Schizophrenia	11.8	3.5	--	6.2*	0.4
Affective and other serious disorders	27.1	17.1	21.4	21.7*	8.3
Total with any mental/cognitive condition	49.2	34.1	52.5	43.8*	18.4

* = p< 0.05 using adjusted Wald F test.
-- = Fewer than 30 cases unweighted.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of weighted linked 2003 MSIS data and MCBS file. 38

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Prevalence of Chronic Physical Conditions

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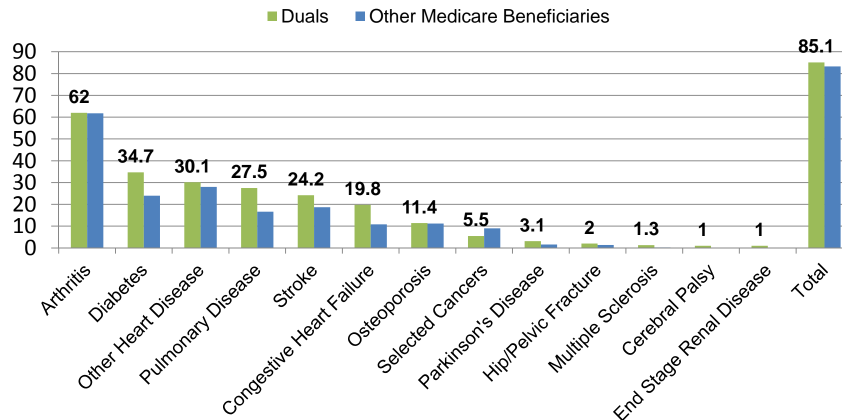
Differences in prevalence between duals and other Medicare beneficiaries are statistically significant for all conditions except arthritis and osteoporosis.



$p < 0.05$ using adjusted Wald F test.
Selected cancers are breast, colorectal, prostate, lung, and endometrial.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of weighted linked 2003 MSIS data and MCBS file. 39

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High-Impact Conditions Affecting Duals

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High Prevalence Conditions Among Duals

- Alzheimer's disease and other dementia
- Congestive heart failure
- Depression
- Diabetes
- Other heart disease
- Hypertension
- Pulmonary disease
- Stroke
- Others?

Conditions Disproportionately Affecting Duals

- Cerebral palsy
- End-stage renal disease
- Multiple sclerosis
- Parkinson's disease
- Schizophrenia
- Others?

Starting place for discussion based on data presented on previous slides 40

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Measure Selection Principles

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Quality Measurement Enterprise

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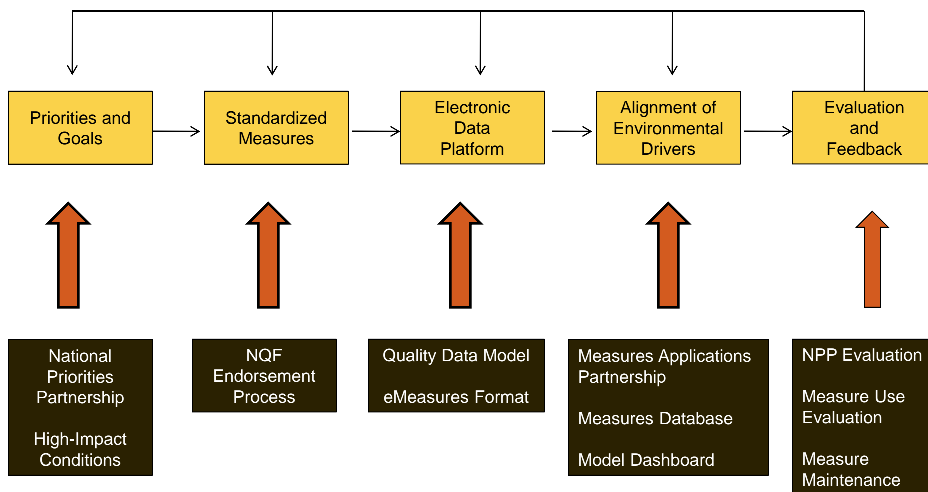

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Measure Selection Principles

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- Promotes “systemness” and joint accountability
  - Promotes shared decision making and care coordination
  - Addresses various levels of accountability
- Addresses the patient perspective
  - Helps consumers make rational judgments
  - Incorporates patient preference and patient experience
- Actionable by providers
- Enables longitudinal measurement across settings and time
- Contributes to improved outcomes
- Incorporates cost
  - Resource use, efficiency, appropriateness
- Promotes adoption of health IT
- Promotes parsimony
  - Applicability to multiple providers, settings, clinicians

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Measure Selection Criteria Project

Ted von Glahn

Arnold Milstein, MD, MPH
Principal Investigator

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Purpose

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Provide input to the MAP Coordinating Committee and workgroups on measure selection criteria to equip MAP with an evidence base to select measures for:

- public reporting
- payment programs
- program monitoring and evaluation

The MAP measure selection criteria will build on, not duplicate, the NQF measure endorsement criteria.

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Major Tasks

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1. Inventory and compare historical criteria sets, including NQF endorsement criteria; prepare comprehensive criteria set ✓
2. Conduct stress tests with focus on payment, reporting and program evaluation to identify criteria gaps and conflicts and approaches to resolve ✓
3. Evaluate findings with key informants – users of performance accountability measures for payment, reporting, and program evaluation
4. Recommend measure selection criteria set for consideration by MAP Coordinating Committee

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Stress Test Approach

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Purpose:
Identify gaps in endorsement criteria that arise when evaluating measures for specific uses and recommend additional measure selection criteria.

Process:

Identify use cases that represent target settings and applications (e.g., ambulatory - reporting) and associated measure sets (e.g., Meaningful Use CQMs). Perform stress test per use case/measure set.

Evaluate measure set against NQF endorsement criteria in context of proposed application. Identify requirements for a given application – do the endorsement criteria address that requirement?

Example 1: Should usability criteria ensure that the proposed ACO measures will meet the specified needs of the users for payment & reporting?

Example 2: Should feasibility criteria ensure that there are certified vendors to aggregate data for PCMH PRO and patient engagement metrics?

Recommend additional measure selection criteria , which could include:

- Adding new criteria or criteria domains (e.g. "Comprehensiveness")
- Building on the endorsement criteria by adding/modifying sub-criteria
- Identifying need for a threshold requirement or to revise an existing threshold

Proposed selection criteria will be synthesized into candidate criteria changes for MAP consideration. 49

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Deliverables

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- Industry-wide **scan of historical measures** criteria, including NQF measure endorsement criteria
- **Synthesis of scanned criteria** and identification of criteria gaps and conflicts that arise when moving from endorsement to application for payment, reporting, and program evaluation
- Recommendations to **resolve gaps, conflicts, and/or lack of criteria harmonization** across the three applications
- **Proposed measure selection criteria set** for payment, reporting, and program evaluation

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Intersection with Workgroups

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- MAP Coordinating Committee adopts or revises proposed criteria set for measure selection

- Each MAP workgroup will employ criteria to advise Coordinating Committee on measures for inclusion in input to HHS

Project Team

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Stanford University (Principal Investigator)
- Arnold Milstein, MD, MPH

UC Davis
- Patrick Romano, MD, MPH

UC San Francisco
- Andrew Bindman, MD
- Edgar Pierluissi, MD

Pacific Business Group on Health
- David Lansky, PhD
- Ted von Glahn, MSPH
- Alana Ketchel, MPP, MPH

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Discussion and Questions

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Opportunity for Public Comment

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Current Clinician Performance Measurement Programs and Opportunities for Alignment

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Current Clinician Performance Measurement Programs and Opportunities for Alignment

- Karen Milgate, CMS
- Michael Rapp, CMS
- Thomas Tsang, ONC

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Discussion and Questions

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Opportunity for Public Comment

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Ad Hoc Safety Workgroup: Input from Clinician Workgroup

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Partnership for Patients

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HHS has a new patient safety initiative called the **Partnership for Patients** focusing on improvement in readmissions and healthcare-acquired conditions (HACs).

Establishes 2 goals to achieve by the end of 2013:

- Preventable HACs would decrease by 40% compared to 2010
- Preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2010

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Partnership for Patients

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The Partnership for Patients has identified nine areas of focus for HACs.

- Adverse Drug Events (ADE)
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line Associated Blood Stream Infections (CLABSI)
- Injuries from Falls and Immobility
- Obstetrical Adverse Events
- Pressure Ulcers
- Surgical Site Infections
- Venous Thromboembolism (VTE)
- Ventilator-Associated Pneumonia (VAP)

The Partnership work is not limited to these areas, and will pursue the reduction of all-cause harm as well.

Guidance from Coordinating Committee

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Develop a coordination strategy for measuring readmissions and healthcare-acquired conditions (HACs) across public and private payers

- Opportunity allows development of organizing principles, not focused on specific set of measures
- Coordination is not about a pricing issue, but moving forward together better
- Workgroup is not just considering what, but also why and how
- Set appropriate expectations given the time constraints (e.g., identify work for subsequent phases)

MAP Workgroup Input

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Considerations from the Coordinating Committee

- How to ensure joint accountability and alignment across settings?
  - What measures should be included in measure sets being suggested by other MAP Workgroups to address HACs and readmissions?
- What are the relevant data and infrastructure issues?
  - What are potential issues when measuring across multiple settings and strategies to mitigate those issues?
  - What are potential issues when measuring at different levels (i.e. individual clinician, facility, regionally, nationally) and strategies to mitigate those issues?
- What is needed to support improvement in these areas within the complex dual eligible population?

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Workgroup Interaction with Coordinating Committee

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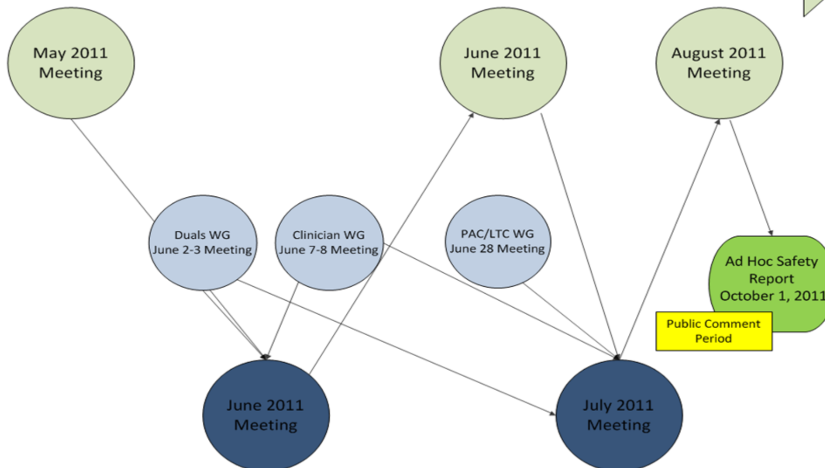

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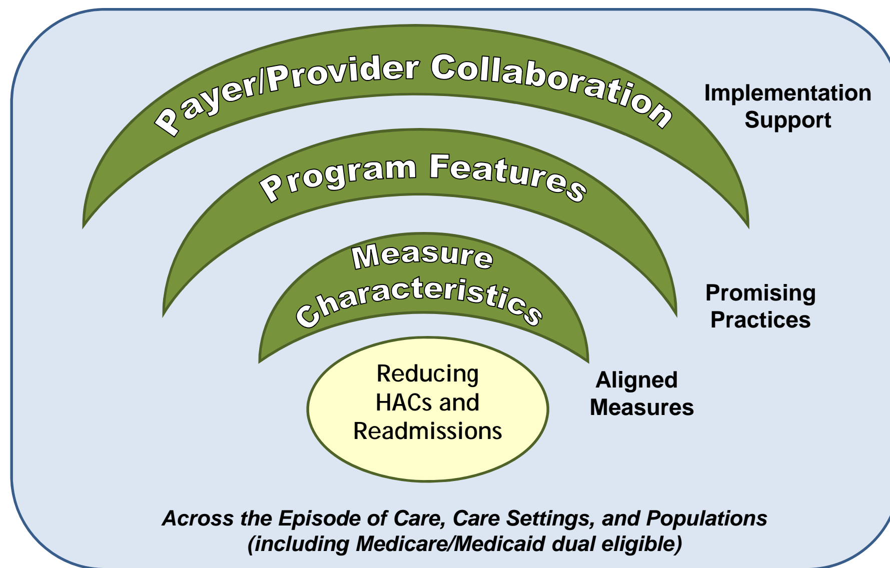
Dimensions of Payer Alignment



Themes: Payer/Provider Collaboration

- Work with hospital and provider groups at the national, state, and local level to:
  - Set goals and identify priorities
  - Recognize and support champions
  - Create improvement collaboratives to drive change and share best practices
- Develop a culture of safety which rewards providers who are improving the care delivery process
- Promote shared accountability across providers and settings
- Developing toolkits for clinical leadership on best practices for reduction of HACs and readmissions
- Other?

Themes: Program Features

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- Collaborate on program features that support improvement by:
  - Creating incentive strategies that move beyond no-pay programs to pay for performance and other value based models
  - Recognizing providers who have improved the care delivery process and report performance to their members or the public
  - Support performance improvement rather then just attainment
- Other?

Themes: Measure Characteristics

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- Use measures that:
  - Align across payers and settings
  - Can be electronically submitted
  - Capture provider performance for health plans but also provide information to providers on how to improve performance
- Other?

Key Questions: Clinician

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What implementation support do clinicians need from payers to reduce the incidence of HACs? Readmissions?

What are essential components payers should incorporate into their programs to best support reduction in HACs? Readmissions?

Which measures/measurement approaches would give clinicians the most useful information for reducing HACs? Readmissions?

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Discussion and Questions

Summary of Day 1 and Look-Forward to Day 2

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Meeting Agenda: Day 2

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- Welcome and Recap of Day 1
- Defining the Elements of a Clinician Performance Measurement Strategy: Data Sources and HIT Implications
- Orientation to the Clinician Performance Measures Table
- Clinician Performance Measures Currently in Use
  - Breakout Sessions
  - Report out
- Summation and Path Forward
- Adjourn

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Welcome and Recap of Day 1

Defining the Elements of a Clinician Performance Measurement Coordination Strategy

Elements of a Coordination Strategy

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- Measure selection principles
  - Selecting measures for specific uses (i.e., public reporting and payment reform)
  - Identifying gaps
  - Addressing value (i.e., quality and cost)
- Data source and HIT implications
  - Burden of measurement/data collection mechanisms
  - Levels of analysis (i.e., group practice vs. individual)
  - Progression towards e-Measures and interoperable data platform
- Special considerations for Medicare/Medicaid dual eligible beneficiaries
- Alignment with other settings and public/private initiatives including new payment and delivery models
- Transition planning

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Data Sources and HIT Implications

Key Questions: Data Sources

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How can the coordination strategy move the system toward electronic measures and interoperable data platforms?

How should the data platform be constructed to support various levels of analysis (e.g., group practice vs. individual)?

How can data collection mechanisms best be coordinated to minimize burden?

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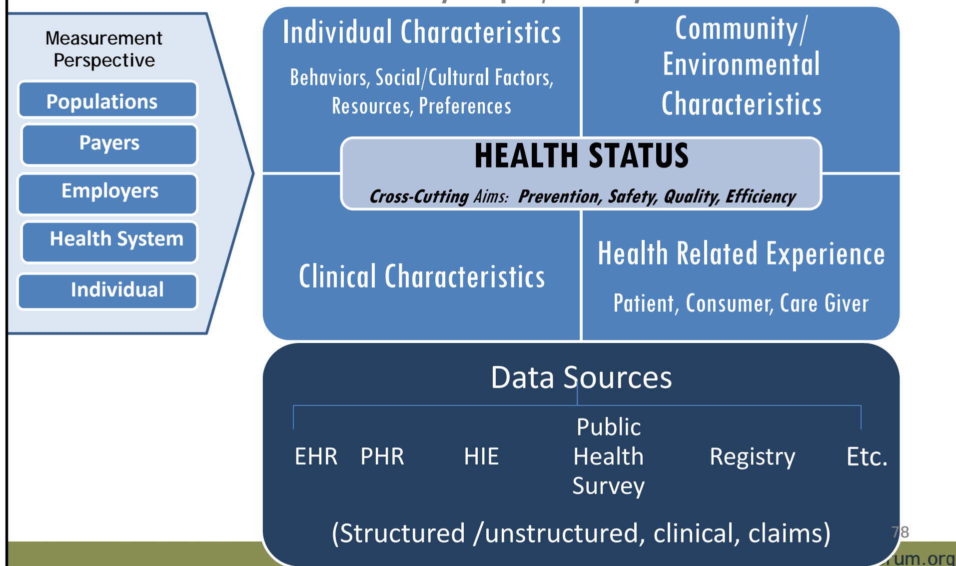
The Performance Measures and Information Requirements That Will Change Overtime



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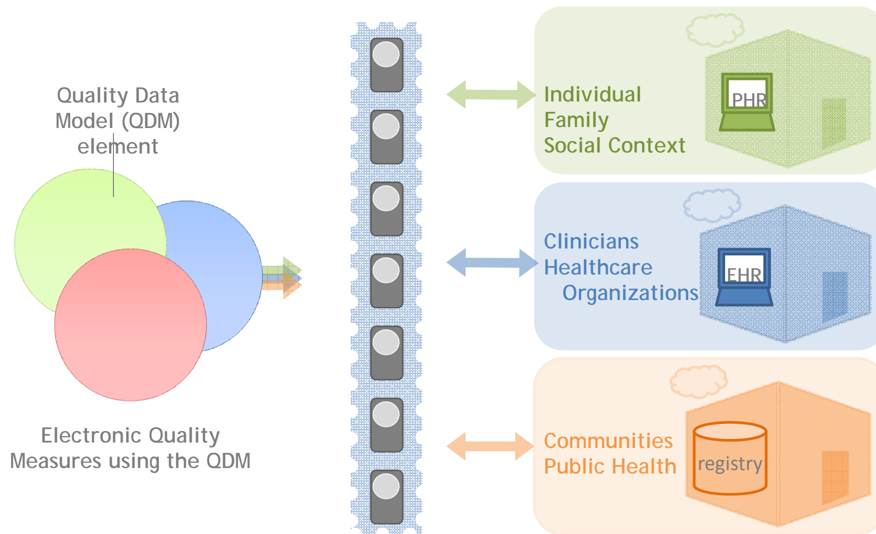

Data Sources

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- Key data sources
  - Claims data
  - Clinical data
  - Patient reported data
- Ideal state
  - Measures integrating information from all three sources
  - Measures assessing care provided across settings and providers

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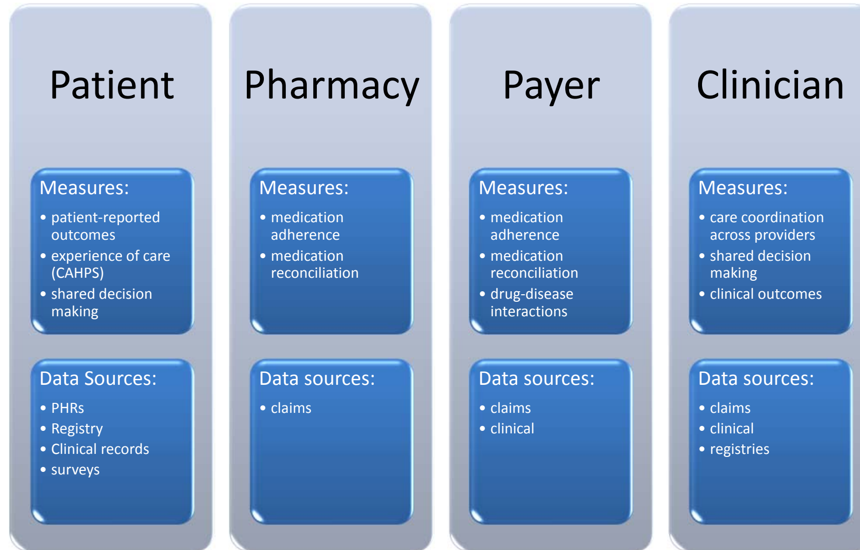

Federal Program HIT/ Data Source Issues

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- Separate reporting processes for the same measures
- Submission of data to CMS vs. measure calculations with certified EHR technology
- Group vs. individual reporting
- Need a standardized set of data elements for EHRs
- Clarification of best use of claims, registries, and EHRs
- Other?

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Opportunity for Public Comment

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Orientation to Clinician Performance Measures Table

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Orientation to the Clinician Performance Measures Table

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The clinician quality programs measure chart includes:

- Measure attributes
  - NQF # and status
  - NQF re-tooled measure
  - Name
  - Description
  - Steward
  - Data source
  - Measure type
  - Setting
  - Program
- Cross-cutting priorities
  - National Quality Strategy
  - Condition/general and specific category

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Orientation to the Clinician Performance Measures Table

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Methodology to populate the measure table

- Extract measure names and descriptions from each program
  - Variations in measure names and descriptions
- Use the NQF number to match the measures across programs
- Use the steward to match the same measures where the NQF number was not available
- Identify variations among programs with respect to data collection mechanisms

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Orientation to the Clinician Performance Measures Table

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Introduction to the data tool

- Pivot tables were created to evaluate various datasets
- Data can be sorted by two-dimensional framework
  - NQS
  - General Condition

Orientation to the Clinician Performance Measures Table

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National Quality Strategy Priorities	Care Coordination
Condition/General Category	(All)

NQF Measure # and Status	Measure Name	NQF Re-tooled eMeasure	Steward	Data Source	Measure Type	Program
0045 Endorsed	Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Yes	AMA-PCPI/NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS
0089 Endorsed	Diabetic Retionpathy: Communication with the Physician Managing On-going Diabetes Care	Yes	AMA-PCPI/NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS, MU
0097 Endorsed	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	Yes	AMA-PCPI/NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS
0509 Endorsed	Radiology: Reminder System for Mammograms	No	AMA-PCPI	Administrative Claims, Other Electronic Clinical Data	Structure/Management	PQRS
0541 Endorsed	Proportion of Days Covered(PDC): 5 Rates by Therapeutic Category	No	PQA	Other Electronic Clinical Data	Process	Medicaid
0554 Endorsed	Medication Reconciliation	No	NCQA	Administrative Claims, Paper Records	Process	ACO
0561 Endorsed	Melanoma: Coordination of Care	No	AMA-PCPI/NCQA	Other Electronic Clinical Data	Process	PQRS

Clinician Performance Measures Currently in Use

Measure Analysis

- Measures (355 across all programs, 69% endorsed)
  - Federal Programs
    - PQRS
    - EHR meaningful use
    - Medicaid Core Measures
    - CHIPRA Measures
    - Proposed ACO measures
    - MA 5-star rating
  - Private Programs
    - IHA
    - BCBS Alternative Quality Contract
- Mapping
  - NQS goals
  - Medicare and Child Health High-Impact Conditions

Measures by NQS Goal

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- Safety (12%)
- Person- and Family- Centered Care (7%)
- Care Coordination (3%)
- Prevention (13%)
- Treatment (50%)
- Healthy Lifestyles-communities (3%)
- Affordable Care (7%)
- HIT (9%)

**Note: categories are not mutually exclusive*

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Measures by Medicare High Impact Condition

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Condition	Number of Measures	% of Measures
Major Depression	4	1.1%
Congestive Heart Failure	7	2%
Ischemic Heart Disease	11	3.1%
Diabetes	22	6.2%
Stroke/Transient Ischemic Attack	15	4.2%
Alzheimer's Disease	0	0%
Breast Cancer	2	0.6%
Chronic Obstructive Pulmonary Disease	6	1.7%
Acute Myocardial Infarction	3	0.8%
Colorectal Cancer	2	0.6%
Hip/Pelvic Fracture	0	0%
Chronic Renal Disease	3	0.8%
Prostate Cancer	3	0.8%
Rheumatoid Arthritis/Osteoarthritis	3	0.8%
Atrial Fibrillation	0	0%
Lung Cancer	2	0.6%
Cataract	2	0.6%
Osteoporosis	5	1.4%
Glaucoma	2	0.6%
Endometrial Cancer	0	0%

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Measures Used in Quality Initiative Programs

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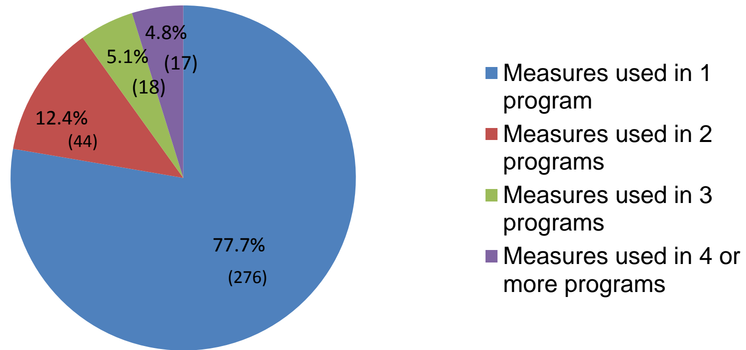
Proportion of Measures Used in Programs



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Small Group Session: Reviewing the Current Measures in Use

Breakout Session Instructions

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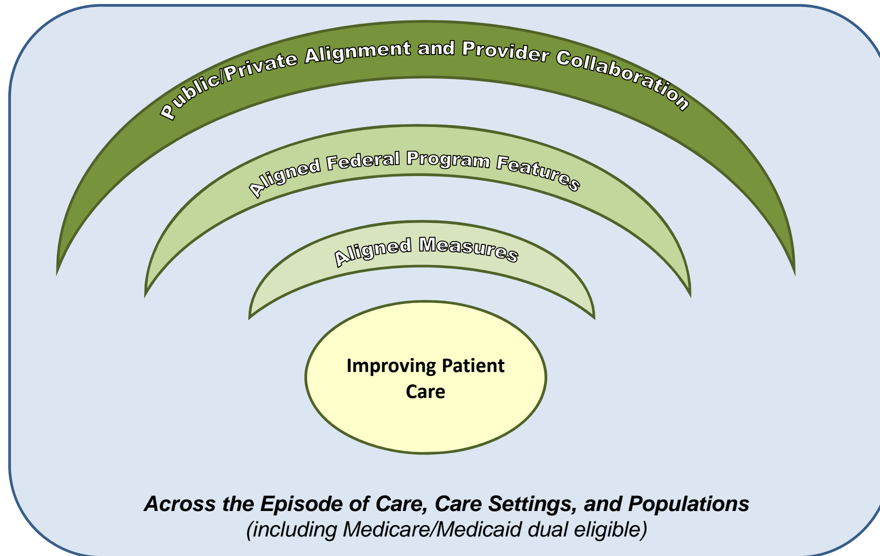

Breakout Session Instructions

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Considerations	Measure	Measure
Shared accountability/promote teamness	H/M/L	H/M/L
Data collection burden/parsimony		
HIT implications		
Level of analysis		
Actionability/ ability to influence result		
Improvability gap		
Discriminates performance for comparability		
Patient-centered		
Longitudinal– across settings and time		
Understandable, meaningful and useful to intended audiences (i.e. consumers, policy makers)		
Potential for unintended consequences		
Additional considerations from group discussion		
Additional considerations from group discussion		

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Opportunity for Public Comment

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Clinician Performance Measures Currently in Use

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Major Decision-Making Themes

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Summation and Path Forward

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Upcoming Work and Timeline

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Coordinating Committee Meeting – June 21-22

June 30, 2011
- Convene a web meeting to discuss the decision-making criteria and framework developed by the Coordinating Committee

July 13-14, 2011
- Conduct second in-person meeting to discuss the coordination strategy for clinician performance measurement

Coordinating Committee Meeting – August 17-18

Late August
- Two-week public comment period for the physician coordination strategy

October 1, 2011
- Final report due to HHS from the MAP Coordinating Committee regarding the clinician coordination strategy

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Measure Applications Partnership
Member Responsibilities

- Strong commitment to advancing the performance measurement and accountability purposes of the Partnership.

- Willingness to work collaboratively with other Partnership members, respect differing views, and reach agreement on recommendations. Input should not be limited to specific interests, though sharing of interests is expected. Impact of decisions on all healthcare populations should be considered. Input should be analysis and solution-oriented, not reactionary.

- Ability to volunteer time and expertise as necessary to accomplish the work of the Partnership, including meeting preparation, attendance and active participation at meetings, completion of assignments, and service on ad hoc groups.

- Commitment to attending meetings. Individuals selected for membership will not be allowed to send substitutes to meetings. Organizational representatives may request to send a substitute in exceptional circumstances and with advance notice. If an organizational representative is repeatedly absent, the chair may ask the organization to designate a different representative.

- Demonstration of respect for the Partnership's decision making process by not making public statements about issues under consideration until the Partnership has completed its deliberations.

- Acceptance of the Partnership's conflict of interest policy. Members will be required to publicly disclose their interests and any changes in their interests over time.

Adopted by the NQF Board of Directors on September 23, 2010

Measure Applications Partnership

Convened by the National Quality Forum

MAP Member Principles for Media and Public Engagement

As a participant in the MAP, you play a central and important role in making measure applications recommendations to the federal government. We anticipate sustained media and public interest in MAP. To ensure we are consistent in our approach to communications, and mindful of the sensitive nature of our collaborative work, please find below MAP Principles for Media and Public Engagement.

Press Releases and Supportive External Materials

NQF staff will develop all MAP-related press releases and supportive external materials, including releases about our public meetings and reports to HHS. MAP Coordinating Committee Co-Chairs will review and approve all press releases as part of their leadership responsibilities. NQF staff will share final press materials with members in advance of their public release. NQF media relations staff will serve as the central point of contact for members' communications staff and the press.

Press Engagement

MAP members will not engage with press on deliberations that are before the MAP. Members or their communications staff should refer press questions about deliberations, MAP processes, or MAP progress to the NQF press office. Once final reports that include recommendations are publicly issued, NQF is prepared to provide press and messaging support to you if you receive press calls. We encourage MAP members to answer press questions about the recommendations once they have been submitted; if you are not comfortable doing so, please refer any press calls to NQF. MAP members who are interested in developing their own press material about their role in MAP are encouraged to share drafts with NQF media relations staff in advance of distribution.

Public Engagement/Talks

MAP members are welcome to include information on MAP in their public engagements, but are asked to refrain from commenting on issues currently being deliberated by the MAP. Once final reports that include recommendations are publicly issued, members are encouraged to integrate information about the reports and recommendations into their scheduled talks. NQF staff will provide communications assistance in the form of Q&A, slides, key messages, and fact sheets to assist you with external engagement on the MAP.

Measure Applications Partnership (MAP) Backgrounder (as of April 6, 2011)

The Measure Applications Partnership (MAP) will play a valuable role in improving the quality and value of healthcare.

As a participant in MAP, we thought you might benefit from this backgrounder for your use as you begin to receive and respond to inquiries about this important Partnership or weave information about MAP into your work. Please let us know if we can provide any additional background.

MAP Basics

1. What is MAP?

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum. MAP was created for the explicit purpose of providing input to the Department of Health and Human Services on the selection of performance measures for public reporting and performance-based payment programs.

2. Why is MAP important?

The choice of measures for gauging and rewarding progress is so important that no one perspective is adequate to inform the task. MAP is a unique voice in healthcare, blending the views of diverse groups who all have a vested interest in improving the quality of healthcare.

Through MAP activities, a wide variety of stakeholders will be able to provide input into HHS's selection of performance measures for public reporting and payment reform programs, which will allow for greater coordination of performance measures across programs, settings, and payers. MAP's balance of interests—representing consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers—ensures that HHS will receive well-rounded input on performance measure selection.

3. How will MAP determine on which priorities and goals to focus?

The MAP Coordinating Committee will compile a decision-making framework, which will include priorities from a number of different sources, including the newly released National Quality Strategy, the upcoming National Patient Safety Initiative and National Prevention and Health Promotion Strategy, the high-priority Medicare and child health conditions, and the patient-focused episodes of care model. Additionally, the committee will develop measure selection criteria to help guide their decision making.

4. **Will MAP recommend only NQF-endorsed measures for government public reporting and payment reform programs? Will part of this effort point out measurement gaps and include those gaps in recommendations?**

MAP will recommend the best measures available for specific uses, giving first consideration to NQF-endorsed measures. If MAP is seeking a type of measure currently not represented in the portfolio of NQF-endorsed measures, it will look outside for other available measures. When non-endorsed measures are used, the measure developer will be asked to submit the measure to an NQF endorsement project for consideration. Gaps identified in the endorsed measures available will be captured to inform subsequent measure development.

MAP Structure

5. **How will MAP be structured?**

MAP will be composed of a two-tiered structure. MAP's overall strategy will be set by the Coordinating Committee, and this committee will provide final input to HHS. Working directly under the Coordinating Committee will be four advisory workgroups—three that are settings-based and one that focuses on the dual eligible beneficiary population. The workgroups are flexible and can be changed as the work in the program evolves. More than 60 organizations representing major stakeholder groups, 40 individual experts, and nine federal agencies are represented in the Coordinating Committee and workgroups.

6. **How will the Coordinating Committee and workgroups be appointed?**

MAP's Coordinating Committee and workgroups were selected based on NQF Board-adopted selection criteria, which included nominations and an open public commenting period. Balance among stakeholder groups was paramount. Due to the complexity of MAP's tasks, it was also imperative that individual subject matter experts were included in the groups. Other considerations included adding individuals with expertise in health disparities and vulnerable populations, state representation, and individuals with experience in health IT. Federal government *ex officio* members are non-voting because federal officials cannot advise themselves.

A Nominating Committee, composed of seven NQF Board members, oversaw the appointment of the members of the Coordinating Committee through a public nominations process that was required by statute. The nomination period remained open for one month each for the Coordinating Committee (Sept. 29-Oct. 28, 2010) and the workgroups (Jan. 10-Feb. 7, 2011). The Nominating Committee proposed a roster for each group, which was vetted publicly, as required by statute. After careful consideration of public comments, the rosters were given final approval by the full NQF Board for the Coordinating Committee on Jan. 24, 2011, and for the workgroups on March 31, 2011. MAP members will serve staggered three-year terms, with the initial members drawing one-, two-, or three-year terms at random, allowing additional opportunities to serve to be available annually.

7. To whom will the committees report?

The Coordinating Committee will be overseen by the NQF Board, which was responsible for establishing MAP and selecting its members. The Board will review any procedural questions that arise about MAP's structure or function and will periodically evaluate MAP's structure, function, and effectiveness. The NQF Board will not review the MAP Coordinating Committee's input to HHS.

The Coordinating Committee will provide its input directly to HHS, while the workgroups will be charged by and report directly to the Coordinating Committee.

MAP: How NQF and HHS Work Together

8. Why did HHS choose NQF for this project?

The Affordable Care Act specifies the involvement of a neutral convener to manage engagement and coordination and to take a leadership role in the quality measurement field. With a wealth of measure endorsement experience, a deep network of members and partners, sufficient analytic support to assist in decision making, its relationship with HHS as a consensus-based entity, as well as its experience in convening the National Priorities Partnership, NQF is uniquely structured to meet these criteria. NQF's independence is also critical in filling this important advisory capacity.

9. Why can't HHS do this on its own?

Choosing measures for gauging and rewarding progress is so important that no one perspective is adequate to inform the task.

NQF's organizational structure and independent nature makes it uniquely positioned to be a neutral convener and to act as an additional resource to provide coordinated expertise into the HHS decision-making process.

10. Are HHS and CMS required to accept and implement NQF's recommendations?

HHS is required to take into consideration any input from MAP in its selection of quality measures for various uses, but final decisions about implementation are solely at HHS's discretion.

The Administrative Procedures Act requires that HHS's decisions be made through routine rulemaking processes. MAP is not a subregulatory process. Should HHS via its decision making decide to select a measure that is not NQF endorsed, it must publish a rationale for its decision.

11. How does all of this relate to the National Quality Strategy?

The National Quality Strategy (NQS) was released on March 21, 2011, by the Secretary of HHS. The NQS is very important to MAP, as it represents the primary basis not only for the MAP decision-making framework developed by the Coordinating Committee, but also for the overall MAP strategy designed to guide the workgroups. The MAP decision-making framework will remain somewhat fluid to allow it to evolve along with the NQS.

12. How quickly will MAP provide input, and how quickly thereafter do you predict the government will implements any or all of its recommendations?

The MAP Coordinating Committee will begin providing input to HHS in fall 2011, and HHS will begin utilizing this input in calendar year 2012.

MAP Impact on the General Public

13. How will the public benefit from this project?

MAP is designed to support broader national efforts to create better, more affordable care. Its work will strengthen public reporting, which has been demonstrated to improve quality, and will give people more and better information when making healthcare choices and help providers improve their performance. MAP recommendations also will help shape payment programs, creating powerful financial incentives to providers to improve care. Consumer and purchaser stakeholders will have a place and a voice in every discussion. Lastly, measure selection decisions made in public programs often have a spillover effect in private insurance markets, so choices made by HHS may have a much broader impact over time.

14. Will the public have input into the MAP process? How will MAP achieve transparency?

MAP's overriding goal in intent and in statute is to maintain transparency for the public and encourage public engagement throughout MAP's work.

The public has been involved in the MAP process from early on, starting with two rounds of public comment on the NQF Board's establishment of MAP to another two rounds of public nominations and public vetting of the rosters for both the MAP Coordinating Committee and its workgroups. All MAP meetings will be open to the public, and meeting summaries and conclusions will be posted on the NQF website. MAP will seek public comment on all input to HHS.

15. What might be the ultimate implication of MAP's work?

The Measure Applications Partnership has real potential to enact positive change in our nation's healthcare system and build on a decade of remarkable work to develop measures that can help bring greater value into healthcare. We now have hundreds of measures, but MAP can help users pick the right ones for their applications.

Some outcomes we hope to see from the project include a defragmentation of care delivery, heightened accountability of clinicians and providers, better and more information for consumer decision making, higher value for spending by aligning payment with performance, a reduced data collection burden through the alignment of measurement activities, and an improvement in the consistent provision of evidence-based care across measured domains.

FOR IMMEDIATE RELEASE **CONTACT: [Insert Name]**
April XX, 2011 **[Insert Phone Number]**
[Insert Email Address]

[ABC Company] CEO Selected as Member of Newly Formed Measure Application Partnership [Coordinating Committee/Workgroup Name]

Washington, DC – [Name, Title, Company], has been selected to participate as a member of the newly established Measure Applications Partnership (MAP) [Coordinating Committee/ Workgroup Name]. MAP is a public-private partnership convened by the National Quality Forum (NQF) for the explicit purpose of providing input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs, as required in The Affordable Care Act.

The National Quality Forum, a private-sector, consensus-based, standard-setting organization whose efforts center on the evaluation and endorsement of standardized performance measurement, formalized its agreement with HHS to convene the multi-stakeholder groups established for MAP in late March.

[Insert quote from committee/workgroup member]

Through MAP activities, the private sector and a wide variety of stakeholders will be able to provide input into HHS's selection of performance measures for public reporting and payment reform programs, which will allow for greater coordination of performance measures across programs, settings, and payers. MAP's balance of interests—representing consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers—ensures that HHS will receive well-rounded input on performance measure selection. MAP activities, including comment periods and meetings, will be made open to the public via the NQF website.

MAP measure selections will be made within the framework of the newly released National Quality Strategy, with the intention of selecting measures that address our national healthcare priorities and goals, such as making care safer and ensuring that each person and family are engaged as partners in their care.

The MAP Coordinating Committee and its four workgroups span more than 60 organizations and include 40 subject matter experts and nine federal agencies. Government agencies are ex-officio members and will not vote on items before the coordinating committee.

"The choice of measures for gauging and rewarding progress is so important that no one perspective is adequate to inform the task," said Janet Corrigan, PhD, MBA, president and CEO of the National Quality Forum. "MAP's diverse composition—representing the full spectrum of

healthcare stakeholders—and NQF's strong background as a neutral convener will be instrumental in ensuring that well-rounded, evidence-based input makes its way to the HHS Secretary for her consideration on which measures to use for public reporting and performance-based payment programs."

The MAP Coordinating Committee will begin providing input to HHS in fall 2011, and HHS will begin utilizing this input in the calendar year 2012. More information about MAP is available here. (INSERT HYPERLINK).

###

Measure Applications Partnership
Clinician Workgroup Charge

Purpose

The charge of the Measure Applications Partnership (MAP) Clinician Workgroup is to advise the Coordinating Committee on a coordination strategy for clinician performance measurement. The initial strategy will address the use of measures for Federal programs, the ability to rely on electronic data sources, priorities articulated in the HHS National Quality Strategy (NQS), and priority conditions defined by NQF's Measure Prioritization Advisory Committee, and the ambulatory/office setting. The Clinician Workgroup will also advise the Coordinating Committee on measures to be implemented through the Federal rulemaking process that are applicable to clinician practice.

Through the two-tiered structure, the MAP Clinician Workgroup will not give input directly to HHS; rather, the Workgroup will advise the Coordinating Committee on the selection of measures and a coordination strategy for clinician performance measurement. The Clinician Workgroup will be guided by the decision making framework and measure selection criteria adopted by the Coordinating Committee, including alignment with the NQS. The Workgroup will give explicit consideration to the performance measures needed for dual eligible beneficiaries, to alignment of measures across all settings of care, and to improving outcomes of care.

The activities and deliverables of the MAP Clinician Workgroup do not fall under NQF's formal consensus development process (CDP).

Tasks

The Clinician Workgroup will review all of the performance measures currently in use for Federal programs and illustrative private sector programs. Attention will be given to where those measures converge and diverge. Convergence will inform the development of a core set of measures, while divergence may be instructive regarding the different purposes of specific programs or emerging measures in the field. The measures currently in use will be mapped to the cross-cutting priorities of the NQS, the high priority conditions identified by the NQF Measure Prioritization Advisory Committee, high impact specialties (e.g., by Part B charges), and the proposed ACO measures.

The Clinician Workgroup will advise the Coordinating Committee on a coordination strategy for clinician measurement and on the selection of measures through the following tasks:

1. Identification of a core set of available clinician performance measures, with focus on:
    a. Clinician measures needed across Federal programs (e.g., PQRS, EHR meaningful use, e-prescribing, resource use reporting, Physician Compare, and the future physician value-based modifier, as well as measures that can better align with hospital and other provider quality measures),
    b. Electronic data sources (e.g., clinically-enriched administrative data, EHRs),
    c. Office setting,

    d. Cross-cutting priorities from the NQS, and
    e. Priority conditions.
2. Identification of critical clinician measure development and endorsement gaps.
3. Development of a coordination strategy for clinician performance measurement, including:
    a. Alignment with other public and private initiatives, (e.g., ACO, PCMH, pay for performance programs, state and regional initiatives),
    b. HIT implications (e.g., coordination of data collection, use of patient-reported data), and
    c. High level transition plan and timeline by month.
4. Input on measures to be implemented through the Federal rulemaking process, based on an overview of the quality problems in the clinician office setting, the manner in which those problems could be improved, and the related measures for encouraging improvement.

Timeframe

Development of the initial clinician measurement coordination strategy will begin in May 2011 and will be completed by October 1, 2011. Input on the clinician measures to be implemented through Federal rulemaking will be completed by February 1, 2012.

Membership

Attachment A contains the MAP Clinician Workgroup roster.

The terms for MAP members are for three years. The initial members will serve staggered terms, determined by random draw at the first in-person meeting. MAP workgroups are convened by the Coordinating Committee as needed, thus a workgroup may be dissolved as the work of the MAP evolves.

Procedures

Attachment B contains the MAP member responsibilities and operating procedures.

Overview of Clinician Quality Programs

Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
Physician Quality Reporting System (PQRS)	• Tax Relief and Health Care Act of 2006 (TRHCA) — The initiative was first authorized by this act. The first measurement period went into effect in 2007. • Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) —- The continuation of the program was authorized for 2008 and 2009. • Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) —- The act made the program permanent; however, the incentive payments were authorized through —- 2010. • Affordable Care Act (ACA), 2010 —-The act expands the incentive payments through 2014 and adds a payment adjustment or penalty for eligible professionals who do not satisfactorily report the PQRS measures. [a]	The PQRS provides an incentive payment to eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries. [b]	For the 2007 measurement period, the reporting mechanism for the PQRS quality data was based on claims. MMSEA added alternative reporting mechanisms including medical registries and reporting measure groups. [c]	The incentive payment for 2007 consisted of 1.5 % (subjected to a cap) of total estimated allowed charges for covered professional services payable under the Medicare Part B Physician Fee Schedule (PFS). The incentive payment amount for 2008 and 2009 remained the same as the 2007 rate; however, the cap was removed. The incentive payment for 2010 measurement reporting period increased from 1.5 % to 2.0 %. According to the ACA, the incentive payment amount for the 2011 reporting period will be 1.0 % of the total estimated allowed charges. For the periods from 2012 through 2014, the incentive payment will be 0.5 %. Starting in 2015, eligible professionals who do not satisfactorily report for the reporting period will be subject to a payment adjustment or penalty, by which the PFS amount will decrease by 1.5 % for 2015 and 2.0 % for 2016 and every year thereafter. [d]	The Physician Compare Web site contains information about physicians and other professionals who satisfactorily participated in the PQRS; however, it does not yet include physician and eligible professional performance information. CMS is required to establish a plan for making information available on physician performance through the Physician Compare by January 1, 2013. The reporting period can begin on or after January 1. [e]

Overview of Clinician Quality Programs

Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
E-Prescribing Incentive Program	Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) — The section authorizes a separate incentive program from and in addition to the PQRS for 2009 through 2013.[f]	The E-Prescribing Incentive Program provides incentive payments to eligible professionals who are successful electronic prescribers, and it is implemented through an annual rulemaking process published in the Federal Register.[g]	*2009 eRX Incentive Program* Eligible professionals must submit information via their Medicare Part B claims. *2010 eRX Incentive Program* Eligible professionals may submit information: 1. To CMS on their Medicare Part B claims 2. To a qualified registry 3. To CMS via a qualified electronic health record (EHR) product.[h]	*2009 eRX Incentive Program* Eligible professionals can earn a 2.0% incentive payment for the 2009 eRx Incentive Program if they report the eRx measure in at least 50% of the cases in which the measure is reportable by the provider during 2009.[i] *2010 eRX Incentive Program* Eligible professionals should report the eRX measure for at least 25 unique electronic prescribing events in which the measure is reportable during 2010, in order to be considered a successful electronic prescriber and qualify to receive a 2.0% incentive payment. The incentive payment also can be applied to a group practice and can amount to 2% of the group practice's total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges for covered professional services furnished during the 2010 reporting year. *2011 and 2012 eRX Incentive Program* The incentive will amount to 1.0% of the total estimated allowed charges submitted not later than 2 months after the end of the reporting period. *2013 eRX Incentive Program*	

Overview of Clinician Quality Programs

Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
				The incentive amount will be reduced to 0.5%, and starting in 2012, eligible professionals who are not successful electronic prescribers may be subject to a payment adjustment or penalty. The PFS amount shall be reduced by 1.0% for 2012, 1.5% for 2013, and 2.0% for 2014.[j]	
Electronic Health Records (EHR)-Meaningful Use	• The American Recovery and Reinvestment Act of 2009 (ARRA) — The act supported the adoption of Electronic Health Records (EHRs) by investing as much as $27 billion over 10 years. • The Health Information Technology for Economic and Clinical Health Act (HITECH) 2009— According to the act, federal incentive payments will be available to eligible professionals upon adopting EHRs and demonstrating use in ways that can enhance quality, safety, and effectiveness of care. [k]	The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) for the "meaningful use" of certified EHR technology to enhance quality, safety, and effectiveness of care.[l]	Medicare eligible professionals, eligible hospitals and critical access hospitals will demonstrate meaningful use by inputting data into CMS' web-based Registration and Attestation System. Providers will complete numerators and denominators for the meaningful use objectives and clinical quality measures, and if applicable, exclusions to specific objectives, and legally attest to the successful demonstration of meaningful use. Additionally, providers can enter a completed report created by the	Medicare EHR Incentive Program: • Participation can start as early as 2011. Payments are also expected to begin in May 2011. • Eligible professionals can receive up to $44,000 over 5 years. Additional incentive will be paid to eligible professionals for providing services in a Health Professional Shortage Area (HSPA). • Eligible professionals must begin participation by 2012 in order to receive the maximum incentive payment. • Medicare eligible professionals, eligible hospitals, and CAHs that do not successfully demonstrate meaningful use will have a payment adjustment in their Medicare reimbursement, beginning 2015 and beyond. Incentive payments for the Medicare EHR Incentive Program will be made approximately four to six weeks after the eligible providers meet the program requirements and successfully attest they	

Overview of Clinician Quality Programs

Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
			EHR system into the online Attestation System. The Attestation system for the Medicare EHR Incentive Program was slated for opening on April 18, 2011. For the Medicaid EHR Incentive Program, the dates for accepting registration are provided to CMS by States and are updated monthly. [m]	have demonstrated meaningful use of certified EHR technologies. Medicaid EHR Incentive Program: • States and territories will offer the incentive program on a voluntary basis, which may begin as early as 2011. Payments will be paid by the states and are expected to begin in 2011. • Eligible professionals can receive up to $63,750 over the 6 years. • There are no payment adjustments. Incentives for the Medicaid EHR Incentive Program will be issued within 45 days of providers successfully submitting their attestation. [n]	
Physician Feedback/Value Modifier — [Previously called The Physician Resource Use Measurement and Reporting (RUR) Program]	• Section 131 of the Medicare Improvements for patients and Providers Act of 2008 (MIPPA) — The section established the Physician Resource Use Measurement and Reporting (RUR) Program. • Section 3003 of the 2010 Patient Protection and Affordable Care Act— This section of the act expended and enhanced the PUR program and renamed it to the Physician Feedback Program. • Section 3007 of the Affordable	The program provides physicians and other medical professionals confidential information with respect to the resources used to treat the Medicare fee-for-service (FFS) patients and the quality of care provided to these patients, in comparison to the peer groups practicing in the same specialty.[p] The PUR/Physician Feedback Program consists of two phases. Phase I was completed in 2009 during which approximately 310 reports containing per capita and episode-based cost information[q]	Under the program, CMS uses claims data to create confidential reports gauging the resources and quality of care utilized in furnishing care to Medicare beneficiaries.[s]	According to the section 3007 of the ACA, CMS is required to include cost and quality data when calculating payments for physicians by applying a value-based payment modifier under the Medicare Physician Fee Schedule (MPFS), which will begin in 2015. By 2017, the value-based payment modifier will be applied to the majority of medical professionals, and ultimately it will be employed for the value-based payment modifier. [t]	

Overview of Clinician Quality Programs

Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
	Care Act— The Section established the value-based payment modifier under the physician fee schedule. [o]	were sent to randomly selected physicians in 12 metropolitan areas throughout the U.S. Formative testing and retrospective analyses of the data from Phase I has assisted CMS in the formation of Phase II. CMS is developing Phase II reports that in addition to resource use measures include quality indices as well. The reports may contain measures used in the PQRS and claims-based measures such as the measures employed in the Generating Medicare Physician Quality Performance Measurement Results (GEM) Project. In Phase II, in addition to individual physicians, CMS may provide reports at the physician group level. [r]			
Physician Compare	Section 10331 of the Patient Protection and Affordable Care Act of 2010— The section sets requirements for the creation of the Physician Compare Web site. [u]	The Physician Compare web site was launched December 30, 2010, to serve as a healthcare professional directory on Medicare.gov. Individuals can search the site to locate a physician or other healthcare professional by specialty, type of professional, location, gender,	To collect the list of eligible professionals who satisfactorily reported PQRS measures, CMS mapped the National Provider identifiers (NPI's) of eligible professionals who		The Physician Compare Web site contains information about physicians and other professionals who satisfactorily participated in the PQRS; however, it does not yet include physician and eligible

Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
		and whether the healthcare professional accepts the Medicare-approved amount as payment in full on all claims. Additional information is also available such as languages spoken, group practice locations, education, and hospital affiliation. The website is updated on a monthly basis.[v]	satisfactorily reported PQRS measures for the 2009 program to Medicare Provider Enrollment, Chain and Ownership System (PECOS) to identify the name and state associated with each NPI. If the states or names could not be matched with NPI, then the National Plan and Provider Enumeration System (NPPES) was referenced for name and state identification.[w]		professional performance information. CMS is required to establish a plan for making information available on physician performance through the Physician Compare by January 1, 2013. The reporting period can begin on or after January 1. [x]
Medicare Advantage/5-star rating	The Affordable Care Act of 2010—The health reform law required the star ratings to be used to award quality-based payments to Medicare Advantage plans, beginning in 2012. [y]	Under this program, CMS rates Medicare Advantage plans on a scale of one to five stars, with five stars indicating the highest quality. MA Plan's quality is measured by computing a summary score which is a cumulative indicator of the following domains: staying healthy; screenings, tests, and vaccines; managing chronic (long-term) conditions; ratings of health plan responsiveness and care; health plan members' complaints and appeals; and health plan telephone customer	The five-star quality scores for MA plans for the 2011 reporting period included the following sources: CMS administrative data, including information about member satisfaction, plans' appeals processes, audit results, and customer service; the Consumer Assessment of Healthcare Providers and Systems (CAHPS); the Healthcare	Under the health reform law, MA plans will receive quality-based payments. Plans with higher quality ratings will receive higher rebates in the amounts of : • 70 % for plans receiving 4.5 or 5 stars; • 60 % for plan receiving 3.5 or 4 stars; • 50 % for plans receiving 3 stars or fewer. Plans with four or more stars will also receive bonus payments, and in certain counties, plans will receive double bonuses. Additionally, to achieve Medicare savings, lower county benchmarks will be phased-in over two, four, or six years, with longer phase-in period for counties with large	CMS posts quality ratings of Medicare Advantage plans on the Medicare.gov website to inform and educate Medicare beneficiaries with respect to their Medicare plan choices. [cc]

Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
		service. For the 2011 reporting period, CMS allocated stars for 36 performance measures and then the scores were averaged to calculate the summary score. The measures are adjusted for patient characteristics, where possible. The summary scores and quality ratings are assigned on the contract level versus plan level, since the data is mostly available to CMS at the contract level. The summary score also takes into account whether contracts have exhibited high and stable quality ratings across all measures, relative to other contracts. In conjunction with the health reform law which has required tying quality-based payments to the five-star rating, CMS has proposed a demonstration that would modify the rating system and provide additional quality-based payments to the MA plans, which would include all MA plans from 2012 through 2014. [z]	Effectiveness Data and Information Set (HEDIS); and the Health Outcome Survey (HOS).[aa]	changes in benchmarks. The bonus payment will be applied only to the new benchmarks, rather than the blended benchmarks which would result in the partial bonus payment to plans until the new benchmarks are fully phased-in. Under the CMS proposed demonstration, bonus payments would be provided to contracts that are rated as average performers (3 or 3.5 stars), in addition to those that receive 4 or more stars. Additionally, contracts that receive 4 or more stars would receive higher bonus payments than what has been authorized under the health reform law. Contracts that receive 5 stars would also receive higher bonus payments than the 4 and 4.5 star contracts with no bonus cap. However, the cap would apply to other contracts. Finally, bonuses for contracts with 5 stars would be applied to the blended benchmark versus the new benchmark, which will be applied for all other contracts. As a result of applying the blended benchmark, the 5 star plans would receive the full bonus amount before the changes are fully phased in. [bb]	

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Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
CHIPRA Initial Core Set Measures	Section 401 of The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009— The section called for the Secretary of the U.S. Department of Health and Human Services (HHS) to identify and publish an initial core measure set of children's health care quality measures for voluntary use by state programs administered under titles XIX and XXI, health insurance issuers, managed care entities, and providers of items and services under Medicaid and CHIP. [dd]	The aim of the CHIPRA initial core set measures is to assist the Centers for Medicare and Medicaid Services (CMS) to better understand the quality of health care children receive through the Medicaid and CHIP programs. According to the CHIPRA legislation, the data collected from the core measures will inform part of the Secretary's Annual Report on the Quality of Care for Children in Medicaid and CHIP.[i] There are measures that overlap between the CHIPRA initial core measures and the EHR Incentive Program.[ii] For the first year of reporting, States collecting the overlapping measures may identify slight variations in measure specifications, which may be caused by using different versions for the same measure. The CHIPRA measures will use the most recent available version of measure specifications. Rarely, the methodology for calculating the measure may also vary between the two programs with no impact on the data result.	All states choosing to report the initial core measures should submit data to the CHIP Annual Template System (CARTS), a web-based data submission tool that is currently used by CHIP Programs. The data submitted to CARTS will include the numerators, denominators, and rates for each measure. Furthermore, states can list quality improvements activities related to the measure and any foreseeable quality improvement plans in CARTS. [ff] States may choose to report the core set measures data for their Medicaid program only, the CHIP program only, or both. The data reported should be representative of the entire population enrolled in Medicaid and	Implementation of the CHIPRA Initial Core Set Measures will assist CMS and states to build a national system for measuring healthcare quality across States, which may include benchmarking their performance against national averages to identify best practices and promote cross-state learning. [hh]	The Department of Health and Human Services (HHS) publishes the Annual Reports on the Quality of Care for Children in Medicaid and CHIP which will include state-specific and national measurement information on the quality of health care furnished to children enrolled in the Medicaid and CHIP programs. [ii]

[i] The first annual report is available at: http://www.cms.gov/MedicaidCHIPQualPrac/Downloads/secrep.pdf

[ii] The measures used in both CHIPRA and EHR include: Childhood immunization status; BMI assessment for children/adolescents; Chlamydia screening; and Appropriate testing for children with pharyngitis

Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
		Per CHIPRA requirements, the CHIPRA initial core set measures will be modified and expanded to better reflect children's health care quality across all settings including Medicaid and CHIP programs, providers, consumers, and health plans. AHRQ will assist CMS to launch a Pediatric Quality Measures Program (PQMP) consisting of seven Pediatric Centers of Excellence in Quality Measurement. The Centers will aim to enhance and simplify the data collection for the initial core set of measures and seek methods to strengthen States' ability to rely on non-Medicaid and CHIP data sources. [ee]	the CHIP program. [gg]		
Medicaid Core Measure Set	The Affordable Care Act of 2010— In accordance with the act, the HHS Secretary is required to identify and publish a core set of health quality measures for Medicaid-eligible adults. [jj]	Under this initiative led by the collaborative effort between CMS and AHRQ, the core measures will be reported to Congress every three years to assess improvements on the quality of care received by adults in Medicaid. To facilitate the assessment of the quality of care, HHS is required to develop a standardized reporting format for the core set of measures by			

Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
		establishing an adult quality measurement program, publishing an annual report by the Secretary on the reporting of adult Medicaid quality information, and producing updates to the initial core set of adult health quality measures that reflect new or enhanced quality measures. The Initial core set that is currently undergoing public comments consists of 51 measures. The measures are classified under the following domains: prevention and health promotion, management of acute conditions, management of chronic conditions, family experiences of care, and availability. Milestones and their corresponding deadlines to meet the ACA requirements regarding adult quality measurement in Medicaid are as follows: • Publish recommended initial core set in the Federal Register for public comments by January 1, 2011; • Publish final initial core set by January 1, 2012;			

Overview of Clinician Quality Programs

Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
		• Develop a standardized reporting format on the core set and procedures to encourage voluntary reporting by the States by January 1, 2013; • Establish a Medicaid Quality Measurement Program to fund development, testing, and validation of emerging and innovative evidence-based measures by January 1, 2013; • Report to Congress by January 1, 2014; • Collect, analyze, and make publicly available the information reported by the States by September 30, 2014; and • Annually publish recommended changes to the initial core set, starting January 1, 2015. [kk]			
ACO Proposed Regulations	Section 3022 of the Affordable Care Act— This section requires CMS to establish the Medicare Shared Savings Program (Shared Savings Program), intended to increase accountability, promote care coordination, and encourage investment in infrastructure and redesigned care processes by supporting the development of Accountable Care Organizations (ACOs). [ll]	ACOs are projected to create incentives for health care providers such as doctors, hospitals, long-term facilities, and other health care providers to better coordinate care for and treatment of an individual patient across all settings. Participation in an ACO is voluntary for both patients and providers.[mm]	There are several mechanisms for data submission across domains which include: • Survey • Claims • Group Practice Reporting Option (GPRO) Data Collection Tool • EHR Incentive Program Reporting • eRX Incentive	The Medicare Shared Savings Program will incentivize ACOs that reduce health care costs while meeting performance standards on quality of care. The quality standards include patient/caregiver care experience, care coordination, patient safety, preventive health, and at-risk population/frail elderly health. On the other hand, ACOs that do not meet quality standards cannot share in program savings and can be held accountable if they do not generate savings. [oo]	

Overview of Clinician Quality Programs

Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
			Program Reporting • CDC National Healthcare Safety Network.[nn]		
IHA (Integrated Healthcare Association — California Pay-for-performance Program)		In 2002, The Integrated Healthcare Association (IHA) Launched the Pay-for-Performance (P4P) initiative to evaluate the performance of contracted physician organizations (POs) across California. The program aimed to develop a common set of measures with public reporting of the scores and to provide health plans[iii] with the information needed to reward POs financially based on their performance.[pp] Performance results released by IHA for measurement year 2008 contain a comparison of average composite scores in four performance measurement domains: clinical quality, patient experience, information technology-enabled systemness, and coordinated diabetes care.[qq] Effective 2011, the IT-Enabled	Participating health plans submit administrative results related to the clinical measures for their contracted POs to the data aggregator (NCQA/DDD). The data for clinical measures is collected from encounters, fee-for-service claims and in-network claims. A PO may collect and submit administrative results for clinical measures directly to the data aggregator. The data for the patient experience domain is captured through the Patient Assessment Survey (PAS). To collect and score	To calculate incentive payments, the measurement domains are weighted. Weighting for each domain differs among health plans. Payment methodology also varies across plans. Plans may choose to pay based on the following methodologies; • Use absolute threshold; • Use relative percentile ranking; • Pay for all or most IHA clinical measures; • Pay for IHA-recommended patient experience measures or use the health plan survey; • Pay for IHA IT measure or choose not to pay; • Pay using aggregated data set; and/or • Pay using IHA-recommended weightings.[tt] Additionally, POs need to meet the encounter rate threshold (number of encounters per member per year) in order for their data to be included in their aggregated scores. Health plans may not provide financial reward to a PO that does	The P4P annual physician group performance results are posted on a public website sponsored by the California Office of the Patients Advocate (OPA). www.opa.ca.gov Additionally, IHA provides financial transparency reports on its website which include the incentive payments made by each health plan participating in P4P, the payment methodology utilized by each health plan, adoption of uniform IHA measurement set, and use of aggregated data set. [vv]

[iii] The eight health included Aetna, Anthem Blue Cross, Blue Shield of California, CIGNA HealthCare of California, Health Net, Kaiser Permanente (public reporting only), UnitedHealthcare/Pacificare, and Western Health Advantage.

Overview of Clinician Quality Programs

Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
		Systemness Domain has been renamed to Meaningful Use of Health IT in concert with the CMS effort to support the adoption and use of EHR and the implementation of "meaningful use" measures. [rr]	data on meaningful use of health IT, POs must declare their intentions for submitting the MU of Health IT survey in advance, attend a training session, submit PO level results using a scoring tool provided by NCQA, and submit an attestation of accuracy for each measure. Health plans and POs are not expected to report on the appropriate resource use measures—Thomson Reuters will run the resource use measures for MY 2011. [ss]	not meet the encounter rate threshold. [uu]	
Blue Cross Blue Shield of Massachusetts Alternative Quality Contract		Blue Cross Blue Shield of Massachusetts launched a new payment arrangement called the Alternative Quality Contract (AQC) in 2009. The AQC is a modified global payment model that links medical groups annual payments to a per member, per month budget and provides incentive payments to improve quality.	Blue Cross has in place a data-reporting system that supports medical group's implementation of timely medical management and includes a series of regular data and performance reports, consultative support, and organized sessions where the groups meet	The program provides quality incentive payments of up to 10 % of the total per member per month payments. Groups can earn bonuses of up to 5 %t based on their performance on 32 care measures for ambulatory or office-based services and up to 5 % for their performance on 32 measures of hospital care. The incentive payments are based on quality measures derived from nationally accepted sets of measures, and the quality	

Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
		The AQC lasts for five years to offer additional time and support to providers to develop the capacity to manage the new payment model. Blue Cross negotiates a base year's budget with each group based on its past year's medical spending on HMO and POS patients seen by their primary care physicians. Upon setting initial budgets, Blue Cross employs trend allowances to manage health care spending growth over the five-year contract period.[ww] Presently, the AQC applies only to HMO and POS plan enrollees.	jointly and share best practices. The reports assist groups in monitoring their performance on the quality bonus measures as well as current performance relative to their budgets. [xx]	bonus system is based on absolute performance. The bonus depends on an overall quality score that is developed by aggregating quality scores from each measure. [yy]	

[a] https://www.cms.gov/PQRS/.
[b] Ibid.
[c] Ibid.
[d] Ibid.
[e] Ibid.
[f] https://www.cms.gov/ERXIncentive/.
[g] Ibid.
[h] Ibid.
[i] Ibid.
[j] https://www.cms.gov/ERxIncentive/04_Statute_Regulations.asp#TopOfPage.
[k] Electronic Health Records at a Glance, July 13, 2010.

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[l] https://www.cms.gov/EHRIncentivePrograms/01_Overview.asp#TopOfPage.
[m] https://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp#TopOfPage.
[n] https://www.cms.gov/EHRIncentivePrograms/01_Overview.asp#TopOfPage.
[o] CY 2011 Medicare Physician Fee Schedule Final Rule.
[p] https://questions.cms.hhs.gov.
[q] CY 2011 Medicare Physician Fee Schedule Final Rule.
[r] Ibid.
[s] https://www.cms.gov/physicianfeedbackprogram/.
[t] Ibid.
[u] http://www.cms.gov/Physician-Compare-Initiative/.
[v] Ibid.
[w] Ibid.
[x] Ibid.
[y] The Henry J. Kaiser Family Foundation. Reaching for the Stars: Quality Ratings of Medicare Advantage Plans, 2011. Feb 2011.
[z] Ibid.
[aa] Ibid.
[bb] Ibid.
[cc] Ibid.
[dd] CHIPRA Initial Core Set Technical Specifications Manual 2011.
[ee] Ibid.
[ff] Ibid.
[gg] Ibid.
[hh] Ibid.
[ii] Ibid.
[jj] http://www.ahrq.gov/about/nacqm/nacqmsum.htm.
[kk] http://www.ahrq.gov/about/nacqm/nacqm1.htm.
[ll] ACO proposed rule March 2011.
[mm] http://www.hhs.gov/news/press/2011pres/03/20110331a.html.
[nn] ACO proposed rule March 2011.
[oo] http://www.hhs.gov/news/press/2011pres/03/20110331a.html.
[pp] http://www.iha.org/pdfs_documents/p4p_california/DraftMY2011P4PManual123010.pdf.
[qq] http://www.iha.org/program_results.html.
[rr] http://www.iha.org/pdfs_documents/p4p_california/DraftMY2011P4PManual123010.pdf.
[ss] Ibid.
[tt] Advancing Quality Through Collaboration: The California Pay for Performance Program, Feb 2006. Available at http://www.iha.org/pdfs_documents/p4p_california/P4PWhitePaper1_February2009.pdf
[uu] http://www.iha.org/pdfs_documents/p4p_california/DraftMY2011P4PManual123010.pdf.
[vv] http://www.iha.org/financial_transparency.html.

[ww] Chernew M, Mechanic R, Landon, B, Safran D. Private-Payer Innovation in Massachusetts: The ‘Alternative Quality Contract’, Health Affairs, 30, no.1 (2011): 51-61.
[xx] Ibid.
[yy] Ibid.

National Quality Strategy Priorities	(Multiple Items)
Condition/General Category	(All)

NQF Measure # and Status	Measure Name	NQF Re-tooled eMeasure	Steward	Data Source	Measure Type	Program
0052 Endorsed	Low Back Pain: Use of Imaging Studies	Yes	NCQA	Administrative Claims	Process	MU, Medicaid, IHA
0058 Endorsed	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	No	NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS, IHA
0069 Endorsed	Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use	Yes	NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS, IHA, BCBS-MA
0389 Endorsed	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients	Yes	AMA-PCPI	Administrative Claims, Other Electronic Clinical Data	Process	PQRS, MU
0469 Endorsed	Elective Delivery Prior to 39 Completed Weeks Gestation	No	Hospital Corporation of America	Paper Records	Outcome	Medicaid
0476 Endorsed	Appropriate Use of Antenatal Steroids	No	Providence St. Vincent Medical Center	Paper Records, Other Electronic Clinical Data	Process	Medicaid
0562 Endorsed	Melanoma: Overutilization of Imaging Studies in Stage 0-IA Melanoma	No	AMA-PCPI	Other Electronic Clinical Data	Process	PQRS
0659 Endorsed	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use	No	AMA-PCPI/NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS
1381 Public and member commenting	Annual number of asthma patients 2 through 20 years old) with one or more asthma-related emergency room visits	No	Alabama Medicaid	Administrative Claims	Outcome	CHIPRA
1389 Withdrawn	Adolescent well-care visits	No	NCQA	Administrative Claims, Paper Records	Use of Services	CHIPRA, BCBS-MA
1392 Public and Member Commenting	Well-Child Visits in the First 15 Months of Life	No	NCQA	Administrative Claims, Paper Records	Use of Services	CHIPRA, BCBS-MA
1506 Public and Member Commenting	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	No	NCQA	Administrative Claims, Paper Records	Use of Services	CHIPRA, BCBS-MA

National Quality Strategy Priorities	(Multiple Items)
Condition/General Category	(All)

NQF Measure # and Status	Measure Name	NQF Re-tooled eMeasure	Steward	Data Source	Measure Type	Program
NA14	Encounters per member per year	No	This is a non-HEDIS measure- the method for identifying encounters by service type is based on the HEDIS Use of Service measures and the General Guidelines	(blank)	(blank)	IHA
NA44	Inpatient Utilization—Acute Care Discharges PTMY	No	Based on HEDIS Use of Services specifications (added risk adjustment)	(blank)	(blank)	IHA
NA45	Inpatient Utilization—Bed Days PTMY	No	Based on HEDIS Use of Services specifications (added risk adjustment)	(blank)	(blank)	IHA
NA46	Emergency Department Visits PTMY	No	Based on HEDIS Use of Services specifications (added risk adjustment)	(blank)	(blank)	IHA
NA47	Outpatient Procedures Utilization—% Done in Preferred Facility	No	Based on HEDIS Use of Services specifications	(blank)	(blank)	IHA
NA48	Generic Prescribing (7 therapeutic areas	No	Thomson Reuters will run this measure for MY 2011	Other Electronic Clinical Data	(blank)	IHA

National Quality Strategy Priorities	(Multiple Items)
Condition/General Category	(All)

NQF Measure # and Status	Measure Name	NQF Re-tooled eMeasure	Steward	Data Source	Measure Type	Program
NA49	Total Cost of Care (baseline)	No	Thomson Reuters will run this measure for MY 2012	(blank)	(blank)	IHA
NA63	Ambulatory Care: Emergency Department Visits	No	NCQA	Administrative Claims	(blank)	CHIPRA
NA72	Ambulatory Care: Outpatient and Emergency Department Visits	No	NCQA	(blank)	(blank)	Medicaid
NA73	Inpatient Utilization: General Hospital/ Acute Care	No	NCQA	(blank)	(blank)	Medicaid
NA74	Mental Health Utilization	No	NCQA	(blank)	(blank)	Medicaid
1390 Not Recommended	Child and Adolescent Access to Primary Care Practitioners	No	NCQA	Administrative Claims	Acess	CHIPRA

National Quality Strategy Priorities	(Multiple Items)
Condition/General Category	(All)

NQF Measure # and Status	Measure Name	NQF Re-tooled eMeasure	Steward	Data Source	Measure Type	Program
0045 Endorsed	Osteoporosis:Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Yes	AMA-PCPI/NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS
0089 Endorsed	Diabetic Retionpathy: Communication with the Physician Managing On-going Diabetes Care	Yes	AMA-PCPI/NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS, MU
0097 Endorsed	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	Yes	AMA-PCPI/NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS
0228 or alternate Endorsed	Care Transition Measure	No	University of Colorado Health Sciences Center	Patient Reported Data/Survey	Patient Experience of Care	ACO
0509 Endorsed	Radiology: Reminder System for Mammograms	No	AMA-PCPI	Administrative Claims, Other Electronic Clinical Data	Structure/Management	PQRS
0541 Endorsed	Proportion of Days Covered(PDC): 5 Rates by Therapeutic Category	No	PQA	Other Electronic Clinical Data	Process	Medicaid
0554 Endorsed	Medication Reconciliation	No	NCQA	Administrative Claims, Paper Records	Process	ACO
0561 Endorsed	Melanoma: Coordination of Care	No	AMA-PCPI/NCQA	Other Electronic Clinical Data	Process	PQRS
0576 Endorsed	Follow-up after hospitalization for mental illness	No	NCQA	Administrative Claims	Process	Medicaid, CHIPRA
0647 Endorsed	Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care) (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	No	AMA-PCPI	Paper Records, Electronic Health Record	Process	Medicaid

National Quality Strategy Priorities	(Multiple Items)
Condition/General Category	(All)

NQF Measure # and Status	Measure Name	NQF Re-tooled eMeasure	Steward	Data Source	Measure Type	Program
0648 Endorsed	Timely Transmission of Transition Record (Inpatient Discharges to Home/Self-Care or Any Other Site of Care)	No	AMA-PCPI	(blank)	Process	Medicaid
0650 Endorsed	Melanoma: Continuity of Care – Recall System	No	AMA-PCPI/NCQA	Other Electronic Clinical Data	Structure/Management	PQRS
1517 Member Voting	Prenatal and Postpartum Care: Postpartum Care Rate	No	NCQA	Administrative Claims, Paper Records	Acess	Medicaid
NA2	30 Day Post Discharge Physician Visit	No	CMS	(blank)	Process	ACO

National Quality Strategy Priorities	(Multiple Items)
Condition/General Category	Endocrine

NQF Measure # and Status	Measure Name	NQF Re-tooled eMeasure	Steward	Data Source	Measure Type	Program
0055 Endorsed	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	Yes	NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS, MU, ACO, MA 5-Star Rating, BCBS-MA, GEM
0056 Endorsed	Diabetes Mellitus: Foot Exam	Yes	NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS, MU, ACO
0057 Endorsed	Diabetes Mellitus: Hemoglobin A1c Testing	No	NCQA	Administrative Claims	Process	PQRS, Medicaid, BCBS-MA, GEM
0059 Endorsed	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	Yes	NCQA	Administrative Claims, Electronic Health Record, Other Electronic Clinical Data	Outcome	PQRS, MU, ACO, BCBS-MA
0060 Endorsed	Annual Pediatric hemoglobin A1C testing	Yes	NCQA	Administrative Claims, Paper Records, Electronic Health Record	Process	CHIPRA
0061 Endorsed	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	Yes	NCQA	Administrative Claims, Electronic Health Record, Other Electronic Clinical Data	Outcome	PQRS, MU, ACO, BCBS-MA
0062 Endorsed	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	Yes	NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS, MU, ACO, MA 5-Star Rating, BCBS-MA, GEM
0063 Endorsed	Diabetes Mellitus: Lipid Profile	No	NCQA	Administrative Claims	Process	PQRS, Medicaid

National Quality Strategy Priorities	(Multiple Items)
Condition/General Category	Endocrine

NQF Measure # and Status	Measure Name	NQF Re-tooled eMeasure	Steward	Data Source	Measure Type	Program
0064 Endorsed	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	Yes	NCQA	Administrative Claims, Electronic Health Record, Other Electronic Clinical Data	Outcome	PQRS, MU, ACO, MA 5-Star Rating, IHA, BCBS-MA
0088 Endorsed	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Yes	AMA-PCPI/NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS, MU
0272 Endorsed	Ambulatory Sensitive Conditions Admissions: Diabetes, short-term complications (AHRQ Prevention Quality Indicator (PQI) #1)	No	AHRQ	Administrative Claims	Outcome	Medicaid, ACO
0274 Endorsed	Diabetes, Long-Term Complications	No	AHRQ	Administrative Claims	Outcome	Medicaid
0285 Endorsed	Lower Extemity Amputations among Patients with Diabetes	No	AHRQ	Administrative Claims	Outcome	Medicaid
0416 Endorsed	Diabetes Mellitus: Diabetic Foot and Ankle care, Ulcer Prevention - Evaluation of Footwear	Yes	APMA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS
0417 Endorsed	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation	No	APMA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS
0575 Endorsed	Diabetes: HbA1c Control < 8%	Yes	NCQA	Administrative Claims, Other Electronic Clinical Data	Outcome	MU, ACO, MA 5-Star Rating

National Quality Strategy Priorities	(Multiple Items)
Condition/General Category	Endocrine

NQF Measure # and Status	Measure Name	NQF Re-tooled eMeasure	Steward	Data Source	Measure Type	Program
0638 Endorsed	Ambulatory Sensitive Conditions Admissions: Uncontrolled Diabetes (AHRQ Prevention Quality Indicator (PQI) #14)	No	AHRQ	Administrative Claims	Outcome	Medicaid, ACO
Appears to be 2 composite measures that are NQF-endorsed; OT1-009 and OT1-029	Diabetes Care (CDC)—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), HbA1c Control (<7.0%) for a Selected Population, LDL Screening and Control (<100), Nephropathy Monitoring, Blood Pressure Control (<140/90), Optimal Diabetes Care	No	HEDIS, the Minnesota Community Measurement Program	Administrative Claims, Paper Records, Other Electronic Clinical Data, Patient Reported Data/Survey	Composite	IHA
NA9	Diabetes Mellitus: Aspirin Use	No	(blank)	(blank)	Process	ACO
NA61	LDL-C Screening for beneficiaries ≤ 75 with Diabetes Conditions	No	(blank)	(blank)	Process	MA 5-Star Rating, BCBS-MA, GEM

National Quality Strategy Priorities	(Multiple Items)
Condition/General Category	Cardiovascular

NQF Measure # and Status	Measure Name	NQF Re-tooled eMeasure	Steward	Data Source	Measure Type	Program
0013 Endorsed	Hypertension: Blood Pressure Measurement	Yes	AMA-PCPI	Electronic Health Record	Process	PQRS, MU, ACO
0017 Endorsed	Hypertension (HTN): Plan of Care	No	AMA-PCPI	Administrative Claims, Other Electronic Clinical Data	Process	PQRS, ACO
0018 Endorsed	Controlling High Blood Pressure	Yes	NCQA	Administrative Claims, Paper Records, Electronic Health Record, Other Electronic Clinical Data	Outcome	PQRS, MU, Medicaid, ACO, MA 5-Star Rating, BCBS-MA
0065 Endorsed	Coronary Artery Disease (CAD): Symptom and Activity Assessment	No	AMA-PCPI	Other Electronic Clinical Data	Process	PQRS
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)	Yes	AMA-PCPI	Other Electronic Clinical Data	Process	PQRS, ACO
0067 Endorsed	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	Yes	AMA-PCPI	Administrative Claims, Other Electronic Clinical Data	Process	PQRS, MU, ACO
0068 Endorsed	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Yes	NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS, MU

National Quality Strategy Priorities	(Multiple Items)
Condition/General Category	Cardiovascular

NQF Measure # and Status	Measure Name	NQF Re-tooled eMeasure	Steward	Data Source	Measure Type	Program
0070 Endorsed	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	Yes	AMA-PCPI	Electronic Health Record, Other Electronic Clinical Data	Process	PQRS, MU, ACO
0071 Submitted	Persistence of β-Blocker Treatment after Heart Attack	No	NCQA	Administrative Claims, Paper Records, Other Electronic Clinical Data	Process	Medicaid, GEM
0072 Withdraw Requested	β-Blocker Treatment after Heart Attack	No	NCQA	Administrative Claims	(blank)	GEM
0073 Endorsed	Ischemic Vascular Disease (IVD): Blood Pressure Management Control	Yes	NCQA	Administrative Claims, Other Electronic Clinical Data	Outcome	PQRS, MU
0074 Endorsed	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	Yes	AMA-PCPI	Other Electronic Clinical Data	Process	PQRS, MU, Medicaid, ACO
0075 Endorsed (PQRS #202)	Ischemic Vascular Disease (IVD): Complete Lipid Profile	Yes	NCQA	Administrative Claims, Other Electronic Clinical Data	Outcome	PQRS, MU, Medicaid, ACO, IHA
0075 Endorsed (PQRS #203)	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control	Yes	NCQA	Administrative Claims, Other Electronic Clinical Data	Outcome	PQRS, MU, Medicaid, ACO, IHA, BCBS-MA
0079 Endorsed	Heart Failure: Left Ventricular Function (LVF) Assessment	No	AMA-PCPI	Other Electronic Clinical Data	Process	PQRS, ACO
0081 Endorsed	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Yes	AMA-PCPI	Electronic Health Record, Other Electronic Clinical Data	Process	PQRS, MU, ACO

National Quality Strategy Priorities	(Multiple Items)
Condition/General Category	Cardiovascular

NQF Measure # and Status	Measure Name	NQF Re-tooled eMeasure	Steward	Data Source	Measure Type	Program
0082 Endorsed(to be retired)	Heart Failure: Patient Education	No	AMA-PCPI	Other Electronic Clinical Data	Process	PQRS, ACO
0083 Endorsed	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Yes	AMA-PCPI	Other Electronic Clinical Data	Process	PQRS, MU, ACO
0084 Endorsed (to be retired)	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation	Yes	AMA-PCPI	Other Electronic Clinical Data	Process	PQRS, MU, ACO
0085 Endorsed (to be retired)	Heart Failure: Weight Measurement	No	AMA-PCPI	Administrative Claims	Process	PQRS, ACO
0090 Endorsed	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	No	AMA-PCPI/NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS
0092 Endorsed	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	No	AMA-PCPI/NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS
0093 Endorsed	12-Lead Electrocardiogram (ECG) Performed for Syncope	No	AMA-PCPI/NCQA	Administrative Claims, Other Electronic Clinical Data	Process	PQRS
0276 Endorsed	Hypertension	No	AHRQ	Administrative Claims	Outcome	Medicaid
0277 Endorsed	Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8)	No	AHRQ	Administrative Claims	Outcome	Medicaid, ACO
0282 Endorsed	Angina Without Procedure	No	AHRQ	Administrative Claims	Outcome	Medicaid

National Quality Strategy Priorities	(Multiple Items)
Condition/General Category	Cardiovascular

NQF Measure # and Status	Measure Name	NQF Re-tooled eMeasure	Steward	Data Source	Measure Type	Program
0067, 0074, 0070,0064, 0066	Coronary Artery Disease (CAD) Composite: All or Nothing Scoring	Yes	(blank)	(blank)	Process & Outcome (Composite)	ACO
NA1	Heart Failure: Left Ventricular Function (LVF) Testing	No	CMS	Other Electronic Clinical Data	Process	PQRS, ACO
NA5	Coronary Artery Disease (CAD): LDL level < 100 mg/dl	No	CMS	(blank)	Outcome	ACO
NA60	LDL-C Screening for beneficiaries ≤ 75 with Cardiovascular Conditions	No	(blank)	(blank)	Process	MA 5-Star Rating, BCBS-MA, GEM

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)
Roster for the MAP Clinician Workgroup

Chair (voting)

Mark McClellan, MD, PhD

Organizational Members (voting)

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	Frederick Masoudi, MD, MSPH
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
Shared Decision Making	Karen Sepucha, PhD
Population Health	Eugene Nelson, MPH, DSc
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)

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, RN, MPH
Office of the National Coordinator for HIT (ONC)	Thomas Tsang, MD, MPH
Veterans Health Administration	Joseph Francis, MD, MPH

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

George Isham, MD, MS

Elizabeth McGlynn, PhD, MPP

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Clinician Workgroup

Chair (voting)

Mark B. McClellan, MD, PhD
Mark McClellan is senior fellow, director of the Engelberg Center for Health Care Reform, and Leonard D. Schaeffer Chair in Health Policy Studies at the Brookings Institution. Established in 2007, the Engelberg Center provides practical solutions to achieve high-quality, innovative, affordable health care with particular emphasis on identifying opportunities on the national, state and local levels. A doctor and economist by training, McClellan has a highly distinguished record in public service and academic research. He is a former administrator of the Centers for Medicare & Medicaid Services (CMS) and former commissioner of the Food and Drug Administration (FDA). He also served as a member of the President's Council of Economic Advisers and senior director for health care policy at the White House. Previously, McClellan served in the Clinton administration as deputy assistant secretary of the Treasury for economic policy, where he supervised economic analysis and policy development on a range of domestic policy issues. McClellan also served as an associate professor of economics and associate professor of medicine with tenure at Stanford University, where he directed Stanford's Program on Health Outcomes Research; was associate editor of the Journal of Health Economics; and co-principal investigator of the Health and Retirement Study (HRS), a longitudinal study of the health and economic status of older Americans. He has twice received the Kenneth J. Arrow Award for Outstanding Research in Health Economics. From time to time, McClellan advises U.S. government officials on health care policy issues. In his capacity as a health policy expert, he is the co-director of the Bipartisan Policy Center's Leaders' Project on the State of American Health Care; co-chair of the Robert Wood Johnson Foundation Commission to Build a Healthier America; and chair of the FDA's Reagan-Udall Foundation. McClellan is also co-chair of the Quality Alliance Steering Committee, sits on the National Quality Forum's Board of Directors, is a member of the Institute of Medicine of the National Academy of Sciences, and is a research associate at the National Bureau of Economic Research. McClellan holds an MD from the Harvard University–Massachusetts Institute of Technology (MIT) Division of Health Sciences and Technology, a PhD in economics from MIT, an MPA from Harvard University, and a BA from the University of Texas at Austin. He completed his residency training in internal medicine at Boston's Brigham and Women's Hospital, is board-certified in Internal Medicine, and has been a practicing internist during his career.

Organizational Members (voting)

American Academy of Family Physicians
Bruce Bagley, MD

American Academy of Nurse Practitioners
Mary Jo Goolsby, EdD, MSN, NP-C, CAE, FAANP
Dr. Mary Jo Goolsby is the director of research and education for the American Academy of Nurse Practitioners (AANP), a professional society representing the interests of over 140,000 nurse practitioners (NP). Dr. Goolsby oversees all organizational research and data-collection activities, including a national NP practice-based research network (PBRN). Her role includes shared oversight of the only comprehensive database of NPs. Additionally, Dr. Goolsby directs all AANP non-conference accredited and unaccredited educational activities. Initiatives within the research and education components include promotion of practice improvement and outcome measurement by NPs. Dr. Goolsby serves on a variety

of expert panels, committees, and workgroups. Professional memberships include AANP, AONE, STTI, NONPF, and ASAE. Dr. Goolsby earned her BSN at Emory University, MSN at the University of Alabama in Huntsville, and EdD in Higher Education at the Florida State University.

American Academy of Orthopaedic Surgeons
Douglas Burton, MD
Douglas C. Burton, MD is a member of the advisory workgroup for the Measure Application Partnership (MAP). He has a strong interest in developing and implementing a national strategy for healthcare quality measurement and reporting and is honored to serve as the representative for the American Academy of Orthopedic Surgeons. Dr. Burton attended Kansas State University in Manhattan, KS and received his medical degree from the University of Texas Southwestern School of Medicine in Dallas, Texas. He completed his orthopedic residency at The University of Kansas Medical Center, in Kansas City, KS and spine fellowships at Texas Back Institute in Plano, TX and Thomas Jefferson University in Philadelphia, PA. He is the Marc & Elinor Asher Spine Professor at the University of Kansas Medical Center in Kansas City, KS.

American College of Cardiology
Frederick A. Masoudi, MD, MSPH
Dr. Masoudi is a practicing cardiologist at the University of Colorado. He received his medical degree from the Johns Hopkins University School of Medicine and served as a resident and chief resident in medicine at the University of California, San Francisco. After completing his fellowship in cardiology and receiving a Masters in Science in Public Health at University of Colorado at Denver (UCD), Dr. Masoudi joined the faculty at UCD. He is currently an Associate Professor. Dr. Masoudi is an expert in clinical registries and quality measurement. He is the Senior Medical Officer and Chair of the Science Oversight Committee of the NCDR. The six NCDR registries focus on high-impact cardiovascular conditions and procedures, including percutaneous coronary intervention; ICDs; carotid stents; acute coronary syndromes; outpatient cardiovascular disease; and pediatric cardiology. He served as the clinical coordinator of the Centers for Medicare and Medicaid Services-sponsored National Heart Care Projects from 1999-2005, and is the clinical coordinator of the CMS Hospital Measures Special Study for acute myocardial infarction and heart failure. These efforts have focused on assessing and improving the health care for Medicare beneficiaries with cardiovascular disease. Dr. Masoudi has published more than 100 peer-reviewed papers on the topics of quality and safety of cardiovascular care; the effectiveness of therapy in community-based settings; the effect of comorbidity on treatment and outcomes, and health status in cardiovascular disease. His most recent research has focused primarily on patterns of care and effectiveness of implantable cardioverter defibrillators (ICDs) in community practice in the multi-center Cardiovascular Research Network. Dr. Masoudi holds positions in national organizations focused on quality of care and outcomes research. He served as the Chair of the American College of Cardiology (ACC)/American Heart Association (AHA) Task Force on Performance Measures (2007-2010); is a member of the American Society of Echocardiography Quality Task Force; and an Associate Editor of *Circulation: Cardiovascular Quality and Outcomes*.

American College of Radiology
David J. Seidenwurm, MD
David Seidenwurm was raised in New York City. He majored in Philosophy as an undergraduate at Stanford, and concentrated in Neuroscience at the Harvard Medical School, where he earned his M.D. in 1982. After Internship at Kaiser Foundation Hospital in San Francisco and Diagnostic Radiology Residency at Stanford he was a Fellow in Neuroradiology at New York University. Subsequently, he was acting Director of Neuro MRI at NYU and Assistant Professor of Radiology at UCSF. He has been a Neuroradiologist at Radiological Associates of Sacramento since 1991. Currently, he is Chairman of the Diagnostic Radiology Division, comprised of 44 radiologists covering 5 hospital Radiology Departments

and 13 independent imaging facilities. Previously, he has served as Chief of Diagnostic Imaging and Radiation Oncology at Sutter Medical Center, Sacramento. He is also a member of the board of directors, and past president of California Managed Imaging, a statewide diagnostic imaging network. Dr. Seidenwurm has been an active contributor to the medical literature. He has been Associate Editor of *Radiology* and a member of the Editorial Board of *Diagnostic Imaging,* among the most influential scientific and professional journals in the field. He has authored numerous peer reviewed scientific papers, consensus statements, and editorial commentaries. His writing has appeared in publications ranging from *JAMA* to *The New Yorker* and *The National Review*. At present, Dr. Seidenwurm holds numerous leadership positions related to medical quality improvement and consensus development at the national level. He is co-chair of the AMA Physicians Consortium committees developing Performance Measures for Stroke, Radiology and Radiation Exposure, previous Chairman of the American College of Radiology Neurological Imaging Appropriateness Criteria Expert Panel and Chairman of the American Society of Neuroradiology Utilization and Appropriateness committee. At present he is the Secretary of the American Society of Neuroradiology.

American Speech-Language-Hearing Association
Janet Brown, MA, CCC-SLP
Janet Brown, MA CCC-SLP, is director of health care services in speech-language pathology at the American Speech-Language-Hearing Association (ASHA), the professional, credentialing, and scientific organization for speech-language pathologists, audiologists, and speech, language, and hearing scientists. ASHA developed the National Outcomes Measure System (NOMS) consisting of 15 Functional Communication Measures in 1998 to respond to the need for more comprehensive and sensitive outcome measures for speech-language pathology treatment. The eight measures frequently used with stroke patients were endorsed by NQF and accepted into the PQRI registry. Ms. Brown received a Master's degree in speech-language pathology from The Catholic University of America.

Association of American Medical Colleges
Joanne Conroy, MD
As Chief Health Care Officer, Joanne M. Conroy, M.D., focuses on the interface between the health care delivery system and academic medicine, paying particular attention to how health care in academic settings can address quality-of-care and patient-centered care issues. Dr. Conroy represents the interests of approximately 400 major teaching hospitals and health systems, including 64 Veterans Affairs medical centers, through the AAMC Council of Teaching Hospitals and Health Systems in addition to overseeing the Group on Faculty Practice, Group on Resident Affairs, Chief Medical Officers Group, and the Compliance Officers Forum. Dr. Conroy started her career in Charleston SC as Chair of Anesthesia and Perioperative Medicine, VPMA of the University Hospital and Senior Associate Dean of the College of Medicine at MUSC. From 2001-2008 she served as Executive Vice President of Atlantic Health System, Chief Operating Officer and President of Morristown Memorial Hospital in Morristown, New Jersey. In those roles, Dr. Conroy gained an understanding of health system operations, hospital-physician relationships, and collaborative partnerships among the various elements of academic health systems. Dr. Conroy earned her B.A. degree in chemistry from Dartmouth College, and was awarded her M.D. degree from the Medical University of South Carolina.

Center for Patient Partnerships
Rachel Grob, PhD
Rachel Grob, PhD, MA, is currently Director of National Initiatives and Scholar in Residence at the Center for Patient Partnerships (CPP), University of Wisconsin-Madison. Rachel's work at the CPP is focused on enhancing the capacity of patients to influence state and federal health policy, and on understanding and improving responsiveness of the health care system to consumers' experiences. She is also leading an array of research and field-building initiatives. Prior to joining the CPP in 2011, Rachel

was Associate Dean of Graduate Studies, Director of the Child Development Institute, and Health Advocacy Program faculty member at Sarah Lawrence College. She is also an investigator in health policy research, Robert Wood Johnson Foundation, 2006-2011. Her publications include articles and book chapters on advocacy and parental/patient perspectives on clinical issues, and her co-edited volume titled Patients as Policy Actors was published in 2011 by Rutgers University Press. She holds degrees from Wesleyan University (B.A.), Sarah Lawrence College (M.A. in Health Advocacy), and City University of New York Graduate Center (Doctorate in sociology).

CIGNA
Richard Salmon, MD, PhD
Dr. Dick Salmon, Vice President and National Medical Executive for Network Performance Improvement and Quality, CIGNA HealthCare, is responsible for the company's clinical network performance improvement initiatives and health plan quality programs. The network performance improvement initiatives include assessment of physician and hospital quality and cost efficiency, responsible communication of that information to plan members, sharing that information with physicians and hospitals and enabling and rewarding improvement through pay for performance programs. The plan quality programs include accreditation, population health improvement and credentialing. Prior to this position, Dr. Salmon developed new care facilitation programs in case management and disease management. He previously was the New England Regional Medical Director, and President and General Manager of CIGNA New Hampshire. Before joining CIGNA HealthCare, Dr. Salmon was the Senior Vice President and Chief Medical Officer for HealthSource, a three million member HMO acquired by CIGNA in 1997. Dr. Salmon has worked extensively with managed care since 1984. His career began in academic medicine at Case Western Reserve University and the affiliated University Hospital, where he was an Assistant Professor of Family Medicine and Chief Resident in Family Practice. Dr. Salmon is Board Certified in Family Practice. He earned his medical degree and a Ph.D. in Biomedical Engineering from Case Western Reserve University.

Consumers' CHECKBOOK
Robert Krughoff, JD
Robert M. Krughoff is founder and president of Center for the Study of Services/Consumers' CHECKBOOK (CSS/CHECKBOOK), an independent, nonprofit consumer organization founded in 1974. The organization publishes local versions of Consumers' CHECKBOOK magazine in seven major metropolitan areas (Seattle/Tacoma, Boston, Chicago, Minneapolis/St. Paul, Philadelphia, San Francisco/Oakland/San Jose, and Washington, DC). The magazine evaluates local service providers ranging from auto repair shops to plumbers to various types of health care providers. CHECKBOOK also has nationally distributed publications and websites to help consumers find quality and save money, including: *Guide to Top Doctors, Consumers' Guide to Hospitals, Guide to Health Plans for Federal Employees,* and *checkbook.org/patientcentral* (which has patient experience ratings of individual physicians). Krughoff also has a role in the work CSS/CHECKBOOK does in survey design, implementation, analysis, and reporting for large-scale surveys in the health care field, including CAHPS surveys of members about health plans and of patients about physicians. Before founding CSS/CHECKBOOK, Krughoff served in the U. S. Department of Health, Education, and Welfare as Director of the Office of Research and Evaluation Planning and as Special Assistant to the Assistant Secretary for Planning and Evaluation. Krughoff is a graduate of Amherst College and the University of Chicago Law School, where he was an associate editor of the *Law Review.*

Kaiser Permanente
Amy Compton-Phillips, MD
Amy Compton-Phillips, MD is the Associate Executive Director for Quality for The Permanente Federation. Amy joined The Permanente Federation in January 2010 but has been with Mid-Atlantic

Permanente Medical Group (MAPMG) since 1993. Amy is an internal medicine physician that served MAPMG in a variety of roles through years including Internal Medicine Service Chief, Physician Director for the Columbia Gateway Medical Center, Physician Director for Population Care, and Guideline Director. Amy has extensive experience in directing patient care programs, including disease management of high risk members and transitions in care for patients newly discharged from a hospital. She has also been active in developing provider and patient education programs using both print and Web-based materials, and has been a frequent presenter at public and Kaiser Permanente national seminars. Amy received her medical degree from the University of Maryland Medical School, where she also completed her residency program, and completed her undergraduate degree at Johns Hopkins University. In addition, she is a graduate of the Advanced Leadership Program at the University Of North Carolina Kenan-Flagler School Of Business. In her spare time, she enjoys skiing, biking, sailing, and carting her children around to a never ending set of after school activities.

Minnesota Community Measurement
Beth Averbeck, MD
Beth Averbeck, MD, is the Associate Medical Director, Primary Care for HealthPartners Medical Group, with expertise in health disparities, diabetes care, internal medicine, primary care redesign, and quality improvement. She has over 15 years of leadership experience in process improvement and clinical operations and plays a key role in HealthPartners Medical Group's efforts to improve quality of care for patients. Through her work and leadership in redesigning ambulatory care, the gap in mammography screening rates between white patients and patients of color in HealthPartners clinics decreased by 46 percent between 2007 and 2009. In 2010, her team was named an American Medical Group Association Acclaim Award honoree, and in 2006, her team received the Acclaim Award for implementation of reliable workflows and processes in ambulatory care. These achievements reflect her desire to improve care for patients of all communities and backgrounds. Under her leadership, HealthPartners received NCQA Medical Home recognition for all primary care clinics in 2009, and in 2010 received Minnesota Health Care Home Certification for all primary care clinics. Beth Averbeck has presented at conferences sponsored by the American Medical Group Association, the Institute for Clinical Systems Improvement, and the Institute for Healthcare Improvement in the areas of transparency, pay for performance, physician culture, electronic medical record decision support, reliability in ambulatory care and reducing disparities in health care. She also serves on the boards for Minnesota Community Measurement and the Institute for Clinical Systems Improvement. She has been with HealthPartners since 1993. She holds an academic appointment as a Clinical Assistant Professor at the University of Minnesota Medical School, where she received her medical degree. In 2010, she was honored by the *Minneapolis/St. Paul Business Journal* with a Women in Business award.

Physician Consortium for Performance Improvement
Mark L. Metersky, MD
Dr. Mark Metersky is a pulmonary and critical care physician and is Professor of Medicine and Director of the Center for Bronchiectasis Care at the University of Connecticut School of Medicine. He has published extensively on the subjects of pulmonary infections, performance measurement and quality improvement and is a frequent lecturer at national and international meetings on these areas. He was elected to be a member of the Executive Committee of the AMA Physician Consortium for Performance Improvement in 2009. He serves on the Technical Expert Panel for the Centers for Medicare and Medicaid Services National Pneumonia Project and is the clinical lead for the Medicare/AHRQ Patient Safety Monitoring System that is managed by Qualidigm (Connecticut's Medicare QIO). Dr. Metersky has had extensive experience in implementing quality improvement efforts, both at his own hospital and at a statewide level, through his work with Qualidigm. He has also served on the Quality Improvement Committee and is the Vice Chair of the Health and Science Policy Committee (the committee that oversees Clinical Practice Guideline production) for the American College of Chest Physicians.

The Alliance
Cheryl DeMars

Cheryl DeMars is the President and CEO of The Alliance, a not for profit cooperative of employers whose mission is to move health care forward by controlling costs, improving quality and engaging individuals in their health. The Alliance represents 165 employers who provide health benefits to 83,000 citizens in Wisconsin, Illinois and Iowa. Prior to assuming the position of CEO in 2006, Ms. DeMars served several roles at The Alliance providing leadership to the organization's cost and quality measurement activities, consumer engagement strategies and efforts to improve the quality and cost of health care on a community-wide basis. Prior to joining The Alliance in 1992, Ms. DeMars was a program manager at Meriter Hospital in Madison, WI. Ms. DeMars currently serves on the Board and Executive Committee of the National Business Coalition on Health. Ms. DeMars was recently appointed to the Clinician Workgroup of the National Quality Forum's Measures Application Partnership, which will provide input to the Department of Health and Human Services (HHS) on the selection of measures for use in public reporting and performance-based payment. She also serves on the Technical Advisory Committee for the Catalyst for Payment Reform. In Wisconsin, Ms. DeMars serves on the Advisory Board of the UW Population Health Institute. Ms. DeMars received a master's degree in social work from the University of Wisconsin–Madison.

Unite Here Health
Elizabeth B. Gilbertson, MS
Elizabeth B. Gilbertson is currently Chief of Strategy for UNITE HERE HEALTH *(formerly the Hotel Employees and Restaurant Employees International Union Welfare Fund)*, a national Taft-Hartley health trust that covers 246,000 lives. She was a founder and Chair/Co-Chair (1999-2010) of the Health Services Coalition, a large labor-management organization that contracts with hospitals and advocates for public policy to improve health care quality, affordability, and access in Nevada. Prior to assuming her current role, Ms. Gilbertson has held a variety of leadership roles for UNITE HERE HEALTH with a focus on the health plan operated by the Fund itself for approximately 120,000 covered lives in Las Vegas. Currently, a major focus of her work is supporting the development of intensive primary care and medical management programs that target the complex chronically ill. Her background includes experience representing nurses in collective bargaining for the Connecticut Nurses Association and District 1199, New England, SEIU. She has served on National Quality Forum task forces on ambulatory care measures, and is a Board member of the National Committee for Quality Assurance (NCQA). She holds a Bachelor's Degree in History from Smith College and Master's Degree in Health Advocacy from Sarah Lawrence College. In addition, she attended the Yale University School of Public Health and has an Associate Degree in Nursing.

Individual Subject Matter Expert Members (voting)

Disparities
Marshall Chin, MD, MPH, FACP
Marshall H. Chin, MD, MPH, FACP, Professor of Medicine at the University of Chicago, is a general internist and health services researcher with extensive experience improving the care of vulnerable patients with chronic disease. He is Director of the Robert Wood Johnson Foundation (RWJF) Finding Answers: Disparities Research for Change National Program Office, a major effort to reduce racial and ethnic disparities in health care. He was a member of the Institute of Medicine Committee on Future Directions for the National Healthcare Quality and Disparities Reports. Dr. Chin is a graduate of the University of California at San Francisco School of Medicine and completed residency and fellowship training in general internal medicine at Brigham and Women's Hospital, Harvard Medical School.

Population Health
Eugene Nelson, MPH, DSc
Dr. Nelson is Professor of Community and Family Medicine at The Dartmouth Institute for Health Policy and Clinical Practice, Dartmouth Medical School**;** Director, Population Health Measurement Program, The Dartmouth Institute**;** Director, Population Health and Measurement, Dartmouth-Hitchcock Medical Center. Dr. Nelson is a national leader in health care improvement and the development and application of measures of quality, system performance, health outcomes, value, and patient and customer perceptions. In the early 1990s, Dr. Nelson and his colleagues at Dartmouth began developing clinical microsystem thinking. His work to develop the "clinical value compass" and "whole system measures" to assess health care system performance has made him a well-recognized quality and value measurement expert. He is the recipient of The Joint Commission's Ernest A. Codman award for his work on outcomes measurement in health care. Dr. Nelson, who has been a pioneer in bringing modern quality improvement thinking into the mainstream of health care, helped launch the Institute for Healthcare Improvement and served as a founding Board Member. He has authored over 150 publications and is the first author of three recent books: (a) Quality by Design: A Clinical Microsystems Approach, (b) Practice-Based Learning and Improvement: A Clinical Improvement Action Guide: Second Edition, and (c) Value by Design: Developing Clinical Microsystems to Achieve Organizational Excellence. He received an AB from Dartmouth College, a MPH from Yale University and a DSc from Harvard University.

Shared Decision Making
Karen Sepucha, PhD

Team-Based Care
Ronald Stock, MD, MA

Health IT/ Patient Reported Outcome Measures
James M. Walker, MD, FACP
James M. "Jim" Walker, MD FACP, designs and studies health IT systems that support safe and effective care. He is the Chief Health Information Officer of the Geisinger Health System, where he leads Geisinger's development of a fully integrated inpatient and outpatient EHR; a networked patient health record (PHR) used by 145,000 patients; and a health information exchange that serves 2.5 million patients in 31 Pennsylvania counties. He is the program director of the Keystone Beacon Community. Dr. Walker serves as the chair of the Medical Informatics Committee of the American College of Physicians, as a member of the HIT Standards Committee of HHS, on the faculty of the CMIO Boot Camp of the American Medical Informatics Association, and as a member of the National Committee on Vital and Health Statistics. He leads AHRQ-funded research and development projects in health-information exchange and HIT safety and is Project Director of the Keystone Beacon Community. He has published numerous peer-reviewed articles and a widely used book, Implementing an Electronic Health Record System (2005). Dr. Walker earned his MD degree at the University of Pennsylvania before completing a residency in internal medicine at the Penn State Hershey Medical Center and a National Library of Medicine fellowship in medical informatics.

Measure Methodologist
Dolores Yanagihara, MPH
Dolores Yanagihara is director of the California Pay for Performance Program with the Integrated Healthcare Association. Her work includes overall administration of the program, guiding the governance committees, negotiating contracts to meet the program's technical needs, spearheading data exchange and data quality improvement efforts, and promoting quality and efficiency measurement and improvement nationally by sharing expertise through committee membership, publications, and speaking engagements. Ms. Yanagihara has over fifteen years experience developing, managing, and evaluating cutting edge public health programs. Her interest in public health was sparked by her tour of duty in the Peace Corps in Sierra Leone, West Africa. She earned a Masters in Public Health in Health Education and International Health from the University of Hawaii at Manoa, and a Bachelor of Science in Biology from the University of Notre Dame.

Federal Government Members (non-voting, ex officio)

Agency for Healthcare Research and Quality (AHRQ)
Darryl Gray, MD, ScD

Centers for Disease Control and Prevention (CDC)
Peter Briss, MD, MPH
Dr. Peter Briss currently serves as the Medical Director of CDC's National Center for Chronic Disease Prevention and Health Promotion. He has been with CDC and the Commissioned Corps of the US Public Health Service for more than 20 years. He has participated in a broad range of cross-disciplinary research and service particularly involving systematic reviews, evidence-informed practice, program evaluation, policy analysis, and research translation. He has applied these interests across a broad range of

health and behavioral topics ranging from health care to community prevention. He has participated in public health teaching, practice, and research at state and federal levels in the U.S. and internationally. Dr. Briss received his medical degree and training in internal medicine and pediatrics at the Ohio State University and his MPH in Health Management and Policy from the University of Michigan. He completed training in epidemiology and preventive medicine at CDC, is board certified in internal medicine and preventive medicine, and continues to serve as an active clinician at Grady Memorial Hospital in Atlanta. He has authored or coauthored approximately 80 professional publications and coedited the Guide to Community Preventive Services.

Centers for Medicare & Medicaid Services (CMS)
Michael Rapp, MD, JD, FACEP
Dr. Rapp is director of the Quality Measurement and Health Assessment Group of the Centers for Medicare and Medicaid Services. The group is responsible for evaluating measurement systems to assess healthcare quality in a broad range of settings. The group actively works with many stakeholders to promote widespread participation in the quality measurement development process. Dr. Rapp is an emergency physician and was in active clinical practice until taking his position at CMS. His public service activities include approximately four years as Chairman of the Department of HHS Practicing Physicians Advisory Council. Dr. Rapp is a fellow of the American College of Emergency Physicians, and a member of the Medical Society of Virginia, the American Medical Association, and the American Health Lawyers Association.

Health Resources and Services Administration (HRSA)
Ian Corbridge, MPH, RN
Ian Corbridge, MPH, RN, is a Public Health Policy Analyst in the Office for Health Information Technology & Quality within the Health Resources & Services Administration (HRSA). HRSA is the primary Federal agency for improving access to healthcare services for people who are uninsured, isolated or medically needy. Ian helps to oversee and align HRSA's quality improvement and performance measurement work. These efforts help to impact the quality of care and well-being for approximately 20 million Americans who benefit directly from HRSA's services. Ian has degrees in nursing and global studies from Pacific Lutheran University and a master's degree in public health from the George Washington University.

Office of the National Coordinator for HIT (ONC)
Thomas Tsang, MD, MPH

Veterans Health Administration (VHA)
Joseph Francis, MD, MPH
Dr. Francis was appointed the Chief Quality and Performance Officer for the Veterans Health Administration (VHA) in December, 2009. In this role, he leads a multi-disciplinary staff responsible for coordinating major national quality management programs, including performance measurement, utilization management, clinical practice guideline development, risk management, peer review, the credentialing and privileging of health professions, and health system accreditation. Prior to that position, he had been VHA's Deputy Chief Quality and Performance Officer. Dr. Francis received his MD degree in 1984 from Washington University in St. Louis and completed a residency and fellowship in General Internal Medicine and a Masters in Public Health at the University of Pittsburgh. Dr Francis joined the VA in 1991, and was appointed Chief Medical Officer of the VA Mid South Healthcare Network (VISN) 9 in 1996. From 2000 until 2004, Dr Francis served as Vice President for Data Management and Quality at St Vincent Hospital in Indianapolis, a 750-bed tertiary care hospital that is part of Ascension Health, the largest Catholic health system in the U.S. In that role, he implemented organizational safety, patient satisfaction, and performance improvement initiatives, and led the Corporate Compliance and Research

Compliance programs. He also led city-wide efforts to prepare for bioterrorism and to establish a smallpox response program for Indianapolis. Dr. Francis returned to VA in June, 2004 to direct its Quality Enhancement Research Initiative (QUERI), a Health Services Research and Development program to accelerate the introduction of evidence-based practices in conditions of high importance to veterans, including polytrauma, mental health, post-traumatic stress disorder, substance use disorder, chronic heart failure, ischemic heart disease, diabetes, spinal cord injury, HIV care, and stroke. From October 2006 to May, 2008, Dr. Francis served the Deputy Chief Research and Development Officer, with responsibility over administration and policy development for VA's $1.7 billion research operations. Board-certified in internal medicine, geriatrics, and medical management, Dr. Francis has been on the medical faculty of the University of Pittsburgh, University of Tennessee, and Vanderbilt University. He has conducted NIH-funded research on acute delirium among older patients, and also served as President of the Alzheimer's Association of Middle Tennessee.

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

George J. Isham, MD, MS

George Isham, M.D., M.S. is the chief health officer for HealthPartners. He is responsible for the improvement of health and quality of care as well as HealthPartners' research and education programs. Dr. Isham currently chairs the Institute of Medicine (IOM) Roundtable on Health Literacy. He also chaired the IOM Committees on *Identifying Priority Areas for Quality Improvement* and *The State of the USA Health Indicators*. He has served as a member of the IOM committee on *The Future of the Public's Health* and the subcommittees on the Environment for Committee on Quality in Health Care which authored the reports *To Err is Human* and *Crossing the Quality Chasm.* He has served on the subcommittee on performance measures for the committee charged with redesigning health insurance benefits, payment and performance improvement programs for Medicare and was a member of the IOM Board on Population Health and Public Health Policy. Dr. Isham was founding co-chair of and is currently a member of the National Committee on Quality Assurance's committee on performance measurement which oversees the Health Employer Data Information Set (HEDIS) and currently co-chairs the National Quality Forum's advisory committee on prioritization of quality measures for Medicare. Before his current position, he was medical director of MedCenters health Plan in Minneapolis and In the late 1980s he was executive director of University Health Care, an organization affiliated with the University of Wisconsin-Madison.

Elizabeth A. McGlynn, PhD, MPP

Elizabeth A. McGlynn, PhD, is the director for the Center of Effectiveness and Safety Research (CESR) at Kaiser Permanente. She is responsible for oversight of CESR, a network of investigators, data managers and analysts in Kaiser Permanente's regional research centers experienced in effectiveness and safety research. The Center draws on over 400 Kaiser Permanente researchers and clinicians, along with Kaiser Permanente's 8.6 million members and their electronic health records, to conduct patient-centered effectiveness and safety research on a national scale. Kaiser Permanente conducts more than 3,500 studies and its research led to more than 600 professional publications in 2010. It is one of the largest research institutions in the United States. Dr. McGlynn leads efforts to address the critical research questions posed by Kaiser Permanente clinical and operations leaders and the requirements of the national research community. CESR, founded in 2009, conducts in-depth studies of the safety and comparative effectiveness of drugs, devices, biologics and care delivery strategies. Prior to joining Kaiser Permanente, Dr. McGlynn was the Associate Director of RAND Health and held the RAND Distinguished Chair in Health Care Quality. She was responsible for strategic development and oversight of the research portfolio, and external dissemination and communications of RAND Health research findings. Dr. McGlynn is an internationally known expert on methods for evaluating the appropriateness and technical

quality of health care delivery. She has conducted research on the appropriateness with which a variety of surgical and diagnostic procedures are used in the U.S. and in other countries. She led the development of a comprehensive method for evaluating the technical quality of care delivered to adults and children. The method was used in a national study of the quality of care delivered to U.S. adults and children. The article reporting the adult findings received the Article-of-the-Year award from AcademyHealth in 2004. Dr. McGlynn also led the RAND Health's COMPARE initiative, which developed a comprehensive method for evaluating health policy proposals. COMPARE developed a new microsimulation model to estimate the effect of coverage expansion options on the number of newly insured, the cost to the government, and the effects on premiums in the private sector. She has conducted research on efficiency measures and has recently published results of a study on the methodological and policy issues associated with implementing measures of efficiency and effectiveness of care at the individual physician level for payment and public reporting. Dr. McGlynn is a member of the Institute of Medicine and serves on a variety of national advisory committees. She was a member of the Strategic Framework Board that provided a blueprint for the National Quality Forum on the development of a national quality measurement and reporting system. She chairs the board of AcademyHealth, serves on the board of the American Board of Internal Medicine Foundation, and has served on the Community Ministry Board of Providence-Little Company of Mary Hospital Service Area in Southern California. She serves on the editorial boards for Health Services Research and The Milbank Quarterly and is a regular reviewer for many leading journals. Dr. McGlynn received her BA in international political economy from Colorado College, her MPP from the University of Michigan's Gerald R. Ford School of Public Policy, and her PhD in public policy from the Pardee RAND Graduate School.

National Quality Forum Staff

Janet M. Corrigan, PhD, MBA

Janet M. Corrigan, PhD, MBA, is president and CEO of the National Quality Forum (NQF), a private, not-for-profit standard-setting organization established in 1999. The NQF mission includes: building consensus on national priorities and goals for performance improvement and working in partnership to achieve them; endorsing national consensus standards for measuring and publicly reporting on performance; and promoting the attainment of national goals through education and outreach programs. From 1998 to 2005, Dr. Corrigan was senior board director at the Institute of Medicine (IOM). She provided leadership for IOM's Quality Chasm Series, which produced 10 reports during her tenure, including: To Err is Human: Building a Safer Health System, and Crossing the Quality Chasm: A New Health System for the 21st Century. Before joining IOM, Dr. Corrigan was executive director of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Among Dr. Corrigan's numerous awards are: IOM Cecil Award for Distinguished Service (2002), American College of Medical Informatics Fellow (2006), American College of Medical Quality Founders' Award (2007), Health Research and Educational TRUST Award (2007), and American Society of Health System Pharmacists' Award of Honor (2008). Dr. Corrigan serves on various boards and committees, including: Quality Alliance Steering Committee (2006–present), Hospital Quality Alliance (2006–present), the National eHealth Collaborative (NeHC) Board of Directors (2008–present), the eHealth Initiative Board of Directors (2010–present), the Robert Wood Johnson Foundation's Aligning Forces for Healthcare Quality (AF4Q) National Advisory Committee (2007–present), the Health Information Technology (HIT) Standards Committee of the U.S. Department of Health and Human Services (2009–present), the Informed Patient Institute (2009 – present), and the Center for Healthcare Effectiveness Advisory Board (2011 – present). Dr. Corrigan received her doctorate in health services research and master of industrial engineering degrees from the University of Michigan, and master's degrees in business administration and community health from the University of Rochester.

NATIONAL QUALITY FORUM

Thomas B. Valuck, MD, JD, MHSA
Thomas B. Valuck, MD, JD, is senior vice president, Strategic Partnerships, at the National Quality Forum (NQF), a nonprofit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Dr. Valuck oversees NQF-convened partnerships—the Measure Applications Partnership (MAP) and the National Priorities Partnership (NPP)—as well as NQF's engagement with states and regional community alliances. These NQF initiatives aim to improve health and healthcare through public reporting, payment incentives, accreditation and certification, workforce development, and systems improvement. Dr. Valuck comes to NQF from the Centers for Medicare & Medicaid Services (CMS), where he advised senior agency and Department of Health and Human Services leadership regarding Medicare payment and quality of care, particularly value-based purchasing. While at CMS, Dr. Valuck was recognized for his leadership in advancing Medicare's pay-for-performance initiatives, receiving both the 2009 Administrator's Citation and the 2007 Administrator's Achievement Awards. Before joining CMS, Dr. Valuck was the vice president of medical affairs at the University of Kansas Medical Center, where he managed quality improvement, utilization review, risk management, and physician relations. Before that he served on the Senate Health, Education, Labor, and Pensions Committee as a Robert Wood Johnson Health Policy Fellow; the White House Council of Economic Advisers, where he researched and analyzed public and private healthcare financing issues; and at the law firm of Latham & Watkins as an associate, where he practiced regulatory health law. Dr. Valuck has degrees in biological science and medicine from the University of Missouri-Kansas City, a master's degree in health services administration from the University of Kansas, and a law degree from the Georgetown University Law School.

Aisha Pittman, MPH
Aisha T. Pittman, MPH, is a Senior Program Director, Strategic Partnerships, at the National Quality Forum (NQF). Miss Pittman leads the Clinician Workgroup and the Post-Acute Cae/Long-Term Care Workgroup of the Measure Applications Partnership (MAP). Additionally, Ms. Pittman leads an effort devoted to achieving consensus on a measurement framework for assessing the efficiency of care provided to individuals with multiple chronic conditions. Ms. Pittman comes to NQF from the Maryland Health Care Commission (MHCC) where she was Chief of Health Plan Quality and Performance; responsible for state efforts to monitor commercial health plan quality and address racial and ethnic disparities in health care. Prior to MHCC, Ms. Pittman spent five years at the National Committee for Quality Assurance (NCQA) where she was responsible for developing performance measures and evaluation approaches, with a focus on the geriatric population and Medicare Special Needs Plans. Ms. Pittman has a bachelor of science in Biology, a bachelor of Arts in Psychology, and a Masters in Public Health all from The George Washington University. Ms. Pittman was recognized with GWU's School of Public Health and Health Services Excellence in Health Policy Award.

Taroon Amin, MPH, MA
Taroon Amin, MPH, MA, is Senior Director in Strategic Partnerships and Performance Measures, at the National Quality Form (NQF), a nonprofit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Mr. Amin provides leadership support to multiple workgroups within the Measures Applications Partnership (MAP) and resource measures under NQF-review in the Consensus Development Process (CDP). Mr. Amin comes to NQF from the Schneider Institutes for Health Policy at Brandeis University, where he was an Agency for Health Care Research and Quality (AHRQ T-32) fellow. During his time there, Taroon worked with Health Care Incentives Improvement Institute (HCI3), American Board of Medical Specialties Research and Education Foundation (ABMS-REF), and American Medical Association-convened Physicians Consortium for Performance Improvement (AMI-PCPI) to develop the Patient-Centered Episode Grouper System (PACES), a public sector episode grouper system for the Medicare Program. Also at Schneider,

Taroon worked with the American Association of Medical Colleges and Teaching Hospitals (AAMC) on the development of Health Innovation Zones (HIZs) in response to Section XVIII of the Patient Protection and Affordable Care Act and also worked with the Government of India on the evaluation of public sector insurance schemes. Before joining Schneider, Taroon led Six Sigma/ Lean quality improvement projects at New York-Presbyterian Hospital, the University Hospitals of Cornell and Columbia and the Morgan Stanley Children's Hospital. Taroon holds a degree in international health systems management from Case Western Reserve University with his international training from Tsinghua University (Beijing), École des Sciences Politiques (Paris) and the Indian Institute of Management (Ahmedabad). Taroon also holds a master's degree in public health from Columbia University and a master's degree in social policy from Brandeis University, where he is currently a PhD candidate. Philanthropically, Mr. Amin serves as founding member of International Health Care Leadership (IHL), an independent non-profit organization developed to train Chinese healthcare professionals how to incorporate healthcare public policy into healthcare reform and hospital management.

Mitra Ghazinour, MPP

Mitra Ghazinour, MPP, is project manager, Strategic Partnerships, at the National Quality Forum (NQF), a nonprofit membership organization with the mission to build consensus on national priorities and goals for performance improvement and endorse national consensus standards for measuring and publicly reporting on performance. Ms. Ghazinour is currently supporting the work of the NQF Measure Applications Partnership (MAP) Clinician and Post-Acute/Long-Term Care (PAC/LTC) workgroups. Prior to working at NQF, she was a research analyst III at Optimal Solutions Group, LLC, serving as the audit team leader for the Evaluation & Oversight (E&O) of Qualified Independent Contractors (QIC) project. Her responsibilities as audit team leader included serving as a point of contact for QIC and CMS, conducting interviews with QIC staff, reviewing case files, facilitating debriefings and meetings, and writing evaluation reports. Ms. Ghazinour also served as the project manager for the Website Monitoring of Part D Benefits project, providing project management as well as technical support. Additionally, she provided research expertise for several key projects during her employment at IMPAQ International, LLC. In the project, Development of Medicare Part C and Part D Monitoring Methods for CMS, Ms. Ghazinour assisted with the collaboration between CMS and IMPAQ on a broad effort to review, analyze, and develop methods and measures to enhance the current tools CMS uses to monitor Medicare Advantage (Part C) and Prescription Drug (Part D) programs. In another effort to support CMS, Ms. Ghazinour coordinated the tasks within the National Balancing Contractor (NBIC) project which entailed developing a set of national indicators to assess states' efforts to balance their long-term support system between institutional and community-based supports, including the characteristics associated with improved quality of life for individuals. She also provided analytic support for the development of the report on the Medicare advantage value-based purchasing programs as part of her work on the Quality Improvement Program for Medicare Advantage Plans project at IMPAQ. Ms. Ghazinour has a Master's degree in Public Policy and a bachelor's degree in Health Administration and Policy Program (Magna Cum Laude) from the University of Maryland, Baltimore County (UMBC).

Rachel Weissburg

Rachel Weissburg is currently employed at the National Quality Forum, a non-profit, multi-stakeholder organization, as part of its Strategic Partnerships department. Specifically, she supports the Measure Applications Partnership, which provides the Dept. of Health and Human Services input on public reporting and payment-based reporting programs. Before coming to NQF Ms. Weissburg worked at The Endocrine Society, the world's oldest and largest association of endocrinologists. She created and managed programs for the Society's public education affiliate, The Hormone Foundation, and collaborated with clinicians – endocrinologists and family practice doctors – to understand their needs and priorities. Under her supervision, the Foundation's award-winning patient materials reached nearly 2

million patients with information about conditions such as diabetes, osteoporosis, growth hormone use, and infertility. Before working with The Hormone Foundation, Ms. Weissburg spent over four years with The Leapfrog Group, a health care membership organization representing purchasers of health care. While at Leapfrog, Ms. Weissburg was responsible for writing the first national policy that asked hospitals to openly acknowledge serious reportable events – or “never events” – and take remedial action if these events occurred in their facilities. She also worked closely with the Centers for Medicare and Medicaid Services, health plans, and other stakeholders to implement similar policies and shift reimbursement models from a fee-for-service to a fee-for-outcome model. She also managed Leapfrog’s membership of Fortune 500 companies and coordinated regional implementation of its transparency and quality initiatives in over twenty-seven communities nationwide.

MEASURE APPLICATIONS PARTNERSHIP
COORDINATING COMMITTEE
Convened by the National Quality Forum

Summary of In-Person Meeting #1

An in-person meeting of the Measure Applications Partnership (MAP) Coordinating Committee was held on Tuesday, May 3 and Wednesday, May 4, 2011. For those interested in reviewing an online archive of the web meeting please click on the link below:

http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Coordinating_Committee.aspx

The next meeting of the Coordinating Committee will be an in-person meeting on June 21-22, 2011, in Washington, DC.

Committee Members in Attendance at the May 3-4, 2011 Meeting:

George Isham (Co-Chair)
Elizabeth McGlynn (Co-Chair)
Richard Antonelli
David Baker, ACP
Christine A. Bechtel, National Partnership for Women and Families
Bobbie Berkowitz
Joseph Betancourt
Judith A. Cahill, AMCP
Mark R. Chassin, The Joint Commission
Maureen Dailey, ANA (substitute for Marla Weston)
Suzanne F. Delbanco, Catalyst for Payment Reform
Joyce Dubow, AARP
Steven Findlay, Consumers Union
Nancy Foster, AHA (substitute for Rhonda Anderson)
Victor Freeman, HRSA
Foster Gesten, NAMD
Aparna Higgins, AHIP
Eric Holmboe, ABMS (substitute for Christine Cassel)
Chip N. Kahn, FAH
William E. Kramer, PBGH
Sam Lin, AMGA
Karen Milgate, CMS
Elizabeth Mitchell (phone), MHMC
Ira Moscovice
Michael A. Mussallem, AdvaMed
John O'Brien, OPM
Peggy O'Kane, NCQA
Frank G. Opelka, ACS
Cheryl Phillips, LeadingAge
Harold Pincus
Carol Raphael
Chesley Richards, CDC
Gerald Shea, AFL-CIO
Carl A. Sirio, AMA
Thomas Tsang, ONC
Nancy J. Wilson, AHRQ

This was the first in-person meeting of the Measure Applications Partnership Coordinating Committee. The primary objectives of the meeting were to:

- Establish the decision making framework for the MAP,
- Consider measure selection criteria,
- Finalize workgroup charges,
- Review the Ad Hoc Safety Workgroup roster, and
- Direct workgroups to consider measurement strategies for HACs and readmissions.

Committee Co-Chairs, George Isham and Beth McGlynn, as well as Janet Corrigan, President and CEO, NQF, began the meeting with a welcome and introductions. This was followed by disclosures of interest by the Committee and a review of the MAP member responsibilities and media policies.

Tom Valuck, Senior Vice President, Strategic Partnerships, NQF, provided an overview of the Coordinating Committee charge and brief review of the strategies and models that contribute to the MAP decision making framework. These inputs include the HHS National Quality Strategy, the HHS Partnership for Patients safety initiative, the NQF-endorsed Patient-focused Episode of Care Model, and the high impact conditions as identified by the NQF-convened Measure Prioritization Advisory Committee. Regarding the high impact conditions, the Committee discussed the importance of viewing these lists as inputs to the MAP, not limitations, and the need to consider how measurement may impact persons with multiple chronic conditions. NQF staff raised how the HHS Multiple Chronic Conditions Framework and the Multiple Chronic Conditions Performance Measurement Framework (currently in development as an NQF project under contract with HHS) will help support this consideration.

The Committee members drew for their terms of membership. The chart below presents the terms for all Coordinating Committee members.

Helen Burstin, Senior Vice President, Performance Measures, NQF, provided background information on NQF's current endorsement criteria. Tom Valuck discussed the relationships among the roles of the National Priorities Partnership, a multi-stakeholder group that provides input to the HHS National Quality Strategy; the role of measure endorsement, which endorses measures for public reporting and quality improvement; and the role of the MAP in selecting measures for particular purposes, such as public reporting and payment reform.

Tom Valuck, Helen Burstin, and Beth McGlynn discussed how the measure selection criteria, which are currently in development and will be used by the MAP with regard to selection of measures, should not duplicate the endorsement criteria and are meant to build on the foundation of endorsement. Arnie Milstein, Director, Stanford Clinical Excellence Research Center, presented the work of the MAP measure selection criteria project. The Committee's discussion led to the following considerations that the measure selection criteria should address:

- Promoting 'systemness' and shared accountability,
- Addressing the various levels of accountability in a cascading fashion to contribute to a coherent measure set,
- Enabling action by providers,
- Helping consumers make rational judgments,
- Assessing quantifiable impact and contributing to improved outcomes, and
- Considering and assessing the burden of measurement.

Additionally, consideration was given to tailoring the criteria for various purposes (e.g., payment reform, public reporting, and program evaluation), addressing public/private alignment, and contributing to parsimony.

George Isham and Nalini Pande, Senior Director, Strategic Partnerships, NQF, discussed the charges and tasks for each of the Workgroups. In discussing the workgroup charges, the Committee offered the following considerations for all of the workgroups:

- While addressing the specific HHS tasks contractually outlined, each workgroup should consider alignment with the private sector;
- Given that this work is on a short timeline, each workgroup should take the timeline into consideration, setting expectations accordingly and identifying what work will need to be done in subsequent phases; and
- There should be a focus on models of care rather than individual measures.

Further, the Coordinating Committee proposed the following:

- The Hospital Workgroup should consider cancer care beyond PPS-exempt cancer hospitals.
- The Dual Eligible Beneficiaries Workgroup should consider opportunities for cross-linking with the post-acute care/long-term care tasks.
- The Post-Acute Care/Long-Term Care Workgroup should specifically look at quality from a family perspective of hospice care delivery.

The first day of the meeting concluded with a review of the evening assignment where Committee Members were asked to further consider a list of inputs to the measure selection criteria; specifically, members were asked to identify historical sets of criteria that should be considered and to recommend additional strategies to resolve the criteria gaps and conflicts in existing criteria. Committee Members were asked to email the Co-Chairs and NQF staff with any additional information they would like to share after the meeting.

The second day of the meeting began with Beth McGlynn providing a recap of day 1, followed by the full Committee providing comments regarding the evening assignment. Additional considerations raised regarding the measure selection criteria included the following:

- Resource use, efficiency, and cost need to be explicitly addressed within the criteria;
- Appropriateness needs to be considered as efficiency cannot be addressed without considering appropriateness;
- Patient preference should be incorporated;
- While there is agreement that there needs to be 'systemness', it is a data challenge to do so, therefore, usability and feasibility need to be addressed to promote 'systemness';
- Measures need to serve multiple audiences and cross points of delivery;
- The criteria stress test needs to look for unintended consequences.

George Isham and Nalini Pande reviewed the healthcare-acquired conditions (HACs) and readmissions tasks, including the formation of the Ad Hoc Safety Workgroup. The Ad Hoc Safety Workgroup must be composed of MAP workgroup members that have already been vetted through the nomination and roster review process. The Committee's Co-Chairs proposed that the Ad Hoc Safety Workgroup be composed of the Hospital Workgroup and all the payers and purchasers represented on the other MAP workgroups and the Coordinating Committee. The Committee accepted this recommendation, while noting that the Ad Hoc Safety Workgroup should invite additional experts to present during Safety

Workgroup meetings. Regarding the charge of the Ad Hoc Safety Workgroup, the Coordinating Committee discussed that alignment of the strategy for addressing HACs and readmissions is more important to this task than specific metrics. Additionally, the current set of metrics does not address regional variation.

The meeting concluded with a summary of day 2 and discussion of next steps. The next meeting of the Coordinating Committee will be in-person on June 21-22, in Washington, DC.

Coordinating Committee Member Terms, Beginning May 2011

1-Year Term	2-Year Term	3-Year Term
National Partnership for Women and Families, represented by Christine A. Bechtel, MA	Bobbie Berkowitz, PhD, RN, CNAA, FAAN	AHA, represented by Rhonda Anderson, RN, DNSc, FAAN
The Joint Commission, represented by Mark R. Chassin, MD, FACP, MPP, MPH	Joseph Betancourt, MD, MPH	Richard Antonelli, MD, MS
Catalyst for Payment Reform, represented by Suzanne F. Delbanco, PhD	AMCP, represented by Judith A. Cahill	ACP, represented by David Baker, MD, MPH, FACP
HRSA, represented by Victor Freeman, MD, MPP	ABMS, represented by Christine Cassel, MD	NAMD, represented by Foster Gesten, MD
AHIP, represented by Aparna Higgins, MA	AARP, represented byJoyce Dubow, MUP	George Isham, MD, MS
PBGH, represented by William E. Kramer, MBA	Consumers Union, represented by Steven Findlay, MPH	Elizabeth McGlynn, PhD, MPP
MHMC, represented by Elizabeth Mitchell	FAH, represented by Chip N. Kahn	CMS, represented by Karen Milgate, MPP
LeadingAge, represented by Cheryl Phillips, MD, AGSF	AMGA, represented by Sam Lin, MD, PhD, MBA, MPA, MS	Ira Moscovice, PhD
Harold Pincus, MD	ACS, represented by Frank G. Opelka, MD, FACS	AdvaMed, represented by Michael A. Mussallem
Carol Raphael, MPA	AMA, represented by Carl A. Sirio, MD	OPM, represented by John O'Brien
AFL-CIO, represented by Gerald Shea	ONC, represented by Thomas Tsang, MD, MPH	NCQA, represented by Peggy O'Kane, MPH
AHRQ, represented by Nancy J. Wilson, MD, MPH	ANA, represented by Marla J. Weston, PhD, RN	CDC, represented by Chesley Richards, MD, MPH